

MEMORANDUM

March 25, 2014

TO: Public Safety Committee
Health and Human Services Committee

FROM: Linda McMillan, Senior Legislative Analyst 

SUBJECT: **Montgomery County Overdose Prevention Plan**

In response to a statewide 54% increase in heroin-related overdose deaths from 2011 (245) to 2012 (378) and a 15% increase in the total number of fatal drug and alcohol-related deaths (663 in 2011 to 761 in 2012), the Department of Health and Mental Hygiene directed all counties to develop an overdose prevention plan. The joint Committee has previously discussed that the increase in opioid and heroin abuse is a national problem and that the significant recent increase in heroin overdoses is driven in part by increased use of prescription opioids and the lower cost of heroin when prescription drugs are no longer available. Information included at ©51-52 says that while the largest proportion of Marylanders dying from overdose are middle age, the largest increase in fatal heroin-related overdoses have been among younger age groups, including a 53% increase in ages 15-24 and a 59% increase in ages 35-44.

At this session, the joint Committee will be briefed on Montgomery County's Opioid Overdose Prevention Plan, the data driving the Plan, and steps that have been implemented thus far. A listing of the members of the Plan Committee is included at ©32.

Council staff suggests that the joint Committee inquire what resources are needed to take the next steps in the Plan and use this opportunity to request any information that may be needed for upcoming budget worksessions. After the overview, the joint Committee may want to focus on the Performance Metrics (©28-31). While not all are complete and some reference the need to look at long-term funding streams, some are very concrete such as:

- Hosting two trainings per year regarding the dangers of prescribing opioid medications.
- Hosting two trainings per year on the use of Naloxone and certifying a certain number of Naloxone administrators.
- Establishing 10 drop box locations.
- Creating 2 media commercials to be shown in schools within the County.

Council staff understands that the State has provided some funding to begin the training and distribution of Naloxone. Will this funding be sufficient to serve the high risk people who have been identified? In addition, the last Performance Metric is very broad in terms of looking to identify gaps and identify funding sources. Has DHHS identified any critical gap, such as a need for residential treatment beds for children that should not wait for the broader strategic plan to be developed?

The Performance Metrics also discuss the creation of an overdose review team similar to the Child and Infant Fatality Review Committee. There is legislation before the General Assembly regarding the creation of this type of team. Once the outcome of any State legislation is known, the joint Committee should return to this issue with DHHS.

Attached Plans

Attached to this memo are two documents: (1) the Montgomery County Overdose Prevention Plan submitted to the Department of Health and Mental Hygiene in August 2013 (©1-36) that include Stakeholder recommendations (©19-27), and (2) the Maryland Opioid Overdose Prevention Plan completed in January 2013 (©37-56).

County Overdose Prevention Plan key points:

- **Preliminary findings** from 2010-2013 data include: (1) Police data showing greater prevalence of overdose in Germantown, Gaithersburg, and Wheaton; (2) indications of increasing use of opiates; (3) increase use of heroin and prescription drugs among school-aged children. There is also a need to explore whether there is a connection in increase in opioid use and suicides for individuals 50-60 years of age. Information included at ©33-36 which has been previously reviewed by the joint Committee shows that Montgomery County's rates for death by intoxication are low compared to the rest of the State.
- **Primary Prevention** seeks to prevent overdoses by reducing risk. The plans calls for (1) Raising awareness of the risk to both providers and the community; (2) Promoting safe practices both in the homes and primary care practice settings; (3) Reducing exposure and associated risks in the home and community. Some of the strategies include public forums provided by MCPS and the Collaboration Council's Drug Free Coalition, targeted outreach to senior and other special population such as inmates, continued participation in the annual drug take back program, establishment of on-going drug take-back boxes.
- **Secondary Prevention** works to detect and treat pre-addiction/abuse thereby reducing the risk for overdose. Strategies include: (1) implementing Screening/Brief Intervention/Referral to Treatment (SBIRT) by healthcare professional in a variety of settings to create a "no wrong door approach;" (2) Implementing Policy changes such as Good Samaritan laws (protection for people calling 911 to report an overdose); Marchman Act laws (opportunity for involuntary commitment when addiction constitutes a danger to self), and prescription drug monitoring.

- **Tertiary Prevention** seeks to address the underlying risk factors for death and promote recovery and resiliency. Strategies include (1) Acute intervention that focus on emergency response to overdose events such as distribution and training in the use of Naloxone and targeted education of first responders in the recognition of overdose and emergency response; (2) Expanding capacity, identifying gaps and preparing to meet the increased demand as a result of health care reform. Expanding the number of physicians credentialed to use Buprenorphine and increasing alternative for medication assisted treatment; (3) Continuing the implementation of Recovery Oriented Systems of Care with peer based recovery programs and recovery coaches.

The report includes recommendations from Stakeholder Meeting held to review a draft of the Plan (©19-27). They include:

- Train all school health room professionals in SBIRT protocols.
- Develop a campaign to ensure that primary care physicians are aware of SBIRT protocols.
- Meet with Emergency Room Director to discuss incorporating SBIRT protocols and establishing short-term de-tox similar to Suburban Hospital.
- Meet with Police Department administrators to see how SBIRT protocols can be implemented into police crisis response protocols.
- Assess the feasibility and related costs of developing the full continuum of care for adolescents and transition age adults.
- Require all treatment providers operating in the County or receiving County funds to submit evidence that the treatment they are providing is developmentally appropriate to all clients.
- Require all treatment providers operating in the County or receiving County funds to submit evidence that they are providing culturally and linguistically appropriate treatment for all clients.
- Develop a timeline for phasing out the use of Methadone and replacing it with Buprenorphine in all County funded programs.
- Develop a campaign to increase the number of doctors prescribing Buprenorphine.
- Ensure that Substance Abuse Disorder (SUD) patients are presented with holistic options for healing neurological and brain functioning equal to other interventions, including pharmacological treatments.

- Create a revised model for co-occurring treatment so that the dually-diagnosed client is dually-educated, dually-treated, and dually-referred for the complete spectrum of mental health disorders, including SUD, that he or she presents.
- Develop a strategy to increase the number of County psychiatrists willing to accept Medicaid.
- Require all treatment providers operating in the County or receiving County funds to maintain an open door policy for members of the patient's treatment team, including the patient, their family members, therapists, school counselors, recovery coaches, case managers, etc.
- Require all treatment providers operating in the County or receiving County funds to ensure a continuum of care, by providing a written follow-up plan for addressing all of the patient's needs, with accompanying referrals.
- Require all treatment providers operating in the County or receiving County funds to ensure that family education and counseling is integrated into any treatment program or plan, particularly for adolescents and transition-aged youth who are living with their parents.
- Require all treatment providers operating in the County or receiving County funds to ensure that seniors have access to family counseling and wrap-around services specific to their needs.
- Ensure that there are equal and ample opportunities for peer recovery specialists with "lived" experience to be utilized in the recovery movement and that these individuals receive training and benefits equal to recovery coaches without "lived" experience.
- Request the Alcohol and Drug Abuse Administration consider introducing legislation similar to Florida's Marchman Act.
- Urge the Alcohol and Drug Abuse Administration to expand its compliance office to include an agent or office in each county to handle complaints, particularly those related to breaches in patient abandonment and insurance parity laws.
- Establish a task force, and include consumers and family members, to devise standards and performance outcomes for treatment providers, as well as a means for measuring these outcomes.
- Create a Quality Assurance Team, including current consumers of services, family members, and advocates, to collaborate with treatment providers to identify what worked and what didn't and offer suggestions for areas of improvement.

- Design and utilize qualitative measurement tools, such as surveys and focus groups, which provide input and feedback regarding the treatment experience of consumers and their families, and monitor long term patient outcomes.
- Ensure that any group, agency, or administrative body, including AODAAC, has a process for including and incorporating a wide and diverse representation of stakeholders, including individuals currently or recently in treatment, family members, transition-age adults, advocates, and other and that all representatives have a vested interest in providing input, and that the process ensures that all input is equally regarded and incorporated into County policy.

Maryland Opioid Overdose Prevention Plan (January 2013) highlights:

- The purpose of these Overdose Prevention Plans is to reduce the unintentional, life-threatening (fatal and non-fatal), poisonings related to the ingestion of both illicit and pharmaceutical opioids.
- Reducing drug-induced deaths is a key health outcome for Maryland as part of the State Health Improvement Process (SHIP).
- The Vital Statistics Administration will oversee enhanced surveillance of overdoses including the development of ongoing overdose surveillance through the DHMH Electronic Surveillance System (ESSENCE), the Maryland Poison Center, the Maryland Institute for Emergency medical Services systems (MIEMSS) and other sources of data.
- Treating individuals with substance use disorders is the foundation of Maryland's approach to reducing overdoses. Maryland will seek continued expansions of access to treatment and expansion of treatment capacity using evidenced-based therapies including methadone and Buprenorphine. Buprenorphine provides greater flexibility for treatment as it can be provided in an office-based setting.
- Maryland has implemented a Prescription Drug Monitoring Program. Upon authorized request, data can be made available to law enforcement, health professional licensing boards, and the Department of Health and Mental Hygiene. De-identified data will be available for research and public education.
- Naloxone, which can rapidly reverse opioid related sedation and respiratory depression, is being made available to high-risk populations through community-based harm-reduction programs. These programs also educate people about helpful responses and potentially harmful responses to overdose.

Montgomery County Overdose Prevention Plan

Submitted to
DHHS
August 2013

Executive Summary:

Drug overdoses are a serious public health challenge in Maryland and specifically in Montgomery County. During the past decade, national increases in the number of fatal overdoses have been driven primarily by an epidemic of pharmaceutical opioid abuse. In Maryland, deaths related to pharmaceutical opioids increased during this time, while those involving illicit drugs declined. However, in 2012, Maryland experienced a shift from pharmaceutical opioids to heroin, mirroring a trend being reported in other states. This emerging trend underscores the importance of continuing to provide support for substance use disorder treatment and recovery services while simultaneously meeting new challenges.

Montgomery County's Department of Health & Human Services (DHHS) in conjunction with the Department of Health and Mental Hygiene (DHMH) is coordinating a number of key initiatives to help reduce opioid-related overdoses in Montgomery County.

Several of the activities identified in this plan are already in operation or planned for in the FY-14 budget cycle. Still others are in development by various County departments or providers. Finally there are several elements that either require additional funding or State action before they can be implemented. As is always the case implementation of the various elements in this plan is dependant on the availability of funding or other resources.

In response to the State's request, Montgomery County is in the process of developing a local overdose prevention plan based on local data, a local needs assessment, and identification of specific interventions and responses. Our planning process and final plan will include:

- Analyzing data on overdose and opioid abuse trends;
- Supporting continued access to substance use disorder treatment, including evidence-based treatment of opioid dependence with methadone and buprenorphine;
- Joining with State efforts to institute a public health focus on opioid overdose that includes local, multidisciplinary reviews of fatal overdose incidents;
- Pursuing initiatives that focus on reducing pharmaceutical opioid-related overdoses, including clinical guidance and education for prescribers and dispensers;
- Developing a plan to address public health emergencies created by an abrupt change in the prescribing, dispensing or use of opioids at the community level, and:
- Exploring local, state and federal funding streams that will enhance present and treatment activities to resolve opioid-related overdoses.

The report provides a brief overview of data sources used and conclusions reached based on initial analysis. This is followed by a set of planned or proposed prevention activities that address primary, secondary and tertiary prevention levels. The activities represent a combination of ongoing, planned and proposed. We have included activities that can be implemented locally as well as those that can only be accomplished in tandem with the State. Finally, we have included activities or issues that will require additional review to determine their feasibility and cost. Following the Intervention section we identify issues and activities that do not fall along the prevention continuum but are necessary or should be considered as part of an overall strategy. We conclude the body of the plan with a section on metrics. Following the body of the plan we have included several attachments that are relevant to the planning process. Of particular note are the recommendations from our advocacy community. While some of the recommendations have been incorporated into the plan we felt it important to include the full text of their recommendations and concerns. Some of these can and will be considered for local implementation. Others are issues that require State level action or decisions.

I. Review and Analysis of Data

Currently, Montgomery County most reliable data sources include the following: The State of Maryland Automated Record Tracking System (SMART); the 2007-2011 Report on Drug and Alcohol Intoxication Deaths in Maryland; the Overdose Prevention Plan Resources on the ADAA website at <http://adaa.maryland.gov/SitePages/Overdose%20Prevention%20Plan.aspx>; the Maryland Statewide Epidemiological Outcomes Workgroup (SEOW) at <http://www.pharmacy.umaryland.edu/programs/seow/>; local emergency

medical services; the Health Services Cost Review Commission (HSCRC) at <http://www.hscrc.state.md.us/>; and data between 2010-2013 from the Montgomery County Police Department.

Preliminary findings include:

- Police data shows greater prevalence of overdose in Germantown, Gaithersburg, and Wheaton, Maryland. *- data*
- SMART (State of Maryland Automated Record Tracking Systems) data shows that those who report to treatment live or reside mainly in Silver Spring, Germantown, or Rockville, Maryland. *- public treatment*
- Preliminary analysis of data seems to indicate increasing use of opiates; current reported overdose deaths are down in Montgomery County while admissions to treatment are increasing.
- When examining the data in greater detail, both the Local Police Department and Community Stakeholder groups such as the Montgomery Heroin Action Coalition have reported there is an increase of heroin and prescription drug abuse, particularly among school-aged children. Incidents of pharm parties where kids grab a handful of pills from bowls of pharmaceuticals also have been reported by Police in Montgomery County. *how many*
- Going forward we will need to explore the increased rates of suicide in Montgomery County to determine whether there is a connection to opioid overdoses: Data acquired in the last 3 years *data* suggests that there is an increase in suicides for individuals between 50-60 years of age.

- In addition a review of programs such as Project Lazarus, a model opioid prevention program located in Wilkes County, North Carolina, makes use of data that could be useful as it becomes available. Recommended data elements include: health related information like number of emergency department visits and hospitalizations due to overdose, number of overdose deaths, number of providers in the community who actively use the Prescription Drug Monitoring Program (PDMP), number of prescriptions, and recipients for opioid analgesics dispensed and other controlled substances.

II. Interventions: Primary, Secondary, Tertiary

To promote clarity and to facilitate discussion across systems we have framed the plan in terms of primary, secondary and tertiary prevention.

Primary Prevention activities seek to prevent the overdose deaths by reducing risk: by altering behaviors or exposure or by enhancing resistance to use and abuse. Our plan focuses on three areas for primary prevention:

- Raising Awareness of the risks – both to providers and the community.
- Promoting safe practices: both in the home and in primary care practice settings.
- Reducing exposure and associated risks in the home and community.

Raising Awareness

1. Montgomery County will conduct targeted outreach activities to behavioral health and medical providers to increase awareness of the risks of opioid abuse and overdose in Montgomery County. We will focus our efforts on the medical community including doctors specifically primary care physicians, psychiatrists, ER doctors, pharmacists, pain specialists, and anyone who prescribes.

a. One suggested strategy geared to the medical community under consideration is: "Prescription Monitoring Is Coming. Is Your Practice in Jeopardy? Are You Ready?"

b. We will also explore partnership with the State to offer CME training to physicians on the risks and effective management of prescription opioids, including pain management.

2. Montgomery County believes that outreach efforts and fora will promote greater awareness of the risks of opioid OD deaths. Public Awareness of the entire Montgomery County community is particularly important because there are widespread misconceptions about the risks of prescription drug misuse and abuse. Montgomery County will need to build public identification of prescription drug abuse as a community issue. Overdose is a common occurrence in the community and that this is a preventable problem that must be spread widely. Planned or proposed activities include:

a. MCPS substance abuse forum targeted to parents and educators.

b. The Collaboration Council through the Drug Free Coalition will work to educate the community about the dangers of opioids and prescription medication use and abuse through public forums, publications and media campaigns.

c. Community town hall series to educate the community on danger of opioids and proper disposal for medications; marketing the effort under the name: Talk It Up, Lock It up Initiative; and Dangers of Prescription Drug Media Campaign with a youth lead. Numbers and locations of fora will be determined.

3. Reducing exposure/access to opioid prescription drugs. Currently residents of Montgomery County do not have a means to dispose of medications properly as there is only a once a year drug take back program that occurs in late, April.

a. Montgomery County Police Department will continue to participate in the federal annual drug take back program.

b. A partnership is in development that will include County and Municipality Police Departments, the County Council Public Safety Committee, local LEAs, the AODAAC Prevention committee and drug free coalitions. MPD is considering, with support from the coalition, establishing on-going drug-take back boxes for constituent disposal.

c. Other activities under consideration: Targeted outreach to Department of Corrections inmate populations, senior citizens.

Secondary Prevention includes procedures that detect and treat pre-addiction/abuse issues and thereby reducing the risk for overdose death. Our plan currently identifies 2 major areas for intervention:

- Screening procedures SBIRT in primary care and pain management clinics.
- Policy changes: Good Samaritan Laws; Marchman Act; Prescription Drug Monitoring Program (PDMP).

1. Effective screening processes in treatment settings.

a. Under active consideration is the full incorporation of Screening, Brief, Intervention, & Referral to Treatment (SBIRT) into the county treatment continuum including primary care and hospital settings.

b. More outreach to address the needs of seniors. The prevalence of seniors who take multiple medications from multiple physicians was identified as a major problem, especially for a number of seniors who may be isolated or do not have care-taking adult children who provide some supervision of their medical care situation.

2. Policy changes at State level will need to be considered in developing a comprehensive long term prevention plan.

a. Good Samaritan Laws need to be in place that allows greater protections for persons calling 911 to report a drug overdose. The AODAAC will explore the feasibility of recommending changes to the current State law.

b. Marchman Act Laws provide an opportunity of involuntary commitment of persons whose addictive behaviors constitute a danger to self. The effectiveness of such laws, already in place in Florida, will be evaluated by a workgroup and recommendations for changes to State law will be made by ADODAAC.

c. The Prescription Drug Monitoring Program (PDMP) will develop and make available training and educational resources on the appropriate clinical use of controlled substances and prescription drug-related abuse and addiction to healthcare practitioners, policy-makers, researchers and the general public.

Tertiary Prevention seeks to prevent overdose deaths in the short and long term by addressing the underlying risk factors for death and promoting recovery and resiliency in the individual or at risk group. Our proposed tertiary prevention plan is divided into two areas:

1. Acute phase interventions focus on emergency response to overdose events (note: this is viewed as secondary prevention because overdose is a risk factor for OD death).

a. Naloxone - County government will target entities in and around the jurisdiction to assist with dissemination of education materials that address Naloxone pharmacotherapy barriers, training, and emergency response techniques such as rescue breathing. Currently opioid users in Montgomery are not able to utilize Naloxone to protect those who are at risk for overdose. This is a complicated issue that involves a review of local jurisdiction laws and collaboration with the local Montgomery County Police Department. Perhaps the greatest immediate obstacle to implementation of Naloxone pharmacotherapy may be the lack of any available funding.

b. In addition to the identification and clarification of all the current barriers to implementation of this Naloxone pharmacotherapy, strategies include educating and certifying those who are able to administer Naloxone. Activities that will lead to implementation of this intervention include the identification of who will conduct the training to certify the individuals to administer the medication and education of the medical community to prescribe Naloxone to clients/recovering clients.

c. Targeted education of first responders – on recognition of opioid overdose and emergency response actions.

2. The long term interventions focus on active treatment and rehabilitation: Ongoing and developing treatment options: Active addictions treatment remains a vital part of the county's prevention strategy. While the county does have a range of treatment options that serve adolescents and adults it must be acknowledged that the system does not have the capacity to meet current demand. Expanding capacity, identifying gaps and preparing to meet the increased demand as a result of health care reform is a long-term and ongoing process. Expanded treatment goals will continue to be addressed in the county's annual strategic plan and budget for addictions treatment.

a. Recent and current treatment activities -During FY 2010 Montgomery County Adult Addiction Continuum of Treatment Services expanded access to medication supported treatment using oral Naltrexone and Vivitrol ® at Avery Road Treatment Center (ARTC) and Outpatient Addiction Services (OAS). The programs continue the identification and treatment of clients who are alcohol dependent and deemed appropriate for the use of Vivitrol, a once per month IM injection. OAS also uses Vivitrol with Adult Drug Court, IOP/OP, and co-occurring clients who do not begin treatment at ARTC. Vivitrol has been approved by the FDA for the treatment of individuals with opioid dependence. OAS also uses disulfiram (antabuse), oral naltrexone, campral, and a full range of psychotropic medications to treat clients with co-occurring mental health disorders.

b. Enhanced treatment options – Increase number of Primary Care Physicians and other doctors credentialed to use Buprenorphine. Regarding education of the County's medical community, the place to start was identified as the County Behavioral Health and Crisis Services Doctors/Psychiatrists who need to be trained in the 8 hour buprenorphine certification

course. In addition it is important to expand this to the greater Montgomery County medical community (County Medical Society) as stakeholders have identified the scarcity of those who are properly credentialed to dispense buprenorphine to young adults who present for treatment as a major gap in service delivery. In some instances young adults have crossed into neighboring jurisdictions to be prescribed buprenorphine due to the lack of credential prescribers in Montgomery County.

c. Increasing Alternatives for Medication Assisted Treatment - In addition to the use of methadone for the treatment of opioid addiction, OAS utilizes buprenorphine/suboxone in the Intensive Outpatient (IOP)/ Outpatient (OP) treatment program. Several clients that are long-time methadone clients have made the decision to switch to suboxone which has yielded mixed results. There is also a noticeable increase in the number of clients who are requesting suboxone upon admission into OAS, so the numbers of client served with this alternative medication continues to increase. There has also been a very dramatic increase in the number of clients being admitted into Medication Assisted Treatment (MAT) who are young adults, 19-23 years of age, who are addicted to prescription pain medications such as oxycontin, hydrocodone, Percocet, and dilaudid. OAS and ARTC have developed a protocol for those clients who enter ARTC and are identified as good candidates for suboxone therapy, to complete the induction process while at ARTC, and then receive follow-up treatment services (including suboxone) at OAS. Likewise, clients may be identified as appropriate candidates for suboxone therapy by OAS, but due to continued use of opiates, require a detoxification at ARTC followed by induction of suboxone then a return to OAS for continued IOP/OP treatment.

In the private sector there are a number of Montgomery County programs that provide methadone and/or buprenorphine and pharmacotherapy that include New Horizons in Burtonsville, White Flint recovery in Rockville, Another Way in Silver Spring, and Kolmac Clinic in Silver Spring and Gaithersburg.

3. ROSC/Wellness and Recovery – In Montgomery County the implementation of Recovery Oriented Systems of Care (ROSC) began in 2012. It has been constructed on the overarching themes of Recovery, Resilience and Self-Determination. The key principles are that this community initiative is holistic, inclusive and geared to build and expand based on all the natural support resources and systems of the local Montgomery County community.

A major part of the initiative is to create peer based recovery support systems in Montgomery County. Individuals in recovery who have “lived experience” with substance use and/or mental health issues help others making the transition from treatment to long-term recovery. Recovery coaches assist individuals with identifying and obtaining resources and services such as housing and employment which are needed to sustain/maintain recovery in the community. Recovery coaches fulfill a unique role by providing practical and moral support not typically offered by other parties in the recovery process such as counselors, therapists and sponsors.

The linkage of this peer support network with prevention of overdose and overdose deaths is that many of these individuals have the “lived experience” that will make them serve as natural beacons of hope in the community. Potentially they will be able to spread the message that overdose deaths are indeed preventable and some of them may be able to join the effort by being trained to administer Naloxone, learn rescue breathing and further the overall message of the prevention and treatment strategies that will save lives.

III. Additional Considerations

There are a number of systems coalition/management/staffing support issues to be addressed. A functioning coalition is critical to implementation of this policy and procedure. A functioning coalition needs to be developed with strong ties to the community and support from each of the key sectors of in the community, along with a preliminary base of community awareness on the issue.

Coalition leaders should have a strong understanding of what the nature of the issue is in the community and what the priorities are for how to use it. The main building blocks for this coalition will be the members of the Opioid Overdose Prevention Death Planning Committee, the Alcohol and Other Drug Abuse Advisory Council, Health and Human Services Staff, Community Stakeholders such as the Heroin Action Coalition and ultimately the Overdose Fatality Review Committee.

As part of the county's efforts to coordinate prevention efforts we will seek to more effectively collaborate with our colleagues in Montgomery County Public Schools (MCPS) so more can be accomplished to reach our school-aged population. At this time MCPS does not have an active member on the local Alcohol and other Advisory Council. MCPS in partnership with members of the current prevention planning workgroup is planning a fall forum which will present an initial opportunity for both County Health and Human Services Personnel and Alcohol and Other Drug Abuse Council Members to engage and collaborate with MCPS. From this beginning we will begin to build an ongoing collaborative relationship that will help make sure the best prevention strategies and other treatment interventions are offered to school children of all ages.

Another part of the discussion suggested that we needed to add a member from the Department of Correction and Rehabilitation (DOCR). Some of the DOCR issues include the exploration of whether there is any possibility to expand the use of the pharmacotherapy to a select portion of the inmate population.

It was also suggested that if possible the Naloxone Pharmacotherapy (administration of med training and the clear breathing) be incorporated into the training curriculum for correctional officers and Crisis Intervention Training (CIT) for police officers. Training for inmates on overdose response techniques that include beneficial responses like rescue breathing and contacting emergency services will also be explored. In some jurisdictions the local Department of Correction and Rehabilitation employees, correctional officers have been trained to administer Naloxone. Whether this is a viable strategy in Montgomery County is to be determined.

Based on the development of a final plan cost projections will be identified to move toward full implementation of the planned interventions and initiatives that it will take to fully implement this plan. The County does not have sufficient resources to fully implement the primary, secondary and tertiary prevention strategies and array of planned initiatives that the State Department of Health and Mental Hygiene has recommended for inclusion in the local jurisdictional opioid overdose prevention policy and procedure. The County will develop recommended strategies through consultation with the DHMH Technical Support and by consulting with other Maryland Local Jurisdictions. Specifically the County will coordinate and outreach other local jurisdictions that have already implemented different interventions and initiatives that are current gaps in the County plan to move toward a

comprehensive opioid and other drug overdose prevention plan that reduces overdose deaths in the jurisdiction. The County will develop, identify and pursue funding streams through the local, state and federal levels that will allow the County to expand planned interventions and initiatives that are current gaps in the County's continuum of a comprehensive overdose prevention plan.

The exploration of changes of Maryland law has been identified as another area that may be worth pursuing in the county effort to prevent overdose deaths.

Two specific laws that have been identified as worth further exploration are as follows:

1. POLICY - Good Samaritan Law: Good Samaritan laws are laws or acts protecting those who choose to serve and tend to others who are injured or ill. They are intended to reduce bystanders' hesitation to assist, for fear of being sued or prosecuted for unintentional injury or wrongful death. Good Samaritan laws vary from jurisdiction to jurisdiction, as do their interactions with various other legal principles, such as consent, parental rights and the right to refuse treatment. Such laws generally do not apply to medical professionals' or career emergency responders' on-the-job conduct, but some extend protection to professional rescuers when they are acting in a volunteer capacity.
2. POLICY - Marchman Act: The Florida legislature passed the Act in 1993, recognizing a "growing trend of substance abuse across the nation and the need for government to play a role in addressing the consequences of addiction upon society as a whole" (Ferrero, R., 2009). The law has been successful in forcing addicted

individuals into treatment when they begin making suicidal comments or taking lethal doses of their drug of choice. It has also worked for addicts who are breaking the law in dangerous ways to get money for their addiction, or for those who have become violent toward family members when under the influence. It is a last resort for most families. Yet, for those who are convinced that the addict's life is in danger, and getting him or her to consent to drug treatment has failed, it is the action necessary to get them the help that may save their life. The Act has been embraced by parents, desperate for a way to save the life of an addicted child. Prior to the law, some parents were forced to file criminal charges against their addicted child, as their only means of getting the treatment he or she needed. There are no criminal penalties or criminal records associated with the Act, because it is considered a means for rehabilitation, rather than punishment.

Summary of Stakeholder Input

This plan has been developed with input from a diverse group that included county government behavioral and public health staff, private primary care and addictions treatment providers, private citizens including members of several advocacy associations. During the planning process a sub-group of the planning committee and advocates met and developed a set of recommendations for possible inclusion as part of the plan. Some of the recommended topics that have been included in this plan are the adoption of SBIRT, exploration of the Marchman Act and Medically Assisted Treatment; Recovery and Peer Support are included in the County's ROSC service delivery description; A number of the other treatment gaps and recommendations contained in the stakeholder input are more

in alignment with the Montgomery county biannual strategic plan submission that is provided to ADAA. To review full details of stakeholder input please see the third attachment. Our intention going forward is to integrate our prevention plan into the county addictions strategic plan.

Performance Metrics

Montgomery County utilizes data sourced from within the county and abroad to measure performance and efficacy for the adopted interventions and initiatives.

The five problem areas Montgomery County has decided to address in its performance metrics plan are as follows:

1. Awareness/Education: Physicians, Nurses, Pharmacists are not educated about the dangers of prescribing opioid medications to consumers. Do not fully understand the risks of pain management and opiates, or treatment options.
2. Prevention Goals: targeted for primary secondary and tertiary prevention.
 - 2a. Opioid users are not able to utilize Naloxone to protect those who are at risk for overdose.
 - 2b. Residents do not have a means to dispose of medications properly which is an indicator to have a full service drug take back program initiative within Montgomery County, MD with multiple drop off locations.

3. We will initiate a Local Overdose Facility Review Team Review process similar to Montgomery Child and Infant Fatality Review Committee Process.

4. Based on the development of a final plan cost projections will be identified to move toward full implementation of the planned interventions and initiatives that it will take to fully implement this plan.

To view full details of the strategies, activities, and measurable outcomes/timelines please see the performance metrics addendum.

V. Attachments

- Opioid Overdose Prevention Plan Committee Roster
- Performance Metrics Table
- Stakeholder Comments
- ADAA Templates
 1. Confidentiality
 2. Overdose Fatality Review Committee

Stakeholder Recommendations for Montgomery County Overdose Prevention Plan

Section 2: Planned Interventions and Initiatives

Section 3: Performance Metrics

“Treating individuals with substance use disorders is the foundation of Maryland’s approach to reducing opioid-related overdoses.” (Maryland Opioid Overdose Prevention Plan)

On Thursday April 25th, from 6:45 to 8:45, stakeholders met to provide recommendations to the Montgomery County Overdose Prevention Committee. The meeting was specifically focused on assessing the County’s current treatment system, identifying gaps which could potentially lead to increased opiate overdose and subsequent fatalities, proposing new treatment interventions and initiatives to bridge these gaps, and establishing performance metrics to assess the effectiveness of current and proposed treatment interventions and initiatives.

To that end, the recommendations pertain to the following sections of the Draft Version of the Montgomery County Opioid Overdose Prevention Plan:

- Section 2A: Education of the Clinical Community;
- Section 2D: Other Interventions / Initiatives; and
- Section 3: Performance Metrics

Section 2: Planned Interventions and Initiatives

A. Education/Training/Expansion of the Clinical Community

SBIRT: In order to reduce fatal overdose deaths, Screening / Brief Intervention / Referral to Treatment (SBIRT) must be available at the initial time and place where the patient exhibits symptoms of Substance Use Disorder (SUD). Any healthcare professional who first determines that a patient is likely to need treatment for SUD should be able to immediately administer SBIRT protocol. This includes high school health-rooms, doctor’s offices, emergency rooms, emergency response teams (police, EMT), etc. This ‘no wrong door’ approach is more effective than referring a person to a single access point.

- **Train all school health room professionals in SBIRT protocol;**
- **Develop a campaign to ensure that primary care physicians are aware of SBIRT protocol;**
- **Meet with Emergency Room Directors in the County to discuss incorporating SBIRT protocols into standard ER procedures, as well as the possibility of establishing short-term detox (3 – 5 days), similar to Suburban Hospital;**
- **Meet with MCPD administrators to discuss how SBIRT protocols can be implemented into police crisis response protocol.**

Task Force to Expand Adolescent Services: Treatment services for adolescents are woefully inadequate. Treatment options must be expanded for children who are addicted to opiates. Treatment for youth and young adults should include a wide range of interventions, including culturally and behaviorally relevant in-patient and outpatient treatment, youth peer-to-peer support provided by individuals with ‘lived’ experience, family peer-to-peer support, and models like the clubhouse and wraparound. A task force should begin to identify gaps in services and devise ways to bridge these gaps.

- **Assess the feasibility and related costs of developing the full continuum of care for adolescents and transition-age adults (18 – 25) in Montgomery County.**

Treatment Services that are Developmentally Appropriate and Culturally Responsive: “It is important that treatment be appropriate to the individual’s age, gender, ethnicity, and culture.” (NIDA, 2009) Currently, most treatment programs fail to recognize developmental and cultural factors that often determine an individual’s ability to engage in treatment, particularly in interventions requiring them to participate in group interaction. Treatment must be tailored to specific developmental age groups, including transition-age adults and senior citizens, as well as culturally diverse populations, including those not fluent in English.

- **Require all treatment providers operating in the County or receiving County funding to submit evidence that the treatment they are providing is developmentally appropriate for ALL clients admitted into their treatment program(s);**
- **Require all treatment providers operating in the County or receiving County funding to submit evidence that the treatment they are providing is culturally and linguistically appropriate for ALL clients admitted into their treatment program(s);**

Medically Assisted Treatment (MAT): Due to the abundant research supporting the greater efficacy and safety of Buprenorphine over Methadone, a plan to phase out the use of Methadone and replace it with Buprenorphine should be implemented. Access to affordable Buprenorphine

treatment must be expanded, particularly for Medicaid patients, who currently have extremely limited access to the medication.

- **Develop a timeline for phasing out the use of Methadone and replacing it with Buprenorphine in all County funded programs;**
- **Develop a campaign to increase the number of doctors prescribing Buprenorphine.**

Complimentary & Alternative Medicine (CAM): In light of the abundant research highlighting the benefits of integrative mind / body therapies and treatment protocols, including meditation, acupuncture, yoga, and others for treating addiction and co-occurring mental health disorders, patients suffering from these disorders must be provided with equal access to alternative therapies in proportion to other treatment interventions, including MAT, 12-step programs, group counseling, etc.

- **Ensure that SUD patients are presented with holistic options for healing neurological and brain functioning equal to other interventions, including pharmacological treatments.**

Task Force to Define a Revised Model for Co-occurring Treatment: Recent research shows that many individuals with SUD also have co-occurring mental health disorders, but few SA treatment facilities address both disorders equally. Thus, a patient in 'treatment' may learn a variety of triggers and coping skills to deal with aspects of their substance use disorder, but none to deal with their anxiety, depression, rage or other symptoms related to a separate mental health disorder. A revised model for providing treatment for both substance abuse and mental health disorders, equally and simultaneously, must be constructed and implemented. A variety of protocols must be developed for treating clients who present with compound disorders. For instance, a patient who is addicted and also severely depressed or paranoid may not be able to get out of bed to attend a traditional treatment program and therefore may need in-home treatment for both disorders, including MAT or CAM.

- **Create a revised model for co-occurring treatment so that the dually-diagnosed client is dually-educated, dually-treated, and dually-referred for the complete spectrum of mental health disorders, including SUD, that he or she presents.**

Expansion of Co-occurring Outpatient Treatment: Our County faces an acute shortage of both adult and child psychiatrists willing to offer services to Medicaid recipients and the uninsured. As a result, many poor and vulnerable residents, including many children, wait two to three months or longer to see a psychiatrist. This long waiting period creates a potentially dangerous situation for adults and children who are depressed or experiencing psychotic symptoms. If they cannot secure medication in a timely manner, it increases their likelihood of harming themselves,

experiencing unnecessarily prolonged mental suffering, or exhibiting aggression or decompensation in functioning. In addition, individuals in recovery from addiction often encounter difficulties in securing psychiatrists who are Suboxone-certified. They often experience interruptions in their treatment because they do not have continued access to Suboxone-certified psychiatrists. Those individuals with co-occurring disorders are thus being underserved in both areas –mental health and substance abuse. This problem must be rectified.

- **Develop a strategy to increase the number of County psychiatrists willing to accept Medicaid.**

Case Management / Treatment Teams: Any gains made in treatment are wasted when the individual recovering from addiction is unable to maintain a lifestyle that supports his or her recovery. Individuals in recovery must be supported to acquire a normal and healthy lifestyle, until they are able to maintain it independently. Ideally, a patient's discharge plan from detox begins the day a patient enters treatment. Therefore, it is logical and necessary that all case managers, family navigators, recovery coaches, and providers, managing a wraparound process, are part of the patient's 'treatment team' while the patient is still in the inpatient / residential phase of their treatment and recovery process. It is essential that all team members have an opportunity to provide necessary input prior to a patient's discharge. This provides a seamless transition from inpatient to outpatient services. The treatment team should ideally consist of the patient, and anyone who will be providing services to the patient upon their release from the inpatient facility, including therapists, probation officers, high school guidance counselors, college advisors, family members, family and youth peer-to-peer support workers (with 'lived' experience), job coaches, pastors, and others. A care coordinator who is trained to facilitate group dynamics should lead the discharge planning meeting.

- **Require all treatment providers operating in the County or receiving County funding to maintain an open door policy for members of the patient's treatment team, including the patient, their family members, therapists, school counselors, recovery coaches, case managers, etc.**

Wrap-around: "Recovery begins when the person who is addicted to drugs or alcohol decreases or stops using, attains health care, meaningful employment, stable housing and appropriate education, and maintains a system of support. There is no 'endpoint' for successful recovery. Those who are addicted need and deserve the staples of a stable life, including a job that provides for self-sufficiency, a safe place to call home, knowledge and skills and family, friends and companionship. Simply 'getting off drugs' is not the answer." (Open Society Institute – Baltimore, 2011)

Effective treatment attends to multiple needs of the individual, not just his or her drug abuse. To be effective, treatment must also address associated medical, psychological, social, vocational,

educational, housing, and legal problems. Many patients require medical services, medication, family therapy, parenting instruction, vocational rehabilitation, educational support, housing assistance, and social and legal services. A continuing care approach often provides the best results, with treatment intensity varying according to a person's changing needs. (NIDA, 2009)

- **Require all treatment providers operating in the County or receiving County funding to ensure a continuum of care, by providing a written follow-up plan for addressing all of the patient's needs, with accompanying referrals.**

Family / Patient Driven Care for Adolescents and Transition-Age Adults: Considering that a parent or grandparent often wears the hat of case manager, recovery coach, wrap-around provider, and advocate for a child or a transition-age adult who is still living in their home, it is imperative that their role as an important member of the treatment team be acknowledged and respected by treatment providers. As such, they are often able to provide valuable background information on the patient and should be included, whenever possible, in discharge planning, particularly when the patient will be living with or be assisted by their family. Support services for family 'caregivers' should be readily accessible and available, including family counseling, family navigation, peer-to-peer support (with peers having 'lived' experience), family awareness and education programs, etc.

Below are the values and principles that are particularly relevant to children, transition-age youth, and young adults and their families:

- Family-driven
- Youth-guided
- Community-based
- Promoting culturally and linguistically competent practices and approaches
- Fostering consumer, family and provider collaboration and partnership
- Employing a broad definition of family
- Age appropriate
- Reflecting the developmental stages of youth
- Acknowledging the nonlinear nature of recovery
- Promoting resilience
- Focusing on "recovery and discovery"
- Strengths-based
- Identifying recovery capital
- Ensuring ongoing family engagement and involvement
- Providing linkages to supporting services
- Ensuring that the range of services and supports address multiple domains in a young person's life
- Including services that foster social connectedness
- Providing specialized recovery supports

- **Require all treatment providers operating in the County or receiving County funding to ensure that family education and counseling is integrated into any treatment program or plan, particularly for adolescents and transition-age youth, who are living with their parents.**

Family / Patient Driven Care for Seniors: Similar to transition-age adults, seniors who are living with or receiving assistance from a son or daughter, must be able to access family support and specialized wrap-around services, as well.

- **Require all treatment providers operating in the County or receiving County funding to ensure that seniors have access to family counseling and wrap-around services specific to their needs.**

Role of Peer Recovery Specialists with ‘Lived’ Experience: There needs to be a distinction made in the Peer Recovery Movement between: 1) peer recovery specialists who have lived experience with mental health, substance abuse, and/or co-occurring disorders and/or raising a child with these disorders; and 2) recovery coaches who do not have lived experience. Both peer recovery specialists and recovery coaches have important roles to play. Training and functions for each position need to be specialized and the assets that each group brings to the table must be recognized and utilized effectively.

- **Ensure that there are equal and ample opportunities for peer recovery specialists with ‘lived’ experience to be utilized in the recovery movement and that these individuals receive training and benefits equal to recovery coaches without ‘lived’ experience.**

D. Other Interventions / Initiatives

Marchman Act: The Florida legislature passed the Act in 1993, recognizing a “growing trend of substance abuse across the nation and the need for government to play a role in addressing the consequences of addiction upon society as a whole” (Ferrero, R., 2009). The law has been successful in forcing addicted individuals into treatment when they begin making suicidal comments or taking lethal doses of their drug of choice. It has also worked for addicts who are breaking the law in dangerous ways to get money for their addiction, or for those who have become violent toward family members when under the influence. It is a last resort for most families. Yet, for those who are convinced that the addict’s life is in danger, and getting him or her to consent to drug treatment has failed, it is the action necessary to get them the help that may save their life. The Act has been embraced by parents, desperate for a way to save the life of an addicted child. Prior to the law, some parents were forced to file criminal charges against

their addicted child, as their only means of getting the treatment he or she needed. There are no criminal penalties or criminal records associated with the Act, because it is considered a means for rehabilitation, rather than punishment. Similar legislation should be introduced in Maryland during the next legislative session.

- **Request that ADAA consider introducing legislation similar to Florida's Marchman Act during the next General Assembly.**

Patient Abandonment and Insurance Parity Laws: Patient abandonment by treatment providers and deficiencies in insurance coverage for SUD and other mental health treatments are against the law. When patients and families encounter these infractions, they are typically in crisis, and must often spend exorbitant amounts of time, emotional effort, and financial resources to resolve their personal or family crisis (which, in the case of opiate addiction, can be a life and death situation). They typically do not have the time, stamina, emotional endurance, or communication skills that are necessary to initiate a complaint and follow it through to resolution, which is not currently resolved in a timely enough manner to benefit them anyway. Therefore, the current complaint process cannot help the patient who is suffering as a result of a violation. Perhaps the filing of a complaint will benefit some unknown recipient of services at some future date, but that is only if the agency receiving the complaint chooses to act on the complaint and sanction the provider or insurer in some way. There is no incentive for patients or their families to spend scarce resources and time in this pursuit. Sadly, the current system practically ensures that a provider or insurer that violates the law will continually get away with providing inadequate and insufficient service to their clients. It ensures that consumers must continually struggle to gain adequate, appropriate, and sufficient services within the very system that is supposedly designed for their benefit. This is a deplorable situation and must be rectified.

Complaints of patient abandonment by suboxone doctors or treatment providers and insurer breaches of mental health / SUD parity must be taken seriously. A speedy process for resolving consumer complaints must be established and sanctions against providers and insurers must be severe. Local officials, designated to receive and respond to these complaints in a prompt and timely manner, must be readily available and easily accessible to consumers. The designee would have the power to intercede on behalf of the patient in order to facilitate a resolution when the patient and/or their family are incapable of doing so for any reason.

- **Urge ADAA to expand its compliance office to include an agent or office of compliance in each County to handle complaints, particularly those related to breaches in patient abandonment and insurance parity laws.**

Section 3: Performance Metrics

The subcommittee members agreed that performance metrics designed to measure client outcomes for prevention and treatment programs is a high priority. Performance goals must be established and client outcomes tracked and measured in order to maintain a high standard of quality and ensure a certain level of treatment effectiveness.

Task Force to Devise a Means of Measuring Treatment Outcomes: Just as consumers have a right to know which cancer clinics have the highest rate of success or which school districts post the highest student achievement scores, consumers and taxpayers of SUD treatment have a right to know which facilities have the highest rate of successful treatment outcomes. The treatment practices and interventions of various programs should be readily available to consumers, as well. Performance metrics for children and youth may look different than those for adults, including such measures as school attendance and graduation rate. Consumers and family members raising children and youth who are in recovery should have input about what these outcomes are.

- **Establish a task force, and include consumers and family members, to devise standards and performance outcomes for treatment providers, as well as a means for measuring these outcomes.**

Stakeholder Input in Treatment Services: Consumers of treatment services often have valuable insight into a program's effectiveness and are able to communicate what worked and what did not. Efforts to include input from all stakeholders, including individuals in treatment, family members, family navigators, peer-to-peer workers (with 'lived' experience), advocacy groups, etc., should be incorporated into treatment service oversight and contract negotiation and renewal. In order to ensure that treatment is driven by consumer needs rather than provider priorities, providers and consumers must have a mechanism for communicating openly and honestly about where improvements can be made. Multiple opportunities to capture qualitative data, e.g., surveys and focus groups with diverse family members, youth, and adults in recovery must be built into the County treatment system in order to maintain a reasonably high quality of treatment and standards for effectiveness. There should be Quality Assurance Teams comprised of consumers and family members, and/or teams that include them.

- **Create a Quality Assurance Team, including current consumers of services, family members, and advocates, to collaborate with treatment providers to identify what worked and what didn't and offer suggestions for areas of improvement;**
- **Design and utilize qualitative measurement tools, such as surveys and focus groups, which provide input and feedback regarding the treatment experience of consumers and their families, and monitor long term patient outcomes.**

Stakeholder Input in Policy: Any county committee or government agency seeking to establish or implement policy and protocol in the area of substance abuse prevention, treatment, or recovery, must include a wide representation from the recovery community, including family members whose children have substance abuse and/or co-occurring disorders, as well as transition-age youth/young adults and adults in treatment or recently recovered.

- **Ensure that any group, agency, or administrative body, including AODAAC, has a process for including and incorporating a wide and diverse representation of stakeholders, including individuals currently or recently in treatment, family members, transition-age adults, advocates, and others, and that all representatives have a vested interest in providing input, and that the process ensures that all input is equally regarded and incorporated into County policy.**

OPIOID OVERDOSE PREVENTION PLAN- PERFORMANCE METRICS

Goal 1: To decrease opioid related deaths by educating and training medical professionals, certifying naloxone prescriber and administrators, and decrease access to opioid medication through an on-going drug take back program.

Problem Statement		Strategies		Activities		Measurable Outcomes/ Timelines
<p>1. Physicians, Nurses, and Pharmacist are not educated about the dangers of prescribing opioid medications to consumers.</p>	⇒	<p>Educate and provide continuing CMUs/CEUs for the appropriate professional discipline on the subject matter.</p> <p>Educate the medical community about opioid addiction.</p> <p>Increase the collective knowledge of best practice prescribing.</p>	⇒	<p>Identify who will conduct the training to medical and other prescribing professionals.</p> <p>Identify location for training.</p>	⇒	<p>Host training 2x per year.</p> <p>Training ____ medical professional that can prescribe.</p> <p>Expected Date of completion_____.</p>
<p>2. Opioid Users are not able to utilize naloxone to protect those who are at risk for overdose.</p>	⇒	<p>Educate and certify individuals who are able to administer naloxone.</p> <p>Making naloxone available contingent on state funding.</p>	⇒	<p>Identify who will conduct the training to certify individuals to administer the medication.</p> <p>Educate the medical community to prescribe naloxone to clients/recovering clients.</p>	⇒	<p>Certify ____ naloxone administrators.</p> <p>Host training 2x per year.</p> <p>Expected Date of completion_____.</p>

OPIOID OVERDOSE PREVENTION PLAN- PERFORMANCE METRICS

Problem Statement	Strategies	Activities	Measurable Outcomes/ Timelines
<p>3. Residents do not have a means to dispose of medications properly which is an indicator to have a full service drug take back program initiative within Montgomery County, MD with multiple drop off locations.</p>	<p>⇒ Partner with County Public Safety Committee, local law enforcement agencies, drug free coalitions.</p> <p>Develop a comprehension plan with law enforcement to have an on-going drug take back program for constituents to dispose of medication properly.</p> <p>Public safety committee will assist law enforcement agencies with implementing an on going drug take back program.</p> <p>Drug free coalitions will inform the community about the dangers of prescription medication which includes opioids and educate on proper disposal methods namely the drug take back program.</p>	<p>⇒ On-going drug take back boxes for constituent disposal.</p> <p>Community town halls to educate the community on dangers of opioids and proper disposal method for medications.</p> <p>Lead an initiative to empower parents to talk to their kids about the dangers of opioid use and abuse as encourage the locking up of medications (Talk it Up, Lock it Up initiative).</p> <p>Dangers of Prescription Drug media campaign (youth lead).</p>	<p>⇒ <u>10</u> drop box locations.</p> <p><u>2</u> town halls per year.</p> <p>Educate _____ about Talk it Up, Lock it Up initiative.</p> <p><u>2</u> media commercials to be shown in schools within the county.</p> <p>Expected Date of completion _____.</p> <p>_____ lbs. forfeited to law enforcement per year.</p>

OPIOID OVERDOSE PREVENTION PLAN- PERFORMANCE METRICS

Problem Statement	Strategies	Activities	Measurable Outcomes/ Timelines
<p>4. We will initiate a Local Overdose Fatality Review Team Review process similar to the Montgomery Child and Infant Fatality Review Committee Process.</p>	<p>Complete the necessary steps to apply to become a DHMH pilot site to conduct multi-agency, multi-disciplinary reviews of information on individuals that have died from drug and alcohol related overdoses in the jurisdiction.</p> <p>⇒ ADAA has provided two templates for Montgomery County to serve as jurisdictional pilot site for the development, planning and implementation of the Overdose Fatality Review Committee Process.</p>	<p>Develop and coordinate a plan of implementation of this committee review process in consultation with DHMH Technical Support and our local Child and Infant Fatality Team Review Process.</p> <p>⇒ Complete charter template, complete required signed confidentiality agreements and all other necessary steps to implement this process in FY 2014.</p>	<p>Collect, receive and review state and local data to reduce the number of deaths in the jurisdiction from alcohol and drug related overdoses in Montgomery County.</p> <p>⇒</p> <p>Expected Date of implementation.</p> <p>Meetings held quarterly or on an as needed basis.</p>

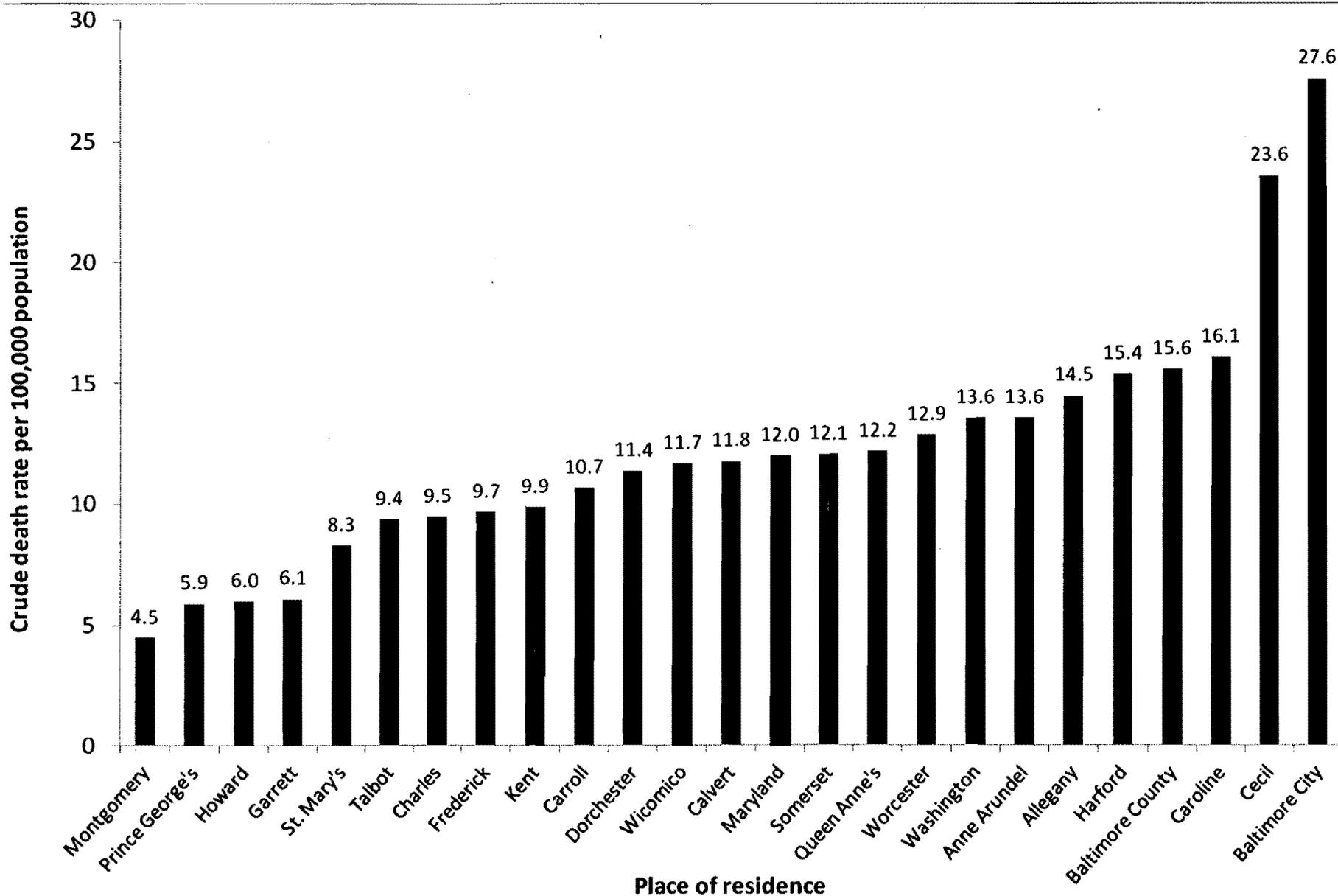
OPIOID OVERDOSE PREVENTION PLAN- PERFORMANCE METRICS

Problem Statement	Strategies	Activities	Measurable Outcomes/ Timelines
<p>5. Based on the development of a final plan cost projections will be identified to move toward full implementation of the planned interventions and initiatives that it will take to fully implement this plan.</p>	<p>⇒ The County does not have sufficient resources to implement the primary, secondary and tertiary prevention strategies to fully implement the array of planned interventions and initiatives that DHMH has recommended for inclusion in the local jurisdictional opioid and other drug overdose prevention policy and procedure.</p> <p>The County will develop recommended strategies through consultation with DHMH Technical Support and by consulting with other Maryland Local Jurisdictions.</p>	<p>⇒ The County will contact, coordinate and outreach other local jurisdictions that have already implemented different interventions and initiatives that are current gaps in our plan to move toward a comprehensive opioid and other drug overdose prevention plan that reduces overdose deaths in the jurisdiction.</p> <p>The county will implement elements of the plan that can be accomplished w/ existing resources.</p>	<p>⇒ Develop, identify and pursue funding streams through the local, state and federal levels that will allow the County to expand its planned interventions and initiatives that are current gaps in the County continuum of overdose prevention plan.</p> <p>Ongoing</p>

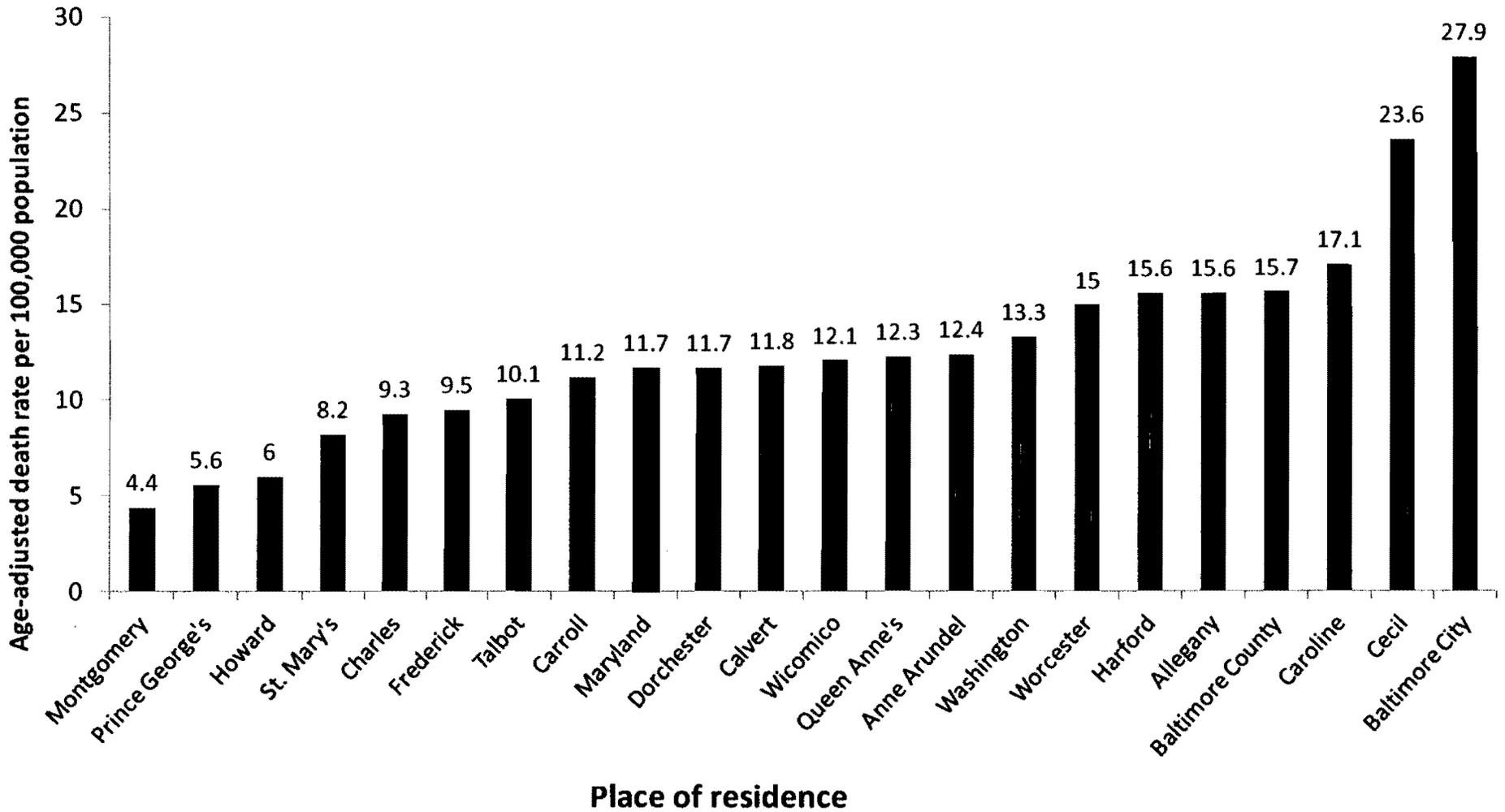
Opioid Overdose Prevention Plan Committee Roster

Name	Organization
Dr. Raymond Crowel	BHCS
Hardy Bennett	BHCS/Treatment Services
Ben Stevenson II	BHCS
Lisa Lowe	Heroin Action Coalition of Montgomery County
Larry Gamble	BHCS/Treatment Services
Ulder Tillman	Public Health Services
Scott Greene	BHCS/CSA/Planning & Management
Alan Trachtenberg	AODAAC
Eric Sterling	AODAAC
Celia Serkin	Montgomery County Federation of Families for Children's Mental Health
Larry Epp	Family Services Agency
Carol Walsh	Collaboration Council
Steve D'Ovidio	Montgomery County Police Department
Timothy Warner	Montgomery County Public Schools
Ursula Hermann	Montgomery County Public Schools
Meghan Westwood	Maryland Treatment Center Contract Services
Dr. Neil Spiegel	Physical Medicine & Rehabilitation
Robin Pollini	Pacific Institute for Research & Evaluation (PIRE)
Jennifer Schiller	Montgomery County Coalition for the Homeless (MCCH)

Crude Death Rates for Total Intoxication Deaths by Place of Residence, Maryland, 2007-2012.



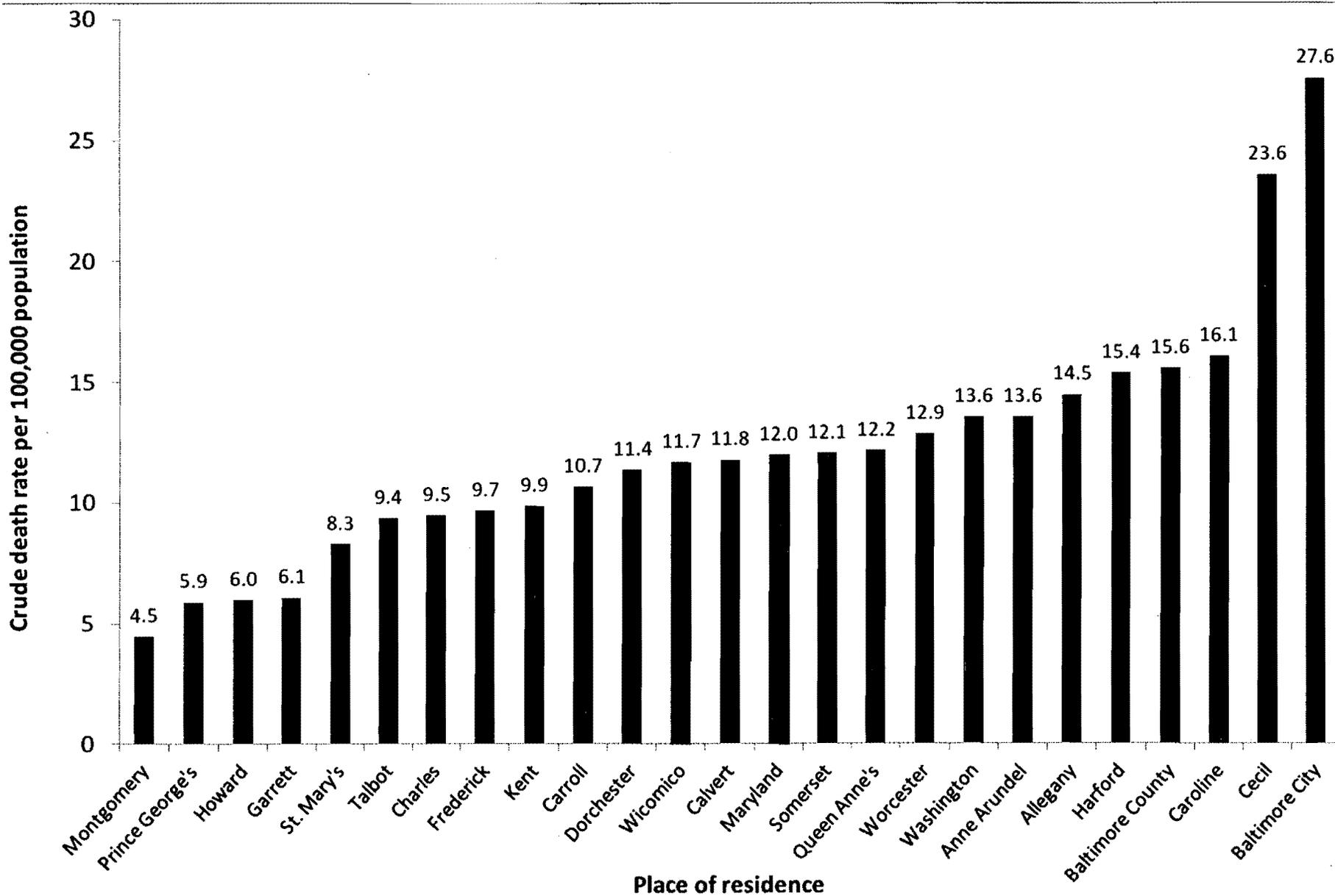
Age-Adjusted Death Rates^{1,2} for Total Intoxication Deaths by Place of Residence, Maryland, 2007-2012.



¹Age-adjusted to the 2000 U.S. standard population

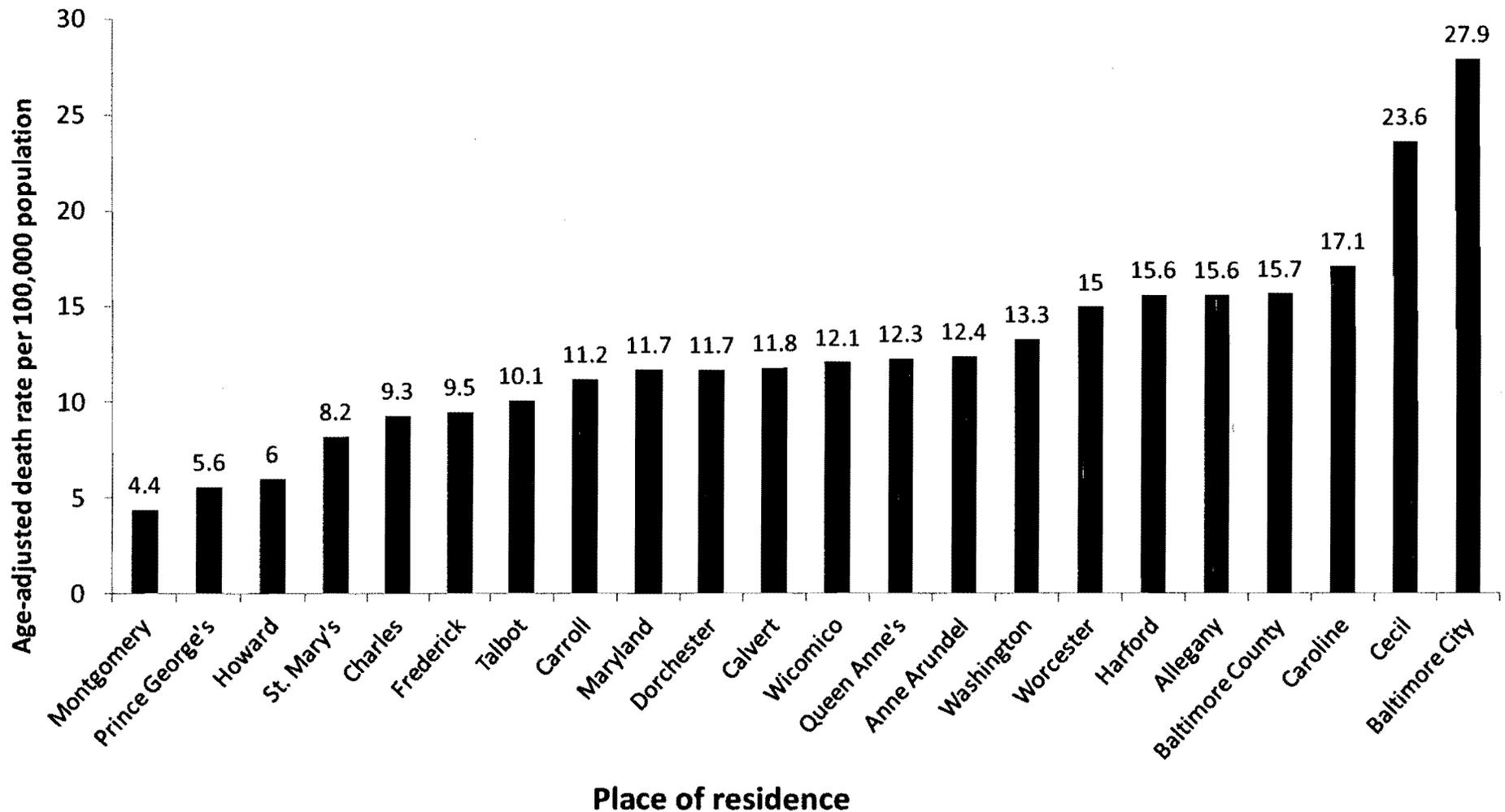
²Since age-adjusted rates based on fewer than 20 deaths are considered unreliable, rates are only shown for jurisdictions with 20 or more intoxication deaths over the six-year period.

Crude Death Rates for Total Intoxication Deaths by Place of Residence, Maryland, 2007-2012.



35

Age-Adjusted Death Rates^{1,2} for Total Intoxication Deaths by Place of Residence, Maryland, 2007-2012.



¹Age-adjusted to the 2000 U.S. standard population

²Since age-adjusted rates based on fewer than 20 deaths are considered unreliable, rates are only shown for jurisdictions with 20 or more intoxication deaths over the six-year period.

Maryland Opioid Overdose Prevention Plan

January 2013

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Executive Summary

Drug overdoses are a serious public health challenge in Maryland and across the country. During the past decade, national increases in the number of fatal overdoses have been driven primarily by an epidemic of pharmaceutical opioid abuse. In Maryland, deaths related to pharmaceutical opioids increased during this time, while those involving illicit drugs declined. However, in 2012, Maryland experienced a shift from pharmaceutical opioids to heroin, mirroring a trend being reported in other states. This emerging trend underscores the importance of continuing to provide support for substance use disorder treatment and recovery services while simultaneously meeting new challenges.

The Department of Health and Mental Hygiene (DHMH) is coordinating a number of key initiatives to help reduce opioid-related overdoses in Maryland, including:

- Analyzing data on overdose and opioid abuse trends;
- Supporting broad access to substance use disorder treatment, including evidence-based treatment of opioid dependence with methadone and buprenorphine;
- Instituting a public health focus on opioid overdose that includes local, multidisciplinary reviews of fatal overdose incidents;
- Pursuing initiatives that focus on reducing pharmaceutical opioid-related overdoses, including clinical guidance and education for prescribers and dispensers, the Prescription Drug Monitoring Program (PDMP) and the Controlled Dangerous Substance Integration Unit (CDSIU);
- Developing a plan to address public health emergencies created by an abrupt change in the prescribing, dispensing or use of opioids at the community level; and,
- Supporting jurisdictions that seek to implement overdose prevention activities involving naloxone.

As part of the state's public health approach, jurisdictions will be required to develop a local overdose prevention plan based on local data, a local needs assessment, and identification of specific interventions and responses.

Purpose & Problem Definition

The goal of the Maryland Opioid Overdose Prevention Plan is to reduce unintentional, life-threatening poisonings related to the ingestion of opioids, including both illicit opioid drugs (i.e. heroin) and pharmaceutical opioid analgesics. The plan encompasses efforts to reduce poisonings related to the ingestion of opioids alone or in combination with other substances, as well as both fatal and non-fatal poisonings. The term “overdose” is used to describe poisonings that meet these criteria.

Data used to determine all overdose death figures for Maryland presented herein were provided by the Office of the Chief Medical Examiner (OCME). The methodology used to determine Maryland overdose death figures was developed by the Vital Statistics Administration in consultation with OCME; the Alcohol and Drug Abuse Administration (ADAA); the Maryland Poison Center at the University of Maryland, Baltimore, School of Pharmacy; and the Baltimore City Health Department.¹

¹ The methodology is available online at <http://dhmh.maryland.gov/vsa/Documents/Methods--drug-report.pdf> and included below as Appendix C.

Epidemiology of Opioid Overdose

Review of national- and state-level data indicates that opioid overdose is a serious and growing public health problem. Although heroin-related overdoses declined in Maryland from 2007 to 2011, the state witnessed a significant rise in overdoses related to pharmaceutical opioid analgesics during this period. Early data from 2012 suggests resurgence in heroin-related overdoses concurrent with the first reduction in pharmaceutical opioid-related overdoses in years.² Chronic opioid use at high dosage levels is a primary risk factor for overdose,³ as is simultaneous multi-drug use. Individuals with substance use disorders and co-occurring mental-health disorders are at high risk.⁴ Persons with pharmaceutical opioid-related substance use disorders are disproportionately white, female, young and residents of rural communities compared to those with substance use disorders related to illicit drugs.

The Department will publish a more detailed review of the epidemiology of overdose in Maryland in February, 2012.

² Maryland Department of Health and Mental Hygiene Fact Sheet, "Heroin Overdose Deaths on the Rise, Rx Opioid Overdose Deaths Down," December, 2012. See Appendix B, below. Also available online at: http://adaa.dhmh.maryland.gov/Documents/content_documents/PDMP/StatewideOverdoseDeathTrendFactsheet_FINAL.pdf

³ Bohnert, et. al., 2011.

⁴ Hall, et. al., 2008.

Key Initiatives

1. Enhanced Epidemiology

The Department's Virtual Data Unit (VDU), housed within the Vital Statistics Administration, will oversee enhanced surveillance of overdoses. The VDU will coordinate with multiple DHMH administrations and other state entities to increase access to and analysis of overdose-related datasets at the state and local level. Specific efforts will include:

- A review of statewide overdose fatality data from OCME including jurisdiction- and region-specific breakdowns, as appropriate, to be published by early February, 2013;
- More detailed review of OCME data to identify patterns of overdose activity and key risk factors; and,
- Development of ongoing overdose surveillance through the DHMH Electronic Surveillance System for the Enhanced Notification of Community-Based Epidemics (ESSENCE), the Maryland Poison Center, the Maryland Institute for Emergency Medical Services Systems (MIEMSS) and other sources of data, to include nonfatal overdose information.

2. Substance Use Disorder Treatment

Treating individuals with substance use disorders is the foundation of Maryland's approach to reducing opioid-related overdoses. In FY2012, nearly 50,000 persons received treatment services supported through Medicaid or grant-funded opportunities. According to the 2011 Joint Chairmen's Report, Medicaid payments for outpatient treatment are projected to increase 190% from \$33,663,362 in FY2009 to \$97,520,628 in FY2012. The total number of individuals accessing services either through the Medicaid system or the ADAA grant-funded system has increased by 32% over a three-year period, from 63,834 (FY2009) to 84,429 (projected FY2012).

Of special relevance to the reduction in overdose is expansion of treatment capacity using evidence based therapies including methadone and buprenorphine.

A large body of evidence supports the effective treatment of opioid dependence with methadone, particularly when combined with counseling. However, this form of treatment is only available in heavily regulated, specialized treatment programs. Buprenorphine is approved for the treatment of opioid dependence in an office-based setting as part of general medical

care, therefore providing greater flexibility compared to methadone. Buprenorphine, a partial opioid agonist, offers a lower potential for overdose than methadone, a full opioid agonist. In 2008, ADAA launched a Statewide Buprenorphine Initiative to increase the availability of buprenorphine maintenance treatment and create links with counseling and care coordination services. Nearly 3,600 treatment admissions involved administration of buprenorphine in FY2012, up 11% from the previous year. From July 2010 to July 2012 the number of Medicaid enrollees filling prescriptions for buprenorphine increased by 38%.

Maryland will seek continued expansions of access to treatment and will monitor access as the behavioral health care system evolves.

3. Public Health Focus on Overdoses

Reducing drug-induced deaths is a key health outcome for Maryland as part of the State Health Improvement Process (<http://dhmh.maryland.gov/SHIP>). Many localities have programs in place to prevent opioid overdoses. These include creating a multi-disciplinary overdose prevention coordination council, incorporation of overdose prevention education into treatment plans for mental health and substance use disorder clients, working with local hospitals to institute Screening, Brief Intervention and Referral to Treatment (SBIRT) in the emergency department and establishing fixed medication drop boxes for the collection and disposal of unused or expired prescription drugs.

To support local action, DHMH will provide regular updates to Maryland counties on overdoses within their jurisdictions or regions, as appropriate. These updates will be sent to the health officers as well as to the addiction coordinators.

In addition, DHMH will require jurisdictions to develop a local overdose prevention plan, based on local data, a local needs assessment, and identification of specific interventions and responses.

4. Efforts to Address Overdoses of Pharmaceutical Opioids

Clinical Education and Training

The Board of Physicians is planning to provide guidance to physicians on appropriate prescribing of opioid analgesics and associated medications. This guidance is expected to

describe a “safe harbor” for appropriate and necessary prescribing for pain as well as explain red flags for inappropriate prescribing.

The University of Maryland, School of Pharmacy, under contract with the Division of Drug Control, is developing clinical guidance to aid pharmacists in making determinations regarding the appropriateness of controlled dangerous substance (CDS) dispensing. This will include instruction on the clinical uses of CDS in pain management and the treatment of other medical conditions, tools to identify fraudulent prescriptions, access to and use of the PDMP and resources for information sharing.

Prescription Drug Monitoring Program

Housed within ADAA, Maryland’s PDMP will monitor the prescribing and dispensing of Schedule II-V CDS, including most commonly used opioid analgesics, and make comprehensive patient CDS prescription history information available in real-time to healthcare providers that prescribe or dispense CDS. Importantly, data disclosure to providers will take place through the statewide health information exchange (HIE), thereby combining two major public health initiatives and facilitating the integration of PDMP data access into provider workflow. The PDMP will also make prescription information available, upon authorized request, to law enforcement agencies, health professional licensing boards and four units of DHMH⁵ to support investigations into improper professional practice, prescription fraud and illegal CDS diversion. De-identified PDMP data will be available for research, public education and reporting purposes. In collaboration with the Advisory Board on Prescription Drug Monitoring; the Boards of Physicians, Nursing and Pharmacy; the University of Maryland, School of Pharmacy; the Governor’s Office of Crime Control & Prevention (GOCCP); Chesapeake Regional Information System for Our Patients (CRISP); and other DHMH agencies and professional organizations, ADAA will provide PDMP training and education on issues related to prescription drug abuse and overdose to an array of stakeholders, including healthcare providers, law enforcement, public health professionals and the general public.

The estimated timeframe for implementation of a fully operational PDMP is 3rd Quarter, 2013.

⁵ Office of the Chief Medical Examiner, Office of Health Care Quality, Office of the Inspector General and Maryland Medical Assistance

Controlled Dangerous Substance Integration Unit

The CDSIU has been implemented within DHMH as a “fusion center” for the sharing and analysis of information relating to the prescribing, dispensing and use of controlled substances. The purpose of forming a CDSIU is to:

- Identify the prescription CDS-related data sets and indicators of potentially problematic prescribing, dispensing and use currently available to each relevant administrative unit of the Department;
- Identify the policies and procedures in place within each unit that govern the analysis of these data sets and indicators and the responses taken;
- Establish policies and procedures for data sharing between units that take into account current restrictions on disclosure and properly balance the need to protect confidential information with the Department’s responsibility to protect public health;
- Conduct strategic planning and implement comprehensive responses to identified CDS-related public health threats; and,
- Establish policies and procedures for data disclosure to and operational coordination with external public health authorities, healthcare providers and federal, state and local law enforcement agencies that have concordant CDS-related responsibilities.

Medical Assistance Quality Assurance/Fraud Detection Programs

Maryland Medical Assistance (MA), in both the Fee-For-Service Program (FFS) and Managed Care Organizations (MCO), currently employs procedures to identify and remedy activities of both recipients and providers that could contribute to the misuse of pharmaceutical opioids. Although these programs have been developed primarily for the purpose of quality assurance, cost containment and fraud detection, they will be utilized as a component of strategies to reduce opioid overdose. These programs include a corrective care management program and prospective drug utilization review.

5. Naloxone

Naloxone, an opioid antagonist long used in emergency medicine to rapidly reverse opioid related sedation and respiratory depression, is being made available to opioid users through community-based harm-reduction programs (including needle-exchange and community-health programs), substance use disorder treatment providers and others that have contact with high-

risk populations. These programs typically train opioid users on risk factors associated with overdose, overdose recognition, naloxone administration and overdose response techniques (including differentiating between beneficial responses like rescue breathing and contacting emergency services and ineffectual/potentially harmful “street remedies” like ice baths, burning fingers and slapping/hitting). Users are also provided with a prescription for and kit containing naloxone (IM injection or intranasal administration). As of 2010, there were 48 known programs in the United States representing 188 community-based sites in 15 states and Washington, DC.

Since 2004, the Baltimore City Health Department’s Staying Alive Drug Overdose Prevention and Response Program (the only program in Maryland) has trained more than 3,000 injection drug users, drug-treatment patients and providers, prison inmates, and corrections officers about how to prevent drug overdoses using naloxone, with more than 220 documented overdose reversals. The Department will work with localities interested in exploring clinical and public health approaches to naloxone.

6. Emergency-Response Plan

The University of Maryland, School of Pharmacy, under contract with ADAA, is developing a plan for coordination between state and local public health authorities, healthcare providers, professional organizations, law enforcement agencies and other stakeholders in response to public health emergencies created by an abrupt change in the prescribing, dispensing or use of opioids at the community level. Emergency situations could include a significant disruption of the heroin market in a region or the closure of a medical practice, opioid treatment program or other provider due to DHMH administrative enforcement actions, the death of a practitioner, natural disaster, etc. The plan will be tailored to geographic areas (particularly rural counties), include a mechanism to identify at-risk individuals and coordinate the provision of overdose treatment and prevention services.

The plan will also address critical issues including timely access to patient medical records and identification of treatment capacity in the area.

Timeline

Activity	Date
Maryland Opioid Overdose Prevention Plan released and notification memo sent to jurisdictional health officers, substance use disorder treatment coordinators and Core Service Agency directors	January 2013
Jurisdictional/Regional Overdose Report: The DHMH Virtual Data Unit will disseminate an analysis of OCME data to each jurisdiction.	February 2013
Overdose Fatality Review Pilots: DHMH will establish process to disclose OCME investigative reports and other available information related to overdose incidents to authorized jurisdictional review teams.	February 2013
Conference: DHMH will hold a conference on overdose prevention best practices and plan development for jurisdictional leaders.	March 2013
Draft Jurisdictional Overdose Prevention Plans Due	April 30, 2013
Final Jurisdictional Overdose Prevention Plans Due	June 30, 2013

Appendix A: National Epidemiology

In 2008, poisoning became the leading cause of injury death in the United States with nearly 9 out of 10 poisoning deaths caused by drugs. During the past three decades, the number of drug poisoning deaths increased six-fold, from about 6,100 in 1980 to 36,500 in 2008. In 2008, about 77% of drug poisoning deaths were unintentional, 13% were suicides, and 9% were of undetermined intent.⁶

Although heroin use continues to be a significant risk factor for overdose across the United States, chronic non-medical use/abuse of pharmaceutical opioid analgesics is likely the most significant single factor in the increasing number of overdose deaths.⁷ Drug poisoning deaths involving opioid analgesics more than tripled from about 4,000 in 1999 to 14,800 in 2008. Opioid analgesics were involved in more than 40% (14,800) of all drug poisoning deaths in 2008, up from about 25% in 1999.⁸ The number of heroin-related deaths has been relatively stable for nearly a decade.

Importantly, multi-drug intoxication, including concurrent use of alcohol, non-opioid pharmaceuticals (sedative-hypnotics, muscle relaxers, and anxiolytics such as benzodiazepines) and other illicit street drugs with heroin and/or pharmaceutical opioids, appears to be a factor in the majority of fatal overdoses.⁹

Of particular note is the impact of methadone. The number of drug poisoning deaths nationally involving methadone increased seven-fold from about 800 deaths in 1999 to roughly 5,500 in 2007. Between 2007 and 2008, the number of deaths involving methadone decreased by nearly 600, the first decrease since 1999.

The large increase in the prescribing of methadone for the treatment of pain (rather than opioid dependence) has been the primary factor contributing to the increasing number of

⁶ Data from the National Vital Statistics System as reported through the Centers for Disease Control and Prevention's online WONDER system.

⁷ Webster, et. al., 2011; Green, et. al., 2011.

⁸ For about one-third (12,400) of the drug poisoning deaths in 2008, the type of drug(s) involved was specified on the death certificate but it was not an opioid analgesic. The remaining 25% involved drugs, but the type of drugs involved was not specified (for example, "drug overdose" or "multiple drug intoxication" was written on the death certificate). From 1999 to 2008, the number of drug poisoning deaths involving only unspecified drugs increased from about 3,600 to about 9,200. Some drug poisoning deaths for which the drug was not specified may involve opioid analgesics.

⁹ CDC, "CDC Grand Rounds...", 2012; Webster, et. al., 2011; Green, et. al., 2011; Warner, et. al., 2011.

methadone-related overdoses.¹⁰ Methadone has a complex pharmacology with multiple medication interactions and a long-half life, making its prescribing for pain by inexperienced physicians risky.

Although ADAA has not identified a national data source that specifically tracks non-fatal opioid overdose trends, increases in opioid-related admissions to hospital emergency departments (ED) indicate that non-fatal overdoses across the U.S. are increasing at a rate similar to fatal overdoses. Although the rate of ED admissions (per 100,000 people) for heroin decreased from 73 in 2004 to 72.6 in 2010, the rate of admissions for misuse/abuse of oxycodone and hydrocodone products increased 255% and 149%, respectively.¹¹ Admissions for “adverse reactions” to pharmaceuticals prescribed to the patient increased from 1.2 million in 2005 to 2.28 million in 2009 (82.9% rate increase).¹²

The highest rates of drug poisoning death are among persons of middle age. In 2008, the drug poisoning death rate was higher for males, people aged 45–54 years, and non-Hispanic white and American Indian or Alaska Native persons than for females and those in other age and racial/ethnic groups. Poisoning death rates were the highest in the Appalachian and Southwest regions, with elevated rates in the South and New England. In 2008, poisoning was the leading cause of injury death in 30 states, including Maryland.

Research indicates that chronic opioid users with a history of substance use and mental health disorders are likely those at greatest risk of overdose, with individuals being prescribed high doses of opioids (>100mg/day morphine equivalent) for extended periods of time also being at high risk.¹³ Increases in the number of individuals seeking treatment for pharmaceutical opioid-related substance use disorders have been concurrent with increases in pharmaceutical opioid-related overdoses. Although heroin-related admission rates (per 100,000 people) decreased by 5% from 1999 to 2009, admission rates for opioids other than heroin increased 430% during the same time period.¹⁴ A primary cause of the increase in pharmaceutical opioid abuse has been drastically increased availability. Drug distribution through the pharmaceutical supply chain increased more than 600% between 1997 and 2007, from 96 mg of morphine to 700 mg per person in 2007,¹⁵ enough for every US citizen to take a typical 5 mg dose of Vicodin every 4

¹⁰ CDC, “Prescription Painkiller Overdoses...”, 2012.

¹¹ SAMHSA, “*The DAWN Report: Highlights of the 2010 Drug Abuse Warning Network (DAWN) Findings...*”, 2012.

¹² SAMHSA, “*The DAWN Report: Highlights of the 2009 Drug Abuse Warning Network (DAWN) Findings...*”, 2010.

¹³ Webster, et. al., 2011.

¹⁴ SAMHSA, “TEDS: 1999-2009.”

¹⁵ CDC, “CDC Grand Rounds...”, 2012.

hours for 3 weeks. The total societal costs of prescription opioid abuse in the United States are estimated at \$55.7 billion. Workplace costs accounted for \$25.6 billion, health care costs accounted for \$25.0 billion, and criminal justice costs accounted for \$5.1 billion. Patients with opioid addiction accounted for over 92% of excess medical and drug costs. Of the workplace costs, the cost of premature death was the largest component, accounting for \$11.2 billion.¹⁶ Medicaid patients and caregivers combined contributed approximately one-third of total excess medical and drug costs.

Although fatal overdoses, ED visits and treatment admissions related to pharmaceutical opioids have increased substantially over the past decade, both the general prevalence and rate of initiation of non-medical use has been stable since the early 2000s. According to SAMHSA's National Survey of Drug Use and Health, reported past month non-medical use of "pain relievers" (persons aged 12 or older) was steady between 2002 (1.9%) and 2010 (2%). Similarly, the number of new non-medical users of pain relievers decreased from 2.3 million in 2002 to 2 million in 2010 after experiencing a slight rise in the mid-2000s. However, there has been a significant increase in non-medical pain reliever use at levels indicative of dependence or addiction. The number of persons reporting 200-365 days of non-medical use in the past year increased 74.6%, while the number reporting use of 1-29 days, 30-99 days or 100-199 days did not increase.

Increasing rates of pharmaceutical opioid abuse and addiction appear to driving an alarming increase in heroin use. Anecdotal reports from law enforcement and treatment providers across the country suggest that people who became opioid-dependent through the abuse of pharmaceutical opioids are initiating heroin use due to its high potency, wide availability and minimal cost compared to pharmaceuticals. The NSDUH has tracked increases in past year heroin use, past year initiation of heroin use and past year heroin dependence since 2007. A larger proportion of individuals who have initiated heroin use in recent years report prior non-medical pain reliever use or dependence than those who initiated heroin during the mid-2000s. The heroin initiation rate is now 20 times greater among individuals who have prior non-medical pain reliever use than those who do not. Rates of initiation of heroin use among those with prior non-medical pain reliever use peak about four years after first non-medical use of pharmaceutical opioids.

¹⁶ Birnbaum, et. al., 2011.

Appendix B: DHMH Factsheet, "Heroin Overdose Deaths on the Rise,
Rx Opioid Overdose Deaths Down," December, 2012

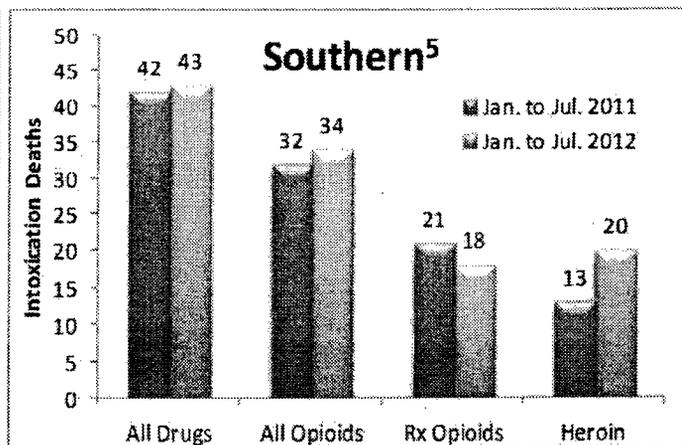
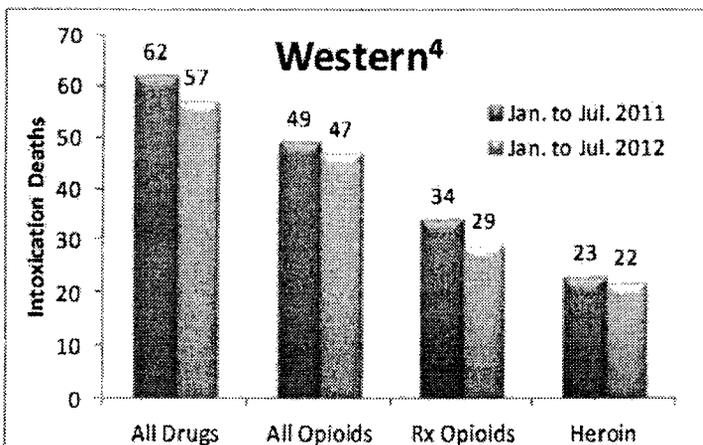
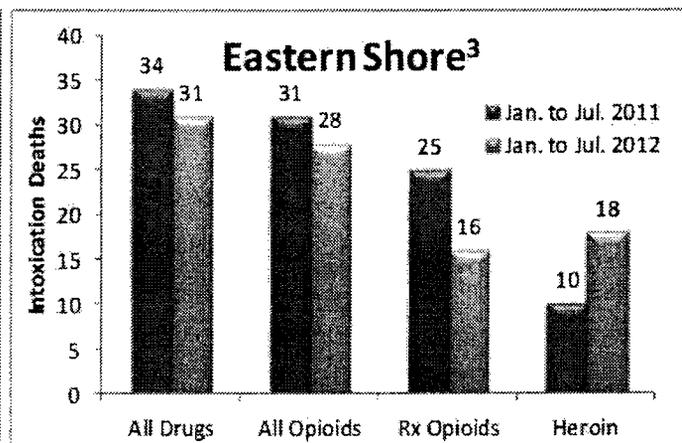
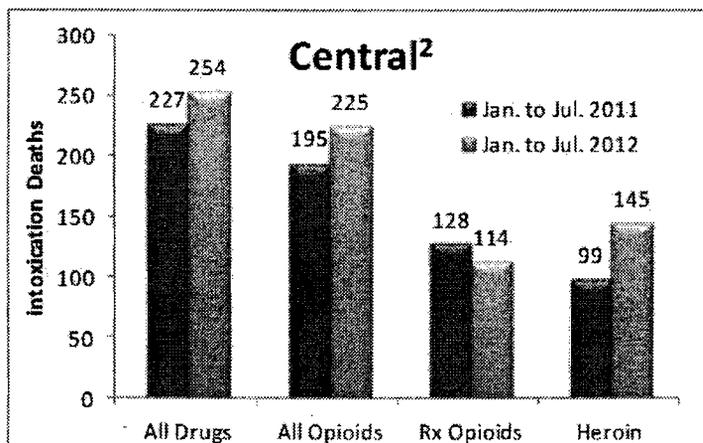


Heroin Overdose Deaths on the Rise, December 2012 Rx Opioid Overdose Deaths Down

The Department of Health and Mental Hygiene has identified a shift from prescription opioids to heroin among drug overdose deaths¹ in Maryland. During the first seven months of 2012, there were 41% more drug overdose deaths related to heroin than during the same period in 2011. This increase coincides with a 15% reduction in the number of prescription opioid-related overdose deaths. Overall, the number of drug overdose deaths has increased 6%, from 365 deaths to 385 deaths.

The largest number of heroin-related deaths continue to occur in Central Maryland (including the Baltimore Metro area), which experienced a 47% increase. Southern Maryland and the Eastern Shore have also seen substantial increases of 54% and 80%, respectively. All Maryland regions had declines in prescription opioid-related deaths with the largest in the Eastern Shore (36%), followed by Western (15%), Southern (14%) and Central (11%) Maryland.

Although the largest proportion of Marylanders that die from drug overdose are of middle age, the largest increases in fatal heroin-related overdoses have been among younger age groups, including a 53% increase among ages 15-24 and a 59% increase among ages 35-44. The reduction in prescription opioid-related deaths have been driven by decreases among ages 15-24 (50%) and 45-54 (32%). Increases in heroin-related deaths have been roughly proportional for whites (42%) and African Americans (43%) as well as for men (40%) and women (46%).

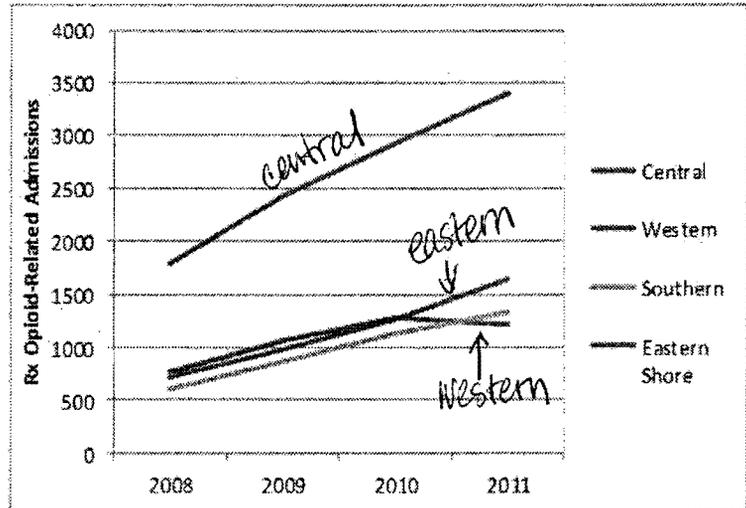


1. Data used to determine all overdose death figures comes from the Office of the Chief Medical Examiner. The methodology used for determining overdose death figures was developed by the Vital Statistics Administration and is available online at: <http://dhrmh.maryland.gov/vsa/Documents/Methods-drug-report.pdf>.
 2. Includes Anne Arundel County, Baltimore City, Baltimore County, Carroll County, Harford County and Howard County.
 3. Includes Caroline County, Cecil County, Dorchester County, Kent County, Queen Anne's County, Somerset County, Talbot County, Wicomico County and Worcester County.
 4. Includes Allegany County, Frederick County, Garrett County, Montgomery County and Washington County.
 5. Includes Calvert County, Charles County, Prince George's County and St. Mary's County.

A Potential Connection Between Abuse of Rx Opioids and Heroin Use

Figure: Prescription Opioid-Related Admissions to Publicly-Funded Substance Use Disorder Treatment Services in Maryland, by Region, 2008-2011⁶

Like many other states, Maryland has experienced rising rates of prescription drug abuse in recent years. Admissions to substance abuse treatment programs related to prescription opioids like oxycodone, hydrocodone and methadone have risen steadily since 2008 (see Figure). Studies and media reports from states as diverse as Ohio⁷, Minnesota⁸, Delaware⁹, New Jersey¹⁰, New York and California¹¹ suggest that individuals who abuse prescription opioids increasingly may be initiating heroin use. For individuals who have developed addiction through prescription opioid abuse, heroin provides a relatively cheap, potent and accessible alternative to pharmaceuticals. Local law enforcement officials have reported that this may be a factor in the increase in heroin-related overdose deaths.¹²



Action by public health and law enforcement

authorities has cut down on the supply of diverted pharmaceuticals and raised awareness among healthcare providers and the general public of the dangers of prescription drug abuse. Pharmaceutical manufacturers have developed abuse-deterrent formulations for some of the most commonly abused prescription opioids. Although these efforts have demonstrated success in recent reductions in the number of prescription opioid-related overdose deaths, the recent increase in heroin-related deaths presents a serious threat to public health and safety.

Maryland's public health response to this challenge will include:

- Outreach to physicians and other health care providers to help them identify potential heroin users and refer them to effective treatment
- Support for innovative local efforts to respond to drug overdose across the state
- Development of the Prescription Drug Monitoring Program (PDMP) to provide support for referral to treatment

6. Data from the Department of Health and Mental Hygiene, Alcohol and Drug Abuse Administration, State of Maryland Automated Record Tracking (SMART) system. SMART records patient and treatment information reported by publicly-funded, certified substance use disorder treatment providers in Maryland. Privately funded treatment providers are not required to report.

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Appendix C: Methodology for Identifying Drug-Related Overdose Deaths, December 2012

The methodology for identifying drug-related overdose deaths in Maryland was developed by the DHMH Vital Statistics Administration with assistance from the DHMH Alcohol and Drug Abuse Administration, the Office of the Chief Medical Examiner (OCME) and the Maryland Poison Center. Assistance was also provided by authors of a Baltimore City Health Department report on intoxication deaths.¹⁷ Currently, this methodology is used to identify all drug-related overdose deaths, as well as deaths that are opioid, heroin, or prescription opioid-related.

Source of data

Data used to identify overdose deaths are obtained from OCME. Maryland law requires OCME to investigate all deaths occurring in the State that result from violence, suicide, casualty, or take place in a suspicious, unexpected or unusual manner. In these instances, information compiled during an investigation is used to determine the cause or causes of death. Depending on the circumstances, an investigation may involve a combination of scene examination, witness reports, review of medical and police reports, autopsy, and toxicological analysis of autopsy specimens. Toxicological analysis is routinely performed when there is suspicion that a death was the result of a drug or alcohol overdose.

Identification of drug-related overdose deaths

A death is considered to be a drug-related overdose death if:

1. The cause of death includes the string "intox" (short for intoxication, which is likely to indicate an overdose); and
2. The cause of death identifies the death as drug-related; and
3. The manner of death is accidental or undetermined.

Identification of opioid-related deaths

Opioids include heroin, an illicit drug, and prescription drugs such as morphine, oxycodone, hydrocodone, hydromorphone, methadone, fentanyl, tramadol and codeine. An opioid is considered to be associated with a death if a specific opioid drug is indicated in the cause of death. If the cause of death does not identify a specific drug (e.g., the cause of death indicates "narcotic overdose"), toxicology results are reviewed to determine whether the presence of any opioid drug was detected. If so, the cause of death is considered to be opioid-related, regardless of the level of the drug.

¹⁷ Office of Epidemiology and Planning, Baltimore City Health Department. Intoxication Deaths Associated with Drugs of Abuse or Alcohol. Baltimore City, Maryland: Baltimore City Health Department. January 2007.

Identification of heroin-related deaths

Cause of death information, toxicology results, and scene investigation reports are reviewed to identify deaths that are heroin-related. These deaths are classified as either “confirmed” or “suspected.” A death is considered to be a confirmed heroin-related death if:

1. “Heroin” is mentioned in the cause of death; or
2. The toxicology screen shows a positive result for 6-monacetylmorphine; or
3. The toxicology screen shows positive results for both morphine and quinine; or
4. The death is identified as heroin-related through scene investigation.

Since heroin is rapidly metabolized into morphine, deaths that do not meet the criteria above, but are associated with morphine through either cause of death information or toxicological results are considered to be heroin-related. Since it is likely, but not certain, that these deaths are heroin-related, they are considered to be ‘suspected’ heroin deaths.

Identification of prescription opioid-related deaths

Prescription opioid-related deaths are defined as deaths that involve one or more prescription opioids, as identified through cause of death information when a specific drug is indicated, and through toxicology results when the cause of death is nonspecific. This includes deaths that involve both a prescription opioid and heroin, but not deaths that result from heroin alone. Since a death may be associated with both heroin and prescription opioids, the sum of the number of prescription opioid deaths and the number of heroin deaths is greater than the overall number of opioid-related deaths.

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Montgomery County Overdose Prevention Planning

Public Safety/Health and Human
Services Committee Hearing

March 27, 2014



Opiate Overdose Prevention

- Overview of a work in progress
- Overdose deaths in context
- State and County Overdose Prevention Plans
- Activities to Date
- Challenges and Opportunities

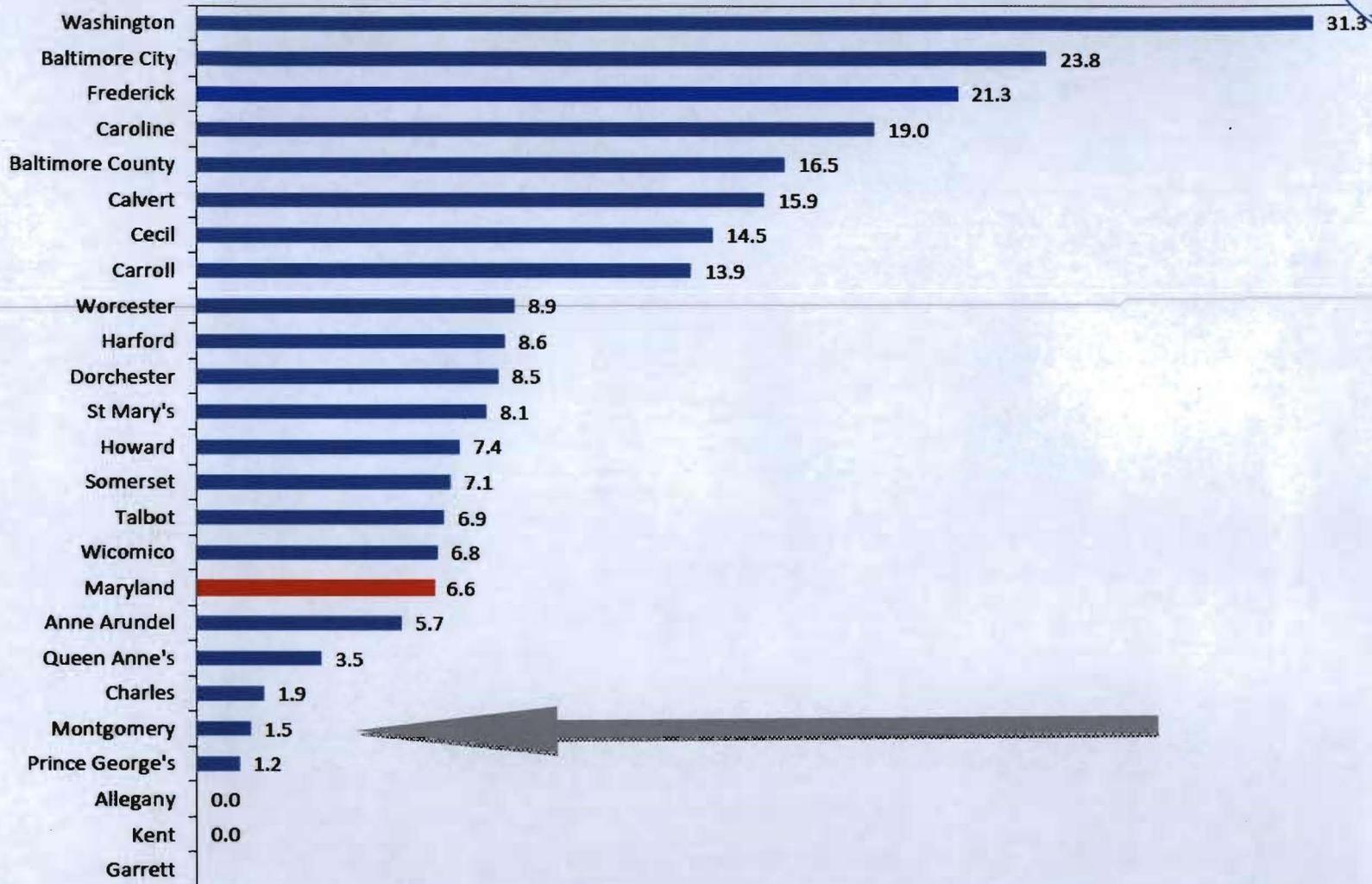


Opioid-Related Emergency Department Visits

Data Source: Health Services Cost Review Commission (HSCRC)



Rate of Opioid-Related Emergency Department Visits in 2012 per 1000 Events



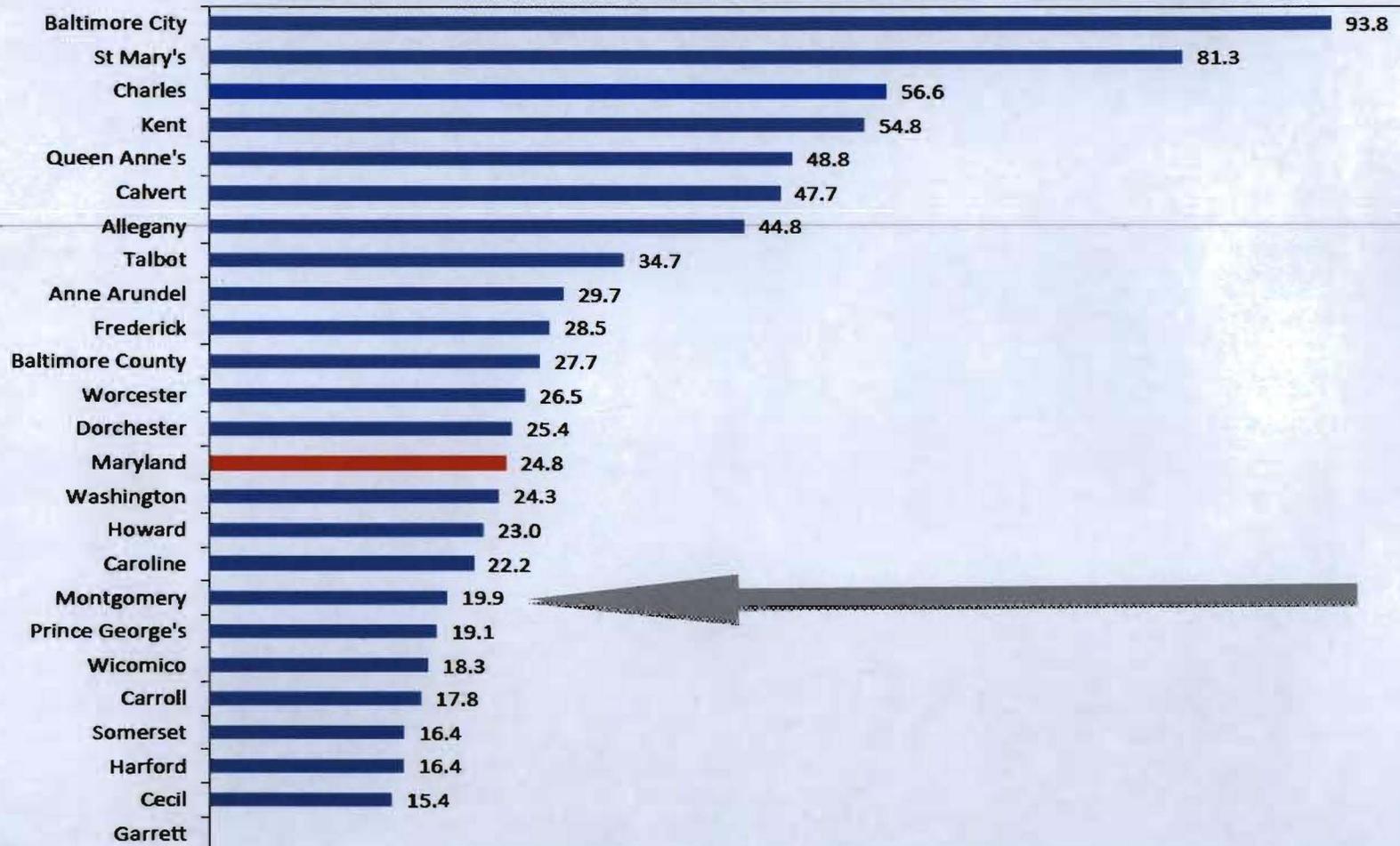
Source: Maryland Jurisdiction Epidemiological Profiles Chartbook, University of Maryland School of Pharmacy, February 13, 2014.



Alcohol-Related Emergency Department Visits

Data Source: Health Services Cost Review Commission (HSCRC)

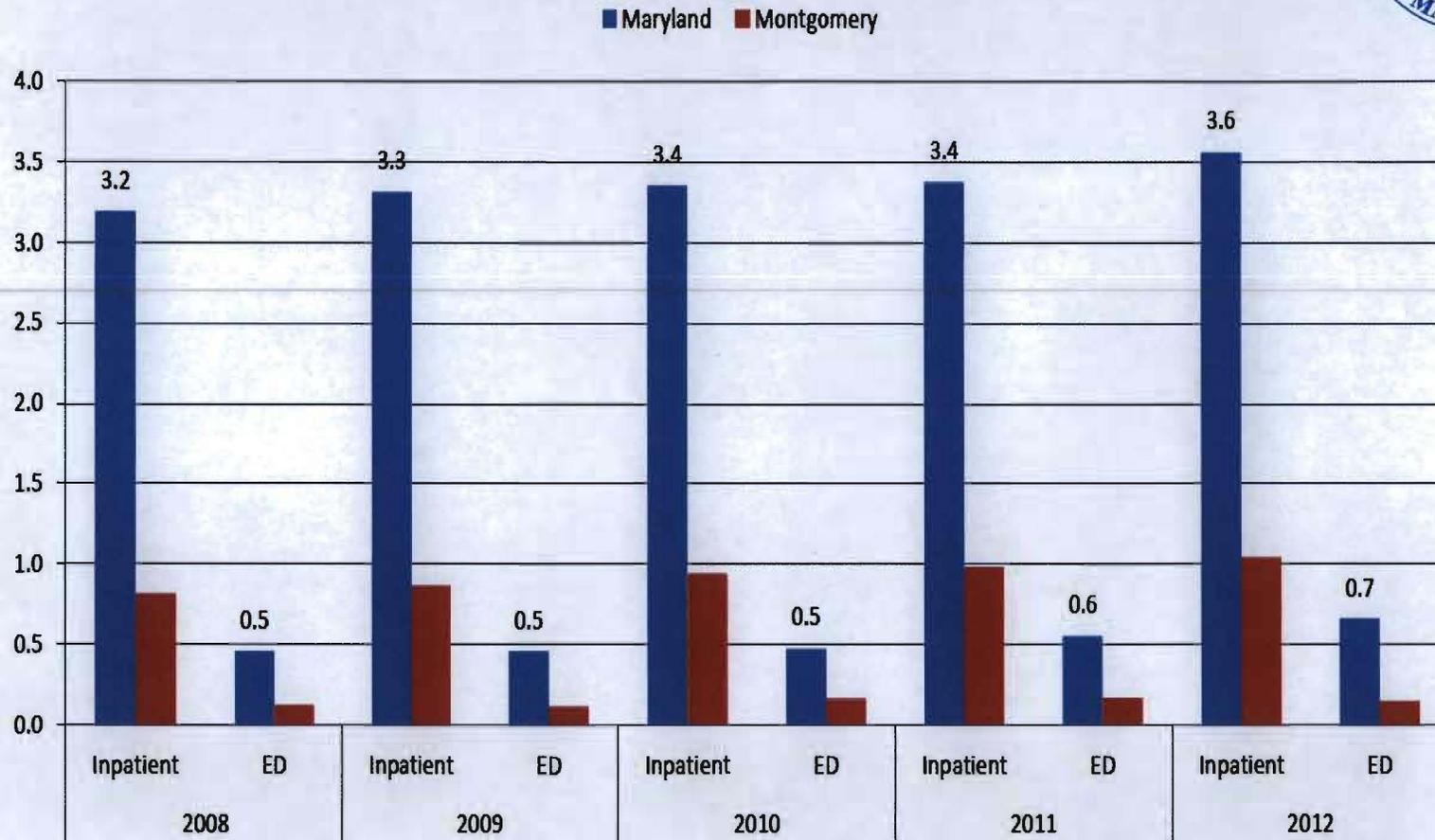
Rate of Alcohol-Related Emergency Department Visits in 2012 per 1000 Events



Source: Maryland Jurisdiction Epidemiological Profiles Chartbook, University of Maryland School of Pharmacy, February 13, 2014.



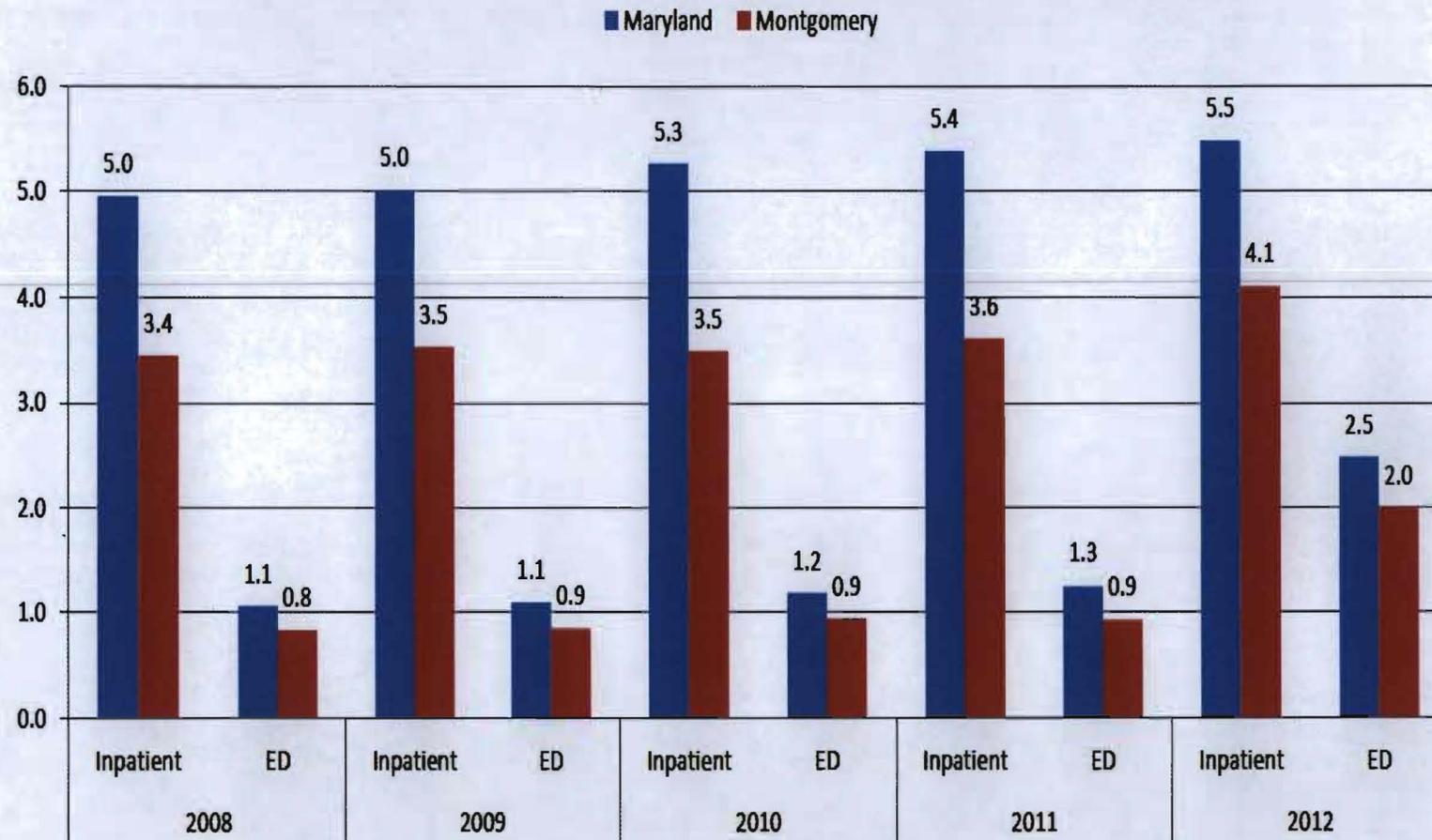
Rate of Opioid-related Inpatient Hospitalizations and ED Visits per 100 Events



Source: Maryland Jurisdiction Epidemiological Profiles Chartbook, University of Maryland School of Pharmacy, February 13, 2014.

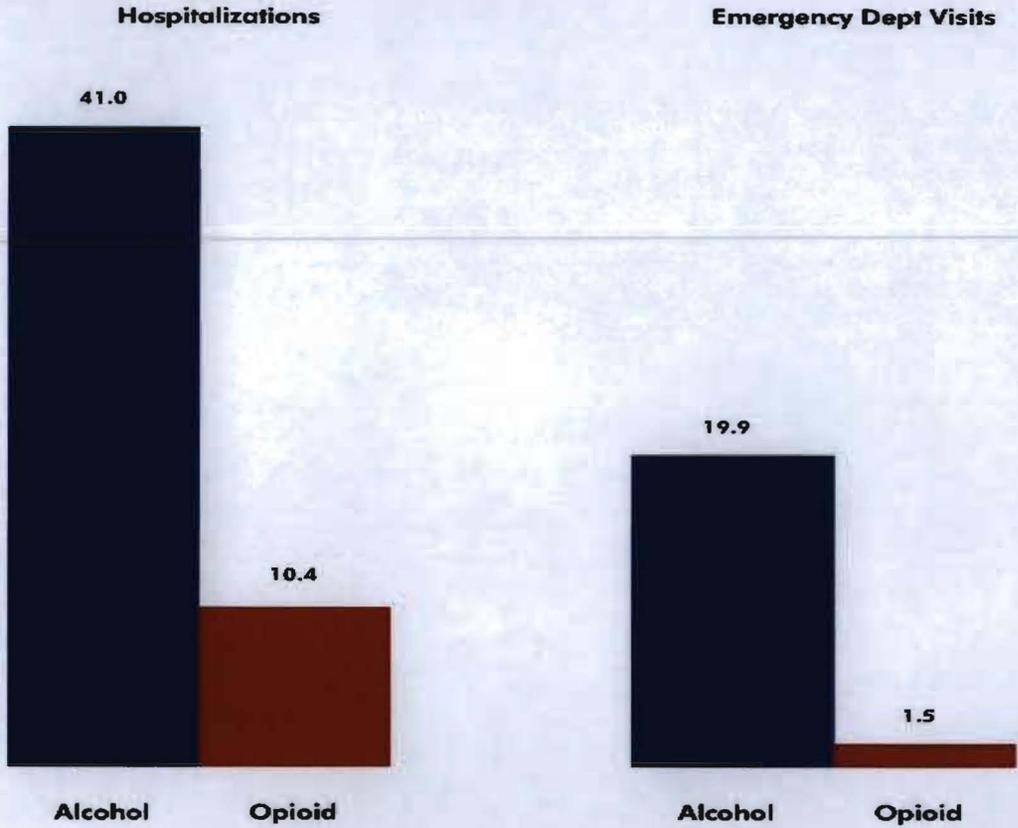


Rate of Alcohol-related Inpatient Hospitalizations and ED Visits per 100 Events



Source: Maryland Jurisdiction Epidemiological Profiles Chartbook, University of Maryland School of Pharmacy, February 13, 2014.

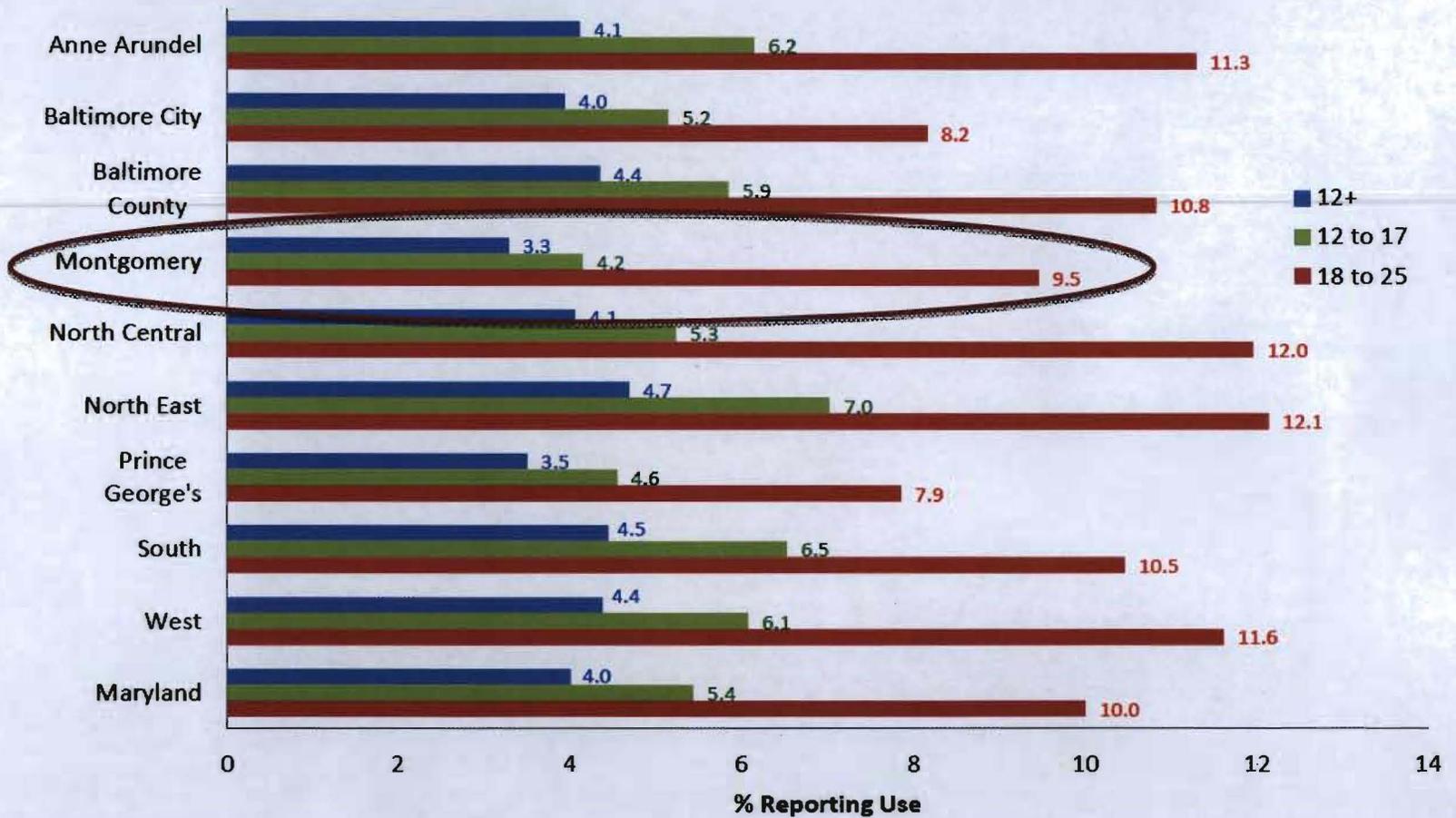
Montgomery County
Rates of Opioid and Alcohol Related Hospitalizations and ED
Visits, 2012
(Per 1,000 Events)





Pain Reliever, Past-Year Non-Medical Use
 Data source: National Survey on Drug Use and Health (NSDUH)

2008-2010 NSDUH: Nonmedical Use of Pain Relievers in Past Year, by Age Group

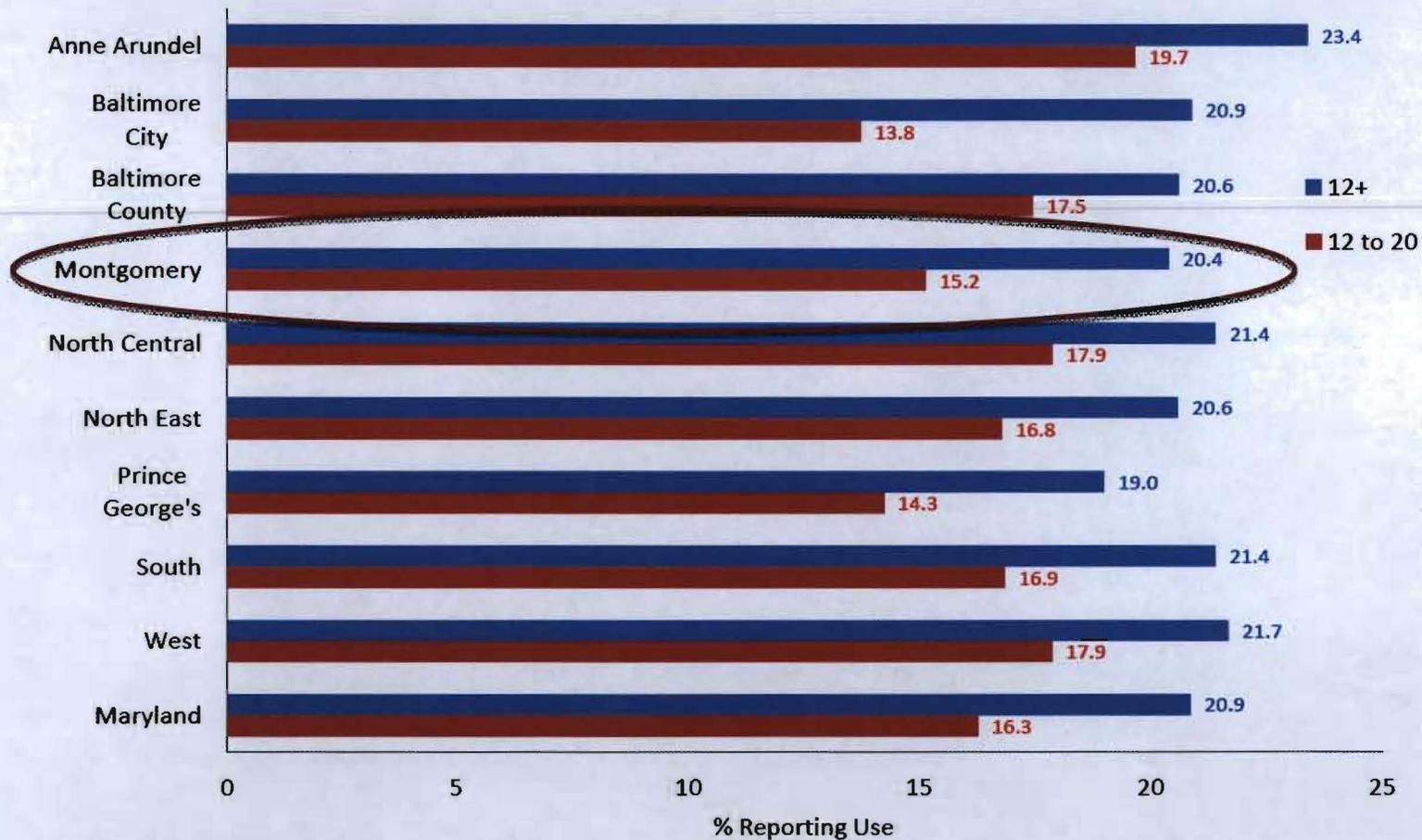


Source: Maryland Jurisdiction Epidemiological Profiles Chartbook, University of Maryland School of Pharmacy, February 13, 2014.



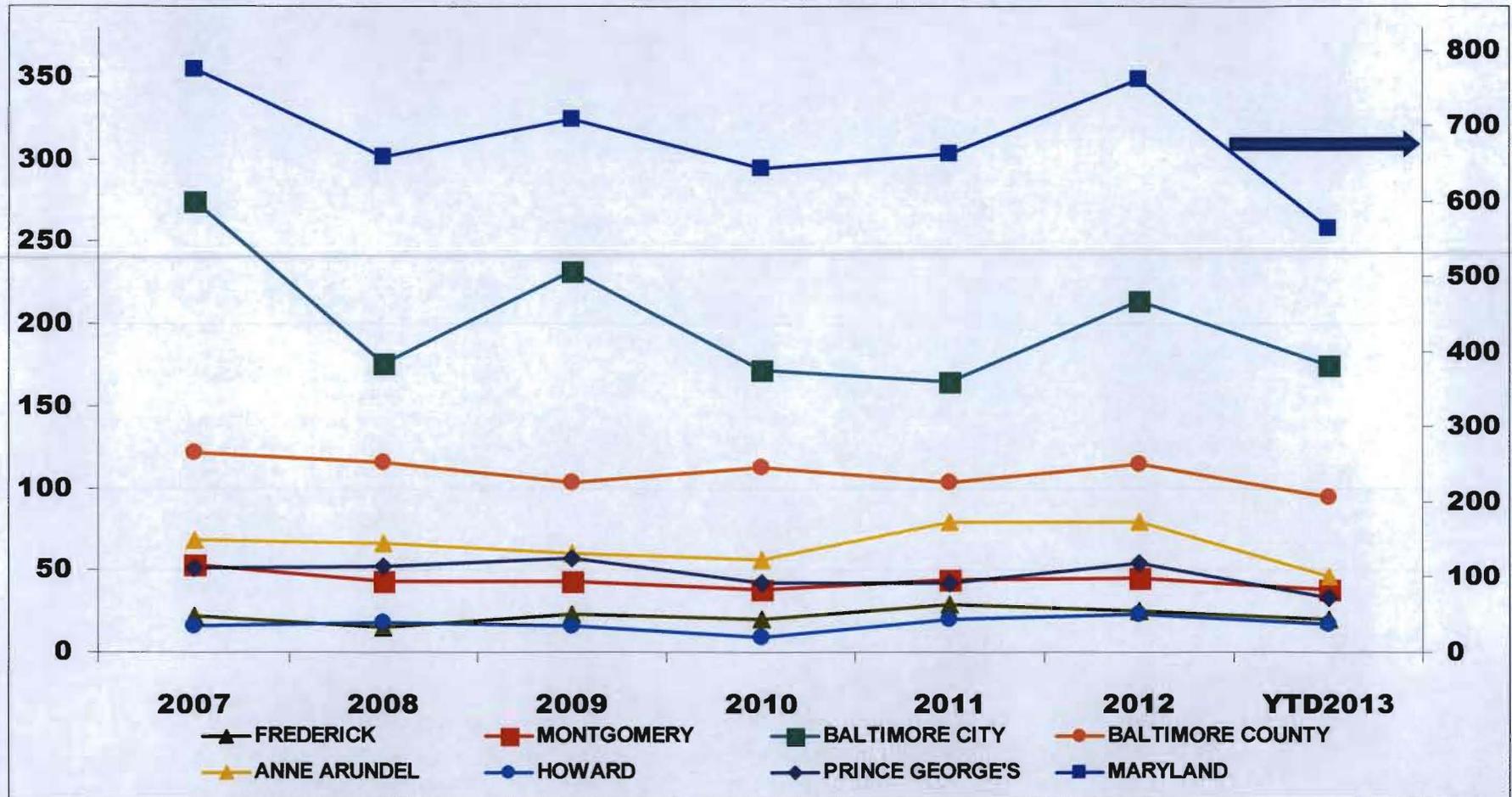
Past-Month Binge Drinking

2008-2010 NSDUH: Past-Month Binge Drinking, by Age Group



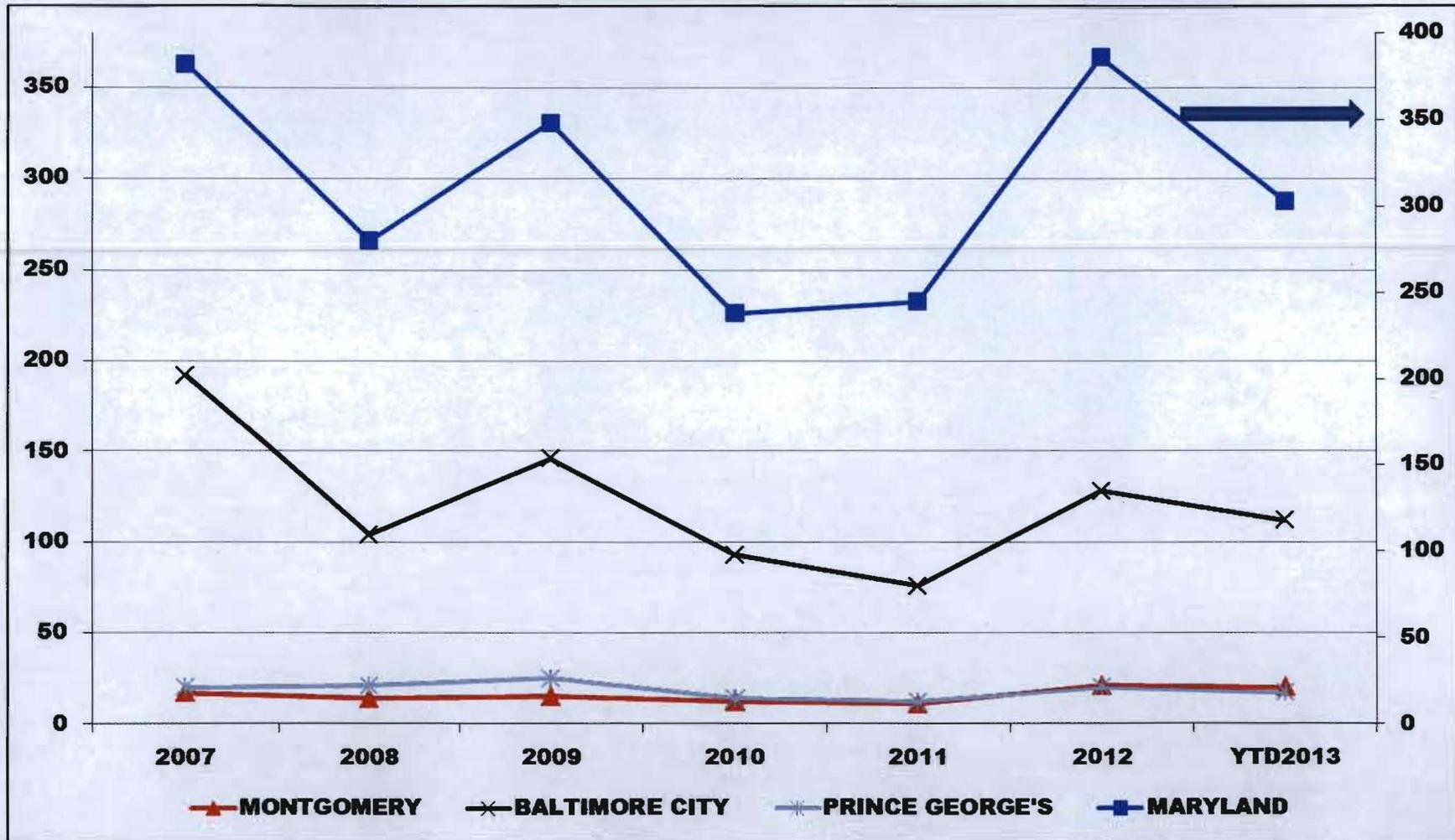
Source: Maryland Jurisdiction Epidemiological Profiles Chartbook, University of Maryland School of Pharmacy, February 13, 2014.

Total Number of Drug and Alcohol-Related Intoxication Deaths by Place of Occurrence, 2007-2012 and YTD 2013 Through September



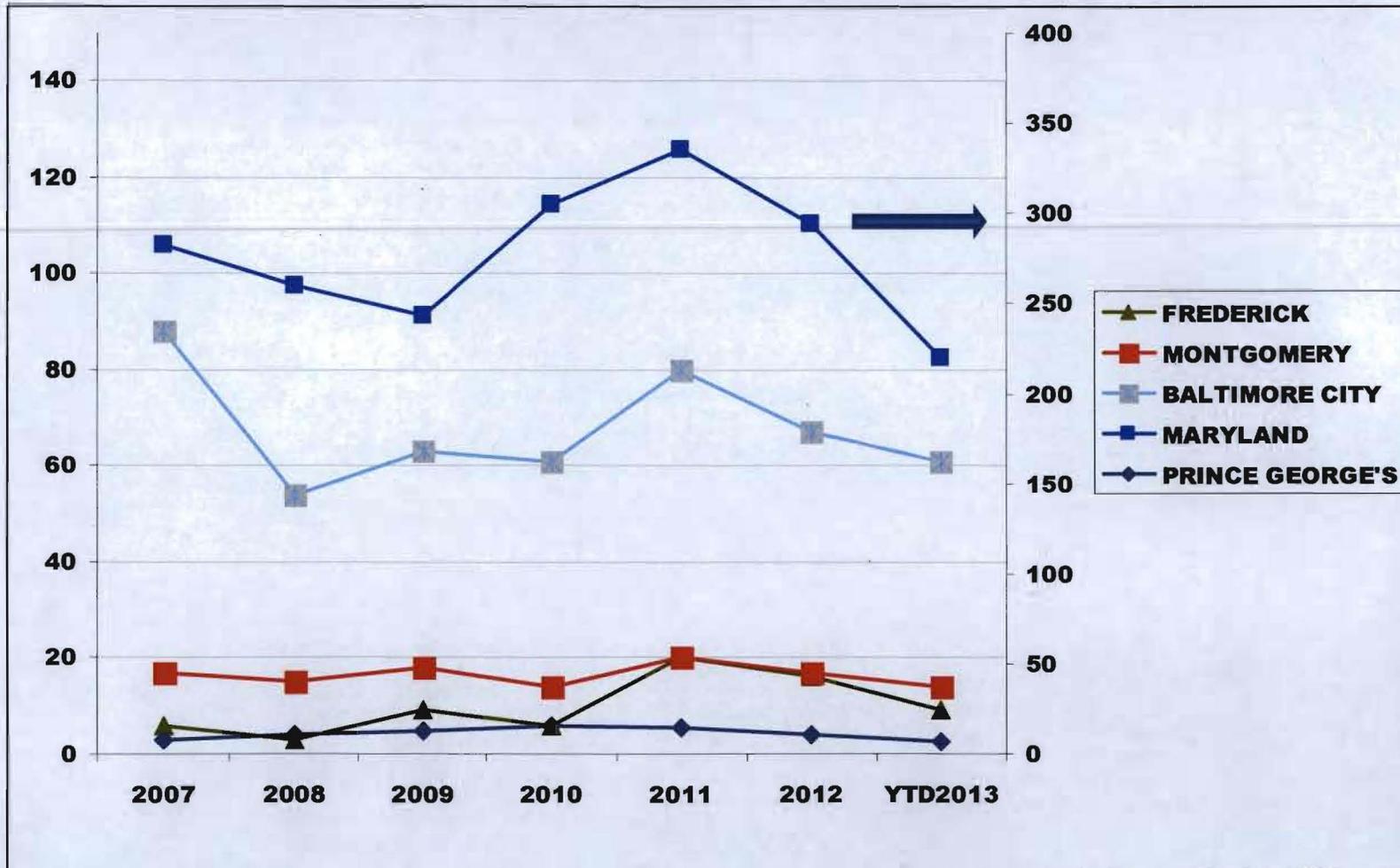
Source: Maryland DHMH Quarterly Report on Intoxication-related Deaths, 2013

Total Number of Heroin-Related Intoxication Deaths by Place of Occurrence, 2007-2012 and YTD 2013 Through September



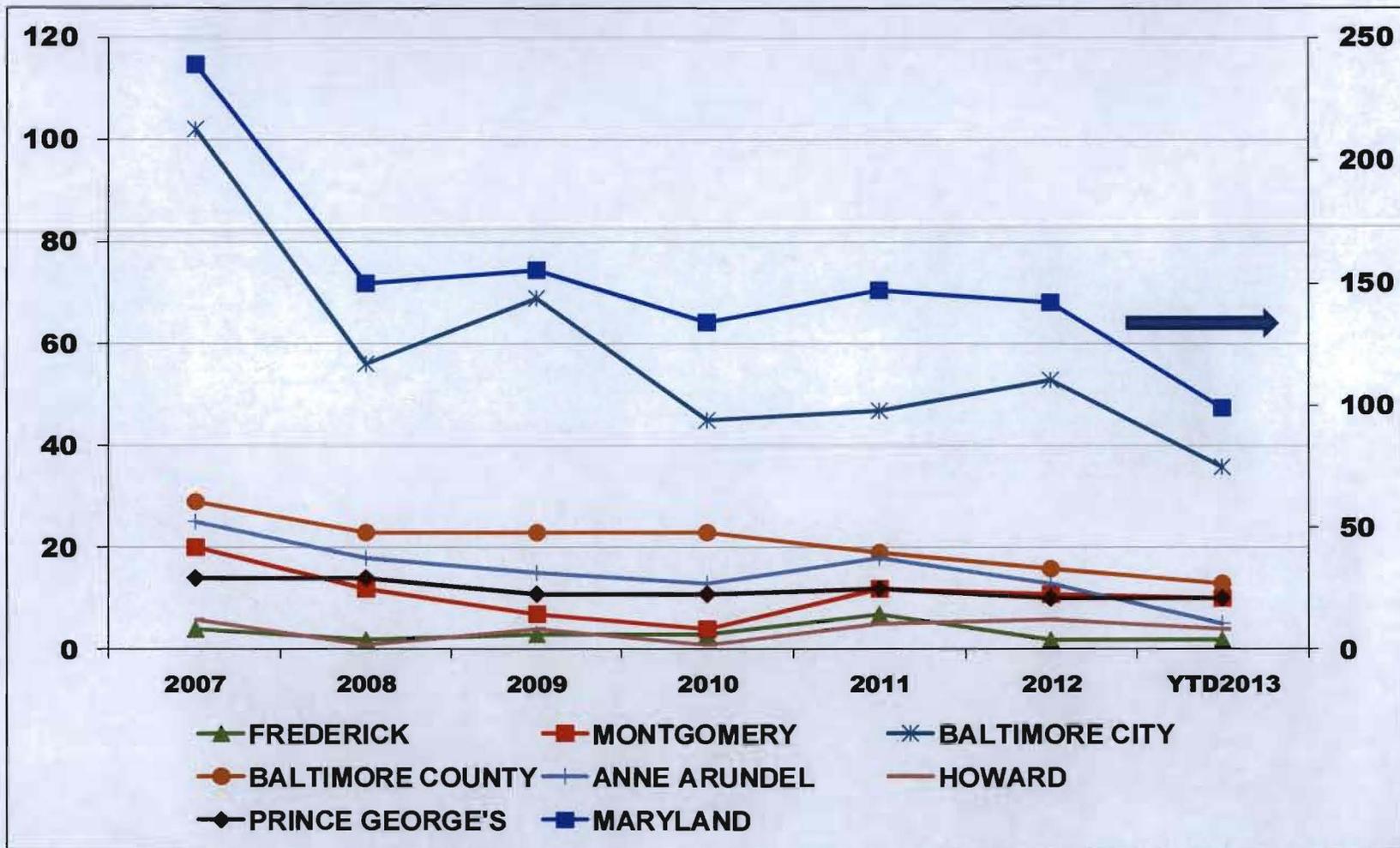
Source: Maryland DHMH Quarterly Report on Intoxication-related Deaths, 2013

Total Number of Prescription Opioid-Related Intoxication Deaths by Place of Occurrence, 2007-2012 and YTD 2013 Through September



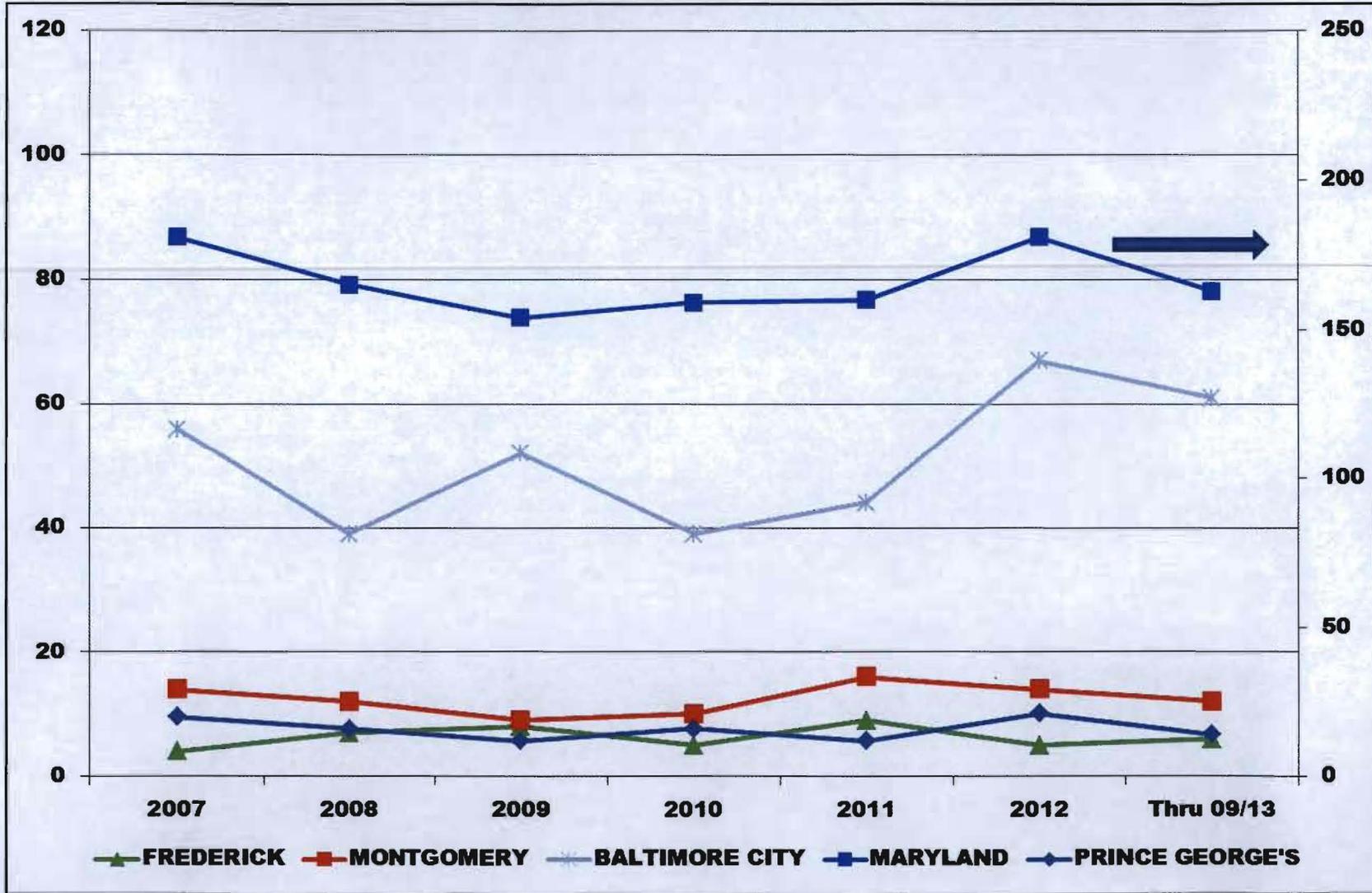
Source: Maryland DHMH Quarterly Report on Intoxication-related Deaths, 2013

Total Number of Cocaine-Related Intoxication Deaths by Place of Occurrence, 2007-2012 and YTD 2013 Through September



Source: Maryland DHMH Quarterly Report on Intoxication-related Deaths, 2013

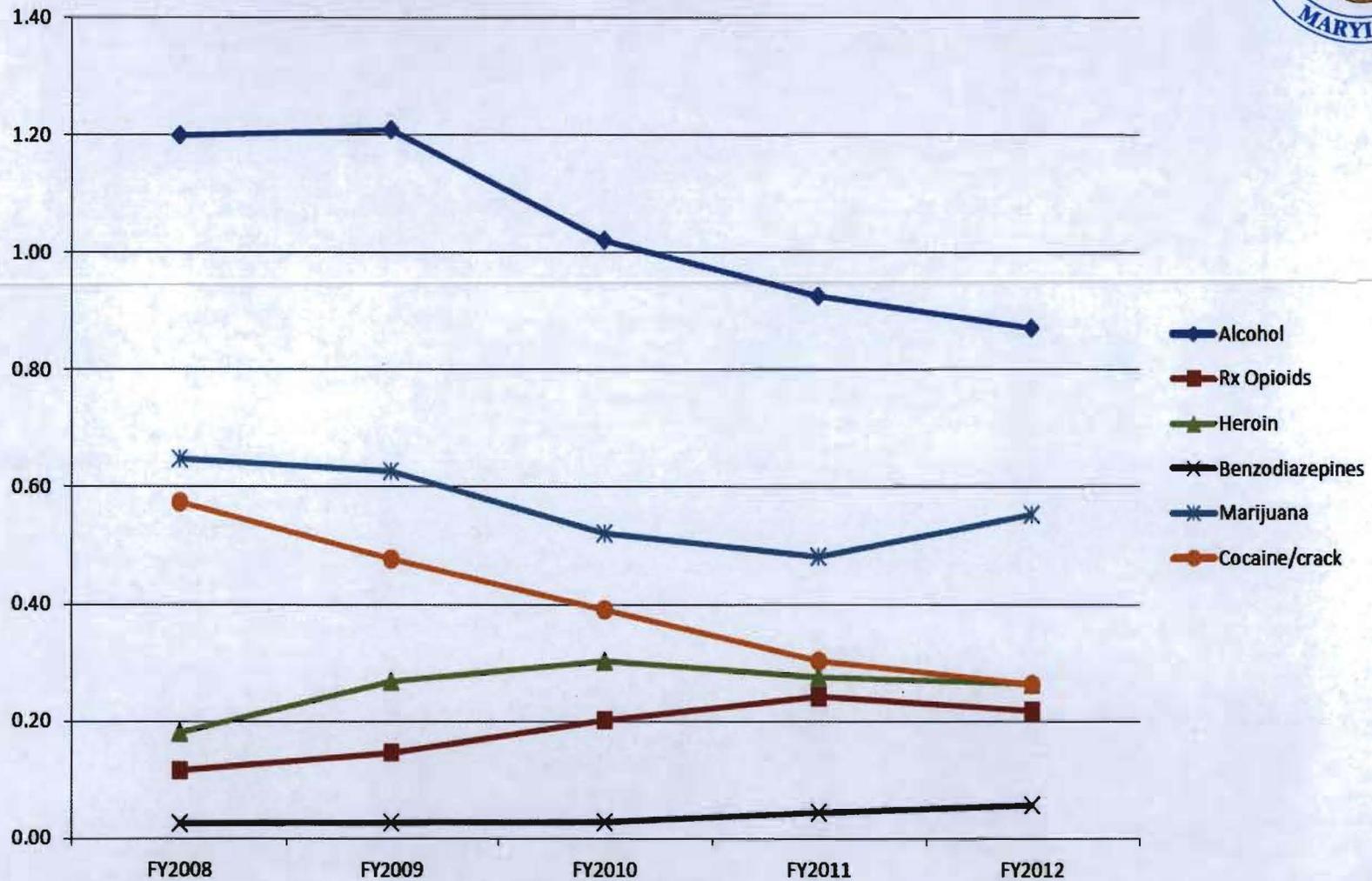
Total Number of Alcohol-Related Intoxication Deaths by Place of Occurrence, 2007-2012 and YTD 2013 Through September



Source: Maryland DHMH Quarterly Report on Intoxication-related Deaths, 2013



Montgomery County Primary Substance Treatment Admissions Trends per 1000 Population

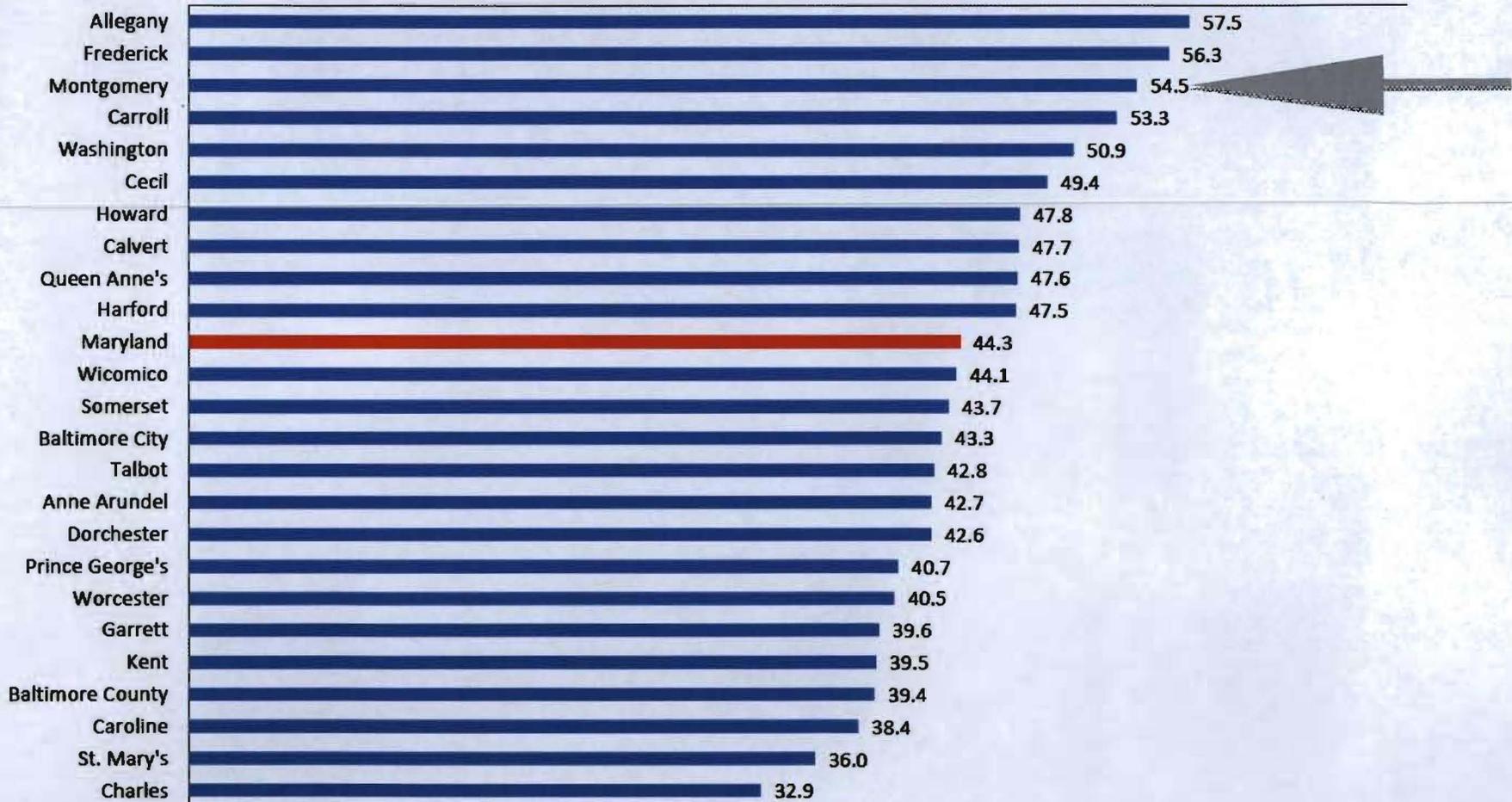


Source: Maryland Jurisdiction Epidemiological Profiles Chartbook, University of Maryland School of Pharmacy, February 13, 2014.



Co-Occurring Mental Illness by County of Patient Residence

Percent of Co-Occurring Mental Illness Among Cases of Patients Residing in Each Jurisdiction FY2012



Source: Maryland Jurisdiction Epidemiological Profiles Chartbook, University of Maryland School of Pharmacy, February 13, 2014.

Montgomery County Plan



•Primary Prevention

- Raising Awareness of the risks – both to providers and the community.
- Promoting safe practices: both in the home and in primary care practice settings.
- Reducing exposure and associated risks in the home and community.

•Secondary Prevention

- Screening procedures SBIRT in primary care and pain management clinics.
- Policy changes: Good Samaritan Laws; Marchman Act; Prescription Drug Monitoring Program (PDMP).

•Tertiary Intervention

- Acute phase interventions focus on emergency response to overdose events
- The long term interventions focus on active treatment and rehabilitation: Ongoing and developing treatment options: Active addictions treatment remains a vital part of the county's prevention strategy.
- ROSC/Wellness and Recovery



OPIOID OVERDOSE PREVENTION PLAN- LOGIC MODEL

Goal 1: To decrease opioid related deaths by providing information and training to medical professionals, certifying Naloxone prescriber and administrators, and decrease access to opioid medication with the potential for illicit use through an on-going drug take back program.

Problem Statement	Strategies	Activities	Measurable Outcomes/ Timelines
<p>1. Physicians, Nurses, and Pharmacist are not informed on how to recognize addictive behaviors and how to manage those behaviors once they have manifested.</p>	<p>Provide information and continuing CMUs/CEUs for the appropriate professional discipline on the subject matter.</p> <p>Provide information for the medical community about opioid abuse and addiction.</p> <p>Increase the collective knowledge of best practice prescribing</p>	<p>Identify/develop appropriate trainings/curriculum.</p> <p>Identify who will conduct the training to medical and other prescribing professionals.</p> <p>Identify location for training.</p>	<p>Host training at least 2x per year.</p> <p>Training ____ medical professional that can prescribe.</p> <p>Expected Date of completion_____.</p>
<p>2. Opioid users do not have access to Naloxone to protect those who are at risk for overdose.</p>	<p>Train and certify individuals to administer Naloxone.</p> <p>Making Naloxone available contingent on state funding.</p>	<p>Identify/develop appropriate training/curriculum.</p> <p>Identify who will conduct the training to certify individuals to administer the medication.</p> <p>Provide information to the medical community for prescribing Naloxone to clients/recovering clients.</p>	<p>Certify ____ Naloxone administrators.</p> <p>Host training at least 2x per year.</p> <p>Expected Date of completion_____.</p>



OPIOID OVERDOSE PREVENTION PLAN-

Problem Statement	Strategies	Activities	Measurable Outcomes/ Timelines
<p>3. Residents are not informed on the risks of opioids, safe handling, and disposal. They are in need of safe means to dispose of medications properly which is an indicator to have a full service drug take back initiative within Montgomery County, MD with multiple drop off locations.</p>	<p>Partner with County Public Safety Committee, local law enforcement agencies, drug free coalitions</p> <p>Develop a comprehensive plan with law enforcement to have an on-going drug take back program for constituents to dispose of medication properly</p> <p>Public safety committee will assist law enforcement agencies with implementing an ongoing drug take back program</p> <p>Many Voices for Smart Choices coalition will inform the community about the dangers of prescription drug misuse which includes opioids and educate on proper disposal methods namely the drug take back program</p>	<p>On-going drug take back boxes for constituent disposal.</p> <p>Community town halls to inform the community about the dangers of opioids and proper disposal methods for medications.</p> <p>Lead an initiative to empower parents to talk to their kids about the dangers of opioid use and abuse as encourage the locking up of medications (Talk it Up, Lock it Up initiative)</p> <p>Dangers of Prescription Drug media campaign (youth lead)</p>	<p>At least <u>10</u> drop box locations</p> <p>At least <u>2</u> town hall per year.</p> <p>Inform _____ about Talk it Up, Lock it Up initiative</p> <p>At least <u>2</u> media commercials to be shown in schools within the county.</p> <p>Expected Date of completion _____</p> <p>_____ lbs. forfeited to law enforcement per year</p>



OPIOID OVERDOSE PREVENTION PLAN

Problem Statement	Strategies	Activities	Measurable Outcomes/ Timelines
<p>4. With insufficient data for drug related fatalities we currently need a review committee to analyze the overdose fatalities in the county to function similar to the Montgomery Child and Infant Fatality Review Committee.</p>	<p>Complete the necessary steps to apply to become a DHMH pilot site to conduct multi-agency, multi-disciplinary reviews of information on individuals who have died from drug and alcohol related overdoses in the jurisdiction. (Local Overdose Fatality Review Committee)</p> <p>ADAA has provided two templates for Montgomery County to serve as jurisdictional pilot site for the development, planning and implementation of the Overdose Fatality Review Committee Process.</p>	<p>Develop and coordinate a plan to implement this committee review process in consultation with DHMH Technical Support and our local Child and Infant Fatality Team Review Process.</p> <p>Complete charter template, complete required signed confidentiality agreements and all other necessary steps to implement this process in FY 2014.</p>	<p>Collect, receive and review state and local data to provide ongoing review of factors involved in drug overdose deaths and inform the development and/or refinement of appropriate interventions in Montgomery County.</p> <p>_____ Expected Date of implementation. Meetings held quarterly or on a as needed basis.</p>



OPIOID OVERDOSE PREVENTION PLAN

Problem Statement	Strategies	Activities	Measurable Outcomes/ Timelines
<p>5. The County does not have sufficient resources to implement the primary, secondary and tertiary prevention strategies to fully implement the array of planned interventions and initiatives that DHMH has recommended for inclusion in the local jurisdictional opioid and other drug overdose prevention policy and procedure.</p>	<p>Based on the development of a final plan cost projections will be identified to move toward full implementation of the planned interventions and initiatives that it will take to fully implement this plan.</p> <p>The County will develop recommended strategies through consultation with DHMH Technical Support and by consulting with other Maryland Local Jurisdictions.</p>	<p>The County will contact, coordinate and outreach other local jurisdictions that have already implemented different interventions and initiatives that are current gaps in our plan to move toward a comprehensive opioid and other drug overdose prevention plan that reduces overdose deaths in the jurisdiction.</p> <p>The county will implement elements of the plan that can be accomplished w/ existing resources. We will identify gaps</p>	<p>Develop, identify and pursue funding streams through the local, state and federal levels that will allow The County to expand its planned interventions and initiatives that are current gaps in the County continuum of overdose prevention plan.</p> <p>Ongoing</p>

Activities, Challenges and Opportunities



.Activities

- Joint planning and coordination of educational fora and awareness actions with MCPS, HHS, MPD and Collaboration Council:

- Drug Prevention Forum - Richard Montgomery in October 2013
- Training/strategy sessions on SA prevention at Walter Johnson
- Joined MCPS Health Education Curriculum Advisory Committee to assist in updating the curriculum around substance abuse prevention
- Joint promotion of MPD's drug take back days in the county
- Additional public education and in-service trainings providing by MCPD, MCPS and Collaboration Council (Many Voices Smart Choices Coalition)

.Upcoming

- Partnership has been established with MCPS Parent Academy and Many Voices for Smart Choices

- Promoting Teen Resiliency- Rockville High School, April 2nd
- Upcoming educational forum at the Northwood High School Wellness Center and other MCPS schools
- Naloxone – small pilot funded one-time-only by State to be completed by June 30, 2014
- Continued work with MPD to address the remaining barriers to establishing an ongoing drug drop-off program in the County



Activities, Challenges and Opportunities

• Challenges and Opportunities

- Fatality Review Panel pending State legislation
- Good Sam laws are still challenging
- State has not yet indicated which elements of the plans they will fund. As they do we will conduct and analyze and develop recommendations for county support.
- Education to primary care physicians and pain management clinics not yet initiated
- Exploration under way to expand education and Naloxone training to ROSC community

• Challenges and Opportunities

- Continued pressures across behavioral health – domestic violence, increased behavioral health problems in corrections, co-occurring disorders population
- Continue to conduct limited educational awareness fora and other low cost activities.
- Continue to gather and monitor data on need to identify targeted interventions
- Explore opportunities to expand Naloxone training to include training in 'rescue breathing'

“Drug distribution through the pharmaceutical supply chain increased more than 600% between 1997 and 2007, from 96 mg of morphine to 700 mg per person in 2007, enough for every US citizen to take a typical 5 mg dose of Vicodin every 4 hours for 3 weeks.”

A primary cause of the increase in pharmaceutical opioid abuse has been drastically increased availability (of prescription opiate pain medications)

Source:

Centers for Disease Control and Prevention. "CDC Grand Rounds: Prescription Drug Overdoses a U.S. Epidemic." *Morbidity and Mortality Weekly*. 61(01); pgs. 10-13, Jan. 13, 2012.

<http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6101a3.htm>

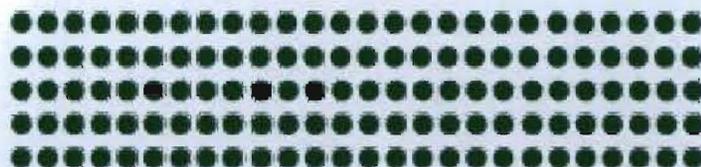
For every **1** death there are...



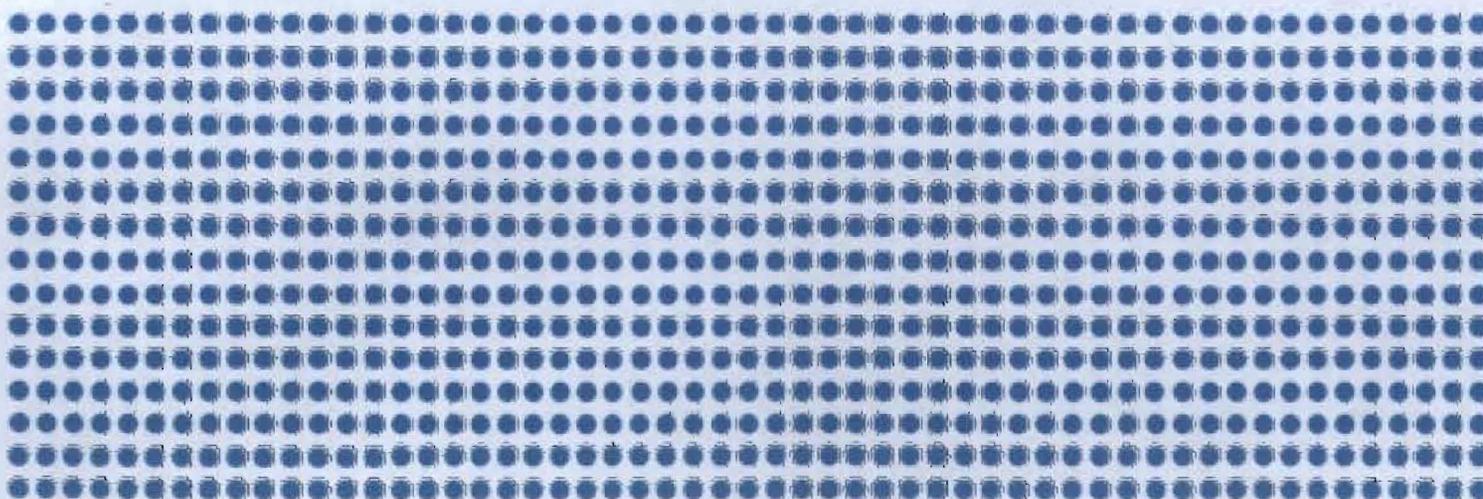
10 treatment admissions for abuse⁹



32 emergency dept visits for misuse or abuse⁶



130 people who abuse or are dependent⁷



825 nonmedical users⁷