Strategic Plan for Opioid Settlement Funds

Bernalillo County and City of Albuquerque

October 16, 2024

Prepared by Vital Strategies

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Executive Summary

The overdose crisis in the U.S. has had a devastating impact on families and communities in Bernalillo County which experienced the highest number of overdose deaths in New Mexico, with an estimated 456 lives lost in 2021. In 2021, the first of several major settlements resulted from state and local government-led litigation against pharmaceutical manufacturers, distributors and retailers which aimed to hold them accountable for their role in the overdose crisis. Bernalillo County and the City of Albuquerque, in response to mirror Resolutions in October 2023 on developing a plan for spending the opioid settlement dollars, selected Vital Strategies to facilitate the strategic planning process. The City and County's call for this Strategic Plan represents a collaborative and forward-thinking approach to addressing the ongoing overdose crisis.

The development of the Strategic Plan involved a multi-phase approach from April to October 2024 that included coordinating technical assistance and planning with the City and County, conducting a rapid landscape analysis, and facilitating community engagement.

- Public input activities included extensive outreach culminating in a series of town halls, listening sessions, and interviews to ensure this Plan was community-informed and aligned with the needs and experiences of City and County residents. More than 1,700 individuals provided public input between May and September. Due to high public interest, the community engagement process was significantly expanded, doubling the number of planned activities and extending the timeline by more than twice the original length.
- The VOICES New Mexico study was designed to complement drug use epidemiology data and community engagement efforts specifically to develop this Plan. The study was tailored to the local context and recruited a high proportion of Native and Hispanic individuals to hear direct perspectives of people who use drugs between June and July.
- The Rapid Landscape Analysis assembled available data sources between April and August to provide a snapshot of the status of drug-related overdose risk in the City and County as well as identify opportunities to strengthen data collection and analysis.

The Strategic Plan outlines the foundational, goals, values, principles and recommendations for spending opioid settlement funds. This initial Plan balances between addressing urgent, high-impact investments today and facilitating inclusive, evidence-driven planning for the lifespan of the funds which will be distributed up to an 18-year period. By concentrating on local initiatives, the recommendations aim to maximize the immediate impact, foster local capacity and sustainability, and align with existing local priorities.

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The 28 recommendations are informed by community input, overdose data, and best practices. The recommendations offer a flexible framework for future collaborative decision-making, ensuring an inclusive process that addresses the needs of all Albuquerque City and Bernalillo County communities.

Collaborative Planning and Coordination

1. Formalize Intergovernmental Cooperation
2. Dedicated Coordination Role
3. Native Nations Consultation and Collaboration
4. Community Advisory Board

Inclusive Funding and Financing Strategies

5. Low Barrier Funding
6. Fund Culturally Specific Services and Programs
7. Native Nations Allocation
8. Provider Participation in Medicaid

Accountable Monitoring and Evaluation

9. Data-Driven Approach
10. Transparency and Reporting

Equity-centered Interventions

11. Prioritize Key Populations
12. Compassionate Messaging

Crisis Response

13. Expand Mobile Crisis Response Services
14. Treatment Through Emergency Medical Services
15. Leveraging the Sobering Center

Prevention

16. Comprehensive Education
17. Connecting Disconnected Youth

Harm Reduction

18. Safer Use Supplies
19. Naloxone Where it Counts
20. Overdose Prevention Center
21. Caring for People Who Use Stimulants

Treatment

22. Treatment Expansion in Jail
23. Community-Based Treatment Access and Quality

Recovery

24. Comprehensive Recovery Support
25. Recovery Housing

Stabilizing Supports

26. Anti-Discrimination Policies
27. Peer Support
28. Civil Legal Aid

Finally, this Plan is a roadmap for action and its flexibility ensures adaptability to evolving needs over the long term, while its emphasis on urgency and collaboration aim to drive short term impacts. By implementing these recommendations, the City and County can leverage opioid settlement funds to save lives, improve health, and enhance the well-being of the community.

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Acknowledgements

Vital Strategies would like to thank the thousands of community members, organizations, service providers, elected and government officials who participated in this process.

Strategic Plan developed and funded by Vital Strategies:

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VOICES New Mexico supported by Pacific Institute for Research and Evaluation, with grant funding from Johns Hopkins Bloomberg School of Public Health and Vital Strategies:

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Community engagement led by SBS Evaluation & Program Development Specialists, LLC, with grant funding from Vital Strategies:

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Aida Revilla, Research Associate
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Tia Bland, Communications Services Director
Kristen Ferguson, Communications Specialist
Tracy Dingmann, Webmaster
Estevan Vásquez, Communications Coordinator
The County Commission for their support of alignment and impact of funding

Planning and coordination in collaboration with City of Albuquerque:

Gilbert Ramirez, Director of Health, Housing and Homelessness
Ellen Braden, Deputy Director of Special Projects and Innovations
Reina Martinez Division Manager of Behavioral Health and Wellness
Connor Woods, Public Affairs Specialist
Mayor Timothy M. Keller and Samantha Sengel, EdD for their support of persons experiencing opioid addiction
The Albuquerque City Council for their support of alignment and impact of funding, specifically Councilors Brook Bassan, Tammy Fiebelkorn, and Renée Grout

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1. Introduction

The overdose crisis in the United States has had devastating impacts on families and communities. The City of Albuquerque and Bernalillo County have long had a history of collaboration to continuously improve the behavioral health system, as well as engaged in individual City and County-level planning initiatives and efforts to bolster the health and wellbeing of this community. However, like many other areas, they have faced challenges such as economic disruption, housing crises, and the global pandemic, all of which have contributed to increased vulnerability to overdose. Nearly everyone in these communities has been affected by drug use or societal responses to it.

In 2021, a new opportunity arose with nationwide settlements holding pharmaceutical distributors accountable for their role in the overdose crisis. By 2023, agreements were finalized with pharmacy chains and manufacturers, leading to the allocation of funds to states and local governments. On October 26, 2023, the City of Albuquerque and Bernalillo County passed mirror Resolutions R23-174 and AR 2023-105 requiring that City and County leadership develop a strategic plan on how to spend opioid settlement dollars before more funds are spent. These resolutions laid the groundwork for a strategic approach to using opioid settlement funds. Recognizing the importance of community input and evidence-based decision-making, the resolutions mandated the development of a comprehensive strategic plan by an outside entity. In response to these directives, the City and County selected Vital Strategies to facilitate the strategic planning process.

Since April 2024, Vital Strategies has worked closely with the City of Albuquerque and Bernalillo County to facilitate community input and solicit feedback from individuals, families, communities and professionals around the needs, barriers, facilitators, and opportunities that can inform the strategic use of the opioid settlement dollars. Vital also worked with subject matter experts locally and in state government to acquire data and assess the full landscape of the community. Through this robust process of information gathering and collaboration, Vital and partners drafted the following: a *Strategic Plan for Opioid Settlement Funds.*

Scope of Strategic Plan

Through extensive community engagement and landscape analysis, this Strategic Plan outlines the foundational principles, goals, values, and recommendations for managing opioid settlement dollars. At the outset of this effort, the vision was to create guidance that will support

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the foundation and infrastructure for a long-term process, as opioid settlement dollars will be distributed over the course of up to 18 years. The plan was developed with input from the community and analysis of the local landscape. It is designed as a living document that integrates flexibility, allowing the plan to adapt over time, while responding to shifts in community needs and leadership. This is not a one-and-done effort; the plan emphasizes a balance between addressing urgent, high-impact investments and facilitating inclusive, evidence-driven planning.

The plan provides a basis from which to create and assess spending proposals and initiatives with a clear rationale and justification that considers key questions:

- How is this investment supported by available local data?
- How is this investment supported by the evidence?
- How is this investment supported by public input?
- How will this investment be sustainable?
- Is this investment consistent with local resolutions and with the national settlements?

While the plan outlines recommended strategies and investments, it is not a detailed spend plan nor an implementation plan. The plan does not dictate specific methods (e.g., competitive RFPs) for allocating funds. It lays out strategies but does not provide detailed action steps, leaving room for future collaborative decisions to define the next stages of the process. This plan and its recommendations emphasize the need for a collaborative approach to decision-making, ensuring that the next steps are determined through a process that involves key stakeholders and aligns with long-term community goals. This strategic approach encourages fostering sustainable, evidence-based investments while remaining inclusive and responsive to all Albuquerque City and Bernalillo County communities.

Planning Team

Following resolutions from both the Bernalillo County Commission and the City of Albuquerque, the lead team for the County and City developed a Memorandum of Understanding (MOU) with Vital Strategies to lead the work to develop a strategic plan for use of opioid settlement funds. Vital Strategies is a global health organization that believes every person should be protected by a strong public health system. Our overdose prevention program works to strengthen and scale evidence-based, data-driven policies and interventions to create equitable and sustainable reductions in overdose deaths. Work across seven U.S. states is supported by funding from the Bloomberg Philanthropies Overdose Prevention Initiative, launched in 2018, and by targeted investments from other partners.

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To meet the requirements outlined in the resolution, and to make sure that opinions and ideas from the community and the people who have been most impacted by the overdose crisis is received, Vital Strategies hired a local consultant, SBS Evaluation & Program Development Specialists, LLC, who served as a community engagement organizer to conduct outreach and facilitate conversations with community members on how opioid settlement funds should be spent.

Throughout the planning process, Vital Strategies regularly coordinated and worked in concert with staff in the Bernalillo County Manager's Office and City of Albuquerque's Department of Health, Housing, and Homelessness. The Bernalillo County Commission and the Albuquerque City Council co-hosted townhalls to gather public input and received progress reports from the planning team regularly.

2. Background

Overdose Crisis

Drug overdoses are a leading cause of accidental deaths in the United States. In the U.S., over 100,000 people die each year to overdose and over 1 million people have died from overdose since 1999.[1] In 2022, over 75% of overdose deaths involve an opioid.[1] Opioids like oxycodone, heroin, and fentanyl are types of drugs that relieve pain. Drug overdose happens when an individual has taken too much of one or more substances. Overdoses can be accidental or intentional and cause serious medical problems or death. Over the past few years, deaths involving illegally made fentanyl have been on the rise.[2] Nationally, deaths caused by the use of drugs like cocaine and methamphetamine are also increasing.[3]

The overdose crisis affects all people—rich or poor, rural, or urban, people of color and white people—but not all populations have been affected the same. Between 2021 and 2022, the rate of drug overdose deaths increased for Native, Black, Hispanic, and Asian populations.[3] The overdose crisis is complex and has changed over time with many deaths now involving synthetic opioids like fentanyl, and increasingly, stimulants like methamphetamine.[3]

In 2021, New Mexico had the 6th highest overdose rate in the country, with an estimate of 1029 overdose deaths and an overdose rate of 50.6.[4] This means that for every 100,000 people in New Mexico, an average of 50.6 people died from an overdose. Just as the impact of the overdose crisis varies from state to state with some states having a higher rate of overdose than

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others, there are also differences in overdose rates county by county within states. In 2021, Bernalillo County experienced the highest number of overdose deaths in the state of New Mexico, with an estimated 456 overdoses.[4] While Bernalillo County did not have the highest overdose rate of all New Mexico counties, the county's overdose rate of 66.3 was higher than the state's rate.[2] Almost half (44%) of the overdoses in New Mexico in 2021 happened in Bernalillo County. [4]

Recent data shows a promising decline in overdose deaths nationwide and in New Mexico.[5] This encouraging trend may be due to a combination of factors, including changes in drug use practices, shifts in the drug supply, and increased public health efforts. Investments in harm reduction strategies and a shift away from punitive responses have been crucial in mitigating the impact of the volatile drug supply. While these positive developments are encouraging, it is important to note that overdose deaths continue to disproportionately affect Black, Hispanic and Native populations. To address this inequity, local governments play a critical role in investing in public health responses that are equitable and inclusive.

Opioid Settlement Funds

"Opioid settlement funds" mean funds resulting from lawsuits filed by state and local governments against companies whose actions are alleged to have contributed to the opioid overdose crisis. They include money from settlements with pharmaceutical distributors, manufacturers, and retail pharmacies. All 50 states and U.S territories will receive a share of more than $50 billion in opioid settlement funds in varying payments over 18 years. Separate settlements totaling more than $1.5 billion are available to federally recognized Tribes and Tribal health organizations. Each state is dividing settlement funds between state and local governments in its own way.

New Mexico will receive around $1 billion dollars over 18 years. Forty-five percent (45%) of the funds will go to the state and 55% will go to local governments. As of October 10, 2024, Bernalillo County had received roughly $24 million and the City of Albuquerque had received roughly $28 million in opioid settlement funds so far, with more dollars expected in future years through the current settlements and potentially ongoing litigation efforts.

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Table 1: Bernalillo County opioid settlement fund expenditures, as of October 10, 2024

Bernalillo County Revenue	$24,344,688.86
Expenditure Line Item	Expenditure Amount
Keep NM Alive Marketing Campaign	$1,002,571.56
City of Albuquerque Reimbursement	($300,000.00)
Metropolitan Detention Center Buprenorphine Program	$256,991.22
Youth Services Center Opioid Settlement Funds	$ -
Outstanding Purchase Orders	$179,968.28
Balance	$23,205,157.80

Table 2: City of Albuquerque opioid settlement fund expenditures, as of October 10, 2024

City of Albuquerque Revenue	$27,700,000.00 estimated
Metropolitan Detention Center Medication Assisted Treatment	$1,500,000.00
Keep NM Alive Media Campaign	$300,000.00
Support Services for Treatment and Recovery	$1,200,000.00
Other Strategies for Opioid Treatment Support Programs	$900,000.00
Recovery Micro Community	$5,000,000.00
Balance	$18,800,000.00 estimated

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Opioid settlement funds are meant to address harm caused by the opioid overdose crisis. As Johns Hopkins Bloomberg School of Public Health states: "Given the economic downturn, many states and localities will be tempted to use opioid settlement dollars to fill holes in their budgets rather than expand needed opioid programs. Jurisdictions should use the funds to supplement rather than replace existing spending".[6] Local governments in New Mexico must spend opioid settlement funds on programming and policies to address harms caused by the opioid overdose crisis (i.e., "Opioid Related Expenditure[s]," defined by the New Mexico Opioid Allocation Agreement as "expenditure[s] consistent with the categories enumerated in Exhibit E to the Distributor Master Settlement Agreement and the J&J Master Settlement Agreement")[7]. These uses include prevention, harm reduction, treatment, recovery, and other strategies[1] to support people who use opioids or have an opioid use disorder, as well as those with co-occurring Substance Use Disorder. In New Mexico, 100% of funds from the 55% local share have to be spent on opioid-related expenditures and localities may not use funds to reimburse costs incurred prior to the applicable settlement agreement.[8] This presents an opportunity to fund programs and initiatives that have not been funded in the past.

3. Goals, Guiding Values, and Principles

The development of this Strategic Plan was guided by core principles of good governance, aligning with the values and principles that the City of Albuquerque and Bernalillo County have incorporated into their various planning initiatives. This plan aims to complement and strengthen existing efforts, rather than conflict with or replace them, by focusing specifically on how settlement funds will be allocated within the broader governance landscape of the City and County. A unified and overarching vision is essential to ensure a coordinated, cross-sectoral approach to addressing the overdose crisis and to promoting the effective management of resources.

In this section, we outline the three key elements that shape the overarching vision of this Strategic Plan:

- **Goals:** Set the *vision* – the ultimate destination and the outcomes we aim to achieve through this plan.

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- **Values:** Establish the *foundation* – the core beliefs and priorities that guide and influence all decisions.
- **Principles:** Provide the *framework* – the practical steps and guidelines that direct how we will achieve our goals.

These elements work in unison to ensure that the Strategic Plan remains focused, values-driven, and systematically executed.

Goals

The goal of this Strategic Plan document is to reflect "careful, deliberate, and strategic use of opioid settlement funding" as defined in the City and County's mirror Resolutions.

Table 3: Objectives and Outcomes of the Strategic Plan

Objectives include:	To foster structural outcomes of:	Resulting in population outcomes of:
• **Support the foundation and infrastructure for a long-term, multi-year process** • **Promote a collaborative, actionable and coordinated approach to planning and implementation of funds** • **Ensure planning, decision-making and implementation is community-informed and evidence-based**	• Improved coordination and collaboration across the county on caring for people who use drugs. • Improved community engagement of directly impacted people. • Established protocols for developing updated spend plans and evaluating impact.	• Equitable and sustainable reduction in overdoses. • Equitable increase in access to medical, behavioral health, and other supportive services for people who use drugs.

Guiding Values

Equity, inclusion, transparency, and accountability are core values necessary to guiding the responsible and effective management of opioid settlement funds. These values should be woven into every phase of the process. A strong foundation in these values will ensure that resources are distributed fairly, centering the needs of disproportionately affected communities to maximize impact, while maintaining public trust through transparent and accountable practices.

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Equity and inclusion are crucial in opioid settlement planning and spending to effectively meet the needs of impacted communities. Applying an equity and inclusion lens supports:

- Assessment of opportunities and needs to maximize impact while avoiding unintended harmful or exclusionary outcomes from policies or practices
- Meaningful collaboration in decision-making processes, ensuring the voices and experiences of those most profoundly affected by the overdose crisis are fully considered and understood
- Purposeful allocation of resources in ways that promote fair and effective support for communities

Transparency and accountability are essential for maintaining public trust and responsible stewardship of funds. These values ensure:

- Information is clear, centralized, and publicly accessible to everyone, especially marginalized and impacted communities
- All communities are kept informed and actively involved in planning and decision-making
- Decision-making is optimized through public input as part of a system of checks and balances preventing blind spots, conflicts of interest, and unintended gaps or harms
- Progress is accurately monitored, tracked and assessed, guiding ongoing improvements in fund management and resource distribution

Principles for Spending Opioid Settlement Funds

As a practical framework, this plan adopts Johns Hopkins Bloomberg School of Public Health's *Principles for the Use of Funds from the Opioid Litigation* – a set of principles developed by a coalition of 31 professional and advocacy organizations across the country and endorsed by more than 60 organizations. These five principles are intended to serve as a guiding framework for ensuring equitable and impactful use of settlement funds. Additional information on the Principles and other settlement guides and resources can be found at www.opioidprinciples.jhsph.edu.

1. **Spend the money to save lives** – Ensure that funds are dedicated to reducing overdose deaths by creating a separate, protected fund used solely for this purpose. These funds should supplement, not replace, existing funding streams. Plan strategically for long-term impact by considering options like an endowment to provide an ongoing source of funding for financial sustainability when the distribution of the opioid settlement funds ceases.

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2. **Use evidence to guide spending** – Prioritize funding programs that are proven to reduce overdose deaths, promote recovery, and remove policy barriers that hinder effective programming. Engage public health officials and behavioral health experts in planning and strengthen data collection to monitor progress and meet community needs.
3. **Invest in youth prevention** – Support evidence-based youth development and prevention programs, including those that build resiliency beginning in elementary school and that foster school cultures that are safe and supportive environments within which children can thrive. Prioritize marginalized groups such as system-involved or housing-unstable youth. Not all programs are equally effective—focus on those that work and invest in long-term evaluations to ensure positive outcomes.
4. **Focus on racial equity** – Support communities impacted by discriminatory practices, fund anti-stigma efforts, and ensure community inclusion in planning and decision-making. Using data, jurisdictions will likely find racial disparities in drug related deaths and injury, arrests and incarceration, access to resources and community investment, and engagement in leadership and planning efforts. Without a focus on equity, jurisdictions risk perpetuating existing inequalities.
5. **Develop a fair and transparent process for deciding where to spend funding** – Use data and community input to assess needs and involve diverse and representative stakeholders, including public health leaders and people with lived and living experience, in decision-making. This ensures that settlement funds are allocated transparently and reflect the needs of the communities served.

Principles for Tribal Consultation

As part of the commitment to equity and inclusion for groups disproportionately affected by the drug overdose crisis, intentionally including Native nations in opioid settlement planning and spending is crucial. When engaging with Native nations, the City and County must engage in a way that respects Tribal sovereignty, which is the inherent authority of Native nations to govern themselves. In recognition of Tribal sovereignty, outreach to Native nations should allow Tribal leaders to determine how and if they would like to be involved in the decision-making process and should be respectful of cultural practices. Guiding principles for Tribal engagement include building respectful relationships and partnerships that promote transparent and open communication, facilitating shared understanding and learning, and addressing any concerns collaboratively.

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In addition to directly engaging with Native nations, the City and County may engage with organizations and agencies that work with or are made up of representatives from Native nations, such as the Indian Health Service, NM Tribal Behavioral Health Providers Association, and the Albuquerque Area Indian Health Board. Tribal leaders or Tribal government staff may request or prefer that consultation, engagement, or collaboration occurs through an external organization or agency.

Native nations have access to funds from the Tribal Opioid Settlements, which are separate from the National Opioid Settlements. Regardless of access to the Tribal Opioid Settlements[9], including Native nations in National Opioid Settlements planning and spending is important because:

- Native people experience disproportionately high rates of fatal overdose.
- Native nations often face numerous barriers to providing adequate overdose prevention services, including limited funding.
- Municipal/County governments and Native nations can learn from each other about different strategies for addressing the overdose crisis—for example, many Native communities provide innovative services (including culturally based services), even with limited resources.
- New opportunities for partnerships on current or future overdose prevention services and data sharing opportunities can be identified.
- Native people residing on Tribal lands may access services within the City or County, and City or County residents may access services on Tribal lands.
- Funding determinations from the National Opioid Settlements were made using data that includes Native people living on Tribal lands within the borders of each state.

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4. Developing the Strategic Plan

The development of the Strategic Plan involved a multi-phase approach from April to October that included coordination of technical assistance, conducting a rapid landscape analysis, and facilitating public input and community engagement, The following sections describe the process of developing the Plan. The results and specific findings from the information gathering activities are integrated into this report's Recommendations and the full findings reports are in Appendix D Community Engagement Summary, Appendix E VOICES New Mexico Summary, and Appendix F Rapid Landscape Analysis Summary. These insights were essential for understanding the local context and form the foundation for the Recommendations tailored to the landscape of the City of Albuquerque and Bernalillo County.

Workplan and Timeline Overview

The development of this Strategic Plan comprised of the following components (detailed workplan located in Appendix C):

Timeline	Activities	Deliverables
April 1 – November 24	Coordination of technical assistance	• Weekly meetings with Vital Strategies planning team • Monthly meetings with Vital Strategies, City, and County planning teams
April 25 – August 17	Conduct rapid landscape analysis	• Summary of findings from rapid landscape analysis
April 25 – September 13	Facilitation of public input process and community engagement	• Community Engagement Plan • Summary of public input activities and findings • VOICES New Mexico findings report
September 14 – October 16	Development of strategic plan that is consistent with the requirements of the City and County resolutions	• Initial Strategic Plan

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Community Engagement

Public input activities included extensive outreach culminating in a series of town halls, listening sessions, and interviews to ensure this Strategic Plan was community informed and aligned with the needs and experiences of City and County residents. The details of the process are in the full Community Engagement Plan[10] along with a summary in English and Spanish. The goals of the community engagement process are as follows:

- Improve community engagement between community members to listen, build relationships and learn from each other
- Get community input, opinions, and ideas from across the City and County
- Ensure that community members are part of the planning process
- Create a report that summarizes the key themes from community experiences (See Appendix D)

More than 1,700 individuals participated in public input activities between May and September. Due to high public interest, the community engagement process was significantly expanded, doubling the number of planned activities and extending the timeline by more than twice the original length. This ensured that more community members could contribute to the strategic planning process.

Figure 1: Summary of Public Input Activities

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Demographics were collected for in-person events and based on self-report. At townhalls, the majority of participants identified as women (60.1%) and participants self-reported race and ethnicity as 45.4% White, 39.8% Hispanic, 3.9% Black, and 2.5% Native. At listening sessions, 62.2% of participants identified as women and reported race and ethnicity as 42% Native, 19% White, 17% Hispanic, and 10% Black. Across both townhalls and listening sessions, the majority of participants were over the age of 35.

Key Take-Aways from Community Engagement

- Perceptions and beliefs about contributors to the overdose crisis focused on accessibility of the drug supply.
- Barriers and problems in addressing the crisis included stigma, housing instability and homelessness, and limited or delated access to treatment services.
- Concerns about currently existing treatment services included difficulty accessing care, workforce shortages, and uneven quality.
- Proposed solutions have been integrated into this Plan's Recommendations and included these themes: prevention-oriented education needs, activities that build resilience, providing housing options, providing MOUD, need for long term and better coordinated care, supporting harm reduction and basic needs, expanding the behavioral health workforce, ensuring treatment quality, addressing criminal-legal involvement, addressing economic and social drivers of health, and accessibility to treatment.
- Accountability and transparency suggestions for spending the funds included creating a publicly accessible dashboard of expenditures, sharing regular updates through news media, establishing an oversight committee, conducting evaluation of funded activities, and continuing public input activities.

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VOICES New Mexico

VOICES is a study to confidentially survey and interview people who use drugs and learn about their experiences with drug use, harm reductions strategies, treatment, overdose and health and social vulnerabilities[11]. This study was fielded in Wisconsin, New Jersey, New Mexico and Michigan. These states are part of the Bloomberg Overdose Prevention Initiative, a multistate campaign to reduce overdose deaths supported by Bloomberg Philanthropies. VOICES is a partnership between Johns Hopkins Bloomberg School of Public Health and Vital Strategies, with data collection supported by the Pacific Institute for Research and Evaluation.

VOICES New Mexico was designed to help complement public health outreach efforts in Bernalillo County and the City of Albuquerque as well as inform community engagement efforts to inform this Strategic Plan. The study was tailored to the local context and aimed to recruit a high proportion of Native, Hispanic, and Black individuals. To recruit participants, the study used a targeted, non-probability sample that focused on adults who had recent experience with drug use. 673 participants were recruited from 11 community service providers located in Bernalillo County from June through August and were asked to complete a 30-minute anonymous phone survey.

Most participants were under age 40 (55.0%). Overall, 23.8% of participants self-reported as Native, 49.5% Hispanic, 2.8% Black non-Hispanic, and 20.3% White non-Hispanic. Most participants reported financial insecurity (80.1%). Approximately two-thirds reported housing insecurity (64.9%) and just under half reported having a chronic medical condition (42.6%) and having self-reported fair or poor health (43.7%). A large majority (90.2%) of participants used drugs in the past 30 days, and among these participants high rates of past month stimulant use (92.3%), particularly methamphetamine use (89.0%), and opioid use (81.9%) and polysubstance use (66.2%) were reported. Less than a quarter of participants (18.6%) survived an overdose in the past year, and about a third (32.7%) were very or quite worried about having an overdose in the future. A summary of the study's results can be found in Appendix E.

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Key Take-Aways from the VOICES New Mexico Study

Harm Reduction Use

- Among people who currently use drugs, 67.5% reported using harm reduction services in the past 30 days, 28.8% reporting using fentanyl test strips in the past 30 days, and 77.4% reported carrying naloxone.
- The top reasons for not using harm reduction services were feeling like services were not needed (43.1%), not knowing where to seek services in their area (22.8%) and transportation issues (5.6%).
- The top barriers to not using fentanyl test strips were not knowing what test strips are (25.7%), not having any test strips (23.1%) not wanting to use test strips (14.0%).
- The most common suggestion for harm reduction supplies was for safer smoking kits.

Substance Use Treatment

- Overall, 41.2% of the sample had engaged in treatment services in the past month.
- Among participants who were currently engaged in treatment and had used opioids in the past 30 days, 68.1% were receiving methadone, 30.2% were receiving buprenorphine, 4.4% were receiving extended release naltrexone, and 8.8% were not receiving MOUD.
- Many respondents have goals of engaging in treatment, either inpatient or intensive outpatient, initiating or maintaining MOUD, and developing the tools necessary to succeed in recovery.
- Suggestions for supporting treatment include financial support for treatment, housing, food, and mental health counseling.

Opportunities for Opioid Settlement Funds Planning

- A vast majority of participants, many of whom were unhoused, advocated for increased funding for better housing services. They deemed existing shelters and temporary housing inadequate and emphasized the need for more options and improved conditions. Additionally, they suggested relaxing restrictions on halfway

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houses and sober living facilities to facilitate access to permanent housing, enabling participants to concentrate on other priorities like treatment.

- Numerous participants proposed using settlement funds to expand treatment facilities and increase access to MOUD. They cited the need for more accessible facilities, longer operating hours, and funding for uninsured patients. Additionally, they emphasized the importance of anti-stigma training for staff.
- Mental health counseling and treatment was typically brought up as important pieces of the recovery journey.
- Peer support services were a commonly discussed issue. To further support mental health services for this population, several people stated how hiring staff with lived experience at treatment centers or harm reduction organizations would improve knowledge sharing, reduce stigma, and encourage more people to initiate treatment.
- Participants voiced a need for funding for people who are criminal legal involved. For example, providing employment/housing assistance as part of reentry programs was discussed as beneficial for many people.

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Rapid Landscape Analysis

The Rapid Landscape Analysis was designed to inform decision-making regarding the investment of resources to reduce overdose risks and to stimulate additional questions about information needed to make informed decisions.[12] Its aim was to assemble a variety of data sources and other information that may provide guidance to decision makers about the current status of drug-related overdose risk in the City and County as well as opportunities for action. The full summary is in Appendix F.

The Basic Drug Use Epidemiology Guide developed by Vital Strategies and CDC Foundation was used as a framework to guide the development of the landscape analysis. The guide suggests asking basic questions about overdose risks and the current interventions that are available to respond to these risks. The methods used to create this landscape analysis were varied and were presented in order to offer a guide for future reference if or when a similar process is repeated to update the information used to plan for overdose prevention response. The steps we followed to gather answers to these questions included:

- Reviewing of publicly available information such as reports and websites generated by various agencies and organizations,
- Consulting with individuals at various city, state and county agencies and organizations who lead or are otherwise responsible for programming to or reporting information relevant to overdose risks,
- Requesting specific information from these agencies and leaders that may contribute to an understanding of overdose risks in the city and county, and
- Analyzing and synthesizing this information so that its findings may be actionable.

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Key Take-Aways from the Rapid Landscape Analysis

Who is experiencing fatal and nonfatal overdoses?

- The rate of fatal overdoses was highest and increased most rapidly during the period 2018-2022 among Black, Native and Hispanic people
- Fatal overdoses occur most frequently among those 35-44 and males
- The highest rates of emergency department visits related to an overdose during the period 2017-2021 were experienced by Black, Native, and Hispanic individuals while the latter presented to emergency departments most frequently

Where are people overdosing in the City and County?

- Drug overdose fatalities were most frequent in zip codes 87108 (161, 17.65%), 87106 (140, 15.35%), 87105 (86, 9.43%), 87102 (83, 9.10%), and 87121 (70, 7.67%).
- The most frequent locations of fatal overdose incidents were at the residence of the person who died (57%) or another's residence (6%), followed by outside (14%)
- AFR EMS responded to overdoses most often at a residence whether single or multi-family dwellings, apartments or hotels (663 or 46%) or in public places such as streets/highways (339 or 23%) and parking lots (196 or 14%).
- Bernalillo County EMS responds to overdoses most frequently in areas (zip codes) that overlap some of the areas of the City where fatal overdoses occur most frequently, however, 10% of its responses were in an area that borders the To'Hajiilee, Cañoncito Band of Navajos Reservation.

What is the impact on City Fire, BernCo EMS, and Albuquerque Community Safety?

- Between May 2022 and April 2024, AFR EMS responded to 1,450 suspected overdoses and administered naloxone on 618 occasions within the city during this period. Overdose related responses were most frequent during this period in city council districts: 6 (447 or 31%), 2 (267 or 18%) and 7 (237 or 16%), followed by 1(139 or 10%) and 9 (124 or 9%)
- By Fire Station: Stations 5, 11, 13, 1 and 12 collectively responded to half of the overdoses in the City with stations 5 (240 or 17%) and 11 (167 or 12%) responding most frequently.

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- AFR EMS responded to overdoses most often at a residence whether single or multi-family dwellings, apartments or hotels (663 or 46%) or in public places such as streets/highways (339 or 23%) and parking lots (196 or 14%). Additionally, 160 or 11% of AFR EMS responses occurred at businesses or commercial establishments.
- Between April 2022 and April 2024, BernCo EMS responded to 1,110 suspected overdoses. Overdose related responses were most frequent during this period in zip codes 87105 (446 of 1,110 or 40%), 87121 (240 or 22%), and 87113 (14%). Additionally, 108 or 10% of responses were in zip code 87114 which borders the To'Hajiilee, Cañoncito Band of Navajos Reservation
- Similar to ABQ EMS responses, the areas most frequently served by ACS were council districts 6, 2 and 7.

Which substances contributed to fatal overdoses?

- Fentanyl was the driver of the majority of fatal overdoses in the County (69%) followed by methamphetamine (54.4%), but their combination in contributing to overdoses was frequent. About half (52.5%) of fentanyl overdoses involved methamphetamine as a contributing factor and two-thirds (66.5%) of methamphetamine overdoses involved fentanyl as a contributing factor.
- Fatal overdoses involving medications for opioid use disorder such as buprenorphine and methadone were extremely rare without the presence of another substance (e.g. fentanyl) as a contributing factor

What is the availability and utilization of substance use disorder (SUD) treatment services?

- Limited information was available regarding psychosocial/counseling treatment.
- There was a small increase in the number of patients in the County that received buprenorphine treatment for at least 10 days (3,163 to 3,373 or 6.6%) between 2021-2023.

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- There has been a decrease in the number of distinct patients with methadone claims paid by Medicaid between 2021 and 2023 (3,013 to 2,318 or 23.1%) while the number of providers remained relatively stable.
- The CARE Campus 2023 annual report notes that there were a total of 443 clients treated with buprenorphine, an increase from 378 in 2022. While there was an increase in the number of clients treated with buprenorphine, almost half (45%) were documented to have declined services, elected to discharge, or there was no disposition annotated.
- The Metropolitan Detention Center has expanded the number of clients in its MAT program and offers both buprenorphine and methadone treatment. During the period December 15, 2022 to December 14, 2023, a total of 1,505 individuals were served by the program with 352 being new clients, averaging 29 new clients each month and providing maintenance treatment to approximately 150 clients each month.
- The City of Albuquerque offers SUD treatment through its PATH (Providing Addiction Treatment and Healing) program which has served 927 people across 10 partner organizations in the first half of fiscal year 2023-2024.

What is the availability and utilization of overdose prevention and harm reduction services?

- Average monthly naloxone distribution to vulnerable individuals increased 22% between FY 2023 and FY 2024
- AFR EMS has estimated it has provided 700 naloxone kits as “leave-behind” kits following encounters with vulnerable individuals in the past 24 months (approximately one per day)
- Local partners contracted by NMDOH have expanded the number of client sessions and unique individuals where they perform their services throughout the County during the period July 2022 – March 2024, especially the International District, Downtown and North Valley
- Distribution of safer smoking/snorting kits increased substantially among all partner organizations operating in the county, and most more than doubled their prior year distribution.

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What substance use services are available for youth?

- Current and lifetime heroin use by Bernalillo County high schoolers was low, while improper use of pain medications was higher
- Improper pain medication use (current and lifetime) was higher among females
- Albuquerque Public Schools offers counseling and Post-overdose Response Team services for students who experience challenges with substance use

Opportunities for future overdose prevention and response planning

- There is currently no centralized local resource that is tasked with the responsibility to coordinate the various sources of data and information that were included in this landscape analysis and then assemble these resources into actionable intelligence that can be used for overdose prevention planning. It was therefore challenging to conduct this landscape analysis.
- There is an opportunity to build capacity to improve coordination between City, County, and State agencies and systems to better understand overdose risks, plan for overdose prevention response, and monitor the interventions aimed to reduce those risks. The strategies to build this capacity are aligned with the New Mexico Opioid Allocation Agreement.

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5. Recommendations

Scope of Recommendations

The City and County's Strategic Plan for utilizing opioid settlement funds represents a collaborative and forward-thinking approach to addressing the ongoing overdose crisis. The recommendations are designed to focus on the actionable steps that can be implemented at the local level. While this plan acknowledges the importance of state and federal policy changes in addressing the overdose crisis, the recommendations do not directly address state or federal policy changes. The recommendations are centered on leveraging existing resources and capabilities within the City and County, and provide a blueprint for local action that can serve as a model for other jurisdictions and contribute to broader efforts to combat the overdose crisis.

By concentrating on local initiatives, the recommendations aim to:

- **Maximize the immediate impact:** By prioritizing actions that can be implemented quickly and effectively, the plan ensures that the settlement funds are used to address the most urgent needs within the community.
- **Foster local capacity and sustainability:** By focusing on building local capacity and infrastructure, the plan aims to create a sustainable framework for addressing the overdose crisis long-term, even after settlement funds are exhausted.
- **Align with existing local priorities:** The plan's recommendations are designed to complement existing local initiatives and strategies, for example, aligning with the Bernalillo County Behavioral Health Authority's behavioral health strategic planning process.[13] Alignment ensures that the settlement funds are used to reinforce and enhance ongoing efforts.

The City and County demonstrated remarkable foresight by enacting mirror Resolutions requiring a comprehensive strategic plan before any funds are allocated. This commitment to thoughtful planning ensures that these resources are directed towards evidence-based solutions that directly address our community's most pressing needs. Further solidifying this commitment, public input has been a core component of the planning process. Through town halls, listening sessions, interviews, and online surveys, a diverse range of voices have been incorporated into the development of this Strategic Plan. This ensures that the plan reflects the collective needs and aspirations of the community it serves. The City and County have each established dedicated

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funds for opioid settlement monies (see Tables 1 and 2 on expenditures), demonstrating their commitment to responsible financial stewardship and ensuring that these funds are used effectively to combat the overdose crisis for years to come. Specific funding appropriations fall under the purview of the City Council and County Commission; as such, these recommendations do not assign funding amounts or percentages.

By integrating a strengths-based approach - building on the existing strengths, assets and resources of the community - with strong leadership, public engagement, and a commitment to responsible use of resources, this Strategic Plan provides a roadmap for effectively utilizing opioid settlement funds to make a lasting impact on the overdose crisis within the City and County.

Strategic Priorities

The strategic priorities for spending opioid settlement funds are intended to align with allowable uses of the funds as defined in the New Mexico Allocation Agreement and the national settlement agreements. Each priority and its specific recommendations are informed by local data from the rapid landscape analysis, public input gathered from community engagement activities, evidence-based interventions, and best practices from around the country.

At the core, the strategic priorities model (see Figure 2) emphasizes the importance of equity-centered interventions. Radiating outwards from this central focus are key components necessary for effective implementation of the recommended interventions. Collaborative planning and coordination ensure a unified approach, while inclusive funding and financing strategies promote equitable access to resources. Accountability and monitoring mechanisms are essential for ensuring transparency and effectiveness. For specific examples of equity-centered interventions, the model highlights the need for prevention efforts, harm reduction strategies, treatment options, recovery services, stabilizing supports, and a robust crisis response system. By addressing these interconnected elements, the model aims to guide the strategic allocation of opioid settlement funds to achieve meaningful and sustainable progress in reducing the harms of the overdose crisis.

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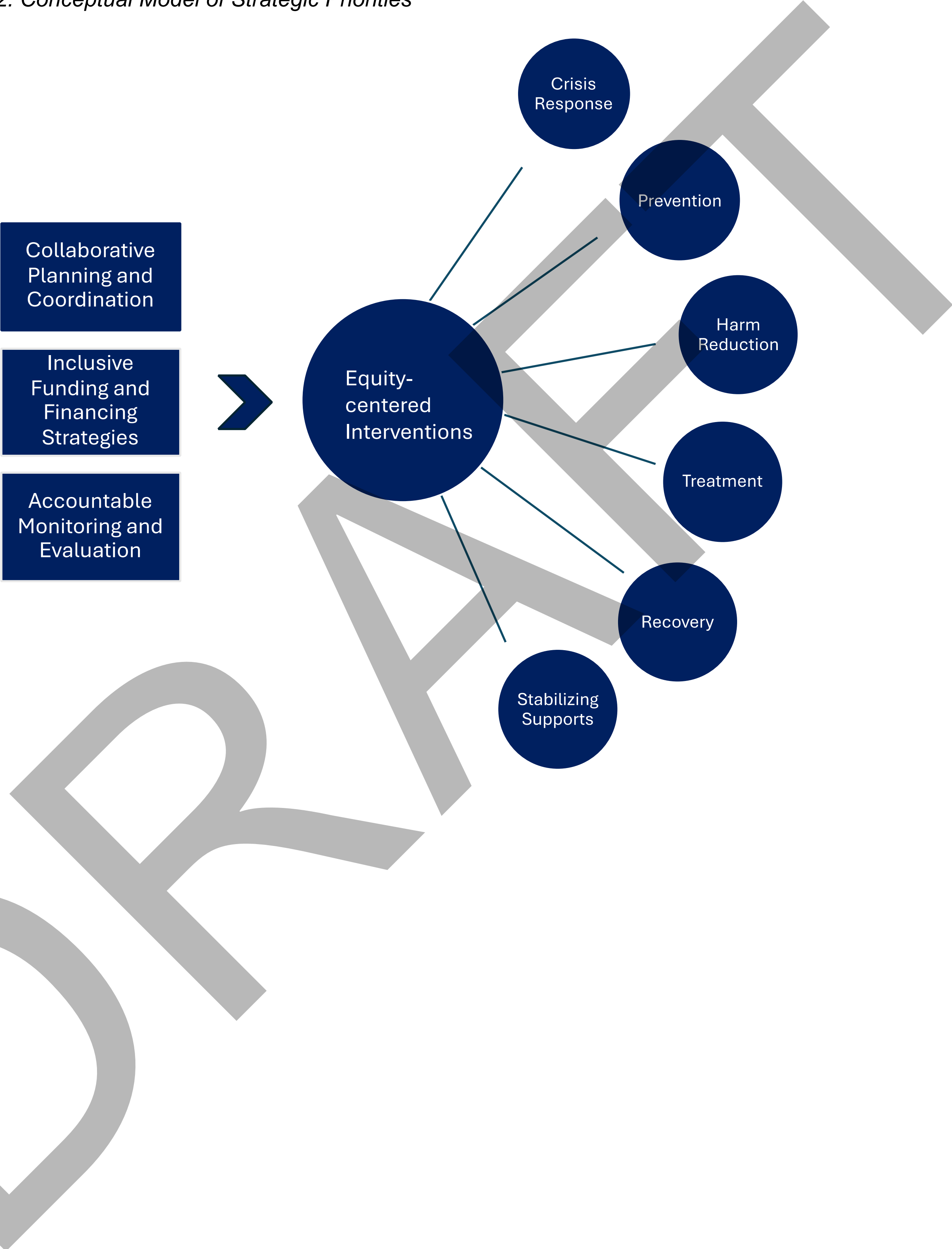
Figure 2: Conceptual Model of Strategic Priorities



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Recommendations

The following 28 recommendations are organized within each of the 10 strategic priorities.

Strategic Priority: Collaborative Planning and Coordination

1. Formalize Intergovernmental Cooperation
Extend the coordination efforts between the City and the County by designating a joint council or committee (e.g. Local Government Coordinating Commission) comprised of representatives from the City, County and Albuquerque Public Schools Commission to oversee the strategic planning and implementation of opioid settlement expenditures. Define a timeline for implementation of the adopted strategic plan and allow for annual planning cycles.

Public Input[10]	Townhall and listening session participants expressed interest in ongoing planning efforts that integrated community engagement.
Epidemiology Data[12]	There is an opportunity to have a centralized database supported by data use agreements with City, County, and State agencies to better understand overdose risks, plan for overdose prevention response, and monitor the interventions aimed to reduce those risks.
Best Practices[14]	Formalizing intergovernmental cooperation can help to improve the effectiveness and efficiency of a comprehensive response to the overdose crisis, while also strengthening relationships and building a more coordinated approach to broader behavioral health strategic planning efforts.

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Strategic Priority: Collaborative Planning and Coordination

2. Dedicated Coordination Role

Create a staff position to work across City and County agencies to support collaborative planning, implementation of the strategic plan, and monitoring and evaluation of progress. Improved coordination between various levels of government could be helpful to establish a local database of information relevant to the overdose crisis. Development of a database could also be helpful for facilitating data sharing from the City and County to Tribal governments.

Public Input[10]	A persistent theme across community feedback was a need to build public trust in government's ability and intention to use funds constructively. Feedback suggested coordination actions including oversight of spending, hiring external evaluators to assess effectiveness and quality, continued public input, and collaboration with stakeholders.
Epidemiology Data[12]	Improved coordination and gathering local data in a centralized database could be updated on an ongoing basis for future planning as well as for monitoring and evaluating whether the landscape changes are a result of local interventions or due to other reasons. In addition, there is currently no local resource that is tasked with the responsibility to coordinate the various sources of data and information that were included in the Rapid Landscape Analysis and then assemble these resources into actionable intelligence that can be used for overdose prevention planning.
Best Practices[15]	A coordination role can help to bring together public health experts and key stakeholders to inform decision-making and ensure that funds are used appropriately. This role can help to increase transparency and accountability in the use of opioid settlement funds, building trust with affected communities. In addition, having a single point of contact can streamline planning and implementation of programs and services, ensuring that they are delivered efficiently and effectively, while meeting the requirements of the National Settlement Agreement. The Agreement allows for a small percentage of the dollars coming to the state to cover the administrative costs associated with convening public health experts to make spending decisions and managing and disbursing the funds.

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Strategic Priority: Collaborative Planning and Coordination	
3. Native Nations Consultation and Collaboration Prioritize consultation and collaboration with Pueblos and Native nations in the geography of Bernalillo County (i.e., Sandia Pueblo, Isleta Pueblo, Laguna Pueblo, and the To'Hajiilee Cañoncito Band of Navajos), recognizing Tribal sovereignty and engaging in culturally respectful collaboration. Consult and engage with groups with direct expertise working with and/or representation from Native nations such as the NM Tribal Behavioral Health Providers Association, Albuquerque Area Indian Health Board (AAIHB), and Indian Health Service (IHS) throughout the planning and implementation process, especially when requested by Tribal leaders and Tribal government staff. Through Tribal consultation, identify opportunities to fund, partner with, or otherwise support Pueblos' and Native nations' current or future overdose prevention services. Explore collaborations with the IHS, AAIHB, and/or the NM Tribal Behavioral Health Providers Association to promote intergovernmental coordination with Native nations, utilizing community input and available data to identify funding priorities, promoting culturally specific programming, investing in training and capacity building for the public health workforce serving Native communities, and establishing metrics for understanding the impact of funded programs. If requested by Native nations and when possible, provide support for Tribal programs and adapt City/County services utilized by Tribal members to better support them. Coordinate improved data sharing processes from the City and County to Tribal governments.	
Public Input[10]	During listening sessions with Native nations, participants identified Tribal programs and initiatives that they may want to develop or expand. There may be opportunities for the City and County to fund, partner with, or otherwise support these programs and initiatives, including consulting with groups such as the NM Tribal Behavioral Health Providers Association, which includes representation from many Native nations' behavioral health programs. Participants also mentioned that non-Tribal programs and services could better serve Tribal members—for example, by helping (re-)enroll eligible Tribal members in Medicaid and connecting them to relevant Tribal services. Participants also emphasized that many Native nations have limited access to data related to the opioid overdose crisis and that the City and County may have access to relevant data for Tribal lands and regarding Tribal members, which should be shared back to Native nations. Lastly, during the community outreach and engagement process, some Tribal leaders and Tribal government staff expressed that they may prefer that consultation and coordination happen through a relevant group comprised of representatives from multiple Native nations such as the NM Tribal Behavioral Health Providers Association, rather than directly through their Native nation.
Epidemiology Data[12]	The rate of fatal overdoses increased during the period 2018-2022 among Native people (39.5 per 100,000 in 2018 to 96.6 in 2022) in the County. The Pueblos and Native nation that share geography with the County all have behavioral health and/or substance use disorder treatment programs, although information regarding the types of services and/or medication availability was not readily available for all four nations for the landscape analysis. In addition, the Albuquerque Area Indian Health Board is a current SAMHSA Tribal Opioid Response grant recipient in collaboration with four of its Consortium Tribes.

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Best Practices[9,16,16–18]	As part of the commitment to equity and inclusion for groups disproportionately affected by the drug overdose crisis, intentionally including Native nations in opioid settlement planning and spending is crucial. Engaging with Native nations in a way that is respectful of Tribal sovereignty is important for promoting equity in settlement planning and spending. Engaging with Native nations and agencies that work with them or are made up of Tribal representatives (e.g., IHS, AAIHB, NM Tribal Behavioral Health Providers Association) promotes collaboration and knowledge sharing between the City/County and Native nations, as well as across nations, leveraging their unique strengths and experiences. Through Tribal consultation and consultation with related agencies, the City and County can help ensure that settlement funds will support programs and services that are culturally relevant and effective, and address the specific needs and challenges faced by Native communities.

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Strategic Priority: Collaborative Planning and Coordination

4. Community Advisory Board
Establish a permanent advisory body, or assign an existing one, to ensure ongoing, meaningful community input on how funds should be allocated, identify emerging community needs, and promote accountability. Board composition should include people who are directly impacted by the overdose crisis and service providers responding to the crisis and reflect the demographic diversity of the City and County.

Public Input[10]	A high number of community members providing feedback suggested a dedicated committee to provide oversight with spending of the funds, made up of stakeholders who should continue to be consulted throughout the years the funds are distributed.
Epidemiology Data[12]	Consider including representation from groups heavily impacted by overdoses. The rate of fatal overdoses was highest and increased most rapidly during the period 2018-2022 among Black, Native and Hispanic people aged 25-64 especially among those 35-44.
Best Practices[19,20]	This approach helps to ensure that funds are allocated in a way that addresses the unique needs and priorities of affected communities. By including individuals with lived and living experience, as well as other key stakeholder groups, a community advisory board can help to ensure that the planning process reflects the diversity of the affected population. This diversity can lead to more equitable and effective outcomes. The valuable insights and expertise of a board can inform decision-making by City and County decision makers and ensure that funds are used effectively. A board can also help to increase accountability and transparency in the use of opioid settlement funds, building trust with affected communities. The Ryan White HIV Program serves as a valuable model for including those directly affected in decision-making. By requiring that at least one-third of the members of community planning councils receive program services themselves, this program helps to ensure that the perspectives of people with lived experience are central to the allocation of funds.

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Strategic Priority: Inclusive Funding and Financing Strategies

5. Low Barrier Funding

Implement a streamlined application process to make funding accessible to a wide range of organizations serving people who use drugs. In recognition of applicants with limited organizational capacity in areas such as grant writing and data collection, minimize high barrier application questions and reporting requirements. The County and City are issuing six-year and three-year multi-award RFPs, respectively, for prevention, intervention, harm reduction, and treatment services. These RFPs will pre-select service providers for future awards based on scope of work and funding. Only providers who applied under these RFPs will be eligible for future contracts[21]. In alignment with public input and inclusive procurement practices, making the funds available in the next procurement cycle to first time applicants or non-traditional applicants will improve the diverse representation of organizations and communities served. In addition, review all funding sources for the overdose crisis, and assess how opioid settlement funds can complement rather than replace (or "supplant") existing resources, and explore sustainable funding vehicles like endowments to ensure long-term availability of funds.

Public Input[10]	Listening session participants expressed that many organizations serving the communities most heavily impacted by the opioid overdose crisis have limited organizational capacity to apply for competitive funding, emphasizing the need for a low barrier application process to help ensure that funds are more likely to reach these communities. During listening sessions with Native nations and the urban Native community, participants expressed concerns around Native organizations and Tribal governments having limited capacity for grant writing, as well as having limited access to data to demonstrate need in a competitive application process.
Epidemiology Data[12]	The Rapid Landscape Analysis summary provides data that can be used to inform where low barrier funding should be prioritized based on demographics, location, and types of services.
Best Practices[6,15,22,23]	Equity and accessibility improve for communities experiencing disparities when funding is available to a diverse range of organizations, including those that may face barriers due to size, location, or other factors. Community-driven solutions are amplified when low barrier funding allows for more flexibility in how funds are used, enabling organizations to tailor their programs and services to the specific needs of their communities. Inclusive procurement practices can lead to more innovative and effective programs and services by considering a wider range of perspectives and expertise. Low barrier funding practices are essential for ensuring that funding is used in a way that maximizes its impact and benefits a wide range of communities.

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Strategic Priority: Inclusive Funding and Financing Strategies

6. Fund Culturally Specific Services and Programs
Ensure that funding opportunities for community organizations allow for culturally specific or culturally based services and programs, especially those serving urban Native communities and neighboring Pueblos and Nations.

Public Input[10]	In listening sessions with the urban Native community and Native nations, participants emphasized the need for more funding opportunities that allow for culturally specific or culturally based approaches to addressing the opioid overdose crisis in their communities. Community members expressed the importance of supporting cultural activities, emphasizing that "culture is prevention."
Epidemiology Data[12]	The Rapid Landscape Analysis summary includes demographic information by service type, when available.
Best Practices[17,24–27]	Native approaches to healing from and preventing substance use disorder include promoting cultural connectedness, such as through cultural teachings and participation in traditional activities. Culturally specific and culturally based programs can be important ways of providing services that are relevant, holistic and effective for Native communities. Funding culturally based services and programs is one way to address historical and ongoing racial inequities that disproportionately impact Native communities. Culturally specific programs can help to mitigate these disparities and promote health equity.

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Strategic Priority: Inclusive Funding and Financing Strategies

7. Native Nations Allocation

Allocate a portion of the funds directly to Pueblos and Native nations in the geography of the County to allow Tribal governments to address the specific needs and priorities of their communities. For interested Native governments, offer or facilitate connections to guidance or technical assistance for planning how to spend the funds.

Public Input[10]	During Native communities listening sessions, leaders, staff, and community members made the following suggestions: • Setting aside a portion of the opioid settlement funds for Native nations without requiring proposal writing because many Tribal programs have limited capacity for grant writing. • Distributing this funding allocation across the four Pueblos/Native nations based on population size. • Not limiting funding based on data because many Native nations have limited data that do not fully reflect their communities' experiences and needs. During the listening sessions, some Native nations with higher capacity for overdose prevention, harm reduction, and SUD-related work identified specific programs and services that they may invest funds in, while others had more limited capacity and may be interested in support or guidance around planning how to spend the funds.
Epidemiology Data[12]	Overdose data was not available for each of the neighboring Nations. However, the Rapid Landscape Analysis found that the rate of fatal overdoses increased during the period 2018-2022 among Native people (39.5 per 100,000 in 2018 to 96.6 in 2022) in the County and 10% of the County EMS overdose responses were in an area that borders the To'Hajiilee, Cañoncito Band of Navajos Reservation.
Best Practices[9,16,17,28]	Direct funding is one way to improve racial equity by investing in Native communities affected by discriminatory policies and addressing the disproportionate impact of the opioid crisis on these communities. This equity-driven approach respects the authority and expertise of Native nations to develop and implement programs and services based on their specific needs. States such as Washington and Wisconsin have set a precedent in this area by setting aside funding from the opioid settlements specifically for Native nations. In addition, funds could support technical guidance for interested nations and invest in reciprocal learning and partnerships across nations to promote collaboration and knowledge sharing. Of note, if City and County planners are interested in seeking or gathering data regarding Native communities, they must do so in a way that respects Indigenous data sovereignty principles such as the CARE Principles for Indigenous Data Governance, starting by confirming that there is interest in the project from the Native nation or community and going through the appropriate channels and protocols to request permission for the project. They should determine who will hold and protect the data, and allow for Indigenous stewardship of the project.

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Strategic Priority: Inclusive Funding and Financing Strategies

8. Provider Participation in Medicaid

Enhance City-wide efforts to work with treatment providers to prioritize Medicaid billing for substance use disorder services for low-income individuals to ensure opioid settlement funds serve as a supplemental resource. Consider incentive programs or reducing administrative burdens to increase provider participation and ultimately increase Medicaid utilization for substance use disorder services. Facilitate Medicaid enrollment through County-run services and explore how the County which delivers SUD services can become a Medicaid provider.

Public Input[10]	Community feedback cited concerns about delays and long waiting periods to access treatment services, and suggested the need for more MOUD providers especially increasing the availability of treatment through primary care providers.
Epidemiology Data[12]	With the exception of methadone Medicaid claims data, no other Medicaid SUD treatment data was available for the Rapid Landscape Analysis. The Medicaid methadone data showed a decrease in number of patients (23.1%) while the number of providers remained stable during the time period 2021 Q4 – 2023 Q3.
Best Practices[29–31]	Increasing Medicaid provider participation and patient utilization for SUD services will serve as a sustainable funding source and allow for opioid settlement funds to supplement rather than be the primary source of monies for Medicaid-eligible populations.

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Strategic Priority: Accountable Monitoring and Evaluation

9. Data-Driven Approach
Develop and utilize key performance indicators to guide and monitor spending, measure the effectiveness of interventions, and identify areas for improvement along the continuum of care. Create a centralized data resource to include data sources from the Rapid Landscape Analysis, the City and County's recently launched Unite Us closed loop referral platform, and the SYNCRONYS statewide health information exchange, among other data sources. Incentivize providers to participate in the City and County's designated referral and reporting platforms to strengthen data available for informing funding decisions.

Public Input[10]	Community feedback included suggestions for monitoring and evaluation and for the results to be made public in addition to working with an external evaluator to reduce bias.
Epidemiology Data[12]	The current lack of a centralized resource to coordinate data and information hinders overdose prevention planning. Creating a dedicated role to gather and analyze data from State, County, and City agencies can improve the effectiveness of future planning efforts including tracking and monitoring key performance indicators.
Best Practices[32,33]	Several resources are available on developing key performance indicators. The Opioid Settlement Principles Resource and Indicators (OSPRI) was developed specifically to guide local governments in aligning overdose prevention outcomes with a practical list of indicators that are aligned with the allowable uses of opioid settlement funds. Another resource that may be adapted for City and County planning is the State Measures for Improving Opioid Use Disorder Treatment which tracks services from diagnosis to recovery, allowing local governments to assess the effectiveness of the treatment system.

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Strategic Priority: Accountable Monitoring and Evaluation	
10. Transparency and Reporting Dedicate funds to develop and publish a dashboard to share regularly updated information on fund allocation, program outcomes, and progress towards goals. Provide an annual report that is available and accessible to the public which describes how the funds have been used, data on indicators, and community engagement.	
Public Input[10]	Community members identified increased transparency and accountability as key priorities for ensuring the effective use of opioid settlement funds. Suggestions included: • Publicly accessible dashboard: A frequently updated online dashboard to track fund expenditures. • Regular communication: Providing regular updates on fund spending through media outlets. • Dedicated oversight: Establishing a committee or board to monitor fund usage and ensure accountability. • Program evaluation: Requiring funded organizations to demonstrate outcomes and effectiveness.
Epidemiology Data[12]	No centralized data resource is available to facilitate analysis and reporting efforts.
Best Practices[19,32–34]	A dashboard can provide regular updates on fund allocation, program outcomes, and progress towards goals. This allows the public to track how funds are being used and the impact they are having. An annual report can offer a more detailed overview of how the funds have been used, including data on indicators and community engagement. This can help to ensure that the public is informed about the use of the funds and can hold decision-makers accountable.

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Strategic Priority: Equity-Centered Interventions

11. Prioritize Key Populations
Fund targeted interventions for people who use drugs and are at risk of overdose, specifically to Hispanic, Black, Native, youth, LGBTQI+, currently or recently incarcerated, pregnant, postpartum, parenting, and unsheltered individuals who use drugs.

Public Input[10]	Community feedback emphasized the need for tailoring outreach and meeting the specific needs of key populations. The listening sessions, organized by stakeholder group were expanded from 7 to 17 sessions in order to meet community demand for gathering input from specific populations.
Epidemiology Data[11]	The VOICES New Mexico study found a high prevalence of people reporting housing insecurity (67.9%, 437 participants) and criminal legal involvement (40.7%, 274 participants) in the County. The study also found differences in harm reduction and treatment utilization by race and ethnicity: Hispanic and Native participants were more likely to have used harm reduction services compared to White participants, and Native participants were less likely to strongly endorse the effectiveness of MOUD compared to White participants.
Best Practices[12,17,35–37]	Interventions for these key populations should tailor evidence-based strategies to each populations specific needs to overcome barriers to care. Additionally, the Rapid Landscape Analysis had limitations in collecting data on specific populations, such as youth and pregnant/parenting people. In addition to gathering data from APS, an inventory of evidence-based prevention programs active in the County and reviewing MCO claims and data from local health providers is a recommended next step to examine the exposure of evidence-based prevention and treatment services for key populations.

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Strategic Priority: Equity-Centered Interventions

12. Compassionate Messaging
Promote overdose prevention and multi-media awareness campaigns that emphasize support, harm reduction, and anti-stigma. Continued investment in the recent addition of compassionate messaging on the Keep NM Alive campaign will amplify the voices of diverse community members sharing overdose prevention resources.

Public Input[10]	Stigma against people who use drugs and people on medication treatment was a common theme throughout the community feedback sessions. Community members were concerned with how stigma is a key barrier to people seeking care and treatment especially for people who are unsheltered.
Epidemiology Data[12]	Data from the Rapid Landscape Analysis on who is impacted by overdoses and where overdoses are occurring can be used to tailor messaging and prioritize locations for education and advertising campaigns.
Best Practices[38–40]	Compassionate messaging should be tailored to the audience, from policymakers to the families of people who use drugs. Messages should be rooted in evidence-based strategies that seek to humanize overdose prevention issues and build on community strengths.

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Strategic Priority: Crisis Response

13. Expand Mobile Crisis Response Services
Increase the availability of mobile crisis response and support services for people who use drugs experiencing a mental health crisis, injury, or overdose. Collaborate with New Mexico Human Services Department to increase public awareness of the 988 telephone and text line for mental health crisis which has recently been improved with the addition of geo-routing which can deploy the closest available mobile crisis response team to the 988 user's location as needed. In turn, mobile crisis teams can connect people with the appropriate level of follow up care, such as local Crisis Triage Centers, emergency departments, or community-based services referrals.

Public Input[10]	Community feedback included suggestions for "no wrong door," "integrated care," and "aftercare" approaches that addressed SUD, mental health, and physical health needs holistically. In addition, suggestions sought for immediate care in settings where people were located and followed with warm hand-offs to aftercare services to prevent people falling "through the cracks" when receiving services across systems of care.
Epidemiology Data[12]	Mobile crisis responses services are intended to reach people where they're at. The majority of fatal overdoses occur in residences (63%) rather than outside (14%). Of the non-fatal overdoses responded to by AFR EMS, 48% are in public settings (streets/highways 23%, parking lots 14%, businesses 11%).
Best Practices[41–43]	Mobile Crisis Response systems integrate the 988 crisis line with mobile teams that can be deployed to community-based locations and crisis triage centers for short term stabilization services. People should be able to enter the crisis response system through any point, from self-referral and walk-ins to drop-offs by crisis teams or other first responders. In addition to supporting the Albuquerque Community Safety co-response program, explore community-led alternatives to law enforcement interactions to expand reach through trusted partners. Best practices for mobile crisis team implementation includes pairing licensed clinicians with peers, responding without law enforcement unless necessary, utilizing real-time GPS technology, and scheduling follow-up appointments for seamless care transition.

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Strategic Priority: Crisis Response

14. Treatment Through Emergency Medical Services
Expand naloxone and buprenorphine access through County EMS, following “medication first” principles and learning from the City EMS’s implementation. EMS are in a unique position of starting treatment when people may be more receptive immediately following an overdose.

Public Input[10]	Community feedback included repeated comments about timeliness in offering treatment at the moment when people are ready and needing to overcome barriers to care like long waiting periods for treatment programs.
Epidemiology Data[12]	AFR EMS responded to 1,450 suspected overdoses and administered naloxone on 618 occasions between May 2022 and April 2024. Overdose related responses were most frequent during this period in city council districts 6 (447 or 31%), 2 (267 or 18%) and 7 (237 or 16%), followed by 1 (139 or 10%) and 9 (124 or 9%). AFR EMS also has community paramedics who perform follow-ups within 30 days after the initial encounter though service information was not available to review for the Rapid Landscape Analysis. BernCo EMS responded to 1,110 suspected overdoses between April 2022 and April 2024. Overdose related responses were most frequent during this period in zip codes 87105 (446 of 1,110 or 40%), 87121 (240 or 22%), and 87113 (14%). While some of these zip codes overlap the boundary of the city, BernCo EMS’ responsibility is to respond in areas of those zip codes that are outside of the City boundary. Additionally, 108 or 10% of responses were in zip code 87114 which borders the To’Hajiilee, Cañoncito Band of Navajos Reservation.
Best Practices[44–46]	Given the high numbers of overdose response calls serviced by City and County EMS, these calls represent opportunities to expand the number of people who are offered naloxone leave-behind and buprenorphine initiation on location. This model can increase treatment engagement for people who survived an overdose, especially for those who refuse EMS transport and connection to hospital-based care. With the October 15, 2024 announcement of the Golden Opportunity initiative, City and County EMS are poised to strengthen referrals to community-based MOUD and naloxone providers.

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Strategic Priority: Crisis Response

15. Leveraging the Sobering Center
Develop a plan for leveraging the Gateway's Sobering Center[47] (currently under construction) to serve participants who are vulnerable to overdose with interventions to reduce overdose risk such as naloxone, initiation of medication treatment, withdrawal management, engagement with peer support or counseling services, or others. The plan should include key performance indicators, stakeholder engagement, and integration pathways connecting to crisis response services and follow up care.

Public Input[10]	N/A
Epidemiology Data[11]	The VOICES New Mexico study found that stimulants were the most common drug used (92.3%), particularly methamphetamine use (89.0%), then opioid use (81.9%), followed by polysubstance use (66.2%). Sobering Center services and settings should accommodate the differing needs of people withdrawing from stimulants, opioids or other drugs.
Best Practices[48,49]	Since the Sobering Center is not yet operational, consider how opioid settlement funds can be braided with other, long term funding sources to support operational costs, pilot programs at the Sobering Center, data collection and evaluation activities, and integration into a comprehensive system of care encompassing the CARE Campus, crisis response services, and community-based harm reduction, treatment, and recovery providers.

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Strategic Priority: Prevention

16. Comprehensive Education
Implement drug use curricula in schools to educate young people about evidence-based strategies, from prevention to harm reduction to recovery, to encourage safer and more resilient youth. Education is also needed for families and professionals that work with youth to encourage supportive, rather than punitive environments.

Public Input[10]	Community members frequently suggested anti-stigmatizing and resilience-building education on drug use with a focus on youth and their families. Suggested topics included prevention, overdose risk reduction, and Substance Use Disorder.
Epidemiology Data[12]	For lifetime drug use, 15.1% of Bernalillo County high schoolers surveyed reported using prescription pain medications without a prescription while only 0.9% had ever used heroin. Reported lifetime use of pain medications without a prescription was higher in females (18.9%) than males (10.7%) while reported lifetime use of heroin did not differ significantly between males and females. Albuquerque Public Schools offers counseling and PORT services for students who have SUD or have been impacted by familial SUD. While some information about prevention and support programming for youth was available through APS, this was the sole source of information about substance use prevention included in this Rapid Landscape Analysis.
Best Practices[50–52]	Comprehensive, age-appropriate education about drug use, including the potential for addiction, overdose, and other health concerns, may be paired with early intervention services, peer education programs, and access to harm reduction and treatment services. An example of comprehensive, evidence-based and compassionate curricula is Safety First which is developed for high school students and aims to first prevent drug use, then offer harm reduction strategies to ultimately keep young people safer.

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Strategic Priority: Prevention

17. Connecting Disconnected Youth
Promote alternatives to punitive disciplinary policies that disconnect youth from education and economic systems that are counterproductive to their growth and achievement. Support Albuquerque Public Schools to offer continued engagement in school and youth-tailored support services for young people exposed to drug and alcohol use through a compassionate approach. Prioritize and tailor services for system-involved youth (including those in custody at the Youth Services Center) that also ensure referrals to appropriate, and evidence-based services such as harm reduction, medication treatment, recovery, and family therapy.

Public Input[10]	Community feedback frequently touched on the need for youth-specific services including education, outreach, and resilience-building activities.
Epidemiology Data[12]	Albuquerque Public Schools offers counseling and PORT services for students who have SUD or have been impacted by familial SUD. While some information about prevention and support programming for youth was available through APS, this was the sole source of information about substance use prevention included in this Rapid Landscape Analysis. No data from Youth Services Center or the Juvenile Detention Alternatives Initiative were available for this Analysis.
Best Practices[53–58]	Examples of evidence-based programs for youth ranging from education and early intervention to addressing risk and protective factors in the home and community are maintained in a registry by the New York State Office of Addiction Services and Supports.

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Strategic Priority: Harm Reduction

18. Safer Use Supplies
Increase the distribution of safer snorting and smoking supplies (pursuant to New Mexico Administrative Code 7.4.6.10) in response to increasing prevalence of smoking and snorting as routes of administration. Supplement funding for local harm reduction programs to expand their reach and services, as they are trusted providers of evidence-based prevention and care services within their communities.

Public Input[10]	The VOICES New Mexico study found that 91% of participants identified smoking as a route of administration, 75% reported using fentanyl and 89% using methamphetamine in past 30 days.
Epidemiology Data[12]	Nine organizations offer harm reduction services contracted by the New Mexico Department of Health. Distribution of sterile syringes increased most among providers operating in the International District and North Valley but decreased overall. However, safer smoking/snorting kits distribution increased substantially among all providers operating in different areas within the County, and most more than doubled their prior year distribution.
Best Practices[59,60]	The SAMHSA harm reduction framework highlights distribution of safer smoking supplies as an important strategy to prevent transmission of infectious diseases related to injecting drugs. As methods of drug use shift towards smoking and snorting, there is an opportunity to fund the increase in demand for safer use supplies and leverage the existing harm reduction infrastructure in the City and County.

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Strategic Priority: Harm Reduction

19. Naloxone Where it Counts
Expand low barrier naloxone access, prioritizing access for people most likely to use naloxone to reverse overdoses such as people who use drugs and their social networks. Consider funding mutual aid and volunteer-led initiatives with existing outreach networks and consider funding low-cost naloxone housing units with 24/7 access in locations based on overdose heatmaps data.

Public Input[10]	Community feedback suggested making naloxone free and easily accessible in public locations like libraries and community centers, as well as accessibly stored in recycled newspaper boxes or vending machines.
Epidemiology Data[11,12]	The VOICES New Mexico study found that many participants wanted more information, training, and access to fentanyl test strips and naloxone. In addition, the Rapid Landscape Analysis found that average monthly naloxone distribution in the County by NMDOH contracted providers increased 22% (753 to 920) between FY 2023 and FY 2024 (partial fiscal year: July 2022 - March 2024) and reported successful reversals remained stable (150 to 151).
Best Practices[61,62]	By focusing naloxone distribution on individuals and communities with the highest risk of opioid overdose, resources can be allocated more efficiently and effectively. Targeted distribution can ensure that naloxone reaches those who need it most, reducing barriers to access and improving health outcomes. By partnering with existing harm reduction outreach networks, the City and County can prevent duplication of efforts while expanding reach to people who are most likely to use naloxone in an overdose reversal. In addition, a variety of naloxone housing units (e.g. newspaper boxes, vending machines, etc.) may be tailored by location and audience.

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Strategic Priority: Harm Reduction

20. Overdose Prevention Centers
Study the feasibility of opening an overdose prevention center which are safe spaces where people can consume their own drugs in a supervised and hygienic environment.

Public Input[10]	Community feedback included suggestions on safer use sites as a means of keeping people alive and offering connections to harm reduction and medical services.
Epidemiology Data[12]	Bernalillo County drug overdose death rates have consistently remained higher than the state rates. Bernalillo County ranked 6th out of all New Mexico counties with a drug overdose death rate of 41.6 per 100,000 and accounted for over 40% of all drug overdose deaths statewide according to the NMDOH during the period 2017-2021.
Best Practices[63]	Overdose prevention centers are designed to reduce the risks associated with drug use, such as overdose, transmission of infectious diseases, and exposure to contaminated equipment. These centers have been shown to significantly reduce overdose deaths, prevent the spread of HIV, hepatitis C, and other blood-borne diseases, improve the overall health and well-being of individuals who use drugs, and do not increase crime in the surrounding area. Overdose prevention centers are not currently permitted under New Mexico state law; however a feasibility study could be a first step towards establishing the framework for implementation.

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Strategic Priority: Treatment

21. Caring for People Who Use Stimulants
Provide evidence-based treatment models for people with stimulant use disorder, including funding for contingency management which is recognized as the most effective intervention for reducing methamphetamine use.

Public Input[10]	Community feedback included comments supportive of contingency management as part of the need for long term, comprehensive care.
Epidemiology Data[11,12]	The VOICES New Mexico study found high rates of stimulant use in the City and County and methamphetamine contributed to over half of fatal overdoses in the most recent two-year period, emphasizing the need to provide treatment options tailored for people who use stimulants. Given the prevalence of methamphetamine use in the County, the lack of availability of Medicaid claims or MCO quality assurance activities prevented the ability to understand the extent to which people diagnosed with 'Stimulant Use Disorder-Amphetamine-Type Substance' were exposed to contingency management.
Best Practices[64–68]	SAMHSA recognizes contingency management, a behavioral intervention that provides tangible rewards for achieving specific goals, as an evidence-based intervention in the treatment of stimulant use disorder.

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Strategic Priority: Treatment

22. Medication Treatment Expansion in Jail
Expand MOUD services at Metropolitan Detention Center to serve people on the waitlist. Offer MOUD services at the Youth Services Center. Establish a licensed Outpatient Clinic Pharmacy at MDC to ensure that people returning to the community leave with a 30-day supply of MOUD.

Public Input[10]	Community feedback noted the need for MOUD services in jails and youth detention centers, specifically citing that few youth MOUD programs are available.
Epidemiology Data[12]	The MDC Buprenorphine/Suboxone Medication Assisted Treatment Program served a total of 1,505 individuals from December 2022 to December 2023, with 352 being new clients, averaging 29 new clients each month and providing maintenance treatment to approximately 150 clients each month. During January – July 2024, there was growth in the number of patients receiving buprenorphine: 551 patients initiated buprenorphine treatment and 183 patients received a bridge prescription upon release. While available reporting was limited for this Rapid Landscape Analysis, MDC also offers methadone treatment to individuals during incarceration. No data from the Youth Services Center was available for this analysis.
Best Practices[36,69,80]	Buprenorphine and methadone treatment in correctional settings is effective for reducing overdose risk especially upon release. Increased funding for medications and staffing capacity will help to meet the treatment needs for buprenorphine and methadone as well as integrated behavioral health services especially for those with co-occurring mental health needs. All formulations (e.g. sublingual, injectable, etc.) of medications should be available and the decision for medication choice should be a patient-led collaboration with the medical provider. Whenever possible, align medication options with those readily available in the community to facilitate a smooth transition for patients. The establishment of an outpatient pharmacy at MDC will facilitate access to take-home mediations upon release and should be integrated into reentry support and connections to community-based harm reduction and treatment services. In addition, the County should collaborate with the New Mexico Health Care Authority on implementing the recently approved 1115 waiver allowing for Medicaid billing 90 days prior to release to improve transitions to community-based healthcare.

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Strategic Priority: Treatment

23. Community-Based Medication Treatment Access and Quality
Improve initiation and continuation of treatment for MOUD in community-based settings through provider outreach, leveraging local expertise (e.g. MOUD ECHO), and utilizing the NMDOH Pathways program at local public health offices. Explore options to increase availability of buprenorphine at local pharmacies.

Public Input[10]	Community members cited concerns about the difficulties accessing care for people who are ready to engage in treatment. Key barriers described included long wait times, limited beds, and workforce shortages.
Epidemiology Data[12]	Almost half of participants who were treated with buprenorphine at CARE Campus do not continue their treatment. MDC and AFR EMS expressed challenges around treatment continuity for their patients. There is limited availability of information about retention in treatment. In addition, there was a 24% reduction in the number of people utilizing methadone between 2021-2023 and assessment of need and access can help identify how to invest in this evidence-based treatment option.
Best Practices[33,70]	A multi-pronged approach to improve community-based treatment access and quality should include increasing the number of prescribers, assessing the quality of treatment programs in following evidence-based models of care, and ensuring medications are accessible at pharmacies. Ensure that counseling and supportive services are available but not required as a condition of receiving medication treatment. Explore options to improve access to buprenorphine through purchasing medications directly and making them available to providers and facilities affiliated with the City and County, such as EMS, Health and Social Service Centers, Gateway Center, and the CARE Campus. Collaborate with NMDOH to identify and address barriers to adequate stocking of buprenorphine by pharmacies in the community.

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Strategic Priority: Recovery

24. Comprehensive Recovery Support
Provide comprehensive wrap-around services such as transportation, job placement and training, financial support, and childcare to foster a safe and economically stable environment for achieving and maintaining recovery.

Public Input[10]	Community feedback pointed to several economic supports such as job training programs, collaborations with businesses to hire people in recovery, direct income support including for families caring for people in recovery, emergency crisis funds. Feedback also named lack of transportation as a key barrier to accessing services and gaining employment.
Epidemiology Data[11]	The VOICES New Mexico study participants reported recovery goals ranging from maintaining medication treatment to financial support for treatment, housing, food, and mental health counseling. Transportation was a commonly reported barrier.
Best Practices [71]	Comprehensive recovery support recognizes a person's holistic needs and should be person-centered and dynamic as a person's needs evolve. Recovery supports can be implemented through case management services, recovery care organizations, reentry support programs, peer support services, or outreach services. Explore braided funding strategies to supplement existing funding sources with opioid settlement funds.

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Strategic Priority: Recovery

25. Recovery Housing
Expand access to recovery housing that is person-centered, supports long term medication treatment, promotes independent living skills, and ensures high quality of care. Provide emergency housing assistance without sobriety requirements to help people maintain stability and minimize disruptions to engaging in harm reduction and treatment services.

Public Input[10]	Community feedback on housing primarily focused on low barrier housing, citing the need to address the intersection of drug use, mental illness, and homelessness through reducing destabilizing actions like clearing encampments and increasing access to low barrier housing that supports people engaged in harm reduction, treatment and recovery. In addition, suggestions for increasing access to 'supportive housing', 'transitional housing', and 'low barrier housing' were used to describe recovery-oriented housing. Community members reported challenges using City-issued housing vouchers and difficulties finding locations that accept the vouchers.
Epidemiology Data[11]	The VOICES New Mexico study found that participants experiencing housing instability were more likely to use drugs in the past 30 days (92.4% vs 86.0%), were more likely to have experienced an overdose in the last year (22.2%% vs 11.5%), and were very worried about experiencing an overdose (23.1% vs 14.0%).
Best Practices[72,73]	Stable housing can provide a safe and supportive environment for individuals in recovery, reducing stress and increasing the chances of successful treatment. Housing services should be tailored to what a person needs. For people in need of emergency housing, consider a crisis fund to facilitate timely stabilization. For people ready for any level of recovery housing, utilize SAMHSA's recovery housing guidelines which provide foundational policies and practices for scaling up recovery housing access. Prioritize funding for the housing gaps according to the *Level of Support* housing capabilities identified in the City of Albuquerque's Recovery Housing Study.

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Strategic Priority: Stabilizing Supports

26. Anti-Discrimination Policies

Review and adjust policies as necessary to ensure that there is no discrimination against people engaging in harm reduction and treatment services, as well as those with criminal legal involvement, in settings funded or operated by the City and County such as housing, skilled nursing facilities, treatment providers, sober living homes, and shelters.

Public Input[10]	Community feedback named concerns about sobriety requirements and systemic prohibitions against medications for opioid use disorder as barriers to accessing healthcare and housing.
Epidemiology Data[11]	The VOICES New Mexico study found that Native respondents were more likely than White non-Hispanic respondents to report discrimination experiences (57.5% vs 44.1%).
Best Practices[74]	Ensure that policies are aligned with the Americans with Disabilities Act which prohibits discrimination against people in recovery including those who are taking legally prescribed MOUD. Review policies to assess for clear and comprehensive definitions on discrimination based on drug use history or participation in medication treatment, using inclusive and non-stigmatizing language, training City and County employees and funded providers on anti-stigma and anti-discrimination, providing reasonable accommodations, monitoring and responding to complaints and violations, and engaging with people in recovery for community input.

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Strategic Priority: Stabilizing Supports

27. Peer Support

Expand the peer support workforce to provide essential community support and guidance to people engaged in harm reduction, treatment, and recovery services. Support peer employment and professional growth including return-to-use support, education and anti-stigma training, pathways to certification, addressing workforce discrimination, and recruiting from disproportionately impacted communities (e.g., Native communities).

Public Input[10]	Community feedback consistently called for enhancing the peer support workforce. Specific ideas included placing peer support workers in mobile units to reach people who do not have access to transportation as well as in public locations such as libraries and community centers.
Epidemiology Data[11]	The VOICES New Mexico study respondents reported a common theme of how peer support services led by people with lived experience could improve knowledge sharing, reduce stigma and encourage more people to initiate treatment and harm reduction services.
Best Practices[75–77]	Peer support services are recognized by SAMHSA as an effective strategy to expand the reach of harm reduction, treatment and recovery support in community settings through sharing knowledge and skills, building mutual empowerment, and supporting goal setting. Assess the availability of peer support services across the continuum of care and identify opportunities to fund workforce development. Identify strategies to enhance the workforce, paying special attention to equity in recruitment practices, compensation, strengths-based supervision, and career advancement opportunities. Peer support workers can expand warm hand-offs from institutional care (e.g., corrections, hospitals, etc.) to community-based care (e.g., outpatient services, harm reduction, etc.). In addition, peer-led recovery housing and peer-run respite centers are models to explore and assess for supplemental funding.

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Strategic Priority: Stabilizing Supports

28. Civil Legal Aid
Fund access to civil legal aid for people who use drugs and their family members who need support in areas such as housing, benefits access, employment, child support and guardianship, and collateral consequences associated with criminal legal involvement.

Public Input[10]	Community feedback reflected the types of challenges that could be served by civil legal aid such as accessing social and financial supports with a history of criminal legal involvement or helping grandparents navigate child support resources.
Epidemiology Data[11]	The VOICES New Mexico study found that over a third of the respondents (40.7%) reported criminal legal involvement in the past year. Hispanic respondents were more likely to have past year criminal legal system involvement (44.3% vs 33.8%) compared to White respondents.
Best Practices[78]	When identifying civil legal aid resources, ensure that services are culturally responsive and accessible to the diversity of people impacted by the overdose crisis. Connect civil legal aid into the system of care for overdose prevention to strengthen the referral network.

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Implementing the Recommendations

The strategic plan is a roadmap for action to ensure that opioid settlement funds are used effectively to save lives and improve the health and well-being of the community, especially those who have been impacted by the overdose crisis. The recommendations are intended to be taken as a whole in order to have the strongest systemic level impact. However, the recommendations remain flexible and may be adopted individually to fit the City and County's specific needs.

Key implementation considerations:

- **Act with urgency** to account for the continued impact of the overdose crisis. Develop an implementation plan by January 2025 using SMARTIE objectives (Specific, Measurable, Achievable, Realistic, Timebound, Inclusion, Equity) for each adopted recommendation.[79]
- **Supplement rather than supplant** existing funding sources.[15] Review current levels of spending across the substance use and overdose prevention spectrum, including key opportunities for Medicaid support, and determine how opioid settlement funds can expand efforts or create new initiatives.
- **Adapt to evolving needs** and plan for the next iteration of the strategic plan. Use the Rapid Landscape Analysis and Community Engagement Plan as roadmaps for annual planning cycles.

The plan's flexibility ensures adaptability to evolving needs, while its emphasis on urgency and collaboration will drive impactful results. By implementing these recommendations, the City and County can leverage opioid settlement funds to save lives, improve health, and enhance the well-being of the community.

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Appendix A: Glossary

- **Equitable:** Everyone has a fair and just opportunity to attain their highest level of health. (CDC)
- **Facilitate:** To help (something, such as a discussion) run more smoothly and effectively. (Merriam Webster)
- **Low Barrier:** Services and processes are easily accessible and have minimal requirements for participation. They are designed to be inclusive and welcoming, especially to individuals who may face challenges in accessing traditional services, such as small organizations seeking funding or people who use drugs seeking SUD services.
- **Medications for Opioid Use Disorder:** Buprenorphine, methadone, and naltrexone are common medications used to treat Opioid Use Disorder. (SAMHSA)
- **Opioid:** Opioids are a class of drugs used to treat moderate to severe pain. Opioids include some prescription pain medications (Vicodin, oxycodone, morphine, etc.), fentanyl (a synthetic opioid), and heroin. Opioids block pain signals between the brain and the body. Opioids can make some people feel relaxed, happy, or "high," and they can be dependence-forming. Side effects may include slowed breathing, constipation, nausea, confusion, and drowsiness. (Faith in Harm Reduction)
- **Opioid Settlement Funds:** Funds resulting from lawsuits filed by state and local governments against companies whose actions contributed to the opioid overdose crisis.
- **Overdose:** Drug overdose happens when an individual has taken too much of one or more substances. Overdoses can be accidental or intentional and cause serious medical problems or death.
- **Overdose Rate:** The rate of individuals ingesting a deadly amount of a drug. This is typically reflected as the number of people who have died per 100,000.
- **Perspectives**: A particular attitude toward or way of regarding something; a point of view. (Oxford Learners Dictionaries)
- **Resolution:** A resolution is a record of decisions or wishes of the council and includes routine administrative and management matters. (Public Health Ontario)
- **Stakeholder:** One who is involved in or affected by a course of action. (Merriam Webster)
- **Stimulant:** Chemical substances ("uppers") that activate the brain and body, producing effects including alertness, increased focus, and increased heart rate. Examples include cocaine and methamphetamine. (NASTAD)
- **Strategic Plan:** Guides and strengthens a community's … ability to carry out its public health functions. It provides a guide for making decisions; allocating human and financial resources; and pursuing time-bound, measurable strategies and priorities. (Minnesota Department of Health)

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Appendix B: Language Guide

There isn't a common way to talk about drug use and drug policy, but the words we choose really matter. Language used in the media, town halls, interviews, or everyday conversations can unintentionally be stigmatizing or harmful. Public health experts and communities are recognizing that our everyday words contribute to the stigma around people who use drugs. To help raise awareness, we provide resources to guides created in recent years. Throughout this plan, we've chosen specific language to reduce stigma, including:

- **Person-First Language**: This type of language focuses on the person, not their condition or experience.
  - Avoid: Terms like "convict," "felon," "criminal," "offender."
  - **Use**: "Person with a history of criminal-legal system involvement" or "formerly incarcerated person." Sometimes these are shortened to acronyms like FIPS (formerly incarcerated person/people).
  - Other examples: "Person with a mental health condition," "person with a disability," "person who engages in sex work," or "person who is unsheltered."
- **Person** *with* **Lived and Living Experience**: The term "lived" is increasingly used to describe people who have a history of drugs use and the term "living" describes people who are currently using drugs. The terms recognize people's expertise and the importance of including them in policy and program development.
- **Describing Drug Use**: How we describe people who use drugs is crucial in reducing stigma. Terms like "druggie" or "junkie" are obviously harmful, but even other common terms like "addict" can be damaging, especially if you're not referring to yourself. When writing about people with substance use disorders (SUD), it's important to see them as whole individuals, not just defined by their addiction.

The Shatterproof Addiction Language provides additional examples as well as an extensive list of resources and other guides that have been created for different audiences, including media: https://www.shatterproof.org/our-work/ending-addiction-stigma/change-your-language

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Appendix C: Vital Strategies Workplan

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Workplan: Bernalillo County and City of Albuquerque strategic planning for opioid settlement funds

Updated April 1, 2024

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PROJECT OVERVIEW

Component 1

Timeframe: March 2024 to October 2024

Vital Strategies will provide in-kind technical assistance on legal/regulatory, communications, data and evaluation, drug policy issues to support the following objectives:

1. Coordination of technical assistance
2. Preparation of a landscape analysis
3. Facilitation of a public planning and meeting process
4. Development of a strategic plan that reflects "careful, deliberate and strategic use of opioid settlement funding," and consistent with the other requirements of the city and county resolutions

Component 2

Timeframe: April 2024 to October 2024

Vital Strategies will hire a short-term, local consultant to assist with the public planning and meeting process and coordinate development of the strategic plan. This coordinator would be supervised by Vital and collaborate closely with the City and County.

Component 3

Timeframe: November 2024 to September 2026

Based on ongoing planning and implementation needs assessed together with the City and County, Vital Strategies can hire a seconded staff placed at either the City or County to support implementation of the first strategic plan and to begin planning for 2025 and 2026. This position could be funded by Vital Strategies in the first year and potentially transition to a City or County position in the second year to continue strategic plan implementation and plan the next cycle of strategic planning.

WORKPLAN

These activities, timeframes, and products are focused on Components 1 and 2 with work to be carried out by the Vital Strategies team and the short-term consultant. Specific actions and timing are estimates and subject to change.

Summary of deliverables

- April 30, 2024 Community engagement plan
- June 30, 2024 Summary of findings from landscape analysis
- August 31, 2024 Summary of public input activities and findings
- October 15, 2024 Initial strategic plan

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Objective 1: Coordination of technical assistance		
Activities	*Timeframe*	*Products*
1.1 Assign technical assistance leads for workplan activities	March – April 2024	Ongoing: -Updated workplans -Regular planning meetings
1.2 Coordinate regular planning meetings with City of Albuquerque and Bernalillo County - March 18: kick-off planning meeting - April 16: consultant applications and workplan updates	March – October 2024	
1.3 Hire a short-term, local consultant to work in Albuquerque from April – October 2024 to facilitate workplan activities and liaise with city and county planning teams - April 2: launch RFP - April 15: close RFP - April 18: select consultant - * April 25: consultant begins (dependent on contracting process)	April 2024	

Objective 2: Preparation of a landscape analysis		
Activities	*Timeframe*	*Products*
2.1 Review of available data and identifying additional data needs - Document review of data shared by City, County, and other stakeholders - April 10: meeting to review landscape analysis planning template	March – May 2024	June 30, 2024: Summary of findings from landscape analysis
2.2 Review of available City and County funding sources and currently funded projects related to overdose prevention and the "local behavioral health, prevention, intervention, and addiction treatment system."	March – May 2024	
2.3 Review of state and local settlements spend plans and other opioid-related spend plans and guidance documents Document reference: BernCo and CABQ mirror resolutions R-23-174 ESTABLISHING A POLICY FOR THE EXPENDITURE OF OPIOID SETTLEMENT MONIES	March – May 2024	
2.4 Conduct rapid landscape analysis (and collaborate with Johns Hopkins School of Public Health -Vital's overdose prevention initiative partner- and/or local academic partners as needed)	April – June 2024	

Vital Strategies

Objective 3: Facilitation of a public planning and meeting process		
Activities	*Timeframe*	*Products*
3.1 Assess how existing advisory bodies could be leveraged for feedback and input on the strategic plan	March – April 2024	April 30, 2024: Community engagement plan August 31, 2024: Summary of public input activities and findings
3.2 Develop plan for engaging community stakeholders in the planning process, including setting regular public meeting dates - April 25 ABCGC + APS meeting: share updates on plan development	March – April 2024	
3.3 Host dedicated community engagement sessions with Pueblos and Nations in the geography of the County (Sandia Pueblo, Isleta Pueblo, Laguna Pueblo, and the Navajo Nation's To'Hajiilee Reservation)	May – July 2024	
3.4 Conduct initial community outreach and engagement (connect with people in active drug use, in addition to people in recovery, along with other stakeholder groups named in the resolutions, such as providers and business groups). Formats may include listening sessions, town halls, surveys, etc.	May – June 2024	
3.5 Support facilitation of public meetings, including (a) five listening sessions, one in each of the Five Commission Districts, with CABQ councilors invited as co-hosts at each of the five sessions and (b) five to seven listening sessions with one session dedicated to meeting with City and County lawmakers - May 20 listening session with lawmakers	May – July 2024	
If City and County would like to form a permanent advisory committee, Vital can: 3.6 Advise on purpose and membership of the committee (include people with lived experience) 3.7 Work with City and County to determine how committee members will be selected (e.g. open application, invitation only, etc.) 3.8 Facilitate committee meetings and liaise with City, County and the committee 3.9 Fund honoraria for participation of committee members	November 2024 onwards	*If City and County would like to form a permanent advisory committee, Vital can produce:* Advisory Committee formation and implementation plan

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<table>
<tr><th colspan="3">Objective 4: Development of strategic plan that reflects "careful, deliberate and strategic use of opioid settlement funding," and consistent with the other requirements of the city and county resolutions</th></tr>
<tr><th>Activities</th><th>Timeframe</th><th>Products</th></tr>
<tr><td>4.1 Incorporate landscape analysis findings, public input findings, and current City and County overdose prevention goals into strategic plan</td><td>August – October 2024</td><td rowspan="2">October 15, 2024: Initial strategic plan including evaluation metrics and high-priority areas for settlement funds spending</td></tr>
<tr><td>4.2 Develop initial list of prioritized interventions, strategies, and programs for spending of settlement funds, consistent with priorities named in the city and county resolutions (Section 7a. through 7d.) and “taking into account evidence-based and promising best practices and principles” (Section 8).</td><td>August – October 2024</td></tr>
<tr><td>If City and County would like to continue beyond November 2024, Vital can:

4.3 Develop updated list of prioritized interventions, strategies, and programs, consistent with priorities named in the city and county resolutions (Section 7a. through 7d.)</td><td>November 2024 – March 2025</td><td>If City and County would like to continue beyond November 2024, Vital can produce:
Updated strategic plan</td></tr>
</table>

ANTICIPATED OUTCOMES

1. Structural (short to medium term)
   - Improved coordination and collaboration across the county on caring for people who use drugs
   - Improved community engagement of directly impacted people
   - Established protocols for developing updated spend plans and evaluating impact
2. Population (long term)
   - Equitable reduction in overdoses
   - Equitable increase in access to medical, behavioral health, and other supportive services for people who use drugs

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Appendix D: Community Engagement Summary

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Qualitative Assessment of Community Input on the Strategic use of Opioid Settlement Funds in the City of Albuquerque and Bernalillo County

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Purpose/Intro

Introduction

Opioid overdose continues to be a public health challenge in New Mexico (NM). Approximately 75% of overdose deaths involved opioids. Opioids can cause slow or stop breathing, thus an opioid overdose can be fatal. In NM, we have seen an increase in Fentanyl usage and it has been found in pills circulated among both adults and youth. There has also been an increase in opioid overdose related emergency department visits, an 18% change in a 4 year period. Overdose deaths are preventable, and, with naloxone, lives can be saved. In addition, most overdose deaths are witnessed, meaning that someone else can intervene or call for help. Progress in addressing this epidemic will need to be multifaceted and involve key stakeholders, local community, service providers, leadership, people who use substances, friends and family of people who use substances, and discussions about harm reduction including barriers and possible solutions.

Background

Vital Strategies, a global health organization, is the lead implementation partner in the Bloomberg Overdose Prevention Initiative and is working in 7 states, including New Mexico, to achieve an equitable reduction in overdoses. They work to establish effective policy and program models that are adaptable across the county, with a focus on the people most at risk for overdose, including those harmed by decades of failed punitive approaches to drug use. Following resolutions from both the Bernalillo County Commission and the City of Albuquerque, the lead team for the County and City developed a memorandum of understanding (MOU) with Vital Strategies to lead the work to develop a strategic plan for use of opioid settlement funds. Vital Strategies hired SBS Evaluation & Program Development Specialists, a local consultant to conduct community outreach and engagement

SBS Evaluation & Program Development Specialists, LLC is a woman-owned evaluation, technical assistance and training firm located and operated in Albuquerque, New Mexico since 2005. With years of experience specializing in public health, behavioral health, substance abuse prevention and treatment, SBS Evaluation & Program Development Specialists is the lead evaluation partner in various federal, state, and local initiatives. They work to establish data-driven-decision making through strategic planning, community engagement and program evaluation.

Purpose

On October 26, 2023, the City of Albuquerque and Bernalillo County passed mirror Resolutions R 23-174 and AR 2023-105 requiring that the City and County leadership develop a strategic plan on how to spend opioid settlement dollars before more funds were spent. The resolution required that public input be gathered on the use of the funds. Community engagement activities sought out opinions and ideas from the community and the people who have been most impacted by the overdose crisis.

Goals of Community Engagement

- **Improve community engagement**

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    - Listen to community concerns and ideas, build relationships, and learn from each other about the different ways the City and County, communities, individuals and families are affected by the overdose crisis.
- **Get community input, opinions, and ideas** from across the City and County on how drug use and current responses to drug use affect the community and how responses and programs can be improved.
- **Ensure that community members are part of the planning process** to inform the development of a City and County strategic plan to equitably and sustainably reduce overdoses.
- **Create a report that summarizes the key themes** from community feedback and share that report with City and County leadership.

Acknowledgement

SBS Evaluation & Program Development Specialists extend our gratitude to all of the community members, people with lived or living experience, parents, family members, service providers, and stakeholders who attended the community engagement sessions and generously shared their knowledge and experiences with our team. Their contributions and their perspectives have been instrumental in this report. We also extend our gratitude to Vital Strategies, Albuquerque City Counselors, and Bernalillo County Commissioners for the opportunity, their leadership and commitment to addressing the opioid epidemic.

Community Engagement

Outreach

The SBS Evaluation team conducted outreach to various community stakeholders to advertise the various methods of engagement, including an online survey, listening sessions, and town halls. The first step was to create an outreach plan, which included a dedicated phone line, dedicated email address, online survey, social media, as well as in-person, outreach. In creating the outreach plan, our goal was to reach both the general community and specific stakeholder groups to ensure community participation from residents. Outreach to 170 organizations included targeted emails and calls, in-person outreach to specific stakeholder groups, advertising at libraries, community centers, and various community groups. Throughout the month of June, approximately 130 organizations were contacted. An additional 40 groups were visited in-person and several presentations in the community and at conferences were made. Additionally, listening sessions, town halls, the online survey, phone number, and email were all advertised on various social media platforms. This included posting on the SBS Evaluation Facebook page, creating a Facebook page specifically for the opioid town halls/listening sessions, advertising on NextDoor, creating events on MeetUp, and posting on LinkedIn. Social media outreach generated 5,969 impressions.

SBS Evaluation created a publicly available online survey used to gather interest in participating in small listening sessions, which was shared widely when conducting outreach. We invited

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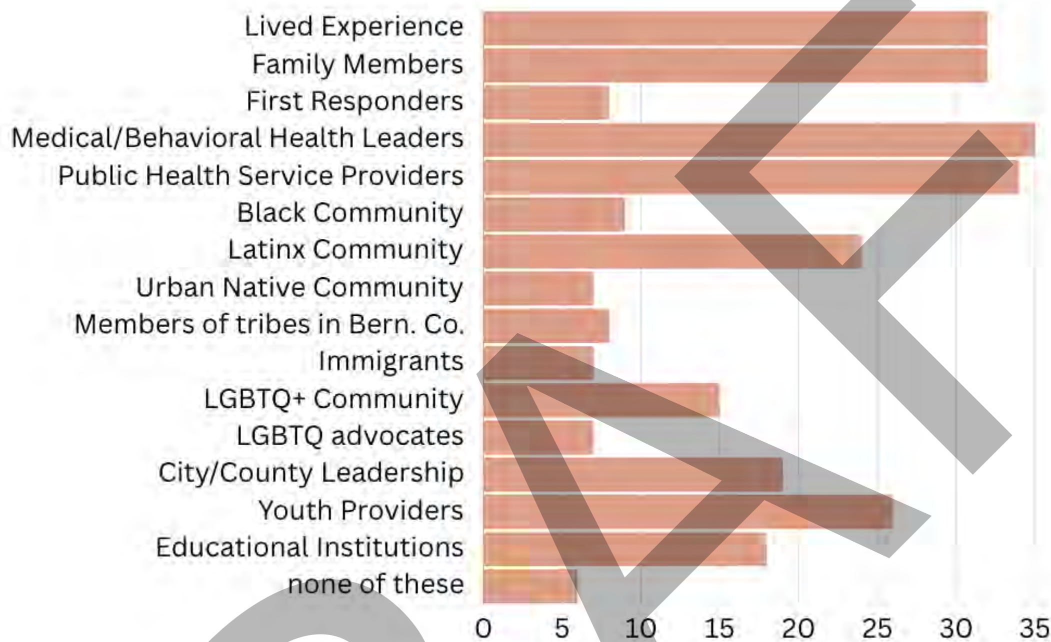
community members to these smaller 5-15 person listening sessions if they identified with one of the specified stakeholder interest groups. Some stakeholders were identified to participate in a listening session through other means of engagement as well. 100 people completed the interest survey to participate in a listening session. The interest survey reached all stakeholder groups (see Figure 0).

Figure 0. Stakeholder groups of those who signed up to participate in a listening session



Note: Survey respondents could select multiple stakeholder identities.

Gathering Community Input

The SBS Evaluation team gathered input from community members in a variety of ways. The goal was to make providing feedback easily accessible, safe, and comfortable; community members could identify a method that worked for them, thus increasing participation. We know that there is fatigue in the community with research that may feel extractive in the face of a monumental problem, so we offered opportunities for low levels of engagement, while also offering opportunities for deep engagement for those who had more to share. Collecting feedback in multiple ways reduces the impact of the bias of each method: we heard people share ideas in large community settings, in small groups of their peers, anonymously through surveys, and in one-on-one interviews (see Table 0). 'Stakeholder' during this project means an individual who has a stake in the opioid crisis, that can include someone who belongs to a group who has been identified through research to be more vulnerable to the opioid crisis or someone that provides services to those with lived experience, a family member of someone with lived/living experience, etc.

Table 0. Summary of community engagement and reach

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Mode of community engagement	Number of sessions	Number of community members reached
Town halls	5	411*
Listening Sessions	16	153
Interviews	8	8
Community feedback line-phone	-	5**
Community feedback line-email	-	27**
Surveys (online)	-	169

*Includes duplicate individuals who attended multiple town halls and listening sessions.
**Number who shared feedback. There were other contacts with questions.

Several demographic characteristics (gender, age range, race-ethnicity, and stakeholder group) are reported in this section. Although we believe that we heard a variety of voices, some populations were reached in small numbers given the short time frame to raise awareness and engage with community members. In particular, monolingual Spanish speakers were reached in very low numbers. Community members under 35 were also underrepresented. Caucasians were overrepresented in these community engagement opportunities compared to their proportion in the community. This bias should be kept in mind while reviewing the findings.

Although there were different formats of data collection, participants at town halls, listening sessions, and the interviews were prompted with the same five guiding questions (see Table 1). Through the various approaches, there was structure through the use of five guiding principles (see Table 2). The phone and email community lines were different in that they were open-ended, allowing the community to share their thoughts around addressing the opioid crisis, ask questions, or provide any general feedback.

Table 1. Five facilitation questions:

1. What are the **most pressing issues** related to the overdose crisis that you believe need immediate attention in Bernalillo County and Albuquerque?
2. From your perspective, what **types of interventions, strategies, programs, and/or services should be prioritized** when deciding how to spend the opioid settlement funds to address the opioid crisis and harms?
3. How can we ensure that these funds are spent in a way that is **equitable** and reaches the communities most impacted by the overdose crisis?
4. How can decision makers be **transparent and accountable** about how these funds are used and what steps can they take to hold the state accountable?

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5. In what ways can **decision makers collaborate with other stakeholder groups** to maximize the impact of settlement funds? If applicable, how can they collaborate with your stakeholder groups in particular? Please specify which groups in your answer.

Table 2. Five Guiding Principles:

1. Spend the money to save lives
2. Use evidence to guide the spending
3. Invest in youth prevention
4. Focus on racial equity
5. Develop a fair and transparent process for deciding where to spend the funding

Town Halls

A total of five town halls were hosted, one in each county district (see table 3 below). These were large in-person sessions open to all community members who wanted to provide feedback. County Commissioners and City Councilors from each district attended the sessions and provided welcome remarks.

Table 3. Town hall engagement numbers

County District	Date of Townhall	County Commissioner	City Councilor(s)	Number of community members reached*
District 1	7/31/24	Barbara Baca	Louis Sanchez and Joaquin Baca	80
District 2	7/2/24	Steven Quezada	Klarissa Pena	32
District 3	8/3/24	Adriann Barboa	Nichole Rogers	190
District 4	7/17/24	Walt Benson	Louis Sanchez and Daniel Champine	43
District 5	7/25/24	Eric Olivas	Tammy Fiebelkorn and Renee Grout	66

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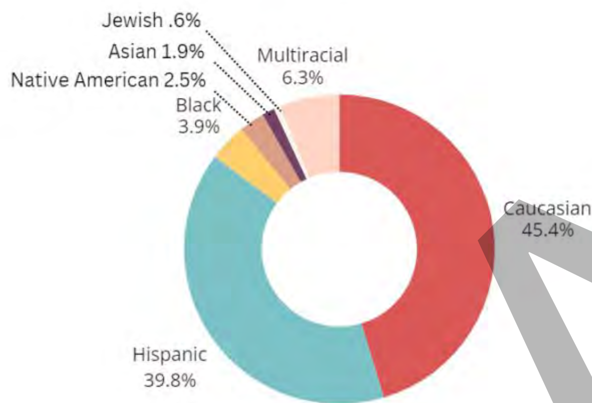
*Total numbers exclude SBS staff, Vital Strategies staff, City Councilors, and County Commissioners

At these sessions, community members were given an overview of the strategic planning process and settlement funds, then prompted with the 5 questions listed in Table 1 above.

Figure 1. Town hall racial-ethnic demographics

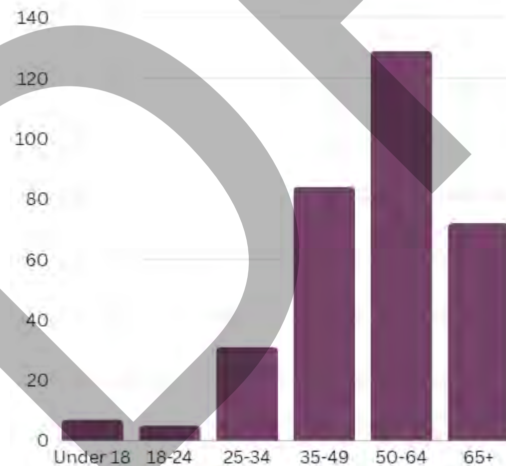


*25.3% missing race-ethnicity

Figure 2. Town hall gender demographics

*28% missing gender

Figure 3. Town hall participants' ages



*19.4% missing age

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Listening Sessions

Listening sessions were held for small groups of 5-15 self-selected stakeholders, with an ideal of 8-10. The goal was to provide longer sharing opportunities and an opportunity for moderated conversations. See Table 4 below (left side) for a list of stakeholder groups identified by Vital Strategies. SBS Evaluation facilitated 16 listening sessions (Table 4- right side), for a total of 153 participants, each targeting a specific stakeholder group.

The stakeholder groups chosen for listening sessions were those that had enough participants for an engaging session. Some stakeholder groups were harder to reach, thus we were unable to schedule a dedicated listening session (e.g. LGBTQ+, Migrant and Immigrant communities, First responders). If further community feedback is pursued, the stakeholder groups that did not have sufficient interest should be prioritized for feedback. However, many participants belonged to multiple stakeholder groups, including the ones mentioned above, thus all stakeholder groups were represented among listening session participants. Two of the four tribal specific listening sessions with tribal communities overlapping with Bernalillo County took place. Multiple attempts were made to host the additional two listening sessions, including formal requests, direct correspondence with Tribal Leadership administration, and contact with tribal program staff but they were unable to participate.

At each listening session, participants received an overview of the strategic planning process and settlement funds, then were prompted with the five facilitation questions listed in Table 1.

Table 4. Stakeholder listening sessions

List of stakeholder groups identified	List of listening sessions held
1. People with Lived and Living Experience 2. Lawmakers and Other City and County Leadership 3. Medical and Behavioral Health Leaders 4. Black Community 5. Latinx Community 6. Urban Native Community 7. Family Members of People who Use Drugs 8. Public Health and Social Services Providers 9. LGBTQ and LGBTQ Advocacy and Service Providers 10. Leaders and members of the Pueblos and Native nations in the geography of Bernalillo County 11. Youth Service Providers, and Parents of youth and young people 12. Educational institutions 13. Migrant and immigrant communities 14. First Responders	1. People with Lived and Living Experience 2. Lawmakers and Other City and County Leadership 3. Medical and Behavioral Health Leaders 4. Black Community 5. Latinx Community 6. Urban Native Community 7. Family Members of People who Use Drugs 8. Public Health and Social Services Providers 9. Youth Service Providers, and Parents of youth and young people 10. Educational institutions 11. Laguna Pueblo 12. To'Hajiilee Indian Reservation 13. Grandparents raising grandkids 14. Keep New Mexico Alive 15. Session for any stakeholder 16. WSCONA (Westside Coalition of

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	Neighborhood Associations)

Figure 4. Listening session race-ethnicities

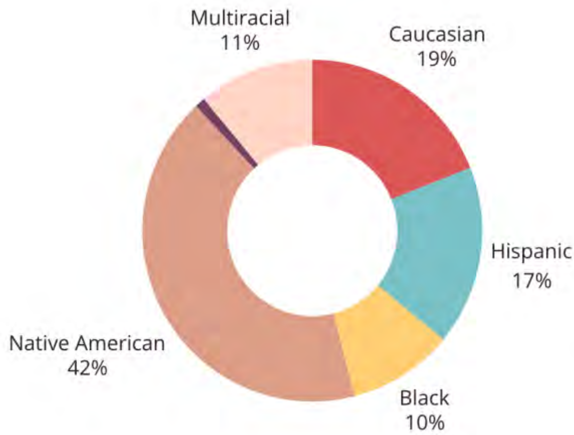


Figure 5. Listening session ages

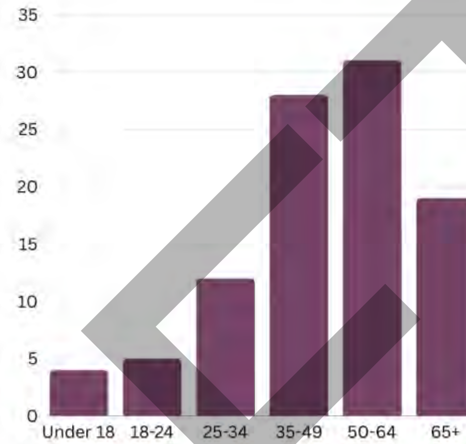


Figure 6. Listening session genders

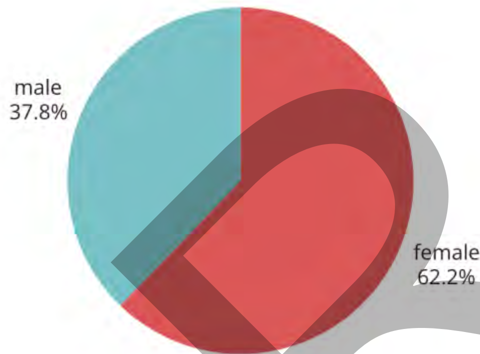
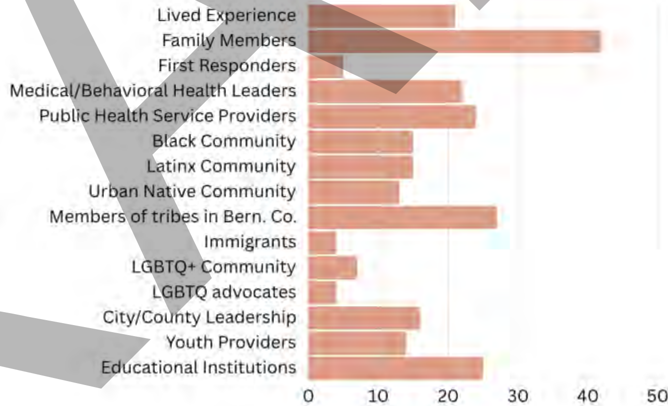


Figure 7. Listening session stakeholder identities



*Full demographics were not collected during virtual/hybrid listening sessions, including the urban Native community (only missing gender & age), lawmakers, educational institutions, grandparents raising grandkids (only missing race-ethnicity & age), and Keep New Mexico Alive sessions.

Incentives

Incentives were provided at each town hall. Incentives included a raffle of household items e.g. vacuum, blender, or keurig. In addition, food was provided for all who attended the town halls, with the exception of one town hall. All participants at listening sessions, with the exception of three one, received a $25 incentive. The sessions that did not receive an incentive either took place before incentives were determined, were not facilitated by the SBS team, or were added last minute. Food was provided during all listening sessions conducted by the SBS team.

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Feedback Survey

The feedback survey was an online option for community members to provide input. The survey was open to all community members, including those that had attended a townhall and/or listening session. There was an English and Spanish version available. 167 people completed the English survey, and 2 completed the Spanish survey. The underrepresentation of monolingual Spanish speakers in this data set (across all kinds of engagement) should be considered when reviewing findings and should be prioritized if future engagement activities take place.

Figure 8. Survey respondent ages

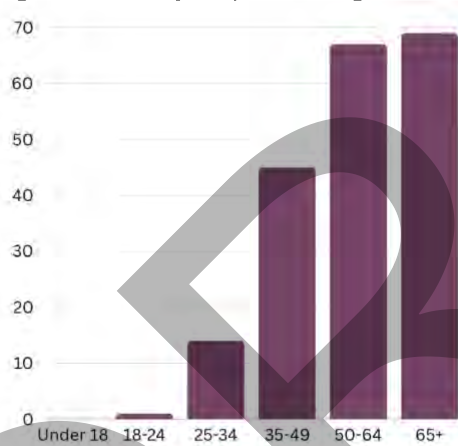
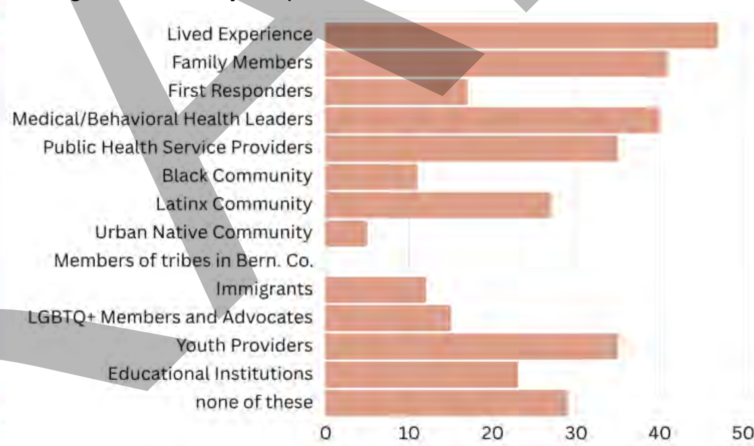


Figure 9. Survey respondent stakeholder identities



The survey prompted respondents to answer five questions–the same five that were posed at town halls and listening sessions (see above).

Community feedback lines–email and phone

SBS Evaluation hosted a phone line and email address that anyone could contact to provide input. Community members also used the line to ask for information about the strategic planning process, ask questions, or obtain information on upcoming town halls or listening sessions. These feedback responses were open-ended rather than in response to the five questions used for the other engagement methods.

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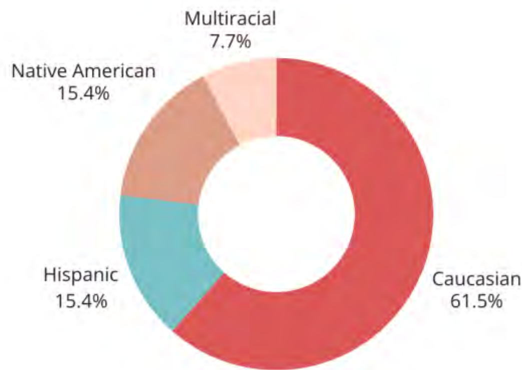
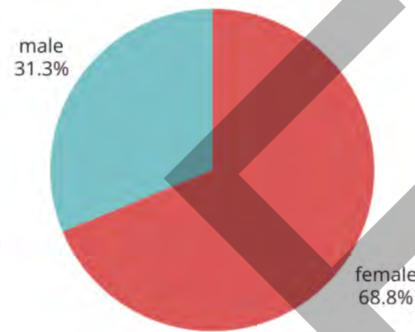
Demographic information was asked when possible, but since there is a lot of missing data, the demographic data for these modes of community engagement should be reviewed with caution as this missing data could potentially bias the results.

Figure 10. Feedback line race-ethnicities



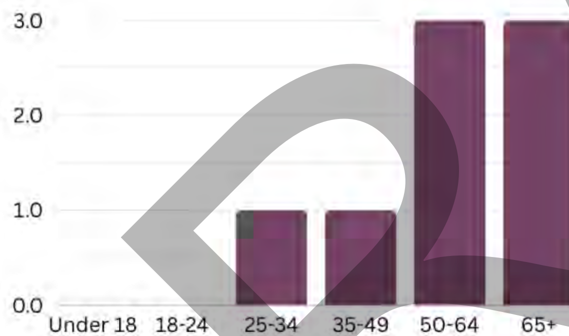
*57% missing race-ethnicity

Figure 11. Feedback line genders



*50% missing gender

Figure 12. Feedback line ages



*73% missing age

Interviews

Eight interviews were conducted with content experts in order to obtain detailed information and provide an opportunity for lengthier responses to the five questions that guided all community engagement discussions. Interviews were held with a treatment provider, youth serving provider, someone with lived experience, someone living through an opioid experience, a grandparent raising grandchildren, judge, medical outreach personnel, and a representative of Keep New Mexico Alive. These were semi-structured interviews that utilized the five guiding questions.

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METHOD OF ANALYSIS

The SBS Evaluation team conducted a thematic analysis to synthesize the large quantity of community feedback collected. When engaging with the community, the Evaluation team took detailed notes, recorded and transcribed the sessions to preserve the actual sentiments of community members for the analysis.

To make sense of so much rich, qualitative data, we began an iterative process of developing "codes" to represent recurring ideas or themes. For example, 'wraparound' was a code used when someone expressed the need for comprehensive care. There were multiple levels of codes, with the 'prevention' code being broader but related to 'education about opioids and the problems caused' and providing 'resilience activities' to the community. Coding the data allowed for urgency, level of importance, and frequency to be determined. We were also able to determine how input varied across community groups[1].

Coding is the means to develop and link themes in a thematic analysis, and it is used across qualitative methods in the social sciences and evaluation. Coding was used to develop cohesive themes about what the community thought should be done with the opioid settlement funds to address the opioid epidemic effectively. The opioid epidemic is a complex issue, so a wide range of topics were shared regarding the source of the problem, harms, solutions, and strategies for how to go about spending the funds in an impactful and ethical manner. Thus, this data should be understood as an *overview* of community sentiment since a list of all unique opinions and particulars would not be possible to include in this report.

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[1] We care about what matters to different community groups to ensure that the ideas of marginalized and underrepresented groups are not lost to the majority opinion.

SUMMARY REPORT OF PUBLIC INPUT

This report on input received through this community engagement process is organized by the overarching domains of Problem, Solution, and Strategy. Within each of these domains, the themes listed are in general order of public concern (i.e. which grouping of ideas were brought up based on frequency).

This section summarizes feedback received from community members as part of a community engagement process. This section does not offer commentary on the views expressed, nor does it represent the views of Vital Strategies or SBS Evaluation & Program Development Specialists, LLC.

Input on Causes and Challenges

The first of the five facilitation questions prompted participants to address key problems and impacts associated with the opioid overdose epidemic before discussing solutions. Overall, participants were solution-oriented, so most feedback presented ideas about solutions to address overdose. However, there were several issues repeatedly identified in response to the first question – i.e. to identify the most pressing challenges. This section presents themes raised through public input about the most pressing issues, perceptions about causes of the overdose crisis, and challenges in addressing overdose.

Within this section we present three subsections:

- Input about what people perceived to be underlying problems that contribute to the overdose crisis.
- Challenges people perceived in creating or accessing solutions to overdose.,
- Community feedback about the nature and quality of currently existing systems that attempt to address overdose.

How do people perceive potential contributors to the overdose crisis?

These were themes raised frequently through public input about peoples' beliefs regarding contributors to the overdose crisis:

- Several respondents saw easy access to opioids supply as a key problem, often mentioning this in connection with limited enforcement and prosecution of distributors.
- Addressing supply by increasing control around national borders was raised as a community concern.
- Easy access to opioids by youth and use in educational settings was also identified as a pressing issue, and the perception that students in schools have overdosed and/or are

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at risk of overdose.

What are key barriers to addressing the overdose crisis?

There were also several key problems highlighted that people perceived as barriers to addressing the opioid overdose epidemic. These included stigma, housing instability and homelessness, and limited or delayed access to treatment services.

Discussions about stigma tended to reference stigma as a barrier which blocks people with a substance use disorder from seeking treatment. Themes in this area included:

- Individuals will not want to seek help from providers who treat them poorly, judge them, or offer ineffective treatment options due to biases against evidence-based services.
- Stigma against medications for opioid use disorder (MOUD), for example based on notions that it substitutes one drug for another, blocks access for people who want MOUD or are in a stage of contemplating seeking MOUD. Stigma against MOUD was also linked to a low number of providers who offer MOUD and a limited number of beds in facilities who do offer MOUD.
- Stigma as a factor that decrease's self-esteem and discourages reintegration into society.
- Stigmatizing behavior towards treatment participants led several who had sought treatment to leave due to the "sub-human" treatment by staff.
- Individuals seeking treatment face stigma-based obstacles such as qualifications and requirements they must meet before being allowed to receive treatment, for example sobriety requirements.

  Illustrative quote: *"The way methadone is delivered is all about stigma. Why should they have to get it before dawn in some sketchy area? If we're going to throw money, be mindful to dismantle stigma. If [individuals with SUD] don't know where else to go, they'll go where it's welcoming."*

Housing instability and/or homelessness were raised both as the subject of severe stigma, and as a barrier to accessing services. Points raised by community members included:

- Unhoused people generally have odds stacked against them
- Shelter services are difficult to access. There are limited beds in the few shelters and limited housing options, and sometimes the options are high barrier.
- Respondents tied being unhoused directly to the SUD cycle, in part because it puts the individual back into the environment where they can easily access the supply.
- Comments frequently expressed that substance use, homelessness, and poor mental health are interconnected and that needs in the three areas need to be addressed simultaneously. In other words, respondents expressed that needs in one area cannot be addressed if the others are not also met.
- Encampment clearing actions further negatively impact people who are already in need. Both causing loss of difficult to obtain supplies, loss of services obtained at the encampments, and loss of a community.

  Illustrative quote: *"It bothers me when people look at [individuals with SUD] on the street with disdain, they are human beings with souls…We [as a society] are desensitized.*

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They're treated like trash. Police come along and throw their stuff in the trash, that's all they have. They try to get them in shelters and they [the shelter] won't take them with their dog. Why not?! [Their dog] stuck with them through thick and thin, the only one who hasn't left them."

What are the top concerns with currently existing services to address substance use and/or the overdose crisis?

Respondents raised two recurring themes around quality and concerns about the services that already exist intended to address the needs of people who use substances.

First, that treatment and services are difficult to access for structural reasons, with long wait times that undermine the value of services:

- Community members talked about ***long wait times of 3-6 months*** due to limited availability of beds and a ***workforce shortage***.
- Community members repeatedly mentioned that timing was essential for individuals with SUD seeking services; "*treatment needs to be available at the moment when the individual is ready, and so it can't be hard to find either."*
- Multiple respondents talked about having minutes *'7 minutes'* to find treatment before an individual changes their mind, yet community members also described waitlists of 30-90 days.

  Illustrative quote: *"We called [a treatment center], said he couldn't get in because he had not elected a provider. So he had to wait 2 weeks. We were on hold [on the phone] for 25 minutes and he walked away because he didn't want to wait anymore."*

Sober Living Homes were mentioned frequently as being an area of particular concern with regards to quality, effectiveness, accountability and regulation.

- A need for stricter regulations and accountability to ensure quality of services was mentioned during several sessions.
- Sober living can be high barrier, rejecting individuals on MOUD, and may not allow marijuana use either, making these facilities inaccessible for some in recovery.
- In addition, people mentioned the Medicaid fraud that took place in Arizona and wanted to avoid that happening in New Mexico.
- One participant described the ease that these facilities have with purchasing a home and calling it a sober living facility but was unsure of the quality and type of services offered if any.
- Some described living conditions to be hectic and not conducive to recovery

  Illustrative quote: *"I called my son, but he was living with 10 other guys and I couldn't even hear what he was saying. How are those conditions conducive for recovery, when you can't even hear your own thoughts, especially when you are going through withdrawals."*

  Illustrative quote: *"My son went to two living sober facilities, does anyone monitor or check on them? My son was in a small house with 10 men living in small quarters and he had bed bugs and would have to cover his arms to cover the bed bug bites when he went to work. He worked with senior citizens and having bed bugs put the elders at risk. He had to pay $450 a month with utilities. Some of the other men there were supportive,*

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but it was really loud and I could not hear him when we got to talked on the phone. How do you stay sane with that many people? That's overcrowding and they do this to make more of a profit."

Input on Proposed Solutions

This section presents different ideas for solutions that were raised to SBS during the community engagement process. We have categorized input into several broad areas, and presented each of those areas in order of the frequency with which they were mentioned.

Prevention-oriented Education Needs

Education was the most mentioned suggestion. Prevention, as a broad topic, was a key need. Respondents overwhelmingly emphasized that opioid settlement funds need to invest in prevention, in particular early prevention with a youth focus. Suggestion for increased education was often specified as school-based and community based meant to reach youth, parents, families, and grandparents. Preventive education for tribal members and leaders was also suggested.

Specific educational topics suggested included:

Naloxone and stigma. One respondent stated that *"accessing Narcan should be stupid easy, we should find it for free in vending machines, at libraries, community centers, hair salons, those metal boxes that hold newspapers, etc."* Respondents expressed a lack of awareness of the opioid overdose epidemic, related harms, and limited knowledge about how youth perceive the dangers associated with opioid use.

Signs and symptoms of substance use disorder. There were several mentions from parents who described a lack of knowledge of signs and symptoms of addiction. xxxx

Stigma reduction. Prevention and education were explained as a means to address a lack of awareness and as a means to decrease stigma. A media campaign was a popular prevention strategy suggested to address both a lack of awareness and the existing stigma. In particular, the idea to amplify the stories of people with lived experience via a media campaign was seen as a way that would address stigma by humanizing people's stories.
Illustrative quote: *"Tell stories of not just people living under bridges, but also moms, dads, leaders. They don't have to talk about their specific recovery group, but they can talk about what recovery looked like for them or what led to them being unhoused. The more people talk about their journey, the more people realize that it is happening in our community to anyone in our community."*
Illustrative quote: *"I had a job and was taking care of my dad who was getting older and had dementia. I kept having to miss work to take him to appointments and take care of him. I lost my*

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job, I don't blame them, because I was missing work a lot, but I had to be there for my dad. Then I got in debt and started using…you know… to cope with all the grief and losing him. Then I lost the house and here I am living on the streets. Now I just try to help my friends, you know we are more likely to help someone in need than anyone else is."

Another key component involved being intentional with the words that are used and the way people are treated. Several respondents expressed having had poor experiences at treatment centers where they were treated as sub-human by the staff, and that this behavior makes people hesitant to remain in the treatment center. Several respondents mentioned that staff must be empathetic, kind, and treat people as people.

Direct knowledge sharing from people with substance use disorder. People with SUD are part of the community and have stories that are relatable. For instance, one respondent shared their story of how they became unhoused after having lost their job due to the demands of caring for an elderly parent. Several people suggested having people with SUD share their stories in schools as prevention education for youth.

Activities that build resilience

After education, topics that we are broadly calling 'resilience activities' were the next most popular suggestion. Community members want safe, welcoming spaces and healthy activities available as protective factors against SUD and as a means of sustaining recovery.

Types of activities. Specific types of activities that were mentioned include sports, cultural activities, healthy coping mechanisms, alternative stress reduction activities, third spaces and community centers.

Target populations for activities. Suggestions to provide activities also frequently were paired with a desire to build activities for specific groups of people: youth, youth in recovery, adults in recovery, people with SUD, families, Native Americans, and to provide resilience activities within jails and schools. Activities for people in recovery and those with active SUD to provide an alternative to using substances.

Types of spaces. The concept of third spaces where resiliency activities could take place. These third spaces included community art rooms, yoga or meditation safe areas, reading nooks, teen specific centers, grounding areas, and culture as prevention centers.

Additional considerations. More specific prevention ideas included making prevention efforts multigenerational, having doctors offer more treatment alternatives to prescription opioids, providing medication disposal opportunities, and having pharmacists educate patients about the harms of opioids and their proper disposal.

Providing housing options

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Respondents suggested a variety of ideas to develop housing options that meet the needs of the unhoused community and people in recovery. Some of the suggestions included housing for single parents, families, or individuals with pets.

Low barrier housing. Foremost, people suggested housing for people in recovery that is low barrier and includes provision of various service needs and support, i.e. 'recovery housing, long term housing with intensive case management and job skills training.'

Supportive housing. Some participants mentioned this specific kind of housing, described as a setting where an individual pays a small portion of affordable rent, is a longer-term solution, and where individuals can partake in services (e.g. substance abuse treatment, mental health support, counseling, intensive case management, etc.), although it may not be geared exclusively toward those in recovery.

Sober living. Some participants mentioned the need for a safe and supportive environment for people in recovery to live with others committed to sobriety who can hold each other accountable. Sober living was specifically suggested as a form of long-term housing (e.g. a few months to a year or more) aftercare that allows people to go back into community but not into the same environment, or same neighborhood, or the same acquaintances. Although sober living was mentioned as being higher barrier due to the limitations associated with it (i.e. no marijuana use allowed, no MOUD allowed, people get kicked out for being a couple of days late with rent payment), sober living with support, employment support, money management, and family support.

Transitional housing was also mentioned as a stepping stone to permanent housing. This temporary housing was seen as needed to help people experiencing homelessness or who are at risk of becoming unhoused. The need for step down housing and other programs that provide people with the opportunity for less intensive supports as they advance in their recovery. Transitional housing was mentioned in combination with the need to provide skills development, life skills, employment assistance, and assistance accessing community resources.

Additional shelter ideas. Some respondents also called for more shelters, and for them to be lower barrier. Community members stressed that shelters should be accessible across the city. These comments included a range of ideas such as a tent city, a community of tiny homes, and beds in public spaces that can be locked to ensure safety and are furnished with a phone charger similar to sleeping pods or sleep boxes seen in some airports.

Challenges in use of housing vouchers. A large number of individuals noted the challenges associated with housing vouchers. Participants expressed that few landlords accept housing vouchers, may refuse services due to stigma, evacuate someone prematurely yet keep the voucher fees collected, refuse to accept the voucher but will take cash, and that landlords may partake in abusive or fraudulent practices with regard to tenants using housing vouchers. In addition, people suggested that not many areas of the state have locations that accept vouchers and those that do are located in areas that would facilitate relapse.

Providing Medications for Opioid Use Disorder

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Provision of MOUD, who should receive it, and where it should be available, were frequently repeated points of discussion. Public input suggested that MOUD programming should be improved and expanded.

Specialty programs and locations. People stated the need for MOUD to be available specifically in jails and detention centers. *"People should have the opportunity to begin or continue their recovery while detained."* Participants also mentioned there are very few programs that offer MOUD for youth or detained youth.

Access through physicians and primary care. Some respondents suggested the need for more doctors to offer MOUD services, including primary care doctors. Related to this point, there were suggestions of an easily accessible treatment location database where people can find providers willing to offer MOUD. In addition, limited knowledge of MOUD practices among practicing physicians was mentioned as a barrier to MOUD services.

Illustrative quote: *"I think we don't see more medical providers providing suboxone or treating addiction because what we're preaching to them is black and white: suboxone or no suboxone. They're not seeing the in-between of how we can treat it: 'There are 72 hours before we introduce suboxone/buprenorphine and so I'd rather just not touch it at all.' We need to get addiction medicine doctors, primary care doctors and peers into one room to have a conversation. Individuals looking for MOUD should be able to find providers who offer it, including primary care physicians, perhaps on some kind of database for community members."*

Long-acting formulation. Several respondents mentioned the need for a long-acting injectable formulation, especially for populations who may have difficulty remembering to take a medication, have limited to no transportation, and potentially difficult to reach. It was suggested that this injectable would make medication adherence manageable unlike the daily administered pill version.

Need for treatment-long term and better coordinated care

Respondents talked about the need to reorient SUD treatment and services to be long term and comprehensive, and a need for improved coordination at a systems level.

Wraparound and integrated care. Commenters envisioned centers that address mental health, SUD, social service needs, basic needs, and other services to treat the individual holistically. Some people mentioned 'integrated care,' the idea of addressing physical and mental health at one location, and others talked about the need for collaboration across systems of care. One example shared included a street outreach component, jail outreach, a safe living space, wound care, critical care, barber shop, life skills training, intensive case management, veteran services, primary care, legal services, and a kennel.

Step down services. 'Step down' treatment and housing were suggested, where patients have the opportunity to stay connected to services but at a least restrictive level. One suggestion included warm hand offs post release from jail or detention center or treatment center. Supportive services once someone has achieved sobriety was suggested especially since relapse is common. Undergirding this discussion was the widespread sentiment that SUD is a

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condition that requires long term support, thus services should be designed with built in long term ‘aftercare’ components.

Hand-off and coordination. Several comments expressed a desire to see various systems – housing, judicial, medical, education, government, and nonprofit – collaborate to fully support people in treatment and recovery, not allowing people to ‘fall through the cracks’ between systems.

Low barrier entry and retention in services. Individuals with lived experience talked about the challenge of qualifying for supportive services, including facing obstacles with services that will only allow entry and continued care based on continued sobriety.

Alternative treatment options. Several comments expressed support for alternative methods for coping with difficult situations as prevention. These services included yoga, massage, AcuDetox, seeding, meditation and traditional medicine. These services were thought to be used by the more affluent populations to reduce stress and as healthy coping mechanisms.

Early Identification and Intervention: Screening, brief intervention and referral to treatment (SBIRT) was mentioned for early detection. Many family members expressed concern at the number of times their family member had been seen at an emergency room or an urgent care clinic but the substance use and the opportunity to intervene had been missed. Community Reinforcement and Family Training (CRAFT) was also mentioned as a tool for working with family members before family ties are fractured.

Grief Counseling. For the children left behind and for the grieving parents. Grief among family members of those that passed due to an overdose was a difficult topic for most to discuss. Several individuals expressed that their grief led to substance use as a coping mechanism and some expressed that they did not have an opportunity to grieve; it was expressed that this was particularly true for youth who went back to school within days of the loss of a parent.

Trauma specific therapy: Both EMDR and RTM were mentioned as therapies that address trauma and could possibly get to the root cause since both therapies are not based on talk therapy, thus participants don’t relieve the traumatic experience. There was a focus on addressing core traumas.

Specific Services/programs. A variety of specific services were mentioned with supportive comments, including: detox, inpatient, low barrier option in-patient, rehab, case management (intensive and not), outpatient, faith-based, rehab for parents (where they can bring their kids or their pets), contingency management (an evidence-based strategy where incentives are provided to reduce substance use).

Supporting harm reduction and basic needs

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Another solution frequently mentioned was the need to invest in supportive strategies that focus on keeping people alive and meeting basic needs as first priorities, described generally as harm reduction or basic community resources, as well as attitudinal approaches towards people with substance use disorder or who use drugs. Some themes included:

<u>Naloxone access.</u> Participants voiced that naloxone should be easy to access. Several people mentioned the need for naloxone to be readily distributed through vending machines, at public events, schools, universities, community centers, and at frequently visited businesses. Respondents commented that naloxone cannot be distributed without education. They suggested creating infographics and posting them around town and training the public on how to use naloxone whenever it is distributed.

Illustrative quote: *“Everyday citizens are a huge part of the fentanyl crisis. Overdoses can happen anywhere! I once found a kid overdosing in a grocery store parking lot. Luckily, the pharmacy there had Narcan and we were able to bring him back before the ambulance arrived to take him to the hospital. Before this, I had no idea what to look for in someone experiencing an overdose. Fortunately, other passersby did know, and we were ale to act swiftly. Everyone should be educated on this and everyone should be carrying doses of Narcan in their glove boxes of their cars. Think of Narcan as a fire extinguisher. You hope to never need one, but you’re glad that you do if you need to save someone’s life.”*

<u>Harm reduction through safe use supplies and spaces.</u> Other suggestions included establishing safer use sites - both formal safe use sites and informal, private spaces that provide safety for current users - syringe exchange and disposal locations, test strips to determine which substances are in the supply, and providing safe supplies (such as foils, glass pipes, and wound care). Commenters noted that safe use sites have been successful in other states and that New Mexico should take lessons from other states and countries.

<u>Outreach and Community connection for harm reduction.</u> Community outreach includes *“boots on the ground. Go up and down and talk to people and see what they need. And have the resources to do that.”* Many mentions were made about the importance of treatment providers and peers going out into the community to talk to people, provide services where people are, and provide resources. This was described as taking services where people need them most, out in the community, out on the streets.

<u>Basic life needs in public spaces.</u> A large portion of participant responses centered around the importance of addressing basic needs and offered ideas for basic amenities particularly in public spaces. These responses were varied in nature, but all involved remembering that there is a person at the center of addiction. Some ideas included having publicly accessible bathrooms and showers available in each district, mobile units with bathrooms and showers that could travel to different locations during the day, and water fountains and charging stations outside of libraries so that people can fill up their water bottles when the library is closed.

Illustrative quote: *“The fact is, not everyone on the street is using and if they are, that does not mean that they want to get clean. We act like everyone needs this or that. There were times when I didn’t want to stop. I want a house, but don’t want to stop using. I want food, but I don’t want to stop using. That’s where harm reduction comes in.”*

Behavioral health workforce

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The next most common topic centered around the behavioral health workforce, including the types of professions and services as well as improving access to this workforce by people with SUD.

Peer support. Several comments called for enhancing peer support resources in New Mexico. Commenters cited the value of a behavioral workforce that includes peer support, including the importance of lived experience with both substance use and behavioral health that helps develop a trusting relationship with community. While numerous respondents mentioned the need for peer support workers, others mentioned community health workers or navigators, as people who would do similar work in the community. Lived experience was mentioned as an invaluable factor in helping others.

Illustrative quote: *"An expansion on peer support is number one. To say people don't want help…it's not that. It's that they don't know what that [help] looks like. They don't have someone standing with them [holding their hand every step of the way]…If we don't teach them how to do it [life skills]; daily support and accountability from a peer support worker works."*

Mobility of behavioral health workforce. Community members suggested that behavioral health workers, especially peers, should be mobile considering transportation challenges which can make it difficult for people in need of services to access them. Suggestions include mobile outreach units that drive around the county with a focus on high-need areas, street medicine teams in each district, as well as peer support workers out in the community with a focus on public locations like libraries, bus lines, and community centers. Expanded hours of these outreach and mobile behavioral health services were also discussed to ensure access of services when needed. Illustrative quote: *"People don't just need help with substance use or their mental health between the hours of 8-5pm, if we want equitable services, we need to make sure that services are available when people need them, not when it is convenient for us."*

Training for behavioral health workforce. Respondents emphasized the need for behavioral health workers to receive more training. Some suggested that trauma-informed training would be valuable, while others indicated the need to increase general workforce capacity (e.g. culturally appropriateness, harm reduction vocabulary, availability of resources, etc.)

Expanding number of behavioral health workers. Alongside the conversation about increasing the capacity of the behavioral health workforce was a discussion about increasing the number of behavioral health workers in the state. To incentivize more people to join the workforce, some respondents suggested that tuition should be free for those pursuing a degree in behavioral health and social services. Another suggestion was to increase wages for behavioral health providers. Providers themselves shared that it is a stressful job that is not compensated fairly: *"an opening case management position is $15 an hour. It's mental and emotional work. If you don't have the support from your agencies or compensation, then no one wants to do it."*

Ensuring treatment quality

There was also discussion about the quality of behavioral health services received, which relates to the capacity of the behavioral health workforce. Respondents suggested regulating treatment so that patients receive a standardized quality of care. Another suggestion was a rating system for treatment facilities similar to restaurants, so that potential clients could know the quality of services to expect.

Policing and Prosecution Discussions

There were numerous discussions surrounding the enforcement of laws and prosecution, both in support of greater enforcement and in opposition to using settlement funds towards law enforcement. Themes that arose included:

Increased enforcement and hot spotting. Some community members expressed a perception of inadequate drug law enforcement, with several stating that the police department should increase enforcement in hotspot locations. Some community members encouraged the public to report instances of drug use or sales to make the department aware of the largest areas of need. A few respondents stated that police are already aware of hotspots but are not active at these locations. Some shared that the department is currently understaffed and supported recruitment efforts for the department.

Illustrative quote: “I live in Albuquerque. I watch active narcotics trafficking activities occur constantly in my neighborhood with no police intervention.”

Investigations and sentencing for fatal overdose cases. Community members expressed the need for investigators to look into cases of overdose and pursue prosecution against the individuals who sold the lethal dose. Multiple family members mentioned that the individuals who sold lethal drugs to their family were never investigated or prosecuted and in some instances, never even investigated. This sentiment was echoed by others who support heavier sentencing for people who sell drugs.

Opposed to funding for police department. Many people urged that no settlement funds at all be awarded to the police department. Reasons included pointing to police budgets that are viewed as already sufficient or too high, or general disappointment with police responses to the overdose crisis and with the availability of substances. Some also expressed disappointment with how their personal loss due to an overdose was handled, with cases not investigated and people left with unresolved pain.

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Support for funding police department. On the other hand, there were a few community members who encouraged funding be spent towards certain police programs - but not for unrestricted use, or for purposes not directly related to overdose, or for "street clean ups". *"Ensure none of this money goes to buying more police vehicles, equipment or more tools. If any money goes to them, [it] should be for training them or anything that could impact substance use. I don't think any money should go to [the] infrastructure of [the] police."*

Drug treatment court and other alternatives to incarceration. Other suggestions included putting more funds towards drug treatment court as a justice system process that routes people to treatment instead of incarceration. Others emphasized programs that encourage individuals to take personal responsibility for their actions.

Addressing economic and social determinants of health

Respondents pointed to several economic social determinants of health that should be addressed because of how these factors can leave people vulnerable to the community impact of the overdose crisis.

Housing was a frequent point of discussion on this subject, but has already been discussed in more detail above.

Employment support and job training for people in recovery. Comments on this topic included supporting people in recovery to pursue CPSW licensure or trades. Respondents suggested more general employment support and working with local businesses to hire and support the job training of people in recovery. Commenters also described that programming could provide support with resumes, applications, work attire, financial management etc. Respondents also suggested providing life skills training.

Direct income support. Another theme for fostering economic stability from community feedback was to increase income. A number of respondents suggested providing stipends for the family members of someone struggling with SUD with the purpose of using the funds for treatment or to help support the family in some cases. Others suggested ideas for universal support, including Universal Basic Income, increasing the minimum wage to a living wage, and education loan forgiveness. A specific idea was a living stipend that is provided just to a smaller vulnerable population instead of universally, such as for the unhoused or for grandparents/guardians raising grandchildren/family.

Financial and other supports for grandparents. Commenters noted the challenge that grandparents face in raising children, when the parents of the children suffer a fatal overdose or have a substance use disorder. This included community comments supporting:

- Assistance with clothing, school supplies, and food for the children, especially for grandparents whose level of income does not qualify them for SNAP but who nonetheless struggle with new costs related to raising a child.
- Funding to support grandparents putting children into sports, dance, art or other community activities.
- Respite support for grandparents or family members raising grandchildren/youth.

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- Social service navigational support for grandparents or family members raising grandchildren/youth.
- Supports in managing grief after loss of a parent or a child, both for the grandparent and for the children.

Illustrative quote: "*You wouldn't believe how many parents are addicted. Grandparents are hurting and have limited funding and most are retired yet trying to provide for their grandkids. The kids need funding if they want to be in baseball, football, some kind of sport. Grandparents need financial, material and respite support, whether from a CYFD policy change or other programmatic support with these settlement funds. We are grieving due to the loss of a child, our grandchildren are grieving the loss of one or two parents, and now add to that an unexpected financial burden that sometimes leads to food insecurity and/or bullying for the child who does not have appropriate clothing.*"

Emergency crisis funds. People suggested other forms of temporary relief to alleviate economic instability in the face of a short term crisis, for example a medical debt, funeral debt, or major unplanned vehicle repair. A specific suggestion was a community crisis fund that community members can access when they experience unexpected costs that they cannot manage. Others suggested covering the funeral costs of loved ones lost to the overdose epidemic.

Accessibility of treatment and services

Community feedback frequently raised the issue of existing treatment and services being difficult to access. Suggestions for improvement in this area fell generally into four categories:

More treatment placements should be available. The majority of participants expressed their concern with wait times being too long (range from 3 months to 12 months), and that this is related generally to needing more treatment placements ("beds") and needing more workforce to staff treatment placements. Some mentioned that vacancies last an average of 6 months.

Treatment placements should be easier to find. A general theme was that people who seek treatment services should know where to go, know where a placement is available, and be able to get a response in a reasonable time. Some suggestions were for a database like OpenBeds to show the public where treatment is available or making dedicated 'navigators' available to help find placements. Suggestions to improve the OpenBeds and similar systems included financial support for the agencies having to update the system daily. Another suggestion was a call line that provides services to meet the needs of those interested in treatment but awaiting treatment placement.

Enrollment into treatment should be free of barriers. Some participants described that even upon finding an available placement, there can be barriers to being accepted/enrolled. This included insurance or administrative barriers, basic documentation requirements (identification, mailing address, birth certificate), intake windows that are limited to certain days or narrow windows of time, sobriety requirements, having a medical provider, and systemic prohibitions or restrictions against people who are on MOUD for treatment.

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People in treatment should not be inappropriately removed from treatment. Several comments noted that after navigating the challenges of enrolling in treatment, individuals can be removed from treatment for unexpected reasons. This includes dismissing patients for noncompliance with administrative rules, for being late to appointments (including being late because of conflicts with their employment schedule), noncompliance with cleaning taste (including when feeling unwell due to withdrawal) and for facing challenges in making timely payments (including being 2 days late with a payment.

Mandated Treatment

Some respondents gave feedback in support of mandated treatment, focused on the idea that people with SUD have an impaired capacity for decision-making. During these discussions, people raised their desire for a way to allow family members, (parents or adult children), of a person with SUD to make medical and other life decisions on their behalf and to have those decisions enforced through mandatory orders.

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Differences between Stakeholder Listening Sessions and General Open Sessions

As part of the analysis, SBS Evaluation looked at the ideas that came from targeted stakeholder listening sessions to see if they differed from the most popular ideas in the full data set (all town halls, surveys, listening sessions, etc). Their perspectives as people generally closer to the overdose epidemic and its harms are important to highlight, especially when so many respondents emphasized that decision makers should consult with stakeholders.

In general, the most popular themes raised in the stakeholder listening sessions were similar to those of the full data set. Stakeholders and others were highly concerned with prevention, education, stigma, and resilience activities.

However, there were some notable and important differences in priorities frequently mentioned in the stakeholder listening session versus priorities that arose in the general data set. It should also be noted that open public feedback sessions tended to draw older and elder attendees, and that targeted stakeholder listening session groups tended to have on average younger voices, so this may also contribute to differences:

- Stakeholders with relevant professional experience were less interested in enforcement and prosecution actions, including activities focused on impacting supply of illicit drugs. Discussions focused more on solutions outside of these strategies.

- Stakeholder in the listening sessions were less focused on conducting new research or generating entirely new ideas about how to address overdose risk. Discussions were generally more oriented toward solutions that are already researched and known to be effective, including those in other states.

- Participants in stakeholder listening sessions were, comparatively, more focused on:
    - Providing funds with fewer restrictions/obstacles
    - Decreasing long wait times for existing treatment services
    - Increasing peer support services
    - Increasing access to MOUD
    - Effective outreach out in the community with the population in need
    - Accessibility of a range of services across the continuum of care

- Naloxone access was mentioned substantially more during general open sessions (i.e., the full data set) as compared to stakeholder listening sessions.

- Unique ideas were shared during stakeholder listening sessions
    - third space (e.g. a place where you can read a book, study, work, meet other people, interact with others, a place where community can feel anchored)
    - GPS tracking system for a transportation service that will take people to MOUD, counseling, peer support drop in center, etc.

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Differences across Town Halls

Each town hall was held in a different county district in order to maximize opportunities for participation. While the town halls were open to the public, the idea was that residents would attend the town hall in their district. Since each district has its own unique challenges and demographics, it was expected that there may be slight differences in the problems and solutions raised across districts It is important to note that while the intention was for residents to attend their district's session, it is uncertain how much this actually happened. The SBS team that organized the events noticed several people attending sessions in multiple districts, and others told the team that they lived in one district but attended a different session due to time constraints. Keeping these limitations in mind, the following section will present the most popular themes of each district's town hall, but do not necessarily represent the opinions of that district.

District 1, the most common themes that emerged were stigma, resilience activities, and MOUD services. Stigma was presented as a main problem when it comes to community members and treatment providers alike not understanding substance use disorder or appropriate interventions. In terms of solutions, several respondents suggested prioritizing resilience activities that would support prevention. These activities included sports opportunities for at-risk youth and opportunities for adults to volunteer in the community.

District 2, housing and peer support were discussed most frequently. Respondents described a lack of affordable housing as the most pressing issue that needs to be addressed in the community. Housing First is a prevention and treatment strategy by meeting an individual's basic needs, treating them as human, and providing them with a more secure environment to recover. Respondents at this town hall also discussed funding peer support programs as a pillar of recovery.

District 3, the main topics of conversation were education, supporting basic needs, and monitoring the allocation of opioid settlement funds. Several people discussed the importance of school-based education programs that teach kids about substance use and recovery. Further discussions focused on treating people with respect and empathy, especially in treatment facilities. We heard from several respondents in various sessions that being treated poorly by providers is one of the main reasons that people do not seek help, both behavioral or medical. This town hall emphasized that all people are deserving of dignity and hope. On the funding side, respondents expressed a desire for a system of checks and balances to hold people accountable. Suggestions included an advisory board or committee that includes members with lived experiences to oversee the allocation of funds and ensure they are being utilized appropriately.

District 4, conversation centered around peer support, program evaluation, and funding already existing programs. Respondents discussed the unique perspective and skills that peer support workers bring to the table. Funding more peer support workers was one of their top priorities. Furthermore, programs that already exist in the county were perceived as currently working well. Respondents suggested that enhanced program evaluation can provide suggestions for program improvement or provide outcome data to reflect program success. Respondents felt that it is

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unnecessary to reinvent new programs, when we can focus on funding and fostering current programs. As one participant put it, there is no need to reinvent the wheel.

District 5, the main themes that emerged were providing publicly accessible updated information about use of funds, evaluating programs, and funding existing programs. A system for public-facing transparency about use of funds was a more prevalent theme at this town hall. Some attendees suggested creating an online audit system that will allow community members to see who has been funded and how the funds are being used. Others reiterated the importance of an online forum where the community can ask questions about the overdose epidemic and the funds. Another major theme that emerged was the importance of evaluating treatment programs. It was mentioned that several facilities are not up to standard and should be properly evaluated so people know what to expect before they arrive. Similar to discussions in district 4, respondents at this town hall felt that current programs could be offered more support, as opposed to creating new programs from the ground up.

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Input on Strategies for Spending the Funds

The fourth and fifth facilitation questions for community engagement asked about accountability, transparency, and how to collaborate with the community to spend these settlement funds appropriately. A persistent theme across modes of data collection was a need to build public trust in the government's ability and commitment to use funds constructively. Community members suggested several measures to foster the distribution of these funds in a way that is ethical, effective, strategic, and transparent.

Accountability of spending and frequent community consultation

Public Dashboard. The community identified the public as the group that would keep the government accountable with these funds. The most common suggestion was to create a publicly accessible, easy to navigate and frequently updated online dashboard of fund expenditures. Many respondents suggested regularly updating the public on programming selected and funds spent via media channels (radio, articles, news).

Community Committee. A high number of respondents also suggested a dedicated committee to provide oversight of spending, which could be a board (paid or volunteers, civilians generally or specific stakeholders). Respondents were concerned with making sure that the funds are spent on needed programs and for services that will help those suffering due to the overdose epidemic, thus evaluation was mentioned frequently accompanying the funding of programs.

Program Evaluation. Community members expressed the desire for funded organizations to demonstrate outcomes through the use of external evaluators. Evaluation was also noted as a means for quality improvement and identifying needed support, not as a punitive method.

Ongoing Community Input. In response to the question about how decision makers should collaborate with stakeholders, the community suggested continued community input. Respondents appreciated the discussion and the ability to provide feedback on such a vital issue that took place. Majority of respondents mentioned their desire for continued community engagement sessions through continued listening sessions and town halls. It was suggested that town halls be used to provide a summary of the strategic plan, allowing those that provided feedback to hear the outcome of the community engagement sessions.

Stakeholders expressed that they want to continue to be consulted throughout the process of opioid settlement fund distribution and that they understand that trends and needs change over the years. One service provider shared, *"My agency is in the heart of the international area. Our providers, our clients know the needs of the community. Listen to the people. The day the bus stops were combed by law enforcement for people with warrants, my client calls me and says 'can I see you today? They arrested over 70 people and I feel unsafe to take the bus.' Talking with stakeholders to learn the unique needs of the community. We need our*

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existing programs but the needs have changed a bit and we need to encourage innovative ideas to tackle this problem."

Differing opinions about spending over time

There were some conflicting opinions about how to plan for spending over time, and which geographic areas of the county to put funds into. A number of people suggested that the funds should be used for long-term programs. Others suggested funding in phases: new programming. Some suggested the funding of some programs that are ready or are currently implemented, have results and need additional support first, followed by the funding of programs that will take longer to establish or are newer. A few instead urged for sustainability planning from the outset, with the idea that these funds are limited and should not be used to build out systems that would require consistent funding.

Feedback about geographic distribution of spending

A number of respondents emphasized targeting the funds to geographic locations with highest need and creating a measure to guide funding allocation. A few suggested the funding of organizations and resources throughout the city. Some who suggested targeting resources raised the idea of an index of some kind through hot spots or developing an index of need to accurately identify areas for investment. Others felt confident about which areas have the most need based on personal and professional experience; the International District was mentioned by several respondents as an area that needs targeted funding.

Broad and low-barrier opportunities to apply for funding

There were a few suggestions about making sure that funding distribution is fair and thoughtful. Commenters stressed that if applications are overly burdensome with restrictive requirements for organizations, then innovation in treatment and services will be stifled. Comments reflected a concern that smaller agencies, without the capacity to complete intense applications or to comply with burdensome reporting and data tracking requirements, are providing important services but could be excluded from funding opportunities.

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Appendix E: VOICES New Mexico Summary

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VOICES

NEW MEXICO

A HEALTH SURVEY

SURVEY RESULTS

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The VOICES study is a partnership between Johns Hopkins Bloomberg School of Public Health, Vital Strategies and Pacific Institute for Research and Evaluation.

October 13, 2024

EXECUTIVE SUMMARY

VOICES is a study of people who use drugs designed to learn about their experiences with drug use, harm reductions strategies, treatment, overdose and health and social vulnerabilities. This study was fielded in Wisconsin, New Jersey, New Mexico and Michigan. These states are part of the Bloomberg Overdose Prevention Initiative, a multistate campaign to reduce overdose deaths supported by Bloomberg Philanthropies. VOICES is a partnership between Johns Hopkins Bloomberg School of Public Health and Vital Strategies, with data collection supported by the Pacific Institute for Research and Evaluation.

VOICES New Mexico was designed to help guide public health outreach efforts in Bernalillo County. The study aimed to recruit a high proportion of racial/ethnic minority individuals. To recruit participants, the study used a targeted, non-probability sample that focused on adults who had recent experience with drug use. Participants were recruited from 11 community service providers and asked to complete a 30-minute anonymous phone survey.

The final sample includes 673 individuals recruited from June-August 2024. Most participants were under age 40 (55.0%). Overall, 23.8% of participants self-reported as Native American, 49.5% Hispanic, and 20.3% White non-Hispanic. Most participants reported financial insecurity (80.1%). Approximately two-thirds reported housing insecurity (64.9%) and just under half reported having a chronic medical condition (42.6%) and having self-reported fair or poor health (43.7%). A large majority (90.2%) of participants used drugs in the past 30 days, and among these participants high rates of past month stimulant use (92.3%), particularly methamphetamine use (89.0%), and opioid use (81.9%) and polysubstance use (66.2%) were reported. About one-fifth of participants (18.6%) survived an overdose in the past year, and about a third (32.7%) were very or quite worried about having an overdose in the future.

The study found variation in access and use of harm reduction and treatment services. Among people who currently use drugs, 67.5% reported using harm reduction services in the past 30 days, 28.8% reporting using fentanyl test strips in the past 30 days, and 77.4% reported carrying naloxone. The top reasons for not using harm reduction services were feeling like services were not needed (43.1%), not knowing where to seek services in their area (22.8%) and transportation issues (5.6%). The top barriers to not using fentanyl test strips were not knowing what test strips are (25.7%), not having any test strips (23.1%) not wanting to use test strips (14.0%). Polysubstance stimulant users were more likely to use harm reduction services compared to non-stimulant users (74.6% vs 39.5%, $p<0.01$) and stimulant only users were less likely to carry naloxone compared to non-stimulant users (52.9% vs 74.4%, $p=0.02$).

Compared to White non-Hispanic respondents (55.8%), Hispanic respondents (69.3%, $p=0.01$) and Native American respondents (72.2%, $p=0.01$) were more likely to use harm reduction services in the past days. Native American respondents were more likely than White non-Hispanic respondents to have a naloxone kit (74.3% vs 69.2%, $p<0.01$). There were no differences across race/ethnicity groups in fentanyl test strip use, overdose experience and substance use treatment.

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INTRODUCTION

Amidst an unprecedented rise in overdose deaths, the VOICES survey was designed to learn more from people who use drugs about their drug use, harm reduction strategies, treatment histories, and perceptions of overdose risk. VOICES was conducted in four states (Wisconsin, New Jersey, New Mexico and Michigan) that are part of the Bloomberg Overdose Prevention Initiative. The findings are being used to examine overdose risk factors and areas for improvement in reducing barriers to harm reduction and treatment. The results of the survey will also allow the VOICES team to compare results across different racial and ethnic groups to identify disparities in treatment and lived experience that may in turn be driving recent fatal overdose trend disparities. This study is supported by the Bloomberg Overdose Prevention Initiative, a multistate campaign to reduce overdose deaths supported by Bloomberg Philanthropies. VOICES is a partnership between Vital Strategies, which is leading technical assistance for the Bloomberg Overdose Prevention Initiative in New Mexico, a multi-disciplinary research team at the Johns Hopkins Bloomberg School of Public Health, and a contracted data collection partner, the Pacific Institute for Research and Evaluation.

METHODS

Overview of Methods

VOICES New Mexico was a targeted, non-probability sample that focused on adults who had recent experience with drug use. The survey was designed to encompass Bernalillo County, to provide racial/ethnic diversity, and to include both people currently in drug treatment and people not in treatment. The survey was designed to be a 30-minute anonymous survey completed by telephone. Individuals received $25 gift cards as compensation for their time. Survey participants were primarily recruited from 11 community service providers (e.g., harm reduction, drug treatment, social services support).

Survey Instrument Development

The survey instrument is in **Appendix A.** Topics covered in the survey were developed by the VOICES team who drew upon survey questions that had been used in similar previous studies and also developed new questions with the input of the advisory boards from VOICES Wisconsin and VOICES New Jersey and key stakeholders in Bernalillo County. Survey domains are listed in Table 1.

Site Recruitment and Survey Data Collection

We partnered with 11 organizations in Bernalillo County who delivered recruitment cards to their clients. Site names are shown in **Appendix B.** The sites included drug treatment programs, harm reduction service providers (e.g., syringe services programs), general medical services, and other social services providers (some sites offered multiple types of services). Among all 11 sites, 10 offered naloxone, 5 offered sterile injection supplies, 4 offered safe smoking supplies, 4 offered sterile snorting supplies, 4 offered fentanyl test strips, 8 offered some substance use disorder treatment services, 4 offered medications for opioid use disorder, and 5 offered peer counseling services. Sites were compensated $1000 for their participation in recruitment activities regardless of number of surveys collected. On average, sites served 156 clients per week.

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Table. 1 Survey Domains and Constructs

Survey Domains	Specific Constructs
Current Drug Use	Type of drugs, frequency, mode
Overdose Experiences and Perceptions	Experience w/ overdose in past year, detail of experience (naloxone, 911 use, ED transfer) Perceptions of overdose risk and drug supply
Harm Reduction Use	Harm reduction services and fentanyl test strips: past month use, barriers to use, service experiences; Naloxone-access, comfort with using
Substance Use Disorder Treatment	Past month use, location, MOUD use, service experience, barriers to treatment
Structural Vulnerabilities	Financial insecurity, housing instability, criminal legal and child welfare involvement, experiences w/ discrimination by providers
General Health and Wellness	Self-reported health, chronic conditions, disability, health and wellness goals
Socio-demographic Characteristics	Age, sex, race, ethnicity, gender, sexual orientation, employment

The recruitment cards, pictured to the left, included a unique alphanumeric participant ID and the study phone number. One side of the recruitment card was written in English and the other side in Spanish. Sites handed out cards through mobile and community/street outreach teams as well as in office and clinic-based settings. Several sites were visited in person during a three-day site visit in May 2024. The survey was conducted between June and August 2024 and offered in English and Spanish. Our data collection partner, Pacific Institute for Research and Evaluation (PIRE), managed a team of interviewers with experience surveying people who use drugs and vulnerable populations. The study line was staffed for a minimum of 40 hours a week, with times adjusted to meet the needs and operating hours of participating sites. We offered limited in person data collection on select occasions to accommodate populations with low telephone access. The vast majority of participants completed the survey via phone line.

Interested study participants were screened for eligibility which included being 18 years of age, use of cocaine/crack, opioids, or methamphetamines in the past year, cognitive ability to consent to participate and complete

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the survey and must not have previously completed the survey as determined by the single-use participant ID.

Data were maintained on a secure server and were checked throughout the study for quality control purposes. Responses were cleaned, recoded to create more parsimonious categories, and checked for logical consistency. This report provides unadjusted overall results and results stratified by select groups. We report group level percentages for each variable. We report tests for equal proportions for pairwise differences between groups or binary variables (yes/no) and within categories of categorical variables. Some questions had open-ended responses, which were hand categorized for this report.

Study Limitations
Several study limitations are important to note when considering the results of this study. First, the site-based sampling strategy may bias the results toward people who are currently engaged with services. Second, VOICES was not designed to be a probability sample of Bernalillo County. While sites span multiple areas of the counties, the data collection strategy is limited in the sample size and representativeness of specific regions. Third, VOICES relies on self-report, which is subject to social desirability bias and recall bias. However, the interviewers for this study have extensive experience talking about drug use and the survey was designed to use non-judgmental language. Fourth, the majority telephonic data collection may have excluded people who are unwilling or unable to participate by phone, including people who are unhoused or have unstable living conditions. To counteract this limitation, the study did make lender phones available but no site requested use of these phones. Fifth, the study sample size is limited, and in some cases has limited statistical power to identify meaningful differences between subgroups (e.g., between different demographic groups or between clients of different programs).

RESULTS
Below is an overview of the results. See tables for full results.

Table 1: Sample Characteristics
The total sample included 673 individuals. About half of the sample (49.6%, n=225) identified as male. Almost half of participants were over the age of 40, with 17.5% (n=118) ages 18 to 29, 37.4% (n=252) ages 30 to 39 years old, 25.6% (n=172) ages 40 to 49 years old, 15.2% (n=102) ages 50 to 59 years old, and 4.3% (n=29) over the age of 60. Approximately, 23.8% (n=160) reported as Native American. Among those that did not report being Native American, 49.5% (n=332) self-reported as Hispanic, 20.3% (n=136) White non-Hispanic, 2.5% (n=17) Black non-Hispanic, 2.8% (n=19) as Multiracial non-Hispanic, 0.4% (n=3) as Asian non-Hispanic, 0.6% (n=4) as another race/ethnicity. 26 participants (3.9%) identified as transgender. Including both legal and informal guardians, 14.6% (n=98) of participants were responsible for a child living in their household.

For self-reported health, 7.1% (n=48) reported excellent health, 15.3% (n=103) very good health, 33.4% (n=225) good health, 31.5% (n=212) fair health, and 12.2% (n=82) poor health. Just under half (42.6%, n=287) of participants reported having a chronic health condition. In a free-response question, the top three self-reported chronic conditions among this sample were depression or anxiety (9.7%, n=65), Hepatitis B or C (6.4%, n=43), and schizophrenia or bipolar disorder (5.8%, n=39). Most participants were enrolled in public insurance, with 88.6% (n=596) of the sample covered by Medicaid.

Housing and financial insecurity was highly prevalent with 64.9% (n=437) of participants being worried about having stable housing in the next year and 80.1% (n=539) being worried about paying for their

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basic needs in the next year. Just over a third of the sample (n=40.7%, n=274 reported criminal legal involvement in the past year.

Table 2. Drug Use Characteristics

The vast majority of participants (90.2%, n=497) reported having used drugs in the past 30 days. Among people who used drugs in the past 30 days, stimulants were the most common drug used (92.3%, n=560). Specifically, 89.0% (n=540) reported using methamphetamine or speed, 40.7% (n=247) reported using cocaine or crack, 7.6% (n=46) reported using other unprescribed stimulants. Among respondents who used drugs in the past 30 days, 81.9% (n=497) reported using opioids, specifically 75.1% (n=456) reported using fentanyl. 33.8% (n=205) reported using heroin, 29.7% (n=180) reported using unprescribed buprenorphine or methadone and 21.9% (n=133) reported using unprescribed opioid analgesics. 26.7% (n=162) of respondents who used drugs in the past 30 days reported using tranquilizers or benzodiazepines. Two-thirds of the sample that used drugs in the past 30 days engaged in polysubstance use (66.2%, n=402), defined as intentionally using two types of drugs at the same time. Frequency of drug use also varied, with 67.5% (n=407) of participants using drugs more than once a day, 7.6% (n=46) using once a day, 15.8% (n=95) using drugs a few times a week, 7.3% (n=44) using drug a few times a month and 1.8% (n=11) using drugs once a month.

Table 3. Overdose Experiences

In the last year, 18.6% (n=125) of participants had experienced an overdose in the last year and 20.1% (n=135) of participants were very worried about having an overdose in the future. Fear of drug supply contamination may have contributed to this, as 26.2% (n=176) were very worried that their drugs are mixed with substances that they did not intend to use. Among overdose survivors, when asked about their most recent overdose experience, naloxone was administered to 73.6% (n=92) of participants, 911 was called for 40.0% (n=50) of participants, and 58.0% (n=29) of participants were treated in the emergency department for their overdose.

Comparing participants who experienced an overdose in the past year to participants who did not, overdose survivors were more likely to have used an opioid (91.6% vs. 79.8% p<0.01), and tranquilizer/benzodiazepine (35.5% vs. 24.8%, p=0.02) in the past month and had no statistically significant difference in stimulant use (94.4% vs. 91.8%, p=0.36) in the past 30 days. Overdose survivors were more likely to report polysubstance use compared to individuals without past-year overdose experiences (79.0% vs 64.1% p<0.01). Overdose survivors were more likely to have past month treatment use (56.8% vs 37.7%, p<0.01). Comparing overdose survivors to those who did not experience an overdose in the past year, there was no statistically significant difference in past month use of harm reduction services (68.0% vs 62.3%, p=0.24), past month use of fentanyl test strips (29.9% vs 28.7%, p=0.24), or carrying naloxone (79.2% vs 75.5%, p=0.38).

Open-Ended Overdose Experiences Responses

Reasons Why 911 Not Called

When asked why 911 was not called during an overdose event, most participants responded that they did not perceive a need for emergency medical services after regaining consciousness with naloxone. Some participants were apprehensive due to potential negative interactions with the police and arrest, especially among those who were in an environment where other people were using drugs. For a few participants, being on probation/parole or an existing warrant for their arrest served as a deterrent from calling 911. One individual reported not calling 911 due to experiencing withdrawal and expressed desire to use more to curb the withdrawal symptoms. Finally, in a couple situations, 911 was not called as the participant was already in a clinical setting when they experienced their overdose.

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Reasons Why Emergency Department Not Used

Few participants reported why they chose to not use emergency department services after an overdose and calling 911. Most participants reported refusing transport to the emergency room after they regained consciousness (normally after naloxone was administered). Several participants reported other deterrents such as shame or desire to use more drugs.

Table 4. Harm Reduction Use

Among people who currently use drugs, about two-thirds (67.5%, n=410) reported having used harm reduction services in the past 30 days. The top reasons for not using harm reduction services were feeling like services were not needed (43.1%, n=85), not knowing where to seek services in their area (22.8%, n=45) and transportation issues (5.6% n=11). Treatment may have been another motivator for lack of harm reduction engagement, as 37.1% (n=73) of people in the group that was currently using drugs but not seeking harm reduction services were engaged in substance use treatment.

Use of harm reduction supplies also varied among people currently using drugs; only 28.8% (n=175) of participants used fentanyl test strips in the past 30 days. However, 77.4% (n=470) reported carrying naloxone. The top reasons cited for not using fentanyl test strips were related to need, knowledge, and access. Approximately 25.7% (n=110) of participants who did not use fentanyl test strips did not know what fentanyl test strips were, 23.1% (n=99) did not have any test strips, and 14.0% (n=60) reported not using test strips because they did not want to use them.

Open-ended Harm Reduction Responses

Improvements to Harm Reduction Programs

Overwhelmingly, participants expressed their support for harm reduction programs, often saying that there was nothing to improve. For those participants who offered suggestions on how to improve harm reduction programs, the most common suggestion was to expand services, including hours of operation, locations, and number of staff. For some clients, nighttime and weekend hours were preferred due to their work schedule. Many participants suggested having more locations in closer proximity to reduce travel time and other transportation burdens. A few participants reported wanting harm reduction programs to provide transportation services to the harm reduction program locations. Similarly, some suggested either providing delivery services, or increasing the frequency of current delivery services to meet the needs of clients.

Several participants mentioned the need for increased access to supplies such as naloxone, fentanyl and xylazine test strips, syringes, oil burners, and other harm reduction materials. Most cited supply shortages as reasons for limited supply at their local organizations. A few suggested increasing other supplies/services such as more snacks, water, pregnancy tests, wound care, etc. Other participants felt that despite having many services, harm reduction programs needed to do more promotion and provide more educational information, because many people were unaware of the variety of available services.

Others wanted more trainings and information in combination with the harm reduction supplies they received, on topics of naloxone administration, overdose symptoms, and more. Participants also suggested providing more complete linkage to mental health services and counseling, housing, and treatment (i.e., outpatient) while also advocating for stigma training for staff at their harm reduction organizations. Several participants mentioned that having more staff with lived experience who could serve as peers for clients would assist with reducing the stigma around using drugs, harm reduction services, and more.

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Desired Harm Reduction Supplies

When asked what harm reduction supplies participants desired, there were a wide array of responses. The most common suggestion was safe smoking supplies. Many provided details on useful smoking supplies, suggesting things like pipes, glassware, bubbles, and foils. Overwhelmingly, participants also advocated for sterile injecting supplies such as sterile water, alcohol wipes, cookers, and a variety of syringe gauges and lengths. Some also mentioned a need for test strips for fentanyl and xylazine, while others suggested providing a safe supply of the drug itself to reduce risk of overdose from "street drugs." Naloxone was another desired supply. Other participants shared the need for additional resources such as wound care, infectious disease testing, food, water, clothing, and counseling services.

Encouraging Use of Fentanyl Test Strips

Many participants voiced a need for more information on fentanyl test strips, stating that they were not aware this resource existed. They mentioned that after being informed of what they are and their availability, they would begin to use it. Others mentioned that accessibility was a continued issue, saying that the test strips were often not offered at sites they visited or that they were not aware where to get the test strips. Many also expressed a need for training or more information on how to use them and in what situations they are an effective resource. For many participants, fentanyl test strips were not useful as they were currently using fentanyl as their drug of choice. However, many of these participants stated that if they stopped using fentanyl or switched to a different drug, they would consider utilizing FTS. Many participants also discussed how the fear of overdosing or witnessing or experiencing an overdose may impact their use of FTS. One stated, "[I] knew more people OD'ing on [fentanyl], I'm trying to test my drugs more." Yet another discussed that if he relapsed, he would consider using the test strips as he would worry about risk of overdose. Other reasons that would encourage participants to utilize FTS were if they began purchasing drugs from a different supplier, worry what was in their drug source, or if they increased their overall drug use frequency.

Increasing Confidence with Using Naloxone

A large portion of participants expressed their desire for formal training (i.e., class or demonstration) on naloxone (Narcan) administration. Others described a need for informal training, in a mutual aid setting where they wanted to learn from someone else administering naloxone or have someone with them as they administered it for the first time to provide instructions. In addition to understanding the administration of naloxone, many participants felt they needed more information and knowledge about the naloxone mechanisms, how to spot an overdose, and other emergency procedures.

A variety of other factors influenced increased confidence with naloxone use. A few participants said that increased access to naloxone and having it on hand at the time of the event would increase their confidence to use it. Participants also reported feeling stressed and panicked when faced with having to administer naloxone, with one participant responding, "I wouldn't want to be responsible if something happened. The blame would go on me." For certain participants, more interpersonal factors influence confidence with naloxone use. Concerns about people going into withdrawal or being angry when they woke up deterred some participants. One participant described how the "sickness of coming back after Narcan is really intense and [they would not] want to make someone else go through that." Some participants expressed that they would not want to administer naloxone at all and would instead call for police and emergency medical services. Finally, a few participants reported unwillingness to administer naloxone because of fear of witnessing a fatal overdose. On the other hand, many spoke about how the hope of saving a life would encourage them to administer naloxone.

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Table 5. Substance Use Treatment
Overall, 41.2% (n=277) of the sample had engaged in treatment services in the past month. This high rate of treatment engagement is likely a reflection of recruitment from treatment organizations and participants' wide range of views on what encompasses treatment services. When asked if it was more effective to treat opioid addiction with medications for opioid used disorder (MOUD) than without MOUD, 51.3% (n=345) of participants strongly agreed and 32.8% (n=221) agreed.

Of the participants with past-month treatment use, 45.1% (n=125) reported receiving treatment at a opioid treatment program (n=86), 29.6% (n=82) at an outpatient rehabilitation facility, 19.9% (n=55) at a residential rehabilitation facility, 11.2% (n=31) at a doctor's office or clinic, and 10.1% (n=28) at a sober living program. Most participants (63.5%, n=176) felt that treatment helped "a lot" to reach their goals and a greater percentage felt that the treatment staff were respectful towards them (84.1%, n=233). Among participants who were currently engaged in treatment and had used opioids in the past 30 days, 68.1% (n=124) were receiving methadone, 30.2% (n=55) were receiving buprenorphine, 4.4% (n=8) were receiving extended-release naltrexone, and 8.8% (n=16) were not receiving MOUD.

Comparing participants who were engaged in treatment to those who were not, there were no significant differences in age, race/ethnicity, gender, drug use in the past 30 days, use of opioids, and use of stimulants. However, there were differences by drug type when stratified by treatment engagement. Compared to the non-treatment engaged population, the treatment engaged population was more likely to utilize the Indian Health Services (23.5% vs 15.6%, p=0.01), to be insured versus uninsured (7.1% vs. 2.9%) and more likely to have past-year overdose experience (74.4% vs 13.7%, p<0.01)

Open-Ended Substance Use Treatment Responses
Substance Use Treatment Goals
When asked about their substance use treatment goals, participants overwhelmingly expressed a desire to stop using drugs, pursue abstinence, and avoid relapse. For many, this looked like engaging in treatment, either inpatient or intensive outpatient, initiating or maintaining MOUD, and developing the tools necessary to succeed in recovery. Some participants cited their goal as continuing MOUD treatment, with several individuals specifically discussing goals to find the right MOUD dose and wanting to eventually taper, or end methadone and buprenorphine treatment. Participants also wanted to maintain their mental and physical health.

Overall, participants reported a desire for normalcy in their day-to-day life and for several, this included rebuilding relationships with family members that were affected by the participant's drug use. Numerous participants also responded to this question by describing specific employment, education, and financial goals, such as getting a job, resuming education goals, and saving money. Most participants mentioned wanting to improve their quality of life through these goals.

Open Ended Health and Wellness Responses
Health Goals
For many participants, their main health goal was to improve overall wellbeing, over several dimensions. Most participants said they wanted to stop using drugs, with some also mentioning that they wanted to curtail or abstain from smoking and drinking. Most participants expressed their desire for a physician visit, often seeking treatment for a specific condition or for routine clinical care. The most common conditions that participants indicated seeking treatment for was hepatitis C and dental health. Others

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indicated that they needed to see mental health professionals for conditions such as depression and anxiety.

Many participants also set specific personal goals for improving their physical health. The most common goals were weight management and building cardiovascular endurance. Other common goals were related to managing chronic conditions, such as controlling blood sugar and pressure, reducing cholesterol, or managing diabetes. Many participants cited taking control of their physical and mental health to gain some independence and increasing their ability to pursue other goals such as housing or education-related goals.

General fitness (going to the gym) and eating healthier were two other physical health goals for many participants. This was often in combination with goals for stable housing, financial health (saving money, buying a house), employment and career aspirations, and educational goals. In particular, the housing, employment, and financial goals for many participants were related to the desire to provide for their family, have their children return home, and rebuild connections with other loved ones.

Supporting Health and Wellness Goals
When prompted with a question of how their health goals can be better supported, participants had a variety of answers. A majority of participants expressed that the primary support was family, friends, and positive relationships that would help them achieve their health goals. Participants stressed the importance of social networks to fall back on and loved ones as motivators for their goals and for moral support. One participant said having a "good support system and positive people around [him] making sure [he] is doing the right thing and staying out of trouble" would help achieve his goal of initiating substance use treatment. Still others discussed how hope for a better future and rebuilding relationships with family and friends were important driving factors in achieving their wellness goals. For many participants a good support system also included finding positive influences among peers to serve as role models for their own recovery paths. Some also discussed reliance on themselves to promote better habits and lifestyle and refrain from using drugs.

Housing and financial resources were also discussed by participants. One participant described restrictions such as not using drugs and being in a treatment program in order to secure housing. The participant also mentioned how being unhoused prevented them from abstaining from drug use. Some participants discussed working with housing organizations to secure housing, but did not have helpful experiences, and responded that there was a need for affordable public housing. Many echoed a need for financial support for things like treatment, housing, food, and mental health counseling. Transportation was another commonly reported barrier, not just for employment, but also for accessing medical care, MOUD, and grocery stores. Many participants listed employment as a health goal in the previous question, and when asked about what would help support his goal, many indicated that job search services would be helpful.

Finally, many participants discussed services for substance use disorder. 12-step programs, NA/AA groups, and meetings were the most cited sources of support. Consistent counseling with professionals was also another need for participants. Within treatment services there was significant variation among participant responses. Some expressed their general desire for rehab and inpatient drug treatment while others requested outpatient centers. Participants also reported that continuing to take medications for opioid use disorder (methadone, buprenorphine, and naltrexone) was supporting their health goals and recovery.

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Table 6. Race and Ethnicity Comparisons
There were not significant differences in demographics comparing Native American and Hispanic respondents to White Non-Hispanic respondents. Some notable demographic differences compared to White non-Hispanic participants include, Hispanic respondents being more likely to be responsible for a child under 18 (17.5% vs 8.8%, p=0.02), more likely to have past year criminal legal system involvement (44.3% vs 33.8%, p=0.04). Native American respondents were more likely than White non-Hispanic respondents to report discrimination experiences (57.5% vs 44.1%, p=0.02).

Regarding drug use patterns, Hispanic respondents were more likely than White non-Hispanic respondents to report any opioid use (86.7% vs 75.0%, p<0.01) and Native American respondents were more likely than White non-Hispanic respondents to report any stimulant use (95.8% vs 89.2%, p=0.04).

Harm reduction use was higher among Hispanic and Native American participants compared to White non-Hispanic respondents. Compared to White non-Hispanic respondents (55.8%), Hispanic respondents (69.3%, p=0.01) and Native American respondents (72.2%, p=0.01) were more likely to use harm reduction services in the past days. Native American respondents were more likely that White non-Hispanic respondents to have a naloxone kit (74.3% vs 69.2%, p<0.01). There were no differences across race/ethnicity groups in fentanyl test strip use.

There was no difference in overdose experience across race/ethnicity groups, but Hispanic (27.7%, p=0.01) and Native American (35.6%, p=0.02) respondents reported being more likely to be very worried about future overdose compared to White non-Hispanic participants (12.5%).

There was no significant differences in use of treatment and attitudes towards treatment by race/ethnicity groups with the exception of Native American respondents being less likely to strongly endorse the effectiveness of medications for opioid use disorder compared to White non-Hispanic respondents (40.6% vs. 55.1%, p=0.01). Among people who used treatment and opioids in the past 30 days, Native American groups were more likely to endorse buprenorphine (33.3% vs 13.5%, p=0.04) and extended-release naltrexone (11.9% vs 0.0%, p=0.03) compared to White non-Hispanic respondents.

Due to low statistical power we were unable to compare results for Black Non-Hispanic participants.

Table 7. Stimulant Use
We examined differences by populations that reported just using stimulants, those that use stimulants and other substances and those that did not use stimulants but used other substances. Compared to non-stimulant users, stimulant only users were more likely to be age 30-39 (36.8% vs 18.6%, p=0.03) and ages 50-59 (24.1% vs 7.0%, p=0.02) and less likely to be age 18-29 (8.0% vs 25.6%, p=0.01) and ages 40-49 (21.8% vs 41.9%, p=0.02). Polysubstance stimulant users were less likely to identify as White non-Hispanic compared to non-stimulant users (17.5% vs 30.2%, p=0.04). There were no differences in overdose experience in the last year by stimulant use categories, but among those that did experience an overdose stimulant only users were less likely to be treated at an emergency department following an overdose (55.0% vs 100%, p<0.01) compared to non-stimulant users.

Polysubstance stimulant users were more likely to use harm reduction services compared to non-stimulant users (74.6% vs 39.5%, p<0.01) and stimulant only users were less likely to carry naloxone compared to non-stimulant users (52.9% vs 74.4%, p=0.02). There was no difference in fentanyl test strip use which was low across all groups (25.6% non-stimulant users, 12.6% stimulant only users and 32.3% polysubstance stimulant users.

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Table 8. Criminal Legal Involvement

Compared to those with no recent criminal legal involvement, respondents who had recent criminal legal involvement were more likely to be age 30-39 (45.3% vs 32.1%, $p<0.01$) and less likely to be age 50-59 (10.9% vs 18.0%, $p=0.01$) and 60+ (2.2% vs 5.8%, $p=0.02$) and more likely to be male (59.1% vs 43.1%, $p<0.01$).

Compared to those without criminal legal involvement, those with criminal legal involvement were less likely to use drugs in the past 30 days (87.2% vs 92.2%, $p=0.03$) though both groups reported a high prevalence of current drug use. There were no differences in use of specific types of drugs, except people with criminal legal involvement were more likely to use unprescribed buprenorphine or methadone (37.2% vs 24.7%, $p<0.01$) and more likely to use tranquilizers or benzodiazepines (33.5% vs 22.3%, $p<0.01$).

There was no difference in overdose experience, harm reduction services use, naloxone carrying or fentanyl test strip use by criminal legal status. Those with criminal legal involvement were more likely to have received treatment in the past 30 days (48.9% vs 35.8%, $p<0.01$) compared to those without recent criminal legal involvement.

Table 9. Housing Instability

There was no statistically significant difference in age, race/ethnicity and gender among participants experiencing housing stability and those who were not. There was variation in drug use characteristics, overdose experience, and fentanyl test strip use. Participants experiencing housing instability were more likely to use drugs in the past 30 days (92.4% vs 86.0%, $p=0.1$), more likely to use opioids (84.9% vs 75.7%, $p=0.01$). There was no statistically significant difference use of stimulants or tranquilizers/benzodiazepines.

Participants experiencing housing instability were more likely have experienced an overdose in the last year (22.2%% vs 11.5%, $p<0.01$) and be very worried about experiencing an overdose (23.1% vs 14.0% , $p=0.01$). Participants experiencing housing instability were more likely to use fentanyl test strips (32.3% vs 22.3%, $p=0.01$) in the past month compared to participants without housing instability. There was no statistically significant difference in past month harm reduction service use, carrying naloxone or past month substance use treatment by housing stability.

Settlement Fund Recommendations

When asked about how the state can utilize opioid settlement funds, an overwhelming majority of participants supported use of these funds for better housing services. Many participants identified as being unhoused and found that the current state of shelters and temporary housing for this population were unlivable and thought that improving current shelters and adding more housing options for people would greatly improve quality of life. Further, they found that working to remove restrictions around things like halfway houses or sober living facilities could also help these participants get access to proper housing which would allow them to focus on other efforts such as initiating treatment, etc. Other social services that participants requested settlements funds go toward included employment assistance, education, and food pantries/food stamps. Overwhelmingly, a large portion of participants also discussed transportation assistance to both treatment and harm reduction facilities as well as their place of work as many struggle with getting to work every day.

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Numerous participants also discussed how settlement funds can be used to bolster treatment facilities and increase access to MOUD. Some participants mentioned how treatment facilities and harm reduction organizations were often inaccessible, describing how more locations of these types of programs would be beneficial for the community. Others mentioned how more funding for uninsured patients, longer hours, and stigma training would be useful initiatives to support at treatment facilities.

Moreover, mental health counseling and treatment was typically brought up as important pieces of the recovery journey. One participant described how underlying mental health issues may contribute to continued drug use, making it important to address mental health among people who use drugs. Another commonly discussed issue was peer support services; to further support mental health services for this population, several people stated how hiring staff with lived experience at treatment centers or harm reduction organizations would improve knowledge sharing, reduce stigma, and encourage more people to initiate treatment. Finally, participants voiced a need for funding for people who are criminal legal involved. Using funding for initiatives like recovery courts or to provide employment/housing assistance as part of reentry programs was discussed as beneficial for many people.

VOICES NEW MEXICO CONTACTS

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The VOICES study is a partnership between Johns Hopkins Bloomberg School of Public Health, Vital Strategies and Pacific Institute for Research and Evaluation. This report was prepared by the research team at Johns Hopkins Bloomberg School of Public Health.

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Appendix A. Survey

I'm going to begin recording now. It will take just a few moments to do that.

Start recording.

Once recording has started, make a verbal note that will be at the beginning of the recording to track which record ID the recording goes with: "This is record ID _______" [state record ID which can be found at top of survey form]

Now I'm going to ask you questions about the past month, so please think back from _____ through today when answering.

I'm going to read a list of drug types. Please tell me if you have used each drug in the past month by saying yes or no.

Do not read. Other examples of types of prescription drug may include:

Opioid pills: Percodan, percocet

Tranquilizers: Valium

Stimulants: Preludin

- ☐ Cocaine or crack
- ☐ Heroin
- ☐ Fentanyl
- ☐ Crystal methamphetamine, speed, or other methamphetamine
- ☐ Opioid pain pills such as Oxycontin, not prescribed to you
- ☐ Tranquilizers or antianxiety drugs such as benzos or Xanax, not prescribed to you
- ☐ Stimulants such as Ritalin or Adderall, not prescribed to you
- ☐ Buprenorphine, Suboxone, methadone not prescribed to you
- ☐ (do not read - select if no to all of above) Did not use any of these drugs in the past month

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Now I'm going to ask you the same question, but I want you to think about the past year, when answering.

I'm going to read a list of drug types again. Please tell me if you have used each drug in the past year by saying yes or no.

Data collector: If no to all, read prompt below:

Just to confirm, you have not used any of the drugs that I have listed within the past year. Is that correct? Is there another drug that you have used in the past year?

If they confirm that they have not used any of the drugs listed, then select "Has not used any of these drugs in the past year". If they have used drugs that are not on the list, you can also select "other" and enter what they have used AND select "Has not used any of these drugs in the past year".

Do not read. Other examples of types of prescription drug may include:

Opioid pills: Percodan, percocet

Tranquilizers: Valium

Stimulants: Preludin

- ☐ Cocaine or crack
- ☐ Heroin
- ☐ Fentanyl
- ☐ Crystal methamphetamine, speed, or other methamphetamine
- ☐ Opioid pain pills such as Oxycontin, not prescribed to you
- ☐ Tranquilizers or antianxiety drugs such as benzos or Xanax, not prescribed to you
- ☐ Stimulants such as Ritalin or Adderall, not prescribed to you
- ☐ Buprenorphine, Suboxone, methadone not prescribed to you
- ☐ (do not read - select if no to all of above) Did not use any of these drugs in the past year
- ☐ other

Please specify any other drug(s) used in the past year.

____

We have reached the end of the survey. I am now going to stop the recording.

Stop the recording, skip the remaining questions on the survey, mark the survey form as complete, and proceed to the incentive form.

In the past month, did you intentionally mix or combine drugs and use them at the same time?

- ○ Yes
- ○ No

In the past year, did you intentionally mix or combine drugs and use them at the same time?

- ○ Yes
- ○ No

Which drugs did you intentionally use at the same time?

Do not read. Check all that apply based on response.

- ☐ Heroin and fentanyl together
- ☐ Cocaine/crack and heroin/opioid together (speedball)
- ☐ Crystal methamphetamine and heroin/opioid together (goofball)
- ☐ Other

Please specify the other types of drugs used at the same time.

____

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In the past month, how often did you use drugs (was it... a few times a week, a few times a month, or more often)?

Do not read. Pick choice that best applies based on response. Prompt with response options if needed.

- ◯ More than once a day
- ◯ Once a day
- ◯ A few times a week
- ◯ A few times a month
- ◯ Only once

In the past year, how often did you use drugs (was it... a few times a week, a few times a month, or more often)?

Do not read. Pick choice that best applies based on response. Prompt with response options if needed.

- ◯ More than once a day
- ◯ Once a day
- ◯ A few times a week
- ◯ A few times a month
- ◯ Only once

In the past month, which ways have you taken drugs (like injecting, smoking, etc.)?

Let respondent answer, check all that apply and confirm that any modes of drug use not endorsed were not used.

- ☐ Injected
- ☐ Smoked
- ☐ Snorted/sniffed
- ☐ Swallowed
- ☐ Some other way

In the past year, which ways have you taken drugs (like injecting, smoking, etc.)?

Let respondent answer, check all that apply and confirm that any modes of drug use not endorsed were not used.

- ☐ Injected
- ☐ Smoked
- ☐ Snorted/sniffed
- ☐ Swallowed
- ☐ Some other way

Please specify the other way(s) drugs taken. ______________________________

Please specify the other way(s) drugs taken. ______________________________

Overdose Experience

Now I'm going to ask you some questions about your experience with overdose.

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Have you had a drug overdose in the last 12 months, that is since ____________.

◯ Yes
◯ No

Read prompt below if needed.

For the purposes of this survey, an overdose is defined as a time when using drugs caused you to have serious problems breathing, you stopped breathing, you had irregular or no heartbeat, you were unresponsive, or you required medical attention from a friend, bystander, or emergency responder.

In the last year, how many drug overdoses have you had?

____

For the next set of questions, think back to the most recent time you had an overdose.

At the time of your most recent overdose, did someone use naloxone (also called Narcan) on you to reverse the overdose?

◯ Yes
◯ No
◯ Don't know

Did someone call 911 for help?

◯ Yes
◯ No
◯ Don't know

Any specific reason why not?

____

Were you treated at a hospital emergency department?

◯ Yes
◯ No

Any specific reason why not?

____

Before you left the hospital, were you offered any of the following?

I'll read the list and you can say yes/no.

☐ Methadone
☐ Buprenorphine
☐ Naloxone or Narcan that you can take home
☐ Appointment for a drug treatment program
☐ Care for other non-overdose health issues (wound care or other health needs)
☐ A visit from a peer recovery worker

Overdose Risk Perception

I know you told me that you did not use any drugs in the last month, but I am still going to ask you a few questions about your perceptions of future risk.

How worried are you about using drugs that are mixed or cut with substances that you did not intend to use? Are you...

Read response list

◯ Very worried
◯ Quite a bit worried
◯ Just a little bit worried
◯ Not at all worried

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How worried are you about having an overdose in the future? Are you...

Read response list.

- ◯ Very worried
- ◯ Quite a bit worried
- ◯ Just a little bit worried
- ◯ Not at all worried

Harm Reduction Services   Now I'm going to ask some questions about your use of harm reduction services.

Harm reduction services include safer drug use supplies like naloxone/Narcan, fentanyl test strips, sterile needles, and safer smoking equipment.

In the past month, have you received any harm reduction services?

- ◯ Yes
- ◯ No

Any specific reason why not?

Do not read the list. Select all applicable responses, and prompt other responses from list if needed.

- ☐ You feel you don't need harm reduction services
- ☐ You don't know about harm reduction services in your area
- ☐ You don't have transportation to get there
- ☐ The hours don't work with your schedule
- ☐ You're worried people might think poorly of you
- ☐ You're worried program staff will treat you poorly
- ☐ You're worried about getting arrested by the police after going
- ☐ You don't feel that harm reduction services are understanding or respectful of your identity or cultural background
- ☐ Some other reason

Please specify the other reason.

____

In the past month, what harm reduction supplies or services did you receive?

Do not read. Check off based on responses and then clarify any remaining supplies not mentioned.

If respondent says doesn't remember, ask "If you can't remember what you got within the past 30 days, what sort of supplies do you usually receive from the harm reduction program?"

- ☐ New needles or other safer injection supplies (e.g. cooker, water, cottons, etc.)
- ☐ Smoking supplies
- ☐ Snorting supplies
- ☐ Naloxone or Narcan
- ☐ Fentanyl test strips
- ☐ Wound care supplies
- ☐ An HIV, Hep C, TB, or syphilis test
- ☐ Safer sex supplies
- ☐ Other
- ☐ None of the above

Please specify other supplies or services received.

____

Overall, in the past month, how would you rate your experience receiving harm reduction services? Was it...

Read list

- ◯ Very good
- ◯ Good
- ◯ Acceptable
- ◯ Poor
- ◯ Very poor

What, if anything, would improve your experience receiving harm reduction services?

____

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Are there any drug use supplies that you want that you cannot currently get?	__________________________________

Drug Testing Tools

Now I want to ask about fentanyl test strips which can be used to quickly check if the drugs contain fentanyl. Have you used fentanyl test strips in the past month?	◯ Yes ◯ No
Any specific reason why not? Do not read list. Select all responses that best fit answer.	☐ I do not want to ☐ I do not know about test strips ☐ I do not have any test strips ☐ It is too difficult to get test strips ☐ Testing takes too long ☐ I don't mind using fentanyl ☐ I am worried about what people might think if I use test strips ☐ I am worried about getting arrested for having fentanyl test strips ☐ I do not know where to get test strips ☐ Other
Please enter the other reason(s) for not using test strips.	__________________________________
The last time you used fentanyl test strips, did your drugs test positive for fentanyl?	◯ Yes ◯ No
What did you do when your drugs tested positive? Did you... Read list. Note that this refers to the last time their drugs tested positive for fentanyl.	☐ Continue using as usual ☐ Use less ☐ Use more slowly ☐ Not use the drugs at all ☐ Use with someone else or have someone check on you
What, if anything, would encourage you to use fentanyl test strips more regularly?	__________________________________

Naloxone Possession

Do you have a naloxone kit? If person is confused mention that naloxone is sometimes called Narcan.	◯ Yes ◯ No

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Question	Response
Where did you get your naloxone/Narcan kits? Do not read list. Select all responses that best fit answer.	☐ Pharmacy ☐ Doctor's office ☐ Harm reduction organization ☐ Drug treatment program ☐ A family member or friend ☐ Prison/jail ☐ Vending machine ☐ A mail order program ☐ NaloxBox - a small box in public locations that has overdose response supplies ☐ Emergency responders ☐ Other
Please specify other places where got naloxone kits.	__________________________
If somebody overdoses while you are with them, how comfortable are you with using naloxone/Narcan on them? Are you... Read list	○ Completely comfortable ○ Fairly comfortable ○ Slightly comfortable ○ Not comfortable at all
What, if anything, would increase your confidence to use naloxone/Narcan to reverse an overdose?	________________________________

Substance Use Disorder Treatment Services

Now I'd like to ask you some questions about experiences you've had with drug treatment services, if any.

Question	Response
In the past month have you attended a group like Narcotics Anonymous, SMART recovery, Wellbriety, or other peer-led group?	○ Yes ○ No
Separate from groups, have you received treatment, medication, or counseling for your use of drugs from a medical provider or professional counselor in the past month?	○ Yes ○ No
Have you wanted to receive treatment, medication, or counseling for your use of drugs in the past month?	○ Yes ○ No
In the last month, at what kinds of places have you received treatment, medication, or counseling for drug use? It can be more than one. Do not read list. Select all applicable responses, and prompt other responses from list if needed.	☐ Doctor's office, or community health center ☐ Methadone Clinic ☐ Emergency room ☐ Hospital overnight ☐ Residential drug rehab facility ☐ Drug rehab facility as an outpatient ☐ Prison or jail ☐ Mobile treatment van ☐ Sober living facility/recovery housing ☐ Other
Please specify the other types of places treatment received.	__________________________

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I am going to read a list of medications you might have received as treatment for drug use. For each one, please tell me if you received this medication in the past month, if at all. Read each of the first three options and check if "yes". Only check "Did not receive any of these medications" if nothing on the list is endorsed by the participant.	☐ Buprenorphine or Suboxone ☐ Methadone ☐ Naltrexone/Vivitrol ☐ (Don't read) Did not receive any of these medications
Have you been given permission to take home your methadone?	○ Yes ○ No
How many days of supply do you get to take home?	__________________________________
I am going to read a list of experiences you may have had at a pharmacy when you pick up your buprenorphine or Suboxone. Please tell me whether you experienced this in the past month by saying yes or no.	☐ The pharmacy did not have buprenorphine in stock ☐ The pharmacy staff treated you poorly ☐ The pharmacy staff gave you helpful information about how to take buprenorphine
In a sentence or two, please tell me your goals for treatment. Prompts if respondent needs clarification: Were there any reasons you wanted to start treatment? How do you think or hope your life may change as a result of being in treatment? What do you hope will happen by going to treatment?	____
In the past month, how much did your treatment for drug use help you reach your goals? Did it help.... Read list	○ Not at all ○ A little ○ A lot
In the past month, how respectful were the treatment staff towards you? Read list Prompt, if needed, "on average, thinking about all of your experiences in the past 30 days, how respectful were the treatment staff towards you?"	○ Not at all ○ A little ○ A lot
There are many reasons why people may not get treatment even if they want it. Has this ever happened to you?	○ Yes ○ No

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What are the reasons why you have not gotten treatment even when you wanted to.

Do not read list. Select all that best fit response.

- ☐ Cost
- ☐ No insurance
- ☐ Concerned about being treated poorly
- ☐ Inconvenient times
- ☐ Inconvenient locations
- ☐ Transportation
- ☐ Childcare
- ☐ Too many rules
- ☐ Was in jail or prison
- ☐ The program could not accommodate your other healthcare or disability needs
- ☐ Concerned about what other people will think/embarrassed
- ☐ Not ready
- ☐ Could not find a provider who speaks preferred language or provides an interpreter when needed
- ☐ No space/capacity at treatment locations
- ☐ Worried about experiencing withdrawal
- ☐ Did not have any information or enough information about treatment
- ☐ Other
- ☐ Did not experience any barriers

Please specify other challenge(s)

____

I'm going to read you a statement. Please tell me how strongly you agree or disagree with this statement.

It is more effective to treat opioid addiction with medications like methadone, buprenorphine, or naltrexone than to treat opioid addiction without medication. Would you say that you...

Read list

- ◯ Strongly agree
- ◯ Agree
- ◯ Disagree
- ◯ Strongly disagree

Structural Vulnerability

Now I am going to ask you some questions about your living situation and other life experiences.

What is your current employment status?

Do not read list. Check answer that best fits and use list as prompt if needed.

- ◯ Employed full time
- ◯ Employed part time
- ◯ Retired
- ◯ Unemployed due to health reason
- ◯ Unemployed due to non-health reason
- ◯ Other

In what zip code do you live or spend most of your time?

If they cannot remember zip code then ask: Can you tell us a major intersection or landmark in that area?

____

Are you worried or concerned that in the next year you may not have stable housing that you own, rent, or stay in as a part of a household?

- ◯ Yes
- ◯ No

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In the past year, has it been difficult for you to pay for your basic needs, like food, housing, or other bills?	◯ Yes ◯ No
Are you currently responsible for any children under the age of 18? Do not read unless clarification needed: This can refer to children in your legal custody or those living in your household who you care for that are not in your legal custody.	◯ Yes ◯ No
In the past year, have you been involved with child protective services regarding a child that is under your care?	◯ Yes ◯ No
In the past year have you spent any time in prison or jail?	◯ Yes ◯ No ◯ Prefer not to answer
In the past year have you been on probation, parole, supervised release or other conditional release from jail or prison?	◯ Yes ◯ No ◯ Prefer not to answer
In the past year, have you been unfairly stopped, questioned, or searched by the police?	◯ Yes ◯ No
In the past year have you been arrested for possession of drugs or drug-related paraphernalia?	◯ Yes ◯ No
Where were you at the time of your most recent arrest? Do not read. Select choice that best applies based on response. Prompt with response options if needed.	◯ In a private residence, including your own home ◯ In your car ◯ On a bus, or other public transportation ◯ In a public place ◯ In a hospital or health care facility ◯ At a harm reduction or syringe access program ◯ At a treatment program ◯ At some other place
Please specify the place the arrest was made.	__________________________________
What was the reason for your most recent drug or drug-related arrest?	____
Have you ever felt unfairly judged or discriminated against based on your race, ethnicity, gender, sexual orientation or a health condition?	◯ Yes ◯ No
Have you ever been made to feel this way by the following people? Read list and check all that apply.	☐ Drug treatment providers ☐ Harm reduction staff ☐ Police ☐ EMS, fire department, or paramedics ☐ Emergency Department ☐ Other medical providers ☐ Someone else

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Please specify who has made you feel this way. __________________________________

Socio-demographic Characteristics We just have a few more questions left.

I'm going to read a list of racial and ethnic groups. Please tell me if you identify with each group by saying yes or no.

Data collector: Read the list and select all categories that apply. If participant says "no" to all, then select "none of the above"

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Middle Eastern or North African
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ (do not read) None of the above

What other racial or ethnic group or groups do you identify with? __________________________________

Specify other racial or ethnic group(s)

What is your gender?

- ◯ Female/Woman
- ◯ Male/Man
- ◯ Non-binary
- ◯ Another gender category

Please specify gender __________________________________

Do you consider yourself to be transgender?

- ◯ Yes
- ◯ No

What is your sexual orientation?

- ◯ Gay, lesbian, or homosexual
- ◯ Heterosexual or straight
- ◯ Bisexual
- ◯ Something else

Please specify your sexual orientation __________________________________

Who do you currently live with? If you live alone, please let me know.

Select all that apply. Choose answer(s) that fits best. Do not read list unless needed as prompt.

- ☐ Alone or by yourself
- ☐ A spouse
- ☐ A non-spouse partner
- ☐ Your parent or parents
- ☐ Your child or children under 18
- ☐ Your adult child or children
- ☐ Your grandparent or grandparents
- ☐ Your grandchild or grandchildren
- ☐ Other family members
- ☐ A roommate who is not a partner or family member
- ☐ Lives with other people at a drug treatment program or recovery housing
- ☐ Unhoused, couch-surfing, or lives in shelter
- ☐ Other

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Please specify who they live with

____

General Health/Wellness

Would you say your health in general is excellent, very good, good, fair or poor?

- ◯ Excellent
- ◯ Very good
- ◯ Good
- ◯ Fair
- ◯ Poor

Has a doctor or other health professional ever told you that you have a chronic or serious medical condition?

If yes, read: Please tell me which ones.

Select all that apply.

If no, check "No chronic or serious medical conditions"

- ☐ A heart condition
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Cirrhosis of the liver
- ☐ Hepatitis B or C
- ☐ HIV or AIDS
- ☐ Kidney disease
- ☐ Cancer
- ☐ Chronic bronchitis or chronic obstructive pulmonary disease (COPD)
- ☐ Depression or anxiety
- ☐ Bipolar disorder or schizophrenia
- ☐ Chronic pain
- ☐ Arthritis
- ☐ Asthma
- ☐ Other mental health condition
- ☐ Other
- ☐ No chronic or serious medical conditions
- ☐ Do not know

Please specify other chronic or serious health condition

____

Do you have serious difficulty concentrating, remembering, or making decisions because of a physical, mental, or emotional condition?

If participant responds "sometimes", then check "yes".

Add clarification if needed that we are asking about these symptoms being caused by a "physical, mental, or emotional condition".

- ◯ Yes
- ◯ No

Do you have serious difficulty walking or climbing stairs?

- ◯ Yes
- ◯ No

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What type of health insurance or health coverage plan do you currently have, if any?

Use list as prompt if necessary.

Select all that apply

☐ Private insurance received through an employer, union or purchased directly through an insurance company (either through yourself or a family member)
☐ Medicare for people 65 and older or people with certain disabilities
☐ Medicaid, Centennial Care, or any kind of government-assistance plan for those with low incomes or disabilities
☐ TRICARE, VA or other military or veteran health care
☐ Uninsured, no insurance
☐ Other

Do you use the Indian Health Service or another tribally-operated program?

○ Yes
○ No
○ Don't know

We've been asking you a lot of questions about your day to day life. In a few sentences, can you please tell me what your future health and wellness goals are?

Prompts if needed: this may include your physical health, mental health, spiritual health or changes related to your job or housing, your relationships, or your overall quality of life.

____

What would support you in achieving your goals?

____

Bernalillo County and the City of Albuquerque are receiving money as part of lawsuits against pharmaceutical companies for their role in the opioid crisis. The City and County are required to spend this money on programs for people who use drugs. What recommendations would you give to City and County government officials as the best way they can help people who use drugs?

Possible prompt:

If you were creating programs using this money, what types of programs and services would you make sure received funding?

____

Is there anything else that we did not discuss that you would like to share?

____

We have reached the end of the survey. I am now going to stop the recording.

Stop the recording.

Please add any notes about this record here, including if you think this participant may be a good candidate for the qualitative survey.

____

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APPENDIX B. Recruitment Site Information

Crossroads for Women
Bernalillo County DBHS CARES Campus
Ideal Option
Transgender Resource Center of New Mexico
Best Chance
Healing Roar
New Mexico Harm Reduction Collaboration
Casa de Salud
Resource Re-entry Center
State of the Heart Recovery
Albuquerque Healthcare for the Homeless

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Appendix F: Rapid Landscape Analysis Summary

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Rapid Landscape Analysis of Overdose Risks and Response Planning Opportunities in the City of Albuquerque and Bernalillo County

— September 2024

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Vital Strategies

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Introduction

The US Centers for Disease Control and Prevention's National Center for Health Statistics indicates that there were over one hundred thousand drug overdose deaths each year in 2023 and 2022. As of 2022, New Mexico had the 8th highest age-adjusted drug overdose death rate in the country. In the most populous county (Bernalillo) and city (Albuquerque) in the state with nearly one-third of its population, there is a substantial opportunity to reduce overdose risks.

Following resolutions from both the Bernalillo County Commission and the City of Albuquerque, the lead team for the County and City developed a memorandum of understanding (MOU) with Vital Strategies to lead the work to develop a strategic plan for use of opioid settlement funds. Vital Strategies is a global public health organization that partners with governments, providers and communities to support health-centered solutions rooted in evidence. It is the lead implementation partner in the Bloomberg Overdose Prevention Initiative and conducts its work in seven target states, including New Mexico, to promote a public health approach to reducing overdose deaths. Because this activity aligns with the goals of the Bloomberg Overdose Prevention Initiative, Vital Strategies agreed to perform this work at no cost to the County and City as part of its portfolio of activities in New Mexico. While the development of a strategic plan will be informed by several components, one of them is the rapid landscape analysis presented in this document.

This rapid landscape analysis attempts to assemble a variety of data sources and other information that may provide guidance to decision makers about the current status of drug-related overdose risk in the County as well as opportunities for action. It is guided by The Principles for the Use of Funds From the Opioid Litigation developed by the Johns Hopkins Bloomberg School of Public Health and endorsed by over 60 organizations around the US.

There were several limitations to this effort. Vital Strategies was requested to perform a rapid landscape analysis in advance of opioid settlement fund strategic planning. Therefore, it was not designed to exhaust all sources of relevant information in a relatively short time period. Vital Strategies is also not a local organization with intimate, historical knowledge of the context in the County. A more detailed description of

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additional limitations is presented in a section below. Despite these limitations, this landscape analysis represents effort to consult with key stakeholders and assemble a basic epidemiology of drug use and the capacity for overdose prevention response in the County. It was designed to inform decision-making regarding the investment of resources to reduce overdose risks and to stimulate additional questions about information needed to make informed decisions in the immediate future and in subsequent years. It was not intended to establish official counts or rates of overdose-related information. These are provided by public health authorities such as the New Mexico Department of Health.

Methods

The methods used to create this landscape analysis were varied and will be communicated in this section not only to inform the reader but to also to offer a guide for future reference if or when this process is repeated to update the information used to plan for overdose prevention response. Each section of the report will describe the sources of information and briefly describe how that source can be used to develop an understanding of overdose risks and opportunities in the County.

The Basic Drug Use Epidemiology Guide[1] developed by Vital Strategies and CDC Foundation was used as a framework to guide the development of this landscape analysis. The guide suggests asking basic questions about overdose risks and the current interventions that are available to respond to these risks. Some of the basic questions asked in this landscape analysis were:

- Who is dying from overdoses?
- Where in the city and county did overdoses occur?
- Which substances contributed to fatal overdoses?
- What is the availability and utilization of substance use disorder (SUD) treatment services?
- What is the availability and utilization of overdose prevention and harm reduction services?

[1] https://phast.org/wp-content/uploads/2022/09/Designed_PHAST-Epi-Guide_9.22.2022.pdf

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The steps we followed to gather answers to these questions included:

- Reviews of publicly available information such as reports and websites generated by various agencies and organizations,
- Consultations with individuals at various city, state and county agencies and organizations who lead or are otherwise responsible for programming to or reporting information relevant to overdose risks (see Table 1 below),
- Requesting specific information from these agencies and leaders that may contribute to an understanding of overdose risks in the city and county, and
- Analyzing and synthesizing this information so that its findings may be actionable.

Table 1. Consultations with and Data Requests from the Following Agencies and Organizations

Organization	City/ County/ State	Role(s)
Bernalillo County Department of Behavioral Health Services	County	Statistical Analyst Program Supervisor
Bernalillo County Fire Department, EMS Division	County	EMS Division Chief
Metropolitan Detention Center	County	Medical Director of Addiction Medicine
Bernalillo County Metropolitan Court	County	District Court Judge, Young Adult Court Court Executive Officer Chief Judge
Albuquerque Fire Rescue, EMS Division	City	EMS Division Chief Medical Director
Albuquerque Health, Housing and Homelessness	City	Special Projects Coordinator
Health Equity Council	City	Team
Albuquerque Community Safety	City	Deputy ABQ Community Safety
Albuquerque Public Schools	City	Senior Nursing Director Senior Director of Counseling Services

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		Executive Director of Students, Family, and Community Supports
Office of the Medical Investigator	State	Chief Epidemiologist Research Scientist
Substance Use Epidemiology Section, Injury and Behavioral Epidemiology Bureau, Epidemiology and Response Division, New Mexico Department of Health	State	Substance Use Epidemiologist Drug Overdose Mortality Epidemiologist
Bureau of Vital Records and Health Statistics, New Mexico Department of Health	State	Public Health Data Scientist
Hepatitis and Harm Reduction Program, Center for Communicable Diseases, Public Health Division, New Mexico Department of Health	State	Hepatitis and Harm Reduction Program Manager Adult Viral Hepatitis Coordinator Substance Use Health Educator
New Mexico Overdose Response Strategy (ORS)[2]	Federal	Public Health Analyst Drug Intelligence Officer

These activities began following an in-person kickoff meeting in March 2024 and concluded in August 2024.

Key Take-Aways

Who is experiencing fatal and nonfatal overdoses?

- The rate of fatal overdoses was highest and increased most rapidly during the period 2018-2022 among Black or African Americans, American Indian or Alaska Natives and Hispanics
- Fatal overdoses occur most frequently among those 35-44 and males

[2] The Overdose Response Strategy (ORS) is a public health-public safety partnership between the High Intensity Drug Trafficking Areas (HIDTA) program and the U.S. Centers for Disease Control and Prevention (CDC).

- The highest rates of emergency department visits related to an overdose during the period 2017-2021 were experienced by Black, American Indian, and Hispanic individuals while the latter presented to emergency departments most frequently

Where are people overdosing in the City and County?

- Drug overdose fatalities were most frequent in zip codes 87108 (161, 17.65%), 87106 (140, 15.35%), 87105 (86, 9.43%), 87102 (83, 9.10%), and 87121 (70, 7.67%).
- The most frequent locations of fatal overdose incidents were at the residence of the person who died (57%) or another's residence (6%), followed by outside (14%)
- AFR EMS responded to overdoses most often at a residence whether single or multi-family dwellings, apartments or hotels (663 or 46%) or in public places such as streets/highways (339 or 23%) and parking lots (196 or 14%).
- Bernalillo County EMS responds to overdoses most frequently in areas (zip codes) that overlap some of the areas of the City where fatal overdoses occur most frequently, however, 10% of its responses were in an area that borders the To'Hajiilee, Cañoncito Band of Navajos Reservation.

Which substances contributed to fatal overdoses?

- Fentanyl was the driver of the majority of fatal overdoses in the County (69%) followed by methamphetamine (54.4%), but their combination in contributing to overdoses was frequent. About half (52.5%) of fentanyl overdoses involved methamphetamine as a contributing factor and two-thirds (66.5%) of methamphetamine overdoses involved fentanyl as a contributing factor.
- Fatal overdoses involving medications for opioid use disorder such as buprenorphine and methadone were extremely rare without the presence of another substance (e.g. fentanyl) as a contributing factor

What is the availability and utilization of substance use disorder (SUD) treatment services?

- Limited information was available regarding psychosocial/counseling treatment.

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- There was a small increase in the number of patients in the County that received buprenorphine treatment for at least 10 days (3,163 to 3,373 or 6.6%) between 2021-2023.
- There has been a decrease in the number of distinct patients with methadone claims paid by Medicaid between 2021 and 2023 (3,013 to 2,318 or 23.1%) while the number of providers remained relatively stable.
- While there was an increase in the number of clients treated with buprenorphine at the CARE Campus in 2023, almost half (45%) were documented to have declined services, elected to discharge, or there was no disposition annotated.
- The Metropolitan Detention Center has expanded the number of clients in its MAT program and offers both buprenorphine and methadone treatment.

What is the availability and utilization of overdose prevention and harm reduction services?

- Average monthly naloxone distribution to vulnerable individuals increased 22% between FY 2023 and FY 2024
- AFR EMS has estimated it has provided 700 naloxone kits as "leave-behind" kits following encounters with vulnerable individuals in the past 24 months (approximately one per day)
- Local partners contracted by NMDOH have expanded the number of client sessions and unique individuals where they perform their services throughout the County during the period July 2022 – March 2024, especially the International District, Downtown and North Valley
- Distribution of safer smoking/snorting kits increased substantially among all partner organizations operating in the county, and most more than doubled their prior year distribution.

What substance use services are available for youth?

- Current and lifetime heroin use by Bernalillo County high schoolers was low, while improper use of pain medications was higher
- Improper pain medication use (current and lifetime) was higher among females
- Albuquerque Public Schools offers counseling and Post-overdose Response Team services for students who experience challenges with substance use

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Opportunities for future overdose prevention and response planning

There is currently no centralized local resource that is tasked with the responsibility to coordinate the various sources of data and information that were included in this landscape analysis and then assemble these resources into actionable intelligence that can be used for overdose prevention planning. It was therefore challenging to conduct this landscape analysis.

There is an opportunity to build capacity to improve coordination between City, County, and State agencies and systems to better understand overdose risks, plan for overdose prevention response, and monitor the interventions aimed to reduce those risks. The strategies to build this capacity are aligned with the New Mexico Opioid Allocation Agreement.

Sources and Their Value to Understanding the Overdose Prevention Landscape

To gather an understanding of the overdose risks and opportunities for intervention in Bernalillo County and the City of Alburquerque, this landscape analysis relied on consultations with and data requests from the following governmental agencies and community organizations. This section will describe the role of each and a brief rationale for the contribution each can have to improving an understanding of overdose risks and opportunities for intervention.

New Mexico Office of the Medical Investigator (OMI)

Office of the Medical Investigator (OMI) in Albuquerque investigates any death occurring in New Mexico that is sudden, violent, untimely, unexpected or where a person is found dead and the cause of death is unknown. The OMI, which is a special program within the Department of Pathology, determines the cause and manner of death in these cases, and provides formal death certification.[3]

[3] https://hsc.unm.edu/omi/

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The information gathered through medical examiner offices like OMI is foundational to inform prevention and response efforts such as an understanding the locations of overdose death incidents, the specific substances that contributed to an accidental fatal overdose, characteristics of the individual who has died as well as characteristics and circumstances surrounding drug overdose deaths.

Emergency Management Services (EMS)

EMS systems play a critical role in responding to the epidemic, not only by responding to and treating overdoses, but also by supporting prevention efforts, linking patients to treatment and sharing data with their public safety and public health partners.[4]

Information from EMS agencies such the Albuquerque Fire Rescue EMS Division (AFR EMS) and Bernalillo County (BernCo EMS) can be used to better understand where agencies are responding to 911 calls to related to an overdose in the community, how often this is occurring, what treatment and transportation was offered to the patient and the what the disposition of the patient was following the encounter.

Substance Use Disorder and Behavioral Health Treatment Services

Substance use disorder treatment services are critical to ensure that individuals who are vulnerable to an overdose and other adverse consequences of substance use have the opportunity engage in treatment to improve their health and to reduce these risks. Information about treatment availability, quality and utilization from payers for these services (often a municipality, state or manage care organization) can be used to better understand who is receiving which services, for which conditions, and to what extent people were exposed to treatment that can be effective at reducing overdose risks.

Bernalillo County Department of Behavioral Health Services and Albuquerque Health, Housing and Homelessness were able to provide some of this information.

[4] https://www.ems.gov/resources/search/?category=opioid-epidemic#sort=date

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New Mexico Department of Health (NMDOH)

Departments of health are the core of public health infrastructure in a state or municipality. These agencies perform a variety of functions related to overdose prevention including surveillance, epidemiology and analysis, and in some cases, direct services such as naloxone distribution and harm reduction services.

This landscape analysis relied upon reports and other information developed and shared by the New Mexico Department of Health (NMDOH). Information from the Substance Use Epidemiology Section within the Epidemiology and Response Division was critical to gain an understanding of details related to drug related deaths and medications dispensed for the treatment of opioid use disorder (buprenorphine and methadone) as well as naloxone distribution. Information from the Hepatitis and Harm Reduction Program within the Public Health Division was critical to gain an understanding of targeted distribution of naloxone within the County as well as other harm reduction and overdose prevention programming and participation.

Who is experiencing fatal and nonfatal overdoses?

This section will primarily examine characteristics of people who experienced a fatal overdose using information from the New Mexico Department of Health (NMDOH) and Office of the Medical Investigator (OMI).[5] While the harms related to alcohol use are a significant issue in the county, the focus of this analysis is overdoses related to drug use. Though acute alcohol poisoning certainly occurs, most alcohol-related deaths result from chronic use and accidents that occur while intoxicated. During the most recent two-year period in Bernalillo County, while alcohol/ethanol was a contributing factor to 22% of fatal

[5] For this landscape analysis, information used from NMDOH includes both unintentional drug overdose deaths and suicide, or intentional self-poisonings. NMDOH reports that unintentional drug overdoses account for 94% of deaths and intentional self-poisonings accounted for 6% of deaths (New Mexico Department of Health. New Mexico Substance Use Epidemiology Profile, 2024. https://www.nmhealth.org/data/view/substance/2889/). Information used from OMI includes unintentional overdose deaths only and will be noted accordingly throughout this section.

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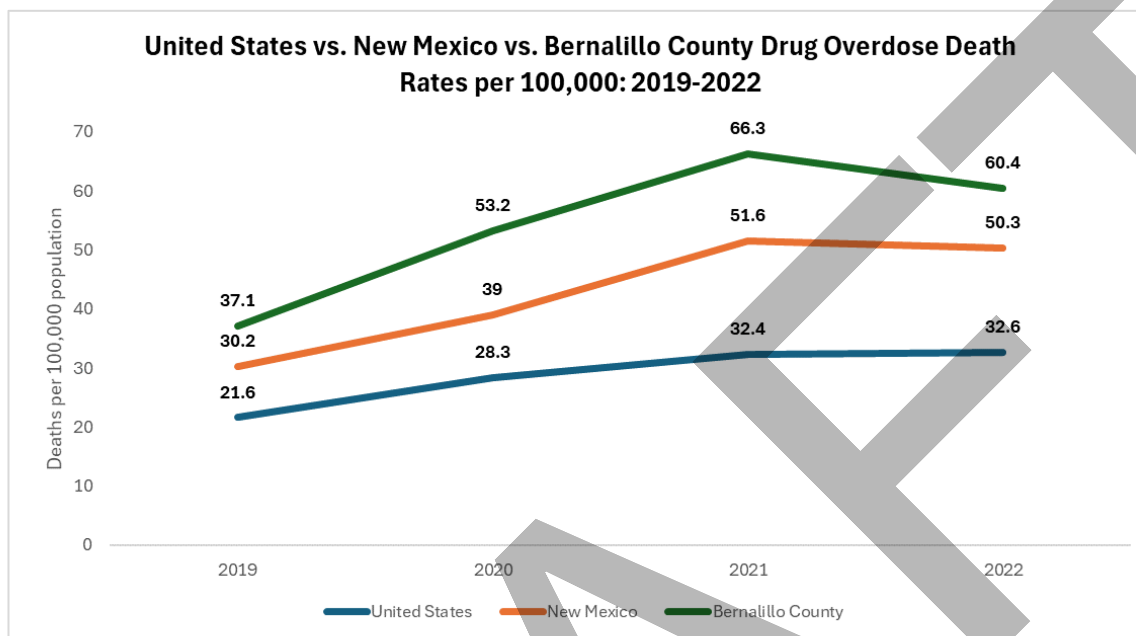
overdoses, only 11 or 1% were caused by acute alcohol or ethanol poisoning alone. Key takeaways from this section are listed below:

- Drug-related overdose deaths in Bernalillo County have increased in the past several years and have remained elevated
- The rate of fatal overdoses was highest and increased most rapidly during the period 2018-2022 among:
    - Black or African Americans, American Indian or Alaska Natives and Hispanics
    - Those aged 25-64, especially among those 35-44; and
    - Males
- The highest rates of emergency department visits related to an overdose during the period 2017-2021 were experienced by Black, American Indian, and Hispanic individuals while the latter presented to emergency departments most frequently

Unintentional drug overdose death rates across the United States have increased dramatically over the past decade and peaked in 2021. New Mexico and Bernalillo County experienced a similar trend, however, rates in both are elevated compared to overall, national rates. In particular, Bernalillo County drug overdose death rates have consistently remained higher than the state rates. Bernalillo County ranked 6th out of all New Mexico counties with a drug overdose death rate of 41.6 per 100,000 and accounted for over 40% of all drug overdose deaths statewide according to the NMDOH during the period 2017-2021.[6]

[6] New Mexico Department of Health. New Mexico Substance Use Epidemiology Profile, 2024. Available online: https://www.nmhealth.org/data/view/substance/2889/

Figure 1. Bernalillo County Drug Overdose Deaths vs National and State Rates[7]



Drug-related overdose deaths in Bernalillo County have increased in the past several years and have remained elevated. The Substance Use Epidemiology Section of the Injury and Behavioral Epidemiology Bureau within the New Mexico Department of Health analyzed death certificate data and observed overdose deaths and age-adjusted death rates increasing from 191 or 27.5 per 100,000 in 2018 to 413 or 60.4 per 100,000 in 2022 (see Figure 2 below). Consulting preliminary data from OMI, there were approximately 425 unintentional fatal overdoses in the County in 2023, suggesting that overdose fatalities and rates remain elevated.[8]

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[7] United States and New Mexico rates are from the CDC National Center for Health Statistics Drug Overdose Mortality by State and NCHS Data Briefs. For USA and NM, age-adjusted rates were calculated using the direct method and the 2000 U.S. standard population. Bernalillo County drug overdose death rates are from the New Mexico Department of Health. The 2022 Bernalillo County rate was calculated using the 2021 population estimates, and NMDOH rates were age adjusted to the 2000 U.S. standard population.

[8] Note that this landscape analysis relies on the work of epidemiologists at the Department of Health to calculate final overdose fatalities and rates. Information from OMI is presented here and throughout this report in order to compliment the work of these epidemiologists by presenting more recent information in the service of this landscape analysis. NMDOH's data is coded for underlying cause of death and includes deaths of NM residents that occur in other states.

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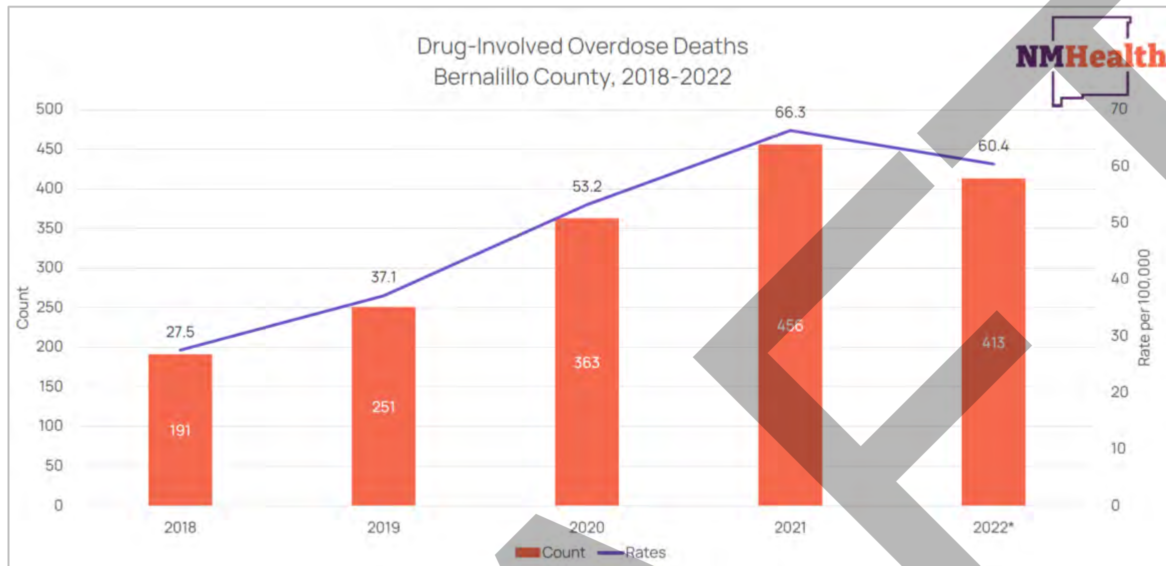
Figure 2. Drug-involved Overdose Deaths 2018-2022: Bernalillo County[9]



The rate of fatal overdoses among males was more than twice the rate among females during the period 2019-2022 (see Figure 3 below). This is consistent with more recent data from OMI during the period January 2022 – March 2024. Seventy-two percent of unintentional fatal overdoses in the County were male and 28% female during this period.

[9] New Mexico Department of Health (NMDOH) Bureau of Vital Records & Health Statistics death certificate data; University of New Mexico Geospatial & Population Studies population estimates. Data were analyzed & prepared by NMDOH Substance Use Epidemiology Section.

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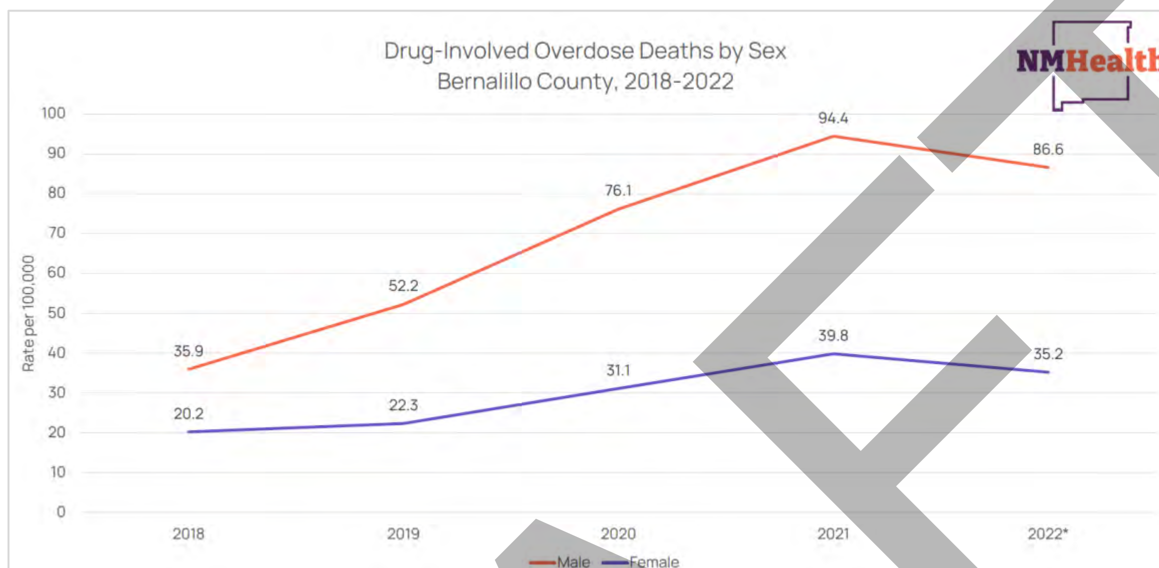
Figure 3. Drug-involved Overdose Deaths by Sex, 2018-2022: Bernalillo County[7]



The rate of fatal overdoses was highest and increased most rapidly during the period 2018-2022 among Black or African Americans (12.8 per 100,000 in 2018 to 104.1 in 2022), American Indian or Alaska Natives (39.5 to 96.6) and Hispanics (29.0 to 67.0) as presented in Figure 4 below. More recent OMI data during the period January 2022 – March 2024 was examined for this analysis but records regarding race were missing for approximately 18% of cases and ethnicity (e.g. Hispanic) was missing or unknown for 36% of cases[10].

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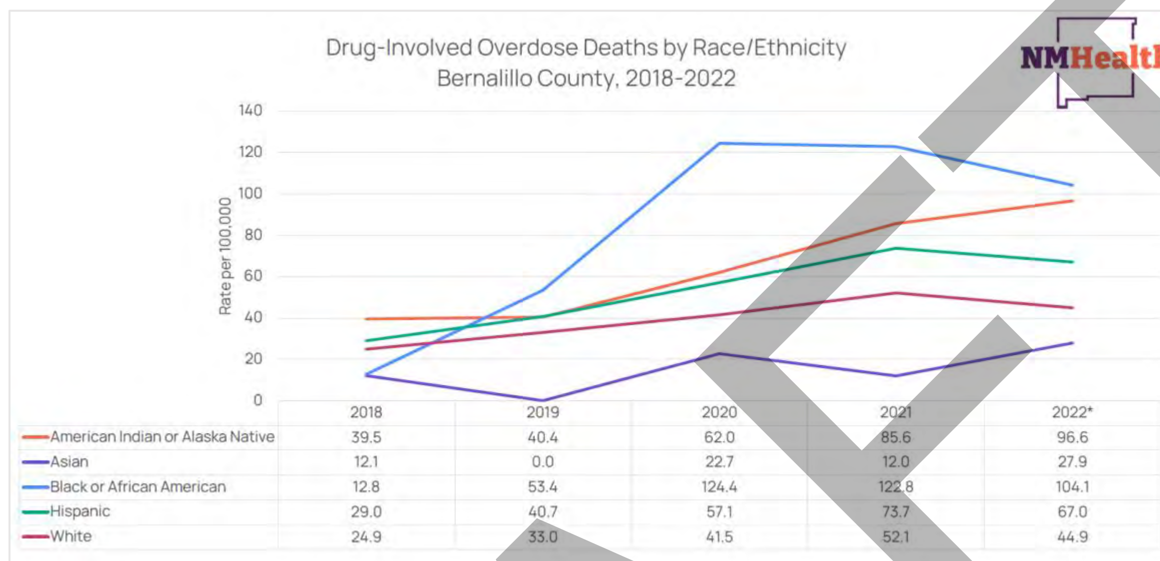
[10] OMI ability to capture accurate race and ethnicity data may be limited, while NMDOH race and ethnicity data is based upon reporting from the funeral home/death certificate, and typically provided by family/next of kin.

Figure 4. Drug Overdose Deaths and Rates by Race/Ethnicity, 2018-2022: Bernalillo County[7]



	2018	2019	2020	2021	2022*
American Indian or Alaska Native	39.5	40.4	62.0	85.6	96.6
Asian	12.1	0.0	22.7	12.0	27.9
Black or African American	12.8	53.4	124.4	122.8	104.1
Hispanic	29.0	40.7	57.1	73.7	67.0
White	24.9	33.0	41.5	52.1	44.9

The rate of fatal overdoses was highest and increased most rapidly during the period 2018-2022 among those aged 25-64 years (see Figure 5 below). Using preliminary data from OMI data to examine age groups more closely during the period January 2022 – March 2024, unintentional overdose deaths occurred most frequently (25.5% or 232 of 910) among those aged 35-44 years as displayed in Figure 6 below.[11]

[11] There were 912 observed accidental drug-related overdoses during this period using data from OMI. Age was unknown for 2 cases.

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Figure 5. Drug Overdose Deaths and Rates by Age Group, 2018-2022: Bernalillo County[7]

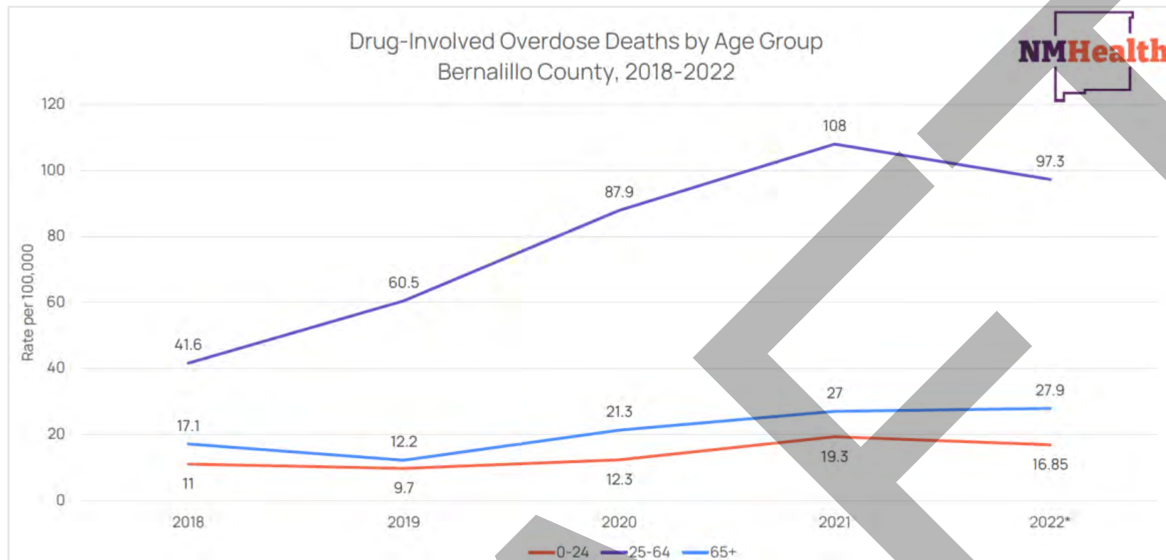
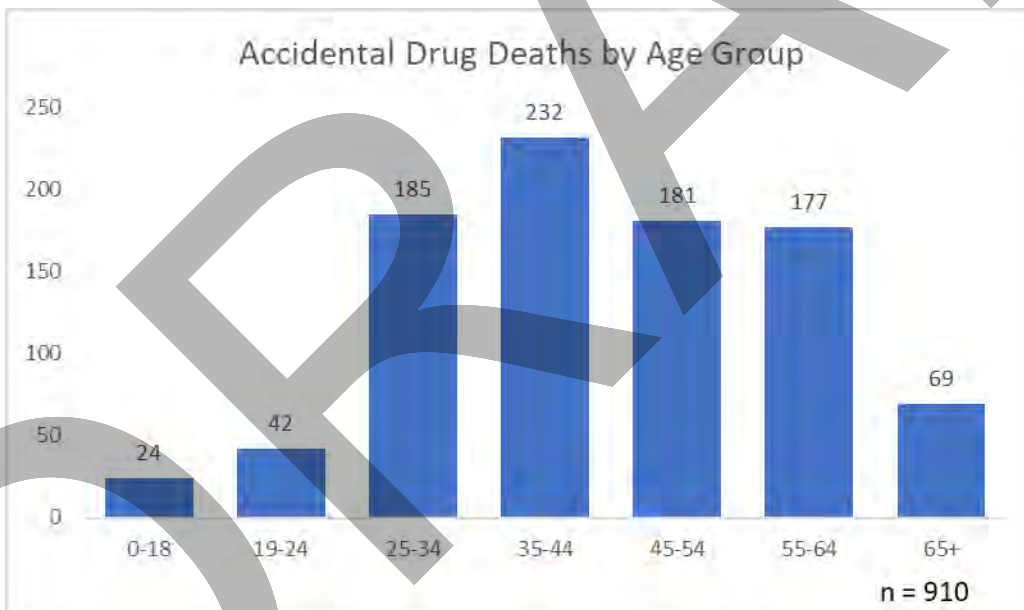


Figure 6. Drug Overdose Deaths by Age Group, 1/1/22-3/31/24: Bernalillo County



Bernalillo County had the largest percentage of opioid overdose related emergency department visits (44.2% of the state total). Table 2 below presents information from the NMDOH Substance Use Epidemiology Profile[12] about emergency department visits for

[12] https://www.nmhealth.org/data/view/substance/2889/ - Table 2, page 48

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opioid-related overdoses during the period 2017-2021. Consistent with fatal overdose rates, the highest rates were experienced by Black (121.5 per 100,000), American Indian (17.7) and Hispanic (90.8) individuals while Hispanic individuals presented to emergency departments most frequently (n=1,585). Information about the specific hospital emergency departments was not available in this report.

Table 2. Opioid Overdose-Related Emergency Department Visits, Bernalillo County: 2017-2021[10]

	Emergency Department	Rate per 100K
American Indian	194	117.7
Asian/Pacific Islander	15	13.5
Black	131	121.5
Hispanic	1,585	90.8
White	825	60.6
All races	2,908	82.5

Where are people overdosing in the City and County?

This section will examine the locations of fatal and non-fatal overdoses within the County using information from the New Mexico Office of the Medical Investigator (OMI), City of Albuquerque EMS Division (AFR EMS), Bernalillo County EMS Division (BernCo EMS), and City of Albuquerque Community Saftey (ACS). Key takeaways from this section are listed below:

- Drug overdose fatalities were most frequent in zip codes 87108 (161, 17.65%), 87106 (140, 15.35%), 87105 (86, 9.43%), 87102 (83, 9.10%), and 87121 (70, 7.67%).

ED visit rates by race have been aggregated for 2017-2021 by NMDOH.

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- The most frequent locations of fatal overdose incidents were at the residence of the person who died (57%) or another's residence (6%), followed by outside (14%)
- Overdose-related EMS responses in Albuquerque increased substantially in the summer of 2023 and have remained elevated
- AFR EMS responded to overdoses most often at a residence whether single or multi-family dwellings, apartments or hotels (663 or 46%) or in public places such as streets/highways (339 or 23%) and parking lots (196 or 14%).
- City of Albuquerque Fire/EMS Stations located near areas where fatal overdoses occur also respond most frequently to emergency calls for overdoses
- Bernalillo County EMS responds to overdoses most freqently in areas (zip codes) that overlap some of the areas of the City where fatal overdoses occur most freuqently, however, 10% of its responses were in an area that borders the To'Hajiilee, Cañoncito Band of Navajos Reservation.
- Alburquerque Community Safety captures detailed information that can be useful in planning for interventions targeted towards vulnerable populations.

Office of the Medical Investigator

OMI records were used to identify where unintentional fatal overdose incidents occurred in the County. During the period 1/1/2022-3/31/2024, there were 912 fatal overdose incidents that we included in this landscape analysis.[13]

OMI does collect specific addresses of incident locations, however, only 38% of records contained reliable addresses. However, each record contained a zip code and these were used to display the locations of fatal overdose that occurred in the community (816 of 912). There were 96 or 11% of incidents where a person died at a hospital but information about the location of the overdose incident was unavailable. These were also displayed for geographic perspective on locations of overdose fatalities (see Figure 7

[13] Note: Following the guidance of OMI, the refined cause of death and manner of death fields were used to identify cases that were accidental and had some form of drug toxicity listed as the cause of death. Please note that counts of overdose deaths differ slightly between OMI and NMDOH. OMI data was included in this analysis to inform overdose prevention planning, however, finalized data and analysis performed by NMDOH should be regarded as the official counts and trends in fatal overdose deaths over time.

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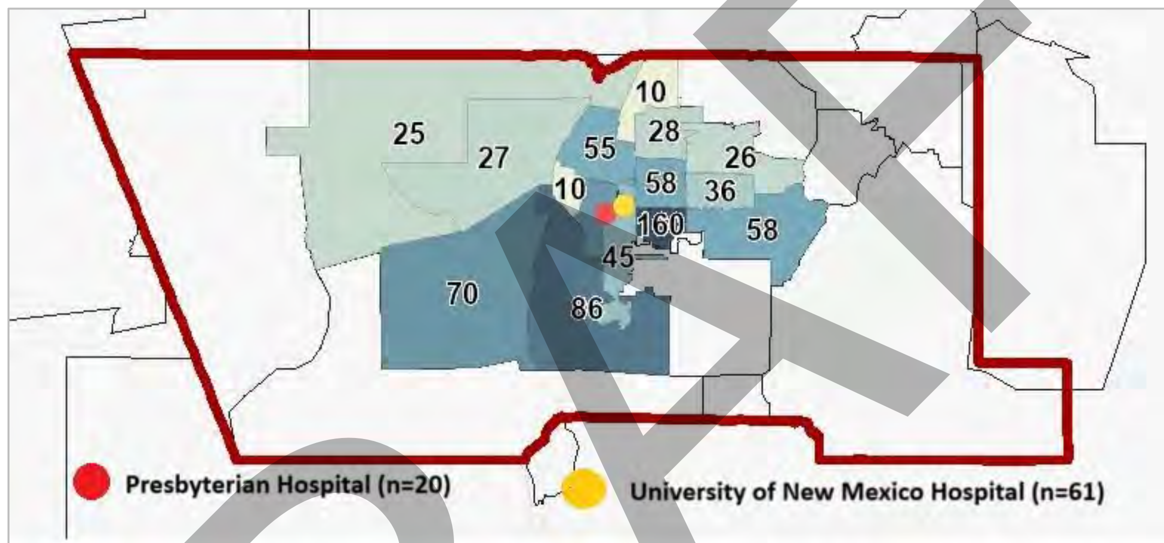
below). Of the 816 incidents that occurred in the community, drug overdose fatalities were most frequent in 87108 (160 or 19.6%), 87105 (86 or 10.5%), 87121 (70 or 8.6%), 87102 (68 or 8.3%), and 87110 and 87213 (58 or 7.1% in each zip code). Of the 96 incidents where a person died at a hospital, 61 or 63.5% occurred at University of New Mexico Hospital, 20 or 20.8% occurred at Presbyterian Hospital and 15 or 15.6% occurred at another medical facility.

Figure 7. Locations of fatal overdose incidents by zip code, Bernalillo County: 1/1/2022 - 3/31/2024



The most frequent locations of these incidents were at a residence (539 of 912 or 59% occurred at the residence of the person who died and 51 or 6% occurred at another's residence) followed by outside (126 or 14%).

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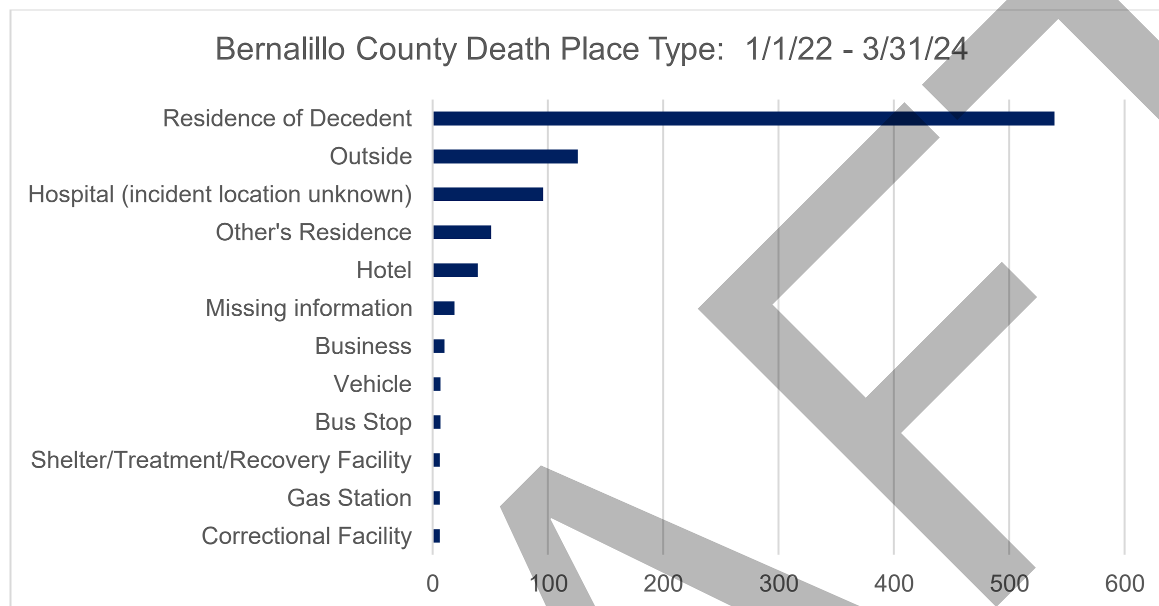
Figure 8. Bernalillo County Death Place Type: 1/1/22-3/31/24



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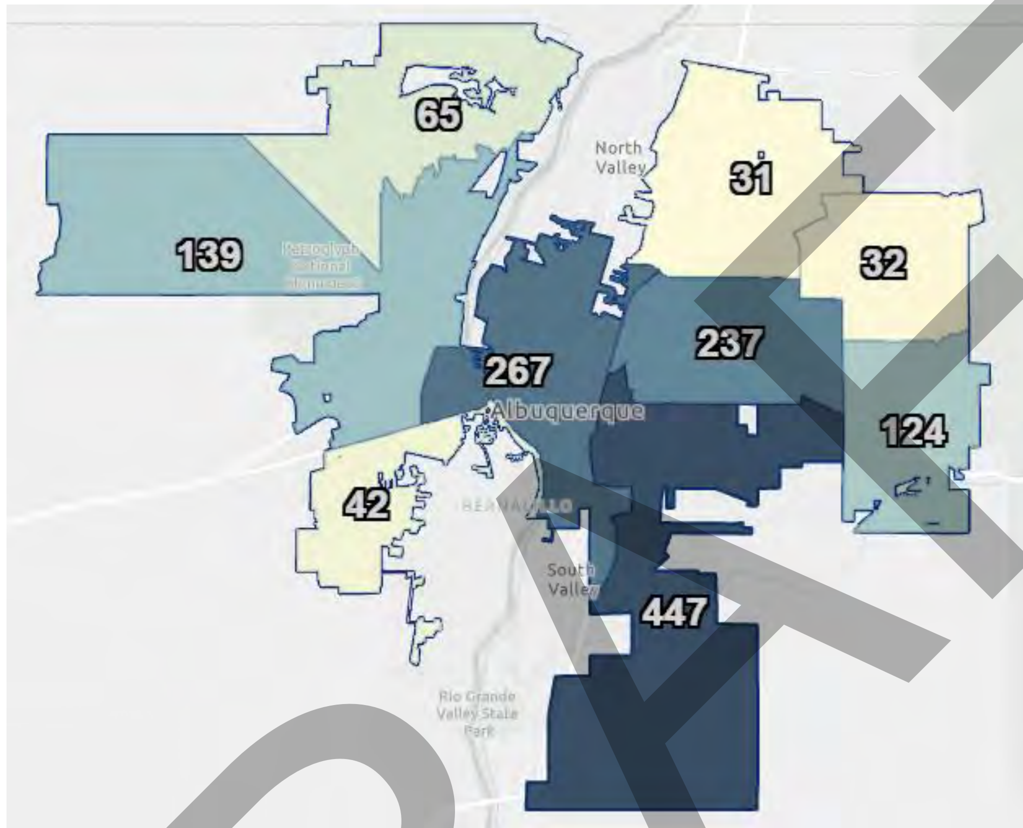
City of Albuquerque Fire Rescue EMS Division (AFR EMS)

AFR EMS shared information about overdose related EMS responses between May 2022 and April 2024 by station.[14] AFR EMS responded to 1,450 suspected overdoses and administered naloxone on 618 occasions within the city during this period. Overdose related responses were most frequent during this period in city council districts 6 (447 or 31%), 2 (267 or 18%) and 7 (237 or 16%), followed by 1(139 or 10%) and 9 (124 or 9%) as shown in Figure 9 below. AFR EMS also has community paramedics who perform follow-ups within 30 days after the initial encounter though service information was not available to review for this landscape analysis.

[14] Note to reader: Vital Strategies translated stations to city council districts in order to define a spatial boundary to visualize overdose response information using the following: https://www.cabq.gov/fire/fire-station-information

Figure 9. Albuquerque EMS Overdose-related Responses by City Council District: May 2022 - April 2024



This analysis also highlights the volume of overdose related responses by firestation to give the reader perspective about the particular stations/locations in the city that respond to the most number of overdoses. Stations 5, 11, 13, 1 and 12 collectively responded to half of the overdoses in the City with stations 5 (240 or 17%) and 11 (167 or 12%) responding most frequently.

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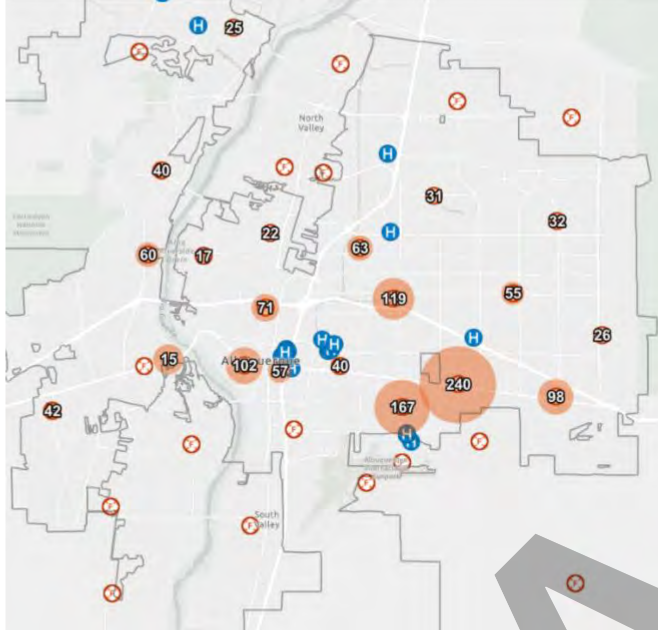
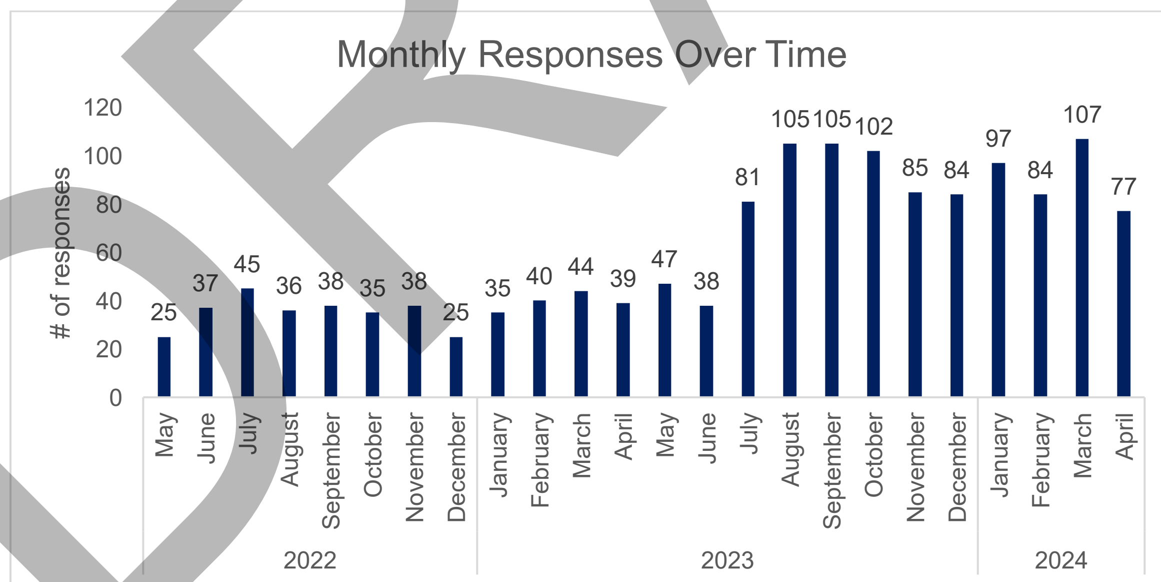
Figure 10. Albuquerque EMS Overdose-related Responses by Fire Station: May 2022 - April 2024



Overdose-related EMS responses in Albuquerque increased substantially in the summer of 2023 (see Figure 11 below). Monthly average responses related to overdoses in July 2022-April 2023 were 37.5 compared to 92.7 for July 2023-April 2024.

Figure 11. Albuquerque EMS Overdose Related Responses by Month: May 2022-April 2024



AFR EMS responded to overdoses most often at a residence whether single or multi-family dwellings, apartments or hotels (663 or 46%) or in public places such as

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streets/highways (339 or 23%) and parking lots (196 or 14%). Additionally, 160 or 11% of AFR EMS responses occurred at businesses or commercial establishments.

Refusal of transportation following naloxone administration has been observed to increase risk of subsequent non-fatal overdose requiring EMS intervention[15] and this increased following the COVID-19 pandemic.[16] About 20% of patients (296) refused transport following a AFR EMS response related to overdose during this period, though it is currently unknown whether this rate increased following the pandemic.

Bernalillo County EMS Division (BernCo EMS)

BernCo EMS shared information about overdose related EMS responses between April 2022 and April 2024 by zip code. During this period, BernCo EMS responded to 1,110 suspected overdoses. Overdose related responses were most frequent during this period in zip codes 87105 (446 of 1,110 or 40%), 87121 (240 or 22%), and 87113 (14%) as shown in Figure 12 below. While some of these zip codes overlap the boundary of the city, BernCo EMS' responsibility is to respond in areas of those zip codes that are outside of the City boundary. Additionally, 108 or 10% of responses were in zip code 87114 which borders the To'Hajiilee, Cañoncito Band of Navajos Reservation.

Overdose responses for BernCo EMS did not increase in the summer of 2023 as they did for AFR EMS and transport refusal following treatment was similar to AFR EMS at 19% (213 of 1,110).

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[15] Zozula A, Neth MR, Hogan AN, Stolz U, McMullan J. Non-transport after Prehospital Naloxone Administration Is Associated with Higher Risk of Subsequent Non-fatal Overdose. Prehosp Emerg Care. 2022 Mar-Apr;26(2):272-279. doi: 10.1080/10903127.2021.1884324. Epub 2021 Feb 26. PMID: 33535012.

[16] Casillas SM, Pickens CM, Stokes EK, Walters J, Vivolo-Kantor A. Patient-Level and County-Level Trends in Nonfatal Opioid-Involved Overdose Emergency Medical Services Encounters — 491 Counties, United States, January 2018–March 2022. MMWR Morb Mortal Wkly Rep 2022;71:1073–1080. DOI: http://dx.doi.org/10.15585/mmwr.mm7134a1

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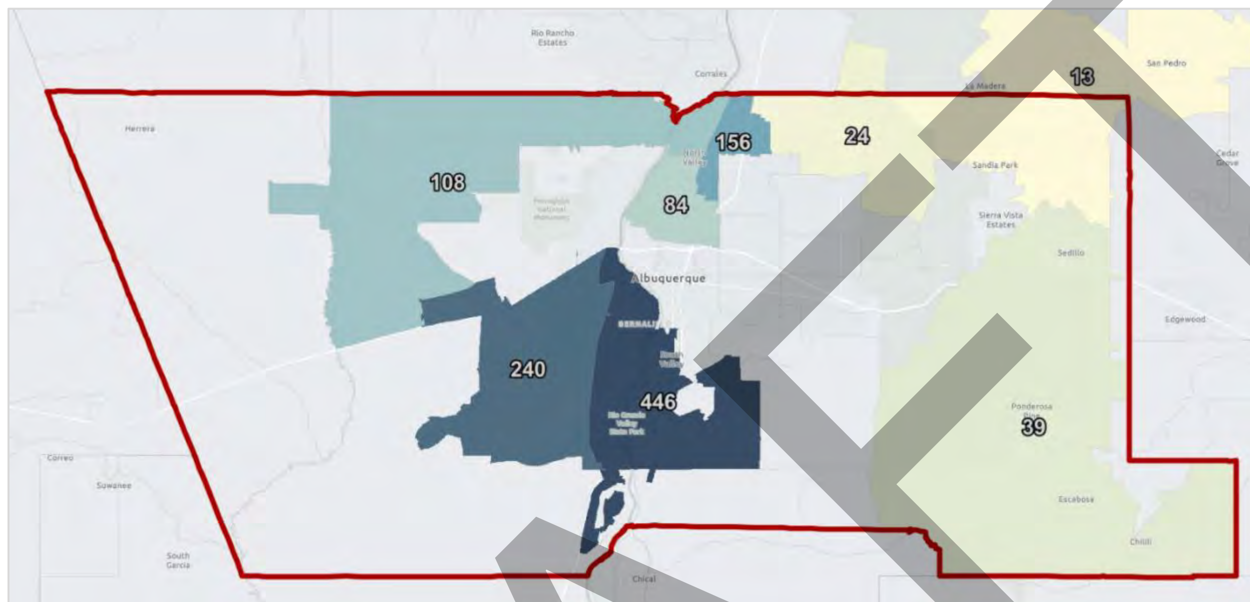
Figure 12. Bernalillo County EMS Overdose-related Responses by Zip Code: April 2022-April 2024



Albuquerque Community Safety (ACS)

ACS is a cabinet-level public safety department, meaning it operates independently from and in collaboration with the police department and fire rescue. ACS uses a public health model with a non-law enforcement-led response. ACS allows 911 dispatch to send trained professionals with backgrounds in behavioral and mental health and social services to non-violent and non-medical calls. The goal is to deliver the right response at the right time and to improve access to the broad range of social services from government and community-based organizations.[17] ACS has a variety of programs including Mobile Crisis Team Clinicians, Behavioral Health Responders, Community Responders, Street Outreach and Resource Responders, and Violence Intervention Program. A description of these services can be found here https://www.cabq.gov/acs/our-response.

Behavioral Health Responders work in pairs and respond in person or by phone to requests for assistance with individuals experiencing issues with mental and behavioral health, inebriation, homelessness, addiction, chronic mental illness as well as other

[17] https://www.cabq.gov/acs/our-role

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issues that do not require police, fire or EMS response. A summary of this program's responses as well as those of its Community Responders and Street Outreach and Resources Responders who encounter individuals vulnerable to overdose during FY24 quarter 2 are included in Table 3 (below) excerpted from the department's extensive reporting on its Transparency website.[18]

Table 3. ACS Call Types by Responder Type – FY 24 Q2[19]

ACS Call Types by Responder Type[2] – FY24 Q2

Call Type	Behavioral Health Responders FY23-Q2	Behavioral Health Responders FY24-Q2	Community/Street Outreach Resp. FY23-Q2	Community/Street Outreach Resp. FY24-Q2
Welfare Check	1,624	3,113	82	134
Unsheltered Ind	1,229	2,120	996	2,055
Behavioral Health	315	781	4	11
Suicide Related	144	465	2	4
Wellness Check	299	337	41	47
Susp Person	60	130	0	7
Disturbance	59	101	5	11
Panhandler	54	92	2	15
Other	115	38	8	11
Needle Pick Up	0	0	0	1
Abandoned Veh	2	5	0	0
Total	**3,901**	**7,182**	**1,140**	**2,296**

While the proportion of these responses that are substance use or overdose related is unknown, Figures 13 and 14 display ACS responses during FY 24 quarter 2 and June 2024, respectively. Similar to ABQ EMS responses, the areas most frequently served by ACS were council districts 6, 2 and 7. This reporting can be useful in helping to understand where interventions might be targeted to reach vulnerable populations since they offer more granular data about the areas within districts that have had the greatest

[18] https://www.cabq.gov/acs/transparency/reports The figures/maps included in this report are those that included Behavioral Health, Community, and Street Outreach Responder reports that contained a geolocation within the city limits according to notes in the ACS reports.

[19] https://www.cabq.gov/acs/documents/acs-quarterly-report-fy24-q2-final.pdf

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need for the services offered by Behavioral Health, Community and Street Outreach Responders.

Figure 13. Citywide ACS Responses during FY24-Q2

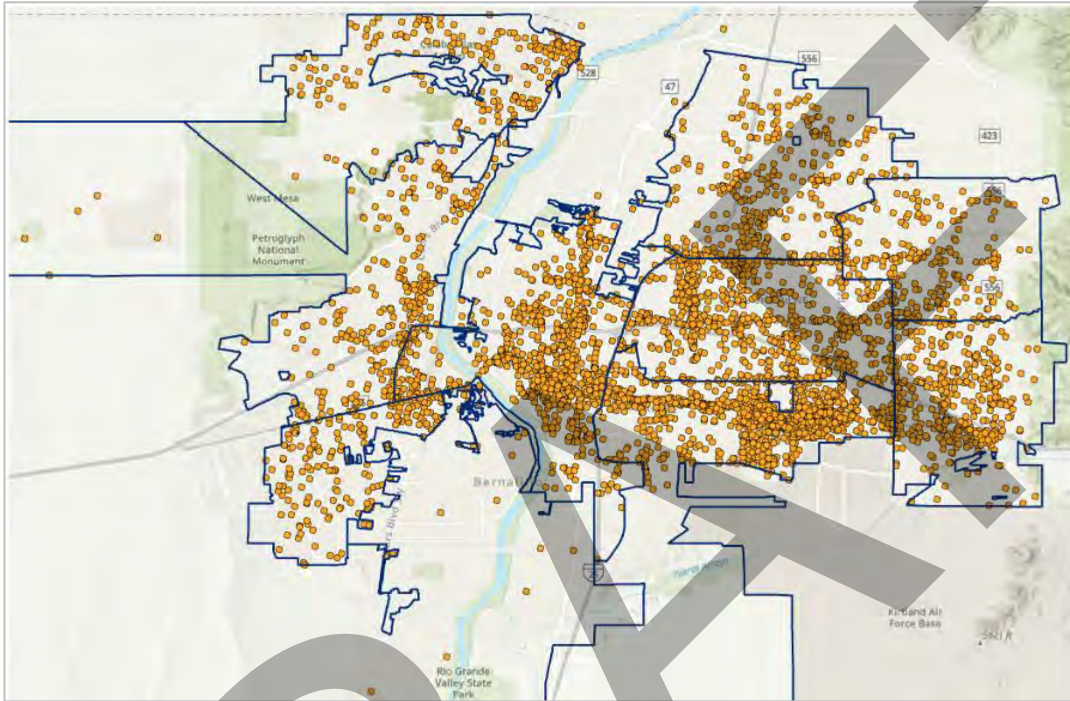

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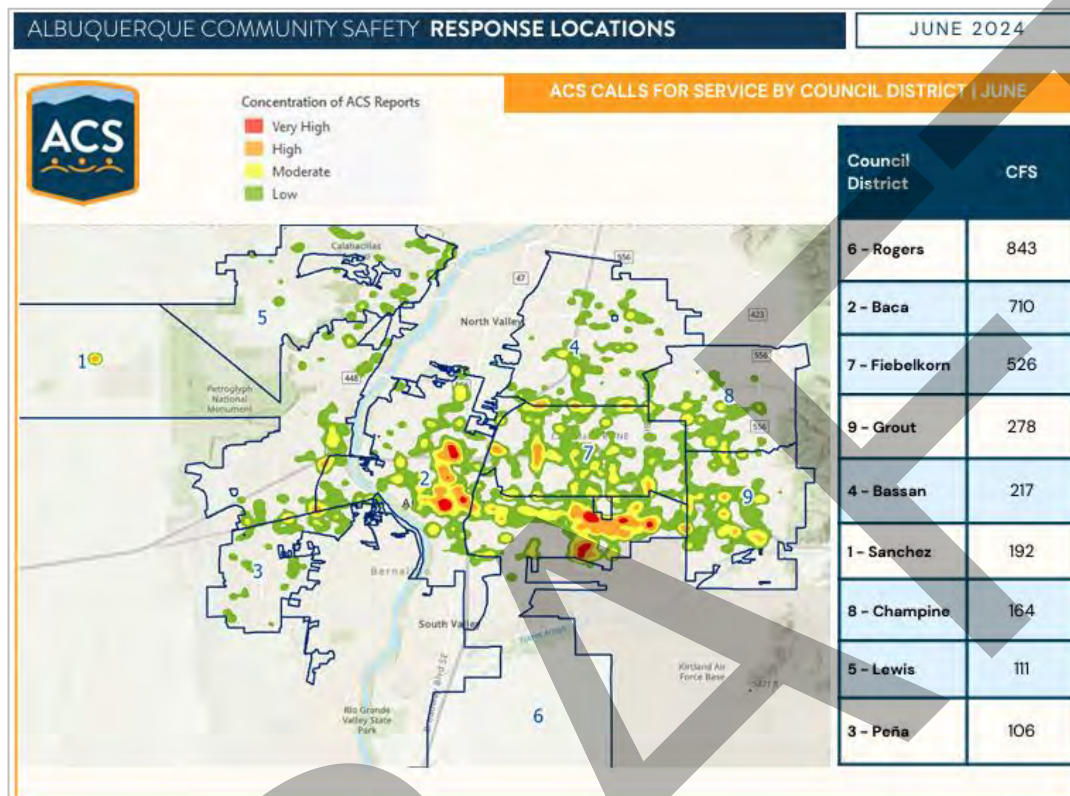
Figure 14. ACS Response Locations June 2024



Council District	CFS
6 - Rogers	843
2 - Baca	710
7 - Fiebelkorn	526
9 - Grout	278
4 - Bassan	217
1 - Sanchez	192
8 - Champine	164
5 - Lewis	111
3 - Peña	106

Which substances contributed to fatal overdoses?

This section will examine the types of substances that contributed to fatal overdoses within the County using information from NMDOH and OMI. Key takeaways from this section are listed below:

- Fentanyl was the driver of the majority of fatal overdoses in the County (69%) followed by methamphetamine (54.4%), but their combination in contributing to overdoses was frequent. About half (52.5%) of fentanyl overdoses involved methamphetamine as a contributing factor and two-thirds (66.5%) of methamphetamine overdoses involved fentanyl as a contributing factor.
- Fatal overdoses involving medications for opioid use disorder such as buprenorphine and methadone were extremely rare without the presence of another substance (e.g. fentanyl) as a contributing factor

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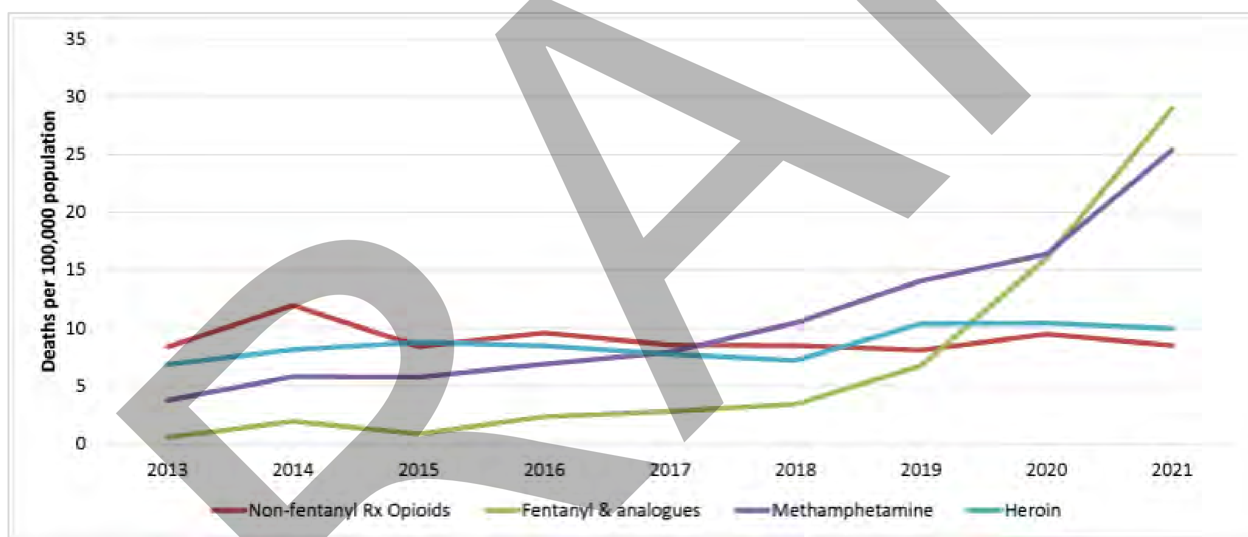
The recently published NMDOH State Epidemiological Profile[7] observed the changes in the overdose epidemic from 2013-2021 in the state of New Mexico. Figure 15 below shows the recent rapid increase in overdose rates resulting from fentanyl and methamphetamine beginning in 2018-2019. It also shows a relatively stable or slightly decreasing rate of fatal overdoses resulting from non-fentanyl prescription opioids. This is consistent with information from the New Mexico Prescription Monitoring Program during 2021 Q4 –2023 Q3 that shows decreasing rates of high dose opioid prescriptions (2,630 to 2,330) and concurrent opioid and benzodiazepine prescription fills (3,057 to 2,661) in the county, measures often reported by prescription monitoring programs related to overdose risks.

Figure 15. Drug Overdose Death Rates by Drug Class 2013-2021: New Mexico



During the period 2017-2021, NMDOH notes that, as expected due to the size of the population, Bernalillo County had the largest of overdose deaths in New Mexico where fentanyl and/or methamphetamine was a contributing factor. OMI data for the recent period January 2022 – March 2024 highlights these and other substances that were the major contributing factors to fatal overdoses in the County in Table 4 below.

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Table 4. Substances Contributing to Overdose Deaths in Bernalillo County: Jan 2022-March 2024

	Number	Percent of Total
Fentanyl	629	69.0%
Methamphetamine	496	54.4%
Fentanyl+ Methamphetamine	330	36.2%
Cocaine	143	15.7%
Cocaine+Fentanyl	71	7.8%
Total	912	

Fentanyl was the driver of the majority of fatal overdoses in the County (69%) followed by methamphetamine (54.4%), but their combination in contributing to overdoses was frequent. About half (52.5%) of fentanyl overdoses involved methamphetamine as a contributing factor and two-thirds (66.5%) of methamphetamine overdoses involved fentanyl as a contributing factor. Cocaine was also a contributing factor in 15.7% of fatal overdoses though fentanyl was also a factor in half (49.6%) these overdoses. Heroin (including its metabolite, morphine) did not appear to contribute substantially to fatal overdoses absent the presence of fentanyl (4%). Similarly, benzodiazepines contributed to less than 5% of fatal overdoses.

Occasionally, medication for opioid use disorder such as buprenorphine and methadone appear in medical examiner records as contributing factors to fatal overdoses but this is an extremely rare event when these medications are used as prescribed under the supervision of a medical professional. These incidents may occur as a result of concurrent drug use while engaged in treatment. During this period, there were 20 fatal overdoses with buprenorphine as a contributing factor, however, in each case, another drug or combination was a contributing factor; most frequently (10 of 20 or 50%) it was in combination with fentanyl and methamphetamine. Similarly, there were 72 fatal overdoses with methadone as a contributing factor but only 7 (9.7%) did not involve another substance as a contributing factor, most frequently fentanyl or methamphetamine or their combination.

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What is the availability and utilization of substance use disorder (SUD) treatment services?

This section will describe the types of treatment services available and utilized based upon available information. Note that limited information was available for this section of the landscape analysis. The description of services below is an incomplete representation of the availability or utilization of SUD treatment services in the County. Key takeaways are listed below:

- Limited information is available regarding psychosocial/counseling treatment.
- There was a small increase in the number of patients in the County that received buprenorphine treatment for at least 10 days (3,163 to 3,373 or 6.6%) between 2021-2023.
- There was a decrease in the number of distinct patients with methadone claims paid by Medicaid between 2021 and 2023 (3,013 to 2,318 or 23.1%) while the number of providers remained relatively stable.
- While there was an increase in the number of clients treated with buprenorphine at the CARE Campus in 2023, almost half (45%) were documented to have declined services, elected to discharge or there was no disposition annotated.
- The Metropolitan Detention Center has expanded the number of clients in its MAT program and offers both buprenorphine and methadone treatment.

Psychosocial/Counseling Treatment

CARE Campus (Bernalillo County)

The Department of Behavioral Health Services provides a variety of direct care programs to reduce the impact of alcoholism, alcohol use, drug dependence, drug use, and mental health conditions within the community. Programs provided include the Observation & Assessment unit, Detoxification from Alcohol and Substance Use, the Residential Supportive Aftercare Program, the Addiction Treatment Program (at MDC), the Mariposa

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Residential Program, and the Crisis Stabilization Unit. Descriptions of these services are described on the department's website.[20]

Table 5 below describes the clients served by CARE Campus during the two-year period, January 1, 2022 – December 31, 2023 provided by BernCo DBHS. A majority of clients that utilized the Detox and Observation and Assessment services, were male (70.1%, 73.1%), between the ages of 30-39 (37.2%, 35.2%), and identified as Hispanic (47.2%, 42.8%).[21] A substantial portion also identified as homeless (37.7%, 46.3%).

Table 5. CARE Campus Clients, January 1, 2022 – December 31, 2023

Program	Detox Program	Observation and	Supportive Aftercare	Crisis Stabilization
Unique Clients	2,897	2,822	102	265
Gender				
Male	2,032 (70.1%)	2,062 (73.1%)	66 (64.7%)	158 (59.6%)
Female	851(29.4%)	741 (26.3%)	34 (33.3%)	105 (39.6%)
Transgender	9 (0.3%)	16 (0.5%)	2 (2.0%)	2 (0.8%)
Unknown	5 (0.2%)	3 (0.1%)	0	0
Age (years)				
18 -19	36 (1.2%)	24 (0.8%)	0	5 (1.9%)
20 - 29	587 (20.3%)	510 (18.1%)	23 (22.5%)	63 (23.8%)
30 - 39	1,079 (37.2%)	994 (35.2%)	42 (41.2%)	69 (26.0%)
40 - 49	632 (21.8%)	655 (23.2%)	22 (21.6%)	50 (18.9%)
50 - 59	364 (12.6%)	428 (15.2%)	8 (7.8%)	47 (17.7%)

[20] https://www.bernco.gov/department-behavioral-health-services/

[21] Note that this is reported differently in this table. Example: Hispanic or Latino (39.2% of clients in Detox) or Hispanic (47.3% in Detox). This landscape analysis presents the higher proportion in this section but further clarification is warranted.

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60 or Older	194 (6.7%)	209 (7.4%)	7 (6.9%)	31 (11.7%)
Unknown	5 (0.2%)	2 (0.1%)	0	0
Race and Ethnicity				
African American	139 (4.8%)	156 (5.5%)	8 (7.9%)	18 (6.8%)
Asian/Pacific Islander	9 (0.3%)	11 (0.4%)	0	1 (0.4%)
Caucasian	772 (26.7%)	689 (24.4%)	32 (31.4%)	101 (38.1%)
Hispanic	1,371 (47.3%)*	1,209 (42.8%)	44 (43.1%)	90 (34.0%)
Native American	375 (12.9%)	515 (18.3%)	12 (11.8%)	28 (10.6%)
Other	52 (1.8%)	40 (1.4%)	3 (2.9%)	8 (3.0%)
Unknown	179 (6.2%)	202 (7.2%)	3 (2.9%)	19 (7.1%)
Hispanic or Latino	1,136 (39.2%)*	1,075 (38.1%)	45 (44.1%)	74 (27.9%)
Other characteristics				
Homeless	1,091 (37.7%)	1,307 (46.3%)	52 (51.0%)	154 (58.1%)
Veteran	113 (3.9%)	109 (3.9%)	5 (4.9%)	17 (6.4%)

Clients appeared to use CARE Campus services differently by diagnosis (see Table 6 below). Those using the Detox service did so most frequently for alcohol use (32.6%) followed by opioid use (22.3%) or Poly-Drug Use Disorder *[sic]*[22] whereas those using the Supportive Aftercare Community service did so primarily for alcohol use (45.1%) or opioid use (40.2). DBHS also shared information about known stimulant use and approximately a quarter of those using these services were known to use stimulants. Information was not available from DBHS about the particular clinical strategies that were delivered in

[22] Specific substances used was not indicated. Note that DSM-5 eliminated the diagnosis of poly-substance dependence

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these settings for stimulant use or opioid use, though medication treatment for opioid use disorder among clients is described in the section below.

Table 6. CARE Campus Clients by Diagnosis: January 1, 2022 – December 31, 2023

Primary Diagnosis	Detox	Supportive Aftercare Community Program	Crisis Stabilization Unit
Amphetamine Use Disorder	8 (0.3%)	--	--
Alcohol Use Disorder	944 (32.6%)	46 (45.1%)	49 (19.9%)
Cannabis Use Disorder	5 (0.2%)	--	3 (1.2%)
Cocaine/Crack Cocaine Use Disorder	25 (0.9%)	2 (1.96%)	2 (0.8%)
Methamphetamine Use Disorder	277 (9.5%)	1 (0.98%)	18 (7.3%)
Opioid Use Disorder	645 (22.3%)	41 (40.2%)	18 (7.3%)
Other Stimulant Use Disorder	22 (0.7%)	5 (4.9%)	--
Poly-Drug Use Disorder	688 (23.7%)	7(6.86%)	32 (13%)
Unknown	283 (9.8%)	--	113 (45.9%)
Other Stimulant Use Disorder	--	--	11 (4.5%)
Total	2,897	102	246
Stimulant Use Known			
Yes	774 (26.7%)	741 (26.3%)	43 (16.2%)

Following these intensive services, some clients continue to participate in outpatient levels of treatment. Records shared by DBHS indicate that there were 431 outpatient client visits in FY 2024 (July 2023-April 2024) and the majority of referrals come from Detox (37%), followed closely by The Living Room (34%). Medication management (61%) was the most frequent service provided, followed by counseling (22%).

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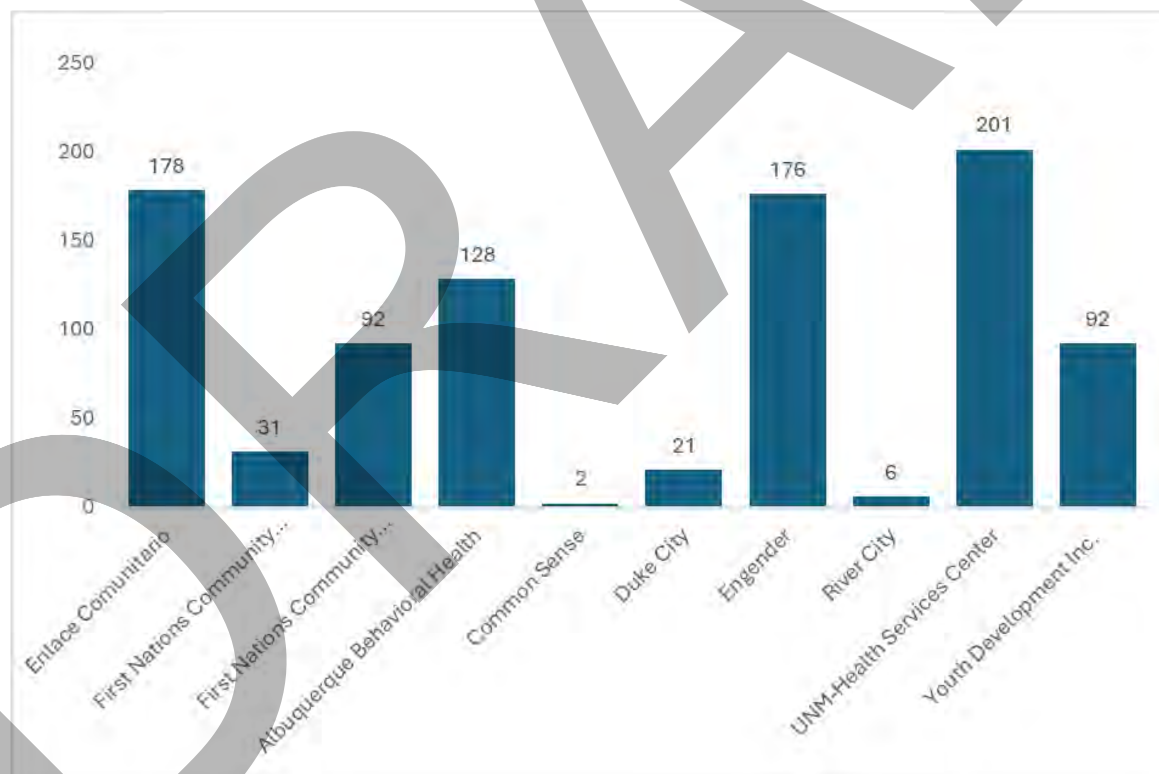
City of Albuquerque Department of Health, Housing and Homelessness

This city department also offers SUD treatment through its PATH (Providing Addiction Treatment and Healing) program, a voucher-based program that offers treatment support to those who are largely uninsured or underinsured. The program engages community agencies that serve people experiencing problems related to alcohol and substance use and expands their capacity to also address medical and social needs including behavioral health care and substance use treatment.[23] The city shared information about the program's partner organizations and the number of people it serves through the program during FY 23 – FY24 (first half). Information about specific services and other utilization information was unavailable. Figure 16 below describes the number of people served during this period by each partner organization and Figure 17 displays the locations of these providers.

Figure 16. Number of clients by partner organization: PATH Program, FY 23 – FY 24 (first half)



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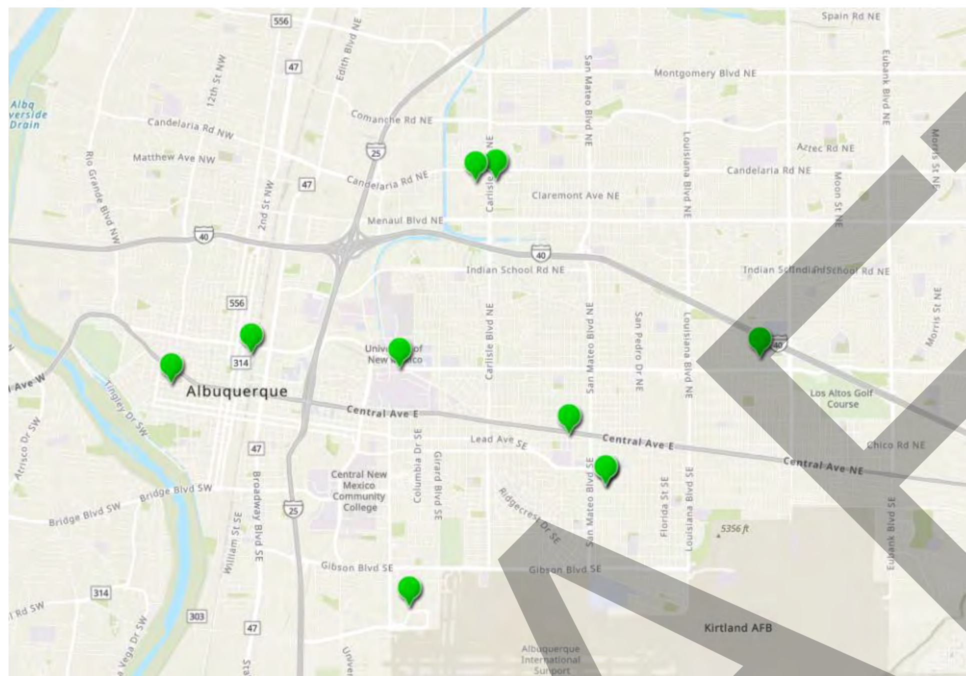
[23] https://www.cabq.gov/health-housing-homelessness/health/substance-abuse

Figure 17. Locations of PATH Program Provider Organization Partners



Treatment programs/resources through Native nations

Because four Native nations share geography with Bernalillo County, this landscape analysis acknowledges that there may be other resources that are utilized by people who live in or are members of these nations. A few resources that were identified through review and consultation include the following:

- The Pueblos and Native nation that share geography with Bernalillo County all have behavioral health and/or substance use disorder treatment programs, although information regarding the types of services and/or medication availability was not readily available for all four nations for this landscape analysis.
- Albuquerque Area Indian Health Board is a current SAMHSA Tribal Opioid Response grant recipient in collaboration with four of its Consortium Tribes.

Medications for Opioid Use Disorder (MOUD)

The activities performed for this landscape analysis assessed some key points of access where residents in the County may receive treatment using buprenorphine or methadone. These include conventional approaches such as a healthcare provider writing prescriptions for buprenorphine and patients filling these prescriptions at a pharmacy or

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methadone clinics that treat patients and dispense medications at the facility. However, this landscape analysis also attempted to assess other access points such as licensed SUD treatment, correctional health, emergency departments, prehospital treatment by EMS, and telemedicine options. This analysis was able to include some information about the access and utilization of these medications within the County.

Prescription Monitoring Program

The NMDOH Substance Use Epidemiology Section produced a NM Drug Overdose Prevention Quarterly Report that includes information related to the Prescription Monitoring Program, such as the prescribers, pharmacies and patients active in methadone and buprenorphine treatment.[24] Updated information for the tables included in that report including some county-specific information was provided by NMDOH Substance Use Epidemiology Section for this landscape analysis (see Table 7 below).

During the period 2021 Q4 – 2023 Q3 in Bernalillo County, there was an increase in buprenorphine-related measures. There was a small increase in the number of patients receiving buprenorphine treatment for at least 10 days (3,163 to 3,373 or 6.6%). There was also a doubling in the number of prescribers during this period among prescribers with less than 10 patients but a smaller increase among prescribers with 10 or more patients.

There was also a decrease in the number of distinct patients with methadone claims paid by Medicaid during this period (3,013 to 2,318 or 23.1%) while the number of providers remained relatively stable. There was no other information available that could be used to explain this decrease in utilization of methadone to treat opioid use disorder.

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[24]NM Drug Overdose Prevention Quarterly Measures Report (https://www.nmhealth.org/data/view/substance/2749/)

Table 7. Medication Assisted Treatment (Buprenorphine and Methadone) by Quarter, Bernalillo County: 2021 Q4 – 2023 Q3

Year and Quarter	2021 Q4	2022 Q1	2022 Q2	2022 Q3	2022 Q4	2023 Q1	2023 Q2	2023 Q3
Buprenorphine MAT prescribers with 10+ treatment patients	110	114	117	127	121	120	119	117
Buprenorphine MAT prescribers with 5 to 9 treatment patients	26	31	28	21	37	40	55	53
Buprenorphine MAT prescribers with 1 to 4 treatment patients	99	109	119	108	101	139	173	199
Buprenorphine MAT patients (>=10 days)	3,163	3,179	3,182	3,192	3,239	3,281	3,355	3,373
Buprenorphine MAT prescriptions filled	10,147	10,318	10,258	10,220	10,074	10,321	10,413	9,989
Medicaid Methadone Treatment								
Number of distinct individuals with methadone claims paid by NM Medicaid	3,013	2,925	2,868	2,901	2,855	2,503	2,833	2,318
Number of distinct NM Medicaid providers of methadone	9	10	9	9	9	9	9	9

City and County Substance Use Services (CARE Campus and PATH Program)

The CARE Campus 2023 annual report describes the utilization of buprenorphine among clients. It notes that there were a total of 443 clients treated with buprenorphine, an increase from 378 in 2022. It also included a chart describing discharge referrals, noting that many of the clients (45%) were documented to have declined services, elected to discharge or there was no disposition annotated. Of the 55% that did receive referral services, most were referred to Duke City Recovery Toolbox, Courageous Transformations and State of the Heart (see Figure 18 below).

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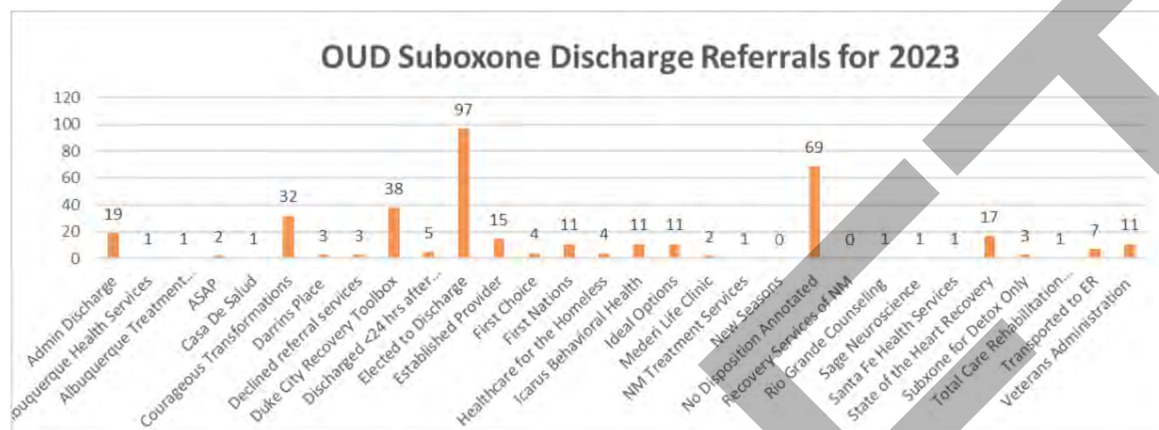
Figure 18. Discharge referrals among clients treated with buprenorphine, CARE Campus: 2023



Metropolitan Detention Center (MDC)

Metropolitan Detention Center (MDC) in partnership with the Bernalillo County Behavioral Health Initiative officially kicked off the Buprenorphine/Suboxone Medication Assisted Treatment (MAT) Program in 2021 including induction and maintenance. According to an annual report shared by the County, during the period December 15, 2022 to December 14, 2023, a total of 1,505 individuals were served by the program with 352 being new clients, averaging 29 new clients each month and providing maintenance treatment to approximately 150 clients each month. During this period, client demographics were as follows: 80% were male, 79% were between 25-44 years old, and 53% were Hispanic/Latino. By race, 30% were White, 8% were Black/African American, 7% were American Indian/Alaska Native and 54% were "Other" or information about race was not reported.[25] Figure 19 below describe the total and new clients served per month (as reported).

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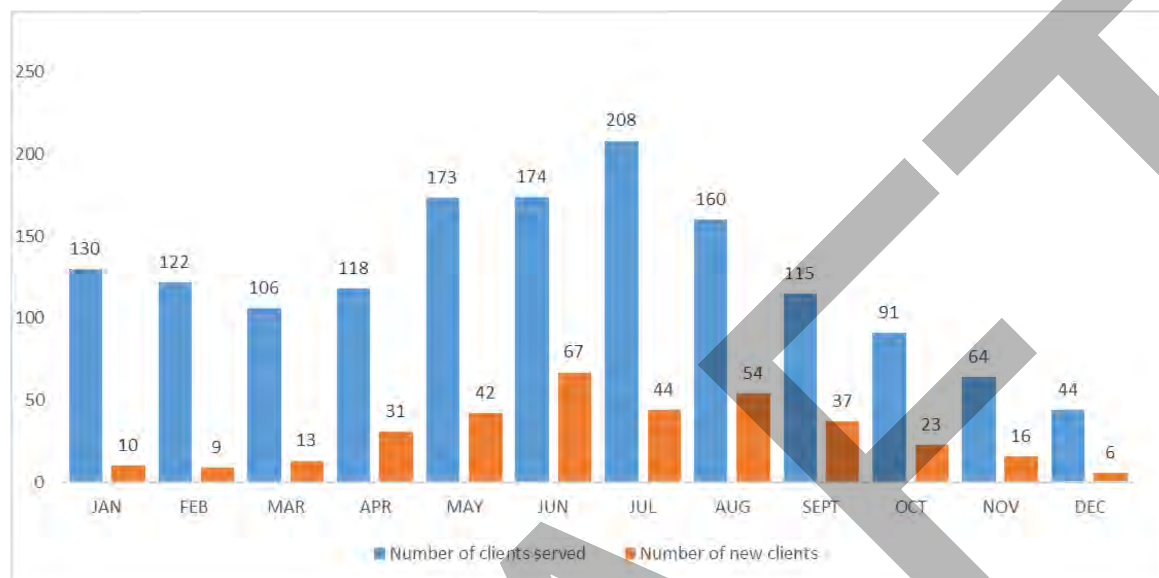
[25] Of 352 new clients, age, race, gender were reported for 285 or 81% of clients and ethnicity was reported for 312 or 89% of clients.

Figure 19. Total and New Clients Served per Month MDC: 12/15/22-12/14/23



Program components also suggest how participants may have avoided treatment disruption upon jail booking and continued treatment post-release. There were 101 program participants that were identified as receiving methadone or buprenorphine prior to jail booking. Additionally, there were 207 people who had a follow-up appointment scheduled at the time of release.

During the period January – July 2024, there has been growth in the number of patients receiving buprenorphine (see Figure 20 below). There were 551 patients who initiated buprenorphine treatment and 183 patients who received a bridge prescription upon release. While available reporting was limited for this landscape analysis, MDC also offers methadone treatment to individuals during incarceration.

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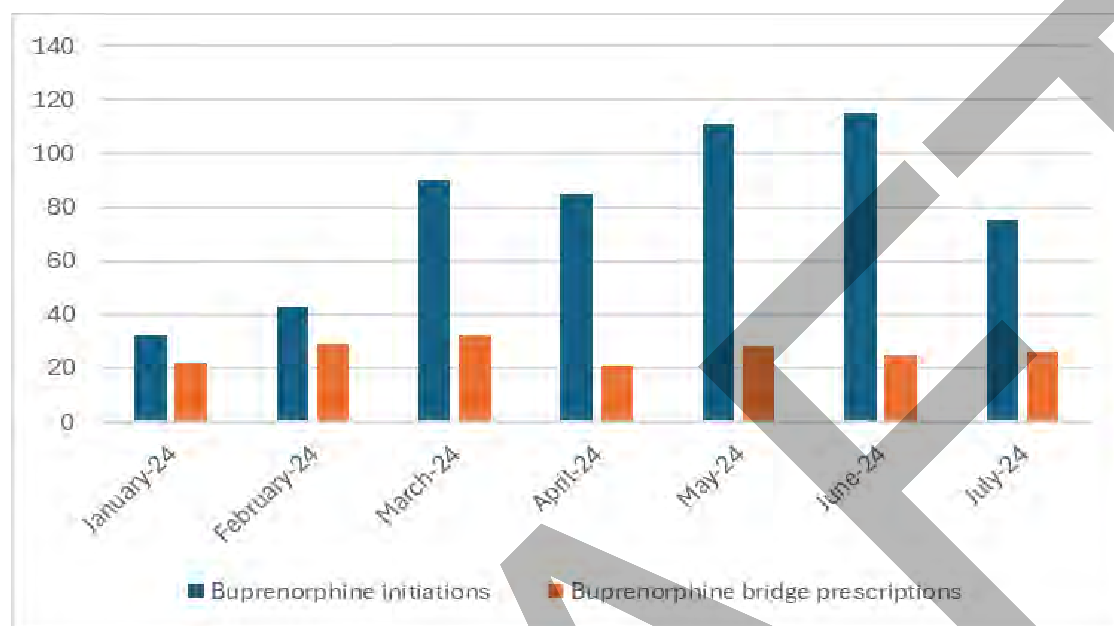
Figure 20. Buprenorphine initiations and bridge prescriptions: January – July 2024



Other sources

While it was beyond the scope of this landscape analysis to present an exhaustive list of access points for MOUD, another intervention worthy to include given its opportunity to target individuals vulnerable to overdose (who may have experienced a non-fatal overdose incident) includes pre-hospital buprenorphine delivered in the field by EMS. While reporting for the number of patients treated was not available, AFR EMS initiates buprenorphine treatment in the field to patients during an encounter where clinically warranted.

What is the availability and utilization of overdose prevention and harm reduction services?

This section will describe the types of treatment services available and utilized based upon available information. Key take-aways include:

- Average monthly naloxone distribution to vulnerable individuals increased 22% (753 to 920) between FY 2023 and FY 2024

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- AFR EMS has estimated it has distributed 700 naloxone kits as “leave-behind” kits following encounters with vulnerable individuals in the past 24 months (approximately one per day)
- Local partners contracted by NMDOH have expanded the number of client sessions and unique individuals where they perform their services throughout the County during the period July 2022 – March 2024, especially the International District, Downtown and North Valley
- Distribution of safer smoking/snorting kits increased substantially among all partner organizations operating in the county, and most more than doubled their prior year distribution.

Naloxone distribution

Naloxone is a medicine that rapidly reverses an opioid overdose. It is an opioid antagonist. This means that it attaches to opioid receptors and reverses and blocks the effects of other opioids. Naloxone can quickly restore normal breathing to a person if their breathing has slowed or stopped because of an opioid overdose.[26]

Naloxone can be universally distributed in a region through a variety of channels such as through community organizations and events and it can be targeted to reach those who are vulnerable to overdose, such as to people who actively use drugs or to someone following an overdose-related encounter with EMS or the emergency department.

New Mexico distributes naloxone in a variety of ways and Figure 20 below describes information from NMDOH that includes naloxone distribution throughout New Mexico (note that this is not specific to the County) from NMDOH programs, NM Department of Human Services and Behavioral Health Services Division and Medicaid prescription fills during the period 2021 Q4 – 2023 Q3.

[26] https://nida.nih.gov/publications/drugfacts/naloxone

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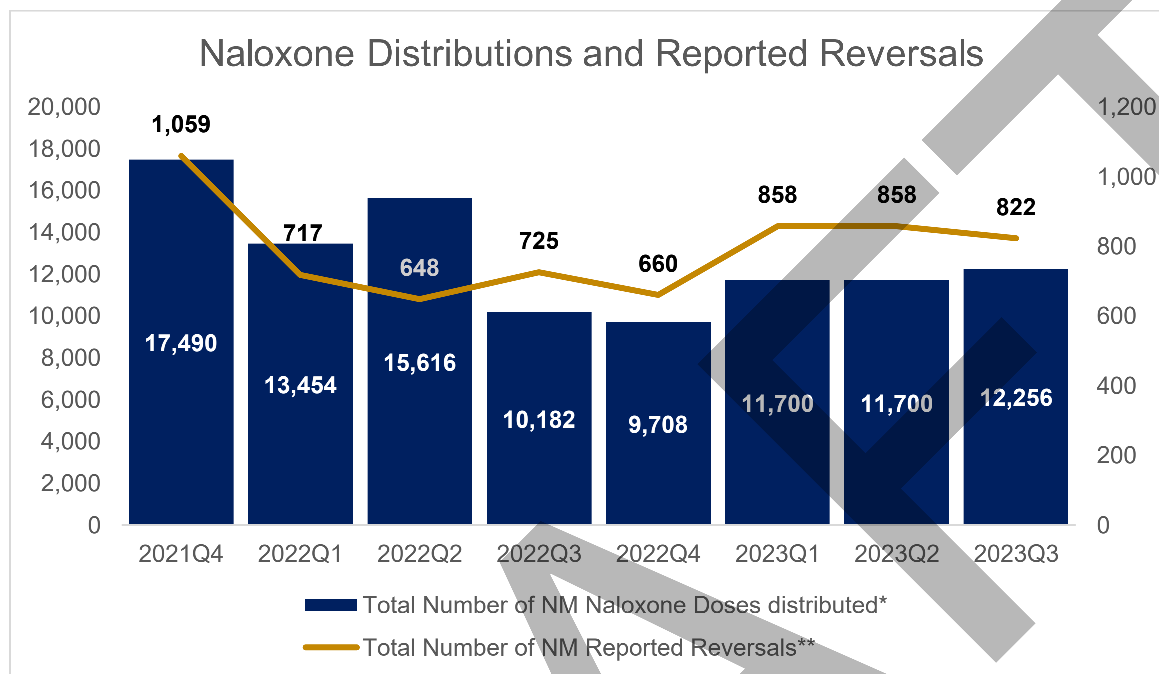
Figure 21. Naloxone distribution and reported reversals: New Mexico 2021 Q4 - 2023 Q3



While information in Figure 20 describes naloxone distribution statewide[27], it is possible to describe the targeted distribution of naloxone to vulnerable individuals in Bernalillo County using information from the Hepatitis and Harm Reduction Program within the Public Health Division of NMDOH. NMDOH operates several administrative offices around the state that oversee regional and statewide office operations. In Bernalillo County, the Hepatitis and Harm Reduction Program has contracted organizations to provide overdose reversal medication and education as well as other harm reduction services in the local areas of Downtown, International District, South Valley, North Valley, Midtown and others. Among these contracted organizations, average monthly naloxone distribution to vulnerable individuals increased 22% (753 to 920) between FY 2023 and FY 2024 (partial fiscal year: July 2022 - March 2024) and reported successful reversals remained stable (see Table 8 and Figure 21 below).

[27] Note that NMDOH includes a note for its naloxone reporting that reported reversals are not necessarily individual level data, as one person could have overdosed and been reversed more than once. Data on reversals are combined across several agencies and programs, and the definition of a reversal may vary.

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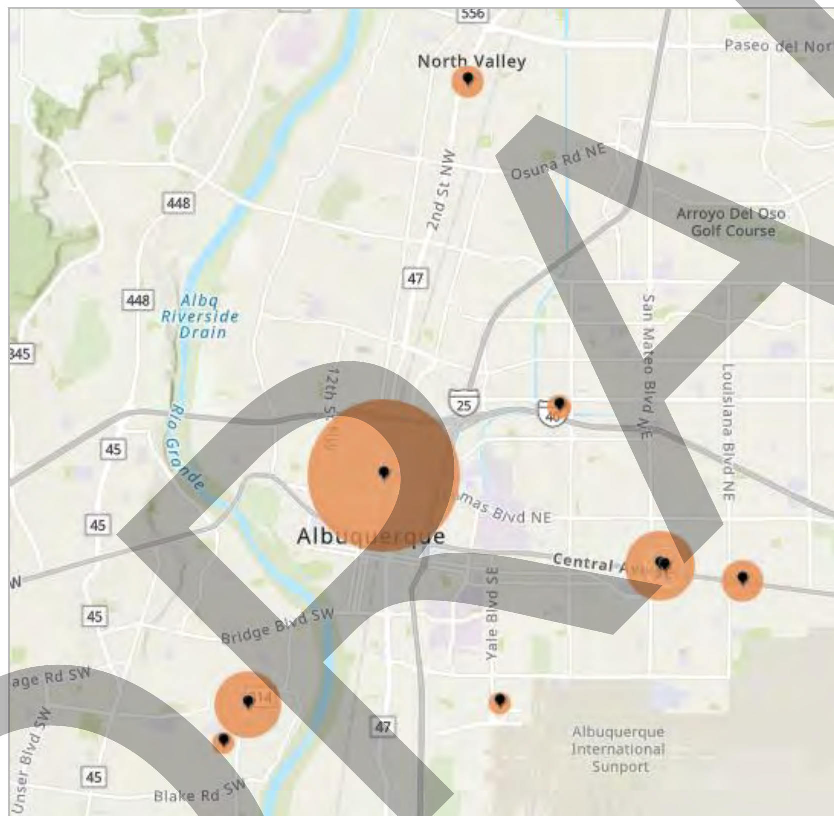
Table 8. Naloxone distribution by NMDOH Hepatitis and Harm Reduction Program Partners in Bernalillo County: FY 2023 – FY 2024

	FY2023		FY 2024 (current year – 10 months)	
	# Kits	Avg/Month	# Kits	Avg/Month
Naloxone Distributed	9,037	753	9,198	920
Successful Reversals	1,800	150	1,513	151.3

Figure 22. Naloxone distribution by Locations of Harm Reduction Program Partners FY 2023-FY 2024[28]



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[28] Note that this map represents locations of partner organization offices and, generally, where service occurs. NMDOH Hepatitis and Harm Reduction Program does not require partners to report service locations and reports that the map might be slightly skewed for one provider location north of downtown because its work is primarily conducted near Wyoming Blvd and Central Ave.

Table 9. Naloxone Distribution by Harm Reduction Program Partners FY 2023- FY 2024 (10 months)

Harm Reduction Provider	Localized Area	# of Kits Distributed FY 2023	# of Kits Distributed FY 2024	Total # of Kits Distributed
New Mexico Harm Reduction Collaborative (NMHRC)	International District	767	2,454	3,221
Transgender Resource Center of New Mexico (TGRCNM)	International District	440	628	1,068
Midtown Public Health Office (PHO)	Midtown	16	110	126
Casa De Salud	South Valley	1,696	1,316	3,012
First Nations Community Healthsource	International District	1,154	154	1,308
Albuquerque Healthcare for the Homeless (HCH)	Downtown	4,906	3,912	8,818
North Valley Public Health Office (PHO)	North Valley	58	624	682
SW Valley Public Health Office (PHO)	South Valley - West	0	0	0
University of New Mexico Addiction and Substance Abuse Program (UNM – ASAP)	UNM Campus	0	0	0

Other sources

While it was beyond the scope of this landscape analysis to present an exhaustive list of access points for naloxone, there were a few other interventions that are part of the landscape of naloxone distribution.

One additional strategy that targets naloxone distribution to individuals vulnerable to overdose (who may have experienced a non-fatal overdose incident) includes leave-behind naloxone kits from EMS. AFR EMS has estimated it has left-behind 700 naloxone

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kits following encounters with vulnerable individuals in the past 24 months (approximately one per day). Field crews are trained to leave behind naloxone regardless of whether the patient was transported following the encounter.

An additional resource for accessing naloxone is the NM HIV-Hepatitis-STD Online Resource Guide[29] that allows a user to locate a point of distribution for naloxone kits and other services. Information about the number of kits distributed by each site was not available for this landscape analysis.

Harm reduction services

Harm reduction is a set of practical strategies and ideas aimed at reducing negative consequences associated with drug use. Harm reduction is also a movement for social justice built on a belief in, and respect for, the rights of people who use drugs. In New Mexico, the Hepatitis and Harm Reduction Program within the Public Health Division of the Department of Health (NMDOH) reduces harm by providing prevention and intervention services as well as overdose reversal medication and education.[30]

Local partners contracted by NMDOH have expanded the number of unique clients and client sessions and unique individuals where they perform their services during the period FY 2023 and FY 2024, especially the International District, Downtown and North Valley (see Figure 22 and Table 10 below).

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[29] https://nmhivguide.org/

[30] https://www.nmlegis.gov/handouts/LHHS%20090221%20Item%208%20Harm%20Reduction.pdf

Figure 23. Unique Clients Served by Harm Reduction Organizations by Month: FY 2023 – FY 2024 (full)

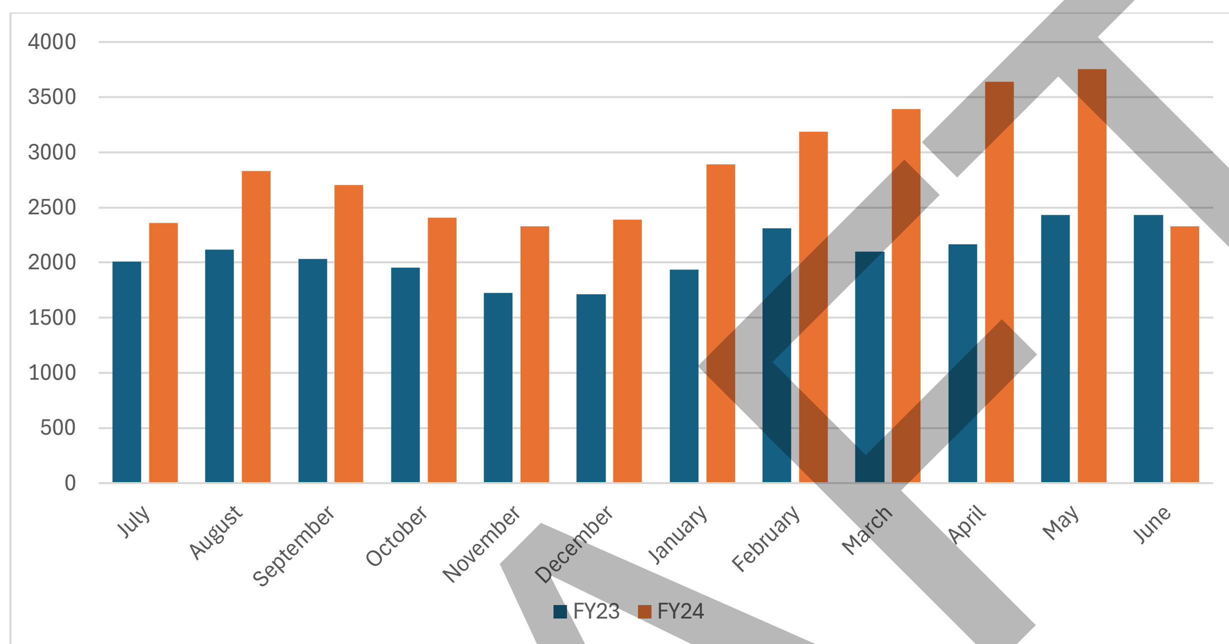

Table 10. Number of Client Sessions/Encounters: FY 2023 – FY 2024 (10 months)

		FY2023		FY2024 (10 months)		
HR Provider Org	**Service Area**	**# Client Sessions**	**Monthly Average**	**# Client Sessions**	**Monthly Average**	**% Change**
NMHRC	International District	1,596	133	3,379	338	154%
TGRCNM	International District	1,746	146	2,770	277	90%
Midtown PHO	Midtown	0	0	16	2	NA
Casa De Salud	South Valley	3,307	276	3,285	329	19%
First Nations CHS	International District	1,896	158	116	12	NA
Albuquerque HCH	Downtown	4,909	409	6,050	605	48%
North Valley PHO	North Valley	31	3	86	9	233%
SW Valley PHO	South Valley- West	0	0		0	NA
UNM - ASAP	UNM Campus	0	0		0	NA

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During this period, local partners contracted by NMDOH substantially expanded harm reduction services including the distribution of sterile syringes and safer smoking and snorting materials. Evidence-based harm reduction strategies minimize negative consequences of drug use.[31] These approaches can also help to establish rapport with vulnerable individuals who may be difficult-to-reach and serve as a source of referral to other services such as health care and basic needs. For example, during 10 months of service in the current program year, NMDOH partners have made 760 linkages to other services following client sessions in the International District and Downtown.

Sterile syringes were distributed in the County as described in Table 11 below, increasing most among providers operating in the International District and North Valley but decreasing overall. However, safer smoking/snorting kits distribution increased substantially among all providers operating in different areas within the county, and most more than doubled their prior year distribution (see Table 12 below). NMDOH reported that the increase in clients in FY 2024 may reflect the addition of needed services. For example, safer smoking kits were in high demand for clients who smoked or vaped fentanyl.[32] This is consistent with literature describing a shift in the route of opioid administration in the US and the increase in smoking, particularly in the western US.[33]

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[31] https://www.hhs.gov/overdose-prevention/harm-reduction

[32] Personal communication

[33] Karandinos.G,, Unick, J., Ondocsin, J., Holm, N., Mars, S., Montero, F., Rosenblum, D.and Ciccarone, D. (2024). Decrease in injection and rise in smoking and snorting of heroin and synthetic opioids, 2000-2021. Drug and Alcohol Dependence. *In Press.* https://doi.org/10.1016/j.drugalcdep.2024.111419

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Table 11. Sterile Syringe Distribution: FY 2023 – FY 2024 (10 months)

		FY2023		FY2024 (10 months)		
HR Provider Org	**Service Area**	**Syringes Distributed**	**Monthly Average**	**Syringes Distributed**	**Monthly Average**	**% Change**
NMHRC	International District	155,405	12,950	152,140	15,214	17%
TGRCNM	International District	163,142	13,595	202,184	20,218	49%
Midtown PHO	Midtown	0	0	2,600	260	NA
Casa De Salud	South Valley	425,185	35,432	324,895	32,490	-8%
First Nations CHS	International District	261,525	21,794	14,480	1,448	NA
Albuquerque HCH	Downtown	814,592	67,883	671,890	67,189	-1%
North Valley PHO	North Valley	8,050	671	9,110	911	36%
SW Valley PHO	South Valley- West	0	0	0	0	NA
UNM - ASAP	UNM Campus	0	0	0	0	NA

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Table 12. Safer Smoke/Snort Kits Distribution: FY 2023 – FY 2024 (10 months)

		FY2023		FY2024 (10 months)		
HR Provider Org	Service Area	Smoke/Snort Kits Distributed	Monthly Average	Smoke/Snort Kits Distributed	Monthly Average	% Change
NMHRC	International District	1,366	114	3,222	322	183%
TGRCNM	International District	408	34	2,528	253	644%
Midtown PHO	Midtown	0	0	1	0	NA
Casa De Salud	South Valley	701	58	1,914	191	228%
First Nations CHS	International District	368	31	47	5	NA
Albuquerque HCH	Downtown	1,184	99	5,342	534	441%
North Valley PHO	North Valley	4	0	80	8	2300%
SW Valley PHO	South Valley- West	0	0	0	0	NA
UNM - ASAP	UNM Campus	0	0	0	0	NA

Youth

This section provides an overview of drug use behaviors among high schoolers in Bernalillo County and prevention/care services currently offered by Albuquerque Public Schools. Key takeaways include:

- Current and lifetime heroin use by Bernalillo County high schoolers was low, while improper use of pain medications was higher
- Improper pain medication use (current and lifetime) was higher among females
- Albuquerque Public Schools offers counseling and PORT services for students who have SUD or have been impacted by familial SUD.

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The New Mexico Youth Risk and Resiliency Survey (NM-YRRS)[34] assesses health risk behaviors and resiliency (protective) factors of New Mexico high school and middle school students. The NM-YRRS is part of the national CDC Youth Risk Behavior Surveillance System (YRBSS). Data is collected from a selection of high schools and middle schools every other year. In 2021, 7.3% of high schoolers reported current (within the past 30 days) improper pain medication use and 0.9% reported current heroin use. For improper pain medication use, 10% of females and 4.5% of males reported current use. The opposite was seen among high schoolers reporting current heroin use, with 0.7% of females and 1.2% of males reporting current use.

[34] New Mexico Youth Risk and Resiliency Survey: High School Survey Results 2021, Bernalillo County. (2021). Epidemiology and Response Division, New Mexico Department of Health; School and Family Support Bureau, New Mexico Public Education Department; and University of New Mexico Prevention Research Center. Hrrps://youthrisk.org/publications/county-reports/2021-high-school-county-report-bernalillo/

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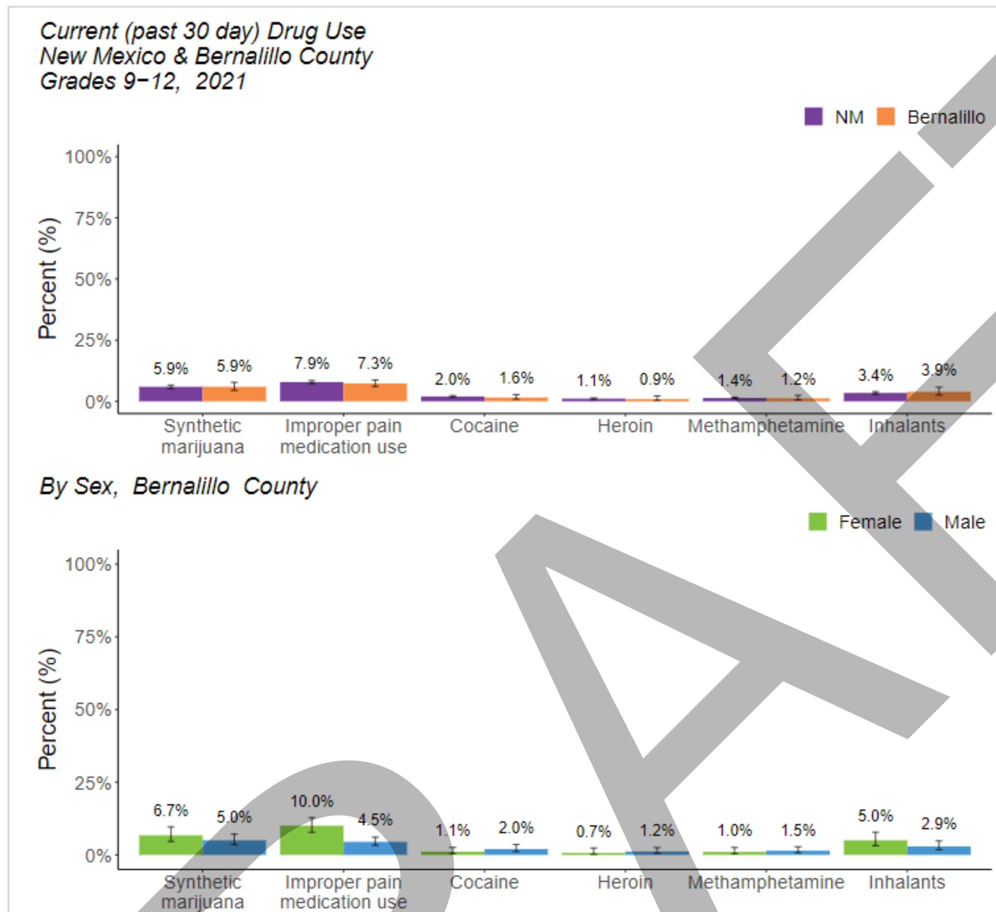
Figure 24. New Mexico and Bernalillo County Current Drug Use Among High School Students: 2021[29]



For lifetime drug use, 15.1% of Bernalillo County high schoolers surveyed reported using prescription pain medications without a prescription while only 0.9% had ever used heroin. Reported lifetime use of pain medications without a prescription was higher in females (18.9%) than males (10.7%) while reported lifetime use of heroin did not differ significantly between males and females.

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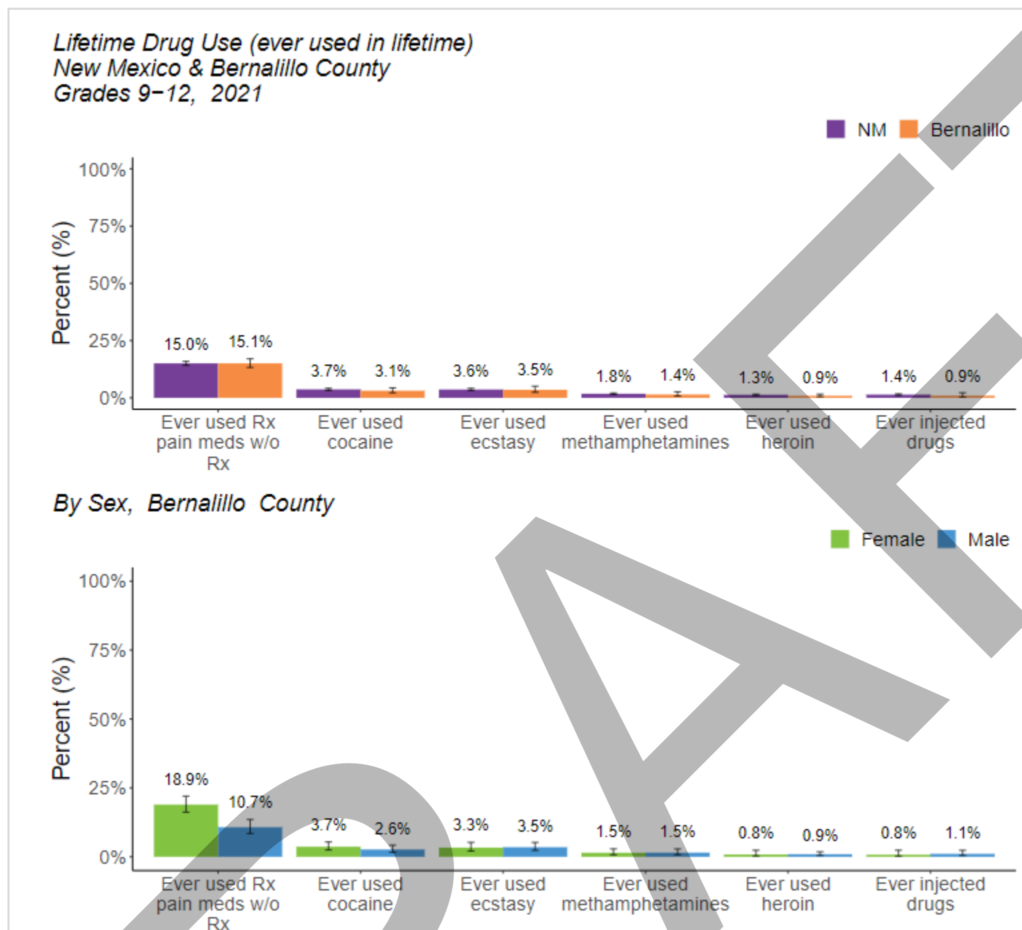
Figure 25. New Mexico and Bernalillo County Lifetime Drug Use Among High School Students: 2021[29]



Albuquerque Public Schools have several overdose prevention and post-overdose care services that are offered through school nursing and counseling staff. All comprehensive APS high schools have crossroads counselors who are solely focused on substance use. Additionally, there are two crossroads counselors that work across all of the APS middle schools. Students can be referred to crossroads counselors by parents, staff, or self-referral due to concerns with either their own substance use or familial substance use. Crossroads counselors use an intervention-based approach, including a parental involvement program instead of suspensions for drug infractions. In most cases, students have 4-6 visits with a crossroads counselor following referral or drug infraction. Nursing staff conduct one on one consultations with students for SUD as needed and are also responsible for providing naloxone training to school staff. Bernalillo County and the city of Albuquerque supply naloxone to APS. If an overdose occurs on campus APS has a

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post-overdose protocol which includes a PORT team to coordinate support for the student's return to school.

Limitations

While some context around the limitations of some analyses were footnoted above, there were several major limitations of this rapid landscape analysis that may be addressed if or when this process is replicated in the future.

Limited information about naloxone distribution

The NMDOH Substance Use Epidemiology Section's reporting on naloxone distribution is comprehensive and includes distribution through state government naloxone programs to local agencies and organizations as well as Medicaid claims but the available information was limited to the state. This limited the ability of this landscape analysis to include information about how much naloxone was distributed and where this was distributed by which types of local organizations and agencies except for those that were distributed by NMDOH Hepatitis and Harm Reduction Program partners as discussed in the section above.

Limited availability of treatment information

This landscape analysis was limited in its ability to present information about treatment for substance use disorders. Included in this analysis was information about treatment services purchased through the City and County, however this is likely to represent a smaller proportion of the total treatment service availability and utilization in the County.

As the single largest payer for behavioral health services in the U.S.,[35] a primary source for SUD treatment information would be the Medicaid Managed Care program in New Mexico, recently renamed Turquoise Care[36]. MCOs contract with local providers to deliver psychosocial treatments and medications. Information from claims or payments for these services can be extremely useful to understand the number of people in

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[35] https://www.macpac.gov/publication/behavioral-health-in-the-medicaid-program%E2%80%95people-use-and-expenditures/

[36] https://www.hca.nm.gov/turquoise-care/

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treatment for various SUDs, the extent to people received evidence-based interventions, the duration of treatment engagement and other patterns of treatment utilization that reduce overdose risk and/or promote recovery. There are frameworks, indicators and measures that have been developed by the Bloomberg Overdose Prevention Initiative partners[37] that may offer suggestions for future monitoring of OUD and SUD treatment in the County using claims information from MCOs but it was not possible to secure this information for this landscape analysis due to time constraints.

Additionally, given the prevalence of methamphetamine use in the County, the lack of availability of Medicaid claims or MCO quality assurance activities prevented the ability to understand the extent to which people diagnosed with Stimulant Use Disorder-Amphetamine-Type Substance were exposed to contingency management, recognized as the most effective intervention for reducing methamphetamine use.[38]

This landscape was also limited in its ability to describe the equity in accessibility of these treatment services. Information about the locations (residential or otherwise) of people who participated in treatment could be used to determine whether provider locations are near or accessible to residents in need but this information was not available. Similarly, given the recent recommendation from NMDOH that the Governor issue an executive order to ensure pharmacies can access sufficient quantities of buprenorphine,[39] information was not available to examine this challenge locally.

Beyond Medicaid, County and City funding for treatment services, there are other sources for treatment information including the Behavioral Health Initiative[40], Albuquerque

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[37] Some examples include a toolkit developed by RTI and Pew Charitable Trust (https://www.pewtrusts.org/-/media/assets/2022/11/14798_pew_metrics_toolkit_111722.pdf) and the OSPRI (Opioid Settlement Principles Resource and Indicators) tool (https://opioidprinciples.jhsph.edu/OSPRI/).

[38]Contingency Management for the Treatment of Substance Use Disorders: Enhancing Access, Quality, and Program Integrity for an Evidence-Based Intervention, US DHHS (2023). https://aspe.hhs.gov/sites/default/files/documents/72bda5309911c29cd1ba3202c9ee0e03/contingency-management-sub-treatment.pdf

[39] https://www.nmhealth.org/publication/view/meeting/8939/

[40] https://www.bernco.gov/county-manager/behavioral-health-initiative/about-the-behavioral-health-initiative/

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Area Indian Health Board, private commercial insurance, TriCare, and others that could be included in a future landscape analysis.

Limited geographic information about overdoses

While information that was generously shared was valuable to understanding where overdoses occur throughout the County, this information was available but at different geographical levels (some by City Council District, others by zip code and none by address or latitude/longitude) that made it challenging to analyze and highlight "hotspots" or specific areas where overdoses frequently occur. This kind of information could be used to plan for specific overdose prevention interventions or compare existing interventions (such as naloxone distribution) with the frequency of overdose incidents in a specific area. Similarly, information about specific locations of hospitals/emergency departments about visits related to overdose was not available.

Limited information about special populations

There were limitations in the ability to include information about some special populations such as youth and pregnant or parenting people. While some information about prevention and support programming for youth was available through APS, this was the sole source of information about substance use prevention included in this analysis. An inventory of evidence-based prevention programs[41] active in the County was intended but this landscape analysis was limited to available sources. Similarly, MCO claims or further exploration and partnership with local health providers was not available to examine the exposure of evidence-based prevention and treatment services for pregnant and parenting people.

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[41] Examples include Blueprints for Healthy Youth Development (https://www.blueprintsprograms.org/) and New York State Office of Addiction Services and Supports Evidence-based Prevention Programs (https://oasas.ny.gov/system/files/documents/2024/07/approved-evidence-based-prevention-programs.pdf)

Discussion and Opportunities

As mentioned in the introduction, this rapid landscape analysis was designed to inform decision-making regarding the investment of resources to reduce overdose risks and to stimulate dialogue about information needed to make informed decisions regarding opioid settlement funds and overdose prevention planning. It was not designed to exhaust all sources of relevant information. Rather, it should be considered as a starting point or as a foundation on which to build upon. This section will discuss opportunities to develop the capacity to conduct a landscape analysis in the future that are aligned with the New Mexico Opioid Allocation Agreement.[42]

These opportunities are consistent with the New Mexico Opioid Allocation Agreement under Exhibit E, Schedule B: Approved Uses,

> "*J. Leadership, Planning and Coordination: Support efforts to provide leadership, planning, coordination, facilitations, training and technical assistance to abate the opioid epidemic through activities, programs, or strategies that may include....2(d) to track, share or visualize key opioid or health-related indicators and supports as identified through collaborative statewide, regional, local or community processes*";

and Schedule A: Core Strategies, *"I. Evidence-based data collection and resource analyzing the effectiveness of the abatement strategies within the state."*

Intergovernmental agency coordination

There is an opportunity to improve coordination between City, County, and State agencies to better understand overdose risks, plan for overdose prevention response, and monitor the interventions aimed to reduce those risks. This landscape analysis attempted to examine the different systems that people who are vulnerable to overdose encounter within the City and County. People encounter City and County EMS agencies, local hospitals, treatment and harm reduction providers, pharmacies, Albuquerque

[42] https://nationalopioidsettlement.com/wp-content/uploads/2022/03/2022.03.15-NEW-MEXICO-OPIOID-ALLOCATION-AGREEMENT.pdf

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Community Safety responders, MDC, and others. The process was challenging because there was no centralized source of information relevant to overdose prevention. Rather, information about treatment had to be gathered through the City (Albuquerque Health, Housing and Homelessness), County (Department of Behavioral Health Services) and, though this information was not available to Vital Strategies, Medicaid Managed Care is managed by the state. Some information about harm reduction services and naloxone distribution within the City and County was available but this is managed through different departments at NMDOH but not locally.

Improved coordination between various levels of government could be helpful to establish a local database of information relevant to overdose prevention planning. This resource could be updated on an ongoing basis for future planning as well as monitoring and evaluating whether the landscape changes in the future as a result of local interventions or for other reasons.

Data and analytics resource

There is an opportunity in Bernalillo County to create an analytics resource. There is currently no local resource that is tasked with the responsibility to coordinate the various sources of data and information that were included in this landscape analysis and others and then assemble these resources into actionable intelligence that can be used for overdose prevention planning. The process in preparing this rapid landscape analysis required consulting with key individuals at various city, state and county agencies and community organizations to assess for available information and then requesting data when it was available. Vital Strategies executed this process as an independent organization. Each city, county, or state agency that was consulted for information relevant to a landscape analysis was responsive to such a request and shared available information. The willingness among agencies at various levels of government to collaborate with Vital Strategies and offer their information is an asset to the City and County. To leverage this asset, creating a dedicated resource to perform this function in a centralized way is necessary in order to prepare analyses that will inform overdose prevention planning in the future.

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For example, such a resource will benefit from a new resource being developed by OMI. As mentioned previously, information from medical examiners is foundational to inform prevention and response efforts and can provide an understanding the locations of fatal overdose incidents, the specific substances that contributed to them, characteristics of the individuals who had died as well as characteristics and circumstances surrounding the incidents. While OMI generously shared with Vital Strategies recent information about fatal overdoses for this landscape analysis which was analyzed and summarized for the reader, many counties may not have the staffing capacity to perform this analysis. With funding from Bloomberg Philanthropies and support from the CDC Foundation, the OMI IT team is working to create an interactive, public-facing data dashboard allowing interested people to query OMI's data for research or prevention initiatives rather than waiting for a staff member to pull the data for them. The initial version of this dashboard, planned for implementation in fall of 2025, will provide basic demographics by cause and manner of death, categorized by county and year. Additional features will be added over time, including breakouts of drug-caused deaths, deaths of people experiencing homelessness, examination type, and maps with totals by county of pronouncement of death. The aim is to provide more timely access to OMI's medicolegal death investigation data than the current annual reports, which are available online dating back to 2000 at https://hsc.unm.edu/omi/reports/. This will be another asset for future overdose prevention response planning in Bernalillo County.

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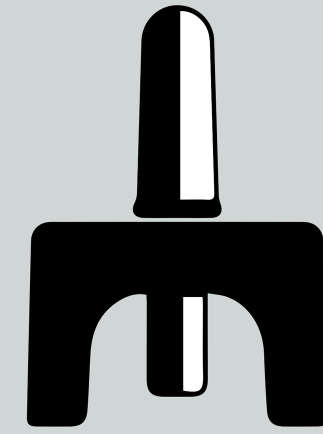
KEY

DAC	Doña Ana County
NMDOH	New Mexico Department of Health
MMC	Memorial Medical Center
BHSD	Behavioral Health Services Division
NM HIDTA	New Mexico High Intensity Drug Tracking Agency
CARA	Comprehensive Addiction & Recovery Act
CYFD	Children Youth & Families Department
CHI	Center for Health Innovation
HHS	Health & Human Services
LCDF	La Clinica de Familia
NMSU	New Mexico State University

CORE STRATEGIES

NALOXONE & OTHER FDA APPROVED DRUG TO REVERSE OPIOID OVERDOSE

1. DAC Health & Human Services
2. Amador Health Center
3. Up Coalition
4. BHSD
5. NMDOH
6. Light team-LC Fire



MAT DISTRIBUTION & TREATMENT

1. NMDOH
2. DAC Detention Center provided by Yes Care
3. Elite Methadone Clinic
4. Ideal Option
5. ALT Recovery
6. Peak Behavioral
7. Amador
8. MMC Bridge Program/Family Medicine
9. Health Council
10. Alianza
11. Full Circle Health Center
12. Agape Pain Management
13. Desert Sky Counseling
14. Healthcare Solutions
15. NM Family Services LLC
16. La Ventana Behavioral Health
17. Major Consult Clinic
18. Desert Poppy

PREGNANT & POSTPARTUM WOMEN

1. MMC Bridge Program Short-term (No Postpartum)
2. MMC Family Medicine
3. DAC Detention Center through methadone providers such as;
   a. ALT Recovery
   b. Elite Methadone Clinic
4. Alianza

EXPANDING SYRINGE SERVICE PROGRAMS

1. NMDOH
2. Amador
3. Alianza

EVIDENCE BASED DATA COLLECTION & RESEARCH

1. NMDOH
2. NM HIDTA
3. DAC and Las Cruces
4. BHSD
5. CARA/CYFD
6. NMSU

EXPANDING TREATMENT FOR NEONATAL ABSTINENCE SYNDROME

PREVENTION PROGRAMS

1. Up Coalition/CHI
2. NMDOH
3. BHSD
4. DAC Health & Human Services

TREATMENT FOR INCARCERATED POPULATIONS

1. DAC Detention Center- Yes Care Program
2. Elite
3. ALT Recovery

EXPANSION OF WARM HAND OFF PROGRAMS & RECOVERY SERVICES

1. Angels Network
2. Choice Recovery
3. Zia Recovery
4. Recovery Houses
   a. Oxford House
   b. Casa de Alma
   c. Casa de Lucerito
5. Community of Hope
6. FYI+
7. Ideal option
8. 4 directions
9. NMDOH
10. LIGHT Team-LC Fire
11. Cross Town
12. HHS Rise Program

The City of Las Cruces & Doña Ana County Opioid Settlement Fund Needs Assessment

Report prepared by:
Crimson Research
August 5, 2024

Executive Summary

The Opioid Settlement funds awarded to Doña Ana County (DAC) and the City of Las Cruces present an opportunity to invest in addressing opioid and substance use in DAC communities. The establishment of an Opioid Settlement Advisory Council, which has contracted NMSU's Crimson Research to provide a needs assessment, is a crucial step towards guiding the investment of these funds into evidence-based prevention, solutions, and abatement efforts. This executive summary will focus on the current existing results from the primary local data collection efforts in the community (i.e., survey and focus groups) and the resulting recommendations. A comprehensive final report is forthcoming August 30, 2024.

Background

Doña Ana County and the City of Las Cruces are the second most populated county and city in New Mexico. DAC and the City of Las Cruces' racial/ethnic groups are Hispanic (68.9% and 61.7%), followed by White (26.2% and 31.4%), Black (2.7% and 2.8%), Asian (1.8%), American Indian/Alaskan Native (1.6%), and Native Hawaiian/Pacific Islander (.3%). Compared to NM state and the nation, DAC and Las Cruces have a higher percentage of Hispanics (48.6% and 19.5%, respectively) and a lower percentage of Whites (80.7% and 75.3%, respectively). Las Cruces, DAC, and NM (2.8%) have a lower percentage of Blacks than the nation (13.7%).

The median household income for both DAC ($51,967) and the City of Las Cruces ($50,372) is below the NM and US rates ($59,726 and $74,755, respectively). DAC's (24.5%) and Las Cruces's (23.1%) poverty level rates are considerably higher than the state rate (17.6%) and nearly double the US poverty rate (12.6%). Lastly, the percentage of DAC (10.1%) and Las Cruces (10.8%) residents without healthcare coverage is higher than the state and US rates (8.2% and 8.0%, respectively; US Census Bureau, 2022).

These socioeconomic factors can significantly impact both the likelihood of substance use and the effectiveness of treatment. For example, these factors impact access to care, financial/treatment cost barriers, barriers to long-term treatment (e.g., ongoing care), continuity of care, access to supportive networks, living conditions, and stress. These factors can complicate substance use issues, treatment, and recovery outcomes. Addressing these socioeconomic factors, beyond the substance use itself, can improve treatment outcomes approaches.

DAC and NM Opioid Use

To understand the pattern of opioid and substance misuse in DAC, it's important to examine the opioid crisis locally and statewide. This includes examining available overdose deaths, emergency department (ED) use, and estimates of prevalence. This report provides both raw numbers (conveys the impact of use) and population rates (allows comparison across different populations). By considering both metrics, the council will be more informed in their decisions on how to best and most effectively invest settlement funds. The majority of existing data is at the

national and state level. When available, DAC data is presented as well. Data for the City of Las Cruces was not available or did not exist.

Overdose Deaths. Overdose (OD) death numbers and rates indicate the impact and severity of drug misuse and provide a metric to examine intervention effectiveness. NM's drug OD death rate has been among the highest in the US for the last two decades. According to research of DAC and NM's drug overdose data:

- In 2022, NM's overdose death rate (50.3, *n* = 1,024) was higher than the US rate (32.6, *n* = 107,941), & was the eighth highest in the US (National Center for Health Statistics, 2022).
- From 2017 – 2021, DAC ranked 28th among NM counties in OD death rates (20.8 per 100,000 vs. the state death rate of 34.4). Counties with the highest rates were Rio Arriba (95.4, *n* = 169), Sierra (69.2, *n* = 30), and Socorro (51.4, *n* = 38).
- DAC had the third-highest number of OD deaths (*n* = 202) among NM counties, which accounted for 5.8% of statewide deaths, behind Bernalillo (*n* = 1,430, 41.3%) and Santa Fe (*n* = 269, 7.8%) counties (New Mexico Department of Health, 2024).

Drugs Involved in Overdose Deaths (OD). From 2017 through 2021, unintentional drug OD accounted for more than 90% of NM drug OD deaths. Specifically, illicit drugs caused 85% of unintentional drug OD deaths, followed by prescription drugs (34%), or a combination of both (20%). In 2021, fentanyl and its analogs were the primary substance involved in NM drug OD deaths, followed by methamphetamine, heroin, and non-fentanyl prescription opioids. NM fentanyl-related OD death rates increased more than ten times from 2010 (2.8) to 2021 (29.2). In 2021, fentanyl was involved in more than one-third of NM drug OD deaths. These categories are not mutually exclusive as OD often involves more than one substance. In NM from 2017 - 2021, 66.1% of OD deaths involved more than one substance New Mexico Department of Health, 2024 (NMDOH, 2024).

- In DAC, from 2021 to 2023, the substances involved in overdose deaths included Fentanyl (46%), methamphetamine (22%), alcohol (8%), cocaine (6%), and other (12%).
- From 2017 to 2021, DAC ranked 23rd among NM counties in fentanyl-related OD death rates (5.9) and was below the statewide rate (11.7, *n* = 1,145). Counties with the highest rates were Rio Arriba (28.1, *n* = 49), Sierra (17.4, *n* = 7), Bernalillo (17.3, *n* = 577), Santa Fe (17.2, *n* = 107), and Socorro (17.0, *n* = 12).
- From 2017 to 2021, DAC had the third-highest number of fentanyl-involved OD deaths (*n* = 59) accounting for 5.2% of statewide fentanyl-involved OD deaths, behind Bernalillo (*n* = 577, 50.4%) and Santa Fe (*n* = 107, 9.3%; NMDOH, 2024).
- NMDOH (2024) 2017 – 2021 Sex & Race/Ethnicity OD death rates and numbers
    - NM males had a higher unintentional drug OD death rate than females (43.6 vs. 19.3)
    - NM Black males had the highest total OD death rate (58.6)
    - NM fentanyl-involved overdose death rates were highest among Blacks (14.8) followed by Hispanics (13.9), Whites (9.3), American Indians (8.1), and

    - Asian/Pacific Islanders (3.4). NM Black males (20.0) and Hispanic males (19.4) had the highest fentanyl-involved OD death rates
    - The 25 – 64 age group among both NM males and females was at highest risk

- The NMDOH's (2024) 2017 – 2021 data for DAC showed:
    - DAC males (25.3) had twice the rate of unintentional drug OD death rate than females (10.5) and a higher rate of fentanyl OD death rates (9.1 and 2.8, respectively).
    - DAC Hispanics (*n* = 124) had the highest number of drug OD deaths followed by Whites (*n* = 72)
    - The highest OD death rates were among Whites (28.1), followed by Hispanics (18.7), Blacks (12.8), Asian/Pacific Islanders (10.2), and American Indians (9.5)

Thus, while, DAC's OD and fentanyl-related OD death rates do not rank high among NM counties and are below the statewide rates, DAC has the third highest OD and fentanyl OD number of deaths. Just under half of DAC OD deaths involve fentanyl (NMDOH, 2024).

Emergency Department Use. In NM, from 2019 to 2021, rates of opioid OD-related ED visits increased considerably from 60.0 to 74.7 (New Mexico Department of Health, 2024). DAC's opioid OD-related ED visits rate was 25.2 (*n* = 265), below the state rate of 61.7 (*n* = 6,578) and ranked twenty-second among NM counties. The number of DAC opioid overdose-related ED visits (*n* = 265) was the sixth highest among NM counties, accounting for 4% of the statewide number of opioid overdose-related ED visits (NMDOH, 2024).

Estimated Prevalence of Substance Use. The 2022 National Survey on Drug Use and Health (NSDUH) provides data estimates of the prevalence of substance use, substance use disorders, and treatment nationally and by state. Among adults, NM ranks first for illicit drug use in the past month, second for drug use disorder in the past year, and third for substance use disorder in the past year among US state estimates and is significantly higher than US estimates (see Table 1; Substance Abuse and Mental Health Services Administration, 2023).

Table 1. Adults 18+ Substance Use Disorders and Use 2022 Estimates

2022 National Survey on Drug Use and Health (NSDUH) Disorder or Use in the Past Year or Month Among Adults 18 or older Annual average percentages and average numbers (in thousands)	NM estimates	US estimates	NM Ranking Among US States (highest to lowest)
Substance Use Disorder in the past year	23.55% (*n* = 380)*	17.82%	3rd
Drug Use Disorder in past year	13.93% (*n* = 225)*	9.41%	2nd
Opioid Use Disorder in past year	2.47% (*n* = 40)	2.19%	12th
Alcohol Use Disorder in the past year	12.24% (*n* = 198)	11.28%	17th
Pain Reliever Use Disorder in the past year	2.68% (*n* = 43)	1.97%	7th
Marijuana use in past year	27.63% (*n* = 446)*	21.43%	9th
Methamphetamine use in the past year	1.72% (*n* = 28)	1.04%	6th
Opioid misuse in the past year	4.05% (*n* = 65)	3.41%	11th
Prescription pain reliever misuse in the past year	3.87% (*n* = 62)	3.21%	10th
Alcohol use in the past month	49.62% (*n* = 801)	52.21%	38th
Illicit drug use in past month	24.59% (*n* = 397)*	16.33%	1st

* significant difference, p =.000; estimates are age-adjusted per 100,000

Among youth aged 12 to 17, NM ranks first among US states for substance use disorder in the past year, drug use disorder in the past year, marijuana use in the past year, and illicit drug use in the past month. NM estimated percentages were significantly higher than the US estimates for substance use disorders, drug use disorders, marijuana use in the past year, and illicit drug use in the past month. NM's estimated opioid use disorder percentage tied with Louisiana for the highest; however, estimated sample sizes were small, and there were no significant differences from other states (see Table 2; SAMHSA, 2023).

Table 2. Youth 12 – 17 Substance Use Disorders and Use 2022 Estimates

2022 National Survey on Drug Use and Health (NSDUH) Disorder or Use in the Past Year or Month Among Youth 12 - 17 Annual average percentages and average numbers (in thousands)	NM estimates	US estimates	NM Ranking Among US States (highest to lowest)
Substance Use Disorder in the past year	16.01% (*n* = 27)*	8.95%	1st
Drug Use Disorder in past year	13.19% (*n* = 23)*	7.17%	1st
Opioid Use Disorder in past year	1.3% (*n* = 2)	1.04%	-
Alcohol Use Disorder in the past year	4.57% (*n* = 8)	3.32%	3rd
Pain Reliever Use Disorder in the past year	1.3% (*n* = 2)	1.04%	2nd
Marijuana use in the past year	19.24% (*n* = 33)*	11.19%	1st
Methamphetamine use in the past year	0.11% (*n* = 0)	0.10%	12th
Opioid misuse in the past year	2.06% (*n* = 4)	1.85%	7th
Prescription pain reliever misuse in the past year	2.06% (*n* = 4)	1.85%	8th
Alcohol use in the past month	7.27% (*n* = 12)	7.03%	23rd
Illicit drug use in past month	13.7% (*n* = 24)*	7.44%	1st

* significant difference, p =.000; estimates are age-adjusted per 100,000

Thus, NM's estimated percentages for adults' illicit drug use in the past month, drug use disorder in the past year, and SUD in the past year were high among US states and were statistically significantly higher than US estimated percentages. Among youth (12 – 17), NM's estimated percentages for SUD in the past year, drug use disorder in the past year, marijuana use in the past year, and illicit drug use in the past month were among the

highest in the US and were significantly higher than US estimated percentages (SAMHSA, 2023).

Substance Use Treatment

Seeking Treatment. According to the 2022 NSDUH survey results and population estimates, among US individuals classified as needing substance use treatment in the past year, about 1 in 4 (24%, 13.1 million) received treatment within the year.

- Among those aged 18 or older (39.7 million) who had a SUD in the past year (classified as needing treatment) and did not receive substance use treatment, 94.7% did not seek treatment or did not think they should get treatment, .8% sought treatment, and 4.5% did not seek treatment but thought they should get it.
- Among those aged 12 to 17 who had an SUD in the past year (classified as needing treatment) and did not receive substance use treatment, 97.5% did not seek treatment or did not think they should get it, .5% sought treatment, and 2.0% did not seek treatment but thought they should get it (SAMHSA, 2023).

2022 NSDUH results and estimates for NM (see Table 3; SAMHSA, 2023):

- Among those aged 18 and older, 5.98% (*n* = 97) received substance use treatment in the past year.
    - 22.5% (*n* = 365) were classified as needing substance use treatment; of those, 74.15% (*n* = 278) did not receive treatment.
- Among those aged 12 to 17, 8.63% (*n* = 15) received substance use treatment in the past year
    - 16.27% (*n* = 28) were classified as needing substance use treatment. No estimates were available for whether they received treatment.
- NM's percentage of adults 18 or older classified as needing substance use treatment but did not receive treatment was slightly lower than the national percentage (74.15% vs. 76.9%). There was no comparable data for the 12 to 17-year-old youth group.
- NM's percentage of adults 18 and older classified as needing treatment was higher than the US (22.5% vs. 20.14%, not significant)
- NM's percentage of youth aged 12 to 17 classified as needing treatment was significantly higher than the US estimate (16.27% vs.11.5%).

Table 3. Estimated Treatment Percentages and Numbers

2022 National Survey on Drug Use and Health (NSDUH) Estimated Treatment percentages and numbers (in thousands)		
Adults 18 or older	**NM**	**U.S.**
Received Substance Use Treatment in the Past Year	5.98% (*n* = 97)	4.65%
Classified as Needing Substance Use Treatment in the Past Year	22.50% (*n* = 365)	20.14%
Classified as Needing Substance Use Treatment & Didn't Receive Substance Use Treatment	74.15% (*n* = 278)	76.90%
Youth 12 - 17		
Received Substance Use Treatment in the Past Year	8.63% (*n* = 15)**	4.60%
Classified as Needing Substance Use Treatment in the Past Year	16.27% (*n* = 28)*	11.50%
Classified as Needing Substance Use Treatment & Didn't Receive Substance Use Treatment	not reported	59.98%

*significant difference, p<.05; ** significant difference, p =.001

Thus, nearly a quarter of US and a quarter of NM adults needing substance use treatment did not receive treatment within the year. In NM, 5.98% of adults and 8.63% of youth received substance use treatment in the past year. For both NM adults and youth, the percentage classified as needing substance use treatment was higher than the percentage that received substance use treatment. Finally, the percentage of NM youth (12 – 17) classified as needing treatment was significantly higher than the US estimated percentage (SAMHSA, 2023).

Reasons for Not Seeking Treatment. The 2022 NSDUH assessed barriers to getting treatment among people 18 and older. Primary reasons for not seeking treatment included thinking they should have been able to handle their drug use on their own (78.2%), not being ready to start treatment (61.3%), not being ready to stop or cut back on using alcohol/drugs (52.9%), didn't know how or where to get treatment (52.2%), thinking that treatment would cost too much (47.9%), being worried about what people would think or say if they got treatment (46.1%), not having enough time for treatment (42.4%), and not having health insurance coverage for treatment (41.9%). Due to low data precision, no estimates were provided for youth aged 12 to 17 (SAMHSA, 2023).

Thus, primary reasons for not seeking treatment reflected personal perceptions of not needing treatment (e.g., can handle it and not being ready), a lack of knowledge of where to get treatment, the cost of treatment, and the stigma associated with treatment.

NM Naloxone Usage/Distribution. NMDOH data suggests that knowledge of where to get naloxone and its critical role in overdose reversal is lacking in the community. Additionally, NM social services fieldwork suggests stigma may prevent high-risk individuals from taking advantage of existing naloxone distribution programs. It is critical to ensure that those using substances and those individuals in contact with the individual know where to acquire naloxone. According to multiple NM data sources (i.e., NMDOH Harm Reduction Program, NM HSD Medicaid Program, NM HSD Office of Substance Abuse Prevention, and Prescription Drug/Opioid Overdose Program) the number of naloxone doses DAC distributed in 2022, accounted for 8.1% (2,884) of the total doses distributed in NM (35,805). The number of DAC naloxone reversals in 2022 was 2.6% (77) of the state's number of reversals (2,986).

Thus, according to multiple NM data sources, in NM and DAC, barriers to the use of naloxone include a lack of knowledge about naloxone, a lack of knowledge of where to get naloxone, and the perceived stigma associated with using naloxone distribution programs.

Summary

In summary, to provide an overview of the opioid crisis locally and in NM, this executive summary included research data on overdose deaths, ED visits, and substance use prevalence estimates. The forthcoming final assessment report will contain detailed secondary data for NM and DAC.

While NM OD death rates have been among the highest in the US, DAC's OD and fentanyl-related death rates do not rank high among NM counties and are below the NM rate. Regarding OD death numbers, DAC's OD and fentanyl-related OD death numbers are the third highest in the state (NMDOH, 2024).

Regarding ED visits, the rate of NM's opioid OD-related ED visits has increased. DAC's rate of opioid OD-related ED visits was below the state's rate and was not among the highest among NM counties (DAC was 22nd). DAC had the sixth-highest number of opioid OD-related ED visits. Increases in OD deaths and OD-related ED visits underscore the severity of the opioid crisis and its impact on the county and state (NMDOH, 2024).

NM's adult estimated percentages of illicit drug use, drug use disorder, and SUD were high among US states and were significantly higher than the US percentages. Among youth, NM's estimated percentages for SUD, drug use disorder, and illicit drug use were among the highest in the US and were significantly higher than the US estimates (SAMHSA, 2023).

Regarding seeking treatment, about a quarter of NM adults needing substance use treatment did not receive treatment. For both NM adults and youth, the percentage of individuals classified as needing substance use treatment was higher than the percentage of individuals who received substance use treatment. The percentage of NM youth classified as needing treatment was significantly higher than the US estimated percentage (SAMHSA, 2023).

Data suggests that the primary reasons for not seeking treatment included denial of needing treatment, thinking they could handle it on their own, not being ready to start treatment, and not being ready to stop using substances. Additional reasons included not knowing where to get treatment, concerns about the cost of treatment, potential stigma, not having time for treatment, and lack of insurance.

Finally, because of naloxone's potential impact on reducing OD deaths, local naloxone data is presented. DAC accounted for 8.1% of total NM naloxone distributed and 2.6% of NM's number of naloxone OD reversals. Barriers to naloxone use included a lack of knowledge about naloxone, a lack of knowledge of where to get naloxone, and the perceived stigma associated with using naloxone distribution programs (NMDOH Harm Reduction Program, 2022).

Primary Assessment Data Collection Methods

For this report and needs assessment, Crimson Research analyzed data collected by County and City staff from a variety of sources:

- DAC Street Outreach Survey. This survey assessed substance use, treatment knowledge and preferences, barriers to treatment, and suggestions on how to use settlement funds among substance users. The first round of survey distribution occurred from April 2 to April 15, 2024. A second administration of the survey began in July 2024 and will close mid-August 2024.
- Focus groups. Three key informant focus groups were conducted with first responders, harm reduction providers, and behavioral health providers. Four lived and/or living experience focus groups were conducted with individuals representing Las Cruces, Southern DAC, the LGBTQIA+ community, and local youth. Focus group questions assessed participants' experience with substance use, treatment, impact on the community, and recommendations to the county for investing the settlement funds. Participants were recruited through invitations, social media announcements, and fliers.
- Town Hall Forums (Chaparral and Hatch, NM). These were conducted as guided discussions with scripted questions developed by Crimson Research. Participants provided their perceptions about substance use in the community, perceived needs to help the community, perceived barriers to getting help with substance use, and suggestions on how the settlement funds might be used.
- Secondary data (NM Substance Use Epidemiology Profile, IBIS, NMDOH BVRHS, CDC)

Results

Local Secondary Data. Local secondary data was limited, difficult to obtain, or absent, particularly for the City of Las Cruces. This data will be presented in the final report once data can be verified as there were concerns regarding accuracy.

Town Hall Outreach. In July 2022, the DAC HHS Opioid Settlement Coordinator conducted two town hall events in Hatch (n = 10) and Chaparral (n = 28). These data were collected too soon for inclusion in this summary, and currently, Crimson Research is transcribing the discussions for analysis, which will be presented in the final report.

DAC Street Outreach Survey

- Substance Use:
    - Of 53 participants, slightly more than half (*n* = 58.1%) reported using methamphetamine, and 48.8% reported using fentanyl in the past 30 days. Reports of other opioids and pharmaceuticals (e.g., heroin, oxycodone/oxycontin) were less than 6% each.

- Primary factors contributing to initial use or relapse included stress (35.8%, *n* = 19), the social environment (32.1%, *n* = 17), a lack of supportive social networks (15.1%, n = 8), and negative emotions (13.2%, *n* = 7).

- Treatment and Experiences with Treatment Programs
  - A majority (71.2%) reported going to substance use treatment in the past, and 39.6% were currently seeking substance use assistance. A majority were open to counseling or doctor appointments (73.2%) and medication-assisted treatment (74.3%).
  - The most useful types of counseling or doctor appointments included both in-person and telehealth (51.4%, *n* = 19), in-person only (40.5%, *n* = 15), and telehealth only (8.1%, *n* = 3).
  - Primary resources for finding treatment and recovery services included asking a healthcare provider (50.9%, n = 27), word-of-mouth (28.3%, n = 15), and seeking an agency (13.2%, n = 7).
  - The primary reasons for not getting treatment, even if they wanted it, included not being ready (28.3%, n = 15), transportation issues (17%, n = 9), cost (9.4%, n = 5), and inconvenient times (9.4%, n = 5). While these reasons are similar to those provided in the 2022 NSDUH survey results (SAMHSA, 2023), transportation issues were more of a barrier among the DAC survey participants.
  - Primary experiences with treatment and recovery programs included NA, AA, substance use counseling, and harm reduction. Most experiences were positive.
  - Primary experiences with harm reduction services included peer support, naltrexone, needle exchange, and awareness of resources and Narcan. Most experiences were positive.

- Barriers to Seeking Help
  - Primary perceived barriers to someone seeking help included emotional state/feelings (primarily embarrassment and shame; n = 19), lack of resources (n = 8), lack of information (n = 6), and a lack of willingness (e.g., timing, don't want to; n = 12).

- Narcan Use
  - Over half of the respondents reported they never carry Narcan (57.1%, *n* = 28), followed by carrying Narcan daily (24. 5%, *n* = 12), and then less than once per month (12.2%, *n* = 6).
  - Carrying Narcan was more likely if they used fentanyl in the past 30 days (60% carried Narcan) vs. those who didn't use fentanyl in the past 30 days (15% carried Narcan)

- Suggestions for Opioid Funds Allocation
  - Provide infrastructure/ resources (e.g., more treatment facilities, housing/shelter, jobs, long-term support; detox center, recreation outlets for youth; *n* = 35),

    - Increase education/information (e.g., community outreach; n = 10)
    - Address regulations (e.g., regulate doctors, more lenient admissions, keep "hard" drugs out of the city; n = 4).

- Primary Additional Comments for the Council
    - Need for support (e.g., community development, peer support for youth, take a different approach.
    - Fentanyl is a primary problem and changed drug habits
    - Need early education in schools; educate people about addiction

Focus Group Highlights. Three key informant focus groups were conducted with first responders (n = 8), harm reduction providers (n = 9), and behavioral health providers (n = 4). Four lived and/or living experience focus groups were conducted with individuals representing Las Cruces (n = 2), Southern DAC (n = 3), LGBTQIA+ (n = 1), and youth (n = 11). Lived/Living Experience participants either had past or current personal experience with either their own or another's substance use, treatment, or recovery. According to group discussions:

- Alcohol, methamphetamine, and fentanyl cause the most problems in the community.
    - As noted above, fentanyl has increased over the last couple of years
- Successful treatments include medication-assisted treatment (which is thought to be underused), harm reduction and Narcan, case management that reduces roadblocks and provides continuity of care, and accessible treatments.
- Perceived barriers to treatment for those needing treatment or resources in the community included transportation issues, treatment resources typically located far away (in El Paso or Las Cruces), lack of access, stigma, cultural norms, and a lack of knowledge of where to acquire information and resources.
- Key Informant suggestions on how to spend settlement funds primarily included (a) providing substance use/addiction education, (b) reducing stigma, (c) creating a centralized facility, (d) addressing transportation issues, (e) increasing accessibility to services (e.g., provide more locations, reduce wait times), and (f) creating sustainable long-term programs.
- Lived/Living Experience suggestions on how to spend settlement funds included investing in (a) youth support services and resources, particularly for children of family members who use substances, (b) community mental health and rehabilitation services, (c) early intervention for youth, (d) improving access to services, and (e) resources to address generational trauma (e.g., family members who witness, live with, and are affected by substance use).

Recommendations

Recommendations are based on the survey and focus group results, and substance use research. Data and research strongly support the need to address opioid use disorders and substance use disorders with a multifaceted approach that includes medical treatment, mental health support, societal interventions, and strong public health strategies.

- **Prevention**
  - Focus group data supports Johns Hopkins Bloomberg School of Public Health's Principle 3 for how settlement funds should be invested - to invest in youth prevention (Johns Hopkins Bloomberg School of Public Health, 2024). Youth prevention efforts should aim to stop substance experimentation before it starts to interrupt the pathways to use, addiction, and potential overdose. Youth prevention programs may also reduce the risk of other negative outcomes, including low educational status, unemployment, unintended parenthood, criminal behavior, and risk of death from a variety of causes (Johns Hopkins Bloomberg School of Public Health, 2024).
  - Provide evidence-based substance use prevention curriculums or programs for youth.
  - Include prevention efforts to address root causes/contributors to substance use in communities.
  - Provide public awareness campaigns about the risks of opioid use and safe prescribing practices.
  - Address regulations to control the prescription and distribution of opioids. This may include enlisting the help of prescribers and pharmacists and training them to recognize and counsel patients at risk for substance use.

- **Treatment**
  - Increase education about naloxone and access to naloxone.
  - NMDOH and NSDUH data support the need for evidence-based early intervention substance use treatment programs for youth.
  - Address and enhance rapid access to treatment. Focus group participants noted long wait times for counseling and rehabilitation appointments.
  - Provide universal access to evidence-based treatments for opioid use disorder, including the use of medication-assisted treatment. Focus groups and survey data support continuing and expanding access to medication-assisted treatment for opioids. Over 70% of survey respondents reported they would be open to medication-assisted treatment.
  - Provide access to evidence-based treatments in hospitals, community centers, treatment centers, and within the criminal justice system. Focus group participants noted gaps within the criminal justice system and a lack of enforcement of mandatory treatment.

- Increase access to counseling treatment/therapy, including behavioral therapies and contingency management, to help address the psychological aspects of addiction. Focus group and survey data support a perceived need for counseling therapy and treatment.
- Provide treatment that not only addresses the substance use, but also co-occurring physical, mental health, and social issues.
- Provide access to treatment in rural areas and/or address transportation issues from rural areas to areas providing treatment and resources.
- Enhance treatments to accommodate individuals needing childcare and pregnant individuals.
- Provide funding for room and board costs for residential substance use disorder/opioid use disorder treatment.

- **Support and Education**
  - Data suggests a need for a stigma reduction campaign to address and reduce the stigma associated with addiction and seeking treatment. Perceived stigma was a reason for not seeking treatment (in both local and national data) and was an obstacle in recovery (successfully reintegrating into the community after treatment).
  - Increase peer support specialists.
  - Address barriers such as transportation and childcare for appointments.
  - Provide education in the community on where to go for help and where to access substance use prevention, treatment, recovery, and harm reduction resources.
  - Provide resources and support programs, including counseling for family members affected by addiction to help them cope and support the individual and their loved ones.

- **Evaluation and Data Management**
  - Address data collection and gaps in city, county, and state methods for tracking substance use, overdose, treatment, and prescription drug monitoring. The City of Las Cruces's lack of data underscores the need for improved data collection and management.
  - Create a method (e.g., dashboard) where agencies and community members can access substance use statistics, data, etc. This will also contribute to transparency.
  - Establish a centralized evaluation team/unit. Because data was difficult to acquire, inconsistent, or nonexistent, an effort should be made to assess, collect and manage all data created through opioid settlement fund activities and programs. This should occur from inception to provide baselines for assessing program outcomes and impact. A centralized evaluation team would have the benefits of being familiar with programs, would build data collection capacity and

reliability, and would contribute to uniformity in the assessments of progress, impacts, and outcomes (Johns Hopkins Bloomberg School of Public Health, 2024).

- Establishing an early centralized evaluation effort would help ensure that funded efforts across programs were meeting the needs of minority populations.

Limitations

There were several limitations in the primary and secondary data collection for this assessment. Both the Outreach Survey and focus groups had small sample sizes, which reduced the ability to generalize to the population. Other agencies were also conducting surveys, which may have impacted our response rate. As a result, a second survey is currently being distributed. Additionally, town halls were conducted to collect additional data and community feedback, and a poll question was conducted at a Hatch back-to-school event to gather community suggestions on how to spend the settlement funds.

Another limitation was the lack of and difficulty obtaining local substance use data. This was particularly evident in efforts to obtain data for Las Cruces. Either the data could not be provided, could not be found, or did not exist.

Conclusion

As can be seen from this brief summary, reducing opioid and other drug use in Doña Ana County and the City of Las Cruces is a daunting problem. However, the opioid settlement funds awarded to DAC and the City of Las Cruces offer a once-in-a-lifetime opportunity to address opioid and substance use in local communities.

In addition to overdose deaths and impacts on physical health, opioid and substance use have numerous impacts on the individual, family/friends, and society. Individual impacts may include physical and mental health consequences (e.g., cardiac issues, depression, anxiety), behavioral problems (e.g., violence, negative lifestyle changes), legal issues, homelessness, and financial difficulties. Consequences to family and friendships may include strained and dysfunctional relationships, family instability, loss of social support, financial strain, and negative impacts on family members and, particularly, children in the family (e.g., increased risk of neglect, abuse, or addiction). Societal impacts include increased healthcare costs, impact on limited resources, unemployment/loss of productivity, crime, burden on the criminal justice system, and impact on public health and safety (e.g., infectious diseases, overdose crisis). The burden on affected individuals, their families, and the community is significant. In 2007, the estimated cost of prescription opioid abuse, dependence, and misuse in New Mexico amounted to $890 million (Birnbaum et al., 2011). Today, adjusting for inflation, that cost would be an estimated $1,352,844,103.

The information in this preliminary summary begins to outline the ways in which DAC and the City of Las Cruces might distribute and use such funds to attain measurable impacts on local citizens and communities. The complete needs assessment will also guide the investment of these funds into evidence-based prevention, solutions, and abatement efforts.

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