

# New Mexico

## UNIFORM APPLICATION

FY 2020/2021 Block Grant Application

SUBSTANCE ABUSE PREVENTION AND TREATMENT

and

COMMUNITY MENTAL HEALTH SERVICES

BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022  
(generated on 09/13/2019 3.46.04 PM)

Center for Substance Abuse Prevention

Division of State Programs

Center for Substance Abuse Treatment

Division of State and Community Assistance

and

Center for Mental Health Services

Division of State and Community Systems Development

## State Information

### State Information

#### Plan Year

Start Year 2020

End Year 2021

#### State SAPT DUNS Number

Number 837710722

Expiration Date

#### I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name New Mexico Human Services Department

Organizational Unit Office of the Secretary

Mailing Address PO Box 2348

City Santa Fe, NM

Zip Code 87504

#### II. Contact Person for the SAPT Grantee of the Block Grant

First Name Angela

Last Name Medrano

Agency Name New Mexico Human Services-Behavioral Health Services Division

Mailing Address PO Box 2348

City Santa Fe

Zip Code 87504-2348

Telephone 505-827-6298

Fax

Email Address angela.medrano@state.nm.us

#### State CMHS DUNS Number

Number 837710722

Expiration Date

#### I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name New Mexico Human Services Department

Organizational Unit Office of the Secretary

Mailing Address PO Box 2348

City Santa Fe

Zip Code 87504-2348

#### II. Contact Person for the CMHS Grantee of the Block Grant

First Name Angela

Last Name Medrano

Agency Name New Mexico Human Services Department-Behavioral Health Services Division

Mailing Address PO Box 2348

City Santa Fe

Zip Code 87504-2348

Telephone 505-827-6298

Fax

Email Address angela.medrano@state.nm.us

### III. Third Party Administrator of Mental Health Services

Do you have a third party administrator?  Yes  No

First Name

Last Name

Agency Name

Mailing Address

City

Zip Code

Telephone

Fax

Email Address

### IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From

To

### V. Date Submitted

Submission Date 8/29/2019 4:02:19 PM

Revision Date

### VI. Contact Person Responsible for Application Submission

First Name Jacqueline

Last Name Nielsen

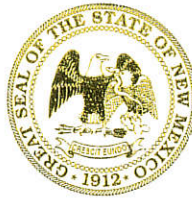
Telephone 505-476-9267

Fax 505-476-9272

Email Address jacqueline.nielsen@state.nm.us

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

#### Footnotes:



# State of New Mexico

Michelle Lujan Grisham  
*Governor*

July 31, 2019

Ms. Odessa Crocker  
SAMHSA  
Office of Financial Resources, Division of Grants Management  
5600 Fishers Lane, Room 17E22  
Rockville, MD 20857

Dear Ms. Crocker:

I hereby delegate authority to Angela Medrano, Deputy Secretary of Human Services Department, as New Mexico's Single State Authority (SSA) for mental health and substance abuse services as long as I am governor, unless modified by my office, or until such time as this delegation of authority is rescinded.

In this capacity, Angela Medrano has the authority to sign funding agreements and certifications; provide assurances of compliance to the secretary of the U.S. Department of Health and Human Services; and to perform similar acts of relevant to the administration of the Substance Abuse Block Grant (SABG), Mental Health Block Grant (MHBG), the Project for Assistance in Transition from Homelessness (PATH), and the SYNAR Program.

Please contact Michelle N. Trujillo at (505) 827-6287 if additional information is required.

Sincerely,

A handwritten signature in black ink that reads "Michelle Lujan Grisham".

Michelle Lujan Grisham  
Governor



# State Information

## Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2020

U.S. Department of Health and Human Services  
 Substance Abuse and Mental Health Services Administrations  
 Funding Agreements  
 as required by  
 Substance Abuse Prevention and Treatment Block Grant Program  
 as authorized by  
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act  
 and  
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

<b>Title XIX, Part B, Subpart II of the Public Health Service Act</b>		
Section	Title	Chapter
Section 1921	Formula Grants to States	<a href="#">42 USC § 300x-21</a>
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Section 1947	Nondiscrimination	<a href="#">42 USC § 300x-57</a>
Section 1953	Continuation of Certain Programs	<a href="#">42 USC § 300x-63</a>
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## ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

## LIST of CERTIFICATIONS

### 1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
  - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
  - b. Collecting a certification statement similar to paragraph (a)
  - c. Inserting a clause or condition in the covered transaction with the lower tier contract

### 2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
  1. The dangers of drug abuse in the workplace;
  2. The grantee's policy of maintaining a drug-free workplace;
  3. Any available drug counseling, rehabilitation, and employee assistance programs; and
  4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  1. Abide by the terms of the statement; and
  2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
  1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
  2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

### 3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

#### **4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)**

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

#### **5. Certification Regarding Environmental Tobacco Smoke**

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

### **HHS Assurances of Compliance (HHS 690)**

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: \_\_\_\_\_

Name of Chief Executive Officer (CEO) or Designee: Angela Medrano

Signature of CEO or Designee<sup>1</sup>: \_\_\_\_\_

Title: Deputy Secretary of Human Services Department

Date Signed: \_\_\_\_\_

mm/dd/yyyy

\_\_\_\_\_ <sup>1</sup>If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

**Footnotes:**



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6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
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  17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
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## LIST of CERTIFICATIONS

### 1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
  - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
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- b. Establishing an ongoing drug-free awareness program to inform employees about--
  1. The dangers of drug abuse in the workplace;
  2. The grantee's policy of maintaining a drug-free workplace;
  3. Any available drug counseling, rehabilitation, and employee assistance programs; and
  4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  1. Abide by the terms of the statement; and
  2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
  1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
  2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

### 3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

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The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

#### **4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)**

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

#### **5. Certification Regarding Environmental Tobacco Smoke**

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

#### **HHS Assurances of Compliance (HHS 690)**

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.



I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: NEW MEXICO

Name of Chief Executive Officer (CEO) or Designee: Angela Medrano

Signature of CEO or Designee<sup>1</sup>: *Angela Medrano*

Title: Deputy Secretary of Human Services Department

Date Signed: 8/12/19.  
mm/dd/yyyy

<sup>1</sup>If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

**Footnotes:**



## State Information

### Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

#### Fiscal Year 2020

U.S. Department of Health and Human Services  
 Substance Abuse and Mental Health Services Administrations  
 Funding Agreements  
 as required by  
 Community Mental Health Services Block Grant Program  
 as authorized by  
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act  
 and  
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

<b>Title XIX, Part B, Subpart II of the Public Health Service Act</b>		
Section	Title	Chapter
Section 1911	Formula Grants to States	<a href="#">42 USC § 300x</a>
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	<a href="#">42 USC § 300x-1</a>
Section 1913	Certain Agreements	<a href="#">42 USC § 300x-2</a>
Section 1914	State Mental Health Planning Council	<a href="#">42 USC § 300x-3</a>
Section 1915	Additional Provisions	<a href="#">42 USC § 300x-4</a>
Section 1916	Restrictions on Use of Payments	<a href="#">42 USC § 300x-5</a>
Section 1917	Application for Grant	<a href="#">42 USC § 300x-6</a>
<b>Title XIX, Part B, Subpart III of the Public Health Service Act</b>		
Section 1941	Opportunity for Public Comment on State Plans	<a href="#">42 USC § 300x-51</a>
Section 1942	Requirement of Reports and Audits by States	<a href="#">42 USC § 300x-52</a>
Section 1943	Additional Requirements	<a href="#">42 USC § 300x-53</a>
Section 1946	Prohibition Regarding Receipt of Funds	<a href="#">42 USC § 300x-56</a>
Section 1947	Nondiscrimination	<a href="#">42 USC § 300x-57</a>
Section 1953	Continuation of Certain Programs	<a href="#">42 USC § 300x-63</a>
Section 1955	Services Provided by Nongovernmental Organizations	<a href="#">42 USC § 300x-65</a>
Section 1956	Services for Individuals with Co-Occurring Disorders	<a href="#">42 USC § 300x-66</a>

## ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
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generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

#### **4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)**

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

#### **5. Certification Regarding Environmental Tobacco Smoke**

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

### **HHS Assurances of Compliance (HHS 690)**

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: \_\_\_\_\_

Signature of CEO or Designee<sup>1</sup>: \_\_\_\_\_

Title: \_\_\_\_\_

Date Signed: \_\_\_\_\_

mm/dd/yyyy

<sup>1</sup>If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

**Footnotes:**



## State Information

### Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

#### Fiscal Year 2020

U.S. Department of Health and Human Services  
 Substance Abuse and Mental Health Services Administrations  
 Funding Agreements  
 as required by  
 Community Mental Health Services Block Grant Program  
 as authorized by  
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act  
 and  
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66



## ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

- State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
  13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
  14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
  15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
  16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
  17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
  18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
  19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

## LIST of CERTIFICATIONS

### 1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
  - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
  - b. Collecting a certification statement similar to paragraph (a)
  - c. Inserting a clause or condition in the covered transaction with the lower tier contract

### 2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
  1. The dangers of drug abuse in the workplace;
  2. The grantee's policy of maintaining a drug-free workplace;
  3. Any available drug counseling, rehabilitation, and employee assistance programs; and
  4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  1. Abide by the terms of the statement; and
  2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
  1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
  2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

### 3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

#### **4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)**

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

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Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

### **HHS Assurances of Compliance (HHS 690)**

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: ANGELA MEDRANO

Signature of CEO or Designee: *Angela Medrano*

Title: Deputy Secretary

Date Signed: 8/13/19.  
mm/dd/yyyy

<sup>1</sup>If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

**Footnotes:**



## State Information

### Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

---

Name

Angela Medrano

Title

Deputy Secretary of Human Services Department

Organization

New Mexico Human Services Department

---

Signature:

Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

**Footnotes:**

See Attachments Page



## State Information

### Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

---

Name

Angela Medrano

Title

Deputy Secretary of Human Services Department

Organization

New Mexico Human Services Department

---

Signature:



Date:

8/26/19.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

**Footnotes:**

## Planning Steps

### Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

#### Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

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#### Footnotes:

NM was encountering errors when the attachments below were uploaded. The lack of attachments is not detrimental to the overall scope of Planning Steps 1. Attachments were for reference only.

Additional Information in relation to Planning Steps 1 are listed below and are available upon request.

Applied Behavioral Analysis Desk Manual  
BH Policy and Billing Manual Master 011019  
Housing Peer Endorsement Manual  
NM Managed Care Policy Manual Final  
NM SAPT Prevention Power Point 7.23.19  
NM Synar Power Point 2019  
Older Adult CPSW Endorsement COAPS 2019 Participant manual Revised 7.23.19  
Progress of Strategic Plan Finance  
Progress of Strategic Plan Regulations  
Progress of Strategic Plan Workforce  
RCoNM Final Brochure  
Veteran CPSW Endorsement Participant Manual Final

## **Planning Step 1: Assess the strengths and needs of the service system to address the specific populations.**

### **Section 1 Behavioral Health in New Mexico**

Over the past couple of decades, New Mexico has experienced the same stressors on its publicly-funded behavioral health system as most other states, perhaps compounded by its complex and unique demographics.

While 5<sup>th</sup> in size among all states, it is only 36<sup>th</sup> in population, with just over 2.1 million residents. With such a small population, its tax base is inadequate to support all of the public needs normally within the purview of a state government. Many of its counties are deemed either rural or frontier, exacerbating the difficulty of creating and maintaining adequate administrative and support service systems for its residents. The state is dependent on extractive industries, and is therefore subject to the boom and bust cycle of oil and gas pricing on the world market. Unemployment is among the highest in the U.S., remaining nearly 50% higher than most of the remainder of the country even a decade after the recession of 2008. The state ranks 50<sup>th</sup> in poverty level at 20.6%, with the level of children living in poverty close to 50% above that percentage. New Mexico is one of the few majority-minority states, where a federal ethnic minority, Hispanics, has the largest population base (47%). It also has the largest percentage of Native Americans in any state (9%). These populations frequently experience disparities in their access to and use of public systems.

Overall child well-being, a complex measure used by the Annie E. Casey Foundation that includes economic well-being, education, health, and family and community elements, ranked New Mexico 49<sup>th</sup> among all states in its 2017 Kids Count Data Book, and 48<sup>th</sup> in economic well-being, 50<sup>th</sup> in education, 37<sup>th</sup> in health, and 49<sup>th</sup> in family and community support. Children in poverty, as noted above, exceeded 29% in 2015, in contrast to a U.S. figure of 21%. The indicators where New Mexico was significantly worse than U.S. averages include children with parents that lack secure employment, teens not in school and not working, 4<sup>th</sup> graders not proficient in reading and 8<sup>th</sup> graders not proficient in math, high school students not graduating on time (an 82% higher rate than the U.S. average!), child and teen deaths per 100,000, children living in high poverty areas, teen birth rates per 1,000, and children in households where the head of the household lacks a high school diploma.

#### **Mental Health Conditions**

The Centers for Disease Control estimate that approximately 18.1% of all individuals in the U.S. ages 18 years and over experience a treatable mental health condition in a given year, and that approximately 4.2% of the population has a serious mental illness (SMI). While it is difficult to accurately estimate the number of individuals with mental disorders at any given point in time, the CDCs use a measure of Frequent Mental Distress (14 or more days in a 30-day period when an individual characterizes his or her mental health as “not good”) as the best available measure by which to compare states

and counties. The New Mexico Department of Health Epidemiology and Response Division's estimates closely parallel the CDCs', estimating that 4.3% of New Mexico's population has an SMI. Using the broader Frequent Mental Distress (FMD) marker, New Mexico as a whole has a rate of 12.0% of individuals with an FMD. This compares to the U.S. figure of 10.7%.

There are significant racial and ethnic variations to the aggregate percentage in New Mexico, with Native American and African American males and Hispanic and Anglo females higher than the average by a range of 8-25%. Similarly, there are significant geographic variations, with five counties – San Miguel (17.7%), Rio Arriba (17.0%), Sierra (16.1%), Curry (15.8%), and Hidalgo (15.5%) – more than 30% above the state's average. These counties, though high in percentage of those with FMD, range in actual number of individuals from around 500 – 6,000, in contrast to Bernalillo County with a percentage of only 10.8% of residents with an FMD but an actual total of nearly 57,000 residents.

There are many positive social correlates – from minor to major - to the presence of an FMD, ranging from functional health issues like obesity, diabetes, asthma, and general poor health to educational and income variations and finally to the presence of existing mental health or substance use issues such as depression or anxiety, alcohol abuse or dependence, and suicidal ideation or attempts. These latter correlates, as might be expected, increase the likelihood of FMD by 4-5 times.

Adult depression (current: reported within the past two weeks at the time of survey administration), among the most common mental disorders and one frequently seen as co-morbid with a range of functional health conditions, other mental and substance use disorders, and a significant risk factor for suicide and attempted suicide, occurs at a rate significantly lower in New Mexico than in the U.S.: 9.9% vs. 17.3%. Some ethnic and racial groups, though, exceed the statewide average, including Native American males, Hispanic females, and African Americans. Six counties exceed the statewide average by more than 25%: Sierra, Curry, Cibola, Grant, San Miguel, and Chaves. But as with the FMD measure, the numbers of surveyed individuals reporting depression from these six counties combined represent half the total reporting from Bernalillo County alone at more than 55,000. All but three New Mexico counties had a lower percentage than the U.S. average.

Youth measures of depression are usually parsed into three discreet facets of the condition: feelings of sadness or hopelessness (among high-school-age youth); youth who seriously considered suicide, and youth who attempted suicide. According to the NMDOH Epidemiology and Response Division (ERD), the prevalence of all three indicators did not vary statistically from U.S. aggregate figures in the most recently analyzed survey, which occurred in 2015. New Mexico youth reported virtually the same level of feelings of sadness or hopelessness over the period from 2003-2015 of approximately 32% (compared to the U.S. figure in 2015 of 30%). In 2015, the rate for

females was nearly twice that of males (42% vs. 23%), a recurring disparity nationwide, according to ERD.

The rate of “seriously considered suicide” in New Mexico has decreased since 2003 (21%), stabilizing from 2009 to 2015 (15.9 – 16.5%), and remaining below the U.S. percentage for the past several years. In 2015, the U.S. percentage was nearly 18%. As with the previous indicator, New Mexico females reported a significantly higher rate than males in 2015: 21.4% vs. 11.6%. White females in the 12<sup>th</sup> grade reported much higher rates (30.4%) than either Native American (14.2%) or Hispanic (16.1%) females in the same grade.

In New Mexico, the rate of youth suicide attempts overall has decreased since 2003 from 14.5% to 9.4% in 2015. While the U.S. rate decreased from 2003 to 2009, it has increased each year since then to 8.6% in 2015. ERD indicates that there was no statistically significant difference between the rate in New Mexico and the U.S. rate in 2015. As with the other two youth indicators, New Mexico females attempted suicide at a rate nearly double that of males in 2015: 12.4% vs. 6.4%.

In 2015, suicide was the leading cause of death for youth in New Mexico between the ages of 15 and 19 years of age. Nationally, in 2015, suicide was the second leading cause of death for this same age range. Looking at all ages, New Mexico’s suicide rate has ranged from 1.5-1.9 times the U.S. rate for the past 30+ years. New Mexico has ranked among the top five states for completed suicides in all but two of those years. In 2016, suicide was the fourth leading cause of death for residents under the age of 55 years. Male suicide rates are more than three times those of females across all ages and ethnic/racial groups. The U.S. rate per hundred thousand residents for the period from 2012-2016 was 12.8 while New Mexico’s was 21.5.

### **Substance Use**

New Mexico has had the highest alcohol-related death rate in the U.S. since 1997. This complex indicator includes two separate factors: chronic disease and injury.

Alcohol-related chronic disease (ARCD) deaths in New Mexico occur at more than twice the rate of the national average. Chronic liver disease is the most common form of ARCD. It impacts Native American men and women and Hispanic men disproportionately, with the highest county rates occurring in Rio Arriba and McKinley Counties, at five times the national average.

Alcohol-related injury (ARI) deaths in the State occur at 1.6 times the national rate. While motor vehicle crashes remain a significant element in this indicator, the most common cause of ARI deaths during the period from 2012-2016 was drug overdose while drinking, followed by motor vehicle crashes, suicides, fall injuries, homicide and alcohol poisoning. The rate of ARI deaths in New Mexico for this period was 28.7 per 100K vs. the U.S. rate of 18.5. The rate of ARI deaths specifically from motor vehicle crashes declined from 1982 – 2010 by 83%, moving New Mexico from first to tenth in

this sub factor of ARI deaths, with further declines following the initiation of a comprehensive prevention campaign starting in 2005 and continuing through 2009.

Drug overdose deaths in New Mexico, like alcohol-related deaths, have been among the highest in the country for many years. In 2015, we ranked eighth among all states at 25.3 per 100K residents, while the U.S. rate was 16.3. Data from 2016 suggest that the New Mexico rate is declining slightly, to 24.6, while the U.S. rate is increasing to around 19.3, although these data are still provisional. Unintentional drug overdose deaths account for 86% of all drug overdose deaths in New Mexico for the period from 2012-2016, with 41% of these deaths due to prescription drugs, 40% caused by illicit drugs, and 19% caused by both. The remaining percentage of drug overdose deaths were suicides, or intentional self-poisoning. The drugs leading to overdose deaths include prescription opioids such as methadone, oxycodone, and morphine (49%); heroin (33%); benzodiazepines (25%); methamphetamine (21%); and cocaine (13%). Multi-drug use is obviously included in these percentages, taken from Vital Records death data.

Rio Arriba County had the highest drug overdose death rate by far, at 89.9 per 100K. Catron County was the next highest at 55.0, followed by San Miguel, Lincoln, and Guadalupe Counties in the 40's. Of the nearly 2,500 drug overdose deaths during 2012-2016, more than half were Hispanic and 40% were White. The prescription drug death rate exceeded the death rate from illicit drugs in 19 of 33 counties.

Opioid overdose-related emergency department visits have increased by nearly 60% since 2010. Neonatal abstinence syndrome in newborns has increased from around two per thousand live births in 2000 to more than twelve. The health care and related social costs of opioid misuse in New Mexico are estimated to exceed \$900,000,000 annually.

### **System Barriers**

Professional and policy leaders of the New Mexico publicly-funded behavioral health system have put in place many programs to address the needs noted in previous sections, as well as the geographic and racial/ethnic disparities in access to service and outright gaps in service availability. These programs will be described in detail in Section 3 of this Guide.

As early as 2002 (Behavioral Health Needs & Gaps in New Mexico), though, a series of barriers to an adequate system of care was identified. Recognition of these systemic constraints on the construction of a comprehensive system of care has largely guided – at least implicitly - the activities of planners and program administrators over the past 15+ years. A brief review of the five critical system barriers identified at that time will serve as a foundation for both a description of the modeling of behavioral health management systems at the state level over this period and a focus for the rationale for prioritization of many of the most important program structuring activities that have occurred. Each of these high-level system barriers had a series of recommendations –

25 in total - for reducing, remediating or eliminating various facets of the identified problem. A recent strategic plan by the New Mexico Behavioral Health Collaborative, discussed at the end of this section, continues to respond to many of these barriers.

### **1. Multiple Disconnected Systems**

This condition, with multiple state agencies and funding sources acting completely independently, inevitably led to gross system inefficiencies and ineffective use of public funds, with little to no accountability for overall community impact. Providers were often forced to provide the same or similar services using differing and often contradictory practice standards, documentation requirements and outcome expectations. Consumers of service were often confused about why access to services varied widely according to the funding source. Service planning at the regional or community provider level was difficult, with consequences to provider capacity and service availability from year to year.

Issues addressed in the recommendations for the remediation of this system barrier included creation of a multi-state-agency entity “to provide leadership, direction and planning for all the state’s behavioral healthcare system” (which led to the New Mexico Behavioral Health (Purchasing) Collaborative a couple of years later); the development of common service system goals; common service definitions and agreed-upon levels of care; common assessment and utilization management tools and protocols; formal regional planning that would lead to codification of core services that should be available in all regions; integration of care across populations with co-occurring conditions; and support for consumer and family services and strengthened advocacy across the state.

In this listing, you will see not only the impetus for the creation of the Collaborative, but the germ of the development of Core Services Agencies and many of the program priorities addressed over the past decade and a half.

### **2. Lack of Consistent, Complete and Reliable Data for Accountability and Planning**

The 2002 study lamented the lack of common reporting system requirements, and called for creating “a single behavioral health provider agency and individual practitioner registry detailing services offered, capacity by service type, staffing patterns, service locations, and special programs or competencies.”

### **3. Inadequate Services and Benefit Design**

The recommendations within this category include a reiteration of the need for development of a common set of core services in all regions and community systems; standards for school-based mental health services and DWI programs; adherence to evidence-based practices in all systems of care; redesigning Medicaid benefits to make optional services that meet evidence-based standards part of the mandatory array; maximizing the availability of support services like housing, vocational rehabilitation,

and education for individuals with mental health, substance use, and especially, co-occurring conditions; and creating a statewide behavioral health research and development capability.

#### **4. Lack of Provider Agency and Individual Practitioner Capacity and Inadequate Information to Track that Capacity**

Recognizing the serious lack of behavioral health practitioners in both public and private service delivery systems throughout all parts of New Mexico, the study authors recommended developing a comprehensive statewide plan for addressing current and future behavioral healthcare human resource needs; modification of licensure regulations to simplify and fast track licensure reciprocity processes; annual collection of practice data from every individual licensed professional and provider agency; establishment of incentives for recruitment of practitioners in rural and underserved areas and prioritizing identification and attraction of Native American and Hispanic professionals; identification and training of alternative practitioners such as medical professionals in severely underserved areas; and creation of a single credentialing process for all major systems of care.

#### **5. Insufficient Resources to Meet the Need**

The recommendations dealing with lack of resources recognized that New Mexico could not add sufficient new public dollars to fully fund identified behavioral health needs. Instead, the authors selected a group of incremental increases that would hopefully improve the operating efficiency of the public system. These include repeating the intent to increase Medicaid funding for additional services; creating a common rate schedule for like-defined services while allowing for negotiation to account for geographic variabilities like distance, transportation costs, liability insurance, costs of distance clinical supervision; increased rates for grossly underfunded services like behavior management, mobile crisis, and education and support groups; start-up funding for infrastructure development of new essential services; and piloting in one region the development of a comprehensive system.

#### **New Mexico Models of Behavioral Health Management in the 2000's**

Some form of the system barriers and the recommendations to resolve them, briefly discussed above, have informed the conversation about publicly funded behavioral health for many years. There is universal recognition of the complex nature of behavioral health needs, disparities in access, and gaps in service among state officials, provider systems, consumer and family members, and advocates. New Mexico's political leaders have implemented a variety of models since the late 1990's which attempted to create effective management and oversight systems. A timeline and brief description of each major model over the past twenty or so years will be presented here to show what is hopefully a logical progression of improving responses to the global goal of improving the behavioral health of New Mexico's residents.



## **1997-1998**

Medicaid managed care (Salud!) was phased in over a year's time. Medicaid-funded behavioral health was carved in (included). Three MCOs were awarded contracts: Presbyterian, Lovelace, and Cimarron.

## **1997-2001**

Two of the MCOs – Presbyterian and Cimarron – contracted with national Behavioral Health Organizations (BHOs) to manage their Medicaid behavioral health (Options and Value BH respectively). The third – Lovelace – managed its Medicaid behavioral health internally. There was little to no coordination among the three MCOs/BHOs on the management of Medicaid behavioral health. Providers experienced significantly different reporting, oversight, documentation and practice management expectations among the three systems, creating significant inefficiencies and confusion.

## **2001-2004**

To eliminate the financial and service system inefficiencies noted above, the State created a system of five Regional Care Coordinators for Medicaid behavioral health. BHOs were not allowed to apply. It was intended that the RCCs be composed of existing provider systems or new provider/consumer coalitions. Awards were made to Presbyterian Medical Services for Regions 1 & 5 (NW NM and Bernalillo County), Rio Grande Behavioral Health for Regions 3 & 4 (SW and SE NM), and a provider coalition for Region 2 (NE/NC NM).

## **2004**

The New Mexico Behavioral Health Purchasing Collaborative was established by the New Mexico Legislature, to include seventeen state agencies and program units. Additional legislation created a Statewide Entity, carving out and integrating for the first time most publicly funded – Medicaid and non-Medicaid - behavioral health. The legislation did not include state-run facilities, developmental disabilities services, DWI programs and a few other specialty programs in Collaborative member agencies. An RFP was released to select the first Statewide Entity.

## **2005-2009**

ValueOptions was selected as the Statewide Entity.

## **2009-2014**

OptumHealth, a subsidiary of United Healthcare, was selected as the new Statewide Entity.

## **June 2013**

Five Arizona providers replaced thirteen New Mexico provider systems, representing approximately 80% of the total consumers treated annually in publicly funded systems.

## **2014-2018**

New Mexico changed the service model back to a Medicaid carve-in with the initiation of Centennial Care 1.0, eliminating the Statewide Entity carve-out. The MCOs selected under this model provided integrated medical, behavioral health, and long-term care services. OptumHealth provided ASO services for non-Medicaid behavioral health systems through June 30, 2017.

## **2015-2016**

Three of five Arizona providers left New Mexico and were generally replaced by Federally Qualified Health Centers providing integrated medical and behavioral health.

## **2017-2018**

An RFP for Centennial Care 2.0 was released. Three MCOs were selected, to begin services on January 1, 2019. The model remains a carve-in to include Medicaid behavioral health, and includes new services not previously paid for by Medicaid funds. Falling Colors is selected as the new ASO for non-Medicaid behavioral health services.

### **Strategic Planning**

In 2001, there were fewer than 52,000 users of publicly-funded behavioral health programs in New Mexico. By the end of CY 2016, there were nearly 174,000 consumers, an increase of 335% over that fifteen-year period. Medicaid-funded consumers (managed care and fee for service) increased by 84% from the year before Centennial Care implementation through 2016, mostly due to the expansion of eligibility allowed by the Affordable Care Act. In contrast, during the last decade, the State's budget only increased by approximately 12% overall. How to maximize the effective and efficient use of increasingly constrained public funds to serve ever greater demand is essential.

The 2015-2017 Behavioral Health Strategic Plan was targeted on three BHSD priority areas of Finance Regulation and Workforce. The primary goal of the planning process was to address the identified problem: *“New Mexico’s behavioral health service delivery system cannot sufficiently make necessary quality gains while continually being overstressed by the demands associated with complex regulations, inflexible financial incentives, and an inadequate workforce.”*

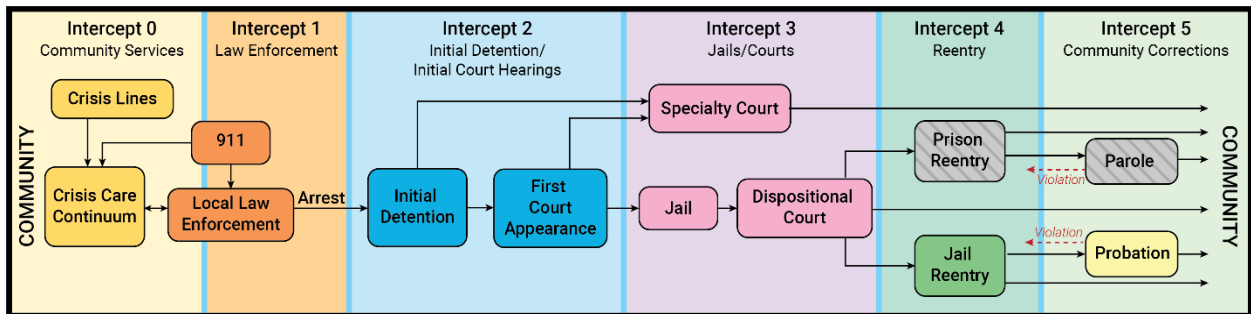
In January 2016, the Strategic Plan with its Goals and Objectives was adopted by the Behavioral Health Collaborative. Those Goals, objectives and accomplishments were monitored and tracked through July 2017. At that point, the accomplishments to date were again reported to the Behavioral Health Collaborative.

Since that time, the Division continues to pursue achievements in the various three domains of the Strategic Plan. The specific accomplishments during the following two years are detailed by each goal area and are contained in the Attachments Section for further review.

In Spring 2019, the Behavioral Health Collaborative convened and the strategic planning process was renewed with new State Agency Cabinet members in place under the newly elected Governor.

### Strategies of the Behavioral Health Collaborative

1. Expansion of Behavioral Health Network - Human Services Department (Lead)
2. Expand CB MH Services for Children - Children Youth and Families Department (Lead)
3. Substance Use Disorder - Department of Health (Lead)
4. Behavioral Health and Criminal Justice System - General focus on the Sequential Intercept Model

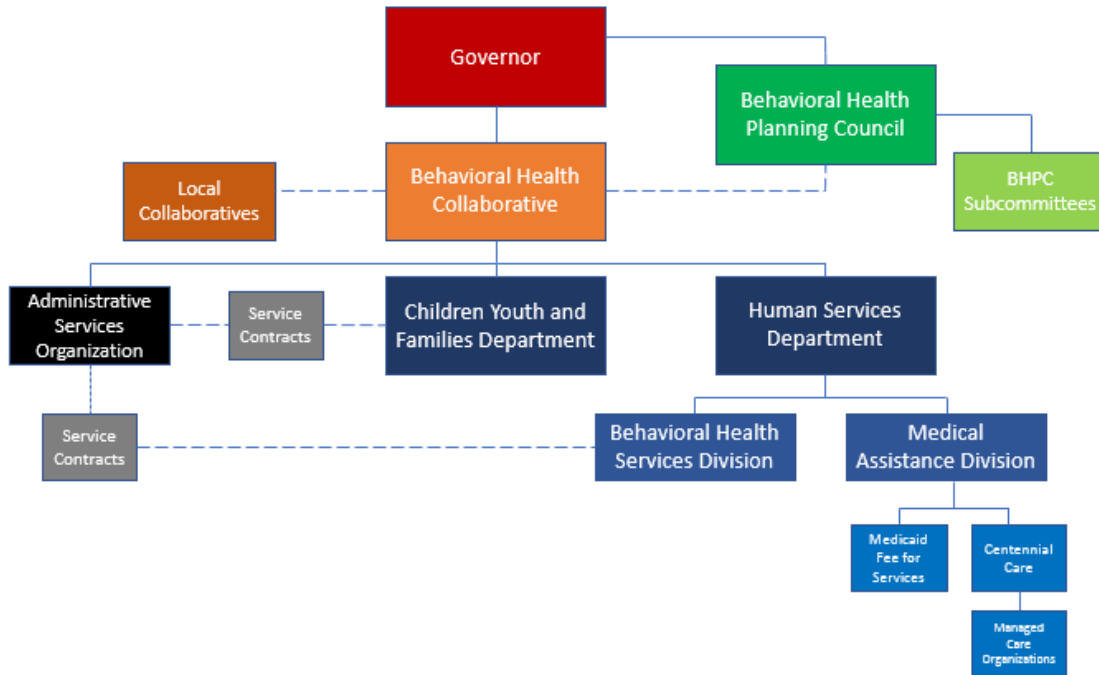


Sequential Intercept Model provides a conceptual framework for communities to organize targeted strategies for justice-involved individuals with behavioral health disorders.

Within the criminal justice system there are numerous intercept points— opportunities for linkage to services and for prevention of further penetration into the criminal justice system.

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## Section 2 Structure of Publicly-Funded Behavioral Health



### Behavioral Health Collaborative

As previously noted, the 2004 legislative session (HB 271) resulted in the creation of what was then called the Interagency Behavioral Health Purchasing Collaborative, later formally shortened to the Behavioral Health Collaborative, and referred to in this document as the Collaborative. As stated in HB 271, “the purpose of creating a single interagency behavioral health purchasing collaborative is to develop a statewide system of behavioral health care that promotes the behavioral health and well-being of children, individuals and families; encourages a seamless system of care that is accessible and continuously available; and emphasizes prevention and early intervention, resiliency, recovery and rehabilitation.”

Current active members of the Collaborative include:

- Human Services Department (HSD)
- Children, Youth and Families Department (CYFD)
- Department of Workforce Solutions (DWS)
- Corrections Department (NMCD)
- Governor’s Commission on Disability (GCD)
- Department of Finance and Administration (DFA)
- Governor’s Health Policy Advisor (GHPC)
- Developmental Disability Planning Council (DDPC)

Aging & Long-Term Services Department (ALTSD)  
Department of Health (DOH)  
Indian Affairs Department (IAD)  
Mortgage Finance Authority (MFA)  
Department of Transportation (DOT)  
Division of Vocational Rehabilitation (DVR)  
Public Education Department (PED)  
Administrative Office of the Courts (non-voting)  
Public Defender Office (non-voting)  
Department of Veterans Services (non-voting)  
Higher Education Department (non-voting)

The Collaborative is chaired by the Secretary of the Human Services Department, with the Secretaries of the Health and Children, Youth and Families Departments alternating annually as co-chairs. The main duties of the Collaborative include the development of a statewide master plan for delivery of behavioral health services that addresses all populations and regional variations, and creation of an inventory of all public behavioral health expenditures. The master plan is to be adopted as part of the statewide Health Plan.

The principles identified in the enabling legislation to guide master plan development are quite detailed (Section 8 HB 271), and include universally accepted emphases on recovery and resiliency, attention to cultural values, home and community-based preferences, individualized and family-based service planning and delivery, and the inclusion of a broad range of services from health promotion and prevention to early intervention, treatment and community support. The Collaborative is directed to specifically “seek and consider suggestions” by Native American entities – urban and traditional - during the development of global service planning.

### **Behavioral Health Planning Council**

The same legislation created a Behavioral Health Planning Council, replacing the Governor’s Mental Health Planning Council. The Council consists of Governor-appointed consumers of behavioral health services, providers, state agency representatives, advocates, and “such other members as the governor may appoint to ensure appropriate cultural and geographic representation.” No more than 49% of Council membership may be a combination of providers and state agency representatives. The business of the Council is largely conducted by three statutory subcommittees: a Native American Subcommittee, the combined Adult/Substance Use/Medicaid Subcommittee, and a Children and Adolescent Subcommittee. In addition to advocacy, program planning, and reporting functions, the Council has a federal mandate to “review and make recommendations for the comprehensive mental health state block grant and the substance abuse block grant applications, the state plan for Medicaid services and any other plan or application for federal or foundation funding for behavioral health services.”

## Human Services Department

### Behavioral Health Services Division

The Behavioral Health Services Division (BHSD) of the Human Services Department is the state entity designated to support the administrative and general programmatic activities of the Collaborative. The Director of BHSD is also the CEO of the Collaborative. BHSD is the Single State Authority for mental health and substance use services. At the time of the creation of the Collaborative, BHSD was a division of the Department of Health, but was soon moved to the Human Services Department to better integrate adult services with Medicaid behavioral health funding.

The Director of BHSD, in this portion of his duties, oversees three bureaus: Finance & Operations, Policy & Prevention, Program/Clinical Support Services & Recovery. In addition to traditional financial operations, the Finance & Operations Bureau manages the relationship with the Administrative Services Organization (ASO) for non-Medicaid services, currently Falling Colors (as of July 1, 2017).

The Policy & Prevention Bureau manages a diverse range of functions. Quality improvement activities form a core focus, but individual staff specialists are also assigned support and oversight of the BH Planning Council, supportive housing, health homes, federal block grants and general policy analysis. Two individual positions divide up management of the behavioral health portion of all Medicaid MCO Centennial Care contracts. The second arm of this complex bureau focuses on prevention, and is the home of the Office of Substance Abuse Prevention (OSAP). One staff director guides the Statewide Epidemiology & Outcomes Workgroup (SEOW) and National Prevention Network activities. Several managers and staff specialists oversee specific programs dealing with prescription drug and opioid abuse and death prevention, underage tobacco use, and school drop-out prevention (through classroom management training). There is some overlap between the prevention activities of this bureau and those that occur within the Department of Health, as will be noted in the description of DOH BH services below.

The Program/Clinical Support Services & Recovery Bureau oversees a broad range of core programs. In addition to a clinical services manager for treatment and recovery programs, there are individual staff specialists overseeing opioid treatment programs (and functioning as the State Opioid Treatment Authority), as well as staff managing both discretionary grants and State General Fund special areas. These latter programs include veterans' services, jail diversion, women's services, Native American traditional services, suicide prevention, among others. The Office of Peer Recovery & Engagement is also supported by this Bureau. This unit manages training and certification for Peer Support Workers, Recovery-Oriented Systems of Care (ROSC), and wellness drop-in centers around the state.

## Medical Assistance Division (Medicaid)

While Medicaid accounts for more than 90% of total publicly-funded behavioral health expenditures through its managed care and fee for service programs, it delegates program and clinical management and oversight to BHSD, CYFD and other state agencies as appropriate to the populations served. There is a single behavioral health staff manager at Medicaid who coordinates closely with BHSD and other state staff.

## Children, Youth and Families Department

### Behavioral Health Services (BHS)

BHS, in collaboration with Protective Services (PS), Juvenile Justice Services (JJS) and Early Childhood Services (ECS), is committed to the provision of quality behavioral health services and supports that are trauma informed, evidence based, culturally competent, and youth and family driven. The majority of clinical behavioral health services for children and adolescents are funded by Medicaid.

BHS consists of three program administrative units. The largest in terms of staff numbers (at more than 40 clinicians and supervisors) provides behavioral health support for JJS (Juvenile Probation) and PS programs through community behavioral health clinicians (CBHCs). CBHCs consult, assess, coordinate, and advocate internally and externally for children and youth in PS and JJS.

The Licensing and Certification Authority (LCA) licenses and/or certifies six Medicaid-funded community and residential programs, including accredited residential treatment centers, residential treatment services, group home services, treatment foster care services, day treatment services, behavior management services, and non-Medicaid-funded community crisis shelters, multi-service homes and new or innovative programs. They also receive and review all CYFD Statewide Central Intake (SCI) reports that allege abuse or neglect of youth participating in any LCA-licensed or -certified Medicaid program. Finally, they receive Critical Incident Reports (CIRs) from their regulated providers and triage them for immediacy of needed intervention and follow-up.

The third unit provides quality management, including administrative and financial support, and data analytical services to the division. It also provides program management and certification or endorsement for most of the more complex programming activities, including High Fidelity Wraparound Facilitator Certification, Infant Mental Health Endorsement, Family Peer Support Certification, and two certification processes currently in development for Youth Peer Support and Youth Support Services Coach programs. Additional non-Medicaid programs administered by BHS will be described in Section 3.

## Department of Health

Behavioral health direct services, data, and licensing oversight and compliance are part of the program offerings in several of the eight divisions within DOH. Most of the population-specific, non-Medicaid funded programs reside in the Public Health Division under the leadership of the Deputy Director of Programs. The Office of Facilities Management oversees the New Mexico Behavioral Health Institute (state psychiatric hospital) and several residential facilities that provide services ranging from adolescent residential treatment and chemical dependency treatment to long-term care and physical rehabilitation. This division also oversees a large community-based program for individuals with intellectual and developmental disabilities. The Developmental Disabilities Supports Division oversees three home and community-based (HCBS) federal waiver programs for adults, and one program for children from birth to three years of age who have or are at risk of having a developmental delay or disability. The Division of Health Improvement provides regulatory and compliance oversight of health facilities, including Community Mental Health Centers, and the HCBS waiver programs in DDS, as well as investigations into abuse, neglect and exploitation occurring within these facilities and programs, and other specialty registries and compliance activities. Finally, the Epidemiology & Response Division provides detailed and valuable reports in a number of public health areas, including mental health and substance abuse. They are an important resource for anyone interested in behavioral health needs, gaps, regional variations and program development.

### Public Health Division (PHD)

This division manages both a large number of Public Health Offices (PHOs) – 53 in 32 counties (all but Harding), grouped into four regions – and a large number of specialty health programs. Some of these programs are well known, such as WIC, family planning, and maternal, child & family health, and others are narrowly targeted and not as visible, but serve some of the neediest individuals and populations in our state. There are both treatment intervention and prevention programs. Almost all of these programs are under the direction of the Deputy Director of Programs, who oversees three bureaus - Infectious Disease, Chronic Disease/Health Systems, and Family Health – and well over twenty discrete service focuses. Behavioral health services are nested within several of these programs, and are largely delivered by PHO staff. The 53 Public Health Offices are managed by the Deputy Director of Regions.

While the Family Health Bureau focuses their programming on family system dynamics, including the WIC nutrition programs, Children's Medical Services (care coordination to children with special health care needs), family planning, Families FIRST, and maternal, child & family health, and does not target behavioral health directly, even in these programs there is a focus on screening, some brief interventions and referrals to treatment (following an SBIRT-like model) at various intervention points that may address substance use or conditions like depression, anxiety or PTSD which are not uncommon among the population using public health services.



The Chronic Disease section of its Bureau is primarily a testing and prevention unit, addressing issues ranging from cancer detection, heart disease and stroke prevention, tobacco prevention and control, diabetes prevention and control, and obesity nutrition and physical activity. Again, although behavioral health is not a focus of these programs, the holistic perspective of public health professionals and the frequent psychological course of individual chronic disease management results in attention to these issues as they arise in the course of their interventions.

The Health Systems section of the Chronic Disease/Health Systems Bureau has the largest behavioral health-related program, school-based health clinics, managed by the Office of School and Adolescent Health (OSAH). This program will be described in detail in Section 3 of this Guide. In addition, this bureau manages other large, statewide health programming systems, including the Office of Oral Health, Office of Rural & Primary Health Care, and the Office of Community Health Workers.

The Infectious Disease Bureau has, among its many programs, several programs where behavioral health interventions are overtly part of the program offerings. These include the Hepatitis Intervention Program where IV drug users constitute a large segment of the target population; the Harm Reduction Program which focuses on syringe exchange, reduction of substance use through acu-detox services, and overdose prevention; and the Refugee Health Program, where mental health and support services are made readily available to assist in the transition to life in the U.S. Additional populations served by this bureau are also at higher risk of mental health and substance use conditions, including those with HIV/AIDS and individuals with STDs. They also manage the Tuberculosis and Immunization Programs.

Public Health Offices, because of their local focus and the inherent nature of their client base, are ideal partners for local behavioral health providers, both for early identification of those needing behavioral health services, but probably more importantly, for creating at least the framework for local integrated care systems.

### Facilities Management (OFM)

DOH operates the New Mexico Behavioral Health Institute (NMBHI) in Las Vegas and several other facilities spread around the state, all providing a variety of therapeutic and rehabilitative services to specific populations. Many but not all of the services provided in these facilities are core behavioral health treatment services.

NMBHI has five distinct divisions and is accredited by The Joint Commission. It is the sole state psychiatric hospital, and has several other program types, serving a variety of populations, among its offerings. The Adult Psychiatric Program admits approximately 1,000 court-ordered and voluntarily-admitted patients per year. The Center for Adolescent Relationship Exploration (CARE) is a 20-bed secure facility for males who have exhibited harmful sexual behavior ages 13-18 years who also have a major mental illness. It is licensed through CYFD as a specialty Residential Treatment Center. A third secure, inpatient program, the Forensic Treatment Program, consists of the

Forensic Treatment Unit (FTU) with 72 beds in four distinct residential units – maximum security, acute care, continuing care, and women’s – for court-ordered individuals facing felony charges who have been found to be incompetent to stand trial and criminally dangerous as defined by state law. Individuals are initially committed to the FTU for a nine-month period intended to restore competency to stand trial, but can be committed for longer periods pursuant to state law.

NMBHI also offers a comprehensive Community-Based Services Program, including full Community Mental Health Center and Core Service Agency services in four counties (based in Las Vegas, Mora, Santa Rosa and Pecos) as well as an assisted living facility on the main campus that focuses on assisting individuals with serious mental illness. This program also provides outpatient restorative services for all ages, including the standard medical therapies (PT and OT).

Finally, NMBHI includes on its campus long-term care residences licensed as Skilled Nursing Facilities (SNFs), including the Meadows Home with three “neighborhoods” and a facility for individuals with Alzheimer’s and other dementia diagnoses.

In addition to NMBHI, DOH oversees other facilities that provide behavioral health services, either as their core function or as a significant portion of their mission.

Sequoyah Adolescent Treatment Center in Albuquerque serves up to 36 males ages 13-17 years who have a history of violence, a mental health disorder, and are amenable to treatment.

Turquoise Lodge Hospital, also in Albuquerque, provides substance use disorder services in an inpatient hospital setting. Both medical detoxification and rehabilitative services are provided, as well as intensive outpatient services (IOP).

The New Mexico Rehabilitation Center (NMRC) is a 43-bed Joint Commission accredited hospital in Roswell that has a dedicated unit with 15 beds for adult patients who require the most intensive level of one-to-one inpatient rehabilitation therapy due to strokes, multiple traumas, traumatic brain/head injuries, spinal cord injuries, MVA/motorcycle accidents, hip and knee replacements, and other orthopedic impairments that affect mobility and daily functional status. NMRC also offers adult substance abuse treatment such as inpatient medical detoxification with eight dedicated beds and inpatient social rehabilitation services. Patients will receive 24/7 care for treatment of opioid, alcohol, benzodiazepine, methamphetamine, heroin, and other substances. In addition, patients who require further treatment for substance use disorders can receive Intensive Outpatient Programming (IOP) when discharged from NMRC back into the community.

DOH also oversees one additional community-based program serving the needs of individuals with intellectual and developmental disabilities in Valencia and Bernalillo Counties. The Los Lunas Community Program offers customized community supports, community integrated employment, and living supports.

## Developmental Disabilities Supports Division (DDSD)

DDSD oversees three home - and community-based Medicaid waiver programs: Developmental Disabilities Waiver, Medically Fragile Waiver, and Mi Via Self-Directed Waiver. Its Intake and Eligibility Bureau manages the Central Registry for individuals waiting for services. As mandated by the federal Individuals with Disabilities Education Act (IDEA), DDSD also administers the Family Infant Toddler (FIT) Program for children from birth to three years of age with or at risk for developmental delay or disability. DDSD also provides several state general funded services, including respite, supported and independent living residential services, and supported employment and other day services. State general funded services are offered to individuals who are not on the Medicaid waivers. Such funding is frequently limited, potentially resulting in waiting lists for these services. There are five regional offices, located in Albuquerque (Metro), Taos (NE), Gallup (NW), Roswell (SE), and Las Cruces (SW), from which services for all counties are coordinated.

Traditional behavioral health services are provided to waiver recipients through regular Medicaid provider systems. Most individuals with intellectual and/or developmental disabilities who are not receiving waiver services still meet Medicaid eligibility criteria for behavioral health services and receive them through the Centennial Care managed care MCOs. Specialty behavioral support services for waiver enrollees and those receiving state general funded services, designed specifically for the populations served by DDSD, are provided through the Bureau of Behavioral Support whose mission is to serve as a “resource for effective collaboration for individuals with intellectual or developmental disabilities and co-occurring disorders.” These services will be described in Section 3 of the Guide.

## Epidemiology & Response Division (ERD)

Although this division is not a direct service provider, its Injury & Behavioral Epidemiology Bureau provides important information about behavioral health needs, gaps and disparities through comprehensive reports and analyses. Within this bureau, program units focus on training organizations in injury prevention and collecting data about issues of potentially high interest to behavioral health providers and community leaders interested in addressing high priority needs. These include topics and activities such as mental health conditions (Behavioral Health Surveys), substance abuse epidemiology, sexual violence services and rape prevention, prescription drug overdose prevention, and violent deaths (National Violent Death Reporting System). Of related interest are other bureaus that target issues such as infectious disease, environmental health, emergency medical systems, health emergency management, vital records and health statistics, and community health assessment. In a later section of this Guide, additional information will be provided about ERD’s Indicator Based Information System (IBIS), a very rich source of scalable data about the state as a whole and how we compare to other states, all the way down to information about individual communities, counties, and regions, and a large number of social or medical conditions that may be

analyzed individually or in clusters. Combined with the New Mexico Environmental Public Health Tracking Network website (NM-EPHT), an enormous amount of useful information is available to interested parties.

## **Department of Finance & Administration (DFA)**

### **Local Government Division: LDWI Programs**

The DFA Local Government Division administers the statewide Local Driving While Intoxicated (LDWI) Grant Fund, serving all 33 counties of New Mexico. The goals of the LDWI program are to reduce the incidence of DWI, alcoholism and alcohol abuse. County LDWI programs are overseen by local DWI planning councils, whose members are appointed by elected officials in each county. The primary role of each council is to construct a plan defining the menu of services from a list provided by the Local Government Division that best meets the needs of their residents. Services must be provided to the entire county, and they are intended to be complementary to other community services rather than duplicative. Local DWI Coordinators are expected to work collaboratively with county health councils, school officials, law enforcement, drug courts, magistrate court judges and staff, prevention and treatment organizations, and local mental health professionals. Funded services include screening; treatment; enforcement; prevention; compliance monitoring and tracking; alternative sentencing; coordination, planning and evaluation; domestic violence reduction; and social detoxification. These services will be detailed in Section 3 of this Guide.

Funded entirely by Liquor Excise Tax Collections (LETC), all 33 county programs receive a quarterly distribution of LETC funds as they are collected, and 6 counties receive social detoxification and alcohol treatment grant funds. A third funding stream allows for competitive grants for targeted programs. In SFY 2016, the most recent year for which there is an annual report, the LDWI program expended \$19.9M in LETC funds via these three funding streams. Of this total, \$14.2M were given in quarterly distributions to counties; \$2.8M were spent on detoxification and treatment programs; and the remaining \$2.9M were allocated through competitive grants. In this state fiscal year, nearly 60% of all funds went to treatment (37%) and prevention (22%). More than 6,000 individual DWI offenders were screened in SFY 2016. Of this total, 64% were found to have an “established” or severe alcohol use problem.

The LDWI program requires detailed data collection from all funded county programs, resulting in a rich source of information on the nature of the DWI problem at the county level, the demographic profiles of offenders, and the efficacy of program interventions. Data are tracked through the ADE, Inc., database. All county programs are required to hire a local evaluator who is focused on assessing the effectiveness of the prevention, compliance, and/or treatment components of the local program. In SFY 2016, the Local Government Division contracted with the DOH Epidemiology & Response Division to conduct a statewide evaluation of the LDWI program. That report is appended to the SFY 2016 Annual Report, available on the DFA website.

## **Administrative Office of the Courts (AOC)**

### **Court Services Division: Problem-Solving Courts**

The AOC Court Services Division supports more than fifty problem-solving courts in District, Metropolitan and Magistrate Courts in New Mexico. As of March 2018, 26 counties had at least one drug court program or were served by the drug court of a neighboring county (Mora, Union, Los Alamos, Rio Arriba). A few counties have multiple types of problem-solving courts. Only Catron, De Baca, Guadalupe, Harding, McKinley and Quay Counties have no such courts or court linkage. There are currently 22 Adult/Felony Drug Courts, 9 DWI Drug Courts, 3 (plus one pilot program) Family Dependency Drug Courts, 11 Juvenile Drug Courts, 5 Mental Health Courts, and 2 Veterans Treatment Courts.

Since the majority of problem-solving courts target individuals with drug use problems, New Mexico courts define these programs quite simply as “a treatment program, within a behavior modification program, administered by a court of law.” Individuals selected to participate in one of these programs are generally referred by a sentencing judge, with agreement by both prosecuting and defense counsel. Following administration of an approved screening tool, a selection panel usually consisting of a judge, defense counsel, district attorney staff, treatment provider, and probation officer then meets to determine whether an individual will be offered admission to one of these court programs. Drug courts may follow one or more of the following intervention models: pre-indictment, post-indictment, deferred sentencing, probation with condition of drug court, probation referral, or parole referral.

Eligibility for participation in a drug court program is generally restricted to the following types of individuals. Those who:

- have been arrested or convicted of drug offenses or drug-related crimes having to do with alcohol or other drugs as defined in the NM Criminal or Children’s Codes;
- have non-drug-related offenses that were committed while under the influence, or committed to support addiction or dependency, or are substantially related to the use or abuse of alcohol or drugs;
- committed distribution or trafficking of illegal substances to support participant’s dependency or addiction to alcohol or drugs (AOD);
- have been arrested for drug offenses or drug related crimes and have qualified for a pre-prosecution or court-ordered AOD diversion program;
- have violated probation by commission of a drug offense, drug-related crime, or drug use;
- have substantiated child abuse and/or neglect findings where alcohol or other drug use is a factor; or
- have a severe alcohol or other drug abuse problem, which has put their children at risk of child abuse and/or neglect that could result in removal upon the filing of a petition.

Approximately \$10,000,000 are annually allocated by the State to support these programs, although these funds do not include the cost of judicial, attorney, probation, law enforcement or other staff time not specifically part of problem-solving court budgets. Of this total, \$7,000,000 in State General Funds are allocated directly to District and Metropolitan Courts as part of their annual budgets, although earmarked for problem-solving courts, and the remaining \$3,000,000 (\$1.4M SGF and \$1.6M Liquor Excise Tax Collections) are allocated to the AOC. Only a very small amount of these funds is allocated to the 2d Judicial District Adult Drug Court in Bernalillo County as this program is administered and funded by the NM Correction Department's Probation and Parole Division.

There are additional periodic federal grant funds totaling around \$500,000, approximately \$400,000 in state behavioral health and local government funds, and program fees totaling approximately \$25,000 that supplement the base budget amounts. While the majority of these funds support program personnel and other operating costs, the Director of the Court Services Division estimates that direct treatment costs amount to 30-40% of the total. Some of these treatment costs are reimbursed by Medicaid, although the amount of Medicaid reimbursement varies greatly among programs, with some reporting no Medicaid billing or reimbursement. In 2017, 821 individuals were served in adult drug courts and 281 in juvenile court programs.

### **Department of Veterans Services (DVS)**

The New Mexico DVS provides both direct services to veterans and their eligible dependents and linkage to federal, state, local and private resources. DVS consists of several Divisions, including Field Services, Health Care, State Benefits and Administrative Services. As a Collaborative member, staff at DVS provide informed linkage for veterans to behavioral health services provided by Medicaid and other Collaborative agencies, as well as the much larger federal VA system. DVS' overall annual budget is approximately \$11M, while the New Mexico VA system has a budget of approximately \$1.6B, including more than \$596M in medical care to nearly 54,000 veterans (2016 data).

The Field Services Division staffs fourteen field offices and approximately the same number of outreach sites throughout New Mexico. Each field office is managed by a nationally certified Veterans Service Officer (VSO), with two VSOs each at the Las Cruces and Albuquerque/Eagle Rock offices. While the priority is assisting veterans and their family members in applying for federal VA and state benefits, linkage to other needed services is also provided, all free of charge. There is also a targeted Women Veterans Program within this unit.

The Health Care Coordination Division is tasked with educating veterans about their available healthcare benefits, and helping them navigate the complex federal VA Health Care System (NMVAHCS), which includes the VA Medical Center in Albuquerque, fifteen Community-Based Outpatient Clinics, and four regional Vet Centers that provide behavioral health counseling and services. Equally strong alliances have also been

formed with non-VA state and private health and behavioral health care providers throughout the state that also serve veterans, including those who are not eligible for VA health care. The Division has created a Network of Care portal for health care and other services for veterans and their families. Management of the State Veterans Home in Truth or Consequences was transferred from DOH to DVS in 2017.

The remaining three programs provide directed services other than behavioral health. The Veterans Business Outreach Center, funded by the federal Small Business Administration, assists transitioning veterans in acquiring the skills needed to develop and operate their own businesses. The State Benefits Division provides access to life benefits such as tax breaks, education, special license plates, hiring and procurement preferences and bonuses, and free and reduced-fee recreational benefits. The Cemeteries program develops and oversees new state veteran cemeteries (currently in Ft. Stanton and Gallup), military honors burials, the Forgotten Heroes program, and the Viet Nam Memorial in Angel Fire.

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## **Section 3**

### **Service Descriptions**

It is important to note that services and programs that are funded by public dollars change over time. That change is more commonly seen among programs funded by State General Funds or other state revenues and discretionary grant funding from the federal government or private foundations. These funding sources allow for more rapid response to changing behavioral health needs and social conditions in local communities and the state as a whole, and often allow for inclusion of individuals who may not meet the stringent clinical and financial criteria required by Medicaid funding. Medicaid itself, though, is able to add funding for new services at a more deliberate pace in the context of federal waiver applications, renewals and state plan amendments, as will be noted below. In all, the State of New Mexico expends in excess of \$375M annually on direct behavioral health services.

#### **Human Services Department**

##### Medical Assistance Division (Medicaid)

Services covered by Medicaid funding are described in detail in the New Mexico Administrative Code (NMAC) Title 8, Chapter 321, Part 2 (8.321.2), **Specialized Behavioral Health Services**<sup>1</sup>. This Rule is currently undergoing a substantial revision, to include new services.

Each covered behavioral service is listed below, with a brief descriptive note, as needed. Additional interpretive guidance will be available in the MAD **Behavioral Health Policy & Billing Manual (BH Manual)**<sup>2</sup>.

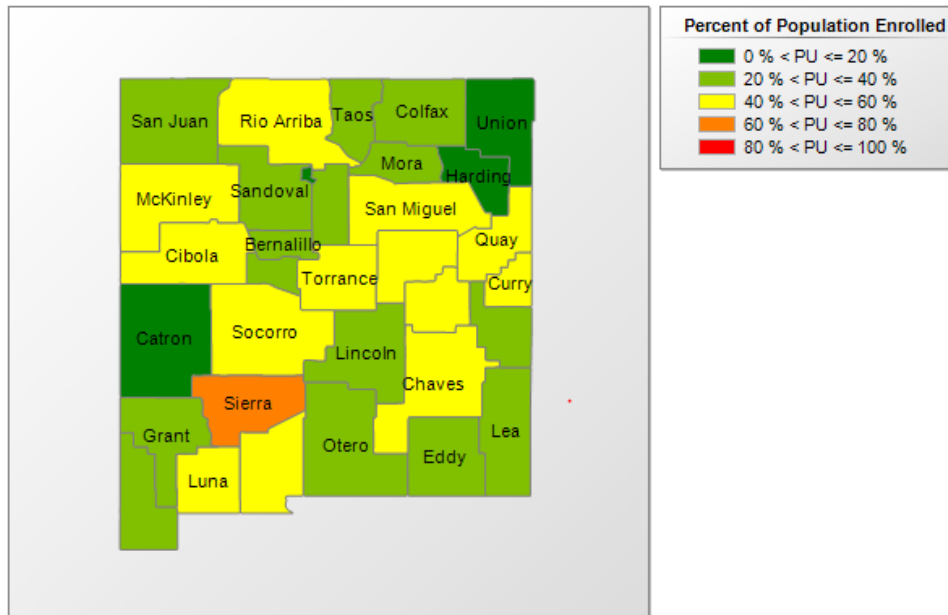
1. Accredited Residential Treatment Center for Adults with Substance Use Disorders (new service)
2. Accredited Residential Treatment Center for Youth
3. Applied Behavior Analysis – for eligible recipients from ages 12 months up to 21 years with confirmed diagnosis of Autism Spectrum Disorder (ASD) or ages 12 to 36 months with documented risk of developing ASD
4. Assertive Community Treatment Services – requires certification by BHSD
5. Behavioral Health Professional Services for Screenings, Evaluations, Assessment and Therapy – describes traditional psychological, counseling and social work assessment and treatment; also allows brief interventions or the use of the Treat First clinical model for up to four encounters with a provisional diagnosis and no comprehensive assessment and treatment plan
6. Behavioral Health Respite Care (Managed Care Only) – short-term direct care and supervision of an eligible recipient in order to afford the parent(s) or caregiver a respite from their care of the recipient
7. Behavior Management Skills Development Services



8. Cognitive Enhancement Therapy (CET) – evidence-based, time-limited treatment model for eligible recipients with cognitive impairment due to a specific limited set of Serious Mental Illnesses
9. Comprehensive Community Support Services (CCSS)
10. Crisis Intervention Services – telephonic, face-to-face, mobile, crisis stabilization services each detailed separately
11. Crisis Triage Center – residential and therapeutic services to youth 14-17 years of age and/or adults, as licensed, to provide voluntary stabilization of behavioral health crises including emergency mental health evaluation and care, not to exceed eight days length of stay per episode of care. Requires BHSD certification. (new service)
12. Day Treatment
13. Family Support Services (Managed Care only)
14. Inpatient Psychiatric Care in Freestanding Psychiatric Hospitals or Psychiatric Units of Acute Care Hospitals
15. Institution for Medical Diseases (IMD) – awaiting State Plan Amendment and 1115 Waiver to increase maximum days from fifteen to thirty (new service)
16. Intensive Outpatient Program for Substance Abuse Disorders (IOP) – requires BHSD certification
17. Intensive Outpatient Program for Mental Health Conditions – IOP services for individuals with an SMI or SED. Requires BHSD certification. (new service)
18. Medication Assisted Treatment (MAT) – individuals with an opioid use disorder receive Suboxone or Vivitrol (naltrexone). Methadone excluded – see Opioid Treatment Program below
19. Multi-Systemic Therapy (MST)
20. Non-Accredited Residential Treatment Centers and Group Homes
21. Opioid Treatment Program (OTP) – Methadone maintenance treatment – requires BHSD certification
22. Partial Hospitalization Services in an Acute Care or Freestanding Psychiatric Hospital
23. Psychosocial Rehabilitation Services (PSR)
24. Recovery Services (Managed Care Only) – peer-to-peer individual or group support to develop and enhance wellness and health care practices
25. Screening, Brief Intervention and Referral to Treatment (SBIRT) (new service)
26. Smoking Cessation Counseling – see 8.310.2 NMAC for details on services and eligible providers
27. Supportive Housing Pre-Tenancy and Tenancy Services (PSH TSS) (new service)
28. Treatment Foster Care I and II

Additionally, MAD pays for behavioral health medications. Prior to ACA Medicaid expansion beginning in 2014, a large percentage of Medicaid-reimbursed prescriptions were for children and youth. ADHD medications represented the second largest number of prescriptions, with substance use withdrawal and treatment prescriptions representing far less than 1% of total prescriptions. By 2016, with the addition of more than 200,000 mostly adult new enrollees, ADHD medications grew by only two percent while substance use medications grew by 733%. Within just the expansion population, encounter data show an overall increase in expenditures for behavioral health prescription drugs of 78% from 2014 through 2016, making prescription drug spending the second largest category of expenditures (26% of total expenditures) for expansion behavioral health since 2014.

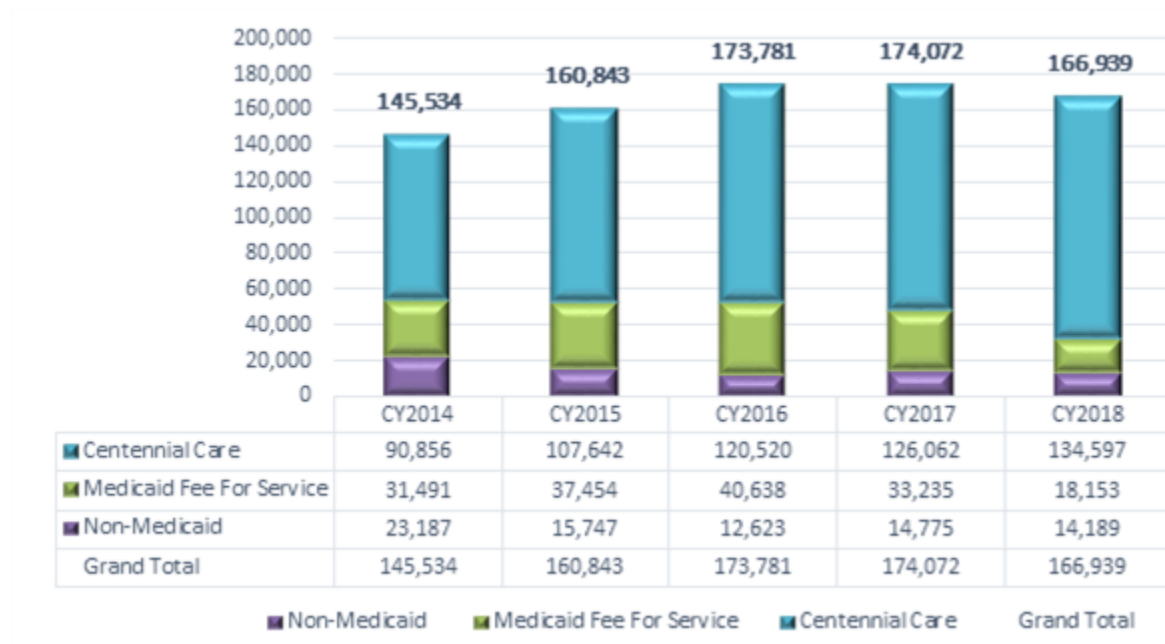
**Medicaid Enrollment by County of Residence as of 07/31/2019<sup>3</sup>**



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## Behavioral Health Utilization with Centennial Care

New Mexico continues to monitor utilization of BH services. The CY19 annual target has already been achieved. The data for this measure is cumulative and collected based on a calendar year. Therefore, this quarter's data reflects twelve months of CY2018. Overall, 166,939 persons were served across all funding sources; this represents a 19.7% increase (or 27,433 persons) over the prior quarter. Medicaid's 134,597 Centennial Care members account for 80.6% of all persons served in this quarter. The Medicaid members served increased 20.5% (or 22,943 persons) over the prior quarter. There were 18,153 Medicaid Fee for Service members served in this period reflecting a 14% (or 2,230 persons) increase over the prior quarter. However, as reflected in this year's quarterly counts, the total number of Medicaid Fee for Service members is lower than in prior years. This is based on a change in MAD's criteria used (i.e., provider type and services codes) for calculating that count. There were 14,189 non-Medicaid members served which reflects a 18.9% increase (or 2,260 persons) over the prior quarter.



### Data Sources and Methodology:

1. *Data Source: STAR DW (Falling Colors; Non-Medicaid), MAD DW (FFS), and the MAD Report 41, Utilization Management unduplicated headcounts.*
2. *Methodology used to collect data: Claims-based data from payment systems*
3. *Responsible persons: Quality Improvement Committee*
4. *Timeframe for data collection and reporting: Quarterly reporting, 30 days after the quarter.*

## Behavioral Health Services Division (BHSD)

### Block Grants

The **Substance Abuse Prevention and Treatment Block Grant** (SABG or SAPT) is the largest source of non-Medicaid federal funds received by the BHSD. Utilization of block grant funds is intended for planning, implementing and evaluating activities to prevent and treat substance use disorders. It is also the largest federal program dedicated to these state-level problems. BHSD collaborates with the Behavioral Health Planning Council to plan and monitor service delivery for priority populations. The BHSD Office of Substance Abuse Prevention (OSAP) is largely funded by the SABG grant.

Targeted populations include women with substance use disorders (SUDs), intravenous drug users (IVDU), services to individuals with tuberculosis, and primary prevention services. BHSD funds service providers for women with an SUD, addressing treatment services for pregnant women, those with dependent children, and those who are attempting to regain custody of their children, as well as unmet needs of women and their families. Individuals who are IVDUs must be identified and services prioritized under the SABG for all providers funded by this grant, per regulation and contracted scope of work. These regulations primarily refer to the development of capacity management and waiting lists for this high need population. Contracted providers are also required to maintain a quality assurance process that tracks and reports routine screening, referral for testing, and treatment of consumers who are infected or at risk of infection with tuberculosis (TB), as well as HIV, Hepatitis C, or sexually transmitted diseases. BHSD partners with the Department of Health's TB Control Officer to implement infection control procedures and linkages with other health care providers to ensure that TB services are routinely made available, primarily through the statewide network of public health offices.

#### SABG Women's Set-Aside Funding

For State Fiscal Year 2020, Interfaith Leap/Sangre de Cristo House, Santa Fe Recovery Center, and Turquoise Lodge received funding for women's services that meet the priorities for the Women's Set Aside funding.

The **Community Mental Health Services Block Grant (MHBG)** funded state block grant, awarded for the purpose of providing comprehensive community mental health services to individuals who are either adults with a serious mental illness (SMI) or children with a severe emotional disturbance (SED), and includes individuals who have dual diagnoses. As with the SABG grant, BHSD works with the Planning Council to plan and monitor service delivery.

A portion of the grant (10%) is earmarked to support evidence-based programs that provide treatment for first episode psychosis (FEP). BHSD contracts with the **UNM Early Psychosis Clinic**<sup>4</sup>, a specialty care service for youth ages 15-30 years and their families. The team at the clinic provides a combination of direct clinical care, access to

consultative providers, and educational and outreach activities. Clinical services are based on the NAVIGATE model for early psychosis which includes individual and family psychoeducation, resilience-focused CBT, evidence-based psychopharmacology, and education and vocational support. Individuals are enrolled for up to two years, with discharge either upon recovery or embedded in long-term services, as appropriate. The clinic currently serves 50-60 youth directly, with others supported through consultation provided to community providers throughout the state. The clinic is currently adding additional outreach staff to expand its consultative capacity.

### **Other Federal Grants & Programs**

The **Projects for Assistance in Transition from Homelessness (PATH)** grant is an annual formula grant from SAMHSA for the purpose of serving people with an SMI and those with co-occurring substance use disorders who are experiencing or are at risk of homelessness. These funds are used to conduct outreach to individuals who are disconnected from mainstream resources. PATH-funded providers in Albuquerque and Santa Fe offer mental health, substance use, case management, additional support services and a limited set of housing services.

**Preadmission Screening and Resident Review (PASRR)** is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long-term care due to a serious mental illness (SMI) or intellectual or developmental disability (I/DD). Any individual with these conditions for whom admission to a nursing facility is deemed appropriate after thorough PASRR evaluation must receive the needed services to treat these conditions. BHSD assigns a content expert to coordinate PASRR-mandated services and contracts for medical evaluation with the University of New Mexico as required under federal rules.

The New Mexico **State Opioid Response (SOR)** expands capacity to address Opioid Use Disorder (OUD) morbidity and mortality via a modified Hub and Spoke model to support the adoption and implementation of Evidence Based Practices (EBP) statewide, that have proven effectiveness to prevent, treat, support recovery and reduce harm related to OUD. SOR supports services to a broad range of ages, and cultural and ethnic groups, including Native American communities and Hispanic populations.

The **Bridges to Wellness** grant purpose is to significantly increase collaboration between behavioral health and primary care providers in rural New Mexico to improve access and utilization of integrated care and increase health promotion services aimed at improving the overall health and wellness of adults in New Mexico with Mental Illness (MI) and/or Substance Abuse Disorders (SUDs) who have chronic physical health conditions.

The BHSD **Office of Substance Abuse Prevention<sup>5</sup> (OSAP)**, as noted above, is primarily funded by the SABG block grant. This unit creates and manages a statewide prevention training plan, and oversees a number of federal prevention grants. It also coordinates the collection and analysis of epidemiological data (SEOW), evaluation of project initiatives, coordinates the enforcement of under-age tobacco retail sales, and

assists in accessing new funding sources. OSAP supports 35-40 community providers (in 20 counties, 3 tribal communities, and 5 university/schools) across the state to implement prevention projects. Federal grant programs overseen by **OSAP** must address at least two of the following indicators to reduce underage drinking, binge drinking for youth and adults, DWI for youth and adults, prescription drug use and misuse for youth and adults, opioid overdose death, illicit drug use for youth and adults, tobacco use for youth and adults.

The OSAP **Statewide Epidemiological and Outcomes Workgroup** (SEOW) supports the activities of several federal grants, including the Prevention “Partnership for Success” (PFS) and the Strategic Prevention Framework for Prescription Drugs (SPF Rx), among others, through a monthly bulletin that documents key resources and summary documents discussed at their monthly meetings. To date, bulletins have included such topics as strategies to address opioid misuse, overdose and treatment with recommendations from the CDC and SAMHSA; and strategies to mitigate underage drinking, and drinking and driving. Funding for the SEOW comes from the PFS grant.

### **OSAP Programs**

The **Prevent Prescription Drug/Opioid Overdose-Related Deaths** (PDO) SAMHSA grant (2016-2021) program is intended to reduce the number of deaths and other adverse events among individuals 18 years of age and older by training first responders and other key community sectors in the use of primary intervention tools like naloxone (Narcan), purchasing naloxone for certain county first responder consortia, and implementing secondary prevention strategies. A PDO Advisory Council oversees grant activities in the three counties – Bernalillo, Santa Fe, and Dona Ana - that are part of the first implementation phase of the program. Expansion activities are occurring in Rio Arriba County and the Metropolitan Detention Center in Albuquerque. Each of the county consortia includes a variety of local agencies, from layperson “first responders” and active opioid users to local jails, law enforcement, fire departments, drug courts, and jail diversion programs; homeless programs and shelters; and drug treatment programs and faith-based organizations. A PDO Media Subcommittee provides guidance on the development and dissemination of materials about overdose prevention and naloxone use through a variety of media.

The **Strategic Prevention Framework for Prescription Drugs** (SPF Rx) program, another SAMHSA-funded initiative, was also awarded to BHSD for a five-year period, 2016-2021. This grant program is intended to raise awareness about the dangers of sharing medications, and to promote collaboration between states, pharmaceutical companies, and medical provider systems in reducing the risks of over-prescribing through adoption of prescription monitoring programs (PMPs). Drug abuse prevention activities and education to schools, parents, prescribers, communities, and users are prioritized. Strategic Prevention Framework training was completed with the grant sub-recipient, the Bernalillo County Community Health Council, in late 2017. Three new

pilot strategies have been developed for implementation in 2018, as well as training on the administration of the New Mexico Community Survey. The survey was administered in March and April of 2018.

The **Prevention “Partnership for Success”** program, a third five-year SAMHSA-funded grant program, was awarded to BHSD in 2015. Complementing the activities of the SPF-Rx and PDO programs, this funding stream is intended to address underage drinking and youth prescription drug abuse through allocation to county-level consortia and higher education institutions. Allocations to nine provider systems were made in November 2015. These included Chaves, Cibola, Curry and Roosevelt Counties, and the five schools in the NM Higher Education Prevention Consortium (NMHEPC) – New Mexico State, New Mexico Tech, San Juan College, the University of New Mexico, and the Institute for American Indian Arts. Each allocated provider must complete all Strategic Prevention Framework trainings, including coalition development, community needs assessment, community capacity and readiness, strategic planning and evidence-based practices, and evaluation. Strategic Plans were completed by seven of the nine providers in August 2017, and the other two will complete training and strategic planning in 2018. All providers participate in monthly webinars, covering such topics as SAMHSA Community Level Instrument requirements, working with school substance abuse policies, engaging community leaders in prevention activities, and reviewing general prevention resources. Onsite technical assistance visits are also provided.

The **Opioid Crisis State Targeted Response** (Opioid STR) two-year (2017-2019) grant program, also known as the New Mexico Opioid HUB, utilizes additional federal funding intended to increase the number of Opioid Treatment Providers (OTPs) and Office-Based Opioid Treatments (OBOTs), increase the availability of qualified staff and programs to address the needs of persons with Opioid Use Disorder (OUD), and improve access to services for individuals with OUD. This initiative creates a centralized hub and regional spoke model that utilizes the expertise of regional institutions and community agencies already providing services, integrating them with newly trained providers, under the guidance of a centralized training hub at the University of New Mexico (Consortium for Behavioral Health Training and Research – CBHTR) able to coordinate and disseminate best practice efforts statewide. As of April 2018, there were over twenty regional entities participating in the program. The grant also supports prevention activities complementing efforts under the PDO grant program. Also, as of April 2018, trainings have been provided to agencies in sixteen of the twenty-nine STR-targeted counties, reaching nearly 650 individuals and distributing more than 1500 Narcan nasal spray units. Although STR is technically over efforts continue through the above-mentioned State Opioid Response (SOR) grant.

Following a pilot period in early 2016, Opioid Crisis STR federal funds also supported the **PAX Good Behavior Games** (PAX GBG) program. Three school districts – Santa Fe, Espanola, and Bloomfield – were initially trained during the period from March through May 2016 to provide this SAMHSA registry evidence-based program developed

at Johns Hopkins University that teaches self-management skills to students, resulting in a dramatic reduction in disruptive behaviors, hyperactivity, and emotional outbursts in the classroom. Longer term outcomes include reduced need for special education services, reductions in addictions, crime, suicidal ideation and attempts, and initiation of sexual activity, with positive impact on high school graduation rates and college attendance. Eleven school districts implemented this program in the 2017-2018 school year. Initial evaluation data in four of these districts showed a reduction in the rate of disruptive or non-attentive behavior ranging from nearly 60% to more than 78%. The program has now been expanded to include New Mexico tribal groups from the Navajo Nation, Pueblos, and Apache tribal entities, with planning and training currently ongoing.

The **Synar Program**, enacted in 1996, is a federal requirement within SABG intended to prohibit the sale and distribution of tobacco products to people under 18 years of age. Synar regulations require states to pass and enforce laws mandating sales restrictions, conduct inspections to test vendor compliance, establish targets resulting in noncompliance reduction, and submission of an annual report detailing activities to enforce the law. The Synar Program does not establish a dedicated federal funding source for implementation, but does allow the use of funds from the primary prevention set-aside of SABG for carrying out the administrative aspects of the program. SABG funds are not used to fund enforcement of youth tobacco access laws.

The **Federal Drug Administration** (FDA) contracts with BHSD through its Tobacco Inspection unit to provide tobacco retailer inspections statewide. The purposes of this program are to decrease the use of tobacco products by minors and to increase communities' awareness and support for this effort. Combined with the SABG-funded Synar Prevention Program, this program is intended to improve the health of New Mexico residents and thereby reduce the healthcare costs of tobacco use. The contract involves advertising and labeling inspections, and undercover buy activities.

The OSAP is active with the **Prevention Policy Consortium** is a collaboration of state agencies that fund prevention activities throughout the state. The group aims to increase the state's capacity and meet gaps in the current prevention system by leveraging resources and supporting evidence-based practices, quality improvement, cultural competence, and training and technical assistance efforts.

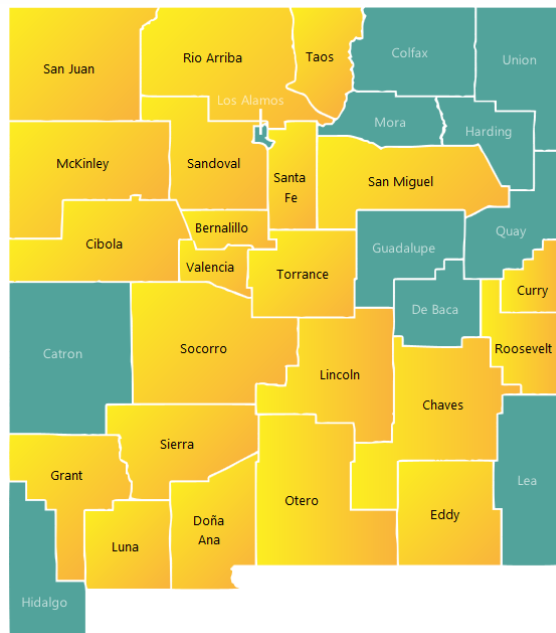
In FY18 a pilot project was implemented provide naloxone upon release in response to NM House Bill 370 mandate, **Naloxone Provision to NM Correction Department (NMCD) and NM Association of Counties (NMAC) Detention Centers**. State general funds were set aside to purchase Narcan and "Naloxone Saves Lives" posters "Stop Overdose Deaths" brochures in Spanish and English. Funds also provided opioid overdose prevention education to the NMCD and NMAC staff and a Train the Trainer module to increase facility capacity to provide Narcan. OSAP providing technical assistance with ordering Narcan, storing the product, training staff and inmates, and conducting outreach to family and friends of inmates. Efforts continue to train staff and supply Narcan.





Additional OSAP supported statewide activities include an annual statewide community survey (New Mexico Community Survey), a substance abuse prevention training system providing 35 training days/year (NM ATODA [alcohol, tobacco and other drug abuse] Prevention Workforce Training System), technical assistance on the Strategic Prevention Framework, coalition building and strategy implementation for providers, overdose prevention education and Narcan training to Tribal communities, and financial support for the Epidemiology and Response Division for the biannual Youth Risk & Resiliency Survey and the Behavioral Health Portal in the online NMDOH Indicator Based Information System (IBIS).

NM HSD OSAP FY19 Prevention Provider Map



Prevention activities<sup>10</sup> are funded in 27 counties. To access counties and what activities are funded click here: <http://www.nmprevention.org/Service-Providers.html#>

## State General Funded Programs

The **Veteran and Family Support Services (VFSS)** program addresses the unmet needs of veterans and their family members who have a primary diagnosis of PTSD or other trauma-related mental health conditions, or a co-occurring substance use disorder.



The BHSD participated in the SAMHSA initiative “Veterans Suicide Prevention Crisis Intercept Mapping and Virtual Implementation Academy”. The Virtual Implementation Academy brought together community, state, and federal stakeholders to develop a Veterans Crisis Intercept Map specific to the Santa Fe community. The facilitated mapping process helped identify and understand local resources and interdependencies to improve prevention, response, and follow-up care efforts for service members, veterans, and their families in crisis. The process continues to evolve as stakeholders continue to meet to identify key action steps to address gaps within the crisis system and implement evidence-based best practices. Attending the Academy enabled State staff to make the necessary connections to collaborate more effectively on veteran initiatives. Examples include but not limited to: **Mayor’s Challenge**, Albuquerque was one of eight cities chosen to participate in the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Department of Veterans Affairs (VA) Mayor’s Challenge to Prevent Suicide Among Service Members, Veterans, and their Families. The goal of the Mayor’s Challenge is to reduce suicides among service members, veterans and their families using a public health approach to suicide prevention; and, **New Mexico Veterans Affairs Healthcare System, Mental Health Summit**, the purpose of the summit is to enhance the mental health and wellbeing of veterans and their family members through increased collaboration between the Veterans Administration and the community. State staff now has the opportunity to attend the Summit in future years.

The BHSD continues to support veteran-focused **Question, Persuade, Refer (QPR)** training throughout the state in collaboration with Straight Scoop for Vets. Straight Scoop for Vets offers free QPR suicide prevention training to veterans and their families. Straight Scoop also offers train-the-trainer programs to sustain trained veterans in providing QPR to the community. In SFY19 trainers funded by BHSD provided the state with an additional 1,500 people completed in the Gatekeeper Training throughout New Mexico. Funding and training is ongoing.

The sacrifices and psychological effects of service members are often incomprehensible to those who have not served in this capacity. It is critical that behavioral health professionals and peer workers understand the issues that may affect veterans and their families. To meet this training need, BHSD partnered with stakeholders to develop and implement the **Certified Peer Support Worker Veteran Endorsement Training**.

The Veteran Endorsement training is a 12-hour, 2-day training targeting Certified Peer Support Workers (CPSW). CPSWs have a unique and critical role as part of the behavior healthcare team. CPSWs have lived through, dealt with, and recovered from substance use and/or mental health issues themselves. They are proof that recovery is possible and are willing to mentor others to achieve similar results.

Criteria for a CPSW Veteran endorsement:

1. Willingness to serve veterans in a non-judgmental and respectful manner.
2. Successfully completing a free one-hour, on-line suicide awareness and prevention training on QPR (Question Persuade and Refer). Training can be accessed at: (<http://qprtraining.com/setup.php>).
3. Complete a twelve-hour, two-day training and scoring an 80% or better on final assessment.
4. To maintain the endorsement, a minimum of 6 Veteran specific CEUs must be completed every 2 years.

The curriculum was piloted twice to an audience of veterans, family members, active military and civilians. Participants stated that they gained a better knowledge of military sexual trauma, posttraumatic stress disorder, and learned about resources available that could help them in their work environments. Overall, the training was well received and the comments expressed appreciation and willingness to recommend the training to a colleague. The curriculum is currently being reviewed by the New Mexico Credentialing Board for Behavioral Health Professionals and final approval is expected in late 2019 or early 2020.

BHSD awarded grants for Veteran services statewide with preference given to areas of the state that are underserved to address the unmet needs of veterans and their families to include: housing, jail diversion and therapeutic support services. The services will be provided to veterans who are 18 years of age or older and their families living with the effects of military service, deployment and coming home. Funding is \$1 million per year for up to four years. Preference was also given to programs located in rural and frontier areas of New Mexico that serve underserved populations, i.e. women, Native Americans, and Sexual and Gender Minorities (SGM); programs that collaborate with other community providers; and/or specialty programs or services that are specifically designed to treat veterans with Post Traumatic Stress Disorder (PTSD). Providers are to deliver services that are founded on the principles and practices of Trauma Informed Care and Recovery Oriented Systems of Care.

BHSD continues to collaborate with outside organizations to reach veterans in rural and frontier areas of New Mexico.

The agencies receiving funding for SFY2020 are: Goodwill Industries of New Mexico, Mesilla Valley Community of Hope, National Veterans Wellness and Healing Center, New Mexico Veterans Integration Center, Not Forgotten Outreach, Horses for Healing, First Nations Community Healthcare, and the Life Link. Proposals for additional services are currently being accepted by BHSD.

Providers addressed one or all or any combination of the services defined below.

1. Housing for veterans or veterans and their families who are homeless or near homeless (i.e. At risk of becoming homeless due to inability to pay rent/mortgage, cover security deposits, and/or to assist with reintegration for veterans recently discharged, or who's current living situation is coming to an end). This may include emergency shelter, regular shelter, transitional housing, long-term or permanent housing. Identifying homeless/near homeless veterans would include, but not limited to, outreach and collaboration with veteran services, housing programs, shelters, community behavioral health and physical health providers, state and local providers serving veterans and/or engaging in street outreach.
2. Therapeutic and Support Services for veterans and their families. Services can be provided to family members exclusive of the veteran to support the family living with the effects of military service, deployment and coming home. Therapeutic services may include, but are not limited to, conducting assessments and providing treatment services, making referrals, coordination of care, equine therapy, children's camps, or retreat activities. Support services may include, but are not limited to, providing food boxes or meals, covering utility deposits or utility bill, transportation assistance to medical/behavioral health appointments and/or to seek housing, employment or other related transportation needs that support the veteran and/or family in healing and self-sufficiency.

**Jail Diversion Services** are intended to divert individuals with a serious mental illness or co-occurring substance use disorder from incarceration and into community-based treatment and support services.

Jail Diversion Services have two tracks:

1. Providers: Establish and maintain a specialized clinical team who will identify, conduct comprehensive assessments and provide the specific behavioral health, medication management and case management services to adults to reduce or eliminate the time they spend in jail by redirecting them from the criminal justice system to community-based treatment and support. Further, providers will assist adults who have been incarcerated to access services upon release.
2. Adult Court Programs: Establish and operate Pre-trial Services Program(s). Hire, train and supervise Pre-trial Service court staff positions meeting minimum qualification requirements. Monitor compliance with court-ordered programs, conditions of release and prescribed treatment services through intensive supervision and case management.

Agencies receiving funding for SFY20 include Susan's Legacy, the 13th Judicial District Court of Valencia and Sandoval Counties, and possibly the Forensic Integration Consortium of Doña Ana County.

During the 2019 New Mexico Legislative Session, \$2.5 million was appropriated to the Human Services Department, Behavioral Health Services Division to carry out the **Intervention Demonstration Project (IDP)** to reduce re-incarceration and homelessness rates, as well as improve reentry services for incarcerated non-violent offenders; specifically, those with behavioral health needs and disorders. The counties designated for the IDP were identified based on consideration of epidemiological data and other source data including alcohol use mortality rates, drug overdose deaths, suicide rates, incarcerations and housing options, as collected by the DOH and New Mexico Association of Counties. Additional consideration was given to counties with evidence of rural character, the likeliness of limited behavioral health resources and other community services needed to address those issues presented by the incarcerated individual.

The IDP will utilize the **Sequential Intercept Model (SIM)** starting with the ideal that individuals move through the criminal justice system in a predictable manner, and there are five intercept points at which interventions can occur. These five intercept points move from pre-incarceration through post release. While interventions that take place at earlier intercept points are more likely to detour incarceration, individuals are still incarcerated.

Funding is intended to support designated communities in their efforts to intervene at the intercept points of incarceration and reentry, for the purposes of: 1) increasing connections to jail based treatments for behavioral health conditions, 2) assisting with transition through broader access to community resources and improved local indigent housing options and, 3) reducing the likelihood of someone reoffending.

**Justice Involved Services** involves working with individuals with an SMI or a co-occurring disorder including a mental health condition and an intellectual or developmental disability (I/DD) when such individuals are at risk of or are already involved with the criminal justice system. Including working with the jail diversion initiative, the program may offer individual and group counseling, intensive coordination of care (both in and outside of jail settings), clinical staffing and presentation of case findings, trainings, and I&R for incarcerated group members. The main goals of this program are to reduce recidivism and the maladaptive use of substances; reunite, strengthen and heal inmate families; and support a successful and sustained recovery-oriented lifestyle.

**Medicaid Enrollment of Inmates** created requirements for correctional facilities and HSD to implement an inmate recidivism reduction transition program through the House Bill 19 Judiciary Committee. As a result, HSD collaborated with the Centennial Care MCOs to develop transition of care guidelines. The Centennial Care MCO established policies and procedures to ensure all eligible members are contacted in a timely manner and are appropriately assessed using HSD prescribed time frames, processes and

tools, to identify needs. The MCO shall coordinate with the discharge planning teams at hospitals and institutions (e.g., nursing facilities, jails/prisons, juvenile detention centers, residential treatment centers (RTC), psychiatric hospitals, behavioral health facilities) to address at a minimum: Need for Home and Community Based Services (HCBS); Follow up appointments; Therapies and treatments; Medications; and/or Durable Medical Equipment.

**Suicide Prevention Services** involves the collaboration of DOH, DVS and other state agencies to reduce the rates of attempted and completed suicides statewide. Current focuses include redesign of the state plan, improving crisis response, targeting services to veterans, and training community partners in the use of QPR and Mental Health First Aide (MHFA).

**LGBTQ Services** support cultural fluency trainings for behavioral health providers working with sex and gender minorities (SGM). These trainings provide best practices in affirming behavioral health services to the SGM population and ongoing consultation with provider systems.

1. New Mexico Community AIDS Partnership leads SGM cultural fluency training for behavioral health providers throughout New Mexico. The training provides understanding of and best practices for providing affirming behavioral health services to the SGM population, and to consult with provider staff regarding implementation of best practices at their organizations.
2. The Transgender Resource Center of New Mexico engages in direct services, advocacy and education. Statewide they provide peer support, information, referrals, legal name change assistance, identity document updates, and trans-specific items plus facilitate eight different support groups and services at their drop-in center. Their advocacy work ranges from individual advocacy to policy work to legislative change. They accompany individual transgender people to medical appointments, name change hearings, and into any other situation where people need help strengthening their voice. They have assisted state agencies and public schools in crafting transgender policy, as well as other entities. In 2019 they were instrumental in getting a bill passed that modernizes the way you change your gender on a New Mexico birth certificate.
3. Santa Fe Mountain Center/The New Mexico Genders and Sexualities Alliance Network (NMGSAN) builds the resiliency, positive identity development, self-efficacy, mental health and empowerment LGBTQ+ youth through peer training and support, and leadership and community development. NMGSAN accomplishes its goals and objectives through Gay Straight Alliance (GSA) club support, trainings, events, education and awareness campaigns and social networking. NMGSAN's primary outcome is for New Mexico schools to be safe and fair learning environments for all students including those who identify as or

are perceived to be LGBTQ+ and protect them from discrimination, harassment, bullying, substance abuse and suicide.

4. The New Mexico Youth Risk and Resiliency Survey (YRRS)<sup>6</sup> is a survey of public high school students (grades 9 - 12) and public middle school students (grades 6 - 8). The survey includes questions about risk behaviors (behaviors contributing to unintentional injury; behaviors associated with violence; mental health, suicidal ideation and suicide attempts; alcohol, tobacco and drug use; sexual activity; and physical activity, nutrition, and body weight) and resiliency (protective) factors.

**Native American Services** focus on providing culturally appropriate health services to this diverse population, including holistic, traditional modes of intervention in therapeutic services, domestic violence, and jail diversion. Native American service providers are: First Nations Community Health Source, Five Sandoval Indian Pueblos, Presbyterian Medical Services-Totah Behavioral Health, Zuni Pueblo-Zuni Recovery Center, Hozho Center for Personal Enhancement/Dine Council of Elders Program and Jemez Pueblo Behavioral Health.

**Adult Forensic Evaluations** are provided pursuant to a court order that supports (1) a finding that a defendant is indigent, and that (2) evidence has been presented to the court which indicates the need for the defendant to be evaluated regarding his or her competency to stand trial. A forensic psychologist and master's level support staff will provide testing, interviewing and a written report that supports a finding of competence or non-competence to proceed with a trial.

The **Transitional Living Services** program provides eligible individuals with emergency, short- and longer-term housing coupled with prevention and intervention activities that emphasize the provision of trauma informed care and recovery-oriented services. Priority populations for these services include Native Americans, veterans, victims of domestic violence or sexual assault, individuals who identify as LGBTQ, homeless individuals, and those involved in the criminal justice system. This program works to assist individuals in regaining permanent independent housing with needed community supports.

**Sexual Assault Prevention, Outreach and Intervention Services** are managed through a contract with the New Mexico Coalition of Sexual Assault Programs. This is a legislatively mandated function and is available to both males and females, regardless of age. Services include provision of an emergency response system, capacity to answer crisis calls from individuals seeking assistance for sexual victimization, intervention and support for victims of sexual assault at the time of crisis in appropriate settings, therapeutic services, and outreach, education, training and advocacy for community systems. Sexual Assault providers are located throughout New Mexico and include: Desert View, Rape Crisis Center Solace Crisis Center, Community Against Violence, and La Piñon Sexual Assault Program.

## Office of Peer Recovery and Engagement (OPRE)

**OPRE** provides consumers of behavioral health services a platform for taking charge of their own recovery. It sponsors and funds consumer-operated wellness (drop-in) centers, and offers a variety of training and educational opportunities. OPRE oversees as well as develops and produces the training materials for the Certified Peer Support Worker (CPSW) program which allows qualified peers to provide Medicaid-billable services, including Comprehensive Community Support Services and Family Support Services.

There are currently five **Wellness Centers** around the state, each partially funded by OPRE. Each Center provides services specific to the needs of the consumer population in its respective area. For example, The Healing Circle Wellness Center in Shiprock specializes in traditional healing practices, conducts traditional coming-of-age ceremonies for men and women, and focuses on Native women's issues. The Inside Out Center in Espanola provides access to clothing, food, help with resume writing and job skills development; referrals for in-patient rehabilitation services, counseling, and other out-patient services. The Mental Health Association in Las Vegas provides discharge planning, access to basic needs, temporary transitional housing and other assistance to those released from NMBHI. The Hozho Center in Gallup sponsors AA and NA meetings and other recovery events, and assists with food, clothing, and job skills development. The Catron County Grassroots Behavioral Health Group in Reserve provides access to phone and computers, and hosts classes. All Centers provide space for consumer support and community meetings.

OPRE also funds two additional programs for veterans that are not wellness centers: the Straight Scoop for Vets program involves a camper/trailer that is taken to various locations where veterans are invited and encouraged to share their concerns, and the Forward Flag program, a veteran drop-in center in Albuquerque.

Under the umbrella of the federal Recovery Oriented System of Care (ROSC) model, OPRE funds **Recovery Communities of New Mexico**. The purpose of this program is "supporting local recovery advocates to improve, empower, and attract their communities to implement recovery initiatives." This initiative develops local partnerships of natural supports, recovery organizations, community service providers and governmental agencies on behalf of individuals and families who seek to start and sustain long term recovery from substance abuse and addiction. These local networks, including prevention and early intervention services, follow the twelve Principles of Recovery in addressing the needs and preferences of the whole person in achieving long term recovery.



## Other Programs

In SFY 2016, the Legislature granted \$1M in annual funding to establish **Behavioral Health Investment Zones (BHIZs)** in high behavioral health need areas of the state. BHIZs were established in Rio Arriba and McKinley Counties, the two counties in New Mexico with the highest levels of mortality caused by a combination of alcohol use, drug overdose, and suicide. Each BHIZ engaged a representative group of individuals and agencies who worked together to create a county-specific strategic plan, following the broad intent to reduce adverse childhood experiences, build development assets, conduct early screening and assessments, improve access to trauma-informed treatment, reduce crime, integrate care, divert individuals with behavioral health issues from ERs and jails, and leverage private funding.

Rio Arriba County created a coalition of providers and advocacy entities that they called the Opioid Use Reduction (OUR) Network, led by the Rio Arriba County Health and Human Services Department (RAHHS). In addition to distribution of Narcan to individuals with an SUD through Network members, a core shared activity across the Network is the use of the Pathways Care Coordination System to provide shared care management to individuals with SUDs who are involved with Network provider agencies. RAHHS is part of a national effort to create a Community Care Coordinators' Learning Network using the Pathways System for managing the care of individuals with Opioid Use Disorder. The collaboration includes the Centers for Medicare and Medicaid Services (CMS) and the Georgia Health Policy Institute at Georgia State University, as well as communities in Washington, Oregon, Georgia, Ohio, and Wisconsin.

Additional activities within the OUR Network include enhanced Crisis Intervention Training (CIT) for Espanola police and Rio Arriba sheriff's deputies. Both law enforcement entities have agreed to participate in a Law Enforcement Assisted Diversion (LEAD) pilot project. A re-entry specialist was hired and placed at the Rio Arriba County Jail. This BHIZ-funded staff person also coordinates Hepatitis C testing of inmates with the Santa Fe Mountain Center and Southwest CARE Center. This project also funds a case manager through Las Cumbres Community Services to coordinate services for pregnant women with SUDs and women with small children. In 2018, RAHHS switched to outcome-based contracts for all agencies receiving funding from the BHIZ program, paying for specific desired outcomes rather than units of service or deliverables.

In 2016, McKinley County developed a BHIZ oversight board, led by the City of Gallup, and including McKinley County, the NWNM Council of Government, the Navajo Nation and Zuni Pueblo. In early 2018, the City of Gallup's City Council approved the creation of an Indigenous Peoples Commission consisting of four Navajo community members, one Zuni tribal member, and one city employee. This commission will advise City Council and the community on matters of cultural diversity, fairness, equal opportunity, and respect for indigenous peoples and cultures.

The McKinley County BHIZ primarily targeted services to the “top 200” protective custody or public inebriation individuals, providing community-based treatment services to individuals with SUDs at the Na’Nihzhoozhi Center (NCI) and residential services at Rehoboth McKinley Christian Health Care Services (RMCHCS). Community trainings in Motivational Interviewing and the Community Reinforcement and Family Training (CRAFT) model, geared to help families assist their members in recognizing the need for SUD treatment, were provided. The City and County have both passed ordinances prohibiting the sale of alcohol before 10:00 a.m. (from 7:00 a.m.). The BHIZ partnership enabled the City of Gallup to successfully apply for an Indian Health Service “Preventing Alcohol-Related Deaths” grant, providing funding for additional treatment and shelter care.

**CareLink New Mexico (CLNM) Health Homes** were first piloted at two agencies in San Juan and Curry Counties in April 2016. Six additional Health Homes were implemented on April 1, 2018, with a seventh starting on July 1, 2018. Through a collaboration with CYFD, two of these Health Homes will use high intensity wraparound services as part of their program offerings for children with an SED.

CLNM Health Homes are funded on a per member per month (PMPM) basis by Medicaid managed care companies for those individuals enrolled in an MCO, and by SGF for those receiving Fee-For-Service Medicaid. The seven newer Health Homes noted above are included in a Medicaid State Plan Amendment with a retroactive go-live date of April 1, 2018.

CLNM Health Homes provide a program or set of services for individuals on Medicaid who have an SMI or SED. Health Homes, at root, provide coordination of behavioral and physical health with family supports and community services such as housing, transportation, job placement and peer supports. Per federal regulation, they must provide six core services:

- Comprehensive care management (including needs assessment & care planning);
- Care coordination;
- Prevention, health promotion and education;
- Comprehensive transitional care;
- Individual and family support services; and
- Referrals to community and social support services.

Health Home members may receive services beyond these core services from another provider of choice, or from their chosen Health Home. The Health Home provider, though, will identify and coordinate all needed services. Eligible providers include:

- Federally Qualified Health Centers (FQHCs);
- Indian Health Services (HIS) hospitals or clinics;

- P.L. 93-638 Tribally-operated hospitals or clinics;
- Core Service Agencies (CSAs);
- Behavioral Health Agencies (BHAs); or
- Community Mental Health Centers (CMHCs).

Providers within these categories who wish to become Health Homes must be Medicaid providers, and meet a detailed set of guidelines that include staffing, service, data, and reporting requirements, in addition to demonstrating the ability to measure and report on specific quality indicators. Interested providers must participate in an application and readiness validation process. Additional detail is contained in the CLNM Health Homes Provider Policy Manual 2017.

The **New Mexico Crisis & Access Line** (NMCAL), operated by ProtoCall Services, Inc. and based in Albuquerque, has been operating since February 2013, providing 24/7 telephonic help, services and support for behavioral health crises. As of April 2018, NMCAL had received nearly 115,000 crisis calls directly and on behalf of the National Suicide Prevention Lifeline, Rio Grande Gorge Bridge suicide prevention call system, and Core Service Agencies throughout New Mexico. This call line has significantly benefited underserved populations, with 62% of its callers not otherwise enrolled in behavioral health care.

NMCAL also operates the **Peer-to-Peer Warmline**, staffed by Certified Peer Support Workers, providing recovery support and guidance. The Warmline incorporated texting capability in January of 2018 to reach those who prefer this contact method. Staff training was provided in 2018 to all crisis line and Warmline staff to improve their ability to provide support for callers with opioid use disorders.

The **New Mexico Behavioral Health Network of Care**<sup>9</sup> (NMNOC) is the official website of the Behavioral Health Collaborative. It can be accessed at <http://www.newmexico.networkofcare.org/mh/>. In addition to news, general information, and documents relating to Collaborative business, provider information, consumer and family resources, and prevention activities, organizations and individuals can now submit requests to post job vacancies, community events, and other public information relevant to those seeking behavioral health services. The site has recently been expanded, too, to incorporate information about opioid use disorders and medication-assisted treatment under the Opioid STR grant/Opioid HUB program. With more than 16,428 monthly visits to the website, the top five keyword searches were substance abuse, depression, housing, health care, and crisis.

Most Viewed:

Home Page: <http://newmexico.networkofcare.org/mh/index.aspx>

Find Services Page: <http://newmexico.networkofcare.org/mh/services/index.aspx>

NM Opioid Hub Page: <http://newmexico.networkofcare.org/mh/content.aspx?cid=4229>

OPRE Page: <http://newmexico.networkofcare.org/mh/content.aspx?cid=8113>

Community Calendar: <http://newmexico.networkofcare.org/mh/calendar.aspx>

The Network of Care website also contains the Aging and Long-Term Services Department for seniors and people with disabilities at <http://www.newmexico.networkofcare.org/Aging>.

**Permanent Supportive Housing (PSH)** has long been a focus of BHSD's state-supported program activities. These efforts, guided early on by a 2007 supportive housing plan for individuals with an SMI or co-occurring SUD, resulted in the Linkages program, a voucher-based permanent tenancy subsidy program jointly administered by BHSD and the NM Mortgage Finance Authority, as well as the creation of Local Lead Agencies (LLAs) to support housing for disabled individuals in new housing partially paid for by federal Low-Income Housing Tax Credits (LIHTC). Additional experience in creating and managing PSH programs was afforded by a SAMHSA grant from 2015 through September 2018, the Housing Supports, Health, and Recovery for Homeless Individuals Grant (HHRHI). This funding continued the focus on providing housing for homeless or precariously housed individuals with an SMI or a co-occurring SUD, but also incorporates/d the use of peers in the recovery model, and combines four evidence-based programs: Permanent Supportive Housing, Supported Employment, Seeking Safety, and Motivational Interviewing. One key output of the HHRHI grant process has been the development of a new Strategic Plan for Supportive Housing in New Mexico: 2018-2023. Written jointly by the Technical Assistance Collaborative and BHSD, the plan was approved by the Collaborative at its January 2018 meeting. It may be accessed in the Behavioral Health Network of Care website, Collaborative section, linked to the Housing Leadership Group subsection.

As previously noted in the Medicaid portion of this Section, a State Plan Amendment to CMS will allow the inclusion of PSH in the Medicaid funding package for Medicaid-eligible individuals enrolled in the Linkages program. The benefit will include pre-tenancy and tenancy sustaining supports provided by peers, and will take effect at the time of implementation of Centennial Care 2.0 on January 1, 2019. The New Mexico Legislature also approved an additional \$100,000 in its 2018 Session to increase support for PSH.

**Screening, Brief Intervention and Referral to Treatment (SBIRT)** services in primary and community health care settings were supported by a SAMHSA grant since 2013. The grant expired at the end of July 2018. SBIRT is a Medicaid-reimbursed service as of January 1, 2019; a direct result of sustainability efforts and outcomes from the SAMHSA SBIRT Grant Award.

The SBIRT program involves universal screening of all patients ages 18 years or older for substance use. By identifying individuals with a substance use disorder (SUD) or at-risk of an SUD, it is the intent of the program to engage these individuals in at least a formal brief intervention during the screening visit, and to refer those in need of additional treatment to appropriate providers in the community. The screening tool

used, the Healthy Lifestyle Questionnaire (HLQ), asks questions from several evidence-based screening documents that focus on substance use, but also includes some dealing with mental health conditions that may indicate depression, anxiety or a trauma history, allowing for referrals to treatment of these conditions, if identified.

The New Mexico **Assertive Community Treatment (ACT)** will establish and certify two new ACT teams in Sandoval and Valencia Counties, both of which comprise rural areas in central New Mexico with limited access to behavioral health services. The population of focus is adults, ages 18 and older, who have a serious mental illness and are at risk of homelessness, substance use, criminal justice involvement, increased hospitalizations and emergency care or mortality. New Mexico expects to serve 90 individuals with this ACT expansion. ACT is funded by a federal SAMHSA Grant Award, through September 2023.

**Community Engagement Teams** utilize community outreach to engage and link a person with a serious mental disorder or illness who is unlikely to live safely in the community to voluntary treatment and other services; to reduce the rate of intervention by law enforcement, involuntary hospitalization or incarceration through early outreach to prevent or lessen the mental deterioration of persons with a serious mental disorder or illness who are unlikely to live safely in the community; and to lessen the duration and severity of a mental disorder or illness of persons with a serious mental disorder or illness that are unlikely to live safely in the community through early detection and targeted intervention.

The New Mexico **Treat First**<sup>7</sup> clinical model of care is an innovative approach to behavioral health clinical practice improvement. The organizing principle is to ensure a timely and effective response to a person's needs as a first priority. It is structured to achieve immediate formation of a therapeutic relationship while gathering needed historical, assessment and treatment planning information over the course of a small number of therapeutic encounters. One of the primary goals has been to decrease the number of members that are "no shows" for the next scheduled appointment because their need was not met upon initial intake.

In January 2019, the Treat First Program moved from its pilot initiative status to Medicaid policy. It has been incorporated into the 2019 Medicaid Supplement and Behavioral Health Policy and Billing Manual. Fourteen agencies providing services in 54 locations received Certifications of Acknowledgement as Treat First Agencies.

A dedicated website was launched by the providers from the Treat First Learning Community to share guidance on the purpose, benefits and guidelines for implementing the Treat First Approach [www.treatfirst.org](http://www.treatfirst.org).

**Crisis Triage Centers (CTC)** are intended to provide stabilization of behavioral health crises, including short-term residential stabilization. A CTC is a health facility that is licensed by the DOH with programmatic approval by BHSD and CYFD. The CTCs provide stabilization of behavioral health crises and detox management, either in a 23-

hour outpatient or a 24/7 short-term residential setting. They will provide emergency behavioral health triage, evaluation, and admission, on a voluntary basis. The CTCs may serve individuals 14 years of age or older who meet admission criteria. The DOH adopted all official rules for licensing a CTC. The new Medicaid behavioral health rule and Behavioral Health Policy & Billing Manual that includes standards, guidance and payment mechanisms for services provided by CTCs was adopted through Supplemental process in January 2019. The Supplement is being developed as temporary supplement to official rule until rule promulgation is final in Fall 2019.

### **Capacity Building**

The BHSD created new capacity building positions to carry out the goals within the 2015 Strategic Plan. The positions are, **Workforce Development Coordinator, Disabilities and Social Services Coordinator, and Justice Liaison.**

The Workforce Development Coordinator develops, implements and maintains the Workforce Development Strategic Plan. This includes strategies to increase interest, graduates, and employment in Behavioral Health Services for the State of New Mexico. This position requires partnering with BHSD Bureaus, as well as their extended external partners who operate a variety of behavioral health services statewide. Additionally, partnerships with higher education institutions and their leaders is key to implement opportunities that are of mutual benefit to the students, the behavioral health provider network, and those in service. Implementing an Internship Program this position also oversees the Internship program that resides under the Behavioral Health Collaborative.

The Disabilities and Social Services Coordinator is the point of contact for state-wide programs that serve those with disabilities and special needs including; severe mental illness, handicap, and/or Autism. This position coordinates with other BHSD program managers to leverage efforts and maximize opportunities that impact consumers.

The Justice Liaison develops and implements programs that address the behavioral health needs of those citizens that are justice involved.

### **Internship Program**

The goal of the Internship Program to develop the future New Mexico workforce for those pursuing degrees in behavioral health fields. The BHSD/BHC partners and provides real-work experiences for students and doctoral appointees pursuing degrees in behavioral health fields. Internships provide meaningful exposure and much needed networking and resources to be ready for jobs as future health care providers. Partnering with higher education institutions, and health care agencies ensures that graduates are work-ready and have a strong understanding of quality tools and skills, hands-on experience along with their education to confidently enter the workforce.

## Medical Detoxification

The state continues efforts to increase capacity for evidence-based, medically-managed detoxification in community hospitals. Training continues within hospitals across the state.

## Bed Registry

The BHSD is collaborating with the DOH to fund and establish a substance abuse bed registry, utilizing software developed by OpenBeds®. The OpenBeds® software streamlines the referral process and enhances the ability to match patients with appropriate and available resources. The patient referral process ultimately improves through an immediate and accurate inventory of available resources and wait times, coupled with the efficiency of an electronic referral process. BHSD's Transformation Transfer Initiative (TTI) grant funding will enhance the registry adding a *psychiatric bed module*, allowing support for a comprehensive behavioral health bed registry. The TTI funding will also be utilized to pay for the psychiatric bed component of the OpenBeds® software subscription services, which will include administration, monitoring, data collection, and training. The primary goal is to make the OpenBeds® software available to NM providers, ensure function, show effectiveness, and support sustainability.

## Efforts to Reduce Stigma

**A Dose of Reality<sup>8</sup> – Stop the Stigma: Prescription Drug Abuse/Naloxone Media Campaign** is a statewide media campaign to raise awareness and to educate teens and their parents about the serious risks for addiction and overdose from prescription painkiller abuse. By April 2016, 64 million Dose of Reality ad impressions had been viewed across TV, internet, digital boards, billboards, news print, and movie theater ads. Two websites provide the media materials free for public use: <http://www.nmprevention.org/Dose-of-Reality/Home.html> and <http://doseofreality.com>. Included are education materials, a parent resource kit, fact sheets, and recent state and national epidemiological data.

**Behavioral Health Week in New Mexico:** Each year, the Behavioral Health Planning Council (BHPC) and the BHSD sponsors a multi-day event that includes a celebration at the New Mexico Legislature with a Declaration of “**Behavioral Health Day**”, training, networking, and collaboration. On Behavioral Health Day at the Legislature, Behavioral Health “Stars” are recognized for their efforts on behalf of the behavioral health community in New Mexico.

The Stars event honors individuals or programs from local communities as well as others from around the state that deserve to be recognized for their work in behavioral health, either on a personal level or community wide level. At the ceremony, individuals and programs from throughout the state are honored as champions of behavioral health services in their local communities. The Stars receive certificates of appreciation signed by the Governor of New Mexico and the CEO of the Behavioral Health Collaborative.

Behavioral Health Day provides the opportunity for legislators to meet the Stars, which have been pivotal in their communities' grassroots efforts surrounding behavioral health. Introducing legislators and the public to the faces and voices of individuals living and working in the behavioral health world helps educate the wider community, which breaks down barriers in reducing the stigma often associated with behavioral health, another common obstacle in the lives of those who struggle with these illnesses.

In addition to the recognition of individual Stars, part of the purpose of Behavioral Health Week is to educate and inform others about mental and substance abuse illnesses and to encourage those who struggle with behavioral health issues to find help to continue their journey.

Each year the State Capitol Rotunda is filled with over 200 participants who represent individuals living with a behavioral health condition, families, advocates, friends, and providers from frontier, rural, urban, and tribal communities across the state.

**Senior Jubilee:** One of the innovative programs funded by the Office of Peer Recovery and Engagement (OPRE) is the Senior Jubilee Program.

#### Senior Jubilee Mission Statement

- **Building** a strong voice for senior health services in culturally diverse rural communities.
- **Enhancing** senior-to-senior and senior/professional interaction by partnering with local, county, and state level agencies, churches, higher education institutions, the medical community, and other interested community individuals and organizations.
- **Increasing** health literacy in staying well and staying safe.
- **Strengthening** communication pipelines and networks by encouraging participation with speakers from all levels of government agencies, institutions, organizations, and businesses.
- **Reducing** stigma related to behavioral health issues.

According to the National Institute on Drug Abuse, "the social and physical changes that accompany aging may well increase vulnerability to drug-related problems."

In addition, senior citizens commit suicide at higher rates than any other age group, especially for men over the age of 65. New Mexico's suicide rate has consistently been more than 50% higher than the national average for all age groups (New Mexico Department of Health).

The Senior Jubilee concept was specifically designed by a rural New Mexico resident to celebrate seniors while building a strong voice for rural and senior health services and increasing health literacy. The Jubilees are building new networks of communication



and socialization for seniors, as well as communication pipelines between local, county, and state levels. This is difficult as 85% of New Mexico counties are designated rural or frontier. The great distance between towns and villages hampers communication and networking for our rural residents, especially for our seniors and elders who often have mobility, transportation, and communication limitations.

The Senior Jubilees celebrate seniors, honoring their unique contributions and collective wisdom, while educating them on the risks of behavioral health disorders by including handouts on substance abuse and mental health topics. Speakers address many health topics focusing on ***The Eight Dimensions of Wellness: Occupational, Environmental, Social, Financial, Intellectual, Spiritual, Emotional and Physical***. A whole health approach is less intimidating for older adults, and serves to reduce stigma around behavioral health issues. These events strengthen connections between different levels of government and seniors by “taking the city to the country” with quality programs packed with health information. The program strives to be culturally competent, focusing on the needs of the community being served.

### **Youth Summits**

Polysubstance misuse is an increasingly difficult challenge youth in New Mexico. According to the 2017 New Mexico Youth Risk and Resiliency Survey, 6.9% of New Mexico high school students report currently using painkillers to get high, 2.8% report current heroin use, 10.9% reported binge drinking, and 20.7% reported drinking alcohol before the age of 13 (<http://youthrisk.org/>). The goal of Youth Summits is to reduce stigma and educate youth, parents, and community members about the factors that contribute to the development of substance use disorder, and how to prevent overdose and seek help.

#### NM Youth Summit Mission Statement

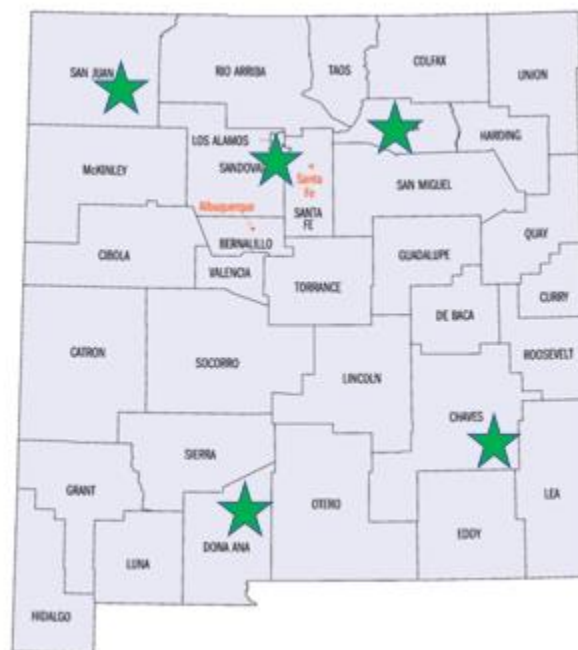
- **Building** a strong youth voice for substance abuse in culturally diverse communities.
- **Strengthening** communication between youth-to-youth and youth-to-professionals.
- **Increasing** youth engagement to be part of the solution.
- **Promoting** the benefits of a healthy lifestyle.
- **Fortifying** youth and families with knowledge and skills to prevent and respond to problematic substance use.

The New Mexico Human Services Department-Behavioral Health Services Division in collaboration with DEA 360, New Mexico Children Youth & Families Department, New Mexico Public Education Department and New Mexico Department of Health will host numerous regional Youth Summits in Fall 2019.

The focus of the regional summits will be based, in part, on youth-identified health risk issues for each region. Each regional summit's agenda is data-driven to reflect the most pressing health risk needs for a given region. Centered on promoting capacity to prevent and respond effectively to problematic substance use among youth, the events will educate, inspire, and engage area youth to be part of the solution to the growing epidemic.

The events, open to all students in grades 6-12, will include general assembly presentations, workshops to increase knowledge and skills toward problematic substance use prevention, storytelling from peers with lived experience, recognition of loved ones lost to substances, and a presentation by Jim Wahlberg, Executive Director of The Mark Wahlberg Youth Foundation with a showing of the film *If Only*. Providers are invited to exhibit at the venue to offer resource material to students, parents and community members.

### Youth Summits 2019



### Recovery Communities of New Mexico Social Media Presence

Social media is an undeniable force in today's world. When used strategically over time, social media is the most powerful and widespread marketing platform our world has yet to see. As a strategic method for promoting and cultivating a recovery movement and a recovery-oriented system of care (ROSC) among the Land of Enchantment, Facebook has proved fruitful in carrying the Recovery Communities of New Mexico (RCoNM) message. Recovery from mental illness and substance use disorders today is still highly stigmatized, leaving the vulnerable isolated and alone. Gathering communities, followers,

advocates, Peer Support Workers and behavioral health providers through a digital platform, allows RCoNM to promote a message of hope, encourage connections with others in recovery, and inspire those needing to hear positive words. In just under two months, the Recovery Communities of New Mexico Facebook page has garnered 249 page followers, acquired 4,124 post engagements, and in the last 28 days alone, our content and logo has reached over 15,357 people. We are gaining momentum and presence in New Mexican lives and many are responding to our content with gratitude and praise; we are making a positive difference! In time, we envision the Recovery Communities of New Mexico Facebook page reaching every New Mexican who is managing a behavioral health condition and those recovering from any and all conditions. We hope to empower the marginalized, give a voice to the vulnerable, and carry a message that prevention works, treatment is effective, and recovery is possible!

Recovery Communities of New Mexico Facebook Insights as of 8/19/2019

Total Page Followers	Post Engagements	Post Reach	Events Responses
332	7,665	29,096	187

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Recovery Month events are sponsored by **Recovery Communities of New Mexico (RCoNM)** every September. Recovery Month events strengthen local and community partnerships, support natural partnerships, and build relationships among recovery organizations, community service providers, and governmental agencies on behalf of individuals and families who seek to start and sustain long term recovery from substance abuse and addiction. The events focus on prevention and early intervention services, address the needs and preferences of the whole person in achieving long term recovery. These events are vital to linking people to services and supports to sustain long-term recovery throughout New Mexico.

#### RCoNM Sponsored Recovery and Community Events 2019



**Mental Health First Aid** is included on SAMHSA’s National Registry of Evidence-based Programs and Practices (NREPP). It is an 8-hour course that teaches participants how to identify, understand and respond to signs of mental illnesses and substance use disorders. The training gives them the skills they need to reach out and provide initial help and support to someone who may be developing a mental health or substance use problem or experiencing a crisis.

Mental Health First Aid trainings are conducted throughout New Mexico by partner BHSD organizations including but not limited to Life Link, New Mexico Crisis and Access Line and the Centennial Care Managed Care Organizations.

## **Certified Peer Support Worker Specialty Endorsements**

The **Veteran Endorsement** training is a 12-hour, 2-day training targeting Certified Peer Support Workers (CPSW). The curriculum was piloted twice to an audience of veterans, family members, active military and civilians. Participants stated that they gained a better knowledge of military sexual trauma, posttraumatic stress disorder, and learned about resources available that could help them in their work environments. Overall, the training was well received and the comments expressed appreciation and willingness to recommend the training. The curriculum is currently being reviewed by the New Mexico Credentialing Board for Behavioral Health Professionals.

The **Certified Older Adult Peer Specialist (COAPS)** training is specific to older adult mental health issues for Certified Older Adult Peer Specialists. COAPS is designed to teach CPSWs how to work with older adults who have behavioral health problems and addresses a myriad of topics related to physical and mental health in older adults including normal aging, cultural competence, anxiety, depression, trauma, substance use, stages of change and more. The program was developed by the University of Pennsylvania, School of Medicine, Department of Psychiatry. The curriculum and endorsement approval is currently being reviewed by the New Mexico Credentialing Board for Behavioral Health Professionals.

The **New Mexico Peer Endorsement Supportive Housing Program** was developed by the Life Link Training Institute with support from the Behavioral Health Services Division and the Office of Peer Recovery and Engagement. The curriculum and endorsement approval is currently being reviewed by the New Mexico Credentialing Board for Behavioral Health Professionals.

The three-day training educates and trains health care professionals specifically CPSWs on the principles of supportive housing; how to deliver effective supportive services to find, get and keep housing; providing a range of service options and approaches; the unique contributions of using peers with housing expertise; how to access subsidized housing; housing models and housing programs; roles and responsibilities of service providers, property managers and local lead agencies; practical housing tools and interventions; an overview of Comprehensive Community Support Services (CCSS) and its use in supportive housing service delivery; guidance for tenancy issues and the eviction prevention process and negotiating requests for reasonable accommodations and modifications.

## **Children, Youth, and Families Department**

### **Behavioral Health Services**

A review of the list of Medicaid-paid services shows that most publicly funded behavioral health services provided to children and youth are reimbursed by this source of funding. These include services provided in community-based programs as well as

higher level services in hospitals and juvenile justice programs, including Sequoyah Adolescent Treatment Center in Albuquerque, administered by DOH. Listed below are additional programs managed by CYFD/BHS that are not funded by Medicaid.

BHS funds **community-based behavioral health services** to reduce or ameliorate the symptoms of a diagnosed substance abuse or mental health disorder for non-Medicaid-eligible children and youth under the age of 18 years (or a person between the ages of 18 and 21 years who received CYFD services by their 18<sup>th</sup> birthday). Non-Medicaid funds are intended for services to individuals not covered by Medicaid, and those who do not have commercial insurance or any other source of funding.

**Activity therapy** services build social competencies, positive values and positive identity development to increase resiliency of youth, and prevent, reduce or ameliorate behavioral health symptoms. Approved services such as equine-assisted therapy and experiential wilderness education engage individuals in learning social skills to enhance their level of functioning, moving them towards self-sufficiency.

**Attachment Healing** is a community-based behavioral health service that supports the development of positive, nurturing and safe relationships between children/youth and their caregiver(s).

**Juvenile Forensic Evaluations** establish a juvenile's competency to participate appropriately in legal proceedings when issues such as mental illness, diminished cognitive abilities, or severe learning disabilities are noted.

**Gender Specific Services** address the unique needs and experiences of individuals who identify as a specific gender.

**Infant/Early Childhood Mental Health Services (IECMH)** provide an array of therapeutic and developmental services designed to reduce both the acute and chronic behavioral, social and emotional disorders and disruptions in the relationship between an infant and parent (or primary caregiver).

**Maternity Programs** provide supportive housing and behavioral health services to young mothers.

**Multisystemic Therapy (MST)** is an intensive home, family, and community-focused treatment for youth with serious antisocial behavior and their families. MST has been shown to reduce the youth's criminal offending, out of home placements, and behavioral health issues and to improve family functioning.

**Shelter Care (Facility and Family-Based)** provides immediate, short term, overnight care for children and adolescents up to the age of eighteen years of age. Services are provided in a 24-hour supervised facility with trained staff or in a licensed foster care home.

**Transitions** is a supportive housing program designed to provide rental subsidies and supportive services for transition age youth, ages 18-21. The program is based on the

Housing First model. CYFD's model was adapted to meet the needs of transition age youth.

The purpose of **Youth Support Services (YSS)** is to promote wellness for all New Mexico children, and to help NM youth steer a course towards a healthy adulthood, free of substance use disorders or unrecognized and untreated mental health disorders. YSS provide experiential and developmental supports intended to replace or enhance natural support deficits.

In addition to these programs, BHS manages the **Adolescent Substance Abuse Reduction Effort (ASURE)**, using a combination of state and federal funds. The ASURE Team, working with transition-aged youths ages 12-21 years, helps develop workforce skills, expand access to community services, and reduce the consequences of unaddressed trauma, substance use and mental health issues or disorders. More recently, CYFD received a SAMHSA grant add-on to ASURE that supports treatment implementation activities (ASURE-TI). This grant allows statewide trainings in CRAFT, Motivational Interviewing, GAIN-SS, ASAM assessment and placement criteria, and Youth Support Services life skills.

BHS is implementing the **Child and Adolescent Needs & Strengths (CANS)**, a multi-purpose information integration tool that is designed to be the output of an assessment process. The purpose of the CANS is to accurately represent the shared vision of the child/youth-serving system, children and youth and families. CYFD created an algorithm to have the CANS generate an Adverse Childhood Experience (ACE) score for youth based on a subset of twenty trauma questions in the CANS. CYFD has begun collecting ACE scores for the individuals served by state-funded services.

**Adolescent Intensive Outpatient (IOP)** substance use treatment provides services for individuals who suffer from drug and alcohol use disorders, or a co-occurring disorder, who do not meet the clinical threshold for residential treatment or medically supervised detoxification, but whose disorder is too complex for effective management in a traditional outpatient treatment setting. There are 14 providers, statewide, who are approved by Medicaid to deliver Adolescent IOP services. These programs take place in a variety of settings, from in a school classroom, to outpatient providers, to a residential program for homeless youth.

A key activity of BHS, one of five strategic planks of the division, is **High-Fidelity Wraparound**. This complex set of activities involves designing and developing care management entities for children and youth with Serious Emotional Disturbances (SED) using a training and coaching model that includes intensive care coordination and peer-to-peer supports. Participants in this process will be able to function independently as a Wraparound Facilitator, certified by the NM Credentialing Board for Behavioral Health Professionals. CYFD is implementing the NM Wraparound CARES model through a pay-for-performance demonstration project at selected Care Link New Mexico Health Homes.

The **Family Peer Support Worker Program** is a supportive service. Certified Peer Support Workers and Certified Family Peer Support Workers assist family members of youth suffering from substance use disorders and behavioral health concerns.

**PullTogether** is a community engagement initiative intended to bring all New Mexicans together to truly make a difference in the lives of our children, and make New Mexico the best place to be a kid.

Through PullTogether, New Mexicans in need can find resources available through state and local agencies, businesses, and nonprofits, such as where to find low-cost child care assistance, free summer meals, substance abuse and behavioral health treatment and services, and tips on how to keep children safe.

PullTogether also serves as a resource for New Mexicans who want to make a difference in their community. Whether through adopting or fostering a child, donating a backpack to a child in need, reporting child abuse or neglect, or even applying for a job at CYFD.

## Department of Health

### Public Health Division

#### **School-Based Health Centers (SBHC)**

SBHCs are overseen by the Office of School & Adolescent Health (OSAH). OSAH's program goals for SBHCs include delivery of integrated health care services, reduction of youth suicides, support for high quality school nursing and school behavioral health, and promotion of Positive Youth Development. Services are provided in a confidential, youth-centered setting where coordination between school and health systems allows for health education and promotion. 94% of OSAH-supported SBHCs are in Health Professional Shortage Areas. 48% of students receiving services at an SBHC during the 2016-17 school year reported that this was the only place they received health care services that year. Community partnerships allow for specialty focuses in SBHCs on pregnant and parenting teens with an emphasis on young fathers, establishment of SBHCs as Safe Zones for LGBTQ teens, training in the use of long-acting, reversible contraceptives, and recognition and treatment of substance use by adolescents.

All SBHCs are required to provide screening and early identification of behavioral health needs, including depression, anxiety, substance use and suicide risk. More than a third of all visits to SBHCs deal with behavioral health concerns. OSAH provides advanced training for all SBHC medical and behavioral health providers on the warning signs, prevention and intervention of youth suicide.

Positive Youth Development (PYD) programs use a strengths-based, resiliency-focused approach to engaging youth in their schools and wider communities. Civic engagement, service learning, program planning, and community development activities are all



supported by youth-adult partnerships, and the Youth Peer-to-Peer Network (in 30 communities around the state).

### **Harm Reduction Program**

This program, established in 1997, has three primary goals: reducing the transmission of infectious disease among persons who inject substances, reducing unintentional overdose deaths related to opiate use, and reducing substance abuse through acu-detox intervention. The Syringe Services Program (SSP) focuses on the exchange of used syringes and other drug paraphernalia and the education by DOH staff and community partners of individuals on risk reduction, safer injection practices and overdose prevention. This program is one of the largest in the nation, collecting approximately 6.75 million used syringes each year. Although New Mexico has less than 1% of the total national population, the SSP represents 7-8% of the total number of syringe exchanges nationally.

The Overdose Prevention Program helps opiate users to recognize and respond to an overdose, and provides these individuals with naloxone and training in its use.

Acu-Detox Treatment is an ear-focused acupuncture procedure that assists in detoxification of substance use and reduction of the desire for re-use. It is offered as an on-the-spot treatment in the course in interaction with impacted individuals.

### **Refugee Health Program**

Funded through a grant from the federal Office of Refugee Resettlement and a services agreement with HSD, utilizing no state general funds, this program provides health screenings and mental health assessments for newly arrived refugees within 90 days of arrival in New Mexico. It is intended to prevent transmission of communicable diseases, and to ensure health care follow-up for conditions impacting these individuals. Mental health services are offered to all newly arrived refugees, and ongoing mental health education and training are provided. Refugees may receive assistance in stress management and self-care, as well as in developing coping skills for adjusting to a new culture with all the physical, social, psychological and spiritual changes associated with relocation. Providers are given training in assessing and treating health and mental health conditions that can exist among people displaced by extreme hardship, war, and human rights abuses. Interpretation and translation services are also provided, needed by 86% of individual refugees during initial domestic health screening.

### **Hepatitis Program**

Current estimates suggest that as many as 55,000 residents of New Mexico are living with the hepatitis C virus (HCV). The state has the highest rate of death due to chronic liver disease and cirrhosis in the country, at nearly 25% higher than any other jurisdiction. 44% of all incarcerated persons have HCV. Highest risk of the disease is

among injection drug users, gay or bisexual men, foreign-born individuals, and those who have been incarcerated. In addition to testing and vaccination in Public Health offices and partner sites, this program has started an innovative demonstration project that links surveillance with both prevention and linkage to care. Prevention education and risk reduction counseling form a core service activity, occurring not only in Public Health Offices, but within correctional and county detention staff and substance use treatment providers.

### **Tuberculosis Program**

The Tuberculosis Program serves people infected with tuberculosis, contacts of active tuberculosis cases, public and private healthcare providers throughout New Mexico, and the general public. The Program purpose is to prevent and control the spread of tuberculosis, by ensuring that active tuberculosis cases receive adequate care, directly observed therapy, and a contact investigation if infectious. Other important program activities are: case management of all active cases; interstate/international referrals; surveillance; training for healthcare workers and other stakeholders; and screening to identify and treat Latent Tuberculosis Infection (LTBI).

The BHSD as the principal agency for the SABG works with the DOH Tuberculosis Control Officer to implement infection control procedures and establish linkages with other health care providers to ensure that tuberculosis services are routinely made available.

The BHSD administration of the SABG funding and provider requirements to provide tuberculosis services to individuals with substance abuse issues are as follows:

- Offer education and information;
- Provide screening, testing or referral for testing and;
- If indicated, referral for treatment services to a public health office.

The providers document the number of individuals referred for testing and/or treatment to BHSD on a quarterly aggregate report. The providers are required to maintain a quality assurance process that provides, manages, tracks, evaluates, and reports the routine screening and testing or referral for testing and/or treatment of those consumers who are infected or at risk of infection with tuberculosis *and* HIV, Hepatitis C, or sexually transmitted diseases.

BHSD collaborates with the New Mexico Department of Health/Public Health Division staff and its statewide network of public health offices to test and provide follow-up with any needed TB treatment to consumers referred by the behavioral health providers.

### **Developmental Disabilities Supports Division**

The Bureau of Behavioral Support (BBS) is the unit within DDSD that most directly focuses on and promotes the behavioral, emotional, and social well-being of the individuals and their support systems served by this Division of DOH. It administers

several statewide programs through provider agency contracts, including crisis response, positive behavioral supports, and sexuality supports for individuals on the DD Waiver and those who are eligible for the waiver but are on the (lengthy) waiting list and therefore receiving state general funded services.

BBS staff are primarily consultative and training specialists. There are behavior and crisis specialists in each of the five regions, with supervision provided by a Statewide Crisis Coordinator and Clinical Director. Within each region there is one or more provider agency trained by BBS staff to provide crisis response in the counties of that region. The role of BBS staff can include direct staffing, mentoring, observation and assessment of crisis response staff (CRS) in specific cases. For Waiver recipients, crisis interventions may result in short-term alternative residential settings for up to 180 days. The Crisis Response Team is accessed through the Statewide Crisis Line @ 505-250-4292.

Behavior supports include a continuum of services, including behavior support consultation by trained provider agency staff members, preliminary risk screening and evaluation by a trained and licensed mental health professional, and socialization and sexuality education to individuals with I/DD.

All training is governed by the Developmental Disabilities Waiver Service Standards and additional DDSD Policies.

## **Department of Finance & Administration**

### **Local DWI Program**

The LDWI Program Guidelines document spells out in detail the eight service categories from which each county program must select, as appropriate to their local needs, and the activities within each that must occur. Each category will be briefly detailed below.

#### **Prevention**

Prevention activities funded by LDWI must focus specifically on preventing DWI and/or alcohol abuse. These funds may be broadly used to support planning, implementation and evaluation of local prevention programming, including staff development leading to certification as a Prevention Specialist. Prevention programs must be evidence-based or carefully (and temporarily) documented as a promising practice. Utilizing a promising practice requires prior written approval from LDWI Program leadership at DFA, and may continue for no more than three years, after which the program must be able to document its evidence basis or modify its prevention activities using an established modality.

County LDWI programs are expected to conduct an annual assessment of prevention needs. If another local organization or coalition has completed an assessment that meets LDWI program criteria, the county DWI program may submit this document. All prevention programming must have a formal evaluation component, whether through an

external contract or one managed internally. It is strongly recommended that a Certified Prevention Specialist provide oversight of the planning and evaluation processes.

### **Law Enforcement**

LDWI program funds may be used to pay for overtime by local officers to support enhanced sobriety checkpoints and saturation patrols, warrant roundups, and activities targeting underage drinking. Some equipment may be funded, with prior approval by LDWI, although law enforcement entities are encouraged to explore other funding sources prior to using LDWI funds. With appropriate justification, full-time DWI law enforcement officers may be hired with these funds.

### **Screening**

Per statute, every New Mexico court must have a universal, mandatory screening program for all individuals convicted of a DWI. Screening and tracking programs serve two main purposes: (1) to determine if a convicted individual needs active substance use treatment, and (2) to track sentencing requirements and their completion and to assist compliance monitors in probation compliance monitoring. Each county must use the DFA-approved screening program which includes a specific screening tool (ADE, Inc.), and may include additional screening tools. To the extent possible, screening programs should be self-funded through assessment of a fee to each offender. Generally, screening programs should be separate from any treatment provider to avoid conflicts of interest.

### **Treatment**

Program funds may be used to contract with outpatient and/or jail-based treatment providers for services that “intervene and address DWI, alcohol problems, and alcohol dependence, alcoholism or alcohol abuse.” Treatment providers may be on staff at a county DWI program or contracted externally, but must be appropriately licensed and able to provide evidence-based services.

### **Compliance Monitoring and Tracking**

There are complicated requirements and limitations for including a compliance monitoring program within LDWI-funded programming. Compliance monitoring is defined as the gathering of data directly from an offender, and per statute, may occur only for misdemeanor convictions in magistrate and district courts for driving while under the influence of liquor or drugs (and related offenses). Since LDWI programs pay only for the management of alcohol-related offenses, compliance monitoring programs may not serve those with purely drug-related offenses. All compliance monitoring programs must integrate with statutorily-mandated screening programs, and per statute must comply with guidelines established by the Administrative Office of the Courts. Fees may be charged for offender participation in a compliance monitoring program, and all fees must be used solely to support the program. Compliance monitoring is not a mandated component of county programs.

Tracking, in contrast, is defined as the gathering of information about an offender from third-party sources such as probation officers or other monitors, court staff, and websites. All court-ordered sanctions for all DWI offenders (not just misdemeanor convictions) must be tracked in the screening program database. Tracking is intended to “record an offender’s progress in the screening and tracking system from time of sentencing through completion of all sentencing requirements.”

### **Coordination, Planning & Evaluation**

This component pays for professional management and oversight of all local DWI program activities, including budgeting, funding requests, meeting all reporting requirements, evaluation of program progress and impact, staffing the Local DWI Planning Council, and attending DWI Grant Council meetings.

### **Alternative Sentencing**

LDWI funding may be used to support alternatives to incarceration, especially teen courts and adult DWI courts, but also devices and activities such as electronic monitoring, alcohol monitoring devices, community custody and community service. There is a limit on the amount of grant funds that may be used for teen courts, and they must adhere to DFA’s Juvenile Adjudication Fund Guidelines. DWI courts must conform to AOC problem-solving court guidelines. Teen court prevention activities, commonly mandated, must be budgeted through the prevention component and meet prevention program requirements.

### **Alcohol-Related Domestic Violence**

CYFD oversees Court-Ordered Domestic Violence Offender Treatment or Intervention Programs (DVIP). LDWI program funds may be used to supplement county DVIP programs, but only to support alcohol-related domestic violence offenses.

### **Alcohol Detoxification Grants**

Funded separately from county LDWI programs, the Alcohol Detoxification Grants program generally funds social detoxification and treatment facilities and community programs. In 2018, six county programs received this funding. These alcohol detox programs will pay for up to ten days of residential social detoxification, followed by out-patient treatment services. Clients of these programs do not have to be charged with or convicted of a DWI to be eligible for services, and may self-refer or be referred by any professional or personal concerned party.

While these funds are intended for social detox, without on-site medical staff, grantees wishing to provide medical detoxification services based on local need may petition LDWI staff and the Human Services Department for permission to pay for the creation of a medical detox program. Grant monies may be used to fund facilities, equipment, services and general operations, as well as professional staffing. The purchase of real estate and vehicles is permitted with the prior written approval of DFA.

## Administrative Office of the Courts

### Problem-Solving Courts

Problem-Solving Courts include both adult and juvenile program types and are identified by specialty and number in Section 2. These programs, regardless of type or age range, are governed by the New Mexico Drug Court Standards Manual, adopted in October 2016. These standards constitute evidence-based practices as promulgated by the National Association of Drug Court Professionals (NADCP) and consist of the Ten Key Components of Drug Courts detailed in the Adult Drug Court Best Practice Standards, Volumes 1 & 2, adopted in their most recent form in 2013 (<http://www.nadcp.org/Standards>). Application of these components and implementation of these standards are overseen by the New Mexico Drug Court Advisory Committee through the Statewide Drug Court Coordinator. The Ten Key Components will be briefly identified below, followed by a brief discussion of strategies specific to juvenile drug courts.

#### Key Components

1. Drug courts will integrate alcohol and other drug treatment services with justice system case processing.
2. Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.
3. Eligible participants are identified early and promptly placed into the drug court program.
4. Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.
5. Abstinence is monitored by frequent alcohol and other drug testing.
6. A coordinated strategy governs drug court responses to participants' compliance.
7. Ongoing judicial interaction with each drug court participant is essential.
8. Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.
9. Continuing interdisciplinary education promotes effective drug court planning, implementation and operations.
10. Forging partnerships among drug courts, public agencies and community-based organizations generates local support and enhances drug court program effectiveness.

The Manual provides descriptive and even prescriptive details for each of these components, guiding program design, implementation, and evaluation. In addition, appendices provide program information on important topics that include performance measure definitions and business rules, probation/surveillance officer policies and procedures, confidentiality, how to deal with violent offenders, minimum treatment

standards, legal criteria for drug court treatment providers, drug testing protocols, sanctions and incentives, fees, and data elements.

While juvenile drug courts are bound by the same set of components and standards, there are additional “strategies” specific to these court programs that address age and developmental issues. The federal Bureau of Justice Assistance supported the writing of a monograph published in 2003, *Juvenile Drug Courts: Strategies in Practice*, that detailed sixteen strategies specific to this particular type of specialty court. While there is some overlap with the NADCP components listed above, many of these strategies are transparently important to any program that works with adolescents who are required to engage a judicial system:

1. Collaborative planning;
2. Teamwork;
3. Clearly defined target population and eligibility criteria;
4. Judicial involvement and supervision;
5. Monitoring and evaluation;
6. Community partnerships;
7. Comprehensive treatment planning;
8. Developmentally appropriate services;
9. Gender appropriate services;
10. Cultural competence;
11. Focus on strengths;
12. Family engagement;
13. Educational linkages;
14. Drug testing;
15. Goal-oriented incentives and sanctions;
16. Confidentiality.

Finally, for those looking for further guidance on working with court-involved adolescents, the federal Office of Juvenile Justice and Delinquency Prevention, in December 2016, published its *Juvenile Drug Treatment Court Guidelines*.

### **Department of Veterans Services**

The Health Care Coordination Division (HCCD) is the primary coordinating and advocacy unit within DVS for health and behavioral health services to veterans and their eligible family members. A key advocacy role centers on ensuring that veterans successfully access the potentially rich array of behavioral health services within the very large and complex federal VA system. While these programs are not under the oversight of DVS, staff work with individual veterans as needed to participate in one or more of the following VA behavioral health programs:

Community Homelessness Assessment, Local Education & Networking Groups

Community Living Center  
Health Care for Homeless Veterans  
Homeless and Residential Rehabilitation and Treatment Programs  
Veterans Justice Outreach Program  
Healthcare Reentry Veterans Program (post-incarceration)  
Grant and Per Diem Program (housing support)  
Home-Based Primary Care Mental Health Program  
HUD Veterans Affairs Supported Housing  
Mental Health Intensive Case Management  
Mental Health Rehabilitation and Residential Treatment Program  
Mental Illness Research, Education and Clinical Centers  
Mental Health Recovery Services  
Psychosocial Rehabilitation and Recovery Services (peer support)  
Substance Use Disorders Program  
Suicide Prevention Program  
VA Evidence-Based Psychotherapy Training Programs

In addition, HCCD staff works with two state homeless and at-risk veteran shelter systems, one in Albuquerque and the other in Las Cruces. The New Mexico Veterans Integration Center in Albuquerque provides housing and transition services, and requires that participants commit to a long-term (up to two years) program of life skills training, counseling and alcohol and illegal drug abstinence. The southern New Mexico program, Mesilla Valley Community of Hope, provides transitional housing in a temporary tent facility, with an intensive program of counseling, permanent housing at a local Housing Authority complex, education, and job training.

HCCD assists in the coordination of transportation services for veterans to DVS Field Offices and VA clinics via the VetConnect 24-Hour Transportation Hotline at 1-800-672-7006.

Finally, two previously mentioned problem-solving courts in the Administrative Office of the Courts' specialty court system provide targeted services to veterans. The Second Judicial District's (Albuquerque) Veterans Treatment Court was established through the advocacy of DVS to assist veterans with PTSD, a traumatic brain injury, or substance abuse. Also in Bernalillo County, DVS advocated at the Metropolitan Court to create a Domestic Violence Early Intervention Program/Veterans Track to help veterans facing first-time domestic violence charges to receive counseling and treatment in lieu of incarceration.

## **Section 4**



## Program Rules, Policies & Procedures

### Medicaid

In addition to providing detail on all Medicaid-reimbursed behavioral health services, NMAC Rule 8.321.2, **Specialized Behavioral Health Provider Enrollment and Reimbursement** (currently being revised), provides essential programmatic and clinical guidance in Section 9, General Provider Instruction. This document in its entirety serves as the primary legal document for the delivery of Medicaid-funded behavioral health services in New Mexico. Additional interpretive guidance and clarification are provided by the **Behavioral Health Policy and Billing Manual: For Providers Treating Medicaid Beneficiaries. Level of Care Guidelines** further support the delivery of behavioral health services within the managed care portion of the Medicaid behavioral health system. Each of these three documents, along with reference to **ASAM Criteria**, will be briefly described in this section. Equivalent guidance for non-Medicaid-funded programs is provided by program managers and quality improvement specialists in the department or administrative unit that contracts for these services.

### New Mexico Administrative Code (NMAC)

In addition to the comprehensive Rule noted above, there are three sequential rules that “provide policies for the standard of delivery for behavioral health services through contracted behavioral health entities and for approval of contracts by the collaborative”: NMAC 7.21.1 **Behavioral Health General Provisions**, 7.21.2 **Standards of Delivery for Behavioral Health Services**, and 7.21.3 **Behavioral Health Entity Contracting**, all effective 9/1/11.

The General Provisions (7.21.1) list key definitions (7.21.1.7) for the operation of and contracting for behavioral health services provided by Collaborative members and subcontractors (behavioral health entities). The Standards of Delivery for Behavioral Health Services (7.21.2) articulate the mission statement of the Collaborative, and detail quality management and improvement expectations; “broad standards” covering commitment to persons served, collaboration and system of care requirements, reporting, behavioral health data, emergency response, sexual assault and forensic evaluation requirements, advance directives, and special coordination expectations (an important section listing 18 service systems and provider types); performance standards; utilization management (UM) standards; credentialing and re-credentialing standards; rights and responsibilities; clinical records; access standards; and delegation. The final rule, Behavioral Health Entity Contracting (7.21.3), is a brief document that summarizes contract procurement and oversight requirements for eligible behavioral health entities (BHEs). Providers should also become familiar with the Supplements to NMAC program rules.

The General Provider Instruction section (8.321.2.9) of the Specialized Behavioral Health Provider Enrollment and Reimbursement Rule covers essential information for

any provider of Medicaid-reimbursed services, including provider participation agreements (PPAs). A full listing of independently licensed providers who may be directly reimbursed by Medicaid is provided:

- Psychiatrists (M.D.)
- Psychologists (Ph.D., Psy.D., Ed.D.)
- Social Workers (LISW, LCSW)
- Counselors (LPCC)
- Marriage and Family Therapists (LMFT)
- Licensed or Certified Alcohol and Drug Abuse Counselors (LADAC, CADAC)
- Clinical Nurse Specialists or Practitioners (CNS, CNP) in Psychiatric Nursing

Certain types of agencies can provide comprehensive behavioral health professional services:

- Community Mental Health Center (CMHC)
- Federally Qualified Health Center (FQHC)
- Indian Health Services (IHS) hospital or clinic
- Tribally operated (PL 93-638) hospital or clinic
- Children, Youth and Families Department (CYFD)
- Hospitals and their outpatient facilities
- Core Service Agency (CSA)
- CareLink New Mexico Health Homes
- Crisis Triage Center licensed by the Department of Health
- Behavioral Health Agency (BHA) with BHSD Supervisory Certificate
- Opioid Treatment Program (OTP) in a methadone clinic with a BHSD Supervisory Certificate
- Political subdivisions of the State of New Mexico with BHSD Supervisory Certificate
- Crisis Services community provider as a BHA with BHSD Supervisory Certificate

The agencies listed above may also bill for services provided by non-independently licensed and certain non-licensed professionals with appropriate supervision of these classes of practitioners:

- Licensed Master's of Social Work (LMSW)
- Licensed Mental Health Counselor (LMHC)
- Licensed Associate Marriage & Family Therapist (LAMFT)
- Psychologist Associate
- Registered Nurse
- Licensed Physician Assistant
- Licensed Professional Art Therapist (LPAT)

Eligible non-licensed practitioners include:

Master's level behavioral health intern  
Psychology intern  
Pre-licensure psychology post-doctorate student  
Certified Peer Support Worker (CPSW)  
Certified Family Peer Support Worker (CFSW)  
Community Support Worker (CSW)

While there are 28 service types detailed in this Rule as approved for Medicaid reimbursement, there is also a listing of services in 8.321.2.9.G that are not reimbursable:

Hypnotherapy  
Biofeedback  
Conditions that do not meet the standard of medical necessity  
Education or vocational services related to traditional academic subjects or vocational training  
Experimental or investigational procedures, technologies or non-drug therapies and related services  
Activity therapy, group activities and other services which are primarily recreational or diversional in nature  
Electroconvulsive therapy  
Services provided by a behavioral health practitioner who is not in compliance with the statutes, regulations, rules or renders services outside his or her scope of practice  
Treatment of intellectual disabilities alone  
Services for which prior authorization is required but was not obtained  
Milieu therapy

Finally, this section details billing and reimbursement principles, utilization review (UR) guidelines, and comprehensive assessment (diagnostic evaluation) and treatment planning and other clinical documentation requirements (also covered in more detail in 8.321.2.14). As detailed in Section 3 of this Guide, subsection L effectively adds a valuable new Medicaid-funded service: interdisciplinary teaming.

### **Behavioral Health Manual**

The new (in 2018-19) **Behavioral Health Policy and Billing Manual (For Providers Treating Medicaid Beneficiaries)** (BH Manual) provides interpretive clarification and additional detail to the Rule described above. It generally replaces the large number of Service Definitions previously serving these functions. As a procedural document, it may be changed as circumstances warrant by the Human Services Department (MAD and BHSD). With appendices and attachments, this document is anticipated to be several hundred pages long. All publicly-funded provider systems – even those few not predominantly delivering Medicaid-funded services - should ensure that clinical, administrative and financial leadership are fully familiar with this document and should

conduct trainings on aspects of it appropriate to various staff levels. Rather than repeating the detailed information in any section of the BH Manual here, we simply provide a comprehensive listing of section topics and appendices as of October 2018.

Section One: Introduction & General Principles

- 1.1 Purpose of this Manual
- 1.2 Severe Emotional Disturbances
- 1.3 Serious Mental Illness
- 1.4 Trauma Informed Care
- 1.5 Recovery and Resiliency
- 1.6 Cultural Competency
- 1.7 Clinical Supervision
- 1.8 Supervisory Certification
- 1.9 Quality – Vision
- 1.10 Mental Health Parity and Addiction Equity Act of 2008
- 1.11 Critical Incidents
- 1.12 Telemedicine
- 1.13 Billing for Behavioral Health

Section Two: Screening, Assessment, Medication and Therapies

- 2.1 Integrated Care and Interdisciplinary Teaming
- 2.2 Treat First Clinical Model
- 2.3 The Comprehensive Assessment
- 2.4 Crisis and Safety Planning
- 2.5 Treatment Plan
- 2.6 Psychiatric Evaluations, Counseling, Therapy, Peer Support, Activity Therapy, Medication Management
- 2.7 Behavioral Health Pharmacology
- 2.8 Screening, Brief Intervention and Referral to Treatment (SBIRT)
- 2.9 Other Screens

Section Three: Special Outpatient Services for Adults & Children

- 3.1 Applied Behavior Analysis – 8.321.2.12 (NMAC 8.321.2 reference)
- 3.2 Comprehensive Community Support Services – 8.321.2.18
- 3.3 Crisis Intervention Services – 8.321.2.19
- 3.4 Crisis Triage Centers – 8.321.2.20
- 3.5 Family Support Services (Managed Care only) – 8.321.2.22
- 3.6 Family Peer Support Services
- 3.7 Intensive Outpatient Program for Substance Use Disorders – 8.321.2.25
- 3.8 Intensive Outpatient Program for Mental Health Conditions – 8.321.2.26
- 3.9 Medication Assisted Treatment for Buprenorphine – 8.321.2.27
- 3.10 Partial Hospitalization Services in Acute Care or Psychiatric Hospital – 8.321.2.31
- 3.11 Peer Support Services
- 3.12 Recovery Services (Managed Care only) – 8.321.2.33
- 3.13 Smoking Cessation Counseling – 8.321.2.35

Section Four: Special Outpatient Services for Children & Adolescents

- 4.1 Behavioral Health Respite Care (Managed Care only) – 8.321.2.15
- 4.2 Behavior Management Services (BMS) – 8.321.2.16
- 4.3 Day Treatment – 8.321.2.21
- 4.4 Multi-Systemic Therapy (MST) – 8.321.2.28

Section Five: Special Outpatient Services for Adults

- 5.1 Assertive Community Treatment Services (ACT) – 8.321.2.13
- 5.2 Cognitive Enhancement Therapy (CET) – 8.321.2.17
- 5.3 Opioid Treatment Program (OTP) – 8.321.2.30
- 5.4 Psychosocial Rehabilitation Services (PSR) – 8.321.2.32
- 5.5 Supportive Housing – 8.321.2.36

Section Six: Inpatient & Residential Services for Children and Adolescents

- 6.1 Accredited Residential Treatment Center (ARTC) – 8.321.2.11
- 6.2 Residential Treatment Centers – 8.321.2.29
- 6.3 Group Home Services – 8.321.2.29
- 6.4 Treatment Foster Care I & II – 8.321.2.37

Section Seven: Inpatient & Residential Services for Adults

- 7.1 Accredited Residential Treatment Centers for Substance Use Disorder – 8.321.2.10
- 7.2 Institution for Mental Disease (IMD) – 8.321.2.24

Appendices

- Severe Emotional Disturbance (SED)
- Serious Mental Illness (SMI)
- Monitoring Tool for Trauma-Informed Care
- Creating Cultures of Trauma-Informed Care
- Promoting Cultural Competence Self-Assessment Checklist for Providers
- Review Tool for Supervisory Certification
- Supervisory Certification Roster of Approved Agencies
- Supervisory Certification Process Flow
- Supervisory Certification Attestation Form
- Critical Incident Report Form
- Behavioral Health Providers Critical Incident Reporting Protocol
- BH Fee Schedule Link
- Tip Sheet for Practitioners in Integrated Care Settings: Practice Principles and Functions for use in behavioral health center
- “Interdisciplinary Teaming in Behavioral HealthCare”
- Practice Standards for Family Teaming
- Highlights of the 1<sup>st</sup> Four Encounters for Treat First
- Treat First Approach Protocol
- Adult and Child Self Check-In and Session Check-Out instruments
- Treat First Educational Website
- Behavioral Health Level of Care Guidelines
- Comprehensive Assessment & Service Plan Adult Form

Comprehensive Assessment & Service Plan Child Form  
Opioid Analgesic Treatment Request  
ABA Billing Instructions  
SBIRT Pre-Screen Instrument  
DAST 10: Drug Abuse Screening Test  
Audit 10: Alcohol Screen  
PHQ9: Patient Health Questionnaire  
PCL-C: Post Traumatic Stress Disorder Checklist  
GAD-7: Generalized Anxiety Disorder Screen  
IOP Attestation Form  
IOP Certification Tool  
IOP Provider Certification Information  
IOP Provider Application  
IOP Site Visit Preparation Form  
IOP Process Flow  
IOP Site Visit Tool  
ACT Readiness Tool  
ACT Review Tool  
DACTS/G01 Scale: Dartmouth Assertive Community Treatment Scale  
ACT Chart Audit Tool  
ACT Service Audit Tool  
ACT Process Flow  
OTP Regulations Crosswalk  
OTP Clinic and Personnel Checklist  
OTP Counselor Questionnaire  
OTP Personnel site review form  
OTP Patient Record Audit Form  
Prudent Parenting and Prevention of Sex Trafficking

### Levels of Care

The **Level of Care Guidelines for Centennial Care MCOs (LOCs)** represent the third core element of clinical guidance, specifically for the Medicaid managed care system. The most recent version of these guidelines was approved in 2015. Modification of these standards resides with BHSD. With the implementation of Centennial Care 2.0 on January 1, 2019, these guidelines will require updating to reflect changes discussed above in NMAC 8.321.2 and the implementation of the BH Policy and Billing Manual. Generally, these services are among the more clinically complex and costly in the array of services. Many require prior approval and/or have complex admission or approval, continued stay, discharge, and exclusionary criteria. All but one LOC involves an out-of-home placement. The guide defines value-added services provided at the discretion of the MCO, and details utilization criteria for two such services for which clinical

expectations are well developed: electroconvulsive therapy and adult transitional living. Listed below are the sections of the current LOC document:

- Medical necessity definition (with quality of service criteria)
- Acute Inpatient Hospitalization
- Awaiting Placement Days (DAP) Rate
- 23 Hour Observation Stay
- Accredited Residential Treatment
- Sub-Acute Residential Treatment
- Residential Treatment Center Services
- Treatment Foster Care I & II
- Group Home
- Adaptive Skills Building (ASB) (now called Applied Behavior Analysis)
- Value Added Services (defined)
- Electroconvulsive Therapy
- Adult Transitional Living Services (TLS)

## ASAM

Finally, all publicly-funded providers should be familiar with **The American Society for Addiction Medicine (ASAM)** Criteria for substance use conditions. These Criteria provide a comprehensive set of guidelines for multi-dimensional assessment, treatment and service planning, placement, continued stay, and transfer or discharge of individuals who have substance use and co-occurring conditions. These guidelines provide a means of matching risk, severity and service needs with type and intensity of services. They are (massively) detailed in *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related and Co-Occurring Conditions*, Third Edition.

Accredited Residential Services for Substance Use Disorders (8.321.2.10 NMAC, effective in 2019) programs must be accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA). Based on the conditions and level of accreditation, the program must design admission and treatment criteria that meet ASAM Level 3 requirements with respect to clinical management (3.1,3.3,3.5), medical monitoring (3.7), and withdrawal management (3.2-WM, 3.7-WM).

Other higher intensity programs working with individuals with substance use disorders (SUDs), such as Intensive Outpatient (IOP) programs, may also require fidelity to ASAM levels and sub-levels. Proper use of the ASAM criteria and levels/sublevels in a training program for therapeutic clinicians can dramatically improve proper diagnosis and subsequent treatment for individuals with complex SUDs and co-occurring disorders

## Section 5:

## Provider Contracting & State Oversight

### Provider Contracting

#### Collaborative Support for At-Risk Providers

All provider contracts have language and behavioral expectations regarding termination of services, whether for cause or provider financial or administrative vulnerability. Providers should, in all cases, be familiar with these contractual clauses for all of their contracts. In general, termination of a contract for any reason requires that a provider continue services to existing consumers until clinically appropriate transfers to another agency or case closure occur. If providers find themselves in financial or other circumstances that could require partial or complete cessation of services, they should contact the CEO of the Collaborative or a designee (often the MCO contract manager in the case of Medicaid managed care programs) well before any closure date is considered. Often, the CEO will be able to provide technical assistance, training and other resources that will allow the provider to continue to provide services. At a minimum, the Collaborative will work with such providers and the local community to ensure that consumers are not harmed by abrupt termination of services. By initiating these contacts at the earliest possible moment, essential services are maintained, providers are often strengthened in the longer term, communities become partners in the survival of competent provider systems, and consumers continue to move towards recovery.

Most publicly funded behavioral health providers intend to serve both Medicaid-eligible individuals and those who qualify for funding from non-Medicaid sources such as federal block grants, state general funds, and discretionary grants. To be paid for eligible services from these different sources, providers must complete separate applications and registration processes. Most of public funding sources are covered by two application types: Medicaid Provider Participation Agreements and Behavioral Health Collaborative Vendor Registration. The former are managed by a fiscal agent, Conduent, and the latter by an Administrative Services Organization (ASO), Falling Colors. Both applications are completed electronically. The Collaborative ASO process covers funding for BHSD and CYFD behavioral health programs. Management of grant funding from the Administrative Office of the Courts (problem-solving courts), the Department of Finance and Administration's Local DWI Program, and some Department of Health programs may be independent of these two processes, although all public behavioral health funders strongly urge or require that services for Medicaid-eligible participants be billed to Medicaid prior to billing other funding sources to maximize the utility of limited state funds.



## **National Provider Identifier (NPI)**

Prior to completion of either application, health care providers and practitioners must apply for and receive a ten-digit National Provider Identifier (NPI) number through the National Plan and Provider Enumeration System (NPPES) of the Centers for Medicare and Medicaid Services (CMS). Further information about the NPI system and application materials is available on the CMS website, as well as the New Mexico Medicaid Portal (click Application-NM Administrative Code-National Provider Identifier).

## **Medicaid Provider Participation Agreement**

Medicaid General Provider Policies are contained in NMAC 8.302.1. Providers should review the details of this Rule prior to applying for permission to bill for Medicaid-funded services.

To obtain a Medicaid Enrollment ID number, one of two types of online applications must be completed. The MAD 335 application is used by groups, organizations, facilities, or individual applicants to whom payments will be made. Such entities include but are not limited to Core Service Agencies, Community Mental Health Centers, Federally Qualified Health Centers, Behavioral Health Agencies, and Accredited Residential Treatment Centers. The MAD 312 application is used for individual applicants within a group practice.

Application is made through the Conduent New Mexico Medicaid Portal: <https://nmmedicaid.portal.conduent.com/webportal/home>. Within the portal, there are significant resources to assist providers. From the Home page, there is an obvious link to clear and helpful FAQs. There are links to Provider Enrollment and Enroll Online pages. By clicking on the Application link, and then on the Providers hyperlink, information including a provider overview, critical incident reporting, fee for service and managed care, governing administrative codes (and NPI information), quality strategies for managed care, and general sites of interest is easily accessed.

After registering for an account on the portal, completion of the correct application is a relatively short and efficient process. Generally, within 7-10 days, assuming the application is complete and accurate, a Medicaid ID number will be issued.

A provider must then credential its independently-licensed providers through the CAQH (Council for Affordable Quality Healthcare) Universal Provider Datasource ProView. This system allows for consolidated basic applications for credentialing at all Managed Care Organizations (MCOs) in the New Mexico Medicaid Centennial Care system, although each MCO will have additional unique credentialing requirements in addition to the information submitted to CAQH. The CAQH process can take as much as 45 days to approve an agency's credentialing submission. Additional information about this process can be found at [www.cagh.org/solutions/cagh-proview-fags](http://www.cagh.org/solutions/cagh-proview-fags).

Finally, each MCO requires that providers complete a roster of practitioners for each agency and/or site and service(s) to be rendered. Rosters should be updated regularly

to reflect changes in direct service personnel. Each MCO has its own detailed provider manual or handbook detailing complete rostering requirements. All MCOs use the same rostering form. Providers are required to execute Agreements with all MCOs for whom they intend to provide Medicaid-reimbursed managed care services. As agents of Medicaid, all MCOs exercise significant, detailed, and regular contractually-mandated oversight of all providers serving their enrolled members.

### **BHSDStar Vendor Application and Registration**

Falling Colors, the ASO for non-Medicaid behavioral health publicly-funded programs (in BHSD and CYFD), has created an online system called BHSDStar. Accessed at [www.bhsdstar.org](http://www.bhsdstar.org), there are manuals, online training guides, specialty program documents, and registration materials for providers. An FAQ document link is provided, covering accounts, client registration, billing submission payment, support desk, vendor registration and general questions.

All vendors of non-Medicaid services, claims based or not, are required to register in the BHSDStar system. Recorded webinars provide detailed training in client registration, claims submission, and how to bill. There is a link on the Home Page User Guides listing to the Vendor Registration Manual. As with Medicaid Provider Participation Agreements, all direct service staff must have an NPI (and, additionally, copies of licensure and certification documents).

Once contracted to provide services, non-claims-based vendors can access the STAR Vendor Manual and claims-based providers the Quick Guide for Claims Submission, Claims User Manual, and Claims Billing Guide, all from the Home page. Special program materials are available for CareLink Health Homes, Consumer Satisfaction, Methadone, Prevention, SBIRT, Synar, and Treat First programs.

## **State Oversight**

### **Critical Incident and Sentinel Event (CI/SE) Reporting**

Many publicly funded behavioral health providers are required to report CI/SEs to one or more state agency or administrative entity according to the criteria stated in the Behavioral Health Provider Critical Incident Reporting Protocol of April 2018. Copies of this protocol and the forms that must be completed can be accessed in several easily available electronic platforms, including the BHSDStar Home page, the Collaborative's Network of Care website in the Provider link, and the New Mexico Medicaid Portal. The 2018 Protocol represents a collaborative effort among HSD, BHSD, CYFD, Centennial Care MCOs, and the Behavioral Health Provider Association of New Mexico, and is intended to provide clarity on the process of filing CI/SEs for recipients of service who do not fall into the fourteen Medicaid categories of eligibility (COEs) that require electronic reporting through the HSD Critical Incident Portal. The Protocol applies to CI/SEs for recipients of Medicaid Managed Care and Fee-for-Service, those governed by the Collaborative's ASO (generally BHSD and CYFD programs), Waiver programs in

DOH overseen by the Division of Health Improvement, and CYFD programs licensed or certified by the Licensing and Certification Authority of Behavioral Health Services.

Reportable CI/SEs include abuse, neglect, exploitation, environmental hazard, medication errors, use of seclusion or restraints, incidents involving injuries, communicable disease, aggression or violence, use and unauthorized possession of weapons, wandering, vehicular accidents, elopement, biohazardous accidents, unauthorized use and possession of legal and illegal substances, suicide and attempted suicide, sexual assault, and other Sentinel Events as defined by The Joint Commission. Behavioral health provider systems must ensure that staff are trained in these reporting requirements, that service recipients and their family members or other representatives are aware of these processes, and that provider quality management systems ensure proper tracking and remediation of all CI/SEs. Additional reporting requirements may exist (see below) if abuse, neglect or exploitation of a recipient of service occurs.

Submission of CI/SEs is generally guided by primary funding source. CI/SEs for individuals within the Medicaid Managed Care system go to their MCO; individuals within the Medicaid Fee-for-Service system have their CI/SEs submitted to HSD's Medical Assistance Division; and those sent on behalf of non-Medicaid consumers are reported to BHSD. As noted above, redundant or duplicate submissions to additional state or accrediting agencies and licensing boards may be necessary, as in the case of recipients of service in children's programs licensed by LCA or members of the DD and Medically Fragile Waiver programs. Questions regarding critical incident reporting for Medicaid consumers can be sent to [HSD-QB-CIR@state.nm.us](mailto:HSD-QB-CIR@state.nm.us) and for BHSD consumers, to [bh.qualityteam@state.nm.us](mailto:bh.qualityteam@state.nm.us).

## Reporting Abuse and Neglect of Adults and Children

There are mandatory and universal requirements for reporting abuse and neglect of children and adults in New Mexico. These standards are in addition to critical incident reporting, which focuses on activities and events that occur to an individual while in active behavioral health treatment (that is, not yet discharged), whether they occur at the location of treatment or elsewhere. Abuse and neglect reporting may be independent of engagement with a behavioral health system, but may also occur in such settings.

The "Duty to Report" provision in the Adult Protective Services Act (27-7-30) states: "Any person, or financial institution, having reasonable cause to believe that an incapacitated adult is being abused, neglected or exploited shall immediately report that information to Adult Protective Services." Adult Protective Services remains on call for emergency reports of adult abuse, neglect, and exploitation 24 hours a day, 7 days a week at **1-866-654-3219 (toll-free) or 1-505-476-4912**. If abuse or neglect of a child is suspected, contact must be made with the Statewide Central Intake of CYFD at **#SAFE (#7233)** from a cell phone or by calling **1-855-333-SAFE**. CYFD's PullTogether website

(pulltogether.org) provides a basic listing of the signs and conditions that constitute abuse and neglect, including evidence of human trafficking.

Certain publicly funded programs require recurring licensing or certification by a state oversight entity such as the DOH Division of Health Improvement (DHI) or the CYFD Licensing and Certification Authority (LCA). Others require special review and approval to operate by a state program unit like BHSD, AOC, or DFA. Within the Medicaid managed care system, Centennial Care MCOs have detailed quality assurance and improvement guidelines as well as clinical practice standards for their contracted providers. Each of these oversight systems will be briefly detailed below.

### **DOH Division of Health Improvement (DHI)**

DHI has a broad scope of responsibility, and impacts a few behavioral health providers quite directly, and many others only tangentially. Among its charges are health facility licensing, including community mental health centers (CMHCs); psychiatric hospitals; oversight of home- and community-based waiver programs; investigation of abuse, neglect and exploitation that occurs in these licensed facilities and programs; management of the Caregivers Criminal History Screening Program which provides criminal background checks on potential providers and caregivers; management of the Employee Abuse Registry; operation of the Certified Nurse Aide Registry; and certification of all clinical laboratories.

CMHCs are governed by NMAC Rule 7.20.3 (2001), Requirements for Community Mental Health Centers. The DHI Health Facilities District Operations Bureau staff conduct regular surveys of these programs as part of their oversight of more than 3,500 health facilities, programs and laboratories in New Mexico. They do not survey or license the offices and treatment facilities of licensed private practitioners. The general survey process is described in the DHI website ([nmhealth.org/about/dhi/hflc](http://nmhealth.org/about/dhi/hflc)).

The decision to certify a CMHC for possible operation, leading to a DHI Health Facilities licensing survey, is made by BHSD, per NMAC 7.20.3, and involves approval “to provide psychosocial rehabilitation services to adults with priority given to individuals with severe disabling mental illness.” At present no new CMHCs are being approved by BHSD, as the state continues its transition to more flexible and integrated care systems such as Health Homes. Since CMHCs are a long-standing federal designation for required services to certain consumer types, existing programs continue to require regular licensure. Mandatory core services at CMHCs must include:

- Professional consultation
- Community-based crisis intervention;
- Therapeutic interventions;
- Medication services; and
- Psychosocial interventions.

## **CYFD BHS Licensing & Certification Authority Bureau (LCA)**

LCA has a concrete and focused mission that very directly impacts most providers of behavioral health services to children and adolescents. As a bureau of CYFD Behavioral Health Services, LCA certifies compliance with state and federal regulations having to do with standards of active treatment, quality of care, health and safety, personnel requirements, and other regulatory standards (see NMAC 7.20.11, 7.20.12, and 7.8.3) at several facility and community-based programs, including:

- Accredited Residential Treatment Centers (ARTC);
- Non-accredited Residential Treatment Centers;
- Group Home Services;
- Treatment Foster Care Services;
- Day Treatment Services;
- Behavioral Management Services (BMS);
- Children's Crisis Shelters (non-Medicaid);
- Multi-Service Homes; and
- New or Innovative Programs

NMAC 7.20.11 not only describes in detail requirements for the clinical aspects of the programs listed above (except for license-only facilities), it also provides highly prescriptive language in many operational categories, including nine pages of regulatory definitions, certification categories and contingencies, sanctions and appeals, personnel requirements, agency and program governance requirements, and quality improvement criteria. Additional treatment and service provision components include client participation expectations, restraint and seclusion limitations, management of medications, and expectations regarding intake, assessments, treatment planning, and discharge.

### **BHSD Specialty Program Certification**

As with programs governed by the licensing activities of DHI and LCA described above, certain programs require BHSD program review and certification prior to initiating service and receiving payment. Some of these will be articulated in the to-be-revised version of NMAC 8.321.2 (Behavioral Health Agencies including crisis service community providers, OTPs, NM political subdivisions) and others as a function of approval to provide Medicaid-reimbursed services (Assertive Community Treatment and Intensive Outpatient Program providers). Each of these services is governed by a unique program review process flow leading to certification. While we will briefly describe the general process leading to certification of these programs, interested providers should communicate directly with appropriate BHSD program and clinical management staff to fully understand requirements. Forms and additional information are also available in the Behavioral Health Policy and Billing Manual appendices.

The most general BHSD program review process targets Supervisory Certification of Behavioral Health Agencies (BHAs) and New Mexico political subdivisions offering behavioral health clinical services. This type of certification was developed in 2015 to allow agencies that had not previously been allowed to bill Medicaid for the services of non-independently-licensed practitioners to begin doing so as long as clinical supervisors of these practitioners had appropriate supervisory training and/or licensing board approval. As with all BHSD certification program reviews, an agency must initiate the process by submitting an application to the BHSD Clinical Services Manager/Team. Unlike other specialty certification processes, described below, no site visit is required for Supervisory Certification.

Assertive Community Treatment (ACT) program approval requires documented prior training in ACT evidence-based practices, and identification of a 10-person ACT team prior to application submission. Once these activities occur and a completed application is submitted and approved by BHSD, a provider may be granted provisional status to begin offering ACT and to bill Medicaid for these services. A site visit is scheduled after at least 180 days of services have occurred, and primarily consists of chart reviews and interviews with staff.

Intensive Outpatient Programs (both for substance use and mental health conditions) follow the ACT model, to include application, provisional approval, and a site visit after at least 180 days of program operation. Adherence to evidence-based practices and adequate staff training are essential components of both ACT and IOP.

**Opioid Treatment Programs (OTPs)** also require BHSD certification but follow a more intensive review protocol or process flow. Prior to BHSD (as the State Opiate Treatment Authority or SOTA) review, programs that dispense methadone must receive federal Drug Enforcement Agency, SAMHSA/CSAT and New Mexico Board of Pharmacy approval, program accreditation by TJC, CARF, or COA (may occur after provisional approval and some months of program operation to qualify for accreditation), and only then BHSD program review. Site visits are required soon after provisional approval, and every three years after this initial visit. This entire process, according to BHSD, takes at least eight months of program planning and review prior to initiating services. As of late 2018, there are 16 OTPs currently operating, and additional programs are needed.

## **BHSD Quality Management Plan**

Core values of BHSD's quality management approach include:

- Customer focus, recovery orientation, clinical excellence;
- Respectful and compassionate communication;
- Improvement through innovation and integrity;
- Staff development;
- Inclusive and diverse partnerships; and
- Action driven by data.

The 2018 BHSD QM Plan focuses on an examination of access to care along several analytical axes. These include a variety of entry-into-service features, such as availability of public information about services, phone access standards, geographical service availability, hours of operation for consumer convenience, public transportation resources, and waiting lists for service. The Plan also intends to look at implementation of programming to maximize the efficiency of limited service access through the use of open access models, increase in evidence-based group programming types, telepsychiatry and other electronic services, and delivery of services in community-based, “natural” environments, with increased use of peer professionals.

### **Clinical Practice Improvement**

In addition to the oversight responsibilities listed earlier, BHSD is strongly committed to supporting the community-based delivery system with knowledge, skills and tools that support the quality of their behavioral health care. Two of the quality improvement initiatives to support clinical practice are discussed below.

With the growth in the utilization of integrated primary care and behavioral health providers in the publicly-funded system of care over the past several years, BHSD saw the need to develop organizational learning strategies that combined physical and behavioral health best practices into a fully integrated care environment. The first quality improvement initiative, **Integrated Quality Service Review (iQSR)** focuses on frontline practice using in-depth case reviews targeting a range of qualitative measures and focus group interviews. Fifteen common personal status or life domain measures of clients and ten clinical best practice functions frame the analytical and learning activities within this quality improvement process. The clinical best practice functions isolate elements in the overall process of delivering services in these integrated settings, and include recognition, connection and rapport; building engagement and commitment; person-centered care coordination and teamwork; crisis screening, prevention, and monitoring; formal assessment and case formulation; identifying wellness and recovery goals; planning and delivering interventions; medication management; and progress tracking, plan adjustment, and transitions.

The second initiative, **Clinical Reasoning and Case Formulation**, provides an intensive two-day training in the delivery of person-centered practice, with a focus on wellness and resiliency for youth and their families, and wellness and recovery for adults. Targeted skills include the development of comprehensive biopsychosocial assessments, using key organizing questions to strengthen accurate clinical analysis, constructing a case formulation, learning the logical order of goal setting, planning effective interventions, and creating case notes that are clinically sufficient and audit compliant. The training process for this initiative includes small group work using case simulations designed to highlight key concepts, organizing tools, and clinical reasoning processes, supplemented by examples of good clinical practice in each of the targeted

areas. Adequate time is included to allow for discussion of the pragmatics of using newly taught skills in specific provider settings.

The iQSR methods have also largely informed the development of the Treat First clinical protocol addressed elsewhere in this guide and in the Medicaid BH Manual (draft).

### **Residential Treatment Center Accreditation and Training**

Residential Treatment Center (RTC) Services provide individualized, trauma informed 24-hour active residential psychotherapeutic intervention/therapeutic care to children/adolescents with severe behavioral, psychological, neurobiological, or emotional problems, to meet their developmental, psychological, social, and emotional needs.

Effective January 1, 2019, RTC services are a Medicaid covered benefit. To provide Medicaid covered RTC services, provider organizations must be accredited through one of the three accreditation bodies, Commission on Accreditation of Rehabilitation Facilities (CARF), Joint Commission (JC), and the Council on Accreditation (COA). BHSD staff is working with provider organizations get the necessary training to gain accreditation so that they can bill Medicaid for RTC services. BHSD staff is also facilitating RTC provider trainings for the American Society of Addiction Medicine (ASAM) criteria. Training is ongoing.

### **Provider Licensing and MCO Contracts**

General provider licensing and certification requirements are addressed in NMAC 8.321.2.9, and the requirements for the licensing of each provider type (social worker, counselor, family therapist, art therapist, etc.) are covered in each state licensing board's website. In the case of MCOs, provider manuals and state contracts are available either through HSD and Medicaid websites or on the individual MCO website.

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## **Section 6**

### **Community Partners and Supports**

Publicly-funded (state and federal) behavioral health programs serve the largest number of New Mexico residents among all funding sources. In CY 2017, a total of 174,072 individuals were provided services by Medicaid managed care, Medicaid fee-for-service, and non-Medicaid state-funded (federal block grants, state general fund, and federal discretionary) behavioral health programs. More than 90% of all publicly-funded services are paid by Medicaid. Non-Medicaid services represent 7-8% of the total. Even with this large commitment of public funds, additional funding is needed to meet the needs of particular populations in different regions of the state. Over the past decade or so particularly, many cities, counties, and regional coalitions have identified funding that addresses gaps in service that significantly impact local residents. The programs created by these funds, many allocated by local government entities, supplement the services that are the subject of this guide. At these local levels, informed citizens and local governmental leaders become partners with the state to craft systems of care that meet specific needs identified as high priorities in particular locales. In this section, we will discuss some examples of these programs, as well as detail additional statewide professional and advocacy groups that can provide support and guidance for provider systems.

#### **Core Service Agencies**

Core Service Agencies (CSA) coordinate care and provide essential services to children, youth and adults who have serious mental illness, severe emotional disturbance, or dependence of alcohol or drugs. The CSAs are multi-service Community Mental Health Centers (CMHC) and Federally Qualified Health Centers (FQHC) that help to bridge treatment gaps in the child and adult treatment systems, promote the appropriate level of service intensity for consumers with complex behavioral health service needs, ensure that community support services are integrated into treatment, and develop the capacity for clients to have a single point of accountability for identifying and coordinating their behavioral health, physical health, and other social services. New Mexico has designated Core Service Agencies to provide basic mental health and substance abuse services in all areas of the state.

#### **Santa Fe County**

Santa Fe County has been active over the past five years in identifying, funding and developing specialized behavioral health programs within its jurisdiction and in conjunction with neighboring counties. In May of 2016, the Chair of the County Commission convened a four-county (Santa Fe, Rio Arriba, Los Alamos, and Taos) behavioral health summit. The purpose of the summit was "...to build a collaboration among northern New Mexico counties to address policy and resource gaps and barriers to serving and supporting residents experiencing behavioral health issues, especially

those who do or might otherwise interact with publicly funded public safety, criminal justice, and health care systems.” The 65 or so participants emerged from the summit with six priority action steps:

1. Develop and fund a crisis triage/drop-in center to include professional and peer-led services.
2. Work collaboratively to address care coordination/navigation needs of individuals and families across counties, systems, and providers.
3. Develop capacity to capture and share data efficiently and effectively.
4. Assure (sic) universal behavioral health screening for children/youth and families at critical junctures in children’s lives.
5. Develop a plan to address short- and long-term workforce development needs.
6. Develop common approaches to helping people understand recovery is possible.

This summit was followed by the completion of a detailed Santa Fe County health services gap analysis, published in October of 2017. While not focused on behavioral health alone, significant attention was placed on the needs of individuals of all ages and from many demographic categories. This 145-page summary report remains a powerful planning tool for policy makers and program developers in all areas of health and behavioral health services.

Concurrent with the publication of the 2017 gap analysis, the County released an RFP for an adult behavioral health crisis center. Facility construction, remodeling and furnishing is funded by a \$2M capital outlay bond from November 2016, and operation of the facility is funded by a June 2017 increase in gross receipts tax, providing \$1.6M per year. The goals of the crisis center include:

- Providing immediate crisis management and de-escalation support;
- Prevention of unnecessary detainment in jails and prisons;
- Reduction of unnecessary utilization of hospital emergency departments; and
- Ensuring that individuals and their families are connected with clinical and social supports, including navigation services to prevent further crisis.

This program will complement and coordinate with the existing County-funded Mobile Crisis Team that provides community-based crisis outreach services to both adolescents and adults. The crisis center will be co-located with a program providing enhanced social detoxification for adults. In April 2018, the County signed a contract with New Mexico Solutions to manage the crisis center.

### **City of Santa Fe**

The City of Santa Fe has also funded behavioral health and other human service programs for many years. Since the late 1980’s, two appointed citizen groups – the

Human Services Committee and the Children & Youth Commission - have recommended funding totaling about \$2M per year, or 5% of annual gross receipts tax revenues, to support safety net services for children and adolescents, families, and adults.

More recently, the City adopted the LEAD – Law Enforcement Assisted Diversion – model of public safety intervention for individuals who have committed non-violent, low level crimes and who have a substance use disorder or mental health condition, and attendant homelessness or extreme poverty. Law enforcement officers may refer such individuals to community-based services rather than pursue incarceration and prosecution. LEAD Santa Fe assigns a case manager for every individual referred to the program. Following intake and screening, services may include intensive case management, emergency and long-term supportive housing, counseling and medication services, harm reduction services, employment assistance, assistance with basic needs, psychosocial rehabilitation, legal aid, and other community referrals. Experience in Seattle, WA, where this program originated, has demonstrated significant reduction in subsequent arrests and a long-term reduction in measurable costs for social and medical interventions for those enrolled in the program. The University of New Mexico Institute of Social Research is conducting an outcome evaluation of the first years of this program to determine its cost effectiveness.

### **City of Albuquerque and Bernalillo County**

Through a joint governing structure - the Albuquerque Bernalillo County Government Commission (ABCGC) - the Albuquerque City Council and Bernalillo County Commission created a Behavioral Health Initiative in 2015, following voter approval of a county gross receipts tax increase to pay for behavioral health services. This tax increase brings in approximately \$17M per year. The City of Albuquerque did not bring new funding to this partnership, but instead aligned its existing behavioral health allocations to the priorities established by ABCGC. Partnering with the University of New Mexico Hospitals, United Way of Central New Mexico, and the New Mexico Behavioral Health Collaborative, ABCGC is developing a regional behavioral health care system intended to meet needs not currently supported by other funding sources. In addition to a Steering Committee, ABCGC has created four program subcommittees: Crisis Services, Community Supports, Supportive Housing, and Prevention, Intervention and Harm Reduction.

Projects prioritized by the Crisis Services Subcommittee include the creation of mobile crisis teams, development of a crisis transportation system, establishment of a crisis stabilization and response (crisis triage) facility, and implementation of a transition planning and resource re-entry program for individuals released from the Metropolitan Detention Center who may have a mental health condition, substance use disorder or other social coping and functioning difficulties. The mobile crisis teams are in operation, and the Resource Re-Entry Center opened in May 2018. The development of a crisis

triage center is awaiting final Medicaid reimbursement, state licensing and program certification rules, here as well as in Santa Fe and Las Cruces.

Several of the Supportive Housing Subcommittee prioritized projects are already in operation, including the Community Connections jail re-entry housing and scattered site permanent supportive housing programs, as well as youth transitional living services.

The Community Supports Subcommittee is focused on improving services in the community that will stabilize high-risk individuals and prevent crises through development of intensive case management activities, court and criminal justice improvements, Medicaid accessibility and outreach, peer support and drop-in services, and an increase in substance use outpatient treatment services.

Finally, the Prevention, Intervention and Harm Reduction Subcommittee has operationalized Community Engagement Teams (CETs) and programs that work towards mitigating the effects of adverse childhood experiences (ACEs). They continue to work on the development of a LEAD program, youth prevention and intervention, school-based substance use intervention, and programs that increase mental health awareness, education and training.

The ABCGC Behavioral Health Initiative was recognized with an Achievement Award by the National Association of Counties in July 2018

### **Dona Ana County**

The Health and Human Services Alliance, a 25-person volunteer board, serves as the primary advisory body to the Dona Ana County Health and Human Services Department. It is intended to improve coordination and collaboration among service providers, nurture public understanding, strengthen accountability, promote informed policy making, and create an opportunity for effective community input.

In 2013, a 12-bed crisis triage center was built next to the County Detention Center. It has been vacant since construction was completed due to a lack of operating funds. With Medicaid expanding its services to include payment for crisis triage centers in its revised Rule, plans for the opening of the center are currently under discussion once again, pending development of facility licensing and program certification standards by DOH and BHSD respectively. It was originally intended to serve as a diversion from incarceration for those with a serious mental health condition, but is now also proposed as a “safe-landing zone” for individuals discharged from the County Detention Center who have an active mental health disorder, estimated at 40% of the total jail population. The County’s Health and Human Services Director estimated in 2017 that there were approximately 86 county residents each month who would benefit from diversion from incarceration and an average of 378 individuals discharged from the Detention Center each month with a mental health condition. Obviously, this potential demand far outstrips the capacity of the center, so additional programming design work remains.

These local behavioral health programs and systems from three of our highest population counties highlight additional local resources and funding available to support provider systems. Other counties and regional coalitions and related care systems could also have been cited, such as Local Collaboratives, housing authorities, faith-based organizations, hospitals and emergency departments, law enforcement and emergency response systems, and many others. In addition to these types of programmatic and financial resources, additional specialized organizations exist to support New Mexico behavioral health provider systems. Three of these will be briefly described.

### **Behavioral Health Providers Association of New Mexico (NMBHPA)**

As described by the Association's Executive Director, the NMBHPA is a professional membership organization working to ensure that publicly-funded behavioral health providers in New Mexico share a unified voice in advocating for their clients and services. Representing various types of provider entities, the Association's strategic goals are to:

- Collaborate in providing an integrated and supported system of services for New Mexico's adult seriously mentally ill population;
- Promote a vision of a value-based system for children and families which includes provider and family voices; and
- Prepare behavioral health providers for success in the changing health care environment by increasing awareness and understanding of the principles and practice of value-based purchasing and care, and integrated care.

### **NAMI New Mexico**

The National Alliance on Mental Illness New Mexico State Chapter (NAMI-NM) provides advocacy, education and support by:

- Providing education programs for families, individuals, providers and communities;
- Promoting innovative, statewide education and treatment in diverse community settings;
- Working to abolish stigma;
- Working with all branches and levels of government to promote systems change and expand resources; and
- Providing safe environments to promote resiliency and recovery.

The Family-to-Family program provides a 12-week training for family members in which advice, support, education and access to resources are taught.

The Peer-to-Peer program is a 10-week (two hours per week) experiential education course on the topic of recovery for any person with a serious mental illness who is

interested in establishing and maintaining wellness. The course uses a combination of lecture, interactive exercises and structured group processes.

Connection is a recovery support group for people living with mental illness. It meets weekly for 90 minutes, free of charge. These groups provide a place that offers respect, understanding, encouragement and hope.

In Our Own Voice – Living with Mental Illness is a national program that provides recovery awareness to both professional and lay audiences, including schools, civic organizations, law enforcement, families, and consumers themselves. These presentations are given by trained consumer presenters.

### **New Mexico Alliance of Health Councils**

Although county and tribal health councils have been active in many areas since as early as 1991, the not-for-profit New Mexico Alliance of Health Councils was incorporated in early 2011 to assist in the coordination of these local councils. The organization was established with three goals:

1. to establish a unified voice to strengthen and promote the value and services of community health councils, through state and local education and advocacy;
2. to assist the health councils in seeking and obtaining funding to support community health improvements; and
3. to build the capacity of all health councils to continue and expand their work, through conferences, training workshops, a newsletter, and web-based information exchange.

There are currently health councils in all 33 counties and in six Native American pueblos. The Alliance is governed by a Steering Committee of all members, an Executive Committee of six regional representatives, and three working committees focusing on policy, capacity building, and resource development.

The Alliance has demonstrated effectiveness in developing community health assessments and program planning, resource development, coordination of and access to services, and influencing policy at the local and state levels. Many of their service development activities have targeted behavioral health issues, such as drug and alcohol use, violence mitigation, and suicide prevention. A program evaluation by UNM and the Department of Health in 2014 documented 142 new programs and initiatives in the first three years of Alliance operation, significant policy impact around the state, and an increase of \$3.5M in new funding for communities to support local health initiatives.

### **Centennial Care Managed Care Organizations Certified Peer Support Worker Initiatives**

Certified Peer Support Workers (CPSW) provide formalized peer support and practical assistance to people who have a behavioral health challenge to help regain control over

their lives in their own unique recovery process. Through wisdom from their own lived experience, peers inspire hope and evidence that recovery is possible. Through a collaborative peer process and information sharing, peers help identify opportunities so that individuals can participate in to meet their personal and recovery goals. After receiving proper training and state certification, these individuals connect with Centennial Care members, share relevant lived experience, model recovery, and assist in navigating the complex behavioral health system.

Blue Cross Blue Shield of New Mexico (BCBSNM) currently employs 20 CPSWs. These staff function as a part of the New Mexico recovery support team.

BSBSNM implemented the use of Peer Support Worker as outreach to members utilizing the Emergency Department (ED) for Behavioral Health and Substance Use Disorders (SUD.) Peer Support Workers attempt to engage with the member while the member is in the ED and then continue to provide support post discharge. In addition to connecting to high/emerging risk members, recovery support staff also engage with members who have been identified as being newly diagnosed with an SUD. For these members, CPSW staff work with members to assist in making and keeping provider appointments, offering support, encouragement, and motivation that is needed to pursue recovery.

Presbyterian Health Plan (PHP) employs ten full time CPSWs. Presbyterian Health Services (hospitals) will employ nine full time CPSWs who will be stationed at Presbyterian Hospital Emergency Departments in Santa Fe, Espanola, and Albuquerque.

PHP CPSWs work with members in their homes, but also in a variety of settings including hospitals and emergency rooms, jails and prisons, drop in centers, Medical Assistance Treatment (MAT) providers (such as methadone programs), homeless shelters, behavioral health and primary care settings, and other locations.

To meet the training and other growth needs PHP is developing a peer mentoring and training program which is managed by a Peer Supervisor under the guidance of the Director of Recovery. The initiative offers assistance to perspective peers seeking placement, support, and guidance to those interested in becoming a CPSW. Established relationships with behavioral health providers facilitate that process. They are currently developing a menu of training topics with various delivery options including distance learning, electronic self-administered courses and face to face opportunities. The project will offer Continuing Education Units (CEU).

Western Skies Community Health Care (WSCC) employs six CPSW positions and three Family Peer Supports. The CPSWs are part of the Member Connections team that consists of both Peer Support and Community Health Workers. The Member Connections team works remotely and assists with member engagement through face-to-face and telephonic outreach in their communities. This type of outreach is focused on engaging members to complete Health Risk Assessments, educating them on the

Medicaid program, assessing social determinates of health needs, and referring to Care Coordination. Members are connected to community social services based on needs and provided support to access services and recovery assistance. The CPSWs support members in identifying barriers to care and self-management, they address provider access issues resulting in ED utilization, and coordinate follow-up care with the member's primary care physician.

### **Life Link**

The Life Link's Anti-Human Trafficking Initiative (Initiative), located in Santa Fe, is New Mexico's only comprehensive aftercare program for victims of human trafficking. Through partnerships statewide Life Link creates community resources to assist individuals into recovery. The Initiative team also provides consultation and training to law enforcement and behavioral health professionals on successful strategies for working with the population. The Life Link's program has received referrals from around the country and is gaining a national reputation for development and implementation of a best-practices approach for working with human trafficking victims. The Initiative strives to provide rights-based, wraparound care to meet the myriad needs of rescued victims as they navigate the difficult road to recovery.

The Initiative is also responsible for the creation and ongoing operation of the 505-GET-FREE hotline. This outreach project was designed to provide an easy-to-remember local number for human trafficking victims to contact in order to get help, information, or resources. The 505-GET-FREE hotline was also the first "text line" in the country, enabling victims to reach out in a private, confidential manner to access assistance. Partnerships with the cities of Santa Fe and Albuquerque have enabled Life Link to publicize the hotline through signage on buses, billboards, and benches.

### **University of New Mexico Division of Community Behavioral Health**

The BHSD has maintained strong partnership and collaboration with the University of New Mexico Division of Community Behavioral Health (CBH) to carry out many statewide initiatives.

#### **Behavioral Health Research and Evaluation**

CBH's behavioral health services research and evaluation efforts focus on New Mexico's behavioral health system and the people it serves, including access, health disparities, and service expansion. Through a collaborative process, this program brings together consumers, family members, providers, and local stakeholders to develop culturally competent research and evaluation projects that benefit communities. Some efforts focus on evaluating existing programs, while others focus on implementing new practices and evaluating out comes.



## Native American Behavioral Health

The mission of the Native American Behavioral Health Program is to improve access to culturally appropriate and quality behavioral health services for Native American populations in New Mexico. The program collaborates with Native communities and agencies to provide consultation, training, research, and evaluation partnerships and services.

## School Community Behavioral Health

Free weekly one-hour behavioral health presentations by psychiatrists, psychologists, nurses, social workers, counselors, sociologists, anthropologists, epidemiologists and clinical researchers involving the assessment, diagnosis, treatment and management of psychosocial challenges for children, adolescents and their families. These presentations include opportunities for case discussion and consultation.

## Tele-Behavioral Health

Promote behavioral health workforce development opportunities for providers of medical and behavioral healthcare in rural/frontier New Mexico. Provide access to psychiatric specialists with expertise in child/adolescent and substance-use disorders via telehealth technology to populations in rural/frontier New Mexico Foster collaboration between primary care and behavioral health providers.

The program provides options for distance education (from didactic instruction to case consultation to collaborative assessment and/or treatment) for providers of medical and behavioral healthcare in rural/frontier areas while also directly improving access to psychiatric services. The approach includes the provision of educational credits for participating providers, and ensures that community providers will be able to bill for time spent co-treating clients through telehealth when appropriate. Emphasis is placed on the dissemination, modeling, and use of evidence-based practice through training, consultation, and a model of patient-and-family-centered interdisciplinary collaborative care.

## Training and Workforce Development

CBH provides multiple training/workforce development opportunities for providers, students and community members representing a variety of professionals, including psychiatry, psychology, social work and primary care. The workforce development program focuses on a wide-range of topics including: clinical practice in rural communities, public behavioral health system and policy development, services research, and culturally competent service provision. CBH is also part of the Consortium for Behavioral Health Training and Research (CBHTR), a partnership between the Behavioral Health Purchasing Collaborative, the Department of Higher Education, and various colleges and universities statewide.

## Helpful Links

These links were referenced in Superscript throughout the document.

- 1. New Mexico Administrative Code (NMAC) Title 8, Chapter 321, Part 2 (8.321.2), Specialized Behavioral Health Services**  
[https://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20321/8\\_321\\_2%207\\_24.pdf](https://www.hsd.state.nm.us/uploads/files/Providers/New%20Mexico%20Administrative%20Code%20Program%20Rules%20and%20Billing/NMAC%20Program%20Rules/Chapter%20321/8_321_2%207_24.pdf)
- 2. Behavioral Health Policy & Billing Manual (BH Manual)**  
[https://www.hsd.state.nm.us/uploads/files/Providers/Manuals%20and%20Guides/BH%20POLICY%20AND%20BILLING%20MASTER\\_.pdf](https://www.hsd.state.nm.us/uploads/files/Providers/Manuals%20and%20Guides/BH%20POLICY%20AND%20BILLING%20MASTER_.pdf)
- 3. Medicaid Enrollment by County of Residence**  
<https://webapp.hsd.state.nm.us/MERReport/RunReport.aspx?Report=Medicaid%20Enrollment%20by%20County%20of%20Residence.rdl>
- 4. UNM Early Psychosis Clinic**  
<https://hsc.unm.edu/health/patient-care/behavioral-health/early-program.html>
- 5. Office of Substance Abuse Prevention**  
<http://www.nmprevention.org/index.html>
- 6. New Mexico Youth Risk and Resiliency Survey**  
<https://nmhealth.org/about/erd/ibeb/yrrs/>
- 7. Treat First**  
[www.treatfirst.org](http://www.treatfirst.org)
- 8. A Dose of Reality**  
<https://www.doseofrealitynm.com/>
- 9. NM Network of Care**  
<http://www.newmexico.networkofcare.org/mh/>
- 10. Counties funded by Office of Substance Abuse Prevention**  
<http://www.nmprevention.org/Service-Providers.html#>

## Planning Steps

### Step 2: Identify the unmet service needs and critical gaps within the current system.

#### Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

A data-driven process must support the state's priorities and goals. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data sets including, but not limited to, the [National Survey on Drug Use and Health](#) (NSDUH), the [Treatment Episode Data Set](#) (TEDS), the [National Facilities Surveys on Drug Abuse and Mental Health Services](#), and the [Uniform Reporting System](#) (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

In addition to in-state data, SAMHSA has identified several [other data sets](#) that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the [Healthy People Initiative](#)<sup>16</sup> HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

<sup>16</sup> <http://www.healthypeople.gov/2020/default.aspx>

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

#### Footnotes:

NM was encountering errors when the attachments below were uploaded. The lack of attachments is not detrimental to the overall scope of Planning Steps 2. Attachments were for reference only.

All data referenced in Planning Steps 2 are listed below and are available upon request.

2017 NM State Profile N-SSATS

Data Quality Profile - TEDS Admissions NM

Data Quality Profile - TEDS Admissions USA

NM BH Barometer Volume 5

NM Substance Use Epidemiology Profile December 2018

NM State of Mental Health November 2018

## Step 2. Identify the unmet service needs and critical gaps within the current system

Over the past couple of decades, New Mexico (NM) has experienced the same stressors on its publicly-funded behavioral health system as most other states, perhaps compounded by its complex and unique demographics.

While 5th in size among all states, it is only 36th in population, with just over 2.1 million residents. With such a small population, its tax base is inadequate to support all of the public needs normally within the purview of a state government. The majority of its counties are deemed either rural or frontier, exacerbating the difficulty of creating and maintaining adequate administrative and support service systems for its residents. The state is dependent on extractive industries, and is therefore subject to the boom and bust cycle of oil and gas pricing on the world market. Unemployment is among the highest in the U.S., remaining nearly 50% higher than most of the remainder of the country even a decade after the recession of 2008. The state ranks 50th in poverty level at 20.6%, with the level of children living in poverty close to 50% above that percentage. New Mexico is one of the few majority-minority states, where a federal ethnic minority, Hispanics, has the largest population base (47%). It also has the largest percentage of Native Americans in any state (9%). These populations frequently experience disparities in their access to and use of public systems. Overall child well-being, a complex measure used by the Annie E. Casey Foundation that includes economic well-being, education, health, and family and community elements, ranked New Mexico 49th among all states in its 2017 Kids Count Data Book, and 48th in economic well-being, 50th in education, 37th in health, and 49th in family and community support. Children in poverty, as noted above, exceeded 29% in 2015, in contrast to a U.S. figure of 21%. The indicators where New Mexico was significantly worse than U.S. averages include children with parents that lack secure employment, teens not in school and not working, 4th graders not proficient in reading and 8th graders not proficient in math, high school students not graduating on time (an 82% higher rate than the U.S. average!), child and teen deaths per 100,000, children living in high poverty areas, teen birth rates per 1,000, and children in households where the head of the household lacks a high school diploma.

### CONTEXTUAL CONDITIONS

#### Large Rule and Frontier State

- Serving small populations is challenging
- Long distances over mountainous terrain make travel difficult, expensive and time consuming

#### Border State

- Immigration
- Drug cartel routes and trafficking
- Unique population structure with high risk factors

#### Economic

- Limited infrastructure – utilities, public works, electric, internet/digital infrastructure, phone
- Lack of community resources at county and city levels
- Low wages
- High workforce turnover
- High poverty, low literacy, low graduation rates, high unemployment, high homelessness

#### Political

- Political party transition for new governor

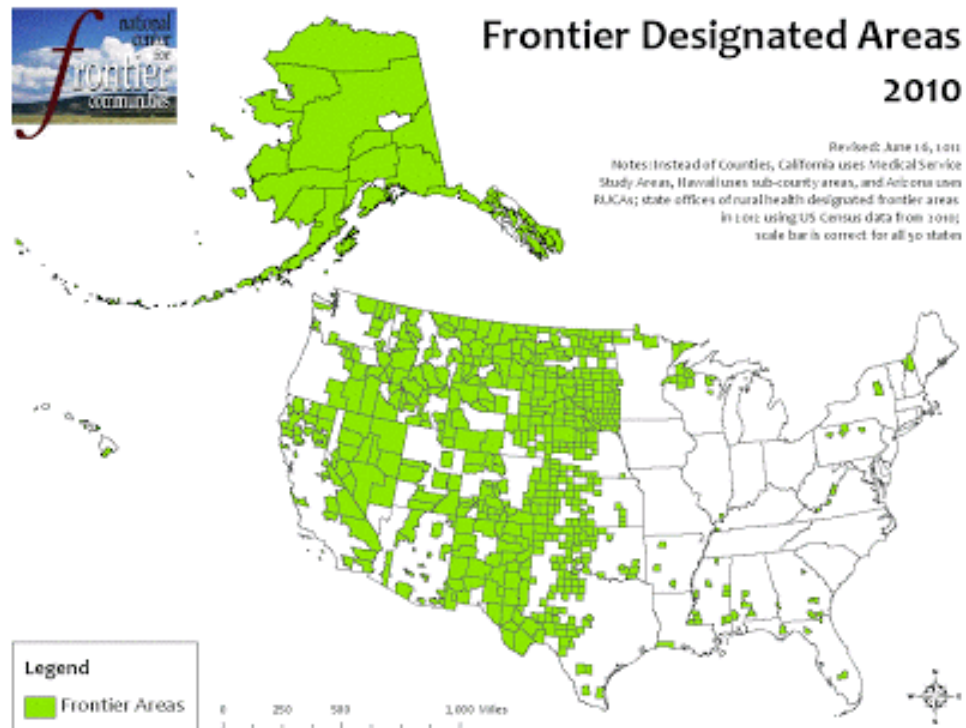
- Conflicting priorities at Local vs State levels
- Grandfathered in licenses exceeding density parameter/limits
- Staffing shortage and lack of structure

**Substance Issues**

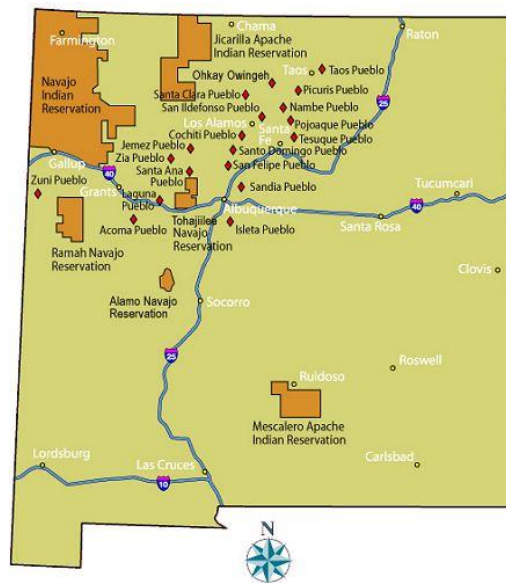
- High opioid overdose rates
- Medical and recreational marijuana
- E- cigarette use surge
- High rise in meth use
- Poly substance use
- Alcohol related deaths

In 2016, 2,103,586 people lived in the 121,298 square miles of the state of New Mexico, the fifth largest state by land mass and one of the most rural states. Nearly forty percent of the state’s population lived in a U.S. Department of Health and Human Services Primary Care Health Professional Shortage area. Nearly 50 percent of residents are Hispanic, 38% are non-Hispanic white, 10.6% are non-Hispanic American Indian or Alaska Native, 2.5% are non-Hispanic Black, and less than 2% non-Hispanic Asian or Pacific Islander. The American Indian population represents 23 federally recognized tribes, pueblos, and nations, as well as urban off-reservation populations. From 2010 to 2016, the number of New Mexicans over the age of 65 increased 3.3%. The median household income (in 2016 dollars) from 2012-2016 was \$45,674.<sup>15</sup> Almost 10% of the population was born outside of the United States. About 85% of the adult population has at least a high school degree. In 2014, veterans represented nearly 10% of the civilian population 18 years and older. *State of Mental Health in New Mexico November 2018*

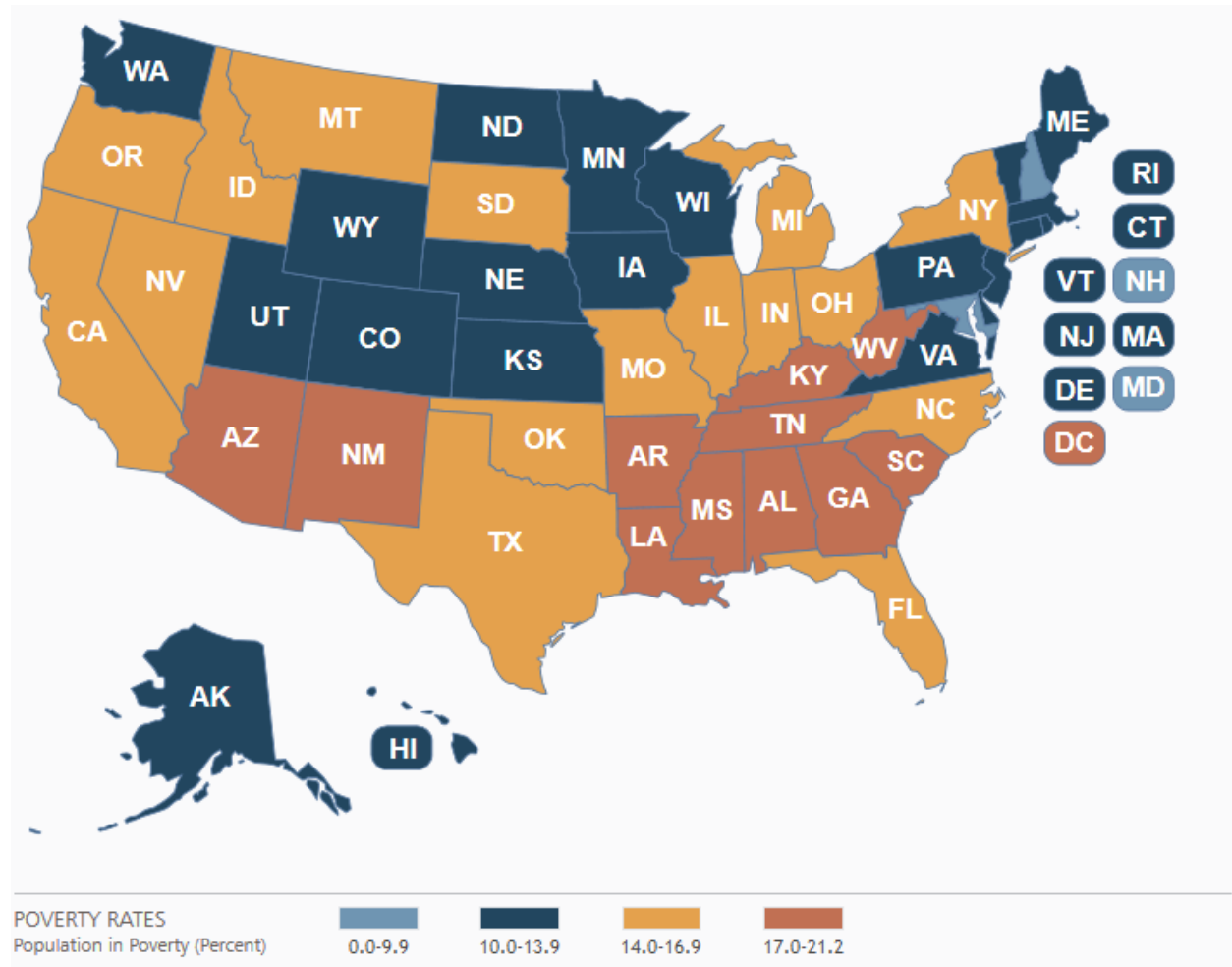
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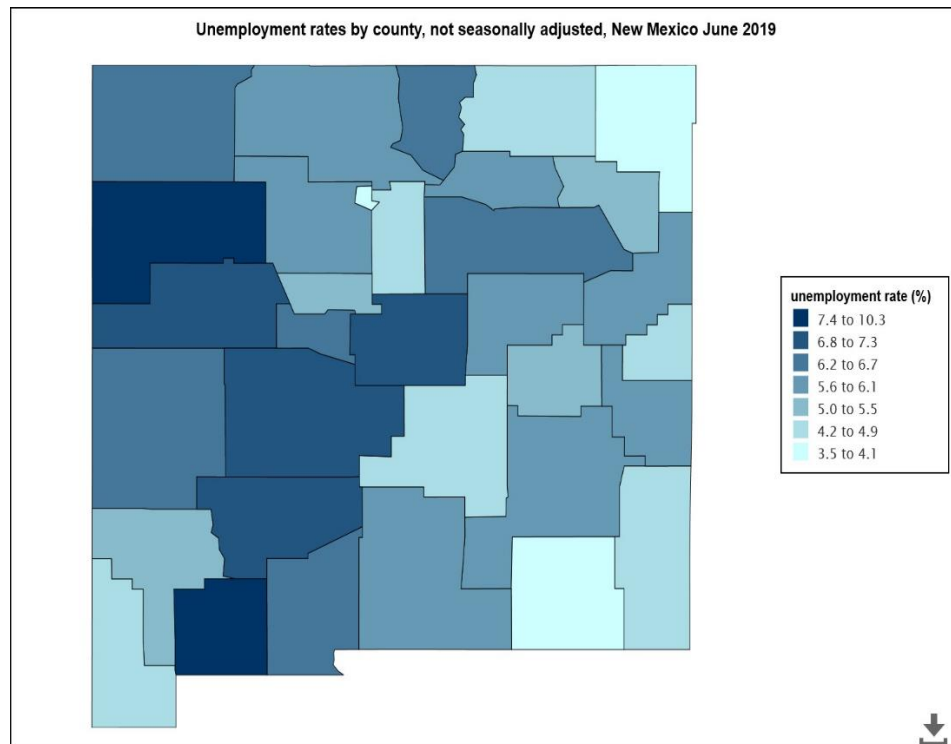
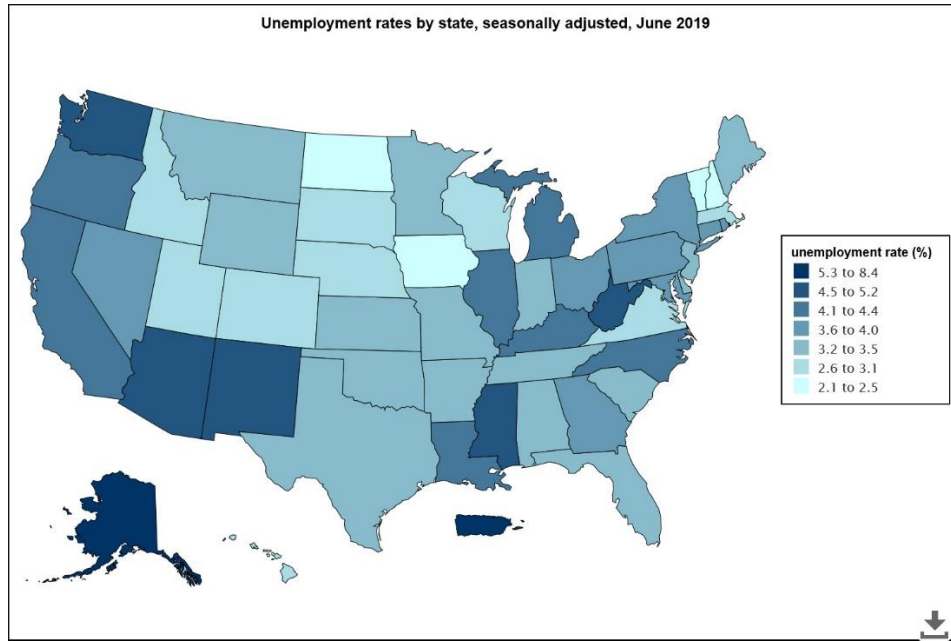
Almost 35% of New Mexicans speak a language other than English at home, but only 12.9% speak Spanish at home. New Mexico is the home of 24 federally recognized Tribal entities: 19 pueblos, Navajo Nation, the Mescalero Apache and Jicarilla Apache Tribes, Ute Mountain and the Fort Sill Apache Tribe. New Mexico is home to 6.2% of the total Native American population in the United States.



New Mexico is a poor state, with 20.4% of residents living in poverty. Consequently, they experience many social problems related to living in poverty. New Mexico is ranked 48<sup>th</sup> in the nation in child poverty (29%).



In May of 2019, the estimated unemployment rate in New Mexico was 5.0%, much higher than any of the surrounding states (US Bureau Labor Statistics, May 2019).



New Mexico has 94 primary Health Professional Shortage Areas (HPSA) identified. In New Mexico, 40.5% of the population is living in a primary health professional shortage area as compared to 19.1% of the US population as a whole. An estimated 26.6% of New Mexico's population is underserved compared to



11.4% of the U.S. population. An estimated 125 additional practitioners are needed in New Mexico to remove the HPSA designations and 254 more practitioners are needed to achieve the target population-to-practitioner rate. "In New Mexico only Los Alamos County does not contain a health professional shortage area." New Mexico has 770.5 R.N.s per 100,000 populations compared to the US rate of 920.9. This ranks New Mexico as 44th in the nation. Additionally, New Mexico has 125.4 LPNs per 100,000 population compared to the U.S. rate of 225. This ranks New Mexico as 42nd in the nation.

Achieving equity in health outcomes depends upon a shared understanding of health disparities among different populations and the factors that create those disparities. Health disparities refer to preventable differences in the quality of health and health care that exist among specific population groups due to systematic inequalities in the social and economic conditions in which people live and work. Health disparities occur across many dimensions, including: socioeconomic status, race/ethnicity, age, gender, sexual orientation, disability status, primary language, and location. A majority of New Mexico residents (over 60%) identify as a person of color and/or American Indian/Alaskan Native. According to 2017 U.S. Census Bureau estimates, 2,088,070 people live in New Mexico. Of these, 48.8% self-identify as Hispanic, 37.4% as non-Hispanic White, 9.6% as American Indian/Alaska Native, 2.1% as Black/African American, 1.4% as Asian, 0.1% as Native Hawaiian/ Pacific Islander, 7.7% as "Other Race", and 3.3% as two or more races. Almost 25% of the population lives in a rural area, 15.7% are living with a disability, 35.4% of the state's population age five and over speaks a language other than English at home, and 19.7% of the population lives below the poverty level. Additionally, 3.9% of New Mexico adults and 11.6% of high school youth identify as lesbian, gay, or bisexual; 0.7% of adults identify as transgender/gender diverse; and 6.3% of high school youth identify as transgender, genderqueer, genderfluid or unsure of their gender identity. In other words, the majority of New Mexicans belong to at least one population group at high risk of experiencing health disparities. Accordingly, to improve the overall health of New Mexico residents, the core principles and values of public health must include the advancement of health equity and the elimination of health of New Mexico residents, the core principles and values of public health must include the advancement of health equity and the elimination of health disparities (Source, Health Equity in New Mexico Report 2019 formerly New Mexico Department of Health Strategic Plan)

Twenty percent (20%) of New Mexicans age 16 and older have literacy skills at level 1, the lowest level on a scale of 1 to 5. Each literacy level is associated with a specific set of skills that are generally accepted as necessary for full participation in society. Individuals at level 1, for example, have difficulty locating simple information in a news article or applying basic math to determine the total on a sales receipt. Nationally, level 1 estimates range from a low of 11% in Alaska, Utah, and Wyoming to a high of 37% in the District of Columbia. The national average for individuals at level 1 or below is 21%. Within New Mexico, level 1 estimates range from a low of 5% in Los Alamos County to a high of 35% in Luna County. In terms of literacy level 2, 46% of New Mexico's population is at this level or below. As a benchmark in practical terms, nearly two-thirds (64%) of all jobs today require literacy skills beyond level 2, while only 12% require skills at level 1 and 24% at level 2, according to a study by the Milken Institute. Based on the statewide population, 46% functionally illiterate population, it is estimated that 899,115 adults are in need of literacy services. In four New Mexico counties, the percentage of adults lacking a high school education exceeds 45% (Mora, Luna, McKinley, and Guadalupe counties). Statewide, 25% of adults age 21 and older and 18.5% of adults age 25 and older lack a high school diploma or its equivalent. (newmexicoliteracy.org)

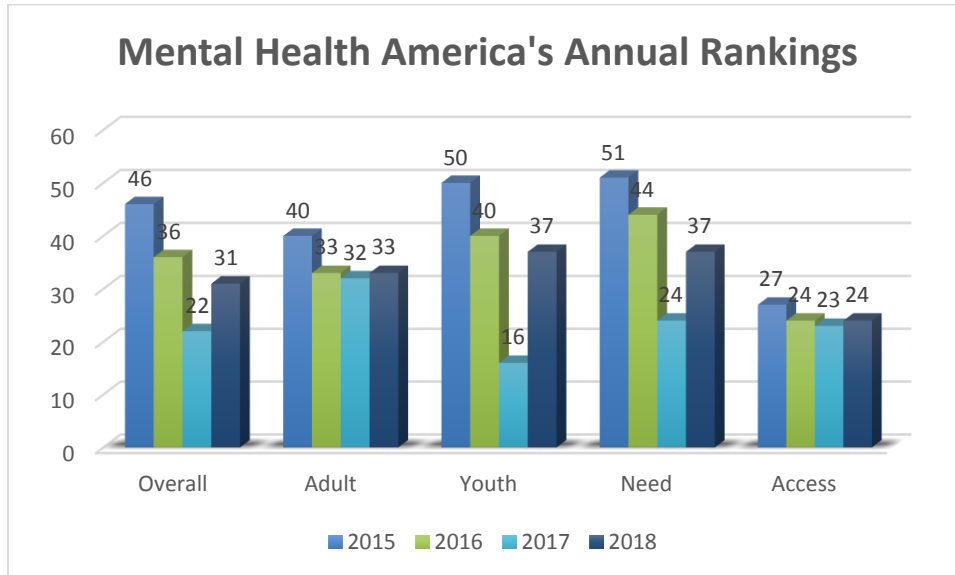
Subpopulations represent the diversity of New Mexico. In 2013, the New Mexico Department of Health's Racial and Ethnic Disparities Report Card reported that Hispanics and Whites in New Mexico have the highest rates of drug induced deaths at 25.6 per 100,000. Native Americans have the highest alcohol related deaths at 121.1 per 100,000, which is 2 ½ times the rate for Hispanics and Whites. Veterans have elevated rates of Substance Use Disorders (SUDs), SMI and CODs as well as high risk for homelessness. Approximately, 20% of Iraq/Afghanistan veterans have PTSD and/or depression (Tanielian and Jaycox, 2008). Data from the 2004-2010 National Survey on Drug Use and Health show that among veterans 21-34, the prevalence of untreated SUD was 16%. Veterans are also more likely to suffer from serious psychological distress compared to nonveteran counterparts (14% vs. 12% respectively; Golub, Vazan, Bennette and Liberty, 2013). Nearly 180,000 veterans live in New Mexico; 28% are Hispanic and 5.5% are Native American (New Mexico Department of Veteran Services, 2015). Approximately, 1000 New Mexico veterans are homeless (Long March Home, Retrieved April 2015). Thus, serving ethnically diverse homeless veterans is a top priority for BHSD.

“Health disparities” was first officially defined as “differences in the incidence, prevalence, mortality and burden of disease and other adverse health conditions that exist among specific population groups in the United States.” Health disparities are relative and they are identified by comparing the health status, access to services and/or health outcomes of population groups. Characteristics such as race or ethnicity, limited English proficiency, disabilities, sexual orientation, gender identity, economic status and geographic location may affect one’s ability to achieve good health. Although there have been national efforts to reduce health disparities and achieve health equity during the past two decades (Healthy People 2000, 2010, 2020 and the National Partnership for Action to End Health Disparities), these efforts have been hampered by a lack of consistency in collecting and reporting health data.

The Patient Protection and Affordable Care Act passed in 2010 not only addresses access to care, it also addresses the need for improved data to identify significant health differences that often exist between segments of the population. As a result, the Office of Minority Health in the United States Department of Health and Human Services has released new minimum data standards for Race and Ethnicity, Sex, Primary Language and Disability Status. Improved data will assist in efforts to target affected populations and monitor efforts to reduce health disparities and move the United States to a status of health equity — “the attainment of the highest level of health for all people”. (Source, New Mexico Department of Health Strategic Plan 2014-2016)

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New Mexico improved fourteen spots, from 36 to 22, from 2016 to 2017. But unfortunately rose from 22 to 31 in 2018 in Mental Health America’s annual rankings, “The State of Mental health in America 2018.”



A high overall ranking indicates lower prevalence of mental illness and higher rates of access to care. A low overall ranking indicates higher prevalence of mental illness and lower rates of access to care. The combined scores of all 15 measures make up the overall ranking. The overall ranking includes both adult and youth measures as well as prevalence and access to care measures.

**The 15 measures that make up the overall ranking include:**

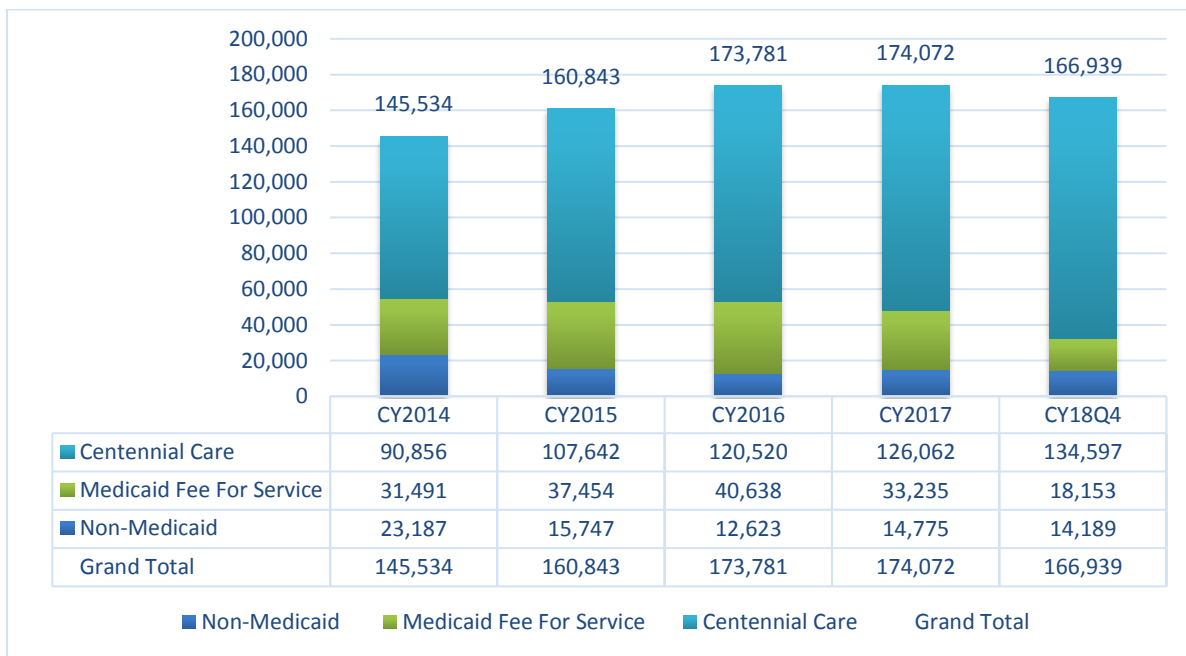
1. Adults with Any Mental Illness (AMI)
2. Adults with Substance Use Disorder in the Past Year
3. Adults with Serious Thoughts of Suicide
4. Youth with At Least one Major Depressive Episode (MDE) in the Past Year
5. Youth with Substance Use Disorder in the Past Year
6. Youth with Severe MDE
7. Adults with AMI who Did Not Receive Treatment
8. Adults with AMI Reporting Unmet Need
9. Adults with AMI who are Uninsured
10. Adults with Disability who Could Not See a Doctor Due to Costs
11. Youth with MDE who Did Not Receive Mental Health Services
12. Youth with Severe MDE who Received Some Consistent Treatment
13. Children with Private Insurance that Did Not Cover Mental or Emotional Problems
14. Students Identified with Emotional Disturbance for an Individualized Education Program
15. Mental Health Workforce Availability

**Other initiatives that helped to improve New Mexico’s ranking were:**

- Mental Health First Aid Training
- Tele-health direct services and continuing education
- Onsite education to hospitals on best practices for substance use detoxification
- Research on Historical Trauma informed interventions for depression
- Workforce development, tele-health supervision, and awareness of BH careers
- Development of supported housing initiatives for individuals with serious mental illness
- Education on screening for suicide risk for primary care providers
- Education for peers with lived experience of behavioral health conditions
- Early intervention for individuals with First Episode Psychosis and their families

**Centennial Care (Medicaid)**

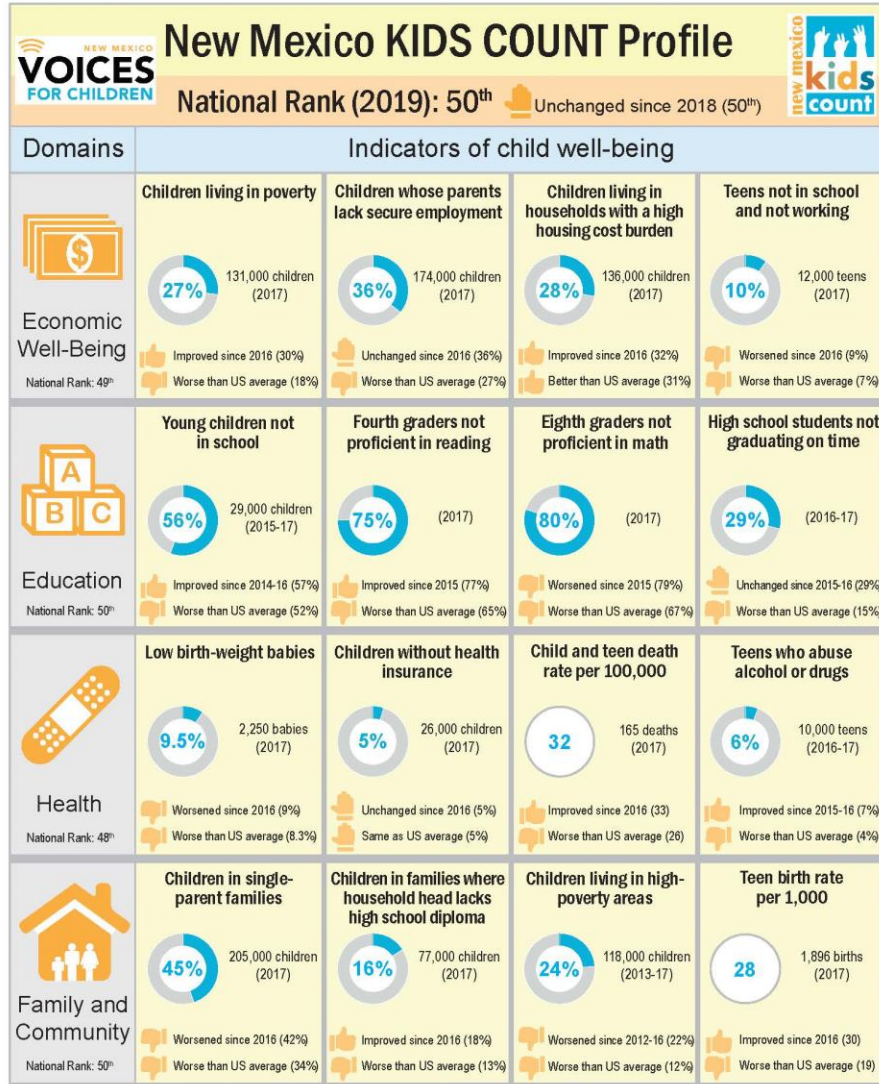
The data for this measure is cumulative and collected based on a calendar year. This graph below reflects twelve months of CY2018. Overall, 166,939 persons were served across all funding sources; this represents a 19.7% increase (or 27,433 persons) over the prior quarter. Medicaid’s 134,597 Centennial Care members account for 80.6% of all persons served in this quarter. The Medicaid members served increased 20.5% (or 22,943 persons) over the prior quarter. There were 18,153 Medicaid Fee for Service members served in this period reflecting a 14% (or 2,230 persons) increase over the prior quarter. However, as reflected in this year’s quarterly counts, the total number of Medicaid Fee for Service members is lower than in prior years. This is based on a change in MAD’s criteria used (i.e., provider type and services codes) for calculating that count. There were 14,189 non-Medicaid members served which reflects a 18.9% increase (or 2,260 persons) over the prior quarter.



## “Kids Count” 2019 Data Book

The Annie E. Casey Foundation’s 2019 Kids Count Data Book ranked New Mexico 50<sup>th</sup> nationally for overall child well-being. Following are the details of the report:

New Mexico’s Child Well-Being Rankings (2018 data):



Source: KIDS COUNT Data Book, Annie E. Casey Foundation, 2018 and 2019  
NEW MEXICO VOICES FOR CHILDREN

5.15.2019

Get more KIDS COUNT data at [datacenter.kidscount.org](http://datacenter.kidscount.org)

*New Mexico’s Economic Well-Being Indicators (2017 data/expressed as a percentage): Education Indicators (2017 data/expressed as a percentage) Health Indicators (2017 data/expressed as a percentage or rate) Family and Community Indicators (2015 data/expressed as a percentage or rate) Children in Single Parent*

## **SEOW -- Statewide Epidemiology and Outcomes Workgroup**

New Mexico's Statewide Epidemiology and Outcomes Workgroup (SEOW) has met monthly for more than a decade. It provides strategic guidance to the state and communities on assessment and epidemiological data for effective data-driven planning. The mission of the SEOW reviews and disseminates data about substance abuse and misuse and their consequences. It also identifies best practice information about evidence-based prevention strategies, policies and practices that can lead to successful outcomes for New Mexicans. The purpose of this two-fold work is to inform communities so that they can better target behaviors and risk factors that can be positively impacted by the implementation of well-chosen, evidence-based prevention approaches that are appropriate for the population. The important work of the SEOW is directed by the Office of Substance Abuse Prevention (NM Human Services Department, Behavioral Health Services Division) and supported by federal funding from the Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration. SEOW includes leading broad, public prioritization processes based on: severity, burden, trends, preventability or changeability, capacity/resources, need, readiness, political will and public concern. A long-term objective of the SEOW is to support local epi workgroups in every New Mexico community.

The vision of the SEOW is that data and products produced by the SEOW will be utilized to expand data-driven decision making and collaboration that support community level outcomes related to behavioral health.

SEOW meets monthly, comprised of representatives from state agencies (Department of Health, Children, Youth and Families Department, Division of Motor Vehicles/DWI, Human Services Department, Aging and Long-Term Services Department/Long Term Services Division, Office of Substance Abuse Prevention, Department of Transportation/ Transportation Services Bureau, etc.)

- Four Evidence-Based Practices Workgroups: Prescription Drug Abuse, Suicide Prevention, Needs Among the Elderly, and Problem ID and Referral
- Development of annual State Substance Abuse Epidemiology Profile
- Development of Substance Abuse Epidemiology County Profiles
- 8 Data Roundtables held to train on accessing and using data for strategic planning and grant writing: 4 in regional areas (Albuquerque, Espanola, Roswell, and Las Cruces) and 4 in Tribal areas (Navajo Nation, Laguna Pueblo, Five Sandoval, and Eight Northern Pueblos)

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## Substance Use/Misuse in New Mexico

### Alcohol Use

All of the ten leading causes of death in New Mexico are, at least partially, attributable to the use of alcohol, tobacco, or other drugs. In 2016, the ten leading causes of death in New Mexico were diseases of the heart, malignant neoplasms, unintentional injuries, chronic lower respiratory diseases, cerebrovascular diseases, diabetes, Alzheimer's disease, chronic liver disease and cirrhosis, suicide, and influenza and pneumonia. Of these, chronic liver disease, unintentional injuries, and suicide are associated with alcohol use; chronic lower respiratory diseases and influenza and pneumonia are associated with tobacco use; heart disease, malignant neoplasms, and cerebrovascular diseases are associated with both alcohol and tobacco use; and unintentional injuries and suicide are associated with the use of other drugs

Death rates from alcohol-related causes increase with age. However, one in five deaths among working age adults (20-64) in New Mexico is attributable to alcohol. Male rates are substantially higher than female rates. American Indians had higher alcohol-related death rates than other race/ethnicities. McKinley and Rio Arriba counties had extremely high alcohol-related death rates, driven by high rates in the American Indian and Hispanic male populations. The counties with the most deaths for the five-year period of 2013-2017 were Bernalillo, McKinley, San Juan, Dona Ana, and Santa Fe. New Mexico has extremely high death rates due to both alcohol-related chronic diseases and alcohol-related injuries.

Alcohol-Related Chronic Disease Death. New Mexico's rate of death due to alcohol-related chronic diseases was more than twice the national rate. Death rates increase with age. American Indians, both male and female, and Hispanic males have extremely high rates. As with total alcohol-related death, McKinley and Rio Arriba counties had the highest rates in the state.

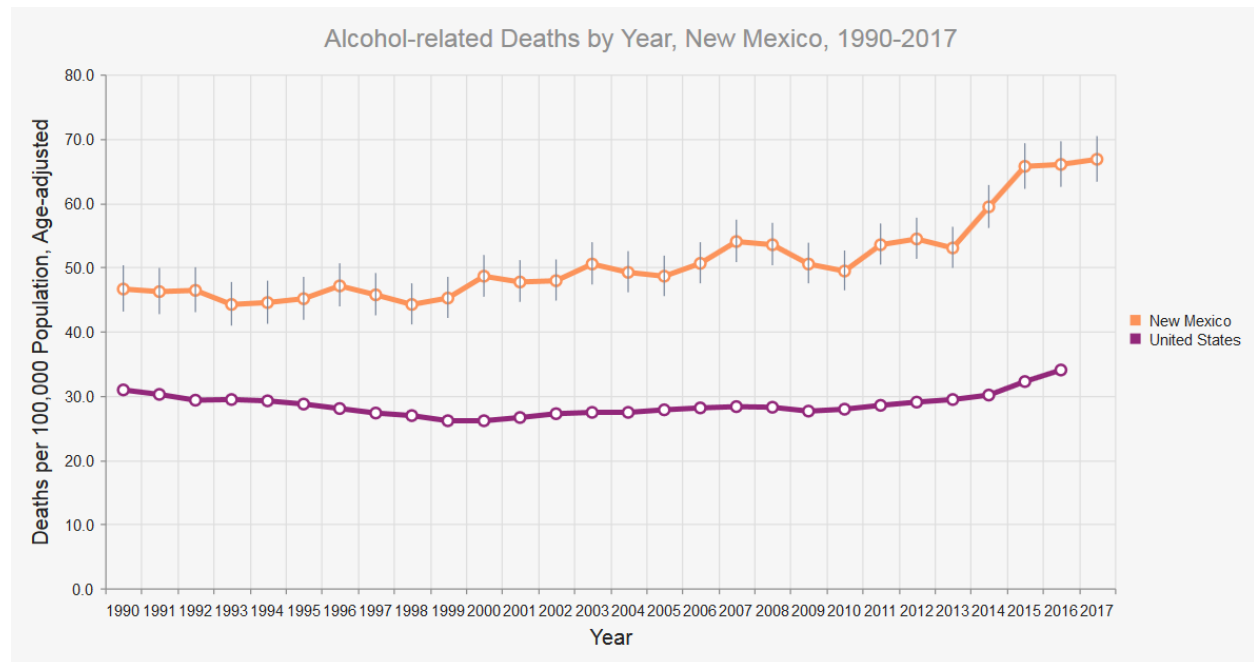
Alcohol-related chronic liver disease (AR-CLD) accounts for the most deaths due to alcohol-related chronic disease. AR-CLD death rates are extremely high among American Indians, both male and female, and Hispanic males. The high rates among American Indians and Hispanic males between the ages of 35 and 64 represent a tremendous burden in terms of years of potential life lost (YPLL). While Bernalillo County had the highest number of deaths due to AR-CLD (677 for the years 2013-2017), two counties that stand out for their very high rates were McKinley and Rio Arriba, which had rates that were more than six times the national rate.

### Alcohol Related Deaths

New Mexico's rate of alcohol-related injury death was approximately 1.4 times the national rate. In the current reporting period (2013-2017), drug overdose surpassed alcohol-related motor vehicle traffic crashes and falls as the leading cause of alcohol-related injury death. Numerous other types of injury death are also associated with excessive alcohol use (particularly binge drinking). Deaths from drug overdose, a portion of which are partially attributable to alcohol, have increased substantially in recent years. Males are more at risk for alcohol-related injury death than females with American Indian males having particularly elevated risk.



The consequences of excessive alcohol use are severe in New Mexico. New Mexico's total alcohol-related death rate has ranked first, second, or third in the US since 1981; and 1st for the period 1997 through 2010 (the most recent year for which state comparison data are available). The negative consequences of excessive alcohol use in New Mexico are not limited to death but also include domestic violence, crime, poverty, and unemployment, as well as chronic liver disease, motor vehicle crash and other injuries, mental illness, and a variety of other medical problems. Nationally, one in ten deaths among working age adults (age 20-64) is attributable to alcohol. In New Mexico this ratio is one in six deaths.



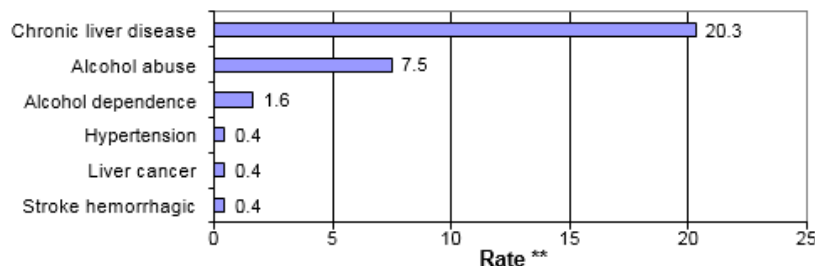
Chronic heavy drinking (defined as drinking, on average, more than two drinks per day for men and more than one drink per day for women) often is associated with alcoholism or alcohol dependence and can cause or contribute to a number of diseases, including alcoholic liver cirrhosis. For the past 15 years, New Mexico’s death rate from alcohol- related chronic disease has consistently been first or second in the nation and 1.5 to two times the national rate. The national death rate from alcohol-related chronic disease in 2015 (13.9) was the same as that in 1990. In contrast, New Mexico’s rate increased 53% from 1990 to 2017.

Chronic heavy drinking (defined as drinking, on average, more than two drinks per day for men and more than one drink per day for women) often is associated with alcoholism or alcohol dependence and can cause or contribute to a number of diseases, including alcoholic liver cirrhosis. For the past 15 years, New Mexico’s death rate from alcohol- related chronic disease has consistently been first or second in the nation and 1.5 to two times the national rate. The national death rate from alcohol-related chronic disease in 2015 (13.9) was the same as that in 1990. In contrast, New Mexico’s rate increased 53% from 1990 to 2017.

Chart 1 shows the six leading causes of alcohol-related chronic disease death in New Mexico during 2013-2017. Alcohol-related chronic liver disease (AR-CLD) was the leading cause of alcohol-related death overall and of alcohol-related chronic disease death during this period. New Mexico also had the highest rate of alcohol dependence death in the US for the period 2010 through 2016 (the most recent year for which state comparison data is available).

**Chart 1: Leading Causes of Alcohol-Related Chronic Disease Death, New Mexico, 2013-2017**

**Alcohol-related\* deaths due to:**



\* Rates reflect only alcohol-attributable portion of deaths from cause

\*\* Rate per 100,000, age-adjusted to the 2000 US standard population

Sources: NMDOH BVRHS death files and UNM-GPS population files; CDC ARDI; SAES

Table 1 shows that death rates from alcohol-related chronic diseases increase with age. The large number of deaths in the 25-64 age category illustrates the very large burden of premature mortality associated with alcohol-related chronic disease. The high rates in this age category among American Indians (both males and females) and Hispanic males further illustrate the heavy burden of premature death due to heavy drinking in these racial/ethnic groups.

**Table 1: Alcohol-Related Chronic Disease Deaths/Rates\* by Age, Sex, and Race/Ethnicity, New Mexico, 2013-2017**

Sex	Race/Ethnicity	Deaths				Rates*			
		Ages 0-24	Ages 25-64	Ages 65+	All Ages	Ages 0-24	Ages 25-64	Ages 65+	All Ages*
Male	American Indian	4	473	60	537	2.2	206.9	163.9	132.2
	Asian/Pacific Islander	0	6	1	7	0.0	13.4	17.5	9.5
	Black	0	24	14	38	0.0	36.3	117.6	33.4
	Hispanic	3	841	257	1,101	0.3	69.1	106.7	49.1
	White	2	546	269	816	0.3	50.8	58.5	28.7
	Total	9	1,901	606	2,516	0.5	72.3	80.1	45.6
Female	American Indian	3	287	60	350	1.7	114.7	112.1	76.4
	Asian/Pacific Islander	0	5	1	5	0.0	7.9	7.2	5.4
	Black	0	13	3	16	0.0	27.4	22.7	15.5
	Hispanic	3	301	127	432	0.3	24.5	43.1	18.0
	White	2	252	139	393	0.3	23.2	26.4	13.6
	Total	8	861	330	1,199	0.5	32.2	36.6	20.9
Total	American Indian	7	759	120	886	2.0	158.7	133.2	102.4
	Asian/Pacific Islander	0	11	2	13	0.0	10.3	11.2	7.1
	Black	0	37	16	54	0.0	32.6	70.2	24.9
	Hispanic	6	1,142	384	1,532	0.3	46.7	71.6	32.9
	White	3	798	408	1,209	0.3	36.9	41.3	20.9
	Total	17	2,762	936	3,715	0.5	52.0	56.5	32.8

\* Age-specific rates (e.g., Ages 0-24) are per 100,000; all-ages rate is per 100,000, age-adjusted to the 2000 US standard population

Sources: NMDOH BVRHS death files and UNM-GPS population files; CDC ARDI; SAES

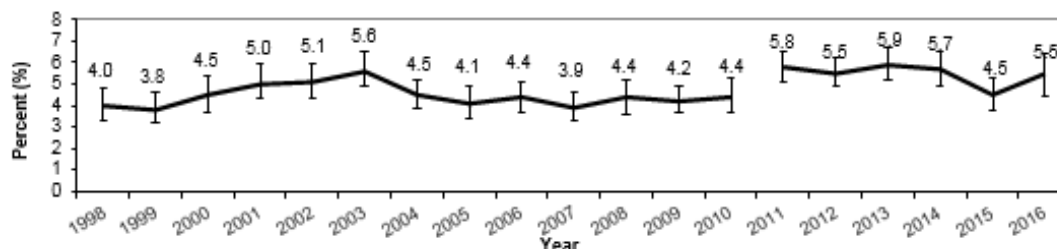
### Adult Heavy Drinking

Heavy drinking (defined as having more than 2 drinks/day for males and more than one drink/day for females) is a pattern of excessive alcohol consumption that can lead to alcohol-related chronic disease

and death. According to the latest estimates from the CDC, numerous chronic disease conditions (e.g., alcoholic liver disease, alcohol dependence syndrome) and a significant proportion of many other conditions (e.g., unspecified liver cirrhosis, pancreatitis) are alcohol-related. For each of these causes, it is chronic heavy drinking (as opposed to acute episodic or binge drinking) that is considered primarily responsible for the incidence and progression of alcohol-related chronic disease. Heavy drinking is also associated with a wide range of other social problems, including alcoholism (also known as alcohol dependence), domestic violence, and family disruption.

Chart 1 shows that adult heavy drinking prevalence has been, more or less, constant since 2005. Heavy drinking prevalence is lower among adults in New Mexico (5.2%) than in the US overall (6.5%). Heavy drinking was most prevalent among adults in the 25-64 age group, with 5.7% reporting past-month heavy drinking. New Mexico men were somewhat more likely to report chronic drinking than women (5.9% v. 4.4%), and American Indian males had the highest reported rate of heavy drinking (7.0%) followed by White females (6.5%) and White males (6.4%).

**Chart 1: Heavy Drinking (past 30 days)\*, Adults Aged 18+, New Mexico, 1998-2016**



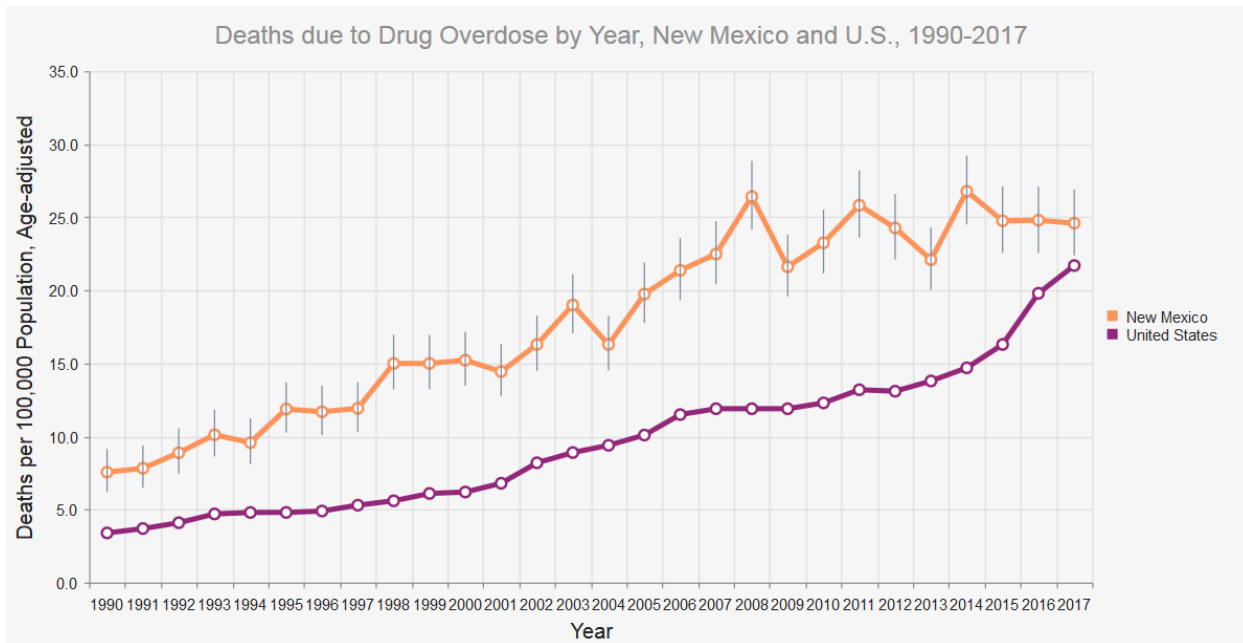
\* Heavy drinking definition: drinking more than 2 drinks/day on average (for men) or more than 1 drink/day (for women) in past 30 days  
 Source: BRFSS; SAES (NOTE: Brackets around reported rates are 95% confidence intervals)

Among men, American Indians had the highest heavy drinking rates (7.0%), followed by Whites (6.4%) and Hispanics (5.8%). Also, American Indian males had the highest rates of alcohol-related chronic disease death (132.2 deaths per 100,000 population), followed by Hispanics (49.1) and Blacks (33.4). Among women, Whites had the highest rates of heavy drinking (6.5%), followed by Blacks (4.4%). However, American Indian females have the highest rates of alcohol-related chronic disease death (76.4 deaths per 100,000 population), followed by Hispanics (18.0) and Blacks (15.5). These differences between heavy drinking rates and alcohol-related chronic disease death rates reflect the long lead time between the behavior and the health-related outcomes of that behavior.

Between 2015-2017 heavy drinking rates were highest in Catron (10.5%), San Miguel (7.2%), and Lea (6.8%) counties and substantially lower in counties that have among the highest rates of alcohol-related chronic disease death rates (e.g., Rio Arriba and McKinley).

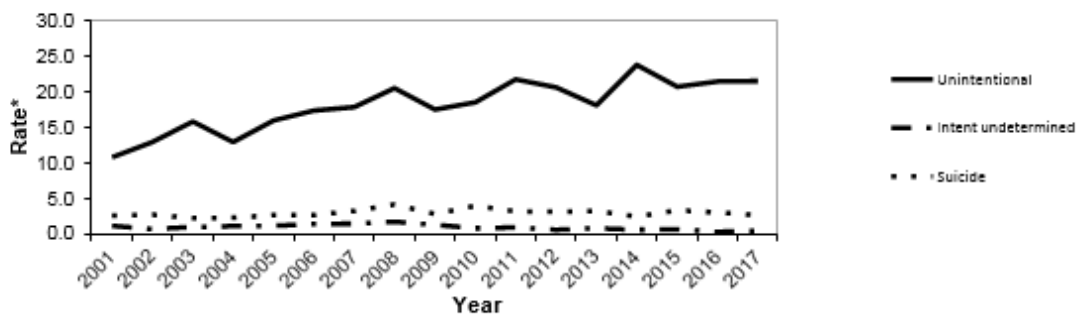
### Deaths Due To Drug Overdose

New Mexico has the highest drug-induced death rate in the nation, and the consequences of drug use continue to burden New Mexico communities. (NM DOH Substance Abuse Epidemiology Profile, 2018)



In 2017, New Mexico had the seventeenth highest total drug overdose death rate in the nation. Drug use can result in overdose death and is also associated with other societal problems including crime, violence, homelessness, loss of productivity, and spread of blood-borne diseases such as HIV and hepatitis. Unintentional drug overdose is the largest subset of total drug overdose death, accounting for 88% of drug overdose deaths in New Mexico in 2017 (Chart 1). The other substantial cause of drug overdose death is suicide, or intentional self-poisoning, which accounts for 11%. Poisoning has been the leading cause of unintentional injury in New Mexico since 2007, surpassing motor vehicle crash deaths, largely as a result of increased unintentional drug overdose deaths associated with prescription drug use.

**Chart 1: Drug Related Death Rates\* by Cause Category, New Mexico, 2001-2017**



\* Rate per 100,000, age-adjusted to the 2000 US standard population  
 \* Cause categories based on ICD-10 codes for drug overdose deaths.

Unintentional drug overdoses account for almost 88% of drug overdose deaths during 2013-2017. 36% of unintentional drug overdose deaths were caused by prescription drugs, while 40% were caused by illicit drugs, and 22% involved both. Vital records death data indicate that the most common drugs causing unintentional overdose death for the period covered in this report were prescription opioids (i.e.,

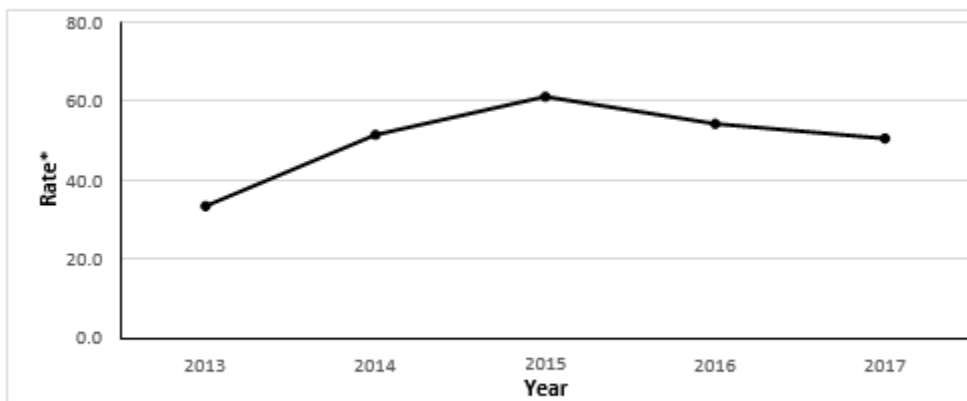
methadone, oxycodone, morphine; 57%), heroin (40%), benzodiazepines (24%), cocaine (13%), and methamphetamine (26%) (not mutually exclusive). In New Mexico and nationally, overdose death from prescription opioids has become an issue of enormous concern. Interventions are currently being formulated, implemented, and assessed in New Mexico and in communities across the country, and may be contributing to decreases in death in the most recent data available

### Opioid Overdose

In addition to the observed increase in drug overdose deaths, there has been an increase in opioid overdose related emergency department (ED) visits. In the US between 2004 and 2009, there has been a 98.4% increase in ED visits related to misuse or abuse of prescription drugs, particularly opioids (Paulozzi, L. J., Jones, C. M., Mack, K. A., & Rudd, R. A. [2011]. Vital Signs: Overdoses of prescription opioid pain relievers-United States, 1999–2008. *Morbidity and Mortality Weekly Report*, 60[43], 6). In New Mexico the emergency department dataset (EDD) is collected in accordance with the NM Public Health Act and New Mexico Administrative Code 7.4.3.10.

Chart 1 shows that between 2013 and 2015, the rate of opioid overdose related emergency department visits increased by 82% in New Mexico.

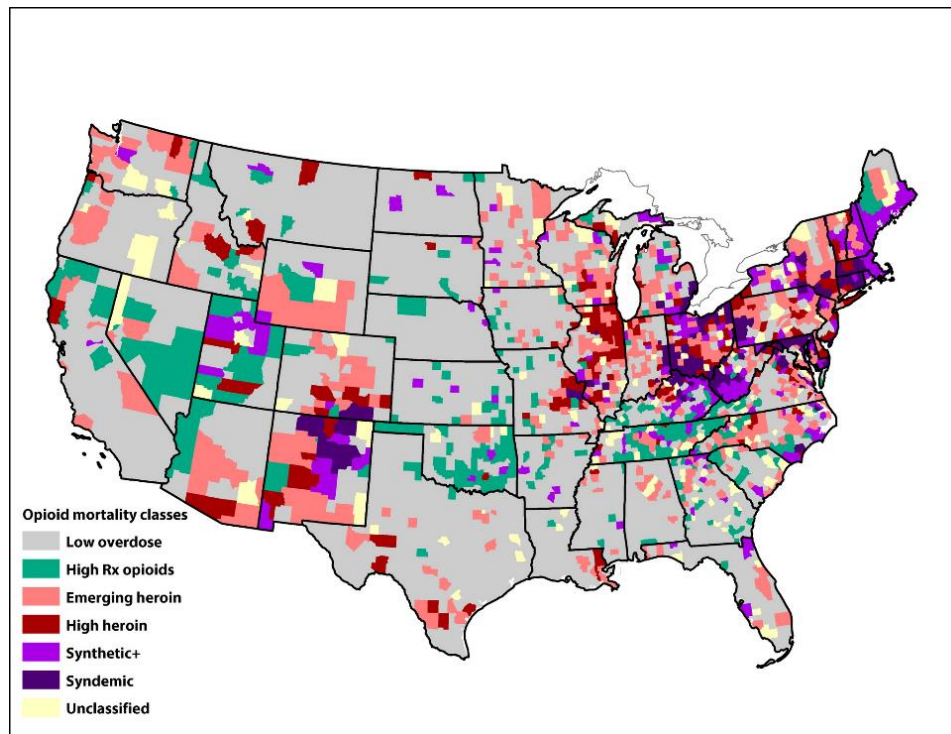
**Chart 1: Opioid Overdose Related Emergency Department Visit Rates\*, New Mexico, 2013-2017**



\* Rates per 100,000 population  
Sources: NMDOH Syndromic Surveillance ED files and UNM-GPS population files; SAES

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Drug mortality rates overall are higher in counties characterized by more economic disadvantage, more blue-collar and service employment, and higher opioid-prescribing rates. High rates of prescription opioid overdoses and overdoses involving both prescription and synthetic opioids cluster in more economically disadvantaged counties with larger concentrations of service industry workers. High heroin and “syndemic” opioid mortality counties (high rates across all major opioid types) are more urban, have larger concentrations of professional workers, and are less economically disadvantaged. Syndemic opioid counties also have greater concentrations of blue-collar workers. (County Census Data)

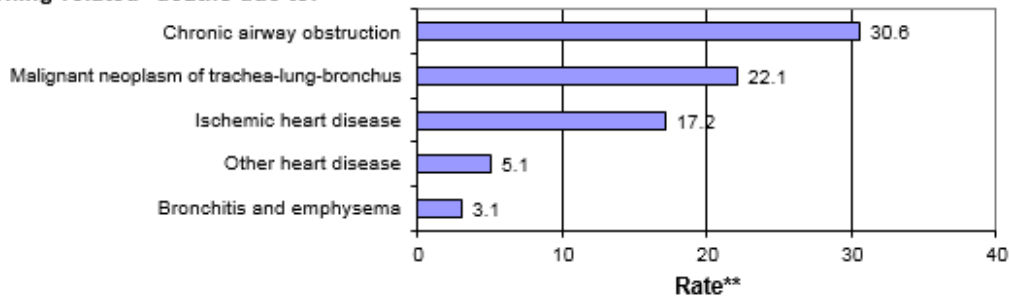


### Smoking Related Death

Smoking is a risk factor for many causes of death and a serious source of preventable death in New Mexico. Chart 1 shows the five leading causes of smoking-related death in New Mexico. Historically, New Mexico's rates for smoking-related causes, such as lung cancer, have been among the lowest in the nation. Nonetheless, a comparison of New Mexico's smoking-related death rates to its alcohol- and drug-related death rates shows that the burden of death associated with smoking is still considerably greater than the burden associated with these other substances. This speaks to the public health importance of smoking prevention efforts, even in a state with low rates relative to the rest of the nation.

**Chart 1: Leading Causes of Smoking-Related Death, New Mexico, 2013-2017**

**Smoking-related\* deaths due to:**



\* Rates reflect only smoking-related portion of deaths from cause  
 \*\* Rate per 100,000, age-adjusted to the 2000 US standard population  
 Sources: NMDOH BVRHS death files and UNM-GPS population files; CDC SAMMEC; SAES

Smoking-related death rates increase sharply in the oldest age group (age 65+), consistent with the fact that smoking-related causes of death are mostly chronic conditions with a long development period. This is in contrast to alcohol- and drug-related deaths, both of which show a large burden of "premature" deaths (deaths before age 65+).

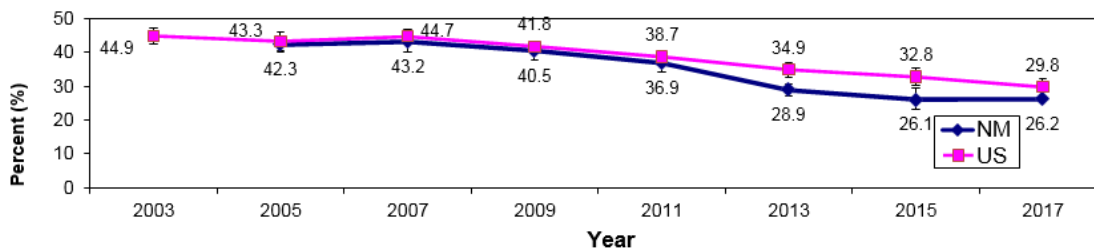
**Youth Current Drinking**

Any alcohol consumption by a person under the age of 21 is considered to be excessive drinking. Alcohol is the most commonly used drug among youth in New Mexico, more than tobacco or other drugs. However, contrary to common perception, most high school students do not drink. "current drinking" is defined as responding one or more days to the question: "During the past 30 days, on how many days did you have at least one drink of alcohol?"

In 2017, 26.2% of high school students reported that they were current drinkers. This is a significant decrease from 43.2% in 2007. Boys and girls are equally likely to be current drinkers, and the percent of youth who drink increases with grade level. However, it is important to note that by ninth grade, close to one in six students are already drinking. Students who identify as Hispanic are most likely to currently drink, followed by White students. American Indian students are the least likely to drink.

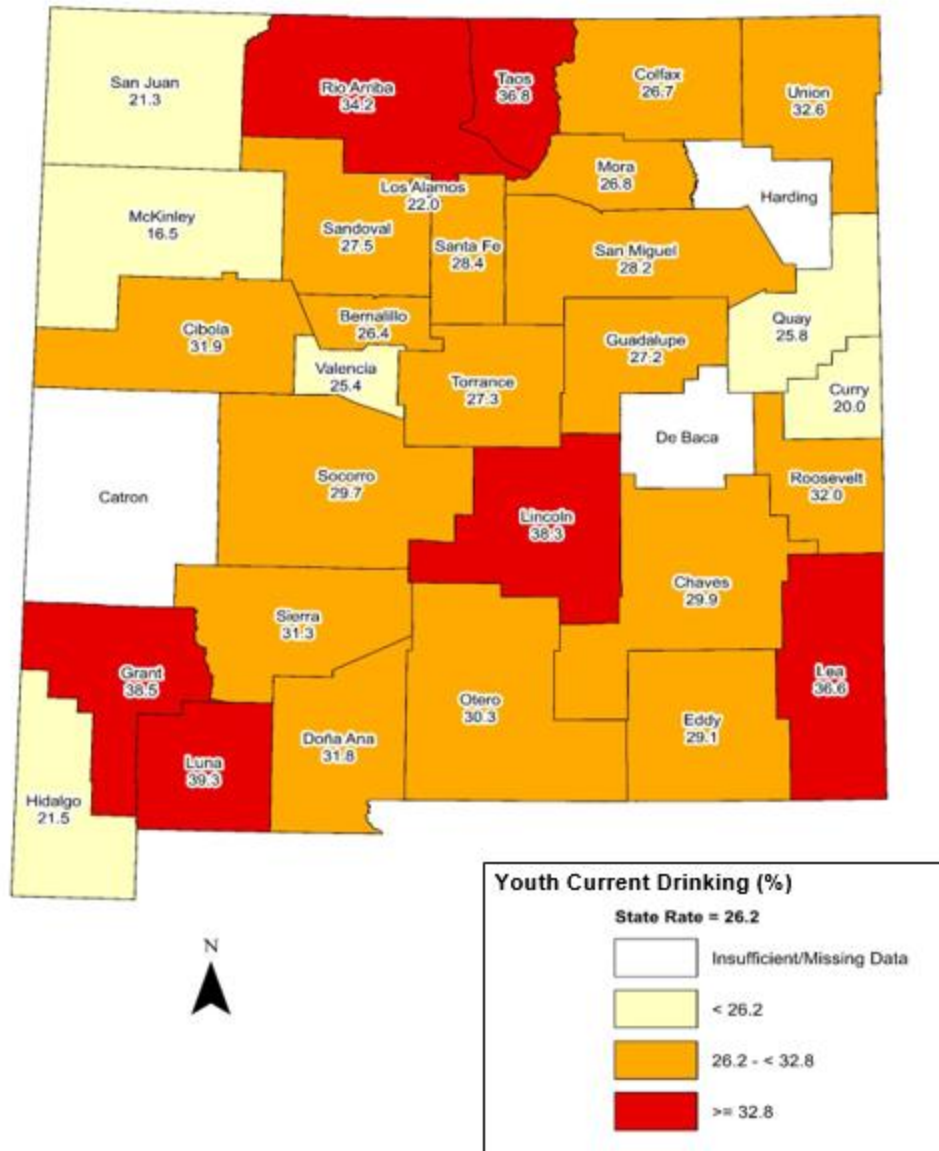
Luna County has the highest prevalence of current drinking among high school students (39.3%), followed by Grant (38.5%), and Lincoln (38.3%) counties. McKinley County has the lowest prevalence (16.5%).

**Chart 1: Current Drinking\* by Year, Grades 9 - 12, New Mexico and US, 2003-2017**



\* "Current drinking" is defined as responding one or more days to the question: "During the past 30 days, on how many days did you have at least one drink of alcohol?"  
 Source: YRRS (NM); CDC YRBS (US); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

Chart 4: Current Drinking\* by County, Grades 9 - 12, New Mexico, 2017



\* Estimate of percent of high school students who reported current drinking in past 30 days  
 Insufficient Data: County estimates not available because of low numbers and/or low response rates  
 Source: YRRS (NM); NMDOH Survey Section; SAES



## Youth Binge Drinking

Binge drinking (defined as having five or more drinks of alcohol for boys or 4 or more drinks for girls in a row within a couple of hours) is a major risk factor for the three leading causes of death among youth (motor vehicle crashes, suicide, and homicide), as well as being associated with poor academic performance and risk behaviors such as impaired driving, riding with a drinking driver, physical fighting, increased number of sexual partners, and other substance use.

In 2017, 10.9% of New Mexico high school students reported binge drinking at least once in the past month. Binge drinking is the norm among current high school drinkers in New Mexico. In 2017, of the 26.2% of students who were current drinkers, 53.9% were binge drinkers. Binge drinking prevalence has been decreasing in New Mexico since 2003, as it has been in the US since at least 2001 (Chart 1). In 2017, the difference between the US (13.5%) and New Mexico (10.9%) rates for binge drinking was not statistically significant.

Binge drinking increases with increasing grade level and does not significantly differ by gender. Overall, Hispanics and Whites have a higher prevalence of current binge drinking compared to other race/ethnicities.



## Youth Substance Use

A number of youth substance use behaviors have improved over the last several years, moving New Mexico's ranking from one of the highest risk states for youth substance abuse in the nation to near the national average.

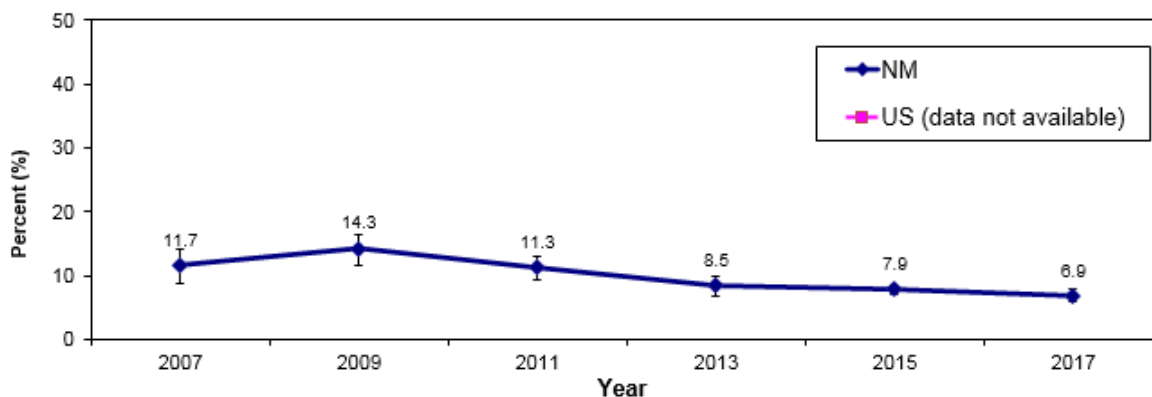
### Youth Use of Painkillers to Get High

The rate of current use of painkillers to get high has shown no noticeable trend since the measure was added to the YRRS survey questionnaire in 2007. Painkiller use to get high had the second highest prevalence (6.9%) of all 30-day drug use measures in the 2017 YRRS, behind marijuana (27.3%). The question about the use of painkillers to get high is not on the national YRBS, and there is no national comparison.

The rate of painkiller use to get high was higher among males (7.4%) than females (6.1%), but this difference is not statistically significant. The prevalence was higher among Asian or Pacific Islander (15.0%) and Black (11.1%) students than among American Indian (8.1), Hispanic (6.7%) and White (5.4%) students.

In 2017, the rate of painkiller use to get high was highest in Sierra (12.9%), Rio Arriba (10.2%), and Chaves (10.0%) counties. The rate was lowest in Quay (1.4%), Hidalgo (1.6%), and Roosevelt (2.1%) counties.

**Chart 1: Used Painkiller to Get High\* by Year, Grades 9 - 12, New Mexico, 2007-2017**



\* Used a painkiller (such as Vicodin, OxyContin, or Percocet) to get high at least one time in the past 30 days  
 Source: YRRS (NM); CDC YRBS (US); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

### Youth Risk and Resiliency Survey (YRRS)

The New Mexico YRRS is administered in odd years and is part of the national Youth Risk Behavior Surveillance System (YRBSS) coordinated and designed by CDC.

For nearly 15 years, New Mexico has asked a series of resiliency questions on its expanded YRRS. Data have consistently been statistically significant. The results show that students were less likely to be binge drinkers or to use painkillers to get high if they reported that any of these resiliency measures were “very much true:”

- In my home, a parent or other adult is interested in my school work
- When I am not at home, one of parents/guardians knows where I am and who I am with
- At my school, a teacher or other adult believes I will be a success
- In my school, there are clear rules about what students can and cannot do
- At school I am involved in sports, clubs, or other extra-curricular activities
- Outside home and school, I am a part of group activities
- I plan to go to college or some other school after high school
- I have a friend about my own age who really cares about me.

New Mexico uses this resiliency data as part of its local assessment process in every community, and helps communities to use the data in local planning work. The stakeholders and resources to address infrastructure and capacity needs at the local level include, first and foremost, county governments of each county. Four counties have expressed enthusiasm and commitment to this project, including assigning staff to manage the project and convene a county-wide coalition to begin work. Existing resources include the DWI prevention program staff and their current activities.

An identified gap reflects the lack of prevention resources on college campuses. College students constitute a sixth high risk, low capacity population for this project. Prevention funding for each of the six members of the New Mexico Higher Education Prevention Consortium currently averages \$8000 annually – for a campus population of approximately 75,000 students. Member campuses rely on volunteers and work study students to accomplish prevention activities, which, because of resource levels, are few. The “New Mexico Student Lifestyles Survey” is a major accomplishment of the Consortium, and provides substantial data on substance-related behaviors and risk factors on college campuses. Operated by the University of New Mexico’s Campus Office of Substance Abuse Prevention (UNM COSAP), the Consortium will work to identify and prioritize infrastructure needs during the initial assessment, capacity and planning phases of the SPF. UNM receives separate prevention funding from the OSAP for campus projects for its student body of 25,000. Existing resources from the Consortium include staff from COSAP, a representative of each college campus, student workers, as well as access to classroom settings where the survey is implemented (COSAP). <http://youthrisk.org/>

For a complete illustration of substance use in New Mexico see Attachments Page:  
New Mexico Substance Use Epidemiology Profile December 2018.

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## Mental Health in New Mexico

Adult mental health issues range in a spectrum: from day-to-day challenges with stress, anxiety, and "the blues"; to persistent mental health challenges arising from chronic physical conditions such as diabetes, asthma, and obesity; to chronic clinically diagnosable psychiatric morbidities such as anxiety disorders, schizophrenia, bipolar disorder, and depression; and to serious life-threatening situations such as suicidal ideation and suicide attempt, which sometimes result from a combination of the mental and physical health challenges mentioned above. A host of measures exist for assessing the mental health status of individuals, but characterizing the mental health status of the population is a relatively new field. If such an assessment can be done using a simple and non-invasive approach with a reasonable level of sensitivity and specificity, the resulting characterization of the population's mental health can help public health and mental health professionals better understand the distribution of mental health issues in the population and design better systems to help identify, address, and mitigate these issues before they become more serious.

### Why is mental health a public health issue?

- Mental health affects a person's ability to lead a healthy, productive life
- Globally and in the United States, mental disorders make up the highest burden of all diseases in middle-and high-income countries
- Mental disorders increase risk of substance abuse and suicide
- Mental disorders are associated with diabetes, heart disease, cancer, and other chronic physical conditions

### How does New Mexico compare to other states?

- New Mexico and the United States have similar rates of mental illness for youth and adults
- However, the New Mexico suicide rate is 59% higher than the United States
  - Suicide is the 2<sup>nd</sup> leading cause of death for New Mexico residents 15 to 44 years old
  - Suicide accounts for 9.8% of all New Mexico Years of Potential Life Lost under 65 years
  - New Mexico has the 5th highest suicide rate in the United States
  - Suicide rates have been increasing in New Mexico and the United States since 2000

### What are the risk factors for mental disorders?

- Genes 17-28% of risk can be accounted for by variations in common genes
- Environment People who experience traumatic childhood events are
  - 17x more likely to have behavioral problems
  - 5x more likely to have alcohol problems
  - 3x more likely to have job problems
  - 2.6x more likely to have depression

- Substance Abuse People with mental disorders are
  - 30x more likely to develop illicit drug dependence
  - 3x more likely to develop alcohol dependence
  - 2.3x as likely to develop nicotine dependence
  - Biology Head injuries and brain abnormalities

**How can we prevent mental illness and suicides at a state level?**

- The evidence-based practices to reduce mental disorders in the general population are:
  - Mental health benefits with financial coverage and access to services, and
  - Multicomponent, healthcare system-level intervention that screens for depression and links primary care providers to mental health specialists
- Approximately half of suicide victims make a healthcare visit within 4 weeks of death
  - 25% visit specialty care
  - 21% visit primary care
  - 13% visit the emergency department
  - ...but only 24% are diagnosed with a mental disorder

*Sources: World Health Organization. The global burden of disease: 2004 update. Geneva, Switzerland 2008. New Mexico Death Certificate Database, Bureau of Vital Records and Health Statistics, NMDOH. National Center for Health Statistics, Centers for Disease Control and Prevention. Guide to Community Preventive Services, Centers for Disease Control and Prevention. Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Behavioral Health Statistics and Quality. (September 4, 2014). The NSDUH Report: Substance Use and Mental Health Estimates from the 2013 National Survey on Drug Use and Health: Overview of Findings. Rockville, MD. Ronald C. Kessler et al., Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication, 62 Arch. Gen. Psychiatry 593, 595 (2005). Ahedani, B K et al. Health Care Contacts in the Year Before Suicide Death. J Gen Intern Med 29(6):870-7.*

**Mental Health Collection Data Sources**

Mental health data can be obtained from survey, morbidity, and mortality data sources. The tables below were taken from the New Mexico Indicator-Based Information System (NM-IBIS) utilizing those data sources: <https://ibis.health.state.nm.us/home/Welcome.html>

**Behavioral Risk Factor Surveillance System (BRFSS)**

The BRFSS is an ongoing random-digit-dialed telephone survey of adults 18 years and older regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. Data are collected in all 50 states, the District of Columbia and U.S. territories. It is conducted annually by the New Mexico Department of Health Survey Section in collaboration with the Centers for Disease Control and Prevention (CDC). Responses are weighted to reflect the general New Mexico adult population by age, sex, ethnicity, geographic region, marital status, education level, home ownership and type of phone. These data exclude institutionalized New Mexico residents, such as those living in nursing homes or prisons. The survey was conducted using only landline phone numbers from 1986 through 2010, and expanded to cellular phone numbers in 2011. For this reason, measurements prior to 2011 should not be directly compared to measurements during and after 2011. The denominator for these indicators is all adults who answered the question.

### **Youth Risk and Resiliency Survey (YRRS)**

The New Mexico YRRS is administered in odd years and is part of the national Youth Risk Behavior Surveillance System (YRBSS) coordinated and designed by CDC. Each state, territorial, tribal, and large urban school district participating in YRBSS employs a two-stage, cluster sample design to produce a representative sample of students in grades 9–12 in its jurisdiction. In the first sampling stage schools are selected with probability proportional to school enrollment size. In the second sampling stage, intact classes of a required subject or intact classes during a required period (e.g., second period) are selected randomly. All students in sampled classes are eligible to participate. A weight is applied to each student record to adjust for student nonresponse and the distribution of students by grade, sex, and race/ethnicity in each jurisdiction. The denominator for each of these indicators is all students who answered the question.

### **Bureau of Vital Records and Health Statistics (BVRHS) Data**

The BVRHS data set contains information from death certificates for all deaths occurring in New Mexico. Death certificates are usually filed by funeral directors who obtain demographic information from an informant, such as a close family member of the decedent. The denominator is the New Mexico population estimate generated by the University of New Mexico Geospatial and Population Studies (GPS) Program.

### **Emergency Department (ED) Visit Data**

The ED dataset is derived from data provided by individual non-federal EDs in New Mexico. Only New Mexico residents are included in this report. The denominator is the New Mexico population estimate generated by the University of New Mexico GPS Program.

Overview of Emergency Department Hospitals. Two facilities previously reporting that did not this year were Union County General and Sierra Vista Hospital are in the Southwest and Northeast regions. Of the 34 reporting facilities, Presbyterian Hospital in Albuquerque had the highest number of Emergency Department (ED) visits, with over 65,000 visits, representing 8 percent of the total ED visits for 2017. Guadalupe County Hospital had the lowest number of ED visits, with just under 4,000 visits, representing 0.5 percent of the total ED visits for 2017.

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## Overview of Emergency Department Hospitals

Table 1. Number of ED Visits and Percentage of Total Visits by Facility, NM, 2017

Facility Name	ED Visits	% of Total
Alta Vista Regional Hospital	14,847	1.8
Artesia General Hospital	11,341	1.4
Carlsbad Medical Center	21,457	2.6
CHRISTUS St. Vincent Regional Medical Center	46,026	5.7
Cibola General Hospital	9,456	1.2
Dr. Dan C Trigg Memorial Hospital	4,169	0.5
Eastern NM Medical Center	26,322	3.2
Gerald Champion Regional Medical Center	21,289	2.6
Gila Regional Medical Center	16,041	2.0
Guadalupe County Hospital	3,921	0.5
Holy Cross Hospital	13,178	1.6
Lea Regional Hospital	19,656	2.4
Lincoln County Medical Center	11,928	1.5
Los Alamos Medical Center	8,335	1.0
Lovelace Medical Center/Heart Hospital of NM	38,724	4.8
Lovelace Regional Hospital-Roswell	12,666	1.6
Lovelace Westside Hospital	23,549	2.9
Lovelace Women's Hospital	33,732	4.2
Memorial Medical Center	37,027	4.6
Mimbres Memorial Hospital	13,357	1.6
Miners' Colfax Medical Center	5,155	0.6
Mountain View Regional Medical Center	38,312	4.7
Nor-Lea General Hospital	9,404	1.2
Plains Regional Medical Center - Clovis	29,963	3.7
Presbyterian Espanola Hospital	25,219	3.1
Presbyterian Hospital	65,110	8.0
Presbyterian Kaseman Hospital	46,906	5.8
Presbyterian Rust Medical Center	40,918	5.0
Rehoboth McKinley Christian Health	17,161	2.1
Roosevelt General Hospital	7,049	0.9
San Juan Regional Medical Center	52,582	6.5
Sierra Vista Hospital	Did Not Report	
Socorro General Hospital	9,501	1.2
Union County General Hospital	Did Not Report	
UNM Hospital	60,596	7.5
UNM Sandoval Regional Medical Center	17,609	2.2

### Hospital Inpatient Discharge Dataset (HIDD)

The HIDD includes inpatient discharges from non-federal hospitals located in New Mexico. Inpatient discharges are defined as departures from a hospital after overnight stay, regardless of the destination after departure. Only New Mexico residents are included in this report. The denominator is the New Mexico population estimate generated by the University of New Mexico GPS Program. Data are collected by the New Mexico Hospital Association.

### Acute Mental Illness

#### Hospital Discharges Demographic Characteristics of Discharged Patients

Among patients less than 15 years old, 54.8% were male. Among patients 15-44 years old, 72.7% were female. The discharge rate among females aged 15-44 was 874.5 per 10,000 population compared to 312.9 per 10,000 population for male patients in the same age group. For each of the five health regions, there were more female discharged patients compared to male discharged patients. The Southwest Region had the highest discharge rate for females at 828.5 per 10,000 population. The highest discharge rate for males was in the Northwest Region at 661.1 per 10,000 population. The Southwest Region had the highest

overall discharge rate (both males and females combined) at 725.7 per 10,000 population. African American and White females had the highest discharge rates: 969.9 and 888.9 per 10,000 population respectively. New Mexico's discharge rates for ages 45-64 and 65+ in 2017 were much lower than the discharge rates for those age groups for the United States in 2010.

### **Discharges by Category of First-Listed Diagnosis**

Other than pregnancy diagnoses, the highest number of discharges and highest discharge rates per 10,000 population was in the category of "Diseases of the circulatory system" for both males and females. The total number of discharges in this category was 19,541 with a discharge rate of 77.7 per 10,000 population. In this category males had 10,630 discharges with a rate of 90.7, and females had 8,911 discharges with a rate of 66.1. This was followed closely by "Diseases of the digestive system," with 8,641 discharges (rate: 80.2) and 8,844 discharges (rate: 75.1) for males and females respectively. In terms of discharges by age groups, for ages 65+ years, "Diseases of the circulatory system" was highest with 12,619 discharges (rate: 355.4). For ages 45-64 years, "Diseases of the digestive system" had the highest number of discharges, 6,023 (rate: 115.0). For ages 15-44, "Mental, behavioral and neurodevelopmental disorders" was highest: 5,378 (rate: 65.9). For ages <15 years, "Diseases of the respiratory system" was highest: 3,131 discharges (rate 76.9). Pregnancy diagnoses (in any diagnosis field) was highest in ages 15-44, with 20,423 discharges (rate: 250.2). By health region, "Diseases of the circulatory system" was the category with the highest discharge rates for the Metro and Southwest Regions. For the Southeast Region, "Diseases of the respiratory system" was highest with 2,072 discharges (rate: 64.8). For 2017 Hospital Inpatient Discharge Data Report New Mexico Department of Health the Northeast and Northwest Regions, "Diseases of the digestive system" had the highest discharge rates with 2,929 discharges (rate: 81.6) for the Northeast and 1,805 discharges (rate: 90.2) for the Northwest. Pregnancy diagnosis in any diagnosis field had the highest rate in the Southwest Region with 3,994 discharges (rate: 108.5).

### **Discharges by Discharge Status**

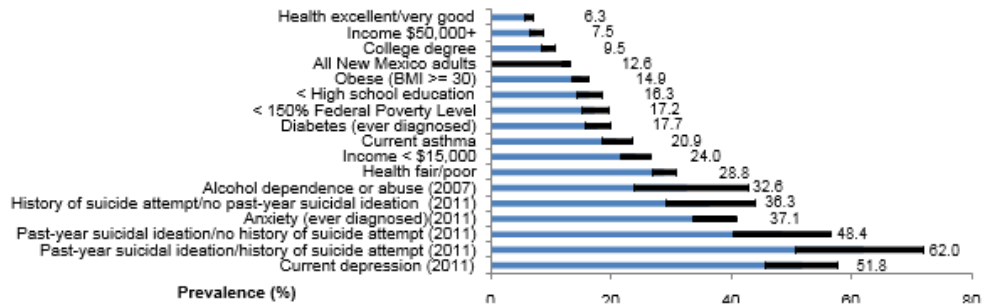
Routine discharges accounted for 70.5% of total discharges (109,153/154,805). There was a higher percentage of females with routine discharges than males, 59.5% and 40.5% respectively (64,957 and 44,196 discharges.) The second highest discharge status was discharges/transfers to home on care of a home health service organization. The rate of "left against medical advice" discharges was highest in 2017 for ages 45-64 (rate: 12.8). This rate was highest in the Northeast Region (rate: 11.0) in 2017. The rate of discharge deaths was highest in the 65+ age group. This rate for 2017 (55.8) decreased from the 2016 rate (62.7). The discharge death rate was highest in the Northwest Region in 2017 (19.4), but was a decrease from the Northwest's 2016 rate (21.0)

### **Frequent Mental Distress**

Among measures that have been suggested by the CDC as potential tools for assessing population well-being and mental health is the frequency with which people experience poor mental health. This measure is based on the single question, "How many days during the past 30 days was your mental health not good?" Respondents who report that they experienced 14 or more days when their mental health was "not good" are classified as experiencing Frequent Mental Distress (FMD). Although FMD is not a clinical diagnosis, evidence suggests that it is associated with a person's mental health status. Chart 1 shows the proportion of people with selected characteristics who experienced FMD.



**Chart 1: Frequent Mental Distress (past 30 days)\* by Selected Characteristics, Adults Aged 18+, New Mexico, 2015-2017**



\* Frequent Mental Distress definition: respondent reported 14 or more days in past 30 days when mental health was "not good"  
 Source: BRFSS; SAES (NOTE: Brackets around reported rates are 95% confidence intervals)

The proportion of the total New Mexico population that experienced FMD was about 12%. As might be expected, people in good health with higher incomes and more education were significantly less likely than the general population to report FMD. People with less education, with chronic health conditions such as obesity, diabetes, or asthma, or with lower income were significantly more likely to report FMD. Of particular relevance regarding FMD's potential usefulness as a measure of population mental health, FMD was many times more prevalent among respondents who reported more serious psychiatric morbidity, including screening positive for alcohol dependence or abuse (33% reported FMD), ever being diagnosed with an anxiety disorder (37% reported past-month FMD), or receiving a diagnosis of current depression based on the Patient Health Questionnaire (52% reported past-month FMD). Among the cohort that reported past-year suicidal ideation with no history of suicide attempt, 48% reported past-month FMD; among the cohort at high risk for suicide that reported both past-year suicidal ideation and a prior suicide attempt, 62% reported past-month FMD. Meanwhile, more than half (52%) of FMD respondents were diagnosed with current depression. These results suggest that this simple question, which is asked annually on the BRFSS, is a useful indicator of population mental health.

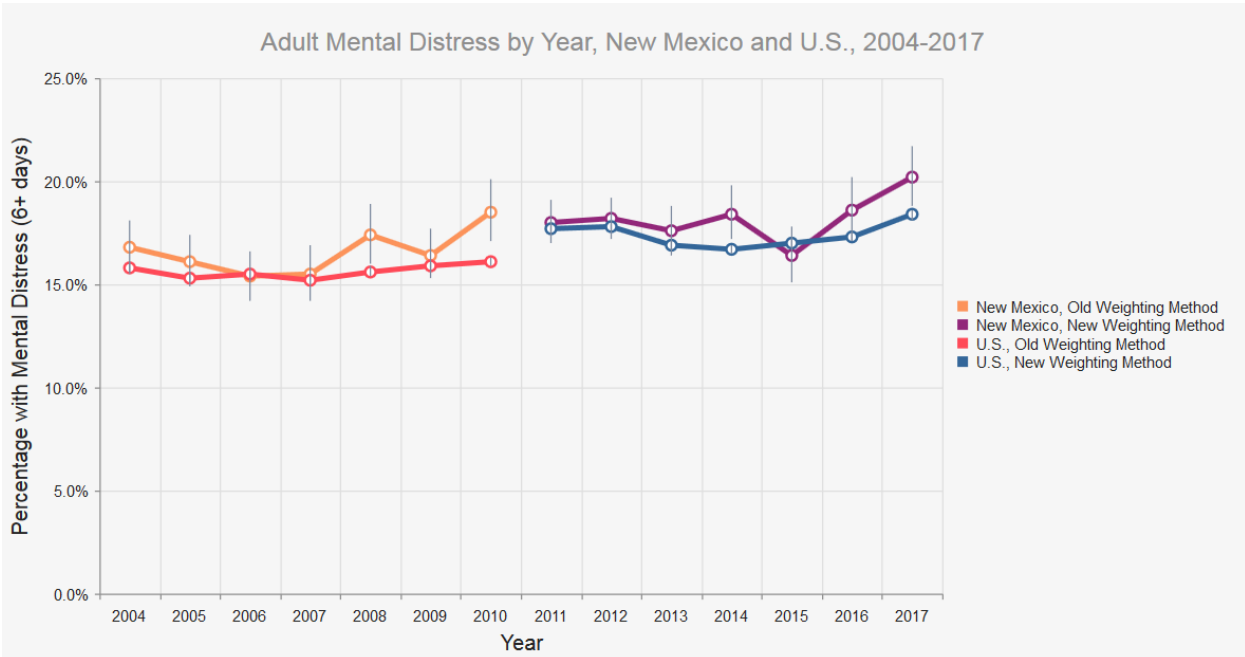
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**Table 1: Frequent Mental Distress (past 30 days) by Age, Sex, and Race, Adults Aged 18+, New Mexico, 2015-2017**

Sex	Race/Ethnicity	Number				Percent*			
		Ages 18-24	Ages 25-64	Ages 65+	All Ages	Ages 18-24	Ages 25-64	Ages 65+	All Ages*
Male	American Indian	2,730	4,749	1,904	9,340	25.8	10.3	25.1	14.5
	Asian/Pacific Islander	-	807	-	1,171	-	8.9	-	9.3
	Black	-	1,553	-	3,726	-	11.5	-	19.2
	Hispanic	5,353	27,793	5,851	38,894	9.1	11.3	11.6	10.9
	White	4,787	24,310	5,594	34,596	15.4	11.5	5.9	10.3
	Total	13,974	59,828	14,015	88,158	13.2	11.4	8.9	11.2
Female	American Indian	1,482	6,100	1,895	9,305	13.8	12.0	17.0	12.9
	Asian/Pacific Islander	-	748	-	1,616	-	6.4	-	10.2
	Black	-	1,349	-	1,556	-	14.1	-	10.8
	Hispanic	8,323	40,509	5,666	54,712	14.7	16.3	9.2	14.9
	White	3,615	35,376	8,351	46,780	13.7	16.6	7.7	13.4
	Total	13,498	83,921	16,407	113,384	13.8	15.7	8.8	13.9
Total	American Indian	4,152	10,881	3,837	18,642	19.6	11.2	20.5	13.6
	Asian/Pacific Islander	-	1,592	-	2,765	-	7.7	-	9.7
	Black	-	2,948	681	5,041	-	12.8	14.0	14.9
	Hispanic	13,559	68,370	11,496	93,603	11.7	13.8	10.3	13.0
	White	8,383	59,594	13,977	81,409	14.6	14.1	6.9	11.9
	Total	27,467	143,685	30,422	201,495	13.5	13.6	8.9	12.5

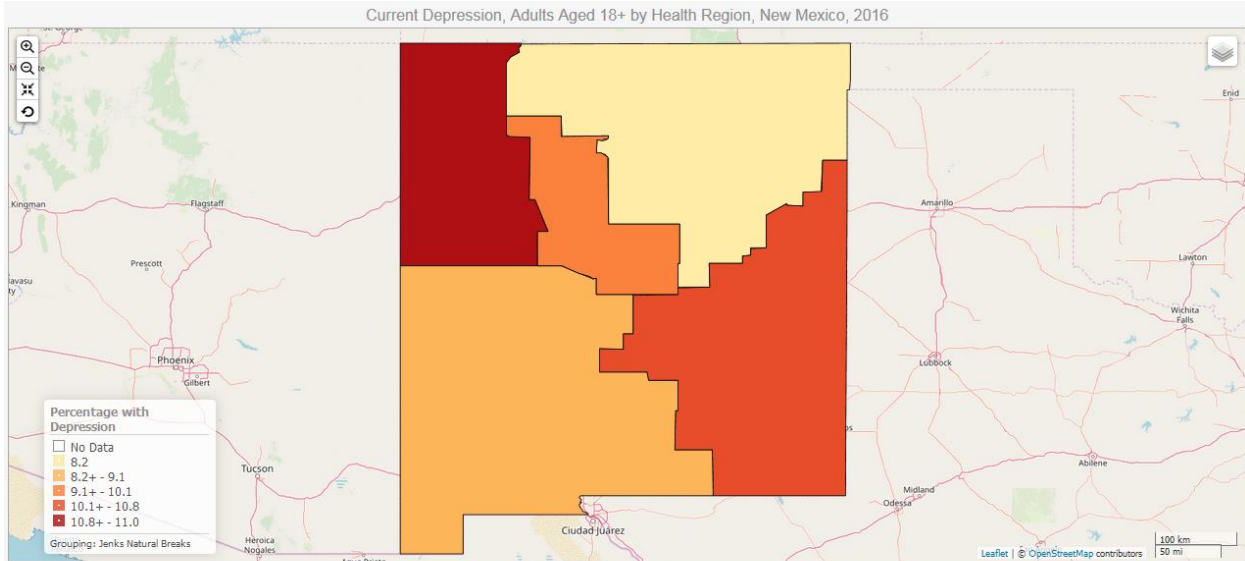
\* Estimate of percent of people in population group who reported Frequent Mental Distress in past 30 days  
 - Excluded due to small number of respondents (< 50) in-cell

Mental health Questions on the New Mexico BRFSS are an attempt to obtain a global measure of recent mental and emotional distress. In 2014, the New Mexico prevalence (18.4%) was slightly higher than the US prevalence (16.7%) of frequent mental distress. Since 2011, the New Mexico prevalence has remained relatively stable while the US prevalence has been decreasing slightly.



## Adult Depression

The prevalence of current depression was highest among adults 25-64 years, slightly higher among females than males across the age range, and higher among Native American adults and Hispanic adults than White adults. Depression was more common among American Indian females and Hispanic females than among White females.

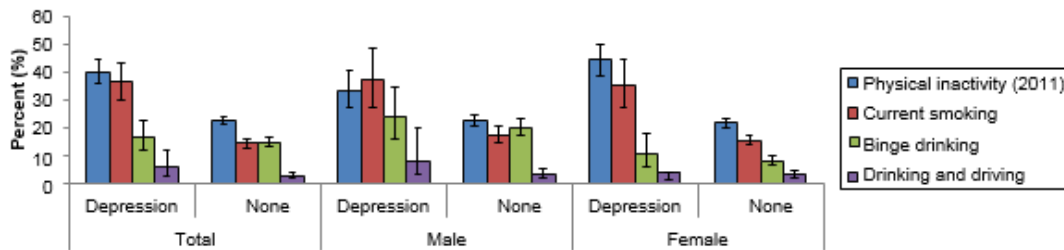


Rates of current depression did not vary meaningfully by region of residence.

Depression is one of the most prevalent and treatable mental disorders. Major depression is usually associated with comorbid mental disorders, such as anxiety and substance use disorders, and impairment of a person's ability to function in work, home, relationships, and social roles. Depression is also a risk factor for suicide and attempted suicide. In addition, depressive disorders have been associated with an increased prevalence of chronic medical conditions, such as heart disease, stroke, asthma, arthritis, cancer, diabetes, and obesity. In 2016, the BRFSS assessed current depression using Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) criteria.

Depression was highest among the youngest age-group 18-24 years (15.1%) and much higher among Black (22.9%) than Hispanic (9.6%) and White adults (9.3%). Depression was more common among Hispanic females (11.5%) and White females (9.6%) than American Indian females (6.8%). Among males, American Indians (17.7%) had the highest prevalence followed by Whites (8.9%). Chart 4 shows that current depression was associated, among both males and females, with significantly higher rates of some unhealthy behaviors including physical inactivity and current smoking. Current depression was associated with higher rates of chronic health conditions, such as asthma and heart disease among males, and asthma, obesity, diabetes, and heart disease among females.

**Chart 4: Unhealthy Behaviors by Depression Status and Sex, New Mexico, 2016**



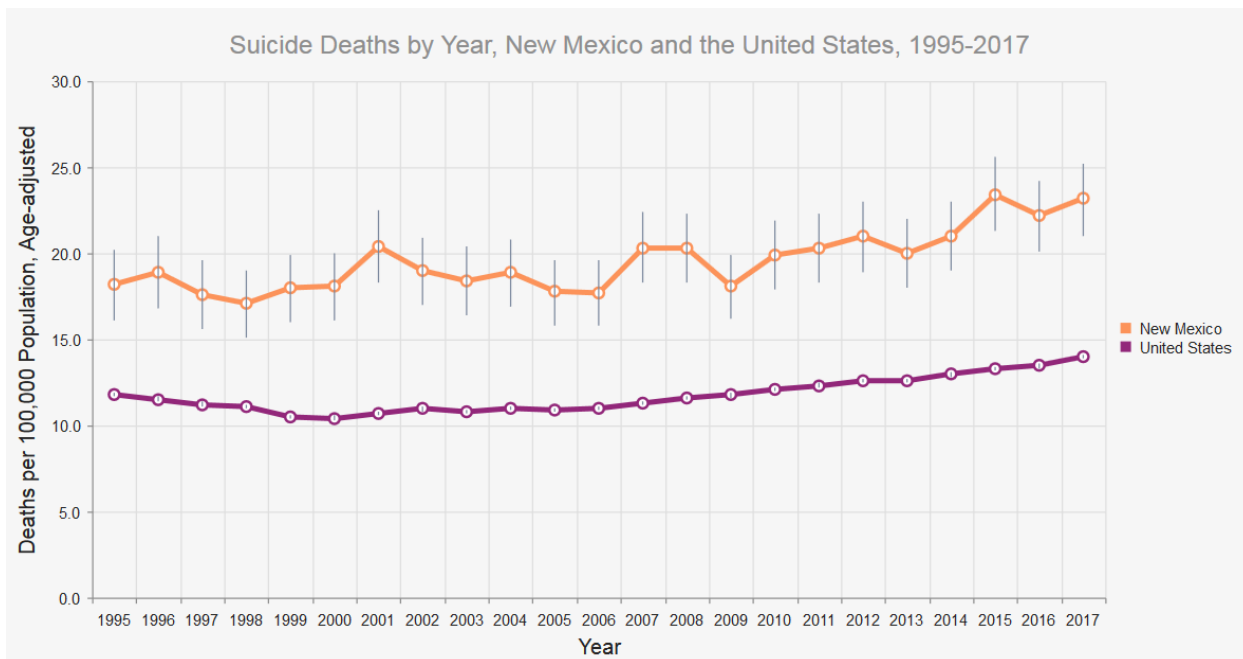
\* Current Depression definition: scored 10 or more on Patient Health Questionnaire depression inventory (PHQ-8); this instrument can establish a provisional depressive disorder diagnosis using Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) criteria.

Source: BRFSS; SAES (NOTE: Brackets around reported rates are 95% confidence intervals)

### Suicide Deaths

Suicidal behaviors are a serious public health problem and a major cause of morbidity and mortality in New Mexico. In 2017, suicide was the ninth leading cause of death in New Mexico, the second leading cause of death by age group for persons 5-34 years of age and the fourth leading cause of death by age group for persons 35-44 years of age. Suicide accounted for 15,048 Years of Potential Life Lost (YPLL), fourth after unintentional injuries, cancer, and heart disease deaths. The YPLL is a measure of premature mortality in a population that describes the impact of injury-related deaths on a society compared to other causes of death. Suicide deaths have been increasing in both New Mexico and the United States, with suicide death rates in New Mexico at least 50% higher than U.S. rates over the past 20 years. Mental disorders, particularly clinical depression, increase the risk for both attempted suicide and suicide. Other risk factors associated with suicide include a previous suicide attempt, alcohol and substance abuse, a family history of suicide, a history of child maltreatment, feelings of hopelessness, isolation, barriers to mental health treatment, loss (of relationships, social connections, work, finances), physical illness, and easy access to lethal methods, such as firearms.

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Over the period from 1981- 2017, New Mexico 's suicide rate has consistently been 1.5 to 1.9 times the US rate. New Mexico has ranked among the top five states for all but two of those years. While the US rate declined 12% between 1981 and 2000, it increased thereafter for a 26% increase from 2000 to 2017. The New Mexico rate followed a similar pattern. In New Mexico in 2017, suicide was the ninth leading cause of death overall, the first leading cause of death for those residents ages 5- 17, and the second leading cause of death for those residents ages 18- 44 (with unintentional injuries at number one).

Male suicide rates were more than three times higher than female rates across all ages and racial/ethnic groups except for Asian/Pacific Islanders and Blacks for the five-year period 2013-2017. This reflects males' choice of more lethal means, i.e. firearms, when attempting suicide. White males and females have higher rates over age 34 compared to other race/ethnicities. The majority (63%) of male suicides - and an even higher proportion of Hispanic and American Indian male suicides - occur, however, before age 65. American Indian females had a significantly higher rate between ages 15-24 compared to other race/ethnicities. Five counties (Bernalillo, Santa Fe, Dona Ana, San Juan, and Sandoval) had substantial numbers of suicides (averaging more than 25 per year). For the time period 2013-2017, all but eleven of New Mexico 's counties had rates one and a half times higher than the comparable US rate. A number of smaller counties also had very high rates, and only two New Mexico counties had a suicide rate lower than the national rate. Note that counts and rates for many counties with small numbers of suicides are unstable, suggesting wide fluctuation across time periods due to random variation (chance) and should be interpreted with caution

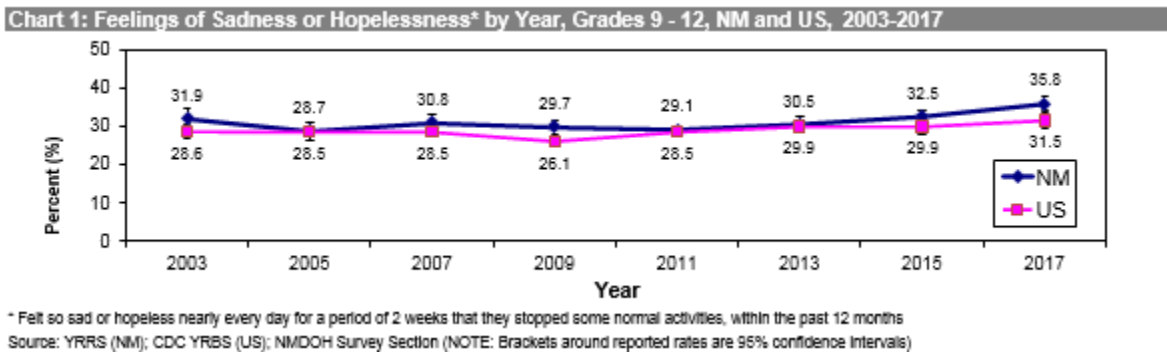
### Youth Sadness or Hopelessness in the Past Year

Persistent feelings of sadness and hopelessness are criteria for, and predictors of, clinical depression for

youth, and youth who experience depression are at a higher risk for being depressed as adults. Persistent sadness in youth has also been linked with suicidal behavior, drug and alcohol use, unsafe sex, and academic and social deficits. Feelings of sadness or loneliness not only affect teens, but those around them, often causing problems in relationships with peers and family members.

The prevalence of persistent feelings of sadness or hopelessness among New Mexico high school students remained stable from 2003-2017 (Chart 1). In 2017, there was a statistically significant difference between the US rate (31.5%) and the New Mexico rate (35.8%). In 2017 in New Mexico, girls (45.1%) were nearly twice as likely to report feelings of sadness or hopelessness than boys (26.6%), reflective of a continuing disparity. There were no statistically significant variations by grade level or by race/ethnicity.

In 2017, the counties with the highest prevalence of persistent feelings of sadness or hopelessness were Sierra (46.2%), McKinley (42.9%), Luna (42.4%), Roosevelt (40.8%), and Santa Fe (39.8%). The counties with the lowest prevalence were Mora (23.3%), Union (25.8%) and Hidalgo (28.0%).



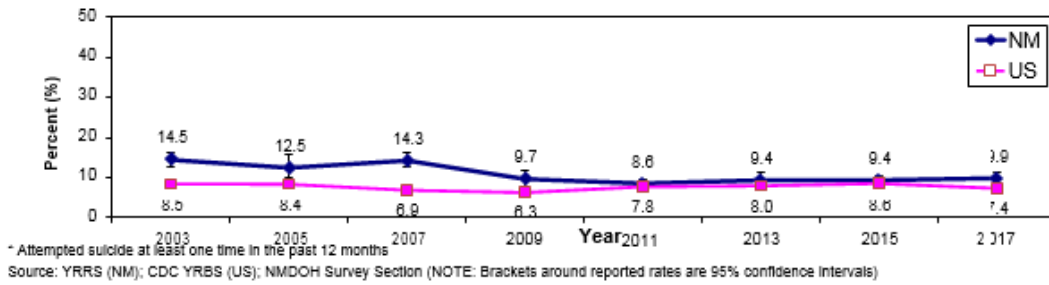
The percentage of New Mexican youths with experiencing feelings of sadness and hopelessness is similar to United States youths.

### Youth Who Attempted Suicide

In New Mexico in 2017, suicide was the leading cause of death for youth between the ages of 5-17. In the US in 2016 (the most recent year for which national data are available) according to the CDC, suicide was the second leading cause of death for this same age group. While girls are more likely than boys to attempt suicide, boys are more likely than girls to die of suicide. A previous suicide attempt is among the strongest risk factors for completed suicide. As seen in Chart 1, the prevalence of past year suicide attempts among New Mexico high school students decreased from 14.5% in 2003 to 9.4% in 2015 with a slight increase to 9.9% in 2017. While the U.S. prevalence decreased from 2003 to 2009, it increased from 2009 (6.3%) to 2015 (8.6%) before dropping slightly (7.4%) in 2017.

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**Chart 1: Attempted Suicide\* by Year, Grades 9 - 12, NM and US, 2003-2017**



In New Mexico in 2017, the prevalence of suicide attempts in the past year was significantly higher for girls (11.9%) compared to boys (7.7%). Table 1 reveals that the percentage of attempts made by girls in the 11th (13.5%) grades was significantly higher than that for boys (6.9%). In 2017, the counties with the highest prevalence of suicide attempts were McKinley (18.3%), Rio Arriba (17.9%), Cibola (16.5%), Sierra (15.1%), and Eddy (13.5%). The counties with the lowest prevalence of suicide attempts were Curry (2.6%), Colfax (6.8%), Union (7.2%), Guadalupe (7.5%) and Los Alamos (7.6%). Only three New Mexico counties were below the national prevalence rate of 7.4%.

**Table 1: Attempted Suicide, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, NM, 2017**

Sex	Race/Ethnicity	9th Grade	10th Grade	11th Grade	12th Grade	All Grades
		Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]
Male	American Indian	7.6 (4.1-13.7)	11.5 (5.8-21.5)	7.6 (4.5-12.4)	13.8 (8.3-22.2)	9.9 (7.2-13.5)
	Asian/Pacific Islander	--	--	--	--	13.1 (7.2-22.5)
	Black	--	--	--	--	15.5 (7.2-30.2)
	Hispanic	7.1 (4.1-11.9)	8.6 (5.8-12.6)	7.0 (4.1-11.5)	7.1 (3.8-12.9)	7.4 (5.9-9.4)
	White	4.8 (2.2-10.1)	8.1 (4.0-15.8)	6.5 (3.6-11.5)	4.3 (1.9-9.4)	5.9 (4.3-8.2)
	Total	6.9 (4.7-9.9)	9.3 (6.8-12.4)	6.9 (5.5-8.6)	7.8 (5.7-10.5)	7.7 (6.5-9.0)
Female	American Indian	16.3 (10.1-25.2)	16.2 (6.4-35.2)	18.1 (11.6-27.1)	8.7 (4.0-17.7)	15.5 (12.4-19.1)
	Asian/Pacific Islander	--	--	--	--	8.2 (3.3-19.0)
	Black	--	--	--	--	20.3 (10.4-35.8)
	Hispanic	9.7 (6.6-14.1)	12.0 (8.6-16.6)	14.0 (9.4-20.3)	9.8 (6.2-15.1)	11.8 (9.4-14.7)
	White	10.8 (6.5-17.4)	8.8 (5.2-14.5)	11.2 (6.4-18.7)	9.4 (5.8-14.7)	10.1 (7.8-13.0)
	Total	11.0 (8.1-14.7)	11.9 (9.1-15.5)	13.5 (10.3-17.6)	10.0 (7.3-13.6)	11.9 (10.0-14.1)
Total	American Indian	11.6 (7.5-17.5)	13.6 (8.1-22.0)	12.9 (9.6-17.1)	11.2 (7.0-17.6)	12.7 (10.4-15.3)
	Asian/Pacific Islander	--	9.4 (3.3-24.2)	--	--	10.9 (6.8-17.1)
	Black	16.2 (7.7-30.9)	18.9 (7.6-39.9)	--	--	18.4 (11.5-28.1)
	Hispanic	8.6 (6.5-11.4)	10.4 (7.8-13.8)	10.8 (7.8-14.7)	8.6 (5.8-12.6)	9.8 (8.1-11.9)
	White	7.8 (5.4-11.0)	8.4 (4.9-14.1)	8.8 (5.9-12.8)	6.7 (4.4-10.0)	7.9 (6.2-10.1)
	Total	9.0 (7.1-11.3)	10.6 (8.5-13.2)	10.3 (8.6-12.2)	8.9 (6.8-11.7)	9.9 (8.5-11.5)

Source: YRRS (NM); NMDOH Survey Section (NOTE: "95% CI" is 95% confidence interval)

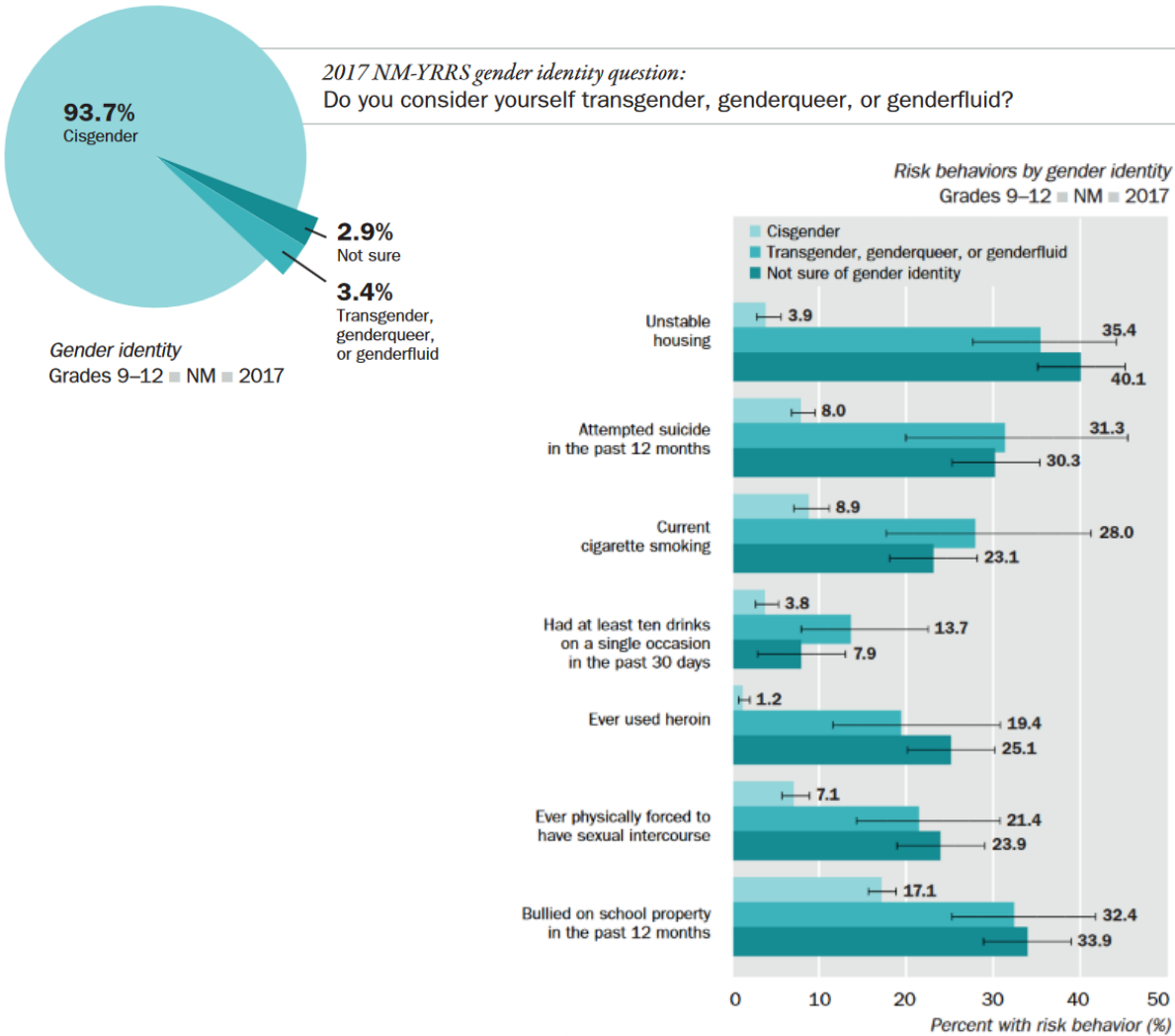
For a complete illustration of mental health epidemiology for New Mexico please see State of Mental Health November 2018. <https://nmhealth.org/data/view/general/2193/>



## Sexual and Gender Minority Youth in New Mexico

Ensuring a safe and healthy environment for youth is critical for them to thrive, both academically and physically. However, a safe and healthy environment is not always available to many lesbian, gay, bisexual, transgender, and questioning (LGBTQ) students. In order to better understand and address the health inequities that LGBTQ students face, this report describes health status data from the New Mexico Youth Risk and Resiliency Survey (NM-YRRS) by sexual orientation.

Gender identity is an individual's concept of self as male, female, a blend of both or neither. A person's gender identity may or may not correspond with the sex they were assigned at birth. When a person's gender identity does not correspond with their sex assigned at birth, they may consider themselves transgender, genderqueer, genderfluid, or another gender. When a person's gender identity matches their sex assigned at birth they are considered cisgender. People who are transgender, genderqueer, or genderfluid may experience health inequities due to unequal access to resources, a history of violence, trauma, and discrimination, and minority stress. In 2017, a question about gender identity was added to the high school YRRS questionnaire





### **Recommendations for improving public health**

- Include LGBTQ as a priority population in health disparity and health equity discussions and reports (along with racial/ethnic minorities, people in poverty, etc.).
- Expand the discussion of LGBTQ health beyond sexual behavior, as there are significant disparities in behavioral health and substance use factors.
- Continue to pursue efforts to accurately collect and monitor health status information among LGBTQ New Mexicans.
- Encourage the creation, implementation and evaluation of evidence-based interventions to reduce health inequities among LGBTQ youth.
- Seek or allocate funding that includes outreach and educational interventions for LGBTQ communities.
- Participate in and offer trainings on LGBTQ health issues to increase cultural competency among health providers and community health partners.
- Include sexual and gender identity demographic questions on forms, surveys, and registries; use inclusive language (e.g., partner, spouse) in communications and health forms.
- Encourage adoption of the above practices by other federal, state, local, and tribal public health agencies.

Adverse Childhood Experiences (ACEs) are categorized into three groups: abuse, neglect, and household challenges. Each category is further divided into multiple subcategories. Participant demographic information is available by gender, race, age, and education. The prevalence of ACEs is organized by category.

All ACE questions refer to the respondent's first 18 years of life.

### **Abuse**

- **Emotional abuse:** A parent, stepparent, or adult living in your home swore at you, insulted you, put you down, or acted in a way that made you afraid that you might be physically hurt.
- **Physical abuse:** A parent, stepparent, or adult living in your home pushed, grabbed, slapped, threw something at you, or hit you so hard that you had marks or were injured.
- **Sexual abuse:** An adult, relative, family friend, or stranger who was at least 5 years older than you ever touched or fondled your body in a sexual way, made you touch his/her body in a sexual way, attempted to have any type of sexual intercourse with you.

### **Household Challenges**

- **Mother treated violently:** Your mother or stepmother was pushed, grabbed, slapped, had something thrown at her, kicked, bitten, hit with a fist, hit with something hard, repeatedly hit for over at least a few minutes, or ever threatened or hurt by a knife or gun by your father (or stepfather) or mother's boyfriend.
- **Substance abuse in the household:** A household member was a problem drinker or alcoholic or a household member used street drugs.

- **Mental illness in the household:** A household member was depressed or mentally ill or a household member attempted suicide.
- **Parental separation or divorce:** Your parents were ever separated or divorced.
- **Incarcerated household member:** A household member went to prison.

**Neglect**

- **Emotional neglect:** Someone in your family helped you feel important or special, you felt loved, people in your family looked out for each other and felt close to each other, and your family was a source of strength and support.
- **Physical neglect:** There was someone to take care of you, protect you, and take you to the doctor if you needed it<sup>2</sup>, you didn't have enough to eat, your parents were too drunk or too high to take care of you, and you had to wear dirty clothes.



<https://www.childtrends.org/publications/prevalence-adverse-childhood-experiences-nationally-state-race-ethnicity>

For a complete illustration of Mental Health in New Mexico see Attachments Page: State of Mental Health November 2018.

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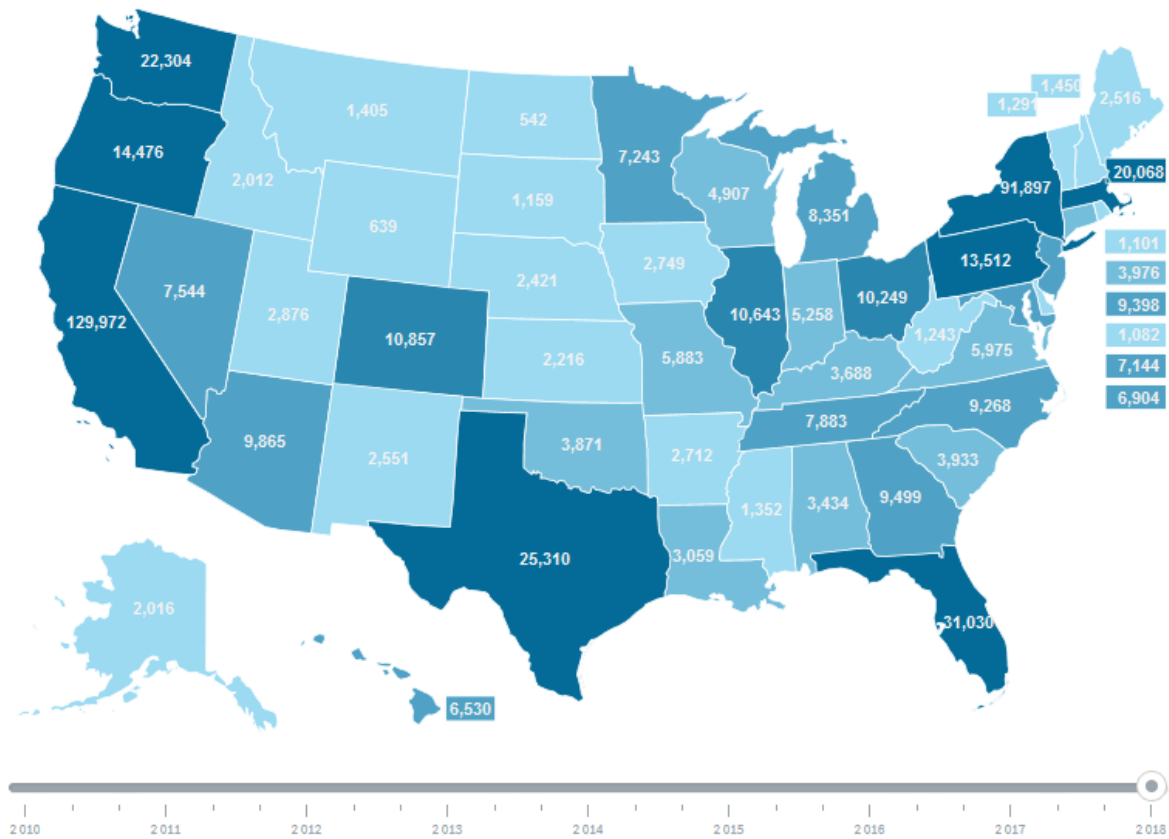
## Homelessness – Supported Housing

### New Mexico Homelessness Statistics

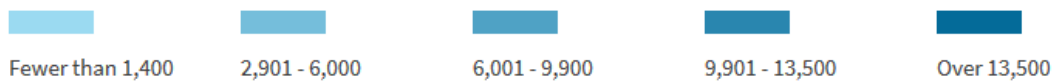
As of January 2018, New Mexico had an estimated 2,551 experiencing homelessness on any given day, as reported by Continuums of Care to the U.S. Department of Housing and Urban Development (HUD). Of that Total, 201 were family households, 290 were Veterans, 182 were unaccompanied young adults (aged 18-24), and 891 were individuals experiencing chronic homelessness.

Public school data reported to the U.S. Department of Education during the 2016-2017 school year shows that an estimated 10,071 public school students experienced homelessness over the course of the year. Of that total, 844 students were unsheltered, 855 were in shelters, 438 were in hotels/motels, and 7,930 were doubled up.

### Total People Experiencing Homelessness



#### Map Key



## Homelessness Statistics for **New Mexico**

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<b>Total Homeless Population</b>	<b>2,551</b>
Total Family Households Experiencing Homelessness	201
Veterans Experiencing Homelessness	290
Persons Experiencing Chronic Homelessness	891
Unaccompanied Young Adults (Aged 18-24) Experiencing Homelessness	182
<hr/>	
<b>Total Number of Homeless Students</b>	<b>10,071</b>
Total Number of Unaccompanied Homeless Students	1,543
Nighttime Residence: Unsheltered	844
Nighttime Residence: Shelters	855
Nighttime Residence: Hotels/motels	438
Nighttime Residence: Doubled up	7,930

### **Homelessness and Supportive Housing Services**

#### **Projects for Assistance in Transition from Homelessness**

The Projects for Assistance in Transition from Homelessness (PATH) grant is an annual formula grant from SAMHSA for the purpose of serving people with an SMI and those with co-occurring substance use disorders who are experiencing or are at risk of homelessness. These funds are used to conduct outreach to individuals who are disconnected from mainstream resources. PATH-funded providers in Albuquerque and Santa Fe offer mental health, substance use, case management, additional support services and a limited set of housing services.

#### **New Mexico's Long Range Supportive Housing Plan**

The New Mexico Behavioral Health Purchasing Collaborative (the Collaborative) has for over ten years led efforts to create and sustain permanent supportive housing opportunities for high-priority consumers with behavioral health disorders and related disabilities, and for youth transitioning from the foster care and juvenile justice system across the state of New Mexico. Beginning with the successful launch of the New Mexico Behavioral Health Purchasing Collaborative Long Range Supportive Housing Plan in December of 2007, New Mexico has sponsored and aggressively supported a sustained statewide effort

to create and maintain independent, decent, safe, and affordable community-based housing options linked to flexible community-based supports as desired by consumers—a model commonly referred to as permanent supportive housing (PSH). Permanent supportive housing is a nationally recognized best practice that supports individuals and families with a broad range of disabilities who may also be homeless, residing in an institutional setting, or at risk of homelessness or institutionalization. Now, with the release of this Strategic Plan for Supportive Housing in New Mexico: 2018–2023, the Collaborative is excited and empowered to continue its aggressive efforts to create new PSH opportunities as well as to advance statewide behavioral health services system realignment efforts. With its experience in building a successful cross-departmental system to create and sustain PSH across the state, the Collaborative looks forward to broadening its efforts, and aspires to lead by example through the adoption of innovative strategies that address the challenges of operating PSH across a rural frontier state with a diverse population. As thoughtfully described in the New Mexico Senate Memorial 44 report from the 2015 legislative session, the housing needs of New Mexico’s most vulnerable citizens are unique in many ways: Poverty, geographic isolation, and other social determinants of health are prevalent in New Mexico and all contribute to homelessness. As a result of risk factors which are more prevalent in New Mexico than in many other states, our most vulnerable citizens who are homeless or ‘at risk of homelessness represent a wide range of people including families with children, people with mental illness, people with low-wage jobs, people suffering from substance abuse addiction, migrant workers, runaway teens and young adults, formerly incarcerated people, and veterans. The challenges that our most vulnerable citizens face in identifying safe, sanitary housing options are further exacerbated by the lack of housing stock available to extremely low-income households. Federal disinvestment in public and affordable housing programs only adds to this. Within this challenging environment, it is more critical than ever for New Mexico to maintain and reinforce its strong, sustained commitment to expanding permanent supportive housing options targeted to our most vulnerable citizens. In addition, it is important to recognize that homelessness in New Mexico often looks different than in more urban states. Homelessness is not as visible in New Mexico, especially in the more rural regions of the state. It is not uncommon in these rural areas, with few or no traditional low-cost housing options, for people to seek out alternative settings including residing in cars, campgrounds, arroyos, and abandoned buildings. The cultural norms of many in New Mexico also encourage family, tribal members, and friends to offer and provide temporary shelter that further contributes to the difficulty in identifying those with housing needs. Over the past 10 years, New Mexico has responded by defining homelessness (at the state level) to include individuals who are precariously housed, and by offering a range of different PSH models that respond directly to the needs and housing challenges discussed above. Continued efforts to address the unique characteristics of homelessness in New Mexico are incorporated in the current plan. The Collaborative also recognizes the important link between PSH, recovery, and the path toward self-sufficiency. Housing instability disproportionately affects people with disabilities, including those with mental illness and substance use disorders, who also often have the lowest incomes. For individuals with disabilities experiencing homelessness, it is nearly impossible to focus on recovery because the immediate needs of homelessness take precedence. Moreover, being homeless is traumatic on many levels, and most people who have experienced homelessness also report having experienced some form of trauma. The stability of housing, combined with housing and community support services, enables individuals to move toward recovery, improved wellness, and greater engagement in their communities. Access to safe, quality, affordable housing —with the supports necessary to maintain that housing —constitutes one of the most basic and powerful social and economic determinants of health. For individuals and families who are trapped in a cycle of crisis, housing instability and homelessness due to trauma, violence, mental illness, or addictions,

access to housing can determine their entire health trajectory. For these vulnerable populations, supportive housing and comprehensive services are a necessary precursor and an essential platform for the delivery of services that lead to improved health and stability. Further, supportive housing provides a foundation for engaging tenants in managing their own care and promoting lifestyle changes that lead to good health. Thus, PSH is an integral component of New Mexico's broader health strategy.

[http://newmexico.networkofcare.org/content/client/1446/NMStrategicHousingPlan2018-2023\\_Jan2018FINAL.pdf](http://newmexico.networkofcare.org/content/client/1446/NMStrategicHousingPlan2018-2023_Jan2018FINAL.pdf)

**Permanent Supportive Housing (PSH)** has long been a focus of BHSD's state-supported program activities. These efforts, guided early on by a 2007 supportive housing plan for individuals with an SMI or co-occurring SUD, resulted in the Linkages program, a voucher-based permanent tenancy subsidy program jointly administered by BHSD and the New Mexico Mortgage Finance Authority, as well as the creation of Local Lead Agencies (LLAs) to support housing for disabled individuals in new housing partially paid for by federal Low-Income Housing Tax Credits (LIHTC). Additional experience in creating and managing PSH programs was afforded by a SAMHSA grant from 2015 through September 2018, the Housing Supports, Health, and Recovery for Homeless Individuals Grant (HHRHI). This funding continued the focus on providing housing for homeless or precariously housed individuals with an SMI or a co-occurring SUD, but also incorporates/d the use of peers in the recovery model, and combines four evidence-based programs: Permanent Supportive Housing, Supported Employment, Seeking Safety, and Motivational Interviewing. One key output of the HHRHI grant process has been the development of a new Strategic Plan for Supportive Housing in New Mexico: 2018-2023. Written jointly by the Technical Assistance Collaborative and BHSD, the plan was approved by the Collaborative at its January 2018 meeting. It may be accessed in the Behavioral Health Network of Care website, Collaborative section, linked to the Housing Leadership Group subsection. A State Plan Amendment to CMS will allow the inclusion of PSH in the Medicaid funding package for Medicaid-eligible individuals enrolled in the Linkages program. The benefit will include pre-tenancy and tenancy sustaining supports provided by peers, and will take effect on or about the time of implementation of Centennial Care 2.0 on January 1, 2019. The New Mexico Legislature also approved an additional \$100,000 in its 2018 Session to increase support for PSH.

### **Emergency Department Information Exchange (EDIE) and PreManage**

A small number of patients generate a disproportionate volume of visits. Many hop between facilities and care settings, making it difficult for the Managed Care Organizations (MCO) to know when and how to coordinate appropriately. The MCOs are utilizing EDIE and PreManage to track high utilizer populations in order to get these individuals into the right services through care coordination.

**Emergency Department Information Exchange (EDIE)** connects to an electronic medical record and provides alerts to ER provider if patient meets the criteria. Cross organizational care coordination is the best opportunity to improve the quality of care and reduce unnecessary emergency department utilization. The focus is on high utilizing patients. The Centennial Care MCOs collaborating

- Real-Time emergency department Information Exchange
- Notifies on High Utilizer/Complex Needs Patients

- Improves Communication and Care Coordination
- First Info Exchange Across all WA/OR Hospitals
- Proactive, Concise, Actionable Data at Point of Care
- Push Technology - Notices/Alerts Within Care Provider Workflow; Anticipates provider needs (no need to look up a patient)

**PreManage** provides alerts to Managed Care Organizations or provider groups on cohorts they have identified. It is a complementary product for health plans, clinics, group practices, etc.

- Expands real-time notifications to medical groups, MCOs, health plans, care coordinators, social workers etc. to better manage their patients.
- Enables health plans and providers to *pull* hospital notifications in real-time from a member/patient eligibility list.
- Notifications available: ED Visits, Inpatient Admission, Discharge, and Transfers
- Creates ability to coordinate care across the community

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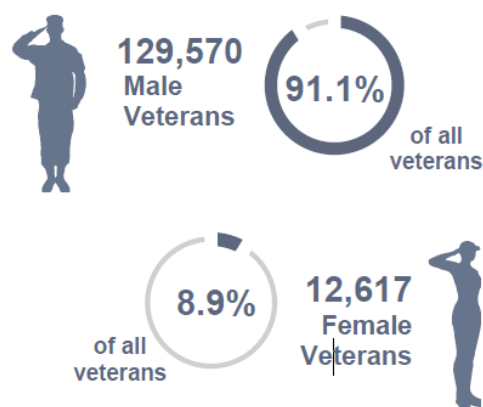
## New Mexico Veteran Profile

### Veterans Living in New Mexico

There were 142,187 veterans living in New Mexico as of 2016. Veterans represented 9.0 percent of the civilian population 18 and older. There were 129,570 male and 12,617 female veterans in the state in 2016. Men made up 91.1 percent of the total veteran population, while women made up 8.9 percent. Within the U.S., veterans represented 7.4 percent of the total population as of 2017. New Mexico was ranked seventeenth in the nation for concentration of veterans. Alaska had the largest concentration of veterans, with 12.2 percent of the population having previously served in the armed forces. The District of Columbia (D.C.) and New York had the smallest concentration of veterans (4.7 percent each).

The concentration of veterans in New Mexico's counties ranged from 5.6 percent (McKinley) to 19.0 percent (Sierra) of the total population 18 and older. The veteran population exceeded 10 percent of the total population in 16 counties and exceeded 15 percent of the total population in four counties. White Sands Missile Range and Holloman Air Force Base, both located in Otero County, likely contribute to that county's large concentration of veterans, which was the third highest (17.5 percent) in the state in 2016, and, to some degree, the concentration in Sierra, its close neighbor. Sierra is also known for its retiree population, which includes many veterans. Curry and Harding Counties also had veteran populations that made up over 15 percent of the total population in 2016. Curry County is the home of Canon Air Force Base. Harding's large concentration was, in part, due to its small total population.

### In New Mexico...



### Veterans by Period of Service

Close to 80 percent of New Mexico's veterans had served in a conflict as of 2016.

- 40.0 percent of all veterans (56,879) and 50.7 percent of all conflict veterans had served in the Vietnam War. The majority (87.9 percent) of those who served in Vietnam did not serve in another conflict (World War II, Korean War, and/or the Gulf War).



- Veterans who served in the Gulf War (56,100) represented 39.5 percent of all veterans and 50.0 percent of conflict veterans in New Mexico. About 17.9 percent of Gulf War veterans served in both periods, August 1990 to August 2001 and September 2001 and later, but no other conflict.
- New Mexico's Korean War veterans (12,483) represented 8.8 percent of all veterans and 11.1 percent of conflict veterans as of 2016. Close to 80 percent of Korean War veterans only served during the Korean War.
- There were 5,341 World War II veterans in New Mexico as of 2016, representing 3.8 percent of all veterans and 4.8 percent of conflict veterans. About 80 percent of World War II veterans served only during the war.

### **Age and Gender of Veterans**

Close to half (47.2 percent) of New Mexico's veterans were between the ages of 55 and 74 in 2016. This primarily reflects the swell in military service members during and around the Vietnam Era. The enlistment of women in the armed forces has generally increased over time. Women made up 5.7 percent of veterans 65 and older in 2016, compared to 13.6 percent of veterans 54 and younger and 12.8 percent of veterans 34 and younger.

### **Race and Ethnicity of Veterans**

The majority (82.7 percent) of New Mexico's veterans identified as being White, alone as of 2016. The second and third most common races reported by veterans were "some other race" (5.8 percent) and Native American/Alaska Native (5.1 percent). The veteran population appears to be somewhat less diverse than the general population. Veterans in New Mexico were more likely to be White than nonveterans; 74.5 percent of nonveterans identified as White, alone. Persons identifying as Black/African American had a larger representation within the veteran population; 3.5 percent of veterans identified as Black/African American compared to just 1.7 percent of nonveterans. The representation of persons identifying as more than one race was similar in both populations (around 2.5 percent). On the other hand, veterans were less likely to be Native American, Asian, or some other race than nonveterans. The largest divergence in population share was between veterans and nonveterans reporting as some other race, for which the nonveteran share exceeded the veteran share by 4.4 percentage points.

When looking at ethnicity, veterans were less likely to be Hispanic/Latino than nonveterans in 2016. Just over 59 percent of veterans reported being White, alone, whereas just over 40 percent of veterans reported that ethnicity. Veterans identifying as Hispanic/Latino represented 30.4 percent of all veterans, while nonveterans identifying as Hispanic/Latino represented 46.2 percent of all nonveterans, a difference of 15.8 percentage points.

### **Disabilities Status of Veterans**

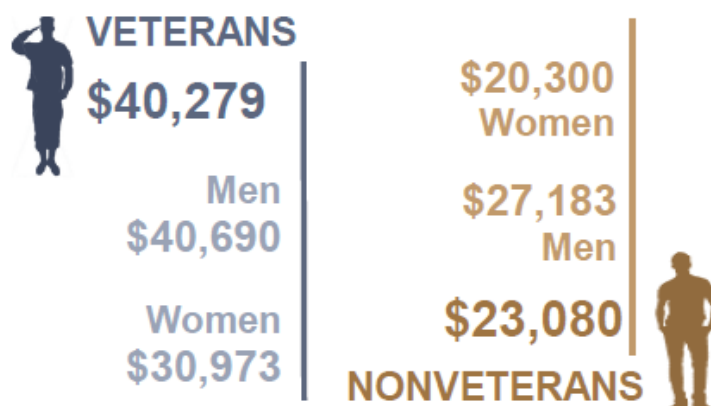
Veterans are almost twice as likely to have a disability than nonveterans. As of 2016, 30.4 percent of veterans reported having a disability, either service-connected or not, compared to 17.5 percent of nonveterans. In the same year, 24.7 percent of New Mexico's veterans reported having a service-connected disability specifically, of which 37.3 percent reported a disability rating of 70 percent or more, indicating the highest degree of disability. About 21.5 percent of veterans reported a rate of 10/20 percent, the second-largest percentage of veterans disabled from their service.

### Educational Attainment of Veterans

Veterans typically have a higher level of educational attainment than nonveterans. This is at least somewhat due to the requirement that people enlisting in the armed forces have a high school diploma or equivalent certificate. In 2016, 5.3 percent of veterans did not have a high school diploma/equivalent certificate, compared to 15.7 percent of nonveterans.

### Income of Veterans, Poverty Status, and the Homeless Veteran Population.

The median annual income of New Mexico’s veterans in New Mexico in 2016 was \$40,279. This was higher than the income of nonveterans (\$23,080) by \$17,199; the state’s nonveteran median annual income was just 57 percent of its veteran median annual income.



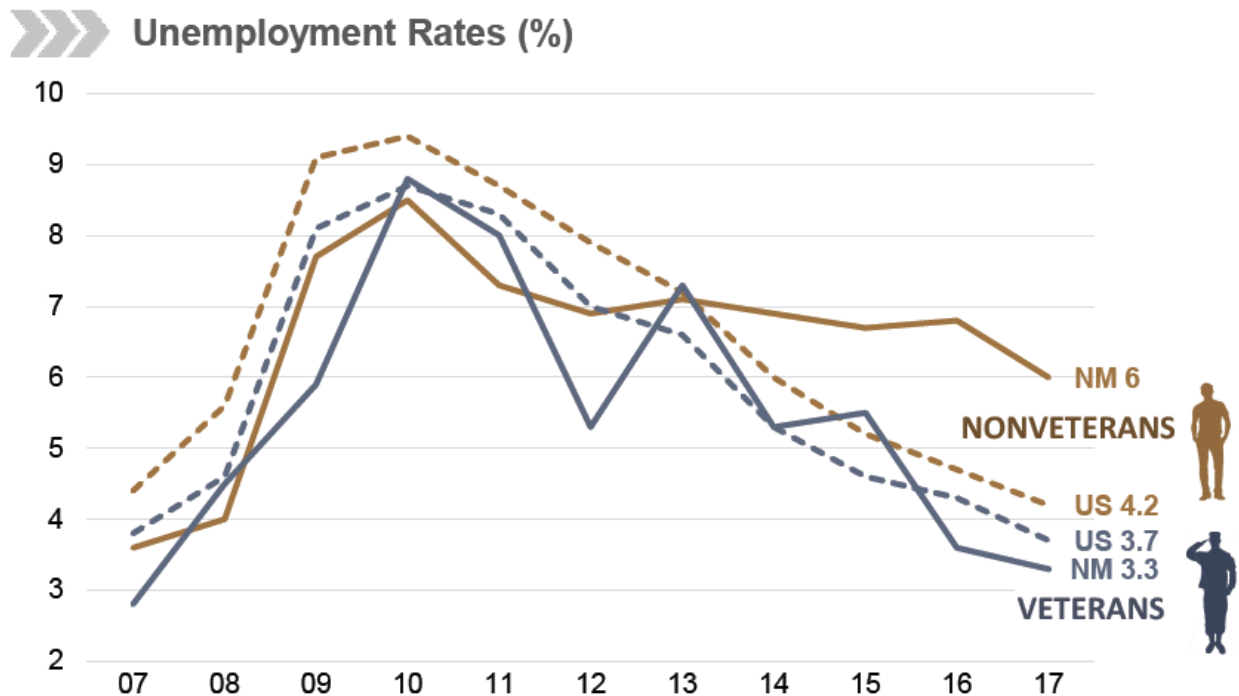
Veterans are less likely to live in poverty than nonveterans in New Mexico. As of 2016, 7.8 percent of all New Mexico veterans were living in poverty, compared to 17.6 percent of nonveterans. In the U.S., 6.9 percent of veterans were living below the poverty level, compared to 12.9 percent of nonveterans.

The U.S. Department of Housing and Urban Development (HUD) estimates the number of homeless individuals (those without safe and stable housing) in January of each year. The estimates, called “point-in-time” counts, include an estimate of homeless veterans. As of January 2017, HUD estimated 248 homeless veterans in New Mexico, with 135 sheltered and 113 unsheltered. (<https://www.hudexchange.info/programs/coc/>)

### Labor Force Participation and Unemployment Rates of Veterans

As of 2017, 45.9 percent of the veteran population in New Mexico was participating in the labor force (i.e., they were employed or actively seeking work). This rate was 3.8 percentage points lower than the rate for veterans nationwide (49.7 percent) and 14.9 percentage points lower than the rate for New Mexico’s nonveterans (60.8 percent). New Mexico’s veteran labor force participation rate tied with that of Michigan and was higher than the rates of eleven other states. Maryland had the largest veteran participation rate (61.6 percent), while New York had the lowest (42.5 percent).

Over the last eleven years, the labor force participation of New Mexico’s veterans ranged between 44.8 percent (2014) and 55.6 percent (2008). The 2017 rate was the second lowest reported over the period. Nonveteran labor force participation rates ranged between a low of 60.4 percent in 2013 and a high of 66.8 percent in 2007. The 2017 rate of 60.8 percent was the third lowest for the period. Labor force participation of veterans and nonveterans generally fell between 2007 and 2017 in New Mexico and the U.S., with participation for both groups in New Mexico declining at a slightly faster rate than in the U.S.



As of 2017, 3.3 percent of New Mexico’s veterans participating in the labor force (i.e., they were employed or actively seeking work) were unemployed. This rate was 0.4 percentage point lower than the rate for veterans nationwide (3.7 percent) and 2.7 percentage points lower than the rate for New Mexico’s nonveterans (6.0 percent). New Mexico’s veteran unemployment rate tied with the rates of Maryland, New Hampshire, and Wisconsin and was lower than the rates of 31 states and D.C. Vermont and Maine tied for the lowest veteran unemployment rate, at 1.7 percent, while Rhode Island’s rate was the highest in the nation, at 7.3 percent.

The veteran unemployment rate in New Mexico and the U.S. followed similar patterns as the nonveteran rate between 2007 and 2017. Veteran and nonveteran rates increased significantly between 2007 and 2010 due to the Great Recession. New Mexico’s veteran unemployment rate hit an 11-year peak in 2010 at 8.8 percent, a rate which was nearly the same as the U.S. veteran rate of 8.7 percent. The state’s nonveteran rate also peaked that year, but at 8.5 percent, which was 0.6 percentage point lower than the U.S. nonveteran rate of 9.4 percent. Unemployment both in the nation and state declined during the 2011–2017 period, albeit at varying rates. New Mexico’s veteran unemployment rate declined swiftly, at a rate faster than the decline of the veteran and nonveteran rates for the U.S. The state’s rate in 2017 was

5.5 percentage points lower than its peak rate in 2010, compared to a drop of 5.0 percentage points for the U.S. veteran rate and 5.2 percentage points for the U.S. nonveteran rate. The state's nonveteran unemployment rate declined more slowly than the U.S. rates, falling by 2.5 percentage points over the seven-year period. *(New Mexico Department of Workforce Solutions, 2018 Veterans Profile)*

### **Military Sexual Trauma (MST)**

MST can occur on or off base and while a Veteran was on or off duty. Examples of MST include unwanted sexual contact, threatening and unwelcome sexual advances, and offensive remarks about a person's body or sexual activities. Physical force may or may not be used. Perpetrators can be anyone: men or women, military personnel or civilians, commanding officers or subordinates, strangers, friends, or intimate partners.

About 1 in 4 women and 1 in 100 men have told their VA health care provider that they experienced MST. Although rates of MST are higher among women, because there are so many more men than women in the military there are considerable numbers of both men and women who have experienced MST. Veterans from all eras of service have reported experiencing MST. Being sexually victimized by someone of the same gender does not make someone gay or indicate that someone is gay.

Sexual assault is more likely to result in symptoms of PTSD than most other types of trauma, including combat. However, PTSD is not the only condition associated with MST. Depression and substance abuse are common, as are physical health concerns such as headaches, gastrointestinal difficulties, chronic pain, chronic fatigue, and sexual dysfunction. MST is often not the only trauma a Veteran has experienced. Veterans who have experienced multiple traumas may be particularly likely to have complicated health issues and to struggle with recovery.

Most sexual trauma victims do not report their experiences to authorities and some do not tell anyone at all. This can be because they do not think they'll be believed, do not think anything will happen as a result of speaking up, are afraid of retaliation, or due to shame, guilt, and disbelief. They may also be concerned about stigma related to having mental health difficulties. Disclosure can be difficult for all MST victims, but men, gay Veterans, transgendered Veterans, ethnic minorities, and other subgroups may find it particularly difficult to disclose or seek help related to experiences of MST.

### **Services Delivery for Veterans**

The Behavioral Health Services Division (BHSD) supports veteran-focused Question, Persuade, Refer (QPR) training throughout the state in collaboration with Straight Scoop for Vets. Straight Scoop for Vets offers free QPR suicide prevention training to veterans and their families. Straight Scoop also offers train-the-trainer programs to sustain trained veterans in providing QPR to the community. In SFY19 trainers funded by BHSD provided the state with an additional 1,500 people completed in the Gatekeeper Training throughout New Mexico. Funding and training is ongoing.

BHSD partnered with stakeholders to develop and implement the Certified Peer Support Worker Veteran Endorsement Training.

The Veteran Endorsement training is a 12-hour, 2-day training targeting Certified Peer Support Workers (CPSW). CPSWs have a unique and critical role as part of the behavior healthcare team. CPSWs have lived through, dealt with, and recovered from substance use and/or mental health issues themselves. They are proof that recovery is possible and are willing to mentor others to achieve similar results.

BHSD funds Veteran specific services statewide with preference given to areas of the state that are underserved to address the unmet needs of veterans and their families to include: housing, jail diversion and therapeutic support services. Services are provided to veterans who are 18 years of age or older and their families living with the effects of military service, deployment and coming home.

The agencies receiving funding for SFY2020 are: Goodwill Industries of New Mexico, Mesilla Valley Community of Hope, National Veterans Wellness and Healing Center, New Mexico Veterans Integration Center, Not Forgotten Outreach, Horses for Healing, First Nations Community Healthcare, and the Life Link. Proposals for additional services are currently being accepted by BHSD.

Providers addressed one or all or any combination of the services defined below.

1. Housing for veterans or veterans and their families who are homeless or near homeless (i.e. At risk of becoming homeless due to inability to pay rent/mortgage, cover security deposits, and/or to assist with reintegration for veterans recently discharged, or who's current living situation is coming to an end). This may include emergency shelter, regular shelter, transitional housing, long-term or permanent housing. Identifying homeless/near homeless veterans would include, but not limited to, outreach and collaboration with veteran services, housing programs, shelters, community behavioral health and physical health providers, state and local providers serving veterans and/or engaging in street outreach.
2. Therapeutic and Support Services for veterans and their families. Services can be provided to family members exclusive of the veteran to support the family living with the effects of military service, deployment and coming home. Therapeutic services may include, but are not limited to, conducting assessments and providing treatment services, making referrals, coordination of care, equine therapy, children's camps, or retreat activities. Support services may include, but are not limited to, providing food boxes or meals, covering utility deposits or utility bill, transportation assistance to medical/behavioral health appointments and/or to seek housing, employment or other related transportation needs that support the veteran and/or family in healing and self-sufficiency.

BHSD continues to collaborate with outside organizations to reach veterans in rural and frontier areas of New Mexico including Collaborative partner the New Mexico Department of Veteran Services (DVS).

The DVS provides both direct services to veterans and their eligible dependents and linkage to federal, state, local and private resources. As a Collaborative member, staff at DVS provide informed linkage for veterans to behavioral health services provided by Medicaid and other Collaborative agencies, as well as the much larger federal VA system. While the priority is assisting veterans and their family members in applying for federal VA and state benefits, linkage to other needed services is also provided, all free of charge. There is also a targeted Women Veterans Program.

DVS educates veterans about their available healthcare benefits, and helps them navigate the complex federal VA Health Care System (NMVAHCS), which includes the VA Medical Center in Albuquerque, fifteen Community-Based Outpatient Clinics, and four regional Vet Centers that provide behavioral health counseling and services. Equally strong alliances have also been formed with non-VA state and private

health and behavioral health care providers throughout the state that also serve veterans, including those who are not eligible for VA health care.

### **Unmet Needs for Pregnant Women**

(Injecting Drug Users, Women with Dependent Children, Persons at Risk for Tuberculosis, Individuals in Need of Primary Substance Abuse Prevention and, for HIV-designated states, Persons at Risk for HIV\*)

Based on information from the Substance Abuse and Mental Health Services Association (SAMHSA), prevalence among people who abuse substances is less for women than men. However, women are as likely to develop substance use disorders as men, and the gender gap is narrowing across ethnicities, especially for younger women. Women accelerate to intravenous drug use at a faster rate than men. Women who have co-occurring disorders have complex needs and should have those needs addressed in a comprehensive approach.

In New Mexico approximately 80% of the women we currently served have children. In some geographic areas and at least 25% of the women served are or have been pregnant while in treatment. Women are at tremendous risk since New Mexicans continue to surpass national rates for the negative consequences of excessive consumption of alcohol and use of both illicit and prescription drugs. Neonatal abstinence syndrome (NAS) refers to withdrawal symptoms, which occur in 55-94% of newborns whose mothers were addicted to or treated with opioids (e.g., methadone or buprenorphine) during pregnancy. NM has experienced a continuous increase in the number of identified NAS cases. In 2017, 330 cases were identified for a rate of 14.0 per 1,000 live births and increase of 59.3% in the last five years and of 324% since 2008. Among 28 states with available data, New Mexico ranked 4th in rate of NAS incidence (Incidence of Neonatal Abstinence Syndrome, Morbidity and Mortality Weekly Report, CDC, August 12, 2016). Because babies with NAS may be fussier and harder to console, support provided for these mothers is very important for the welfare and recovery of both mother and child. *See Neonatal Abstinence Syndrome Surveillance in New Mexico November 2018* <https://nmhealth.org/data/view/report/2194/>

For over 15 years, New Mexico's death rate for alcohol related chronic diseases (e.g., chronic liver disease and cirrhosis, alcohol dependence, etc.) have been first in the nation with rates 1.5-2 times the national rate. In addition, over the last 15 years, New Mexico's death rate for alcohol related injury (motor vehicle crashes, drowning, suicide, homicide, etc.) has consistently been among the worst in the nation ranging from 1.4-1.8 times the national rate (NMDOH, 2011). Between 2005 and 2009 a total of 480 women died of alcohol related deaths and 778 women died of drug induced deaths; of these 69% were minority women (NMDOH 2011). The serious problem of alcoholism in New Mexico is an example of persisting disparity. The rate of alcohol related deaths in New Mexico was 88% higher than the national rate. In 2006, the estimated cost of alcohol abuse in New Mexico was more than \$2.5 billion, or \$1,250 per person (NMDOH, 2011). This economic burden falls heavily on New Mexico, since it is one of the nation's poorest states with the second highest percentage (21.5%) of people living in poverty.

New Mexico is among the states with drug overdose death rates that are higher than national rates; it ranked eighth compared to the other 50 states in 2015. In 2014, 40% of the 47,055 fatal drug overdoses in the U.S. were due to prescription opioid drugs (e.g., oxycodone, hydrocodone, codeine, morphine, fentanyl) and 22% were related to heroin.<sup>1</sup> In 2015, 1,753,287 opioid prescriptions were written in New Mexico, dispensing enough opioids for each adult in the state to have 800 morphine milligram equivalents (MME), or roughly 30 opioid doses. History of chronic pain is found in 50-80% of people that die of prescription opioid overdose. The risk of overdose increases with increasing opioid dose. In 2014, 1.9 million U.S. residents had a prescription opioid use disorder and 586,000 had a heroin use disorder. Chronic opioid use (for over 3 months) is associated with increased rates of addiction, tolerance, anxiety, hospitalizations, pain (hyperalgesia), and overdose death. Combinations of opioids and alcohol and/or other drugs such as sedatives (e.g., benzodiazepines) increase the risk of death. The problem affects people of all races/ethnicities, genders, ages, and income levels.

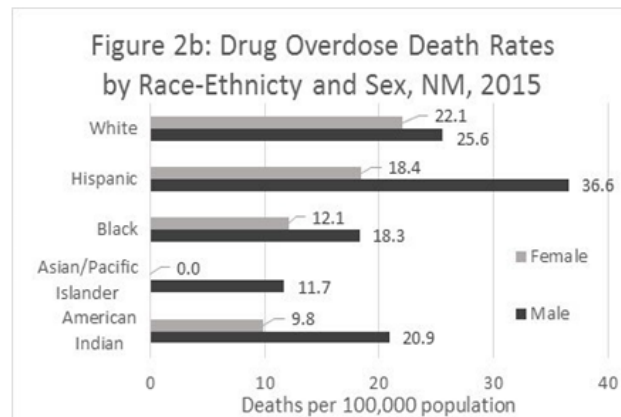
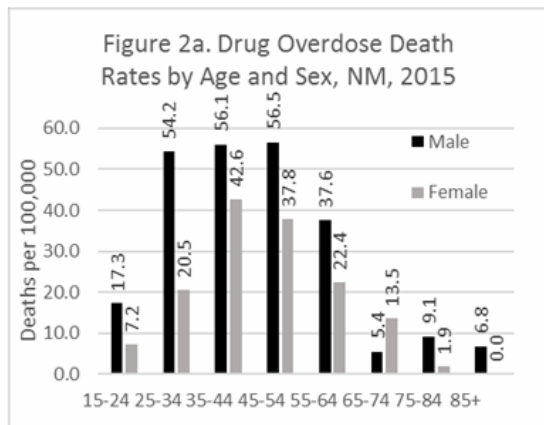
New Mexico's drug overdose death rate has been high compared to the national rate; New Mexico had the second rate in 2014, but showed improvement to the eighth highest rate in 2015 by declining by 7.5%. Implementation of federal and state guidelines, regulations, and laws, along with education and various medical strategies are intended to reduce drug overdose death rates. Examples include US Centers for Disease Control and Prevention Guidelines for prescribing opioids for chronic, non-cancer pain, prescription monitoring programs (PMPs) such as the New Mexico PMP (<http://nmpmp.org/>), safer opioid prescribing practices by health care providers, broader access to medication assisted treatment (MAT) such as buprenorphine/naloxone and methadone, and increased distribution of naloxone (opioid antagonist that can be used as a nasal spray to prevent overdose deaths).

Drug overdose death rates tripled between 1990 and 2015 in New Mexico. The 2015 age-adjusted rate in New Mexico was 24.8 deaths per 100,000 population compared to the 2015 national rate of 16.3 deaths per 100,000.

Males 25-54 years of age were at the highest risk for drug overdose death while for females the highest risk was among those aged 35-54 years. Males had higher rates than females in most age and racial/ethnic groups, particularly among people under age 35 years. Hispanic males had the highest rates, followed by White males and White females (36.6, 25.6 and 22.1 deaths per 100,000, respectively). Among Hispanics and American Indians, males had rates that were roughly two times those of females. The difference between male and female rates was smaller among Blacks and even smaller among Whites.

The type of drug listed in 2015 OMI records showed that 72.5% of drug overdose deaths in New Mexico involved opioids. Of the deaths that involved opioids, 50.4% involved prescription opioids, 43.3% involved heroin and 6.3% involved both. Fentanyl contributed to 5.4% of opioid-involved overdose deaths. In 2015, 23.8% of all overdose deaths involved methamphetamine, 23.6% involved benzodiazepines, 10.8% involved cocaine and 22.0% involved alcohol. *New Mexico Epidemiology Report, Drug Overdose Death in New Mexico March 2017*





BHSD funds service providers for women with an SUD, addressing treatment services for pregnant women, those with dependent children, and those who are attempting to regain custody of their children, as well as unmet needs of women and their families. Individuals who are IVDUs must be identified and services prioritized under the SABG for all providers funded by this grant, per regulation and contracted scope of work. These regulations primarily refer to the development of capacity management and waiting lists for this high need population. Contracted providers are also required to maintain a quality assurance process that tracks and reports routine screening, referral for testing, and treatment of consumers who are infected or at risk of infection with tuberculosis (TB), as well as HIV, Hepatitis C, or sexually transmitted diseases. BHSD partners with the Department of Health’s TB Control Officer to implement infection control procedures and linkages with other health care providers to ensure that TB services are routinely made available, primarily through the statewide network of public health offices.

For State Fiscal Year 2020, Interfaith Leap/Sangre de Cristo House, Santa Fe Recovery Center, and Turquoise Lodge received funding for women’s services that meet the priorities for the Women’s Set Aside funding.

BHSD continuously solicits applications statewide for the provision of treatment services to pregnant women and women with dependent children who have substance use disorders.

Applicants must demonstrate the ability to prioritize women’s services to women as follows: service provision for all required services to: 1) pregnant substance users; 2) women substance users with dependent children; and 3) women substance users who are attempting to regain custody of their children. Women with dependent children, for the purposes of section 96.123 from the Federal Register/Vol.58, No. 60/Wednesday, March 31, 1993/Rules and Regulations include women who are attempting to regain custody of their children. The core service requirements of the Women’s Set-Aside funding are crucial to the ability of women with substance use disorders who are pregnant and/or parenting dependent children to access services, receive treatment, and live a healthy life in recovery with



their families. The funding for this program comes from the Substance Abuse Prevention and Treatment Block Grant (SABG); Interim Final Rule (45 CFR § 96.120-96.137), which implements the Title XIX, Part B, Subpart II and Subpart III of the Public Health Services (PHS) Act.

### **Tuberculosis Program**

The Tuberculosis Program serves people infected with tuberculosis, contacts of active tuberculosis cases, public and private healthcare providers throughout New Mexico, and the general public. The Program purpose is to prevent and control the spread of tuberculosis, by ensuring that active tuberculosis cases receive adequate care, directly observed therapy, and a contact investigation if infectious. Other important program activities are: case management of all active cases; interstate/international referrals; surveillance; training for healthcare workers and other stakeholders; and screening to identify and treat Latent Tuberculosis Infection (LTBI).

The BHSD as the principal agency for the SABG works with the DOH Tuberculosis Control Officer to implement infection control procedures and establish linkages with other health care providers to ensure that tuberculosis services are routinely made available.

The BHSD administration of the SABG funding and provider requirements to provide tuberculosis services to individuals with substance abuse issues are as follows:

Offer education and information; Provide screening, testing or referral for testing and; If indicated, referral for treatment services to a public health office.

The providers document the number of individuals referred for testing and/or treatment to BHSD on a quarterly aggregate report. The providers are required to maintain a quality assurance process that provides, manages, tracks, evaluates, and reports the routine screening and testing or referral for testing and/or treatment of those consumers who are infected or at risk of infection with tuberculosis *and* HIV, Hepatitis C, or sexually transmitted diseases.

BHSD collaborates with the New Mexico Department of Health/Public Health Division staff and its statewide network of public health offices to test and provide follow-up with any needed TB treatment to consumers referred by the behavioral health providers.

*\*New Mexico is not an HIV-designated state.*

## Centennial Care Managed Care Organization (MCO) Facility Liaison Programs



In April 2019 Presbyterian began training CPSW and CHW staff to be SOAR advocates. They now have 8 certified SOAR Advocates located in Albuquerque (4), Las Cruces (2), Espanola/Santa Fe (1), and Farmington (1). The Certified SOAR Advocates will assist Members in applying for SSI/SSDI. The Members selected for this program must be homeless and disabled due to either mental illness and/or chronic health conditions. Statistically, applicants who utilize a SOAR Advocate have a much higher likelihood of approval for their SSI/SSDI applications. Once approved we will assist them in obtaining affordable housing and support services to succeed at staying housed.

PHP has designated Care Coordinators at each BH inpatient hospital who are notified of members admission in order to increase engagement efforts and begin the Transition of Care process prior to release. These individuals have the flexibility to respond to the notification in real time to provide support, relevant clinical information, and transitional planning alongside the discharge planners and hospital staff in efforts to decrease readmissions and establish meaningful services post release. In addition, the Care Coordinators engage Peer Support and Community Health workers when appropriate to help with engagement efforts and building rapport. The designated Care Coordinators are well versed on which providers have capacity for 7 day follow up appointments, who the members have had success with historically for services delivery, as well as have relationships with statewide Care Coordinators in areas that the member might be returning to, in order to help with the warm handoff process and the transferring of relevant clinical information to avoid gaps in care. In addition, hospital based Care Coordination staff often reach out to the Presbyterian Housing Specialist for resources to assist those Members' discharging from the hospital with housing resources. With the recently trained staff available to also assist those Members with SSI/SSDI applications through the SOAR program the likelihood of them obtaining an income, and subsequently housing is much higher. Research has shown that people who are housed are much less likely to become hospitalized or utilize ED's. Lastly, Presbyterian is in the process of establishing a relationship with Heading Home's Street Connect program with a mutual goal being to assist those Members who are homeless and experiencing mental illness. Albuquerque Street Connect and the Presbyterian housing specialist and SOAR advocates will work hand in hand to reach our homeless, high utilizer, Members. <https://headinghome.org/abq-streetconnect/>



Blue Cross Blue Shield uses the Medicaid 2.0 Value-Added Services funds to assist members with housing, in the form of Transitional Living Services (TLS). We have been able to help a lot of formerly homeless members get their lives stable, then move on and can live independently. Seeing a decrease in admissions among several members who have participated in this Value-Added Service (VAS). Blue Cross Blue Shield

has set up several vendors to utilize our TLS VAS funding, including 3 in the Metro area and one in Las Cruces. Blue Cross Blue Shield are working with a provider in the Santa Fe area to bring them on board to begin utilizing these funds. We have had several success stories including the two below. Two of these vendors specialize in working with folks who are experiencing Substance Use Disorder (SUD) issues and two are geared more towards helping those with Serious Mental Illness (SMI).

One success story is about a 26-year-old female, who had been in the hospital 4 times between December 2018 and February 2019, which amounted to 33 hospital days. Member's family could no longer deal with member's erratic mood swings and accompanying behaviors; she was not welcome to come home. Member was placed with TLS for 60 days while the agency worked intensively with member to get on the correct medication regimen and to learn some coping skills to assist with staying out of the hospital. Member did discharge from TLS for 3 days in April for a hospitalization with the intent of medication adjustment; member then readmitted to the TLS to complete her stay. Member discharged from TLS at the end of April and has not been re-hospitalized since. It is reported that member is living back with her family, as her symptoms and behaviors under control, and is planning to continue her education this fall.

A second example of using these services to assist with homelessness prevention and reduction in re-hospitalization is a 56-year-old female with physical and mental health problems. Between November of 2018 and March of 2019, member was hospitalized 5 times for a combination of mental and physical health admissions. She spent a total of 48 days inpatient during this period. Member had no home to return to. When she discharged from the hospital on March 26, 2019, she was accepted into a TLS setting. TLS requested 30 days of VAS funds to assist with stabilization of this member's physical and behavioral health issues. In the period of time that BCBSNM provided this service, the facility assisted member with getting her SSI funds back on track; assisted with getting her into both medical and psychiatric follow-up appointments and got her enrolled with a home care program for personal care hours. After the one month of assistance, member has been able to pay her own way at the facility by using her SSI funds. She remains in the home and has not required the hospital since arriving at the facility.

### **Reducing ED Admissions Utilizing the Edie Platform**

Blue Cross Blue Shield has a team of Recovery Support Assistants (RSA's) (peer support) assigned to the Edie program to reduce excessive Emergency Department (ED), usage. We have a supervisor who monitors the Edie platform daily and assigns those members who have excessive ED and acute admissions to a RSA. Those RSA's then go to the facility and meet the member at those facilities to start work with them to educate about alternatives to ED, educate them on the different resources available for SUD or mental health services. The RSA's follow those assigned members, providing coaching, mentoring, and modeling recovery behavior. Based on data collected on the RSA program, shows a 64% reduction in hospital admissions and the same for readmissions on those members that the RSA's are involved with. Blue Cross Blue Shield have found that a lot of our members who are visiting the ED regularly are homeless so this face to face contact provides us with the ability to engage with them and identify those needs and start to address those housing needs.

### **Justice Liaison Project**

Blue Cross Blue Shield has a justice project where there are Justice assigned Liaisons to each jail, detention, and prison facility in the state. Blue Cross Blue Shield utilizes both licensed clinicians and Certified Peer Support Workers as a team to meet members in the facilities before release to perform a Transition of

Care Assessment which in turn is used to develop a Transition of Care Plan. Both liaisons engage with the member before release and then follow the member once released in the community. They follow the members for a minimum of 90 days, working with them to ensure the Transition of Care Plan is meeting their needs and they are utilizing the provided resources. A lot of these members were high admitters to acute care and ED services and had a high percentage of homeless members. We have been able to reduce both; admissions and homelessness. These liaisons work closely with our care coordination staff to ensure continuity of care.

### **Reducing admissions with the Transition of Care Liaison Program**

Blue Cross Blue Shield has a Transition of Care Liaison team whose responsibility is to be a liaison to all the acute care psychiatric hospitals in the state as well as RTC's, and TFC's. The Liaisons are assigned a specific facility and/or agency and it is their job to meet all BCBS members who admit to these facilities. They then work with the member and the discharge planner at the facility to perform a Transition of Care assessment (TOCA) and subsequent Transition of Care Plan (TOCP). With the completed assessment and plan, they continue to engage with the member to meet the plan goals. They follow the member for a minimum of 90 days, working closely with the members to ensure the plan is adequate and member centered. Additionally, they work to assist member's in aftercare appoints that may include medication management, transportation, or outpatient services. They work in tandem with the assigned Care Coordinator to ensure all needs of the member are being met. Preliminary data has shown a decrease in our admission rates for those identified members who are engaged in the Transition of Care Program.

### **Additional Efforts and Collaborations**

Community Social Services employs a housing specialist that focuses on working with members who are experiencing homelessness or housing instability. Our CHW (Community Health Workers) housing specialist focuses building partnerships with many community organizations that provide resources to attain permanent supportive housing. Additionally, Community Social Services has received in-services by several organizations such as Hope Works, Coalition to End Homelessness, Albuquerque Public Housing, the Heading Home Project and Steel Bridge.

Currently we are collaborating with University of New Mexico Clinics and Lutheran Family Services to address a current and very urgent situation. We have ninety-six people, all refugee families, who will be losing their housing as of 8/31/19 due to the landlord not renewing their lease at the housing complex where they all live. We are working diligently to secure housing for these families as many of the families are large and have school-aged children who need to be registered for school in the coming weeks. There is intensive "foot-work" and collaboration among many agencies to accomplish this mission.

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Western Sky Community Care has a two-pronged approach, meet community members experiencing homelessness where they are with direct needs and through systems changes address the larger housing crisis in New Mexico.

### **Heading Home Second Site**

In partnership with New Mexico Appleseed, WSCC is working to secure federal funding for Albuquerque Heading Home's second location meal program. Presently, the site does not have capacity for warm meals over the weekend. Additionally, in partnership with University of New Mexico Health Sciences Center, WSCC is working to create a funders collaborative to underwrite Albuquerque Healthcare for the Homeless Clinic for the site. Moreover, WSCC is working with the City of Albuquerque to donate and install a washer and dryer on site to combat on-going issues with hygiene. From a policy standpoint, WSCC in partnership with the Albuquerque Chamber of Commerce is supporting the passing of a bond to build a permanent community structure more closely resembling the Las Cruces Community of Hope model.

### **Albuquerque Healthcare for the Homeless**

WSCC partnered with AHCH to provide 500 bath towels for their public shower program. Community members will have access to fresh towels and shower for improved hygiene leading to better outcomes towards health. WSCC also underwrote the First Day of Summer Campaign matching donors' funds up to \$2,500. The campaigns will double the impact and provide 5,000 daily bus passes to people least likely to benefit from and most likely to struggle with transportation resources. Lastly, in partnership with AHCH through the WSCC collaborative grant with Meow Wolf, WSCC is aiming to support emergency healthcare for artists experiencing homelessness.

### **Albuquerque Heading Home**

WSCC underwrote the construction of a community garden and pack porch for tenant's use. AHA tenants will foster community and participate in garden therapy supporting their behavioral health needs.

### **Community of Hope**

WSCC underwrote tarps for all community members staying on the complex. Community members will have access to a fresh towel and shower for improved hygiene leading to better outcomes in behavioral health.

### **Alliance for School Based Health Centers**

WSCC in partnership with the ASBHC funds micro grants for school nurses, most underwriting resources for students experiencing homelessness.

### **Flu Shot Clinics**

In partnership with Walgreens, WSCC facilitates flu shot clinics in the community for individuals experiencing homelessness.

### **Rolling Clean**

WSCC is quietly exploring a partnership that will allow for a mobile shower unit for the greater Albuquerque area for community members experiencing homelessness.

### **Community Foundation of Southern New Mexico**

WSCC in partnership with the CFSNM funds micro grants for nonprofits within Dona Ana County, underwriting resources for their most fragile community members. Most grants address limited resources and capacity issues resulting from lack of resources for asylum seekers. It is WSCC belief that increasing resources for nonprofits in the area supports our members and those who are entering refugee status.

In addition to the above, to address the impact that homelessness has on readmissions to inpatient acute care, WSCC employs a dedicated Supportive Housing Specialist. Members who are identified with housing needs are referred for assistance in finding and obtaining funding for temporary or permanent housing. WSCC Supporting Housing Specialist focuses on gathering all available member resources in the State of New Mexico and partnering with those agencies; she attends Housing Community meetings including but not limited to the New Mexico Coalition to End Homeless: Albuquerque housing Strategic Collaborative, Neighborhood Impact Work Group by the City of Albuquerque, Returning Citizens Collaborative group, MCO Housing Specialist Luncheon/Community Meetings, State Quarterly Housing Meetings, and Ad hoc meetings with Hope Works, Healthcare for the Homeless and Heading Home. WSCC Supporting Housing Specialist also provides WSCC Care Coordination/Member Connection/BH Liaison staff training on Housing resources quarterly.

WSCC interventions to reduce hospital readmissions for those with Behavioral Health needs include WSCC BH Liaisons engaging members prior to discharge to assess their needs and barriers to a successful discharge. BH Liaisons create a Transition of Care plan for the member in which barriers, goals and interventions are addressed with an overall focus on preventing a readmission. BH Liaisons are also educating members and assisting them in scheduling WSCC Value Added Service of transportation to the pharmacy through our transportation vendor within 7 days of discharge to obtain their prescriptions. BH Liaisons call members that discharge from an Inpatient Psych facility back to the community within 3 days of discharge to complete a post discharge assessment and assist the member in addressing any current barriers to successfully meeting Transition of Care Plan goals. For members discharging to the community who are in need of community benefits, the 3 day follow up is conducted at member's home. All Inpatient acute admission and continued stays are staffed daily with WSCC's BH Medical Director with a special emphasis on members with multiple admissions. Also, during the utilization review process for facilities, WSCC Behavioral Health Utilization Managers discuss barriers that have contributed to unsuccessful community integration in the past and suggest alternatives for those members. The BH Liaisons also complete HRAs/CNAs and make referrals to care coordination. Once CC is assigned, the BH Liaison will complete a warm transfer to assigned CC who will continue with the 3 monthly touchpoints and 75-day reassessment after discharge. For members in CYFD custody, WSCC has regular meetings as well as ad hoc

discussions with CYFD on discharge issues. For members who are eligible for CareLink New Mexico (CLNM), referrals to these agencies are encouraged. If the member is already a CLNM enrollee, the CLNM agency will be involved in discharge planning from admission. BH Liaisons will refer members who are refusing CC but are considered at high risk of readmissions to our Member Connections team, which consists of CHWs and Peer Support Specialists to make additional outreach attempts to such members in an effort to engage them.

## **Annual Consumer Family/Caregiver and Youth Satisfaction Surveys – Centennial Care**

The New Mexico Consumer, Family/Caregiver and Youth Satisfaction Project (CFYP) is a yearly effort to survey the satisfaction of New Mexico Adult Individuals, Family/Caregivers and Youth receiving state funded mental health and substance abuse treatment and support services.

The CFYP surveys have two purposes:

- To inform a quality improvement process to strengthen services in New Mexico; and,
- To fulfill federally mandated data reporting requirements.

Adults and family members of youth in care answer the survey through telephone interviews. Telephone interviews were obtained from a pool of randomly-selected individuals or families who received behavioral health services from New Mexico Medicaid or Behavioral Health programs between July 2017 and January 2018.

The reader will see trend data in each of the domains which reflects the respondents' satisfaction across the most recent four years of Centennial Care (2015-2018).

### **Who we surveyed - Adults**

Our sample was drawn from those individuals who had received care anytime between July 1, 2017, and January 31, 2018. However, when called, respondents were free to speak about their experiences throughout the entire previous twelve months. Survey telephone calls were conducted in June and July 2018. For the 2018 survey, we heard from 1,045 adult respondents. The sample well represented the population receiving services, with some exceptions noted below. The respondents ages 45-64 years old (42%) were overrepresented in the sample. They represent only 29.7 percent of those receiving services during the same period. The reverse is true of the two youngest age group, 18-24 years, who were 10 percent of the sample but are 14.1 percent of the population receiving services. Similarly, the 25-34 age group (or, 24.1% of respondents) are underrepresented as compared to the that group in the population served (28.6%). Forty-five percent (45.2%) of the respondents identified their ethnicity as Hispanic. That is very similar to the population receiving services (46.6%) during the same period. Like the population receiving services, 86.6 percent of the respondents identified themselves as Caucasian. Native American respondents (4.3%) were slightly underrepresented as compared to those receiving services (6.5%). African American respondents (2.5%) were the same proportion as those receiving services.

### **Adult Domain: Access**

**Definition:** *Entry into behavioral health services is quick, easy and convenient.*

**Observations:** The average proportion of positive responses for Access was 82.2 percent. This is similar to the prior year's performance of 81.9 percent. However, this is below the national 2017 average of 89.2 percent, Respondents were least satisfied with access to their psychiatrist.

### **Adult Domain: Participation in Treatment**

**Definition:** *Adults feel that they are a part of their treatment team.*

**Observations:** The average proportion of positive responses for Participation in Treatment was 85.1 percent. This is below the 2017 National Average of 87.4 percent. However, it is an increase (2.8%) over the prior year's performance of 82.2 percent. While adults were generally satisfied asking questions about their treatment or medications, they were notably less satisfied about the process of setting their treatment goals.

### **Adult Domain: Improved Functioning**

**Definition:** *Adults feel they can manage their daily activities better.*

**Observations:** The average proportion of positive responses for Improved Functioning was 74.1 percent. This is below the national 2017 average of 78.3 percent. It is, however almost a two-point increase over the prior year's performance of 72.1 percent. Adults were least satisfied about managing their symptoms and being able to do what they wanted to do.

### **Adult Domain: Social Connectedness**

**Definition:** *Adults feel they are connected in their family and friends, have social supports and belong to their community.*

**Observations:** The average proportion of positive responses for Social Connectedness was 78.7 percent. This meets that national 2017 average of 78.6 percent. This is a one-point improvement over the prior year's performance of 77.7 percent. The area in which adults were less satisfied had to do with their sense of belonging in their community.

### **Adult Domain: Outcomes**

**Definition:** *The extent to which services provided to individuals with behavioral health needs have a positive or negative effect on their well-being, life circumstances, and capacity for self-management and recovery.*

**Observations:** The average proportion of positive responses for Outcomes was 72.3 percent, slightly lower (1.1% point) than the prior year performance (73.4%). This is significantly below the national 2017 average of 82.8 percent. Satisfaction was notably lower in the areas of symptom management, handling social situations, work, and housing.

### **Adult Domain: Quality and Appropriateness**



**Definition:** *Services are individualized to address the consumer's strengths and needs, cultural context, preferences and recovery goals.*

**Observations:** The average proportion of positive responses for Quality & Appropriateness was 88.5 percent. This is similar to the prior year's performance of 88.7 percent. However, it is lower (2.5 points) than the national 2017 average of 90.9 percent. While adults were generally pleased with areas in this domain, they were less satisfied with staff's encouragement to use consumer-run programs and for help in watching out for side effects in their care.

### **Adult Domain: Satisfaction**

**Definition:** *Adults are generally happy with the services they are provided.*

**Observations:** The average proportion of positive responses for Satisfaction was 89.2 percent. This is almost a 3-point increase over the prior year's performance of 86.4 percent. However, it is lower (1.6 points) than the national 2017 average of 90.8 percent. Adults were less satisfied with the range of provider choices available to them.

### **Adult: Other Areas**

Problems in the support areas are often crucial factors affecting behavioral health recovery. The following highlight a few. In addition, questions were asked about Care Coordination at the health plan level. These questions were only asked of those who had been assigned this service.

**Housing:** When asked "Is your housing situation getting in the way of your mental health/recovery?" a smaller cohort of the total sample (11.6%) said "Yes." Among those respondents, 44.63 percent indicated they "agreed or strongly agreed" to this subscale of items:

- My housing needs were part of my treatment plan.
- When I had a housing problem, I was assisted by staff.
- If I had to wait to get housing assistance, I still received support for my other needs from my treatment team.

**Employment:** When asked "Does having work (either paid or volunteer) help you with your recovery from mental health or substance abuse disorders?" 46 percent of the total sample said "Yes". Among those respondents, on average, the majority (49.8%) indicated they "agreed or strongly agreed" to this subscale of items:

- My work goals were not part of my treatment plan.
- When I had a problem with work, I was assisted by staff.
- Because of the staff's help in general, my work situation is better.

**Substance Abuse:** A smaller cohort of respondents (16%) said they had received services for drug or alcohol use in the past year. But among those respondents, on average, almost all (96%) indicated they "agreed or strongly agreed" to this subscale of items:

- I have the tools I need to understand and continue with my recovery.
- The substance abuse services I received helped me reduce my use of drugs and/or alcohol

**Medications:** Over two-thirds of respondents (67%) indicated that they received medication services as part of their treatment in the past year. Among those respondents, on average, 78.9 percent indicated they “agreed or strongly agreed” to this subscale of items:

- I am getting my medications when I need them.
- The medication(s) I am taking helps me control symptoms that used to bother me.
- I was offered a choice in, or alternative to, medication.

**Care Coordination:** About 16.8 percent of respondents had been assigned care coordination assistance at higher levels (Level 2 or 3) in Centennial Care. The percent of positive response per each item was as follows:

- 84.2% You were involved in developing your goals for your Care Plan.
- 81.8% Your physical health was included in your Care Plan.
- 82.2% Your Care Coordinator reviewed progress on your goals when you met together.
- 73.8% When your Care Coordinator talked with you on the phone, it helped you with your goals.
- 78.9% Your Care Coordinator assisted you when there was an interruption or change in your care.

### **Who we surveyed - Child Family/Caregivers**

Our sample was drawn randomly from those children who had received care between July 1, 2017, and January 31, 2018. We spoke to their Family/Caregivers; and, they were free to speak about their experiences of their children in service through the entire previous twelve months. Telephone surveys were conducted in June and July 2018. For the 2018 survey, we heard from 1,020 Family/Caregiver respondents.

#### **Child Family/Caregiver Domain: Access**

**Definition:** *Entry into behavioral health services is quick, easy and convenient.*

**Observations:** The average proportion of positive responses for Access was 81.7 percent. This is very similar to the prior year’s performance of 81.8 percent. However, it is below the national 2017 average of 87.4 percent.

#### **Child Family/Caregiver Domain: Participation in Treatment Planning**

**Definition:** *Families feel that they are a part of their child’s treatment team.*

**Observations:** The average proportion of positive responses for Participation in Treatment was 90.5 percent. This is almost a 3-point increase over the prior year’s performance of 87.6 percent and a statistically significant improvement. And it exceeds the national 2017 average of 88.5 percent. Families feel very positive about being part of their child’s treatment team, choosing the child’s treatment goals and choosing their child’s services.

### **Child Family/Caregiver Domain: Improved Functioning**

**Definition:** *Families feel their child is better able to do the things they want to do, and have someone with whom they can enjoy things.*

**Observations:** The average proportion of positive responses for Improved Functioning was 75.5 percent. Although this is above the national 2017 average of 74.8 percent, it is 2.5 points lower than the prior year's performance of 78 percent. While generally satisfied, families are least positive about their child doing being better able to cope when things go wrong.

### **Child Family/Caregiver Domain: Social Connectedness**

**Definition:** *Families feel they have the social supports to listen to them when they need to talk and have help to deal with their child's problems or crises.*

**Observations:** The average proportion of positive responses for Social Connectedness was 91.4 percent. This is above that national 2017 average of 87.1 percent and is similar to the prior year's performance of 91.5 percent. Families were very satisfied with themselves, and their child, getting the help that they need.

### **Child Family/Caregiver Domain: Outcomes**

**Definition:** *The extent to which services provided to families with behavioral health needs have a positive or negative effect on their child's ability to get along with family and friends, do better in school, handle daily activities and cope with problems.*

**Observations:** The average proportion of positive responses for Outcomes was 76.1 percent which is 2 points lower than the prior year's performance of 78.2 percent. However, it is notably higher than the 2017 national average of 73 percent. Satisfaction was lowest in the areas of school and coping when things went wrong.

### **Child Family/Caregiver Domain: Cultural Sensitivity**

**Definition:** *The extent to which services provided to families are delivered in a manner that is respectful of cultural background, language and spiritual beliefs.*

**Observations:** The average proportion of positive responses for Cultural Sensitivity was 94.6 percent. This is above that national 2017 average of 93.3 percent, but slightly lower than the prior year's performance of 95.5 percent. Families are very satisfied with staff's respect for and sensitivity to the family's cultural background and spiritual beliefs. They also felt they were spoken to in a way they understood.

### **Child Family/Caregiver Domain: Satisfaction**

**Definition:** *Families are generally happy with the services that are provided to their child.*

**Observations:** The average proportion of positive responses for Satisfaction was 82.6 percent. This is notably below (5.5 points) the national 2017 average of 88.1 percent, as well as slightly lower than the prior year's performance of 84 percent. While families were very satisfied with the services their child received, they were less satisfied about getting the amount of help they wanted or needed.

### **Child Family/Caregiver: Other Areas**

**Access to Care:** This is an important area for all families. Most Family respondents (81.2%) indicated that staff who understood their situation returned calls within 24 hours all or most of the time. Most respondents (80.2%) indicated that when their children needed behavioral health services, they received them within two weeks all or most of the time. Nearly all children and families (98.7%) received the information needed and their services in the language they preferred. When needed, 64.2 percent of the respondents indicated they were provided an interpreter, and when provided 98% felt it was helpful. Only 3 percent indicated that language was a barrier to getting an appointment. An additional indication of their satisfaction is reflected in the finding that 84.8 percent of the respondents indicated they would recommend the agency to a friend or family member.

**Medications:** One-third (35.5%) of families indicated that their children received medication services as part of their treatment in the last year. Of those respondents, most (56.1%) indicated they “agreed or strongly agreed” to this subscale of items: However, access to a psychiatrist was rated notably lower than the other two items.

- My child had difficulty getting in to see a psychiatrist when we wanted.
- Staff told me what side effects to watch for regarding prescribed medications for my child.
- I was offered alternatives to or choices about, my child taking medication.

**Care Coordination:** Only 3.6 percent of respondents had their child assigned by their Managed Care Health Plan to the higher level of Centennial Care service called Care Coordination (Level 2 or 3). Within this smaller group, the percent of positive response per each item was as follows:

- 77.8% I participated in developing my child’s Care Plan.
- 80.6% My child’s physical health was included in his/her Care Plan.
- 77.2% I had contact with my health plan’s Care Coordinator and we talked about my child’s goals.
- 65.7% I had contact with my health plan’s Care Coordinator and we talked about action steps to take to meet my child’s goals.
- 54.6% My health plan’s Care Coordinator helped me get services that actually helped my child, even if there had been changes or loss of services.
- 62.2% I am satisfied with my overall experience with my health plan’s Care Coordination services.

**Behavioral Services received at School:** Forty-six percent (46.4%) of the families indicated that their child received Behavioral Health Services at school. Few respondents (17.2%) indicated they needed assistance in getting special education services related to behavioral health services for their child

Use of newer behavioral health services: We wanted to know whether families were interested in receiving three newer services: Respite, Family and Youth Specialist services.

- Three fourths of respondents (77.2%) would use Family Specialist services if offered to them.
- Most respondents (86.2%) would encourage their child to use Youth Specialist services if offered to them. Fifty-eight percent (58%) said they would use Respite Services if they were offered to them.

- Very few respondents (8%) had received Respite Services. But of those almost all were satisfied with the services:
  - 88.9% Found services helpful
  - 87.7% Found the location convenient
  - 92.6% Found the times available were flexible to meet their needs.
  - 85.2% Were satisfied with the quality of training of the respite provider
  - 87.7% Were satisfied that there were enough hours available convenient to the family
  - 93.8% Would recommend the service to another parent.
  - Importantly, the majority of respondents (52.9%) would use Respite Service if they were available to them.

# Planning Steps

## Quality and Data Collection Readiness

### Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's [NBHQF](#). The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at <http://www.samhsa.gov/data/quality-metrics/block-grant-measures>. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare,

etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?
4. If not, what changes will the state need to make to be able to collect and report on these measures?  
*Please indicate areas of technical assistance needed related to this section.*

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**Footnotes:**

New Mexico  
Office of Substance Abuse Prevention  
5-Year Comprehensive Evaluation Plan

August 2019

Written by:

PACIFIC INSTITUTE FOR RESEARCH AND EVALUATION



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## Background

The New Mexico Office of Substance Abuse Prevention (OSAP) establishes an integrated and comprehensive substance abuse prevention services delivery system through the promotion of sound policy, effective practice and cooperative partnerships to ensure the availability of quality prevention. It is committed to the implementation of evidence-based prevention programs and infrastructure development activities. The OSAP provides the infrastructure and other necessary support to local stakeholders in selecting and implementing policies, programs, and practices proven to be effective in research settings and communities.

The OSAP is dedicated to improving and maximizing the impact of New Mexico's substance abuse prevention system. To this end, OSAP seeks to build the capacity of the state's local prevention providers to deliver effective prevention services aimed at reducing alcohol, tobacco and other drug abuse.

Prevention goals are addressed via multiple funding sources of which OSAP is the recipient, and local prevention programs across the state are funded by the various funding streams to address the substance abuse prevention priorities. Currently, OSAP receives funding from the following sources:

Funding Title	Abbreviation	Source	Duration
Substance Abuse Prevention and Treatment Block Grant	SAPT Block Grant	SAMHSA	Yearly allocation
Partnerships for Success 2015	PFS 2015	SAMHSA	5-year grant; ends September 2020
Grant to Prevent Prescription Drug/Opioid Overdose-Related Deaths	PDO	SAMHSA	5-year grant; ends August 2021
Strategic Prevention Framework for Prescription Drugs	SPF Rx	SAMHSA	5-year grant; ends August 2021
Synar Tobacco Prevention	Synar	SAMHSA	Yearly allocation

Programs receiving **SAPT Block Grant** funding typically address underage alcohol use (any consumption, binge drinking, and/or DWI), adult binge drinking and/or DWI, and prescription opioid abuse. These programs must implement evidence-based environmental prevention strategies to address their goals. They may also implement evidence-based direct service prevention programming targeting adolescents. These same programs receive Synar funding to implement prescribed strategies addressing access to tobacco products among minors.

Programs receiving **PFS 2015** funding are required to focus on youth and young adults age 12 to 25 and address alcohol and prescription opioid misuse and abuse in this age range. These programs must implement evidence-based environmental prevention strategies to address their goals. These same programs have an Emerging Trends for Tobacco priority which provides funding to implement prescribed strategies addressing access to tobacco products among minors.

Programs receiving **PDO** funding provide training and access to naloxone to strategically identified laypersons to prevent opioid overdose deaths.

The program receiving **SPF Rx** funding works with the community to increase the perception of harms of prescription opioids and reduce diversion, and with local opioid prescribers to address prescribing practices and use of the Prescription Monitoring Program (PMP).

According to priorities determined by the funding source, programs identify goals that reflect local needs. The selection of goals, objectives, strategies and activities must be justified based on the results of a comprehensive needs assessment in the funded community. Local strategic plans include SMART goals and objectives, evidence-based strategies selected from an OSAP approved list, and activities required for implementation of the strategies that reflect the highest level of fidelity to the strategy.

The OSAP is committed to using data to guide state-level prevention goals and relies heavily on data provided by the NM Department of Health Epidemiology and Response Division (DOH ERD) to assess ongoing state-level trends and identify new and emerging trends of substance use behaviors and consequences. At a local level, the OSAP also relies on local prevention partners to collect, analyze, and report out on local behaviors, consequences, and related factors not available at the state. These data contribute to needs assessments and evaluations at the local and when aggregated, at the state level. **This evaluation plan is intended to lay out the multiple paths through which data will be collected and used to evaluate the OSAP's ongoing prevention efforts over the next five years.**

## State Level Evaluation

NM Office of Substance Abuse Prevention (OSAP) State-Level Prevention Goals are the following:

- 1) Reduce underage drinking
- 2) Reduce underage binge drinking
- 3) Reduce underage DWI
- 4) Reduce adult binge drinking
- 5) Reduce adult DWI
- 6) Reduce prescription painkiller misuse
- 7) Reduce prescription painkiller and other opioid overdose death
- 8) Reduce illicit drug misuse
- 9) Reduce underage use of tobacco products.

## State-Level Outcomes Evaluation

**Summary Description:** The state evaluators will complete a state-level outcome evaluation as part of their yearly reporting requirements to OSAP. The state evaluator, Pacific Institute for Research & Evaluation (PIRE), will coordinate the collection of community-level data on targeted intervening variables and consumption measures on a yearly basis using primarily two instruments. The NM Community Survey (NMCS) will collect data from NM residents 18 and older and the Annual Strategies for Success (A-SFS) will collect data from middle and high school students. A third data collection tool, the Baseline/Posttest Strategies for Success (BP-SFS) is used only by Direct Service providers, which currently is only one community. NMCS data will be aggregated and weighted to reflect state population distributions with respect to age, race/ethnicity, and gender according to most recent US Census data. The state evaluator will examine data estimates from the NMCS, A-SFS, and BP-SFS with comparable estimates from the NM YRBSS, the NM BRFSS, and the NM NSDUH. An evaluation report of the aggregated NMCS, A-SFS, and BP-SFS data will be provided to OSAP and local and state stakeholders on a yearly basis and trends will be tracked over time. Findings are presented at the OSAP recipient meetings in the fall of each year.

Consequence data will be examined on a monthly and/or yearly basis. The State Substance Abuse Epidemiological Profile will be updated on a yearly basis with new data by NMDOH Epidemiology and Response Division. State-level data dashboards with key indicators will be maintained to track trends by funding mechanism over time. National Outcome Measures (NOMS) data are provided to CSAP on an annual basis by OSAP.

To track progress on these goals at the state-level, data from multiple sources are reviewed and analyzed. Data on consequences, consumption (outcomes), and related factors (intervening variables) are tracked over time to assess whether consequences and consumption behaviors are decreasing and changes in intervening variables are taking place indicative of positive effects of prevention efforts.

**Sources of State-Level Consumption and Intervening Variable Data:**

Data Source	Collected	Coordinating Agency
NM Community Survey (NMCS)	Annual	PIRE/Local Prevention Provider (LPP)
NM Annual Strategies for Success (A-SFS)	Annual	PIRE/LPP
NM Baseline/Posttest Strategies for Success (BP-SFS)	Annual	PIRE/LPP
NM Youth Risk and Resiliency Survey (YRRS or YRBSS)	Biannual - odd years	NMDOH- ERD
NM Behavioral Risk Factors Surveillance Survey (BRFSS)	Annual	NMDOH- ERD
NM National Survey of Drug Use and Health (NSDUH)	Annual	SAMHSA
NM Opioid Prescribers Survey (OPS)	Annual	PIRE/LPP

**Sources of State-Level Consequence Data:**

Data Source	Collected	Coordinating Agency
Alcohol-related motor vehicle crash and fatality (DOT)	Monthly/Annual	NMDOT/PIRE
Prescription Monitoring Program (PMP)	Quarterly/Annual	NMDOH
Death Data (Overdose & ARMVCF)	Annual	NMDOH

**State Level Process Evaluation**

At the state level, process goals include:

1. Improve and enhance prevention efforts at the local level by increasing fidelity to evidence-based prevention strategies.
2. Improve, enhance, and expand training and TA initiatives that result in a more effective prevention workforce.
3. Develop and utilize local and state level data dashboards for real time monitoring and evaluation of local prevention efforts.
4. Improve planning and accountability processes at the community level through the development of an objective reviewing system of local progress reports.

**Sources of State Level Process Data:**

Data Source	Collected	Coordinating Agency
NM Dept. of Public Safety, Special Investigations Unit (SIU) data	Annual	PIRE/OSAP
Synar activities and results	Annual	OSAP
Media activities	Quarterly	PK PR/ PIRE
Training and technical assistance activities	Monthly	Coop/OSAP
Mid-year and end-of-year community reports	Semi-annual	PIRE/Coop/OSAP
SAMHSA’s Performance Accountability and Reporting System (SPARS)	Semi-annual	PIRE/Coop/OSAP
PFS 15 EBPPP (Evidence Based Programs Policies and Practices in SPARS)	Annual	PIRE
SPF Rx AII (Annual Implementation Instrument submitted through PEP-C)	Annual	PIRE
Meeting minutes (SEOW, PDO, PDO CQI, PPC, Core Team)	Monthly	Coop
Monthly activity reports from state contractors in STAR	Monthly	PIRE/Coop/OSAP

## Local Level Evaluation Plan

NM OSAP funded programs must choose two or more of the following long-term goals to address:

- 1) Reduce underage binge drinking (also considered ‘underage drinking’)
- 2) Reduce underage DWI (also considered ‘underage drinking’)
- 3) Reduce adult binge drinking
- 4) Reduce adult DWI
- 5) Reduce prescription painkiller misuse
- 6) Reduce illicit drug misuse

At the local level, SMART goals and objectives are derived from the results of the local needs assessment and yearly evaluation data collected. Local providers are required by OSAP to collect data that directly measures the targeted goals and objectives, report out on these data on a yearly basis, and track changes over time.

## Local Level Outcomes Evaluation

**Summary Description:** Each funded community is required to complete a mid-year and end-of-year local-level report as part of their yearly reporting requirements to OSAP. These reports track progress on implementation of identified strategies and started goals and objectives. In addition, each funded community will complete end-of-year reports on local level data collected through the implementation of the NMCS, the A-SFS, and the BP-SFS.

The local-level outcome evaluation will track community-level changes in consumption behaviors and substance-use related intervening variables. Outcomes evaluations will target the priorities, intervening variables, consumption behaviors, and consequences outlined in each community's strategic plan.

### Sources of Local Level Consumption and Intervening Variable Data:

Data Source	Collected	Coordinating Agency
NM Community Survey (NMCS)	Annual	PIRE/Local Prevention Provider (LPP)
NM Annual Strategies for Success (A-SFS)†	Annual	PIRE/LPP
NM Baseline/Post Strategies for Success (BP-SFS)†	Annual	PIRE/LPP
NM Opioid Prescribers Survey (OPS)	Annual	PIRE/LPP
Narcan/Naloxone Training and Distribution Form	Continuous	PIRE/LPP
Narcan/naloxone Trainee Demographic Form	Continuous	PIRE/LPP
Naloxone training evaluation tools (Post and Follow-up Forms)	Continuous	PIRE/LPP
Narcan/Naloxone Record of Use Form	Continuous	PIRE/LPP
NM Youth Risk and Resiliency Survey (YRRS or YRBSS)**	Biannual - odd years	NMDOH
NM Behavioral Risk Factors Surveillance Survey (BRFSS)**	Annual	NMDOH
Local Law Enforcement Activity Data	Monthly/Annual	LPP
School Policy and Enforcement Data	Annual	LPP

† Available in select communities

† Available only in communities with direct services programming

\*\* Available in larger communities

**Sources of Local Level Consequence Data:**

Data Source	Collected	Coordinating Agency
Arrest Data/NM Children, Youth & Families Dept. (CYFD) data	Semi Annual	Local Law Enforcement/Local Prevention Provider
Alcohol-related motor vehicle crash and fatality data (DOT)	Monthly/Annual	NMDOT/PIRE
Prescription Monitoring Program (PMP)	Monthly/Quarterly	NMDOH
Death Data	Annual	NMDOH
Graduation Rates/School Drop Out data	Annual	NMPED

**Local Level Process Evaluation**

At the local level, process goals include:

1. Increasing fidelity to evidence-based prevention strategies by tracking activities.
2. Improve documentation of progress on meeting stated goals and objectives.
3. Increase utilization of local and state level data dashboards for real time monitoring and evaluation of local prevention efforts.
4. Increase regular collection of process data from local stakeholders including local law enforcement, schools, and others.



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**Sources of Local Level Process Data:**

Data Source	Collected	Coordinating Agency
School Disciplinary Activities Data (activities, results, suspensions, graduation rates)	Monthly/Semi Annual/Annual	Local Prevention Provider (LPP)
Fidelity Checklists for In-School programming	Twice per session	LPP/Evaluator
Police Enforcement Activities Data (Sobriety Checkpoints, Party Patrols, etc.)	Monthly/Semi Annual	LPP
Enforcement Consequences (citations, arrests, convictions)	Monthly/Semi Annual	LPP
NM Dept. of Public Safety, Special Investigations Unit (SIU) activities & data	Annual	LPP
Synar Activities and Results	Annual	LPP
Responsible Beverage Server Training Activities	Annual	LPP
Media Activities (print/audio/video)	Monthly	LPP
Alcohol Outlet Density data	Annual	LPP
Pricing/Advertising/Placement/Location data	Monthly	LPP
Educational Activities & Materials (e.g., Parent handbooks, trainings)	Monthly	LPP
Take Back Events data (e.g., # of events, weight of Rx drugs returned)	Monthly	LPP
On-site Rx Drop Box data (e.g., # of boxes, weight of Rx drugs returned)	Monthly	LPP
Lock Box Distribution data	Monthly	LPP
Pharmacy Rx Drug Returns data (e.g., # of participating pharmacies, weight of Rx drugs returned)	Monthly	LPP
Other Prevention Activities (e.g. # of planning meetings, community events and presentations)	Monthly	LPP
Annual Implementation Instrument (SPF Rx-AII) via PEP-C (process data by strategy)	Annual	PIRE/ LPP
PFS 15 EBPPP #s reached and served by strategy (Evidence Based Programs Policies and Practices)	Annual	PIRE LPP

## Primary Data Collection Instruments

Primary Data Collection Instruments	Description
NM Community Survey	Annual survey of NM residents 18 and older. Communities develop detailed protocol for data collection and replicate each year. Convenience sample; recruitment via time and venue-based sampling approach and on-line recruitment via Facebook & Instagram. Instrument & Protocol available at: <a href="http://www.nmprevention.org/NM-Community-Survey.html">http://www.nmprevention.org/NM-Community-Survey.html</a>
NM Annual Strategies for Success (A-SFS)	Annual survey of students in grades 6-12; Communities develop detailed data collection protocol that is replicated each year. Instrument & Protocol available at: <a href="http://www.nmprevention.org/PFSII.html">http://www.nmprevention.org/PFSII.html</a>
NM Baseline-Post Strategies for Success (BP-SFS)	Baseline and post-test survey of participants in direct service prevention programming. Instrument & Protocol available at: <a href="http://www.nmprevention.org/Direct-Service.html">http://www.nmprevention.org/Direct-Service.html</a>
School Disciplinary Policy Analysis & Tracking Tool	LPP (Local Prevention Provider) tracks in Management Information Systems (MIS)
Local Law Enforcement Activity & Arrest Tracking Tool	LPP tracks in MIS
Juvenile Citation Tracking Tool (CYFD)	LPP tracks in MIS
Retail Access and Promotion Tracking Tool	LPP tracks in MIS
Media Tracking Tool	LPP tracks in MIS
Educational Events Tracking Tool (e.g, RBS, Synar)	LPP tracks in MIS
NM Opioid Prescribers Survey (OPS)*	Annual survey of NM prescribers to assess opioid prescribing practices and use of PMP
Narcan/Naloxone Training and Distribution Form	Used to track training, naloxone distribution and replacement at hub and spoke level for PDO
Narcan/naloxone Trainee Demographic Form	Demographics of trainees. Available at: <a href="http://www.nm-pdo.org/">http://www.nm-pdo.org/</a>
Naloxone training evaluation tools (Post and Follow-up Forms)	Post and follow-up questionnaire given to formal naloxone trainees to assess knowledge Available at: <a href="http://www.nm-pdo.org/">http://www.nm-pdo.org/</a>

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Primary Data Collection Instruments	Description
Narcan/Naloxone Record of Use Form	Completed by those who administer naloxone Available at: <a href="http://www.nm-pdo.org/">http://www.nm-pdo.org/</a>
Mid and End of Year Reports	Developed by OSAP – contains individual program objective and key process data. Available at: <a href="http://www.nm-pdo.org/">http://www.nm-pdo.org/</a>

**Data Collection by Funding Stream**

Data Source	Funding Sources				
	SAPT	PFS 2015	PDO	SPF Rx	Synar
Alcohol-related motor vehicle crash and fatality data (DOT)	X	X			
Prescription Monitoring Program data (PMP)	X	X	X	X	
Death Data (Overdose & ARMVCF)	X	X	X	X	
Synar Inspection Data					X
Arrest Data/NM Children, Youth & Families Dept. (CYFD) data	X	X			
NM Community Survey (NMCS)	X	X	X	X	
NM Annual Strategies for Success (A-SFS)	X	X			
NM Baseline/Posttest Strategies for Success (BP-SFS)	X				
NM Opioid Prescribers Survey (OPS)				X	
Forms for tracking naloxone distribution			X		
Naloxone training evaluation tools			X		
Tool for tracking naloxone use			X		
NM Youth Risk and Resiliency Survey (YRRS or YRBSS)	X	X			
NM Behavioral Risk Factors Surveillance Survey (BRFSS)	X	X			
NM National Survey of Drug Use and Health (NSDUH)	X	X			

**Data Collection Schedule for State Level Data**

<b>Primary Data<sup>‡</sup></b>	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
NM Community Survey									X	X	X	
NM Annual Strategies for Success (A-SFS)											X	
NM Baseline-Post Strategies for Success (BP-SFS)											X	
Media Activities Data	X											
Synar Inspection Data	X											
NM Opioid Prescribers Survey (OPS)	X											
Forms for tracking naloxone distribution	X	X	X	X	X	X	X	X	X	X	X	X
Naloxone training evaluation tools	X	X	X	X	X	X	X	X	X	X	X	X
Tool for tracking naloxone use	X	X	X	X	X	X	X	X	X	X	X	X
Program Periodic Reports	X						X					
Training and TA	X	X	X	X	X	X	X	X	X	X	X	X
Meeting Minutes (e.g., SEOW, PDO Advisory, PDO CQI, PPC, etc.)	X	X	X	X	X	X	X	X	X	X	X	X
Monthly Progress Reports for STAR	X	X	X	X	X	X	X	X	X	X	X	X
SPF Rx Annual Implementation Instrument (AII) (in SPARS)							X					
SAMHSA Performance Accountability and Reporting System (SPARS) – SPF Rx & PFS 15 Quarterly reporting	X			X			X			X		
PFS 2015 PEP-C EBPPP and Annual Community Outcomes				X								
<b>Secondary Data*</b>												
Youth Risk and Resiliency Survey Data (YRRS) <sup>†</sup>		X	X									
Behavioral Risk Factor Surveillance Survey Data (BRFSS)		X	X									
National Survey on Drug Use and Health Data (NSDUH)		X	X									
Alcohol-Related Motor Vehicle Crash Data (ARMVC)												X
Prescription Drug Monitoring Program Data (PMP)	X			X			X			X		
Death Data		X	X									
NM Dept. of Public Safety, Special Investigations Unit (SIU) data	X						X					

<sup>‡</sup> Collected; reported

\* Reviewed; analyzed

<sup>†</sup> Available every other year

**Data Collection Schedule for Local Level Data**

<b>Primary Data<sup>†</sup></b>	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
NM Community Survey									X	X	X	
NM Annual Strategies for Success (A-SFS)			X	X	X	X	X	X	X	X	X	
NM Baseline-Post Strategies for Success (BP-SFS)		X	X	X	X	X	X	X	X	X	X	
Media Activities Data (Alcohol &/or Rx Drug related)	X	X	X	X	X	X	X	X	X	X	X	X
Educational Materials, Training Events & Activities (e.g., RBS; Parent Handbooks)	X	X	X	X	X	X	X	X	X	X	X	X
Alcohol Pricing/Advertising/Placement/Location data	X	X	X	X	X	X	X	X	X	X	X	X
Take Back Events Data	X	X	X	X	X	X	X	X	X	X	X	X
Rx Drop Box Data	X	X	X	X	X	X	X	X	X	X	X	X
Lock Box Distribution Data	X	X	X	X	X	X	X	X	X	X	X	X
Pharmacy- Rx Drug Data	X	X	X	X	X	X	X	X	X	X	X	X
Other Prevention Activities Data	X	X	X	X	X	X	X	X	X	X	X	X
Synar Inspection Data	X	X	X	X	X	X	X	X	X	X	X	X
NM Opioid Prescribers Survey (OPS)	X											
Narcan/Naloxone Training and Distribution Forms	X	X	X	X	X	X	X	X	X	X	X	X
Naloxone Training & Evaluation Forms	X	X	X	X	X	X	X	X	X	X	X	X
Narcan/Naloxone Record of Use	X	X	X	X	X	X	X	X	X	X	X	X
Meeting Minutes (e.g., Coalition, etc.)	X	X	X	X	X	X	X	X	X	X	X	X
PFS 2015 PEP-C EBPPP (#s reached and served by strategy)	X	X	X	X	X	X	X	X	X	X	X	X
SPF Rx Annual Implementation Instrument (AII)	X	X	X	X	X	X	X	X	X	X	X	X
<b>Secondary Data*</b>												
Arrest Data/CYFD Data							X					X
Outlet Density Data							X					
School Disciplinary Activities Data							X					X
Local Law Enforcement Activity Data	X	X	X	X	X	X	X	X	X	X	X	X
NM Dept. of Public Safety, Special Investigations Unit (SIU) data	X						X					

† Collected; reported

\* Reviewed; analyzed

## Quality and Data Collection Readiness

New Mexico gathers data on mental health needs, gaps, problems, responses, and progress using a complex, multi-faceted reporting system that joins administrative information systems data with purposeful reporting, surveying, and data capture processes and epidemiological analyses. Primary data for the public behavioral health services system comes from client registration processes in Medicaid and in providers' access to the ASO's registration system, coupled with comprehensive detail on the claims and encounters of those clients with the system. Claims are extremely detailed as to rendering and billing provider, diagnoses, procedure type and intensity, date, time, location, billed and paid amounts, and claim processing particulars. That information is complemented with diverse additional sources, including:

1. Survey-based consumer satisfaction measurement systems for adults, youth, and family members of children involved with the system;
2. Admission and discharge records for the state behavioral health institute (state hospital);
3. Service records from invoice-based providers for services such as SBIRT, supportive housing, certain opiate treatment efforts, nursing home admissions screenings, and behavioral health care for the homeless;
4. Emergency department and hospital inpatient discharge data related to behavioral health issues;
5. Mortality and medical investigator records;
6. Behavioral health quality and performance reports from Medicaid managed care organizations and from the ASO;
7. Provider record reviews and site visits;
8. Child welfare databases regarding children's social services, foster care, and juvenile justice;
9. Public education records regarding educational achievement, enrollment, and attendance.

New Mexico is fortunate to have an integrated records system at the state level that joins all Medicaid client and claims data in a central state repository in a very timely fashion, with strong analysis tools, and including all Medicaid behavioral health and physical health encounters in a standard form, covering both mental illness and substance abuse issues, and both for adults and children. That system remains separate from non-Medicaid behavioral health records, but HSD is working to join those in the medium term, as part of its data warehouse integration project and as part of its Medicaid Managed Care System enhancements associated with the SAMHSA/CMS BH-Medicaid Information Technology Architecture (MITA) principles. In the interim, BHSD has developed processes that allow drawing data from multiple sources in fashions that allow for de-duplication across systems, tracking clients' services across multiple payers' diverse data sources, and matching clients between systems to gain a complete understanding of how the services related to their needs or they fell short.

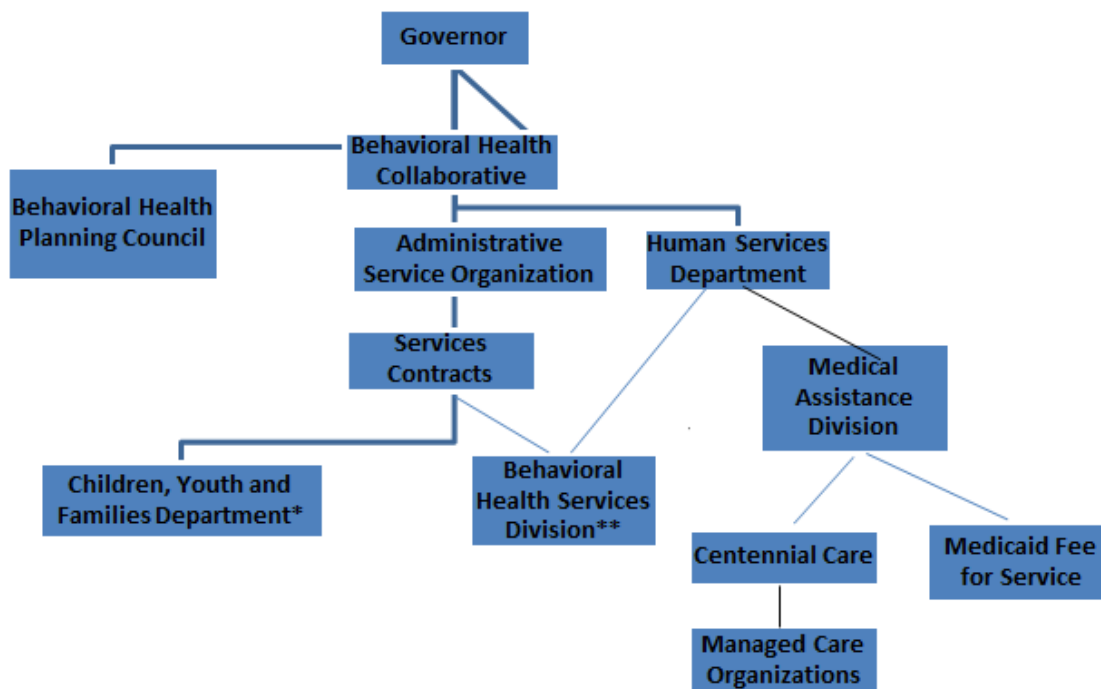
New Mexico's current data collection systems on substance abuse and mental illness are part of larger systems, for Medicaid clients, and separate, for non-Medicaid clients, but with the capability to match non-Medicaid clients with their Medicaid records to allow a more complete picture of the clients' experiences with the physical and behavioral health systems. The reporting systems for Medicaid and non-Medicaid services are largely distinct, but with processes to bridge those to permit integrated, comprehensive reports on physical/behavioral health and on mental illness/substance abuse. The

Medicaid system, in turn, has links to the state’s larger human services systems for nutritional assistance (SNAP), home energy assistance (LIHEAP), cash assistance, Medicare premium payments, and more.

New Mexico is currently able to collect and report on some of the proposed new quality measures at the individual level, while others currently are not available through current systems. For example, with some refinements the state can report on employment of substance abuse clients, educational attendance, new criminal charges, and DWI arrests. The system currently does not allow for tracking providers’ conversations with clients other than those associated with procedure codes, so the shared-decision-making measure can’t be tracked by individual, nor can suicidal ideation, prescription drug misuse, stable housing, or homelessness. Screening information for tobacco use, underage drinking, or depression is sometimes available from certain providers and payers, but is not universally captured by providers under current processes. Depression screening at 12 months for remission is not currently universally conducted nor captured.

New Mexico contemplates developing various provider compensation processes to promote their capture of the additional measures, in tandem with claims- or outcome-associated coding and submission mechanisms to allow capture at the MCO and state level. The systems involved are fragile and complex, so each measure requires careful design and collaboration across systems in order to obtain meaningful results. Many of the measures are currently captured at the system level rather than individual ones, with survey methods, and the benefit to being able to track those down to the individual level remains unclear in view of the problematic reporting and privacy issues involved.

Below is a flow chart depicting New Mexico’s Block Grant Reporting Flow.





# Planning Tables

**Table 1 Priority Areas and Annual Performance Indicators**

**Priority #:** 1  
**Priority Area:** Access to Medication Assisted Treatment (MAT)  
**Priority Type:** SAT  
**Population(s):** PWWDC, PP, PWID

**Goal of the priority area:**

Increase access to Medication- Assisted Treatment (MAT) using the three FDA- approved medications for the treatment of opioid use disorder.

**Objective:**

Train 50% of state detention centers in MAT

**Strategies to attain the objective:**

Leverage the State Opioid Response Grant 2018-2020, partnerships with state, county and city stakeholders and detention centers and MAT providers.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1  
**Indicator:** Number of detention centers trained in MAT  
**Baseline Measurement:** 0 Flor still checking if this is people or detention centers  
**First-year target/outcome measurement:** 16 Detention Centers  
**Second-year target/outcome measurement:** 16 Detention Centers

**Data Source:**

BHSD and UNM ECHO Data

**Description of Data:**

**Data issues/caveats that affect outcome measures::**

**Indicator #:** 2  
**Indicator:** Number State Approved Adult Residential Treatment Centers (RTC) utilizing MAT  
**Baseline Measurement:** 0  
**First-year target/outcome measurement:** 2  
**Second-year target/outcome measurement:** 2

**Data Source:**

Human Services Department Data (Behavioral Health Services Division and Medical Assistance Division)

**Description of Data:**

Training and Certification Certificates

**Data issues/caveats that affect outcome measures::**

**Priority #:** 2  
**Priority Area:** Safer Opioid Prescribing  
**Priority Type:** SAT  
**Population(s):** PWWDC, PP, PWID

**Goal of the priority area:**

Increase safer opioid prescribing skills

**Objective:**

Host safer opioid prescribing trainings in treatment

**Strategies to attain the objective:**

Leverage SOR Grant, ECHO Model and partnerships with stakeholders and providers.

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1  
**Indicator:** Number of prescribers/providers trained in safer opioid prescribing skills  
**Baseline Measurement:** 0  
**First-year target/outcome measurement:** 100  
**Second-year target/outcome measurement:** 100

**Data Source:**

NM Human Services Department Behavioral Health Services Department and University of NM.

**Description of Data:**

Training certifications issued.

**Data issues/caveats that affect outcome measures::**

**Indicator #:** 2  
**Indicator:** Number of trainings on safer opioid prescribing skills  
**Baseline Measurement:** 0  
**First-year target/outcome measurement:** 3  
**Second-year target/outcome measurement:** 3

**Data Source:**

NM Human Services Department and University of NM Data

**Description of Data:**

Trainings completed and certifications issued.

**Data issues/caveats that affect outcome measures::**

**Priority #:** 3  
**Priority Area:** Workforce Development  
**Priority Type:** MHS  
**Population(s):** SMI, SED, PWWDC, PP, ESMI, PWID

**Goal of the priority area:**

Increase the number of Certified Peer Support Workers

**Objective:**

Host certification trainings

**Strategies to attain the objective:**

Schedule trainings in rural and frontier areas

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1

**Indicator:** Number of Certified Peer Support Worker Trainings

**Baseline Measurement:** 4

**First-year target/outcome measurement:** 2

**Second-year target/outcome measurement:** 2

**Data Source:**

NM Human Services, Behavioral Health Services Division, Office of Peer Recovery and Engagement

**Description of Data:**

Completed scheduled trainings and number if certifications issued.

**Data issues/caveats that affect outcome measures::**

**Indicator #:** 2

**Indicator:** Number of State recognized Certified Peer Support Worker specialty endorsements for targeted populations.

**Baseline Measurement:** 0

**First-year target/outcome measurement:** 1

**Second-year target/outcome measurement:** 3

**Data Source:**

NM Human Services Department, Behavioral Health Services Division, Office of Peer Recovery and Engagement

**Description of Data:**

State approved specialty endorsement recognition of CPSW specialty endorsements:

- Supportive Housing
- Veterans
- Older Adults

**Data issues/caveats that affect outcome measures::**

**Priority #:** 4

**Priority Area:** Binge Drinking & Underage Drinking

**Priority Type:** SAP

**Population(s):** Other (Adolescents w/SA and/or MH, Students in College, Rural, Underserved Racial and Ethnic Minorities)

**Goal of the priority area:**

**Objective:**

**Strategies to attain the objective:**

For youth, reduce social access through Social Host ordinances, Parent Party Patrols, Parents Who Host Lose the Most campaigns, and media to increase awareness of the problem; reduce retail access through restrictions on alcohol placement, advertising, and sales; strengthen law enforcement of minors in possession laws, sales to minors laws, providing alcohol to minors laws, and age verification, and strengthening enforcement of school ATOD policies. For adults, reduce retail access through restrictions on alcohol placement and hours of sales, outlet density, alcohol license transfers, and the Responsible Beverage Service Model; strengthen law enforcement of sales to intoxicated patrons and DWI laws, increase sobriety checkpoints and saturation patrols; and increased perceived risk of arrest through the publication of law

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1  
**Indicator:** New Mexico High School Students who Report Drinking Alcohol in past 30 Days  
**Baseline Measurement:** 26.2% among grades 9-12, 2017 available FY2020  
**First-year target/outcome measurement:** Progress to end of SFY 2021: 26.1% (2019 data available)  
**Second-year target/outcome measurement:** Progress to end of SFY 2022: 26.0%

**Data Source:**

NM Youth Risk & Resiliency Survey (YRRS)

**Description of Data:**

Survey of schools conducted every two years

**Data issues/caveats that affect outcome measures::**

Data is collected every two years, so no updates are available in the year in between

**Indicator #:** 2  
**Indicator:** NM HS Students who Binge Drank in Past 30 Days  
**Baseline Measurement:** 10.9% among grades 9-12, 2017 available in FY2020  
**First-year target/outcome measurement:** Progress to end of SYF 2021: 9.9%  
**Second-year target/outcome measurement:** Final to end of SYF 2022: 8.9%

**Data Source:**

NM Youth Risk & Resiliency Survey (YRSS)

**Description of Data:**

Survey data of schools collected every two years

**Data issues/caveats that affect outcome measures::**

Since data is collected every two years, so no updates are available in the year in between  
New Data issues/caveats that affect outcome measures:

**Indicator #:** 3

**Indicator:** NM Adults who Binge Drank in Past 30 Days  
**Baseline Measurement:** 14.7% among adults 18+, 2017 available in FY20  
**First-year target/outcome measurement:** Progress to end of SYF 2019: 14.6%  
**Second-year target/outcome measurement:** Final to end of SYF 2020: 14.5

**Data Source:**

NM Behavioral Risk Factor Surveillance System (BRFSS)

**Description of Data:**

Phone survey

**Data issues/caveats that affect outcome measures::**

Phone survey, so misses people with no land line or cell phone  
2018 BRFSS data not available/finalized yet from NMDOH

**Priority #:** 5  
**Priority Area:** Prescription Drug Misuse & Abuse  
**Priority Type:** SAP  
**Population(s):** Other (Adolescents w/SA and/or MH, Students in College, Rural, Underserved Racial and Ethnic Minorities)

**Goal of the priority area:**

Reduce the misuse of prescription drugs

**Objective:**

**Strategies to attain the objective:**

Coordinate prescription drug misuse/abuse prevention services across state agencies (map resources, identify gaps, identify effective strategies, develop implementation plan; work to improve detection of abuse with treatment providers and law enforcement); improve data collection, analysis, and access to identify key indicators, integrate into reporting requirements and applications; consistently collect identified indicators among representative sample of youth (NM YRRS); and improve cross agency training on PDA to increase workforce competencies & use of EBPs (provide prescription drug abuse prevention training online)

**Annual Performance Indicators to measure goal success**

**Indicator #:** 1  
**Indicator:** NM HS students who report using pain killers to get high in past 30 days  
**Baseline Measurement:** 6.9% among grades 9-12, 2017 available in FY2020  
**First-year target/outcome measurement:** Progress to end of SFY 2021: 6.65%  
**Second-year target/outcome measurement:** Final to end of SFY 2022: 6.4%

**Data Source:**

NM Youth Risk & Resiliency Survey (YRRS)

**Description of Data:**

Survey data of schools conducted every two years

**Data issues/caveats that affect outcome measures::**

Since data is collected every two years, so no updates are available in the year in between.

**Indicator #:** 2  
**Indicator:** Pain relievers misuse in past year, 12 years of age +  
**Baseline Measurement:** 4.15% among age 12 and over, 2013-2014 available in FY2020  
**First-year target/outcome measurement:** Progress to end of SFY 2021: 4.05%  
**Second-year target/outcome measurement:** Progress to end of SFY 2022: 3.95%

**Data Source:**

National Survey on Drug Use & Health (NSDUH)

**Description of Data:**

Survey data

**Data issues/caveats that affect outcome measures::**

N/A

**Indicator #:** 3  
**Indicator:** Prescription drug overdose death rates per 100,000  
**Baseline Measurement:** 15.4 deaths per 100,000; 2017 available in FY2020  
**First-year target/outcome measurement:** 15.3 deaths per 100,000 in FY21  
**Second-year target/outcome measurement:** 15.2 deaths per 100,000 in FY22

**Data Source:**

NM Bureau of Vital Record & Health Statistics (BVRHS), 2018

**Description of Data:**

Vital records

**Data issues/caveats that affect outcome measures::**

2018 BVRHS data not available/finalized yet from NMDOH

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

**Footnotes:**

## Planning Tables

**Table 2 State Agency Planned Expenditures [SA]**

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2020/2021. ONLY include funds expended by the executive branch agency administering the SABG

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	\$6,406,240		\$48,982,779	\$0	\$13,241,058	\$0	\$0
a. Pregnant Women and Women with Dependent Children**	\$1,573,161		\$0	\$0	\$0	\$0	\$0
b. All Other	\$4,833,079		\$48,982,779	\$0	\$13,241,058	\$0	\$0
2. Primary Prevention	\$2,679,525		\$0	\$2,546,740	\$0	\$0	\$0
a. Substance Abuse Primary Prevention	\$0		\$0	\$0	\$0	\$0	\$0
b. Mental Health Primary Prevention							
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)							
4. Tuberculosis Services	\$0		\$0	\$0	\$0	\$0	\$0
5. Early Intervention Services for HIV	\$0		\$0	\$0	\$0	\$0	\$0
6. State Hospital							
7. Other 24 Hour Care							
8. Ambulatory/Community Non-24 Hour Care							
9. Administration (Excluding Program and Provider Level)	\$478,198		\$0	\$0	\$0	\$0	\$0
<b>10. Total</b>	<b>\$9,563,963</b>	<b>\$0</b>	<b>\$48,982,779</b>	<b>\$2,546,740</b>	<b>\$13,241,058</b>	<b>\$0</b>	<b>\$0</b>

\* Prevention other than primary prevention

\*\* The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.

**Footnotes:**



# Planning Tables

**Table 2 State Agency Planned Expenditures [MH]**

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2020/2021.

Planning Period Start Date: 7/1/2019      Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention							
a. Substance Abuse Primary Prevention							
b. Mental Health Primary Prevention <sup>†</sup>		\$0	\$0	\$0	\$0	\$0	\$0
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)**		\$407,014	\$0	\$0	\$0	\$0	\$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			\$588,298	\$0	\$95,644	\$0	\$0
7. Other 24 Hour Care		\$0	\$0	\$0	\$0	\$0	\$0
8. Ambulatory/Community Non-24 Hour Care		\$3,459,621	\$139,262,985	\$2,557,472	\$19,075,685	\$0	\$0
9. Administration (Excluding Program and Provider Level)***		\$203,507	\$0	\$0	\$0	\$0	\$0
<b>10. Total</b>	<b>\$0</b>	<b>\$4,070,142</b>	<b>\$139,851,283</b>	<b>\$2,557,472</b>	<b>\$19,171,329</b>	<b>\$0</b>	<b>\$0</b>

\* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

\*\* Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside

\*\*\* Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.

**Footnotes:**

8/27/19

Column C Row 8: Includes Children's Medicaid services and is an estimate based on an average of the last three fiscal year expenditures.

Column C Row 6: An estimate based on the average of the last three fiscal year expenditures.

# Planning Tables

**Table 3 SABG Persons in need/receipt of SUD treatment**

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	1280	34
2. Women with Dependent Children	0	0
3. Individuals with a co-occurring M/SUD	21000	686
4. Persons who inject drugs	92500	368
5. Persons experiencing homelessness	2359	275

**Please provide an explanation for any data cells for which the state does not have a data source.**

Row 2 is not available. Claims systems did not capture women with dependent children. HSD is in the process of updating claims and data systems and will work to include this data element.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

**Footnotes:**

# Planning Tables

**Table 4 SABG Planned Expenditures**

Planning Period Start Date: 10/1/2019      Planning Period End Date: 9/30/2021

Expenditure Category	FFY 2020 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment *	\$6,406,240
2 . Primary Substance Abuse Prevention	\$2,679,525
3 . Early Intervention Services for HIV **	\$0
4 . Tuberculosis Services	\$0
5 . Administration (SSA Level Only)	\$478,198
<b>6. Total</b>	<b>\$9,563,963</b>

\* Prevention other than Primary Prevention

\*\* For the purpose of determining the states and jurisdictions that are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state's AIDS case

rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

0930-0168 Approved: 06/07/2017 Expires: 06/30/2020

**Footnotes:**

8/2019

Table 4 Table 4 Primary Prevention amount of 2,758,525 and Total of 9,563,963 are correct amounts.

Table 5a Primary Prevention is 2,020,525

Table 6 Resource Development is 738,000 comes from Primary Prevention Table 4 Row 2.

# Planning Tables

**Table 5a SABG Primary Prevention Planned Expenditures**

Planning Period Start Date: 10/1/2019    Planning Period End Date: 9/30/2021

Strategy	A	B
	IOM Target	FFY 2020 SA Block Grant Award
1. Information Dissemination	Universal	\$104,366
	Selective	
	Indicated	
	Unspecified	
	<b>Total</b>	<b>\$104,366</b>
2. Education	Universal	
	Selective	\$94,500
	Indicated	
	Unspecified	
	<b>Total</b>	<b>\$94,500</b>
3. Alternatives	Universal	\$9,500
	Selective	
	Indicated	
	Unspecified	
	<b>Total</b>	<b>\$9,500</b>
4. Problem Identification and Referral	Universal	\$2,500
	Selective	
	Indicated	
	Unspecified	
	<b>Total</b>	<b>\$2,500</b>
	Universal	\$1,325,750

5. Community-Based Process	Selective	
	Indicated	
	Unspecified	
	<b>Total</b>	<b>\$1,325,750</b>
6. Environmental	Universal	\$350,500
	Selective	
	Indicated	
	Unspecified	
	<b>Total</b>	<b>\$350,500</b>
7. Section 1926 Tobacco	Universal	\$133,409
	Selective	
	Indicated	
	Unspecified	
	<b>Total</b>	<b>\$133,409</b>
8. Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	<b>Total</b>	<b>\$0</b>
<b>Total Prevention Expenditures</b>		<b>\$2,020,525</b>
<b>Total SABG Award*</b>		<b>\$9,563,963</b>
<b>Planned Primary Prevention Percentage</b>		<b>21.13 %</b>

\*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

0930-0168 Approved: 06/07/2017 Expires: 06/30/2020

**Footnotes:**

9/2019

With the exception of Education, New Mexico does not collect this data by IOM classification.

# Planning Tables

**Table 5b SABG Primary Prevention Planned Expenditures by IOM Category**

Planning Period Start Date: 10/1/2019      Planning Period End Date: 9/30/2021

Activity	FFY 2020 SA Block Grant Award
Universal Direct	
Universal Indirect	
Selective	
Indicated	
<b>Column Total</b>	<b>\$0</b>
<b>Total SABG Award*</b>	<b>\$9,563,963</b>
<b>Planned Primary Prevention Percentage</b>	<b>0.00 %</b>

\*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

0930-0168 Approved: 06/07/2017 Expires: 06/30/2020

**Footnotes:**

Not Applicable



## Planning Tables

**Table 5c SABG Planned Primary Prevention Targeted Priorities**

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2020 and FFY 2021 SABG awards.

Planning Period Start Date: 10/1/2019    Planning Period End Date: 9/30/2021

Targeted Substances	
Alcohol	<input checked="" type="checkbox"/>
Tobacco	<input checked="" type="checkbox"/>
Marijuana	<input type="checkbox"/>
Prescription Drugs	<input checked="" type="checkbox"/>
Cocaine	<input type="checkbox"/>
Heroin	<input type="checkbox"/>
Inhalants	<input type="checkbox"/>
Methamphetamine	<input type="checkbox"/>
Synthetic Drugs (i.e. Bath salts, Spice, K2)	<input type="checkbox"/>
Targeted Populations	
Students in College	<input checked="" type="checkbox"/>
Military Families	<input type="checkbox"/>
LGBTQ	<input type="checkbox"/>
American Indians/Alaska Natives	<input checked="" type="checkbox"/>
African American	<input type="checkbox"/>
Hispanic	<input checked="" type="checkbox"/>
Homeless	<input type="checkbox"/>
Native Hawaiian/Other Pacific Islanders	<input type="checkbox"/>
Asian	<input type="checkbox"/>
Rural	<input checked="" type="checkbox"/>
Underserved Racial and Ethnic Minorities	<input checked="" type="checkbox"/>

**Footnotes:**

# Planning Tables

**Table 6 Non-Direct Services/System Development [SA]**

Planning Period Start Date: 10/1/2019      Planning Period End Date: 9/30/2021

FY 2020			
Activity	A. SABG Treatment	B. SABG Prevention	C. SABG Combined*
1. Information Systems		\$5,000	
2. Infrastructure Support		\$0	
3. Partnerships, community outreach, and needs assessment		\$139,500	
4. Planning Council Activities (MHBG required, SABG optional)			
5. Quality Assurance and Improvement		\$47,500	
6. Research and Evaluation		\$258,000	
7. Training and Education		\$288,000	
<b>8. Total</b>	<b>\$0</b>	<b>\$738,000</b>	<b>\$0</b>

\*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

0930-0168 Approved: 06/07/2017 Expires: 06/30/2020

**Footnotes:**

9/2019

Table 4 Table 4 Primary Prevention amount of 2,758,525 and Total of 9,563,963 are correct amounts.

Table 5a Primary Prevention is 2,020,525

Table 6 Resource Development is 738,000 comes from Primary Prevention Table 4 Row 2.

## Planning Tables

**Table 6 Non-Direct-Services/System Development [MH]**

MHBG Planning Period Start Date:

MHBG Planning Period End Date:

Activity	FFY 2020 Block Grant
1. Information Systems	\$0
2. Infrastructure Support	\$0
3. Partnerships, community outreach, and needs assessment	\$0
4. Planning Council Activities (MHBG required, SABG optional)	\$61,600
5. Quality Assurance and Improvement	\$0
6. Research and Evaluation	\$0
7. Training and Education	\$0
<b>8. Total</b>	<b>\$61,600</b>

0930-0168 Approved: 06/07/2017 Expires: 06/30/2020

**Footnotes:**

# Environmental Factors and Plan

## 1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

### Narrative Question

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Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.<sup>22</sup> Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.<sup>23</sup> It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.<sup>24</sup>

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.<sup>25</sup> SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.<sup>26</sup> For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.<sup>27</sup>

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.<sup>28</sup>

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.<sup>29</sup> The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.<sup>30</sup> Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes<sup>31</sup> and ACOs<sup>32</sup> may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.<sup>33</sup> Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.<sup>34</sup>

One key population of concern is persons who are dually eligible for Medicare and Medicaid.<sup>35</sup> Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.<sup>36</sup> SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.<sup>37</sup> Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.<sup>38</sup> SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration. SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.<sup>39</sup> Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs. SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.<sup>40</sup>

SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.<sup>41</sup> However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

<sup>22</sup> BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. *Med Care*. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, *Bulletin of the World Health Organization*, 2013; 91:102-123 <http://www.who.int/bulletin/volumes/91/2/12-108282.pdf>; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, *World Psychiatry*. Feb 2011; 10(1): 52-77

<sup>23</sup> Research Review of Health Promotion Programs for People with SMI, 2012, <http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper>; About SAMHSA's Wellness Efforts, <https://www.samhsa.gov/wellness-initiative>; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, *JAMA*; 2007; 298: 1794-1796; Million Hearts, <https://www.samhsa.gov/health-care-health-systems-integration>; Schizophrenia as a health disparity, <http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml>

<sup>24</sup> Comorbidity: Addiction and other mental illnesses, <http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses> Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, *JAMA Psychiatry*. 2014; 71(3):248-254. doi:10.1001/jamapsychiatry.2013.3726; <http://www.samhsa.gov/co-occurring/>

<sup>25</sup> Social Determinants of Health, Healthy People 2020, <http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39>; <https://www.cdc.gov/nchstp/socialdeterminants/index.html>

<sup>26</sup> <http://www.samhsa.gov/health-disparities/strategic-initiatives>

<sup>27</sup> <http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/>

<sup>28</sup> Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. [https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating\\_12.22.pdf](https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf); Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, <https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf>; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. <http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf>; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, <http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf>; American Psychiatric Association, <http://www.psych.org/practice/professional-interests/integrated-care>; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series ( 2006), Institute of Medicine, National Affordable Care Academy of Sciences, [http://books.nap.edu/openbook.php?record\\_id=11470&page=210](http://books.nap.edu/openbook.php?record_id=11470&page=210); State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, <http://nasadad.org/nasadad-reports>

<sup>29</sup> Health Care Integration, <http://samhsa.gov/health-reform/health-care-integration>; SAMHSA-HRSA Center for Integrated Health Solutions, (<http://www.integration.samhsa.gov/>)

<sup>30</sup> Health Information Technology (HIT), <http://www.integration.samhsa.gov/operations-administration/hit>; Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series, <https://www.integration.samhsa.gov/operations-administration/telebehavioral-health>; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, <http://www.americantelemed.org/home>; National Telehealth Policy Resource Center, <http://telehealthpolicy.us/medicaid>;

<sup>31</sup> Health Homes, <http://www.integration.samhsa.gov/integrated-care-models/health-homes>

<sup>32</sup> New financing models, <https://www.integration.samhsa.gov/financing>

<sup>33</sup> Waivers, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html>; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf>

<sup>34</sup> What are my preventive care benefits? <https://www.healthcare.gov/what-are-my-preventive-care-benefits/>; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); <http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html>

<sup>35</sup> Medicare-Medicaid Enrollee State Profiles, <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html>; About the Compact of Free Association, <http://uscompact.org/about/cofa.php>

<sup>36</sup> Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, <http://www.cbo.gov/publication/44308>

<sup>37</sup> BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

<sup>38</sup> TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

<sup>39</sup> Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, <http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORk/PEP13-RTC-BHWORk.pdf>; Creating jobs by addressing primary care workforce needs, <https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n>

<sup>40</sup> About the National Quality Strategy, <http://www.ahrq.gov/workingforquality/about.htm>; National Behavioral Health Quality Framework, Draft, August 2013, <http://samhsa.gov/data/NBHQF>

<sup>41</sup> Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, <http://www.cms.gov/ccio/resources/letters/index.html>; Affordable Care Act, Indian Health Service, <http://www.ihs.gov/ACA/>

**Please respond to the following items in order to provide a description of the healthcare system and integration activities:**

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.  
  
New Mexico is participating in the Medicaid expansion under the provisions of the Affordable Care Act (ACA). The New Mexico Human Services Department (HSD) proposed improvements to the Centennial Care 2.0 program and sought input from stakeholders throughout New Mexico for consideration before submitting a final waiver amendment to the federal Centers for Medicare and Medicaid Services (CMS).  
HSD released a draft Section 1115 Demonstration Waiver amendment application for Centennial Care 2.0. The draft amendment outlined HSD's modifications to improve the program. HSD sought federal authority to amend the 1115 Centennial Care 2.0 Waiver.
2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.  
  
Centennial Care 2.0 features an integrated, comprehensive Medicaid delivery system in which a member's Managed Care Organization (MCO) is responsible for coordinating his/her full array of services, including acute care (including pharmacy), behavioral health services, institutional services and home and community-based services (HCBS).  
The waiver amendment provides the opportunity for the state to continue advancing successful initiatives under the demonstration while continuing to implement new, targeted initiatives to address specific gaps in care and improve healthcare outcomes for Centennial Care members. Key initiatives under the Centennial Care 2.0 program include:
  - Refine care coordination to better meet the needs of high-cost, high-need members, especially during transitions in their setting of care;
  - Continue to expand access to long-term services and supports (LTSS) and maintain the progress achieved through rebalancing efforts to serve more members in their homes and communities;
  - Improve the integration of behavioral and physical health services, with greater emphasis on other social factors that impact population health;
  - Expand payment reform through value-based purchasing arrangements to achieve improved quality and better health outcomes;
  - Continue the Safety Net Care Pool and time-limited Hospital Quality Improvement Initiative; and
  - Further simplify administrative complexities and implement refinements in program and benefit design.
3. a) Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs?  Yes  No  
  
b) and Medicaid?  Yes  No



4. Who is responsible for monitoring access to M/SUD services by the QHP?

Centennial Care Managed Care Organizations and Conduent for Fee for Service are responsible for monitoring services by the QHP.

There are three MCOs that HSD currently contracts with to administer the Centennial Care program:

- 1. Blue Cross Community Centennial
- 2. Presbyterian Health Plan
- 3. Western Sky Community Care

Native Americans can choose to opt out of Centennial Care, and are placed in the Fee for Service program. New Mexico's Medicaid program has fee for service providers that are managed by Conduent.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state?  Yes  No

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education  Yes  No

b) Health risks such as

ii) heart disease  Yes  No

iii) hypertension  Yes  No

iv) high cholesterol  Yes  No

v) diabetes  Yes  No

c) Recovery supports  Yes  No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care?  Yes  No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services?  Yes  No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

The NM Office of Superintendent of Insurance (OSI) works to ensure compliance with all Parity law provisions. BHSD is initiating monitoring efforts with the OSI to ensure all insurance plans offered in NM provide are in compliance with the Parity law. Medicaid covers 50% of NM health insurance and NM has ensured that Medicaid is 100% compliant with Parity law.

10. Does the state have any activities related to this section that you would like to highlight?

New Mexico lawmakers passed new legislation designed to close gaps in the state's current telehealth insurance coverage law, provide coverage clarity to patients, and ensure payment parity to in-network health care providers. The Legislature passed, nearly unanimously (98-1), legislation ensuring that commercial health plans will cover medical services delivered in-person or via telemedicine. Excerpt from the National Law Review April 3, 2019

The bill was signed into law by Governor Michelle Lujan Grisham on 4/4/2019.

Please indicate areas of technical assistance needed related to this section

N/A

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**Footnotes:**

# Environmental Factors and Plan

## 2. Health Disparities - Requested

### Narrative Question

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In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)<sup>42</sup>, [Healthy People, 2020](#)<sup>43</sup>, [National Stakeholder Strategy for Achieving Health Equity](#)<sup>44</sup>, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for [Culturally and Linguistically Appropriate Services in Health and Health Care](#) (CLAS)<sup>45</sup>.

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."<sup>46</sup>

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status<sup>47</sup>. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations<sup>48</sup>. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

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<sup>42</sup> [http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS\\_Plan\\_complete.pdf](http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf)

<sup>43</sup> <http://www.healthypeople.gov/2020/default.aspx>

<sup>44</sup> [https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS\\_07\\_Section3.pdf](https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf)

<sup>45</sup> <http://www.ThinkCulturalHealth.hhs.gov>

**Please respond to the following items:**

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?
  - a) Race  Yes  No
  - b) Ethnicity  Yes  No
  - c) Gender  Yes  No
  - d) Sexual orientation  Yes  No
  - e) Gender identity  Yes  No
  - f) Age  Yes  No
2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population?  Yes  No
3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers?  Yes  No
4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations?  Yes  No
5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards?  Yes  No
6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care?  Yes  No
7. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

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**Footnotes:**

## Environmental Factors and Plan

### 3. Innovation in Purchasing Decisions - Requested

#### Narrative Question

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While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

$$\text{Health Care Value} = \text{Quality} \div \text{Cost}, (\mathbf{V} = \mathbf{Q} \div \mathbf{C})$$

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,<sup>49</sup> The New Freedom Commission on Mental Health,<sup>50</sup> the IOM,<sup>51</sup> NQF, and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).<sup>52</sup> The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."<sup>53</sup> SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series (**TIPS**)<sup>54</sup> are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (**KIT**)<sup>55</sup> was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

<sup>49</sup> United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

<sup>50</sup> The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

<sup>51</sup> Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

<sup>52</sup> National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

<sup>53</sup> <http://psychiatryonline.org/>

<sup>54</sup> <http://store.samhsa.gov>

<sup>55</sup> <http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf>

**Please respond to the following items:**

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions?  Yes  No
  
2. Which value based purchasing strategies do you use in your state (check all that apply):
  - a)  Leadership support, including investment of human and financial resources.
  - b)  Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
  - c)  Use of financial and non-financial incentives for providers or consumers.
  - d)  Provider involvement in planning value-based purchasing.
  - e)  Use of accurate and reliable measures of quality in payment arrangements.
  - f)  Quality measures focus on consumer outcomes rather than care processes.
  - g)  Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
  - h)  The state has an evaluation plan to assess the impact of its purchasing decisions.
  
3. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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**Footnotes:**

## Environmental Factors and Plan

### 4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

#### Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention\* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (**RAISE**) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

\* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

#### Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)?  Yes  No
2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI?  Yes  No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

The EARLY Program, located within the Department of Psychiatry and Behavioral Sciences, University of New Mexico Health Sciences, provides Coordinated Specialty Care (CSC) to individuals ages 15-30 living in Bernalillo County who are experiencing a first episode psychosis (FEP). In addition, the EARLY program offers community outreach and provider training and consultation across the state of New Mexico.

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?  
New Mexico has integrated behavioral health and physical health under its 1115 Medicaid managed care waiver, Centennial Care.
4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI?  Yes  No
5. Does the state collect data specifically related to ESMI?  Yes  No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI?  Yes  No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

The EARLY Program, located within the Department of Psychiatry at the University of New Mexico (UNM), provides evidence based Coordinated Specialty Care (CSC) to individuals aged 15-30 years old, living in New Mexico, and experiencing a first episode psychosis (FEP) within the past 12 months. Program staff utilize aspects of multiple CSC models (NAVIGATE, EASA, OnTrackNY, etc.) to best accommodate individual needs while striving for fidelity to the general evidence based model as outlined in the First Episode Psychosis Services Fidelity Scale (FEPS-FS). EARLY program staff have received training in and utilize both Cognitive Behavioral Therapy for Psychosis (CBTp) and Individual Resiliency Training (IRT) approaches for individual therapy. In addition, EARLY will be joining clinical staff from the SAMHSA funded Clinical High Risk for Psychosis (CHR-P) program at UNM, CONNECT, for training in the evidence based PIER model for Multi-family Group intervention for early psychosis.

8. Please describe the planned activities for FFY 2020 and FFY 2021 for your state's ESMI programs including psychosis?

Program Evaluation:

As one of the study sites for the SAMHSA funded Ten Percent Evaluation of CSC programs, EARLY collected outcome data and participated in annual fidelity assessments. In the FY2020, EARLY will commence an internal program evaluation to monitor fidelity to the CSC model and collect participant outcomes. A system for measuring participant level and program level outcomes has been developed and will be rolled out in the Fall of 2019. A process for fidelity assessment will be completed prior to FY2020 with the intention of conducting annual assessments moving forward.

Program Development:

EARLY will focus on increasing participant engagement by offering social group activities, encouraging service user feedback and peer leadership, as well as advocating for a friendly, age appropriate space that is easily accessible by public transportation and conducive to a multidisciplinary team based model.

The EARLY program will continue to conduct community outreach and psychoeducation, provider training, and case consultations across the state. However, the following additional efforts will be implemented with the aim of increasing capacity and access to evidence based care for early psychosis:

- In FY2020, EARLY staff will provide the first four-day annual training on CSC and the early intervention of psychosis to any interested New Mexico behavioral health providers. As the aim of the training will be to increase capacity to rural areas, there will be an option to attend the remotely via zoom. In addition, the training will be recorded and distributed in person to interested providers. CEUS will be available to all attendees across disciplines. Feedback from the training will help to inform and improve the training for FY2021.
- Outreach and psychoeducation presentations will begin to target agencies and providers outside of Albuquerque that are interested in implementing the CSC model and becoming satellite programs.
- EARLY will identify interested agencies for satellite programs and assist in the implementation of CSC teams and procedures.
- EARLY satellite programs will be required to attend the annual training and receive formal ongoing consultation and supervision facilitated by the UNM EARLY clinical team using the ECHO model.
- EARLY program management will begin the evaluation of CSC satellite programs across the state of New Mexico.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

Require sites to provide aggregated client data

Require sites to report individual client data (e.g., demographic information, diagnosis, whether the young person is working or in school, number of previous hospitalizations, legal involvement, change in symptomology etc)

Require sites to report services that are provided to clients (e.g., number of hours of different types of therapy, evidence-based practices etc)

Require sites to report program activities that do not involve direct client contact (e.g., outreach, staff training, collaboration)

Require sites to report enrollment information

Require sites to use certain assessments - CSI, Global Social/Role Functioning

Maintain a database for data collection from sites

Provisions for collecting and reporting data, demonstrating the impact of this initiative.

a) Data source: This information is tracked and obtained by the clinic program assistant who maintains an active referral sheet.

b) Description of data: This referral sheet tracks referrals, active patients, inactive patients, patients the CLINIC is trying to engage in services, demographic information, and services that the patient is receiving (e.g. family psychoeducation, CCSS, psychiatrist name). Medical records are also reviewed on a regular basis by the program therapist to confirm engagement in services, and the CSW regularly reports on her patient panel during the weekly clinic meeting.

c) Data issues/potential caveats that affect outcome measures: Data depends on consistent tracking.

10. Please list the diagnostic categories identified for your state's ESMI programs.

Diagnosis of primary affective or non-affective psychosis not due to ongoing or primary substance use disorder or medical condition (including head injury or other neurologic disorder). Diagnoses include:

- Schizophrenia
- Schizoaffective Disorder (bipolar or depressive type)
- Schizophreniform
- Major Depressive Disorder with psychotic features
- Bipolar Disorder with psychotic features
- Delusional Disorder
- Brief Psychotic Disorder
- Other Specified schizophrenia spectrum and other psychotic disorder
- Unspecified schizophrenia spectrum and other psychotic disorder
- 

While EARLY does not specifically exclude for comorbidity, individuals with psychotic symptoms better explained by a comorbid diagnosis may be referred to other specialized programs (for example, the ACTION clinic for trauma, STAR or ASAP for substance use, or other clinics specializing in autism spectrum disorders, developmental disorders/disabilities, or traumatic brain injury/neurological disorders).

The onset date of psychotic symptoms meeting threshold for the above diagnoses, or the first episode of psychosis, must have occurred within the past 12 months from the referral to the EARLY program. However, Individuals referred to EARLY who have experienced threshold symptoms of psychosis for over 12 months but never received treatment specifically for these symptoms are considered on a case-by-case basis.

Please indicate areas of technical assistance needed related to this section.

N/A

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**Footnotes:**



## Environmental Factors and Plan

### 5. Person Centered Planning (PCP) - Required MHBG

#### Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning?  Yes  No
2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.  
N/A
3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.  
Centennial Care 2.0 pairs consumers with Care Coordinators. Care Coordinators are assigned based on their needs assessment scores.  
The following primary care coordination functions are requirements and are performed by staff employed by the MCO.
  - Conducting Health Risk Assessments (HRAs) for members newly enrolled in Centennial Care or members who have had a change in condition and who are not currently identified for Care Coordination Level 2 or 3 services;
  - Conducting Comprehensive Needs Assessments (CNAs) initially, semi-annually or annually;
  - Administer the Community Benefit Service Questionnaire (CBSQ) as applicable
  - Semi-annual or quarterly in-person visits with the member;
  - Quarterly or monthly telephone contact with the member;
  - Comprehensive Care Plan (CCP) development and updates; and
  - Targeted Health Education, including disease management, based on the member's individual diagnosis (as determined by the CNA).
4. Describe the person-centered planning process in your state.  
Person-centered planning, must revolve around the individual Centennial Care member and reflect his/her chosen lifestyle, cultural, functional, and social needs for successful community living. The goal of the care plan development process is for Centennial Care member to achieve a meaningful life in the community. Upon enrollment a Care Coordinator is assigned, based on the results of the CNA. The member receives information and training from the Care Coordinator about covered SDCB services or requirements for their care plan.  
Please indicate areas of technical assistance needed related to this section.  
N/A

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#### Footnotes:

Uploaded: HSD Medical Assistance Division Managed Care Policy Manual for a comprehensive look at Patient Centered Planning for all services.

## Environmental Factors and Plan

### 6. Program Integrity - Required

#### Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: <http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf>. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

#### Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?  Yes  No
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?  Yes  No
3. Does the state have any activities related to this section that you would like to highlight?

#### Clinical Practice Improvement

The Behavioral Health Services Division is strongly committed to supporting the community-based delivery system with knowledge, skills and tools that support the quality of their behavioral health care thus minimizing waste fraud and abuse. Quality improvement initiatives to support clinical practice are discussed below. With the growth in the utilization of integrated primary care and behavioral health providers in the publicly-funded system of care over the past several years, BHSD saw the need to develop organizational learning strategies that combined physical and behavioral health best practices into a fully integrated care environment. The first quality improvement initiative, Integrated Quality Service Review (iQSR) focuses on frontline practice using in-depth case reviews targeting a range of qualitative measures and focus group interviews. Fifteen common personal status or life domain measures of clients and ten clinical best practice functions frame the analytical and learning activities within this quality improvement process. The clinical best practice functions isolate elements in the overall process of delivering services in these integrated settings, and include recognition, connection and rapport; building engagement and commitment; person-centered care coordination and teamwork; crisis screening, prevention, and monitoring; formal assessment and case formulation; identifying wellness and recovery goals; planning and delivering interventions; medication management; and progress tracking, plan

adjustment, and transitions.

The second initiative, Clinical Reasoning and Case Formulation, provides an intensive two-day training in the delivery of person-centered practice, with a focus on wellness and resiliency for youth and their families, and wellness and recovery for adults. Targeted skills include the development of comprehensive biopsychosocial assessments, using key organizing questions to strengthen accurate clinical analysis, constructing a case formulation, learning the logical order of goal setting, planning effective interventions, and creating case notes that are clinically sufficient and audit compliant. The training process for this initiative includes small group work using case simulations designed to highlight key concepts, organizing tools, and clinical reasoning processes, supplemented by examples of good clinical practice in each of the targeted areas. Adequate time is included to allow for discussion of the pragmatics of using newly taught skills in specific provider settings.

#### Financial/Program Management

BHSD assigns Program Managers that are responsible for monitoring the block grant and its providers. They are currently the primary resource for conveying information to providers and intermediaries about program requirements. In addition, block grant requirements are written into contracts, as appropriate.

The budget, once operationalized, is reviewed regularly to ensure expenditures are on track. Modification is made, as necessary throughout the year, to ensure proper expenditure of the funds.

The analysis of expenditures is dependent on the contracting methodology used. BHSD uses two contracting methodologies: 1) Contracting directly with a contractor through a professional services contract (for private entities) or a governmental services agreement (for public entities) or 2) Entering into contract with an Administrative Services Organization (ASO) which, in turn, contracts with vendors/programs.

For block grant recipients under the Administrative Services Organization (ASO) contract, expenditures are analyzed through a report called the CI-13 (commonly known as the Burnrate Report), generated by the ASO. All expenditures in that contract are reported by funding source and vendor and provide data on allocations, YTD expenditures, YTD balances and percentage of funds spent. This report is reviewed on a regular basis by BHSD and ASD staff and budget adjustments are made to address appropriate findings such as underspending.

For block grant recipients with a direct contract with BHSD, expenditures are analyzed through HSD's automated financial system called SHARE (Statewide Human Resources, Accounting and Reporting Enterprise). SHARE reports are printed by BHSD and ASD on a regular basis. These reports provide data from an accounts payable, budget and grants perspective and budget adjustments are made to address appropriate findings, as necessary.

The HSD contracts with independent auditors annually for audit of the whole department. As part of that audit, Major Programs of the Department are selected for further review based on 3rd quarter financial data through the "Single Audit" process. SABG, as a major program, is regularly chosen to be audited under the single-audit. MHBG can be chosen should there be matters requiring further investigation.

Please indicate areas of technical assistance needed related to this section

N/A

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#### Footnotes:

# Environmental Factors and Plan

## 7. Tribes - Requested

### Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)<sup>56</sup> to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

<sup>56</sup> <https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf>

### Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?
2. What specific concerns were raised during the consultation session(s) noted above?
3. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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### Footnotes:

## Environmental Factors and Plan

### 8. Primary Prevention - Required SABG

#### Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

#### Please respond to the following items

#### Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)?  Yes  No
2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply)  Yes  No
  - a)  Data on consequences of substance-using behaviors
  - b)  Substance-using behaviors
  - c)  Intervening variables (including risk and protective factors)
  - d)  Other (please list)
3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)
  - Children (under age 12)
  - Youth (ages 12-17)
  - Young adults/college age (ages 18-26)
  - Adults (ages 27-54)
  - Older adults (age 55 and above)
  - Cultural/ethnic minorities
  - Sexual/gender minorities
  - Rural communities
  - Others (please list)Military
4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- Archival indicators (Please list)

DWI crashes, New Mexico Office of the Medical Investigator (OMI) Drug related deaths and Alcohol related deaths

- National survey on Drug Use and Health (NSDUH)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Youth Risk Behavioral Surveillance System (YRBS)
- Monitoring the Future
- Communities that Care
- State - developed survey instrument
- Others (please list)

New Mexico Substance Abuse Epidemiological Profile, New Mexico Prescription Monitoring Program (PMP), New Mexico Children, Youth and Families Department (CYFD) Juvenile Justice Services Annual Report

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds?  Yes  No

If yes, (please explain)

In an effort to stabilize prevention efforts in New Mexico, the Office of Substance Abuse Prevention (OSAP) makes decisions about the allocation of SABG primary prevention funds in a standardized way by first giving communities a minimum of \$100,000 (<http://www.nmprevention.org/>). Based on previous experience from the SPF SIG grant, we have learned that communities need at least \$100,000 in support to set up a comprehensive prevention program, hire and maintain staff, cover overhead and supplies, and evaluate services for effective outcomes--and thereby, remain sufficiently stable to truly make an impact.

Secondly, in conjunction with the New Mexico Department of Health, the Statewide Epidemiological and Outcomes Workgroup (SEOW) develops an annual Substance Abuse Epidemiological Profile as an annual needs assessment. The OSAP and key members from the SEOW develop and use an indicator matrix to help assess risk at the County level for underage drinking and prescription drug abuse. The selected indicators aimed to capture communities with high prevalence and low resources. Risk was assessed at the county level because data below the county level are not readily available in New Mexico, largely because of the very rural nature of the state and low population density.

The final matrix contains the following risk indicators below:

- Population
- Prevention funding per capita
- Median household income
- Population living below the federal poverty level
- Percentage of minority population
- High school graduation percentage
- Current drinker (middle and high school)
- Current binge drinker (middle and high school)
- Use pain killer to get high (middle and high school)
- Lifetime painkiller use without a prescription (middle and high school)
- Juvenile arrests for minors in possession of alcohol and driving under the influence

With the assistance of the SEOW, OSAP determined which counties met both criteria of having high prevalence of underage drinking and prescription drug misuse, and were low in resources. Counties received a point if an indicator from the above mentioned categories fell in the top/bottom seven counties (having either the lowest ranking for things like high school graduation and income, or highest prevalence of substance use). Two scores were calculated for each of the 33 counties in New Mexico using the indicator matrix; a score for prescription drug misuse and another score for alcohol related measures. Total scores for both the alcohol and prescription drug categories included points for large populations, low prevention funding, high poverty, high minority prevalence and low high school graduation.

If no, (please explain) how SABG funds are allocated:

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

## Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce?  Yes  No

If yes, please describe

The New Mexico Credentialing Board for Behavioral Health Professionals (NMCBBHP) is a member of the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse (IC&RC/AODA) for the purpose of credentialing qualified substance abuse counselors and prevention specialists (<http://www.nmcbbhp.org/>). IC&RC and NMCBBHP are committed to public protection through the establishment of quality, competency-based certification programs for professionals engaged in the prevention and treatment of addictions and related problems. The NMCBBHP certification was developed by alcohol and other drug abuse professionals for alcohol and other drug abuse professionals.

The competency-based, peer review process measures and tests the knowledge and skills of an individual prior to awarding the credential. The NMCBBHP offers the IC&RC International Written Professional Examination four (4) times per year. This exam is required for CADC, CS, CPS and CJP Certification. Through NMCBBHP certification and renewals, professionals ensure they are maintaining continuing education requirements and ethical standards of care for their clients and communities.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce?  Yes  No

If yes, please describe mechanism used

The OSAP is dedicated to improving and maximizing the impact of New Mexico's substance abuse prevention workforce. To this end, OSAP seeks to build the capacity of the state's local prevention providers to deliver effective prevention services aimed at reducing alcohol, tobacco and other drug abuse. OSAP funds and manages the NM ATODA Prevention Workforce Training System (<https://nmpreventionworkforce.org/>), which provides approximately 36 training days per year to support and maintain an educated substance abuse prevention workforce to achieve Certified Prevention Specialist certification. All OSAP funded programs are required to have one person on staff working toward their CPS certification, which can be applied for and awarded through the NMCBBHP. In addition, phone, email, and onsite technical assistance is available by OSAP staff and technical assistance contractors. A well-educated workforce can help New Mexico achieve significant substance abuse prevention outcomes locally and state-wide.

The Workforce Training System is specifically designed to assist OSAP in achieving its prevention priorities. To expand the capacity of preventionists across the state regardless of their funding stream, OSAP opened the training to prevention professionals and advocates interested in furthering their professional knowledge of evidence-based substance abuse prevention. Those who are interested in becoming Certified Prevention Specialists are encouraged to attend. Trainings offered include theories and strategies for each of the substance abuse prevention domains: individuals, families, schools, and communities. The Training System acknowledges the diversity that lies within New Mexico's boundaries and strives to offer courses applicable to all communities.

Coop Consulting:

The OSAP contracts with Coop Consulting to provide training and technical assistance used to increase capacity and expertise to address substance abuse prevention issues and trends, such as prescription drug abuse prevention strategies. Coop Consulting performs project coordination of activities and project development to OSAP community prevention providers as identified by the OSAP Director to increase provider capacity to implement quality prevention direct services and environmental strategies. Coop Consulting provides technical assistance to carry out the Strategic Prevention Framework, environmental strategies, coalition building, integration of mental health prevention and promotion, etc. Coop Consulting provides a suite of services such as site visits, phone calls, emails, regular communication, Skype/online communication, trainings, webinars, and trainings on each Strategic Prevention Framework (SPF) category as well as identifying relevant research from the prevention science literature on evidence based practices.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?  Yes  No

If yes, please describe mechanism used

The OSAP utilizes the SPF steps as the formal mechanism to implement prevention strategies, a formal contractual requirement found in all sub-recipient detailed scopes of work. Provider's Goal 1 is based on the five steps of the SPF process which includes conducting a needs assessment, building capacity, strategic planning, implementation, and evaluation infused with cultural competency and sustainability. Providers begin with assessment, collecting and utilizing data to identify needs and gaps in areas where capacity needs to be built. Providers identify priorities and intervening variables by applying the SPF data driven process. In the assessment phase programs may utilize tools such as, Readiness Survey Assessment tool & Guiding Questions to Determine Readiness. Templates are provided to programs as needed. Providers understand community readiness and the importance it plays in effective community mobilization. The providers determine their community's capacity and readiness to address ATOD priorities.



SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

## Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years?  Yes  No  
  
If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan  
See Attachments Page
2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan)  Yes  No  N/A
3. Does your state's prevention strategic plan include the following components? (check all that apply):
  - a)  Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
  - b)  Timelines
  - c)  Roles and responsibilities
  - d)  Process indicators
  - e)  Outcome indicators
  - f)  Cultural competence component
  - g)  Sustainability component
  - h)  Other (please list):
  - i)  Not applicable/no prevention strategic plan
4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds?  Yes  No
5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds?  Yes  No

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

OSAP uses the SEOW as an Evidence-Based Workgroup to vet strategies and only funds activities and services that have been approved by that group. These selected strategies, along with standardized goals and objectives are provided in OSAP'S "SMART Goals and Objectives" document given to every funded prevention provider. The SEOW reviews evidence-based programs and data supported by SAMHSA, CSAP, CDC Community Guide, and the US Preventative Services Taskforce guidelines that have at minimum, peer reviewed studies, meta-analyses or longitudinal studies to substantiate effectiveness.

OSAP follows the SAMHSA SAPT reporting definitions for evidence-based programs. The guidance document for identifying and selecting evidence-based interventions, provides the following definition for evidence-based programs:

- Being reported with positive effects in a peer-reviewed journal
- Documentation of effectiveness based on the following guidelines:
  - o Guideline 3: The intervention is supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to identifying and selecting evidence-based interventions scientific standards of evidence and with results that show a consistent pattern of credible and positive effects; and
  - o Guideline 4: The intervention is reviewed and deemed appropriate by a panel of informed prevention experts that includes: well-qualified prevention researchers who are experienced in evaluating prevention interventions similar to those under review; local prevention practitioners; and key community leaders as appropriate, officials from law enforcement and education sectors or elders within indigenous cultures.

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. **Alternative programs** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

## Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:
  - a)  SSA staff directly implements primary prevention programs and strategies.
  - b)  The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
  - c)  The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
  - d)  The SSA funds regional entities that provide training and technical assistance.
  - e)  The SSA funds regional entities to provide prevention services.
  - f)  The SSA funds county, city, or tribal governments to provide prevention services.
  - g)  The SSA funds community coalitions to provide prevention services.
  - h)  The SSA funds individual programs that are not part of a larger community effort.
  - i)  The SSA directly funds other state agency prevention programs.
  - j)  Other (please describe)
  
2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:
  - a) Information Dissemination:
    - a. Information Dissemination: Media campaigns such as A Dose of Reality campaign to increase awareness of prescription drug abuse, radio/TV public service announcements about law enforcement efforts and Synar results, and a New Mexico prevention website informing the public about prevention efforts across the state are provided regularly. These types of activities are used because they increase awareness by informing and educating the public about substance abuse issues, consequences, and impacts in New Mexico.
  - b) Education:
    - b. Education: Classroom and/or small group sessions such as Dare to Be You and Strengthening Families are implemented in New Mexico. These two programs are used because they have documented effectiveness in reducing substance use or initiation, and increasing resiliency skills and appropriate decision-making.
  - c) Alternatives:
    - c. Alternatives: Youth/adult leadership activities and community service projects are programs to role model healthy behaviors and activities not involving or revolving around substance use.
  - d) Problem Identification and Referral:
    - d. Problem Identification and Referral: Students and family members participating in Dare To Be You and Strengthening

Families who are at higher risk of substance use are provided with referrals to local agencies or programs to reduce potential abuse.

**e)** Community-Based Processes:

e. Community-Based Processes: As part of the Strategic Prevention Framework along with using a coalition-based approach, these activities are crucial to increasing community capacity to effectively address substance abuse issues locally. Activities include coalition building, community training, systematic planning, and multi-agency coordination and collaboration.

**f)** Environmental:

f. Environmental: All OSAP providers are required to implement strategies addressing the community environment as they influence substance use in order to create population level effect and change. Activities include establishing/promoting effective substance use policies in schools; technical assistance to maximize local enforcement of regulations and codes governing alcohol, tobacco, and drug use, availability, and distribution; modifying alcohol and tobacco advertising practices; modifying product placement strategies; changing environmental codes, ordinances, regulations, & legislation as they impact substance use/abuse; advocating for effective public policies as they impact substance use/abuse; alcohol beverage service/sales education and compliance checks; Synar tobacco activities; and advocating for stricter ATOD law enforcement; and education about the benefits of reducing the cost of alcohol-related problems to the community. Prescription strategies include train providers to encourage increased use of the PMP; develop and train a "speakers bureau" of speakers who are informed and available to meet with PTAs and other parent groups to make presentations and share information regarding Rx abuse and prevention; develop and disseminate parent handbook to include research information and YRRS data; PSAs and media to support safe disposal efforts and non-sharing with parents and elderly; work with pharmacies to always share information with customers about the dangers of abuse, proper storage and disposal, and sharing and encourage the use of lock boxes.

- 3.** Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means?  Yes  No

If yes, please describe

The OSAP reviews all Department of Finance and Administration (DFA) DWI Prevention applications and Department of Health CDC funded SOWs to prevent duplication of services and activities, and to coordinate services that are complimentary as well. OSAP conducts an annual review of Scopes of Work with providers that have multiple contracts to insure the work is specific to the funding stream. OSAP expenditure forms detail all funding received by other state agencies. Internally, OSAP separates all funding sources.

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. **Information Dissemination** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. **Education** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
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4. **Problem Identification** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. **Community-based Process** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. **Environmental Strategies** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

## Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years?  Yes  No

If yes, please attach the plan in BGAS by going to the [Attachments Page](#) and upload the plan

See Attachments Page

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- a)  Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- b)  Includes evaluation information from sub-recipients
- c)  Includes SAMHSA National Outcome Measurement (NOMs) requirements
- d)  Establishes a process for providing timely evaluation information to stakeholders
- e)  Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- f)  Other (please list:)
- g)  Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- a)  Numbers served
- b)  Implementation fidelity
- c)  Participant satisfaction
- d)  Number of evidence based programs/practices/policies implemented
- e)  Attendance
- f)  Demographic information
- g)  Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

- a)  30-day use of alcohol, tobacco, prescription drugs, etc
- b)  Heavy use
- Binge use
- Perception of harm

- c)  Disapproval of use
- d)  Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)
- e)  Other (please describe):

**Footnotes:**

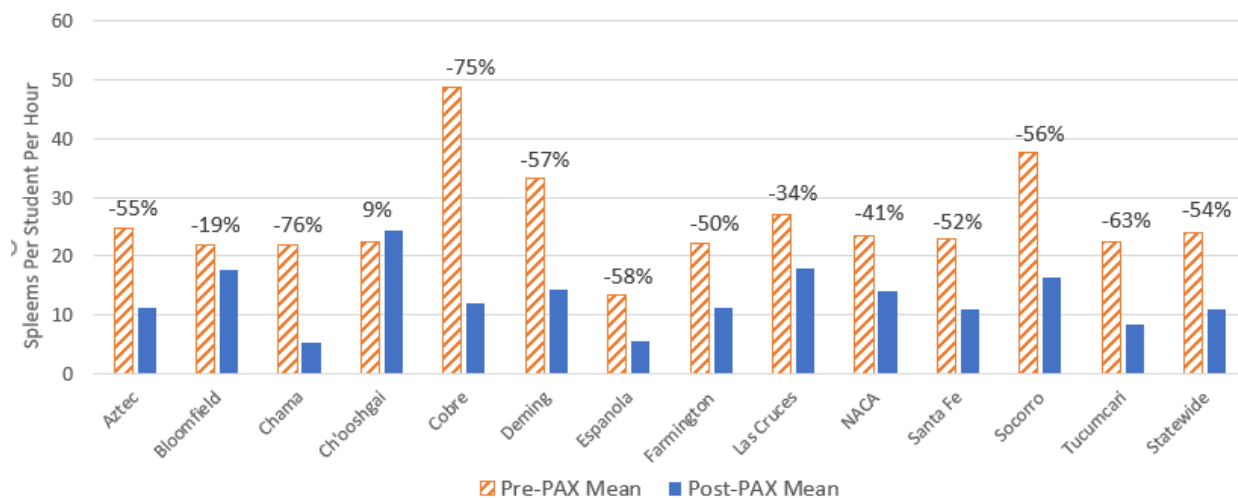
## State of New Mexico PAX Good Behavior Game 2018-19 Outcome Results

Behavioral observations were made in 390 classrooms across the state. Counts of spleems were conducted early in the school year and again in late spring near the end of the school year. Spleems are non-attentive, disruptive, or off-task behaviors by students during classroom instructional time. Examples of spleems include students having their head down on their desk, talking with their neighbor, or shooting a rubber band across the room. Results were positive, with a decrease of 54.2%, similar to last year's decrease of 56.5%.

### Spleems per student per hour and compared pre/post, New Mexico school year 18-19

District	Pre-PAX Implementation			Post-PAX Implementation			Count change	Percent change	p-value (<.05 = sig.)
	Mean	SD	Students	Mean	SD	Students			
Aztec - 45 classes	24.8	12.0	880	11.2	3.9	840	-13.6	-54.9%	<0.001 **
Bloomfield - 10 classes	22.0	9.3	244	17.7	14.2	247	-4.2	-19.3%	0.450
Chama - 9 classes	21.8	10.1	133	5.3	3.2	137	-16.6	-75.9%	0.002 **
Ch'ooshgai - 10 classes	22.3	8.0	167	24.4	6.8	176	2.0	9.1%	0.551
Cobre - 23 classes	48.8	24.3	354	12.0	9.3	435	-36.8	-75.4%	<0.001 **
Deming - 26 classes	33.2	13.9	549	14.2	6.7	552	-19.0	-57.2%	<0.001 **
Espanola - 66 classes	13.3	7.0	1064	5.5	3.7	1030	-7.8	-58.4%	<0.001 **
Farmington - 58 classes	22.2	14.6	1227	11.1	8.2	1220	-11.2	-50.2%	<0.001 **
Las Cruces - 15 classes	27.2	11.6	233	17.9	5.2	218	-9.2	-34.0%	0.014 **
NACA - 4 classes	23.4	5.7	83	13.9	3.5	79	-9.5	-40.6%	0.065 *
Santa Fe - 89 classes	22.9	20.4	1586	11.0	7.3	1661	-11.9	-52.1%	<0.001 **
Socorro - 10 classes	37.6	12.0	174	16.4	3.8	158	-21.2	-56.4%	<0.001 **
Tucumcari - 23 classes	22.5	12.9	387	8.3	5.2	392	-14.2	-63.2%	<0.001 **
<b>Statewide - 390 classes</b>	<b>24.0</b>	<b>17.0</b>	<b>7081</b>	<b>11.0</b>	<b>7.8</b>	<b>7145</b>	<b>-13.0</b>	<b>-54.2%</b>	<b>&lt;0.001 **</b>

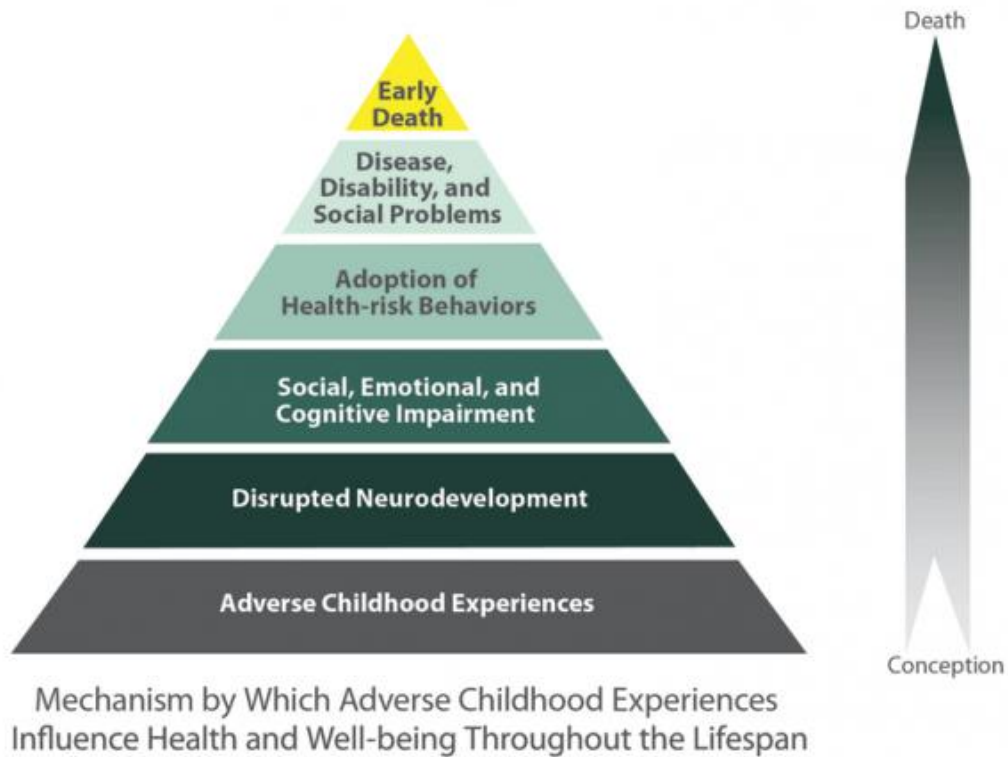
*Note: Results for Jemez Valley Public Schools are not shown because of confidentiality issues due to small sample size. For p-values, \*\* indicates statistical significance at the 95% confidence level and \* indicates statistical significance at the 90% confidence level.*



Spleems per student per hour decreased for twelve of the thirteen sites (eleven independent New Mexico school districts and two individual school campus sites) and the state as a whole. These drops were statistically significant at the 95% confidence level for all but three districts (although Native American Community Academy is significant at the 90% confidence level). The percentage decrease in Spleems ranged from 19.3% in Bloomfield Public Schools to 75.9% in Chama Valley Independent Schools.



# Strategies to Prevent and Mitigate the Effects of Adverse Childhood Experiences



## New Mexico Statewide Epidemiological Outcomes Workgroup White Paper Series

November 15, 2018

*Produced by Coop Consulting, Inc. on behalf of the  
New Mexico Statewide Epidemiological Outcomes Workgroup*

**Mission** New Mexico’s Statewide Epidemiological and Outcomes Workgroup (SEOW) reviews and disseminates data about substance abuse and misuse and their consequences. It also identifies best practice information about evidence-based prevention strategies, policies and practices that can lead to successful outcomes for New Mexicans. The purpose of this two-fold work is to inform communities so that they can better target behaviors and risk factors that can be positively impacted by the implementation of well-chosen, evidence-based prevention approaches that are appropriate for the population. The important work of the SEOW is directed by the Office of Substance Abuse Prevention (Behavioral Health Services Division, Human Services Department) and supported by federal funding from the Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration.

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Adverse childhood experiences (ACEs) are stressful or traumatic events during childhood and adolescence that research have been shown to be a serious risk factor for later life substance use and mental health disorders. Professionals across many different fields are working to prevent and mitigate the effects of ACEs, and a growing body of research has identified evidence-based strategies to address this issue. This brief summarizes the latest evidence-based primary and secondary prevention strategies aimed at reducing children’s exposure to ACEs and their impact on later life health outcomes.

### **Environmental Strategies – Community Education and Capacity Building**

A key component of any initiative working towards preventing ACEs is to raise awareness and develop capacity within a community to identify and provide support for children at risk for experiencing ACEs. Activities such as developing marketing materials that teach about ACEs and resilience, holding public meetings, and conducting trainings on trauma-informed care can help to create an entire community that is prepared to identify children who have experienced ACEs and to mitigate the effects of that exposure.



The City of Walla Walla, Washington received funding from Washington’ ACEs Public-Private Initiative (APPI) to conduct an ACEs awareness campaign in their

community. This multi-faceted campaign, which included traditional marketing materials, social media, and public events, was coupled with an effort to form neighborhood coalitions that foster more community cohesiveness through things like block parties and neighborhood cleanup days. The evaluation of this program found residents had increased awareness of ACEs and more positive attitudes about their community after these efforts, although it is unclear if increased awareness translated into changes in behavior.<sup>1</sup>

The Washington State Family Policy Council conducted a cross-site evaluation comparing 28 community public health coalitions funded by the Council to 10 community coalitions that were not funded. The funding was used to develop the capacity of the coalitions, which included the “development of a shared focus, collaborative leadership, continuous learning and improvement, and a system-wide focus on results”. The study found that after a 7-year funding period, ACE prevalence was significantly lower among young adults in high capacity communities and that funded communities showed greater improvements in other related socioeconomic indicators.<sup>2</sup>

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<sup>1</sup> Verbitsky-Savitz, Natalya, et al. *Preventing and Mitigating the Effects of ACEs by Building Community Capacity and Resilience: APPI Cross-Site Evaluation Findings*. Washington, DC: Mathematica Policy Research (2016).

<sup>2</sup> Hall, Judy, et al. "Reducing adverse childhood experiences (ACE) by building community capacity: A summary of Washington Family Policy Council research findings." *Journal of Prevention & Intervention in the Community* 40.4 (2012): 325-334.

## Environmental Strategies – Law Enforcement and School Disciplinary Policies

Reexamining how juvenile justice personnel deal with adolescent substance use and antisocial behavior can help to mitigate the effects of ACEs on adult outcomes and consequentially the intergenerational transfer of ACEs. Alternatives to traditional juvenile incarceration practices, such as the Missouri Model on which New Mexico’s juvenile corrections program is based, have shown promising results in reducing recidivism and other negative outcomes later in life.<sup>3</sup> A recent study of juvenile offenders in Texas observed over a five-year period found that those who were incarcerated had a significantly greater likelihood of recidivism compared to similar youth offenders who were placed in a community-based corrections program.<sup>4</sup>



Out-of-school suspensions and expulsions also raise serious questions about how schools treat students who may exhibit mental health problems as a result of ACEs. Students who have developmental disabilities or other mental issues are disproportionately represented in school suspensions and expulsions.<sup>5</sup> The American Academy of Pediatrics argues that those who are expelled or given out-of-school suspension have a higher risk of future antisocial behavior and problematic substance use.<sup>6</sup>

Lincoln Alternative High School in Walla Walla, Washington gained national attention by implementing ACEs-related initiatives through the Washington ACEs Public-Private Initiative. The goal of these initiatives was to create an entirely “trauma-informed school”. The school aimed to reduce stress among students and faculty by developing positive student-teacher relationships and creating a safe and supportive community within the school. This included changes in disciplinary policies that led to the school using primarily in-school suspensions for infractions and spending time exploring the root causes of bad behavior with a student. Consistent improvement was seen over a five-year period – the number of office referrals per student decreased by 69% and graduation rates increased by 75%.<sup>7</sup> The transformation of the school was documented in a critically-acclaimed 2015 movie, *Paper Tigers*.

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<sup>3</sup> Mendel, Richard A. *The Missouri Model: Reinventing the Practice of Rehabilitating Youthful Offenders*. Annie E. Casey Foundation. 2010.

<sup>4</sup> Fabelo, Tony, et al. *Closer to home: An analysis of the state and local impact of the Texas juvenile justice reforms*. Council of State Governments Justice Center. 2015.

<sup>5</sup> Ford, Tamsin, et al. "The relationship between exclusion from school and mental health: a secondary analysis of the British Child and Adolescent Mental Health Surveys 2004 and 2007." *Psychological Medicine* 48.4 (2018): 629-641.

<sup>6</sup> Lamont, Jeffrey H., et al. "Out-of-school suspension and expulsion." *Pediatrics* 131.3 (2013): e1000-e1007.

<sup>7</sup> Verbitsky-Savitz, Natalya, et al. *Preventing and Mitigating the Effects of ACEs by Building Community Capacity and Resilience: APPI Cross-Site Evaluation Findings*. Washington, DC: Mathematica Policy Research (2016).

## School-Based Prevention – Building Resilience among Youth through Cooperative Learning

*Cooperative learning* is an educational approach that emphasizes “positive interdependence” in classrooms, in which students can only attain their desired academic and social goals if others around them also achieve theirs. This approach promotes mutual assistance and sharing, which in turn improves students’ social acceptance and reduces rejection or exclusion.

*PAX Good Behavior Game* (GBG) is a teaching strategy that promotes cooperative learning. Children in GBG classrooms learn to regulate their emotions and monitor their classmates' behavior in a game-like setting, reinforcing on-task and pro-social behavior. A long-term study of students in GBG classrooms found reductions in substance abuse, antisocial personality disorder, and the use of mental health services in young adulthood.<sup>8</sup>



## Family-Based Prevention – Reducing Children’s Exposure to ACEs through Direct Service

*Home Visitation Programs* provide information, support, and training about child health, development, and care to families in their homes. Home visiting programs may be delivered by nurses or other professionals, and the content of programs vary depending on the model used.



The Nurse-Family Partnership (NFP) model arranges home visits from registered nurses to low-income first-time mothers. Evaluations have found evidence that the NFP model can 1) reduce child abuse and neglect, 2) reduce prenatal smoking, and 3) improve cognitive and academic outcomes of children born to mothers with low resources.<sup>9</sup>

*Parenting and Family Skills Programs* are interventions aimed at reducing substance use in the household and improving parent-child relationships by teaching various communication, problem-solving, and other skills to both parents and their children.

The (SFP) is a 14-session evidence-based parenting skills and family life skills training program specifically designed for families currently involved with or at risk of involvement with child protective services. Research has showed that the SFP significantly improved the reunification rate for families in which one or more parents had a substance use disorder and the child was in out-of-home placement.<sup>10</sup>

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<sup>8</sup> Poduska, Jeanne M., et al. "Impact of the Good Behavior Game, a universal classroom-based behavior intervention, on young adult service use for problems with emotions, behavior, or drugs or alcohol." *Drug and Alcohol Dependence* 95 (2008): S29-S44.

<sup>9</sup> Laura and John Arnold Foundation. *Evidence Summary for the Nurse Family Partnership*. 2017.

<sup>10</sup> Brook, Jody, Thomas P. McDonald, and Yueqi Yan. "An analysis of the impact of the Strengthening Families Program on family reunification in child welfare." *Children and Youth Services Review* 34.4 (2012): 691-695.

## Trauma-Informed Practice and Prevention in Medical Settings

A trauma-informed practice is a treatment approach used by doctors and other medical professionals that involves understanding, recognizing, and responding to the effects of trauma. An emerging field of research has shown how this approach can help prevent re-traumatizing individuals seeking care for substance abuse or mental health problems and help them to embrace a message of hope and recovery.

While many pediatricians are aware of ACEs and the effect they have on children, many still do not screen their patients for ACEs. One reason for this is that they often cannot bill insurance companies or Medicaid for prevention services, even though many rigorous cost-benefit analyses of preventative services for youth have shown their benefits to society outweigh their costs by reducing future behavioral health problems.<sup>11</sup> Including screening for ACEs and offering behavioral health services and family-based interventions in a primary care setting could reduce the stigma associated with accessing these services and increase the number of children and families utilizing them.<sup>12</sup>

### ACEs Training Resources

- The University of New Mexico ACTION Program offers training to medical professionals, school workers and others in the community on a variety of topics related to childhood trauma and trauma-informed care. Training topics include trauma-informed systems of care, screening and assessment, and school-based care.  
<https://psychiatry.unm.edu/>
- The Southwest Family Institute provides professional development and training opportunities to medical professionals and other community health organizations. The Thriving Students program provides specialized training to assist educators in addressing the needs of students who have serious social, emotional, and academic challenges.  
<http://swfamily.com/institute-programs-resources/>
- The CDC has launched a new free online training on preventing adverse childhood experiences. Module 1 is an ACEs overview. Module 2 is a public health approach to preventing ACEs. Additional modules for specific professions such as mental health providers and medical providers are coming soon.  
<https://vetoviolenace.cdc.gov/apps/aces-training/>

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<sup>11</sup> Biglan, Anthony, Mark J. Van Ryzin, and J. David Hawkins. "Evolving a more nurturing society to prevent adverse childhood experiences." *Academic Pediatrics* 17.7 (2017): S150-S157.

<sup>12</sup> Leslie, Laurel K., et al. "Primary health care: potential home for family-focused preventive interventions." *American Journal of Preventive Medicine* 51.4 (2016): S106-S118.

# E-Cigarettes



## **New Mexico Statewide Epidemiological Outcomes Workgroup White Paper Series**

October 18, 2018

*Produced by Coop Consulting, Inc. on behalf of the  
New Mexico Statewide Epidemiological Outcomes Workgroup*



**Mission** New Mexico’s Statewide Epidemiological and Outcomes Workgroup (SEOW) reviews and disseminates data about substance abuse and misuse and their consequences. It also identifies best practice information about evidence-based prevention strategies, policies and practices that can lead to successful outcomes for New Mexicans. The purpose of this two-fold work is to inform communities so that they can better target behaviors and risk factors that can be positively impacted by the implementation of well-chosen, evidence-based prevention approaches that are appropriate for the population. The important work of the SEOW is directed by the Office of Substance Abuse Prevention (Behavioral Health Services Division, Human Services Department) and supported by federal funding from the Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration.

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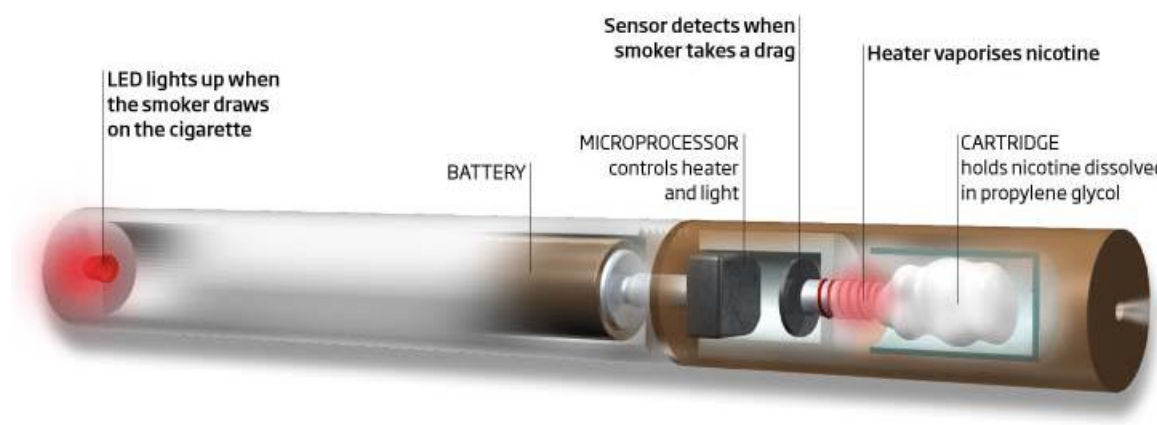
## What are e-cigarettes and how do they compare to traditional cigarettes?

E-cigarettes are nicotine delivery devices that aerosolize nicotine and other chemicals to simulate smoking a traditional cigarette. "Aerosolizing" is the process of converting liquids into small particles that are light enough to be carried in the air. E-cigarettes were developed to mimic the way nicotine is delivered in a traditional cigarette without the harmful effects of tobacco smoke.<sup>1</sup>

The US Food and Drug Administration (FDA) does not currently regulate e-cigarettes, unlike traditional tobacco products. Therefore, the engineering and ingredients of e-cigarettes vary greatly from brand to brand. Most e-cigarettes, however, consist of the following components:

- A battery, which is used to power the e-cigarette
- E-cigarette liquid, which usually contains nicotine in a solution containing propylene glycol or glycerin; most also contain additional flavoring chemicals
- An atomizer, which heats the liquid so that it becomes aerosolized. These generally contain a microprocessor, a metal coil, and a wick that is soaked in the liquid.

Figure 1. Components of an E-Cigarette



Source: Washington Poison Center

The chemical composition of the e-cigarette liquid ("e-liquid") that is aerosolized is largely unknown, since e-cigarettes are not currently regulated. Consumers rarely know exactly what ingredients are being aerosolized, as many e-cigarettes are sold without packaging containing information on their ingredients or risks. Studies have found e-liquids to contain the following ingredients:<sup>2,3</sup>

<sup>1</sup> Demick, Barbara. "A high-tech approach to getting a nicotine fix." *Los Angeles Times* 2009.

<sup>2</sup> Goniewicz, Maciej Lukasz, et al. "Levels of selected carcinogens and toxicants in vapour from electronic cigarettes." *Tobacco Control* 23.2 (2014): 133-139.

<sup>3</sup> Goniewicz, Maciej L., Peter Hajek, and Hayden McRobbie. "Nicotine content of electronic cigarettes, its release in vapour and its consistency across batches: regulatory implications." *Addiction* 109.3 (2014): 500-507.

- *Propylene glycol* – a synthetic liquid mixed with nicotine to maintain moisture. It is approved by the FDA as a “generally safe” food additive with no known risks, although its effects through inhalation are unknown.
- *Vegetable glycerin* – a liquid obtained from plant sources that is mixed with nicotine to maintain moisture. It is approved by the FDA as a “generally safe” food additive with no known risks, although its effects through inhalation are unknown.
- *Carbonyls (formaldehyde, acetaldehyde, propylene oxide)*<sup>4</sup> – compounds that are created when propylene glycol comes into contact with a heated metal coil. These are generally considered harmful to humans – formaldehyde is a confirmed carcinogen, and acetaldehyde is classified as a possible carcinogen.
- *Nicotine* – a stimulant that is highly addictive and causes increase in heart rate and blood pressure. Nicotine itself, in small doses, poses little to no health risks<sup>5</sup>, although nicotine poisoning can cause nausea, vomiting, and potentially respiratory arrest.
- *Tobacco byproducts (particulates, alkaloids)* – compounds formed when curing tobacco and found in e-liquid flavorings. These can cause cancer with repeated exposure.
- *Metals (chromium, copper, aluminum, nickel)* – metals that are present in the atomizer filament and wick in similar levels to traditional cigarettes.<sup>6</sup> Chromium is a known carcinogen, and exposure to other metals can cause irritation.

Exposure to aerosolized e-cigarette liquid is likely to be less harmful than traditional cigarette smoke, although it cannot be considered safe. A lack of regulation in the manufacturing of e-cigarettes and e-liquids and opacity by manufacturers about the ingredients and components contained in e-cigarettes further contribute to the risk associated with e-cigarettes exposure.

### **Prevalence of and Trends in E-Cigarette Use**

Relatively little data is available on the prevalence of and trends in e-cigarette use since they are a new phenomenon. However, it is clear that e-cigarette use has increased among both adults and youth since they were first introduced in 2004.

The latest data from the National Health Interview Survey indicates that nationally, 15.3% of adults in 2016 had ever used an e-cigarette, an increase from 12.6% in 2014.<sup>7</sup> In contrast, the same data show that current e-cigarette use (defined as every day or every other day)

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<sup>4</sup> Bekki, Kanae, et al. "Carbonyl compounds generated from electronic cigarettes." *International Journal of Environmental Research and Public Health* 11.11 (2014): 192-200.

<sup>5</sup> Royal College of Physicians of London. *Nicotine without smoke tobacco harm reduction*. 2016.

<sup>6</sup> Williams, Monique, et al. "Metal and silicate particles including nanoparticles are present in electronic cigarette cartomizer fluid and aerosol." *PLoS one* 8.3 (2013): e57987.

<sup>7</sup> Bao, Wei, et al. "Changes in Electronic Cigarette Use Among Adults in the United States, 2014-2016." *JAMA* 319.19 (2018): 2039-2041.

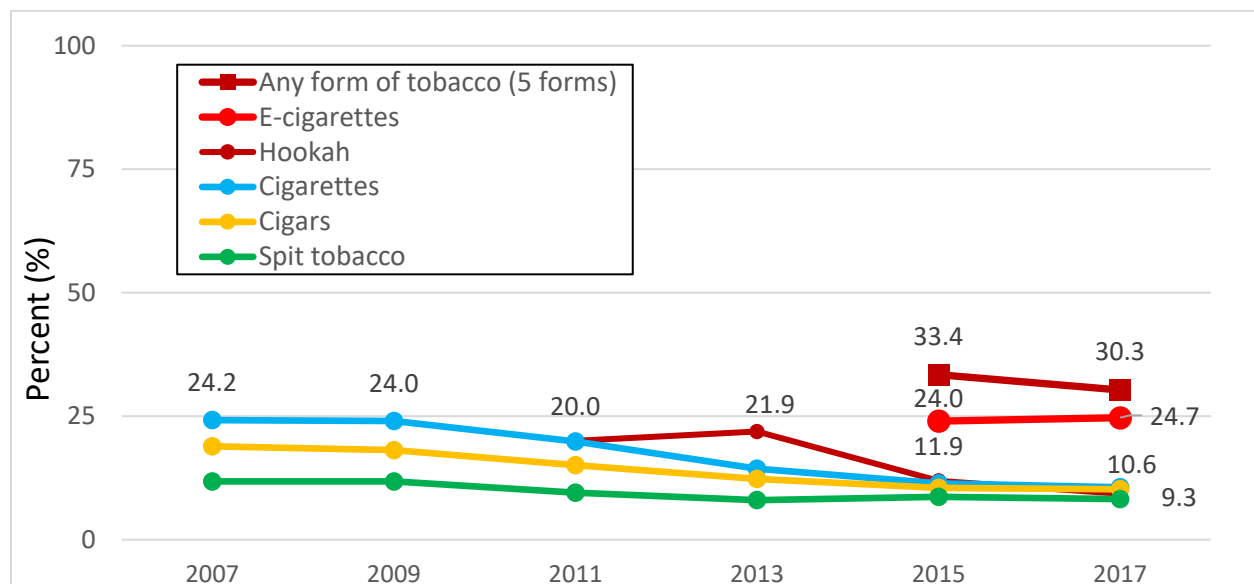
decreased from 3.7% in 2014 to 3.2% in 2016. These trends indicate that some individuals are trying but not continuing to use e-cigarettes.

Nationally, the prevalence of current e-cigarette use among adults is highest among 1) those 18 to 44, 2) males, 3) non-Hispanic whites, and 4) current or former smokers. State-specific results from the Tobacco Use Supplement to the 2014-2015 Current Population Survey indicate that 7.3% of adult New Mexicans had ever used an e-cigarette and 2.5% of adult New Mexicans currently use e-cigarettes, percentages lower than the national average.<sup>8</sup>

E-cigarette use among those under 18 is much more prevalent. Data from the 2017 Youth Risk Behavior Survey indicate that 42.2% of high school students nationally had ever used an e-cigarette, compared to 51.0% of New Mexico high school students. These data also indicate that 13.2% of high school students nationally had used an e-cigarette in the past 30 days, compared to 24.7% of New Mexico high school students.

The use of traditional cigarettes by New Mexico high school students has declined dramatically over the past ten years, from 24.2% in 2007 to 10.6% in 2017. However, there has been a concurrent rise in e-cigarette use among adolescents to a level in 2017 that is similar to the level of traditional cigarette use in 2007. When the use of any form of tobacco (traditional or e-cigarette) is considered, it is estimated that 30.3% of New Mexico high school students currently use tobacco. This indicates that more high school students use some form of tobacco now than they did in 2007, a trend that is largely accounted for by e-cigarette use.

Figure 2. Current Tobacco Use, Grades 9-12, 2007-2017, New Mexico



Source: New Mexico Department of Health, Epidemiology and Response Division

<sup>8</sup> Odani, Satomi, et al. "State-Specific Prevalence of Tobacco Product Use Among Adults—United States, 2014–2015." *Morbidity and Mortality Weekly Report* 67.3 (2018): 97.

Data from the 2017 Youth Risk Behavior Survey indicate that 23.4% of middle school students had ever used an e-cigarette, and 10.9% had used an e-cigarette in the past 30 days. Among both middle and high school students in New Mexico, e-cigarette use is higher among males, Hispanics, and students in higher grades. These data show that nearly 1 in 3 high school seniors had used an e-cigarette in the past 30 days.

Chen et al. (2017) investigated in more depth patterns of e-cigarette smoking onset among children and youth.<sup>9</sup> They found that while the minimum age for traditional cigarette smoking initiation is about 4 or 5 years of age, the minimum age of onset for e-cigarettes is 7 years of age. Different from conventional cigarette smoking, with peak initiation risk at 14 to 15 years of age, the likelihood of initiating e-cigarette use continues to increase up to age 18 years. They note that the pattern of e-cigarette use initiation is more similar to that of alcohol and marijuana, with a rapid increase after 14 years of age and a peak risk around 17 to 18 years of age.

### **E-Cigarette Marketing and Health Disparities**

E-cigarettes are heavily marketed in both traditional print and television advertising as well as in online advertising. These advertisements often feature celebrities and messages that are similar to those advertising traditional tobacco products.<sup>10</sup> Ads often suggest that e-cigarettes are a safer alternative to traditional cigarettes and are helpful to those who want to quit smoking tobacco. Currently there are no laws that address the marketing of e-cigarettes in the same way as laws restricting the advertising of traditional tobacco products.

Major tobacco companies have purchased e-cigarette brands in anticipation of emerging market opportunities. Lorillard first purchased blu eCigs in 2012, followed by Altria (formerly Philip Morris) purchasing the brand Green Smoke in 2014 and RJ Reynolds recently acquiring the VUSE brand – all major e-cigarette brands. After acquisition of blu eCigs, a national marketing campaign was introduced by Lorillard and advertising expenditures increased from \$2.1 million in 2011 to \$14.0 million in 2012.

Television advertisements are particularly problematic as they are the primary way in which youth are exposed to e-cigarette advertising. One study found that youth exposure to television e-cigarette advertisements increased by 256% between 2011 and 2013.<sup>11</sup> Research has indicated a significant relationship between youth exposure to e-cigarette advertising and

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<sup>9</sup> Chen, Xinguang, Bin Yu, and Yan Wang. "Initiation of electronic cigarette use by age among youth in the US." *American Journal of Preventive Medicine* 53.3 (2017): 396-399.

<sup>10</sup> De Andrade, Marisa, Gerard Hastings, and Kathryn Angus. "Promotion of electronic cigarettes: tobacco marketing reinvented?." *British Medical Journal* 347 (2013): f7473.

<sup>11</sup> Duke, Jennifer C., et al. "Exposure to electronic cigarette television advertisements among youth and young adults." *Pediatrics* (2014).

future intentions to use e-cigarettes<sup>12</sup>, making the proliferation of e-cigarette television advertising a serious public health concern.

Figure 2. E-Cigarette Marketing



Source: Campaign for Tobacco-Free Kids

The marketing of “kid-friendly” flavors further contributes to the likelihood of e-cigarette use among youth. One study found 7,764 unique e-cigarette flavors, including some with names like “cotton candy”, “gummy bears”, and “banana split”.<sup>13</sup> In 2018, the FDA issued warning letters to e-cigarette manufactures that misleadingly labeled e-liquids as food products such as juice

<sup>12</sup> Farrelly, Matthew C., et al. "A randomized trial of the effect of e-cigarette TV advertisements on intentions to use e-cigarettes." *American Journal of Preventive Medicine* 49.5 (2015): 686-693.

<sup>13</sup> Zhu, Shu-Hong, et al. "Four hundred and sixty brands of e-cigarettes and counting: implications for product regulation." *Tobacco Control* 23.3 (2014): iii3-iii9.

boxes, candies, and cookies (see below).<sup>14</sup> Candy and fruit-flavored tobacco products were banned in 2009, although flavored e-cigarette products are still legal to sell.

Figure 3. “Kid-friendly” e-cigarette flavoring



Source: Food and Drug Administration

Targeted tobacco marketing strategies towards specific subpopulations has contributed to health disparities in tobacco use and related health outcomes by race, socioeconomic status, and sexual orientation.<sup>15</sup> While data are limited with respect to disparities in e-cigarette use, a recent CDC report indicates a similar pattern is emerging.<sup>16</sup> The report found that e-cigarette use was highest among adults without a high school degree, those with annual incomes under \$20,000, and among those who identify as LGBT.

### Health Effects

E-cigarettes are often advertised as being a safe way to smoke without the harmful health effects cause by traditional tobacco products. While e-cigarettes undoubtedly contain fewer and less toxic chemicals compared to conventional cigarettes, data are currently insufficient to determine the potential health effects and toxicity of e-cigarettes.

Many e-cigarette products contain nicotine, which has been shown to affect brain development and cell functioning in developing humans, and therefore nicotine use by youths and pregnant women can have negative health effects.<sup>17</sup> There is some evidence that the effect of nicotine on the developing brain makes young people more vulnerable to nicotine addiction. Exposure to nicotine at a young age leads to the generation of more nicotine receptors in the brain,

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<sup>14</sup> U.S. Food and Drug Administration. *FDA, FTC take action against companies misleading kids with e-liquids that resemble children's juice boxes, candies and cookies*. 2018.

<sup>15</sup> Dilley, Julia A., et al. "Does tobacco industry marketing excessively impact lesbian, gay and bisexual communities?." *Tobacco Control* 17 (2008): 385-390.

<sup>16</sup> Agaku, Israel T., et al. "Tobacco product use among adults--United States, 2012-2013." *Morbidity and Mortality Weekly Report* 63.25 (2014): 542-547.

<sup>17</sup> Yuan, Menglu, et al. "Nicotine and the adolescent brain." *The Journal of Physiology* 593.16 (2015): 3397-3412.

causing greater dependency, while adults over the age of 25 are generally unable to create more nicotine receptors.<sup>18</sup>

Many e-cigarette flavorings are known to cause respiratory irritation, and research indicates that certain e-cigarette flavorings may be more toxic or irritating than others.<sup>19</sup> The health effects of long-term exposure to aerosolized e-liquid are not yet known, as the products have not been on the market long enough to study them in depth.



### Role in Cigarette Smoking Cessation

The Cochrane Collaboration did a rigorous systematic review in 2016 of published research on the role of e-cigarettes in smoking cessation.<sup>20</sup> They found that compared to the use of e-cigarettes without nicotine, e-cigarettes containing nicotine may boost the chances of long-term cessation, and that there are no increased health risks associated with e-cigarette use compared to smokers who do not use e-cigarettes. However, they noted that there is not yet enough evidence to determine if e-cigarettes are a better cessation aid than the nicotine patch. They rated their confidence in these findings as “low” due to the limited amount of evidence that is currently available.

Large-scale studies using a variety of strategies (i.e., patches, gums, e-cigarettes) are needed to demonstrate if e-cigarettes are effective as a cessation aid. The US Public Health Service does not currently recommend e-cigarettes as a treatment for tobacco addiction in its guidelines, although the American Heart Association has issued a recommendation that e-cigarettes be offered to patients who have failed to quit smoking using currently-approved methods.<sup>21</sup>

<sup>18</sup> Kandel, Eric R., and Denise B. Kandel. "A molecular basis for nicotine as a gateway drug." *New England Journal of Medicine* 371.10 (2014): 932-943.

<sup>19</sup> Muthumalage, Thivanka, et al. "Inflammatory and Oxidative Responses Induced by Exposure to Commonly Used e-Cigarette Flavoring Chemicals and Flavored e-Liquids without Nicotine." *Frontiers in Physiology* 8 (2018): 1130.

<sup>20</sup> McRobbie, Hayden, et al. *Electronic cigarettes for smoking cessation and reduction*. 2014.

<sup>21</sup> Bhatnagar, Aruni, et al. "Electronic cigarettes: a policy statement from the American Heart Association." *Circulation* 130.16 (2014): 1418-1436.



## Regulation

The Family Smoking Prevention and Tobacco Control Act gives the FDA authority to regulate the manufacturing, distribution, and marketing of tobacco products. The law only specifies cigarettes, loose tobacco, and smokeless tobacco as subject to regulation. At the time the law was passed in 2009, e-cigarettes had not yet entered the market and policymakers did not anticipate the need to include them in this legislation.

In 2016, the FDA issued a ruling stating that they would extend their regulating authority to cover e-cigarettes and any other previously unregulated “tobacco products”. However, in August 2017, the FDA delayed a key provision that requires manufacturers to undergo an FDA review of the product’s impact on health and whether it appeals to kids. The FDA delayed the deadline for filing applications until August 2022, and has said that e-cigarette products can remain on the market during the interim period and throughout the review process, which was not given a timeline.<sup>22</sup>

Currently there are no federal restrictions on e-cigarette flavoring or the indoor use of e-cigarettes. There are few federal restrictions on e-cigarette marketing, except that the FDA can deem labeling or advertising as “misleading” at their discretion. There were no regulations on e-cigarette packaging until August 2018, when all e-cigarette products containing nicotine were required to have a warning label that nicotine is an addictive chemical. There is currently no federal tax on e-cigarettes. In 2016, the FDA established a federal minimum age of 18 for the sale of e-cigarette products, although this does not currently apply to Internet sales.<sup>23</sup>

States have the ability to regulate e-cigarettes themselves, and many are starting to do so. Eight states have imposed a tax on e-cigarettes, thirteen states have expanded their smoke-free air laws to include e-cigarettes, and more than 100 municipalities have banned the sale of flavored e-cigarettes.<sup>24</sup> Laws concerning the sale of e-cigarettes in New Mexico are limited. There is currently no special tax placed on e-cigarettes, no permit is required to sell them, and e-cigarettes are not included in New Mexico’s legal definition of tobacco products. The City of Santa Fe is the only municipality in the state that has included e-cigarettes in their indoor smoke-free ordinances.



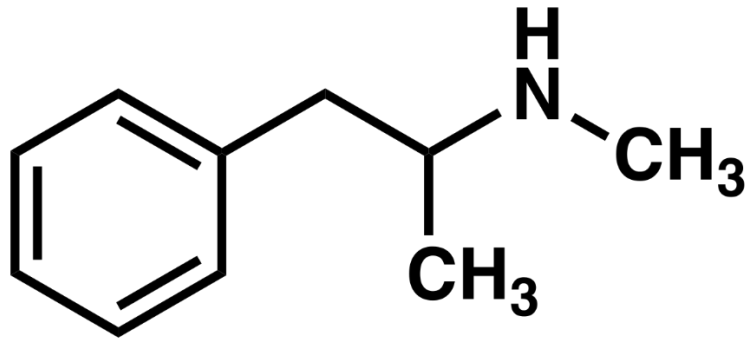
<sup>22</sup> U.S. Food and Drug Administration. *Regulations for E-Cigarettes, Cigars, and All Other Tobacco Products*. 2018.

<sup>23</sup> Truth Initiative. *E-Cigarettes: Facts, Stats, and Regulation*. 2018.

<sup>24</sup> Truth Initiative. *E-Cigarettes: Facts, Stats, and Regulation*. 2018.



# Methamphetamine



## New Mexico Statewide Epidemiological Outcomes Workgroup White Paper Series

May 16, 2019

*Produced by Coop Consulting, Inc. on behalf of the  
New Mexico Statewide Epidemiological Outcomes Workgroup*

**Mission** New Mexico’s Statewide Epidemiological and Outcomes Workgroup (SEOW) reviews and disseminates data about substance abuse and misuse and their consequences. It also identifies best practice information about evidence-based prevention strategies, policies and practices that can lead to successful outcomes for New Mexicans. The purpose of this two-fold work is to inform communities so that they can better target behaviors and risk factors that can be positively impacted by the implementation of well-chosen, evidence-based prevention approaches that are appropriate for the population. The important work of the SEOW is directed by the Office of Substance Abuse Prevention (Behavioral Health Services Division, Human Services Department) and supported by federal funding from the Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration.

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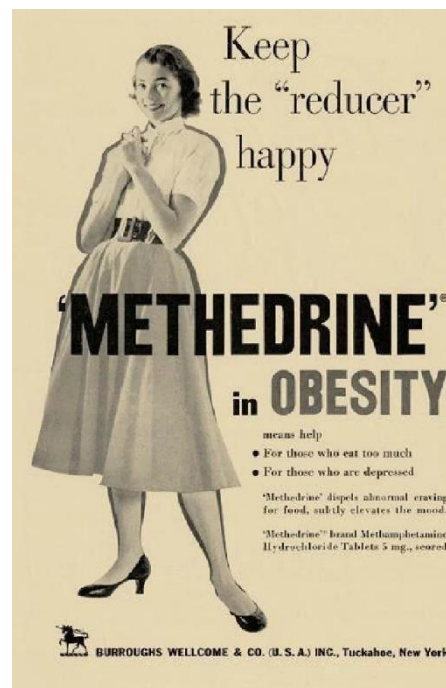
## Introduction

Methamphetamine use and its associated health consequences have evolved into a serious public health concern. While public health officials have focused primarily on the opioid epidemic in recent years, another epidemic of methamphetamine use has been quietly brewing behind the scenes. Methamphetamine use is surging, particularly in the American West. This white paper provides basic information about methamphetamine, how it is made, how it affects the body, as well information on the use of methamphetamine specific to New Mexico.

## What is methamphetamine?

Methamphetamine is part of a class of chemicals derived from the structure of amphetamine. These chemical compounds are formed by replacing one or more atoms in the core amphetamine chemical structure with substitutes. Some forms of amphetamine occur in nature, for example ephedrine which is contained in the leaves of the Ephedra plant (which grows in much of the world, including the southwest United States). In fact, early Mormon pioneers drank a tea known as “Mormon tea” for medicinal purposes that was made from the stems of Ephedra plants.<sup>1</sup> Examples of amphetamine derivatives that are not naturally occurring include pseudoephedrine (“Sudafed”), MDMA (“ecstasy”), and cathinone (“bath salts”).

Methamphetamine was first synthesized in Japan in 1893 by a Japanese chemist using ephedrine extracted from the Ephedra plant.<sup>2</sup> During World War II, methamphetamine was produced in tablet form under the name “Pervitin” by Nazi Germany and was used extensively by all branches of the Nazi military.<sup>3</sup> In the United States, Obetrol and Methedrine were popular diet pills in the 1950s and 60s containing methamphetamine that were eventually pulled from the market due to their addictive properties. Methamphetamine is currently regulated as a Schedule II drug and is available by prescription under the name Desoxyn to treat ADHD and obesity.



<sup>1</sup> Bonner, Franklin T., and Robert P. Karrfalt. "The Woody Plant Seed Manual." *Agricultural Handbook No. 727*. (2008): 27.

<sup>2</sup> Rusyniak, Daniel E. "Neurologic Manifestations of Chronic Methamphetamine Abuse." *Neurologic Clinics* 29.3 (2011): 641-55.

<sup>3</sup> Defalque, Ray J., and Amos J. Wright. "Methamphetamine for Hitler's Germany: 1937 to 1945." *Bulletin of Anesthesia History* 29.2 (2011): 21-4.

## What form does methamphetamine come in and how is it produced?

Illicit methamphetamine varies in color and consistency due to the variety of recipes used to produce it, the competency of the producer, and the cutting agents used. Methamphetamine that looks like crystal or ice tends to be relatively pure, while methamphetamine in powder form tends to be cut with other substances. Methamphetamine that is in a gooey or wax form is thought to be the result of an incomplete cooking process.<sup>4</sup> Methamphetamine is sometimes distributed in the form of tablets, often in combination with other stimulants. Tablets containing a mixture of methamphetamine and caffeine called “Yaba” (“crazy pill” in Thai) are distributed in Southeast Asian countries and sometimes in the United States illicit drug market.<sup>5</sup>

Methamphetamine in New Mexico is primarily smuggled in from Mexico by drug trafficking organizations, although some is produced in clandestine labs within the state.<sup>6</sup> There are two types of clandestine labs. One is a “super lab” that is highly organized and can produce 10 or more pounds of methamphetamine per batch. The other is a smaller “mom and pop” lab that can only manufacture 1 to 4 ounces per batch. The latter typically produce only enough for personal use and just enough extra to finance the operation.<sup>7</sup>

An estimated 34 different chemicals can be used to produce methamphetamine. Among the most common are ephedrine, pseudoephedrine, phenylpropanolamine, red phosphorous, iodine, hydrochloric acid, and anhydrous ammonia. These precursor chemicals are often obtained by stealing, smuggling, or deriving them from other unregulated materials. Lab cooks can derive these precursors from materials such as cold and allergy medications, lye, battery acid, antifreeze, and fertilizer.<sup>8</sup>

The Combat Methamphetamine Epidemic Act of 2005 regulated the sale of cold and allergy medicine containing ephedrine, pseudoephedrine, or phenylpropanolamine (which are essential precursor ingredients for methamphetamine production) by instituting a purchase monitoring program and limiting the amount sold per person to 9 grams per month.<sup>9</sup>

Methamphetamine can be produced by a number of different methods, although almost all of them require ephedrine or pseudoephedrine. A popular method that is uncomplicated and requires fewer cold or allergy pills is known as the “shake and bake”, in which the pills are combined with common household chemicals and shaken in a soda bottle. This method is extremely dangerous – if too much pressure builds up in the bottle during the production process it has a tendency to explode and cause severe injury to the producer.

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<sup>4</sup> McKetin, Rebecca, and Jennifer McLaren. *The methamphetamine situation in Australia: A review of routine data sources*. Australasian Centre for Policing Research, 2004.

<sup>5</sup> National Drug Intelligence Center. *Yaba Fast Facts*. U.S. Department of Justice, 2003.

<sup>6</sup> National Drug Intelligence Center. *New Mexico Drug Threat Assessment*. U.S. Department of Justice, 2002.

<sup>7</sup> Scott, Michael. *Clandestine Drug Labs*. U.S. Department of Justice; 2002.

<sup>8</sup> Sevick, James R. *Precursor and essential chemicals in illicit drug production: approaches to enforcement*. U.S. Department of Justice, Office of Justice Programs, National Institute of Justice, 1993.

<sup>9</sup> Food and Drug Administration. *Legal requirements for the sale and purchase of drug products containing pseudoephedrine, ephedrine, and phenylpropanolamine*. U.S. Department of Health and Human Services, 2006.

## Effects of Methamphetamine Use

Methamphetamine is a powerful stimulant of the central nervous system that increases levels of dopamine in the brain. Methamphetamine causes a 300% greater increase in dopamine compared to cocaine, and can cause a high for 8 to 24 hours compared to 20 to 30 minutes for cocaine.<sup>10</sup> Short-term effects include increased heart rate and blood pressure, increased sensations of pleasure, reduced appetite, increased activity and sleeplessness. Overdose from extreme intoxication may result in a wide range of symptoms, such as heart arrhythmia or cardiac arrest, seizure, kidney failure, extreme fever, and stroke.

Methamphetamine has serious toxic effects on the body from regular long-term use. Methamphetamine users may lose their teeth abnormally quickly from a condition known as “meth mouth”. The condition is not thought to be caused by methamphetamine itself but a combination of chronic dry mouth, poor oral hygiene, and teeth grinding associated with long-term methamphetamine use.<sup>11</sup> Other long-term physical effects include permanent damage to blood vessels from prolonged elevated blood pressure and heart rate (leading to heart attacks or strokes), liver and kidney damage, and weight loss due to chronic malnutrition.

Chronic methamphetamine use has unique psychological effects on users. It is associated with “punding”, which is behavior characterized by an obsession with prolonged, compulsive, purposeless tasks such as assembling and disassembling, arranging, or sorting random household objects.<sup>12</sup> Another psychological symptom of methamphetamine abuse is known as “meth mites”, or the belief that one is infested with and being bitten by bugs. These delusions may cause users to repetitively pick at their skin resulting in scarring and skin infections.<sup>13</sup>



Other neurological effects of methamphetamine abuse include paranoia, hallucinations, anxiety, irritability and violence. However, only a small percentage of regular users develop full-blown psychosis requiring acute psychiatric care.<sup>14</sup> Long-term damage to the nervous system caused by methamphetamine abuse can lead to dyskinesia, or involuntary and uncontrollable muscle movements similar to Parkinson’s disease.<sup>15</sup>

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<sup>10</sup> Center for Disease Control and Prevention. *Methamphetamine Use and Risk for HIV/AIDS*. 2007.

<sup>11</sup> Clague, Jason, Thomas R. Belin, and Vivek Shetty. "Mechanisms Underlying Methamphetamine-Related Dental Disease." *Journal of the American Dental Association* 148.6 (2017): 377-386.

<sup>12</sup> Rusyniak, Daniel E. "Neurologic Manifestations of Chronic Methamphetamine Abuse." *Neurologic Clinics* 29.3 (2011): 641-55.

<sup>13</sup> Frieden, Joyce. "Skin Manifestations May Signal Crystal Meth Use." *Family Practice News* 36 (2006): 47.

<sup>14</sup> Shoptaw, Steven J., Uyen Kao, and Walter W. Ling. "Treatment for Amphetamine Psychosis." *Cochrane Database of Systematic Reviews*. 2008.

<sup>15</sup> Das, Aparna, Daniel Price, and Jeffrey Clothier. "Case Series: Choreoathetoid Movements Associated with Methamphetamine: A Case Report and Review of Literature." *American Journal on Addictions* 27.5 (2018): 364-367.

## Prevalence of and Trends in Methamphetamine Use and Overdose

In 2016, the National Survey on Drug Use and Health (NSDUH) began publishing national and state-level estimates of past year methamphetamine use among the population 12 and older (see Table 1). Methamphetamine use was higher for all age groups reported in New Mexico in 2017 than it was nationally. All age groups increased in past year methamphetamine use from 2016, with the largest increase among the population 26 and older. Nationally, methamphetamine use among this age group decreased, indicating that increases in use in New Mexico have occurred primarily among older populations compared to national trends.

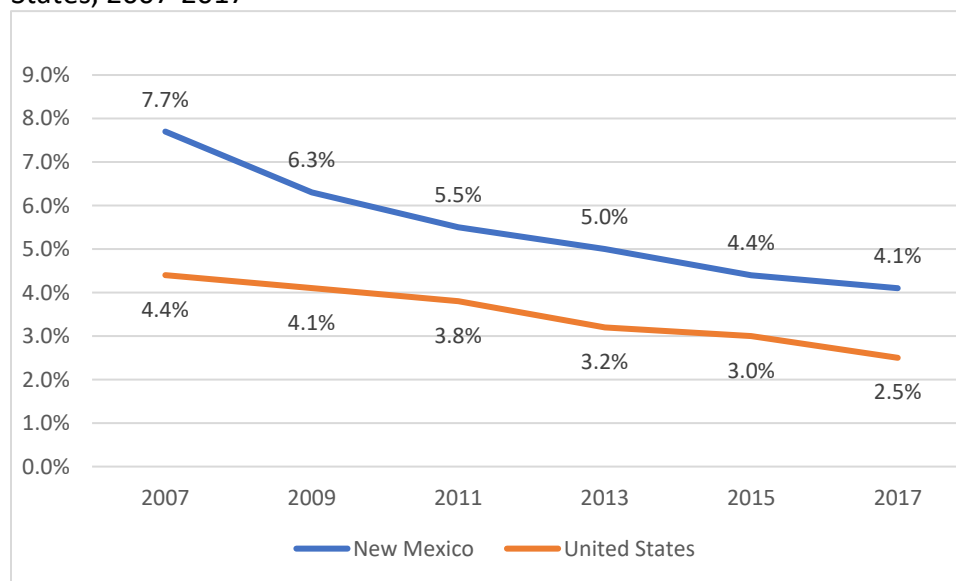
Table 1. Past Year Methamphetamine Use, New Mexico and United States, 2016-2017

	New Mexico			United States		
	2016	2017	Change from 2016	2016	2017	Change from 2016
12 to 17	0.27%	0.31%	15%	0.14%	0.16%	14%
18 to 25	2.01%	2.25%	12%	0.85%	0.93%	9%
26+	0.86%	1.12%	30%	0.58%	0.55%	-5%

Source: SAMHSA, National Survey of Drug Use and Health

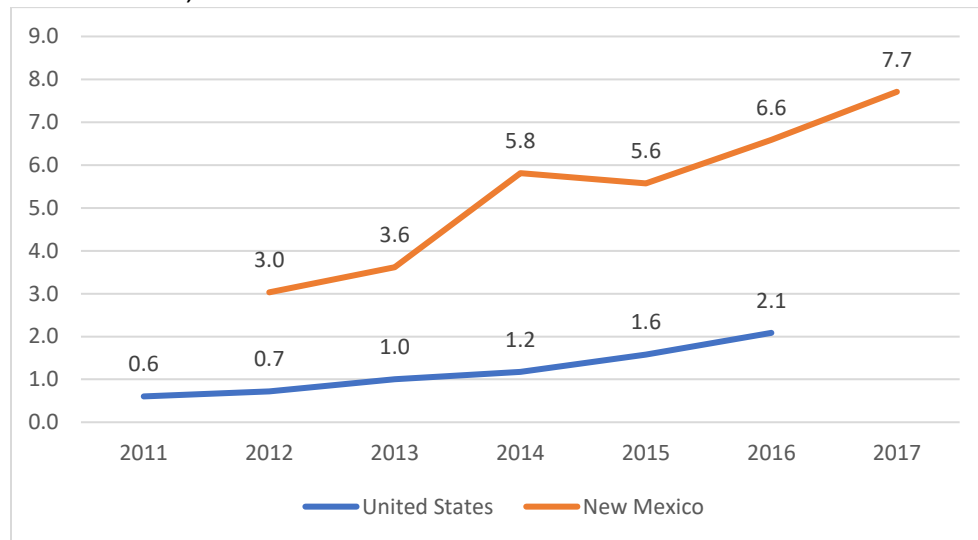
The data in Chart 1 support this conclusion. Both nationally and in New Mexico, lifetime methamphetamine use has decreased among high school students. Lifetime methamphetamine use among New Mexico high school students decreased by approximately 43% between 2007 and 2017, similar to a nationwide decline of 46%.

Chart 1. Lifetime Methamphetamine Use Among High School Students, New Mexico and United States, 2007-2017



Source: CDC, Youth Risk Behavior Surveillance System

Chart 2. Methamphetamine-Related Overdose Deaths per 100,000 population, New Mexico and United States, 2011-2017



Source: New Mexico Department of Health, Epidemiology and Response Division; CDC

Methamphetamine-related overdose deaths have increased sharply despite a reported decline in lifetime methamphetamine use in younger populations. Nationally, methamphetamine overdose deaths have tripled from 0.6 per 100,000 population in 2011 to 2.1 per 100,000 in 2016 (national data are not yet available for 2017). In New Mexico the rate is historically higher than the national average, and more than doubled between 2012 and 2017.

Recent research suggests methamphetamine use is surging particularly among chronic opioid users. Qualitative data suggests methamphetamine serves as an opioid substitute, and that to some extent limiting access to opioids may be associated with rising methamphetamine use.<sup>16</sup>

### Prevention and Treatment of Methamphetamine Use

Little research exists on strategies targeted specifically at methamphetamine use beyond school-based drug education programs and media campaigns.<sup>17</sup> Direct service programs such as the Strengthening Families Program have been shown to reduce methamphetamine use among adolescents.<sup>18</sup> Many studies have shown that treatment is effective, specifically the Matrix Model which combines cognitive-behavioral therapy, family education, social support, and individual counseling.<sup>19</sup> More research is needed on effective prevention, harm reduction, and treatment strategies specifically targeting methamphetamine use and overdose death as rates of use and overdose death continue to rise in New Mexico.

<sup>16</sup> Ellis, Matthew S., Zachary A. Kasper, and Theodore J. Cicero. "Twin Epidemics: The Surging Rise of Methamphetamine Use in Chronic Opioid Users." *Drug and Alcohol Dependence* 193 (2018): 14-20.

<sup>17</sup> Piper, B. "A Four-Pillars Approach to Methamphetamine: Policies for Effective Drug Prevention, Treatment, Policing and Harm Reduction." *Drug Policy* (2008): 2-24.

<sup>18</sup> Spoth, Richard L., et al. "Long-term Effects of Universal Preventive Interventions on Methamphetamine Use among Adolescents." *Archives of Pediatrics & Adolescent Medicine* 160.9 (2006): 876-882.

<sup>19</sup> King, Ryan S. *The Next Big Thing?: Methamphetamine in the United States*. The Sentencing Project, 2006.

# Substance Abuse Prevention for High-Risk Youth Populations



**New Mexico Statewide Epidemiological Outcomes Workgroup**

**White Paper Series**

June 20, 2019

*Produced by Coop Consulting, Inc. on behalf of the  
New Mexico Statewide Epidemiological Outcomes Workgroup*



**Mission** New Mexico’s Statewide Epidemiological and Outcomes Workgroup (SEOW) reviews and disseminates data about substance abuse and misuse and their consequences. It also identifies best practice information about evidence-based prevention strategies, policies and practices that can lead to successful outcomes for New Mexicans. The purpose of this two-fold work is to inform communities so that they can better target behaviors and risk factors that can be positively impacted by the implementation of well-chosen, evidence-based prevention approaches that are appropriate for the population. The important work of the SEOW is directed by the Office of Substance Abuse Prevention (Behavioral Health Services Division, New Mexico Human Services Department) and supported by federal funding from the Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration.

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## LGBTQ Youth

The following risk factors for substance use have been identified specifically for LGBTQ youth:

- **Bullying.** LGBTQ youth who are bullied in school are at a higher risk for drug and alcohol use than straight youth, while LGBTQ youth who aren't victimized are not at increased risk.<sup>1</sup>
- **Family rejection.** LGBTQ youth's risk of drug and alcohol use increases as their family's acceptance of their sexual or gender identity decreases.<sup>2</sup>

**Besides early exposure to drug/alcohol abuse and trauma, stigmatization around mental illness and substance dependence is the strongest predictor of adolescent substance abuse.**<sup>3</sup>

The following supports can help to mitigate the effects of these risk factors for substance use:

- **Caring adults.** Fewer LGBTQ youth feel supported by the adults at their school compared to heterosexual youth, but those who do feel supported by their teachers and administrators are no more likely to abuse drugs or alcohol than their heterosexual peers.<sup>4</sup>
- **School and home climate.** The presence of peer-support groups, the availability of counseling, and anti-bullying policies in school is associated with less victimization of LGBTQ youth.<sup>5</sup>
- **Opposing zero tolerance policies.** LGBTQ youth suffer disproportionate educational and criminal punishments not explained by greater engagement in substance abuse and criminal behavior.<sup>6</sup>

The following services are provided to help reinforce these supports in New Mexico:

- Equality New Mexico, through the New Mexico Safe Schools Initiative, facilitates trainings, workshops, and presentations in LGBTQ cultural competency, bullying and safe schools.<sup>7</sup>
- The Transgender Resource Center of New Mexico provides support, community, and connection to transgender people and their families through advocacy, education, and direct services.
- The Family Acceptance Project has strategies, resources and tools that can be used by health, social service, and school-based providers to increase accepting behaviors among families.<sup>8</sup>

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<sup>1</sup> Bontempo, Daniel E., and Anthony R. d'Augelli. "Effects of at-school victimization and sexual orientation on lesbian, gay, or bisexual youths' health risk behavior." *Journal of Adolescent Health* 30.5 (2002): 364-374.

<sup>2</sup> Ryan, Caitlin, et al. "Family acceptance in adolescence and the health of LGBT young adults." *Journal of Child and Adolescent Psychiatric Nursing* 23.4 (2010): 205-213.

<sup>3</sup> Fleury, Marie-Josée, et al. "Predictors of alcohol and drug dependence." *The Canadian Journal of Psychiatry* 59.4 (2014): 203-212.

<sup>4</sup> Darwich, Lina, Shelley Hymel, and Terry Waterhouse. "School avoidance and substance use among lesbian, gay, bisexual, and questioning youths: The impact of peer victimization and adult support." *Journal of Educational Psychology* 104.2 (2012): 381.

<sup>5</sup> Goodenow, Carol, Laura Szalacha, and Kim Westheimer. "School support groups, other school factors, and the safety of sexual minority adolescents." *Psychology in the Schools* 43.5 (2006): 573-589.

<sup>6</sup> Himmelstein, Kathryn EW, and Hannah Brückner. "Criminal-justice and school sanctions against nonheterosexual youth: A national longitudinal study." *Pediatrics* 127.1 (2011): 49-57.

<sup>7</sup> For more information, visit <http://eqnm.org/new-mexico-safe-schools-initiative>

<sup>8</sup> For more information, visit <https://familyproject.sfsu.edu/>

## Homeless Youth

The following risk factors for substance use have been identified specifically for homeless youth:

- **Street experiences.** A study examining the roles of family experiences and street experiences in substance abuse among homeless adolescents found that street victimization (defined as having been robbed, beaten, or sexually assaulted) was overwhelmingly the greatest predictor of substance abuse. The odds of street victimization for females were twice those for males.<sup>9</sup>
- **Deviant peers.** Homeless youth who reported to have peers who carried weapons or were recently incarcerated were more likely to report past 3-month drug use.<sup>10</sup>

The following supports can help to mitigate the effects of these risk factors for substance use:

- **Case management and therapy services.** A study of youth accessing services from nurses at a drop-in center in Santa Monica found significant reductions in substance abuse among those who also received therapy services through that location.<sup>11</sup>
- **Community reinforcement approach (CRA/CRAFT).** A study of youth accessing services at a drop-in center in Albuquerque found significantly greater reductions in substance abuse among youth offered CRA/CRAFT instead of regular case management services.<sup>12</sup>
- **Motivational interviewing.** Homeless adolescents recruited from drop-in centers who received one session of motivational interviewing reported reduced drug use at 1- follow ups, although the intervention did not have an effect at 3 months and did not affect alcohol use.<sup>13</sup>
- **Family preservation services.** A study of runaway youth randomly assigned to family therapy services instead of regular case management at a drop-in center in Albuquerque found greater reductions in substance abuse among those who received family therapy.<sup>14</sup>

Nationwide, approximately 40% of homeless youth identify as LGBTQ.<sup>15</sup> Homelessness coupled with the social isolation and rejection that many LGBTQ youth experience makes them at very high risk for substance abuse problems. Special considerations should be taken for this population, including ensuring safety and respect when accessing services. The National Alliance to End Homelessness has issued a set of best practices for working with LGBT homeless youth.<sup>16</sup>

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<sup>9</sup> Whitbeck, Les B., Danny R. Hoyt, and Wa-Ning Bao. "Depressive symptoms and co-occurring depressive symptoms, substance abuse, and conduct problems among runaway and homeless adolescents." *Child Development* 71.3 (2000): 721-732.

<sup>10</sup> Bousman, Chad A., et al. "Predictors of substance use among homeless youth in San Diego." *Addictive Behaviors* 30.6 (2005): 1100-1110.

<sup>11</sup> Nyamathi, Adeline, et al. "Impact of nursing intervention on decreasing substances among homeless youth." *The American Journal on Addictions* 21.6 (2012): 558-565.

<sup>12</sup> Slesnick, Natasha, et al. "Treatment outcome for street-living, homeless youth." *Addictive Behaviors* 32.6 (2007): 1237-1251.

<sup>13</sup> Peterson, Peggy L., et al. "Short-term effects of a brief motivational intervention to reduce alcohol and drug risk among homeless adolescents." *Psychology of Addictive Behaviors* 20.3 (2006): 254.

<sup>14</sup> Slesnick, Natasha, and Jillian L. Prestopnik. "Ecologically based family therapy outcome with substance abusing runaway adolescents." *Journal of Adolescence* 28.2 (2005): 277-298.

<sup>15</sup> Laura E. Durso and Gary J. Gates. *Serving Our Youth: Findings from a National Survey of Service Providers Working with LGBT Youth who are Homeless or At Risk of Becoming Homeless*. 2012.

<sup>16</sup> Lambda Legal. *National Recommended Best Practices for Serving LGBT Homeless Youth*. 2009.

## Foreign-Born Youth

*Size of the foreign-born population under 18 in New Mexico: 13,900 (2017 Census estimate)*

The majority of foreign-born youth in New Mexico are from Mexico and other Latin American countries. National peer-reviewed studies have repeatedly found generally lower substance use among foreign-born Hispanics compared to U.S.-born Hispanics.<sup>17</sup> However, there has been some research indicating that Hispanics who become more acculturated to American society develop rates of substance abuse at similar levels as U.S.-born Hispanics.<sup>18</sup> Furthermore, research indicates variation among Hispanic subgroups with regards to alcohol abuse, with native Puerto Ricans, Cubans, and South Americans in the U.S. having alcohol abuse rates similar to U.S. natives and Mexicans having the lowest rate.<sup>19</sup>

The underlying effect of acculturation status on substance abuse among foreign-born Hispanic youth has been a point of interest for researchers. Some have argued that higher levels of “frustrated social expectations” experienced by well-acculturated Hispanic youth place them at a higher risk of experiencing behavioral health problems. They argue this is due to “a loss of ethnic identity within their culture of origin, less social support from their families and friends, and lower socioeconomic status.”<sup>20</sup>

The fact that foreign-born youth in New Mexico have higher rates of substance abuse than the U.S.-born population raises some questions. Do foreign-born youth in New Mexico experience a greater number of traumatic events compared to U.S.-born New Mexican youth and/or foreign-born youth in other parts of the United States? How do they differ from U.S.-born New Mexican youth and/or foreign-born youth elsewhere with regards to place of origin, education level, immigration status, or acculturation status? Do they experience more stigma or marginalization within the school system compared to U.S.-born New Mexican youth?

There was little evidence found of prevention strategies specifically targeting foreign-born youth as a high-risk population as a result of the prevailing research finding lower substance use among foreign-born youth. A study of Familias Unidas, a Hispanic-specific, family-based substance abuse prevention intervention found that while it was effective at reducing youth substance use among U.S.-born Hispanics, it did not have any significant effect on foreign-born Hispanics, indicating that specifically tailored interventions may be needed for foreign-born youth.<sup>21</sup>

*The SEOW should discuss why patterns of greater substance abuse among foreign-born youth in New Mexico do not follow national trends of lower substance abuse among this population and identify the causes for this anomaly to better inform prevention efforts.*

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<sup>17</sup> Prado, Guillermo, et al. "What accounts for differences in substance use among US-born and immigrant Hispanic adolescents? Results from a longitudinal prospective cohort study." *Journal of Adolescent Health* 45.2 (2009): 118-125.

<sup>18</sup> Gfroerer, Joseph C., and Lucilla L. Tan. "Substance use among foreign-born youths in the United States: does the length of residence matter?." *American Journal of Public Health* 93.11 (2003): 1892-1895.

<sup>19</sup> Szaflarski, Magdalena, Lisa A. Cubbins, and Jun Ying. "Epidemiology of alcohol abuse among US immigrant populations." *Journal of Immigrant and Minority Health* 13.4 (2011): 647-658.

<sup>20</sup> De La Rosa, Mario. "Acculturation and Latino Adolescents' Substance Use: A Research Agenda for the Future." *Substance Use & Misuse* 37.4 (2002): 429-456.

<sup>21</sup> Cordova, David, et al. "Do the effects of a family intervention on alcohol and drug use vary by nativity status?" *Psychology of Addictive Behaviors* 26.3 (2012): 655.

## Disabled Youth

*Size of the disabled population under 18 years of age in New Mexico: 19,000 (2017 Census estimate)*

There are numerous factors that increase the risk for substance abuse among youth with disabilities:<sup>22</sup>

- Isolation due to an inability to participate in some social activities
- Inability to fully participate in school, leading to an abundance of idle time
- A greater likelihood of experiencing physical or sexual abuse
- Chronic pain or other health problems as a result of their disability
- Easy access to prescription drugs due to their disability
- Mental health problems resulting from pain, isolation, or trauma
- Difficulty accessing substance abuse prevention education and/or treatment

What can be done to better prevent and treat substance abuse disorders in disabled youth?

- **Screening for disability.** Substance use disorders can obscure a disability and vice versa. An initial screening for disability-related considerations along with substance use disorders when youth are accessing services can help identify potential barriers to treatment that arise from a disability and individuals with a substance use disorder who might not have been identified.
- **Making treatment accommodations.** Despite treatment programs being required to make accommodations to people with disabilities under the ADA, providers may be unprepared when first confronted with a person with a physical or cognitive disability. This may enable the person to use their disability to avoid treatment. CSAT has developed a series of treatment protocols for people with physical and cognitive disabilities.<sup>23</sup>

## Resources

The Substance Abuse Resources & Disability Issues (SARDI) Program at Wright State University has published two manuals addressing substance abuse prevention for people with disabilities:

*Alcohol, Tobacco and Other Drug Prevention Activities for Youth and Adults with Disabilities*

Substance abuse prevention activities for use in disability agencies or special education classrooms. This manual contains over 30 activities for use in schools and social service agencies. The 240-page manual includes an introduction to prevention, and guidelines for implementing activities.

*Substance Abuse Resources & Disability Issues Training Manual*

This manual was developed for anyone interested in learning about or teaching aspects of substance abuse prevention among persons with disabilities.

Available at: <https://medicine.wright.edu/sardi/materials>

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<sup>22</sup> Block, Pamela, et al. "Alcohol and Substance Use by Adolescents and Young Adults with Recent Spinal Cord and Traumatic Brain Injuries." *Disability Studies Quarterly* 21.2 (2001).

<sup>23</sup> Center for Substance Abuse Treatment. "Substance use disorder treatment for people with physical and cognitive disabilities." (1998).

# New Mexico Substance Use Epidemiology Profile

Substance Abuse Epidemiology Section  
Injury and Behavioral Epidemiology Bureau  
Epidemiology and Response Division  
New Mexico Department of Health

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## Statewide Epidemiological and Outcomes Workgroup (SEOW)

The Statewide Epidemiological and Outcomes Workgroup (SEOW) currently functions as a guiding body for all OSAP grant recipient prevention strategies in the state of New Mexico and as a platform for rich discussion, collaboration, and epidemiological data and information sharing at the state level and is a core component of the Partnerships for Success 2015 grant. Under the Strategic Prevention Framework State Incentive Grant from SAMHSA over a decade ago, the SEOW guided the development of the first New Mexico Substance Use Epidemiology Profile as part of its mission to create a focus on community-based and data-driven planning and accountability. The ongoing focus of the SEOW is the development and informed use of assessment data and indicators for use in community planning, prioritization, and evaluation and the support of evidence-based strategies, policies, and practices in all community prevention activity. The current membership of New Mexico SEOW includes representatives from BHSD: Dr. Wayne Lindstrom and Mika Tari. Community Members: Sharon Aguilar, Pamela Drake, Tanya Henderson, Athena Huckaby, and John Steiner. CYFD Children's Behavioral Health: Michael Hock. DFA DWI Program: Julie Krupcale. Evaluators: Ann Del Vecchio, Natalie Skogerboe, and Sindy Sacoman. NMDOH-ERD Injury and Behavioral Epidemiology Bureau: Jim Davis, Karen Edge, Ihsan Mahdi, Annaliese Mayette, Carol Moss, Hayley Peterson, Luigi Garcia Saavedra, and Chris Trujillo. NMHSD-BHSD Office of Substance Abuse Prevention: Karen Cheman, Anwar Walker, Antonette Silva-Jose, Heather Burnham, and Jay Quintana. NM Prevention Workforce Training System, Kamama Consulting: Paula Feathers. Pacific Institute for Research & Evaluation (PIRE): Liz Lilliott, Martha Waller, Kim Zamarin, Marissa Elias, and Lei Zhang; and, is coordinated and staffed by Michael Coop, Andrea Niehaus, Tina Ruiz, McKenzie Wannigman, and Tim Werwath of Coop Consulting, Inc.

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# INTRODUCTION

## New Mexico Substance Use Epidemiology Profile

The New Mexico Substance Use Epidemiology Profile is a tool for substance use prevention planners at the state, county, and community level. Its primary purpose is to support efforts related to the Statewide Epidemiological and Outcomes Workgroup (SEOW). The SEOW is intended to: develop resources to help communities conduct needs assessments regarding substance use and its consequences; build capacity to address those needs; and plan, implement, and evaluate evidence-based programs, policies, and practices designed to address the intervening variables related to identified substance-related problems. This document will be useful to those preparing proposals for funding and to program planners designing substance use prevention interventions. SEOW is funded by the New Mexico Human Services Department (NMHSD) Behavioral Health Services Division (BHSD) Office of Substance Abuse Prevention (OSAP) and the Substance Abuse and Mental Health Services Administration Center for Substance Abuse Prevention (SAMHSA-CSAP).

## Important Notes about Comparability to Previous Reports

This report is the ninth in a series that began with the New Mexico State Epidemiology Profile published in 2005, and continued with the publication of updates in 2010, 2011, 2013, 2014, 2016, February 2017, and November 2017. These reports are available at: <https://nmhealth.org/data/substance/>.

Important methodological changes have occurred over time. As a result, these reports may not be comparable with all others in the series, in several important ways. These changes and their impact on the comparability of reports in this series are described in more detail in a technical note at the end of this section. The following categories cannot be compared between the reports in this series:

- Death counts and/or rates for any *Alcohol-Related Death* indicators cannot be compared between the 2005 report and any later reports.

- Race/ethnicity reporting for indicators can be compared between the 2013 and subsequent reports but not to reports prior to 2013.

- Beginning with 2011 estimates, the Behavioral Risk Factor Surveillance System (BRFSS) updated its surveillance methods. Any shift in prevalence between 2010 and 2011 must be interpreted with caution, as it may be partially due to change in methods necessary to keep up with changes in cell phone use in the US and take advantage of improved statistical procedures.

- Data for risk behaviors (BRFSS-based) indicators have been aggregated for years 2015-2017, except for Adult Depression and Adult Drinking and Driving, which are not asked every year. These two indicators are reported on a single-year basis.

- Reports from 2005, 2010, and 2011 reflected a special *small numbers rule* specific to them. This rule, devised by SEOW during the design of the original 2005 report, suppressed the reporting of death rates for table cells based on fewer than two deaths per year. This rule was replaced by the standard *NMDOH small numbers rule* used in other NMDOH publications. This rule establishes suppression of reporting only for table cells based on three or fewer events coming from a population of fewer than 20 people.

- Opioid Overdose Related ED visits data cannot be compared to previous editions of the Substance Use Epidemiology Profile as the data source changed for the 2018 report. The 2018 report uses ED Syndromic Surveillance. Previous reports used the Annual ED data file.

## How to Use this Report

This report presents commonly used indicators of substance use in New Mexico. These indicators include outcome measures (e.g., alcohol-related death) reported in the *Consequences* section, mental health indicators associated with substance use (e.g., depression) in the *Mental Health* section, and consumption measures (e.g., self-reported substance use behavior from statewide surveys) reported in the *Consumption* section. The presentation of each major indicator includes: a text description of the major data findings; a detailed table with results by gender, age-group, and race/ethnicity; a table detailing county results by race/ethnicity; a bar chart and a map with rates for each New Mexico county; and additional charts illustrating other pertinent findings. There are also appendices that provide population denominators used in the calculation of death rates, substance use and mental health indicators from the National Survey on Drug Use and Health (NSDUH), and the International Classification of Diseases, Clinical Modification, 9th (ICD-9-CM) and 10th (ICD-10-CM) diagnosis codes used to produce indicators based on hospital data.

A combined five-year period is used when presenting deaths, emergency department visits, and hospital discharges. Combining counts over multiple years is necessary because in many New Mexico counties, there may be very few events (deaths, emergency department visits, or hospital discharges) due to a given cause in any given year. Combining counts over multiple years allows the calculation of rates that are more stable and, therefore, more meaningful than those calculated based on very few cases. In this report, death, emergency department visits, and hospitalization rates were calculated and reported for 2013-2017, the most current available five-year period.

## INTRODUCTION (continued)

### Use of this Report: The Problem Statements

This report presents considerable detail in the form of numbers, proportions, rates, and other statistical summaries; many of these can be found in tables and charts. This information is synthesized in *Problem Statements*, which provide a brief narrative overview of the data and detailed statistics. These *Problem Statements* are designed to help explain and frame the epidemiological data presented in each section of the report.

### Use of this Report: Tables and Charts

Each of the outcome indicators is presented with at least two tables. Table 1 for each indicator presents the number of events (deaths, emergency department visits, hospital discharges, or number of persons engaging in or experiencing a risk behavior) and their respective rates (or the weighted behavior prevalence rates) by sex, age-group (or grade in the case of Youth Risk and Resiliency Survey [YRRS] data), and race/ethnicity. In sections that report on causes of death, these tables include the number of deaths on the left side of the table and age-adjusted death rates per 100,000 population on the right side of the table. In sections that report on emergency department visits or hospital discharges, these tables include the number of emergency department visits or hospital discharges on the left side and age-adjusted rates per 100,000 population on the right side. For BRFSS-based indicators, these tables include an estimate of the number of persons engaging in or experiencing the risk behavior on the left side and the prevalence rate of the behavior in the population on the right side. For the aggregated indicators, the number of people was estimated by multiplying the percentage of persons engaging in or experiencing the risk behavior by the population estimate for the corresponding group. In sections that report specifically on youth risk behaviors, Table 1 includes only prevalence rates. These tables are very useful in determining the most important risk groups at the statewide level. Table 2 for each indicator presents results for each NM county by race/ethnicity. Again, the number of events are presented on the left side of the table and the age-adjusted rates on the right side of the table. These tables are useful in determining which counties have the most severe substance use issues and which racial/ethnic groups are at the highest risk within each county. Youth data are presented by county only.

Discussion of each indicator also includes a county bar chart that graphically presents age-adjusted death rates (or weighted behavior prevalence rates) for each NM county in descending order. Adjacent to each county name on the left side of the chart, the number of events occurring (or the estimated number of persons engaging in or experiencing the behavior) in the county and the percent of NM events occurring (or the weighted percent of New Mexicans engaging in or experiencing the behavior) in each county are presented. Counties with the highest rates are easily identified at the top of the chart, while counties with low rates are at the bottom. The state rate is depicted with a darker colored bar, and for most indicators, the most recent available US rate is also included, depicted with a cross-hatched bar, making it easy to compare the county rate to the state and national rate in each instance.

Finally, maps showing rates by county have been included for each indicator. The counties have been categorized and shaded according to the county rates. Map shading categories have been chosen to identify counties that have rates lower than the state rate, counties that have rates somewhat higher than the state rate, and counties that have rates substantially higher than the state rate. The latter category (corresponding to the darkest-shaded counties) represent rates that are higher than the state rate by a selected amount. For maps based either on death or hospital-related event rates, this amount corresponds to rates that are 50% or higher than the state rate; for those based on behavioral data (BRFSS or YRRS), this amount corresponds to rates that are 25% higher than the state rate.

### Use of this Report: Rates and Numbers

Both rates and the numbers of events are presented in the tables and charts of this report. While the rates are very important for indicating the degree of an issue in a given county or population group, they only provide part of the picture needed for comparing the burden of a problem from one county or group to another. The number of events also needs to be considered when making planning decisions. For example, Rio Arriba County has an alcohol-related death rate (139.4 per 100,000 population) more than twice that of Bernalillo County (59.0 per 100,000 population). However, the number of alcohol-related deaths in Bernalillo County (2,139) is over seven times the number in Rio Arriba County (278). While the problem is more severe in Rio Arriba County (reflected in higher rate), Bernalillo County bears a larger proportion of the statewide burden (31.5% of all alcohol-related deaths in the state compared to 4.1% for Rio Arriba County). When prioritizing the distribution of resources and selecting interventions, it is important to look at both the total number of deaths and the death rate. Because of its extremely high rate of alcohol-related deaths, interventions that address this problem are very important in Rio Arriba County. At the same time, Bernalillo County is also very important when considering interventions because it bears much of the statewide burden of alcohol-related deaths.

## INTRODUCTION (continued)

### Use of this Report: Why are some rates missing from the tables?

For survey-based measures of risk behaviors (i.e., BRFSS and YRRS), rates based on fewer than 50 respondents for a given table cell have been removed from this report. While prevalence estimates can be calculated based on very small numbers of respondents, estimates based on fewer than 50 respondents can be unstable and are often misleading. Such estimates are of questionable value for planning purposes and have been excluded from this report.

Morbidity and mortality numbers and rates are not reported when the number of events are three or less with a denominator (population) of less than twenty, in accordance with the *NMDOH small numbers rule* (<https://ibis.health.state.nm.us/view/docs/Standards/NMSmallNumbersRule2006.pdf>).

Although not suppressed, mortality and morbidity rates calculated with less than ten events (numerator) should be considered unstable. When rates are calculated using small numbers of events, rates can vary widely from one reporting to the next for reasons different from actual changes in the frequency of occurrence of the events measured.

Specifically, for indicators using Emergency Department Data (EDD) or Hospital Inpatient Discharge Data (HIDD), missing rates correspond to events for which data on race-ethnicity, sex, or county of residence were missing. Although these events are included in the total count of events for NM, rates cannot be calculated and are, therefore, not reported. Footnotes on the corresponding tables for these indicators will refer to the number of events missing. EDD and HIDD indicators have been produced by searching for specific diagnostic codes on these datasets. For EDD, all diagnosis fields have been used (thus, the inclusion of the word 'Related' in the name of the indicator). For HIDD, only the main diagnosis was used. The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) and ICD-10-CM codes used are listed in Appendix 4.

### Other Data Resources

The data presented here come from various sources. Other valuable publications have been written utilizing these data sources. The New Mexico Substance Use Epidemiology Profile should be seen as complementary to these other publications, and program planners will want to refer to these other documents for additional information. These publications include:

- **Other reports produced by the Substance Abuse Epidemiology Section (SAES)**, Injury and Behavioral Epidemiology Bureau (IBEB), Epidemiology and Response Division (ERD), New Mexico Department of Health (NMDOH).  
Available online at:  
<http://nmhealth.org/about/erd/ibeb/sap/>
- **New Mexico Behavioral Risk Factor Surveillance System (BRFSS) reports**, produced by the Survey Section, IBEB-ERD-NMDOH.  
Available online at:  
<https://nmhealth.org/about/erd/ibeb/brfss/>
- **New Mexico Youth Risk and Resiliency Survey (YRRS) reports**, produced by NMDOH, NM Public Education Department, and the UNM Prevention Research Center.  
Available online at:  
<https://nmhealth.org/about/erd/ibeb/yrrs/>
- **Emergency Department Data (EDD) Syndromic Surveillance**, produced by the Health Systems Epidemiology program, ERD-NMDOH  
Available online at:  
<http://nmhealth.org/about/erd/hsep/edd/>
- **Hospital Inpatient Discharge Data (HIDD) Annual Reports**, produced by the Health Systems Epidemiology program, ERD-NMDOH  
Available online at:  
<http://nmhealth.org/about/erd/hsep/hidd/>

## INTRODUCTION (continued)

### Technical Note: Methodological Changes since Previous Reports

#### Changes to the Definition of Alcohol-Related Death

In 2013, the Centers for Disease Control and Prevention (CDC) updated the Alcohol-Related Disease Impact (ARDI) Alcohol-Attributable Fractions (AAFs), which are central to the estimation of alcohol-related deaths and alcohol-related death rates in this report (<https://www.cdc.gov/alcohol/announcement.html>). The updated AAFs were implemented in the 2015 and subsequent reports. The key difference between the updated CDC's ARDI AAFs used in the 2015 and subsequent reports and the AAFs used in previous reports is that the age-specific AAFs for alcohol-attributable motor-vehicle traffic crashes have been updated.

The AAFs are the proportion of a given cause of death that can be attributed to excessive alcohol use. The CDC ARDI AAFs are the standard AAFs recommended for use by the CDC. These AAFs were first reported in Midanik, L., Chaloupka, F., Saitz, R., Toomey, T., Fellows, J., Dufour, M., Landen, M., Brounstein, P., Stahre, M., Brewer, R., Naimi, T., & Miller, J. (2004). Alcohol-attributable deaths and years of potential life lost - United States, 2001. *Morbidity and Mortality Weekly Report*, 53[37]:866-870). The ARDI AAFs are further described on the CDC website: ([http://nccd.cdc.gov/DPH\\_ARDI/default/Default.aspx](http://nccd.cdc.gov/DPH_ARDI/default/Default.aspx)).

#### Changes to Race/Ethnicity Categories

The original 2005 report in this series used the National Center for Health Statistics (NCHS) standard race/ethnicity categories for reporting by race/ethnicity. These NCHS standard race/ethnicity categories break out Hispanic for each race category (e.g., White, Black, etc.) and combine the Hispanic portion of each race category (e.g., White Hispanic, Black Hispanic, etc.) when reporting the Hispanic category.

The 2010 report implemented new race/ethnicity reporting standards used by NMDOH for all indicators except those based on the YRRS. These NMDOH standard race/ethnicity categories report only the White Hispanic category as Hispanic; and report the Hispanic subset of other race groups (e.g., Black Hispanic) in the corresponding race category (e.g., Black). The 2011 report implemented the NMDOH race/ethnicity reporting categories for all YRRS-based indicators as well.

In 2012, NMDOH adopted a new standard for reporting race/ethnicity. The New Mexico reporting standard uses the estimates by bridged race and Hispanic ethnicity. Presentation of race and ethnicity will be done together in the same table. Race/ethnicity will be viewed as a single social and cultural construct. Persons designated as Hispanic ethnicity, regardless of race, will be categorized as 'Hispanic.' Persons not designated as Hispanic will be categorized by their single race ('Black or African American,' 'American Indian or Alaska native,' 'Asian or Pacific Islander,' 'White,' or 'Other'). For more information, refer to the *NMDOH Guidelines for Race/Ethnicity Data* at: [https://ibis.health.state.nm.us/docs/Standards/Race\\_Guidelines.pdf](https://ibis.health.state.nm.us/docs/Standards/Race_Guidelines.pdf). These changes in the race/ethnicity categories make the 2013 and subsequent reports' counts and rates by race/ethnicity comparable to each other but not comparable to all previous reports.

#### Changes to the Emergency Department Data

In this report, Emergency Department (ED) Syndromic Surveillance was used instead of the Annual ED data file. Syndromic Surveillance is the near-real time data collection of emergency department visits in New Mexico. Patient level information per the observations are updated daily as data is continuously being received. Case identification in the syndromic surveillance database may be queried by chief complaints and discharge diagnoses; although, the cases identified in this report relied solely on the discharge diagnoses codes as indicators of drug-related cases.

During the time period of the data in the report (2013-2017), the number of participating emergency departments participating in Syndromic Surveillance Reporting expanded greatly.

#### Changes to the NSDUH Questionnaire and data collection:

In 2015, a number of changes were made to the NSDUH questionnaire and data collection procedures resulting in the establishment of a new baseline for a number of measures. Therefore, estimates for several measures included in prior reports are not available. For details, see Section A.6 of the "2015-2016 NSDUH: Guide to State Tables and Summary of Small Area Estimation Methodology" at: <https://www.samhsa.gov/data/report/2015-2016-nsduh-guide-state-tables-and-summary-sae-methodology>

# EXECUTIVE SUMMARY

## Consequences of Substance Use

### Introduction

All of the ten leading causes of death in New Mexico are, at least partially, attributable to the use of alcohol, tobacco, or other drugs. In 2016, the ten leading causes of death in New Mexico were diseases of the heart, malignant neoplasms, unintentional injuries, chronic lower respiratory diseases, cerebrovascular diseases, diabetes, Alzheimer's disease, chronic liver disease and cirrhosis, suicide, and influenza and pneumonia. Of these, chronic liver disease, unintentional injuries, and suicide are associated with alcohol use; chronic lower respiratory diseases and influenza and pneumonia are associated with tobacco use; heart disease, malignant neoplasms, and cerebrovascular diseases are associated with both alcohol and tobacco use; and unintentional injuries and suicide are associated with the use of other drugs.

### Alcohol-Related Deaths and Hospitalizations

Over the past 30 years, New Mexico has consistently had among the highest alcohol-related death rates in the United States, and it has had the highest alcohol-related death rate since 1997. The negative consequences of excessive alcohol use in NM are not limited to death but also include domestic violence, crime, poverty, and unemployment, as well as chronic liver disease, motor vehicle crash and other injuries, mental illness, and a variety of other medical problems. In 2010, the economic cost of excessive alcohol consumption in New Mexico was \$2.2 billion (\$2.77 per drink or an average of \$1,084 per person) (Sacks, Jeffrey J., et al. "2010 national and state costs of excessive alcohol consumption." *American Journal of Preventive Medicine* 49.5 (2015): e73-e79).

Death rates from alcohol-related causes increase with age. However, one in five deaths among working age adults (20-64) in NM is attributable to alcohol. Male rates are substantially higher than female rates. American Indians had higher alcohol-related death rates than other race/ethnicities. McKinley and Rio Arriba counties had extremely high alcohol-related death rates, driven by high rates in the American Indian and Hispanic male populations. The counties with the most deaths for the five-year period of 2013-2017 were Bernalillo, McKinley, San Juan, Dona Ana, and Santa Fe. New Mexico has extremely high death rates due to both alcohol-related chronic diseases and alcohol-related injuries.

- Alcohol-Related Chronic Disease Death. NM's rate of death due to alcohol-related chronic diseases was more than twice the national rate. Death rates increase with age. American Indians, both male and female, and Hispanic males have extremely high rates. As with total alcohol-related death, McKinley and Rio Arriba counties had the highest rates in the state.

- Alcohol-related chronic liver disease (AR-CLD) accounts for the most deaths due to alcohol-related chronic disease. AR-CLD death rates are extremely high among American Indians, both male and female, and Hispanic males. The high rates among American Indians and Hispanic males between the ages of 35 and 64 represent a tremendous burden in terms of years of potential life lost (YPLL). While Bernalillo County had the highest number of deaths due to AR-CLD (677 for the years 2013-2017), two counties that stand out for their very high rates were McKinley and Rio Arriba, which had rates that were more than six times the national rate.

- Chronic liver disease hospitalizations (CLD-HIDD) can provide information on CLD risk at an earlier time point in the disease's development than AR-CLD mortality, and the number of emergency department visits can be used as a measure of the impact of CLD on the medical system. Women are at lower risk than men. Women who identify as Asian or Pacific Islander have the lowest rates whereas men who identify as American Indian have the highest rates. McKinley County had the highest rate of CLD-HIDD, followed by Rio Arriba, Cibola, Sierra, and Luna. De Baca and Eddy counties had the lowest rates. It is important to note that hospitalizations from federal facilities (e.g. Indian Health Services and Veterans Administration) are not included in these results.

- Alcohol-Related Injury Death. NM's rate of alcohol-related injury death was approximately 1.4 times the national rate. In the current reporting period (2013-2017), drug overdose surpassed alcohol-related motor vehicle traffic crashes and falls as the leading cause of alcohol-related injury death. Numerous other types of injury death are also associated with excessive alcohol use (particularly binge drinking). Deaths from drug overdose, a portion of which are partially attributable to alcohol, have increased substantially in recent years. Males are more at risk for alcohol-related injury death than females with American Indian males having particularly elevated risk.



## EXECUTIVE SUMMARY (continued)

### Consequences of Substance Use (continued)

New Mexico's alcohol-related motor vehicle traffic crash (AR-MVTC) death rate has decreased substantially over the past 30 years. After substantial declines during the 1980s and 1990s, NM's rate stagnated for almost ten years. However, a comprehensive program to prevent driving while intoxicated (DWI) initiated in 2004, resulted in substantial rate declines, particularly during the period 2005-2008. Nonetheless, rate disparities remain; both male and female American Indians have elevated rates, especially among middle age males (age 25-64). Mora, McKinley, Catron, Guadalupe, and Cibola were the counties with the highest alcohol-impaired motor vehicle traffic crash (AI-MVTC) death rates. However, Mora, Catron, and Guadalupe counties had low numbers of deaths, whereas McKinley County had the third highest number of deaths behind Bernalillo and San Juan counties.

#### Smoking-Related Death

Historically, New Mexico has had one of the lowest smoking-related death rates in the nation. Nonetheless, New Mexico's burden of death associated with smoking is considerably greater than the burden associated with alcohol and other drugs. Among all racial/ethnic groups, males have higher smoking-related death rates than females. Among both males and females, Whites have the highest rates, followed by Blacks. The counties with the highest rates and relatively heavy burdens of smoking-related death (i.e., 20 or more deaths a year) were Sierra, De Baca, Luna, Quay, Torrance, Eddy, and Lea. The high rates in most of these counties, and in the state overall, were driven by high rates among Whites.

#### Drug Overdose Death

In 2017, New Mexico had the seventeenth highest drug overdose death rate in the nation. The consequences of drug use continue to burden New Mexico communities. Drug overdose death rates remained higher for males than for females. The highest drug overdose death rate was among Hispanic males. Rio Arriba County had the highest drug overdose death rate in the state. Bernalillo County continued to bear the highest burden of drug overdose death in terms of total numbers of deaths. Unintentional drug overdoses account for 88% of drug overdose deaths. The most common drugs causing unintentional overdose death for the period covered in this report were prescription opioids (i.e., methadone, oxycodone, morphine; 57%), heroin (40%), benzodiazepines (24%), cocaine (13%), and methamphetamine (26%) (not mutually exclusive). In New Mexico and nationally, overdose death from opioids has become an issue of enormous concern as these potent drugs are widely available.

Opioid overdose related emergency department (OOR-ED) visits increased 98.4% in the US between 2004 and 2009. In NM, between 2013 and 2017, ED visits increased by 51%. Male rates of OOR-ED visits were higher compared to female rates. For both groups, Blacks and Hispanics had higher rates compared to other racial/ethnic groups. Rio Arriba County had the highest rate of OOR-ED visits during 2013-2017 with 155.3 OOR-ED visits per 100,000 population.

## Suicide and Mental Health

#### Suicide and Mental Health

Suicide is a serious and persistent public health problem in New Mexico. Over the period 1981 through 2010, New Mexico's suicide rate was consistently among the highest in the nation, at 1.5 to 1.9 times the US rate. Male suicide rates were around three times higher than those of females across all racial/ethnic groups, except Asian/Pacific Islanders and Blacks. For the five-year period 2013-2017, all but eleven counties had suicide rates that were at least one and a half times higher than the most recent available US rate.

Indicators in this report also document: the prevalence of frequent mental distress and current depression among New Mexico adults; persistent sadness or hopelessness, suicidal ideation, and suicide attempt among New Mexico youth; and the association between risk and resiliency factors and substance abuse and mental health indicators among New Mexico youth.

## EXECUTIVE SUMMARY (continued)

### Alcohol, Tobacco, and Other Drug Consumption Behavior

Substance use behaviors are important to examine not only because substance use can lead to very negative consequences in the short-term, but also because substance use can have long-term negative consequences. For example, while drinking by youth is a behavior that can lead directly to alcohol-related injury or death, it can also lead to very serious consequences in adulthood, ranging from alcohol abuse or dependence to a variety of diseases associated with chronic heavy drinking.

#### Substance Use Indicators included in this Report

- **Adult Binge Drinking.** Binge drinking (defined as drinking five or more drinks on a single occasion for men, or four or more drinks on a single occasion for women) is associated with numerous types of injury death, including motor vehicle traffic crash fatalities, drug overdose, falls, suicide, and homicide. Among adults (age 18 or over) of all ethnicities, binge drinking was more commonly reported by males than females, mirroring higher rates of alcohol-related injury death among males. Among males, Hispanics were more likely to report binge drinking than other race/ethnicities. Young adults (age 18-24) were more likely than other age groups to report binge drinking.

- **Youth Current Drinking.** Any alcohol consumption by a person under the age of 21 is considered to be excessive drinking. Alcohol is the most commonly used drug among youth in New Mexico, more than tobacco or other drugs. However, contrary to common perception, most high school students do not drink. In 2017, 26.2% of high school students reported that they were current drinkers. This is a significant decrease from 43.3% in 2005.

- **Youth Binge Drinking.** Youth binge drinking has significantly decreased over the last decade. In 2017, New Mexico public high school students were less likely to report binge drinking than US high school students. Among New Mexico high school students, binge drinking was more commonly reported by upper grade students than lower grade students. There was no significant difference in the binge drinking rate between male and female high school students. Binge drinking rates were lower among American Indian youth than other racial/ethnic groups.

- **Youth Having Ten or More Drinks.** On average, underage drinkers consume more drinks per drinking occasion than adult drinkers and risk of harm increases as the number of drinks consumed on an occasion increases. Students in the 12th grade are more likely to drink ten or more drinks on an occasion than 9th grade students. In 2017, boys and girls did not have significantly different rates of drinking ten or more drinks on an occasion.

- **Adult Heavy Drinking.** In NM, between 2015-2017, adult heavy drinking (defined as drinking, on average, more than two drinks per day for men or more than one drink per day for women) was less commonly reported (5.2%) than in the rest of the nation in 2016 (6.5%). Heavy drinking was more prevalent among middle-aged (age 25-64) adults, with 5.7% reporting past-month heavy drinking. New Mexico men were almost 1.4 times more likely to report chronic drinking than women (5.9% v. 4.4%).

- **Adult Drinking and Driving.** In 2016, adult past-30-day drinking and driving was reported in New Mexico by 1.0% of adults aged 18 and over. Past-30-day drinking and driving was more prevalent among young (age 18-24) and middle-age (age 25-64) adults than among older adults (age 65+). New Mexico men were twice as likely to report drinking and driving than women (1.9% v. 0.8%). Hispanic males (2.7%) were more likely to report drinking and driving than American Indian (1.8%) and White (1.2%) males.

- **Youth Drinking and Driving.** In 2017, New Mexico high school students were more likely to report driving after drinking alcohol than other US students (6.5% v. 5.5%). Driving after drinking was more common among boys than girls and was less common among White and American Indian youth than among other racial/ethnic groups. Twelfth grade students were more likely to report drinking and driving than ninth and tenth grade students.

## EXECUTIVE SUMMARY (continued)

### Alcohol, Tobacco, and Other Drug Consumption Behavior (continued)

- Youth Drug Use. In 2017, past-30-day marijuana and methamphetamine use were more prevalent among New Mexico students than among US students. The use of marijuana was more commonly reported by American Indian students than by students in other racial/ethnic groups. Asian or Pacific Islander students were more likely to report past-30-day use of cocaine, painkillers, heroin, methamphetamine, and inhalants than students of other racial/ethnic groups.

- Adult Tobacco Use. Between 2015-2017, the prevalence of adult smoking was slightly higher for New Mexico compared to the 2016 US estimates (17.2% vs. 17.0% respectively). Smoking was most prevalent among middle-aged groups and was more common among men than women for all age categories.

- Youth Tobacco Use. In 2017, smoking was more prevalent among New Mexico high school students (10.6%) than in the nation overall (8.8%). New Mexico boys were more likely than girls to report current smoking (11.9% vs. 9.0%). Black (8.8%), White (9.7%) and Hispanic (10.7%) students had lower rates of current cigarette smoking than American Indian (12.6%) and Asian or Pacific Islander (12.0%) students.

### Data Sources

National/New Mexico population data, 1981-1989: U.S. Census Bureau. Estimates of the Population of States by Age, Sex, Race, and Hispanic Origin: 1981 to 1989. Available from: <http://www.census.gov/programs-surveys/popest/data/data-sets.1980.html> as of October 12, 2018.

National/New Mexico population data, 1990-1999: U.S. Census Bureau. Estimates of the Population of States by Age, Sex, Race, and Hispanic Origin: 1990 to 1999, Internet Release Date August 30, 2000. Available from: <http://www.census.gov/programs-surveys/popest/data/data-sets.1990.html> as of October 12, 2018.

National population data, 2000-2010: National Center for Health Statistics (NCHS). Intercensal estimates of the resident population of the United States for July 1, 2000-July 1, 2010, by year, county, age, bridged race, Hispanic origin, and sex. Available from: <http://www.census.gov/programs-surveys/popest/data/data-sets.2000.html> as of October 12, 2018.

New Mexico population data, 2000-2017: University of New Mexico (UNM), Geospatial and Population Studies (GPS). Annual Estimates of the Population of New Mexico by County, Age, Sex, Race, and Hispanic Origin, 2000 to 2017 (8/24/2018 update).

National death data: National Center for Health Statistics (NCHS). Multiple Cause-of-Death files, 1981-2017, machine readable data files and documentation. National Center for Health Statistics, Hyattsville, Maryland. Available from: [http://www.cdc.gov/nchs/data\\_access/VitalStatsOnline.htm#Mortality\\_Multiple](http://www.cdc.gov/nchs/data_access/VitalStatsOnline.htm#Mortality_Multiple). Death rates were calculated by the New Mexico Department of Health (NMDOH), Epidemiology and Response Division (ERD), Injury and Behavioral Epidemiology Bureau (IBEB), Substance Abuse Epidemiology Section (SAES).

New Mexico death data: New Mexico Department of Health, Epidemiology and Response Division, Bureau of Vital Records and Health Statistics (BVRHS). Death rates were calculated by the New Mexico Department of Health, Epidemiology and Response Division, Injury and Behavioral Epidemiology Bureau, Substance Abuse Epidemiology Section.

National/New Mexico motor vehicle traffic crash fatality data: National Highway Traffic Safety Administration (NHTSA), Fatality Analysis Reporting System (FARS).

(1) VMT reporting: Fatalities, Fatalities in Crashes by Driver Alcohol Involvement, Vehicle Miles Traveled (VMT), and Fatality Rate per 100 Million VMT, by State, 1982-2016. Report provided by NHTSA National Center for Statistics and Analysis, Information Services Team. 2008-2016 death rates per 100 Million VMT calculated by the New Mexico Department of Health, Epidemiology and Response Division, Injury and Behavioral Epidemiology Bureau, Substance Abuse Epidemiology Section.

## EXECUTIVE SUMMARY (continued)

### Data Sources (continued)

(2) Per 100,000 population reporting: Persons killed, by state and Highest Driver Blood Alcohol Concentration (BAC) in Crash - State: USA, Year. Available from: <https://www-fars.nhtsa.dot.gov/States/StatesAlcohol.aspx>. Death rates were calculated by the New Mexico Department of Health, Epidemiology and Response Division, Injury and Behavioral Epidemiology Bureau, Substance Abuse Epidemiology Section.

New Mexico Emergency Department Visits: New Mexico Department of Health, Epidemiology and Response Division, Health Systems Epidemiology Unit. Visit rates were calculated by the New Mexico Department of Health, Epidemiology and Response Division, Injury and Behavioral Epidemiology Bureau, Substance Abuse Epidemiology Section

New Mexico Hospital Inpatient Discharges: New Mexico Department of Health, Epidemiology and Response Division, Health Systems Epidemiology Unit. Discharge rates were calculated by the New Mexico Department of Health, Epidemiology and Response Division, Injury and Behavioral Epidemiology Bureau, Substance Abuse Epidemiology Section

National adult behavioral data: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Adult and Community Health. Behavioral Risk Factor Surveillance System Online Prevalence Data, 1995-2016. Available from: [http://www.cdc.gov/brfss/data\\_tools.htm](http://www.cdc.gov/brfss/data_tools.htm) as of October 12, 2018.

New Mexico adult behavioral data: New Mexico Department of Health, Epidemiology and Response Division, Injury and Behavioral Epidemiology Bureau, Survey Unit. New Mexico Behavioral Risk Factor Surveillance System (BRFSS). More reporting available from: <https://nmhealth.org/about/erd/ibeb/brfss/> as of October 12, 2018.

National youth behavioral data: Centers for Disease Control and Prevention (CDC). Surveillance Summaries, June 8, 2012. MMWR. 2012;61(SS-4). More reporting available from: <http://www.cdc.gov/HealthyYouth/yrbs/index.htm> as of October 12, 2018.

New Mexico youth behavioral data: New Mexico Department of Health, Epidemiology and Response Division, Injury and Behavioral Epidemiology Bureau, Survey Unit; and the New Mexico Public Education Department, School and Family Support Bureau. New Mexico Youth Risk and Resiliency Survey (YRRS). More reporting available from: [www.youthrisk.org](http://www.youthrisk.org) as of October 12, 2018.

New Mexico substance use disorder and mental health data: Substance Abuse and Mental Health Services Administration, Office of Applied Studies. Sub-state Estimates from the 2014-2016 National Surveys on Drug Use and Health and Statewide Estimates from 2015-2016. Available from: <https://www.samhsa.gov/data/nsduh/2014-2016-substate-reports>, <https://www.samhsa.gov/data/nsduh/state-reports-NSDUH-2016>  
More reporting available from: <https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health> as of September 26, 2018



## Section 1

### Consequences



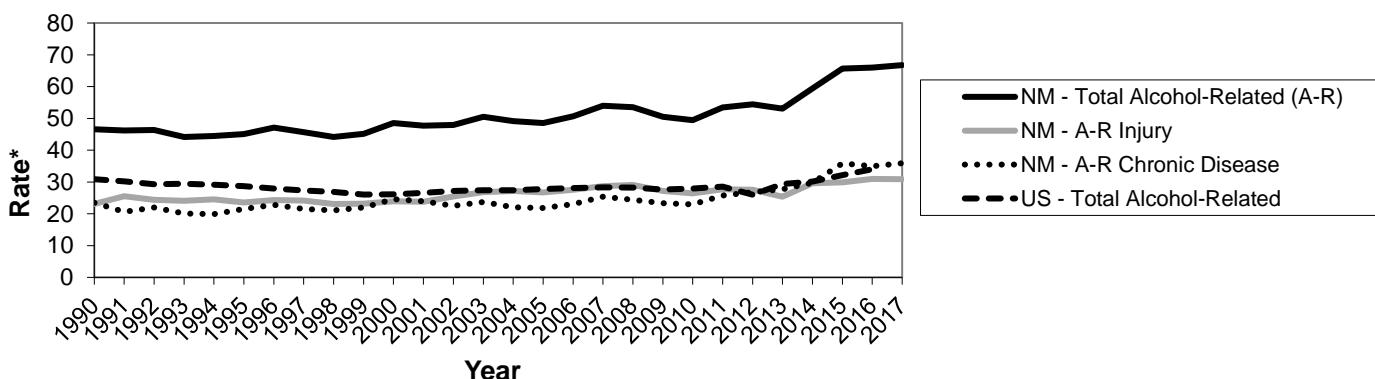
# ALCOHOL-RELATED DEATH

## Problem Statement

The consequences of excessive alcohol use are severe in New Mexico. New Mexico's total alcohol-related death rate has ranked first, second, or third in the US since 1981; and 1st for the period 2006 through 2010 (Stahre M, etal. Contribution of Excessive Alcohol Consumption to Deaths and Years of Potential Life Lost in the United States. Preventing Chronic Disease. 2014;11:E109. doi:10.5888/pcd11.130293). The negative consequences of excessive alcohol use in New Mexico are not limited to death but also include domestic violence, crime, poverty, and unemployment, as well as chronic liver disease, motor vehicle crash and other injuries, mental illness, and a variety of other medical problems. Nationally, one in ten deaths among working age adults (age 20-64) is attributable to alcohol. In New Mexico this ratio is one in five deaths.

Chart 1 shows the two principal components of alcohol-related death: deaths due to chronic diseases (such as chronic liver disease), which are strongly associated with chronic heavy drinking; and deaths due to alcohol-related injuries, which are strongly associated with binge drinking. Each category will be considered in more detail later in this report. New Mexico's total alcohol-related death rate increased 16% from 1990 through 2012, driven by a 19% increase in alcohol-related injury death rates from 2001 through 2012. By contrast, the US alcohol-related death rate decreased 8% from 1990 through 2011. Although the alcohol-related chronic disease death rate has remained fairly stable from 1990 to 2009 in NM, from 2010 to 2017 there has been a 56% increase in the alcohol-related chronic disease death rate.

**Chart 1: Alcohol-Related Death Rates\*, New Mexico and United States, 1990-2017**



\*US data are available up to 2016

\* Rate per 100,000, age-adjusted to the 2000 US standard population

Sources: NMDOH BVRHS death files and UNM-GPS population files (NM); NCHS death and population files (US); CDC ARDI; SAES

**Table 1: Alcohol-Related Deaths and Rates\* by Age, Sex, and Race/Ethnicity, New Mexico, 2013-2017**

Sex	Race/Ethnicity	Deaths				Rates*			
		Ages 0-24	Ages 25-64	Ages 65+	All Ages	Ages 0-24	Ages 25-64	Ages 65+	All Ages*
Male	American Indian	50	767	87	904	26.0	335.8	238.9	218.9
	Asian/Pacific Islander	2	12	4	18	6.2	27.6	55.7	24.1
	Black	7	61	17	84	15.1	91.3	142.4	70.3
	Hispanic	174	1,476	367	2,016	16.5	121.3	152.2	88.4
	White	65	1,018	514	1,598	13.2	94.7	111.9	64.0
	Total	298	3,356	999	4,653	16.4	127.5	132.1	87.8
Female	American Indian	21	375	75	470	11.0	149.8	140.2	102.0
	Asian/Pacific Islander	1	7	2	10	2.4	12.7	14.4	10.0
	Black	2	20	4	26	5.1	42.2	32.5	26.1
	Hispanic	52	509	222	783	5.1	41.3	75.2	32.7
	White	22	456	361	839	4.9	41.8	68.4	30.0
	Total	98	1,372	665	2,135	5.7	51.3	73.8	37.6
Total	American Indian	70	1,142	162	1,374	18.5	238.6	180.3	156.9
	Asian/Pacific Islander	2	20	6	28	4.4	19.2	30.3	15.7
	Black	9	81	20	110	10.5	70.9	87.5	50.9
	Hispanic	226	1,984	589	2,799	10.9	81.1	109.8	59.7
	White	87	1,474	876	2,437	9.2	68.1	88.6	46.8
	Total	396	4,728	1,665	6,789	11.2	89.1	100.4	62.2

\* Age-specific rates (e.g., Ages 0-24) are per 100,000; all-ages rate is per 100,000, age-adjusted to the 2000 US standard population

Sources: NMDOH BVRHS death files and UNM-GPS population files; CDC ARDI; SAES



# ALCOHOL-RELATED DEATH (continued)

## Problem Statement (continued)

Table 1 shows that death rates from alcohol-related causes increase with age. However, there were substantial numbers of alcohol-related deaths in the 0-24 year age category (these are mostly injury-related), and large numbers and high rates of alcohol-related death in the 25-64 year age category (due to both chronic disease and injury). Table 1 also shows extremely high alcohol-related death rates among American Indians (more than twice the state rate for both males and females) and a relatively high rate among Hispanic males relative to White non-Hispanic males. As will be shown in later sections, the rate disparities for American Indian males are driven by this group's relatively high rates of both alcohol-related injury and alcohol-related chronic disease death; whereas the rate disparities for Hispanic males and American Indian females are driven largely by their relatively high alcohol-related chronic disease death rates.

Table 2 shows that McKinley and Rio Arriba counties had the highest rates of alcohol-related death, with rates more than twice the state rate and more than four times the national rate. Several other counties (Cibola, San Miguel, San Juan, and Taos) had a substantial burden (20 or more alcohol-related deaths per year) and rates more than twice the US rate. Furthermore, only two New Mexico counties had rates lower than the national rate. High rates among American Indian males and females drive the rates in McKinley, Cibola, and San Juan counties. Rio Arriba and Taos counties have high rates among American Indian males and females and Hispanic males; deaths among Hispanic males drive the high rates in San Miguel County (data by gender not shown).

**Table 2: Alcohol-Related Deaths and Rates\* by Race/Ethnicity and County, New Mexico, 2013-2017**

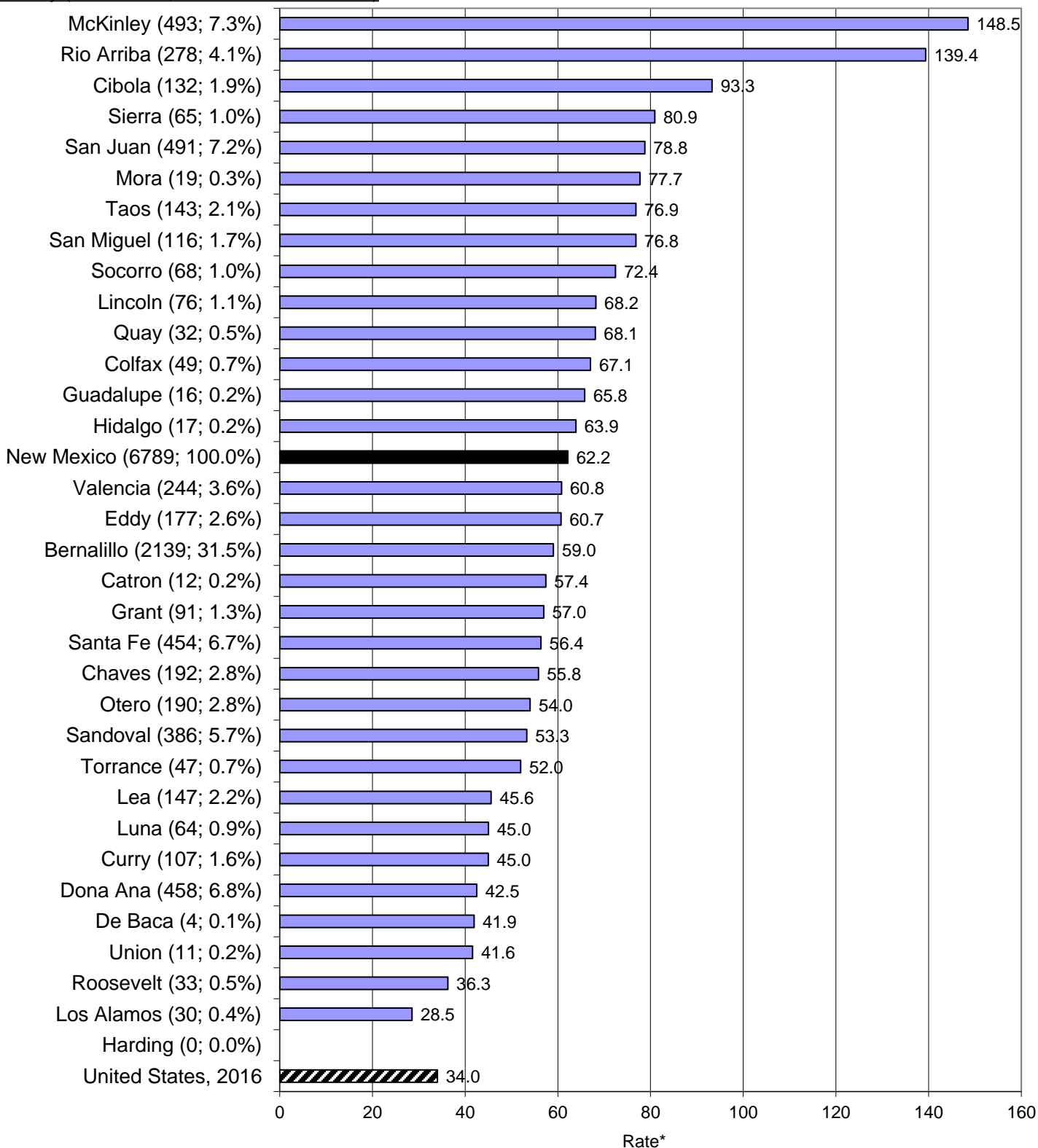
County	Deaths						Rates*					
	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races
Bernalillo	199	11	58	990	866	2,139	149.6	11.6	58.8	63.7	49.0	59.0
Catron	1	0	0	3	8	12	152.9	0.0	0.0	81.2	44.2	57.4
Chaves	1	0	3	90	96	192	20.3	0.0	60.9	56.1	56.5	55.8
Cibola	78	0	0	32	22	132	147.9	0.0	0.0	61.0	70.9	93.3
Colfax	0	0	0	31	18	49	0.0	0.0	0.0	94.4	44.4	67.1
Curry	1	1	8	35	62	107	71.0	21.0	58.7	43.5	44.7	45.0
De Baca	0	0	0	2	2	4	0.0	0.0	0.0	59.6	35.3	41.9
Dona Ana	4	4	7	265	175	458	60.1	34.4	36.7	41.5	42.1	42.5
Eddy	3	0	3	73	98	177	97.3	0.0	74.7	59.5	62.7	60.7
Grant	2	0	1	40	48	91	191.9	0.0	90.3	53.9	60.1	57.0
Guadalupe	0	0	0	16	0	16	0.0	0.0	0.0	83.7	0.0	65.8
Harding	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0	0.0
Hidalgo	0	0	0	9	7	17	0.0	0.0	0.0	66.3	59.6	63.9
Lea	0	0	8	61	77	147	0.0	0.0	64.0	42.2	52.2	45.6
Lincoln	4	0	0	18	53	76	178.8	0.0	0.0	56.0	70.5	68.2
Los Alamos	0	0	0	4	26	30	0.0	0.0	0.0	26.4	32.3	28.5
Luna	0	0	1	24	38	64	0.0	0.0	58.9	32.9	60.2	45.0
McKinley	447	0	1	29	16	493	181.5	0.0	57.7	66.6	42.7	148.5
Mora	0	0	0	17	2	19	0.0	0.0	0.0	83.9	50.5	77.7
Otero	43	0	5	45	96	190	239.2	0.0	41.5	41.8	44.8	54.0
Quay	1	1	0	16	13	32	381.5	186.0	0.0	84.4	50.2	68.1
Rio Arriba	61	0	2	194	21	278	225.8	0.0	244.7	135.9	64.3	139.4
Roosevelt	1	0	1	12	19	33	77.5	0.0	71.5	39.6	34.7	36.3
Sandoval	122	0	8	109	144	386	157.9	0.0	46.8	44.5	35.8	53.3
San Juan	326	0	1	45	118	491	140.0	0.0	22.1	42.7	38.9	78.8
San Miguel	1	1	0	95	17	116	130.7	113.2	0.0	83.2	45.8	76.8
Santa Fe	25	5	1	258	159	454	137.3	42.0	11.1	68.5	38.5	56.4
Sierra	0	0	0	13	51	65	0.0	0.0	0.0	75.4	79.7	80.9
Socorro	17	0	0	31	20	68	183.0	0.0	0.0	71.0	44.3	72.4
Taos	22	0	0	80	41	143	203.7	0.0	0.0	81.2	52.6	76.9
Torrance	1	0	1	16	29	47	41.6	0.0	61.8	49.1	54.9	52.0
Union	0	0	0	8	3	11	0.0	0.0	0.0	89.7	16.5	41.6
Valencia	12	2	2	138	87	244	86.5	92.8	37.9	63.4	54.1	60.8
New Mexico	1,374	28	110	2,799	2,437	6,789	156.9	15.7	50.9	59.7	46.8	62.2

\* All rates are per 100,000, age-adjusted to the 2000 US standard population

# ALCOHOL-RELATED DEATH (continued)

Chart 2: Alcohol-Related Death Rates\* by County, New Mexico, 2013-2017

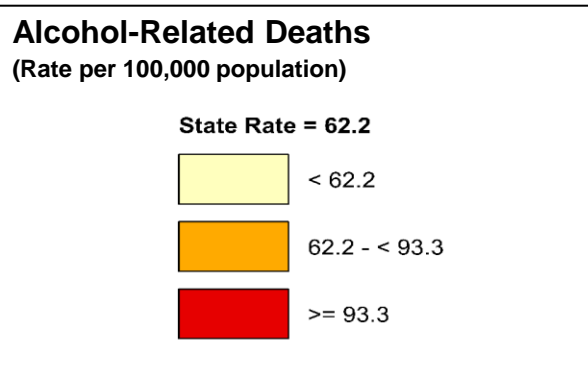
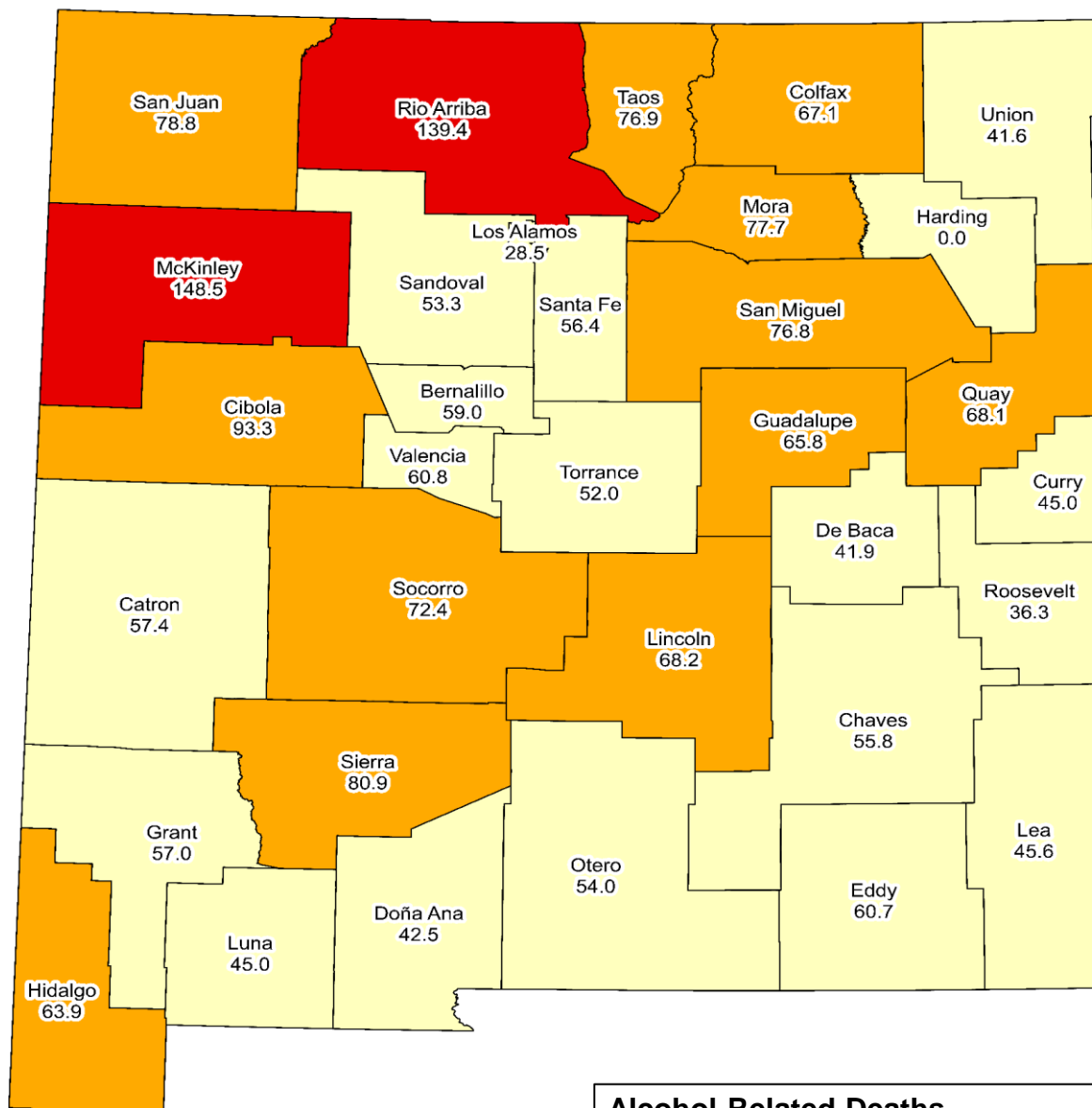
County (# of deaths; % of statewide deaths)



\* All rates are per 100,000, age-adjusted to the 2000 US standard population

# ALCOHOL-RELATED DEATH (continued)

Chart 3: Alcohol-Related Death Rates\* by County, New Mexico, 2013-2017



\* All rates are per 100,000, age-adjusted to the 2000 US standard population  
Sources: NMDOH BVRHS death files and UNM-GPS population files; CDC ARDI; SAES

# ALCOHOL-RELATED CHRONIC DISEASE DEATH

## Problem Statement

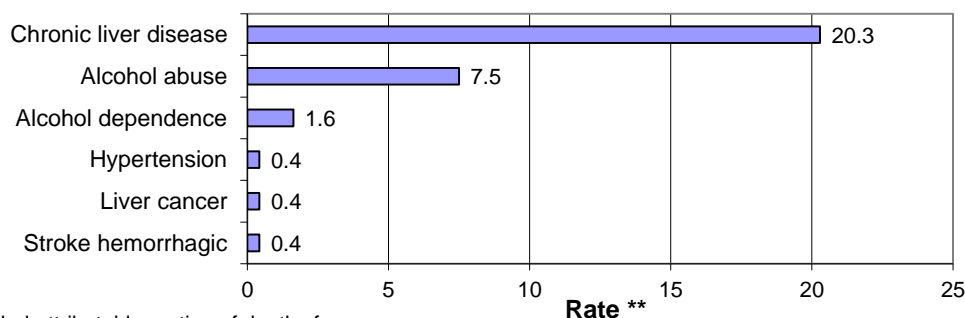
Chronic heavy drinking (defined as drinking, on average, more than two drinks per day for men and more than one drink per day for women) often is associated with alcoholism or alcohol dependence and can cause or contribute to a number of diseases, including alcoholic liver cirrhosis. For the past 15 years, New Mexico's death rate from alcohol-related chronic disease has consistently been first or second in the nation and 1.5 to two times the national rate. The national death rate from alcohol-related chronic disease in 2015 (13.9) was the same as that in 1990. In contrast, New Mexico's rate increased 53% from 1990 to 2017.

Chart 1 shows the five leading causes of alcohol-related chronic disease death in New Mexico during 2013-2017. Alcohol-related chronic liver disease (AR-CLD) was the leading cause of alcohol-related death overall and of alcohol-related chronic disease death during this period. This cause of death will be discussed in more detail later in this report. New Mexico also had the highest rate of alcohol dependence death in the US for the period 2010 through 2016 (the most recent year for which state comparison data is available).

Table 1 shows that death rates from alcohol-related chronic diseases increase with age. The large number of deaths in the 25-64 age category illustrates the very large burden of premature mortality associated with alcohol-related chronic disease. The high rates in this age category among American Indians (both males and females) and Hispanic males further illustrate the heavy burden of premature death due to heavy drinking in these racial/ethnic groups.

**Chart 1: Leading Causes of Alcohol-Related Chronic Disease Death, New Mexico, 2013-2017**

### Alcohol-related\* deaths due to:



\* Rates reflect only alcohol-attributable portion of deaths from cause

\*\* Rate per 100,000, age-adjusted to the 2000 US standard population

Sources: NMDOH BVRHS death files and UNM-GPS population files; CDC ARDI; SAES

**Table 1: Alcohol-Related Chronic Disease Deaths/Rates\* by Age, Sex, and Race/Ethnicity, New Mexico, 2013-2017**

Sex	Race/Ethnicity	Deaths				Rates*			
		Ages 0-24	Ages 25-64	Ages 65+	All Ages	Ages 0-24	Ages 25-64	Ages 65+	All Ages*
Male	American Indian	4	473	60	537	2.2	206.9	163.9	132.2
	Asian/Pacific Islander	0	6	1	7	0.0	13.4	17.5	9.5
	Black	0	24	14	38	0.0	36.3	117.6	33.4
	Hispanic	3	841	257	1,101	0.3	69.1	106.7	49.1
	White	2	546	269	816	0.3	50.8	58.5	28.7
	Total	9	1,901	606	2,516	0.5	72.3	80.1	45.6
Female	American Indian	3	287	60	350	1.7	114.7	112.1	76.4
	Asian/Pacific Islander	0	5	1	5	0.0	7.9	7.2	5.4
	Black	0	13	3	16	0.0	27.4	22.7	15.5
	Hispanic	3	301	127	432	0.3	24.5	43.1	18.0
	White	2	252	139	393	0.3	23.2	26.4	13.6
	Total	8	861	330	1,199	0.5	32.2	36.6	20.9
Total	American Indian	7	759	120	886	2.0	158.7	133.2	102.4
	Asian/Pacific Islander	0	11	2	13	0.0	10.3	11.2	7.1
	Black	0	37	16	54	0.0	32.6	70.2	24.9
	Hispanic	6	1,142	384	1,532	0.3	46.7	71.6	32.9
	White	3	798	408	1,209	0.3	36.9	41.3	20.9
	Total	17	2,762	936	3,715	0.5	52.0	56.5	32.8

\* Age-specific rates (e.g., Ages 0-24) are per 100,000; all-ages rate is per 100,000, age-adjusted to the 2000 US standard population

Sources: NMDOH BVRHS death files and UNM-GPS population files; CDC ARDI; SAES

# ALCOHOL-RELATED CHRONIC DISEASE DEATH (continued)

## Problem Statement (continued)

Table 1 also shows that, in general, males are more at risk than females for alcohol-related chronic disease death. Male rates are almost two to three times higher than female rates across all racial/ethnic groups except Asian/Pacific Islanders. American Indians are most at risk among the racial/ethnic groups with total, male, and female rates more than twice the corresponding state rates. As mentioned earlier, Hispanic males are also at an elevated risk, with rates more than one and a half times the state rate (49.1 vs. 32.8).

Table 2 shows that McKinley, Rio Arriba, and Cibola counties have the highest death rates for diseases associated with alcohol-related chronic disease. In these counties, the rates are more than 4 times the national rate (13.9). The high rates in McKinley and Cibola counties are driven by unusually high rates in the American Indian population. In Rio Arriba County, the rate is driven by high rates in both the Hispanic and American Indian populations. It is worth noting the considerable variation exists across counties in American Indian alcohol-related chronic disease death rates, with substantially lower rates seen in San Juan County than in Cibola, McKinley, and Rio Arriba counties. It is also important to remember that these chronic disease deaths represent only the tip of the iceberg of health and social problems associated with chronic heavy alcohol use in New Mexico. For every alcohol-related death, there are many living persons (and their families) impaired by serious morbidity and reduced quality of life due to chronic alcohol abuse.

**Table 2: Alcohol-Related Chronic Disease Deaths and Rates\* by Race/Ethnicity and County, New Mexico, 2013-2017**

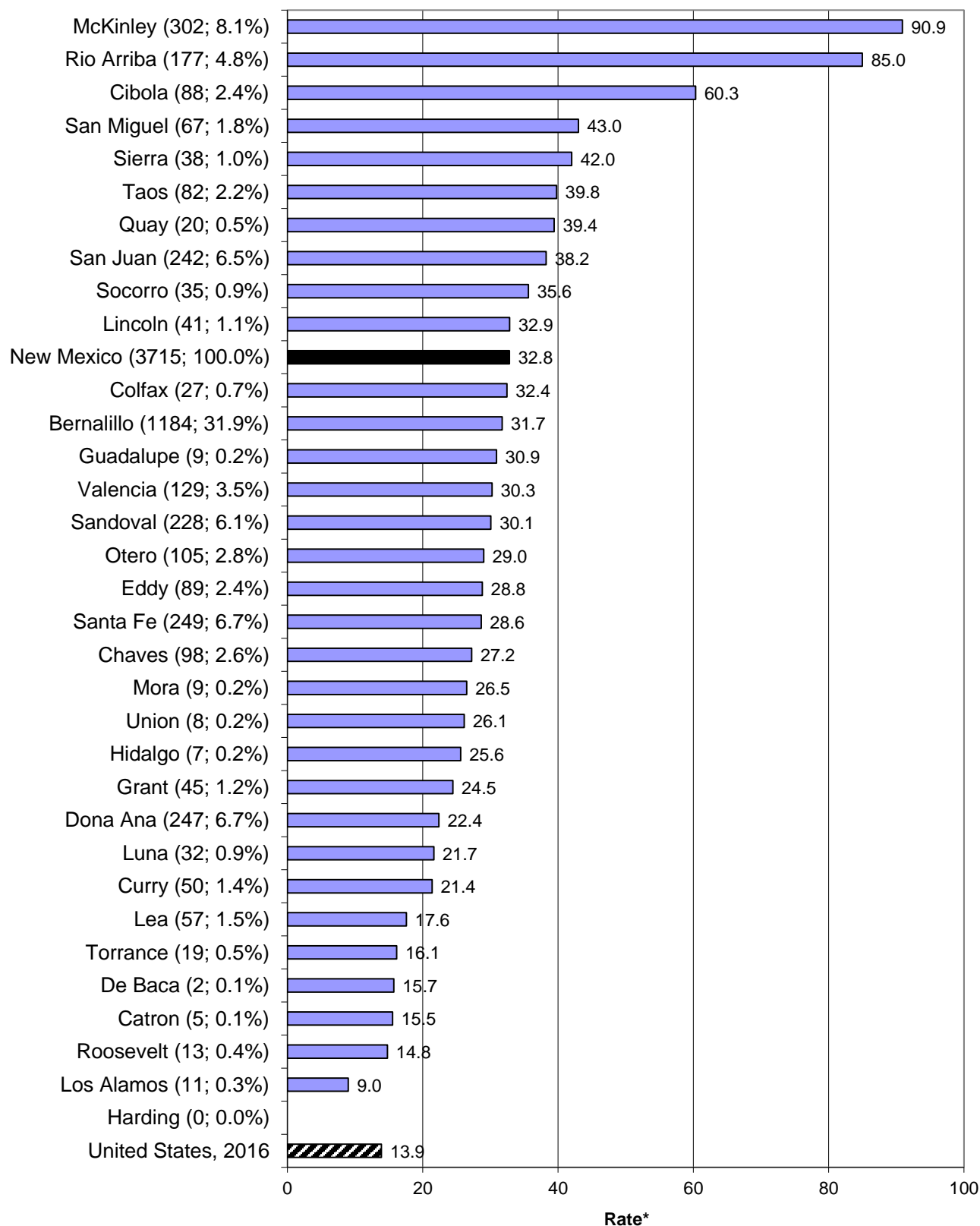
County	Deaths						Rates*					
	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races
Bernalillo	146	3	29	542	457	1,184	111.7	3.5	28.8	35.4	24.1	31.7
Catron	0	0	0	2	2	5	0.0	0.0	0.0	52.9	6.0	15.5
Chaves	0	0	2	45	49	98	0.0	0.0	31.2	29.9	25.8	27.2
Cibola	56	0	0	21	11	88	104.8	0.0	0.0	38.9	36.9	60.3
Coffax	0	0	0	18	9	27	0.0	0.0	0.0	52.8	16.7	32.4
Curry	1	0	4	14	31	50	58.8	0.0	29.1	21.1	21.9	21.4
De Baca	0	0	0	1	1	2	0.0	0.0	0.0	29.2	7.9	15.7
Dona Ana	4	3	4	146	89	247	55.4	25.2	21.4	23.3	20.2	22.4
Eddy	1	0	2	38	49	89	47.7	0.0	44.3	32.0	27.9	28.8
Grant	1	0	1	20	22	45	132.9	0.0	90.3	25.1	23.0	24.5
Guadalupe	0	0	0	9	0	9	0.0	0.0	0.0	40.5	0.0	30.9
Harding	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0	0.0
Hidalgo	0	0	0	4	2	7	0.0	0.0	0.0	33.6	12.8	25.6
Lea	0	0	2	25	29	57	0.0	0.0	18.9	20.5	17.4	17.6
Lincoln	3	0	0	10	28	41	143.1	0.0	0.0	27.5	30.5	32.9
Los Alamos	0	0	0	2	10	11	0.0	0.0	0.0	12.3	9.0	9.0
Luna	0	0	1	14	17	32	0.0	0.0	51.6	18.8	23.9	21.7
McKinley	279	0	1	15	7	302	114.5	0.0	43.7	32.9	14.9	90.9
Mora	0	0	0	7	1	9	0.0	0.0	0.0	30.6	9.5	26.5
Otero	32	0	3	23	46	105	182.2	0.0	23.5	22.0	19.3	29.0
Quay	1	1	0	11	6	20	381.5	186.0	0.0	55.4	22.2	39.4
Rio Arriba	49	0	0	113	15	177	180.1	0.0	0.0	76.0	40.1	85.0
Roosevelt	0	0	0	5	8	13	0.0	0.0	0.0	19.9	14.7	14.8
Sandoval	86	0	6	66	69	228	111.6	0.0	33.8	26.7	14.9	30.1
San Juan	174	0	0	17	50	242	75.4	0.0	0.0	16.6	15.0	38.2
San Miguel	0	1	0	56	9	67	0.0	113.2	0.0	47.4	24.2	43.0
Santa Fe	19	3	0	147	76	249	104.8	22.7	0.0	38.1	16.1	28.6
Sierra	0	0	0	8	29	38	0.0	0.0	0.0	50.2	34.8	42.0
Socorro	10	0	0	14	10	35	115.9	0.0	0.0	31.4	22.0	35.6
Taos	15	0	0	46	21	82	126.0	0.0	0.0	45.2	19.5	39.8
Torrance	0	0	0	9	10	19	0.0	0.0	0.0	22.9	14.3	16.1
Union	0	0	0	7	1	8	0.0	0.0	0.0	73.4	3.2	26.1
Valencia	7	2	0	75	44	129	56.7	53.0	0.0	34.3	22.0	30.3
New Mexico	886	13	54	1,532	1,209	3,715	102.4	7.1	24.9	32.9	20.9	32.8

\* All rates are per 100,000, age-adjusted to the 2000 US standard population  
Sources: NMDOH BVRHS death files and UNM-GPS population files; CDC ARDI; SAES

# ALCOHOL-RELATED CHRONIC DISEASE DEATH (continued)

Chart 2: Alcohol-Related Chronic Disease Death Rates\* by County, New Mexico, 2013-2017

County (# of deaths; % of statewide deaths)

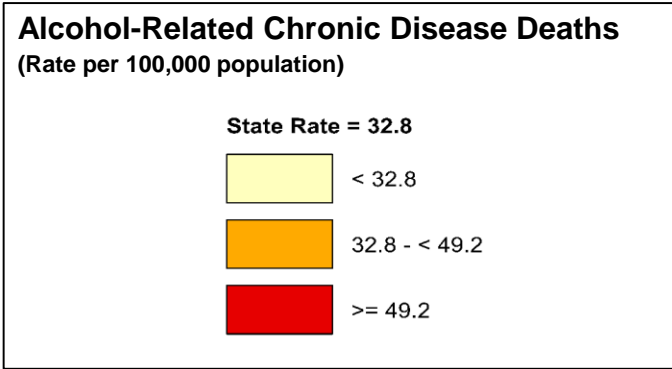
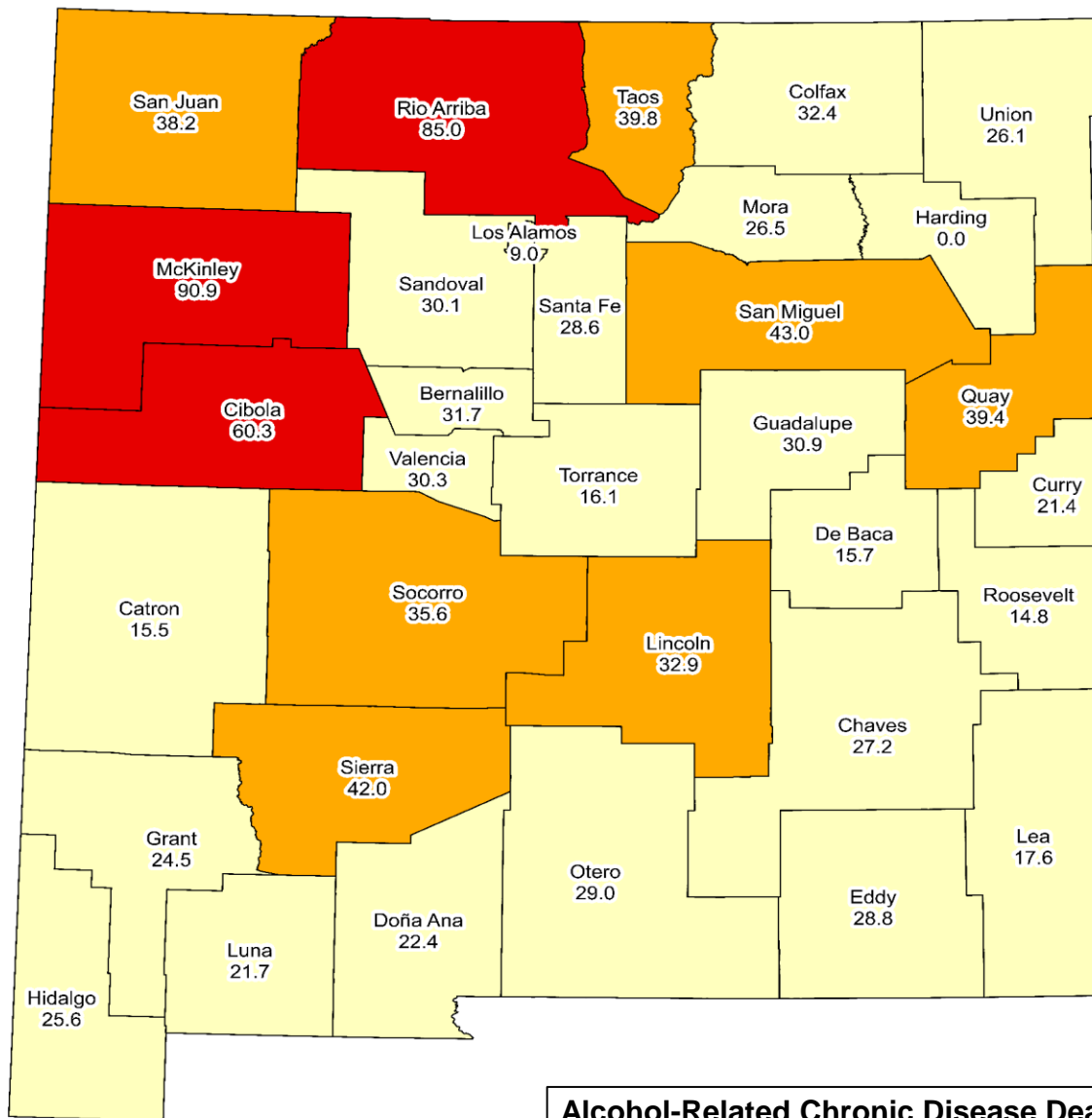


\* All rates are per 100,000, age-adjusted to the 2000 US standard population

Sources: NMDOH BVRHS death files and UNM-GPS population files (NM); NCHS death and population files (US); CDC ARDI; SAES

# ALCOHOL-RELATED CHRONIC DISEASE DEATH (continued)

Chart 3: Alcohol-Related Chronic Disease Death Rates\* by County, New Mexico, 2013-2017



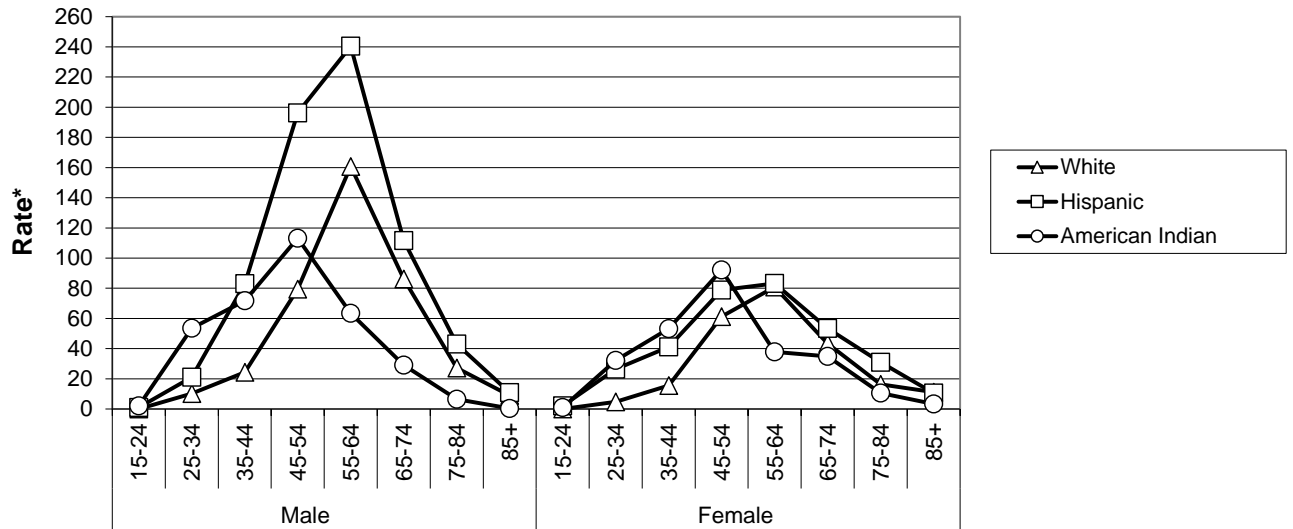
\* All rates are per 100,000, age-adjusted to the 2000 US standard population  
Sources: NMDOH BVRHS death files and UNM-GPS population files; CDC ARDI; SAES

# ALCOHOL-RELATED CHRONIC LIVER DISEASE (CLD) DEATH

## Problem Statement

Alcohol-related chronic liver disease (AR-CLD) is a progressive disease caused by alcohol abuse. It imposes a heavy burden of morbidity and mortality in New Mexico, and it is the principal driver of New Mexico's consistently high alcohol-related chronic disease death rate. Over the past 30 years, New Mexico's AR-CLD rate has trended upward while the national rate has decreased 20%. In 1993, AR-CLD surpassed alcohol-related motor vehicle crash death as the leading cause of alcohol-related death in New Mexico. Since 1997, New Mexico's death rate from AR-CLD has consistently been substantially higher than the death rate from alcohol-related motor vehicle crashes.

**Chart 1: Alcohol-Related CLD Death Rates\* by Age, Sex, and Race/Ethnicity, New Mexico, 2013-2017**



\* Age-specific rates per 100,000

Sources: NMDOH BVRHS death files and UNM-GPS population files; CDC ARDI; SAES

**Table 1: Alcohol-Related CLD Deaths and Rates\* by Age, Sex, and Race/Ethnicity, New Mexico, 2013-2017**

Sex	Race/Ethnicity	Deaths				Rates*			
		Ages 0-24	Ages 25-64	Ages 65+	All Ages	Ages 0-24	Ages 25-64	Ages 65+	All Ages*
Male	American Indian	2	302	36	340	1.0	132.2	98.1	83.2
	Asian/Pacific Islander	0	3	0	3	0.0	6.3	0.0	3.7
	Black	0	7	7	14	0.0	10.2	58.7	11.7
	Hispanic	1	541	165	707	0.1	44.4	68.7	31.3
	White	0	275	122	397	0.0	25.6	26.6	13.7
	Total	3	1,131	331	1,465	0.2	43.0	43.7	26.4
Female	American Indian	1	215	49	265	0.5	86.1	91.4	58.1
	Asian/Pacific Islander	0	2	0	3	0.0	4.2	0.0	2.8
	Black	0	7	2	9	0.0	14.8	15.5	8.0
	Hispanic	2	230	95	327	0.2	18.7	32.1	13.6
	White	0	162	71	233	0.0	14.9	13.4	8.0
	Total	3	618	217	838	0.2	23.1	24.1	14.6
Total	American Indian	3	517	85	605	0.8	108.1	94.1	70.0
	Asian/Pacific Islander	0	5	1	6	0.0	5.1	4.1	3.2
	Black	0	14	9	22	0.0	12.1	37.1	9.7
	Hispanic	3	770	260	1,034	0.1	31.5	48.5	22.1
	White	0	437	193	631	0.0	20.2	19.6	10.8
	Total	6	1,749	548	2,303	0.2	33.0	33.0	20.3

\* Age-specific rates (e.g., Ages 0-24) are per 100,000; all-ages rate is per 100,000, age-adjusted to the 2000 US standard population

Sources: NMDOH BVRHS death files and UNM-GPS population files; CDC ARDI; SAES



# ALCOHOL-RELATED CHRONIC LIVER DISEASE (CLD) DEATH (continued)

## Problem Statement (continued)

As Table 1 shows, more than 75% of AR-CLD deaths occur before age 65. Chart 1 shows the demographic distribution of AR-CLD death rates and graphically illustrates the extremely high burden of premature mortality this disease places on the American Indian population (both male and female), as well as on the Hispanic male population. The high death rates among American Indians and Hispanic males in the 35-64 age range represent a tremendous burden in terms of years of potential life lost (YPLLs), which estimates the average years a person would have lived if he or she had not died prematurely.

Chart 2 shows that AR-CLD death rates in McKinley and Rio Arriba counties are more than six times the national rate. Two-thirds of New Mexico's counties have rates more than twice the US rate. A number of counties with rates less than twice the US rate (e.g., Curry, Dona Ana, Grant) still have high rates compared to the US, and substantial numbers of deaths. The American Indian and/or Hispanic male rates tend to drive the county rates in all counties (data not shown). It is worth noting the relatively lower rates for American Indians in Valencia and San Juan counties and for Hispanics in Dona Ana County (Table 2).

**Table 2: Alcohol-Related CLD Deaths and Rates\* by Race/Ethnicity and County, New Mexico, 2013-2017**

County	Deaths						Rates*					
	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races
Bernalillo	86	1	14	350	226	677	66.8	1.4	12.3	22.8	11.8	18.0
Catron	0	0	0	1	1	2	0.0	0.0	0.0	37.3	1.5	9.6
Chaves	0	0	1	32	27	61	0.0	0.0	28.3	21.0	14.2	17.2
Cibola	37	0	0	18	8	63	69.2	0.0	0.0	34.7	24.8	43.0
Colfax	0	0	0	15	6	20	0.0	0.0	0.0	41.6	11.8	24.5
Curry	1	0	2	11	19	33	58.7	0.0	16.9	16.3	13.9	14.6
De Baca	0	0	0	1	0	1	0.0	0.0	0.0	25.2	0.0	11.7
Dona Ana	4	1	1	96	43	146	53.8	6.1	5.0	15.3	9.2	13.0
Eddy	1	0	0	24	30	55	45.0	0.0	0.0	20.8	17.5	18.2
Grant	0	0	0	14	10	24	0.0	0.0	0.0	17.1	9.3	12.3
Guadalupe	0	0	0	8	0	8	0.0	0.0	0.0	35.7	0.0	27.0
Harding	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0	0.0
Hidalgo	0	0	0	4	1	5	0.0	0.0	0.0	32.7	5.6	21.3
Lea	0	0	0	15	14	29	0.0	0.0	0.0	12.2	8.4	9.1
Lincoln	2	0	0	7	18	28	103.9	0.0	0.0	17.7	18.6	19.8
Los Alamos	0	0	0	1	4	6	0.0	0.0	0.0	10.3	3.9	4.6
Luna	0	0	0	8	10	18	0.0	0.0	0.0	10.3	13.1	11.3
McKinley	200	0	1	13	2	216	82.4	0.0	42.9	27.7	3.2	65.0
Mora	0	0	0	5	1	6	0.0	0.0	0.0	21.8	8.3	19.8
Otero	26	0	1	14	24	66	150.7	0.0	10.3	13.4	10.0	18.8
Quay	1	0	0	8	2	12	381.5	0.0	0.0	39.4	7.4	23.3
Rio Arriba	31	0	0	83	8	123	112.2	0.0	0.0	55.3	17.9	57.8
Roosevelt	0	0	0	5	6	12	0.0	0.0	0.0	17.9	13.2	13.1
Sandoval	58	0	1	44	33	138	76.1	0.0	6.4	17.4	7.5	18.1
San Juan	122	0	0	13	35	171	52.5	0.0	0.0	12.9	10.5	26.8
San Miguel	0	1	0	40	5	46	0.0	112.9	0.0	33.4	10.6	29.3
Santa Fe	13	2	0	100	37	152	67.4	20.4	0.0	25.5	7.9	17.5
Sierra	0	0	0	6	16	23	0.0	0.0	0.0	32.2	20.0	24.6
Socorro	5	0	0	9	6	20	53.6	0.0	0.0	18.2	13.6	19.8
Taos	11	0	0	26	9	46	94.4	0.0	0.0	26.0	7.1	22.7
Torrance	0	0	0	5	5	10	0.0	0.0	0.0	12.3	7.5	8.5
Union	0	0	0	5	0	5	0.0	0.0	0.0	52.9	0.0	18.6
Valencia	5	0	0	53	20	80	39.2	0.0	0.0	24.4	9.6	18.4
New Mexico	605	6	22	1,034	631	2,303	70.0	3.2	9.7	22.1	10.8	20.3

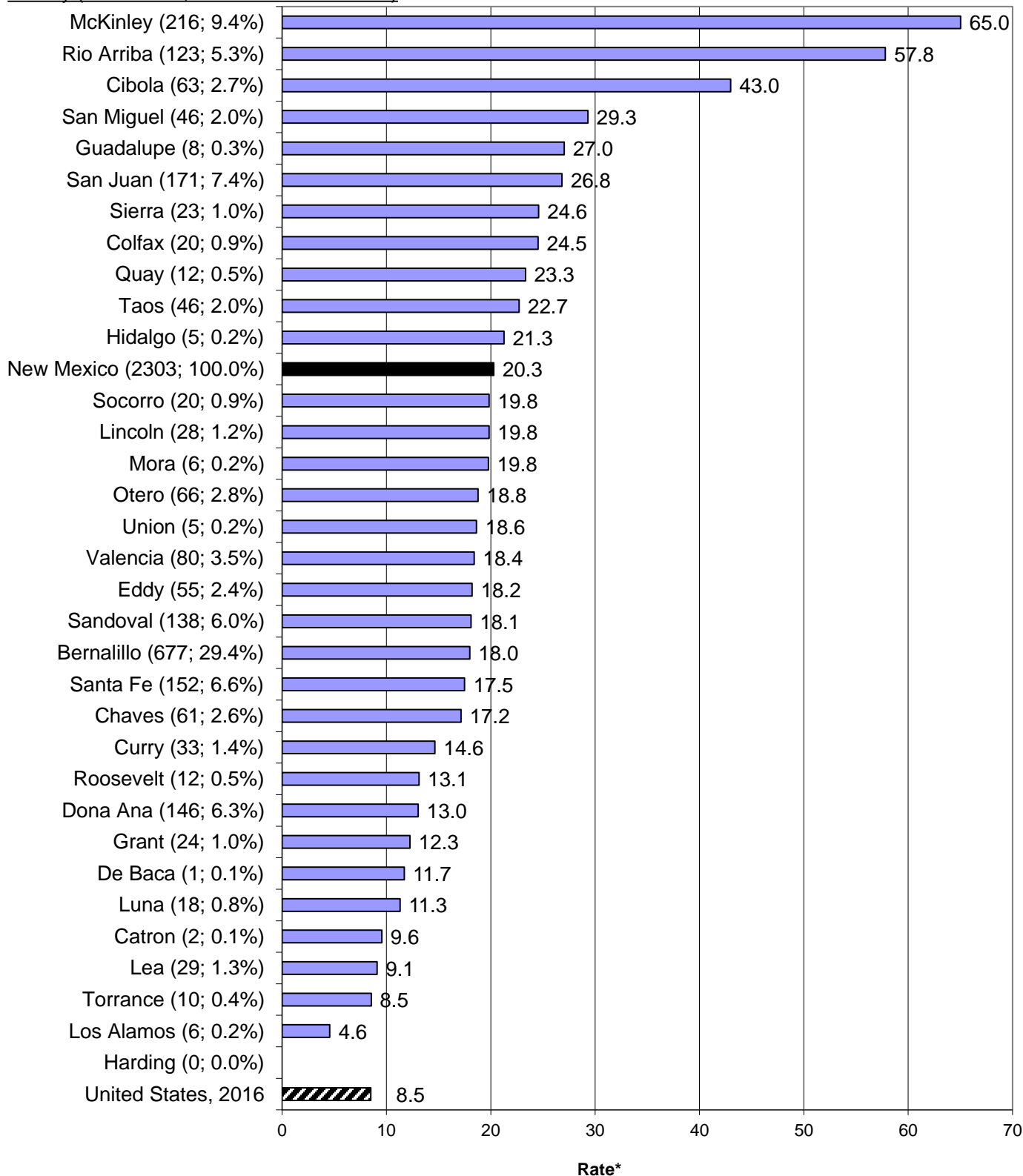
\* All rates are per 100,000, age-adjusted to the 2000 US standard population

Sources: NMDOH BVRHS death files and UNM-GPS population files; CDC ARDI; SAES

# ALCOHOL-RELATED CHRONIC LIVER DISEASE (CLD) DEATH (continued)

Chart 2: Alcohol-Related CLD Death Rates\* by County, New Mexico, 2013-2017

County (# of deaths; % of statewide deaths)

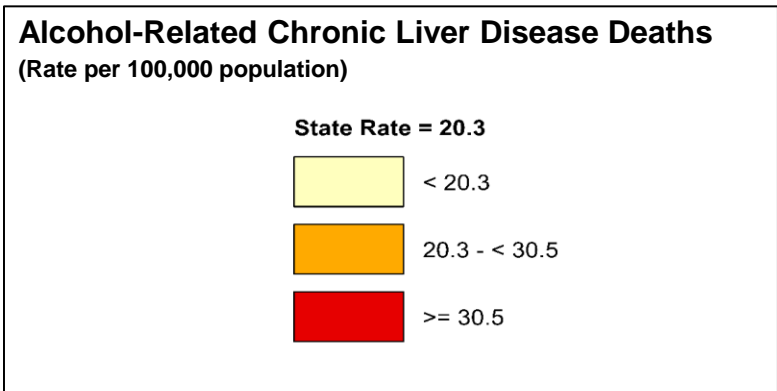
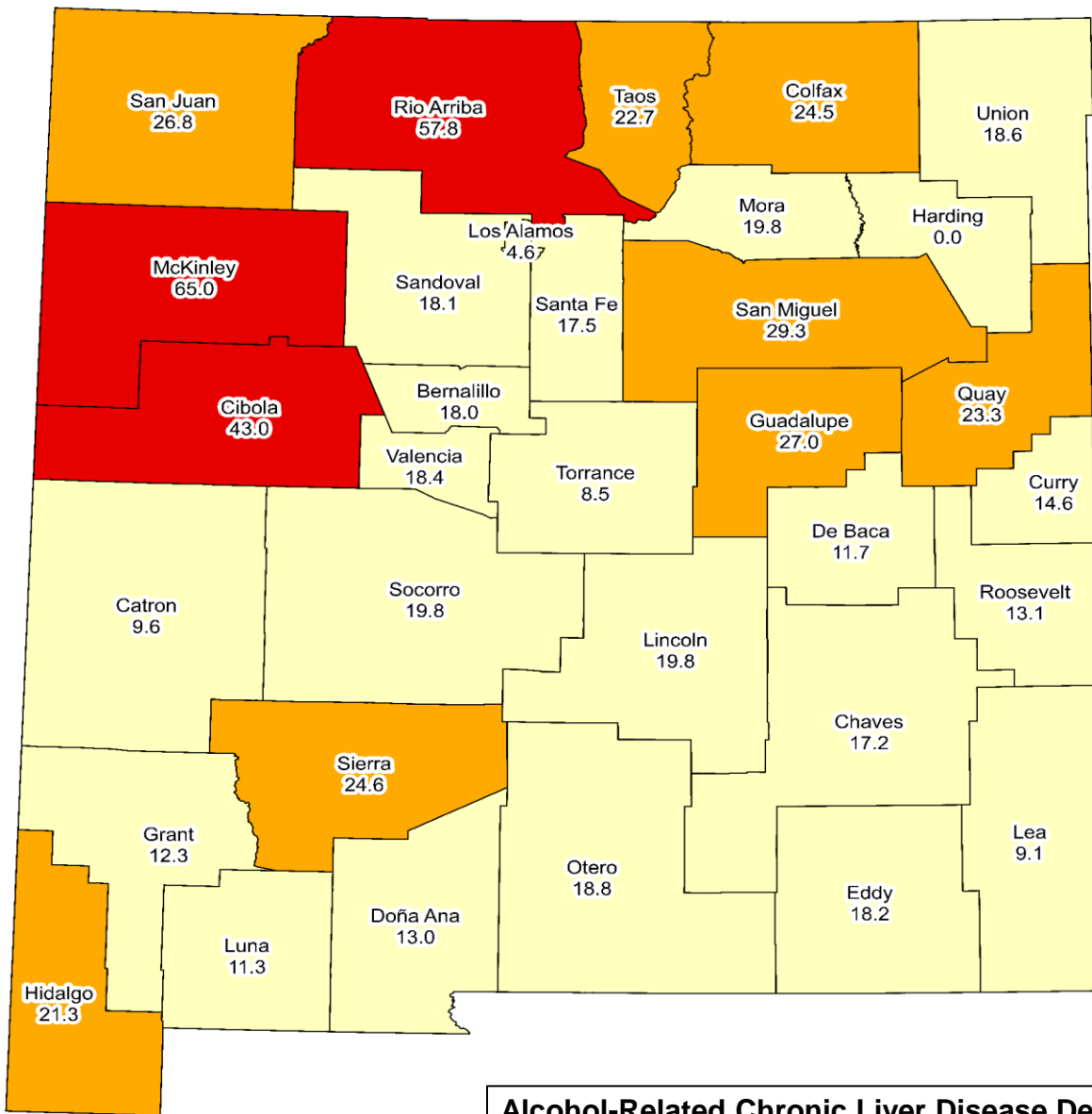


\* All rates are per 100,000, age-adjusted to the 2000 US standard population

Sources: NMDOH BVRHS death files and UNM-GPS population files (NM); NCHS death and population files (US); CDC ARDI; SAES

# ALCOHOL-RELATED CHRONIC LIVER DISEASE (CLD) DEATH (continued)

Chart 3: Alcohol-Related CLD Death Rates\* by County, New Mexico, 2013-2017



\* All rates are per 100,000, age-adjusted to the 2000 US standard population

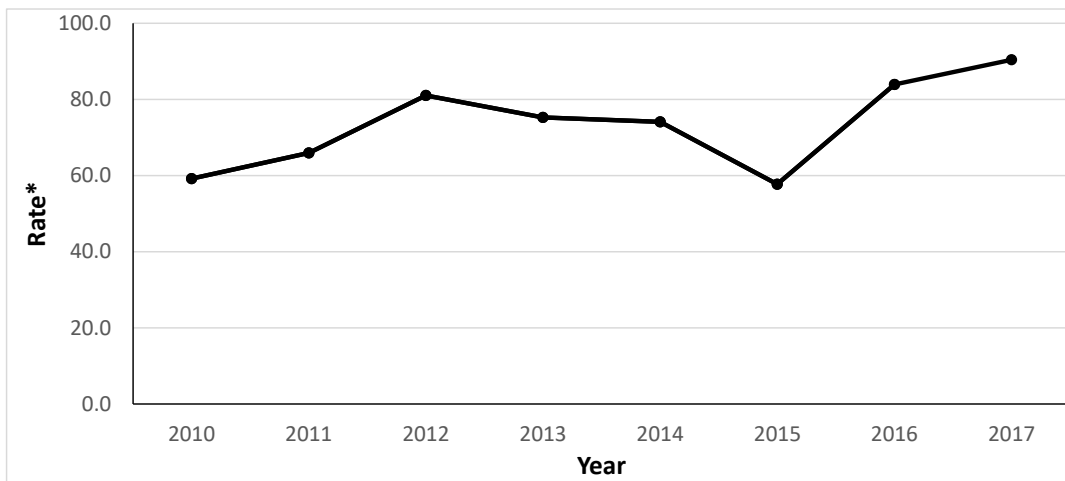
Sources: NMDOH BVRHS death files and UNM-GPS population files; CDC ARDI; SAES

# CHRONIC LIVER DISEASE (CLD) HOSPITAL DISCHARGES

## Problem Statement

Excessive alcohol use is the most common cause of CLD. Other causes (e.g. acetaminophen use) are less common. CLD can develop over many years, in some cases 20-30 years, and data on hospitalizations can provide information on CLD risk at an earlier time point in the disease's development than AR-CLD mortality. However, CLD hospitalizations are not limited to alcohol-related conditions and include all hospital stays where the primary diagnosis was determined to be CLD. Additionally, CLD hospitalizations measure number of hospital stays rather than individuals diagnosed with CLD (i.e. a person can be hospitalized more than once). The rate of CLD hospitalizations in 2017 (90.4 hospitalizations per 100,000) has increased 52.7% since 2010 (59.2 hospitalizations per 100,000). Women are at lower risk than men. Women who identify as Asian or Pacific Islander have the lowest rates whereas men who identify as American Indian have the highest rates.

**Chart 1: Alcohol-Related CLD Discharge Rates\*, New Mexico, 2010-2017**



\* Rates per 100,000 population

Sources: NMDOH HIDD files and UNM-GPS population files; SAES

**Table 1: CLD Hospital Discharges and Rates\* by Age, Sex, and Race/Ethnicity, New Mexico, 2013-2017**

Sex	Race/Ethnicity	Hospital Discharges				Rates*			
		Ages 0-24	Ages 25-64	Ages 65+	All Ages	Ages 0-24	Ages 25-64	Ages 65+	All Ages*
Male	American Indian	9	947	96	1,047	4.7	414.5	263.0	249.4
	Asian/Pacific Islander	0	26	4	30	0.0	58.1	52.9	36.9
	Black	0	26	7	33	0.0	39.0	60.4	27.9
	Hispanic	24	1,616	388	2,028	2.3	132.8	161.1	90.3
	White	16	1,147	342	1,503	3.2	106.7	74.4	66.0
	Total	55	3,873	864	4,785	3.0	147.2	114.2	92.0
Female	American Indian	10	670	184	864	5.3	267.9	344.7	184.8
	Asian/Pacific Islander	0	14	9	23	0.0	24.4	74.2	22.1
	Black	1	27	4	32	2.5	57.1	34.5	35.0
	Hispanic	28	906	349	1,284	2.7	73.6	118.0	54.2
	White	10	725	350	1,084	2.2	66.5	66.2	43.7
	Total	49	2,412	922	3,383	2.8	90.2	102.3	60.8
Total	American Indian	19	1,617	280	1,911	5.0	337.9	311.5	216.4
	Asian/Pacific Islander	0	40	13	53	0.0	39.2	66.0	28.7
	Black	1	53	11	65	1.2	46.5	47.5	30.6
	Hispanic	52	2,522	737	3,312	2.5	103.0	137.3	71.9
	White	26	1,873	692	2,588	2.7	86.5	70.0	54.8
	Total	104	6,287	1,786	8,170	2.9	118.5	107.7	76.2

\* Age-specific rates (e.g., Ages 0-24) are per 100,000; all-ages rate is per 100,000, age-adjusted to the 2000 US standard population

There were 242 visits for which Race-Ethnicity or Sex was missing

Sources: NMDOH HIDD files and UNM-GPS population files; SAES

# CHRONIC LIVER DISEASE (CLD) HOSPITAL DISCHARGES (continued)

## Problem Statement (continued)

The number of hospitalizations for CLD can be used as a measure of the impact of CLD on the medical system and the need for care. Between 2013 to 2017, there were 8,170 hospitalizations reported by non-federal facilities. This equates to approximately 22.4 hospitalizations for CLD every day in New Mexico.

For 2013-2017, McKinley County had the highest rate of CLD hospitalizations (157.2 hospitalizations per 100,000 population), followed by Rio Arriba (126.3 hospitalizations per 100,000 population), Cibola (121.3 hospitalizations per 100,000 population), and Sierra (105.9 hospitalizations per 100,000 population). De Baca (0.0 hospitalizations per 100,000 population) and Eddy County (6.6 hospitalizations per 100,000 population) had the lowest rates.

It is important to note that federal facilities (e.g. Indian Health Services and Veterans Administration) are not included in these results.

**Table 2: CLD Hospital Discharges and Rates\* by Race/Ethnicity and County, New Mexico, 2013-2017**

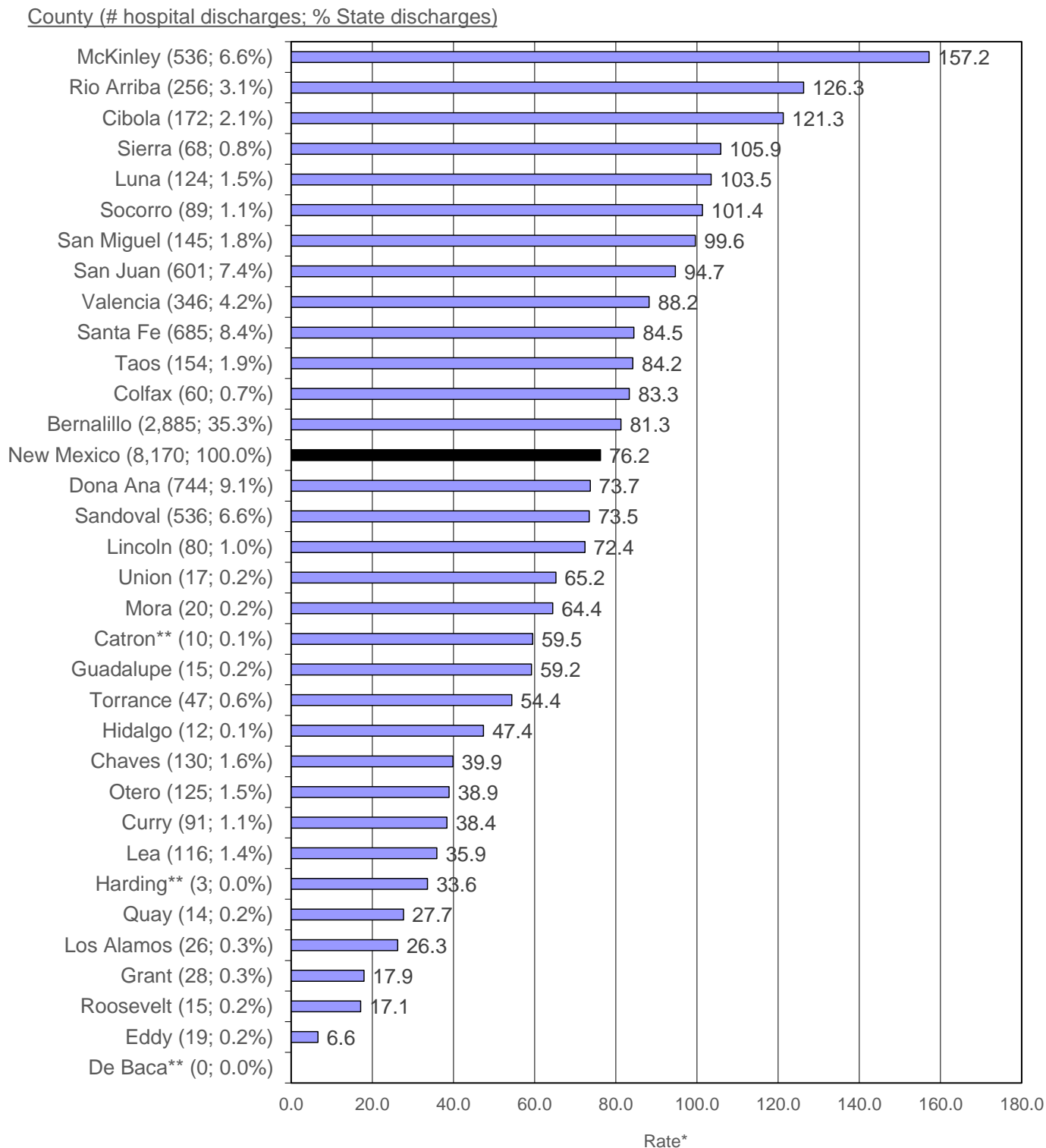
County	Hospital Discharges						Rates*					
	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races
Bernalillo	446	26	23	1,218	1,093	2,885	312.9	26.0	23.7	78.7	67.3	81.3
Catron	0	0	0	4	6	10	0.0	0.0	0.0	111.7	52.0	59.5
Chaves	2	0	1	18	107	130	73.4	0.0	19.1	11.2	69.8	39.9
Cibola	99	5	1	25	29	172	192.9	729.4	59.2	48.4	85.6	121.3
Colfax	0	0	0	36	23	60	0.0	0.0	0.0	108.9	65.2	83.3
Curry	0	0	12	45	34	91	0.0	0.0	88.6	56.1	24.9	38.4
De Baca	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0	0.0
Dona Ana	9	0	5	456	253	744	116.0	0.0	27.3	74.1	77.9	73.7
Eddy	1	0	0	7	11	19	32.0	0.0	0.0	5.9	6.6	6.6
Grant	0	0	0	13	14	28	0.0	0.0	0.0	16.6	20.4	17.9
Guadalupe	0	0	0	10	5	15	0.0	0.0	0.0	52.4	100.7	59.2
Harding	0	0	0	3	0	3	0.0	0.0	0.0	82.8	0.0	33.6
Hidalgo	0	0	0	6	6	12	0.0	0.0	0.0	47.9	44.0	47.4
Lea	0	0	2	64	48	116	0.0	0.0	16.5	43.6	34.5	35.9
Lincoln	4	1	2	25	47	80	158.5	187.7	269.0	81.2	62.6	72.4
Los Alamos	0	0	0	7	19	26	0.0	0.0	0.0	51.0	25.2	26.3
Luna	0	0	2	79	41	124	0.0	0.0	135.1	111.3	107.6	103.5
McKinley	427	11	3	41	26	536	170.3	283.1	128.6	94.9	65.4	157.2
Mora	0	0	0	18	2	20	0.0	0.0	0.0	72.8	49.7	64.4
Otero	40	2	1	41	32	125	212.6	36.2	8.6	38.3	18.1	38.9
Quay	0	0	0	10	4	14	0.0	0.0	0.0	49.1	16.5	27.7
Rio Arriba	84	0	0	145	24	256	310.6	0.0	0.0	103.5	77.3	126.3
Roosevelt	0	0	0	7	8	15	0.0	0.0	0.0	20.9	15.0	17.1
Sandoval	211	2	3	144	146	536	269.2	15.5	18.8	59.1	38.4	73.5
San Juan	377	0	1	60	152	601	164.9	0.0	39.3	60.0	53.6	94.7
San Miguel	4	0	0	117	21	145	280.2	0.0	0.0	104.9	61.6	99.6
Santa Fe	65	4	3	402	202	685	333.3	32.1	38.2	107.7	51.8	84.5
Sierra	1	0	0	22	44	68	119.2	0.0	0.0	137.8	88.3	105.9
Socorro	34	0	1	36	17	89	365.1	0.0	92.6	83.7	45.0	101.4
Taos	34	0	0	75	34	154	337.7	0.0	0.0	76.4	46.8	84.2
Torrance	0	0	2	12	31	47	0.0	0.0	178.4	38.2	62.1	54.4
Union	0	0	0	13	4	17	0.0	0.0	0.0	137.2	25.6	65.2
Valencia	73	2	3	153	105	346	513.5	76.2	59.2	71.2	65.7	88.2
New Mexico	1,911	53	65	3,312	2,588	8,170	216.4	28.7	30.6	71.9	54.8	76.2

\* All rates are per 100,000, age-adjusted to the 2000 US standard population. There were 242 visits for which Race-Ethnicity or Sex was missing

Sources: NMDOH HIDD files and UNM-GPS population files; SAES

# CHRONIC LIVER DISEASE (CLD) HOSPITAL DISCHARGES (continued)

Chart 2: CLD Discharges Rates\* by County, New Mexico, 2013-2017



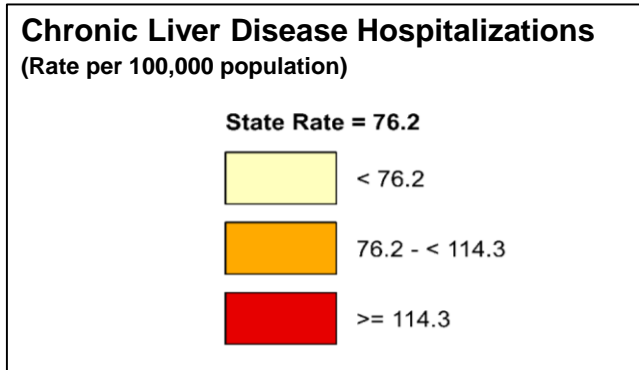
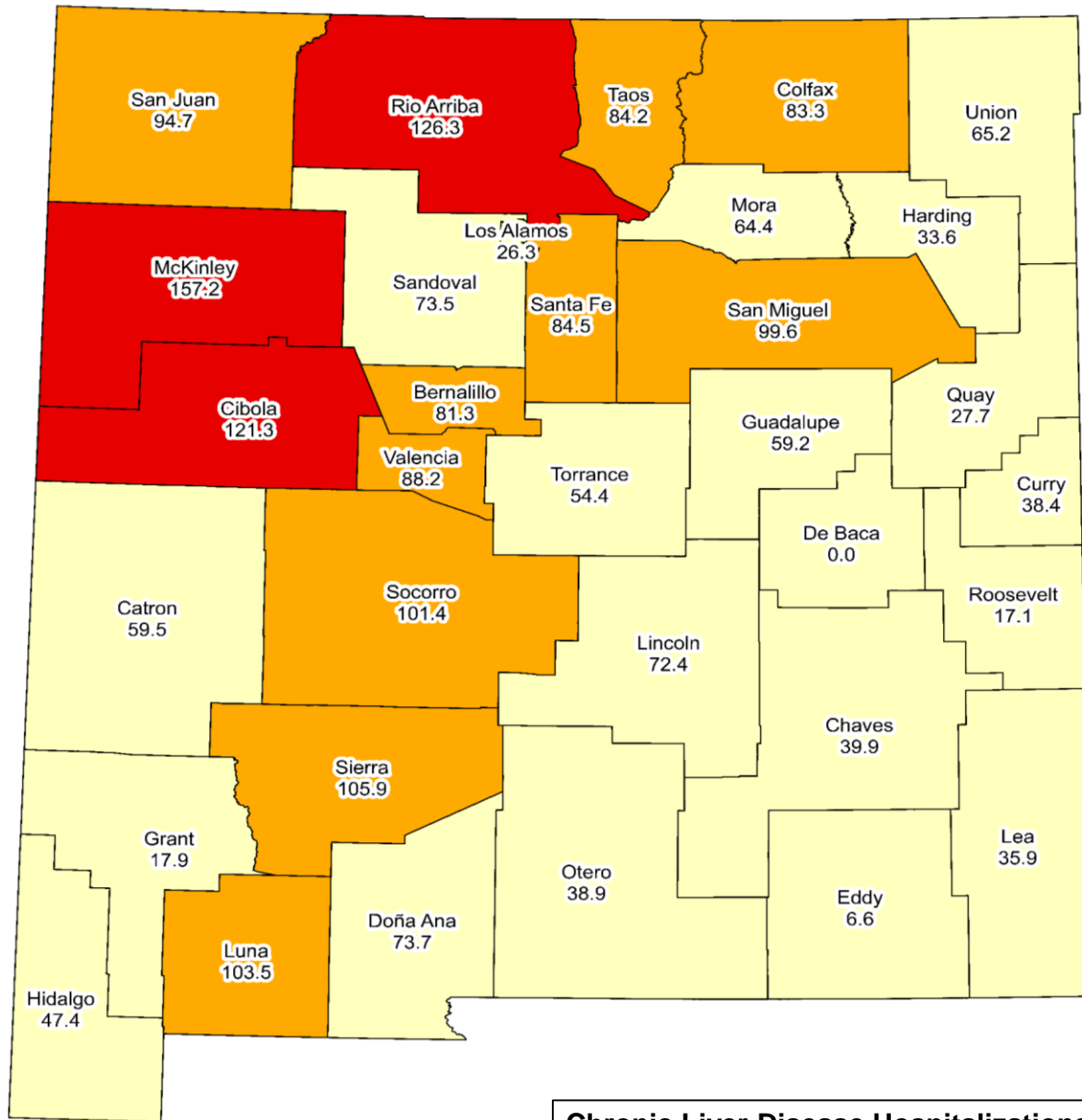
\* All rates are per 100,000, age-adjusted to the 2000 US standard population

\*\* Unstable rate due to small number of cases (<10)

Sources: NMDOH HIDD files and UNM-GPS population files (NM); SAES

# CHRONIC LIVER DISEASE (CLD) HOSPITAL DISCHARGES (continued)

Chart 3: Alcohol-Related CLD Discharges Rates\* by County, New Mexico, 2013-2017



\* All rates are per 100,000, age-adjusted to the 2000 US standard population

Sources: NMDOH HIDD files and UNM-GPS population files; SAES

# ALCOHOL-RELATED INJURY DEATH

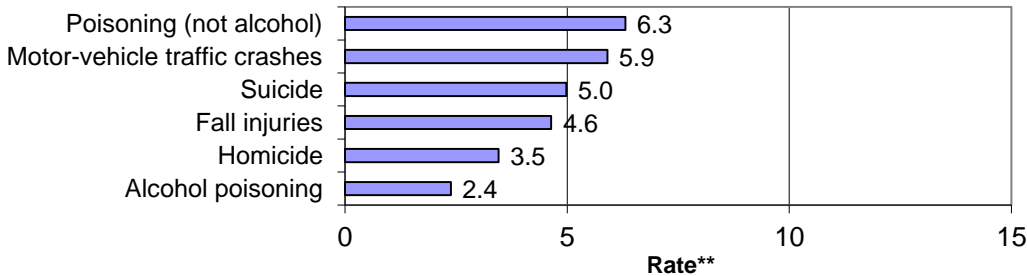
## Problem Statement

Binge drinking (defined as having five drinks or more on an occasion for men and four drinks or more on an occasion for women) is a high-risk behavior associated with numerous injury outcomes, including motor vehicle fatalities, homicide, and suicide. Since 1990, New Mexico's death rate for alcohol-related (AR) injury has consistently been among the highest in the nation, ranging from 1.4 to 1.8 times the national rate. While NM's alcohol-impaired motor vehicle crash fatality rates have declined almost 60% during this period, death rates from other AR injuries have increased. Chart 1 shows the top six leading causes of alcohol-related injury death between 2013 and 2017 with AR poisoning (i.e. drug overdose) death ranking at number one. Since the early 1990s, the AR fall death rate peaked in 2007-09 and has declined since while AR poisoning has continued to rise. During the period 2008-2017, AR poisoning deaths replaced AR motor vehicle crash deaths as the leading cause of alcohol-related injury death in New Mexico.

Table 1 shows that total death rates from AR injuries increase with age. However, there were substantially high numbers and rates of AR injury death in the lowest age category (ages 0-24) with especially high rates among American Indian and Hispanic males. Deaths in this age category represent a very large burden of premature mortality (YPLL: Years of Potential Life Lost).

**Chart 1: Top 6 Leading Causes of Alcohol-Related Injury Death, New Mexico, 2013-2017**

### Alcohol-related\* deaths due to:



\* Rates reflect only alcohol-attributable portion of deaths from cause

\*\* Rates are rolling 5-year average per 100,000, age-adjusted to the 2000 US standard population

Sources: NMDOH BVRHS death files and UNM-GPS population files; CDC ARDI; SAES

**Table 1: Alcohol-Related Injury Deaths and Rates\* by Age, Sex, and Race/Ethnicity, New Mexico, 2013-2017**

Sex	Race/Ethnicity	Deaths				Rates*			
		Ages 0-24	Ages 25-64	Ages 65+	All Ages	Ages 0-24	Ages 25-64	Ages 65+	All Ages*
Male	American Indian	45	295	27	367	23.7	128.9	75.0	86.7
	Asian/Pacific Islander	2	6	3	11	6.0	14.1	38.2	14.5
	Black	7	37	3	47	14.9	55.0	24.8	36.9
	Hispanic	171	635	110	915	16.2	52.2	45.5	39.2
	White	64	472	246	781	12.9	43.9	53.4	35.3
	Total	289	1,455	393	2,137	15.9	55.3	52.0	42.2
Female	American Indian	18	88	15	120	9.3	35.1	28.1	25.6
	Asian/Pacific Islander	1	3	1	4	2.4	4.8	7.2	4.5
	Black	2	7	1	10	5.1	14.8	9.8	10.7
	Hispanic	49	208	95	352	4.8	16.9	32.1	14.7
	White	20	204	222	446	4.5	18.7	42.0	16.4
	Total	90	511	335	936	5.2	19.1	37.2	16.7
Total	American Indian	63	382	42	488	16.5	79.9	47.1	54.5
	Asian/Pacific Islander	2	9	4	15	4.3	8.9	19.1	8.7
	Black	9	44	4	57	10.4	38.3	17.3	25.9
	Hispanic	220	842	204	1,267	10.6	34.4	38.1	26.9
	White	84	676	468	1,228	8.9	31.2	47.3	25.9
	Total	379	1,966	728	3,073	10.7	37.0	43.9	29.3

\* Age-specific rates (e.g., Ages 0-24) are per 100,000; all-ages rate is per 100,000, age-adjusted to the 2000 US standard population

Sources: NMDOH BVRHS death files and UNM-GPS population files; CDC ARDI; SAES



# ALCOHOL-RELATED INJURY DEATH (continued)

## Problem Statement (continued)

Table 1 shows that males are more at risk of AR injury death than females. Male rates are two to four times higher than female rates across all racial/ethnic categories. American Indian males had the highest risk, with a rate nearly three times the state rate and more than twice the White male rate. American Indian females also are at an increased risk compared to females in other racial/ethnic groups.

Table 2 shows that AR injury is a serious issue in many New Mexico counties. McKinley, Rio Arriba, Mora, and Catron counties have rates more than twice the US rate (Chart 2). More than half of NM counties have rates 1.5 times that of the US rate or more. A number of counties have both high rates and a relatively heavy burden (e.g., 20 or more alcohol-related injury deaths per year). Rio Arriba County's high rate is driven by high rates in both the Hispanic and American Indian population. In McKinley and San Juan counties, elevated rates are driven by high rates in the American Indian population. Santa Fe County's high rate is driven by elevated rates in the Hispanic and American Indian population.

**Table 2: Alcohol-Related Injury Deaths and Rates\* by Race/Ethnicity and County, New Mexico, 2013-2017**

County	Deaths						Rates*					
	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races
Bernalillo	53	8	30	449	409	955	38.0	8.1	29.9	28.3	24.9	27.3
Catron	1	0	0	1	6	8	152.9	0.0	0.0	28.2	38.2	41.9
Chaves	0	0	2	45	47	94	0.0	0.0	29.7	26.3	30.8	28.6
Cibola	22	0	0	12	11	45	43.1	0.0	0.0	22.2	34.0	32.9
Cofax	0	0	0	13	9	22	0.0	0.0	0.0	41.6	27.7	34.6
Curry	0	1	4	20	31	57	0.0	20.0	29.5	22.5	22.7	23.6
De Baca	0	0	0	1	2	3	0.0	0.0	0.0	30.3	27.5	26.2
Dona Ana	0	1	3	119	86	211	0.0	9.1	15.3	18.3	21.9	20.1
Eddy	2	0	1	35	50	87	49.6	0.0	30.4	27.5	34.9	31.9
Grant	1	0	0	20	26	46	59.0	0.0	0.0	28.8	37.1	32.5
Guadalupe	0	0	0	7	0	8	0.0	0.0	0.0	43.2	0.0	34.9
Harding	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0	0.0
Hidalgo	0	0	0	5	5	10	0.0	0.0	0.0	32.7	46.8	38.3
Lea	0	0	6	36	47	90	0.0	0.0	45.1	21.7	34.9	28.0
Lincoln	1	0	0	9	25	35	35.7	0.0	0.0	28.4	40.0	35.3
Los Alamos	0	0	0	2	16	18	0.0	0.0	0.0	14.1	23.3	19.6
Luna	0	0	0	10	20	32	0.0	0.0	0.0	14.1	36.3	23.4
McKinley	168	0	0	14	9	192	67.0	0.0	0.0	33.8	27.8	57.6
Mora	0	0	0	9	1	11	0.0	0.0	0.0	53.4	41.0	51.2
Otero	11	0	2	22	49	85	57.0	0.0	18.0	19.9	25.6	25.0
Quay	0	0	0	5	7	13	0.0	0.0	0.0	28.9	28.0	28.7
Rio Arriba	12	0	1	81	7	101	45.7	0.0	242.4	59.9	24.2	54.4
Roosevelt	0	0	1	7	12	20	0.0	0.0	71.4	19.7	20.0	21.5
Sandoval	37	0	2	43	75	158	46.3	0.0	12.9	17.8	20.9	23.2
San Juan	151	0	1	28	68	249	64.6	0.0	19.0	26.0	23.8	40.5
San Miguel	1	0	0	39	7	48	130.7	0.0	0.0	35.8	21.6	33.8
Santa Fe	6	2	0	110	83	206	32.5	19.3	0.0	30.4	22.4	27.7
Sierra	0	0	0	4	23	28	0.0	0.0	0.0	25.2	44.9	38.9
Socorro	7	0	0	16	10	33	67.1	0.0	0.0	39.6	22.3	36.8
Taos	7	0	0	34	20	61	77.8	0.0	0.0	36.1	33.1	37.1
Torrance	1	0	1	8	19	28	40.5	0.0	57.1	26.2	40.7	35.8
Union	0	0	0	1	2	4	0.0	0.0	0.0	16.3	13.3	15.5
Valencia	5	1	1	63	43	114	29.8	39.9	35.9	29.2	32.1	30.5
New Mexico	488	15	57	1,267	1,228	3,073	54.5	8.7	25.9	26.9	25.9	29.3

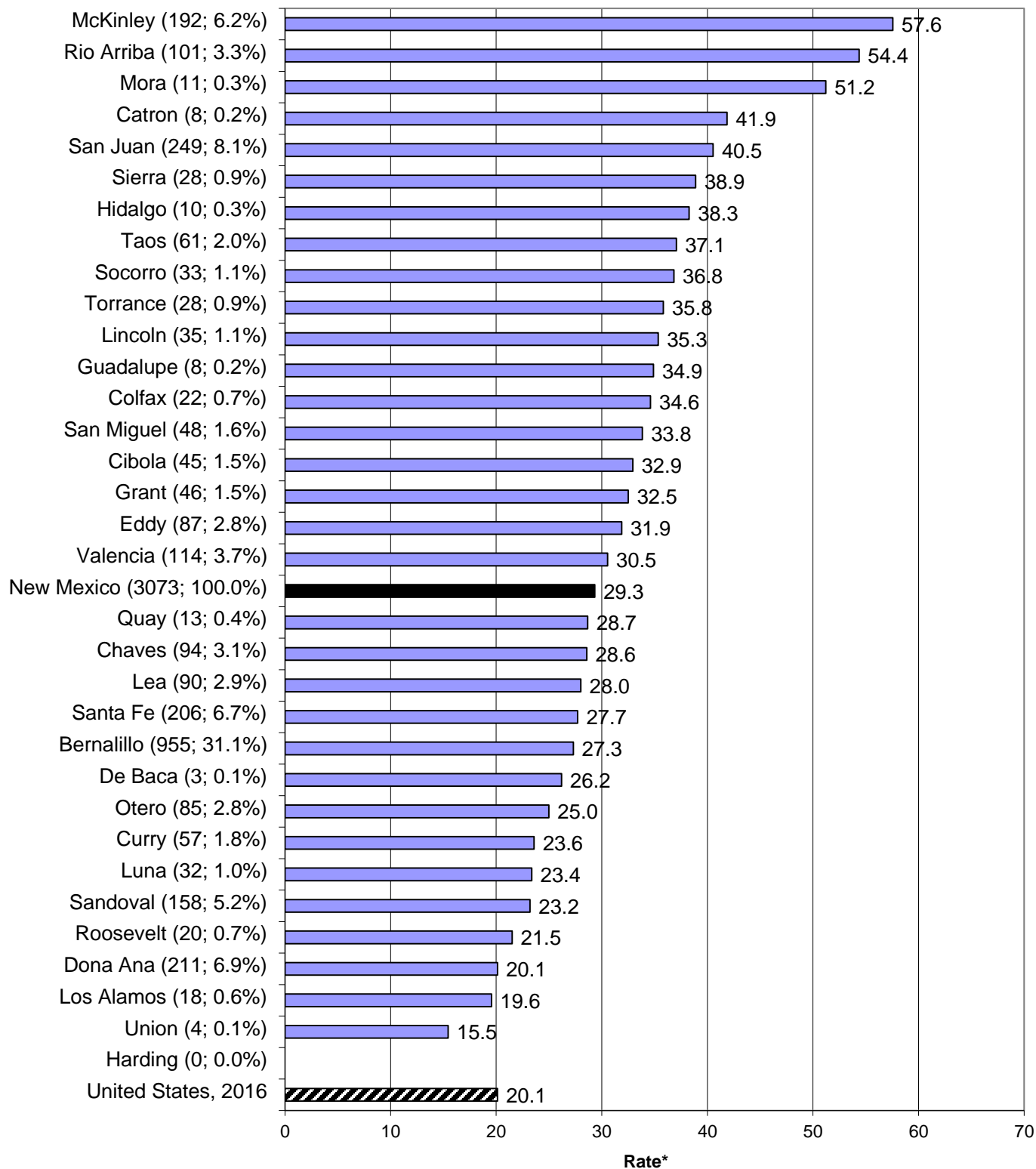
\* All rates are per 100,000, age-adjusted to the 2000 US standard population

Sources: NMDOH BVRHS death files and UNM-GPS population files; CDC ARDI; SAES

# ALCOHOL-RELATED INJURY DEATH (continued)

Chart 2: Alcohol-Related Injury Death Rates\* by County, New Mexico, 2013-2017

County (# of deaths; % of statewide deaths)

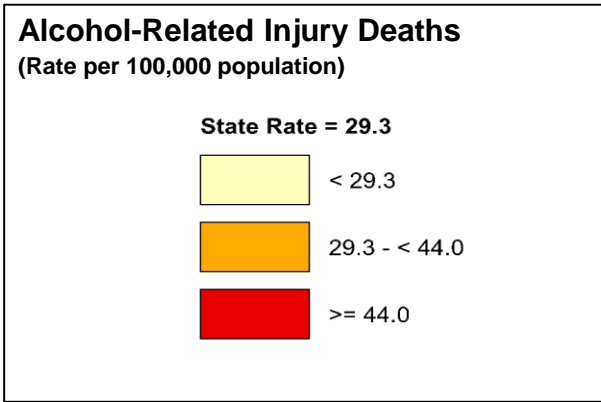
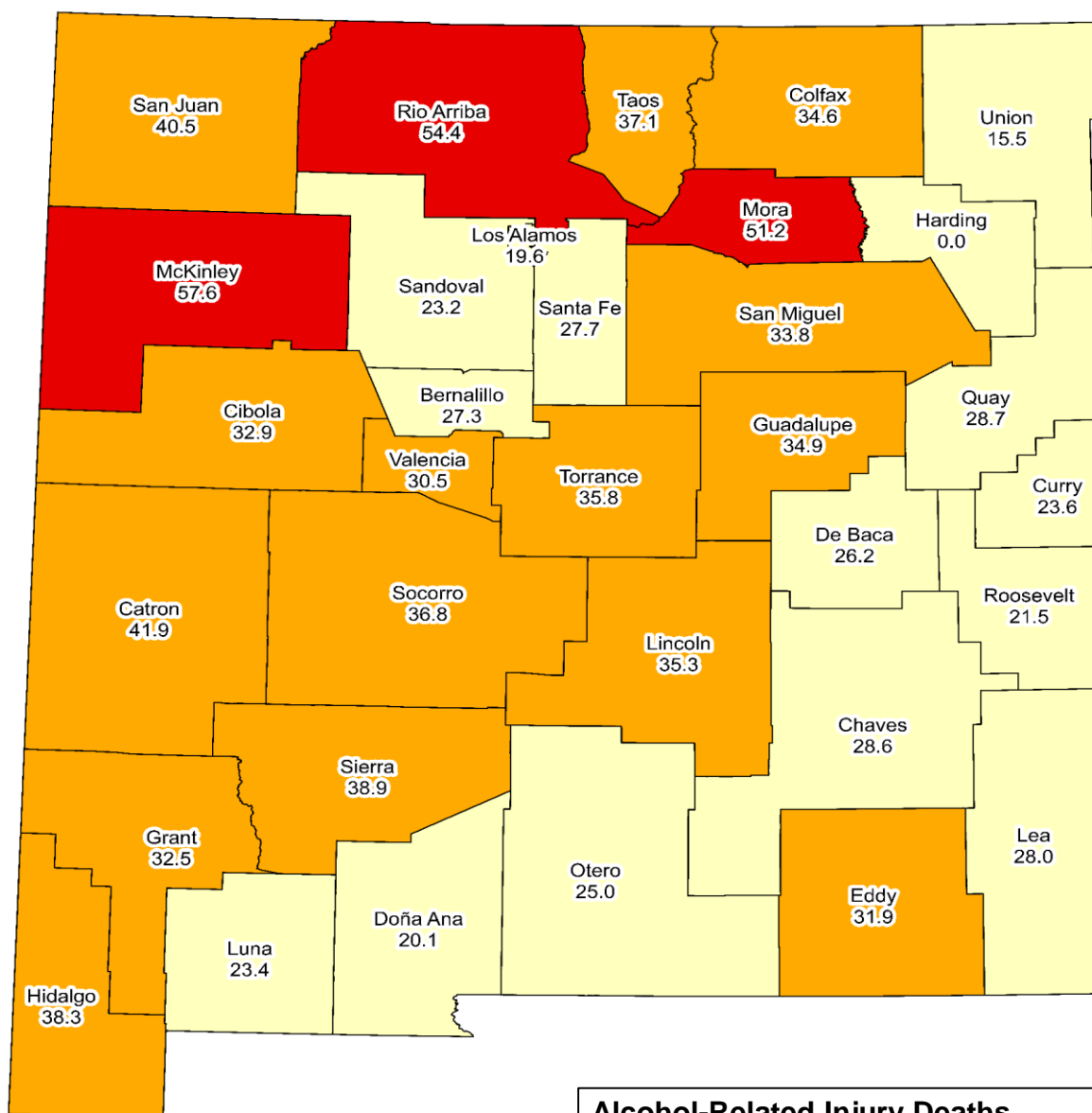


\* All rates are per 100,000, age-adjusted to the 2000 US standard population

Sources: NMDOH BVRHS death files and UNM-GPS population files (NM); NCHS death and population files (US); CDC ARDI; SAES

# ALCOHOL-RELATED INJURY DEATH (continued)

Chart 3: Alcohol-Related Injury Death Rates\* by County, New Mexico, 2013-2017



\* All rates are per 100,000, age-adjusted to the 2000 US standard population

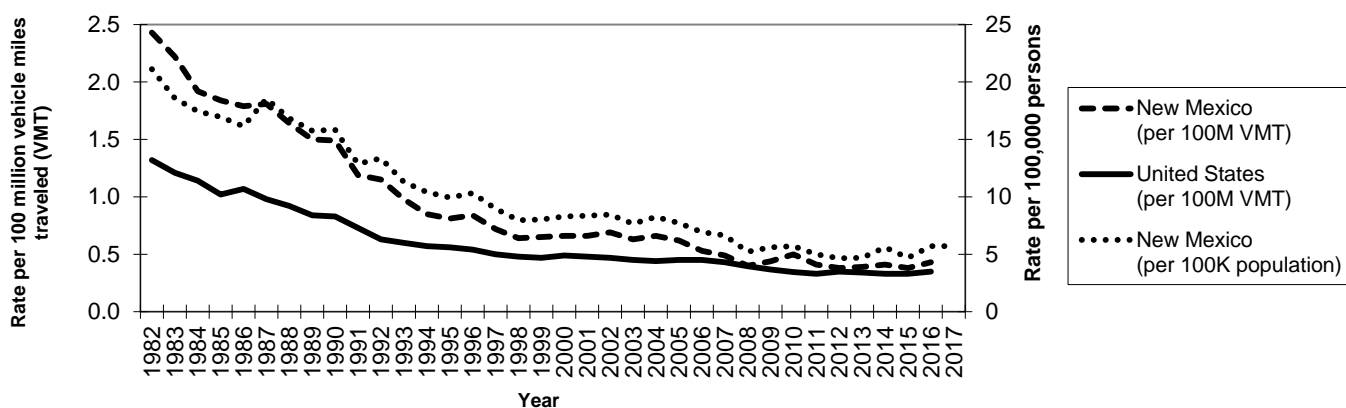
Sources: NMDOH BVRHS death files and UNM-GPS population files; CDC ARDI; SAES

# ALCOHOL-RELATED MOTOR VEHICLE TRAFFIC CRASH (MVTC) DEATH

## Problem Statement

Alcohol-related motor vehicle traffic crash (AR-MVTC) death has historically been the leading cause of alcohol-related injury death until being surpassed by poisoning (i.e. AR drug overdose). AR-MVTC deaths provide a hopeful example of a substance-related health outcome that has been successfully reduced by using a public health approach, both nationally and in New Mexico. From 1982 through 2010, in response to a wide range of policy and preventive interventions, New Mexico's alcohol-impaired motor vehicle traffic crash (AI-MVTC) fatality rate declined more dramatically than the US rate, decreasing 83% and dropping New Mexico from first to tenth among states in AI-MVTC fatalities per 100,000 population. In terms of deaths per 100 million vehicle miles traveled (VMT), New Mexico's AI-MVTC fatality rate in 2016 (0.43) was about one-sixth what it was in 1982 (2.4). Furthermore, a comprehensive AR-MVTC prevention campaign in place from 2005-2009 was successful in reinitiating rate decreases that had been stalled since the late 1990s. From 2004 to 2012, New Mexico's AI-MVTC fatality rate per 100 million VMT dropped 42%. Rates increased slightly in 2014 and dropped back in 2015.

**Chart 1: Alcohol-Impaired MVTC Fatality Rates\*, New Mexico and United States, 1982-2017**



\* Deaths in motor vehicle traffic crashes with highest driver blood alcohol content (BAC)  $\geq 0.08$ ; rates are crude rates per 100 million vehicle miles traveled (VMT) (NM and US through 2016); and per 100,000 population (NM through 2017)

Source: National Highway Traffic Safety Administration (NHTSA) Fatality Analysis Reporting System (FARS); NCHS (population)

**Table 1: Alcohol-Related MVTC Deaths/Rates<sup>1,2</sup> by Age, Sex, and Race/Ethnicity, New Mexico, 2013-2017**

Sex	Race/Ethnicity	Deaths				Rates*			
		Ages 0-24	Ages 25-64	Ages 65+	All Ages	Ages 0-24	Ages 25-64	Ages 65+	All Ages*
Male	American Indian	22	87	2	112	11.6	38.2	5.9	24.4
	Asian/Pacific Islander	1	0	0	1	2.3	0.0	0.0	1.9
	Black	2	6	1	9	3.6	9.6	5.2	7.0
	Hispanic	56	140	6	201	5.3	11.5	2.5	8.1
	White	21	97	11	129	4.3	9.0	2.3	6.6
	Total	101	332	20	453	5.6	12.6	2.6	9.0
Female	American Indian	9	32	1	42	4.6	13.0	1.5	8.5
	Asian/Pacific Islander	0	0	0	0	0.0	0.0	0.0	0.0
	Black	1	1	0	3	2.5	3.0	0.0	2.7
	Hispanic	21	39	2	62	2.1	3.2	0.6	2.5
	White	7	21	4	32	1.5	2.0	0.7	1.7
	Total	38	95	6	139	2.2	3.5	0.7	2.8
Total	American Indian	31	120	3	154	8.1	25.0	3.3	16.2
	Asian/Pacific Islander	1	1	0	2	1.2	0.7	0.0	1.0
	Black	3	8	1	11	3.1	6.9	2.9	5.2
	Hispanic	77	179	8	263	3.7	7.3	1.5	5.3
	White	28	118	14	161	3.0	5.4	1.5	4.2
	Total	139	427	26	592	3.9	8.0	1.6	5.9

\* Age-specific rates (e.g., Ages 0-24) per 100,000 population; all-ages rate per 100,000 population, age-adjusted to 2000 US standard population

<sup>1</sup> Alcohol-related motor vehicle traffic crash (AR-MVTC) deaths estimated based on CDC ARDI alcohol-attributable fractions (BAC $\geq 0.10$ )

<sup>2</sup> These death counts/rates are estimates. They do not equal the actual deaths/rates reported in Charts 1-3 based on FARS. ARDI-based deaths/rates are included here to describe the demographic distribution of AR-MVTC deaths, which is not available from FARS.

Sources: NMDOH BVRHS death files and UNM-GPS population files; CDC ARDI; SAES

# ALCOHOL-RELATED MOTOR VEHICLE TRAFFIC CRASH (MVTC) DEATH

## Problem Statement (continued)

Table 1 shows the demographic distribution of AR-MVTC deaths in New Mexico. Because demographic data are not readily available from the system of record for motor vehicle crash death (the Fatality Analysis Reporting System [FARS] used for Charts 1-3), death certificate data for alcohol-related motor vehicle crash deaths were used here to provide the demographic descriptions in Tables 1 and 2. Because they are based on different data sources, the total and county-level rates reported in Tables 1 and 2 do not match the rates reported in Charts 1-3.

The most pronounced feature of the demographic profile of AR-MVTC deaths is the elevated rates among both male and female American Indians. A finer breakdown by age (not shown) shows that rates are especially high - five to nine times the corresponding White rates - among American Indian males and females ages 25-44. Hispanic and White rates are highest in the age range 15-54. Chart 2 shows that, among counties for which stable rates can be calculated, San Juan, McKinley, Lea, and Eddy counties have substantial AI-MVTC fatalities and high rates; other counties have high rates but fewer deaths. Table 2 shows that the McKinley and San Juan county rates are driven by the American Indian rates (both male and female rates are high, data not shown).

**Table 2: Alcohol-Related MVTC Deaths and Rates\*<sup>1,2</sup> by Race/Ethnicity and County, New Mexico, 2013-2017**

County	Deaths						Rates*					
	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races
Bernalillo	17	0	4	83	39	143	11.1	0.0	3.9	4.9	2.9	4.2
Catron	1	0	0	0	2	2	99.9	0.0	0.0	0.0	17.2	17.0
Chaves	0	0	0	12	6	18	0.0	0.0	0.0	6.4	5.1	5.8
Cibola	12	0	0	3	1	15	23.1	0.0	0.0	5.3	2.9	11.6
Colfax	0	0	0	1	1	3	0.0	0.0	0.0	4.6	2.7	4.6
Curry	0	0	2	6	5	12	0.0	0.0	9.9	5.4	4.2	5.0
De Baca	0	0	0	0	1	1	0.0	0.0	0.0	0.0	20.2	10.3
Dona Ana	0	0	1	32	9	42	0.0	0.0	5.9	4.5	2.8	4.1
Eddy	1	0	1	11	12	25	41.9	0.0	30.4	8.1	10.2	9.7
Grant	0	0	0	2	2	4	0.0	0.0	0.0	2.3	2.9	2.9
Guadalupe	0	0	0	3	0	3	0.0	0.0	0.0	18.7	0.0	15.6
Harding	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0	0.0
Hidalgo	0	0	0	0	1	1	0.0	0.0	0.0	0.0	5.3	2.2
Lea	0	0	1	17	12	30	0.0	0.0	10.9	9.2	9.7	9.2
Lincoln	0	0	0	2	6	7	0.0	0.0	0.0	4.8	12.0	8.9
Los Alamos	0	0	0	0	1	2	0.0	0.0	0.0	0.0	2.4	1.8
Luna	0	0	0	2	3	6	0.0	0.0	0.0	2.6	8.0	4.8
McKinley	54	0	0	3	2	59	20.6	0.0	0.0	7.0	6.3	17.4
Mora	0	0	0	3	1	4	0.0	0.0	0.0	17.7	41.0	21.6
Otero	4	0	1	4	6	15	19.5	0.0	3.6	3.7	3.7	4.7
Quay	0	0	0	1	1	2	0.0	0.0	0.0	7.8	4.9	6.5
Rio Arriba	1	0	0	11	1	13	5.2	0.0	0.0	8.2	5.4	7.5
Roosevelt	0	0	0	2	2	5	0.0	0.0	0.0	5.8	4.4	5.8
Sandoval	10	0	1	8	6	24	11.6	0.0	4.4	3.0	2.1	3.7
San Juan	46	0	0	8	16	71	17.9	0.0	0.0	7.0	6.5	11.3
San Miguel	0	0	0	4	1	6	0.0	0.0	0.0	3.9	2.5	4.0
Santa Fe	1	0	0	16	9	27	4.2	0.0	0.0	4.3	3.0	3.8
Sierra	0	0	0	1	2	3	0.0	0.0	0.0	6.3	8.8	7.7
Socorro	2	0	0	3	1	6	18.4	0.0	0.0	6.8	3.7	7.4
Taos	2	0	0	7	3	12	23.6	0.0	0.0	8.9	6.5	8.5
Torrance	0	0	0	2	2	5	0.0	0.0	0.0	6.0	6.4	6.6
Union	0	0	0	0	1	1	0.0	0.0	0.0	0.0	3.6	3.3
Valencia	2	0	0	16	6	24	11.5	0.0	0.0	7.1	6.1	6.8
New Mexico	154	2	11	263	161	592	16.2	1.0	5.2	5.3	4.2	5.9

\* All rates are per 100,000 population, age-adjusted to the 2000 US standard population

<sup>1</sup> Alcohol-related motor vehicle traffic crash (AR-MVTC) deaths estimated based on CDC ARDI alcohol-attributable fractions (BAC>=0.10)

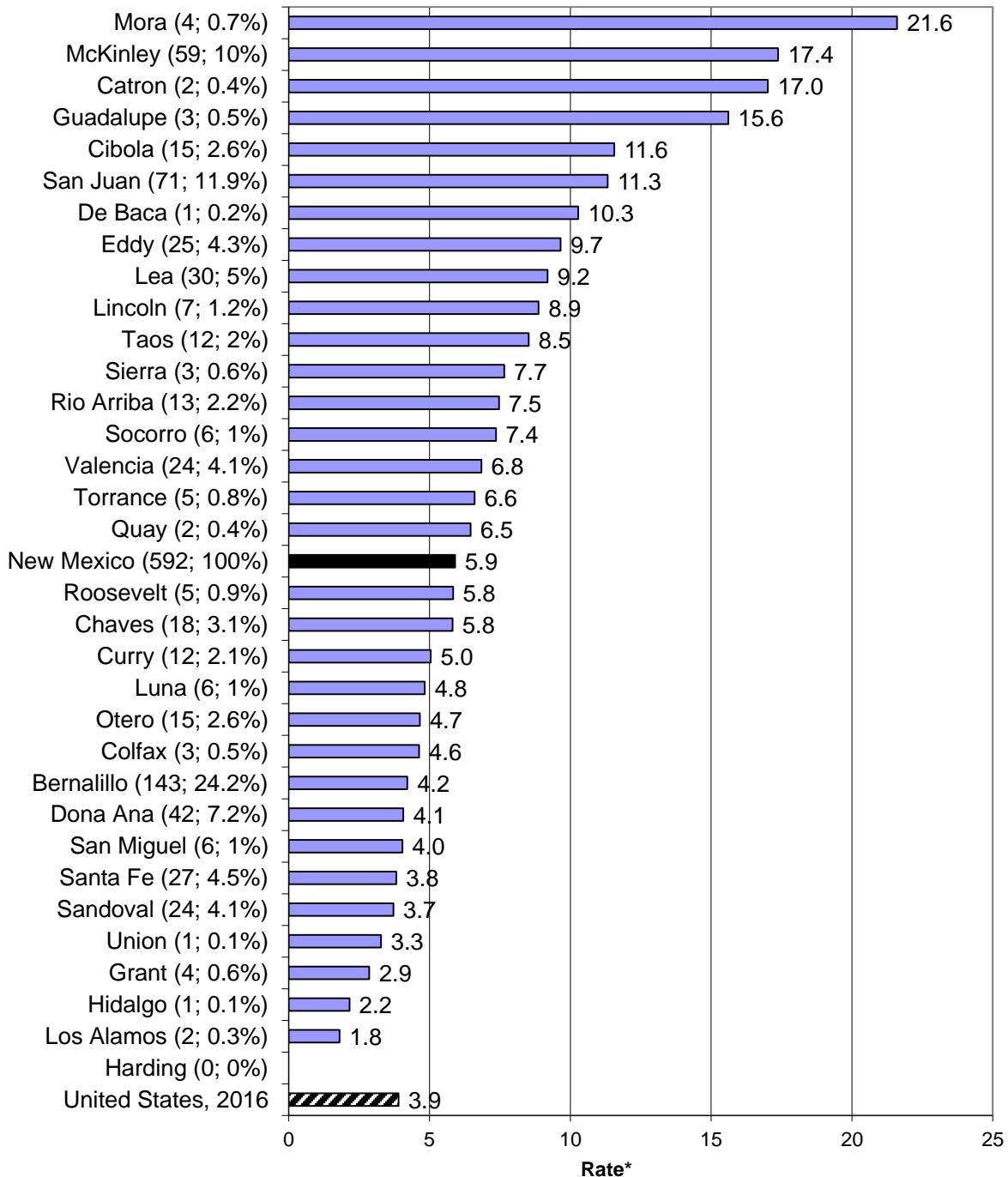
<sup>2</sup> See footnote 2 for Table 1

Sources: NMDOH BVRHS death files and UNM-GPS population files; CDC ARDI; SAES

# ALCOHOL-RELATED MOTOR VEHICLE TRAFFIC CRASH (MVTC) DEATH

Chart 2: Alcohol-Impaired MVTC Fatality Rates<sup>\*,1,2</sup> by County, New Mexico, 2013-2017

County (# of deaths; % of statewide deaths)



\* All rates are crude per 100,000 population

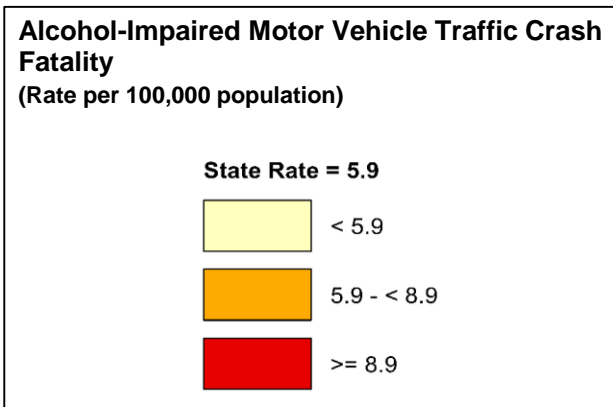
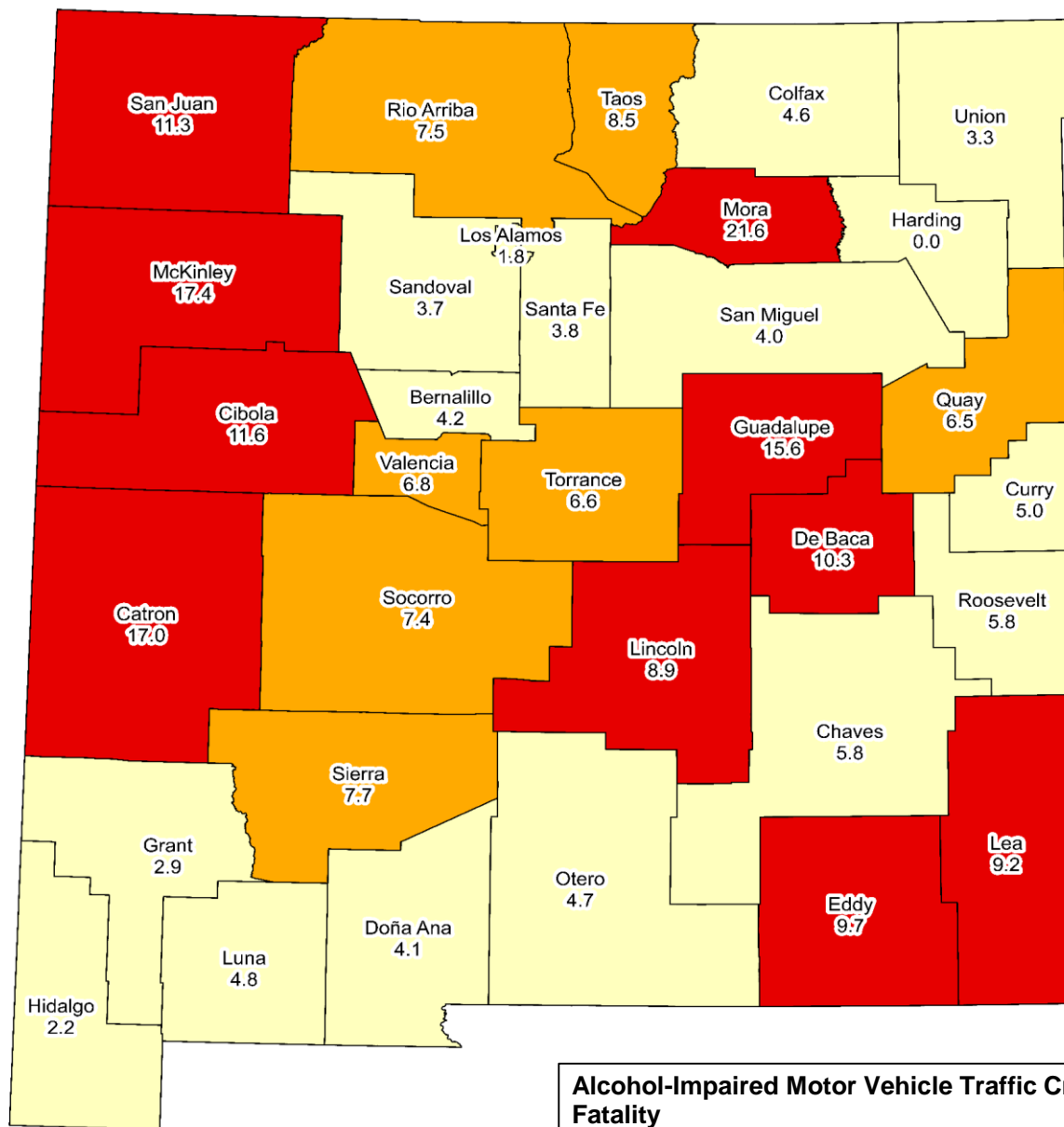
<sup>1</sup> Alcohol-impaired MVTC deaths are from FARS (highest driver BAC >=0.08); NM population from GPS, US population from NCHS

<sup>2</sup> Numerator (deaths) based on county of occurrence; denominator (population) based on county of residence

Source: National Highway Traffic Safety Administration (NHTSA) Fatality Analysis Reporting System (FARS); NCHS (US population); GPS (NM population)

# ALCOHOL-RELATED MOTOR VEHICLE TRAFFIC CRASH (MVTC) DEATH

Chart 3: Alcohol-Impaired MVTC Fatality Rates<sup>1,2</sup> by County, New Mexico, 2013-2017



\* All rates are crude per 100,000 population

1 Alcohol-impaired MVTC deaths are from FARS (highest driver BAC ≥ 0.08); NM population from GPS, US population from NCHS

2 Numerator (deaths) based on county of occurrence; denominator (population) based on county of residence

Source: National Highway Traffic Safety Administration (NHTSA) Fatality Analysis Reporting System (FARS); NCHS (US population); GPS (NM population)

# SMOKING-RELATED DEATH

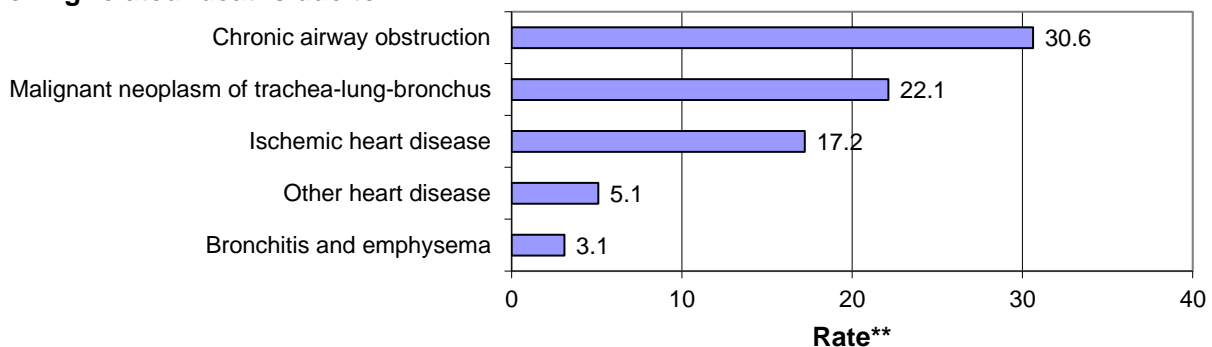
## Problem Statement

Smoking is a risk factor for many causes of death and a serious source of preventable death in New Mexico. Chart 1 shows the five leading causes of smoking-related death in New Mexico, and Table 1 shows the cumulative deaths and rates for all smoking-related causes. Historically, New Mexico's rates for smoking-related causes, such as lung cancer, have been among the lowest in the nation. Nonetheless, a comparison of New Mexico's smoking-related death rates to its alcohol- and drug-related death rates shows that the burden of death associated with smoking is still considerably greater than the burden associated with these other substances. This speaks to the public health importance of smoking prevention efforts, even in a state with low rates relative to the rest of the nation.

Table 1 shows the demographic distribution of smoking-related death in New Mexico. Smoking-related death rates increase sharply in the oldest age group (age 65+), consistent with the fact that smoking-related causes of death are mostly chronic conditions with a long development period. This is in contrast to alcohol- and drug-related deaths, both of which show a large burden of "premature" deaths (deaths before age 65+).

**Chart 1: Leading Causes of Smoking-Related Death, New Mexico, 2013-2017**

### Smoking-related\* deaths due to:



\* Rates reflect only smoking-related portion of deaths from cause

\*\* Rate per 100,000, age-adjusted to the 2000 US standard population

Sources: NMDOH BVRHS death files and UNM-GPS population files; CDC SAMMEC; SAES

**Table 1: Smoking-Related Deaths and Rates\* by Age, Sex, and Race/Ethnicity, New Mexico, 2013-2017**

Sex	Race/Ethnicity	Deaths				Rates*			
		Ages 0-24	Ages 25-64	Ages 65+	All Ages	Ages 0-24	Ages 25-64	Ages 65+	All Ages*
Male	American Indian	0	97	175	272	0.0	42.6	478.1	92.4
	Asian/Pacific Islander	0	17	16	33	0.0	38.7	211.6	54.5
	Black	0	53	85	138	0.0	79.5	733.4	144.6
	Hispanic	0	653	1,511	2,164	0.0	53.7	627.5	114.4
	White	0	1,123	3,624	4,747	0.0	104.4	788.3	145.5
	Total	0	1,963	5,434	7,397	0.0	74.6	718.5	131.9
Female	American Indian	0	51	100	151	0.0	20.3	186.8	35.3
	Asian/Pacific Islander	0	9	31	40	0.0	15.8	256.6	44.7
	Black	0	22	44	66	0.0	47.3	379.0	68.4
	Hispanic	0	298	893	1,190	0.0	24.2	301.8	50.4
	White	0	606	2,598	3,204	0.0	55.6	491.4	81.2
	Total	0	992	3,675	4,667	0.0	37.1	407.6	67.3
Total	American Indian	0	148	274	423	0.0	31.0	305.1	58.1
	Asian/Pacific Islander	0	26	47	74	0.0	25.8	239.4	48.9
	Black	0	75	129	204	0.0	66.1	556.2	105.4
	Hispanic	0	950	2,404	3,354	0.0	38.8	448.0	78.7
	White	0	1,728	6,222	7,950	0.0	79.8	629.5	110.3
	Total	0	2,955	9,109	12,063	0.0	55.7	549.5	96.2

\* Age-specific rates (e.g., Ages 0-24) are per 100,000; all-ages rate is per 100,000, age-adjusted to the 2000 US standard population

Sources: NMDOH BVRHS death files and UNM-GPS population files; CDC SAMMEC; SAES



# SMOKING-RELATED DEATH (continued)

## Problem Statement (continued)

Table 1 also shows that male rates are roughly 2-3 times higher than female rates across all racial/ethnic groups except for Asian/Pacific Islanders. Among males and females, Whites have the highest rates followed by Blacks.

Table 2 and Chart 2 show that the counties with the highest rates are Sierra, De Baca, Luna, Quay, and Torrance. The high rates in most of these counties (and in the state overall) are driven by high rates among Whites. However, there are notably elevated rates among Hispanics in Quay, Sierra, Union, and Curry counties and a substantial burden of smoking-related death among Hispanics in several other counties (e.g., Bernalillo, Dona Ana, and Santa Fe). The high rates of smoking-related death among Blacks in Bernalillo, Curry, Dona Ana, Lea, and Otero counties are also notable. The smoking-related death rates among the American Indian and Asian/Pacific Islander populations are relatively low.

NOTE: These tables are based on the Centers for Disease Control and Prevention Smoking Attributable Mortality, Morbidity, and Economic Costs (SAMMEC) methodology. However, CDC's SAMMEC site reports age-adjusted rates based on the age 35+ population; whereas this report calculates age-adjusted rates for the entire population. As a result, the smoking-attributable mortality rates reported here are lower than those reported by the CDC's SAMMEC site.

**Table 2: Smoking-Related Deaths and Rates\* by Race/Ethnicity and County, New Mexico, 2013-2017**

County	Deaths						Rates*					
	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races
Bernalillo	60	44	96	1,084	2,295	3,607	74.2	54.2	114.3	82.3	99.6	93.4
Catron	1	0	0	5	31	37	76.1	0.0	0.0	70.9	86.6	81.4
Chaves	3	1	7	112	387	510	106.1	46.7	101.1	85.0	155.6	129.5
Cibola	26	0	1	43	75	145	46.4	0.0	40.6	88.8	145.1	93.0
Colfax	1	0	0	40	70	112	61.7	0.0	0.0	98.1	98.6	101.2
Curry	2	1	17	59	237	315	109.4	18.7	155.0	102.5	145.1	132.6
De Baca	0	0	0	4	24	28	0.0	0.0	0.0	65.4	193.3	152.3
Dona Ana	5	4	14	373	600	1,000	69.2	46.0	95.6	64.8	108.6	85.3
Eddy	1	2	5	83	361	454	41.1	101.1	108.3	82.0	169.0	139.0
Grant	1	0	2	72	160	236	108.3	0.0	110.0	75.0	104.3	92.6
Guadalupe	0	0	0	24	10	35	0.0	0.0	0.0	101.4	178.7	115.3
Harding	0	0	0	3	2	5	0.0	0.0	0.0	101.1	99.9	99.8
Hidalgo	0	0	0	10	28	38	0.0	0.0	0.0	57.9	151.4	104.6
Lea	2	0	17	70	328	420	86.5	0.0	129.9	73.9	170.5	136.0
Lincoln	4	0	0	22	149	175	277.6	0.0	0.0	72.3	103.5	97.4
Los Alamos	0	1	1	5	63	69	0.0	36.8	47.2	35.3	58.9	54.7
Luna	2	1	1	61	197	262	110.1	45.3	80.2	84.2	207.4	146.1
McKinley	131	1	0	32	58	221	60.4	27.8	0.0	71.8	99.0	68.2
Mora	0	0	0	21	5	26	0.0	0.0	0.0	67.7	41.6	62.0
Otero	13	4	12	63	385	479	98.2	88.4	110.0	66.1	138.8	118.2
Quay	1	1	0	26	77	105	98.8	119.6	0.0	129.1	152.1	142.0
Rio Arriba	14	0	1	140	56	211	54.2	0.0	73.0	81.2	104.2	82.8
Roosevelt	2	0	0	20	104	127	243.1	0.0	0.0	83.5	136.8	126.2
Sandoval	37	4	11	123	488	666	56.3	36.9	62.5	66.5	93.1	83.4
San Juan	85	2	5	61	443	597	45.4	51.4	125.8	74.2	111.2	88.5
San Miguel	1	3	1	140	66	211	561.8	174.3	48.9	100.6	116.8	105.1
Santa Fe	7	3	3	281	437	735	47.8	28.9	66.0	77.0	66.4	69.9
Sierra	2	0	1	22	219	245	129.6	0.0	128.7	104.9	198.1	179.7
Socorro	6	0	0	40	67	114	82.1	0.0	0.0	84.0	120.2	102.7
Taos	5	0	1	91	74	172	39.4	0.0	54.3	70.7	57.6	64.0
Torrance	3	0	2	38	106	150	135.8	0.0	194.8	118.3	148.5	139.1
Union	0	0	0	11	21	32	0.0	0.0	0.0	127.1	88.7	96.9
Valencia	10	1	8	175	324	522	85.8	47.1	166.6	82.6	141.2	113.3
New Mexico	423	74	204	3,354	7,950	12,063	58.1	48.9	105.4	78.7	110.3	96.2

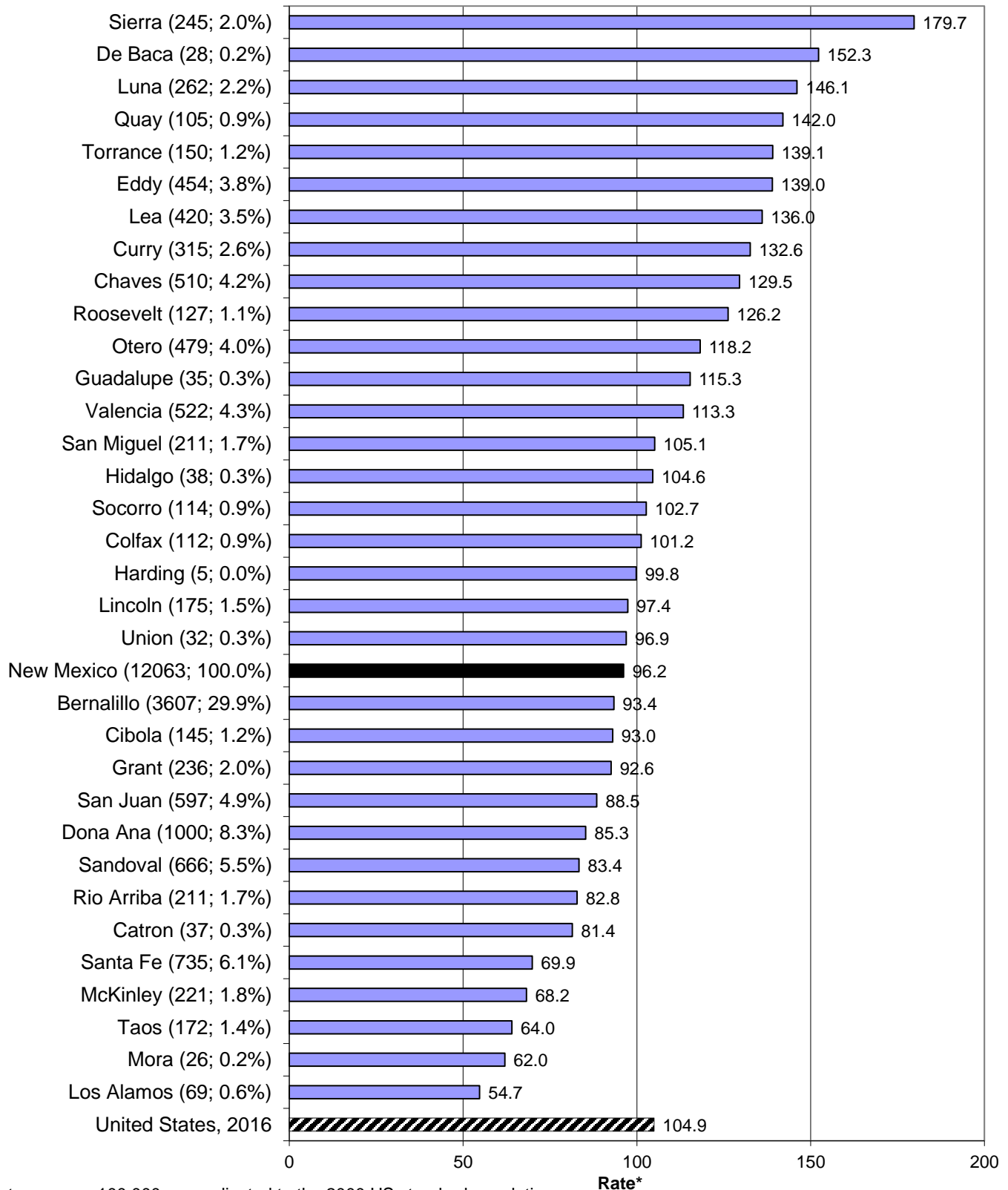
\* All rates are per 100,000, age-adjusted to the 2000 US standard population

Sources: NMDOH BVRHS death files and UNM-GPS population files; CDC SAMMEC; SAES

# SMOKING-RELATED DEATH (continued)

Chart 2: Smoking-Related Death Rates\* by County, New Mexico, 2013-2017

County (# of deaths; % of statewide deaths)

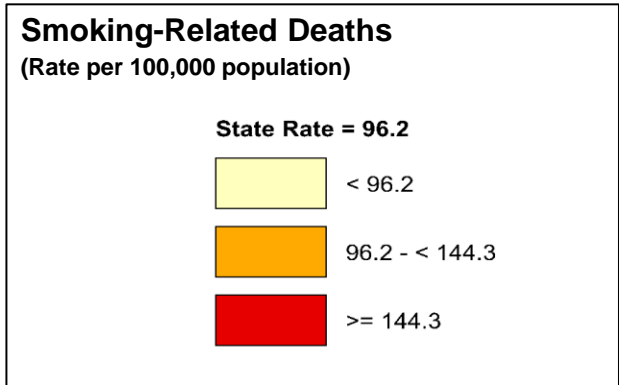
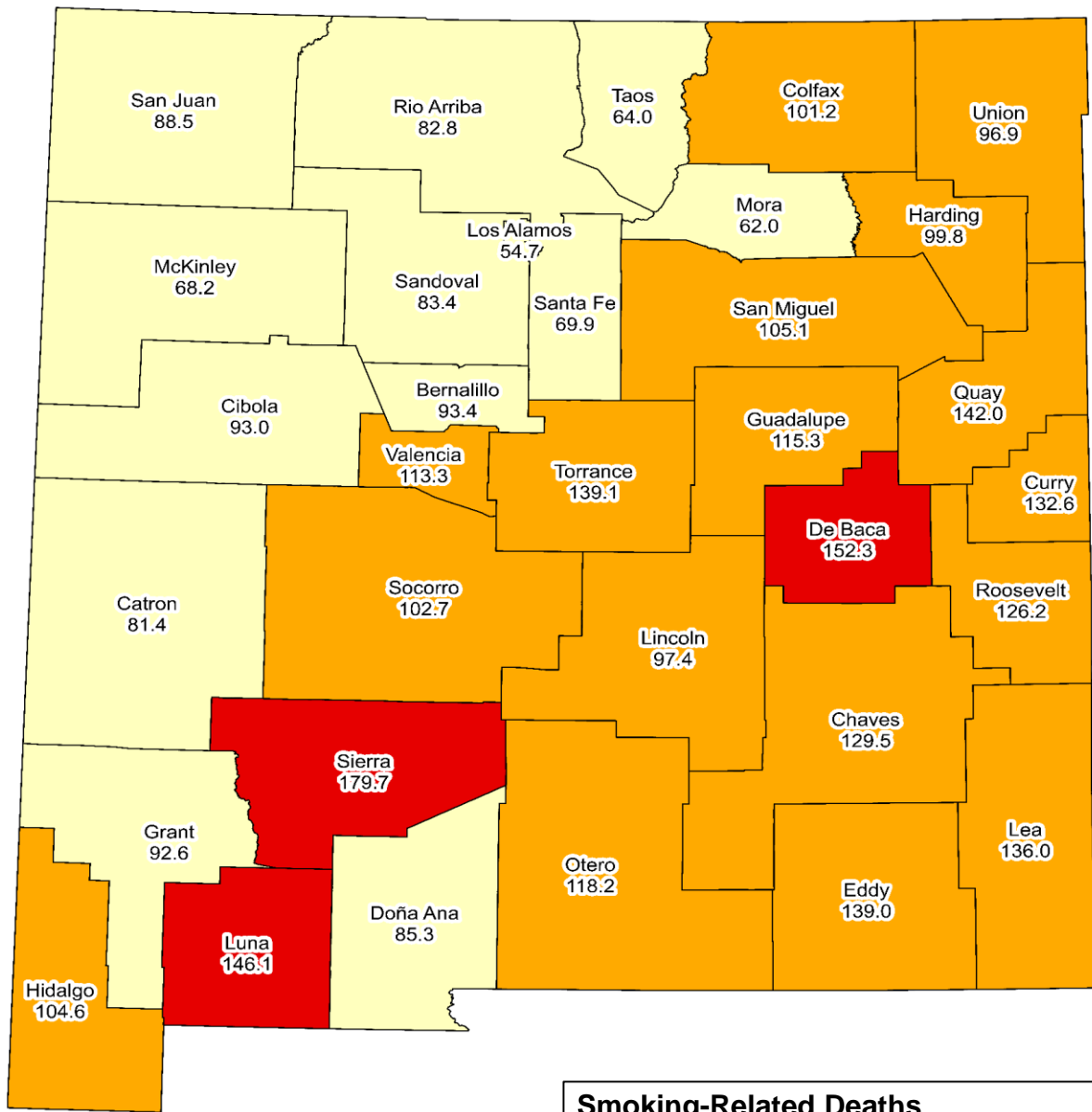


\* All rates are per 100,000, age-adjusted to the 2000 US standard population

Sources: NMDOH BVRHS death files and UNM-GPS population files (NM); NCHS death and population files (US); CDC SAMMEC; SAES

# SMOKING-RELATED DEATH (continued)

Chart 3: Smoking-Related Death Rates\* by County, New Mexico, 2013-2017



\* All rates are per 100,000, age-adjusted to the 2000 US standard population

Sources: NMDOH BVRHS death files and UNM-GPS population files; CDC SAMMEC; SAES

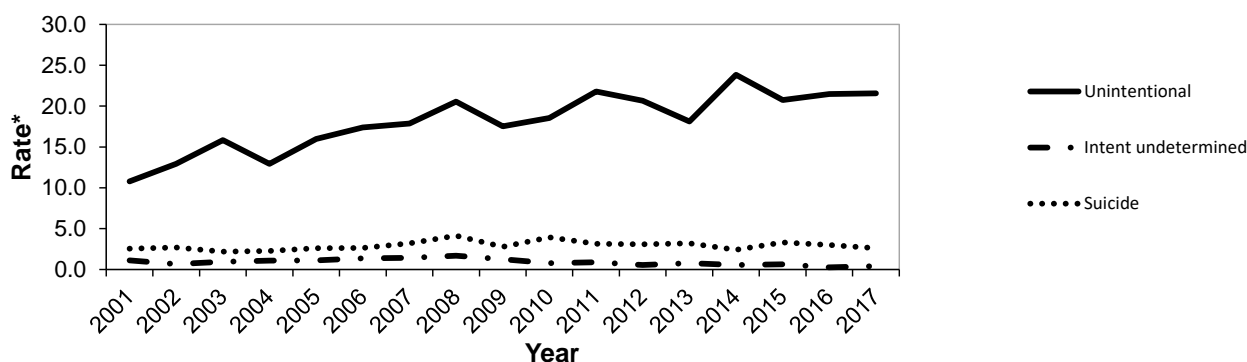
# DRUG OVERDOSE DEATH

## Problem Statement

In 2017, New Mexico had the seventeenth highest total drug overdose death rate in the nation. Drug use can result in overdose death and is also associated with other societal problems including crime, violence, homelessness, loss of productivity, and spread of blood-borne diseases such as HIV and hepatitis. Unintentional drug overdose is the largest subset of total drug overdose death, accounting for 88% of drug overdose deaths in New Mexico in 2017 (Chart 1). The other substantial cause of drug overdose death is suicide, or intentional self-poisoning, which accounts for 11%. Poisoning has been the leading cause of unintentional injury in New Mexico since 2007, surpassing motor vehicle crash deaths, largely as a result of increased unintentional drug overdose deaths associated with prescription drug use.

Unintentional drug overdoses account for almost 88% of drug overdose deaths during 2013-2017. 36% of unintentional drug overdose deaths were caused by prescription drugs, while 40% were caused by illicit drugs, and 22% involved both. Vital records death data indicate that the most common drugs causing unintentional overdose death for the period covered in this report were prescription opioids (i.e., methadone, oxycodone, morphine; 57%), heroin (40%), benzodiazepines (24%), cocaine (13%), and methamphetamine (26%) (not mutually exclusive). In New Mexico and nationally, overdose death from prescription opioids has become an issue of enormous concern. Interventions are currently being formulated, implemented, and assessed in New Mexico and in communities across the country, and may be contributing to decreases in death in the most recent data available.

**Chart 1: Drug Related Death Rates\* by Cause Category, New Mexico, 2001-2017**



\* Rate per 100,000, age-adjusted to the 2000 US standard population

\* Cause categories based on ICD-10 codes for drug overdose deaths.

**Table 1: Drug Overdose Deaths and Rates\* by Age, Sex, and Race/Ethnicity, New Mexico, 2013-2017**

Sex	Race/Ethnicity	Deaths				Rates*			
		Ages 0-24	Ages 25-64	Ages 65+	All Ages	Ages 0-24	Ages 25-64	Ages 65+	All Ages*
Male	American Indian	5	77	0	82	2.6	33.7	0.0	19.3
	Asian/Pacific Islander	1	5	0	6	3.8	11.2	0.0	6.9
	Black	3	34	1	38	6.4	50.9	8.6	29.9
	Hispanic	89	750	24	863	8.4	61.6	10.0	36.6
	White	41	459	33	533	8.3	42.7	7.2	27.1
	Total	139	1,338	61	1,538	7.7	50.8	8.1	31.1
Female	American Indian	3	41	2	46	1.6	16.4	3.7	9.9
	Asian/Pacific Islander	1	2	0	3	3.9	3.5	0.0	3.1
	Black	3	13	0	16	7.5	27.5	0.0	16.8
	Hispanic	37	351	12	400	3.6	28.5	4.1	16.8
	White	17	391	51	459	3.8	35.9	9.6	21.2
	Total	61	805	66	932	3.5	30.1	7.3	18.0
Total	American Indian	8	118	2	128	2.1	24.7	2.2	14.5
	Asian/Pacific Islander	2	7	0	9	3.9	6.9	0.0	4.8
	Black	6	47	1	54	6.9	41.2	4.3	24.5
	Hispanic	126	1,101	36	1,263	6.1	45.0	6.7	26.7
	White	58	850	84	992	6.1	39.3	8.5	24.3
	Total	200	2,143	127	2,470	5.6	40.4	7.7	24.6

\* Age-specific rates (e.g., Ages 0-24) are per 100,000; all-ages rate is per 100,000, age-adjusted to the 2000 US standard population

Sources: NMDOH BVRHS death files and UNM-GPS population files; SAES

## DRUG OVERDOSE DEATH (continued)

### Problem Statement (continued)

Table 1 shows that Hispanic men had the highest total drug overdose death rate. Hispanic men had higher unintentional drug overdose death rates than White men across the age range (Chart 4). The rates of total drug overdose death (Table 1) and unintentional drug overdose death (Table 3) among men were more than 1.5 times that of women. Among women, drug overdose death from prescription drugs was more common than from illicit drugs across the age range. Illicit drugs were the predominant drug type causing death among males across the age range, and the rates were highest among males aged 25-54 years.

Rio Arriba County had the highest total drug overdose death rate (89.9 deaths per 100,000) and unintentional drug overdose death rate (86.2 deaths per 100,000; Table 3) among all New Mexico counties during 2013-2017. However, the problem of drug overdose is by no means limited to Rio Arriba County. As expected, Bernalillo County had the largest number of unintentional drug overdose deaths (Table 3). According to Chart 2, close to one-third of New Mexico counties had total drug overdose death rates one and a half times higher than the US rate (21.7 deaths per 100,000 population).

The death rate from prescription drugs exceeded the statewide death rate from illicit drugs in almost half (14 of 33) of the counties (Table 3).

**Table 2: Drug Overdose Deaths and Rates\* by Race/Ethnicity and County, New Mexico, 2013-2017**

County	Deaths						Rates*					
	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races
Bernalillo	34	4	30	475	352	902	21.6	4.0	30.3	29.1	24.2	26.3
Catron	0	0	0	0	3	3	0.0	0.0	0.0	0.0	40.9	29.5
Chaves	1	1	2	26	39	69	39.3	40.1	39.8	16.4	29.5	22.9
Cibola	4	0	0	10	9	23	8.4	0.0	0.0	19.7	26.5	16.8
Colfax	0	0	0	14	8	22	0.0	0.0	0.0	51.4	24.1	38.5
Curry	1	0	1	11	23	36	42.2	0.0	9.2	12.2	18.8	15.4
De Baca	0	0	0	2	0	2	0.0	0.0	0.0	84.8	0.0	34.4
Dona Ana	0	1	5	92	63	164	0.0	5.5	24.1	14.0	22.9	17.0
Eddy	1	0	0	16	45	62	26.6	0.0	0.0	12.0	34.5	23.0
Grant	0	0	0	23	25	48	0.0	0.0	0.0	39.0	46.7	41.5
Guadalupe	0	0	0	9	1	10	0.0	0.0	0.0	56.1	14.6	44.9
Harding	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0	0.0
Hidalgo	0	0	0	3	5	9	0.0	0.0	0.0	26.6	55.1	41.0
Lea	0	0	6	15	40	61	0.0	0.0	41.8	8.1	32.9	18.8
Lincoln	0	0	0	13	22	35	0.0	0.0	0.0	43.2	45.5	42.7
Los Alamos	0	0	0	5	11	16	0.0	0.0	0.0	37.7	19.9	20.5
Luna	0	0	0	7	12	19	0.0	0.0	0.0	10.8	41.0	19.2
McKinley	22	0	1	11	6	40	9.5	0.0	48.5	25.2	21.9	12.6
Mora	0	0	0	2	0	2	0.0	0.0	0.0	15.8	0.0	13.5
Otero	3	0	3	16	42	64	13.8	0.0	29.0	14.5	24.5	20.0
Quay	0	0	0	5	4	9	0.0	0.0	0.0	25.2	23.2	21.2
Rio Arriba	10	0	0	143	4	158	37.2	0.0	0.0	111.8	22.7	89.9
Roosevelt	0	0	1	3	7	11	0.0	0.0	103.8	8.4	14.0	12.1
Sandoval	13	1	2	48	62	129	17.3	10.6	13.3	18.7	20.7	19.6
San Juan	26	0	2	17	57	103	11.4	0.0	47.6	16.7	20.0	16.7
San Miguel	0	0	0	50	3	53	0.0	0.0	0.0	53.4	7.4	44.9
Santa Fe	6	2	0	139	67	219	33.1	17.0	0.0	37.9	23.0	32.5
Sierra	1	0	0	2	14	17	130.3	0.0	0.0	11.0	37.2	29.5
Socorro	1	0	0	12	2	15	9.7	0.0	0.0	32.3	4.6	19.6
Taos	3	0	0	23	15	42	37.3	0.0	0.0	28.8	26.9	29.2
Torrance	1	0	0	11	11	23	44.6	0.0	0.0	36.0	25.9	29.6
Union	0	0	0	1	0	1	0.0	0.0	0.0	12.8	0.0	4.8
Valencia	1	0	1	59	38	101	5.9	0.0	23.7	27.3	29.2	27.1
New Mexico	128	9	54	1,263	992	2,470	14.5	4.8	24.5	26.7	24.3	24.6

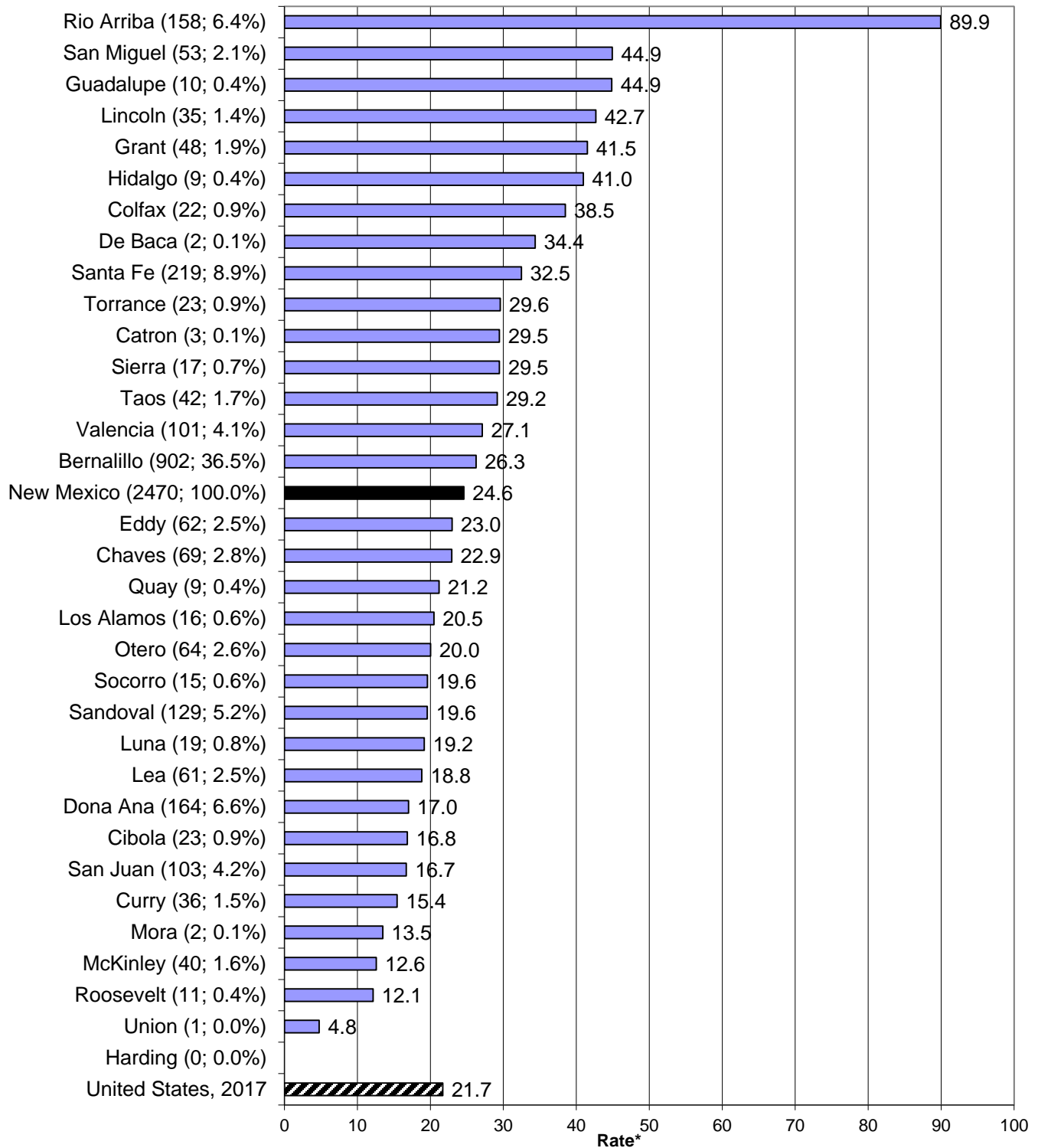
\* All rates are per 100,000, age-adjusted to the 2000 US standard population

Sources: NMDOH BVRHS death files and UNM-GPS population files; SAES

# DRUG OVERDOSE DEATH (continued)

Chart 2: Drug Overdose Death Rates\* by County, New Mexico, 2013-2017

County (# of deaths; % of statewide deaths)

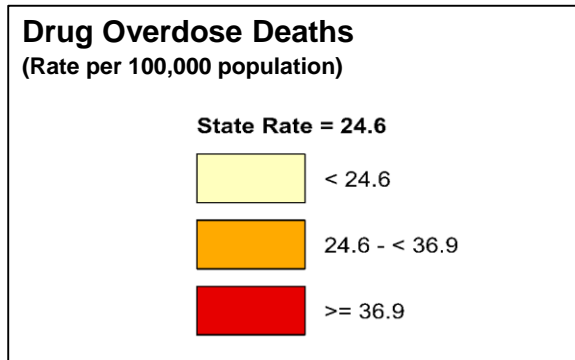
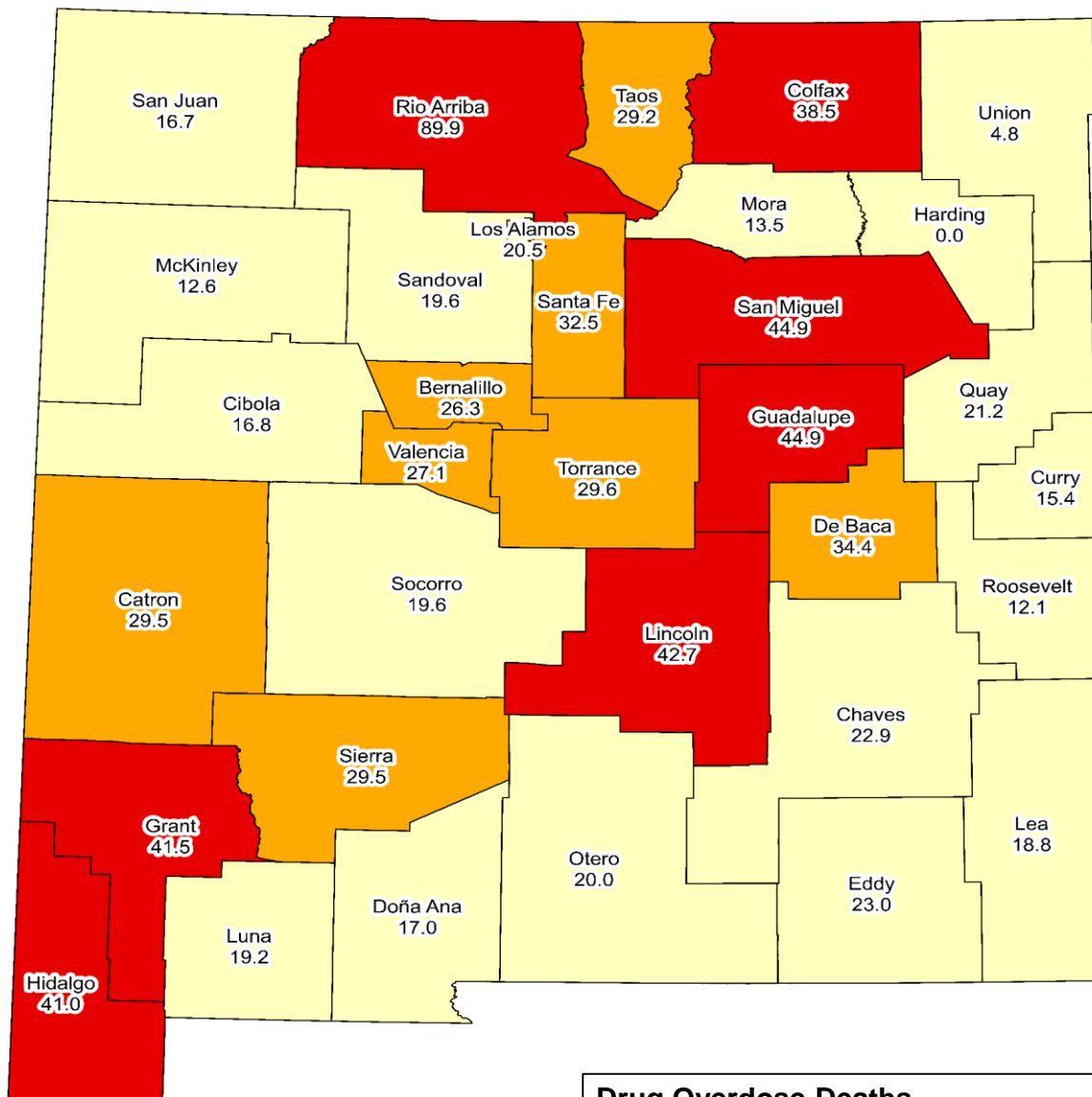


\* All rates are per 100,000, age-adjusted to the 2000 US standard population

Sources: NMDOH BVRHS death files and UNM-GPS population files (NM); NCHS death and population files (US); SAES

# DRUG OVERDOSE DEATH (continued)

Chart 3: Drug Overdose Death Rates\* by County, New Mexico, 2013-2017

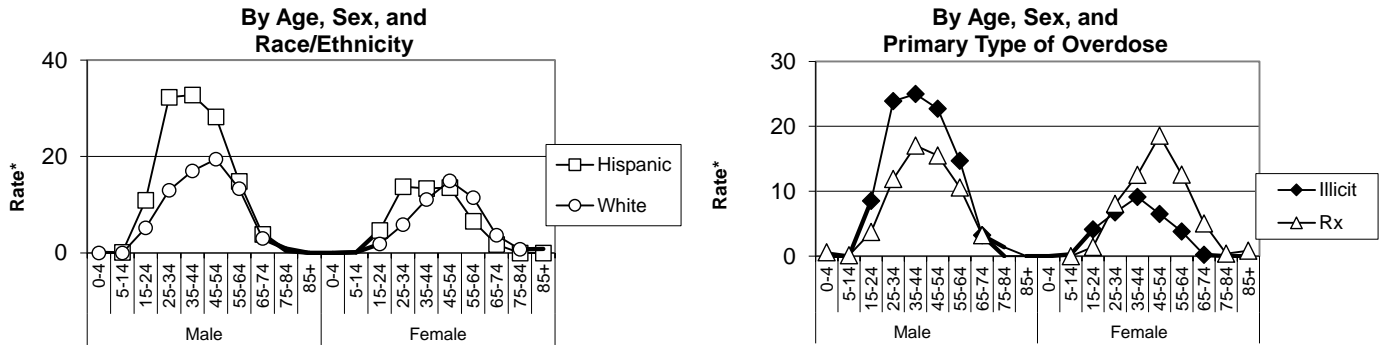


\* All rates are per 100,000, age-adjusted to the 2000 US standard population

Sources: NMDOH BVRHS death files and UNM-GPS population files; SAES

# DRUG OVERDOSE DEATH (continued)

Chart 4: Unintentional Drug Overdose Death Rates\* by Selected Characteristics, New Mexico, 2013-2017



Source: Bureau of Vital Records and Health Statistics; UNM-GPS population files; SAES

Table 3: Unintentional Drug Overdose Deaths and Rates\*, New Mexico, 2013-2017

County	Deaths					Total	Rates*					Total
	Sex		Overdose Type				Sex		Overdose Type			
	Male	Female	Illicit	Rx	Both		Male	Female	Illicit	Rx	Both	
Bernalillo	531	260	318	267	189	791	31.7	14.8	9.3	7.8	5.6	23.2
Catron	0	2	0	1	0	2	0.0	3.2	0.0	12.6	0.0	14.8
Chaves	38	23	26	22	11	61	25.2	14.9	8.2	7.4	3.6	20.0
Cibola	13	7	8	9	2	20	18.7	9.6	6.2	6.0	1.6	14.6
Colfax	16	5	10	4	6	21	55.5	18.1	19.0	6.8	11.2	37.8
Curry	22	12	8	16	6	34	17.8	11.1	3.8	7.0	2.3	14.6
De Baca	2	0	1	1	0	2	68.8	0.0	15.9	18.4	0.0	34.3
Dona Ana	99	43	52	51	32	142	21.5	8.7	5.4	5.3	3.4	14.9
Eddy	39	17	24	18	13	56	28.2	13.1	8.9	6.5	4.9	20.9
Grant	22	17	20	16	2	39	41.8	27.5	18.0	13.3	2.1	34.6
Guadalupe	6	4	6	3	1	10	46.2	45.4	28.5	13.5	2.9	44.9
Harding	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0	0.0
Hidalgo	4	4	2	6	0	8	28.6	3.5	6.9	25.9	0.0	32.8
Lea	33	22	24	26	3	55	18.6	14.9	7.5	7.9	0.8	16.9
Lincoln	18	16	13	17	4	34	44.0	38.9	18.9	18.0	4.6	41.6
Los Alamos	9	5	4	10	0	14	24.4	11.3	5.8	12.2	0.0	18.0
Luna	8	8	5	8	3	16	16.2	16.4	6.3	6.9	2.9	16.2
McKinley	21	11	15	9	3	32	14.7	6.5	4.8	3.3	0.8	10.5
Mora	1	1	0	1	1	2	11.9	15.1	0.0	7.4	6.1	13.5
Otero	26	23	17	24	8	49	16.7	14.6	5.9	7.2	2.6	15.7
Quay	4	3	2	1	4	7	16.4	15.2	2.6	3.2	9.7	15.6
Rio Arriba	113	38	62	35	50	151	130.8	41.7	35.7	18.0	30.0	86.2
Roosevelt	8	3	2	8	1	11	16.5	7.5	2.4	8.7	1.0	12.1
Sandoval	71	45	41	51	23	116	22.6	12.6	6.5	7.3	3.7	17.6
San Juan	53	33	30	45	8	86	17.5	11.0	4.9	7.4	1.5	14.3
San Miguel	26	16	18	14	9	42	46.7	26.0	15.0	12.3	8.2	36.2
Santa Fe	120	63	74	63	45	183	36.7	19.9	11.8	9.0	7.3	28.3
Sierra	8	9	5	10	2	17	29.7	29.7	9.4	15.3	4.7	29.5
Socorro	10	3	8	3	2	13	26.8	8.7	11.4	3.8	2.7	17.9
Taos	22	11	12	14	5	33	31.5	13.3	8.8	8.8	4.0	22.5
Torrance	12	9	10	9	1	21	29.2	24.9	13.4	10.2	1.8	27.0
Union	1	0	0	1	0	1	8.0	0.0	0.0	4.8	0.0	4.8
Valencia	58	24	34	26	20	82	32.1	13.4	9.2	7.4	5.8	22.9
<b>Total</b>	<b>1,415</b>	<b>738</b>	<b>851</b>	<b>791</b>	<b>454</b>	<b>2,153</b>	<b>28.7</b>	<b>14.6</b>	<b>8.6</b>	<b>7.8</b>	<b>4.7</b>	<b>21.7</b>

\* All rates are per 100,000, age-adjusted to the 2000 US standard population; Drug overdose type categories are mutually exclusive.

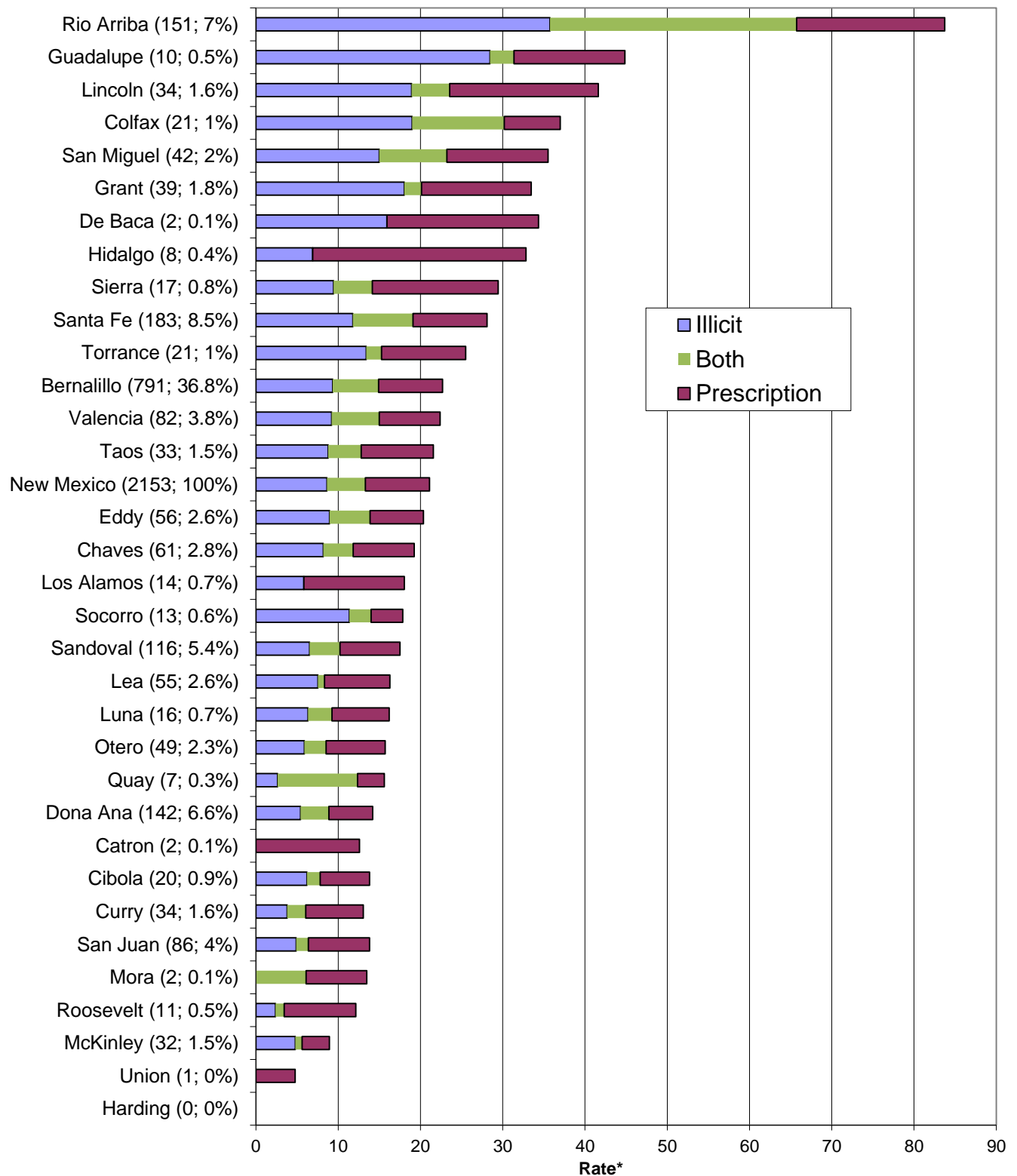
Source: NMDOH Bureau of Vital Records and Health Statistics; UNM-GPS population files; SAES



# DRUG OVERDOSE DEATH (continued)

Chart 5: Unintentional Drug Overdose Death Rates\* by County and Drug Type, New Mexico, 2013-2017

County (# of deaths; % of statewide deaths)



\* All rates are per 100,000, age-adjusted to the 2000 US standard population

Source: NMDOH Bureau of Vital Records and Health Statistics; UNM-GPS population files; SAES

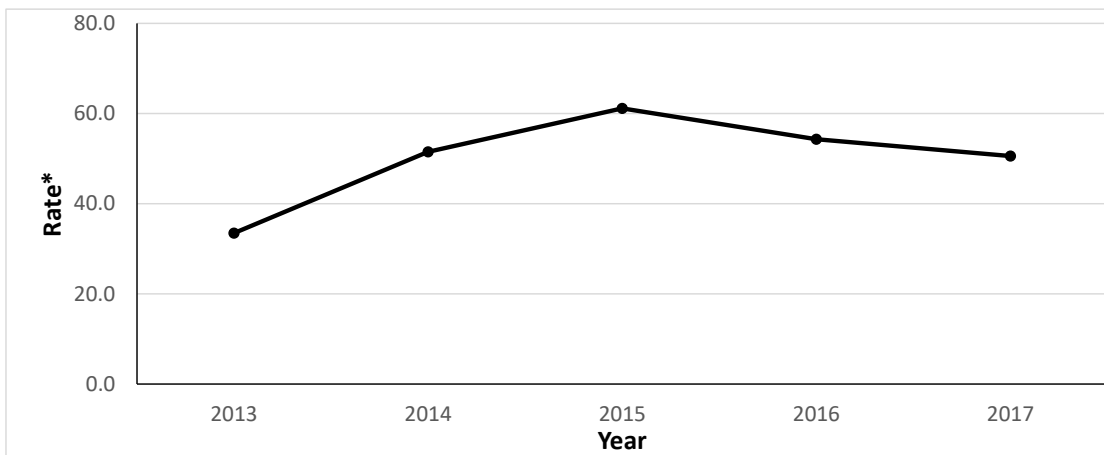
# OPIOID OVERDOSE RELATED EMERGENCY DEPARTMENT VISITS

## Problem Statement

In addition to the observed increase in drug overdose deaths, there has been an increase in opioid overdose related emergency department (ED) visits. In the US between 2004 and 2009, there has been a 98.4% increase in ED visits related to misuse or abuse of prescription drugs, particularly opioids (Paulozzi, L. J., Jones, C. M., Mack, K. A., & Rudd, R. A. [2011]. Vital Signs: Overdoses of prescription opioid pain relievers-United States, 1999–2008. *Morbidity and Mortality Weekly Report*, 60[43], 6). In New Mexico the emergency department dataset (EDD) is collected in accordance with the NM Public Health Act and New Mexico Administrative Code 7.4.3.10.

Chart 1 shows that between 2013 and 2015, the rate of opioid overdose related emergency department visits increased by 82% in New Mexico.

**Chart 1: Opioid Overdose Related Emergency Department Visit Rates\*, New Mexico, 2013-2017**



\* Rates per 100,000 population

Sources: NMDOH Syndromic Surveillance ED files and UNM-GPS population files; SAES

**Table 1: Opioid Overdose Related Emergency Department Visits and Rates\* by Age, Sex, and Race/Ethnicity, New Mexico, 2013-2017**

Sex	Race/Ethnicity	Emergency Department Visits				Rates*			
		Ages 0-24	Ages 25-64	Ages 65+	All Ages	Ages 0-24	Ages 25-64	Ages 65+	All Ages*
Male	American Indian	11	109	6	127	1.7	24.8	2.1	28.6
	Asian/Pacific Islander	5	16	2	23	5.4	18.6	3.3	27.3
	Black	30	95	15	140	18.4	74.1	16.4	108.9
	Hispanic	332	1,246	72	1,650	9.0	53.3	3.8	66.1
	White	152	495	99	747	8.8	24.0	2.7	35.5
	Total	580	2,139	202	2,927	9.2	42.3	3.4	54.8
Female	American Indian	17	83	9	109	2.6	17.3	2.1	22.0
	Asian/Pacific Islander	5	6	1	12	5.7	5.4	1.0	12.1
	Black	20	104	24	148	14.4	114.5	26.2	155.1
	Hispanic	243	735	83	1,061	6.8	31.1	3.5	41.4
	White	124	464	146	734	7.9	22.2	3.5	33.5
	Total	445	1,498	279	2,222	7.4	29.1	3.9	40.4
Total	American Indian	29	194	15	239	2.2	21.1	2.1	25.4
	Asian/Pacific Islander	10	22	3	35	5.5	11.2	1.9	18.7
	Black	50	199	39	288	16.6	90.8	21.3	128.7
	Hispanic	600	2,068	156	2,824	8.3	44.0	3.7	55.9
	White	287	990	258	1,536	8.7	23.8	3.3	35.8
	Total	1,099	3,859	502	5,469	8.9	37.8	3.8	50.6

\* Age-specific rates (e.g., Ages 0-24) are per 100,000; all-ages rate is per 100,000, age-adjusted to the 2000 US standard population

\*\*There were 876 visits for which race-ethnicity was missing.

Sources: NMDOH Syndromic Surveillance ED files and UNM-GPS population files; SAES

# OPIOID OVERDOSE RELATED EMERGENCY DEPARTMENT VISITS (continued)

## Problem Statement (continued)

The male rate of opioid overdose related emergency department visits during 2013-2017 was 26.3% higher than the rate among women (Table 1). Among both sexes, Blacks had the highest rate compared to all other racial/ethnic groups. Table 1 also shows that for both sexes, those in the 25-64 age group had the highest rate (37.8 opioid-related overdose emergency department visits per 100,000 population).

Rio Arriba, Taos, and San Miguel counties had the highest rates of opioid overdose related emergency department visits during 2013-2017 (Chart 2). Table 2 shows that in Rio Arriba (155.3 per 100,000) and Santa Fe (54.4 per 100,000) counties, the rates were driven by Hispanics (191.2 and 72.4 opioid overdose related emergency department visits per 100,000; respectively) whereas in San Juan (44.3 per 100,000) it is driven by Whites (57.6 per 100,000). Bernalillo County had the biggest percentage of opioid overdose related emergency department visits (45.0% of the state total), followed by Santa Fe County (7.5%). It is important to note that federal facilities (e.g. Indian Health Services and Veterans Administration) are not included in these results.

**Table 2: Opioid Overdose Related Emergency Department Visits and Rates\* by Race/Ethnicity and County, New Mexico, 2013-2017**

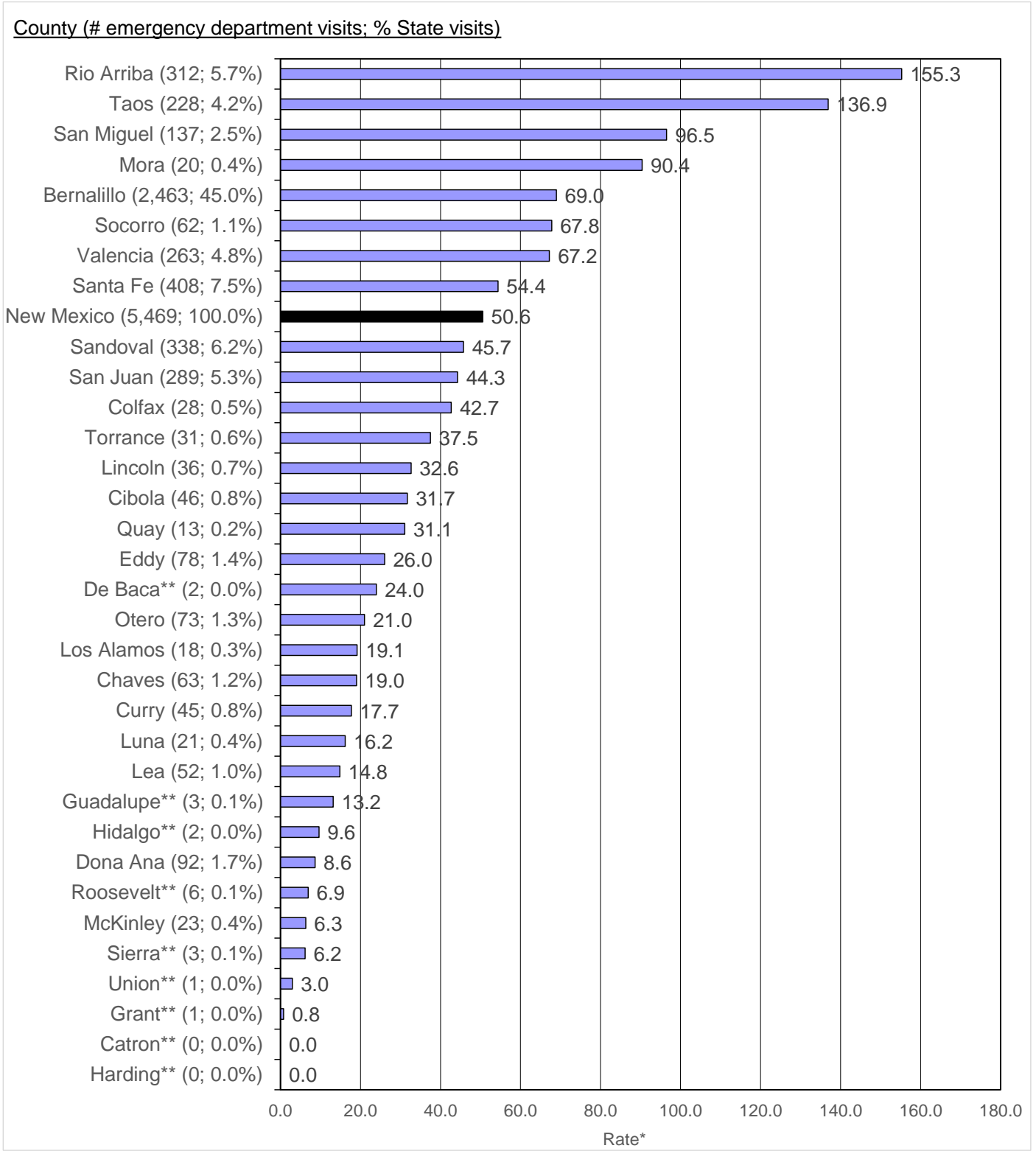
County	Emergency Department Visits						Rates*					
	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races
Bernalillo	78	22	192	1,306	651	2,463	49.4	22.2	190.4	76.1	44.7	69.0
Catron	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0	0.0
Chaves	0	1	11	21	25	63	0.0	25.8	203.6	12.5	17.4	19.0
Cibola	4	0	0	28	14	46	7.2	0.0	0.0	51.2	44.8	31.7
Colfax	0	0	1	18	8	28	0.0	0.0	202.8	58.1	24.6	42.7
Curry	0	0	2	24	18	45	0.0	0.0	8.0	26.5	13.4	17.7
De Baca	0	0	1	0	1	2	0.0	0.0	1,495.7	0.0	20.0	24.0
Dona Ana	0	0	4	46	41	92	0.0	0.0	22.2	6.9	12.7	8.6
Eddy	0	0	3	37	38	78	0.0	0.0	66.7	27.2	25.9	26.0
Grant	0	0	0	0	0	1	0.0	0.0	0.0	0.0	0.0	0.8
Guadalupe	0	0	0	2	1	3	0.0	0.0	0.0	11.6	42.1	13.2
Harding	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0	0.0
Hidalgo	0	0	0	0	2	2	0.0	0.0	0.0	0.0	23.9	9.6
Lea	0	0	5	22	24	52	0.0	0.0	38.6	12.4	17.8	14.8
Lincoln	0	0	0	7	26	36	0.0	0.0	0.0	21.2	39.7	32.6
Los Alamos	0	2	0	3	13	18	0.0	28.6	0.0	17.8	18.6	19.1
Luna	0	0	0	9	12	21	0.0	0.0	0.0	11.3	32.4	16.2
McKinley	4	0	0	11	3	23	1.5	0.0	0.0	22.4	7.0	6.3
Mora	0	0	0	15	2	20	0.0	0.0	0.0	82.6	49.7	90.4
Otero	5	0	2	17	46	73	27.1	0.0	14.0	15.4	23.8	21.0
Quay	0	0	0	4	9	13	0.0	0.0	0.0	23.1	47.3	31.1
Rio Arriba	14	0	0	273	18	312	47.7	0.0	0.0	191.2	68.2	155.3
Roosevelt	0	0	0	3	2	6	0.0	0.0	0.0	9.0	3.4	6.9
Sandoval	27	4	27	132	132	338	32.1	31.0	159.2	47.5	39.3	45.7
San Juan	75	1	1	48	160	289	31.4	22.9	20.2	38.5	57.6	44.3
San Miguel	0	0	1	124	9	137	0.0	0.0	62.4	110.7	37.2	96.5
Santa Fe	5	1	9	284	98	408	24.4	8.0	114.6	72.4	33.8	54.4
Sierra	0	0	0	0	3	3	0.0	0.0	0.0	0.0	9.4	6.2
Socorro	8	0	0	38	11	62	81.0	0.0	0.0	86.6	28.9	67.8
Taos	1	0	3	58	47	228	10.2	0.0	310.9	63.0	89.1	136.9
Torrance	1	0	1	15	10	31	44.4	0.0	69.0	45.4	21.0	37.5
Union	0	0	0	0	1	1	0.0	0.0	0.0	0.0	4.2	3.0
Valencia	7	2	20	148	59	263	48.3	76.2	400.7	64.5	41.9	67.2
New Mexico	239	35	288	2,824	1,536	5,469	25.4	18.7	128.7	55.9	35.8	50.6

\* All rates are per 100,000, age-adjusted to the 2000 US standard population. There were 312 visits for which County of Residence was missing.

Sources: NMDOH Syndromic Surveillance ED files and UNM-GPS population files; SAES

# OPIOID OVERDOSE RELATED EMERGENCY DEPARTMENT VISITS (continued)

Chart 2: Opioid Overdose Related Emergency Department Visit Rates\* by County, New Mexico, 2013-2017



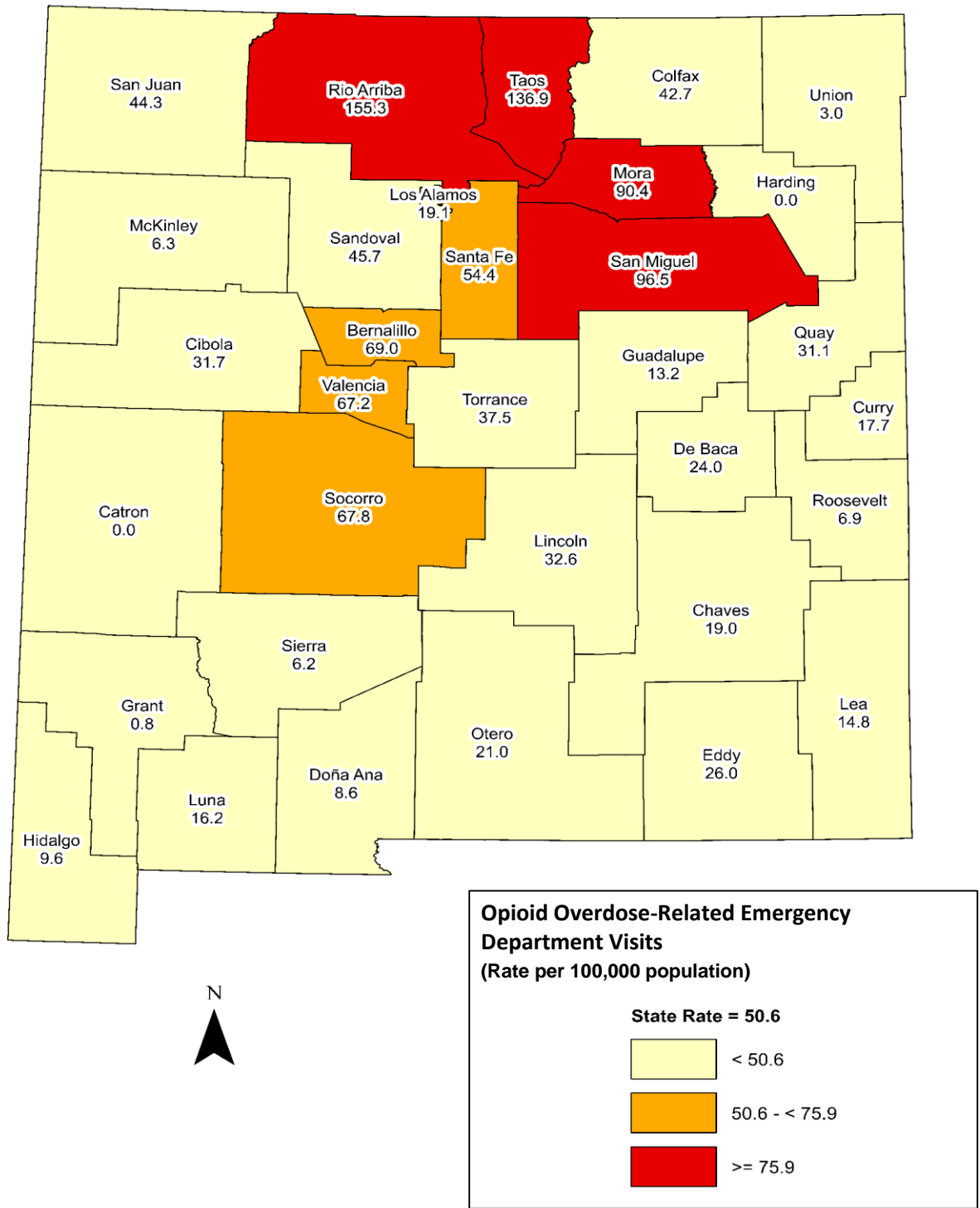
\* All rates are per 100,000, age-adjusted to the 2000 US standard population

\*\* Unstable rate due to small number of cases (<10)

Sources: NMDOH Syndromic Surveillance ED files and UNM-GPS population files (NM); SAES

# OPIOID OVERDOSE RELATED EMERGENCY DEPARTMENT VISITS (continued)

Chart 2: Opioid Overdose Related Emergency Department Visit Rates\* by County, New Mexico, 2013-2017



\* All rates are per 100,000, age-adjusted to the 2000 US standard population

Sources: NMDOH EDD files and UNM-GPS population files; SAES

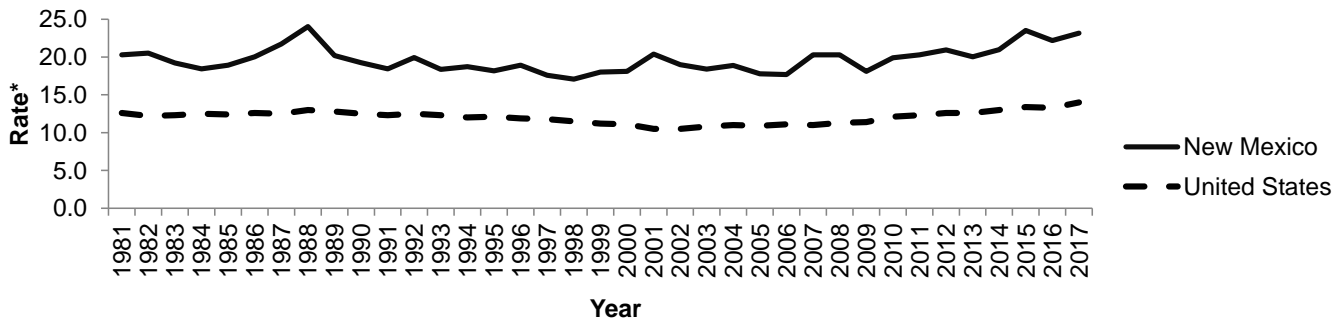
# SUICIDE

## Problem Statement

Suicide is a serious and persistent public health problem in New Mexico. As shown in Chart 1, over the period from 1981-2017, NM's suicide rate has consistently been 1.5 to 1.9 times the US rate. NM has ranked among the top five states for all but two of those years. While the US rate declined 12% between 1981 and 2000, it increased thereafter for a 26% increase from 2000 to 2017. The NM rate followed a similar pattern. In NM in 2017, suicide was the ninth leading cause of death overall, the first leading cause of death for those residents ages 5-17, and the second leading cause of death for those residents ages 18-44 (with unintentional injuries at number one).

Table 1 and Chart 2 show that male suicide rates were more than three times higher than female rates across all ages and racial/ethnic groups except for Asian/Pacific Islanders and Blacks for the five-year period 2013-2017. This reflects males' choice of more lethal means, i.e. firearms, when attempting suicide. White males and females have higher rates over age 34 compared to other race/ethnicities. The majority (63%) of male suicides - and an even higher proportion of Hispanic and American Indian male suicides - occur, however, before age 65. American Indian females had a significantly higher rate between ages 15-24 compared to other race/ethnicities (Chart 2). Table 2 shows that five counties (Bernalillo, Santa Fe, Dona Ana, San Juan, and Sandoval) had substantial numbers of suicides (averaging more than 25 per year). As Chart 3 demonstrates, for the time period 2013-2017, all but eleven of NM's counties had rates one and a half times higher than the comparable US rate. A number of smaller counties also had very high rates, and only two New Mexico counties had a suicide rate lower than the national rate. Note that counts and rates for many counties with small numbers of suicides are unstable, suggesting wide fluctuation across time periods due to random variation (chance) and should be interpreted with caution.

**Chart 1: Suicide Rates\*, New Mexico and United States, 1981-2017**



\* U.S. data available up to 2016

\*\*Rate per 100,000, age-adjusted to the 2000 US standard population

Source: NMDOH BVRHS death files and UNM-GPS population files (NM); CDC Wonder (US)

**Table 1: Suicide Deaths and Rates\* by Age, Sex, and Race/Ethnicity, New Mexico, 2013-2017**

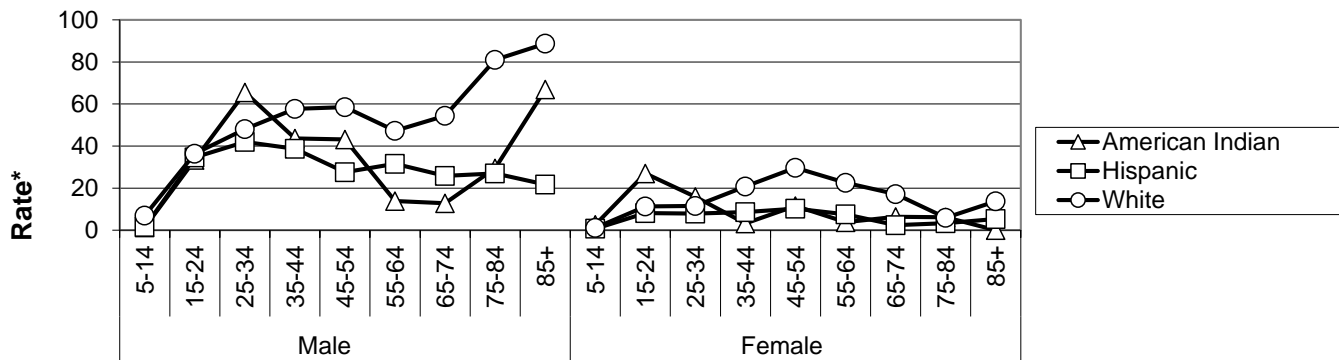
Sex	Race/Ethnicity	Deaths				Rates*			
		Ages 0-24	Ages 25-64	Ages 65+	All Ages	Ages 0-24	Ages 25-64	Ages 65+	All Ages*
Male	American Indian	27	103	8	138	14.1	45.1	21.9	31.0
	Asian/Pacific Islander	1	7	2	10	3.8	15.6	26.4	11.3
	Black	9	12	1	22	19.3	18.0	8.6	16.5
	Hispanic	152	433	62	647	14.4	35.6	25.7	26.7
	White	93	563	301	957	18.8	52.4	65.5	42.6
	<b>Total</b>	<b>284</b>	<b>1,123</b>	<b>382</b>	<b>1,789</b>	<b>15.7</b>	<b>42.7</b>	<b>50.5</b>	<b>34.3</b>
Female	American Indian	23	23	3	49	12.1	9.2	5.6	9.4
	Asian/Pacific Islander	2	3	1	6	7.9	5.2	8.2	6.5
	Black	0	6	0	6	0.0	12.7	0.0	7.2
	Hispanic	36	106	9	151	3.5	8.6	3.0	6.2
	White	24	237	71	332	5.3	21.7	13.4	14.3
		<b>Total</b>	<b>85</b>	<b>377</b>	<b>84</b>	<b>546</b>	<b>4.9</b>	<b>14.1</b>	<b>9.3</b>
Total	American Indian	50	126	11	187	13.2	26.3	12.2	19.6
	Asian/Pacific Islander	3	10	3	16	5.8	9.8	15.2	8.6
	Black	9	18	1	28	10.4	15.8	4.3	12.5
	Hispanic	188	539	71	798	9.1	22.0	13.2	16.3
	White	117	800	372	1,289	12.4	37.0	37.6	28.3
		<b>Total</b>	<b>369</b>	<b>1,500</b>	<b>466</b>	<b>2,335</b>	<b>10.4</b>	<b>28.3</b>	<b>28.1</b>

\* Age-specific rates (e.g., Ages 0-24) are per 100,000; all-ages rate is per 100,000, age-adjusted to the 2000 US standard population

Sources: NMDOH BVRHS death files and UNM-GPS population files; SAES

# SUICIDE (continued)

Chart 2: Suicide Rates\* by Age, Sex, and Race/Ethnicity, New Mexico, 2013-2017



\* Age-specific rates per 100,000

Sources: NMDOH BVRHS death files and UNM-GPS population files; SAES

Table 2: Suicide Deaths and Rates\* by Race/Ethnicity and County, New Mexico, 2013-2017

County	Deaths						Rates*					
	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races
Bernalillo	22	6	10	262	418	725	15.9	6.0	10.0	16.0	27.1	20.8
Catron	1	0	0	3	3	7	142.3	0.0	0.0	122.8	23.5	56.2
Chaves	1	0	1	16	47	66	39.3	0.0	29.2	8.8	35.0	20.4
Cibola	11	0	0	6	12	29	20.6	0.0	0.0	12.3	40.6	21.0
Colfax	0	0	0	8	7	15	0.0	0.0	0.0	24.1	26.8	22.8
Curry	0	1	5	10	28	44	0.0	13.2	33.0	10.5	20.4	18.2
De Baca	0	0	0	0	2	2	0.0	0.0	0.0	0.0	31.4	17.6
Dona Ana	2	0	4	72	90	170	20.7	0.0	21.3	10.5	25.2	16.0
Eddy	0	0	0	27	43	70	0.0	0.0	0.0	21.7	32.8	26.8
Grant	2	0	0	14	29	45	147.6	0.0	0.0	21.8	41.7	32.4
Guadalupe	0	0	0	2	0	2	0.0	0.0	0.0	12.0	0.0	9.1
Harding	0	0	0	0	0	0	0.0	0.0	0.0	0.0	0.0	0.0
Hidalgo	0	0	0	7	5	12	0.0	0.0	0.0	66.0	67.2	64.8
Lea	1	1	1	16	39	58	36.1	30.5	6.4	8.7	28.8	17.7
Lincoln	0	0	0	4	27	31	0.0	0.0	0.0	11.6	36.6	26.5
Los Alamos	0	0	0	1	12	13	0.0	0.0	0.0	5.5	19.1	15.0
Luna	0	0	0	8	23	32	0.0	0.0	0.0	11.2	40.7	22.7
McKinley	63	0	0	16	8	87	23.5	0.0	0.0	35.0	22.4	24.8
Mora	0	0	0	6	0	6	0.0	0.0	0.0	35.3	0.0	29.7
Otero	4	1	1	17	63	88	19.3	21.8	5.6	15.6	32.7	25.9
Quay	0	0	1	4	10	15	0.0	0.0	146.8	19.0	42.9	33.2
Rio Arriba	5	0	0	36	10	51	16.3	0.0	0.0	26.8	39.3	26.9
Roosevelt	0	1	1	6	10	18	0.0	18.8	16.4	12.9	19.2	17.8
Sandoval	15	1	0	43	70	129	17.7	10.6	0.0	16.1	20.7	18.7
San Juan	51	1	1	19	86	158	20.0	62.6	22.8	16.9	30.2	24.5
San Miguel	1	0	0	30	11	43	372.3	0.0	0.0	28.9	38.0	31.2
Santa Fe	3	2	2	72	105	186	11.9	14.8	32.1	19.1	27.7	23.7
Sierra	0	0	0	4	21	25	0.0	0.0	0.0	25.3	38.1	36.1
Socorro	1	0	0	10	15	26	9.7	0.0	0.0	23.6	40.5	28.6
Taos	2	0	0	25	29	56	23.3	0.0	0.0	29.4	52.0	36.0
Torrance	0	0	0	4	21	25	0.0	0.0	0.0	15.0	43.8	30.1
Union	0	0	0	4	1	5	0.0	0.0	0.0	45.3	12.6	27.0
Valencia	2	2	1	46	41	93	11.9	80.3	26.1	20.4	29.8	24.7
New Mexico	187	16	28	798	1,289	2,335	19.6	8.6	12.5	16.3	28.3	21.9

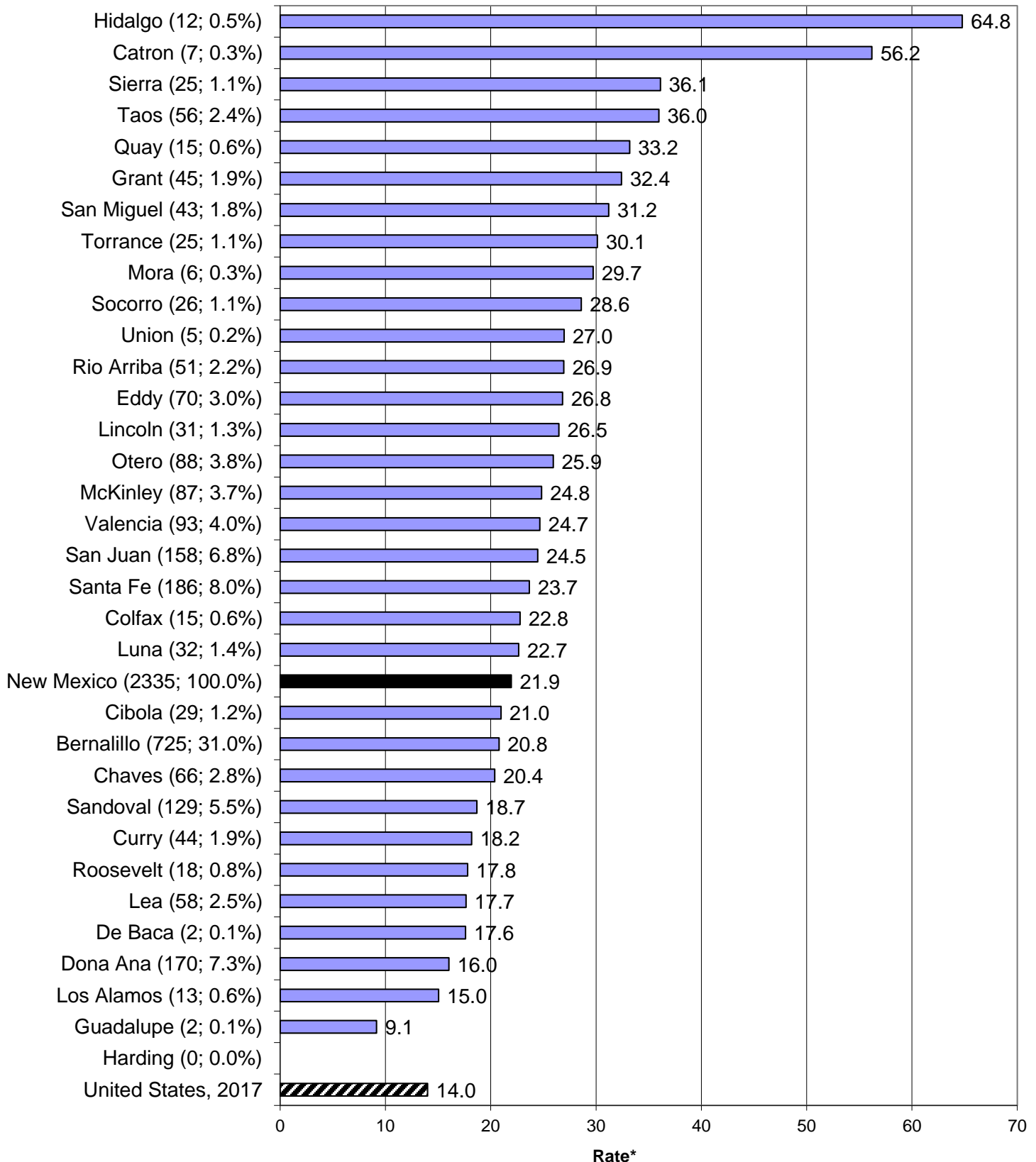
\* All rates are per 100,000, age-adjusted to the 2000 US standard population

Sources: NMDOH BVRHS death files and UNM-GPS population files; SAES

# SUICIDE (continued)

Chart 3: Suicide Rates\* by County, New Mexico, 2013-2017

County (# of deaths; % of statewide deaths)



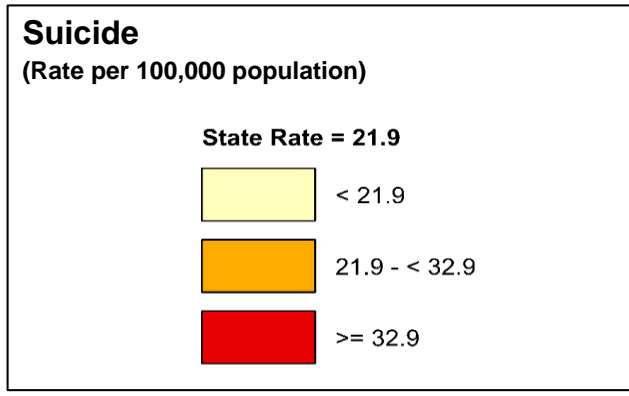
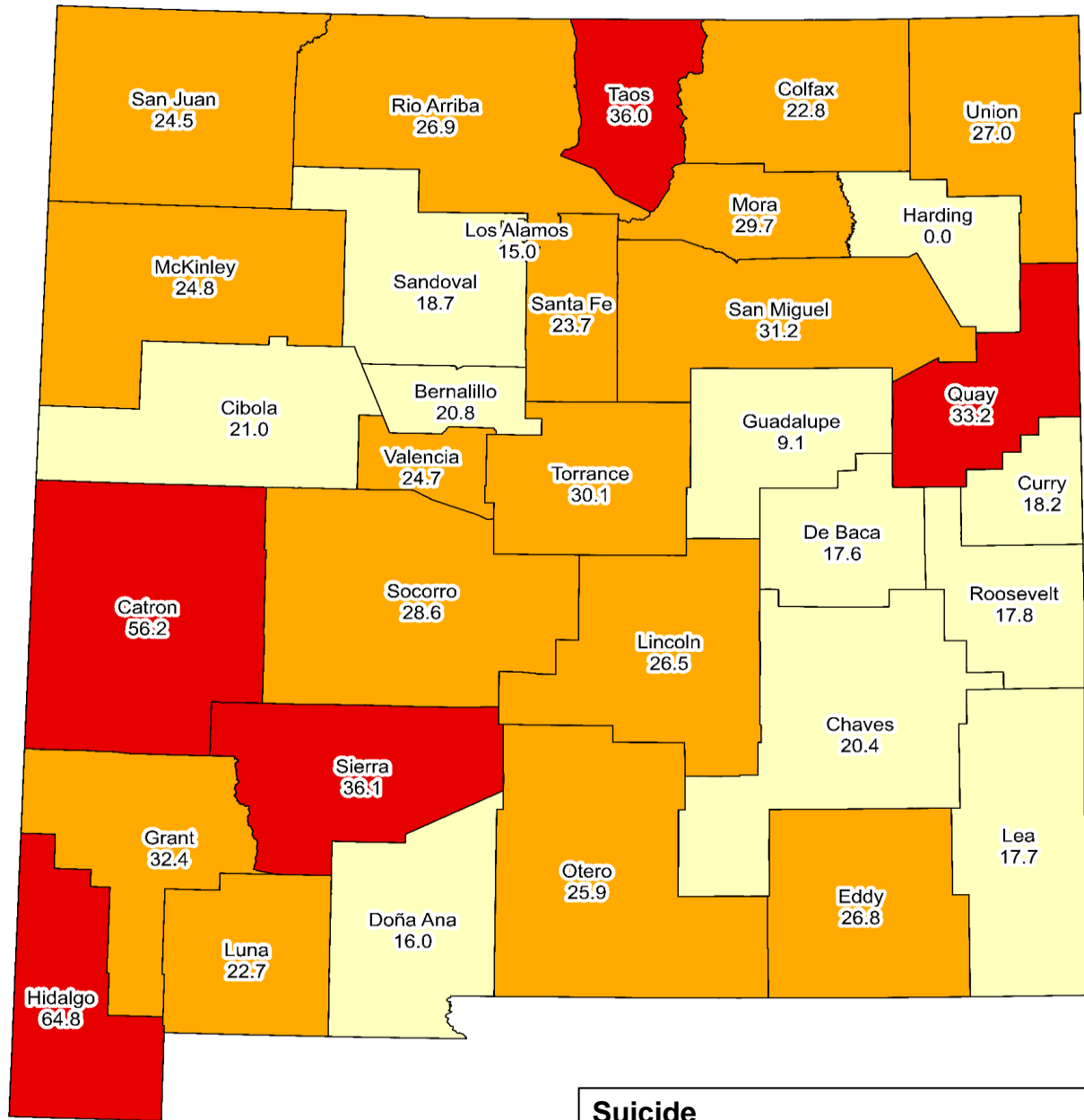
\* All rates are per 100,000, age-adjusted to the 2000 US standard population

Sources: NMDOH BVRHS death files and UNM-GPS population files (NM); NCHS death and population files (US); CDC ARDI; SAES



# SUICIDE (continued)

Chart 4: Suicide Rates\* by County, New Mexico, 2013-2017



\* All rates are per 100,000, age-adjusted to the 2000 US standard population

## Section 2

### Mental Health



# ADULT MENTAL HEALTH

## Problem Statement

Adult mental health issues range in a spectrum: from day-to-day challenges with stress, anxiety, and "the blues"; to persistent mental health challenges arising from chronic physical conditions such as diabetes, asthma, and obesity; to chronic clinically diagnosable psychiatric morbidities such as anxiety disorders, schizophrenia, bipolar disorder, and depression; and to serious life-threatening situations such as suicidal ideation and suicide attempt, which sometimes result from a combination of the mental and physical health challenges mentioned above. A host of measures exist for assessing the mental health status of individuals, but characterizing the mental health status of the population is a relatively new field. If such an assessment can be done using a simple and non-invasive approach with a reasonable level of sensitivity and specificity, the resulting characterization of the population's mental health can help public health and mental health professionals better understand the distribution of mental health issues in the population and design better systems to help identify, address, and mitigate these issues before they become more serious.

Among measures that have been suggested by the CDC as potential tools for assessing population well-being and mental health is the frequency with which people experience poor mental health. This measure is based on the single question, "How many days during the past 30 days was your mental health not good?" Respondents who report that they experienced 14 or more days when their mental health was "not good" are classified as experiencing Frequent Mental Distress (FMD). Although FMD is not a clinical diagnosis, evidence suggests that it is associated with a person's mental health status. Chart 1 shows the proportion of people with selected characteristics who experienced FMD. The proportion of the total New Mexico population that experienced FMD was about 12%. As might be expected, people in good health with higher incomes and more education were significantly less likely than the general population to report FMD. People with less education, with chronic health conditions such as obesity, diabetes, or asthma, or with lower income were significantly more likely to report FMD. Of particular relevance regarding FMD's potential usefulness as a measure of population mental health, FMD was many times more prevalent among respondents who reported more serious psychiatric morbidity, including screening positive for alcohol dependence or abuse (33% reported FMD), ever being diagnosed with an anxiety disorder (37% reported past-month FMD), or receiving a diagnosis of current depression based on the Patient Health Questionnaire (52% reported past-month FMD). Among the cohort that reported past-year suicidal ideation with no history of suicide attempt, 48% reported past-month FMD; among the cohort at high risk for suicide that reported both past-year suicidal ideation and a prior suicide attempt, 62% reported past-month FMD. Meanwhile, more than half (52%) of FMD respondents were diagnosed with current depression (Chart 1). These results suggest that this simple question, which is asked annually on the BRFSS, is a useful indicator of population mental health.

**Table 1: Frequent Mental Distress (past 30 days) by Age, Sex, and Race, Adults Aged 18+, New Mexico, 2015-2017**

Sex	Race/Ethnicity	Number				Percent*			
		Ages 18-24	Ages 25-64	Ages 65+	All Ages	Ages 18-24	Ages 25-64	Ages 65+	All Ages*
Male	American Indian	2,730	4,749	1,904	9,340	25.8	10.3	25.1	14.5
	Asian/Pacific Islander	-	807	-	1,171	-	8.9	-	9.3
	Black	-	1,553	-	3,726	-	11.5	-	19.2
	Hispanic	5,353	27,793	5,851	38,894	9.1	11.3	11.6	10.9
	White	4,787	24,310	5,594	34,596	15.4	11.5	5.9	10.3
	Total	13,974	59,828	14,015	88,158	13.2	11.4	8.9	11.2
Female	American Indian	1,462	6,100	1,895	9,305	13.8	12.0	17.0	12.9
	Asian/Pacific Islander	-	748	-	1,616	-	6.4	-	10.2
	Black	-	1,349	-	1,556	-	14.1	-	10.8
	Hispanic	8,323	40,509	5,666	54,712	14.7	16.3	9.2	14.9
	White	3,615	35,376	8,351	46,760	13.7	16.6	7.7	13.4
	Total	13,498	83,921	16,407	113,384	13.8	15.7	8.8	13.9
Total	American Indian	4,152	10,861	3,837	18,642	19.6	11.2	20.5	13.6
	Asian/Pacific Islander	-	1,592	-	2,765	-	7.7	-	9.7
	Black	-	2,948	681	5,041	-	12.8	14.0	14.9
	Hispanic	13,559	68,370	11,496	93,603	11.7	13.8	10.3	13.0
	White	8,383	59,594	13,977	81,409	14.6	14.1	6.9	11.9
	Total	27,467	143,685	30,422	201,495	13.5	13.6	8.9	12.5

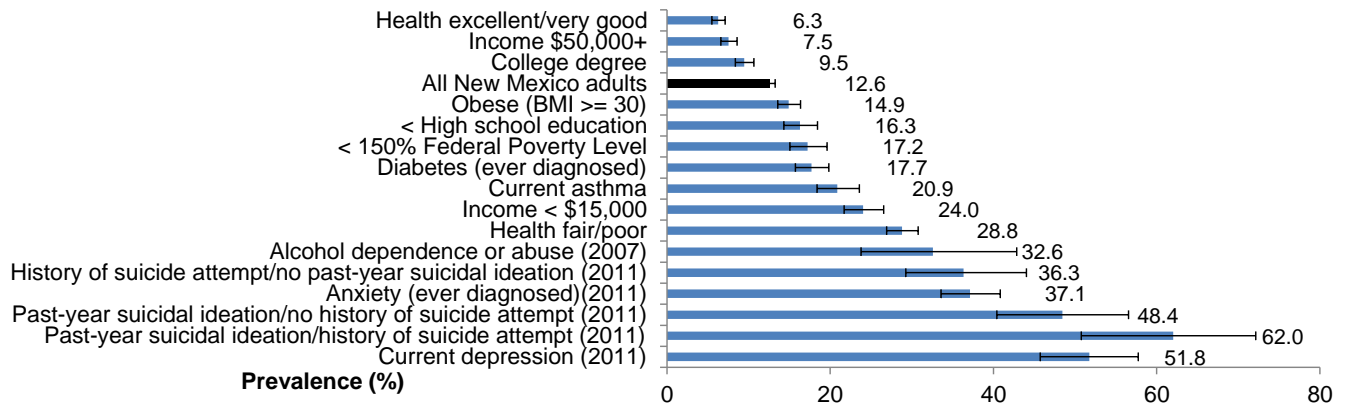
\* Estimate of percent of people in population group who reported Frequent Mental Distress in past 30 days

- Excluded due to small number of respondents (< 50) in cell

Source: BRFSS; SAES

# ADULT MENTAL HEALTH (continued)

Chart 1: Frequent Mental Distress (past 30 days)\* by Selected Characteristics, Adults Aged 18+, New Mexico, 2015-2017



\* Frequent Mental Distress definition: respondent reported 14 or more days in past 30 days when mental health was "not good"

Source: BRFSS; SAES (NOTE: Brackets around reported rates are 95% confidence intervals)

Table 2: Frequent Mental Distress (past 30 days) by Race and County, Adults Aged 18+, New Mexico, 2015-2017

County	Number						Percent*					
	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races
Bernalillo	2,451	-	-	22,114	28,485	53,585	11.1	-	-	9.1	12.2	10.2
Catron	-	-	-	-	-	443	-	-	-	-	-	13.9
Chaves	-	-	-	4,204	2,132	6,652	-	-	-	16.9	9.8	13.8
Cibola	1,397	-	-	792	625	2,741	17.8	-	-	10.0	13.4	13.2
Cofax	-	-	-	-	347	1,387	-	-	-	-	6.5	13.4
Curry	-	-	-	1,828	2,887	6,361	-	-	-	13.4	14.5	17.2
De Baca	-	-	-	-	-	-	-	-	-	-	-	-
Dona Ana	-	-	-	12,672	4,930	18,490	-	-	-	12.2	9.5	11.4
Eddy	-	-	-	1,887	3,007	5,130	-	-	-	10.0	13.8	12.2
Grant	-	-	-	1,479	1,144	2,639	-	-	-	13.9	9.8	11.5
Guadalupe	-	-	-	-	-	-	-	-	-	-	-	-
Harding	-	-	-	-	-	-	-	-	-	-	-	-
Hidalgo	-	-	-	-	-	-	-	-	-	-	-	-
Lea	-	-	-	3,043	2,997	6,517	-	-	-	12.0	14.7	13.5
Lincoln	-	-	-	-	1,163	2,189	-	-	-	-	10.5	13.5
Los Alamos	-	-	-	-	574	1,226	-	-	-	-	5.4	8.7
Luna	-	-	-	1,038	777	1,776	-	-	-	9.3	11.8	9.7
McKinley	4,130	-	-	566	627	5,380	10.6	-	-	8.8	11.2	10.4
Mora	-	-	-	-	-	-	-	-	-	-	-	-
Otero	315	-	-	1,535	3,522	6,013	11.1	-	-	9.0	12.8	12.0
Quay	-	-	-	-	403	1,247	-	-	-	-	11.0	18.7
Rio Arriba	-	-	-	4,010	651	5,171	-	-	-	18.9	14.0	17.0
Roosevelt	-	-	-	-	1,178	1,908	-	-	-	-	13.8	12.8
Sandoval	3,345	-	-	3,894	4,739	12,679	27.2	-	-	10.2	9.0	11.8
San Juan	4,375	-	-	1,850	5,253	11,957	12.4	-	-	11.4	12.9	12.8
San Miguel	-	-	-	3,967	110	4,036	-	-	-	23.0	2.4	17.8
Santa Fe	-	-	-	8,224	5,243	14,833	-	-	-	14.6	9.0	12.3
Sierra	-	-	-	-	1,130	1,548	-	-	-	-	16.7	16.2
Socorro	-	-	-	-	-	1,662	-	-	-	-	-	12.5
Taos	-	-	-	1,779	1,792	4,443	-	-	-	12.2	16.7	16.4
Torrance	-	-	-	-	-	1,169	-	-	-	-	-	9.6
Union	-	-	-	-	-	-	-	-	-	-	-	-
Valencia	-	-	-	2,371	982	3,346	-	-	-	7.2	4.5	5.8
New Mexico	18,642	2,765	5,041	93,603	81,409	201,495	13.6	9.7	14.9	13.0	11.9	12.5

\* Estimate of percent of people in population group who reported Frequent Mental Distress in past 30 days

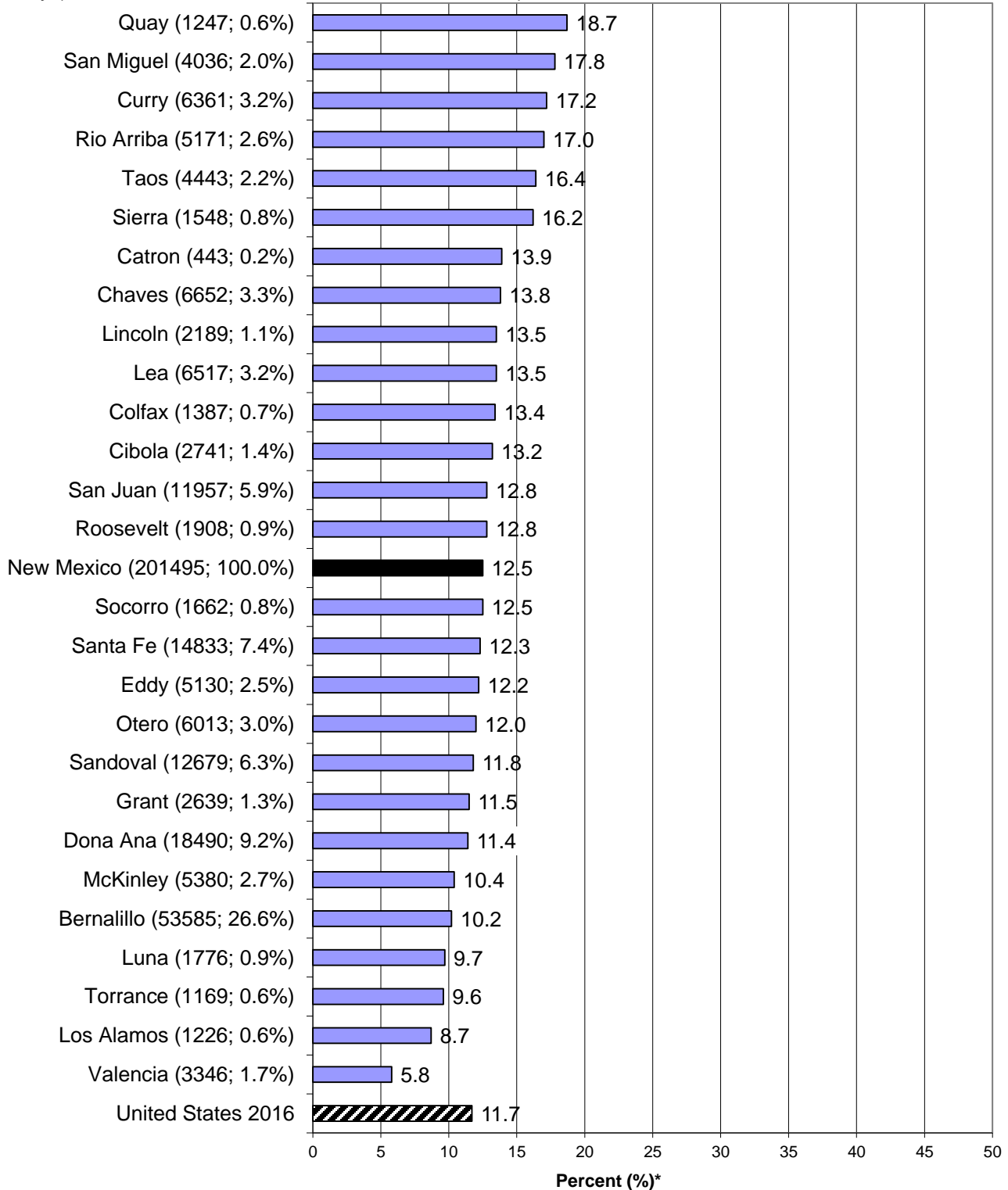
- Excluded due to small number of respondents (< 50) in cell

Source: BRFSS; SAES

## ADULT MENTAL HEALTH (continued)

Chart 2: Frequent Mental Distress (past 30 days)\* by County, Adults Aged 18+, New Mexico, 2015-2017

County (# of adults with FMD; % of statewide FMD adults)



\* Estimate of percent of people in population group who reported Frequent Mental Distress in past 30 days

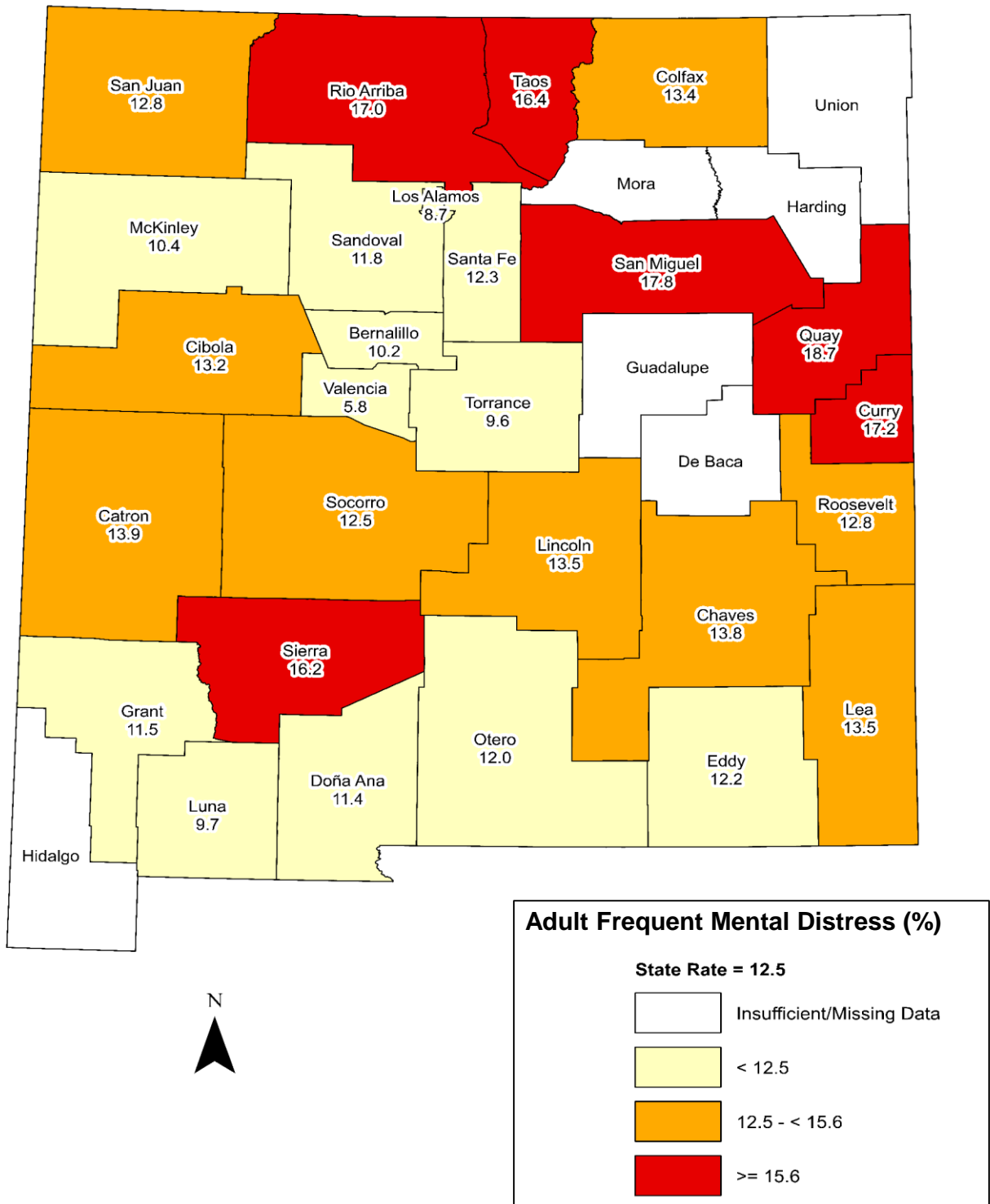
The following counties were not included due to small number of respondents (<50) in cell:

De Baca, Guadalupe, Harding, Hidalgo, Mora, and Union

Source: NMBRFSS (NM); CDC BRFSS (US); SAES

# ADULT MENTAL HEALTH (continued)

Chart 3: Frequent Mental Distress (past 30 days)\* by County, Adults Aged 18+, New Mexico, 2015-2017



Insufficient data: Rate not reported due to small number of respondents (< 50) in cell

Source: BRFSS; SAES

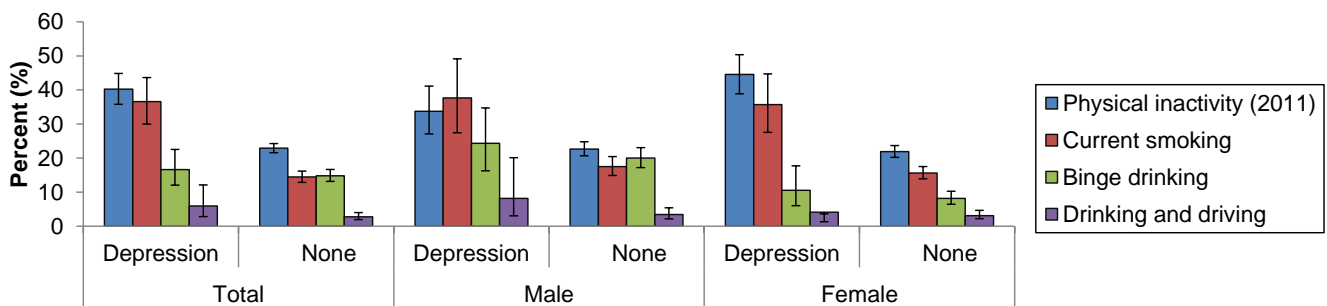
# ADULT MENTAL HEALTH - DEPRESSION

## Problem Statement (continued)

Depression is one of the most prevalent and treatable mental disorders. Major depression is usually associated with comorbid mental disorders, such as anxiety and substance use disorders, and impairment of a person's ability to function in work, home, relationships, and social roles. Depression is also a risk factor for suicide and attempted suicide. In addition, depressive disorders have been associated with an increased prevalence of chronic medical conditions, such as heart disease, stroke, asthma, arthritis, cancer, diabetes, and obesity. In 2016, the BRFSS assessed current depression using Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV) criteria.

Table 3 shows the prevalence of current depression was highest among the youngest age-group 18-24 years (15.1%) and much higher among Black (22.9%) than Hispanic (9.6%) and White adults (9.3%). Depression was more common among Hispanic females (11.5%) and White females (9.6%) than American Indian females (6.8%). Among males, American Indians (17.7%) had the highest prevalence followed by Whites (8.9%). Chart 4 shows that current depression was associated, among both males and females, with significantly higher rates of some unhealthy behaviors including physical inactivity and current smoking. Chart 5 shows that current depression was associated with higher rates of chronic health conditions, such as asthma and heart disease among males, and asthma, obesity, diabetes, and heart disease among females.

**Chart 4: Unhealthy Behaviors by Depression Status and Sex, New Mexico, 2016**



\* Current Depression definition: scored 10 or more on Patient Health Questionnaire depression inventory (PHQ-8); this instrument can establish a provisional depressive disorder diagnosis using Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) criteria.

Source: BRFSS; SAES (NOTE: Brackets around reported rates are 95% confidence intervals)

**Table 3: Current Depression (past 2 weeks) by Age, Sex, and Race, Adults Aged 18+, New Mexico, 2016**

Sex	Race/Ethnicity	Number*				Percent**			
		Ages 18-24	Ages 25-64	Ages 65+	All Ages	Ages 18-24	Ages 25-64	Ages 65+	All Ages*
Male	American Indian	-	3,801	-	11,390	-	8.2	-	17.7
	Asian/Pacific Islander	-	-	-	-	-	-	-	-
	Black	-	-	-	-	-	-	-	-
	Hispanic	4,201	20,716	2,472	27,336	7.1	8.4	4.9	7.7
	White	-	18,354	3,783	29,910	-	8.7	4.0	8.9
	Total	16,945	43,807	8,460	70,551	16.0	8.3	5.4	8.9
Female	American Indian	-	3,538	727	4,903	-	7.0	6.5	6.8
	Asian/Pacific Islander	-	-	-	-	-	-	-	-
	Black	-	-	-	-	-	-	-	-
	Hispanic	6,983	31,465	3,525	42,203	12.3	12.7	5.7	11.5
	White	-	24,573	6,450	33,489	-	11.5	5.9	9.6
	Total	13,661	64,454	10,700	87,583	14.0	12.1	5.7	10.7
Total	American Indian	-	7,302	3,129	16,242	-	7.5	16.7	11.9
	Asian/Pacific Islander	-	-	-	-	-	-	-	-
	Black	-	-	-	7,743	-	-	-	22.9
	Hispanic	11,204	52,270	5,977	69,557	9.7	10.6	5.3	9.6
	White	-	42,992	10,366	63,464	-	10.1	5.1	9.3
	Total	30,698	108,323	19,170	158,167	15.1	10.2	5.6	9.8

\* Estimate of number of people in population group who reported current (past 2-week) depression based on DSM-IV criteria

\*\* Estimate of percent of people in population group who reported current (past 2-week) depression based on DSM-IV criteria

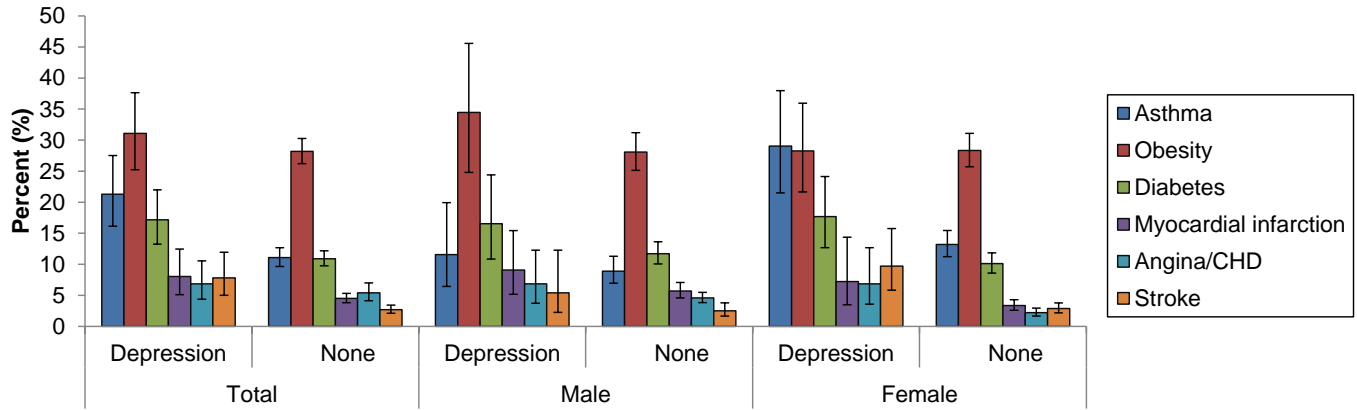
- Excluded due to small number of respondents (< 50) in cell

Source: BRFSS; SAES



# ADULT MENTAL HEALTH - DEPRESSION (continued)

Chart 5: Chronic Health Conditions by Depression Status and Sex, New Mexico, 2016



Source: BRFSS; SAES

Table 4: Current Depression (past 2 weeks) by Race and County, Adults Aged 18+, New Mexico, 2016

County	Number*						Percent**					
	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races
Bernalillo	-	-	-	21,896	26,854	55,033	-	-	-	9.0	11.5	10.4
Catron	-	-	-	-	-	-	-	-	-	-	-	-
Chaves	-	-	-	4,870	1,681	6,962	-	-	-	19.6	7.7	14.4
Cibola	-	-	-	586	582	3,930	-	-	-	7.4	12.5	18.9
Colfax	-	-	-	-	-	-	-	-	-	-	-	-
Curry	-	-	-	-	4,071	6,987	-	-	-	-	20.4	18.9
De Baca	-	-	-	-	-	-	-	-	-	-	-	-
Dona Ana	-	-	-	7,008	3,038	11,570	-	-	-	6.8	5.8	7.1
Eddy	-	-	-	1,569	2,699	4,643	-	-	-	8.3	12.3	11.0
Grant	-	-	-	-	1,783	3,579	-	-	-	-	15.3	15.6
Guadalupe	-	-	-	-	-	-	-	-	-	-	-	-
Harding	-	-	-	-	-	-	-	-	-	-	-	-
Hidalgo	-	-	-	-	-	-	-	-	-	-	-	-
Lea	-	-	-	2,333	473	3,031	-	-	-	9.2	2.3	6.3
Lincoln	-	-	-	-	197	328	-	-	-	-	1.8	2.0
Los Alamos	-	-	-	-	-	424	-	-	-	-	-	3.0
Luna	-	-	-	-	-	1,321	-	-	-	-	-	7.3
McKinley	2,759	-	-	-	804	3,604	7.1	-	-	-	14.3	7.0
Mora	-	-	-	-	-	-	-	-	-	-	-	-
Otero	-	-	-	-	3,336	6,024	-	-	-	-	12.2	12.0
Quay	-	-	-	-	-	-	-	-	-	-	-	-
Rio Arriba	-	-	-	1,478	456	2,499	-	-	-	7.0	9.8	8.2
Roosevelt	-	-	-	-	-	1,331	-	-	-	-	-	8.9
Sandoval	-	-	-	-	3,090	11,841	-	-	-	-	5.8	11.0
San Juan	4,320	-	-	633	5,448	10,960	12.3	-	-	3.9	13.4	11.7
San Miguel	-	-	-	-	-	3,335	-	-	-	-	-	14.7
Santa Fe	-	-	-	4,919	4,372	10,099	-	-	-	8.8	7.5	8.4
Sierra	-	-	-	-	-	2,027	-	-	-	-	-	21.2
Socorro	-	-	-	-	-	-	-	-	-	-	-	-
Taos	-	-	-	-	709	1,067	-	-	-	-	6.6	3.9
Torrance	-	-	-	-	-	-	-	-	-	-	-	-
Union	-	-	-	-	-	-	-	-	-	-	-	-
Valencia	-	-	-	-	34	3,515	-	-	-	-	0.2	6.1
New Mexico	16,242	-	7,743	69,557	63,464	158,167	11.9	-	22.9	9.6	9.3	9.8

\* Estimate of number of people in population group who reported current (past 2-week) depression based on DSM-IV criteria

\*\* Estimate of percent of people in population group who reported current (past 2-week) depression based on DSM-IV criteria

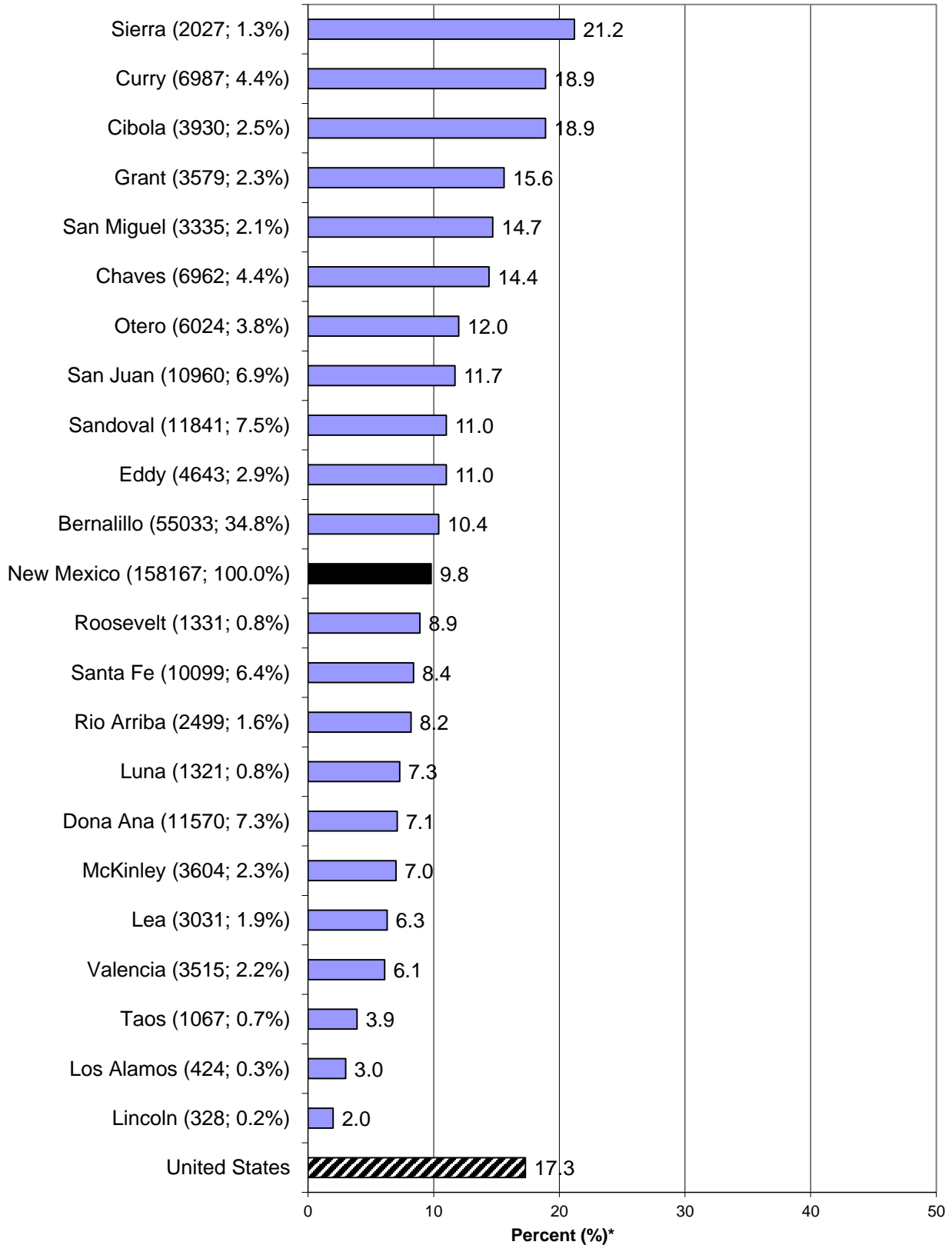
- Excluded due to small number of respondents (< 50) in cell

Source: BRFSS; SAES

# ADULT MENTAL HEALTH - DEPRESSION (continued)

Chart 6: Current Depression (past 2 weeks)\* by County, Adults Aged 18+, New Mexico, 2016

County (# of adults with current depression; % of statewide currently depressed adults)



\* Estimate of percent of people in population group who reported current (past 2-week) depression based on DSM-IV criteria

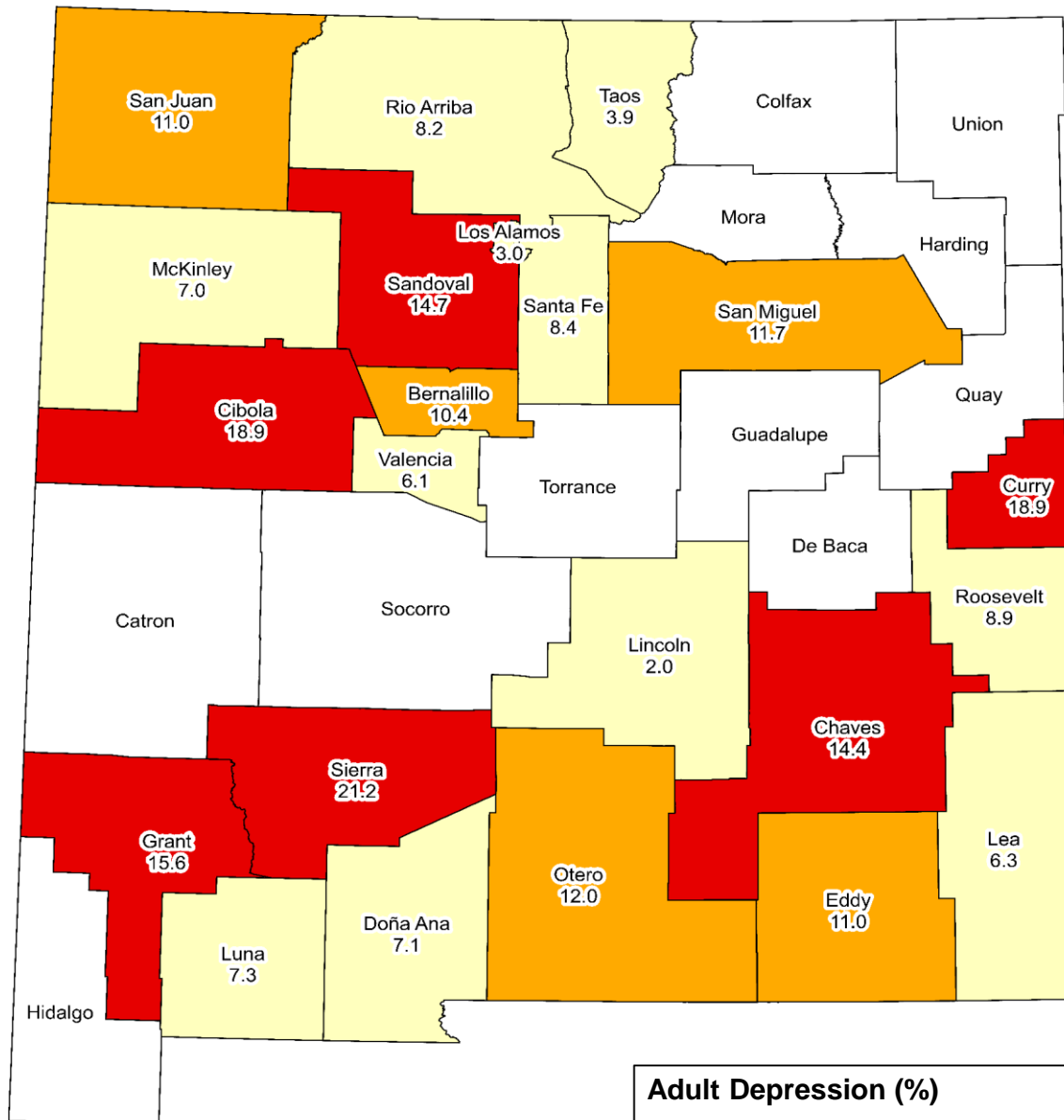
The following counties were not included due to small number of respondents (< 50) in cell:

Catron, Colfax, De Baca, Guadalupe, Harding, Hidalgo, Mora, Quay, Socorro, Torrance, and Union

Source: NMBRFSS (NM); CDC BRFSS (US); SAES

# ADULT MENTAL HEALTH - DEPRESSION (continued)

Chart 7: Current Depression (past 2 weeks)\* by County, Adults Aged 18+, New Mexico, 2016



\* Estimate of percent of people in population group who reported current (past 2-week) depression based on DSM-IV criteria  
 Insufficient data: Rate not reported due to small number of respondents (< 50) in cell

Source: BRFSS; SAES

# YOUTH FEELINGS OF SADNESS OR HOPELESSNESS

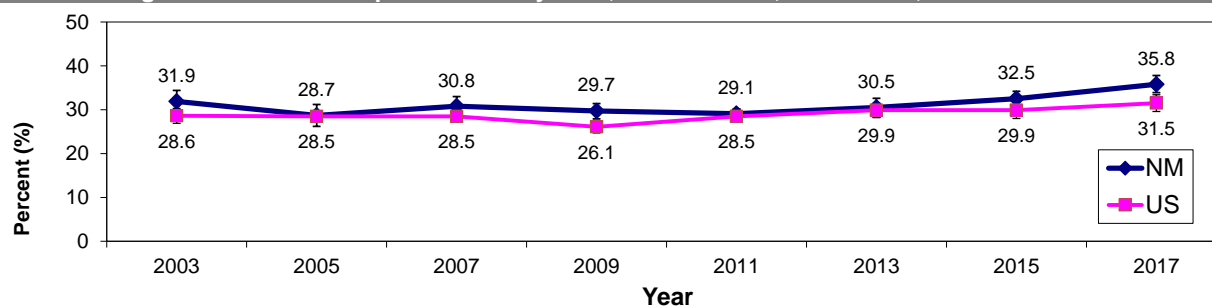
## Problem Statement

Persistent feelings of sadness and hopelessness are criteria for, and predictors of, clinical depression for youth, and youth who experience depression are at a higher risk for being depressed as adults. Persistent sadness in youth has also been linked with suicidal behavior, drug and alcohol use, unsafe sex, and academic and social deficits. Feelings of sadness or loneliness not only affect teens, but those around them, often causing problems in relationships with peers and family members.

The prevalence of persistent feelings of sadness or hopelessness among NM high school students remained stable from 2003-2017 (Chart 1). In 2017, there was a statistically significant difference between the US rate (31.5%) and the NM rate (35.8%). In 2017 in NM, girls (45.1%) were nearly twice as likely to report feelings of sadness or hopelessness than boys (26.6%), reflective of a continuing disparity (Chart 2). There were no statistically significant variations by grade level or by race/ethnicity.

As Charts 3 and 4 demonstrate, in 2017, the counties with the highest prevalence of persistent feelings of sadness or hopelessness were Sierra (46.2%), McKinley (42.9%), Luna (42.4%), Roosevelt (40.8%), and Santa Fe (39.8%). The counties with the lowest prevalence were Mora (23.3%), Union (25.8%) and Hidalgo (28.0%).

**Chart 1: Feelings of Sadness or Hopelessness\* by Year, Grades 9 - 12, NM and US, 2003-2017**



\* Felt so sad or hopeless nearly every day for a period of 2 weeks that they stopped some normal activities, within the past 12 months

Source: YRRS (NM); CDC YRBS (US); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

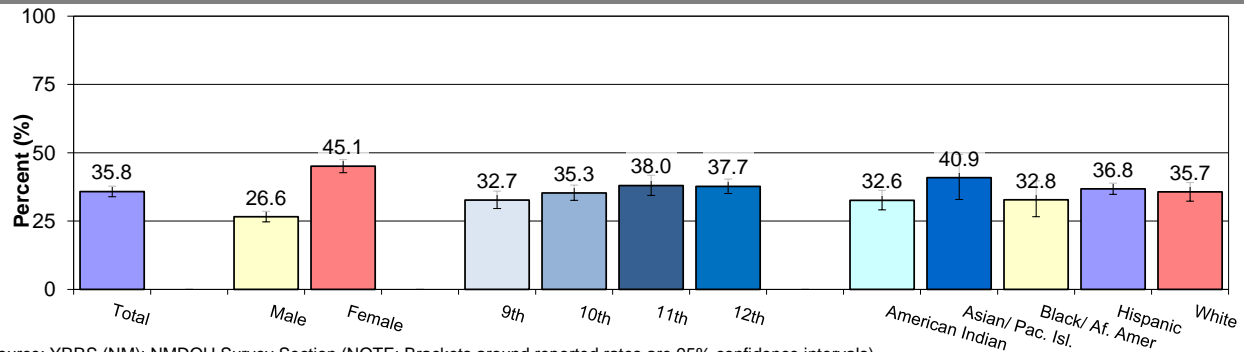
**Table 1: Feelings of Sadness or Hopelessness, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, NM, 2017**

Sex	Race/Ethnicity	9th Grade	10th Grade	11th Grade	12th Grade	All Grades
		Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]
Male	American Indian	22.2 (13.6-34.2)	25.5 (18.9-33.4)	19.1 (14.3-25.2)	30.2 (23.6-37.8)	23.9 (20.4-27.9)
	Asian/Pacific Islander	--	--	--	--	36.8 (25.2-50.3)
	Black	--	--	--	--	20.4 (14.7-27.6)
	Hispanic	22.2 (17.0-28.4)	27.9 (22.6-33.9)	31.7 (27.1-36.7)	32.0 (25.5-39.2)	28.0 (25.5-30.7)
	White	20.7 (15.4-27.3)	30.0 (22.1-39.2)	29.3 (20.6-39.8)	24.8 (19.3-31.2)	26.1 (22.1-30.5)
	<b>Total</b>	21.3 (17.4-25.8)	28.2 (24.6-32.2)	29.5 (25.4-33.9)	28.9 (25.3-32.7)	26.6 (24.7-28.6)
Female	American Indian	42.9 (28.3-58.8)	41.2 (34.5-48.2)	43.7 (38.3-49.3)	42.6 (32.9-53.1)	42.6 (37.4-47.9)
	Asian/Pacific Islander	--	--	--	--	46.4 (36.2-56.9)
	Black	--	--	--	--	48.8 (39.5-58.3)
	Hispanic	42.6 (35.4-50.1)	46.7 (39.6-53.9)	44.6 (37.3-52.1)	44.6 (40.3-48.9)	44.9 (41.6-48.3)
	White	49.2 (39.9-58.6)	35.3 (28.8-42.4)	49.2 (40.2-58.2)	50.6 (43.6-57.4)	46.0 (41.5-50.7)
	<b>Total</b>	44.6 (39.2-50.1)	42.4 (38.0-47.0)	46.7 (42.2-51.3)	46.4 (42.8-49.9)	45.1 (42.7-47.5)
Total	American Indian	31.9 (23.9-41.0)	32.5 (27.3-38.2)	30.5 (25.8-35.7)	36.3 (28.8-44.5)	32.6 (29.1-36.3)
	Asian/Pacific Islander	--	42.4 (30.8-55.0)	50.4 (31.3-69.4)	--	40.9 (32.9-49.4)
	Black	20.8 (14.0-29.9)	35.8 (25.9-47.1)	--	--	32.8 (26.6-39.7)
	Hispanic	32.5 (28.3-36.9)	37.7 (32.9-42.7)	38.6 (34.5-42.7)	38.7 (34.9-42.7)	36.8 (34.8-38.9)
	White	34.8 (28.1-42.1)	32.8 (27.5-38.6)	38.8 (31.9-46.2)	36.6 (32.2-41.3)	35.7 (32.3-39.1)
	<b>Total</b>	32.7 (29.6-36.0)	35.3 (32.6-38.2)	38.0 (34.4-41.8)	37.7 (35.1-40.4)	35.8 (33.9-37.8)

Source: YRRS (NM); NMDOH Survey Section (NOTE: "95% CI" is 95% confidence interval)

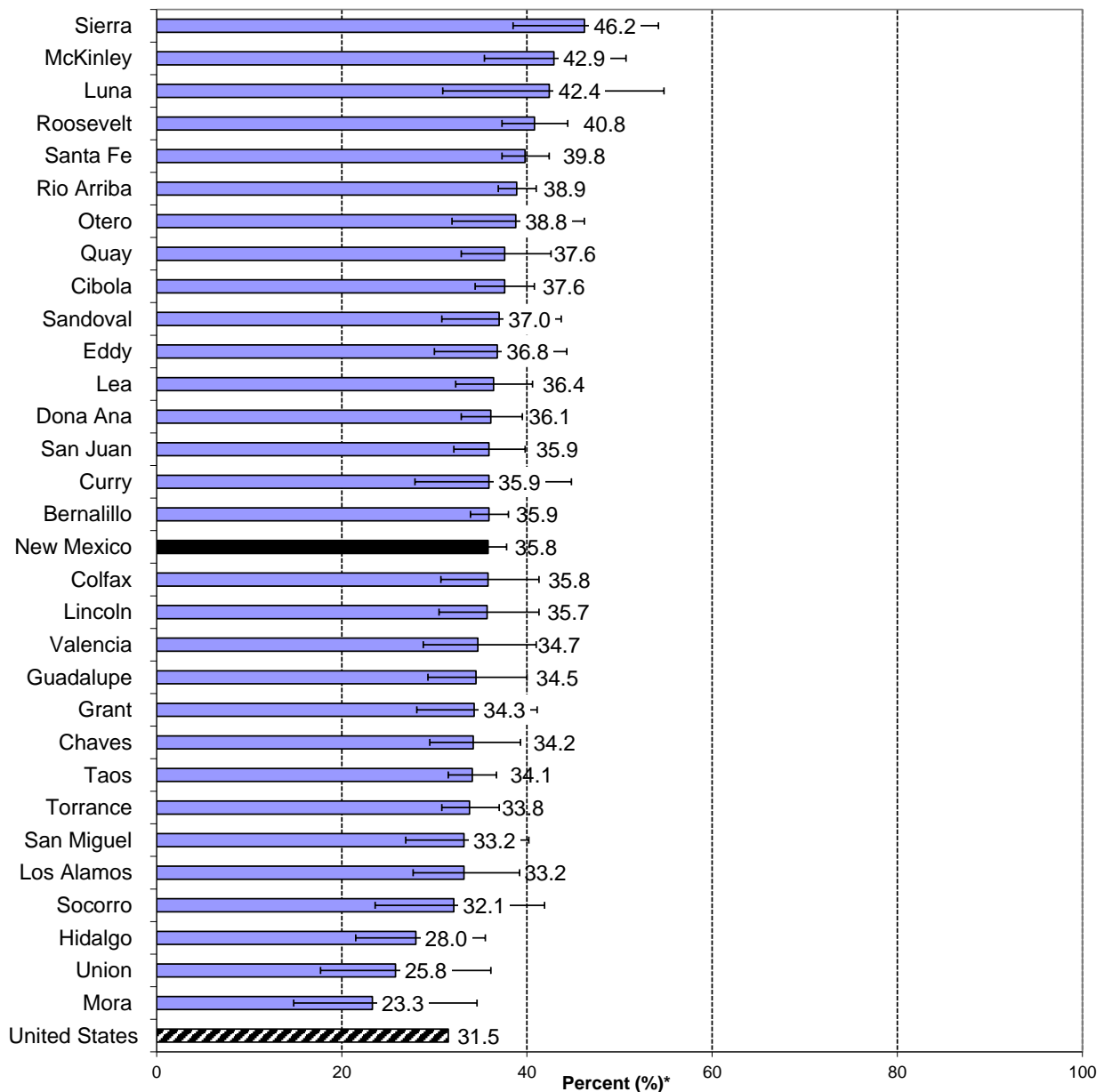
# YOUTH FEELINGS OF SADNESS OR HOPELESSNESS (continued)

Chart 2: Feelings of Sadness or Hopelessness, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, NM, 2017



Source: YRRS (NM); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

Chart 3: Feelings of Sadness or Hopelessness\* by County, Grades 9 - 12, NM, 2017



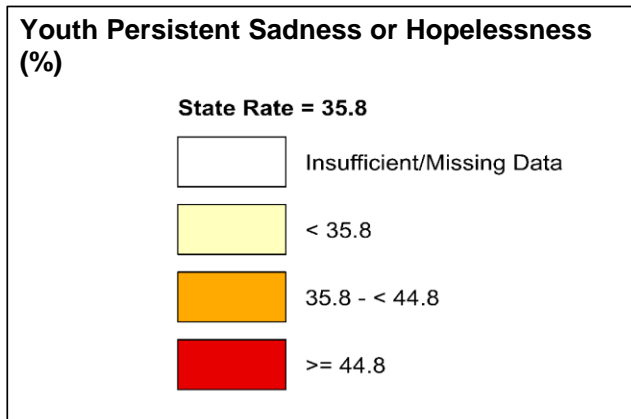
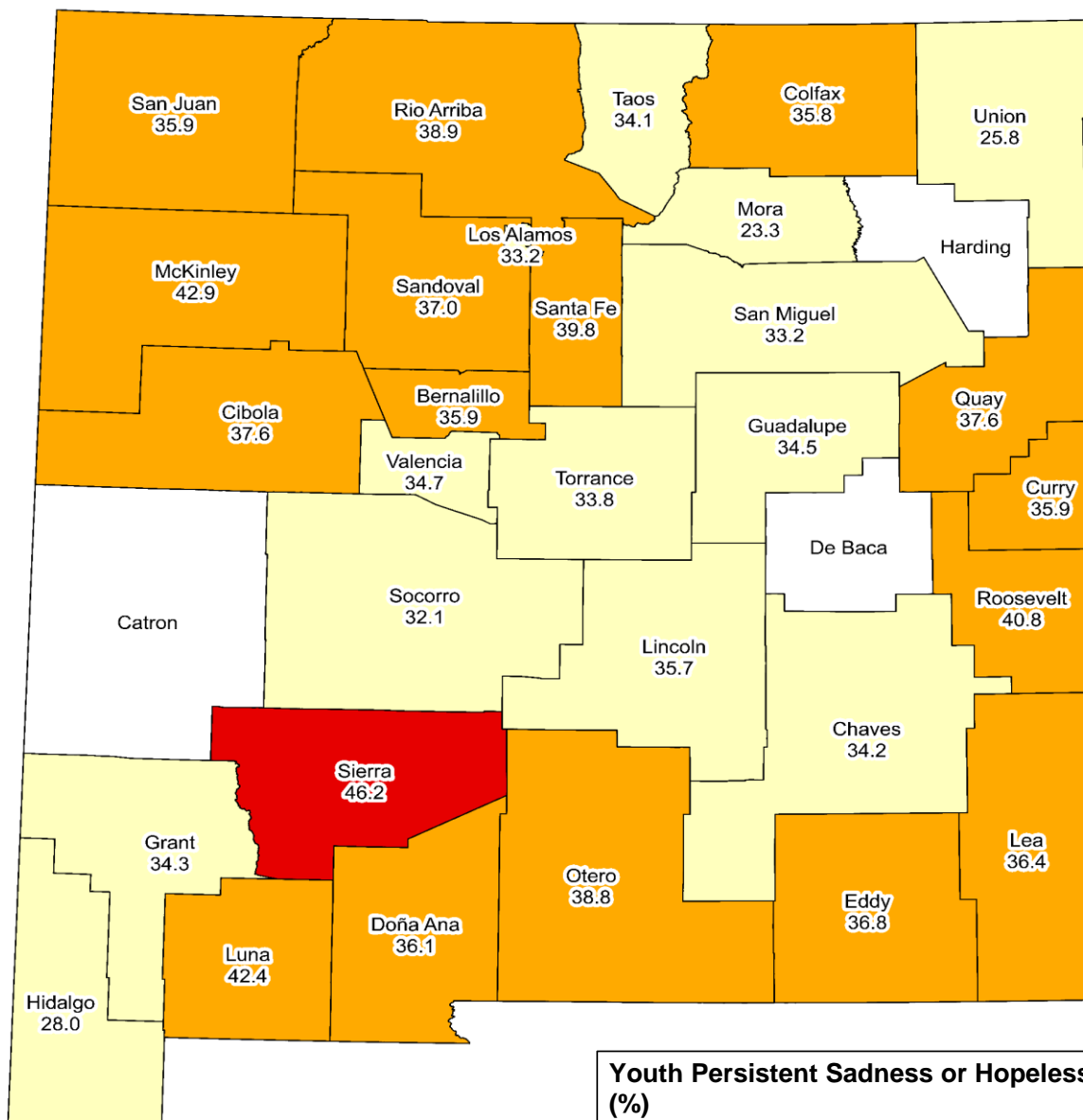
\* Estimate of percent of high school students who reported persistent feelings of sadness or hopelessness within the past 12 months

De Baca, Catron, and Harding County estimates not available because of small numbers and/or low response rates

Source: YRRS (NM); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

# YOUTH FEELINGS OF SADNESS OR HOPELESSNESS (continued)

Chart 4: Feelings of Sadness or Hopelessness\* by County, Grades 9 - 12, NM, 2017



\* Estimate of percent of high school students who reported persistent feelings of sadness or hopelessness within the past 12 months

Insufficient Data: County estimates not available because of small numbers and/or low response rates

Source: YRRS (NM); NMDOH Survey Section; SAES



# YOUTH SERIOUSLY CONSIDERED SUICIDE

## Problem Statement

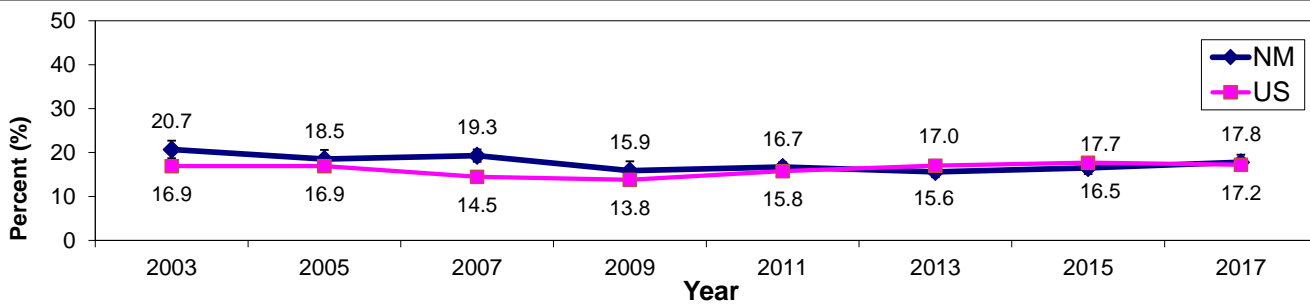
Suicide is a complex behavior with no single determining cause. Suicidal ideation refers to thoughts of suicide or wanting to take one's own life. Suicidal ideation is a risk factor for suicide attempt/death.

Among NM high school students, the rate of "Seriously Considered Suicide" decreased significantly from 20.7% in 2003 to 16.5% in 2015 (Chart 1) and then increased in 2017 to 17.8%. The difference between rates from 2009 to 2017 was not statistically significant. The US rate decreased from 2003 to 2009 but then increased from 2009 to 2017 (13.8% to 17.2%). There was no statistical difference between the NM and US rates for 2017.

In 2017 (Chart 2), New Mexico girls (22.7%) reported higher rates of having seriously considered suicide than boys (13.0%). This difference between girls and boys was significant across all grades (Table 1).

As Charts 3 and 4 demonstrate, in 2017, the counties with the highest prevalence of youth seriously considering suicide were Roosevelt (29.7%), McKinley (24.8%), Eddy (23.9%), Sierra (23.4%), and Otero (23.4%). The counties with the lowest prevalence were Mora (8.0%) and Curry (11.8%). Only nine of the 33 NM counties had prevalence rates lower than the national rate in 2017.

**Chart 1: Seriously Considered Suicide\* by Year, Grades 9 - 12, NM and US, 2003-2017**



\* Estimate of percent of high school students seriously considered suicide at least once in past 12 months

Source: YRRS (NM); CDC YRBS (US); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

**Table 1: Seriously Considered Suicide, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, NM, 2017**

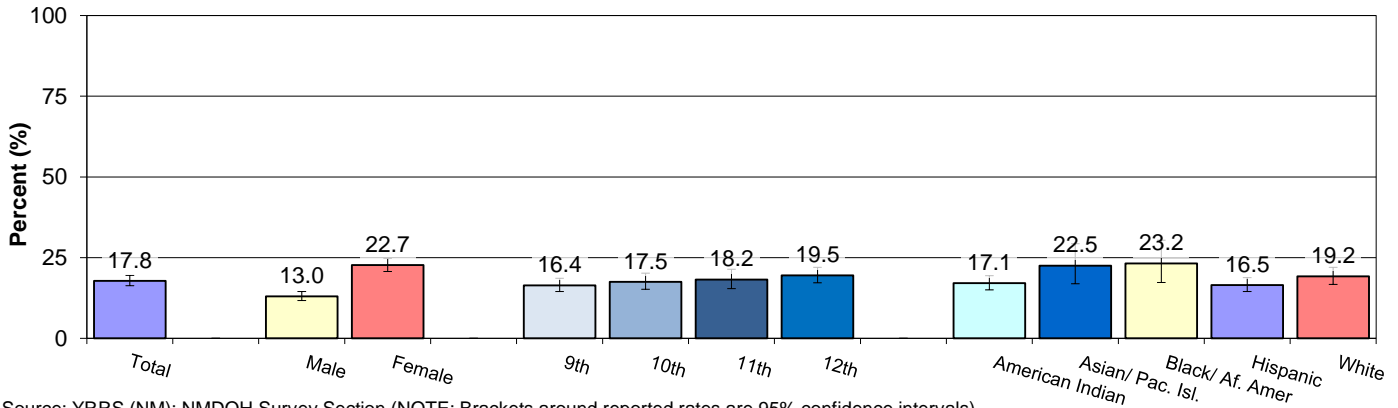
Sex	Race/Ethnicity	9th Grade	10th Grade	11th Grade	12th Grade	All Grades
		Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]
Male	American Indian	12.7 (8.5-18.6)	10.8 (5.9-18.9)	15.0 (8.0-26.3)	12.6 (6.2-23.9)	12.6 (9.7-16.3)
	Asian/Pacific Islander	--	--	--	--	18.9 (12.4-27.6)
	Black	--	--	--	--	15.9 (10.2-24.1)
	Hispanic	11.3 (7.9-15.8)	12.3 (8.3-17.7)	10.9 (7.5-15.6)	15.7 (12.4-19.8)	12.5 (10.4-14.9)
	White	10.8 (6.8-16.9)	15.3 (9.5-23.9)	13.4 (8.7-20.3)	14.0 (10.4-18.5)	13.3 (10.4-16.8)
	Total	11.4 (8.9-14.5)	13.5 (10.4-17.3)	12.7 (10.2-15.6)	15.1 (13.0-17.4)	13.0 (11.7-14.5)
Female	American Indian	24.5 (19.4-30.3)	18.0 (11.2-27.6)	22.0 (17.2-27.7)	23.7 (16.9-32.2)	22.3 (19.4-25.5)
	Asian/Pacific Islander	--	--	--	--	27.4 (17.7-39.7)
	Black	--	--	--	--	32.0 (21.7-44.5)
	Hispanic	16.3 (13.5-19.5)	20.7 (16.5-25.7)	23.1 (16.9-30.7)	20.7 (16.6-25.5)	20.2 (17.6-23.0)
	White	27.2 (20.4-35.3)	23.8 (17.5-31.6)	24.8 (18.3-32.8)	27.3 (21.2-34.5)	25.8 (22.5-29.4)
	Total	21.6 (17.8-26.0)	21.7 (18.9-24.9)	23.8 (19.3-28.9)	23.7 (20.1-27.7)	22.7 (20.7-24.8)
Total	American Indian	17.8 (14.6-21.6)	14.0 (9.9-19.4)	18.5 (13.3-25.2)	18.0 (12.4-25.3)	17.1 (15.0-19.4)
	Asian/Pacific Islander	--	22.0 (12.9-35.0)	22.4 (12.4-37.2)	--	22.5 (16.9-29.3)
	Black	19.8 (12.8-29.2)	25.2 (13.6-42.1)	--	--	23.2 (17.3-30.4)
	Hispanic	14.0 (11.8-16.6)	16.7 (13.0-21.1)	17.4 (13.6-22.0)	18.4 (15.8-21.2)	16.5 (14.5-18.8)
	White	18.9 (15.3-23.1)	19.3 (14.7-24.9)	18.9 (13.9-25.0)	20.1 (16.3-24.5)	19.2 (16.7-22.0)
	Total	16.4 (14.5-18.6)	17.5 (15.2-20.2)	18.2 (15.4-21.4)	19.5 (17.2-22.0)	17.8 (16.3-19.5)

Source: YRRS (NM); NMDOH Survey Section (NOTE: "95% CI" is 95% confidence interval)



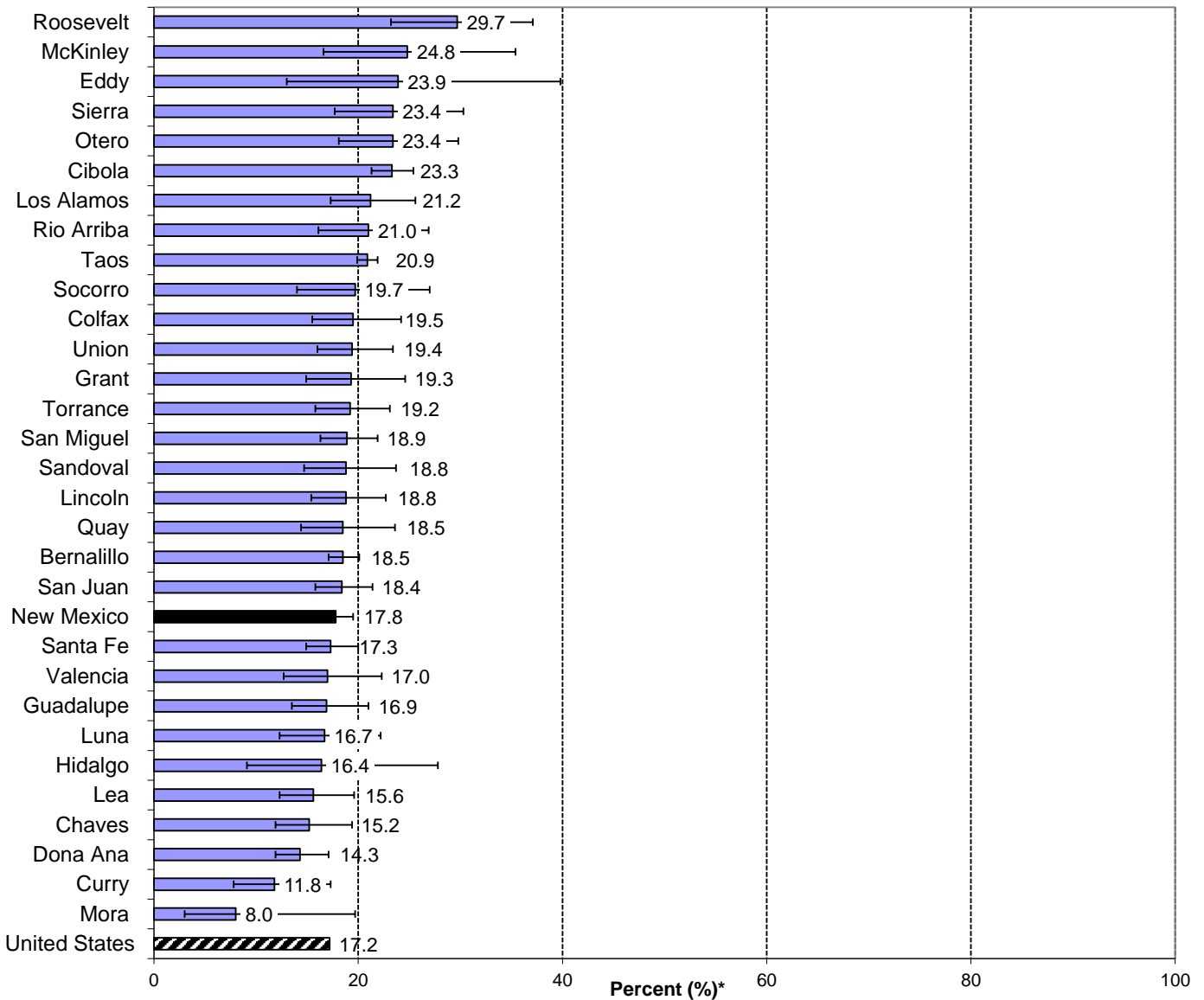
# YOUTH SERIOUSLY CONSIDERED SUICIDE (continued)

Chart 2: Seriously Considered Suicide, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, NM, 2017



Source: YRRS (NM); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

Chart 3. Seriously Considered Suicide\* by County, Grades 9 - 12, NM, 2017



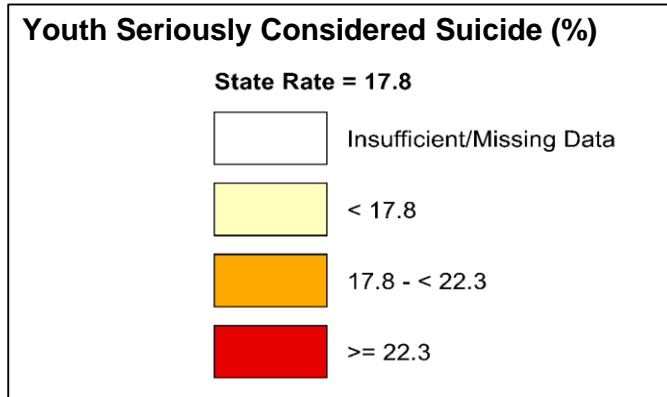
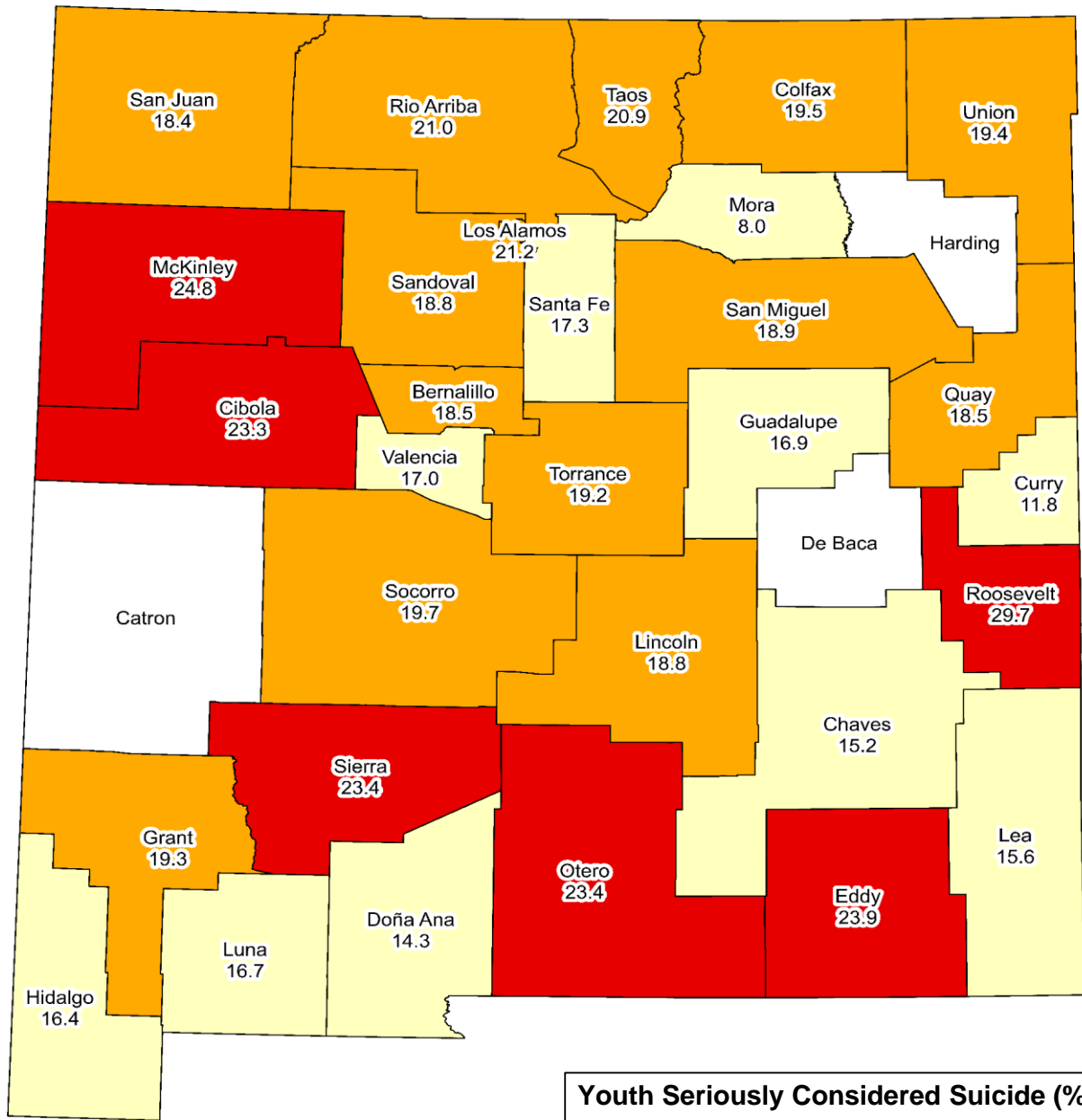
\* Estimate of percent of high school students seriously considered suicide at least once in past 12 months

De Baca, Catron, and Harding County estimates not available because of small numbers and/or low response rates

Source: YRRS (NM); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

# YOUTH SERIOUSLY CONSIDERED SUICIDE (continued)

Chart 4: Seriously Considered Suicide\* by County, Grades 9 - 12, NM, 2017



\* Estimate of percent of high school students seriously considered suicide at least once in past 12 months  
 Insufficient Data: County estimates not available because of small numbers and/or low response rates

Source: YRRS (NM); NMDOH Survey Section; SAES



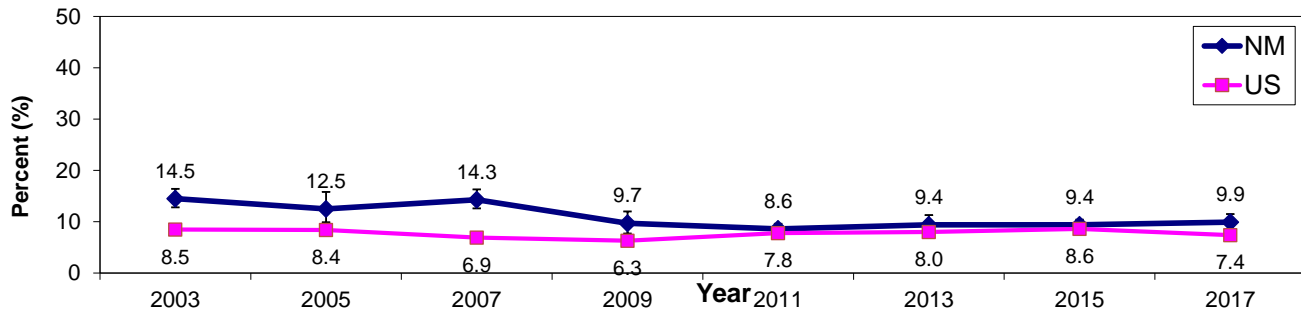
# YOUTH ATTEMPTED SUICIDE

## Problem Statement

In NM in 2017, suicide was the leading cause of death for youth between the ages of 5-17. In the US in 2016 (the most recent year for which national data are available) according to the CDC, suicide was the second leading cause of death for this same age group. While girls are more likely than boys to attempt suicide, boys are more likely than girls to die by suicide. A previous suicide attempt is among the strongest risk factors for completed suicide. As seen in Chart 1, the prevalence of past year suicide attempts among NM high school students decreased from 14.5% in 2003 to 9.4% in 2015 with a slight increase to 9.9% in 2017. While the U.S. prevalence decreased from 2003 to 2009, it increased from 2009 (6.3%) to 2015 (8.6%) before dropping slightly (7.4%) in 2017.

In NM in 2017, the prevalence of suicide attempts in the past year (Chart 2) was significantly higher for girls (11.9%) compared to boys (7.7%). Table 1 reveals that the percentage of attempts made by girls in the 11th (13.5%) grades was significantly higher than that for boys (6.9%). In 2017, the counties with the highest prevalence of suicide attempts were McKinley (18.3%), Rio Arriba (17.9%), Cibola (16.5%), Sierra (15.1%), and Eddy (13.5%). The counties with the lowest prevalence of suicide attempts were Curry (2.6%), Colfax (6.8%), Union (7.2%), Guadalupe (7.5%) and Los Alamos (7.6%). Only three NM counties were below the national prevalence rate of 7.4%.

**Chart 1: Attempted Suicide\* by Year, Grades 9 - 12, NM and US, 2003-2017**



\* Attempted suicide at least one time in the past 12 months

Source: YRRS (NM); CDC YRBS (US); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

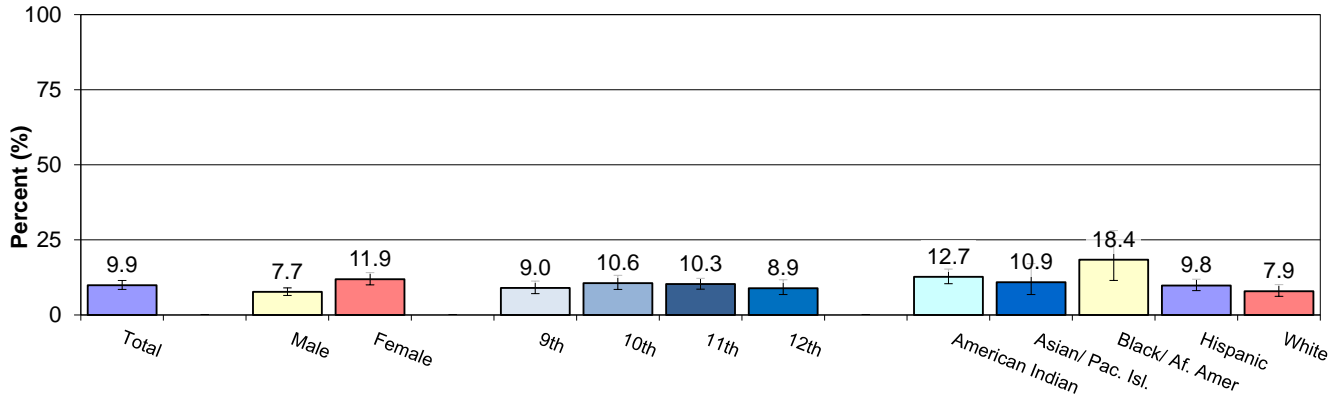
**Table 1: Attempted Suicide, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, NM, 2017**

Sex	Race/Ethnicity	9th Grade	10th Grade	11th Grade	12th Grade	All Grades
		Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]
Male	American Indian	7.6 (4.1-13.7)	11.5 (5.8-21.5)	7.6 (4.5-12.4)	13.8 (8.3-22.2)	9.9 (7.2-13.5)
	Asian/Pacific Islander	--	--	--	--	13.1 (7.2-22.5)
	Black	--	--	--	--	15.5 (7.2-30.2)
	Hispanic	7.1 (4.1-11.9)	8.6 (5.8-12.6)	7.0 (4.1-11.5)	7.1 (3.8-12.9)	7.4 (5.9-9.4)
	White	4.8 (2.2-10.1)	8.1 (4.0-15.8)	6.5 (3.6-11.5)	4.3 (1.9-9.4)	5.9 (4.3-8.2)
	Total	6.9 (4.7-9.9)	9.3 (6.8-12.4)	6.9 (5.5-8.6)	7.8 (5.7-10.5)	7.7 (6.5-9.0)
Female	American Indian	16.3 (10.1-25.2)	16.2 (6.4-35.2)	18.1 (11.6-27.1)	8.7 (4.0-17.7)	15.5 (12.4-19.1)
	Asian/Pacific Islander	--	--	--	--	8.2 (3.3-19.0)
	Black	--	--	--	--	20.3 (10.4-35.8)
	Hispanic	9.7 (6.6-14.1)	12.0 (8.6-16.6)	14.0 (9.4-20.3)	9.8 (6.2-15.1)	11.8 (9.4-14.7)
	White	10.8 (6.5-17.4)	8.8 (5.2-14.5)	11.2 (6.4-18.7)	9.4 (5.8-14.7)	10.1 (7.8-13.0)
	Total	11.0 (8.1-14.7)	11.9 (9.1-15.5)	13.5 (10.3-17.6)	10.0 (7.3-13.6)	11.9 (10.0-14.1)
Total	American Indian	11.6 (7.5-17.5)	13.6 (8.1-22.0)	12.9 (9.6-17.1)	11.2 (7.0-17.6)	12.7 (10.4-15.3)
	Asian/Pacific Islander	--	9.4 (3.3-24.2)	--	--	10.9 (6.8-17.1)
	Black	16.2 (7.7-30.9)	18.9 (7.6-39.9)	--	--	18.4 (11.5-28.1)
	Hispanic	8.6 (6.5-11.4)	10.4 (7.8-13.8)	10.8 (7.8-14.7)	8.6 (5.8-12.6)	9.8 (8.1-11.9)
	White	7.8 (5.4-11.0)	8.4 (4.9-14.1)	8.8 (5.9-12.8)	6.7 (4.4-10.0)	7.9 (6.2-10.1)
	Total	9.0 (7.1-11.3)	10.6 (8.5-13.2)	10.3 (8.6-12.2)	8.9 (6.8-11.7)	9.9 (8.5-11.5)

Source: YRRS (NM); NMDOH Survey Section (NOTE: "95% CI" is 95% confidence interval)

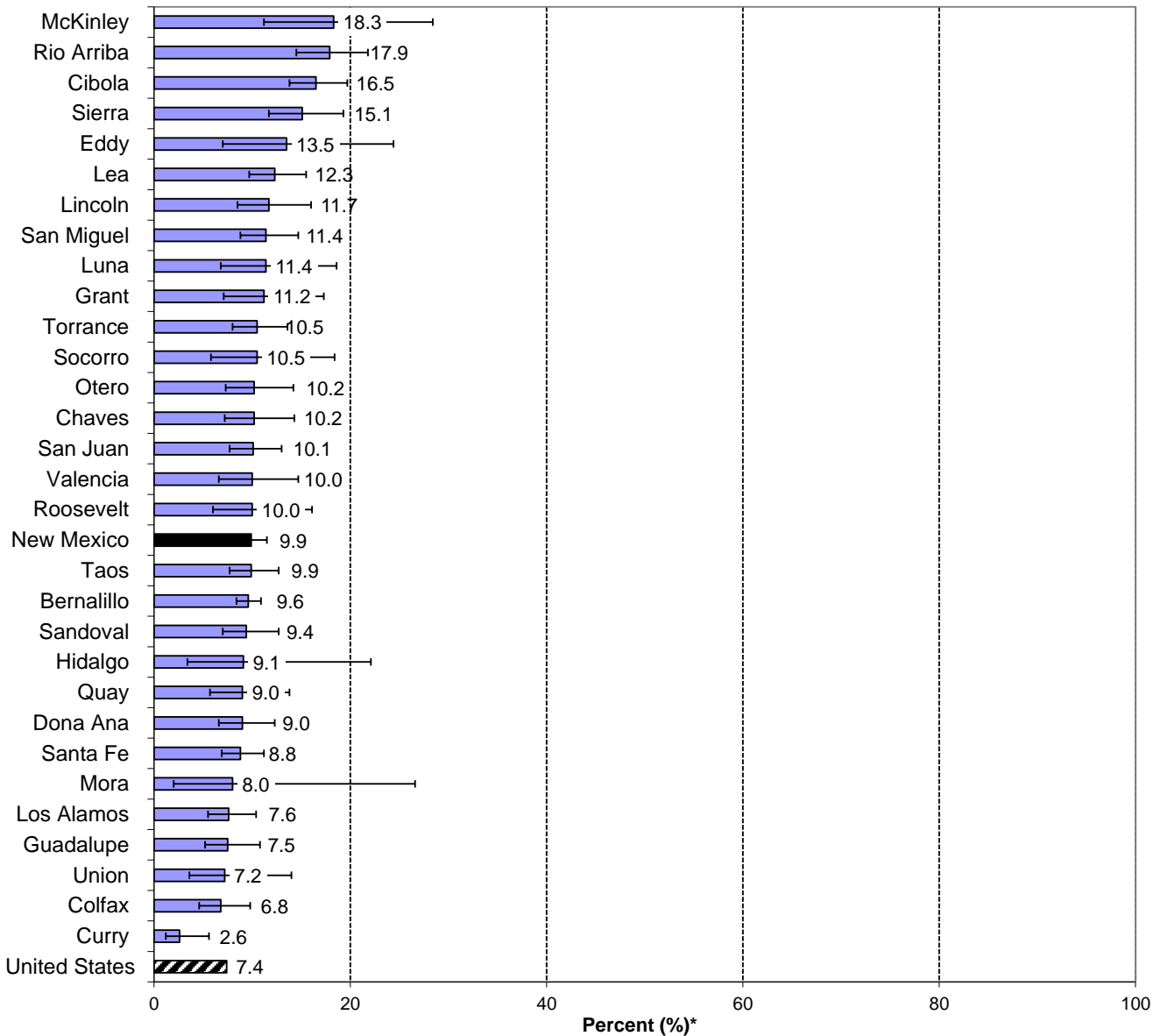
# YOUTH ATTEMPTED SUICIDE (continued)

Chart 2: Attempted Suicide, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, NM, 2017



Source: YRRS (NM); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

Chart 3: Attempted Suicide\* by County, Grades 9 - 12, NM, 2017

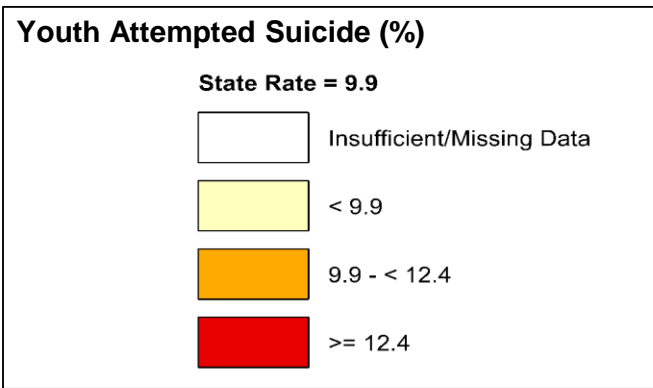
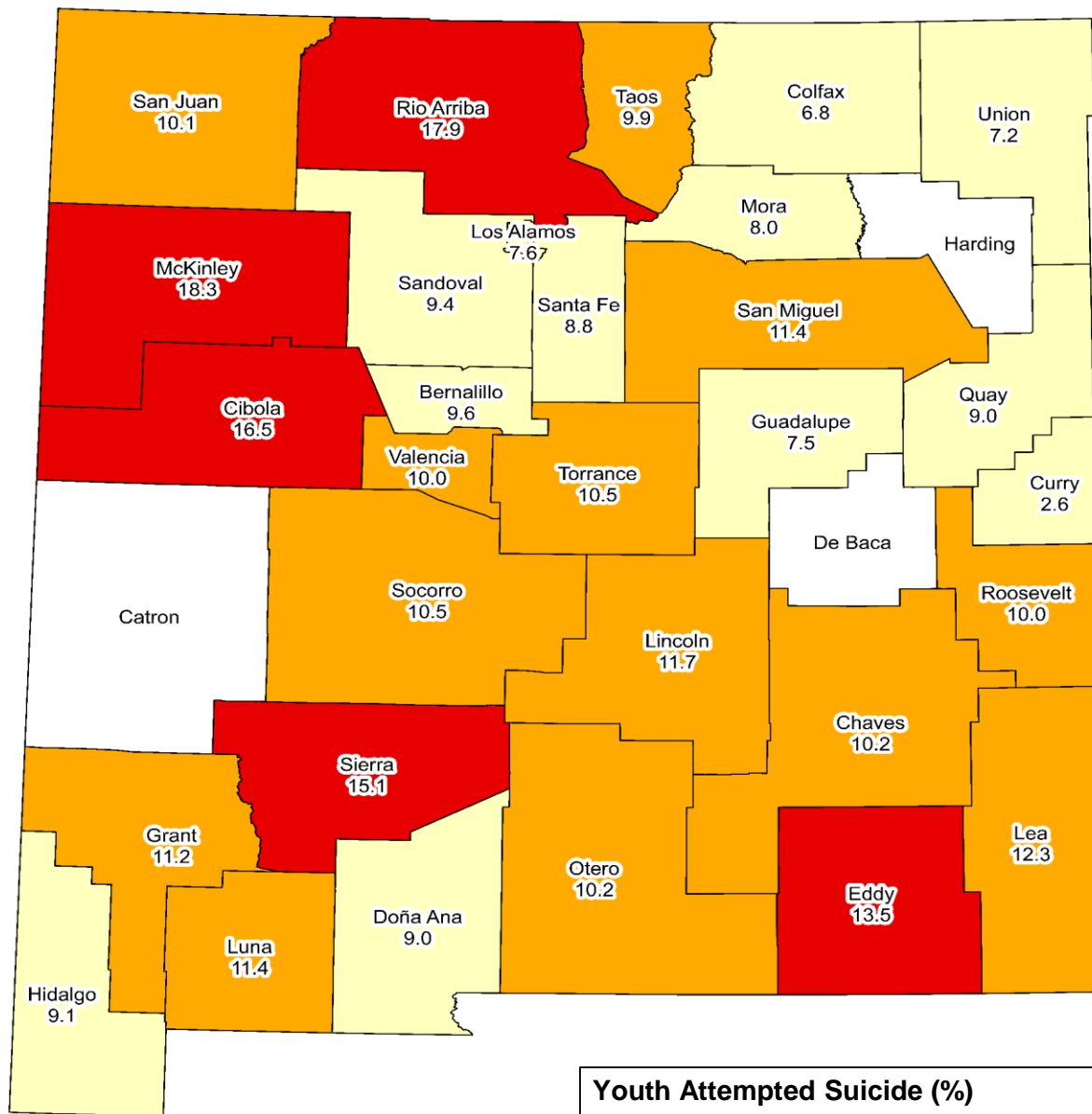


\* Estimate of percent of high school students who reported attempting suicide at least one time in the past 12 months  
 De Baca, Catron, and Harding County estimates not available because of small numbers and/or low response rates

Source: YRRS (NM); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

# YOUTH ATTEMPTED SUICIDE (continued)

Chart 4: Attempted Suicide\* by County, Grades 9 - 12, NM, 2017



\* Estimate of percent of high school students who reported attempting suicide at least one time in the past 12 months

Insufficient Data: County estimates not available because of small numbers and/or low response rates

Source: YRRS (NM); NMDOH Survey Section; SAES



# YOUTH RISK AND RESILIENCY

## Association Between Risk and Resiliency

Strong relationships with parents, peers, schools, and adults in the community can be protective factors against risk behaviors that endanger the health and well-being of young people. These protective factors, or resiliency factors, are measured by several questions in the NM Youth Risk and Resiliency Survey (YRRS). Results from the 2017 YRRS demonstrate that youth with high levels of these resiliency factors were less likely than other students to engage in binge drinking, drug use, tobacco use, and suicidal ideation and attempts.

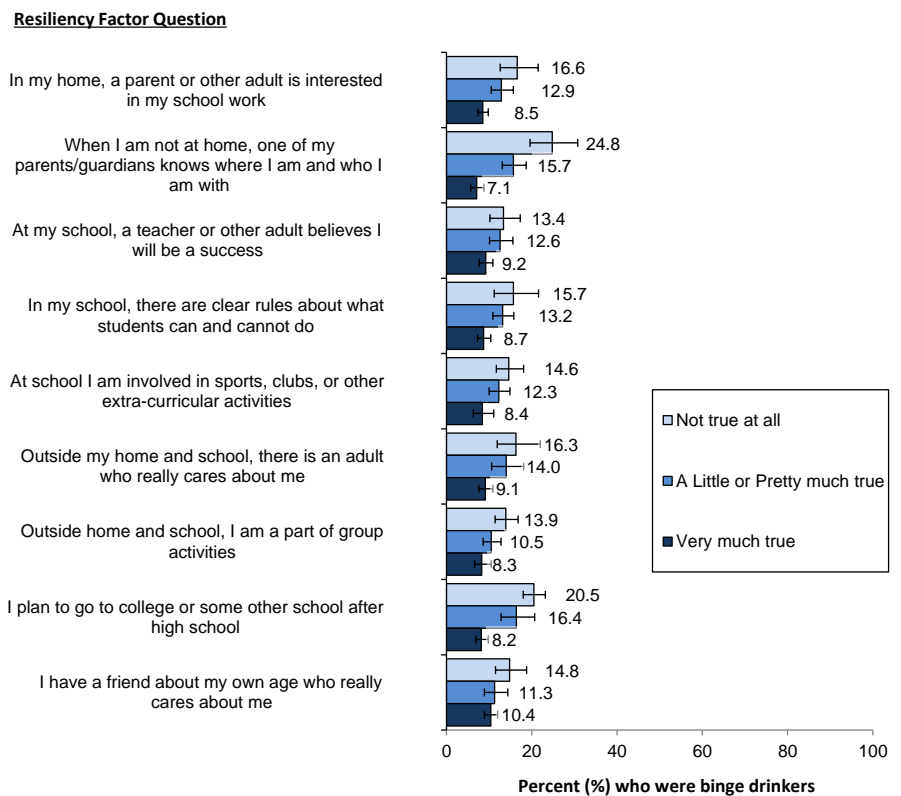
Resiliency factor results presented in the following charts are for:

- In my home, a parent or other adult is interested in my school work
- When I am not at home, one of my parents/guardians knows where I am and who I am with
- At my school, a teacher or other adult believes I will be a success
- In my school, there are clear rules about what students can and cannot do
- At school I am involved in sports, clubs, or other extra-curricular activities
- Outside my home and school, there is an adult who really cares about me
- Outside home and school, I am a part of group activities
- I plan to go to college or some other school after high school
- I have a friend about my own age who really cares about me

Students were asked how true each of these statements was for them. In each chart, results are organized by assigning one of three colored bars to those who said the statement was "Very much true", another bar to those who said the statement was "A little true" or "Pretty much true" and another to those who said "Not true at all". The length of each bar represents the percent of students who reported engaging in each risk behavior. In general, students who said "Very much true" to each resiliency factor (dark colored bars) had a lower prevalence of risk behaviors than other students, and students who said "Not true at all" (light colored bars) had higher rates of risk behaviors.

**Chart 1: Binge Drinking\* by Selected Resiliency Factors, Grades 9-12, 2017**

Students were less likely to be binge drinkers if they said "Very much true" to any of the resiliency questions:



\* Had 5 or more drinks on a single occasion for boys or 4 or more drinks for girls (i.e., in a row or within a couple of hours) at least once in the past 30 days



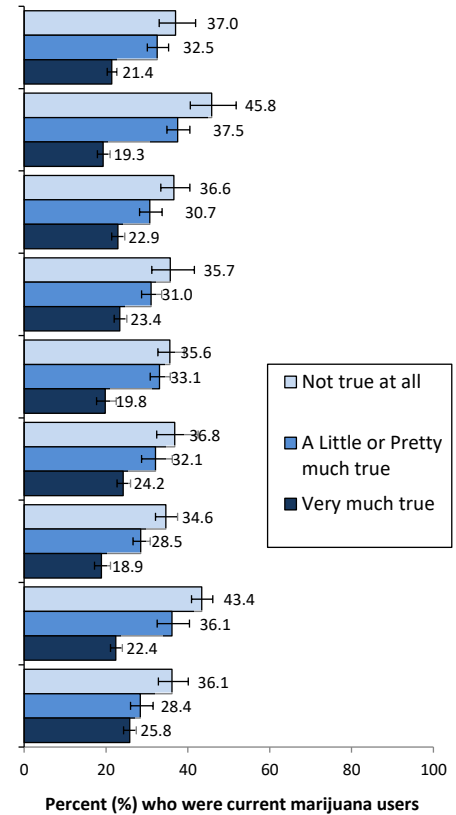
# YOUTH RISK AND RESILIENCY (continued)

**Chart 2: Current Marijuana Use\* by Selected Resiliency Factors, Grades 9-12, 2017**

Students were less likely to be current marijuana users if they said "Very much true" to any of the resiliency questions:

**Resiliency Factor Question**

- In my home, a parent or other adult is interested in my school work
- When I am not at home, one of my parents/guardians knows where I am and who I am with
- At my school, a teacher or other adult believes I will be a success
- In my school, there are clear rules about what students can and cannot do
- At school I am involved in sports, clubs, or other extra-curricular activities
- Outside my home and school, there is an adult who really cares about me
- Outside home and school, I am a part of group activities
- I plan to go to college or some other school after high school
- I have a friend about my own age who really cares about me



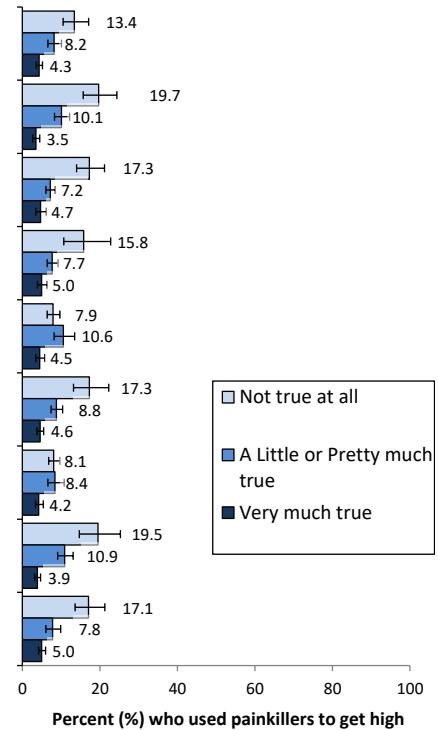
\* Used marijuana in the past 30 days

**Chart 3: Used Pain Killers to Get High\* by Selected Resiliency Factors, Grades 9-12, 2017**

Students were less likely to use pain killers to get high if they said "Very much true" to any of the resiliency questions:

**Resiliency Factor Question**

- In my home, a parent or other adult is interested in my school work
- When I am not at home, one of my parents/guardians knows where I am and who I am with
- At my school, a teacher or other adult believes I will be a success
- In my school, there are clear rules about what students can and cannot do
- At school I am involved in sports, clubs, or other extra-curricular activities
- Outside my home and school, there is an adult who really cares about me
- Outside home and school, I am a part of group activities
- I plan to go to college or some other school after high school
- I have a friend about my own age who really cares about me



\* Used a pain killer, like Vicodin, OxyContin, or Percocet, to get high in the past 30 days

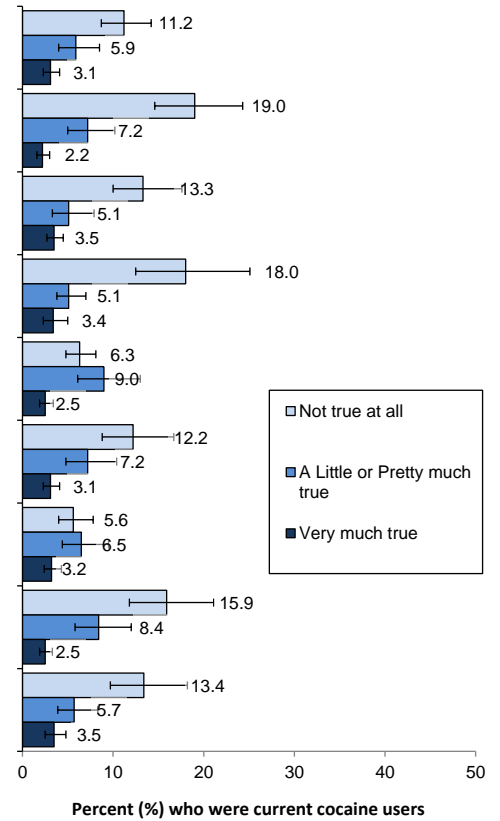
# YOUTH RISK AND RESILIENCY (continued)

**Chart 4: Current Cocaine Use\* by Selected Resiliency Factors, Grades 9-12, 2017**

Students were less likely to be current cocaine users if they said "Very much true" to any of the resiliency questions:

**Resiliency Factor Question**

- In my home, a parent or other adult is interested in my school work
- When I am not at home, one of my parents/guardians knows where I am and who I am with
- At my school, a teacher or other adult believes I will be a success
- In my school, there are clear rules about what students can and cannot do
- At school I am involved in sports, clubs, or other extra-curricular activities
- Outside my home and school, there is an adult who really cares about me
- Outside home and school, I am a part of group activities
- I plan to go to college or some other school after high school
- I have a friend about my own age who really cares about me



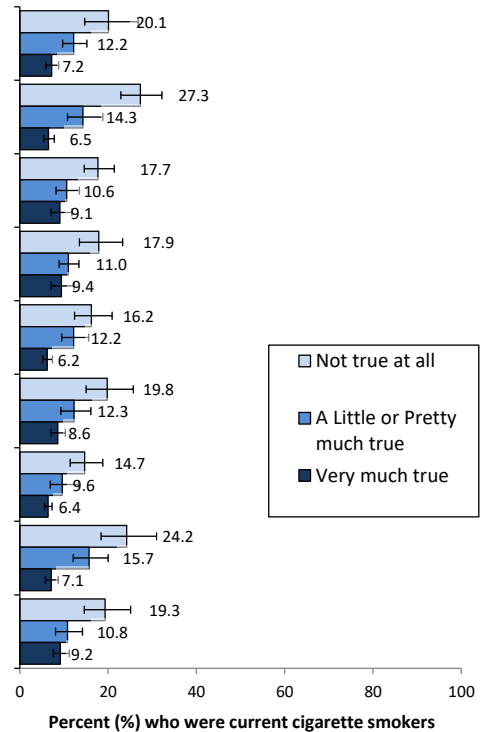
\* Used any form of cocaine, including powder, crack, or freebase in the past 30 days

**Chart 5: Current Cigarette Smoking\* by Selected Resiliency Factors, Grades 9-12, 2017**

Students were less likely to be current cigarette smokers if they said "Very much true" to any of the resiliency questions:

**Resiliency Factor Question**

- In my home, a parent or other adult is interested in my school work
- When I am not at home, one of my parents/guardians knows where I am and who I am with
- At my school, a teacher or other adult believes I will be a success
- In my school, there are clear rules about what students can and cannot do
- At school I am involved in sports, clubs, or other extra-curricular activities
- Outside my home and school, there is an adult who really cares about me
- Outside home and school, I am a part of group activities
- I plan to go to college or some other school after high school
- I have a friend about my own age who really cares about me



\* Smoked cigarettes on at least one of the past 30 days

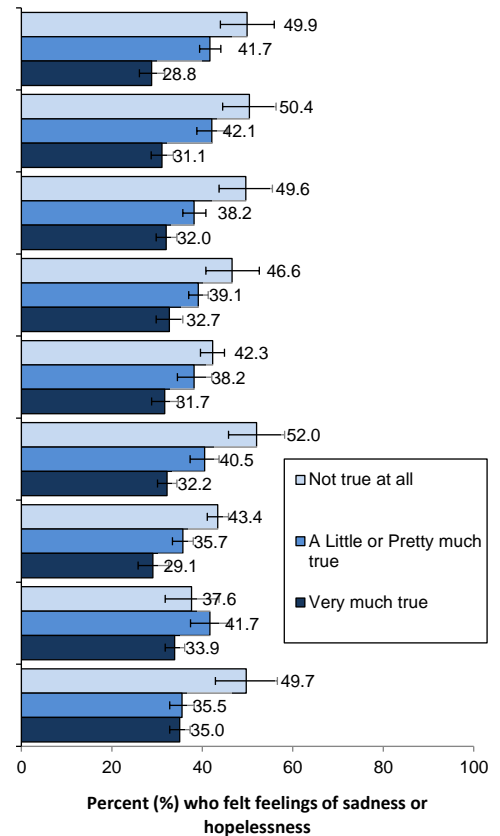
# YOUTH RISK AND RESILIENCY (continued)

**Chart 6: Feelings of Sadness or Hopelessness\* by Selected Resiliency Factors, Grades 9-12, 2017**

Students were less likely to have feelings of sadness and hopelessness if they said "Very much true" to any of the resiliency questions:

**Resiliency Factor Question**

- In my home, a parent or other adult is interested in my school work
- When I am not at home, one of my parents/guardians knows where I am and who I am with
- At my school, a teacher or other adult believes I will be a success
- In my school, there are clear rules about what students can and cannot do
- At school I am involved in sports, clubs, or other extra-curricular activities
- Outside my home and school, there is an adult who really cares about me
- Outside home and school, I am a part of group activities
- I plan to go to college or some other school after high school
- I have a friend about my own age who really cares about me



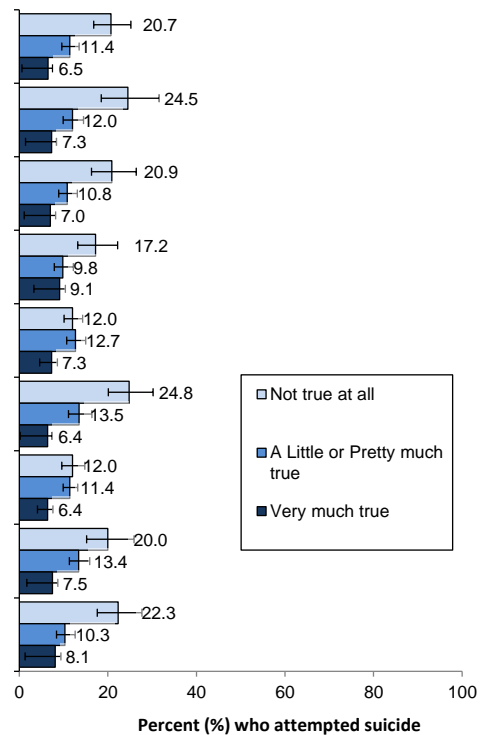
\* Felt so sad or hopeless almost every day for at least two weeks that they stopped some normal activities, within the past 12 months

**Chart 7: Suicide Attempts\* by Selected Resiliency Factors, Grades 9-12, 2017**

Students were less likely to attempt suicide if they said "Very much true" to any of the resiliency questions:

**Resiliency Factor Question**

- In my home, a parent or other adult is interested in my school work
- When I am not at home, one of my parents/guardians knows where I am and who I am with
- At my school, a teacher or other adult believes I will be a success
- In my school, there are clear rules about what students can and cannot do
- At school I am involved in sports, clubs, or other extra-curricular activities
- Outside my home and school, there is an adult who really cares about me
- Outside home and school, I am a part of group activities
- I plan to go to college or some other school after high school
- I have a friend about my own age who really cares about me



\* Attempted suicide at least once in the past 12 months

## Section 3

### Consumption



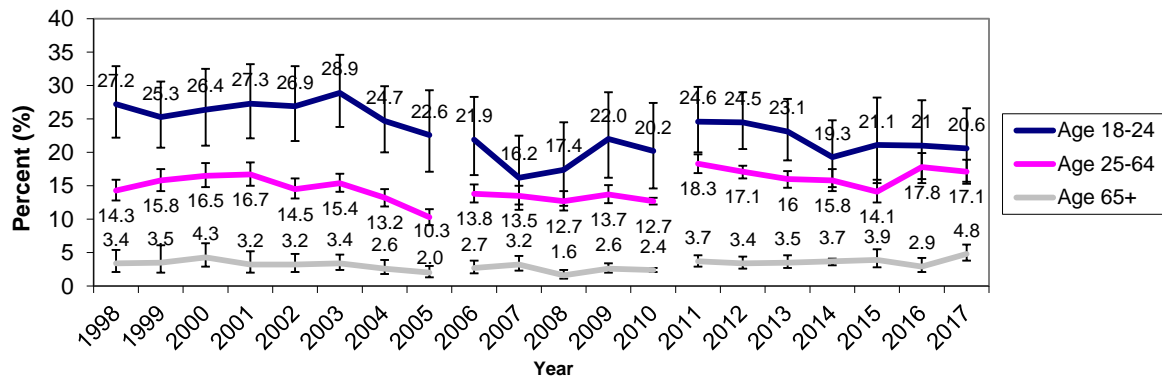
# ADULT BINGE DRINKING

## Problem Statement

Binge drinking is defined as a pattern of alcohol consumption that brings the blood alcohol concentration (BAC) level to 0.08% or above. This pattern of drinking usually corresponds to five or more drinks on a single occasion for men, or four or more drinks on a single occasion for women, generally within about two hours. According to the latest estimates from the Centers for Disease Control and Prevention, about 47% of homicides, 32% of fall injury deaths, 29% of drug overdose deaths, and 23% of suicide deaths are alcohol attributable. Likewise, alcohol consumption is the primary causal factor in roughly 45% of motor vehicle crash deaths among males aged 20-44, and in more than a third of motor vehicle crash deaths among females aged 20-44. Binge drinking is also associated with a wide range of other social problems, including domestic and sexual violence, crime, and risky sexual behavior.

Table 1 shows that binge drinking rates decrease with age and are higher among males. Chart 1 shows that binge drinking prevalence among younger adults has remained relatively stable. Chart 2 shows that adults who do binge drink continue to do so on average four to five times per month and drink well above the binge drinking threshold when they do. County-level results are shown in Table 2 and Charts 3-4.

**Chart 1: Binge Drinking (past 30 days)\* by Age, Adults Aged 18+, New Mexico, 1998-2017**



\* Binge drinking definition: 1998-2005, drinking five or more drinks on an occasion at least once in the past 30 days; 2006-present, drinking five or more drinks (for men) or four or more drinks (for women) on an occasion at least once in the past 30 days

\*\*In 2011, BRFSS updated its surveillance methods. Any shift in prevalence between 2010 and 2011 must be interpreted with caution, as it may be partially due to changes in methodology.

Source: BRFSS; SAES (NOTE: Brackets around reported rates are 95% confidence intervals)

**Table 1: Binge Drinking (past 30 days) by Age, Sex, and Race, Adults Aged 18+, New Mexico, 2015-2017**

Sex	Race/Ethnicity	Number				Percent*			
		Ages 18-24	Ages 25-64	Ages 65+	All Ages	Ages 18-24	Ages 25-64	Ages 65+	All Ages*
Male	American Indian	3,078	9,563	350	12,996	29.1	20.7	4.6	20.2
	Asian/Pacific Islander	-	520	-	1,501	-	5.7	-	11.9
	Black	-	2,372	-	3,389	-	17.5	-	17.4
	Hispanic	13,390	63,534	3,502	80,568	22.7	25.8	6.9	22.7
	White	9,575	39,319	5,272	53,632	30.9	18.7	5.6	15.9
	Total	26,727	114,219	9,941	150,453	25.2	21.7	6.3	19.1
Female	American Indian	1,312	5,963	8	7,494	12.4	11.8	0.1	10.4
	Asian/Pacific Islander	-	991	-	1,288	-	8.5	-	8.1
	Black	-	1,334	-	1,466	-	13.9	-	10.2
	Hispanic	8,643	24,607	903	34,248	15.2	9.9	1.5	9.3
	White	6,281	24,062	2,528	32,352	23.8	11.3	2.3	9.3
	Total	16,001	58,093	3,610	77,421	16.4	10.9	1.9	9.5
Total	American Indian	4,258	15,385	380	20,316	20.1	15.9	2.0	14.9
	Asian/Pacific Islander	-	1,455	-	2,913	-	7.0	-	10.2
	Black	-	3,607	817	4,582	-	15.6	16.8	13.5
	Hispanic	22,074	87,601	4,360	114,294	19.1	17.7	3.9	15.8
	White	15,752	63,365	7,704	85,638	27.4	15.0	3.8	12.5
	Total	42,578	171,879	13,487	227,150	20.9	16.2	3.9	14.1

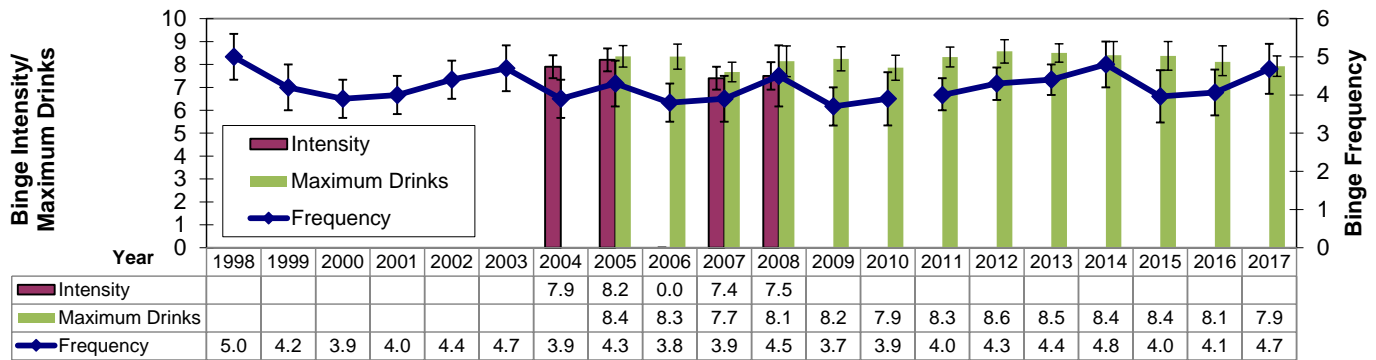
\* Estimate of percent of people in population group who reported binge drinking at least once in past 30 days

- Excluded due to small number of respondents (< 50) in cell

Source: BRFSS; SAES

# ADULT BINGE DRINKING (continued)

Chart 2: Binge Drinking Frequency and Intensity\*, Adult Binge Drinkers Aged 18+, New Mexico, 1998-2017



\* Binge frequency is the number of binge episodes in the past 30 days; binge intensity is the average number of drinks on the last binge occasion; maximum drinks is the maximum number of drinks in the past month, among binge drinkers

Source: BRFSS; SAES

Table 2: Binge Drinking (past 30 days) by Race and County, Adults Aged 18+, New Mexico, 2015-2017

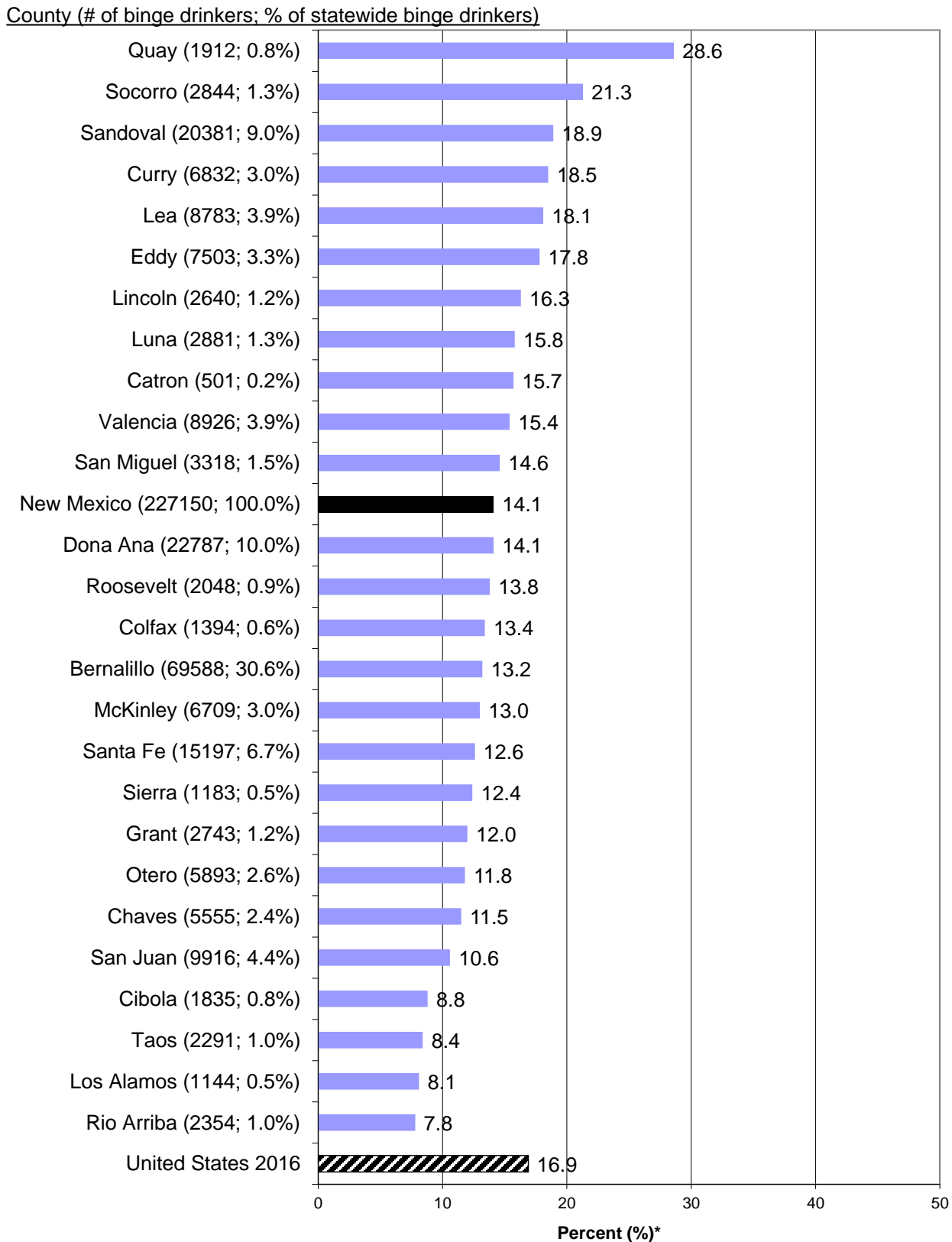
County	Number						Percent*					
	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races
Bernalillo	3,005	-	-	37,539	26,991	69,588	13.6	-	-	15.5	11.6	13.2
Catron	-	-	-	-	-	501	-	-	-	-	-	15.7
Chaves	-	-	-	3,570	1,709	5,555	-	-	-	14.4	7.9	11.5
Cibola	897	-	-	731	299	1,835	11.4	-	-	9.2	6.4	8.8
Colfax	-	-	-	-	590	1,394	-	-	-	-	11.1	13.4
Curry	-	-	-	2,833	3,158	6,832	-	-	-	20.7	15.8	18.5
De Baca	-	-	-	-	-	-	-	-	-	-	-	-
Dona Ana	-	-	-	16,791	5,240	22,787	-	-	-	16.2	10.1	14.1
Eddy	-	-	-	4,439	2,943	7,503	-	-	-	23.5	13.5	17.8
Grant	-	-	-	1,540	1,264	2,743	-	-	-	14.5	10.9	12.0
Guadalupe	-	-	-	-	-	-	-	-	-	-	-	-
Harding	-	-	-	-	-	-	-	-	-	-	-	-
Hidalgo	-	-	-	-	-	-	-	-	-	-	-	-
Lea	-	-	-	4,785	3,663	8,783	-	-	-	18.9	18.0	18.1
Lincoln	-	-	-	-	1,774	2,640	-	-	-	-	16.0	16.3
Los Alamos	-	-	-	-	999	1,144	-	-	-	-	9.4	8.1
Luna	-	-	-	2,212	349	2,881	-	-	-	19.9	5.3	15.8
McKinley	5,397	-	-	980	250	6,709	13.9	-	-	15.2	4.4	13.0
Mora	-	-	-	-	-	-	-	-	-	-	-	-
Otero	725	-	-	1,393	3,569	5,893	25.5	-	-	8.2	13.0	11.8
Quay	-	-	-	-	1,024	1,912	-	-	-	-	27.9	28.6
Rio Arriba	-	-	-	1,547	416	2,354	-	-	-	7.3	9.0	7.8
Roosevelt	-	-	-	-	1,131	2,048	-	-	-	-	13.2	13.8
Sandoval	-	-	-	10,982	5,451	20,381	-	-	-	28.7	10.3	18.9
San Juan	2,586	-	-	2,543	4,835	9,916	7.3	-	-	15.7	11.9	10.6
San Miguel	-	-	-	2,367	446	3,318	-	-	-	13.7	9.8	14.6
Santa Fe	-	-	-	7,221	7,118	15,197	-	-	-	12.8	12.2	12.6
Sierra	-	-	-	-	1,008	1,183	-	-	-	-	14.9	12.4
Socorro	-	-	-	-	-	2,844	-	-	-	-	-	21.3
Taos	-	-	-	1,226	1,092	2,291	-	-	-	8.4	10.2	8.4
Torrance	-	-	-	-	-	-	-	-	-	-	-	-
Union	-	-	-	-	-	-	-	-	-	-	-	-
Valencia	-	-	-	6,342	1,686	8,926	-	-	-	19.2	7.8	15.4
New Mexico	20,316	2,913	4,582	114,294	85,638	227,150	14.9	10.2	13.5	15.8	12.5	14.1

\* Estimate of percent of people in population group who reported binge drinking at least once in past 30 days  
 - Excluded due to small number of respondents (< 50) in cell

Source: BRFSS; SAES

# ADULT BINGE DRINKING (continued)

Chart 3: Binge Drinking (past 30 days)\* by County, Adults Aged 18+, New Mexico, 2015-2017



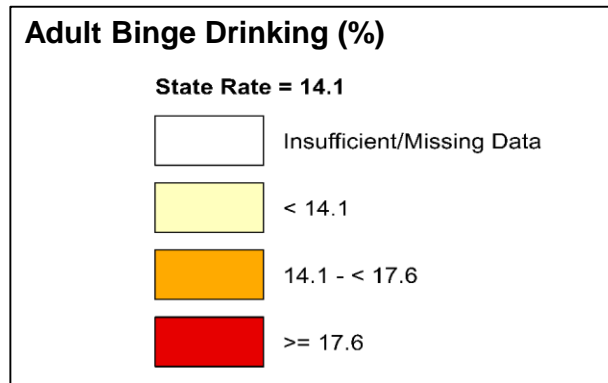
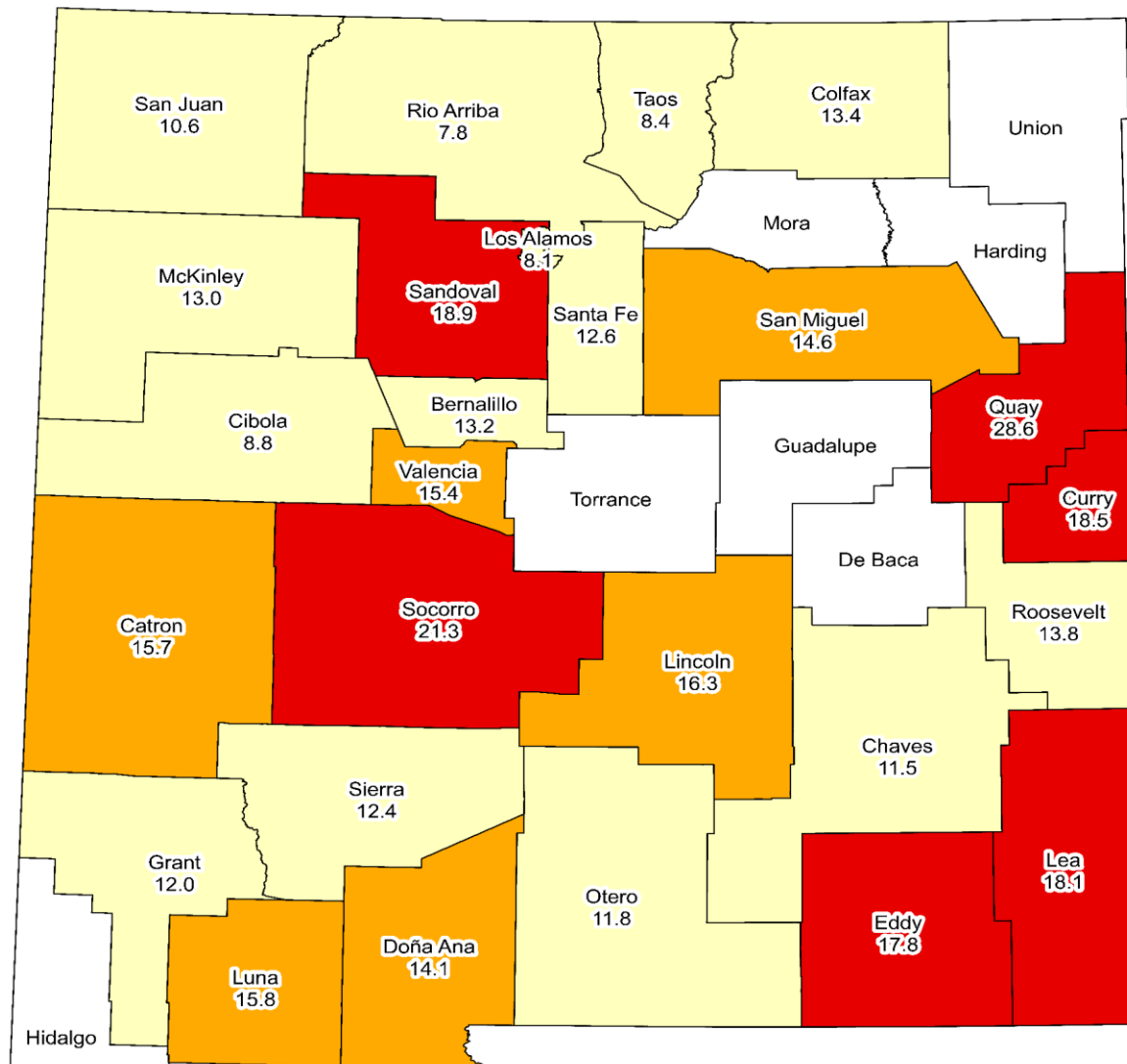
\* Estimate of percent of people in population group who reported binge drinking at least once in past 30 days

Source: NMBRFSS (NM); CDC BRFSS (US); SAES



# ADULT BINGE DRINKING (continued)

Chart 4: Binge Drinking (past 30 days)\* by County, Adults Aged 18+, New Mexico, 2015-2017



\* Estimate of percent of people in population group who reported binge drinking at least once in past 30 days

Insufficient data: Rate not reported due to small number of respondents (< 50) in cell

Source: BRFSS; SAES

# YOUTH CURRENT DRINKING

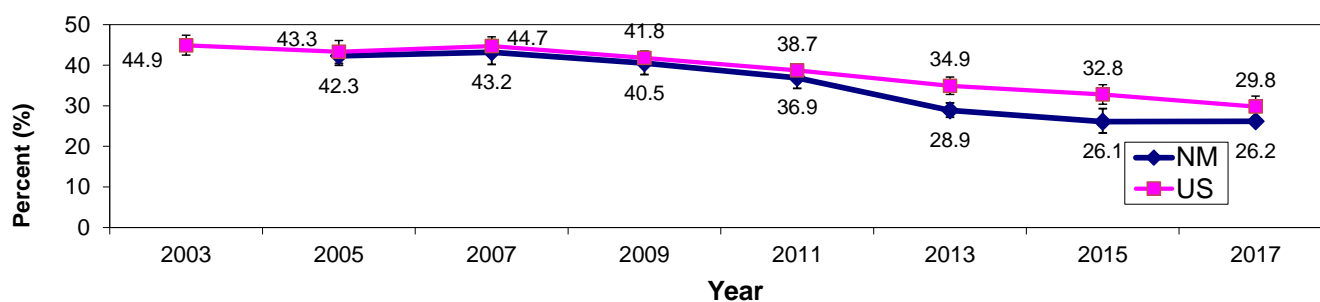
## Problem Statement

Any alcohol consumption by a person under the age of 21 is considered to be excessive drinking. Alcohol is the most commonly used drug among youth in New Mexico, more than tobacco or other drugs. However, contrary to common perception, most high school students do not drink. "Current drinking" is defined as responding one or more days to the question: "During the past 30 days, on how many days did you have at least one drink of alcohol?"

In 2017, 26.2% of high school students reported that they were current drinkers. This is a significant decrease from 43.2% in 2007. Boys and girls are equally likely to be current drinkers, and the percent of youth who drink increases with grade level. However, it is important to note that by ninth grade, close to one in six students are already drinking. Students who identify as Hispanic are most likely to currently drink, followed by White students. American Indian students are the least likely to drink.

Luna County has the highest prevalence of current drinking among high school students (39.3%), followed by Grant (38.5%), and Lincoln (38.3%) counties. McKinley County has the lowest prevalence (16.5%).

**Chart 1: Current Drinking\* by Year, Grades 9 - 12, New Mexico and US, 2003-2017**



\* "Current drinking" is defined as responding one or more days to the question: "During the past 30 days, on how many days did you have at least one drink of alcohol?"

Source: YRRS (NM); CDC YRBS (US); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

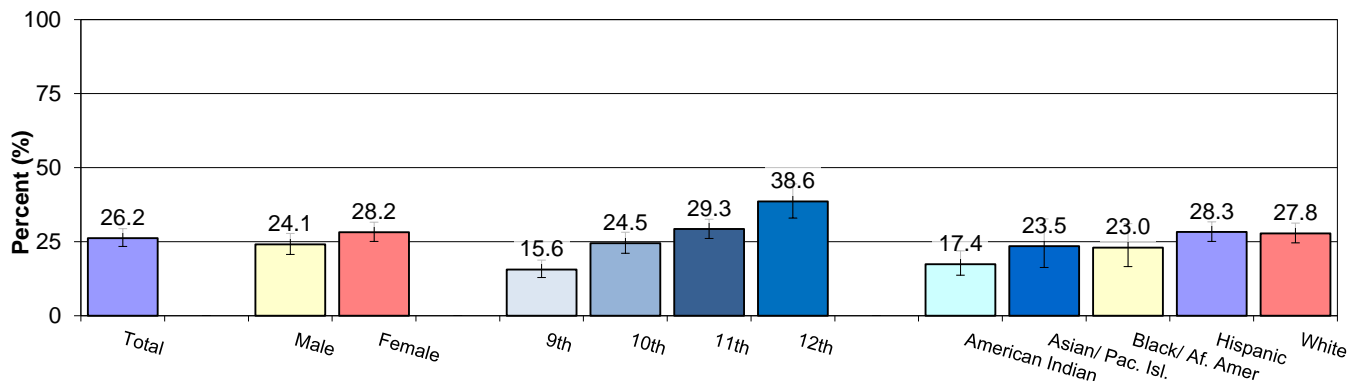
**Table 1: Current Drinking, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, New Mexico, 2017**

Sex	Race/Ethnicity	9th Grade	10th Grade	11th Grade	12th Grade	All Grades
		Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]
Male	American Indian	9.8 (5.7-16.4)	13.5 (9.2-19.3)	11.6 (7.6-17.4)	27.0 (15.4-42.9)	14.3 (10.5-19.1)
	Asian/Pacific Islander	--	--	--	--	23.9 (13.4-38.9)
	Black	--	--	--	--	16.7 (10.7-25.1)
	Hispanic	17.3 (13.2-22.4)	22.6 (17.1-29.2)	31.6 (26.4-37.4)	41.6 (34.5-49.1)	27.3 (23.9-30.9)
	White	10.7 (5.9-18.6)	23.7 (17.6-31.1)	30.2 (23.4-38.0)	36.6 (25.8-49.0)	25.0 (20.5-30.0)
	Total	13.6 (10.1-18.0)	21.3 (17.1-26.2)	27.8 (23.9-32.0)	37.5 (30.4-45.2)	24.1 (20.7-27.8)
Female	American Indian	10.5 (5.7-18.6)	24.1 (17.8-31.8)	23.8 (12.5-40.7)	26.7 (17.5-38.4)	20.4 (15.9-25.8)
	Asian/Pacific Islander	--	--	--	--	23.1 (13.3-36.9)
	Black	--	--	--	--	30.1 (17.4-46.9)
	Hispanic	18.1 (13.1-24.6)	27.2 (21.5-33.8)	31.5 (24.3-39.8)	40.0 (33.6-46.9)	29.0 (25.0-33.4)
	White	18.1 (12.7-25.2)	31.8 (24.6-40.0)	34.1 (27.7-41.2)	44.3 (37.0-51.8)	31.0 (27.0-35.3)
	Total	17.2 (14.4-20.5)	27.7 (23.1-32.9)	30.7 (26.4-35.4)	39.5 (34.2-45.0)	28.2 (25.1-31.6)
Total	American Indian	10.6 (7.7-14.5)	18.2 (14.5-22.6)	17.5 (11.8-25.3)	26.9 (17.7-38.5)	17.4 (13.7-21.9)
	Asian/Pacific Islander	--	22.1 (12.4-36.4)	--	--	23.5 (16.3-32.7)
	Black	19.5 (9.9-34.7)	--	--	--	23.0 (16.6-31.1)
	Hispanic	18.1 (15.0-21.7)	25.0 (20.7-29.8)	31.6 (26.2-37.5)	40.7 (34.5-47.3)	28.3 (25.1-31.7)
	White	14.5 (10.4-19.8)	27.5 (22.9-32.5)	32.1 (27.4-37.2)	40.0 (33.4-47.0)	27.8 (24.6-31.3)
	Total	15.6 (12.9-18.8)	24.5 (21.1-28.2)	29.3 (26.1-32.6)	38.6 (33.0-44.5)	26.2 (23.4-29.4)

Source: YRRS (NM); NMDOH Survey Section (NOTE: "95% CI" is 95% confidence interval)

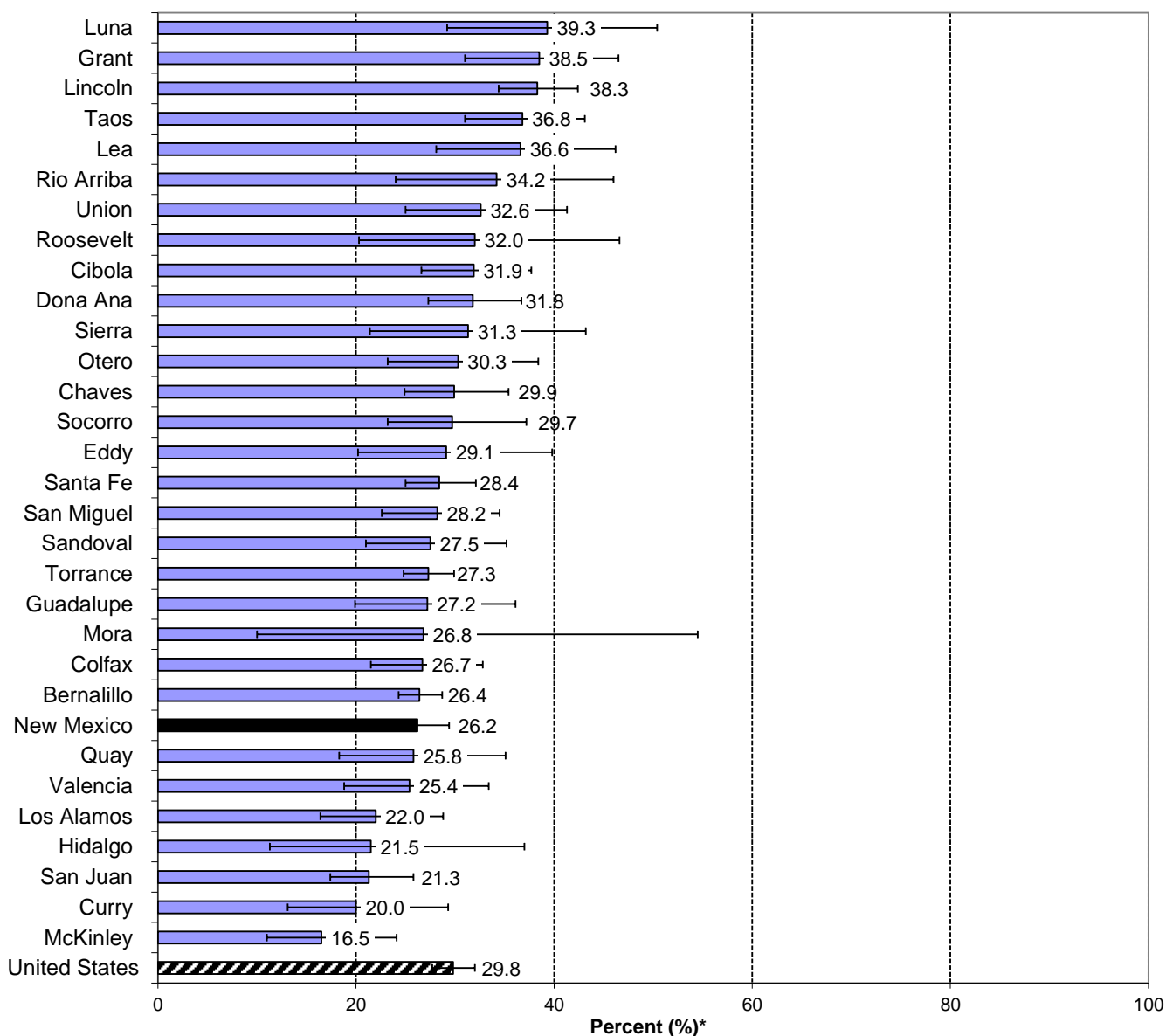
# YOUTH CURRENT DRINKING (continued)

Chart 2: Current Drinking, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, New Mexico, 2017



Source: YRRS (NM); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

Chart 3: Current Drinking\* by County, Grades 9 - 12, New Mexico, 2017



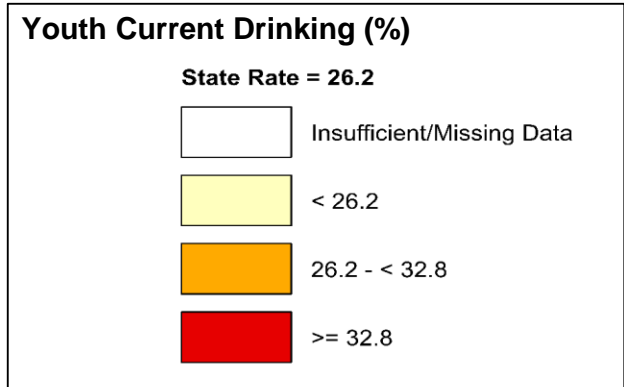
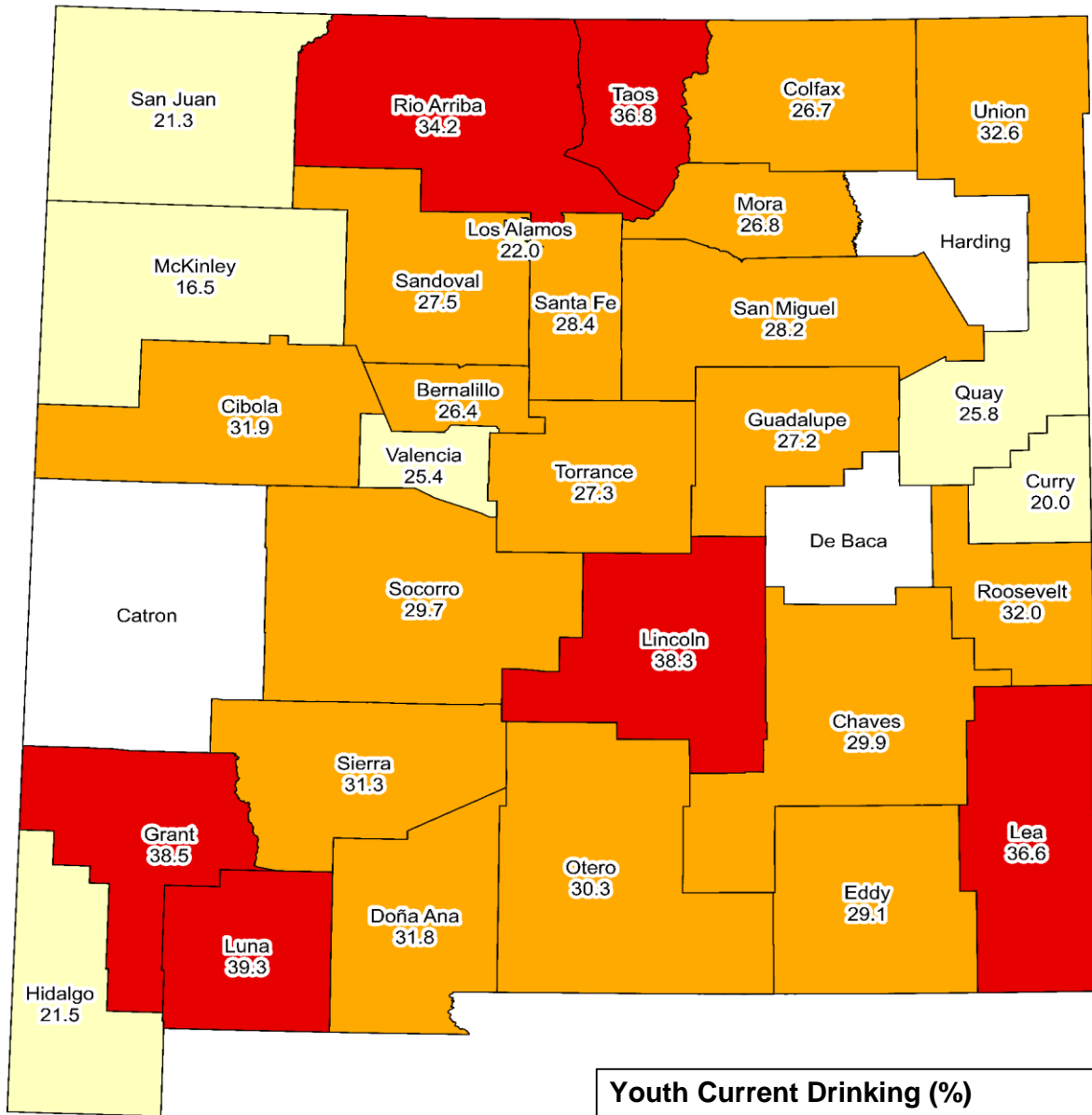
\* Estimate of percent of high school students who reported current drinking in past 30 days

De Baca, Catron, and Harding County estimates not available because of low numbers and/or low response rates

Source: YRRS (NM); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

# YOUTH CURRENT DRINKING (continued)

Chart 4: Current Drinking\* by County, Grades 9 - 12, New Mexico, 2017



\* Estimate of percent of high school students who reported current drinking in past 30 days  
 Insufficient Data: County estimates not available because of low numbers and/or low response rates



# YOUTH BINGE DRINKING

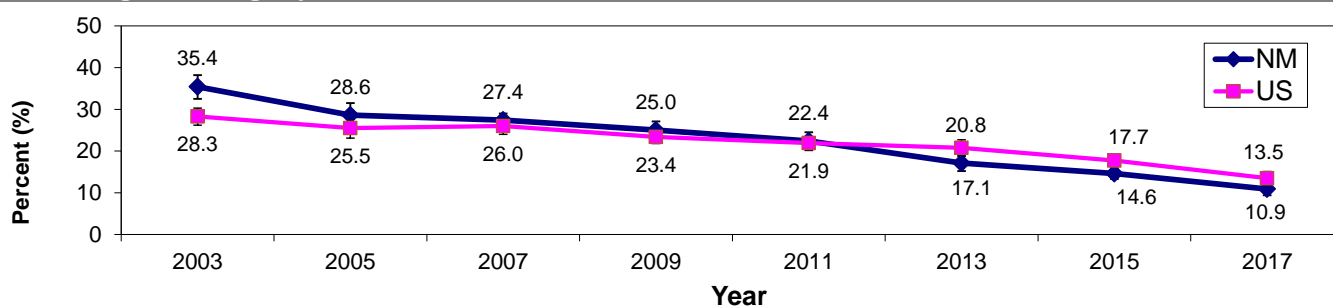
## Problem Statement

Binge drinking (defined as having five or more drinks of alcohol for boys or 4 or more drinks for girls in a row within a couple of hours [see note below Chart 1]) is a major risk factor for the three leading causes of death among youth (motor vehicle crashes, suicide, and homicide), as well as being associated with poor academic performance and risk behaviors such as impaired driving, riding with a drinking driver, physical fighting, increased number of sexual partners, and other substance use.

In 2017, 10.9% of NM high school students reported binge drinking at least once in the past month. Binge drinking is the norm among current high school drinkers in New Mexico. In 2017, of the 26.2% of students who were current drinkers, 53.9% were binge drinkers. Binge drinking prevalence has been decreasing in NM since 2003, as it has been in the US since at least 2001 (Chart 1). In 2017, the difference between the US (13.5%) and NM (10.9%) rates for binge drinking was not statistically significant.

Binge drinking increases with increasing grade level and does not significantly differ by gender (Chart 2). Overall, Hispanics and Whites have a higher prevalence of current binge drinking compared to other race/ethnicities.

**Chart 1: Binge Drinking\* by Year, Grades 9 - 12, New Mexico and US, 2003-2017**



\*In 2017 - Had 5 or more drinks of alcohol for boys or 4 or more drinks for girls in a row, or within a couple of hours, in the past 30 days.

For years 2015 and earlier - 5 or more drinks of alcohol in a row, or within a couple of hours, for both boys and girls.

Source: YRRS (NM); CDC YRBS (US); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

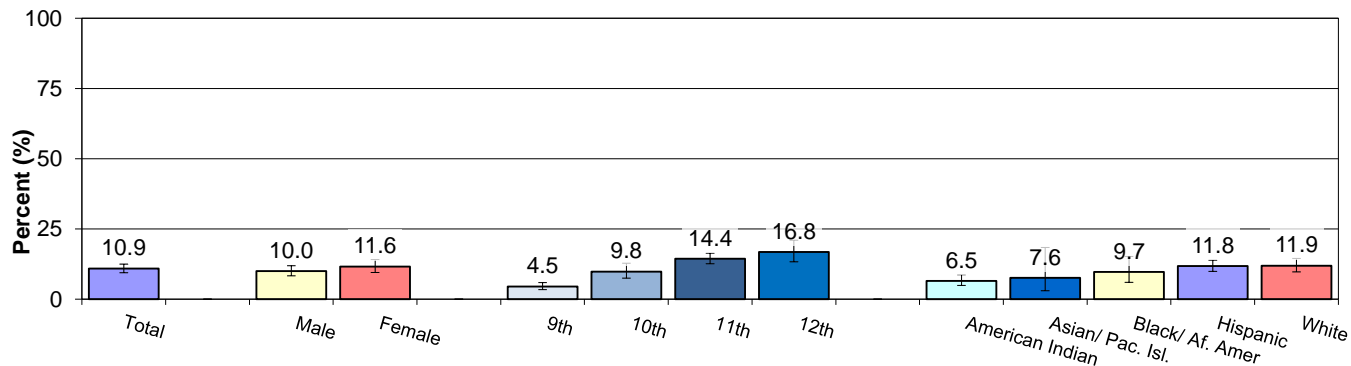
**Table 1: Binge Drinking, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, New Mexico, 2017**

Sex	Race/Ethnicity	9th Grade	10th Grade	11th Grade	12th Grade	All Grades
		Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]
Male	American Indian	4.3 (2.0-9.1)	6.0 (3.0-11.7)	3.6 (1.1-10.6)	9.7 (5.8-15.9)	5.6 (3.7-8.3)
	Asian/Pacific Islander	--	--	--	--	6.8 (2.0-20.4)
	Black	--	--	--	--	8.5 (3.5-19.4)
	Hispanic	4.2 (2.4-7.3)	9.1 (5.7-14.3)	15.1 (11.5-19.7)	20.0 (15.4-25.6)	11.4 (9.4-13.7)
	White	3.2 (1.1-8.7)	8.5 (4.7-14.9)	17.4 (13.1-22.8)	13.5 (6.1-27.2)	10.5 (7.7-14.1)
	Total	3.7 (2.4-5.7)	8.6 (5.9-12.6)	13.8 (10.8-17.5)	16.0 (12.1-20.9)	10.0 (8.3-11.9)
Female	American Indian	3.0 (1.1-7.9)	8.4 (3.5-18.6)	13.9 (7.6-23.9)	6.8 (3.3-13.3)	7.5 (4.9-11.2)
	Asian/Pacific Islander	--	--	--	--	8.8 (2.8-24.3)
	Black	--	--	--	--	9.6 (5.4-16.3)
	Hispanic	6.0 (3.1-11.3)	11.8 (7.8-17.3)	12.9 (8.8-18.5)	18.4 (13.4-24.8)	12.0 (9.6-15.1)
	White	5.2 (2.4-11.1)	11.0 (7.1-16.5)	20.5 (13.9-29.1)	19.5 (13.3-27.6)	13.4 (10.5-17.0)
	Total	5.1 (3.6-7.2)	11.1 (8.4-14.5)	14.9 (12.0-18.3)	17.4 (13.0-22.9)	11.6 (9.5-14.1)
Total	American Indian	3.7 (1.9-7.1)	7.0 (4.2-11.4)	8.8 (5.7-13.5)	8.2 (5.2-12.7)	6.5 (4.9-8.7)
	Asian/Pacific Islander	--	12.3 (3.9-32.8)	--	--	7.6 (3.0-18.4)
	Black	3.1 (0.7-12.7)	13.7 (5.4-30.7)	--	--	9.7 (6.0-15.2)
	Hispanic	5.3 (3.3-8.5)	10.5 (7.7-14.3)	13.9 (10.9-17.5)	19.2 (15.6-23.4)	11.8 (9.9-13.9)
	White	4.2 (2.2-7.8)	9.7 (6.4-14.3)	18.9 (14.9-23.6)	16.2 (10.3-24.6)	11.9 (9.7-14.5)
	Total	4.5 (3.4-5.9)	9.8 (7.5-12.8)	14.4 (12.6-16.4)	16.8 (13.3-21.0)	10.9 (9.4-12.5)

Source: YRRS (NM); NMDOH Survey Section (NOTE: "95% CI" is 95% confidence interval)

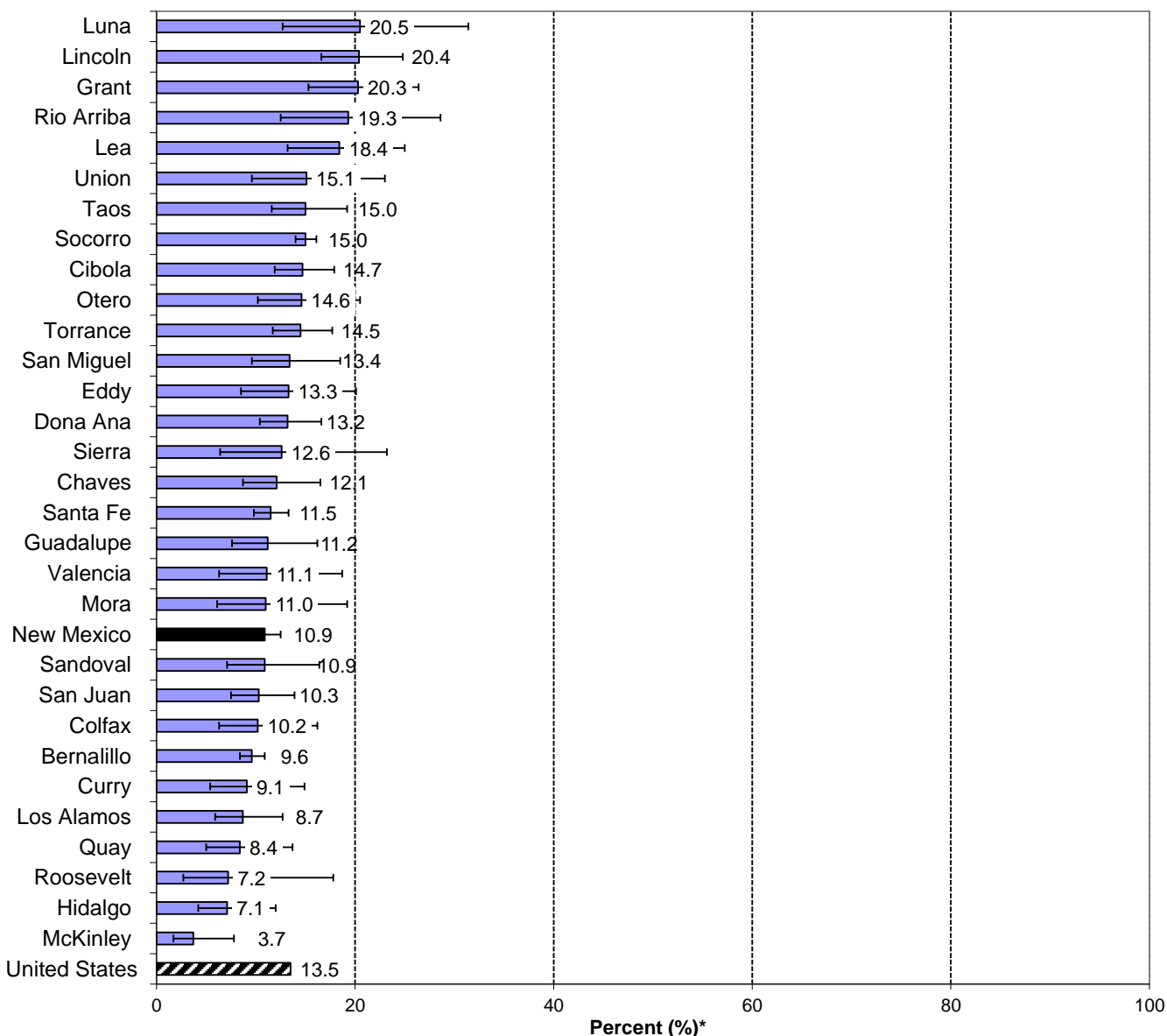
# YOUTH BINGE DRINKING (continued)

Chart 2: Binge Drinking, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, New Mexico, 2017



Source: YRRS (NM); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

Chart 3: Binge Drinking\* by County, Grades 9 - 12, New Mexico, 2017



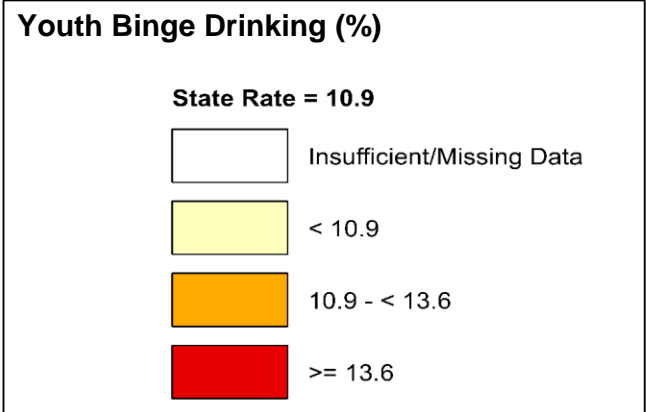
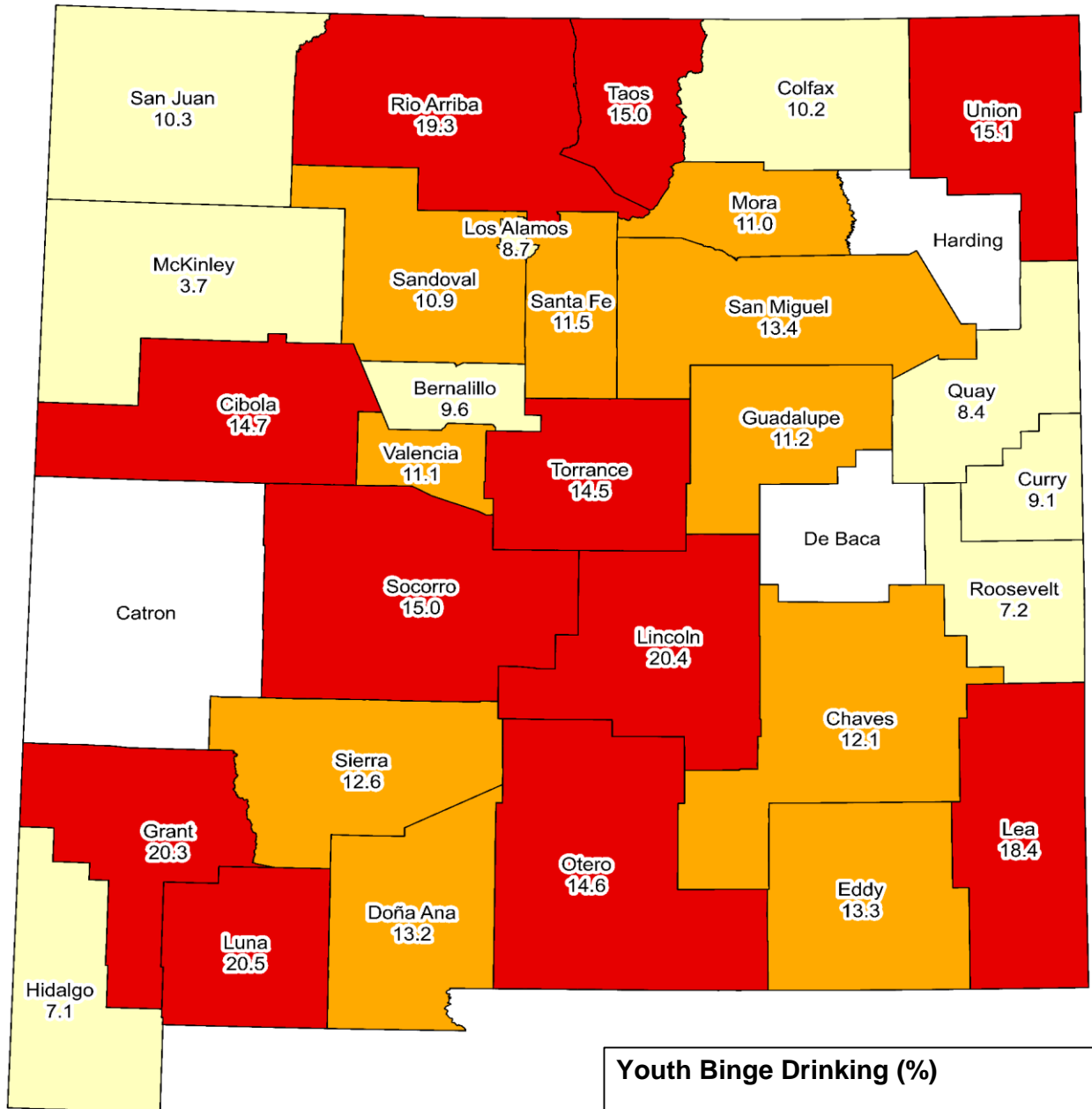
\* Estimate of percent of high school students who reported binge drinking at least once in past 30 days

De Baca, Catron, and Harding County estimates not available because of low numbers and/or low response rates

Source: YRRS (NM); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

# YOUTH BINGE DRINKING (continued)

Chart 4: Binge Drinking\* by County, Grades 9 - 12, New Mexico, 2017



\* Estimate of percent of high school students who reported binge drinking at least once in past 30 days  
 Insufficient Data: County estimates not available because of low numbers and/or low response rates





# YOUTH 10 PLUS DRINKS

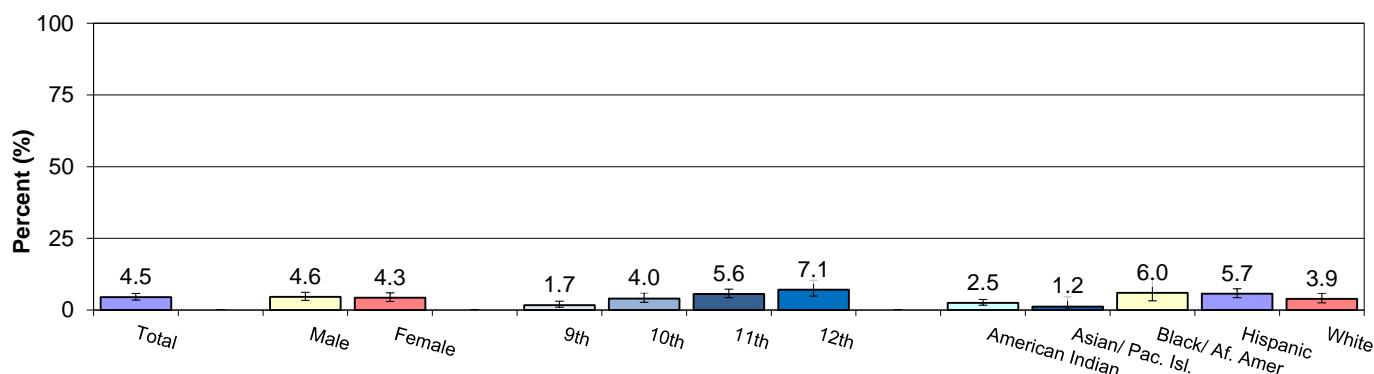
## Problem Statement

On average, underage drinkers consume more drinks per drinking occasion than adult drinkers. The risk of harm increases as the number of drinks consumed on an occasion increases.

The maximum number of drinks that a student consumed on an occasion is determined by the question: "During the past 30 days, what is the largest number of alcoholic drinks you had in a row, that is, within a couple of hours?"

Students in the 12th grade are more likely to drink 10 or more drinks on an occasion than 9th grade students. There is no significant difference between genders. Asian/Pacific Islander students have the lowest prevalence of consuming ten or more drinks on an occasion. Prevalence was fairly similar by county, ranging from 1.8% of students (McKinley County) to 9.8% of students (Socorro County). In 2017, there was no difference in rates between New Mexico (4.5%) and the US (4.4%).

**Chart 1: 10 Plus Drinks, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, New Mexico, 2017**



Source: YRRS (NM); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

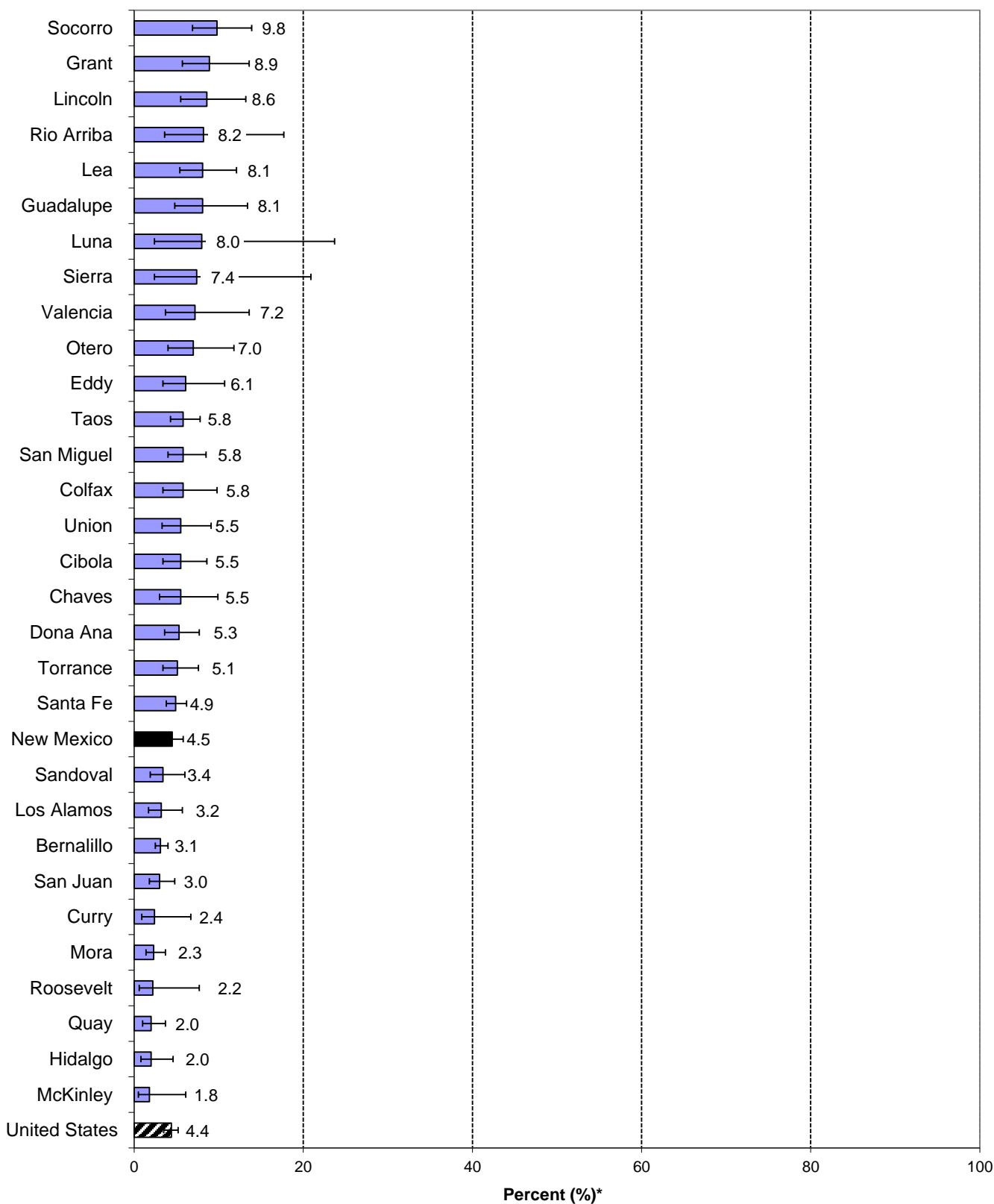
**Table 1: 10 Plus Drinks, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, New Mexico, 2017**

Sex	Race/Ethnicity	9th Grade	10th Grade	11th Grade	12th Grade	All Grades
		Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]
Male	American Indian	1.7 (0.6-4.8)	2.9 (1.4-6.0)	1.0 (0.2-5.2)	3.2 (1.2-8.8)	2.1 (1.3-3.5)
	Asian/Pacific Islander	--	--	--	--	1.0 (0.1-6.9)
	Black	--	--	--	--	5.1 (1.7-14.0)
	Hispanic	0.9 (0.3-3.1)	3.8 (2.0-7.1)	9.5 (6.7-13.1)	13.3 (9.5-18.3)	6.3 (4.6-8.6)
	White	1.3 (0.1-10.0)	1.8 (0.6-5.1)	6.2 (3.0-12.3)	6.6 (2.8-15.0)	3.9 (2.4-6.0)
	Total	1.2 (0.6-2.4)	3.1 (1.9-5.0)	6.4 (4.4-9.3)	9.2 (6.5-12.8)	4.6 (3.4-6.2)
Female	American Indian	1.1 (0.1-8.3)	4.2 (0.9-17.3)	4.2 (0.9-17.2)	2.4 (0.8-6.7)	2.8 (1.3-5.9)
	Asian/Pacific Islander	--	--	--	--	1.4 (0.2-8.9)
	Black	--	--	--	--	5.4 (2.0-14.1)
	Hispanic	3.2 (1.4-7.4)	7.5 (4.3-12.7)	3.4 (1.4-8.4)	4.6 (1.7-12.0)	5.0 (3.3-7.5)
	White	0.8 (0.1-6.0)	2.1 (0.9-4.9)	7.2 (3.7-13.8)	6.9 (3.5-13.1)	4.0 (2.4-6.5)
	Total	2.0 (0.9-4.4)	5.0 (3.1-8.1)	4.6 (3.0-7.1)	5.3 (2.9-9.4)	4.3 (3.0-6.0)
Total	American Indian	1.4 (0.6-3.7)	3.5 (1.9-6.3)	2.9 (1.0-8.0)	2.8 (1.2-6.3)	2.5 (1.7-3.7)
	Asian/Pacific Islander	--	1.8 (0.2-12.9)	--	--	1.2 (0.3-4.6)
	Black	3.1 (0.7-13.0)	--	--	--	6.0 (3.2-10.9)
	Hispanic	2.3 (1.1-4.8)	5.7 (3.4-9.5)	6.1 (4.2-9.0)	8.5 (6.0-11.9)	5.7 (4.3-7.4)
	White	1.0 (0.2-5.1)	1.9 (1.0-3.6)	6.7 (4.0-11.1)	6.7 (3.4-12.9)	3.9 (2.5-5.9)
	Total	1.7 (1.0-3.1)	4.0 (2.7-6.0)	5.6 (4.3-7.3)	7.1 (4.9-10.4)	4.5 (3.5-5.8)

Source: YRRS (NM); NMDOH Survey Section (NOTE: "95% CI" is 95% confidence interval)

# YOUTH 10 PLUS DRINKS (continued)

Chart 2: 10 Plus Drinks\* by County, Grades 9 - 12, New Mexico, 2017

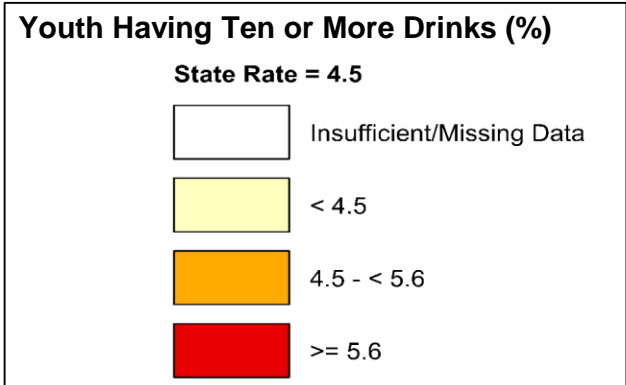
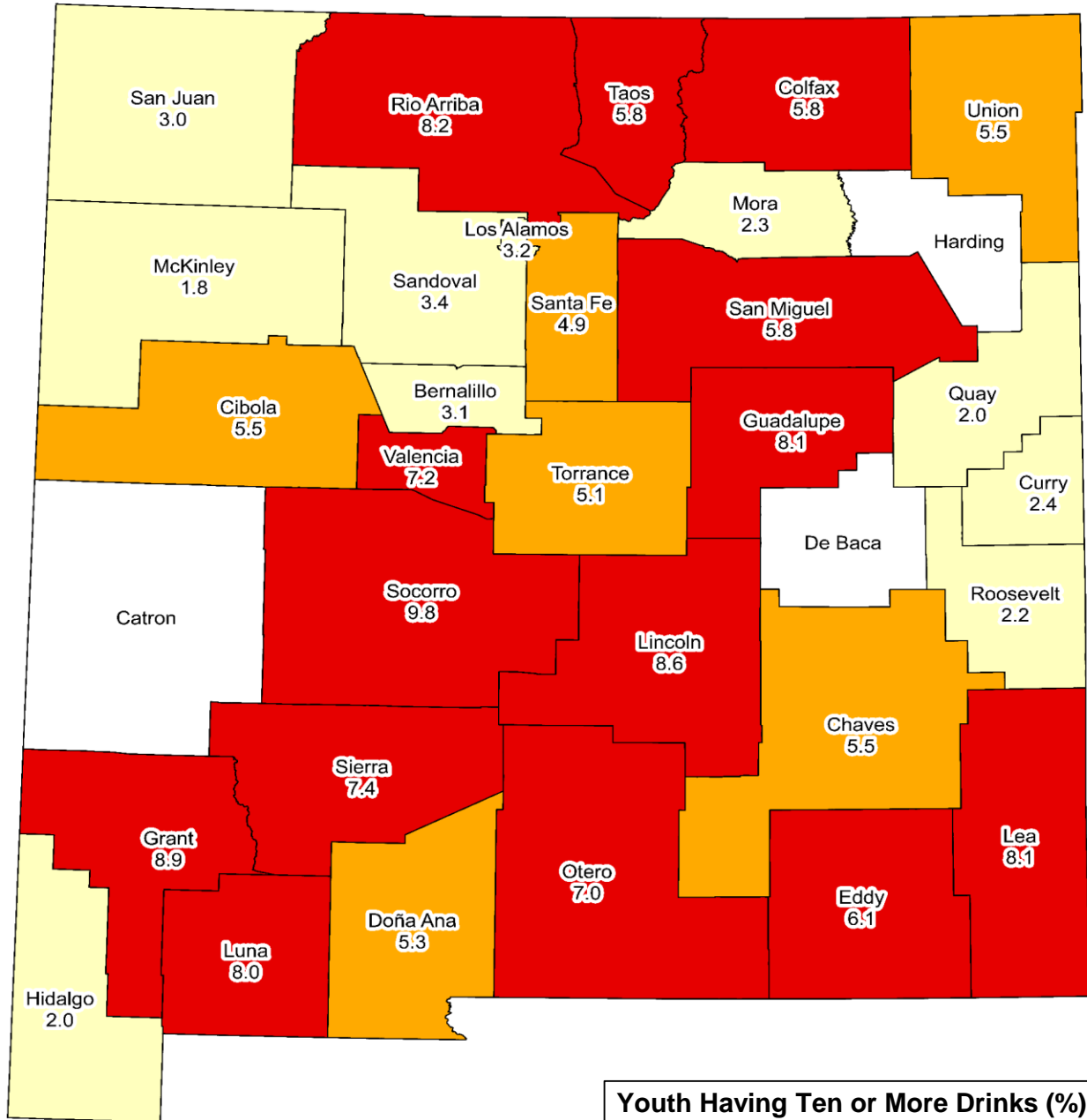


\* Estimate of percent of high school students who reported high intensity drinking at least once in past 30 days  
 De Baca, Catron, and Harding County estimates not available because of low numbers and/or low response rates

Source: YRRS (NM); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

# YOUTH 10 PLUS DRINKS (continued)

Chart 3: 10 Plus Drinks\* by County, Grades 9 - 12, New Mexico, 2017



\* Estimate of percent of high school students who reported high intensity drinking at least once in past 30 days

Insufficient Data: County estimates not available because of low numbers and/or low response rates

Source: YRRS (NM); NMDOH Survey Section; SAES



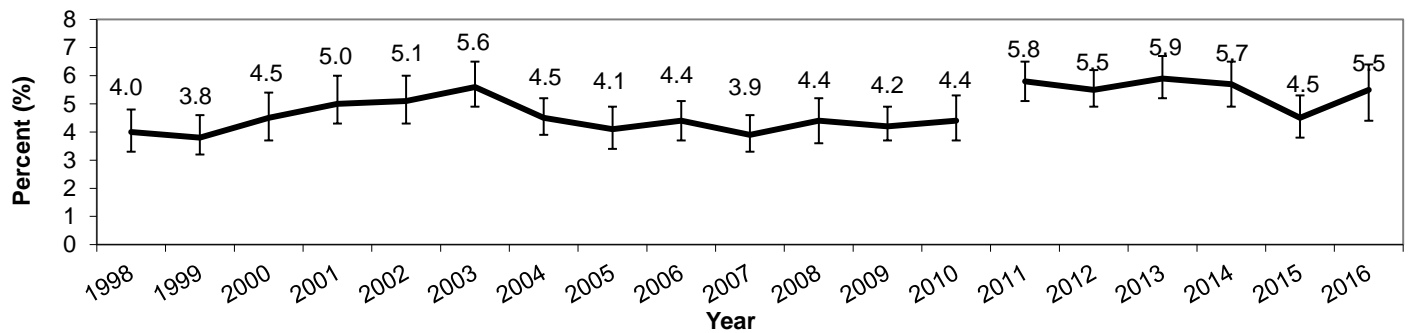
# ADULT HEAVY DRINKING

## Problem Statement

Heavy drinking (defined as having more than 2 drinks/day for males and more than one drink/day for females) is a pattern of excessive alcohol consumption that can lead to alcohol-related chronic disease and death. According to the latest estimates from the CDC, numerous chronic disease conditions (e.g., alcoholic liver disease, alcohol dependence syndrome) and a significant proportion of many other conditions (e.g., unspecified liver cirrhosis, pancreatitis) are alcohol-related. For each of these causes, it is chronic heavy drinking (as opposed to acute episodic or binge drinking) that is considered primarily responsible for the incidence and progression of alcohol-related chronic disease. Heavy drinking is also associated with a wide range of other social problems, including alcoholism (also known as alcohol dependence), domestic violence, and family disruption.

Chart 1 shows that adult heavy drinking prevalence has been, more or less, constant since 2005. Heavy drinking prevalence is lower among adults in New Mexico (5.2%) than in the US overall (6.5%). As shown in Table 1, heavy drinking was most prevalent among adults in the 25-64 age group, with 5.7% reporting past-month heavy drinking. New Mexico men were somewhat more likely to report chronic drinking than women (5.9% v. 4.4%), and American Indian males had the highest reported rate of heavy drinking (7.0%) followed by White females (6.5%) and White males (6.4%).

**Chart 1: Heavy Drinking (past 30 days)\*, Adults Aged 18+, New Mexico, 1998-2016**



\* Heavy drinking definition: drinking more than 2 drinks/day on average (for men) or more than 1 drink/day (for women) in past 30 days  
Source: BRFSS; SAES (NOTE: Brackets around reported rates are 95% confidence intervals)

**Table 1: Heavy Drinking (past 30 days) by Age, Sex, and Race/Ethnicity, Adults Aged 18+, New Mexico, 2015-2017**

Sex	Race/Ethnicity	Number				Percent*			
		Ages 18-24	Ages 25-64	Ages 65+	All Ages	Ages 18-24	Ages 25-64	Ages 65+	All Ages*
Male	American Indian	574	3,448	559	4,539	5.4	7.5	7.4	7.0
	Asian/Pacific Islander	-	0	-	0	-	0.0	-	0.0
	Black	-	268	-	647	-	2.0	-	3.3
	Hispanic	2,821	16,131	1,586	20,506	4.8	6.6	3.1	5.8
	White	2,675	14,164	4,700	21,372	8.6	6.7	4.9	6.4
	Total	5,819	34,035	7,099	46,765	5.5	6.5	4.5	5.9
Female	American Indian	240	2,251	0	2,534	2.3	4.4	0.0	3.5
	Asian/Pacific Islander	-	50	-	51	-	0.4	-	0.3
	Black	-	610	-	633	-	6.4	-	4.4
	Hispanic	867	8,577	456	9,873	1.5	3.5	0.7	2.7
	White	1,616	14,814	6,096	22,629	6.1	6.9	5.6	6.5
	Total	2,646	26,884	6,725	36,231	2.7	5.0	3.6	4.4
Total	American Indian	789	5,668	599	7,032	3.7	5.8	3.2	5.1
	Asian/Pacific Islander	-	41	-	40	-	0.2	-	0.1
	Black	-	993	239	1,314	-	4.3	4.9	3.9
	Hispanic	3,709	24,597	2,021	30,256	3.2	5.0	1.8	4.2
	White	4,253	28,979	10,814	44,009	7.4	6.8	5.3	6.4
	Total	8,429	60,867	13,813	82,894	4.1	5.7	4.0	5.2

\* Estimate of percent of people in population group who reported heavy drinking in past 30 days  
- Excluded due to small number of respondents (< 50) in cell

Source: BRFSS; SAES

# ADULT HEAVY DRINKING (continued)

## Problem Statement (continued)

Among men, American Indians had the highest heavy drinking rates (7.0%), followed by Whites (6.4%) and Hispanics (5.8%). Also, American Indian males had the highest rates of alcohol-related chronic disease death (132.2 deaths per 100,000 population), followed by Hispanics (49.1) and Blacks (33.4). Among women, Whites had the highest rates of heavy drinking (6.5%), followed by Blacks (4.4%). However, American Indian females have the highest rates of alcohol-related chronic disease death (76.4 deaths per 100,000 population), followed by Hispanics (18.0) and Blacks (15.5). These differences between heavy drinking rates and alcohol-related chronic disease death rates reflect the long lead time between the behavior and the health-related outcomes of that behavior.

Between 2015-2017, as shown in Table 2 and Chart 2, heavy drinking rates were highest in Catron (10.5%), San Miguel (7.2%), and Lea (6.8%) counties and substantially lower in counties that have among the highest rates of alcohol-related chronic disease death rates (e.g., Rio Arriba and McKinley).

**Table 2: Heavy Drinking (past 30 days) by Race/Ethnicity and County, Adults Aged 18+, New Mexico, 2015-2017**

County	Number						Percent*					
	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races
Bernalillo	639	-	-	10,492	14,462	25,979	2.9	-	-	4.3	6.2	4.9
Catron	-	-	-	-	-	334	-	-	-	-	-	10.5
Chaves	-	-	-	1,066	1,205	2,245	-	-	-	4.3	5.5	4.6
Cibola	785	-	-	489	81	1,237	10.0	-	-	6.2	1.7	5.9
Colfax	-	-	-	-	209	584	-	-	-	-	3.9	5.6
Curry	-	-	-	624	1,033	1,640	-	-	-	4.6	5.2	4.4
De Baca	-	-	-	-	-	-	-	-	-	-	-	-
Dona Ana	-	-	-	4,431	2,970	8,089	-	-	-	4.3	5.7	5.0
Eddy	-	-	-	1,365	1,199	2,826	-	-	-	7.2	5.5	6.7
Grant	-	-	-	454	614	1,079	-	-	-	4.3	5.3	4.7
Guadalupe	-	-	-	-	-	-	-	-	-	-	-	-
Harding	-	-	-	-	-	-	-	-	-	-	-	-
Hidalgo	-	-	-	-	-	-	-	-	-	-	-	-
Lea	-	-	-	2,045	1,182	3,282	-	-	-	8.1	5.8	6.8
Lincoln	-	-	-	-	710	1,068	-	-	-	-	6.4	6.6
Los Alamos	-	-	-	-	0	0	-	-	-	-	0.0	0.0
Luna	-	-	-	805	0	943	-	-	-	7.2	0.0	5.2
McKinley	1,861	-	-	77	92	2,118	4.8	-	-	1.2	1.6	4.1
Mora	-	-	-	-	-	-	-	-	-	-	-	-
Otero	195	-	-	303	1,487	1,993	6.9	-	-	1.8	5.4	4.0
Quay	-	-	-	-	394	420	-	-	-	-	10.7	6.3
Rio Arriba	-	-	-	110	261	550	-	-	-	0.5	5.6	1.8
Roosevelt	-	-	-	-	284	360	-	-	-	-	3.3	2.4
Sandoval	-	-	-	2,185	2,325	6,707	-	-	-	5.7	4.4	6.2
San Juan	686	-	-	644	2,812	4,146	1.9	-	-	4.0	6.9	4.4
San Miguel	-	-	-	511	606	1,624	-	-	-	3.0	13.3	7.2
Santa Fe	-	-	-	1,507	5,654	7,381	-	-	-	2.7	9.7	6.1
Sierra	-	-	-	-	588	641	-	-	-	-	8.7	6.7
Socorro	-	-	-	-	-	809	-	-	-	-	-	6.1
Taos	-	-	-	0	477	554	-	-	-	0.0	4.4	2.0
Torrance	-	-	-	-	-	-	-	-	-	-	-	-
Union	-	-	-	-	-	-	-	-	-	-	-	-
Valencia	-	-	-	885	898	1,826	-	-	-	2.7	4.1	3.1
New Mexico	7,032	40	1,314	30,256	44,009	82,894	5.1	0.1	3.9	4.2	6.4	5.2

\* Estimate of percent of people in population group who reported heavy drinking in past 30 days

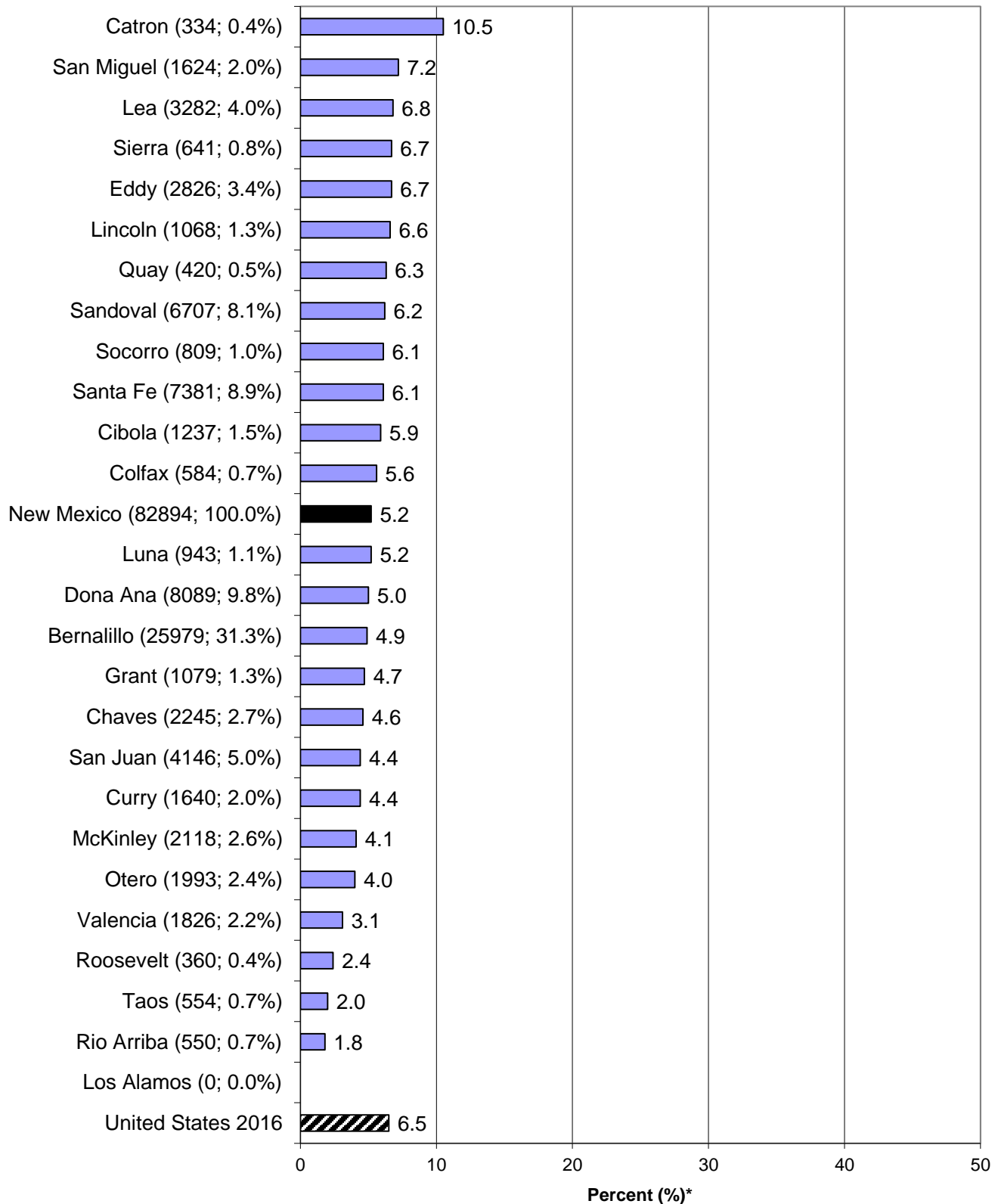
- Excluded due to small number of respondents (< 50) in cell

Source: BRFSS; SAES

# ADULT HEAVY DRINKING (continued)

Chart 2: Heavy Drinking (past 30 days)\* by County, Adults Aged 18+, New Mexico, 2015-2017

County (# of heavy drinkers; % of statewide heavy drinkers)



\* Estimate of percent of people in population group who reported heavy drinking in past 30 days

The following counties were excluded due to small number of respondents (< 50):

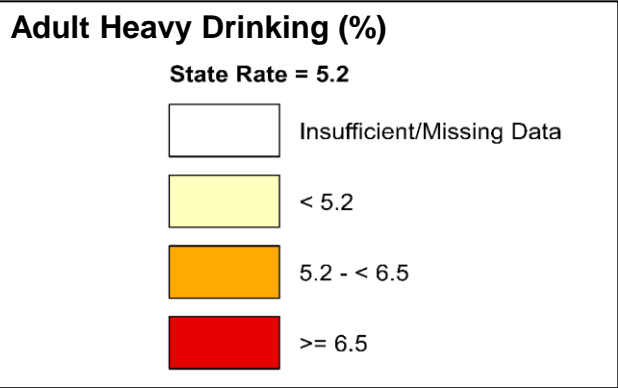
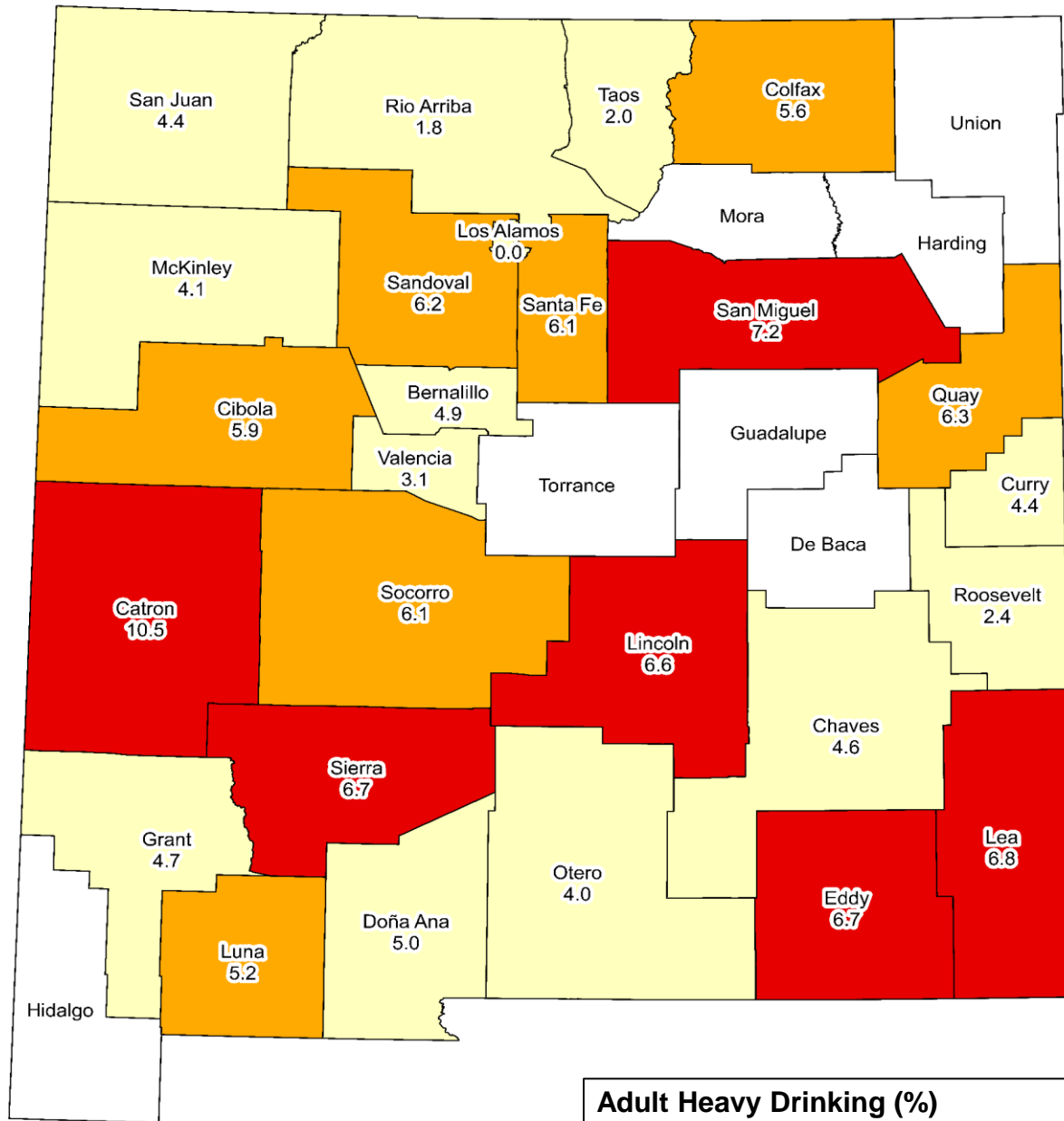
De Baca, Guadalupe, Harding, Hidalgo, Mora, Torrance, and Union

Source: NMBRFSS (NM); CDC BRFSS (US); SAES



# ADULT HEAVY DRINKING (continued)

Chart 3: Heavy Drinking (past 30 days)\* by County, Adults Aged 18+, New Mexico, 2015-2017



\* Estimate of percent of people in population group who reported heavy drinking in past 30 days  
 Insufficient data: Rate not reported due to small number of respondents (< 50) in cell  
 Source: NMBRFSS (NM); CDC BRFSS (US); SAES

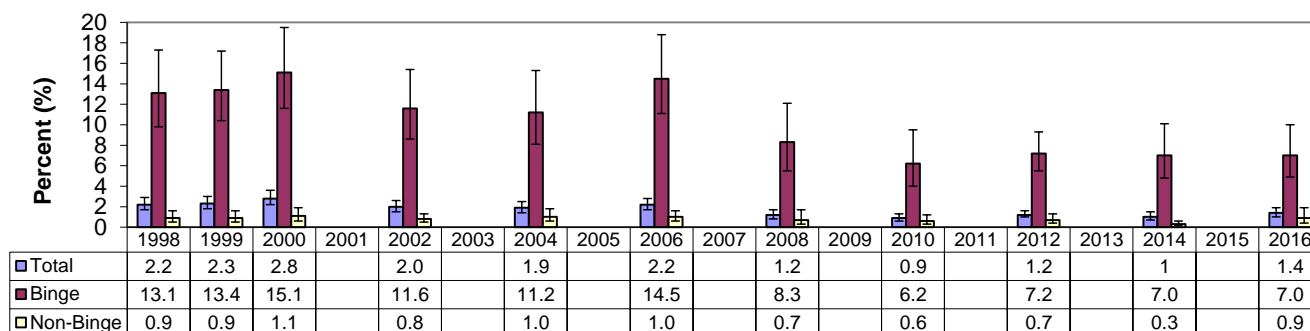
# ADULT DRINKING AND DRIVING

## Problem Statement

Adult drinking and driving is a precursor to alcohol-related motor vehicle crash injury and death. Any drinking and driving is dangerous (i.e., associated with an elevated risk of crash and injury), but driving after binge drinking (which is defined as a level of drinking likely to lead to a 0.08 BAC) is particularly risky. Unfortunately, as shown in Chart 1, binge drinkers are much more likely to report driving after drinking than non-binge drinkers. For example, in 2012, only 1.2% of the general population reported driving after drinking, but 7.2% of binge drinkers reported engaging in this risky behavior in the past 30 days compared to only 0.7% of non-binge drinkers. On a positive note, Chart 1 shows that driving after drinking prevalence decreased significantly between 2006 and 2010 (from 2.2% to 0.9%), including a substantial decline among binge drinkers (from 14.5% to 6.2%).

As shown in Chart 2, in 2016 driving after drinking was most prevalent among middle-age adults, with 1.7% of those aged 25-64 reporting past-month drinking and driving. Chart 2 shows a decline (although not statistically significant) in drinking and driving by young adults (age 18-24) and a fluctuating pattern among those aged 25-64. Table 1 shows that New Mexico men were twice as likely to report drinking and driving than women (1.9% v. 0.8%). Hispanic males (2.7%) were more likely to report drinking and driving than American Indian (1.8%) and White (1.2%) males. Table 2 and Chart 3 show drinking and driving rates by county.

**Chart 1: Drinking and Driving (past 30 days)\* by Drinking Status, Adults Aged 18+, New Mexico, 1998-2016**



\* Drinking and driving definition: drove after having "perhaps too much to drink" at least once in past 30 days

Source: BRFSS; SAES (NOTE: Brackets around reported rates are 95% confidence intervals)

**Table 1: Drinking and Driving (past 30 days) by Age, Sex, and Race, Adults Aged 18+, New Mexico, 2016**

Sex	Race/Ethnicity	Number*				Percent**			
		Ages 18-24	Ages 25-64	Ages 65+	All Ages	Ages 18-24	Ages 25-64	Ages 65+	All Ages*
Male	American Indian	-	974	-	1,171	-	2.1	-	1.8
	Asian/Pacific Islander	-	-	-	-	-	-	-	-
	Black	-	-	-	-	-	-	-	-
	Hispanic	0	9,782	140	9,731	0.0	4.0	0.3	2.7
	White	-	2,871	577	4,131	-	1.4	0.6	1.2
	Total		626	13,754	905	15,174	0.6	2.6	0.6
Female	American Indian	-	516	0	531	-	1.0	0.0	0.7
	Asian/Pacific Islander	-	-	-	-	-	-	-	-
	Black	-	-	-	-	-	-	-	-
	Hispanic	1,613	1,541	0	3,307	2.8	0.6	0.0	0.9
	White	-	2,601	493	3,095	-	1.2	0.5	0.9
	Total		1,785	4,662	522	6,893	1.8	0.9	0.3
Total	American Indian	-	1,436	229	1,654	-	1.5	1.2	1.2
	Asian/Pacific Islander	-	-	-	0	-	-	-	0.0
	Black	-	-	-	665	-	-	-	2.0
	Hispanic	1,678	11,209	148	12,949	1.4	2.3	0.1	1.8
	White	804	5,470	1,060	7,205	1.4	1.3	0.5	1.1
	Total		2,415	18,381	1,425	22,003	1.2	1.7	0.4

\* Estimate of number of people in population group who drove after "perhaps too much to drink" at least once in past 30 days

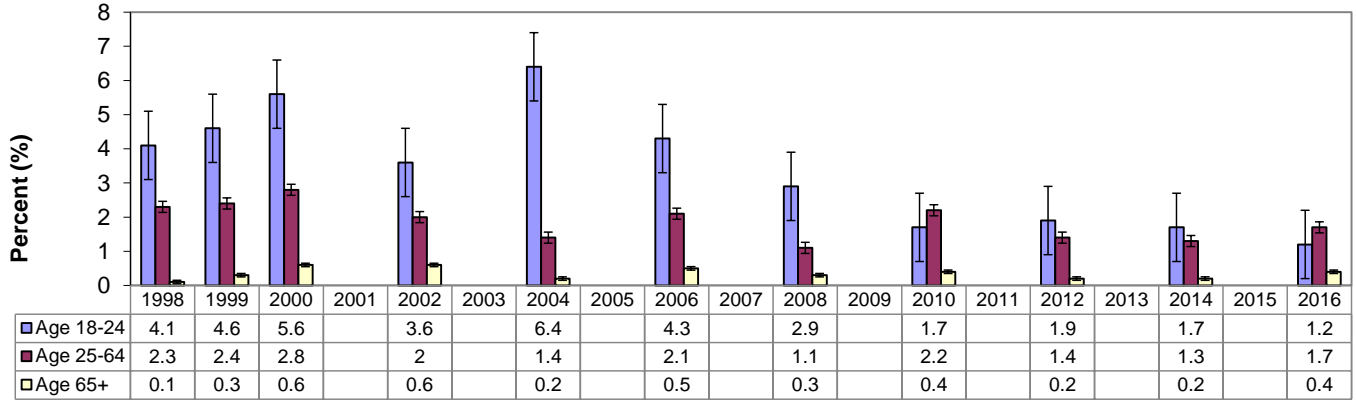
\*\* Estimate of percent of people in population group who drove after "perhaps too much to drink" at least once in past 30 days

- Excluded due to small number of respondents (< 50) in cell

Source: BRFSS; SAES

# ADULT DRINKING AND DRIVING (continued)

Chart 2: Drinking and Driving (past 30 days)\* by Age, Adults Aged 18+, New Mexico, 1998-2016



\* Drinking and driving definition: drove after having "perhaps too much to drink" at least once in past 30 days

Source: BRFSS; SAES (NOTE: Brackets around reported rates are 95% confidence intervals)

Table 2: Drinking and Driving (past 30 days) by Race/Ethnicity and County, Adults Aged 18+, New Mexico, 2016

County	Number*						Percent**					
	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races
Bernalillo	-	-	-	3,005	1,056	4,596	-	-	-	1.2	0.5	0.9
Catron	-	-	-	-	-	-	-	-	-	-	-	-
Chaves	-	-	-	270	711	867	-	-	-	1.1	3.3	1.8
Cibola	-	-	-	0	41	52	-	-	-	0.0	0.9	0.3
Colfax	-	-	-	-	-	-	-	-	-	-	-	-
Curry	-	-	-	-	0	454	-	-	-	-	0.0	1.2
De Baca	-	-	-	-	-	-	-	-	-	-	-	-
Dona Ana	-	-	-	4,942	635	5,435	-	-	-	4.8	1.2	3.4
Eddy	-	-	-	820	157	968	-	-	-	4.3	0.7	2.3
Grant	-	-	-	-	256	308	-	-	-	-	2.2	1.3
Guadalupe	-	-	-	-	-	-	-	-	-	-	-	-
Harding	-	-	-	-	-	-	-	-	-	-	-	-
Hidalgo	-	-	-	-	-	-	-	-	-	-	-	-
Lea	-	-	-	1,024	0	1,127	-	-	-	4.0	0.0	2.3
Lincoln	-	-	-	-	0	0	-	-	-	-	0.0	0.0
Los Alamos	-	-	-	-	-	0	-	-	-	-	-	0.0
Luna	-	-	-	-	-	0	-	-	-	-	-	0.0
McKinley	655	-	-	-	0	1,236	1.7	-	-	-	0.0	2.4
Mora	-	-	-	-	-	-	-	-	-	-	-	-
Otero	-	-	-	-	972	1,228	-	-	-	-	3.5	2.5
Quay	-	-	-	-	-	-	-	-	-	-	-	-
Rio Arriba	-	-	-	170	200	460	-	-	-	0.8	4.3	1.5
Roosevelt	-	-	-	-	-	0	-	-	-	-	-	0.0
Sandoval	-	-	-	-	0	896	-	-	-	-	0.0	0.8
San Juan	302	-	-	0	369	660	0.9	-	-	0.0	0.9	0.7
San Miguel	-	-	-	-	-	0	-	-	-	-	-	0.0
Santa Fe	-	-	-	1,232	948	2,425	-	-	-	2.2	1.6	2.0
Sierra	-	-	-	-	0	0	-	-	-	-	0.0	0.0
Socorro	-	-	-	-	-	0	-	-	-	-	-	0.0
Taos	-	-	-	-	663	701	-	-	-	-	6.2	2.6
Torrance	-	-	-	-	-	-	-	-	-	-	-	-
Union	-	-	-	-	-	-	-	-	-	-	-	-
Valencia	-	-	-	-	0	0	-	-	-	-	0.0	0.0
New Mexico	1,654	0	665	12,949	7,205	22,003	1.2	0.0	2.0	1.8	1.1	1.4

\* Estimate of number of people in population group who drove after "perhaps too much to drink" at least once in past 30 days

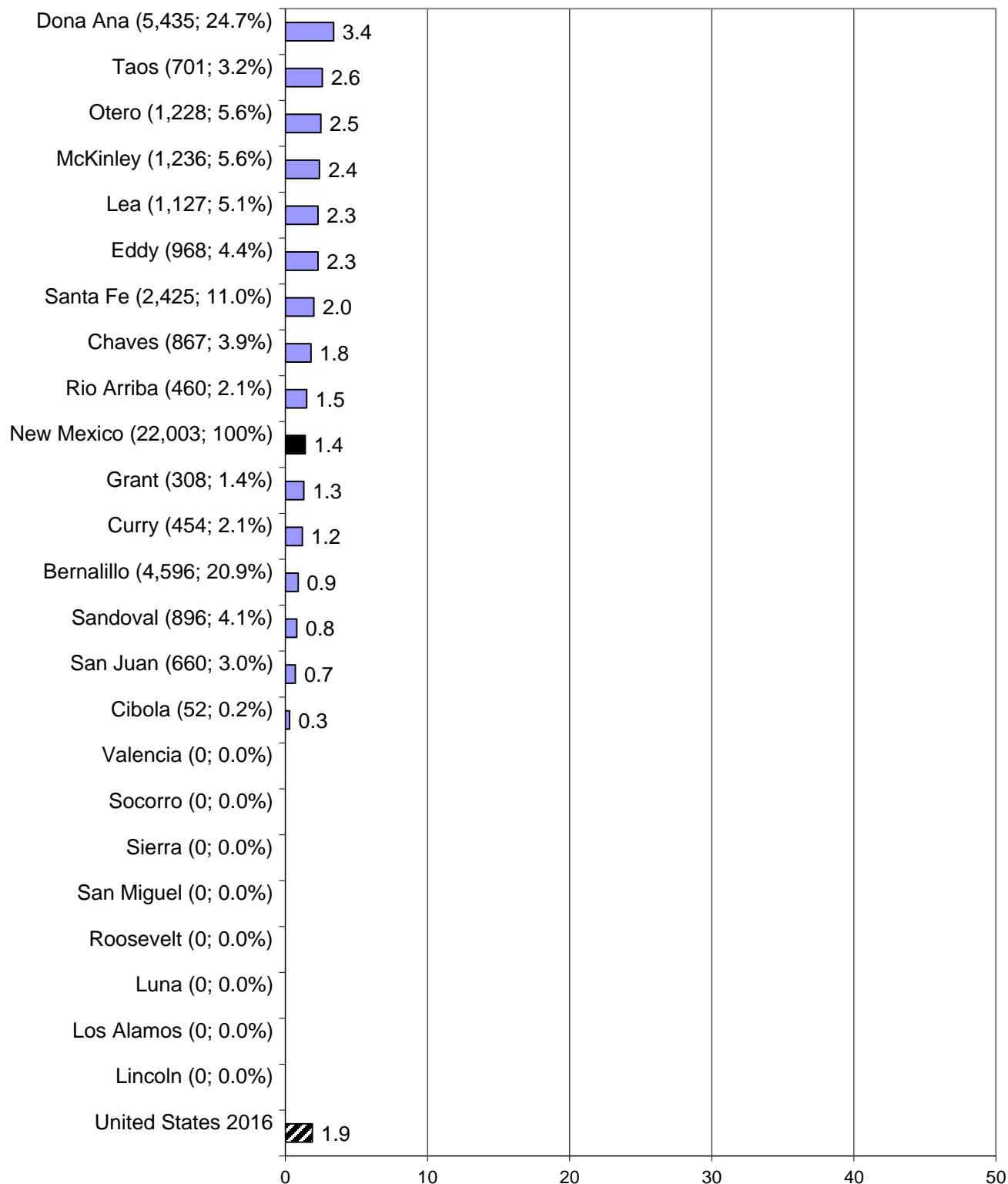
- Excluded due to small number of respondents (< 50) in cell

Source: BRFSS; SAES

# ADULT DRINKING AND DRIVING (continued)

Chart 3: Drinking and Driving (past 30 days)\* by County, Adults Aged 18+, New Mexico, 2016

County (# of drinking drivers; % of statewide drinking drivers)



\* Estimate of percent of people in population group who drove after having "perhaps too much to drink" at least once in past 30 days

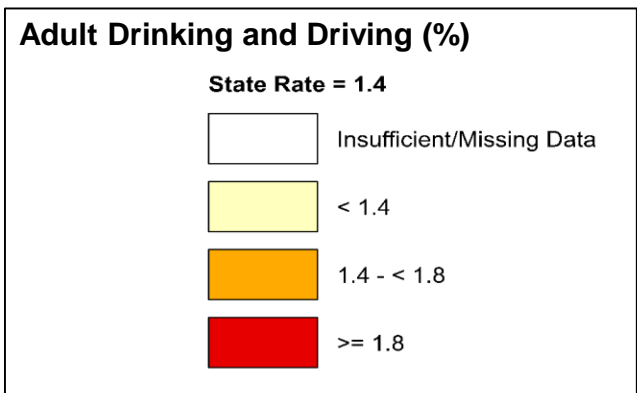
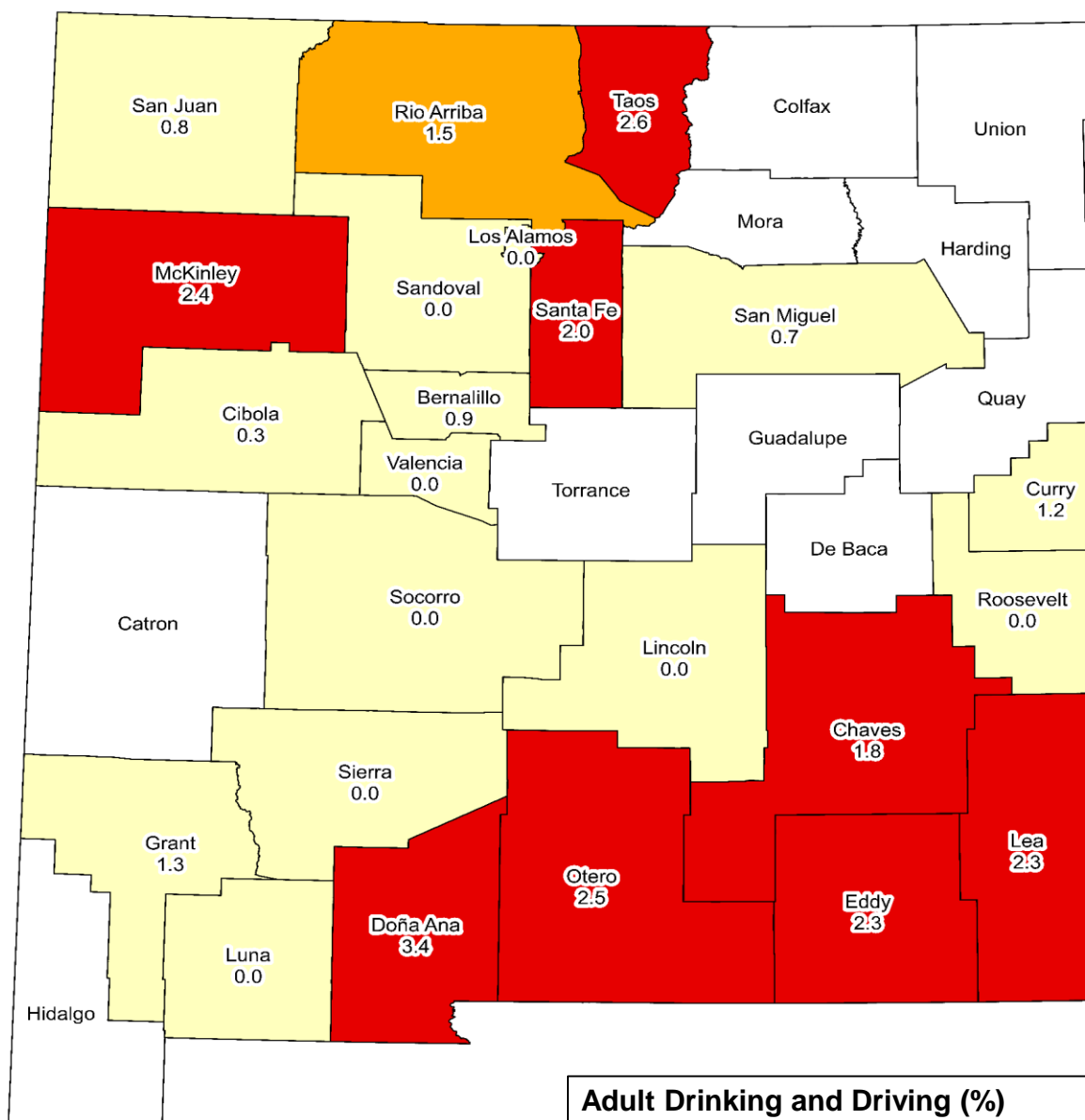
The following counties were not included due to small number of respondents (< 50) in cell:

Catron, Colfax, De Baca, Guadalupe, Harding, Hidalgo, Mora, Quay, Torrance, and Union

Source: BRFSS; SAES

# ADULT DRINKING AND DRIVING (continued)

Chart 4: Drinking and Driving (past 30 days)\* by County, Adults Aged 18+, New Mexico, 2016



\* Estimate of percent of people in population group who drove after having "perhaps too much to drink" at least once in past 30 days  
 Insufficient data: Rate not reported due to small number of respondents (< 50) in cell

Source: BRFSS; SAES

# YOUTH DRINKING AND DRIVING

## Problem Statement

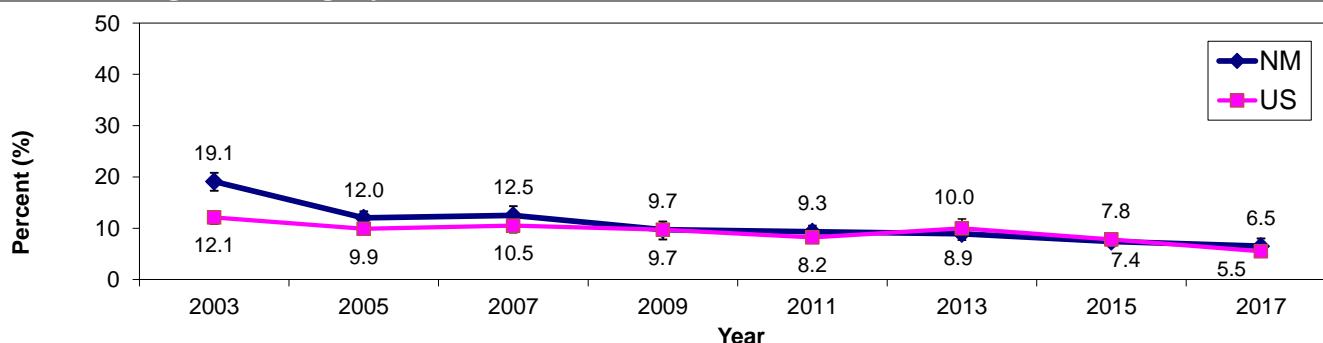
Drinking and driving is a major risk factor for motor vehicle accidents. Motor vehicle crashes were the leading cause of unintentional injury deaths for ages 15-19 years in the US in 2016. According to the National Highway Traffic Safety Administration (NHTSA), alcohol impaired-driving fatalities accounted for 28% of the total motor vehicle traffic fatalities in the US in 2016.\* The rate of drinking and driving among New Mexico high school students has been decreasing since 2003 and decreasing among US high school students since at least 2001. In recent years, NM had a higher rate than the US, but since 2009 there has not been a statistical difference between the two rates.

In 2017, the prevalence of past-30-day drinking and driving was 6.5% among NM high school students. Drinking and driving increased in prevalence with increasing grade levels. There were no statistically significant differences by gender or by race/ethnicity.

In 2017, the drinking and driving rate was highest in Luna (15.3%), Grant (11.9%), Rio Arriba (11.7%), Taos (10.9%), and Lea (10.7%) counties. The rate was lowest in Curry (2.3%), Socorro (3.2%), Guadalupe (4.0%), and Quay (4.2%) counties.

\*National Center for Statistics and Analysis. (2017, October). *Alcohol-impaired driving: 2016 data* (Traffic Safety Facts, Report No. DOT HS 812 450). Washington, DC: National Highway Traffic Safety Administration. <https://crashstats.nhtsa.dot.gov/Api/Public/ViewPublication/812450>

**Chart 1: Drinking and Driving\* by Year, Grades 9 - 12, New Mexico and US, 2003-2017**



\* Drove a car or other vehicle when they had been drinking, in the past 30 days

Source: YRRS (NM); CDC YRBS (US); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

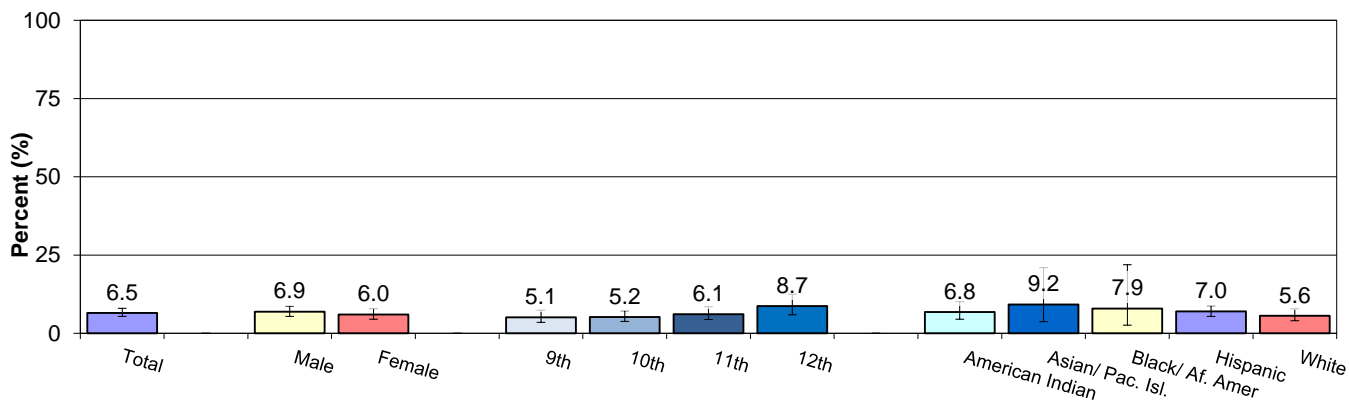
**Table 1: Drinking and Driving, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, New Mexico, 2017**

Sex	Race/Ethnicity	9th Grade	10th Grade	11th Grade	12th Grade	All Grades
		Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]
Male	American Indian	9.4 (2.7-28.1)	9.5 (3.8-21.9)	6.7 (3.1-13.8)	10.0 (5.2-18.3)	8.9 (5.0-15.4)
	Asian/Pacific Islander	--	--	--	--	--
	Black	--	--	--	--	7.7 (1.8-28.1)
	Hispanic	4.2 (1.8-9.3)	5.0 (2.3-10.5)	7.2 (4.9-10.3)	13.8 (9.8-19.3)	7.7 (5.8-10.1)
	White	1.6 (0.2-11.3)	2.3 (0.7-7.2)	7.0 (4.3-11.2)	6.3 (2.8-13.4)	4.8 (3.2-7.3)
	Total	5.1 (3.0-8.7)	5.2 (3.1-8.6)	6.9 (4.9-9.6)	10.0 (6.7-14.6)	6.9 (5.4-8.7)
Female	American Indian	3.6 (1.0-11.7)	2.9 (0.8-10.2)	4.1 (1.5-10.9)	5.6 (1.8-15.9)	3.9 (2.3-6.7)
	Asian/Pacific Islander	--	--	--	--	--
	Black	--	--	--	--	--
	Hispanic	4.2 (1.7-9.8)	5.5 (2.9-10.3)	5.5 (3.8-7.9)	7.1 (3.5-13.8)	6.1 (4.2-8.7)
	White	4.9 (1.3-16.4)	6.5 (3.2-12.7)	5.7 (1.8-16.5)	8.3 (4.5-14.9)	6.5 (4.0-10.4)
	Total	4.1 (2.4-6.8)	5.3 (3.1-8.9)	5.4 (3.5-8.3)	7.4 (4.1-12.8)	6.0 (4.5-7.9)
Total	American Indian	7.7 (4.1-14.1)	6.4 (2.6-14.9)	5.3 (3.0-9.0)	8.0 (5.2-12.2)	6.8 (4.5-10.1)
	Asian/Pacific Islander	--	--	--	--	9.2 (3.7-21.0)
	Black	--	--	--	--	7.9 (2.6-21.9)
	Hispanic	4.7 (2.6-8.3)	5.2 (3.4-7.9)	6.3 (4.5-8.6)	10.1 (6.9-14.5)	7.0 (5.4-8.8)
	White	3.3 (1.2-8.8)	4.4 (2.3-8.3)	6.4 (3.5-11.5)	7.2 (3.9-12.9)	5.6 (4.0-7.8)
	Total	5.1 (3.5-7.4)	5.2 (3.8-7.2)	6.1 (4.4-8.5)	8.7 (5.9-12.5)	6.5 (5.4-8.0)

Source: YRRS (NM); NMDOH Survey Section (NOTE: "95% CI" is 95% confidence interval)

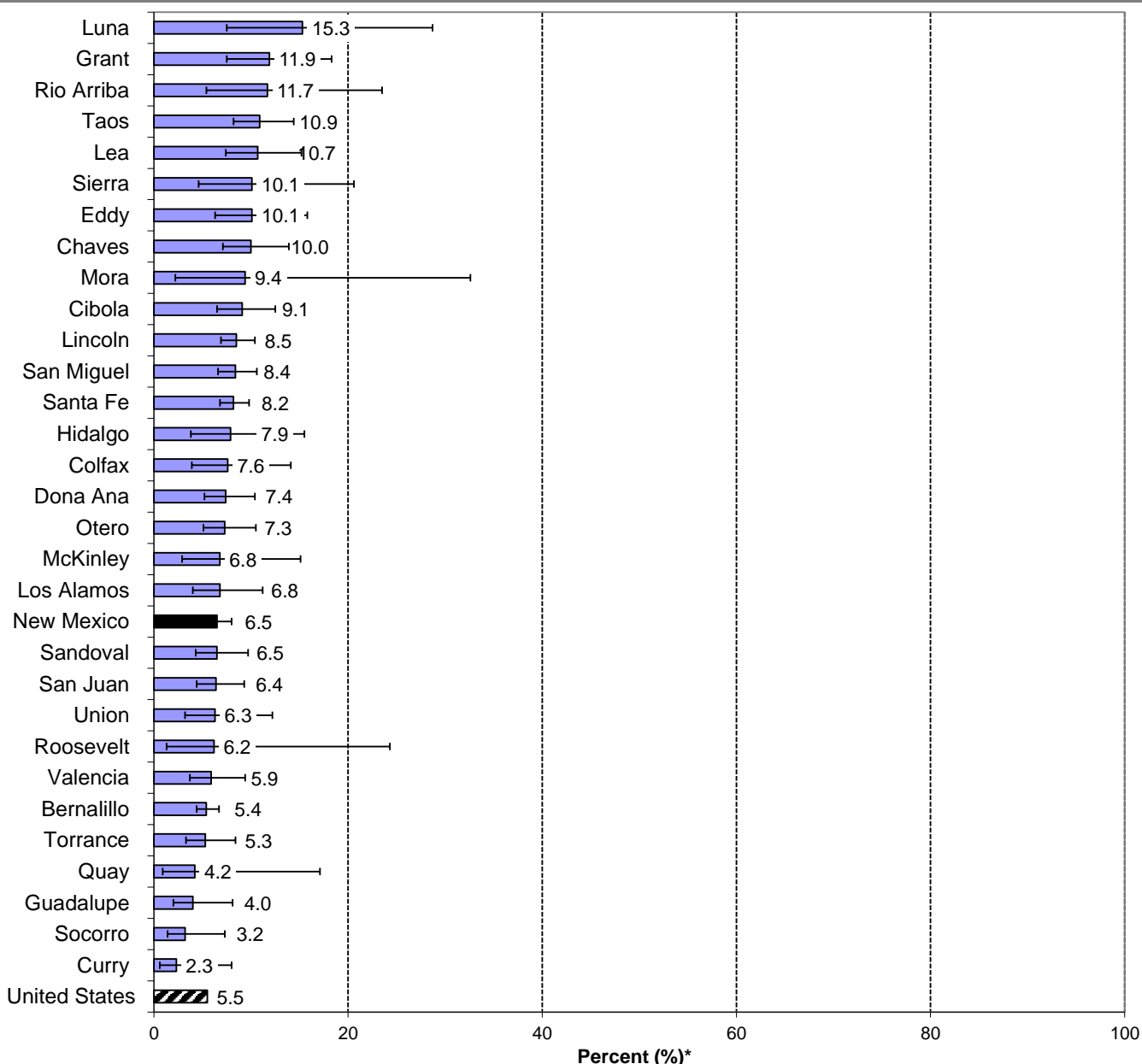
# YOUTH DRINKING AND DRIVING (continued)

Chart 2: Drinking and Driving, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, New Mexico, 2017



Source: YRRS (NM); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

Chart 3: Drinking and Driving\* by County, Grades 9 - 12, New Mexico, 2017



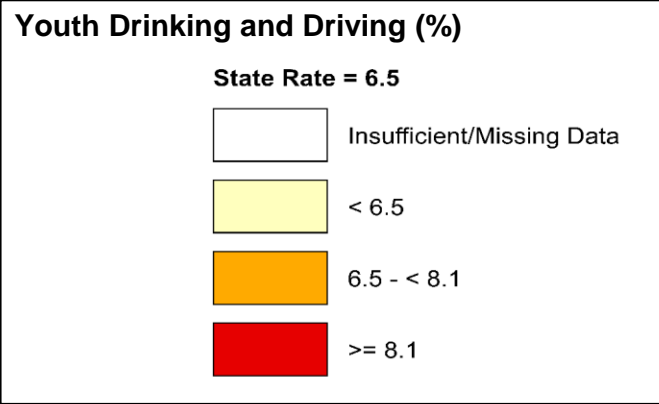
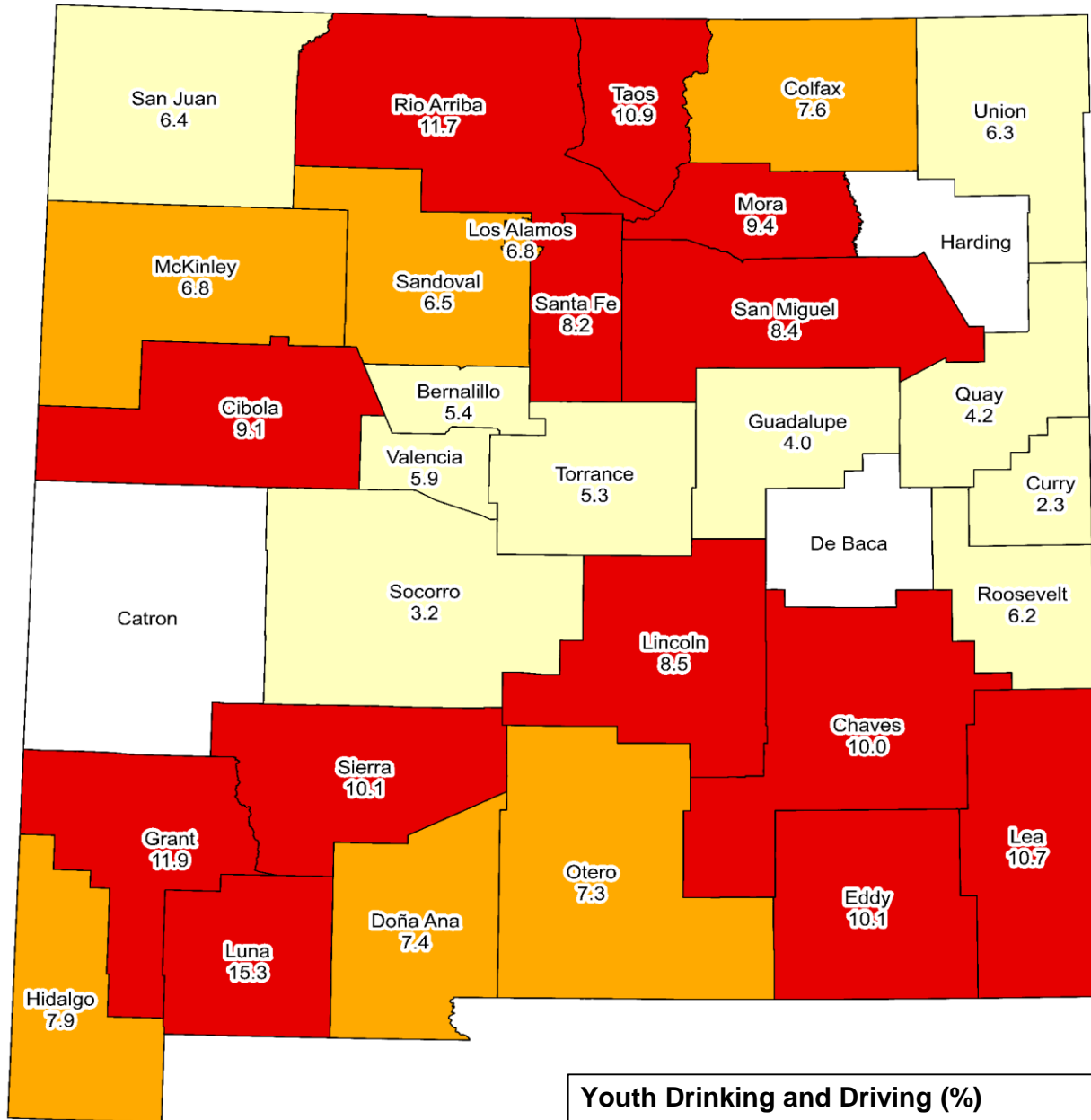
\* Estimate of percent of high school students who reported drinking and driving at least once in past 30 days

De Baca, Catron, and Harding County estimates not available because of low numbers and/or low response rates

Source: YRRS (NM); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

# YOUTH DRINKING AND DRIVING (continued)

Chart 4: Drinking and Driving\* by County, Grades 9 - 12, New Mexico, 2017



\* Estimate of percent of high school students who reported drinking and driving at least once in past 30 days  
 Insufficient Data: County estimates not available because of low numbers and/or low response rates





# YOUTH CURRENT MARIJUANA USE

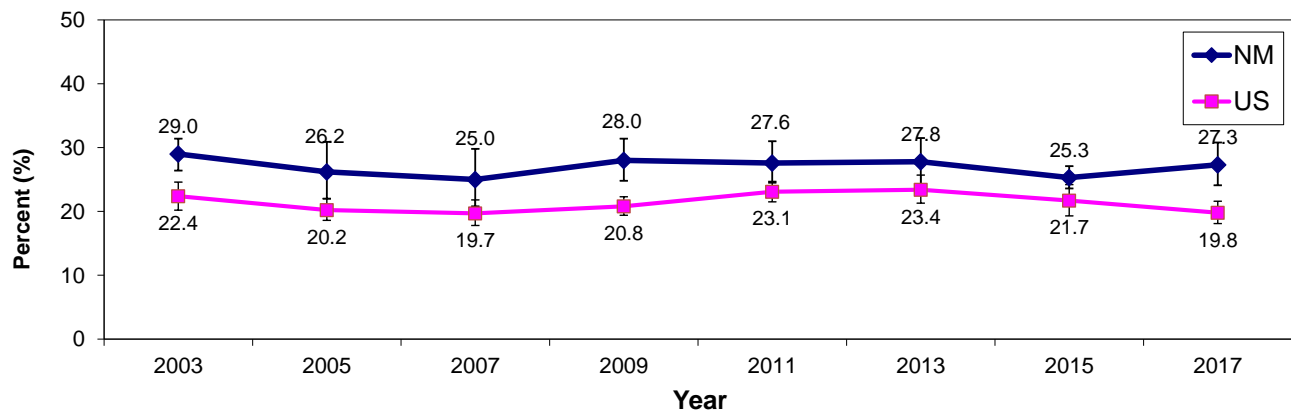
## Problem Statement

There has been no apparent trend in the rate of current marijuana use by New Mexico high school students in recent years, but it has remained significantly higher than the US rate. In 2017, the difference between the New Mexico rate (27.3%) and the US rate (19.8%) was larger compared to the previous years.

The prevalence of current marijuana use increases with increasing grade level. There was no statistically significant variation by gender. The rate among American Indian (34.6%) students was higher than among Black (29.1%), Hispanic (29.0%), Asian/Pacific Islander (19.7%), and White (22.1%) students.

In 2017, the rate of past 30-day marijuana use was highest in Taos (42.9%), Rio Arriba (37.3%), and Cibola (36.3%) counties. The rate was lowest in Union (12.5%), Hidalgo (13.5%), Curry (13.9%), and Los Alamos (16.6%) counties.

**Chart 1: Current Marijuana Use\* by Year, Grades 9 - 12, New Mexico and US, 2003-2017**



\* Used marijuana at least one time in the past 30 days

Source: YRRS (NM); CDC YRBS (US); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

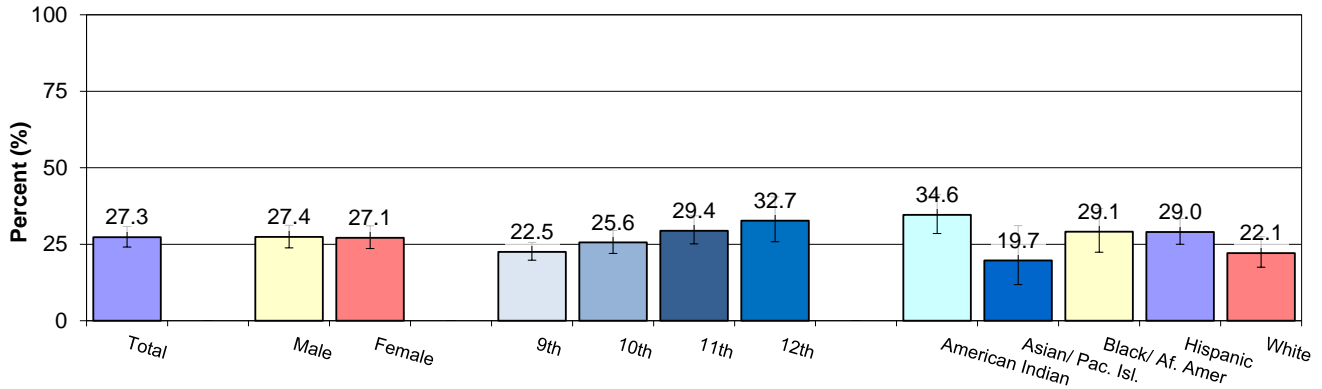
**Table 1: Current Marijuana Use, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, New Mexico, 2017**

Sex	Race/Ethnicity	9th Grade	10th Grade	11th Grade	12th Grade	All Grades
		Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]
Male	American Indian	32.1 (22.1-44.0)	32.7 (21.9-45.8)	32.2 (24.1-41.6)	36.8 (22.0-54.7)	33.2 (25.3-42.2)
	Asian/Pacific Islander	--	--	--	--	21.3 (12.4-34.0)
	Black	--	--	--	--	32.5 (20.6-47.1)
	Hispanic	21.7 (17.2-26.9)	28.3 (23.5-33.6)	33.9 (27.5-41.0)	34.5 (27.1-42.8)	29.0 (25.4-32.9)
	White	19.6 (14.6-25.8)	23.4 (15.9-33.1)	26.0 (19.6-33.6)	21.0 (11.5-35.1)	22.5 (16.9-29.2)
	Total	22.9 (18.9-27.4)	26.9 (22.6-31.7)	30.3 (25.8-35.2)	30.7 (22.5-40.2)	27.4 (23.8-31.2)
Female	American Indian	30.3 (23.3-38.2)	36.7 (28.8-45.3)	40.2 (31.7-49.4)	38.3 (28.5-49.3)	35.9 (31.1-40.9)
	Asian/Pacific Islander	--	--	--	--	17.7 (8.2-34.1)
	Black	--	--	--	--	23.3 (13.6-36.8)
	Hispanic	24.3 (21.3-27.6)	23.6 (18.7-29.3)	30.0 (21.8-39.7)	37.7 (28.2-48.3)	28.9 (23.7-34.6)
	White	14.3 (9.4-21.0)	22.8 (17.9-28.7)	23.1 (14.6-34.4)	28.5 (20.3-38.5)	21.7 (17.4-26.8)
	Total	21.8 (19.2-24.6)	24.3 (20.7-28.3)	28.6 (23.1-34.8)	34.7 (27.5-42.6)	27.1 (23.6-31.0)
Total	American Indian	31.5 (24.8-39.2)	34.5 (26.1-44.0)	36.1 (28.9-43.8)	37.6 (26.4-50.2)	34.6 (28.5-41.2)
	Asian/Pacific Islander	--	18.1 (8.3-35.0)	19.2 (9.3-35.5)	--	19.7 (11.8-31.1)
	Black	27.5 (16.2-42.5)	19.6 (12.2-30.0)	--	--	29.1 (22.4-36.7)
	Hispanic	23.3 (20.4-26.3)	25.8 (21.6-30.6)	31.8 (25.8-38.5)	36.3 (28.7-44.6)	29.0 (25.0-33.4)
	White	17.0 (13.0-21.9)	23.0 (18.0-29.0)	24.6 (17.8-33.0)	24.4 (15.5-36.2)	22.1 (17.5-27.5)
	Total	22.5 (19.8-25.6)	25.6 (22.0-29.5)	29.4 (25.1-34.3)	32.7 (25.8-40.5)	27.3 (24.1-30.8)

Source: YRRS (NM); NMDOH Survey Section (NOTE: "95% CI" is 95% confidence interval)

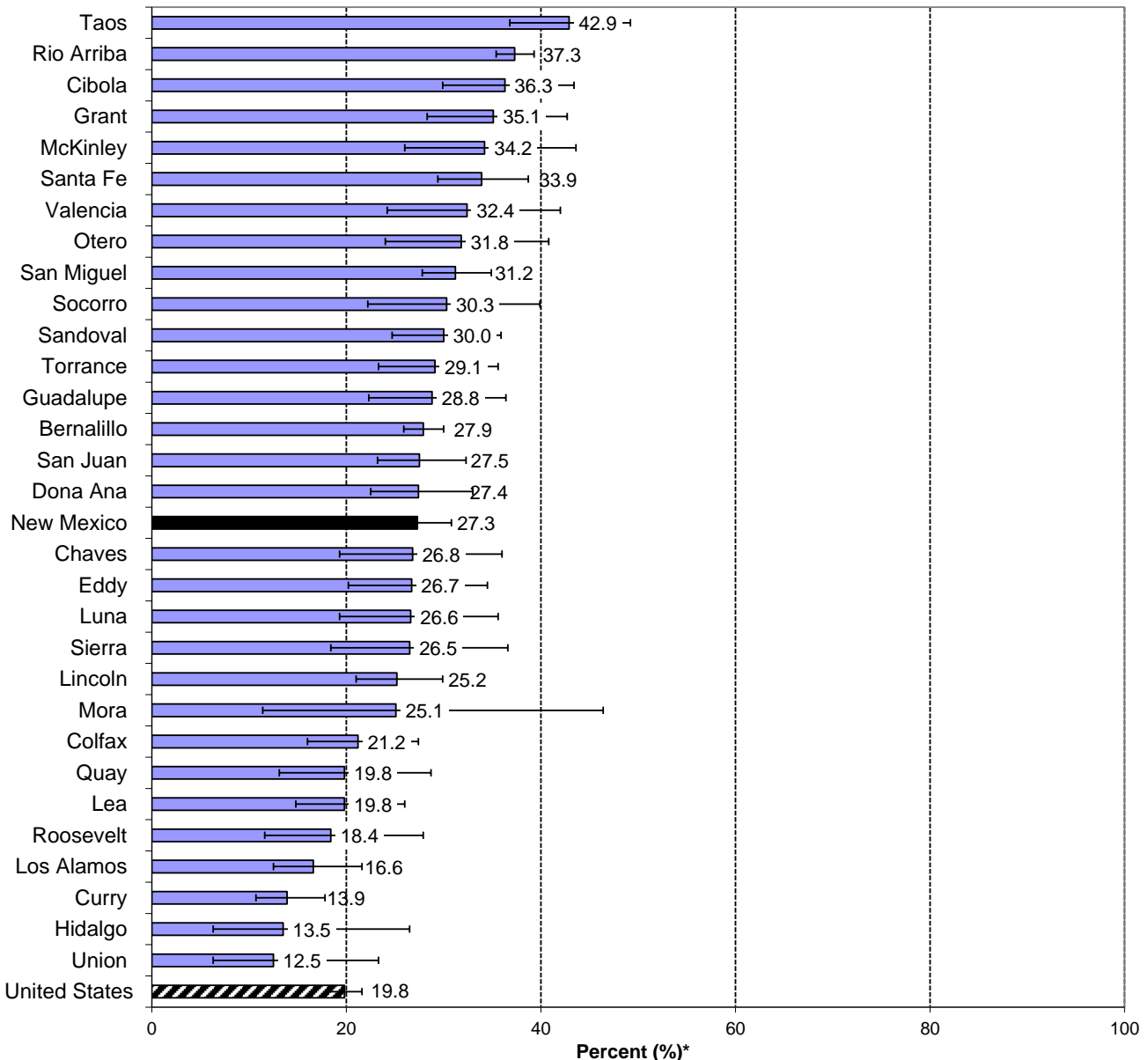
# YOUTH CURRENT MARIJUANA USE (continued)

Chart 2: Current Marijuana Use, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, New Mexico, 2017



Source: YRRS (NM); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

Chart 3: Current Marijuana Use\* by County, Grades 9 - 12, New Mexico, 2017



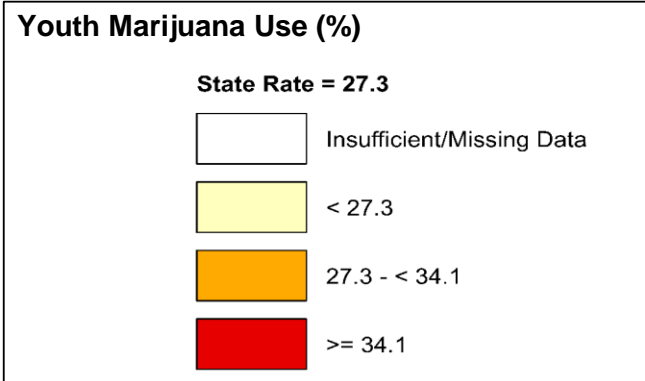
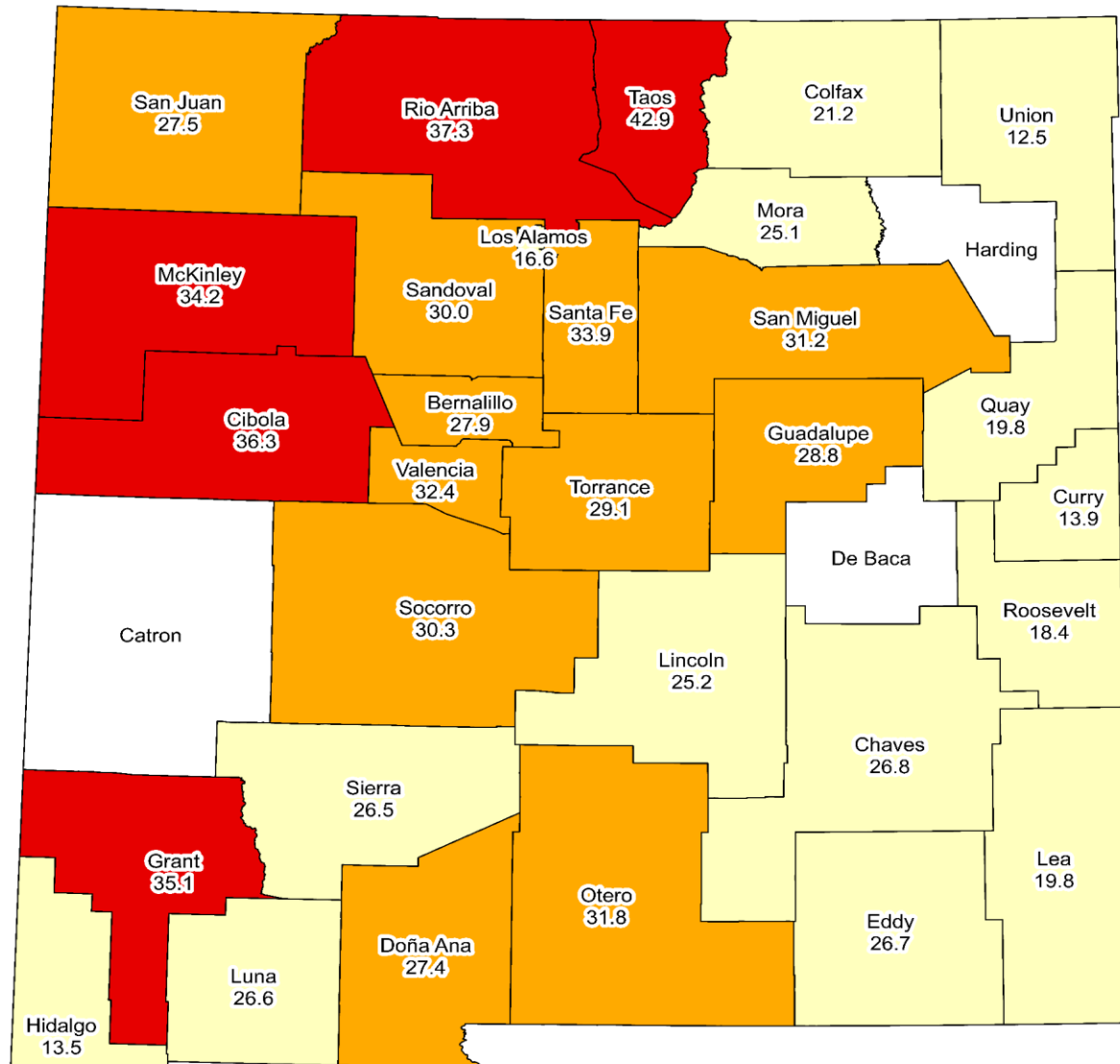
\* Estimate of percent of high school students who reported marijuana use at least once in past 30 days

De Baca, Catron, and Harding County estimates not available because of low numbers and/or low response rates

Source: YRRS (NM); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

# YOUTH CURRENT MARIJUANA USE (continued)

Chart 4: Current Marijuana Use\* by County, Grades 9 - 12, New Mexico, 2017



\* Estimate of percent of high school students who reported marijuana use at least once in past 30 days  
 Insufficient Data: County estimates not available because of low numbers and/or low response rates



# YOUTH CURRENT COCAINE USE

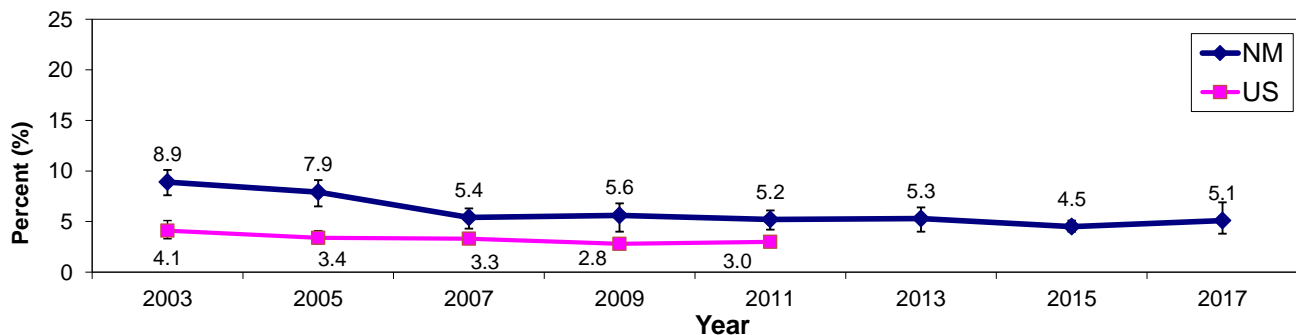
## Problem Statement

The New Mexico rate of current cocaine use by youth decreased from 2003 (8.9%) to 2007 (5.4%). The US rate decreased from 4.1% in 2003 to 2.8% in 2009 and did not significantly change from 2009 to 2011. The New Mexico rate in 2017 (5.1%) was higher than the last available US rate (3.0% in 2011) and has been consistently higher than the US rate since 2003.

The difference in the rate between males (6.8%) and females (3.3%) was statistically significant. The rate of current cocaine use generally increased in prevalence with increasing grade levels. Asian or Pacific Islander (9.4%) and Black (8.5%) students had higher rates of current cocaine use than Hispanic (5.8%), American Indian (5.1%), or White (3.4%) students. Differences between racial/ethnic groups were not statistically significant.

In 2017, the rate of past 30-day cocaine use was highest in Sierra (9.9%), Rio Arriba (9.4%), Luna (7.6%), Valencia (7.5%), and Grant (7.2%) counties. The rate was lowest in Hidalgo (0.7%), Union (0.7%), Curry (0.8%), Quay (0.8%), and Los Alamos (1.6%) counties.

**Chart 1: Current Cocaine Use\* by Year, Grades 9 - 12, New Mexico and US, 2003-2017**



\* Used cocaine at least one time in the past 30 days

Source: YRRS (NM); CDC YRBS (US); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

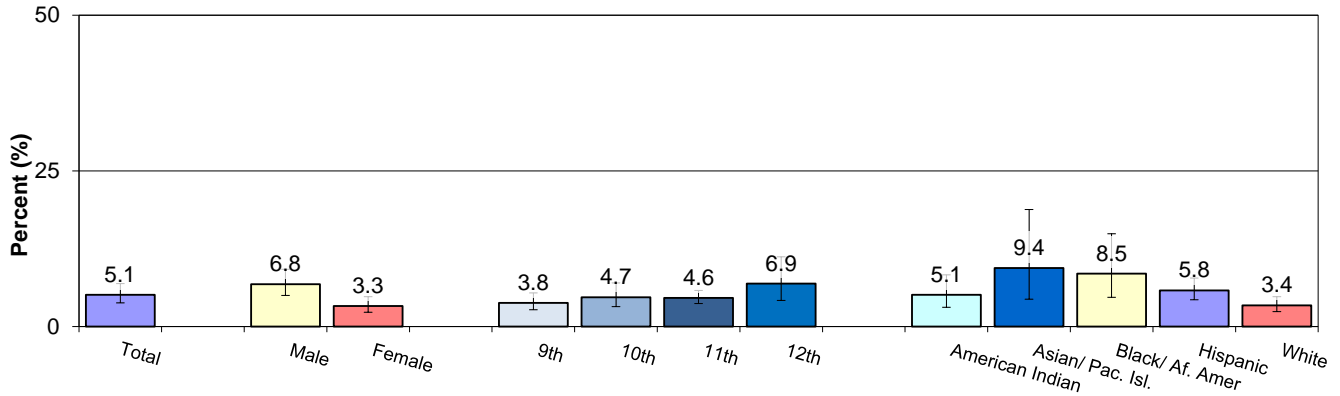
**Table 1: Current Cocaine Use, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, New Mexico, 2017**

Sex	Race/Ethnicity	9th Grade	10th Grade	11th Grade	12th Grade	All Grades
		Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]
Male	American Indian	2.1 (0.8-5.6)	7.8 (2.5-22.0)	2.5 (0.5-11.6)	6.6 (1.9-20.3)	4.5 (2.9-6.9)
	Asian/Pacific Islander	--	--	--	--	11.6 (4.6-26.3)
	Black	--	--	--	--	12.9 (7.2-22.1)
	Hispanic	6.4 (4.0-10.0)	8.8 (5.8-13.2)	7.1 (4.6-10.9)	11.2 (6.8-17.8)	8.5 (6.3-11.3)
	White	3.6 (1.4-9.1)	2.7 (1.2-5.8)	3.4 (1.7-6.7)	7.0 (3.2-14.4)	4.1 (2.7-6.1)
	Total	5.1 (3.3-7.7)	6.9 (4.4-10.6)	5.9 (4.5-7.6)	9.5 (5.8-15.1)	6.8 (5.0-9.2)
Female	American Indian	5.6 (1.7-17.0)	7.8 (2.9-19.1)	3.6 (0.8-15.0)	3.7 (1.8-7.5)	5.2 (2.7-9.9)
	Asian/Pacific Islander	--	--	--	--	6.3 (3.0-12.6)
	Black	--	--	--	--	1.4 (0.3-7.0)
	Hispanic	0.9 (0.3-2.6)	2.9 (1.3-6.1)	3.1 (1.7-5.7)	4.7 (1.8-11.4)	3.3 (1.9-5.7)
	White	2.2 (0.6-7.4)	0.5 (0.1-4.0)	3.9 (2.3-6.5)	4.6 (1.6-12.2)	2.7 (1.5-4.7)
	Total	2.0 (1.3-3.2)	2.6 (1.5-4.5)	3.4 (2.3-4.9)	4.4 (2.1-9.0)	3.3 (2.3-4.8)
Total	American Indian	4.2 (1.8-9.4)	7.8 (3.1-18.6)	3.0 (1.1-7.9)	5.2 (2.7-9.9)	5.1 (3.1-8.3)
	Asian/Pacific Islander	--	8.9 (2.8-25.2)	12.3 (4.1-31.4)	--	9.4 (4.4-18.8)
	Black	8.3 (2.9-21.7)	5.5 (1.2-22.2)	--	--	8.5 (4.7-14.9)
	Hispanic	3.9 (2.5-6.1)	5.7 (4.0-8.1)	5.0 (3.7-6.6)	7.7 (4.5-12.8)	5.8 (4.3-7.8)
	White	2.9 (1.4-5.7)	1.6 (0.8-3.4)	3.6 (2.4-5.5)	5.8 (3.1-10.9)	3.4 (2.4-4.8)
	Total	3.8 (2.7-5.4)	4.7 (3.2-7.0)	4.6 (3.7-5.8)	6.9 (4.2-11.2)	5.1 (3.8-6.9)

Source: YRRS (NM); NMDOH Survey Section (NOTE: "95% CI" is 95% confidence interval)

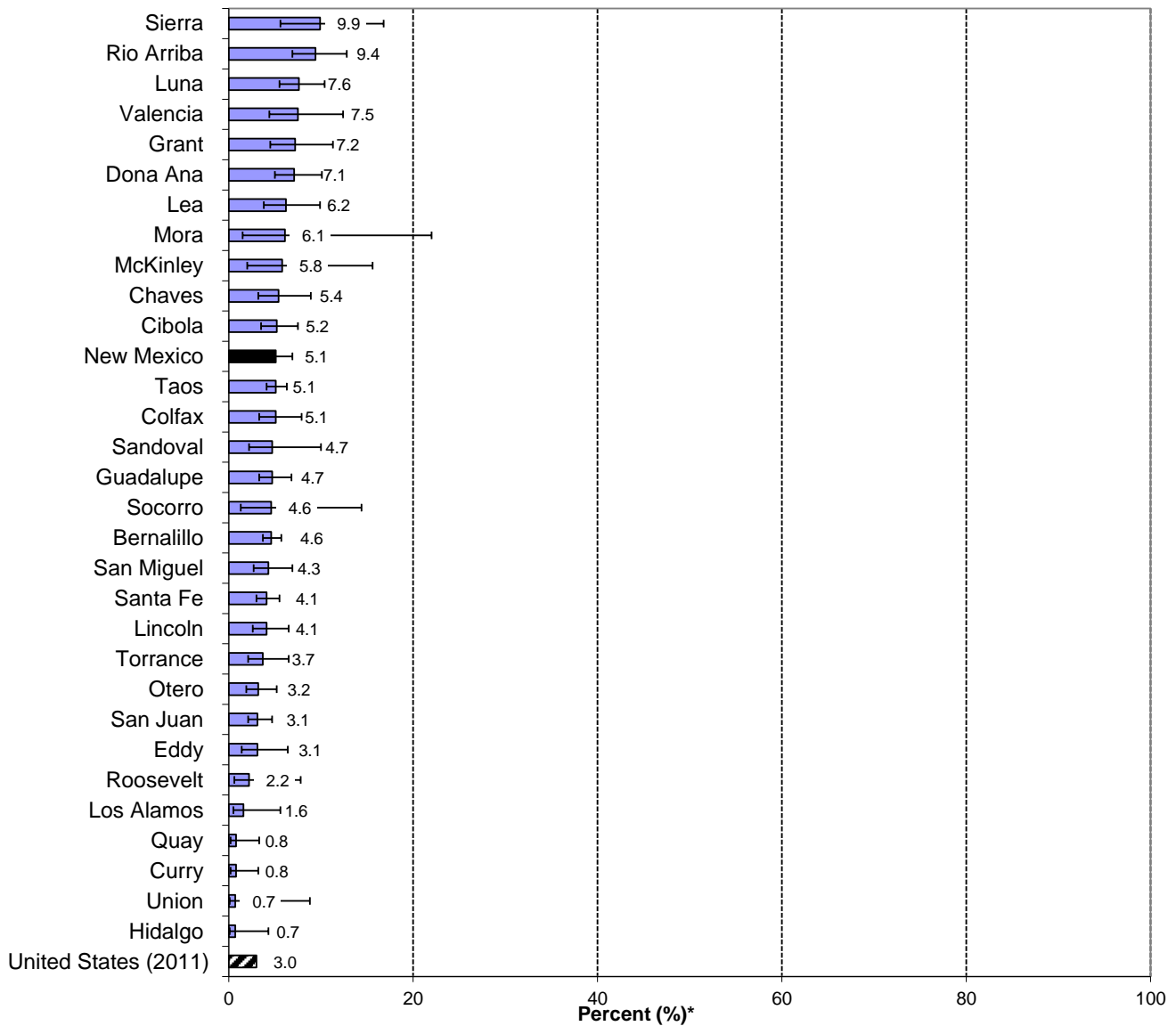
# YOUTH CURRENT COCAINE USE (continued)

Chart 2: Current Cocaine Use, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, New Mexico, 2017



Source: YRRS (NM); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

Chart 3: Current Cocaine Use\* by County, Grades 9 - 12, New Mexico, 2017



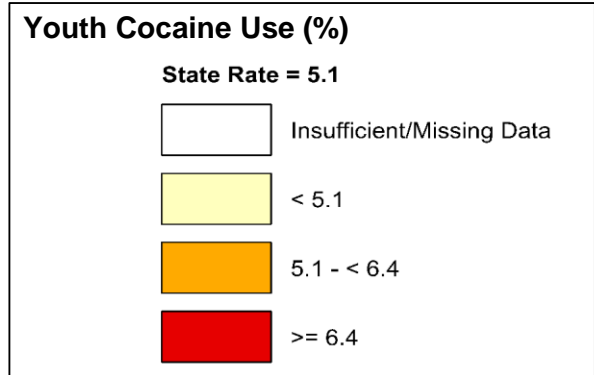
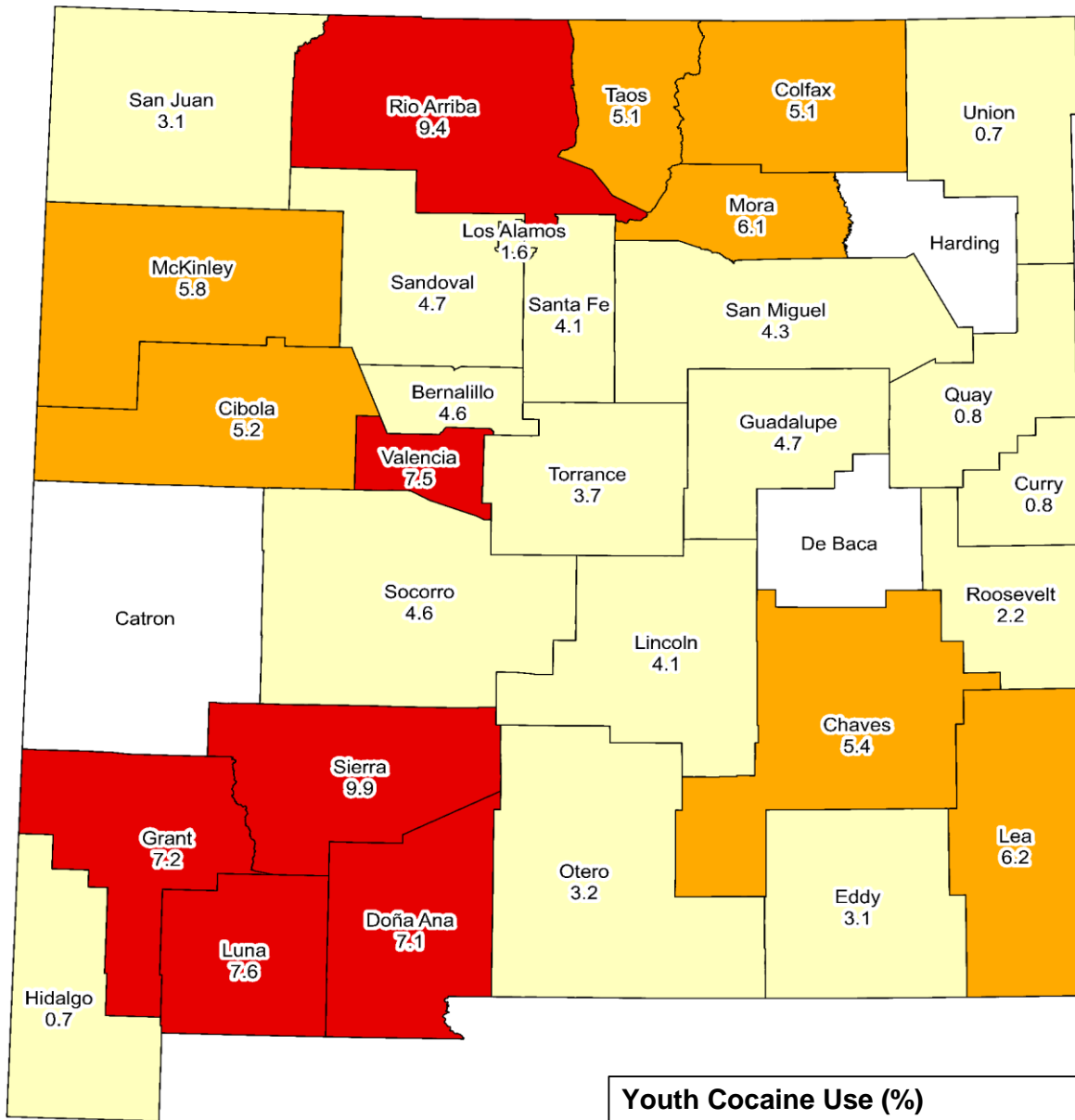
\* Estimate of percent of high school students who reported cocaine use at least once in past 30 days

De Baca, Catron, and Harding County estimates not available because of low numbers and/or low response rates

Source: YRRS (NM); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

# YOUTH CURRENT COCAINE USE (continued)

Chart 4: Current Cocaine Use\* by County, Grades 9 - 12, New Mexico, 2017



\* Estimate of percent of high school students who reported cocaine use at least once in past 30 days  
 Insufficient Data: County estimates not available because of low numbers and/or low response rates





# YOUTH USED PAINKILLER TO GET HIGH

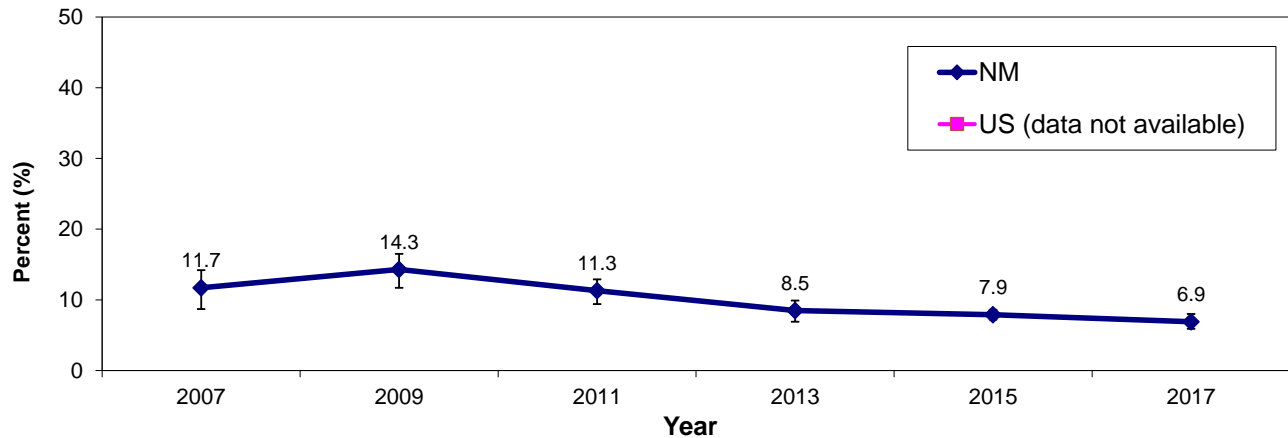
## Problem Statement

The rate of current use of painkillers to get high has shown no noticeable trend since the measure was added to the YRRS survey questionnaire in 2007. Painkiller use to get high had the second highest prevalence (6.9%) of all 30-day drug use measures in the 2017 YRRS, behind marijuana (27.3%). The question about the use of painkillers to get high is not on the national YRBS, and there is no national comparison.

The rate of painkiller use to get high was higher among males (7.4%) than females (6.1%), but this difference is not statistically significant. The prevalence was higher among Asian or Pacific Islander (15.0%) and Black (11.1%) students than among American Indian (8.1), Hispanic (6.7%) and White (5.4%) students.

In 2017, the rate of painkiller use to get high was highest in Sierra (12.9%), Rio Arriba (10.2%), and Chaves (10.0%) counties. The rate was lowest in Quay (1.4%), Hidalgo (1.6%), and Roosevelt (2.1%) counties.

**Chart 1: Used Painkiller to Get High\* by Year, Grades 9 - 12, New Mexico, 2007-2017**



\* Used a painkiller (such as Vicodin, OxyContin, or Percocet) to get high at least one time in the past 30 days

Source: YRRS (NM); CDC YRBS (US); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

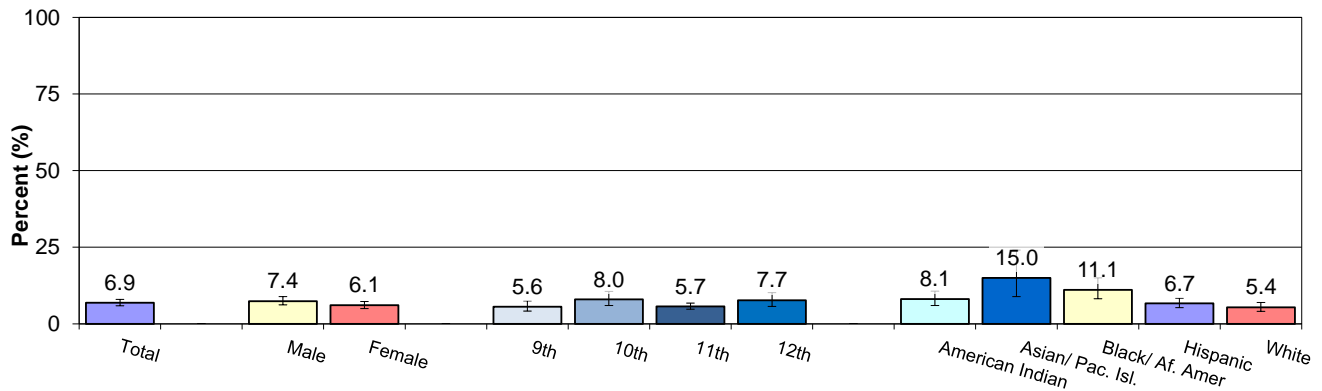
**Table 1: Used Painkiller to Get High, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, New Mexico, 2017**

Sex	Race/Ethnicity	9th Grade	10th Grade	11th Grade	12th Grade	All Grades
		Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]
Male	American Indian	7.9 (4.1-14.7)	7.6 (4.2-13.4)	4.4 (1.9-10.0)	5.5 (2.0-14.2)	6.6 (4.1-10.6)
	Asian/Pacific Islander	--	--	--	--	17.9 (9.9-30.1)
	Black	--	--	--	--	13.9 (9.5-19.9)
	Hispanic	5.0 (2.6-9.4)	10.8 (7.8-14.8)	6.1 (3.7-9.8)	11.5 (8.6-15.3)	8.3 (6.6-10.2)
	White	3.4 (1.2-9.5)	6.5 (3.6-11.6)	4.3 (2.2-8.5)	4.8 (1.9-11.5)	4.7 (3.1-7.2)
	Total	5.7 (3.5-9.2)	9.0 (6.7-12.0)	5.7 (4.2-7.7)	9.8 (7.1-13.3)	7.4 (6.2-8.9)
Female	American Indian	9.2 (4.7-17.1)	14.9 (5.6-33.9)	6.8 (3.8-11.9)	5.7 (3.6-8.9)	9.2 (6.7-12.5)
	Asian/Pacific Islander	--	--	--	--	11.0 (5.9-19.8)
	Black	--	--	--	--	6.1 (2.6-13.5)
	Hispanic	2.5 (1.6-3.8)	7.1 (4.8-10.3)	5.0 (3.2-7.5)	5.1 (2.3-10.8)	5.2 (3.8-7.2)
	White	7.6 (4.6-12.3)	4.7 (2.7-8.0)	5.9 (2.9-11.4)	5.8 (2.7-12.1)	6.1 (4.4-8.2)
	Total	5.2 (4.1-6.5)	7.1 (5.0-9.8)	5.7 (4.1-8.0)	5.5 (3.2-9.3)	6.1 (5.0-7.3)
Total	American Indian	9.0 (5.4-14.6)	10.9 (5.0-22.1)	5.5 (3.4-8.8)	5.6 (3.2-9.7)	8.1 (6.0-10.7)
	Asian/Pacific Islander	--	12.6 (5.5-26.5)	11.2 (5.7-20.9)	--	15.0 (8.9-24.1)
	Black	9.8 (4.3-21.0)	4.1 (1.9-8.5)	--	--	11.1 (8.2-15.0)
	Hispanic	4.0 (2.3-6.7)	8.9 (6.4-12.1)	5.5 (3.9-7.6)	8.1 (6.1-10.6)	6.7 (5.3-8.4)
	White	5.5 (3.5-8.7)	5.6 (3.3-9.3)	5.1 (3.2-8.1)	5.3 (2.8-9.8)	5.4 (4.1-7.0)
	Total	5.6 (4.2-7.5)	8.0 (6.0-10.6)	5.7 (4.8-6.8)	7.7 (5.7-10.2)	6.9 (5.9-8.0)

Source: YRRS (NM); NMDOH Survey Section (NOTE: "95% CI" is 95% confidence interval)

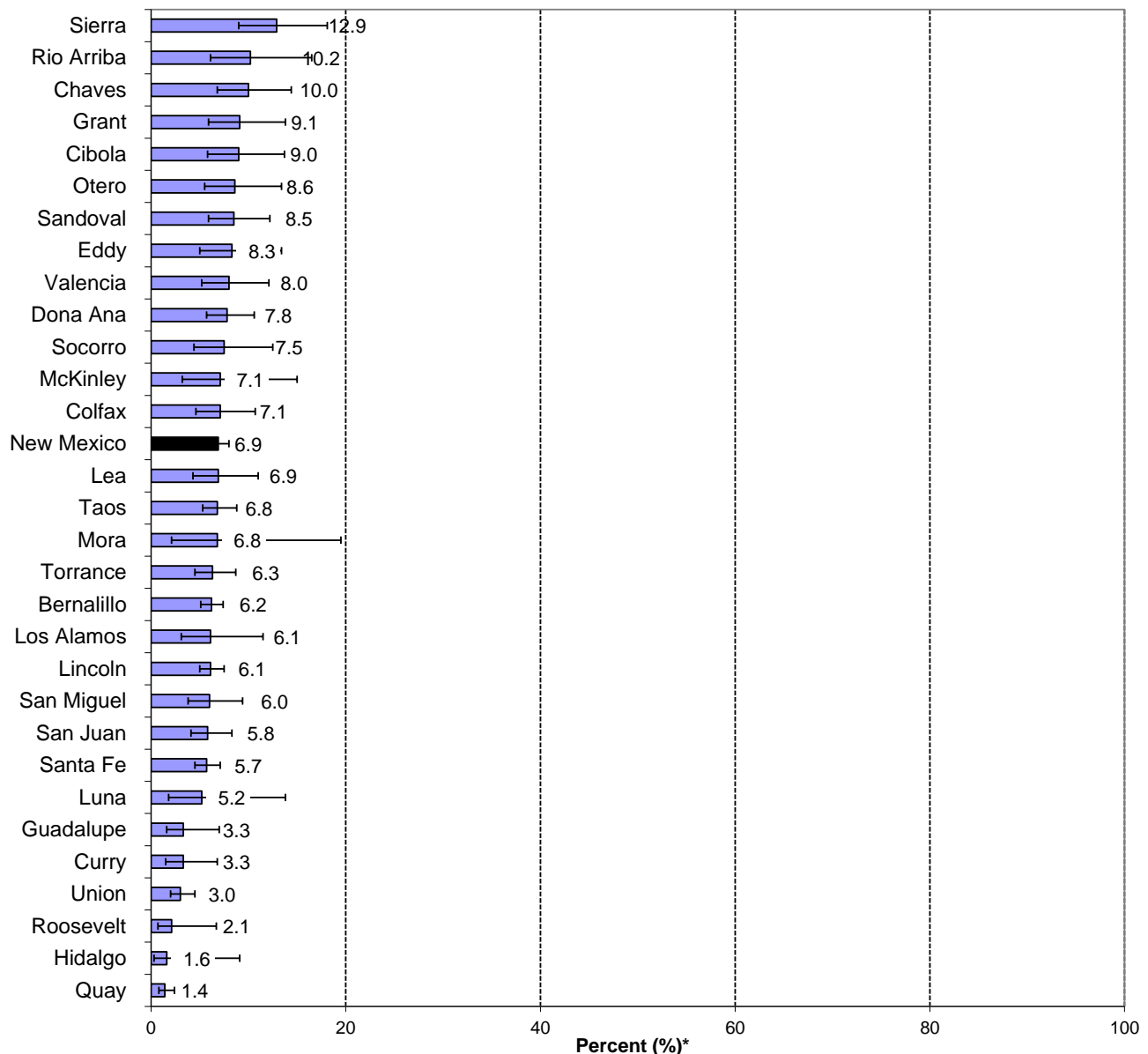
# YOUTH USED PAINKILLER TO GET HIGH (continued)

Chart 2: Used Painkiller to Get High, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, New Mexico, 2017



Source: YRRS (NM); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

Chart 3: Used Painkiller to Get High\* by County, Grades 9 - 12, New Mexico, 2017

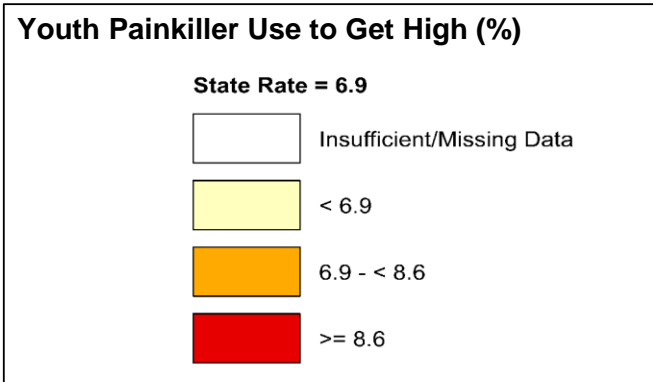
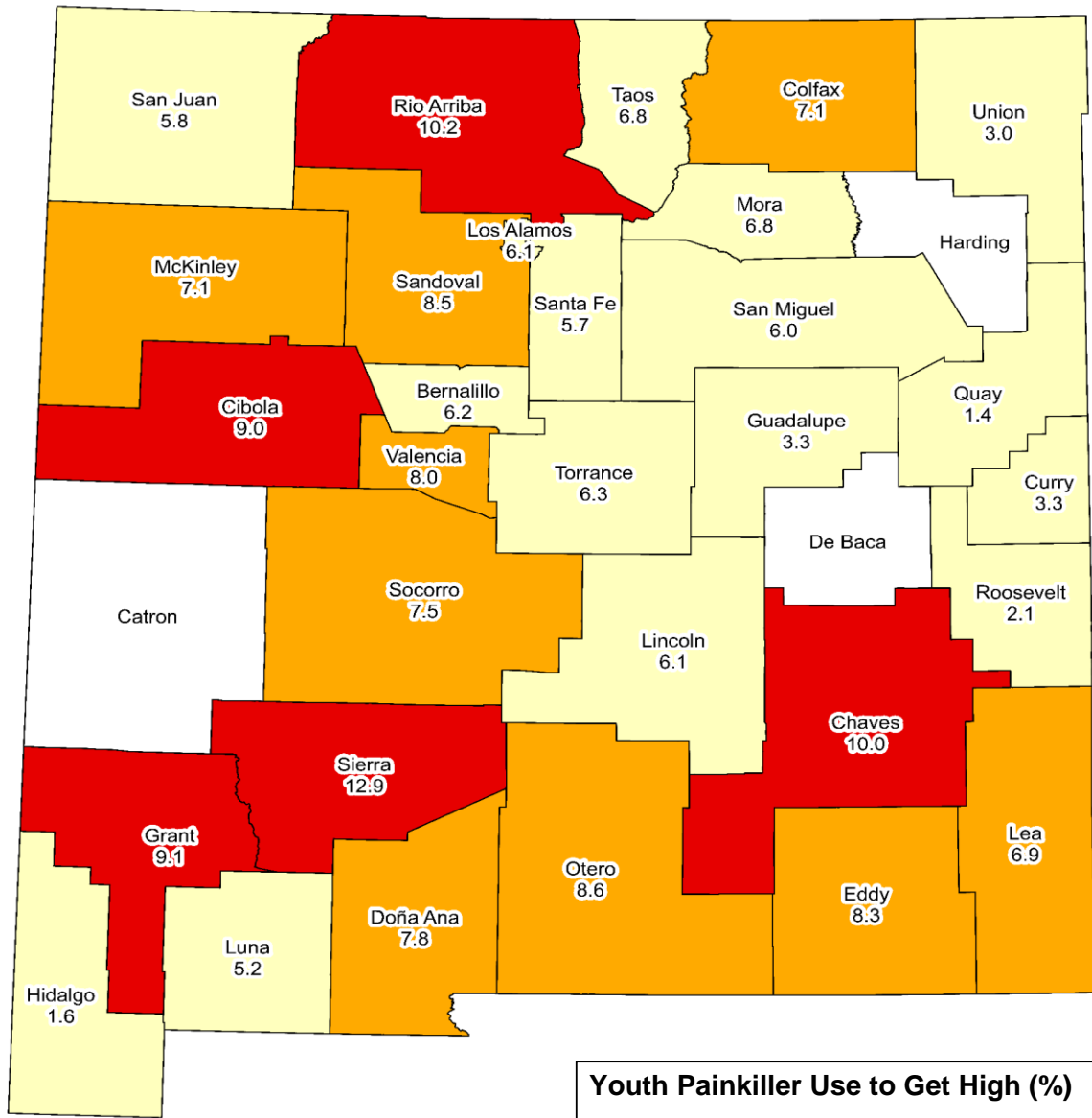


\* Estimate of percent of high school students who reported pain killer use to get high at least once in past 30 days  
 De Baca, Catron, and Harding County estimates not available because of low numbers and/or low response rates

Source: YRRS (NM); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

# YOUTH USED PAINKILLER TO GET HIGH (continued)

Chart 4: Used Painkiller to Get High\* by County, Grades 9 - 12, New Mexico, 2017



\* Estimate of percent of high school students who reported pain killer use to get high at least once in past 30 days  
 Insufficient Data: County estimates not available because of low numbers and/or low response rates



# YOUTH HEROIN USE

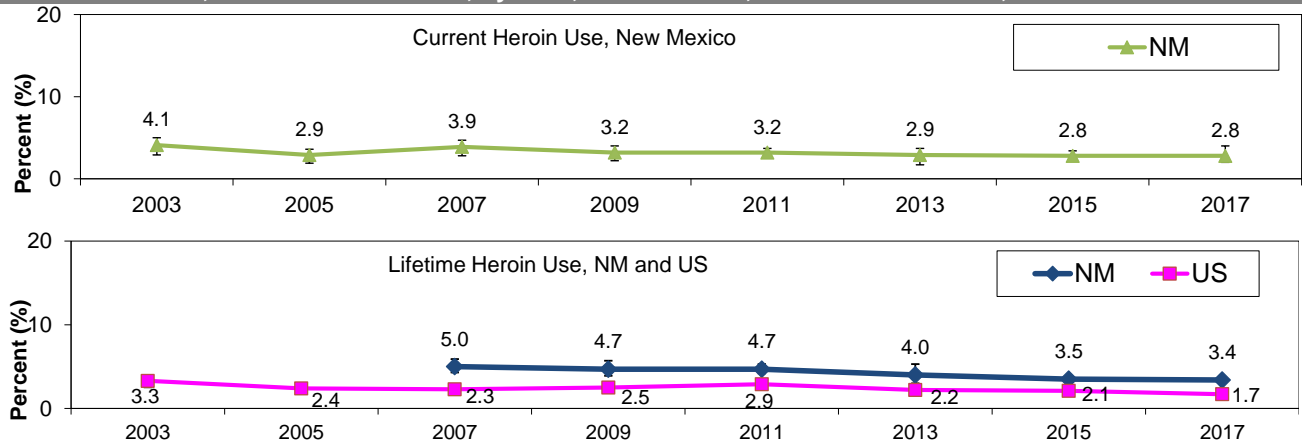
## Problem Statement

The rate of lifetime heroin use by youth has not significantly varied in recent years, neither in New Mexico nor the US. The New Mexico rate for lifetime heroin use has been consistently higher than the US rate. This remained true in 2017, with a rate of 3.4% for New Mexico and 1.7% for the US. For current heroin use, there is no apparent trend in the New Mexico rate. There is no national comparison for current heroin use.

Asian or Pacific Islander (6.4%) and Black (6.0%) students were more likely to be current heroin users than Hispanic (3.1%), American Indian (2.9%), or White (1.8%) students. The prevalence of current heroin use was not associated with grade level. Males were more likely to report current heroin use (3.6%) than females (1.9%); this difference was not statistically significant.

In 2017, the highest rates for lifetime heroin use were in Sierra (6.0%), Valencia (5.5%), Rio Arriba (5.4%), and Grant (5.1%) counties and the lowest in Union (0.0%), and Curry (0.0%) counties.

**Chart 1: Heroin Use\*, Current and Lifetime, by Year, Grades 9 - 12, New Mexico and US, 2003-2017**



\* Current use: Used at least once in the past 30 days; Lifetime use: Ever used in lifetime

Source: YRRS (NM); CDC YRBS (US); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

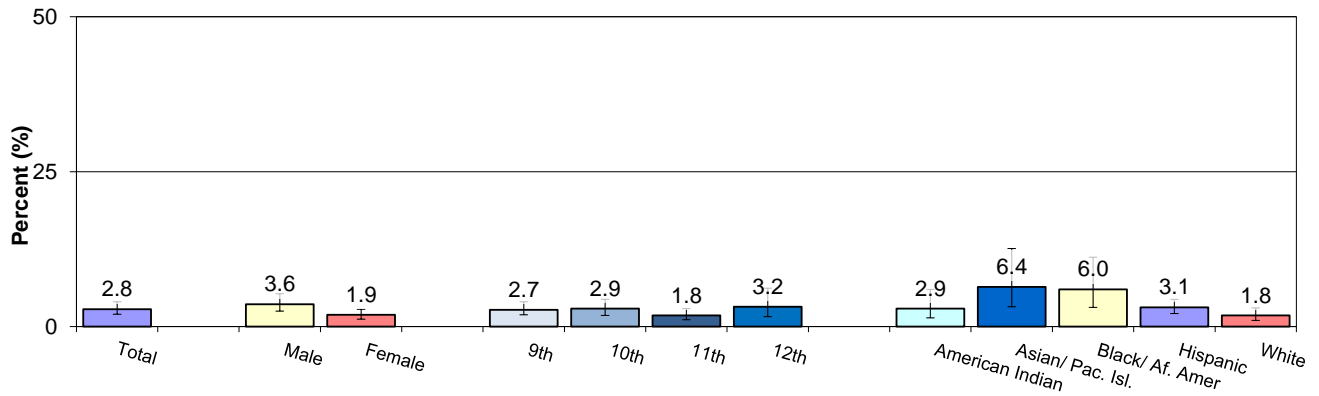
**Table 1: Current Heroin Use, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, New Mexico, 2017**

Sex	Race/Ethnicity	9th Grade	10th Grade	11th Grade	12th Grade	All Grades
		Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]
Male	American Indian	1.7 (0.5-5.5)	2.9 (0.5-15.5)	0.0 (-.)	2.8 (0.7-10.1)	1.9 (1.0-3.4)
	Asian/Pacific Islander	--	--	--	--	7.3 (2.8-17.8)
	Black	--	--	--	--	9.2 (4.9-16.7)
	Hispanic	3.9 (2.3-6.6)	5.1 (3.0-8.6)	2.2 (1.2-4.2)	5.1 (2.3-11.1)	4.2 (2.9-6.1)
	White	1.7 (0.4-6.7)	2.8 (1.1-6.8)	2.2 (0.9-5.5)	3.3 (1.1-9.5)	2.5 (1.3-4.7)
	Total	3.5 (2.0-6.0)	4.1 (2.7-6.2)	2.6 (1.5-4.4)	4.3 (2.2-8.2)	3.6 (2.5-5.3)
Female	American Indian	5.5 (1.5-17.7)	4.9 (0.9-21.6)	0.3 (0.0-1.8)	2.5 (0.6-10.7)	3.5 (1.4-8.5)
	Asian/Pacific Islander	--	--	--	--	5.2 (2.2-11.5)
	Black	--	--	--	--	0.4 (0.0-2.7)
	Hispanic	0.9 (0.3-3.2)	1.9 (0.9-3.9)	0.5 (0.1-1.9)	2.7 (0.8-8.6)	1.9 (1.1-3.5)
	White	1.1 (0.3-3.6)	0.0 (-.)	1.8 (0.7-4.7)	1.2 (0.3-4.9)	1.0 (0.5-2.2)
	Total	1.6 (0.9-2.7)	1.6 (0.8-3.3)	1.0 (0.5-1.9)	2.1 (0.8-5.2)	1.9 (1.2-2.8)
Total	American Indian	4.0 (1.6-9.4)	3.8 (0.7-17.5)	0.1 (0.0-0.9)	2.6 (0.8-8.4)	2.9 (1.4-6.0)
	Asian/Pacific Islander	--	6.4 (1.7-21.7)	9.3 (2.5-29.6)	--	6.4 (3.2-12.6)
	Black	7.8 (2.6-21.5)	2.2 (0.3-15.8)	--	--	6.0 (3.1-11.2)
	Hispanic	2.6 (1.8-3.9)	3.4 (2.1-5.5)	1.3 (0.6-2.6)	3.8 (1.6-8.8)	3.1 (2.1-4.4)
	White	1.4 (0.5-3.7)	1.4 (0.6-3.6)	2.0 (1.0-4.2)	2.3 (1.0-5.3)	1.8 (1.0-3.0)
	Total	2.7 (1.9-4.0)	2.9 (1.8-4.4)	1.8 (1.1-2.9)	3.2 (1.6-6.2)	2.8 (2.0-4.0)

Source: YRRS (NM); NMDOH Survey Section (NOTE: "95% CI" is 95% confidence interval. 95% CIs are not calculated for zero rates)

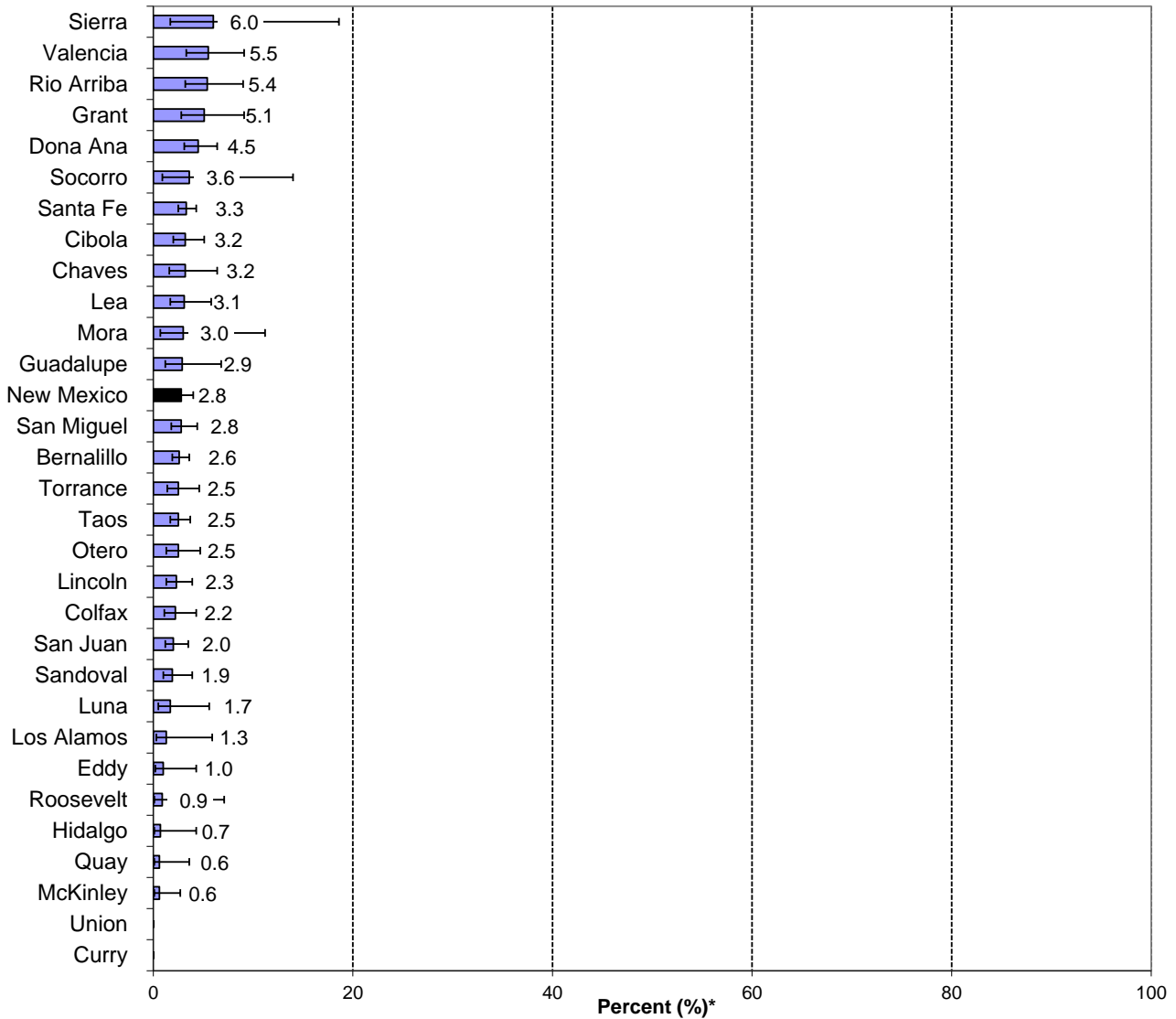
# YOUTH HEROIN USE (continued)

Chart 2: Current Heroin Use, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, New Mexico, 2017



Source: YRRS (NM); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

Chart 3: Current Heroin Use\* by County, Grades 9 - 12, New Mexico, 2017

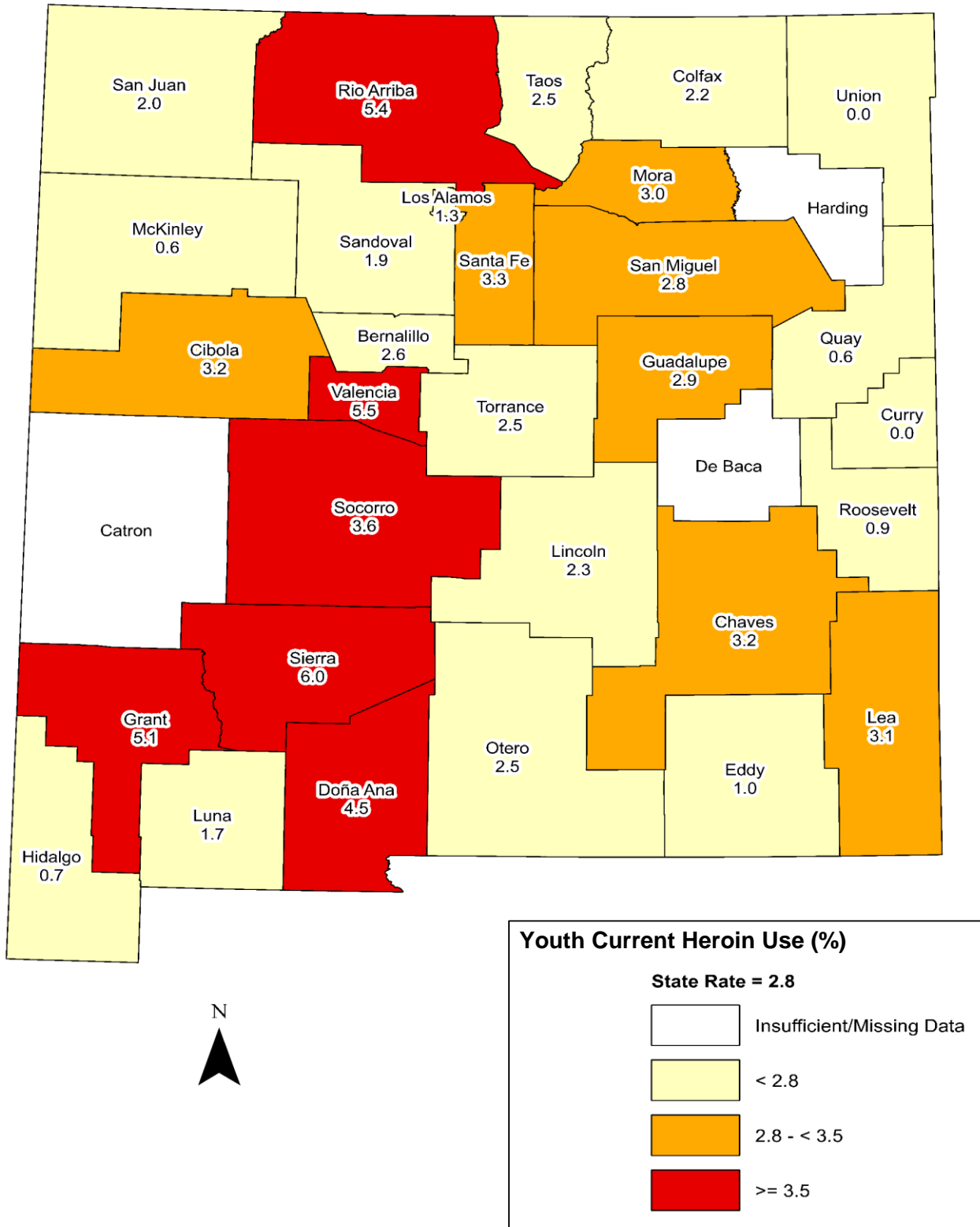


\* Estimate of percent of high school students who reported heroin use at least once in the past 30 days  
 De Baca, Harding, and Catron County estimates not available because of low numbers and/or low response rates

Source: YRRS (NM); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

# YOUTH HEROIN USE (continued)

Chart 4: Current Heroin Use\* by County, Grades 9 - 12, New Mexico, 2017



\* Estimate of percent of high school students who reported heroin use at least once in the past 30 days  
 Insufficient Data: County estimates not available because of low numbers and/or low response rates





# YOUTH METHAMPHETAMINE USE

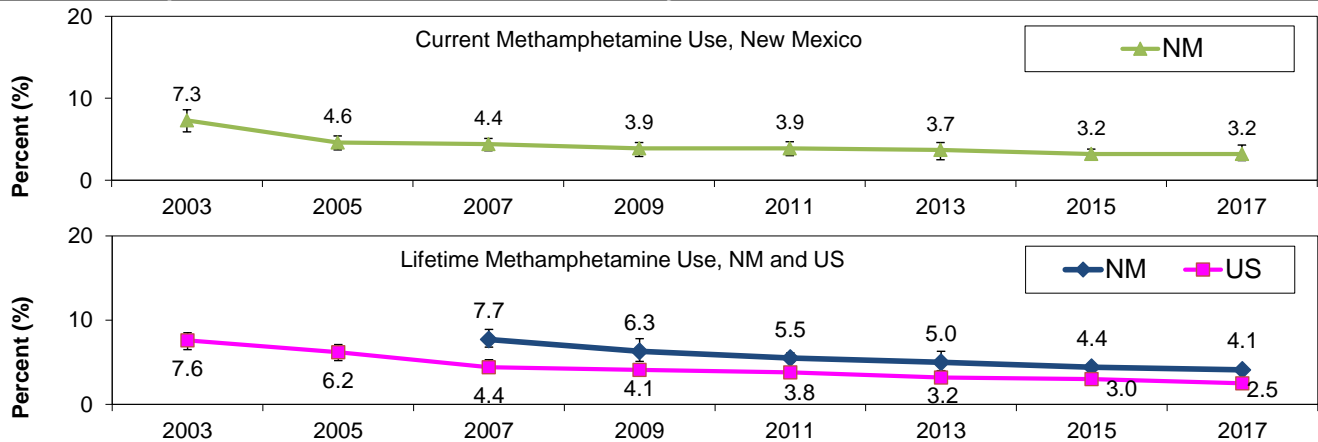
## Problem Statement

New Mexico's rate of lifetime methamphetamine use decreased from 7.7% in 2007 to 4.1% in 2017. The US rate decreased from 1999 (9.1%, not shown) to 2017 (2.5%). The New Mexico rate for lifetime methamphetamine use has been consistently higher than the US rate. This remained true in 2017. For current methamphetamine use, New Mexico prevalence decreased from 7.3% in 2003 to 4.6% in 2005, but there has been no statistically significant change since then. There is no national comparison for current methamphetamine use.

Asian or Pacific Islander (6.3%) and Black (5.3%) students were more likely to be current methamphetamine users than Hispanic (3.4%), American Indian (3.5%), or White (2.3%) students. Prevalence of current methamphetamine use was not associated with grade level. Males were more likely to report current methamphetamine use (4.3%) than females (1.9%).

In 2017, the highest rates of current methamphetamine use were in Sierra (7.5%), Grant (6.3%), Rio Arriba (6.0%), and Valencia (5.9%) counties, and the lowest rates were in Union (0.0%), Quay (0.6%), and Hidalgo (0.7%) counties.

**Chart 1: Methamphetamine Use\*, Current and Lifetime, by Year, Grades 9 - 12, New Mexico and US, 2003-2017**



\* Current use: Used at least once in the past 30 days; Lifetime use: Ever used in lifetime

Source: YRRS (NM); CDC YRBS (US); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

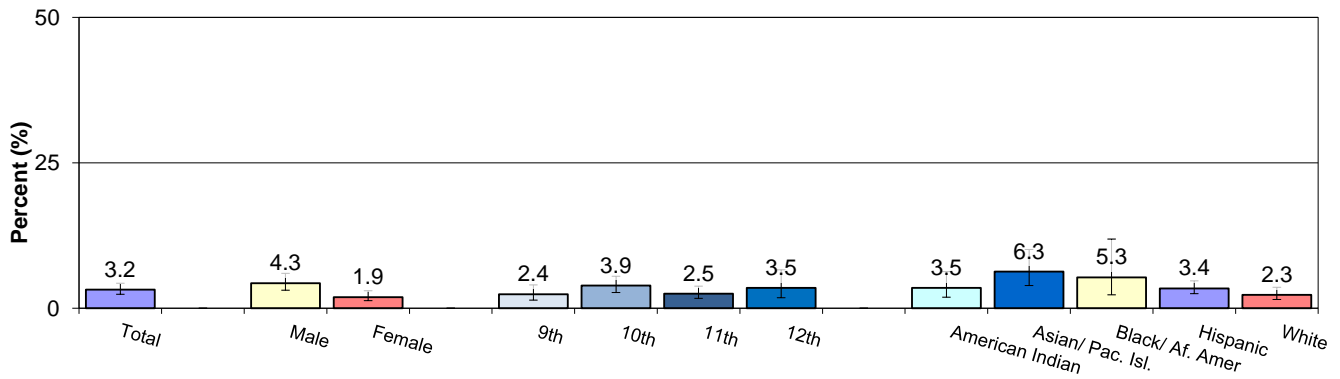
**Table 1: Current Methamphetamine Use, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, New Mexico, 2017**

Sex	Race/Ethnicity	9th Grade	10th Grade	11th Grade	12th Grade	All Grades
		Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]
Male	American Indian	1.4 (0.5-4.1)	5.3 (1.9-13.9)	3.7 (1.2-11.4)	2.8 (0.7-10.0)	3.2 (2.0-4.9)
	Asian/Pacific Islander	--	--	--	--	6.9 (3.3-13.9)
	Black	--	--	--	--	8.2 (3.4-18.6)
	Hispanic	3.9 (1.8-8.5)	6.5 (4.3-9.6)	3.2 (1.4-7.3)	5.0 (2.6-9.3)	4.8 (3.3-7.0)
	White	1.3 (0.3-6.6)	4.0 (2.6-6.2)	2.9 (1.5-5.3)	5.6 (1.9-15.3)	3.4 (2.1-5.4)
	Total	3.0 (1.4-6.5)	5.6 (4.0-7.8)	3.7 (2.5-5.7)	4.9 (2.5-9.2)	4.3 (3.1-6.0)
Female	American Indian	4.9 (1.2-17.7)	4.9 (1.0-21.7)	0.0 (-.)	2.5 (0.5-10.6)	3.2 (1.2-8.4)
	Asian/Pacific Islander	--	--	--	--	5.5 (2.2-13.0)
	Black	--	--	--	--	0.0 (-.)
	Hispanic	0.3 (0.0-2.7)	2.3 (1.1-4.8)	1.1 (0.3-4.0)	3.1 (1.1-7.9)	2.0 (1.1-3.7)
	White	1.5 (0.4-4.7)	0.5 (0.1-3.7)	2.0 (0.9-4.1)	0.6 (0.1-4.6)	1.2 (0.5-2.6)
	Total	1.3 (0.6-2.9)	2.1 (1.2-3.8)	1.3 (0.7-2.5)	2.1 (0.9-5.2)	1.9 (1.3-3.0)
Total	American Indian	3.5 (1.4-8.9)	5.1 (1.5-15.8)	1.9 (0.6-6.2)	2.6 (0.8-8.4)	3.5 (1.9-6.3)
	Asian/Pacific Islander	--	5.8 (3.2-10.5)	9.5 (3.5-23.2)	--	6.3 (3.9-10.1)
	Black	5.5 (1.2-21.2)	5.6 (1.2-22.4)	--	--	5.3 (2.3-11.9)
	Hispanic	2.4 (1.1-4.9)	4.3 (2.8-6.4)	2.1 (1.0-4.2)	3.9 (2.2-6.9)	3.4 (2.5-4.7)
	White	1.4 (0.5-3.8)	2.3 (1.6-3.3)	2.4 (1.5-3.8)	3.3 (1.3-8.4)	2.3 (1.5-3.6)
	Total	2.4 (1.4-4.0)	3.9 (2.7-5.5)	2.5 (1.7-3.8)	3.5 (1.8-6.6)	3.2 (2.4-4.3)

Source: YRRS (NM); NMDOH Survey Section (NOTE: "95% CI" is 95% confidence interval, 95% CIs are not calculated for zero rates)

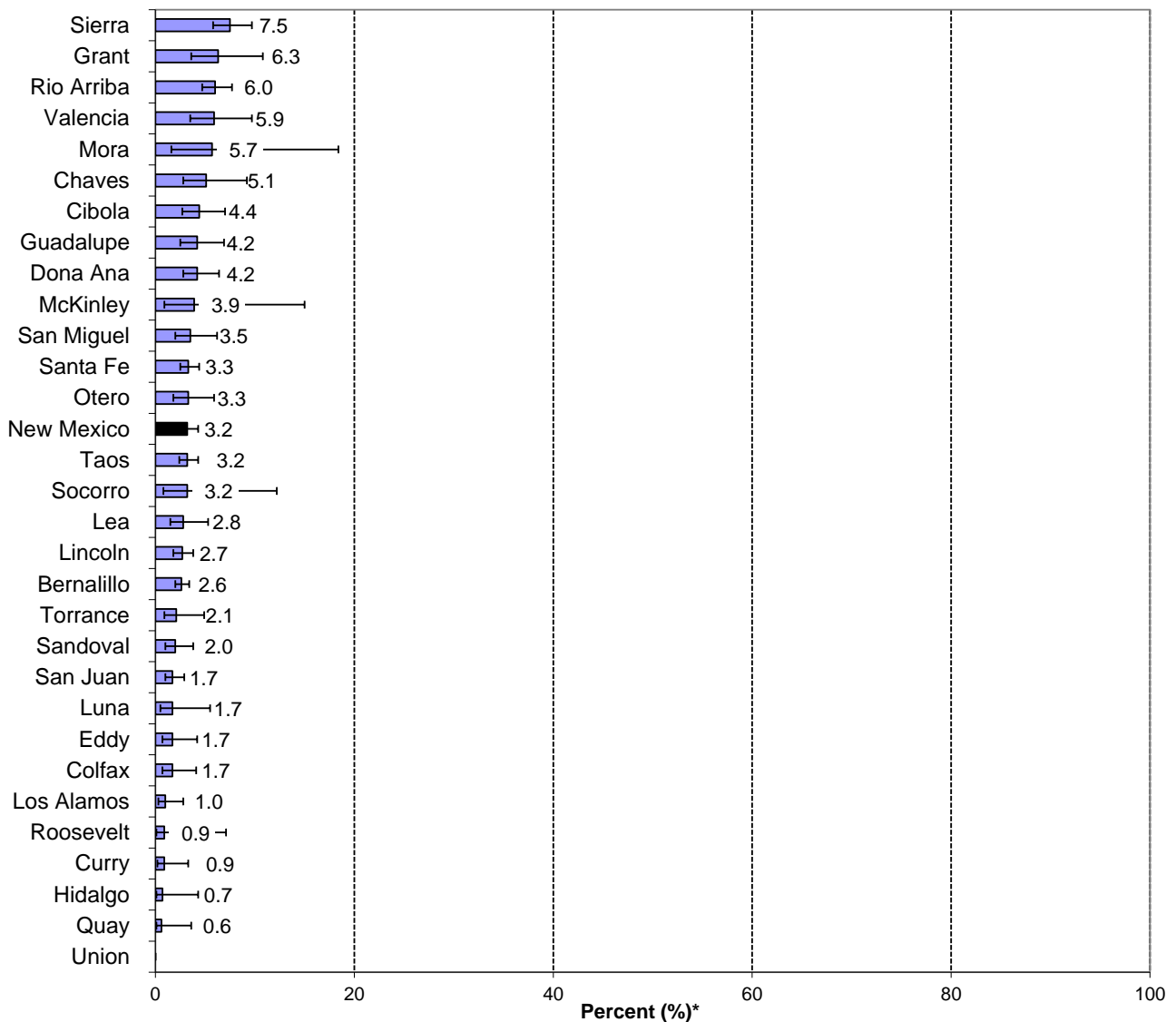
# YOUTH METHAMPHETAMINE USE (continued)

Chart 2: Current Methamphetamine Use, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, New Mexico, 2017



Source: YRRS (NM); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

Chart 3: Current Methamphetamine Use\* by County, Grades 9 - 12, New Mexico, 2017

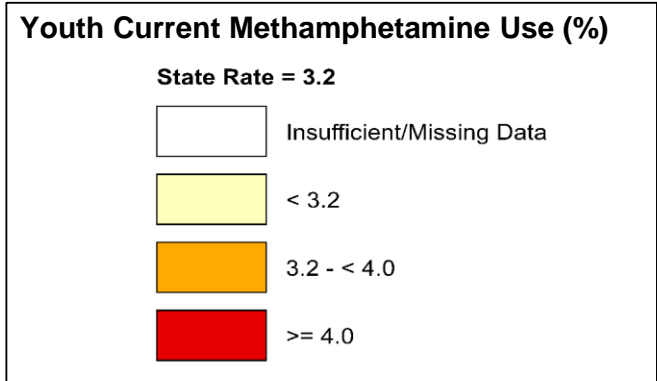
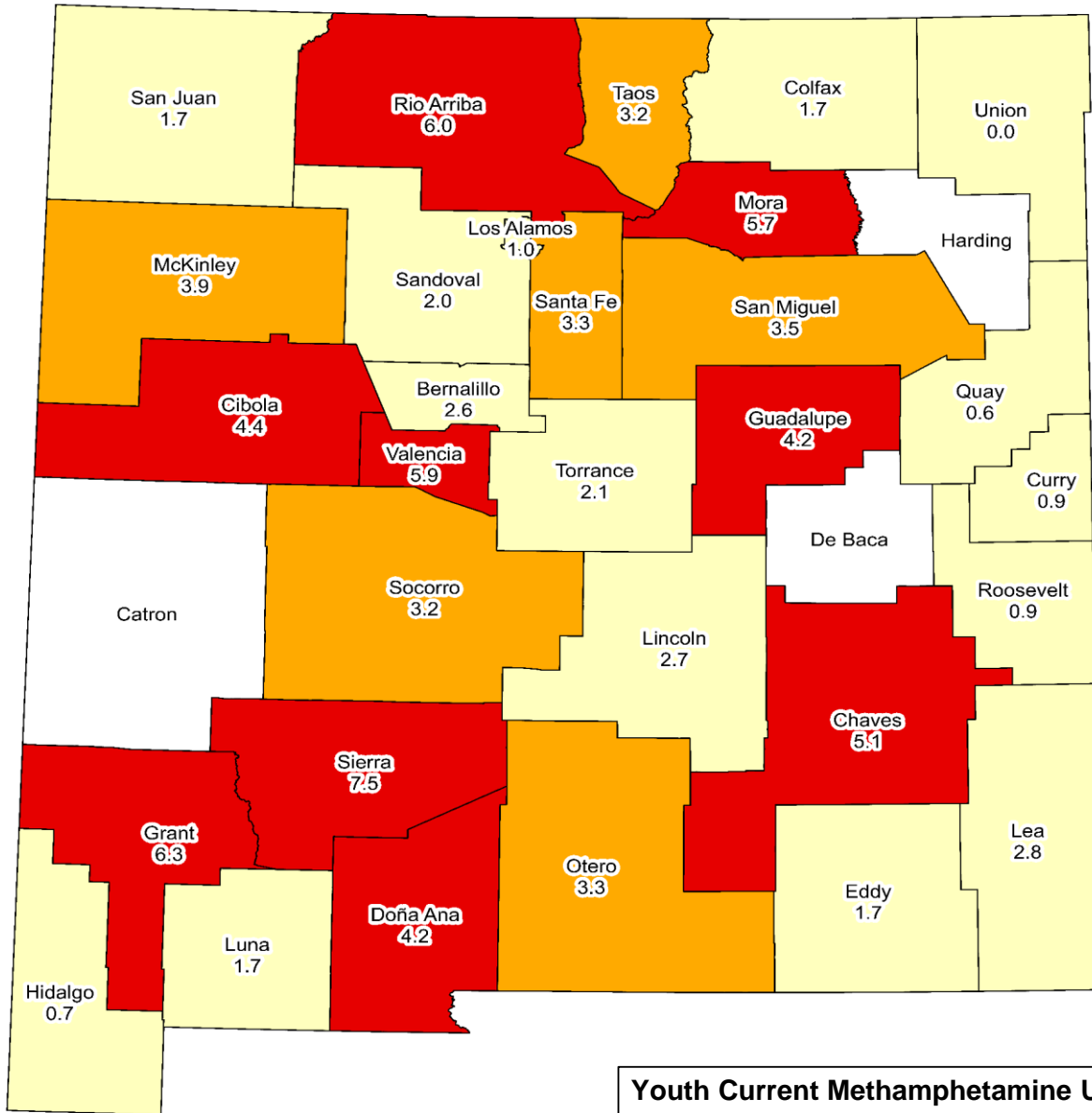


\* Estimate of percent of high school students who reported methamphetamine use at least once in the past 30 days  
De Baca, Harding, and Catron County estimates not available because of low numbers and/or low response rates

Source: YRRS (NM); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

# YOUTH METHAMPHETAMINE USE (continued)

Chart 4: Current Methamphetamine Use\* by County, Grades 9 - 12, New Mexico, 2017



\* Estimate of percent of high school students who reported methamphetamine use at least once in the past 30 days

Insufficient Data: County estimates not available because of low numbers and/or low response rates

Source: YRRS (NM); NMDOH Survey Section; SAES



# YOUTH CURRENT INHALANT USE

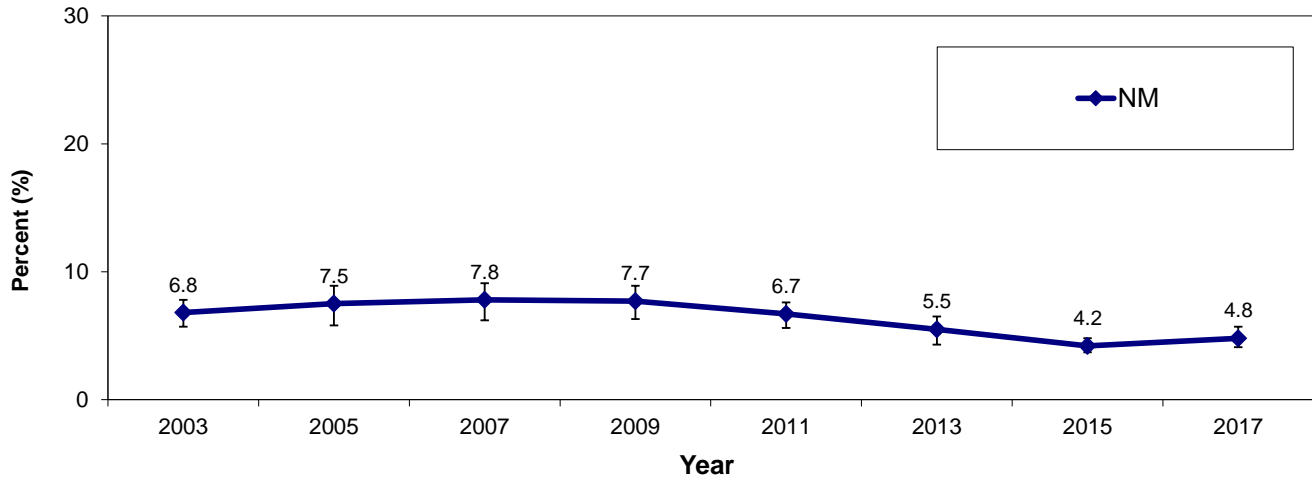
## Problem Statement

The rate of current use of inhalants (sniffing glue, breathing the contents of aerosol spray cans, or inhaling paints or sprays) was 4.8% in 2017 and has not varied significantly over recent years. There is no national comparison for current inhalant use.

Asian or Pacific Islander (11.7%) and Black (5.8%) students were more likely to use inhalants than Hispanic (4.6%), American Indian (4.9%), or White (4.4%) students. Prevalence of inhalant use was not associated with grade level. There was no statistically significant difference in prevalence of inhalant use between males (5.3%) and females (4.2%).

In 2017, the highest rates for current inhalant use were in Rio Arriba (9.1%), Grant (8.3%), and Cibola (7.5%) counties and the lowest rates in Union (0.8%), Curry (0.9%), and Roosevelt (1.1%) counties.

**Chart 1: Current Inhalant Use\* by Year, Grades 9 - 12, New Mexico and US, 2003-2017**



\* Used inhalants (sniffed glue, breathed contents of aerosol spray cans, or inhaled paints or sprays) at least one time in the past 30 days  
 Source: YRRS (NM); CDC YRBS (US); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

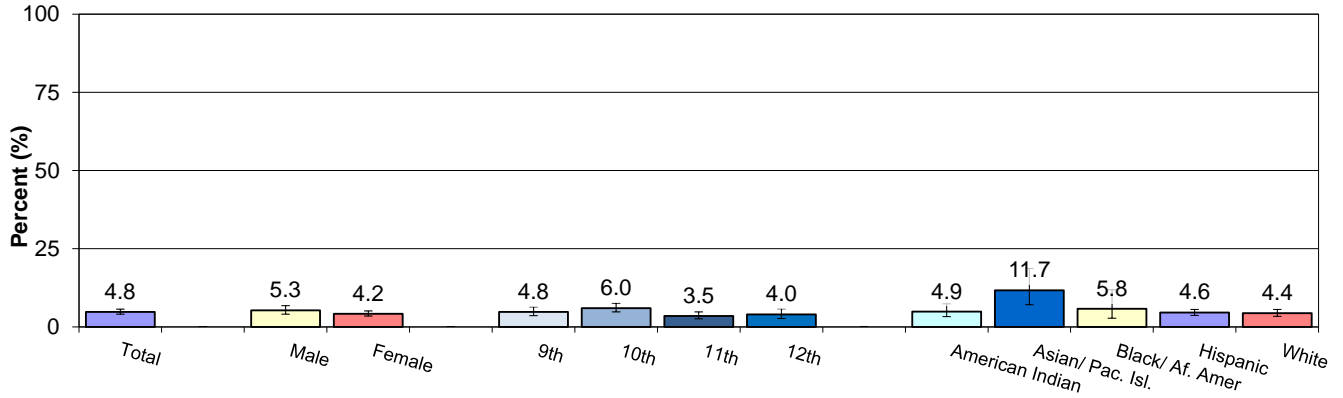
**Table 1: Current Inhalant Use, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, New Mexico, 2017**

Sex	Race/Ethnicity	9th Grade	10th Grade	11th Grade	12th Grade	All Grades
		Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]
Male	American Indian	2.4 (0.9-6.7)	3.8 (0.9-14.7)	5.0 (2.1-11.5)	2.4 (0.7-7.7)	3.3 (2.2-5.1)
	Asian/Pacific Islander	--	--	--	--	13.3 (6.9-23.9)
	Black	--	--	--	--	6.9 (3.0-14.8)
	Hispanic	4.8 (2.8-8.3)	7.6 (4.8-11.8)	2.4 (1.2-4.6)	7.2 (4.4-11.7)	5.5 (4.0-7.6)
	White	3.7 (1.3-10.0)	6.4 (3.7-10.8)	4.2 (2.4-7.3)	4.4 (1.7-10.5)	4.6 (3.2-6.7)
	Total	4.7 (2.8-7.7)	6.5 (4.9-8.7)	4.4 (3.0-6.3)	5.7 (3.4-9.1)	5.3 (4.1-6.8)
Female	American Indian	7.4 (3.4-15.3)	8.0 (2.6-22.2)	5.5 (2.5-11.4)	1.8 (0.3-9.1)	6.2 (3.8-10.0)
	Asian/Pacific Islander	--	--	--	--	9.6 (4.9-17.9)
	Black	--	--	--	--	3.0 (0.9-9.5)
	Hispanic	2.6 (1.0-6.7)	5.3 (3.3-8.5)	2.2 (0.8-5.6)	2.3 (0.8-6.5)	3.6 (2.5-5.2)
	White	5.7 (2.6-12.3)	5.0 (2.9-8.7)	2.5 (0.9-7.2)	3.0 (1.1-8.3)	4.2 (2.9-5.9)
	Total	4.6 (3.2-6.5)	5.5 (3.9-7.8)	2.7 (1.6-4.6)	2.4 (1.3-4.2)	4.2 (3.5-5.1)
Total	American Indian	5.2 (3.0-8.9)	5.7 (1.8-16.5)	5.2 (2.9-9.2)	2.1 (0.8-5.1)	4.9 (3.3-7.4)
	Asian/Pacific Islander	--	8.5 (4.6-15.4)	12.3 (4.1-31.4)	--	11.7 (7.1-18.7)
	Black	8.7 (3.3-21.1)	2.8 (0.5-14.4)	--	--	5.8 (2.8-11.9)
	Hispanic	3.9 (2.6-5.9)	6.4 (4.7-8.7)	2.3 (1.3-3.8)	4.6 (2.7-7.7)	4.6 (3.7-5.6)
	White	4.7 (2.5-8.8)	5.7 (3.7-8.6)	3.4 (1.8-6.3)	3.7 (2.1-6.5)	4.4 (3.4-5.6)
	Total	4.8 (3.6-6.4)	6.0 (4.8-7.6)	3.5 (2.6-4.8)	4.0 (2.7-5.8)	4.8 (4.1-5.7)

Source: YRRS (NM); NMDOH Survey Section (NOTE: "95% CI" is 95% confidence interval)

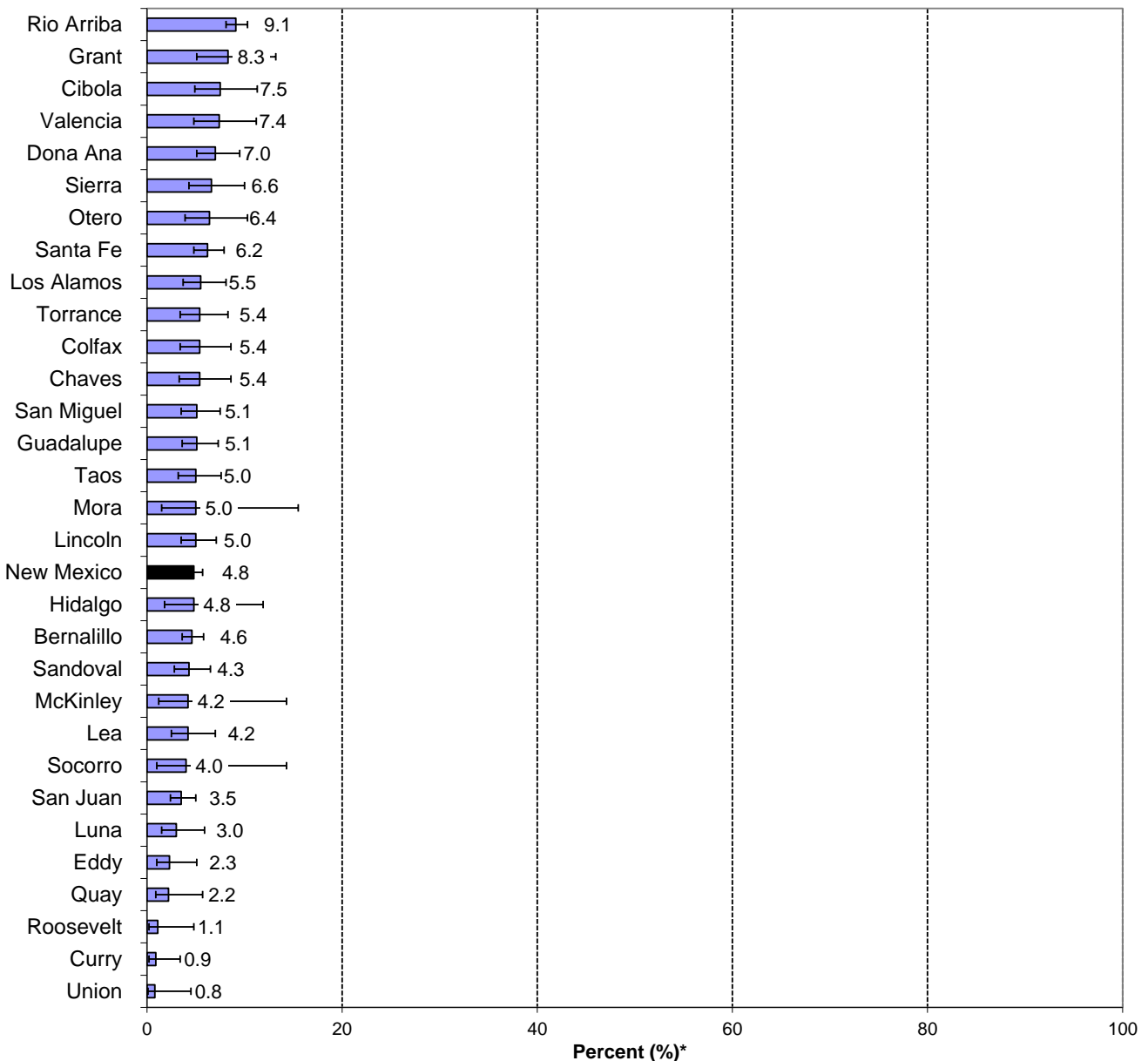
# YOUTH CURRENT INHALANT USE (continued)

Chart 2: Current Inhalant Use, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, New Mexico, 2017



Source: YRRS (NM); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

Chart 3: Current Inhalant Use\* by County, Grades 9 - 12, New Mexico, 2017



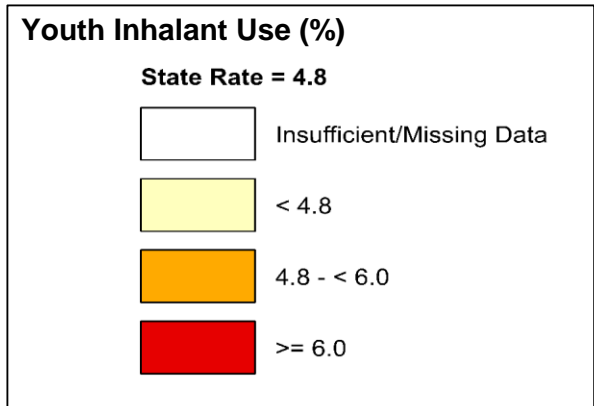
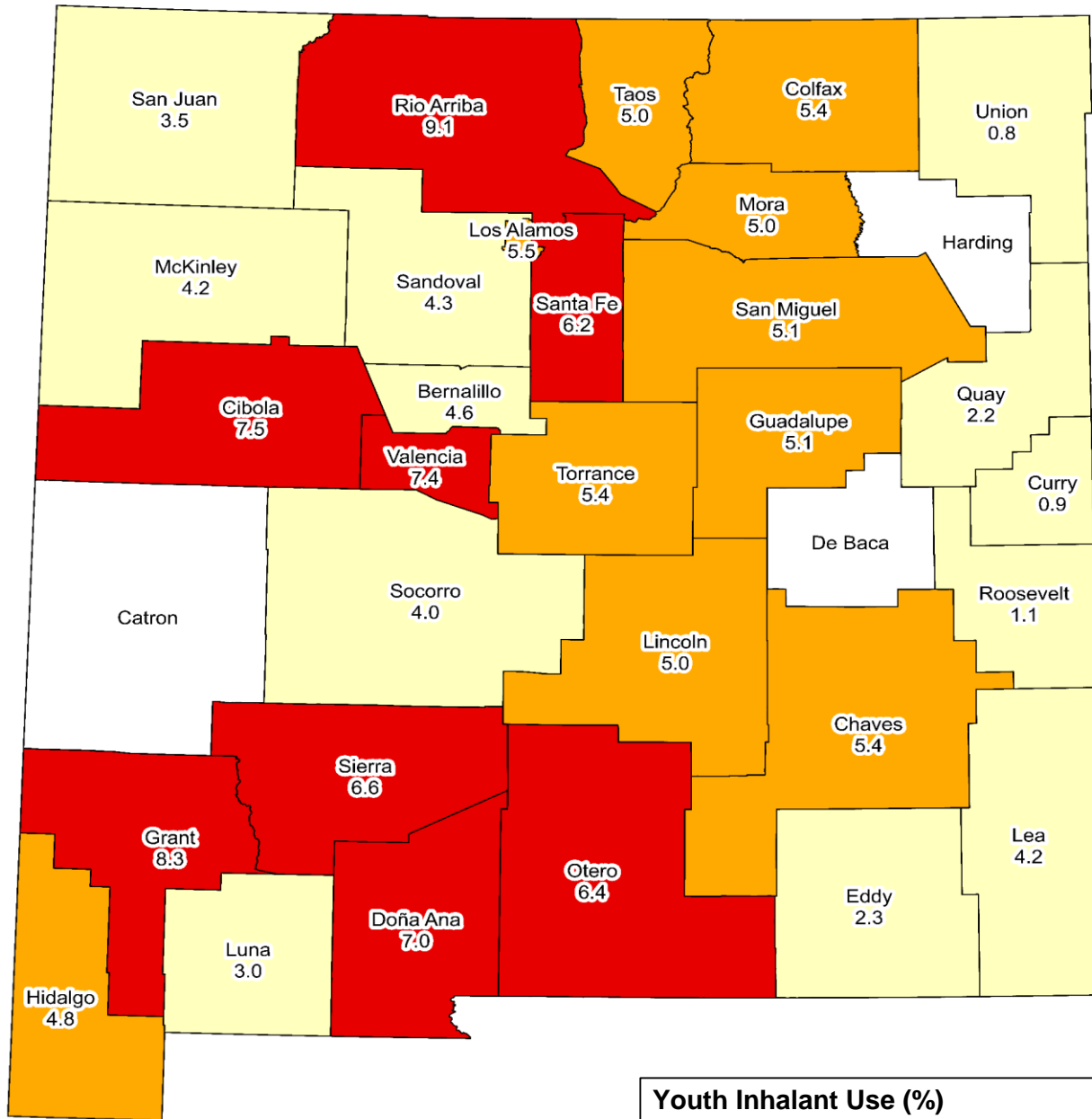
\* Estimate of percent of high school students who reported inhalant use at least once in past 30 days

De Baca, Catron, and Harding County estimates not available because of low numbers and/or low response rates

Source: YRRS (NM); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

# YOUTH CURRENT INHALANT USE (continued)

Chart 4: Current Inhalant Use\* by County, Grades 9 - 12, New Mexico, 2017



\* Estimate of percent of high school students who reported inhalant use at least once in past 30 days  
 Insufficient Data: County estimates not available because of low numbers and/or low response rates





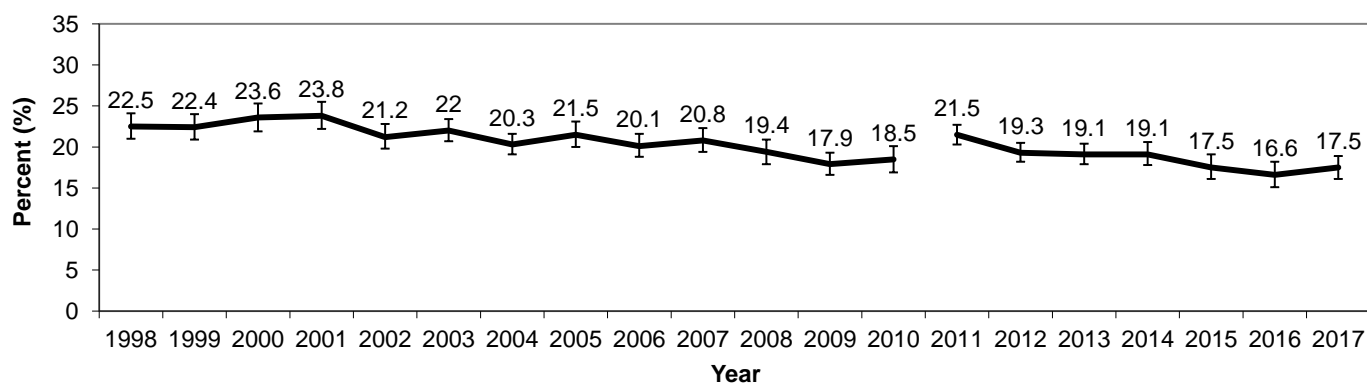
# ADULT CIGARETTE SMOKING

## Problem Statement

Adult cigarette smoking (defined as having smoked 100 or more cigarettes in lifetime, and currently smoking) is associated with significant rates of smoking-related death and morbidity. According to the CDC's Smoking Attributable Mortality, Morbidity, and Economic Costs (SAMMEC) website, smoking is responsible for a significant proportion of the deaths from numerous types of malignant neoplasms (e.g., lung, esophageal, and laryngeal cancers), from cardiovascular diseases (e.g., ischemic heart disease, cerebrovascular disease), and from several respiratory diseases (e.g., bronchitis, emphysema, chronic airway obstruction). Combined, these smoking-related deaths make smoking the leading behavioral cause of death in the US.

In 2017, current smoking rates among adults in New Mexico (17.5%) were slightly more than the US overall (17.0%). As shown in Chart 1, New Mexico's adult smoking prevalence rate has decreased since 1998. In 2017, as shown in Table 1, smoking was more prevalent among adults aged 25-64 (19.7%) than among young adults aged 18-24 (16.4%) or adults aged 65 and over (10.2%). New Mexico men were more likely to smoke than women (19.7% v 14.9%). Among males, Blacks had the highest smoking prevalence (33.6%), followed by Hispanics (21.9%) and American Indians (19.6%). Among females, the highest prevalence of smoking was among Blacks (24.6%) followed by Whites (16.3%).

**Chart 1: Cigarette Smoking (past 30 days)\*, Adults Aged 18+, New Mexico, 1998-2017**



\* Cigarette smoking definition: smoked  $\geq$  100 cigarettes in lifetime and smoked cigarettes in past 30 days

Source: BRFSS; SAES (NOTE: Brackets around reported rates are 95% confidence intervals)

**Table 1: Cigarette Smoking (past 30 days) by Age, Sex, and Race/Ethnicity, Adults Aged 18+, New Mexico, 2015-2017**

Sex	Race/Ethnicity	Number				Percent*			
		Ages 18-24	Ages 25-64	Ages 65+	All Ages	Ages 18-24	Ages 25-64	Ages 65+	All Ages*
Male	American Indian	3,353	8,410	738	12,652	31.6	18.2	9.7	19.6
	Asian/Pacific Islander	-	1,568	-	2,199	-	17.3	-	17.5
	Black	-	4,275	-	6,533	-	31.6	-	33.6
	Hispanic	11,529	59,389	7,013	78,000	19.5	24.1	13.9	21.9
	White	3,488	42,646	9,272	55,560	11.3	20.3	9.8	16.5
	Total	19,960	116,827	18,680	155,245	18.8	22.2	11.9	19.7
Female	American Indian	626	6,027	328	7,115	5.9	11.9	3.0	9.8
	Asian/Pacific Islander	-	1,823	-	1,831	-	15.7	-	11.5
	Black	-	2,603	-	3,552	-	27.2	-	24.6
	Hispanic	6,501	38,807	5,345	51,237	11.5	15.6	8.7	14.0
	White	6,025	41,698	9,627	56,644	22.8	19.6	8.9	16.3
	Total	13,511	91,937	16,238	121,633	13.8	17.2	8.7	14.9
Total	American Indian	3,750	14,394	1,100	19,690	17.7	14.9	5.9	14.4
	Asian/Pacific Islander	-	3,425	-	4,221	-	16.5	-	14.8
	Black	-	6,758	1,281	9,770	-	29.2	26.4	28.9
	Hispanic	18,071	98,122	12,339	129,154	15.6	19.8	11.0	17.9
	White	9,658	84,345	18,880	112,193	16.8	19.9	9.3	16.4
	Total	33,394	208,756	34,915	276,767	16.4	19.7	10.2	17.2

\* Estimate of percent of people in population group who have smoked  $\geq$  100 cigarettes in lifetime and who smoked cigarettes in past 30 days

- Excluded due to small number of respondents (< 50) in cell

Source: BRFSS; SAES

# ADULT CIGARETTE SMOKING (continued)

## Problem Statement (continued)

Smoking prevalence rates were highest among Black men (33.6%) while smoking-related death rates were highest among White men (145.5 per 100,000 population) and Black men (144.6 per 100,000 population). Among women, Blacks had the highest smoking prevalence rates (24.6%). However, White women had the highest smoking-related death rates (81.2 deaths per 100,000 population) followed by Blacks (68.4 deaths per 100,000 population).

As shown in Table 2 and Chart 2, the counties with the highest smoking rates were Curry (32.7%), Socorro (27.9%), Quay (26.9%), and Valencia (26.2%); these four counties had rates one and a half times higher than the national rate. The counties with the lowest rates were Los Alamos (8.3%), McKinley (10.6%), and Colfax (13.3%).

**Table 2: Cigarette Smoking (past 30 days) by Race/Ethnicity and County, Adults Aged 18+, New Mexico, 2015-2017**

County	Number						Percent*					
	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races	American Indian	Asian/Pacific Islander	Black	Hispanic	White	All Races
Bernalillo	2,544	-	-	41,825	33,429	86,811	11.5	-	-	17.3	14.4	16.5
Catron	-	-	-	-	-	689	-	-	-	-	-	21.6
Chaves	-	-	-	4,825	4,383	9,330	-	-	-	19.4	20.2	19.3
Cibola	1,851	-	-	1,893	814	4,489	23.5	-	-	23.9	17.4	21.6
Colfax	-	-	-	-	585	1,376	-	-	-	-	11.0	13.3
Curry	-	-	-	3,780	6,385	12,091	-	-	-	27.6	32.0	32.7
De Baca	-	-	-	-	-	-	-	-	-	-	-	-
Dona Ana	-	-	-	14,495	7,330	22,355	-	-	-	14.0	14.1	13.8
Eddy	-	-	-	2,542	4,704	7,650	-	-	-	13.5	21.5	18.1
Grant	-	-	-	1,247	1,771	3,157	-	-	-	11.7	15.2	13.8
Guadalupe	-	-	-	-	-	-	-	-	-	-	-	-
Harding	-	-	-	-	-	-	-	-	-	-	-	-
Hidalgo	-	-	-	-	-	-	-	-	-	-	-	-
Lea	-	-	-	3,341	4,891	8,809	-	-	-	13.2	24.0	18.2
Lincoln	-	-	-	-	2,270	3,964	-	-	-	-	20.5	24.4
Los Alamos	-	-	-	-	902	1,176	-	-	-	-	8.5	8.3
Luna	-	-	-	2,150	2,303	4,279	-	-	-	19.3	35.0	23.5
McKinley	2,469	-	-	1,557	978	5,477	6.4	-	-	24.2	17.4	10.6
Mora	-	-	-	-	-	-	-	-	-	-	-	-
Otero	302	-	-	2,144	5,376	8,509	10.6	-	-	12.6	19.6	17.0
Quay	-	-	-	-	860	1,794	-	-	-	-	23.4	26.9
Rio Arriba	-	-	-	4,743	923	6,342	-	-	-	22.3	19.9	20.9
Roosevelt	-	-	-	-	1,657	2,554	-	-	-	-	19.4	17.2
Sandoval	-	-	-	5,331	7,730	18,589	-	-	-	13.9	14.6	17.3
San Juan	4,282	-	-	3,654	7,621	15,918	12.1	-	-	22.6	18.7	17.0
San Miguel	-	-	-	4,439	388	4,649	-	-	-	25.7	8.5	20.5
Santa Fe	-	-	-	9,523	6,689	16,899	-	-	-	16.9	11.4	14.0
Sierra	-	-	-	-	1,313	1,844	-	-	-	-	19.4	19.3
Socorro	-	-	-	-	-	3,717	-	-	-	-	-	27.9
Taos	-	-	-	1,699	713	3,825	-	-	-	11.7	6.6	14.1
Torrance	-	-	-	-	-	-	-	-	-	-	-	-
Union	-	-	-	-	-	-	-	-	-	-	-	-
Valencia	-	-	-	8,535	5,013	15,179	-	-	-	25.8	23.1	26.2
New Mexico	19,690	4,221	9,770	129,154	112,193	276,767	14.4	14.8	28.9	17.9	16.4	17.2

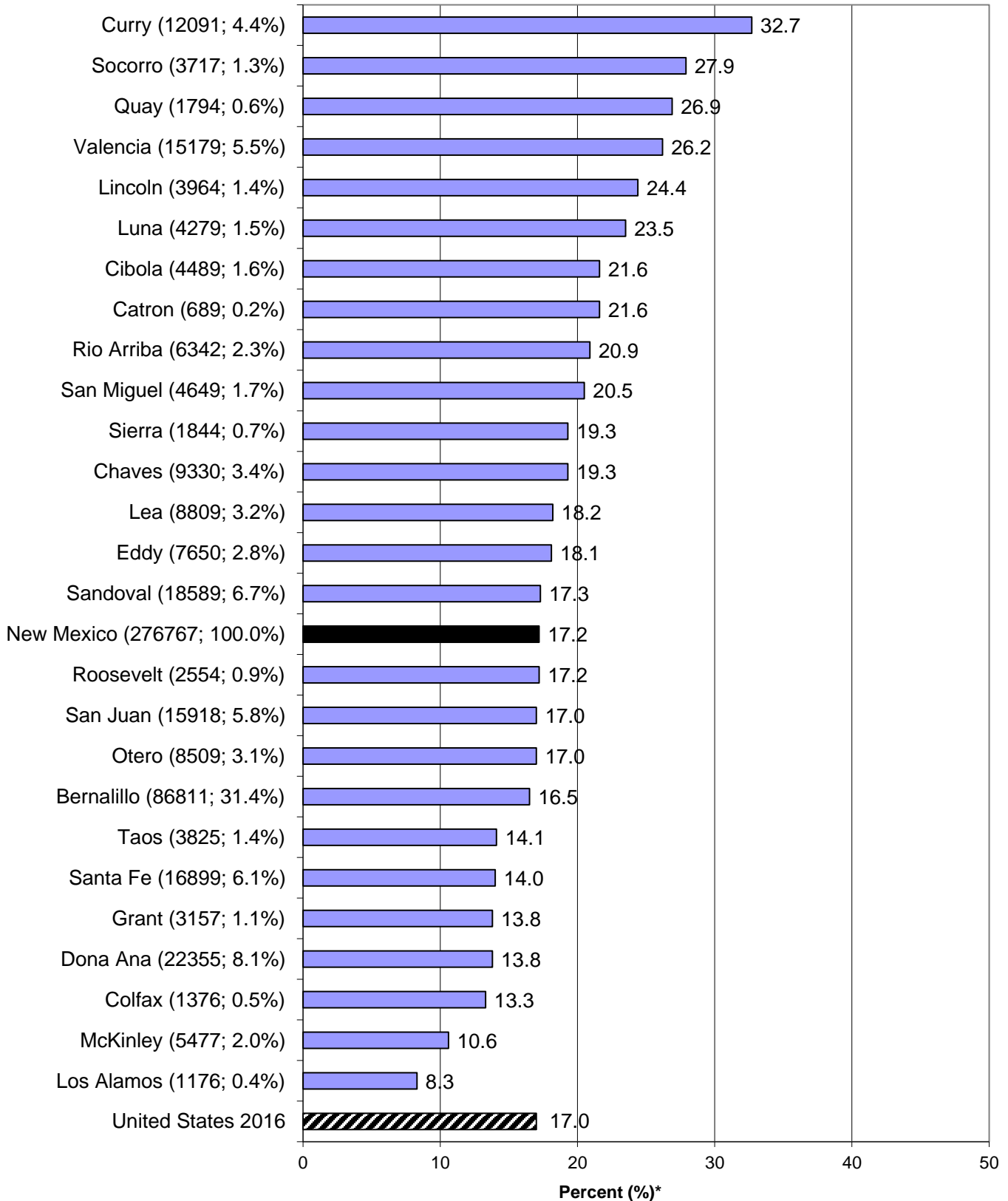
\* Estimate of percent of people in population group who have smoked >= 100 cigarettes in lifetime and who smoked cigarettes in past 30 days

- Excluded due to small number of respondents (< 50) in cell

# ADULT CIGARETTE SMOKING (continued)

Chart 2: Cigarette Smoking (past 30 days)\* by County, Adults Aged 18+, New Mexico, 2015-2017

County (# of smokers; % of statewide smokers)



\* Estimate of percent of people in population group who have smoked >= 100 cigarettes in lifetime and who smoked cigarettes in past 30 days

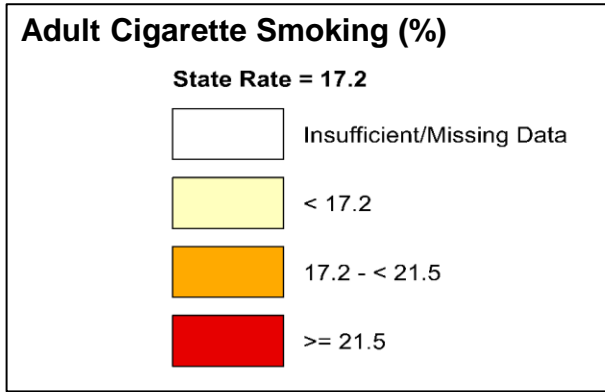
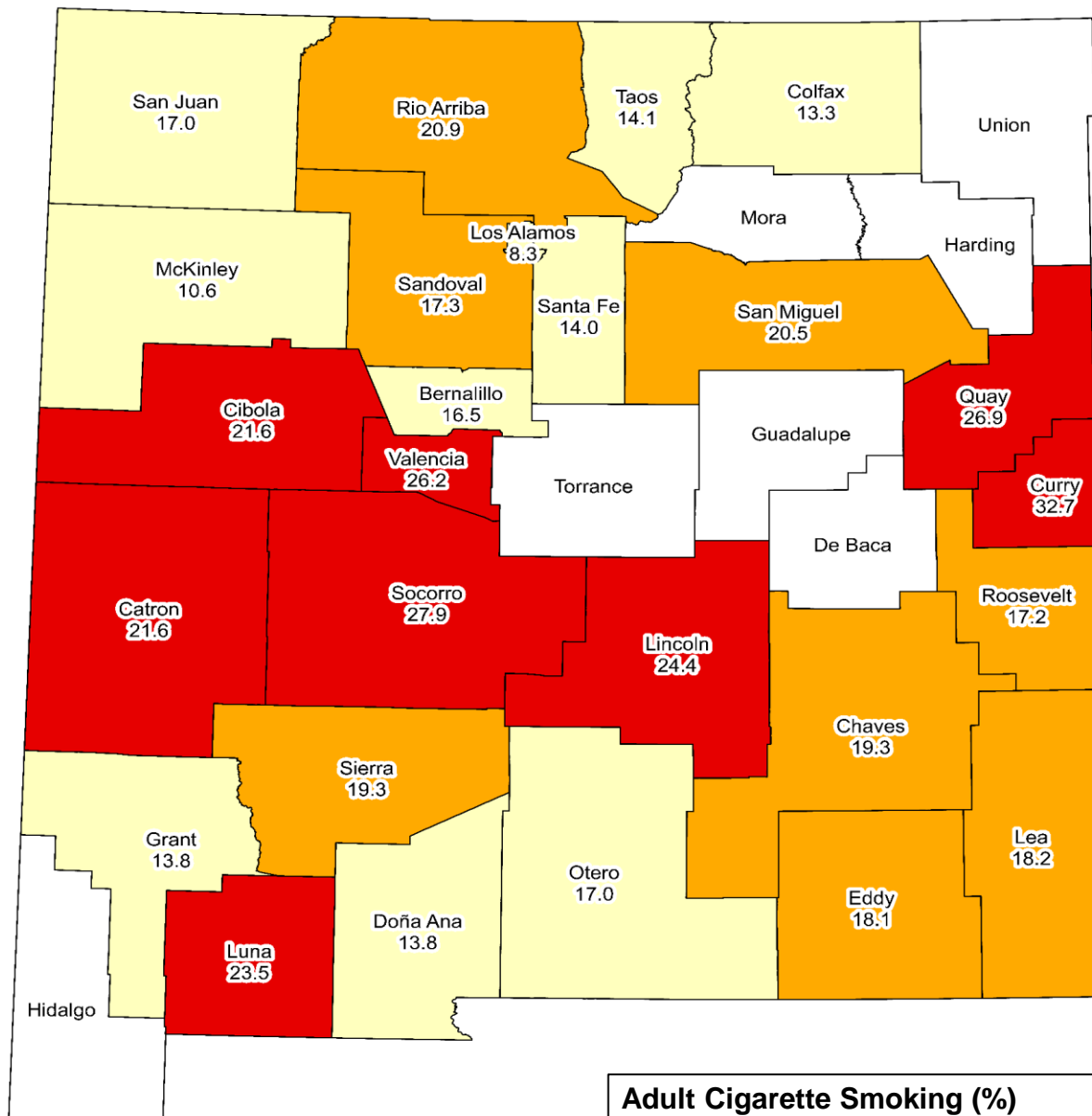
The following counties were excluded due to small number of respondents (< 50):

De Baca, Guadalupe, Harding, Hidalgo, Mora, Torrance, and Union

Source: NMBRFSS (NM); CDC BRFSS (US); SAES

# ADULT CIGARETTE SMOKING (continued)

Chart 3: Cigarette Smoking (past 30 days)\* by County, Adults Aged 18+, New Mexico, 2014-2016



\* Estimate of percent of people in population group who have smoked >= 100 cigarettes in lifetime and who smoked cigarettes in past 30 days

Insufficient data: Rate not reported due to small number of respondents (< 50) in cell

Source: BRFSS; SAES

# YOUTH CURRENT CIGARETTE SMOKING

## Problem Statement\*

Cigarette smoking is the leading cause of preventable death in the US. Cigarette smoking increases risk for several cancers and other chronic conditions. Smoking is initiated and established primarily during adolescence, with more than 80% of adult smokers first smoking before age 18.\*\*

The prevalence of current cigarette smoking among NM high school students has decreased from 30.2% in 2003 to 10.6% in 2017. This coincides with a decrease in the US rate that has occurred over the past several years. The NM rate was consistently higher than the US rate until 2011. In 2011, NM and US rates were not statistically distinguishable (US=18.1%; NM=19.9%). In 2017, the NM rate (10.6%) was higher than the US rate (8.8%).

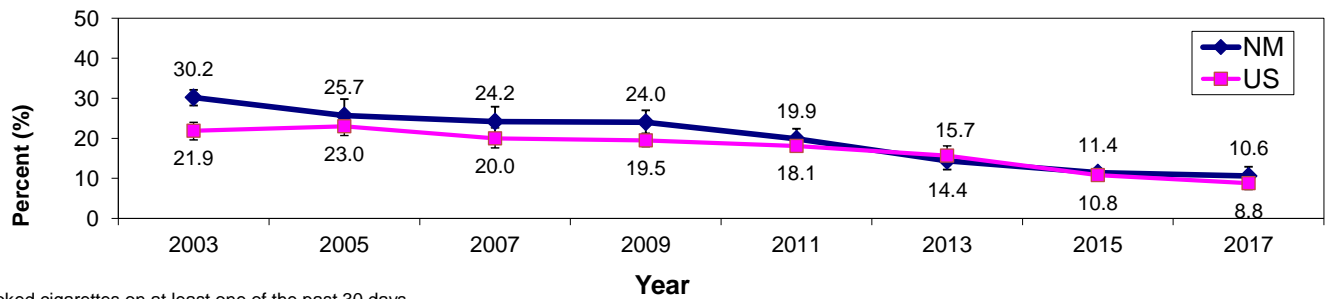
Boys (11.9%) were more likely to be current cigarette smokers than girls (9.0%). Black (8.8%), White (9.7%) and Hispanic (10.7%) students had lower rates of current cigarette smoking than American Indian (12.6%) and Asian or Pacific Islander (12.0%) students. Chart 2 shows that prevalence increased significantly with grade level. In 2017, the counties with the highest prevalence of current smoking were Rio Arriba (17.8%), Otero (17.6%), and Cibola (16.8%). The counties with the lowest prevalence of current smoking were Curry (4.2%), Sierra (7.4%), and Hidalgo (7.6%).

\* YRRS tobacco questions do not distinguish between ceremonial/traditional and commercial tobacco use.

\*\* Youth and Tobacco Use. Centers for Disease Control and Prevention.

[https://www.cdc.gov/tobacco/data\\_statistics/fact\\_sheets/youth\\_data/tobacco\\_use/index.htm](https://www.cdc.gov/tobacco/data_statistics/fact_sheets/youth_data/tobacco_use/index.htm)

**Chart 1: Current Cigarette Smoking\* by Year, Grades 9 - 12, New Mexico and US, 2003-2017**



\* Smoked cigarettes on at least one of the past 30 days

Source: YRRS (NM); CDC YRBS (US); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

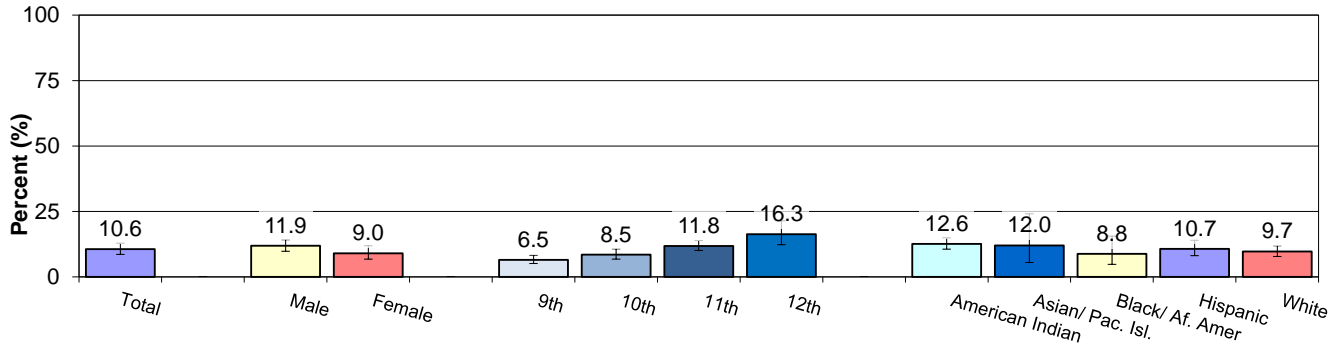
**Table 1: Current Cigarette Smoking, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, New Mexico, 2017**

Sex	Race/Ethnicity	9th Grade	10th Grade	11th Grade	12th Grade	All Grades
		Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]
Male	American Indian	11.7 (6.1-21.4)	11.1 (8.0-15.1)	13.9 (7.9-23.1)	22.2 (15.8-30.4)	13.9 (11.1-17.3)
	Asian/Pacific Islander	--	--	--	--	10.8 (3.7-27.8)
	Black	--	--	--	--	11.6 (5.7-21.9)
	Hispanic	7.1 (4.4-11.4)	10.9 (7.5-15.7)	12.4 (9.0-16.9)	20.6 (14.9-27.9)	12.3 (9.6-15.7)
	White	5.1 (2.7-9.7)	9.0 (5.3-14.8)	14.3 (10.4-19.4)	14.8 (11.1-19.6)	10.5 (8.3-13.3)
	Total	7.3 (4.9-10.6)	10.1 (7.7-13.2)	13.2 (11.3-15.3)	18.8 (14.6-23.9)	11.9 (9.8-14.2)
Female	American Indian	8.3 (3.9-16.8)	8.9 (3.8-19.7)	12.4 (5.8-24.7)	12.8 (8.4-19.0)	10.2 (7.4-13.9)
	Asian/Pacific Islander	--	--	--	--	13.5 (5.7-29.0)
	Black	--	--	--	--	3.8 (1.5-9.5)
	Hispanic	4.9 (2.2-10.7)	7.5 (4.9-11.3)	10.9 (6.0-19.2)	13.0 (7.8-21.0)	9.1 (6.1-13.4)
	White	5.0 (2.5-9.8)	5.7 (3.2-10.0)	9.4 (5.2-16.4)	16.4 (10.6-24.5)	8.8 (6.2-12.3)
	Total	5.3 (3.6-7.8)	7.0 (5.0-9.6)	10.5 (7.9-13.8)	13.8 (9.4-19.8)	9.0 (6.8-11.9)
Total	American Indian	10.7 (6.0-18.1)	10.2 (6.6-15.3)	13.4 (7.8-22.1)	17.5 (15.1-20.1)	12.6 (10.6-14.9)
	Asian/Pacific Islander	--	9.4 (3.2-24.4)	--	--	12.0 (5.5-24.1)
	Black	7.4 (1.7-26.8)	5.6 (1.4-19.8)	--	--	8.8 (4.8-15.6)
	Hispanic	6.2 (4.5-8.5)	9.1 (6.9-11.8)	11.6 (8.3-16.0)	16.6 (11.5-23.3)	10.7 (8.1-14.0)
	White	5.1 (3.1-8.1)	7.4 (5.3-10.1)	11.9 (9.1-15.5)	15.6 (11.5-20.8)	9.7 (7.8-11.9)
	Total	6.5 (5.1-8.3)	8.5 (6.8-10.7)	11.8 (10.1-13.9)	16.3 (12.3-21.4)	10.6 (8.6-12.9)

Source: YRRS (NM); NMDOH Survey Section (NOTE: "95% CI" is 95% confidence interval)

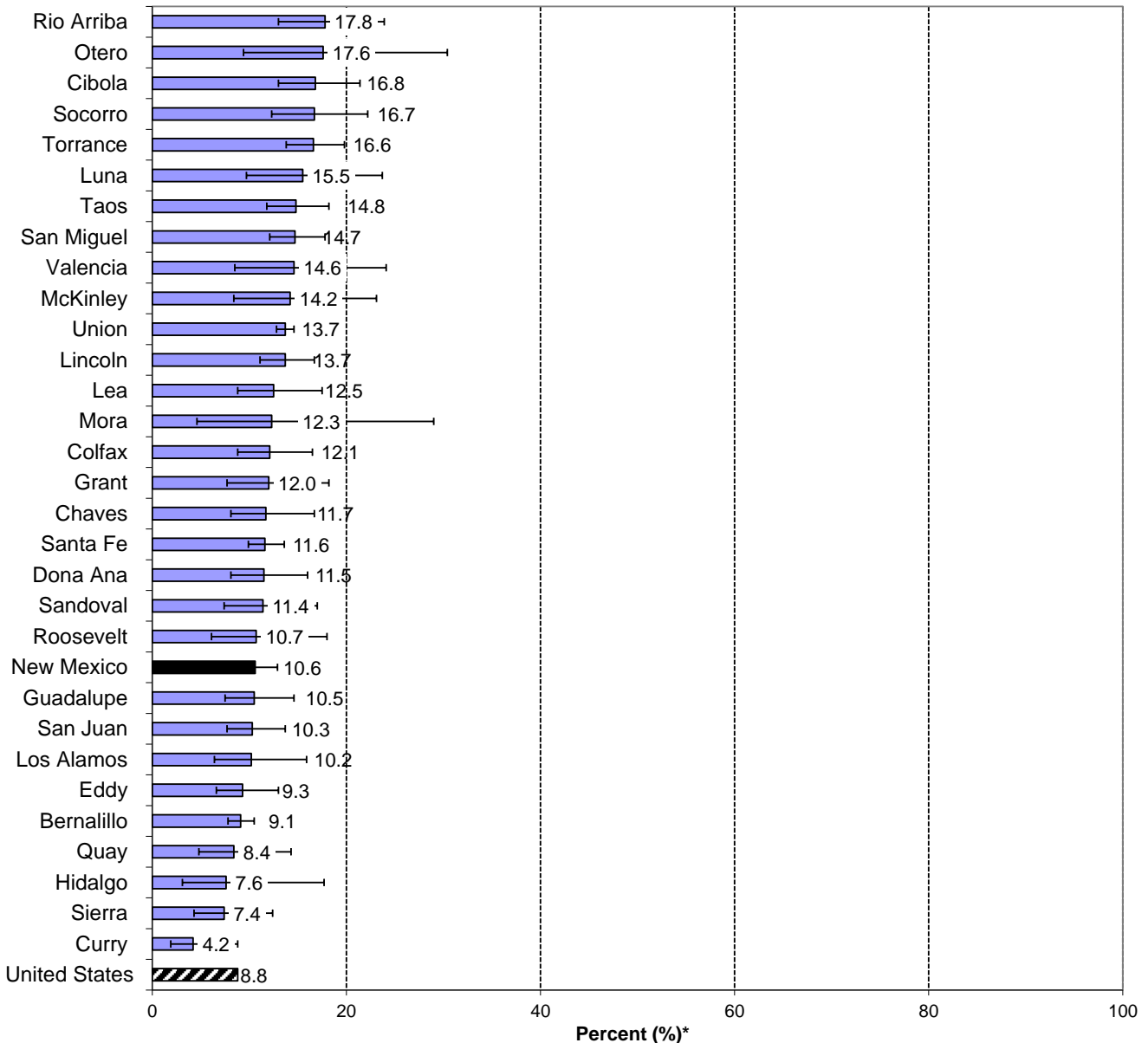
# YOUTH CURRENT CIGARETTE SMOKING (continued)

Chart 2: Current Cigarette Smoking, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, New Mexico, 2017



Source: YRRS (NM); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

Chart 3: Current Cigarette Smoking\* by County, Grades 9 - 12, New Mexico, 2017

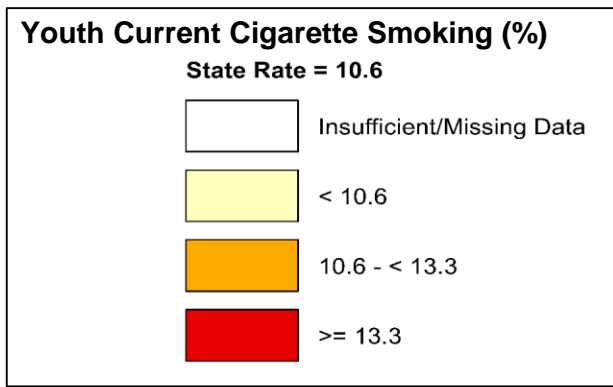
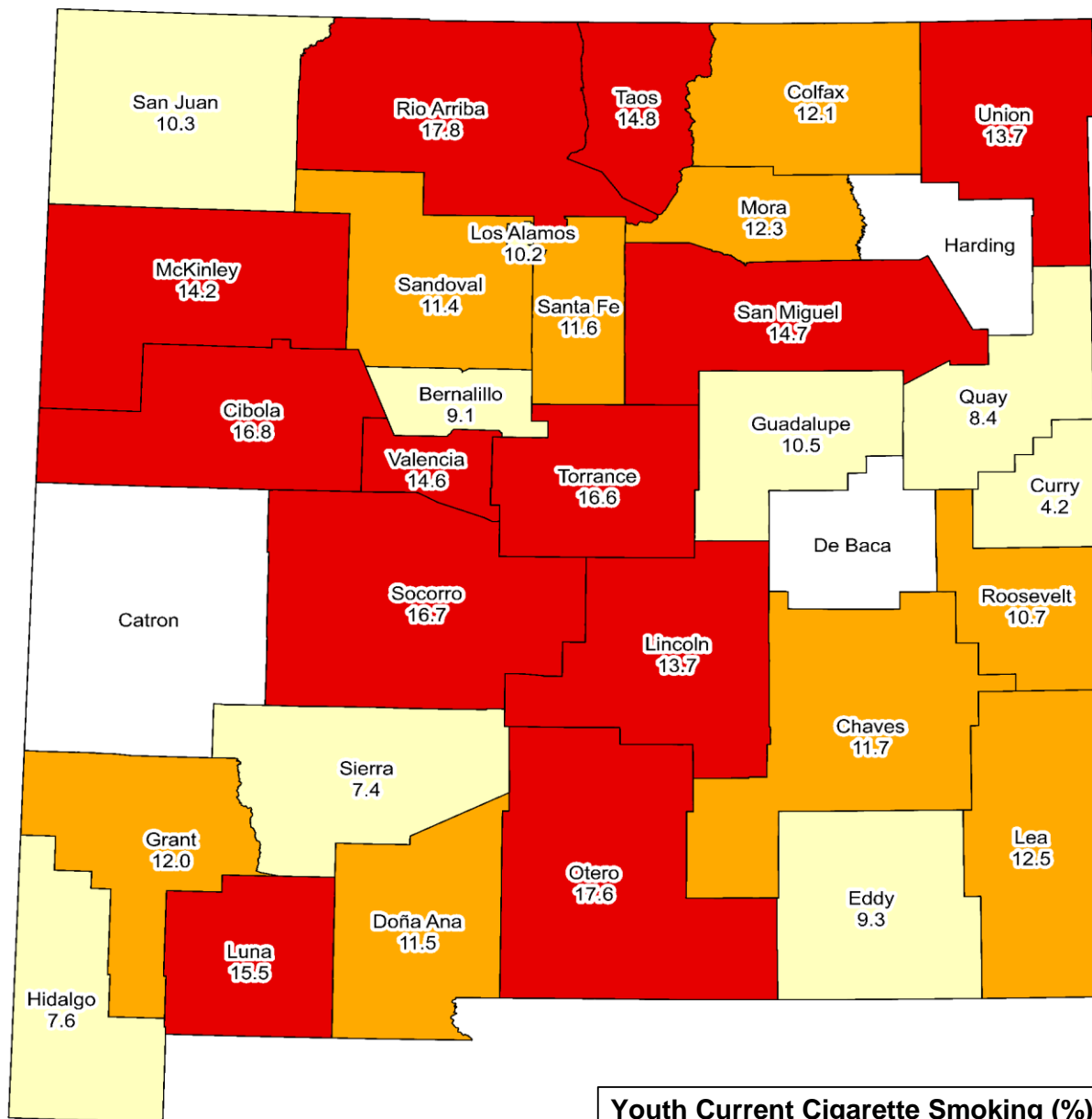


\* Estimate of percent of high school students who reported smoking cigarettes on at least one of the past 30 days  
 De Baca, Catron, and Harding County estimates not available because of low numbers and/or low response rates

Source: YRRS (NM); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

# YOUTH CURRENT CIGARETTE SMOKING (continued)

Chart 4: Current Cigarette Smoking\* by County, Grades 9 - 12, New Mexico, 2017



\* Estimate of percent of high school students who reported smoking cigarettes on at least one of the past 30 days

Insufficient Data: County estimates not available because of low numbers and/or low response rates

Source: YRRS (NM); NMDOH Survey Section; SAES





# YOUTH FREQUENT CIGARETTE SMOKING

## Problem Statement\*

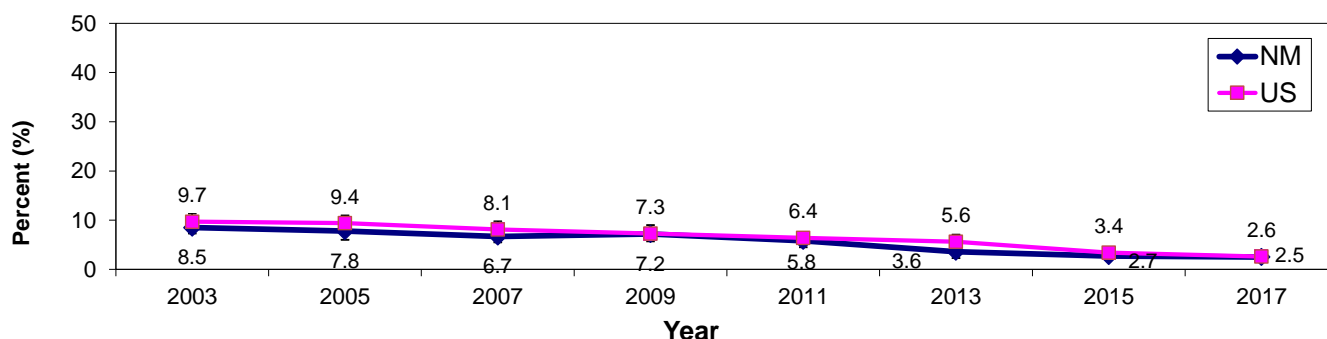
Frequent cigarette smoking means smoking cigarettes on at least 20 of the past 30 days. The prevalence of frequent cigarette smoking among New Mexico high school students has decreased from 8.5% in 2003 to 2.5% in 2017. This coincides with a decrease in the US rate of frequent smoking over the past several years. In 2017, the New Mexico prevalence of frequent smoking was not statistically different from the US rate (2.6%).

Boys (3.0%) were more likely to be frequent smokers than girls (1.9%). Asian or Pacific Islander (5.3%) students had a higher prevalence of frequent smoking than students of other race/ethnicities, but these differences were not statistically significant. The prevalence of frequent smoking increased with grade level (9th=0.9%; 10th=2.0%; 11th=2.9%; 12th=4.4%), but these rates were also not statistically different.

In 2017, the highest rates for frequent cigarette smoking were in Luna (6.2%), Otero (5.1%), and Roosevelt (5.0%) counties. The lowest rates were in McKinley (0.1%), Hidalgo (0.7%), and Curry (1.0%) counties.

\* YRRS tobacco questions do not distinguish between ceremonial/traditional and commercial tobacco use.

**Chart 1: Frequent Cigarette Smoking\* by Year, Grades 9 - 12, New Mexico and US, 2003-2017**



\* Smoked cigarettes on at least 20 of the past 30 days

Source: YRRS (NM); CDC YRBS (US); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

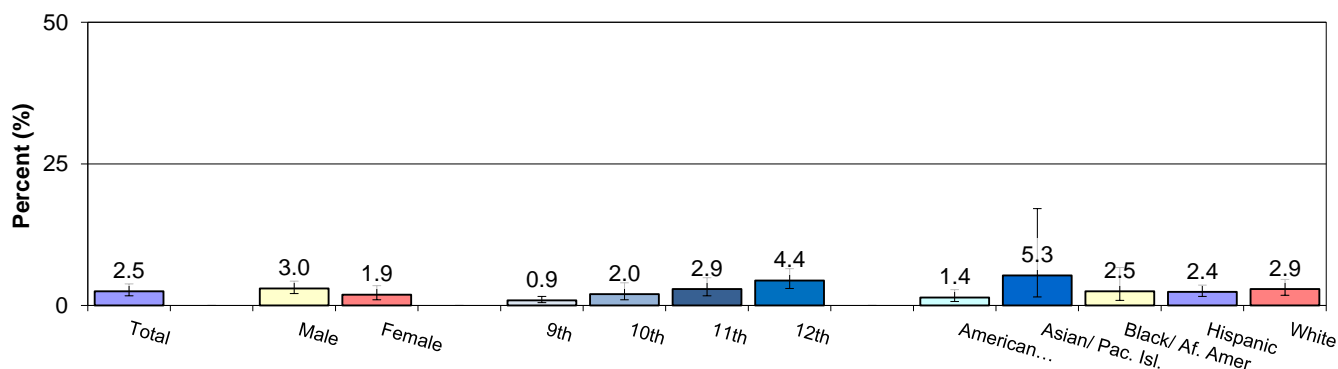
**Table 1: Frequent Cigarette Smoking, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, New Mexico, 2017**

Sex	Race/Ethnicity	9th Grade	10th Grade	11th Grade	12th Grade	All Grades
		Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]	Percent [95% CI]
Male	American Indian	1.3 (0.4-4.1)	1.2 (0.3-4.9)	1.5 (0.4-5.1)	5.5 (2.1-13.6)	2.1 (1.0-4.3)
	Asian/Pacific Islander	--	--	--	--	4.8 (1.1-19.0)
	Black	--	--	--	--	2.6 (0.7-9.3)
	Hispanic	0.9 (0.3-3.0)	3.4 (1.2-9.7)	2.8 (1.5-5.1)	4.7 (2.6-8.4)	2.8 (1.6-5.0)
	White	0.5 (0.1-3.9)	2.7 (0.8-8.1)	4.4 (2.4-7.9)	7.1 (4.2-11.8)	3.5 (2.2-5.5)
	Total	1.0 (0.4-2.1)	2.8 (1.2-6.1)	3.0 (1.9-4.5)	6.0 (4.2-8.7)	3.0 (2.1-4.3)
Female	American Indian	1.0 (0.1-7.4)	0.0 (-.)	1.6 (0.2-11.2)	0.0 (-.)	0.7 (0.2-2.9)
	Asian/Pacific Islander	--	--	--	--	6.0 (1.1-26.2)
	Black	--	--	--	--	0.8 (0.1-5.7)
	Hispanic	0.4 (0.1-1.4)	1.8 (0.7-4.9)	2.9 (0.9-9.0)	2.3 (0.9-5.8)	1.9 (1.0-3.6)
	White	0.8 (0.1-5.7)	1.2 (0.3-5.6)	3.5 (1.3-8.9)	4.0 (1.5-10.1)	2.3 (1.2-4.5)
	Total	0.6 (0.2-1.8)	1.3 (0.7-2.6)	2.9 (1.1-7.0)	2.7 (1.2-5.9)	1.9 (1.0-3.5)
Total	American Indian	1.2 (0.4-3.2)	0.7 (0.2-2.7)	1.5 (0.5-4.8)	2.7 (1.1-6.4)	1.4 (0.7-2.8)
	Asian/Pacific Islander	--	2.8 (0.3-19.3)	--	--	5.3 (1.5-17.1)
	Black	2.2 (0.4-12.3)	0.0 (-.)	--	--	2.5 (0.9-6.7)
	Hispanic	0.9 (0.4-2.2)	2.6 (1.2-5.3)	2.8 (1.6-5.1)	3.4 (2.4-5.0)	2.4 (1.6-3.6)
	White	0.6 (0.1-2.8)	2.0 (0.9-4.4)	4.0 (2.1-7.4)	5.6 (3.2-9.6)	2.9 (1.8-4.6)
	Total	0.9 (0.5-1.6)	2.0 (1.0-4.0)	2.9 (1.7-4.9)	4.4 (3.0-6.5)	2.5 (1.7-3.8)

Source: YRRS (NM); NMDOH Survey Section (NOTE: "95% CI" is 95% confidence interval, 95% CIs are not calculated for zero rates)

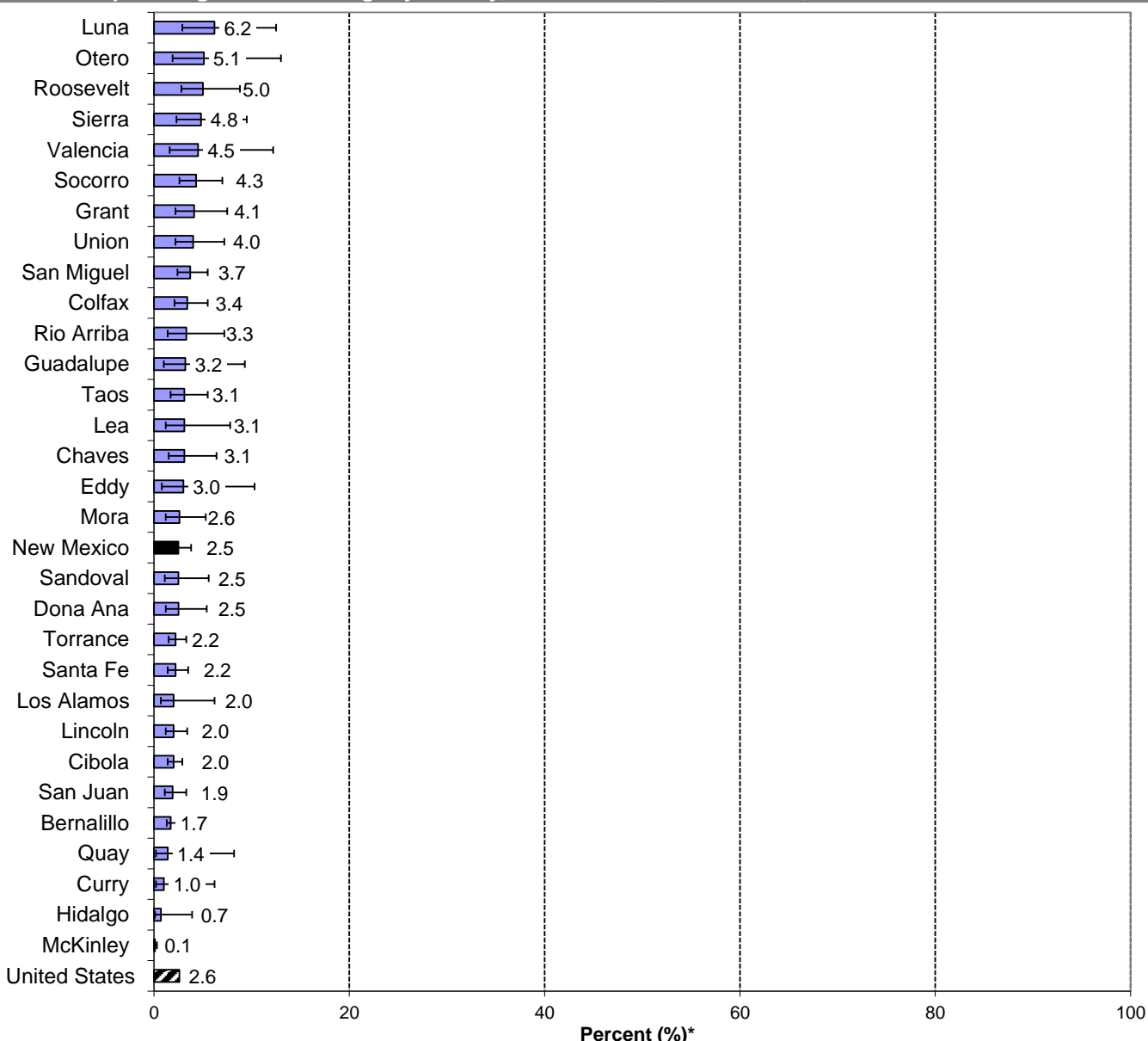
# YOUTH FREQUENT CIGARETTE SMOKING (continued)

Chart 2: Frequent Cigarette Smoking, by Grade Level, Gender, and Race/Ethnicity, Grades 9 - 12, New Mexico, 2017



Source: YRRS (NM); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

Chart 3: Frequent Cigarette Smoking\* by County, Grades 9 - 12, New Mexico, 2017

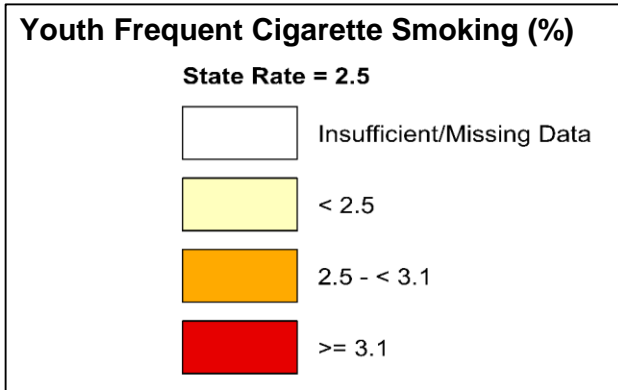
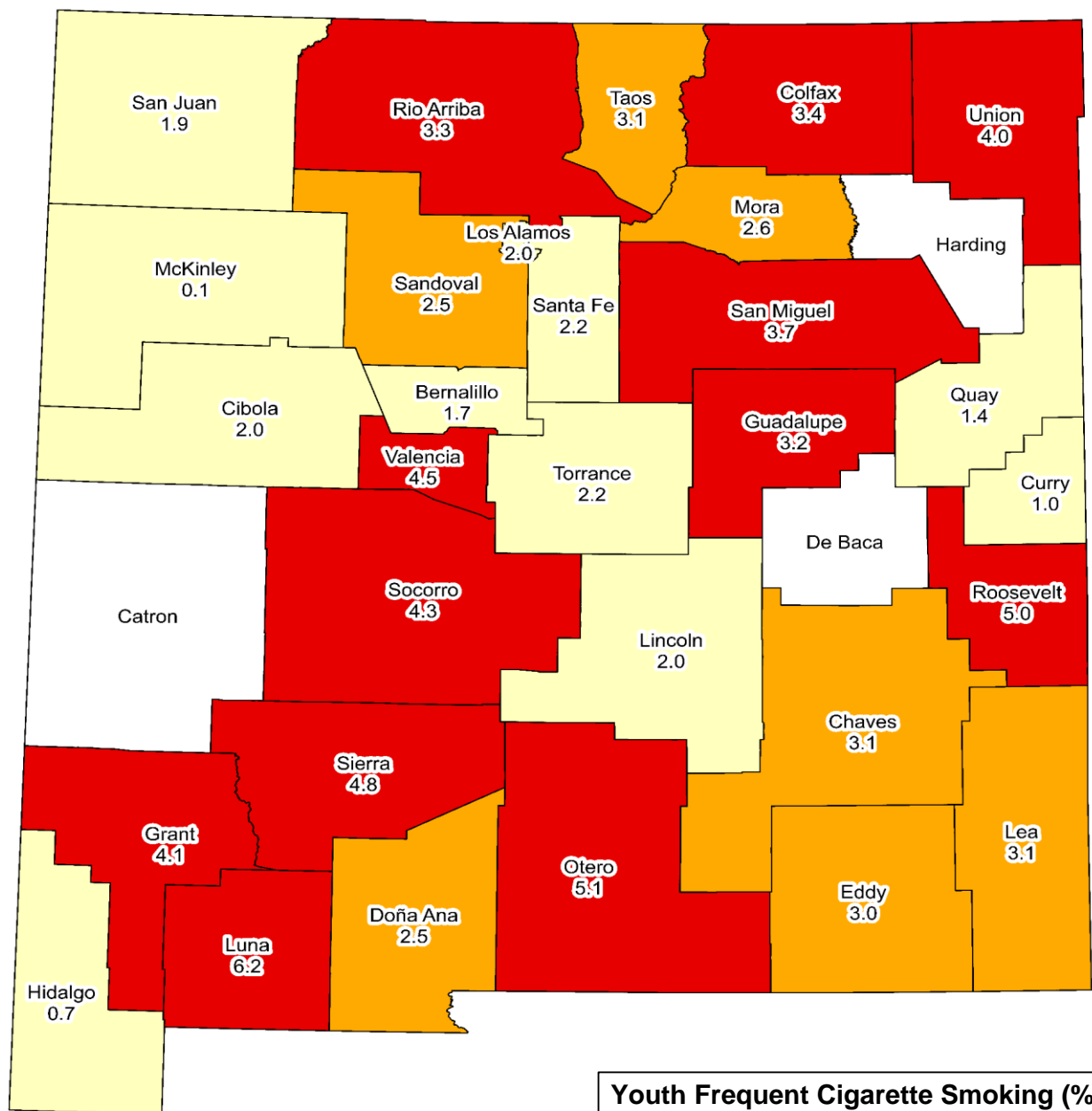


\* Estimate of percent of high school students who reported smoking cigarettes on at least 20 of the past 30 days  
 De Baca, Catron, and Harding County estimates not available because of low numbers and/or low response rates

Source: YRRS (NM); NMDOH Survey Section (NOTE: Brackets around reported rates are 95% confidence intervals)

# YOUTH FREQUENT CIGARETTE SMOKING (continued)

Chart 4: Frequent Cigarette Smoking\* by County, Grades 9 - 12, New Mexico, 2017



\* Estimate of percent of high school students who reported smoking cigarettes on at least 20 of the past 30 days

Insufficient Data: County estimates not available because of low numbers and/or low response rates

Source: YRRS (NM); NMDOH Survey Section; SAES



## **Appendix 1**

### **State Population by Age, Sex, Race/Ethnicity, and County**



## Appendix 1: Male Population, New Mexico, 2015\*

Sex	County Name	Race/Ethnicity																							
		White				Black				Hispanic				American Indian				Asian/Pacific Islander				All Race/Ethnicities			
		0-24	25-64	65+	All Ages	0-24	25-64	65+	All Ages	0-24	25-64	65+	All Ages	0-24	25-64	65+	All Ages	0-24	25-64	65+	All Ages	0-24	25-64	65+	All Ages
Male	Bernalillo	30,934	76,783	27,324	135,041	3,899	5,901	1,029	10,829	68,164	82,169	14,092	164,425	5,399	7,385	829	13,614	2,605	5,147	887	8,639	111,002	177,385	44,161	332,547
	Catron	227	574	626	1,427	5	21	3	29	86	175	116	376	14	21	16	51	0	2	0	2	333	792	761	1,885
	Chaves	3,703	6,630	2,855	13,188	260	300	60	621	8,511	8,380	1,513	18,404	147	158	27	333	126	146	12	284	12,748	15,614	4,468	32,830
	Cibola	613	1,506	703	2,823	60	103	19	183	1,846	3,404	548	5,799	2,120	2,512	527	5,159	27	39	8	75	4,668	7,564	1,806	14,038
	Colfax	569	1,478	999	3,046	26	33	5	64	1,118	1,618	525	3,262	24	73	13	110	11	24	1	36	1,748	3,226	1,544	6,518
	Curry	4,610	6,789	1,860	13,260	783	812	106	1,701	5,199	4,802	630	10,631	89	73	21	183	179	197	27	403	10,861	12,672	2,645	26,178
	De Baca	116	266	143	526	3	6	0	9	152	158	77	387	5	3	3	11	0	1	0	1	277	434	224	934
	Dona Ana	8,982	14,281	7,720	30,984	791	1,130	184	2,104	33,385	31,076	6,494	70,955	403	421	91	915	480	639	95	1,214	44,041	47,547	14,585	106,173
	Eddy	4,146	7,538	2,433	14,117	189	285	53	526	5,901	6,694	1,125	13,720	144	172	32	348	64	110	21	194	10,443	14,799	3,664	28,906
	Grant	1,372	3,065	2,324	6,762	80	67	12	160	2,868	3,200	1,139	7,207	48	76	26	150	54	35	14	103	4,422	6,444	3,516	14,381
	Guadalupe	72	271	81	425	7	58	0	66	623	1,025	310	1,958	11	37	4	52	1	19	0	21	716	1,411	395	2,522
	Harding	30	92	68	189	0	5	0	5	40	75	48	162	1	0	0	1	0	0	0	0	70	171	116	357
	Hidalgo	210	428	264	903	15	3	3	22	510	651	185	1,346	2	4	3	9	5	10	1	17	743	1,097	456	2,296
	Lea	3,908	7,269	2,168	13,344	574	843	121	1,536	10,079	9,967	1,034	21,079	112	195	29	336	70	128	16	213	14,741	18,401	3,367	36,509
	Lincoln	1,168	2,928	2,202	6,298	25	47	11	83	1,248	1,541	389	3,178	125	104	14	244	11	21	11	43	2,578	4,641	2,628	9,847
	Los Alamos	1,831	3,606	1,305	6,742	35	49	10	95	638	747	109	1,494	25	49	8	83	188	376	56	621	2,717	4,829	1,489	9,035
	Luna	771	1,687	1,435	3,893	50	78	19	147	3,658	3,583	918	8,159	22	39	19	81	21	44	11	77	4,522	5,430	2,403	12,356
	McKinley	808	1,930	779	3,517	142	134	29	304	2,719	2,243	531	5,493	11,665	12,891	2,077	26,633	122	157	16	296	15,456	17,355	3,431	36,242
	Mora	57	198	168	423	4	5	6	15	571	985	405	1,960	2	5	5	12	1	4	2	7	635	1,197	587	2,418
	Otero	4,780	8,736	3,824	17,341	597	689	149	1,435	5,748	5,617	1,078	12,443	937	945	124	2,006	168	222	20	410	12,230	16,209	5,196	33,635
	Quay	448	997	676	2,121	33	40	9	82	711	877	281	1,869	13	30	7	50	20	23	8	52	1,226	1,966	982	4,174
	Rio Arriba	405	1,341	833	2,578	42	57	11	110	4,872	7,105	2,086	14,063	1,051	1,379	259	2,689	22	33	7	63	6,393	9,915	3,196	19,503
	Roosevelt	1,893	2,469	882	5,243	150	106	11	267	2,013	1,754	266	4,033	55	32	11	99	87	39	2	129	4,199	4,400	1,173	9,771
	San Juan	7,032	13,889	4,593	25,514	264	320	32	616	6,269	5,866	928	13,063	10,198	12,196	1,967	24,361	139	208	25	373	23,901	32,480	7,545	63,926
	San Miguel	487	1,233	795	2,516	144	105	12	262	3,623	5,617	1,709	10,948	59	55	10	124	77	44	13	134	4,391	7,055	2,539	13,985
	Sandoval	7,702	16,574	6,859	31,135	621	918	159	1,699	10,714	12,923	2,214	25,852	3,654	4,103	617	8,374	333	514	106	954	23,026	35,032	9,956	68,014
	Santa Fe	4,939	16,090	9,544	30,573	232	536	94	862	13,867	19,667	4,199	37,733	651	1,006	198	1,854	293	568	118	979	19,982	37,867	14,153	72,001
	Sierra	584	1,593	1,682	3,859	21	24	11	57	667	783	264	1,714	19	47	22	89	3	11	10	24	1,295	2,458	1,990	5,743
	Socorro	957	1,531	779	3,267	49	76	7	132	1,690	2,062	586	4,337	473	446	76	995	34	44	9	87	3,202	4,159	1,457	8,818
	Taos	933	2,898	1,848	5,679	39	66	17	122	3,132	4,772	1,549	9,453	303	485	140	928	28	57	8	94	4,435	8,278	3,563	16,276
	Torrance	1,014	2,224	1,058	4,296	58	112	16	186	1,338	1,761	409	3,508	73	111	30	214	21	18	6	46	2,504	4,226	1,520	8,250
	Union	316	684	269	1,269	14	69	2	85	334	653	99	1,085	8	29	1	39	2	14	2	18	674	1,450	373	2,496
	Valencia	3,073	6,917	3,033	13,023	170	350	96	616	9,260	11,323	2,476	23,060	525	748	126	1,399	93	94	17	204	13,121	19,432	5,748	38,302
	Male Total	98,691	214,498	92,132	405,321	9,384	13,347	2,300	25,030	211,558	243,269	48,333	503,159	38,379	45,832	7,334	91,545	5,290	8,988	1,534	15,812	363,301	525,934	151,632	1,040,867

\* 2015 population is reported here because 2015 was the mid-point year for the 2013-2017 timeframe used in this report

SOURCE: University of New Mexico Geospatial and Population Studies





## Appendix 1: Female Population, New Mexico, 2015\*

Sex	County Name	Race/Ethnicity																							
		White				Black				Hispanic				American Indian				Asian/Pacific Islander				All Race/Ethnicities			
		0-24	25-64	65+	All Ages	0-24	25-64	65+	All Ages	0-24	25-64	65+	All Ages	0-24	25-64	65+	All Ages	0-24	25-64	65+	All Ages	0-24	25-64	65+	All Ages
Female	Bernalillo	28,976	77,792	33,298	140,067	3,362	4,474	1,043	8,880	66,211	86,620	18,766	171,597	5,466	8,754	1,323	15,543	2,653	6,284	1,245	10,181	106,668	183,923	55,676	346,267
	Catron	213	599	502	1,315	7	7	3	18	86	129	97	313	21	26	11	58	3	3	2	8	331	765	616	1,712
	Chaves	3,280	6,933	3,572	13,785	214	240	81	535	8,132	8,533	1,697	18,363	81	138	44	264	84	174	36	294	11,792	16,018	5,430	33,241
	Cibola	560	1,488	751	2,799	56	84	14	154	1,706	2,248	687	4,641	2,187	2,850	800	5,838	25	45	9	80	4,536	6,715	2,261	13,511
	Colfax	511	1,543	1,032	3,085	30	22	4	56	1,072	1,461	602	3,134	12	31	8	52	14	30	8	53	1,639	3,086	1,655	6,380
	Curry	3,617	6,163	2,372	12,152	599	651	130	1,380	4,668	4,669	784	10,121	59	114	21	195	131	277	52	461	9,075	11,874	3,360	24,308
	De Baca	130	253	181	564	4	1	1	6	142	162	81	385	1	5	1	7	1	1	0	2	279	422	264	965
	Dona Ana	8,291	14,091	8,408	30,790	600	757	169	1,526	33,414	34,117	7,914	75,446	407	404	100	911	483	777	154	1,414	43,194	50,146	16,747	110,086
	Eddy	3,833	7,225	2,894	13,952	154	151	49	354	5,952	6,273	1,314	13,539	106	154	22	282	64	156	35	255	10,108	13,960	4,314	28,382
	Grant	1,275	3,461	2,264	7,000	49	46	15	112	2,659	3,369	1,426	7,454	46	89	30	165	35	75	23	133	4,065	7,041	3,758	14,864
	Guadalupe	65	157	92	315	1	3	0	4	485	756	345	1,586	8	8	1	17	7	12	1	21	568	937	439	1,943
	Harding	35	93	67	194	1	0	0	1	40	56	41	138	0	0	0	0	0	0	1	1	75	149	109	334
	Hidalgo	226	452	242	920	10	8	4	23	474	603	235	1,313	5	4	1	10	5	8	0	13	722	1,075	482	2,279
	Lea	3,694	6,872	2,694	13,260	528	556	163	1,246	9,485	8,679	1,140	19,303	99	119	32	249	46	142	22	209	13,851	16,367	4,050	34,268
	Lincoln	1,020	3,199	2,303	6,521	31	28	9	68	1,194	1,521	425	3,139	117	145	32	294	11	33	11	56	2,372	4,925	2,781	10,078
	Los Alamos	1,750	3,365	1,345	6,460	37	66	8	111	634	812	173	1,619	19	45	8	73	176	344	62	582	2,617	4,632	1,596	8,844
	Luna	676	1,615	1,566	3,856	66	65	24	156	3,587	3,601	1,023	8,211	30	38	20	89	13	53	36	102	4,372	5,372	2,670	12,414
	McKinley	799	1,874	848	3,521	133	98	20	251	2,414	2,187	592	5,193	11,603	14,397	3,228	29,229	75	236	38	350	15,024	18,793	4,726	38,543
	Mora	66	234	147	447	1	8	0	9	528	876	407	1,811	5	6	1	12	1	6	2	9	602	1,130	557	2,289
	Otero	3,648	8,084	3,956	15,688	445	504	128	1,077	5,214	5,742	1,323	12,279	813	1,121	170	2,104	110	355	111	576	10,230	15,807	5,688	31,725
	Quay	415	1,133	704	2,252	40	33	7	80	702	937	337	1,976	8	22	7	38	13	25	10	49	1,179	2,150	1,065	4,395
	Rio Arriba	377	1,384	923	2,685	49	37	9	96	4,811	7,053	2,419	14,283	1,120	1,494	389	3,003	43	77	4	124	6,400	10,046	3,744	20,191
	Roosevelt	1,909	2,431	1,093	5,433	103	60	6	169	1,967	1,692	291	3,950	60	53	12	127	101	55	5	160	4,141	4,291	1,408	9,839
	San Juan	6,905	13,896	5,520	26,322	266	204	31	501	6,035	5,551	1,075	12,661	10,096	12,711	2,709	25,516	139	264	37	440	23,440	32,626	9,373	65,440
	San Miguel	486	1,280	931	2,697	122	68	17	208	3,461	5,561	1,981	11,003	78	84	9	171	55	55	49	159	4,203	7,049	2,986	14,238
	Sandoval	7,094	17,388	7,838	32,321	554	705	219	1,478	10,262	13,609	2,669	26,540	3,558	4,461	1,015	9,034	347	817	174	1,338	21,817	36,980	11,914	70,711
	Santa Fe	4,575	18,413	11,055	34,042	202	302	76	580	13,798	19,155	5,220	38,174	758	1,048	229	2,035	254	745	189	1,188	19,588	39,663	16,769	76,020
	Sierra	545	1,712	1,602	3,860	13	15	9	38	597	790	312	1,699	23	38	16	77	1	15	15	32	1,181	2,571	1,955	5,706
	Socorro	654	1,541	769	2,965	41	42	4	87	1,673	2,023	643	4,339	532	519	75	1,124	35	53	18	106	2,934	4,178	1,509	8,622
	Taos	825	3,370	2,093	6,287	37	42	16	96	2,952	4,655	1,844	9,451	261	513	177	950	25	135	18	179	4,099	8,715	4,148	16,963
	Torrance	900	2,170	977	4,047	35	43	11	89	1,171	1,498	439	3,108	53	78	28	159	15	27	12	55	2,174	3,816	1,468	7,458
	Union	256	521	328	1,104	5	4	0	9	247	343	130	720	7	9	5	22	0	5	6	12	515	883	469	1,867
	Valencia	2,768	7,054	3,343	13,165	131	146	50	328	8,712	11,064	2,862	22,638	512	754	157	1,423	117	184	43	345	12,239	19,203	6,457	37,898
	Female Total	90,375	217,786	105,710	413,870	7,930	9,471	2,324	19,725	204,486	246,343	59,297	510,126	38,151	50,235	10,685	99,071	5,085	11,472	2,430	18,987	346,028	535,306	180,445	1,061,779

\* 2015 population is reported here because 2015 was the mid-point year for the 2013-2017 timeframe used in this report

SOURCE: University of New Mexico Geospatial and Population Studies



## Appendix 1: Total Population, New Mexico, 2015\*

Sex	County Name	Race/Ethnicity																							
		White				Black				Hispanic				American Indian				Asian/Pacific Islander				All Race/Ethnicities			
		0-24	25-64	65+	All Ages	0-24	25-64	65+	All Ages	0-24	25-64	65+	All Ages	0-24	25-64	65+	All Ages	0-24	25-64	65+	All Ages	0-24	25-64	65+	All Ages
Both	Bernalillo	59,910	154,576	60,622	275,108	7,262	10,375	2,072	19,709	134,375	168,788	32,858	336,022	10,865	16,139	2,152	29,156	5,257	11,430	2,132	18,820	217,670	361,308	99,836	678,814
Sexes	Catron	441	1,173	1,129	2,742	12	28	6	47	173	304	213	689	35	47	27	109	3	5	2	10	664	1,557	1,377	3,597
	Chaves	6,982	13,563	6,427	26,973	475	540	141	1,156	16,644	16,912	3,210	36,767	229	296	72	597	209	321	48	579	24,540	31,633	9,898	66,071
	Cibola	1,174	2,994	1,453	5,622	117	187	34	337	3,552	5,652	1,236	10,439	4,307	5,363	1,327	10,997	53	84	17	154	9,204	14,279	4,067	27,550
	Colfax	1,079	3,021	2,030	6,131	56	55	9	120	2,189	3,079	1,127	6,396	36	104	22	162	26	54	9	89	3,387	6,313	3,198	12,898
	Curry	8,227	12,952	4,232	25,411	1,382	1,463	236	3,082	9,866	9,470	1,415	20,752	148	187	42	377	310	474	80	864	19,935	24,546	6,005	50,486
	De Baca	246	520	324	1,090	7	7	1	15	295	319	159	773	6	8	4	18	1	2	0	3	556	856	488	1,899
	Dona Ana	17,273	28,372	16,129	61,774	1,390	1,887	353	3,630	66,800	65,193	14,408	146,401	810	825	192	1,826	963	1,416	250	2,629	87,235	97,693	31,331	216,260
	Eddy	7,980	14,763	5,327	28,069	342	437	102	880	11,854	12,967	2,439	27,259	249	327	54	630	128	266	56	450	20,552	28,759	7,977	57,288
	Grant	2,647	6,526	4,588	13,762	130	114	28	272	5,527	6,569	2,565	14,660	94	165	56	315	89	110	37	236	8,487	13,484	7,274	29,245
	Guadalupe	139	428	173	740	8	62	0	70	1,108	1,781	654	3,544	19	45	5	70	8	32	1	41	1,283	2,347	834	4,464
	Harding	64	184	135	383	1	5	0	6	80	131	89	300	1	0	0	1	0	0	1	1	146	320	225	691
	Hidalgo	436	880	506	1,823	26	11	7	44	984	1,254	420	2,659	7	8	4	20	10	19	1	30	1,465	2,173	938	4,575
	Lea	7,601	14,140	4,862	26,604	1,101	1,399	283	2,783	19,564	18,645	2,174	40,382	211	314	61	585	116	269	38	423	28,592	34,768	7,417	70,777
	Lincoln	2,188	6,128	4,505	12,819	56	74	21	151	2,442	3,062	813	6,318	242	249	47	538	23	54	23	99	4,950	9,566	5,408	19,925
	Los Alamos	3,581	6,971	2,650	13,202	73	115	18	206	1,271	1,559	282	3,113	44	95	16	155	365	720	118	1,203	5,334	9,460	3,085	17,879
	Luna	1,445	3,302	3,001	7,749	117	143	44	303	7,245	7,184	1,941	16,370	53	77	40	169	35	97	47	179	8,894	10,802	5,073	24,770
	McKinley	1,608	3,804	1,626	7,038	274	231	49	554	5,133	4,430	1,123	10,686	23,269	27,289	5,305	55,862	198	393	54	645	30,480	36,147	8,158	74,785
	Mora	124	432	315	870	5	13	6	24	1,099	1,860	812	3,771	7	11	6	24	2	10	4	16	1,237	2,327	1,144	4,707
	Otero	8,429	16,820	7,780	33,028	1,042	1,194	277	2,512	10,962	11,358	2,401	24,722	1,750	2,066	294	4,110	278	577	131	987	22,460	32,016	10,884	65,360
	Quay	862	2,130	1,380	4,373	74	72	16	163	1,413	1,814	617	3,844	21	52	14	87	34	49	18	101	2,405	4,117	2,047	8,568
	Rio Arriba	782	2,725	1,756	5,263	92	94	20	206	9,683	14,158	4,505	28,346	2,170	2,873	648	5,691	66	110	11	187	12,793	19,961	6,940	39,694
	Roosevelt	3,802	4,899	1,975	10,676	253	166	17	436	3,980	3,446	558	7,983	117	85	24	225	188	94	7	289	8,339	8,690	2,581	19,610
	San Juan	13,936	27,786	10,113	51,835	529	524	64	1,117	12,304	11,418	2,003	25,725	20,294	24,907	4,676	49,877	279	472	63	813	47,342	65,106	16,918	129,366
	San Miguel	973	2,513	1,726	5,213	267	173	29	469	7,084	11,178	3,689	21,951	137	139	19	296	132	99	62	294	8,594	14,103	5,525	28,223
	Sandoval	14,796	33,962	14,697	63,456	1,177	1,623	378	3,177	20,978	26,532	4,883	52,392	7,213	8,564	1,632	17,408	680	1,332	280	2,292	44,843	72,012	21,870	138,725
	Santa Fe	9,514	34,503	20,599	64,615	434	837	171	1,442	27,666	38,822	9,419	75,907	1,408	2,054	427	3,890	547	1,313	307	2,167	39,569	77,529	30,923	148,021
	Sierra	1,130	3,305	3,284	7,719	34	40	20	95	1,265	1,573	576	3,413	43	85	39	166	4	26	25	56	2,476	5,029	3,944	11,449
	Socorro	1,612	3,072	1,548	6,232	90	117	11	219	3,362	4,085	1,230	8,677	1,004	965	150	2,119	68	97	28	193	6,136	8,337	2,967	17,439
	Taos	1,757	6,268	3,941	11,966	76	108	34	218	6,083	9,426	3,393	18,903	563	998	317	1,879	54	192	26	272	8,535	16,992	7,711	33,238
	Torrance	1,914	4,394	2,035	8,343	93	154	27	275	2,509	3,259	848	6,616	126	189	59	373	36	46	18	100	4,679	8,042	2,988	15,708
	Union	573	1,205	596	2,373	19	73	2	94	581	996	229	1,805	16	39	6	61	2	19	8	29	1,189	2,332	842	4,364
	Valencia	5,840	13,972	6,376	26,188	302	496	146	944	17,972	22,387	5,338	45,698	1,036	1,502	283	2,822	209	278	60	548	25,360	38,635	12,204	76,200
Both	Both Sexes Total	189,065	432,284	197,842	819,191	17,314	22,817	4,624	44,755	416,044	489,612	107,630	1,013,285	76,531	96,067	18,018	190,616	10,375	20,460	3,964	34,799	709,329	1,061,240	332,077	2,102,646

\* 2015 population is reported here because 2015 was the mid-point year for the 2013-2017 timeframe used in this report

SOURCE: University of New Mexico Geospatial and Population Studies



## **Appendix 2**

**Substance Use and Mental Health in New Mexico, by Age Group, 2015-2016**

**National Survey on Drug Use and Health (NSDUH)**



**Appendix 2A. Selected Drug Use, Past Year Alcohol Use Disorder, and Past Year Mental Health Measures in New Mexico, by Age Group: Estimated Numbers (in Thousands), Annual Averages Based on 2015-2016 NSDUHs**

Measure	12+	12-17 Years	18-25 Years	26+ Years	18+ years
<b>ILLICIT DRUGS<sup>2</sup></b>					
Past Month Illicit Drug Use <sup>2</sup>	206	18	56	132	188
Past Year Cocaine Use	32	2	12	19	31
Perceptions of Great Risk from Using Cocaine Once a Month	1,187	88	141	959	1,099
Past Year Heroin Use	6	0	2	4	6
Perceptions of Great Risk from Trying Heroin Once or Twice	1,440	109	185	1,146	1,331
Past Year Pain Reliever Misuse	79	7	18	54	73
First Use of Marijuana <sup>3</sup>	21	9	8	4	12
Past Month Marijuana Use	180	16	51	114	165
Past Year Marijuana Use	272	25	73	173	247
Perceptions of Great Risk from Smoking Marijuana Once a Month	493	40	32	421	453
Past Month Use of Illicit Drugs <sup>2</sup> Other Than Marijuana	61	5	18	38	56
<b>ALCOHOL</b>					
Past Month Alcohol Use	833	16	122	695	817
Past Month Binge Alcohol Use <sup>9</sup>	440	10	80	350	430
Past Month Alcohol Use (12-20 Years) <sup>8</sup>	51	–	–	–	–
Past Month Binge Alcohol Use (12-20 Years) <sup>8,9</sup>	31	–	–	–	–
Perceptions of Great Risk from Having Five or More Drinks of an Alcoholic Beverage Once or Twice a Week	831	74	93	664	757
<b>TOBACCO PRODUCTS<sup>4</sup></b>					
Past Month Tobacco Product Use	430	8	77	345	422
Past Month Cigarette Use	349	5	64	279	344
Perceptions of Great Risk from Smoking One or More Packs of Cigarettes per Day	1,249	106	147	996	1,143
<b>PAST YEAR DEPENDENCE, ABUSE, AND TREATMENT</b>					
Illicit Drug Use Disorder <sup>1</sup>	55	7	18	30	48
Pain Reliever Use Disorder <sup>1</sup>	11	1	2	8	10
Alcohol Use Disorder <sup>1</sup>	120	5	26	90	115
Substance Use Disorder <sup>1</sup>	153	12	37	104	141
Needing But Not Receiving Treatment at a Specialty Facility for Illicit Drug Use <sup>10</sup>	47	8	17	23	40
Needing But Not Receiving Treatment at a Specialty Facility for Alcohol Use <sup>10</sup>	107	4	26	77	103
Needing But Not Receiving Treatment at a Specialty Facility for Substance Use <sup>10</sup>	144	10	35	98	133
<b>PAST YEAR MENTAL HEALTH ISSUES</b>					
Major Depressive Episode <sup>7</sup>	–	21	21	83	104
Any Mental Illness <sup>5</sup>	–	–	53	245	298
Serious Mental Illness <sup>6</sup>	–	–	11	57	69
Received Mental Health Services <sup>11</sup>	–	–	24	177	201
Had Serious Thoughts of Suicide	–	–	20	47	66

+ All figures are estimated numbers in thousands  
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015 and 2016.





**Appendix 2B. Selected Drug Use, Past Year Alcohol Use Disorder, and Past Year Mental Health Measures in New Mexico, by Age Group: Percentages, Annual Averages Based on 2015-2016 NSDUHs**

Measure	12+	12-17 Years	18-25 Years	26+ Years	18+ years
<b>ILLICIT DRUGS<sup>2</sup></b>					
Past Month Illicit Drug Use <sup>2</sup>	11.98	11.03	24.89	9.93	12.08
Past Year Cocaine Use	1.88	0.96	5.42	1.40	1.98
Perceptions of Great Risk from Using Cocaine Once a Month	69.06	53.08	62.86	72.09	70.75
Past Year Heroin Use	0.37	0.17	0.82	0.32	0.39
Perceptions of Great Risk from Trying Heroin Once or Twice	83.81	65.68	82.68	86.23	85.71
Past Year Pain Reliever Misuse	4.61	3.97	8.14	4.09	4.67
First Use of Marijuana <sup>3</sup>	2.50	6.99	8.79	0.60	1.69
Past Month Marijuana Use	10.50	9.46	22.85	8.55	10.61
Past Year Marijuana Use	15.83	15.34	32.79	13.04	15.88
Perceptions of Great Risk from Smoking Marijuana Once a Month	28.65	24.06	14.34	31.65	29.14
Past Month Use of Illicit Drugs <sup>2</sup> Other Than Marijuana	3.57	3.25	8.16	2.84	3.60
<b>ALCOHOL</b>					
Past Month Alcohol Use	48.47	9.91	54.35	52.30	52.59
Past Month Binge Alcohol Use <sup>9</sup>	25.57	5.77	35.57	26.36	27.68
Past Month Alcohol Use (12-20 Years) <sup>8</sup>	20.80	–	–	–	–
Past Month Binge Alcohol Use (12-20 Years) <sup>8,9</sup>	12.88	–	–	–	–
Perceptions of Great Risk from Having Five or More Drinks of an Alcoholic Beverage Once or Twice a Week	48.35	44.67	41.72	49.92	48.74
<b>TOBACCO PRODUCTS<sup>4</sup></b>					
Past Month Tobacco Product Use	25.01	4.81	34.50	25.93	27.17
Past Month Cigarette Use	20.28	2.95	28.80	21.01	22.13
Perceptions of Great Risk from Smoking One or More Packs of Cigarettes per Day	72.69	64.28	65.75	74.91	73.59
<b>PAST YEAR DEPENDENCE, ABUSE, AND TREATMENT</b>					
Illicit Drug Use Disorder <sup>1</sup>	3.20	4.49	8.02	2.23	3.06
Pain Reliever Use Disorder <sup>1</sup>	0.64	0.65	1.09	0.57	0.64
Alcohol Use Disorder <sup>1</sup>	6.98	2.76	11.56	6.74	7.43
Substance Use Disorder <sup>1</sup>	8.91	7.15	16.72	7.81	9.09
Needing But Not Receiving Treatment at a Specialty Facility for Illicit Drug Use <sup>10</sup>	2.76	4.55	7.66	1.72	2.57
Needing But Not Receiving Treatment at a Specialty Facility for Alcohol Use <sup>10</sup>	6.23	2.57	11.78	5.76	6.62
Needing But Not Receiving Treatment at a Specialty Facility for Substance Use <sup>10</sup>	8.35	6.22	15.78	7.37	8.58
<b>PAST YEAR MENTAL HEALTH ISSUES</b>					
Major Depressive Episode <sup>7</sup>	–	12.61	9.36	6.27	6.71
Any Mental Illness <sup>5</sup>	–	–	23.51	18.46	19.19
Serious Mental Illness <sup>6</sup>	–	–	5.09	4.32	4.43
Received Mental Health Services <sup>11</sup>	–	–	10.60	13.35	12.95
Had Serious Thoughts of Suicide	–	–	8.88	3.50	4.28

\* \_ Not available

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015 and 2016.



## **Appendix 3**

**Substance Use and Mental Health by National Regions, Age 12+, 2015-2016**

**National Survey on Drug Use and Health (NSDUH)**



**Appendix 3A. Substance Use and Mental Health, U.S. Regions & New Mexico, Percentages, Annual Averages Based on 2015 and 2016 NSDUHs**

INDICATORS*	TOTAL U.S.	NORTHEAST	MIDWEST	SOUTH	WEST	NEW MEXICO
<b>ILLICIT DRUGS<sup>2</sup> among persons aged 12 or older</b>						
Past Month Illicit Drug Use <sup>2</sup>	10.36 (10.11 - 10.62)	11.20 (10.69 - 11.73)	9.77 (9.34 - 10.22)	8.87 (8.52 - 9.24)	12.62 (12.06 - 13.20)	11.98 (10.36 - 13.81)
Past Year Cocaine Use	1.84 (1.75 - 1.94)	2.26 (2.06 - 2.48)	1.51 (1.36 - 1.66)	1.60 (1.48 - 1.74)	2.22 (2.02 - 2.44)	1.88 (1.42 - 2.48)
Perceptions of Great Risk from Using Cocaine Once a Month	71.89 (71.52 - 72.25)	69.12 (68.32 - 69.91)	72.18 (71.56 - 72.80)	75.25 (74.72 - 75.76)	68.37 (67.60 - 69.13)	69.06 (66.62 - 71.40)
Past Year Heroin Use	0.33 (0.29 - 0.38)	0.46 (0.37 - 0.58)	0.33 (0.26 - 0.41)	0.28 (0.23 - 0.34)	0.32 (0.25 - 0.41)	0.37 (0.20 - 0.71)
Perceptions of Great Risk from Trying Heroin Once or Twice	85.44 (85.15 - 85.73)	85.10 (84.50 - 85.68)	85.53 (85.05 - 86.00)	86.73 (86.33 - 87.12)	83.57 (82.98 - 84.14)	83.81 (81.89 - 85.55)
Past Year Pain Reliever Misuse	4.46 (4.31 - 4.62)	4.05 (3.78 - 4.34)	4.45 (4.21 - 4.70)	4.43 (4.21 - 4.65)	4.85 (4.53 - 5.19)	4.61 (3.86 - 5.48)
First Use of Marijuana <sup>3</sup>	1.96 (1.88 - 2.03)	2.07 (1.95 - 2.20)	2.04 (1.93 - 2.16)	1.70 (1.61 - 1.80)	2.24 (2.10 - 2.38)	2.50 (2.15 - 2.90)
Past Month Marijuana Use	8.60 (8.38 - 8.83)	9.50 (9.03 - 9.98)	8.28 (7.91 - 8.68)	7.05 (6.73 - 7.38)	10.68 (10.19 - 11.20)	10.50 (9.06 - 12.13)
Past Year Marijuana Use	13.71 (13.42 - 13.99)	14.84 (14.23 - 15.48)	13.06 (12.55 - 13.58)	11.78 (11.34 - 12.23)	16.49 (15.85 - 17.16)	15.83 (13.94 - 17.93)
Perceptions of Great Risk from Smoking Marijuana Once a Month	28.41 (27.96 - 28.86)	26.44 (25.56 - 27.35)	25.56 (24.80 - 26.32)	32.09 (31.41 - 32.78)	26.59 (25.76 - 27.43)	28.65 (26.13 - 31.30)
Past Month Use of Illicit Drugs <sup>2</sup> Other Than Marijuana	3.42 (3.28 - 3.57)	3.46 (3.20 - 3.74)	3.17 (2.95 - 3.39)	3.30 (3.11 - 3.50)	3.83 (3.55 - 4.13)	3.57 (2.93 - 4.35)
<b>ALCOHOL among persons aged 12 or older</b>						
Past Month Alcohol Use	51.21 (50.76 - 51.66)	56.02 (55.14 - 56.90)	54.36 (53.62 - 55.10)	47.48 (46.85 - 48.12)	50.67 (49.81 - 51.53)	48.47 (45.53 - 51.42)
Past Month Binge Alcohol Use <sup>9</sup>	24.58 (24.21 - 24.95)	26.28 (25.52 - 27.06)	26.48 (25.84 - 27.14)	23.26 (22.72 - 23.80)	23.68 (23.00 - 24.38)	25.57 (23.25 - 28.03)
Past Month Alcohol Use (12-20 Years) <sup>8</sup>	19.83 (19.18 - 20.49)	23.98 (22.95 - 25.04)	20.92 (20.13 - 21.73)	18.39 (17.73 - 19.07)	18.18 (17.32 - 19.07)	20.80 (18.20 - 23.66)
Past Month Binge Alcohol Use (12-20 Years) <sup>8,9</sup>	12.71 (12.19 - 13.26)	15.62 (14.73 - 16.55)	13.93 (13.25 - 14.63)	11.49 (10.89 - 12.12)	11.50 (10.72 - 12.32)	12.88 (10.97 - 15.05)
Perceptions of Great Risk from Having Five or More Drinks of an Alcoholic Beverage Once or Twice a Week	44.30 (43.86 - 44.75)	43.01 (42.12 - 43.91)	39.62 (38.88 - 40.36)	46.17 (45.53 - 46.80)	46.52 (45.68 - 47.36)	48.35 (45.66 - 51.04)
<b>TOBACCO among persons aged 12 or older</b>						
Past Month Tobacco Product Use <sup>4</sup>	23.72 (23.34 - 24.09)	22.75 (22.01 - 23.51)	26.56 (25.91 - 27.22)	25.43 (24.91 - 25.96)	19.18 (18.56 - 19.83)	25.01 (22.69 - 27.47)
Past Month Cigarette Use	19.23 (18.87 - 19.60)	18.46 (17.80 - 19.13)	21.31 (20.71 - 21.92)	20.57 (20.07 - 21.08)	15.82 (15.22 - 16.43)	20.28 (18.20 - 22.52)
Perceptions of Great Risk from Smoking One or More Packs of Cigarettes per Day	72.80 (72.43 - 73.18)	74.59 (73.86 - 75.31)	68.94 (68.24 - 69.62)	72.41 (71.88 - 72.93)	75.55 (74.86 - 76.22)	72.69 (70.37 - 74.90)
<b>PAST YEAR DEPENDENCE, ABUSE, AND TREATMENT</b>						
Illicit Drug Use Disorder <sup>1</sup>	2.81 (2.70 - 2.93)	2.84 (2.60 - 3.11)	2.61 (2.41 - 2.83)	2.65 (2.48 - 2.82)	3.24 (2.98 - 3.53)	3.20 (2.55 - 4.01)
Pain Reliever Use Disorder <sup>1</sup>	0.71 (0.65 - 0.77)	0.67 (0.58 - 0.77)	0.71 (0.63 - 0.80)	0.73 (0.65 - 0.81)	0.69 (0.60 - 0.80)	0.64 (0.49 - 0.86)
Alcohol Use Disorder <sup>1</sup>	5.73 (5.55 - 5.92)	6.01 (5.62 - 6.42)	5.90 (5.58 - 6.24)	5.25 (4.99 - 5.52)	6.14 (5.78 - 6.54)	6.98 (5.79 - 8.40)
Substance Use Disorder <sup>1</sup>	7.62 (7.42 - 7.82)	7.93 (7.50 - 8.38)	7.74 (7.39 - 8.10)	7.00 (6.70 - 7.32)	8.26 (7.83 - 8.70)	8.91 (7.56 - 10.46)
Needing But Not Receiving Treatment at a Specialty Facility for Illicit Drug Use <sup>10</sup>	2.53 (2.42 - 2.64)	2.54 (2.32 - 2.78)	2.36 (2.18 - 2.56)	2.34 (2.18 - 2.50)	2.98 (2.75 - 3.24)	2.76 (2.20 - 3.46)
Needing But Not Receiving Treatment at a Specialty Facility for Alcohol Use <sup>10</sup>	5.48 (5.30 - 5.66)	5.68 (5.34 - 6.04)	5.58 (5.29 - 5.89)	5.01 (4.76 - 5.26)	5.99 (5.64 - 6.36)	6.23 (5.21 - 7.44)
Needing But Not Receiving Treatment at a Specialty Facility for Substance Use <sup>10</sup>	7.08 (6.89 - 7.28)	7.20 (6.80 - 7.63)	7.14 (6.80 - 7.50)	6.50 (6.21 - 6.80)	7.87 (7.46 - 8.30)	8.35 (7.05 - 9.87)
<b>MENTAL HEALTH among persons aged 18 or older</b>						
Any Mental Illness <sup>5</sup> in past year	18.07 (17.73 - 18.42)	17.86 (17.19 - 18.56)	18.01 (17.42 - 18.62)	17.95 (17.44 - 18.48)	18.48 (17.85 - 19.12)	19.19 (17.18 - 21.37)
Serious Mental Illness <sup>6</sup> in past year	4.13 (3.97 - 4.30)	4.07 (3.76 - 4.40)	4.37 (4.11 - 4.66)	4.05 (3.81 - 4.30)	4.09 (3.79 - 4.41)	4.43 (3.57 - 5.49)
Had serious thoughts of suicide in past year	4.04 (3.89 - 4.20)	4.03 (3.73 - 4.36)	4.14 (3.88 - 4.42)	3.84 (3.61 - 4.08)	4.30 (4.00 - 4.61)	4.28 (3.44 - 5.31)
Received Mental Health Services <sup>11</sup>	14.28 (13.97 - 14.59)	15.74 (15.07 - 16.42)	15.75 (15.19 - 16.33)	13.52 (13.05 - 14.02)	13.06 (12.47 - 13.67)	12.95 (11.24 - 14.88)
Major Depressive Episode <sup>7</sup> in past year	6.70 (6.49 - 6.91)	6.80 (6.40 - 7.23)	6.89 (6.55 - 7.26)	6.60 (6.30 - 6.91)	6.61 (6.24 - 7.00)	6.71 (5.64 - 7.97)

\* All figures are percent prevalence rates; figures in parentheses are 95% confidence intervals  
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015 and 2016.



**Appendix 3B. Substance Use and Mental Health, U.S. Regions & New Mexico, by Age Group, Percentages, Annual Averages Based on 2015 and 2016 NSDUHs**

INDICATORS <sup>+</sup>	AGE GROUP	TOTAL U.S.	NORTHEAST	MIDWEST	SOUTH	WEST	NEW MEXICO
<b>ILLICIT DRUGS<sup>2</sup> among persons aged 12 or older</b>							
Past Month Illicit Drug Use <sup>2</sup>	Age 12-17	8.34 (7.98 - 8.71)	8.45 (7.78 - 9.17)	8.28 (7.73 - 8.88)	7.82 (7.32 - 8.35)	9.14 (8.41 - 9.93)	11.03 (8.95 - 13.53)
	Age 18-25	22.75 (22.13 - 23.39)	25.93 (24.64 - 27.25)	21.68 (20.69 - 22.69)	20.26 (19.41 - 21.13)	25.25 (23.97 - 26.56)	24.89 (21.33 - 28.81)
	Age 26+	8.54 (8.26 - 8.83)	9.11 (8.51 - 9.75)	7.95 (7.45 - 8.48)	7.13 (6.70 - 7.58)	10.89 (10.22 - 11.59)	9.93 (8.14 - 12.05)
	Age 18+	10.57 (10.29 - 10.85)	11.45 (10.90 - 12.03)	9.93 (9.46 - 10.41)	8.98 (8.60 - 9.38)	12.98 (12.38 - 13.61)	12.08 (10.35 - 14.05)
		0.58	0.58	0.55	0.45	0.81	0.96
Past Year Cocaine Use	Age 12-17	0.58 (0.48 - 0.69)	0.58 (0.46 - 0.73)	0.55 (0.43 - 0.69)	0.45 (0.36 - 0.58)	0.81 (0.63 - 1.04)	0.96 (0.59 - 1.55)
	Age 18-25	5.46 (5.09 - 5.86)	6.67 (6.03 - 7.39)	4.40 (3.95 - 4.91)	4.75 (4.31 - 5.22)	6.61 (5.92 - 7.38)	5.42 (3.86 - 7.57)
	Age 26+	1.39 (1.29 - 1.50)	1.73 (1.52 - 1.97)	1.14 (0.98 - 1.31)	1.22 (1.09 - 1.37)	1.64 (1.43 - 1.87)	1.40 (0.99 - 1.96)
	Age 18+	1.97 (1.87 - 2.08)	2.42 (2.20 - 2.65)	1.61 (1.45 - 1.78)	1.72 (1.58 - 1.87)	2.36 (2.14 - 2.60)	1.98 (1.48 - 2.63)
		56.54 (55.84 - 57.24)	56.41 (55.12 - 57.70)	55.60 (54.44 - 56.74)	58.39 (57.35 - 59.42)	54.52 (53.16 - 55.88)	53.08 (49.23 - 56.88)
Perceptions of Great Risk from Using Cocaine Once a Month	Age 12-17	65.07 (64.36 - 65.78)	61.75 (60.31 - 63.16)	64.94 (63.77 - 66.10)	68.70 (67.65 - 69.74)	62.01 (60.63 - 63.37)	62.86 (58.85 - 66.69)
	Age 18-25	74.84 (74.39 - 75.28)	71.69 (70.72 - 72.65)	75.40 (74.64 - 76.15)	78.36 (77.73 - 78.98)	71.12 (70.19 - 72.03)	72.09 (69.17 - 74.83)
	Age 26+	73.44 (73.04 - 73.83)	70.30 (69.43 - 71.15)	73.89 (73.22 - 74.55)	76.99 (76.42 - 77.54)	69.78 (68.96 - 70.60)	70.75 (68.11 - 73.26)
	Age 18+	0.07 (0.04 - 0.11)	0.08 (0.05 - 0.15)	0.08 (0.04 - 0.15)	0.07 (0.04 - 0.13)	0.05 (0.02 - 0.11)	0.17 (0.06 - 0.45)
		65.41 (64.74 - 66.08)	66.03 (64.74 - 67.31)	65.34 (64.29 - 66.37)	66.78 (65.82 - 67.72)	62.86 (61.60 - 64.11)	65.68 (62.11 - 69.09)
Past Year Heroin Use	Age 12-17	0.64 (0.53 - 0.77)	0.81 (0.64 - 1.02)	0.65 (0.52 - 0.83)	0.58 (0.47 - 0.71)	0.59 (0.45 - 0.77)	0.82 (0.45 - 1.51)
	Age 26+	0.31 (0.26 - 0.36)	0.45 (0.34 - 0.58)	0.30 (0.23 - 0.39)	0.26 (0.20 - 0.33)	0.30 (0.22 - 0.40)	0.32 (0.15 - 0.68)
	Age 18+	0.36 (0.31 - 0.41)	0.50 (0.39 - 0.63)	0.35 (0.28 - 0.44)	0.30 (0.25 - 0.37)	0.34 (0.27 - 0.44)	0.39 (0.20 - 0.77)
		82.80 (82.25 - 83.34)	82.74 (81.72 - 83.72)	82.49 (81.67 - 83.27)	83.73 (82.99 - 84.45)	81.68 (80.66 - 82.67)	82.68 (79.62 - 85.37)
		88.23 (87.89 - 88.56)	87.53 (86.83 - 88.20)	88.46 (87.89 - 89.01)	89.61 (89.15 - 90.05)	86.36 (85.67 - 87.03)	86.23 (83.92 - 88.25)
Perceptions of Great Risk from Trying Heroin Once or Twice	Age 12-17	87.45 (87.15 - 87.75)	86.86 (86.23 - 87.46)	87.60 (87.08 - 88.09)	88.78 (88.36 - 89.18)	85.68 (85.05 - 86.28)	85.71 (83.64 - 87.56)
	Age 18-25	3.72 (3.48 - 3.97)	2.82 (2.45 - 3.23)	4.00 (3.63 - 4.40)	3.94 (3.61 - 4.31)	3.72 (3.27 - 4.24)	3.97 (2.99 - 5.25)
	Age 26+	4.00 (3.81 - 4.19)	3.68 (3.36 - 4.02)	3.88 (3.59 - 4.18)	3.96 (3.71 - 4.23)	4.40 (4.02 - 4.80)	4.09 (3.23 - 5.16)
	Age 18+	4.54 (4.38 - 4.71)	4.17 (3.87 - 4.48)	4.49 (4.23 - 4.77)	4.48 (4.25 - 4.72)	4.97 (4.62 - 5.34)	4.67 (3.87 - 5.63)
		5.25 (5.03 - 5.49)	5.34 (4.97 - 5.74)	5.25 (4.94 - 5.57)	4.91 (4.64 - 5.19)	5.75 (5.36 - 6.16)	6.99 (5.87 - 8.31)
Past Year Pain Reliever Misuse	Age 12-17	7.74 (7.33 - 8.17)	8.85 (8.18 - 9.57)	8.16 (7.61 - 8.75)	6.78 (6.36 - 7.23)	8.18 (7.54 - 8.87)	8.79 (7.00 - 10.97)
	Age 26+	0.39 (0.34 - 0.44)	0.44 (0.36 - 0.53)	0.38 (0.32 - 0.46)	0.29 (0.24 - 0.35)	0.53 (0.44 - 0.64)	0.60 (0.41 - 0.88)
	Age 18+	1.40 (1.32 - 1.48)	1.54 (1.41 - 1.67)	1.47 (1.37 - 1.59)	1.17 (1.09 - 1.27)	1.62 (1.48 - 1.76)	1.69 (1.37 - 2.07)
		5.25 (5.03 - 5.49)	5.34 (4.97 - 5.74)	5.25 (4.94 - 5.57)	4.91 (4.64 - 5.19)	5.75 (5.36 - 6.16)	6.99 (5.87 - 8.31)
		7.74 (7.33 - 8.17)	8.85 (8.18 - 9.57)	8.16 (7.61 - 8.75)	6.78 (6.36 - 7.23)	8.18 (7.54 - 8.87)	8.79 (7.00 - 10.97)
First Use of Marijuana <sup>3</sup>	Age 12-17	0.39 (0.34 - 0.44)	0.44 (0.36 - 0.53)	0.38 (0.32 - 0.46)	0.29 (0.24 - 0.35)	0.53 (0.44 - 0.64)	0.60 (0.41 - 0.88)
	Age 18+	1.40 (1.32 - 1.48)	1.54 (1.41 - 1.67)	1.47 (1.37 - 1.59)	1.17 (1.09 - 1.27)	1.62 (1.48 - 1.76)	1.69 (1.37 - 2.07)

+ All figures are percent prevalence rates; figures in parentheses are 95% confidence intervals

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015 and 2016.





**Appendix 3B. Substance Use and Mental Health, U.S. Regions & New Mexico, by Age Group, Percentages, Annual Averages Based on 2015 and 2016 NSDUHs**

INDICATORS <sup>+</sup>	AGE GROUP	TOTAL U.S.	NORTHEAST	MIDWEST	SOUTH	WEST	NEW MEXICO
<b>ILLICIT DRUGS<sup>2</sup> among persons aged 12 or older</b>							
Past Month Marijuana Use	Age 12-17	6.75	7.15	6.69	6.13	7.52	9.46
		(6.43 - 7.09)	(6.51 - 7.84)	(6.19 - 7.22)	(5.68 - 6.62)	(6.87 - 8.23)	(7.60 - 11.71)
	Age 18-25	20.30	23.64	19.28	17.74	22.73	22.85
		(19.71 - 20.90)	(22.44 - 24.87)	(18.35 - 20.24)	(16.99 - 18.52)	(21.54 - 23.96)	(19.40 - 26.72)
	Age 26+	6.88	7.46	6.63	5.40	9.01	8.55
		(6.64 - 7.13)	(6.94 - 8.02)	(6.20 - 7.08)	(5.05 - 5.78)	(8.44 - 9.62)	(6.98 - 10.43)
	Age 18+	8.79	9.72	8.45	7.14	11.01	10.61
		(8.55 - 9.04)	(9.22 - 10.24)	(8.04 - 8.87)	(6.81 - 7.50)	(10.48 - 11.57)	(9.08 - 12.36)
Past Year Marijuana Use	Age 12-17	12.29	12.39	12.67	11.25	13.55	15.34
		(11.86 - 12.74)	(11.56 - 13.27)	(11.95 - 13.43)	(10.67 - 11.86)	(12.68 - 14.46)	(12.88 - 18.17)
	Age 18-25	32.60	37.45	31.69	29.66	34.39	32.79
		(31.89 - 33.31)	(36.03 - 38.89)	(30.64 - 32.75)	(28.74 - 30.59)	(33.09 - 35.72)	(28.81 - 37.04)
	Age 26+	10.73	11.45	9.97	8.90	13.79	13.04
		(10.43 - 11.05)	(10.74 - 12.20)	(9.37 - 10.61)	(8.38 - 9.45)	(13.03 - 14.60)	(10.91 - 15.52)
	Age 18+	13.85	15.07	13.10	11.83	16.80	15.88
		(13.54 - 14.16)	(14.41 - 15.76)	(12.54 - 13.67)	(11.35 - 12.33)	(16.10 - 17.52)	(13.83 - 18.18)
Perceptions of Great Risk from Smoking Marijuana Once a Month	Age 12-17	27.17	26.85	26.44	29.75	23.90	24.06
		(26.51 - 27.83)	(25.65 - 28.08)	(25.46 - 27.45)	(28.78 - 30.74)	(22.74 - 25.09)	(20.84 - 27.61)
	Age 18-25	14.32	12.56	12.50	16.68	13.58	14.34
		(13.83 - 14.83)	(11.69 - 13.49)	(11.74 - 13.30)	(15.91 - 17.48)	(12.65 - 14.55)	(11.78 - 17.35)
	Age 26+	30.92	28.67	27.67	34.94	29.16	31.65
		(30.36 - 31.49)	(27.61 - 29.75)	(26.78 - 28.58)	(34.13 - 35.75)	(28.16 - 30.18)	(28.63 - 34.82)
	Age 18+	28.54	26.40	25.46	32.34	26.87	29.14
		(28.05 - 29.03)	(25.45 - 27.37)	(24.65 - 26.29)	(31.60 - 33.08)	(25.97 - 27.78)	(26.45 - 31.97)
Past Month Use of Illicit Drugs <sup>2</sup> Other Than Marijuana	Age 12-17	2.71	2.25	2.73	2.88	2.74	3.25
		(2.49 - 2.95)	(1.92 - 2.64)	(2.40 - 3.11)	(2.58 - 3.22)	(2.37 - 3.17)	(2.29 - 4.60)
	Age 18-25	7.32	7.73	6.94	6.95	7.92	8.16
		(6.92 - 7.74)	(7.02 - 8.51)	(6.39 - 7.54)	(6.47 - 7.46)	(7.21 - 8.69)	(6.24 - 10.62)
	Age 26+	2.86	2.90	2.58	2.75	3.26	2.84
		(2.71 - 3.03)	(2.60 - 3.23)	(2.34 - 2.85)	(2.54 - 2.98)	(2.94 - 3.61)	(2.17 - 3.70)
	Age 18+	3.50	3.57	3.21	3.34	3.94	3.60
		(3.35 - 3.65)	(3.29 - 3.88)	(2.98 - 3.46)	(3.14 - 3.56)	(3.64 - 4.27)	(2.90 - 4.47)
<b>ALCOHOL among persons aged 12 or older</b>							
Past Month Alcohol Use	Age 12-17	9.40	10.95	9.82	8.71	9.06	9.91
		(8.99 - 9.83)	(10.18 - 11.77)	(9.18 - 10.49)	(8.18 - 9.27)	(8.35 - 9.84)	(8.01 - 12.20)
	Age 18-25	57.75	63.92	61.60	54.56	54.76	54.35
		(56.96 - 58.52)	(62.44 - 65.38)	(60.42 - 62.76)	(53.45 - 55.67)	(53.35 - 56.16)	(50.32 - 58.32)
	Age 26+	55.10	59.67	58.56	51.03	55.01	52.30
		(54.56 - 55.65)	(58.59 - 60.75)	(57.65 - 59.46)	(50.26 - 51.79)	(53.95 - 56.08)	(48.63 - 55.94)
	Age 18+	55.48	60.27	59.00	51.53	54.98	52.59
		(54.99 - 55.97)	(59.30 - 61.23)	(58.18 - 59.81)	(50.83 - 52.22)	(54.03 - 55.92)	(49.34 - 55.82)
Past Month Binge Alcohol Use <sup>9</sup>	Age 12-17	5.33	6.16	5.87	4.83	5.09	5.77
		(5.03 - 5.65)	(5.61 - 6.75)	(5.42 - 6.35)	(4.44 - 5.24)	(4.59 - 5.64)	(4.49 - 7.38)
	Age 18-25	38.69	44.03	42.30	35.80	36.08	35.57
		(37.90 - 39.49)	(42.60 - 45.47)	(41.13 - 43.49)	(34.81 - 36.80)	(34.77 - 37.42)	(31.89 - 39.43)
	Age 26+	24.52	25.61	26.33	23.43	23.82	26.36
		(24.08 - 24.97)	(24.70 - 26.55)	(25.53 - 27.14)	(22.77 - 24.10)	(22.97 - 24.69)	(23.59 - 29.33)
	Age 18+	26.54	28.18	28.63	25.18	25.61	27.68
		(26.14 - 26.96)	(27.35 - 29.02)	(27.92 - 29.35)	(24.59 - 25.77)	(24.86 - 26.37)	(25.15 - 30.37)
Perceptions of Great Risk from Having Five or More Drinks of an Alcoholic Beverage Once or Twice a Week	Age 12-17	43.30	42.95	39.60	45.48	43.36	44.67
		(42.59 - 44.00)	(41.61 - 44.30)	(38.52 - 40.70)	(44.47 - 46.49)	(42.04 - 44.68)	(40.86 - 48.54)
	Age 18-25	36.91	34.19	32.12	39.22	39.56	41.72
		(36.22 - 37.61)	(32.93 - 35.48)	(31.07 - 33.19)	(38.24 - 40.21)	(38.26 - 40.88)	(37.87 - 45.68)
	Age 26+	45.66	44.45	40.89	47.40	48.09	49.92
		(45.12 - 46.20)	(43.38 - 45.52)	(39.98 - 41.80)	(46.62 - 48.18)	(47.06 - 49.13)	(46.77 - 53.08)
	Age 18+	44.41	43.02	39.62	46.24	46.84	48.74
		(43.93 - 44.89)	(42.06 - 43.98)	(38.82 - 40.42)	(45.55 - 46.92)	(45.94 - 47.75)	(45.90 - 51.58)

+ All figures are percent prevalence rates; figures in parentheses are 95% confidence intervals

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015 and 2016.



**Appendix 3B. Substance Use and Mental Health, U.S. Regions & New Mexico, by Age Group, Percentages, Annual Averages Based on 2015 and 2016 NSDUHs**

INDICATORS <sup>+</sup>	AGE GROUP	TOTAL U.S.	NORTHEAST	MIDWEST	SOUTH	WEST	NEW MEXICO
<b>TOBACCO among persons aged 12 or older</b>							
Past Month Tobacco Product Use <sup>4</sup>	Age 12-17	5.66	5.39	6.68	5.91	4.52	4.81
		(5.36 - 5.97)	(4.90 - 5.93)	(6.18 - 7.21)	(5.48 - 6.37)	(4.06 - 5.02)	(3.71 - 6.23)
	Age 18-25	31.48	31.65	35.22	32.37	26.69	34.50
		(30.79 - 32.19)	(30.41 - 32.92)	(34.12 - 36.34)	(31.47 - 33.30)	(25.56 - 27.86)	(30.93 - 38.26)
	Age 26+	24.58	23.21	27.52	26.65	19.68	25.93
(24.13 - 25.03)		(22.32 - 24.12)	(26.72 - 28.33)	(26.01 - 27.31)	(18.90 - 20.48)	(23.14 - 28.94)	
Age 18+	25.56	24.38	28.62	27.46	20.70	27.17	
	(25.16 - 25.97)	(23.58 - 25.21)	(27.92 - 29.34)	(26.89 - 28.04)	(20.01 - 21.41)	(24.63 - 29.86)	
Past Month Cigarette Use	Age 12-17	3.80	3.44	4.70	3.88	3.13	2.95
		(3.56 - 4.06)	(3.08 - 3.84)	(4.28 - 5.15)	(3.55 - 4.25)	(2.75 - 3.56)	(2.17 - 3.98)
	Age 18-25	25.12	24.93	27.66	25.95	21.72	28.80
		(24.43 - 25.81)	(23.75 - 26.15)	(26.60 - 28.75)	(25.04 - 26.89)	(20.59 - 22.88)	(25.13 - 32.78)
	Age 26+	20.09	19.05	22.26	21.71	16.35	21.01
(19.65 - 20.53)		(18.25 - 19.88)	(21.51 - 23.04)	(21.07 - 22.37)	(15.61 - 17.11)	(18.52 - 23.73)	
Age 18+	20.81	19.87	23.04	22.31	17.13	22.13	
	(20.41 - 21.21)	(19.16 - 20.60)	(22.38 - 23.71)	(21.76 - 22.87)	(16.47 - 17.80)	(19.84 - 24.60)	
Perceptions of Great Risk from Smoking One or More Packs of Cigarettes per Day	Age 12-17	68.71	71.53	67.33	67.79	69.47	64.28
		(68.06 - 69.35)	(70.25 - 72.78)	(66.18 - 68.45)	(66.84 - 68.72)	(68.19 - 70.73)	(60.46 - 67.93)
	Age 18-25	68.29	69.57	65.05	67.64	71.20	65.75
		(67.66 - 68.90)	(68.35 - 70.77)	(63.99 - 66.08)	(66.75 - 68.53)	(70.01 - 72.36)	(62.24 - 69.09)
	Age 26+	74.04	75.74	69.78	73.75	77.03	74.91
(73.58 - 74.49)		(74.84 - 76.61)	(68.93 - 70.63)	(73.10 - 74.39)	(76.19 - 77.84)	(72.02 - 77.59)	
Age 18+	73.22	74.88	69.10	72.88	76.17	73.59	
	(72.81 - 73.63)	(74.08 - 75.65)	(68.35 - 69.85)	(72.31 - 73.45)	(75.43 - 76.90)	(71.05 - 75.98)	
<b>PAST YEAR DEPENDENCE, ABUSE, AND TREATMENT</b>							
Illicit Drug Use Disorder <sup>1</sup>	Age 12-17	3.30	2.94	3.20	3.07	4.01	4.49
		(3.07 - 3.55)	(2.56 - 3.36)	(2.86 - 3.57)	(2.78 - 3.39)	(3.54 - 4.55)	(3.35 - 5.99)
	Age 18-25	7.14	7.63	6.51	6.81	7.84	8.02
		(6.78 - 7.51)	(6.93 - 8.39)	(5.97 - 7.09)	(6.33 - 7.33)	(7.13 - 8.60)	(6.20 - 10.33)
	Age 26+	2.04	2.06	1.89	1.91	2.36	2.23
(1.91 - 2.17)		(1.81 - 2.34)	(1.68 - 2.12)	(1.73 - 2.10)	(2.08 - 2.68)	(1.62 - 3.06)	
Age 18+	2.76	2.83	2.55	2.60	3.16	3.06	
	(2.64 - 2.89)	(2.58 - 3.11)	(2.34 - 2.79)	(2.42 - 2.79)	(2.88 - 3.46)	(2.39 - 3.91)	
Pain Reliever Use Disorder <sup>1</sup>	Age 12-17	0.55	0.44	0.55	0.59	0.57	0.65
		(0.46 - 0.66)	(0.34 - 0.58)	(0.43 - 0.71)	(0.46 - 0.74)	(0.44 - 0.75)	(0.40 - 1.05)
	Age 18-25	1.03	0.98	1.05	1.04	1.05	1.09
		(0.90 - 1.18)	(0.81 - 1.19)	(0.87 - 1.25)	(0.89 - 1.23)	(0.85 - 1.29)	(0.72 - 1.67)
	Age 26+	0.67	0.65	0.67	0.69	0.65	0.57
(0.60 - 0.75)		(0.54 - 0.77)	(0.57 - 0.79)	(0.60 - 0.79)	(0.54 - 0.77)	(0.39 - 0.83)	
Age 18+	0.72	0.69	0.73	0.74	0.71	0.64	
	(0.66 - 0.79)	(0.60 - 0.80)	(0.63 - 0.83)	(0.66 - 0.83)	(0.61 - 0.82)	(0.47 - 0.88)	
Alcohol Use Disorder <sup>1</sup>	Age 12-17	2.23	2.28	2.29	2.08	2.38	2.76
		(2.03 - 2.45)	(1.99 - 2.61)	(2.03 - 2.57)	(1.85 - 2.35)	(2.06 - 2.75)	(1.99 - 3.82)
	Age 18-25	10.80	11.69	11.66	9.86	10.85	11.56
		(10.35 - 11.28)	(10.89 - 12.54)	(11.00 - 12.35)	(9.32 - 10.42)	(10.08 - 11.68)	(9.59 - 13.88)
	Age 26+	5.31	5.49	5.37	4.87	5.80	6.74
(5.10 - 5.52)		(5.04 - 5.98)	(4.99 - 5.78)	(4.56 - 5.20)	(5.36 - 6.27)	(5.34 - 8.46)	
Age 18+	6.09	6.36	6.28	5.58	6.53	7.43	
	(5.90 - 6.29)	(5.94 - 6.80)	(5.93 - 6.65)	(5.30 - 5.88)	(6.13 - 6.96)	(6.14 - 8.97)	
Substance Use Disorder <sup>1</sup>	Age 12-17	4.61	4.24	4.75	4.21	5.40	7.15
		(4.34 - 4.90)	(3.81 - 4.72)	(4.34 - 5.20)	(3.85 - 4.60)	(4.84 - 6.01)	(5.62 - 9.07)
	Age 18-25	15.20	16.73	15.53	14.19	15.36	16.72
		(14.67 - 15.75)	(15.73 - 17.79)	(14.73 - 16.35)	(13.49 - 14.92)	(14.42 - 16.36)	(13.99 - 19.85)
	Age 26+	6.72	6.91	6.79	6.16	7.39	7.81
(6.48 - 6.96)		(6.41 - 7.44)	(6.38 - 7.23)	(5.80 - 6.54)	(6.88 - 7.93)	(6.30 - 9.65)	
Age 18+	7.93	8.28	8.05	7.29	8.55	9.09	
	(7.71 - 8.15)	(7.82 - 8.76)	(7.67 - 8.45)	(6.97 - 7.63)	(8.09 - 9.04)	(7.64 - 10.79)	

+ All figures are percent prevalence rates; figures in parentheses are 95% confidence intervals

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015 and 2016.



**Appendix 3B. Substance Use and Mental Health, U.S. Regions & New Mexico, by Age Group, Percentages, Annual Averages Based on 2015 and 2016 NSDUHs**

INDICATORS <sup>+</sup>	AGE GROUP	TOTAL U.S.	NORTHEAST	MIDWEST	SOUTH	WEST	NEW MEXICO
<b>PAST YEAR DEPENDENCE, ABUSE, AND TREATMENT</b>							
Needing But Not Receiving Treatment at a Specialty Facility for Illicit Drug Use <sup>10</sup>	Age 12-17	3.14	2.72	2.86	2.91	4.05	4.55
		(2.91 - 3.38)	(2.37 - 3.12)	(2.55 - 3.21)	(2.63 - 3.22)	(3.56 - 4.60)	(3.36 - 6.12)
	Age 18-25	6.62	6.77	6.00	6.45	7.30	7.66
		(6.27 - 6.98)	(6.12 - 7.49)	(5.48 - 6.57)	(5.99 - 6.94)	(6.59 - 8.07)	(5.84 - 10.00)
	Age 26+	1.78	1.83	1.69	1.59	2.12	1.72
(1.66 - 1.90)		(1.60 - 2.10)	(1.50 - 1.91)	(1.43 - 1.76)	(1.86 - 2.41)	(1.21 - 2.43)	
Age 18+	2.47	2.52	2.31	2.28	2.87	2.57	
	(2.35 - 2.59)	(2.29 - 2.78)	(2.12 - 2.52)	(2.12 - 2.45)	(2.62 - 3.15)	(2.00 - 3.30)	
Needing But Not Receiving Treatment at a Specialty Facility for Alcohol Use <sup>10</sup>	Age 12-17	2.15	2.17	2.20	2.06	2.23	2.57
		(1.95 - 2.36)	(1.88 - 2.50)	(1.95 - 2.48)	(1.83 - 2.31)	(1.93 - 2.57)	(1.84 - 3.58)
	Age 18-25	10.47	11.16	10.64	9.67	11.06	11.78
		(10.02 - 10.94)	(10.40 - 11.97)	(10.03 - 11.27)	(9.12 - 10.24)	(10.26 - 11.91)	(9.81 - 14.08)
	Age 26+	5.05	5.17	5.14	4.60	5.58	5.76
(4.84 - 5.26)		(4.77 - 5.61)	(4.79 - 5.52)	(4.30 - 4.91)	(5.16 - 6.02)	(4.56 - 7.25)	
Age 18+	5.82	6.01	5.93	5.31	6.38	6.62	
	(5.63 - 6.01)	(5.64 - 6.40)	(5.62 - 6.27)	(5.05 - 5.59)	(6.00 - 6.78)	(5.52 - 7.93)	
Needing But Not Receiving Treatment at a Specialty Facility for Substance Use <sup>10</sup>	Age 12-17	4.38	4.09	4.40	4.03	5.13	6.22
		(4.11 - 4.66)	(3.66 - 4.58)	(4.03 - 4.81)	(3.68 - 4.40)	(4.60 - 5.72)	(4.83 - 7.99)
	Age 18-25	14.34	15.59	14.75	13.38	14.56	15.78
		(13.82 - 14.88)	(14.62 - 16.61)	(13.97 - 15.56)	(12.70 - 14.09)	(13.64 - 15.53)	(13.20 - 18.77)
	Age 26+	6.20	6.19	6.20	5.67	7.06	7.37
(5.98 - 6.43)		(5.73 - 6.67)	(5.80 - 6.63)	(5.33 - 6.02)	(6.58 - 7.58)	(5.92 - 9.14)	
Age 18+	7.36	7.50	7.43	6.76	8.15	8.58	
	(7.15 - 7.57)	(7.06 - 7.95)	(7.06 - 7.82)	(6.45 - 7.08)	(7.71 - 8.62)	(7.19 - 10.21)	
<b>MENTAL HEALTH among persons aged 18 or older</b>							
Any Mental Illness in past year <sup>5</sup>	Age 18-25	21.89	22.58	22.25	20.50	23.21	23.51
		(21.33 - 22.46)	(21.49 - 23.71)	(21.32 - 23.20)	(19.72 - 21.31)	(22.11 - 24.35)	(20.48 - 26.84)
	Age 26+	17.44	17.10	17.30	17.53	17.67	18.46
		(17.05 - 17.83)	(16.36 - 17.87)	(16.64 - 17.98)	(16.96 - 18.12)	(16.98 - 18.38)	(16.23 - 20.92)
	Age 18+	18.07	17.86	18.01	17.95	18.48	19.19
(17.73 - 18.42)		(17.19 - 18.56)	(17.42 - 18.62)	(17.44 - 18.48)	(17.85 - 19.12)	(17.18 - 21.37)	
Serious Mental Illness <sup>6</sup> in past year	Age 18-25	5.46	5.56	5.94	5.03	5.62	5.09
		(5.15 - 5.78)	(5.05 - 6.12)	(5.47 - 6.44)	(4.65 - 5.44)	(5.08 - 6.21)	(3.87 - 6.66)
	Age 26+	3.91	3.83	4.11	3.89	3.82	4.32
		(3.73 - 4.10)	(3.49 - 4.20)	(3.82 - 4.43)	(3.63 - 4.16)	(3.50 - 4.18)	(3.37 - 5.51)
	Age 18+	4.13	4.07	4.37	4.05	4.09	4.43
(3.97 - 4.30)		(3.76 - 4.40)	(4.11 - 4.66)	(3.81 - 4.30)	(3.79 - 4.41)	(3.57 - 5.49)	
Had serious thoughts of suicide in past year	Age 18-25	8.57	8.81	8.66	8.06	9.09	8.88
		(8.21 - 8.94)	(8.12 - 9.54)	(8.07 - 9.29)	(7.54 - 8.61)	(8.40 - 9.83)	(7.11 - 11.03)
	Age 26+	3.30	3.26	3.38	3.15	3.48	3.50
		(3.13 - 3.47)	(2.94 - 3.62)	(3.11 - 3.68)	(2.91 - 3.40)	(3.17 - 3.82)	(2.66 - 4.60)
	Age 18+	4.04	4.03	4.14	3.84	4.30	4.28
(3.89 - 4.20)		(3.73 - 4.36)	(3.88 - 4.42)	(3.61 - 4.08)	(4.00 - 4.61)	(3.44 - 5.31)	
Received Mental Health Services <sup>11</sup>	Age 18-25	12.28	13.59	14.36	11.18	11.21	10.60
		(11.83 - 12.75)	(12.73 - 14.50)	(13.61 - 15.13)	(10.59 - 11.78)	(10.44 - 12.03)	(8.57 - 13.03)
	Age 26+	14.61	16.08	15.99	13.91	13.37	13.35
		(14.26 - 14.97)	(15.35 - 16.85)	(15.36 - 16.64)	(13.37 - 14.47)	(12.71 - 14.06)	(11.49 - 15.46)
	Age 18+	14.28	15.74	15.75	13.52	13.06	12.95
(13.97 - 14.59)		(15.07 - 16.42)	(15.19 - 16.33)	(13.05 - 14.02)	(12.47 - 13.67)	(11.24 - 14.88)	
Major Depressive Episode in past year <sup>7</sup>	Age 12-17	12.63	12.13	13.53	11.90	13.32	12.61
		(12.19 - 13.08)	(11.35 - 12.96)	(12.80 - 14.30)	(11.30 - 12.53)	(12.50 - 14.19)	(10.45 - 15.15)
	Age 18-25	10.59	11.08	11.01	9.91	10.89	9.36
		(10.17 - 11.01)	(10.31 - 11.91)	(10.36 - 11.70)	(9.38 - 10.47)	(10.15 - 11.68)	(7.59 - 11.49)
	Age 26+	6.06	6.11	6.20	6.05	5.88	6.27
(5.83 - 6.30)		(5.66 - 6.59)	(5.82 - 6.62)	(5.72 - 6.40)	(5.47 - 6.32)	(5.08 - 7.71)	
Age 18+	6.70	6.80	6.89	6.60	6.61	6.71	
	(6.49 - 6.91)	(6.40 - 7.23)	(6.55 - 7.26)	(6.30 - 6.91)	(6.24 - 7.00)	(5.64 - 7.97)	

+ All figures are percent prevalence rates; figures in parentheses are 95% confidence intervals

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015 and 2016.

## Appendix 2A, 2B, 3A, & 3B. FOOTNOTES

1. Substance Use Disorder is defined as meeting criteria for illicit drug or alcohol dependence or abuse. Dependence or abuse is based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).
2. Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, methamphetamine, or prescription-type psychotherapeutics used nonmedically.
3. Average annual marijuana initiation rate =  $100 * \{[X1 \div (0.5 * X1 + X2)] \div 2\}$ , where X1 is the number of marijuana initiates in the past 24 months and X2 is the number of persons who never used marijuana.
4. Tobacco Products include cigarettes, smokeless tobacco (i.e., chewing tobacco, snuff, dip, or "snus"), cigars, or pipe tobacco.
5. Any mental illness is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a substance use disorder, that met the criteria found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), regardless of the level of impairment in carrying out major life activities.
6. Serious mental illness is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a substance use disorder, that met the criteria found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and resulted in serious functional impairment in carrying out major life activities.
7. Major depressive episode (MDE) is defined as in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), which specifies a period of at least 2 weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms. There are minor wording differences in the questions in the adult and adolescent MDE modules. Therefore, data from youths aged 12 to 17 were not combined with data from adults aged 18 or older to produce an estimate for those aged 12 or older.
8. Underage drinking is defined for individuals aged 12 to 20; therefore, the "12+" estimate reflects that age group and not individuals aged 12 or older.
9. Binge Alcohol Use is defined as drinking five or more drinks (for males) or four or more drinks (for females) on the same occasion (i.e. within a couple hours of each other) on at least 1 day in the past 30 days.
10. Respondents were classified as needing treatment for a substance use problem if they met the criteria for substance use disorder as defined in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) or received treatment for illicit drug or alcohol use at a specialty facility (i.e., drug and alcohol rehabilitation facility [inpatient or outpatient], hospital [inpatient only], or mental health center).
11. Mental health services are defined as having received inpatient treatment/counseling or outpatient treatment/counseling or having used prescription medication for problems with emotions, nerves, or mental health. Respondents were not to include treatment for drug or alcohol use.

## **Appendix 4**

### **International Classification of Diseases, Clinical Modification, 9th and 10th Edition**





## Appendix 4: International Classification of Diseases, Clinical Modification, 9th and 10th Edition

ICD-9-CM		ICD-10-CM	
Description	Code	Code	Description
<b>Opioid Overdose/Poisoning</b>			
Poisoning by opium (alkaloids), unspecified	965.00	T40.0 [X1-X4]	Poisoning by opium
Poisoning by other opiates and related narcotics	965.09	T40.2 [X1-X4]	Poisoning by other opioids
Accidental poisoning by other opiates and related narcotics	E850.2		
Poisoning by methadone	965.02	T40.3 [X1-X4]	Poisoning by methadone
Accidental poisoning by methadone	E850.1		
Poisoning by heroin	96.50	T40.1 [X1-X4]	Poisoning by heroin
Accidental poisoning by heroin	E850.0	T40.4 [X1-X4]	Poisoning by other synthetic narcotics
<b>Chronic Liver Disease</b>			
Acute and subacute necrosis of liver	570.xx	K70-K77	Diseases of liver
Chronic liver disease and cirrhosis	571.xx		
Liver abscess and sequelae of chronic liver disease	572.xx		
Other disorders of liver	573.xx		





KAMAMA  
CONSULTING

The NM ATODA Prevention Workforce Training System staff is fortunate to work with the Office of Substance Abuse Prevention and with each of you to prevent and reduce substance abuse in our communities.

### Notable Policies

- All workshops are free to designated Core Team members of OSAP-funded programs. Otherwise, there is a per-workshop fee as indicated in the training descriptions.
- Register at least three business days before the training.
- A minimum of three days notification is required for cancellation or substitutions.
- Participants must attend the full duration of the training to receive a certificate.

Please read all policy and payment information on our website:

[nmpreventionworkforce.org](http://nmpreventionworkforce.org)

The Training System is sponsored by New Mexico Behavioral Health Services Division / Office of Substance Abuse Prevention (OSAP), in collaboration with Kamama Consulting.



## NM ATODA PREVENTION WORKFORCE TRAINING SYSTEM

### Training Calendar: July-September, 2019

#### Training Descriptions

##### **Marijuana: Preventing the Abuse of this Complicated Drug Santa Fe, July 11**

Marijuana is one of the most challenging drugs for Preventionists to discuss and address in their communities. It is the most commonly used illicit drug and there is a widespread belief that it is not harmful. Marijuana use has become normalized in many communities and is now legal for recreational use in states as close as Colorado. This training goes beyond the general drug information and will explore

issues related to the decriminalization of marijuana as it has been categorized as medicine for some conditions in our state. Special attention to how these conflicting messages can impact prevention efforts will help participants identify ways they can approach marijuana use and abuse in their community.

**Trainer:** Brian Serna, LPCC LADAC  
**Continuing Education Hours (CEHs):** 6.6 drug-specific hours  
**Fee:** \$130

*Descriptions continued on back...*

**Register Online** [nmpreventionworkforce.org](http://nmpreventionworkforce.org)

Technical Support: 1-505-333-8240 or email [support@nmpreventionworkforce.org](mailto:support@nmpreventionworkforce.org)

### Prevention Code of Ethics Albuquerque, July 18

This course is designed to acquaint the substance abuse prevention professional with the ethical standards established by the New Mexico Credentialing Board for Behavioral Health Professionals. Participants will be provided with the Prevention Code of Ethics and use this code to demonstrate knowledge of the standards in case studies. Participants will become familiar with a decision making model that can be helpful when facing ethical dilemmas. This session provides the required six hours of ethics training for certification or re-certification. This course is also required before Advanced Ethics training is taken.

NOTE: OSAP usually offers Ethics twice in a fiscal year. Plan ahead and take this training if you will need Ethics by or before July of 2020.

**Trainer:** Ginny Adame, CPS

**CEHs:** 6 Ethics | **Fee:** \$130

### Substance Abuse Prevention Skills Training (SAPST)

Albuquerque, August 6 - 9

This training is one of the most important a Preventionist can take. This “boot camp” uses an interactive format to introduce the history of prevention and examines theories put into practice in our profession. Participants will also take an in depth look at the Strategic Prevention Framework and the activities that fall under each component (assessment, capacity, planning, implementation, evaluation, cultural competence and sustainability) of the framework. You will be provided with a manual that will serve as an excellent reference for years to come. This training has been updated with a lot of new information and will be useful to both the novice and experienced preventionist.

*Note: Training is held from 9:00 am - 5:00 pm.*

**Trainers:** Tiffany Martinez and Jorge Gonzales

**CEHs:** 31.2 | **Fee:** \$450

### Trauma Sensitive Lens: Recognizing, Understanding and Responding to the Impact of Childhood Trauma

Albuquerque, September 11

Much of our substance abuse prevention work stems from intergenerational trauma and present day trauma. It is important for preventionists to be aware of the impact of trauma on individuals and community and how it contributes to many public health issues. Knowledge is power and this training will provide the opportunity for participants to develop a greater understanding of how trauma impacts all aspects of life. This training will also explain why many children and families we strive to help do the things they do, and are compelled to repeat patterns of unhealthy behavior. A practical overview of basic brain function and impact of trauma on the brain’s organization, function and structure, and current research in the field of trauma and neuroscience will be provided. Participants will explore the struggles preventionists may encounter and practice recognizing and responding to children and families affected by trauma. Ideas and suggestions, as well as activities and methods to incorporate into the way you work in the community will also be reviewed.

**Trainer:** Donna Lucero, MA, LPCC, NCC

**CEHs:** 6.6 | **Fee:** \$130

### Evidence-based Substance Abuse Prevention ONLINE, September 16 - 24

This online training will provide a comprehensive overview of concepts that are critical in understanding evidence-based substance abuse prevention. A historical review of prevention strategies will highlight the evolution of our rich and diverse profession. Participants will also study substance abuse prevention outcomes as well as the theories and models that are the foundation of prevention. The diverse views of prevention through the lens of various funding agencies, which often impact what will and will not be funded will be explored. As a take away, you will develop your own resource guide that will be a useful and valuable reference moving forward. This is an intense and comprehensive training that will provide a solid foundation of knowledge for evidence-based prevention.

**Trainer:** Paula Feathers, MA

**CEHs:** 6.6 | **Fee:** \$130

Register Online [nmpreventionworkforce.org](http://nmpreventionworkforce.org)

Technical Support: 1-505-333-8240 or email [support@nmpreventionworkforce.org](mailto:support@nmpreventionworkforce.org)

# College Community Module

Please remember your answers are anonymous.

Please think about the college community you live in as you answer these questions.

How much do you agree or disagree with the following statements? (Circle the number of your response)		Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1	Underage drinking among college students is a problem in my community.	0	1	2	3	4
2	Binge drinking by college students is a problem in my community.	0	1	2	3	4
3	Drinking and driving by college students is a problem in my community.	0	1	2	3	4
4	My local college or university needs to do more to stop underage drinking and binge drinking among college students.	0	1	2	3	4
5	Local law enforcement needs to do more to stop underage drinking and binge drinking among college students.	0	1	2	3	4
6	College student drinking contributes to drinking among teens in my community.	0	1	2	3	4
7	College drinking harms the personal safety and well-being of my community members.	0	1	2	3	4
8	Stores, bars and restaurants in my community do not do enough to discourage sales to intoxicated customers.	0	1	2	3	4
9	Stores, bars and restaurants in my community do not do enough to discourage sales to minors.	0	1	2	3	4
10	Problems due to drinking hurt my community financially (such as costs associated with property damage, use of criminal justice system and public services).	0	1	2	3	4
11	In the past year, I have experienced problems associated with alcohol misuse in my community (such as litter, property damage, personal safety, noise, assault, etc.).	0	1	2	3	4
	a) <i>Please describe:</i>					

# New Mexico Community Survey 2019

You must be 18 or older and currently live in New Mexico to take this survey.

Site ID: \_\_\_\_\_  
Location: \_\_\_\_\_  
Date: \_\_\_\_\_  
Surveyor Initials: \_\_\_\_\_  
Survey #: \_\_\_\_\_

## The purpose of the study:

- This survey is funded by the NM Office of Substance Abuse Prevention (NM OSAP) and the Responsible Gaming Association of NM, and administered by the Pacific Institute for Research and Evaluation (PIRE).
- Findings from this survey will be used to better understand substance abuse and gambling issues across New Mexico. The more New Mexico residents who complete the survey, the better NM OSAP can respond to the problems and areas of most concern.

## What you can expect:

- **Your participation in this survey is completely voluntary.** You may choose not to answer a question and you may quit the survey at any time.
- The survey should take you approximately 25 minutes to complete.
- There is a very slight risk that your responses will be seen by data collectors, however we have taken precautions to prevent this by providing an envelope to put your completed survey into, and then another closed container to place your sealed envelope.
- Do NOT put your name or any identifying information on the survey.
- There is a risk that some questions may upset you. You do not have to answer any question you don't want to answer. We provide contact information to everyone completing the survey about local resources for substance abuse, mental health and gambling concerns.
- When you are done, please place the survey in the envelope provided, seal the envelope and place in the box provided by the data collectors.

### IMPORTANT:

- **You must be 18 or older and currently live in New Mexico to take this survey.**
- **There are no right or wrong answers.**
- **Your answers are anonymous.**
- **Please answer the questions as honestly as possible.**

This survey is conducted by the (Name your coalition or agency here) on behalf of the NM Office of Substance Abuse Prevention. If you have questions about the purpose of this study please contact Dr. Martha Waller at: [mwaller@pire.org](mailto:mwaller@pire.org) or toll-free at 1-855-346-2631. If you have questions or concerns about this procedure or your rights as a survey participant in the study, please contact Elysia Oudemans toll-free at 1-866-PIRE-ORG x 2757 or [oudemans@pire.org](mailto:oudemans@pire.org) Please refer to the "New Mexico Community Survey" when you call.

### DIRECTIONS:

Please think about where you currently live in New Mexico as you answer the following questions. Provide only 1 answer for each question unless otherwise specified.

1	How old are you?	<input type="checkbox"/> 18 to 20 <input type="checkbox"/> 21 to 25	<input type="checkbox"/> 26 to 30 <input type="checkbox"/> 31 to 40	<input type="checkbox"/> 41 to 50 <input type="checkbox"/> 51 to 60	<input type="checkbox"/> 61 to 70 <input type="checkbox"/> 71 or older
2	Are you:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> I choose not to identify			
3	How long have you lived in New Mexico?	<input type="checkbox"/> Less than 1 year <input type="checkbox"/> 1 – 5 years		<input type="checkbox"/> More than 5 years <input type="checkbox"/> I don't live in NM	
4	Which one or more of the following would you say is your race or ethnicity? (Check all that apply.)	<input type="checkbox"/> White <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Black or African American <input type="checkbox"/> Native American/American Indian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> Asian <input type="checkbox"/> Alaska Native <input type="checkbox"/> Other [Please write in your race/ethnicity] _____	
5	Are you on active duty in the U.S. Armed Forces, Military Reserves, or National Guard or a veteran of the U.S. Armed Forces?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
6	Are you currently an undergraduate in college?	<input type="checkbox"/> Yes <input type="checkbox"/> No (go to question 8)			
7	What college/university do you currently attend?				
8	What is the highest grade or year of school you completed to date?	<input type="checkbox"/> Less than high school <input type="checkbox"/> High school graduate or GED		<input type="checkbox"/> Some college or technical school <input type="checkbox"/> College graduate, graduate or professional school graduate	
9	Do you identify as LGBTQ (Lesbian, Gay, Bisexual, Transgender, Queer, or Questioning)?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
10	What is your zip code? (for geographic sorting purposes only)				
11	Are you a parent or caretaker of someone <u>under 21</u> currently living in your household?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
12	For the <u>past 30 days</u> , have you had a permanent and stable place to live?	<input type="checkbox"/> Yes <input type="checkbox"/> No			

The next questions are about your personal perceptions of the community where you are *currently* living.  
Please remember that your responses are anonymous.

13	How easy do you think it is for teens in your community to get alcohol?	<input type="checkbox"/> Very easy <input type="checkbox"/> Somewhat easy	<input type="checkbox"/> Somewhat difficult <input type="checkbox"/> Very difficult	<input type="checkbox"/> Don't know
14	How easy do you think it is for teens in your community to get alcohol from stores and restaurants?	<input type="checkbox"/> Very easy <input type="checkbox"/> Somewhat easy	<input type="checkbox"/> Somewhat difficult <input type="checkbox"/> Very difficult	<input type="checkbox"/> Don't know
15	In your opinion, how likely are police in your community to break up parties where teens are drinking?	<input type="checkbox"/> Very likely <input type="checkbox"/> Somewhat likely	<input type="checkbox"/> Not very likely <input type="checkbox"/> Not at all likely	<input type="checkbox"/> Don't know
16	How likely are police in your community to arrest an adult for <u>giving</u> alcohol to someone under 21?	<input type="checkbox"/> Very likely <input type="checkbox"/> Somewhat likely	<input type="checkbox"/> Not very likely <input type="checkbox"/> Not at all likely	<input type="checkbox"/> Don't know
17	In your opinion, if you were driving after you had too much to drink, how likely is it you would be <u>stopped by police</u> ?	<input type="checkbox"/> Very likely <input type="checkbox"/> Somewhat likely	<input type="checkbox"/> Not very likely <input type="checkbox"/> Not at all likely	<input type="checkbox"/> Don't know



How much do you agree or disagree with the following statement?		
18	Problems due to drinking hurt my community financially (such as costs associated with property damage, use of criminal justice system and public services).	<input type="checkbox"/> Strongly disagree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly agree <input type="checkbox"/> Neither Agree nor Disagree
As you answer the next few questions, please define one drink as equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor. A 40-ounce beer would count as 3 drinks, or a cocktail drink with 2 shots of liquor would count as 2 drinks.		
19	In general, how many alcoholic drinks do you typically consume in a week (including weekends)?	<input type="checkbox"/> None _____ Drinks a week (1 or more)
20	Think specifically about the past <u>30 days</u> . During the past <u>30 days</u> , on how many days did you drink <u>one or more drinks</u> of an alcoholic beverage (if any)?	<input type="checkbox"/> 0 days <input type="checkbox"/> 6 to 9 days <input type="checkbox"/> All 30 days <input type="checkbox"/> 1 or 2 days <input type="checkbox"/> 10 to 19 days <input type="checkbox"/> 3 to 5 days <input type="checkbox"/> 20 to 29 days
21	Considering all types of alcoholic beverages, how many times during the past <u>30 days</u> did you have <u>5 or more</u> drinks on an occasion (if any)?  <b>If Female: 4 or more drinks on an occasion OR</b> <b>If Male: 5 or more drinks on an occasion</b>	<input type="checkbox"/> None  _____ Times in past 30 days
22	During the past <u>30 days</u> , how many times have you driven when you've had perhaps too much to drink?	<input type="checkbox"/> None _____ Times in past 30 days
23	During the past <u>30 days</u> , have you driven a vehicle after drinking <u>5 or more</u> alcoholic beverages?	<input type="checkbox"/> Yes <input type="checkbox"/> No
24	<i>If you are 18 to 20 years old, please answer this question: During the past 30 days, how did you get your alcohol? (Check all that apply.)</i>	<input type="checkbox"/> I have not drunk alcohol in the past 30 days. <input type="checkbox"/> Adult family member who is 21 or older gave it or bought it for me. <input type="checkbox"/> Someone not related to me who is 21 or older gave it or bought it for me. <input type="checkbox"/> I got it at a college party (e.g., fraternity, sorority, tailgate, college dorm). <input type="checkbox"/> I got it at some other type of party. <input type="checkbox"/> My parent or guardian gave it or bought it for me. <input type="checkbox"/> I took it from my home or someone else's home. <input type="checkbox"/> I bought it at a store, restaurant, bar or public place. <input type="checkbox"/> Someone under age 21 bought or gave it to me. <input type="checkbox"/> I got it some other way. <i>[Please describe]:</i> _____
25	In your opinion, when is it okay for someone to provide alcohol to minors (i.e., under 21) (not for religious purposes)? Check all that apply.	<input type="checkbox"/> If parents give their permission <input type="checkbox"/> If they are supervised by an adult <input type="checkbox"/> If they are drinking at home <input type="checkbox"/> If they are responsible (mature for their age, a good student, etc.) <input type="checkbox"/> If there is a celebration (e.g., wedding, quinceañera, graduation) <input type="checkbox"/> As long as they are not driving and are safe <input type="checkbox"/> If they are in the military <input type="checkbox"/> Other <i>[Please describe]:</i> _____ <input type="checkbox"/> Never
26	In the <u>past year</u> , have you purchased or otherwise provided alcohol (beer, wine, liquor) for someone under 21, even if it was for your own child? (not including alcohol used for religious purposes)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

The following questions have to do with prescription painkillers such as Vicodin, OxyContin (also called Oxy or OC), or Percocet (also called Percs).		
27	In the <u>past year</u> , were you <u>prescribed painkillers</u> by a medical professional (even if you did not take them)?	<input type="checkbox"/> Yes <input type="checkbox"/> No (if no, go to question 31)
28	When you were prescribed painkillers, were you also prescribed naloxone or Narcan, at the same time?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know
29	When you were prescribed painkillers, did anyone talk to you about the risks involved in using them? (check all that apply)	<input type="checkbox"/> Health care provider <input type="checkbox"/> Pharmacy Staff <input type="checkbox"/> No one talked with me <input type="checkbox"/> Not sure
30	When you were prescribed painkillers, did anyone talk to you about storing them safely? (check all that apply)	<input type="checkbox"/> Health care provider <input type="checkbox"/> Pharmacy Staff <input type="checkbox"/> No one talked with me <input type="checkbox"/> Not sure
31	How much do you think people risk harming themselves (physically or in other ways) using <b>prescription painkillers</b> for a non-medical reason?	<input type="checkbox"/> No risk <input type="checkbox"/> Moderate risk <input type="checkbox"/> Slight risk <input type="checkbox"/> Great risk
32	In the last <u>30 days</u> , did you <u>use prescription painkillers</u> for any reason (even if you were not prescribed them)?	<input type="checkbox"/> Yes <input type="checkbox"/> No (If you answer no, please skip to question 38)
33	During the past 30 days, how many times did you use a <b>painkiller</b> to get high, like Vicodin, OxyContin (also called Oxy or OC), or Percocet (also called Percs)?	<input type="checkbox"/> 0 times <input type="checkbox"/> 10 to 19 times <input type="checkbox"/> 1 or 2 times <input type="checkbox"/> 20 to 39 times <input type="checkbox"/> 3 to 9 times <input type="checkbox"/> 40 or more times
34	If you used a painkiller or other opioid, did you have access to naloxone or Narcan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
35	If you've taken <b>prescription painkillers</b> in the last <u>30 days</u> , on how many days did you take them?	_____ days in the last 30 days (1-30)
36	If you took <b>painkillers</b> in the last 30 days, why did you take them? (Check all that apply)	<input type="checkbox"/> To treat pain that my doctor or dentist identified (for example, injury, surgery, tooth extraction, illness) <input type="checkbox"/> For pain not identified by my physician (e.g., minor injury) <input type="checkbox"/> To have fun with a friend or friend(s) socially <input type="checkbox"/> To help me sleep <input type="checkbox"/> To get high, messed up or stoned <input type="checkbox"/> To cope with anxiety or stress <input type="checkbox"/> Another reason [Please describe]: _____
37	If you used <b>painkillers</b> in the <u>last 30 days</u> for any reason, where did you get them? (Check all that apply)	<input type="checkbox"/> A doctor or doctors prescribed or gave them to me <input type="checkbox"/> A family member shared them <input type="checkbox"/> A friend shared them <input type="checkbox"/> They were bought from somebody (e.g., friend, dealer, family member) <input type="checkbox"/> They were taken from someone (including friends or relatives) without asking <input type="checkbox"/> Other place (e.g., Mexico, internet) [Please describe]: _____
38	In the <u>past year</u> , have you given or otherwise shared <u>any prescription drugs</u> with someone that was not prescribed them (even if that person was a close friend or family member)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
39	Are <u>all your prescription painkillers</u> stored in a locked cabinet or box so that others cannot get to them (including youth and family)?	<input type="checkbox"/> Yes <input type="checkbox"/> I do not have any prescription painkillers <input type="checkbox"/> No

40	What statement best reflects your understanding of the New Mexico Good Samaritan Law that helps protect people from drug-related charges when they call 911 to help others who are overdosing?	<input type="checkbox"/> I know a lot about the law and can explain it to others. <input type="checkbox"/> I've heard of the law, but am unsure how it works. <input type="checkbox"/> I have never heard of this law
<b>You are almost done! Just one last question!</b>		
41	Is there anything else you'd like to tell us or add about the issues we have asked about today?	

## Thank you for your participation!

The information you provide is helping the State of New Mexico improve its substance abuse prevention and mental health services by better understanding what is needed and where it is needed.

If you have questions or concerns about the survey procedure or your rights as a participant please contact Elysia Oudemans toll-free at 1-866-PIRE-ORG x 2757 or at [oudemans@pire.org](mailto:oudemans@pire.org). If you have questions about the purpose of this study, please contact Dr. Martha Waller toll-free at 1-855-346-2631 or at [mwaller@pire.org](mailto:mwaller@pire.org). Please refer to the "New Mexico Community Survey" when you call.

Please take one of the "Take Home" documents with you that provides a lot of additional information in case you want it later! THANKS AGAIN!

# Mental Health Module

Please remember your answers are anonymous.

These next questions are about your mental and emotional health.

1	During the past 4 weeks (28 days), how much of the time did you feel ... <i>(Circle the best response)</i>					
a)	...so sad nothing could cheer you up?	All of the time	Most of the time	Some of the time	A little of the time	None of the time
b)	...nervous?	All of the time	Most of the time	Some of the time	A little of the time	None of the time
c)	...restless or fidgety?	All of the time	Most of the time	Some of the time	A little of the time	None of the time
d)	...hopeless?	All of the time	Most of the time	Some of the time	A little of the time	None of the time
e)	... that everything was an effort?	All of the time	Most of the time	Some of the time	A little of the time	None of the time
f)	...worthless?	All of the time	Most of the time	Some of the time	A little of the time	None of the time
g)	...anxiety?	All of the time	Most of the time	Some of the time	A little of the time	None of the time
2	<u>In the past year</u> , was there any time when you <u>thought</u> you had a mental health, nervous, emotional, drug or alcohol problem?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
3	At any time <u>in the past year</u> , did you seriously think about trying to kill yourself?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
4	<u>In the past year</u> , have you sought help from someone other than your friends or family for your emotions, nerves, mental health, or your use of alcohol or drugs?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
5	<u>During the past year</u> , have you had difficulty accessing treatment for a mental health or substance abuse problem?				<input type="checkbox"/> Yes <input type="checkbox"/> No	

# Opioid Module

Please remember your answers are anonymous.

These questions have to do with people you know who might use painkillers or other opioids.

1	Do you have close family members or friends who often use <b>prescription painkillers</b> (opiates like Vicodin, OxyContin (also called Oxy or OC), or Percocet (also called Percs)?) This could include those who use them with or without a prescription. <i>(If no, then skip to question 2.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> I don't know <input type="checkbox"/> No
	A. <b>If YES to Question 1:</b> In your opinion, could any of these people who frequently use <b>prescription painkillers</b> be at risk of overdose?	<input type="checkbox"/> Yes <input type="checkbox"/> I don't know <input type="checkbox"/> No
	B. <b>If YES to Question 1:</b> Do any of these people who frequently use <b>prescription painkillers</b> live with you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	In your opinion, when is it acceptable to share your prescription painkillers/opioids with others? <i>(check all that apply)</i>	<input type="checkbox"/> When it's an emergency and someone is in pain <input type="checkbox"/> When someone is dependent on them and needs them to get by <input type="checkbox"/> If they belong to you, you have the right to share them <input type="checkbox"/> When there is no health care available to get a prescription <input type="checkbox"/> Parents or guardians can share their medication with their child <input type="checkbox"/> When someone can't afford them <input type="checkbox"/> When a doctor or other provider says you can share them <input type="checkbox"/> It is never okay to share a prescription painkiller with another person
3	Do you have close family members or friends who use <b>heroin</b> ? <i>(If no, then skip to question 4.)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> I don't know <input type="checkbox"/> No
	A. <b>If YES to Question 3:</b> In your opinion, could any of these people who use <b>heroin</b> be at risk of overdose?	<input type="checkbox"/> Yes <input type="checkbox"/> I don't know <input type="checkbox"/> No
	B. <b>If YES to Question 3:</b> Do any of these people who use <b>heroin</b> live with you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Do you agree or disagree with the following statements?</b>		
4	I have Naloxone/Narcan to help prevent an overdose death.	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
5	I know how to get Naloxone/Narcan if I need it.	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree
6	I know how to use Naloxone/Narcan to try to prevent an overdose death.	<input type="checkbox"/> Strongly Agree <input type="checkbox"/> Agree <input type="checkbox"/> Disagree <input type="checkbox"/> Strongly Disagree

# Tobacco Module

Please remember your answers are anonymous.

The next questions are about tobacco use.

1	Do you now smoke cigarettes every day, some days, or not at all? <i>(not including tobacco used for ceremonial or religious purposes)</i>	<input type="checkbox"/> Every day <input type="checkbox"/> Some days <input type="checkbox"/> Not at all
2	Do you currently use chewing tobacco or snuff, every day, some days, or not at all? <i>(not including tobacco used for ceremonial or religious purposes)</i>	<input type="checkbox"/> Every day <input type="checkbox"/> Some days <input type="checkbox"/> Not at all
3	In the <u>past year</u> , have you purchased or otherwise provided tobacco (cigarettes, chew, snuff) for someone under 18, even if it was for your own child? <i>(not including tobacco used for ceremonial or religious purposes)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
The next 2 questions ask about electronic vapor products, such as blu, NJOY, or Starbuzz. Electronic vapor products include e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens.		
4	Have you ever used an electronic vapor product?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5	During the past 30 days, on how many days did you use an electronic vapor product?	<input type="checkbox"/> 0 days <input type="checkbox"/> 10 to 19 days <input type="checkbox"/> 1 or 2 days <input type="checkbox"/> 20 to 29 days <input type="checkbox"/> 3 to 5 days <input type="checkbox"/> All 30 days <input type="checkbox"/> 6 to 9 days

# Writing Goals and SMART Objectives for Prevention

NM OSAP's Guide to Improve Strategic Planning  
for Prevention Programs

**NM OSAP – PIRE**

**3/21/2018**

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# OVERVIEW

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In order to streamline and enable OSAP prevention programs to write quality strategic plans, to facilitate the periodic reporting and review process, and to ensure that all OSAP-funded prevention programming are evidence-based and targeting identified outcome indicators, we have put together the following list of Goals and SMART objectives for your use.

Begin by identifying the goals you intend to address. Next select an OSAP-approved strategy and identify the corresponding Objective, filling in the relevant information. The information you provide for each objective must be SMART:

**Specific** – Include your specific geographic location that you wish to affect (county, town, school, community, pueblo, etc.). Also include the projected change you wish to make. It must be measurable (increased from 1 to 2, decreased from 6% to 5%, etc.) If you choose to increase anything by a %age, you should state your baseline %age. If do not have baseline data, state that you do not have it at this time, though you will be expected to present it in your periodic reporting.

**Measurable** – Change in your objective must be measurable within the fiscal year. Do not propose a change that is either not measurable (ie, focus group data) or that you cannot measure (i.e., if law enforcement will not provide you with enforcement data, then do not write an objective to change it because you will have no data to measure changes).

**Achievable** – Choose a target an IV, strategy, indicator that you can make changes in over the time you have (eg, until June 30 2019). This is where your community needs and readiness assessments come in. Does your coalition have the capacity to achieve an objective? Is your community ready for this strategy? If you have a strong adversary in the school system, even if that is where the needs assessment indicates a problem, your stated objective of stopping all off-campus suspensions may not be achievable.

**Realistic** – You determine the amount of change your program hopes to make. Don't over-estimate the change you want to make in 1 year; it must be realistic. Be conservative so that meeting your objectives can be celebrated.

**Time limited** – “...June 30, 20XX” (with the end of the current fiscal year) should be

**For every objective you write, ask yourself and other stakeholders does it meet the SMART criteria?**

# GOALS

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A few words about GOALS: The OSAP requires providers to focus on two or more of four long term outcomes, which correspond to **GOALS in your SOW**.

- 1) Reduce underage binge drinking (also considered 'underage drinking')
- 2) Reduce underage DWI (also considered 'underage drinking')
- 3) Reduce adult binge drinking
- 4) Reduce adult DWI
- 5) Reduce prescription painkiller misuse and abuse (among 12-25 year olds (for PFS); among youth and adults)

These goals will require you to address more than one Intervening Variable (IV) and corresponding strategy for each, and therefore, will require more than one objective. You do not need to restate the goal for each objective.

## INTERVENING VARIABLES & CONTRIBUTING FACTORS

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As the OSAP logic models indicate, there are multiple Intervening Variables (IVs) associated with your consumption behavior goals that you will need to address in your prevention efforts. IVs are broad constructs/concepts such as Social Access. However, the community-level and measurable part of each IV is what we call the Contributing Factor (CF). For example, CFs are the locally-identified aspects of social access such as stealing alcohol from convenience stores, having of-age family members purchase alcohol for underage youth, or stealing prescription drugs from grandparents. These all reflect different aspects of social access that may vary from place to place, requiring a community-specific approach to address it effectively. Your community needs assessment should help you identify the most important IVs, and by extension, the most relevant CFs in your community.

# EVIDENCE-BASED PREVENTION STRATEGIES

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Each **strategy** approved for implementation by OSAP and the SEOW (State Epidemiological Outcomes Workgroup) is listed in the charts below, with a complete list to be found at the end of this document. Only strategies from the approved list may be implemented using OSAP funds unless there is a strong theoretical basis for assuming an alternative strategy should work well. The strategies selected for implementation must directly address the IVs/CFs your program has identified to be targeted. How your objective is written, complete with appropriate indicators, helps assure that you are implementing the evidence-based strategy with fidelity to the corresponding IV.

## WRITING YOUR SCOPE OF WORK/ STRATEGIC PLAN

---

Using the strategic planning form and example provided by OSAP, use the examples below to assist you. The strategic plan you develop for your program will derive from your SOW document and vice versa, which goes into your annual contract with OSAP. These two documents (your strategic plan and SOW) are intimately linked and should match each other with respect to goals, objectives, indicators, etc. If they don't match, then your SOW takes legal precedence (you are contractually obligated to complete your SOW) but it also means you need to correct one or the other, or both as soon as possible.

**The SOW will be structured as below. Maintaining the SOW structure in your strategic plan will assure that you are following your strategies as contracted.**

### **Goal**

Related to one of the statewide indicators, underage drinking, DWI and Binge Drinking, Adult DWI and Binge Drinking and Prescription Painkiller misuse. Indicates the geographic scope and the age or generation. (for new providers only: coalition capacity and community readiness.) If the goal is a capacity or readiness-related, the goal language will correspond to increasing coalition capacity or community readiness.

### **Goal Indicator(s)**

How will you measure changes in the indicator among the targeted population(s)? These indicators do not have to be measured annually, so you may use the YRRS for youth. Use the measures provided to you in this document.

### **Intervening Variable and Contributing Factor (IV/CF)**

Identify the Intervening Variable you are addressing & present the contributing factor(s).

### **Strategy(ies)**

Use strategies from approved list of OSAP approved strategies (number strategy according to list at the end of this document).

### **SMART Objective**

Adapt your SMART Objective from the list in this document, always ending with fiscal year (June 30, 201X).

### **Objective Indicator(s)/measure(s)**

Always measurable annually (i.e., not from YRRS) Select one or more indicators from the corresponding objective in the charts below, and see commentary below for more details.

### **Activities/Benchmarks**

Base your activities on what is required to implement a strategy with fidelity. These will help inform your selection of process measures for your evaluation plan.

### **Data-informed Justification for Strategy Selection**

This is your local data-informed decision to select your strategy: why is this strategy the best one to address the objective and change the target indicator? Use local data from your Needs Assessment to demonstrate need. Any changes to your SOW require a data-informed justification.

# EXAMPLE GOALS & OBJECTIVES

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Below, we provide generic versions of the **goals** corresponding to the five outcome indicators established by OSAP. OSAP-**approved strategies** for each goal are listed with a corresponding **objective** template and examples of **indicators** you may use to track progress on the objective. Further, we provide you an example of a SMART objective for each strategy.

**Use these templates to design your strategic plan: copy and paste either from the template or the example objective.** The initiation of each objective begins with the language of the Intervening Variable that it addresses. For example, “Reduce youth retail access to alcohol by....” Each template should also include the essential elements to the SMART objective, so just by copying and pasting the objective and filling in your own language as relevant to your community and needs, we can insure that all essential components to the objective are included.

**A few words about indicators:** You are asked to identify Goal and Objective (strategy-level or outcome) indicators. You will need to document both Goal and Objective indicators separately in your periodic reporting to OSAP. Goal indicators can be long term, and do not have to be measurable annually.

Objective indicators must be measured annually for contracting purposes. You are **not** expected to state all possible indicators that relate to any strategy or IV. Track the one or two most relevant and/or obtainable, and are reflected in the language of your objective.

*List outcome indicators that reflect the work as defined in the Objective.* Since the objective is defined by your intervening variable, your indicators should not include any measurement of another IV. For example, if your objective is meant to address social access, do not include as your outcome indicator perceived risk. While this would be an important indicator to track so you can understand your work as a whole, it is not an Outcome indicator for that strategy. Even if the indicator is still a measure of one particular intervening variable, the selected indicator may only reflect a specific strategy within that IV. So, for example, if your objective is to increase the number of adult DWI enforcement activities, do not make sales to minors citations one of your indicators. The Objective language you choose may also reflect something very specific: if you state that you wish to improve a school ATOD policy by one policy, the number of school suspensions does not reflect that increase or improvement of a school policy.

“Some measurable change” does not always mean a percent or rate. By reading the example objectives, you can see how alternatives to the percent change can be created that still maintain the integrity of the SMART objective as outlined. Make sure that if you define a percent change, that you can measure that change in percent for periodic reporting.

Sometimes there will be example **process indicators**. These are not required for your SOW, but may come in handy to remind you of your tracking/evaluation needs. You should make sure you

report those as process indicators in your SOW if you choose to include them and you should include in your Excel dashboards for periodic reporting. They include items like kind, reach and frequency of media campaigns, arrests and citations for enforcement activities, number of physicians and pharmacists reached, etc. Tracking these process measures will help you understand got to your outcomes, and improve the quality of your prevention work.

Any indicator (Goal, Objective/Outcome and process) listed in your SOW should be defined and approved by your local evaluator: here you are documenting that you intend to collect these measures. Don't list an indicator that you do not know how to collect or do not ever intend to collect. Your evaluator should help you determine the feasibility of collecting those data and whether they actually measure the objective you are addressing.

Your input is very important. We continuously improve our process through your critical insight, knowledge and communication. If you wish to use an indicator that you do not find on the list of approved indicators, please contact PIRE to discuss.

## GOALS FOR ALCOHOL-RELATED INDICATORS

You can combine as many as two indicators at a time in one goal.

For example,

“Reduce Youth and Adult DWI in Bernalillo County”

“Reduce Adult DWI and Binge Drinking Sierra County”

Please be sure that your Objectives correspond to your long-term goal, and that you list all indicators you intend to collect for your Goal. **Indicators should only reflect what is referenced in the language of the goal or objective -- for goals you only should have indicators for binge drinking, DWI, 30-day drinking (underage only), or using painkillers to get high.** Do not include IV measures as indicators of Goals such as retail access or law enforcement activities.

*For example:*

**GOAL: Reduce (underage drinking/binge drinking/drinking and driving) among (youth under 21) and (adults 21 and older) in (your location).**

**Possible Outcome Indicator(s) for Goal:**

- YRRS: Binge drinking & driving while intoxicated measures (every two years)
- Annual SFS (ASFS): underage drinking, binge drinking & driving while intoxicated measures (past 30 days)
- Community Survey (18-20 yr. olds only): underage drinking, binge drinking and two drinking and driving indicators (past 30 days)
- Community Survey (21+ yr. olds only): binge drinking and two drinking and driving indicators (past 30 days)
- Annual SLS (Student Lifestyle Survey): 30-day underage drinking, binge drinking (past two weeks), driven under the influence (past 12 months).
- BRFSS (From Epi Profile) adult binge drinking and self-reported DWI (assuming you have these data at the community level).

After you have written your SMART Goal, and identified indicators or measures of that goal, you then must identify which IVs are most influential in your community and if addressed adequately through prevention strategies, will affect the stated goal positively. This is where having a good needs assessment will help you tremendously because you will be able to easily identify the IVs most at play in your community. You will be asked to justify the strategies you've selected and your needs assessment data and results should be used in your justification.

For each intervening variable, we provide multiple prevention strategies associated with varying contributing factors. We also provide a corresponding SMART objective and indicators/measures for each objective. Use these as templates for your own objectives, strategies, measurements that you will included in your OSAP SOW and strategic plan.

## INTERVENING VARIABLE 1: ENFORCEMENT OF ALCOHOL-RELATED LAWS

**Strategy A1a:** Promotion & coordination of stronger enforcement of all existing youth and adult alcohol & drug related laws (*citations and arrests for: minors in possession, sales to minors, providing alcohol to a minor, Social Host Ordinance violations; DWIs, sales to intoxicated, server liability*).

**Objective a:** Increase enforcement of (underage/all) drinking laws (by some measurable change) in (location) by June 30, 2019.

**Possible OUTCOME Indicators for Objective a:**

- Citation or arrests by law/regulations (eg, MIPs, retailer sales to intox or sales to minors, DWI arrests (underage and adult), providing alcohol to a minors (4<sup>th</sup> degree felony) citations, etc.)
- Sentencing adherence

**Note:** *Those who select this strategy should also try to track actual enforcement activities (as in A1b) as process measures so they can have a more complete picture to present to community stakeholders.*

**Example Objective a:**

*Increase enforcement of underage drinking laws in Hidalgo County by increasing MIP citations by 5 from a baseline of 10 citations in 2016 by June 30, 2019.*

**Example OUTCOME Indicator a:**

- # of MIP citations



## ENFORCEMENT OF ALCOHOL-RELATED LAWS

**Strategy A1b:** Promotion & coordination in order to increase enforcement efforts/activities: sobriety checkpoints, saturation patrols, party and SHO patrols & SIU activity (compliance checks, shoulder taps, sales to intox checks).

**Objective b:** Increase law enforcement activities to deter (youth alcohol consumption/adult DWI/adult problem drinking) (by some measurable change) in (location) by June 30, 2019.

**Possible OUTCOME Indicators for Objective b:** *(select one or more of these according to specific work in your community.)*

- Sobriety checkpoints
- Coordinated sobriety checkpoints (interjurisdictional)
- Saturation patrols
- Party & SHO patrols
- SIU activity (Shoulder taps, sales to intox and compliance checks)
- Other DWI enforcement efforts
- College campus specific enforcement activities

**Note:** *Those selecting this strategy should also try to track the outcomes or results of these enforcement activities as process measures so they can have a more complete picture to present to y stakeholders. Track agencies involved in each enforcement activity as well)*

**Example Objective b:**

*Increase law enforcement activities to deter youth alcohol consumption by increasing party patrols from 4 in 2016 to at least 12 (or once a month) in Bernalillo County by June 30, 2019.*

**Example OUTCOME Indicator b:**

- *Number of party patrols*

**Strategy A1c:** Education & coordination for stricter enforcement of youth graduated licenses

**Objective c:** Increase enforcement of youth graduated license regulations (by some measurable change) in (your location) by June 30 2019.

**Possible OUTCOME Indicators for Objective c:**

- # of citations for driving without appropriate licensing
- % of youth drivers whose progression of licensing is delayed because of non-adherence to GDL driving regulations.

**Example Objective c:**

*Increase enforcement of youth graduated license regulations by at least doubling the citations in Silver City for youth driving without an appropriate license from 2 in FY 2016 to 8 by June 30 2019.*

**Example OUTCOME Indicator c:**

- *number of citations for youth driving without appropriate license.*

**Strategy A1d:** Develop and strengthen enforcement of ATOD policies at schools (includes the elimination of zero-tolerance policies that lead to suspension and expulsion from school)

**Note that the Goal for this strategy can be any of the long term statewide youth-related goals listed on pg. 4. Do not make a unique goal (like ATOD use on school grounds, YRRS)**

**Objective d:** Increase the application of appropriate ATOD policies (by some measurable change) in (name of school district, school, university, college) by June 30, 2019.

**Possible OUTCOME Indicators for Objective d:**

- # and kind of policies revised or enhanced (e.g., re: use on campus, consequences, use space restrictions, cameras real or fake, elimination of zero-tolerance policies, closed campus policy)
- # and kind of highly visible enforcement/monitoring activities on campus (lunch monitors, ATOD use space monitors, monitoring of school sporting events)
- # youth caught and consequences, including referrals to alternative services (i.e., 8 youth caught, 2 given after school community service; 6 referred to SBHC), decreased repeat offenders.
- decreased ATOD-related suspensions and expulsions
- ASFS: use of ATOD on school grounds (note that this must be used with other policy/enforcement indicators listed above)
- ASFS: perception of risk of getting caught on campus for ATOD infractions (*NOTE: here you may change this strategy to the IV of perception of risk of consequences and not law enforcement and change the language of the objective accordingly*).

**Example Objective d:**

*Increase the application of appropriate underage drinking policies by increasing the number or frequency of at least 3 highly visible monitoring activities in Taos County schools by June 30, 2019 (currently no monitoring activities are tracked).*

**Example OUTCOME Indicator d:**

- *kind and frequency of new monitoring activities: 1-daily random campus walk targeting ATOD hotspots by staff; 2-daily lunchtime patrols by law enforcement; 3- daily school lunch patrol by staff/volunteers*

## INTERVENING VARIABLE 2: LOW PERCEIVED RISK OF LEGAL CONSEQUENCES

**Strategy A2a:** Publicizing enforcement efforts and activities (party patrols, SHO patrols, sobriety checkpoints, saturation patrols, SID activities, etc.)

**Objective a:** Increase perceived risk of legal consequences for breaking alcohol-related (or underage drinking) laws (and/or regulations) by (measurable amount) by highly publicizing (list alcohol-related enforcement activities) to (location) by June 30, 2019.

**Possible OUTCOME Indicators for Objective a:**

- Change in specific perception of risk questions in NMCS (e.g., risk of arrest for providing alcohol for minors, risk of police breaking up parties where teens are drinking, risk of getting stopped for DWI)
- Change in perception of risk for young adults (18-20 or 18-25) or another specific subpopulation identifiable by data (arrest for providing alcohol to minors, for police breaking up UAD parties, stopped for DWI).
- Change in ASFS questions about getting caught for drinking and getting into trouble for drinking in the community.
- For colleges only: change in select ASLS questions (eg, for risk of arrest for providing alcohol to minors, risk of police responding to off campus drinking parties, risk of getting arrested for DWI).

**Example Objective a:**

*Increase perceived risk of legal consequences for breaking underage drinking-related laws and regulations by 5 % by highly publicizing all enforcement activities related to the provision of alcohol to a minor to the UNM community by June 30, 2019.*

**Example OUTCOME Indicator a:**

- *Change in NMCS for UNM (UNM campus+nearby neighborhood) – likely and very likely to be arrested for providing alcohol to a minor (Baseline NMCS 55% reported likely to very likely to be arrested for UNM, no baseline for surrounding areas)*
- *Change in SLS at UNM (2016 to 2019), perception of risk of arrest for giving alcohol to someone under 21*

## INTERVENING VARIABLE 3: RETAIL ACCESS

**Strategy A3a:** Responsible Beverage Service Model (a package including alcohol merchant education, store manager policies, age verification, server training)

**Objective a:** Decrease (easy) retail access to alcohol (by minors and/or intoxicated persons) by (a specific measurable amount) by implementing the Responsible Beverage Service Model in (your location) by June 30, 2019.

**Possible OUTCOME Indicators for Objective a:**

- Annual SFS or brief periodic school survey results for where youth accessed alcohol (retail sources)
- ASLS results for college student access to alcohol through retail sources
- NMCS results for 18-20 year old drinkers reporting retail access to alcohol
- NMCS results of minors' easy access to alcohol in retail outlets
- % retailer compliance violations to specific compliance operations visits (reduction: specify kind of visit and kind of violation, eg, Sales to Minors (STM), Sales to Intox, (STI) etc.). Typically these are SIU operations but can be another entity: specify.
- Objective observation of retailers – % they are carding, visible evidence of overserving

**Important Process measures:**

- Number and kind of participating outlets
- Policy and practical changes made in outlets

**Example Objective a:**

*Decrease retail access by under-age students by reducing retailer STM violations from 22% violations/compliance operations in FY 2017 to 10% by implementing the Responsible Beverage Service Model in Socorro County by June 30, 2019.*

**Example OUTCOME Indicator a:**

- *% of STM violations per compliance operations (# of sales to minors violations/# of SIU checks).*

## RETAIL ACCESS

### **Strategy A3b:** Restrictions on alcohol placement in stores

**Objective b:** Decrease (easy) retail access to alcohol by minors (*optional* by measurable amount) by restricting alcohol placement in retail stores (by a measurable amount) in (your location) by June 30, 2019.

#### **Possible OUTCOME Indicators for Objective b:**

##### **First indicator/retail access (optional)**

- NMCS results for 18-20 year olds about where they accessed alcohol (retail sources).
- NMCS results of ease of access to alcohol in retail outlets
- ASLS results for college student access to alcohol through retail sources
- Annual SFS or brief periodic school survey for where youth accessed alcohol (retail sources)

##### **Second indicator (required):**

- Number of retailers where alcohol location is changed to make it more difficult for youth to steal.

#### **Example Objective b:**

*Decrease retail access of alcohol to minors by 5% (2015 SFS minors 34% and NMCS 18-20 55%) by restricting alcohol placement in 4 out of 5 retail stores approached in Silver City by June 30, 2019.*

#### **Example OUTCOME Indicator b:**

- *NMCS 18-20 and SFS HS 30-day retail access to alcohol (first indicator)*
- *number of retail stores approached (denominator) and number of stores restricting placement at follow-up(s) (second indicator)*

## RETAIL ACCESS

**Strategy A3c:** Restrictions on alcohol advertising by schools, day care centers, etc.

**Objective c:** Reduce the promotion of alcohol to minors by restricting/reducing/eliminating the location of alcohol advertising in (measurable amount) in of areas where youth congregate) (in your location) by June 30, 2019.

**Possible OUTCOME indicators for Objective c:**

- # of locations where advertising was removed/ # of locations advertising alcohol where youth congregate
- # of alcohol advertisements in each location pre-intervention/ # of alcohol advertisements in each location post intervention

**Example Objective c:**

*Reduce the promotion of alcohol to minors by restricting the location of alcohol advertising in 4 out of 5 areas where youth congregate in Silver City by June 30, 2019.*

**Example OUTCOME Indicator c:**

- # of areas where alcohol advertising was removed/ # of locations advertising alcohol where youth congregate

**Strategy A3d:** Restrictions on alcohol sales (days, hours)

**Objective d:** Reduce ease of retail access to alcohol by minors (*optional* + by intoxicated) (*opt:* by measurable change) by restricting alcohol sales and times by (measurable amount) in (location) by June 30, 2019.

**Possible OUTCOME Indicators for Objective c:**

- Dates, times and locations of alcohol sales
- NMCS results for 18-20 year olds about where they accessed alcohol.
- NMCS results of ease of access to alcohol in retail outlets
- ASFS results for where youth accessed alcohol.
- SLS results for college student access to alcohol through retail sources
- Add a NMCS question about ease of those who are already drunk to continue to purchase alcohol.

**Possible Optional indicators:**

- Retail access for minors: NMCS 18-20 for retail source of 30 day drinkers
- ASFS: retail source of 30 day drinkers

**Example Objective d:**

*Reduce easy retail access to alcohol among minors and the intoxicated in Cibola County by 3% in the NMCS (2015 minor baseline 77%; intox baseline 88%) by restricting alcohol sales after midnight in the Route 66 Casino by June 30, 2019.*

**Example OUTCOME Indicator d:**

- dates, times and location of restriction of alcohol sales
- NMCS – ease of retail access by minors
- Additional question in NMCS – ease of retail access by those already drunk

## RETAIL ACCESS

### Strategy A3e: Restrictions on alcohol outlet density

**Objective e:** Reduce (easy) retail access to alcohol (optional: by some measurable change) by (preventing the increase of/reducing) alcohol outlet density (by some measurable change) in (location) by June 30, 2019.

**Possible OUTCOME Indicators for Objective e:**

- Outlet density (by measure as provided annually by NM Epi, eg, by road mile; by # per target zip code or by annual self-administered land survey of outlets)

**Possible optional OUTCOME Indicators for Objective e:**

- NMCS results for 18-20 year olds about where they accessed alcohol.
- NMCS results of ease of access to alcohol in retail outlets
- SLS results for college student access to alcohol through retail sources
- ASFS results for where youth accessed alcohol

**Example Objective e:**

*Reduce retail access to alcohol in Grant County by reducing outlet density by 3% in the 88061 zip code by June 30, 2019.*

**Example OUTCOME Indicator e:**

- *alcohol outlets in 88061 zip code over multiple years*

### Strategy A3f: Prevention of alcohol license transfers or new licenses

**Objective f:** Reduce (easy) retail access of alcohol to minors (optional: by some measurable change) by preventing the transfer of alcohol licenses or adding new licenses (and/or by some measurable change) in (your location) by June 30, 2019.

**Possible OUTCOME Indicators for Objective f:**

- # of new licenses
- # of transferred licenses

**Possible Optional OUTCOME Indicators for Objective f:**

- NMCS results for 18-20 year olds about where they accessed alcohol.
- NMCS results of ease of access to alcohol in retail outlets
- ASFS results for where youth accessed alcohol.
- SLS results for college student access to alcohol through retail sources

**Example Objective f:**

*Reduce retail access to alcohol among minors by preventing the transfer of at least one alcohol license or the addition of any new licenses in Santa Fe by June 30, 2019.*

**Example OUTCOME Indicator f:**

- *Number of new licenses and license transfers*
- *Number of license transfers prevented/total license transfers applied for*
- *Number of new licenses prevented/total number of new licenses applied for*

## RETAIL ACCESS

### **Strategy A3g:** Restrictions on local alcohol discounts and sales

**Objective g:** Reduce (easy) retail access to minors (opt: by some amount) by restricting sales and discounts (by some amount) (in your location) retail outlets by June 30, 2019.

#### **Possible OUTCOME indicators for Objective g:**

- # of stores committing to reducing sales and discounts for alcohol more commonly consumed by minors
- Random price checks to ensure that prices have not lowered/been discounted.
- NMCS results for 18-20 year olds about where they accessed alcohol (retail).
- NMCS results of ease of access to alcohol in retail outlets
- ASFS results for where youth accessed alcohol.
- SLS results for college student access to alcohol through retail sources

#### **Example Objective g:**

*Reduce retail access to minors by restricting sales and discounts of alcohol most commonly consumed by minors (especially alcohol pops) in at least 5 McKinley County retail outlets by June 30, 2019.*

#### **Example OUTCOME Indicator g:**

- # of retail outlets in the county participating (MOU/MOA) and in compliance (proven by monitoring)
- Kinds of alcohol sales not discounted (36-packs, alco-pops)



## INTERVENING VARIABLE 4: YOUTH SOCIAL ACCESS (FOR YOUTH ONLY)

### **Strategy A4b:** Developing and coordinating a Parent/Community Party Patrol

**Objective b:** Decrease youth social access to alcohol at drinking parties (by some measurable amount) by developing and coordinating a (Parent/Community) Party Patrol in (location) by June 30, 2019.

**Possible OUTCOME indicators for Objective b:**

- Party patrol initiated & patrols instated

*The next measures are generally required when reporting youth consumption for underage drinking priority.*

- NMCS 18-20 year-old drinker's 30-day source of alcohol at a party
- ASFS HS/MS drinkers' 30-day source of alcohol - at a party
- SLS results for college student access to alcohol at a on or off campus party.
- # of Parties/time period (identified at baseline vs. at post via weekend patrols & at pertinent times @ community hotspots)

**Example Objective b:**

*Decrease youth social access to alcohol at drinking parties by 5% (from a baseline of 40% in the 2016 HS-SFS; 44% 18-20 NMCS) by developing and coordinating a Parent Party Patrol in Silver City by June 30, 2019.*

**Example OUTCOME Indicator b:**

- Party patrol initiated
- change in the SFS HS, SLS & NMCS 18-20 (2015-2017)– underage access to alcohol @ a party;

**Example Process indicator b:** number of parents, patrols and sites implemented.

## YOUTH SOCIAL ACCESS TO ALCOHOL...

### **Strategy A4c:** Parents Who Host Lose the Most

**Objective c:** Reduce social access to alcohol among youth from parents or guardians (by some measurable change) by implementing Parents Who Host Lose the Most Campaign (PWHLTM) in (location) by June 30, 2019.

**Possible OUTCOME indicators for Objective c:**

- NMCS those parents/guardians who admit providing alcohol to minors

*The next measures are generally required when reporting youth consumption for underage drinking priority.*

- NMCS question about source of alcohol 18-20 – parents/guardians or stolen from home
- ASFS question about source of alcohol as parent or guardian or stolen from home
- SLS results for college student access to alcohol – from parents.

**Example Objective c:**

*Reduce social access to alcohol among youth from parents by 3% by implementing Parents who Host Lose the Most Campaign in Catron County by June 30, 2019.*

**Example OUTCOME Indicator c:**

*Change in SFS and NMCS 18-20 FY15 to FY18- alcohol accessed from a parent or guardian or stolen from home*

### **Strategy A4d:** Media to increase awareness of 4<sup>th</sup> degree felony, social host laws

**Objective d:** Reduce youth social access to alcohol (by some measurable change) by implementing a media campaign to increase awareness of the 4<sup>th</sup> degree felony and social host laws in (location) by June 30, 2019.

**Possible OUTCOME indicators for Objective d:** *as this strategy is often used for subpopulations such as colleges, workforce make sure that indicators reflect the population*

- NMCS question about providing alcohol to minors (among a specific population such as 18-25 year old near peers, among petroleum workforce, among college students, etc.)

*Both measures from the source and recipient are ideal, although for recipient be aware of the n and age group:*

- NMCS question about source of alcohol 18-20 from (population as reflected in survey, such as friends or at a party).
- SFS question about source of alcohol as (population as reflected in survey, such as friends or at a party.)
- SLS results for college student access to alcohol from someone else over or under 21.

**Example Objective d:**

*Reduce youth social access to alcohol from near peers (18-25) by 3% by implementing a media campaign to increase awareness of the 4<sup>th</sup> degree felony and social host laws in WNMU in Grant County by June 30, 2019.*

**Example OUTCOME Indicator d:**

- NMCS question about providing alcohol to a minor, respondents 18-25 2017-2019.

## INTERVENING VARIABLE 5: INDIVIDUAL CHARACTERISTICS

### **Strategy: Direct Services for alcohol or prescription drug abuse “hot spots”**

1. Curriculum-based for youth: Dare To Be You, Project Venture, Too Good for Drugs
2. Parenting Skill Building: Strengthening Families, Parents as Teachers, Triple-P (Positive Parenting Program)

One special consideration is that **Direct Service providers will need to also include Individual Level Characteristics as an IV** because these will be directly addressed in the prevention program. All direct services programs currently approved by OSAP have been demonstrated to have an impact upon substance abuse. Your CFs related to Individual Level Characteristics should then reflect what the program specific documentation states it should change in order to eventually impact substance use and abuse. For example, in its Program Overview, Botvin Life Skills indicates that it:

*Promotes healthy alternatives to risky behavior designed to:*

- 1) *Teach students the necessary skills to resist social (peer) pressure to smoke, drink, and use drugs.*
- 2) *Help students to develop greater self-esteem and self-confidence*
- 3) *Enable students to effectively cope with anxiety*
- 4) *Increase their knowledge of the immediate consequences of substance abuse*
- 5) *Enhance cognitive and behavioral competency to reduce and prevent a variety of health risk behaviors*

These 5 CFs ideally should be assessed in your evaluation to confirm you are making changes in your Individual Characteristics IV. However, we are aware that programs do not necessarily have the resources to provide this sort of analysis. Since the SFS was developed to address several kinds of prevention programs, it does not necessarily assess these CFs as identified by Botvin or other programs directly. If you only use the SFS, you should identify measures in the SFS that could act as a “proxy” for these CFs. For example, depending upon the specifics of your site’s programming, many questions in Module D of the SFS could be of use.

For other youth curricula, such as Dare to Be You, Project Venture, Too Good for Drugs, or Strengthening Families, prevention programs will need to identify the actual individual level characteristics that should change as a result of the program, and make sure you have a way to assess changes from pre to post. If there are too many to manage, consider grouping CFs into larger categories and/or choose those (probably more than 1) that will best help you and OSAP

assess your success. A list of Internal and External Assets measured in the SFS can be found at the very end of this document.

An example for a program using Botvin and only the SFS to evaluate it would be the following:

**Goal: Decrease binge drinking among Hidalgo County 9<sup>th</sup> graders in the 2015-16 school year**

**Goal Indicator:** SFS binge drinking (fall pre-test and spring post-test)

#### **IV: Individual Characteristics**

**CF: *Low student self-esteem and self-confidence***

**Strategy:** Botvin Life Skills School-based Curriculum

**Example Objective:** *Through implementing Botvin Life Skills training with Hidalgo County 9<sup>th</sup> graders, increase student self-reported self-esteem and self-confidence by 5% in order to resist alcohol peer pressure to use (baseline TBD) by June 30, 201X.*

**Example Objective OUTCOME indicator(s):**

*SFS in Module D questions relative to self-confidence (average increase of these three measures will be taken)*

*D9- I do many things well*

*D14- I stand up for myself without putting others down*

*D18- I have a purpose in life*

**Approved parenting programs:**

**Parenting Skill Building  
Strengthening Families  
Parents as Teachers  
Triple-P (Positive Parenting Program)**

**Please conduct the same process of review and determination of need for programming and communicate with your evaluator about how to construct your plan, objectives and indicators.**

## A6. COMMUNITY CONCERN/AWARENESS

(FOR PROGRAMS ALREADY IN IMPLEMENTATION FOR MORE THAN A YEAR)

**Strategy A6a:** Education about the benefits of reducing the cost of alcohol-related problems to the community.

**Objective a:** Increase community concern about the cost of problem drinking (by X%) in (location) by June 30, 2019 by educating the community about the high cost of alcohol-related problems and evidence-based means to decrease it.

**Possible OUTCOME indicators for 6a:**

- NMCS “Problems due to drinking hurts my community financially”
- Other representative survey question that specifies concern about cost of alcohol to community.

**Example Objective 6a:** *Increase community concern about the cost of problem drinking by 5% in Bernalillo County by June 30, 2019 by educating the community about the high cost of alcohol-related problems and evidence-based means to decrease it.*

**Example OUTCOME indicators for 6a:**

- *NMCS “Problems due to drinking hurts my community financially”*

## GOALS FOR PRESCRIPTION PAINKILLER MISUSE AND ABUSE INDICATORS

- Use just one Goal for all your prescription painkiller related Strategies and their corresponding Objectives
- List all the indicators you will (can) collect for your Goal,
- Identify age or generation group(s) in your goal.
- Remember that goals do not have to be measurable every year as do Objectives, but the more frequently they can be measured the better.

*For example,*

**GOAL: Reduce prescription painkiller misuse among (youth) and (adults and optional age range) in (your location).**

### **Possible Goal Indicator(s):**

- Adults: NM Community Survey: prescription Drug items: using painkiller to get high (adults 18-25);
- Adults: NMCS 30-day prescription painkiller use for any reason
- Adults: NMCS 30-day users of painkillers who used them to get high.
- Youth: YRRS: Past 30 day prescription pain-killers to get high
- A-SFS: Past 30 day prescription pain-killers to get high.
- College only A-SLS: Past 30 day Prescription painkillers to get high

After you have written your Goal for prescription painkillers and identified indicators or measures of that goal, you must then identify which IVs are most influential in your community and that, if addressed through prevention strategies, should affect the stated goal positively. Below we provide strategies associated with contributing factors, corresponding SMART objectives, and indicators/measures for each objective by IVs.

## INTERVENING VARIABLE 2: REGULATED/RETAIL ACCESS

**Strategy R2a:** Increase timely use of the PDMP by *medical providers* to record prescriptions as in accordance with the CDC guidelines (i.e., identify potential red flags such as dangerous prescribing practices or co-prescriptions, diversion or doctor or pharmacy “shopping”)

**Objective a:** Decrease regulated access to prescription painkillers for overuse, misuse and abuse through medical providers in (your location) by (measurable amount) through improving medical provider use of the PMP in accordance with CDC guidelines by June 30, 2019.

**Possible OUTCOME Indicators for Objective a:**

- Ratio of total number of opioid prescriptions filled in county/number of pharmacy PMP checks/queries in county (NMDOH)
- Total number of Patients with Multiple Provider Episodes for your county (quarterly report: 4 Prescribers or 4 pharmacies) (quarterly report PMP, NMDOH)
- % Patient Days with Overlapping Opioid Prescriptions (quarterly report: PMP, NMDOH)
- % of Chronic opioid users with a PMP request in the past 3 months by county (quarterly report; PMP NMDOH)
- % of New Opioid Patients with a PMP request in the past 3 months by county (quarterly report; PMP NMDOH)

**Example Objective a:**

*Decrease regulated access to prescription painkillers for overuse, misuse and abuse through medical providers in Bernalillo County by 1) decreasing the % of patient days with overlapping opioid prescriptions and 2) increasing by 5% the percent of chronic opioid users with a PMP request in the past 3 months through improving medical provider use of the PMP in accordance with CDC guidelines by June 30, 2019*

**Example OUTCOME Indicator a:**

- 1) *% Patient Days with Overlapping Opioid Prescriptions (PMP, NMDOH)*
- 2) *% of Chronic opioid users with a PMP request in the past 3 months by county (quarterly report; PMP NMDOH)*

## **INTERVENING VARIABLE 2: REGULATED/RETAIL ACCESS**

**Strategy R2b:** Increase timely use of the PDMP *by pharmacists* to identify potential red flags such as dangerous prescribing practices or co-prescriptions, diversion or doctor or pharmacy “shopping”)

**Objective b:** Decrease regulated access to prescription painkillers for overuse, misuse and abuse through pharmacies by (measurable amount) through improving pharmacy use of the PMP in (your location) by June 30, 2019.

**Possible OUTCOME Indicators for Objective b:**

- 3) Ratio of total number of opioid prescriptions filled in county/number of pharmacy PDMP checks/queries in county (NMDOH)
- 4) Total number of Patients with Multiple Provider Episodes for your county (quarterly report: 4 Prescribers or 4 pharmacies) (quarterly report PMP, NMDOH)
- 5) % Patient Days with Overlapping Opioid Prescriptions (quarterly report: PMP, NMDOH)
- 6) % of Chronic opioid users with a PMP request in the past 3 months by county (quarterly report; PMP NMDOH)
- 7) % of New Opioid Patients with a PMP request in the past 3 months (quarterly report; PMP NMDOH)

**Example Objective b:**

*Decrease regulated access to prescription painkillers for overuse, misuse and abuse through pharmacies in Luna County by 1) decreasing by 10% the total number of patients with multiple provider episodes and 2) increasing by 5% the percent of new opioid patients with a PMP request in the past 3 months through improving pharmacy use of the PMP in Luna County by June 30, 2019.*

**Example OUTCOME Indicators b:**

- 1) *total number of patients with multiple provider episodes (more than 4 pharmacies or providers) July 2019-June 2019.*
- 2) *the percent of new opioid patients with a PMP request in the past 3 months, Luna County*



### INTERVENING VARIABLE 3: SOCIAL ACCESS

**Strategy R3a:** Target *parents* to restrict youth social access to prescription pain-killers by working directly with PTAs or similar parent groups to encourage locking up meds, proper disposal, use of lock boxes, and to share information with parents on adolescent prescription drug misuse and abuse, as well as dangers of sharing.

**Objective a:** Restrict youth social access to prescription painkillers from parents (opt: by amount) in (location) by 1) increasing parents' self-reported locking up of painkillers (by amount), and 2) reducing sharing prescription meds with others (by amount) through a parent social access campaign with PTAs or similar parent groups by June 30, 2019.

**Possible OUTCOME Indicators for Objective a:**

- (Optional) Annual SFS (or a brief student survey): youth access to prescription meds through sources other than an MD
- 1) NMCS: self-reported locking up of prescription painkillers\*;
- 2) Parent sharing of meds among parents/caretakers of underage living in home;

**Possible Process Indicators for Objective a:**

- Tools developed for parents; dissemination of tool to # of parents; language
- # of new policies and practices implemented by providers to educate parents

**Example Objective a:** Restrict youth social access to prescription painkillers from parents in San Miguel County by 1) increasing parents' self-reported locking up of painkillers by 3%; and 2) reducing sharing prescription meds with others by 7% through a parent social-access campaign with the LVSD PTO by June 30, 2019.

**Example OUTCOME Indicators for Objective a:**

- 1) NMCS: parent self-reported locking up of painkillers
- 2) NMCS parent sharing of meds

**Example Process Indicators for Objective a:**

- Parent Handbook developed
- # of parents receiving and trained in handbook.

## SOCIAL ACCESS TO PRESCRIPTION PAINKILLERS...

**Strategy R3b:** Target *parents* to restrict youth social access to prescription pain-killers by developing and disseminating a culturally appropriate “parent handbook” that includes a medicine cabinet inventory, info handouts, federal guidelines on proper disposal of prescription drugs, & YRRS results related to prescription drug non-medical

**Objective b:** Restrict youth social access to prescription painkillers from parents ( (1) opt. by amount) in (location) by 2) increasing parents’ self-reported locking up of painkillers (by amount), and 3) reducing parent sharing with others (by amount) by developing and disseminating a parent handbook with community-level prescription drug prevention information by June 30, 2019.

**Possible OUTCOME Indicators for Objective b:**

- 1) (optional) Annual SFS (or a brief student survey): youth access to prescription meds through a family member or stolen from home.
- 2) NMCS: parent self-reported locking up of painkillers,
- 3) NMCS parent sharing of meds

**Possible Process Indicators for Objective b:**

- Parent handbook; dissemination to # of parents
- # of new policies and practices implemented by providers to educate parents

**Example Objective b:** Restrict youth social access to prescription painkillers from parents in *San Miquel County* by 1) increasing parents’ self-reported locking up of painkillers by 3%; and 2) reducing sharing with others by 2% by developing and disseminating a community-relevant parent handbook with prescription drug prevention information by June 30, 2019.

**Example OUTCOME Indicators for Objective b:**

- 1) NMCS: parent/guardian self-reported locking up of painkillers;
- 2) NMCS parent/guardian sharing of meds

**Example Process Indicators for Objective b:**

- Parent Handbook developed
- # of parents receiving and trained in handbook.
- # of handbooks disseminated

## SOCIAL ACCESS TO PRESCRIPTION PAINKILLERS...

**Strategy R3c:** Target *parents* to restrict youth social access to prescription pain-killers by creating tools and promoting and implementing policies that insure that SBHCs & prescribers share information with parents on adolescent prescription drug misuse and abuse, proper storage & disposal, and dangers of sharing.

**Objective c:** Restrict youth social access to prescription painkillers from parents (opt: by amount) in (location) by increasing parents' self-reported locking up of painkillers\*, (by amount) and reducing sharing with others (by amount) by creating, promoting and implementing tools and policies that insure that SBHCs & prescribers share information with parents on adolescent prescription drug misuse and abuse, proper storage & disposal, and dangers of sharing by June 30, 2019.

**Possible OUTCOME Indicators for Objective c:**

- 3) NMCS: self-reported locking up of painkillers; sharing of *meds among parents/caretakers of underage living in home*;
- 4) Annual SFS (or a brief student survey): youth access to prescription meds through sources other than an MD

**Possible Process Indicators for Objective c:**

- Tools developed for pediatricians and SBHC to talk to parents
- dissemination of tool to # of providers
- # of new policies and practices implemented by providers to educate parents

**Example Objective c:** Restrict youth social access to prescription painkillers from parents in San Miguel County by increasing parents' self-reported locking up of painkillers by 3%; and reducing sharing with others by 7% by creating, promoting and implementing tools and policies that insure that SBHCs & prescribers share information with parents on adolescent prescription drug misuse and abuse, proper storage & disposal, and dangers of sharing by June 30, 2019.

**Possible OUTCOME Indicators for Objective c:**

- 5) NMCS: *self-reported secure storage; sharing of meds among parents/caretakers of underage living in home*;

**Possible Process Indicators for Objective c:**

- *Tools developed for pediatricians and SBHC to talk to parents*
- *dissemination of tool to # of providers*
- *# of new policies and practices implemented by providers to educate parents*

## SOCIAL ACCESS TO PRESCRIPTION PAINKILLERS...

**Strategy R3d:** Restrict social access through the *elderly (or another sub-population of intentional or unintentional social access\*)* (locking up meds, provide lock boxes, not sharing meds, etc.) with strategies that educate on proper storage, disposing, and sharing of medications and respond to local social norms and conditions.

**Objective d:** Restrict social access to prescription painkillers through (sub-population, eg. the elderly) in (location) by increasing their self-reported locking up of painkillers (by amount), (opt: increasing safe disposal of medications (by amount)), and reducing their self-reported sharing with others (by amount) through a community campaign by June 30, 2019.

### **Possible OUTCOME Indicators for Objective d:**

- NMCS: self-reported locking up of painkillers; sharing of meds (of a particular subpopulation – eg, elderly is 60 and older, through college students, from near peers (18-25)) NOT the general population.
- **Optional:** own survey question regarding safe disposal and/or weight of drugs (preferably opioids) returned from areas frequented by older populations (eg. senior center dropbox).

*\*note that the subpopulation must be defined as a source of painkillers by using data. You must be able to measure change among that population. If you are concerned about a population's misuse of painkillers, as opposed to being the source of painkillers then consider R4a as your strategy.*

### **Possible PROCESS Indicators for Objective d:**

- # of lock boxes provided to (sub-population)
- # of drop boxes established for continuous drop-off.
- # of presentations/educational events conducted with sub-population/#s attending
- # of pledge cards retrieved from (sub- population) (to not share, to lock up and safely dispose of medications).
- # of materials disseminated specifically to sub-population.

**Example Objective d:** Restrict social access to prescription painkillers through those over 60 in San Miguel County by 1) increasing their self-reported locking up of painkillers by 3%; 2) increasing weight of medications returned to senior center drop box by 5%; and 3) reducing their NMCS self-reported sharing with others by 7% through a community campaign by June 30, 2019.

### **Example OUTCOME Indicators for Objective d:**

- NMCS 2016-2019: self-reported locking up of painkillers and sharing of meds over 60 in San Miguel County
- Weight of drugs returned to senior center drop-boxes in Las Vegas.

### **Possible Process Indicators for Objective d:**

- # of lock boxes provided to adults over 60.
- # of drop boxes established for continuous drop-off.
- # of pledge cards retrieved from adults over 60 (to not share, to lock up and safely dispose of medications).

## SOCIAL ACCESS TO PRESCRIPTION PAINKILLERS...

**Strategy R3e:** Work with *pharmacies* to always share information with customers about the dangers of abuse, proper storage & disposal, and dangers of sharing of prescription opioids and other potentially abused drugs.

**Objective e:** Restrict social access to prescription painkillers for abuse in (location) by increasing **pharmacy direct education of patients** (1 by X%) in order to increase community self-reported locking up of painkillers (2 by X%) and reduce their sharing with others (by X%) by June 30, 2019.

**Possible OUTCOME Indicators for Objective e:**

1. NMCS: When you were prescribed painkillers, did anyone talk to you about storing them safely? (pharmacy staff)
2. NMCS: self-reported locking up of painkillers;
3. NMCS: sharing of meds

**Possible Process Indicators for Objective e:**

- # of new policies and practices implemented in # of pharmacies to share information with customers.
- # of materials disseminated to # of customers

**Example Objective e:** Restrict social access to prescription painkillers for abuse in Sandoval County by increasing **pharmacy direct education of patients** by 5% in order to increase community self-reported locking up of painkillers by 2% and reduce their sharing with others by 10% by June 30, 2019.

**Example OUTCOME Indicators for Objective e:**

1. NCMS – pharmacist talked to me about locking up and not sharing painkillers
2. NMCS Bernalillo County - self-reported locking up of painkillers;
3. NNMCS Bernalillo County – self-reported sharing of meds;

**Example Process Indicators for Objective e:**

- # of new policies and practices implemented in # of pharmacies to share information with customers.

**Strategy R3f:** Work with *pharmacies* to provide or sell lock boxes to customers (e.g., providing them to new customers or those who switch medications to them) and/or offer onsite drop-boxes or other opportunities for safe continuous medications return.

**Objective f:** Restrict social access to prescription painkillers for abuse in (location) by increasing (1) self-reported locking up of painkillers (by amount) and (2- opt: safe disposal of medications (by amount)) by helping pharmacies provide lock boxes to customers and offer onsite drop-boxes for safe and continuous return of medications by June 30, 2019.

**Possible OUTCOME Indicators for Objective f:**

Indicator 1: NMCS: self-reported locking up of painkillers

Optional Indicator 2:

Weight of drugs returned (opioids especially) to participating pharmacies  
Survey of pharmacy customers about how they dispose of unused meds.

**Possible Process Indicators for Objective f:**

- # of lock boxes provided to customers at pharmacies
- # of onsite drop-boxes provided
- # of pharmacies accepting meds return

***Example Objective f:*** Restrict social access to prescription painkillers for abuse in San Miguel County by increasing 1) NMCS self-reported locking up of painkillers by 3% and 2) safe disposal of medications to pharmacy by 10 lbs. by helping pharmacies provide lock boxes to customers and offer onsite drop-boxes for safe and continuous return of medications by June 30, 2019.

**Example OUTCOME Indicators for Objective f:**

1. NMCS 2016 to 2019: San Miguel County - self-reported locking up of painkillers
2. Weight of meds returned to participating pharmacies (especially Opioids)

**Example Process Indicators for Objective f:**

3. # of lock boxes provided to adults by pharmacies
4. # of pharmacies accepting meds return

## SOCIAL ACCESS TO PRESCRIPTION PAINKILLERS...

**Strategy R3g:** Work directly with *medical providers* to create and implement institutional policies such that medical providers educate patients on proper storage of meds and encourage the use of lock boxes.

**Objective g:** By June 30, 2019, restrict social access to prescription painkillers for abuse in (location) by increasing self-reported locking up of painkillers (1. by amount) (*opt: and safe disposal of medications (2. by amount)*) and reducing self-reported sharing with others (3. by amount) by creating and implementing institutional policies so that **medical providers** increase their direct education of patients by (4. By amount) to reduce social access.

**Possible Outcome Indicators for Objective g:**

Indicator 1: NMCS: % self-reported locking up of painkillers;

*Optional Indicator 2: weight of medications returned or patient survey identifying what medications were returned and how.*

Indicator 3: NMCS % self-reported sharing of meds

Indicator 4: NMCS: When you were prescribed painkillers, did anyone talk to you about storing them safely? (*health care provider*)

**Possible Process Indicators for Objective g:**

- # of lock boxes provided to adults by practitioners
- # of new policies and practices implemented in # of providers to educate patients.
- Development and dissemination of provider guide (with training) at # of providers.

**Example Objective g:** *By June 30, 2019, restrict social access to prescription painkillers for abuse in Roosevelt County by increasing self-reported locking up of painkillers 1) by 5% and reducing self-reported sharing with others 2) by 5% by creating and implementing institutional policies so that **medical providers** increase their direct education of patients 3) by 3% to reduce social access.*

**Example Outcome Indicators for Objective g:**

*Indicator 1: Roosevelt NMCS: % self-reported locking up of painkillers; .*

*Indicator 2: Roosevelt NMCS % self-reported sharing of meds*

*Indicator 3: Roosevelt NMCS: When you were prescribed painkillers, did anyone talk to you about storing them safely? (*health care provider*)*

**Example Process Indicators for Objective g:**

- # of lock boxes provided to adults by practitioners
- # of new policies and practices implemented by # of providers to share information with patients.
- *PIRE SPF Rx provider survey results for your county if n is sufficient (policies and communications with patients).*



## SOCIAL ACCESS TO PRESCRIPTION PAINKILLERS...

**Strategy R3h:** Work directly with **medical providers** so they can directly educate or encourage patients to reduce social access: develop and disseminate among providers a “provider guide” that could include medicine cabinet inventory, model policies for offices, info handouts, federal guidelines on proper disposal of prescription drugs, & local data related to prescription drug non-medical use, ways to bring the topic up for discussion with patients & parents.

**Objective h:** By June 30, 2019, restrict social access to prescription painkillers for abuse in (location) by (1) increasing self-reported locking up of painkillers (by %) *(opt: (2) and safe disposal of medications (by %)* and (3) reducing self-reported sharing with others (by %) by developing and disseminating a “provider guide” so that (4) **medical providers** increase their direct education of patients (by %) to reduce social access.

### **Possible Outcome Indicators for Objective h:**

1. NMCS: self-reported locking up of painkillers;
2. *(optional) Patient survey about how opioids were disposed of*
3. NMCS: sharing of meds
4. NMCS: When you were prescribed painkillers, did anyone talk to you about storing them safely? *(health care provider)*

### **Possible Process Indicators for Objective h:**

- Development and dissemination of provider guide (with training) at # of providers. Follow-up encounters for quality improvement.
- PIRE SPF Rx provider survey results for your county if n is sufficient (policies and communications with patients).

### **Optional Outcome Indicator h:**

- Weight of drugs (esp. opioids) returned to Take Back events and area Drop Boxes for continuous disposal.

**Example Objective h:** By June 30, 2019, restrict social access to prescription painkillers for abuse in San Miguel County by (1) increasing NMCS self-reported locking up of painkillers by 3% and (2) reducing self-reported sharing with others by 7% by developing and disseminating a “provider guide” so that (3) **medical providers** can directly educate or encourage patients to reduce social access by 5%.

### **Example Outcome Indicators for Objective h:**

- (1) NMCS 2016 to 2019: San Miguel County - self reported self-reported locking up of painkillers; sharing of meds
- (2) NMCS 2016 to 2019: San Miguel County - self reported sharing of meds
- (3) NMCS 2016 to 2019: San Miguel County: When you were prescribed painkillers, did anyone talk to you about storing them safely? *(health care provider)*

### **Example Process Indicators for Objective h:**

- Development and dissemination of provider guide (with training) at # of providers. # of Follow-up encounters for quality improvement.



#### **INTERVENING VARIABLE 4: SOCIAL NORMS/ATTITUDES**

**Strategy R4a:** Use media resources to increase awareness of prescription painkiller harm & potential for addiction, and to increase awareness of dangers of sharing, how to store and dispose of prescription drugs safely.<sup>4</sup> (e.g., collaborating with a “Dose of Reality” campaign, creating media around prescription drug “Take Back” events regarding safe storage and disposal, or use of local drop/lock-boxes). Can be directed towards a specific subpopulation at risk, eg, Spanish speakers, college students, LGBTQ community, etc.

***For this objective, choose only one or two outcomes/indicators that are most relevant to your community, not all:***

**Objective:** In concert with other prescription painkiller prevention activities, implement a media campaign in (your location/opt: (among a specific subpopulation))

- to increase community awareness of the harms of prescription painkiller misuse and abuse (by X amount),
- to decrease prescription painkiller use (by X amount),
- to decrease risky drinking with painkiller use (by amount)
- to decrease prescription drug sharing (by X amount)
- to increase locking up of painkillers by (X amount)

... by June 30, 2019.

**Possible Outcome Indicators for Objective:** NMCS questions about:

- harms of prescription painkiller abuse;
- self-reported 30-day use of prescription painkillers
- self-reported sharing prescription drugs with others
- self-reported locking up of painkillers
- self-reported 30-day binge drinkers and 30-day use of prescription painkillers

**Possible Process Indicator:**

- Kinds and frequency of media

**Example Objective:**

*In concert with other prescription painkiller prevention activities, including a “Dose of Reality” implement a media campaign in Sierra County to increase community awareness of the harms of prescription painkiller misuse and abuse by 5% and to decrease prescription painkiller use by 2% by June 30, 2019.*

**Example OUTCOME Indicator:**

- *NMCS 2016 to 2019: perception of harm of prescription painkiller misuse and self-reported 30-day use of prescription painkillers.*

**Example Process Indicator:**

- *Media plan*
- *Kinds and frequency of media.*

## **DEVELOPING SMART OBJECTIVES FOR COALITION CAPACITY AND COMMUNITY READINESS STRATEGIES**

Your Goal will be to improve coalition capacity and/or to increase community readiness

There are no intervening variables for this section.

Use the same principles as your other objectives. Refer to the beginning of this document for guidance.

- Make the Goal and Objective SMART
- Begin the Objective with the language of each numbered strategy below (“Enhance Coalition structure by....”)

Your outcome indicators that you will track will most likely be the corresponding scores on the coalition and readiness instruments you implemented.

Incorporate the bulleted items under the numbered items into your activities in your scope of work. Not all are required, but most will be helpful. You are not expected to cut and paste these bullets, but make them appropriate to your SOW. An example is provided for the first strategy on the next couple pages.

Following are the list of Coalition Capacity and Community Readiness. You must design your own SMART objectives for them using the model on the next page.

## WRITING COALITION CAPACITY and READINESS STRATEGY OBJECTIVES

**Strategies to enhance coalition structure (from sections A & B on the coalition checklist) Include all or most of the bullets below in your SOW:**

- Clarify vision, mission and goals of (coalition) with coalition members and by documenting and sharing a synopsis with all coalition members at the beginning of each meeting.
- Strengthen (coalition) structure and membership by defining members' roles and responsibilities.
- Build (coalition) capacity by improving the structure and organization of our meetings.
- Build (coalition) capacity by identifying subcommittees to address important tasks based on members' skills.

**Example Goal: Increase Eddy County DWI coalition capacity to support underage drinking prevention**

**Example Objective 1:** *Increase Eddy County DWI Coalition's Capacity by one point in sections A and B in the coalition checklist by implementing strategies to enhance coalition structure by June 30 2019.*

**Example Indicator:** *coalition checklist scores in sections A and B*

**Example activities**

- **July 2017:** *meet with core team to define vision, mission and goals and identify potential subcommittees.*
- **August 2017:** *meet with coalition to review vision, mission and goals and refine. Assign subcommittees*
- **By September 2017** *include coalition vision mission and goals in the header or footer of coalition documentation and print and disseminate relevant documents*
- **By September 2017** *organize coalition binders and disseminate to each member. Provide binder to each new member and instruct coalition members to bring binders to meetings.*
- **September 2017** *map coalition roles and responsibilities with broader coalition Coalition coordinator provides each subcommittee with own strategic plan, arrange meeting dates, times and roles for each subcommittee.*
- **By October 2017** *include map of coalition roles and responsibilities in binders*
- **By October 2017** *review meeting structure and organization, research best practices for meeting management*
- **By November 2017** *define and approve updated meeting structure with group. Include documentation in coalition binders.*
- *Check in quarterly with subcommittee progress*
- *During bi-annual reporting review coalition structure and organization for quality improvement.*

## Combined Capacity and Readiness Strategy (Implementation year 2)

**Strategy E1:** Increase coalition and community capacity to support ongoing prevention structure by implementing efforts to maintain community prevention system enhance communications, coalition outreach, relationships with local government and community leaders, data driven planning, and environmental change; and increase community awareness, readiness among leadership, and resources to prevention in (location) by June 30, 2019.

**Objective:** Increase Coalition and Community Capacity to prevent underage drinking and/or prescription opioid misuse by (measurable change) by implementing activities to

**Possible OUTCOME indicators for Objective:**

- OSAP Coalition Checklist average score (or similar instrument)The OSAP survey is conducted annually with coalition members and collaborative partners.
- OSAP Community Readiness Score for underage drinking or for prescription opioid misuse. (This survey is conducted annually with coalition members, collaborative partners, and engaged community members).
- Additional funding obtained to sustain prevention of underage drinking or prescription opioid misuse

**Example Objective:**

Increase Coalition and Community Capacity to prevent prescription opioid misuse by one point in the community readiness score for prescription opioids and by increasing funding to prevent RxO misuse by implementing activities to enhance communications, coalition outreach, relationships with local government and community leaders, data driven planning, environmental change, increase community awareness, readiness among leadership, and resources to prevention in (location) by June 30, 2019.

**Core Activities:**

1. Host regular meetings and track meeting processes (agendas, meeting minutes, attendance), observable communication (outreach and collaboration with community programs and sectors) and approaches with coalition members (orientation, asking to join a committee or complete a task).
2. Develop and implement a method to inform the community about prevention efforts (convening community meetings, town halls, etc.).
3. Develop and implement a method to keep elected officials and community leaders informed about pressing issues, needs, and outcomes.
4. Develop and implement a plan to increase the level of knowledge, concern, and buy-in from community leaders (specify people/positions) for prevention efforts and their importance.
5. Review progress on the strategic plan and coalition efforts with the coalition at least quarterly and record feedback on progress and accomplishments (share all relevant data).
6. Review Health Impact Disparities Statement with the coalition to ensure that populations experiencing health disparities are being included in prevention planning (data collection and analysis) and implementation efforts (adapt based on need).
7. Increase the level of prevention funding by developing and implementing a plan to identify and seek funding from additional sources to support the sustainability of prevention efforts.

**OSAP FY 2019 INTERVENING VARIABLES & APPROVED STRATEGIES TO ADDRESS  
ADULT AND YOUTH<sup>1</sup> DWI AND BINGE DRINKING<sup>2</sup>**

**A1. Low Enforcement of ATOD Laws**

- a. Promotion & coordination of stronger enforcement of all existing youth and adult alcohol & drug related laws (*citations and arrests for*: minors in possession, sales to minors, providing alcohol to a minor, Social Host Ordinance violations; DWIs, sales to intoxicated, server liability)
- b. Promotion & coordination in order to increase enforcement efforts/activities: sobriety checkpoints, saturation patrols, party and SHO patrols & SIU activity (compliance checks, shoulder taps, sales to intox checks).
- c. Education & coordination for stricter enforcement of youth graduated licenses.
- d. **REQUIRED FOR ALL PROGRAMS:** Develop and strengthen enforcement of ATOD policies at schools (includes the elimination of zero-tolerance policies that lead to suspension and expulsion from school) Also applies to reducing prescription drug abuse.

**A2. Low Perceived Risk of Arrest/ Legal Consequence**

- a. Publicizing enforcement efforts and activities (party patrols, SHO patrols, sobriety checkpoints, saturation patrols, SID activities, etc.)

**A3. Retail Access**

- a. Responsible Beverage Service Model (a package including alcohol merchant education, store manager policies, age verification, server training)
- b. Restrictions on alcohol placement in stores
- c. Restrictions on alcohol advertising by schools, day care centers, etc.
- d. Restrictions on alcohol sales (days, hours)
- e. Restrictions on alcohol outlet density
- f. Prevention of alcohol license transfers or new licenses
- g. Restrictions on local alcohol discounts and sales

**A4. Social Access (for youth only)**

- b. Developing and coordinating a Parent Party Patrol
- c. Parents Who Host Lose the Most
- d. Media to increase awareness of 4<sup>th</sup> degree felony and Social Host Laws

**A5. Individual Characteristics (FOR DIRECT SERVICES ONLY)**

- b. Botvin Life Skills Training
- c. Dare To Be You
- d. Project Venture
- e. Too Good for Drugs
- f. Parenting Skill Building: Strengthening Families, Parents as Teachers, Triple-P (Positive Parenting Program)
- g. SBIRT- Screening, Brief Intervention, Referral, Treatment

**A6. Community Awareness (for programs already in implementation for more than a year)**

- a. Education about the benefits of reducing the cost of alcohol-related problems to the community.

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<sup>1</sup> Strategies approved only for youth are in blue font. Black font can apply to adults as well as youth, depending upon the particular approach.

<sup>2</sup> Please note that numbering/lettering is purposeful due to billing and contracting requirements. Please follow this numbering system for strategies.

## OSAP FY 2019 INTERVENING VARIABLES & APPROVED STRATEGIES TO ADDRESS PRESCRIPTION PAINKILLER MISUSE AND ABUSE

### 2. Retail Access

- a. Increase timely use of the PDMP by *medical providers* to record prescriptions and identify potential abusers, e.g., user education.
- b. Increase timely use of the PDMP by *pharmacists* to identify potential abusers.

### 3. Social Access

- a: Target **parents** to restrict youth social access to prescription pain-killers with by working directly with PTAs or similar parent groups to encourage locking up meds, proper disposal, use of lock boxes, and to share information with parents on adolescent prescription drug misuse and abuse, as well as dangers of sharing.
- b: Target **parents** to restrict youth social access to prescription pain-killers by developing and disseminating a culturally appropriate “parent handbook” that includes a medicine cabinet inventory, info handouts, federal guidelines on proper disposal of prescription drugs, & YRRS results related to prescription drug non-medical use).
- c: Target **parents** to restrict youth social access to prescription pain-killers by creating tools and promoting and implementing policies that insure that SBHCs & prescribers share information with parents on adolescent prescription drug misuse and abuse, proper storage & disposal, and dangers of sharing.
- d: Restrict social access through the **elderly (or another sub-population of intentional or unintentional social access)** (locking up meds, provide lock boxes, not sharing meds, etc.) with strategies that educate on proper storage, disposing, and sharing of medications and respond to local social norms and conditions.
- e: Work with **pharmacies to** always share information with customers about the dangers of abuse, proper storage & disposal, and dangers of sharing of prescription opioids and other potentially abused drugs.
- f: Work with **pharmacies to** provide or sell lock boxes to customers (e.g., providing them to new customers or those who switch medications to them) and offer onsite drop-boxes or other opportunities for safe continuous medications return.
- g: Work directly with **medical providers** to create and implement institutional policies such that medical providers educate patients on proper storage of meds and encourage the use of lock boxes.
- h: Work directly with **medical providers** so they can directly educate or encourage patients to reduce social access: develop and disseminate among providers a “provider guide” that could include medicine cabinet inventory, model policies for offices, info handouts, federal guidelines on proper disposal of prescription drugs, & local data related to prescription drug non-medical use, ways to bring the topic up for discussion with patients & parents.

### 4. Social Norms/Attitudes

- a. Use media resources to increase awareness of prescription painkiller harm & potential for addiction, and to increase awareness of dangers of sharing, how to store and dispose of prescription drugs safely. (e.g., collaborating with a “Dose of Reality” campaign, creating media around prescription drug “Take Back” events regarding safe storage and disposal, or use of local drop/lock-boxes). Can be directed towards a specific subpopulation at risk, eg, Spanish speakers, college students, LGBTQ community, etc.

## COALITION CAPACITY STRATEGIES

### **C1. Strategies to enhance coalition structure (from sections A & B on the coalition checklist) *Include all or most of the bullets below in your SOW:***

- Clarify vision, mission and goals of (coalition) with coalition members and by documenting and sharing a synopsis with all coalition members at the beginning of each meeting.
- Strengthen (coalition) structure and membership by defining members' roles and responsibilities.
- Build (coalition) capacity by improving the structure and organization of our meetings.
- Build (coalition) capacity by identifying subcommittees to address important tasks based on members' skills.

### **C2. Strategies to enhance coalition growth and leadership (from sections C & F on the coalition checklist) *Include all or most of the bullets below in your SOW:***

- Strengthen (coalition) leadership by having two leading members attend leadership training, practice relationship building and gaining stakeholder buy-in, and assessing progress toward goals.
- Coalition members provide orientation and mentoring to new recruits/members
- Different coalition members are given opportunities to take the lead on coalition components/work

### **C3. Strategies to enhance outreach and communications (from sections D & E on the coalition checklist) *Include all or most of the bullets below in your SOW:***

- Build (coalition) capacity by increasing outreach and communications between members, key stakeholders, and specific groups, through sharing of activities and seeking feedback from community residents.
- Development and dissemination of newsletters, website updates, social media promotion, and work with local media groups to promote coalition efforts.
- Regular communication is maintained with coalition members and regular meetings are held.

### **C4. Strategies to enhance relationships with local government and other community leaders (from section H on the coalition checklist) *Include all or most of the bullets below in your SOW:***

- Build (coalition) capacity by recruiting new and improving relationships with local officials and community leaders.
- Develop a method to keep elected officials/community leaders informed about pressing issues, needs, and outcomes.
- Assign coalition members to attend important community meetings and events



**C5. Strategies to enhance data driven planning and environmental change (from sections G, I & J on the coalition checklist) *Include all or most of the bullets below in your SOW:***

- Build (coalition) capacity by learning to collect, analyze and use data in our prevention planning.
- Review progress on the strategic plan/coalition efforts with the coalition and record feedback on progress and accomplishments.
- Brainstorm ideas for improving integration with local resources and take appropriate actions
- Build (coalition) capacity by educating all members on the use and value of environmental prevention strategies.

**C6. Strategies to enhance cultural competency (from section K on the coalition checklist). *Include all or most of the bullets below in your SOW:***

- Build (coalition) capacity by recruiting/maintaining members that reflect the diverse cultural and economic makeup of our community
- Subcommittee/task force reviews activities and products for cultural appropriateness prior to dissemination/implementation
- Provide translation of materials and interpretation into languages other than English spoken in your population.
- Disparities, racism, and poverty are included in coalition discussions, planning and goals
- Work to address possible and unintentional barriers to diverse community participation and representation in coalition.

**C7. Strategies to enhance funding and sustainability (from section L on the coalition checklist). *Include all or most of the bullets below in your SOW:***

- Build (coalition) capacity by identifying and applying for funding from additional sources to support prevention efforts.
- Develop plan and identify researchers/writers for specific grants or funding opportunities
- Develop/review a sustainability plan that addresses organizational and programmatic sustainability and program effectiveness.



## COMMUNITY READINESS BUILDING STRATEGIES

**D1. Strategies to increase community awareness.** *Include all or most of the bullets below in your SOW:*

- Increase awareness of community prevention efforts, who programs serve, gaps in prevention services, the longevity of efforts, etc.
- Develop a plan / action steps for informing the community about prevention efforts (convening community meetings, etc.)
- Assess and address the strengths and weaknesses of current efforts
- Identify formal and informal policies, practices or laws related to these issues

**D2. Strategies to increase readiness among community leaders.** *Include all or most of the bullets below in your SOW:*

- Identify what leaders are critical to the issue(s) at hand and/or experts that could help your efforts
- Increase the level of knowledge/concern/buy –in from community leaders (specify people/positions) for prevention efforts
- Involve community leaders in prevention efforts

**D3. Strategies to improve community climate toward prevention.** *Include all or most of the bullets below in your SOW:*

- Identify and resolve obstacles to substance abuse prevention (under what circumstances is it acceptable? What unique factors in our community make planning and implementation difficult? Etc.)
- Increase support for substance abuse prevention efforts by gathering and disseminating data on the nature of the problem, use assessment data to plan prevention programs and policies, collaborate with agencies working on other prevention issues (HIV, delinquency, etc.), leveraging resources, and sharing successes/outcomes.

**D4. Strategies to increase knowledge of the issues.** *Include all or most of the bullets below in your SOW:*

- Develop and disseminate information / conversations about the dynamics of substance abuse in the community, data related to priority issues, and current and planned efforts to address the issues. Materials and methods will need to be adapted according to the selected/identified group or population.
- Develop and disseminate information / conversations about preventing access to substance in the home and community. Materials and methods will need to be adapted according to the selected/identified group or population.
- Develop and disseminate information about prevention and its importance to the community, including information on the IOM Continuum of Care and why prevention is as important as treatment in improving community health.

**D5. Strategies to increase resources to prevention.** *Include all or most of the bullets below in your SOW:*

- Identify available resources for substance abuse prevention (personnel, financial, organizational, etc.)
- Increase the level of prevention funding by identifying and applying for funding from additional sources to support prevention efforts.
- Increase the number of agencies/partners involved in prevention efforts

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Evaluators

New Mexico  
Office of Substance Abuse Prevention  
5-Year Comprehensive Evaluation Plan

August 2019

Written by:

PACIFIC INSTITUTE FOR RESEARCH AND EVALUATION

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## Background

The New Mexico Office of Substance Abuse Prevention (OSAP) establishes an integrated and comprehensive substance abuse prevention services delivery system through the promotion of sound policy, effective practice and cooperative partnerships to ensure the availability of quality prevention. It is committed to the implementation of evidence-based prevention programs and infrastructure development activities. The OSAP provides the infrastructure and other necessary support to local stakeholders in selecting and implementing policies, programs, and practices proven to be effective in research settings and communities.

The OSAP is dedicated to improving and maximizing the impact of New Mexico's substance abuse prevention system. To this end, OSAP seeks to build the capacity of the state's local prevention providers to deliver effective prevention services aimed at reducing alcohol, tobacco and other drug abuse.

Prevention goals are addressed via multiple funding sources of which OSAP is the recipient, and local prevention programs across the state are funded by the various funding streams to address the substance abuse prevention priorities. Currently, OSAP receives funding from the following sources:

Funding Title	Abbreviation	Source	Duration
Substance Abuse Prevention and Treatment Block Grant	SAPT Block Grant	SAMHSA	Yearly allocation
Partnerships for Success 2015	PFS 2015	SAMHSA	5-year grant; ends September 2020
Grant to Prevent Prescription Drug/Opioid Overdose-Related Deaths	PDO	SAMHSA	5-year grant; ends August 2021
Strategic Prevention Framework for Prescription Drugs	SPF Rx	SAMHSA	5-year grant; ends August 2021
Synar Tobacco Prevention	Synar	SAMHSA	Yearly allocation

Programs receiving **SAPT Block Grant** funding typically address underage alcohol use (any consumption, binge drinking, and/or DWI), adult binge drinking and/or DWI, and prescription opioid abuse. These programs must implement evidence-based environmental prevention strategies to address their goals. They may also implement evidence-based direct service prevention programming targeting adolescents. These same programs receive Synar funding to implement prescribed strategies addressing access to tobacco products among minors.

Programs receiving **PFS 2015** funding are required to focus on youth and young adults age 12 to 25 and address alcohol and prescription opioid misuse and abuse in this age range. These programs must implement evidence-based environmental prevention strategies to address their goals. These same programs have an Emerging Trends for Tobacco priority which provides funding to implement prescribed strategies addressing access to tobacco products among minors.

Programs receiving **PDO** funding provide training and access to naloxone to strategically identified laypersons to prevent opioid overdose deaths.

The program receiving **SPF Rx** funding works with the community to increase the perception of harms of prescription opioids and reduce diversion, and with local opioid prescribers to address prescribing practices and use of the Prescription Monitoring Program (PMP).

According to priorities determined by the funding source, programs identify goals that reflect local needs. The selection of goals, objectives, strategies and activities must be justified based on the results of a comprehensive needs assessment in the funded community. Local strategic plans include SMART goals and objectives, evidence-based strategies selected from an OSAP approved list, and activities required for implementation of the strategies that reflect the highest level of fidelity to the strategy.

The OSAP is committed to using data to guide state-level prevention goals and relies heavily on data provided by the NM Department of Health Epidemiology and Response Division (DOH ERD) to assess ongoing state-level trends and identify new and emerging trends of substance use behaviors and consequences. At a local level, the OSAP also relies on local prevention partners to collect, analyze, and report out on local behaviors, consequences, and related factors not available at the state. These data contribute to needs assessments and evaluations at the local and when aggregated, at the state level. **This evaluation plan is intended to lay out the multiple paths through which data will be collected and used to evaluate the OSAP's ongoing prevention efforts over the next five years.**

## State Level Evaluation

NM Office of Substance Abuse Prevention (OSAP) State-Level Prevention Goals are the following:

- 1) Reduce underage drinking
- 2) Reduce underage binge drinking
- 3) Reduce underage DWI
- 4) Reduce adult binge drinking
- 5) Reduce adult DWI
- 6) Reduce prescription painkiller misuse
- 7) Reduce prescription painkiller and other opioid overdose death
- 8) Reduce illicit drug misuse
- 9) Reduce underage use of tobacco products.

## State-Level Outcomes Evaluation

**Summary Description:** The state evaluators will complete a state-level outcome evaluation as part of their yearly reporting requirements to OSAP. The state evaluator, Pacific Institute for Research & Evaluation (PIRE), will coordinate the collection of community-level data on targeted intervening variables and consumption measures on a yearly basis using primarily two instruments. The NM Community Survey (NMCS) will collect data from NM residents 18 and older and the Annual Strategies for Success (A-SFS) will collect data from middle and high school students. A third data collection tool, the Baseline/Posttest Strategies for Success (BP-SFS) is used only by Direct Service providers, which currently is only one community. NMCS data will be aggregated and weighted to reflect state population distributions with respect to age, race/ethnicity, and gender according to most recent US Census data. The state evaluator will examine data estimates from the NMCS, A-SFS, and BP-SFS with comparable estimates from the NM YRBSS, the NM BRFSS, and the NM NSDUH. An evaluation report of the aggregated NMCS, A-SFS, and BP-SFS data will be provided to OSAP and local and state stakeholders on a yearly basis and trends will be tracked over time. Findings are presented at the OSAP recipient meetings in the fall of each year.

Consequence data will be examined on a monthly and/or yearly basis. The State Substance Abuse Epidemiological Profile will be updated on a yearly basis with new data by NMDOH Epidemiology and Response Division. State-level data dashboards with key indicators will be maintained to track trends by funding mechanism over time. National Outcome Measures (NOMS) data are provided to CSAP on an annual basis by OSAP.

To track progress on these goals at the state-level, data from multiple sources are reviewed and analyzed. Data on consequences, consumption (outcomes), and related factors (intervening variables) are tracked over time to assess whether consequences and consumption behaviors are decreasing and changes in intervening variables are taking place indicative of positive effects of prevention efforts.

**Sources of State-Level Consumption and Intervening Variable Data:**

Data Source	Collected	Coordinating Agency
NM Community Survey (NMCS)	Annual	PIRE/Local Prevention Provider (LPP)
NM Annual Strategies for Success (A-SFS)	Annual	PIRE/LPP
NM Baseline/Posttest Strategies for Success (BP-SFS)	Annual	PIRE/LPP
NM Youth Risk and Resiliency Survey (YRRS or YRBSS)	Biannual - odd years	NMDOH- ERD
NM Behavioral Risk Factors Surveillance Survey (BRFSS)	Annual	NMDOH- ERD
NM National Survey of Drug Use and Health (NSDUH)	Annual	SAMHSA
NM Opioid Prescribers Survey (OPS)	Annual	PIRE/LPP

**Sources of State-Level Consequence Data:**

Data Source	Collected	Coordinating Agency
Alcohol-related motor vehicle crash and fatality (DOT)	Monthly/Annual	NMDOT/PIRE
Prescription Monitoring Program (PMP)	Quarterly/Annual	NMDOH
Death Data (Overdose & ARMVCF)	Annual	NMDOH

**State Level Process Evaluation**

At the state level, process goals include:

1. Improve and enhance prevention efforts at the local level by increasing fidelity to evidence-based prevention strategies.
2. Improve, enhance, and expand training and TA initiatives that result in a more effective prevention workforce.
3. Develop and utilize local and state level data dashboards for real time monitoring and evaluation of local prevention efforts.
4. Improve planning and accountability processes at the community level through the development of an objective reviewing system of local progress reports.



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**Sources of State Level Process Data:**

Data Source	Collected	Coordinating Agency
NM Dept. of Public Safety, Special Investigations Unit (SIU) data	Annual	PIRE/OSAP
Synar activities and results	Annual	OSAP
Media activities	Quarterly	PK PR/ PIRE
Training and technical assistance activities	Monthly	Coop/OSAP
Mid-year and end-of-year community reports	Semi-annual	PIRE/Coop/OSAP
SAMHSA’s Performance Accountability and Reporting System (SPARS)	Semi-annual	PIRE/Coop/OSAP
PFS 15 EBPPP (Evidence Based Programs Policies and Practices in SPARS)	Annual	PIRE
SPF Rx AII (Annual Implementation Instrument submitted through PEP-C)	Annual	PIRE
Meeting minutes (SEOW, PDO, PDO CQI, PPC, Core Team)	Monthly	Coop
Monthly activity reports from state contractors in STAR	Monthly	PIRE/Coop/OSAP

## Local Level Evaluation Plan

NM OSAP funded programs must choose two or more of the following long-term goals to address:

- 1) Reduce underage binge drinking (also considered ‘underage drinking’)
- 2) Reduce underage DWI (also considered ‘underage drinking’)
- 3) Reduce adult binge drinking
- 4) Reduce adult DWI
- 5) Reduce prescription painkiller misuse
- 6) Reduce illicit drug misuse

At the local level, SMART goals and objectives are derived from the results of the local needs assessment and yearly evaluation data collected. Local providers are required by OSAP to collect data that directly measures the targeted goals and objectives, report out on these data on a yearly basis, and track changes over time.

## Local Level Outcomes Evaluation

**Summary Description:** Each funded community is required to complete a mid-year and end-of-year local-level report as part of their yearly reporting requirements to OSAP. These reports track progress on implementation of identified strategies and started goals and objectives. In addition, each funded community will complete end-of-year reports on local level data collected through the implementation of the NMCS, the A-SFS, and the BP-SFS.

The local-level outcome evaluation will track community-level changes in consumption behaviors and substance-use related intervening variables. Outcomes evaluations will target the priorities, intervening variables, consumption behaviors, and consequences outlined in each community's strategic plan.

### Sources of Local Level Consumption and Intervening Variable Data:

Data Source	Collected	Coordinating Agency
NM Community Survey (NMCS)	Annual	PIRE/Local Prevention Provider (LPP)
NM Annual Strategies for Success (A-SFS)†	Annual	PIRE/LPP
NM Baseline/Post Strategies for Success (BP-SFS)†	Annual	PIRE/LPP
NM Opioid Prescribers Survey (OPS)	Annual	PIRE/LPP
Narcan/Naloxone Training and Distribution Form	Continuous	PIRE/LPP
Narcan/naloxone Trainee Demographic Form	Continuous	PIRE/LPP
Naloxone training evaluation tools (Post and Follow-up Forms)	Continuous	PIRE/LPP
Narcan/Naloxone Record of Use Form	Continuous	PIRE/LPP
NM Youth Risk and Resiliency Survey (YRRS or YRBSS)**	Biannual - odd years	NMDOH
NM Behavioral Risk Factors Surveillance Survey (BRFSS)**	Annual	NMDOH
Local Law Enforcement Activity Data	Monthly/Annual	LPP
School Policy and Enforcement Data	Annual	LPP

† Available in select communities

† Available only in communities with direct services programming

\*\* Available in larger communities

**Sources of Local Level Consequence Data:**

Data Source	Collected	Coordinating Agency
Arrest Data/NM Children, Youth & Families Dept. (CYFD) data	Semi Annual	Local Law Enforcement/Local Prevention Provider
Alcohol-related motor vehicle crash and fatality data (DOT)	Monthly/Annual	NMDOT/PIRE
Prescription Monitoring Program (PMP)	Monthly/Quarterly	NMDOH
Death Data	Annual	NMDOH
Graduation Rates/School Drop Out data	Annual	NMPED

**Local Level Process Evaluation**

At the local level, process goals include:

1. Increasing fidelity to evidence-based prevention strategies by tracking activities.
2. Improve documentation of progress on meeting stated goals and objectives.
3. Increase utilization of local and state level data dashboards for real time monitoring and evaluation of local prevention efforts.
4. Increase regular collection of process data from local stakeholders including local law enforcement, schools, and others.

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**Sources of Local Level Process Data:**

Data Source	Collected	Coordinating Agency
School Disciplinary Activities Data (activities, results, suspensions, graduation rates)	Monthly/Semi Annual/Annual	Local Prevention Provider (LPP)
Fidelity Checklists for In-School programming	Twice per session	LPP/Evaluator
Police Enforcement Activities Data (Sobriety Checkpoints, Party Patrols, etc.)	Monthly/Semi Annual	LPP
Enforcement Consequences (citations, arrests, convictions)	Monthly/Semi Annual	LPP
NM Dept. of Public Safety, Special Investigations Unit (SIU) activities & data	Annual	LPP
Synar Activities and Results	Annual	LPP
Responsible Beverage Server Training Activities	Annual	LPP
Media Activities (print/audio/video)	Monthly	LPP
Alcohol Outlet Density data	Annual	LPP
Pricing/Advertising/Placement/Location data	Monthly	LPP
Educational Activities & Materials (e.g., Parent handbooks, trainings)	Monthly	LPP
Take Back Events data (e.g., # of events, weight of Rx drugs returned)	Monthly	LPP
On-site Rx Drop Box data (e.g., # of boxes, weight of Rx drugs returned)	Monthly	LPP
Lock Box Distribution data	Monthly	LPP
Pharmacy Rx Drug Returns data (e.g., # of participating pharmacies, weight of Rx drugs returned)	Monthly	LPP
Other Prevention Activities (e.g. # of planning meetings, community events and presentations)	Monthly	LPP
Annual Implementation Instrument (SPF Rx-AII) via PEP-C (process data by strategy)	Annual	PIRE/ LPP
PFS 15 EBPPP #s reached and served by strategy (Evidence Based Programs Policies and Practices)	Annual	PIRE LPP

## Primary Data Collection Instruments

Primary Data Collection Instruments	Description
NM Community Survey	Annual survey of NM residents 18 and older. Communities develop detailed protocol for data collection and replicate each year. Convenience sample; recruitment via time and venue-based sampling approach and on-line recruitment via Facebook & Instagram. Instrument & Protocol available at: <a href="http://www.nmprevention.org/NM-Community-Survey.html">http://www.nmprevention.org/NM-Community-Survey.html</a>
NM Annual Strategies for Success (A-SFS)	Annual survey of students in grades 6-12; Communities develop detailed data collection protocol that is replicated each year. Instrument & Protocol available at: <a href="http://www.nmprevention.org/PFSII.html">http://www.nmprevention.org/PFSII.html</a>
NM Baseline-Post Strategies for Success (BP-SFS)	Baseline and post-test survey of participants in direct service prevention programming. Instrument & Protocol available at: <a href="http://www.nmprevention.org/Direct-Service.html">http://www.nmprevention.org/Direct-Service.html</a>
School Disciplinary Policy Analysis & Tracking Tool	LPP (Local Prevention Provider) tracks in Management Information Systems (MIS)
Local Law Enforcement Activity & Arrest Tracking Tool	LPP tracks in MIS
Juvenile Citation Tracking Tool (CYFD)	LPP tracks in MIS
Retail Access and Promotion Tracking Tool	LPP tracks in MIS
Media Tracking Tool	LPP tracks in MIS
Educational Events Tracking Tool (e.g, RBS, Synar)	LPP tracks in MIS
NM Opioid Prescribers Survey (OPS)*	Annual survey of NM prescribers to assess opioid prescribing practices and use of PMP
Narcan/Naloxone Training and Distribution Form	Used to track training, naloxone distribution and replacement at hub and spoke level for PDO
Narcan/naloxone Trainee Demographic Form	Demographics of trainees. Available at: <a href="http://www.nm-pdo.org/">http://www.nm-pdo.org/</a>
Naloxone training evaluation tools (Post and Follow-up Forms)	Post and follow-up questionnaire given to formal naloxone trainees to assess knowledge Available at: <a href="http://www.nm-pdo.org/">http://www.nm-pdo.org/</a>

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Primary Data Collection Instruments	Description
Narcan/Naloxone Record of Use Form	Completed by those who administer naloxone Available at: <a href="http://www.nm-pdo.org/">http://www.nm-pdo.org/</a>
Mid and End of Year Reports	Developed by OSAP – contains individual program objective and key process data. Available at: <a href="http://www.nm-pdo.org/">http://www.nm-pdo.org/</a>

**Data Collection by Funding Stream**

Data Source	Funding Sources				
	SAPT	PFS 2015	PDO	SPF Rx	Synar
Alcohol-related motor vehicle crash and fatality data (DOT)	X	X			
Prescription Monitoring Program data (PMP)	X	X	X	X	
Death Data (Overdose & ARMVCF)	X	X	X	X	
Synar Inspection Data					X
Arrest Data/NM Children, Youth & Families Dept. (CYFD) data	X	X			
NM Community Survey (NMCS)	X	X	X	X	
NM Annual Strategies for Success (A-SFS)	X	X			
NM Baseline/Posttest Strategies for Success (BP-SFS)	X				
NM Opioid Prescribers Survey (OPS)				X	
Forms for tracking naloxone distribution			X		
Naloxone training evaluation tools			X		
Tool for tracking naloxone use			X		
NM Youth Risk and Resiliency Survey (YRRS or YRBSS)	X	X			
NM Behavioral Risk Factors Surveillance Survey (BRFSS)	X	X			
NM National Survey of Drug Use and Health (NSDUH)	X	X			

**Data Collection Schedule for State Level Data**

<b>Primary Data<sup>‡</sup></b>	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
NM Community Survey									X	X	X	
NM Annual Strategies for Success (A-SFS)											X	
NM Baseline-Post Strategies for Success (BP-SFS)											X	
Media Activities Data	X											
Synar Inspection Data	X											
NM Opioid Prescribers Survey (OPS)	X											
Forms for tracking naloxone distribution	X	X	X	X	X	X	X	X	X	X	X	X
Naloxone training evaluation tools	X	X	X	X	X	X	X	X	X	X	X	X
Tool for tracking naloxone use	X	X	X	X	X	X	X	X	X	X	X	X
Program Periodic Reports	X						X					
Training and TA	X	X	X	X	X	X	X	X	X	X	X	X
Meeting Minutes (e.g., SEOW, PDO Advisory, PDO CQI, PPC, etc.)	X	X	X	X	X	X	X	X	X	X	X	X
Monthly Progress Reports for STAR	X	X	X	X	X	X	X	X	X	X	X	X
SPF Rx Annual Implementation Instrument (AII) (in SPARS)							X					
SAMHSA Performance Accountability and Reporting System (SPARS) – SPF Rx & PFS 15 Quarterly reporting	X			X			X			X		
PFS 2015 PEP-C EBPPP and Annual Community Outcomes				X								
<b>Secondary Data*</b>												
Youth Risk and Resiliency Survey Data (YRRS) <sup>†</sup>		X	X									
Behavioral Risk Factor Surveillance Survey Data (BRFSS)		X	X									
National Survey on Drug Use and Health Data (NSDUH)		X	X									
Alcohol-Related Motor Vehicle Crash Data (ARMVC)												X
Prescription Drug Monitoring Program Data (PMP)	X			X			X			X		
Death Data		X	X									
NM Dept. of Public Safety, Special Investigations Unit (SIU) data	X						X					

<sup>‡</sup> Collected; reported

\* Reviewed; analyzed

<sup>†</sup> Available every other year



**Data Collection Schedule for Local Level Data**

<b>Primary Data<sup>†</sup></b>	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June
NM Community Survey									X	X	X	
NM Annual Strategies for Success (A-SFS)			X	X	X	X	X	X	X	X	X	
NM Baseline-Post Strategies for Success (BP-SFS)		X	X	X	X	X	X	X	X	X	X	
Media Activities Data (Alcohol &/or Rx Drug related)	X	X	X	X	X	X	X	X	X	X	X	X
Educational Materials, Training Events & Activities (e.g., RBS; Parent Handbooks)	X	X	X	X	X	X	X	X	X	X	X	X
Alcohol Pricing/Advertising/Placement/Location data	X	X	X	X	X	X	X	X	X	X	X	X
Take Back Events Data	X	X	X	X	X	X	X	X	X	X	X	X
Rx Drop Box Data	X	X	X	X	X	X	X	X	X	X	X	X
Lock Box Distribution Data	X	X	X	X	X	X	X	X	X	X	X	X
Pharmacy- Rx Drug Data	X	X	X	X	X	X	X	X	X	X	X	X
Other Prevention Activities Data	X	X	X	X	X	X	X	X	X	X	X	X
Synar Inspection Data	X	X	X	X	X	X	X	X	X	X	X	X
NM Opioid Prescribers Survey (OPS)	X											
Narcan/Naloxone Training and Distribution Forms	X	X	X	X	X	X	X	X	X	X	X	X
Naloxone Training & Evaluation Forms	X	X	X	X	X	X	X	X	X	X	X	X
Narcan/Naloxone Record of Use	X	X	X	X	X	X	X	X	X	X	X	X
Meeting Minutes (e.g., Coalition, etc.)	X	X	X	X	X	X	X	X	X	X	X	X
PFS 2015 PEP-C EBPPP (#s reached and served by strategy)	X	X	X	X	X	X	X	X	X	X	X	X
SPF Rx Annual Implementation Instrument (AII)	X	X	X	X	X	X	X	X	X	X	X	X
<b>Secondary Data*</b>												
Arrest Data/CYFD Data							X					X
Outlet Density Data							X					
School Disciplinary Activities Data							X					X
Local Law Enforcement Activity Data	X	X	X	X	X	X	X	X	X	X	X	X
NM Dept. of Public Safety, Special Investigations Unit (SIU) data	X						X					

<sup>†</sup> Collected; reported

\* Reviewed; analyzed

# Five-Year Substance Misuse Prevention Plan 2019-2024

New Mexico Office of Substance Abuse Prevention

DRAFT AUGUST 9, 2019

**New Mexico Office of Substance Abuse Prevention**

**Five-Year Substance Misuse Prevention Plan**

These issues align with SAMHSA’s first strategic initiative; prevention of substance abuse and mental illness. The NM Office of Substance Abuse Prevention has established the following goals to accomplish over the next five years.

**GOAL 1:** Increase state capacity to plan, implement, monitor and evaluate a coordinated prevention system.

- Objectives, Action Steps, Indicators, Responsible Parties, Benchmarks and Target Populations to be added

**GOAL 2:** Reduce underage drinking by X% in New Mexico by June 2023\*\*

- Objectives, Action Steps, Indicators, Responsible Parties, Benchmarks and Target Populations to be added

**GOAL 3:** Reduce adult binge drinking and heavy drinking by X% in New Mexico by June 2023\*\*

- Objectives, Action Steps, Indicators, Responsible Parties, Benchmarks and Target Populations to be added

**GOAL 4:** Reduce opioid overdose in New Mexico by X% by June 2023\*\*

- Objectives, Action Steps, Indicators, Responsible Parties, Benchmarks and Target Populations to be added

**GOAL 5:** Reduce the misuse of prescription painkillers by X% among New Mexicans by June 2023 \*\*

- Objectives, Action Steps, Indicators, Responsible Parties, Benchmarks and Target Populations to be added

**GOAL 6:** Reduce to or maintain Synar non-compliance of tobacco sales below 10% by/until June 2023

- Objectives, Action Steps, Indicators, Responsible Parties, Benchmarks and Target Populations to be added

**POTENTIAL GOALS and Populations and Behaviors**

**Direct Service** -- Increase resiliency in youth in targeted populations/communities in New Mexico by 5% by June 2023 [direct service, tribal, PAX]

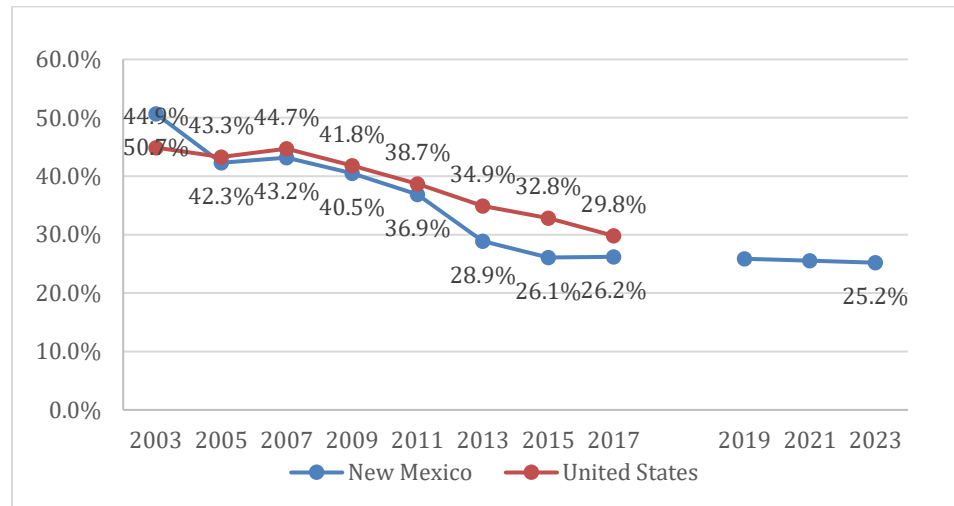
**E-cigs Use** - collect and document data on youth e-cigs use and policy initiatives, develop program models, cost analysis, and create knowledge base and capacity to address use of e-cigs.

**High-Risk Youth** – unstable housing, disabled, foreign-born, LGBTQ target pops in YRRS data.

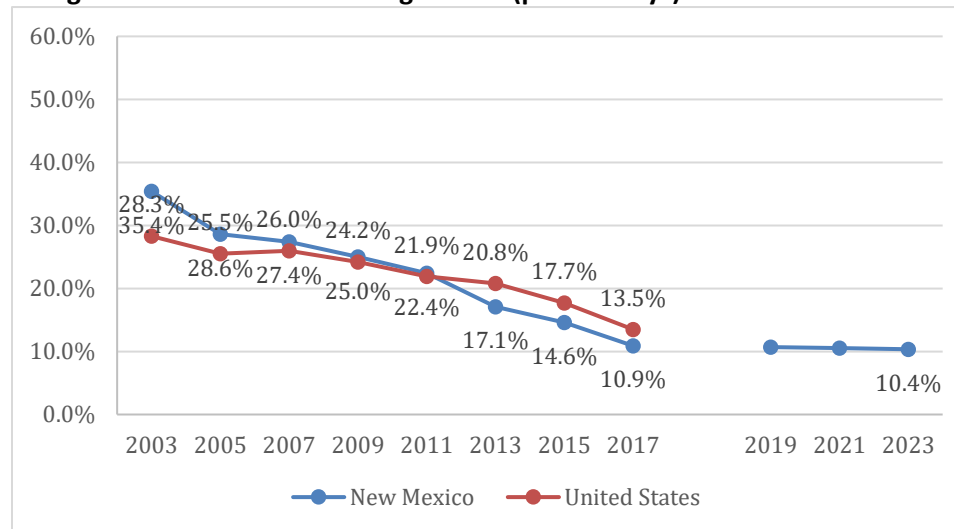
**Distracted Driving** (youth use of legal cannabis) - *DWI is going to be looking at how to address distracted driving.*

**Goal 2: Reduce underage drinking by X% in New Mexico by June 2023**

**\*\*High school students who drank alcohol (past 30 days) YRRS**



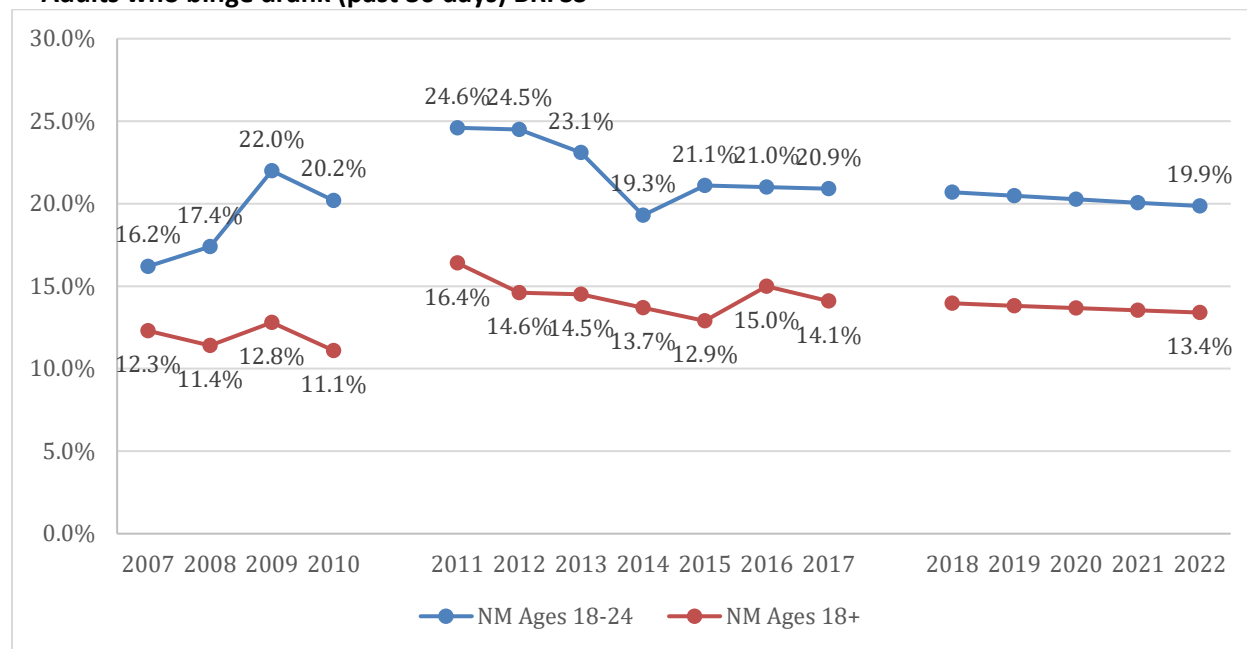
**\*\*High school students who binge drank (past 30 days) YRRS**



\*\* = SAPT reporting indicator      Revised: August 9, 2019

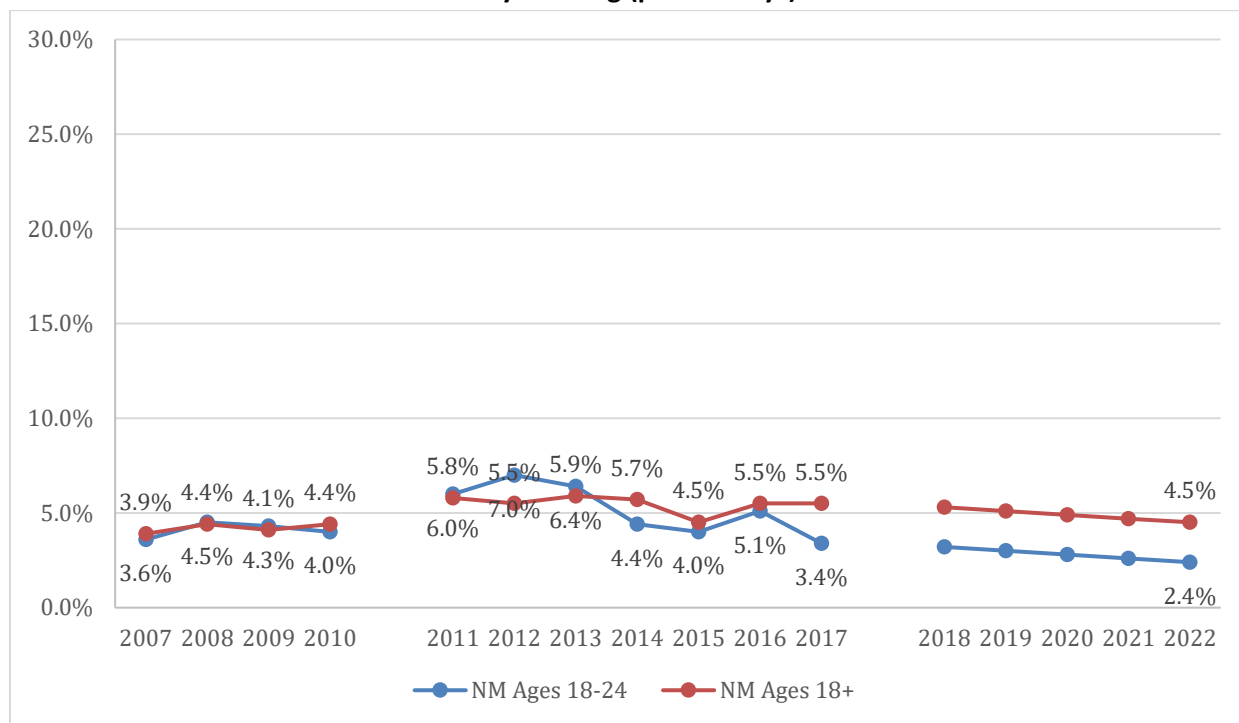
**GOAL 3: Reduce adult binge drinking and heavy drinking by X% in New Mexico by June 2023**

**\*\*Adults who binge drank (past 30 days) BRFSS**



In 2011, BRFSS updated its surveillance methods. Any shift in prevalence between 2010 and 2011 must be interpreted with caution, as it may be partially due to changes in methodology.

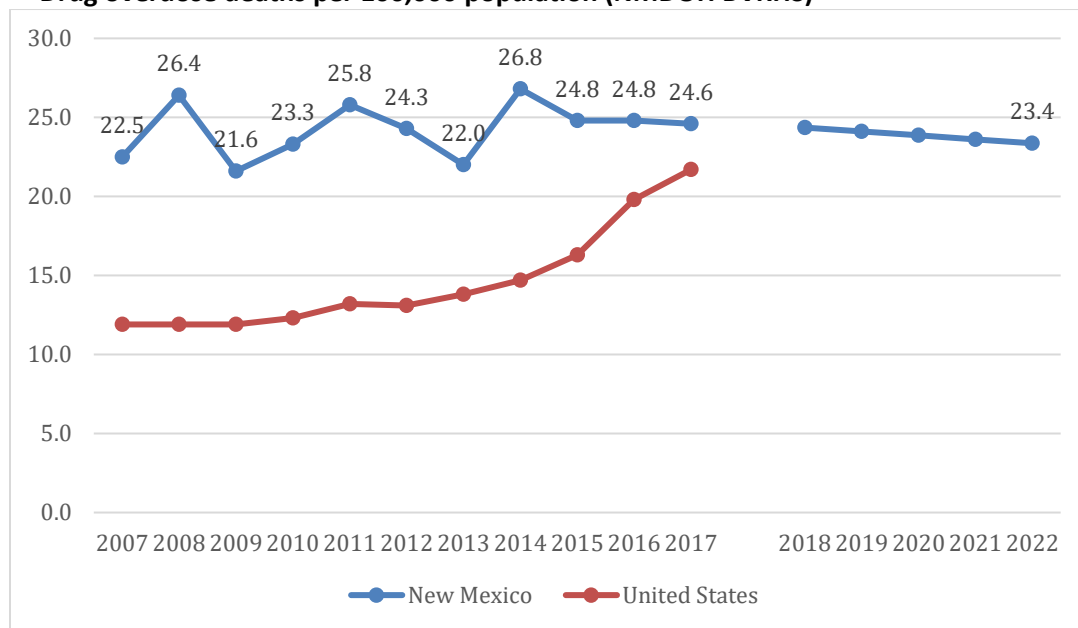
**Adults who met criteria for chronic heavy drinking (past 30 days) BRFSS**



**GOAL 4: Reduce opioid overdose death in New Mexico by X% by June 2023**

**ALL AGES**

**\*\*Drug overdose deaths per 100,000 population (NMDOH BVRHS)**



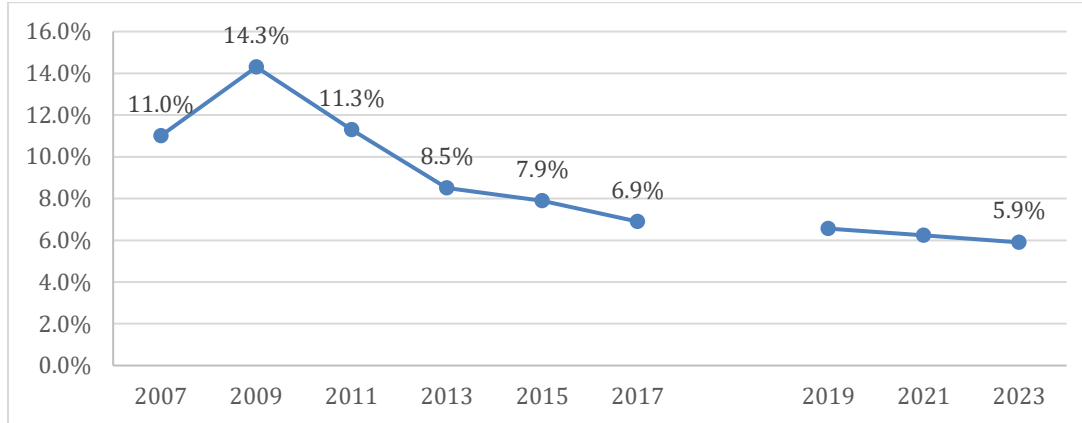
\*\* = SAPT reporting indicator

Revised: August 9, 2019

**GOAL 5: Reduce the misuse of prescription painkillers by X% among New Mexicans by June 2023 \*\***

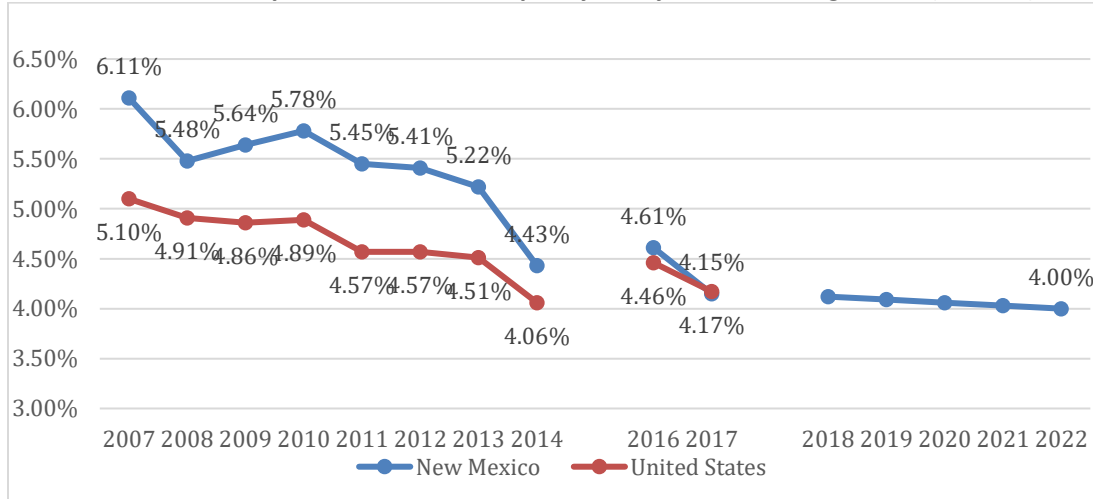
**YOUTH**

**\*\*New Mexico high school students who used painkillers to get high in the past 30 days (YRRS)**



**ADULTS**

**\*\*Nonmedical use of pain relievers in the past year by individuals aged 12+ (NSDUH)**

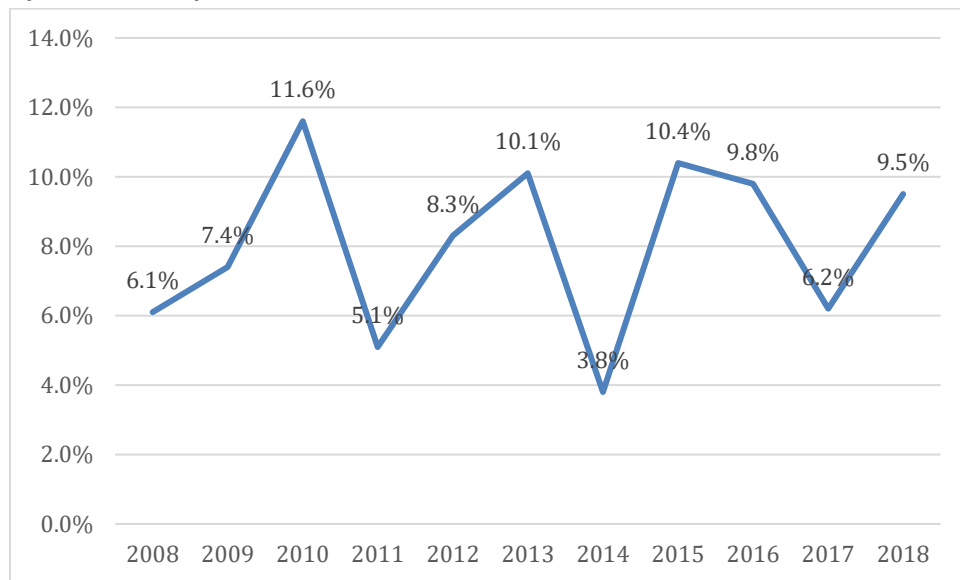


In 2015, NSDUH changed the way it asked about prescription painkiller misuse and estimates for that year were not calculated. Any shift in prevalence between 2014 and 2016 must be interpreted with caution, as it may be partially due to changes in methodology.



**GOAL 6: Reduce to or maintain Synar non-compliance of tobacco sales below 10% by/until June 2023**

**Synar non-compliance rate**



\*\* = SAPT reporting indicator

Revised: August 9, 2019

# *FIVE YEAR SUBSTANCE MISUSE PREVENTION PLAN 2019-2024*

PREVENTION POLICY CONSORTIUM, STATE OF NEW MEXICO

DRAFT AUGUST 9, 2019

## WORKING DRAFT: NM 5 Year Substance Abuse Prevention Plan

Prevention Policy Consortium (Coordinated by Office of Substance Abuse Prevention)

Five-Year Substance Misuse Prevention Plan

The long-term substance abuse prevention goals will be accomplished through the efforts of multiple state agencies and stakeholders. Include coordination of services, data collection, analysis reporting, performance monitoring and evaluation, and training and technical assistance.

**GOAL 1:** Sustain and enhance capacity to plan, implement, monitor and evaluate a coordinated prevention system.

- *Potential measures to guide the sustainability of prevention programs: Training, TA, Evaluation, Planning, Monitoring, Fiscal Management and Responsibility, Cultural Competence/Sensitivity/Humility, Clear Communication of OSAP Goals (expectations and policies), Communication that prevention works, Coordination of OSAP Prevention System to address gaps.*
- *Focus on the OSAP system capacity (i.e. sharing data, planning initiatives together). Potential of regional epidemiological workgroups that can serve as unified group for local prevention efforts. Concern that current system relies heavily on one person; consider using an internship/mentorship model that supports the lead coordinator to cross-train, guide, and mentor an additional person to learn and sustain the local prevention work.*
- Objectives, Action Steps, Indicators, Responsible Parties, Benchmarks and Target Populations to be added.

**GOAL 2:** Reduce underage drinking by 1% in state targeted or funded (for this priority) communities across New Mexico by June 2023\*\*

- *Consider moving to performance indicators for this goal – so that the percent change is realistic and not an insignificant amount at 1%. Need to identify measures that reflect short-term change based on activities that have worked to reduce outcomes and sustain prevention efforts.*
- *Need aggregated data for all OSAP programs implementing prevention efforts to address UAD.*
- Objectives, Action Steps, Indicators, Responsible Parties, Benchmarks and Target Populations to be added.

**GOAL 3:** Reduce adult binge drinking and heavy drinking by 1% in state targeted or funded (for this priority) across New Mexico by June 2023\*\*

- Objectives, Action Steps, Indicators, Responsible Parties, Benchmarks and Target Populations to be added.

**GOAL 4:** Reduce opioid overdose in New Mexico by 1.2% by June 2023\*\*

- Objectives, Action Steps, Indicators, Responsible Parties, Benchmarks and Target Populations to be added.

**GOAL 5:** Reduce the misuse of prescription painkillers by 1% among New Mexicans by June 2023\*\*

- Objectives, Action Steps, Indicators, Responsible Parties, Benchmarks and Target Populations to be added.

**GOAL 6:** Increase resiliency in youth in state targeted or funded (for this priority) communities in New Mexico by 5% by June 2023 [direct service, PAX]

- *Need to define targeted populations/communities – PAX schools, OSAP programs implementing direct service, DOH programs, etc.*
- Objectives, Action Steps, Indicators, Responsible Parties, Benchmarks and Target Populations to be added.

**GOAL 7:** Reduce youth tobacco use in New Mexico by X% by June 2023.

\*\* = SAPT reporting indicator      Revised: August 9, 2019

## WORKING DRAFT: NM 5 Year Substance Abuse Prevention Plan

- Objectives, Action Steps, Indicators, Responsible Parties, Benchmarks and Target Populations to be added.

**GOAL 8:** Enhance capacity of prevention programs and enhance workforce development in the prevention system.

- *Pursue possibility of having the Certified Prevention CEUs embedded into Medicaid similar to the Certified Peer Support Worker CEUs.*
- Objectives, Action Steps, Indicators, Responsible Parties, Benchmarks and Target Populations to be added.

### POTENTIAL NEW GOAL AREAS

#### SUBSTANCE

**E-cigs Use** (collect and document data on youth e-cigs use and policy initiatives, develop program models, cost analysis, and create knowledge base and capacity to address use of e-cigs)

- *NM Tobacco Act states that E-cigs can't be sold to minors and can't have certain displays visible to minors; this will eventually become part of Synar prevention.*

#### POPULATION

**High-Risk Youth** – unstable housing, disabled, foreign-born, LGBTQ target pops in YRRS data?]

- *Challenging to address high-risk youth population w/existing OSAP programs - reality that high-risk youth need intervention rather than primary prevention. Consider adding a goal to develop a system/process to identify high-risk youth as part of addressing health disparities.*

#### QUALITY IMPROVEMENT FOCUS

**Trauma-Informed Care** – ACES

- *Consider Strengthening Families and Botvin Life Skills as potential prevention efforts.*

WORKING DRAFT: NM 5 Year Substance Abuse Prevention Plan

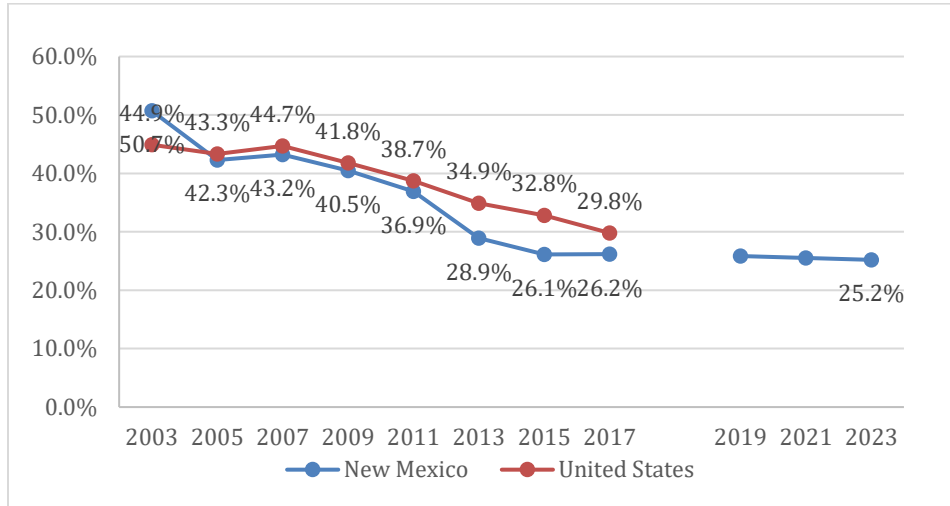
**TO DEVELOP**

**GOAL 1: Sustain and enhance capacity to plan, implement, monitor and evaluate a coordinated prevention system**

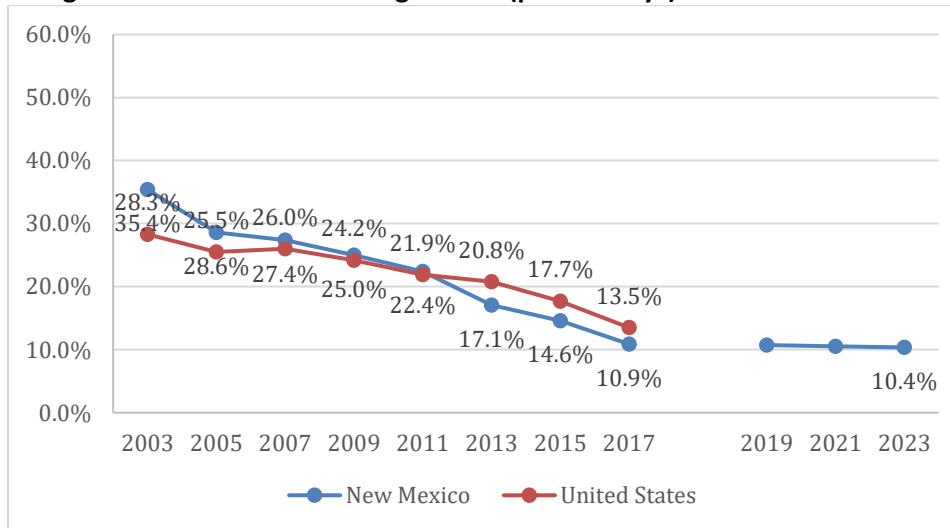
WORKING DRAFT: NM 5 Year Substance Abuse Prevention Plan

Goal 2: Reduce underage drinking by X% in New Mexico by June 2023

**\*\*High school students who drank alcohol (past 30 days) YRRS**



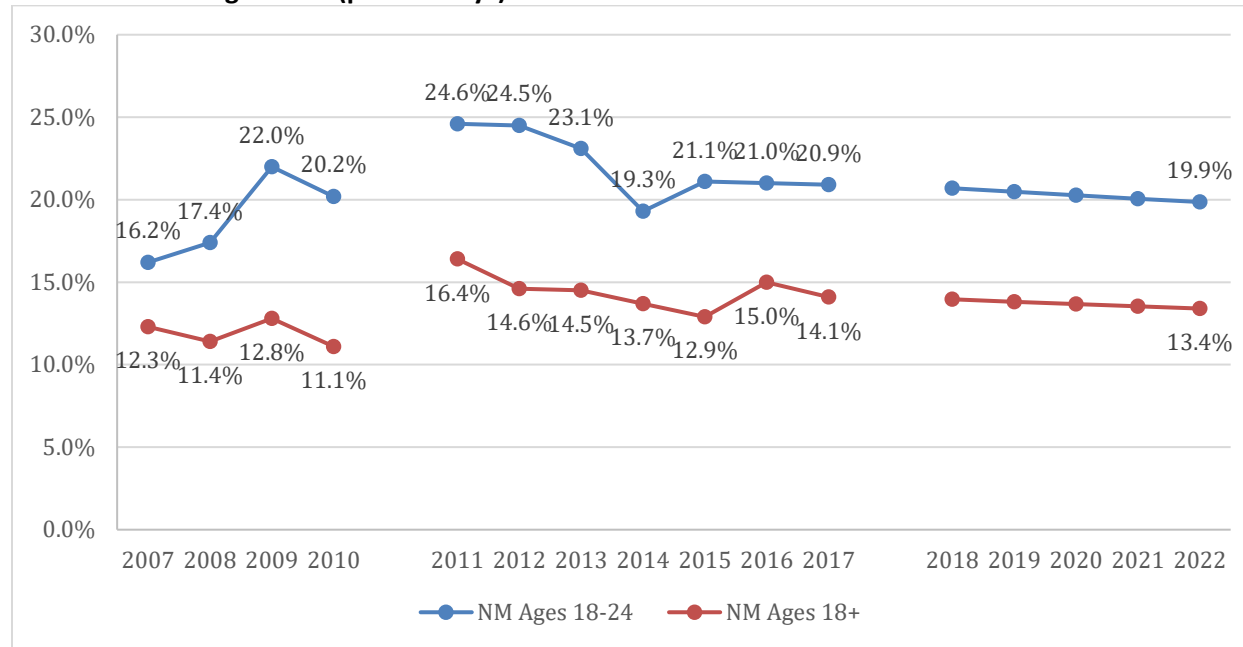
**\*\*High school students who binge drank (past 30 days) YRRS**



\*\* = SAPT reporting indicator Revised: August 9, 2019

**WORKING DRAFT: NM 5 Year Substance Abuse Prevention Plan**  
**GOAL 3: Reduce adult binge drinking and heavy drinking by X% in New Mexico by June 2023**

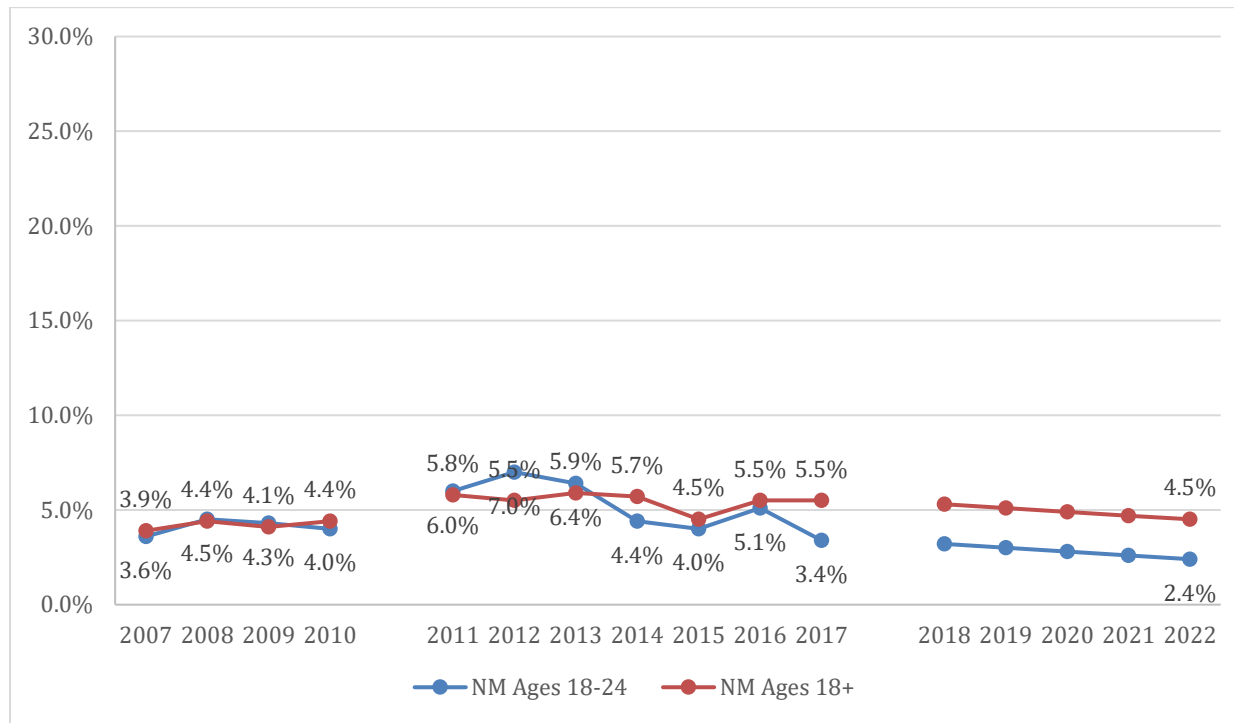
**\*\*Adults who binge drank (past 30 days) BRFSS**



In 2011, BRFSS updated its surveillance methods. Any shift in prevalence between 2010 and 2011 must be interpreted with caution, as it may be partially due to changes in methodology.

WORKING DRAFT: NM 5 Year Substance Abuse Prevention Plan

Adults who met criteria for chronic heavy drinking (past 30 days) BRFSS



\*\* = SAPT reporting indicator

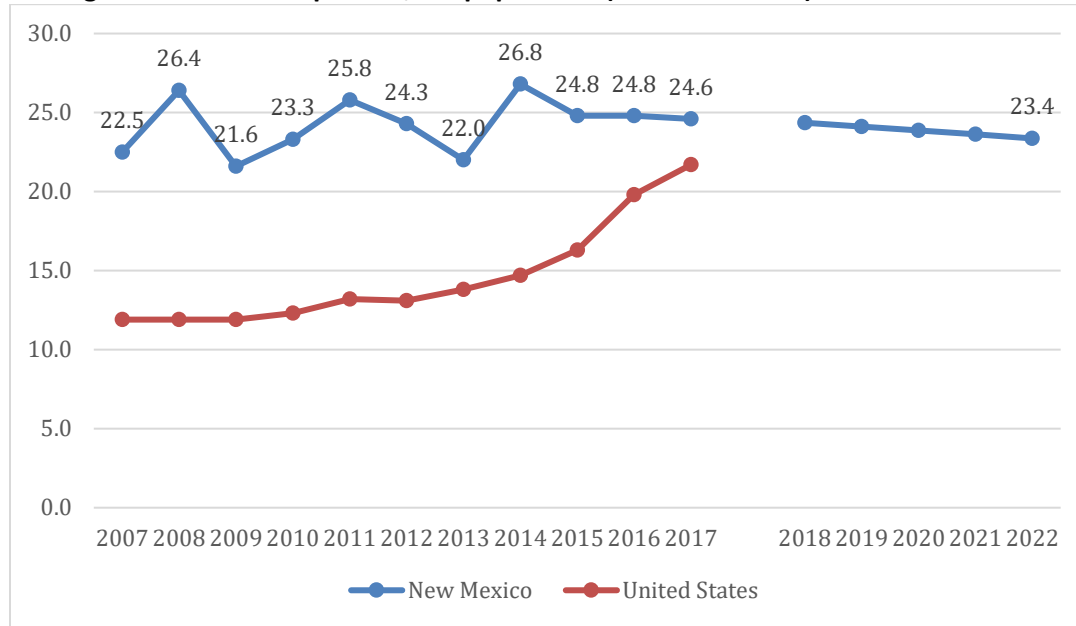
Revised: August 9, 2019



**WORKING DRAFT: NM 5 Year Substance Abuse Prevention Plan**  
**GOAL 4: Reduce opioid overdose in New Mexico by X% by June 2023**

**ALL AGES**

**\*\*Drug overdose deaths per 100,000 population (NMDOH BVRHS)**



\*\* = SAPT reporting indicator

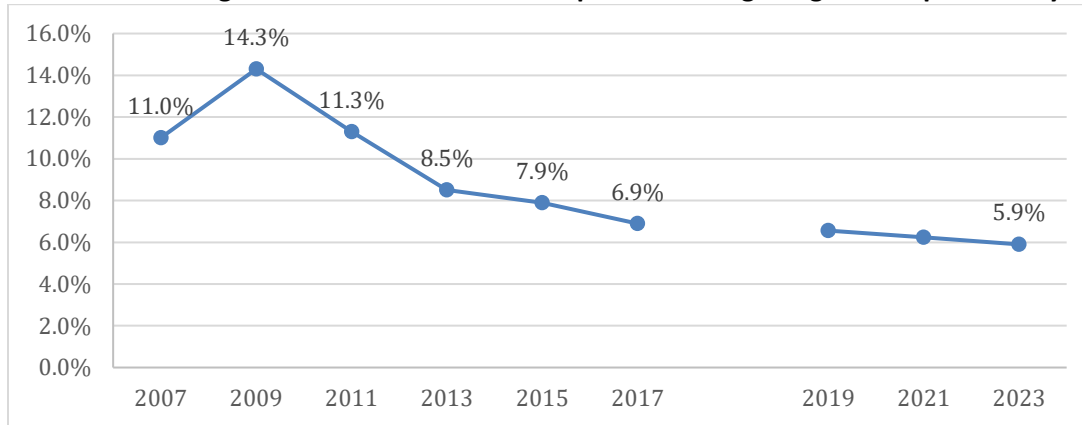
Revised: August 9, 2019

WORKING DRAFT: NM 5 Year Substance Abuse Prevention Plan

GOAL 5: Reduce the misuse of prescription painkillers by X% among New Mexicans by June 2023 \*\*

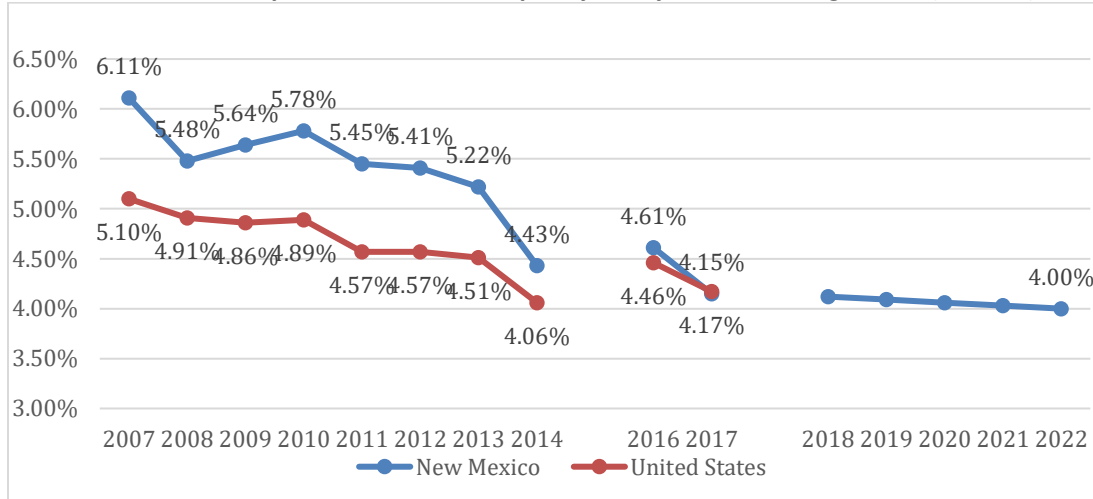
**YOUTH**

\*\*New Mexico high school students who used painkillers to get high in the past 30 days (YRRS)



**ADULTS**

\*\*Nonmedical use of pain relievers in the past year by individuals aged 12+ (NSDUH)



In 2015, NSDUH changed the way it asked about prescription painkiller misuse and estimates for that year were not calculated. Any shift in prevalence between 2014 and 2016 must be interpreted with caution, as it may be partially due to changes in methodology.

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Revised: August 9, 2019

WORKING DRAFT: NM 5 Year Substance Abuse Prevention Plan

**TO DEVELOP:**

**GOAL 6: Increase resiliency in youth in state targeted or funded (for this priority) communities in New Mexico by 5% by June 2023 [direct service, PAX, DOH, DFA/DWI]**

**GOAL 7: Reduce youth tobacco use in New Mexico by X% by June 2023.**

# Environmental Factors and Plan

## 9. Statutory Criterion for MHBG - Required for MHBG

### Narrative Question

#### Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

### Please respond to the following items

#### Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occurring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

To maximize the integration of health care services, NM "carved in" all Medicaid behavioral services and home- community-based institutional services in 2014. The capitation for MCOs participating in program was designed incentives support people their homes communities. Care management focuses on risk assessment, identification high need recipients, development a comprehensive plan that cuts across treatment medical periodic evaluation as its effectiveness modification needed, evaluation. Whereas coordination is service through which executed by linking recipients needed services; integrating treatment, supports; increasing recipient's motivation understand actively manage his or her chronic conditions. Both are delivered strong partnerships with recipient his/family, appropriate. The capitation for the MCOs participating in the program was designed to maximize the incentives to support people in their homes and communities. Care management focuses on risk assessment, identification of high need recipients, development of a comprehensive care management plan that cuts across behavioral health treatment and medical services, periodic evaluation of the plan as to its effectiveness and modification of the plan as needed, based on that evaluation. Whereas care coordination is the service through which the care management plan is executed by linking recipients to needed services; integrating treatment, services and supports; and by increasing the recipient's motivation to understand and actively manage his or her chronic health conditions. Both services are delivered through strong partnerships with the recipient and his/her family, as appropriate.

Care Coordinators are assigned based on their needs assessment scores.

The following primary care coordination functions are requirements and are performed by staff employed by the MCO.

- Conducting Health Risk Assessments (HRAs) for members newly enrolled in Centennial Care or members who have had a change in condition and who are not currently identified for Care Coordination Level 2 or 3 services;
- Conducting Comprehensive Needs Assessments (CNAs) initially, semi-annually or annually;
- Administer the Community Benefit Service Questionnaire (CBSQ) as applicable
- Semi-annual or quarterly in-person visits with the member;
- Quarterly or monthly telephone contact with the member;
- Comprehensive Care Plan (CCP) development and updates; and
- Targeted Health Education, including disease management, based on the member's individual diagnosis (as determined by the CNA).

Care Coordination and person-centered planning, must revolve around the individual Centennial Care member and reflect his/her chosen lifestyle, cultural, functional, and social needs for successful community living. The goal of the care plan development process is for Centennial Care member to achieve a meaningful life in the community. Upon enrollment a Care Coordinator is assigned, based on the results of the CNA. The member receives information and training from the Care Coordinator about covered SDCB services or requirements for their care plan.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

- |                            |   |
|----------------------------|---|
| a) Physical Health         | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| b) Mental Health           | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| c) Rehabilitation services | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| d) Employment services     | <input type="radio"/> Yes <input checked="" type="radio"/> No |
| e) Housing services        | <input checked="" type="radio"/> Yes <input type="radio"/> No |
| f) Educational Services    | <input type="radio"/> Yes <input checked="" type="radio"/> No |

- g)** Substance misuse prevention and SUD treatment services  Yes  No
- h)** Medical and dental services  Yes  No
- i)** Support services  Yes  No
- j)** Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)  Yes  No
- k)** Services for persons with co-occurring M/SUDs  Yes  No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)  
N/A

**3.** Describe your state's case management services

Care Coordinators are assigned based on their needs assessment scores.

The following primary care coordination functions are requirements and are performed by staff employed by the MCO.

- Conducting Health Risk Assessments (HRAs) for members newly enrolled in Centennial Care or members who have had a change in condition and who are not currently identified for Care Coordination Level 2 or 3 services;
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**4.** Describe activities intended to reduce hospitalizations and hospital stays.

Emergency Department Information Exchange (EDIE) and PreManage

A small number of patients generate a disproportionate volume of visits. Many hop between facilities and care settings, making it difficult for the MCOs to know when and how to coordinate appropriately.

Emergency Department Information Exchange (EDIE) connects to an electronic medical record and provides alerts to ER provider if patient meets the criteria. Cross organizational care coordination is the best opportunity to improve the quality of care and reduce unnecessary emergency department utilization. The focus is on high utilizing patients.

- Real-Time emergency department Information Exchange
- Notifies on High Utilizer/Complex Needs Patients
- Improves Communication and Care Coordination
- First Info Exchange Across all WA/OR Hospitals
- Proactive, Concise, Actionable Data at Point of Care
- Push Technology - Notices/Alerts Within Care Provider Workflow; Anticipates provider needs (no need to look up a patient)

PreManage provides alerts to Managed Care Organizations or provider groups on cohorts they have identified. It is a complementary product for health plans, clinics, group practices, etc.

- Expands real-time notifications to medical groups, MCOs, health plans, care coordinators, social workers etc. to better manage their patients.
- Enables health plans and providers to pull hospital notifications in real-time from a member/patient eligibility list.
- Notifications available: ED Visits, Inpatient Admission, Discharge, and Transfers
- Creates ability to coordinate care across the community

Certified Peer Support Workers

The Centennial care Managed care organizations utilize and employ Certified Peer Support Workers as outreach to members utilizing the Emergency Department (ED) for Behavioral Health and Substance Use Disorders (SUD.) Peer Support Workers attempt to engage with the member while the member is in the ED and then continue to provide support post discharge. In addition to connecting to high/emerging risk members, recovery support staff also engage with members who have been identified as being newly diagnosed with an SUD. For these members, CPSW staff work with members to assist in making and keeping provider appointments, offering support, encouragement, and motivation that is needed to pursue recovery.

Benefits include: Decreased ED visits related to substance use; Improved recovery capital (e.g. housing stability, independence, and self-care); Reduced recidivism, Improved recovery outcomes.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

**Criterion 2**

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	4.39	1.05
2.Children with SED	10.00	2.35

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Data from the US National Survey on Drug Use and Health, NM Department of Health Epidemiology, NM Behavioral Health Barometer, NM HSD/BHSD Star Claims System.

### Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

- a) Social Services  Yes  No
- b) Educational services, including services provided under IDE  Yes  No
- c) Juvenile justice services  Yes  No
- d) Substance misuse prevention and SUD treatment services  Yes  No
- e) Health and mental health services  Yes  No
- f) Establishes defined geographic area for the provision of services of such system  Yes  No

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

**Criterion 4**

**a.** Describe your state's targeted services to rural population.

New Mexico lawmakers passed new legislation designed to close gaps in the state's current telehealth insurance coverage law, provide coverage clarity to patients, and ensure payment parity to in-network health care providers. The Legislature passed, nearly unanimously (98-1), legislation ensuring that commercial health plans will cover medical services delivered in-person or via telemedicine. Excerpt from the National Law Review April 3, 2019  
The bill was signed into law by Governor Michelle Lujan Grisham on 4/4/2019.

Project ECHO

Project ECHO is a lifelong learning and guided practice model that revolutionizes medical education and exponentially increases workforce capacity to provide best-practice specialty care and reduce health disparities. The heart of the ECHO model™ is its hub-and-spoke knowledge-sharing networks, led by expert teams who use multi-point videoconferencing to conduct virtual clinics with community providers. In this way, primary care doctors, nurses, and other clinicians learn to provide excellent specialty care to patients in their own communities. Link: <https://echo.unm.edu/>

**b.** Describe your state's targeted services to the homeless population.

New Mexico's Five Year Supportive Housing Plan (2018-2023) builds upon many successes, including:

- Creation and expansion of the State's PSH program, called Linkages. Linkages began operating in 2007 with \$300,000 in funding, serving approximately 30 consumers. Linkages is now over a \$1.6 million program and currently supports approximately 180 consumers and their families.
- Initiation in 2009 of the Transitions PSH Program, to assist youths up to age 21 who are involved with juvenile justice or protective services.
- Establishment in 2009 of the Special Needs/Set Aside Housing Program (Low Income Housing Tax Credit), which incentivizes development of units for New Mexico's special needs population and provides screening, placement and support services for special needs tenants.
- Adoption of a coordinated assessment system that helps people experiencing homelessness connect to housing and services more quickly with continued efforts to extend the system throughout the state. A database of clients awaiting suitable housing is maintained in the New Mexico Homeless Management Information System.

Outreach

Outreach activities known to be frequented by injection drug users. Substance abuse outreach activities allow also identify mental health needs and get consumers into available services

Human Trafficking

The Life Link's Anti-Human Trafficking Initiative (Initiative), located in Santa Fe, is New Mexico's only comprehensive aftercare program for victims of human Trafficking. Through partnerships with state government, law enforcement, community stakeholders, healthcare providers, and other interested crisis response, intensive case management, advocacy, benefit acquisition, mental health and substance abuse services, emergency and permanent supportive housing, trauma treatment, and linkage to additional community resources to assist them. The Initiative team also provides consultation and training to law enforcement and behavioral health professionals on successful strategies for working with the population. The Life Link's program has received referrals from around the country and is gaining a national reputation for development and implementation of a best-practices approach for working with human trafficking victims. The Initiative strives to provide rights-based, wraparound care to meet the myriad needs of rescued victims as they navigate the difficult road to recovery.

CPSW Housing Specialty Endorsement

**c.** Describe your state's targeted services to the older adult population.

Senior Jubilee

One of the innovative programs funded by the Office of Peer Recovery and Engagement (OPRE) is the Senior Jubilee Program.

Senior Jubilee Mission Statement:

- Building a strong voice for senior health services in culturally diverse rural communities.
- Enhancing senior-to-senior and senior/professional interaction by partnering with local, county, and state level agencies, churches, higher education institutions, the medical community, and other interested community individuals and organizations.
- Increasing health literacy in staying well and staying safe.
- Strengthening communication pipelines and networks by encouraging participation with speakers from all levels of government agencies, institutions, organizations, and businesses.



- Reducing stigma related to behavioral health issues.

According to the National Institute on Drug Abuse, “the social and physical changes that accompany aging may well increase vulnerability to drug-related problems.”

In addition, senior citizens commit suicide at higher rates than any other age group, especially for men over the age of 65. New Mexico’s suicide rate has consistently been more than 50% higher than the national average for all age groups (New Mexico Department of Health).

The Senior Jubilee concept was specifically designed by a rural New Mexico resident to celebrate seniors while building a strong voice for rural and senior health services and increasing health literacy. The Jubilees are building new networks of communication and socialization for seniors, as well as communication pipelines between local, county, and state levels. This is difficult as 85% of New Mexico counties are designated rural or frontier. The great distance between towns and villages hampers communication and networking for our rural residents, especially for our seniors and elders who often have mobility, transportation, and communication limitations.

The Senior Jubilees celebrate seniors, honoring their unique contributions and collective wisdom, while educating them on the risks of behavioral health disorders by including handouts on substance abuse and mental health topics. Speakers address many health topics focusing on The Eight Dimensions of Wellness: Occupational, Environmental, Social, Financial, Intellectual, Spiritual, Emotional and Physical. A whole health approach is less intimidating for older adults, and serves to reduce stigma around behavioral health issues. These events strengthen connections between different levels of government and seniors by “taking the city to the country” with quality programs packed with health information. The program strives to be culturally competent, focusing on the needs of the community being served.

#### New Mexico Certified Peer Support Worker Older Adult Endorsement

The Certified Older Adult Peer Specialist (COAPS) program was developed by the University of Pennsylvania, School of Medicine, Department of Psychiatry, and is designed to train Certified Peer Support Workers (CPSWs) as older adult behavioral health specialists and wellness coaches.

The State of New Mexico is considering the University of Pennsylvania’s COAPS training curriculum as the basis for the New Mexico CPSW Older Adult Endorsement.

This specialized training in older adult mental health issues for Certified Older Adult Peer Specialists (COAPS) is designed to teach CPSWs how to work with older adults who have behavioral health problems and addresses a myriad of topics related to physical and mental health in older adults including normal aging, cultural competence, anxiety, depression, trauma, substance use, stages of change and more.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

**Criterion 5**

Describe your state's management systems.

In Spring 2019, the Behavioral Health Collaborative convened and the strategic planning process was renewed with new State Agency Cabinet members in place under the newly elected Governor.

Strategies of the Behavioral Health Collaborative

1. Expansion of Behavioral Health Network - Human Services Department (Lead)

- ? Strategy for provider rate increases
- ? Funding for additional BHSD Staff
- ? Identify provider gaps (mapping)(housing)
- ? Educational tweaks for clinical providers
- ? Mapping of educational institutions & licensure programs
- ? Peace-Corp/Ameri-Corp program models
- ? Education & outreach on new Medicaid Services
- ? Training & support for family members
- ? Baseline data on providers for collaborative
- ? Services for older adults who don't qualify for Medicaid
- ? Collaborate with Mortgage Finance Authority (MFA)
- ? State Personnel Office (SPO) Classification study for health care classifications

2. Expand CB MH Services for Children - Children Youth and Families Department (Lead)

- ? Systemic needs assessment
- ? Visible outcome measures
- ? Diversified Crisis Line for youth (texting)
- ? Non face to face tele health (text therapy)
- ? Distribute kits to school districts (suicide prevention)
- ? Increase number of School Based Health Center's
- ? Support for kinship caregivers (Grandparents)
- ? Therapeutic Behavioral Health services
- ? Implement Family First Act (keep kids with parents)
- ? Workforce Development (Partner with Workforce Solutions)
- ? Identify Specialized Services (partner with Managed Care Organization's)
- ? Cultural diversity of providers

3. Substance Use Disorder - Department of Health (Lead)

- ? Ensure sustainability of grant funded initiatives
- ? Expansion of trainings for providers on Medication Assisted Treatment (MAT)
- ? Development of policies for providers to reduce stigma
- ? Partnerships with criminal justice entities
- ? Possible Medication Assisted Treatment (MAT) pilot in correctional facility (CYFD, BHSD, NMCD)
- ? Medicaid support for grandparents
- ? Policy or legislation Re: Prescribing of Opioids
- ? Expand Prescription Drug Monitoring Program (PDMP) utilization by providers
- ? Payment for community providers who present cases with Extension Community Healthcare Outcome (ECHO)
- ? Modify educational materials for grandparents/caregivers (various languages and formats)
- ? Strategy to inform the courts
- ? Expansion of supportive housing/rental assistance programs
- ? Expansion of Extension Community Healthcare Outcome (ECHO) programs (Medication Assisted Treatment (MAT), Community Healthcare Worker (CHW) and identify funding source
- ? Increase supply of affordable housing

4. Behavioral Health and Criminal Justice System - General focus on the Sequential Intercept Model

**Footnotes:**

# Environmental Factors and Plan

## 10. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

---

### Criterion 1

#### Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

- i) Screening  Yes  No
- ii) Education  Yes  No
- iii) Brief Intervention  Yes  No
- iv) Assessment  Yes  No
- v) Detox (inpatient/social)  Yes  No
- vi) Outpatient  Yes  No
- vii) Intensive Outpatient  Yes  No
- viii) Inpatient/Residential  Yes  No
- ix) Aftercare; Recovery support  Yes  No

b) Services for special populations:

- Targeted services for veterans?  Yes  No
- Adolescents?  Yes  No
- Other Adults?  Yes  No
- Medication-Assisted Treatment (MAT)?  Yes  No

**Criterion 2**

**Criterion 3**

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability?  Yes  No
2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities?  Yes  No
3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care?  Yes  No
4. Does your state have an arrangement for ensuring the provision of required supportive services?  Yes  No
5. Has your state identified a need for any of the following:
  - a) Open assessment and intake scheduling  Yes  No
  - b) Establishment of an electronic system to identify available treatment slots  Yes  No
  - c) Expanded community network for supportive services and healthcare  Yes  No
  - d) Inclusion of recovery support services  Yes  No
  - e) Health navigators to assist clients with community linkages  Yes  No
  - f) Expanded capability for family services, relationship restoration, and custody issues?  Yes  No
  - g) Providing employment assistance  Yes  No
  - h) Providing transportation to and from services  Yes  No
  - i) Educational assistance  Yes  No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The BHSD program manager's work closely with the providers, review reports, invoices, perform site visits and lend technical assistance when needed to ensure compliance and corrective action as needed. BHSD has an evaluation tool utilized during site visits and chart reviews. The BHSD Quality Improvement & Compliance Team is in the process of developing new tools, reports and site visit schedules to assess provider capacity to provide required services.

**Provider Scope of Work**

All federal provider requirements for treatment, capacity, and reporting are written within each scope of work. The scope of work is monitored by reports and technical assistance throughout the year to maintain fidelity.

Independent Peer Review (IPR) process. The IPR assesses the quality, appropriateness and efficacy of programs that provide services funded by the block grant. Professional counselors and administrators in New Mexico convene to plan, implement, review and report on the SABG service delivery system in New Mexico.

**Criterion 4,5&6****Persons Who Inject Drugs (PWID)**

1. Does your state fulfill the:
  - a) 90 percent capacity reporting requirement  Yes  No
  - b) 14-120 day performance requirement with provision of interim services  Yes  No
  - c) Outreach activities  Yes  No
  - d) Syringe services programs  Yes  No
  - e) Monitoring requirements as outlined in the authorizing statute and implementing regulation  Yes  No
2. Has your state identified a need for any of the following:
  - a) Electronic system with alert when 90 percent capacity is reached  Yes  No
  - b) Automatic reminder system associated with 14-120 day performance requirement  Yes  No
  - c) Use of peer recovery supports to maintain contact and support  Yes  No
  - d) Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?  Yes  No
3. States are required to monitor program compliance related to activities and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The BHSD program manager's work closely with the providers, review reports, invoices, perform site visits and lend technical assistance when needed to ensure compliance and corrective action as needed. BHSD has an evaluation tool utilized during site visits and chart reviews. The BHSD Quality Improvement & Compliance Team is in the process of developing new tools, reports and site visit schedules to assess provider capacity to provide required services.

**Provider Scope of Work**

All federal provider requirements for treatment, capacity, and reporting are written within each scope of work. The scope of work is monitored by reports and technical assistance throughout the year to maintain fidelity.

Independent Peer Review (IPR) process. The IPR assesses the quality, appropriateness and efficacy of programs that provide services funded by the block grant. Professional counselors and administrators in New Mexico convene to plan, implement, review and report on the SABG service delivery system in New Mexico.

**Tuberculosis (TB)**

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery?  Yes  No
2. Has your state identified a need for any of the following:
  - a) Business agreement/MOU with primary healthcare providers  Yes  No
  - b) Cooperative agreement/MOU with public health entity for testing and treatment  Yes  No
  - c) Established co-located SUD professionals within FQHCs  Yes  No
3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

**Provider Scope of Work**

All federal provider requirements for treatment, capacity, and reporting are written within each scope of work. The scope of work is monitored by reports and technical assistance throughout the year to maintain fidelity.

**Department of Health Collaboration:**

The Tuberculosis Program is administered through the New Mexico Department of Health. The Program serves people infected

with TB, contacts of active TB cases, public and private healthcare providers throughout New Mexico, and the general public. The Program purpose is to prevent and control the spread of Tuberculosis, by ensuring that active TB cases receive adequate care, directly observed therapy, and a contact investigation if infectious. Other important program activities are: case management of all active cases; interstate/international referrals; surveillance; training for healthcare workers and other stakeholders; and screening to identify and treat Latent TB Infection (LTBI).

The New Mexico Human Services Department, Behavioral Health Services Davison's (BHSD) as the principal agency for the SABG works with the State Department of Health/TB Control Officer to implement infection control procedures and establish linkages with other health care providers to ensure that TB services are routinely made available.

The NM Behavioral Health Services Davison's (BHSD) administration of the SABG funding and provider requirements to provide tuberculosis services to individuals with substance abuse issues are as follows:

The BHSD requires behavioral health providers, particularly those receiving SABG funds, to

- offer education and information;
- provide screening, testing or referral for testing and;
- if indicated, referral for treatment services to a public health office;
- The providers document the number of individuals referred for testing and/or treatment to BHSD on a quarterly aggregate report.

The providers are required to maintain a quality assurance process that provides, manages, tracks, evaluates, and reports the routine screening and testing or referral for testing and/or treatment of those consumers who are infected or at risk of infection with tuberculosis and HIV, Hepatitis C, or sexually transmitted diseases. The provider tracks all TB testing referrals and active and latent TB cases on their consumers.

BHSD collaborates with the New Mexico Department of Health/Public Health Division staff and its statewide network of public health offices to test and provide follow-up with any needed TB treatment to consumers referred by the behavioral health providers.

### Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery?  Yes  No
2. Has your state identified a need for any of the following:
  - a) Establishment of EIS-HIV service hubs in rural areas  Yes  No
  - b) Establishment or expansion of tele-health and social media support services  Yes  No
  - c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS  Yes  No

### Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.C.Â§ 300x-31(a)(1)F)?  Yes  No
2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program?  Yes  No
3. Do any of the programs use SABG funds to support elements of a Syringe Services Program?  Yes  No

If yes, please provide a brief description of the elements and the arrangement

NM is not an HIV Designated State.

BHSD does not provide SABG funds for needle exchange programs.

The New Mexico Department of Health provides state and non-block grant federal funding for the needle exchange program in New Mexico.



**Criterion 8,9&10****Service System Needs**

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement  Yes  No
2. Has your state identified a need for any of the following:
  - a) Workforce development efforts to expand service access  Yes  No
  - b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services  Yes  No
  - c) Establish a peer recovery support network to assist in filling the gaps  Yes  No
  - d) Incorporate input from special populations (military families, service members, veterans, tribal entities, older adults, sexual and gender minorities)  Yes  No
  - e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations  Yes  No
  - f) Explore expansion of services for:
    - i) MAT  Yes  No
    - ii) Tele-Health  Yes  No
    - iii) Social Media Outreach  Yes  No

**Service Coordination**

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care?  Yes  No
2. Has your state identified a need for any of the following:
  - a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services  Yes  No
  - b) Establish a program to provide trauma-informed care  Yes  No
  - c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education  Yes  No

**Charitable Choice**

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C. § 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)?  Yes  No
2. Does your state provide any of the following:
  - a) Notice to Program Beneficiaries  Yes  No
  - b) An organized referral system to identify alternative providers?  Yes  No
  - c) A system to maintain a list of referrals made by religious organizations?  Yes  No

**Referrals**

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs?  Yes  No
2. Has your state identified a need for any of the following:
  - a) Review and update of screening and assessment instruments  Yes  No
  - b) Review of current levels of care to determine changes or additions  Yes  No
  - c) Identify workforce needs to expand service capabilities  Yes  No

- d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background  Yes  No

### Patient Records

1. Does your state have an agreement to ensure the protection of client records?  Yes  No
2. Has your state identified a need for any of the following:
- a) Training staff and community partners on confidentiality requirements  Yes  No
  - b) Training on responding to requests asking for acknowledgement of the presence of clients  Yes  No
  - c) Updating written procedures which regulate and control access to records  Yes  No
  - d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure  Yes  No

### Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers?  Yes  No
2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C. § 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

It is written in the NM IPR procedures that the IPR Committee shall review no less than 5% of the total number of SABG providers for each State Fiscal year.

In SFY19 the IPRC reviewed 30% of the SABG providers.

3. Has your state identified a need for any of the following:
- a) Development of a quality improvement plan  Yes  No
  - b) Establishment of policies and procedures related to independent peer review  Yes  No
  - c) Development of long-term planning for service revision and expansion to meet the needs of specific populations  Yes  No
4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds?  Yes  No

If Yes, please identify the accreditation organization(s)

- i)  Commission on the Accreditation of Rehabilitation Facilities
- ii)  The Joint Commission
- iii)  Other (please specify)  
Council on Accreditation (COA)

**Criterion 7&11****Group Homes**

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program?  Yes  No
2. Has your state identified a need for any of the following:
  - a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service  Yes  No
  - b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing  Yes  No

**Professional Development**

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:
  - a) Recent trends in substance use disorders in the state  Yes  No
  - b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services  Yes  No
  - c) Performance-based accountability  Yes  No
  - d) Data collection and reporting requirements  Yes  No
2. Has your state identified a need for any of the following:
  - a) A comprehensive review of the current training schedule and identification of additional training needs  Yes  No
  - b) Addition of training sessions designed to increase employee understanding of recovery support services  Yes  No
  - c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services  Yes  No
  - d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort  Yes  No
3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?
  - a) Prevention TTC?  Yes  No
  - b) Mental Health TTC?  Yes  No
  - c) Addiction TTC?  Yes  No
  - d) State Targeted Response TTC?  Yes  No

**Waivers**

*Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924, and 1928 (42 U.S.C. § 300x-32 (f)).*

1. Is your state considering requesting a waiver of any requirements related to:
  - a) Allocations regarding women  Yes  No
2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:
  - a) Tuberculosis  Yes  No
  - b) Early Intervention Services Regarding HIV  Yes  No
3. Additional Agreements
  - a) Improvement of Process for Appropriate Referrals for Treatment  Yes  No
  - b) Professional Development  Yes  No

c) Coordination of Various Activities and Services

Yes  No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

<http://164.64.110.134/nmac/title08>

**Footnotes:**

## Environmental Factors and Plan

### 11. Quality Improvement Plan- Requested

#### Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

#### Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2018-FFY 2019?  Yes  No

Please indicate areas of technical assistance needed related to this section.

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#### Footnotes:

# Environmental Factors and Plan

## 12. Trauma - Requested

### Narrative Question

**Trauma**<sup>57</sup> is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma<sup>58</sup> paper.

<sup>57</sup> Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

<sup>58</sup> Ibid

### Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues?  Yes  No
2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?  Yes  No
3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?  Yes  No
4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?  Yes  No
5. Does the state have any activities related to this section that you would like to highlight.

Please indicate areas of technical assistance needed related to this section.

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### Footnotes:

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## 13. Criminal and Juvenile Justice - Requested

### Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.<sup>59</sup>

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.<sup>60</sup>

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

<sup>59</sup> Journal of Research in Crime and Delinquency: : *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNeil, Dale E., and Ren?e L. Binder. [OJJDP Model Programs Guide](#)

<sup>60</sup> <http://csgjusticecenter.org/mental-health/>

### Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services?  Yes  No
2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms?  Yes  No
3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system?  Yes  No
4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?  Yes  No
5. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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### Footnotes:



## Environmental Factors and Plan

### 14. Medication Assisted Treatment - Requested (SABG only)

#### Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

#### Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders?  Yes  No
2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women?  Yes  No
3. Does the state purchase any of the following medication with block grant funds?  Yes  No
  - a)  Methadone
  - b)  Buprenorphine, Buprenorphine/naloxone
  - c)  Disulfiram
  - d)  Acamprosate
  - e)  Naltrexone (oral, IM)
  - f)  Naloxone
4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately\*?  Yes  No
5. Does the state have any activities related to this section that you would like to highlight?

*\*Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

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#### Footnotes:

# Environmental Factors and Plan

## 15. Crisis Services - Requested

### Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.<sup>61</sup> SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427)<sup>62</sup>,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

<sup>61</sup><http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848>

<sup>62</sup>Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

### Please check those that are used in your state:

#### 1. Crisis Prevention and Early Intervention

- a)  Wellness Recovery Action Plan (WRAP) Crisis Planning
- b)  Psychiatric Advance Directives
- c)  Family Engagement
- d)  Safety Planning
- e)  Peer-Operated Warm Lines
- f)  Peer-Run Crisis Respite Programs
- g)  Suicide Prevention

#### 2. Crisis Intervention/Stabilization

- a)  Assessment/Triage (Living Room Model)
- b)  Open Dialogue
- c)  Crisis Residential/Respite
- d)  Crisis Intervention Team/Law Enforcement
- e)  Mobile Crisis Outreach
- f)  Collaboration with Hospital Emergency Departments and Urgent Care Systems

#### 3. Post Crisis Intervention/Support

- a)  Peer Support/Peer Bridgers
- b)  Follow-up Outreach and Support
- c)  Family-to-Family Engagement
- d)  Connection to care coordination and follow-up clinical care for individuals in crisis
- e)  Follow-up crisis engagement with families and involved community members

f)  Recovery community coaches/peer recovery coaches

g)  Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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**Footnotes:**

## Environmental Factors and Plan

### 16. Recovery - Required

#### Narrative Question

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The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

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#### **Please respond to the following:**

1. Does the state support recovery through any of the following:

- a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?  Yes  No
- b) Required peer accreditation or certification?  Yes  No
- c) Block grant funding of recovery support services.  Yes  No
- d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?  Yes  No

2. Does the state measure the impact of your consumer and recovery community outreach activity?  Yes  No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.  
 NM promotes recovery as defined in SAMHSA’s Recovery Support Strategic Initiative by fully involving people with lived experience in program design, implementation, and evaluation, including hiring Certified Peer Support Workers onto prevention and treatment teams. We will also address behavioral health disparities by encouraging strategies to decrease disparities in access, service use, and outcomes among the diverse populations (e.g., people living in rural and frontier communities, culturally diverse populations, and veterans).

Recovery Oriented System of Care (ROSC)—Recovery Communities of New Mexico  
 RCNM Mission: Supporting local recovery advocates to improve, empower, and attract their communities to implement recovery initiatives.  
 RCNM Vision: Improved quality of life through recovery.  
 The ROSC initiative is to develop local partnerships of natural supports, recovery organizations, community service providers, and governmental agencies on behalf of individuals and families who seek to start and sustain long term recovery from substance abuse and addiction. These local networks, including prevention and early intervention services, will address the needs and preferences of the whole person in achieving long term recovery.

The BHSD Office of Peer Recovery and Engagement (OPRE) was created to advance consumer and family driven services through training and education that support and empower individuals in the recovery process and to legitimize their voices in statewide behavioral health policy and initiatives. OPRE’s vision is to assure that the voice of New Mexican consumers and family member is heard and included in all major decisions pertaining to mental health and substance abuse issues. The mission is accomplished through progress on the following strategies: training, program development and advocacy, funding and participation/information dissemination. Together, Consumers and Communities will develop the necessary training and skills to help individuals integrate successfully into their communities.

Behavioral Health Week in New Mexico  
 Each year, the Behavioral Health Planning Council (BHPC) and the BHSD sponsors a multi-day event that includes a celebration at the New Mexico Legislature with a Declaration of Behavioral Health Day, training, networking, and collaboration. On Behavioral Health Day at the Legislature, Behavioral Health “Stars” are recognized for their efforts on behalf of the behavioral health community in New Mexico and it is a Statewide opportunity to recognize and celebrate recovery.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.  
 NM promotes recovery as defined in SAMHSA’s Recovery Support Strategic Initiative by fully involving people with lived experience in program design, implementation, and evaluation, including hiring Certified Peer Support Workers onto prevention and treatment teams. We will also address behavioral health disparities by encouraging strategies to decrease disparities in access, service use, and outcomes among the diverse populations (e.g., people living in rural and frontier communities, culturally diverse populations, and veterans).

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5. Does the state have any activities that it would like to highlight?

Behavioral Health Week in New Mexico

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Certified Peer Support Worker Specialty Endorsements

The BHSD Office of Peer Recovery and Engagement is actively collaborating with partners to bring CPSW specialty endorsement in Veteran, Older Adult, and Housing. The endorsement training is for CPSW who would like to specialize in specific recovery journeys. CPSWs have a unique and critical role as part of the behavior healthcare and recovery team. CPSW's have lived through, dealt with, and recovered from substance use and/or mental health issues themselves. They are proof that recovery is possible and are willing to mentor others to achieve similar results.

Criteria for a CPSW Specialty endorsement:

1. Willingness to serve veterans/older adults/housing recipients in a non-judgmental and respectful manner.
2. Successfully completing a free one-hour, on-line suicide awareness and prevention training on QPR (Question Persuade and Refer). Training can be accessed at: (<http://qprtraining.com/setup.php>).
3. Complete a training and scoring an 80% or better on final assessment. Training hours depend on specialty and curriculum.
4. To maintain the endorsement, a minimum of Specialty specific CEUs must be completed every 2 years.

Please indicate areas of technical assistance needed related to this section.

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<b>Footnotes:</b>
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## Environmental Factors and Plan

### 17. Community Living and the Implementation of Olmstead - Requested

#### Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in [Olmstead v. L.C., 527 U.S. 581 \(1999\)](#), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights ([OCR](#)) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

#### Please respond to the following items

- Does the state's Olmstead plan include :
  - Housing services provided.  Yes  No
  - Home and community based services.  Yes  No
  - Peer support services.  Yes  No
  - Employment services.  Yes  No
- Does the state have a plan to transition individuals from hospital to community settings?  Yes  No
- What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Please indicate areas of technical assistance needed related to this section.

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#### Footnotes:

## Environmental Factors and Plan

### 18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

#### Narrative Question

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MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.<sup>63</sup> Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.<sup>64</sup> For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.<sup>65</sup>

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.<sup>66</sup> Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.<sup>67</sup>

According to data from the 2015 Report to Congress<sup>68</sup> on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and



- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

<sup>63</sup>Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

<sup>64</sup>Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

<sup>65</sup>Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from [www.cdc.gov/injury/wisqars/index.html](http://www.cdc.gov/injury/wisqars/index.html).

<sup>66</sup>The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

<sup>67</sup>Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM>

<sup>68</sup>[http://www.samhsa.gov/sites/default/files/programs\\_campaigns/nitt-ta/2015-report-to-congress.pdf](http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf)

**Please respond to the following items:**

- Does the state utilize a system of care approach to support:
  - The recovery and resilience of children and youth with SED?  Yes  No
  - The recovery and resilience of children and youth with SUD?  Yes  No
- Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:
  - Child welfare?  Yes  No
  - Juvenile justice?  Yes  No
  - Education?  Yes  No
- Does the state monitor its progress and effectiveness, around:
  - Service utilization?  Yes  No
  - Costs?  Yes  No
  - Outcomes for children and youth services?  Yes  No
- Does the state provide training in evidence-based:
  - Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families?  Yes  No
  - Mental health treatment and recovery services for children/adolescents and their families?  Yes  No
- Does the state have plans for transitioning children and youth receiving services:
  - to the adult M/SUD system?  Yes  No
  - for youth in foster care?  Yes  No
- Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The Behavioral Health Collaborative purpose is creating a single interagency behavioral health purchasing collaborative is to develop a statewide system of behavioral health care that promotes the behavioral health and well-being of children, individuals and families; encourages a seamless system of care that is accessible and continuously available; and emphasizes prevention and early intervention, resiliency, recovery and rehabilitation.

The Collaborative is chaired by the Secretary of the Human Services Department, with the Secretaries of the Health and Children, Youth and Families Departments alternating annually as co-chairs. The main duties of the Collaborative include the development of a statewide master plan for delivery of behavioral health services that addresses all populations and regional variations, and creation of an inventory of all public behavioral health expenditures. The master plan is to be adopted as part of the statewide Health Plan.

The NM Children Youth and Families Department Behavioral Health Services (BHS), in collaboration with Protective Services (PS), Juvenile Justice Services (JJS) and Early Childhood Services (ECS), is committed to the provision of quality behavioral health services and supports that are trauma informed, evidence based, culturally competent, and youth and family driven. The majority of clinical behavioral health and physical health services for children and adolescents are funded by Medicaid. BHS consists of three program administrative units. The largest in terms of staff numbers (at more than 40 clinicians and supervisors) provides behavioral

health support for JJS ( Juvenile Probation) and PS programs through community behavioral health clinicians (CBHCs). CBHCs consult, assess, coordinate, and advocate internally and externally for children and youth in PS and JJS.

The Licensing and Certification Authority (LCA) licenses and/or certifies six Medicaid-funded community and residential programs, including accredited residential treatment centers, residential treatment services, group home services, treatment foster care services, day treatment services, behavior management services, and non-Medicaid-funded community crisis shelters, multi-service homes and new or innovative programs. They also receive and review all CYFD Statewide Central Intake (SCI) reports that allege abuse or neglect of youth participating in any LCA-licensed or -certified Medicaid program. Finally, they receive Critical Incident Reports (CIRs) from their regulated providers and triage them for immediacy of needed intervention and follow-up.

The third unit provides quality management, including administrative and financial support, and data analytical services to the division as a whole. It also provides program management and certification or endorsement for most of the more complex programming activities, including High Fidelity Wraparound Facilitator Certification, Infant Mental Health Endorsement, Family Peer Support Certification, and two certification processes currently in development for Youth Peer Support and Youth Support Services Coach programs.

7. Does the state have any activities related to this section that you would like to highlight?

PullTogether is a community engagement initiative intended to bring all New Mexicans together to truly make a difference in the lives of our children, and make New Mexico the best place to be a kid.

Through PullTogether, New Mexicans in need can find resources available through state and local agencies, businesses, and nonprofits, such as where to find low-cost child care assistance, free summer meals, substance abuse and behavioral health treatment and services, and tips on how to keep children safe.

PullTogether also serves as a resource for New Mexicans who want to make a difference in their community. Whether through adopting or fostering a child, donating a backpack to a child in need, reporting child abuse or neglect, or even applying for a job at CYFD.

Please indicate areas of technical assistance needed related to this section.

N/A

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**Footnotes:**

# Environmental Factors and Plan

## 19. Suicide Prevention - Required for MHBG

### Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

### Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years?  Yes  No

2. Describe activities intended to reduce incidents of suicide in your state.

Currently suicide prevention services involves the collaboration of Department of Health (DOH) and Department of Veterans Services (DVS) and other state agencies to reduce the rates of attempted and completed suicides statewide. Current focuses include improving crisis response, targeting services to veterans, and training community partners in the use of QPR (Question, Persuade, and Refer).

DOH in collaboration with other state agencies, stakeholders, providers and individuals and families with lived experience convened in April of 2019 forming the Suicide Prevention Coalition (SPC). The primary goal is to redraft the Suicide Prevention Strategic Plan and carry it through legislation. The plan framework is informed by Center for Disease Control (CDC) Preventing Suicide: A Technical Package of Policy, Programs, and Practices, Zero Suicide's Seven-Point framework, as well as the 2015 Recommendations for a State Plan for Preventing Suicide in New Mexico and related goal areas of the NM State Health Improvement Plan. Planning meetings are ongoing.

3. Have you incorporated any strategies supportive of Zero Suicide?  Yes  No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments?  Yes  No

5. Have you begun any targeted or statewide initiatives since the FFY 2018-FFY 2019 plan was submitted?  Yes  No

If so, please describe the population targeted.

New Mexico will focus on populations in which data reveals the highest rates. However there is also special focus on Veterans, Youth, LGBTQ, and Native American populations.

The BH Collaborative and the BH Planning Council have stated suicide prevention as one of the primary focus areas of need.

491 New Mexicans died by suicide, an age-adjusted rate of 23.2 deaths/100,000 residents.

Suicide accounted for 8.7% of all years of potential life lost before 75 years in NM

Suicide was the 9th leading cause of death among New Mexico residents. Among NM residents 10-34 years, suicide was the second leading cause of death by age group and among those 35-44 years, it was the fourth leading cause.

New Mexico had the fourth highest suicide rate in the U.S.

Please indicate areas of technical assistance needed related to this section.

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### Footnotes:

Regarding all Questions on this page: The NM Department of Health in collaboration with other state agencies, stakeholders, providers and individuals and families with lived experience convened in April of 2019 forming the Suicide Prevention Coalition (SPC). The primary goal is to redraft the Suicide Prevention Strategic Plan and carry it through legislation. The plan framework is informed by Center for Disease Control (CDC) Preventing Suicide: A Technical Package of Policy, Programs, and Practices, Zero Suicide's Seven-Point framework, as well as the 2015 Recommendations for a State Plan for Preventing Suicide in New Mexico and related goal areas of the NM State Health Improvement Plan. Planning meetings are ongoing.

The Revised Suicide Prevention Plan will focus on reflecting all of the areas of need on this page.

## Environmental Factors and Plan

### 20. Support of State Partners - Required for MHBG

#### Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

#### Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period?  Yes  No
2. Has your state identified the need to develop new partnerships that you did not have in place?  Yes  No

If yes, with whom?

See Footnote.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

The Behavioral Health Collaborative (Collaborative) was created during the 2004 Legislative Session. The enabling statute allows several state agencies and multiple resources across state government involved in behavioral health prevention, treatment, and recovery to work as one to improve mental health and substance abuse services in New Mexico. This cabinet-level group represents 15 state agencies and the Governor's office.

New Mexico is undertaking a transformational process with regards to improving behavioral health services to adult, children, youth, and families, driven by a focus on recovery and resiliency.

The vision of the Collaborative is to be a single, statewide behavioral health delivery system in which funds are managed effectively and efficiently and to create an environment in which the support of recovery and development of resiliency is expected, mental health is promoted, the adverse effects of substance abuse and mental illness are prevented or reduced, and behavioral health recipients are assisted in participating fully in the lives of their communities.

*Please indicate areas of technical assistance needed related to this section.*

N/A

**Footnotes:**

Questions 1 and 2: New Mexico's behavioral health structure consists of high level State Partners working through the BH Collaborative. Partners include and contribute to the overall delivery of the health and behavioral healthcare system Partners include but are not limited to: Human Services, Children, Youth and Families; Health; Finance & Administration; and Veterans Services Departments, as well as the Administrative Office of the Courts, New Mexico Behavioral Health Providers Association, Medicaid Managed Care Organizations and the BH Planning Council..

## Environmental Factors and Plan

### 21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

#### Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf).<sup>69</sup>

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

<sup>69</sup> <https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf>

#### Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

New Mexico utilizes the Behavioral Health Collaborative, the Behavioral Health Planning Council and its five subcommittees, and the State Epidemiology Outcomes Workgroups (SEOW) to plan and implement substance misuse prevention, SUD treatment and recovery services. The Behavioral Health Planning Council was presented with the Two Year Grant Application Planning steps 1 and 2 and expenditure tables on 7/22/2019. Updates presented on 8/14/19.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?  Yes  No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?  Yes  No

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The New Mexico Behavioral Health Planning Council was statutorily established and is comprised of a minimum 51% consumer and family representation. The role is to advise the Governor and New Mexico BH Collaborative on policies, programs, and funding; and to provide input on an ongoing basis in all BH involved and related initiatives. The New Mexico Behavioral Health Planning Council will continue to serve in this capacity.

The New Mexico Behavioral Health Planning Council has played key advisory roles on many initiatives in our state, both federally and locally funded, to help ensure consumer voice and choice and meaningfully involved and a central role in decision making. They are focused on and will continue to be a potent voice for children, adults and families, and providers that serve New Mexico's consumer-centered, recovery and resiliency-focused coordinated quality behavioral health care system.

BHPC works closely with BHSD to advise them on the combined SAMHSA Block Grant Application for Mental Health and Substance Abuse.

BHPC (Behavioral Health Planning Council)

A. Duties of the BHPC

The Council Shall:

(1) Advocate for adults, children and adolescents with serious mental illness or severe emotional, neurobiological and behavioral disorders, as well as those with mental illness or emotion problems, including substance abuse and co-occurring disorders;

- (2) Report annually to the governor and legislature on the adequacy and allocation of mental health services throughout the state;
- (3) Encourage and support the development of a comprehensive, integrated community-based behavioral health system of care, including mental health and substance abuse services, and services for persons with co-occurring disorders;
- (4) Advise state agencies responsible for behavioral health services for children and adults, as those agencies are charged in Section 9-7-6.4 NMSA 1978;
- (5) Meet regularly and at the call of the chair, which shall be selected by the council membership from among its members;
- (6) Establish subcommittees, to meet at least quarterly, as follows
  - (a) A Medicaid subcommittee, chaired by the secretary of human services or a designee, which may also serve as a subcommittee of the Medicaid advisory committee;
  - (b) A child and adolescent subcommittee, chaired by the secretary of the children, youth and families or a designee;
  - (c) An adult subcommittee, chaired by the secretary of health or designee;
  - (d) A substance abuse subcommittee, chaired by the secretary of health or a designee, which shall include DWI issues and shall include representation from local DWI council; and
  - (e) Other subcommittees as may be established by the chair of the council to address specific issues. All subcommittees may include nonvoting members appointed by the chair for purposes of providing expertise necessary to the charge of the respective subcommittee;
- (7) Review and make recommendations for the comprehensive mental health state Block Grant and the substance abuse block grant applications, the state plan for Medicaid services and any other plan or application for federal or foundation funding for behavioral health services; and
- (8) Replace the governor's mental health planning council and act in accordance with Public Law 102-321 of the federal Public Health Service Act."

B. State Statute establishing the BHPC

2013 New Mexico Statutes, Chapter 24 - Health and Safety, Article 1 - Public Health, Section 24-1-28, Behavioral health planning council created; powers and duties; membership.  
 Universal Citation: NM Stat § 24-1-28 (2013)

24-1-28. Behavioral health planning council created; powers and duties; membership.

There is created the "behavioral health planning council".

A. The council shall consist of the following members, all of whom shall be appointed by and serve at the pleasure of the governor:

(1) Consumers of behavioral health services and consumers of substance abuse services, as follows:

- (a) Adults with serious mental illness;
- (b) Seniors;
- (c) Family members of adults with serious mental illness and of children with serious emotional or neurobiological disorders; and
- (d) Persons with co-occurring disorders;
- (2) Native American representatives from a pueblo, an Apache tribe, the Navajo Nation and an urban Native American population;
- (3) Providers;
- (4) State agency representation from agencies responsible for:
  - (a) Adult mental health and substance abuse;
  - (b) Children's mental health and substance abuse;
  - (c) Education;
  - (d) Vocational rehabilitation;
  - (e) Criminal justice;
  - (f) Juvenile justice;
  - (g) Housing;
  - (h) Medicaid and social services;
  - (i) Health policy planning;
  - (j) Developmental disabilities planning; and
  - (k) Disabilities issues and advocacy.
- (5) Such other members as the governor may appoint to ensure appropriate cultural and geographic representation; and
- (6) Advocates.

B. Providers and state agency representatives together may not constitute more than forty-nine percent of the council membership.

C. The council shall:

- (1) Advocate for adults, children and adolescents with serious mental illness or severe emotional, neurobiological and behavioral disorders, as well as those with mental illness or emotional problems, including substance abuse and co-occurring disorders;
- (2) Report annually to the governor and the legislature on the adequacy and allocation of mental health services throughout the state;
- (3) Encourage and support the development of a comprehensive, integrated, community-based behavioral health system of care, including mental health and substance abuse services, and services for persons with co-occurring disorders;
- (4) Advise state agencies responsible for behavioral health services for children and adults, as those agencies are charged in

Section 9-7-6.4 NMSA 1978;

- (5) Meet regularly and at the call of the chair, which shall be selected by the council membership from among its members;
- (6) Establish subcommittees, to meet at least quarterly, as follows:
  - (a) A Medicaid subcommittee, chaired by the secretary of human services or a designee, which may also serve as a subcommittee of the Medicaid advisory committee;
  - (b) A child and adolescent subcommittee, chaired by the secretary of children, youth and families or a designee;
  - (c) An adult subcommittee, chaired by the secretary of health or a designee;
  - (d) A substance abuse subcommittee, chaired by the secretary of health or a designee, which shall include DWI issues and shall include representation from local DWI councils;
  - (e) A Native American subcommittee, chaired by the secretary of Indian affairs or a designee; and
  - (f) Other subcommittees as may be established by the chair of the council to address specific issues. All subcommittees may include nonvoting members appointed by the chair for purposes of providing expertise necessary to the charge of the respective subcommittee;
- (7) Review and make recommendations for the comprehensive mental health state block grant and the substance abuse block grant applications, the state plan for Medicaid services and any other plan or application for federal or foundation funding for behavioral health services; and
- (8) Replace the governor's mental health planning council and act in accordance with Public Law 102-321 of the federal Public Health Service Act.

### C. BHPC Subcommittees

Within the Behavioral Health Planning Council (BHPC) structure there are five Subcommittees that meet monthly. They were established by statute as part of the BHPC to enhance the goals of the Collaborative. Following is a description of the subcommittees.

1. Adult Subcommittee – The mission of the Adult subcommittee is to make recommendations to the Behavioral Health Planning Council regarding services for adult consumers and their families across the full spectrum of needs.
2. Medicaid Subcommittee - The mission of the Medicaid Subcommittee to the BH Planning Council is to educate and advise the Council and the Medicaid Advisory Committee on matters relating to behavioral health in New Mexico's Medicaid program.
3. Substance Abuse Subcommittee - The Substance Abuse Subcommittee of the Behavioral Health Council serves to provide guidance and recommendations regarding substance abuse/dependence, prevention and treatment services for communities, families and individuals. The subcommittee is committed to the ongoing development of a system that recognizes substance abuse/dependence as a preventable and treatable illness for which high quality services are available.  
Note: ASAM -- Adult, Substance Abuse, and Medicaid Subcommittee was created to combine the first three subcommittees into one large subcommittee.
4. CASC – Children and Adolescents Subcommittee: The mission of the Children's Subcommittee of the Behavioral Health Planning Council serves to: advocate for families, children and adolescents with or at-risk of emotional, neurobiological and behavioral disorders, including substance abuse and co-occurring disorders; encourage and support the development of a comprehensive, integrated, culturally competent, high quality and timely community-based behavioral health system, which includes Local Collaboratives; and advise and make recommendations for increased and improved behavioral health service for families, children and adolescents.
5. NASC - Native American Subcommittee: The Native American Subcommittee's mission is to assure excellence in behavioral health services to all Native American people in New Mexico. Co-chaired by the Indian Affairs Department, the NASC is comprised of Planning Council members from Region 6-the Native American Region and other Planning Council members and non-members interested in Native American behavioral health needs and services. The NASC has established 5 priorities issue areas for evaluating and recommending improvements for Native American behavioral health: best practices, cultural competency, comprehensive services, workforce development, and quality management systems

*Please indicate areas of technical assistance needed related to this section.*

*Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.<sup>70</sup>*

<sup>70</sup>There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

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#### Footnotes:



## Environmental Factors and Plan

### Advisory Council Members

For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency  
 State Vocational Rehabilitation Agency  
 State Criminal Justice Agency  
 State Housing Agency  
 State Social Services Agency  
 State Health (MH) Agency.

Start Year: 2020 End Year: 2021

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
CINDY COLLIER	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		NM,	CHICKENLADY1963@HOTMAIL.COM
PAMELA DRAKE	Others (Advocates who are not State employees or providers)		FARMINGTON NM,	DRAKE@SJCPARTNERSHIP.ORG
MICHAEL ESTRADA	State Employees	NM DEPARTMENT OF CORRECTIONS	NM,	MICHAEL.STRADA@STATE.NM.US
GAIL FALCONER	Family Members of Individuals in Recovery (to include family members of adults with SMI)		MORIARTY NM,	GAIL.FALCONER@GMAIL.COM
DEAN HOPPER	State Employees	NM PUBLIC EDUCATION DEPARTMENT	NM,	DEAN.HOPPER@STATE.NM.US
ALICIA IVERSON	State Employees	NM CHILDREN YOUTH & FAMILIES DEPARTMENT	NM,	ALICIA.IVERSON@STATE.NM.US
JANE JACKSON-BEAR	Providers		NM,	JANE.JACKSON-BEAR@BIA.GOV
CAROL KANE	Family Members of Individuals in Recovery (to include family members of adults with SMI)		NM,	TIMHOLLOW@GMAIL.COM
TIM KANE	Family Members of Individuals in Recovery (to include family members of adults with SMI)		LAS CRUCES NM,	TIMHOLLOW@GMAIL.COM
SUSIE KIMBLE	Others (Advocates who are not State employees or providers)		LAS CRUCES NM,	KIMBLESAND@ZIANET.COM
ALICE KING	State Employees	DIVISION OF VOCATIONAL REHABILITATION	LAS VEGAS NM,	ALICE.KING@STATE.NM.US
CAROL LUNA-ANDERSON	Family Members of Individuals in Recovery (to include family members of adults with SMI)		SANTA FE NM,	CAROL@THELIFELINK.COM
DR. THOMAS MASSARO	State Employees	NM DEPARTMENT OF HEALTH	NM,	THOMAS.MASSARO@STATE.NM.US
SANDTINA MELENDREZ	Family Members of Individuals in Recovery (to include family members of adults with SMI)		NM,	sandtina.melendrez@gmail.com

KENDRA MORRISON	Parents of children with SED/SUD		LOS LUNAS NM,	STRATEGICADVSYS@GMAIL.COM
JACQUELINE NIELSEN	State Employees	NM HUMAN SERVICES DEPARTMENT-BHSD	SANTA FE NM,	JACQUELINE.NIELSEN@STATE.NM.US
NANCY PASSIKOFF	Others (Advocates who are not State employees or providers)		RATON NM,	NPASSIKOFF@BACAVALLEY.COM
ROBINSON TOM	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		NM,	ROBINSONJTOM@ROCKETMAIL.COM
LYNN TRUJILLO	State Employees	NM DEPARTMENT OF INDIAN AFFAIRS	NM,	LYNN.TRUJILLO@STATE.NM.US
LISA TRUJILLO	Family Members of Individuals in Recovery (to include family members of adults with SMI)		NM,	LISA.TRUJILLO@GMAIL.COM

\*Council members should be listed only once by type of membership and Agency/organization represented.

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**Footnotes:**

STATE HOUSING AGENCY IS VACANT  
SOCIAL SERVICES IS THE NM HUMAN SERVICES DEPT.

# Environmental Factors and Plan

## Advisory Council Composition by Member Type

Start Year: 2020 End Year: 2021

Type of Membership	Number	Percentage of Total Membership
<b>Total Membership</b>	<b>20</b>	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	2	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	6	
Parents of children with SED/SUD*	1	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	3	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
<b>Total Individuals in Recovery, Family Members &amp; Others</b>	<b>12</b>	<b>60.00%</b>
State Employees	7	
Providers	1	
Vacancies	0	
<b>Total State Employees &amp; Providers</b>	<b>8</b>	<b>40.00%</b>
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
<b>Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations</b>	<b>0</b>	
Youth/adolescent representative (or member from an organization serving young people)	0	

\* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

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**Footnotes:**

## Environmental Factors and Plan

### 22. Public Comment on the State Plan - Required

Narrative Question

[Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. § 300x-51\)](#) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

#### Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?
  - a) Public meetings or hearings?  Yes  No
  - b) Posting of the plan on the web for public comment?  Yes  No  
If yes, provide URL:  
<http://www.newmexico.networkofcare.org/mh/>
  - c) Other (e.g. public service announcements, print media)  Yes  No

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**Footnotes:**