

**HEROIN & OPIOID EMERGENCY TASK FORCE**  
**CENTRAL MARYLAND REGIONAL SUMMIT MINUTES**

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

**PANELISTS**

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

**INTRO**

**Introduction & Opening Remarks**

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

**MAYOR & COUNTY EXECUTIVES**

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

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

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

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

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

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

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

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

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

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

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

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

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

**LAW ENFORCEMENT**

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

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

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

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

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

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

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

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

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

### **V. Ron Bateman, Anne Arundel County Sheriff**

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

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

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

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

#### *Questions from Panelists*

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

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

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

### **ADDICTION TREATMENT EXPERTS, ADVOCATES, AND EDUCATORS**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

settings. Not one/not all may work for any one person because everyone's different. There are only 3, so they cannot be pitted above each other, but this is happening.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- E. Recommend: interested clinics should look into this family of products.
- F. Ms. Williams requested information to be sent, and Dr. Salako-Akande agreed.

## **PUBLIC COMMENT**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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