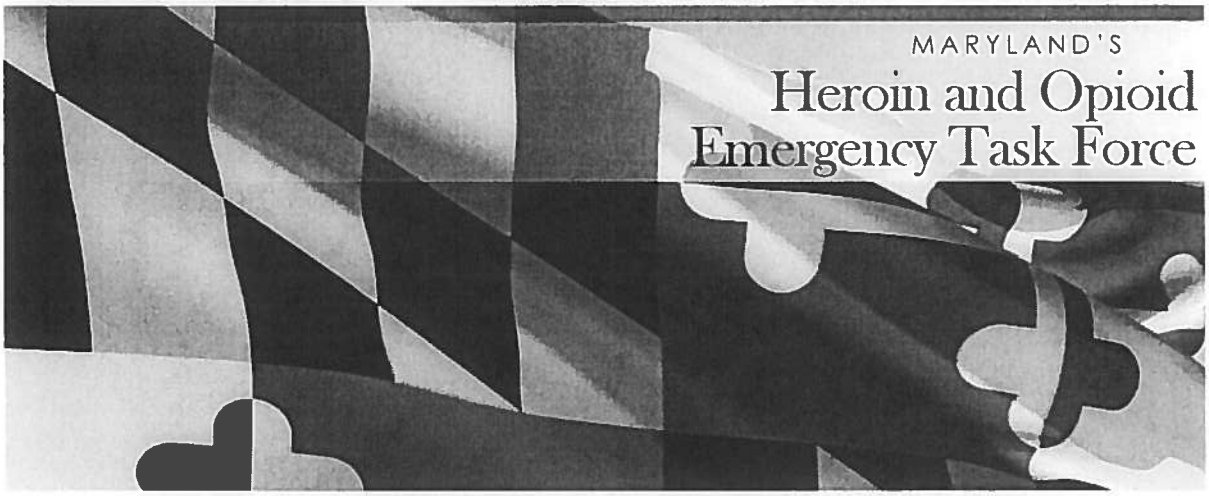
APPENDIX E



Heroin & Opioid Emergency Task Force
Southern Maryland Regional Summit
Wednesday, April 29, 2015, 10:00am – 3:30pm
College of Southern Maryland – Prince Frederick Campus

Summit Agenda

10:00am – 10:05am	Introduction by Lt. Governor Boyd K. Rutherford
10:05am – 10:50am	County Commission Presidents *Commission President Steven R. Weems, Commission President Peter F. Murphy, Commission President James R. Guy*
10:50am – 11:00am	10-minute Break
11:00am – 12:00pm	Law Enforcement *Sheriff Mike Evans, Sheriff Troy D. Berry, State's Attorney Laura L. Martin, State's Attorney Anthony B. Covington, State's Attorney Rick D. Fritz*
12:00pm – 12:45pm	Lunch Break
12:45pm – 2:05pm	Addiction Treatment Experts, Advocates, & Educators
2:05pm – 2:15pm	10-minute Break
2:15pm – 3:30pm	Public Comment
3:30pm	Adjournment

Maryland Heroin and Opioid Emergency Task Force
Southern Maryland Summit Minutes

April 29, 2015, 10:00 AM – 3:30 PM

College of Southern Maryland, Prince Frederick, MD

WELCOME

The Maryland Heroin and Opioid Emergency Task Force convened for its third summit at 10:00 AM on April 29th, 2015, at the College of Southern Maryland in Prince Frederick, MD. The summit was open to the public and concluded at 3:30 PM.

Sheriff Timothy Cameron welcomed task force members, elected officials, law enforcement representatives, local addiction treatment experts, and the public.

In an effort to get an understanding of the broader issue, the Task Force's plan is to go out into Maryland communities and employ a holistic effort for the following main topics:

- Prevention
- Closing the heroin pipeline
- Treatment & Recovery
- Law Enforcement

The interim report will be available during the summer of 2015 with a final report complete by the end of the year.

TASK FORCE ATTENDANCE

Judge Julie S. Solt
Sheriff Timothy Cameron
Senator Katherine Klausmeier
Delegate Brett Wilson
Dr. Michael Finegan
Elizabeth Embry
Linda Williams
Nancy W. Dudley

DRAFT

ELECTEDS/ LAW ENFORCEMENT

Calvert County
Commission President Steven R. Weems
State's Attorney Laura L. Martin
Sheriff Mike Evans

Calvert County has the highest drug-related death toll in the tri-county area. According to Commission President Weems, Calvert County's rehab centers are overtaxed with clients and the heroin problem "isn't an hour away, it's on our roads."
On the law enforcement side, more than half of the County's burglaries, sexual assaults, and homicides are related to heroin and opiates. The County uses a three-prong approach: legislation, prosecution, and treatment. State's Attorney Martin focuses on prosecuting the dealers and not necessarily the offenders, and stresses that Maryland needs more treatment facilities. Some of the county's recent efforts include social media outreach programs, prescription drug boxes, and K9 drug system dogs.

Representatives from Calvert County's recommendations for the task force were:

- Come up with new ideas for outreach and how to educate young people
- Providing more treatment centers
- Additional police staff
- The State should allow longer treatment (beyond 90 days), at the provider's request
- Forcing addicts to enter treatment centers, or face jail time

Charles County
Commission President Peter F. Murphy
Deputy State's Attorney Karen Piper Mitchell
Delegate Sally Young Jameson
Sheriff Troy D. Berry

In relation to heroin, Charles County's Health Department treats 400-500 people per year. Charles County currently offers 35 support groups with on-staff physicians to treat addiction. While Charles County has shown success in the fight again heroin, such as having 98% of their clients leave jail with a GED, Commission President Murphy states that prevention is the most difficult component of the heroin battle. This is because many people begin using drugs due to physical or emotional abuse, a lack of parental involvement, or peer pressure.
State's Attorney Covington believes the problem begins with doctors who are trying to make a profit. Another area of concern is the court system. In the past, first time offenders were required to go to the health department; now, the same offense only constitutes a monetary fine.

Representatives from Charles County's recommendations for the task force were:

- Short-term rehabs do not work for long-time addicts
- Change our viewpoint and state policies on open incarceration

- Encourage public to dispose of drugs properly (not flushing down the toilet)
- Investigate why prescription drugs are the second leading cause of overdose in the nation

St. Mary's County
Commission President James R. Guy
State's Attorney Rick D. Fritz

In St. Mary's County, thirty-four percent of arrests are opioid-related. Nonetheless, St. Mary's County has shown success in several different areas: medical disposal (collected over 300,000 controlled pills since 2011), prevention (pharmacy toolkits, youth mentoring), treatment (outpatient treatment services for female inmates), and recovery support (Walden Sierra, Beacon of Hope Adult Recovery Center, The Cove Adolescent Clubhouse). Commission President Guy believes that drug abuse is a behavioral and mental health issue, and State's Attorney Fritz further elaborates that this is not just a medical problem because some criminals will not bring themselves into counseling. He is concerned about the growing percentage of women using heroin, which is almost at fifty percent. Moving forward, the solution must focus on education, treatment, and law enforcement.

Representatives from St Mary's County's recommendations for the task force were:

- Provide more transitional resources (long-term recovery housing and affordable housing)
- Readily available and timely county-level data on opioids use, misuse, and abuse
- Marijuana is a gate-way drug, and the law should not allow recreational use

LOCAL ADDICTION TREATMENT PROFESSIONALS

Ten local addiction treatment professionals provided their testimony to the Task Force. Among the various themes/requests for the Task Force:

- Investigate a nationwide electronic medical record
  This will allow doctors to better identify potential prescription drug abuse. The solution must lie within a nationwide structure; doctors in Maryland should be able to access a patient's medical history in the other 49 states. Task Force should be wary of trade-offs between better access to information and an inefficient system.
- Investigate non-punitive random drug testing as a school health screening program
  For background reference, review Veronia School District 47J v. Acton (1995) and Board of Education v. Earls (2002)
- Investigate what percentage of doctors/providers utilize the Prescription Drug Monitoring Program (PDMP)
- Investigate the cost-benefit analysis of prison sentences versus drug treatments

- Investigate proactive, multigenerational, holistic, wrap-around services to include recovery support, expanding the peer-support workforce as an essential component of the State's response
- Investigate entrepreneurial opportunities for sober living houses – private facilities might be cheaper to operate than state-housing
- Investigate whether healthcare policies should remove the fifth vital sign: pain
- Provide more access to transportation resources, and halfway/sober housing

  Addicts need access to jobs, probation officers, AA meetings, emergency rooms to/from Walden House
- Provide incentives to employers that hire recovering addicts

  Jobs will help addicts become productive members of society and maintain a drug-free life
- Provide funding for Good Samaritan Law advertising
- Provide forums/outlets for parents of heroin addicts to share their thoughts
- Provide supplemental health education courses to middle and high school students
- Provide legal representation for the children of addicts
- Provide mental health counseling
- Provide probation officers to be available during evening and weekend hours – it is difficult for addicts to maintain jobs while complying with court orders
- Provide a wide range of treatment support option to all populations, such as stabilization centers, detox monitoring centers, treatment network options, adolescent and pregnant women care, and so forth
- Provide smaller, targeted prevention grants for rural counties
- Provide a statewide anti-stigma campaign
- Provide current, up to date, state and county drug use data that is easily assessable for grant applications
- Focus on training doctors to refer more patients to treatment centers as opposed to simply prescribing drugs
- Focus on prevention services, harm reduction strategies, law enforcement, workforce policies, and the self-help community
- Focus on the follow common themes among addicts: lack of stable housing, lack of consistent transportation, lack of care coordination, and the presence of undiagnosed physical and mental disorders
- Mandate Narcan to be available over-the-counter
- Mandate that all police and EMS carry Narcan
- Develop a statewide interagency prevention plan
- Encourage drug education in the workplace
- Treatment should be individualized; one-size does not fit all
- Chemicals are required for recovering addicts to stay stable & detox does not work
- Emphasize that individuals need to take responsibility for their own actions; do not blame your parents, work, lack of education, and so forth
- Hire experts to speak to students and develop social media campaigns, in their respective fields

PUBLIC COMMENTS

Eight individuals provided their testimony to the Task Force for the public comments hearing. Among the various themes/requests for the Task Force:

- Investigate a nationwide electronic medical record
- Investigate ways to eliminating administrative/bureaucratic burdens, such as reducing paperwork requirements

  Allows doctors to spend more time performing client services rather than completing forms
- Investigate synergies of combining substance abuse and mental health departments into a singular behavioral health unit
- Investigate the effectiveness of the NOPE program (as opposed to the DARE program)
- Investigate how to make treatment programs more financially accessible
- Investigate *Adverse Childhood Experiences* studies
- Provide doctors with incentives to accept insurance for Buprenorphine

  Doctors are limited to prescribing Buprenorphine to 100 patients, and many will only accept cash.
- Provide more effective advertising and outreach campaigns

  Despite numerous public forums, many patients consistently state that they "had no idea these programs existed." Local and state government should collaborate their efforts to advertise available resources, and train health providers to direct heroin addicts to the appropriate facilities.
- Provide a list of long-term and short-term care facilities (broken down by county)
- Provide additional funding for neonatal/prenatal intervention
- Provide additional funding for local health departments
- Provide additional funding for children's services because it is the highest cost program in the mental health system, and uneconomical conditions are forcing providers to eliminate these services
- Provide more educational material about Narcan
- Focus on allocating more money on the front-end of the problem (prevention) to avoid long-term back-end problems (treatment)
- Focus on long-term treatment facilities

  Short-term treatment (90 days or less) does not work, and the patient will return from either a relapse facility or jail
- Focus on Buprenorphine treatment over Vivitrol treatment
- Mandate random student drug-testing throughout Maryland public schools
- Mandate statewide syringe exchange programs, in which people can exchange potentially-infected syringes for sterile equipment

  This action will reduce the spread of bloodborne pathogens, such as HIV and Hepatitis C
- Treating chemicals (heroin) with chemicals (Suboxone) will not work
- Teach the public that this is a medical issue, and eliminate the social stigma in which recovering addicts are labeled as "failures"
- Advocate for nurse practitioners to prescribe Buprenorphine, which must be mandated at the federal level

- Invite school representatives to upcoming regional summit panels
- Invite local health departments, and social service departments to upcoming regional summit panels

ADJOURNMENT

The summit concluded at 3:30 PM.

CONTACT

Submit questions, comments, and/or concerns to: heroin.taskforce@maryland.gov
For more information, please visit: http://ltgovernor.maryland.gov

Mayor & County Executives (10 mins)

✓ Steven Weems, President, Calvert County Commissioners
✓ Peter Murphy, President, Charles County Commissioners
✓ James R. Guy, President, St. Mary's County Commissioners +1

Law Enforcement (10 mins)

✓ Rick Fritz, State's Attorney, St. Mary's County
✓ Sheriff Mike Evans, Calvert County
✓ Laura Martin, Calvert County State's Attorney
✗ Sheriff Troy D. Berry, Charles County
✓ Karen Piper Mitchell, Deputy State's Attorney, Charles County

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

✓	Dr. Kathleen O'Brien	(Walden - Treatment)
✓	Christopher Shea	(St. Mary's Co. Community Alcohol Coalition)
✓	Emily Harman	(Parents Affected by Addiction)
✓	Debbi Mister	(Calvert Alliance Against Substance Abuse, Inc.)
✓	Laura Webb	(Walden - Recovery)
✓	Ginger Rosela	(Advocates for A drug-free Calvert County)
✗	Jason David	(Outlook Recovery LLC)
✓	Carol Porto	(Carol M. Porto Treatment Center)
✓	Mary Lynn Logsdon	(Jude House)
✓	Cheryl Wyatt	(MedStar St. Mary's)
✓	Jeannie Beatty	(M.E.N.D.)
✗	Justine Maas	(Bridges of South County)

✓ Laurence Polsky
✓ Doris McDonald
} Calvert Health Department

Public Comment (3 mins)

✗ Debbie Reynolds
✗ Matthew Thomas Zibreg
~~Ginger Rosels~~
✗ Morgan Brensinger
✗ Melisssa Kramer
✓ DeForest Rathbone
✓ Catherine Meyers

SIGN IN SHEET FOR PUBLIC COMMENT
Lt. Governor's Drug Task Force Meeting - Prince Frederick
DATE: 4/29/15

Time	Name	Town of Residence	Phone/Email
✓ 9:30	Larry Polsky	Prince Frederick	410 535-5400 lawrence.polsky@maryland.gov
✓ 9:35	Doris McDonald	Prince Frederick	410 535-3079 doris.mcdonald@maryland.gov
~~9:35~~	~~Debbi Mister~~	~~Huntingtown~~	~~[illegible]@cca.[illegible]~~
✓ 9:41	Dee Rathbone	Leonardtown	DZR@prodigy.net DAR
✓ 10:00	Cindy Jones	Valley Lee	Singingblond@hotmail.com
✓ 10:00	Sean Beatty MEND	Calvert	mend2015@yahoo.com
✓ 10:00	Chris Shea	St. Mary's	chrismd104@gmail.com
✓ 10:30	John Alvarez	Frederick Md	jackharvey@gmail.com
✓ 12:00	Cheryl Wyatt	Ley Pk.	240-298-2015 cwyatt@mephealth.com
✓ 12:00	Kirsten Forseth	(Calvert Co) Chesapeake Beach	kirsten.forseth@maryland.gov
✓	Debe Podraska	Port Tobacco ~~Wal dirt~~	dpk4mom@gmail.com
✓	Linda Coughlin	PhD - pharmacist	

CALVERT COUNTY HEALTH DEPARTMENT

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www.calverthealth.org

STATE OF MARYLAND

April 29, 2015

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

Lt. Governor Rutherford and Members of the Heroin and Opioid Emergency Task Force:

The Calvert County Health Department feels strongly that intervention efforts started at a young age are critical to effectively reducing harm from drug use. We've taken that concept to the extreme and designed a program aimed at children…in the womb.

As has happened across the state and across the country, this surge in opiate abuse has disproportionately affected women, and most often during their reproductive years. Women with addiction problems are less likely to use contraception and therefore more likely to have unintended pregnancies. Pregnancies affected by opiates are more likely to result in premature birth and low birth weights (the leading causes of neonatal death in the U.S.) and a host of childhood developmental problems and social service nightmares.

Our local health department coordinated a novel program, Healthy Beginnings, to provide one-stop access to multiple health and social services for pregnant women struggling with drug use.

Under one roof, we organize substance abuse counseling, mental health counseling, social services, information on continuing education and vocational training, health insurance enrollment, smoking cessation classes tailored toward pregnancy and postpartum, WIC services, postpartum contraception, and transportation assistance for those without a car. When appropriate, we also coordinate Medication Assisted Therapy for opiate use. The health department is located just across the parking lot from both of our county's obstetric practices, so after program participants receive help at our facility, they can walk less than 50 yards to their prenatal appointments.

We are almost a year into our program that is underwritten by the Maryland Community Health Resource Commission. So far, we have enrolled close to 50 pregnant women. Prior to the launch of our Healthy Beginnings program, most pregnant drug users kept only a few prenatal appointments and it was common to see women present to the hospital in labor with no prenatal care. In almost all cases, the babies would go into opiate withdrawal, known medically as neonatal abstinence syndrome (NAS), requiring a prolonged stay in the neonatal intensive care unit (NICU). Since the launch of Healthy Beginnings, 65% of our patients have attended at least 7 prenatal appointments. 87% have delivered babies that are of normal weight and only 17% percent of babies have required NICU admissions. We have seen no neonatal deaths.

Preventing NICU admissions is important on several levels. First, neonatal abstinence syndrome can result in everything from the inability of the baby to feed, to respiratory complications, to seizures. Babies without intrauterine heroin or prescription opiate exposure are much more likely to be able to breastfeed, bond with their mother, and avoid multiple early-life health complications. In addition, a typical NICU stay for a full term baby with NAS costs well over $50,000. A baby born 2-3 months prematurely or at very low birth weight can easily cost a half million dollars in hospital expenses alone. This doesn't include the ongoing medical care the child will need, social service costs, and the increased possibility of special education needs as he or she gets older.

In addition, 54% of women in Healthy Beginnings started a method of contraception after delivery. In the year prior to the start of this program, the percentage of women in Calvert County who screened positive for opiate use during pregnancy and reported using birth control after their pregnancy was zero.

As an important adjunct to the program, our reproductive health nurse practitioner and members of our Maternal Child division have performed 32 outreach sessions at substance abuse treatment facilities across Southern Maryland. This outreach has resulted in the delivery of long-acting contraceptives to close to 50 women. This has almost certainly prevented dozens of unintended pregnancies in women who are still struggling to get their addiction and underlying mental health conditions under control.

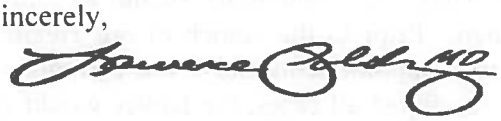
LHDs are uniquely situated to coordinate this type of program. We routinely provide outreach to pregnant women, particularly those who are economically disadvantaged, we work with social service departments, we help enroll people in health insurance plans, many of us are direct behavioral health treatment providers, and we have ties to our community hospitals and local physicians.

The CCHD has extended the scope of our Healthy Beginnings program into something we call "Bridge to Health". This initiative targets women of childbearing age with addiction problems or are at high risk. Our Reproductive Health staff screen their patients for substance abuse and mental health risk factors and our Behavioral Health staff screen their patients for contraceptive needs. As a result, over the last 6 months, we have linked 114 women of reproductive age with much needed behavioral health counseling. In addition, 247 behavioral health patients have been counseled for contraceptive needs.

Success in treating chronic health conditions, including substance abuse and mental health problems, requires a partnership between patient and provider. It also requires a willingness for the patient to change behaviors and lifestyle. There is no group of people more motivated to change behaviors that affect health than pregnant women.

I encourage you to consider investing in prenatal and reproductive health interventions as you formulate your recommendations to the Governor. I would also humbly suggest that you consider adding Local Health Departments and Social Service Departments to the panels of the upcoming regional summits. Thank you very much for your time and attention.

Sincerely,



Larry Polsky, MD, MPH, FACOG

St. Mary's County Opioid Prevention Efforts

Background Information

- Local Opioid Overdose Prevention Plans required by state (January 2013)
- St. Mary's Opioid Overdose Prevention Workgroup developed (March 2013)
  - Members
    - Department of Aging & Human Services; Sheriff's Office; Walden Sierra; Health Dept.; Public Schools; Medstar St. Mary's Hospital; local pharmacies.
  - Department of Aging & Human Services performed a quantitative needs assessment, drafted and submitted the St. Mary's County Opioid Overdose Prevention Plan in June 2013.
  - Data Trends for St. Mary's County
    - Intoxication Deaths
      - 2007–2009 = 4 heroin and 17 opioid.
      - 2011–2013 = 17 heroin and 12 opioid.
    - Substance Abuse Treatment
      - 2008-2012 = sharp rise in opioid related admissions for white females ages 18-34.
      - St. Mary's Detention Center data showed female inmate population as underserved with limited access to treatment services.

Initiatives and Successes (based on Center for Disease Control's Blueprint for public health)

- Medication Disposal (Sheriff's Office)
  - 24/7 collection site at Sheriff's Office in Leonardtown.
  - Provided drug take-back at 2014 health fair and collected over 46,000 pills.
  - Coordinated drug pick-up for homebound residents in Nov./Dec. 2014.
  - One of few Sheriff's offices in Maryland to count and categorize all pills collected (as opposed to weighing).
  - Over 300,000 controlled pills collected since 2011 (over 130,000 collected since 2014 Drug Summit).
- Prevention, Education, and Awareness
  - Ongoing presentations to community (Department of Aging & Human Services, Walden, Sheriff's Office, and Health Department)
    - Schools, senior activity centers, PTAs, naval base, parent groups, businesses, hospitals and physicians.
  - Communication Campaigns (Department of Aging & Human Services)
    - Developed local Smart Medicine Campaign to create awareness and education on dangers, signs of misuse, and responsible medication management.
    - Organizing youth-driven communication campaign for middle and high schools.
    - Organizing youth training to teach youth how to use participatory photography to bring about positive social change on issues.
  - Pharmacy Toolkits (Department of Aging & Human Services)
    - Developed education and resource toolkits and engaged 5 pharmacies to distribute toolkits with prescriptions that contain opiates (St. John's, Tidewater, Target, McKay's, and Giant).
  - Youth Mentoring (Department of Aging & Human Services)
    - Contracted with Basketball 4 L.Y.F.E. to use Asset Development framework in life skills and youth mentoring programs to reduce substance abuse and disciplinary referrals from DJS.
  - Parent Education (Department of Aging & Human Services)
    - Provides evidence-based workshops to the community to reduce substance abuse, adverse childhood experiences, and problem behaviors.
  - Naloxone – Overdose Response Program (Health Department & Law Enforcement)
    - 130 law enforcement officials trained and equipped to administer Naloxone to prevent opioid overdose.

- Overdose Fatality Review Team/OFRT (Health Department)
    - In the process of establishing a OFRT to review overdoses and identify opportunities for public health action.
- Qualitative Needs Assessment (Health Department)
    - Contracted with vendor to complete a qualitative needs assessment on opioid use, misuse, and abuse in St. Mary's County.

- Treatment
    - Screening, Brief Intervention and Referral to Treatment/SBIRT (Walden Sierra)
        - Walden has trained primary care practices and local school counselors on implementing SBIRT.
    - Outpatient Treatment Services for Female Inmate Population (Walden Sierra and Sheriff's Office)
        - Assessment, treatment, and linkage to community outpatient and/or residential care.
- Recovery Support
    - Recovery Centers (Walden Sierra)
        - Beacon of Hope adult recovery center
            - Over 1,000 visits/month (over 120 non-duplicated/month)
        - The Cove adolescent clubhouse/recovery center
            - Over 150 visits/month (15-20 non-duplicated/month)

Other Successes

- Drug Summit for Parents (March 2014)
    - Over 600 attendees with regional, state, and national attention.
- Regional Opioid Overdose Response Workgroup Symposium (July 2014)
    - St. Mary's County organized and hosted a regional symposium to engage law enforcement, treatment & prevention, Social Services, Health Departments, and clinical professionals throughout all three counties.
- $100k FY15 non-recurring county funds
    - St. Mary's County commissioners reallocated county funding to support local opioid prevention efforts.
- Opioid Misuse Prevention Program (OMPP) Grant Award
    - Department of Aging & Human Services and local Health Department collaborated to successfully apply for OMPP grant to develop and implement a strategic plan to reduce opioid misuse and abuse. Over $100k received for FY15.
- Student Led Drug Summit (March 2015)
    - SMCPS students organized a student drug summit with local overdose prevention workgroup members serving as adult advisors. Over 150 students in attendance.

Challenges

- Funding
    - Commitment of adequate and long term funding to support initiatives.
    - Availability of funding for treatment services including Medication Assisted Therapies.
    - Funding for treatment of high-risk populations such as female inmates.
- Prescription Drug Monitoring Program
    - Prescribers are not required to use this tool which limits its usefulness.
    - There is also no data available on how many physicians are using this tool within each county.
- Data
    - Availability and timeliness of county level data for opioid use, misuse, and abuse indicators.
- Transitional Resources
    - Availability of long-term recovery housing and affordable housing.

Testimony before the Governor's Heroin Taskforce, April 29 2015

Dr. Kathleen O'Brien, CEO, Walden Sierra Behavioral Health

Addiction is a complex brain disease that alters reward, motivation, memory and related circuitry. These alterations manifest in biological, psychological, social and spiritual dysfunction most commonly exemplified as an increase in emergency room visits, overdose deaths, crime, homicides, high school drop-outs and loss of employment.

Today people in the United States make up 4.6% of the world's population but consume 80% of the global supply of opioids, including 99% of the hydrocodone produced, with Vicodin being the most prescribed medication in the United States. For many prescription opioid users, the shift to illegal and highly addictive heroin use is swift and of growing concern. Heroin is a cheaper more readily available option when prescription supplies dwindle or when the cost of medication is prohibitive.

While 25-34 year olds remain the largest group of opioid abusers, it is the 18-24 year olds that are the fastest growing group of opioid users. Due to the complex nature of addiction, and in particular the opiate addiction, a wide range of treatment and recovery support options need to be made available for all populations struggling with this disease. This includes establishing stabilization centers to include detoxification monitoring and mental and physical health assessments; providing services that are trauma-informed, culturally appropriate and person-centered; expanding both Medication Assisted Treatment (MAT) as well as Non-MAT options; establishing treatment and recovery networks throughout the community; and assuring that services are accessible and timely for all individuals in need of treatment including adolescents and pregnant women.

Having worked in this field in Maryland for 4 decades I am proud of the work we have done thus far, but urge this taskforce to organize our efforts more strategically at the community, county and state level in an effort to make opioids less available and accessible for nonmedical use and increase the services to those who have SUDs in order to lessen the impact on children families and the community.

I recommend the taskforce consider 5 pillars

I. Prevention services
   - Educating citizens about the dangers of Heroin use in the community
   - Incorporate education specifically on heroin and prescription pill abuse into middle and high school health curriculum
   - Conduct town Hall meetings through the community
     - We have conducted a Community summit with over 600 in attendance…followed by several initiatives including youth summit and day long forum at Patuxent River Naval Air…broadcast around the country
   - Collaborate with pharmacies to inform customers of proper use and disposal options

II. Harm reduction strategies
   - prescription drug drop off
   - naloxone training and distribution
   - provide targeted prevention and tx services for pregnant women
   - Specialized Drug courts should prioritize Opiate addict population for these intensive services.

III. Law enforcement practices
   - Provide basic SUD training for all persons working in the criminal justice system
     - enhance efforts around drug driving
   - State's Attorney's office…PBJ treatment diversion programs
   - Expand alternative to incarceration programs

- Day reporting Center…IOP tx mandatory to be eligible
- Re Entry programs…early release contingent on tx requirements

IV. Treatment infrastructure

- Accreditation through CARF or Joint Commission….no more delays, to ensure quality
- Increase access to treatment
- Walden moved to same day access, tx on demand model to improve access
  - ER diversion Walden is working with hospital to divert directly to detox bed…reducing ER cost and improving tx outcome
- Increase funding to insure a comprehensive continuum of quality care across the start.
- Increase Funding for
  - Detoxification
  - MAT clinics – need to expand. Also review tx component
  - Intensive outpatient treatment
  - More specialized tx..ie adolescent, pregnant women, co occurring
  - Residential treatment
  - Sober supportive housing
- Encourage housing and transportation be a part of medical benefit in early stabilization
- Increase funding for Evidence based treatment for persons who are incarcerated
  - funding for MAT tx while incarcerated (vivitrol project)
  - Develop alternatives to incarceration for persons to receive treatment, ie check in centers, and inpatient tx as part of time served.

- Create a strategy for workforce Development

- Incentivize persons to pursue careers in addiction medicine and treatment.

- Require state funded programs to utilize evidence based practices
- Training
  - SBIRT(screening and brief intervention)
  - Train all clinicians, school counselors and primary care, ER, and OBGYN physicians in SBIRT so they can recognize the disease of addiction. Walden has trained physicians and school guidance counselors
- Motivational interviewing
- require training of all clinicians in motivational interviewing so they can respond effectively to clients who are not yet ready to change behavior
- Courts
- Fund court assessors at the district court level to increase access to tx earlier in the disease process
  - Drug courts - opiate addicts should be the priority population utilizing the resources
  - 42CFR and IMD exclusion
- Seek changes to 42CFR
- work at the state and federal level to eliminate the IMD exclusion

V. Workplace policies
- Encourage successful drug free workplace programs.
- SAMHSA Drug free workplace kit recommends at least 5 components.
  1. Written policy
  2. Employee education
  3. Supervisor training
  4. An EAP
  5. Drug testing

What my experience in the treatment field informs my comments. We are fortunate to work closely with families and with the self-help community, including celebrate recovery and 12 step fellowships. Unfortunately heroin addicts do not do well with self-help alone, their success rate is less than 6%...much lower than other substance use disorders. Many require MAT and almost all require quality treatment. A commonality of the clients we see can be condensed to four domains

1. lack of stable housing
2. lack of consistent transportation
3. a lack of coordinated care
4. the presence of undiagnosed trauma, MH or physical health co-occurring with SUD

Once these issues are addressed the clients begin to improve their health and decrease cost...

If we organize ourselves and focus on the 5 pillars and the 4 domains, Maryland can change the landscape of services for those in need. My hope is the taskforce will listen to recommendations and create a portfolio of effective, actionable strategies for leaders and communities creating a safer, healthier future throughout Maryland.

Best Practice in Long Term Drug Rehabilitation

No Quick Fix: Long Term Addiction and Criminal Behavior takes a Long Term Plan/Solution

It is a statement of our culture when we are happy to send a drug addict to prison for 20 years with no regards for the costs when it comes to addiction related criminal behavior and then in contrast, we feel 90 days of long term treatment should be enough for them to get their life back. We worry about that the cost of 90 to 150 days of actual treatment is too expensive. When you look at the length of time spent in addiction and in prison, 120 to 150 days of treatment to get a plan to effectively return to the community with the skills and resources required to stay clean and sober, it is a cheap trade off. When addiction has taken everything, a year of help costs the community nothing if our citizens can become responsible, taxpaying sober contributing individuals with a future.

This paper is addressing those long term drug addicts with may years of incarceration and pending charges directly related to addiction.

HOW TO PAY FOR LONG TERM COMPREHENSIVE TREATMENT: Without out creating more debt to the budget:

Most addicts get long jail sent $ 82,000 a year. Over ten year, it will cost 820,000 for ten years

That is a lot of money for no return when the root problem is addiction.

Most people serve 1/2 their time and them are release.

If you allocated 6 months of treatment @ 6,0000 a month: **$36,000 It is half as expensive as jail and if they stay out of jail for one year, you have saved: $44,000 the first year and $82,000 for the nine year they are not incarcerated.**

At any given time there are 4,000 to 6,000 addicts awaiting treatment placement. Setting aside 36,000 per inmate for treatment is cheap compared to putting them in prison.

With a transfer of the fund that are for prison detention of addicts to treatment for addicts, the system can more than afford to pay for comprehensive treatment and long term treatment for a long term problem placing Maryland at the for front of curbing the heroin and other drug epidemic.

We all know short term does not work for a long term problem,

We can easily pay for long term treatment and save million in the State budget!

An addict that can hold a job, be in the community and be responsible can respond to a 30 to 60 day residential stay and outpatient community treatment, but long term use and incarceration takes a long term approach for a successful outcome.

Look at what is stacked against the average addict who has criminal charges and long term jail time.

When a person becomes an addict in their teenage years, all brain functioning stops and becomes immediately addicted to the drugs of choice. It will crave that "high" feeling for a long time even after they stop the drugs. Opiates and crack and have an immediate effect on how the brain responds to pleasure and stimulus.

Most of the long term addicts with criminal backgrounds come out of jail without a high school diploma and with no job experience. There social skills are poor due to long term incarcerations. The community structure in prison is nothing like the general community. Self esteem is none existent and they know very little about respect for themselves and for others.

With years of anti social conditioning, trauma, abuse and addiction, the deck is stacked against the long term addict in the prison system.

There needs to be a better balance. More needs to be done in terms of treatment and less focus on punishment. Not to say punishment for crime is necessary. A person that has spent years in jail, does not have time with only 90 days of treatment to re-learn and acclimate to the community and get everything they can from treatment. Addicts who come for treatment, need to focus on treatment.

The first 30 days in any program is spent on a black out and just getting used to the program and re-educating their brain which many have not used for some time. Following the structure and adjusting to life on the outside is a full-time job when a client comes into treatment. That is in addition to the 36 groups and learning, individual counseling sessions and oh yes, the feelings that have been buried for many years all coming at them at once.

The next two months in treatment are spent learning about their actions, coping skills, dealing with last 30 days, they learn some relapse prevention, start networking the community and developing a community resource group.

According to the Baltimore City Drug Court Report on the Felony Diversion Initiative for addiction published don the Md. gov web page, over the court of 4 year, 85 participants, this treatment program saved **$173,125** per year with a ten year savings of **$1,731,250** dollar savings when you had comprehensive treatment, case management and a four year follow-up.

Costs: it costs about $50,000 a year to house an inmate in the Prison System.

A client is lucky enough to get funding for 120 to 150 days, they can work on getting a GED, job readiness, job training, seek employment and most importantly housing. All while practicing sobriety and continuing to learn about addiction, recovery and relapse prevention. A comprehensive program has recreation, therapy, mental health, case management, empowerment, esteem building, job skill development, social skill development, family support counseling an more. It is odd to say lucky enough to get that much funding for treatment. I have never heard a judge ask if we have the money to pay for anyone's incarceration. We just sentence them to long terms with no regards for the cost. We should have a State policy of treatment over incarnation which has proven to return functioning, employed, individuals with a home to go to with community support. All of those issues help keep the person addicted. They had no job history, not resume, no work skills and no time to learn them before they are sent back out into the community who is less than thrilled to have them return home.

It is important that addicts be given enough treatment time to get their life back. This cannot happen overnight. Treatment costs less than incarceration by tens of thousands of dollars a year. Treatment is designed to treat then entire person, not just lock them away for their crimes.

Addicts needs a variety of professional services which take time to develop in the individuals.

Last year we served 396 clients

82% of our clients are opiate abusers/Heroin

Of that number there have been 6 known deaths: 1 overdose and 5 by natural causes: long term addiction leads to early deaths in many occasions.

100% of our women all experienced child hood traumas of a sexual or abusive nature which led to addiction.

90% of our clients come out of jail without a GED!

Our program, The Jude House in Southern Maryland, has seen a 68% increase in successful discharges and placements for those who have stayed 120 days or longer in the past year. In 2013: only 37% graduated the full length of time. Last year: 98% graduated successfully.

96% have left the program with housing in place. 62% have left with gainful employment.

Prior to the new program, clients stayed 60 to 90 days and only 37% completed the program. In the last year. with a 90 to 120 day program, with extensions granted based on the clinical needs of each clients, our successful graduation with honors rate is now 98%.

Providing the best chance possible for those addicted serves everyone. Themselves, the community at large and our State with reformed individuals contributing to the growth and wealth of our State.

The State needs a coordinated plan:

Adequate funding for those long term addicts with long tern jail sentences:

Being out the community for 10 to 20 years means lots of re-thinking and lots of case management to include education and job training.

The best chance for a full sober life is a plan which include a GED, employment and supportive housing. Now you have to have a job to qualify for sober housing programs. That mane a longer stay in rehab to get the addiction treatment, learn job skills, get Bonded by DLLR and find a job. The they need 30 days with support to work and save money to move into sober living house.

The program can work. A focus on the front end with a comprehensive plan, jails, treatment, case management, parole and probation being on board will change the recidivism rate of the addicted offender.

A quick turnaround in numbers does not serve anyone especially the addicts. We need to help the addicts with a criminal history become acclimated to treatment and recovery, be in the community, have some self worth and esteem, set a good foundation for a future drug free life.

When clients get discharged without the necessary support system in place and the tools needed to remain clean and sober, we have seen the numbers of the short term program return over and over to incarceration and criminal behavior. Short term stays for the long time addict do not work for long time recovery. We have a saying, 7 miles in and 7 miles out. It took a long time for a drug addict to lose everything, with takes just a s long for them to get it all back!

Investment in long term treatment for a lifelong issue is one our State should be making.

Recommendations:

- Anyone not serving their full sentence should only be allowed to be paroled with a GED: It is ad that after years in prisons, this populations does not have a GED. No GED, No Parole
- Convert the Detention dollars to treatment dollars for each person who goes to long term treatment.
- Commit to 4 to 6 months of residential treatment for long term addicts with long criminal history to allow them the best chance of recovery.
- What you spend on the front end will come back on spades and Millions to the budget in reduces prison dollars.

Mary Lynn Logsdon, Executive Director of The Jude House.

PARENT'S INPUT TO GOVERNOR'S HEROIN TASK FORCE SUMMIT IN SOUTHERN MARYLAND

By DeForest Rathbone, Valley Lee, MD, 301-994-2733 DZR@prodigy.net

I am Dee Rathbone, a retired federal government engineer who has been a parent drug prevention activist for the past 40 years going back to drug-caused riots in my own children's high school in Fairfax Co., VA in 1974. As one of the original members of Nancy Reagan's drug prevention movement, I have been involved in the evolution of the nation's school drug crisis and the evolution of prevention efforts throughout that period and continue here in my MD home. Please let me share my grassroots perspectives on the cause and cure for this prolonged national health crisis of schoolchild drug use and its subsequent addiction, violence and death.

First and foremost is that too many well-meaning laws have resulted in devastating unintended consequences of damage to children and families. These laws and court rulings have essentially stripped parents from the protective shield of measures that protected children, families and communities throughout the ages of history. Some examples follow:

- In their *Tinker* decision of 1969, the U. S. Supreme Court stripped away the schools' right to act with the parents' authority on site, before which teachers could turn a kid's pockets inside out to discover any dangerous items he might possess. That ruling resulted in schools becoming inundated with drugs and alcohol which resulted in massive intoxication, fights and terror in schools throughout the 1970s, after which the SC relented slightly with their *TLO* decision of 1985 allowing "reasonable suspicion" searches of students. This meant kids could only be searched for dangerous possessions **IF** they showed outward signs to warrant attention. Those handcuffs on teachers remained in effect until they relented by allowing random suspicionless searches by biologic drug testing in approval of Random Student Drug Testing (RSDT) in their 1995 and 2001 decisions. Currently about two thirds of the nation's schools do no student drug testing, resulting in the steadily increasing teen drug use and addiction and subsequent drug overdose deaths. Child drug addiction and death ARE NOT THE FAULT OF PARENTS, TEACHERS OR POLICE; THEY ARE THE DIRECT RESULT OF FAILED GOVERNMENTAL DRUG POLICIES. See following examples.
- In the 1960s many states lowered the drinking age from 21 to 18. This terrible legislation resulted in massive teen drinking and sharing their newfound pleasures with their younger friends; and that in turn created a virtual blood-bath on the highways from teen drunk driving fatalities. When we parents appealed to Nancy Reagan, she convinced Pres. Reagan to lead Congress to return the drinking age to 21 which since then has resulted in reducing the teen drunk driving fatalities by over 70%. Unfortunately, a permanent taste for alcohol by teens had become entrenched although at a lower rate than before.
- Recent laws decriminalizing smoked marijuana for medicine has sent teenagers the message that pot must not be harmful if legislators declare it to be medicine, thus leading to significant increased use by children. In addition, relaxed federal laws on marijuana use and production in some states has created a legal marijuana industry that provides violent-psychosis strength pot to schoolchildren through the mail and their social network.
- Over the years the juvenile justice laws have become so toothless they are little deterrent to student misbehavior and criminal acts. Drug traffickers exploit this by employing teen drug pushers to distribute their dangerous products freely in schools resulting in massive drug use, addiction, violence and deaths among schoolchildren, see the attached SMC 2013 Youth Survey commentary.

Therefore, it is impossible to prevent students from addiction, violence and death by the conventional means of education, threats, criminal prosecution, or incarceration. Only health screening them by RSDT is the proven strategy to reduce schoolchild drug use and its terrible consequences. There are numerous examples and studies verifying this which we have documented in our Briefing Packet on RSDT. Therefore, we urgently request that the Governor's Task Force makes as a first priority, the statewide consideration of RSDT in all schools. Thank you.

Terrorizing Violence from SMC School Drug Problems

The Enterprise recently disclosed a frightening drug-related act of terror in a SMC school, see John Warton's 4/6/15 article, "Assault charged after boy's injury at Chopticon." It cited police reports that a violent bully allegedly picked up a helpless student and threw him down a set of concrete steps at Chopticon high school breaking his arm in two places. The reason cited? The bully suspected the victim to be a snitch on **drug possession at the school**. This act of drug terror has sent all SMC schoolchildren the brutal message that they better not inform on any drug activities in the schools for fear of their lives. See the article at link:
http://www.somdnews.com/article/20150406/NEWS/150409523&template=southernMaryland

Added to that is a Chopticon student's drug overdose death during the school break last Christmas. Plus the recent case of the mother who is so frustrated over the school system's response to her daughter's behavioral health problems that she allegedly threatened to bomb the school, see The Enterprise 4/3/15. **Such dangers are becoming exponentially worse** these days due to the increasing prevalence of **violent-psychosis-inducing high-potency marijuana** being aggressively marketed to kids from the "legal" Big Marijuana industry in Colorado. And the inability of current school policies to protect students from such dangerous drugs.

Unfortunately those are only a few examples of the type of drug-related harms causing fear, depression and suicidal thoughts among helpless non-drug-using schoolchildren as disclosed in the most recent SMC Youth Survey. That survey revealed that 25% (about 2,500) students had been offered, sold or given drugs on school property; 19.8% (about 1,980) students had been bullied; 6.4% **(about 640) students had felt so unsafe they cut school in the past 30 days;** 24.3% (about 2,430) students felt sad and hopeless (depressed); and 16.1% **(about 1,610) had seriously considered suicide!**

Thus, the prevalence of drugs in schools is causing much more than just direct harm to the users; it is a major contributor to massive terror among vulnerable innocent young schoolchildren. All of those **examples constitute evidence of the dire need for school officials to implement urgent new school behavioral health policies that will prevent such damage to our children from the dangerous drug culture in schools.** While the vast majority of SMC schoolchildren may be drug-free, all of them, their teachers and school staff are seriously threatened by the potential for violence by the few among them who may be psychotic drug users.

Fortunately, the new SMC school administration and new school board leadership are perfectly positioned to consider and implement a proven school behavioral health strategy that has virtually eliminated drug use and related terrorizing violence in thousands of other schools throughout the nation: **routine random health screening of students to prevent exposure of kids to dangerous drugs and to identify those in need of treatment.** It is fully supported by parents as previously reported in Nicole Clark's 8/27/14 Enterprise article, see at link:
http://www.somdnews.com/article/20140827/NEWS/140829358&template=southernMaryland

Therefore we parents urgently request county and school officials to appoint an ad hoc task force to give fair consideration to that schoolchild health/safety initiative and include us parents in that effort.

DeForest Rathbone, 301-994-2733, DZR@prodigy.net NICAP 4/20/15

THE SUMMARIZED CASE FOR SCHOOL DRUG TESTING

- **ONE-THIRD OF SECONDARY SCHOOL STUDENTS USE DRUGS/ALCOHOL** CAUSING HEALTH/SAFETY PROBLEMS, ACADEMIC FAILURES, DROPOUTS.
- U. S. SUFFERS **4,000 DRUG OVERDOSE DEATHS EVERY MONTH** MOST OF WHICH STARTED WITH TEEN USE OF MARIJUANA WITH A SCHOOLMATE.
- MANY PARENTS FIRST LEARN OF THEIR CHILD'S DRUG USE AT THE **EMERGENCY ROOM, THE JAIL CELL OR AT THE AUTOPSY TABLE!**
- RANDOM DRUG TESTING **GREATLY REDUCES DRUG USE** PER THE PROVEN EXPERIENCE OF MILITARY, BUSINESSES, & MANY U.S. SCHOOLS.
- A **FEDERAL SCHOOL DRUG TESTING LAW** WAS ENACTED IN THE "NO CHILD LEFT BEHIND ACT OF 2001." IT AUTHORIZES AND FUNDS LOCAL SCHOOL USE OF **NONPUNITIVE RANDOM STUDENT DRUG TESTING (RSDT) TO DETER, DETECT AND TREAT SCHOOLCHILD DRUG ABUSE.**
- SUPREME COURT HAS TWICE APPROVED **HEALTH/SAFETY-BASED RSDT.**
- **PROFESSIONAL DRUG LEGALIZATION LOBBYISTS** PROMOTE DECEPTIVE OPPOSITION ARGUMENTS THAT IMPEDE KNOWLEDGE OF **RSDT'S TRUE LEGALITY, EFFECTIVENESS, AFFORDABILITY AND POPULARITY.**
- U.S. DRUG CZAR'S OFFICE AND U.S. EDUCATION DEPT. SUPPORT PARENTS' APPEALS TO **SCHOOL ADMINISTRATORS AND SCHOOL BOARDS** TO CONSIDER ADOPTING **RSDT** AS A SCHOOL HEALTH SCREENING PROGRAM.
- MANY PARENTS ADVOCATE A FEDERAL MANDATE TO PROTECT **ALL KIDS** BY **RSDT** IN THE MODEL OF THE FEDERAL 21 DRINKING AGE MANDATE. **ANYTHING LESS LEAVES THE MOST-AT-RISK KIDS BEHIND ON DRUGS ENDANGERING THEMSELVES, CLASSMATES, TEACHERS, AND PARENTS.**
- SEVERAL THOUSAND SCHOOLS USE **RSDT** EFFECTIVELY **REDUCING TEEN DRUG USE BY MORE THAN 90% AND REDUCING CHILD DRUG/ALCOHOL ADDICTION, SCHOOL VIOLENCE, OVERDOSE DEATHS, HIGH RATES OF YOUTH INCARCERATION AND DISRUPTED EDUCATION ENVIRONMENT.**
- **RSDT** CAN ELIMINATE THE **PEDIATRIC ONSET BRAIN DISEASE OF DRUG ADDICTION** JUST AS THE **SALK VACCINE** ELIMINATED JUVENILE POLIO.

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U.S. DRUG CZAR EXPLAINS CAUSES AND RSDT TOOL TO PREVENT TEEN DRUG ADDICTION AND OVERDOSE DEATH

AN INTERVIEW WITH U.S. DRUG CZAR JOHN WALTERS

Introduction: *In response to news of a huge increase in **drug overdose deaths** and arrests for **drug trafficking** among Fairfax County youths in **2008**, Fox News TV5 reporter Sherri Ly interviewed U.S. Drug Czar John Walters for his expert views on the cause and potential cure for these horrific family tragedies. Following is a brief summary of key points with commentary of that 11/26/08 interview. Transcript of the full original interview is available from NICAP.*

- Child drug use is quite difficult for parents to detect *"because children that get involved in drugs do everything they can to hide it."* (NICAP note: Most parents first learn of their child's drug use either at the jail cell, the emergency room or at the autopsy table.)

- Teens are fragile and susceptible to addiction because of young immature brains still developing through age 20 to 25.

- Children are exposed to attractive pro-drug messages on their computers and cell phones. *"The computer brings every predator and dangerous influence into your own child's home- into the bedroom if that's where the computer exists. Drug dealers are in that computer and they're only a couple of keystrokes away from your child."*

- The health screening tool of Random Student Drug Testing (RSDT/SBIRT) is now available to help identify for diagnosis and treatment, children exposed to the disease of drug addiction. ***"There is no doubt in my mind that had this young OD death victim been in a school-- middle school or high school that had random drug screening since that's where this apparently started -- <u>she would not be dead today!</u>"***

- We can use the tools of screening, and **we can use the occasion of a horrible event like this to bring the community together and say it's time for us to use the shock and the sorrow for something positive in the future.** I haven't met a parent of a child who's been lost who doesn't say I just want to use this now for something positive. And that's understandable, and I think we ought to honor that wish.

- We need to continue to make this disease smaller. **It afflicts our young people. It obviously also afflicts adults, but <u>this is a problem that starts during adolescence -- and pre-adolescence in some cases --</u> in the United States.** We can make this smaller. We not only have the tools of better prevention but also better awareness and more recognition of addiction as a disease. We need to make that still broader. **We need to use random testing. If we want to continue to make this smaller, and make it smaller in a permanent way, <u>random testing is the most powerful tool we can use in schools</u>.**

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DRUG-RELATED DANGERS TO STUDENTS IN ST. MARY'S COUNTY SCHOOLS

As Documented in the following excerpts from the 2013 Maryland Youth Risk Behavior Survey. The full Survey is available at link:

http://phpa.dhmh.maryland.gov/cdp/SitePages/youth-risk-survey.aspx#stmary SMC data accessible through this link.

BACKGROUND

In order to break through widespread denial of school drugs and violence, Congress enacted laws that require local schools to conduct student surveys and report acts of crime, drugs and violence in their schools. This information is important to help public officials identify the causes of such problems and to more effectively select prevention strategies and allocate resources to address these problems.

STUDENT SURVEY SUMMARY

The 2013 (latest available) St. Mary's County Youth Risk Behavior Survey results are **similar to all previous surveys** throughout the past two decades in that they indicate **serious involvement of many schoolchildren in illegal substance abuse and related dangerous behaviors.** The survey data are presented as *percentages* of students involved in each category of the survey. However, to give a more complete picture of the magnitude of the problem, those raw percentages have been converted into the calculated equivalent **number of students involved** based upon a secondary school enrolment of approximately 10,000 students.

Category	Reported Percentage	Number of Students
Current Use of Cigarettes	15.3%	1,530
Current Use of Marijuana	19.9% (27.7% Nat'l)	1,990
Current Use of Pills	9.2%	920
Current Use of Alcohol	34.0%	3,400
Current Binge Drinkers	19.2%	1,920
Drove Under the Influence of Alcohol Recently	**11.3%**	**1,130**
Been a Passenger with a Drinking Driver Recently	**21.2%**	**2,120**
Lifetime Use of Cocaine	6.7%	670
Lifetime Use of Heroin	**4.5%**	**450**
Used a Needle to Inject any Illegal Drug	4.1%	410
Lifetime Use of Meth	5.0%	500
Lifetime Use of Ecstasy	8.6%	860
Lifetime Use of Steroids	4.8%	480
Offered, Sold or Given Drugs on School Property	**25.0%**	**2,500**
Involved in a Physical Fight in Past Year	11.3%	1,130
Involved in a Fight that Required Medical Attention	5.2% (2011)	520
Carried a Weapon on School Property	3.8%	380
Threatened by Weapons on School Property	**8.1%**	**810**
Were Raped	9.9%	990
Had Been Bullied	19.8%	1,980
Felt Unsafe so Cut School in Past 30 Days	6.4%	640
Felt Sad and Hopeless (Depressed)	24.3%	2,430
Seriously Considered Suicide	**16.1%**	**1,610**
Actually Attempted Suicide	12.5%	1,250
Attempted Suicide that Required Medical Care	5.2% (2011)	520

The 2011 Maryland State Survey specifically highlighted the following ***suicide*** data: In the last 12 months, over one fourth (29.7%) of Maryland youth reported experiencing feelings of sadness and hopelessness "every day for two or more weeks in a row" to the point they "stop doing usual activities." Although notable, this percentage—as well as the percentage of youth who considered attempting suicide, or made a plan for committing suicide, or actually attempted suicide—has remained largely unchanged between 2005 and 2011. However, **the percentage of youth whose suicide attempts required medical care increased significantly between 2005 and 2011.**

NOTE: The following categories were included in the *2001* Survey but not in the 2011 and 2013 Surveys. Assuming no major differences in rates between those three surveys, the *2001* percentages are reported below with calculations to the number of students based on the current secondary school enrollment.

Used Any Drug Other Than Alcohol	24%	2,400
Use Two or More Drugs	12%	1,200
Been High on Drugs at School	**14%**	**1,400**
Been Drunk at School	**10%**	**1,000**
Drove Under the Influence of *Drugs*	**10%**	**1,000**
Been a Passenger with a Drug-Using Driver	**21%**	**2,100**
Arrested for Drug-Related Incidents	**4%**	**400**
Arrested for Alcohol-Related Incidents	**4%**	**400**
Unsuccessfully Tried to Stop Using Drugs	5%	500
Unsuccessfully Tried to Stop Drinking	5%	500
Had Poor School Performance Because of Drug Use	6%	600
Was Absent From School Due to Drug Use	8%	800
Had Health Problems Due to Drug Use	5%	500
Had Family Problems Due to Drug Use	6%	600
Had Poor School Performance Because of Alcohol Use	5%	500
Was Absent From School Due to Alcohol Use	9%	900
Had Health Problems Due to Alcohol Use	5%	500
Had Family Problems Due to Alcohol Use	6%	600

Whether these numbers are precisely accurate or not, **they represent a reasonable estimate of the actual condition**. Their gross magnitude may be seen as a desperate ***cry out for help*** by the students who completed the surveys. If these totals seem to be an exaggerated statement of St. Mary's County's schoolchild drug problem, we should consider the anguish of even one family whose child has been damaged or destroyed by drugs and violence in his/her school. **As reported by testimony at the March 7, 2014 St. Mary's County "Drug Summit for Parents," in the past three years, SMC recorded 254 drug overdose treatments that included 20 juveniles, and 18 drug overdose deaths.** Studies have shown that most OD deaths had their origin in exposure of kids to drugs during their teen years.

Since the above figures were developed from Survey questions alone, these data need to be confirmed by biologic testing that is objective and accurate. That is why in a recent letter published in the 6/25/14 Enterprise (attached) Parent drug prevention leaders called for a **"one-time confidential health screening of SMC secondary school kids to verify with scientific certainty the actual exposure of students to the disease of drug addiction."** A scientific structured random sampling of a **representative number of students** by hair testing to confirm drug use over a three month period, would be relatively inexpensive and produce the valuable information SMC Health and School officials need to adopt new effective drug prevention policies.

This paper produced by National Institute of Citizen Anti-drug Policy (NICAP)
DeForest Rathbone, Chairman, 301-994-2733, DZR@prodigy.net 6/29/14

Maria Buehler Calvert County mariabuehler@hotmail.com

Calvert County had 6 intoxication deaths in 2013
Calvert County had 13 intoxication deaths from January through June of 2014

GOAL: To Promote And Facilitate Life Saving And Life Restoring Resources

MD has seen an 88% increase in the number of heroin related deaths since 2011

STATE

Prescription Limit Law

Limit the quantity/days supplied/refills for CDS
MD only for emergency prescriptions/certain member benefit plans
6 other states limit number of days supply by class of drug

Physical Exam Law

42 other states have laws requiring physical exam of a patient by a health care provider prior to prescribing CDS

Tamper Resistant Prescriptions

Laws to prevent use of fraudulent prescriptions to obtain CDS
MD only required if patient to be reimbursed for prescription by Medicare/ Medicaid
10 other states require tamper resistant prescriptions for all CDS

Pain Clinic Laws

Prevent facilities from prescribing CDS indiscriminately/inappropriately
3 other states have such law at this time

Improve Lock In Program

Individuals suspected of misusing CDS must use single prescriber/pharmacy
Expanded for all not just Medicaid/those with previous record of CDS

Mandatory Utilization MD Prescription Drug Monitoring Program

Real time/With mandatory photo ID
This will increase physician oversight
Or we need specific Doctor shopping laws which prohibit patients from withholding from any health-care provider that they have received any CDS from another provider or the same/similar within a specified time interval or previously /MD currently has general - 20 other states

have specific laws
State ID mandatory requirement for all CDS prescriptions
22 other states require but 20 of those still leave discretion to pharmacy

Mandatory Prescriber Education
22 other states require programs in which are evidence based/objective information about pharmaceuticals to discourage abuse

Workers Compensation Premium Discount
For businesses who implement drug free workplace policy
11 other states offer such discount

COUNTY

LEAD
Pre booking diversion program for small amounts/non violent-social worker assesses mental health/addiction services/ etc/ immediately following arrest

Hotline
Partner with existing privately owned Hot Line to encourage abusers or loved ones to seek treatment **(WE HAVE DONE)**

Improved Awareness Campaign (IN PROGRESS)
Through Calvert Alliance Against Substance Abuse
Overly user friendly web site focused on heroin/prescription abuse
County wide statistics, prescribed CDS-fatal and non fatal overdoses & make information easily available through web site
Overdose Prevention Training For Families
Calendar of meetings available in the tri county area
Major focus on family and friends options most often the ones who call
No mention on sheriffs page concerning anything related to drugs, treatment or help
CAASA web site offers little help-these pages should have links to dedicated page
Involve recovering addicts in awareness campaign - stories shared on website
Recognize 90 Day Inpatient rehab necessary/Out of county rehab most

effective

Push Good Samaritan Law

Push Narcan is available with all 1st responders

Specific targeted campaign to those abusing Narcan availability

Business to Business Initiative (IN PROGRESS)

Implement drug free workplace policy

Campaign to include yard signs (Drug Free Business, hot line number for treatment options and crime solvers number to report activity

Larger signs for hot spots, training for supervisors, educational campaign

Continue to lobby for drug task force police relationship with businesses

These are our friends, neighbors and loved ones fighting for their lives...

DISTRICT

Major and Minor Town Center Heroin Task Force Dedicated Officer

District Specific Community Action Groups

Targeted Awareness/Community Meetings

Door To Door Initiative

In neighborhoods after raids/break ins/upsurge in crime

Emily Harman
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https://www.facebook.com/PABAParents1

Thank you for the opportunity to speak to Maryland's Heroin and Opioid Emergency Task Force.
I am a founding member of Parents of Teens Unite, an organization that merged last year with a similar organization - Parents Affected By Addiction (PABA). The mission of PABA is to support, educate, empower, and provide awareness to parents and families in Calvert, Charles, and St. Mary's Counties of the prevalent use of drugs in Southern Maryland.

PABA's vision is to create a network of support and empowerment for parents and families whose children and loved ones are using drugs; encourage recovering addicts to tell their stories of pain (experienced personally and inflicted on loved ones), turning points, and recovery; advocate and lobby for anti-drug laws and legislation. PABA's vision is to use the pain we have experienced in living with and loving an addict to help others who might walk down a similar path.

PABA meets monthly in one of the three Southern Maryland counties. Anywhere from 20-40 people attend our meetings and it is not always the same people. New people attend every meeting. The stories are heartbreaking. We struggle with what to do.

I know that the Task Force has heard numerous stories about the pain and suffering of families impacted by the disease of addiction. I wish there was one solution - a permanent fix to this problem - but I know there is not. Based on my involvement in PABA and within my community, I recommend the Task Force consider the following four recommendations.

1) Consider implementing Non-Punitive Random Student Drug Testing as a school health screening program: We believe this is something the Task Force should consider because many parents first learn of their child's drug use after it is too late. Random drug testing greatly reduces drug use per the proven experience of the U.S. Military, businesses and many U.S. schools. The U.S. Supreme Court has twice determined health/safety based Random Student Drug Testing is Constitutional:

   Vernonia School District 47J v. Acton decided June 1995 (athletes)
   Earls Case decided June 2002 (extracurricular activities)

Here is a link to an article about a recent announcement by a school system in Georgia to test students who participate in athletics, any type of extracurricular non-athletic program and those who drive and park on campus. http://www.wsbtv.com/news/news/local/carroll-county-start-randomly-drug-testing-student/nk3W3/

2) Encourage/require drug education events in the work place: Through my work in the community and with PABA, I have observed that parents of school aged children typically don't attend drug related education events in the evenings or on weekends. This is not because they don't care about their children. They do. They are busy with homework, sports practice, music lessons, etc. We are finding that the students involved in numerous activities and getting good grades are using drugs too. The addict is not who we imagine. Parents don't think it will happen to their children.....until it does....and then it could be too late. Holding drug education events in the workplace will help ensure parents learn about this epidemic and the signs to look for in their own home. (Disassembled pens, missing spoons, q-tips laying around, unauthorized credit card charges, a child rushing to get the mail before the parent picks it up, etc...) This is an issue for employers because productivity in the workplace is being impacted by this epidemic. Employees could be addicted themselves or they could be distracted at work because of the impact of the addiction on a family member. This training can also help to change the social stigma of substance misuse - to help recognize it as an illness - a chronic brain disease - vs a moral issue. These workplace sessions can be used to educate employees on two landmark pieces of legislation that will save lives: 1) the Overdose Prevention Bill, allowing family members to obtain Naloxone (a drug that reverses overdose); and 2) the Good Samaritan Bill, which allows witnesses of an overdose to call for help without the fear of criminal prosecution. Most Marylanders remain unaware of this legislation.
3) Improve Data: Develop a method to collect data on the real impact of this epidemic. We parents don't believe the numbers tell the true story. For example, it is my understanding that the death certificate might say someone who died of an overdose died because their heart stopped. We believe the numbers of heroin related reported deaths are misleadingly low. Also, we would like to know how many emergency calls/runs are made on drug-related issues? How many children are being born addicted to drugs? How many people are in jail due to drug related issues? How many grandparents are raising their grandchildren? What is the real cost of this epidemic? The public needs to know the entire story - the sense of urgency is not there.
4) Treatment and Living Skills Resources: The state's treatment capacity does not come close to addressing the need - particularly in the area of adolescent and transition-age residential treatment and recovery services. While advocates support medically assisted treatment for those who want it, it should not be considered a substitute for long term residential treatment options which promote abstinence. Maryland must find a way to maintain a full continuum of treatment options, rather than just those that are the least costly or most

profitable. Maryland needs more halfway houses and sober living houses. Many addicts have nowhere to go once they are discharged from treatment and resort back to the life they once knew - life as an addict. We need to identify ways to teach them new skills so they can be employed and productive members of society.