

APPENDIX D



**Heroin & Opioid Emergency Task Force
Central Maryland Regional Summit
Wednesday, April 15, 2015, 9:00am – 6:00pm
University of Baltimore, School of Law - Moot Court Room**

Summit Agenda

- | | |
|--------------------------|--|
| 9:00am – 9:05am | Opening Remarks by University of Baltimore President Kurt L. Schmoke |
| 9:05am – 9:10am | Introduction by Lt. Governor Boyd K. Rutherford |
| 9:10am – 10:30am | Mayor & County Executives
<i>Mayor Stephanie Rawlings-Blake, County Executive Kevin B. Kamenetz, County Executive Allan H. Kittleman, County Executive Steve R. Schuh, Commission President J. Douglas Howard</i> |
| 10:30am – 10:45am | 15-minute Break |
| 10:45am – 12:15pm | Law Enforcement
<i>Judge Ellen M. Heller, Sheriff Ron Bateman, State's Attorney Marilyn Mosby, State's Attorney Scott D. Shellenberger, State's Attorney Dario Broccolino, Colonel Larry Suther</i> |
| 12:15pm – 1:00pm | Lunch |
| 1:00pm – 3:30pm | Addiction Treatment Experts, Advocates, & Educators |
| 3:30pm – 3:45pm | 15-minute Break |
| 3:45pm – 6:00pm | Public Comment |
| 6:00pm | Adjournment |

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ANALYTICAL DATA

Elemental analysis: C, 68.12%; H, 5.84%; N, 26.04%. Found: C, 68.12%; H, 5.84%; N, 26.04%. IR (KBr): 3300 (broad), 1650, 1550, 1450, 1380, 1280, 1100, 750, 700. ¹H NMR (CDCl₃): 7.2-7.8 (m, 5H), 4.5-5.5 (m, 2H), 1.0-1.5 (m, 10H). MS (EI): m/z 150 (M⁺), 165, 180, 195, 210, 225, 240, 255, 270, 285, 300, 315, 330, 345, 360, 375, 390, 405, 420, 435, 450, 465, 480, 495, 510, 525, 540, 555, 570, 585, 600, 615, 630, 645, 660, 675, 690, 705, 720, 735, 750, 765, 780, 795, 810, 825, 840, 855, 870, 885, 900, 915, 930, 945, 960, 975, 990, 1005, 1020, 1035, 1050, 1065, 1080, 1095, 1110, 1125, 1140, 1155, 1170, 1185, 1200, 1215, 1230, 1245, 1260, 1275, 1290, 1305, 1320, 1335, 1350, 1365, 1380, 1395, 1410, 1425, 1440, 1455, 1470, 1485, 1500, 1515, 1530, 1545, 1560, 1575, 1590, 1605, 1620, 1635, 1650, 1665, 1680, 1695, 1710, 1725, 1740, 1755, 1770, 1785, 1800, 1815, 1830, 1845, 1860, 1875, 1890, 1905, 1920, 1935, 1950, 1965, 1980, 1995, 2010, 2025, 2040, 2055, 2070, 2085, 2100, 2115, 2130, 2145, 2160, 2175, 2190, 2205, 2220, 2235, 2250, 2265, 2280, 2295, 2310, 2325, 2340, 2355, 2370, 2385, 2400, 2415, 2430, 2445, 2460, 2475, 2490, 2505, 2520, 2535, 2550, 2565, 2580, 2595, 2610, 2625, 2640, 2655, 2670, 2685, 2700, 2715, 2730, 2745, 2760, 2775, 2790, 2805, 2820, 2835, 2850, 2865, 2880, 2895, 2910, 2925, 2940, 2955, 2970, 2985, 3000, 3015, 3030, 3045, 3060, 3075, 3090, 3105, 3120, 3135, 3150, 3165, 3180, 3195, 3210, 3225, 3240, 3255, 3270, 3285, 3300, 3315, 3330, 3345, 3360, 3375, 3390, 3405, 3420, 3435, 3450, 3465, 3480, 3495, 3510, 3525, 3540, 3555, 3570, 3585, 3600, 3615, 3630, 3645, 3660, 3675, 3690, 3705, 3720, 3735, 3750, 3765, 3780, 3795, 3810, 3825, 3840, 3855, 3870, 3885, 3900, 3915, 3930, 3945, 3960, 3975, 3990, 4005, 4020, 4035, 4050, 4065, 4080, 4095, 4110, 4125, 4140, 4155, 4170, 4185, 4200, 4215, 4230, 4245, 4260, 4275, 4290, 4305, 4320, 4335, 4350, 4365, 4380, 4395, 4410, 4425, 4440, 4455, 4470, 4485, 4500, 4515, 4530, 4545, 4560, 4575, 4590, 4605, 4620, 4635, 4650, 4665, 4680, 4695, 4710, 4725, 4740, 4755, 4770, 4785, 4800, 4815, 4830, 4845, 4860, 4875, 4890, 4905, 4920, 4935, 4950, 4965, 4980, 4995, 5010, 5025, 5040, 5055, 5070, 5085, 5100, 5115, 5130, 5145, 5160, 5175, 5190, 5205, 5220, 5235, 5250, 5265, 5280, 5295, 5310, 5325, 5340, 5355, 5370, 5385, 5400, 5415, 5430, 5445, 5460, 5475, 5490, 5505, 5520, 5535, 5550, 5565, 5580, 5595, 5610, 5625, 5640, 5655, 5670, 5685, 5700, 5715, 5730, 5745, 5760, 5775, 5790, 5805, 5820, 5835, 5850, 5865, 5880, 5895, 5910, 5925, 5940, 5955, 5970, 5985, 6000, 6015, 6030, 6045, 6060, 6075, 6090, 6105, 6120, 6135, 6150, 6165, 6180, 6195, 6210, 6225, 6240, 6255, 6270, 6285, 6300, 6315, 6330, 6345, 6360, 6375, 6390, 6405, 6420, 6435, 6450, 6465, 6480, 6495, 6510, 6525, 6540, 6555, 6570, 6585, 6600, 6615, 6630, 6645, 6660, 6675, 6690, 6705, 6720, 6735, 6750, 6765, 6780, 6795, 6810, 6825, 6840, 6855, 6870, 6885, 6900, 6915, 6930, 6945, 6960, 6975, 6990, 7005, 7020, 7035, 7050, 7065, 7080, 7095, 7110, 7125, 7140, 7155, 7170, 7185, 7200, 7215, 7230, 7245, 7260, 7275, 7290, 7305, 7320, 7335, 7350, 7365, 7380, 7395, 7410, 7425, 7440, 7455, 7470, 7485, 7500, 7515, 7530, 7545, 7560, 7575, 7590, 7605, 7620, 7635, 7650, 7665, 7680, 7695, 7710, 7725, 7740, 7755, 7770, 7785, 7800, 7815, 7830, 7845, 7860, 7875, 7890, 7905, 7920, 7935, 7950, 7965, 7980, 7995, 8010, 8025, 8040, 8055, 8070, 8085, 8100, 8115, 8130, 8145, 8160, 8175, 8190, 8205, 8220, 8235, 8250, 8265, 8280, 8295, 8310, 8325, 8340, 8355, 8370, 8385, 8400, 8415, 8430, 8445, 8460, 8475, 8490, 8505, 8520, 8535, 8550, 8565, 8580, 8595, 8610, 8625, 8640, 8655, 8670, 8685, 8700, 8715, 8730, 8745, 8760, 8775, 8790, 8805, 8820, 8835, 8850, 8865, 8880, 8895, 8910, 8925, 8940, 8955, 8970, 8985, 9000, 9015, 9030, 9045, 9060, 9075, 9090, 9105, 9120, 9135, 9150, 9165, 9180, 9195, 9210, 9225, 9240, 9255, 9270, 9285, 9300, 9315, 9330, 9345, 9360, 9375, 9390, 9405, 9420, 9435, 9450, 9465, 9480, 9495, 9510, 9525, 9540, 9555, 9570, 9585, 9600, 9615, 9630, 9645, 9660, 9675, 9690, 9705, 9720, 9735, 9750, 9765, 9780, 9795, 9810, 9825, 9840, 9855, 9870, 9885, 9900, 9915, 9930, 9945, 9960, 9975, 9990, 10005.

HEROIN & OPIOID EMERGENCY TASK FORCE
CENTRAL MARYLAND REGIONAL SUMMIT MINUTES

Wednesday, April 15, 2015, 9:00AM-6:00PM
University of Baltimore School of Law, Moot Court Room

PANELISTS

- **Professor Johnson:** Chairman, Department of Psychiatry, University of Maryland; Head of Brain Science Research Consortium
- **Julie Solt:** Circuit Court Judge for Frederick County, presiding judge of Frederick County Drug Treatment Court
- **Linda Williams:** Executive Director of Addiction Connection to Resource
- **Tracey Myers-Preston:** Executive Director of Maryland Addictions Directors Council
- **Sheriff Tim Cameron,** St Mary's County
- **Elizabeth Embry,** Chief of Criminal Division, Attorney General's Office
- **Delegate Brett Wilson,** Assistant State's Attorney, Washington County

INTRO

Introduction & Opening Remarks

Lt. Governor Boyd K. Rutherford welcomed everyone to the second regional summit, borne out of the executive order from Governor Hogan given a little over a month ago. **University of Baltimore President Kurt L. Schmoke** stressed that the heroin epidemic be conducted primarily as a public health issue, not a criminal justice one; needs medical intervention, not incarceration. **The Lt. Governor** stated that the Task Force would look at the full spectrum to address the heroin epidemic with the end goal of getting holistic solutions. An interim report is due in Summer 2015, and a final report is due at the end of 2015.

MAYOR & COUNTY EXECUTIVES

I. Kevin B. Kamenetz, *County Executive of Baltimore County*

- A. Typical profile of a heroin user is now a 23-year-old male from affluent suburb who started from abusing prescription painkillers. Baltimore County is fourth in the state for all intoxication deaths. Fewer prescriptions of painkillers → heroin filling that need; heroin more accessible and cheaper.
- B. Baltimore County's plan is called DEAL – (D): Drug Prescription Take Back Boxes where unused drugs can be dropped off anonymously, 24/7; (E): educate and engage the prescribers, treatment providers and the public; (A): Advocate for use of Naloxone and appropriate treatment, especially by friends and family via free training; (L): Lethality Review Team to study trends in Baltimore County.
- C. Recommendations: anticipate another \$4M this year from state for essential funding – reach those uninsured, peer recovery specialist hiring.

II. Dr. Leana Wen (for Mayor Stephanie Rawlings-Blake), *Health Commissioner for Baltimore City; Chair for Behavioral Systems Baltimore; ER physician*

- A. Heroin and opioid abuse is underlying issue of many other problems; 19K out of the 640K in Baltimore are using heroin. Addiction is a chronic disease, like diabetes or high blood pressure; only 1/10 nationwide are getting needed treatment.
- B. Baltimore City Mayor has Heroin Prevention & Treatment Task Force to make actionable recommendations – final report in July 2015.
- C. Recommendations:
 1. Decrease barriers to Naloxone – Governor should sign bills passed allowing immunity and standing orders.

2. Improved access in jails: start treatment as soon as addict gets in jail (OD is the end of the line). Use hot-spotting (geospatial mapping) to look for trends in OD death data: almost all patients who died of overdose have been through jail system.
 3. Statewide public education campaign to fight stigma, encourage treatment access, teaching saving lives –launched in Baltimore, like in NY, VT, RI. Look at history of addressing heroin abuse for future approach.
- D. LG: OD rate is higher than murder or automobile accident death rates; those coming out of correctional systems are more susceptible. We are expanding Naloxone access.
- E. In response to Ms. Embry's questions regarding data and engaging the provider community, Dr. Wen said the mayor's task force and partners in the city are working to get more data on number of users, access, quality of treatment; developing 24/7 intake/referral line as single point of entry to get immediate connection to treatment. Working with provider groups for Naloxone access. Dr. Wen added that they are working on getting more data from Drug Stat (program through Behavioral Drug Systems.)

III. J. Douglas Howard, *President of the Board of Commissioners in Carroll County; Chairman of Maryland Rural Coalition of Counties*

- A. Local government functions are threatened by drug addiction. Carroll's biggest challenge is believing there's a real problem with drug addiction, though biggest driver of crime is related to drugs. Availability of less-stigmatized drugs is increasing. Law enforcement needs to focus on people coming in for drugs.
- B. Attacking on two fronts: (1) Not in Carroll program has \$2.2M over 3 years to add 5 law enforcement in Sheriff's department; (2) Partnership with State's Attorney, who is forming an overdose response team focusing on prosecution of repeat drug trafficking offenders; prevention and education; and early intervention for those with minor offenses (treatment and education liaison for early intervention created).
- C. Other efforts include working with nonprofits and partnerships with schools, libraries, educating everyone, drug task force, with a focus on not duplicating efforts, acting on information, successful partnering, community resolve, getting info out through partnerships, media, commissioner town hall meetings.

--- Jack Young, *City Council President*, commented that people need to want treatment.

IV. Allan Kittleman, *County Executive of Howard County*

- A. Howard Co. had steady increase in heroin use/OD, especially in Caucasian men 18-30, due to inexpensiveness of heroin (5 OD deaths in 2013, 8 in 2014, 7 in 2015). Route 7 & 40 have problems.
- B. Efforts: police department working with local jurisdictions and other states i.e. WV; 250 field officers are trained with Narcan; narcotic division gets immediate notice of overdose cases. Corrections department is training/counseling inmates and family; use of Narcan; step program is training addicts in Vivitrol and OD (grant from GOCCP allows this). Health department trained 200 in Narcan and 2 or more people from Health work with corrections.
- C. Needs and problems: public awareness (HC DrugFree coordinated drug take back program which took out over 800lbs of prescription meds, works with school system); multidisciplinary approach; focus on rehabilitation and treatment; concern that legislation giving immunity to people reporting problems takes away ability to have court-mandated treatment; insurance (easier to get treatment if uninsured/need to work with insurance companies, state, Senate Finance Committee and House Economic Matters Committee)
- D. In response to the LG's question, Mr. Kittleman said they are applying for a grant to implement Vivitrol use in county jail.

- E. Del. Wilson commented that Judiciary Committee will talk about immunity issue so that there is noncriminal way to offer immunity but at the same time require some time of treatment.
- F. In response to Ms. Williams's comment on insurance, Mr. Kittleman says it is also a mental health issue. The budget to be presented to the county council next week puts extra money to hire more mental health counselors and get people more immediate help and insurance coverage.

V. Steve R. Schuh, County Executive of Anne Arundel County; 8 years as state delegate

- A. Anne Arundel had 308 OD/48 fatalities in 2014; 1 OD/day and 1 fatality a week; growing.
- B. Progress is being made at the state level via HB 368 (immunity in Narcan administration for first responders and other professionals). At the county level, all relevant departments are pulling together as a task force to review/expand/create programs. The focus is on education in schools and via speaking events and town halls; investing in treatment options especially in mid/south county areas; and going after dealers aggressively with a stronger narcotics unit, intra-county law enforcement unit made of multiple department representatives, and anti-heroin prosecutorial unit in State's Attorney's office.
- C. Recommendations: have heroin town halls, which highlight human dimension and include experts, providers, and community; have the state play a significant role; have resources.

LAW ENFORCEMENT

I. Judge Ellen Heller: former administrative judge of the circuit court of Baltimore City; drug court in Baltimore City at the Circuit Court for Baltimore City

- A. Failing the 44-year war on drugs despite spending so much – failing in incarceration rate, rate of drug use, world drug supply, international interdiction issues, corruption, racial disparities in arrest and incarceration. Drug addiction is a disease and treatment can work.
- B. Background on drug courts: first in Miami in 1989; first in Baltimore City in 1994; now 36 drug courts in Maryland; only Garrett, Kent, Queen Anne's, and Allegheny do not have drug courts. Components of a drug court include judge, state's attorney, public defender, in-court assessors, probation agents, case managers, social workers, continuing care coordinators. Most people in drug courts don't have a history of violent crimes, or have not committed one for ten years. Studies show effectiveness of drug courts and show that they save the state money (incarceration costs \$35-37/year in Maryland, but 6 months of residential and outpatient costs \$15-16K/year).
- C. Recommendations
 - 1. Partner with public health; public health initiatives are essential.
 - 2. Have quality (residential) programs and mental health treatment in the programs.
 - 3. Organize support services for re-entry into society.
 - 4. Set up walk-in referral centers to get access, referral to treatment, emergency help, help with insurance.
 - 5. Educate.
 - 6. Pre-charge, pre-booking programs, like Seattle's LEAD program: Law Enforcement Assistant Diversion, where police officers are given discretion to divert drug addicts they know to treatment. LEAD program is partnership of law enforcement, public health, community, mayor. Here it can be the state governor.

II. Scott D. Shellenberger, State's Attorney, Baltimore County

- A. Reasons for increase in heroin deaths: less availability of OxyContin; increased purity (allows intravenous use) and accessibility; decreased price of heroin. Heroin is being cut with many different agents.
- B. The expansion of Good Samaritan law in MD was good. There is more ability to use Narcan – Baltimore County EMS units carry them.
- C. Recommendations

1. Expand use of Narcan across Maryland and encourage all health departments to use it properly; accessible to family members.
2. Pass bill sponsored by MD State's Attorneys' Association allowing prosecution of drug dealers who can be proven to have sold/given drug resulting in death of individual.
3. Don't sign HB 121 (currently on Governor's desk) repealing mandatory minimums for prosecution and sentencing of drug dealers.

III. Dario Broccolino, *State's Attorney, Howard County*

- A. Efforts in Howard Co. include mental health task force; program with hospital and Horizon Foundation for mental health services + publicizing the program; District Court diversion program and efforts to get heroin users into treatment.
- B. Challenges: probation department is overwhelmed with the number of cases; drug court ran out of money earlier but is now running again.
- C. Efforts: reentry program for drug dealers started by warden; Drug Free Program (education).
- D. Comments: war on drugs isn't going to be won by prosecutors; sometimes incarceration is a solution when all else fails.
- E. Recommendations
 1. Look at warden's reentry program to put in place on statewide basis.
 2. Go to the drug court graduation in your jurisdiction if there is one to see the impact it has.

IV. Colonel Larry Suther (for Sheriff DeWees), *Carroll County Sheriff's Office*

- A. 29 OD deaths in 2014 in Carroll County.
- B. Efforts: new unit in sheriff's office, with partners, will focus on shutting down the supply chain; peer-to-peer counselors help with reentry in detention center; tracing back origin of drugs, follow up with prosecution.

V. Ron Bateman, *Anne Arundel County Sheriff*

- A. Recommendations
 1. Education: law enforcement can teach starting in elementary schools. Someone in uniform speaking to them grabs their attention.
 2. On heroin supply chain: focus on federal partners in DEA, South America, Mexico, SE & SW Asia, Afghanistan, where heroin is manufactured before being shipped to US. Work with allies to cut supply and demand.
 - a. Forge enforcement-related partnerships in police agencies to work with State's Attorney to prosecute and arrest dealers, making sure they get big sentences.
- B. LG stated having a DEA representative present and working with support of federal partners.

VI. Wes Adams, *State's Attorney, Anne Arundel County*

- A. Stats: 550K people in Anne Arundel; 1 heroin OD/week. Since 2015: 69 heroin OD, 26 with other opioids mixed in; 13 heroin fatalities. Administered Naloxone 62 times, 57 from EMS; 3 from law enforcement; 2x from hospital.
- B. Progress: 11 people graduated this year from drug court; putting together task force; brought in good prosecutor, work with HIDTA to track back to dealers; working with gangs, narcotics, Stop Heroin Program, neighborhoods, targeting housing projects funded by drug unit.
- C. Recommendations
 1. Early intervention and education, from 4/5th grade. Kids can't be taught about drugs for the first time at 18; it must be ingrained.
 2. Consider how behavior of children is controlled: mixed messages are sent when they are overmedicated but forbidden to take drugs. Adults are teaching drug abusive behavior.
 3. Focus on public relations matter; look at effect that had on smoking

4. Have Governor veto/repeal HB 121 because this bill is devastating to prosecution of repeat drug dealers. Mandatory minimums are necessary.

Questions from Panelists

(1) Del. Wilson asked if anyone was familiar with day report centers (a report center for nonviolent offenders, an alternative to incarceration; a neighboring Pennsylvania county has these). Wes Adams stated that there were no similar programs in Anne Arundel County, and that the behavior being modeled is the root of the problem and must be kept in check. Judge Heller stated that people must know where to go after the active part of the drug court process; they must have support services without fearing getting in trouble; relapse is a part of recovery.

(2) Ms. Embry addressed the concept of an overdose event as the trigger for investigations into drug dealer organizations that sold the drugs leading to the overdose. She asked if this was being done systematically and whether it was effective. Mr. Suther stated that they tried to trace back with every overdose and work with the user to do so. Mr. Adams stated that information was being gathered to trace back; this is one of the programs being run with HIDTA.

(3) Ms. Williams asked about pre-charging/pre-booking: when an officer diverts someone to treatment, will they be charged and booked afterwards? Judge Heller informed that they are not charged and booked afterwards in Seattle's LEAD program; they are pre-booked. Even if they do not succeed and relapse, they are not charged. In MD, even after someone is charged, one can set a charge – put it on a shelf and let someone be diverted. Ms. Williams commented that she tries to keep her clients out of the system because once they are in, it is difficult to get permission for them to go to treatment, and judges take probation violation personally. Mr. Shellenberger said that the the majority of state's attorney's offices offer drug diversion programs. If heroin users can be diverted, they will be sent in exchange for case being steted. If they successfully complete drug treatment, many SA offices will reopen stet and nol pros (dimiss – no criminal record). There is current exploration with health department to expand diversion program to other opioids (not just marijuana); i.e. first-time arrests for possession of OxyContin. Since October 2014, Baltimore County has been trying to fill the slots previously used for marijuana for possession of other opioids.

ADDICTION TREATMENT EXPERTS, ADVOCATES, AND EDUCATORS

I. Barbara Allen, parent advocate; Co-Founder, Executive Director of James' Place, nonprofit in Howard County; National Board of Directors for Compassionate Friends

- A. Personally lost son, brother, and niece lost through heroin; has worked at local, state, national level for advocacy on both the prevention and help/grief side – supporting 1800 people.
- B. Recommendations
 - a. Have all counties take advantage of events like the Target America Exhibit, Maryland Science Center, 2014 – put together by DEA – for 7th graders.
 - b. Educate, public campaign, i.e. “don't run, call 911.”
 - c. Keep Naloxone and spread its availability with families, law enforcement; keep its cost down. Maybe pay Narcan programs with forfeiture funds instead of waiting for grant money, as suggested/practiced (?) in NY and MA
 - d. Have a real time Prescription Drug Monitoring Program for physicians
 - e. Provide alternative care. Shorter treatment = longer aftercare. In Portugal, Italy, Spain, it's 2-3 years of treatment.
 - f. Ensure immediate access to treatment. Governor Shumlin (VT) is coordinating with other states to find beds.
 - g. Support all paths to recovery. Medical assisted treatment would improve quality of care and make recovery last.

- h. Give options for aftercare – i.e. as in Jane’s Place, which has educational programs.
 - i. Pass Second Chance legislation.
 - j. Remove stigma and change language surrounding addiction.
- C. Prof. Johnson asked for data on relationship between the length of treatment with active treatment and aftercare. Ms. Allen said she would provide data from the US and foreign countries.

II. David Byram, VP Market Access and Government Affairs for Orexo, manufacturer of Zubsolv (buprenorphine and naloxone)

- A. Buprenorphine is not a silver bullet; needs to be have comprehensive treatment model including psychosocial counseling and patient accountability measures – cannot treat just the patient’s brain; but buprenorphine can be very effective and can help return patients as functioning members of community contributing to tax base.
- B. Maintenance treatment for period of up to 1 year demonstrates 75% of patient retention in treatment, while short-term detox/taper has 0% retention.
- C. Black cloud around medication due to diversion, misuse, widely varied prescribing patterns, inconsistent toxicology screenings, other challenges. There are not many treatment guidelines, but American Society of Addiction Medicine will release their first treatment guidelines soon.
- D. Diversion is a problem in MD; driven by the legacy tablet and film formulations of buprenorphine. Expensive, especially when patients are not committed to treatment. MD is spending \$22M in their Medicaid program for buprenorphine treatment; it could be used for patients committed to their recovery and funding for Good Samaritan laws and Naloxone instead.
- E. At Orexo, there are 4 phases of treatment: induction, stabilization, maintenance, medical tapering component – this last one is forgotten.
- F. Recommendations
 - a. PAIRS should demonstrate that they could provide treatment. Physicians should treat at capacity.
 - b. Continue involvement of law enforcement
 - c. Make different treatment options be available to patients
 - d. In working with PAIRS, reconsider approaches with buprenorphine; follow those of United Healthcare, nationally managed Medicaid program of WellCare. (VID. 3 MIN 18)
- G. Mr. Byram had no information for Ms. Williams on Ibogaine – hydrochloride.

III. Dr. Marvin “Doc” Cheatham, President of Matthew Henswood Neighborhood Association; President of 3 civil rights associations; President, locally, of Southern Christian Leadership Conference, NAACP, National Accident Network

- A. In September 16, 2014, Matthew Henswood Association for a US congressional hearing on heroin to start a formal US Senate process to collect and analyze information related to Baltimore’s heroin history. Association will give written recommendations to panel and audience.
- B. Dr. Cheatham gave numerous facts from US government agencies, DEA, Baltimore City Department of Health, HIDTA, federal report, media/news, on heroin and Baltimore – on numbers, potency of heroin especially in Baltimore,
- C. Recommendations
 - 1. Fix improper and failed police implementation.
 - 2. Harm reduction: increase and expand failed opiate overdose prevention training; establish protocols for facilities that house or serve individuals with opiate overdose risk; make syringe exchange widely available and accessible; provide targeted prevention and services for pregnant women; enhance awareness of heroin use by parents and caregivers, its impact on children and the need for child-focused assistance and support.
 - 3. Law enforcement: read *The New Jim Crow* (Michelle Alexander); initiate/expand drug-endangered children programs; increase #, funding, reach of drug courts; bold public initiatives; change in attitude; hold doctors accountable in prescribing pain medication.

4. Prevention: promote safe and healthy neighborhoods; provide opportunities for youth participation and activities conducive to protection; increase community awareness and substance abuse prevention messaging; reduce access to prescription meds for nonmedical use; recruit businesses and employers, local government agencies, medical centers, nonprofits to participate in substance abuse prevention and intervention activities.
5. Treatment: establish/increase inpatient stabilization centers/facilities throughout MD, especially in Baltimore to allow patients time to detox and coordinate follow-up services like continuing treatment options, stabilizing houses, or community recovery; outpatient treatment more widely accepted in all communities, not just in poor communities; expansion of addiction treatment services in jails – mitigate revolving door phenomenon.
6. Workplace: provide/expand assistance for employees with drugs problems. Employers should provide education and prevention resources.

IV. Danny Brannon, *President/CEO of RightTurn Impact; degree in addictions counseling; recipient of Pearson Prize for Higher Education*

- A. RightTurn is a residential recovery treatment program in Baltimore serving 1200 annually, 50K+ Marylanders since inception in 1992. Its goals are: educating addicts (self-diagnosis/detection, providing treatment tools like 12-step meetings, home groups, etc.; personal responsibility; support network). It is most effective when recovered addicts help those trying to recover. There are 800+ NA meetings weekly in Baltimore and surrounding counties. Up to 30K+ addicts living clean in Baltimore.
- B. Recommendations
 - a. 12-step model in recovery. Go online, find open NA meeting close to you, and see it.
 - b. Abstinence is the best policy for addicts. Short-term detox, Suboxone if needed for 3-5 days, residential treatment, long-term recovery house living; daily attendance/active participation in 12-step meetings - addicts need to have relationships with other recovering addicts: this works for the longest time and brings lasting change.
 - c. Don't treat drug addiction on drugs, which mask physical symptoms of addiction and do not address the thinking. Maintenance programs may help long-term addicts, but otherwise, give addict a chance to get clean without them first.
 - d. Consequences need to outweigh benefits to help addicts get clean, i.e. incarceration.
 - e. Drug program money would be better spent for long-term transitional recovery for offenders as they get out of jail, since in jail there is no support mechanism to recover.
 - f. Create detox, residential treatment, recovery houses, peer-to-peer support, recovery coaches, 12-step meetings, law enforcement, accountability.
- C. Mr. Brannon replied that he did not have empirical evidence on efficacy on AA or NA as asked for by Prof. Johnson, but he stated that his personal visits to 12-step meetings and knowledge of hundreds in recovery is proof that he has. He noted that anonymous programs are hard to track. Prof. Johnson further asked whether it was practical to have addicts treat other addicts, i.e. 60k people treating 60K addicts. Mr. Brannon replied that 12-step recovery, peer mentoring and support is what worked. Prof. Johnson asked whether stigma was a barrier to treatment if people had to go to meetings where they had to reveal everything, rather than just going to a doctor or self-help group and not have to disclose everything; Mr. Brannon replied that shame and secrecy of addiction kept people sick.

V. Bernard McBride, *President/CEO Behavioral Health System (BHS) of Baltimore*

- A. Heroin is at the center; involves other substances like alcohol and tobacco.
- B. BHS formed 2013 to address behavioral health issues, including addiction; goal is have ease of access to services and programs for addicts, and there is a lot of work to be done to create this.

- C. Partnerships with services providers important. BHS has sponsored Capacity Development Initiative to improve quality of care to improve it. This includes helping providers meet new admin requirements. Challenges: not a consistent oversight and level of standard demanded of providers. DHMH must up the bar to create more effective/unified way to decide who provides services; overseeing those services; and supporting providers to improve.
- D. Partnership with people who use the services or need them & their relatives also important. There is a need to improve using them as part of the service system. Need to support families.
- E. Criminal justice partners – cannot arrest our way out of the problem.

VI. Carlos Hardy, CEO/Founder of Maryland Recovery Organization; 4 years worked at former Baltimore Substance Abuse Systems (BSAS)

- A. MRO is a peer-led, peer-driven recovery community organization; personally is in long-term recovery: 21 years, 7 months since addict
- B. Recommendations
 - 1. Need to earmark funding and promulgate pretreatment service model in MD; meet people where they are at, have “treatment on demand” – at least send them somewhere first.
 - 2. Messaging: need to expand message beyond “treatment works and recovery happens” to “here’s what recovery looks like” → not problem-, but solution-oriented. Focus on the voice of those recovering. Need positive reinforcing message to encourage treatment.
 - 3. Have peers as emerging and fairly compensated workforce
- C. Ms. Williams asked about peer recovery coaches, being started in her county and training them. Mr. Hardy replied that BSAS trained the first 250 peers operating in Baltimore and expressed that he would like the creation of a Peer AmeriCorps model, where peers earn a living stipend, volunteer hours, and access educational grants. They can bring addicts into pretreatment program for when slots open in treatment programs.
- D. LG noted that at the first regional summit, one of the local communities talked about their local newspaper’s weekly column having a recovering person talk about their story in a positive way.

VII. Dr. Nancy Rosen-Cohen, Executive Director, Maryland affiliate of National Council on Alcoholism and Drug Dependence

- A. Treatment: make all levels of care easily accessible; ensure treatment high quality, adhering to state and national accrediting bodies’ standards and enforced by those with appropriate authority. Resources needed for high quality and complete continuum of care. Need treatment services for uninsured, older adults, residential levels of care.
- B. State role should enforce compliance by commercial insurance carriers with the federal Parity Act. Private sector must provide adequate treatment for those with insurance. State must force insurance companies to abide by the federal law. Increase grant funding that goes to the 23 counties and Baltimore City.
- C. Education: have greater use of evidence-based programs since elementary school to prevent drug use. Public dollars from school systems should be used to integrate primary and environmental strategies at all levels. Have ongoing education – not one-time speakers.
- D. Local health departments should continue to work with local communities to develop strategies to reduce access to alcohol and tobacco by youth.
- E. Remove stigma, negative language and labels. Language and policies must change to support those seeking treatment and those in recovery.
- F. More resources for recovery support (housing, transportation access, care coordination, employment)
- G. Reentry & criminal justice reform: law enforcement practices and sentencing structure must eventually change; too many, and disproportionately those of color, are incarcerated instead of treated. Decriminalization of small amounts of marijuana last year is the first step to changing this paradigm. General Assembly session this year shows passed legislation that demonstrates trend

toward reform. Reducing mandatory minimum sentences for drug-related crime, expunging and shielding of certain criminal records to help people obtain housing and employment, creation of a justice reinvestment council → these will help people in recovery. MD should enhance reentry services for those incarcerated for 18mos or more: services that include: linkage to safe and affordable housing; warm handoff to substance use and/or mental health disorder services; application assistance for benefits so they can be available upon release; appropriate ID; connections to other community-based services; linkage to jobs.

VIII. Rev. Milton Williams, Senior Pastor of small black congregation in East Baltimore; founder of Turning Point Clinic (largest methadone nonprofit treatment center in the world)

- A. Turning Point was given \$1M from state to start treatment center → largest treatment center anywhere; has treated over 5K heroin addicts in the past 3 years. It is open-access, rapid intake, walk-in clinic using incentives (\$20 for each patient for transport and lunch).
- B. Rural and suburban heroin problem is different from urban heroin problem. In the inner city, most heroin addicts don't want to stop using drugs, something professionals and government don't want to accept.
- C. Recommendations
 1. Use incentives: i.e. breakfast & lunch for heroin addicts: if I were granted money to provide breakfast and lunch for heroin addicts, I could increase my clinic from 2K patients to 4K in 18 months. This would reduce crime, pressure on courts, sentences and prisons, ER visits.
 2. Directed care philosophy: Street Smart Medicine – I could develop a primary care, urgent care facility to incorporate in current treatment center. Would save state and taxpayers \$10-20M a year.
 3. Tie welfare benefits into drug testing. Welfare money is being used to buy drugs. Addicts should show that they are in treatment before another cent goes to them.
- D. Del. Wilson asked whether faith came into Rev. Williams's treatment, or if the focus was just on medical methodology. Rev. Williams responded that spiritual counseling along with medicinal and clinical counseling offers hope and healing. God helping through this problem makes all the difference in the world.

IX. Dr. Yngvild Olsen, Addiction Medicine Physician, Internist in Baltimore City; President of Maryland chapter of the American Society for Addiction Medicine; President of the state chapter for the American Association for the Treatment of Opioid Dependence

- A. Science of addiction: Opioid Use Disorder (OUD) is a chronic brain disease defined by established diagnostic criteria with known risk factors. It has a spectrum of severity depending on # of diagnostic criteria a person has. There is no one form of OUD.
- B. Risk factors: 40-60% of risk of developing addiction is genetically based. Someone who has a parent with alcohol use disorder can develop opioid use disorder. Other risk factors include the presence of other psychiatric conditions; early childhood trauma; younger age of exposure to potentially addictive substances. People with one substance use disorder are at risk for having another substance use disorder or multiple other ones.
- C. Symptoms of substance use disorders are behaviors driven by dysfunctional set of neurocircuits that have to do with reward, motivation, learning, and memory → craving and compulsive need to obtain/use substances. Brain differences are seen to have addicts acting in unbelievable ways.
- D. Risk factors and brain differences don't go away = no cure for this. Risk of relapse never goes to 0. Recovery and remission happen for a lot of people. It takes up to 5+ years for relapse risk to drop significantly.
- E. Good treatment combines medication, counseling, recovery support services. There are 3 available medications – all work in different ways, different side effects, provided in different

- settings. Not one/not all may work for any one person because everyone's different. There are only 3, so they cannot be pitted above each other, but this is happening.
- F. Stigma – there is a great deal of it for addiction and its treatment. This prevents accessing lifesaving care or delays it significantly.
- G. Recommendations (based on science/expands on existing work)
- a. All healthcare professionals should be trained in screening and ID of conditions (Maryland has Screening, Brief Intervention and Referral to Treatment (SBIRT), funded by SAMHSA). It needs to be expanded and included earlier in physician and healthcare professional training.
 - b. Assessment of severity of condition need to be done by appropriately trained healthcare practitioners using tested instruments and approaches, no matter the setting (court, ER, specialty treatment facility, etc.)
 - c. Decisions about which type of treatment, including which, if any, medications to recommend should be left up to appropriately trained healthcare practitioners and done according to good medical practice and evidence-based frameworks such as ASAM criteria and national ASAM guidelines coming out later this month + others in literature.
 - d. Policies exclude/restrict treatment for opioid use disorder should be changed based on the science. Those held by insurance carriers, healthcare facilities, employers, courts, prisons, and detention centers.
 - e. MedChi Addiction and Payer Relations Committee has endorsed resolution on removing commercial payer barriers to buprenorphine – now being considered by MedChi House of Delegates – presented for adoption on April 25 meeting.
 - f. Barriers to access to Methadone injectable Naltrexone need to be addressed
 - g. Regulations and financing structures limiting or restricting access to effective, long-term treatment are counterproductive because of chronic nature, elevated relapse risk over several years, pace of sustained behavior change. Need to talk about expectations: how long does it take for someone to achieve recovery from opioid use disorder and other medical/psychiatric conditions that they have? Incentivize high-quality care instead – much more likely to achieve positive outcomes instead of restricting and regulating.
 - h. Prevention needs to focus on age-appropriate messaging to children and families about risk factors, brain circuits, healthy decisionmaking – i.e. with young kids
 - i. Environmental strategies – decrease modifiable risk factors: focusing on preventing childhood trauma, minimize exposure to addictive substances, intervening early. MD has adopted strategic prevention framework from SAMHSA.
 - j. Concerted, sustained broad public awareness campaign – demystification; have those in recovery share their voices.
- H. Ms. Williams asked whether more education on addiction would bring stigma down. Dr. Olsen replied that it would, significantly. Much of the stigma is bound up on misconceptions on what this really is and what is happening in the brain. Ms. Williams asked about talking to children at a young age; Dr. Olsen supports age-appropriate conversations.
- I. LG asked about training physicians on risk factors. Dr. Olsen said it would involve different things: understanding risk factors, screening tools that can ID individuals at higher risk/in need of further assessment.
- J. Ms. Embry asked whether strategies should be mandated or voluntarily adopted by healthcare professional organizations. Dr. Olsen replied that MD has SBIRT and a reimbursement mechanism for it; other implementation aspects need to be considered. The big grant that the state received will hopefully be able to spread it across many other healthcare settings; Marla Oros (MS, RN) has been leading this work. There have been attempts to get into schools. Harder to think about how to practically mandate it as opposed to getting it into a best practice. It is Medicaid reimbursable. -- Dr. Nancy Rosen-Cohen says it is not private insurance-reimbursable (nor Medicare reimbursable).

- K. Prof. Johnson asked about ensuring that medical students have significant amount of time/training in addiction, and whether doctors who are prescribing opiates should go on some kind of mandatory course or certification every year to be able to continue prescribing. Dr. Olsen replied that there are many opportunities for med students to gain experience through first two years or even as part of rotation; and yes, there should be education for pain prescribing; how to ID risk factors for substance use disorders; how to ID and risk-stratify individuals who might get in trouble if you right that first prescription.
- L. Ms. Myers-Preston commented that doctors are required to have one CME that's just beginning, so progress is being made.
- M. Del. Wilson asked to what extent does emotional trauma (recent or historical) have on creation of addictive problem or its treatment. Dr. Olsen replied that functional imaging studies following individuals in early childhood (5) who had some of those experiences; trauma has impact on brain development; brains don't develop till 25. Prefrontal cortex (judgement, awareness) is the last to develop. Early exposure to substances and emotional trauma can change how development occurs; delays it. Individuals who start using substances early on have stunted psychological development.

X. Joyce Mahoney, mother of 2; bachelors in business and human service; masters in social work, Ph.D in psychology counseling; social worker in Carroll County

- A. Heroin victims are younger = crisis level.
- B. Recommendations
 - 1. Look at what we do have. Incorporate what other jurisdictions with reduced heroin overdoses are doing; hold stakeholders accountable.
 - 2. Treatment services should be tailored to meet multiple needs. Choice of setting and treatment depends on the drug of choice, history of the drug use, previous attempts at treatment, social needs, criminal record, personality, characteristics. Carroll County doesn't have evaluation process to match people according to needs.
 - 3. Existing modalities should go through rigorous evaluation and resources put into those that are successful. Look at: completion, attrition rates; # of days abstinent; # of days worked; days at school; improved family relationships; medical status; legal status; mental health.
 - 4. Need a mandated standard given by the state.
 - a. State should mandate all local detention centers to have drug treatment as exists in Carroll. Local jurisdictions should look at case management services and the 8505 process. How many are getting 8505s to divert them from prison and then they go right back to drugs? Should they get that evaluation again? Get diverted again?
 - b. Don't legalize marijuana; it is a gateway drug and cannot be a new business opportunity – it will ensure that we will continue to have heroin overdoses.
 - c. LG: the Task Force's objective is to look at what works. The government often doesn't ask: are you spending it wisely, efficiently, getting results? We will be looking at that.

XI. Tony Torsch, mother of 3, grew up in Baltimore; moved to Perry Hall; GRASP, nonprofit.

- A. Part of Grief Recovery After Substance Passing (GRASP), grief support group for those who have lost people to substance abuse
- B. Personal story: lost son from heroin overdose – started with prescription painkillers due to shoulder injury. Fought for 7 years. Lived in the suburbs but still heroin problem.
- C. Recommendations
 - 1. Third parties should use Naloxone. It is now available for third parties to administer. It is not too late for some families in Maryland.
 - 2. Look really hard at what Colorado and Washington are doing.
 - 3. Mandatory urine screenings needed for doctors that write prescriptions.

4. Awareness campaign – Good Samaritan law, Naloxone. Local health departments should be very responsive to calls and needs.
5. Have evening meeting of task force so families can be more involved (LG commented that it would be difficult because of the length of time the summits take).
6. Awareness, prevention, treatment.

XII. Tim Weber, Carroll County resident, Founder of Weber Sober Homes; nonprofit Triangle Recovery Club; in June 2015 will be Treatment Liaison for State's Attorney's Office, Carroll County

- A. Personally in long-term recovery from drug and alcohol, 13 years on heroin. Sober home 12-step model recovery, still continuing.
- B. Weber Sober Homes require the guys to get a job within 2 weeks or leave the house. Triangle Recovery Club has Heroin Anonymous.
- C. Carroll County stats – 2014: 893 opioid overdoses admissions to Carroll County hospitals; 2014 first 9 months: 30 overdose deaths. Health department, SA's office, Sheriff's Office, community have speak-outs; vigils.
- D. Recommendations
 1. Let kids in schools hear people who have recovered; let them know that it's ok to be in recovery.
 2. Create a crisis place. There is a window of opportunity only to effectively treat a heroin addict – when they want it.
 3. Don't let it be a whisper after these loud voices.

XIII. Dr. Laura Pimentel, Emergency Medicine Physician, Baltimore City (UMMC)

- A. ER sees many medical consequences of narcotic addiction, including pulmonary edema, apnea, seizures, trauma from falling or assault; immobility, breakdown of muscles and kidney failure after prolonged laying down; complications of drug use, especially IV drug users: skin infections; heart issues; spinal abscesses. Involves substantial cost and procedures; repeat patients.
- B. Patients seeking prescriptions are problematic because they frequently present real pain – divert from patients with real emergencies and may also divert drugs for sale on the street.
- C. Recommendations
 1. Development of high-risk care plans for patients who are frequent utilizers of emergency services related to narcotic use is very successful: almost 80% decrease in resource utilization in patients who had care plans. Care plans outline scope of the problem, provides outpatient resources, one specific physician to manage their narcotic use.
 2. Examine Methadone: rate of death from overdose in patients on Methadone is out of proportion relative to other opioids. Concerned about incidence of lethal heart arrhythmias and interactions with other prescription drugs; would like a look to see how it is used in Maryland and especially in Baltimore: clinics, practices with regard to patients on long-term therapy, very high doses; whether they are being appropriately weaned from Methadone.
- D. Ms. Embry asked whether the prescription-seeking patients or those abusing Methadone are recognized via communicating with other hospitals who may have seen the same patients or providers. Dr. Pimentel replied that CRISP shows info from other hospitals; PDMPs help understand a patient's pattern. She suggested developing care plans identifying where patients have been, see who's managing this patient for opioids and pain management to control # of prescriptions. Any licensed physician and non-physicians with appropriate need to know can access CRISP and subscribe to event notifications to see every time a patient seeks care with entity associated with information exchange.

XIV. Alvin Nichols, Executive VP of Concerted Care Group

- A. Concerted Care Group is a new treatment provider in Baltimore (Feb. 19, 2015) – privately owned and financed. Provides primary care; medical, behavioral, and mental health services, substance treatment center = all in one; collaborates w/other providers. Focuses on coordinated care, range of services, evidence-based outcomes. 431 patients within 7 weeks: 64% live within 3 miles; 33% live within same zip code (21218); 57% men, 43% women; 49% are 39-50 years old; 44% older than 50; 6% between 25-35 years old
- B. Recommendations
 - a. Lower barriers: care shouldn't be restricted to geography. People should be able to access care no matter where it is.
 - b. Data: use the many data sources and integrate into one large database to see impact on people and coordinate more effectively; examine how data could be available in highly restrictive environment (within public policy arena) to see where/how services available and what kind of treatment being provided through that mechanism, i.e. through ValueOptions and universities.
 - c. Stigma: look at public service announcements; educate the community.

XV. Dr. Elizabeth Katz, clinical psychologist, 25 years of treatment and research on addictions, 7 on opioid addictions

- A. Increase ability to ID those at risk of developing substance use disorders. SBIRT model must be expanded to do better.
- B. Peer advocates and faith-based organizations should do outreach into the community.
- C. Offer interim maintenance to those who cannot get treatment because there are no treatment slots.
- D. Work within windows of opportunity, since desire to stop using fluctuates. Disseminate more effective strategies to increase motivation to enter and stay/comply in treatment. Train healthcare and addiction treatment providers to use motivational interviewing more. Can be used briefly in as little as 5 minutes.
- E. Use incentive-based models, as evidence shows they are highly effective. There are low-cost/creative ways to implement, i.e. Ken Silverman's therapeutic workplace approach where opioid-addicted pregnant women who test negative for drugs allowed access to work in data entry business and get paid at the end of the day.
- F. Expand access to treatment; look at France, where practitioners don't have to have specialized training to administer buprenorphine and have no limit to # of patients they can treat, leading to reduction in HIV prevalence and overdose deaths in that country.
- G. Address psychosocial interventions: wraparound services talked about by Mr. Nichols is what we need.

XVI. Dr. Ajibike Salako-Akande, Founder of Getwele Natureceuticals

- A. For 16 years has researched cravings for drugs and counseled patients. Heroin addiction is primarily a craving problem. Metabolites from drugs produce new drugs, sometimes more potent than original. Creates craving, euphoria, tolerance – a cycle.
- B. Some of the current treatments given now can in turn cause addiction because they break down into products that cause this same cycle. The body is never rid of these metabolites.
- C. Getwele developed a family of four natural products to help with craving; tested and researched for past 16 years, meet FDA regulations. Currently at medical food stage – doesn't need to get to the drug level before they can be used. Safe, effective, cost-effective, natural, little or no side effects. High % success, evidence-based, with research documents. Calms person down, helps with appetite, sleep, which helps with staying in treatment.
- D. Challenge: people look down on natural products, especially the medical community. But anything that works should be allowed. Complementary and alternative medicine. Nutritional management is the missing piece of addiction management.

E. Recommend: interested clinics should look into this family of products.

F. Ms. Williams requested information to be sent, and Dr. Salako-Akande agreed.

PUBLIC COMMENT

I. Vince Dugan, CEO of RedXDefense (Rockville MD): explained a detector for law enforcement his company developed that detects explosives, narcotics, and gunshot residue with help of bomb squad detective and retired homicide captain. Explained that the product is easy to use and inexpensive, has been used by law enforcement in Montgomery County for two years; samples can be tested and a red light will show for no drugs and green will show for drugs. Offered RedX to fund the pilot program if there is any interest in the product. Mr. Dugan also stressed the importance of educating parents to be more vigilant.

II. Lon Wagner, Director of Communications, AmeriTalks: explained that in 2014, AmeriTalks processed 16K+ samples in the state, with results showing that: (1) Nearly ½ contained drug not prescribed by doctor ordering the test; (2) 20% samples contained illicit drug, including heroin. Link between prescription opioids and heroin abuse. Offered 2 initiatives that could significantly strengthen MD's fight against opioid abuse: (1) medication monitoring to ascertain adherence to prescription. Anonymous medication monitoring info can show diversion patterns, drug trafficking, broken down by county and demographics. (2) Training for people prescribing drugs...(?)

III. Robert Tousey: 23 years in recovery from alcohol and 5 years post-treatment from major depression. Family history of abuse, relatives dying young although successful in life. Son and daughter-in-law are 13 years in recovery from heroin through the grace of God, 12-steps fellowships, good treatment. Practiced law 15 years representing people suffering from substance abuse; now a pastor – officiate many funerals of people who die from substance abuse. In common to Mr. Tousey, his son's, and his daughter in law's successful recovery was a 12-step program. Stresses that 12-step programs + treatment = success. In response to questions from Prof. Johnson, Mr. Tousey offered to send surveys showing the success of self-help groups; that treatment is only a temporary starting point, and that if treatment were longer, there would be a better foundation and more successful recovery – but there is still a peer-to-peer need.

IV. Pastor Basha Jordan, Jr.: Pastor of Hope Alive Ministry Deliverance Fellowship, inner city of Baltimore. Licensed clinician; has recovery drug and alcohol recovery radio broadcast (Heaven600, 7:30am Saturday) for 23 years with listening audience of almost 300K; has traveled giving drug and alcohol conferences & speeches; director for House of Hope (men's recovery house); work with drug court; participated in program funded from SAMHSA, Baltimore Recovery Collaborative; was a provider for males coming out of jail/drug court system; was on Board of Directors for Tuerk House (treatment center) and on Board of Directors of National Council on Alcoholism and Drug Dependence; garnered support of ministers when needed to address problems of our community. Pastor Jordan explained that he was a recovering addict who used drugs and alcohol for 30 years of his life. He stressed that addiction is symptomatic and is not the problem; the problem is that individuals have gotten away from a higher power. This is a spiritual problem, and we need a spiritual solution. Pastor Jordan recommended: (1) Education of young individuals (2) Law enforcement must totally eliminate all open-air drug markets in Baltimore City; drugs is almost an economic necessity in my African-American community. (3) No loitering allowed around bars and liquor stores (4) Set up free treatment centers in every zip code of Baltimore for addicts who don't have healthcare or insurance. (5) Address learned behavior. (6) Have someone on task force panel who has come through the process of addiction and who is a practicing recovering addict.

V. Alisha Ellis: student attorney in Drug Policy and Health Strategies Clinic, UMD School of Law. Explained about Parity Act and its objective; stressed that private insurance carriers have to respond to

OD epidemic by ensuring timely and clinically appropriate treatment. Emphasized that those with private insurance must be able to access comprehensive substance use services they are paying for. Identified various problems with this, including denials of necessary treatment and low reimbursement rates. Advocated for better enforcement of Parity Act. Recommend: (1) MIA should be appointed to the Interagency Heroin and Opioid Emergency Coordinating Council (2) Task force should work with MIA and General Assembly's new Joint Committee on Behavioral Health and Opioid Use Disorder to ensure that the state evaluate private insurance and plans for compliance with Parity Act before they're sold in MD (3) AG's Office with MIA should work to ensure Parity compliance, as in NY. AG's Office should investigate in MD; systematic oversight of compliance. The LG commented that Commissioner Redmer (Director of MIA) has directed his staff to participate with the Interagency Council.

VI. Tony Fowler: lifelong MD resident, father of 5: 3 adult children; 2 had friends who died of heroin OD in past year. Career federal employee. Brought to attention SW Pennsylvania's efforts to raise awareness of mental health issues thru local media: TV, radio, print, online media; training for college students studying media. Also flagged EIC's efforts with journalists for accurate depiction of mental health issues. Recommend: training media reps to deliver effective messages concerning mental health problems, including drug addiction.. Use EIC's efforts as model to ensure accurate reporting on suicide and mental health concerns.

VII. Dr. Babak Imanoeel: addiction specialist, internist, medical director of medical maintenance treatment program in Westminister, MD, 1 of 3. Explained that there are currently 3 drugs approved for opioid addiction: Methadone, Vivitrol, Saboxone. Explained limitations of treatment: Methadone can only be administered in a federally licensed facility. None of the treatment programs in Carroll accept insurance other than medical assistance; Medicare doesn't cover treatment of addiction. Only 2 providers in Carroll that prescribe Saboxone accepting of insurance currently full (federal government has mandated maximum of patients per provider). Naltrexone is highly effective but no private provider currently providing this. Only health department has this program – with less than a dozen patients on this medication. There is a significant lack of treatment providers in Carroll County. Since 2007 there has been no increase in reimbursement for this treatment. Recommendations: (1) Take away stigma – educating physicians, law enforcement, correctional facility, community, public service announcements; (2) Relax zoning laws re opening treatment centers. (3) Increase funding for treatment. Added that the increase in Methadone OD is caused by Methadone prescribed by pain management physicians, and not by Methadone maintenance treatment programs.

VIII. Pam Bezirdijan: Respectfully ask LG and task force to look into her son's case or have someone from legal team inquire with US Attorney as to why such a harsh charge is being handed down. Her son was contacted by a friend for heroin; when pressed, provided it, took it together, and his friend was dead the next morning. Son being indicted by the federal Justice Department on for felony distribution – charge that can mean federal prison for 5-7 years. He has fully cooperated with the US Attorney's efforts to build their case against the dealer who sold the drugs to him. Ms. Bezirdijan said that the dealer has a long rap sheet including violent crimes; her son was not a dealer; just an active user who sadly made the wrong decision. Delegate Dumais and MoCo State's Attorney John McCarthy stress that legislation does not aim at an addict who might have shared the drug with a friend; such cases should be looked at differently than those involving dealing, manufacturing, or violent crimes – but DOJ is having completely opposite attitude and behavior, wanting to throw these addicts in prison for a long time. Please look into this and possibly other similar cases. The LG said to provide Ms. Bezirdijan's info and testimony; we can contact US Attorney for MD to see what's going on.

IX. Sharan Lindsay: Emphasized difficulty of finding sober living options in Baltimore County and difficulty to bring in high-quality structured sober living in the area. Everyone in the community wants everyone off drugs but nobody wants to see the process it takes to have someone get clean and sober.

Baltimore City/County, Howard, Carroll, Harford, have very few high-quality effectively operating structured sober living environments. Ms. Lindsay said she was ready and willing to help but cannot operate within state of MD. Most addicts are shipped into Philadelphia, who has over 300 recovery houses and 128K+ recovering addicts. There needs to be more opportunities for those who are willing to make alternatives for those in recovery.

X. Annette Mrozinski: recovering addict. Shared story of becoming addict since young and having a son at 15; went through arrests, hospitalizations, house raids for 20 years; house was a shooting gallery and her son was an addict by 19, currently doing 25 years mandatory minimum with no parole; she used to have dreams for him. Hopes that this one-sentence-fits-all harsh sentences will be changed and that drug treatment will be more readily available. Long-term treatment is far less expensive than long-term prison sentences, and twice as effective.

XII. Melissa: Addiction does not discriminate. 48 years old in recovery; married; 2 teens in private schools, master's, stable, but still became an addict, started when she broke her back 2 years ago, and took painkillers, soon 2-3x the prescribed dose; created chaos in family due to addiction. Doctor could not prescribe her detox drugs; most doctors can prescribe narcotics, but only a handful are qualified to give detox drugs. Bel Air, Towson, Ellicott City, only have 29 doctors who can. Prescriptions were being refilled at 2-3x the rate. Not all doctors make prudent decisions - hers was not educated enough about addiction. Detox drugs more expensive than painkillers; alternative Vivitrol shot for 30 days was \$1600. Despite my medical and legal family background and the ability to pay, it took 2-3 weeks to find facility to take me and get everything lined up to get me there. Insurance companies are giving financial incentive to stay addicted. If options aren't offered, many people won't seek the treatment they need. Public awareness regarding treatment options need to be increased. Education (early) & prevention are key. We won't stop the supply, but we can reduce addiction by educating early. We need to destigmatize; we do recover.

XIII. Israel Cason: founder of "I Can't We Can." Founded 1997, grassroots, self-supporting, 24/7, offers treatment on demand regardless of financial status; has served over 20K people. Was heroin addict for 30 years; served on O'Malley's transition team (health committee); testified before Congressional committee on substance abuse; was on exec board of BSAS; committee on OSI on treatment instead of incarceration and prison reentry program. Confused about what is intended to help in Baltimore City. Asked how any solutions would help Baltimore City specifically. Stressed that solutions need to be customized; need for holistic approach; that the only solution is lifestyle change. Prevention from young age is needed, as is universal language dealing with addiction problem. The LG commented that those in office before should be accountable for not having responded to heroin epidemic sooner.

XIV. Susan Redmer: a pharmacist; explained that pharmacists can be an important ally as first line of defense in recognizing drug abuse: can spot alterations, falsifications, doctor-shopping, and record all dispensed controlled substances into state PDMP; can call police. Problems with pharmacist and police communication; usually police don't arrive before the addict leaves. Some police stations in Baltimore County and Harford County have an officer assigned to investigate fraudulent prescriptions, which helps. Pharmacy journals have identified many states where only 40% of physicians are checking into the program. Propose that MD Board of Pharmacy require that 4 of the Continuing Education units of the 30 include comprehensive curriculum on medical basis of addiction and opioid abuse. Physicians need training on using monitoring tools available to assess risk of abuse. Make it mandatory for patient education on first prescription of opioid. There's not enough time in a physician visit for this. "Do you have any questions for the pharmacist?" is not enough. State should provide brochures outlining medication assistant therapies and drug treatment programs available in the area. This can be put in along with the prescription.

XV. Maura Taylor: shared story of daughter who did well, graduated college, married, but who had a daughter (Maura's granddaughter) who died of Sudden Infant Death (SID); thereafter daughter went into heroin addiction. We are educated; I spent 5 years on Anne Arundel County Alcohol and Drug Advisory Council as the Board of Education representative. No treatment options available in MD; scholarship to treatment center in California. Psychological treatment needed. We need to ask how we got here to this addiction crisis. It has to do with the 122 tons of opiates handed out by pharmaceutical companies and doctors; what are other states doing like in CA and Chicago who are suing pharmaceutical companies to get money back because they have left states with huge addiction problem that costs so much; AG needs to look into this, similar to tobacco companies. Don't give corporate tax breaks for private school students, fund a recovery high school like in other states (MA, NJ). There's \$200M being held – hasn't been decided how it will be appropriated vis-a-vis supplemental appropriation. Use it for this instead. The LG commented that the money cannot be used for that purpose. The federal government is spending \$500/second – that money would be much better spent on treatment. Need to elevate the conversation and make it important; cover it in the news. Want Second Chance Act; sign HB 121; glad that SB 303 and HB 222 didn't pass this session.

XVI. Susan Hixon: Howard Co. Parent and educator. Son has social anxiety; depression since middle school. Became addicted from emotional pain, not physical. This took everything financially for about 8 years for the family of 5. Frustrations: getting mental health treatment is not easy; many psychiatrists and psychologists don't take insurance, and when they do, they have a high copay; psychiatrists and psychologists don't treat the same things, so many times you need both – it's hard enough to get to one. Horrendous inpatient copays. ERs unequipped for mental health problems. – create long waits, don't help with withdrawal, no services in the weekends. No halfway house that's affordable. Detox centers are very important. Health issues not addressed enough. Need for immediate response. Education is important; health is often pushed aside for other subjects, or even in their own classes.

XVII. Pat Whitlock (and Kim Smith, Stacy Laskin): counselors at Howard Recovery (?); representing Cindy Glass, founder of Jeremy's Run. Wrote a letter about her son Jeremy who died from heroin addiction: in 2008, age 20. Knee injury during HS football led to multiple prescriptions for opiate painkillers, generously prescribed = addiction = heroin. Difficulties with getting insurance coverage for treatment. Didn't cover addiction services. Outpatient treatment – insurance paid 1/5 cost. Residential treatment facility – insurance company didn't pay past a couple days = paid out of pocket over \$100K. Insurance companies don't provide adequate resources or guidance when it comes to addiction. Addiction needs to be treated as a disease." Jeremy's Run is for awareness, education, insurance reforms. As an aside: there is no parity in behavioral health services; please take a look at it.

XVIII. Jordan Ayres: grew up in middle class home. Started pot, drinking, then heroin at young age; went through 13 treatment centers, jail, homelessness; OD, was dead for 23 minutes. Went to FL. Now doing marketing for treatment center (Just Believe Recovery Center) helping addicts nationwide. Unable to maintain recovery if at home, where comfort triggered use. More people should be allowed to go to treatment out of state if that is an option.

XVIX. [No Name]: addressed Jordan Ayres and said that triggers can be identified and can be worked through if there are tools. Started drinking at 6, then started smoking. Grew up with chemical dependency. "with alcohol in my brain." Introducing chemicals change the neurons in the brain. Cure: Israelis have studied endocannabinoid system since 1964 → isolating and profiling cannabinoids → this isn't allowed here. Must figure it out and figure out science behind this.

XX. Henry Jones: juvenile justice system worker for ten years (89-99); 99-2009 hit the streets and dealt with the homeless people; presidential award winner from Kennedy Foundation (Harvard). Talked about

available beds; concerned about funding; said that there are a lot of successful programs.
Recommendation: let's get those kids in some treatment beds.

XXI. Jen Newman: National Board Certified teacher; 22 years in Baltimore County; currently a consulting teacher traveling across Baltimore Co. K-12 for teacher effectiveness. Have worked with at-risk kids. Passionate about education. Daughter 2.5 years in and out of rehab. Teachers may do their best, but it is nowhere near enough. Will send recommendations. Explained that educators know which kids are using and know which programs that work and those that don't; educators need information that can be gained through personal experience (that it is a brain disease). There is a need to educate students, parents; put whole collective program together; have Maryland be a leader in this education effort.

XXII. Bob Galaher: recovering for over 28 years; in September 2014 outpatient medication assisted treatment center, southern MD, privately financed/run, treating over 175 patients, individualized treatment; noticed drastic improvements in people's lifestyles. Noted similarities involved in industry forums: between this task force effort and in postal service: focus on quality delivery system, finding solutions, carrots vs. sticks. Stated that the effort's challenge is to continue. Offered help.

XXIII. Reesa Davis: counselor at Recovery Network. Want to see more treatment for elderly community. Influx of people in second phase of life coming in addicted to heroin, opiates. Uncomfortable for them to be in therapy with 25 year olds. Would like to see funding towards that. Kids coming in from marijuana don't see that as a drug → coercive treatment; they're taking places from people who need treatment.

XXIV. Debra Dauer: Board of Directors, one of the founders for Impact Society. Almost 9 years clean from alcohol, opiates, crack. Single mom of son. Spent last 5 years with Impact Society focusing on recovery houses. Takes meetings in Baltimore County Detention Center once a month; develop relationships with women there. Need more resources and places to direct those coming out of correctional systems, or else they risk failing because they will reenter the same cycle they were in before. Explained that she was on Post-Prom Committee – to get kids to come to the prom party after school instead of drink and do drugs. There are problems with lack of insurance; follow-up after ER. There should be more recovery houses, options for treatment that's affordable for people, education for kids so they know that a pill can end up into a heroin addiction.

HEROIN & OPIOID EMERGENCY TASK FORCE
CENTRAL MARYLAND REGIONAL SUMMIT DETAILED NOTES

Wednesday, April 15, 2015, 9:00AM-6:00PM
University of Baltimore School of Law, Moot Court Room

PANELISTS

- **Professor Johnson:** Chairman, Department of Psychiatry, University of Maryland; Head of Brain Science Research Consortium
- **Julie Solt:** Circuit Court Judge for Frederick County, presiding judge of Frederick County Drug Treatment Court
- **Linda Williams:** Executive Director of Addiction Connection to Resource
- **Tracey Myers-Preston:** Executive Director of Maryland Addictions Directors Council
- **Sheriff Tim Cameron,** St Mary's County
- **Elizabeth Embry,** Chief of Criminal Division, Attorney General's Office
- **Delegate Brett Wilson,** Assistant State's Attorney, Washington County

INTRO

Introduction by Lt. Governor Boyd K. Rutherford

Second regional summit, borne out of the executive order from Governor Hogan given a little over a month ago; chance to listen to community and those at the front lines.

Opening Remarks by University of Baltimore President Kurt L. Schmoke

Heroin is a 25 year-old issue that should be conducted primarily as a public health – not criminal justice – war needing medical intervention, not incarceration.

Lieutenant Governor

This task force will look at full spectrum to address heroin epidemic with the end goal of getting holistic solutions. An interim report is due in Summer 2015, and a final report is due at the end of 2015.

MAYOR & COUNTY EXECUTIVES

I. Kevin B. Kamenetz, *County Executive of Baltimore County*

- A. Typical profile of a heroin user is now a 23-year-old male from affluent suburb who started from abusing prescription painkillers. Baltimore County is fourth in the state for all intoxication deaths. Fewer prescriptions of painkillers → heroin filling that need; heroin more accessible and cheaper.
- B. Baltimore County's plan is called DEAL – (D): Drug Prescription Take Back Boxes where unused drugs can be dropped off anonymously, 24/7; (E): educate and engage the prescribers, treatment providers and the public; (A): Advocate for use of Naloxone and appropriate treatment, especially by friends and family via free training; (L): Lethality Review Team to study trends in Baltimore County.
- C. Recommendations: anticipate another \$4M this year from state for essential funding – reach those uninsured, peer recovery specialist hiring.

II. Dr. Leana Wen (for Mayor Stephanie Rawlings-Blake), *Health Commissioner for Baltimore City; Chair for Behavioral Systems Baltimore; ER physician*

- A. Heroin and opioid abuse is underlying issue of many other problems; 19K out of the 640K in Baltimore are using heroin. Addiction is a chronic disease, like diabetes or high blood pressure; only 1/10 nationwide are getting needed treatment.
- B. Baltimore City Mayor has Heroin Prevention & Treatment Task Force to make actionable recommendations – final report in July 2015.

C. Recommendations:

1. Decrease barriers to Naloxone – Governor should sign bills passed allowing immunity and standing orders.
2. Improved access in jails: start treatment as soon as addict gets in jail (OD is the end of the line). Use hot-spotting (geospatial mapping) to look for trends in OD death data: almost all patients who died of overdose have been through jail system.
3. Statewide public education campaign to fight stigma, encouragement treatment access, teaching saving lives –launched in Baltimore, like in NY, VT, RI. Look at history of addressing heroin abuse for future approach.

D. LG: OD rate is higher than murder or automobile accident death rates; those coming out of correctional systems are more susceptible. We are expanding Naloxone access. Comments from LG: in Baltimore and statewide (data thru Sep. 2014), overdose rate is higher than murder rate and rate of deaths from automobile accidents. Individuals coming out of correctional systems are a lot more susceptible; look at jail and juvenile systems. We are expanding access to Naloxone, etc. You made a point that I have over and over again: overdose is the end of the line. 1/10 addicts may die, but the 9/10 are still addicts and need treatment.

a. Q from Ms. Embry: Do you feel, as Health Commissioner, that you have adequate data?

a. Dr. Wen: the mayor's task force is focusing on this. We want to make sure we have data on # using heroin, # seeking treatment; what is the access to treatment in terms of # of slots; quality of treatment; these are the 3 workgroups we have (data, access, quality of treatment). We are also working with partners in the city (provider community, treatment community, nonprofits) to identify real-time way of addressing this issue. We are about to develop a 24/7 intake/referral line. Currently, people in crisis get a card with phone 5 #s on it. 2 of these #s don't work and others work only at some times; 1 requires your insurance. Someone overdosed can't use these phone #s effectively. We need single point of entry to get connected to treatment immediately.

b. Ms. Embry: What strategy do have in engaging the provider community?

a. Dr. Wen: Emergency Department Chairs are convening later today; working with provider groups on increasing access to Naloxone. , meetings with Health Commissioner – increasing access to Naloxone; why aren't we giving them Naloxone as we would give an EpiPen?

c. Linda Williams: Private providers don't give specifics though.

a. A: We're working on it. We used to have a program run through Behavioral Drug Systems called Drug Stat; it's being restarted to convene providers who must give data and also the rest of the provider community. We have good estimates but we need to find better ways to engage everyone.

II. J. Douglas Howard, *President of the Board of Commissioners in Carroll County; Chairman of Maryland Rural Coalition of Counties*

- a. Our role in local government: public safety, infrastructure, education; all of this is threatened by drug addiction, use, trafficking.
- b. One of the biggest challenges in Carroll County is to believe that there's a real problem.
- c. Availability of less-stigmatized drugs is increasing in our community. This is a health crisis, but we must do more on the enforcement side – focus on those who come into our community w/no other ties to our community except drugs.
- d. We are attacking on two fronts
 - a. Program called Not in Carroll: \$2.2M commitment over next 3 years to add additional specifically trained/designated law enforcement to Sheriff's department – first responder in overdose.

- b. Partnership with state's attorney, who is forming overdose response team. Focusing on (1) prosecution of repeat offenders from drug trafficking (2) prevention, education (3) early intervention needed for those with minor offenses.
- c. One of the positions created by state's attorney is a treatment and education liaison from their department for early intervention.
- e. Other efforts
 - a. Working closely with nonprofits; we rely on partnerships, i.e. school systems, libraries. Education effort must embrace everyone, i.e. business community because there is a huge impact on economy because of drug pervasiveness.
 - b. Drug task force
- f. Want to make sure not duplicating efforts; that we have information AND activity; that we are partnering successfully.
- g. Single biggest driver of crime in Carroll is somehow related to drugs.
- h. Drugs being trafficked are not pure heroin.
- i. Resources are important but community resolve is even more so.
- j. LG: you mentioned getting information out. What steps are you taking to do that?
 - a. A: through partnerships with health department; nonprofits; adding liaison; meet with local newspaper; commissioners have town hall meetings.
 - b. LG: when we traveled through the state, the biggest problem was heroin.
- k. Linda Williams from Harford County thanked Carroll County for being at the forefront.
- l. Jack Young, City Council President: I referred people into treatment; made sure that people who came for treatment wanted it for themselves. Drugs affect the whole family.

III. **Allan Kittleman, County Executive of Howard County**

- a. Howard Co. has problem with heroin overdose and abuse; has seen steady increase in use and overdose; especially in Caucasian young men 18-30.
 - a. Due to inexpensiveness of heroin.
 - b. 2013: 5 deaths from overdose; 2014: 8; 2015: 7.
- b. Legislation passed to give immunity to folks reporting problems.
 - a. Helpful: gets people to come out and help someone suffering.
 - b. Hurts: takes away ability to have court-mandated treatment.
- c. Active police department working with local jurisdictions and other states i.e. WV.
 - a. Route 7 known as "heroin highway" – it goes through Howard County. Waverly shopping center has heroin problems; Route 40 also has problems.
 - b. 250 field officers are trained with Narcan and will have that on their belts.
 - c. New policy: narcotic division is told right away when there is overdose.
- d. Active corrections department: training and counseling inmates and family members; how to use Narcan, help with addictive tendencies: step program where they ID the addicts, who then go through treatment center, receive overdose training, training in Vivitrol. GOCCP grants for this.
- e. Health department – trained 200 people in Narcan to help them be able to help others. 2+ from health department work within corrections department to assist with opioid cases.
- f. Needs and problems in Howard County
 - a. Public awareness – Joan Webb Scornaienchi, present at the summit – Executive Director of nonprofit HC DrugFree: designed to get public awareness, work with school system. Coordinated a drug take back program last week and had over 800 lbs of prescription medication given to us to take out of the system.
 - b. Multidisciplinary approach – police department, health department.
 - c. Beyond stiffer penalties, look to rehabilitation and treatment.

- d. Concern about immunity bill – unintended consequences of taking away court-mandated treatment. Look at how we can deal with this issue.
- e. Insurance is a problem – mental health is part of the issue; sometimes it is easier for someone who doesn't have insurance to be treated. We can work with the insurance companies, state, Senate Finance Committee, House Economic Matters Committee.
- f. There is a time when we have to make sure that people can take care of themselves. This needs to be looked at in addition to opioid issues.
- g. LG: are you using Vivitrol in county jail?
 - a. A: Applying for a grant to implement this program.
- h. Comment from Del. Wilson: immunity issue: we heard this issue on the Judiciary Committee. The problem is the court system is the only way to break into that cycle and to get them out of it; we are planning to talk about it to amend so that there is noncriminal way to offer immunity but at the same time require some time of treatment.
- i. Comment from Linda Williams: it's easier to get a lot of people in with no insurance. Insurance companies need to be held to a higher standard.
 - a. Mr. Kittleman: it is also an issue with mental health. We are presenting our budget to the county council next week and are going to put extra money to hire more mental health counselors; those without insurance can be seen right away; those with insurance have a 6-week lag or so; will put in money to get people help right away to help in crisis time; then work with insurance to get it covered right away. It is a twofold issue: mental health and substance abuse.
 - b. LG: mental health is very important to Governor and me.

IV. Steve R. Schuh, County Executive of Anne Arundel County; 8 years as state delegate

- a. 2014: 308 overdoses; 48 were fatal; this is continuing to grow. We are running about 1 overdose per day and a fatality a week.
- b. Progress: state level: AA delegation in collaboration with Governor's Office and LG passed HB 368 protecting first responders/other professionals from liability during administration of Narcan. Now our EMS police and fire professionals can administer Narcan without fear of facing unnecessary lawsuits.
- c. County level addressing problem:
 - a. Pull together all relevant departments and offices to create task force – including health, social services, mental health, public safety, state's attorney, sheriff, police and fire etc.
 - b. Task: review all existing programs to develop strategies for expanding programs that are working the best and to make recommendations to establish new programs combating heroin abuse → basis of heroin action plan which is now being implemented.
 - c. Heroin is the octopus from hell – problem in all aspects
 - 1. Anne Arundel heroin action plan attacks it from every angle
 - 2. Education: working with School board and community college and leaders to educate young people about dangers of these drugs. Town halls, hosting speaking events, effecting changes in curriculum to strengthen anti-drug message
 - 3. Healthcare: investing in more treatment options especially in mid/south county areas where traditionally more limited options for treatment.
 - 4. Public safety – going after dealers as aggressively as we can; beefed up narcotics unit; formed intra-county law enforcement unit consisting of multiple department reps to go after dealers; increasing staff in state's attorney's office to create dedicated anti-heroin prosecutorial unit.

- d. There's a real human dimension to the problem of addiction. This dimension was brought home to me during a recent heroin town hall conducted in Anne Arundel Community College's main hall – may be what the rest of the state wants to do.
 - a. Panel of experts including health officer, social services officer, scientist (expert in addiction), several others including inmate in jail.
 - b. Providers in the community set up tables to connect people to resources.
 - c. Over 400 people at the event; room filled with emotion and pain.
 - d. It was a call to action.
- e. We need the state to play a significant role in all of this.
- f. We need resources to do this; working together through effective partnership between state & county governments; between health, education, law enforcement systems acting sooner rather than later.

LAW ENFORCEMENT

- I. **Judge Ellen Heller: former administrative judge of the circuit court of Baltimore City retired 2003; since then has presided over drug court, 1 of 2 for adults in Baltimore City at the Circuit Court for Baltimore City (established by earmark grants).**
 - a. This is a problem for all of us in the state – it's everybody's very serious challenge. It's not just a police/arrest issue.
 - b. We are failing the war on drugs, now 44 years old. Have spent hundreds of billions of dollars but we have the highest incarceration rate in our country, in the world; no fewer drug use; have not diminished the world supply; we have international interdiction issues; we have not reduced corruption; racial disparities in arrest and incarceration.
 - c. Drug addiction is a disease and treatment can work.
 - d. Info/background
 - i. First drug court established in Miami, 1989. In 1994, Baltimore City established a drug court at the district court level; in 1994, at the circuit court level. Model used today created with additional support services since 2003.
 - ii. 36 drug courts in MD. 20/24 jurisdictions in our state have drug courts (none in Garrett, Kent, Queen Anne's, Allegheny).
 - e. We must partner with public health. Drug courts DO help. Studies show reduced recidivism, substance abuse, cost; they rehabilitate people.
 - f. Components in our drug court: judge (monitoring: 1x/month or more); state's attorney, public defender; in-court assessors who are certified Behavioral Health System Baltimore; they have graduate degrees; probation agents supervising (trained to get continuing education); case managers (help with job training, housing, educational opportunities, benefits, insurance); licensed social workers (mental health); continuing care coordinators (welcomes someone into program, 24/7 point of contact; trained addiction counselor).
 - g. Most people in drug courts don't have a history of crimes of violence/haven't committed one for 10 years.
 - h. We give treatment depending upon severity of addiction
 - i. In the court I sat in for many years (major records, severe addictions), a good % started with 6 mos of residential treatment and then had intensive outpatient; then had total of 2 years probation although that is reduced to 18 mos if someone has done well.
 - j. Effectiveness of drug courts
 - i. Study by National Institute of Justice (2011) largest national study of 23 courts in 5 states – study that lasted 7 years – found that drug court participants were 1/3 less likely to report using drugs 18 mos after enrollment in program. 18 mos afterwards they were responsible for less than 1/2 as many criminal acts as

comparison group of that study. Saving of almost \$6k per participant. NIJ also did national study in 2002 and found that 84% of drug court grads had not been rearrested/charged with serious crimes in 1st year after graduation. 72.5% in second year.

k. Savings from drug courts

- i. In MD, to go thru 6 mos of residential and outpatient, (most drug courts don't do this, but we do), it costs \$15-16K/year for supportive treatment. Incarceration costs \$35-37K/year.

l. Challenges/Recommendations

- i. Shortage of quality programs
- ii. In MD, under Affordable Care Act, outpatient programs are affordable or free, to the participant not free. It's hard to find quality programs and residential programs.
- iii. Need for mental health treatment in these programs.
- iv. Drug treatment practices can vary depending on judges.
- v. Support service needs to be organized for after graduates go back into the world.
- vi. Public health initiatives are essential.
- vii. Set up walk-in referral centers (can be run by health department, nonprofit, hospital) where someone can get access to treatment, referral to treatment, emergency help direction for overdose or getting through/cutting need for insurance or benefits.
- viii. Education is important.
- ix. Pre-charge, pre-booking programs as in Seattle's LEAD program: Law Enforcement Assistant Diversion: police officers are given the discretion to divert drug addicts they know in their community to treatment in the community. LEAD program is partnership of law enforcement, public health, community, mayor. Here it can be the state governor.

II. Scott D. Shellenberger, State's Attorney, Baltimore County

a. Heroin deaths in state have skyrocketed over last several years and have taken over homicides for leading cause of death.

b. Reasons for increase

- i. Statewide database to lowering availability of OxyContin in pharmacies/thru doctors drove people to heroin.
- ii. Increased purity: heroin is one of the few drugs in the last 25 years whose purity has increased and price has gone down. Increased purity allows individuals to no longer do the drug intravenously; they can ingest it by snorting. Heroin is being cut with many different agents – i.e. fentanyl – depresses breathing and heartrate, increasing deaths.
- iii. Extremely readily available product and incredibly cheap

c. 2014 expansion of Good Samaritan law in MD was good = individuals can dial 911 and report overdose as opposed to just leaving scene.

d. Expanded ability to use Narcan – Baltimore County EMS units carries them.

- i. Suggestion: expansion use of Narcan throughout state. Encourage throughout all health departments use of this and proper training to use it so all family members can get that

e. Recommendations

- i. Pass bill sponsored by MD State's Attorneys' Association earlier in 2015 that allows prosecutors to prosecute drug dealers who can be proven to have sold/given drug that resulted in death of individual.

- ii. Federal government has this statute for years; exists in many states but not in MD. The bill didn't pass this year. This is an important approach. It's about treatment and partnerships, but suppliers are the providers of this deadly drug and we need to have the tools to go after them if they cause a death. Not targeting an individual handing over a package; it is real drug dealers we are after.
- iii. Don't pass HB 121 on Governor's desk that repeals mandatory minimums we've had for 20 years for prosecution and sentencing of drug dealers. HB 121: "If you sell marijuana 3x AND are convicted 3x, you can now get a 2-year mandatory sentence in jail." Not sure this is how we should deal with drug dealers – 2 years is so short. We are sending some mixed messages in the state about our feelings on drugs. Don't forget the dealers of drugs! They often have a lot of violence surrounding them.

III. Dario Broccolino, State's Attorney, Howard County

- a. Suggestion: go to the drug court graduation in your jurisdiction if there is one to see the impact it has.
- b. Heroin-related deaths – curve is going up in Howard County (5 in 2013, 8 in 2014, so far in 2015 there have been 7)
- c. Efforts
 - i. County Executive Ulman started mental health task force, supported by County Executive Kittleman. Sent out press release about cooperative program with Howard Co Gen Hospital and Horizon Foundation for mental health services in more timely manner.
 - ii. District Court has diversion program, starting to look at heroin users to provide intermediary step between drug court and just sending them to court – social worker on staff is well-connected to treatment providers and will try to get heroin users into treatment programs; will monitor beyond the probation department, who is overwhelmed in capacity of cases.
 - iii. Earlier this year drug court ran out of money to continue to put people in treatment programs, but now up and running again.
 - iv. Jail is doing outstanding job. Warden started reentry program for drug dealers and others. In jail they get occupational therapy, educational programs; treatment plan for reentry to community; suggest that we look at this program to put in place on a statewide basis.
 - v. Howard County Drug Free Program – constant education.
- d. War on drugs is not going to be won by prosecutors.
- e. Sometimes have to push people into treatment. When all else fails, incarceration may deny them access to the drugs.
- f. In drug court, it is recognized that there will be failures along the way and breaking probation won't be taken personally. Drug court recognizes that there are constant ups and downs.

IV. Colonel Larry Suther (for Sheriff DeWees), Carroll County Sheriff's Office

- a. Commissioner Howard spoke about new unit being put together in sheriff's office: 5 detectives. We don't have the resources to shut down the supply chain in Carroll County. Usually the user leaves the county to get the drugs; this unit will focus on shutting down the supply chain. Will work collaboratively to do this – health department, schools, state attorney's office
- b. Peer-to-peer counselors help with reentry in our detention center.
- c. 29 overdose deaths last year in Carroll County.
- d. Try to trace back where drugs came from, follow up with prosecution.

V. Ron Bateman, Anne Arundel County Sheriff

- a. Family story with heroin – relative from middle-class family without drug problem history.
- b. 36 years in law enforcement
- c. Role (for law enforcement)
 - i. Education: law enforcement can teach starting in elementary schools. Someone in uniform speaking to them grabs their attention.
 - ii. Enforcement
- d. Manufacturing/dealers
 - i. I spent 5 years in narcotics. Drugs have evolved – the drug of choice now is heroin.
 - ii. It goes beyond MD – must focus on federal partners in DEA, South America, Mexico, SE & SW Asia, Afghanistan. Heroin is manufactured abroad and shipped to us. We must work with allies to cut down supply and demand.
- e. Recommend: partnerships that are enforcement-related in police agencies who work together with State's Attorney Wes Adams to try to prosecute and arrest dealers, making sure they get big sentences. We will make some good headway in identifying dealers.
- f. LG: we have DEA rep here; we have support of federal authorities and are working with federal partners.

VI. Wes Adams, State's Attorney, Anne Arundel County

- a. Stats: 550K people in Anne Arundel averaging a heroin overdose a week. 69 heroin overdoses, 26 other opioids mixed in; 13 heroin fatalities since year began. Administered Naloxone 62 times, 57 from EMS; 3 from law enforcement; 2x from hospital. No one portion of county is spared – not concentrated anywhere.
- b. Personal story: I grew up in addicted family, programs; still battling in family, had personal addiction too.
- c. Progress
 - i. We graduated 11 people this year from drug court. 6 months inpatient is great. But there are so many others at stake still.
 - ii. With help of Sheriff Bateman and County Executive putting together task force, brought in good prosecutor, work with HIDTA to track back to dealers, working with gangs, narcotics, Stop Heroin Program, neighborhoods, targeting specific instances of housing projects funded by drug unit.
- d. Recommendations
 - i. Early intervention and education. In education should start at 4/5th grade. Drug courts get kids at 18, but drug abuse is starting at age 11. Kids can't be taught about drugs for the first time at 18; it must be ingrained.
 - ii. Consider how we control the behavior of our children: we are potentially raising a generation of drug addicts by the way we control their behavior. We overmedicate them (to stop squirming, etc.) but tell them not to take drugs at the same time. 6th and 7th graders are peddling ADHD meds at school, modeling drug abusive behavior. We teach kids smoking, drinking, ADHD meds. It is behavior that leads to drug abuse, not necessarily the badness of the drug; this issue needs to be attacked.
 - iii. Public relations matter; look at effect on smoking
 - iv. Have Governor veto/repeal HB 121. It's devastating to prosecution of repeat drug dealers. It has nothing to do with drug users. [Costs \$8-13 per hit of heroin in Anne Arundel, where OxyContin costs \$80 each.] A single drug dealer could have 230-320 pills sold at one time. Subsequent offender faces mandatory

minimum 10 years without parole. But this won't be possible if HB 121 is passed. Our drug law says: eligible for parole at 25% of your time served on a felony drug conviction. A 20-year sentence is really 5 years. So mandatory minimums are necessary.

Questions for Panel

1. Q for whole panel from Del. Brett Wilson: are you familiar with day report centers? (something that neighboring county in PA does; instead of incarceration, it's a report center for nonviolent offenders = no incarceration expense but there is supervision to maintain their place in society).
 - a. Wes Adams: we don't have a program like that in Anne Arundel. I think that it's the behavior being modeled that's creating the difficulty. Any supervision to keep that behavior in check would be beneficial.
 - b. Judge Heller: it's important after people leave the active part of a drug court that there's somewhere to go if there's a relapse. Relapse is part of recovery. Support services are needed. They need to be able to go someplace without worrying about getting in trouble.
2. Q for Carroll County from Elizabeth Embry: concept of overdose event as trigger for investigation into drug dealer organization that sold the drugs leading to the overdose. Are you doing this systematically, and if so, is it effective?
 - a. Mr. Suther: Yes; we try with every overdose to trace back. We also work with the user because usually they want help and want to cooperate. Once program is set up at state's attorney's office, we will have someone we can refer them to; not just the health department.
 - b. Wes Adams: gathering info to create connections between users; traces back to suppliers and dealers; one of the programs we are running with HIDTA. Helping us in strategic target prosecutions.
3. Q from Linda Williams: with pre-charging/pre-booking, when an officer diverts someone to treatment, after they go to treatment will they be charged and booked?
 - a. Judge Heller: in Seattle's LEAD program they are not; it's pre-booking. Even if they do not succeed and relapse, they are not charged. In MD, even after they are charged, one can set a charge – put it on a shelf and let someone be diverted.
 - b. Ms. Williams: I try to keep my clients out of system because once they are in, I can get them a great treatment place, but parole/probation says they can't go. I could get more efficient treatment if I didn't have this block. Judges take probation violation personally.
 - c. Mr. Shellenberger: The MD State's Attorneys' Association scans all state attorney's offices. Majority offer drug diversion programs. Heroin users are charged, make it to SA office; if can be diverted, they will be sent in exchange for case being setted. If they successfully complete drug treatment, many SA offices will reopen set and nol pros (dismiss – no criminal record). Almost all SA offices offer some type of diversion program. Currently exploring with health department to expand diversion program to other opioids (not just marijuana); i.e. first-time arrests for possession of OxyContin. At district court level, judges are finding these individuals and not necessarily sending them to treatment they need. Started in October 2014 trying to fill the slots we had used for marijuana (since possession under 10g has been decriminalized) for possession of other opioids.

ADDICTION TREATMENT EXPERTS, ADVOCATES, AND EDUCATORS

- I. **Barbara Allen, parent advocate; Co-Founder, Executive Director of James' Place, nonprofit in Howard County; National Board of Directors for Compassionate Friends**
 - a. Personally have lost son, brother, and niece lost through heroin

- b. Work at local, state, national level for advocacy on both the prevention and help/grief side – supporting 1800 people – life and after death
- c. Target America Exhibit, Maryland Science Center, 2014 – put together by DEA – for 7th graders; not all counties took advantage of this.
- d. Issues specific to parent advocacy/Recommendations
 - i. Keeping people alive. Good Samaritan law is good.
 - ii. Educate – don't run, call 911 – many states have billboards saying this.
 - iii. Keep Naloxone and spread its availability with families, law enforcement.
 - 1. Atlanta RX Drug Summit last week: DA for Norfolk County, MA: "won't be long before public will sue first responders for not having Naloxone on hand." Naloxone is not a deterrent to drug abuse; it is a deterrent to death.
 - 2. Keep its cost down.
 - 3. Task Force from a county in NY and MA paying Narcan programs with forfeiture funds instead of waiting for grant money
 - iv. Prescription drug monitoring program: real-time PDMP needed – physician can see what history of that individual is and can recommend something else/ensure they're not doctor-shopping
 - v. Provide alternative care. Shorter treatment = longer aftercare. In Portugal, Italy, Spain, it's 2-3 years of treatment.
 - vi. Immediate access Governor Shumlin in VT working diligently – "find a bed, find the money" – coordinating with other states to find beds.
 - vii. Quality of care – standards vary dramatically. But there are many paths to recovery – don't argue which is best, just support them. Many excellent ones throughout the country. Medical assisted treatment would improve quality of care and make recovery last.
 - viii. Aftercare – Jane's Place gives options for aftercare, i.e. educational programs.
 - ix. Second chance legislation – we made some progress on this this year.
 - x. At the Rx Summit, CDC Director Frieden was asked a question about ebola and its huge response. What about heroin and opioid abuse? He said – we messed up.
 - xi. Stigma – remove it. For example, say recurrence, not relapse. Think about how we might be thinking about it unconsciously. Remap our own thinking to see if we are the problem.
 - xii. Q from Prof. Johnson: length of treatment relationship with active treatment and aftercare: do you have data that you can provide to support that?
 - 1. A: Yes, for US and foreign countries and will provide it.

II. David Byram, VP Market Access and Government Affairs for Orexo, manufacturer of Zubsolv (buprenorphine and naloxone), approved for maintenance treatment of opioid dependence and addiction

- a. Buprenorphine is not a silver bullet; needs to be have comprehensive treatment model including psychosocial counseling, patient accountability measures (contracts, etc.). We must be specific about managing all of the patient's challenges, not just the patient's brain.
- b. Buprenorphine in the hands of skilled physicians and motivated patients can be very productive & continue to save many lives; opportunity to return patients to their loved ones as functioning members of society; no longer dependents of state and community but functioning members of community contributing to tax base.
- c. Maintenance treatment for period of up to 1 year demonstrates 75% of patient retention in treatment. Short-term detox/taper has 0% retention.

- d. Black cloud around medication due to diversion, misuse, widely varied prescribing patterns, inconsistent toxicology screenings, other challenges
 - i. Not a lot of treatment guidelines for various pathways to treatment
 - ii. Next week, American Society of Addiction Medicine will release their first treatment guidelines ever! Hopefully will help us as we manage this process.
- e. Diversion is expensive to the state. If patients are committed to recovery, they'll do well; but those who aren't won't – 30-40% buprenorphine has ended up on the street. MD is spending \$22M in their Medicaid program to support buprenorphine treatment; those monies could be used productively in patients who are committed to their recovery. Good Samaritan laws, Naloxone could be funded.
- f. At Orexo, there are 4 phases of treatment: induction, stabilization, maintenance, medical tapering component – this last one is forgotten.
 - i. Buprenorphine is not a silver bullet – but is an opportunity for patients to regain their cognitive clarity, begin working on psychosocial aspects. Changing behaviors and mindsets is long-term recovery.
- g. Diversion in MD has been a problem since it was flagged in 2008 by The Baltimore Sun. Driven by the legacy tablet and film formulations of buprenorphine.
- h. Recommendations
 - i. We have to all be in this together.
 - ii. PAIRS not required to demonstrate that they could provide treatment. 640 physicians in MD provide buprenorphine. They should treat at capacity, but aren't.
 - iii. Law enforcement involvement is encouraging. Sometimes help when patients aren't committed to their own recovery.
 - iv. Different options must be available to patients – more intensive outpatient, residential.
 - v. In working with PAIRS, when they put in a comprehensive treatment model + take medication with known street value off the formulary for Medicaid reimbursement and coverage = drop in 23% prescription volume to as high as 40% in managed Medicaid programs. Seen in United Healthcare, national managed Medicaid program of WellCare. There is opportunity in this state as well. Make the best use of your resources; reconsider approaches taken with buprenorphine and its previous formulations. (MINUTE 18, VIDEO 3)
- i. Linda Williams: can you tell me about Ibogaine – hydrochloride?
 - i. A: no information.

III. Dr. Marvin “Doc” Cheatham, *President of Matthew Henswood Neighborhood Association; President of 3 civil rights associations; President, locally, of Southern Christian Leadership Conference, NAACP, National Accident Network*

- a. 70-year history of heroin in Baltimore. USA's 44-year failed war on drugs.
- b. In September 16, 2014, Matthew Henswood Association called press conference for a US congressional hearing on heroin. US Senators Barbara Makulsky & Benjamin Carr sent representatives, but no congressmen from Baltimore City and no members of Baltimore City Council were present. Wanted a formal process of US Senate to collect and analyze information related to Baltimore's 60-year history and being heroin capital of US.
 - i. Seek short and long-range solutions. We will give written recommendations to the panel and the audience. Asked for oral/written testimony from experts, citizens, legislators, medical, legal, law enforcement communities. Senate Rule 26, para. 1: a committee is authorized to hold hearings during sessions, recesses, and adjourned period of the Senate. We called for a congressional hearing.

- c. Facts: US government agencies estimate that 1/10 of city residents are addicted to this drug. US DEA: Baltimore has the highest per capita heroin addiction rate in the country. In a city of 645k, Baltimore City Department of Health estimated 10 years ago that there were 60k drug addicts; 48k on heroin. Federal report recently released: 60k on heroin. Federal government has designated Baltimore as high-intensity drug trafficking area = eligible for special federal assistance to local police. Tom Carr, director of Washington/Baltimore HIDTA: heroin epidemic in Baltimore dates back to 1950s and is now ingrained part of city's culture. HIDTA Feb. report: 1/10 residents of the city snorts, smokes, or heats and injects with needles – more significantly potent than heroin sold in other areas of country. In mid-1990s Baltimore became a main east coast distribution port for high purity South American heroin smuggled from Colombia – more potent than East Asian and Mexican counterparts = more addictive and deadly. ABC News report, 2014: 304 fatal heroin-related overdoses in Baltimore and similar # heroin-related in hospital emergencies. 2014 Baltimore Sun article: National Geographic depicts Baltimore as heroin capital of America. HIDTA predicted in Feb. 2014 situation report that # of heroin addicts in Baltimore will continue to rise. US AG Holder: addiction to heroin and other opiates impacting Americans in every state of every background.
- d. We feel that improper and failed police implementation is part of the problem.
- e. Recommendations
 - i. Harm reduction: increase and expand failed opiate overdose prevention training; establish protocols for facilities that house or serve individuals with opiate overdose risk; syringe exchange should be widely available and accessible; provide targeted prevention and services for pregnant women to protect the health of the unborn child or drug-affected newborn; enhance awareness of heroin use by parents and caregivers, its impact on children and the need for child-focused assistance and support.
 - ii. Law enforcement: read *The New Jim Crow* (Michelle Alexander); initiate drug-endangered children programs, and expand them...the moment children are conceived; increase #, funding, reach of drug courts; bold public initiatives; change in attitude to demand the decrease; hold doctors accountable for judicious prescribing of pain medication
 - iii. Prevention: most of the drugs going to other counties are mostly sold in Baltimore; folks who aren't from the community are coming in to buy. Promote safe and healthy neighborhoods; provide opportunities for youth participation and activities that reduce risk and enhance protection; increase community awareness and substance abuse prevention messaging; reduce access to prescription meds for nonmedical use; recruit businesses and employers, local government agencies, medical centers, nonprofits to participate in substance abuse prevention and intervention activities.
 - iv. Treatment: establish and increase inpatient stabilization centers/facilities throughout MD, especially in Baltimore to allow patients time to detox and coordinate follow-up services like continuing treatment options, stabilizing houses, or community recovery; outpatient treatment more widely accepted in all communities, not just in poor communities; expansion of addiction treatment services in jails – mitigate revolving door phenomenon.
 - v. Workplace: provide/expand assistance for employees with drugs problems. Employers should provide education and prevention resources.

IV. Danny Brannon, President/CEO of RightTurn Impact; degree in addictions counseling; recipient of Pearson Prize for Higher Education

- a. Residential recovery treatment program in Baltimore serving 1200 annually. 12-bed recovery house for men, 12 for women. Statewide coordinator for SADD (Students Against Destructive Decisions, leading prevention education program in the world). Founded 1992; treatment services given to 50K+ Marylanders since inception.
- b. Addiction is a disease; a primary illness – chronic, progressive, morbidity, potentially fatal; I know firsthand its horrors.
- c. Any addict can be clean. Believer in 12-step program. Encourage clients to go to NA and AA meetings when they leave our program.
- d. RightTurn's goals
 - i. Education: educate addicts about disease of addiction – it is no different than any other disease.
 - ii. Self-diagnosis: bio/psychosocial signs and symptoms; break through denial by honestly looking at effects of drugs in all areas of their lives; ID role drugs play in their lives – look at relationship to drugs. Detection is important. Must be owned.
 - iii. Provide treatment tools – to recover from addiction; intro to 12-step meetings; building recovery networks; sponsorships, home groups, prayer, meditation, nutrition, sleep, helping others, giving back and finding meaning and purpose.
 - iv. Personal responsibility through education, learning experiences, self-disclosure, sharing – culture to show clients we care. Build rapport, influence, inspire, motivate for change. Addicts seeking recovery need to do footwork every day. It's more than not using; take personal responsibility. If untreated will get worse.
- e. Most effective: recovered addicts helping those trying to recover.
 - i. AA is in over 100 countries worldwide with undeniable success. The second largest 12-step program is Narcotics Anonymous effective like AA. All over the world; free. 10-60K in Baltimore area are addicts. They must know there are 800+ NA meetings weekly in Baltimore and surrounding counties. Up to 30K+ addicts living clean in Baltimore.
- f. What works
 - i. 12-step model in recovery. Go online, find open NA meeting close to you, and see the miracles of recovery with your own eyes.
 - ii. Abstinence is the best policy for addicts. Short-term detox, Suboxone if needed for 3-5 days, followed by residential treatment, long-term recovery house living with rules, guidelines, safe supportive with accountability; daily attendance/active participation in 12-step meetings (belonging to a home group, sponsorship). Addicts need to make lasting, meaningful relationships with others and find other recovering addicts who they can identify with, trust, and walk with. Sense of belonging, loyalty, family. This is what works for most people for the longest time. 12 steps bring about lasting change in the way addicts think.
- g. What doesn't work is treating drug addiction on drugs (long-term maintenance programs like Methadone and Suboxone). It's like putting a Band-Aid on a cancerous tumor. It masks physical symptoms of addiction and does nothing to address the thinking, where addiction lives (it's a brain disease). Maintenance programs probably do help long-term addicts who have never been able to stay clean, but in common practice, for a young person who used heroin for 6 months, putting them on other drugs to treat them is absurd. Give them a chance to get clean before convincing them that they can never get clean without drugs.
- h. What's needed
 - i. Consequences need to outweigh benefits to help addicts get clean. There needs to be consequences for breaking the law, breaking treatment and probation;

incarceration is a viable solution. Any chance for recovery demand consequences.

- ii. Drug programs in jails are ineffective because addicts need to be vulnerable, open up, express – and there's no crying in prison. This money would be much better spent for long-term transitional recovery for offenders as they get out of jail.
 - iii. Maryland needs detox, residential treatment, recovery houses, peer-to-peer support, recovery coaches, 12-step meetings, law enforcement, accountability.
- i. Question from Prof. Johnson: Do you have any empirical evidence on efficacy on AA or NA? Published studies?
 - i. I don't have written documentation for you, but I've personally visited 12-step meetings all over the country and know countless 100s in recovery. Have been to conventions where there are 10K people in recovery. Hard to track an anonymous program.
 - j. Q from Prof. Johnson: you've advocated addicts treating addicts. Is it practical to have 60k people treat the 60K addicts here?
 - i. A: Through 12-step recovery, peer mentoring and support, that's what works.
 - k. Q from Prof. Johnson: need to de-stigmatize the disease: could it be a barrier to treatment if people have to go to places where they have to reveal all, other than just going to a doctor or self-help group and not have to disclose everything, just get treatment?
 - i. A: shame and secrecy of addiction keeps people sick.

V. Bernard McBride, *President/CEO Behavioral Health System (BHS) of Baltimore*

- a. It's appropriate to focus on heroin, but heroin is just the center of a target, which includes other substances like alcohol and tobacco. Hard to separate this problem.
- b. BHS formed 2013 to address behavioral health issues, including addiction; goal is to promote system to help those struggling with substance abuse – so they can easily get access to services and programs that are effective for them. This state doesn't exist today; there's a lot of work to be done
- c. Importance of partnerships:
 - i. Our most obvious partner: the people who provide services. High priority for BHS to support/work with local providers. Quality of service is all over the ballpark and so is organization. Job is to support their survival and help them improve their level of care.
 - ii. For 1.5 years, BHS has sponsored Capacity Development Initiative: engage providers in looking with us and each other at quality of care to improve it. Part of that process = help providers trying to respond to new admin requirements that are integral part of Affordable Care Act and other changes state has made.
 - iii. Challenges: not a consistent oversight and level of standard demanded of providers. Priority for us collectively, with DHMH at the lead must up the bar to create more effective/unified way to decide who provides services and overseeing those services and supporting providers to be better at what they do. We are the local partner in this process.
 - iv. Closely related: availability of data to look at system that we're overseeing. Health Commissioner said this morning that we have a working number only. The more important # is how many are using and want to stop using and need care. Who's in care in the state now? It's a challenge but getting better bc Recent changes in which state is administering services helps getting data in central place.
 - v. Another major partner: partnership with people who use the services or need them; or people closely related to those who use the services.

1. Long history in MD of promoting importance of people in recovery as part of the service system. We need to improve on using them as part of the service system, but we have a long way to go to make the best use of them as resources; one of the most untapped resources that we have to get to
 2. We need to help families who have loved ones who are addicts. On mental health side much more robust history of supporting families like NAMI. We want to help this = will help as resource to system and help us get at most negative impacts that heroin/drugs has on our system
- vi. Criminal justice partners – won't arrest our way out of our problem.

VI. Carlos Hardy, CEO/Founder of Maryland Recovery Organization; 4 years worked at former Baltimore Substance Abuse Systems (BSAS)

- a. Peer-led, peer-driven recovery community organization
- b. Personally person in long-term recovery 21 years, 7 months since addict
- c. 165 years ago: "There is no slavery on earth to be compared to with the bondage in which opium casts its victims. There is scarcely one known instance of escape from its toils, when once they have fairly enveloped a man." (Henry Charles Carey)
- d. It's the opium that eats the man.
- e. 3 topics
 - i. Need to earmark funding and promulgate pretreatment service model in MD
 1. Addiction can take everything away and can lead to insanity and death; if addict reaches a stage where they have had enough, they'll have motivation to change – rock-bottom. Some people have a high rock bottom (lost relatively little but still feel ready for help)
 2. We lost so many needlessly because as a system we couldn't meet people where they were at.
 3. What's 'treatment on demand'? Within 24 hours? 3 days? Bottom line: when someone comes we have to meet them where they're at. We must be able to at least send them somewhere; hold on to them.
 - ii. Messaging: need to expand message beyond "treatment works and recovery happens" to "here's what recovery looks like" → not problem, but solution oriented – who are we trying to reach?
 1. Each group has its priorities – but where's the voice of the people who are using??
 2. Today the messages: this is a heroin epidemic; urban, suburban, rural issue; need mandatory sentencing for selling heroin if someone dies; main stream systems marginalizing, identifying addiction as self-inflicted disability. Op-eds, letters to editors, etc., are mean-spirited. Not one positive reinforcing message that if you were using you would want to come into treatment system
 - iii. Role of peers as emerging and fairly compensated workforce
 1. We have missed our most critical asset: person in recovery.
 2. Role of recovery community – tipping point on this. Mutual aid groups since 1857 predate treatment programs.
 3. Peers must be fairly compensated. Rush to professionalize them – that's a mistake. Recovery is organic and may not be linear. It's different for us. Recovery is not a cash cow to be harvested for someone's profit. "Bring what you're good at" – we are key informants (recovering addicts)

iv. Q: Linda Williams: What do you think of peer recovery coaches? We're starting this in our county and sending them to training – teaching them guidelines.

1. A: BSAS trained the first 250 peers operating in Baltimore – there is a formal training; but a concern with utilizing peers is their understanding of ethics. I'd like us to create a Peer AmeriCorps model – peers can earn a living stipend, volunteer hours, access educational grants; an army to go out into the community and bring addicts into pretreatment program for when slots open in treatment programs.

2. LG: first regional summit: one of the local communities talked about their local newspaper re weekly column of recovering person talking about their story in a positive way.

VII. Dr. Nancy Rosen-Cohen, Executive Director, Maryland affiliate of National Council on Alcoholism and Drug Dependence

a. Treatment

- i. Make all levels of care easily accessible when someone is in need of treatment
- ii. Make sure treatment is available and high quality, adhering to state and national accrediting bodies' standards and enforced by those with appropriate authority.
- iii. Resources needed to ensure that programs meet high standards and make sure every part of the state has complete continuum of care.
- iv. Importance of state's role in enforcing compliance by commercial insurance carriers with the federal Parity Act. Private sector must do its part to provide adequate treatment for those with insurance. State must force insurance companies to abide by the federal law. Increase grant funding that goes to the 23 counties and Baltimore City.
- v. Need treatment services for those remaining uninsured.
- vi. Need treatment services for older adults because Medicare doesn't pay for a lot of substance use disorder treatment services
- vii. Need treatment services for residential levels of care

b. Education

- i. Must have greater use of evidence-based programs in elementary, middle, high schools to prevent drug use, including tobacco and alcohol
- ii. Public dollars from school systems should be used to integrate primary and environmental strategies at all levels.
- iii. Research proves that ongoing education is what works – not one-time speakers.

c. Local health departments should continue to have flexibility to work with local communities to develop strategies to reduce access to alcohol and tobacco by youth.

d. Stigma

- i. Key to prevention is to remove stigma
- ii. Addicts seen as criminals, substituting drugs when treating, etc.
- iii. How we talk about people matters. Labels demean and enforces discrimination. Language and policies must change to support those seeking treatment and those in recovery.

e. Recovery support

- i. Resources need to be put in this as we are approaching heroin epidemic with an ongoing treatment mindset rather than an episodic one.
- ii. Housing, transportation access, care coordination, employment

f. Reentry & criminal justice reform

- i. Until law enforcement practices and sentencing structure change, there will be too many people with substance use disorder chronic disease will be incarcerated

instead of treated by health care professionals – disproportionate number of people of color.

- ii. Decriminalization of small amounts of marijuana last year is the first step to changing this paradigm.
- iii. General Assembly session this year shows passed legislation that demonstrates trend toward reform. Reducing mandatory minimum sentences for drug-related crime, expunging and shielding of certain criminal records to help people obtain housing and employment, creation of a justice reinvestment council → these will help people in recovery.
- iv. Recommend that MD enhance reentry services for those incarcerated for 18mos or more. When someone is close to their release date, they should receive services that include: linkage to safe and affordable housing; warm handoff (offender and counselor meet before release) to substance use and/or mental health disorder services; application assistance for benefits so they can be available upon release; appropriate ID; connections to other community-based services; linkage to jobs – all this need to be given before reentry.

VIII. Rev. Milton Williams, Senior Pastor of small black congregation in East Baltimore, on frontlines of heroin epidemic; founder of Turning Point Clinic (largest methadone nonprofit treatment center in the world – over 2K heroin patients in recovery)

- a. Several years ago, state gave \$1M to start treatment center → largest treatment center anywhere
- b. Past 3 years: treated over 5K heroin addicts treated
- c. Baltimore has stigma of being heroin capital but we must change that stigma and brand
- d. Rural and suburban heroin problem is different from urban heroin problem that I'm fighting every day.
 - i. Urban setting: inner city: most heroin addicts don't want to stop using drugs. Professionals and government don't want to accept this. People in the inner city have a whole different set of issues and problems.
- e. I created an open-access, rapid intake, walk-in, clinic that uses incentives
 - i. I have a private donor gives \$20 for each patient who walks into my doors – for transport and lunch. I challenged the system.
- f. My thinking out of the box/ideas
 - i. Breakfast & lunch for heroin addicts: if I were granted money to provide breakfast and lunch for heroin addicts, I could increase my clinic from 2K patients to 4K in 18 months. This would reduce crime, pressure on courts, sentences and prisons, ER visits.
 - ii. Directed care philosophy: Street Smart Medicine – I could develop a primary care, urgent care facility to incorporate in current treatment center. Would save state and taxpayers \$10-20M a year.
 - iii. Tie welfare benefits into drug testing. Welfare money is being used to buy drugs. Addicts should show that they are in treatment before another cent goes to them.
- g. Q from Del. Wilson: does faith come into your treatment, or is it just medical methodology?
 - i. A: spiritual counseling along with medicinal and clinical counseling offers hope and healing. God helping us through this problem makes all the difference in the world.

IX. Dr. Yngvild Olsen, Addiction Medicine Physician, Internist in Baltimore City; President of Maryland chapter of the American Society for Addiction Medicine; President of the state chapter for the American Association for the Treatment of Opioid Dependence

- a. Science of addiction – Opioid Use Disorder (OUD) – background; risk factors
 - i. Chronic brain disease – one of many other substance use disorders defined by established diagnostic criteria; has known risk factors
 - ii. Covers spectrum of severity (mild, moderate, severe) – depending on # of diagnostic criteria a person has. There is no one form of OUD.
 - iii. 40-60% of risk of developing addiction is genetically based. Some mutations have been identified, but they're not necessarily specific to a particular substance use disorder. Someone who has a parent with alcohol use disorder can develop opioid use disorder.
 - iv. Other risk factors: presence of other psychiatric conditions; early childhood trauma; younger age of exposure to potentially addictive substances.
 - v. People with one substance use disorder are at risk for having another substance use disorder or multiple other ones.
 - vi. Symptoms of all substance use disorders are behaviors: driven by dysfunctional set of neurocircuits that have to do with reward, motivation, learning, and memory (very deep, in oldest parts of the brain) → craving and compulsive need to obtain and use substances
 - vii. Brain differences are seen to have addicts acting in unbelievable ways.
 - viii. Risk factors and brain differences don't go away = no cure for this. Risk of relapse never goes to 0. Recovery and remission happen for a lot of people. It takes years – up to 5+ - for relapse risk to drop significantly.
- b. Treatment/medication
 - i. Good treatment combines medication, counseling, recovery support services.
 - ii. 3 available medications – all work in different ways, different side effects, provided in different settings. Not one/not all may work for any one person because everyone's different. There are only 3, so they cannot be pitted above each other, but this is happening.
- c. Stigma – there is a great deal of it for addiction and its treatment. This prevents accessing lifesaving care or delays it significantly.
- d. Recommendations (based on science/expands on existing work)
 - i. All healthcare professionals should be trained in screening and ID of conditions (Maryland has Screening, Brief Intervention and Referral to Treatment (SBIRT), funded by SAMHSA). It needs to be expanded and included earlier in physician and healthcare professional training. A lot of my peers don't understand risk factors, treatment options, how to recommend them.
 - ii. Assessment of severity of condition need to be done by appropriately trained healthcare practitioners using tested instruments and approaches, no matter the setting (court, ER, specialty treatment facility, etc.)
 - iii. Decisions about which type of treatment, including which, if any, medications to recommend should be left up to appropriately trained healthcare practitioners and done according to good medical practice and evidence-based frameworks such as ASAM criteria and national ASAM guidelines coming out later this month + others in literature.
 - iv. Policies exclude/restrict treatment for opioid use disorder should be changed based on the science. Those held by insurance carriers, healthcare facilities, employers, courts, prisons, and detention centers.
 - v. MedChi Addiction and Payer Relations Committee has endorsed resolution on removing commercial payer barriers to buprenorphine – now being considered by MedChi House of Delegates – presented for adoption on April 25 meeting.
 - vi. Barriers to access to Methadone injectable Naltrexone need to be addressed

- vii. Regulations and financing structures limiting or restricting access to effective, long-term treatment are counterproductive because of chronic nature, elevated relapse risk over several years, pace of sustained behavior change. Need to talk about expectations: how long does it take for someone to achieve recovery from opioid use disorder and other medical/psychiatric conditions that they have? Incentivize high-quality care instead – much more likely to achieve positive outcomes for everyone instead of restricting and regulating.
 - viii. Prevention needs to focus on age-appropriate messaging to children and families about risk factors, brain circuits, healthy decisionmaking – i.e. with young kids
 - ix. Environmental strategies – decrease modifiable risk factors: focusing on preventing childhood trauma, minimize exposure to addictive substances, intervening early. MD has adopted strategic prevention framework from SAMHSA.
 - x. Concerted, sustained broad public awareness campaign – demystification; have those in recovery share their voices.
- e. Q from Linda Williams: do you believe that if we educated more on addiction – judges, other doctors, teachers, everyone, will it bring stigma down?
 - i. A: significantly. Much of the stigma is bound up on misconceptions on what this really is and what is happening in the brain.
 - ii. Williams: Wise to talk to their children at a young age: “we have this disease in our family?”
 - iii. A: Absolutely; age-appropriate. Talk about relatives with heart disease, and this too.
 - f. Q from LG: training physicians on risk factors.
 - i. Olsen: It’s a # of different things: understanding risk factors, that there are some very well validated screening tools that can ID individuals who may need or be at higher risk for hazardous use and/or need of further assessment to see whether they have diagnosable substance use disorder & assessed severity. It’s the diagnosis and assessment of severity that will enable health care practitioner to recommend and talk to individuals about their treatment options.
 - g. Q from Ms. Embry: should strategies be mandated, or voluntarily adopted by healthcare professional organizations?
 - i. Olsen: MD has some good precedence for this: ESBIRT has been incorporated in community health centers across Baltimore and areas outside; there is a reimbursement mechanism for it (which had been the challenge for a long time); there are other implementation aspects that need to be considered. The big grant that the state received will hopefully be able to spread it across many other healthcare settings like ERs and hospitals; Marla Oros (MS, RN) has been leading this work; there have been attempts to get into schools. It’s an easy, practical initiative to ID high-risk groups of individuals. Harder to think about how to practically mandate it as opposed to getting it into a best practice.
 - ii. Embry: In terms of reimbursement, is it Medicaid reimbursable?
 - iii. Olsen: It is Medicaid reimbursable. Private insurance I would have to look into (- Dr. Nancy Rosen-Cohen says it’s not. Medicare, I believe, is not either.)
 - h. Q from Prof. Johnson: what would be your thoughts on trying to ensure that medical students have significant amount of time/training in addiction? Do you think that doctors who are prescribing opiates should go on some kind of mandatory course or certification every year to be able to continue prescribing?
 - i. There are tremendous number of opportunities for med students to gain experience through first two years or even as part of rotation; i.e. spending time in opioid treatment program and seeing people get better. Where I work, we have

urban health residents from Johns Hopkins; medical and pediatric residents. Did a survey/study as a fellow where we asked primary care, psychiatry, ambulatory-type physicians re willingness to prescribe buprenorphine; the only thing that was significantly predictive of their willingness was having had a positive experience caring for someone with opioid use disorder.

- ii. And yes, there should be education for pain prescribing; how to ID risk factors for substance use disorders; how to ID and risk-stratify individuals who might get in trouble if you right that first prescription.
 - iii. Myers-Preston: doctors are required to have one CME that's just beginning, so we are making progress in that area. We will be working to connect them with treatment providers.
- i. Q from Del. Wilson: to what extent does emotional trauma (recent or historical) have on creation of addictive problem or its treatment?
 - i. Olsen: functional imaging studies following individuals in early childhood (5) who had some of those experiences; trauma has impact on brain development; brains don't develop till 25. Prefrontal cortex (judgement, awareness) is the last to develop. Early exposure to substances and emotional trauma can change how development occurs; delays it. Individuals who start using substances early on have stunted psychological development.

X. Joyce Mahoney, mother of 2; bachelors in business and human service; masters in social work, Ph.D in psychology counseling; social worker in Carroll County

- a. This is not a new problem, but the victims are younger, which brings it to the crisis level. Many professionals want to ignore it because it's "not affecting regular families," only "addicts in Baltimore City."
- b. This drug is different from the rest; we have allowed our country to be flooded with opiate painkillers.
- c. Recommendations
 - i. What we need to do is to look at what we DO have. What are other jurisdictions who are seeing reduced heroin overdoses doing? Incorporate these and hold accountable all the stakeholders.
 - ii. Treatment services should be tailored to meet the multiple needs of individuals. It can take place in any setting: hospitals, residential programs, sober homes, walk-in clinics, church basements, etc. Choice of the setting and type of treatment, whether mandated by the court or not, depends on the drug of choice, history of the drug use, any previous attempts at treatment, social needs, criminal record, personality, characteristics. This is what the evaluation process tries to discover so we can match up right treatment modality for that person. But in Carroll County, we don't have this. How do we put the resources into what we know is working?
 - iii. The most effective type of treatment and for whom it is most effective is difficult to ascertain for drug treatment professionals. Surest way to make this determination is through rigorous evaluation of modalities of we have now; come to a consensus that drug abuse costs us. An individual must be willing. Have the people who have signed up completed? What are attrition rates? Has the person increased # of days abstinent? # of days worked? At school? Improved family relationships? Medical status? Fewer ER, hospitalizations? Legal status? Mental health? Noncriminal public safety factors gone down? These are factors needed to be looked at in the modalities. If it's working, that's where we put our resources. Where is that mandated standard to look at? That's what I'd like to see

the state do –i.e. “if you want to open a nonprofit, here are the things we’d like to see happen; or else give us reasons why it’s not working.”

iv. Treatment professional at detention center said 90% of inmates in Carroll County Detention Center are there for drug-related crime or they are addicted to alcohol and drugs. Maybe it’s time for the state to say that all local detention centers should have drug treatment (90-day drug treatment for men and one for women in Carroll). Local jurisdictions should look at case management services and the 8505 process. How many are getting 8505s to divert them from prison and then they go right back to drugs? Should they get that evaluation again? Get diverted again? We need to start looking at reality of what we’re doing with the court system. Why isn’t the state making drug courts mandatory in every jurisdiction? It’s the only way to lower numbers in actual jails.

- d. Personal note: I have evidence – list of peer articles. Secondly, it is well established that marijuana is a gateway drug; it cannot be a new business opportunity – it will ensure that we will continue to have heroin overdoses.
- e. LG: that is the task force’s objective: looking at what works. The government often doesn’t ask: are you spending it wisely, efficiently, getting results? We will be looking at that.

XI. Tony Torsch, mother of 3, grew up in Baltimore; moved to Perry Hall; GRASP; nonprofit.

- a. Part of
 - i. Grief Recovery After Substance Passing (GRASP): grief support group for those who have lost people to substance abuse
 - ii. Nonprofit raising money to help in-between individuals – a little insurance may mean a long wait, but without insurance, you can get to free services fairly quickly; this nonprofit helps those in between.
 - iii. Overdose response program
- b. Personal story: lost son from heroin overdose. We were a normal family. He suffered a shoulder injury and started with prescription opioids (OxyContin); stopped; then one day said he had a pill addiction. For 7 years, until he was 24, went to inpatient and outpatient, out of state, etc. I take issue with suburban versus urban; we weren’t in the city. He didn’t want to stop using his drug because his disease wouldn’t let him. Going from marijuana to heroin doesn’t happen.
- c. Recommendations
 - i. Naloxone is now available for third parties to administer. It was not available to us; we didn’t know about it; it had only been available in Baltimore City as part of Staying Alive program – and was only to be given only to person in active addiction, which didn’t make sense. With Senator Klausmeier, parents, Ellen Weber in school of law and her group → passing of Naloxone law: makes it possible for third party to give. It was too late for us, but it isn’t for other families in Maryland.
 - ii. Good that some of the money earmarked to go to local health departments for Naloxone is being used to train law enforcement.
 - iii. My foundation was the second private entity to be approved for Naloxone. Because of the hike in price, we’re going to be out of a program very soon, possibly next month. We don’t qualify for state funding.
 - iv. We need to look really hard at what Colorado and Washington are doing. Not sure if benefits outweigh the problems, but it’s worth looking at
 - v. Mandatory urine screenings needed for docs that write prescriptions – part of harm reduction.

- vi. Awareness campaign – Good Samaritan law, Naloxone. Not too many people know about these things.
- vii. Local health departments should be very responsive to calls and needs.
- viii. Can we have an evening meeting so families can see the good work you are doing and you can see what's working and not for them?
- ix. Awareness, prevention, treatment.
- d. LG: Evening meeting will be considered, but it takes 6 hours so it's difficult.
- e. Ms. Williams: We will change the things we can't accept.

XII. Tim Weber, Carroll County resident, Founder of Weber Sober Homes (started 2009); nonprofit organization Triangle Recovery Club; in June 2015 will be Treatment Liaison for the State's Attorney's Office, Carroll County

- a. Personally: in long-term recovery from drug and alcohol; 13 years on heroin in Baltimore; finally walked into Howard Co. Gen. Hospital; then went to sober home and did 12-step model recovery, still continuing.
- b. Weber Sober Homes require the guys to get a job within 2 weeks; if they don't get a job, they have to leave the house. Right now there are 7 in each house, all with jobs. 11 of them are 24 and under, heroin addicts, been to 5-6 treatment centers, many have criminal records as a result of their addiction.
- c. Carroll County stats – 2014: 893 opioid overdose admissions to Carroll County hospitals; 2014 first 9 months: 30 overdose deaths.
- d. Health department, SA's office, Sheriff's Office, community have speak-outs; vigils.
- e. Let kids in schools hear people who have recovered; let them know that it's ok to be in recovery.
- f. Triangle Recovery Club – provide clean, safe facility for 12-step meetings – has Heroin Anonymous meetings; 2 years ago by this September. A lot of people want help; they just don't know how to get it.
- g. Need a crisis place. There is a window of opportunity only to effectively treat a heroin addict – when they want it. Having to wait 2 weeks is a lifetime.
- h. Don't let it be a whisper after these loud voices.

XIII. Dr. Laura Pimentel, Emergency Medicine Physician, Baltimore City (UMMC)

- a. Scope of problem: trajectory of heroin deaths escalating (published by WashPost Jan 2015)
- b. Medical consequences/the ways ER experiences narcotic addiction
 - i. Different patients on overdose: pulmonary edema, apnea, seizures, trauma from falling or assault; after prolonged laying down: immobility, breakdown of muscles and kidney failure
 - ii. Complications of drug use, especially IV drug users: skin infections (cellulitis to abscesses to life-threatening infections); heart issues; spinal abscesses.
 - iii. Substantial cost and expense (bloodwork, antibiotics, echocardiograms, surgery); repeat patients.
- c. Seeking prescriptions
 - i. Oxycodon, OxyContin, etc. These patients are problematic because they frequently present real pain – divert from patients with real emergencies.
- d. Recommendations
 - i. Data derived from our practice suggests that development of high-risk care plans for patients who are frequent utilizers of emergency services related to narcotic use has been found to be very successful: almost 80% decrease in resource utilization in the # of milligrams of morphine equivalents prescribed/given to

patients who had care plans. Care plans outlined scope of the problem, provides outpatient resources, one specific physician to manage their narcotic use.

- ii. Methadone: huge # in Baltimore on it; it has benefits, but problems too: rate of death from overdose in patients on methadone is out of proportion relative to other opioids. Concerned about incidence of lethal heart arrhythmias and interactions with other prescription drugs; would like a look to see how it is used in Maryland and especially in Baltimore: clinics, practices with regard to patients on long-term therapy, very high doses; whether they are being appropriately weaned from Methadone.
- e. LG: You highlighted the cost of the problem.
 - i. Pimentel: Yes, it's a very resource-intensive problem: real disease or problem/those obtaining prescriptions or divert drugs for sale on the street.
- f. Q from Ms. Embry: when you see prescription-seeking patients or those abusing Methadone, are you communicating with other hospitals who may have seen the same patients or providers?
 - i. Pimentel: development of health information exchange in Maryland (CRISP) has allowed us to see what other hospitals and prescription drug monitoring program passed and implemented in past couple of years enormously helpful to understand a patient's pattern. Suggest we move to developing care plans that identify where they've been but who's managing this patient for opioids and pain management to control # of prescriptions and those who are authorized to prescribe for particular individual. I think any licensed physician and non-physicians with appropriate need to know can access CRISP and subscribe to event notifications – every time a patient seeks care with entity associated with information exchange, they'll receive a notification.

XIV. Alvin Nichols, *Executive VP of Concerted Care Group*

- a. Concerted Care Group is a new treatment provider in Baltimore (Feb. 19, 2015) – privately owned and financed; medical center providing primary care medical & behavioral services, mental health services, substance treatment center all in one.
 - i. Ensure patient has complete access or information to care that they need in that facility and collaborate with other providers.
 - ii. Focus: respect quality of care, high quality, for patients and providers.
 - iii. Case management, coordinated care, identify needs and resources required to make best outcomes, developing range of services like job readiness programs.
 - iv. Premise: evidence-based outcomes needed; know as much as we can about those in our treatment.
 - v. 431 patients in our facility within 7 weeks. Of those, 64% live within 3 miles; 33% live within same zip code (21218); 57% men, 43% women; 49% are 39-50 years old; 44% older than 50; 6% between 25-35 years old
- b. Barriers
 - i. Assertion that there was community was over-saturated with services; people looking for the treatment were coming from other places. But care shouldn't be restricted to geography. People should be able to access care no matter where it is.
- c. Data – look at ways to activate the many data sources we have; create more comprehensive understanding of what we are and what we are doing. ValueOptions – payer vehicle that MD has for paying for Medicaid claims has complete database on every patient in that database, type of treatment, geography. Worth examining: how data could be available in highly restrictive environment (within public policy arena) to see where/how services available and what kind of treatment being provided through that

mechanism, what kind of care is being delivered. It's already in place. We should look at different multiple sets of data – integrate into large database – look comprehensively at how we are impacting people in treatment, how we can help them be more effective, how to coordinate care more effectively. Not as concerned about spending more money to get more data than I am about organizing to create more and better use of the data that we have.

- d. Stigma: stories that amplify the crisis are anecdotal. MD should look at public service announcements, educating our community. One way we can gather that data is through our universities.

XV. Dr. Elizabeth Katz, *clinical psychologist, 25 years of treatment and research on addictions, 7 on opioid addictions*

- a. Need to increase ability to ID who is at risk of developing substance use disorders.
 - i. SBIRT model must be expanded to do better job at identifying at-risk individuals
- b. Peer advocates and faith-based organizations to do outreach into the community
- c. Interim maintenance: offer medication support to individuals who cannot get treatment because there are no treatment slots. Good way to keep people motivated – can then transition to treatment and tend to do better.
- d. Desire to stop using: motivation fluctuates – windows of opportunity to capture. Dependent on circumstances. → Important to disseminate more effective strategies to increase motivation to enter and stay/comply in treatment. Motivational interviewing would be highly effective = train healthcare and addiction treatment providers to use motivational interviewing more. Can be used briefly in as little as 5 minutes – to increase likelihood that they will begin their steps to stop using.
- e. Incentive-based models: considerable evidence in Baltimore showing using contingency management interventions, usually through monetary-based vouchers, are highly effective at engaging individuals in treatment and getting them to discontinue substance use. There are low-cost versions of this approach that are effective. Creative ways to implement: Ken Silverman (Hopkins) has therapeutic workplace approach where opioid-addicted pregnant women who test negative for drugs allowed access to work in data entry business and get paid at the end of the day.
- f. Good access to treatment – expand access; decrease barriers.
 - i. Patients who had used illegally purchased buprenorphine therapeutically was using it because they couldn't afford to obtain it legitimately. Are we making these types of treatments sufficiently available so patients can take advantage of them?
 - ii. France started buprenorphine treatment in 1995: practitioners don't have to have specialized training to administer it; there is no limit to # of patients they can treat – reduction in HIV prevalence and overdose deaths in that country since introduction of buprenorphine.
- g. Psychosocial interventions: psychosocial needs need to be addressed; in particular, research says to match services to patients' needs. The kind of wraparound services talked about by Mr. Nichols is what we need.

XVI. Dr. Ajibike Salako-Akande, *Founder of Getwele Natureceuticals*

- a. For the past 16 years have been researching cravings for drugs; counseling patients.
- b. Heroin addiction is primarily a craving problem. Craving is created by initial euphoria (reward). Over time, user won't eat properly; they will prefer drug to food = deplete brain chemistry and lack nutrients. Metabolites from drugs produce new drugs, sometimes more potent than original. Creates craving, euphoria, tolerance – a cycle. Some of the

current treatments we give now can also cause addiction – break down into products that cause this same cycle. The body is never rid of these metabolites.

- c. We have developed a family of four natural products to help with craving.
 - i. Tested and researched for past 16 years, meet FDA regulations.
 - ii. Currently at medical food stage – don't need to get it to the drug level before we can use it.
 - iii. Safe, effective. Mechanism by which they reduce the craving has been identified in animals.
 - iv. Calms person down, less aggression, appetite, sleep – help them stay in treatment. Attitudes toward recovery improve; desire to use goes down over time so eventually they can get to cognitive therapy, life skills, go to school.
- d. Challenge: people look down on natural products, especially the medical community. But we should allow anything that works; allow any process. We are bringing this as a complementary and alternative medicine in managing addiction. Nutritional management is the missing piece of addiction management, especially in the areas where we have severe problems of people not being able to be abstinent or stop using drugs. Very cost-effective, all natural, little or no side effects, looking for interested clinics. High % success, evidence-based, with research documents.
- e. Ms. Williams requested information to be sent, and Dr. Salako-Akande agreed.

PUBLIC COMMENT

- I. **Vince Dugan, CEO of RedXDefense (Rockville MD):** 10 years ago, we did R&D for sophisticated explosive detector for military; 5 years ago started work on a different detector for law enforcement: primary market law enforcement. Much smaller; does explosives, narcotics, gunshot residue. Military were being killed by IEDs. Their strategy was to “get left of boom.” If you fight the IED at the side of the road, you will lose. If you fight drugs after that person is addicted, you will lose that fight. Was in MoCo last week attending public forum on heroin addiction. Struck by # of parents who didn't know their kids had drug problems till they were addicted. Why are we not educating the parents to be more vigilant? Maybe they need the right tools. Sheriff Bateman made good points. Educate our kids in grammar school. Incarcerate the drug dealers. Intradict supply of narcotics. They're all “left of boom” for narcotics. It may not be possible to do this 100%, though. When we developed product for law enforcement, we got retired homicide captain from NYPD, retired bomb squad detective from San Bernadino County, who gave us advice we needed to develop this product. This product is easy to use and inexpensive. May apply here. It's been tested and works. Law enforcement in MoCo have been using it for 2 years. Samples can be tested by the “keeper,” and a red or green light will show. RedX will fund the pilot program if you want to test it out; we just want a debriefing that tells me why it works or doesn't.
- II. **Lon Wagner, Director of Communications, AmeriTalks:** Baltimore – solutions for painkiller misuse/abuse – assess if medications are being taken correctly; identify potential misuse, abuse, diversion. Data shows that MD is among 10 worst in nation for prescription opioid misuse abuse. In 2014, AmeriTalks processed 16K+ samples residing in the state: results show 2 problems: (1) Nearly ½ contained drug not prescribed by doctor ordering the test; (2) 20% samples contained illicit drug, including heroin. Link between prescription opioids and heroin abuse. Patients testing positive for heroin = trend of people testing positive for drug cocktails; samples testing positive for heroin were 7x more likely to contain non-prescribed synthetic opiate (i.e. Methadone) than samples testing negative for heroin. 20% of heroin-positive samples tested positive for sedatives like Xanax; 19% of heroin-positive samples

also tested positive for cocaine. There are 2 initiatives that could significantly strengthen MD's fight against opioid abuse: (1) medication monitoring to ascertain adherence to prescription. Anonymous medication monitoring info can show diversion patterns, drug trafficking, broken down by county and demographics. (2) Training for people prescribing drugs...(?)

III. Robert Tousey: 23 years in recovery from alcohol; 5 years post-treatment from major depression. Family history of abuse, relatives dying young although successful in life: addiction knows no barriers. My son and DIL are 13 years in recovery from heroin through the grace of God, 12-steps fellowships, good treatment – now successful with 3 children. I practiced law 15 years representing people in criminal justice system who were there because of substance abuse; represented people before the Workers Compensation Commission who suffered injuries and became addicted to pain medication, specifically OxyContin. Now a pastor; officiate many funerals of people who die from substance abuse – DWI, suicide, OD, etc. 16 y.o. in Hereford HS was given drugs by his dad that killed him. Son's story: attending Salisbury University; got arrested; I told him that he could stay there or go to RightTurn – he stayed there till his trial date. My DIL went to Father Martin's Ashley; I went to intensive outpatient program. In common to all of us was a 12-step program following up. Has kept him and his family alive. 12-step programs + treatment = success; I will share studies with you + history of AA, precursor of NA.

- a. Q from Prof. Johnson: even from what you told me, most people who use self-help groups do not get better. What information do you have?
- b. Tousey: every person is different; with different success rates. I'll send you a survey. The best success is when you combine treatment with 12-step program. By economics, treatment is a temporary starting point.
- c. Johnson: treatment seems to be short-lived, so other services have to pick up, like self-help. Do you think that if the treatment was longer and more available and linked, would this be one way in which services would be improved?
- d. Tousey: longer treatment would give better foundation = more successful recovery. But there is still a peer-to-peer need.

IV. Pastor Basha Jordan, Jr.: Pastor of Hope Alive Ministry Deliverance Fellowship, inner city of Baltimore. Licensed clinician; has recovery drug and alcohol recovery radio broadcast (Heaven600, 7:30am Saturday) for 23 years with listening audience of almost 300K. Have traveled US giving drug and alcohol conferences & speeches; director for House of Hope (men's recovery house); work with drug court; participated in program funded from SAMHSA, Baltimore Recovery Collaborative – I was a provider for males coming out of jail/drug court system; was on Board of Directors for Tuerk House (treatment center) and on Board of Directors of National Council on Alcoholism and Drug Dependence; garnered support of ministers when needed to address problems of our community. I am a recovering addict; used drugs and alcohol for 30 years of my life. Recovery works; I've been to some of the best schools in this city but never knew I suffered from the disease of addiction. Addiction is symptomatic; it is not the problem. The problem is individuals have gotten away from a higher power. People seek a spiritual solution to an inward problem. Alcohol, drugs, are a spirit. This is a spiritual problem, and we need a spiritual solution. Alcohol is a drug; if you want to deal with heroin, don't be limited to just heroin. Individuals who use heroin also drink alcohol; alcohol is the #1 drug in America today. Suggest:

- i. Education – educate young individuals.
- ii. Law enforcement – in Baltimore, much higher deaths than elsewhere in MD. Drugs is almost an economic necessity in my African-American community.

- iii. Law enforcement must totally eliminate all open-air drug markets in Baltimore City.
- iv. There should be no loitering allowed around bars and liquor stores.
- v. Set up free treatment centers in every zip code of Baltimore for addicts who don't have healthcare or insurance. Addiction is generated through genes or learned behavior.
- vi. Address learned behavior. I'm tired of burying youth who are sometimes driven to suicide; they have learned this from a young age, drinking leftover beer from their parents' parties.
- vii. Spiritual problem of addiction: committee needs to be there who has come through the process of addiction and who is a practicing recovering addict. This will ensure success, like MADD. You need someone like me sitting up there with you.
- viii. AA came out of the church

V. **Alisha Ellis:** student attorney in Drug Policy and Health Strategies Clinic, UMD School of Law. Parity Act created to address insurance discrimination against people with behavioral health condition. OD crisis is not limited to public with public insurance. Private insurance carriers have major role to play in response to OD epidemic by ensuring timely and clinically appropriate treatment. With expansion of private insurance under ACA, 100K Marylanders enrolled in a plan under this year's open enrollment alone. They must be able to access comprehensive substance use services they expect to get and are paying for.

- a. Problems identified in our work with consumers and providers:
 - i. Limited days of care authorized for drug treatment regardless of severity of patient's condition;
 - ii. Denials of medically necessary drug treatment;
 - iii. Lack of substance use providers on network panels;
 - iv. Delays or denials to get on provider panels despite huge unmet consumer demand;
 - v. Mental health providers being offered low reimbursement rates, even lower than Medicaid rates.
- b. These problems negatively affect access to care and recovery – discourage providers from participating in insurance plans; discourage consumers from getting care that they need. This can be addressed by better enforcement of Parity Act. The Maryland Insurance Administration is required to approve only those private commercial insurance plans that comply with the Parity Act and to investigate insurance company compliance with the Act. But they don't receive the critical information needed to evaluate Parity Act compliance before approving the plan for sale. Consumers have no way of knowing which plans will cover the drug treatment they need and are paying for.
- c. Recommendations that the clinic would help
 - i. MIA should be appointed to the Interagency Heroin and Opioid Emergency Coordinating Council. Much like DHMH, who is charged with overseeing publicly funded behavioral health systems, the Council should include the MIA, which is responsible for regulating private insurance plans.
 - ii. Task force should work with MIA and General Assembly's new Joint Committee on Behavioral Health and Opioid Use Disorder to ensure that the state evaluate private insurance and plans for compliance with Parity Act before they're sold in MD. Although MIA investigates individual complaints, consumers should not be left with burden of filing complaint at the height of their addiction. MIA should determine if plans comply with Parity Act before they're sold so patients don't have to figure out if their treatment will be covered.

- iii. AG's Office with MIA should work to ensure Parity compliance. AG's Office in NY through Consumer Protection Division has enforced their residents' right to equitable substance use services by investigating compliance with Parity Act. AG's Office should investigate in MD; systematic oversight of compliance.
- d. LG: Commissioner Redmer (Director of MIA) has directed his staff to participate with the Interagency Council.
- e. Ellis: look at the work NY has done; has had great impact.

VI. Tony Fowler: lifelong MD resident, father of 5: 3 adult children; 2 had friends who died of heroin OD in past year. Career federal employee – have been involved over the years in many initiatives involving public engagement. Groups involved in “reinventing the wheel.” Bring to your attention promising activity in neighboring state: training media reps to deliver effective messages concerning mental health problems, including drug addiction. Entertainment Industries Council, WPXI Channel 11 in Pittsburgh, news outlets in SW Pennsylvania have been working to raise awareness of mental health issues thru local media: TV, radio, print, online media; training for college students studying media. EIC bringing awareness and awards program to journalists in a variety of media to accurately depict mental health issues through news and human interest stories. EIC has provided briefings to 1000+ journalists in California to enhance accurate reporting on suicide and mental health concerns. Effort has generated interest in mental health treatment community and could serve as national model which MD task force can follow to address heroin use. Will follow up with info. Evidence is overrated.

VII. Dr. Babak Imanuel: addiction specialist, internist, medical director of medical maintenance treatment program in Westminster, MD (Carroll County), 1 of 3. There are currently 3 drugs approved for opioid addiction: Methadone, Vivitrol, Saboxone. The most effective one is Methadone, which can only be administered in a federally licensed facility such as ours. None of the treatment programs in Carroll accept insurance other than medical assistance (?). Medicare doesn't cover treatment of addiction (?). Only 2 providers in Carroll that prescribe Saboxone that accept any type of insurance – currently full. Federal government has a mandated max of 100 patients per provider, and those 2 providers are currently full. Some providers accept cash, but nobody accepts insurance. Naltrexone: highly effective but no private provider currently providing this. Only health department has this program – with less than a dozen patients on this medication. There is a significant lack of treatment providers in Carroll County. Since 2007 there has been no increase in reimbursement for this treatment. All the costs have increased, but reimbursement has not changed at all. Recommendations:

- i. Take away stigma – educating physicians, law enforcement, correctional facility, community, public service announcements;
- ii. Relax zoning laws re opening treatment centers. In Baltimore, I could only open in an industrial zone – those aren't easy to come by;
- iii. Increase funding for treatment.

b. Note: Increase in Methadone OD is caused by Methadone prescribed by pain management physicians, and not by Methadone maintenance treatment programs.

VIII. Pam Bezirdijan: parent; son is recovering heroin addict graduate of UB Law School was involved in tragic situation. Childhood friend contacted him to purchase heroin for him because he said he had seasonal depression. My son hesitated and said this drug wasn't anything to mess with. Son was already using and purchased drugs for his friend. They used heroin together and went separate ways. Friend was dead the next morning in his father's bathtub with needle in his arm. Investigation of text messages led to my son; toxicology reports showed friend died from heroin and cocaine combination. My son cooperated fully

with the detectives. Parents of the man who died don't hold my son fully responsible because the texts showed their son initiated the request for heroin. 1 year later, my son is being indicted by the federal Justice Department on for felony distribution – charge that can mean federal prison for 5-7 years – indictment came after son fully agreed to cooperate with the investigation that will lead to the dealer who known to have long history of dealing and violent crimes. My son has lost his friend, lives painfully every day with remorse, lost his dream to practice law, willing to put his life on the line as informant on drug dealer. Must testify against drug dealer – punishment is delayed for years = living in limbo. In return for our son's cooperation, he is being slapped with even harsher penalties than the dealers. This is because they are saying that he is responsible for his friend's death. Every legal authority we have consulted, anyone with knowledge about drugs, has told us that this is a case that is handled at the state level as a misdemeanor with probation. President Obama, US AG Holder, Governor Hogan, LG Rutherford, Mayor Schموke, State Delegate Dumais all agree that the handling of the heroin epidemic cannot be by retribution and passing down harsh charges and sentences. In cases that do not involve dealing and violent crimes, it should be looked at as a public health issue. Obama recently commuted sentences of 22 inmates who were incarcerated for a long time for drug-related offenses not involving violence. Public attitude of federal and local officials is in sharp contradiction to what the justice system is doing. My lawyer reminds me that my son's case is purely a political issue. Dealing with a person's life shouldn't be based on politics or career advancement.

- a. Respectfully ask LG and task force to look into this case or have someone from legal team inquire with US Attorney as to why such a harsh charge is being handed down to our son. Our son has fully cooperated with the US Attorney's efforts to build their case against the dealer who sold the drugs to him. The dealer has a long rap sheet including violent crimes. Our son was not a dealer; just an active user who sadly made the wrong decision when pressed by a friend and bought drugs from this dealer. Delegate Dumais and Montgomery County State's Attorney John McCarthy stress that legislation does not aim at an addict who might have shared the drug with a friend; such cases should be looked at differently than those involving dealing, manufacturing, or violent crimes – but DOJ is having completely opposite attitude and behavior, wanting to throw these addicts in prison for a long time. This story shows the toll this horrible epidemic has had on two families: one family lost a son and the other is losing a son to a Justice Department that is going against the calls of both federal and state officials. Solution doesn't lie in incarceration but in education, prevention and rehabilitation. Please look into this and possibly other similar cases.
- b. LG: yes, give me your son's info and your testimony; we can contact US Attorney for MD to see what's going on.

IX. Sharan Lindsay: "Finding sober living options in Baltimore County is like finding water in a desert. Local government housing ordinances that have been in place for years to prevent fraternity and sorority housing in/around Towson have created umbrella issue for anyone trying to open a recovery residence in Baltimore County → "not in my backyard" thought process; creates impossible mountain to climb for anyone trying to bring in high quality structured sober living in the area. Everyone in the community wants everyone off drugs but nobody wants to see the process it takes to have someone get clean and sober. They don't want addicts around them, but they don't want recovery around them either. End result = in Baltimore City/County, Howard, Carroll, Harford, the number of high-quality effectively operating structured sober living environments can be counted on two hands. In such a tight-knit community like Baltimore and surrounding areas, this is a shame, heartbreaking and sad. Shows little true support for those suffering from deadly illnesses like alcoholism and addiction." – Published by NAAR (National Association for Recovery Residences). As a

profession, I go before CEOs, CFOs, and directors of patient financial services for major medical groups. We use our ER as new PCPs. Most addicts on heroin are also on crack cocaine and alcoholism. We are putting a Band-Aid over the bullet wound. I am ready and willing but cannot operate within state of MD. I am founder/CEO of House of the Admirer Recovery Wellness Center and Transitional Housing. Most addicts are shipped into Philadelphia who has over 300 recovery houses and 128K+ recovering addicts. MD is dumping its issues onto other states. We need to stop this now and open opportunities for those who are willing to make alternatives for those in recovery.

X. Annette Mrozinski: recovering addict. Was 12 when I first got high; wanted to be a ballerina or vet. June 2 1976 had a son before I was 15. Kicked out of Catholic school; tried to get my life together for my son. Got GED but my addiction was just starting out. Next 20 years of life: arrests, hospitalizations, house raids: I lived to use and used to live. My house was a shooting gallery – where people took drugs. My son had dreams and wanted to be a professional baseball player; but I never went to any of his baseball games. I wanted him to be a doctor, a lawyer, a politician. By 19 he was a full-blown heroin addict. At 21 he had spent several years in prison already. I joined 12-step recovery program; in July this year I am 20 years clean; but my son still not clean. He's doing 25 years mandatory minimum with no parole; no sentence investigation, no genetic testing; no testimony as to what led up to that; he's a three-time loser in Maryland. An officer testified in his trial that addicts don't mix drugs – but stats show that addicts die from that same combination every day. Heroin addiction ruins lives, no matter who. In spite of my son's circumstances, he hopes that this one-sentence-fits-all harsh sentences will be changed and that drug treatment will be more readily available. Long-term treatment is far less expensive than long-term prison sentences, and twice as effective.

XI. Melissa: Addiction does not discriminate. 48 years old in recovery; married; 2 teens in private schools, master's, stable, but still became an addict. Broke my back 2 years ago, and 3 weeks into painkillers was on fast track to addiction; crushing and snorting pills to sleep; taking pills at 2-3x the prescribed dose. Buying drugs on the street and lying, cheating, stealing. A year of active addiction; created chaos in family. Asked doctor but he said he didn't know how to get her off painkillers and could not prescribe detox drugs. Most doctors can prescribe narcotics, but only a handful are qualified to give detox drugs. Between Bel Air, Towson, Ellicott City, I could only find 29 doctors. I take full responsibility for my addiction because I was prescribed pills for the pain. I didn't want to get on OxyContin because I had struggled getting off it last year after surgery. He said I already had physical addiction because I had been on drugs for 2 weeks when I went to see him; but I didn't have mental or emotional addiction; so because of that, he said I would be ok; but less than a year later I would be in a 28-day drug rehab center. I was taking painkillers too fast (not blaming doctor; just a fact) so that prescriptions were being refilled at 2/3x– told doctor that and was given double the dose. My father's a doctor, so it's nothing against doctor, but not all doctors make prudent decisions. Mine was not educated enough about addiction. When I went to another doctor to get the detox drugs, while my insurance carrier paid for painkillers for a year, I had a \$20/dose copay for detox. Alternative Vivitrol shot for 30 days was \$1600. Insurance companies are giving financial incentive to stay addicted. If options aren't offered, many people won't seek the treatment they need. Public awareness regarding treatment options need to be increased. Despite my medical legal family background and the ability to pay, it took 2-3 weeks to find facility to take me and get everything lined up to get me there. Education (early) & prevention are key. We won't stop the supply, but we can reduce addiction by educating early. Once the wheels of addiction start turning, there are few things that can stop it. Primary cause accidental deaths in this country are caused by OD on

prescription painkillers. Last year, 15K people died from overdose on pp. US consumes 80% of painkillers but make up only 5% of population. NIDA Director: addiction is a public health crisis. We need to destigmatize; we do recover.

XII. Israel Cason: founder of "I Can't We Can." Founded 1997, grassroots, self-supporting, 24/7, offers treatment on demand regardless of financial status; was heroin addict for 30 years. Since inception, we serve over 20K people and operate with total abstinence. Served on O'Malley's transition team (health committee); testified before Congressional committee on substance abuse; was on exec board of BSAS; committee on OSI on treatment instead of incarceration and prison reentry program. Confused about what is intended to help in Baltimore City. There is a heroin epidemic in Maryland. If that's the case, how will any of this solution apply to Baltimore since we have been heroin capital for over 60 years? There are unique circumstances for certain jurisdictions, needing unique solutions. Principles of addiction are the same, but solutions should change based on environment. We use a holistic approach; therapeutic community; premise: approach must be holistic; includes the whole person. The only solution is lifestyle change. Prevention is part of the approach to stop the fuel that feeds the addiction = emphasis on babies coming up and children. Go to the root of the problem. Suggest that we develop universal language dealing with addiction problem. Same words are used in different contexts – substance abuse, disease of chemical dependency...these trigger different trains of thought.

a. LG: why are we having this task force now, when heroin's been an issue in Baltimore City for so long, 30, 40 years? My response is that you need to ask the people who were in office before. Don't ask me or the Governor because we've decided to do something now; we've been here about 90 days in office.

XIII. Susan Redmer: want to volunteer services to task force; I am a pharmacist. Pharmacists can be an important ally; task force needs to consider the large number of health care professionals. Pharmacists serve as first line of defense in recognizing drug abuse; many there can spot alterations and falsifications; will often call police. Problems with pharmacist and police communication; usually police don't get there in time (before the addict is gone). Some police stations in Baltimore County and Harford County have an officer assigned to investigate fraudulent prescriptions, which seems to help quite a bit. Pharmacists are the first to witness aberrant or drug-seeking behavior; addict will ask pharmacist 100x about a question and doctor only once. We play an important part in stopping doctor shopping. Pharmacists must record all controlled substances that are dispensed – logged into state PDMP. Pharmacy journals have identified many states where only 40% of physicians are checking into the program. Propose that MD Board of Pharmacy require that 4 of the CEs of the 30 include comprehensive curriculum on medical basis of addiction and opioid abuse. Physicians need training on using monitoring tools available to assess risk of abuse. Make it mandatory for patient education on first prescription of opioid. There's not enough time in a physician visit for this. "Do you have any questions for the pharmacist?" is not enough. State should provide brochures outlining medication assistant therapies and drug treatment programs available in the area. This can be put in along with the prescription.

XIV. Maura Taylor: my daughter did well, graduated college, married, but her daughter died of SID; thereafter daughter went into heroin addiction. We are educated; I spent 5 years on Anne Arundel County Alcohol and Drug Advisory Council as the Board of Education representative. In 1998-2002, heroin was in every single HS of Anne Arundel. It's been around a long time in the suburbs. My kids knew; my daughter still became a heroin addict. No treatment options available in MD; she had health insurance and got 2-week stint in Pathways, did not even touch the surface; thru series of huge miracles = scholarship to

treatment center in California for women who suffered from trauma. Psychological treatment needed – see what got you to the drug in the first place. A year in treatment. It would have cost so much if it hadn't been covered. We need to ask how we got here to this addiction crisis. It has to do with the 122 tons of opiates handed out by pharma companies and doctors; what are other states doing like in CA and Chicago who are suing pharmaceutical companies to get money back because they have left states with huge addiction problem that costs so much; AG needs to look into this, similar to tobacco companies. Don't give corporate tax breaks for private school students, fund a recovery high school like in other states (MA, NJ). There's \$200M being held – hasn't been decided how it will be appropriated vis-a-vis supplemental appropriation. Use it for this instead.

- a. Boyd: money cannot be used for that purpose.
- b. The federal government is spending \$500/second – that money would be much better spent on treatment. Need to elevate the conversation and make it important; value those who suffer; I have yet to hear a story about someone dying from heroin OD on the news; we hear about homicides. Want Second Chance Act; sign HB 121; glad that SB 303 and HB 222 didn't pass this session.

XV. Susan Hixon: Howard Co. Parent and educator. Son has social anxiety; depression since middle school. Difficult to treat him; the stigma is great, looked at treating as “drugging him.” Became addicted from emotional pain, not physical. Taking everything financially for about 8 years now for the 5 of us. Frustrations in getting help: getting mental health treatment is not easy; many psychiatrists and psychologists don't take insurance, and when they do, they have a high copay; psychiatrists and psychologists don't treat the same things, so many times you need both – it's hard enough to get your kid to one. Inpatient copays have been horrendous and we have quit treatments because of money. Have been to all ERs and only got help once – they are not equipped for mental health problems. Psychologist has told them to take him to ER; when my son said he was going to kill himself he ended up waiting so long he went into withdrawal. Are ERs going to help, or not? ERs don't help with withdrawal. No services in the weekends – I've lost him by Monday. No halfway house that's affordable. Detox centers are very important. Health issues not addressed enough. These issues are sporadic and you need to respond right away. Education is important; health is often pushed aside for other subjects, or even in their own classes.

XVI. Pat Whitlock (and Kim Smith, Stacy Laskin): counselors at Howard Recovery (?); today representing Cindy Glass, founder of Jeremy's Run. Wrote a letter about her son Jeremy who died from heroin addiction: “in 2008, at age 20, our son Jeremy died. Knee injury during HS football → multiple prescriptions for opiate painkillers, generously prescribed = addiction = heroin. Difficulties with getting insurance coverage for treatment. Didn't cover addiction services. Outpatient treatment – insurance paid 1/5 cost. Residential treatment facility – insurance company didn't pay past a couple days = paid out of pocket over \$100K. Insurance companies don't provide adequate resources or guidance when it comes to addiction. Addiction needs to be treated as a disease.” Jeremy's Run is for awareness, education, insurance reforms. As an aside: there is no parity in behavioral health services; please take a look at it.

XVII. Jordan Ayres: I grew up in middle class home. At 13/14 smoking pot, drinking. At 17, heroin. 13 treatment centers, 12 in MD. Through jail, homeless; OD, dead for 23 minutes. Went to FL. Now work for company: marketing for treatment center (Just Believe Recovery Center) – help addicts nationwide. For me, I couldn't do it here. At home, I was comfortable and so I got high. I left treatment March 19, 2010. In March 20, I was already on it again. My

friend came back home and died because of this. More people should be allowed to go to treatment out of state if that is an option.

XVIII. [No Name]: (addressing Jordan Ayres: triggers can be identified; but they can be worked through if you have tools). Started drinking at 6, then started smoking. Chemical dependency. I grew up with alcohol in my brain. When you introduce chemicals, your neurons change and develop and start compensating for whatever chemical it is you are putting in your body. Cure: Israelis have studied endocannabinoid system since 1964 → isolating and profiling cannabinoids → this isn't allowed here. Must figure it out and figure out science behind this.

XIX. Henry Jones: juvenile justice system worker for ten years (89-99); we had a lot of heroin and weed kids; 99-2009 we hit the streets and dealt with the homeless people; presidential award winner from Kennedy Foundation (Harvard). Don't know how I'm still alive; have been in shootouts, etc. There are about 200-300 beds at X School; we built the new facility downtown with about 144 beds; I was part of the people who planned that at Denver (Hickey School) to build an assessment. Knows O'Malley. Heroin situation – concerned about funding. There are a lot of successful programs. Recommendation: let's get those kids in some treatment beds.

XX. Jen Newman: National Board Certified teacher; 22 years in Baltimore County; currently a consulting teacher traveling across Baltimore Co. K-12 for teacher effectiveness. Have worked with at-risk kids. Passionate about education. Daughter 2.5 years in and out of rehab. While I did the best that I could as a teacher, it was nowhere near enough. I will send recommendations but wanted to have a face to go with it. We know as educators which of our kids are using. We know the programs that work and those that don't; as an educator, I never had the information that I've had from a personal perspective, i.e. brain disease. As a parent, I talked to my kids, etc.; I asked for help, took the drugs to school; never got enough to know that my daughter had such a serious problem. We have to educate our students, our parents; put whole collective program together; have huge bill just for daughter's testing even with insurance coverage. I would like to see Maryland be a leader in education for kids and families and put the supports in place to help everyone lead healthy and productive lives.

XXI. Bob Galaher: recovering for over 28 years; recently opened outpatient medication assisted treatment center, southern MD (September); privately financed/run. Challenges with it: opened in September 2014 treating over 175 patients; since then, noticed drastic improvements in people's lifestyles; retired from postal service 38 years from HQ; involved in industry forums; saw a lot of similarities here trying to get a handle on this "industry." Looking for quality delivery system, find solutions, carrots vs. sticks... One of your biggest challenges is to put that governance platform to continue. Our place tries to individualize treatment. It's a complex situation with complex people. I'm willing to help.

XXII. Reesa Davis (?): counselor at Recovery Network. Want to see more treatment for elderly community. Influx of people in second phase of life coming in addicted to heroin, opiates. Uncomfortable to be in therapy with 25 year olds. Would like to see funding towards that. Kids coming in from marijuana don't see that as a drug → coercive treatment; they're taking places from people who need treatment.

XXIII. Debra Dauer: Board of Directors, one of the founders for Impact Society. Almost 9 years clean from alcohol, opiates, crack. Single mom of son. Spent last 5 years with Impact Society focusing on recovery houses. I take meetings in Baltimore County Detention Center once a month; develop relationships with women in there. I don't think there is a lot of support for them – what they will do when they leave. Need more resources and place where they can be

directed. They're going to go back to abusive boyfriends, parents who are using, no one is watching their kids; it's a cycle set up for them to fail when they leave. My son's father, then my boyfriend, died from this disease. I am on the Post-Prom Committee – to get these kids to come to the prom party after school instead of drink and do drugs. Make it good enough so they'll come. Another problem: lack of insurance; ER – but then what? There should be more recovery houses, options for treatment that's affordable for people; engage the kids and let them know what's going on. The biggest thing I have seen: they are all starting on pills. They're going to start robbing cause they have a habit in a week. The bottom line is they'll be snorting heroin because it's \$10. We lose 2-4 kids a month. They need to know that a pill can lead to a bag of heroin. I will send more by letter.

Mayor & County Executives (10 mins)

- ✓ Dr. Leana Wen (for Mayor Stephanie Rawlings-Blake)
- ✓ County Executive Kevin B. Kamenetz
- ✓ County Executive Allan H. Kittleman arriving at 10:45am
- ✓ County Executive Steve R. Schuh arriving at noon
- ✓ Commission President J. Douglas Howard

Law Enforcement (10 mins)

- ✓ Ron Bateman, Anne Arundel County Sheriff has to leave by 10:45am
- ✓ Wes Adams, State's Attorney, Anne Arundel County
- ✓ Scott D. Shellenberger, State's Attorney, Baltimore County
- ✓ Dario Broccolino, Howard County State's Attorney
- ✓ Colonel Larry Suther (for Sheriff DeWees)
- ✓ Judge Ellen Heller

Addiction Treatment Experts, Advocates, & Educators (6 mins)

- ✓ Rev. Milton Williams
- ✓ Dr. Marvin "Doc" Cheatham
- ✓ Bernard McBride
- ✓ Barbara Allen
- ✓ Danny Brannon
- ✓ Nancy Rosen-Cohen
- ~~Karl Spector, MD~~
- ✓ Yngvild Olsen
- ✓ Joyce Mahoney
- ✓ ~~Carlos Hardy~~ *STET*
- ✓ David Byram
- ~~Tyrone R. Eaton~~
- ✓ Tim Weber
- ✓ Toni Torsch
- ✓ Dr. Laura Pimentel
- ✓ Dr. Elizabeth Katz
- ~~Michael Hayes~~
- ✓ Alvin Nichols



✓ Dr. Bilz

Public Comment (3 mins)

- ✓ Vince Dugan (wants 5 mins)
- ✓ Lon Wagner
- ✓ Robert Tousey → Pastor Bacha Jordan ✓
- ✓ Alisha Ellis → Leon ~~Pomell~~

✓ Tony Fowler					
✓ Babak Imanoel	_____				
✓ Laurence/Pam Bezirdjian					
✓ Sharan Lindsay					
✓ JoAnn Melton					
✓ Dominic Spano					
✓ Jane Aiello					
✓ Katherine Sewell					
✓ John Corona					
✓ Kristi Sanders					
William Parks					
Scott Nolen					
Alton Byrd					
Dawn Brown					
Vickie Walters					
✓ Dr. Ajibike Salako-Akande	- Expert panel				
Ray Kelly					
Carin Miller					
Concerned Father	concernedfather@live.com				
✓ Maura Taylor					
Marian Currens					
Valerie Albee					
Michael Simpson					
✓ Bob Galaher					
Molly Greenberg					
Angela Fulmer					
Randal Landis					
Andrea Wildason					
✓ Melissa Kramer					
✓ Annette Mrozinski					
✓ Susan Hixon					
✓ Jordan Ayres					
Deborah Agus					
Lisa Cohen					
✓ Debra Dauer					
✓ Kim Smith, Rat Whitlock and Stacy Laskin					

~~_____~~

SIGN IN SHEET FOR PUBLIC COMMENT
Lt. Governor's Drug Task Force Meeting - Baltimore
DATE: 4/15/15

Time	Name	Town of Residence	Phone/Email
8:45 am	Dr. A D Salas-Alexandre	Baltimore City	443-240-7051
8:48	Alicia MORAN	Annapolis	410-991-7027 aliciamoranmedia@gmail.com
8:48	Rev. R.		
8:53	BARBARA ALLEN	ELICOTT CITY	410-481-4149
8:55	KURT SEMMORCE	ANNAPOLIS	(410) 837-4866
8:55	HUCK McCANN		
9:00	Sharon Lindsay	Balto. City	Fibournoylans@gmail.com 443 220 1292
9:00	David Byram	—	804-979-3417 david.byram@orexo.com
	Scott Stellerberg	BALTO	
	Tony Fowler	Annapolis	415-246-3794
	L. M... ..	ELC	
	Pat Whitlock/Cynthia Glass	BALTO. CITY	410-340-5049
	Dean Purcell	Balto. City	443-854-0556
	Ellen Heltet	Balto. City	410 413 7020
9:15	Minister Penderstar	Baltimore City Hope Alive Ministry	443 865-1404 Cynthia P141@aol.com



MHAA

We are family members who advocate for Prevention, Education, and Quality Treatment for children and adults with heroin, other opiates and opioid use disorders including individuals with co-occurring substance use and mental illness

March 27, 2015

The Honorable Larry Hogan
100 State Circle
Annapolis, MD 21401

Re: Supplemental Budget Request: MADC requests \$10.5 million to expand access to high-quality substance use disorder treatment services that will address the heroin and opioid epidemic in Maryland.

Dear Governor Hogan:

We are writing to say that while we would normally support this kind of a request, **we are hesitant to do so now**. In the past, when requests for funding have been awarded, we were never able to see how our taxpayer's money was spent and, more importantly, how our families were suppose to have benefitted from the care they received.

We would only support this request under the following circumstances:

1. Families want to know how the provider's define high quality treatment services? What do they think high quality should look like? How does that differ from what we are currently seeing and how will that change?
2. We would like to know what our current treatment capacity is. For example, how many outpatient programs do we now license vs. how many inpatient services (residential vs. medical assisted treatment (MAT) and does this meet the needs of the individuals who are currently seeking treatment. What exactly are the services these programs provide? How, specifically, will this money make a difference in providing better access? What will be different?
3. We would like to know that all clinicians and programs will be clinically competent to care for individuals with co-occurring substance use and mental disorders and that there will be a measurement to demonstrate their level of competency. What criteria will they have to meet to deem themselves and their programs co-occurring capable? (Right now it's just hearsay and there is no expectation from the top to use research based or evidenced based instruments to make this determination even though the Behavioral Health Administration (BHA) is allowing many providers to advertise themselves on its website as providing co-occurring services). Since national statistics tell us that out of all the people we treat 70% of them have a co-occurring disorder, it would only make sense to put our efforts in this direction to prevent treatment from continuing to be fragmented

and to decrease the recidivism rates, especially when addressing the heroin and opioid epidemic.

4. All clinicians and programs must demonstrate that they are truly integrated according to nationally accepted standards such as integrated screening instruments, etc. along with a process to measure outcomes. There is not very much being done in reference to true integration nor is there a high caliber data collection system in place to collect these measures accurately.
5. Finally, it is our understanding that ADAA and MHA are now merged and supposedly integrated with one budget under the Behavioral Health Administration (BHA). Why then would a request for a supplemental budget for only substance use disorders be necessary?

If providers want to ask for 10.5 million then taxpayers and families with this disease deserve to see a detailed plan that supports good outcomes and shows evidence that their money is being well spent. What we've seen so far is way too general and with no room for accountability.

Sincerely,
Maryland Heroin Awareness Advocates
mdheroinawareness@gmail.com

Carin Miller
Ginger Rosela
Beth Schmidt
Caressa Flannery
Tina Canter
Debbie Fling
Terry Paddy
Sherry Pullen
Lisa Rippeon
Wendy Messner
Jennifer Naylor
Ramie Bruguera
Gayle Petersen

Lt. Governor Boyd K. Rutherford
Secretary David R. Brinkley
Secretary Van T. Mitchell
Senator Edward J. Kasemeyer, Chair, Budget and Taxation Committee and committee members
Senator Richard S. Madaleno, Jr., Chair of Health and Human Services Subcommittee
Delegate Peter Hammen, Chair, Health and Government Operations Committee and committee members
Delegate Maggie McIntosh, Chair, Appropriations Committee and committee members
Senator Thomas M. Middleton, Chair, Finance Committee and committee members
Delegate Theodore Sophocleus, Vice Chair, Health and Human Resources Subcommittee
Delegate Craig J. Zucker, Chair, Health and Human Resources Subcommittee

Heroin and Opioid Task Force

Laura Pimentel MD

Clinical Associate Professor

University of MD School of Medicine

Scope of the Problem

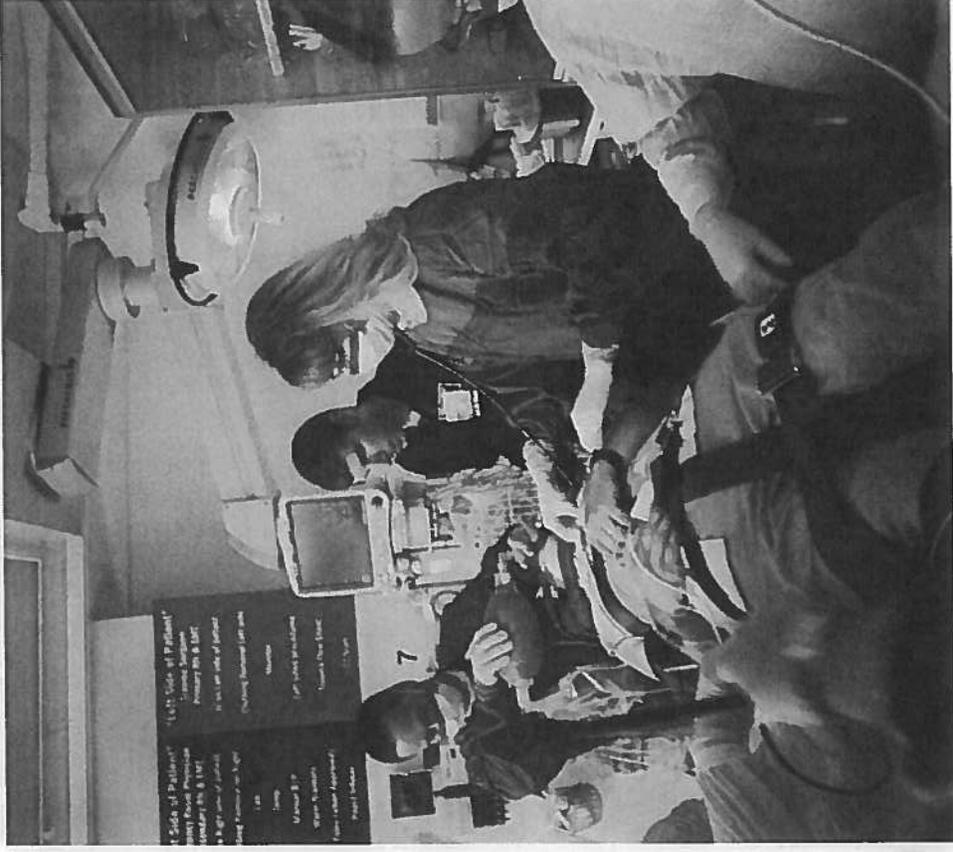
Overdose deaths from heroin in Maryland spiked from 247 in 2011 to 392 in 2012, a *nearly 60 percent increase*. The number climbed to 464 in 2013, and there were *296 overdose deaths in the first six months of 2014*.

The largest number of deaths has consistently been in *Baltimore*, but some of the highest per-capita rates have been in rural counties, such as Cecil and Wicomico.

Washington Post 1-24-2015

Emergency Department Experience

- Acute Intoxication and Overdose
 - Respiratory Depression
 - Pulmonary edema
 - Seizures
 - Muscle breakdown
 - = causing kidney damage



Complications of IV Drug Abuse

- Skin Infections
 - Cellulitis
 - Abscesses
 - Necrotizing Fasciitis



Endocarditis

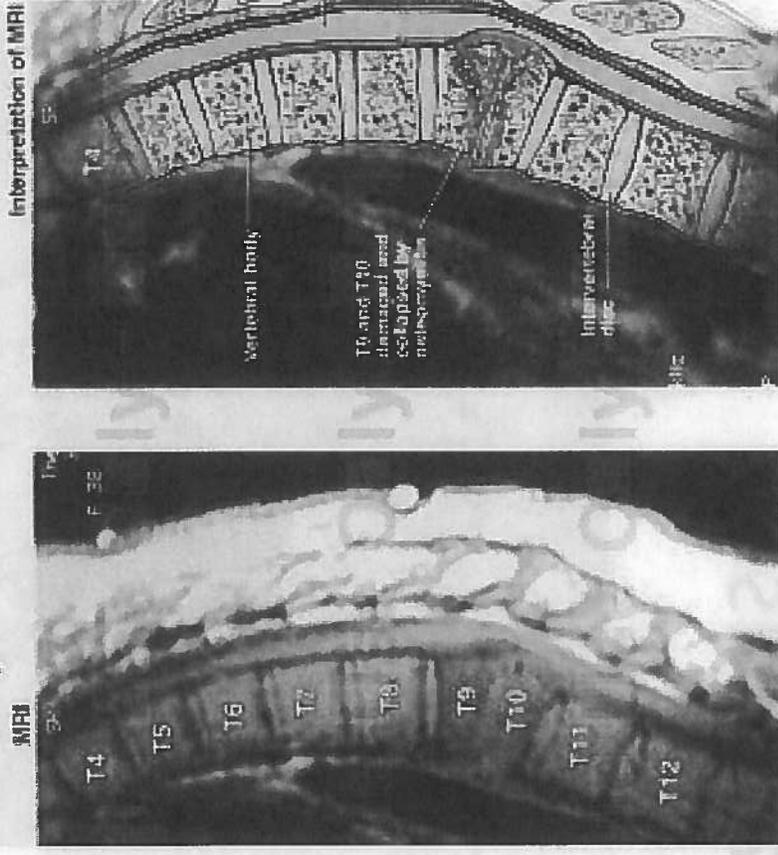
- Heart Infection
 - IV drug users with fevers
 - Hospital Admission
 - Cultures
 - Blood work
 - Echocardiogram for heart imaging
 - Long term antibiotics
 - Possible open heart surgery for valve replacement



Spinal Abscess and Infection

- IV Drug users
- Fevers and back pain
- Blood work
- Cultures
- MRI
- Long-term antibiotics
- Surgery

Epidural Abscess.



Narcotic seeking behavior

- Expensive evaluations for feigned complaints
 - CTs, MRIs, blood work
- Misuse of resources to the detriment of patients with emergencies
- Frequent revisits
- Trail of unpaid bills
- Diversion of drugs for resale on the street

Methadone

- Overdose death rate out of proportion to other narcotics
- Lethal cardiac arrhythmias
- Interaction with other medications

CHRONIC METHADONE THERAPY COMPLICATED BY TORSADES DE POINTES: A CASE REPORT

Laura Pimentel, MD^{*†} and Douglas Mayo, MD^{*}

^{*}University of Maryland School of Medicine, Baltimore, Maryland and [†]Department of Emergency Medicine, Mercy Medical Center, Baltimore, Maryland

- *Journal of Emergency Medicine* 34:287-290, April 2008

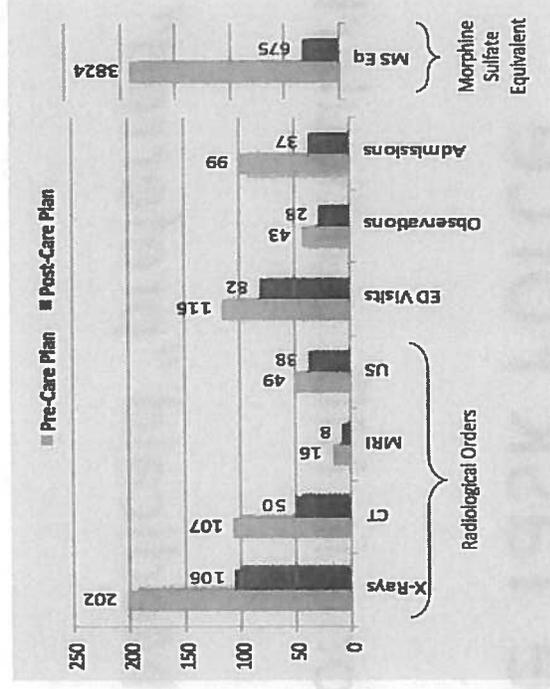
Recommendations

- Consider funding for statewide care plans for patients who frequently utilize the ED related to opiate use and complications

8 High Risk Care Plans Effectively Decrease Emergency Department Resource Utilization

Abtained L, Barrueto F, Jr., Pimentel L, Comer A, Browne BJ, Hirshon JM/University of Maryland School of Medicine, Baltimore, MD; University of Maryland Upper Chesapeake Health, Bel Air, MD

— Annals of Emergency Medicine 10-2014



Methadone Use Task Force

- Use and abuse of Methadone in MD, particularly Baltimore city
- Status of methadone as a Medicaid “preferred” drug in MD
- Methadone clinic policies for weaning patients from the drug
- Evaluate the economic incentives of Methadone clinics
 - Are there perverse incentives for high doses and chronic therapy?

Questions?

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ibjwemue@lathenmijq

3anoitsauD



1450. South Rolling Road, Halethorpe MD 21227

Tel: 443-240-7051; Fax: 410-455-5527

website: www.getwele.com; email: drbiks@getwele.com

4-30-15

To The Heroin Task Force-Central Maryland

Introducing a Complementary & Alternative Protocol for the Management of Heroin Addiction. Summary of Presentation & Recommendations of April 15th 2015:

My name is Ajibike Salako-Akande, M.D, M. Ed., BCPC (Dr. Biks), the CEO of Getwele Natureceuticals, an Affiliate Company of Life Sciences Incubator at bwtech@UMBC. I am both a Primary Care Physician and a Substance Abuse Rehab Specialist (CADT). I am a Board Certified Professional Counselor approved by American Psychotherapy Association and also a Short-Term Post-Doctoral Fellow of Complementary & Alternative Medicine in substance abuse.

On April 15, 2015, I was one of the presenters at the Heroin Task Force Summit. I presented in an effort to raise awareness as to a Complementary and Alternative method to aid in the management of Heroin Addiction. At the end of the summit each presenter was asked to submit a summary of presentation and recommendations.

For the last 16 years I have provided counseling services, research, psychosocial support and case management to aid drug addicts and the mentally ill that included ex/sex-offenders, at a clinic in Baltimore City that I ran for 9 years. I also incorporated a Complementary & Alternative management method to these individuals' treatment. The remainder of this time, I spent doing both animal and human research studies to evaluate these alternative methods on craving reduction of alcohol/drugs.

Clearly, as we heard at the Governor's Heroin Task Force meeting, Heroin abuse is a very difficult drug problem to treat and it is a growing public health epidemic. My research shows that persistent craving is a major problem for this difficulty that drives its relapse. According to a 2012 National Institute of Drug Abuse report, 40-60% of treated clients for alcohol/drugs will relapse; and a 2011 United Nations Office of Drug and Crime study reported that ex-offenders that have drug abuse challenges have a 70% relapse rate.

Many relapses occur as a result of persistent craving, and persistent cravings occur due to: a) The memory of previous reward experiences associated with drug use that leads to wanting to repeat the behavior, hence the individual craves for the drug; b) Long time use of drugs result in depletion of brain chemicals; c) A lack of nutrients, because the individual prefers drugs to food; d) Drug metabolites from the drugs of addiction within the body can create new and more potent drugs with cyclical problems of euphoria, tolerance, craving and relapse.

In simple terms, persistent craving is a key element we must address in order to help those desiring to recover. We know that persistent craving drives relapse, creates health problems, leads to lost productivity and in some cases can lead to overdose deaths.

As a result of my years of counseling and research, I saw the need to better address the persistent craving that addicts go through. So I believe I have been able to develop a family of 4 products that can help to reduce craving for heroin, cocaine, alcohol, marijuana and cigarettes.

I have tested these products for the last 16 years and have been able to show, in both human and animal studies that they are effective and safe. The mechanism of action that the nutrients use to reduce craving have also been identified.

My research shows that use of the nutraceutical compounds can help to replenish the brain and body chemistry, and also help repair and stabilize the brain functions to reduce craving and drug seeking behavior; which in turn help prevents, relapse. The compounds are also shown to lead to improved nutritional status and general well being. They create an almost immediate calmness in clients, help improve sleep, appetite, and also help reduce irritability and aggression.

The compounds are relatively inexpensive and offer cost-effective, all-natural, non-addictive option to recovering addicts that provide results with little to no side effects. Data from a five year human study showed that 26 of 31 test individuals had an 80% success rate, and showed evidence of a reduction in craving as reported by reduction in the clients' desire to use, and urine tests with negative drug metabolites. Individuals reported less drug seeking behavior, improved sleep patterns, less anxiety and improved appetite.

Clinical observation showed individuals exhibited calmness, less agitation, less recidivism, improved attitudes in treatment, enhanced recovery and increased treatment retention. We believe this protocol can result is healthy adults with less desire to use and seek for drugs and hence can be productive.

Recommendations: Getwele Natureceuticals recommends to the DHMH:

- a) Evaluate this protocol
- b) Conduct additional testing as appropriate, and
- c) Adopt the protocol for:
 - a. Treatment
 - b. Medical & Psychological Craving Management
 - c. Relapse Prevention
- d) Protocol is cheap, cost effective and non-addictive. Can be done in Outpatient clinics & Doctors' offices.
- e) Most individuals will not need hospital admission, hence money will be saved. Funds saved can be used for expansion of treatment offices

Ajibike O Salako-Akande (Dr. Biks), M.D. M.Ed, BCPC, CEO Getwele Natureceuticals

cc David Fink, PhD Entrepreneur in Residence, bwtec@UMBC.
Alicia Moran, PR bwtech@UMBC

MATTHEW A. HENSON
NEIGHBORHOOD ASSOCIATION
 P. O. Box 23761 - Baltimore, Maryland 21203
www.mahna.co - CivilRights@verizon.net - 410/669-VOTE

SUMMIT TESTIMONY

**MARYLAND'S
 HEROIN & OPIOD EMERGENCY TASK FORCE
 CENTRAL MARYLAND REGIONAL SUMMIT**

WEDNESDAY, APRIL 15, 2015, 9:00 AM – 6:00 PM
 UNIVERSITY OF BALTIMORE,
 SCHOOL OF LAW, MOOT COURT ROOM
 1401 N. CHARLES STREET - BALTIMORE, MARYAND 21202
 UNITED STATES

TESTIMONY

**BALTIMORE'S 70 YEAR HEROIN HISTORY
 MARYLAND'S HEROIN EPIDEMIC &
 THE UNITED STATES FAILED WAR ON DRUGS**

Dr. Marvin L. 'Doc' Cheatham, Sr.
 Civil Rights & Election Law Consultant
 President Matthew A. Henson Neighborhood Association
 [Past President Baltimore Chapter Southern Christian Leadership
 Conference; Baltimore City Branch National Association for the
 Advancement of Colored People & Greater Baltimore Chapter National
 Action Network]

Good Afternoon.

Honorable Lt. Governor Boyd K. Rutherford, Distinguished Mayor and County Executives.

With my testimonial time being limited let me respect the fact that protocol has already been established.

I am Dr. Marvin L. 'Doc' Cheatham, Sr. President of one of this city's most progressive and aggressive community associations – Matthew A. Henson Neighborhood Association.

I have entitled my brief testimony as: Baltimore's 70 Year Heroin History, Maryland's Heroin Epidemic & the United States Failed War on Drugs.

On September 16, 2014 the Matthew A. Henson Neighborhood Association held a Press Conference where we called for a United States Congressional Hearing. We are pleased to say that representatives of United States Senator Barbara Mikulski and United States Senator Benjamin Cardin did attend however none of the Congressmen representing Baltimore City nor any of our City Council representatives attended.

We called for this formal process of the United States Senate to both collect and analyze information related to Baltimore City having a 70 years history of having the 'label of heroin capital of the United States' and experiencing decades of heroin problems.

We sought then as we continue to seek today, immediate, short and long-range solutions what we know is an epidemic.

Who did we hope to hear and what were we anticipating? We were asking for oral and written testimony from experts, citizens, legislators and the medical, legal and law enforcement community.

Senate Rule XXVI, paragraph 1 states that a committee "is authorized to hold hearings ... at such times and places during the sessions, recesses, and adjourned periods of the Senate" as it sees fit.

What data has been stated and acquired to substantiate this awful label? United States government agencies "...estimate that as many as one in 10 of the city's residents are addicted to the drug."

"...The U.S. Drug Enforcement Agency says the city has the highest per capita heroin addiction rate in the country."

"...In a city of 645,000, the Baltimore Department of Health estimates there are 60,000 drug addicts, with as many as 48,000 of them hooked on heroin."

"... A federal report recently released puts the number of heroin addicts alone at 60,000."

LAW

- ❖ Initiate drug endangered children programs in Maryland and if there are some expand them;
- ❖ Increase the number, funding and reach of Maryland drug courts;
- ❖ Bold public initiatives and a change in attitude to decrease the demand;
- ❖ Holding doctors accountable is essential when we consider the fact that injudicious prescribing of pain medications which undeniably contribute to the problem that we want instant results and total pain relief after an injury or procedure.

PREVENTION

- ❖ Promote safe and healthy neighborhoods;
- ❖ Provide opportunities to support youth participation in activities that reduce risk and enhance protection;
- ❖ Increase community awareness and substance abuse prevention messaging in order to reduce substance abuse;
- ❖ Reduce access to prescription medications for non-medical use;
- ❖ Recruit businesses and employers, local government agencies, medical centers and non-profits to participate in substance abuse prevention and intervention activities.

TREATMENT

- ❖ Establish and increase in-patient stabilization centers/facilities throughout Maryland, especially Baltimore City, to allow patients time to detox as well as coordinate follow-up services such as continuing treatment options, stabilize housing or community recovery support;
- ❖ Outpatient treatment more widely accepted in all communities including locally elected officials communities - not just the poor communities;
- ❖ Expansion of addiction treatment services in jails would help to mitigate much of the revolving door phenomenon.

WORKPLACE

- ❖ Provide and/or expand assistance for employees who are misusing or abusing drugs;
- ❖ Employer should provide employees education and prevention resources.

1. The first part of the document discusses the importance of maintaining accurate records of all transactions and activities. It emphasizes the need for transparency and accountability in financial reporting.

2. The second part of the document outlines the various methods and techniques used to collect and analyze data. It includes a detailed description of the experimental procedures and the statistical analysis performed.

3. The third part of the document presents the results of the study. It includes a series of tables and graphs that illustrate the findings and trends observed during the experiment.

4. The fourth part of the document discusses the implications of the results and the potential applications of the findings. It also addresses the limitations of the study and suggests areas for future research.

5. The fifth part of the document provides a conclusion and summarizes the key points of the study. It reiterates the importance of the findings and the need for further investigation in this field.

ORAL TESTIMONY FROM REVEREND MILTON EMANUEL WILLIAMS, JR
HEROIN TASK FORCE SUMMIT MEETING, APRIL 15, 2015

Lt. Governor Rutherford, distinguished Heroin Task Force and fellow Panel members, **Greetings from the ghetto.**

I am Reverend Milton Emanuel Williams, Jr., Pastor of East Baltimore's New Life Evangelical Baptist Church, and president of the largest independent, faith-based, non-profit methadone treatment center in America—now treating 2,000 heroin addicts daily.

I've been fighting this war in the trenches for 30 years. And I am here today to give you a long overdue **frontline report** on a war we are **losing**.

Martin Luther King had a **dream**. I have a *nightmare*.

And I am **more** than ready to wake up and start winning. Forgive me if I stand before you today wondering if **you** are ready to help me do so.

For **decades**, our political leaders in Baltimore and Annapolis have seemed reluctant to do that. **For decades** they have sought, instead, to **minimize** our heroin problem—even persisting in **denial** of the national media's branding of Baltimore as the "*Heroin Capital of America*." And while they have been good at identifying the brain-changing effects of this disease, and counting its costs and consequences, they have actually never **defined** the problem.

I can do that for you in a word: **Government**.

The **problem** is that Maryland's powers that were believed if they slapped a band aid on it and polished existing, failing policies and practices, the heroin problem would be fixed. **Fixed** is right. The plague attacking suburban and rural areas now threatens **all** of Maryland. But you know that.

What **past** State and City governments and their study groups **failed to comprehend**, however, is that you are destined to follow the beaten path to failure if you **don't know** what you **don't know**.

Your presence here today, Lt. Governor Rutherford, and that of your Task Force, is a positive indication that **this** administration is **not willing** to make that same mistake.

I pray that you will read my written report, coming as it does from the ghetto warfront. It is not only highly informative. It includes proposals for desperately needed **new** treatment practices that will save the State and its' taxpayers **multi-millions of dollars!** Not to mention thousands of lives and futures. **I guarantee it.** Now, in the brief time I have remaining, allow me to pose a few questions you might ask yourself before delivering **your own** report to Governor Hogan from the combat zone of Maryland's **two front** war. A war now being fought in two distinctly different neighborhood settings. The Outer and Inner City.

THE AMERICAN WEST

The American West was a vast and diverse region that played a crucial role in the nation's expansion. It was a land of opportunity and challenge, where pioneers sought new frontiers and settlers built a new life.

The West was a land of discovery and exploration. Explorers like Lewis and Clark opened up the continent to the world, revealing the vast potential of the American West. Their journeys were filled with hardship and triumph, as they pushed the boundaries of human knowledge.

The West was a land of settlement and growth. Pioneers and settlers moved westward in search of better land and new opportunities. They built towns, cities, and a new way of life that shaped the American West.

The West was a land of conflict and struggle. As settlers moved westward, they often encountered resistance from Native Americans and other groups. The struggle for land and resources was a defining feature of the American West.

The West was a land of innovation and progress. The discovery of gold and other resources led to a period of rapid economic growth. The West became a center of innovation and progress, shaping the future of the United States.

The West was a land of culture and identity. The diverse peoples of the West created a unique culture and identity that shaped the American West. From the rugged cowboys to the hardworking miners, the West was a land of diverse and resilient people.

The West was a land of hope and dreams. For many, the West was a land of hope and dreams, where a better life was just around the next bend in the trail. The West was a land of promise and potential, where the future was being written.

The West was a land of challenge and adversity. The West was a land of challenge and adversity, where the harsh conditions of the frontier tested the strength and resilience of those who dared to venture westward.

The West was a land of discovery and exploration. The West was a land of discovery and exploration, where the unknown was being revealed and the frontiers were being pushed back.

The West was a land of settlement and growth. The West was a land of settlement and growth, where the seeds of a new nation were being planted and the future was being built.

The West was a land of conflict and struggle. The West was a land of conflict and struggle, where the struggle for land and resources was a defining feature of the American West.

The West was a land of innovation and progress. The West was a land of innovation and progress, where the discovery of gold and other resources led to a period of rapid economic growth.

The West was a land of culture and identity. The West was a land of culture and identity, where the diverse peoples of the West created a unique culture and identity that shaped the American West.

The West was a land of hope and dreams. The West was a land of hope and dreams, where a better life was just around the next bend in the trail. The West was a land of promise and potential, where the future was being written.

*For example, do you know heroin addicts in the ghetto have **no desire** to end their addiction?

*Do you know **more** addicts show up for treatment when their monthly **welfare money** runs out?

*Do you know that many more show up only to avoid jail time for **crimes** they would otherwise commit to buy their heroin?

*Do you know the true victim of heroin is not the addict, but the **community**?

*Do you know treatment—even **forced** treatment—is actually **prevention**?

*Do you recognize the fact that **Welfare Reform** requiring drug tests before recipients can get their checks would save taxpayers from **paying the addict's heroin bill**?

*Did you know our Turning Point Clinic was able to **triple** patient admissions in **three years** with incentives, and by shortening the time required for admission from **weeks** to a single **day**?

*Do you know a grant of one million dollars to pay for the addict's breakfast or lunch would enable Turning Point to **double** our daily patient population to 4,000?

*Do you know that **spiritual counseling**—an optional treatment at Turning Point—is truly a **God Send** that leads to more hope and healing?

*Can you see how a State-supported "**Faith Based Initiative**" encouraging churches of all **denominations** to welcome outcast addicts into their congregation and provide counseling would add another powerful weapon to our State's war arsenal?

*Do you realize **heroin deaths**, which **tripled** in America in just the last three years, could exceed **half** the number **traffic deaths** by the end of this year?

*And, finally, my written testimony shows Turning Point **alone**, with one bold, new **game-changing** addition to treatment practice, could save Maryland's medical program up to *twenty million* a year in **reduced ER visits and hospital stays**.

When Ronald Regan took office, promising to end the "Cold War," they said it couldn't be done. It took a few years. But President Regan proved the **impossible** is, indeed, **possible**.

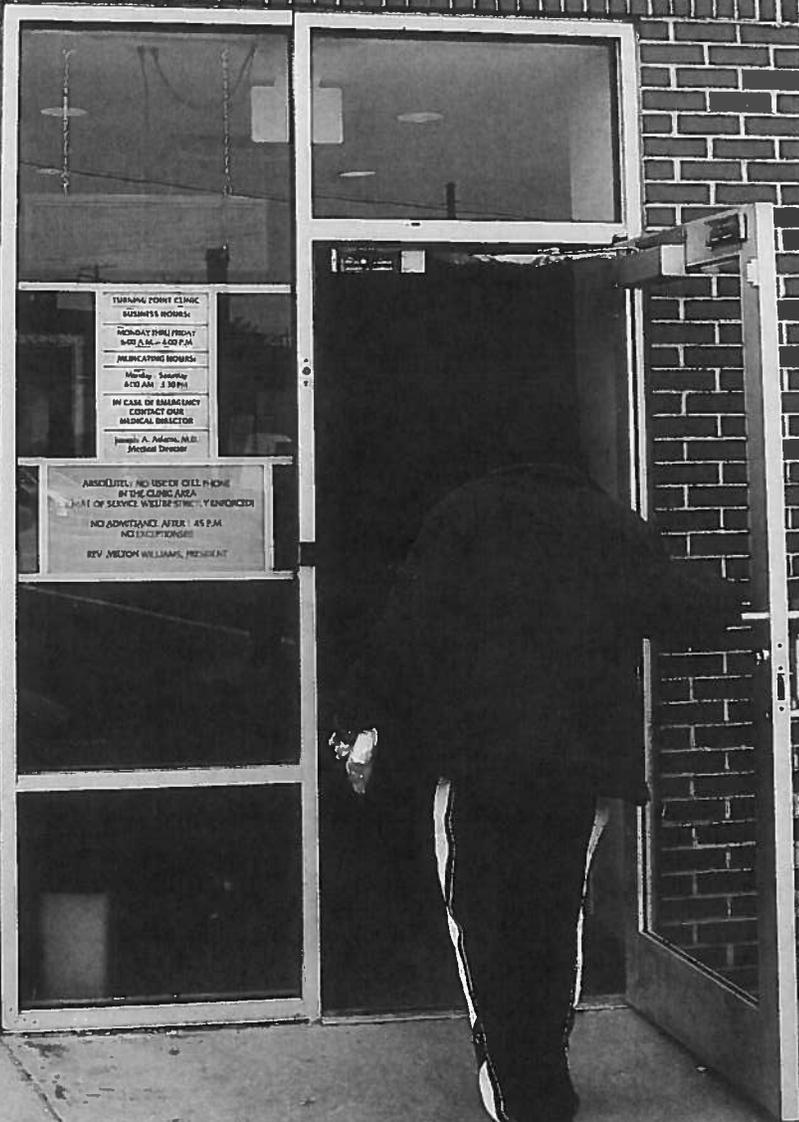
When Larry Hogan took the helm as Maryland's governor, promising to find new ways to push back on the heroin pushers, those of us battling this evil enemy in the ghetto felt hope for the first time in decades. We knew—at long last—someone besides **Almighty God** is finally hearing our fervent pleas and prayers. A banner was raised on our building, declaring, "**Thank God For Governor Hogan**".

And, in conclusion, may I add, thank God for **you**, Lt. Governor Rutherford, and your Task Force. Thank you for listening.

The evidence in this case is...
The defendant...
The court...
The judge...
The jury...
The verdict...
The sentence...
The appeal...
The case...
The law...
The facts...
The issues...
The arguments...
The conclusions...
The findings...
The orders...
The directions...
The instructions...
The questions...
The answers...
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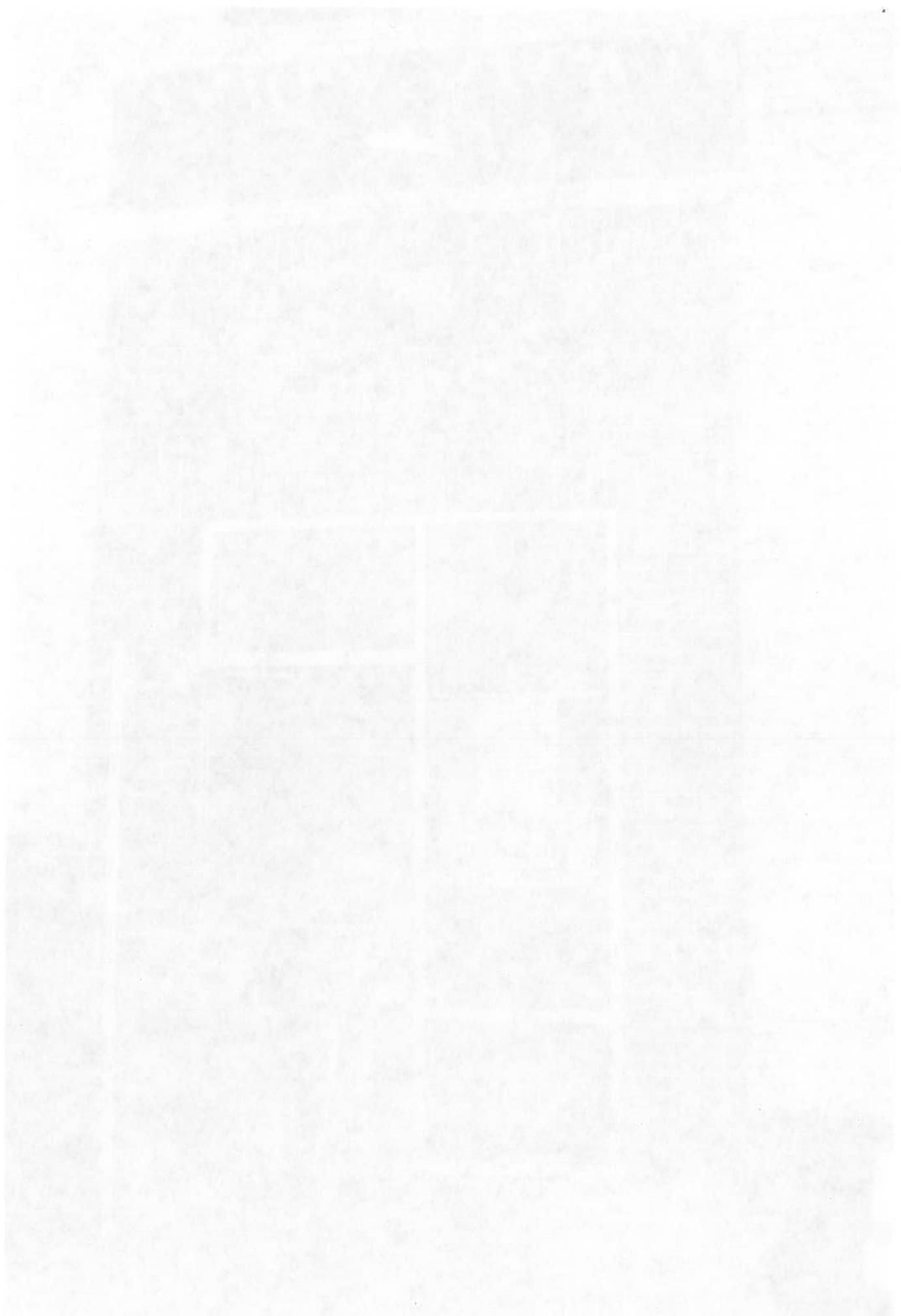
TURNING POINT CLINIC

2401



TURNING POINT CLINIC
WOMEN'S SERVICES
MONDAY THROUGH FRIDAY
8:00 A.M. - 4:00 P.M.
SALICATING MONDAYS
MAY - Sunday
8:00 AM - 3:30 PM
IN CASE OF EMERGENCY
CONTACT OUR
MEDICAL DIRECTOR
James A. Adams, M.D.
Medical Director

ABSOLUTELY NO USE OF CELL PHONE
IN THE CLINIC AREA
LIMIT OF SERVICE WILL BE STRICTLY ENFORCED
NO ADMITTANCE AFTER 4:45 P.M.
NOT EMPLOYEES
REV. MICHAEL WILLIAMS, PRESIDENT



**Thank God for
Governor Hogan!**





**Written Testimony From Reverend Milton Emanuel Williams, Jr.
Heroin Task Force Summit Meeting, April 15, 2015**

Thank you for the opportunity to testify on an issue of great and rightful importance. Fighting the heroin problem in Baltimore has been my life's work for over 30 years. This paper contains my urgent recommendations to win this desperate battle.

I am Rev. Milton Emanuel Williams, Jr., Pastor of New Life Evangelical Baptist Church, located in the East Side ghetto of Baltimore, Maryland. My church runs what is the largest food pantry in Maryland. I am also President and CEO of Turning Point, which is a non-profit methadone clinic. Turning Point began 12 years ago and has become what I believe is the largest single substance abuse clinic in America, serving 2000 patients daily.

Turning Point employs about 100 people. Our staff of 40 "counselors" are almost all licensed psycho-therapists and social workers. Five of our staff hold doctorates, and two others are doctoral candidates. Our Medical Director is board certified in Addiction Medicine. We have three nurse practitioners, including one who is a psychiatric NP. We electronically audit every patient form and every EMR entry for every patient every month. We have made the proper functioning of Turning Point an obsession. This is surely not true of most methadone clinics.

We have been proclaiming for years that we have a life-destroying epidemic in our communities. Often we have had to battle inappropriate policies in order to fight the heroin battle. This must change. And it can change.

The heroin problem in Baltimore is not the suburban and rural problem you heard about last month. The appropriate policies to combat it are fundamentally different. I am concerned that the Task Force might focus only on the suburban and rural problem. But one size does not fit all. The concentration of addicts in the inner city, their number, and the self-perpetuating aspects of the problem make it complex and, so far, nonresponsive to current drug policies. But, I can assure you that the net social and economic benefits per dollar of taxpayer money spent on the inner city problem will far exceed the per dollar benefits spent on the suburban and rural problem. The taxpayer will actually save money!

METHADONE—A MIRACLE DRUG

Methadone is a substitution treatment which requires heroin addicts to take daily doses of methadone to mitigate the desire for heroin. Such substitution therapies have been attacked for not being an actual cure. Some advocate counseling or faith-based programs instead. Turning Point is America's only faith-based methadone program, so I know that most lifelong addicts need more than just faith and counseling.

Decades of research have proven that long term heroin addicts, and others addicted to opiates, in most cases simply cannot cease drug use. Some evidence suggests that their brains have been permanently chemically altered by years of heroin use. (This is not necessarily true of young addicts who have been using opiates for only a relatively short while.) Heroin addiction is said to be a disease, treatable as such. I'd like to clarify that the addiction is **not** the disease, but the disease is the manner in which the brain has been chemically altered by heroin. That is what must be treated with methadone. **There is no more effective treatment for any addiction of any type ever devised than methadone treatment for heroin.**¹

¹ See "Drugs and Drug Policy," Oxford Press, Mark Kleiman, Jonathan Caulkins, and Angela Hawken (2011). "Does methadone maintenance work? Usually,...of all the forms of substance abuse treatment, methadone maintenance has the strongest evidence base, grounded in carefully conducted random trials. Methadone maintenance reduces criminality, mortality from overdose, and the spread of HIV, and it improves social outcomes ranging from employment to family stability." Page 125.

Methadone is dirt cheap; it is totally effective in eliminating withdrawal symptoms; it blocks the effects of heroin, so a methadone patient can't get high on heroin; it has very few and no serious side effects; it can be taken long term; and it is safe (but only if taken as prescribed). It is as close to a miracle drug as anyone could reasonably expect to find. So, why do so many people still oppose methadone treatment? It is the misguided and uninformed belief that long term heroin addicts can cease drug use without ongoing substitution therapy. Methadone is safe for pregnant women, which means that the 42% of our patients who are women will not be giving birth to heroin addicted babies.

WHAT'S THE PROBLEM, THEN?

The vast majority of inner city heroin addicts have no desire to cease drug use. Many seek treatment simply when they do not have welfare money to buy drugs. That they seek treatment, precisely when the alternative would be robbing someone or brutalizing family members, is a good, not bad, motive. But, current state and federal drug policy considers offering such "on-demand" treatment almost a sin. They derisively call it "gas and go." Well, is "rob and go" better?

Determining the size of Baltimore City's heroin problem was one of the four areas the Mayor's drug task force was supposed to investigate over nine months. But after only two weeks, they concluded somehow that there are only 19,000 heroin **users**. This implies there are less than 5,000 **addicts**. But my clinic alone, which is one of about 24 methadone clinics in the City, has treated that many addicts in the past 3 years! It is inconceivable that Baltimore does not have easily more than 60,000 heroin addicts. (Our detailed analysis is available, which confirms other independent estimates.)

This estimate, and the number of heroin addicts already in treatment, demonstrates that the vast majority of addicts do not want treatment. Although methadone is in many ways a miracle drug, no medication can likely change the fact that lifelong heroin addicts in the ghetto know and care about little else but drug use and getting high. That is the problem of the inner city that we must, and can, address.

"GOOD" CLINIC VS. "BAD" CLINIC

Turning Point is rather unique among methadone clinics, because it has grown so big, so fast, having tripled in size in three years. Other clinics have been around much longer, and, accordingly, mostly have patients who have been in the program for years. Our average patient has been with us only about a year and a half. What this means is that we see every day the stark contrast between patients who want to cease drug use (those who have been in the program many years) and those who simply present themselves for medication because they have run out of welfare money to buy drugs.

In other words, there are essentially **two clinics** operating under the same roof. To underscore that the patient clientele served by each is so very different, let's call one "good" clinic and the other "bad" clinic.

The "good" clinic is what everyone hopes a methadone clinic will be, a place full of people working diligently towards total recovery. Although the "good" clinic benefits the community by helping addicts become drug (and crime) free, it is primarily oriented toward benefiting the individual patient.

The "bad" clinic is frequented by patients who simply do not have money to buy drugs. Some will become good patients, but for most that will not happen. But medicating these people anyway is not all bad, because, if the patient is going without the medication that the "bad" clinic provides, they would be involved in domestic violence, robbing/burglarizing people, and often selling their children for sex. For the \$80 Medicaid pays for a week's worth of methadone treatment, I think anyone would agree that this is a wise investment of taxpayer money. **In total contrast with the "good" clinic, the "bad" clinic exists overwhelmingly for the benefit of the COMMUNITY, FAMILY and the TAXPAYER!**

There is no disagreement on the good things the “good” clinic does for people. But policy makers and regulators have been loath to acknowledge the existence and benefit of the “bad” clinic. They fail to comprehend that most inner-city heroin addicts have no interest in seeking recovery. And they cannot grasp the fact that medicating “bad” patients when they do not have money to buy drugs is a “good” thing to do. In their own way, these patients are trying to avoid committing drug-related crimes, whether we accept that fact or not.

The “bad” clinic is not only relevant, because some patients will become “good” patients, but is actually of greater benefit to the addicts, their families and community, because there are far more of them. If policy makers would accept this fact, the population of addicts in treatment would explode. We need policies and clinics to address the reality of inner-city addiction. The inner city desperately needs the “bad” clinic.

THE PROBLEM WITH THE PROBLEM

The “economics” of recovery do not make sense to most lifelong addicts. This is why there will always be many more “bad” patients than “good” patients. We must avoid the temptation to believe that more is possible with most inner city addicts than is realistic. Such wishful thinking will not help address the problem. Consider the following:

1. Most patients serious about recovery are over 40 years of age. It simply takes that long to get tired of their lives of addiction.
2. These people have typically known only a life of drugs and getting high since they were 10, 12 or 15 years old. They have limited education, skills, jobs, or realistic prospects. Many have multiple felony convictions. Generally, their families and friends are all addicts. Recovery would require a total (and usually impossible) transformation of every aspect of their lives. That is a lot to expect from anyone!
3. But don't they see and want the great benefits available if they give up heroin? Well, the answer is usually “no.” They can't readily make new friends and find worthwhile pursuits (e.g. jobs, recreation, etc.). Most have little interest in education.
4. Don't they at least want to live longer lives, avoiding the hassle and hazards of continually finding drug money, and injecting or snorting heroin? Not usually. Most lifelong addicts have every chronic disease imaginable—HIV, Hepatitis C, cirrhosis, diabetes, heart disease, COPD, kidney disease. The list goes on. Statistically, even if they give up drugs, they are not likely to enjoy healthy lives. Simply put, they do not have much to care about. The “economics” are just not there.

What Alcoholics Anonymous taught us 80 years ago is just as true today with drug addicts. Even the most devout atheist can perhaps appreciate that a person having lived for decades a life of total self-absorption and drug use must learn to focus on something else. And for us at Turning Point, that often means the Church. I try to be as ecumenical as anyone else in my thinking. Our faith-based program is optional. But, for most lifelong, inner city, heroin addicts, the one thing that might make recovery compelling is the Church. New Life Evangelical Baptist Church has been described by SAMHSA (the federal drug agency) as the only church ever, anywhere, to truly open its doors to heroin addicts.

TREATMENT MUST BE CONVENIENT

Getting patients into treatment is the key to rescuing the community from their crime, restoring the family, and relieving the taxpayer. **Clinics like Turning Point, and the “bad” clinic in particular, can be an enormous benefit, but only if we get more “bad” patients into treatment.** (Of course, avoiding the need and expense to incarcerate them is no small benefit as well!)

We know every time we see a heroin addict drinking methadone that the patient is not that day abusing family members, or robbing or burglarizing.

Many Turning Point patients do not show up for treatment around the first of the month. That's when welfare checks come out. One way or another, directly or indirectly, we must all understand that the government "buys" much of the illegal drugs in the inner-city. Whether a patient, having run out of government money, seeks medication a few times a month out of a desire not to rob or burglarize, or whether simply to avoid withdrawals, the point is the same: **The social benefit due entirely to the presence of a conveniently located methadone clinic is vast!**

But treatment must be available "on demand" for these "bad" patients. Streamlining the new intake process is essential. To admit a new patient presently takes hours. Well, "hours" is an eternity to a suffering addict. There is no reason a new patient cannot be safely medicated on his or her first visit and out the door in 20 minutes. Extended treatment hours would also be important.

We could double the number of heroin addicts in treatment, through incentives and/or proper welfare management. This would also double the number who ultimately become drug free, and immediately double the benefit to the community, families, and the taxpayer. So, what if all heroin addicts could find treatment, immediately available, whenever they did not have money to buy drugs? Although we have no existing means by which to force patients to cease heroin, we can medicate them when they need it.

Therein lies the operating philosophy of Turning Point. We believe in providing treatment broadly, immediately, effectively, and safely organized and managed. And, where possible, getting patients seriously interested in and committed to their own recovery.

DRUG TREATMENT IS REALLY "STREET SMART MEDICINE"

I introduced the concept of "bad" patients. But, sometimes, "bad" is actually good. Many of our "good" patients started out as "bad" patients. Today, a third of our "new" patients are actually prior patients who decided to give treatment another chance. In other words, they are becoming "good" patients. So, the more "bad" patients you admit, the more "good" patients you will end up with. But there is more to the story. Methadone treatment costs Medicaid only \$80 per week per patient. It pays for itself many times over.

But there is much more that can be achieved in terms of saving taxpayer money. **Turning Point's own research suggests that our patients needlessly/avoidably waste up to \$20 million each year in emergency room visits.** A patient returned recently from the University of Maryland Hospital ER. His ER physician phoned one of our nurse practitioners, pleading "Is there anything you can do to simply make him take his blood pressure medicine? If not, then he is going to end up here in two weeks again, costing another \$50,000." This is routine for drug addicts.

Lifelong, inner-city heroin addicts do not take their health (or most anything else) very seriously. They have every chronic disease imaginable, but are notoriously not interested in seeing their doctors and taking their medication. But, because most must come to the methadone clinic each day for medication, we have a unique opportunity to oversee (and force, if needed) compliance with their doctor's orders. How? We make participation in the methadone program contingent on doing so: "You want your methadone, then we must watch you take your blood pressure medicine," for example. This truly is "Street Smart Medicine."

Turning Point is planning to build a primary care and urgent care facility on property recently acquired just across the street from its methadone clinic. This will make "**Directed Care**," as I call it, relatively convenient for patients. There are issues, of course, such as how to get paid for the added cost of providing services. This may require changes to Medicaid rules, but, given the vast savings that would be available to Medicaid, that should not be much of a problem.

Making Directed Care work on a large scale (i.e. to engender the participation of most of the City's heroin addicts), could achieve hundreds of millions of dollars in Medicaid savings, but will require incentives, and/or tying welfare to drug testing and required participation in treatment.

NEAR- AND LONG-TERM RECOMMENDATIONS

1. Baltimore has a staggeringly huge number of heroin addicts—at least 60,000—and probably far more. We need to recognize this as State budgets are prepared, and new policies are developed that deal effectively with the drug problem. **RECOMMENDATION—Do not be misled by the Mayor’s “task force” estimate of no more than 5,000 addicts. If that were true, I’d have been (quite happily) out of a job long ago!**
2. Stop focusing on the tip of the iceberg, i.e. “good” patients, and develop strategies to get more of the vast sea of heroin addicts who are not interested in becoming “good” patients, or even in becoming “bad” ones, into treatment. Streamlined new patient processing is the first thing we must implement. **RECOMMENDATION—Develop policies that explicitly permit and encourage the safe and rapid initial dosing of patients seeking methadone treatment. Remove the stigma associated with such a treatment philosophy. Make participation, even sporadic participation in treatment, the goal, and do not focus only on recovery. For most inner city addicts, recovery is simply a “bridge too far.”**
3. We need to think in terms of a substance abuse treatment Reformation. If drug treatment is what we all seek (recovery for addicts, but most prominently relief for the community and family, and big savings for the taxpayer), then we must first admit that methadone clinics are not presently very effective in bringing that about, even among “good” patients. Incentives to get many more new patients into treatment, and to stay there, will help. **RECOMMENDATION—Provide funding for breakfast and lunch for patients. Turning Point runs the largest food pantry in Maryland. We would like to begin free, hot meal service for patients in 2015. This will require limited grant funding. It will bring in, and keep, larger numbers of heroin addicts in treatment. With funding of perhaps \$1MM, I can double the number of patients in treatment.**
4. Medicaid has not increased reimbursement rates for methadone treatment in over five years. Better facilities and personnel will help bring in and retain more patients. **RECOMMENDATION—Medicaid needs to be paying at least \$100 per week per patient if we are going to clean up methadone clinic facilities and improve the quality of the services they are able to provide. This will bring in and keep more patients in treatment. Funding for patients who are not eligible for Medicaid must also be made available. This alone could add 50% more patients to the Clinic roster. But the State must surely not let such increased reimbursement rates, available to non-profit and for-profit clinics alike, be used to line the pockets of clinic operators. The State must enforce real standards. With current rates, that is very difficult, because those rates do not sustain the salaries that are needed for quality staff and services.**
5. The community needs to be better educated as to the enormous unseen benefits methadone programs provide. Politicians must take the lead in this. They also must resist the temptation to inhibit the development of new clinics as constituents cry “not in my backyard! One way to do this is the model Turning Point is using. **RECOMMENDATION—Provide funding for the development of other clinics in Baltimore, with mental health, and primary and urgent care components. This will create meaningful redevelopment projects in blighted areas, providing construction and then permanent jobs to many. This should mitigate “NIMBY” concerns. These “campuses” would be built in blighted commercial areas, or boarded-up former residential areas. This is what we are doing presently in East Baltimore. These will require some funding, but the savings to Medicaid will pay for it many times over.**

6. Community churches, with congregations truly open to taking in heroin addicts, will be an important part of any successful Reformation. My church and clinic are sister organizations. I want to see this model replicated, elsewhere in Baltimore, and around the country. Last month, I appointed my first Manager of Faith-Based Programs. **RECOMMENDATION--Provide pilot grant funding for such programs. Usually, the church is the only thing still standing in the inner city ghetto. Let's use it as an effective bulwark against heroin addiction by making it an integral partner in drug prevention and treatment.**

7. **RECOMMENDATION--Pass legislation and adopt policies that will make "Directed Care" practical, and develop other methadone clinics so that Directed Care can become the norm when it comes to inner city primary and urgent care. Of course, these medical clinics will not only serve addicts, but all in the community. These Directed Care clinics will need to be large in order to make the numbers work. In Baltimore, there has been talk of going in the opposite direction, toward many, but smaller, methadone clinics. Although now is not the time to make the economic case, such talk is pure folly. These patients need MORE and not FEWER resources. Moreover, large, Directed Care clinics will SAVE vast amounts of Medicaid dollars. A number of inefficient, small clinics will cost more taxpayer money, which governments do not have, and small clinics could never provide the resources needed by addicts.**

8. The best thing that policy makers and legislators can do to get more people into treatment, and keep them there, is this: **Welfare management!** Many states are implementing (or have proposals) linking welfare to drug testing: If you want your welfare and food stamps, then cease drug use. Or, at least be in treatment! With methadone being a near perfect substitute for heroin, such a policy of welfare reform, and mandated treatment, is hard to criticize. If we are going to force people into Directed Care, then we must first force them into methadone treatment.

RECOMMENDATION—Find ways to link welfare and drug testing. If there are legal challenges, as there are in some states, then make welfare no longer an entitlement but an incentive for poor people to live responsible lives. This will do more to cure the ills that afflict the inner city family (or what is left of it) than anything else one could imagine.

9. Education and other elements of education and prevention remain the keystone of any rational drug policies. There has come to be almost no stigma in the inner city associated with drug use. **RECOMMENDATION — We, in the treatment community, must keep our doors and arms open wide to accept new patients. The worst thing we can do is to make addicts feel guilty. Current anti-drug campaigns, while no silver bullet, remain a viable approach to keeping young people, (aka tomorrow's users and addicts), from ever trying drugs. Funding inner city, church-run anti-drug campaigns and programs would be a key component in winning this battle.**

The Governor needs to appoint someone, not to study, but to bring about a substance abuse treatment reformation. I have spent 30 years of my life fighting heroin in East Baltimore. I want to start winning. I assure you it will take astonishingly little to do so. And I challenge you: Hold me accountable if, following my recommendations, we do not accomplish just that. My conviction is that we accomplish nothing less than the complete transformation of the inner city environment, the salvation (and resurrection) of the inner city family that welfare and drugs have destroyed, and the saving of hundreds of millions of Medicaid dollars each year. I am asking the new Maryland Governor and Lt. Governor to help me.

A quarter century ago, an African-American columnist, Dorothy Gaiter, wrote in The Miami Herald that "Being poor is no crime and should not result in a sentence to live among the lawless." Maybe our Reformation can make her aspiration a reality, finally.



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Factors contributing to the rise of buprenorphine misuse: 2008–2013

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ABSTRACT

Objective: The purpose of the present study was to examine the motivations underlying the use of buprenorphine outside of therapeutic channels and the factors that might account for the reported rapid increase in buprenorphine misuse in recent years.

Methods: This study used: (1) a mixed methods approach consisting of a structured, self-administered survey ($N = 10,568$) and reflexive, qualitative interviews ($N = 208$) among patients entering substance abuse treatment programs for opioid dependence across the country, centered on opioid misuse patterns and related behaviors; and (2) interviews with 30 law enforcement agencies nationwide about primary diverted drugs in their jurisdictions.

Results: Our results demonstrate that the misuse of buprenorphine has increased substantially in the last 5 years, particularly amongst past month heroin users. Our quantitative and qualitative data suggest that the recent increases in buprenorphine misuse are due primarily to the fact that it serves a variety of functions for the opioid-abusing population: to get high, manage withdrawal sickness, as a substitute for more preferred drugs, to treat pain, manage psychiatric issues and as a self-directed effort to wean themselves off opioids.

Conclusion: The non-therapeutic use of buprenorphine has risen dramatically in the past five years, particularly in those who also use heroin. However, it appears that buprenorphine is rarely preferred for its inherent euphorogenic properties, but rather serves as a substitute for other drugs, particularly heroin, or as a drug used, preferable to methadone, to self-medicate withdrawal sickness or wean off opioids.

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1. Introduction

Buprenorphine is a dose-dependent, mixed opioid agonist/antagonist with very high affinity for the mu-opioid receptor, but with limited intrinsic activity compared to other, more commonly used opioid analgesics (Walsh et al., 1994). Moreover, it has a very low dissociation constant from the opioid receptor, generating a very long half-life and limiting dosing frequency (Bickel et al., 1988; Donaher and Welsh, 2006; Greenwald et al., 2003). These properties have made this drug a particularly attractive agent for opioid substitution therapy programs across the world (Donaher and Welsh, 2006; Johnson et al., 1992; Ling et al., 1998; Fiellin and O'Connor, 2002; Degenhardt et al., 2009; Bell et al., 2009; Sullivan et al., 2008; Alford et al., 2011). While it is maintained that these programs have been successful in reducing use of illicit opioids, buprenorphine itself has become a leading drug of choice for

non-therapeutic purposes (e.g., produce euphoria/get high) in many countries which have such programs (Bell, 2010; Auriacombe et al., 2004; Carrieri et al., 2006; Aalto et al., 2007; Yokell et al., 2011; Guichard et al., 2003; Vidal-Trecan et al., 2003; Lavonas et al., 2014).

Recognizing this fact, the manufacturer reformulated buprenorphine with low doses of naloxone prior to its release in the United States for opioid treatment (Reckitt Benckiser Pharmaceuticals Inc., 2014). It was assumed that naloxone would antagonize the euphoric properties of buprenorphine, or precipitate withdrawal in opioid tolerant individuals (Chiang et al., 2003; Mendelson and Jones, 2003; Walsh and Eissenberg, 2003; Stoller et al., 2001). Thus, its risk of misuse was considered to be quite low (Mammen and Bell, 2009; Alho et al., 2007; Comer et al., 2010; Schuster, 2006). Based on early assessments of the drug, the Food and Drug Administration not only approved buprenorphine and buprenorphine/naloxone as part of comprehensive opioid harm reduction program in 2002, but there was sufficient confidence with these drugs that they were approved to be prescribed for home use rather than made available only in stand-alone methadone clinics, which are inconvenient, carry a significant social stigma, and use an inherently less safe

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opioid (methadone) with significant adverse side-effects (Peterson et al., 2010; Schwartz et al., 2008; Zaller et al., 2009). However, given the experience in Europe, the FDA was cautious in its approach, requiring specialized training and limitations of 30 buprenorphine patients at one time for physicians (Substance Abuse and Mental Health Services Administration (SAMHSA), 2014; Drug Addiction Treatment Act of, 2000; Center for Substance Abuse Treatment (CSAT), 2004). With the early apparent success of these programs, restrictions were lifted in 2006 such that up to 100 patients could be treated by an individual physician. Additionally, the introduction of less expensive generics in 2009 further contributed to large increases in buprenorphine prescriptions in the past five years (Drug Enforcement Administration, 2009). As expected from earlier work showing a direct link between the extent of therapeutic exposure and diversion for non-therapeutic purposes (Cicero et al., 2007a,b), there have been reports of an increase in the diversion and misuse of buprenorphine (Drug Enforcement Administration, 2009; Substance Abuse and Mental Health Services Administration and Drug Abuse Warning Network (DAWN), 2011; United States Department of Justice and National Drug Intelligence Center (NDIC), 2011; Wish et al., 2012).

The purpose of the present study was to examine multiple factors that might account for the rapid increase in buprenorphine misuse in recent years and the motivations underlying the use of buprenorphine outside of therapeutic channels. To address this issue, we used a mixed methods approach utilizing data from structured, self-administered surveys ($N=10,568$) and reflexive, qualitative interviews ($N=208$) among patients entering substance abuse treatment programs across the U.S. with a primary (DSM-IV) diagnosis of opioid dependence. To assess diversion, data were analyzed from semi-structured interviews among a sample of drug-diversion law enforcement units across the country ($N=30$).

2. Methods

This report utilized data from the Researched Abuse, Diversion and Addiction-Related Surveillance (RADARS[®]) System, a comprehensive series of programs that collect and analyze post-marketing data on the misuse and diversion of prescription opioid analgesics and heroin (Cicero et al., 2007a,b).

2.1. Study Sample 1: SKIP

The Survey of Key Informants' Patients (SKIP) Program consists of over 150 public and privately funded treatment centers (Key Informants), balanced geographically with coverage in 48 states, that recruit patients/clients entering treatment to complete an anonymous survey centered on opioid misuse patterns and related behaviors. Subjects must be 18 years or older and meet DSM-IV criteria for substance abuse with a primary drug that is an opioid (prescription or heroin). Surveys, received on a rolling basis throughout the analyzed period, were identified by a unique case number and sent directly to Washington University in St. Louis (WUSTL) by the respondent. Participants were compensated with a \$20 Wal-Mart gift card. Surveys were categorized by half-year and quarter, with SKIP data for this study analyzed from January 1st, 2008 to September 30th, 2013.

2.2. Study Sample 2: RAPID

To supplement and add context to the structured SKIP survey, a sub-set of patients indicated, by a mail-in postcard provided with the SKIP survey, their willingness to give up their anonymity and participate in an unstructured interview-based study, dubbed Researchers and Participants Interacting Directly (RAPID). During the fourth quarter of 2013, 208 treatment clients consented to participate in a self-administered internet questionnaire via SurveyMonkey. Those participants who indicated prior experience with buprenorphine were re-contacted to further describe their opinions and experiences with buprenorphine $N=(106)$. All participants in the RAPID program were compensated with a \$20 Wal-Mart gift card. Study protocols for the SKIP and RAPID programs were approved by the WUSTL institutional review board.

2.3. Study Sample 3: Drug diversion

The Drug Diversion program of the RADARS[®] System collects data from a national sample of law enforcement and regulatory agencies with agents assigned to prescription drug diversion investigations. The program includes approximately

260 investigators in 49 states. For this study, thirty investigators participating in the Drug Diversion program in the second quarter of 2013 were randomly selected to participate in a one-time, semi-structured telephone interview. These investigators represented 23 states and were asked general questions about their units, caseload information, primary sources of diversion and primary diverted drugs in their jurisdictions. The study was deemed exempt by the institutional review board at Nova Southeastern University.

2.4. Data analysis

Both SKIP and RAPID programs gather socio-demographic variables (e.g., sex, current age and race/ethnicity). In addition, SKIP and RAPID participants identified their primary drug (e.g., the drug used to get high most frequently in the month prior to treatment), with SKIP respondents asked to also identify all opioid compounds used to get high in the month prior to treatment stratified by formulation and product, including whether or not each product was injected. "Misuse" is used throughout this report to reference both non-therapeutic use and use outside of legal therapeutic channels. Except where noted, SKIP analyses included the entire sample of both heroin and prescription opioid users due to the fact that there was high concurrent use of both drugs; 85% of heroin users also indicated the past month misuse of prescription opioids.

RAPID interview responses to the question "Please briefly explain in your own words the reasons you took buprenorphine or how buprenorphine affected you," were dual-reviewed, and using the principles of thematic analysis, 13 motivations for using buprenorphine were identified. In order to get a more accurate account of the variability in other buprenorphine-related motivations, a series of true/false questions was developed based on eleven identified motivations, with "to get high" and "to treat/prevent withdrawal sickness" excluded because they were asked directly through other SKIP and RAPID questions. Other RAPID data reported in this study were based on direct questions, with participants asked to explain their responses in an open-ended format.

The Drug Diversion program analyzed the responses of law enforcement investigators interviewed about the most commonly diverted prescription drugs in their area. In addition to identifying specific drugs, a review of the interview responses led to the identification of other topics of interest. Topics noted by at least three interviewees were then developed into themes and the presence of a theme (Y/N) was coded back to the interviews. Qualitative data from the Drug Diversion and RAPID programs were reviewed and coded using NVivo version 9. Quantitative data in both SKIP and RAPID datasets were analyzed using IBM SPSS Statistics v21.

3. Results

3.1. Demographics

Table 1 summarizes the gross demographic features of those participating in the SKIP ($N=10,568$; mean N per quarter = 449.1 ± 36.6 SE) and RAPID ($N=208$) programs. As can be seen, the RAPID subset, though much smaller, was quite similar to the larger SKIP sample. The majority of respondents were white and in

Table 1
Comparison of SKIP and RAPID demographic data.

	SKIP ($n=10,568$)	RAPID ¹ ($n=208$)
Gender		
Male	50.4	48.4
Average age (\pm SEM)	34.2 ± 0.11	34.9 ± 0.81
Race/ethnicity		
White	78.4	86.4
African American	9.0	4.3
Latino	4.9	3.7
Other	7.7	5.6
Primary drug		
Buprenorphine	1.6	0.7
Fentanyl	1.0	2.0
Heroin	29.8	36.2
Hydrocodone	19.7	20.4
Hydromorphone	3.8	1.3
Methadone	5.6	2.0
Morphine	4.0	3.3
Oxycodone	32.4	29.6
Oxymorphone	1.1	1.3
Tamadol	0.0	0.0
Tramadol	1.1	3.3

¹ Data collected from January 1, 2008–September 30, 2013.

² Data collected from October 1, 2013–December 31, 2013.

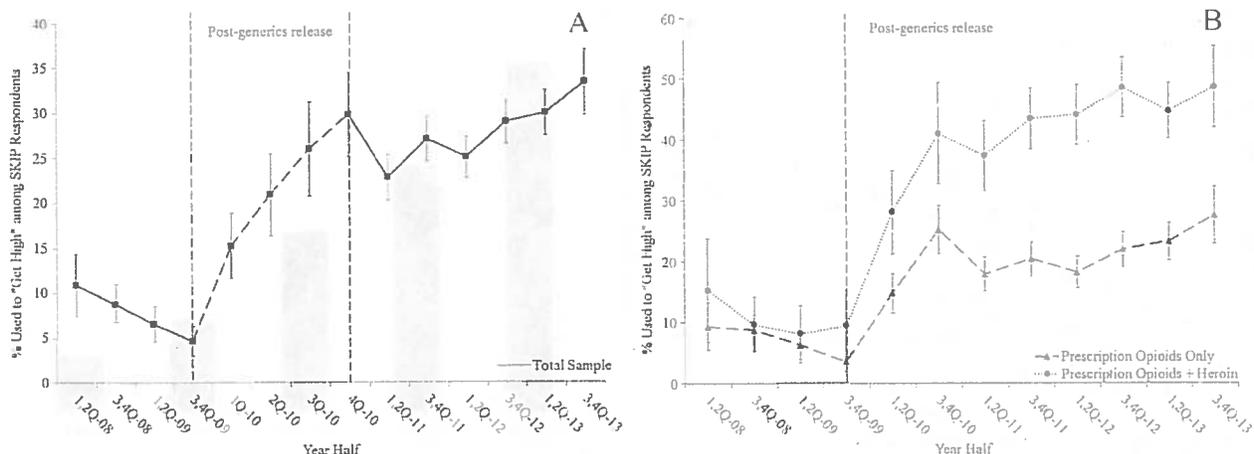


Fig. 1. The percent (95% CI) of the total SKIP sample (A) who used buprenorphine in the past month to get high as a function of half-year intervals from 2008 to the end of 2013. The year following the release of generics (dashed lines) is expressed in quarter-year intervals to emphasize the steepness in the rate of increase; (B) shows the misuse (95% CI) of buprenorphine in those SKIP respondents who used other prescription opioids to get high versus those who used other prescription opioids and heroin. Due to the fact that 85% of heroin users also used prescription opioids, the Ns for those using only heroin were too small (<35) for meaningful analysis.

their early thirties at the time of survey completion, with an even distribution of males and females. Heroin and oxycodone were the most popular primary drugs (i.e., the drug used most often in the past month) in both groups, with buprenorphine one of the least preferred.

3.2. Buprenorphine misuse

Although buprenorphine was endorsed as a primary drug by less than 2 percent of each sample (Table 1), as shown in Fig. 1A the number of SKIP respondents who indicated past month use of buprenorphine to get high was much higher and the rate almost quadrupled from 2008 to 2013. Most notably, there was a steep increase in every quarter of 2010 (detailed in Fig. 1A), the year following the introduction of buprenorphine generics in 2009. Data from law enforcement agents charged with investigating pharmaceutical diversion also indicated that buprenorphine was a significant problem in 2013. It was the fourth most commonly diverted prescription drug as determined by case reports; oxycodone was mentioned by 96.7% of respondents, followed by hydrocodone (80%), alprazolam (57%), buprenorphine (33%) and methadone (30%).

3.3. Heroin

As shown in Fig. 1B, those respondents who used both heroin and other prescription opioids to get high in the past month also misused buprenorphine at rates twice that reported by those only using prescription opioids. Moreover, as shown in Fig. 2A, increases in heroin use paralleled the increase in buprenorphine misuse, most notably in the years following the introduction of a tamper-resistant formulation of OxyContin® in the second half of 2010. Forty percent of drug diversion investigators (N = 12) also noted a parallel increase in heroin and buprenorphine use:

We've seen an increase in heroin and suboxone, they are often packaged together. Suboxone is being prescribed in huge amounts, this girl had 24 refills on her and she was dealing... we arrested her shooting up in a restaurant.

3.4. Methadone

As shown in Fig. 2B, as the past month misuse of buprenorphine increased over time, methadone misuse declined, such that, two years after the introduction of buprenorphine generics, methadone was less commonly misused than buprenorphine. In this context,

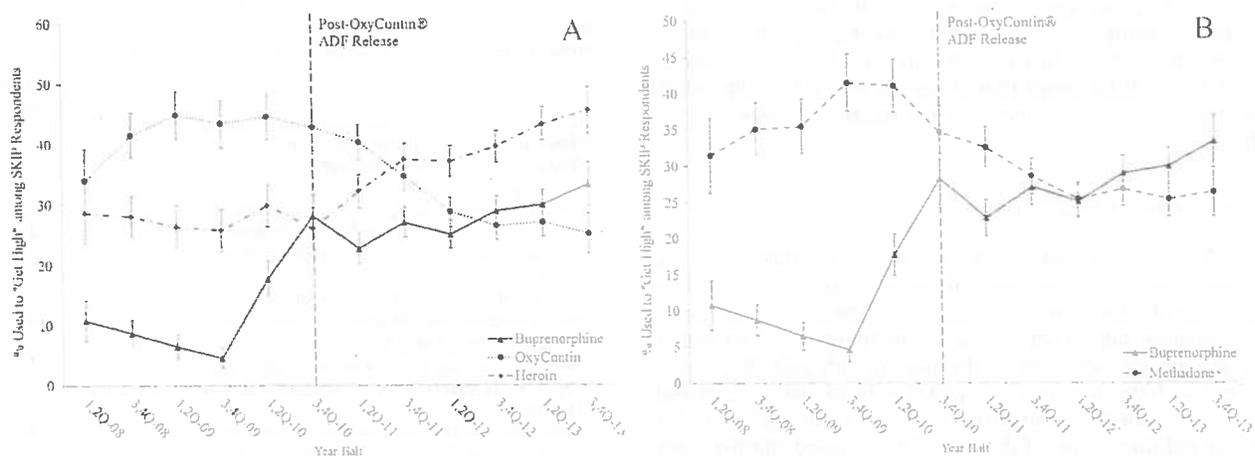


Fig. 2. The percent(95% CI) of the total SKIP sample that used buprenorphine, OxyContin® and/or heroin to get high in the past month plotted as a function of half-year intervals from 2008 to 2013 (A); (B) shows the percent (95% CI) of the total SKIP sample that used buprenorphine and/or methadone to get high in the past month. The introduction of an abuse deterrent formulation of OxyContin® is denoted by the dashed vertical line.

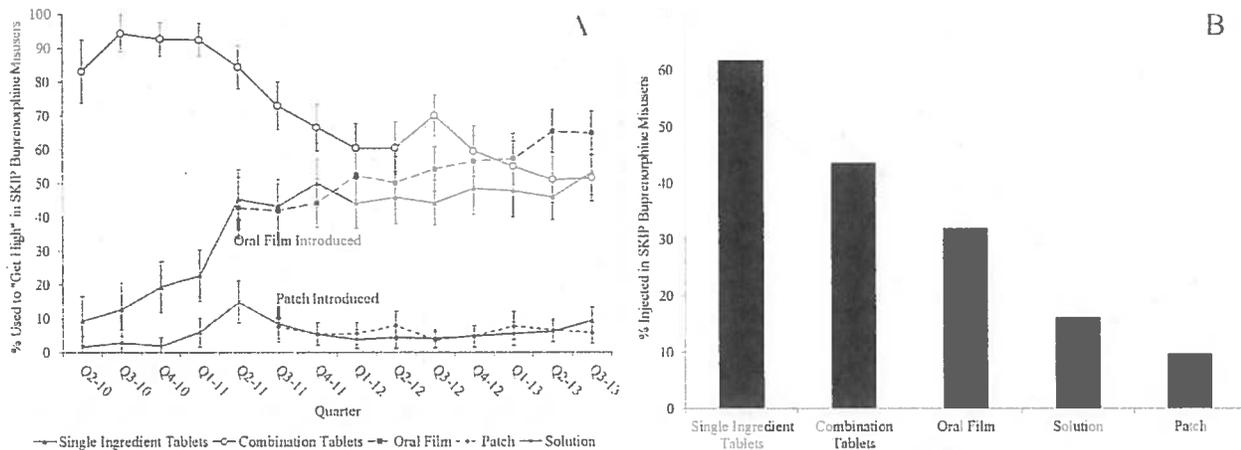


Fig. 3. Buprenorphine product formulations used by SKIP respondents indicating any past month use of buprenorphine to get high plotted as a function of quarter-year intervals (95% CI) (A); (B) shows the total percentage of buprenorphine product formulations injected by SKIP respondents indicating any past month injection of buprenorphine to get high.

40% of respondents in the RAPID interviews indicated they had used both buprenorphine and methadone for the purpose of treating or preventing withdrawal sickness, either under a doctor's care or on their own initiative as a self-directed pharmacotherapy for opioid dependence. When asked which drug they preferred, 61.5% chose buprenorphine compared to just 25.6% favoring methadone (9.3% had no preference). Reasons given for the preference of buprenorphine included "lasts longer", "methadone is worse to come off of," and "does not get me high". As one respondent noted:

Methadone made me feel high just like the meds I was trying to come off of where the suboxone just makes me feel normal. On methadone I wanted to sleep all the time and the suboxone I don't. Also I felt the methadone clinics were legal drug dealers who didn't care about anything but the money I was paying them. My suboxone doctor actually cares about me and how I'm doing in my recovery and what's going on in my life.

Our data also indicate that lack of access to a buprenorphine treatment program could be an important factor in the unsupervised use of buprenorphine to treat opioid dependence. For example:

Before I started my treatment program I had a friend get a script, he sold me a couple [buprenorphine] to try and see if they would ease my withdraw. They did, so the next day I called his doctor and tried to get an appointment, the wait was over a month. I ended up going into a traditional treatment program about a week later where they tried to just control the symptoms and it was hell for more than 2 weeks before I finally called the suboxone doc back and basically begged my way in their office.

3.5. Buprenorphine formulations

Fig. 3A shows the misuse of buprenorphine subdivided by formulation type. In the first quarter of 2010 (the earliest date for which data were available), Suboxone® (buprenorphine + naloxone) tablets were the overwhelming choice, with over 90% of buprenorphine users in the past month selecting them. Coincident with the discontinuation of the combination tablet and the introduction of the combination oral film, misuse of the tablet decreased and the misuse of the oral film increased sharply. Very substantial increases in single ingredient (e.g., subutex) tablets misuse also occurred. Buprenorphine patches and solutions were rarely endorsed as drugs of misuse.

3.6. Intravenous injection of buprenorphine

Over one-third (34.4%, $n = 461$) of buprenorphine misusers in the SKIP sample indicated they had injected it in the month prior to treatment. This was particularly prevalent in those misusing both prescription opioids and heroin: 71.1% of those who injected buprenorphine had also used heroin in the past 30 days. As shown in Fig. 3B, single ingredient tablets were the most commonly injected (61.8%), but a surprisingly high number injected the buprenorphine + naloxone tablet (43.6%) or oral film (32.1%). Given that naloxone should have antagonized the euphorogenic effects of buprenorphine, providing a low quality high, we asked RAPID participants how they circumvented the barriers of this formulation. Participants reported a number of simple and easy methods, unethical to specify in this paper, which they believed separated buprenorphine from naloxone, resulting in what they termed "pure buprenorphine" for injection.

3.7. Other motivations for buprenorphine use

Nearly 70% of RAPID follow-up participants indicated that they had used buprenorphine, for any reason, at some point in the past. As shown in the response to the True-False questions in Table 2, very few individuals indicated that they used buprenorphine

Table 2
Motivations for prior buprenorphine use outside of a treatment program.

	RAPID ($n = 106$)
"I have used Buprenorphine at least once..."	
Because it gives me a better high than other prescription opioid drugs	2.9
Because it was my drug of choice to get high with	3.9
To maintain my abstinence from other drugs	62.9
Because I was trying to wean myself off drugs on my own	54.8
To hold me over during work/social events	52.9
Because I knew I would not have access to other drugs for a period of time	59.6
Because it was cheaper than other drugs	15.4
Because my drug of choice to get high with was not available	60.4
Because it was the only drug that was available	53.9
To treat my bodily pain when other drugs were unavailable	50.0
Because it helped treat anxiety, depression or other psychological symptoms	33.0

because it produced a better high than other opioids. These data are consistent with our observations in the much larger SKIP sample where very few individuals listed buprenorphine as their drug of choice (Table 1). The primary reasons given for using buprenorphine seem to be divisible into two main categories: (1) use of buprenorphine for the express purpose of treating/preventing withdrawal sickness; and (2) as a substitute to get high when other, more preferred drugs were unavailable (Table 2). Several responses to our open-ended question asking why participants used buprenorphine illustrate these often interrelated points:

When I first took [buprenorphine] I was mainly shooting heroin . . . and then used subutex to keep me from getting sick until I'd use again. Sure the thought of actually using it to get off heroin crossed my mind but I began to use it to get high as well.

I have taken buprenorphine in the past to wean off heroin, both under and not under the care of a physician. I also used it when actively using to keep from getting sick if I did not have enough heroin, and as a substitute.

3.8. Co-morbidity and buprenorphine use

A somewhat surprising finding was that 50% of buprenorphine users indicated treating pain was one of the many reasons for using it (Table 2). A third of the sample also indicated they used buprenorphine to help with psychiatric problems. These points are underscored by the following quotes:

I had some left over from my doctor (who I was no longer seeing) and had some horrific pain in my back that my Norco didn't touch so I decided to go back and use Suboxone.

To get high, to get off opioid, to control physical pain, to numb emotional pain, to avoid withdrawal, to avoid facing life without the safety of a fog, to make uncomfortable situations tolerable, to make unsafe situations feel safe, I used it just like I used opioid—to face a reality I had no idea how to live in.

4. Discussion

Our results demonstrate that the misuse of buprenorphine has increased substantially in the last 5 years, confirming and extending earlier reports of such increases (Drug Enforcement Administration, 2009; Substance Abuse and Mental Health Services Administration and Drug Abuse Warning Network (DAWN), 2011; United States Department of Justice and National Drug Intelligence Center (NDIC), 2011; Wish et al., 2012; Lavinon et al., 2014). Certainly, much of this increase has been fueled by an increase in the therapeutic use of buprenorphine, which was accelerated by the release of generics in 2009. Given that it has been shown that there is a direct correlation between the extent of therapeutic use and diversion to street use (Cicero et al., 2007a,b; Lavinon et al., 2014), increases in buprenorphine misuse are not unexpected. However, our quantitative and qualitative data suggest that another major reason buprenorphine misuse has increased in recent years is due to the fact that it serves a variety of functions for the opioid-abusing population: to get high, manage withdrawal sickness, as a substitute for more preferred drugs, to treat pain, manage psychiatric issues (i.e., depression and anxiety) and as a self-directed treatment to wean off other misused opioids. This is especially evident when viewed in the context of the rise in heroin use in the same time frame which, at least in part, seems to be related to the introduction of an abuse-deterrent formulation of OxyContin®. While this greatly reduced OxyContin's popularity as a drug of abuse, it appears to have been followed by a concomitant increase in both heroin and buprenorphine use. The reasons buprenorphine misuse

has increased so sharply in the past five years, particularly among heroin users, are not fully understood, but may be reflective of three factors.

First, while it is clear that buprenorphine was very rarely the drug of choice, our data indicate that it was an acceptable alternative for getting high when more preferred drugs were unavailable (e.g., cost, lack of supply), particularly in intravenous injection drug users.

Second, aside from the use of buprenorphine to get high, its long half-life makes it ideal to ward off opioid withdrawal sickness until preferred drugs are available or as a self-directed treatment to detox and wean off opioids.

Self-medication, rather than entry into a treatment program, may be related to lack of access or cost of these programs. In this context, our study participants preferred buprenorphine to methadone by more than a 2:1 margin when asked specifically about its efficacy in treating withdrawal sickness. Given that methadone is readily available on the street, access is unlikely to be a factor. Rather it would appear that methadone has more undesirable properties such as side effects, social stigma associated with stand-alone treatment clinics and difficulty in weaning off it.

Finally, our data also suggest that pain management and self-medication of serious psychiatric problems are clearly motivating factors in the use of buprenorphine. Over 50% of our sample indicated that buprenorphine was useful to help them manage their pain and over a third used it to "numb their emotional pain." These data reinforce the construct that substance abuse is a disorder that rarely exists as a stand-alone entity, but often represents a coping mechanism to treat physical and emotional issues.

Why heroin users are more inclined to use buprenorphine than those who exclusively use prescription opioids is not completely clear, but may be related to our finding that unadulterated buprenorphine is, of course, available in the single ingredient tablet and easily can be extracted from the more common and accessible formulation, buprenorphine + naloxone, making it suitable for injection, a route preferred by many heroin users. In contrast, most other opioids readily available on the street contain acetaminophen, which addicts generally tend to avoid for safety concerns (i.e., liver damage) and the fact that acetaminophen makes these compounds unusable for intravenous injection (Cicero et al., 2013). An additional factor which may favor the use of buprenorphine by those who prefer or use heroin regularly is that the immediacy and intensity of withdrawal is much greater in heroin addicts than prescription drug users and, given the medical complications in these individuals, efforts to wean themselves off heroin using buprenorphine may be more intense than for prescription opioid users. Obviously, these suggestions are speculative and more direct studies should be carried out to examine this.

In 2011, the company marketing buprenorphine + naloxone tablets, under the brand name Suboxone®, argued that the tablet was inherently unsafe due to pediatric exposure and withdrew it from distribution. As a replacement, they introduced an oral film as a safer alternative, which perhaps not coincidentally also extended their patent exclusivity. Although Lavinon et al. (2014) reported that the film has reduced child exposure as reflected in poison control center calls, our data indicate it is misused as readily as the original buprenorphine + naloxone formulation indicating that, at least in terms of use to get high, the delivery device – film or tablets – may be irrelevant for those seeking buprenorphine. The larger question is whether the addition of naloxone to the buprenorphine in the combination product actually discouraged use to get high. On the one hand, those who injected it did extract the buprenorphine from the combination product to remove the naloxone which apparently blunted the euphoric effect. However, oral users did not bother to go through the steps of extraction, and apparently did get some euphoric effect albeit one likely less in quality.

There are limitations to our study which need to be noted. A treatment sample may not be representative of those using opioids “recreationally” or of the racial and gender composition of all opioid users. In addition, like all self-administered surveys, there are the usual problems involving ambiguous response and the inability to ask follow-up questions for clarification. Mitigating this problem, to some extent, is the qualitative data provided by our interviews with study participants which allowed much more in-depth analysis of responses and information not covered in the SKIP survey. Finally, the absence of exposure data does not allow an estimate of the correlation between therapeutic exposure and abuse in the current paper, which could be useful, but this topic has been covered in our earlier work (Lavonas et al., 2014), which supports the association of increases in misuse as a function of increases in exposure.

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Contributors

Author Cicero designed the study and wrote the protocol. Author Ellis performed data analysis and research coordination. All authors participated in reviewing the data and drafting the manuscript.

Conflict of interest statement

Authors Cicero and Surratt serve as consultants on the Scientific Advisory Board of the non-profit post-marketing surveillance system, RADARS®. All other authors declare they have no conflict of interest.

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The diversion and injection of a buprenorphine-naloxone soluble film formulation[☆]



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ABSTRACT

Background: We compared the diversion and injection of a new formulation of buprenorphine, a buprenorphine-naloxone film product (BNX film), with buprenorphine-naloxone tablets (BNX tablets), mono-buprenorphine (BPN) and methadone (MET) in Australia.

Methods: Surveys were conducted with people who inject drugs regularly (PWID) (2004–2012) and opioid substitution treatment (OST) clients (2012, $N = 543$). Key outcome measures: the unsanctioned removal of supervised doses, diversion, injection, motivations, drug liking and street price. Levels of injection among PWID were adjusted for background availability of medication using sales data. Doses not taken as directed by OST clients were adjusted by total number of daily doses dispensed.

Results: Among out-of-treatment PWID, levels of injection for BNX film were comparable to those for MET and BNX tablet formulations, adjusting for background availability: BPN injecting levels were higher. Among OST clients, recent injecting of one's medication was similar among clients in all OST types; weekly or more frequent injection of prescribed doses was reported by fewer BNX film clients (3%; 95% CI: 1–6) than BPN clients (11%; 95% CI: 3–17), but at levels similar to those observed among MET and BNX tablet clients. The proportion of BNX film doses injected was lower than that for BPN and BNX tablets, and equivalent to that for MET. The majority of BNX film doses injected by OST clients were unsupervised doses, although some injection of supervised doses of BNX film did occur. The median price of all buprenorphine forms on the illicit market was the same.

Conclusions: Non-adherence and diversion of the BNX film formulation was similar to MET and BNX tablet formulations; BPN had higher levels of all indicators of non-adherence and diversion.

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1. Introduction

Methadone (MET) and buprenorphine are “essential medicines” in the treatment of opioid dependence (World Health Organization). Opioid substitution therapy (OST) has been long-established in Australia: MET has been prescribed with public subsidy since the 1970s, mono-buprenorphine (BPN) tablets (marketed as Subutex[®]) since 2001 and buprenorphine-naloxone tablets (BNX tablets, marketed as Suboxone[®]) since 2006. In October 2011, a newer buprenorphine formulation was introduced

with public subsidy—buprenorphine-naloxone sublingual film (BNX film, marketed as Suboxone[®] Film).

Minimising the extent of diversion and injection of the pharmaceutical opioids used in opioid substitution therapy (OST) reduces harms to the individual (such as injection-related injuries and diseases, and overdose) and protects the reputation and integrity of OST programmes. Reports of OST medication diversion and/or injection can undermine public and clinical support for OST. This may in turn limit future investment and development, and hinder efforts to make OST more attractive and accessible. Understanding the extent of medical and extra-medical use of these important medications is relevant to policy and practice and confidence in the treatment system.

From 2006 to 2008, post-marketing surveillance studies of the diversion and injection of BNX tablets were required in Australia by federal regulatory authorities; the methodology and findings of

[☆] Supplementary material can be found by accessing the online version of this paper. Please see Appendix A.

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which have been detailed elsewhere (Larance et al., 2011). These studies found that levels of BNX tablet injection among people who inject drugs (PWID) were lower relative to BPN, but comparable to those for MET, adjusting for background availability; and among OST clients, fewer BNX tablet clients reported recently injecting their medication, than BPN and MET clients (Degenhardt et al., 2009; Larance et al., 2011).

More recently (2011), BNX film was introduced in Australia and further post-marketing surveillance studies have been conducted. The manufacturer information states that the benefits of BNX film are: it is dissolved faster than BNX tablets; it has a more favourable taste; and doses are individually wrapped, more child resistant and more portable (Reckitt Benckiser Inc., 2013). However, there has been little published research on the safety and efficacy of BNX film (Soyka, 2012). One randomised-controlled trial found that BNX film adheres to the sublingual mucosa more rapidly and dissolves more quickly than BNX tablets, particularly at high doses (Lintzeris et al., 2013). Given these characteristics, we hypothesised that buprenorphine-naloxone film may be more difficult to remove from mouth than BNX tablets, resulting in less removal of supervised doses from the dosing site and subsequent diversion or injection of supervised doses in comparison to BNX tablets.

This paper examines the uptake of BNX film in Australia and presents the findings of surveillance studies of the diversion and injection of MET, BPN, BNX tablets and BNX film conducted during 2012. Where possible, the 2012 data are compared to those collected in earlier post-marketing surveillance studies (Degenhardt et al., 2009; Larance et al., 2011).

Specifically, this paper seeks to answer the following questions: (1) Is there less diversion and injection of BNX film, compared to methadone, mono-buprenorphine and buprenorphine-naloxone tablets, among OST clients and out-of-treatment people who inject drugs (PWID)? (2) Are there additional benefits of BNX film in the context of supervised dosing, for example less unsanctioned removal of supervised doses from the dosing site, compared to MET, mono-buprenorphine and BNX tablets? and (3) Is there less demand for diverted BNX film, compared to MET, mono-buprenorphine and BNX tablets?

2. Methods

2.1. Data sources

2.1.1. Sales data. Background availability of medications is important in post-marketing evaluations of abuse liability: the more widely available a medication is, the more opportunity there may be for extra-medical use and/or diversion (Dart, 2009; McCormick et al., 2009). National sales data for BPN, BNX tablets and BNX film were provided by IMS Health (IMS)/Reckitt Benckiser, who also provided commercially available data on sales of methadone liquid (including brand names Methadone syrup[®] and Biodone[®]). Sales data are expressed in 'factored units' of average daily doses of methadone in Australia assumed to be 70 mg, and average daily doses of buprenorphine assumed to be 12 mg; these levels are derived from previous research on client doses in Australia (Lintzeris et al., 2007; Winston et al., 2008).

2.1.2. Interviews with people who inject drugs regularly (PWID). The Illicit Drug Reporting System (IDRS) has been monitoring Australian drug trends nationally since 2000. A key component of the IDRS is the annual interviews with approximately 900 PWID conducted in June each year in each capital city around the country. The core quantitative IDRS interview monitors patterns of drug use and includes questions on price, purity and availability of the main drug types. Further details of the interviews are reported elsewhere (Stifford and Burns, 2012). The IDRS sample of PWID are able to comment in detail on inner-city drug markets, where emerging trends are most likely to be observed. They also represent a group who are able to comment on the availability of diverted OST medications. This study utilises data from the IDRS samples of PWID collected from 2004 to 2012 to place the 2012 BNX film data in the context of recent trends in OST medication injection more generally.

As the IDRS intentionally recruits a sentinel sample of PWID who are regularly injecting, IDRS participants who report receiving OST are not representative of treatment populations more generally. For this reason a separate study of OST clients was conducted (below). To give the best indication of the illicit market and use of diverted OST medications among PWID who are not in treatment, the in-treatment

Table 1
Key demographic characteristics of the 2012 samples of PWID and OST clients.

	Out-of-treatment PWID (IDRS) n = 541	OST clients n = 544
Mean age in years (SD)	39 (9.8)	39 (9.2)
Male (% 95% CI)	70 (66–74)	68 (64–72)
Unemployed/receiving government benefits (% 95% CI)	87 (84–90)	84 (81–87)
Homeless/no fixed abode (% 95% CI)	26 (22–30)	14 (11–17)
Prison history (% 95% CI)	55 (51–59)	56 (53–61)

IDRS group were excluded from analyses (unless otherwise stated). This resulted in a sample of 472 out-of-treatment PWID in 2012. The demographic characteristics of 2012 sample are detailed in Table 1.

2.1.3. Interviews with OST clients. Independent samples of MET (n=210), BPN (n=79), BNX-tablet (n=75) and BNX film (n=180) clients were interviewed from May–July 2012 (N=544 OST clients in total). Participants were recruited from OST services in Sydney, Melbourne and Adelaide (see Supplementary Table 1 for characteristics of current treatment episode¹). Recruitment strategies were targeted in each jurisdiction to ensure representation from a range of treatment settings that reflected the mix of public clinics, private clinics, GP, and pharmacy dispensers in that jurisdiction. Comparisons between the total sample characteristics and the most recent National Opioid Pharmacotherapy Statistics Annual Data (NOP SAD) report (2011 data) indicated in general there was representation of the full range of treatment settings (Australian Institute of Health and Welfare, 2012). The treatment settings in which the Melbourne sample was recruited were most representative of those in national data. There was however, possible over-representation of some prescriber settings (public clinics in Adelaide and private clinics in Sydney) and dosing sites (private clinics in Sydney; see Supplementary Table 1).²

To be eligible for the study, participants were required to be aged 18 years and older; and to have been in their current treatment episode for at least one month. OST clients were asked similar questions to those asked in the IDRS, as well as questions regarding adherence with treatment, the removal of supervised doses from the dosing site, selling or giving away medications to others, and injection of their medication. Demographic characteristics of the OST client sample are presented in Table 1.

2.2. Outcome measures and analyses

The primary outcome measures from the interviews with out-of-treatment PWID were the prevalence and frequency of OST medication injection. Ratios were calculated by using prevalence of injection among PWID as the numerator, and sales data expressed per million units of medication sold during the corresponding monitoring period as denominator, plotting the data for each year (2004–2012). By using these ratios, the levels of injection documented among PWID were adjusted according to background availability of each medication (i.e., amounts being prescribed). Secondary measures included experience of precipitated withdrawal, motivations for using diverted OST medications, and street price.

The primary outcome measures from the OST client interviews were specific indicators of non-adherence, including the prevalence and frequency of the unsanctioned removal of doses intended to be consumed under the supervision of a clinician, the injection of doses and the diversion of doses to others. Diversion in this paper specifically refers to the selling and/or giving away of a dose of prescribed OST medication. The total numbers of daily doses injected were aggregated and adjusted by the total number of daily doses dispensed to the group as a whole.

Where possible, responses were analysed by OST-type. Percentages, 95% confidence intervals (CIs) and Chi-square tests of significance are used to examine differences in proportions. For continuous, normally distributed variables, independent samples t-tests are used to examine differences. For continuous variables with skewed distribution, medians and Mann–Whitney's U-test for significant differences are reported. All analyses were conducted in SPSS Version 17.0.

2.3. Ethics approval

Ethics approval was obtained from the University of New South Wales Human Research Ethics Committee (HREC), the University of Adelaide HREC, the Alfred Hospital HREC and the New South Wales Health HRECs for Sydney Local Health District (LHD), Western Sydney LHD, South Eastern Sydney LHD and South Western Sydney LHD.

¹ Supplementary material can be found by accessing the online version of this paper. Please see Appendix A.

² Supplementary material can be found by accessing the online version of this paper. Please see Appendix A.

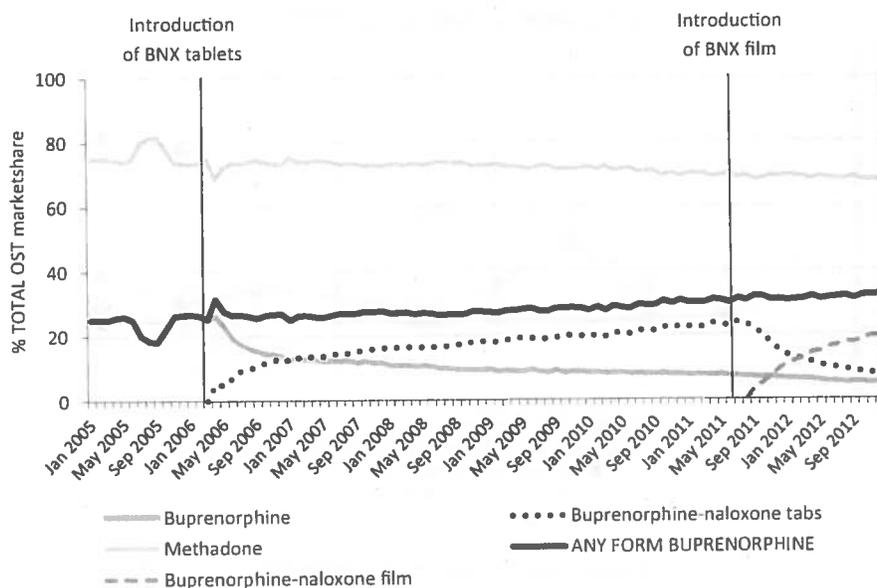


Fig. 1. Percentage of Australian OST market share accounted for by MET, BPN, BNX tablets and BNX film, by month, January 2005–December 2012.

3. Results

3.1. Uptake of BNX film in Australia

From 2005 to 2012, MET retained the largest OST market share in Australia (68% in 2012). There was a modest increase in overall market share of any form of buprenorphine as an OST (from 25% in 2005 to 32% in 2012). Since the introduction of BNX tablets and BNX film, BPN tablet sales have steadily declined (Fig. 1). From March, 2007 to March, 2012, BNX tablets accounted for the largest market share of total buprenorphine sales. From April, 2012, BNX film became the predominant form of buprenorphine sold in Australia, accounting for 19.4% of OST market share December, 2012.

3.2. Injection of diverted OST medications among out-of-treatment PWID

Among out-of-treatment PWID ($n=472$), fewer PWID reported recent (i.e., past six months) injection of BNX film (5%, 95% CI: 3–7) and BNX tablets (10%, 95% CI: 7–13) compared to BPN (16%, 95% CI: 13–32) and MET (17%, 95% CI: 14–20³). With respect to regular (i.e., weekly or more frequent) injection, significantly fewer out-of-treatment PWID reported regular injection of BNX film (1%, 95% CI: 0–2), compared to MET (4%, 95% CI: 2–6), BPN (6%, 95% CI: 5–9) and BNX tablets (3%, 95% CI: 2–5).

Adjusting for the volume of sales, BPN was injected by out-of-treatment PWID at higher levels than MET across the study period (Fig. 2). When BNX tablets were first introduced in 2006, the adjusted level of any BNX tablet injection was higher than that for BPN, although regular (i.e., weekly or more frequent) injection was less common. These levels dropped substantially by 2007, and stayed low from 2008 to 2012, with a significantly lower adjusted level of BNX tablet injection relative to BPN, and comparable to levels of MET injection. In 2012, the adjusted level of recent and regular injection of BNX film was comparable to that for MET and BNX tablets, but significantly lower than that for BPN. The adjusted

level of recent and regular BPN injection among out-of-treatment PWID has remained significantly higher than the other OST types from 2007 to 2012.

3.3. Indicators of medication attractiveness among PWID

3.3.1. Experience of precipitated withdrawal. Among PWID who reported injecting BPN ($n=105$), BNX tablet ($n=77$) or BNX film ($n=37$) in the past 180 days, the majority (78%, 89% and 77%, respectively) did not experience withdrawal symptoms on the occasions that they injected these medications.

3.3.2. Motivations for using diverted buprenorphine-naloxone film. The most common motivation for using diverted BNX film among out-of-treatment PWID was self-treatment of withdrawal symptoms (Table 2).

3.3.3. Street price. In 2012, the median prices reported by PWID for 2 mg (AUD\$10) and 8 mg (AUD\$28) BNX film on the illicit market were very similar to those for BPN tablets (AUD\$10 and AUD\$25, respectively) and BNX tablets (AUD\$10 and AUD\$30, respectively; Fig. 3). Illicit MET remained stable at between AUD\$0.50–AUD\$1 per ml.

Table 2

Main motivation for using diverted OST medication among out-of-treatment PWID who have used in last 6 months (%).

	MET ($n=69$)	BPN ($n=34$)	BNX tablets ($n=17$)	BNX film ($n=19$)
Self-treatment	59%	56%	71%	58%
Away from home	NR	0	0	0
Substitution for other opioids	6%	21%	NR	NR
Intoxication	16%	NR	0	0
Sharing with partner/friend	0	NR	0	NR
Other	12%	NR	NR	21%

Notes: Among those out-of-treatment PWID who had used that diverted OST medication in the last six months, who responded to the question. Other reasons included financial stress, needed a higher dose that day, faster onset, preference for injecting, and difficulty ceasing injection. NR = not reported as $n \leq 3$.

³ See Supplementary Table 2 by accessing the online version of this paper. Please see Appendix 4.

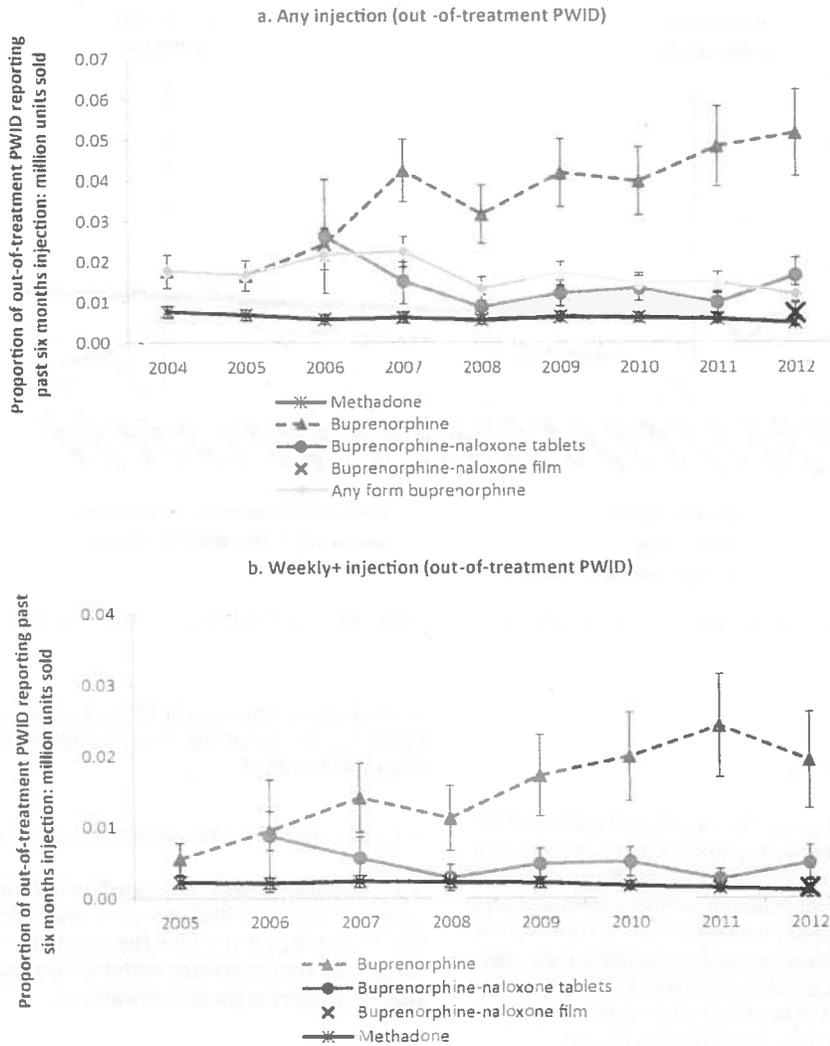


Fig. 2. Ratio of injection of OST medication in the past six months by out-of-treatment PWID: volume of sales of OST medications, 2004–2012. Notes: 95% CIs are plotted throughout. Data were derived from the IDRS participants (PWID): only those PWID who reported receiving no OST medications (MET, BPN, BNX tablets or BNX film) in the six months prior to interview were included in these analyses ($n = 460$ in 2004, $n = 436$ in 2005, $n = 465$ in 2006, $n = 448$ in 2007, $n = 456$ in 2008, $n = 475$ in 2009, $n = 452$ in 2010, $n = 422$ in 2011, and $n = 472$ in 2012). “Weekly+ injection” reports the percentages reporting injecting these medications on a weekly or more frequent basis in the past six months. Data on days of injection are only available for 2005 onwards, and could not be aggregated for buprenorphine forms. Sales data provided by Reckitt Benckiser/IMS. MET data includes both Methadone Syrup[®] and Biodone[®]. One ‘unit’ is an estimated daily dose of 70 mg MET and 12 mg of BPN/BNX [Lintzeris et al., 2007; Winstock et al., 2008].

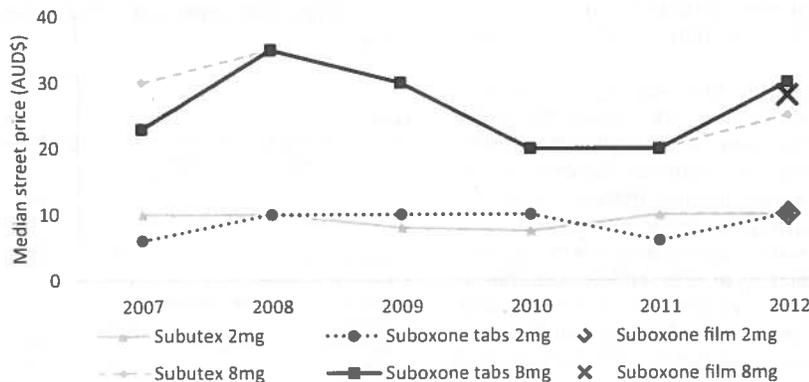


Fig. 3. Median street price of BPN, BNX tablets and BNX film reported by the total IDRS sample of PWID, 2007–2012. Notes: Includes prices reported by total sample of PWID, 2007–2012 (see [Safford and Burns, 2012] for sample sizes).

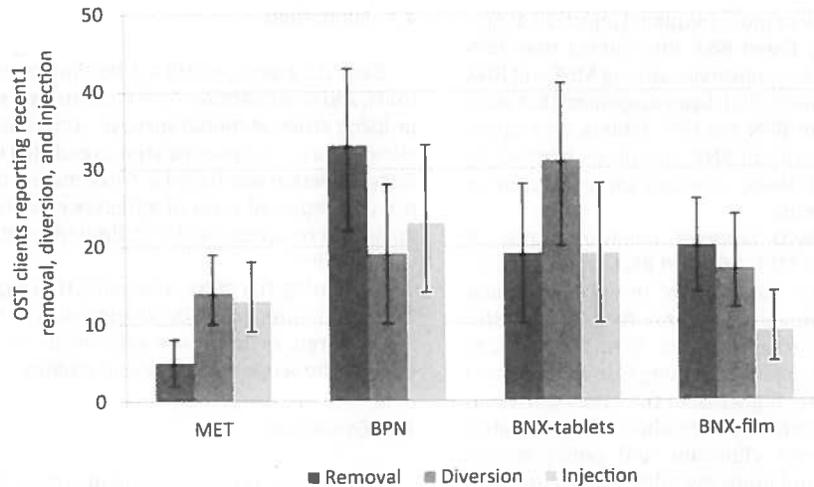


Fig. 4. Proportion of OST clients reporting recent (past six months) removal of a supervised dose from a dosing site, diversion and injection, by OST type, 2012. *Notes:* Among OST clients receiving that treatment as their main form of treatment: MET = 210, BPN = 79, BNX tablets = 75, BNX film = 180. "Recent" = at least once in the past six months. 95% confidence intervals are reflected in the error bars.

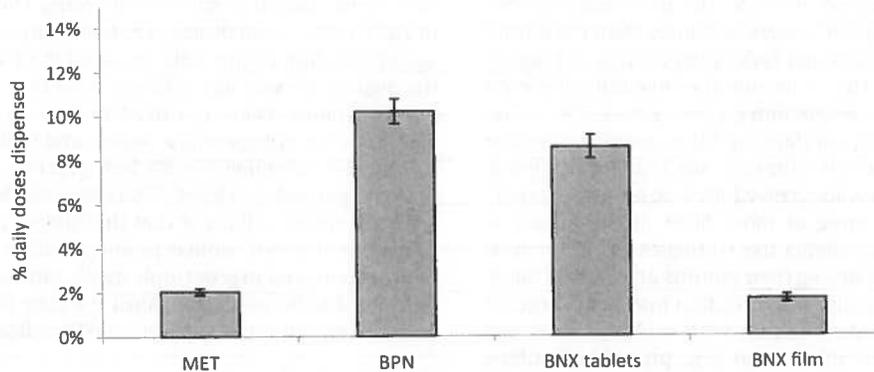


Fig. 5. Percentage of the total doses dispensed to OST clients that were injected, aggregated data, by OST-type, 2012. *Notes:* Based on total number of doses dispensed in the past 180 days to participants receiving that treatment as their main form of treatment.

3.4. Non-adherence among OST clients

3.4.1. Removal of supervised doses. Fig. 4 shows that there were no significant differences in the percentage of BPN (33%), BNX tablet (19%) or BNX film (20%) clients reporting removal of a supervised dose from the dosing site in the past six months; removal of supervised doses was reported by significantly fewer MET clients (5%). Among BNX film clients receiving supervised doses ($n = 174$), 43% reported that more than three or more films were usually placed in their mouth at once during supervised dosing.

3.4.2. Diversion of doses. Significantly fewer MET clients reported diversion compared to BNX tablet clients, but there were no significant differences between BPN, BNX tablet and BNX film clients in the levels of diversion reported.

3.4.3. Injection of doses. There were no significant differences between the OST client groups in the proportion reporting having injected their OST medication at least once in the past six months (see Supplementary Material⁴). The prevalence of regular (i.e., weekly or more frequent) injection among BNX film clients

(3%) was significantly lower than that observed among BPN clients (11%), but similar to that among BNX-tablet (9%) and identical to MET (3%) clients (Fig. 4).

3.4.4. Frequency of injection relative to overall OST provision. Among the total dispensed doses that were injected by OST clients in the past 180 days, the majority of BNX film (54%), BNX tablet (79%) and MET (64%) doses were unsupervised. In contrast, the majority of BPN dispensed doses injected (97%) were supervised doses. Adjusting for the total number of doses dispensed to each OST client group as a whole (Fig. 5), more BPN (10%) and BNX tablet (9%) doses were injected, compared to the BNX film and MET doses (both 2%).

4. Discussion

Although one clinical trial has found BNX film formulation to have faster dissolution and rapid mucosal adhesion than the BNX tablet formulation (Lintzeris et al., 2013), there has been no published research to date examining whether the BNX film formulation offers advantages in terms of non-adherence and diversion in real life settings. This is the first published study to provide post-marketing surveillance data on the diversion and injection of BNX film, making direct comparisons with MET, BPN and BNX tablets.

Our study found no differences across OST medications in the proportion of clients reporting past six months' injection of their

⁴ Supplementary material can be found by accessing the online version of this paper. Please see Appendix A.

medication. Regular (i.e., weekly or more frequent) injection of prescribed doses was reported by fewer BNX film clients than BPN clients, but at levels similar to those observed among MET and BNX tablet clients. The proportion of BNX film doses dispensed that were injected was lower than that for BPN and BNX tablets, and equivalent to that for MET. The majority of BNX film doses injected by OST clients were unsupervised doses, although some injection of supervised doses of film did occur.

Fewer out-of-treatment PWID reported recent injection of diverted BNX film, compared to MET, BPN and BNX tablets. Adjusting for background availability, the levels of recent and regular injection of BNX film were comparable to those for MET and BNX tablets, but significantly lower than those for BPN. The adjusted level of recent and regular BPN injection among out-of-treatment PWID has remained significantly higher than the other OST types from 2007 to 2012. Although BPN tablets are indicated in pregnancy and confirmed naloxone allergy, clinicians and policy-makers should consider using BNX formulations over BPN tablets for other buprenorphine clients, given the higher levels of diversion and injection BPN tablets.

There were high levels of supervised dosing among BNX film clients in the current study, possibly as a result of over-representation of clinic settings in NSW. The percentage of BNX film clients reporting removal of supervised doses from the dosing site was similar to that for BPN and BNX tablet clients, and higher than that for MET clients. This is despite the mucosal adherence and dissolution advantages of BNX film (Lintzeris et al., 2013). The practice of placing multiple, overlapping films under the tongue may prevent effective mucosal adhesion: we found that almost half of the BNX film clients who received their doses under supervision reported receiving three or more films in the mouth at once. It is also possible that clients use strategies to aid removal of supervised doses, such as drying their mouths or sleight of hand. Pharmacists and clinics that dispense BNX film may need targeted education campaigns regarding dosing with multiple films and strategies to reduce the risk of removal (e.g., providing drinking water).

Like BNX tablets, the diverted BNX film product has value in illicit markets. Over the period 2007–2012, there was no difference between the different buprenorphine formulations in terms of street price, including that for BNX film in 2012. The circumstances in which BNX film or tablets may be injected without precipitating withdrawal are similar to those in which BPN may be injected, consistent with the three preparations having a similar street value (Larance et al., 2011).

The most common motivation for using diverted BNX film among out-of-treatment PWID was self-treatment of withdrawal symptoms, a result consistent with the very early observations on the use of diverted methadone in New York in the 1970s (Inciardi, 1977). That is, PWID appear to use these medications to manage adverse withdrawal symptoms, rather than to achieve a euphoric effect.

Internationally, OST programmes face a number of difficult policy trade-offs. Supervised dosing may reduce the overall level of diversion of OST medications to out-of-treatment and opioid-naïve populations, but may increase injection-related infections among OST clients who later inject supervised doses removed from their mouth, and impact negatively on the outcomes and attractiveness of OST. Increasing treatment flexibility through reduced regulation and increased unsupervised dosing may result in larger numbers of people entering treatment, more diverse treatment populations (including groups other than heroin users, such as people dependent on pharmaceutical opioids), less crime and possibly better treatment retention, but it may also result in increased levels of medication injection among both in- and out-of-treatment populations.

4.1. Limitations

Each data source utilised herein has its strengths and limitations, and small sample sizes have limited statistical power. Despite utilising cross-sectional surveys, comparison of the PWID and OST client data indicates consistent trends in OST medication injection. Data collection was based in three major cities; the patterns of drug use and reported rates of adherence may differ in remote or rural areas where access to OST is limited or other cities with different OST policies.

Evaluating the clinical benefits that may be unique to the BNX film formulation (cf. BNX tablets), such as fewer poisonings involving children, or improved efficiencies of supervised dosing, was outside the scope of the present studies.

4.2. Conclusions

At this time, there is no evidence that the BNX film is superior to the BNX tablet in reducing non-adherence and diversion. A minority of PWID, both among those receiving formal OST and those *not* receiving formal OST, reported recent injection of BNX film, despite its agonist–antagonist formulation and its enhanced mucosal adhesion in the context of supervised dosing. Our studies indicate that in 2012, under usual dosing (i.e., non-trial) conditions, the percentage of BNX film clients who removed their supervised doses from the dosing site was not different from that for the other forms of buprenorphine. There is a need to develop ways to better assess suitability for unsupervised dosing, and to better understand how to improve compliance with best practice supervised dosing (at both a client and staff level). There may also be a need to accept that some diversion will occur that the current clinical delivery methods cannot control; similar problems affect the extra-medical use of other pain and psychotropic medications. However, these problems need to be weighed against the clear benefits to the patients and the community of supplying OST medications to those in need.

Role of funding source

These studies were funded by Reckitt Benckiser by way of an untied educational grant. This study's design, conduct and interpretation of findings are the work of the investigators. The funder played no role in the conception or writing of this paper.

Contributors

BL undertook the analyses and wrote the first draft of the paper. All authors contributed to the manuscript and approved the final version.

Conflict of interest

BL, LD and RPM have received untied educational grants from Reckitt Benckiser for the post-marketing surveillance of buprenorphine-naloxone tablets (2006–2008), the development of an opioid-related behaviour scale (2010). PD, NL and RA have also received untied educational grants from Reckitt Benckiser. All such studies' design, conduct and interpretation of findings are the work of the investigators; Reckitt Benckiser had no role in these.

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Appendix A. Supplementary data

Supplementary data associated with this article can be found, in the online version, at <http://dx.doi.org/10.1016/j.drugalcdep.2013.12.005>.

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THE HISTORY OF THE UNITED STATES

The first part of the book deals with the early years of the nation, from the time of the first settlers to the end of the Revolutionary War. It covers the period of the early colonial period, the struggle for independence, and the formation of the new government.

The second part of the book deals with the period of the early republic, from the end of the Revolutionary War to the beginning of the Civil War. It covers the period of the early republic, the struggle for a stronger central government, and the expansion of the nation.

The third part of the book deals with the period of the Civil War and Reconstruction, from the beginning of the Civil War to the end of Reconstruction. It covers the period of the Civil War, the Reconstruction era, and the struggle for civil rights.

The fourth part of the book deals with the period of the late republic, from the end of Reconstruction to the beginning of the Progressive Era. It covers the period of the late republic, the Progressive Era, and the struggle for reform.

The fifth part of the book deals with the period of the Progressive Era and the early 20th century, from the beginning of the Progressive Era to the end of the First World War. It covers the period of the Progressive Era, the First World War, and the struggle for reform.

The sixth part of the book deals with the period of the interwar years, from the end of the First World War to the beginning of the Second World War. It covers the period of the interwar years, the First World War, and the struggle for reform.

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The eighth part of the book deals with the period of the Cold War and the late 20th century, from the end of the Second World War to the end of the Cold War. It covers the period of the Cold War, the late 20th century, and the struggle for reform.

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Maryland Heroin and Opioid Task Force Regional Summit
The Role of Private Insurance in the Overdose Crisis:
Enforcing the Parity Act Will Expand Access to Treatment Services
April 15, 2015

My name is Alisha Ellis and I am a student attorney in the Drug Policy and Public Health Strategies Clinic at the University of Maryland, Francis King Carey School of Law. The Clinic's mission is to expand access to health services for persons with substance use disorders and to fight discrimination faced by these individuals because of their disability. Alcohol and drug overdose deaths in Maryland have increased every year since 2010, among families of all socio-economic backgrounds, despite the fact that more Marylanders than ever have access to insurance coverage. Private insurance carriers have a major role to play in Maryland's response to the overdose epidemic by ensuring that consumers can access the substance use and mental health treatment services that by law must be included in every commercial policy offered in the state. Strong enforcement of the Mental Health Parity and Addiction Equity Act (Parity Act), a law that addresses long-standing insurance discrimination against persons with behavioral health conditions, is essential to ensure that persons at risk of overdose receive timely and adequate treatment.

When Maryland consumers purchase private insurance plans, they should be confident that they will be able to access care when they need it, whether that care is for a medical condition or a substance use disorder. Yet consumers face significant barriers when attempting to access behavioral health services through their private insurance, including limited or non-existent networks of drug treatment providers and frequent denials of authorization for higher levels of medically necessary treatment. Providers also report barriers, including lengthy delays or outright denials when seeking admission to private insurance panels, despite long waiting lists of patients who need their care, as well as non-negotiable reimbursement rates far below those in the Medicaid program. As a result of these obstacles, individuals who need drug treatment are often counseled to apply for Medicaid, even if their families are paying for private health insurance. Others are simply unable to access care. An untreated substance use disorder, like any chronic condition, will lead to an acute medical crisis, and individuals who cannot access appropriate treatment seek care in emergency departments and far too many lose their lives to overdose. The cost of these preventable emergencies burdens not only the consumers themselves, but their families and the entire health care system.

The federal Parity Act bars private insurance plans from discriminating against individuals with mental health or substance use disorders from imposing more restrictive financial requirements, treatment limitations and medical management and plan design standards on behavioral health benefits compared to medical benefits. Since January 1, 2014, all commercial health plans sold in Maryland have been required to comply with the Parity Act. Proper enforcement of the Parity Act is one way to ensure that consumers will be able to access the substance use treatment services they expect to get and are paying for.

Full implementation of the Parity Act is a critical step in the process of addressing the overdose epidemic in Maryland. The Clinic recommends that the Task Force:

- **Include the Maryland Insurance Administration in the State's Coordination Efforts:** The Maryland Insurance Administration (MIA) should be a member of the Inter-Agency Heroin and Opioid Emergency Coordinating Council. Just as the Inter-Agency Council includes the Department of Health and Mental Hygiene, the agency responsible for the publicly funded behavioral health system, it must also include the MIA, which has authority to approve private insurance plans for sale and investigate compliance with insurance standards including the Parity Act. The MIA must be fully integrated into the State's efforts to combat the overdose epidemic in order to address the needs of Marylanders with private insurance coverage.
- **Transparency in Private Health Plan Coverage:** Insurance carriers must provide the MIA with all of the plan information the agency needs to enforce Parity Act standards. Although the MIA has begun to review financial requirements and treatment limitations, it does not receive information about key plan design features that limit access to care before approving plans for sale. Without these disclosures, Maryland consumers cannot know whether the plans that they buy comply with federal law. We recommend that the Task Force work with the MIA and the General Assembly's new Joint Committee on Behavioral Health and Opioid Use Disorders to ensure that the State evaluate private insurance plans for compliance with the Parity Act before they are sold in Maryland.
- **Enhanced Enforcement of the Parity Act:** The Consumer Protection Division of the Office of the Attorney General should work with the Maryland Insurance Administration to ensure full compliance with the Parity Act. The State cannot rely on private insurance companies to regulate themselves. These entities have repeatedly resisted even modest efforts to demonstrate compliance with the Parity Act, even though federal law bars the sale of plans that do not meet these non-discrimination standards. While the MIA and the Attorney General's Health Education and Advocacy Unit work with consumers who file individual complaints, a complaint-driven process unfairly places the burden for enforcing federal law on the shoulders of consumers. We recommend that the Attorney General work with the Insurance Commissioner to determine how their agencies can use their powers of investigation and oversight to ensure systemic compliance with the Parity Act.

With more than 100,000 Marylanders newly covered by Qualified Health Plans through the State Exchange, private insurance has a larger role than ever in the fight to end the overdose epidemic. The Parity Act is a critical tool for families struggling with substance use disorders to get the care they need. Ensuring that health plans comply with the Parity Act will reduce health care costs, improve access to drug treatment, and ultimately reduce overdose deaths.

Thank you for considering our recommendations.

For additional information or assistance, please contact Alisha Ellis (Alisha.Ellis@clinic.law.umaryland.edu), Michael Curto (Michael.A.Curto@clinic.law.umaryland.edu) or Ellen Weber, Supervising Attorney, (eweber@law.umaryland.edu) (410-706-5090) at the University of Maryland Carey School of Law, Drug Policy Clinic.

Addiction is more similar to a chronic medical condition, such as diabetes or hypertension than it is to an acute illness.

Substance use disorders and chronic diseases share similar characteristics. Like many chronic medical conditions, both initial use of a substance and recovery from addiction involve choice. This does not mean that people choose to become addicted. Rather, addiction and other chronic conditions are a consequence, at least in part, of the choice to try drugs, to eat unhealthy foods, and/or to be sedentary (other factors, such as genetics, also play a role) (Satel & Lilienfield, 2014). In addition both addiction and chronic diseases are characterized by "...prolonged duration, intermittent acute and chronic exacerbations, and substantial morbidity and mortality (O'Connor, 2013, p. 1132). The "intermittent acute and chronic exacerbations" can be explained by the fact that classically conditioned cues (i.e., people, places, and things), which have become strongly associated with substance use, elicit cravings, strong urges to use, and drug-seeking (Satel & Lilienfield, 2014). This classical conditioning is particularly problematic in opioid dependence. Withdrawal, which is a highly aversive state, becomes classically conditioned to a myriad of environmental cues. Contact with these cues reactivates withdrawal memories, thereby leading to drug-seeking and relapse among abstinent individuals (Frenois et al., 2008). Finally, McLellan et al., (2000) found similar rates of compliance with treatment recommendations (i.e., medication consumption and lifestyle changes) and of symptom recurrence (i.e., relapse) at 1 year follow-up between substance use disorders and other chronic illnesses (approximately 40 to 60% for substance use disorders; 30 to 50% for type I diabetes; 50 to 70% for hypertension, and 50 to 70% for asthma) (NIDA, 2012).

Addiction is more similar to a chronic medical condition than it is to a brain disease, such as schizophrenia and alzheimer's.

True brain diseases, such as schizophrenia and Alzheimer's disease develop irrespective of the individuals' behavior and persist despite the sufferer's desire to improve. While the brain disease model has reduced stigma associated with having an addiction, it is also responsible for the medicalizing of addiction. In other words, this framework has led to the prioritization of biological over other treatments despite the myriad of research demonstrating the efficacy of psychosocial interventions (Satel & Lilienfield, 2014).

It is not necessary to have stricter standards for clinical judgment in addiction treatment than we do for treatment of other chronic conditions.

Type II Diabetes is similar to addiction in that it is, in part, a result of lifestyle choices (i.e., unhealthy diet; failure to exercise) and can be addressed through a combination of lifestyle changes and medication. Clinical practice guidelines for Type II Diabetes suggest that lifestyle changes are the foundation of any effective treatment. However, lifestyle changes alone will be insufficient in most cases to achieve glycemic control and therefore medication is also recommended. (USDHHS AHRQ, 2013). While there are general guidelines regarding when, what, and how much medication to prescribe, clinical judgment is ultimately required to make these decisions.

Medication Assisted Treatment (MAT) with methadone or buprenorphine is not switching one addiction for another; this assumption comes from equating physical dependence with addiction

Physical dependence (characterized by tolerance and withdrawal) is a biological process that allows the body to adapt to the presence of a substance. Even when taken as prescribed, people can develop physical dependence on prescription medications; this does not mean that they are addicted to this medication, however. Physical dependence is only one aspect of addiction. Addiction also includes impairment in social, emotional, and

occupational functioning, difficulties in stopping despite a desire to do so, and continued use despite negative consequences (NIDA, 2005; Satel & Lilienfeld, 2014) While it is true that patients taking methadone and/or buprenorphine will experience physical dependence, these medications also help to reduce the social, emotional, and behavioral problems that are characteristic of an addiction.

There are more benefits associated with the use of Suboxone than risks

Suboxone is a highly effective MAT for treating heroin addiction. Buprenorphine maintenance has been shown to be as effective as moderate doses of methadone (Ling & Wesson, 2003). However, because some studies have shown it to be less effective than higher doses of methadone, it may be that methadone is the treatment of choice for individuals with higher levels of dependence (SAMHSA 2014). It was noted that greatest efficacy was achieved when doses of 8 mg or higher of buprenorphine were used though some patients experience symptom relief with very low doses. (Ling & Wesson, 2003) In addition to having a favorable impact on treatment retention and drug use, buprenorphine, combined with psychosocial counseling was associated with improvements in health-related quality of life such as vitality, social functioning, physical, emotional, and bodily pain (Raisch et al., 2011).

Two other benefits of buprenorphine have been noted. First, because it is a partial agonist, the risk of overdose death due to respiratory depression is lower than with full agonists. Second, the buprenorphine/naloxone combination tablet (Suboxone) was developed to reduce diversion. Specifically, naloxone is ineffective when taken sublingually but becomes bioavailable when the tablet is crushed and prepared for injection. Because naloxone is a full antagonist, it will block the euphoric effects of buprenorphine and will trigger withdrawal. As such, reports suggest that Suboxone can be administered with less oversight due to the decreased risk of diversion (Lobmaier et al., 2010).

Although the general consensus is that buprenorphine has few iatrogenic effects (Lobmaier et al., 2010), there have been a few reports of risks associated with buprenorphine administration.

Serotonin Syndrome. A published case study linked non-prescribed suboxone consumption with serotonin syndrome in a 54 year old man who was taking a tricyclic antidepressant (Isenberg, Wong, & Curtis, 2008). Moreover, in a presentation to the American Academy of Addiction Psychiatry, it was reported that 43% of patients taking suboxone demonstrated at least mild serotonin syndrome (Lowry, 2012). However, both reports indicated that buprenorphine by itself is unlikely to trigger serotonin syndrome. Rather, the risk of serotonin syndrome is increased when buprenorphine is administered in combination with medications that increase serotonin (e.g., SSRI's; Tricyclic antidepressants).

Death due to Respiratory Depression. Some early studies in France showed an increased risk of death due to respiratory depression when patients combined buprenorphine with high doses of central nervous system depressants such as alcohol and benzodiazepines (Raynaud et al., 1998; Tracqui et al., 1998).

These risks can be mitigated by carefully reviewing all medications that an individual is taking as well as carefully screening for alcohol and benzodiazepine use before, and while, prescribing buprenorphine.

BEST PRACTICE RECOMMENDATIONS FOR TREATING OPIOID ADDICTION

Screening, Brief Intervention, and Referral to Treatment (Powers et al., 2005)

Screening for the presence of a substance use disorder, using validated measures, in both mental and primary care settings is critical for identifying individuals who can benefit from addiction services. Those identified as

being at risk for having a substance use disorder should receive a brief intervention targeted toward determining appropriate levels of care and referral to treatment (Powers et al., 2005).

One such brief intervention with empirical support is the FRAMES technique. FRAMES stands for (1) Feedback, in which the client is given personally relevant feedback about the effects of their substance use on their health, etc; (2) Responsibility, in which clinicians recognize and acknowledge the client's autonomy to make choices about what s/he does, or does not do, about his/her addiction; (3) Advice, in which the clinician provides clear advice about the need to discontinue use; (4) Menu, in which the clinician provides the client with a list of options for helping him/her discontinue use; (5) Empathy, in which the clinician demonstrates an understanding of the client's thoughts and feelings about his/her use and any feedback s/he has been given, and (6) Self-efficacy, in which the clinician attempts to help the client feel confident about his/her ability to make the necessary changes (Center for Substance Abuse Treatment, 2012a).

Involvement in Evidence-Based Behavioral Treatments (NIDA et al., 2005; Powers et al., 2005)

Both the National Quality Forum (NQF) and the National Institute on Drug Abuse recommend that drug addicted individuals be treated using evidence-based approaches which include: (a) motivational interviewing; (b) motivational enhancement therapy; (c) cognitive behavioral therapy; (d) family and couples therapy (consistent with findings that social support enhances treatment outcomes); (e) contingency management; (f) community reinforcement approach treatment; and (g) twelve-step facilitation.

Contingency management, which uses principles of operant conditioning, specifically positive reinforcement [application of a positive stimulus] and negative punishment [removal of a pleasant stimulus], is a highly effective intervention for treating opioid addiction.

In a meta-analysis of specific behavioral therapies, Pearson et al. (2012), found a strong positive effect for Contingency Management (CM) interventions. Another meta-analysis by Prendergast et al (2005), which examined controlled trials of CM, found large effect sizes for CM when targeting opiates and moderate effects when targeting multiple drugs.

Contraindicated Treatment Approaches. In addition to listing a number of evidence-based approaches, the NQF (Pearson et al., 2012) identified several contraindicated treatments for addiction. These include: (a) Acupuncture, relaxation training, psychoeducational groups, or simple drug screening as standalone treatments; (b) Detoxification as a standalone intervention; (c) Individual psychodynamic psychotherapy; (d) Unstructured group therapy; (e) Confrontation as a treatment approach; and (f) Treatment discharge due to ongoing drug use or relapse.

While detoxification should not be considered a treatment by itself, it may serve several important functions. First, detoxification may present an opportunity to transition patients into longer-term treatment (Katz et al., 2011). It may also serve to reduce use and related harms (e.g., criminal activity and needle-sharing) (Diaper et al., 2014).

Medication Assisted Treatment (MAT)

In addition to evidence-based behavioral therapy, the NQF also recommends that MAT should be considered for any individual who reports opioid use (Powers et al., 2005); however, not all individuals who report using opioids will need MAT. Federal guidelines regarding the use of opioid maintenance therapies (OMT) were initially published in 2005 and most recently revised in 2012 (Center for Substance Abuse Treatment, 2012).

These guidelines suggest that certain users are not good candidates for opioid pharmacotherapy. (1) Individuals whose opioid use does not meet criteria for an opioid dependence diagnosis (as defined using DSM IV-TR) with two exceptions; pregnant women and offenders being released from incarceration who are at high risk from relapse. Since these guidelines were published, DSM 5 was released and the distinction between abuse and dependence has been eliminated. As such, the criteria for using MAT may need to be adjusted to include those individuals who show evidence of severe physical dependence on opioids (i.e., tolerance to the drug and withdrawal when abstinent) and a high risk of relapse if MAT is not used. (2) Individuals who report less than one year of opioid use and no prior treatments for opioid addiction. These individuals might benefit from a medically-assisted detoxification, however, if their withdrawal symptoms are sufficiently severe that they are at risk for early treatment termination and relapse. (3) Individuals who cannot make it to the clinic on a regular basis for medication dosing although this is less of an issue for patients who are receiving Office-Based Opioid Treatment with buprenorphine. (4) Individuals with a history of allergic reactions to synthetic opioid agonists such as methadone.

A number of medications are available for the treatment of opioid addiction including methadone, buprenorphine, and naltrexone. Evidence supports the efficacy of methadone maintenance for encouraging retention in treatment and producing reductions in heroin use. Buprenorphine, at moderate to high doses, has also been shown to increase retention and reduce heroin use effectively. In general, outcomes for buprenorphine and methadone are comparable. More research needs to be done on the efficacy of naltrexone. While buprenorphine was found to be superior to oral naltrexone, results are promising for sustained-release naltrexone (Lobmaier et al., 2010).

Anesthesia-assisted rapid opioid detoxification (AAROD) is NOT recommended

Government agencies and professional societies, including the American Society of Addiction Medicine, have recommended against using AAROD in clinical settings (ASAM 2005). Research has shown that AAROD is no more effective than other approaches to detoxification (Diaper et al., 2014) and it is dangerous. For example, of 75 patients who underwent AAROD between Sept. 2011 and 2012, 2 died and 5 others experienced serious adverse events (Centers for Disease Control and Prevention, 2012). Collins et al., (2005), in a study which compared AAROD to buprenorphine or clonidine-assisted detoxification, found that 8.6% of patients undergoing AAROD experienced a serious adverse event. Given similar efficacy, it is recommended that safer detoxification methods (i.e., with buprenorphine, methadone, or clonidine) should be used.

Effective opioid-addiction treatment provides comprehensive services and matches treatment to individual client's needs

Although some preliminary evidence has supported the efficacy of integrated primary medical care and addiction treatment, a randomized controlled trial of chronic care management as compared to standard primary care for substance use disorders failed to show any significant differences between groups in abstinence from opioids, addiction severity, health-related quality of life, or drug problems (Saitz et al., 2013). O'Connor (2013) concludes that this does not rule out the efficacy of chronic care management for addiction. He argues that several factors might have influenced the outcomes including the severity of addiction of included participants as well as the way in which chronic care management was implemented in this study (i.e., through a primary care medical center). Thus, additional research is needed before we can make any conclusions about the efficacy of a chronic care model of treatment for addiction (O'Connor, 2013). Having said that, research does suggest that effective opioid-addiction treatment include psychosocial interventions, social services, medical

and mental health care, and pharmacotherapy. Moreover, because each opioid-addicted patient is different, treatment should be tailored ideographically to each individual's specific set of needs (Pearson et al., 2005).

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I thought that maybe I would tell you what I know about private treatment providers not being included in the numbers before the May meeting.

Back about 13 years ago I was at a meeting at ADAA when Dr. Peter Luongo introduced the HATS System (I believe it is now known as the SMART System). This is the system that gathers all the information from providers.

At that time the private providers were included. That was before there were so many private doctors were involved in treatment. I am not sure why they are no longer included, but I can tell you why the private providers did not want to participate.

Whenever the state would update their system, the private provider would have to pay to update his system so as to be compatible with the state.

Private providers that do not receive state money have the attitude that they should not have to take their time and their employees time to participate in SMART. Not a good attitude.

Even though the patient's name was not on the report, it did require their social security number. So no real anonymity. Many felt that this was against HIPPA and the patient's themselves felt that it was an invasion of privacy. I can understand that completely, but I also understand the reason for the social security number. This way ADAA would not count someone more than once who was receiving different services. I am not sure how to resolve this issue.

Last, even though the form that the state required was not hard, it was very time consuming. The form needed to be filled out when each patient came in and again when they left or completed treatment. I think if there was a basic form once a month that asked how many patients, their ages, sex, drug of choice and zip code, that would simplify the form and be less time consuming.

I would like the private providers numbers to be included, but I am not sure what the solution is.

From Linda
Williams
4/14/15

Todd Gardner
Chief Operating Officer, Ameritox

Prepared testimony for the
Maryland Heroin and Opioid Emergency Task Force

April 15, 2015

My name is Todd Gardner and I am the Chief Operating Officer of Ameritox. Headquartered in Baltimore, our mission-driven company was formed to provide solutions for the growing problem of prescription painkiller misuse and abuse. Our laboratory in Greensboro, NC, provides urine drug testing and analysis as part of a medication monitoring program for physicians and clinicians treating patients who suffer from chronic pain. Our 800 employees work with medical professionals and hospitals across the country to help assess whether patients are taking their prescribed medications correctly and to identify potential misuse, abuse or diversion of medications.

I thank the Task Force for giving me the opportunity to discuss how we can address the challenges of prescription opioid and heroin abuse, which present significant medical, economic and law-enforcement issues. The work of this Task Force is urgent and we applaud Governor Hogan and Lt. Governor Rutherford for meeting this epidemic head on.

According to Ameritox data and analysis, Maryland is among the 10 worst states in the nation for prescription opioid misuse and abuse, and illicit drug abuse. Ameritox processed more than 16,000 samples from patients residing in the state in 2014, many of which were collected from the Baltimore Metropolitan Statistical Area. The results of these tests showed two major problems: First, nearly half – 48.4 percent – of the samples contained a drug that was not prescribed by the doctor who ordered the test. Second, 20 percent of the samples contained an illicit drug. Heroin was included in the panel of illicit drugs for which we tested.

Clearly, prescription drug abuse in this state has reached a critical level.

Background

In the 1980s and 1990s, Vicodin, OxyContin, Percocet and other prescription painkillers gained wide use in the U.S. These opioids were designed to mimic the body's own natural painkillers and ease short-term acute pain typically occurring after a surgery, on-the-job accident, or other traumatic event.

By 2012, health care providers were writing more than 250 million prescriptions for opioids each year – enough for every American adult to have their own bottle of pills.¹ Also by this time, opioid abuse was spiraling out of control.

The most recent national estimates from 2013 reveal that 4.5 million American teens and adults report using prescription painkillers for non-medical purposes.² And the number of unintentional overdose deaths from prescription painkillers has quadrupled since 1999.³

The proliferation of prescription opioids and the always-looming specter of incorrect or illicit use of these medications were the reasons Ameritox was launched as a company. Ameritox test results confirm others' assessments concluding that rampant prescription opioid misuse and abuse is a catalyst for Maryland's heroin abuse epidemic.

The evidence linking the increase in non-medical use of prescription opioids and heroin abuse in the United States is now impossible to ignore. A generation of Americans has been accustomed to being prescribed painkillers for everything from chronic back and knee pain to wisdom tooth extraction.

Many of the hundreds of millions of active prescriptions for opioids are part of long-term treatment for these patients – far longer than a short-term prescription to relieve pain.

Getting patients weaned off long-term use of powerful medications is difficult and many patients suffer from withdrawal and a physical need to achieve the same level of comfort. With an 80mg pill of OxyContin going for \$80 on the black market,⁴ and heroin going for about \$3 per use, it's easy to see why so many turn to heroin abuse.

Identifying Communities at Greater Risk

¹ "Opioid Painkiller Prescribing." *Centers for Disease Control and Prevention*. Centers for Disease Control and Prevention, 01 July 2014. Web. 10 Apr. 2015.

² Substance Abuse and Mental Health Services Administration, Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

³ *America's Addiction to Opioids: Heroin and Prescription Drug Abuse* (2014) (testimony of Nora D. Volkow, M.D. before the U.S. Senate Caucus on International Narcotics Control). Print.

⁴ Dasgupta, Nabarun et al. "Crowdsourcing Black Market Prices For Prescription Opioids." Ed. Gunther Eysenbach. *Journal of Medical Internet Research* 15.8 (2013): e178. *PMC*. Web. 13 Apr. 2015.

Beyond our work with the chronic pain community, Ameritox is working to address the relationship between chronic pain and serious mental illness. Through its 2014 launch of Ingenuity Health, a medication monitoring service for patients prescribed antipsychotic medications, we are better able to assess the behavior of this community. Our data show that patients using opioids like oxycodone for chronic pain are also frequently prescribed antipsychotic medications to treat depression and other mental health conditions.

Ameritox also recently acquired PRIUM, a service focused on preventing and eliminating stagnating workers' compensation claims. PRIUM is a peer-review program that works with clinicians after identifying potential prescription opioid fraud, misuse and abuse in workers' compensation cases.

We believe that specific outreach should be made to doctors who deal with patients receiving workers' compensation. Workers' compensation claimants are at a higher risk for misuse and abuse because many are not treated by pain specialists and may be on prescribed dosages that exceed recommended limits.

Data Suggest Strong Links Between Prescription Misuse or Abuse and Heroin

Data from the Substance Abuse and Mental Health Services Administration (SAMHSA) indicates that four out of five heroin users abused prescription drugs first.⁵ A 2014 study by JAMA Psychiatry found that 66 percent of heroin users had abused both heroin and prescription painkillers in the past 30 days.⁶

Ameritox's study of patient samples also revealed a very concerning trend of testing positive for "drug cocktails" – combinations of powerful drugs. The samples testing positive for heroin were seven times more likely to also contain a non-prescribed synthetic opioid (such as Fentanyl or methadone) than samples that tested negative for heroin. And in 20 percent of cases, a sample that tested positive for heroin also tested positive for a sedative, such as Xanax or Valium; 19 percent of the time, a sample that contained heroin also contained cocaine. Drug cocktails using heroin are on the rise, giving the drug an even more deadly effect.

Lowering the Threat Level: How to Improve Responsible Medication Use and Decrease Use of Illicits

⁵ U.S.A. Department of Health and Human Services,. SAMHSA. *Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States*. By Pradip K. Muhuri. Web. <<http://www.samhsa.gov/data/sites/default/files/DR006/DR006/nonmedical-pain-reliever-use-2013.htm>>.

⁶ Kuehn BM. Driven by Prescription Drug Abuse, Heroin Use Increases Among Suburban and Rural Whites. JAMA. 2014;312(2):118-119. doi:10.1001/jama.2014.7404.

The state of emergency in Maryland is clear, but a path forward to reversing this epidemic must be multi-faceted. Law enforcement, public health officials, doctors, and patient advocates all largely agree, that preventing the misuse and abuse of opioids requires a multi-system approach – and cooperation from everyone.

Being part of the solution is at the core of our mission and drives every part of our business. After many conversations with members of the communities we serve, we believe there are two initiatives that could significantly strengthen Maryland's fight against opioid abuse.

Promoting the Value of Medication Monitoring

Adherence to a prescription can only be ascertained through medication monitoring. Once medication abuse is determined, a physician or clinician can employ an informed plan of action for the patient. Without knowing what is happening to the OxyContin, Percocet, or Vicodin after a doctor writes a prescription, painkiller misuse and abuse will not subside.

Urine drug monitoring for those being treated with opioid therapy long-term (more than three months) has become a standard of clinical care. In 2009, the American Academy of Pain Medicine and the American Pain Society recommended such monitoring for patients on chronic opioid therapy.

Monitoring can be used at the clinical and epidemiological level. It provides a clear window into whether a patient is taking the medications he or she has been prescribed, and if the patient is taking any other drugs. In addition, public health officials can use anonymous medication monitoring data to understand and analyze diversion and drug trafficking trends, broken down by county and demographics such as sex, age, and ethnicity.

The most valuable impact of monitoring can be seen at the patient level, where volatile drug combinations, and even overdose are risks. For example, a 79-year-old woman, being treated by a physician working with Ameritox, received the same Vicodin prescription for years to ease the pain of severe osteoarthritis and chronic shoulder pain.

Last year, she requested that her physician write her a higher dose of Vicodin and some additional "painkillers" for her "really bad days." Her physician decided to test her urine. The results showed that the woman was not taking her medication as prescribed – she was taking only a few pills each month.

The physician confronted the patient, who broke down and stated that she had only been taking only the bare minimum amount of medication to "get by." Her recently divorced, unemployed son had moved in with her and had been acting as her primary caregiver. She shared with her doctor that her son was under financial

stress and had been selling the majority of her Vicodin tablets in order to cover his alimony, child support, and mortgage payments.

Had her doctor not run the urine test, he might have prescribed additional pain medications. Doing so would have contributed further to the epidemic of prescription opioid diversion and abuse while doing nothing to properly treat the patient.

Education Outreach

A second critical area of potential action is in the area of formal training in the practice of pain management. It is a medical specialty, but most doctors who prescribe pain medications, including general practitioners, orthopedists, plastic surgeons, or dentists, do not receive this training.

We strongly recommend that such training be provided at the medical school level. Key topics should include appropriate dosage, risks associated with long-term use of opioids, responsible weaning techniques, and the threat of escalation to harder substances, such as heroin.

Tightening Supply Will Only Take Us So Far

We recognize as well that in addressing the epidemic of pain medication abuse, many policymakers will seek to address the issue of supply and access. Such efforts typically look at the problem within the criminal code, and seek to choke off supplies by prosecuting doctors and pharmacies who contribute to pain medication abuse. But in our experience, when the supply of legal pain medication is choked off to patients who are abusing or diverting their pills, they simply seek out alternative drugs such as heroin. The problem of abuse and misuse of pain medication may appear to go away, but the problem of drug abuse remains, and may get worse.

We agree that tighter regulations on pain prescriptions are a part of the solution, but they are only one part. What's also required is greater training for and support of medical professionals who work with patients in pain every day. We owe this community diagnostic tools and a greater understanding of the long-term impact of certain medications. Patients must be treated properly with the full benefit of modern medicine, so that they do not suffer and are given a chance at a life free from debilitating pain.

Conclusion

We want to share with the committee one final point: This work will require significant effort and many years. It will also require the input of many different individuals, organizations and companies.

Ameritox will happily play a significant role and contribute what we can to a solution. We will share our data and analysis with you and any other public body devoted to this issue. We are grateful for this opportunity to help shape Maryland's effort to stop the misuse and abuse of prescription opioids and heroin that have claimed so many lives of our neighbors.

Thank you Mr. Chairman and the esteemed members of the Heroin and Opioid Emergency Task Force:

My name is David Byram and I am the VP, Managed Markets and State Government Affairs at Orexo. Orexo is the manufacturer of a proprietary buprenorphine / naloxone compound product – Zubsolv – approved for the maintenance treatment of opioid dependence but different from legacy products because its unique delivery system allows it to achieve the same clinical results with significantly less buprenorphine. I am pleased to have this brief opportunity to share with you our recommendations and concerns around the expansion of treatment with buprenorphine products to address the current opioid epidemic affecting the state of Maryland and its impact on quality treatment.

In the hands of skilled physicians and motivated patients, buprenorphine/naloxone products have and will continue to save countless lives – returning patients to their loved ones as functioning members of society and capable of transforming addicted patients from dependents of the state to contributing members of the community and tax base. In fact, it has been demonstrated that maintenance treatment for a period of one year retains 75% of patients vs. 0% in those that receive only a brief buprenorphine taper (Kakko, et al. Lancet. 2003 Feb 22; 361(9358):662-8).

Despite the great advancement that buprenorphine has brought to the treatment of opioid addiction, there is a “black cloud” around this medication that is being driven by diversion and misuse coupled with widely varied prescribing patterns, inconsistent toxicology screening, and other unique challenges inherent in effectively managing patients with addiction. These conditions have combined to yield a significant rate of buprenorphine diversion – putting this efficacious medication at risk while robbing the state of precious dollars that could be better invested to address this epidemic.

Diversion is costly to Medicaid programs. In recent actions undertaken by payers across the country within both employer provided insurance and Medicaid programs there has been a reduction of prescriptions between 20-40% when medications with a known street value are removed from coverage and reimbursement. This has been documented initially with the introduction of full agonist opioid abuse deterrent formulations and most recently with partial agonist/antagonist medications. In addition, a reduction of this magnitude could positively impact the rising unintended pediatric exposures resulting from the opioid drug class and specifically previous formulations of buprenorphine. The opportunity is to achieve similar clinical results without compromising both public health and public safety should be a major goal of this opioid addiction treatment expansion. For a state like Maryland that spends roughly \$22 million annually for buprenorphine at wholesale acquisition cost this represents a potential loss of between \$4.5 - \$10 million to the illicit drug market that could be invested in treatment for patients committed to recovery and prepared to take personal accountability for change.

A major concern has been the growing level of diversion surrounding legacy tablet and film formulations as documented in various Maryland media communications identifying not only seizures by law enforcement but also seizures within correctional facilities. In fact, the Baltimore Sun highlighted these concerns in an extensive expose on this and other issues nearly six years ago – and from what we see, the diversion of the previous formulations since that expose has not abated.

In recent academic research articles by Cicero et al, Factors contributing to the rise of buprenorphine misuse: 2008–2013. *Drug Alcohol Depend.* (2014) and B. Larance et al. / *Drug and Alcohol Dependence* 136 (2014) 21–27 – the authors support and acknowledge the benefits of Buprenorphine therapy but also point out the need for a focus on the delivery of accountable office based opioid addiction treatment. I have included the seminal studies with my testimony.

Perhaps the most critical difference between Zubsolv and other competitors in this market is that Orexo's patented technology enables a patient to gain the same clinical results with 29% less medication while maintaining a 4:1 buprenorphine to naloxone ratio. For those of us, without an addiction, the thought of obtaining equivalent clinical results from a medication using less active ingredient would be hailed as a treatment advancement. However, to an addicted individual – not fully dedicated to their recovery – the notion of less medication and the expected negative impact on the medication's non-medical value, has made Zubsolv an unpopular choice for patients who are seeking to divert buprenorphine products.

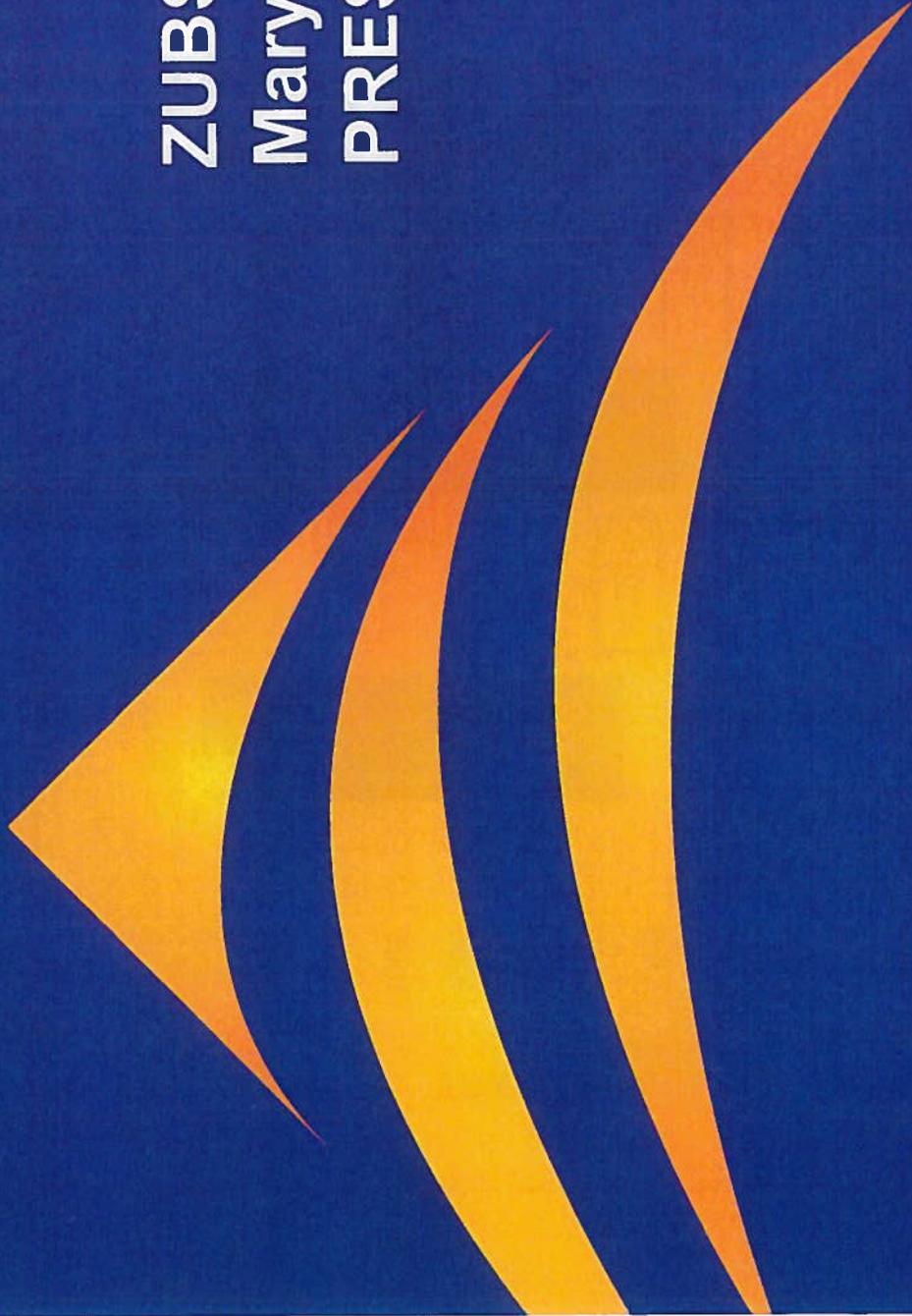
After the implementation of payer formulary actions, IMS data shows (and you can see from the documents provided) that anywhere between 23% and 40% of the buprenorphine prescriptions have "evaporated" with patients seemingly walking away from seeking Zubsolv from their plan – either dropping their "treatment" all together – or perhaps moving to other plans that will continue to provide them with the more valued, higher buprenorphine dosage forms. Further driving this phenomena are the unintended consequences of Zubsolv's menthol flavoring designed to mask the bitter taste of buprenorphine. While admittedly not studied in controlled clinical trials, individuals have reported an uncomfortable burning sensation when attempting to abuse the medication inter-nasally or intravenously. As an aside, the IMS claims data we shared, closely mirrors the estimated diversion of this drug in published studies such as *Why Buprenorphine Is So Successful in Treating Opiate Addiction in France*, M. Fatseas, MD, PhD, and Marc Auriacombe, MD.

That a level of diversion is occurring among this patient cohort is not necessarily unexpected. Indeed, it is safe to say that the vast majority of addicted patients have, as symptoms of their disease, diverted opiates. However, because of the stigma around this disease in addition to limited physician capacity, the statutory cap on patient treatment slots and the actions taken to close down opioid pill mills, an underground market has developed and continues to flourish that we believe propagates the diversion, misuse and abuse of buprenorphine products.

Maryland and its localities have long been in the vanguard of promoting quality buprenorphine treatment and been known nationally for its innovative approaches to treating addicted individuals. The state needs to continue to lead in addressing these issues and ensure our limited resources are well spent. To that end, we would encourage the state to work with Medicaid and other payers to increase their ranks of waived physicians to meet this epidemic. This includes greater focus on appropriate reimbursement for treating this disease, greater oversight of network capacity standards and a public physician recruitment campaign – all designed to further reduce the stigma around this disease while increasing treatment opportunities.

We know that Zubsolv can be a critical part of this effort as well. With a demonstrated ability to reduce waste and fraud due to the lower effective dose, 4:1 naloxone ratio and highest rated packaging around pediatric exposures we can collaborative ensure the state is in the best position to meet and ultimately quell this epidemic.

ZUBSOLV Maryland PRESENTATION

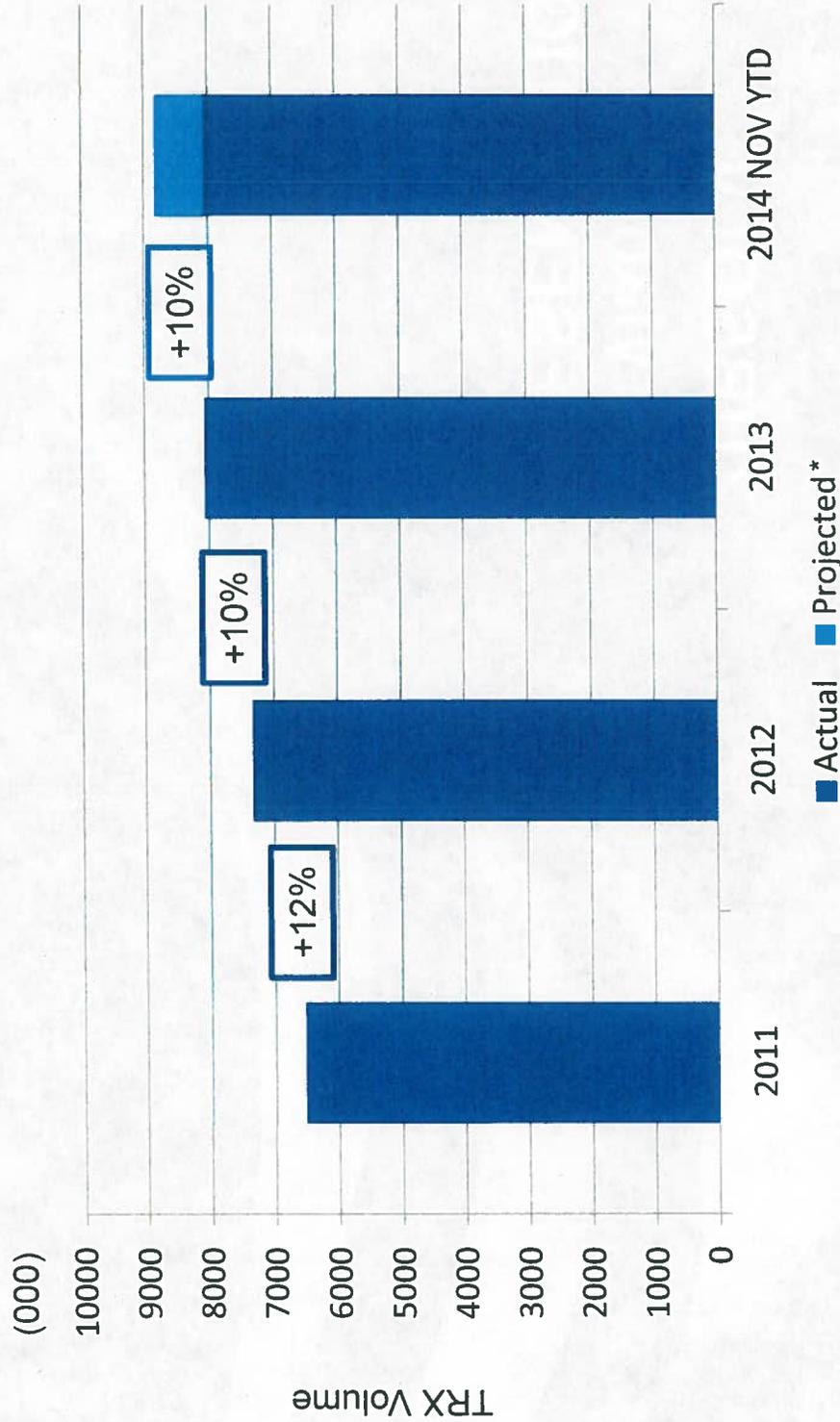


zubsolv
estraperone
and
maloxone)
C
buprenorphine and maloxone) C

orexo

BUPRENORPHINE CONTINUES DOUBLE-DIGIT GROWTH - VOLUME GROWTH STRICTLY INCREASED DOSING

Total Prescriptions – Yearly Trends



Source: IMS NPA

*Projection based on 2014 YTD growth rate

ZUBSOLV exclusive Buprenorphine therapy - Commercial Payer Formulary

- Top 3 National Health Plan : ~ 27% of buprenorphine category volume “evaporates” with ZUBSOLV category exclusivity
 - Evaporation is RAPID and SUSTAINED
 - Remaining Rx’s convert to ZUBSOLV
 - Patients experience similar clinical results with no increase in medical costs
 - Plan has reduced expenditures by over \$12M annually based solely on elimination of prescription volume prior to any rebate consideration

TRx Volume

Product	TRx's as reported by top 3 Commercial Plan on Rebate Claims												Last 3 Months
	14-Apr	14-May	14-Jun	14-Jul	14-Aug	14-Sep	14-Oct	14-Nov	14-Dec	15-Jan	vs 2Q14		
Zubsolv	147	295	616	5,323	6,289	6,282	6,553	5,789	6,642	6,390	1678.9%		
Suboxone Film	11,285	11,227	10,405	3,839	3,297	3,142	3,267	2,830	3,099	2,606	-74.1%		
buprenorphine/naloxone	1,782	3,051	1,717	1,274	607	590	518	444	501	413	-79.3%		
Totals	13,214	14,573	12,738	10,436	10,193	10,014	10,338	9,063	10,242	9,409	-29.1%		

Pre-Exclusivity Weekly Average = 2,851 TRx's



Post-Exclusivity Weekly Average = 2,227 TRx's

ZUBSOLV Exclusive July 1, 2014

Kentucky Care Study - Shift in Enrollment

Plan Name	KENTUCKY MANAGED MEDICAID ANALYSIS - OPIOID ADDICTION MEDICATIONS									
	Avg of weeks 11/7 thru 12/19					Avg weeks 1/9 thru 2/20/15				
	Avg TRX's/Week	Avg Sales/Week	Annualized Sales	% of State's Total	Avg TRX's/Week	Avg Sales/Week	Annualized Sales	% of State's Total	\$ Difference Annualized	TRX % change
Wellcare	2,410 \$	482,000 \$	25,064,000	51.1%	1,449 \$	289,800 \$	15,069,600	31.2%	\$ (9,994,400)	-39.9%
Passport	623 \$	124,600 \$	6,479,200	13.2%	1,096 \$	219,200 \$	11,398,400	23.6%	\$ 4,919,200	75.9%
Caresource	565 \$	113,000 \$	5,876,000	12.0%	986 \$	197,200 \$	10,254,400	21.3%	\$ 4,378,400	74.5%
Anthem	305 \$	61,000 \$	3,172,000	6.5%	398 \$	79,600 \$	4,139,200	8.6%	\$ 967,200	30.5%
Coventry	811 \$	162,200 \$	8,434,400	17.2%	711 \$	142,200 \$	7,394,400	15.3%	\$ (1,040,000)	-12.3%
Totals	4,714 \$	942,800 \$	49,025,600		4,640 \$	928,000 \$	48,256,000		\$ (769,600)	-1.6%

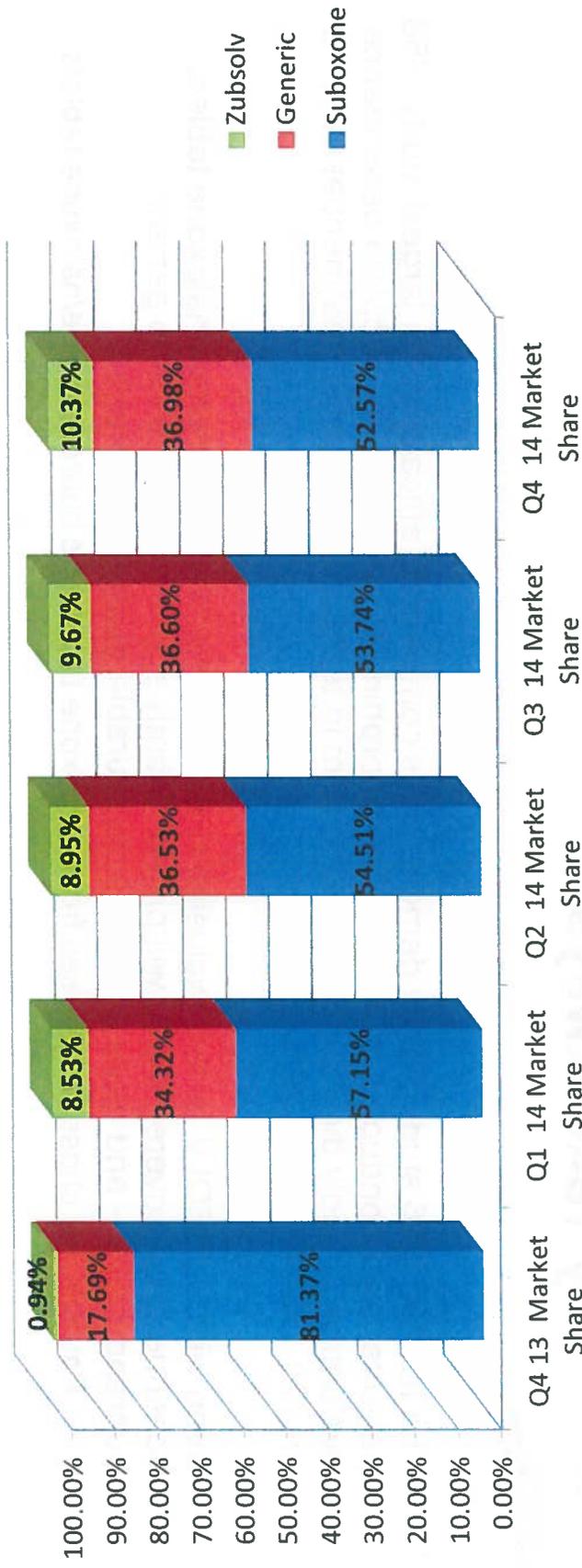
TRX's are IMS Plantrak and Sales are based off an avg TRX cost of \$200.

- Non-participating physicians actively told patients to switch to Managed Medicaid plans that continued to carry the Suboxone Film or generic tablets
- Wellcare has experienced a 25% disenrollment of patients due to the formulary decision
- To date, only 1 report of Zubsolv diversion in areas where accounts have implemented an exclusive Zubsolv formulary strategy
- To date, no reported increase in medical costs from payers that have implemented exclusive Zubsolv formulary coverage



ZUBSOLV exclusive branded Buprenorphine therapy - Pharmacy Benefit Manager Formulary

- Top 3 National PBM: ZUBSOLV brand exclusivity results in -
 - Patients chasing 8mg dose to generics
 - Minor market “evaporation”
 - Zubsolv’s lack of diversion value impacts patient behavior and demand



Key Take-Aways

- The ISTART/006 study clearly demonstrates comparable efficacy in the largest study (758 patients) ever conducted looking at Buprenorphine in the treatment of opioid dependence evaluating Zubsolv directly to Suboxone Film in terms of retention in treatment at days 15 and 22, COWS and SOWS scores.
- Even with ZUBSOLV as the exclusive brand, if generic buprenorphine/naloxone tablets continue to be covered share will predominantly shift from Suboxone to generic buprenorphine – and there will be no measurable market evaporation
 - Patients will chase 8mg doses from Suboxone to generic buprenorphine/naloxone tablets
- If ZUBSOLV is the category exclusive buprenorphine/naloxone product covered then:
 - Greater than 30% market volume (TRx) evaporation will occur
 - The market volume decline is rapid (within 8 -12 weeks) and sustained
 - Market share will convert to ZUBSOLV
 - No adverse consequences or adverse medical outcomes
- A ZUBSOLV category exclusive contract may result in significant managed care organization PMPY savings through reduced category spend and ZUBSOLV benefit share contract rebates



Effective Implementation of an Exclusive Zubsolv Contract

- The “WellCare model”
 - 6 Weeks from Implementation:
 - Plan sends letter to physicians on the pending change and interim policy
 - Formal notification sent to affected members
 - Plan shares list of pharmacies where members are currently obtaining their buprenorphine prescriptions allowing Orexo to restock those stores
 - 4 Weeks from Implementation:
 - Plan approves “Dear Pharmacist” letter sent by manufacturer to all pharmacies with a claim in the last 90 days supplemented by field staff visits
 - Final 2 Weeks from Implementation:
 - Plan utilizes State Pharmacy Directors to visit targeted high prescribers and in coordination with the manufacturer sales force, work to address any concerns the provider may have
 - First Week of Implementation, Going Forward:
 - Plan and manufacturer share data/information to address any and all outstanding issues that may develop.

NARCOTICS ANONYMOUS 2013 MEMBERSHIP SURVEY

At every NA world convention since 1996, NA World Services has distributed demographic surveys. In 2013, the survey was disseminated at the world convention which was held in Philadelphia, Pennsylvania. Additionally, this survey was available for members who chose to participate online and via mail and fax. With the high response that we received to the initial online survey, we made this available to our members for five months. There were 16,750 responses. We collect this data to provide information about our fellowship, strengthen our public relations efforts, and learn more about how and where we carry our message of recovery.

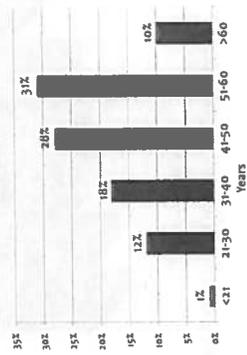
NA Membership

NA is composed of people who come from many races, cultures, age groups, professions, and backgrounds. The only requirement to become an NA member is the desire to stop using drugs. The decision to become a member in the NA Fellowship rests with the individual.

There are no annual dues or fees for membership. We are self-supporting through member contributions and the sales of recovery literature. NA is a community-based organization that holds more than 63,000 weekly meetings in 132 countries.*

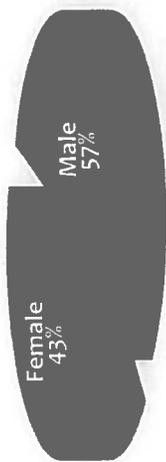
Age

Based on survey responses, the average age of NA members is 43.40 years



Gender

The gender composite changed from 2011. In that survey, 47% were female and 53% were males.



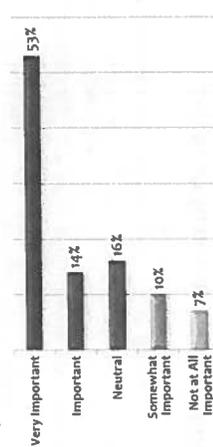
Ethnicity

The ethnic diversity of our membership seems to be correlated with geographic location; the 2013 survey was made available at WCNA in Philadelphia, Pennsylvania, in our international journal *The NA Way Magazine*, and on our website. When we conducted this survey in 2013:

- 76% of respondents were Caucasian,
- 13% were African-American,
- 5% were Hispanic,
- 2% were Asian,
- 1% was Indigenous, and
- 3% identified as multiracial.

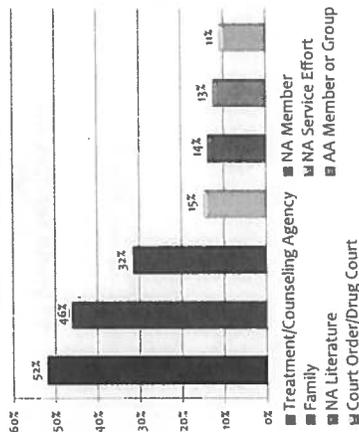
Illustrating how the ethnic breakdown of membership tends to be tied to geographic location, in 2011 in San Diego, California, 74 percent of respondents were Caucasian, 11 percent were African-American, 8 percent were Hispanic, and 7 percent were other.

Importance of First NA Meeting



Influence to Attend First NA Meeting

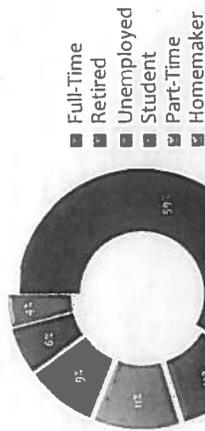
Multiple answers were permitted, only the top seven choices are shown.



Meeting Attendance

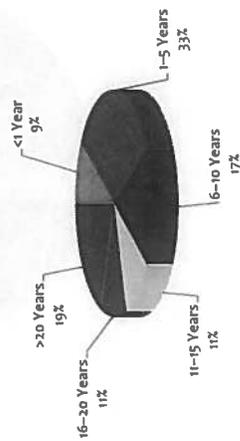
Regular attendance at NA meetings provides the opportunity to experience the NA message of recovery. Members surveyed attend an average of 4.79 meetings per week.

Employment Status



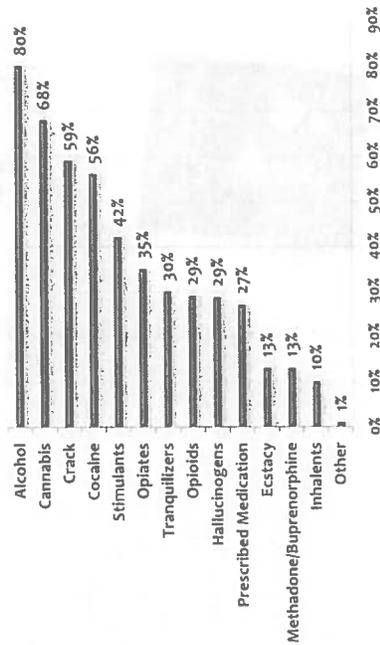
Years Drug-Free

Based on survey responses, the average length of cleantime in NA is 11.07 years.



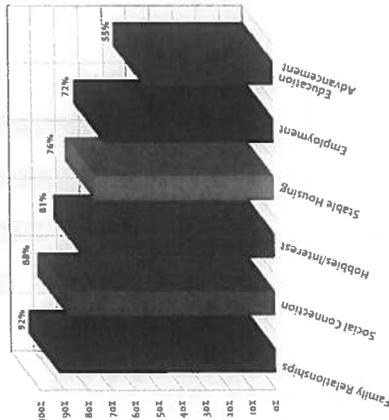
Drugs Used on a Regular Basis

Multiple answers were allowed.



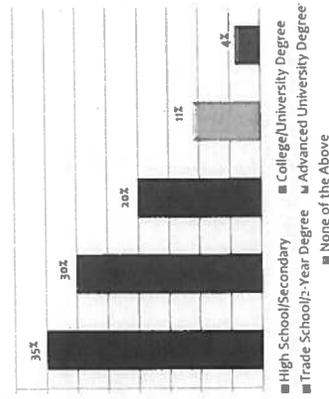
Quality of Life Improvement Areas

Multiple answers were allowed.



In 2013 the two areas that received overwhelming improvement with NA attendance were family relationships, where 92 percent of our members stated enrichment, and social connection, which was realized by 88 percent of the respondents. NA's literature states that active addiction is marked by increased isolation and destruction with relationships. Recovery in NA has helped survey respondents to repair the damage in their lives from drug addiction.

Educational Attainments of Members



About NA

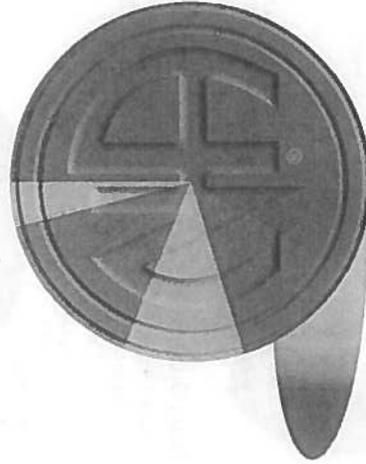
Narcotics Anonymous is a worldwide fellowship of recovering addicts whose primary purpose is to help addicts stop using drugs by utilizing a twelve-step approach. NA is not a religious organization and does not require any particular belief system. It teaches basic spiritual principles such as honesty, open-mindedness, and willingness, to name a few. The specific practical application of these principles is determined by the individual member.

NA members learn from one another how to live drug-free and recover from the effects of addiction. Although not associated with any religion, political group, organization, or institution, NA cooperates with professionals and the public by providing information about the fellowship.

In many communities, Narcotics Anonymous is listed in the white pages of the telephone directory. Another way to obtain local meeting information is by accessing the "NA Meeting Search" link at www.na.org. Questions about NA meetings in other countries or general information about the fellowship can be obtained by contacting NA World Services.



Membership Survey



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Item No. ZPR001001

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Mississauga, Ontario
Tel. +1 905 507 0100

World Service Office-IRAN
Tehran, Iran
Tel. +98(21)8868 1652
www.na-iran.org

ABOUT A.A.

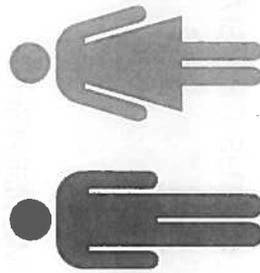
A.A. can be found almost everywhere, almost all the time – in more than 114,000 groups throughout the world. We welcome opportunities to cooperate with others who are providing help to alcoholics.

Look for A.A. in your phone book, newspaper or write to: Grand Central Station, Box 459, New York, NY 10163. General information is available on our Web site: www.aa.org

IN 2011 more than 8,000 A.A. members from the U.S. and Canada participated in a random survey of the membership. Such studies have been conducted every three to four years since 1968 by the General Service Office.

Alcoholics Anonymous conducts this survey to keep members informed on current trends in membership characteristics. The survey also provides information about A.A. to the professional community and to the general public as part of A.A.'s purpose to carry our message to those who still suffer from alcoholism.

GENDER OF MEMBERS



65%
Men

35%
Women

COMPOSITION OF MEMBERSHIP

White	87%
Hispanic	5%
Black	4%
Native American	2%
Asian	1%
Other	1%



A.A. PREAMBLE

Alcoholics Anonymous is a fellowship of men and women who share their experience, strength and hope with each other that they may solve their common problem and help others to recover from alcoholism.

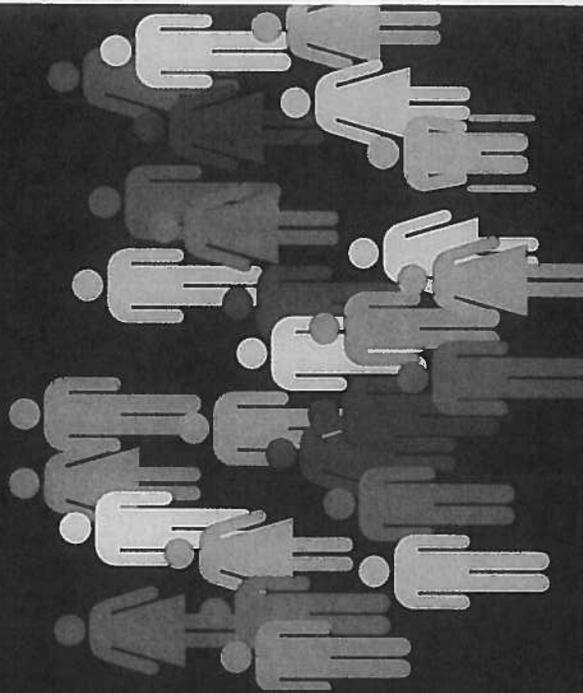
The only requirement for membership is a desire to stop drinking. There are no dues or fees for A.A. membership; we are self-supporting through our own contributions.

A.A. is not allied with any sect, denomination, politics, organization or institution; does not wish to engage in any controversy, neither endorses nor opposes any causes. Our primary purpose is to stay sober and help other alcoholics to achieve sobriety.

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ALCOHOLICS ANONYMOUS

2011 MEMBERSHIP SURVEY



The contents of this pamphlet are available in a table-top display available from G.S.O. (M-13).

The display is 27 inches high and 39 inches wide, has a durable easel in the back, and can be folded in half for storage.

To order, write: A.A. World Services Grand Central Station Box 459, New York, NY 10163.

The pamphlet contents are also on G.S.O.'s A.A. Web site,

www.aa.org

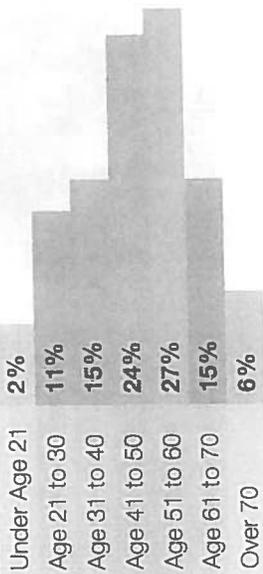
P-48

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Box 459 Grand Central Station,
New York, N.Y. 10163

35M - 11/13 (RP)

This is A.A., General Service Conference-approved literature.

AGE OF MEMBERS



Average Age of Members is **49** Years.

MARITAL STATUS OF MEMBERS

Married	36%
Single	34%
Divorced	22%
Other	8%

GROUP MEMBERSHIP



86% of the members belong to a home group.

INTRODUCTION TO A.A.*

Through an A.A. member	34%
Treatment facility	32%
Self-motivated	29%
Family	25%
Court order	12%
Other	8%
Counseling agency	7%
Health Professional	7%
Employer or fellow worker	4%
Non-A.A. friend or neighbor	3%
Correctional facility	2%
Al-Anon or Alateen member	2%
A.A. literature	2%
Newspaper/magazine/radio/TV	1%
Member of clergy	1%
Internet	1%

RELATIONSHIP WITH HEALTH CARE PROFESSIONALS

75% of members' doctors know they are in A.A.
40% of members said they were referred to A.A. by a health care professional

ADDITIONAL HELP . . .



BEFORE coming to A.A., **63%** of the members received some type of treatment or counseling, such as medical, psychological, spiritual, etc.

74% of those members who received treatment or counseling said it played an important part in directing them to A.A.

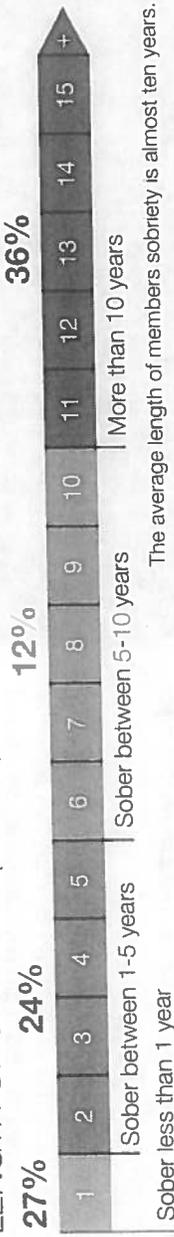
AFTER coming to A.A., **62%** of the members received some type of treatment or counseling, such as medical, psychological, spiritual, etc.

82% of those members who received treatment or counseling said it played an important part in their recovery from alcoholism.

MEMBERS OCCUPATIONS

17%	Retired
10%	Other (including self-employed)
10%	Unemployed
9%	Manager / Administrator
8%	Professional / Technical
8%	Skilled trade
6%	Disabled (not working)
6%	Health professional
5%	Laborer
5%	Sales worker
3%	Educator
3%	Student
3%	Service worker
2%	Clerical worker
2%	Homemaker
2%	Transportation
1%	Craft worker

LENGTH OF SOBRIETY (YEARS)



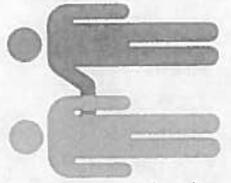
Members attend an average of **2.6 A.A. meetings** per week.



MEETING ATTENDANCE

SPONSORSHIP

81% of members have a sponsor.
72% got a sponsor within 90 days.



* These numbers do not add up to 100% because respondents were allowed to select more than one.

CRIMINAL JUSTICE

Seattle's New Drug Offender Program Has Been a Rousing Success

Belltown is the most densely populated neighborhood in Seattle, and it's also the site of much of the city's crime. For years, police officers in the area went the traditional route of finding and locking up criminals, but now they also have an alternative that's looking like a better option in some cases.

Seattle's Law Enforcement Assisted Diversion program (LEAD) has taken hold of the neighborhood in the past three years. Instead of sending a low-level offender to jail, the officer can offer the offender the option of taking them to the precinct, having them meet with a social worker, and

APRIL 16TH 2015

Thor Benson •
@thor_benson



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POPULAR STORIES



Today at Fast Food Restaurants is

becoming part of the LEAD program. From there, the offender's crime is taken off the record, and they can take advantage of existing low-income assistance programs. Case workers work closely with the person to help them find housing, help them get health care, and generally support them in making life changes.

"The case manager works with the client to figure out what they need," Susan Collins, a clinical psychologist at the University of Washington School of Medicine, told ATTN:. "They're typically caught up in the revolving door of street to jail to street cycle.

attn:

 Tweet

 Mail

means to support themselves.

 Share

"These are usually folks who are low-level drug and prostitute offenders who are basically selling drugs and engaging in sex work to try and sustain their lives on the streets. Most of them are homeless and struggling to get by. These aren't big drug king pins," she said.

Collins and her colleagues recently released a study that found the LEAD program is

Going to be Interesting...



I Am a McDonald's Worker. Here Is a Day in My Life.



Compare This McDonald's Worker's Pay to the CEO's



Next Time You Judge Someone on Food Stamps, Remember This...



Georgia, NIH, and Sanjay Gupta Headline Marijuana's Big Week

working. The study looked at 203 people who were part of LEAD and a control group of 115 who were not, but had similar criminal backgrounds. Comparing the likelihood of arrest six months before the study and six months into the study, they found that LEAD participants were 60 percent less likely to be arrested than the control group. Looking at two years prior to the program and comparing it to the period after, LEAD participants were 58 percent less likely to have one arrest than the other 115. They also found that LEAD participants were 39 percent less likely to be charged with a felony.

LEAD case workers tailor assistance to individual client needs, as opposed to prison programs that are typically the same for every participant. Collins said that another important factor helping the program is that case workers meet their clients in the community, get to know them, and establish a feeling of trust. "People are used to being burned by the system," she said, but participants learn over time that their case worker will stick with them indefinitely, even if they keep using hard drugs or make other mistakes.



Why We Need More Women Designing Buildings

The program has received attention from officials in other states and even foreign countries. Santa Fe, N.M., has already started its own LEAD program, and Albany, N.Y., is preparing a similar program.

Lisa Daugaard, deputy director of Seattle's Public Defender Association and supervisor of the Racial Disparity Project, spearheaded the LEAD program. She said "both the city and the county have said they intend to engage in a planning process over the next several months to devise a way to take LEAD to scale across the city and/or the county." She said that she believes the program will significantly save taxpayers' money when it's expanded to the county level, as the county "pays for all jail and justice system costs for people charged with felony drug crimes."

The final verdict will be known once the upcoming studies are finished. Collins and her team plan to do further studies looking at whether LEAD reduces strain on the criminal justice system and cost to taxpayers.

SHARE YOUR OPINION

Would you be in favor of
decriminalizing all drugs?

Yes

No

Enter your email address and we will let
you know the results.

FINISH

OTHER STORIES WORTH YOUR ATTENTION



**Officer Who Shot
Man In "F*ck
Your Breath"
Video Is Charged
With
Manslaughter**



**Police
Departments
Won't Get Rich
off Your Property
in This State**

...and you can be sure
that we will be there for you.



OTHER STORIES WORTH YOUR ATTENTION



Police
Department's
What's the Deal?
off your property
in this state.



Officer Who Sings
Mrs. M. Ter
Your Health
video is changed
with
Administration



Crime

LEAD program for low-level drug criminals sees success



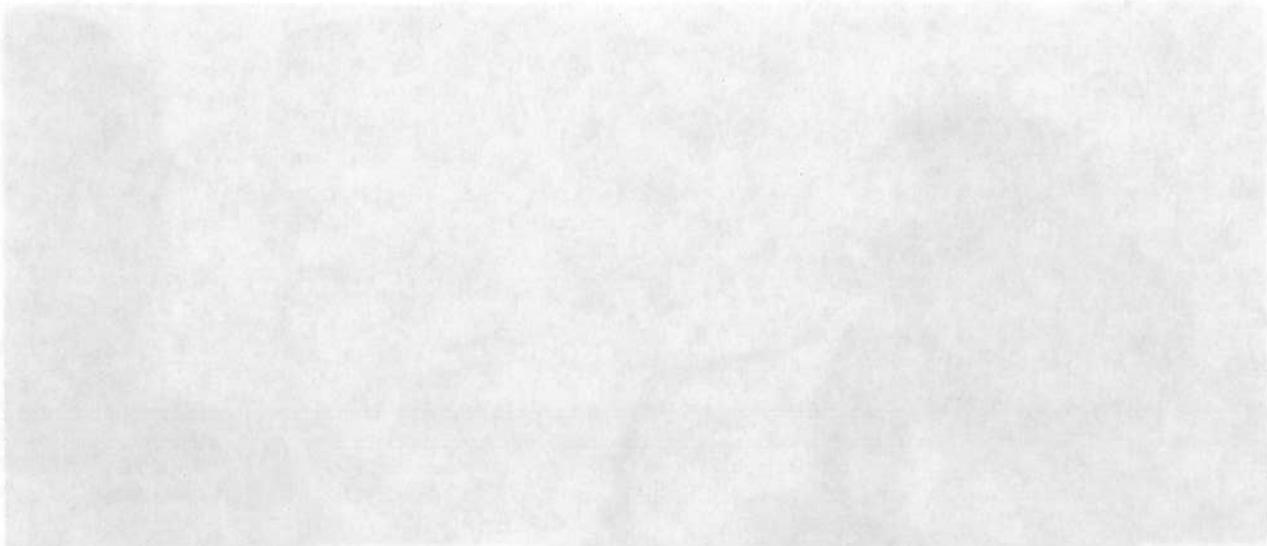
Originally published April 8, 2015 at 11:05 am Updated April 9, 2015 at 12:00 pm



With tears in her eyes after telling her story, Misti [Name obscured] years, stands with her LEAD case manager Chr

34, sober for more

LEAD program for low-level drug criminals sees success



The plan's architects hoped a new approach to dealing with low-level drug crimes would slow the number of people who repeatedly cycle through the criminal-justice system. They have new stats to back up their early suppositions.

By Sara Jean Green 
Seattle Times staff reporter

A real-world experiment that's played out on the streets of Belltown over the past three years is producing significant results by interrupting the cycle of arrest, prosecution and incarceration for nonviolent drug offenders.

The Law Enforcement Assisted Diversion (LEAD) program is working even better than its creators had hoped, reducing criminal-recidivism rates by up to 60 percent for the

poor, chronically homeless, low-level drug dealers, users and prostituted people it was designed to help.

UNLIMITED
DIGITAL ACCESS

\$1
4 WEEKS

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The Seattle Times

When LEAD was launched as a four-year pilot project in October 2011, no one knew if it would work, said Lisa Daugaard, policy director for the King County Public Defender Association, who worked with police and prosecutors to develop the innovative program that was unlike anything ever tried in the country.

Based on a harm-reduction model that drew from decades of public-health research, LEAD's architects were hopeful a new approach to dealing with low-level drug crimes would slow the number of frequent fliers who repeatedly cycle through the criminal-justice system.

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- 2 Want cheaper rent? Go vintage
- 3 Let's 'go out in the alleyway,' Inslee tells reporter
- 4 Fernando Rodney testing patience as Mariners closer
- 5 Mayor doubts contractor followed Highway 410 demolition plan

Now having stats to back up their early suppositions isn't a total surprise, "but I think the degree of difference in outcomes exceeded even our expectations," Daugaard said.

The results of a non-random, statistically controlled evaluation by the University of Washington, released Wednesday, show that LEAD is having a statistically significant impact in reducing the likelihood of new arrests for program participants.

Granted, the sample size was small: 203 participants in the LEAD program were compared with a control group of 115 people, who met the same criteria but weren't hand-selected by a group of Seattle police officers to receive social services instead of a ride to jail.

The evaluation's findings were announced at a news conference at Belltown Community Center, where city and county officials, including Seattle Mayor Ed Murray, Police Chief Kathleen O'Toole and Sheriff John Urquhart, extolled the unique collaboration that created LEAD and has fostered a more-humane approach to combating chronic drug abuse and mental-health issues.

Two additional studies will be released later this year, the first comparing LEAD's costs to costs associated with utilizing the traditional criminal-justice system. The other study will analyze the psychosocial, housing and quality-of-life outcomes for LEAD participants over time.

Voluntary participants

As a pilot, LEAD was funded with \$4 million over four years from private foundations.



The way it worked: On random "green-light nights," select squads of officers assigned to the Seattle Police Department's West Precinct offered the program to people they arrested in Belltown.

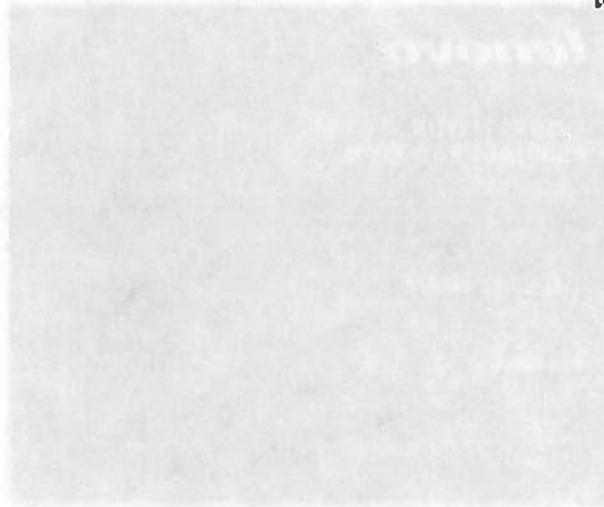
Participants qualified for the program as long as they weren't carrying more than 3 grams of drugs, had no felony convictions for serious violent crimes or certain other offenses, and weren't suspected of promoting prostitution or exploiting minors in a drug-dealing enterprise.

While men are more likely to be arrested for using or selling drugs, women involved with drugs are most often arrested for prostitution, which made the misdemeanor offense also a qualifying crime for participation in LEAD.

The program cuts out the criminal-justice system and assigns voluntary participants to case workers, who can provide immediate help — a hot meal, a warm coat, a safe place to sleep — as well as longer-term services for drug treatment, stable housing and job training. Services are individually tailored and relapses are expected.

Those private funds will run out this year, said Daugaard, noting the city of Seattle committed money to LEAD in 2014 and 2015, with the King County government being asked to help fill the funding gap in 2016.

“It’s no longer considered a pilot. We’re now more in the standard implementation phase,” Daugaard said. The King County Sheriff’s Office has diverted four people in Skyway to LEAD and is expected to soon offer the program in White Center.



While a group of about 40 Seattle officers assigned to five West Precinct squads have been slowly offering the program to people in downtown neighborhoods outside of Belltown, it’s going to take time to expand LEAD to other neighborhoods and “bring it to scale,” she said.

Arrest numbers improve

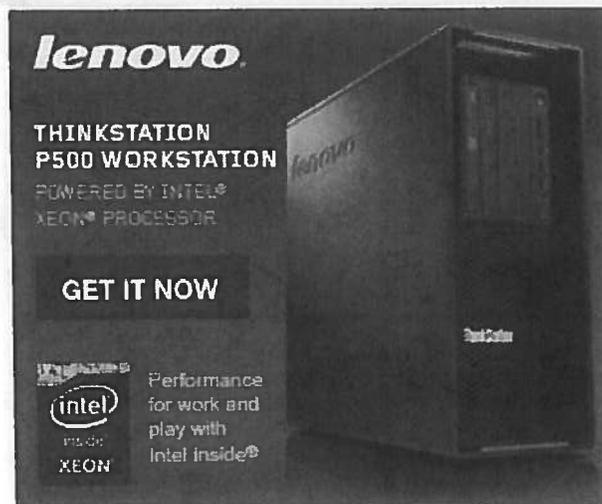
Susan Collins, a clinical psychologist and UW associate professor, co-authored the LEAD evaluation with two colleagues, UW assistant professor Seema Clifasefi and research scientist Heather Lonczak. They work out of the university’s Harm Reduction and Research Treatment Lab at Harborview Medical Center.

The researchers compared LEAD participants to the control group, first looking at the short term — the likelihood someone was arrested in the six months before becoming a part of the study versus the likelihood of arrest six months after researchers started tracking them.

They found members of the LEAD group had a 60 percent lower likelihood of arrest compared to the control group in those subsequent six months.

Collins and her co-authors also took a longer view, comparing arrest data for the two groups between October 2009 — two years before LEAD started — and the end of the pilot project in late July.

LEAD participants had 58 percent lower odds of at least one subsequent arrest compared with the control group, a number that dropped to a 34 percent lower likelihood when warrant arrests, mostly related to older crimes, were removed from the analysis. LEAD participants were also 39 percent less likely to be charged with a felony compared with the control group.



“The analysis always showed that, compared to the control group, the LEAD program seemed to have a positive effect on arrests,” Collins said. “It’s a lot harder to do an evaluation like this under real-world conditions, so they’re pretty impressive findings, given the constraints.”

“Big wins” cited

The overall trends for the LEAD program “look very promising,” she said. “They’re very robust initial findings.”

King County Senior Deputy Prosecutor Mary Barbosa, who is her office’s liaison to the

LEAD program, said participants are among the hardest to serve and most vulnerable in the city. Eighty percent of LEAD participants were homeless when they entered the program, and many have addiction and mental-health issues that are too severe for the court system to adequately address.

If LEAD participants backslide or commit new felony drug crimes, they are held accountable. But because police and prosecutors are familiar with their life situations, they are able to use their discretion so as not to interrupt the progress being made.

For instance, Barbosa may not write an arrest warrant for someone if she knows that person has an upcoming appointment to get into stable housing.

The goal of LEAD is “to reduce the harm people are doing to themselves and the community,” she said. “Maybe they’re going to the ER (emergency room) once a month instead of four times a month — that’s still progress.”

Results vary but there are “big wins,” she said, citing the person who completed an apprenticeship program and is employable for the first time in years; the person living in an apartment after decades on the streets; and the addict who marked six months of sobriety, the longest period of time anyone can remember.

“The moments of celebration are big and more fulfilling than seeing someone go off to prison for five years,” Barbosa said.

How LEAD gets applied “doesn’t look the same for everybody” in the program, she said. “We’ll work with them if they’re interested in getting treatment — or just getting lunch. The relationship develops over time.”

Sara Jean Green: 206-515-5654 or sgreen@seattletimes.com



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Susan Hixon

443-845-2374

3410 Hickory Drive, Ellicott City, MD 21043

March 1, 2015

March 1, 2015

Lt. Governor Boyd K. Rutherford
State of Maryland
100 State Circle
Annapolis, MD 21401

Maryland Heroin Task Force,

I am writing as a parent of a heroin addict. I wanted to share my family's story in hopes that this Task Force truly understands the horror of how the illness drug addiction and mental illness can debilitate a young person and all those who love them. Drug addiction is an illness that a person will struggle with all of their lives just like diabetes or high cholesterol. I mentioned mental illness because many addicts have an underlying reason for beginning drugs such as anxiety or depression. That is the case for my son and many of his friends.

As a teacher I have seen many young people suffering from mental illness. Children in elementary school are suffering not just adolescents. I have taught young boys who are suicidal in 4th grade! I have taught young children with Bipolar Disorder and other Mood Disorders, Anxiety, PTSD, ADHD, and many others. As these children grow older, they will come into contact with Opioids and become addicts because of the relief from what they are battling.

My son, Adam, was our first born and our only child for six years. He was extremely well cared for and loved. He had all of the stereotypical qualities of a perfect life. I was home with him until he was four, his father volunteered in his classrooms, we ate dinner every night as a family, and he was enrolled in extracurricular activities. He had best friends and they were active in youth group and church activities together.

The only problem for Adam when he was young was a major "shyness" that grew as he got older. He was very attached to us and it was difficult to part from him. As he got older, he only participated in social situations if he was following his outgoing best friends. By middle school he only really spoke to people who were close. He would not only sit apart from crowds, but he would obsess that they were judging him and talking about him. By 7th grade, he was suffering from depression and his grades and behavior began to slip. He was diagnosed with ADHD by a psychiatrist at Sheppard Pratt. Adam felt that the medication did nothing to help and refused to continue. By 9th grade, Adam tried

Marijuana and found that helped him "fit in". This led to oxycodone. His then girlfriend insisted that he stop that so he proceeded to quit on his own. He was very ill, but he told me that he had a stomach virus. Some time later, I discovered him sitting on the couch one night awake but almost unresponsive. I took him to my doctor the next day and she sent him right to the ER.

That day began a six year struggle that is still going on. Sheppard Pratt diagnosed him with Social Anxiety and got him into a substance abuse IOP in Columbia. That was the first of many drug programs, psychologists and psychiatrists. We have tried many depression and anxiety medications, but once he was addicted to Heroin, it became impossible to know where one begins and the other ends. Currently he is spending a week at Mountain Manor for the third time over the past couple of years. We even were able to use a small inheritance and send him to an extremely expensive wilderness facility in North Carolina. That cost over \$40,000 and after that, we found a halfway house near that facility. The halfway house was \$175 per week. Adam was suffering from depression still and never became independent so when our money began to run out we had to bring him home and he relapsed yet again. Eventually he ended up in Jessup for 8 months. When he was released he got a job, but eventually relapsed this past August.

The media, government, and medical community always say if you are suffering from mental illness or addiction "just get help". The only places that you can get in easily and quickly is ones that do not take insurance. If you have to use your insurance like most normal people, you spend a lot of time calling around and then wait for an appointment. Then no one will treat you for everything. The psychiatrist would see him for 15 minutes and give meds that Adam would never take. Then the psychiatrist would suggest that you go to a psychologist for a diagnosis and counseling. Then the psychologist will send you to a drug counseling program and then they will send you somewhere else for suboxone. Now don't forget that every time you visit anyone you are paying the \$30 copay. That adds up quickly especially when you have other children to care for, utilities etc. Only someone without insurance is able to get free services, but no one seems to realize that having insurance is very expensive and that you will spend several days finding a provider to take you and your insurance. When ever he was in a daily program, the copays added up so that we had a large bill by the time he graduated or quit.

As for drug treatment, it is very difficult to get detoxing help. Emergency rooms will not help and if you actually find a center that the insurance will cover, you will not get in during an emergency. Another important thing we have discovered is that there are no drug

emergencies on the weekends. I didn't know that addicts take off on the weekends, but most places won't see you and many don't even answer the phone. Only drug hotlines are answering then and they aren't able to help until Monday. My son has gone through withdrawal several times. It is more than just sitting over the toilet. They lose their mind and have very little control. Twice he has freaked out and stolen my car. Since we can never get assistance right away, he must steal money and begin using again.

One major way to fight heroin in this state, is to increase services, especially for those who decide to risk withdrawal, the minute they make that decision. Their minds do not work like non-addicts. Anytime we have had to wait for help after he has made that decision, we lose him once that addictive part of his brain takes over. Adam walked out of the YMCA the afternoon before he was going to Mountain Manor once and we didn't see him for 2 months. During that time, he was living on the streets and committing crimes in order to keep up with his drug problem. Did you know that some addicts need a couple hundred dollars a day to survive? Also, even people who have insurance are going to have problems paying copays and deductibles. They need help just as much as people living in poverty. It would be great if people who are looking for help could have a more streamlined process. Last Monday when my son was in crisis, he spent HOURS on the phone finding a place and making sure that it was going to cost as little as possible.

Finally, I want to impress on you how mental illness is the underlying cause of addiction and how difficult it is to find treatment especially during emergencies. Twice a psychologist has called and said that Adam needed to go to the ER because he was suicidal. Both times he just sat in a room and was evaluated by a psych assistant after many hours and then just sent home. Parents are always told, if you feel that your child is in danger go to the ER. But we have tried many hospitals in the Baltimore area and have never received care. In fact, when he was in 12th grade, he sat in the ER for an entire day and then at 5:00, the staff decided that he was fine and should go home. Sitting in traffic on Little Patuxent Parkway in Columbia, he jumped out of the car and took off. It was around 10 degrees and he had no coat or phone on him. He was gone for three days. That is fine??????????

I know that this has been very long, but this doesn't come close to describing all that our family has gone through. I didn't even talk about the theft, lies, and erratic behaviors at home. Adam has sold all of my family rings and antiques. Most things that he has sold of mine are irreplaceable. He has sold all of the nice things that we have ever bought him. He has stolen money from us and all of his friend's families. I used to save up money for Christmas in my desk, but one November when I went to take out the thousand dollars for

the kids' Christmas, it was gone. Just recently, I went to get money out of my savings and he had figured out my pin number and dried us out. This is the same year that I took leave to be able to deal with him better. I have no income and now no savings.

Even worse than the monetary loses, we have lost our son. It is heart breaking to watch him live this way. Adam never smiles and he has told us that he has wanted to die for many years. He has decided that he will never stop Heroin because his brain doesn't work right without it. There is nothing we can do to bring joy into his life. Only he can do that, but he doesn't know how. I just told him yesterday that after Mountain Manor, he can not come home again. It is killing everyone. He is trying to get into a halfway house, but he needs to be given a grant to pay the rent. If that doesn't go through, he will be on the streets of Baltimore again. All of the hopes for college and the great things that our child will do are gone. We know that he will always have this illness. Also, we know that he will be dead at a very young age. We already had to save his life in August. The paramedics said that we found him around 30 minutes before he was gone. He was found by our 5 year old daughter who also watched us give him CPR.

Again sorry to take so much of your time, but this problem must be addressed and heard by all. I wanted you to understand that death from Heroin is not the worst part of the epidemic, it is LIVING with Heroin. Please do all that you can to eliminate this epidemic by educating everyone about this drug and by making mental health treatment and addiction treatment much easier to access.

Thank you for your time. My husband, my son, and myself would be happy to give any information or assistance that we can. I hope that part of your task force does include addicts and their families.

Sincerely yours,

Susan Hixon



Heroin Taskforce -GOV- <heroin.taskforce@maryland.gov>

Contact Form- Policy Suggestion, Other

1 message

Maura Taylor <mauramtaylor@gmail.com>
Reply-To: mauramtaylor@gmail.com
To: heroin.taskforce@maryland.gov

Fri, Mar 13, 2015 at 10:31 AM

From: Maura Taylor <mauramtaylor@gmail.com>
Subject: Heroin Task Force
Telephone Number: 4436436717
City: Baltimore
County: Baltimore City
Organization:
Role: N/A
Field: Other
Topic: Policy Suggestion
Comments:

Good morning,

I have followed with interest the recent articles regarding the Heroin and Opioid Emergency Task Force. I am uncertain as to the outreach of the group, but as a parent of a daughter who suffers from the disease of addiction, with heroin often being her drug of choice, I am very interested in this group. Please provide me with the meeting schedule, since these meetings fall under the Open Meetings Act, and any additional information that will allow me to provide input.

As I have told my delegates and senator, and as I have testified in Annapolis, I firmly believe the heroin/opiate problem is a result of doctors who mismanaged patients and pharmaceutical companies that made extraordinary profits at the expense of individuals' lives. The drug problem, however, is not limited to heroin or opiates (and methadone must be part of the conversation) and it will not be resolved cheaply or easily. Fortunately, we have 40 years of empirical data from the failed public policies that comprise the war on drugs. Let's learn from them. We know that more enforcement and more incarceration absolutely do not work in any shape or form and disproportionately and disparately impact minorities. We know that quality, affordable, accessible treatment helps. We know that we need a collection of legislation---second chance act for felony offenders so they have an opportunity to redirect their lives, drug treatment instead of incarceration, expansion of the Good Samaritan Act, restorative justice practices, elimination of check the box on job applications, and prevention and education.

I have also long advocated for recovery high schools in Maryland. I can provide a draft bill I hoped would at least be introduced, but, in defense of my District 46 delegates, I did send it close to the drop deadline. Recovery high schools are successful in many states. New Jersey just opened its first one this past fall, Massachusetts has long had them. I hope that as part of this effort, th

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(<http://governor.maryland.gov/ltgovernor>)

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*Innote to Central MD
summit.*

Education-Pilot Recovery High School

An act concerning the establishment of a pilot recovery high school and supplementing chapter....of the Maryland Education Code.

1. The State Department of Education is authorized to create a pilot recovery high school for the purpose of demonstrating the effectiveness of the recovery high school model in Maryland. The state superintendent shall issue a request for proposals to operate the pilot recovery high school. A proposal shall be submitted to the state superintendent no later than December 1 of the school year prior to the school year in which the recovery high school is to begin operation. The approval of the State Board of Education shall be required in order for the recovery high school to be in operation.

2. After two years of operation, the pilot recovery high school shall submit to the state board of education, an analysis of the recovery high school's educational outcomes including, but not limited to, student graduation rates, retention rates, course performance and performance on the state assessments. The results will be used to develop a model for Maryland recovery public high schools. Local school systems will be encouraged to use this model to establish recovery high schools in their districts.

3. a. Any school district in the State that has a student who is currently enrolled or resides in the municipality in which the district is located and who the district considers to be both clinically and academically appropriate for referral to the recovery high school may refer that student for voluntary enrollment in the school. If the student is admitted to the recovery high school, the sending district shall ensure that payment for the student is made in accordance with the provisions of subsection b. of this section, and that upon completion of all State and local graduation requirements the student receives a State-endorsed high school diploma.

b. (1) A sending district shall pay directly to the recovery high school for each student attending the high school who meets the criteria of paragraph (2) of this subsection an amount equal to 100% of the sum of the budget year equalization aid per pupil, adjustment aid per pupil, and the prebudget. In addition, the sending district shall pay directly to the recovery high school the security categorical aid attributable to the student and a percentage of the district's special education categorical aid equal to the percentage of the district's

special education students enrolled in the recovery high school. The district shall also pay directly to the recovery high school any federal funds directly attributable to the student.

(2) A sending district shall pay the amount required pursuant to paragraph (1) of this subsection for each student who:

(a) is currently enrolled in the district or currently resides in the municipality in which the district is located;

(b) is considered by a certified alcohol and drug counselor to be clinically appropriate, using the criteria for substance use disorders as defined in the most recent Diagnostic and Statistical Manual of Mental Disorders; and

(c) meets all matriculation criteria as outlined by the sending district and the Department of Education. The determination of academic eligibility shall be based on existing documentation provided by the district.

c. The recovery high school shall submit to the State board the academic data considered necessary by the State board to provide information regarding each student's academic performance, subject to applicable health confidentiality laws and regulations.

4. The State Board of Education, in consultation with the Department of Health, shall adopt regulations to effectuate the purposes of this act.

5. This act shall take effect immediately.

6. This act shall be known and may be cited as the Recovery High School Act.

As used in this act:

Recovery High School means a public school that serves students diagnosed with substance use disorder or dependence as defined by the most recent Diagnostic and Statistical Manual of Mental Disorders, and that provides both a comprehensive four-year high school education and a structured plan of recovery.

Sending district means the district where the student attending or planning to attend the recovery high school resides, and that, upon the recommendation of a certified alcohol and drug counselor, refers the student for enrollment in the recovery high school.



Governor Mail -GOV- <governor.mail@maryland.gov>

Contact Governor Form [8] Heroin Topic

1 message

mgoodman7271@gmail.com <mgoodman7271@gmail.com>

Sun, Mar 22, 2015 at 4:26 PM

To: governor.mail@maryland.gov

NAME Mindy Goodman ADDRESS 4003 Long Lake Drive Owings Mills, Maryland 21117 Phone Number: 410-356-7271 Work Number: 443-506-1662 This is being submitted on behalf of New Chapters Consulting & Coaching. My relationship to the organization is President. Original Message: Dear Governor Hogan, I have been reading about your recent public meeting about the growing heroin crisis in Maryland. I am an Independent Educational Consultant helping families find therapeutic placements, including for substance abuse treatment and dual diagnosis treatment. I am thrilled that you are taking on this huge public health crisis. I have several suggestions that may be able to help. The first has to do with reforming insurance. It takes much, much longer than a detox stay to be able to battle addiction. The stages of change, an addiction model, takes a year to completely change a single behavior. Battling in the community where someone first became addicted is counter productive. Maryland was the first state to mandate longer insurance coverage for c-section and mastectomy for women and mandating longer stays for substance abuse and mental health treatment could be one way to help fight this battle. Adult residential care can and does work but it take time. It can take a year or more and insurance companies find ways not to fund these necessary programs. The other suggestion is the institution of drug and mental health courts in every county. Often time even Judges will have a person with little insight self direct their treatment. Go get treatment, stay out of trouble and charges will be dropped. If the person could they would. Drug courts with wrap around treatment that is not self directed but with accountability could be very effective. If people can do well they will do well. Retribution or punishment, are not the answer in healing the problems affiliated with drug use. Criminalizing a disease has never been a deterrent to any form of illness. Thank you for taking on this difficult topic. Sincerely, Mindy Goodman

Richard

LT Governor -GOV- <lt.governor@maryland.gov>



Heroin Task Force

Howard, Doug <dhoward@ccg.carr.org>
To: LT Governor -GOV- <lt.governor@maryland.gov>

Mon, Mar 23, 2015 at 1:47 PM

Diane,

Thank you for your prompt response and your e-mail follow up. I am attaching the outline that I will be presenting to the Carroll County Commissioners (of which I am one) tomorrow. I have also enclosed the spreadsheet detailing the \$1.9 million commitment I am seeking over the next three years. Please pass this information on to Lt. Governor Rutherford. I will forward more detailed plans from the Sheriff's Department and State's Attorney's office when they have been approved.

We applaud the commitment to this issue expressed by both Lt. Governor Rutherford and Governor Hogan. I would welcome the opportunity to work with the administration in some capacity as it takes on the great challenge of addressing this issue across the state. I will access the website for future summit dates and other activities.

I can be reached for questions or general contact at 443-538-4862 or at this e-mail address. We will continue to coordinate with your office as our efforts progress in this regard.

Doug Howard

President, Board of County Commissioners

Carroll County

Chairman

Maryland Rural Coalition of Counties

From: LT Governor -GOV- [mailto:lt.governor@maryland.gov]

Sent: Friday, March 20, 2015 3:40 PM

To: Howard, Doug

Subject: Heroin Task Force

NOT IN CARROLL

Drug Enforcement Support Program

OVERVIEW

The growing problem of Heroin and other drugs in our community is not a new problem nor is it unique to our jurisdiction. However, it is one that has recently seen a dramatic rise in overdose deaths and the presence of drug selling operations that threaten the future of our community. And while education and treatment will continue to be amongst our most important means for addressing the drug problem in our community, we also know that the law enforcement side needs the strategy, resources, training and commitment to attack those that provide these illegal drugs in our community.

We know that it will take a coordinated effort across our community and with other agencies and jurisdictions to be effective in this effort. We have the benefit of a new Sheriff, Jim DeWees and a new State's Attorney, Brian DiLeonardo, each of whom identified this as a major area of concern during their campaigns and came to office with plans to address the issue. We also know that this a priority for our new governor, Larry Hogan and a central area of responsibility for our new Lt. Governor Boyd Rutherford. We fully expect to work closely with them on this endeavor.

Carroll County Commissioners are being asked to make a commitment of \$1.9 million over three years to support the manpower and resources to implement the Sheriff's program, Repeat Offender Proactive Enforcement, and the State's Attorney's program, Drug Overdose Response Team. Funding for the first year would be provided from one-time surplus funds from prior years. Funding for the 2nd and 3rd years would be from grant funding and supplemented if necessary with even reductions in OPEB, economic development and education funding.

Failure to address these issues now will lead to more overdose deaths, more crime, more need for treatment and incarceration and will undermine our primary objectives of public safety, economic development and education. The programs are ready, the funding is available, the need is without question. Therefore, it is being requested that the County Commissioners of Carroll County act without delay and improve the funding for the implementation of these efforts.

REPEAT OFFENDER PROACTIVE ENFORCEMENT (SHERIFF'S DEPARTMENT)

The Sheriff seeks to address this issue with the creation and implementation of the Carroll County Sheriff's Office Repeat Offender Proactive Enforcement Team (ROPE). This specialized team will investigate street and mid-level narcotics complaints. They will monitor and investigate career criminals living and operating in Carroll County. To accomplish this, the Sheriff is seeking the addition for four Deputy First Class positions and the corresponding equipment and training for them. A detailed plan for the role, coordination and focus of the ROPE program is attached.

DRUG OVERDOSE RESPONSE TEAM ATTORNEY OFFICE)

(STATE'S

It is the belief of the State's Attorney that to tackle this difficult issue, Carroll County must focus on three areas: (1) aggressive pro-active enforcement and prosecution efforts, (2) a comprehensive and sustained prevention outreach effort, and (3) closely and intensively supervised treatment for newer users entering the court system. To accomplish this, the State's Attorney is seeking three positions and the equipment needed to support them. They include: Supervising Drug Prosecutor, State's Attorney Drug Investigator and the Education and Treatment Liaison. The attached report provides detail.

CONCLUSION

Carroll County Commissioners are scheduled to vote on this matter on Thursday, March 26th.

	Salary	Fringe	One-Time/Start-Up					
State's Attorney Office								
Prosecuter-Specialty Unit Supervisor	\$77,834.00	\$33,133.60	\$3,230.00					
Investigator II - Specialty Unit	\$45,000.00	\$18,000.00	\$4,730.00					
Education and Treatment Liason	\$42,100.00	\$16,840.00	\$10,230.00					
Department Total	\$164,934.00	\$67,973.60	\$18,190.00					
Sheriffs Department								
Deputy First Class	\$51,230.00	\$17,500.00	\$55,123.00					
Deputy First Class	\$51,230.00	\$17,500.00	\$55,123.00					
Deputy First Class	\$51,230.00	\$17,500.00	\$55,123.00					
Deputy First Class	\$51,230.00	\$17,500.00	\$55,123.00					
Office Set-Up			\$105,000.00					
Department Total	\$204,920.00	\$70,000.00	\$325,492.00					
Combined Total	\$369,854.00	\$137,973.60	\$343,682.00					
				Total Needed				
Annual Funding								Funding Source
Annual Amount FY16	\$369,854.00	\$137,973.60	\$343,682.00	\$851,509.60				One-Time Surplus Funds
Annual Amount FY17	\$380,949.62	\$142,112.81		\$523,062.43				Grants or 1/3 OPEB Over, Econ Dev, Education
Annual Amount FY18	\$392,378.11	\$146,376.19		\$538,754.30				Grants or 1/3 OPEB Over, Econ Dev, Education
				\$1,913,326.33				



Heroin Taskforce -GOV- <heroin.taskforce@maryland.gov>

Contact Form- Policy Suggestion, Other

1 message

Brandee Izquierdo <brandee.izquierdo@maryland.gov>
Reply-To: brandee.izquierdo@maryland.gov
To: heroin.taskforce@maryland.gov

Wed, Apr 1, 2015 at 9:56 PM

From: Brandee Izquierdo <brandee.izquierdo@maryland.gov>
Subject: Heroin Task Force
Telephone Number: 4434694343
City: Baltimore
County: Baltimore County
Organization: Behavioral Health Administration-Office of Consumer Affairs
Role: N/A
Field: Other
Topic: Policy Suggestion
Comments:

I'd like introduce myself as the Director of the Office of Consumer Affairs for the Behavioral Health Administration. Along with this introduction, I'd like bring attention to a workforce that has yet to be recognized for its full potential with regard to its utilization as part of a solution for the heroin epidemic throughout the State of Maryland. This is the workforce of Certified Peer Recovery Specialists, people having lived experience and specific training with a grassroots approach to combat issues related to mental health, substance use, and co-occurring disorders. This is a systemic problem that weaves its way across jurisdictions and throughout regions and is only becoming more prevalent throughout the state. Implementing Peer Support within jails, institutions, maintenance programs, emergency rooms, and incorporating them into crisis teams will give a component of recovery that is otherwise lacking throughout the system.

I've enclosed a synopsis of a policy that would include Certified Peer Recovery Specialists as a part of the solution for prevention. This is just a glimpse of the benefits peer support has to offer within the State of Maryland.

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This e-mail was sent from a contact form on Lt. Governor Boyd Rutherford
(<http://governor.maryland.gov/ltgovernor>)

 **synopsis.docx**
13K

Brandee Izquierdo, Director Consumer Affairs

As Maryland addresses a state of emergency plan on heroin addiction, the problem doesn't lie in the increased number of overdose deaths related to heroin on the east coast. The problem is the reactive response to the heroin epidemic rather than the proactive approach to prevention; the focus in on the heroin, not the addict. According to the Washington Post, "heroin-related deaths have nearly doubled in Maryland since 2010" (Svrluga, 2014). These statistics sparked a statewide campaign initiating the training for friends, family members, and first responders to administer the drug naloxone to prevent overdose. However, this is just a quick fix "band aid" effect on the underlying issues as to why people choose to use the drug in the first place as death statistics continue to rise. Administering naloxone will resolve the immediate issue. However, this doesn't solve the problem of the addiction which, once the recipient is well, leads an addict straight back into the arms of evil with a safe haven drug on the street to rescue them. With the administration of naloxone, a policy should be set forth to extend treatment and/or recovery services to the recipient of the drug. Community outreach and peer recovery services should be present in the aftermath of naloxone being administered. After one is given a naloxone kit, they must report its use and have the recipient report to the hospital for follow up. This is a perfect opportunity for the intervention of recovery services to take place. This may not be the solution to overdose prevention, yet a step in the right direction as a person in recovery with shared life experience can open the door to hope and an alternative to an addictive lifestyle. These services could guide one in the right direction to get help and produce longevity in recovery as a support system during the early stages. As the recipient starts to gain life skills conducive to a productive lifestyle, the quick fix "band aid" may no longer be necessary and overdose numbers may begin to diminish.



Heroin Taskforce -GOV- <heroin.taskforce@maryland.gov>

Contact Form- Policy Suggestion, Addiction Treatment

1 message

Rev. Dr. Basha P. Jordan, Jr <prophetbasha@aol.com>

Tue, Apr 14, 2015 at 4:18 PM

Reply-To: prophetbasha@aol.com

To: heroin.taskforce@maryland.gov

From: Rev. Dr. Basha P. Jordan, Jr <prophetbasha@aol.com>

Subject: Heroin Task Force

Telephone Number: 443-250-9635

City: Baltimore

County: Baltimore County

Organization: Hope Alive Ministry/Outreach

Role: Officer

Field: Addiction Treatment

Topic: Policy Suggestion

Comments:

1. Baltimore City needs to provide and publicize free detox and drug/alcohol treatment for addicts and alcoholics in Baltimore city who have no health care.
2. Each police district in Balto. eliminate all known open air drug markets
3. Provide drug/alcohol prevention education classes in elementary and middle schools.
4. The drug/alcohol epidemic is a spiritual problem needing Spiritual leaders familiar with drug/alcohol addiction on the Task Force

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This e-mail was sent from a contact form on Lt. Governor Boyd Rutherford
(<http://governor.maryland.gov/ltgovernor>)



Contract Form - Policy Extension Agreement

1 message

For the policy to remain in force, the policyholder must...

...and the premium must be paid on or before the due date...

If the policyholder fails to pay the premium on time, the policy...

...will be terminated and the policyholder will be notified...

...in writing at least 30 days before the termination date...

...and the policyholder will be responsible for any unpaid...

...premium and interest charges.

This agreement is subject to the terms and conditions of the...

...policy contract.

By signing this agreement, the policyholder agrees to the...

...terms and conditions of this extension agreement.

Signature of Policyholder: _____

I, the undersigned, hereby agree to the terms and conditions of this...

...agreement and to pay the premium on or before the due date...

...of each month until the policy is terminated or the term of the...

...policy expires, whichever is earlier.

This agreement is made this _____ day of _____, 20____.

Signature of Agent: _____

This agreement is subject to the terms and conditions of the...

...policy contract.

