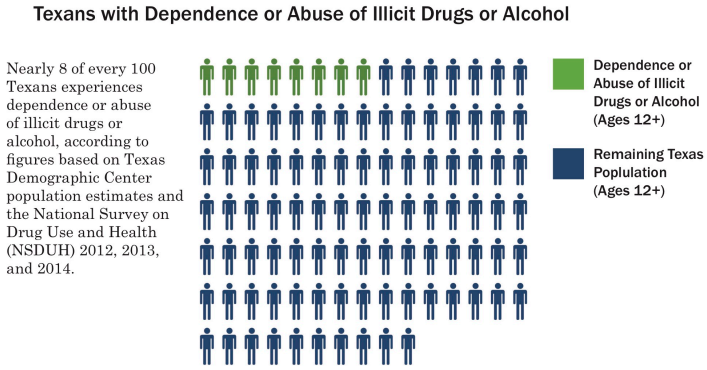
Meadows Mental Health Policy Institute

Texas Substance Use Disorder Landscape – February 2018

This document summarizes key facts regarding substance use disorder (SUD) needs and current services in Texas. Primary source documents are available from the Meadows Mental Health Policy Institute (MMHPI) for deeper background reading regarding all information included.

How many Texans need SUD services?

- **While many people use substances, only some use is harmful enough to be considered misuse (examples include underage drinking, experimental drug use). An even smaller percentage meets diagnostic criteria for having substance use disorders (SUD),** which is a pattern of harmful, continued use that causes impairment. Substance use disorders fall on a spectrum from mild to severe; severe SUD is commonly referred to as addiction.



- **Nearly eight (8) of every 100 Texans has a substance use disorder.** This includes five (5) in 100 youth (almost 140,000) and eight (8) in 100 adults (1.65 million, comparable to the number suffering depression each year).[1] Most of these Texans have an alcohol-related SUD; about one in five has a drug-related SUD.
- **SUDs are the leading contributor to children entering the Child Protective Services (CPS) system**, contributing to two-thirds of CPS cases in 2016.[2]
- **Drug overdose is a leading cause of maternal deaths in Texas**. Most of these deaths are due to licit or illicit use of prescription opioids.[3]
- Individuals with severe SUDs commonly have co-occurring mental health conditions that also require intervention. **At least one third of adults[4] and one fourth of youth[5] with SUDs in Texas have co-morbid psychiatric conditions.** This likely underrepresents the true prevalence of co-morbidity. Studies of individuals in SUD treatment programs often report that around two-thirds of people with SUD also have mental illness.
- **Opioids** (prescription and heroin) **are one of the biggest threats,** killing over 1,000 Texans per year (more on this below).[6] In comparison, there were 987 alcohol-related motor-vehicle deaths in Texas in 2016.[7]
- **Methamphetamine** (which is not an opioid) **is also a threat**, causing 715 deaths in 2016, the highest reported of any other substance besides opioids and alcohol.

- The tables below compare substance use rates to substance use disorders by severity. **Nearly one (1) in 10 Texas youth has consumed alcohol in the past month.** While adults report higher rates of alcohol-related substance use disorders, **youth report higher rates of illicit drug-related substance use disorders**.[8]

Substance Use and Substance Use Disorders in the Past Year – Youth Ages 12-17[9]

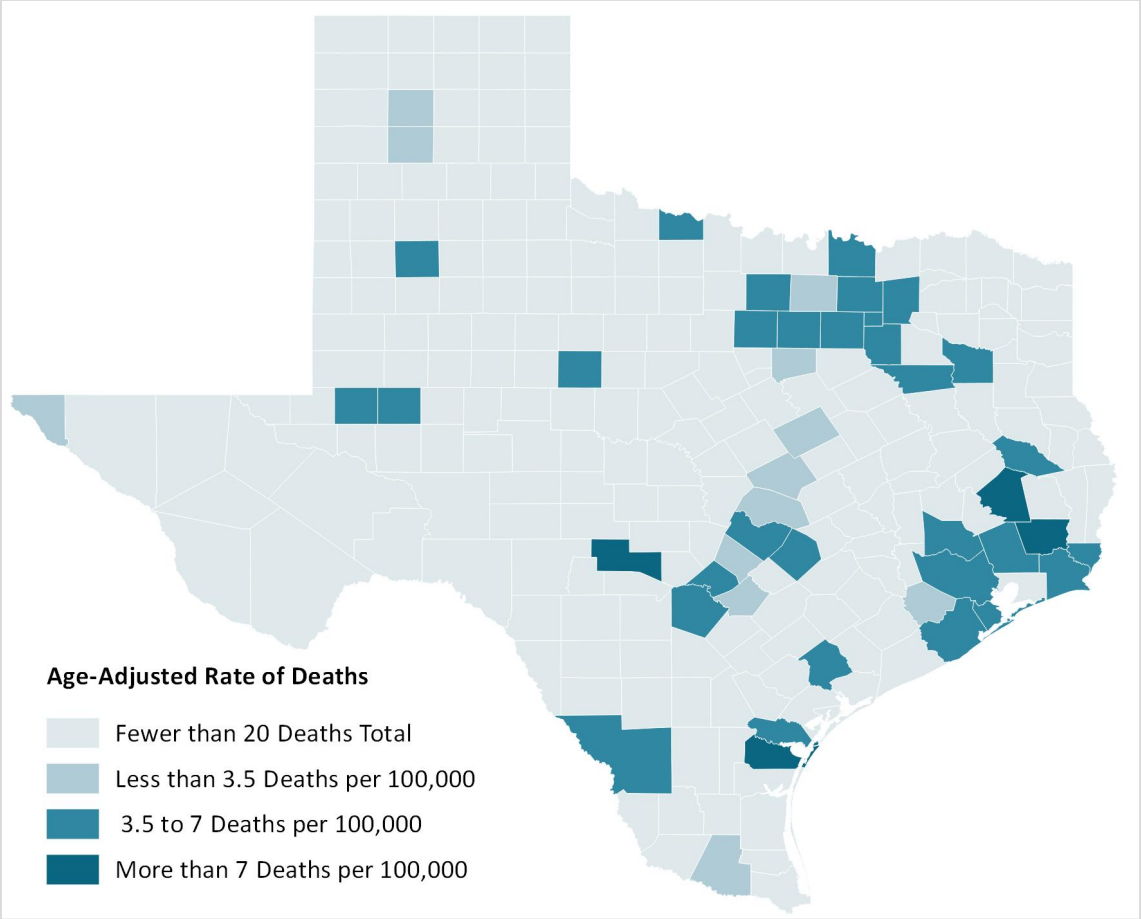
Substance	Substance Use		Substance Use Disorder – Mild		Substance Use Disorder – Moderate and Severe	
	Rate	Estimate	Rate	Estimate	Rate	Estimate
Alcohol[10]	10%	250,000	1.9%	45,000	1%	30,000
All Illicit Drugs	N/A	N/A	1.7%	40,000	1.9%	45,000
Marijuana	12%	290,000	N/A	N/A	N/A	N/A
Cocaine	0.7%	15,000	N/A	N/A	N/A	N/A
Heroin	0.05%	1,000	N/A	N/A	N/A	N/A

Substance Use and Substance Use Disorders in the Past Year – Adults Ages 18+[11]

Substance	Substance Use		Substance Use Disorder – Mild		Substance Use Disorder – Moderate and Severe	
	Rate	Estimate	Rate	Estimate	Rate	Estimate
Alcohol[12]	53%	10,600,000	4%	760,000	3%	650,000
All Illicit Drugs	N/A	N/A	0.6%	110,000	1.5%	300,000
Marijuana	10%	2,000,000	N/A	N/A	N/A	N/A
Cocaine	2%	300,000	N/A	N/A	N/A	N/A
Heroin	0.1%	25,000	N/A	N/A	N/A	N/A

- **Overdose deaths are rising, especially for adults between the ages of 45 and 64.**
- Rates of overdose related to **opioids** vary substantially by region; see the map on the next page for a county-by-county overview of opioid-related deaths in Texas.[13]
- Of all opioid-related deaths, **heroin resulted in the most deaths in 2016** (530 deaths). From 1999 to 2016, the rate of heroin-related deaths has nearly quadrupled, from 0.5 to 1.9 deaths per 100,000.[14] The rate of **synthetic opioid-related deaths is also increasing**.

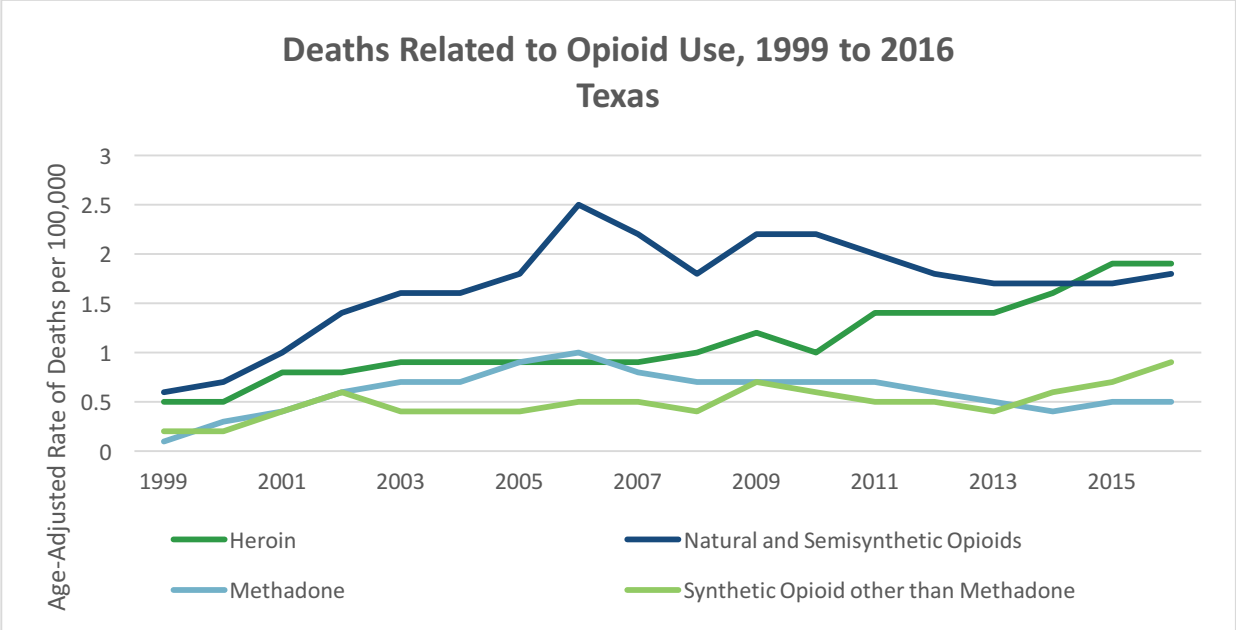
Age-Adjusted Opioid-Related Deaths by County, 2011 - 2016[15]



The Opioid Crisis: Facts

Opioid use and the number of deaths associated with it have risen nationally and in Texas.

- From 1999 to 2014, the number of drug overdoses from opioid use tripled in the U.S. Among 47,055 drug overdoses in the U.S. in 2014, over 60% involved an opioid. Over 1,000 Texans died from opioid overdoses in 2016.[16]
- In Texas, opioid-involved overdose deaths increased 400% from 1999 to 2015. More recent data indicate that Texas is starting to be hit even harder by the opioid crisis.
- In Texas, better monitoring to discourage inappropriate opioid prescriptions, which began a few years ago, has been associated with a slower rate of growth in deaths related to these opioids. However, deaths due to heroin have risen much more dramatically during that period. In general, simply discontinuing opioid prescriptions, without providing treatment for opioid use disorders, can lead to switching to illegal sources of opioids.
- Further, in the past few years, highly potent and dangerous synthetic opioids have started to appear in Texas, as elsewhere in the nation, resulting in a spike in overdose deaths in that category. The lethality of heroin and other opioids is greater when used in combination with other categories of drugs, such as benzodiazepines or alcohol.



Note: The deaths noted in the graph above constitute deaths due to **misuse of opioids**, regardless if these drugs are illicit (such as heroin) or medications/treatments that are misused (such as methadone and oxycodone).

What has been the federal response to the opioid crisis?

- Partly because of this crisis, Congress enacted the **21st Century Cures Act** in December 2016, making one billion dollars available to states to fight the opioid crisis.
  - The Substance Abuse and Mental Health Services Administration (SAMHSA) has awarded Texas **$27.4 million** per year in grants for the biennium. This is known as the **Texas Targeted Opioid Response (TTOR)**.
  - The TTOR program will allow the Health and Human Services Commission (HHSC) to expand prevention, early intervention, and treatment efforts for people at high risk for opioid use disorders.
- President Trump declared the opioid crisis a **national public health emergency** under federal law on October 26, 2017. This declaration, set to expire on January 23, 2018, was renewed for 90 additional days. While there is not yet additional federal funding behind this declaration, the bipartisan budget agreement announced by Senate leaders on February 7, 2018 dedicates **$6 billion** in funding to fight the opioid crisis.
- The **President's Commission on Combating Drug Addiction and the Opioid Crisis**, chaired by Governor Chris Christie, released its report and summary of recommendations on November 1, 2017.[17]

There are many pathways to opioid-related misuse, overdose and death, including:

- Overuse or misuse of opioids originally prescribed (appropriately or not) to treat pain;
- Progression to use of, and addiction to, illicit opioids (e.g., heroin) because of abrupt discontinuation of prescribed pain medication;
- Progression from recreational use and/or addiction to other substances or to prescription or non-prescription opioids (sometimes resulting in overdose), including use of dangerously potent illicit opioids such as fentanyl (100 times more potent than heroin) and carfentanyl (100 times more potent than fentanyl);
- Overuse or misuse of opioids for pain by individuals who have co-occurring mental health conditions (depression, anxiety, trauma), which may lead to overdose in combination with other prescribed mental health medications – these are often termed "deaths of despair"; and
- Prenatal opioid use may result in **Neonatal Abstinence Syndrome (NAS)**, a drug-withdrawal syndrome where the baby is born dependent on the drug.

What are some examples of opioids?

- Percocet
- Vicodin (hydrocodone)
- OxyContin (oxycodone)
- Morphine
- Methadone

- Heroin
- Fentanyl (100 times more potent than heroin)
- Carfentanyl (100 times for potent than Fentanyl; intended use is for large animals)

What can be used to prevent overdose deaths?

- Naloxone is a short acting opioid antagonist (blocker) that can be used by first responders, Good Samaritans, and medical personnel to rapidly reverse overdose and prevent death.
- Rescue Breathing is a skill that can be taught to people to help prevent overdose death.

Medication-Assisted Treatment (MAT)

- MAT is the use of medications, ideally in combination with counseling and behavioral therapies, to treat substance use disorders and prevent opioid overdose.
- Currently in Texas, MAT is only provided to 14% of the people being admitted for opioid use disorders to HHSC-funded indigent care SUD services (non-Medicaid).
- Medications used in MAT to treat opioid use disorders include methadone, buprenorphine, and naltrexone.
  - Texas has only 85 licensed providers of methadone, which is still considered the gold standard for treatment of severe opioid use disorder, with over 50 years of research supporting its effectiveness.
  - Methadone (a long-acting opioid agonist that reduces craving) can only be provided by an **opioid treatment program** (OTP). OTPs are closely licensed and regulated by SAMHSA, the Drug Enforcement Administration (DEA), and the state.
  - Buprenorphine (an opioid partial agonist that reduces craving without euphoric properties), and the combination medication buprenorphine and naloxone, can be provided by an OTP or physicians who have received a minimum of eight hours of training on the medication in addition to having received a special waiver from the DEA.
    - In their first year, certified providers may only treat 30 patients at a time with buprenorphine, followed by up to 100 patients in subsequent years after submitting an additional notification.
    - A final rule published in July 2016 increased the patient limits to 275 patients at a given time for certified qualified physicians.
  - Naltrexone, a relatively long-acting opioid antagonist that reduces cravings for alcohol and prevents users from getting high on opioids (also available as a monthly injection), does not require special training or certification to prescribe. Naltrexone can be particularly effective when used in combination with community reinforcement and external contingencies.

- The **Comprehensive Addiction and Recovery Act of 2016** includes a provision that, for the first time, allows physician assistants and nurse practitioners to prescribe buprenorphine.
- Texas Medicaid covers methadone that is provided in an OTP, as well as buprenorphine and naltrexone, both oral and injectable, under the Vendor Drug Program formulary for opioid use disorder treatment. However, the state currently requires standard prior authorization criteria for long-acting injectable Naltrexone (Vivitrol) as a non-preferred drug, which requires contraindication to the preferred drug, allergic reaction to the preferred drug, or treatment failure with the preferred drug first. However, when Vivitrol is provided as a clinician-administered drug in the office, rather than as a pharmacy benefit, there is no prior authorization criteria.
- HHSC strongly recommends, but does not require, that counseling be provided in conjunction with MAT.

Can prevention work?

- Yes, early screening and detection in primary care and adopting pain management approaches that reduce dependence on opioid prescriptions will help.
- Public education campaigns about the importance of safely discarding unused opioid prescriptions have been shown to reduce diversion.
- Efforts to make naloxone more available to first responders and family members have been demonstrated to directly save the lives of people who have overdosed.
- One Texas expert notes that past efforts have led to reductions in the abuse of some opioids. For example, the Texas Poison Center Network received far fewer calls concerning hydrocodone after it became more tightly regulated. Methadone misuse cases dropped after the legal distribution of one form of it was limited to narcotic treatment programs. Educating the public about the misuse of prescription drugs, as well as educating providers about opioid prescribing, has had positive impacts.

What about the SUD treatment workforce?

- **In the face of this enormous public health crisis, Texas has a dramatic shortage of SUD treatment providers.** In a 2015 nationwide analysis, Texas was identified as having the third lowest ratio of SUD providers (17.7) per 1,000 adults living with a SUD. By comparison, the national average is 32.1 providers per 1,000 adults living with a SUD.[18]

Public System: How many get care and what are the costs related to both untreated needs and treated needs?

- There are **14 Texas Outreach, Screening, Assessment & Referral (OSAR) agencies**, 12 of which are local mental health authorities (LMHAs), and two (2) of which are local

behavioral health authorities (LBHAs). OSARs provide outreach, screening, and assessment to people to determine the need of SUD services. Those who need SUD services are then referred to services in the most appropriate and available setting. OSARs are one, but not the only, front door to SUD services for indigent people. OSARs also do not include funding for the population-level planning role that LMHAs have for mental illness.

- **How many adults receive care today in the public sector?**
  - **The vast majority of the 1.6 million adults in need receive no SUD treatment.**
  - Of the approximately 680,000 adults in poverty with an SUD in Texas,[19] just under 35,000 (most of them uninsured) received SUD services through the HHSC contracted provider system in 2016. In addition, just under 6,000 adults received Medicaid-funded SUD treatment in 2015.
  - There is some evidence that treatment pays for itself. In 2015, the average annual combined Medicaid treatment cost per person with an untreated SUD was $1,000 more than for people with SUD needs who received SUD treatment.
  - MMHPI estimates that unmet SUD needs result in **$350 million per year in emergency room charges**. This estimate excludes comorbid medical conditions (e.g., alcoholic hepatitis), intoxication caused accidents, and co-occurring psychiatric conditions, so **the full emergency room charges related to SUDs are much higher**.
- **How many youth receive care today in the public sector?** Approximately 65,000 Texas youth ages 12-17 who live in poverty have an SUD.[20] In 2016, just under 5,000 youth out of just over 130,000 with SUD needs were served through the HHSC contracted provider system. As of the date of this report, the number of youth with SUD needs served through the Medicaid program is unknown.
- **Current public sector spending** across state agencies for specific line items for SUD in the General Appropriations Act for the 85th Texas Legislature (Senate Bill 1) is summarized in the following table:

Substance Use Disorder Specific Spending in Texas	FY18-19 All Funds
Health and Human Services Commission (HHSC) Non-Medicaid	$380 Million
Department of Criminal Justice (TDCJ)	$165 Million
Department of Family and Protective Services (DFPS)	$17 Million
All Other Agencies	None Identified
SUBTOTAL: 85R Cross-Article Summary	**$562 Million**
HHSC Estimated Medicaid and CHIP Expenditures	Not Broken Out
GRAND TOTAL	**Unknown**

Private System: How many get care, and what are the costs of untreated needs?

- **How many get care?** We do not know precisely, but we estimate **about one in three**.
- **More importantly, what kind of care do they get?**
  - Since 2013, commercial insurance has been subjected to the requirements of the 2008 federal parity law entitled the Mental Health Parity and Addiction Equity Act (MHPAEA). Through 85(R) HB 10, the Texas Department of Insurance (TDI) has the authority to enforce and monitor the application of MHPAEA in commercial insurance to ensure parity in behavioral health and physical health benefits. HB 10 also requires TDI to adopt rules associated with implementing enforcement and monitoring compliance with the legislation.
  - The federal and state rules apply to behavioral health benefits as they currently exist, which:
    - Only cover a core subset of care – inpatient, outpatient office, medications;
    - Typically pay less than the cost of delivering SUD services (in contrast to MRIs, catheters, labs);
    - May have prior authorization requirements or other barriers to immediate access to MAT for opioid use disorders;
    - Are still typically managed as a separate cost center, requiring two contracts – one for physical health and one for behavioral health.

What are the costs of unmet needs in the private sector? This is currently unknown. However, as cited above, this drives emergency room costs at the local level, and research shows that it generally costs more to provide other, non-SUD medical services to people with unmet SUD treatment needs than it does to provide medical services (including the added cost of SUD treatment) to people with SUDs who received treatment.

End Notes and Citations

[1] Substance Abuse and Mental Health Services Administration (SAMHSA) (2015). *Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health* (HHS Publication No. SMA 15-4927, NSDUH Series H-50).

[2] House Committee on County Affairs. (2017). *Interim report to the 85th Legislature*. Available at: http://www.house.state.tx.us/_media/pdf/committees/reports/84interim/County-Affairs-Committee-Interim-Report-2016.pdf

[3] Texas Department of State Health Services. (2016). *Maternal Mortality and Morbidity Task Force and Department of State Health Services joint biennial report.*

[4] The estimates of co-occurring psychiatric and substance abuse disorders (COPSD) in the adult population of each county in Texas were based on the national rates of comorbidity of any mental illness (AMI) with substance use disorder (SUD) found in SAMHSA's 2015 report, *Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health* (HHS Publication No. SMA 15-4927, NSDUH Series H-50), and the 2014-2015 National Survey on Drug Use and Health (NSDUH) rates of AMI and SMI for Texas. The AMI prevalence rate was multiplied by the rate of comorbidity with SUD. This rate (AMI/SUD) was then multiplied by the Texas Demographic Center's estimates of 2015 adult population for each county, resulting in the COPSD estimates by county for AMI/SUD.

[5] The estimate for comorbid psychiatric and substance use disorders for youth were based on national rates of comorbidity between major depressive episodes (MDE) and SUD among youth ages 12-17, found in SAMHSA's 2015 report, *Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health* (HHS Publication No. SMA 15-4927, NSDUH Series H-50), and the 2014-2015 National Survey on Drug Use and Health (NSDUH) rates of MDE for Texas. The MDE prevalence rate was multiplied by the respective rate of comorbidity with SUD. This rate was then multiplied by the Texas Demographic Center's estimates of 2015 youth population for Texas, resulting in the comorbid MDE and SUD estimate.

[6] Centers for Disease Control and Prevention, National Center for Health Statistics. (2017, December). *Multiple cause of death 1999-2016*. CDC WONDER Online Database. Retrieved on January 15, 2018 from http://wonder.cdc.gov/mcd-icd10.html
Data are from the Multiple Cause of Death Files, 1999-2016, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10.html on Jan 15, 2018 12:58:29 PM. Overdose deaths are classified using underlying cause-of-death ICD-10 codes: X40-44, X60-64, X85, and Y10-Y14. Opioid- specific cause of deaths use the underlying cause of death codes and the substance-specific multiple-cause-of death codes: T40.1 (heroin), natural and semisynthetic opioids (T40.2), methadone (T40.3), and synthetic opioids other than methadone (T40.4).

[7] Texas Department of Transportation. (2017, April 20). *DUI (Alcohol) fatalities by age*. Retrieved from: http://ftp.dot.state.tx.us/pub/txdot-info/trf/crash_statistics/2016/36.pdf

[8] Prevalence rates obtained from 2014-2015 National Survey on Drug Use and Health: Model-Based Prevalence estimates (50 States and the District of Columbia). Prevalence rates were applied to Texas Demographic Center population estimates for 2015. The 2016 Texas School Survey of Drug and Alcohol Use reports higher prevalence rates for youth as follows: 28.6% of youth reported consuming alcohol in the past month and 53% have ever consumed alcohol; 12.2% used marijuana in the past month and 21% have ever used marijuana; 2.8% reported ever using cocaine; 0.7% reported ever using heroin; overall, 12.8% of youth reported using any illicit drug in the past month and 22.6% reported ever using any illicit drug.

[9] Prevalence rates obtained from 2014-2015 National Survey on Drug Use and Health: Model-Based Prevalence estimates (50 States and the District of Columbia). Prevalence rates were applied to Texas Demographic Center population estimates for 2015. For any use, the alcohol use rate is "past month" whereas other substances are "past year." For mild use, the rate is based off of NSDUH rates for substance abuse. For moderate to severe use, the rate is based off NSDUH rates for dependence.

[10] For alcohol use only, estimates are for the past month, not past year.

[11] Prevalence rates obtained from 2014-2015 National Survey on Drug Use and Health: Model-Based Prevalence estimates (50 States and the District of Columbia). Prevalence rates were applied to Texas Demographic Center population estimates for 2015. For any use, the alcohol use rate is "past month" whereas other substances are

"past year." For mild use, the rate is based off NSDUH rates for substance abuse. For moderate to severe use, the rate is based off NSDUH rates for dependence.

[12] For alcohol use only, estimates are for the past month, not past year.

[13] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2016 on CDC WONDER Online Database, released December 2017. Data are from the Multiple Cause of Death Files, 1999-2016, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10.html on Jan 15, 2018 12:58:29 PM. Overdose deaths are classified using underlying cause-of-death ICD-10 codes: X40-44, X60-64, X85, and Y10-Y14. Substance specific cause of deaths use the underlying cause of death codes and the substance-specific multiple-cause-of death codes: T40.1 (heroin), natural and semisynthetic opioids (T40.2), methadone (T40.3), and synthetic opioids other than methadone (T40.4).

[14] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2016 on CDC WONDER Online Database, released December 2017. Data are from the Multiple Cause of Death Files, 1999-2016, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10.html on Dec 28, 2017 12:39:35 PM

[15] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2016 on CDC WONDER Online Database, released December 2017. Data are from the Multiple Cause of Death Files, 1999-2016, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10.html on Jan 15, 2018 12:58:29 PM. Overdose deaths are classified using underlying cause-of-death ICD-10 codes: X40-44, X60-64, X85, and Y10-Y14. Substance specific cause of deaths use the underlying cause of death codes and the substance-specific multiple-cause-of death codes: T40.1 (heroin), natural and semisynthetic opioids (T40.2), methadone (T40.3), and synthetic opioids other than methadone (T40.4).

[16] Centers for Disease Control and Prevention, National Center for Health Statistics. (2017, December). *Multiple cause of death 1999-2016*. CDC WONDER Online Database. Retrieved on January 15, 2018 from http://wonder.cdc.gov/mcd-icd10.html
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[17] Available at: https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-1-2017.pdf

[18] Vestal, C. (2015, April 1). *How severe is the shortage of substance abuse specialists?* Retrieved February 05, 2018, from http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/4/01/how-severe-is-the-shortage-of-substance-abuse-specialists

[19] The percentage of adults in poverty with an SUD is based on ABODILAL (Illicit Drug or Alcohol Dependence in Past Year) x Poverty Cross-tabulation, National Survey on Drug Use and Health, 2014. The percentage was applied to the estimated number of adults in poverty in Texas. Poverty estimates are based off the American Community Survey 2015 poverty proportions, applied to the Texas Demographic Center's 2016 population estimates.

[20] The percentage of youth in poverty with an SUD is based on ABODILAL (Illicit Drug or Alcohol Dependence in Past Year) x Poverty Cross-tabulation, National Survey on Drug Use and Health, 2014. The percentage was applied to the estimated number of youth in poverty in Texas. Poverty estimates are based off the American Community Survey 2015 poverty proportions applied to the Texas Demographic Center's 2016 population estimates.