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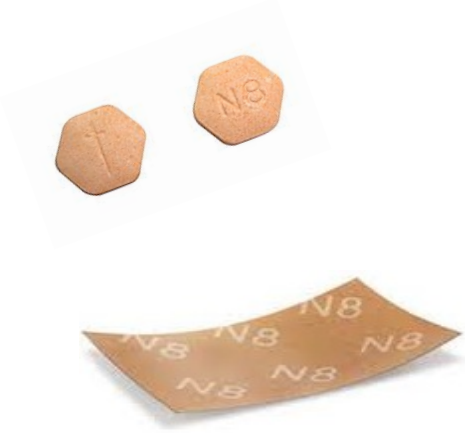
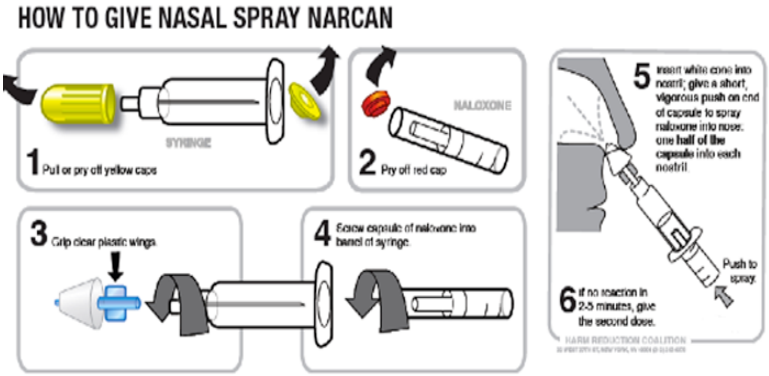
Senate Memorial 45

Harm Reduction Related to Opioid Use and Dependency

Study Group Subcommittee Reports and Recommendations:

- **Naloxone and Syringe Exchange**
- **Medication Assisted Treatment**
- **Medically Supervised Injection Facilities**





Report compiled on behalf of the Senate Memorial 45 Harm Reduction Study Group by the
Robert Wood Johnson Foundation Center for Health Policy
The University of New Mexico

SENATE MEMORIAL 45

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SM45 STUDY GROUP

INTRODUCTION

Senate Memorial 45, passed in 2012 during the second session of the Fiftieth Legislature, requested the University of New Mexico's Robert Wood Johnson Foundation Center for Health Policy to conduct a feasibility study on how to enhance and expand New Mexico's harm reduction services related to opioid misuse and dependency. Appendix A has the memorial.

SM45 follows on the work of the New Mexico Drug Policy Task Force created by SM18 in 2011. That task force issued a report providing background, evidence review, and recommendations regarding drug and alcohol dependency prevention and treatment as well as harm reduction. The present SM45 report draws upon that report of the SM18 Task Force with respect to harm reduction and provides an update of its recommendations. Harm reduction is an intervention that presumes that the person (opioid user) will be continuing the risky or harmful behavior (for example, continued injection drug use). The goal is to reduce the risk from drug use (for example, risk of infectious disease or death from overdose). Harm reduction is therefore distinguished from prevention of the use of drugs from starting and is also distinguished from intervention through treatment to stop the behavior.

The SM45 Harm Reduction Study Group was convened following notification of the agencies identified in the memorial and invitation to others engaged in the subject areas of the study group's work. (Some agencies either declined or did not respond.) At the initial meeting, subcommittees were formed to cover the following: (1) Naloxone/Syringe Exchange Programs, (2) Medication Assisted Treatment, and (3) Medically Supervised Injection Facilities Feasibility. Chairs and cochairs were identified, participants were assigned to the subcommittees, and others were invited or volunteered to join in. Persons not actively participating in a subcommittee were maintained on a contact list and invited to respond to the various drafts of subcommittee reports. Appendix B provides a listing of active participants, technical advisors, and reviewers.

Recommendations have been made by the respective subcommittees by consensus after reviewing comments from the wider group of reviewers. The present report summarizes the recommendations.

An Interim Report with preliminary recommendations was presented to the Legislative Interim Health and Human Services Committee on November 26, 2012, and is available through the Robert Wood Johnson Foundation Center for Health Policy.

Neither the SM45 Interim Report nor the present report has final recommendations from the Medically Supervised Injection Facilities Feasibility Subcommittee. Final recommendations have been deferred because the analysis of feasibility requires assessment of the likely acceptance of such a facility by active injection drug users. This assessment requires a survey for which the resources have not been available. The subcommittee intends to continue its work and submit recommendations at a later date.

REPORT OF THE

NALOXONE/SYRINGE EXCHANGE PROGRAM SUBCOMMITTEE

Emergency: New Mexico continues to lead the nation in fatal drug overdoses—more than two times the national average.

BACKGROUND

New Mexico is facing opioid overdose death rates of unprecedented proportions. This is an epidemic that creates devastating personal tragedy for every family who has lost a loved one, and it constitutes a public health crisis for our state. We are losing our children, our parents, and our grandparents. Since 1991, the drug overdose death rate has increased 242%.

While the face of overdose has traditionally been that of a heroin user, overdose is also dramatically impacting senior citizens and middle-aged New Mexicans, who are increasingly overdosing from prescription pain medications. Both classes of drugs are referred to as *opioids*.

An analysis of 1,812 unintentional drug overdose deaths recorded in New Mexico (2005–2009) determined that about 60% were caused by illicit drugs and 40% by prescription drugs, principally opioid painkillers.[1]

Proven strategies are available to reduce the harms associated with opioid drug use, treat dependence and addiction, enhance public safety, and prevent fatalities. Notably, the opioid antagonist drug naloxone, if administered in an opioid overdose situation, can rapidly reverse the effects of the drug and save a life.

While not classified as a controlled substance, naloxone requires a prescription from a licensed provider. It is not available over the counter. Naloxone is not addictive and produces no pharmacological effects if the individual has not taken opioids.

New Mexico has been a national leader in the use of harm reduction strategies to prevent overdose fatalities, being first with public programs promoting the distribution and use of naloxone (Narcan®) to reverse an overdose caused by any opioid.

Field reports collected by the Department of Health indicate there have been thousands of lives saved in New Mexico because of the department's Harm Reduction Program. This program targets primarily users of illicit drugs (notably heroin). Research indicates that it is a highly cost-effective way of saving lives.[2]

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1. New Mexico Department of Health. *New Mexico Substance Abuse Profile*. July 2011.
2. Coffin PO, Sullivan SD. Cost-effectiveness of distributing naloxone for heroin to lay users for overdose reversal. *Ann Intern Med.* 2013;158(1):1–9.

The epidemic of opioid overdose deaths in New Mexico, however, continues unabated, driven in part by the increase in deaths from prescription opioids. In spite of its successes, the Harm Reduction Program has not been able to match the extent of the problem. Recent reductions in funding for the program are of concern. Heroin is not about to disappear from use, and the amount of prescription pain medicines is rising dramatically. Furthermore, naloxone is not routinely made available to households where there is risk of overdose from prescription opioids.

The most direct way of combating the continuing high rate of overdose deaths is to greatly expand the distribution, availability, and use of naloxone for out-of-hospital lifesaving rescues. The subcommittee feels the current situation should be managed as an emergency in order to deploy the steps necessary to achieve the needed level of expansion.

Steps are needed to ensure the following:

- Coverage of prescription naloxone (Narcan®) by commercial insurance and Medicaid. Pharmacies need to be ready to provide naloxone in kits for intranasal administration, which is suitable for lay use.
- Availability of naloxone for persons being released from incarceration, many of whom return to their prior drug using environments. Without loss of tolerance to the opiate drugs, they are at high risk of overdose and death.
- Availability of and access to syringe exchange programs. For intravenous drug users, syringe exchange programs offer protection against transmission of serious infectious diseases, such as AIDS and hepatitis C. They can and should be sites for Narcan® distribution. They also offer opportunities for education about drugs and drug treatment. These programs, however, are not deployed in some areas of need in the state. Use of injection drugs often starts in mid-teen or even early teenage years. Current regulation excludes teens under age eighteen from participating in syringe exchange programs.

NALOXONE (NARCAN®) RECOMMENDATIONS

The following recommendations of the subcommittee are experience based, rational, and compassionate. They are responsible public health policies and actions that can take us to the next level in responding to New Mexico's crisis in preventing unintended opioid overdose deaths.

RECOMMENDATIONS TO INCREASE PROVIDER PRESCRIBING AND ESTABLISH PHARMACIST PRESCRIPTION AUTHORITY FOR NALOXONE (NARCAN®)

1. The New Mexico Department of Health, in partnership with the New Mexico Pharmacists Association community-based medical systems and pharmacies, should continue to develop, evaluate, and enhance current pilot projects where local pharmacies procure or assemble kits for dispensing intranasal naloxone by prescription to persons identified to be at risk for overdose. This should include conducting appropriate education and training.

2. The New Mexico Board of Pharmacy, under the Pharmacist Prescriptive Authority Act and in consultation with the New Mexico Medical Board, should develop and approve a protocol and training curriculum allowing pharmacists to prescribe naloxone. This will

have particular relevance to coprescribing with prescription opioids for chronic pain control and other situations where there may be identifiable risk for overdose.

3. The New Mexico Board of Pharmacy should monitor the prescribing of naloxone through the Prescription Monitoring Program as part of an evaluation of prescription naloxone usage and effectiveness.

RECOMMENDATION FOR PROVIDER EDUCATION AND COPRESCRIBING WITH NALOXONE (NARCAN®) WITH PRESCRIPTION OPIOIDS

1. Currently mandated prescriber education on pain management should incorporate training about harm reduction strategies and specifically reference the recent guidelines that have been reviewed by the New Mexico Department of Health and others. Prescriber training should specify when a patient should receive education about risk of opioid overdose and about coprescription of naloxone. These guidelines serve as a starting point and should be periodically reviewed and expanded to benefit as much of the population as possible that is at risk for opioid overdose.

RECOMMENDATIONS FOR EXPANDED ACCESS TO NALOXONE (NARCAN®) AND SYRINGE SERVICES PROGRAMS

1. Medicaid should cover outpatient naloxone. Coverage should be required as a condition for medical plans contracting as managed care organizations under Medicaid.

2. Commercial health insurance, likewise, should cover naloxone. In particular it should be covered when used as a coprescription given to patients who are being prescribed opioids. The New Mexico Health Insurance Exchange and New Mexico Insurance Division should require that health insurance offered through the exchange to individuals and small businesses specify coverage for outpatient naloxone as a condition for being a qualified health plan within the exchange. (This may take legislation if the Insurance Division or the exchange itself does not otherwise ensure this coverage.)

3. The New Mexico Department of Health and local county administrations in partnership with the New Mexico Association of Counties should develop policies and pilot programs for making naloxone available at time of release from jails for inmates who are at risk for resuming opioid use.

4. The New Mexico Corrections Department, likewise, should make naloxone available to inmates and their families at time of inmates' release from incarceration.

5. The New Mexico Department of Health should propose a plan (including funding) for expanding the capacity of local public health offices so that nonclinical staff can dispense naloxone for intranasal administration. This would require a protocol with standing orders so that public health nurses do not have to be present to dispense the naloxone.

6. Legislature should appropriate $1,000,000 in increased recurring funding in support of the Department of Health's Harm Reduction Program in order to restore funding to previous levels and expand the program to allow the following:
   a. Statewide expansion of the syringe exchange program to increase the number of sites and extend hours.
   b. Overdose prevention education.
   c. Increased dispensing of naloxone.
   d. Training and education to rural providers in community health centers to address harm reduction in primary care settings. This training and education should include clinical guidelines for the prescription of naloxone to persons at risk of overdose from opioid pain medication.

7. The New Mexico Department of Health should eliminate the age restriction for participation in syringe services programs in order to reduce blood-borne infections and promote opportunities for entry into treatment.

REPORT OF THE

MEDICATION ASSISTED TREATMENT SUBCOMMITTEE

"Addiction— whether to alcohol, illicit drugs, or prescription drugs—is a chronic medical disease of the brain that is treatable."—National Institute on Drug Abuse
(http://www.drugabuse.gov/publications/media-guide/science-drug-abuse-addiction)

Acceptance and application of this fundamental concept is essential in successfully dealing with persons with drug addictions. Failure to do this means that such persons will have increased likelihood of continuing to impact community and burden the health care and criminal justice systems—all at enormous public cost and often with ruinous consequences to person and family.

Every public agency dealing with persons with addiction disorders should include in its mission the promotion of recovery and safety.

BACKGROUND

The Department of Health estimates as many as 200,000 abusers of illicit or prescription drugs in New Mexico, with at least 24,000 of those being injection drug users (some estimate this number to be 50,000). There is a particular problem with persons misusing or abusing prescription opioid pain medications, with the rates of dependency and unintentional overdose deaths having increased fourfold in the United States from 1999 to 2008 and with New Mexico as the state with the highest rate.[3]

Among the most important opportunities possible to help persons with opioid addiction within the existing health care structure is medication assisted treatment (MAT).[4]

MAT is therapy with either methadone or buprenorphine and is one important component of the continuum of care for restoring persons with opioid addiction to stable and productive lives. Given the high risks involved with opioid addiction, MAT can be lifesaving. The therapeutic effectiveness of MAT and its cost-effectiveness have been well documented.

Methadone is itself an opioid drug but has a substantially reduced euphoric effect compared with opioids of abuse. Because it stays in the body and on the receptors for a prolonged period of time,

3. Centers for Disease Control and Prevention. Vital signs: overdoses of prescription opioid pain relievers, United States, 1999–2008. *MMWR*. 2011;60(43):1487–1492.

4. MAT is described and referenced in detail in the Senate Memorial 18 Drug Policy Task Force Report, Fall 2011, pages 48-53.Available from: http://healthpolicy.unm.edu/sites/default/files/documents/SM18ReportandCover.final_.pdf.

it tends to inhibit the effect of other opioids that are abused. It also reduces cravings for other opioids and lowers the rate of overdose from injected opioids. Methadone for purposes of MAT is distributed only in federally certified clinics, where clients receive their treatments once a day while being directly observed by clinic staff, guaranteeing documented compliance. There are only eleven certified clinics in New Mexico: eight in Albuquerque and one each in Espanola, Santa Fe, and Las Cruces.

Buprenorphine has opioid properties but blocks the effects of other opioids, reducing or eliminating cravings for opioids of abuse. The most commonly used proprietary formulation of buprenorphine is Suboxone®. It is taken under the tongue one to two times a day with prescriptions given only by physicians (typically primary care physicians) who have undergone a specialized eight-hour training course and have received a waiver from the Drug Enforcement Administration (DEA) to write prescriptions for it. Directly observed therapy is not required.

In 2009 the Substance Abuse and Mental Health Services Administration published an analysis that demonstrated that, on average, each dollar invested in treating drug addiction yields a savings to the public of $12 in medical and criminal justice expenditures.[5] The costs of MAT in particular are overwhelmingly offset by savings in terms of moneys spent on medical complications of addiction, related criminal behavior, criminal justice proceedings, and subsequent incarceration; in terms of social costs; and in terms of restored families and economic productivity.[6] Methadone returns on average at least $4 for every dollar invested in treatment just with respect to reductions in crime and incarceration alone.[7]

INSUFFICIENT NUMBER OF PHYSICIANS TO TAKE ON PATIENTS WHO WOULD BENEFIT WITH MAT

New Mexico is favored in having some physicians who offer MAT with buprenorphine in their practices. These few physicians, however, are able to address only a small fraction of the population who might benefit.

While Medicaid in New Mexico covers physician visits for methadone and buprenorphine, as well as the drugs themselves, barriers exist and disincentives presently severely constrain the availability of MAT in New Mexico.

a. Physicians with certification to treat with buprenorphine are limited by regulation in the numbers of patients to be managed at one time. Each is allowed up to 30 patients at one time in the first year after certification and up to 100 thereafter if the support services are available.

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5. Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Cost offset of treatment services. April 2009. https://www.samhsa-gpra.samhsa.gov/CSAT/view/docs/SAIS_GPRA_CostOffsetSubstanceAbuse.pdf. Accessed November 2012.

6. Connock M, Juarez-Garcia A, Howett S, et al. Methadone and buprenorphine for the management of opioid dependence: a systematic review and economic evaluation. *Health Technol Assess.* 2007;11:1–171.

7. Harwook HJ, Hubbard RL, Collin JJ, Rachal JV. The costs of crime and the benefits of drug abuse treatment: a cost-benefit analysis using TOPS data. In: *Compulsory Treatment of Drug Abuse: Research and Clinical Practice* (NIDA Research Monograph Series). Rockville, MD: Department of Health and Human Services, 1988.

b. Only a few physicians choose to take the required training for certification to administer buprenorphine. Even with certification, only a small number of physicians take on patients for MAT. Reasons are multifold: many simply have a distaste for caring for persons with opioid use disorders or don't want them in their offices or clinics; addiction is a chronic illness often associated with co-occurring mental disorders, and management is challenging, time consuming, and frustrating; over time, many patients relapse and some return to illicit opioid use; and many physicians feel that reimbursement is insufficient for the time and effort likely to be needed. Some physicians and clinic administrators have been outspoken in their decision to have a policy of not managing patients with substance dependency disorders. Not all certified methadone clinics accept Medicaid.
c. Medical education is inadequate in training and orientating physicians toward addiction as a chronic disease and in providing role models for managing substance use disorders.
d. Successful management with MAT requires concurrent counseling and often necessitates social support (wraparound) services that may be insufficiently available to many primary care physicians or not covered under current financing of health care.
e. There is a black market for Suboxone®, and it has street value for opioid users. The possibility of diversion is a concern for some prescribing physicians. (In many instances, illicit use of Suboxone® is driven by the same reason that the drug is used clinically, namely, it is a substitute for other addictive opioids, and it is difficult if not impossible for addicts to obtain legitimate access.)[8]
f. Some physicians are put off by onerous preauthorization and reauthorization processes as conditions for insurance or Medicaid payments and by the prospect of DEA audits of prescribing practices.

More broadly, physician incentives and rewards for this work are meager and insufficient to overcome the disincentives. Until this is addressed, it is unreasonable to expect enough physicians to simply step forward for certification and participation and fulfill the state popultion's needs for treatment.

Even patients who have insurance coverage and might benefit from buprenorphine may have to wait weeks or even months to find a physician who is certified and willing to consider MAT, while it is inaccessible for almost all patients who are uninsured. A goal for New Mexico should be that every person with opioid use disorder has the opportunity to be evaluated for suitability for MAT at the time the need for such assessment is identified and, if appropriate, have access to this important treatment option at that time.

The subcommittee is looking to the health plans and the funding intermediaries to help address the issue of incentives and to be the entities for ensuring that providers are certified and available to meet the needs of their enrolled patients for MAT. This needs to be among the contractual conditions they accept for holding the money to provide health care services.

With the passing of the Patient Protection and Affordable Care Act, the creation of the New Mexico Health Insurance Exchange, and the proposed changes in Medicaid, there are now unique opportunities to address this issue.

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8. Bazazi AR, Yokell M, Fu J, et al. Illicit use of buprenorphine/naloxone among injecting and noninjecting opioid users. *J Addict Med*. 2011;5(3):175–180.

PERSONS RELEASED FROM INCARCERATION NEED BUT ARE NOT GETTING TREATMENT

Approximately 87% of New Mexico prisoners have some kind of substance use disorder. Managing addictive disorders during and after incarceration substantially helps the prospects for reintegration and is associated with reduced rates of both substance dependency and criminal recidivism. More specifically, MAT is currently not available to inmates in the prisons. Studies have shown that prerelease MAT with counseling is associated with less postrelease heroin use and overdose and may reduce criminal activity and recidivism.[9,10] Prerelease MAT when associated with counseling and close follow-up can more than pay for itself.

Funding constraints and budget cutbacks in recent years have led to reductions in addiction treatment services in the prisons. Research on the cost-benefit ratio of drug dependency treatment indicates this is a false savings for the state.

RECOMMENDATIONS RELATED TO MEDICATION ASSISTED TREATMENT (MAT)

RECOMMENDATIONS TO HAVE HEALTH CARE PLANS, MEDICAID, AND OTHER PUBLICLY FUNDED SERVICES INCREASE AVAILABILITY OF PHYSICIANS DOING MAT:

1. Health insurance offered through the New Mexico Health Insurance Exchange and Medicaid should specify coverage for treatment of substance dependency disorders and addiction as essential health benefits so as to include MAT. (Legislation is needed if the New Mexico Insurance Department, Office of Health Care Reform, and/or Medicaid cannot ensure.)

2. Health plans must make MAT an available treatment option as a condition for being qualified within the New Mexico Health Insurance Exchange and for contracting as managed care organizations for Medicaid. The administering entities (i.e., the New Mexico Insurance Division, the Health Insurance Exchange itself, and the Medical Assistance Division) should require that health plans ensure the availability of physicians who are certified and willing to treat patients with buprenorphine. Should a managed care organization have a local shortage of such physicians, it must provide access to an available certified physician out of network. (Legislation may be needed if Medicaid and other administering entities cannot ensure.)

3. Publicly funded health care purchasing authorities should offer benefit packages that meet or exceed New Mexico's basic health benefit under the Affordable Care Act and the Health Insurance Exchange. The legislature should explore how the Health Care Purchasing Act may be used to articulate a basic health benefit to be offered through the

9. Kinlock TW, Gordon MS, Schwartz RP, et al. A randomized clinical trial of methadone maintenance for prisoners: results at twelve months post-release. *J Subst Abuse Treat*. 2009;37(3):277–285.

10. Chandler RK, Fletcher BW, Volkow ND. Treating drug abuse and addiction in the criminal justice system. *JAMA*. 2009;301:183–190.

quasi-public health care purchasing authorities that would align with those used by the Health Insurance Exchange and Medicaid. Such a basic health benefit should specifically include treatment of drug use disorders and addictions and cover MAT.

4. As a condition for funding, medical provider entities receiving grants, loans, appropriations, or other direct support from the state for services that include primary care must be able to make MAT available as a treatment option. An example would be community health centers. (Legislation may be needed if state agencies handling such support cannot ensure.)

5. The legislature should create an income tax credit for individual physicians who manage an active census of patients on buprenorphine for a full year. Additionally, community health centers that manage and maintain patients on buprenorphine should be able to apply for incentive grants to compensate for relative losses of revenue due to physicians' under-compensated time with patients. (This will require authorization and an appropriation.)

RECOMMENDATIONS FOR STATE AGENCIES TO EXPAND PROGRAMS THAT PRIVATE SECTOR IS UNLIKELY TO REACH AND FOR PHYSICIAN TRAINING

1. The New Mexico Department of Health should plan, establish, and maintain (or arrange for) programs to provide MAT in each of its regions for persons without insurance, on the basis of local needs. This includes persons being released from incarceration and intravenous drug users. (This will likely require appropriation.)

2. The New Mexico Department of Health, the Human Services Department, and the Children, Youth, and Families Department should expand buprenorphine MAT and associated treatment services to persons younger than sixteen years old when such treatment is deemed indicated by a qualified licensed provider.

3. The Behavioral Health Services Division of the New Mexico Human Services Department should create an online statewide service directory of buprenorphine providers, noting those currently accepting new patients for MAT.

4. Buprenorphine certification and direct experience providing MAT should be a requirement for any physician completing a New Mexico residency in family practice or general internal medicine or completing training in New Mexico leading to certification in pain management. These recommendations should be considered also for physicians completing residencies in psychiatry, pediatrics, emergency medicine, and obstetrics/gynecology.

5. The University of New Mexico Health Sciences Center should take a lead in addressing the population burden of opioid dependency disorders.

6. Legislature needs to be responsive to funding requests that target these recommendations.

RECOMMENDATIONS FOR MAT FOR PRISONERS AND PAROLEES WITH SUBSTANCE USE DISORDERS

1. In the context of restoring and building treatment programs for prisoners with substance dependency disorders, the New Mexico Corrections Department, in collaboration with the Department of Health and the Human Services Department, should plan for access to MAT management immediately upon the release of any prisoners identified as being at risk for resumption of opioid use. Such a program should be developed and piloted in 2013 with intent to implement generally by 2014. In addition, the Corrections Department should develop and pilot a prerelease MAT program that includes counseling and arrangement for postrelease treatment.

2. The New Mexico Corrections Department and Medical Assistance Division should work to ensure that persons being released from prison who will be eligible for Medicaid are enrolled, that enrollment is effective upon the moment of release, and that they are connected with a local care provider with access to MAT.

3. The New Mexico Department of Health, coordinating with the Behavioral Health Services Division, should expand its programs to provide advice and technical assistance to county jails and evaluate pilot sites, in order to accomplish the following:
   a. Make available continuing MAT for prisoners already on MAT at the time of incarceration, whether that be methadone or buprenorphine.
   b. Plan for access to MAT management immediately upon the release of any prisoners identified as being at risk for resumption of opioid use. (This is in addition to providing naloxone.)
   c. Ensure that persons being released from jail who will be eligible for Medicaid are enrolled and that enrollment is effective upon the moment of release.

REPORT OF THE

MEDICALLY ASSISTED INJECTION DRUG FACILITY FEASIBILITY

SUBCOMMITTEE

BACKGROUND AND FINDINGS

NEW MEXICO NEEDS INNOVATIVE HARM REDUCTION FOR INJECTION DRUG USE

Drug use, injection drug use, and high rates of unintentional drug overdose death in New Mexico have prompted numerous strategies, programs, and policies to help improve and save lives in our state. Over the last fifteen years, the principles of harm reduction have been incorporated by the state government in New Mexico, providing vital services to individuals and communities across the state. New Mexico's Harm Reduction Program is a model for the nation and includes statewide reporting systems for drug overdose, state-mandated needle exchange programs, distribution of naloxone to those at potential risk of opioid overdose, and the 911 Good Samaritan policy.

While New Mexico's Harm Reduction Program helps prevent drug-related overdose deaths and the spread of blood-borne diseases, more comprehensive services are needed.

- Since 1989, New Mexico has been among the top three states in the United States with the highest rates of drug-induced deaths. A recent study by the Centers for Disease Control and Prevention indicates that New Mexico leads the nation in drug overdose deaths, with a rate of 27 per 100,000.[11]
- The Substance Abuse Epidemiology Unit at the New Mexico Department of Health estimates there were nearly 24,000 adult injection drug users in New Mexico in 2006. Others report the number to be as high as 50,000.
- An average of 300 to 400 inmates a month go through detoxification for heroin and opioids at the Bernalillo Metropolitan Detention Center. The number exceeded 530 in June 2011.[12]
- According to the *Opioids Needs Assessment,* prepared for the City of Albuquerque in June 2011, 3.6% of New Mexico high school students reported injection drug use, compared to 2.0% of U.S. high school students overall.[13]

WHAT IS A MEDICALLY SUPERVISED SAFE INJECTION FACILITY (SIF)?

11. Centers for Disease Control and Prevention. *Vital Signs: Overdoses of Prescription Opioid Pain Relievers, United States, 1999–2008*. November 1, 2011.

12. Communication from Matthew Ellwell, Director of Operations, Metropolitan Detention Center, Bernalillo County, NM, 2012

13. Greenfield B, Owens M, Ley D. *Opioid Needs Assessment*. Prepared for the City of Albuquerque. June 30, 2011

Medically supervised safe injection facilities (SIFs) are controlled health care settings where injection drug users (IDUs) can self-administer preacquired drugs with sterile injection supplies under clinical supervision. SIFs provide users with health care, counseling, and referrals to health and social services, including drug treatment, housing, and employment assistance. SIF medical professionals do not actually inject the users; their primary role is to educate regarding safe injection practices, monitor for disease, provide necessary medical care and first aid, and respond to overdose. SIFs tend to attract older, long-term users who are more difficult to reach through more traditional prevention and treatment settings. Therefore, for the most complex users, SIF medical professionals serve as a gateway to treatment and social support programs. Worldwide there are sixty-five safe injection facilities in twenty-seven cities in eight countries.

EVALUATION OF SIFS

Experience-based evidence predominantly from the SIF in Vancouver, British Columbia, has been published in peer-reviewed journals and describes that facility as medically effective, economically efficient, and socially appropriate in reducing incidence of and harm caused by injection drug use. According to the published evidence, the Vancouver SIF:

- Attracts and retains a high risk population of IDUs who are at a heightened risk for infectious disease and overdose[14,15,16]
- Reduces the transmission of blood-borne viruses[17,18]
- Successfully manages overdoses and prevents overdose fatalities[18]
- Increases safer injection practices[19,20]
- Increases access and referrals to treatment programs and social services, including, but not limited to, medication assisted treatment and detoxification services[18,21,22,23,24][

14. Wood E, Tyndall MW, Li K, et al. Do supervised injecting facilities attract higher risk injection drug users? *Am J Prev Med*. 2005;29:126–130.

15. Tyndall MW, Kerr T, Zhang R, et al. Attendance, drug use patterns, and referrals made from North America's first supervised injection facility. *Drug Alcohol Depend*. 2006;83:193–198.

16. Wood E, Tyndall MW, Qui Z, et al. Service uptake and characteristics of injection drug users utilizing North America's first medically supervised safer injecting facility. *Am J Public Health*. 2006; 96: 770–773.

17. Kerr T, Tyndall M, Zhang R, et al. Circumstances of first injection among illicit drug users accessing a medically supervised safer injection facility. *Am J Public Health*. 2007; 97(7): 1228–1230.

18. Lightfoot B. Gaining insite: harm reduction in nursing practice. *Canadian Nurse*. 2009;105(4):16–22.

19. Stoltz J, Wood E, Small W, et al. Changes in injecting practices associated with the use of a medically supervised safer injection facility. *J Public Health*. 2007;29(1):35–39.

20. Wood E, Tyndall MW, Montaner JS, et al. Summary of findings from the evaluation of a pilot medically supervised safer injecting facility. *CMAJ*. 2006;175(11):1399–1404.

21. Wood E, Tyndall MW, Zhang R, et al. Attendance at supervised injecting facilities and use of detoxification services. *N Engl J Med*. 2006;354:2512–2514.

22. Wood E, Tyndall M, Zhang R, et al. Rate of detoxification service use and its impact among a cohort of supervised injecting facility users. *Addiction*. 2007;102:916–919.

- Saves the taxpayer in societal costs associated with expensive emergency room visits, crime, and violence[21]
- Reduces the social harms associated with injection drug use, such as public disorder, public intoxication, public injecting, and publicly discarded syringes[21,24,25,26]

IMPLEMENTING A NEW MEXICAN SIF IS LEGALLY FEASIBLE

Implementing a SIF in New Mexico is legally feasible. The most appropriate administrative home for a state-regulated SIF is in the New Mexico Department of Health, which already regulates the state's needle exchange programs under the Harm Reduction Act[27], and therefore is in the best position to house a SIF program. Furthermore, SIFs are complementary and share the same goals as the Harm Reduction Act, fill critical service gaps by providing more services than existing needle exchange programs, and extend already existing harm reduction interventions by providing instruction in safe injection practices while the user is actually injecting.

A SIF pilot could be created by New Mexico statute. For example, the New Mexico State Legislature could enact a safe injection facility act to start and develop a pilot program, with an initial appropriation that would be designated as recurring funding in the budget of the Department of Health.

NEXT STEPS

Under the continuing auspices of SM45, the subcommittee plans to continue to study the feasibility of implementing a legal medically supervised injection facility staffed with medical professionals to reduce overdose deaths, increase access to health services, and further expand access to safe injection equipment to prevent the transmission of HIV and hepatitis C. A legal SIF would be an incremental extension of the New Mexico syringe exchange program already authorized by state law. Next steps of the study include a robust data gathering process, with a survey of intravenous drug users to assess perception of need and preferences. Such a survey would have approval by an institutional review board.

If the feasibility study shows that a SIF could reduce overdose deaths and increase access to treatment in New Mexico, a pilot SIF, overseen by the Department of Health, should be considered for a community in New Mexico. It would have a rigorous evaluation component.

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23. DeBeck T, Kerr T, Bird L, et al. Injection drug use cessation and use of North America's first medically supervised safer injecting facility. *Drug Alcohol Depend*. 2011;113:172–176.

24. Small W, Van Borek N, Fairbairn N. Access to health and social services for IDU: the impact of a medically supervised injection facility. *Drug Alcohol Rev*. 2009; 28(4):341–346.

25. Wood E, Kerr T, Small W, et al. Changes in public order after the opening of a medically supervised safer injecting facility for illicit injection drug users. *CMAJ*. 2004; 171(7):731–734.

26. Fewer addicts shooting up on streets since injection site opened: police. *Nanaimo Daily News*. 2003;94:355–59.

27. Harm Reduction Act, Sections 24-2C-1, et seq., NMSA 1978 (Laws 1997, Chapter 256).

APPENDIX A

SENATE MEMORIAL 45

50th Legislature, 2nd Session
Introduced by Senator Richard C. Martinez

A MEMORIAL REQUESTING THE UNIVERSITY OF NEW MEXICO'S ROBERT WOOD JOHNSON FOUNDATION CENTER FOR HEALTH POLICY TO CONDUCT A FEASIBILITY STUDY ON HOW TO ENHANCE AND EXPAND NEW MEXICO'S HARM-REDUCTION SERVICES RELATED TO OPIOID MISUSE AND DEPENDENCY.

WHEREAS, New Mexico has long been concerned about the high rates of opioid misuse and dependency and the impact on the people of New Mexico; and

WHEREAS, the federal Centers for Disease Control and Prevention have recently declared the United States to have a crisis and epidemic of opioid abuse and addiction; and

WHEREAS, New Mexico is facing opioid overdose death rates of unprecedented proportions; and

WHEREAS, New Mexico ranks number one in the country in overdose-related deaths, as reported by the Centers for Disease Control and Prevention on November 1, 2011; and

WHEREAS, the rate for New Mexico overdose-related deaths is 27 per 100,000 population, more than twice the national average; and

WHEREAS, nationally, overdose death rates now outnumber traffic fatality rates; and

WHEREAS, the Department of Health's Substance Abuse Epidemiology Unit at the University of New Mexico estimates that there were nearly 24,000 adult intravenous drug users in New Mexico in 2006, and others report that number to be as high as 50,000; and

WHEREAS, the federal Substance Abuse and Mental Health Services Administration recently conducted a review of emergency room visits for nonmedical use of opioid analgesics and found that the number of visits for nonmedical opioid use increased 111% between 2004 and 2008; and

WHEREAS, people who use opioids, including heroin and prescription medications, are at risk for health-related harm associated with the use, such as blood-borne infections like human immunodeficiency virus and hepatitis C, skin infections at injection sites, venous damage, and, ultimately, death due to overdose; and

WHEREAS, drug abuse and dependence is a complex issue that requires innovative approaches to harm reduction in drug use; and

WHEREAS, there are evidence-based approaches that are proven to work in reducing the harm associated with opioid use, including medically supervised injection facilities, opioid overdose reversal antidotes such as naloxone, access to safe syringes and access to medication-assisted treatment, including methadone and buprenorphine; and

WHEREAS, individuals suffering from addiction need access to high-quality treatment that is health-focused, yet these individuals remain highly underserved; and

WHEREAS, harm reduction strategies for opioid use and overdose can save both lives and money; and

WHEREAS, there is a need to enhance the existing system in New Mexico and explore more comprehensive and innovative models; and

WHEREAS, medically supervised injection sites are controlled health care settings where drug users can more safely use drugs under clinical supervision, and where they have access to health care, counseling, and referral[s] to health and social services, including drug treatment; and

WHEREAS, medically supervised injection sites have proven to reduce transmission of blood-borne viruses, prevent overdose fatalities, foster safer injection practices, and increase access or referrals to addiction treatment programs, including medication-assisted treatment and detoxification services; savings to taxpayers by reducing societal costs associated with costly emergency room visits and increased crime and violence; and a reduction in social harms associated with intravenous drug use, such as public disorder, public intoxication, public injecting of drugs, and publicly discarded syringes; and

WHEREAS, medically supervised injection sites are best-suited to serve older, long-term users, who are more difficult to reach through more traditional prevention and treatment settings and who often avoid, or have never had contact with, the treatment system; and

WHEREAS, worldwide, there are sixty-five safe injection facilities in twenty-seven cities in eight countries, including Vancouver, Canada;

NOW, THEREFORE, BE IT RESOLVED BY THE SENATE OF THE STATE OF NEW MEXICO that the University of New Mexico's Robert Wood Johnson Foundation Center for Health Policy be requested to conduct a feasibility study to evaluate how to expand and enhance opioid harm-reduction services in New Mexico; and

BE IT FURTHER RESOLVED that the University of New Mexico's Robert Wood Johnson Foundation Center for Health Policy explore emerging and novel approaches to opioid harm reduction, including exploring the feasibility of implementing a pilot medically supervised injection site, staffed with medical professionals, to reduce overdose deaths, increase access to health services and treatment, and further expand access to safe injection equipment to prevent the transmission of human immunodeficiency virus and hepatitis C; and

BE IT FURTHER RESOLVED that the University of New Mexico's Robert Wood Johnson Foundation Center for Health Policy include in its study input from the Department of Health, the Children, Youth, and Families Department, the Human Services Department, the Interagency Behavioral Health Purchasing Collaborative, the Behavioral Health Planning Council, the University of New Mexico, the New Mexico Public Health Association, the Drug Policy Alliance, the New Mexico Women's Justice Project, the Navajo AIDS Network, the Santa Fe Mountain Center, Casa de Salud, New Mexico AIDS Services, Health Care for the Homeless, staff from established supervised injection sites, harm-reduction researchers, harm-reduction advocates, people in recovery from opioid addiction, and individuals or family members who have experienced an overdose; and

BE IT FURTHER RESOLVED that the University of New Mexico's Robert Wood Johnson Foundation Center for Health Policy report its findings and any legislative recommendations to

the Interim Legislative Health and Human Services Committee and other appropriate interim committees by November 1, 2012; and

BE IT FURTHER RESOLVED that copies of this memorial be transmitted to the University of New Mexico's Robert Wood Johnson Foundation Center for Health Policy and to each of the agencies, organizations, and individuals named to participate in the study.

APPENDIX B

SM45

SUBCOMMITTEE MEMBERSHIPS AND PARTICIPATING ADVISORS

Naloxone/Syringe Exchange Subcommittee

Emily Kaltenbach, Cochair	Drug Policy Alliance
Jeanne Block, Cochair	Project ECHO
Monica Ault	Drug Policy Alliance
Andrew Ganz	Department of Health, Harm Reduction
Melissa Heinz	Department of Health, Injury Prevention
Vivian Heye	Harm reduction volunteer
Deborah Reynolds	Department of Health, Hepatitis Harm Reduction
Harris Silver	Physician, epidemiologist
Olivia Sloan	Drug Policy Alliance
Bill Wiese	RWJF Center for Health Policy
Dominick Zurlo	Graduate student, UNM

Medication Assisted Treatment Subcommittee

Harris Silver, Cochair	Physician, epidemiologist, analyst
Bill Wiese, Cochair	RWJF Center for Health Policy
Miriam Komaromy	Project ECHO
Bernie Lieving	Southwest CARE Center

Medically Supervised Injection Facility Feasibility Subcommittee

Emily Kaltenbach, Cochair	Drug Policy Alliance
Steve Lucero, Cochair	Hispanic Medical Association
Monica Ault	Drug Policy Alliance

Technical Advisors

Anne Foster	Medicaid
Cliff Rees	Network for Public Health Law
Brad Whorton	Department of Health, Epidemiology

NOTE AND DISCLAIMER

These reports and recommendations are based on discussions by the SM45 Study Group's Naloxone/Syringe Exchange, Medication Assisted Treatment, and Medically Supervised Injection Facility Feasibility Subcommittees.

The views expressed in this document represent a consensus of the subcommittees that was reached following opportunities for review and comment from interested parties working with the SM45 Study Group.

Compiling and editing for the Study Group: William Wiese

These reports and recommendations do not necessarily represent the Robert Wood Johnson Foundation Center for Health Policy, the University of New Mexico, or collaborating organizations or funders.
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