Substance Use Disorder and Mental Health Diagnoses among Medicaid-Enrolled Youth before the Pandemic

Findings from New Mexico

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Key Takeaways

- Medicaid is the largest single funder of health services for youth—about two-fifths of adolescents and one-quarter of young adults in the United States are enrolled in Medicaid, and behavioral health–related services are a critical need. However, little detail exists on youth behavioral health conditions—specifically substance use disorders (SUDs) or mental health conditions—at the state, county, or city level.
- We find that close to one in four (about 44,000) youth Medicaid enrollees in New Mexico had a SUD or mental health diagnosis in 2018, corroborating findings of substantial issues with behavioral health conditions even before the COVID-19 pandemic.
- We find that the extent and types of behavioral health diagnoses varied across geographic areas and demographic categories within New Mexico, pointing to the importance of having community stakeholders, including youth, help shape culturally effective approaches to prevention and treatment.
- That about half of New Mexico youth enrollees with a SUD and about one in three with only a mental health diagnosis (no SUD) had at least one emergency department (ED) visit suggests EDs may be an important place to identify and intervene for youth currently experiencing or at risk of experiencing behavioral health conditions.
- Most New Mexico adolescent enrollees with behavioral health conditions did not get Medicaid-paid health services in schools during the year, indicating New Mexico schools may need to substantially scale up and/or introduce new services if they get new funds to provide behavioral health services.

- Pursuing strategies that would equitably strengthen individuals, families, and communities and expand outreach about and access to high-quality prevention and treatment of behavioral health conditions could have long-term implications for New Mexico youth experiencing behavioral health disorders and promote overall youth well-being—an imperative that has become even more critical because of the pandemic.

Introduction

It is well known that there is an ongoing crisis in youth behavioral health in the US and that the COVID-19 pandemic has exacerbated the crisis (see accompanying report *Substance Use Disorder and Mental Health Diagnoses among Medicaid-Enrolled Youth before the Pandemic: Summary of Findings from Four States and the District of Columbia*). However, little detail exists on youth behavioral health conditions at the state, county, or city level. Because the prevalence and type of SUD and mental health condition vary over time, place, and populations (Mokdad et al. 2016; Substance Abuse and Mental Health Services Administration 2020, Miech et al. 2023), providing communities with information about prevalence and characteristics of youth with behavioral health issues that is as specific to their communities as possible is a critical component of shaping the most appropriate responses. Given the impact of pandemic mitigation on young people and people with low incomes, and the fact that Medicaid is the largest single funder of behavioral health services for youth, it also important to disseminate information about the prevalence and characteristics of youth with behavioral health conditions insured by Medicaid from before, during, and after the pandemic. This information can help stakeholders better assess how these issues are evolving in their states and communities and design responsive policy.

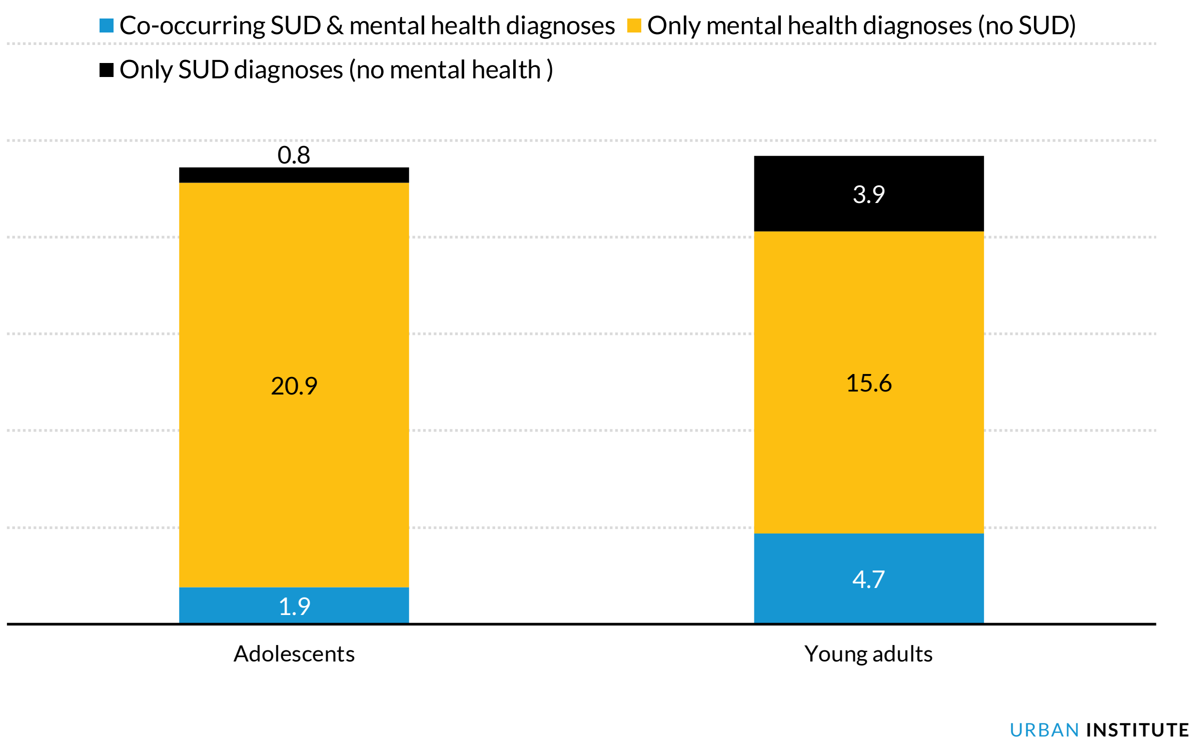
In this brief, we provide descriptive statistics to show the prevalence of behavioral health diagnoses among New Mexico Medicaid-enrolled youth and characteristics of youth with these diagnoses before the pandemic. We focus on Medicaid-enrolled adolescents (ages 12 to 18) and young adults (ages 19 to 25), hereafter "youth." Medicaid is the largest single funder of health services for youth—about two-fifths of adolescents and one-quarter of young adults in the United States are enrolled in Medicaid—and many states are innovating their Medicaid programs to improve behavioral health–related services, including services tailored to youth (National Academies of Sciences, Engineering, and Medicine et al. 2022).[1] We focus on youth with a behavioral health diagnosis because we rely on Medicaid claims data and can only see those youth with a behavioral health condition who have a record indicating they have a behavioral health diagnosis. We provide estimates of the characteristics of enrolled youth with co-occurring diagnoses of SUD and a mental health condition, a SUD diagnosis only (and no mental health condition), a mental health condition diagnosis only (and no SUD), and no SUD or mental health diagnosis. We primarily compare youth with SUD and mental health diagnoses with youth with neither diagnosis. For additional detail on our motivation see our brief summarizing findings for California, Colorado, Massachusetts, New Mexico, and Washington, DC (Lynch and Clemans-Cope 2023). For additional detail on our methods, including the limitations of our data and analysis, see our methodology appendix (Lynch and Edwards 2023).

Results

Close to one in four adolescent (23.6 percent) and young adult (24.2 percent) Medicaid enrollees in New Mexico had a SUD or mental health diagnosis in 2018 (figure 1), representing nearly 44,000 New Mexico youth enrollees. This excludes the likely substantial number of enrolled youth with an undiagnosed SUD or mental health condition, who, for example, did not get health care, were not asked about behavioral health, or did not report symptoms (Barocas et al. 2018; Garnick et al. 2019).

FIGURE 1

Share of Adolescent and Young Adult New Mexico Medicaid Enrollees with Either a SUD or Mental Health Diagnosis Alone or Co-occurring SUD and Mental Health Diagnoses, 2018



Source: New Mexico Transformed Medicaid Statistical Information System data from 2018.
Note: SUD = substance use disorder.

Though adolescent and young adult enrollees had similar levels of any behavioral health diagnoses, young adults were more likely than adolescents to have a SUD diagnosis and less likely to only have a mental health diagnosis (i.e., without SUD). However, mental health diagnoses without SUD were substantially more prevalent than SUD diagnoses (either alone or co-occurring) among both young adults (15.6 versus 8.6 percent) and adolescents (20.9 versus 2.7 percent).

SUD Diagnoses and No Mental Health Diagnoses

Among Medicaid-enrolled youth in New Mexico, those with SUD diagnoses only were older and more likely to be male than youth with no SUD or mental health diagnoses (table 1). Adolescents and young adults with only SUD diagnoses were more likely to identify as American Indian or Alaska Native than youth with no SUD or mental health diagnoses. Adolescents with only SUD diagnoses were more likely to reside in McKinley, San Juan, Sandoval, or Valencia counties and rural or small-town commuting areas than were adolescents with no SUD or mental health diagnoses. In contrast, young adults with only SUD diagnoses were more likely to reside in San Juan or Santa Fe counties and metropolitan commuting areas.

TABLE 1

Demographic Characteristics of Medicaid-Enrolled Adolescents and Young Adults in New Mexico, by Behavioral Health Diagnoses, 2018

Percent of Study Population

	Adolescents				Young Adults			
	Co-occurring SUD and mental health n=2,128	**Mental health only n=23,758**	**SUD only n=858**	**No SUD or mental health n=86,803**	**Co-occurring SUD and mental health n=3,328**	**Mental health only n=11,113**	**SUD only n=2,773**	**No SUD or mental health n=54,130**
Age								
12	2.0	15.4	1.5	16.6				
13	5.3	15.5	4.7	15.3				
14	10.2	15.1	9.0	14.6				
15	15.0	14.9	14.7	13.9				
16	22.5	14.7	18.9	13.7				
17	23.9	13.1	24.8	13.2				
18	21.1	11.4	26.5	12.7				
19					5.3	15.5	4.7	15.3
20					10.2	15.1	9.0	14.6
21					15.0	14.9	14.7	13.9
22					22.5	14.7	18.9	13.7
23					23.9	13.1	24.8	13.2
24					21.1	11.4	26.5	12.7
25					20.4	13.6	22.5	13.1
Sex								
Female	46.0	48.6	37.2	49.7	50.3	63.9	48.3	57.2
Male	54.0	51.4	62.8	50.3	49.7	36.1	51.8	42.8
Race/ethnicity								
American Indian/Alaska Native	18.3	12.9	31.4	16.3	13.9	8.7	22.5	16.9
Asian	n.s.	0.4	n.s.	0.7	n.s.	0.6	n.s.	0.9
Black/African American	3.0	2.2	1.5	1.9	2.5	2.7	2.0	2.6
Hispanic	52.8	54.5	54.6	64.1	53.5	51.1	56.8	58.1

	Adolescents				Young Adults			
	Co-occurring SUD and mental health n=2,128	**Mental health only n=23,758**	**SUD only n=858**	**No SUD or mental health n=86,803**	**Co-occurring SUD and mental health n=3,328**	**Mental health only n=11,113**	**SUD only n=2,773**	**No SUD or mental health n=54,130**
Native Hawaiian/ Pacific Islander	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.
White	24.9	29.0	12.0	16.4	28.9	34.8	17.9	20.4
Multiracial	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.
Missing	0.8	1.1	n.s.	0.6	0.9	2.0	0.5	1.2
Disability								
Yes	8.4	12.5	2.1	1.3	8.4	12.5	2.7	2.9
County								
Bernalillo	25.9	28.7	19.1	27.1	26.5	30.7	26.6	26.9
Chaves	3.7	3.5	3.5	3.8	2.8	3.7	1.6	3.2
Dona Ana	10.5	14.0	10.3	13.1	10.7	15.2	8.1	14.8
Lea	2.4	3.2	2.3	3.7	1.9	3.1	1.7	3.2
McKinley	5.6	3.8	11.5	5.7	3.1	2.6	5.1	5.4
Otero	3.1	2.7	2.1	2.2	2.8	2.8	2.1	2.3
San Juan	8.8	6.1	13.6	7.1	5.7	4.7	9.9	6.7
Sandoval	8.2	6.9	7.2	6.3	4.4	5.4	4.8	5.0
Santa Fe	6.2	5.9	4.2	5.5	13.9	7.2	15.6	7.7
Valencia	3.5	4.3	4.4	4.0	3.7	4.3	3.7	3.6
Less populous counties	22.1	20.9	21.7	21.5	24.3	20.4	20.9	21.2
Missing	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.
Rural-urban commuting area								
Metropolitan	63.3	66.6	55.2	63.4	67.3	68.3	70.9	64.7
Micropolitan	24.2	21.8	22.6	23.0	21.5	21.6	15.7	22.5
Small town	7.0	6.3	11.3	6.6	6.9	6.3	7.2	6.3
Rural	5.3F	5.3	10.7	6.9	4.2	3.8	6.1	6.4
Missing	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.

Source: Authors' estimates derived from the 2018 New Mexico Transformed Medicaid Statistical Information System Analytic Files.

Notes: SUD = substance use disorder. n.s. = data not shown; we suppressed statistics in cells that relied on fewer than 11 cases, per guidance from the Centers for Medicare and Medicaid Services. Blank cells indicate the column heading does not apply.

Female youth with only a SUD were substantially more likely to be pregnant or recently pregnant than those with no SUD or mental health diagnoses. Among youth with only a SUD, roughly 4 in 10 young adults and 14.1 percent of adolescents were pregnant or recently pregnant, compared with 20.2 percent of young adults and 1.9 percent of adolescents with no SUD or mental health diagnoses (table 2).

Marijuana use disorder was the most prevalent diagnosed SUD among adolescents with a SUD only, with roughly 6 in 10 (59.0 percent) having a marijuana use disorder diagnosis (table 2). Roughly one in three adolescents (33.9 percent) and young adults (35.9 percent) with only a SUD had an alcohol use disorder diagnosis. Among youth with only a SUD, other psychostimulants and opioid use disorder were more prevalent among young adults (15.2 percent and 33.2 percent) than adolescents (3.5 percent and 3.6 percent).

TABLE 2

Types of Substance Use Disorder and Mental Health Diagnoses among Medicaid-Enrolled Adolescents and Young Adults in New Mexico, by Behavioral Health Diagnoses, 2018

Percent of Study Population

	Adolescents				Young Adults			
	Co-occurring SUD and mental health n=2,128	Mental health only n=23,758	SUD only n=858	No SUD or mental health n=86,803	Co-occurring SUD and mental health n=3,328	Mental health only n=11,113	SUD only n=2,773	No SUD or mental health n=54,130
Pregnancy/ recent birth among females								
Yes	8.7	2.0	14.1	1.9	25.9	19.2	38.8	20.2
Type of SUD diagnosis								
Alcohol	26.3		33.9		33.7		35.9	
Cocaine	3.5		3.0		6.6		3.5	
Marijuana	67.6		59.0		34.6		22.2	
Opioid	6.6		3.6		32.2		33.2	
Tobacco	3.9	0.5	2.1	0.4	17.9	1.8	8.5	0.6
Other psychostimulant	10.7		3.5		29.4		15.2	
Other specified SUD	9.6		4.2		7.8		2.1	
Unspecified SUD	n.s.		n.s.		3.1		3.1	
Type of mental health diagnosis								
Anxiety	59.3	41.1			70.0	61.6		
Bipolar	31.4	10.8			25.2	13.1		
Depressive	61.4	33.4			49.6	41.0		
Personality	10.1	5.0			7.6	6.0		
Posttraumatic stress	31.3	13.3			34.3	20.4		
Psychotic	17.9	4.1			18.9	5.2		
Suicidality	33.4	7.2			24.6	4.7		
Autism	1.5	6.0			0.8	4.9		
Conduct	48.5	31.6			13.3	11.1		
Development	3.2	6.6			0.6	2.2		
Intellectual	1.4	2.8			1.3	5.9		
Learning	7.0	26.1			0.9	5.0		
Other	12.5	11.1			10.1	9.2		

Source: Authors' estimates derived from the 2018 New Mexico Transformed Medicaid Statistical Information System Analytic Files.

Notes: SUD = substance use disorder. n.s. = data not shown; we suppressed statistics in cells that relied on fewer than 11 cases, per guidance from the Centers for Medicare and Medicaid Services. Blank cells indicate the column heading does not apply.

Among youth with only a SUD diagnosis, the ED was a common setting for receiving care, with 48.0 percent of adolescents and 49.1 percent of young adults having at least one ED visit (table 3). By comparison, among youth with no SUD or mental health diagnoses, 17.4 percent of adolescents and 22.0 percent of young adults had at least one ED visit. The share of youth with office-based care was also high among those with only a SUD diagnosis (80.5 percent among adolescents and 74.6 percent among young adults). The share of youth with inpatient hospital care was relatively high among those with only a SUD diagnosis (9.8 percent among adolescents and 24.7 percent among young adults) compared with youth with no behavioral health diagnosis (1.8 percent among adolescents and 8.6 percent among young adults). Medicaid-paid school-based care was rare among adolescents with only a SUD diagnosis (3.0 percent) and even rarer among young adults with only a SUD diagnosis (too rare to report). We observe little care at SUD treatment centers and suspect that methadone maintenance may not be recorded as nonresidential SUD treatment. Telehealth was also rare among these youth.

TABLE 3

Setting of Health Care Services Received by Adolescent and Young Adult New Mexico Medicaid Enrollees, by Behavioral Health Diagnoses, 2018

Percent of Study Population

	Adolescents				Young Adults			
	Co-occurring SUD and mental health n=2,128	Mental health only n=23,758	SUD only n=858	No SUD or mental health n=86,803	Co-occurring SUD and mental health n=3,328	Mental health only n=11,113	SUD only n=2,773	No SUD or mental health n=54,130
Clinic	4.7	4.3	2.2	3.7	5.1	3.4	3.6	2.4
Community mental health	7.5	2.5	1.6	0.1	6.1	2.5	0.6	n.s.
Emergency department	60.2	29.5	48.0	17.4	58.3	37.8	49.1	22.0
Inpatient	27.9	6.7	9.8	1.8	39.5	14.0	24.7	8.6
Laboratory	28.7	13.9	13.4	6.7	30.0	27.9	24.2	14.6
Mobile van	n.s.	0.4	n.s.	0.3	0.5	n.s.	n.s.	n.s.
Nonresidential SUD treatment center	n.s.	n.s.	n.s.	n.s.	1.9	n.s.	3.4	n.s.
Office	91.8	92.8	80.5	81.9	82.7	89.5	74.6	60.0
Outpatient hospital	37.2	27.3	24.2	14.8	46.8	38.8	35.4	19.4
Psychiatric hospital	30.3	5.5	1.8	0.1	13.6	3.4	0.7	n.s.
Residential SUD treatment center	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.	n.s.
Rural health clinic	n.s.	0.2	n.s.	0.1	n.s.	0.3	n.s.	0.1
School	14.5	35.3	3.0	2.5	0.6	4.9	n.s.	0.3
Telehealth	2.6	1.5	n.s.	0.0	2.0	1.6	n.s.	0.0
Urgent care center	18.1	15.6	14.2	12.2	16.6	18.7	13.3	11.7

Source: Author's estimates derived from the 2018 New Mexico Transformed Medicaid Statistical Information System Analytic Files.

Notes: SUD = substance use disorder. n.s. = no data; we suppressed statistics in cells that relied on fewer than 11 cases, per guidance from the Centers for Medicare and Medicaid Services.

Mental Health Diagnoses and No SUD Diagnoses

The demographic characteristics of youth with mental health diagnoses only (and no SUD diagnoses) were generally similar to the characteristics of youth with no SUD or mental health diagnoses (table 1). However, youth with mental health diagnoses only were more likely to identify as White than were youth with no SUD or mental health diagnoses. In addition, differences between these groups were substantial by disability status: 12.5 percent of adolescents and young adults with mental health diagnoses only experienced disability compared with 1.3 percent of adolescents and 2.9 percent of young adults with no SUD or mental health diagnoses. This may stem in part from some mental health conditions being reported as a functional limitation or being the condition that qualifies an individual for disability-based Medicaid eligibility.

Among adolescents with mental health diagnoses only, anxiety disorders (41.1 percent), depressive disorders (33.4 percent), conduct disorders (31.6 percent), and learning disorders (26.1 percent) were the most prevalent diagnoses (table 2). Their rate of diagnosed suicidality (7.2 percent) was also notable, involving more than 1,700 adolescent enrollees in this group in 2018. For young adults with mental health diagnoses only, anxiety disorders (61.6 percent), depressive disorders (41.0 percent), and posttraumatic stress disorders (20.4 percent) were the most prevalent diagnoses.

Youth with mental health diagnoses only were substantially more likely to receive care in the ED (29.5 percent of adolescents and 37.8 percent of young adults) than youth with no SUD or mental health diagnoses (17.4 percent of adolescents and 22.0 percent of young adults; table 3). However, youth with mental health diagnoses only were substantially more likely to have an office visit than an ED visit. School-based care was not highly prevalent but was more prevalent among adolescents with a mental health diagnosis only (35.3 percent) than among adolescents with only a SUD diagnosis (3.0 percent) or no SUD or mental health diagnoses (2.5 percent). Telehealth was rare.

Co-occurring SUD and Mental Health Diagnoses

Youth with co-occurring SUD and mental health diagnoses were similar to those with only SUD in a number of ways:

- They were more likely to be older and male when compared with youth with no behavioral health diagnoses (table 1).
- Female youth with co-occurring diagnoses were more likely to be pregnant or recently pregnant than those with no SUD or mental health diagnoses (e.g., 8.7 percent of adolescents with co-occurring diagnoses versus 1.9 percent of adolescents with no behavioral health diagnoses; table 2).
- Marijuana use disorder was by far the most prevalent SUD among youth with co-occurring conditions (table 2).

Youth with co-occurring diagnoses generally had higher or similar rates of SUD as youth with only a SUD (excepting alcohol use disorder among adolescents and young adults and opioid use disorder among young adults; table 2). Similarly, youth with co-occurring diagnoses generally had higher rates of the mental health diagnoses we studied than did youth with only a mental health condition (exceptions included learning disorders among adolescents and intellectual disorders among young adults). Among adolescents with co-occurring diagnoses, depressive disorders (61.4 percent), anxiety disorders (59.3 percent), and conduct disorders (48.5 percent) were the most prevalent mental health diagnoses. These adolescents also had a high rate of diagnosed suicidality (33.4 percent), representing more than 700 adolescents. Among young adults with co-occurring diagnoses, anxiety disorders (70.0 percent), depressive disorders (49.6 percent), and posttraumatic stress disorders (34.3 percent) were the most prevalent mental health diagnoses. Suicidality (24.6 percent) was also substantial and involved more than 800 young adults with co-occurring diagnoses.

Adolescents and young adults with co-occurring diagnoses were also more likely to experience a disability (8.4 percent among both adolescents and young adults; table 1) than adolescents and young adults with only a SUD (2.1 and 2.7 percent) or no SUD or mental health diagnoses (1.3 and 2.9 percent).

A large majority of youth with co-occurring diagnoses had at least one ED visit and one office-based visit (table 3). Fewer than one in five (14.5 percent) adolescents with co-occurring diagnoses received care in a school setting. Inpatient hospital care was prevalent (27.9 percent among adolescents and 39.5 percent among young adults), as was inpatient psychiatric care for adolescents (30.3 percent and 13.6 percent among young adults). Few youth with co-occurring diagnoses were recorded with care at a SUD treatment center. Only about 2 percent of youth with co-occurring diagnoses had telehealth services.

Discussion

We find that about one in four (about 44,000) youth Medicaid enrollees in New Mexico had a SUD or mental health diagnosis in 2018. This corroborates findings of substantial issues with behavioral health conditions even before the pandemic and underscores the urgent need to increase behavioral health prevention and treatment services and attend to systemic drivers of youth well-being.

Systemic drivers of youth well-being are not fully understood, but experts generally agree that social connectedness and well families and communities are important factors (National Academies of Sciences, Engineering, and Medicine et al. 2022). Policies and programs that invest in families and communities have been found to have longer-term effects and to be more cost effective than services provided only to children because they affect a broader population of children and the adults in their lives (Hoagwood et al. 2018). These include programs and policies that address parent needs, support family relationships, and invest in schools and communities (National Academies of Sciences, Engineering, and Medicine et al. 2022).

That large numbers of youth had mood and other mental and substance use disorders suggests many youth were not well situated for the isolation and instability associated with COVID-19 mitigation. School closures during the pandemic may have been especially destabilizing for the adolescent Medicaid enrollees with mental health diagnoses who saw health service providers at school and for the roughly 2,400 adolescent and 1,340 young adult New Mexico enrollees whose conditions were acute enough to be diagnosed with suicidality during the year before the pandemic started (National Academies of Sciences, Engineering, and Medicine et al. 2020).

Geographic and other demographic variation in rates of SUD and mental health diagnoses points to the importance of having community stakeholders, including youth, help shape culturally effective approaches to prevention and treatment. That female enrollees with behavioral health diagnoses were more likely to be pregnant or recently pregnant highlights the importance of access to noncoercive family planning and identification and parent-friendly treatment of behavioral health conditions before, during, and after pregnancy. It also raises questions about (1) the extent to which pregnancy is potentially a unique time when individuals may be more likely to seek care for SUD and/or mental health conditions (Wright et al. 2016) and (2) the extent to which providers may be more likely to seek to identify these conditions during pregnancy.

That majorities of youth with co-occurring SUD and mental health diagnoses and large shares of youth with mental health diagnoses only or SUD diagnoses only had at least one ED visit suggests EDs may be an important place to identify and intervene for youth currently experiencing or at risk of experiencing SUD and mental health conditions and to refer them to and have them begin treatment. EDs in California and elsewhere have innovative initiatives under way focused on adults with opioid use disorder, which can be looked to for examples of ED models for providing recommended behavioral health services (Antezzo and Manz 2022; D'Onofrio et al. 2015; Herring et al. 2021). However, EDs often lack the resources, including staffing, to identify and manage youth with behavioral health issues, and fewer than one in five youth presenting to an ED with a mental health issue see a mental health provider (Hoge et al. 2022; Kalb et al. 2019). That large majorities of youth receive care in other outpatient settings indicates that youth with behavioral health diagnoses can also be reached in other health care settings.

Most New Mexico adolescents with behavioral health conditions did not get services in schools, indicating that New Mexico schools may need to substantially scale and/or introduce new services if they get new funds to provide behavioral health services.

Conclusion

Pursuing strategies that would equitably strengthen individuals, families, and communities and expand outreach about and access to high-quality prevention and treatment of behavioral health conditions could have long-term implications for New Mexico youth experiencing behavioral health disorders and promote overall youth well-being—an imperative that has become even more critical because of the pandemic.

Notes

[1] Xavier Becerra and Miguel A. Cardona, "Key Policy Letters Signed by the Education Secretary or Deputy Secretary," July 29, 2022, https://www2.ed.gov/policy/gen/guid/secletter/220729.html, a joint letter from the secretary of the US Department of Health and Human Services and the secretary of the US Department of Education to governors regarding current and upcoming federal resources to help better support the mental health of students; and Daniel Tsai, "Information on School-Based Services in Medicaid: Funding, Documentation and Expanding Services," August 18, 2022, https://www.medicaid.gov/federal-policy-guidance/downloads/sbscib081820222.pdf.

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