

FINAL REPORT



HEROIN & OPIOID EMERGENCY TASK FORCE

Lieutenant Governor Boyd K. Rutherford, Chair



DECEMBER 1, 2015



Heroin and Opioid Emergency Task Force

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December 1, 2015

Larry Hogan
Governor, State of Maryland
100 State Circle
Annapolis, MD 21401

Dear Governor Hogan:

Thank you for appointing me to chair the Heroin and Opioid Emergency Task Force to address Maryland's growing heroin and opioid crisis. Serving in this role has been an informative and eye-opening experience.

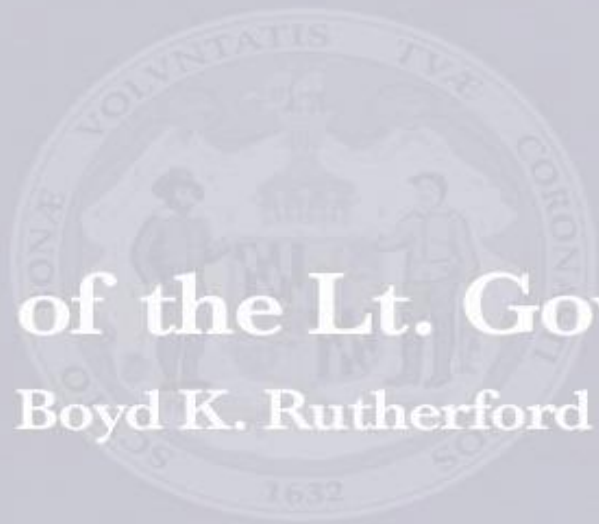
I want to commend you for shining a spotlight on this issue. Many of the concerns our Task Force received from affected Marylanders at the regional summits echo the concerns we heard during our campaign last year. Your decision to bring all of the key stakeholders together to find real solutions showed tremendous leadership. It also engendered a greater understanding of the gravity of this epidemic.

This final report is the culmination of the work of the Task Force, which includes 33 recommendations to tackle this emergency. These recommendations cover a number of areas, ranging from prevention and access to treatment to alternatives to incarceration and enhanced law enforcement.

While this brings the duties of the Task Force to a close, it does not end our State's commitment to finding solutions. Our challenge to combat substance use disorder in Maryland will endure, and I look forward to your continued leadership in this effort.

Sincerely,

Boyd K. Rutherford
Lieutenant Governor, State of Maryland
Chair, Heroin and Opioid Emergency Task Force



Office of the Lt. Governor

Boyd K. Rutherford

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I. EXECUTIVE SUMMARY

On February 24, 2015, Governor Hogan issued Executive Order 01.01.2015.12, which created the Heroin and Opioid Emergency Task Force. The Task Force is composed of 11 members with expertise in addiction treatment, law enforcement, education, and prevention. Lieutenant Governor Boyd K. Rutherford served as the Chair. The Task Force was charged with advising and assisting Governor Hogan in establishing a coordinated statewide and multi-jurisdictional effort to prevent, treat, and significantly reduce heroin and opioid abuse.

Specifically, Governor Hogan ordered the Task Force to provide recommendations for policy, regulations, or legislation to improve access to high quality heroin and opioid addiction treatment and recovery services. In addition, the Task Force was asked to provide recommendations to improve federal, State, and local law enforcement and public health coordination. It also had to provide recommendations to increase public awareness and reduce stigma associated with addiction while equipping parents and educators with tools to prevent youth and adolescent use of heroin and opioids. Lastly, the Task Force was asked to recommend alternatives to incarceration for nonviolent offenders whose crimes are driven primarily by their drug addiction.

This Final Report, in conjunction with the August 2015 Interim Report, completes all of the Task Force's duties. It is divided into seven major sections: Military Department Counterdrug Program Strategy; A Step Toward Treatment on Demand; Task Force Final Recommendations; Recently Approved Resource Allocations; Update on Maryland Medication Assisted Treatment Reentry Programs; Update on Interim Report Preliminary Recommendations; and Update on Interim Report Resource Allocations.

In the Military Department Counterdrug Strategy section, the report provides general background on the Maryland National Guard Counterdrug Program, which primarily focuses on providing law enforcement agencies with military-unique criminal analysis capabilities. In addition, the Guard's Civil Operations program will enhance partnerships with community-based coalitions that share a common goal to deter and prevent the illicit abuse of controlled substances.

In the A Step Toward Treatment on Demand section, the Department of Health and Mental Hygiene, local hospitals, skilled nursing and rehabilitation centers, and law enforcement will be brought together to develop a pilot program that establishes a full continuum of substance use disorder services in a target area, including leveraging excess capacity in various health care facilities to provide additional care, residence, and treatment for individuals with heroin and opioid use disorders.

The Task Force Final Recommendations section details 33 recommendations. Eight recommendations relate to expanding access to treatment; five relate to enhancing quality of care; two relate to boosting overdose prevention efforts; six relate to escalating law enforcement options; six relate

to reentry and alternatives to incarceration; four relate to promoting education tools for youth; parents, and school officials; and two relate to improving State support services.

The Recently Approved Resource Allocations section lists nine recent grants totaling \$608,832, which are administered through the Governor's Office of Crime Control and Prevention. These are aimed at tackling the opioid and heroin crisis.

The Update on Maryland Medication Assisted Treatment Reentry Programs section explains that approximately 304 clients have been evaluated and 61 have been accepted into the various reentry programs. Twenty-one Vivitrol injections have been given in the detention centers and six injections in the community as of November 4, 2015.

The Update on Interim Report Preliminary Recommendations section details the progress of the 10 recommendations from the August 2015 Interim Report, which dealt with improving prevention and education efforts for youth, adolescents, law enforcement and the jail-based population, the quality of care in hospital emergency rooms, highlighting and leveraging faith-based resources, and a public awareness campaign.

The Update on Interim Report Resource Allocations provides details on the implementation of \$2 million released by Governor Hogan for fiscal year 2016 in additional treatment and prevention funding and \$189,000 in Governor's Office of Crime Control and Prevention grant funding to local law enforcement.



II. SYNOPSIS OF FINAL RECOMMENDATIONS

Below are synopses of the Heroin and Opioid Task Force's final recommendations.

EXPANDING ACCESS TO TREATMENT

1. Implementing a Statewide Buprenorphine Access Expansion Plan

The Task Force recommends that the Behavioral Health Administration develop a plan to increase access to buprenorphine, including: a) increasing the number of physicians authorized and willing to prescribe buprenorphine in all regions of the state, and; b) integrating physician buprenorphine services with the publicly funded behavioral health treatment and recovery systems at the local level.

2. Reviewing the Substance Use Disorder Reimbursement Rates Every Three Years

The Task Force recommends that the Department of Health and Mental Hygiene review Medicaid rates for substance use disorder treatment every three years.

3. Expanding Access to Treatment through Payments to Non-Contracting Specialists and to Non-Contracting Nonphysician Specialists

The Task Force recommends legislation to require that the allowed amount an insurance carrier uses to pay benefits to non-contracting providers be no less than 140% of the allowed Medicare amount.

4. Improving Provider Panel Lists

The Task Force recommends legislation to require carriers to provide prospective enrollees with a list of providers for the enrollee's health benefit plan, including names, addresses, specialty areas, and whether each provider is accepting new patients.

SYNOPSIS

- ✓ **Expanding Access to Treatment**
- ✓ **Enhancing Quality of Care**
- ✓ **Boosting Overdose Prevention Efforts**
- ✓ **Escalating Law Enforcement Options**
- ✓ **Reentry and Alternatives to Incarceration**
- ✓ **Promoting Educational Tools to Youth, Parents, and School Officials**
- ✓ **Improving State Support Services**

5. Expanding Access to Training for Certified Peer Recovery Specialists

The Task Force recommends that the Department of Health and Mental Hygiene bring the nationally recognized Connecticut Community for Addiction Recovery trainers to Maryland to provide Connecticut Addiction Recovery coaching modules to enable our trainees to meet Maryland's Certified Peer Recovery Specialist credentialing requirements.

6. Providing Recovery Support Specialists to Assist Pregnant Women with Substance Use Disorders

The Task Force recommends that the Behavioral Health Administration pilot a recovery support specialist program to work with women during pregnancy.

7. Transitioning Inmates to Outpatient Addictions Aftercare and Community Providers

The Task Force recommends that the Department of Public Safety and Correctional Services create a transition process allowing inmates leaving incarceration with known substance use disorders to be engaged with community resource providers (faith-based organizations, peer support, and outpatient treatment programs) prior to release.

8. Incentivizing Colleges and Universities to Start or Expand Collegiate Recovery Programs

The Task Force recommends that the Maryland Higher Education Commission develop strategies to incentivize colleges and universities to create collegiate recovery programs.

ENHANCING QUALITY OF CARE

1. Requiring Mandatory Registration and Querying of the Prescription Drug Monitoring Program

The Task Force recommends legislation to require prescribers and dispensers to register with and use the Prescription Drug Monitoring Program when prescribing or dispensing controlled substances that contain an opioid or a benzodiazepine.

2. Authorizing the Opioid-Associated Disease Prevention and Outreach Program

The Task Force recommends legislation authorizing any Maryland county to establish an Opioid-Associated Disease Prevention and Outreach Program to provide outreach, education, and linkage to treatment services, including the exchange of sterile syringes, to people who inject drugs.

3. Requiring and Publishing Performance Measures on Addiction Treatment Providers

The Task Force recommends that the Department of Health and Mental Hygiene select generally accepted performance measures for addiction treatment providers and begin publishing provider-specific, regional and statewide data on them.

4. Requiring Continuing Professional Education on Opioid Prescribing for the Board of Podiatric Medical Examiners and Board of Nursing and on Opioid Dispensing for the Board of Pharmacy

The Task Force recommends that the Board of Podiatric Medical Examiners and the Board of Nursing require the completion of one credit hour of continuing education related to opioid prescribing similar to that required by the Board of Physicians and the Board of Dental Examiners. In addition, the Board of Pharmacy should require the completion of one credit hour of continuing education related to opioid dispensing.

5. Requiring Drug Monitoring for Medicaid Enrollees Prescribed Certain Opioids Over an Extended Time

The Task Force recommends regulation requiring some form of medication monitoring for Medicaid enrollees who are being prescribed certain opioids for more than 90 days for chronic pain arising from conditions that are not terminal.

BOOSTING OVERDOSE PREVENTION EFFORTS

1. Expanding Online Overdose Education and Naloxone Distribution

The Task Force recommends that the Behavioral Health Administration contract with a Web developer to create an online Overdose Response Program-compliant training module.

2. Implementing a Good Samaritan Law Public Awareness Campaign

The Task Force recommends that the Department of Health and Mental Hygiene, in consultation with the Maryland Chapter of the National Council on Alcohol and Drug Dependence and family advocacy organizations, contract with a professional public relations/marketing organization to develop a comprehensive media campaign, including television, radio and social media, to raise awareness of the Good Samaritan Law in geographic overdose hotspots.

ESCALATING LAW ENFORCEMENT OPTIONS

1. Enacting a Maryland Racketeer Influenced and Corrupt Organization Statute

The Task Force recommends legislation to amend existing Maryland law to better model it after the federal Racketeer Influenced and Corrupt Organization Act (RICO) to aid in the prosecution of, and provide civil penalties for, drug trafficking as part of an ongoing criminal enterprise.

2. Creating a Criminal Penalty for Distribution of Heroin or Fentanyl Resulting in Fatal or Nonfatal Overdose

The Task Force recommends legislation creating a crime for the direct or indirect distribution of heroin or fentanyl, the use of which is a contributing cause in the nonfatal overdose or death of another.

3. Creating a Multi-Jurisdictional Maryland State Police Heroin Investigation Unit

The Task Force recommends the creation of a multi-jurisdictional Maryland State Police Heroin Investigation Unit.

4. Designating HIDTA the Central Repository for Maryland Drug Intelligence

The Task Force recommends that all Maryland State Police heroin and opioid investigative activities be entered into the High Intensity Drug Trafficking Area's (HIDTA) Case Explorer and be designated as the central repository for statewide drug intelligence, and that all allied agencies report their drug intelligence to HIDTA.

5. Enhancing Interdiction of Drug-Laden Parcels

The Task Force recommends that the Maryland State Police negotiate the inclusion of inspectors from various parcel services into existing State Police parcel interdiction units as task force members.

6. Strengthening Counter-Smuggling Efforts in Correctional Facilities

The Task Force recommends that the Department of Public Safety and Correctional Services examine its current Front Entry Search policy and procedures to determine whether they align with national best practices and, if necessary, modify them in order to assist in eliminating the introduction of contraband into all correctional facilities.

REENTRY AND ALTERNATIVES TO INCARCERATION

1. Establishing a Day Reporting Center Pilot Program to Integrate Treatment into Offender Supervision

The Task Force recommends that the Department of Public Safety and Correctional Services and the Governor's Office of Crime Control and Prevention collaborate with the Maryland Judiciary to establish a day reporting center pilot program.

2. Expanding the Segregation Addictions Program in Correctional Facilities

The Task Force recommends the expansion of the Department of Public Safety and Correctional Services Segregation Addiction Program by adding three additional substance use counselors, which would quadruple the current capacity to 88 inmates.

3. Implementing a Swift and Certain Sanctions Grid for Probation and Parole

The Task Force recommends legislation developing a swift and certain sanctions grid for nonviolent offenders released on probation and parole whose offenses relate to their substance use disorder.

4. Institutionalizing a Substance Use Goal into the Maryland Safe Streets Initiative

The Task Force recommends that the Governor's Office of Crime Control and Prevention incorporate a new goal into Safe Streets that will allow the local Safe Streets coalition to address the issue of violent crime related to drug trafficking, substance use and addiction, with

a focus on heroin and opioids. It also recommends establishing peer recovery specialists within the Safe Streets model.

5. Establishing a Recovery Unit at Correctional Facilities

The Task Force recommends that the Department of Public Safety and Correctional Services establish a pilot Recovery Unit at Eastern Correctional Institution to house offenders who are engaged in drug addiction programs and are invested in recovery.

6. Studying the Collateral Consequences of Maryland Laws and Regulations on Employment of Ex-Offenders

The Task Force recommends that the Governor’s Office of Crime Control and Prevention conduct a study of Maryland laws and regulations that establish a “Collateral Consequence,” particularly unnecessary barriers to employment of ex-offenders.

PROMOTING EDUCATIONAL TOOLS FOR YOUTH, PARENTS, AND SCHOOL OFFICIALS

1. Creating a User-Friendly Educational Campaign on School Websites

The Task Force recommends that the Maryland State Department of Education assist local school boards in the development and promotion of a drug education and information segment on school websites.

2. Training for School Faculty and Staff on Signs of Student Addiction

The Task Force recommends that the Maryland State Department of Education assist school staff, including teachers, school resource officers, coaches, athletic directors, and guidance counselors, to receive training on the disease of addiction and signs that a student is abusing heroin or prescription opioids.

3. Promoting Evidence-Based Prevention Strategies that Develop Refusal Skills

The Task Force recommends that the Maryland State Department of Education promote evidence-based programs to help students resist peer pressure while maintaining self-respect.

4. Support Student-Based Film Festivals on Heroin and Opioid Abuse

The Task Force recommends that the Maryland State Department of Education evaluate the success of student-based film festivals and consider replicating it as a statewide initiative.

IMPROVING STATE SUPPORT SERVICES

1. Implementing Comprehensive Heroin and Opioid Abuse Screening at the Department of Juvenile Services and the Department of Human Resources

The Task Force recommends that the Department of Juvenile Services develop a questionnaire that will be specifically designed to guide Department of Juvenile Services staff in a productive discussion with the youth and parent regarding opiates, including heroin, fentanyl, and prescription opioids, and other drugs. Similarly, the Task Force recommends that the Department

of Human Resources implement a comprehensive screening tool to identify clients and families affected by heroin and opioid use.

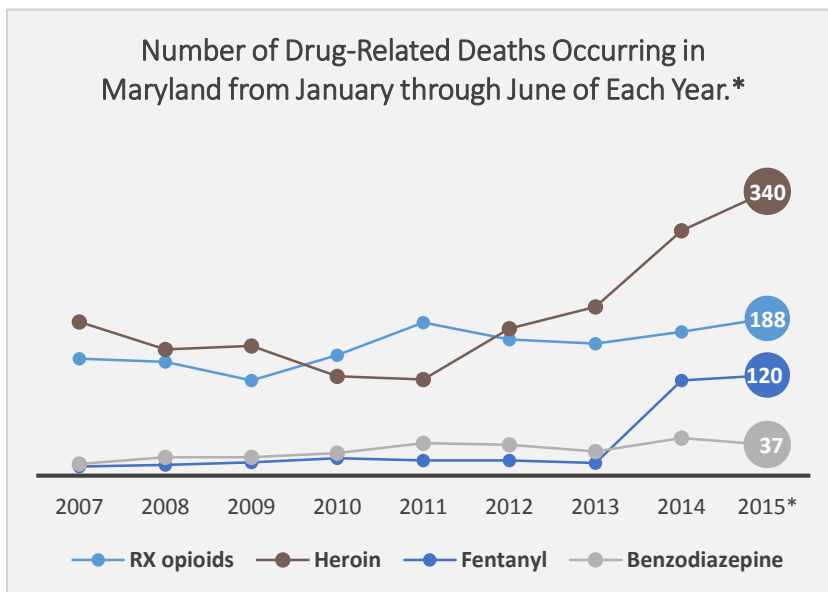
2. Establishing the Maryland Center of Excellence for Prevention and Treatment under the Behavioral Health Advisory Council

The Task Force recommends that a Center of Excellence for Prevention and Treatment be established under the Behavioral Health Advisory Council and housed in an academic setting. The Center would serve as the main body to provide critical oversight, a unifying strategy, and accountability for all prevention and treatment programming across the State. It would also serve as a source of independent information, data analysis, and evaluation of the effectiveness and coordination of prevention and treatment programming in Maryland; and to provide oversight such that programming is fully accountable across all agencies in accordance with metrics, outcome measures, standards of care, and performance evaluation.



III. INTRODUCTION

For the past eight years, Maryland has seen rising rates of drug- and alcohol-related overdose deaths. In 2013, there were 464 heroin overdose deaths versus 387 homicides and 482 motor vehicle fatalities. In 2014, there were 578 heroin overdose deaths versus 421 homicides and 511 motor vehicle fatalities. There has been a 60 percent rise in the total number of fatal drug- and alcohol-related overdoses in Maryland, from 649 deaths in 2010 to 1,039 deaths in



DATA SOURCE: MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
*2015 COUNTS ARE PRELIMINARY

2014. According to the most recently available data, the number of deaths continued to increase in 2015. There were 599 drug- and alcohol-related deaths in the first half of 2015 (January to June), almost double the number of deaths that occurred in the same period in 2010.

The overall rise in the number of drug- and alcohol-related deaths is largely attributable to increases in the number of heroin and fentanyl-related deaths. In 2015, heroin-related overdose deaths increased by 186 percent, from 119 to 340, when comparing the first six months of 2010 to the first six months of 2015; this increase is in stark contrast to the 35 percent decline that occurred during the first six months of 2007 to the first six months of 2010. Data from recent years demonstrates that increases in heroin-related deaths have occurred among all demographic groups and across all regions of the state. Evidence suggests that the rise in heroin-related deaths may, in part, originate from increased prescription opioid misuse, as heroin is a cheaper, more potent, and widely available alternative.

An emerging threat in Maryland is the spike in fentanyl-related overdose deaths. Beginning in late 2013, there were sudden and large increases in the number of deaths involving fentanyl in a number of states, including Maryland. The majority of these deaths were not the result of overdoses of pharmaceutical fentanyl, but instead involved an illicit, powdered form of fentanyl that was mixed with, or substituted for, heroin or other illicit substances. Fentanyl is many times more potent than heroin, and greatly increases the risk of an overdose death.

A total of 120 fentanyl-related deaths occurred in Maryland between January and June 2015. This is an average of 20 deaths per month, compared with an average of two deaths per month in Maryland during the years 2007-2012. Many

“We are now faced with a situation where deaths from heroin overdoses are outpacing the murder rate.”

—Lt. Governor Boyd K. Rutherford

of the fentanyl deaths occurring in Maryland since October 2013 occurred following the use of fentanyl in combination with other substances, mainly heroin. Fentanyl-related deaths also frequently involved the concurrent use of prescription opioids, alcohol, and/or cocaine.

In response, under the direction of Governor Larry Hogan and pursuant to Executive Orders 01.01.2015.12 and 01.01.2015.13, State resources have been devoted to confronting this heroin and opioid epidemic through a comprehensive approach that includes education, treatment, improvements to quality of care, law enforcement, alternatives to incarceration, and overdose prevention. Specifically, over 300 State employees are working on this health crisis in some capacity. In addition, approximately 770 State troopers are trained and equipped with naloxone. Excluding Medicaid expenditures, agencies have spent approximately \$189 million in fiscal year (FY) 2015 and FY 2016 (to date) on combatting the heroin and opioid epidemic. Though Medicaid expenditures to date are imprecise, the total estimated expenditures including Medicaid are approximately \$400 million.

In addition, earlier this year, the Task Force held six regional summits throughout the State to hear testimony from those with substance use disorders, family members, educators, faith leaders, elected officials, law enforcement, addiction treatment professionals, and other stakeholders. An approximate total of 223 people testified before the Task Force—21 elected officials, 31 law enforcement officials, 78 addiction treatment professionals, and 93 members of the general public. In addition, dozens of people submitted written testimony, suggestions, and comments to the Task Force through its Web portal and email address.

Excluding the Task Force members, 431 stakeholders contributed to the production of this Final Report and the 33 recommendations herein. All of the recommendations below are informed by a commitment to a behavioral health system that ensures high-quality, integrated addiction treatment services.



IV. MILITARY DEPARTMENT COUNTERDRUG STRATEGY

The Maryland National Guard, led by Adjutant General Linda L. Singh, is a critical component of the State's efforts in combating the heroin and opioid epidemic. In 2016, the Maryland National Guard Counterdrug Program will primarily focus on providing the State's law enforcement agencies with military-unique criminal analysis capabilities in support of the State's fight against the heroin and opioid epidemic. The Counterdrug Program will assign Criminal Analysts to the following agencies: Maryland Coordination and Analysis Center, W/B HIDTA, U.S. Department of Homeland Security Investigations-Immigration and Customs Enforcement (Division of Money-Laundering Investigation Initiative and Port Group Initiative), Baltimore City Police Department, and the Drug Enforcement Agency Baltimore Office. These Criminal Analysts will analyze and disseminate intelligence products within the law enforcement community in order to enhance their ability to quickly close cases and bring illegal drug traffickers to justice.

A balanced approach to confronting the State's drug threats and vulnerabilities will be obtained by supporting both interdiction and prevention. Civil Operations support will also be provided to coalitions and community organizations. The Civil Operations program targets Maryland's primary drug threats by integrating, enhancing, and building partnerships with community-based coalitions that share a common goal to deter and prevent the illicit abuse of controlled substances. The Program helps coalition partners target emerging drug threats and trends among youths, such as club drugs, designer drugs, and prescription drugs. The Civil Operations plan emphasizes proactive assistance through long-term relationships with supported coalitions and community-based organizations.

This plan focuses on non-duplication of efforts by sharing all common resources devoted to educating children, young adults, and the community at large concerning the dangers of drugs, drug abuse, and drug related crime and violence. Additionally, the intent is to assist communities to reduce bullying and cyber-bullying among youths—a major contributor to substance use and often linked to youth violence and even suicide. Civil Operations takes an active leadership and organizing role in coalition development and the coordination of drug awareness/prevention efforts among various partners within the broader Maryland community. Finally, Civil Operations promotes the readiness of Maryland National Guard forces by promoting drug education and awareness activities within the National Guard community and assisting the G1, Alcohol and Drug Control Officer Prevention Coordinator, Yellow Ribbon Reintegration Program, and Family Support Program.



V. A STEP TOWARD TREATMENT ON DEMAND

There is a growing need across the State for treatment services for individuals with heroin and opioid addiction. Unfortunately, barriers to accessing treatment in a timely manner for some populations remains a significant problem. The key to improving access to high-quality treatment lies in creating a delivery system that provides a full continuum of substance use services and care.

There are health care facilities in Maryland that are well suited to provide the necessary clinical care and support services for individuals on an urgent basis and assist in transitioning patients to the appropriately assessed level of care. Offering crisis services will relieve pressure on hospital acute-care systems. In addition, health care facilities in non-metro counties, where the rate of addiction to heroin and opioids is growing and in-patient treatment is insufficient, could be possible targets for services.

At the request of the Task Force, stakeholders, including the Department of Health and Mental Hygiene, local hospitals, skilled nursing and rehabilitation centers, and law enforcement, will be brought together to develop a pilot program that establishes a full continuum of substance use disorder services in a target area. Unique incentives and new models will be explored, including leveraging excess space in various health care facilities to provide additional care, residence, and treatment for individuals with heroin and opioid use disorders. The pilot program will identify target populations, gaps in the delivery system and support services, and measures to ensure safety for all residents. The greatest challenge, however, will be navigating federal and state regulations, insurance, and Medicaid reimbursement for treatment services.



VI. TASK FORCE FINAL RECOMMENDATIONS

The Task Force final recommendations below are arranged in categories consistent with Executive Order 01.01.2015.12: Expanding Access to Treatment; Enhancing Quality of Care; Boosting Overdose Prevention Efforts; Escalating Law Enforcement Options; Promoting Educational Tools for Youth, Parents, and School Officials; Reentry and Alternatives to Incarceration; and Improving State Support Services.

EXPANDING ACCESS TO TREATMENT

1. Implementing a Statewide Buprenorphine Access Expansion Plan

Buprenorphine is a partial opioid agonist medication with demonstrated efficacy in the treatment of opioid use disorder. The federal Drug Abuse Treatment Act (DATA) of 2000 allows physicians who have completed required training to prescribe buprenorphine medications (most commonly Suboxone) for opioid addiction treatment. Buprenorphine can be prescribed by a physician in an office setting and dispensed by a pharmacy, providing greater flexibility compared to opioid treatment programs, which, under federal regulation, typically require patients to be dosed on-site at a clinic. Maryland has made great strides in expanding access, particularly at the local level through model strategies like the Baltimore Buprenorphine Initiative (BBI). However, there is still a shortage of buprenorphine providers. The Behavioral Health Administration estimates that there are currently less than 800 physicians actively prescribing in the state. Of providers authorized to treat up to 30 patients, less than half of those are active prescribers.

The shortage of providers creates problems for both patients and the treatment system. Opioid addicted individuals who cannot access a provider may seek diverted buprenorphine in an attempt to self-treat. Scarcity creates an incentive for prescribers to run cash-only practices, denying access to those with private insurance and Medicaid. Due to high demand, these practices can expand quickly and become unstable, compromising quality of care. Early access expansion initiatives were successful in bringing on eager early adopters. A new plan development process is needed to understand what gaps and barriers to access remain in different areas of the State and to identify an appropriate strategy to meet the increased demand created by the opioid addiction epidemic.

As such, the Task Force recommends that Behavioral the Health Administration (BHA) develop a plan to increase access to buprenorphine including: a) increasing the number of physicians authorized and willing to prescribe buprenorphine in all regions of the state, and; b) integrating physician buprenorphine services with the publicly-funded behavioral health treatment and recovery systems at the local level. BHA should hire a project coordinator and convene a steering committee of internal and external experts, including individuals involved in development of existing model strategies, to advise plan development. BHA should conduct a

systematic review of buprenorphine initiatives in Maryland and other states, review buprenorphine funding currently provided to local jurisdictions, and analyze data from the Prescription Drug Monitoring Program, Medicaid claims and other sources to detail current prescribing trends.

2. Reviewing the Substance Use Disorder Reimbursement Rates Every Three Years

Despite efforts to provide rate increases for substance use disorder providers to account for the increased cost to deliver care, the State budget has not included a substantial (or adequate) rate increase for over 10 years. Low rates negatively impact the quality of, and access to, treatment services. Furthermore, the gap between reimbursement rates and costs further erodes the workforce shortage in the State.

To attract physicians to the field, the State must offer higher reimbursement. Over the past few years, the mental health workforce has received a cost of living adjustment (COLA) increase while the substance use disorder treatment workforce has not. All this has occurred at a time when practitioners are in higher demand. Payment rates must be reviewed to ensure high-quality services. With this in mind, a commitment to proper reimbursement for substance use disorder treatment providers is common sense.

The Task Force recommends that the Department of Health and Mental Hygiene review Medicaid rates for substance use disorder treatment every three years. With such a review, the State can promote a more thriving workforce and expanded capacity while increasing access to high-quality care.

3. Expanding Access to Treatment through Payments to Non-Contracting Specialists and to Non-Contracting Nonphysician Specialists

In order to address the issue of network adequacy, the Task Force recommends legislation to require that the allowed amount an insurance carrier uses to pay benefits to non-contracting providers be not less than 140% of the allowed Medicare amount. This new provision to Insurance Article, Section 15-830 would only apply when the provider network is inadequate, not when the patient voluntarily goes out-of-network for services. This law would give carriers more incentive to contract with providers and will assure members that they get a reasonable benefit when a network provider is not readily available.

4. Improving Provider Panel Lists

There continues to be a large number of complaints regarding the accuracy of the information contained in insurance provider directories. Currently, carriers must update their directories within a specific period but only when they are contacted by the provider with a change to the information. The Task Force recommends legislation requiring carriers to provide prospective enrollees with a list of providers for the enrollee's health benefit plan, including names, addresses, specialty areas, and whether each provider is accepting new patients. The provider panel list is required to be accurate upon publication and annually thereafter. This legislation would protect consumers as they enroll in coverage ensuring that the provider lists are accurate

and provide necessary information to make an informed decision. By providing accurate provider directories, consumers will be able to more easily find behavioral health care providers who are in-network with their insurance carrier.

5. Expanding Access to Training for Certified Peer Recovery Specialists

Maryland's newest behavioral health system workforce members, identified as peer recovery coaches, are individuals in long-term recovery, family members, and allies with lived experience in substance use disorder or mental illness. They provide recovery support services to individuals seeking treatment or long-term recovery help to sustain their recovery. There are approximately 500 peer recovery coaches trained and employed or volunteering throughout Maryland in local health departments, hospitals, treatment centers, community centers, and recovery centers. However, the peer coaches are experiencing challenges with access to the trainings needed to meet Maryland's Certified Peer Recovery Specialist credential, and to enhance their professional development within the workforce.

Therefore, the Task Force recommends that the Department of Health and Mental Hygiene facilitate the travel of individuals who have completed the nationally recognized Connecticut Community for Addiction Recovery (CCAR) trainer of trainers (TOT) modules to Maryland to provide CCAR recovery coaching TOT modules for trainees to meet Maryland's CPRS credentialing requirements. These trainers must also be approved by the Maryland Addiction and Behavioral Health Professionals Certification Board to offer continuing education hours before they can begin to train others in the CCAR Recovery Coach model. These trainings would enhance the State's ability to meet the currently unmet training needs of the peer workforce. It would also enhance the marketability and earning power of individuals in recovery who are often stigmatized or discriminated against because of their past. Each newly trained Maryland peer recovery coach would commit to train at least two other people to become certified peer recovery coaches.

6. Providing Recovery Support Specialists to Assist Pregnant Women with Substance Use Disorders

There are tremendous medical, social, emotional, and financial consequences and costs stemming from pregnant women with substance use disorders. Women are more likely to have multiple co-morbidity (three or more psychiatric diagnoses in addition to substance use disorder) than are men. According to data from the Department of Human Resources, approximately 29,000 cases of substance-exposed newborns were reported between 2013 and 2014. Data from Department of Health and Mental Hygiene shows that 60 percent of the women who engage in the public behavioral health system sought treatment for heroin, oxycodone, or non-prescription methadone. This population of women also had a history of trauma, intimate partner violence, criminal justice involvement, and less involvement with medical professionals,

*Approximately **29,000** cases of substance-exposed newborns were reported between 2013 and 2014*

and late prenatal care. Unfortunately, these women experience greater social stigma than men which tends to keep them isolated and unwilling to seek help.

In response, the Task Force recommends that Behavioral Health Administration pilot a recovery support specialist program to work with women during pregnancy. The recovery support specialist would be stationed within three targeted jurisdictions that have been identified as having the highest rates of prenatal substance use. The recovery support specialist will work with the women to assist them with remaining abstinent during treatment and work with them to ensure compliance with medical appointments, support services, and their treatment. They will also work with treatment staff to support the women if there is a relapse, as well by assisting with placement in higher levels of treatment, if necessary.

7. Transitioning Inmates to Outpatient Addictions Aftercare and Community Providers

An offender's best chance of success upon completion of in-prison treatment services involves pre-release linkages with post treatment services. The establishment of these links prior to an offender's release would produce the best outcomes, primarily reducing recidivism. Beginning with inmates returning to Baltimore City, the Task Force recommends that the Department of Public Safety and Correctional Services create a transition process allowing inmates leaving incarceration with known substance use disorders to be engaged with community resource providers (faith-based organizations, peer support, and outpatient treatment programs) prior to release. All offenders should have made successful application for health insurance and have requisite medical, mental health, and addictions appointments scheduled prior to release.

8. Incentivizing Colleges and Universities to Start or Expand Collegiate Recovery Programs

Too many college campuses are fraught with the opportunity to drink and use drugs. If a student who is in recovery is in such an "abstinence-hostile" environment, it is challenging to say the least. Having a safe meeting place for those in recovery to gather and provide mutual support, along with having safe and "sober" housing where students will not be exposed to alcohol and other drugs, is ideal.

The Task Force recommends that the Maryland Higher Education Commission develop strategies to incentivize colleges and universities to create collegiate recovery programs (CRPs). The CRP

"The goal of this emergency task force is to shine a light on heroin and the havoc it is causing in Maryland. From preventing our kids from using heroin in the first place to increasing and improving access to treatment services for those in recovery, this task force will employ every resource available to take a holistic approach to address this public health emergency."

—Lt. Governor Boyd K. Rutherford

movement began at Brown University in 1977. Rutgers University (1983) also created a school-based recovery support service program. Texas Tech University (1986) evolved the CRP into a fully developed recovery community. A CRP is a supportive environment within the campus culture that reinforces the decision to disengage from addictive behavior. It is designed to provide an educational opportunity alongside recovery support to ensure that students do not have to sacrifice one for the other.

To send an adolescent away to residential treatment only to return to the same environment

(particularly the school environment in which he/she might have used drugs with their friends) is setting them up for failure. CRP's can provide a safe environment for college students, offering alcohol/drug-free activities and the mutual support of others similarly engaged in recovery efforts while rebuilding their lives and their hope for a brighter future through educational advancement. CRPs are not only a place for those in recovery, but also for those seeking recovery.

ENHANCING QUALITY OF CARE

1. Requiring Mandatory Registration and Querying of the Prescription Drug Monitoring Program

Prescription drug monitoring programs (PDMP) are recommended by the American Medical Association and the Centers for Disease Control and Prevention as an important component of a comprehensive strategy to address the opioid addiction and overdose epidemic. The Maryland PDMP was created to assist medical, pharmacy, and public health professionals in the identification and prevention of prescription drug abuse, support law enforcement and regulatory agencies in the identification and investigation of prescription drug diversion. It also promotes balanced use of prescription data that preserves the professional practice of healthcare providers and legitimate patient access to optimal pharmaceutical-assisted care. Healthcare providers may access their patients' PDMP data through Chesapeake Regional Information System for our Patients (CRISP), the state-designated health information exchange (HIE). Maryland's PDMP is unique in the country as having been fully integrated at implementation into a statewide HIE. In addition to PDMP data, CRISP users can access information on patient encounters at all acute care hospitals in Maryland and multiple hospitals in DC and Delaware, laboratory and radiology reports, and other clinical documents. Provider interest in and use of PDMP data has helped drive increases in registration with CRISP and utilization of other CRISP services, providing a major opportunity to expand use of this important clinical tool throughout the state.

Despite consistent increases in user registration and access since implementation, widespread adoption of PDMP use has not occurred thus far. There is no requirement on prescribers or dispensers to access PDMP data before prescribing or dispensing a controlled substance medication. Currently, 33 states have laws or regulations that require healthcare practitioners to either register with the PDMP in order to query data (mandatory registration) and/or to query PDMP data at specific times, such as when first prescribing a controlled substance to a patient (mandatory use). Although the specific requirements of mandatory use laws vary considerably across the country, states that have recently adopted broad use mandates have seen decreases in the number of patients receiving controlled substance prescriptions from multiple providers, an indicator of possible prescription drug misuse, addiction, or diversion. The Department of Health and Mental Hygiene estimates that over 300 individuals in Maryland received controlled substance prescriptions from five or more prescribers during the month of July 2015 alone. Nearly as many received prescriptions from 15 or more prescribers during the first nine months of 2015, with some seeing as many as 40 prescribers during this period.

These numbers indicate potentially large-scale misuse and diversion that could be addressed through consistent prescriber and dispenser use of the PDMP.

Over 300 individuals in Maryland received controlled substance prescriptions from five or more prescribers during the month of July 2015 alone

States that mandate comprehensive PDMP use, such as New York, Ohio, Kentucky, and Tennessee, have experienced decreases in prescribing of commonly abused controlled substances and decreased doctor shopping.¹

Therefore, the Task Force recommends legislation requiring prescribers and dispensers to register with and use the Prescription Drug Monitoring Program when prescribing or dispensing controlled substances that contain an opioid or a benzodiazepine. The legislation should establish a phased implementation approach that starts with mandatory registration and then proceeds to mandatory use. The implementation timeline should conform to DHMH's estimated dates for when the PDMP's information technology and administrative capacity can be enhanced to support increases in provider registration and use, with the goal of implementing a use mandate within 2 years of the legislation's effective date. The legislation may allow the DHMH Secretary to determine specific compliance deadlines in regulations following consultation with the Advisory Board on Prescription Drug Monitoring and other stakeholders. Consideration should be given to tying the registration mandate to initial receipt or renewal of prescriber's State Controlled Dangerous Substance (CDS) permit, which would allow for a rolling registration requirement as practitioners renew their permits on a 2-year schedule.

The use mandate should apply broadly to healthcare providers when prescribing or dispensing a drug to a patient for the first time to treat a specific condition, and then at regular intervals after the initial query should the treatment for the specific condition continue to include prescribing or dispensing medication containing an opioid and/or benzodiazepine. The legislation should also provide exceptions to the use mandate when the PDMP is unavailable for query due to technical problems, in emergency situations where accessing the PDMP would adversely impact a patient's medical condition, and in clinical situations that present a relatively low risk of drug misuse or diversion due to patients seeking drugs from multiple providers, including prescribing and dispensing to patients who are in hospice care, being treated for cancer-related pain or residing in nursing homes and other facilities often served by a single dispenser.

Finally, the legislation should also expand the types of clinical support staff that prescribers can delegate to access PDMP on their behalf to include unlicensed staff like medical assistants and emergency room scribes. Currently, prescribers and dispensers can only delegate access to PDMP data to other licensed healthcare practitioners. This is not consistent with how many healthcare facilities pull patient data for prescriber decision-making and CRISP currently allows unlicensed staff to access non-PDMP clinical data in the Patient Query Portal.

¹ Johns Hopkins Bloomberg School of Public Health, THE PRESCRIPTION OPIOID EPIDEMIC: AN EVIDENCE BASED APPROACH, November 2015.

Robust educational campaigns would accompany introduction of both the registration and use mandate so that affected healthcare professionals are informed about the requirements as well as how to appropriately access and make use of PDMP data in their prescribing and dispensing decision-making. In addition, although the web-based CRISP Patient Query Portal provides a wealth of information, it requires a separate log-in from hospital or ambulatory clinic electronic medical records (EMRs) utilized by most practitioners within the practice setting. Health IT integrations, such as creating a single sign-on (SSO) connection between the CRISP Query Portal and a practitioner's EMR, or displaying PDMP data directly within an EMR, would ease the time and IT burden on clinical providers. Additionally, automating and streamlining the registration process would reduce administrative burden under a registration mandate. Finally, ensuring high data quality is essential to appropriate utilization of the PDMP data by prescribers and dispensers under a mandate, as well as the ability of the Program to resolve in a timely manner the higher volume of data errors sometimes discoverable only by clinical users during access of PDMP data.

2. Authorizing the Opioid-Associated Disease Prevention and Outreach Program

The Task Force recommends legislation authorizing any county in Maryland to establish an Opioid-Associated Disease Prevention and Outreach Program to provide outreach, education, and linkage to treatment services, including the exchange of sterile syringes to people who inject drugs. This recommendation builds on Chapter 251 of the Acts of 1998, which established the Prince George's County AIDS Prevention Sterile Needle and Syringe Exchange Program in Title 24, Subtitle 9 of the Health – General Article. Syringe exchange programs are also authorized in Baltimore City.

This recommendation is timely as Maryland and many other states across the country are looking for evidence-based strategies such as syringe exchange to address opioid addiction, overdose, and related problems. Syringe exchange programs – an evidence-based approach to the reduction of drug overdoses and drug-related health issues such as HIV and Hepatitis C virus – provide free sterile syringes and collect used syringes from people who inject drugs, to reduce transmission of blood-borne pathogens, including HIV, hepatitis B virus, and hepatitis C virus. For example, in response to an outbreak of HIV and hepatitis C (HCV), the Indiana General Assembly passed legislation in 2015 to authorize syringe exchange programs in the state. This Task Force's recommendation builds on conversations that Maryland Department of Health and Mental Hygiene officials have had with Indiana officials to comprehensively address the health of all persons who inject drugs with the goal of preventing deaths, preventing and treating health conditions and complications, providing access and linkage to care, and reducing hospitalizations and medical costs associated with injection drug use.

This proposal, as a structural intervention, also plays an important role in bridging users who are ready for recovery into substance-related treatment by ensuring that patients receive additional services essential to improving their overall health, including linkages to prenatal services, and reduce hospitalizations, medical complications, and costs for these patients and hospitals. Disease prevention and outreach programs also create strategic opportunities to

disseminate Naloxone – a fast-acting medication that interrupts and thwarts an overdose in progress – to people who inject drugs, thus saving lives.

Drug- and alcohol-related intoxication deaths increased dramatically from 2010 (649) through 2014 (1,039), as non-prescription users of prescription opioids have faced increased difficulty acquiring pain medications and have switched to heroin, which is generally more readily

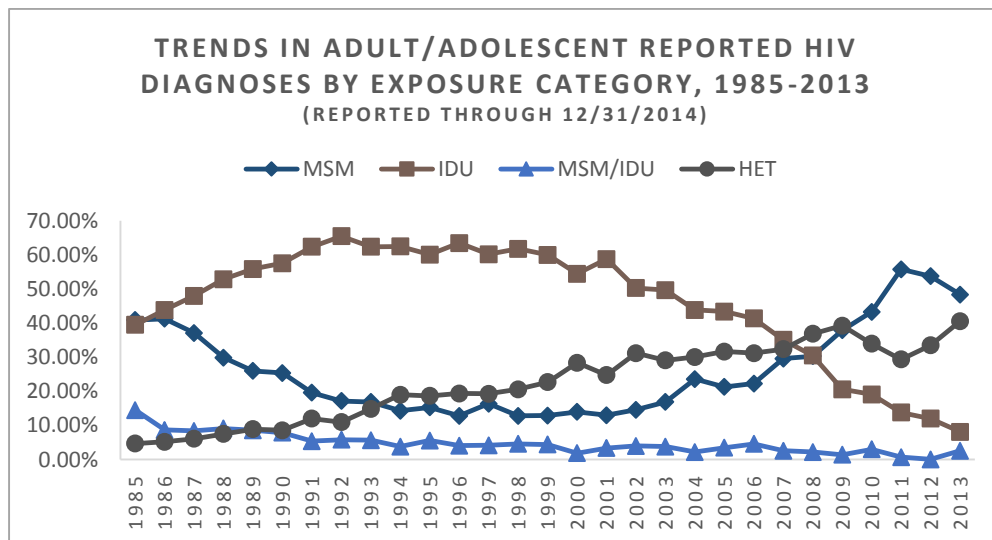
"This is a problem that does not have an easy or overnight solution. This task force will employ every resource available in order to develop a holistic approach to fight this public health emergency."

–Lt. Governor Boyd K. Rutherford

available and less expensive. There was a 25 percent increase in the number of heroin-related deaths between 2013 (464) and 2014 (578), and heroin-related deaths have more than doubled between 2010 (238) and 2014 (578). Whereas injection drug use is widely considered an urban problem, in 2014 heroin use and related overdose deaths occurred in every county in Maryland and in Baltimore City.

There has been an increase in sharing of needles among heroin users, because possession of needles is a crime in all Maryland jurisdictions except for Baltimore City and Prince George’s County. Needle sharing and reuse increases the spread of diseases, including HIV and HCV.

Reduction in HIV transmission among people who inject drugs is one of the success stories of HIV prevention in general, and this success is attributed in large part to sterile syringe access. An examination of HIV prevalence among people who inject drugs worldwide found that on average, the prevalence of HIV infection among people who inject drugs increased by 5.9 percent per year in select cities without syringe exchange programs, and decreased by 5.8 percent per year in select cities with syringe exchange programs. Furthermore, syringe exchange programs are well documented as cost-effective and cost saving for the prevention of HIV. In Maryland, since the launch of Baltimore City Health Department’s (BCHD) Needle Exchange Project, the proportion of new infections attributed to the sharing of injection drug equipment declined from 62.0 percent in 1994 to 11.9 percent in 2011 (see graph below).



Additionally, sterile syringe exchange programs promote the prevention of the spread of HCV infections among people who inject drugs. In developed countries, 50-80 percent of HCV infection occurs in people who have injected drugs, and the prevalence of HCV among people who have injected drugs is approximately 65 percent. In the United States, the rate of new HCV infections has risen, more than doubling from 0.3 cases per 100,000 people in 2010 to 0.7 cases in 2013.

Prevention of HIV and HCV is critical, because these diseases not only lead to loss of life or quality of life, but also require expensive treatment. For example, best-practice treatment of HCV is primed to cost the United States healthcare system an additional \$65 billion dollars in the next 5 years. Sterile syringe exchange, in conjunction with outreach, education, counseling, and linkage to care programs increases access to and initiation of HCV treatment. This is critical in preventing the spread of HCV and the incidence of new HCV infections.

3. Requiring and Publishing Performance Measures on Addiction Treatment Providers

There is a growing body of knowledge about the critical characteristics of successful substance use disorder (SUD) treatment, including patient engagement, quality clinical practices and transitions in care. Access to treatment, for example, is extremely sensitive to delays in intake and first appointment time. Similarly, if patients are not assisted in making transitions in care, dropout rates are high and any benefits of initial interventions are wasted. In spite of this, most providers or systems do not collect and report information on any key performance areas. Performance information is not just important to payers, but also to patients and their families and could inform their selection of types of treatment and specific providers.

The Task Force recommends that the Department of Health and Mental Hygiene select generally accepted performance measures and begin publishing provider-specific, regional and statewide performance data. Priority targets include the following:

- **Initiation and Engagement in Treatment (I&ET):** I&ET shows what percentage of patients who are given a SUD diagnosis actually begin treatment and remain in treatment for 30 days.
- **Treatment completion rates:** While most experts acknowledge that SUD is a remitting and relapsing condition, there are variations in completion rates across providers that relate to the quality of care provided.
- **Continuing care rates:** The State can begin gathering data on the transition from withdrawal management to any treatment. The importance of this transition demands attention if withdrawal management is to have a useful role in the SUD continuum of care.

4. Requiring Continuing Professional Education on Opioid Prescribing for the Board of Podiatric Medical Examiners and Board of Nursing and on Opioid Dispensing for the Board of Pharmacy

Effective for the 2015 license renewal, all Maryland physicians are required to complete one credit hour of continuing medical education dedicated to appropriate opioid prescribing. Similarly, the Board of Dental Examiners required that every dentist seeking license renewal in

2015 and thereafter must complete a 2-hour Board-approved course on proper prescribing and disposal of prescription drugs. However, this education requirement does not apply to podiatrists or nurses, who can also prescribe opioids. As such, the Task Force recommends that the Board of Podiatric Medical Examiners and the Board of Nursing require the completion of one credit hour of continuing education related to opioid prescribing similar to that required by the Board of Physicians and the Board of Dental Examiners.

In addition, while pharmacists do not prescribe opioids, they should have a complete understanding of their role in this epidemic as one of the main providers to dispense opioids. The Task Force also recommends that the Board of Pharmacy require the completion of one credit hour of continuing education related to opioid dispensing.

5. Requiring Drug Monitoring for Medicaid Enrollees Prescribed Certain Opioids Over an Extended Time

Although the Prescription Drug Monitoring Program can alert doctors to certain problems related to doctor shopping, it cannot uncover the patient who only gets his prescription drugs from only one doctor, filled at the same pharmacy, once a month on a regular schedule, but sells for profit or otherwise diverts the pills. According to a study conducted by Ameritox, a provider of medication monitoring services, 48 percent of samples in Maryland contained a drug not prescribed by the doctor who ordered the screen, which is the second worst rate they have found in the country.² Numerous states, including Kentucky, Indiana, Washington, and Georgia, have mandated some form of medication monitoring for those who are being prescribed opioids for the long-term. Medication monitoring is a simple, in-office urine drug test that screens for the prescribed opioid, and other non-prescribed and illicit drugs.

48 percent of samples in Maryland contained a drug not prescribed by the doctor who ordered the screen

The Task Force recommends regulation requiring some form of medication monitoring for Medicaid enrollees who are being prescribed certain opioids for more than 90 days for chronic pain arising from

conditions that are not terminal. Cancer patients would be excluded from these rules. Other exceptions to the requirement may include hardship on the patient in certain cases.

Drug monitoring for Medicaid enrollees could lead to better health outcomes by detecting possible diversion of prescription opioids or the presence of non-prescribed or illicit drugs in urine samples.

² Ameritox tested 16,248 samples, from September 1, 2013 to August 31, 2014, all of which were submitted by doctors and clinics located in Maryland. 7,866 of the 16,248 samples contained a drug that the doctor who sent off the test had not prescribed. 3,249 contained an illicit drug, a category that included marijuana.

BOOSTING OVERDOSE PREVENTION EFFORTS

1. Expanding Online Overdose Education and Naloxone Distribution

Since March 2014, the Department of Health and Mental Hygiene (DHMH) Behavioral Health Administration (BHA) has administered the overdose response program (ORP) to increase online overdose education and naloxone distribution throughout the State. BHA authorizes local-level entities, including local health departments (LHD), community-based organizations, treatment providers and others, to conduct trainings and issue certificates to trainees.

Over **7,000** individuals trained through existing online models

ORP certificate holders are then legally authorized to be prescribed and dispensed naloxone for use on someone believed to be experiencing an opioid overdose.

This decentralized training model has advantages, including: expedited program implementation through utilization of existing funding streams and LHD personnel, flexibility for local jurisdictions, and reduction in State administration costs. However, limitations include uneven online overdose education and naloxone distribution availability statewide and training that is less focused on targeting populations – like drug users and family/friends – who are more likely to witness and respond to an overdose.

A state-level online overdose education and naloxone distribution program – paired with improved pharmacy access – could improve access for Marylanders living in underserved geographic areas and those with other personal or social barriers to accessing existing programs. Existing online training models, including getnaloxonenow.org, has trained over 7,000 people. As such, the Task Force recommends that BHA contract with a web developer to create an online ORP-compliant training module. The training should be interactive and require trainees to demonstrate knowledge of overdose recognition and response in order to obtain a certificate.

As currently required of ORP entities, BHA should track identifying information about trainees. DHMH should identify a staff physician to issue a statewide standing order for dispensing to ORP certificate holders by licensed pharmacists, as authorized by Senate Bill 516 (2015). BHA and the physician will then work together to develop a standing order protocol requiring that pharmacists provide hands-on instruction to certificate holders in how to assemble and use the specific naloxone delivery device. In addition, BHA should develop a process to track naloxone dispensing through the Prescription Drug Monitoring Program. Through ongoing coordination with pharmacies and pharmacy organizations and possible PDMP-based data collection, DHMH will expand dissemination of information on pharmacy naloxone availability.

2. Implementing Good Samaritan Law Public Awareness Campaign

In 2014, the Department of Health and Mental Hygiene initiated the “Be a Hero, Save a Life” campaign to raise awareness of how to recognize opioid overdose, respond with naloxone, and access treatment services through 211. During this past legislative session, Senate Bill 654 expanded “Good Samaritan” protections for those who experience, or seek help for someone

experiencing, an overdose, to include immunity from arrest, charge or prosecution for many drug and alcohol possession crimes, as well as violation of a condition of pre-trial release, probation, or parole.

The Task Force recommends that the Department of Health and Mental Hygiene, in consultation with the Maryland Chapter of the National Council on Alcohol and Drug Dependence (NCADD) and family advocacy organizations, contract with a professional public relations/marketing organization to develop a comprehensive media campaign, including television, radio, and social media, to raise awareness of the Good Samaritan Law in geographic overdose hotspots.

ESCALATING LAW ENFORCEMENT OPTIONS

1. Enacting a Maryland Racketeer Influenced and Corrupt Organization Statute

The In 1970, Congress passed the Racketeer Influenced and Corrupt Organizations (RICO) Act in an effort to combat Mafia groups. Since that time, the law has been expanded and used to go after a variety of organizations, from corrupt police departments to motorcycle gangs. Beginning in 1970, 33 states, as well as Puerto Rico and the US Virgin Islands, adopted state RICO laws to cover additional state offenses under a similar scheme. Maryland is not one of these states.

The benefits of a state RICO law in Maryland would allow local prosecutors to aggregate a series of events and provide a full picture of the type of illegal activity surrounding many drug distribution rings that are present in our communities. Frequently, a drug ring will not only distribute drugs, they will employ violence, break into houses, take over homes, and distribute out of them. In short, they will “lock down” a particular community in order to provide a drug distribution area. For example, a Maryland RICO law would help the State effectively combat drug trafficking where an organization has terrorized certain communities. Here the organization, through violence and financial influence, maintains houses to deal drugs in the community. Focusing on the organization and allowing prosecutors to hold contributing members of the criminal enterprise responsible for the results of the enterprise rather than the small individual acts of the actors is a significantly more powerful tool than prosecuting the single cases, which would otherwise make up the predicate acts, on an individual basis.

Most recently, Federal authorities used RICO to prosecute BGF members for criminal conduct arising inside of the Baltimore City Jail. To fully hold these perpetrators accountable under existing State statutes would have been impossible.

A Maryland RICO law should not be thought of or used as a way to punish the commission of an isolated criminal act. Rather, the law establishes severe consequences for those who engage in a pattern of wrongdoing as a member of a criminal enterprise. RICO requires the prosecution to prove that an “enterprise” (a group consisting of at least three people) committed at least two or more predicate acts (enumerated crimes associated with organized criminal activity) that constitutes a pattern of racketeering activity. Any member of any criminal enterprise can be charged with RICO racketeering if he can be shown to have committed two of 27 federal or eight state charges within a 10-year period as part of the enterprise. A person can be charged

even if that person did not directly commit the crime but only agreed to the commission or conspired with the perpetrators in any way.

While conspiracy laws are generally sufficient to prosecute a simple drug conspiracy, they do not accurately capture the broad array of crimes that are present in many of the street level narcotics operations too small for the federal authorities to touch. Moreover, these street level operations fit more accurately under RICO than they do under the complicated and unwieldy Maryland Gang Statute (which originally was modelled after Federal RICO but was subsequently altered during legislative deliberations into its present form.)

Additionally, RICO statutes provide for broad civil forfeiture remedies as a tool for dismantling criminal enterprises. Following a conviction, the government is automatically given a forfeiture of all of the defendant's interest in the organization. So not only do defendants lose all their money and property that can be traced back to the criminal conduct, but the organization itself can be severely crippled.

Finally, being able to prosecute a group as a whole allows the State to dismantle the entire group at once. This is important because when parts of the organization are taken down piecemeal, as under the current statutory scheme, the leaders that are still in place can recruit replacements and keep the organization running and the drugs and violence flowing. Similarly, in cross-jurisdictional prosecutions (since many of the organizations cross lines) only one dealer can be prosecuted at a time or only the small crime that occurs in the individual jurisdiction. RICO would allow counties to work cooperatively to build a RICO case using those acts to get back at the root of the problem and inhibit the flow of drugs inside the State between counties.

Therefore, Task Force recommends legislation to amend the Maryland Gang Statute to better model it after the federal Racketeer Influenced and Corrupt Organization Act (RICO) to aid in the prosecution of, and provide civil penalties for, drug trafficking as part of an ongoing criminal enterprise.

2. Creating a Criminal Penalty for Distribution of Heroin or Fentanyl Resulting in Fatal or Nonfatal Overdose

While the possession, distribution, and manufacturing of heroin or fentanyl is subject to criminal prosecution, contributing to the cause of fatal or nonfatal overdose of another by distribution of heroin or fentanyl is not a specific crime under State law. As such, the Task Force recommends legislation to create a felony crime for the direct or indirect distribution of heroin or fentanyl, the use of which contributes to the fatal or nonfatal overdose of another. A sentence imposed under the bill must be separate from and consecutive to a sentence for any crime based on the act establishing the violation. The legislation, however, should establish a complete immunity defense for a person if evidence of the crime was solely obtained as a result of the person's seeking, assisting, or providing medical assistance.

3. Creating a Multi-Jurisdictional Maryland State Police Heroin Investigation Unit

The Task Force recommends the creation of a multi-jurisdictional Maryland State Police Heroin Investigation Unit. The activities of this unit would be directed by intelligence gathered from the High Intensity Drug Trafficking Areas program (HIDTA) and the many drug task forces throughout the State. Its efforts would be focused on mid- to upper-level heroin and opioid distribution operations that affect multiple jurisdictions. The unit would be housed in the Criminal Enforcement Division.

Due to the multi-jurisdictional nature of the investigations, involvement of allied department personnel on case-specific investigations might be needed. To reduce the burden placed on the manpower resources of the local allied law enforcement departments, short term or temporary task forces could be established for specific targets, which could be accomplished with statewide authority granted by the Superintendent of State Police. When investigations lead to out-of-state heroin and opioid sources, the unit could temporarily collaborate with or turn investigations over to the appropriate federal law enforcement agency to further investigate.

4. Designating HIDTA the Central Repository for All Maryland Drug Intelligence

Intelligence is essential to combating Maryland's heroin and opioid epidemic. In order to begin to gather the needed intelligence, the Maryland State Police directed that the Criminal Enforcement Division (CED) be notified and respond to all suspected heroin and opioid overdoses reported to the State Police. In an attempt to identify the source of supply, CED Troopers conduct follow up investigations and document the information learned to include cell phone data into the HIDTA Case Explorer and Communications Analysis Portal (i.e. CAP) databases. While this has been beneficial, it only represents a very small portion of Maryland State Police heroin and opioid data.

To increase the amount of intelligence gained, the Task Force recommends that all Maryland State Police heroin and opioid investigative activities be entered into Case Explorer. This should include the activities of the uniformed troopers assigned to the Field Operations Bureau and CED and involve any heroin and opioid related contact, arrest, or debriefing. In order to ensure this effort is working to its maximum potential, the State Police should assign one investigator to serve as a program manager/liaison to HIDTA's statewide heroin and opioid intelligence project. This person would work out of the HIDTA office building in Greenbelt and would be given full access to the HIDTA databases and all State Police heroin and opioid briefings. They would ensure all relevant State Police data is entered into the proper HIDTA database and that drug trends and drug trafficking organization targeting intelligence is pushed back out to the appropriate law enforcement investigators in the field.

HIDTA representatives have indicated their willingness to pass the management of the HIDTA heroin and opioid project over to a Maryland State Police employee who would be given full access to HIDTA databases and office space within their Greenbelt office. In addition, the full support of their analytical staff would be available to the State Police representative identified to fill this role. The representative would be considered a representative of HIDTA, and as such

would have full access to allied agency intelligence, which they could use to reach out to allied agencies to obtain permission to share relevant intelligence on multi-jurisdictional or cross-border heroin and opioid targets.

Finally, to optimize this intelligence gathering process, the Task Force recommends that HIDTA be designated as the central repository for statewide drug intelligence and require all State agencies and encourage local allied law enforcement agencies to report their drug intelligence to HIDTA. Without this requirement and the cooperation of all law enforcement and correctional facilities, some holes will remain in the intelligence product produced. Currently, information collected by some local law enforcement in connection with a heroin or fentanyl overdose and the heroin trafficking organizations that supply the drugs exists only within that agency. Heroin trafficking is not confined within jurisdictions and the strategies to combat it should not be limited either.

5. Enhancing Interdiction of Drug-Laden Parcels

Current intelligence and the experiences of the existing Maryland State Police parcel interdiction units indicates that a large majority of drug trafficking organizations are using various parcel services to ship their drugs throughout the country and State. For example, it is estimated that the U.S. Postal Service holds approximately 80 percent of the drug parcel market in Maryland. Investigation into these parcels would provide a positive benefit toward combating this issue, but the existing State Police parcel units do not get the opportunity to work them or forward them to drug task forces throughout the state. If given the opportunity these investigations would enable State Police parcel units and drug task forces to take more heroin and opioids off the street, while also furthering investigation into the drug trafficking organizations operating throughout Maryland.

As such, the Task Force recommends that the Maryland State Police negotiate the inclusion of inspectors from various parcel services into existing State Police parcel interdiction units as task force members. This solution will allow information to be shared on a daily basis as well as for the resources of the State Police parcel units to be used daily as a force multiplier within the parcel facilities.

6. Strengthening Counter-Smuggling Efforts in Correctional Facilities

The Department of Public Safety and Correctional Services (DPSCS) continues to combat the introduction of contraband and illegal substances into its correctional facilities. Contraband may enter a facility through a variety of means, including an individual physically smuggling contraband into the facility on their person. The Task Force recommends that DPSCS examine their current Front Entry Search policy and procedures to determine whether they align with national best practices and, if necessary, modify them in

“Both the task force and the council allow for increased efforts for a coordinated, statewide effort to help prevent abuse, treat addiction, fight drug trafficking, and reduce non-violent drug-related crime.”

—Governor Larry Hogan

order to assist in eliminating the introduction of contraband into all correctional facilities. DPSCS should also identify ways to impose gradual disciplinary measures against correctional officers whose improper conduct enables the smuggling of contraband and illegal substances.

REENTRY AND ALTERNATIVES TO INCARCERATION

1. Establishing a Day Reporting Center Pilot Program to Integrate Treatment into Offender Supervision

Drug treatment courts are specialized court dockets that target criminal defendants and offenders who have alcohol or drug dependency problems. As opposed to traditional courts, drug treatment courts emphasize a collaborative partnership between the drug court team, led by the judge and the offender. While drug treatment courts are a far less expensive alternative to incarceration, the challenge exists of expanding the reach of drug courts and maintaining costs without weakening their efficacy.

Day reporting centers are non-residential, on-site wrap around services, which can include substance use treatment, cognitive behavioral therapy, employment training, mental health counseling, job readiness and training, and education. To be most effective, these centers should be highly structured and dissuade socialization, especially among offenders of varying risk levels. They can provide a more cost-effective approach to supervising individuals with substance use disorders and be just as, or more, effective at reducing recidivism than substance use treatment alone.

Perhaps most importantly, day reporting centers provide the ability to employ a diversity of approaches to the variety of challenges facing criminal justice involved individuals. Options can include pretrial diversion programming, swift and certain sanctioning approaches to parole or probation, or wrap around services for medication-assisted treatment programs. As such, the Task Force recommends the Department of Public Safety and Correctional Services and the Governor's Office of Crime Control and Prevention collaborate with the Maryland Judiciary to establish a day reporting center pilot program.

2. Expanding the Segregation Addictions Program

The Segregation Addiction Program (SAP) at the Department of Public Safety and Correctional Services (DPSCS) is an American Society of Addiction Medicine and Correctional COMAR Level I outpatient abstinence-based substance use treatment program. The curriculum is based upon Education, Motivational Enhancement Therapy and Cognitive Behavioral Therapy. There are currently 22 total slots for men in this 90-day program housed at the Maryland Correctional Training Center (MCTC). Offenders participate in seminars, individual and group therapy sessions, role-play activities, complete homework assignments, and attend self-help meetings. Offenders participate voluntarily in this program, and eligibility is determined by receiving a substance use related infraction, especially those offenders who have received a positive urinalysis for a contraband substance. Offenders accepted into the program have their segregation time converted to cell restriction and follow a step down process of regaining privileges such as property, commissary, phones, and visits over the 90 days.

The Task Force recommends the expansion of this program to try to meet demand. For example, during June 2015, there were 85 possible candidates at MCTC alone and only 11 available slots. The Task Force recommends adding three additional substance use counselors, which would quadruple the current capacity to 88 inmates. Expanding access to treatment would allow DPSCS to serve the inmates who need it most, as well as reduce the use of segregation for inmates whose substance use problems are the root cause of disciplinary issues.

3. Implementing a Swift and Certain Sanctions Grid for Probation and Parole

According to data from the Department of Public Safety and Correctional Services, almost 75 percent of parole and mandatory release offenders return to prison for technical violations, and over 40 percent of probation revocations to prison are for technical violations. Those convicted of possession of a controlled substance are the most likely to be revoked for technical violations of community supervision.

Under the swift and certain sanction model, probationers or parolees who violate the conditions of supervision are immediately brought before a judge, hearing officer, or probation/parole administrator who determines a sanction appropriate for the violation committed. In addition

*Almost **75** percent of parole and mandatory release offenders return to prison for technical violations*

to swiftness, the model also entails certainty—violations are likely to be detected, and all detected violations are addressed.

This model of swift and certain sanctions has been employed in a number of states. One study found that the use of swift, certain, and proportional sanctions as part of a drug court program led to lower re-arrest rates. Responding with swift, certain, and proportional sanctions induces behavior change more effectively than delayed, random, and severe sanctions. In addition, research has shown that rewarding pro-social behavior and attitudes (e.g., case plan progress, practicing a new skill, taking initiative, being honest, etc.) encourages offenders to change behavior, attitudes, and reduces violations of supervision.

In Maryland, for offenders on standard parole and probation supervision, there is no system-wide framework for responding to technical violations using swift, certain, and proportional sanctions. Rather, responses vary by region, agent, and supervision type. As such, the Task Force recommends legislation developing a swift and certain sanctions grid for nonviolent offenders released on probation and parole whose offenses relate to their substance use disorder.

4. Institutionalizing a Substance Use Goal into the Maryland Safe Streets Initiative

The Maryland Safe Streets Initiative (Safe Streets) is an offender-based model established to institute collaboration and information sharing across all levels of government to reduce crime. The objective of Safe Streets is violent crime reduction through seamless coordination, consistent interagency collaboration, and information sharing by focusing on the core group of offenders who commit the majority of violent offenses locally.

While the Safe Streets Initiative has contributed to significant violent crime reductions in many of these jurisdictions, more recent violent crime trends have emerged; at least in part due to the heroin and opioid epidemic plaguing the state. The National Institute on Drug Abuse reports that opiate disorder “has a strong and negative effect on the probability of future arrest for a violent crime.”

Due to the link between heroin and opioid use and violent crime, the Task Force recommends that the Governor’s Office of Crime Control and Prevention incorporate a new goal into Safe Streets that will allow the local Safe Streets coalition to leverage appropriate resources to address the issue of violent crime related to drug trafficking, substance use, and addiction, with a focus on heroin and opioids. In addition to increasing the enforcement aspect of Safe Streets to target heroin and opioid trafficking, substance use treatment could also be addressed in a similar manner by leveraging a multijurisdictional approach.

What has made Safe Streets successful in the reduction of violent crime is the collaboration and information sharing of various public safety agencies. This multi-agency approach could be replicated from a treatment perspective, including agencies responsible for reentry services including transitional housing, employment, medical care, substance use or mental health treatment, and counseling. To best provide these services, the Task Force recommends establishing peer recovery specialists within the Safe Streets model. Peer recovery specialists are individuals who are in recovery or have life experiences from any life-altering events or disruption. They have initiated their recovery journey and are willing to assist others who are in the recovery process. The specialists could be referred by the individual probation and parole agents, the local detention center caseworkers, law enforcement, or other stakeholders in the criminal justice system.

By utilizing a new substance use goal, these agencies could serve as a force multiplier to identify and disrupt the source networks of the heroin drug trade, hold these offenders accountable, and prosecute them to the fullest extent of the law.

5. Establishing a Recovery Unit at Correctional Facilities

Currently within the Maryland Department of Corrections, offenders are unable to engage in substance use treatment until they are within two years of their anticipated release dates. However, intrinsic motivation to enter treatment is at its highest during particularly stressful times such as following an arrest or an overdose. Peers often give feedback in ways that the substance user can more readily assimilate. Using peer support and feedback also serves to prepare those incarcerated for using peer support organizations in the community.³ Peer support programs, which utilize offenders serving life sentences as program counselors, such as the TC program at the R.J. Donovan Correctional facility in San Diego, have provided benefits for the offenders in treatment as well as the peer counselors.

³ Substance Abuse and Mental Health Services Administration, TIP 44: SUBSTANCE ABUSE TREATMENT FOR ADULTS IN THE CRIMINAL JUSTICE SYSTEM, 2014.

In an effort to treat the ongoing addiction issues within the prison, the Task Force recommends that the Department of Public Safety and Correctional Services (DPSCS) establish a pilot Recovery Unit at Eastern Correctional Institution (ECI) to house offenders who are engaged in drug programming and are invested in recovery. DPSCS should identify and train offenders with significant incarceration periods to work as peer mentors in this unit. In addition to forging a more positive environment for recovery to occur, the use of peer mentors establishes purpose and meaning in the lives of those working in that capacity.

6. Studying the Collateral Consequences of Maryland Laws and Regulations on Employment of Ex-Offenders

The Task Force recommends that the Governor’s Office of Crime Control and Prevention conduct a study of Maryland laws and regulations that establish a “Collateral Consequence” of a criminal conviction. The study should identify those restrictions that appear overbroad and serve as an unnecessary barrier to employment of ex-offenders. Collateral Consequences are legal restrictions on employment and access to public services of ex-offenders after they have accounted for their crimes. The impact of these collateral consequences is often discussed in the context of offender reentry, but they attach not only to felonies and incarcerated individuals, but also to misdemeanors and individuals who have never been incarcerated. Collateral consequences tend to last indefinitely, long after an individual is fully rehabilitated. While these restrictions are well meaning and some are completely appropriate, several may be excessive.

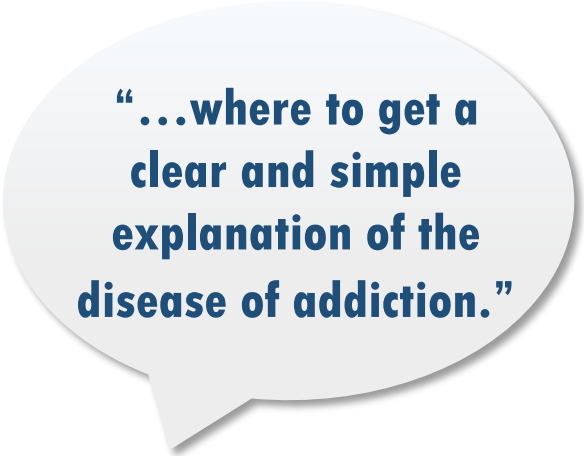
PROMOTING EDUCATIONAL TOOLS FOR YOUTH, PARENTS, AND SCHOOL OFFICIALS

1. Creating a User-Friendly Educational Campaign on School Websites

The mantra of parents throughout the Task Force’s regional summits was “If Only I Had Known”. The Task Force recommends that the Maryland State Department of Education assist local school boards in the development and promotion of a drug education and information segment on school websites. The first part of the campaign would be geared toward parents and caregiver and include:

IF ONLY I HAD KNOWN...

- (1) The physical signs of addiction to all the different drugs;
- (2) The environmental cues of addiction (e.g.: why are some of my spoons missing?);
- (3) Where to get a clear and simple explanation of the disease of addiction;
- (4) At what age and how to talk to my children about drugs;
- (5) Where to look for hidden drugs;
- (6) What the different drugs looked like;



“...where to get a clear and simple explanation of the disease of addiction.”

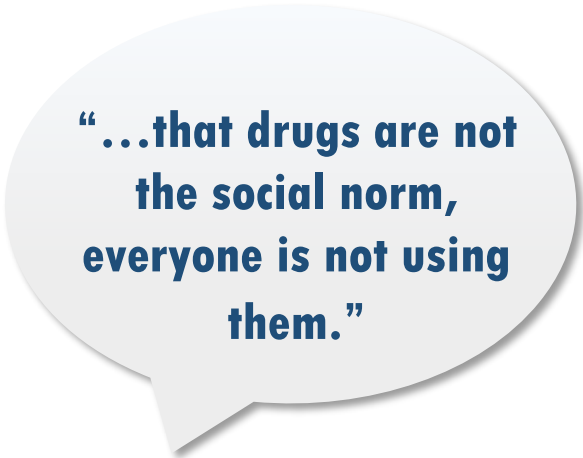
- (7) That I could buy drug tests at the pharmacy; and
- (8) Where to get help in my area.

Most, if not every, public and private schools have a website. They vary in each county, i.e. ED Line in Harford County, Connect ED in Baltimore County and, ParentSchool Power Portal in Cecil County. Parents are constantly accessing these websites for information, checking school activities, lunches, notes from teachers and schedules. A tab labeled “If Only I Had Known Drug Education” will give parents an opportunity to privately view and obtain information on important drugs and addictions. The website will also contain links to SAMSHA, National Institute on Drug Abuse, Foundation for a Drug-free World, and approved interactive websites that educate children, such as BrainTrain4Kids, which teaches children 7 to 9 years old about the brain and the effects of drugs on the brain and body.

Similarly, a school student portal could offer a campaign geared toward adolescents to include:

IF ONLY I HAD KNOWN...

- (1) That I could become addicted to prescription drugs;
- (2) That prescription drugs could lead to heroin;
- (3) That I could become addicted to heroin after using one time;
- (4) What heroin does to the brain and body;
- (5) That heroin would destroy my family;
- (6) How bad the withdrawals are from heroin;
- (7) That heroin is not a drug that can be used recreationally;
- (8) That heroin can be stronger than love; and
- (9) That drugs are not the social norm, everyone is not using them.



“...that drugs are not the social norm, everyone is not using them.”

2. Training for School Faculty and Staff on Signs of Student Addiction

The Task Force recommends that the Maryland State Department of Education assist school staff including teachers, school resource officers, coaches, athletic directors, and guidance counselors receive training on the disease of addiction and signs that a student is abusing heroin or prescription opioids. Schools should require that information about the risks of opioid use and misuse, especially when pertaining to a sports injury, be discussed at athletic events, meetings, back to school nights, and trainings for parents, students, and faculty.

3. Promoting Evidence-Based Prevention Strategies that Develop Refusal Skills

Many prevention approaches focus on helping young people develop the knowledge, attitudes, and skills they need to make good choices or change harmful behaviors. Refusal skills are a set of skills designed to help children avoid participating in high-risk behaviors. Programs designed to deter drug use commonly contain refusal skills in their curricula. The Task Force recommends

that the Maryland State Department of Education promote these programs to help students resist peer pressure while maintaining self-respect. The Substance Abuse and Mental Health Services Administration (SAMHSA) lists programs that are evidence-based, tailored to children and adolescents at all ages that can be used in school settings, including LifeSkills Training, Project ALERT, and the new version D.A.R.E. (Drug Abuse Resistance Education) program, now called Keepin' it REAL.

4. Supporting Student-Based Film Festivals on Heroin and Opioid Abuse

In Frederick County, a public-private partnership has developed around the creation of a student film festival for the 2015-2016 school year. Councilman William Shreve, with the support of Dr. Theresa Alban, the President of the Public School Superintendents Association of Maryland, is leading this project. Students will create 30-60 second videos and send videos for posting on Frederick County Public Schools website by the end of January 2016. The Task Force recommends that the Maryland State Department of Education evaluate the success of this program and consider replicating it as a statewide initiative. The Student Film Festival would then be taken statewide for the 2016-2017 school year. A social norming theme could also be

“Prevention is key. We must shutdown the pipeline of new users!”

—Lt. Governor Boyd K. Rutherford

included in this campaign to help young people understand that using drugs is not the social norm and everyone does not use drugs. The Film Festival could be a Red Carpet event held in Baltimore or Annapolis.

IMPROVING STATE SUPPORT SERVICES

1. Implementing Comprehensive Heroin and Opioid Abuse Assessment and Screening at the Department of Juvenile Services and the Department of Human Resources

Currently, the Department of Juvenile Services (DJS) performs a Maryland Comprehensive Assessment and Service Planning (MCASP) assessment on every youth brought to an intake office. The MCASP screening touches on youth's social and family life as well as other risk factors and prior involvement in the court system. To gather more detailed information about youth who are brought to an intake office, the Task Force recommends that the DJS develop a questionnaire that will be specifically designed to guide DJS staff in a productive discussion with the youth and parent regarding opiates, including heroin, fentanyl, and prescription opioids, and other drugs.

The questionnaire will touch on availability of prescription painkillers and other opiates in the home and history, if any, of abuse. In creating this questionnaire, DJS should seek the expertise of individuals in the field of teenage substance use to develop the questions in order to get the maximum information from the youth and his/her family. Based on the risk factors gathered from the questionnaire, DJS could refer youth and families for appropriate services including substance use counseling and treatment.

Similarly, the Task Force recommends that the Department of Human Resources (DHR) implement a comprehensive screening tool to identify clients and families affected by heroin and opioid

use. An initial screening tool should be applied to all DHR customers, unless the risk of abuse is so obvious no screening need be applied (e.g. Substance Exposed Newborns). This measure will require DHR to update intake procedures across all units. If customers are found to be at risk of heroin or opioid abuse – either individually or in their families - an assessor will apply a more detailed screening tool to verify their abuse or risk of abuse. If the individual or family is verified to be at risk, the assessor will refer them to the appropriate resources that will assist the family’s recovery from the impact of heroin and opioid abuse.

DJS and DHR must make it emphatically clear to their respective clients that the information derived solely from the assessment and screening process will not be shared with law enforcement without a lawful warrant nor will it impact their eligibility for social services.

2. Establishing the Maryland Center of Excellence for Prevention and Treatment under the Behavioral Health Advisory Council

In 2015, the General Assembly passed legislation replacing the Maryland Advisory Council on Mental Hygiene and the State Drug and Alcohol Abuse Council with the Behavioral Health Advisory Council. The advisory council is tasked with promoting and advocating for the enhancement of behavioral health services across the State for individuals who have behavioral health disorders and their family members.

The council must promote and advocate for (1) planning, policy, workforce development, and services to ensure a coordinated, quality system of care that is outcome-guided and integrates prevention, recovery, evidence-based practices, and cost-effective strategies that enhance behavioral health services across the State and (2) a culturally competent and comprehensive approach to publicly funded prevention, early intervention, treatment, and recovery services that support and foster wellness, recovery, resiliency, and health for individuals who have behavioral health disorders and their family members.

“People don’t like to talk about this problem. The consequences of this heroin crisis are not easy or comfortable to acknowledge. Yet we must acknowledge it.”

—Governor Larry Hogan

Because the legislation did not specify a targeted approach for drug prevention and treatment, the Task Force recommends that a Center of Excellence for Prevention and Treatment (MCEPT) be established under the Council, but housed in an academic institution, such as the University of Maryland School of Medicine or Johns Hopkins University School of Medicine. Being housed in academia, MCEPT would be a strong exemplar of an active public-private partnership, with additional outreach and liaison functions with the broader research community and groups within the private sector.

The Center would serve as the main body to provide critical oversight, a unifying strategy, and accountability for all prevention and treatment programming across the State; to serve as a source of independent information, data analysis, and evaluation of the effectiveness and coordination of prevention and treatment programming in Maryland; and to provide oversight

such that programming is fully accountable across all agencies in accordance with metrics, outcome measures, standards of care, and performance evaluation.

The driving force behind the Center would be a high-level board of directors selected by the Governor, in consultation with the Behavioral Health Advisory Council. This multidisciplinary team, representative of the best minds in prevention and treatment academia, research, and public policy, as well as individuals from State agencies, the faith community, and the private sector, would support the Council with oversight power and by developing and implementing meaningful and effective prevention and treatment policies and programs. The overall context of a unifying strategy will seek accountability through progress towards measurable goals, enforcement of metrics, and adherence to standards of excellence in care.

Finally, the Center board of directors would be responsible for producing written products, including an annual report on the status of implementation of substance use-related legislation, as well as white papers and policy recommendations for consideration by the Council.

The Center would address three broad areas of concern:

- 1) Adherence to Standards of Excellence for all Maryland Prevention and Treatment Programming by: a) linking standards of Excellence with a program-rating system to inform and guide consumer choice and b) publishing “Models of Excellence for Prevention and Treatment” targeted to policymakers, program providers, law enforcement personnel, and the private sector community of parents, teachers, and civic groups;
- 2) Support of the Critical Juncture between Maryland’s Criminal Justice and Treatment Systems by: a) improving the efficacy of prevention and treatment programming in the correctional system, including re-entry programming; and b) standardizing practices which achieve both the goals of treatment support and law enforcement, e.g., consultation of the Prescription Drug Monitoring Program (PDMP) by all Maryland opioid treatment providers; and
- 3) Oversight of Programmatic and Fiscal Accountability for Maryland Prevention and Treatment Programming by: a) monitoring the implementation of substance use-related legislation; b) ensuring that evidence-based practices are implemented with fidelity; and c) providing oversight for the evaluation of prevention and treatment programs with the objective of streamlining prevention and treatment services for their highest impact and effectiveness. Oversight of best practices will be ensured by the MPECT since its recommendations will be used by the Governor and Legislature to set budget priorities for prevention and treatment programs and centers.

VII. RECENTLY APPROVED RESOURCE ALLOCATIONS

On October 7, 2015, Lieutenant Governor Boyd K. Rutherford announced the following nine new grants, totaling \$608,832 aimed at tackling the opioid and heroin crisis to be administered through the Governor's Office of Crime Control and Prevention:

1. Allegany County State's Attorney's Office

The Allegany County State's Attorney's Office, Prosecution Partnership Targeting Priority Offenders program, which received \$55,532, will support the Cumberland Safe Streets Program in targeting priority offenders, many of them drug traffickers, who are responsible for much of the crime in the community. The program will fund a dedicated prosecutor for priority offenders as well as provide technical capabilities to target, track, and successfully prosecute those offenders identified as high target offenders.



2. The Family Recovery Program, Inc., Baltimore City

The Family Recovery Program, Inc.'s Parents in Recovery Together project, which received \$100,000, will help Family Recovery Program clients in Baltimore City work with peer recovery advocates to gain support and skills targeting relapse, crime prevention, parenting, and trauma. Peer recovery advocates will be trained in evidence based practices, assist clients in making and maintaining appointments, and accompany clients to meet with partner agencies.

3. Hampstead Police Department, Carroll County

The Hampstead Police Department's Mobile License Plate Reader Technology program in Carroll County, which received \$18,150, is able to scan hundreds of license plates a minute and give law enforcement real time knowledge, a crucial investigative tool in identifying and tracking drug traffickers coming into and through Maryland.

4. The Center for Children, Inc., Charles County

The Center for Children, Inc. in Charles County, which received \$69,000, will run an Adolescent Substance Use Disorder Integration Initiative to provide training for a new co-occurring Department of Health and Mental Hygiene licensed treatment program in Southern Maryland. Funds will be spent on startup personnel, training costs for staff, and initial implementation.

5. Charles County Circuit Court

The Charles County Circuit Court's, Family Recovery Court program, which received \$98,554, is designed to serve parents with a Charles County Circuit Court case where substance use is identified as a barrier preventing them from providing safe, appropriate care for their children. The Family Recovery Court uses a holistic approach to support parents and families with consistent monitoring, intensive treatment, referrals to ancillary services, and the collaborative

“The question, at the end of the day, ... is what is the best approach? Nothing is completely off the table.”

—Lt. Governor Boyd K. Rutherford

efforts of a Drug Court team. Program funds will provide assistance with fees incurred for medication assisted treatment and inpatient treatment for Family Recovery Court participants that are opioid dependent and have prior or current criminal charges.

6. Howard County Department of Corrections

The Howard County Department of Corrections' Targeted Reentry Services program, which received \$49,706, will enhance the County's Transition from Jail to the Community initiative to reduce recidivism by targeting offenders who have been identified as having medium to high risk of reoffending and placing them in programs specific to their assessed risk factors.

7. St. Mary's County Detention Center

The St. Mary's County Detention Center, which received \$52,000, will partner with Walden Sierra to institute a Vivitrol option for opiate addicted individuals participating in treatment and reentry services. The program provides screening and prerelease counseling, transitional case management, post-release behavioral health support, and administration of Vivitrol. To date, the program has screened 27 individuals.

8. Montgomery County Police Department

The Montgomery County Police Department's Heroin Overdose Prevention & Education program, which received \$35,000, offers a comprehensive approach to address the heroin problem by supporting additional personnel time, law enforcement training, and heroin awareness messaging.

9. Somerset County Local Management Board

The Somerset County Local Management Board's, Anti-Gang Enforcement and Strategies Initiative, which received \$130,890, enhances enforcement and prosecution of gang-related

crimes and supports anti-gang community outreach initiatives. Program funds provide personnel, equipment, training, and technology to address the growing presence of gangs and corresponding spikes in drugs and violence.



VIII. UPDATE ON MARYLAND MEDICATION ASSISTED TREATMENT REENTRY PROGRAMS

On June 2, 2015, the Governor's Office of Crime Control and Prevention awarded \$500,000 to programs in local jails and detention centers across Maryland for Medication Assisted Treatment (MAT) reentry programs, specifically the Anne Arundel County Department of Detention Services, Carroll County Health Department, Calvert County Health Department, Cecil County Sheriff's Office

Awarded \$500,000 to programs in local jails and detention centers across Maryland

Law Enforcement Facility, Frederick County Detention Center, Howard County Department of Corrections, Montgomery County Department of Corrections & Rehabilitation, St. Mary's County Detention Center, and Washington

County Detention Center. Inmates who qualify for the program must be housed within county detention centers, be identified as opiate users, and be within three months of release. Uninsured program participants are enrolled in Medicaid immediately upon release in order to pay for the post-release injections.

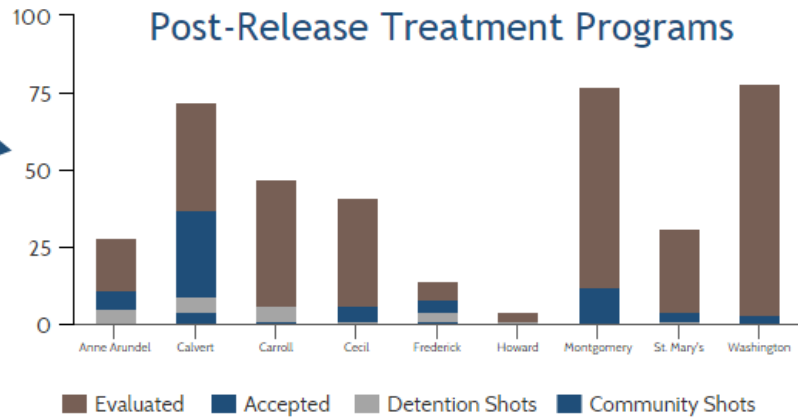
The MAT reentry programs combine drug treatment with extensive behavioral health counseling, wherein selected inmates receive monthly injections of Vivitrol, a non-narcotic and non-addictive substance that blocks the euphoric effects of heroin, other opiates, and alcohol. Vivitrol manufacturer, Alkermes, Inc., has trained county detention center and community health providers on the use of the drug. Alkermes donates the initial dose of Vivitrol, which is administered in the jail or detention center just before inmates are released. Subsequent injections are administered by local health departments, cooperating practitioners in the community, or by the original local detention centers. Unlike opioid-based medications such as methadone or buprenorphine, which require daily administration, Vivitrol is a once-a-month injection.

To ensure the best possible outcomes, comprehensive post-release treatment programs are established for each ex-offender. They include intensive treatment for substance use disorders, and community-based support services such as housing, mental health treatment, education, and employment. Each jurisdiction has developed a program to track and monitor the offenders' post-release progress, program compliance, recidivism, and subsequent substance use.

As of November 4, 2015, approximately 304 clients have been evaluated and 61 accepted into the various programs. Twenty-one injections have been given in the detention centers and six injections in the community, as outlined in the following chart:

As of
November 4, 2015,

approximately 304 clients have been evaluated and 61 accepted into the various programs. 21 shots have been given in the detention centers and 6 shots in the community,



The Governor's Office of Crime Control and Prevention hosts monthly performance review calls and bimonthly program director meetings with the funded agencies to share best practices and emphasize what is being done by high performing agencies. In addition, the Office will host advanced trainings for program directors and administrators to provide a refresher clinical overview and accelerate projects.



IX. UPDATE ON INTERIM REPORT PRELIMINARY RECOMMENDATIONS

1. Earlier and Broader Incorporation of Heroin and Opioid Prevention into the Health Curriculum

In August, the Maryland State Department of Education (MSDE) began developing lesson and resources for the health curriculum and introducing health-specific materials at Content Briefing with Local Education Agencies (LEAs). MSDE compiled and shared a list of resources on heroin and opioid prevention in response to the LEAs' request for that information. Throughout the process, these materials will continue to be revised and edited in collaboration with LEAs. Beginning in November and extending into December, MSDE will be disseminating materials from all content areas to the Health Coordinators for the remainder of the 2015-2016 school year.

2. Infusion of Heroin and Opioid Prevention into Additional Disciplines

In August, the Maryland State Department of Education briefed State Content Coordinators on an overview of the heroin and opioid epidemic and on the materials that need to be developed in all content areas. MSDE then began developing, revising, and editing resources and lessons integrating education on heroin and opioid use for other content areas. In September, MSDE introduced and disseminated materials for the 2015-2016 school year at LEA Content Coordinators' Briefings. Specific briefings include: Professional Development Coordinators; Service Learning Coordinators; Science & ELL Coordinators; Fine Arts Coordinators; Physical Education Coordinators; and Gifted & Talented Coordinators. In December, MSDE will disseminate materials for the remainder of the 2015-2016 school year for School Nurses and Social Studies Coordinators. Between January and March 2016, MSDE will disseminate materials for the remainder of the 2015-2016 school year for Reading/English Language Arts Coordinators, Math Coordinators, and Environmental Education Coordinators.

Preliminary Recommendation Overview

1. Earlier and Broader Incorporation of Heroin and Opioid Prevention into the Health Curriculum
2. Infusion of Heroin and Opioid Prevention into Additional Disciplines
3. Heroin and Opioid Addiction Integrated into Service-Learning Projects
4. Student-based Heroin and Opioid Prevention Campaign
5. Video PSA Campaign
6. Maryland Emergency Department Opioid Prescribing Guidelines
7. Maryland State Police Training on the Good Samaritan Law
8. Maryland State Police Help Cards and Healthcare Follow-Up Unit
9. Faith-based Addiction Treatment Database
10. Overdose Awareness Week

3. Heroin and Opioid Addiction Integrated into Service Learning Projects

In August, the Maryland State Department of Education's Service-Learning Specialist, curriculum specialist, and stakeholders worked to develop, revise, edit, and finalize the Service-Learning Project ensuring that the project is linked to the curriculum. The service-learning heroin project has been posted on the main page of the service-learning website. In September, MSDE met with Service Learning Coordinators in all 24 Local Education Agencies (LEAs) to introduce and explain the new topics. The LEA staff has worked with local curriculum specialists to understand relevant areas where service learning projects could best be infused. In November and December, the Service-Learning coordinators will share the project content with peers and schools.

4. Student-based Heroin and Opioid Prevention Campaign

The campaign would focus on prevention and a few key objectives including: 1) Discouraging teens and preteens from trying heroin; 2) Educating students and parents on how to identify and respond to signs of addiction; and 3) Inform youth, parents, and communities on how to access support services. MSDE held the kickoff media event with Lt. Governor Boyd K. Rutherford at Towson High School on October 1, 2015. MSDE has developed a webpage to anchor the public education campaign and provide links to resources and information which

PREVENTION

- 1) **Discouraging teens and preteens from trying heroin even once**
- 2) **Educating students and parents on how to identify and respond to signs of addiction**
- 3) **Inform youth, parents, and communities on how to access support services.**

has also been distributed to all 24 Local Education Agencies. It also met with Teachers of the Year from all 24 LEAs to plan development of a year-long project of their choosing. MSDE hosted a meeting with partner agencies including the Department of Health and Mental Hygiene, Department of Commerce, Division for Tourism, Film and the Arts and the Governor's Office to coordinate on messaging, collaborate on public service announcements and pool resources. In November, MSDE developed and distributed a communication toolkit with information for schools to use when communicating with their communities. MSDE also met with faith-based and community-based organizations to plan a faith-based and community-based project.

In November, fine arts students were asked to develop a student-designed poster, logo, and slogan to be unveiled in the spring. In December, MSDE and partner agencies will unveil public service announcements. MSDE will also work with LEA fine arts teachers to plan and produce student theatre productions, partner with Maryland PTA to plan focus groups with parents and student users in 2016, and create a social media campaign by youth to engage youth. Next year, MSDE will finalize Teachers of the Year projects, invite teachers to blog about new

instruction on prevention, student feedback, and lessons learned, and announce and publicize the student theatre productions focused on risk and prevention. Students will be asked to complete an anonymous survey on prevention, causes, signs and effects of addiction, and how to access support services, before the end of the school year.

5. Video PSA Campaign

The Department of Commerce Film Office and Maryland Higher Education Commission (MHEC) in collaboration with the Department of Health and Mental Hygiene and Maryland State Department of Education (MSDE) determined the four message topics for the public service announcements:

Topic 1 - Public Awareness for Elementary and Middle School-aged Students

Topic 2 - Education about the Maryland Crisis Hotline

Topic 3 - Public Awareness about the Good Samaritan Law Related to Overdose Emergencies

Topic 4 – Naloxone Education

Due to time constraints and semester curriculum already in place, and in order to meet the December first deadline, the Maryland Film Office contacted Morgan State University and

*Approximately **40** students will be involved in the production and post-production of PSA's.*

Stevenson University to produce the State's first set of PSAs. The Film Office will contact all universities with film programs to participate in similar productions next semester.

Students from Morgan and Stevenson have submitted a total of 15 scripts. These scripts were reviewed by subject matter experts and educators who have been tasked to participate in this project as to the scripts accuracy and messaging. Due to limited time available to the students, five scripts were selected to go into production. According to the professors overseeing the PSA's, a total of approximately 40 students will be involved in the production and post-production process. Production began on November 9, 2015. The committee, experts, and educators will determine which will be aired.

In addition, officials from the Governor's Office, MHEC, and MSDE met with a public relations official at WBFF-TV to explore broadcast support for the State's heroin and opioid campaign. The WBFF-TV expressed enthusiasm about the possibility of airing the spots and exploring other venues to air them, including the B'more Healthy Expo at the Baltimore Convention Center in March 2016. Copies of the PSAs will be sent to WBFF-TV for review.

6. Maryland Emergency Department Opioid Prescribing Guidelines

All 47 of Maryland's acute care hospitals have committed to adopt and work with emergency medicine personnel and their staffs to implement the Maryland Emergency Department Opioid Prescribing Guidelines.

As part of the commitment to implementing the guidelines, every acute care hospital will provide the Maryland Hospital Association (MHA) with periodic updates on the progress of implementation. While the guidelines are based on promising interventions and expert opinions, there will be a need to examine them during the implementation process to determine their effectiveness and alignment with evidenced based practices. MHA has committed to work with the Maryland College of Emergency Physicians to convene emergency medicine leaders, poison control centers and other experts, in the Spring, to discuss implementation, barriers, and the potential need for revisions. Part of the focus on this meeting will be the voluntary utilization of Maryland's Prescription Drug Monitoring Program, education and training needs for providers and patients, and the identification of additional resource needs to support implementation.

7. Maryland State Police Training on the Good Samaritan Law

The Maryland State Police has met with the Maryland Police Correctional Training Commission (MPCTC) to begin the process of developing training for statewide dissemination to all Maryland Law Enforcement agencies. All involved in the training development have agreed that a web based training platform would be the best method for facilitating this training.

8. Maryland State Police Help Cards and Healthcare Follow-Up Unit

In conjunction with the Maryland State Police, the Behavioral Health Administration (BHA) developed a help card containing information on the newly created crisis hotline in Maryland. The BHA, within DHMH, sponsors a crisis hotline available 24/7 throughout Maryland. This provides immediate access to information about treatment resources for those with mental health and substance use problems. During working hours, they provide a warm hand-off to the local jurisdictional evaluation center. If unable to directly reach the evaluation center, the Crisis Hotline will follow up the next day with the caller to make sure they follow through with the referral. The hotline also provides information to those who want to intervene with someone who struggles with mental health or substance use disorders. The hotline originally served those with mental health crises. BHA provided training to the hotline staff to increase their competence in managing calls about substance use problems.

The hotline number is 800-422-0009.

9. Faith-based Addiction Treatment Database

The Governor's Office of Community Initiatives' (GOCI) Interfaith Coordinator has identified at least 20 different facilities in Baltimore City and the Counties of Anne Arundel, Allegany, Calvert, Caroline, Carroll, Cecil, Charles, Frederick, Harford, and Montgomery for inclusion in its database of faith-based organizations that provide addiction treatment services. The database is continually updated as more faith-based organizations are identified. The GOCI will also begin reaching out to faith leaders to emphasize the crucial role faith-based communities play in dealing with individuals suffering from addiction. Participants will discuss strategies on how to best talk with their memberships about the disease of addiction and how to provide support to families and individuals seeking help. Topics of peer support, value systems, family, forgiveness, reducing stigma, overdose prevention, instilling of hope and

motivation, resiliency, communication and collaboration should be covered themes. A core goal of this proposal is to inspire leaders within communities to take action in the fight to assist our fellow Marylanders struggling against addiction. See <http://goci.maryland.gov/interfaith>.

10. Overdose Awareness Week

From Sunday, August 30, 2015 to Saturday, September 5, 2015 the first Overdose Awareness Week was observed in Maryland. The Behavioral Health Administration (BHA) helped communities across the State coordinate events to recognize the work being done to reduce opioid misuse in the community, promote treatment options, and celebrate recovery. Statewide events included candlelight vigils in Baltimore City and Baltimore and Cecil counties, community discussions in Somerset and St. Mary's counties, Naloxone trainings in Harford and Calvert counties, and media coverage in Frederick and Howard counties. BHA also held a Naloxone Conference to educate attendees about the State's Overdose Response Program and different models of overdose education and naloxone distribution.

"I lost my first cousin to a heroin overdose just a couple of years ago, so I know the kind of devastation it can cause families and communities."

—Governor Larry Hogan



X. UPDATE ON INTERIM REPORT RESOURCE ALLOCATIONS

1. Restoring the A.F. Whitsitt Center to a 40-bed Capacity

The supplemental budget award of \$800,000 was approved by the Department of Health and Mental Hygiene. The Center received an additional \$45,149 for equipment and furniture for patient group rooms, to update restrooms, purchase supplies for the medical room, and for staff phones and computers.

On October 1, 2015, the first patient (under the expansion award) was admitted. The fully functional new wing renovations will expand bed capacity to 40 and are expected to be completed by early to mid-December.

2. Providing Community-Based Naloxone Training and Distribution

In July 2015, the Behavioral Health Administration (BHA) issued a solicitation for proposals from each jurisdiction's Local Addictions Authority (LAA) for funding to support naloxone training and distribution under the Overdose Response Program (ORP) for FY2016. Proposals were received

\$800,000 to help restore the A.F. Whitsitt Center to a 40-bed facility

from

LAA's representing 22 jurisdictions. Following a period of dialogue with applicants to address any issues in the proposals, BHA issued awards to 20 jurisdictions in October. Revised budgets are currently being submitted for final approval by BHA. To meet the aggregate funding request from all jurisdictions that exceeded the \$500,000 of supplemental State funding, BHA added nearly \$300,000 in "one time only" federal funds, for a total of \$800,000 in grants.

The solicitation encouraged partnership with community-based organizations to expand the reach of the program and the targeting of people at highest risk for overdose along with their friends and family members. BHA reviewed all proposals and competitively awarded funds

Resource Allocations

1. Restoring the A.F. Whitsitt Center to a 40-bed Capacity
2. Providing Community-Based Naloxone Training and Distribution
3. Piloting Overdose Survivor Outreach Program in Hospital Emergency Departments
4. Piloting Naloxone Distribution to Individuals Screened Positive for Opioid Use Disorder at Release from Local Detention Centers
5. Expanding Supportive Recovery Housing for Women with Children
6. Supporting Detoxification Services for Women with Children
7. Targeted Outreach and Education to Aberrant/High-Risk Opioid and Other Controlled Substance Prescribers
8. Overtime for Dorchester County Law Enforcement
9. Maryland State Police Gang/Heroin Disruption Project
10. License Plate Reader Technology

based on the quality of the proposal, innovation demonstrated by the proposed strategy, the strategy's likelihood of reaching people at high risk for overdose, sustainability, and plans for program evaluation. All funded jurisdictions proposed to provide naloxone as part of the training. Many proposed to incorporate standing orders into program operations by the end of the fiscal year. Some examples of innovative proposals include:

- partnership with hospitals to offer training in emergency departments;
- hiring of outreach workers for street-based training and naloxone distribution;
- collaboration with a community center that serves the recovery community;
- development of promotional cards for EMS distribution to overdose survivors; and
- expansion of training locations to include halfway houses, senior centers, and homeless shelters.

BHA will continue to provide technical assistance to grantees and conduct ongoing monitoring of implementation, including requests for regular updates starting in January 2016. ORP entities are required to submit reports to BHA monthly on the numbers of people trained and certified and naloxone units dispensed. These reports will be used to track training numbers and people reached through this funding.

3. Piloting Overdose Survivor Outreach Program in Hospital Emergency Departments

As a first step to implementation of the Overdose Survivors Outreach Program (OSOP) in Baltimore City, BHA has provided Behavioral Health Systems Baltimore (BHSB) with initial funding to develop and implement specialized training and protocols for peer support specialists to conduct outreach to overdose survivors and linking them with treatment and recovery support services. BHSB's peer recovery specialists as well as peers employed by Bon Secours and Mercy hospitals will receive specialized training with overdose survivors and new protocols for coordinating referrals and follow up contacts. BHA estimates that trainings will be completed and the referral protocol implemented in January 2016. BHA and BHSB are also in discussions with an additional city hospital about incorporating their referrals for overdose survivors into the new protocol.

BHA is also coordinating activities funded under OSOP with those supported by a recently awarded grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) designed to improve peer support for individuals in medication-assisted treatment for opioid addiction. As part of this collaboration, BHA is supporting Anne Arundel Health Department's (AAHD) efforts to hire peers to work with Baltimore Washington Medical Center (BWMC) emergency department staff and provide intervention and referral support for overdose survivors. An initial workflow model for patient identification and referral has been developed with the goal of beginning implementation in December. The AAHD/BWMC initiative will also include intensive training for peers on motivational interviewing and treatment services to be conducted in early 2016.

4. Piloting Naloxone Distribution to Individuals Screened Positive for Opioid Use Disorder at Release from Local Detention Centers

Following release of the Interim Report, BHA requested that the local health departments from Charles, Calvert, and St. Mary's Counties submit a proposal to partner with their local detention centers to implement a pilot overdose education and naloxone distribution program for at-risk individuals leaving incarceration. Each county submitted proposals reflecting buy-in from their local detention centers in September 2015. All proposals included a description of methods for identifying individuals eligible for receiving naloxone through screening done at the time of intake to the facility. Training will be done by health department staff placed in the jails for treatment services, and naloxone will be purchased by the health department and provided upon the inmate's release by either jail or health department staff. The programs plan to train inmates under the ORP using the Program's curriculum, issuing certificates to trainees and dispensing using a physician's standing order. In October, BHA approved all three proposals and issued awards of approximately \$50,000 for each county. A conference call with grantees was held in mid-November, and program implementation is expected to begin in December 2015.

Approximately \$50,000
to Charles, Calvert, and St.
Mary's Counties.

Success of the pilot project will be measured by the county's ability to establish functioning protocols for the screening, training, and equipping with naloxone of inmates at the local detention center. Performance measures will include the number of people eligible for naloxone training, number of people trained, and number of naloxone kits dispensed. The project also required local health departments to incorporate protocols for referring eligible inmates to treatment and report to BHA regarding the number of people screened eligible for treatment services and the number of referrals made to substance use disorder treatment upon release.

5. Expanding Supportive Recovery Housing for Women with Children

BHA has awarded funding to the Anne Arundel County. The Anne Arundel County Health Department/Local Addictions Authority has selected Chrysalis House (Crownsville) as the vendor. Chrysalis House has located a site for the Supportive Recovery Housing in Brooklyn. Residents have already been accepted into the program and are living in the home. The house has five bedrooms that are occupied by four adults and five children (i.e. 4 families). The house is completely full.

6. Supporting Detoxification Services for Women with Children

Detoxification is an important, but resource intensive process. Clients require 24-hour monitoring for assessment and ongoing monitoring of sub-acute biomedical and behavioral conditions related to opioid and alcohol withdrawal. Based on national data and BHA's understanding that women historically do better in treatment with their children, BHA utilizes a model of residential detoxification services with childcare services on site in Baltimore City. BHA has awarded funding to Behavioral Health Systems Baltimore (BHSB) to provide these services. The

vendor, Gaudenzia, has been awarded funding and is currently providing detoxification services to four women with children at the Park Heights residential treatment program. It is the only program that provides residential detoxification with childcare on site in the state. This allows mothers to detox in a safe environment and children can receive appropriate wrap around services. These services include, but are not limited to, pediatric and mental health referrals, afterschool programming, and recreational activities that are age appropriate.

7. Targeted Outreach and Education to Aberrant/High-Risk Opioid and Other Controlled Substance Prescribers

BHA is working with the University of Maryland, School of Pharmacy (UMSP) to develop a process for identifying and conducting targeted outreach and education to aberrant opioid and other controlled substance prescribers. The first step will include development of clinical guidelines for primary care practitioners that address, first, when opioid prescribing is, or is not, appropriate, and, second, how to mitigate the risks of opioid prescribing should it be initiated. The guidelines will be developed in consultation with subject matter experts and stakeholders from government, academia, and in clinical practice. Promotion of the guidelines will foster a more knowledgeable clinician base and provide consensus-based standards for reference by government agencies, payers, and health systems. The guidelines may also inform data analysis methods for identifying aberrant prescribers through a “drug utilization review” process similar to those currently operated by Maryland Medical Assistance and private insurers. Guidelines may also be used as the basic educational material for outreach and academic detailing for high-risk prescribers. BHA is currently negotiating an agreement with UMSP with the goal of beginning the guidelines development process in December 2015.

8. Overtime for Dorchester County Law Enforcement

The Dorchester County Council’s Combating Heroin Use and Trafficking program is assisting the County’s Heroin Task Force. Outdated mobile data terminals will be replaced and overtime will be spent on additional investigations.

9. Maryland State Police Gang/Heroin Disruption Project

Since receiving the overtime funds, the Unit has seized several hundred grams of heroin and crack cocaine.

10. License Plate Reader Technology

The Ocean City Police Department has initiated installation and implementation of the technology.



XI. CONCLUSIONS

Over the past ten months, the Heroin and Opioid Emergency Task Force held regional summits in six locations around the State. The Task Force listened to local elected officials, treatment professionals, researchers, law enforcement, and families of individuals who fought and in many cases died due to their addiction. We heard many heart wrenching stories of loss as well as stories of triumph over the disease of addiction. The Task Force listened to calls for help: from treatment officials for improved access to treatment; from law enforcement for alternatives to incarceration as well as more tools to interrupt heroin traffickers; from families not wishing to have other families go through what they have; and from elected officials concerned about the destruction it is doing to their communities.

While the Task Force is proud of this report, this is not the end of the work to eliminate the scourge of heroin from our State. It represents a step in a long-term struggle to address a major challenge that is holding people and our communities back from their full potential. This challenge will not be solved overnight. There are additional factors that this report does not directly address, such as challenging home environments and the intersection of addiction and mental illness. With the completion of this report, the difficult work is just beginning.



XII. ACKNOWLEDGMENTS

The Task Force is tremendously grateful for the outpouring of support and expertise provided by hundreds of people to help the State combat the heroin and opioid epidemic.

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APPENDICES



The State of Maryland

Executive Department

EXECUTIVE ORDER
01.01.2015.12

Heroin and Opioid Emergency Task Force

- WHEREAS, Substance abuse is an illness that threatens a person's well-being, productivity, livelihood, and relationships;
- WHEREAS, The number of heroin deaths have nearly doubled between 2010 and 2013, and now the number of deaths attributable to heroin and opioids exceeds the number of homicides in the State;
- WHEREAS, Many new heroin users began with a dependency on legal prescription opioids, then migrated to illegally obtained opioids including heroin, which is less expensive and often more readily available;
- WHEREAS, Heroin and opioid drug abuse constitutes a public health crisis for the citizens of Maryland;
- WHEREAS, Drug-related crimes, even when committed by otherwise non-violent persons, harm not only the victims of these crimes but also adds significant costs to the State, counties, and municipalities;
- WHEREAS, A large number of occupants entering our detention and correctional facilities are suffering from previously untreated substance abuse disorders;
- WHEREAS, This crisis is exacerbated by the trafficking of large quantities of heroin into and throughout our State, which requires increased efforts by law enforcement; and
- WHEREAS, The State must take immediate steps to structure our State agencies, laws, and regulations to establish best practices.
- NOW, THEREFORE, I, LAWRENCE J. HOGAN, JR., GOVERNOR OF THE STATE OF MARYLAND, BY VIRTUE OF THE AUTHORITY VESTED IN ME BY THE CONSTITUTION AND LAWS OF

MARYLAND, HEREBY PROCLAIM THE FOLLOWING
EXECUTIVE ORDER, EFFECTIVE IMMEDIATELY:

A. Establishment: There is a Governor's Heroin and Opioid
Emergency Task Force (Task Force).

B. Membership.

(1) The Task Force shall consist of the following:

(a) The Lieutenant Governor;

(b) An appointee of the President of the Senate;

(c) An appointee of the Speaker of the House;

(d) An appointee of the Attorney General; and

(e) Seven public members to be appointed by
the Governor with a range of experience related to heroin and
opioid addiction treatment such as public health, mental health,
public safety, and family support services.

(2) Staff members from the Offices of the Governor
and Lieutenant Governor, the Governor's Office of Crime
Control and Prevention, the Governor's Office of Community
Initiatives, and the Office of Problem Solving Courts, will also be
regular participants.

(3) Other State agencies, as well as representatives
from federal agencies and law enforcement, and their staffs, may
be asked to participate at the invitation of the Chair.

C. Duties.

(1) The Task Force shall advise and assist the Governor
in establishing a coordinated state-wide and multijurisdictional
effort to prevent, treat, and significantly reduce heroin and opioid
abuse.

(2) The Task Force shall advise the Governor and the
Director of Homeland Security on immediate steps to improve
coordination between federal, State, and local law enforcement
regarding the trafficking and distribution of heroin and opioids in
Maryland.

(3) The Task Force shall submit an interim report no later than six months from the date of this Executive Order on the findings to date relating to the impact of heroin and opioid drug abuse upon public health officials, law enforcement, addiction treatment professionals, families, and other parties.

(4) The Task Force shall submit a final report to the Governor by December 1, 2015 that includes, but is not limited to recommendations for policy, regulations, or legislation to address the following:

(a) Improvement in access to heroin and opioid drug addiction treatment and recovery services across the State, including in our detention and correctional facilities, as well as development of specific metrics to track progress;

(b) Improvement and standardization of the quality of care for heroin and opioid drug addiction treatment and recovery services across the State as well as development of specific metrics to track progress;

(c) Improvement in federal, State, and local law enforcement coordination to address the trafficking and distribution of heroin and opioids throughout the State;

(d) Improvement of coordination between federal, State, county, and municipal agencies to more effectively share public health information and reduce duplicative research and reporting;

(e) Improvement in help available for parents, educators, community groups, and others to prevent youth and adolescent use of heroin and opioids;

(f) Development of alternatives to incarceration for nonviolent offenders whose crimes are driven primarily by their drug addiction; and

(g) Increased public awareness of the heroin and opioid abuse crisis, including ways to remove prejudices associated with persons suffering from substance abuse disorders.

D. Procedures.

(1) The Lieutenant Governor shall chair the Task Force. The Chair shall:

- (a) Oversee the implementation of this Executive Order and the work of the Task Force;
- (b) Determine the Task Force's agenda; and
- (c) Identify additional support as needed.

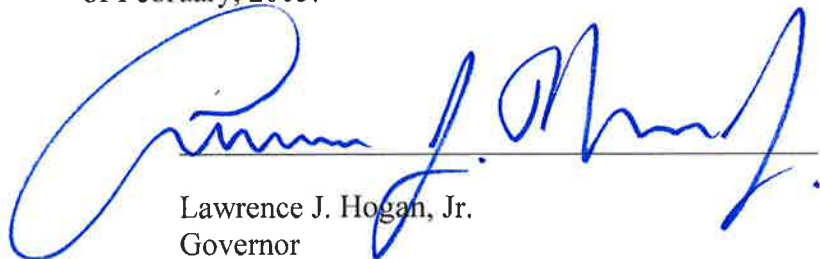
(2) The Task Force shall convene within 21 days of this Executive Order and meet as frequently as necessary to meet the deadlines established herein.

(3) The Task Force shall conduct regional summits in various parts of the State, including the Eastern Shore, Southern Maryland, Western Maryland, Central Maryland, and the Washington, D.C. Suburbs, to study the impact of heroin and opioid drug abuse in their communities upon public health officials, law enforcement, addiction treatment professionals, families, and other parties.

(4) A majority of the Task Force members shall constitute a quorum for the transaction of any business.

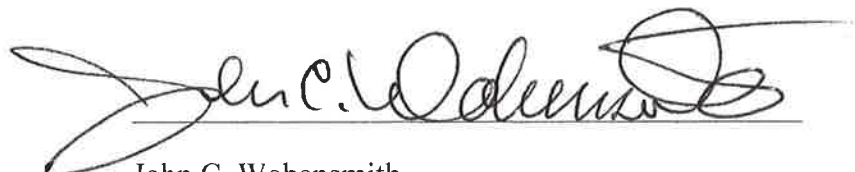
(5) The Task Force may adopt other procedures as necessary to ensure the orderly transaction of business.

GIVEN Under My Hand and the Great Seal of the State of Maryland, in the City of Annapolis, effective this 24th Day of February, 2015.



Lawrence J. Hogan, Jr.
Governor

ATTEST:



John C. Wobensmith
Secretary of State



INTERIM REPORT



HEROIN & OPIOID EMERGENCY TASK FORCE

Lieutenant Governor Boyd K. Rutherford, Chair



AUGUST 24, 2015



Office of the Lt. Governor

Boyd K. Rutherford

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August 24, 2015

Larry Hogan
Governor, State of Maryland
100 State Circle
Annapolis, MD 21401

Dear Governor Hogan:


Through our travels during the 2014 gubernatorial campaign, we heard stories from families, law enforcement, and healthcare professionals of the devastation heroin and opioid abuse has wreaked on communities. As a candidate, you stood alone in publicly recognizing the crisis that has engulfed our State.

I applaud your leadership in creating the Heroin and Opioid Emergency Task Force and thank you for appointing me as Chair. Over the past six months, the Task Force has brought together hundreds of stakeholders in order to develop a plan to tackle this emergency and provide you with holistic and comprehensive recommendations.

Enclosed is our Interim Report, which includes our findings and Task Force workgroup updates. Though final recommendations are not due until later this year, the Interim Report includes 10 recommendations, which can be implemented by the relevant state agency within a few weeks. It also includes 10 funding announcements: seven Department of Health and Mental Hygiene allocations to improve access to treatment and quality of care and three Governor's Office of Crime, Control, and Prevention grants to support law enforcement efforts.

Thank you for your continued leadership and support. We look forward to submitting our Final Report on December 1, 2015.

Sincerely,

A handwritten signature in black ink, appearing to read "Boyd K. Rutherford". The signature is fluid and cursive, with a large initial "B" and "R".

Boyd K. Rutherford
Lieutenant Governor, State of Maryland
Chair, Heroin and Opioid Emergency Task Force

I. EXECUTIVE SUMMARY

On February 24, 2015, Governor Hogan issued Executive Order 01.01.2015.12, which created the Heroin and Opioid Emergency Task Force. The Task Force is composed of 11 members with expertise in addiction treatment, law enforcement, education, and prevention. Lieutenant Governor Boyd K. Rutherford serves as the Chair. The Task Force was charged with advising and assisting Governor Hogan in establishing a coordinated statewide and multi-jurisdictional effort to prevent, treat, and significantly reduce heroin and opioid abuse.

In addition, the Task Force must provide recommendations for policy, regulations, or legislation to address the following:

- a) Improvement in access to heroin and opioid drug addiction treatment and recovery services across the State, including in our detention and correctional facilities, as well as development of specific metrics to track progress;
- b) Improvement and standardization of the quality of care for heroin and opioid drug addiction treatment and recovery services across the State, as well as development of specific metrics to track progress;
- c) Improvement in federal, state, and local law enforcement coordination to address the trafficking and distribution of heroin and opioids throughout the State;
- d) Improvement of coordination between federal, state, county, and municipal agencies to more effectively share public health information and reduce duplicative research and reporting;
- e) Help for parents, educators, community groups, and others to prevent youth and adolescent use of heroin and opioids;
- f) Development of alternatives to incarceration for nonviolent offenders whose crimes are driven primarily by their drug addiction; and
- g) Increased public awareness of the heroin and opioid abuse crisis, including ways to remove prejudices associated with persons suffering from substance use disorders.

This Interim Report details the Task Force's findings from the regional field summits relating to the impact of heroin and opioid drug use on public health, law enforcement, addiction treatment professionals, families, and communities at large. It is divided into four major sections: Summit Findings, Workgroup Areas of Further Study, Preliminary Recommendations, and Approved Resource Allocations.

The Summit Findings section reflects information provided by the hundreds of stakeholders who testified at the regional summits and in subsequent stakeholder conversations with members of the

Task Force. There are five subsections: a) Access to Treatment; b) Quality of Care; c) Law Enforcement; d) Drug Courts and Reentry; and e) Education and Prevention. Major themes reflected in this section include: insufficient federal, state, and local funding; a critical shortage of residential and outpatient treatment options; inconsistent quality of care standards; an increase in heroin- and opioid-related criminal activity; the promising preliminary outcomes of day reporting centers and jail-based Vivitrol (*i.e.* naltrexone) programs; and the need to raise public awareness and reach young people earlier in more innovative ways.

The Task Force subdivided into five workgroups, which mirrored the five major categories of information provided to the Task Force at the regional summits and through electronic submissions: a) Access to Treatment and Overdose Prevention; b) Quality of Care and Workforce Development; c) Intergovernmental Law Enforcement Coordination; d) Drug Courts and Reentry; and e) Education, Public Awareness, and Prevention. The Workgroup Areas of Further Study section details the objectives, guiding principles, and specific issues under consideration by each workgroup.

The Preliminary Recommendations section details 10 recommendations that can be implemented within a few weeks at little or nominal cost to the relevant state agency. Five recommendations relate to improving prevention and education efforts for youth and adolescents, two relate to law enforcement and the jail-based population, one relates to quality of care in hospital emergency rooms, another relates to highlighting and leveraging faith-based resources, and the last relates to an immediate weeklong public awareness push.

The Approved Resource Allocations section details how \$2,000,000 in additional treatment and prevention funding, released by Governor Hogan for fiscal 2016, will be spent. Generally, funds will be spent on naloxone training and distribution to local health departments and local detention centers, overdose survivor outreach programs in hospital emergency departments, prescriber education to improve quality of care, recovery housing for women with children, detoxification services for women with children, and to increase bed capacity at the A.F. Whitsitt Center, a state-operated residential treatment facility on the Eastern Shore. It also details how \$189,000 in Governor's Office of Crime Control and Prevention grant funding to local law enforcement will be spent for overtime pay, gang and heroin disruption efforts, and license plate reader technology.

The final report is due on December 1, 2015, and will contain further recommendations.

II. SYNOPSIS OF PRELIMINARY RECOMMENDATIONS

Below are synopses of the Heroin and Opioid Task Force's preliminary recommendations to Governor Hogan that can be implemented within weeks upon authorization.

1. Earlier and Broader Incorporation of Heroin and Opioid Prevention into the Health Curriculum

The Task Force recommends that the Maryland State Department of Education's Division of Curriculum, Assessment, and Accountability develop age-appropriate lessons and resources on heroin and opioid use in support of the Maryland Comprehensive Health Curriculum.

2. Infusion of Heroin and Opioid Prevention into Additional Disciplines

The Task Force recommends that MSDE's Division of Curriculum, Assessment, and Accountability develop Disciplinary Literacy lessons integrating education on heroin and opioid use with College and Career-Ready Standards.

3. Heroin and Opioid Addiction Integrated into Service Learning Projects

The Task Force recommends that MSDE's Service-Learning Office create service learning curriculum-based projects that engage students in addressing the heroin and opioid public health crisis.

4. Student-based Heroin and Opioid Prevention Campaign

The Task Force recommends that MSDE partner with the Office of the Governor and state agencies on a coordinated, multi-tiered public education campaign that discourages students from using heroin or abusing opioids.

5. Video PSA Campaign

The Task Force recommends the recruitment of university film students to develop and produce Public Service Announcements (PSA) to be distributed for broadcast and State social media platforms.

6. Maryland Emergency Department Opioid Prescribing Guidelines

The Task Force recommends that each acute care hospital work with its Emergency Department personnel to implement, as medically appropriate, the opioid prescribing guidelines developed by the Maryland Hospital Association.

7. Maryland State Police Training on the Good Samaritan Law

The Task Force recommends that the Maryland State Police provide training to field and investigative personnel on the legal requirements of the Good Samaritan Law.

8. Maryland State Police Help Cards and Health Care Follow-Up Unit

The Task Force recommends that the Maryland State Police provide heroin and opioid “Help Cards” to all MSP troopers and develop, in conjunction with the Department of Health and Mental Hygiene, a healthcare follow-up unit.

9. Faith-based Addiction Treatment Database

The Task Force recommends that the Governor’s Office of Community Initiatives’ Interfaith Coordinator develop a comprehensive database of faith-based organizations that provide addiction treatment services.

10. Overdose Awareness Week

The Task Force recommends that the first week of September be declared Maryland Overdose Awareness Week, which will include a conference for Overdose Response Program (ORP) entities and other local events to raise awareness of the addiction and overdose problem.

III. SYNOPSIS OF APPROVED RESOURCE ALLOCATIONS

Below are synopses of approved resource allocations that Governor Hogan, in consultation with the Heroin and Opioid Emergency Task Force, has prioritized in the effort to combat the heroin and opioid public health crisis.

1. Restoring the A.F. Whitsitt Center to a 40-bed Capacity

Governor Hogan will allocate an additional \$800,000 in fiscal 2016 to the A.F. Whitsitt Center to restore capacity to 40 beds, allowing an additional 240 patients to receive treatment each year.

2. Providing Community-Based Naloxone Training and Distribution

Governor Hogan has directed \$500,000 in supplemental grant awards to Local Health Departments (LHD) to support ORP trainings.

3. Piloting Overdose Survivor Outreach Program in Hospital Emergency Departments

Governor Hogan has directed the Behavioral Health Administration (BHA) to allocate \$300,000 towards establishing a pilot Overdose Survivor Outreach Program (OSOP) in Baltimore City.

4. Piloting Naloxone Distribution to Individuals Screened Positive for Opioid Use Disorder at Release from Local Detention Centers

Governor Hogan has directed BHA to provide \$150,000 through supplemental awards to three Southern Maryland LHDs - Calvert, Charles, and St. Mary's Counties - to implement overdose education and naloxone distribution programs for individuals released from local detention centers.

5. Expanding Supportive Recovery Housing for Women with Children

Governor Hogan has directed BHA to allocate \$100,000 for recovery housing, prioritizing those jurisdictions that currently do not have recovery housing for women with children and those with a significant waiting list.

6. Supporting Detoxification Services for Women with Children

Governor Hogan has directed BHA to make an additional \$50,000 available to residential detoxification services with childcare services on site in Baltimore City.

7. Targeted Outreach and Education to Aberrant/High-Risk Opioid and Other Controlled Substance Prescribers

Governor Hogan has directed BHA to allocate \$100,000 to conduct targeted outreach and education for practitioners identified as engaging in high-risk prescribing practices.

8. Overtime for Dorchester County Law Enforcement

Governor Hogan, through the Office of Crime Control and Prevention (GOCCP), will provide Dorchester County with \$24,700 to provide overtime for law enforcement to address the opioid and heroin epidemic.

9. Maryland State Police Gang/Heroin Disruption Project

Governor Hogan, through GOCCP, will provide Maryland State Police (MSP) with \$40,000 to support MSP's Gang/Heroin Disruption Project.

10. License Plate Reader Technology

Governor Hogan, through GOCCP, will provide the Ocean City Police Department with \$124,635 to fund license plate reader (LPR) technology at the northern end of Ocean City to target heroin entering Maryland across state lines.

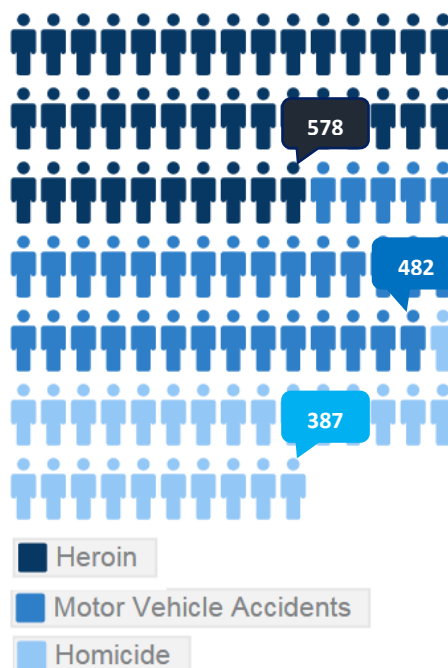
HEROIN & OPIOID EMERGENCY TASK FORCE

INTERIM REPORT

IV. INTRODUCTION

Throughout the 2014 gubernatorial campaign, then-candidates Larry Hogan and Boyd K. Rutherford visited every corner of the State and everywhere they traveled, heard the same tragic stories of how the heroin and opioid epidemic was destroying families and communities. It was clear that it was a public health crisis affecting Marylanders of all walks of life, regardless of socio-economic status, race, religion, education, or any other demographic. The State's prior response focused almost entirely on overdose prevention. Such efforts are important given that fatal overdoses from heroin outpaced the State's homicide rate and deaths from automobile accidents.¹ However, this administration is taking a comprehensive approach through education, treatment, quality of care, law enforcement, alternatives to incarceration, and overdose prevention.

On February 24, 2015, after only a month in office, Governor Hogan issued Executive Order 01.01.2015.12, formally creating the Heroin and Opioid Emergency Task Force. The Task Force was authorized to employ every resource available to take a holistic approach to address this public health emergency.



DATA SOURCE: MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 2014 ANNUAL REPORT

¹ In 2014, there were 578 heroin overdose deaths versus 421 homicides and 511 motor vehicle fatalities. See DHMH: Drug- and Alcohol-Related Intoxication Deaths in Maryland, 2014, and DHMH Vital Statistics Administration, Unpublished data, 2015. In 2013, there were 464 heroin overdose deaths versus 387 homicides and 482 motor vehicle fatalities. See DHMH: Drug- and Alcohol-Related Intoxication Deaths in Maryland, 2013, and DHMH: Maryland Vital Statistics Annual Report, 2013.

Task Force members include:

- Lieutenant Governor Boyd K. Rutherford, Chair
- Circuit Court Judge Julie S. Solt, Frederick County
- Sheriff Timothy Cameron, St. Mary's County
- Senator Katherine Klausmeier, District 8, Baltimore County
- Delegate Brett Wilson, District 2B, Washington County
- Nancy Whittier Dudley, President, Resilient Soul Services, Inc.
- Elizabeth Embry, Chief of the Criminal Division, Office of the Attorney General
- Dr. Michael B. Finegan, Peninsula Mental Health Services
- Dr. Bankole Johnson, Psychiatry Department Chair, UMD School of Medicine
- Tracey Myers-Preston, Executive Director, MD Addiction Directors Council
- Linda Williams, Executive Director, Addiction Connections Resource, Inc.

Pursuant to the Executive Order, the Task Force is required to submit recommendations on ways to improve public awareness, access to treatment, quality of care, alternatives to incarceration for

"As I travel throughout our State, I hear the devastating stories from our families and friends who hurt from the devastation heroin has wreaked on our communities."

—Governor Larry Hogan

non-violent drug abusers, and law enforcement coordination. The Task Force held six regional summits throughout the State to hear testimony from persons with substance use disorders, family members, educators, faith leaders, elected officials, law enforcement, addiction treatment professionals, and other

stakeholders. The summits were held in Elkton, Baltimore City, Prince Frederick, Hagerstown, Salisbury, and Silver Spring. Participants offered unique perspectives into this public health crisis. An approximate total of 223 people testified before the Task Force—21 elected officials, 31 law enforcement officials, 78 addiction treatment professionals, and 93 members of the general public. In addition, dozens of people submitted written testimony, suggestions, and comments to the Task Force through its Web portal and email address.

This interim report reflects the Task Force's findings, the ongoing efforts of its workgroups, preliminary recommendations, and approved resource allocations with the understanding that a final report with further recommendations will be submitted to Governor Hogan on December 1, 2015.

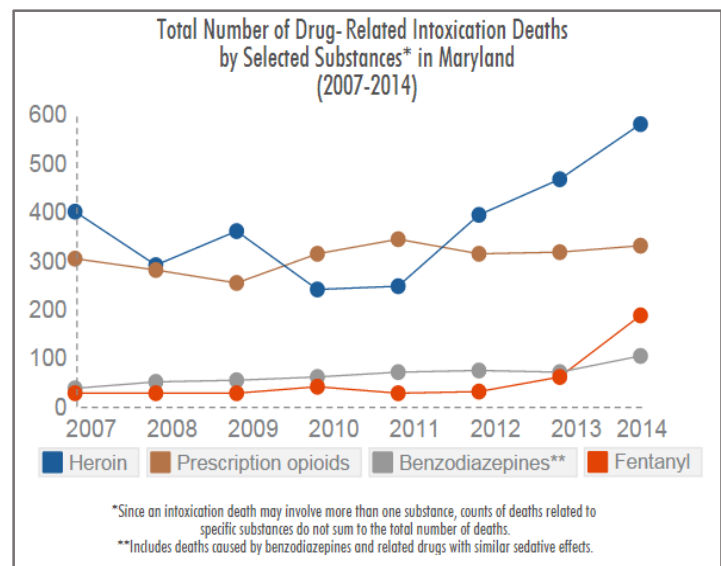
V. SUMMIT FINDINGS

The Heroin and Opioid Emergency Task Force held six regional summits to solicit input and guidance from a wide variety of sources. Testimony delivered at the summits can broadly be categorized into five areas: a) Access to Treatment; b) Quality of Care; c) Law Enforcement; d) Drug Courts and Reentry; and e) Education and Prevention. Below is a summary of the findings from the regional summits.

a. Access to Treatment

A strong recurring theme in the testimony delivered at the summits was the lack of sufficient resources to address the heroin and opioid epidemic and the serious issues Marylanders face as they try to access care. Stakeholders across the State reported a critical shortage of qualified treatment professionals and insufficient capacity at both inpatient and outpatient treatment facilities. The problem is acute in rural counties, where it is difficult to attract and retain treatment professionals. These challenges, among others, highlighted the need to realign and secure additional funding and launch efforts to expand the capacity and collaboration of the treatment system.

At each summit, there was compelling testimony that addressed the overwhelming inability to access treatment immediately. Families consistently reported experiencing multiple and repeated barriers, such as excessively long waiting periods, high deductibles and co-pays, delayed insurance authorization challenges, lack of appropriate levels of care in their respective county or region, among others. Such delays can result in serious consequences including death.



DATA SOURCE: MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 2014 ANNUAL REPORT

Health department and other county officials reported a shortage of long-term residential treatment options, though long-term rehabilitation is not always essential or necessary for every patient. Relatedly, testimony delivered to the Task Force highlighted the need to improve the transition of care for patients when they move from high-intensity residential

treatment to lower-intensity outpatient treatment to ensure high-quality and seamless continuity of patient care.

Stakeholders offered a variety of opinions about the most appropriate treatment needed in the community. Many cited limited or no availability of treatment that includes medication and advocated for the need for additional resources to utilize medication as an important component of treatment. On the other hand, some local parent coalitions were disturbed that medication usage during treatment has seemingly emerged as the sole option to address heroin and opioid dependency and that long-term abstinence-based residential treatment appears to have largely vanished as a valuable treatment option. The testimony also highlighted competing views in the community between those that would like to increase capacity and local treatment options and those that have voiced resistance to new or expanding programs in their communities.

b. Quality of Care

Individuals, families, community groups, and others from the private sector expressed deep concern regarding the increased challenges of providing effective substance use disorder treatment for heroin and opioid dependency. Established standards of care for addiction medicine and practice are not applied at all treatment facilities, resulting in inconsistent quality of care across providers in the State. Currently, notions of quality of care are often based on diagnoses, availability of services, and provider comfort rather than an evidence-based, outcome-driven approach. Additionally, person-centered care is often missing in Maryland's approach to behavioral health, which highlights the active involvement of patients and their families in the design of new care models and in decision-making about individual options for treatment.

Testimony from the public, including parents of children who overdosed and/or died, raised concerns with questionable prescribing practices of some physicians and dentists as well as the quality of some substance use disorder treatment programs, which were not diligent in monitoring the prescribing of opioid replacement medications and providing inadequate medication-only care. At the same time, there appeared to be some confusion by the public as to realistic expectations of the substance use disorder treatment system and what kinds of treatments are best for whom. Finally, there was great dissatisfaction regarding standards of care generally, gaps in communication and collaboration between health care services and law enforcement, and lack of accountability for outcomes.

A broad range of opinions were expressed regarding the use of medications to treat opioid dependency. There was general consensus on the value of Vivitrol (*i.e.* naltrexone), an opioid

antagonist, when dispensed in the context of a comprehensive treatment program. Yet there is concern that the public might be led to believe that naltrexone is a cure-all, which is not yet borne out by sufficient data. Opinions were decidedly mixed regarding opioid replacement interventions, such as methadone and buprenorphine. For example, these medications were described as “an essential component in the long-term treatment of opioid dependency”; “helpful for short-term use only”; “destructive to the patient seeking long-term recovery”; “useful as a ‘stabilizing agent’ only to prepare the patient to receive treatment”; and “extremely problematic to the operation of treatment programs and other community-based programs since the replacement medications are so often sold by patients for cash to then purchase heroin.” A number of people stressed that a key component for addiction treatment and successful recovery is the assumption of personal responsibility. They go on to argue that many patients enter treatment as passive recipients and many treatment regimens involving medication-assisted drug treatment programs fail to promote the theme of personal responsibility.

Nevertheless, there is data on the effectiveness of opioid replacement in the treatment of opioid addiction from decades of research and endorsed by government agencies, including the federal Substance Abuse and Mental Health Services Administration (SAMHSA). According to SAMHSA, opioid replacement therapies have been shown to increase treatment retention while decreasing mortality, criminality, and risk of infectious disease.

Incidents of abuse by both prescribers and patients were reported in most counties. Some recurring concerns that point to the potential for medication diversion or abuse include: the worker’s compensation system where medications are reimbursed at 100 percent with no co-pay; in physicians’ offices, where medications are marked up at a rate of 500-600 percent; and in some medication-assisted drug treatment programs that maintain patients at higher doses and for a longer period of time than may be medically necessary.

c. Law Enforcement

Though it is evident that we cannot arrest our way out of the State’s heroin and opioid problem, law enforcement still plays a very important role in combating this public health crisis. The scale of the heroin and opioid crisis is swamping law enforcement and depleting

“We can’t arrest our way out of this problem.”

–St. Mary’s County Sheriff Tim Cameron

their resources, leaving local law enforcement ill-equipped to respond to the magnitude of the heroin and opioid problem in Maryland. Sheriffs and police chiefs across the State explained that they are devoting more and more of their resources to fighting heroin trafficking and related crime. In Kent County, 75-80 percent of drug enforcement activity

focuses on stemming the flow of heroin into the county. In St. Mary's County, 34 percent of all arrests are opioid-related. In Queen Anne's County, heroin is the driving force behind car thefts, thefts from autos, and burglaries. In Calvert County, more than half of all burglaries, sexual assaults, and homicides are related to heroin and opiates. In Allegany County, open-air drug markets are now common. To combat this problem, local jurisdictions have increased the numbers of sheriffs and prosecutors and created new intervention teams.

One of the key strategies presented at the summits is inter-agency collaboration. In Carroll County, prosecutors, sheriffs, members of the health department, and others have formed an overdose response team that focuses on prevention and education, prosecution of repeat drug trafficking offenders, and early intervention for those with minor offenses (treatment and education). They are also adding five detectives to the sheriff's office. Anne Arundel County has a similar collaboration and works closely with Anne Arundel County police and the United States Drug Enforcement Administration to bring cases against distributors and interrupt supply networks. In Caroline County, the Maryland State Police, collaborating with five local police departments, built a 25 co-defendant case. Cecil County has increased funding for their forensic lab. These collaborations were widely praised, but a common theme emerged that additional help is needed with heroin trafficking across State borders.

Some law enforcement officials suggested initiating a criminal investigation in response to every heroin or opioid overdose to identify whether the person who supplied the drugs should be criminally charged and to learn more about the supply network. In the meantime, some counties are referring every fatal overdose to federal authorities for prosecution of the supplier for homicide, since Maryland does not have an equivalent statute that would allow for a homicide charge. On the legislative front, many sheriffs and prosecutors were in favor of a change to Maryland statute to allow for prosecution of suppliers in the case of a fatal overdose and expressed concern about the decriminalization of small amounts of marijuana. The mandatory minimum sentencing laws for repeat offenders were met with mixed reactions. Some wanted stricter mandatory minimums while others praised the General Assembly for relaxing the mandatory minimum sentencing laws. Advocates also praised legislation signed by Governor Hogan that shields certain criminal records to help people obtain housing and employment, and legislation that created the Justice Reinvestment Council.

d. Drug Courts and Reentry

While many of the stakeholders who testified at the summits agreed that incarcerating an offender is not the appropriate way to solve the heroin and opioid epidemic, the criminal justice system does offer an interface to intervene and connect the individual with the resources needed for recovery. Drug courts represent one such opportunity for an offender to

connect with substance use disorder services. Drug court eligibility requirements vary in each jurisdiction, as do the available resources. These programs include needs assessments on arrest, diversion, jail-based substance use disorder treatment, and reentry programs.

Circuit Court Judge Nelson Rupp testified about the extensive conditions for completing the Montgomery County Drug Court program. This program highlighted the value of rapid communication and decisive action by the court and treatment program to deal with non-compliance. The program requires a minimum 30 days in a pre-release center, attending night court weekly, counseling two to three times a week, obtaining a job before moving into a sober home, living in a sober home, and getting slips signed by a sponsor and human services partner. A probation agent also makes periodic home checks. The program takes about two years to complete. Since its inception in 2004, approximately 163 participants have graduated from the Montgomery County Drug Court.

According to Retired Circuit Court Judge Ellen Heller, the Baltimore City Drug Court program includes addiction and mental health treatment, job training, housing, and education. She emphasized the cost savings for treating offenders instead of incarcerating them, but noted that the availability of quality programs, delays in accessing treatment, and the prevalence of co-occurring disorders remain prominent challenges for drug courts. She also identified other alternatives to incarceration for addicted offenders, including pre-charge and pre-booking programs in other jurisdictions.

Howard County State's Attorney Dario Broccolino testified that his county has both a drug court and a reentry program through the Howard County Detention Center. While the reentry program is new, it features drug treatment referral and occupational therapy. Baltimore County State's Attorney Scott Shellenberger identified diversion programs that are being expanded to include offenses other than marijuana. Calvert County State's Attorney Laura Martin noted the sizeable increase in addicted offenders in her county. Calvert County has a drug court; however, it has less than 30 participants. Calvert County is interested in increasing the number of participants because the success of the program makes the community safer. Sheriff Evans from Calvert County noted that forcing addicts into treatment through the criminal justice system is effective.

Testimony delivered at the Western Maryland summit discussed the use of Vivitrol (*i.e.* naltrexone) as part of law enforcement treatment options, particularly in Washington County where the Vivitrol pilot program has resulted in zero recidivism or failed tests thus far. Washington County has also been exploring a day reporting center to assist with wraparound services, such as drug and mental health treatment, job training, drug testing, life

skills, and other services, outside of the jail. Frederick County recently received a grant from the Governor's Office of Crime Control and Prevention to include Vivitrol as part of the detention center treatment options. It is important to note, however, that use of extended-release naltrexone in opioid addiction treatment is relatively novel when compared to opioid replacement therapy, and therefore less research exists to describe its effectiveness.

Other stakeholders recommended increased decriminalization efforts, reducing mandatory sentencing, expanding expungement availability, and enhancing reentry services for incarcerated inmates with sentences longer than 18 months. These services include mental health and substance use disorder treatment, housing, and other community benefits. It was also noted that individuals in recovery often have an added hurdle of criminal records to further frustrate employment and housing challenges.

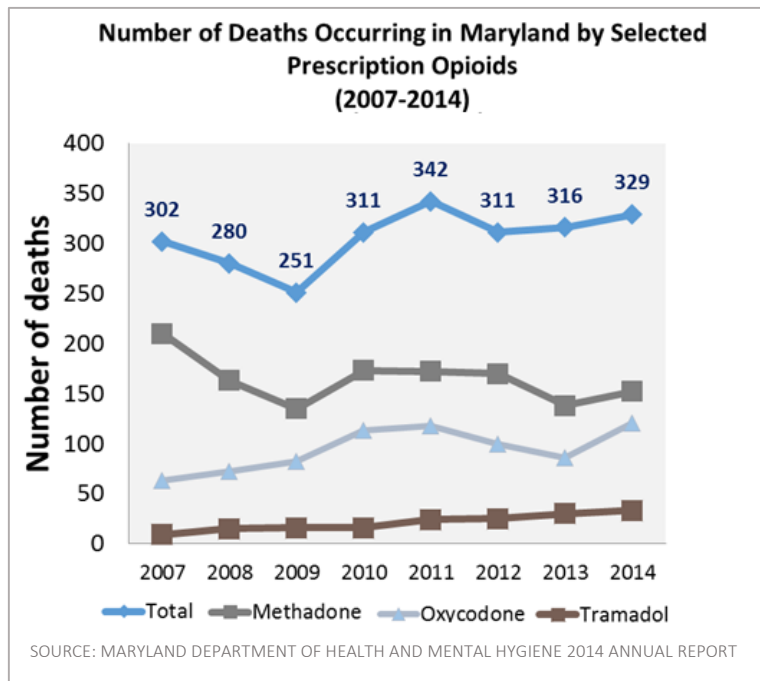
e. Education and Prevention

At each regional summit, people expressed the need to start educating children at a younger age about the dangers of prescription medications, heroin, and other opioids. It was pointed out that there has been a

growing problem of young people stealing prescription medications from family members and distributing them at parties (i.e. pill parties), with no idea of the medication's prescribed use or effect. Relatedly, it was suggested that parents need to become educated on heroin and opioid abuse, specifically how to talk with their children about drugs and what signs to look for that may indicate drug abuse.

Similarly, teachers, law enforcement, judges, and even health care professionals need additional training to more effectively identify substance use disorders.

Stakeholders recommended that the State undertake a large-scale, coordinated media campaign employing all forms of media in order to educate the public and reduce the stigma associated with substance use disorders and addiction treatment. A number of creative ideas



were discussed to involve young people in the development of media campaigns in order to reach target populations. Others suggested that the State should publicize how to safely store and dispose of unused prescription medications.

Earlier this year, Governor Hogan signed legislation to extend civil immunity under the Good Samaritan Act to rescue and emergency care personnel administering medications or treatment in response to an apparent drug overdose. Despite the expanded protections, stakeholders suggested that additional education is needed to clarify the law for the public so that there is no resistance to offer help to a person overdosing on illicit drugs.

Summit participants urged the expansion of peer recovery coaches, resource centers, and naloxone training. It was also recommended that the State do a better job of reaching out to faith-based community organizations because they reach diverse communities and provide counseling services. Such services can be critically important for individuals that are trying to maintain recovery.

VI. WORKGROUP AREAS OF FURTHER STUDY

Following the regional summits, the Task Force subdivided into five workgroups to further study the main areas of concern raised during the summits: a) Access to Treatment and Overdose Prevention; b) Quality of Care and Workforce Development; c) Intergovernmental Law Enforcement Coordination; d) Drug Courts and Reentry; and e) Education, Public Awareness, and Prevention. The policy areas to be studied by each workgroup reflect the duties assigned to the Task Force in the underlying Executive Order. Each workgroup is co-chaired by two Task Force members who solicited the participation of stakeholders interested in the particular subject area. Below are specific issues under consideration by each respective workgroup.

Task Force Workgroups

- a) Access to Treatment and Overdose Prevention Workgroup
- b) Quality of Care and Workforce Development Workgroup
- c) Intergovernmental Law Enforcement Coordination Workgroup
- d) Drug Courts and Reentry Workgroup
- e) Education, Public Awareness, and Prevention Workgroup

a. Access to Treatment and Overdose Prevention Workgroup

Task Force members Dr. Michael Finegan and Tracey Myers-Preston serve as co-chairs of the Access to Treatment and Overdose Prevention Workgroup. The workgroup is supported by staff from the Department of Health and Mental Hygiene, Department of Human Resources, Maryland Insurance Administration, Department of Juvenile Services, Governor's Office of Crime Control and Prevention, and the Governor's Office of Children. The workgroup is focusing on the challenges individuals and families face with regard to accessing treatment, financial barriers to accessing treatment, and identifying and prioritizing target populations, such as adolescents, pregnant women, and the justice-involved population. Currently, individuals and families lack sufficient information regarding how to access treatment and how best to navigate the treatment system. Further compounding this problem is insufficient access to outpatient and residential treatment, especially for youth and adolescents.

Data provided by the Department of Health and Mental Hygiene indicates that serious deficiencies exist in the treatment system that prevent an individual from accessing the full range of care settings and levels of care. The admission data for fiscal year 2014 by level of care indicates inconsistent use and lack of availability of the full continuum of care in each

part of the State. With the exception of Baltimore City, every county has significant gaps in services. Counties located in Western Maryland and on the Eastern Shore provide the majority of their services in outpatient settings, possess very limited access to residential services, and lack other services across the continuum of care. Furthermore, across the State, there is concern related to transportation, childcare, care for aging parents, and maintaining employment while in treatment.

Another important area of study that the workgroup will examine is the extent to which jurisdictions are funding intervention, assessment, referral, and treatment services beyond traditional business hours, as best practices consistently support the theory that treatment must be readily available. Given the fact that individuals may be uncertain about entering treatment, the system must be positioned to take advantage of any opportunity when an individual expresses a readiness to enter treatment. Treatment must be immediately available and readily accessible. Some facilities have implemented a “no wrong door” approach that includes a 24-hour phone-based hotline, emergency room diversion, screening and referral for treatment, and same-day access to services via walk-in appointments.

The workgroup will identify which programs in the State are offering treatment on demand and providing after-hours services, and will explore methods to incentivize treatment providers to similarly establish urgent care. The workgroup will also determine what technical assistance the State can provide that would allow treatment providers to offer assessments and referrals to treatment beyond traditional business hours.

Care should be individualized, clinically driven, patient-directed, and outcome-informed. Matching the treatment setting, intervention, and services to each individual is critical to achieving positive outcomes. Patients should be afforded the opportunity to receive care at the appropriate level and step up or down in services based on the individual’s response to treatment. With this in mind, the workgroup will explore whether the use of outpatient services rather than residential service is truly the result of clinical need or is instead based on availability. Funding clinically inappropriate services is a waste of precious resources, as recovery will not likely be achieved and the patient will continue to cycle in and out of the healthcare system, or worse. The workgroup will also examine whether public dollars are being spent on higher levels of service than what is assessed. For example, a judge could order residential treatment for individuals based upon criminal justice or housing concerns rather than clinical need.

b. Quality of Care and Workforce Development Workgroup

Task Force members Dr. Bankole Johnson and Nancy Dudley serve as co-chairs of the Quality of Care and Workforce Development Workgroup. The workgroup is supported by staff from the Department of Health and Mental Hygiene and Department of Human Resources and will examine a number of factors affecting quality, outcomes, and workforce development.

Standardized quality of care at treatment centers across the State is critically important to ensure that patients have access to evidence-based care. Testimony delivered at the regional summits highlighted inconsistencies across the State. As a result, the workgroup will address inconsistencies in the quality of care across treatment centers and recommend strategies to standardize and enhance quality of care in order to produce the best outcomes for patients. Patient satisfaction surveys and outcome measures will also be explored to ensure patients are treated with the highest quality of care and that patients and their families are actively involved in their treatment plan. The workgroup will also consider ways to bridge the gap in care for individuals with comorbidities, such as chronic pain, psychiatric disorders, and pregnancy. Finally, an adequate supply of treatment professionals is critical to handle the demand demonstrated across the State. As part of its work, the workgroup will identify strategies to cultivate sufficient numbers of qualified, trained, diverse, and competent treatment professionals.

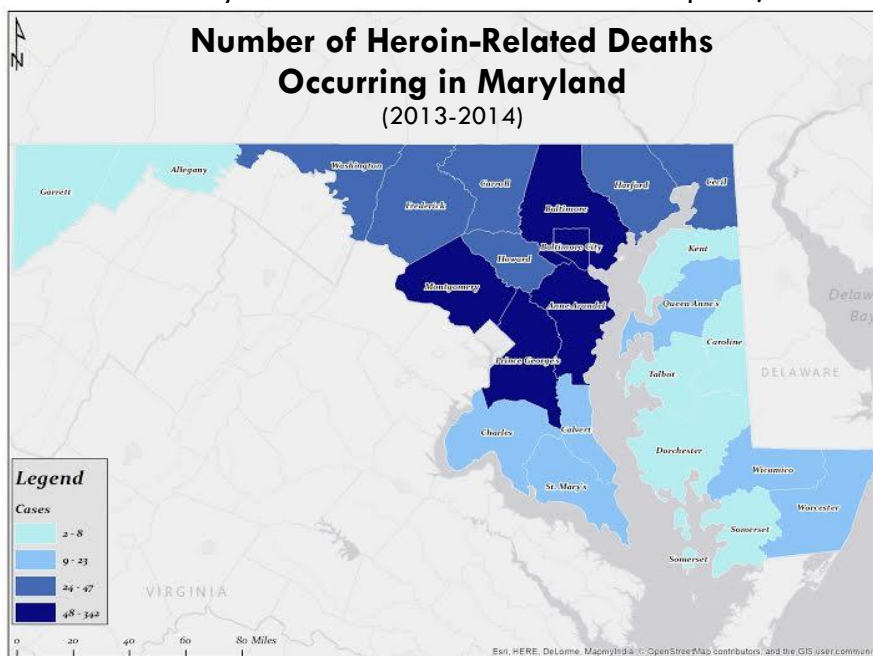
During the course of the regional summits, the workgroup noted deep confusion by the public as to what constitutes effective treatment for heroin and opioid dependency. Effective treatment of individuals with opioid use disorder should be evidence-based, outcome-driven, continuous, comprehensive, compassionate, and based upon integrating both the medical and psychosocial needs of the individual. There is also significant evidence for the efficacy, safety, and life-saving role of medications in the treatment of opioid use disorder. Decisions regarding medication-assisted treatment should be made in collaboration between a patient and a knowledgeable and trained healthcare practitioner. As a corollary, healthcare professionals should provide information to patients about all the different medication options, their pros and cons, and discuss with patients the role of medications as part of individualized treatment planning. Patients should be encouraged to play an active role in their treatment for it to have optimal efficacy and achieve optimal outcomes, including long-term recovery. In short, patients who participate actively in their own treatment have the best outcomes.

c. Intergovernmental Law Enforcement Workgroup

Task Force members Sheriff Tim Cameron and Elizabeth Embry serve as co-chairs of the Intergovernmental Law Enforcement Workgroup. The workgroup is supported by staff from the Governor's Office of Crime Control and Prevention, Maryland State Police, Department of

Human Resources, and Maryland State Department of Education. The workgroup is developing recommendations to improve federal, state, and local law enforcement coordination to address heroin and opioid trafficking across the State. To reach this broad objective, the workgroup developed a work plan covering five core areas: data sharing, intelligence gathering and methods of real-time dissemination, heroin interdiction strategies, prescription drug enforcement and monitoring, and possible legislation that will enable law enforcement to combat the heroin epidemic more effectively.

Improved data sharing among local, state, and federal law enforcement concerning heroin-related enforcement activity is vital for coordinated law enforcement efforts against heroin traffickers in Maryland. While there are structures in place, there are gaps and technological



hurdles that need to be addressed. The workgroup will produce specific recommendations to develop a fully functioning, centralized, statewide system used by all local, state, and federal law enforcement to capture data on heroin-related crime.

Similar to the sharing of data, the collection and dissemination of intelligence on heroin trafficking from debriefings, confidential informants, social media, cell phones, and investigations into overdoses occurs inconsistently and may be delayed by protocols designed to protect sensitive information. The workgroup will create recommendations to eliminate unnecessary barriers to the sharing of intelligence among law enforcement agencies and disseminate the best available guidance on how to allocate the responsibility of sharing that information within an agency.

In addition to existing strategies for interdiction, the workgroup will look at allocating additional resources to methods that are underutilized. Partnerships with law enforcement in neighboring states are piecemeal and should be expanded and standardized. The workgroup will develop these recommendations based on proven strategies. Criminal

enforcement of doctors and pharmacies responsible for illegally prescribing or dispensing opiates has been sparse. This is due, in part, to the fact that the transactions occur in private, and in part to the lack of prescription data accessible to law enforcement. The workgroup will explore expanding the usefulness of the Maryland Prescription Drug Monitoring Program (PDMP) to law enforcement through mandatory registration and querying and dedicating investigative and prosecutorial resources to enforcement. Many members of local law enforcement have developed partnerships with local pharmacies so that they are alerted if there is suspicious behavior. In some cases, these initiatives could be replicated and the workgroup will evaluate the feasibility of expanding those partnerships statewide.

Lastly, the workgroup will examine the challenges drug addiction creates in maintaining safety inside correctional facilities. Inmates come up with inventive ways to smuggle contraband drugs inside the facilities. Contraband can be treated as a form of currency, incite violence, and derail an inmate's substance use treatment program. During fiscal year 2015, the Department of Public Safety and Correctional Services (DPSCS) confiscated 187 opiates and approximately 3,350 forms of Suboxone. One of the primary means by which inmates attempt to smuggle contraband is by having their friends and acquaintances conceal it in letters and in the folds of greeting cards. In order to minimize opportunities for introduction of contraband into the facility by mail, especially contraband available in forms visually undetectable, the workgroup will evaluate measures to disrupt smuggling of drugs through inmate personal correspondence mail.

d. Drug Courts and Reentry Workgroup

Task Force members Judge Julie Solt and Delegate Brett Wilson serve as co-chairs of the Drug Courts and Reentry Workgroup. The workgroup is supported by staff from the Department of Public Safety and Correctional Services, Department of Juvenile Services, Governor's Office of Crime Control and Prevention, Department of Human Resources, Maryland State Department of Education, and the Governor's Office of Children. Due to the close correlation between addiction and criminal activity, the criminal justice system, via drug courts and reentry programs, is frequently a gateway to treating heroin- and opioid-addicted offenders.

The workgroup is exploring opportunities with diversion programs, drug courts, day reporting centers, Health General Placements (*i.e.* 8-505/8-507 programs²), and reentry programs.

The workgroup is currently working with the Maryland State's Attorneys' Association to collect

² 8-505/8-507 programs refer to programs created to give effect to powers granted to the judiciary under MD. CODE ANN., HEALTH-GEN. §8-505 and §8-507 to evaluate a defendant to determine whether, by reason of drug or alcohol abuse, the defendant is in need of and may benefit from treatment and is willing to participate in treatment.

data on which jurisdictions have diversion programs, whether treatment is required where the offender is identified as being heroin- or opioid-addicted, and the recidivism rate for diverted offenders. The workgroup will be exploring recommendations on best practices for successful diversion programs for heroin- and opioid-dependent offenders.

With respect to drug courts, the workgroup is researching how existing programs differ in each jurisdiction. The workgroup will determine whether there is a way to create some uniformity across the various drug court programs with respect to core functions and program requirements. The workgroup has also been in contact with the judiciary regarding the 8-505/8-507 process. It has received information and concerns relating to manipulation of the program to reduce incarceration length, funding issues, delays in treatment, and the appropriate length of treatment.

In addition, the workgroup is examining the merits of day reporting centers, which are designed to operate through the home detention programs available in all Maryland jurisdictions. These centers provide the types of services often needed by addicted offenders, such as drug and mental health treatment, job training, drug testing, life skills, and other services all located under one roof. The workgroup will develop recommendations on how to implement day reporting centers, particularly in areas of the state with fewer local resources. Lastly, the workgroup is gathering data on various reentry programs with the goal of identifying what works, why it works, and which can be duplicated across the state.

e. Education, Public Awareness, and Prevention Workgroup

Task Force members Senator Katherine Klausmeier and Linda Williams serve as co-chairs of the Education, Public Awareness, and Prevention Workgroup. The workgroup is supported by staff from the Maryland State Department of Education, Department of Health and Mental Hygiene, Department of Human Resources, Governor's Office of Community Initiatives, and the Governor's Office of Children. The workgroup is developing recommendations to address ways to engage youth and adolescents, prevention strategies, relapse prevention, overdose death prevention, and the reduction of stigma. Any recommendations will reflect the importance of messaging for specific audiences, including children, parents, families, educators, public health officials, law enforcement, addiction treatment professionals, community groups, and other stakeholders.

“From preventing our kids from using heroin in the first place to increasing and improving access to treatment services for those in recovery, this task force will employ every resource available to take a holistic approach to address this public health emergency.”

—Governor Larry Hogan

The workgroup will be studying environmental factors including the broader physical, social, cultural, and institutional forces that contribute to illicit drug use and addiction. It will begin with strategies to stop heroin and opioid abuse before it has a chance to occur. This level of prevention involves education in schools, including use of research-informed curriculum in elementary, middle, and high schools as well as community-based youth services and other nonprofit organizations with a history of providing effective drug education. It also includes the education or re-education of health care professionals about the disease of addiction, the use of screening tools, and problems that can arise from overprescribing opioids.

Next, the workgroup will explore strategies targeted toward those most at risk for problems with heroin or opioids. The workgroup will develop recommendations related to intensive substance abuse education for at-risk and high-risk individuals such as those charged with drug-related offenses or children of addicted parents.³ In addition, the workgroup will consider the use of social workers or licensed counselors in middle and high schools to provide support as well as screenings, brief intervention, and referrals to treatment (*i.e.* SBIRTs).

The workgroup will pursue strategies to reduce heroin and opioid abuse and support the recovery efforts of people with substance use disorders. The workgroup is exploring ways to provide more supportive environments for young people, such as recovery clubs, recovery high schools, and collegiate recovery centers. It is also developing recommendations for increased naloxone training. The workgroup is focusing on ways to reduce the stigma associated with addiction, including educating the public on the brain science of addiction to clarify that it is a disease rather than a moral weakness. It also agrees that the State should employ a large-scale, coordinated media campaign to educate the public on heroin and opioid abuse.

The Centers for Disease Control and Prevention states that 45 percent of heroin addicts were also addicted to prescription painkillers. The Drug Enforcement Agency has stated that at least 70 percent of new heroin users started with prescription painkillers. Accordingly, the Task Force will explore reintroducing legislation similar to House Bill 3 of 2015 introduced by then-Delegate Kelly Schulz, which will require a prescriber and a dispenser to query the Prescription Drug Monitoring Program (PDMP) to review a patient's prescription monitoring data before prescribing or dispensing a monitored prescription drug. The PDMP was established in 2011 and is housed within the Department of Health and Mental Hygiene (DHMH) to support healthcare providers and their patients in the safe and effective use of prescription drugs. The PDMP collects and stores information on drugs that contain controlled

³ The workgroup has identified the need for law enforcement, corrections, parole, and probation officers to learn about the disease of addiction and appropriate responses to relapse.

dangerous substances and are dispensed to patients in Maryland. The PDMP also assists in investigations of illegal or inappropriate prescribing, misuse, diversion, or other prescription drug abuse.

Currently, the law does not require prescribers or dispensers to query their patients' PDMP data when prescribing or dispensing controlled substances. As such, the Task Force will explore requiring a prescriber and a dispenser to query the PDMP to review a patient's prescription monitoring data before prescribing or dispensing a monitored prescription drug. Requiring prescribers and dispensers to access PDMP prior to prescribing or dispensing a controlled prescription drug will increase the number of registered PDMP users and the number of inquiries. If legislation is pursued, the Task Force envisions extensive outreach to stakeholders to reach consensus on which healthcare professionals should be required to register and query the PDMP, and under what circumstances. DHMH will also need to increase the technical capabilities of the PDMP to support additional users and increased queries.

In furtherance of its efforts to stem the pipeline of new users, the Task Force will explore possible strengthening of prescriber and pharmacist disclosures. Prescription opioid medications are among the most widely prescribed drugs for the management of moderate to severe chronic pain. The potential for misuse, abuse, or diversion should be concerning for both prescribers and dispensers of opioid prescription medication. There is a role that both prescribers and dispensers can play to ensure the safe use of opioid pain management therapy. Pharmacists are a central point of contact for patients when they fill prescriptions and present an opportunity to further inform patients of any potential adverse side-effects.

The Task Force will explore whether additional, verbal counseling should be required when prescribing or dispensing an opioid prescription drug to patients in Maryland. Prescribers have a responsibility to counsel patients about the specific details of the drugs they are prescribing. They also have a responsibility to monitor patient use, abuse, or diversion of drugs. The Task Force will explore whether prescribers should verbally counsel their patients on how to secure and properly dispose of opioid prescription drugs, as well as the risks of misuse or abuse of opioid prescription drugs. The Task Force will examine the role pharmacists play to ensure that patients understand the risks and benefits of the opioid prescription drugs and whether face-to-face verbal counseling is practical.

VII. PRELIMINARY RECOMMENDATIONS

Though the Task Force is working diligently to develop final recommendations for the December 1, 2015 final report, this interim report includes 10 recommendations with a heavy emphasis on education and prevention strategies targeted toward youth and adolescents.

1. **Earlier and Broader Incorporation of Heroin and Opioid Prevention into the Health Curriculum**

The Task Force heard extensive testimony relating to improving the education of children and adolescents on heroin and opioids at earlier ages. As such, the Task Force recommends that the Maryland State Department of Education's Division of Curriculum, Assessment, and Accountability develop age-appropriate lessons and resources on heroin and opioid use in support of the Maryland Comprehensive Health Curriculum by the MSDE Educational Specialist in Health and Physical Education (PE), Local Education Agency (LEA) Health/PE Coordinators, and Master Teachers. In addition, the Task Force recommends that corresponding professional development and training for school personnel will ensure effective implementation of the materials that are created.

Due to the variety of delivery formats for comprehensive health education amongst the LEAs, lessons and resources will be developed for the traditional focused health classroom as well as cross-curricular resources that can be used by teachers throughout a school. Lessons and resources will be written with consideration given to the age and prior learning of students. Lessons and resources will look at the physical and mental effect heroin and opioid abuse has on a person. In addition, focus will be given to the larger consequence of heroin and opioid

Recommendation Overview

1. **Earlier and Broader Incorporation of Heroin and Opioid Prevention into the Health Curriculum**
2. **Infusion of Heroin and Opioid Prevention into Additional Disciplines**
3. **Heroin and Opioid Addiction Integrated into Service-Learning Projects**
4. **Student-based Heroin and Opioid Prevention Campaign**
5. **Video PSA Campaign**
6. **Maryland Emergency Department Opioid Prescribing Guidelines**
7. **Maryland State Police Training on the Good Samaritan Law**
8. **Maryland State Police Help Cards and Healthcare Follow-Up Unit**
9. **Faith-based Addiction Treatment Database**
10. **Overdose Awareness Week**

abuse within families and communities. These lessons are ready for dissemination for the 2015-2016 school year.

2. Infusion of Heroin and Opioid Prevention into Additional Disciplines

For students to be fully prepared for the challenges and expectations of college and career, it is critical that they develop literacy skills in all content areas. As a part of Maryland's College and Career-Ready Standards, it is critical that educators in all science, technical subjects, and history/social studies

classrooms incorporate content-specific literacy into their instruction. As such, the Task Force recommends that MSDE's Division of Curriculum, Assessment, and Accountability develop Disciplinary Literacy

lessons integrating education on heroin and opioid use with College and Career-Ready Standards (English Language Arts and mathematics) through the collaborative efforts of MSDE staff, LEA Content Coordinators, and Master Teachers.

“Virtually every 3rd grader can tell you that cigarettes are bad for you, but most don't know that taking someone else's prescription drugs is harmful.”

—Lt. Governor Boyd K. Rutherford

The use of the heroin and opioid topic as a central theme in social studies, science, fine arts, and other subjects supports the importance of introducing related college and career-ready standards to other disciplines. Since the standards emphasize research skills and the development of point of view related to these skills, this topic will generate interesting and pertinent classroom discussion and assignments in all content areas. The desire to incorporate a disciplinary literacy theme as part of standards-based education requires all subjects and disciplines to align their work with the theme chosen: heroin and opioid addiction. These lessons will be planned for dissemination during the 2015-2016 school year.

3. Heroin and Opioid Addiction Integrated into Service-Learning Projects

Service-learning is a teaching method that combines meaningful service to the community with curriculum-based learning. Through service-learning, students improve their academic, social, and civic skills by applying what they learn in school to the real world. When meaningful reflection is added, students can use the experience to reinforce the link between their service and their learning. All 24 local school systems in Maryland implement service-learning graduation requirements. Each implements the requirements slightly differently because they tailor the specifics of their program to their local community.

The Task Force recommends that MSDE's Service-Learning Office create service-learning curriculum-based projects that engage students in addressing the heroin and opioid public health crisis. The goal is to provide educators with rigorous and meaningful service-learning

curriculum models and guidance on how to re-engage students in the fight against heroin and opioid abuse. This curriculum will be aligned to newly developed heroin and opioid prevention education infused into course curriculum. To accomplish this task, MSDE's service-learning specialist will conduct meetings with Service-Learning Coordinators in the 24 LEAs. Staff will then work with curriculum specialists to understand relevant areas where these service-learning projects could be best infused. Staff will create the projects and share them at coordinator meetings and via MSDE's website.

4. Student-based Heroin and Opioid Prevention Campaign

The Task Force recommends that MSDE partner with the Office of the Governor and State agencies on a coordinated, multi-tiered public education campaign that discourages students from using heroin or abusing opioids. The campaign will focus on educating students and parents on how to identify and respond to signs of addiction and informing students, parents, and communities on how to access support services. To foster participation at the local level, the campaign will partner with all 24 school systems and youth-serving organizations throughout Maryland to communicate with students and adults during in-school and after-school activities. Target audiences will include students, parents, school personnel, and community and faith-based leaders.

Activities will include the following:

- a) Pre- and post-campaign surveys/research to gauge public awareness and success;
- b) Fall events at schools with multiple state leaders highlighting a success story or successful local overdose prevention plan that includes the LEA;
- c) A student-led contest to design a campaign name, logo, and slogan to support Governor Hogan's overall statewide strategy;
- d) Web pages to share key messages and resources, including communication toolkits, downloadable posters, and links to federal, state, and local campaigns, information, and contacts;
- e) Focus groups with parents and students to discuss and gain knowledge of prevention and support needs and partner with DHMH and other agencies on health risk communication;
- f) Social media campaign by youth to engage youth, led by the student member of the State Board of Education, the Maryland Association of Student Councils, and others; and

- g) MSDE and State agencies will pursue earned media focused on prevention, what parents and students are saying, and school services that address the specific needs identified by parents and students.

5. Video PSA Campaign

Though the Education, Public Awareness, and Prevention Workgroup is developing the outlines of a large-scale, coordinated media campaign employing all forms of media, the Task Force recommends the immediate launch of video public service announcements via broadcast and social media throughout Maryland. The Department of Business and Economic Development's Division of Tourism, Film, and the Arts and the Maryland Higher Education Commission will seek students from local higher education institutions to develop and produce 30-second public service announcements. The best PSAs will be featured on State social media platforms and submitted to local broadcast stations for airing. The Governor's Communications Office will direct distribution of approved PSAs.

6. Maryland Emergency Department Opioid Prescribing Guidelines

According to the Centers for Disease Control and Prevention, the strongest risk factor for heroin addiction is addiction to prescription opioid painkillers. As such, hospitals can play an important preventive role in the fight to reduce opioid misuse and abuse. Earlier this summer,

"There are some steps that could be taken to better inform doctors, dentists, pharmacists ... about the effects of prescription medications."

—Lt. Governor Boyd K. Rutherford

the Maryland Hospital Association developed standardized opioid prescribing guidelines for hospital emergency departments.⁴ The guidelines are informed by a patient-focused brochure developed by the Maryland Chapter of the American College of Emergency

Physicians (MDACEP) that was released in 2014. They were crafted to allow emergency medicine physicians flexibility in prescribing opioids when medically necessary while encouraging best practices in an effort to reduce the risk of opioid addiction. These guidelines, which are endorsed by MDACEP, promote:

- a) Screening and patient education to help detect and treat existing substance misuse conditions and safeguard patients against unnecessary risks of developing such conditions;
- b) Enhanced information sharing among providers using existing tools like the State's health information exchange (CRISP) and the state's prescription drug monitoring program; and

⁴ See Appendix B.

- c) Standardized prescribing practices to reduce unnecessary prescriptions (and the amount of pills prescribed) to diminish inadvertent or purposeful misuse of opioids.

The Task Force recommends that each acute care hospital work with its Emergency Department personnel to implement, as medically appropriate, these guidelines and provide the Maryland Hospital Association with periodic updates on the progress of the implementation.

7. Maryland State Police Training on the Good Samaritan Law

The Task Force recommends that the Maryland State Police (MSP) provide training to field and investigative personnel on the legal requirements of the Good Samaritan Law. It is apparent that some confusion exists among law enforcement agencies on what actions they can and cannot take when confronted with a police response that falls under the protection of this law. Unless efforts are taken to remove confusion, valuable intelligence and opportunities to combat this issue could be lost. It is recommended that the State's Attorneys' Association be included in this training, as conformance to this law should be consistent statewide.

8. Maryland State Police Help Cards and Healthcare Follow-Up Unit

The Task Force recommends that the Maryland State Police provide heroin and opioid "Help Cards" to all MSP troopers, with the distribution of the cards beginning in the Western Maryland barracks. The cards should contain health department, treatment, and financial assistance resource information. The cards should be distributed by troopers when encountering heroin- or opioid-related arrests or other encounters. They also can be provided to family members who contact MSP facilities seeking assistance or guidance for addicted family members, friends, or colleagues.

The Task Force also recommends that the Department of Health and Mental Hygiene assist the MSP in developing a healthcare follow-up unit that would be responsive to law enforcement, school personnel, and citizen referrals of persons involved in or at risk of being involved in heroin and opioid use. Often when these contacts occur, persons with substance use disorders are at their most vulnerable state, and quick treatment interaction may be the difference between recovery and continued abuse.

9. Faith-based Addiction Treatment Database

There is a groundswell of passion and commitment among faith groups to help combat the heroin and opioid health crisis. A number of representatives from the faith community, including pastors and members of congregations, stepped forward in support of individuals, families, and programs that are battling heroin and opioid dependency. Such faith-based groups are offering numerous forms of support, including space for 12-step meetings; outreach to individuals and families in crisis due to drug abuse; and non-clinical case

management support for drug dependent individuals who are either waiting to enter treatment, need support during treatment, or who require post-treatment support in order to enter into long-term recovery. Unfortunately, many people with substance use disorders and their families are unaware of the addiction treatment services faith-based organizations in their communities provide. As such, the Task Force recommends that the Governor's Office of Community Initiatives' (GOCI) Interfaith Coordinator develop a comprehensive database of faith-based organizations that provide such services and include contact information, hours of operation, and types of services. The database should be made accessible via GOCI's website and easily navigable by the general public.

10. Overdose Awareness Week

August 31 is International Overdose Awareness Day and September is the SAMHSA-sponsored National Recovery Month. The Task Force recommends that the first week of September be declared Maryland Overdose Awareness Week, which will include a conference for Overdose Response Program (ORP) entities, vigils, and other local events to raise awareness of the addiction and overdose problem.

VIII. APPROVED RESOURCE ALLOCATIONS

In May 2015, Governor Hogan authorized \$2 million in additional funding for fiscal year 2016 to combat the heroin and opioid health crisis in Maryland. Over the last six months, the Task Force has had the opportunity to solicit input from well over 300 people on how to best utilize scarce resources to address this public health epidemic. Among the top suggestions received were requests for increased overdose prevention and addiction treatment funding, particularly for the Eastern Shore, ex-offenders, and women with children. Based on the work of the Task Force and the input provided by stakeholders, below are the initial funding announcements approved and authorized by Governor Hogan.

1. Restoring the A.F. Whitsitt Center to a 40-bed Capacity

Established in 1993, the A.F. Whitsitt Center is a 24-hour, seven-day-a-week residential treatment facility for adults suffering from chemical dependency and co-occurring disorders. It also offers a medically monitored detoxification for alcohol-, opiate-, and benzodiazepine-dependent individuals. As a Commission on Accreditation of Rehabilitation Facilities (CARF) accredited residential treatment facility, it offers a wide variety of treatment levels including Level 0.5 early intervention, Level 1 outpatient, Level 2.1 intensive outpatient, Level 3, and 3.7D residential treatment services.

Upon completion of the residential program, individuals are connected to a care coordinator through whom they have access to referral and linkage to community-based clinical and recovery support services.

The Center is located in Kent County on the grounds of the former Upper Shore Community Mental Health Center. The catchment area encompasses the entire Eastern Shore of

Resource Allocations Overview

- 1. Restoring the A.F. Whitsitt Center to a 40-bed Capacity**
- 2. Providing Community-Based Naloxone Training and Distribution**
- 3. Piloting Overdose Survivor Outreach Program in Hospital Emergency Departments**
- 4. Piloting Naloxone Distribution to Individuals Screened Positive for Opioid Use Disorder at Release from Local Detention Centers**
- 5. Expanding Supportive Recovery Housing for Women with Children**
- 6. Supporting Detoxification Services for Women with Children**
- 7. Targeted Outreach and Education to Aberrant/High-Risk Opioid and Other Controlled Substance Prescribers**
- 8. Overtime for Dorchester County Law Enforcement**
- 9. Maryland State Police Gang/Heroin Disruption Project**
- 10. License Plate Reader Technology**

Maryland. Demographically, Cecil County residents represents 53 percent of the patients, Talbot County represents 10 percent, Queen Anne's County represents 10 percent, Kent County represents 10 percent, Caroline and Dorchester Counties represent 9 percent, and the remaining Lower Shore counties represent 3 percent.

Although individuals can be referred by a physician, the primary source of referrals comes from county detention centers in the Center's catchment area. Judges from the Kent County Circuit and District Court send referrals as well. It treats just under 600 patients annually, prioritizing treatment toward low-income patients and patients requiring medical assistance. These patients tend to have failed outpatient treatment and are high-risk for fatal overdose.

Originally funded for 40 beds with average stay of 30 days, budget cuts in fiscal year 2012 resulted in reduced capacity, shorter lengths of stay, and a longer wait list. Today, the capacity is only 26 beds with an average length of stay of 21 days and an average wait time of four weeks for admission. Due to extraordinary demand and the fact that the Center is the only health department-operated 3.7D residential facility on the Eastern Shore, Governor Hogan has allocated \$800,000 in fiscal year 2016 to restore capacity to 40 beds allowing an additional 240 patients to receive treatment each year.

2. Providing Community-Based Naloxone Training and Distribution

The Overdose Response Program (ORP) is the State's primary vehicle for training community members on opioid overdose recognition and response and equipping them with naloxone. Although the ORP law only requires the Department of Health and Mental Hygiene to exercise regulatory oversight over local-level entities that conduct naloxone training and distribution, the Behavioral Health Administration (BHA) has historically provided funding to local health departments (LHDs) to promote and expand ORP trainings. Responses to a DHMH survey of ORP training entities conducted in early 2015 showed that many would cease or significantly curtail training and distribution if state funding was not available. As such, Governor Hogan directed \$500,000 in supplemental grant awards to LHDs to support ORP trainings. The funding may support the purchase of naloxone and related supplies, personnel time, and promoting and implementing training events.

Applicants will be asked to maximize naloxone funding opportunities from other sources and take advantage of new legal authorities to facilitate wider distribution. BHA will prioritize funding for applications that propose to use standing orders for naloxone prescribing and dispensing as authorized by Chapter 356 of 2015, legislation introduced by Senator Klausmeier to improve the State's ORP program. Standing orders remove the requirement that a healthcare practitioner, such as a doctor or nurse, be physically present for prescribing

and dispensing to occur, which will allow for broader and more efficient naloxone distribution to those most likely to experience, or be in a position to respond to, an opioid overdose. This was a major barrier identified by ORP training entities. In addition, BHA will prioritize funding to LHDs that partner with community-based organizations to expand the number of available trainings. Community-based ORP entities often include highly motivated volunteers with direct connections to high-risk individuals, their families, and friends.

3. Piloting Overdose Survivor Outreach Program in Hospital Emergency Departments

In 2014, DHMH issued a report showing that nearly 60 percent of all overdose decedents in 2013 had previously been treated for an overdose at a Maryland hospital in the year prior to death, with almost 10 percent having been treated for overdose five or more times. This indicates an urgent need to improve coordination between hospitals and public health authorities to target the provision of behavioral health treatment, recovery, and harm reduction services for opioid overdose survivors. In response, DHMH announced a new initiative in December 2014 to work with hospitals, local health departments, and behavioral health/addictions authorities to improve information sharing with hospitals and establish effective outreach and care coordination collaborations.

To further these efforts, Governor Hogan has directed BHA to allocate \$300,000 toward establishing a pilot Overdose Survivor Outreach Program (OSOP) in Baltimore City. The goal of OSOP will be to coordinate and supplement programs that identify and intervene with addicted individuals in hospital emergency departments to ensure ongoing, in-community follow-up and engagement with overdose survivors after discharge. OSOP will seek to implement peer support services for overdose survivors at multiple points in the continuum of care, including emergency medical services, treatment referral, care coordination, and while enrolled in a treatment program. Overdose education and naloxone distribution services will be incorporated and targeted for opioid overdose survivors. OSOP will also seek to identify and support additional hospitals in Baltimore City and neighboring jurisdictions interested in implementing screening, intervention, and referral protocols and partnering with the local addictions authority to improve care coordination services. Lessons learned from the pilot will inform the State's strategy to expand ED-based interventions to other hospitals throughout the State and be incorporated into technical assistance materials to support implementation.

Funding may be used to support hiring and training peer recovery support specialists, expanding the capacity of Behavioral Health Systems Baltimore (BHSB) to conduct outreach services, training hospital staff, and other necessary services. Importantly, funding will be coordinated to maximize the impact of other existing grant programs, including those focused on implementing Screening, Brief Intervention and Referral to Treatment (SBIRT) in hospitals

and community health centers and expanding access to recovery support services in medication-assisted treatment programs. Other existing funding streams will be leveraged, as available, to provide ongoing recovery support services, including Maryland Recovery Net, a fee-for-service recovery support system overseen by BHA and managed by Value Options that provides access to transportation, housing, peer support, and other services. BHA will work with BHSB and other State and local partners to improve data collection and analysis on survivors receiving services.

4. Piloting Naloxone Distribution to Individuals Screened Positive for Opioid Use Disorder at Release from Local Detention Centers

In 2014, the DHMH Vital Statistics Administration (VSA) worked with the Department of Public Safety and Correctional Services to match medical examiner records of overdose deaths with corrections data. Findings from the analysis supported existing research showing that opioid-addicted individuals are at increased risk of overdose immediately following release from incarceration. These findings indicate that targeting overdose education and naloxone distribution to high-risk individuals at the time of release may be an effective strategy for reducing overdose deaths. Models supporting these strategies currently exist across the country. For example, the New York State prison system has recently launched a program to dispense naloxone at the time of release. The Baltimore City Health Department has conducted overdose education trainings in the Baltimore City Detention Center.

Seeking solutions to these challenges, Governor Hogan directed BHA to provide \$150,000 through supplemental awards to three Southern Maryland LHDs - Calvert, Charles, and St. Mary's Counties - to implement overdose education and naloxone distribution programs for individuals released from those counties' local detention centers. Focusing the pilot in one region of the state will help maximize impact and evaluation in these three counties that collectively experienced an 88 percent increase in overdose deaths between 2013 and 2014. Historically, these counties have also had limited naloxone distribution through ORPs and there were no opioid treatment programs that received a supply of the Evzio naloxone auto-injector donation. There is an urgent need to target distribution to high-risk individuals in these counties. BHA will work with the LHDs to ensure that those being released are screened for opioid use disorder and that naloxone distribution is targeted accordingly. Detention centers and LHDs will be required to collect and report to BHA information on the individuals served by the program to evaluate impact and estimate the feasibility of expanding the program statewide.

5. Expanding Supportive Recovery Housing for Women with Children

Research shows that parental substance use is associated with numerous negative outcomes for children. Parental substance use has been shown to increase the likelihood that a family will experience financial problems, shifting of adult roles onto children, child abuse and neglect, violence, disrupted environments, and inconsistent parenting. Research also shows that a complex and harmful cycle exists in which a history of child abuse and neglect increases a person's risk of substance use later in life and that individuals with substance use disorders are more likely to abuse or neglect their children in turn. In addition, children of parents with substance use disorders are known to have a heightened risk for developing substance use problems themselves. Women, the traditional caregivers, face many obstacles and challenges in engaging in treatment and recovery services that could prevent these negative outcomes. Those obstacles include a lack of collaboration among social service systems, limited options for women who are pregnant, lack of culturally congruent programming, few resources for women with children, fear of loss of child custody, and the stigma of substance use.

In 2012, BHA initiated a series of focus groups to explore substance use among women with children at every women and children's residential treatment program and at several co-ed, intensive outpatient programs. The results were universal: the overarching need identified for

“We are going to attack this problem from every direction using everything we've got.”

—Governor Larry Hogan

women with dependent children was recovery housing that would allow a mother to bring all of her children into recovery with her. Since 2013, BHA has funded recovery houses in Baltimore City and Anne Arundel County.

There are currently nine vendors: six in Baltimore City with 11 houses and three in Anne Arundel County with four houses. The houses are in constant demand with waiting lists, as treatment providers are often looking for options similar to these homes when women are ready to be discharged from more intensive treatment.

As such, Governor Hogan directed BHA to allocate an additional \$100,000 for recovery housing, prioritizing those jurisdictions that currently do not have recovery housing for women with children and those with a significant waiting list. The funding will support the lease/rent of a house, furnishing for the building, and a peer house manager to reside in the facility with the families.

6. Supporting Detoxification Services for Women with Children

Detoxification is an important, but resource-intensive process. Clients require 24-hour monitoring for assessment and ongoing monitoring of sub-acute biomedical and behavioral conditions related to opioid and alcohol withdrawal. A comprehensive nursing assessment

including client and family history; vital signs; and medication, psychiatric, medical, and substance use history are all provided upon admission to the treatment. Because women historically do better in treatment with their children than without their children, BHA utilizes a model of residential detoxification services with childcare services on site in Baltimore City. This allows mothers to detox in a safe environment and children can receive appropriate wraparound services. These services include, but are not limited to, pediatric and mental health referrals, after-school programming, and recreational activities that are age appropriate.

As such, Governor Hogan will direct BHA to make an additional \$50,000 available to continue operation of this program. Treatment programs will have an opportunity to submit a request for the funding and will identify the best practices that they will utilize to move the women into long-term residential treatment or intensive outpatient treatment. BHA will require a yearly report that documents how the program used the funding and the outcomes associated with the funding.

7. Targeted Outreach and Education to Aberrant/High-Risk Opioid and Other Controlled Substance Prescribers

The widespread overprescribing of opioid analgesics for the treatment of pain has been identified as a major driver of the opioid addiction and overdose epidemic. Increased opioid prescribing has refocused the medical community on the lack of strong evidence for the safety and efficacy of long-term opioid therapy for chronic non-cancer pain. However, many providers, including both primary care and pain specialists, may continue to prescribe inappropriately based on outdated or erroneous information about the risks and benefits of opioids for most patients. High-risk prescribing practices, including maintaining patients at high opioid doses, rapid dose escalation, and co-prescribing opioids, benzodiazepines, and other controlled substances, may be common among a relatively small subset of practitioners. This small group may be disproportionately contributing to new cases of addiction, overdose, and diversion.

Aberrant prescribers are at high risk for disciplinary actions by licensing boards and criminal enforcement actions by public safety authorities. These actions can create other unintended consequences when the prescriber's patients are abruptly cut off from their prescriptions. These patients often have multiple co-occurring somatic and behavioral health issues, and a large influx of patients with complex needs can quickly overwhelm a local healthcare system in medically underserved areas.

DHMH has promoted continuing medical education (CME) courses on opioid prescribing provided by MedChi and the Maryland Society of Addiction Medicine and is organizing a live CME training for physicians, nurses, and pharmacists to take place in Maryland in October 2015. The Maryland Board of Physicians has also required a one-hour CME credit on appropriate opioid prescribing as part of its licensing process for all physicians starting in 2015. However, to date there have been no clinical education initiatives narrowly targeted at high-risk prescribers.

As such, Governor Hogan has directed DHMH to allocate \$100,000 to conduct targeted outreach and education for practitioners identified as engaging in high-risk prescribing practices. DHMH will develop clinical tools and deploy appropriate personnel to provide direct consultation and support services to improve the quality of treatment provided to patients with chronic pain that are receiving opioid prescriptions. Educational content may also include information on use of the PDMP and CRISP, screening and referral for substance use disorders, buprenorphine, naloxone, and other overdose prevention priorities for the Department. In collaboration with academic partners, practitioner organizations and other stakeholders, DHMH will also investigate establishing an inter-disciplinary pain and addiction medicine collaborative that can provide ongoing clinical consultation to primary care providers across the state.

High-risk practices will be identified by DHMH through analyses of Medicaid claims data, pharmacy inspections/surveys, medical examiner records, and other intra-departmental data sources. DHMH will also conduct an analysis of the PDMP law and regulations to determine whether PDMP data and legal authorities could be used to identify providers or as a means of outreach and education.

8. Overtime for Dorchester County Law Enforcement

Governor Hogan, through the Office of Crime Control and Prevention (GOCCP), will provide Dorchester County with \$24,700 to provide overtime for law enforcement to address the opioid and heroin epidemic. Overtime will be used to gather intelligence in conjunction with numerous regional law enforcement agencies to examine the point of origin of the heroin and locations from which drugs are entering Dorchester County. This information will enable law enforcement to target efforts in regards to control and enforcement and will be valuable in prosecuting heroin trafficking cases.

9. Maryland State Police Gang/Heroin Disruption Project

Governor Hogan, through GOCCP, will provide Maryland State Police (MSP) with \$40,000 to support MSP's Gang/Heroin Disruption Project. The funds will provide overtime to members

of the MSP Gang Enforcement Unit to conduct home visits with parole and probation officers to Violence Prevention Initiative (VPI) offenders, work beyond scheduled shifts to further heroin investigations, conduct surveillance, and serve arrest warrants. These inter-jurisdictional efforts will help law enforcement arrest street-level drug dealers and those transporting heroin into Maryland.

10. License Plate Reader Technology

Governor Hogan, through GOCCP, will provide the Ocean City Police Department with \$124,635 to fund license plate reader (LPR) technology at the northern end of Ocean City. The LPR will allow law enforcement to target heroin coming into the State and will be linked into the Maryland Coordination and Analysis Center (MCAC) database.

IX. CONCLUSION

The Heroin and Opioid Emergency Task Force has worked diligently to determine the scale of Maryland's heroin and opioid problem, investigate areas of specific concern and opportunity, and gather a broad coalition of stakeholders to assist in finding solutions. The Interim Report's 10 recommendations and 10 funding disbursements represent the input of hundreds of contributors and will have an immediate positive effect in combating this public health crisis. Even so, the work of the Task Force and its workgroups is nowhere near complete. Over the next four months, the Task Force will continue to leverage all available resources to produce additional recommendations for the Final Report that will span areas ranging from education and prevention to insurance coverage to alternatives to incarceration.

X. ACKNOWLEDGEMENTS

The Task Force is tremendously grateful for the outpouring of support and expertise provided by hundreds of people to help the State combat the heroin and opioid epidemic.

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APPENDICES

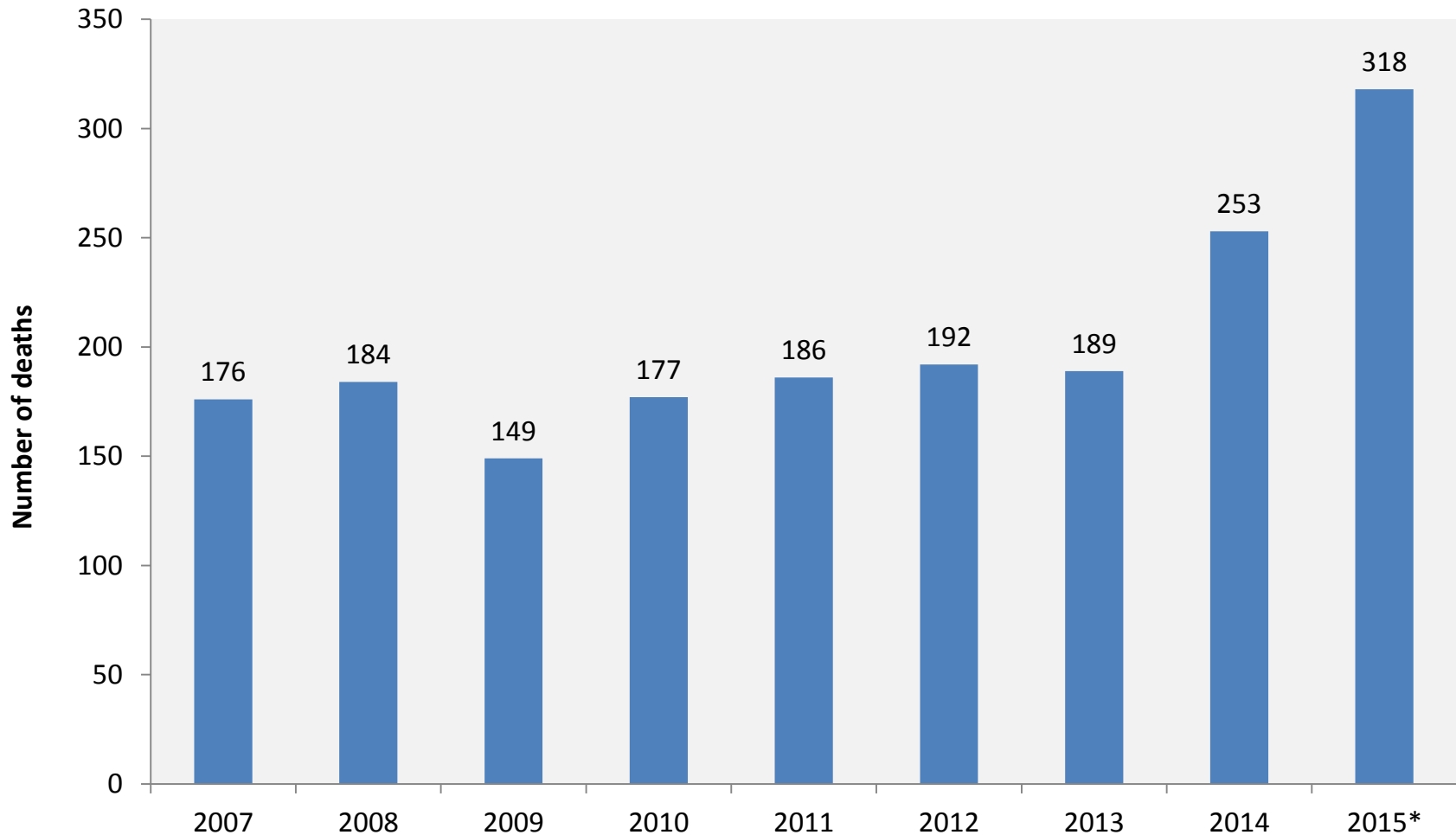
Drug and Alcohol-Related Intoxication Deaths in Maryland

Data update through 1st quarter 2015

This report contains counts of drug and alcohol-related intoxication deaths* occurring in Maryland through the first quarter of 2015, the most recent period for which reasonably complete data are available. Counts are also shown for the same period of 2007-2014 to allow for comparison of trends over time. Counts for 2015 are preliminary and subject to change.

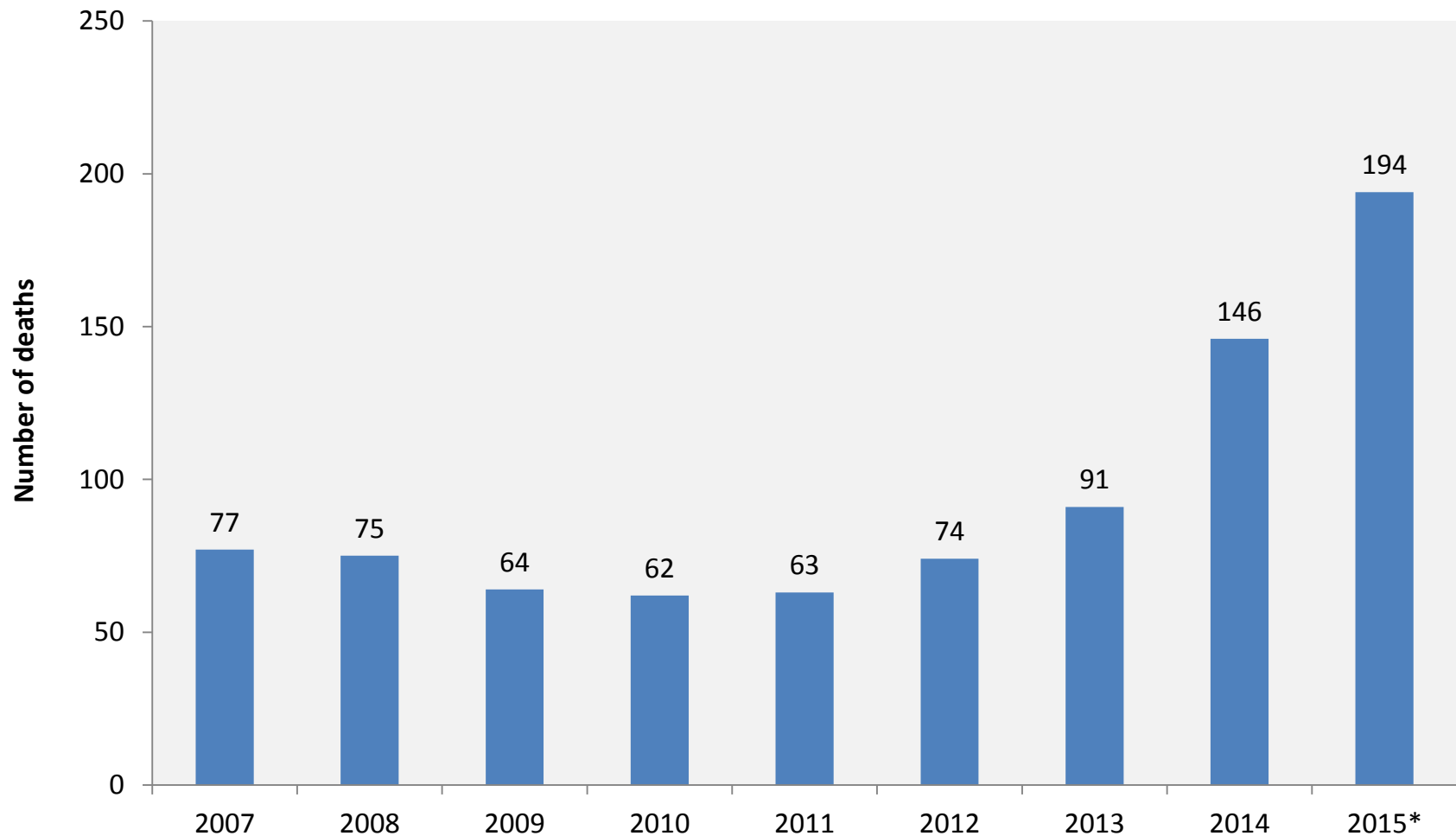
*Deaths resulting from recent ingestion or exposure to alcohol or other types of drugs, including heroin, cocaine, phencyclidine (PCP), prescription opioids, benzodiazepines, methamphetamines and other prescribed and unprescribed drugs.

Figure 1. Total Number of Unintentional Intoxication Deaths Occurring in Maryland from January-March of Each Year.*



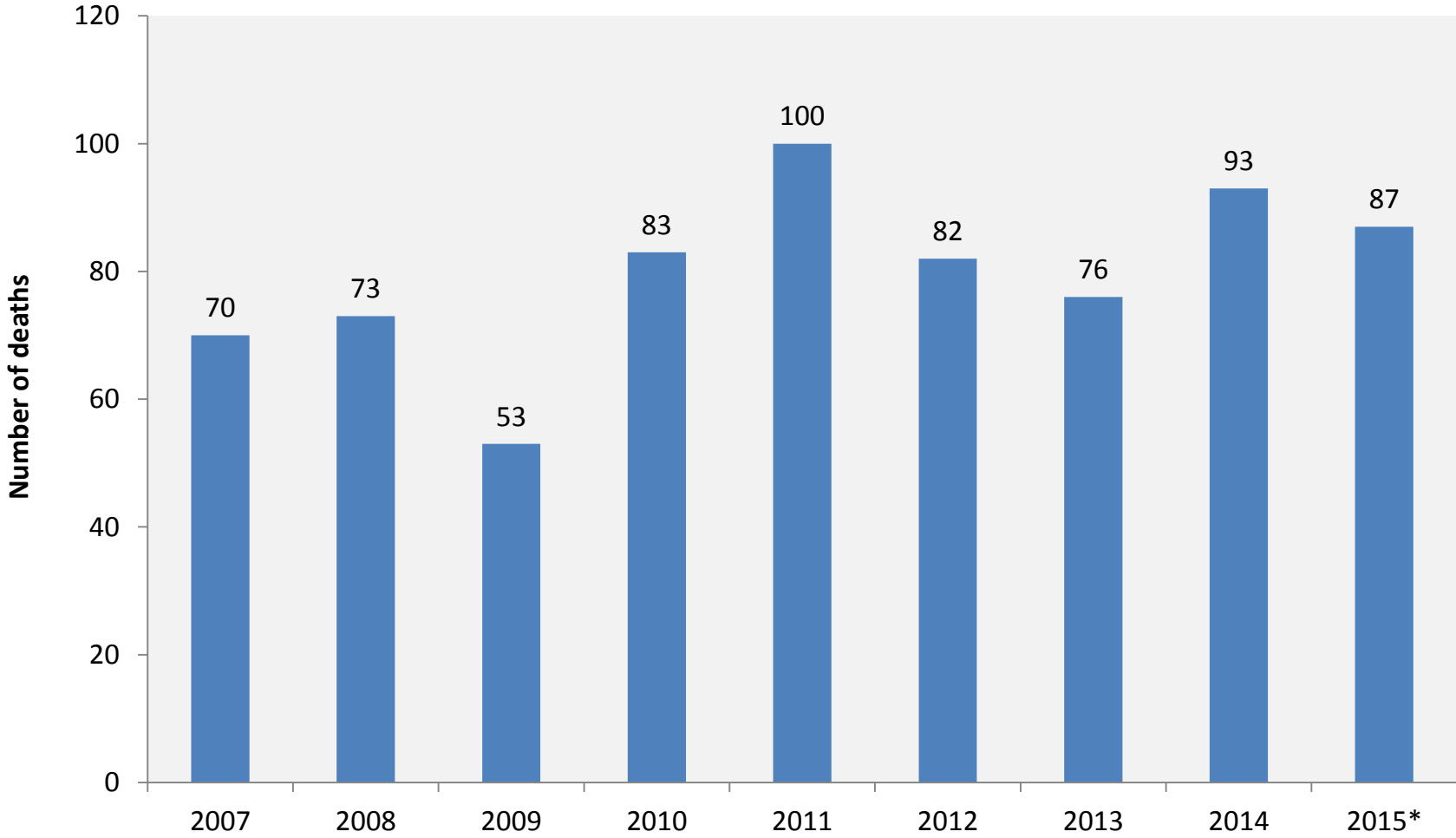
*2015 counts are preliminary.

Figure 2. Number of Heroin-Related Deaths Occurring in Maryland from January through March of Each Year.*



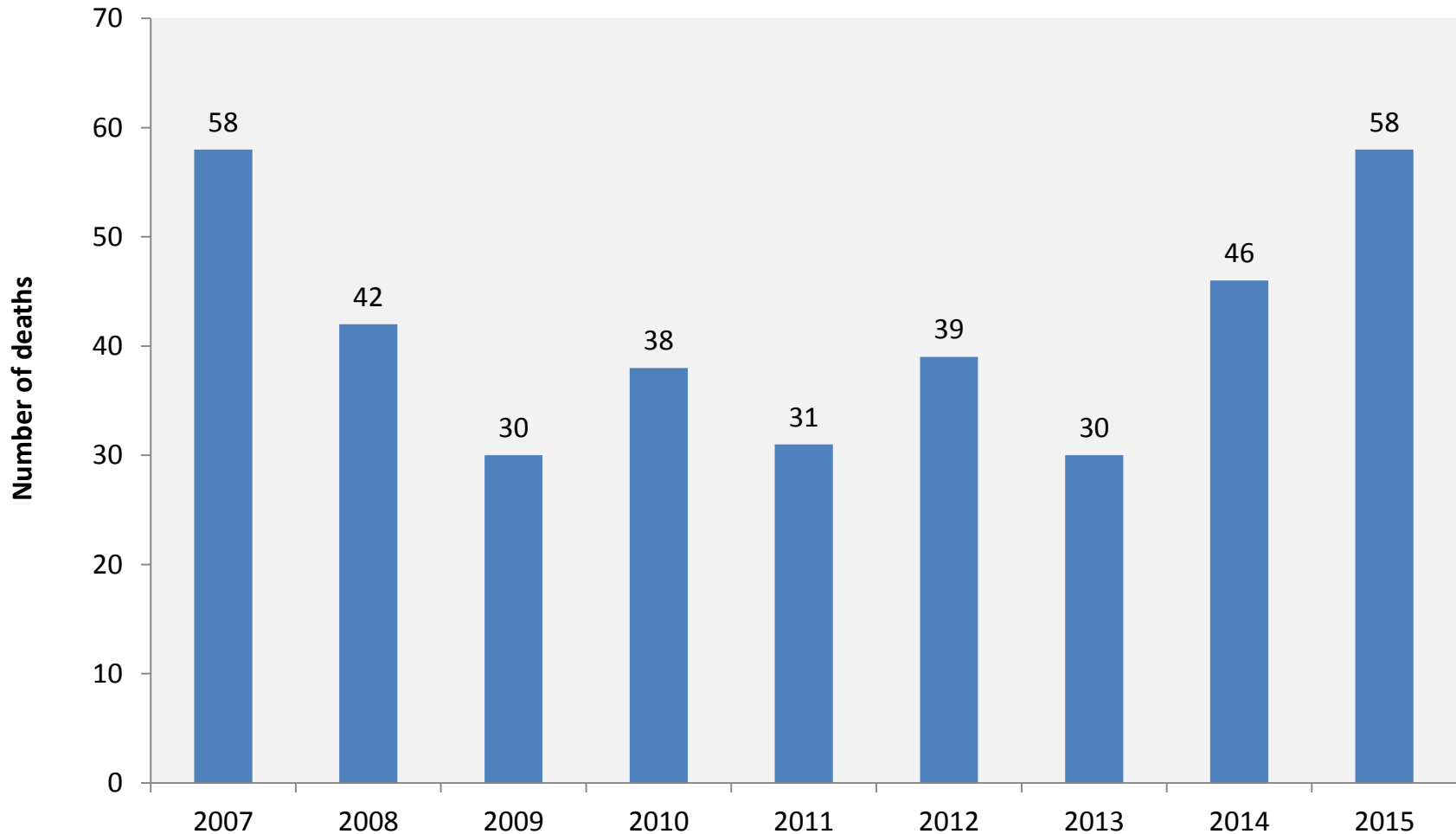
*2015 counts are preliminary.

Figure 3. Number of Prescription Opioid-Related Deaths Occurring in Maryland from January through March of Each Year.*



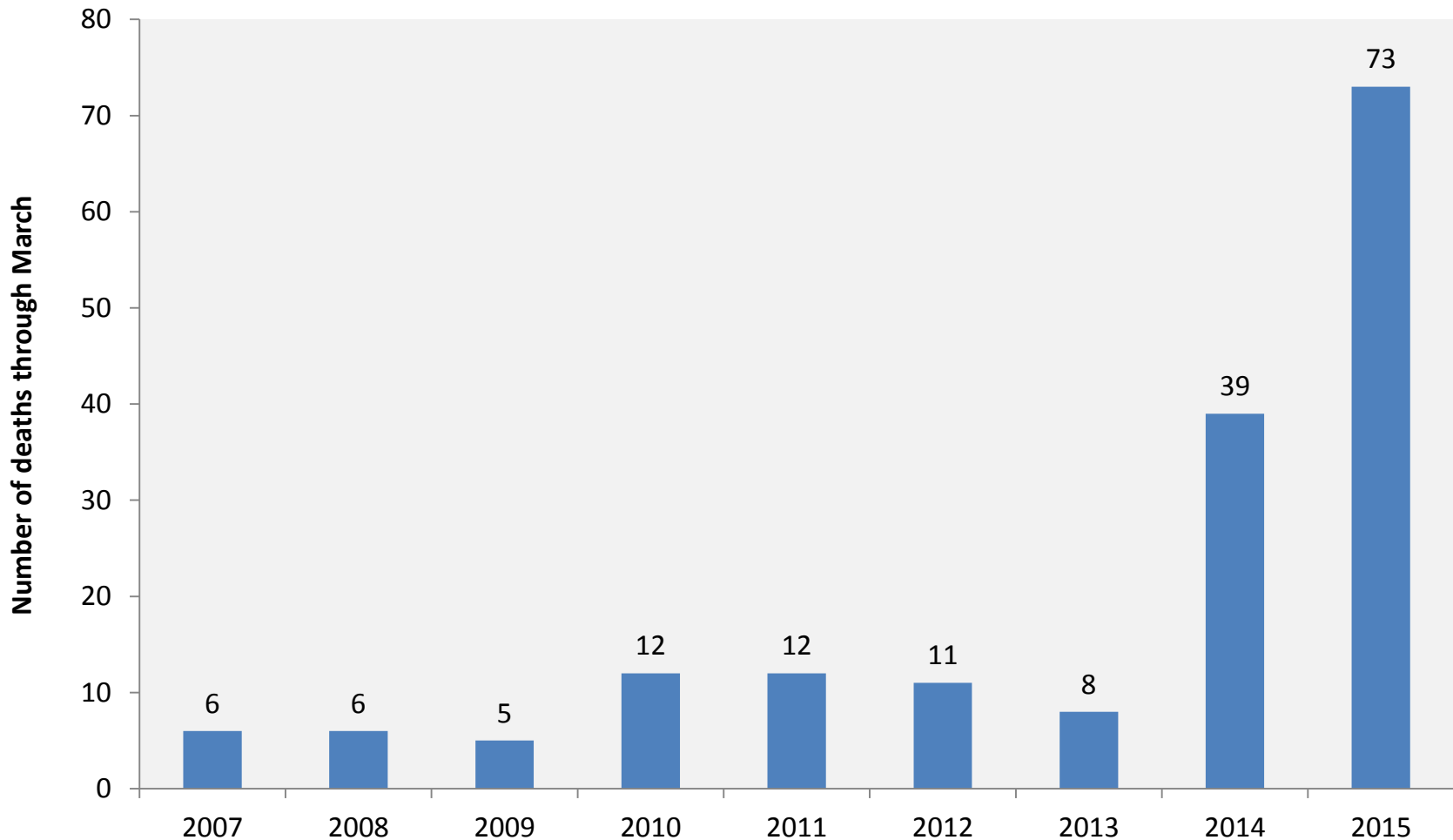
*2015 counts are preliminary.

Figure 4. Number of Cocaine-Related Deaths Occurring in Maryland from January through March of Each Year.*



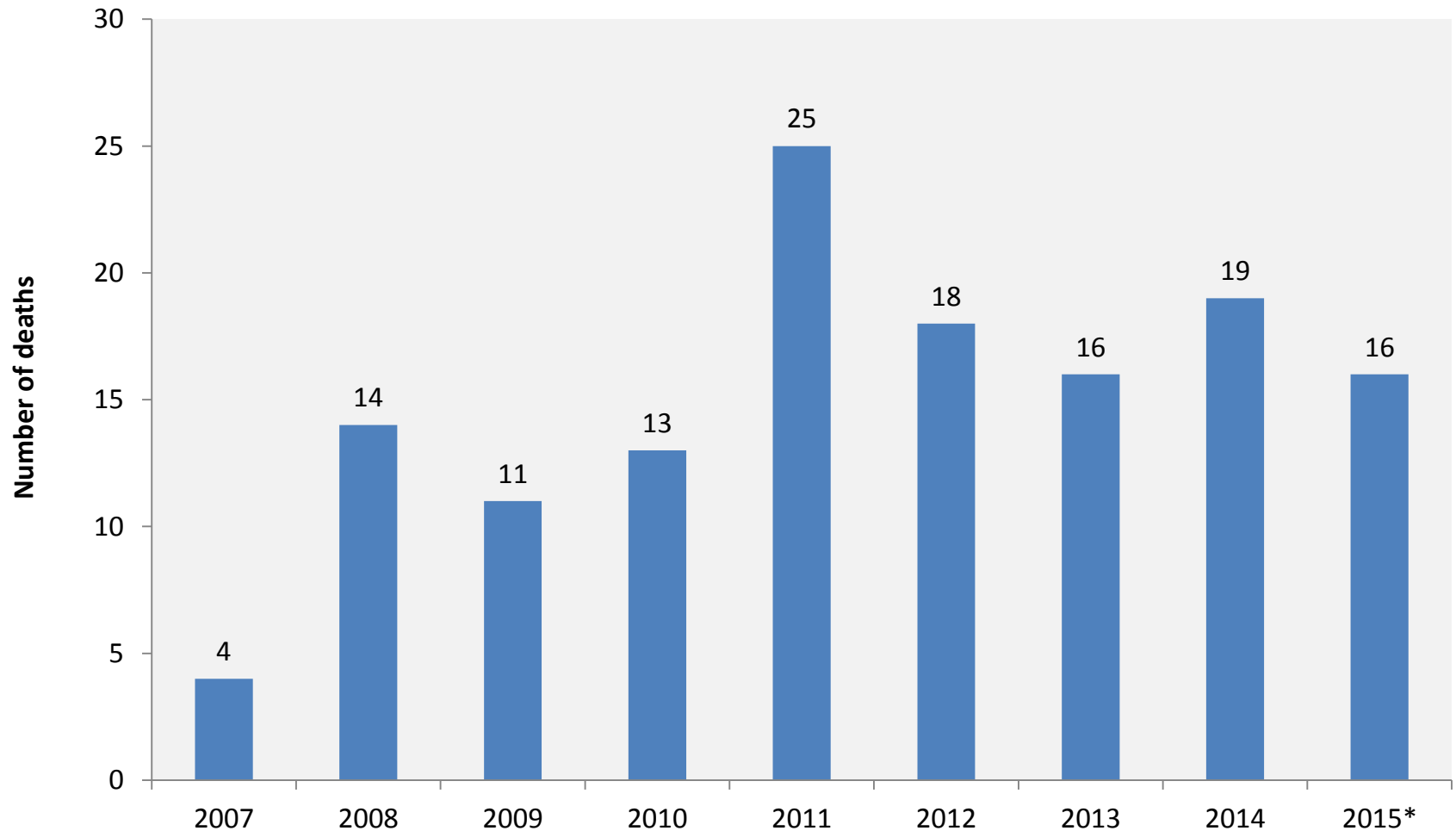
*2015 counts are preliminary.

Figure 5. Number of Fentanyl-Related Intoxication Deaths Occurring in Maryland Through March of Each Year.*



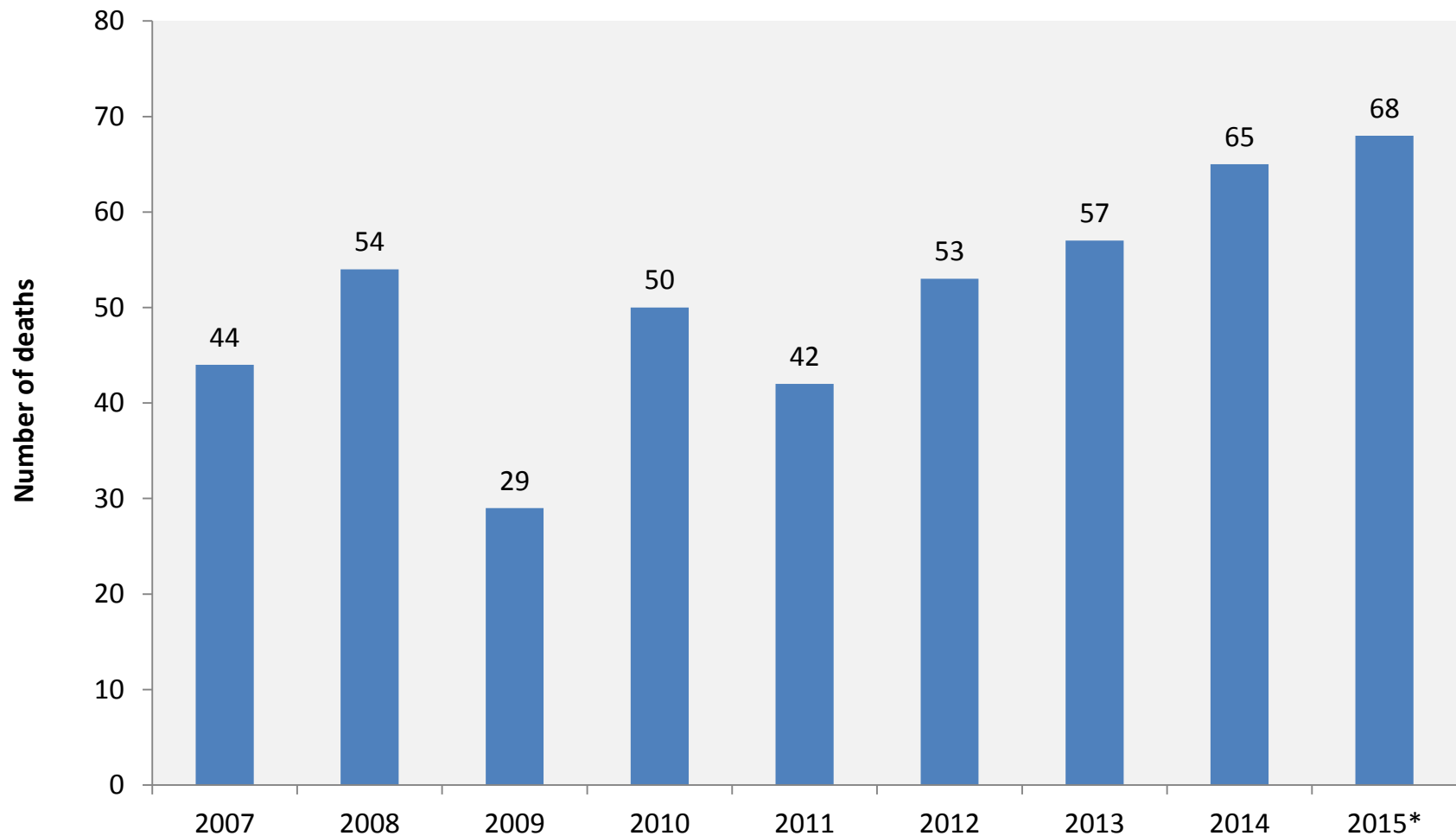
*2014 counts are preliminary and include deaths reported by OCME through March 2014.

Figure 6. Number of Benzodiazepine-Related Deaths Occurring in Maryland from January through March of Each Year.*



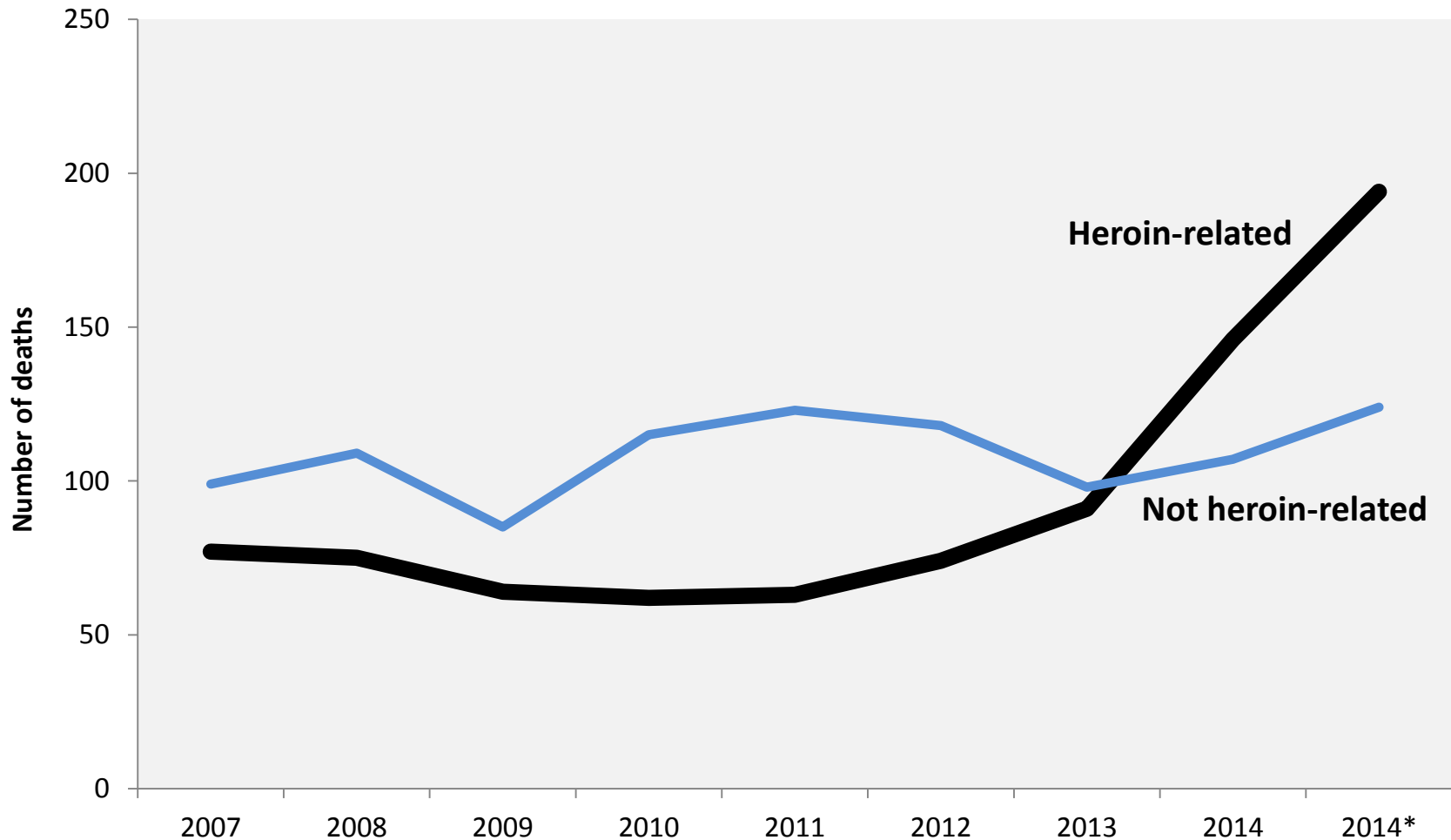
*2015 counts are preliminary.

Figure 7. Number of Alcohol-Related Deaths Occurring in Maryland from January through March of Each Year.*



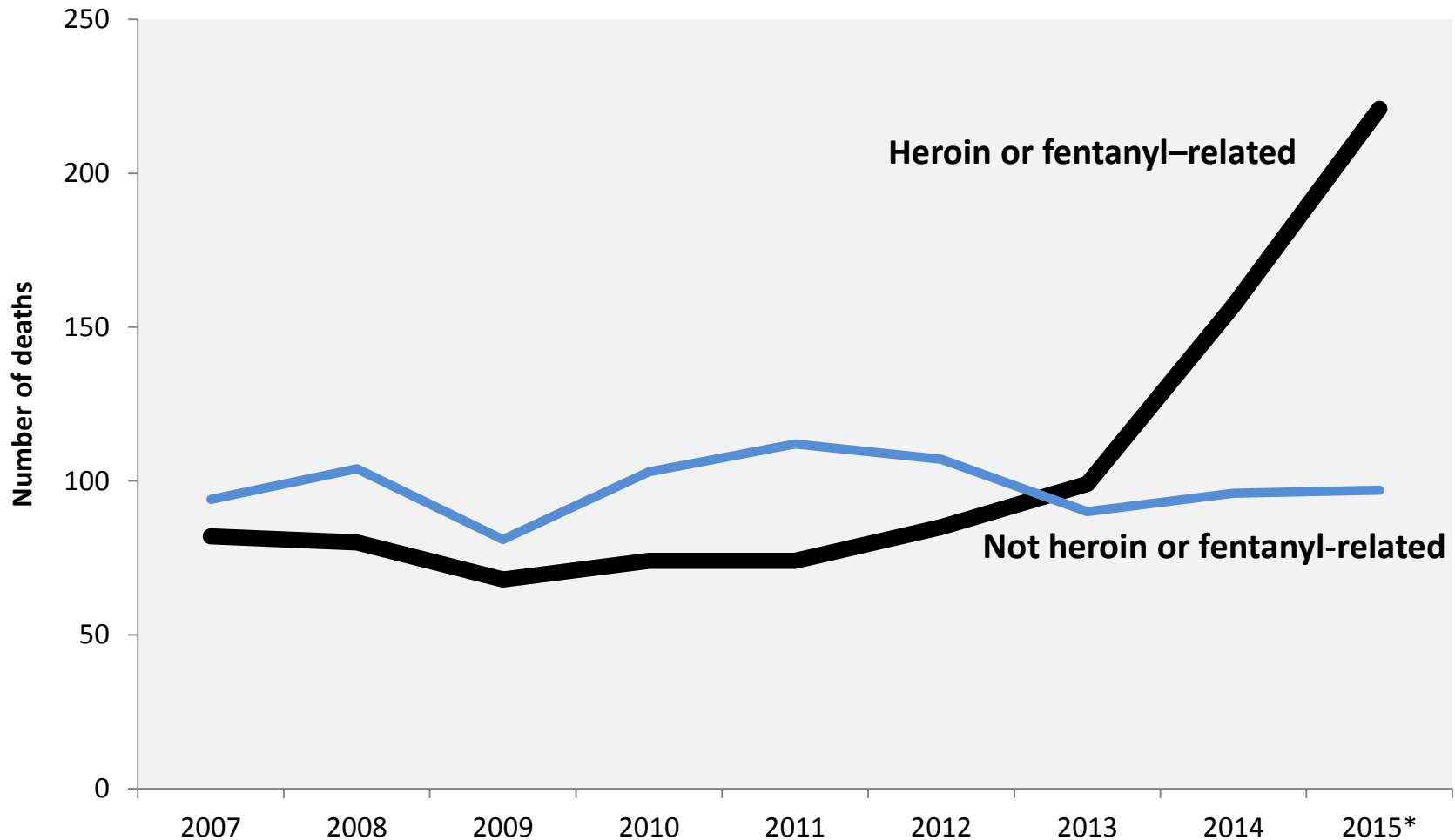
*2015 counts are preliminary.

Figure 8. Number of Drug and Alcohol-Related Intoxication Deaths Involving Heroin Through March of Each Year.*



*2015 counts are preliminary.

Figure 9. Number of Drug and Alcohol-Related Intoxication Deaths Involving Heroin or Fentanyl Through March of Each Year.*



*2015 counts are preliminary.



Figure 10

Total Number of Drug and Alcohol-Related Intoxication
Deaths by Place of Occurrence, Maryland.
January -- March, 2015 and 2014.

State of Maryland	Drug & Alcohol Intoxication Deaths		2015 vs 2014
COUNTY	Jan. - Mar. 2015	Jan. -Mar. 2014	# DIFFERENCE
Allegany County	5	1	4
A. A. County	27	23	4
Baltimore City	116	74	42
Baltimore County	47	40	7
Calvert County	5	9	-4
Caroline County	0	1	-1
Carroll County	11	14	-3
Cecil County	6	10	-4
Charles County	6	6	0
Dorchester County	0	0	0
Frederick County	3	11	-8
Garrett County	1	1	0
Harford County	9	7	2
Howard County	7	3	4
Kent County	2	0	2
Montgomery County	23	10	13
P.G. County	13	16	-3
Queen Anne's County	1	3	-2
Somerset County	6	1	5
St. Mary's County	3	3	0
Talbot County	2	0	2
Washington County	19	11	8
Wicomico County	4	6	-2
Worcester County	2	3	-1
Total	318	253	65

¹Includes deaths that were the result of recent ingestion or exposure to alcohol or another type of drug, including heroin, cocaine, prescription opioids, benzodiazepines, and other prescribed and unprescribed drugs.

²Includes only deaths for which the manner of death was classified as accidental or undetermined.

³Counts for 2015 are preliminary.

TABLE 1. TOTAL NUMBER OF DRUG AND ALCOHOL-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2014 AND YTD 2015 THROUGH MARCH.^{1,2,3}

	TOTAL INTOXICATION DEATHS								
	2007	2008	2009	2010	2011	2012	2013	2014	YTD 2015
MARYLAND	815	694	731	649	671	799	858	1,040	318
WESTERN AREA	110	99	97	96	109	115	138	161	51
GARRETT	1	3	3	3	2	0	6	2	1
ALLEGANY	14	9	9	15	12	14	15	12	5
WASHINGTON	16	26	18	20	21	27	28	40	19
FREDERICK	23	15	23	20	30	26	37	42	3
MONTGOMERY	56	46	44	38	44	48	52	65	23
CENTRAL AREA	550	443	479	411	420	519	557	677	217
BALTIMORE CITY	287	184	239	172	167	225	246	304	116
BALTIMORE COUNTY	131	118	106	115	107	119	144	170	47
ANNE ARUNDEL	71	70	63	56	79	83	78	101	27
CARROLL	14	17	22	15	8	29	24	38	11
HOWARD	16	19	16	10	21	24	29	21	7
HARFORD	31	35	33	43	38	39	36	43	9
SOUTHERN AREA	86	94	93	74	73	93	84	110	27
CALVERT	14	9	14	6	12	12	6	17	5
CHARLES	13	16	11	13	11	13	9	21	6
ST. MARY'S	6	11	9	12	8	12	10	9	3
PRINCE GEORGE'S	53	58	59	43	42	56	59	63	13
EASTERN SHORE									
AREA	69	58	62	68	69	72	79	92	23
CECIL	25	10	24	24	28	25	26	29	6
KENT	3	4	2	5	2	0	4	6	2
QUEEN ANNE'S	4	5	4	4	5	2	8	10	1
CAROLINE	1	4	2	2	11	4	2	7	0
TALBOT	5	4	3	3	1	5	7	4	2
DORCHESTER	4	5	2	6	2	5	5	0	0
WICOMICO	9	13	12	13	11	21	17	20	4
SOMERSET	6	3	4	1	3	3	4	3	6
WORCESTER	12	10	9	10	6	7	6	13	2

¹ Includes deaths that were the result of recent ingestion or exposure to alcohol or another type of drug, including heroin, cocaine, prescription opioids, benzodiazepines, and other prescribed and unprescribed drugs.

² Includes only deaths for which the manner of death was classified as accidental or undetermined.

³ Counts for 2015 are preliminary.

TABLE 2. HEROIN-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2014 AND YTD 2015 THROUGH MARCH.^{1,2,3}

	HEROIN-RELATED DEATHS								
	2007	2008	2009	2010	2011	2012	2013	2014	YTD 2015
MARYLAND	399	289	360	238	247	392	464	578	194
WESTERN AREA	33	35	39	27	34	49	68	86	30
GARRETT	0	0	1	0	1	0	2	1	1
ALLEGANY	3	4	2	3	3	6	3	5	4
WASHINGTON	5	13	11	6	8	11	14	21	11
FREDERICK	8	4	9	6	11	10	21	26	2
MONTGOMERY	17	14	16	12	11	22	28	33	12
CENTRAL AREA	323	203	264	171	165	272	319	379	140
BALTIMORE CITY	200	107	151	93	76	131	150	192	86
BALTIMORE COUNTY	56	51	53	42	38	64	76	86	25
ANNE ARUNDEL	38	24	31	18	24	38	41	53	14
CARROLL	9	5	7	3	2	13	14	16	5
HOWARD	8	8	7	3	10	12	16	9	5
HARFORD	12	8	15	12	15	14	22	23	5
SOUTHERN AREA	28	35	36	25	27	38	38	60	9
CALVERT	5	3	7	1	5	6	2	13	4
CHARLES	2	5	3	6	6	5	5	10	2
ST. MARY'S	1	3	0	4	4	7	6	5	0
PRINCE GEORGE'S	20	24	26	14	12	20	25	32	3
EASTERN SHORE									
AREA	15	16	21	15	21	33	39	53	15
CECIL	8	4	12	4	8	11	11	15	4
KENT	1	1	0	0	1	0	0	2	1
QUEEN ANNE'S	0	1	3	2	2	2	5	7	0
CAROLINE	0	0	0	0	3	3	2	6	0
TALBOT	1	2	0	0	1	2	2	4	2
DORCHESTER	1	2	0	2	1	3	3	0	0
WICOMICO	1	3	3	5	3	9	11	12	3
SOMERSET	2	1	1	0	1	2	1	1	4
WORCESTER	1	2	2	2	1	1	4	6	1

¹ Includes deaths confirmed or suspected to be related to recent heroin use.

² Includes only deaths for which the manner of death was classified as accidental or undetermined.

³ Counts for 2015 are preliminary.

TABLE 3. PRESCRIPTION OPIOID-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2014 AND YTD 2015 THROUGH MARCH.^{1,2,3}

	PRESCRIPTION OPIOID-RELATED DEATHS								
	2007	2008	2009	2010	2011	2012	2013	2014	YTD 2015
MARYLAND	302	280	251	311	342	311	316	329	87
WESTERN AREA	42	38	40	36	58	48	51	52	15
GARRETT	0	2	2	1	1	0	2	2	0
ALLEGANY	9	5	6	8	5	5	8	6	1
WASHINGTON	7	10	4	7	11	9	11	16	7
FREDERICK	6	4	9	6	21	16	14	9	0
MONTGOMERY	20	17	19	14	20	18	16	19	7
CENTRAL AREA	190	189	148	197	212	196	207	216	60
BALTIMORE CITY	95	60	63	61	82	74	86	83	25
BALTIMORE COUNTY	48	51	37	60	68	47	54	59	18
ANNE ARUNDEL	22	36	20	31	33	33	28	32	6
CARROLL	4	11	10	9	5	17	12	15	5
HOWARD	6	6	4	6	9	5	13	7	3
HARFORD	15	25	14	30	15	20	14	20	3
SOUTHERN AREA	25	28	31	33	30	29	26	35	7
CALVERT	8	3	4	3	7	6	3	7	1
CHARLES	6	6	7	4	5	7	5	9	3
ST. MARY'S	3	7	7	9	3	5	4	3	1
PRINCE GEORGE'S	8	12	13	17	15	11	14	16	2
EASTERN SHORE									
AREA	45	25	32	45	42	38	32	26	5
CECIL	19	6	10	20	20	18	12	12	0
KENT	2	3	2	3	1	0	4	2	1
QUEEN ANNE'S	4	1	1	2	2	0	3	3	1
CAROLINE	0	2	1	2	5	1	0	1	0
TALBOT	2	1	2	2	0	1	4	0	0
DORCHESTER	2	1	1	4	1	3	3	0	0
WICOMICO	5	4	8	7	7	9	4	3	1
SOMERSET	4	3	1	1	3	2	2	1	1
WORCESTER	7	4	6	4	3	4	0	4	1

¹ Includes deaths that were related to recent ingestion of one or more prescription opioids.

² Includes only deaths for which the manner of death was classified as accidental or undetermined.

³ Counts for 2015 are preliminary.

TABLE 4. COCAINE-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2014 AND YTD 2015 THROUGH MARCH.^{1,2,3}

	COCAINE-RELATED DEATHS								
	2007	2008	2009	2010	2011	2012	2013	2014	YTD 2015
MARYLAND	248	157	162	135	148	153	154	198	58
WESTERN AREA	29	16	11	12	22	21	26	26	7
GARRETT	0	0	0	1	0	0	0	0	0
ALLEGANY	2	1	1	1	0	2	2	2	2
WASHINGTON	3	1	0	3	3	5	6	6	3
FREDERICK	4	2	3	3	7	2	5	8	1
MONTGOMERY	20	12	7	4	12	12	13	10	1
CENTRAL AREA	178	108	124	93	97	108	102	138	44
BALTIMORE CITY	106	57	72	45	48	59	47	82	27
BALTIMORE COUNTY	30	25	25	23	19	17	27	28	11
ANNE ARUNDEL	26	18	15	13	18	13	12	19	3
CARROLL	2	2	3	6	3	7	7	2	1
HOWARD	6	1	4	1	5	7	5	3	2
HARFORD	8	5	5	5	4	5	4	4	0
SOUTHERN AREA	20	20	15	19	15	16	13	22	4
CALVERT	1	2	1	3	2	3	0	2	0
CHARLES	3	3	2	2	1	1	0	0	0
ST. MARY'S	1	1	1	2	0	2	1	1	1
PRINCE GEORGE'S	15	14	11	12	12	10	12	19	3
EASTERN SHORE									
AREA	21	13	12	11	14	8	13	12	3
CECIL	5	3	4	3	7	2	5	4	0
KENT	1	2	0	1	0	0	0	1	1
QUEEN ANNE'S	3	0	2	0	1	0	0	0	0
CAROLINE	0	0	1	0	1	1	0	1	0
TALBOT	4	0	1	0	0	0	3	0	1
DORCHESTER	1	1	0	1	1	1	1	0	0
WICOMICO	2	5	2	3	3	4	3	4	1
SOMERSET	1	0	1	1	0	0	0	0	0
WORCESTER	4	2	1	2	1	0	1	2	0

¹ Includes deaths that were related to recent use of cocaine.

² Includes only deaths for which the manner of death was classified as accidental or undetermined.

³ Counts for 2015 are preliminary.

TABLE 5. ALCOHOL-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2014 AND YTD 2015 THROUGH MARCH.^{1,2,3}

	ALCOHOL-RELATED DEATHS								
	2007	2008	2009	2010	2011	2012	2013	2014	YTD 2015
MARYLAND	187	175	162	160	161	195	239	270	68
WESTERN AREA	29	34	25	25	32	27	34	45	10
GARRETT	1	2	1	1	1	0	2	1	0
ALLEGANY	5	0	3	4	2	4	2	3	1
WASHINGTON	3	10	4	5	4	3	6	11	3
FREDERICK	5	7	8	5	9	5	11	12	2
MONTGOMERY	15	15	9	10	16	15	13	18	4
CENTRAL AREA	114	96	100	94	99	126	154	166	51
BALTIMORE CITY	56	41	54	39	44	71	86	86	31
BALTIMORE COUNTY	38	23	22	29	22	24	32	39	8
ANNE ARUNDEL	12	12	9	10	21	15	22	18	8
CARROLL	3	4	5	4	4	4	4	9	2
HOWARD	2	7	5	3	4	6	6	6	1
HARFORD	3	9	5	9	4	6	4	8	1
SOUTHERN AREA	31	27	21	22	19	30	29	30	5
CALVERT	3	3	4	0	2	2	1	4	1
CHARLES	5	5	1	4	3	2	4	5	1
ST. MARY'S	2	1	3	2	2	3	2	3	0
PRINCE GEORGE'S	21	18	13	16	12	23	22	18	3
EASTERN SHORE									
AREA	13	18	16	19	11	12	22	29	2
CECIL	5	4	7	6	3	6	9	5	0
KENT	0	0	0	1	0	0	1	1	0
QUEEN ANNE'S	1	2	0	1	3	0	1	7	0
CAROLINE	1	0	1	0	1	0	1	2	0
TALBOT	0	3	0	0	0	2	2	0	0
DORCHESTER	2	0	0	1	0	1	0	0	0
WICOMICO	1	6	3	4	2	2	6	7	0
SOMERSET	0	0	1	0	1	1	1	2	2
WORCESTER	3	3	4	6	1	0	1	5	0

¹ Includes deaths that were related to recent ingestion of alcohol.

² Includes only deaths for which the manner of death was classified as accidental or undetermined.

³ Counts for 2015 are preliminary.

**TABLE 6. FENTANYL-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2014
AND YTD 2015 THROUGH MARCH.^{1,2,3}**

	FENTANYL-RELATED DEATHS								
	2007	2008	2009	2010	2011	2012	2013	2014	YTD 2015
MARYLAND	26	25	27	39	26	29	58	185	73
WESTERN AREA	5	1	2	7	6	5	7	16	7
GARRETT	0	1	0	0	1	0	0	0	0
ALLEGANY	3	0	1	2	1	1	1	1	0
WASHINGTON	0	0	0	2	1	1	4	1	1
FREDERICK	0	0	0	2	3	1	2	6	0
MONTGOMERY	2	0	1	1	0	2	0	8	6
CENTRAL AREA	14	19	16	20	10	16	35	141	57
BALTIMORE CITY	3	2	4	4	2	4	12	71	40
BALTIMORE COUNTY	6	9	9	6	4	5	11	36	12
ANNE ARUNDEL	3	5	3	5	2	3	6	23	2
CARROLL	0	2	0	2	0	1	2	4	1
HOWARD	1	0	0	0	0	2	3	5	1
HARFORD	1	1	0	3	2	1	1	2	1
SOUTHERN AREA	1	1	4	3	3	2	10	16	5
CALVERT	0	1	1	0	1	0	0	5	1
CHARLES	0	0	0	0	1	1	3	1	1
ST. MARY'S	0	0	1	1	1	0	1	3	0
PRINCE GEORGE'S	1	0	2	2	0	1	6	7	3
EASTERN SHORE									
AREA	6	4	5	9	7	6	6	12	4
CECIL	2	1	0	2	2	0	0	1	1
KENT	0	0	0	0	0	0	0	1	0
QUEEN ANNE'S	1	0	0	0	0	0	1	1	0
CAROLINE	0	0	0	1	4	0	0	0	0
TALBOT	1	1	0	1	0	1	0	2	1
DORCHESTER	0	0	0	2	0	0	2	0	0
WICOMICO	1	1	3	1	1	4	1	7	0
SOMERSET	1	1	0	1	0	0	2	0	1
WORCESTER	0	0	2	1	0	1	0	0	1

¹ Includes deaths that were related to recent use of pharmaceutical or illicitly-produced fentanyl.
² Includes only deaths for which the manner of death was classified as accidental or undetermined.
³ Counts for 2015 are preliminary.

Drug- and Alcohol-Related Intoxication Deaths in Maryland

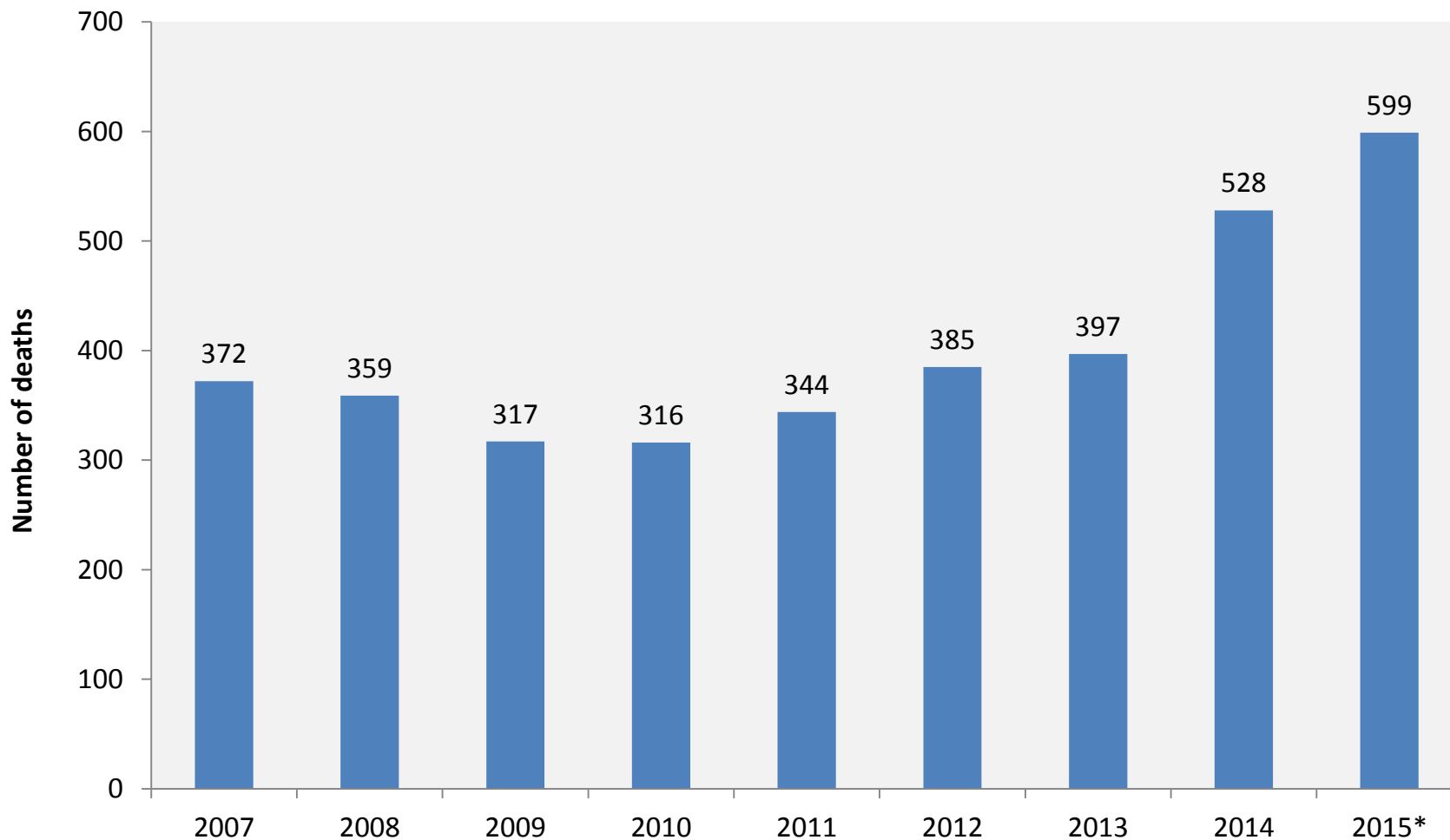
Data update through 2nd quarter 2015

This report contains counts of drug and alcohol-related intoxication deaths* occurring in Maryland through the second quarter of 2015, the most recent period for which reasonably complete data are available. Counts are also shown for the same period of 2007-2014 to allow for comparison of trends over time. Counts for 2015 are preliminary and subject to change.

*Deaths resulting from recent ingestion or exposure to alcohol or other types of drugs, including heroin, cocaine, phencyclidine (PCP), prescription opioids, benzodiazepines, methamphetamines and other prescribed and unprescribed drugs.

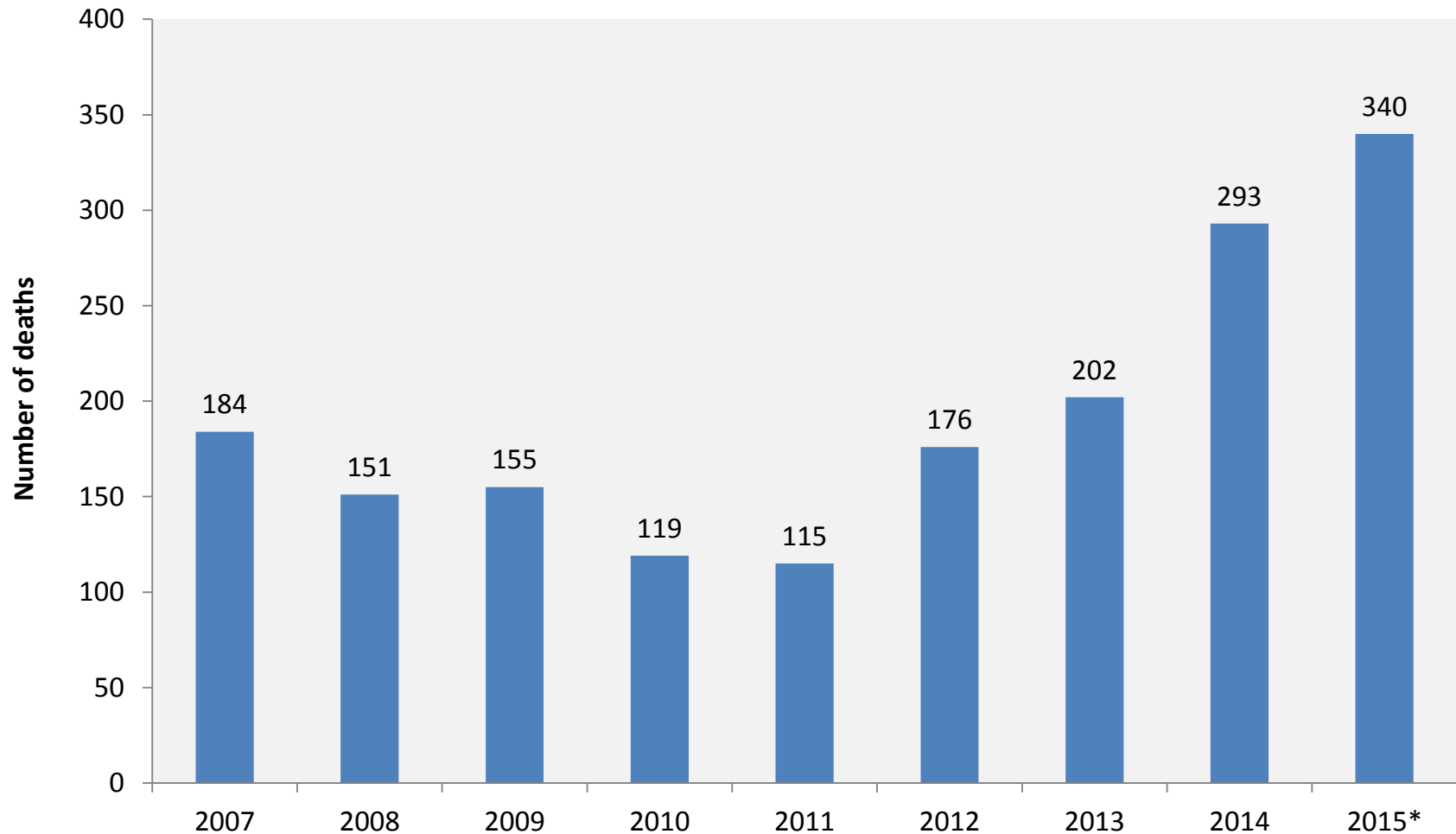


Figure 1. Total Number of Unintentional Intoxication Deaths Occurring in Maryland from January-June of Each Year.*



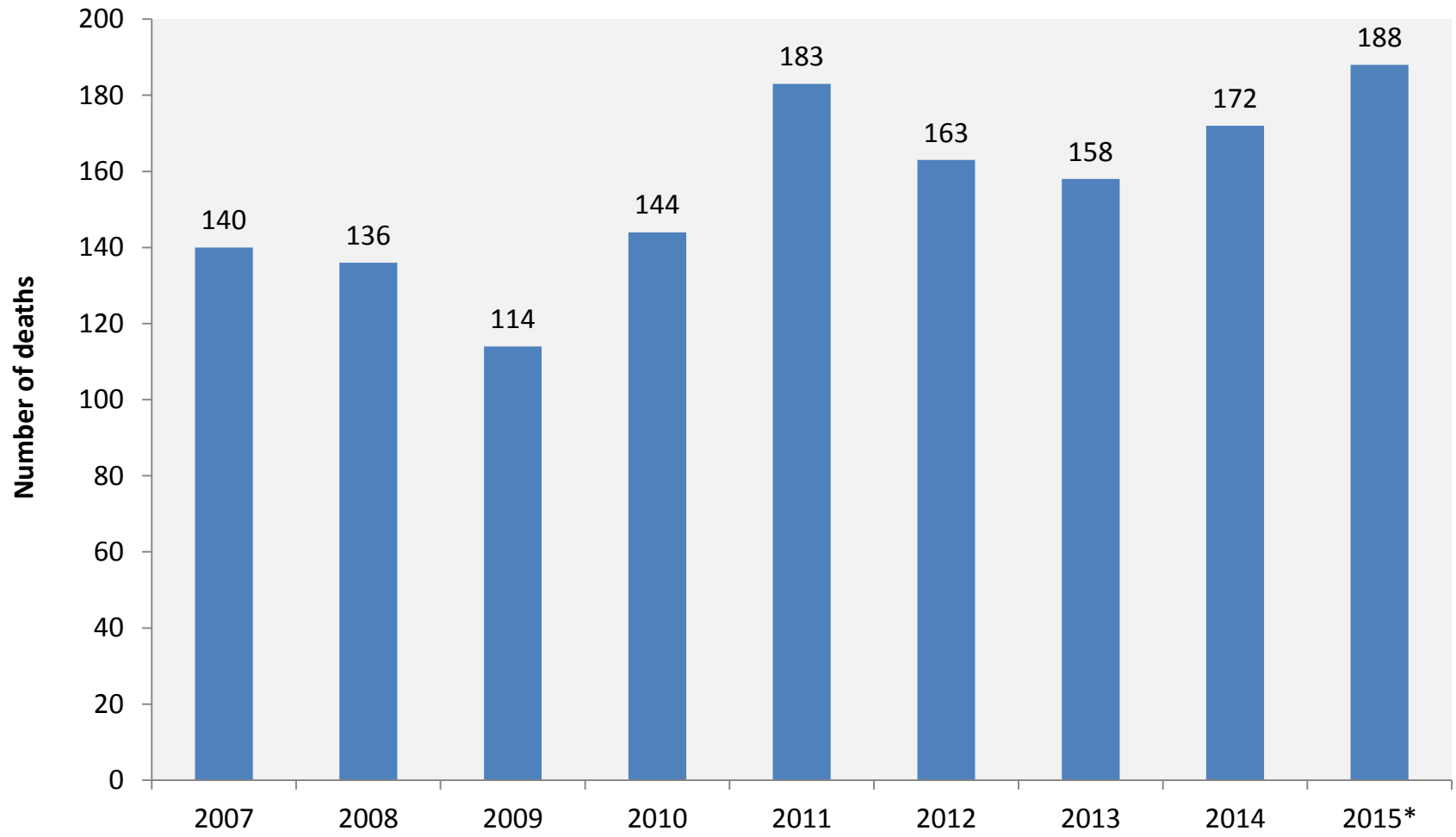
*2015 counts are preliminary.

Figure 2. Number of Heroin-Related Deaths Occurring in Maryland from January through June of Each Year.*



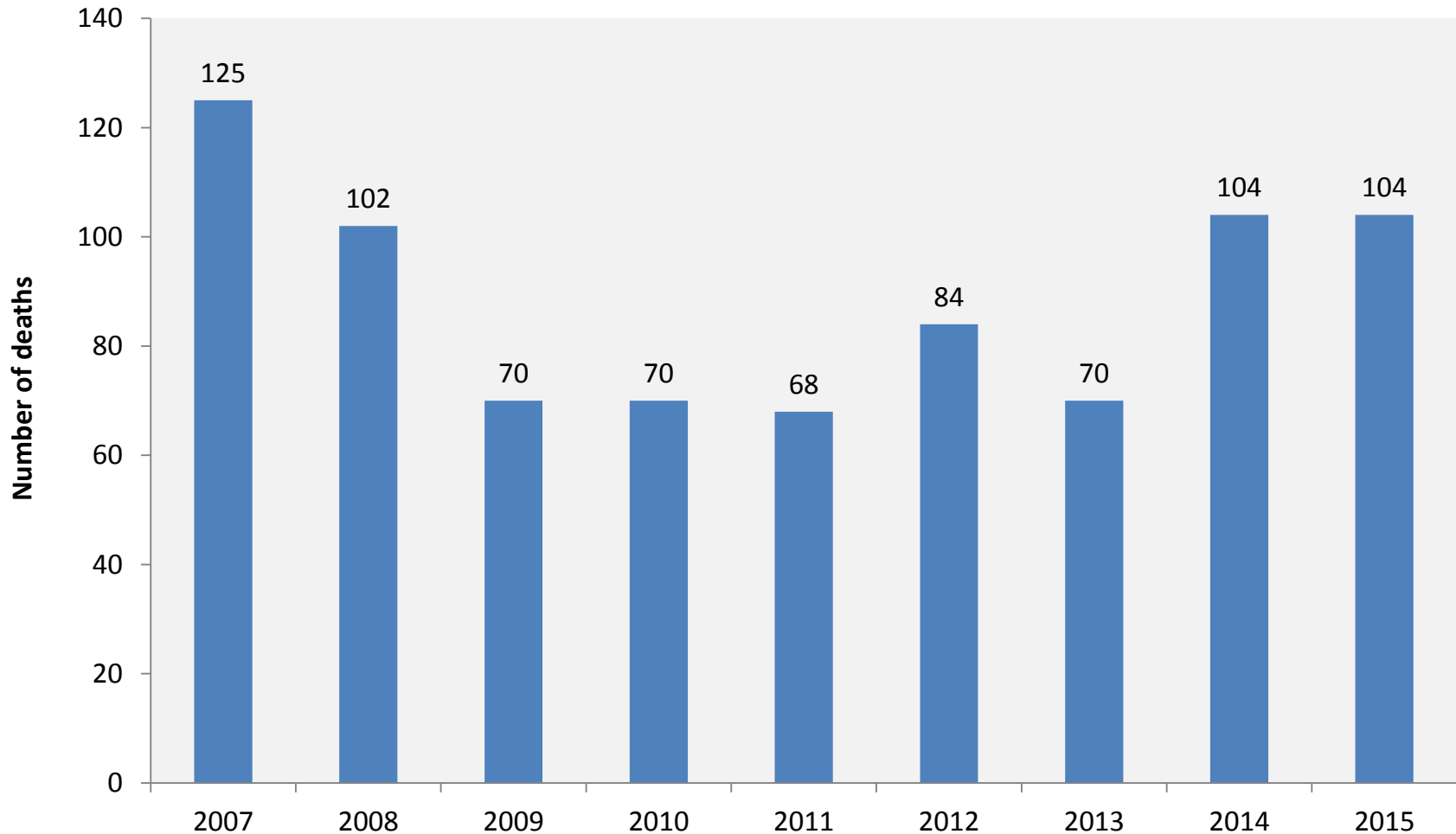
*2015 counts are preliminary.

Figure 3. Number of Prescription Opioid-Related Deaths Occurring in Maryland from January through June of Each Year.*



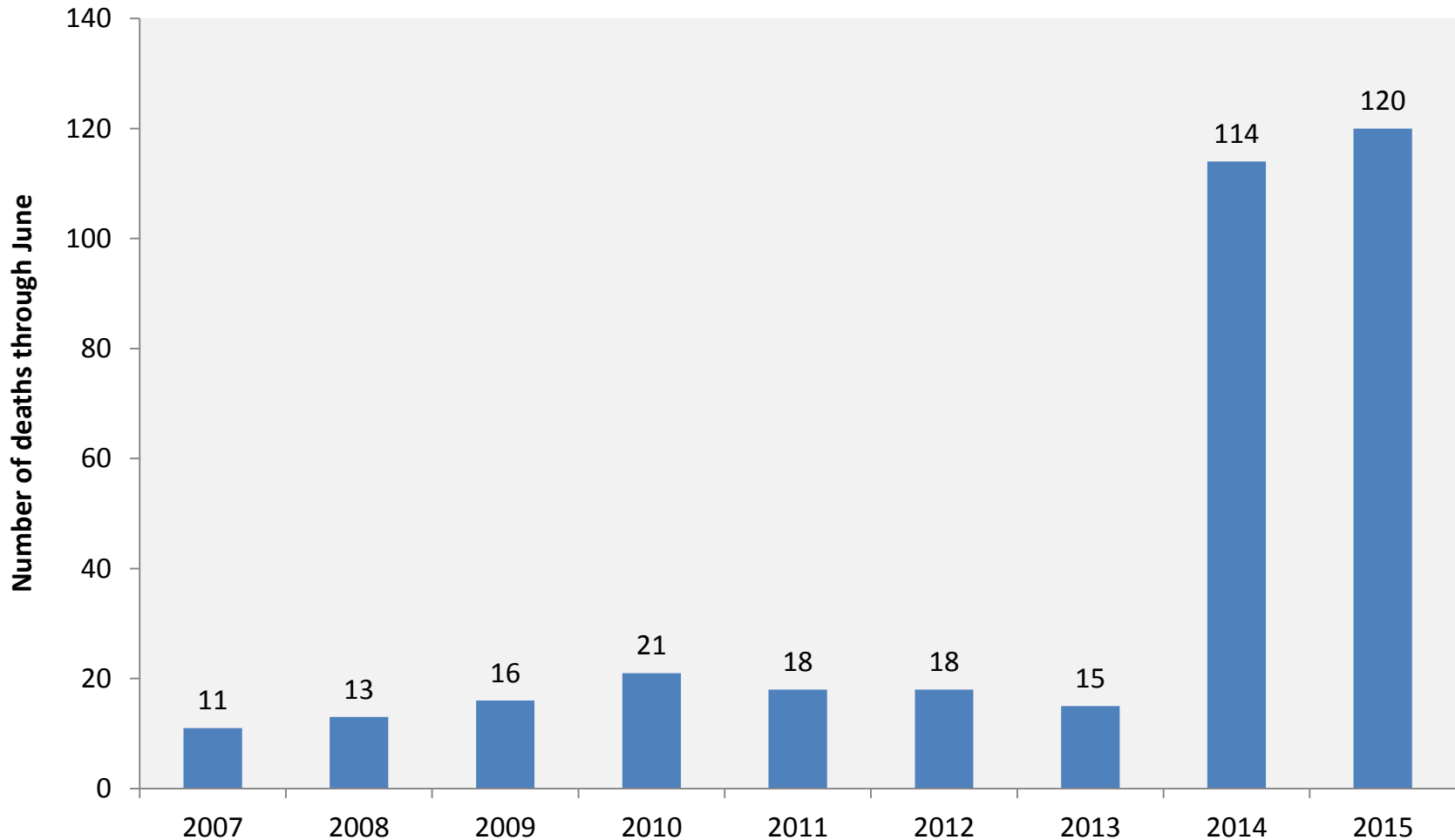
*2015 counts are preliminary.

Figure 4. Number of Cocaine-Related Deaths Occurring in Maryland from January through June of Each Year.*



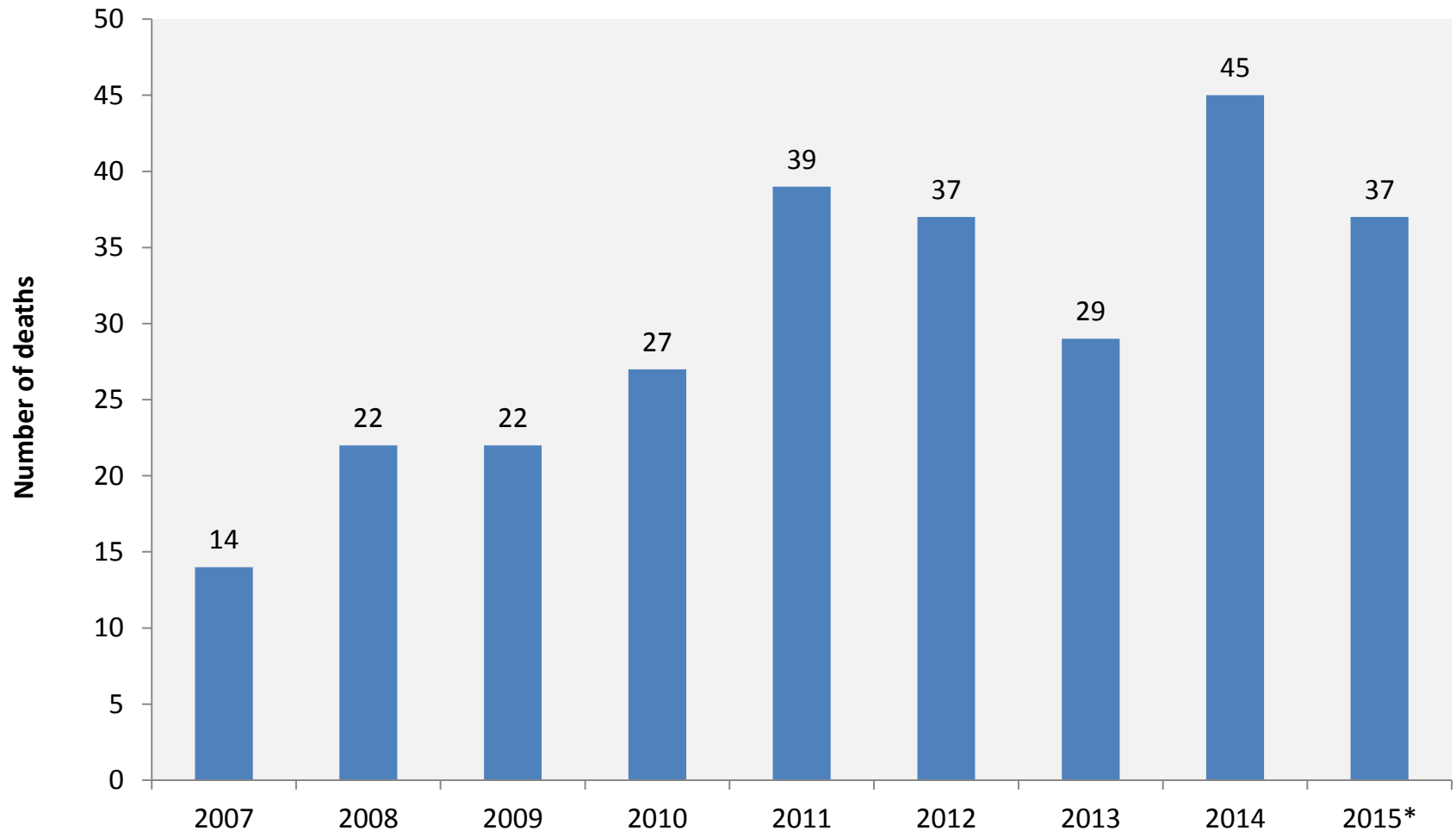
*2015 counts are preliminary.

Figure 5. Number of Fentanyl-Related Intoxication Deaths Occurring in Maryland Through June of Each Year.*



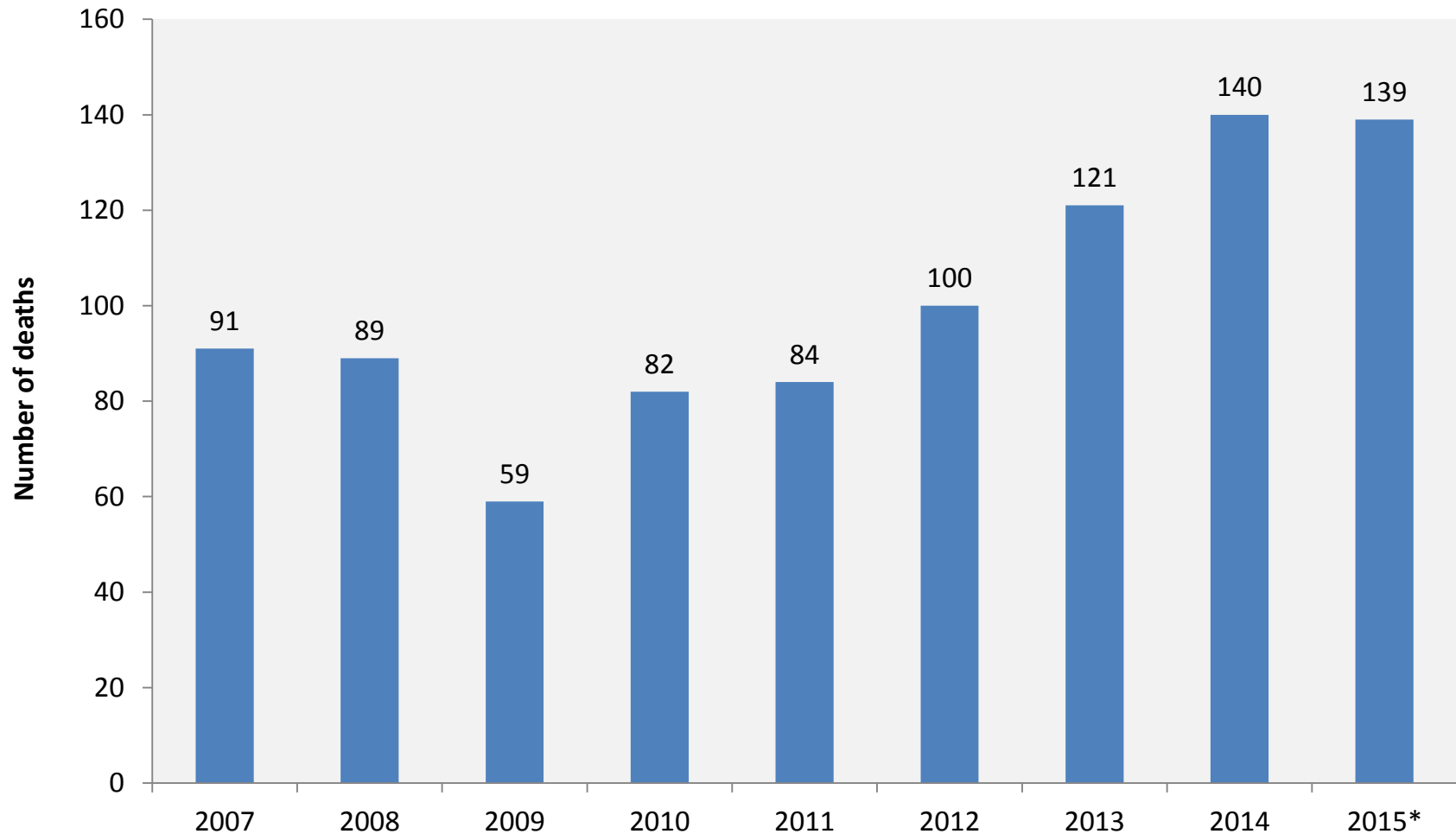
*2015 counts are preliminary.

Figure 6. Number of Benzodiazepine-Related Deaths Occurring in Maryland from January through June of Each Year.*



*2015 counts are preliminary.

Figure 7. Number of Alcohol-Related Deaths Occurring in Maryland from January through June of Each Year.*



*2015 counts are preliminary.

Figure 8


 <p>MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE</p>	<p>Total Number of Drug and Alcohol-Related Intoxication Deaths by Place of Occurrence, Maryland. January – June, 2015 and 2014.</p>		
State of Maryland	Drug & Alcohol Intoxication Deaths		2015 vs 2014
COUNTY	Jan. - Jun. 2015	Jan. - Jun. 2014	# DIFFERENCE
Allegany County	12	4	8
A. A. County	50	51	-1
Baltimore City	188	162	26
Baltimore County	102	83	19
Calvert County	11	13	-2
Caroline County	0	4	-4
Carroll County	19	22	-3
Cecil County	13	20	-7
Charles County	10	8	2
Dorchester County	0	0	0
Frederick County	18	19	-1
Garrett County	3	1	2
Harford County	22	16	6
Howard County	11	10	1
Kent County	2	2	0
Montgomery County	38	28	10
P.G. County	33	35	-2
Queen Anne's County	2	6	-4
Somerset County	6	1	5
St. Mary's County	10	6	4
Talbot County	2	2	0
Washington County	36	19	17
Wicomico County	7	12	-5
Worcester County	4	4	0
Total	599	528	71
¹ Includes deaths that were the result of recent ingestion or exposure to alcohol or another type of drug, including heroin, cocaine, prescription opioids, benzodiazepines, and other prescribed and unprescribed drugs.			
² Includes only deaths for which the manner of death was classified as accidental or undetermined.			
³ Counts for 2015 are preliminary.			

TABLE 1. TOTAL NUMBER OF DRUG AND ALCOHOL-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2014 AND YTD 2015 THROUGH JUNE.^{1,2,3}

	TOTAL INTOXICATION DEATHS								
	2007	2008	2009	2010	2011	2012	2013	2014	YTD 2015
MARYLAND	815	694	731	649	671	799	858	1,041	599
WESTERN AREA	110	99	97	96	109	115	138	161	107
GARRETT	1	3	3	3	2	0	6	2	3
ALLEGANY	14	9	9	15	12	14	15	12	12
WASHINGTON	16	26	18	20	21	27	28	40	36
FREDERICK	23	15	23	20	30	26	37	42	18
MONTGOMERY	56	46	44	38	44	48	52	65	38
CENTRAL AREA	550	443	479	411	420	519	557	678	392
BALTIMORE CITY	287	184	239	172	167	225	246	305	188
BALTIMORE COUNTY	131	118	106	115	107	119	144	170	102
ANNE ARUNDEL	71	70	63	56	79	83	78	101	50
CARROLL	14	17	22	15	8	29	24	38	19
HOWARD	16	19	16	10	21	24	29	21	11
HARFORD	31	35	33	43	38	39	36	43	22
SOUTHERN AREA	86	94	93	74	73	93	84	110	64
CALVERT	14	9	14	6	12	12	6	17	11
CHARLES	13	16	11	13	11	13	9	21	10
ST. MARY'S	6	11	9	12	8	12	10	9	10
PRINCE GEORGE'S	53	58	59	43	42	56	59	63	33
EASTERN SHORE									
AREA	69	58	62	68	69	72	79	92	36
CECIL	25	10	24	24	28	25	26	29	13
KENT	3	4	2	5	2	0	4	6	2
QUEEN ANNE'S	4	5	4	4	5	2	8	10	2
CAROLINE	1	4	2	2	11	4	2	7	0
TALBOT	5	4	3	3	1	5	7	4	2
DORCHESTER	4	5	2	6	2	5	5	0	0
WICOMICO	9	13	12	13	11	21	17	20	7
SOMERSET	6	3	4	1	3	3	4	3	6
WORCESTER	12	10	9	10	6	7	6	13	4

¹ Includes deaths that were the result of recent ingestion or exposure to alcohol or another type of drug, including heroin, cocaine, prescription opioids, benzodiazepines, and other prescribed and unprescribed drugs.

² Includes only deaths for which the manner of death was classified as accidental or undetermined.

³ Counts for 2015 are preliminary.

TABLE 2. HEROIN-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2014 AND YTD 2015 THROUGH JUNE.^{1,2,3}

	HEROIN-RELATED DEATHS								
	2007	2008	2009	2010	2011	2012	2013	2014	YTD 2015
MARYLAND	399	289	360	238	247	392	464	578	340
WESTERN AREA	33	35	39	27	34	49	68	86	60
GARRETT	0	0	1	0	1	0	2	1	1
ALLEGANY	3	4	2	3	3	6	3	5	8
WASHINGTON	5	13	11	6	8	11	14	21	20
FREDERICK	8	4	9	6	11	10	21	26	11
MONTGOMERY	17	14	16	12	11	22	28	33	20
CENTRAL AREA	323	203	264	171	165	272	319	379	233
BALTIMORE CITY	200	107	151	93	76	131	150	192	125
BALTIMORE COUNTY	56	51	53	42	38	64	76	86	58
ANNE ARUNDEL	38	24	31	18	24	38	41	53	22
CARROLL	9	5	7	3	2	13	14	16	8
HOWARD	8	8	7	3	10	12	16	9	8
HARFORD	12	8	15	12	15	14	22	23	12
SOUTHERN AREA	28	35	36	25	27	38	38	60	25
CALVERT	5	3	7	1	5	6	2	13	7
CHARLES	2	5	3	6	6	5	5	10	3
ST. MARY'S	1	3	0	4	4	7	6	5	2
PRINCE GEORGE'S	20	24	26	14	12	20	25	32	13
EASTERN SHORE									
AREA	15	16	21	15	21	33	39	53	22
CECIL	8	4	12	4	8	11	11	15	7
KENT	1	1	0	0	1	0	0	2	1
QUEEN ANNE'S	0	1	3	2	2	2	5	7	0
CAROLINE	0	0	0	0	3	3	2	6	0
TALBOT	1	2	0	0	1	2	2	4	2
DORCHESTER	1	2	0	2	1	3	3	0	0
WICOMICO	1	3	3	5	3	9	11	12	5
SOMERSET	2	1	1	0	1	2	1	1	4
WORCESTER	1	2	2	2	1	1	4	6	3

¹ Includes deaths confirmed or suspected to be related to recent heroin use.

² Includes only deaths for which the manner of death was classified as accidental or undetermined.

³ Counts for 2015 are preliminary.

TABLE 3. PRESCRIPTION OPIOID-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2014 AND YTD 2015 THROUGH JUNE.^{1,2,3}

	PRESCRIPTION OPIOID-RELATED DEATHS								
	2007	2008	2009	2010	2011	2012	2013	2014	YTD 2015
MARYLAND	302	280	251	311	342	311	316	330	188
WESTERN AREA	42	38	40	36	58	48	51	52	31
GARRETT	0	2	2	1	1	0	2	2	1
ALLEGANY	9	5	6	8	5	5	8	6	3
WASHINGTON	7	10	4	7	11	9	11	16	12
FREDERICK	6	4	9	6	21	16	14	9	5
MONTGOMERY	20	17	19	14	20	18	16	19	10
CENTRAL AREA	190	189	148	197	212	196	207	217	128
BALTIMORE CITY	95	60	63	61	82	74	86	84	48
BALTIMORE COUNTY	48	51	37	60	68	47	54	59	39
ANNE ARUNDEL	22	36	20	31	33	33	28	32	17
CARROLL	4	11	10	9	5	17	12	15	11
HOWARD	6	6	4	6	9	5	13	7	4
HARFORD	15	25	14	30	15	20	14	20	9
SOUTHERN AREA	25	28	31	33	30	29	26	35	19
CALVERT	8	3	4	3	7	6	3	7	5
CHARLES	6	6	7	4	5	7	5	9	6
ST. MARY'S	3	7	7	9	3	5	4	3	3
PRINCE GEORGE'S	8	12	13	17	15	11	14	16	5
EASTERN SHORE									
AREA	45	25	32	45	42	38	32	26	10
CECIL	19	6	10	20	20	18	12	12	3
KENT	2	3	2	3	1	0	4	2	1
QUEEN ANNE'S	4	1	1	2	2	0	3	3	2
CAROLINE	0	2	1	2	5	1	0	1	0
TALBOT	2	1	2	2	0	1	4	0	0
DORCHESTER	2	1	1	4	1	3	3	0	0
WICOMICO	5	4	8	7	7	9	4	3	2
SOMERSET	4	3	1	1	3	2	2	1	1
WORCESTER	7	4	6	4	3	4	0	4	1

¹ Includes deaths that were related to recent ingestion of one or more prescription opioids.
² Includes only deaths for which the manner of death was classified as accidental or undetermined.
³ Counts for 2015 are preliminary.

TABLE 4. COCAINE-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2014 AND YTD 2015 THROUGH JUNE.^{1,2,3}

	COCAINE-RELATED DEATHS								
	2007	2008	2009	2010	2011	2012	2013	2014	YTD 2015
MARYLAND	248	157	162	135	148	153	154	198	104
WESTERN AREA	29	16	11	12	22	21	26	26	16
GARRETT	0	0	0	1	0	0	0	0	0
ALLEGANY	2	1	1	1	0	2	2	2	4
WASHINGTON	3	1	0	3	3	5	6	6	8
FREDERICK	4	2	3	3	7	2	5	8	2
MONTGOMERY	20	12	7	4	12	12	13	10	2
CENTRAL AREA	178	108	124	93	97	108	102	138	73
BALTIMORE CITY	106	57	72	45	48	59	47	82	44
BALTIMORE COUNTY	30	25	25	23	19	17	27	28	18
ANNE ARUNDEL	26	18	15	13	18	13	12	19	7
CARROLL	2	2	3	6	3	7	7	2	1
HOWARD	6	1	4	1	5	7	5	3	2
HARFORD	8	5	5	5	4	5	4	4	1
SOUTHERN AREA	20	20	15	19	15	16	13	22	10
CALVERT	1	2	1	3	2	3	0	2	0
CHARLES	3	3	2	2	1	1	0	0	1
ST. MARY'S	1	1	1	2	0	2	1	1	4
PRINCE GEORGE'S	15	14	11	12	12	10	12	19	5
EASTERN SHORE									
AREA	21	13	12	11	14	8	13	12	5
CECIL	5	3	4	3	7	2	5	4	1
KENT	1	2	0	1	0	0	0	1	1
QUEEN ANNE'S	3	0	2	0	1	0	0	0	0
CAROLINE	0	0	1	0	1	1	0	1	0
TALBOT	4	0	1	0	0	0	3	0	1
DORCHESTER	1	1	0	1	1	1	1	0	0
WICOMICO	2	5	2	3	3	4	3	4	2
SOMERSET	1	0	1	1	0	0	0	0	0
WORCESTER	4	2	1	2	1	0	1	2	0

¹ Includes deaths that were related to recent use of cocaine.

² Includes only deaths for which the manner of death was classified as accidental or undetermined.

³ Counts for 2015 are preliminary.

TABLE 5. ALCOHOL-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2014 AND YTD 2015 THROUGH JUNE.^{1,2,3}

	ALCOHOL-RELATED DEATHS								
	2007	2008	2009	2010	2011	2012	2013	2014	YTD 2015
MARYLAND	187	175	162	160	161	195	239	270	139
WESTERN AREA	29	34	25	25	32	27	34	45	26
GARRETT	1	2	1	1	1	0	2	1	1
ALLEGANY	5	0	3	4	2	4	2	3	3
WASHINGTON	3	10	4	5	4	3	6	11	5
FREDERICK	5	7	8	5	9	5	11	12	9
MONTGOMERY	15	15	9	10	16	15	13	18	8
CENTRAL AREA	114	96	100	94	99	126	154	166	98
BALTIMORE CITY	56	41	54	39	44	71	86	86	54
BALTIMORE COUNTY	38	23	22	29	22	24	32	39	21
ANNE ARUNDEL	12	12	9	10	21	15	22	18	12
CARROLL	3	4	5	4	4	4	4	9	4
HOWARD	2	7	5	3	4	6	6	6	2
HARFORD	3	9	5	9	4	6	4	8	5
SOUTHERN AREA	31	27	21	22	19	30	29	30	12
CALVERT	3	3	4	0	2	2	1	4	2
CHARLES	5	5	1	4	3	2	4	5	1
ST. MARY'S	2	1	3	2	2	3	2	3	3
PRINCE GEORGE'S	21	18	13	16	12	23	22	18	6
EASTERN SHORE									
AREA	13	18	16	19	11	12	22	29	3
CECIL	5	4	7	6	3	6	9	5	0
KENT	0	0	0	1	0	0	1	1	0
QUEEN ANNE'S	1	2	0	1	3	0	1	7	0
CAROLINE	1	0	1	0	1	0	1	2	0
TALBOT	0	3	0	0	0	2	2	0	0
DORCHESTER	2	0	0	1	0	1	0	0	0
WICOMICO	1	6	3	4	2	2	6	7	0
SOMERSET	0	0	1	0	1	1	1	2	2
WORCESTER	3	3	4	6	1	0	1	5	1

¹ Includes deaths that were related to recent ingestion of alcohol.

² Includes only deaths for which the manner of death was classified as accidental or undetermined.

³ Counts for 2015 are preliminary.

**TABLE 6. FENTANYL-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2014
AND YTD 2015 THROUGH JUNE.**^{1,2,3}

	FENTANYL-RELATED DEATHS								
	2007	2008	2009	2010	2011	2012	2013	2014	YTD 2015
MARYLAND	26	25	27	39	26	29	58	186	120
WESTERN AREA	5	1	2	7	6	5	7	16	13
GARRETT	0	1	0	0	1	0	0	0	0
ALLEGANY	3	0	1	2	1	1	1	1	1
WASHINGTON	0	0	0	2	1	1	4	1	3
FREDERICK	0	0	0	2	3	1	2	6	1
MONTGOMERY	2	0	1	1	0	2	0	8	8
CENTRAL AREA	14	19	16	20	10	16	35	142	86
BALTIMORE CITY	3	2	4	4	2	4	12	72	52
BALTIMORE COUNTY	6	9	9	6	4	5	11	36	20
ANNE ARUNDEL	3	5	3	5	2	3	6	23	5
CARROLL	0	2	0	2	0	1	2	4	3
HOWARD	1	0	0	0	0	2	3	5	2
HARFORD	1	1	0	3	2	1	1	2	4
SOUTHERN AREA	1	1	4	3	3	2	10	16	14
CALVERT	0	1	1	0	1	0	0	5	2
CHARLES	0	0	0	0	1	1	3	1	3
ST. MARY'S	0	0	1	1	1	0	1	3	0
PRINCE GEORGE'S	1	0	2	2	0	1	6	7	9
EASTERN SHORE									
AREA	6	4	5	9	7	6	6	12	7
CECIL	2	1	0	2	2	0	0	1	2
KENT	0	0	0	0	0	0	0	1	0
QUEEN ANNE'S	1	0	0	0	0	0	1	1	0
CAROLINE	0	0	0	1	4	0	0	0	0
TALBOT	1	1	0	1	0	1	0	2	1
DORCHESTER	0	0	0	2	0	0	2	0	0
WICOMICO	1	1	3	1	1	4	1	7	0
SOMERSET	1	1	0	1	0	0	2	0	1
WORCESTER	0	0	2	1	0	1	0	0	3

¹ Includes deaths that were related to recent use of pharmaceutical or illicitly-produced fentanyl.
² Includes only deaths for which the manner of death was classified as accidental or undetermined.
³ Counts for 2015 are preliminary.