Report to Interim LHHS on House Memorial 9:

Medication Assisted Treatment for Opiate Addiction

November 4, 2009

Introduction

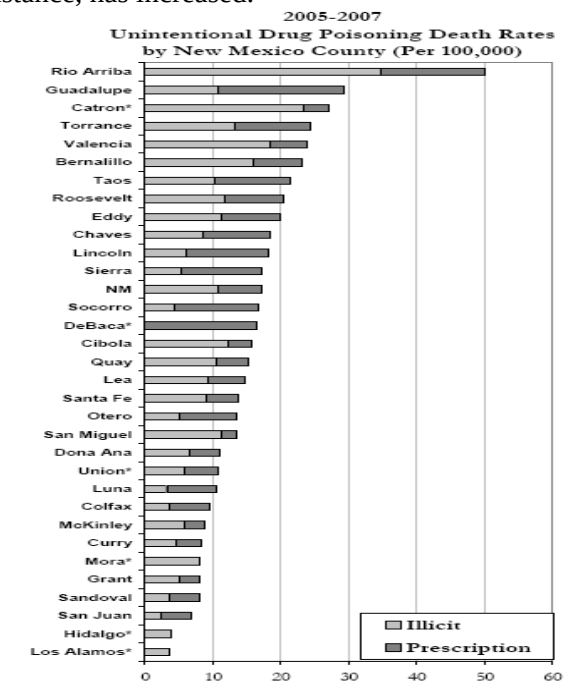
Opioid Death Rates

For the last 20 years New Mexico has been among the states with the highest drug-induced death rates. National household survey data for 2006-2007 estimated 9.2 percent of New Mexico adults, or roughly 132,000, used an illicit drug or misused prescription drugs in the past month.

Roughly 3/4 of all unintentional drug overdose deaths were caused by either heroin or opioids in the 2007-2008 time frame. There were overall drops in cocaine, methadone and methamphetamine overdose deaths.

Although deaths from prescription drug overdose were relatively unchanged, prescription opioids, either alone or in combination with other substances, caused roughly 1/2 of all unintentional drug overdose deaths.

Counties with noteworthy heroin overdose deaths in the 2007-2008 period were Rio Arriba, Bernalillo, Eddy, Dona Ana and Chavez. The street price for an ounce of heroin is less than 1/5 of the price in 1991 while the price of cocaine, for instance, has increased.



* Less than 4 deaths in the county over 3 years; there were no deaths in Harding County
NOTE: Rates are age-adjusted to the 2000 US Standard Population
SOURCE: The New Mexico Office of the Medical Investigator

"Too many New Mexicans are dying of drug overdoses, a last step in a long chain of events for people who use drugs. It is reasonable to believe our rates would be worse if we didn't have programs in place that prevent overdoses and provide substance abuse treatment and prevention to people who need it. Programs like buprenorphine can keep people functional so they can reverse the poverty cycle that tends to lead to substance abuse."
Dr. Alfredo Vigil, Secretary of Health, Behavioral Health Collaborative Executive

Opioid Addiction Among Youth

The age of heroin users is becoming younger. As in other parts of the county there seems to be a widespread ignorance about the addictive nature of smoking heroin, which is the gateway to opiate addiction for many New Mexico youth.

New Mexico in 2007 began tracking past 30 day use of prescription pain killers among youth in Grades 9-12. Of "other drugs", prescription pain killers have the 2nd highest prevalence. 11.7% of this group of youth reported using pain killers such as Percocet, OxyContin or Vicodin to 'get high'. And there's evidence that New Mexico youth are using drugs at earlier ages.

A 2006 national survey found that prescription opioids were the first drugs that adolescent and young adults used illicitly, followed by marijuana. In one state adolescents reported that prescription opiates were easier to buy than beer.

Drug Use - How Does NM Compare? Grades 9 – 12, 2007

Behavior		NM	US*	Compared to US, NM rate is...**	NM rank compared to other states***
Marijuana	Current use	25.0%	19.7%	-ns-	2
First use before age 13		**18.2%**	**8.3%**	**Higher**	**1**
Use on school property		7.9%	4.5%	Higher	1
Cocaine	Lifetime use	11.6%	7.2%	Higher	3
	Current use	5.4%	3.3%	Higher	2
Heroin	Lifetime use	5.0%	2.3%	Higher	4
Methamphetamine	Lifetime use	7.7%	4.4%	Higher	3
Ecstasy	Lifetime use	8.4%	5.8%	Higher	4
Injection drug	Lifetime use	3.6%	2.0%	Higher	3

* Youth Risk Behavior Survey, CDC, 2007
** Based by 95% confidence intervals (ns = no statistically significant difference
*** Of the 39 states that participated in the 2007 YRBS, CDC; 1 = Highest Rate

Addiction: A Chronic Disease

Dependence on opioids, whether prescription drugs or heroin, is a chronic, relapsing disease. Despite evidence that addiction is a treatable disease of the brain, most individuals do not receive treatment.

Although an estimated 23 million Americans suffer from alcohol and drug addiction, only one in ten of these people get treatment.

When addictions are untreated not only are health outcomes poorer and comorbid conditions more common, but also medical care becomes episodic or fragmented and many health issues go unaddressed.

According to the Department of Health, New Mexico has approximately 25, 000 injection drug users, only approximately 10-15% of whom are receiving medication assisted treatment. There are health consequences, as well as social costs, associated with illegal injection drug abuse, including high rates of Hep C and HIV-AIDS.

Addiction, like other chronic diseases such as diabetes, asthma or hypertension, is prolonged, does not resolve spontaneously, has complications if untreated, can be treated successfully, can be helped by medication.

[For additional New Mexico information related to overdose, see also Shah N. *Current Efforts and Ideas to Reduce Drug Overdose in New Mexico*, attached.]

Addiction: The Impact

Opioid addiction affects individuals, families, communities, and health care costs in New Mexico.

The Department of Health Harm Reduction Program provides a nasal spray form of Narcan, a drug that reverses a heroin overdose. The Program has trained more than 5,100 people on how to use Narcan, including family and friends of people who are at risk of overdosing. The Department estimates that, state-wide, since 2001, 1568 overdoses have been reversed through the use of Narcan.

The Agency for Healthcare Research and Quality found in 2007 that one in fourteen stays in community hospitals in 2004 involved substance related disorders, costing $2 billion nationally in 2004. Half of those patients were admitted from emergency departments.

The New Mexico Corrections Department estimates that over 85% of the individuals housed in state prisons have an abuse or addiction problem and that approximately 260 (out of a total of 3,000) are untreated opiate addicts released back into their community.

SAMHSA, the Substance Abuse and Mental Health Services Administration in the Department of HHS, has estimated that, over an 11 year period, a single male heroin addict costs taxpayers $2.1 million in court costs, jail time, ER visits, ambulances, hospital care, etc.

Whether short-lived or chronic, the growing list of recognized health consequences of abuse and addiction underscores the fact that drug abuse is not just a brain disease that exists in medical isolation - it manifest itself throughout the body with the broad array of medical consequences.

- February 2004, Dr. Nora Volkow, Director, National Institute on Drug Abuse

Stories of changed lives, like Cathy's, are why I am doing medication management at Region 5, Department of Health in Las Cruces. At DOH we view addictions as a public health problem that impacts individuals, families and communities. Opiate replacement therapy is a tool in harm reduction at the DOH, along with syringe exchange and overdose prevention. Our goal is to improve health and quality of life, treat drug use related problems such as Hepatitis C, and to decrease crime to have safer and healthier communities. - Meribeth Hauenstein, Las Cruces Sun-News Sept. 30, 2009

What Works: the evidence base

Medication Assisted Treatment, or MAT, refers to the treatment of individuals with addiction to heroin or opiate pain-killers, primarily with the use of prescribed medications known as methadone, suboxone or buprenorphine.

The use of medication to treat both substance abuse and alcoholism is a thoroughly researched and documented evidence-based treatment that is well-respected around the world. MAT is generally unfamiliar to the public in general in spite of its effectiveness and its high degree of regulation by the Drug Enforcement Administration, the NM Board of Pharmacy and/or the State Opioid Treatment Authority at HSD/BHSD. Methadone Treatment Programs are also required to be accredited by a national accrediting organization such as JCAHO or CARF.

Methadone was the first medical intervention approved for the treatment of drug addiction in 1964. Methadone is dispensed in programs regulated by SAMHSA and the DEA. These OTPs (opioid treatment programs) are also monitored locally by the State Opioid Treatment Authority, located within the Behavioral Health Services Division of the Human Services Department. Methadone is not prescribed, but is dispensed from these programs, which also include staff trained to provide other recovery supports.

The Drug Addiction Treatment Act of 2000 (DATA 2000) significantly changed the clinical context for medication assisted treatment, allowing for certain medications (buprenorphine and suboxone for opioid addictions) to be prescribed from office settings by physicians who have received some additional training and a DEA waiver. There are many more years of data and effectiveness research on buprenorphine/suboxone available internationally, particularly from France, which has a mature system of medication assisted treatment.

Wider availability, decreased stigma in seeking treatment, and the integration of behavioral and primary care needs are all factors encouraging expansion of office-based medication assisted treatment.

Methadone

According to the State Opioid Treatment Authority at HSD/BHSD, there are an estimated 2,650 people in methadone treatment in OTP's currently operating in Espanola, Santa Fe, Albuquerque, Belen-- and until July 30, 2009 in Las Cruces. With the exception of UNM/ ASAP, methadone treatment clinics are for–profit businesses. The majority of patients receive no public subsidies for their treatment.

Division of Vocational Rehabilitation also offers time-limited methadone treatment assistance to a small number of drug abuse/dependent individuals. In FY09 the number was 34.

Because of the difficulty of weaning off methadone, methadone patients, in most cases, anticipate a lifetime of medication assisted treatment. For the majority of these recovering individuals, this means paying for their own medication, anywhere from $250-$350 per month. Current state expenditure of Behavioral Health Collaborative agencies is slightly less than $2.5 million annually, for methadone treatment for indigent and special populations at UNM and OTPs in Santa Fe, Espanola and Albuquerque. Funding outside of UNM covers time limited treatment. A total of 600 persons were served by state funding for methadone in FY09. The State also funds the UNM Milagro program for heroin-addicted pregnant women.

There is a methadone program at the Bernalillo Metropolitan Detention Center supported by $200,000 of State General Funds. Between January and June, 2009, 273 patients received methadone. Of 211 patients discharged, 86% returned to treatment at their original community methadone clinic.

Suboxone

Suboxone is an alternative to methadone for some people. Treatment with suboxone consists of three phases: induction, stabilization, and maintenance. Those people less likely to be appropriate for an office-based treatment with suboxone include those with significant untreated psychiatric comorbidity, significant medical complications or comorbid dependence on high doses of benzodiazepines.

Suboxone is buprenorphine combined with naloxone, which further reduces the abuse potential compared with buprenorphine alone. If someone attempted to dissolve and inject suboxone, the naloxone would produce an immediate withdrawal syndrome. Among its attractions for both patients and physicians are that it has a low abuse potential, less withdrawal discomfort, and greater safety in overdose. Patients describe the 'feeling' associated with taking suboxone as "feeling normal" rather than a sensation of being 'high'.

Suboxone treatment is an office based treatment, provided by registered physicians who prescribe suboxone and buprenorphine. Physicians, many of them in primary care settings, are permitted by DEA to manage MAT for a limited number of patients, a maximum of 100 patients at any one time. Project Echo at DOH clinics throughout the state offers a small amount of free time-limited suboxone. Project Echo sites are located in Santa Fe, Albuquerque, Carlsbad, Crownpoint, Espanola, Las Cruces, Penasco and Taos.

It is estimated that the state spends $250,000 for suboxone treatment. As with methadone, the majority of patients pay for suboxone or buprenorphine out of pocket or with insurance, including Medicaid and SCI. An analysis of Medicaid and SCI claims data show a rising number of suboxone claims since 2007, with no denials.

Region Five's Public Health Office in Las Cruces has a suboxone program widely praised for its approach to high-risk individuals. It has initiated collaborations with the Dona Ana County Detention Center to address detoxification and jail and prison release issues.

Barriers to Treatment

Limited Access to Treatment: The total number of persons in MAT treatment in New Mexico is estimated to be between 3,000 and 3,500 individuals, approximately 10- 15% of the state's injection drug addicted population. The number without geographical access to treatment is hard to compute, but Eddy, Chavez and remote parts of Rio Arriba counties (cited in the heroin overdose data above) have no Medication Assisted Treatment.

Approximately 200 individual physicians located in many areas of the state are registered to prescribe suboxone and buprenorphine, but many do not. Presbyterian Health Care in Albuquerque for reasons unknown does not prescribe suboxone. Incentivizing the growth of Office-based Opioid Treatment through increased physician participation could involve identifying a community support system of community support workers, group counseling and medical consultants.

Coverage: Insurance barriers are often the most significant barriers to medication assisted treatment aside adequate numbers of prescribing physicians. In New Mexico's publicly funded healthcare system, all three Salud managed care organizations permit the prescribing of suboxone, but with differing mechanisms and requirements for prior authorization. Likewise the statewide entity for behavioral health also includes suboxone on its formulary. Methadone is not included in the Medicaid formulary but some limited coverage of individuals has been possible through Behavioral Health Services Division funding (see above). But, a recent study by the National Conference of State Legislatures found that *coverage is necessary, but it is not sufficient for access.*

Outreach to patients and physicians: Even in states having methadone coverage in their Medicaid program and buprenorphine allowed in their formularies, that coverage merely opens the door to implementation. Significant outreach to physicians is needed to dispel myths and provide training and support that encourage more office-based primary care prescribing of suboxone. Project ECHO in New Mexico is one such successful effort to increase the number of prescribers available.

Outreach to people who could benefit from medication assisted treatment is also critical. Among the most powerful outreach tools used in New Mexico are people, people who have successfully entered into recovery using suboxone or methadone and significantly altered their lives, acquiring jobs and even breaking multi-generational cycles of opiate addiction.

Availability of counseling and recovery supports: While suboxone alone is a powerful tool for overcoming opiate dependence and addictions, long term recovery including improvements to psychosocial functioning, employment stability, and lifestyle changes requires counseling or some form of long-term recovery supports. Counseling, various kinds of support groups, and access to ongoing assistance as needed is essential and clinically critical to long term recovery. The Panel learned of a promising internet based training program called Smart Recovery, by which peers and para-professionals could learn to facilitate recovery support groups. This is of particular interest in areas with few behavioral health practitioners.

Inadequate financial resources: While the Panel recognizes that autumn 2009 is not a good time to propose program or Medicaid expansion, when opportunities for further general or federal or grant funding arise, both methadone and suboxone medication assisted treatments are cost effective as well as clinically effective, producing real outcomes in people's lives and real outcomes in communities experiencing widespread opiate addiction.

The Panel and Next Steps

The Department of Health and the Behavioral Health Collaborative convened a specialized panel of experts in July to begin work related to House Memorial 9, introduced by Representative Stewart.

The Panel met and worked over the next four months, reviewing a large quantity of direct experiences, data, and literature on both methadone and buprenorphine. Due to the very technical issues being discussed and the desire to produce both longer range and practical, achievable recommendations, the Panel decided to concentrate its efforts to produce this report and to recommend to the Collaborative that this work continue. . The Panel received additional information from other states working to increase access to medication assisted treatments.

In addition to the recommendations of this report, the Panel also agreed that ongoing collaboration and possible development of additional recommendations would be beneficial. That work could continue with coordination by the State Opioid Treatment Authority. Further development of work may also engage individual communities and the consumers and providers in those communities as new opportunities arise.

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Recommendations

Creativity, Commitment and Collaboration Don't Always Cost Money

The Opioid Addiction Panel identified many strategies to increase access to medication assisted treatment. Some of our recommendations are short term, many are longer term and will require resources or policy changes that have financial implications. And we also found many ways to remove barriers to treatment and expand access that do not require new money but do require creativity, ingenuity, commitment, and collaboration in local communities.

The Panel found excellence and creativity in treating people with opioid addictions already present in some parts of the state that might be expanded to new regions or local communities.

- For example, the work by Public Health staff in Region 5 to negotiate rapid scheduling of counseling and support appointments with behavioral health practitioners is a creative approach to encouraging local doctors to take the DEA training and offer suboxone to their patients.

The experiences of the panel also spoke to the commitment, determination and motivation of people who experience the possibility of hope, who learn what suboxone or methadone can offer them in their efforts to recover from addictions and dependence.

- An informal survey of Opioid Treatment Programs in New Mexico revealed that 45-80% of patients are stable and gainfully employed.
- According to the state Opioid Treatment Authority at HSD/BHSD, there are an estimated 2,650 people in methadone treatment in Espanola, Santa Fe, Albuquerque, Belen, and until July 30, 2009 in Las Cruces. With the exception of UNM/ASAP methadone treatment clinics are for-profit businesses. The majority of patients receive no public subsidies for their treatment.

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Stories of Hope

A Bernalillo mother became addicted to prescription pain pills after sustaining an injury. Her life began to revolve around finding another way to acquire more medications. She thought 'addicts' were other people, not people like her. Today she is in recovery, working, raising her child, and speaks to groups to encourage others to "turn their lives around" with the help of Suboxone.

A man has been addicted to heroin and other substances for over 20 years, being in and out of jail, and periodically trying something new to attempt to address his addictions. He tried methadone, which has helped some people he knows but it didn't work so well for him. Now he's been in recovery for over three years. Suboxone worked for him and instead of cycling through the jail, he has a full time job.

A couple in Northern New Mexico belong to a family that's experienced intergenerational heroin addiction. They have children and this summer had a new baby. This child was born to clean parents. Both are on Suboxone. Their doctor encourages couples and mothers with adult children, families, to begin treatment together. It doesn't take long before they feel better and they can support each other as they continue their recovery.

Recommendations for The Behavioral Health Collaborative & Member Agencies:

- Prioritize Medication Assisted Treatment in the Collaborative Comprehensive Behavioral Health Plan and the Department of Health Strategic Plan.
- Develop an outpatient clinic connected to Turquoise Lodge where patients who were detoxed from opiates as inpatients can be inducted and receive continuing supportive and behavioral health services until established for services in a primary care setting.
- Establish a long term goal to make medication assisted treatments such as methadone or buprenorphine as easy to access as heroin and narcotic pills.
- Require all DOH doctors in Public Health Regions and Bureaus to support prescribing Suboxone and be available for the induction process on a regular schedule.
- Employ existing staff in each Region to support centers of collaboration for Medication Assisted Treatment (MAT) in at least one site.
- Seek opportunities within current contracts for Project ECHO to support Medication Assisted Treatment (MAT).
- Require FQHC recipients of state funding to have providers for MAT and to accept patients for this service.
- Study the current utilization of suboxone by Medicaid eligible clients and opportunities for expansion of Medication Assisted Treatment, including both suboxone and methadone.
- Work to coordinate with NM Salud programs to achieve similar preauthorization processes for Suboxone in all three managed care organizations.
- Work with Salud Managed Care Organizations to ensure primary care providers in each region who are licensed and willing to treat patients with buprenorphine.
- Partner with the NM Association of Counties to develop recommendations about use of the NC Jail Medical Plan (Model).
- Investigate with the Statewide Entity for behavioral health (SE) pilot or other programs to expand access to buprenorphine and suboxone or develop voucher based programs.
- Develop incentives for nonprofit clinics/programs to provide MAT in their service menu for mental health and substance abuse disorders.
- Develop substance abuse treatment standards that require publicly funded programs to train staff in medication assisted treatment and prohibit exclusion of MAT patients.

Recommendations for Communities, for Health Councils and Local Collaboratives:

- Collaborate with UNM and the Telehealth Commission to increase telemedicine capacity throughout the state to participate in Project ECHO; and to have direct service mental health counseling for persons in MAT.
- Work to have addiction services, including medication assisted treatment, on priority lists for all county health councils and local collaboratives.
- Support formation of local and state advocacy/activity mechanisms for addiction related matters.
- Strengthen referral networks to/from public health or other primary care sites for target populations as is done with TB.
- Offer technical assistance and support to local drug courts permitting medication assisted treatment. When additional funding is available, create in each Region a community care team like in Vermont to expand and enhance scope and scale of addiction services throughout state.

Recommendations for Local Detention Facilities, Corrections, and Law Enforcement:

- Work with Public Health offices in Las Cruces, Albuquerque and Santa Fe to provide buprenorphine induction for persons recently released from jails and prisons and appropriate referrals to primary care providers and for continuing treatment.
- Develop standard protocols for counseling and referral of persons released from prisons who have a history of opiate addiction before or during their incarceration, including the high risk of relapse to opiate use, overdose death after their release, and training in use of naloxone (Narcan).
- Develop formal discharge planning for all person exiting county jails and state prisons concerning substance use disorders.
- Work with county detention center affiliate of Association of Counties to develop pre-release engagement strategies for opioid dependent inmates.
- Encourage other county detention facilities to follow the lead of Espanola, Santa Fe, Las Vegas, Las Cruces, and Albuquerque by allowing persons enrolled in a local methadone maintenance program to receive methadone during their incarceration, either through delivery from a local clinic or contract with an independent contractor.
- Provide education and training to NMCD Probation/Parole Offices to facilitate referral of persons in community custody for Medication Assisted Treatment.

Other Recommendations:

- Work with congressional delegation and SAMHSA officials to extend qualification for DEA waiver to prescribe Suboxone to Nurse Practitioners, Certified Nurse Specialists and Physicians Assistants.
- Offer many diverse opportunities for continuing education in addiction treatment and use of Medication Assisted Treatment; including local workshops, online asynchronous learning, preceptorships or mini-sabbaticals, consultation helpline
- Support Hepatitis C toll free hotline to include MAT with Suboxone
- Have more English-Spanish bilingual audiovisual materials available for awareness campaigns
- Provide strong national advocacy so that NP/CNS/PAs may qualify for DEA waiver to prescribe Suboxone
- Investigate use of Skype and other similar web based tools for providing counseling support to people receiving Suboxone in rural areas.
- Include educational information about Suboxone and other Medication Assisted Treatments in all public service advertising about opiate use.

For Further Study:

- Factors affecting retention in MAT programs
- Mechanisms for longer term evaluation of effectiveness of Suboxone in New Mexico
- Use of Suboxone in New Mexico for detoxification and for longer term maintenance of recovery from opioid dependence.
- Potential funding for innovative family-based or intergenerational suboxone induction and treatment programs
- Current cost analysis of adding methadone to the Medicaid formulary

Citations

[These citations represent documents substantiating statements in the report and not the full array of documents reviewed by the Panel.]

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TIP 43: *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs* (SMA) 08-4214

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Current Efforts and Ideas to Reduce Drug Overdose in New Mexico

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August 2009

BACKGROUND

Since 1989, New Mexico has been among the U.S. States with the highest drug-induced death rates; in 2005, New Mexico (20.9 deaths per 100,000) ranked second following Utah (21.3 deaths per 100,000)(CDC WONDER). New Mexico continues to characterize and address the problem of drug overdose death, the largest subset of drug-induced death (Goldstein and Herrera, 1995; Landen et al., 2003; *MMWR*, 2005; Shah et al., 2005; Mueller et al., 2006; Shah et al., 2008; Baca and Grant, 2007; Krinsky et al., 2009). In 2006, unintentional drug overdose accounted for roughly 9 percent of life lost due to premature death in New Mexico (8,043 of 91,859 years of potential life lost before age 65 from all causes of death), higher than the U.S. percentage of 5.6 (WISQARS, CDC). But it is not solely a State-level public health issue. A multidisciplinary approach should engage medicine (i.e., providers, hospitals), insurers, regulatory entities, medical examiners, poison control, law enforcement and non-governmental organizations. Strategies are being developed for preventing drug overdose, some of which can be led by State health agencies. This report outlines a sample of ongoing efforts and ideas, not necessarily evidence-based, compiled as a result of a stakeholder brainstorming session.

In 2008, the statewide unintentional drug overdose death rate was 19.6 per 100,000, an increase from 17.5 per 100,000 in 2007. Death from illicit drugs increased slightly (10.1 deaths per 100,000 in 2007; 10.8 per 100,000 in 2008), driven by a 37 percent increase in death from heroin, while the death rate from prescription drugs remained relatively stable (11.1 per 100,000 in 2007 and 10.8 per 100,000 in 2008). The unintentional drug overdose death rate in Bernalillo County increased 8 percent from 23.7 per 100,000 in 2007 to 25.6 per 100,000 in 2008. Compared to other regions of the state during 2006-2008, Bernalillo County had the highest death rate from heroin, cocaine and prescription opioids. The Southeast Region had the highest death rate from methamphetamine (2.9 per 100,000). The Northeast Region had the highest overdose death rate from tranquilizers/muscle relaxants (6.8 per 100,000) and the combined effects of drugs and alcohol (7.2 per 100,000) (unpublished data).

National household survey data for 2006-2007 estimated 9.2 percent of New Mexico adults, or roughly 132,000, used an illicit drug or misused prescription drugs in the past month. This was a significant increase compared to 7.9 percent reported in 2005-2006. Based on DSM-IV, 2.9 percent of adults in New Mexico were abusing or dependent on illicit drugs in the past year, roughly 42,000 residents (2006-2007). This was also a significant increase as estimated from the 2005-2006 surveys (2.4 percent) (National Survey on Drug Use and Health [NSDUH]).

WHAT WE ARE DOING

The following are current efforts to prevent drug overdose in New Mexico but by no means a complete inventory. The State government coordinates with professional associations and national organizations to

increase drug-related surveillance capacity and collaboration. The use of various quantitative and qualitative data sources can highlight patterns at the State and sub-State level, and open communication avenues with local stakeholders to converse about emerging trends. Ongoing surveillance is necessary since the patterns of use and overdose are dynamic and change over time. In 2003, drug overdose was placed on the New Mexico reportable conditions regulation as a condition of public health significance and a pilot overdose surveillance project has been concluded. The New Mexico Office of the Medical Investigator and Poison Control Center are also sources of surveillance information and important partners in terms of "early warning" (sentinel surveillance) and educational outreach about drugs.

There are other efforts underway. For instance, New Mexico entities are collaborating with the CDC on a study to identify risk factors for overdose death among New Mexicans who are prescribed controlled substances, particularly potent opioids. This study utilizes death data and the Prescription Drug Monitoring Program (PMP) at the Board of Pharmacy, a registry of prescriptions filled for controlled substances Schedules II-IV. In addition to identifying overdose risk factors, the study may be able to: (1) characterize the extent to which drug overdose victims die from prescription drugs that were obtained illegally; (2) promote the development of prevention programs and policy initiatives aimed at reducing individual and community risk; and (3) encourage more physicians to access the PMP for the purpose of patient safety and improved care coordination.

The State Opioid Treatment Authority is implementing a requirement for opiate replacement therapy where Opiate Treatment Programs (OTP) will be expected to access the PMP when a patient enrolls into treatment. OTP physicians can use the PMP as a tool to improve care and help prevent adverse events associated with medication-assisted treatment. But as noted in recent years, there is evidence that the increase in methadone-associated death is not linked to opioid addiction treatment. A growing body of research suggests that the increase in death is in fact related to methadone prescribed for pain management. Therefore, the PMP is a useful tool for all physicians who prescribe controlled substances.

It is estimated that roughly 25,000 injection drug users are living in New Mexico, according to a synthetic methodology based on national adult lifetime drug injection prevalence from the NSDUH. The Department of Health (DOH) implements the statewide syringe exchange program as part of the Harm Reduction Program. This program also provides overdose prevention trainings and naloxone prescription for heroin users and their families and friends. This is important since research in New Mexico has shown that overdoses are familiar occurrences and many are "handled at home" by family and friends (Willging et al., The New Mexico Epidemiology Report, 2004, No. 5). The program also provides community health and social service referrals; health education and disease prevention information; acupuncture detoxification; and in some locations, primary medical care.

Harm reduction is invaluable as a conduit to healthcare and treatment for high risk subgroups, provided adequate treatment slots are available (Shah et al., 2000), and also reaches user networks through secondary exchange (Strathdee et al., 1999; Des Jarlais et al., in press). It is important to increase penetration of harm reduction services and outreach since the burden from heroin increased in 2008 and the population of concurrent illicit and prescription drug users is growing. Compared to heroin decedents during 2003-2007, decedents from heroin overdose in 2008 were significantly younger, more likely to have died from heroin combined with an opioid other than methadone or antidepressant, but less likely to have died from heroin in combination with cocaine. Potential reasons for the 2008 death rate increase include: (1) varying heroin purity or adulteration led to overdose (i.e., different supplier); (2) those who normally speedball (use cocaine and heroin simultaneously) overdosed after adjusting their routine due to cocaine scarcity and/or high price (per law enforcement intelligence); (3) there was a high number of heroin initiates, perhaps former or current prescription opioid users; (4) young users lacked the experience, education or were in a circumstance in which fatal overdose was unavoidable. Combinations of factors impact overdose rates and there are undoubtedly unmeasured influences and other explanations.

Via Medicaid, patient review is conducted to identify patients who misuse medical services. Based on this review, these patients can be restricted to one physician and one pharmacy. This kind of coordination saves Medicaid dollars, helps the at-risk patient reduce medically unnecessary drug use, and decreases the inappropriate use of services. Washington State enacted a Patient Review Program and reported a net savings of roughly $1.5 million per month as an outcome.

New Mexico is also developing drug take-back programs. Programs for the safe and proper disposal of drugs are important as they can reduce diversion/abuse of unused drugs and help protect the environment (by reducing the volume that enters the wastestream). The Board of Pharmacy also hopes to purchase an incinerator that meets World Health Organization guidelines for the safe disposal of unwanted pharmaceuticals that are collected at statewide take-back events.

Also, the promotion of State interagency and stakeholder task forces continue in New Mexico. These collaborations can be good foundations for launching effective long-term strategies and affecting policy.

OTHER IDEAS TO REDUCE DRUG ABUSE AND OVERDOSE

There are other strategies worth consideration in the realm of regulation, medicine and education, though formal evaluation of approaches is drastically needed. Prescription opioids, either alone or in combination with other substances, caused roughly half of all unintentional drug overdose deaths in New Mexico during 2007-2008; the proportion increased to three-quarters of all deaths considering heroin along with opioids. The provision of naloxone and training to all opioid users, not only heroin users and their family/friends, might result in the reduction of overdose death rates. Another potential regulatory strategy is E-Prescribing where practitioners, and not one of their agents, send prescriptions (and preferably, the diagnosis code as well) electronically to pharmacies. This innovation may reduce prescription pad theft and tampering. Other potential legal strategies include tightening regulation of pain clinics, many of which have proliferated in the southern U.S., and implementation or expansion of drug courts for non-violent offenders.

Providers have a pivotal role in preventing drug overdose. Professional norms for overdose survivors treated in the hospital, similar to those for suicide survivors, might be formalized. This can be considered a window of opportunity to provide referrals to treatment and overdose education discharge material (*MMWR*, 2008). Endorsement of evidence-based practice guidelines for the clinical management of chronic non-cancer pain, prescribing opioids, and dosing guidelines is increasingly important as more physicians are prescribing these drugs (i.e., can be sponsored by State government, medical boards, licensing boards) (McLellan and Turner, 2008). Low-cost trainings and continuing education could be targeted to medical students, generalist physicians, pharmacists and made available via Webinar, for example. With patient consent, providers may also educate family members of opioid patients about recognizing the signs of overdose and how to respond.

Increased availability of medication-assisted treatment should also be a priority since the risk of overdose is reduced for people who are in treatment compared to those not in treatment. In New Mexico since 2002, data indicate that 15-22 percent of all clients in substance abuse treatment were being treated with methadone or buprenorphine in facilities with OTPs (National Survey of Substance Abuse Treatment Services, SAMHSA). However, because of the growing problems associated with opioid addiction, it seems warranted to increase resources allocated to medication-assisted therapy and/or increase the accessibility of these services. According to SAMHSA, there are roughly 115 physicians in New Mexico who have waivers to prescribe and treat patients with buprenorphine. But there is much more capacity to treat since the percentage of physicians who are treating patients with buprenorphine is likely a small portion of those who are qualified and certified.

Finally, it is paramount to raise awareness and increase the visibility of problems that can result from drug use. Educational messages can be delivered to youth through school nurses/health clinics. Media campaigns can also be influential as seen in Utah where prescription drug overdose death rates recently decreased (Utah DOH supported a "Use Only As Directed" campaign). In summary, champions who can help integrate surveillance, prevention and response should be identified in order to connect with stakeholders. Together, these groups could review and develop effective, New Mexico-specific approaches to reduce the negative consequences of drug use.

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Detail on the strategies outlined in this report is available here:
http://www.stipda.org/displaycommon.cfm?an=1&subarticlenbr=204

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