Opioid Needs Assessment

Albuquerque, NM

June 30, 2011

Prepared for the City of Albuquerque by:

Brenna Greenfield, M.S.[1]*

Mandy Owens, B.S.[1]*

David Ley, Ph.D.[2]

[1]University of New Mexico, Center on Alcoholism, Substance Abuse, and Addictions

[2]New Mexico Solutions

**The first two authors contributed equally to the report and were listed alphabetically.*

Acknowledgments

We are grateful to the following individuals for the information they shared with us during the data collection process. Their passion and dedication for this population was readily apparent. Thank you to:

- Pamela Arenella
- Sally Baclofer
- Snehal Bhatt
- Michael Bogenschutz
- Julie Bohan
- Valerie Carrejo
- Cameron Crandall
- Meg Curtin Rey-Bear
- Jessica Davis
- Olin Dodson
- Gerri Dupree
- Cynthia Geppert
- Stephanie Harvey
- Jeff Holland
- Andrew Hsi
- Vanessa Jacobsohn
- Barbara Kashinski
- Miriam Komaromy
- Barbara Krause
- David Leech
- James Libertoff
- Mary Murphy
- Nina Shah
- Jack Siamu
- Adrian Silva
- Matthew Tandy
- Bruce Trigg
- Ashley Tsang
- Peter Walsh
- Jennifer Weiss
- George White
- Allison Winter
- Andru Ziwasimon
- Dominic Zurlo

Executive Summary

New Mexico has consistently high rates of drug-induced deaths, and opioid-related treatment admissions have been steadily increasing over the last two decades. Youth in New Mexico are at particular risk: they report significantly higher rates of non-medical prescription opioid use than those over age 25, are more likely than their national counterparts to have tried heroin, and represent an increasing proportion of heroin overdoses. Interviews were conducted with 24 agencies in Albuquerque that serve the opioid-using population to identify recent changes in the population and gaps in treatment availability. Across agencies, approximately 22% of clients were under age 25 and 60% were Hispanic. Recent changes included a noticeable increase in youth seeking treatment for opioid use and a general increase in non-medical prescription opioid use. Most providers noted a lack of youth services (no residential or detoxification facilities were identified for individuals under 18) and difficulties finding Suboxone providers. Additionally, stigma, a poor inter-agency communication and referral system, barriers to prescribing Suboxone, and lack of funding prevent opioid users from quickly accessing effective treatment. Recommendations for addressing these issues include: developing youth-specific treatment programs, raising awareness about youth opioid use, increasing the availability of Suboxone through provider incentives and education, developing a resource guide for individuals seeking treatment in Albuquerque, and prioritizing efforts to increase inter-agency communication and referrals.

Key Terms

Buprenorphine: A partial opioid agonist that activates the same receptors as full opioid agonists like heroin or oxycodone. Because it only *partially* fills the opioid receptors, it has similar yet less of the effects of full opioid agonists (e.g., respiratory depression, euphoria), which means it has a lower risk of abuse and addiction. Similarly, because it partially activates the opioid receptors, medical professionals prescribe it to help individuals with opioid dependence stop using other opioids without experiencing intense highs or severe withdrawal symptoms. Prescription buprenorphine is available alone (Subutex®) or with naloxone (Suboxone®); no generic version is available. In 2000, the Drug Addiction Treatment Act approved the use of buprenorphine by physicians for opioid detoxification or maintenance treatment with several limitations, including a maximum of 30 patients during the first year of prescribing and 100 patients in years thereafter, depending on authorization (see: http://buprenorphine.samhsa.gov/titlexxxv.html).

Methadone: Methadone is a full opioid agonist that occupies the same receptors as heroin and other prescription opioids. It is available in tablet or liquid form, and can be prescribed for pain management, to mitigate opioid withdrawal, or for Methadone Maintenance Treatment (MMT). At high levels, it fills the opioid receptors and blocks the effects of other opioids. Lengths of MMT can range from days for opioid detoxification purposes, to many years. Unlike Suboxone®, methadone prescribers are not required to undergo specialized training or submit documentation to the federal government, nor are they limited to a number of patients.

Naloxone (Naloxone hydrochloride): An injectable opioid antagonist that is used to reverse the effects of opioid use, such as slowed breathing and decreased heart rate. Naloxone can often be found as the brand Narcan®, and is commonly used to treat opioid overdoses, including overdoses from heroin, methadone, and prescription opioids.

Naltrexone: Naltrexone is an opiate antagonist that is used in the treatment of opioid dependence. In 2010, an injectable long-acting version of naltrexone (Vivitrol®) was approved for the treatment of opioid dependence. Naltrexone works by blocking other opioids, so that an individual who is on naltrexone and attempts to take an opioid will not feel the desired effect of that opioid.

Opiates: Often used as a synonym for "opioids," opiates actually refer to natural derivations from the opium poppy plant. "Opioids," however, are a more generalized term for opioid agonists (see below).

Opioids: Refers to full opioid and partial opioid agonists, and includes natural derivations and semi-synthetic forms of opium. Once absorbed into the body, opioids bind to opioid receptors in the brain, and produce depressant effects including sedation, slowed respiration, constipation, and euphoric feelings.

Prescription opioids: Prescription opioids include hydrocodone (Vicodin®), oxycodone (OxyContin®), propoxyphene (Darvon®), hydromorphone (Dilaudid®), meperidine (Demerol®), and diphenoxylate (Lomotil®).

Suboxone®: Available in tablet or film version. Suboxone® is the brand name for the combination of buprenorphine and naloxone (see above), and is not currently available in a generic form. The naloxone component in Suboxone® is meant to decrease the abuse potential of suboxone. If injected, it will inhibit the effects of buprenorphine and cause an opioid user to experience withdrawal symptoms. To begin a regular Suboxone® regimen, individuals must engage in an induction process, lasting 2-3 days, which entails supervision and monitoring. Once regularly using Suboxone®, a person may go through withdrawal if the regimen is discontinued without a taper.

Background

Opioid Use

New Mexico. High schoolers in New Mexico are significantly more likely than the national average to have tried heroin or injected an illegal drug during their lifetime (Centers for Disease Control and Prevention [CDC], 2009). Specifically, 4.7% of New Mexico high schoolers reported lifetime use of heroin, compared to only 2.5% of U.S. high schoolers. Likewise, 3.6% of New Mexico high schoolers reported lifetime injection drug use, compared to a significantly smaller 2.0% of U.S. high schoolers (CDC, 2009). Male high schoolers in New Mexico were more likely than females to report lifetime heroin use (5.8 versus 3.6%, respectively) or injection drug use (2.7 versus 1.3%, respectively).

Bernalillo County. The National Survey on Drug Use and Health provides annual national and state-specific data on drug use. Between 2002 and 2004, individuals in Bernalillo County between the ages of 18 and 25 had significantly higher rates of past-year non-medical use of prescription pain pills and past-year illicit drug use (not including marijuana) than individuals over 25 years of age:

Age:	12-17	18-25	26+
Past-year nonmedical use of prescription pain pills (%)	8.31	11.28	4.01
Past-month illicit drug use, other than marijuana (%)	6.11	9.66	3.77

Source: U.S. Department of Health and Human Services, Office of Applied Studies [U.S. DHHS, OAS], 2009b

Drug-Induced Overdose in New Mexico

Elevated levels of drug-induced overdose rates have been an area of concern for New Mexico for the past two decades. Specifically, drug-induced death rates per capita are higher in New Mexico than almost any other state in the country, second only to Utah (Shah, 2009). During the years of 2003 to 2007, New Mexico averaged 20.0 drug-induced deaths per 100,000, and slightly decreased to 19.6 deaths per 100,000 in 2008 (Shah, 2009).

Age. Despite stable or consistent use of heroin from 2008 to 2009, young adults experienced a significant increase in proportions of people who died from heroin overdose since 2004. Prior to 2004, only two percent of individuals who overdosed on heroin were individuals less than twenty-one. In 2008, this proportion increased to eight percent, and increased again in 2009 to 12 percent (Shah, 2011). This increase in percentage of overdoses by people under 21 highlights a startling trend among New Mexico's youth.

Expanding across age groups in New Mexico, from 2003 to 2007 there were the following reported number of overdoses:

Age:	<25	25-64	65+
Number of drug overdoses	150	1,707	72
(Deaths per 100,000)	(4.2)	(33.6)	(6.0)

Source: Shah, 2011

Race and ethnicity. Throughout the state, there were a reported 1,929 deaths due to drug overdose from 2003 to 2007 (Shah, 2011). Of this group, 844 (44%) Whites and 950 (49%) Hispanics represented the racial/ethnic groups most affected by unintentional drug overdoses. American Indians were the third most common group affected by drug overdoses with 86 (4%) reported deaths (Shah, 2011).

Gender. With nearly a 2 to 1 ratio, males represented the primary sex to have overdosed from drugs during 2003-2007. A reported 1,255 (65%) males died from drug overdose during these years, as compared to 674 females (35%) (Shah, 2011).

Death rates by drug-type. Overall, there was a decrease in the total prescription opioid overdose death rate from 2008 (9.1 deaths per 100,000) to 2009 (8.4 deaths per 100,000; Shah, 2011). Within the category of prescription opioids, oxycodone overdose deaths increased from 2008 to 2009 (2.9 deaths per 100,000 and 3.7 deaths per 100,000, respectively). Behind heroin and cocaine, oxycodone was the third leading cause of drug-induced death in 2009 (Shah, 2011). Rates in overdose deaths due to methadone declined in 2009, and reached their lowest level since 2002 (Shah, 2011). There was no apparent change in route of administration of illicit or prescription drugs related to overdoses prior and leading up to 2009 (Shah, 2011).

Drug-Induced Overdose in Bernalillo County

The rates of drug-induced deaths per 100,000 in the state are highest in Rio Arriba County, and have shown an increase from 2001-2003 (39.5 per 100,000; Shah, 2005) to 2003-2007 (47.7 per 100,000; Shah, 2010). During the years of 2002 to 2006, Rio Arriba County represented the second highest drug-induced death rate in the United States (Shah, 2010). Bernalillo County also experienced an increase in drug-induced death rates from 2001-2003 (20.0 per 100,000; Shah, 2005) to 2003-2007 (24.7 per 100,000; Shah 2010), and experienced the highest number of unintentional deaths in the state from 2003-2007 (777 deaths; Shah, 2010).

Race and ethnicity. From 2003 to 2007, there were 777 unintentional drug induced deaths in Bernalillo County, a rate of 24.9 deaths per 100,000. Of this group, Hispanics represented the largest proportion of drug-induced deaths, with 431 deaths (34.4 deaths per 100,000). Whites followed Hispanics in proportion of drug-induced deaths with 302 deaths (19.7 deaths per 100,000; Shah, 2010). Next, twenty-one American Indians and twenty-one Blacks died from drug-induced deaths between 2003 to 2007, rates of 11.1 and 19.9 deaths per 100,000, respectively (Shah, 2010).

Gender. From 2004 to 2008, there were 735 drug-induced deaths in Bernalillo County. Most individuals who died from drug overdoses during this period were male (519 deaths, 33.0 deaths per 100,000); females represented 216 deaths (19.1 deaths per 100,000; Shah, 2010).

Death rates by drug-type. The Albuquerque Drug Enforcement Administration identified prescription drugs as the primary drug of concern in 2010 (Shah, 2011). Also, most methadone overdose deaths were in Albuquerque versus the rest of the state (rate ratio of 1.85 deaths; Shah, 2011). The methadone clinics in NM are concentrated in Albuquerque, which may partially account for this difference. No further data were available for overdose rates broken down by drug-type in Bernalillo County or for the city of Albuquerque.

Emergency Department Overdose Visits

Due to New Mexico's high rates of drug-induced overdose rates, drug overdose became a reportable condition in 2003 (Shah, 2006). This allowed the New Mexico State Department of Health to track and measure rates of overdose visits in emergency rooms across the state.

From July 2004 to August 2005 the state surveyed individuals entering the emergency departments of hospitals in two northern New Mexico counties. During this time period, there were 561 emergency room visits due to overdose, which represented 506 unique individuals. Of this group, 264 (52%) individuals were male, the median age was 34.7 years, and 68% lived in metropolitan areas. There were 321 (63%) Hispanics, 141 (28%) non-Hispanic Whites, and 18 (4%) American Indians reported in this sample (Shah, 2006).

When overdose visits were broken down by substance, 15% of overdose cases were due at least partly to prescription opioids (excluding methadone), and 13% were due to heroin (Shah, 2006). The use of heroin was six times more likely to appear in overdose cases that were unintentional than in cases that were associated with attempted suicide (Shah, 2006).

Poison Center Calls

Since 2000, the New Mexico Poison and Drug Information Center has seen a steady increase of incoming calls regarding opioids, including heroin, codeine, hydrocodone, and oxycodone. In 2000, there was a total of 302 callers inquiring about opioid use and potential overdose, which has increased by more than double in 10 years. Even since 2008, there has been an increase in inquiries regarding opioid use, with a reported 644 callers in 2008, 711 callers in 2009, and 737 callers in 2010 (New Mexico Poison and Drug Information Center, 2011). Within the first trimester of 2011 (January 1st - April 30th), 256 calls were made to the Poison Center regarding opioid use, which puts 2011 calls on track to be the highest yearly rate yet (768 calls).

Calls by drug-type. From 2008 to 2010, calls regarding heroin use and potential overdose remained consistent around 43 calls per year. Since 2008, however, there has been an increase in calls regarding other opioids. In 2008, there were 261 calls to the NM Poison and Drug Information Center regarding oxycodone use, with and without aspirin and acetaminophen. This number increased to 332 calls in 2010. Additionally, the number of calls regarding hydrocodone, with or without aspirin and acetaminophen, increased from 290 calls in 2008 to 304 in 2010. Codeine, in combination with and without aspirin and acetaminophen, increased in number of calls from 2008 (62 calls) to 2009 (86 calls), and then decreased in 2010 (78; New Mexico Poison and Drug Information Center, 2011).

These data are not representative of opioid use and potential overdose rates around the state. One reason for this is the increase in awareness and education of the treatment of opioid overdose by medical professionals and the community. Unlike the treatment of other alcohol or drug overdoses, opioid overdose can be effectively treated with the administration of Narcan® (naloxone hydrochloride).

Criminal Justice System

Children, Youth, and Families Department (CYFD). The State of New Mexico's CYFD oversees a variety of services for young adults in New Mexico, including prevention, intervention, rehabilitation, and family treatments. An estimated 25,000 individuals are referred to the CYFD per year (CYFD, 2011), many of whom who are supervised by Juvenile Probation Officers (JPO).

In 2010, 18,473 specimens were collected from juveniles supervised by the CYFD across the state. Among this group, Bernalillo County collected 3,068 specimens (17%) to test for substance use. Of the total number of specimens collected from Bernalillo County, 1,131 (36%) tested positive for alcohol or drug use (CYFD, 2011). When looking at the individual level, 875 (18%) of juveniles supervised in Bernalillo County were screened for alcohol or drug use. Of this

group, 464 individuals (53%) tested positive for substance use in 2010. This proportion was the second highest in the state by region, behind the southeast region who reported 57% of juveniles testing positive in 2010 (CYFD, 2011).

Additional data broken down by region were not available for specimens that tested positive for alcohol or drug use. Across the state, however, 567 (3%) of the 18,427 specimens collected tested positive for opiate use. Of this group of specimens tested, opiates were the third most common positive screen, behind alcohol and marijuana (CYFD, 2011). This percentage, however, may not be an accurate representation of juveniles supervised by CYFD using heroin or opioids due to the small proportion screened by JPOs and the short duration that opioids appear in urine.

Prescribing Methadone and Buprenorphine in Jails

Methadone. The Metropolitan Detention Center (Bernalillo County) has adopted a program of continuing methadone maintenance for individuals with heroin and opioid dependence entering the jail and throughout incarceration. The primary aims of the methadone program are to address the high rates of individuals with heroin and opioid dependence, and prevent post-release overdose and death.

Suboxone®. To help attend to high rates of hepatitis C in intravenous (IV) drug users, the Department of Health began to target incarcerated IV heroin users. Currently, 15-30 (total) IV heroin users incarcerated in Bernalillo County Jail can be screened to participate in a program that aims to begin individuals on a Suboxone® maintenance program after release from jail. If eligible, and permitting space in the program, individuals will have 3 to 4 days of Suboxone® medication available at the time of release, and will then be referred to the Department of Health Suboxone® Clinic. Case managers will then regularly meet with individuals, and refer them to community providers to continue their Suboxone® programs. The goals of this program are to help decrease the spread of diseases associated with IV use (e.g., hepatitis C), take a harm-reduction approach to treating this population, and help address the estimated 300 individuals detoxifying from opioids a month in the Bernalillo County Jail (Trigg & Murphy, n.d).

Comparison of methadone and buprenorphine. In an urban jail in New York City, researchers randomly assigned individuals with heroin dependence (*N* =116) sentenced to 10 to 90 days to either methadone or buprenorphine maintenance throughout incarceration (Magura et al., 2008). Individuals randomized to buprenorphine were more likely to follow-up with community treatment referrals after release. There were no other differences in groups including: completion rates of medication programs while in jail, relapse to illicit opioids after

release, self-reported recidivism rates, and self-reported post-release incarceration (Magura et al., 2008).

Opioid Use and Treatment

Among individuals 18 years and older entering substance abuse treatment at 95 different facilities in New Mexico between 2006 and 2008, prescription opioid abuse was most prevalent for those who lived in the Albuquerque area (Brownstein, Green, Cassidy, & Butler, 2010). The included substance abuse treatment facilities were those that administered the computer version of the Addiction Severity Index (ASI-MV®) at intake; no further information about these facilities was provided. At intake, nine percent of individuals who lived in zip codes beginning with the three digits 871- (primarily Albuquerque) reported past-month abuse of prescription opioids. This higher rate of abuse was matched by increased rates of legal prescription opioid availability in and around Albuquerque.

Between 2002 and 2004, past-year illicit drug abuse or dependence (i.e., marijuana, cocaine, heroin, prescription opioids, hallucinogens, or inhalants) in Bernalillo County ranged from two percent for those over age 26, up to 12 percent for individuals aged 18 to 25 (U.S. DHHS, OAS, 2009b). This highlights the fact that the time between 18 and 25 years of age is a risk period for not only problematic alcohol use, but also problematic drug use. As illustrated in the table below, most of the individuals with past-year illicit drug abuse or dependence in Bernalillo County did not receive treatment:

Age:	12-17	18-25	26+
Past-year illicit drug abuse or dependence (%)	6.56	12.21	2.16
Past-year needed but did not receive treatment (%)	6.12	10.58	1.97

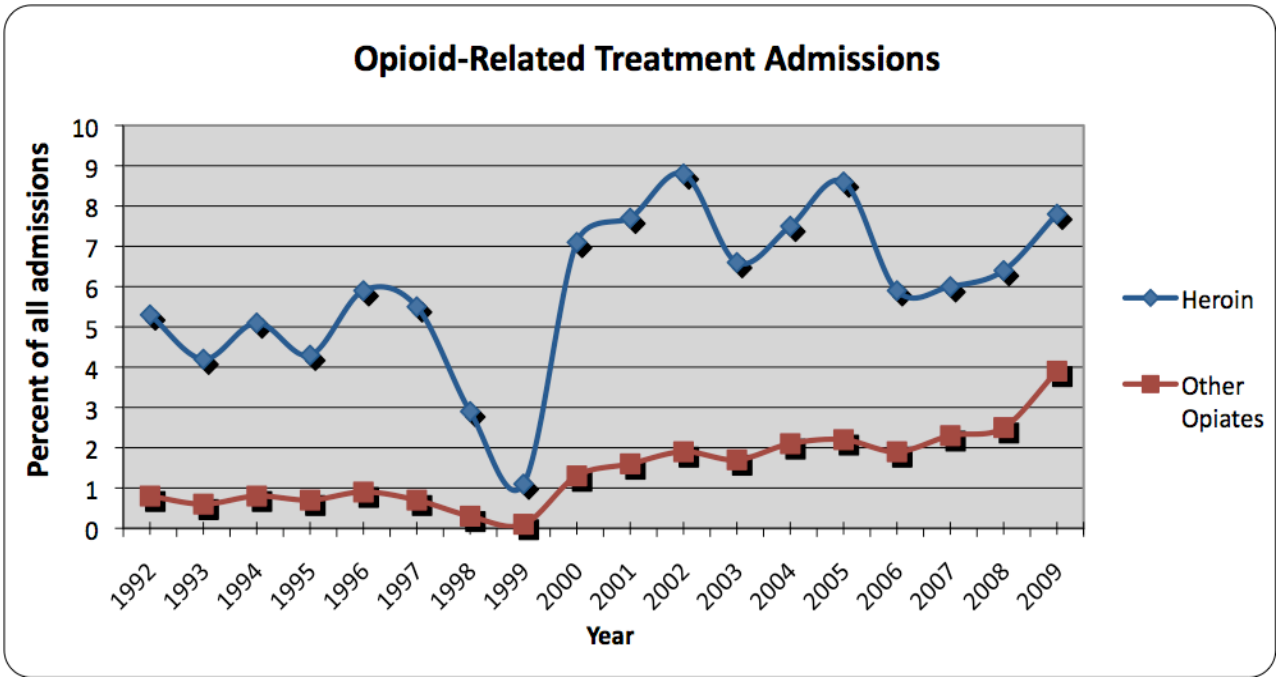
Source: U.S. DHHS, OAS, 2009b

Treatment Admissions. The National Survey of Substance Abuse Treatment Providers (N-SSATS) gathers data on public and private facilities in the United States that provide substance abuse treatment services. On a single day in 2009, there were 2,339 clients receiving treatment in methadone treatment facilities in New Mexico (U.S. DHHS, OAS, 2009a). This figure included clients at 96.9% of all methadone treatment facilities in New Mexico, many of which are located in Albuquerque.

The Treatment Episode Data Set (TEDS) provides information on annual treatment admissions to substance abuse treatment facilities that receive state or federal block grant funding. Because it generally does not include those in private treatment facilities or hospitals, the TEDS likely underestimates the number of people in treatment. In 2009, 790 individuals were

admitted to treatment in New Mexico for heroin use, while 391 individuals were admitted for other opiate use (defined as "non-prescription use of methadone, codeine, morphine, oxycodone, hydromorphone, meperidine, opium, and other drugs with morphine-like effects"). These admissions represented 7.8% (heroin) and 3.9% (other opiates) of all treatment admissions. After alcohol, heroin was the second most common substance prompting treatment admission in New Mexico (U.S. DHHS, OAS, 1992-2009). At the county level, treatment admission data were not publicly available for this period.

Since 1992, treatment admissions for heroin or other opiate use have been steadily increasing in New Mexico. The graph below displays the percentage of treatment seekers from 1992 to 2009 who sought treatment for opioid use (U.S. DHHS, OAS, 1992-2009). Taken together, an additional 677 individuals sought treatment for heroin or other opiate use in 2009 as compared to 1992. This group of treatment seekers made up a larger percentage than previously: they included 11.7% of all individuals in treatment in 2009, versus 6.1% in 1992 (U.S. DHHS, OAS, 1992-2009).



Note: No explanation was given for the sudden drop in admissions in 1998 and 1999. This could be related to lower survey participation or less treatment availability during those years. Data source: U.S. DHHS, OAS, 1992-2009.

Among individuals who were admitted to treatment in 2009 because of heroin use, 39.1% were female and 20.8% were less than 25 years old (U.S. DHHS, OAS, 1992-2009). Compared to Hispanics/Latinos admitted to treatment across all alcohol and drug categories (45.4%), the proportion of Hispanics/Latinos admitted to treatment because of heroin use was

disproportionately higher (74.4%; U.S. DHHS, OAS, 1992-2009). A slightly higher percentage of females (44.5%) and individuals under 25 (24.4%) entered treatment in 2009 for other opiate use than for heroin use. Among “other opiate” users, 55.8% were Hispanic or Latino (U.S. DHHS, OAS, 1992-2009), which suggests that Hispanics may be more likely than other groups to use heroin (at least in state-funded treatment facilities).

Method

Description of the Provider Survey

The questions used on the provider survey (see Appendix A) were compiled based on the goals of the needs assessment. These goals included: (a) a survey of available treatment services in the community, (b) a general overview of demographic characteristics of clients with opioid dependence, and (c) an appraisal of treatment gaps in Albuquerque. The first goal was achieved by assessing the agency's treatment orientation, number of medical and counseling staff, funding, and types of services available. Next, demographic information about clients with opioid dependence was collected. Last, a series of open-ended questions assessed population characteristics, services most helpful for clients with opioid dependence, recent changes, community gaps in the treatment for this population, and city-wide issues regarding treatment in Albuquerque. Phone and in-person meetings took approximately thirty to ninety minutes.

Contacting Treatment Providers

The third author of the report asked the staff at his treatment agency to compile a list of treatment providers in Albuquerque who offered services for individuals with opioid dependence. This initial contact list was augmented by online searches for "opioid treatment in Albuquerque," the first and second authors' knowledge of available treatment services, and a list found on the Substance Abuse and Mental Health Services Administration (SAMHSA) website of treatment providers in Albuquerque (http://findtreatment.samhsa.gov). A list of Suboxone® providers in Albuquerque was retrieved from SAMHSA website (http://buprenorphine.samhsa.gov) and the Suboxone Directory (www.suboxone-directory.com) in April of 2011. Data collectors, Brenna Greenfield and Mandy Owens, then contacted treatment providers and scheduled phone or in-person meetings with either the director of the treatment agency, for agencies that dealt specifically primarily with substance dependence, or with individuals within the agency who were most involved in the treatment of opioid dependence.

A snowball data collection method was used to ensure a representative sample of respondents: at each interview, providers were asked to name other individuals in the community that should be approached for the needs assessment. The interview process continued in this manner until no new names were provided, at which point saturation of the treatment community was assumed. It should be noted that no formal interviews were conducted with opioid users or 12-Step groups: this is a limitation of the current report.

Response Rate

Treatment providers. From April to June 2011, 37 treatment providers were contacted and invited to participate in the data collection portion of the needs assessment. Of those contacted, 24 meetings were conducted by phone, e-mail, or in-person to collect treatment information, for an overall response rate of 65%. Five (14%) treatment providers did not provide any response to contact attempts, one treatment provider refused to participate, and seven (19%) treatment providers responded to the interview request, but scheduling difficulties prevented these interviews from being completed during the data collection window. The non-interviewed providers represent primarily smaller, low-volume providers, and the response set can be considered representative of available treatment services in Albuquerque.

Suboxone® providers. Eighty-seven Suboxone® providers were compiled from SAMHSA's online resource and the Suboxone Directory. Twenty-one (24%) providers were confirmed as currently prescribing Suboxone®; six (7%) were reported as no longer prescribing; nine (10%) were no longer at the facility listed; and fifty-one (59%) were unavailable at the number provided or were not contacted.

Community contacts. Additional community contacts were made, resulting in eight phone or in-person meetings. These community contacts included meetings with state employees knowledgeable of the opioid dependent population, state organizations, community activists, and other individuals working with these clients.

Qualitative Data Analysis

Data were analyzed using NVivo 9, a qualitative coding software program. Once interviews with providers and community members were completed, they were transcribed and uploaded into NVivo. Interview responses were coded into specific response types under larger categories such as "recent changes," "gaps in treatment," and "city-wide issues."

Coding. The first two authors coded the transcripts, and answers were then discussed to resolve any ambiguities. This process entailed developing "nodes" under which answers could be coded (i.e., "Age" was used to capture consistent reports of increases in heroin and opioid use by adolescents). Once coded, answers were compiled and reported in aggregate form.

Quantitative Results

Services Provided: Agencies Interviewed Only

The table below is a summary of available services offered by the treatment agencies interviewed. This table does not include interviews with individual Suboxone® providers. Alternative treatments refer to services such as acupuncture, massage, aromatherapy, etc.

Agency	Counseling	Methadone	Suboxone®	<18 Allowed	Alternative Treatments	Other
ABQ Treatment Services		✔				
Casa de Salud			✔	✔	✔	On-site Needle Ex.
Central NM Treatment Services	✔	✔				
Center for Family & Adolescent Research	✔					
Desert Oasis	✔				✔	Residential (Rio Rancho)
Endorphin Power Company						Housing
First Choice North Valley			✔	✔		
First Choice South Valley	✔		✔	✔		
Healthcare for the Homeless	✔		✔			
MATS						Detox
New Mexico Solutions	✔			✔	✔	
Supportive Aftercare						Housing
Stanford Clinic (DOH)			✔			On-site Needle Ex.
Turquoise Lodge	✔		✔			Residential
UNM ASAP	✔	✔	✔	✔		Medical care
UNM SE Heights Clinic			✔	✔		
UNM Student Health & Counseling	✔		✔			
Veteran Affairs	✔		✔			
Youth Development Inc.	✔			✔	✔	On-site Needle Ex.
TOTAL (*n*=19)	11	3	9	7	4	N/A

Services Provided: City-Wide

The service-types in the table below were located within Albuquerque by the authors. These totals reflect only treatment agencies (not individual primary care physicians or Suboxone® providers), and may not be exhaustive. Additionally, some treatment agencies were counted multiple times if they provided various types of treatment (i.e., outpatient counseling and Suboxone®).

Treatment Vouchers*	Detox Facility*	Residential Facility*	Outpatient Counseling	Methadone*	Suboxone	Needle Exchange
2	**2**	**1**	**25**	**6**	**12**	**6**

***Adult Only**
***N*=36**

- There appears to be no services available for individuals under 18 for detoxification, residential treatment, or methadone.
- Only "Outpatient Counseling" includes programs specifically for youth under 18.
- The authors only identified one residential treatment program within Albuquerque city limits.

Demographics of Individuals in Treatment

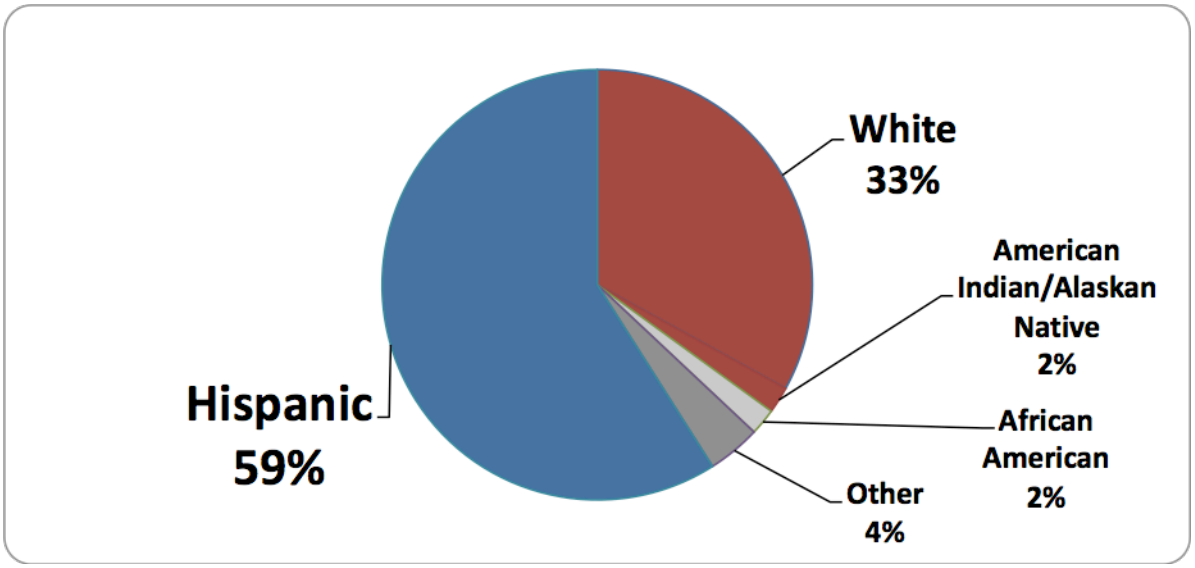
Demographic information was collected from 13 agencies during phone and in-person interviews. If actual agency data were not available, interviewees provided estimates of demographic rates at their agencies. All proportions and averages are estimates within the agency, and apply to clients with opioid dependence only.

1. Gender and Age (*n*=13)

	Gender (% Male)	Age	% Clients <18	% Clients 18-25
Average	**60.4%**	**35 years**	**3.5%**	**18%**

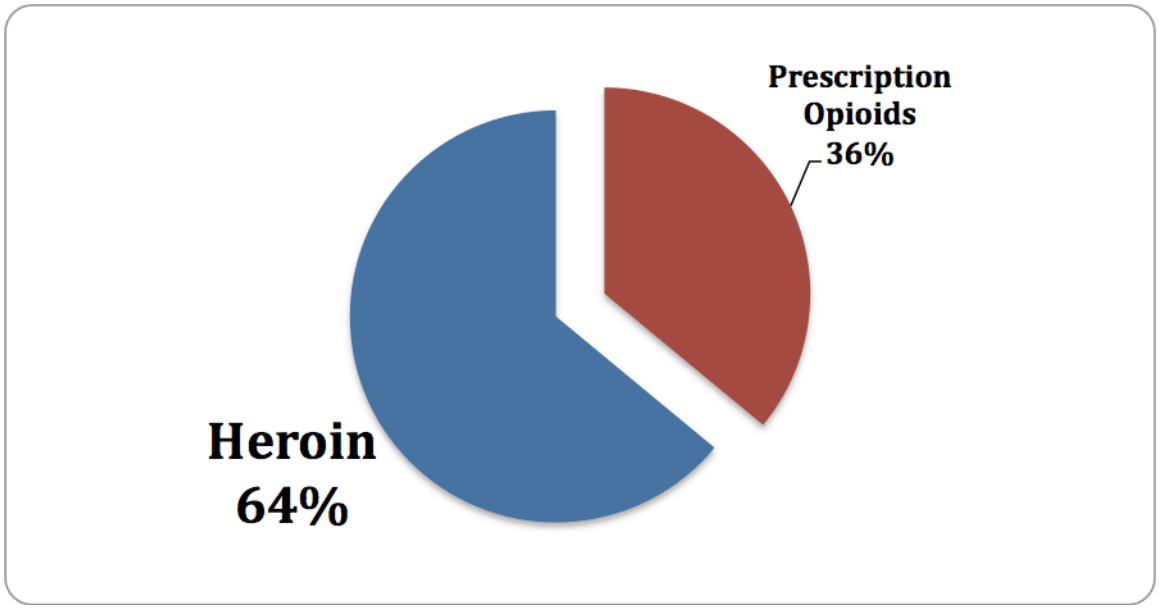
- Proportions of clients under age 25 were relatively consistent across all treatment modalities (methadone, primary care settings, etc.), indicating that young adults are equally accessing various types of treatments across Albuquerque.

2. Race/Ethnicity (*n*=13)

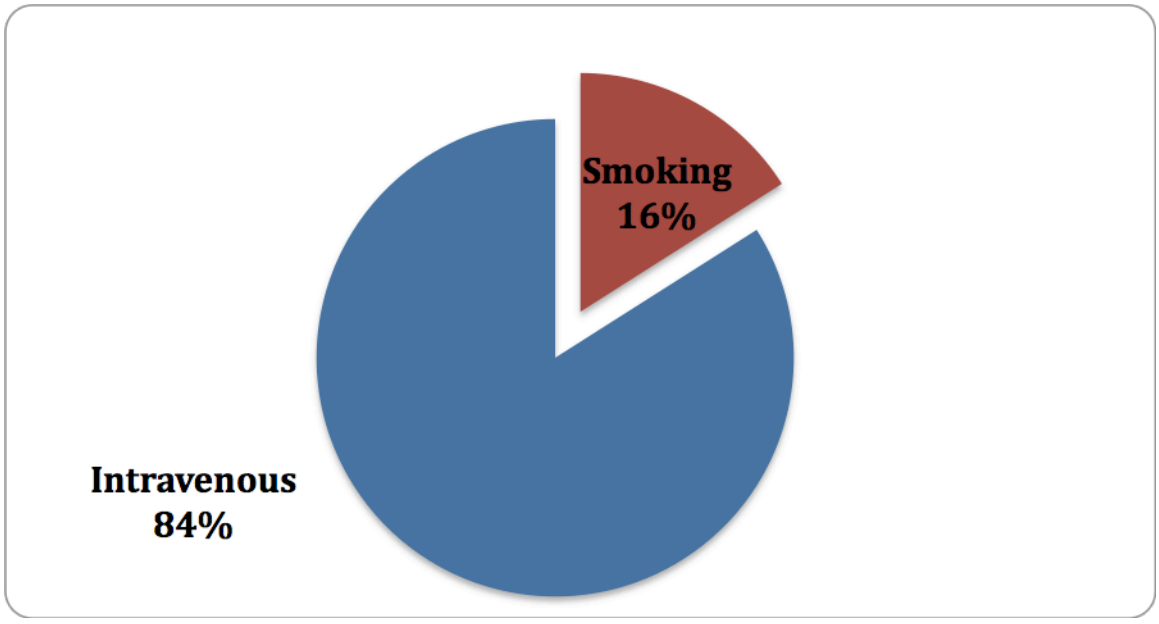


- Compared to the general composition of racial/ethnic groups in New Mexico, Hispanics were overrepresented among individuals in treatment. These results must be interpreted with caution because individuals included in the Hispanic group may represent a wide range of national origins and backgrounds, and providers may differ in how they assign labels of race and ethnicity. However, the overrepresentation of Hispanics in this population does reflect historical trends of heroin use among Hispanic families that have lived in New Mexico for several generations (Goldstein & Herrera, 1995) as well as recent TEDS data (see Background section: Opioid Use, and Treatment).

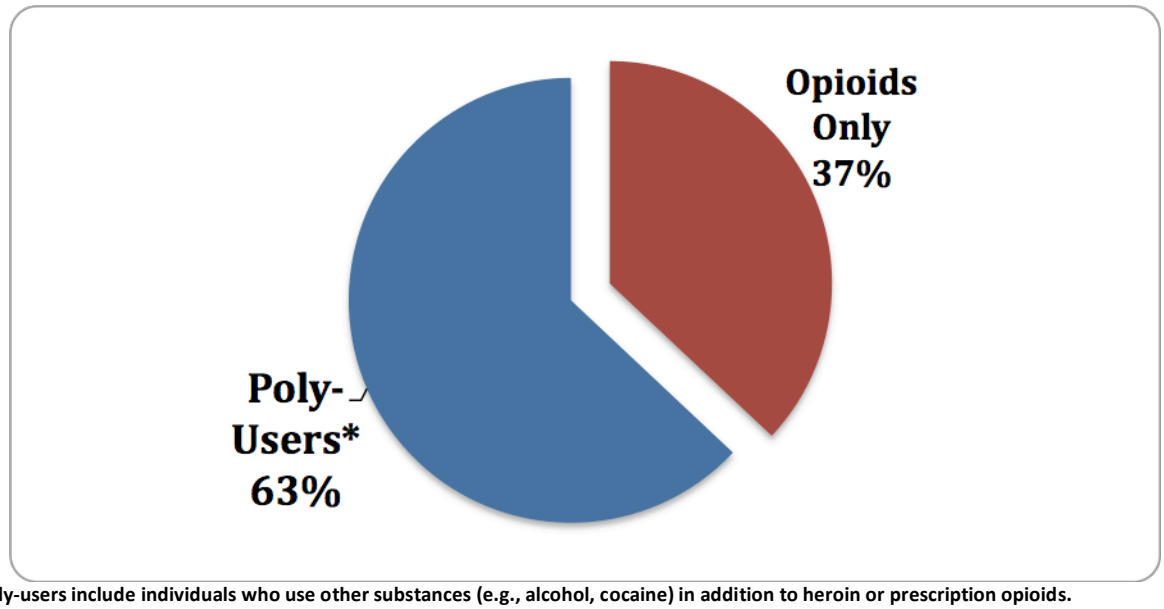
3. Drug Type (*n*=11)



4. Route of Administration of Heroin Use (*n*=12)

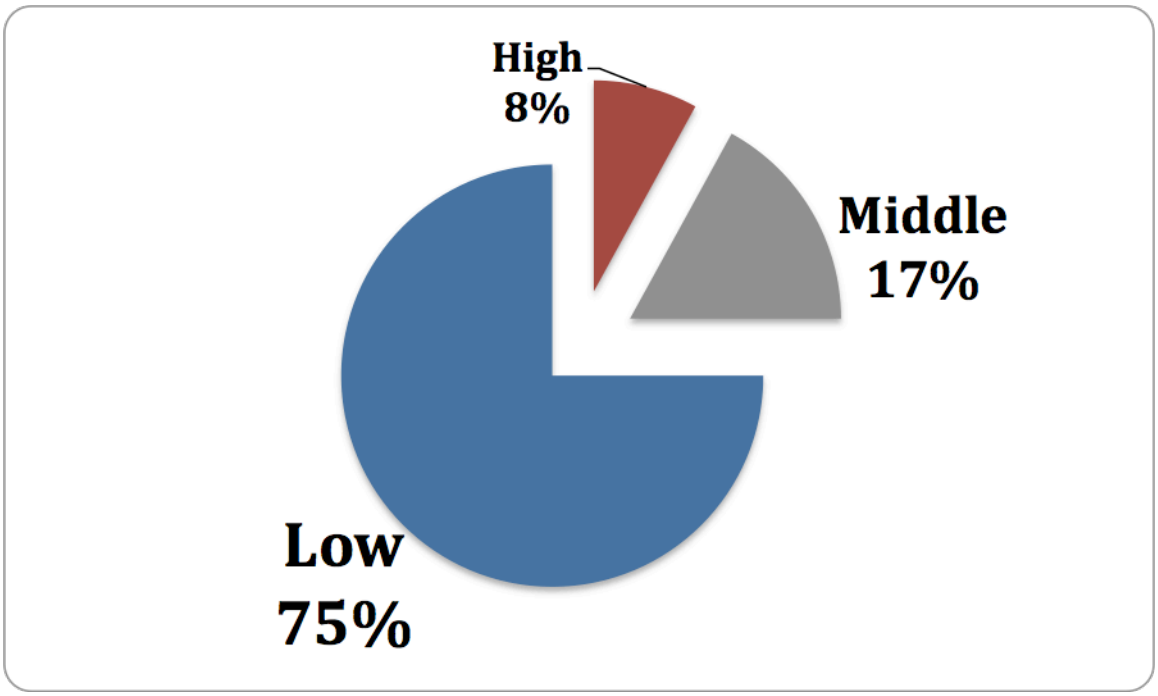


5. Poly-Substance Users (*n*=11)



*Poly-users include individuals who use other substances (e.g., alcohol, cocaine) in addition to heroin or prescription opioids.

4. Socioeconomic Status (*n*=12)



Funding

Note: Percentages reflect approximations of the percentages of funding streams for each agency, as recorded by interviewers. These percentages have not been verified by funding sources. Additionally, agencies where funding streams were not assessed are not included.

Agency	Medicaid	State	County	City	Private Insurance	Self-Pay	Unknown /Other
ABQ Treatment Ser.	0%	10%	0%	0%	0%	90%	0%
Casa de Salud	0%	30%	20%	0%	0%	50%	0%
Central NM Treatment	0%	0%	0%	0%	0%	100%	0%
Private Physician	0%	0%	0%	0%	60%	40%	0%
Endorphin Power Co.	0%	0%	0%	0%	0%	100%	0%
First Choice North Valley	N/A*	N/A*	0%	0%	N/A*	<5%	N/A*
MATS	0%	0%	90%	0%	0%	0%	10%
NM Solutions	20%	0%	0%	40%	30%	10%	0%
Stanford Clinic (DOH)	0%	100%	0%	0%	0%	0%	0%
Turquoise Lodge	N/A	N/A*	N/A	N/A	N/A	N/A*	N/A*
YDI – Needle Exchange	1%	45%	5%	10%	0%	1%	37%
Average	2.3%	31%	2.8%	5.5%	10%	44%	5%

N/A = Not assessed
***Accepted, but percentages unknown**

Qualitative Results

Note: For the following sections, results are listed in order from most common response to least common response. Because of the open-ended format of the interviews, when a provider did not mention a particular topic, this could either mean that (a) they did not think it was an issue, or that (b) they do feel it is an issue, but did not happen to mention it during the interview.

Population Characteristics

"Opioid withdrawal is medically like the flu, but psychologically you feel like you are dying."

1. Price and its relation to opioid use.

In Albuquerque, heroin is relatively inexpensive, while prescription opioids can be quite expensive when purchased on the street. This has had two effects. First, long-time heroin users tend to be poorer, while prescription opioid users tend to come from a higher SES. Heroin use is also harder to hide. One provider said that the "heroin population is not working. If you need a fix five to six times a day, it is hard to hold a job. Alcohol dependent individuals can hold a job." Second, among younger individuals, and those with chronic pain who previously had opioid prescriptions, it is common to initiate use with prescription opioids and then switch to heroin because of the lower price. This transition from prescription opioids to heroin in Albuquerque is consistent with trends across the country.

2. Opioid users versus other substance users.

When comparing opioid users to other substance users, provider comments' varied. One provider in primary care said that opioid users are usually more ready to deal with their use than are alcohol users, but this may be a function of the added barriers opioid users face in accessing treatment: only the very motivated may persist. Five providers said that the opioid using population is harder to treat, needs more support, and leaves against staff advice more often than those who use other substances. One provider said that opioid users are similar to alcohol and benzodiazepine users: this may be a function of similar physiological withdrawal profiles.

3. Withdrawal drives addiction.

Three providers commented on the more prominent withdrawal symptoms that are present with opioid use. Although this was only a small portion of all providers, it is a noteworthy feature of this population that has created a need for some type of medical therapy, which and has led to the use of methadone and buprenorphine in the treatment of opioid dependence.

4. Specific medical issues are associated with heroin use.

Three providers cited medical issues that go along with injection drug use. Medical issues mentioned included abscesses and blood diseases such as HIV/AIDS and Hepatitis C. These

medical issues are a concern specific to this population, and the number of individuals using heroin intravenously does seem to be holding steady or declining slightly (see Recent Changes #4 above). One provider said, “These patients are getting old now. Some have been on methadone since the Vietnam area. Approximately sixty to ninety percent of them are Hep[atitis] C positive.”

5. Heroin use is multi-generational.

Three providers (all at methadone clinics or needle exchange programs) said that they see generations of families addicted to heroin. One provider commented that a whole family may be on methadone: parents bring their children along to the methadone clinic, and children may have their first memories there. Parents and grandparents often have introduced their children to heroin, leading one provider to say, “Many patients started [using] at 10, 11, or 12 years old. Someone wasn’t taking care of the kids; it is a very deeply ingrained problem.”

6. Many opioid users have chronic pain issues.

Because opioids have analgesic properties, individuals with chronic pain are drawn to them, or may be prescribed them by a doctor and then develop a dependence on them. One treatment provider said that, “More individuals are starting [with prescription pain pills] and then transitioning to heroin because they can’t afford the prescription or the doctor refuses to prescribe it.” Two providers mentioned chronic pain as a characteristic that differentiates opioid users from other substance users. This characteristic also increases the complexity of their treatment. Individuals who began taking prescription opioids for pain and are now addicted are left with fewer options for managing their pain while still trying to treat their opioid dependence.

What makes for successful outcomes?

"We need to re-humanize the doctor-patient relationship."

1. Combining counseling with medications.
Across the board, most providers (*n* = 6) believed that counseling coupled with medication (e.g., Suboxone®, methadone) is the best strategy for treating this population. Types of counseling mentioned included relapse prevention, individual and group therapy, and case management. However, if the interviews had included members of 12-step groups, who traditionally disprove of medication use, these responses may have looked substantially different.

2. Counseling alone.
Two treatment providers identified counseling services on their own as an effective form of treatment. Counseling services offer options for individuals looking for treatment without medication. These providers ascribed to 12-step oriented treatment methods, including a philosophy of eschewing medication use in the treatment of opioid dependence.

3. Twelve Step meetings.
Two interviewees mentioned 12-step meetings as a useful form of treatment, which is likely an under-representation of the number of individuals who attend these meetings and benefit from them. One provider said that individuals who put more effort into their buprenorphine treatment, including attending meetings, are more likely to be sober. Meetings are useful because they are available at almost any time of day, provide a sober social support system, and are free. At the same time, individuals using methadone or buprenorphine may have trouble finding meetings where their medication-assisted therapy is accepted or supported.

4. Alternative treatments.
Beyond counseling and medication, alternative treatments are also seen as viable options for opioid dependence (*n* = 2). Examples include acupuncture, massage, and meditation. One provider noted that these modalities are helpful in "getting clients in touch with their bodies and experiencing their addictions as physical sensations."

5. Client engagement.
Two providers cited consistent client engagement in treatment and other recovery activities as associated with improved outcomes. Greater success in treatment could be seen with consistency in:

- Twelve-step meeting attendance
- Medication regimen
- Outpatient treatment
- Doctor's appointments
- Following through with referral

6. Treating clients with respect and dignity.

Substance users, and heroin users in particular, have long faced discrimination from both community members and treatment providers. Treatment providers (*n* = 2) have found that maintaining relationships of respect and dignity with these individuals helps to facilitate their progress and development in recovery. This includes treating clients with opioid dependence "like people and not like addicts", reducing biases and stigmas amongst the treatment staff, and engaging in "non-paternalistic counseling."

Recent Changes

"We are sitting on a new epidemic of young people. They start out with pills and then switch to heroin, and it is a struggle to get them into therapy."

1. More young people are using opioids and seeking treatment.
Nearly every interviewee (*n* = 13) said that the opioid-using population has gotten younger in the past two years. This increase has come in the form of more young people seeking treatment for opioid use, or being encouraged to seek treatment by family members. Young people are not seeking only one type of treatment: these changes were reported across treatment types, including primary care settings, the VA, substance abuse counseling providers, and methadone clinics (e.g., one clinic cited a 10 to 15% increase of under 25-year-olds in the past two years). This increase is coupled with a lack of treatment options within Albuquerque for individuals under 18, leading to a noticeable increase in calls to treatment facilities that seem youth-oriented from concerned family members.

2. Non-medical prescription opioid use has increased.
Mirroring nation-wide trends, providers in Albuquerque (*n* = 8) repeatedly voiced that prescription pain pills have become increasingly commonplace. One outpatient treatment center noted a huge jump in pain pill use in the last five to ten years. Another treatment center said that there has been an increase in individuals using exclusively pain pills, while others noted that individuals use a combination of opioids (both pills and heroin). Additionally, changes (#1) and (#2) were often linked: three providers mentioned an increase among prescription pain pill use among youth.

3. Most opioids users have tried Suboxone®, either prescribed or on the street.
Four providers mentioned that most opioid users in Albuquerque have tried Suboxone® before entering treatment (at $5/8mg, according to one provider). One said: "More clients have tried Suboxone®, either on the street or through a prescription. It is widely available. Most of these individuals have tried to detox with it on their own, or they used it because they couldn't get other opiates."

4. No significant change in IV heroin use.
Clinics that see primarily IV heroin users have not seen any recent changes: they are "just as busy," or have seen a decrease in the adult population and number of HIV cases (*n* = 4). A needle exchange clinic noted that there has been a decrease in the number of individuals accessing their services. Another treatment provider noted that "there is no epidemic – the issue has always been there." In sum, heroin and IV use has been steady in Albuquerque in the past few years, and individuals in this category tend to be older.

5. Relative to alcohol and other drugs, the number of individuals seeking treatment for opioid use has increased.

Consistent with state treatment data, four providers noted that the number of opioid users seeking treatment has been growing at faster rates than the number of individuals seeking treatment for other substances (particularly the alcohol dependent population). This likely reflects the increase in non-medical prescription pain pill use in Albuquerque.

6. Quality of heroin has changed: now mostly smoked instead of injected.

Two providers commented that the quality of heroin is now higher, which allows people to get enough of a high by smoking heroin – injection may not be necessary. Young people feel more comfortable smoking a substance instead of injecting it, it is rumored to be "less addictive," and one primary care provider noted an increase in younger women smoking heroin. An outpatient substance abuse treatment center noted that, "Sixty percent of clients now smoke heroin. The route of administration has changed; it used to be almost all IV."

7. High-profile heroin overdoses have increased media attention and awareness of prescription pill use among youth.

In the past two years, media attention on heroin use and overdose among youth has increased. Many of these stories have focused largely on teens from middle and upper classes. Because of the increased media attention, one interviewee at a school-based health clinic said that, "If you had asked me a year ago if there was an increase in opioid use, I would have said yes. But one year later, I'm not sure what to say because I have not seen an influx of young adults seeking treatment that would match the media attention." Another provider said that, "the higher SES groups are affected, that is why there is now the so-called epidemic." In sum, there is some justified resentment against the sudden media attention for high profile overdose cases among providers who have worked for years with individuals with opioid dependence, and for whom "the epidemic has always been there." Opioid use has been an issue in Albuquerque for decades, but it is now beginning to affect more youth across all social classes. In turn, this has led to an increase in parents looking for treatment resources for their children, often times without success. One provider said that the momentum generated by concerned parents [such as the Heroin Awareness Committee] should be used to catalyze changes in Albuquerque in the system of care for opioid users.

Gaps in Treatment/Services to Add

"It is a struggle to find consistent counseling, and there are no efforts to increase availability."

1. Treatment for young people.

As the number of young people seeking treatment for opioid use has increased (see Recent Changes #1, above), the lack of treatment options in Albuquerque for individuals under age 18 has become apparent. The director of a residential treatment center that only accepts individuals over 18 years noted that many families are bringing their children in for treatment on their 18th birthday. Interviewees from three separate agencies (two youth outpatient programs that do not offer detoxification and one needle exchange program) recounted that they are getting calls "all day long" from concerned parents who want help for their children. The interviewees may spend from 30 to 40 minutes on the phone with these parents attempting to aid them in their search for treatment. However, those receiving the calls are often as uncertain regarding treatment options as the parents calling.

The receptionist at one outpatient treatment center for youth said that they had recently had a family come in with a child that was in acute opioid withdrawal. The family had been turned away everywhere else they had gone, and the outpatient treatment center similarly had to turn them away. While medication-assisted is available for youth at a few primary care clinics, there is no facility within the city of Albuquerque dedicated to youth detoxification from opioids.

Ten providers cited a lack of treatment for youth as a significant issue in Albuquerque. The current system does not have the capacity to deal with this demand. There are several outpatient substance abuse treatment facilities for youth, but they are not equipped to deal with the added challenge of the very physical withdrawal that characterizes opioid use. Those programs that could handle youth opioid users often do not accept individuals under age 18. Additionally, the referral system between providers is poor, and youth may be sent to places that do not exist, such as the "UNMH Withdrawal Program." Several treatment centers mentioned that they are hoping to start outpatient youth treatment programs, but these efforts do not seem to be well-coordinated with other efforts to increase youth treatment services.

Providers noted that expanding current substance abuse treatment services to include younger individuals may not be enough: "It is a struggle to get them in therapy. Suboxone® was designed for primary care, and young people are not totally there. They want to party with their friends on the weekend, and they figure out they can take Suboxone® during the week and heroin on the weekend." One Suboxone® provider said that "those who are forced into treatment by their parents are far less likely to succeed." Similar to adults, they may sell or use Suboxone® to get by until their next fix. Another provider noted that "young kids need more supervision. It is hard to keep them in treatment; I would want to see them weekly if office-

based. Our agency doesn't have the best treatment for them, I would want to see them in a separate clinic. Resources for young adults in the community are limited."

2. Mental health care and counseling

Nine providers mentioned a lack of available counseling and psychiatric services. Providers called for more counseling in primary care, and increased case management for this population. Coverage for counseling services may be limited, and finding employees for the job may also be difficult. In primary care, there may be no psychiatrist available to assist with clients who have serious mental issues, such as schizophrenia. One physician said, "The mentally ill are never clean when I see them."

3. Easily available Suboxone® providers

When providers have clients on Suboxone® and wish to refer them elsewhere, it can be almost impossible for them to do so. This has led some providers licensed in Suboxone® to not prescribe it: for example, they may be willing to do an induction, but do not have anywhere to refer their client. Some providers who do not currently provide Suboxone® mentioned wanting to start prescribing Suboxone® in-house, possibly to circumvent the difficulty of making referrals. One provider mentioned that it had taken her six months to find Suboxone® referrals for former clients, which is an unacceptable length of time when someone needs to be on a maintenance dose of Suboxone®.

4. Day-to-day needs.

Several providers (*n* = 5) mentioned the broad spectrum of needs that many opioid users have that might make it difficult for them to stay in treatment, resulting in "diminishing returns". Cited needs included housing, education, and employment. One primary care provider stated that, "I would like to connect clients with programs that help them with life skills and getting a job. People have too much time on their hands."

5. Medical care

Three providers said that medical care is not widely available for this population, and should be incorporated into current services. This was particularly true for those on methadone seeking Hepatitis C treatment: doctors tell them they can't smoke, be overweight, or be on methadone to receive treatment. This has led one program to provide urgent/primary care medical services on-site.

6. Women

Three providers mentioned women as an underserved population. Milagro, a residential program for pregnant women connected to the University of New Mexico Addiction and Substance Abuse Programs, was recently closed. One provider said that, "Women in residential treatment are viewed as extravagant. We need a plan for homeless women with kids. When they relapse, their kids also experience the relapse." Another provider said that the majority of treatment programs are for men, and there should be more for women.

City-Wide Issues

"By not having a standardized referral system we create gaps in service delivery."

1. Interagency communication and referrals

By far the most notable treatment barrier for clients is an inefficient referral system. Eleven treatment providers across varying treatment modalities reported this as a difficulty. Many of these limitations related to:

- Locating a treatment agency that provided the necessary services (i.e., detoxification, youth services, etc.)
- Making referrals to an agency that the individual could afford or was covered by his or her insurance
- Referring individuals in immediate need of services to providers without long wait lists
- Trouble finding Suboxone® providers who were actively prescribing and had space available

These obstructions increase the reluctance of providers to work with this population, so much so that one interviewee reported: "Agencies do their own thing because there is too much frustration when trying to communicate between agencies." Additionally, these multiple hurdles to care make clients with opioid dependence less likely to succeed. As providers commented: "There are too many barriers for low-functioning addicts to get treatment" and "only the persistent will make it."

2. Funding

The majority of treatment providers (*n* = 9), from primary care physicians to counseling agencies, reported funding as a limiting factor in providing services for clients. Methadone clinics, specifically, have experienced constraints after Medicaid stopped paying for methadone for opioid replacement treatment. Suboxone® is also difficult for individuals to pay for, due to its high costs compared to methadone, and insurance companies cover few physicians who prescribe Suboxone®. Other limitations of funding include:

- Medications
- Prescribing staff
- Counseling staff
- Case management services
- Treatment facilities

Only one treatment provider reported that, throughout Albuquerque, additional funding for this population was not needed. Instead, there is a large opioid dependent population in the middle to upper class that can afford treatment, but lack accessible services. At the same time, another treatment agency noted that there are treatment options for the poor and wealthy, but few options for middle class individuals. Overall, increased and strategic funding directed towards gaps in services would go a long way towards improving care and reducing the individual and societal consequences of opioid dependence.

3. Stigma

Individuals who use opioids, particularly heroin users, contend with multiple stereotypes (e.g., labels of "junkie," "addict") that negatively impact the quality of care they receive. Numerous interviewees (*n* = 9) acknowledged negative perceptions this population faces, both within the recovery community and from larger society.

Clients with opioid dependence are seen by some providers as "difficult to treat," with higher rates of relapse than the general substance abuse treatment seeking population. As one provider said, "it is frustrating when they don't succeed", highlighting how taxing it may be for providers, which in turns make them more reluctant to work with this population. Additionally, increases in prescription opioid misuse have made doctors wary of individuals who may be "pill shopping." Because of these perceptions, treatment providers are disinclined to prescribe Suboxone® and work with this population.

Providers licensed to prescribe Suboxone repeatedly expressed hesitance about publicly advertising their services because they anticipated an onslaught of individuals looking for Suboxone, and a change in the make-up of their waiting rooms. There is an element of secrecy about who is actually licensed to prescribe Suboxone in Albuquerque, which does not benefit clients. One primary care clinic first stated that "we don't have those kind of [opioid dependent] patients," and when it was suggested that they probably do have those types of patients, they said that "we don't want to treat those types of patients." This sentiment is likely not limited to this single clinic. Some primary care providers only prescribe Suboxone to patients who are currently being seen for other medical issues, and do not accept new patients if they are primarily seeking Suboxone. These types of stereotypes make the treatment system more difficult to navigate and contribute to City-Wide Issue #1 above (interagency communication and referrals).

This stigma is also apparent when individuals with opioid dependence attempt to seek medical services. One provider explained that individuals who tell medical staff about their opioid, methadone, or Suboxone® use often are given poorer care or less medical services. Because of this, they may not reveal their use, which can precipitate a no-win situation: if they tell the medical staff about their use, they experience worse care. However, if they do not tell the medical staff about their use, the medical staff may find out anyway, and then the patient is seen as a liar, thus perpetuating the "addict" stereotype.

As mentioned earlier, there is a philosophical divide between those who support medication-assisted therapy and those who support 12-step-based recovery. Some participants in 12-step based recovery do not believe that individuals taking medication of any kind, including methadone and Suboxone®, are "truly" abstinent. This non-acceptance of medication-assisted therapy among 12-step adherents means that individuals with opioid dependence who choose to use Suboxone® or methadone are less likely to be welcomed by a 12-step group, and therefore less likely to reap the benefits of 12-step participation. Mutual help groups such as SMART Recovery may be one solution to this divide, but a SMART Recovery group that Bonnie Kraybill of Project ECHO recently tried to start had very limited participation and was discontinued. Additionally, another facility tried to initiate a Methadone Anonymous group, but was unsuccessful due to time and space constraints.

Providers and patients taking methadone, as well as Suboxone®, have been scrutinized as "replacing heroin with another drug." Treatment providers have made efforts to educate patients and the community about the effectiveness of these medications, and emphasize the importance of considering them as legitimate treatments for opioid dependence. As one provider stated, "Suboxone® is not the same thing as heroin, you are not substituting one for the other".

One treatment provider reported that individuals who use prescription opioids often do not identify themselves as "addicts" because society does not see them as a stereotypical heroin user, and pill use may be seen as "safer." Those who use prescription opioids may be reluctant to seek treatment because of these perceptions. This dichotomy between societal perceptions of pill users and heroin users has created barriers for individuals in middle to upper classes accessing treating for their prescription opioid use. One treatment provider reported that increasing Suboxone® providers in primary care settings would help open treatment to this population, by decreasing stigmas in treatment environments and making them feel more comfortable with getting help.

4. Prescribing Suboxone®

Federal regulations have placed restrictions on providers prescribing Suboxone® for the treatment of opioid dependence. In order for physicians to prescribe Suboxone® they must undergo specialized training, prescribe to a maximum of 30 patients their first year, after one year of prescribing may prescribe to 100 patients, all the while keeping detailed documentation of their patients for the Drug Enforcement Administration (DEA). Five treatment providers reported barriers of this type, which further limits services for this population. As one provider reported, "the federal government doesn't make it easy to prescribe." Complying with onerous requirements from the DEA coupled with the high demands of this population have made it difficult to encourages physicians to prescribe Suboxone® for the treatment of opioid dependence, and one provider said that "only one third of doctors trained actually prescribe Suboxone®."

5. Provider education.

Eight interviewees reported that there are numerous gaps in the knowledge of treatment providers working (or reluctant to work) with clients with opioid dependence, and suggest educating providers on these various topics. These topics include:

- Educating doctors about methadone and Suboxone®, and prescribing other medications in conjunction with them
- Orienting doctors and nurses to the induction process for Suboxone®, and emphasizing the low technicality and burden of the process
- Mandating prescribers to consult the Board of Pharmacy to verify the other prescriptions a client is taking (to help reduce "doctor shopping")
- Educating providers that there are effective treatments for opioid dependencies (methadone and Suboxone®), and that prescribing Suboxone® does not have to overtake a clinic's range of care

6. Community education.

Despite the increase in media coverage, eight interviewees reported a need for the education of adolescents, parents, and other community agencies regarding heroin and opioid use in Albuquerque. Suggested areas for education include:

- Prevention and intervention approaches for adolescents
- Treatments for opioid overdose (e.g., Narcan®)
- Services available for the treatment of heroin and opioid addictions (e.g., methadone, Suboxone®, needle exchanges, treatment)
- Integrating medications for heroin and opioid treatment into jails
- Chemical changes in the brain due to opioid addiction

7. The University of New Mexico

Several treatment providers (*n* = 8), both within and outside of UNM, reported concerns with the accessibility and availability of Suboxone® providers within the University of New Mexico system. Some cited an unsupportive and non-collaborative institutional environment as contributing to this issue. One interviewee commented, "UNM is the key to reducing the burden of this disease in Albuquerque." At the same time, efforts are being made to address Suboxone availability at UNM and in the community, both with Project ECHO, which provides free Suboxone trainings for eligible medical professionals, and with a buprenorphine task force that was convened this year.

Conclusions and Recommendations

Youth Services

There has been an increase in young heroin and pill users, and Albuquerque does not have the treatment services to accommodate them.

Conclusions

- Agencies reported notable increases in the number of referrals for heroin and opioid treatment for young people in the past two years
- There are no detoxification facilities in Albuquerque for individuals under 18 years of age

Recommendations

- **Develop additional treatment facilities or programs for youth.** Viable options include adding Suboxone® availability to an existing youth outpatient treatment program (e.g., CFAR, NM Solutions, or Hogares). This would allow youth with opioid dependence to access treatment programs where they might have been otherwise excluded. Another option might be to have youth detox as part of an existing program (e.g., ASAP, Turquoise Lodge/MOTU), and then transfer to outpatient services at one of the aforementioned youth outpatient programs. Finally, a currently established outpatient substance abuse treatment center mentioned a desire to start an adolescent clinic in the NE Heights. This idea could be supplemented with city funds.
- **Prevention and awareness efforts.** Evidence-based opioid-use prevention programs in the City of Albuquerque and through Albuquerque Public Schools should be considered. The Heroin Awareness Committee is dedicated to this cause: they have been holding awareness events at local high schools to educate parents and youth about heroin use. To build on their efforts through other venues, the City of Albuquerque might (a) place advertisements on Facebook pages of teenagers living in Albuquerque that link to a website with confidential information about treatment services or other facts about opioid use, or (b) purchase billboards throughout the city with slogans targeting youth opioid use such as: "Just because they're prescription pills doesn't mean they're safe. If you're concerned about your pill use or someone you know, call this confidential number/go to this website for more information." Additionally, educating parents about treatment options and overdose prevention (e.g., Narcan®) may help attenuate the fears of parents of youth abusing opioids, and help prevent overdoses.

Non-Medical Use of Prescription Opioids

Across ages and social classes, more people are abusing prescription pain pills.

Conclusions

- There has been an increase in prescription pill use in Albuquerque
- Many individuals abusing prescription opioids transition to heroin due to the high cost of prescription pills

Recommendations

- Providers prescribing opioids should be required to refer to the Board of Pharmacy lists to ensure clients are not "doctor shopping" for prescription pills. The City of Albuquerque could provide incentives to physicians who use the system.

Availability of Suboxone®

Suboxone® has been identified as an effective treatment for opioid dependence, especially in conjunction with counseling. Funding and providers, however, are sparse and hard to find.

Conclusions:

- Numerous treatment providers endorse Suboxone® as a helpful treatment for heroin and opioid addiction
- Providers who wish to prescribe Suboxone® face multiple barriers, including uncertainty about working with this population, hesitant nursing staff and supervisors, and extra paperwork
- Because there is no generic version of buprenorphine, Suboxone® can be difficult for individuals to afford
- Some insurance companies in Albuquerque either do not cover Suboxone®, or have limited Suboxone® providers in their plan

Recommendations:

- Provide incentives for doctors who are actively prescribing Suboxone®, which may encourage new doctors to prescribe Suboxone®, and keep current doctors prescribing.
- Increase the number of providers within the UNM system who are trained and prescribe Suboxone®, which already is being facilitated through Project ECHO and a UNM task force on buprenorphine.
- Educate clinic staff, including nurses, about the low technicality of Suboxone® and its induction process. Clinic staff should be included in the Suboxone® training process.
- Create a secure online forum for current Suboxone® prescribers and those who are interested in prescribing Suboxone® (similar to a doctor-to-doctor communication network). This will help to reduce feelings of isolation among individuals who are the only Suboxone® provider in their agencies, prevent burn-out among those who are currently prescribing, and provide an introduction to individuals who are considering prescribing Suboxone®.
- Consider recently developed telephone-based counseling services that could increase the availability of counseling for individuals taking buprenorphine in primary care settings.

Referral System

Community members looking for services for themselves, their family, or their friends don't know where to go.

Conclusions

- Many treatment providers are unsure where to refer clients with opioid dependence
- Parents and treatment providers are experiencing difficulties finding substance abuse treatment for adolescents under 18 years old
- Inter-agency communication is minimal and considered by providers as a barrier to effective treatment
- There is a short "window" of opportunity and motivation in which an opioid-using individual seeking treatment can be engaged in services, and the barriers to access may impede individuals who could benefit from treatment, were it readily available

Recommendations

- The City of Albuquerque should sponsor the creation of a print and online resource guide that provides information about the effects of opioids and available treatment resources. This resource guide is sorely needed in the community, and funds should be set aside for its renewal every six to twelve months. Alternatively, efforts could be made to keep existing guides (e.g., mycommunitynm.org, SAMHSA provider list) up-to-date, and direct individuals seeking treatment to guides that have legitimate and correct information.
- Convene a community stakeholder and treatment provider summit to improve inter-agency communication and referral strategies. UNM has already begun this process within their own system – the City of Albuquerque should use this momentum to bring non-UNM agencies to the table. Better inter-agency communication could also be accomplished by choosing a community leader who is socially adept and well connected, and pay this individual a stipend to work on the referral system.
- Implement incentives for inter-agency collaboration and/or provision of multiple coordinated services to clients with opioid dependence.
- Explore the use of City 311 system and other warm-line resources to provide current information to clients seeking treatment and recovery services in conjunction with the treatment resource guide.

References

Brownstein, J.S., Green, T.C., Cassidy, T.A., & Butler, S. F. (2010). Geographic information systems and pharmacoepidemiology: using spatial cluster detection to monitor local patterns of prescription opioid abuse. *Pharmacoepidemiology, 19,* 627-637.

Centers for Disease Control and Prevention. (2009). *Youth Online: High School YRBS.* Retrieved from http://apps.nccd.cdc.gov/youthonline/App/Default.aspx?SID=HS

Children, Youth, and Families Department (CYFD). (2011). Juvenile Justice Services Data Analysis/FACTS Bureau. Retrieved from CYFD.

Goldstein, A., & Herrera, J. (1995). Heroin addicts and methadone treatment in Albuquerque: A 22-year follow-up. *Drug and Alcohol Dependence, 40,* 139-150.

Magura, S., Lee, J. D., Hershberger, J., Joseph, H., Marsch, L., Shropshire, C., & Rosenblum, A. (2009). Buprenorphine and methadone maintenance in jail and post release: A randomized clinical trial. *Drug and Alcohol Dependence*, *99,* 222-230, doi: 10.1016/j.drugalcdep.2008.08.006.

National Institute of Drug Abuse (NIDA). NIDA notes: Young Opioid Abusers Benefit From Extended Buprenorphine-Naloxone Treatment**.** Retrieved from http://www.nida.nih.gov/NIDA_notes/NNvol23N1/Young.html

National Institute of Drug Abuse. Drug Abuse Patterns & Trends in ABQ & NM. Retrieved from www.nida.nih.gov/PDF/CEWG/CEWGVol2June08WebFINAL.pdf

New Mexico Department of Health. (October, 2010). New Mexico substance abuse epidemiology profile. Retrieved from http://www.health.state.nm.us./erd/HealthData/SubstanceAbuse/2010 New Mexico Substance Abuse Epidemiology Profile.pdf

New Mexico Poison and Drug Information Center. (2011). Opioid data fro 2000 to 2010. Retrieved from New Mexico Poison and Drug Information Center.

SAMHSA. Buprenorphine physician and treatment locator. Retrieved from http://buprenorphine.samhsa.gov/bwns_locator/dr_facilitylocatordoc.htm

Shah, N. (2006). Drug overdose death in New Mexico. Retrieved from http://www.google.com/url?sa=t&source=web&cd=3&ved=0CCgQFjAC&url=http%3A%2F%2Fwww.health.state.nm.us%2Fpdf%2FDrug%2520Overdose%2520Death%2520in%25

20New%2520Mexico%25202006.pdf&rct=j&q=nina%20shah%202006%20new%20mexico&ei=VFkLToPQOPPRiAKru7W2AQ&usg=AFQjCNH3AmX7KDnYckUMKF1WFhaCQ3GLSQ&cad=rja

Shah, N. (2009). Current efforts and ideas to reduce drug overdose in New Mexico. Unpublished paper.

Shah, N. (2011). DRAFT: Update brief on major drug abuse indicators for Albuquerque and New Mexico, January 2011. *National Institute on Drug Abuse: Community Epidemiology Word Group.* Retrieved from http://www.nida.nih.gov/about/organization/cewg/Reports.html.

U.S. Department of Health and Human Services, Office of Applied Studies. (1992-2009). *New Mexico Treatment Episode Data Set.* Retrieved from http://wwwdasis.samhsa.gov/webt/tedsweb/tab_year.choose_year_web_table?t_state=NM

U.S. Department of Health and Human Services, Office of Applied Studies. (2009a). *2009 State Profile – New Mexico National Survey on Substance Abuse Treatment Services (N-SSATS).* Retrieved from http://wwwdasis.samhsa.gov/webt/tedsweb/tab_year.choose_year_state_profile?t_state=NM

U.S. Department of Health and Human Services, Office of Applied Studies. (2009b). *National Survey on Drug Use and Health, 2002, 2003, and 2004, New Mexico state treatment planning areas.* Retrieved from http://oas.samhsa.gov/substate2k6/HTML/NM.htm

Appendix A: City of Albuquerque Opioid Needs Assessment

1. Date: _____ 2. Data Collector: _____

3. Agency: _____ 3a. Contact Person/Title: _____

3b. Agency Address: _____

4. Treatment Orientation:

(a) Abstinence (c) Both

(b) Harm-Reduction: _____ (d) Other: _____

5. Number of on-site staff:

(a) Substance Abuse Counselors: _____ (c) Psychiatrists: _____

(b) Lic. Mental Health Providers: _____ (d) Other: _____

6. Services Provided:

(a) Long-term residential (>28 days): ____ - ____ months

(b) Short-term residential (≤28 days): ____ - ____ days

(c) Detox Only: (i) Medical (ii) Psycho-social/Outpatient

(d) Intensive Outpatient (6+ hours per week)

(e) Outpatient: (i) Individual (ii) Group (iii) Other: _____

(f) Dual-Diagnosis (Substance use + mental health)

(g) Methadone Maintenance

(h) Suboxone, Physicians (Max # of patients): _____

(i) Housing (non-residential): (i) Sober/Half-way (ii) Formal/In-house counselor

(j) Adolescent Treatment Services

(k) Case Management

(l) Bilingual Services: _____

(m) Peer-Run Recovery Groups (AA, SMART, etc.): _____

(n) Alternative Treatments: _____

(o) Other: _____

7. Substances Treated: ALL ALC COC OPI MAR AMP Other: _____

8. Agency/Service Funding:

(a) Medicaid (Federal): _____ %

(b) Medicare (Federal): _____ %

(c) ATR (Federal): _____ %

(d) Grants/Other (Federal): _____ %

(e) BHSD/DOH (State): _____ %

(f) County: _____ %

(g) AMCI (City): _____ %

(h) Private Insurance: _____ %

(i) Self-pay: _____ %

General Demographics:

9. Total number of current clients: _____

10. Maximum capacity of clients: _____ 10a. Capacity met? Y N

11. Percent of total clients who are heroin/opioid dependent: _____ %

Demographics of Clients with Opioid Dependence:

12. Percent male: _____ %

13. Average age: _____

14. Percent of clients <18 years old: _____ %

14a. Percent 18-25 years old: _____ %

15. SES: LOW: _____ % MIDDLE: _____ % UPPER_____ %

16. Ethnicity:

(a) American Indian/Alaskan Native: _____ %

(b) Asian-Amer. or Pacific Islander: _____ %

(c) Hispanic, Cuban: _____ %

(d) Hispanic, NM or Spanish-Amer.: _____ %

(e) Hispanic, Mexican: _____ %

(f) Hispanic, Puerto-Rican: _____ %

(g) Hispanic, Other Latin American: _____ %

(h) White, not of Hispanic origin: _____ %

(i) African-American/Black: _____ %

(j) Other: _____: _____ %

17. Percent heroin as drug of choice: _____ %

17a. Administration of heroin: IV: _____ % Other: _____: _____ %

18. Percent Rx as drug of choice: _____ %

19. Percent poly-users: _____ %

19a. Other substances commonly used with heroin/opioids: _____

20. Percent with co-morbid mental health issue: _____%

20a. Most common other mental health issue: _____

21. Percent referred by criminal justice system: _____ %

22. From where are your clients who are heroin/opioid dependent?

(a) NE _____ %

(b) NW _____ %

(c) SE _____ %

(d) SW _____ %

23. How have these numbers (re: heroin/opioid dependent clients) changed in the past two years?

24. What services appear most helpful for your heroin/opioid dependent clients?

25. What services are you hoping to provide more of for your heroin/opioid dependent clients?

26. What limitations are you experiencing in serving your heroin/opioid dependent clients?

27. How do heroin/opioid dependent clients differ from other clients at your facility?

28. Where are there gaps in Albuquerque's resources for the treatment of heroin/opioid dependence?

29. Are there other agencies and providers of resources that you are aware of in ABQ that would be helpful for our assessment?

30. Are there any additional comments/questions?

Appendix B: Albuquerque Resource Guide (#s match map)

Vouchers

1. Albuquerque Metropolitan Central Intake
3121 Amherst NE, Suite B
Ph: (505) 271-9033
Services: Treatment vouchers

2. Walsh Counseling
1113 Rhode Island St NE, Suite B
Ph: (505) 266-0441
Services: Assessments, treatment vouchers

Detoxification

Desert Oasis
(Provider did not wish to disclose address)
Ph: (505) 867-0214
Services: Detoxification (during treatment)

3. Metropolitan Assessment Treatment Services (MATS)
Supportive Aftercare (SAC)
5901 Zuni Rd SE
Ph: (505) 468-1555
Services: Detoxification, housing

Treatment Services

4. Albuquerque Health Services (formerly Metamorphosis NM, Inc.)
Northeast Clinic (4a)
112 Monroe St NE
Ph: (505) 260-9917

Northwest Clinic (4b)
172 Montano Rd NW
Ph: (505) 344-4427
Services: Counseling, methadone, Suboxone®

5. Albuquerque Treatment Center
209 San Mateo Blvd NE
Ph: (505) 262-1538
Services: Methadone, Spanish speaking

6. Casa de Salud
1608 Isleta SW
Ph: (505) 907-8311
Services: Suboxone®, medical treatment, alternative treatments, needle exchange, Spanish speaking

7. Center for Family and Adolescent Research (CFAR)
707 Broadway Blvd NE, Suite 402
Ph: (505) 842-8932
Services: Counseling

8. Central New Mexico Treatment Center
630 Haines Ave NW
Ph: (505) 268-5611
Services: Methadone, Spanish speaking

9. Crossroads
805 Tijeras Ave NW
Ph: (505) 242-1010
Services: Counseling, housing (homeless women)

10. Desert Hills Center for Youth and Families
5310 Sequoia Road NW
Ph: (505) 836-7330
Services: Counseling

Desert Oasis
6828 Kalgan Rd
Rio Rancho, NM
Ph: (505) 867-0214
Services: Residential treatment

11. Dragonfly Counseling Associates
540 Chama St NE, Suite 2
Ph: (505) 265-0753
Services: Counseling

12. Evolution Group
218 Broadway Blvd SE
Ph: (505) 242-6988
Services: Counseling

13. First Choice Community Healthcare
North Valley
1231 Candelaria Rd NW
Ph: (505) 362-3175
Services: Suboxone®, primary care, Spanish speaking

14. First Choice Community Healthcare
South Broadway
1401 William St NE
Ph: (505) 768-5450
Services: Suboxone®, primary care

15. First Choice Community Healthcare
South Valley
2001 N. Centro Familiar SW
Ph: (505) 452-4028
Services: Suboxone®, primary care, counseling

Thursdays at 1 pm: Informational meeting for individuals living in the South Valley who would like to begin using Suboxone

16. First Nations Community Healthsource
5608 Zuni Rd SE
Ph: (505) 262-2481
Services: Counseling, Suboxone®

17. Healthcare for the Homeless
1217 1st St NW
Ph: (505) 766-5197
Services: Counseling, Suboxone, needle exchange

18. Hogares Outpatient
4903 4th St NW
Ph: (505) 345-8471
Services: Counseling

Indian Health Services
801 Vassar Dr NE
Ph: (505) 248-4713
Services: Suboxone®

19. New Mexico AIDS Services/UNM Truman Street Health Clinic
625 Truman St NE
Ph: (505) 938-7100
Services: Counseling, needle exchange

20. New Mexico Solutions
707 Broadway Blvd NE, Suite 500
Ph: (505) 268-0701
Services: Counseling, youth services, Spanish speaking

21. Pathways, Inc.
617 Truman St NE
Ph: (505) 254-0606
Services: Counseling

22. Recovery Services of New Mexico
1528 Five Points Rd SW
Ph: (505) 242-6919
Services: Counseling, methadone

23. Relevancy Inc.
2727 San Pedro NE, Suite 120
Ph: (505) 830-1038
Services: Counseling

24. Rio Grande Counseling
1010 Las Lomas Rd, Suite 4
Ph: (505) 246-8700
Services: Counseling

25. St. Martins Hospitality Center
1201 3rd St NW
Ph: (505) 242-4399
Services: Counseling

26. Stanford Clinic (Department of Health)
1111 Stanford Dr NE
Ph: (505) 841-4162
Services: Needle exchange, Suboxone®, Spanish speaking

27. Turquoise Lodge (Medical Observation and Treatment Unit)
5901 Zuni Rd SE
Ph: (505) 383-1141
Services: Residential treatment, Suboxone, counseling

28. UNM Addiction and Substance Abuse Programs
2450 Alamo Dr SE
Ph: (505) 925-2400
Services: Counseling, methadone, Suboxone®

29. UNM Department of Psychiatry – Dual Diagnosis Clinic
2600 Marble NE
Ph: (505) 272-2800
Services: Counseling, Suboxone®
Note: must have co-morbid mental health issue that causes significant impairment

30. UNM Southeast Heights Clinic
8200 Central Ave SE
Ph: (505) 268-5885
Services: Suboxone®, primary care

31. UNM Student Health and Counseling
1 University of New Mexico
http://shac.unm.edu/location.html
Ph: (505) 277-3136
Services: Suboxone® (with counseling)
Note: must be UNM student

32. Veterans Affairs Medical Center
1501 San Pedro St SE
Ph: (505) 265-1711
Services: Counseling, Suboxone®, Spanish speaking

33. Youth Development Inc.
6301 Central NW
http://www.ydinm.org/public/contact.aspx
Ph: (505) 352-3444
Services: Counseling, needle exchange, Spanish speaking

Housing

34. Endorphin Power Company (EPC)
509 Cardenas Dr SE
http://www.EndorphinPower.org
Ph: (505) 268-3372
Services: Housing, on-site recovery meetings

Supportive Aftercare (SAC)
5901 Zuni Rd SE
Ph: (505) 468-1555
Services: Housing

Community Resources

Heroin Awareness Committee (HAC)
http://www.saynotoheroin.org

Narcotics Anonymous
Ph: (505) 260-9889
http://www.riograndena.org

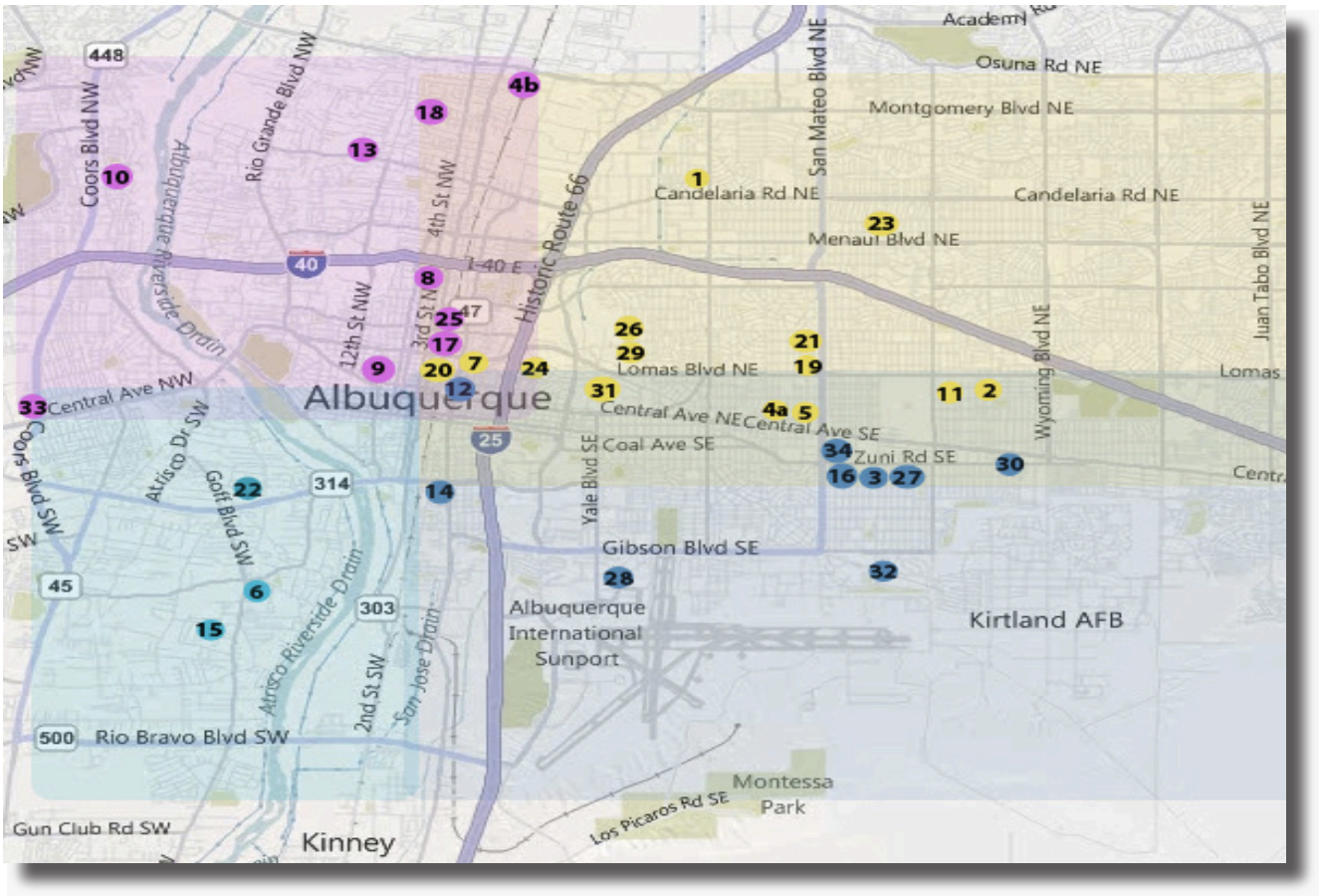
SAMHSA Treatment Locator:
http://findtreatment.samhsa.gov

SAMHSA Buprenorphine Provider Finder:
http://buprenorphine.samhsa.gov/bwns_locator/index.html

Treatment and other resources:
http://wwww.mycommunitynm.org

Project ECHO: Integrated Addiction and Psychiatry TeleECHO Clinic
(training/support for Suboxone prescribers)
http://echo.unm.edu/clinics.shtml - intergratedaddictionandpsychiatry

Albuquerque Opioid Treatment Services



Map Legend

Services Codes: C = Counseling; **DF** = Detox Facility; **H** = Housing; **M** = Methadone; **N** = Needle Exchange; **S**= Suboxone; **V**= Vouchers; and **Y**= Youth Services

Southeast

12. Evolution Group
Services: C

14. First Choice - South Broadway
Services: S

16. First Nations Community Healthsource
Services: C, N, S (American Indian/ Alaska Natives)

3. MATS/MOTU/SAC
Services: DF, H, S

27. Turquoise Lodge Hospital
Services: C, S

28. UNM Addiction and Substance Abuse Programs
Services: C, M, S

30. UNM Southeast Heights Clinic
Services: S

32. Veterans Affairs Medical Center
Services: C, H, S (veterans)

34. Endorphin Power Company
Services: H

Southwest

6. Casa de Salud
Services: N, S

15. First Choice - South Valley
Services: C, S (South Valley residents)

22. Recovery Services of New Mexico
Services: M

Northeast

4a. Albuquerque Health Services
Services: M, S, C

1. Albuquerque Metropolitan Central Intake
Services: V

5. Albuquerque Treatment Services LLC
Services: M

7. Center for Family and Adolescent Research
Services: C, Y

11. Dragonfly Counseling Associates
Services: C

19. New Mexico AIDS Services /UNM Truman Street Health Clinic
Services: C, N (HIV/AIDS)

20. New Mexico Solutions
Services: C, Y

21. Pathways, Inc
Services: C

23. Relevancy Inc
Services: C

24. Rio Grande Counseling
Services: C

26. Stanford Clinic (Department of Health)
Services: N, S

29. UNM Department of Psychiatry Dual Diagnosis Clinic
Services: C, S (mental health)

31. UNM Student Health and Counseling
Services: C, S (UNM students)

2. Walsh Counseling
Services: V

Northwest

4b. Albuquerque Health Services
Services: C, M, S

8. Central New Mexico Treatment Center
Services: M

10. Desert Hills Center for Youth and Families
Services: C, Y

13. First Choice - North Valley
Services: S, Y

17. Health Care for the Homeless
Services: C, N, S (homeless)

18. Hogares Inc.
Services: C, Y

25. St. Martins Hospitality Center
Services: C (homeless)

33. Youth Development, Inc.
Services: C, N, Y

9. Crossroads
Services: C, H (women/homeless)