# APPENDIX F

**Heroin & Opioid Emergency Task Force**
**Western Maryland Regional Summit**
**Monday, May 18, 2015, 10:00am – 4:00pm**
**Hager Hall Conference & Event Center, Hagerstown, Maryland**

## Summit Agenda

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| **10:00am – 10:05am** | Introduction by Lt. Governor Boyd K. Rutherford |
| **10:05am – 11:00am** | County Executive and Commission Presidents and Chairman<br>*County Executive Jan Gardner, Commission President William Valentine, Commission President Terry Baker (Invited), Commission Chairman Paul Edwards* |
| **11:00am – 11:05am** | 5-minute Break |
| **11:05am – 12:00pm** | Law Enforcement<br>*Sheriff Craig Robertson (Invited), Sheriff Douglas Mullendore, State's Attorney J. Charles Smith, State's Attorney Lisa Thayer Welch* |
| **12:00pm – 12:45pm** | Lunch Break |
| **12:45pm – 2:45pm** | Addiction Treatment Experts, Advocates, & Educators |
| **2:45pm – 3:00pm** | 15-minute Break |
| **3:00pm – 4:00pm** | Public Comment |
| **4:00pm** | Adjournment |

**HEROIN & OPIOID EMERGENCY TASK FORCE**
**WESTERN MARYLAND REGIONAL SUMMIT MINUTES**
Monday, May 18, 2015, 10:00AM-6:00PM
Hager Hall Conference and Event Center, Hagerstown, MD

**Task Force Members in Attendance**

- **Lt. Governor Boyd Rutherford**
- **Judge Julie Solt**
- **Linda Williams**
- **Tracey Myers-Preston**
- **Elizabeth Embry**
- **Delegate Brett Wilson**
- **Nancy Dudley**
- **Senator Katherine Klausmeier**
- **Dr. Michael Finegan**

## INTRO

**Lieutenant Governor Rutherford** stated that "we cannot arrest our way out" of the heroin problem, and that the Task Force remains committed to attacking the heroin epidemic from every angle. He further said that a Department of Health and Mental Hygiene report would be released the next day, with numbers reflecting trends moving in the wrong direction. The Task Force's goal is to: find ways to prevent new users; increase and improve the quality of care and access to addiction services; address trafficking and distribution; improve interagency coordination; and explore alternatives to incarceration. All of these efforts have a positive impact on increasing awareness of the challenges Maryland faces regarding heroin.

## COUNTY EXECUTIVES AND COMMISSION PRESIDENTS

**I. Rebecca Hogamier,** ***Director of Behavioral Health Services for Washington County Health Department***

A. Focus on medication-assisted treatment using injectable Naltrexone (non-narcotic, non-addictive medication)
B. Concern for lack of exit strategy for those using opioids and lack of experience in tapering. Physicians believe that taking a patient off medication means a return to addiction, but there are lower doses of buprenorphine that would make tapering simpler. These formulas are illegal to prescribe to recurring addicts.
C. Opioid dependence is rising and the number of certified treating physicians is declining. There are 4 practices in Washington County prescribing buprenorphine, and 3 of these have waiting lists. Getting certified to prescribe buprenorphine is easy (8-hour online course). Prescribing buprenorphine is like installing an ATM in the doctor's waiting room.
D. Rigorous checks/balances to prevent abuse/diversion makes it unattractive to treat the addicted population.
E. Washington County doesn't have resources to properly detox individuals. Currently can only incarcerate individuals.
**F. Recommendation: state should reconsider requiring behavioral health-treatment providers to be independently accredited when grant funding is restructured in 2016.**
G. Questions
    **a.** Q from Tracy Myers Preston: what other costs are there for the provider community?
        i. A: Developing accreditation/costs for accreditation (should be used to treat opiate-dependent individuals instead).

b. Q from LG: do they get put out of business if they can't afford accreditation?
    i. A: Yes.
c. Q: What about small treatment providers?
    i. A: They can't afford accreditation process. It's going backwards. The required accreditation process will likely eliminate smaller, existing treatment providers, which is what we need at this point. The resources required to be accredited could be used to treat the opiate-dependent individual.

**II. Bill Valentine, *President of the Board of Allegany County Commissioners***

A. Allegany is a small county; proud of sheriff's department, state police and municipal working together, but county needs a lot more help.
B. Most drugs in Allegany originate from the Baltimore area.
    *a.* In the past year, 8 were arrested from Baltimore City.
C. Allegany demographics: 89% Caucasian, 8% black; 87% HS graduation. Per capita $21K. Median household $39K. 17.5% below poverty levels. Very impoverished county. Blue collar 51.1%.
D. 302 patients with Methadone; 270 with Suboxone. Average length treatment is 14 months.
E. Health Department established a local overdose prevention task force in April 2013.
F. Local law enforcement is trained in administration of Naloxone
G. January 2015 establishment of overdose fatality review team; March 2015 started a prevention project.
H. There is an increase of drug use in the county; there is a 2-3x return on selling drugs in Allegany.
I. County's judicial system has a hard time cracking down.
J. Questions
    *a.* Q from Dr. Finegan: Of the 302 patients, what percentage is receiving wraparound behavioral health services? What is the average length of treatment? How is finishing treatment defined? Majority of dealers are addicts themselves buying heroin for themselves and their friends: this is different from the crack epidemic.
        *i.* A: Yes, heroin is a circular problem. Average length of treatment is 14 months; there is a two-way traffic of drugs here.

**III. Pat Panuska, *Allegany County Health Officer***

A. Allegany has outpatient and inpatient units with clients from all over the states.
B. Costs
    a. One of biggest issues is a workforce issue: cannot hire people because of costs and have to cut out other things.
    b. Fringe costs are greater than hiring costs in some cases.
    c. This affects all the county's health departments. 2% cuts went across the board, and local health departments got 13% cuts.
C. Recommendations
    a. Regulations are time-consuming.
    b. There are a lot of dedicated folks who want to do this work, but they get overloaded. Headed towards fee-for-service. Grants are falling short because they keep going down and costs keep going up.

**IV. Rodney Glotfelty, *Garrett County Health Officer***

A. Garrett is a very rural county, westernmost in Maryland
B. Things have changed drastically in the availability of prescriptions and heroin
    a. Cell phones make connections easier by creating a network.
    b. 2012 no deaths; 2013: 6 deaths; 2014: 2 deaths.

c. Inpatient and ER patients have tripled since 2008. In 1998, 90% were in for alcohol and now it has changed.

C. Barriers mean less access to treatment.

D. Garrett resources

a. No inpatient, no methadone – the closest is 150 miles away. 52 residents travel to get medication-assisted treatment

b. The only recovering housing is transitional housing program for the homeless.

c. Health department provides outpatient treatment, working closely with 1 physician who gives medication-assisted treatment. Other physicians are not really interested in it; there is a stigma attached to this.

E. Recommendations

a. Need state grant funds for recovery housing; funding for infrastructure.

b. Continued emphasis on prevention has to be priority.

F. Questions

a. Q from Dr. Finegan: How many behavioral health people do you have?

i. A: 18 at health department; 4/5 others in community; 1 psychiatrist.

b. Q from Del. Wilson on prevention: there is a link between pain medication and the heroin epidemic. What educational opportunities and programs are there for prescription providers on the addictiveness of these drugs?

i. A: PDPs for physicians – but the problem is how to get the physicians to use the tool. Doctors are already very busy and one more thing they need to do deters them.

**V. Jan Gardner, *County Executive, Frederick County***

A. Heroin problem affects mostly young adults in their twenties, but also people in their 40s-60s.

B. It is not just an urban issue. Rural northern area is also affected.

C. Heroin has become the drug of choice in our drug court.

D. In Frederick, over 100 are in methadone treatment; over 500 are trained for Narcan. Saved 9 lives this year.

E. A quarter of high school students are offered drugs on school grounds.

F. Families are starting organizations to help others; county is making sure the efforts are coordinated.

G. Efforts

a. Jan Gardner created a heroin consortium that meets every few months.

b. First responders trained with Narcan.

c. Paramedics given information.

d. Vivitrol available at Adult Detention Center through a grant.

e. Drug court successful with 64 participants.

f. Drug disposal events twice a year, with boxes around the county.

g. 211 hotline: go-to place for referrals and connection to services. Originally a suicide prevention program. Serves all western Maryland. Concerned of impact if some counties in Western Maryland opt out. Partnership with Frederick Memorial Hospital. No capacity for detox center; need funding.

**VI. Barbara Brookmeyer, *Frederick County Health Officer***

A. Grant funding right now is only for those who aren't eligible for Medicaid and are uninsured and low-income. What's the plan for individuals who aren't eligible for Medicaid, aren't yet enrolled, and those at detention center?

B. Questions

a. Q from Ms. Williams: Grants are shrinking and Medicaid isn't expanding; is that what you're saying?

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i. A: if we can't compel Medicaid applications, we can't use grants for them.

b. Q from Ms. Embry: how do you measure success for your pilot programs?
   i. A: by seeing if people are getting into treatment and also seeing how long they follow through for.

c. Q: What about police response?
   i. A: It depends on the situation. We rely on volunteers.
   ii. Q from Ms. Dudley: Who are the volunteers?
   iii. A: Those who have family or individual experience. There's a peer recovery coach academy (48-hour). So far successful in keeping up demand but need more staff for hand-holding later.

d. Q from Dr. Finegan: You have a 10% recidivism rate – how are you getting that?
   i. A: Health Department recidivism rate at state fiscal year: measures someone returning to detention center in that year's time (who was discharged from that program).

e. Q: Challenge of compelling people – why aren't they signing up?
   i. A: They just don't want to; don't want government knowing their business.

**VII. Jeff Cline, *Washington County Commissioner VP***

A. Cline has had personal experiences in the community; sees kids who are using their positive energy into drug use.

B. Heroin is no longer a law enforcement problem. It's a disease and epidemic throughout Maryland.

C. Recommendations
   a. Please continue this outreach and consider funding to smaller counties. Help counties bring these programs together. This help is needed.
   b. There is a way of thinking of "not wanting to pay tax for someone on drugs" that needs to be overcome, because everyone is paying for drugs somehow (even if not through taxes). This disease needs treatment.

D. Q from Ms. Embry on technology: is technology being explored in rural counties? Is there a potential to use technology to overcome some of the challenges that come with distance?
   a. A: Technology is being used to provide psychiatric services for children.

**<u>LAW ENFORCEMENT</u>**

**I. Douglas Mullendore, *Sheriff, Washington County***

A. It is not only the youth taking drugs.

B. Washington County set up the Prescription Drug Monitoring Program 5 years ago.

C. Increase in heroin deaths since 2009; more each year than fatal accidents and homicides put together.

D. 4.5 years ago, Mullendore worked with the Health Department to implement Vivitrol in detention centers.

E. Patrol deputies respond to overdoses and criminal investigators to respond as well – cases are then traced back to the distributor. If it is fatal case, the narcotics task force is brought in.

F. Robberies, burglaries, thefts are committed by people with heroin addiction. The addict and also their family must be treated.

G. Questions
   a. Q from LG: If a crime is directly related to addiction, does it still go on record?
      i. A: That depends on the judge.
   b. Q from Ms. Embry: What are some statistics on the Vivitrol program?
      i. A: Vivitrol is a voluntary program; there are 18 or so on that program. Spice is a huge problem in Washington County.
   c. Q from Ms. Williams: How long would you keep a person on Vivitrol for? Do you provide it?

i. A: The length of time an individual is on Vivitrol depends on the person. Yes, we provide it.

**II. Craig Robertson, *Sheriff, Allegany County***

A. Drug sources in Allegany come from the Baltimore area.
B. Open-air drug markets were unheard of 2 years ago but now they are common.
C. Attractions to bring drugs into Allegany: heroin dealer can triple his earnings by selling in Allegany. A few years ago local addicts would go to Baltimore, but now individuals are coming from Baltimore and keeping shop in Allegheny.
D. Spice is a mix of heroin and fentanyl that leads to immediate overdose. In the past 8 months, there have been deaths due to this.
E. Heroin has gone beyond the borders of narcotics – now it is also criminal, related to thefts, etc.
F. Recommendation
   a. Epidemic can't be stopped by law enforcement. Law enforcement working with agencies and health department of county led to the training of over 150 officers for Narcan and drop-off collection boxes. Law enforcement needs stiffer stance in court system (sentencing or with regards to treatment).

**III. Charles Smith, *Frederick County State's Attorney***

A. The Annapolis atmosphere is not conducive to prosecuting. HB 222 was defeated by the Senate, although it would have held drug dealers responsible. Something like this in effect is needed.
B. Recommendations
   a. Encourage LG and administration to support this. If dealers were held responsible, a major dent would be made. It's a law in the federal system already. Instead, there is a bill that says "you're a dealer, but we're going to repeal mandatory minimums. Enhanced penalties are needed to deal with large-scale heroin dealers to hold them more accountable. A great deal can be done legislatively.
   b. Adult drug courts – problem-solving courts need to be more coordinated across the state.
   c. School curriculum needs to be addressed – it is woefully inadequate.
   d. Need community effort for other problems addicts deal with: housing, employment, court-ordered Vivitrol.
C. Program in SA's office: youthful offender program. Started as diversion program for youth 12-17. It is now a youthful drug offender program, with 80-90% of the kids dealing with heroin/opiate/other drug addiction. It is not a "scare straight" program. Age range is decreasing; there are 12 year-olds with addiction.
D. Timeframe to addiction is really compressed – a matter of months.
E. Questions
   a. Comment from Ms. Williams: Marijuana is different now than before.
      i. Mr. Smith: Yes, people are dying of marijuana now.
      ii.

**IV. Lisa Thayer Welch, *Garrett County State's Attorney***

A. Significant interstate issues. Need to put things together and effectively have a multi-state drug court.

**V. Chuck Jenkins, *Sheriff, Frederick County***

A. Law enforcement initiatives are among the most aggressive, but we can't arrest our way out of the problem.
B. Heroin became a real problem in late 2012.

**<u>ADDICTION TREATMENT EXPERTS</u>**

DRAFT

**I. Judge Dana Wright, *Washington County Juvenile Drug Court***

A. An option as a judge in facing this problem is traditional probation; forced abstinence in jail does not work.
B. We have good outpatient resources in Washington County community but struggle in parole and probation.
C. Focus on funding treatment and supporting funding of treatment is important.
D. So far, there have been no violations of the Vivitrol program.
E. Challenges
    a. Monitoring dollars – better sense of this needs to be developed.
    b. Judiciary needs to have better conversations to use resources better; improve at data management.
F. Q from Dr. Finegan: Are there consequences for not going to treatment?
    a. A: We have authority to make parents make kids do something but structured enforcement is complicated. Resources have to keep being applied.

**Kim Eaton, *Day Report Center, Franklin County***

A. In 2006, Franklin County opened the Day Report Center to reduce recidivism and need for jail bed days.
B. Day Report Center program refers addicts to doctors. Medication used the majority of the time is Saboxone (cost, stability, ability to self-administer). MAT program. Known opiate addicts now graduate 67%. Use of Saboxone saves money on treatment (inpatient in PA: $215/day for 14-21 days; 1 person can cost county $3-4500). MAT program – avg cost $1125. Money supported by fines = no cost to county. Issues to develop program. Specialized case manager and oversight needed. When treatment is better option than incarceration – fiscally sound, morally correct, publicly minded = should be an option. Need help more than punishment
H. Nancy: how do you define treatment a success? How do you verify sobriety?
    a. A: Random drug testing; we test for Saboxone and other substances; success is marked by graduation from the Day Report Center.
    b. Q: Do you have any data post-graduation?
    c. A: Recidivism rate (those going back back in jail) is very low.

**Carin Miller, *Maryland Heroin Awareness Advocates***

A. Founded Maryland Heroin Awareness Advocates, a support group. Miller's husband is an addict of 31 years; now addicted to Saboxone.
B. Challenges/Recommendations
    a. Insurance companies and Medicaid.
    b. Each addict needs to have individual assessment + tailor-made treatment program just for them to find underlying cause of addiction.
    c. Barriers to access to treatment are an injustice.
    d. Funds should be spent on Vivitrol.
    e. Don't underplay what's going on in schools. Need statewide comprehensive campaign. State's 211 campaign needs to be more harsh and visible, not cartoons.
    f. Prescriptions are expensive; each of our trainees only leave with 2 doses; funding is an issue.
C. Comment from LG: GOCCP will have grants for Vivitrol. We are having conversations with State Superintendent of Schools for earlier drug awareness education.

**Sheri Denham, *Registered Nurse on opiate literature review***

A. Addiction crosses all barriers.

B. Addiction is caused by health care providers shown by trends of pharmaceutical sales (sales have skyrocketed).
   a. Cocaine and heroin have remained consistent, but prescription-related deaths have increased. Opiate-related sales and deaths have risen together. Research project studies the correlation.
C. Research project: literature review looking at 27 articles addressing opiate addiction. Overall, 74% obtain prescriptions from healthcare provider or friend/family's healthcare provider.
   a. Conclusion: there is a direct correlation between initial exposure to opiates and subsequent opiate and heroin addiction. Healthcare providers are at least partially responsible for this.
D. Recommendations
   a. Target nurses/medical personnel and educate them about opiate addiction. Nurses need to take ownership of prescriptive behaviors to educate their patients.
   b. Prescription is linked to approvals and reimbursement. Need better treatment options for them.
   c. Need to know how to treat levels of pain safely.

**Allen Twigg, *Meritus Medical Center***

A. Meritus Medical Center treats predominantly younger people: 25 and under.
B. There are increased regulations and scrutiny of physician prescribing; there is more caution about prescribing now. But if there are fewer prescription medications available, something is going to fill that gap --- heroin in this case.
C. Psychiatric hospitalization average length of stay is 3.5 days. Very short stay; can't start Vivitrol in that amount of time because it requires 7-10 days of abstinence before starting Vivitrol.
D. Caroll County has an ER prescription opiate and heroin program, meeting May 29. It has been implemented for 3 years with pretty good success.

**Ramsey Farah, *Phoenix Health System***

A. Challenge with the Prescription Drug Monitoring Program (PDMP) and who can afford the time to maintain it.
B. Phoenix Health has an Opiate Treatment Program – is PDMP still needed?
C. Recommendations
   a. Stigma – everyone hates Methadone. Measure not by dose but by other success measures. Depends on genes. Stigma has got to go.
   b. We have to change education. Talk to the media.
   c. Nothing good from marijuana.
D. Private insurance is not interested.

**Deanna Bailey, *Alternative Drug and Alcohol Counseling Center***

A. Pharmaceuticals were rampant in 1990s. These kids are now in their 30s.
B. Heroin addiction treatment today is still limited.
C. Recommendations
   *a.* Treatment is only as good as the willingness of the client.
   *b.* Outpatient treatment programs need to come in and help patients understand what's happening. Individuals with addictions grew up with limited feeling of well-being, happiness, security, safety, comfort. In outpatient, we try to ask, how can an individual feel good without a drug? Some cases need medical support; others go cold turkey. If we get them motivated and refer them to Methadone and Suboxone, we lose them as clients because Medicaid doesn't allow billing for two places. We provide intense outpatient – substance abuse. No mental health.

**Jacque Burrier, *Project Hope***

A. Project Hope advocates positive, comprehensive, nonpartisan approach to heroin problem. No addict chooses this lifestyle. Waiting lists for treatment are long.
B. Recommendations
    a. This is a family disease; the whole family needs to be treated.
    b. One of the first steps is making the whole state aware of the magnitude of this problem.

**Claude Nelson, *Drug Abuse Resistance Education (DARE) Coordinator***

A. Concern is not just as a program coordinator but also from a personal standpoint: Nelson is a parent in a family with this addiction.
B. DARE wants to make better and productive citizens, through Prevention, Intervention, Enforcement (PIE).

**Richard Benchoff, *Wells House, Inc.***

A. Heroin is the main problem along with prescription drugs.
B. Recommendations
    a. Treatment length must be longer. 28 days of treatment is not enough.
    b. Issues with insurance companies hamper addressing this problem. Parity Act (Congress) is a good thing.
    c. People following treatment regimens for other diseases have no stigma (i.e. diabetes). Stigma is horrible.
    d. We need more treatment slots. All aspects must be expanded to address this problem.

**Marte Birnbaum, *Gale Recovery***

A. Gale Recovery is a 3.1 halfway house serving western Maryland, in community for 40 years. 3.1 programs are covered by insurance but are not getting any more funding after FY 16. Town hall meeting May 28.
B. Recommendations
    a. There is a lack of understanding of substance use disorders.
    b. Insure kids on parents' insurance.
    c. Make recovery available to complete treatment behind the walls.
    d. Treatment has to be long enough to be effective.

**Becky Meyers, *Alleghany Outpatient,* and Kathy Miller, *Allegany Inpatient***

A. Only 20 prescribers have active account. PDMP was set up in December 2013. Our kids know how to locate and use prescription drugs.
B. Inpatient is a 60-day treatment program.
C. In cases where kids are coming from outpatient programs, when the kid is brought into treatment but then leaves (AWOL), it is very costly. If kids come through Department of Juvenile Services, they are more likely to stay in treatment rather than if they came via outpatient programs.
D. With adults, legal consequences make an impact. But a person may go to court and there may get referred to inpatient treatment to complete 28 days, with nothing about continuing care.
    I. The better the treatment, the better the outcome. Working with patient to get them to understand their denial, seriousness of addiction, getting to point of acceptance.
E. Recommendations
    a. Legal system should have more clout in saying "you need treatment and also continued care – intensive outpatient, halfway house; long-term.)
    b. Psychiatric treatment: one of the struggles is an increase in patients who are also sicker psychiatrically. Need more money for psychiatrist, nurses, etc. We can handle these people in residential treatment programs but we need more doctors and nursing staff.

c. Regulation around Suboxone needed – a lot of our patients come into treatment and have been prescribed Suboxone and buprenorphine, but then they sell them on the streets.

J. Q from Dr. Finegan: Do you have any recommendations for DJS?
   a. A: Have DJS focus on access to getting treatment. We have the beds; where are the kids?

**Gina Carbaugh, *Richard Carbaugh's Hope Foundation***

A. Based on Carbaugh's son, who died 2 years ago at 8 months clean. His problems stemmed from personal issues; was in 8 different treatments, spent thousands of dollars. DJS helped him get into treatment facility for 4 months. Sent to Annapolis to halfway house; then getting his life on track.

B. Recommendations
   a. Need more treatment facilities. In northern part of county there is one but it is unsuitable for younger individuals.
   b. Problem is finding treatment and detox: insurance is a huge barrier.
   c. Lengthen treatment: if there is help, it's only 2 weeks, which is not long enough. I work as a crisis nurse and we see FDA and CDC there.
   d. Lessen approval of opiate drugs: why are they letting opiate drugs be approved weekly?
   e. More efforts for detox and treatment, especially for young individuals.

**PUBLIC COMMENT**

**Kevin Simmers** – 30 days ago I buried my daughter. Police officer for 30 years. At 14, my daughter started using marijuana. She then went through a couple treatment programs. Drug use escalated to pill form when she was 17. She got into treatment in Hagerstown and was in and out of treatment programs; in 2014 – inpatient. June 2014 overdosed and Narcan was administered to her. Finally found treatment facility in Annapolis – she completed 25/30 days of program. Had to pick her up because insurance didn't pay anymore. She had a 85K bond when she was in jail. She couldn't get Vivitrol shot because insurance had to approve. Was going to get it on Friday; she passed on Monday. Insurance approved on Wednesday.

**April Rouzer:** Works with substance use prevention in Washington County; noticed in past year that even though strategies can be effective, we still need more resources. Implemented Naloxone district programs and implemented a fatality review team process. Poly-using is usually what causes fatalities. Look at education, campaign, advertising, and have a paradigm shift that addiction is a disease. Taxpayers need to have this shift; proper prescribing practices are also needed. In 2013, local hospital saw 616 overdoses. In 2014, 617 overdoses. 80% were related to opioid overdoses. Need protocol mandating that the ER mandate referrals through local treatment providers. ESPERT – need medical providers to use uniformed screening tool.

**Jamie Rowland:** third-generation Hagerstown resident with family background of chronic health problems and addiction. Now in clinical and psychotherapy services. Active in Washington County for overdose prevention. Work with people on Medicare systems. Large prison systems here, so families often relocate from Prince George's and Baltimore when their family members are incarcerated in the prisons. When released, released into community. Contributes to chronic issue with alcoholism and homeless students. Higher unemployment than state. People are trying to numb the pain.

**Pastor Brett McKoy**: Too many people stuck behind shame and pain and not sharing. Seats emptying at today's summit is a problem; it was packed in the beginning, but when the (common) people spoke, they left. Lost his son.

**Susie Gruber**: My son is an addict. I have been on pain management for 11 years. Nurse practitioners today say they are on overload; they are given $10-20,000 bonuses for the number of prescriptions they give out. Can only keep 100 patients on Suboxone a month. Can keep them on it but can't take them off

it. Pain needs to be managed better. There should be narcotics tax. My son went to health department for Vivitrol; there was a long wait, and you also have to be clean for 10 days before being allowed to take it. But what addict is clean for 10 days?

**Debbie Fling**: Have 2 sons, both addicts and incarcerated due to addiction; it has been devastating. I am an awareness advocate. Needed to step up and do what I need to do. There's a lot of drugs in the prison system. I also work with Project Act. Stigma is terrible; I didn't want people to know my son was an addict before I worked with Project Act. Vivitrol - $700 a shot is my understanding. Can't get it without insurance. You have to apply for it and have to be clean – at risk of losing our kids in between that time. We should get funding toward Vivitrol before their release into the streets. We need coverage of this. Advertising, commercials, in your face to make household conversation. Funding for treatment.

- Comment from LG: Vivitrol doesn't work if a person isn't clean. There is a grant to local prison facilities to start Vivitrol in correction facilities as people start to transition out.

**Thomas Werner**: 40-year resident of Frederick County. Education and prevention is important. Increasing number of addicts is overwhelming the resources that we have. We can't keep up. We need to stop the influx of users. 2013 Youth Behavioral Risk Assessment – kids vulnerable to drugs on school property – felony. Maryland education should start earlier. 10-12th grade has no mandatory specific drug education. Recommend that: 1. Parents are the ones primarily responsible for children's education 2. Initiate independent audit of drug education and prevention in Maryland school systems to see degree of compliance with existing law and efficacy of letter of the law treatments. 3. Use enormous advances of communications technology to initiate drug prevention and education program.

**Bob Kozloski**: Want to create safer drug environment in Maryland. Address supply – hold Maryland physicians and licensing boards accountable for unmanaged prescriptions. Improve strength of PDMP – mandatory reporting of physicians. Improve recovery programs to treat disease. Increase penalties for drug dealers and doctors associated with drug OD deaths. My son died 3 years ago, overdosed on OxyContin. I made a complaint to physician's board, but their licenses are just suspended and they can get them back. See bills initiated by State's Attorney's office to address shortfall, i.e. bill in NJ: liability-induced death act. Licensing board needs to manage disciplinary actions of doctors – criminal homicide charges. Electronic system. Must be progressive, proactive.

**Rose Marie Souder**: Methadone clinic moved behind my house, 50 feet away. Concerned that people are making a profit off of selling drugs to their clients.

**Robert Harsh**: Lost niece 3 months ago. Look at regulating treatment centers.

**Barbara Hovermill:** Also lives in Methadone clinic neighborhood like previous 2 people. This brings active criminal activity. $7.7B industry (Methadone) – the profit-making sickens me. Question drug enforcement agencies. How can these drugs be legal and available? Some drugs are being sold on the legal market. Health department in our county is doing a good job by offering Vivitrol to those who have successfully completed detox program. This should be pushed. Invest in our communities and make people well.

**Dee Miles**: Lost son; was great athlete; played football in college – wanted to be a coach and tutor. Went to southern Maryland to work construction with his father; the girl my son was seeing gave him pills to snort. She gave him heroin; he was 6'5 so he wasn't much affected – until he began shooting heroin. Older woman on job site seduced him and made him do opiates with her – strapped him up with a belt to give him heroin. He overdosed in the bathroom; I tried to resuscitate him; got Narcan; in hospital was released in 3 hours. Bought opiates again when he got money. We need awareness to parents and

neighbors; get Narcan; an ambulance might take 15-20 min in a rural place. Good Samaritan laws should be advertised so kids would know they wouldn't get in trouble.

**Christina Price:** 20 year-old daughter is a heroin addict, on and off for the last few years. A year ago she got off rehab; used Vivitrol; urge to use is still there, which led her to using spice. 30 days later started using heroin again after not having gotten a new shot of Vivitrol. In August 2014 didn't answer when in bathroom – was blue on the floor after overdosing. Taken to ICU. Probation officer told her to go to IOP. She didn't like drug class at health department because they only talked about drugs and how they can get a hookup – too many triggers. People who are serious about being clean should be separated with those who are court-ordered. Doesn't know how to deal with her triggers. She totaled 3 cars; police refused to arrest her because by the time they could measure her blood, the drugs would be out of her system and it would be a waste of time. Gap between incarceration, getting out, treatment, too long. She is homeless now and doesn't have any treatment. Concerned Persons Group (referred from Health Department) helped me gain sanity – learn about disease and not be enabler. Should be more similar groups.

**Betty Joe Shifler**: Work for psychiatrist. Husband's doctor said that you had to have very addictive personality to get addicted. Orthopedic surgeon gave 90 oxycodon after husband's second surgery. Doesn't need all of that and it stays at home. Doctors need to be more educated and regulated.

**Charles Casey:** Large segment of the population is misinformed or uninformed. Have learned from today that there's an underlying social issue. Suggest fixing the system – must have mental and physical part.

**Julie Zebroski**: Mother, grandmother, business owner. Brought up in the church. Son went to prison and came home a drug addict. His brother is one too. 14 days is not enough. Afraid of losing sons. Involved in prison ministry; involved to help. Prison isn't the answer.

**Brad Graham**: Member of recovery committee. 2007 succumbed to alcoholism. Got stabilizing housing – one of the cornerstones to recover. Lack of funding for housing in general. Stabilize people who want to get treatment. It can work.

**David Lidz**: Executive Director of a nonprofit in Hagerstown that provides jobs for people in early recovery. We don't let clients with Suboxone come in our house anymore – once it gets in the house, it gets stolen, traded, sold, misused. Looking for long-term solutions.

**Susan Fox:** Drug Enforcement Administration educator for a foundation. Seeds of prevention need to be sowed early. Went from Florida to Baltimore and Hagerstown for prevention. Need to do prevention for all ages and drug topics. All drugs are an issue; the addiction is one and the same. Prevention should be part of the school curriculum.

**B. Marie Byers**: Volunteer – driver's ed should also have drug/alcohol requirement; now schools are too interested in testing. Was on school board 30 years and national board 12 years. Education should start in 3rd grade, not 5th.

**Bill Gaertner:** Ex-offender, out of prison 1.5 years; was in prison with domestic violence and alcohol 8.5 years. Running reentry program. Not enough transition housing. Please help us with housing.

Clive

/ Jeff ~~Klass~~

**County Executive and Commission Presidents (10 mins)**

Vice

~~Terry Baker,~~ President, Washington Co Commissioners

✓ Rebecca Hogameir, Washington County Health Officer

✓ Rodney Glotfelty, Garrett County Health Officer

✓ County Executive Jan Gardner, Frederick County

✓ Barbara Brookmyer, Frederick County Health Officer

✓ William Valentine, President, Allegany Co. Commissioners

✓ Pat Panuska, Allegany County Health Officer

**Law Enforcement (10 mins)**

✓ J. Charles Smith, State's Attorney, Frederick County

✓ Lisa Thayer Welch, State's Attorney, Garrett County

✓ Douglas Mullendore, Sheriff, Washington County

✓ Craig Robertson, Sheriff, Allegany County

✓ Sheriff Jenkins, Frederick County

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

✓ Judge Dana Wright (Washington County Juvenile Drug Court)

✓ Allen Twigg (Meritus Medical Center)

✓ Kimberly Eaton (Day Report Center in Franklin County)

✓ Carin Miller (Maryland Heroin Awareness Advocates)

✓ Sheri Denham (Registered Nurse on opiate literature review) – get her research paper!

✓ Marte Birnbaum (Gale Recovery)

✓ Dr. Ramsey Farah (Phoenix Health System)

✓ Jacque Burrier (Project Hope)

✓ ~~Paddy Garrick (peer)~~ Claude Nelson, DARE Coordinator

✓ Deanna Bailey (Alternative Drug & Alcohol Counseling Center)

✓ Richard Benchoff (Wells House, Inc.) ✓

✓ Becky Meyers (Allegany Outpatient) & Kathy Miller (Allegany Inpatient)

✓ Gina Carbaugh (Richard Carbaugh's Hope Foundation)

**Public Comment (3 mins)**

✓ April Rouzer

~~Heather Hinkle-Ashkettle~~

~~Lisa Griffith~~

✓ Pastor Brett McKoy

~~Donna Evans~~

✓ Kevin Simmers

✓ Susie Gruber

~~Pamela Eichelberger~~

~~Carin Miller~~

~~Donna Marshall Downing~~

~~Michael O. Twigg~~

~~Glenn Young~~

✓ Debbie Fling
✓ Thomas A. Werner
~~Sharon Lindsay~~
✓ Bob Kozloski
~~Barbara Leatherman~~
~~Korey Choib~~
✓ Rose Marie Snider
✓ Reisert Harsh
✓ Barbara Hovermill
~~Ralph Young~~
✓ Dee Miles
✓ Christina Price
~~John Benisek~~
✓ Jamie Rowland

# SIGN IN SHEET FOR PUBLIC COMMENT
## Lt. Governor's Drug Task Force Meeting - Hagerstown
## DATE: 5/18/15

| Time | Name | Town of Residence | Phone/Email |
|---|---|---|---|
| 9:30 | Bob Kozloski | FREDERICK | 301-662-6349 Kozlosk.B6@GMAIL.COM |
| | | | |
| 9:35 | TOM WERNER | FREDERICK | 301-473-5592 tom@wernerweb.com |
| ~~9:35~~ | ~~Tom Kelley~~ | ~~HAGERS~~ ~~Hagerstown~~ | ~~301-573-1082~~ ~~tkelley@~~ |
| 940 | Gina Carbaugh | Fred., MD | 240-575-0235 richardcarbaughshope[illegible] |
| 940 | April Rouzer | Washington | 240.313.3356 April.Rouzer@maryland[illegible].com |
| 940 | Kathy Thompson | Washington | 240 409 3749 Kathy@Potomacha.com |
| 940 | Justin Rashops | Washington | 240 625-8188 |
| ✓ 9:40 | Beth Jo Shifler | Washington | 301-739-3493 bjshifler@myactu.[illegible] |
| 9:40 | Kathy | | |
| | [illegible] | | |
| 9:50 | Aaron Stover | Williamsport | 240-675-0911 |
| 9:50 | Carly Jones | Hagerstown | carlyjones@transitions llc.com |
| 9:50 | Charles Casey | Cumberland | 540-247-3805 |
| 9:50 | ~~Chief Gregg Eyler~~ | Thurmont | 240-274-2334 geyler@ ~~Frederickcountymd.gov~~ |

# SIGN IN SHEET FOR PUBLIC COMMENT
## Lt. Governor's Drug Task Force Meeting - Hagerstown
## DATE: 5/18/15

| Time | Name | Town of Residence | Phone/Email |
|---|---|---|---|
| 9:50 | John Stanfield | D.C. | 202 667 6404 |
| 9:52 | Barbara Leathirman | Sharpsburg MD | 240-217-0317 |
| 9:52 | Robin Gruber | Woodsboro Md | dizzyde@ |
| ✓ | Julie Zelnoski | Walkersville | 240-310-8388 julie@frederick.com |
| ✓ 9:50 | Brad Graham | Hagerstown | 301 739 7748 x204 bgraham@wellshouse.org |
| 950 | Susie Gruber | Hag. MD | 11836 Walnut St Hag. MD |
| ✓ 10 | David Lidz | Smithsburg MD | 410.403 9484 david.lidz@ladders2leaders.org |
| | Christina Price | Hagerstown MD | 240-469-4737 cpringe@aol.com |
| ✓ 9:55 | B. Marie Byers | Hagerstown, MD | bmarbyers@juno.com |
| 10:00 | Dee Miles | Smithsburg MD | Agentdeeke@aol.com 240-675-6734 |
| 1005 | Jason Mellott | Cumberland MD | |
| 1005 | Delegate Karen Lewis Young | 3A | 3016827339 |
| 10:05 | Jim Raley | Frostburg Md | 301-707-1061 jimraley oca inc@outlook.com |
| ~~10:05~~ | ~~Garrett Rice~~ | ~~Hagerstown~~ | ~~240-241-4332 garrett.rice@cmcc~~ |
| ~~10:32~~ | ~~Caressa Flaherty~~ | ~~Frederick~~ | ~~301 606 8935 crateapilsp@comcast.net~~ |

# SIGN IN SHEET FOR PUBLIC COMMENT
## Lt. Governor's Drug Task Force Meeting - Hagerstown
## DATE: 5/18/15

| Time | Name | Town of Residence | Phone/Email |
|---|---|---|---|
| ✓ 10:55 | Susan Fox - DEA Educator | Baltimore/ Work-Hagerstown | 813-579-0880 susan.fox@deamuseum.org |
| | ~~Jill~~ | | |
| ✓ | Bill Gaertner | Hagerstown | 814-574-4354 |
| | ~~Korey Shurb~~ | Frederick | Korey1977@yahoo.com 240-529-2995 |
| | ~~Michael Jones~~ | ~~Fairfield PA~~ | ~~717 321-0117 MAMIKE88500@gmail~~ |
| | ~~Debbie Fling~~ | Keedysville | 301-514-7373 |
| | ~~Jamie Rowland~~ | Hagerstown | jlrowland03@gmail.com |
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Franklin County, Pennsylvania
Medication Assisted Treatment (MAT) Program
An Adult Probation and Day Reporting Center Collaboration
Report Update: May 2015

## BACKGROUND

April 2006 - Franklin County opened a Day Reporting Center (DRC) with the goals to reduce recidivism and the need for jail beds. The addition of the DRC saved the county $9 million in the cost of building a new jail. The new jail was built with 464 beds instead of 600 because the DRC was used as an intermediate punishment in lieu of jail.

From the start, the program was a success with all populations except known opiate addicts. Every known opiate addict who entered the DRC failed. Most heroin addicts failed within one week of release from jail. The relapse rate was 100%. The Adult Probation Department (APD) policy was to incarcerate every heroin addict when relapse occurred. When funding was available these offenders went to an inpatient rehab facility for 14 to 28 days. Relapse following inpatient treatment was 100%.

## CASE STUDY 1

June 2006 -A female heroin addict was released from jail to the DRC program. Ms. Scott (pseudonym) was 34 years old. She admitted to using heroin since age 15. Ms. Scott immediately tested positive for opiates and admitted using heroin. She was incarcerated and referred to a substance abuse inpatient facility. When she successfully completed this program she returned to the DRC.

After her 28-day inpatient stay, Ms. Scott looked transformed. She had gained weight and her hair and skin were vibrant. The DRC Director did not immediately recognize her due to the extreme change in her appearance.

Ms. Scott reported that she was very happy to be sober for the first time in many years. She stated that she wanted to continue what she began in rehab because she had a 2-year-old daughter to raise. She was very focused on being present for her daughter in a way that she had never been before. Ms. Scott stated she was determined to maintain her sobriety and she felt she had learned all the skills she needed while in rehab.

Eight days after being released from the rehab program, Ms. Scott was found dead in a hotel room from a heroin overdose.

After Ms. Scott's death, the DRC program discussed alternative solutions with the APD. No one knew what to do with heroin addicts or opiate addicts in general. The relapse and unsuccessful DRC discharge rate for heroin addicts continued to be 100%.

MEDICATION ASSISTED TREATMENT (MAT) PROGRAM

July 2007 – One year following Ms. Scott's death from a heroin overdose, the DRC and APD continued to struggle with the issues of treating opiate addicts. A DRC addiction counselor suggested we investigate the use of Suboxone to treat opiate addictions. The Suboxone representative was the proprietor of a local outpatient addiction program. She was known to the DRC Director and the APD Chief. Both considered her to be a reliable source of information. The DRC Director contacted her to inquire how Suboxone might be utilized by the program to increase the success rates for opiate addicts. She provided product information and contacts with Suboxone certified physicians.

After the DRC Director investigated Suboxone supported treatment she formulated a plan with the APD Chief. The APD Chief allowed the DRC Director to use ACT 198 funds for a project that was titled Medication Assisted Treatment (MAT). In Pennsylvania, offenders found guilty of drug related crimes must pay a fine that supports ACT 198. This fund is then divided between the state and local municipalities. The funds have to be used for addiction related services. The funds had always been used for inpatient treatment.

With the help of the Suboxone representative, the DRC Director formed a relationship with a local physician and pharmacy. DRC clients with an opiate addiction were referred to this physician for Suboxone induction. The DRC Director wrote court orders asking for ACT 198 funds to be used to pay for the physician appointments and the Suboxone prescriptions.

The MAT plan was purposely created to be as simple as possible. The DRC Director added the responsibilities for this program to her already full schedule. The AP Chief was willing to oversee the funding and asked only that he receive copies of court orders at the end of each month. The President Judge agreed to sign all court orders for the MAT program.

Bi-weekly the DRC Director writes court orders for all current physician and pharmacy bills. These court orders are emailed to the President's Judge's Administrative Assistant (AA). The AA prints the court orders for the Judge to sign. The DRC Director picks up the court orders at her convenience, has each true and attested by the Court Recorder's Office, and sends the court orders and the bills to the county Fiscal Department for payment.

The MAT program does not screen offenders for participation. Any DRC offender who requests help is granted the opportunity without any regard to whether that person is "ready" for treatment. All MAT participants are in substance abuse treatment at the DRC. MAT participants must comply with all DRC policies and procedures. Failure to check in or attend class results in a DRC sanction and possible discontinuation in the MAT program. Drug screens positive for any substance may result in discharge from both programs.

MAT offenders meet with the DRC Director to be enrolled into the program. At that time the offender must sign Release of Information forms that enable the DRC Director to exchange information with the physician and the pharmacy. The DRC Director calls the physician's office to schedule the initial intake appointment while the offender is present. The DRC Director sends a standardized fax to the physician's office stating ACT 198 funds will be used to pay the bill. The same fax is sent to pharmacy approving payment for the medication. A similar fax is sent to both parties when the offender is removed from the MAT program for any reason. Reasons include successful transition, DRC graduation, or failure to comply with program rules.

When the MAT program started offenders were allowed up to four 8mg Suboxone tabs per day. Due to funding issues, as well as diversion concerns, that was reduced to two 8mg tabs per day. Now the standard policy is for the MAT program to pay for one 8mg film per day with the offender paying for any additional medication needed.

The offender must pick up medication weekly. This procedure helps reduce the amount of medication available to the offender and therefore, reduces the risk of diversion. Additionally, if the offender is discharged from the DRC program for any reason, the amount of medication the offender has on hand is minimal.

The offender is told the MAT program is designed to help establish the person on medication. The offender must develop a plan to sustain the medication once the funding from the MAT program ends. Offenders may apply for Medical Assistance, find employment, become a Suboxone indigent client for one year, or ask family members for help. Often offenders find that once they demonstrate the medication is helping maintain their sobriety family members are willing to provide some financial support.

CASE STUDY 2

July 2007 - The first client to be placed on Suboxone through the MAT program was an African American male in his mid twenties. Mr. Long (pseudonym) had a long history of drug use starting in his early teens. He experimented with numerous drugs before he tried heroin. When he did not have heroin he snorted Oxycodone.

Mr. Long agreed to try Suboxone even though he was extremely doubtful it would help him. He immediately reported that he was amazed that he did not "crave" heroin when he took the medication. As he continued with his outpatient substance abuse treatment he began to make improvements in his life. He found a job and he was able to keep it. He started to date a woman who did not use substances. His attitude and appearance improved.

Mr. Long had been taking Suboxone for several months when his father died of a drug overdose. His father had been taking several prescription medications for pain. It was not clear if the overdose was accidental or deliberate. Mr. Long was devastated. He was tearful, remorseful, and depressed. He came in to the DRC every day and discussed with staff his overwhelming desire to use heroin just to avoid the emotional pain he was experiencing.

Two weeks after his father's death, Mr. Long stated that he was beginning to function again. He was thankful for the support he received. He seemed amazed that he made it through the ordeal and did not relapse.

Several months later, Mr. Long successfully completed the DRC program. A file review in July 2011 indicated that Mr. Long had no new charges. He was employed full time. He had no probation violations and was stepped down to a lower probation intensity level.

Mr. Long was the first Suboxone client at the DRC and he remains successful in his ability to maintain his sobriety and be a productive citizen.

MAT STATISTICS

May 2015 - Since July 2007 when the MAT program started, 189 offenders have received help with medical treatment and medications to manage addictions and are no longer in the DRC program. There are 14 offenders in the MAT program who are currently participating in the DRC program and therefore not included in this data section. See Table 1 for details.

Table 1: MAT Program Participants (July 2007 – May 2015)

| Reason | Drug | Total number of clients | Successful | Unsuccessful |
|---|---|---|---|---|
| Alcohol Dependence | Antabuse | 5 | 2 (40%) | 3 (60%) |
| Depression/Anxiety | Various | 11 | 7 (64%) | 4 (36%) |
| Opiate Dependence | Suboxone | 173 | 118 (68%) | 55 (32%) |
| | | 189 | 127 (67%) | 62 (33%) |

The DRC overall program success rate is 64%. The DRC success rate for MAT Program offenders is 67%. The success rate for MAT Program offenders specifically taking Suboxone is 68%.

The success rate for heroin addicts changed from 100% failure to 68% success. In fact, opiate dependent offenders taking Suboxone while in the DRC have a greater success rate than all other offenders in the program combined.

There are other Suboxone programs in the area managed by county agencies. The MAT program is by far the most successful Suboxone program. The combination of the DRC program stipulations along with the reduction in treatment barriers appears to be a winning combination.

In addition to phenomenal program success rates, the use of Suboxone saves the county money on treatment. The average cost of inpatient substance abuse treatment is currently approximately $215 per day with an average length of stay of 14 - 21 days (Amber Gift, Franklin County Drug and Alcohol Department Case Management Specialist, Personal

Communication, May 11, 2015). One person in inpatient treatment costs the county between $3,010.00 to $4,515.00.

A review of the cost for clients in the MAT Program shows an average cost per person of just $1,125.00. This is money spent over the course of treatment in the DRC. The average length of stay in the DRC program is approximately 225 days. This equates to just $5.00 additional cost per day for each MAT Program offender. Since the money used is from a fund supported by fines there is virtually no cost to the county.

The APD Chief recently reported that probation offenders' deaths due to drug overdoses have decreased. This is attributed to the use of Suboxone as part of several probation supported programs.

In 2007, Franklin County APD reported the highest probation offender death rate from overdose on record. Four offenders died from drug overdose in 2007. This rate dropped to three in 2008. In 2009, four deaths were reported and in 2010, no deaths were reported. From 2011 through 2014, zero to 1 death per year has been reported. While any number of deaths from drug overdose is regretful, Franklin County's programs that utilize evidence-based addiction practices combined with pharmacological intervention are proving to be making a difference in both relapse prevention and overdose death rates.

CASE STUDY 3

March 2011 – An APD Officer (PO) called the DRC director to discuss an offender. Mr. Martin (pseudonym) was a 29 year old heroin addict. He had been to numerous treatment programs over the years. He was in one long-term addiction program for more than 2 years. He just returned home from another program in which he had been sober for over 6 months. Mr. Martin reported to his PO that he was not able to maintain his sobriety because he thought about shooting up heroin all the time. He was asking for help. The PO called the DRC to ask what could be done to help Mr. Martin.

The DRC Director contacted a local doctor's office and arranged for Mr. Martin to be seen that same day. Mr. Martin was directed to go to the doctor's appointment and then go directly to see the DRC Director.

When Mr. Martin arrived in the DRC Director's office he was tearful. He stated that he was inducted on Suboxone while in the doctor's office. He reported that he did not "crave" heroin for the first time in as long as he could remember. He broke down and sobbed while he stated that he had just found out that his girlfriend was having a baby in July. She had not wanted to tell him for fear he would be overwhelmed and use the news as a reason to relapse. He stated that he wanted to be alive for his baby's birth and he knew that he would never be able to make it on his own.

In July, Mr. Martin's daughter was born. He was there for her birth. He has been clean during his entire treatment at the DRC. He currently has Medical Assistance which pays for his doctor visits and medication. He is employed full time for the first time in his life.

He graduated from the DRC program in late 2011. He has not recidivated since and continues to live without drugs.

## MAT PROGRAM DESIGN CONSIDERATIONS

There are several key issues to be addressed when developing a MAT program. The Franklin County MAT program model is streamlined and incorporated into an existing DRC program. This combination of programs supports the offender pharmacologically, cognitively, and behaviorally. It appears from the success of the program that this blend of treatments is a recipe for achieving long-term sobriety from an addition that was previously thought to be hopeless at best and deadly at worst.

## FUNDING

The first program consideration is funding. If funding is tied to another program, such as a DRC, then it would be pertinent to establish a combined budget so staff could be shared. Once a dollar amount is earmarked for an MAT program then the number of clients to be served can be established. The program may want to limit the amount of funding provided to each offender. This would allow for a specific number of offenders to be served. If this is not done, then it will be important to set a budget that is reviewed monthly or quarterly to insure funding is judiciously spent.

It is important for discharge planning to start as soon as the person enters the MAT program. The offender should be given an MA application to complete and return it to the assistance office. A person may qualify for MA without ever realizing that is possible. MA will cover all costs for Suboxone.

Offenders can qualify for MA as long as they are in compliance with their probation stipulations. This includes payments on fines. The APD will be asked to complete an MA form that indicates the person is up to date on fines. It will be important for the MAT program to work closely with the APD to aid in this process. In some cases it may be possible to restart an offender's payment plan in order for the person to be in compliance. Then the person will have to remain in compliance in order for the MA to continue. This would at least start the person on MA and give the person a reason to stay in compliance.

## CASE MANAGEMENT

A specialized case manager will be needed to oversee the program. The MAT program could be an added component to an addiction counselor's job description. This would be a logical additional responsibility since treatment is already being provided for the offender. The only added duty is the time to arrange the initial appointment. The use of standardized forms makes this extremely short. Since no assessments are necessary it is a simple process.

It will be necessary for the case manager to respond immediately to any requests for help due to the high risk of drug overdose for those who have abstained from heroin for any

period of time. It may be helpful for the referral agency to identify known opiate users on the referral form so appropriate steps can be taken during the intake process.

## PROGRAM MANAGEMENT

In addition to the specialized case manager duties, fiscal oversight will be needed. A DRC program manager could review payment for physician and pharmacy bills. There should be no need for additional staffing. This person could also be responsible for the budget. An Excel spreadsheet can be utilized to track data.

## MEDICAL SERVICES

The program will need to establish relationships with a Suboxone certified physician as well as a pharmacy. Depending on the budget for the program, this may require writing a request for proposal (RFP) for the pharmacy. An RFP is not needed for the physician because this is a professional service. An RFP could insure the program receives the best pricing available for the medication. A contract with a physician could also result in a reduced rate for MAT program referrals.

Depending on the geographical area, it may be beneficial to have more than one medical provider. It is important to remove as many barriers as possible so the offender is able to access all needed services. The use of a chain pharmacy could also be beneficial so the offender has multiple sites to pick up medications. However, it is important to keep the program simple so there are less tracking issues.

The relationship with the physician is crucial to the function of the program. The physician must understand the need for immediate intake appointments. Appointments that are beyond a one-week wait-time are not feasible for this population. The risk of incarceration or death due to relapsing is extremely high. If at all possible, the program should establish a "preferred status" with a physician so offenders are given the first available appointment. An even more preferable option is to establish weekly appointment times that are dedicated to program participants. A certain day of the week for Suboxone induction/intake appointments may be helpful to both the program and the physician.

Many physicians want to see the Suboxone patient weekly or biweekly following induction. A physician may agree to see the patient less often for monitoring appointments if he or she knows the patient is being monitored daily by a DRC. This would be cost beneficial and may be doable as long as the offender is checking in daily.

## DRUG SCREENS

A program should consider random drug testing for substances as well as Suboxone. Testing for Suboxone ensures the offender is taking the medication and reduces diversion concerns. The cost of drug testing has to be considered in the budget. If the MAT program is tied to another program, such as a DRC, then the drug testing schedules could be linked.

The cost to test for just Suboxone is under $1.00 per test. This additional cost to monitor the offender could ensure the medication is being taken as directed and not diverted. Evidence-based research indicates it is imperative to address compliance issues as soon as possible. The only way to do this is to monitor the offender and sanction any noncompliant behaviors.

Sanctions for positive drug screens or a drug screen that shows Suboxone has not been taken as directed should be graduated. A range of program sanctions should be developed and tied into the sanctions for the collaborative program.

In addition to sanctions, rewards are important. Providing clean drug samples should be recognized as an accomplishment. Small tokens can be given to the offender when clean samples are tested. Research has found that small prizes or rewards are very effective in treatment.

PROGRAM LENGTH

If a MAT program is tied to a DRC, then it will be important to establish the length of time for participation in the MAT program. If funding is available, it may be best to allow the offender to participate in the MAT program until discharge from the DRC. However, it may be feasible to link the MAT program to the phase progression used by most DRCs. For example, offenders may receive help in the first phases of the program with the understanding they have to be self-sufficient by the Aftercare phase. This allows the program to continue to track the offenders' progress as they establish their own ability to pay for their treatment needs.

CASE STUDY 4

May 2011 - Ms. Grove (pseudonym) started the DRC program in September 2008. She was discharged for a lack of progress in January 2009. She returned in March 2009 only to be incarcerated for a new shoplifting charge shortly after intake. Ms. Grove returned for a third time in July 2009 and was rearrested for a new robbery charge within two weeks. She returned to the program for the fourth time in November 2009. She was caught drinking twice and was discharged for lack of progress in July 2010.

At the time of her discharge in July 2010, the DRC Director spoke to her about her apparent inability to complete the program. The Director was under the impression that Ms. Grove had a problem with alcohol. After Ms. Grove insisted several times that her problem was not alcohol, the Director finally asked what the problem was if it was not alcohol. Ms. Grove stated that she was addicted to snorting Oycodone. She then explained how all of her charges were connected to her need to support her growing habit. She was snorting in excess of 30 pills per day. Ms. Grove stated that she did not want anyone to know about her addiction because she was afraid she would not retain custody of her children. After a discussion about Suboxone, Ms. Grove agreed that if she was allowed to return to the DRC she would try the medication.

Ms. Grove was incarcerated for one week and returned to the DRC program. An appointment for Suboxone induction had been made for her while she was in jail. She

went to the appointment on the first day of her release. She immediately reported a relief from the constant desire to use opiates.

In May 2011, Ms. Grove successful graduated from the DRC after failing four previous times. She has been sober since her Suboxone induction.

Ms. Grove is employed full time. She has maintained custody of her children. She has not recidivated.

## SUMMARY

The Franklin County APD and the DRC Director have collaborated since 2007 in an MAT program aimed at helping high-risk opiate addicted offenders establish sobriety and successfully complete the DRC program. Over 190 people have been helped by the program with a success rate of 67%.

Duplicating this system in other areas will involve establishing a funding stream and possibly linking it to another program, such as a DRC. While each project will be unique, there are lessons to be learned from the Franklin County model that can aid other counties in creating a workable program.

It should be recognized that there is a value that cannot be measured by the lives that are saved. Substance users are sons, daughters, mothers, fathers, family members, neighbors, and citizens. The criminal justice system has the responsibility to incarcerate individuals who are a danger to the public. We need to recognize when treatment is a better option than incarceration for helping individuals to be productive members of society in the long term. When it is fiscally sound, morally correct, and public-minded then treatment should be considered as an option. After all, we are talking about people who need help more than they need punishment.

**THE MUST READ ARTICLES ARE:**

Dearth, D (2014, February 16). "No area unscathed by heroin overdoses in Washington County" *Hagerstown Herald – Mail*. Retrieved from http://www.heraldmailmedia.com

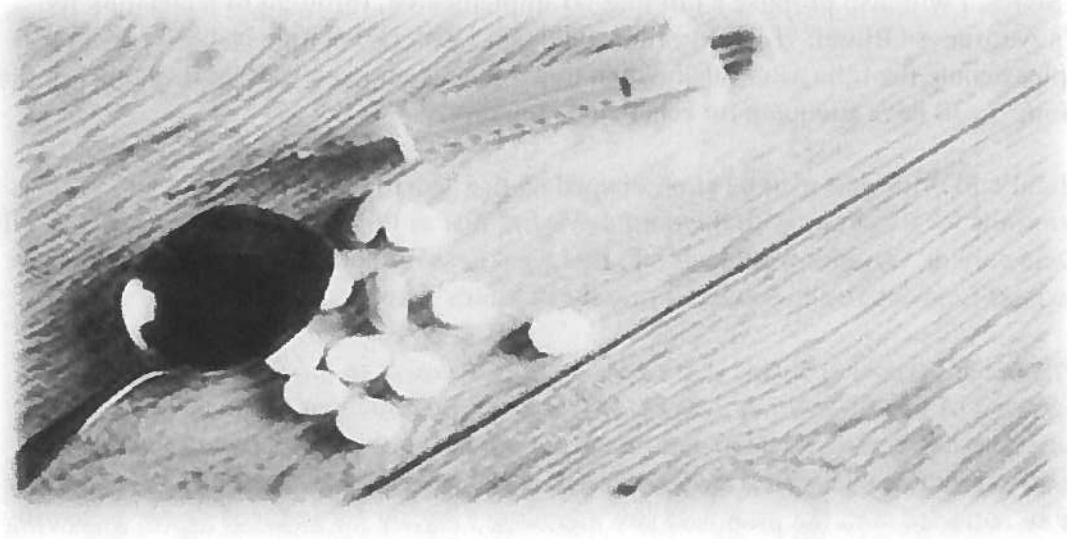
Freedberg, S (2013, March 28). "Methadone Deaths Tied to For-profit Clinics Prompts Bills". *Bloomberg Business*. Retrieved from http://www.bloomberg.com

Swisher, S (2013, April 20). "Methadone treatment raises questions about profit motive, patient care". *Daytona Beach News-Journal*. Retrieved from http://www.news-journalonline.com/

*UNTOPPABLE FATHER*

**Bob Kozloski**

*Committed to Honor Son and Help Others*



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**Vision:** Create a safer and more responsible drug environment in Maryland

**Mission:**

- Reduce Opiate drug overdoses
- Hold Maryland Physicians and Licensing Board accountable for dispensing unmanaged prescriptions for profit
- Improve and strengthen PDMP by having mandatory reporting by Physicians of dispensed opiate prescriptions
- Improve Recovery programs and facilities to treat the disease of drug addiction
- Increase penalties of drug dealers and doctors associated to drug overdose deaths

Having experienced the overdose death of my son from OxyContin 3 years ago, I would like to become a member of your task force, or least be able to share my experience, my goals and mission. I have taken on this mission in support of my son because of an overdose on prescription drugs by "pill mill" Doctors only after 2 days he came out of rehab. I submitted a complaint to the Physician Licensing Board, where they suspended their licenses. Their licenses were suspended but they are being given the opportunity to get them back.

I summoned for criminal prosecution by the States Attorney Offices of Frederick County and Prince Georges County, where these Doctors practiced. I was told by the State Attorney of Frederick, they would not press charges. They believed the legislative support (laws) were too weak to create a case. I would like to see a bill sponsored by the States Attorney's office to address this shortfall, if that is the case. Following the lead of other States, I will also propose a bill that NJ implemented, (brought to legislature by State's Attorneys Office), "Liability Induced death Law" (NJ statute N.J.S.A, 2 C:35-9). Also please note the time after rehab when this tragic event occurred. Makes one ask the question, "Is 30 days adequate for rehab and recovery?"

Maryland's PDMP must also be strengthened so that Doctors also must register prescriptions for narcotics with the online system, just as Pharmacies are required. A bill like Delaware or Virginia would address this weakness. I plan on writing this proposal for the next Legislative session reflecting those States' law.

The Physician Licensing Board also needs an improvement in the monitoring and management of the disciplinary actions of Doctors who endanger the lives of the Public. Doctors, as well as, street dealers should be prosecuted to the full extent of the law (criminal homicide charges), if they are associated with the overdose victim death. This would be included with the proposed law mentioned earlier for induced death, following the lead of other States. This will reduce the supply, accessibility, and improve the relaxed environment we provide here in Maryland for the sale of opiate products for profit. Did you know a dealer who was associated to an overdose death recently here in Maryland only received 7 years? 7 years for murder? Do we want that to continue? We need to look into these laws further and keep Maryland from being a welcome State for dealing and suppling drugs with minimal incarceration.

In addition to the above proposals to impact and address the opiate overdose epidemic here in Maryland would be the implementation of Electronic prescribing (I – Stop Program). This was recently enacted in New York. 84% of those on heroin start with prescription drugs, and overdose deaths by prescription drugs is 2x that of heroin overdoses.

In conclusion we need to be progressive and get up to speed with other States. Maryland needs to be more proactive in the fight against this epidemic and not be status quo. Maryland is one of the least active and progressive States vs. many other US States. I am concerned that State Legislatures, past Attorney General, current State Prosecution Attorneys and previous Governor this fight to reduce opiate deaths were and are not fully engaged to completely support this effort. It will take everyone's commitment and initiative to make this battle successful.

Where cancer has touched someone in every family, drug abuse and its consequences has now become the new cancer in every family. I hope and pray that no one else or their family has to go through what my family and I have experienced. It will live with us forever.

# Iatrogenic Opioid Addiction: Prescribing a Dose of Addiction

Sheri Denham, Ashley Harris

Scholarly Inquiry II

April 22, 2015

# Iatrogenic Opioid Addiction: Prescribing a Dose of Addiction

## Introduction

The correlation between pharmaceuticals and opioid abuse is a topic many researchers are considering in hopes of improved addiction prevention measures. This literature review will discuss the relationship between opioid prescription medications and subsequent abuse and addiction of opioids, including heroin. This literature review used Simmons College Library databases including CINAHL and PubMed. Keywords used in the search included the following: opioid abuse/addiction, iatrogenic addiction, heroin abuse/addiction, and prescription misuse/abuse. The review of the literature revealed common themes among researchers: (1) etiology of opioid addiction, (2) risk factors of addiction, (3) availability of opioids, (4) iatrogenic addiction, and (5) regulation and prevention when prescribing opioid medications.

## Etiology

The abuse of opiates is a growing national epidemic. Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) defines prescription drug abuse as the intentional or unintentional use of medication without a prescription or the use of the medication in a way other than prescribed. The results from the 2013 National Survey on Drug Use and Health indicate that about 15.3 million people aged 12 or older used prescription drugs non-medically in the past year (SAMHSA, 2014). The abuse of prescription drugs is growing rapidly and they are used more often than any other drug except marijuana and alcohol (SAMHSA, 2014).

Opioid abuse among individuals is steadily increasing as evidenced by the growing number of overdoses each year. The increase in opioid abuse is especially worrisome due to the potential and very real side effect of respiratory depression and subsequent death (Compton & Volkow, 2006). Of the 22,114 deaths relating to pharmaceutical overdose in 2012, 16,007 (72%)

involved opioid analgesics (CDC, 2014). The dose at which respiratory depression can occur is highly individualized and cannot be predicted with absolute certainty, increasing the dangers of unregulated dosing.

Limited research has focused on quantitative and qualitative information to ascertain the populations most at risk for developing misuse and abuse of prescription drugs and the etiology surrounding their initial exposure to opiates. In a qualitative study, Rigg and Murphy (2013) inquired about the etiology surrounding the initial exposure of ninety opioid addicts in south Florida currently undergoing treatment for opioid addiction. Participants in all trajectories described that their tolerance level builds and the amount of drug to reach a desired effect quickly magnifies (Rigg & Murphy, 2013). Rigg and Murphy (2013) discovered the misuse of prescription drugs occurred in four contexts: (1) heroin abusers became prescription drug abusers due to the lack of availability of heroin in south Florida, (2) the initial use of prescription drugs was related to introduction by a male figure in romantic heterosexual relationships, (3) the abuse of prescription drugs by cocaine users was to avoid the "crash" effects of binge cocaine use, and (4) first initiations occurred in the health system. Contrary to the previous belief that prescription opioids leads to heroin abuse, the pain clinics offered previous heroin users a more socially acceptable, legal, and longer acting means of managing their addiction with prescription opioids versus heroin (Rigg & Murphy, 2013). This demonstrates that the transition between heroin and prescription opioids can be bidirectional.

In a mixed methodological study, Redican, Marek, Brock, and McCance-Katz (2012), highlighted the etiological factors of opioid prescription misuse in Southwest Virginia. The findings from this study include the following: (1) opioid use (due to workforce related injuries) progressing to abuse, (2) a desire to get high, (3) overprescribing and physician issues, (4) lack

of information, and (5) cultural acceptance of drug taking as problem solving behavior. Although not a stand-alone issue, an identified common thread among opioid abuse literature is the initial use of prescription drug use in the context of the health system.

Under treatment of pain is another critical issue of subsequent opioid abuse and addiction. The term *pseudoaddiction* is used to describe behavior that can occur when pain is inadequately controlled. Problematic behaviors such as doctor shopping, illicit opioid use, and running out of medications early are considered characteristic of addictive behavior (Bailey, Hurley, & Gold, 2010). With the rising scrutiny of opioid prescription practices some physicians are experiencing "opiophobia", that is the fear physicians have of treating pain with opioids (Ronald & Libby, 2005). Because treatment of pain with opioids, unlike most other professionally sanctioned medical treatments, is subject to a heightened level of scrutiny from outside agents, some of which have the power to levy significant legal or professional sanctions, trust in patients in this context can be hard to achieve and easily fractured (Miller, 2007). According to Miller (2007), the risk to the patient is usually greater with under-prescribing but the risk to the physician is greater with overprescribing. It is imperative for providers to recognize signs of opioid abuse and addiction and to also be aware of risk factors that can predispose their patients.

## Risk Factors

Prescription of opioids occurs in two contexts of pain management: acute pain with a limited exposure to opioid medication and chronic pain with an extended period of opioid medication use (Compton & Volkow, 2006). Treatment of acute pain conditions with brief short-term prescriptions of opioid analgesics are rarely associated with abuse or addiction, although extra medication left in a medicine cabinet represents a potential source of misuse for family

members and others in the home (Compton & Volkow, 2006). Although not fully understood or researched, people with chronic pain are thought to be at risk as tolerance develops from extended use of opioid pain analgesics. According to an expert panel from the American Society of Addiction Medicine, the American Pain Society, and the American Academy of Pain Medicine, *tolerance* can be defined as a state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug's effects over time (Bailey et. al., 2010). Compulsive consumption of opioids to satisfy craving and allay withdrawal, irrespective of the presence of actual injury or tissue damage, may be seen as a hallmark of addiction among chronic pain patients (Garland, Froelinger, Zeidan, Partin, & Howard, 2013). Depression, previous substance abuse, and traumatic life events are all potential situations that make a person more susceptible to prescription opioid abuse. Unresolved emotional and social distress coupled with persistent pain may lead patients to self-medicate these uncomfortable feeling states with opioids (Yu-Ping & Compton, 2013). Recovering addicts report that prescription opioids not only take the physical pain away but also take emotional pain away, creating a more significant potential for abuse (Riggs & Murphy, 2013). Opioid addiction coupled with comorbid psychological issues can make pain management even more difficult for healthcare providers.

Initial exposure to opiates from a healthcare provider leading to subsequent opiate addiction is not strongly stated as a causative effect throughout the literature; however, there is mounting evidence to suggest a strong correlation (Bailey, et al., 2010; Beauchamp, Winstanley, Ryan, & Lyons, 2014; Fishbain, Lewis & Gao, 2010; Galinkin & Koh, 2014). The literature suggests an increase in accessibility of opiates by prescribers, an increase in the quantity of dispensed medications, and prescribing opioid medications as a first-line analgesic instead of less addictive options (King, 2014) as contributing factors.

## Iatrogenic Addiction

In 2012 healthcare providers wrote 259 million prescriptions for painkillers (CDC, 2014). Although written prescriptions for pain medication are not the sole driving force of opioid abuse, the literature suggests prescribers' behaviors contribute to subsequent abuse potential (Coffin & Banta-Green, 2014). The liberal use of opioids in practice has the potential for causing iatrogenic addiction. Iatrogenic addiction is a term used to describe opiate addiction that is caused by healthcare providers. There is a trend that when physicians medicate patients for pain, they do not start with non-opioids but rather begin treating with opioids (Redican, Marek, Brock, & McCance-Katz, 2012). The more permissive attitude toward opioids for pain treatment began in the 1980s, after several reports suggested a low potential for iatrogenic addiction in patients treated with opioids (Beauchamp et al., 2014). In 1995, the president of the American Pain Society introduced a campaign entitled "Pain is the Fifth Vital Sign" at the society's annual meeting. This campaign encouraged health care professionals to assess pain with the "same zeal" as they do with vital signs and urged more aggressive use of opioids for chronic non-cancer pain (Kolodny et al., 2015). Other factors included attempts to improve pain management, emphasis on patient satisfaction and inclusion of pain relief in patient satisfaction assessments, aggressive marketing of opioids by the pharmaceutical industry, and welfare and health care reform (Beauchamp et al., 2014).

There is an unspoken expectation by patients that a visit to the doctor is not complete unless they walk out of the office with a prescription in hand (Redican et al., 2012). Opioid naive patients (absence of opioid medication use the 2 weeks before admission into the hospital [Lail, Sequeira, Lieu, & Dhalla, 2014]) receiving a prescription for opiates within seven days of a short stay outpatient surgery were 44% more likely to become long-term opiate users within

one year compared to patients not receiving an opiate prescription (Redican et al., 2012). Another study reported that 44% of patients in a methadone clinic reported that prescribed opiates led to their addiction (Compton & Volcow, 2006). In a survey of 433 heroin users, 169 (39%) reported being hooked on prescription-type opiates first (Peavy et al., 2012). A prevalence study computed the incidence of opiate related fatalities in Utah by medical specialty. Family practice and Internal medicine had the highest incidence of opiate related fatalities, accounting for 30% of opiate related deaths in the state of Utah (Porucznik, Johnson, Rolfs, Sauer, 2014).

## Availability

There are two common ways that opioid medications are obtained: through medical prescription and through illicit (i.e. unlawful) sources (Compton & Volkow, 2006). The availability of these medications is steadily increasing with the perceived availability of illicit drugs among youth as "easy." With a growing concern of use and abuse of illicit drugs and the pathway to opioid abuse, there seems to be a driving force behind the abuse of opioid medications. Among persons aged 12 or older who used pain relievers non-medically in the past year, 53 percent obtained the majority of the pain relievers from a friend or relative for free, about 21 percent received them through a prescription from one doctor, another 11 percent bought pain relievers from a friend or relative, and 4 percent took pain relievers from a relative or friend without asking (SAMHSA, 2014). According to SAMHSA (2014), an annual average of 4.3 percent got the pain relievers from a drug dealer or other stranger; 2.6 percent got pain relievers from more than one doctor; 0.1 percent bought pain relievers on the Internet; and 4.3 percent got pain relievers in other ways, including 0.7 percent who stole pain relievers from a doctor's office, clinic, hospital, or pharmacy. The increase in availability of opioid pain

medication puts users at increased risk of abuse and overdose. The CDC (2014) states that those at highest risk of overdose are people who use prescription opioids nonmedically 200 or more days a year. These highest risk users get opioids through their own prescriptions 27 percent of the time, an equal percentage as reportedly obtained from friends or family for free or for purchase (CDC, 2014). These high-risk users are about four times more likely than the average user to buy the drugs from a dealer or other stranger (CDC, 2014). With illicit opioid use on the rise and an increasing prevalence of the availability of opiates, the relationship between prescriptive practices and abuse/misuse becomes more scrutinized.

## Regulations and Screening

The Food and Drug Administration (FDA) is responsible for governing the regulation of opioids and other drugs reaching the market for prescription and over the counter use (Homenko, 2012). The FDA acknowledges that the burden of the opioid epidemic needs to be tackled on multiple fronts to overcome this problem. Opioids have been used since the 1970's and healthcare providers and regulatory bodies know their potential for addiction. In 2007, Congress passed the Food and Drug Administration Amendment Act (FDAAA) that gave the FDA greater authority in regulating opioids after reaching the market (Homenko, 2012). The FDAAA allowed the FDA the authority to implement the Risk Evaluation Mitigation Strategies (REMS). The REMS strategies are divided into three tiers: (1) staged evaluations of the potential of addiction after a new drug reaches the market, (2) written educational materials for providers and patients, and (3) a tool ETASU, which is reserved for the highest risk drugs. Elements to Assure Safe Use (ETASU). ETASU would require drug companies to offer specialized training and certifications to prescribers prior to receiving authority to prescribe high-risk medications (Homenko, 2012). Under ESATU, the FDA can enforce designated prescribing locations,

enforce more accurate monitoring of documentation governing safe drug use and patient monitoring, and encourage patients' to enroll in drug specific registries. The FDA can enforce the development of training programs about opioid addiction for healthcare providers, but the FDA has no authority over mandating healthcare providers to actually participate in the training programs (Homenko, 2012). Enforcement of required opioid specific REMS training programs prior to being issued a DEA number or renewal of a DEA number is a suggestion that would require enforcement by the DEA. The federal government does not have authority governing medical practices. Approval and enforcement of medical practice training programs would be required by the state licensing boards (Homenko, 2012).

## Clinical Recommendations

Prescribers must own the fact that their prescriptive behaviors have a direct correlation with the creation, maintenance, and potential subsequent death of an opiate addict. Prescribers have an ethical duty to take advantage of the educational opportunities provided as part of the REMS program. Opiates should not be the first line drug of choice for pain management. Alternatives to opioid therapy should be tried as a first line management. Intravenous Tylenol and Ibuprofen have been shown to have significant efficacy in the control of pain in postoperative patients (Koh, Nguyen, & Jahr, 2015). Other effective alternatives to opioid therapy include oral NSAIDS, Tylenol, less addictive antidepressants, heat and cold therapy, physical therapy, hydrotherapy, transcutaneous electrical nerve stimulation, magnetic field therapy, and accupunture (Adams & Arminio, 2008). Opiate addiction requires specialized consideration with both the prevention and the treatment side of the equation. Proactive screening for the potential of abuse and documented measures addressing risk factors are beginning steps to responsible prescribing practices. Empowering patients through education

enables them to make informed decisions about their health and outcomes. Collaboration between the prescriber and the patient demonstrates a partnership in reaching the common goals of pain management, addiction prevention, and when needed, addiction treatment. Denying a patient pain medication based on the assumption that he/she are drug-seeking increases the likelihood of them obtaining opiates illegally and intensifies their opiate abuse (Fibbi, Silva, Johnson, Langer, Lankenau, 2012). Opiate addiction is a physical addiction with intense, unpleasant withdraws including; sweating, increased heart rate, nausea, vomiting, and hypersensitivity to pain. Specialized rehabilitation program increases successful recovery and are more effective than cutting off the addict prescription.

## Conclusion

There is not enough evidence in the literature to prove that the prescription of opioids is the causative factor leading to opioid addiction; however, there is mounting evidence to suggest this as one of the possible causes (Bailey, et. al., 2010; Beauchamp, et. al., 2014; CDC, 2014; Fishbain, et. al., 2010; Galinkin & Koh, 2014). Opioid deaths and adverse events have been directly correlated to healthcare providers (Porucznik et al., 2014). With the correlation between the rising number of opioid prescriptions and the rising number of opioid related deaths, it is imperative that this correlation be further studied for a cause and effect relationship. Retrospective studies evaluating opiate addicts initial exposure to opioids would provide invaluable insight to the opiate epidemic. Another method of future research would be to implement a longitudinal study following opiate naive patients who are prescribed opiates, and evaluating them for a subsequent addiction.

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# IATROGENIC OPIOID ADDICTION

## PRESCRIBING A DOSE OF ADDICTION

SHERI DENHAM, RN, BSN

# WHAT ARE OPIOIDS? WHO'S AN ADDICT?

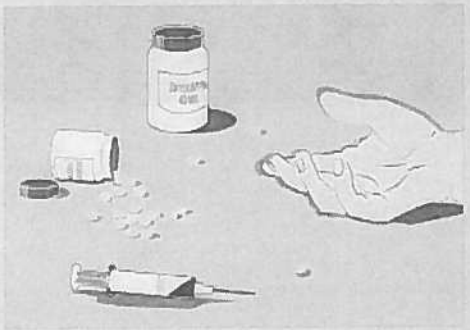
## CAN OPIOID ADDICTION HAPPEN TO YOU?

LYN IS A FREELANCE WRITER
AND A HEROIN ADDICT

# OPIATE ADDICTION DOES NOT DISCRIMINATE

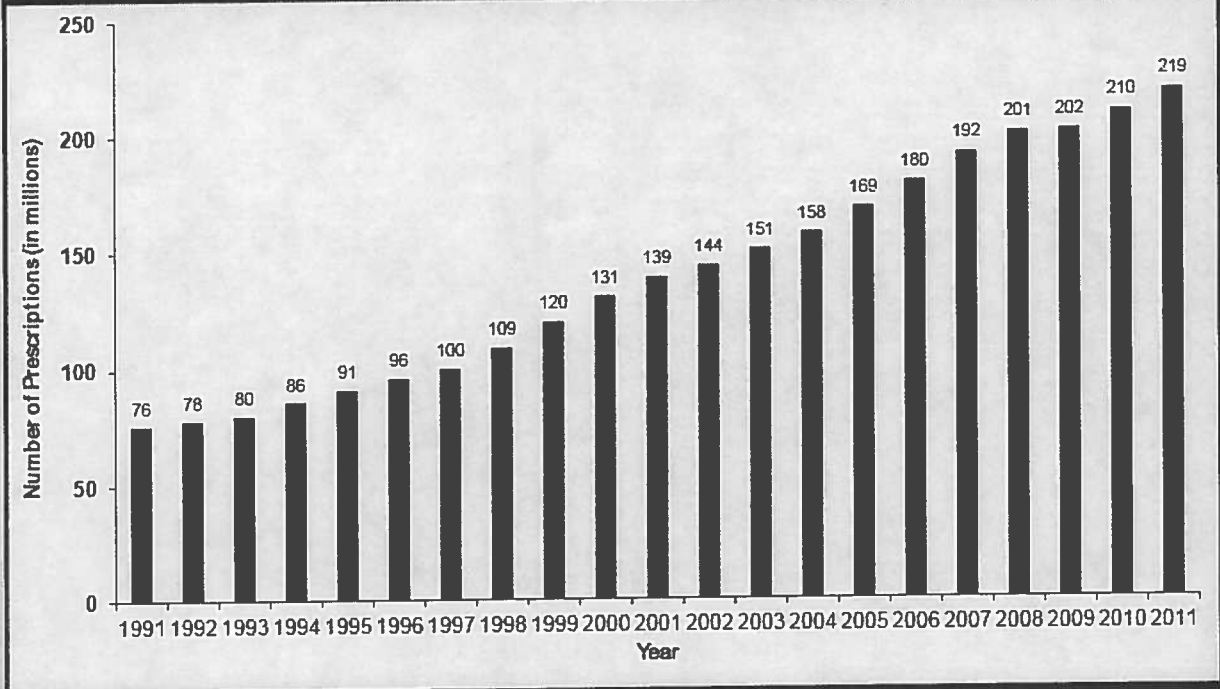
**HIGHLY FUNCTIONAL ADDICTION**

# THE OPIOID EPIDEMIC



- 26.4 -36 MILLION ABUSE OPIOIDS
- 517,000 PEOPLE ABUSE HEROIN (2013)
- 15.3 MILLION PEOPLE REPORTED NON-MEDICAL USE OF OPIOIDS IN THE PAST YEAR
- OPIATE RELATED DEATHS HAVE QUADRUPLED SINCE 1999
- 16,007 OPIOID PRESCRIPTION RELATED DEATHS (2013)
- IN 2012, 259 MILLION PRESCRIPTIONS WERE WRITTEN FOR OPIOIDS

# Opioid Prescriptions Dispensed by Retail Pharmacies—United States, 1991–2011

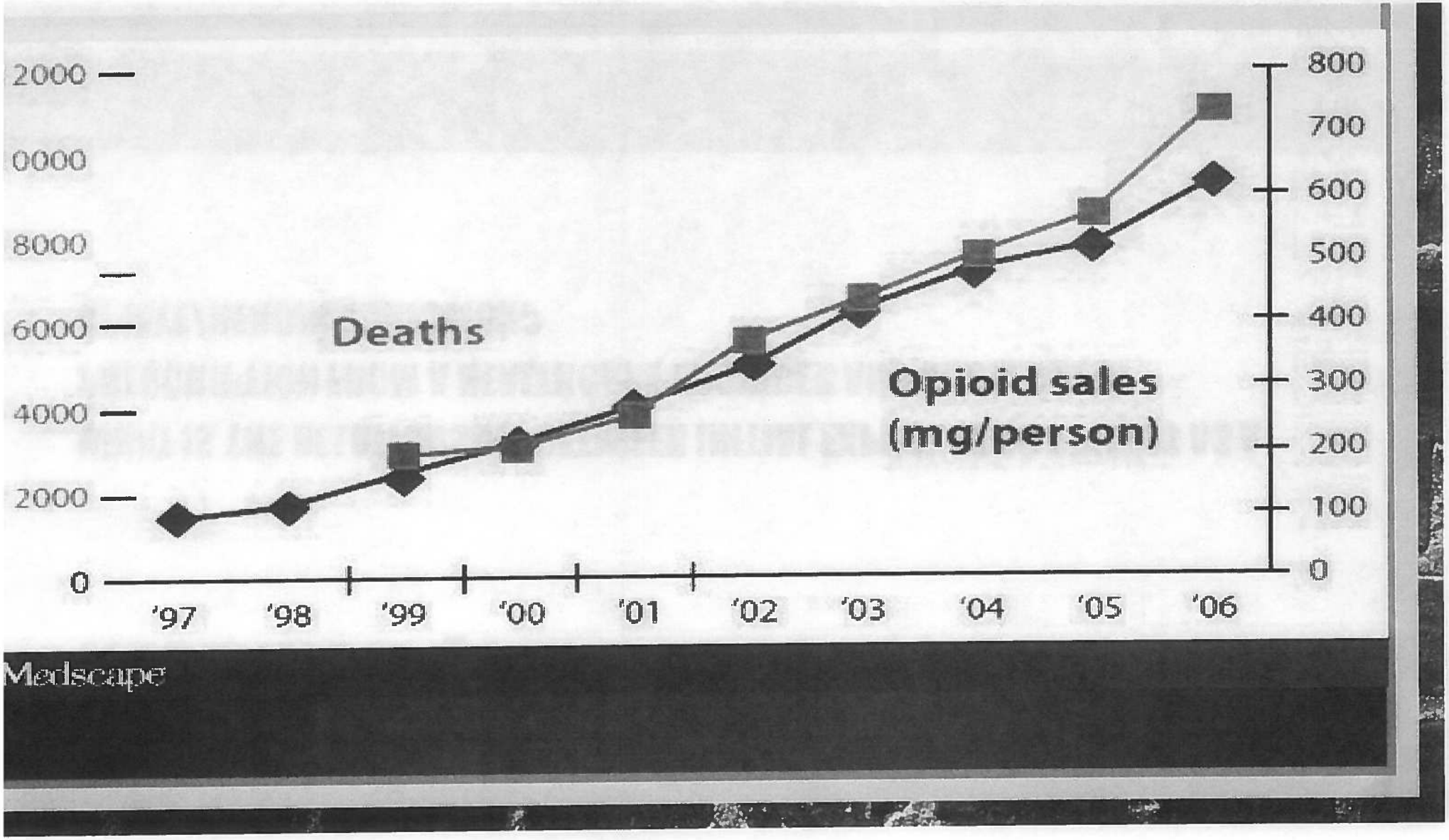



IMS Vector One. From "Prescription Drug Abuse: It's Not what the doctor ordered." Nora Volkow National Prescription Drug Abuse Summit, April 2012. Available at http://www.slideshare.net/OPUNITE/nora-volkow-final-edits.

# Overdose Deaths Involving Opioids, Cocaine and Heroin: United States, 1999–2010

| | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| opioid analgesic | 4030 | 4400 | 5528 | 7456 | 8517 | 9857 | 10928 | 13723 | 14408 | 14800 | 15597 | 16651 |
| cocaine | 3822 | 3544 | 3833 | 4599 | 5199 | 5443 | 6208 | 7448 | 6512 | 5129 | 4350 | 4183 |
| heroin* | 1963 | 1843 | 1784 | 2092 | 2084 | 1879 | 2010 | 2089 | 2402 | 3041 | 3279 | 3038 |

Source: CDC


2000
0000
8000
6000
4000
2000
0
Deaths
Opioid sales
(mg/person)
800
700
600
500
400
300
200
100
0
'97
'98
'99
'00
'01
'02
'03
'04
'05
'06
Medscape

# RESEARCH QUESTION

**WHAT IS THE RELATIONSHIP BETWEEN INITIAL EXPOSURE TO OPIATES AS A PRESCRIPTION FROM A HEALTHCARE PROVIDER AND SUBSEQUENT OPIATE/HEROIN ADDICTION?**

# LITERATURE REVIEW

- REVIEWED 27 ARTICLES WITH KEYWORDS OPIOID ADDICTION/ABUSE, IATROGENIC ADDICTION, HEROIN ABUSE/ADDICTION, AND PRESCRIPTION ABUSE/MISUSE
- IDENTIFIED TOPICS OF DISCUSSION
  - ETIOLOGY OF OPIOID ADDICTION
  - RISK FACTORS OF OPIOID ADDICTION
  - INCREASED AVAILABILITY OF OPIOIDS
  - IATROGENIC ADDICTION
  - REGULATIONS AND SCREENING OF PRESCRIPTIVE OPIOIDS
  - CLINICAL RECOMMENDATIONS
  - PLAN FOR DISSEMINATION

# ETIOLOGY OF OPIOID ADDICTION

- UNDERSTANDING THE ETIOLOGY OF PRESCRIPTION OPIOID ABUSE: IMPLICATIONS FOR PREVENTION AND TREATMENT, RIGG, K. K., & MURPHY, J. W. (2013)
  - QUALITATIVE STUDY
  - MISUSE OF PRESCRIPTION OPIOIDS OCCURRED IN FOUR CONTEXTS
- EXPLORING THE ETIOLOGIC FACTORS AND DYNAMICS OF PRESCRIPTION DRUG ABUSE IN SOUTHWEST VIRGINIA, REDICAN, K.J., MAREK, L.I. , BROCK, D.J.P., & MCCANCE-KATZ, E.F. (2012)
  - MIXED METHODOLOGY
  - SEVEN THEMES OCCURRED IN PRESCRIPTION OPIOIDS ABUSE/MISUSE

# ETIOLOGY OF OPIOID ADDICTION

- 44% OF PATIENTS IN A METHADONE CLINIC REPORTED THAT PRESCRIBED OPIATES LED TO THEIR ADDICTION (COMPTON & VOLCOW, 2006)
- OPIOID NAÏVE PATIENTS RECEIVING A PRESCRIPTION OF AN OPIOID WITHIN 7 DAYS OF AN OUTPATIENT PROCEDURE WERE 44% MORE LIKELY TO BECOME LONG-TERM OPIATE ADDICTS WITHIN 1 YR COMPARED TO THOSE RECEIVING NON-OPIOID PAIN MANAGEMENT (REDICAN ET AL., 2012)
- IN A SURVEY OF 433 HEROINE USERS, 39% REPORTED INITIALLY BEING HOOKED ON PRESCRIPTION OPIATES (PEAVY ET AL., 2012)

# RISK FACTORS OF OPIOID ADDICTION

- ACUTE VS CHRONIC PAIN MANAGEMENT
- HISTORY OF SUBSTANCE ABUSE
- DEPRESSION
- TRAUMATIC LIFE EVENTS
- EMOTIONAL STRESS
- ANY PATIENT BEING PRESCRIBED OPIATES FOR SHORT AND LONG TERM PAIN MANAGEMENT

# IATROGENIC ADDICTION

- AVAILABILITY
  - 53% OF ABUSERS OBTAINED PAIN MEDICATION FROM A FAMILY MEMBER OR FRIEND
  - 21% OF ABUSERS OBTAINED PAIN MEDICATION FROM A HEALTHCARE PROVIDER
- IATROGENIC ADDICTION
  - VARIABLE TERMINOLOGY
  - VARIED VIEWPOINTS
- PRESCRIPTIVE BEHAVIORS
  - IN 2012 HEALTH CARE PROVIDERS WROTE 259 MILLION PRESCRIPTIONS FOR PAINKILLERS (CDC, 2014)
  - LIBERAL BEHAVIORS
  - OPIOID VS NON-OPIOID PAIN MEDICATION

# IATROGENIC ADDICTION

- PAIN AS THE 5TH VITAL SIGN
- EMPHASIS ON PATIENT SATISFACTION
- AGGRESSIVE MARKETING OF OPIOIDS
- FINES TO HEALTHCARE FACILITIES BY GOVERNMENT REGULATING AGENCIES FOR DOCUMENTED UNTREATED PAIN LEVELS GREATER THAN 4/10

# REGULATIONS AND SCREENING

- FOOD AND DRUG ADMINISTRATION
  - FOOD AND DRUG ADMINISTRATION AMENDMENT ACT (FDAAA)
    - RISK EVALUATION MITIGATION STRATEGIES (REMS)
      - STAGED EVALUATIONS OF THE POTENTIAL OF ADDICTION AFTER A NEW DRUG REACHES THE MARKET
      - WRITTEN EDUCATIONAL MATERIALS FOR PROVIDERS AND PATIENTS
      - ELEMENTS TO ASSURE SAFE USE (ETASU)

I'D BE BETTER OFF WITH A BRAIN TUMOR. That way you wouldn't put off getting me the help I need. You'd understand that my condition is only going to get worse and not hope it will go away by itself.
IF I HAD A BRAIN TUMOR YOU'D UNDERSTAND I NEED TREATMENT NOT INDIFFERENCE.

# CLINICAL SIGNIFICANCE FOR OPIOID PRESCRIBERS

**THE OPIOID EPIDEMIC CANNOT BE IGNORED**

# CLINICAL RECOMMENDATIONS

- TAKE OWNERSHIP OF PRESCRIPTIVE BEHAVIORS
- CHOOSE NON-OPIOID PAIN MANAGEMENT AS FIRST LINE THERAPY WHEN APPROPRIATE
- PROACTIVE SCREENING FOR ABUSE AND RISK FACTORS OF ABUSE
- PATIENT EDUCATION (IF TAKEN FOR AN UNSPECIFIED LENGTH OF TIME, YOU WILL LIKELY BECOME ADDICTED)
- PRESCRIBER EDUCATION- PARTICIPATE WITH THE EDUCATIONAL OPPORTUNITIES OFFERED BY THE REMS PROGRAM
- DO NOT DENY AN ADDICT PAIN MEDICATION SIMPLY BECAUSE THEY HAVE AN ADDICTION- THIS INTENSIFIES THEIR ADDICTION. COLLABORATE WITH THE PATIENT AND DEVELOP A PLAN FOR REHABILITATION

# PRESCRIBERS

YOU ARE PARTIALLY RESPONSIBLE FOR THE CREATION AND MAINTENANCE OF 15.3 MILLION OPIATE ADDICTS, 36 MILLION "OPIOID ABUSERS", AND THE DEATHS OF 16,007 PEOPLE IN 2014 WITH YOUR 259 MILLION PRESCRIPTIONS WRITTEN FOR OPIOID NARCOTICS.

# CONCLUSION

- THERE IS A DIRECT CORRELATION BETWEEN INITIAL EXPOSURE TO OPIATES AS A PRESCRIPTION FROM A HEALTHCARE PROVIDER AND SUBSEQUENT OPIATE ADDICTION

# QUESTIONS

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Personal
Born in Pittsburgh, PA
Frederick County, MD Resident since 1974.
Married, three daughters
Politics - 'Unaffiliated'

Education
B.S. Engineering U.S. Naval Academy 1958 - top 5%
M.S.M.E. - RPI ; Post Masters - Hood - computer related courses

Experience
U.S. Navy - Shipboard Engineering and Operations
Pratt & Whitney Aircraft – Gas turbine engine computer performance analysis
U.S. Dept. of Energy – Early Internet and Web User
Computer Consultant & Web Site Developer
Health, Wellness, Drug Abuse, Poverty Volunteer

U.S. Navy – 1958-62
Electrical Officer – Heavy Cruiser
Operations Officer (Electronics, Navigator, Communications) – Destroyer

Pratt & Whitney Aircraft – 1962-74
Engineering Management– Gas turbine performance analysis

U.S. Dept. of Energy – 1974-1995
Engineer > Project Manager > Officer Director > $40 million Programs

Sole Proprietor Web Site Development Company - 1995 - 2011
~20 Local Clients - Financial, Healthcare, Commercial

Volunteer Activities

Current
Member Maryland State Overdose Advisory Council
Member Frederick County School Health Council - 6 Years
Member of Frederick County Health Department Long Term Health Program
Volunteer/ Board Member (previous) - St. Vincent de Paul - 7 Years
Member of the Frederick Chamber of Commerce Workplace Wellness Committee
Comments at BOE meetings on 2013 YRBS & need for action on drug problem
Letters to Editor of Frederick News Post on drug abuse problem

Previous (< 2010)
Frederick County Schools Blue Ribbon Comm. - $30M Student Computer Upgrade
Frederick County Schools Technology Advisory Committee
Executive Committee – Frederick County Healthcare Coalition
Wellness presentations to Rotaries and other community organizations
Frederick County Child Health Partnership – Wrote/Implemented RWJ Grant

Good afternoon Mr. Rutherford, Lieutenant Governor of the State of Maryland, Task Force members and fellow citizens.

My name is Tom Werner, a forty (40) year resident of Frederick County. I have been helping address the Heroin and Opioid Emergency and advocating for a range of solutions but, in particular more emphasis on education and prevention.

There is a well-documented high relapse rate of 50 to 80 percent, regardless of the type of treatment. With the ever-increasing influx of new users, combined with this relapse rate, it is virtually impossible to reduce the total number of users by only increasing treatment. Estimates of the ratio of dollars spent on treatment relative to prevention and education is approximately 15 to 20 to 1.

Our youth are transitioning from the social gateway substances of alcohol and marijuana to 'harder' drug use - reference the Maryland DHMH 2013 Youth Risk Behavior Survey results. Parents do have the prime responsibility for the behavior of their children. However our school system has a critical role in this issue.

Maryland law requires K-12 Drug Education. Unfortunately, in 10th, 11th and 12th grades grades, the letter of the law is being complied with by squeezing minimal drug education into academic classes - history, biology and the like. This minimal approach sends a message to our students that drug education and prevention is not a priority in our society and, that drug use is not a critical barrier to their life-long success.

In conclusion, my three specific recommendations are:

1. First: The Maryland and local PTA's need to be urged to become actively involved in this issue to help engage and educate parents.
2. Second: initiate an independent audit of the drug prevention education in the Maryland school system to ascertain, over the past two years, the degree of compliance with the existing law, and the efficacy and any deficiencies in the current program.
3. Third: We have the opportunity for Maryland to become a national leader in the education and prevention of drug addiction by implementing a program targeting students, young adults, parents and the general public that takes advantage of the recent enormous advances in cost-effective digital communication technology - in 2014, over 87% of the U.S. population had internet access..

I look forward to working with all of you, and I thank you very much for your time.

My name is Rebecca Hogamier. I am the director for the Division of Behavioral Health Services for the Washington County Health Department. The Division offers medication assisted treatment using buprenorphine and injectable extended release naltrexone. The Division was the first in the country in partnership with the Washington County Detention Center and Conmed Healthcare Management, Inc. to offer medication assisted treatment to the opioid and alcohol dependent incarcerated population using injectable extended release naltrexone, a non-narcotic, non-addicted medication.

One issue of concern is the lack of an exit strategy for individuals using or prescribed opioid full or partial agonist, such as heroin, methadone, oxycontin, or buprenorphine. If you ask the doctors who have been prescribing buprenorphine for months or years, they will admit that they lack experience and a plan for tapering. Actually there are no established guidelines or protocol for titration. Many physicians believe that if you take the patient off the medication the individual will return to active addiction. There are lower doses of buprenorphine on the market that would make tapering a more simple process; these formulas are illegal to prescribe to recovering addicts.

While opioid dependence rises and the demand for buprenorphine increases, the number of certified treating physicians is declining. In Washington County, there are only four practices that are willing to prescribe buprenorphine. Three of the four have a waiting list and the remaining practice, no longer takes new patients.

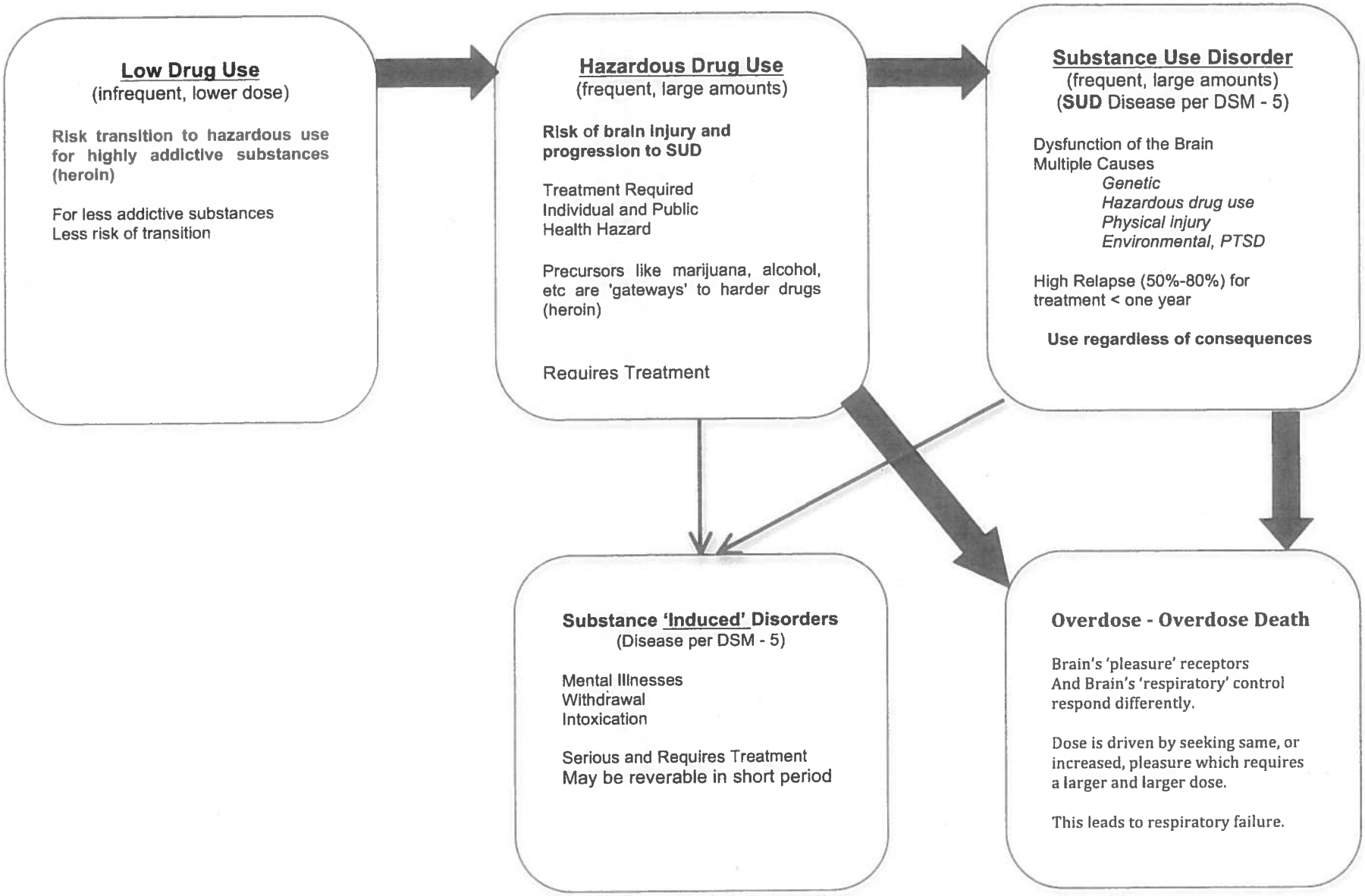
Getting certified to prescribe buprenorphine is easy. It only requires the completion of an eight hour online course, no background in addiction medicine and by the way the course does not address a process for titrating. Although, prescribing protocols recommend that patients should receive treatment for substance use disorders prior to or while receiving the medication, very few prescribing physicians verify if the individual is receiving treatment.

Many physicians have found that prescribing buprenorphine, is like, installing an ATM in their waiting rooms. Not to mention the rigorous checks and balance to ensure that the medication is not being abused or diverted. This makes it unattractive for many physicians to embark on treating the addicted population.

I receive calls daily from individuals requesting to be titrated off methadone and buprenorphine. It saddens me as a public health agency that we do not have the resources to properly detox these individuals. Presently the only way an individual can be detoxed is to be incarcerated. Then the opioid addicted individual can receive a non-narcotic, non-addictive medication.

Lastly, at a time of shrinking resources and restructuring of grant funding, I respectfully request that the State reconsider requiring behavioral health treatment providers to be independently accredited. The process is costly and labor intensive. The required accreditation process will likely eliminate smaller existing treatment providers. The resources required to be accredited could be used to treat the opioid dependent individuals.

# Drug Usage and Outcomes



## Frederick County, MD High School Survey

### Summary Tables - Weighted Data

QN58: Percentage of students who were offered, sold, or given an illegal drug by someone on school property during the past 12 months

| | Total | | | Male | | | Female | | |
|---|---|---|---|---|---|---|---|---|---|
| | Percentage | 95% confidence interval | N | Percentage | 95% confidence interval | N | Percentage | 95% confidence interval | N |
| Total | 27.2 | ( 25.5 - 29.0 ) | 3,265 | 30.1 | ( 27.7 - 32.7 ) | 1,684 | 23.9 | ( 21.7 - 26.2 ) | 1,562 |
| **Age** | | | | | | | | | |
| 15 or younger | 27.3 | ( 24.6 - 30.1 ) | 1,521 | 30.3 | ( 26.6 - 34.2 ) | 752 | 23.8 | ( 20.7 - 27.2 ) | 760 |
| 16 or 17 | 26.9 | ( 24.6 - 29.3 ) | 1,550 | 29.5 | ( 26.2 - 33.1 ) | 822 | 24.0 | ( 20.9 - 27.3 ) | 721 |
| 18 or older | 28.9 | ( 22.0 - 37.0 ) | 191 | 33.1 | ( 24.2 - 43.3 ) | 110 | - | - | 80 |
| **Grade** | | | | | | | | | |
| 9th | 25.9 | ( 22.6 - 29.5 ) | 924 | 30.6 | ( 26.0 - 35.7 ) | 447 | 21.3 | ( 17.7 - 25.4 ) | 474 |
| 10th | 27.8 | ( 24.4 - 31.4 ) | 947 | 30.0 | ( 25.8 - 34.6 ) | 511 | 25.0 | ( 20.7 - 29.9 ) | 432 |
| 11th | 27.0 | ( 23.8 - 30.4 ) | 761 | 30.1 | ( 25.7 - 34.9 ) | 402 | 23.3 | ( 19.2 - 28.0 ) | 354 |
| 12th | 27.4 | ( 23.9 - 31.3 ) | 584 | 29.4 | ( 24.4 - 34.9 ) | 297 | 25.3 | ( 20.8 - 30.5 ) | 285 |
| **Race/Ethnicity** | | | | | | | | | |
| Asian | 25.0 | ( 19.0 - 32.1 ) | 150 | - | - | 81 | - | - | 69 |
| Black* | 35.6 | ( 30.0 - 41.6 ) | 330 | 38.4 | ( 31.2 - 46.2 ) | 177 | 32.2 | ( 24.7 - 40.7 ) | 151 |
| Hispanic/Latino | 31.5 | ( 26.5 - 36.9 ) | 348 | 35.6 | ( 28.5 - 43.3 ) | 174 | 27.5 | ( 20.9 - 35.3 ) | 168 |
| White* | 25.3 | ( 23.2 - 27.5 ) | 2,122 | 28.0 | ( 25.0 - 31.2 ) | 1,079 | 22.5 | ( 19.9 - 25.2 ) | 1,039 |
| All other races | - | - | 60 | - | - | 38 | - | - | 22 |
| Multiple races | 22.8 | ( 16.9 - 30.1 ) | 174 | - | - | 84 | - | - | 87 |

Note: 64 students were excluded from this analysis.
*Non-Hispanic.
N = Number of students in this subgroup.
- = Fewer than 100 students in this subgroup.

## Frederick County, MD High School Survey

### Summary Tables - Weighted Data

QN49: Percentage of students who used marijuana one or more times during the past 30 days

| | Total | | | Male | | | Female | | |
|---|---|---|---|---|---|---|---|---|---|
| | Percentage | 95% confidence interval | N | Percentage | 95% confidence interval | N | Percentage | 95% confidence interval | N |
| Total | 19.0 | ( 17.2 - 20.9 ) | 3,221 | 21.7 | ( 19.2 - 24.3 ) | 1,655 | 16.0 | ( 13.9 - 18.3 ) | 1,544 |
| **Age** | | | | | | | | | |
| 15 or younger | 13.8 | ( 11.9 - 16.0 ) | 1,502 | 15.7 | ( 13.2 - 18.6 ) | 740 | 11.3 | ( 9.1 - 13.9 ) | 751 |
| 16 or 17 | 22.5 | ( 19.9 - 25.2 ) | 1,531 | 25.3 | ( 21.9 - 29.1 ) | 810 | 19.6 | ( 16.5 - 23.1 ) | 713 |
| 18 or older | 23.2 | ( 17.9 - 29.6 ) | 185 | 27.6 | ( 20.2 - 36.5 ) | 105 | - | - | 79 |
| **Grade** | | | | | | | | | |
| 9th | 11.3 | ( 9.2 - 13.8 ) | 915 | 11.8 | ( 9.3 - 14.8 ) | 442 | 10.3 | ( 7.8 - 13.4 ) | 470 |
| 10th | 17.9 | ( 15.2 - 20.9 ) | 937 | 21.1 | ( 17.3 - 25.4 ) | 501 | 13.9 | ( 10.6 - 18.0 ) | 430 |
| 11th | 19.4 | ( 16.4 - 22.7 ) | 749 | 22.6 | ( 18.3 - 27.5 ) | 394 | 16.1 | ( 12.6 - 20.2 ) | 350 |
| 12th | 26.7 | ( 22.8 - 30.9 ) | 577 | 30.2 | ( 25.0 - 35.9 ) | 293 | 23.3 | ( 18.4 - 28.9 ) | 282 |
| **Race/Ethnicity** | | | | | | | | | |
| Asian | 9.6 | ( 5.8 - 15.4 ) | 148 | - | - | 80 | - | - | 68 |
| Black* | 25.0 | ( 20.1 - 30.7 ) | 324 | 28.3 | ( 21.8 - 35.8 ) | 173 | 21.1 | ( 14.5 - 29.6 ) | 149 |
| Hispanic/Latino | 24.5 | ( 19.3 - 30.6 ) | 338 | 25.7 | ( 18.7 - 34.3 ) | 173 | 22.2 | ( 16.1 - 29.9 ) | 160 |
| White* | 17.5 | ( 15.6 - 19.6 ) | 2,104 | 20.0 | ( 17.3 - 23.1 ) | 1,067 | 15.0 | ( 12.7 - 17.5 ) | 1,032 |
| All other races | - | - | 56 | - | - | 34 | - | - | 22 |
| Multiple races | 20.9 | ( 14.9 - 28.4 ) | 170 | - | - | 80 | - | - | 87 |

Note: 108 students were excluded from this analysis.
*Non-Hispanic.
N = Number of students in this subgroup.
- = Fewer than 100 students in this subgroup.

## Frederick County, MD High School Survey

### Summary Tables - Weighted Data

QN100: Percentage of students who took a prescription drug without a doctor's prescription one or more times during the past 30 days

| | Total | | | Male | | | Female | | |
|---|---|---|---|---|---|---|---|---|---|
| | Percentage | 95% confidence interval | N | Percentage | 95% confidence interval | N | Percentage | 95% confidence interval | N |
| Total | 9.8 | ( 8.6 - 11.3 ) | 3,284 | 11.8 | ( 9.9 - 14.0 ) | 1,698 | 7.0 | ( 5.8 - 8.3 ) | 1,562 |
| **Age** | | | | | | | | | |
| 15 or younger | 7.7 | ( 6.1 - 9.5 ) | 1,527 | 8.4 | ( 6.2 - 11.3 ) | 755 | 5.7 | ( 4.2 - 7.6 ) | 760 |
| 16 or 17 | 10.4 | ( 8.8 - 12.2 ) | 1,562 | 12.6 | ( 10.3 - 15.4 ) | 832 | 7.7 | ( 6.0 - 9.7 ) | 721 |
| 18 or older | 17.2 | ( 11.8 - 24.4 ) | 192 | 22.9 | ( 15.2 - 32.9 ) | 111 | - | - | 80 |
| **Grade** | | | | | | | | | |
| 9th | 6.7 | ( 4.9 - 9.1 ) | 928 | 7.9 | ( 5.3 - 11.6 ) | 449 | 4.8 | ( 3.2 - 7.3 ) | 475 |
| 10th | 8.2 | ( 6.4 - 10.6 ) | 952 | 9.9 | ( 7.3 - 13.4 ) | 514 | 5.5 | ( 3.6 - 8.3 ) | 432 |
| 11th | 11.0 | ( 9.1 - 13.3 ) | 765 | 12.8 | ( 9.6 - 16.7 ) | 405 | 8.8 | ( 6.5 - 11.8 ) | 355 |
| 12th | 11.5 | ( 8.6 - 15.4 ) | 589 | 15.0 | ( 10.4 - 21.1 ) | 302 | 7.7 | ( 5.3 - 11.2 ) | 285 |
| **Race/Ethnicity** | | | | | | | | | |
| Asian | 3.7 | ( 1.6 - 8.2 ) | 151 | - | - | 81 | - | - | 70 |
| Black* | 10.1 | ( 7.0 - 14.3 ) | 332 | 12.6 | ( 8.2 - 19.0 ) | 178 | 6.6 | ( 3.5 - 12.0 ) | 151 |
| Hispanic/Latino | 15.4 | ( 11.2 - 20.9 ) | 352 | 16.2 | ( 10.7 - 23.9 ) | 180 | 12.4 | ( 8.1 - 18.6 ) | 166 |
| White* | 8.6 | ( 7.2 - 10.2 ) | 2,129 | 10.6 | ( 8.4 - 13.4 ) | 1,084 | 6.4 | ( 5.1 - 8.0 ) | 1,040 |
| All other races | - | - | 61 | - | - | 39 | - | - | 22 |
| Multiple races | 10.9 | ( 6.7 - 17.3 ) | 173 | - | - | 83 | - | - | 87 |

Note: 45 students were excluded from this analysis.
*Non-Hispanic.
N = Number of students in this subgroup.
- = Fewer than 100 students in this subgroup.

**Overdose Statistics**
**Received from Frederick County Sheriff's Office (A.H.)**

| **Frederick County Heroin Overdose Cases Non-Fatal Heroin-Related Overdoses** | **2012** | **2013** | **2014 YTD** |
|---|---|---|---|
| Frederick County Sheriff's Office | 9 | 23 | 35 |
| Frederick Police Department | 3 | 17 | 29 |
| Brunswick Police Department | 0 | 0 | 1 |
| Thurmont Police Department | 0 | 2 | 1 |
| **Total** | **12** | **42** | **66** |

| **Fatal Heroin-Related Overdoses** | **2012** | **2013** | **2014 YTD** |
|---|---|---|---|
| Frederick County Sheriff's Office | 5 | 12 | 20 |
| Frederick Police Department | 1 | 6 | 10 |
| Brunswick Police Department | 0 | 1 | 1 |
| Thurmont Police Department | 0 | 0 | 1 |
| **Total** | **6** | **19** | **32** |

| **Frederick County Heroin-Related Overdoses*** | **2012** | **2013** | **2014 YTD** |
|---|---|---|---|
| Total Non-Fatal Heroin Overdoses | **12** | **42** | **66** |
| Total Fatal Heroin-Related Overdoses | **6** | **19** | **32** |
| **Total Heroin-Related Overdoses** | **18** | **61** | **98** |

*MSP figures not currently available
**2014 YTD** = 1/1/14 to 12/31/14

See Questions: 58, 100, 49

Dr. Olsen is, and has been, advising on the Medical aspects
of the Drug Abuse Problem. She helped author a 'laymans' summary for Substance Use and a simplified diagram describing it. She is the Medical Director of the REACH Drug Abuse Treatment Facility in Baltimore.

## Biographical Sketch - Dr. Yngvild Olsen

Dr. Yngvild Olsen graduated from Harvard Medical School in 1997, from the residency training program in internal medicine at Boston Medical Center in 2000, and from the Fellowship in General Internal Medicine at the Johns Hopkins School of Medicine in 2001. From July 2000 through June 2001, she served as Primary Care Chief Resident at Boston Medical Center. During her fellowship, she received a Masters in Public Health from the Johns Hopkins University Bloomberg School of Public Health.
Dr. Olsen currently serves as Medical Director of the Institutes for Behavior Resources Inc/REACH Health Services in Baltimore City. This is an outpatient substance use disorder treatment program that provides a broad range of services and includes a health home.

She has previously served as the Vice President of Clinical Affairs for the Baltimore Substance Abuse Systems, where she played a central role in the expansion of buprenorphine treatment for opioid addiction in both the treatment and medical systems. She also has served as the Deputy Health Officer for the Harford County Health Department, where she oversaw local substance use treatment services, and as the Medical Director for the Johns Hopkins Hospital's outpatient substance use treatment services.

Dr. Olsen has written and lectured extensively on opioid use disorder and its treatments. She has published in numerous journals, including the *Journal of the American Medical Association*, the *New England Journal of Medicine*, and the *Journal of Addictive Diseases*, on such topics as smoking in substance use treatment programs, the public health impact of buprenorphine treatment expansion, the stigma associated with medication-assisted treatment, and the dual challenges of pain treatment and addiction.

As an addiction medicine specialist trained in internal medicine, she teaches appropriate opioid prescribing to primary care physicians and instructs on medical co-occurring conditions to psychiatrists and other behavioral health providers.

She is the President of the Maryland Society of Addiction Medicine, the President of the Maryland Association for Treatment of Opioid Dependence, serves on the Maryland Overdose Prevention Advisory Council, and is a member of the board of the Journey Home, Baltimore's effort to end homelessness.

From: **Yngvild Olsen** yngvild.olsen@gmail.com
Subject: Re: FNP Front Page Article 5-10-15 - "Funding for drug treatment runs scarce"
Date: May 17, 2015 at 10:08 PM
To: Thomas Werner tom@wernerweb.com
Cc: Jacque Burrier projecthope21788@yahoo.com, Andrea Walker AWalker@frederickcountymd.gov

Dear Tom,

I'm glad you have signed up to give public comments at tomorrow's event. I finally heard back late last week from my contact on the taskforce who mentioned that it probably didn't make any sense for me to testify again since the taskforce staff are trying very hard not to have the same people heard from more than once.

In looking through the 6 areas that you identified, I would just highlight the following:

Prevention/Education -- critical -- and it needs to start early, before high school since that is already too late. In age appropriate ways it can start as early as elementary school and certainly by 6th grade.

2. Intervention -- I would consider reframing this as proactive community outreach since there is beginning to be more funding opportunities for outreach -- conceptually similar to intervention but not as clinical sounding so Medicaid and the state may be more easily able to fund it without getting into some of the clinical vs non clinical regulatory issues.

3. Detox -- this is now termed withdrawal management according to the new ASAM criteria and the DSM 5 -- a little bit of semantics but important clinically since it's actually the liver that detoxifies while healthcare providers manage withdrawal. So language that better mirrors the chronic disease understanding of addiction.

What the science tells us about withdrawal management from opioids is that relapse rates are extremely high following this procedure, no matter how prolonged it is. Relapse risk for opioid use disorder remains very high over the first few years of recovery so thinking about withdrawal management capability to me is potentially putting eggs into a basket that has a lot of big holes in it.

The other piece is that while injectable naltrexone (Vivitrol) is one medication option, there is no data on its efficacy or safety past 12 months, unlike the other 2 medication options we have for opioid use disorder (methadone and buprenorphine).

So I think the way I would reframe #4 is to say that access to all these medications need to be expanded and the focus should be on improving the quality of care, not a specific medication.

The other reason for this is that the choice of medication really is so dependent on a number of different medical and other factors that the decision of which medication to recommend to any specific person really should be left up to the physician and the patient.

So that brings me to a point that is not included in the list which is the workforce of healthcare providers that are adequately and appropriately trained to deliver all these different treatments. That is woefully lacking and not something that I think has adequately been discussed. So may something to consider.

I hope this all makes sense and I look forward to hearing how tomorrow goes!

Best,

Yngvild

Yngvild Olsen, M.D., M.P.H.

Follow me on Twitter: @YngvildOlsen
Check out my new blog: http://updateonopioids.blogspot.com

On Thu, May 14, 2015 at 8:28 AM, Thomas Werner <tom@wernerweb.com> wrote:

Good morning,

My 'take away' on priorities after and two years of listening/analysis and the generous 'education' by you and others.
Consider More:

1. **Prevention / Education** - significantly reduce the influx of new users
2. Intervention - get users 'into detox/treatment' - in certain cases diversion from incarceration
3. Detox Capability (3 - 10 days) - insufficient capability now - emergency !
4. Vivitrol (after 7-10 days detox) - other Medically Assisted Therapy (MAT) as appropriate
5. IOP - concurrent Intensive out-patient therapy
6. Recovery (NA, Sober living houses, jobs, education)

In addition, obviously, continue with criminal justice efforts to reduce supply.

I have requested, and hope to be able to make, public comment at the May 18th Heroin and Opioid Task Force Meeting In Hagerstown. Reading the voluminous comments from the previous Task Force Meetings they seem to boil down to the six(6) above.

With the current influx of ever increasing users, it will be extremely difficult to 'catch up' with treatment - should reallocate funding to more effective approaches.
See
5-10-15 FNP

http://fredericknewspost.md.newsmemory.com/publink.php?shareid=08bfb4b81

All comments appreciated - still learning.
Thank you,

Tom Werner
Thomas Werner
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301-473-5592
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*5/18/2015*

*Vision: Create a safer and more responsible drug environment in Maryland*

*Mission:*
*Reduce Opiate drug overdoses*
*Hold Maryland Physicians and Licensing Board accountable for dispensing unmanaged prescriptions for profit*
*Improve and strengthen PDMP by having mandatory reporting by Physicians of dispensed opiate prescriptions*
*Improve Recovery programs and facilities to treat the disease of drug addiction*
*Increase penalties of drug dealers and doctors associated to drug overdose deaths*

*Having experienced the overdose death of my son from OxyContin 3 years ago, I would like to become a member of your task force, or least be able to share my experience, my goals and mission. I have taken on this mission in support of my son because of an overdose on prescription drugs by "pill mill" doctors only 2 days after coming out of rehab and recovery. I submitted a complaint to the Physician Licensing Board, where they suspended their licenses. Their licenses were suspended but they are being given the opportunity to get them back. After taking a license away for wrongfully, and negligently prescribing addictive narcotics, how could we give them the option to get their license back?*

*I summoned for criminal prosecution by the States Attorney Offices of Frederick County and Prince Georges County, where these doctors practiced. I was told by the State Attorney of Frederick, they would not press charges. They believed the legislative support (laws) in Maryland were too weak to create a case.*
*If that is the case, I would like to see a bill(s) proposed by the States Attorney's office to address this shortfall. Following the lead of other States, I will also propose a bill that NJ implemented, (brought to legislature by State's Attorneys Office), "Liability Induced death Law" (NJ statute N.J.S.A, 2 C:35-9).*
*Also please note the time after rehab when this tragic event occurred - less than 48 hours. It then makes one ask the question, "Is 30 days adequate for rehab AND recovery?"*

*Maryland's PDMP must be strengthened as well so that doctors must register narcotic prescriptions with the online system, just as Pharmacies are required to do. A bill like this in Delaware or Virginia would address this weakness. I plan on writing this proposal for the next Legislative session reflecting those States' law.*

*The Physician Licensing Board also needs an improvement in the monitoring and management of the disciplinary actions of Doctors who endanger the lives of the Public.*
*Doctors, as well as, street dealers should be prosecuted to the full extent of the law (criminal homicide charges), if they are associated with the overdose victim death. This would be included with the proposed law mentioned earlier for induced death, following the lead of other States. This will reduce the supply, accessibility, and improve the relaxed environment we provide here in Maryland for the sale of opiate products for profit.*
*Did you know a dealer who was proven to be associated to an overdose death recently here in Maryland only received 7 years? 7 years for murder? Do we want that to continue? Where is justice served, when we need it to be? We need to look into these laws further and keep Maryland from being a welcome State for dealing and suppling drugs with minimal incarceration.*

*In addition to the above proposals to impact and address the opiate overdose epidemic here in Maryland, would be the implementation of Electronic prescribing (I – Stop Program). This was recently enacted in New York. Research has shown that 84% of those on heroin start with prescription drugs, and overdose deaths by prescription drugs is 2x that of heroin overdoses.*

*In conclusion, we need to be progressive and get up to speed with other States. Maryland needs to be more proactive in the fight against this epidemic and not be status quo. Maryland is one of the least active and progressive States vs. many other US States. I am concerned that State Legislatures, past Attorney General, current State Prosecution Attorneys, and previous Governor's fight to reduce opiate deaths were and still are not fully engaged to completely support this effort. It will take everyone's commitment and initiative to make this battle successful.*

*Where cancer has touched someone in every family, drug abuse and its consequences has become the different kind of cancer in every family. I hope and pray that no one else or their family has to go through what my family and I have experienced. It lives with us daily and it will live with us forever.*

*Thank you for the opportunity to share these actions with you.*

*UNTOPPABLE FATHER*

**Bob Kozloski**
*Committed to Honor Son and Help Others*