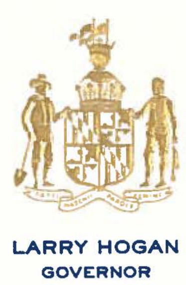

STATE OF MARYLAND
OFFICE OF THE GOVERNOR

LARRY HOGAN
GOVERNOR

October 21, 2019

The Honorable Frank Pallone, Jr.
Chairman
House Energy & Commerce Committee
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Greg Walden
Ranking Member
House Energy & Commerce Committee
2125 Rayburn House Office Building Washington,
D.C. 20515

Dear Chairman Pallone, Ranking Member Walden, and Committee Members:

I write in response to the Committee's September 18, 2019 letter requesting information on how Maryland is using federal funds to address the opioid crisis. We thank the Committee for its time and focus on this critical issue and its efforts to date.

As I testified before the Senate Committee on Health, Education, Labor, and Pensions in March 2018, the one issue that Marylanders are most concerned about, that we hear again and again, in every corner of our state, is heroin and opioid addiction.

Immediately after taking office, we set up a Heroin and Opioid Emergency Task Force, chaired by Lt. Governor Boyd Rutherford, which developed 33 specific recommendations focused on a four-pronged approach: education, prevention, enforcement, and treatment. We have moved forward on nearly all of these recommendations.

In March 2017, Maryland became the first state in the nation to declare a state of emergency in response to the heroin, opioid, and fentanyl crisis. In order to truly treat this crisis as we would a natural disaster or public safety emergency, we activated an Opioid Operational Command Center to more rapidly coordinate between state and local agencies, and dedicated an additional $50 million in funding over five years. In total, we have spent nearly half a billion dollars in state and federal funds to combat opioid and substance use disorders.

STATE HOUSE, ANNAPOLIS, MARYLAND 21401
(410) 974-3901 1-800-811-8336
TTY USERS CALL VIA MD RELAY

Through legislation and effective implementation, we have taken positive strides. We've expanded our state's Good Samaritan Law and Prescription Drug Monitoring Program, imposed stricter penalties on individuals distributing fentanyl, and passed legislation limiting the amount of opioids a health care provider can prescribe. In June 2017, our Department of Health issued a standing order allowing all Marylanders to be able to receive the life-saving drug naloxone from pharmacies, and in January 2018, I authorized our attorney general to file suit against opioid manufacturers and distributors that have helped create the addiction crisis gripping our state and nation.

Yet, in spite of all of our efforts, and in spite of us fighting with every tool we have at our disposal, this crisis continues to evolve, particularly with the threat of fentanyl and other synthetic additives, which can be 50 times to 100 times stronger than heroin.

Combatting a crisis of this scale requires all levels of government working together. No state or community can go it alone. The majority of the deadly fentanyl is being shipped in from China or smuggled in from Mexico, and we need the federal government to continue its efforts to step up enforcement and stop this poison from ravaging our state and our nation.

Maryland is cautiously optimistic in 2019. Through our tireless efforts over the past few years, Maryland has had the first six-month decline in the total number of opioid-related fatalities in at least a decade. However, the heroin and opioid epidemic remains a crisis, and we will continue to respond with every tool available.

Together, we can and we must do more in order to save the lives of thousands of Marylanders and Americans. We know this threat remains high and so request ongoing financial support from Congress to continue efforts initiated through federal funds. We also need greater federal support, especially more targeted and aggressive federal enforcement efforts for fentanyl and other synthetic opioids.

Please find the attached documents with Maryland's responses to the Committee's questions from September 18, 2019. Should you have any questions, please contact my Director of Federal Relations, Tiffany Waddell, at tiffany.waddell@maryland.gov or 202-624-1432.

Sincerely,

Larry Hogan
Governor

Cc:
Senator Ben Cardin
Senator Chris Van Hollen
Majority Leader Steny Hoyer
Rep. Andy Harris
Rep. Dutch Ruppersberger
Rep. John Sarbanes
Rep. Anthony Brown
Rep. David Trone
Rep. Jamie Raskin

(Attachments)

Maryland Appendix of Attachments

1. Maryland Responses to the House Energy and Commerce Committee Questions
2. Final Report, Heroin & Opioid Emergency Task Force (December 1, 2015)[1]
3. 2018 Annual Report, Opioid Operational Command Center (May 2019)[2]
4. Maryland Inter-Agency Heroin and Opioid Coordination Plan, State Fiscal Year 2019 Mid-Year Update[3]
5. Maryland State Targeted Response Assessment (July 2017)
6. Excel Spreadsheet with Funding Information
7. 2018 Report on Unintentional Drug- And Alcohol-Related Intoxication Deaths in Maryland[4]
8. Preliminary Data update through 2nd quarter 2019 Unintentional Drug - and Alcohol-Related Intoxication Deaths in Maryland[5]

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[1] Retrievable at https://beforeitstoolate.maryland.gov/wp-content/uploads/sites/34/2018/10/CoordinationPlan-_-Midyear-10.4.pdf

[2] Retrievable at https://beforeitstoolate.maryland.gov/wp-content/uploads/sites/34/2019/05/OOCC-FinalAnnual-Report-2018.pdf

[3] Retrievable at https://beforeitstoolate.maryland.gov/wp-content/uploads/sites/34/2018/10/CoordinationPlan-_-Midyear-10.4.pdf

[4] Retrievable at https://bha.health.maryland.gov/Documents/Annual_2018_Drug_Intox_Report.pdf

[5] Retrievable at https://health.maryland.gov/vsa/Documents/Overdose/2019_Q2_Drug_Intox_Report.pdf

House Energy and Commerce Committee Questions

Maryland Responses

October 9, 2019

Maryland has dedicated significant resources, including federal funds, in an effort to combat the heroin and opioid crisis. Maryland is focused on a four-pronged approach: education, prevention, enforcement, and treatment. This approach is encapsulated in the Maryland Inter-Agency Heroin and Opioid Coordination Plan, and it ensures that Maryland's state agencies follow a common statewide vision.

For more information, please see the 2018 Opioid Operational Command Center Annual Report (attached and available here: https://beforeitstoolate.maryland.gov/wpcontent/uploads/sites/34/2019/05/OOCC-Final-Annual-Report-2018.pdf).

1. Since 2016, how much federal funding for opioid use disorder prevention, treatment and recovery has Maryland received?

Maryland receives opioid use disorder (OUD) prevention, treatment and recovery funding from a number of targeted federal funding sources, including through the U.S. Department of Justice (DOJ), the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), and the Centers for Disease Control (CDC). A critical tool was the recent federal State Opioid Response (SOR) two-year grant.

For specific breakdowns, please see the Excel attachment.

Federal Fiscal Year 2016

- $413,930 in total federal funds to Maryland for prevention, treatment and recovery.

Federal Fiscal Year 2017

- $947,180 - two-year grant - Enhanced State Opioid Overdose Surveillance Program (ESOOS) (CDC).
- $920,733 in total federal funds to Maryland for prevention, treatment and recovery.

Federal Fiscal Year 2018

- $10,291,333 in total federal funds to Maryland for prevention, treatment and recovery.

Federal Fiscal Year 2019

- $45,468,734 in total federal funds to Maryland for prevention, treatment and recovery.

Federal Fiscal Year 2020

- $7.2 million Overdose Data to Action Grant (CDC) to further enhance overdose surveillance activities to better inform the use of evidence-based prevention activities at the local level.
- Approximately $58 million in total federal funds to Maryland for prevention, treatment and recovery.

a. What challenges, if any, exist in deploying federal funds to local communities in an expedited manner?

The primary challenge, especially with the SOR Grant, is to analyze and award funds to very complex and innovative projects in a short amount of time due to the federal fiscal year and to ensure that they meet both program integrity objectives and comply with state procurement requirements.

b. To date, how much of this federal funding has your state used or allocated? Please provide a list of each funding recipient, the purpose for allocating money to them (e.g. prevention, treatment, etc.) and the amount that has been allocated to them.

All federal funds have been allocated. For grants to local jurisdictions, please see the 2018 Opioid Operational Command Center Annual Report, pages 48-81. For SOR Grant information, please see the Excel attachment.

C. If your state has not used the entirety of federally allocated funds, please explain why.

All federal funds have been allocated. Maryland has worked cooperatively with local government and community-based program recipients to ensure that federal funds are used to combat the opioid epidemic.

2. Please describe how your state determines which local government entities (i.e. counties, cities and towns) receive federal grant funding to address the opioid crisis. Specifically, please identify localities impacted most by the opioid epidemic in your state, and include the total amount allocated to each locality, as well as the factors your state considers in distributing these funds.

The Maryland Opioid Operational Command Center (OOCC) coordinates all state agencies' efforts and works with local governments to ensure that every jurisdiction's priorities are acknowledged and, when possible, addressed through coordinated state and federal action.

The Maryland Department of Health (MDH) works internally and with local governments' local health departments (LHDs), local addiction authorities (LAAs) and local behavioral health authorities (LBHAs) to provide oversight, planning and monitoring. After developing internal funding recommendations, MDH ensures that its efforts are coordinated with other agencies through the OOCC.

Whenever required by law, Maryland conducts a competitive solicitation and procurement process to ensure that projects are awarded with maximum transparency and accountability.

When allocating funds to local government entities (typically a county or Baltimore City), Maryland considers use and consequence data, the impact on the jurisdiction, and the proposal(s) submitted by the jurisdiction.

The three local jurisdictions most impacted by the opioid epidemic in Maryland, as measured by the number of opioid-related intoxication deaths in 2018, are:

- Baltimore City,
- Baltimore County, and
- Anne Arundel County.

Maryland's 2018 Unintentional Drug- and Alcohol-Related Intoxication Deaths Report can be found here: https://bha.health.maryland.gov/Documents/Annual_2018_Drug_Intox_Report.pdf

Prior years' reports can be found here:
https://bha.health.maryland.gov/OVERDOSE_PREVENTION/Pages/Data-andReports.aspx

For funding amounts, please see the 2018 Opioid Operational Command Center Annual Report, pages 48-81. For SOR Grant information, please see the Excel attachment.

3. Please describe how your state determines which non-governmental organizations (i.e. non-profits, treatment centers, or other entities) receive federal grant funding to address the opioid crisis. Specifically, please identify the nongovernmental organizations that have received funds in your state, and include the total amount allocated to each entity as well as the factors your state considers in distributing these funds.

Please see the answer to #2. When the funds are not awarded to local jurisdictions who then award to community-based organizations, the same process and criteria are used.

4. Do federally appropriated funds to address the opioid crisis provide your state with the flexibility to focus on the hardest hit regions or localities? Please describe how, if at all, this flexibility has helped Maryland in using funds to target vulnerable populations or at-risk areas. If no, please explain what additional flexibility should be considered in helping your state address the hardest hit regions or localities.

Yes, all federally appropriated funds have assisted Maryland in its fight against the opioid crisis.

A few localities mention that there are other substances of greater concern than opioids. While the flexibility of funding for programs not typically funded through other federal programs is helpful, the strict separation between OUD treatment funding and SUD treatment funding generally has limited innovative interventions in target populations.

5. In what ways, specifically, have federal funds extended to Maryland helped change your state's treatment system and/or led to a reduction in opioid overdoses?

In September 2019, Maryland released data that demonstrated that the state has experienced its first six-month decline in the total number of opioid-related fatalities in at least a decade.

In the first two quarters of 2019, there were 1,182 total unintentional intoxication deaths in the state, an 11.3% decrease as compared to the same period in 2018. Of that total, 89.7% (1,060) were opioid-related deaths, primarily attributable to fentanyl. All opioidrelated deaths declined by 11.1%.

In addition, heroin-related deaths have decreased by 14.9% through June 2019 when compared with the same period in 2018. Prescription opioid-related deaths declined by 3.5% in the first six months of 2019 compared to the same period in 2018. Details are available in the Second Quarter 2019 Preliminary Update:
https://health.maryland.gov/vsa/Documents/Overdose/2019_Q2_Drug_Intox_Report.pdf

For more details, please see the OOCC's 2018 Annual Report, which is available here (and attached as Attachment 2):
https://beforeitstoolate.maryland.gov/wpcontent/uploads/sites/34/2019/05/OOCC-Final-Annual-Report-2018.pdf

Some key state initiatives that were sponsored in part by federal funds include:

- **The Overdose Response Program** allows for programs that are registered with MDH to provide naloxone via a standing order outside of healthcare settings to any Marylanders. Programs provide training and access to naloxone throughout the state. Increased availability of naloxone helps saves lives. A total of 33,992 doses of Naloxone were provided to 11 non-profits and 12 Local Health Departments (LHD) across the state.

- **Substance Use Crisis Beds & Walk-in Stabilization Centers:** Service consumers, families, policy makers and other stakeholders have long identified lack of timely, low-barrier access to treatment services as a major system gap. This is particularly important for individuals with opioid or other SUDs experiencing instability in housing, employment, social relationships and other factors that influence willingness and ability to seek treatment. Although crisis services had existed in the mental health system, there was no corollary in the addiction services system. In response, Maryland used federal funds to implement short-term substance use crisis beds offering expedited admission, medical stabilization, assessment, peer support and referral to ongoing specialty care. Over the course of the two-year Opioid STR grant, 63 substance use crisis beds were created in the State, serving 2,962 Marylanders. STR also supported creation of the Maryland Crisis Stabilization Center in Baltimore City, which served 640 people during the grant period.

- **Improving Substance Use Disorder Screening & Supported Treatment Referral:** Maryland has used federal grant funds to develop innovative screening, brief intervention and referral to treatment (SBIRT) strategies designed to improve healthcare and other service providers' ability to identify individuals with SUDs and connect them to needed specialty care. This includes a robust training and technical assistance infrastructure supporting implementation of universal SBIRT in hospital emergency departments and inpatient units, primary care practices, schools, correctional facilities and other settings throughout the state. SBIRT services are enhanced through the employment of peer recovery coaches who assist with connections to treatment and an array of ongoing recovery support services. These enhanced SBIRT services are being expanded to over a dozen hospitals, OB/GYN practices, college medical and counseling centers and K-12 schools in Maryland.

- **Expanding Access to Medication-Assisted Treatment (MAT) for Opioid Use Disorder:** Maryland has used federal grant funds to make significant investments in MAT access and quality including prioritized training and technical assistance services to MAT providers and integration of recovery supports into clinical care. In partnership with the University of Maryland, Maryland has launched the Maryland Addiction Consultation Service (MACS) to assist physicians, physician assistants and nurse practitioners in obtaining the federally-required waiver training to prescribe buprenorphine for OUD and develop the clinical skills necessary to provide effective, coordinated care for their patients. Federal funds are also being used to hire peer recovery coaches at opioid treatment programs (OTP) and in other specialty care settings to provide continuous recovery support.

- **Expanding Recovery Support Services:** Maryland has used federal grant funds to expand access to an array of non-clinical services that support long-term recovery by meeting the personal and social needs of individuals with SUDs, particularly those receiving services through the treatment system.

6. What performance measures is Maryland using to monitor the impact of federal funds for opioid use disorder and other substance use disorder treatment?

Maryland's OOCC tracks the 174 state-level metrics for OUD and other SUD treatment programs. Please see pages 19-23 on the 2018 OOCC Annual Report.

7. According to the Substance Abuse and Mental Health Service Administration, State Targeted response to the Opioid Crisis (STR) Grants provide funding to states to:(1) Conduct needs assessments and strategic plans; (2) identify gaps and resources to build on existing substance use disorder prevention and treatment activities; (3) implement and expand access to clinically appropriate, evidence-based practices for treatment-particularly for the use of medication assisted treatment (MAT) and recovery support

services; and (4) advance coordination with other federal efforts for substance misuse prevention.

A. Has your state conducted a needs assessment and strategic plan? If yes, please describe the plan.

Maryland conducted a statewide needs assessment and strategic plan under the Governor's Heroin & Opioid Emergency Task Force in 2015. The Task Force's final report can be found here (and is attached): https://governor.maryland.gov/ltgovernor/wp-content/uploads/sites/2/2015/12/HeroinOpioid-Emergency-Task-Force-Final-Report.pdf

The most recent Maryland opioid response strategic coordination plan can be found here: https://beforeitstoolate.maryland.gov/wpcontent/uploads/sites/34/2018/10/Coordination-Plan-_-Midyear-10.4.pdf.

To further build on the 2015 Task Force's work and its 33 recommendations, Maryland conducted a Statewide Needs Assessment in 2017-18 as required by the STR grant to assess capacity and need for opioid treatment in Maryland. The Statewide Needs Assessment (July 2017) is attached.

B. Has your state identified gaps and resources to build on existing substance use disorder prevention and treatment activities? If yes, please describe those findings.

Please see the results of the STR assessment, completed in July 2017, pages 5-20 (attached).

C. Has your state implemented and expanded access to clinically appropriate, evidence-based practices for treatment-particularly for the use of MAT and recovery support services? If yes, please describe how you have done so.

Maryland received two Institution for Mental Disease (IMD) waiver approvals from the Centers for Medicare and Medicaid Services (CMS) in 2016 and 2018. The waiver approvals collectively expanded Maryland's ability to leverage Medicaid to assist in expanding access to medication-assisted treatment (MAT). The waivers, along with the transition to a Medicaid Behavioral Health fee-for-service payment model, have greatly expanded Maryland's ability to offer MAT services.

Funding has been awarded or in process of being awarded to provide MAT within local detention centers using all three FDA approved medications through SOR funds. Screening, Brief, Intervention, and Referral to Treatment (SBIRT) is being implemented in hospital emergency departments, OB/GYN units, colleges and universities.

D. Has your state advanced coordination with other federal efforts for substance use disorder prevention? If yes, please describe how.

The Opioid Operational Command Center (OOCC) is the Maryland state government entity responsible for coordinating across all state agencies and with their federal partners. By coordinating activity at the state level, Maryland is able to leverage both new and ongoing federal activities to support innovations that address the opioid crisis at the state level.

For the latest information on state and federal coordination efforts, please see the OOCC's 2018 Annual Report and the Maryland Inter-Agency Heroin and Opioid Coordination Plan, FY19 Mid-Year Update.

8. What additional resources would be most helpful to provide to communities struggling with opioid and other substance use disorders, including prevention and/or treatment options?

- Maryland respectfully requests that:
  - the Committee recommend to the House Budget Committee to maintain or increase support for federal opioid response program funds and resources; and
  - the Committee recommend to the House Appropriations Committee to maintain or increase support of federal opioid response program funds and resources.
- In particular, Maryland is asking Congress to provide level funding for SAMHSA State Opioid Response (SOR) grants. Under the SOR program, Maryland has received $83.7 million over two years, and this funding is the cornerstone of the state's opioid response efforts.

FINAL REPORT

HEROIN & OPIOID EMERGENCY TASK FORCE

Lieutenant Governor Boyd K. Rutherford, Chair

DECEMBER 1, 2015

Boyd K. Rutherford, Chair
Lieutenant Governor, State of Maryland

Julie S. Solt
Frederick County Circuit Court Judge

Timothy Cameron
St. Mary's County Sheriff

Katherine Klausmeier
State Senator, District 8 - Baltimore County

Brett Wilson
Delegate, District 2B - Washington County

Nancy Whittier Dudley
President, Resilient Soul Services, Inc.

Elizabeth Embry
Chief of the Criminal Division, Office of the Attorney General

Dr. Michael B. Finegan
Executive Director, Peninsula Mental Health Services

Professor Bankole Johnson
The Dr. Irving J. Taylor Professor and Chair in the Department of Psychiatry, University of Maryland School of Medicine

Tracey Myers-Preston
Executive Director, MD Addiction Directors Council

Linda Williams
Executive Director, Addiction Connections Resource, Inc.

December 1, 2015

Larry Hogan
Governor, State of Maryland
100 State Circle
Annapolis, MD 21401

Dear Governor Hogan:

Thank you for appointing me to chair the Heroin and Opioid Emergency Task Force to address Maryland's growing heroin and opioid crisis. Serving in this role has been an informative and eye-opening experience.

I want to commend you for shining a spotlight on this issue. Many of the concerns our Task Force received from affected Marylanders at the regional summits echo the concerns we heard during our campaign last year. Your decision to bring all of the key stakeholders together to find real solutions showed tremendous leadership. It also engendered a greater understanding of the gravity of this epidemic.

This final report is the culmination of the work of the Task Force, which includes 33 recommendations to tackle this emergency. These recommendations cover a number of areas, ranging from prevention and access to treatment to alternatives to incarceration and enhanced law enforcement.

While this brings the duties of the Task Force to a close, it does not end our State's commitment to finding solutions. Our challenge to combat substance use disorder in Maryland will endure, and I look forward to your continued leadership in this effort.

Sincerely,

Boyd K. Rutherford
Lieutenant Governor, State of Maryland
Chair, Heroin and Opioid Emergency Task Force

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I. EXECUTIVE SUMMARY

On February 24, 2015, Governor Hogan issued Executive Order 01.01.2015.12, which created the Heroin and Opioid Emergency Task Force. The Task Force is composed of 11 members with expertise in addiction treatment, law enforcement, education, and prevention. Lieutenant Governor Boyd K. Rutherford served as the Chair. The Task Force was charged with advising and assisting Governor Hogan in establishing a coordinated statewide and multi-jurisdictional effort to prevent, treat, and significantly reduce heroin and opioid abuse.

Specifically, Governor Hogan ordered the Task Force to provide recommendations for policy, regulations, or legislation to improve access to high quality heroin and opioid addiction treatment and recovery services. In addition, the Task Force was asked to provide recommendations to improve federal, State, and local law enforcement and public health coordination. It also had to provide recommendations to increase public awareness and reduce stigma associated with addiction while equipping parents and educators with tools to prevent youth and adolescent use of heroin and opioids. Lastly, the Task Force was asked to recommend alternatives to incarceration for nonviolent offenders whose crimes are driven primarily by their drug addiction.

This Final Report, in conjunction with the August 2015 Interim Report, completes all of the Task Force's duties. It is divided into seven major sections: Military Department Counterdrug Program Strategy; A Step Toward Treatment on Demand; Task Force Final Recommendations; Recently Approved Resource Allocations; Update on Maryland Medication Assisted Treatment Reentry Programs; Update on Interim Report Preliminary Recommendations; and Update on Interim Report Resource Allocations.

In the Military Department Counterdrug Strategy section, the report provides general background on the Maryland National Guard Counterdrug Program, which primarily focuses on providing law enforcement agencies with military-unique criminal analysis capabilities. In addition, the Guard's Civil Operations program will enhance partnerships with community-based coalitions that share a common goal to deter and prevent the illicit abuse of controlled substances.

In the A Step Toward Treatment on Demand section, the Department of Health and Mental Hygiene, local hospitals, skilled nursing and rehabilitation centers, and law enforcement will be brought together to develop a pilot program that establishes a full continuum of substance use disorder services in a target area, including leveraging excess capacity in various health care facilities to provide additional care, residence, and treatment for individuals with heroin and opioid use disorders.

The Task Force Final Recommendations section details 33 recommendations. Eight recommendations relate to expanding access to treatment; five relate to enhancing quality of care; two relate to boosting overdose prevention efforts; six relate to escalating law enforcement options; six relate

to reentry and alternatives to incarceration; four relate to promoting education tools for youth; parents, and school officials; and two relate to improving State support services.

The Recently Approved Resource Allocations section lists nine recent grants totaling $608,832, which are administered through the Governor's Office of Crime Control and Prevention. These are aimed at tackling the opioid and heroin crisis.

The Update on Maryland Medication Assisted Treatment Reentry Programs section explains that approximately 304 clients have been evaluated and 61 have been accepted into the various reentry programs. Twenty-one Vivitrol injections have been given in the detention centers and six injections in the community as of November 4, 2015.

The Update on Interim Report Preliminary Recommendations section details the progress of the 10 recommendations from the August 2015 Interim Report, which dealt with improving prevention and education efforts for youth, adolescents, law enforcement and the jail-based population, the quality of care in hospital emergency rooms, highlighting and leveraging faith-based resources, and a public awareness campaign.

The Update on Interim Report Resource Allocations provides details on the implementation of $2 million released by Governor Hogan for fiscal year 2016 in additional treatment and prevention funding and $189,000 in Governor's Office of Crime Control and Prevention grant funding to local law enforcement.

II. SYNOPSIS OF FINAL RECOMMENDATIONS

Below are synopses of the Heroin and Opioid Task Force's final recommendations.

EXPANDING ACCESS TO TREATMENT

1. **Implementing a Statewide Buprenorphine Access Expansion Plan**

   The Task Force recommends that the Behavioral Health Administration develop a plan to increase access to buprenorphine, including: a) increasing the number of physicians authorized and willing to prescribe buprenorphine in all regions of the state, and; b) integrating physician buprenorphine services with the publicly funded behavioral health treatment and recovery systems at the local level.

2. **Reviewing the Substance Use Disorder Reimbursement Rates Every Three Years**

   The Task Force recommends that the Department of Health and Mental Hygiene review Medicaid rates for substance use disorder treatment every three years.

3. **Expanding Access to Treatment through Payments to Non-Contracting Specialists and to Non-Contracting Nonphysician Specialists**

   The Task Force recommends legislation to require that the allowed amount an insurance carrier uses to pay benefits to non-contracting providers be no less than 140% of the allowed Medicare amount.

4. **Improving Provider Panel Lists**

   The Task Force recommends legislation to require carriers to provide prospective enrollees with a list of providers for the enrollee's health benefit plan, including names, addresses, specialty areas, and whether each provider is accepting new patients.

SYNOPSIS

- ✓ **Expanding Access to Treatment**
- ✓ **Enhancing Quality of Care**
- ✓ **Boosting Overdose Prevention Efforts**
- ✓ **Escalating Law Enforcement Options**
- ✓ **Reentry and Alternatives to Incarceration**
- ✓ **Promoting Educational Tools to Youth, Parents, and School Officials**
- ✓ **Improving State Support Services**

5. **Expanding Access to Training for Certified Peer Recovery Specialists**

   The Task Force recommends that the Department of Health and Mental Hygiene bring the nationally recognized Connecticut Community for Addiction Recovery trainers to Maryland to provide Connecticut Addiction Recovery coaching modules to enable our trainees to meet Maryland's Certified Peer Recovery Specialist credentialing requirements.

6. **Providing Recovery Support Specialists to Assist Pregnant Women with Substance Use Disorders**

   The Task Force recommends that the Behavioral Health Administration pilot a recovery support specialist program to work with women during pregnancy.

7. **Transitioning Inmates to Outpatient Addictions Aftercare and Community Providers**

   The Task Force recommends that the Department of Public Safety and Correctional Services create a transition process allowing inmates leaving incarceration with known substance use disorders to be engaged with community resource providers (faith-based organizations, peer support, and outpatient treatment programs) prior to release.

8. **Incentivizing Colleges and Universities to Start or Expand Collegiate Recovery Programs**

   The Task Force recommends that the Maryland Higher Education Commission develop strategies to incentivize colleges and universities to create collegiate recovery programs.

ENHANCING QUALITY OF CARE

1. **Requiring Mandatory Registration and Querying of the Prescription Drug Monitoring Program**

   The Task Force recommends legislation to require prescribers and dispensers to register with and use the Prescription Drug Monitoring Program when prescribing or dispensing controlled substances that contain an opioid or a benzodiazepine.

2. **Authorizing the Opioid-Associated Disease Prevention and Outreach Program**

   The Task Force recommends legislation authorizing any Maryland county to establish an Opioid-Associated Disease Prevention and Outreach Program to provide outreach, education, and linkage to treatment services, including the exchange of sterile syringes, to people who inject drugs.

3. **Requiring and Publishing Performance Measures on Addiction Treatment Providers**

   The Task Force recommends that the Department of Health and Mental Hygiene select generally accepted performance measures for addiction treatment providers and begin publishing provider-specific, regional and statewide data on them.

4. **Requiring Continuing Professional Education on Opioid Prescribing for the Board of Podiatric Medical Examiners and Board of Nursing and on Opioid Dispensing for the Board of Pharmacy**

   The Task Force recommends that the Board of Podiatric Medical Examiners and the Board of Nursing require the completion of one credit hour of continuing education related to opioid prescribing similar to that required by the Board of Physicians and the Board of Dental Examiners. In addition, the Board of Pharmacy should require the completion of one credit hour of continuing education related to opioid dispensing.

5. **Requiring Drug Monitoring for Medicaid Enrollees Prescribed Certain Opioids Over an Extended Time**

   The Task Force recommends regulation requiring some form of medication monitoring for Medicaid enrollees who are being prescribed certain opioids for more than 90 days for chronic pain arising from conditions that are not terminal.

Boosting Overdose Prevention Efforts

1. **Expanding Online Overdose Education and Naloxone Distribution**

   The Task Force recommends that the Behavioral Health Administration contract with a Web developer to create an online Overdose Response Program-compliant training module.

2. **Implementing a Good Samaritan Law Public Awareness Campaign**

   The Task Force recommends that the Department of Health and Mental Hygiene, in consultation with the Maryland Chapter of the National Council on Alcohol and Drug Dependence and family advocacy organizations, contract with a professional public relations/marketing organization to develop a comprehensive media campaign, including television, radio and social media, to raise awareness of the Good Samaritan Law in geographic overdose hotspots.

Escalating Law Enforcement Options

1. **Enacting a Maryland Racketeer Influenced and Corrupt Organization Statute**

   The Task Force recommends legislation to amend existing Maryland law to better model it after the federal Racketeer Influenced and Corrupt Organization Act (RICO) to aid in the prosecution of, and provide civil penalties for, drug trafficking as part of an ongoing criminal enterprise.

2. **Creating a Criminal Penalty for Distribution of Heroin or Fentanyl Resulting in Fatal or Nonfatal Overdose**

   The Task Force recommends legislation creating a crime for the direct or indirect distribution of heroin or fentanyl, the use of which is a contributing cause in the nonfatal overdose or death of another.

3. **Creating a Multi-Jurisdictional Maryland State Police Heroin Investigation Unit**

   The Task Force recommends the creation of a multi-jurisdictional Maryland State Police Heroin Investigation Unit.

4. **Designating HIDTA the Central Repository for Maryland Drug Intelligence**

   The Task Force recommends that all Maryland State Police heroin and opioid investigative activities be entered into the High Intensity Drug Trafficking Area's (HIDTA) Case Explorer and be designated as the central repository for statewide drug intelligence, and that all allied agencies report their drug intelligence to HIDTA.

5. **Enhancing Interdiction of Drug-Laden Parcels**

   The Task Force recommends that the Maryland State Police negotiate the inclusion of inspectors from various parcel services into existing State Police parcel interdiction units as task force members.

6. **Strengthening Counter-Smuggling Efforts in Correctional Facilities**

   The Task Force recommends that the Department of Public Safety and Correctional Services examine its current Front Entry Search policy and procedures to determine whether they align with national best practices and, if necessary, modify them in order to assist in eliminating the introduction of contraband into all correctional facilities.

REENTRY AND ALTERNATIVES TO INCARCERATION

1. **Establishing a Day Reporting Center Pilot Program to Integrate Treatment into Offender Supervision**

   The Task Force recommends that the Department of Public Safety and Correctional Services and the Governor's Office of Crime Control and Prevention collaborate with the Maryland Judiciary to establish a day reporting center pilot program.

2. **Expanding the Segregation Addictions Program in Correctional Facilities**

   The Task Force recommends the expansion of the Department of Public Safety and Correctional Services Segregation Addiction Program by adding three additional substance use counselors, which would quadruple the current capacity to 88 inmates.

3. **Implementing a Swift and Certain Sanctions Grid for Probation and Parole**

   The Task Force recommends legislation developing a swift and certain sanctions grid for nonviolent offenders released on probation and parole whose offenses relate to their substance use disorder.

4. **Institutionalizing a Substance Use Goal into the Maryland Safe Streets Initiative**

   The Task Force recommends that the Governor's Office of Crime Control and Prevention incorporate a new goal into Safe Streets that will allow the local Safe Streets coalition to address the issue of violent crime related to drug trafficking, substance use and addiction, with

a focus on heroin and opioids. It also recommends establishing peer recovery specialists within the Safe Streets model.

5. **Establishing a Recovery Unit at Correctional Facilities**

   The Task Force recommends that the Department of Public Safety and Correctional Services establish a pilot Recovery Unit at Eastern Correctional Institution to house offenders who are engaged in drug addiction programs and are invested in recovery.

6. **Studying the Collateral Consequences of Maryland Laws and Regulations on Employment of Ex-Offenders**

   The Task Force recommends that the Governor's Office of Crime Control and Prevention conduct a study of Maryland laws and regulations that establish a "Collateral Consequence," particularly unnecessary barriers to employment of ex-offenders.

PROMOTING EDUCATIONAL TOOLS FOR YOUTH, PARENTS, AND SCHOOL OFFICIALS

1. **Creating a User-Friendly Educational Campaign on School Websites**

   The Task Force recommends that the Maryland State Department of Education assist local school boards in the development and promotion of a drug education and information segment on school websites.

2. **Training for School Faculty and Staff on Signs of Student Addiction**

   The Task Force recommends that the Maryland State Department of Education assist school staff, including teachers, school resource officers, coaches, athletic directors, and guidance counselors, to receive training on the disease of addiction and signs that a student is abusing heroin or prescription opioids.

3. **Promoting Evidence-Based Prevention Strategies that Develop Refusal Skills**

   The Task Force recommends that the Maryland State Department of Education promote evidence-based programs to help students resist peer pressure while maintaining self-respect.

4. **Support Student-Based Film Festivals on Heroin and Opioid Abuse**

   The Task Force recommends that the Maryland State Department of Education evaluate the success of student-based film festivals and consider replicating it as a statewide initiative.

IMPROVING STATE SUPPORT SERVICES

1. **Implementing Comprehensive Heroin and Opioid Abuse Screening at the Department of Juvenile Services and the Department of Human Resources**

   The Task Force recommends that the Department of Juvenile Services develop a questionnaire that will be specifically designed to guide Department of Juvenile Services staff in a productive discussion with the youth and parent regarding opiates, including heroin, fentanyl, and prescription opioids, and other drugs. Similarly, the Task Force recommends that the Department

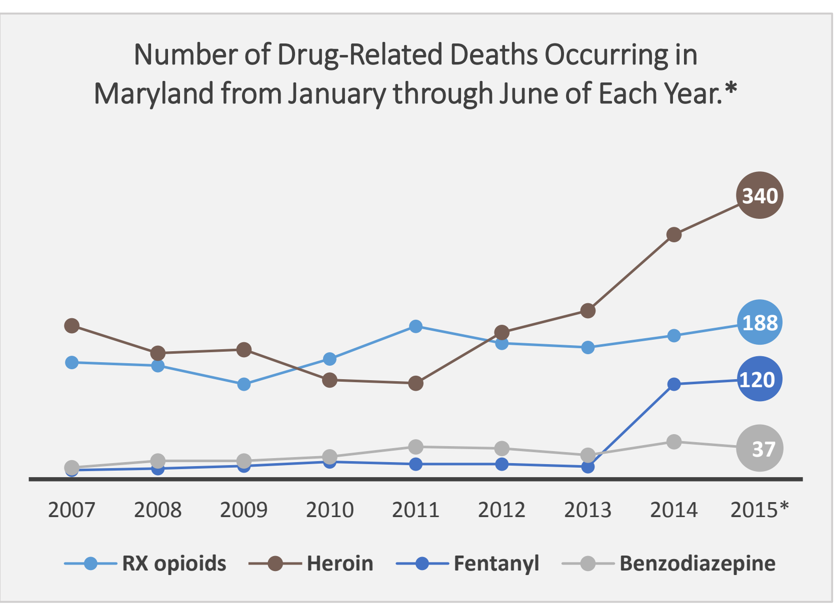
of Human Resources implement a comprehensive screening tool to identify clients and families affected by heroin and opioid use.

2. Establishing the Maryland Center of Excellence for Prevention and Treatment under the Behavioral Health Advisory Council

The Task Force recommends that a Center of Excellence for Prevention and Treatment be established under the Behavioral Health Advisory Council and housed in an academic setting. The Center would serve as the main body to provide critical oversight, a unifying strategy, and accountability for all prevention and treatment programming across the State. It would also serve as a source of independent information, data analysis, and evaluation of the effectiveness and coordination of prevention and treatment programming in Maryland; and to provide oversight such that programming is fully accountable across all agencies in accordance with metrics, outcome measures, standards of care, and performance evaluation.

III. INTRODUCTION

For the past eight years, Maryland has seen rising rates of drug- and alcohol-related overdose deaths. In 2013, there were 464 heroin overdose deaths versus 387 homicides and 482 motor vehicle fatalities. In 2014, there were 578 heroin overdose deaths versus 421 homicides and 511 motor vehicle fatalities. There has been a 60 percent rise in the total number of fatal drug- and alcohol-related overdoses in Maryland, from 649 deaths in 2010 to 1,039 deaths in 2014. According to the most recently available data, the number of deaths continued to increase in 2015. There were 599 drug- and alcohol-related deaths in the first half of 2015 (January to June), almost double the number of deaths that occurred in the same period in 2010.



DATA SOURCE: MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
*2015 COUNTS ARE PRELIMINARY

The overall rise in the number of drug- and alcohol-related deaths is largely attributable to increases in the number of heroin and fentanyl-related deaths. In 2015, heroin-related overdose deaths increased by 186 percent, from 119 to 340, when comparing the first six months of 2010 to the first six months of 2015; this increase is in stark contrast to the 35 percent decline that occurred during the first six months of 2007 to the first six months of 2010. Data from recent years demonstrates that increases in heroin-related deaths have occurred among all demographic groups and across all regions of the state. Evidence suggests that the rise in heroin-related deaths may, in part, originate from increased prescription opioid misuse, as heroin is a cheaper, more potent, and widely available alternative.

An emerging threat in Maryland is the spike in fentanyl-related overdose deaths. Beginning in late 2013, there were sudden and large increases in the number of deaths involving fentanyl in a number of states, including Maryland. The majority of these deaths were not the result of overdoses of pharmaceutical fentanyl, but instead involved an illicit, powdered form of fentanyl that was mixed with, or substituted for, heroin or other illicit substances. Fentanyl is many times more potent than heroin, and greatly increases the risk of an overdose death.

A total of 120 fentanyl-related deaths occurred in Maryland between January and June 2015. This is an average of 20 deaths per month, compared with an average of two deaths per month in Maryland during the years 2007-2012. Many of the fentanyl deaths occurring in Maryland since October 2013 occurred following the use of fentanyl in combination with other substances, mainly heroin. Fentanyl-related deaths also frequently involved the concurrent use of prescription opioids, alcohol, and/or cocaine.

> ***"We are now faced with a situation where deaths from heroin overdoses are outpacing the murder rate."***
>
> *–Lt. Governor Boyd K. Rutherford*

In response, under the direction of Governor Larry Hogan and pursuant to Executive Orders 01.01.2015.12 and 01.01.2015.13, State resources have been devoted to confronting this heroin and opioid epidemic through a comprehensive approach that includes education, treatment, improvements to quality of care, law enforcement, alternatives to incarceration, and overdose prevention. Specifically, over 300 State employees are working on this health crisis in some capacity. In addition, approximately 770 State troopers are trained and equipped with naloxone. Excluding Medicaid expenditures, agencies have spent approximately $189 million in fiscal year (FY) 2015 and FY 2016 (to date) on combatting the heroin and opioid epidemic. Though Medicaid expenditures to date are imprecise, the total estimated expenditures including Medicaid are approximately $400 million.

In addition, earlier this year, the Task Force held six regional summits throughout the State to hear testimony from those with substance use disorders, family members, educators, faith leaders, elected officials, law enforcement, addiction treatment professionals, and other stakeholders. An approximate total of 223 people testified before the Task Force—21 elected officials, 31 law enforcement officials, 78 addiction treatment professionals, and 93 members of the general public. In addition, dozens of people submitted written testimony, suggestions, and comments to the Task Force through its Web portal and email address.

Excluding the Task Force members, 431 stakeholders contributed to the production of this Final Report and the 33 recommendations herein. All of the recommendations below are informed by a commitment to a behavioral health system that ensures high-quality, integrated addiction treatment services.

IV. MILITARY DEPARTMENT COUNTERDRUG STRATEGY

The Maryland National Guard, led by Adjutant General Linda L. Singh, is a critical component of the State's efforts in combating the heroin and opioid epidemic. In 2016, the Maryland National Guard Counterdrug Program will primarily focus on providing the State's law enforcement agencies with military-unique criminal analysis capabilities in support of the State's fight against the heroin and opioid epidemic. The Counterdrug Program will assign Criminal Analysts to the following agencies: Maryland Coordination and Analysis Center, W/B HIDTA, U.S. Department of Homeland Security Investigations-Immigration and Customs Enforcement (Division of Money-Laundering Investigation Initiative and Port Group Initiative), Baltimore City Police Department, and the Drug Enforcement Agency Baltimore Office. These Criminal Analysts will analyze and disseminate intelligence products within the law enforcement community in order to enhance their ability to quickly close cases and bring illegal drug traffickers to justice.

A balanced approach to confronting the State's drug threats and vulnerabilities will be obtained by supporting both interdiction and prevention. Civil Operations support will also be provided to coalitions and community organizations. The Civil Operations program targets Maryland's primary drug threats by integrating, enhancing, and building partnerships with community-based coalitions that share a common goal to deter and prevent the illicit abuse of controlled substances. The Program helps coalition partners target emerging drug threats and trends among youths, such as club drugs, designer drugs, and prescription drugs. The Civil Operations plan emphasizes proactive assistance through long-term relationships with supported coalitions and community-based organizations.

This plan focuses on non-duplication of efforts by sharing all common resources devoted to educating children, young adults, and the community at large concerning the dangers of drugs, drug abuse, and drug related crime and violence. Additionally, the intent is to assist communities to reduce bullying and cyber-bullying among youths—a major contributor to substance use and often linked to youth violence and even suicide. Civil Operations takes an active leadership and organizing role in coalition development and the coordination of drug awareness/prevention efforts among various partners within the broader Maryland community. Finally, Civil Operations promotes the readiness of Maryland National Guard forces by promoting drug education and awareness activities within the National Guard community and assisting the G1, Alcohol and Drug Control Officer Prevention Coordinator, Yellow Ribbon Reintegration Program, and Family Support Program.

V. A STEP TOWARD TREATMENT ON DEMAND

There is a growing need across the State for treatment services for individuals with heroin and opioid addiction. Unfortunately, barriers to accessing treatment in a timely manner for some populations remains a significant problem. The key to improving access to high-quality treatment lies in creating a delivery system that provides a full continuum of substance use services and care.

There are health care facilities in Maryland that are well suited to provide the necessary clinical care and support services for individuals on an urgent basis and assist in transitioning patients to the appropriately assessed level of care. Offering crisis services will relieve pressure on hospital acute-care systems. In addition, health care facilities in non-metro counties, where the rate of addiction to heroin and opioids is growing and in-patient treatment is insufficient, could be possible targets for services.

At the request of the Task Force, stakeholders, including the Department of Health and Mental Hygiene, local hospitals, skilled nursing and rehabilitation centers, and law enforcement, will be brought together to develop a pilot program that establishes a full continuum of substance use disorder services in a target area. Unique incentives and new models will be explored, including leveraging excess space in various health care facilities to provide additional care, residence, and treatment for individuals with heroin and opioid use disorders. The pilot program will identify target populations, gaps in the delivery system and support services, and measures to ensure safety for all residents. The greatest challenge, however, will be navigating federal and state regulations, insurance, and Medicaid reimbursement for treatment services.

VI. TASK FORCE FINAL RECOMMENDATIONS

The Task Force final recommendations below are arranged in categories consistent with Executive Order 01.01.2015.12: Expanding Access to Treatment; Enhancing Quality of Care; Boosting Overdose Prevention Efforts; Escalating Law Enforcement Options; Promoting Educational Tools for Youth, Parents, and School Officials; Reentry and Alternatives to Incarceration; and Improving State Support Services.

EXPANDING ACCESS TO TREATMENT

1. Implementing a Statewide Buprenorphine Access Expansion Plan

Buprenorphine is a partial opioid agonist medication with demonstrated efficacy in the treatment of opioid use disorder. The federal Drug Abuse Treatment Act (DATA) of 2000 allows physicians who have completed required training to prescribe buprenorphine medications (most commonly Suboxone) for opioid addiction treatment. Buprenorphine can be prescribed by a physician in an office setting and dispensed by a pharmacy, providing greater flexibility compared to opioid treatment programs, which, under federal regulation, typically require patients to be dosed on-site at a clinic. Maryland has made great strides in expanding access, particularly at the local level through model strategies like the Baltimore Buprenorphine Initiative (BBI). However, there is still a shortage of buprenorphine providers. The Behavioral Health Administration estimates that there are currently less than 800 physicians actively prescribing in the state. Of providers authorized to treat up to 30 patients, less than half of those are active prescribers.

The shortage of providers creates problems for both patients and the treatment system. Opioid addicted individuals who cannot access a provider may seek diverted buprenorphine in an attempt to self-treat. Scarcity creates an incentive for prescribers to run cash-only practices, denying access to those with private insurance and Medicaid. Due to high demand, these practices can expand quickly and become unstable, compromising quality of care. Early access expansion initiatives were successful in bringing on eager early adopters. A new plan development process is needed to understand what gaps and barriers to access remain in different areas of the State and to identify an appropriate strategy to meet the increased demand created by the opioid addiction epidemic.

As such, the Task Force recommends that Behavioral the Health Administration (BHA) develop a plan to increase access to buprenorphine including: a) increasing the number of physicians authorized and willing to prescribe buprenorphine in all regions of the state, and; b) integrating physician buprenorphine services with the publicly-funded behavioral health treatment and recovery systems at the local level. BHA should hire a project coordinator and convene a steering committee of internal and external experts, including individuals involved in development of existing model strategies, to advise plan development. BHA should conduct a

systematic review of buprenorphine initiatives in Maryland and other states, review buprenorphine funding currently provided to local jurisdictions, and analyze data from the Prescription Drug Monitoring Program, Medicaid claims and other sources to detail current prescribing trends.

2. Reviewing the Substance Use Disorder Reimbursement Rates Every Three Years

Despite efforts to provide rate increases for substance use disorder providers to account for the increased cost to deliver care, the State budget has not included a substantial (or adequate) rate increase for over 10 years. Low rates negatively impact the quality of, and access to, treatment services. Furthermore, the gap between reimbursement rates and costs further erodes the workforce shortage in the State.

To attract physicians to the field, the State must offer higher reimbursement. Over the past few years, the mental health workforce has received a cost of living adjustment (COLA) increase while the substance use disorder treatment workforce has not. All this has occurred at a time when practitioners are in higher demand. Payment rates must be reviewed to ensure high-quality services. With this in mind, a commitment to proper reimbursement for substance use disorder treatment providers is common sense.

The Task Force recommends that the Department of Health and Mental Hygiene review Medicaid rates for substance use disorder treatment every three years. With such a review, the State can promote a more thriving workforce and expanded capacity while increasing access to high-quality care.

3. Expanding Access to Treatment through Payments to Non-Contracting Specialists and to Non-Contracting Nonphysician Specialists

In order to address the issue of network adequacy, the Task Force recommends legislation to require that the allowed amount an insurance carrier uses to pay benefits to non-contracting providers be not less than 140% of the allowed Medicare amount. This new provision to Insurance Article, Section 15-830 would only apply when the provider network is inadequate, not when the patient voluntarily goes out-of-network for services. This law would give carriers more incentive to contract with providers and will assure members that they get a reasonable benefit when a network provider is not readily available.

4. Improving Provider Panel Lists

There continues to be a large number of complaints regarding the accuracy of the information contained in insurance provider directories. Currently, carriers must update their directories within a specific period but only when they are contacted by the provider with a change to the information. The Task Force recommends legislation requiring carriers to provide prospective enrollees with a list of providers for the enrollee’s health benefit plan, including names, addresses, specialty areas, and whether each provider is accepting new patients. The provider panel list is required to be accurate upon publication and annually thereafter. This legislation would protect consumers as they enroll in coverage ensuring that the provider lists are accurate

and provide necessary information to make an informed decision. By providing accurate provider directories, consumers will be able to more easily find behavioral health care providers who are in-network with their insurance carrier.

5. Expanding Access to Training for Certified Peer Recovery Specialists

Maryland's newest behavioral health system workforce members, identified as peer recovery coaches, are individuals in long-term recovery, family members, and allies with lived experience in substance use disorder or mental illness. They provide recovery support services to individuals seeking treatment or long-term recovery help to sustain their recovery. There are approximately 500 peer recovery coaches trained and employed or volunteering throughout Maryland in local health departments, hospitals, treatment centers, community centers, and recovery centers. However, the peer coaches are experiencing challenges with access to the trainings needed to meet Maryland's Certified Peer Recovery Specialist credential, and to enhance their professional development within the workforce.

Therefore, the Task Force recommends that the Department of Health and Mental Hygiene facilitate the travel of individuals who have completed the nationally recognized Connecticut Community for Addiction Recovery (CCAR) trainer of trainers (TOT) modules to Maryland to provide CCAR recovery coaching TOT modules for trainees to meet Maryland's CPRS credentialing requirements. These trainers must also be approved by the Maryland Addiction and Behavioral Health Professionals Certification Board to offer continuing education hours before they can begin to train others in the CCAR Recovery Coach model. These trainings would enhance the State's ability to meet the currently unmet training needs of the peer workforce. It would also enhance the marketability and earning power of individuals in recovery who are often stigmatized or discriminated against because of their past. Each newly trained Maryland peer recovery coach would commit to train at least two other people to become certified peer recovery coaches.

6. Providing Recovery Support Specialists to Assist Pregnant Women with Substance Use Disorders

There are tremendous medical, social, emotional, and financial consequences and costs stemming from pregnant women with substance use disorders. Women are more likely to have multiple co-morbidity (three or more psychiatric diagnoses in addition to substance use disorder) than are men. According to data from the Department of Human Resources, approximately 29,000 cases of substance-exposed newborns were reported between 2013 and 2014. Data from Department of Health and Mental Hygiene shows that 60 percent of the women who engage in the public behavioral health system sought treatment for heroin, oxycodone, or non-prescription methadone. This population of women also had a history of trauma, intimate partner violence, criminal justice involvement, and less involvement with medical professionals, and late prenatal care. Unfortunately, these women experience greater social stigma than men which tends to keep them isolated and unwilling to seek help.

Approximately 29,000 cases of substance-exposed newborns were reported between 2013 and 2014

In response, the Task Force recommends that Behavioral Health Administration pilot a recovery support specialist program to work with women during pregnancy. The recovery support specialist would be stationed within three targeted jurisdictions that have been identified as having the highest rates of prenatal substance use. The recovery support specialist will work with the women to assist them with remaining abstinent during treatment and work with them to ensure compliance with medical appointments, support services, and their treatment. They will also work with treatment staff to support the women if there is a relapse, as well by assisting with placement in higher levels of treatment, if necessary.

7. Transitioning Inmates to Outpatient Addictions Aftercare and Community Providers

An offender's best chance of success upon completion of in-prison treatment services involves pre-release linkages with post treatment services. The establishment of these links prior to an offender's release would produce the best outcomes, primarily reducing recidivism. Beginning with inmates returning to Baltimore City, the Task Force recommends that the Department of Public Safety and Correctional Services create a transition process allowing inmates leaving incarceration with known substance use disorders to be engaged with community resource providers (faith-based organizations, peer support, and outpatient treatment programs) prior to release. All offenders should have made successful application for health insurance and have requisite medical, mental health, and addictions appointments scheduled prior to release.

8. Incentivizing Colleges and Universities to Start or Expand Collegiate Recovery Programs

Too many college campuses are fraught with the opportunity to drink and use drugs. If a student who is in recovery is in such an "abstinence-hostile" environment, it is challenging to say the least. Having a safe meeting place for those in recovery to gather and provide mutual support, along with having safe and "sober" housing where students will not be exposed to alcohol and other drugs, is ideal.

The Task Force recommends that the Maryland Higher Education Commission develop strategies to incentivize colleges and universities to create collegiate recovery programs (CRPs). The CRP movement began at Brown University in 1977. Rutgers University (1983) also created a school-based recovery support service program. Texas Tech University (1986) evolved the CRP into a fully developed recovery community. A CRP is a supportive environment within the campus culture that reinforces the decision to disengage from addictive behavior. It is designed to provide an educational opportunity alongside recovery support to ensure that students do not have to sacrifice one for the other.

> ***"The goal of this emergency task force is to shine a light on heroin and the havoc it is causing in Maryland. From preventing our kids from using heroin in the first place to increasing and improving access to treatment services for those in recovery, this task force will employ every resource available to take a holistic approach to address this public health emergency."***
>
> *–Lt. Governor Boyd K. Rutherford*

To send an adolescent away to residential treatment only to return to the same environment

(particularly the school environment in which he/she might have used drugs with their friends) is setting them up for failure. CRP's can provide a safe environment for college students, offering alcohol/drug-free activities and the mutual support of others similarly engaged in recovery efforts while rebuilding their lives and their hope for a brighter future through educational advancement. CRPs are not only a place for those in recovery, but also for those seeking recovery.

ENHANCING QUALITY OF CARE

1. Requiring Mandatory Registration and Querying of the Prescription Drug Monitoring Program

Prescription drug monitoring programs (PDMP) are recommended by the American Medical Association and the Centers for Disease Control and Prevention as an important component of a comprehensive strategy to address the opioid addiction and overdose epidemic. The Maryland PDMP was created to assist medical, pharmacy, and public health professionals in the identification and prevention of prescription drug abuse, support law enforcement and regulatory agencies in the identification and investigation of prescription drug diversion. It also promotes balanced use of prescription data that preserves the professional practice of healthcare providers and legitimate patient access to optimal pharmaceutical-assisted care. Healthcare providers may access their patients' PDMP data through Chesapeake Regional Information System for our Patients (CRISP), the state-designated health information exchange (HIE). Maryland's PDMP is unique in the country as having been fully integrated at implementation into a statewide HIE. In addition to PDMP data, CRISP users can access information on patient encounters at all acute care hospitals in Maryland and multiple hospitals in DC and Delaware, laboratory and radiology reports, and other clinical documents. Provider interest in and use of PDMP data has helped drive increases in registration with CRISP and utilization of other CRISP services, providing a major opportunity to expand use of this important clinical tool throughout the state.

Despite consistent increases in user registration and access since implementation, widespread adoption of PDMP use has not occurred thus far. There is no requirement on prescribers or dispensers to access PDMP data before prescribing or dispensing a controlled substance medication. Currently, 33 states have laws or regulations that require healthcare practitioners to either register with the PDMP in order to query data (mandatory registration) and/or to query PDMP data at specific times, such as when first prescribing a controlled substance to a patient (mandatory use). Although the specific requirements of mandatory use laws vary considerably across the country, states that have recently adopted broad use mandates have seen decreases in the number of patients receiving controlled substance prescriptions from multiple providers, an indicator of possible prescription drug misuse, addiction, or diversion. The Department of Health and Mental Hygiene estimates that over 300 individuals in Maryland received controlled substance prescriptions from five or more prescribers during the month of July 2015 alone. Nearly as many received prescriptions from 15 or more prescribers during the first nine months of 2015, with some seeing as many as 40 prescribers during this period.

These numbers indicate potentially large-scale misuse and diversion that could be addressed through consistent prescriber and dispenser use of the PDMP.

> ***Over 300 individuals in Maryland received controlled substance prescriptions from five or more prescribers during the month of July 2015 alone***

States that mandate comprehensive PDMP use, such as New York, Ohio, Kentucky, and Tennessee, have experienced decreases in prescribing of commonly abused controlled substances and decreased doctor shopping.[1] Therefore, the Task Force recommends legislation requiring prescribers and dispensers to register with and use the Prescription Drug Monitoring Program when prescribing or dispensing controlled substances that contain an opioid or a benzodiazepine. The legislation should establish a phased implementation approach that starts with mandatory registration and then proceeds to mandatory use. The implementation timeline should conform to DHMH's estimated dates for when the PDMP's information technology and administrative capacity can be enhanced to support increases in provider registration and use, with the goal of implementing a use mandate within 2 years of the legislation's effective date. The legislation may allow the DHMH Secretary to determine specific compliance deadlines in regulations following consultation with the Advisory Board on Prescription Drug Monitoring and other stakeholders. Consideration should be given to tying the registration mandate to initial receipt or renewal of prescriber's State Controlled Dangerous Substance (CDS) permit, which would allow for a rolling registration requirement as practitioners renew their permits on a 2-year schedule.

The use mandate should apply broadly to healthcare providers when prescribing or dispensing a drug to a patient for the first time to treat a specific condition, and then at regular intervals after the initial query should the treatment for the specific condition continue to include prescribing or dispensing medication containing an opioid and/or benzodiazepine. The legislation should also provide exceptions to the use mandate when the PDMP is unavailable for query due to technical problems, in emergency situations where accessing the PDMP would adversely impact a patient's medical condition, and in clinical situations that present a relatively low risk of drug misuse or diversion due to patients seeking drugs from multiple providers, including prescribing and dispensing to patients who are in hospice care, being treated for cancer-related pain or residing in nursing homes and other facilities often served by a single dispenser.

Finally, the legislation should also expand the types of clinical support staff that prescribers can delegate to access PDMP on their behalf to include unlicensed staff like medical assistants and emergency room scribes. Currently, prescribers and dispensers can only delegate access to PDMP data to other licensed healthcare practitioners. This is not consistent with how many healthcare facilities pull patient data for prescriber decision-making and CRISP currently allows unlicensed staff to access non-PDMP clinical data in the Patient Query Portal.

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[1] Johns Hopkins Bloomberg School of Public Health, THE PRESCRIPTION OPIOID EPIDEMIC: AN EVIDENCE BASED APPROACH, November 2015.

Robust educational campaigns would accompany introduction of both the registration and use mandate so that affected healthcare professionals are informed about the requirements as well as how to appropriately access and make use of PDMP data in their prescribing and dispensing decision-making. In addition, although the web-based CRISP Patient Query Portal provides a wealth of information, it requires a separate log-in from hospital or ambulatory clinic electronic medical records (EMRs) utilized by most practitioners within the practice setting. Health IT integrations, such as creating a single sign-on (SSO) connection between the CRISP Query Portal and a practitioner's EMR, or displaying PDMP data directly within an EMR, would ease the time and IT burden on clinical providers. Additionally, automating and streamlining the registration process would reduce administrative burden under a registration mandate. Finally, ensuring high data quality is essential to appropriate utilization of the PDMP data by prescribers and dispensers under a mandate, as well as the ability of the Program to resolve in a timely manner the higher volume of data errors sometimes discoverable only by clinical users during access of PDMP data.

2. Authorizing the Opioid-Associated Disease Prevention and Outreach Program

The Task Force recommends legislation authorizing any county in Maryland to establish an Opioid-Associated Disease Prevention and Outreach Program to provide outreach, education, and linkage to treatment services, including the exchange of sterile syringes to people who inject drugs. This recommendation builds on Chapter 251 of the Acts of 1998, which established the Prince George's County AIDS Prevention Sterile Needle and Syringe Exchange Program in Title 24, Subtitle 9 of the Health – General Article. Syringe exchange programs are also authorized in Baltimore City.

This recommendation is timely as Maryland and many other states across the country are looking for evidence-based strategies such as syringe exchange to address opioid addiction, overdose, and related problems. Syringe exchange programs – an evidence-based approach to the reduction of drug overdoses and drug-related health issues such as HIV and Hepatitis C virus – provide free sterile syringes and collect used syringes from people who inject drugs, to reduce transmission of blood-borne pathogens, including HIV, hepatitis B virus, and hepatitis C virus. For example, in response to an outbreak of HIV and hepatitis C (HCV), the Indiana General Assembly passed legislation in 2015 to authorize syringe exchange programs in the state. This Task Force's recommendation builds on conversations that Maryland Department of Health and Mental Hygiene officials have had with Indiana officials to comprehensively address the health of all persons who inject drugs with the goal of preventing deaths, preventing and treating health conditions and complications, providing access and linkage to care, and reducing hospitalizations and medical costs associated with injection drug use.

This proposal, as a structural intervention, also plays an important role in bridging users who are ready for recovery into substance-related treatment by ensuring that patients receive additional services essential to improving their overall health, including linkages to prenatal services, and reduce hospitalizations, medical complications, and costs for these patients and hospitals. Disease prevention and outreach programs also create strategic opportunities to

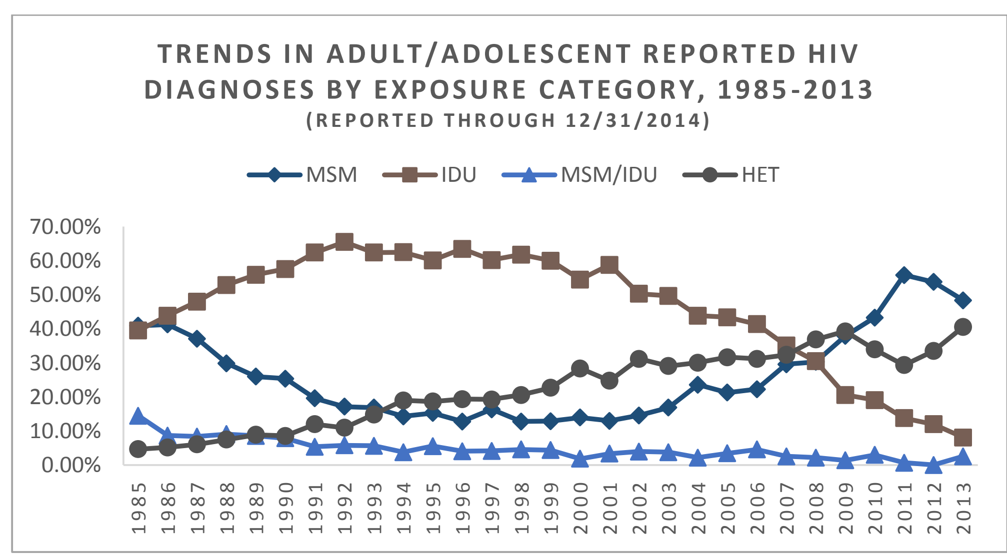
disseminate Naloxone – a fast-acting medication that interrupts and thwarts an overdose in progress – to people who inject drugs, thus saving lives.

Drug- and alcohol-related intoxication deaths increased dramatically from 2010 (649) through 2014 (1,039), as non-prescription users of prescription opioids have faced increased difficulty acquiring pain medications and have switched to heroin, which is generally more readily available and less expensive. There was a 25 percent increase in the number of heroin-related deaths between 2013 (464) and 2014 (578), and heroin-related deaths have more than doubled between 2010 (238) and 2014 (578). Whereas injection drug use is widely considered an urban problem, in 2014 heroin use and related overdose deaths occurred in every county in Maryland and in Baltimore City.

> ***"This is a problem that does not have an easy or overnight solution. This task force will employ every resource available in order to develop a holistic approach to fight this public health emergency."***
>
> *–Lt. Governor Boyd K. Rutherford*

There has been an increase in sharing of needles among heroin users, because possession of needles is a crime in all Maryland jurisdictions except for Baltimore City and Prince George's County. Needle sharing and reuse increases the spread of diseases, including HIV and HCV.

Reduction in HIV transmission among people who inject drugs is one of the success stories of HIV prevention in general, and this success is attributed in large part to sterile syringe access. An examination of HIV prevalence among people who inject drugs worldwide found that on average, the prevalence of HIV infection among people who inject drugs increased by 5.9 percent per year in select cities without syringe exchange programs, and decreased by 5.8 percent per year in select cities with syringe exchange programs. Furthermore, syringe exchange programs are well documented as cost-effective and cost saving for the prevention of HIV. In Maryland, since the launch of Baltimore City Health Department's (BCHD) Needle Exchange Project, the proportion of new infections attributed to the sharing of injection drug equipment declined from 62.0 percent in 1994 to 11.9 percent in 2011 (see graph below).



Additionally, sterile syringe exchange programs promote the prevention of the spread of HCV infections among people who inject drugs. In developed countries, 50-80 percent of HCV infection occurs in people who have injected drugs, and the prevalence of HCV among people who have injected drugs is approximately 65 percent. In the United States, the rate of new HCV infections has risen, more than doubling from 0.3 cases per 100,000 people in 2010 to 0.7 cases in 2013.

Prevention of HIV and HCV is critical, because these diseases not only lead to loss of life or quality of life, but also require expensive treatment. For example, best-practice treatment of HCV is primed to cost the United States healthcare system an additional $65 billion dollars in the next 5 years. Sterile syringe exchange, in conjunction with outreach, education, counseling, and linkage to care programs increases access to and initiation of HCV treatment. This is critical in preventing the spread of HCV and the incidence of new HCV infections.

3. Requiring and Publishing Performance Measures on Addiction Treatment Providers

There is a growing body of knowledge about the critical characteristics of successful substance use disorder (SUD) treatment, including patient engagement, quality clinical practices and transitions in care. Access to treatment, for example, is extremely sensitive to delays in intake and first appointment time. Similarly, if patients are not assisted in making transitions in care, dropout rates are high and any benefits of initial interventions are wasted. In spite of this, most providers or systems do not collect and report information on any key performance areas. Performance information is not just important to payers, but also to patients and their families and could inform their selection of types of treatment and specific providers.

The Task Force recommends that the Department of Health and Mental Hygiene select generally accepted performance measures and begin publishing provider-specific, regional and statewide performance data. Priority targets include the following:

- **Initiation and Engagement in Treatment (I&ET):** I&ET shows what percentage of patients who are given a SUD diagnosis actually begin treatment and remain in treatment for 30 days.
- **Treatment completion rates:** While most experts acknowledge that SUD is a remitting and relapsing condition, there are variations in completion rates across providers that relate to the quality of care provided.
- **Continuing care rates:** The State can begin gathering data on the transition from withdrawal management to any treatment. The importance of this transition demands attention if withdrawal management is to have a useful role in the SUD continuum of care.

4. Requiring Continuing Professional Education on Opioid Prescribing for the Board of Podiatric Medical Examiners and Board of Nursing and on Opioid Dispensing for the Board of Pharmacy

Effective for the 2015 license renewal, all Maryland physicians are required to complete one credit hour of continuing medical education dedicated to appropriate opioid prescribing. Similarly, the Board of Dental Examiners required that every dentist seeking license renewal in

2015 and thereafter must complete a 2-hour Board-approved course on proper prescribing and disposal of prescription drugs. However, this education requirement does not apply to podiatrists or nurses, who can also prescribe opioids. As such, the Task Force recommends that the Board of Podiatric Medical Examiners and the Board of Nursing require the completion of one credit hour of continuing education related to opioid prescribing similar to that required by the Board of Physicians and the Board of Dental Examiners.

In addition, while pharmacists do not prescribe opioids, they should have a complete understanding of their role in this epidemic as one of the main providers to dispense opioids. The Task Force also recommends that the Board of Pharmacy require the completion of one credit hour of continuing education related to opioid dispensing.

5. Requiring Drug Monitoring for Medicaid Enrollees Prescribed Certain Opioids Over an Extended Time

Although the Prescription Drug Monitoring Program can alert doctors to certain problems related to doctor shopping, it cannot uncover the patient who only gets his prescription drugs from only one doctor, filled at the same pharmacy, once a month on a regular schedule, but sells for profit or otherwise diverts the pills. According to a study conducted by Ameritox, a provider of medication monitoring services, 48 percent of samples in Maryland contained a drug not prescribed by the doctor who ordered the screen, which is the second worst rate they have found in the country.[2] Numerous states, including Kentucky, Indiana, Washington, and Georgia, have mandated some form of medication monitoring for those who are being prescribed opioids for the long-term. Medication monitoring is a simple, in-office urine drug test that screens for the prescribed opioid, and other non-prescribed and illicit drugs.

> ***48** percent of samples in Maryland contained a drug not prescribed by the doctor who ordered the screen*

The Task Force recommends regulation requiring some form of medication monitoring for Medicaid enrollees who are being prescribed certain opioids for more than 90 days for chronic pain arising from conditions that are not terminal. Cancer patients would be excluded from these rules. Other exceptions to the requirement may include hardship on the patient in certain cases.

Drug monitoring for Medicaid enrollees could lead to better health outcomes by detecting possible diversion of prescription opioids or the presence of non-prescribed or illicit drugs in urine samples.

[2] Ameritox tested 16,248 samples, from September 1, 2013 to August 31, 2014, all of which were submitted by doctors and clinics located in Maryland. 7,866 of the 16,248 samples contained a drug that the doctor who sent off the test had not prescribed. 3,249 contained an illicit drug, a category that included marijuana.

BOOSTING OVERDOSE PREVENTION EFFORTS

1. Expanding Online Overdose Education and Naloxone Distribution

Since March 2014, the Department of Health and Mental Hygiene (DHMH) Behavioral Health Administration (BHA) has administered the overdose response program (ORP) to increase online overdose education and naloxone distribution throughout the State. BHA authorizes local-level entities, including local health departments (LHD), community-based organizations, treatment providers and others, to conduct trainings and issue certificates to trainees. ORP certificate holders are then legally authorized to be prescribed and dispensed naloxone for use on someone believed to be experiencing an opioid overdose.

> Over **7,000** ***individuals trained through existing online models***

This decentralized training model has advantages, including: expedited program implementation through utilization of existing funding streams and LHD personnel, flexibility for local jurisdictions, and reduction in State administration costs. However, limitations include uneven online overdose education and naloxone distribution availability statewide and training that is less focused on targeting populations – like drug users and family/friends – who are more likely to witness and respond to an overdose.

A state-level online overdose education and naloxone distribution program – paired with improved pharmacy access – could improve access for Marylanders living in underserved geographic areas and those with other personal or social barriers to accessing existing programs. Existing online training models, including getnaloxonenow.org, has trained over 7,000 people. As such, the Task Force recommends that BHA contract with a web developer to create an online ORP-compliant training module. The training should be interactive and require trainees to demonstrate knowledge of overdose recognition and response in order to obtain a certificate.

As currently required of ORP entities, BHA should track identifying information about trainees. DHMH should identify a staff physician to issue a statewide standing order for dispensing to ORP certificate holders by licensed pharmacists, as authorized by Senate Bill 516 (2015). BHA and the physician will then work together to develop a standing order protocol requiring that pharmacists provide hands-on instruction to certificate holders in how to assemble and use the specific naloxone delivery device. In addition, BHA should develop a process to track naloxone dispensing through the Prescription Drug Monitoring Program. Through ongoing coordination with pharmacies and pharmacy organizations and possible PDMP-based data collection, DHMH will expand dissemination of information on pharmacy naloxone availability.

2. Implementing Good Samaritan Law Public Awareness Campaign

In 2014, the Department of Health and Mental Hygiene initiated the "Be a Hero, Save a Life" campaign to raise awareness of how to recognize opioid overdose, respond with naloxone, and access treatment services through 211. During this past legislative session, Senate Bill 654 expanded "Good Samaritan" protections for those who experience, or seek help for someone

experiencing, an overdose, to include immunity from arrest, charge or prosecution for many drug and alcohol possession crimes, as well as violation of a condition of pre-trial release, probation, or parole.

The Task Force recommends that the Department of Health and Mental Hygiene, in consultation with the Maryland Chapter of the National Council on Alcohol and Drug Dependence (NCADD) and family advocacy organizations, contract with a professional public relations/marketing organization to develop a comprehensive media campaign, including television, radio, and social media, to raise awareness of the Good Samaritan Law in geographic overdose hotspots.

ESCALATING LAW ENFORCEMENT OPTIONS

1. Enacting a Maryland Racketeer Influenced and Corrupt Organization Statute

The In 1970, Congress passed the Racketeer Influenced and Corrupt Organizations (RICO) Act in an effort to combat Mafia groups. Since that time, the law has been expanded and used to go after a variety of organizations, from corrupt police departments to motorcycle gangs. Beginning in 1970, 33 states, as well as Puerto Rico and the US Virgin Islands, adopted state RICO laws to cover additional state offenses under a similar scheme. Maryland is not one of these states.

The benefits of a state RICO law in Maryland would allow local prosecutors to aggregate a series of events and provide a full picture of the type of illegal activity surrounding many drug distribution rings that are present in our communities. Frequently, a drug ring will not only distribute drugs, they will employ violence, break into houses, take over homes, and distribute out of them. In short, they will "lock down" a particular community in order to provide a drug distribution area. For example, a Maryland RICO law would help the State effectively combat drug trafficking where an organization has terrorized certain communities. Here the organization, through violence and financial influence, maintains houses to deal drugs in the community. Focusing on the organization and allowing prosecutors to hold contributing members of the criminal enterprise responsible for the results of the enterprise rather than the small individual acts of the actors is a significantly more powerful tool than prosecuting the single cases, which would otherwise make up the predicate acts, on an individual basis.

Most recently, Federal authorities used RICO to prosecute BGF members for criminal conduct arising inside of the Baltimore City Jail. To fully hold these perpetrators accountable under existing State statutes would have been impossible.

A Maryland RICO law should not be thought of or used as a way to punish the commission of an isolated criminal act. Rather, the law establishes severe consequences for those who engage in a pattern of wrongdoing as a member of a criminal enterprise. RICO requires the prosecution to prove that an "enterprise" (a group consisting of at least three people) committed at least two or more predicate acts (enumerated crimes associated with organized criminal activity) that constitutes a pattern of racketeering activity. Any member of any criminal enterprise can be charged with RICO racketeering if he can be shown to have committed two of 27 federal or eight state charges within a 10-year period as part of the enterprise. A person can be charged

even if that person did not directly commit the crime but only agreed to the commission or conspired with the perpetrators in any way.

While conspiracy laws are generally sufficient to prosecute a simple drug conspiracy, they do not accurately capture the broad array of crimes that are present in many of the street level narcotics operations too small for the federal authorities to touch. Moreover, these street level operations fit more accurately under RICO than they do under the complicated and unwieldy Maryland Gang Statute (which originally was modelled after Federal RICO but was subsequently altered during legislative deliberations into its present form.)

Additionally, RICO statutes provide for broad civil forfeiture remedies as a tool for dismantling criminal enterprises. Following a conviction, the government is automatically given a forfeiture of all of the defendant's interest in the organization. So not only do defendants lose all their money and property that can be traced back to the criminal conduct, but the organization itself can be severely crippled.

Finally, being able to prosecute a group as a whole allows the State to dismantle the entire group at once. This is important because when parts of the organization are taken down piecemeal, as under the current statutory scheme, the leaders that are still in place can recruit replacements and keep the organization running and the drugs and violence flowing. Similarly, in cross-jurisdictional prosecutions (since many of the organizations cross lines) only one dealer can be prosecuted at a time or only the small crime that occurs in the individual jurisdiction. RICO would allow counties to work cooperatively to build a RICO case using those acts to get back at the root of the problem and inhibit the flow of drugs inside the State between counties.

Therefore, Task Force recommends legislation to amend the Maryland Gang Statute to better model it after the federal Racketeer Influenced and Corrupt Organization Act (RICO) to aid in the prosecution of, and provide civil penalties for, drug trafficking as part of an ongoing criminal enterprise.

2. Creating a Criminal Penalty for Distribution of Heroin or Fentanyl Resulting in Fatal or Nonfatal Overdose

While the possession, distribution, and manufacturing of heroin or fentanyl is subject to criminal prosecution, contributing to the cause of fatal or nonfatal overdose of another by distribution of heroin or fentanyl is not a specific crime under State law. As such, the Task Force recommends legislation to create a felony crime for the direct or indirect distribution of heroin or fentanyl, the use of which contributes to the fatal or nonfatal overdose of another. A sentence imposed under the bill must be separate from and consecutive to a sentence for any crime based on the act establishing the violation. The legislation, however, should establish a complete immunity defense for a person if evidence of the crime was solely obtained as a result of the person's seeking, assisting, or providing medical assistance.

3. Creating a Multi-Jurisdictional Maryland State Police Heroin Investigation Unit

The Task Force recommends the creation of a multi-jurisdictional Maryland State Police Heroin Investigation Unit. The activities of this unit would be directed by intelligence gathered from the High Intensity Drug Trafficking Areas program (HIDTA) and the many drug task forces throughout the State. Its efforts would be focused on mid- to upper-level heroin and opioid distribution operations that affect multiple jurisdictions. The unit would be housed in the Criminal Enforcement Division.

Due to the multi-jurisdictional nature of the investigations, involvement of allied department personnel on case-specific investigations might be needed. To reduce the burden placed on the manpower resources of the local allied law enforcement departments, short term or temporary task forces could be established for specific targets, which could be accomplished with statewide authority granted by the Superintendent of State Police. When investigations lead to out-of-state heroin and opioid sources, the unit could temporarily collaborate with or turn investigations over to the appropriate federal law enforcement agency to further investigate.

4. Designating HIDTA the Central Repository for All Maryland Drug Intelligence

Intelligence is essential to combating Maryland's heroin and opioid epidemic. In order to begin to gather the needed intelligence, the Maryland State Police directed that the Criminal Enforcement Division (CED) be notified and respond to all suspected heroin and opioid overdoses reported to the State Police. In an attempt to identify the source of supply, CED Troopers conduct follow up investigations and document the information learned to include cell phone data into the HIDTA Case Explorer and Communications Analysis Portal (i.e. CAP) databases. While this has been beneficial, it only represents a very small portion of Maryland State Police heroin and opioid data.

To increase the amount of intelligence gained, the Task Force recommends that all Maryland State Police heroin and opioid investigative activities be entered into Case Explorer. This should include the activities of the uniformed troopers assigned to the Field Operations Bureau and CED and involve any heroin and opioid related contact, arrest, or debriefing. In order to ensure this effort is working to its maximum potential, the State Police should assign one investigator to serve as a program manager/liaison to HIDTA's statewide heroin and opioid intelligence project. This person would work out of the HIDTA office building in Greenbelt and would be given full access to the HIDTA databases and all State Police heroin and opioid briefings. They would ensure all relevant State Police data is entered into the proper HIDTA database and that drug trends and drug trafficking organization targeting intelligence is pushed back out to the appropriate law enforcement investigators in the field.

HIDTA representatives have indicated their willingness to pass the management of the HIDTA heroin and opioid project over to a Maryland State Police employee who would be given full access to HIDTA databases and office space within their Greenbelt office. In addition, the full support of their analytical staff would be available to the State Police representative identified to fill this role. The representative would be considered a representative of HIDTA, and as such

would have full access to allied agency intelligence, which they could use to reach out to allied agencies to obtain permission to share relevant intelligence on multi-jurisdictional or cross-border heroin and opioid targets.

Finally, to optimize this intelligence gathering process, the Task Force recommends that HIDTA be designated as the central repository for statewide drug intelligence and require all State agencies and encourage local allied law enforcement agencies to report their drug intelligence to HIDTA. Without this requirement and the cooperation of all law enforcement and correctional facilities, some holes will remain in the intelligence product produced. Currently, information collected by some local law enforcement in connection with a heroin or fentanyl overdose and the heroin trafficking organizations that supply the drugs exists only within that agency. Heroin trafficking is not confined within jurisdictions and the strategies to combat it should not be limited either.

5. Enhancing Interdiction of Drug-Laden Parcels

Current intelligence and the experiences of the existing Maryland State Police parcel interdiction units indicates that a large majority of drug trafficking organizations are using various parcel services to ship their drugs throughout the country and State. For example, it is estimated that the U.S. Postal Service holds approximately 80 percent of the drug parcel market in Maryland. Investigation into these parcels would provide a positive benefit toward combating this issue, but the existing State Police parcel units do not get the opportunity to work them or forward them to drug task forces throughout the state. If given the opportunity these investigations would enable State Police parcel units and drug task forces to take more heroin and opioids off the street, while also furthering investigation into the drug trafficking organizations operating throughout Maryland.

As such, the Task Force recommends that the Maryland State Police negotiate the inclusion of inspectors from various parcel services into existing State Police parcel interdiction units as task force members. This solution will allow information to be shared on a daily basis as well as for the resources of the State Police parcel units to be used daily as a force multiplier within the parcel facilities.

6. Strengthening Counter-Smuggling Efforts in Correctional Facilities

The Department of Public Safety and Correctional Services (DPSCS) continues to combat the introduction of contraband and illegal substances into its correctional facilities. Contraband may enter a facility through a variety of means, including an individual physically smuggling contraband into the facility on their person. The Task Force recommends that DPSCS examine their current Front Entry Search policy and procedures to determine whether they align with national best practices and, if necessary, modify them in

> ***"Both the task force and the council allow for increased efforts for a coordinated, statewide effort to help prevent abuse, treat addiction, fight drug trafficking, and reduce non-violent drug-related crime."***
>
> *–Governor Larry Hogan*

order to assist in eliminating the introduction of contraband into all correctional facilities. DPSCS should also identify ways to impose gradual disciplinary measures against correctional officers whose improper conduct enables the smuggling of contraband and illegal substances.

REENTRY AND ALTERNATIVES TO INCARCERATION

1. Establishing a Day Reporting Center Pilot Program to Integrate Treatment into Offender Supervision

Drug treatment courts are specialized court dockets that target criminal defendants and offenders who have alcohol or drug dependency problems. As opposed to traditional courts, drug treatment courts emphasize a collaborative partnership between the drug court team, led by the judge and the offender. While drug treatment courts are a far less expensive alternative to incarceration, the challenge exists of expanding the reach of drug courts and maintaining costs without weakening their efficacy.

Day reporting centers are non-residential, on-site wrap around services, which can include substance use treatment, cognitive behavioral therapy, employment training, mental health counseling, job readiness and training, and education. To be most effective, these centers should be highly structured and dissuade socialization, especially among offenders of varying risk levels. They can provide a more cost-effective approach to supervising individuals with substance use disorders and be just as, or more, effective at reducing recidivism than substance use treatment alone.

Perhaps most importantly, day reporting centers provide the ability to employ a diversity of approaches to the variety of challenges facing criminal justice involved individuals. Options can include pretrial diversion programming, swift and certain sanctioning approaches to parole or probation, or wrap around services for medication-assisted treatment programs. As such, the Task Force recommends the Department of Public Safety and Correctional Services and the Governor's Office of Crime Control and Prevention collaborate with the Maryland Judiciary to establish a day reporting center pilot program.

2. Expanding the Segregation Addictions Program

The Segregation Addiction Program (SAP) at the Department of Public Safety and Correctional Services (DPSCS) is an American Society of Addiction Medicine and Correctional COMAR Level I outpatient abstinence-based substance use treatment program. The curriculum is based upon Education, Motivational Enhancement Therapy and Cognitive Behavioral Therapy. There are currently 22 total slots for men in this 90-day program housed at the Maryland Correctional Training Center (MCTC). Offenders participate in seminars, individual and group therapy sessions, role-play activities, complete homework assignments, and attend self-help meetings. Offenders participate voluntarily in this program, and eligibility is determined by receiving a substance use related infraction, especially those offenders who have received a positive urinalysis for a contraband substance. Offenders accepted into the program have their segregation time converted to cell restriction and follow a step down process of regaining privileges such as property, commissary, phones, and visits over the 90 days.

The Task Force recommends the expansion of this program to try to meet demand. For example, during June 2015, there were 85 possible candidates at MCTC alone and only 11 available slots. The Task Force recommends adding three additional substance use counselors, which would quadruple the current capacity to 88 inmates. Expanding access to treatment would allow DPSCS to serve the inmates who need it most, as well as reduce the use of segregation for inmates whose substance use problems are the root cause of disciplinary issues.

3. Implementing a Swift and Certain Sanctions Grid for Probation and Parole

According to data from the Department of Public Safety and Correctional Services, almost 75 percent of parole and mandatory release offenders return to prison for technical violations, and over 40 percent of probation revocations to prison are for technical violations. Those convicted of possession of a controlled substance are the most likely to be revoked for technical violations of community supervision.

Under the swift and certain sanction model, probationers or parolees who violate the conditions of supervision are immediately brought before a judge, hearing officer, or probation/parole administrator who determines a sanction appropriate for the violation committed. In addition to swiftness, the model also entails certainty—violations are likely to be detected, and all detected violations are addressed.

> ***Almost 75 percent of parole and mandatory release offenders return to prison for technical violations***

This model of swift and certain sanctions has been employed in a number of states. One study found that the use of swift, certain, and proportional sanctions as part of a drug court program led to lower re-arrest rates. Responding with swift, certain, and proportional sanctions induces behavior change more effectively than delayed, random, and severe sanctions. In addition, research has shown that rewarding pro-social behavior and attitudes (e.g., case plan progress, practicing a new skill, taking initiative, being honest, etc.) encourages offenders to change behavior, attitudes, and reduces violations of supervision.

In Maryland, for offenders on standard parole and probation supervision, there is no system-wide framework for responding to technical violations using swift, certain, and proportional sanctions. Rather, responses vary by region, agent, and supervision type. As such, the Task Force recommends legislation developing a swift and certain sanctions grid for nonviolent offenders released on probation and parole whose offenses relate to their substance use disorder.

4. Institutionalizing a Substance Use Goal into the Maryland Safe Streets Initiative

The Maryland Safe Streets Initiative (Safe Streets) is an offender-based model established to institute collaboration and information sharing across all levels of government to reduce crime. The objective of Safe Streets is violent crime reduction through seamless coordination, consistent interagency collaboration, and information sharing by focusing on the core group of offenders who commit the majority of violent offenses locally.

While the Safe Streets Initiative has contributed to significant violent crime reductions in many of these jurisdictions, more recent violent crime trends have emerged; at least in part due to the heroin and opioid epidemic plaguing the state. The National Institute on Drug Abuse reports that opiate disorder "has a strong and negative effect on the probability of future arrest for a violent crime."

Due to the link between heroin and opioid use and violent crime, the Task Force recommends that the Governor's Office of Crime Control and Prevention incorporate a new goal into Safe Streets that will allow the local Safe Streets coalition to leverage appropriate resources to address the issue of violent crime related to drug trafficking, substance use, and addiction, with a focus on heroin and opioids. In addition to increasing the enforcement aspect of Safe Streets to target heroin and opioid trafficking, substance use treatment could also be addressed in a similar manner by leveraging a multijurisdictional approach.

What has made Safe Streets successful in the reduction of violent crime is the collaboration and information sharing of various public safety agencies. This multi-agency approach could be replicated from a treatment perspective, including agencies responsible for reentry services including transitional housing, employment, medical care, substance use or mental health treatment, and counseling. To best provide these services, the Task Force recommends establishing peer recovery specialists within the Safe Streets model. Peer recovery specialists are individuals who are in recovery or have life experiences from any life-altering events or disruption. They have initiated their recovery journey and are willing to assist others who are in the recovery process. The specialists could be referred by the individual probation and parole agents, the local detention center caseworkers, law enforcement, or other stakeholders in the criminal justice system.

By utilizing a new substance use goal, these agencies could serve as a force multiplier to identify and disrupt the source networks of the heroin drug trade, hold these offenders accountable, and prosecute them to the fullest extent of the law.

5. Establishing a Recovery Unit at Correctional Facilities

Currently within the Maryland Department of Corrections, offenders are unable to engage in substance use treatment until they are within two years of their anticipated release dates. However, intrinsic motivation to enter treatment is at its highest during particularly stressful times such as following an arrest or an overdose. Peers often give feedback in ways that the substance user can more readily assimilate. Using peer support and feedback also serves to prepare those incarcerated for using peer support organizations in the community.[3] Peer support programs, which utilize offenders serving life sentences as program counselors, such as the TC program at the R.J. Donovan Correctional facility in San Diego, have provided benefits for the offenders in treatment as well as the peer counselors.

[3] Substance Abuse and Mental Health Services Administration, TIP 44: SUBSTANCE ABUSE TREATMENT FOR ADULTS IN THE CRIMINAL JUSTICE SYSTEM, 2014.

In an effort to treat the ongoing addiction issues within the prison, the Task Force recommends that the Department of Public Safety and Correctional Services (DPSCS) establish a pilot Recovery Unit at Eastern Correctional Institution (ECI) to house offenders who are engaged in drug programming and are invested in recovery. DPSCS should identify and train offenders with significant incarceration periods to work as peer mentors in this unit. In addition to forging a more positive environment for recovery to occur, the use of peer mentors establishes purpose and meaning in the lives of those working in that capacity.

6. Studying the Collateral Consequences of Maryland Laws and Regulations on Employment of Ex-Offenders

The Task Force recommends that the Governor's Office of Crime Control and Prevention conduct a study of Maryland laws and regulations that establish a "Collateral Consequence" of a criminal conviction. The study should identify those restrictions that appear overbroad and serve as an unnecessary barrier to employment of ex-offenders. Collateral Consequences are legal restrictions on employment and access to public services of ex-offenders after they have accounted for their crimes. The impact of these collateral consequences is often discussed in the context of offender reentry, but they attach not only to felonies and incarcerated individuals, but also to misdemeanors and individuals who have never been incarcerated. Collateral consequences tend to last indefinitely, long after an individual is fully rehabilitated. While these restrictions are well meaning and some are completely appropriate, several may be excessive.

PROMOTING EDUCATIONAL TOOLS FOR YOUTH, PARENTS, AND SCHOOL OFFICIALS

1. Creating a User-Friendly Educational Campaign on School Websites

The mantra of parents throughout the Task Force's regional summits was "If Only I Had Known". The Task Force recommends that the Maryland State Department of Education assist local school boards in the development and promotion of a drug education and information segment on school websites. The first part of the campaign would be geared toward parents and caregiver and include:

IF ONLY I HAD KNOWN…

(1) The physical signs of addiction to all the different drugs;
(2) The environmental cues of addiction (e.g.: why are some of my spoons missing?);
(3) Where to get a clear and simple explanation of the disease of addiction;
(4) At what age and how to talk to my children about drugs;
(5) Where to look for hidden drugs;
(6) What the different drugs looked like;

> **"…where to get a clear and simple explanation of the disease of addiction."**

(7) That I could buy drug tests at the pharmacy; and
(8) Where to get help in my area.

Most, if not every, public and private schools have a website. They vary in each county, i.e. ED Line in Harford County, Connect ED in Baltimore County and, ParentSchool Power Portal in Cecil County. Parents are constantly accessing these websites for information, checking school activities, lunches, notes from teachers and schedules. A tab labeled "If Only I Had Known Drug Education" will give parents an opportunity to privately view and obtain information on important drugs and addictions. The website will also contain links to SAMSHA, National Institute on Drug Abuse, Foundation for a Drug-free World, and approved interactive websites that educate children, such as BrainTrain4Kids, which teaches children 7 to 9 years old about the brain and the effects of drugs on the brain and body.

Similarly, a school student portal could offer a campaign geared toward adolescents to include:

IF ONLY I HAD KNOWN…

(1) That I could become addicted to prescription drugs;
(2) That prescription drugs could lead to heroin;
(3) That I could become addicted to heroin after using one time;
(4) What heroin does to the brain and body;
(5) That heroin would destroy my family;
(6) How bad the withdrawals are from heroin;
(7) That heroin is not a drug that can be used recreationally;
(8) That heroin can be stronger than love; and
(9) That drugs are not the social norm, everyone is not using them.

> **"…that drugs are not the social norm, everyone is not using them."**

2. Training for School Faculty and Staff on Signs of Student Addiction

The Task Force recommends that the Maryland State Department of Education assist school staff including teachers, school resource officers, coaches, athletic directors, and guidance counselors receive training on the disease of addiction and signs that a student is abusing heroin or prescription opioids. Schools should require that information about the risks of opioid use and misuse, especially when pertaining to a sports injury, be discussed at athletic events, meetings, back to school nights, and trainings for parents, students, and faculty.

3. Promoting Evidence-Based Prevention Strategies that Develop Refusal Skills

Many prevention approaches focus on helping young people develop the knowledge, attitudes, and skills they need to make good choices or change harmful behaviors. Refusal skills are a set of skills designed to help children avoid participating in high-risk behaviors. Programs designed to deter drug use commonly contain refusal skills in their curricula. The Task Force recommends

that the Maryland State Department of Education promote these programs to help students resist peer pressure while maintaining self-respect. The Substance Abuse and Mental Health Services Administration (SAMHSA) lists programs that are evidence-based, tailored to children and adolescents at all ages that can be used in school settings, including LifeSkills Training, Project ALERT, and the new version D.A.R.E. (Drug Abuse Resistance Education) program, now called Keepin' it REAL.

4. Supporting Student-Based Film Festivals on Heroin and Opioid Abuse

In Frederick County, a public-private partnership has developed around the creation of a student film festival for the 2015-2016 school year. Councilman William Shreve, with the support of Dr. Theresa Alban, the President of the Public School Superintendents Association of Maryland, is leading this project. Students will create 30-60 second videos and send videos for posting on Frederick County Public Schools website by the end of January 2016. The Task Force recommends that the Maryland State Department of Education evaluate the success of this program and consider replicating it as a statewide initiative. The Student Film Festival would then be taken statewide for the 2016-2017 school year. A social norming theme could also be included in this campaign to help young people understand that using drugs is not the social norm and everyone does not use drugs. The Film Festival could be a Red Carpet event held in Baltimore or Annapolis.

> ***"Prevention is key. We must shutdown the pipeline of new users!"***
>
> *–Lt. Governor Boyd K. Rutherford*

IMPROVING STATE SUPPORT SERVICES

1. Implementing Comprehensive Heroin and Opioid Abuse Assessment and Screening at the Department of Juvenile Services and the Department of Human Resources

Currently, the Department of Juvenile Services (DJS) performs a Maryland Comprehensive Assessment and Service Planning (MCASP) assessment on every youth brought to an intake office. The MCASP screening touches on youth's social and family life as well as other risk factors and prior involvement in the court system. To gather more detailed information about youth who are brought to an intake office, the Task Force recommends that the DJS develop a questionnaire that will be specifically designed to guide DJS staff in a productive discussion with the youth and parent regarding opiates, including heroin, fentanyl, and prescription opioids, and other drugs.

The questionnaire will touch on availability of prescription painkillers and other opiates in the home and history, if any, of abuse. In creating this questionnaire, DJS should seek the expertise of individuals in the field of teenage substance use to develop the questions in order to get the maximum information from the youth and his/her family. Based on the risk factors gathered from the questionnaire, DJS could refer youth and families for appropriate services including substance use counseling and treatment.

Similarly, the Task Force recommends that the Department of Human Resources (DHR) implement a comprehensive screening tool to identify clients and families affected by heroin and opioid

use. An initial screening tool should be applied to all DHR customers, unless the risk of abuse is so obvious no screening need be applied (e.g. Substance Exposed Newborns). This measure will require DHR to update intake procedures across all units. If customers are found to be at risk of heroin or opioid abuse – either individually or in their families - an assessor will apply a more detailed screening tool to verify their abuse or risk of abuse. If the individual or family is verified to be at risk, the assessor will refer them to the appropriate resources that will assist the family's recovery from the impact of heroin and opioid abuse.

DJS and DHR must make it emphatically clear to their respective clients that the information derived solely from the assessment and screening process will not be shared with law enforcement without a lawful warrant nor will it impact their eligibility for social services.

2. Establishing the Maryland Center of Excellence for Prevention and Treatment under the Behavioral Health Advisory Council

In 2015, the General Assembly passed legislation replacing the Maryland Advisory Council on Mental Hygiene and the State Drug and Alcohol Abuse Council with the Behavioral Health Advisory Council. The advisory council is tasked with promoting and advocating for the enhancement of behavioral health services across the State for individuals who have behavioral health disorders and their family members.

The council must promote and advocate for (1) planning, policy, workforce development, and services to ensure a coordinated, quality system of care that is outcome-guided and integrates prevention, recovery, evidence-based practices, and cost-effective strategies that enhance behavioral health services across the State and (2) a culturally competent and comprehensive approach to publicly funded prevention, early intervention, treatment, and recovery services that support and foster wellness, recovery, resiliency, and health for individuals who have behavioral health disorders and their family members.

> ***"People don't like to talk about this problem. The consequences of this heroin crisis are not easy or comfortable to acknowledge. Yet we must acknowledge it."***
>
> *–Governor Larry Hogan*

Because the legislation did not specify a targeted approach for drug prevention and treatment, the Task Force recommends that a Center of Excellence for Prevention and Treatment (MCEPT) be established under the Council, but housed in an academic institution, such as the University of Maryland School of Medicine or Johns Hopkins University School of Medicine. Being housed in academia, MCEPT would be a strong exemplar of an active public-private partnership, with additional outreach and liaison functions with the broader research community and groups within the private sector.

The Center would serve as the main body to provide critical oversight, a unifying strategy, and accountability for all prevention and treatment programming across the State; to serve as a source of independent information, data analysis, and evaluation of the effectiveness and coordination of prevention and treatment programming in Maryland; and to provide oversight

such that programming is fully accountable across all agencies in accordance with metrics, outcome measures, standards of care, and performance evaluation.

The driving force behind the Center would be a high-level board of directors selected by the Governor, in consultation with the Behavioral Health Advisory Council. This multidisciplinary team, representative of the best minds in prevention and treatment academia, research, and public policy, as well as individuals from State agencies, the faith community, and the private sector, would support the Council with oversight power and by developing and implementing meaningful and effective prevention and treatment policies and programs. The overall context of a unifying strategy will seek accountability through progress towards measurable goals, enforcement of metrics, and adherence to standards of excellence in care.

Finally, the Center board of directors would be responsible for producing written products, including an annual report on the status of implementation of substance use-related legislation, as well as white papers and policy recommendations for consideration by the Council.

The Center would address three broad areas of concern:

1) Adherence to Standards of Excellence for all Maryland Prevention and Treatment Programming by: a) linking standards of Excellence with a program-rating system to inform and guide consumer choice and b) publishing "Models of Excellence for Prevention and Treatment" targeted to policymakers, program providers, law enforcement personnel, and the private sector community of parents, teachers, and civic groups;

2) Support of the Critical Juncture between Maryland's Criminal Justice and Treatment Systems by: a) improving the efficacy of prevention and treatment programming in the correctional system, including re-entry programming; and b) standardizing practices which achieve both the goals of treatment support and law enforcement, e.g., consultation of the Prescription Drug Monitoring Program (PDMP) by all Maryland opioid treatment providers; and

3) Oversight of Programmatic and Fiscal Accountability for Maryland Prevention and Treatment Programming by: a) monitoring the implementation of substance use-related legislation; b) ensuring that evidence-based practices are implemented with fidelity; and c) providing oversight for the evaluation of prevention and treatment programs with the objective of streamlining prevention and treatment services for their highest impact and effectiveness. Oversight of best practices will be ensured by the MPECT since its recommendations will be used by the Governor and Legislature to set budget priorities for prevention and treatment programs and centers.

VII. RECENTLY APPROVED RESOURCE ALLOCATIONS

On October 7, 2015, Lieutenant Governor Boyd K. Rutherford announced the following nine new grants, totaling $608,832 aimed at tackling the opioid and heroin crisis to be administered through the Governor's Office of Crime Control and Prevention:

1. **Allegany County State's Attorney's Office**

   The Allegany County State's Attorney's Office, Prosecution Partnership Targeting Priority Offenders program, which received $55,532, will support the Cumberland Safe Streets Program in targeting priority offenders, many of them drug traffickers, who are responsible for much of the crime in the community. The program will fund a dedicated prosecutor for priority offenders as well as provide technical capabilities to target, track, and successfully prosecute those offenders identified as high target offenders.

2. **The Family Recovery Program, Inc., Baltimore City**

   The Family Recovery Program, Inc.'s Parents in Recovery Together project, which received $100,000, will help Family Recovery Program clients in Baltimore City work with peer recovery advocates to gain support and skills targeting relapse, crime prevention, parenting, and trauma. Peer recovery advocates will be trained in evidence based practices, assist clients in making and maintaining appointments, and accompany clients to meet with partner agencies.

3. **Hampstead Police Department, Carroll County**

   The Hampstead Police Department's Mobile License Plate Reader Technology program in Carroll County, which received $18,150, is able to scan hundreds of license plates a minute and give law enforcement real time knowledge, a crucial investigative tool in identifying and tracking drug traffickers coming into and through Maryland.

4. **The Center for Children, Inc., Charles County**

   The Center for Children, Inc. in Charles County, which received $69,000, will run an Adolescent Substance Use Disorder Integration Initiative to provide training for a new co-occurring Department of Health and Mental Hygiene licensed treatment program in Southern Maryland. Funds will be spent on startup personnel, training costs for staff, and initial implementation.

5. **Charles County Circuit Court**

   The Charles County Circuit Court's, Family Recovery Court program, which received $98,554, is designed to serve parents with a Charles County Circuit Court case where substance use is identified as a barrier preventing them from providing safe, appropriate care for their children. The Family Recovery Court uses a holistic approach to support parents and families with consistent monitoring, intensive treatment, referrals to ancillary services, and the collaborative efforts of a Drug Court team. Program funds will provide assistance with fees incurred for medication assisted treatment and inpatient treatment for Family Recovery Court participants that are opioid dependent and have prior or current criminal charges.

> ***"The question, at the end of the day, … is what is the best approach? Nothing is completely off the table."***
>
> *–Lt. Governor Boyd K. Rutherford*

6. **Howard County Department of Corrections**

   The Howard County Department of Corrections' Targeted Reentry Services program, which received $49,706, will enhance the County's Transition from Jail to the Community initiative to reduce recidivism by targeting offenders who have been identified as having medium to high risk of reoffending and placing them in programs specific to their assessed risk factors.

7. **St. Mary's County Detention Center**

   The St. Mary's County Detention Center, which received $52,000, will partner with Walden Sierra to institute a Vivitrol option for opiate addicted individuals participating in treatment and reentry services. The program provides screening and prerelease counseling, transitional case management, post-release behavioral health support, and administration of Vivitrol. To date, the program has screened 27 individuals.

8. **Montgomery County Police Department**

   The Montgomery County Police Department's Heroin Overdose Prevention & Education program, which received $35,000, offers a comprehensive approach to address the heroin problem by supporting additional personnel time, law enforcement training, and heroin awareness messaging.

9. **Somerset County Local Management Board**

   The Somerset County Local Management Board's, Anti-Gang Enforcement and Strategies Initiative, which received $130,890, enhances enforcement and prosecution of gang-related

crimes and supports anti-gang community outreach initiatives. Program funds provide personnel, equipment, training, and technology to address the growing presence of gangs and corresponding spikes in drugs and violence.

VIII. UPDATE ON MARYLAND MEDICATION ASSISTED TREATMENT REENTRY PROGRAMS

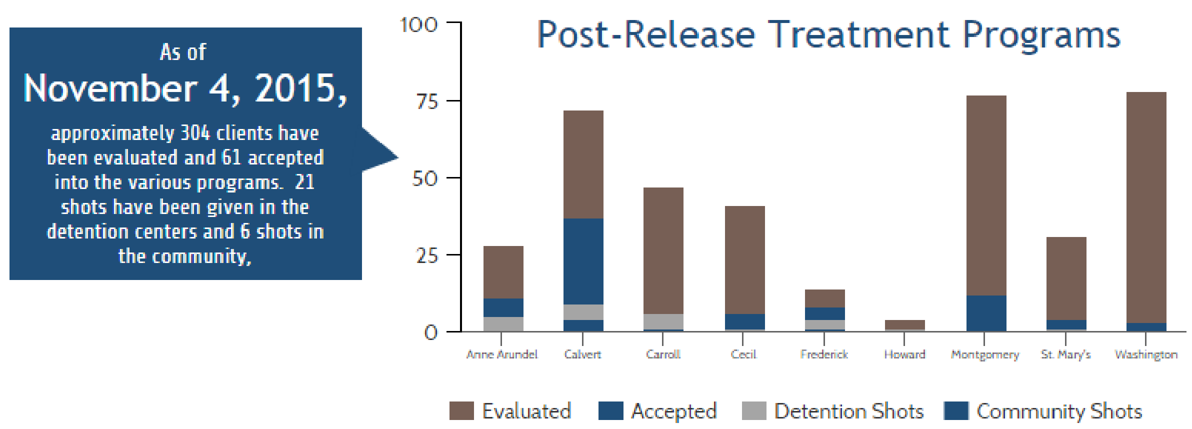
On June 2, 2015, the Governor's Office of Crime Control and Prevention awarded $500,000 to programs in local jails and detention centers across Maryland for Medication Assisted Treatment (MAT) reentry programs, specifically the Anne Arundel County Department of Detention Services, Carroll County Health Department, Calvert County Health Department, Cecil County Sheriff's Office Law Enforcement Facility, Frederick County Detention Center, Howard County Department of Corrections, Montgomery County Department of Corrections & Rehabilitation, St. Mary's County Detention Center, and Washington County Detention Center. Inmates who qualify for the program must be housed within county detention centers, be identified as opiate users, and be within three months of release. Uninsured program participants are enrolled in Medicaid immediately upon release in order to pay for the post-release injections.

Awarded $500,000 to programs in local jails and detention centers across Maryland

The MAT reentry programs combine drug treatment with extensive behavioral health counseling, wherein selected inmates receive monthly injections of Vivitrol, a non-narcotic and non-addictive substance that blocks the euphoric effects of heroin, other opiates, and alcohol. Vivitrol manufacturer, Alkermes, Inc., has trained county detention center and community health providers on the use of the drug. Alkermes donates the initial dose of Vivitrol, which is administered in the jail or detention center just before inmates are released. Subsequent injections are administered by local health departments, cooperating practitioners in the community, or by the original local detention centers. Unlike opioid-based medications such as methadone or buprenorphine, which require daily administration, Vivitrol is a once-a-month injection.

To ensure the best possible outcomes, comprehensive post-release treatment programs are established for each ex-offender. They include intensive treatment for substance use disorders, and community-based support services such as housing, mental health treatment, education, and employment. Each jurisdiction has developed a program to track and monitor the offenders' post-release progress, program compliance, recidivism, and subsequent substance use.

As of November 4, 2015, approximately 304 clients have been evaluated and 61 accepted into the various programs. Twenty-one injections have been given in the detention centers and six injections in the community, as outlined in the following chart:



The Governor's Office of Crime Control and Prevention hosts monthly performance review calls and bimonthly program director meetings with the funded agencies to share best practices and emphasize what is being done by high performing agencies. In addition, the Office will host advanced trainings for program directors and administrators to provide a refresher clinical overview and accelerate projects.

IX. UPDATE ON INTERIM REPORT PRELIMINARY RECOMMENDATIONS

Preliminary Recommendation Overview

1. **Earlier and Broader Incorporation of Heroin and Opioid Prevention into the Health Curriculum**
2. **Infusion of Heroin and Opioid Prevention into Additional Disciplines**
3. **Heroin and Opioid Addiction Integrated into Service-Learning Projects**
4. **Student-based Heroin and Opioid Prevention Campaign**
5. **Video PSA Campaign**
6. **Maryland Emergency Department Opioid Prescribing Guidelines**
7. **Maryland State Police Training on the Good Samaritan Law**
8. **Maryland State Police Help Cards and Healthcare Follow-Up Unit**
9. **Faith-based Addiction Treatment Database**
10. **Overdose Awareness Week**

1. Earlier and Broader Incorporation of Heroin and Opioid Prevention into the Health Curriculum

In August, the Maryland State Department of Education (MSDE) began developing lesson and resources for the health curriculum and introducing health-specific materials at Content Briefing with Local Education Agencies (LEAs). MSDE compiled and shared a list of resources on heroin and opioid prevention in response to the LEAs' request for that information. Throughout the process, these materials will continue to be revised and edited in collaboration with LEAs. Beginning in November and extending into December, MSDE will be disseminating materials from all content areas to the Health Coordinators for the remainder of the 2015-2016 school year.

2. Infusion of Heroin and Opioid Prevention into Additional Disciplines

In August, the Maryland State Department of Education briefed State Content Coordinators on an overview of the heroin and opioid epidemic and on the materials that need to be developed in all content areas. MSDE then began developing, revising, and editing resources and lessons integrating education on heroin and opioid use for other content areas. In September, MSDE introduced and disseminated materials for the 2015-2016 school year at LEA Content Coordinators' Briefings. Specific briefings include: Professional Development Coordinators; Service Learning Coordinators; Science & ELL Coordinators; Fine Arts Coordinators; Physical Education Coordinators; and Gifted & Talented Coordinators. In December, MSDE will disseminate materials for the remainder of the 2015-2016 school year for School Nurses and Social Studies Coordinators. Between January and March 2016, MSDE will disseminate materials for the remainder of the 2015-2016 school year for Reading/English Language Arts Coordinators, Math Coordinators, and Environmental Education Coordinators.

3. **Heroin and Opioid Addiction Integrated into Service Learning Projects**

   In August, the Maryland State Department of Education's Service-Learning Specialist, curriculum specialist, and stakeholders worked to develop, revise, edit, and finalize the Service-Learning Project ensuring that the project is linked to the curriculum. The service-learning heroin project has been posted on the main page of the service-learning website. In September, MSDE met with Service Learning Coordinators in all 24 Local Education Agencies (LEAs) to introduce and explain the new topics. The LEA staff has worked with local curriculum specialists to understand relevant areas where service learning projects could best be infused. In November and December, the Service-Learning coordinators will share the project content with peers and schools.

4. **Student-based Heroin and Opioid Prevention Campaign**

   The campaign would focus on prevention and a few key objectives including: 1) Discouraging teens and preteens from trying heroin; 2) Educating students and parents on how to identify and respond to signs of addiction; and 3) Inform youth, parents, and communities on how to access support services. MSDE held the kickoff media event with Lt. Governor Boyd K. Rutherford at Towson High School on October 1, 2015. MSDE has developed a webpage to anchor the public education campaign and provide links to resources and information which has also been distributed to all 24 Local Education Agencies. It also met with Teachers of the Year from all 24 LEAs to plan development of a year-long project of their choosing. MSDE hosted a meeting with partner agencies including the Department of Health and Mental Hygiene, Department of Commerce, Division for Tourism, Film and the Arts and the Governor's Office to coordinate on messaging, collaborate on public service announcements and pool resources. In November, MSDE developed and distributed a communication toolkit with information for schools to use when communicating with their communities. MSDE also met with faith-based and community-based organizations to plan a faith-based and community-based project.

PREVENTION

1) **Discouraging teens and preteens from trying heroin even once**
2) **Educating students and parents on how to identify and respond to signs of addiction**
3) **Inform youth, parents, and communities on how to access support services.**

In November, fine arts students were asked to develop a student-designed poster, logo, and slogan to be unveiled in the spring. In December, MSDE and partner agencies will unveil public service announcements. MSDE will also work with LEA fine arts teachers to plan and produce student theatre productions, partner with Maryland PTA to plan focus groups with parents and student users in 2016, and create a social media campaign by youth to engage youth. Next year, MSDE will finalize Teachers of the Year projects, invite teachers to blog about new

instruction on prevention, student feedback, and lessons learned, and announce and publicize the student theatre productions focused on risk and prevention. Students will be asked to complete an anonymous survey on prevention, causes, signs and effects of addiction, and how to access support services, before the end of the school year.

5. Video PSA Campaign

The Department of Commerce Film Office and Maryland Higher Education Commission (MHEC) in collaboration with the Department of Health and Mental Hygiene and Maryland State Department of Education (MSDE) determined the four message topics for the public service announcements:

Topic 1 - Public Awareness for Elementary and Middle School-aged Students

Topic 2 - Education about the Maryland Crisis Hotline

Topic 3 - Public Awareness about the Good Samaritan Law Related to Overdose Emergencies

Topic 4 – Naloxone Education

Due to time constraints and semester curriculum already in place, and in order to meet the December first deadline, the Maryland Film Office contacted Morgan State University and Stevenson University to produce the State's first set of PSAs. The Film Office will contact all universities with film programs to participate in similar productions next semester.

Approximately 40 students will be involved in the production and post-production of PSA's.

Students from Morgan and Stevenson have submitted a total of 15 scripts. These scripts were reviewed by subject matter experts and educators who have been tasked to participate in this project as to the scripts accuracy and messaging. Due to limited time available to the students, five scripts were selected to go into production. According to the professors overseeing the PSA's, a total of approximately 40 students will be involved in the production and post-production process. Production began on November 9, 2015. The committee, experts, and educators will determine which will be aired.

In addition, officials from the Governor's Office, MHEC, and MSDE met with a public relations official at WBFF-TV to explore broadcast support for the State's heroin and opioid campaign. The WBFF-TV expressed enthusiasm about the possibility of airing the spots and exploring other venues to air them, including the B'more Healthy Expo at the Baltimore Convention Center in March 2016. Copies of the PSAs will be sent to WBFF-TV for review.

6. Maryland Emergency Department Opioid Prescribing Guidelines

All 47 of Maryland's acute care hospitals have committed to adopt and work with emergency medicine personnel and their staffs to implement the Maryland Emergency Department Opioid Prescribing Guidelines.

As part of the commitment to implementing the guidelines, every acute care hospital will provide the Maryland Hospital Association (MHA) with periodic updates on the progress of implementation. While the guidelines are based on promising interventions and expert opinions, there will be a need to examine them during the implementation process to determine their effectiveness and alignment with evidenced based practices. MHA has committed to work with the Maryland College of Emergency Physicians to convene emergency medicine leaders, poison control centers and other experts, in the Spring, to discuss implementation, barriers, and the potential need for revisions. Part of the focus on this meeting will be the voluntary utilization of Maryland's Prescription Drug Monitoring Program, education and training needs for providers and patients, and the identification of additional resource needs to support implementation.

7. Maryland State Police Training on the Good Samaritan Law

The Maryland State Police has met with the Maryland Police Correctional Training Commission (MPCTC) to begin the process of developing training for statewide dissemination to all Maryland Law Enforcement agencies. All involved in the training development have agreed that a web based training platform would be the best method for facilitating this training.

8. Maryland State Police Help Cards and Healthcare Follow-Up Unit

In conjunction with the Maryland State Police, the Behavioral Health Administration (BHA) developed a help card containing information on the newly created crisis hotline in Maryland. The BHA, within DHMH, sponsors a crisis hotline available 24/7 throughout Maryland. This provides immediate access to information about treatment resources for those with mental health and substance use problems. During working hours, they provide a warm hand-off to the local jurisdictional evaluation center. If unable to directly reach the evaluation center, the Crisis Hotline will follow up the next day with the caller to make sure they follow through with the referral. The hotline also provides information to those who want to intervene with someone who struggles with mental health or substance use disorders. The hotline originally served those with mental health crises. BHA provided training to the hotline staff to increase their competence in managing calls about substance use problems.

The hotline number is 800-422-0009.

9. Faith-based Addiction Treatment Database

The Governor's Office of Community Initiatives' (GOCI) Interfaith Coordinator has identified at least 20 different facilities in Baltimore City and the Counties of Anne Arundel, Allegany, Calvert, Caroline, Carroll, Cecil, Charles, Frederick, Harford, and Montgomery for inclusion in its database of faith-based organizations that provide addiction treatment services. The database is continually updated as more faith-based organizations are identified. The GOCI will also begin reaching out to faith leaders to emphasize the crucial role faith-based communities play in dealing with individuals suffering from addiction. Participants will discuss strategies on how to best talk with their memberships about the disease of addiction and how to provide support to families and individuals seeking help. Topics of peer support, value systems, family, forgiveness, reducing stigma, overdose prevention, instilling of hope and

motivation, resiliency, communication and collaboration should be covered themes. A core goal of this proposal is to inspire leaders within communities to take action in the fight to assist our fellow Marylanders struggling against addiction. See http://goci.maryland.gov/interfaith.

10. Overdose Awareness Week

From Sunday, August 30, 2015 to Saturday, September 5, 2015 the first Overdose Awareness Week was observed in Maryland. The Behavioral Health Administration (BHA) helped communities across the State coordinate events to recognize the work being done to reduce opioid misuse in the community, promote treatment options, and celebrate recovery. Statewide events included candlelight vigils in Baltimore City and Baltimore and Cecil counties, community discussions in Somerset and St. Mary's counties, Naloxone trainings in Harford and Calvert counties, and media coverage in Frederick and Howard counties. BHA also held a Naloxone Conference to educate attendees about the State's Overdose Response Program and different models of overdose education and naloxone distribution.

> ***"I lost my first cousin to a heroin overdose just a couple of years ago, so I know the kind of devastation it can cause families and communities."***
>
> *–Governor Larry Hogan*

X. UPDATE ON INTERIM REPORT RESOURCE ALLOCATIONS

Resource Allocations

1. **Restoring the A.F. Whitsitt Center to a 40-bed Capacity**
2. **Providing Community-Based Naloxone Training and Distribution**
3. **Piloting Overdose Survivor Outreach Program in Hospital Emergency Departments**
4. **Piloting Naloxone Distribution to Individuals Screened Positive for Opioid Use Disorder at Release from Local Detention Centers**
5. **Expanding Supportive Recovery Housing for Women with Children**
6. **Supporting Detoxification Services for Women with Children**
7. **Targeted Outreach and Education to Aberrant/High-Risk Opioid and Other Controlled Substance Prescribers**
8. **Overtime for Dorchester County Law Enforcement**
9. **Maryland State Police Gang/Heroin Disruption Project**
10. **License Plate Reader Technology**

1. Restoring the A.F. Whitsitt Center to a 40-bed Capacity

The supplemental budget award of $800,000 was approved by the Department of Health and Mental Hygiene. The Center received an additional $45,149 for equipment and furniture for patient group rooms, to update restrooms, purchase supplies for the medical room, and for staff phones and computers.

On October 1, 2015, the first patient (under the expansion award) was admitted. The fully functional new wing renovations will expand bed capacity to 40 and are expected to be completed by early to mid-December.

2. Providing Community-Based Naloxone Training and Distribution

In July 2015, the Behavioral Health Administration (BHA) issued a solicitation for proposals from each jurisdiction's Local Addictions Authority (LAA) for funding to support naloxone training and distribution under the Overdose Response Program (ORP) for FY2016. Proposals were received from LAAs representing 22 jurisdictions. Following a period of dialogue with applicants to address any issues in the proposals, BHA issued awards to 20 jurisdictions in October. Revised budgets are currently being submitted for final approval by BHA. To meet the aggregate funding request from all jurisdictions that exceeded the $500,000 of supplemental State funding, BHA added nearly $300,000 in "one time only" federal funds, for a total of $800,000 in grants.

***$800,000** to help restore the A.F. Whitsitt Center to a 40-bed facility*

The solicitation encouraged partnership with community-based organizations to expand the reach of the program and the targeting of people at highest risk for overdose along with their friends and family members. BHA reviewed all proposals and competitively awarded funds

based on the quality of the proposal, innovation demonstrated by the proposed strategy, the strategy's likelihood of reaching people at high risk for overdose, sustainability, and plans for program evaluation. All funded jurisdictions proposed to provide naloxone as part of the training. Many proposed to incorporate standing orders into program operations by the end of the fiscal year. Some examples of innovative proposals include:

- partnership with hospitals to offer training in emergency departments;
- hiring of outreach workers for street-based training and naloxone distribution;
- collaboration with a community center that serves the recovery community;
- development of promotional cards for EMS distribution to overdose survivors; and
- expansion of training locations to include halfway houses, senior centers, and homeless shelters.

BHA will continue to provide technical assistance to grantees and conduct ongoing monitoring of implementation, including requests for regular updates starting in January 2016. ORP entities are required to submit reports to BHA monthly on the numbers of people trained and certified and naloxone units dispensed. These reports will be used to track training numbers and people reached through this funding.

3. Piloting Overdose Survivor Outreach Program in Hospital Emergency Departments

As a first step to implementation of the Overdose Survivors Outreach Program (OSOP) in Baltimore City, BHA has provided Behavioral Health Systems Baltimore (BHSB) with initial funding to develop and implement specialized training and protocols for peer support specialists to conduct outreach to overdose survivors and linking them with treatment and recovery support services. BHSB's peer recovery specialists as well as peers employed by Bon Secours and Mercy hospitals will receive specialized training with overdose survivors and new protocols for coordinating referrals and follow up contacts. BHA estimates that trainings will be completed and the referral protocol implemented in January 2016. BHA and BHSB are also in discussions with an additional city hospital about incorporating their referrals for overdose survivors into the new protocol.

BHA is also coordinating activities funded under OSOP with those supported by a recently awarded grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) designed to improve peer support for individuals in medication-assisted treatment for opioid addiction. As part of this collaboration, BHA is supporting Anne Arundel Health Department's (AAHD) efforts to hire peers to work with Baltimore Washington Medical Center (BWMC) emergency department staff and provide intervention and referral support for overdose survivors. An initial workflow model for patient identification and referral has been developed with the goal of beginning implementation in December. The AAHD/BWMC initiative will also include intensive training for peers on motivational interviewing and treatment services to be conducted in early 2016.

4. **Piloting Naloxone Distribution to Individuals Screened Positive for Opioid Use Disorder at Release from Local Detention Centers**

Following release of the Interim Report, BHA requested that the local health departments from Charles, Calvert, and St. Mary's Counties submit a proposal to partner with their local detention centers to implement a pilot overdose education and naloxone distribution program for at-risk individuals leaving incarceration. Each county submitted proposals reflecting buy-in from their local detention centers in September 2015. All proposals included a description of methods for identifying individuals eligible for receiving naloxone through screening done at the time of intake to the facility. Training will be done by health department staff placed in the jails for treatment services, and naloxone will be purchased by the health department and provided upon the inmate's release by either jail or health department staff. The programs plan to train inmates under the ORP using the Program's curriculum, issuing certificates to trainees and dispensing using a physician's standing order. In October, BHA approved all three proposals and issued awards of approximately $50,000 for each county. A conference call with grantees was held in mid-November, and program implementation is expected to begin in December 2015.

Approximately* $50,000 *to Charles, Calvert, and St. Mary's Counties.

Success of the pilot project will be measured by the county's ability to establish functioning protocols for the screening, training, and equipping with naloxone of inmates at the local detention center. Performance measures will include the number of people eligible for naloxone training, number of people trained, and number of naloxone kits dispensed. The project also required local health departments to incorporate protocols for referring eligible inmates to treatment and report to BHA regarding the number of people screened eligible for treatment services and the number of referrals made to substance use disorder treatment upon release.

5. **Expanding Supportive Recovery Housing for Women with Children**

BHA has awarded funding to the Anne Arundel County. The Anne Arundel County Health Department/Local Addictions Authority has selected Chrysalis House (Crownsville) as the vendor. Chrysalis House has located a site for the Supportive Recovery Housing in Brooklyn. Residents have already been accepted into the program and are living in the home. The house has five bedrooms that are occupied by four adults and five children (i.e. 4 families). The house is completely full.

6. **Supporting Detoxification Services for Women with Children**

Detoxification is an important, but resource intensive process. Clients require 24-hour monitoring for assessment and ongoing monitoring of sub-acute biomedical and behavioral conditions related to opioid and alcohol withdrawal. Based on national data and BHA's understanding that women historically do better in treatment with their children, BHA utilizes a model of residential detoxification services with childcare services on site in Baltimore City. BHA has awarded funding to Behavioral Health Systems Baltimore (BHSB) to provide these services. The

vendor, Gaudenzia, has been awarded funding and is currently providing detoxification services to four women with children at the Park Heights residential treatment program. It is the only program that provides residential detoxification with childcare on site in the state. This allows mothers to detox in a safe environment and children can receive appropriate wrap around services. These services include, but are not limited to, pediatric and mental health referrals, afterschool programming, and recreational activities that are age appropriate.

7. **Targeted Outreach and Education to Aberrant/High-Risk Opioid and Other Controlled Substance Prescribers**

   BHA is working with the University of Maryland, School of Pharmacy (UMSP) to develop a process for identifying and conducting targeted outreach and education to aberrant opioid and other controlled substance prescribers. The first step will include development of clinical guidelines for primary care practitioners that address, first, when opioid prescribing is, or is not, appropriate, and, second, how to mitigate the risks of opioid prescribing should it be initiated. The guidelines will be developed in consultation with subject matter experts and stakeholders from government, academia, and in clinical practice. Promotion of the guidelines will foster a more knowledgeable clinician base and provide consensus-based standards for reference by government agencies, payers, and health systems. The guidelines may also inform data analysis methods for identifying aberrant prescribers through a "drug utilization review" process similar to those currently operated by Maryland Medical Assistance and private insurers. Guidelines may also be used as the basic educational material for outreach and academic detailing for high-risk prescribers. BHA is currently negotiating an agreement with UMSP with the goal of beginning the guidelines development process in December 2015.

8. **Overtime for Dorchester County Law Enforcement**

   The Dorchester County Council's Combating Heroin Use and Trafficking program is assisting the County's Heroin Task Force. Outdated mobile data terminals will be replaced and overtime will be spent on additional investigations.

9. **Maryland State Police Gang/Heroin Disruption Project**

   Since receiving the overtime funds, the Unit has seized several hundred grams of heroin and crack cocaine.

10. **License Plate Reader Technology**

    The Ocean City Police Department has initiated installation and implementation of the technology.

XI. CONCLUSIONS

Over the past ten months, the Heroin and Opioid Emergency Task Force held regional summits in six locations around the State. The Task Force listened to local elected officials, treatment professionals, researchers, law enforcement, and families of individuals who fought and in many cases died due to their addiction. We heard many heart wrenching stories of loss as well as stories of triumph over the disease of addiction. The Task Force listened to calls for help: from treatment officials for improved access to treatment; from law enforcement for alternatives to incarceration as well as more tools to interrupt heroin traffickers; from families not wishing to have other families go through what they have; and from elected officials concerned about the destruction it is doing to their communities.

While the Task Force is proud of this report, this is not the end of the work to eliminate the scourge of heroin from our State. It represents a step in a long-term struggle to address a major challenge that is holding people and our communities back from their full potential. This challenge will not be solved overnight. There are additional factors that this report does not directly address, such as challenging home environments and the intersection of addiction and mental illness. With the completion of this report, the difficult work is just beginning.

XII. ACKNOWLEDGMENTS

The Task Force is tremendously grateful for the outpouring of support and expertise provided by hundreds of people to help the State combat the heroin and opioid epidemic.

Office of the Governor and Agency Staff

Sam Abed
Richard Alcorta
Jon Armiger
Linda Auerback
Julie Ayers
Michael Baier
Diane Banchiere
Gray Barton
Bradley Beard
Paul Beatty
Amy Bernstein
Marian Bland
Susan Bradley
Alberta Brier
Jim Brown
Laura Bruner
Laura Burns-Heffner
Monique Cheatham
Sara Cherico
Edward Clarke
Joseph Cleary
Lisa Cleary
Kevin Conroy
Michelle Darling
Sandra Davis-Hart
Larry Dawson
Steve DeBoy
Adam Dubitsky
Nancy Egan
Shawn Eum
Ronald Fisher
Michael Ford
Rebecca Frechard
Andrea Garvey
Jack Gerbes
Michael Gill
Jennifer Gray
Debbie Green
Kathleen Green
Deborah Grinnage-Pulley
Erin Haas
Jeannie Haddaway-Riccio
Lisa Hadley
Kata Hall
James Hedrick
Geoff Hengerer
Christopher Hersl
Brian Holler
Jennie Hunter-Cevera
Amber Ivey
Brandee Izquierdo
Kate Jackson
Sue Jenkins
Diane Jennings
Henry Johnson
Gayle Jordan-Randolph
Catherine Kelly
Netsanet Kibret
Mary Kwei
Kristina Kyles-Smith
Heather Lageman
Arlene Lee
Kevin Loeb
Marilyn Lorenzo
Mac Love
Sam Malhotra
Renee Markle
Hannah Marr
Rianna Matthews-Brown
Steve McAdams
William McCurry
Erin McMullen
Van Mitchell
Erin Montgomery
Katherine Morris
Stephen Moyer
Sara Muempfer
Mark Newgent
Barry Page
William Pallozzi
Ed Parker
Brad Peganoff
Bill Pencek
Mary Pollock
Vertell Porter-Brown
Michael Preston
Terrence Proctor

James Pyles
Al Redmer
Kathleen Rebbert-Franklin
Phyllis Reese
David Ruel
Robert Scholz
Christopher Shank
Linda Singh
Cara Sullivan
Richard A. Tabuteau
Alison Taylor
Penelope Thornton Talley
Kay Teng
Ann Walker
John White
Winston Wilkinson
Katie Wunderlich

Contributors

Ken Abrams
Wes Adams
Jeff Adams
Uma Ahluwalia
Valerie Albee
Lynn Albizo
Robert Ali
Daniel Alioto
Irnande Altema
Barbara Allen
John Alverez
Carl Anderton
Dena Anthony
Stefan Antony
Steven Arentz
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Jackie Ball
Ron Bateman
Gail Bates
Candy Bathon
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Sean Beatty
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Marte Birnbaum
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Leslie Brown
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Tina Canter
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Israel Cason
Patrick Chaulk
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Theodore Cicero
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Carroll Conquest
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Mark Donovan

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Sharon Walser
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Nancy White
Pat White
Pat Whitlock
Summer Widmyer
Anita Wiest
Dan Williams
John Winslow
Patricia Winters
Catherine Woolley
Gaynell Wright
Dana Wright
Cheryl Wyatt
Sharon Wylie
Jack Young
Karen Young
Julie Zebroski

APPENDICES

Executive Department

EXECUTIVE ORDER
01.01.2015.12

Heroin and Opioid Emergency Task Force

WHEREAS, Substance abuse is an illness that threatens a person's well-being, productivity, livelihood, and relationships;

WHEREAS, The number of heroin deaths have nearly doubled between 2010 and 2013, and now the number of deaths attributable to heroin and opioids exceeds the number of homicides in the State;

WHEREAS, Many new heroin users began with a dependency on legal prescription opioids, then migrated to illegally obtained opioids including heroin, which is less expensive and often more readily available;

WHEREAS, Heroin and opioid drug abuse constitutes a public health crisis for the citizens of Maryland;

WHEREAS, Drug-related crimes, even when committed by otherwise non-violent persons, harm not only the victims of these crimes but also adds significant costs to the State, counties, and municipalities;

WHEREAS, A large number of occupants entering our detention and correctional facilities are suffering from previously untreated substance abuse disorders;

WHEREAS, This crisis is exacerbated by the trafficking of large quantities of heroin into and throughout our State, which requires increased efforts by law enforcement; and

WHEREAS, The State must take immediate steps to structure our State agencies, laws, and regulations to establish best practices.

NOW, THEREFORE, I, LAWRENCE J. HOGAN, JR., GOVERNOR OF THE STATE OF MARYLAND, BY VIRTUE OF THE AUTHORITY VESTED IN ME BY THE CONSTITUTION AND LAWS OF

MARYLAND, HEREBY PROCLAIM THE FOLLOWING EXECUTIVE ORDER, EFFECTIVE IMMEDIATELY:

A. Establishment: There is a Governor's Heroin and Opioid Emergency Task Force (Task Force).

B. Membership.

(1) The Task Force shall consist of the following:

(a) The Lieutenant Governor;

(b) An appointee of the President of the Senate;

(c) An appointee of the Speaker of the House;

(d) An appointee of the Attorney General; and

(e) Seven public members to be appointed by the Governor with a range of experience related to heroin and opioid addiction treatment such as public health, mental health, public safety, and family support services.

(2) Staff members from the Offices of the Governor and Lieutenant Governor, the Governor's Office of Crime Control and Prevention, the Governor's Office of Community Initiatives, and the Office of Problem Solving Courts, will also be regular participants.

(3) Other State agencies, as well as representatives from federal agencies and law enforcement, and their staffs, may be asked to participate at the invitation of the Chair.

C. Duties.

(1) The Task Force shall advise and assist the Governor in establishing a coordinated state-wide and multijurisdictional effort to prevent, treat, and significantly reduce heroin and opioid abuse.

(2) The Task Force shall advise the Governor and the Director of Homeland Security on immediate steps to improve coordination between federal, State, and local law enforcement regarding the trafficking and distribution of heroin and opioids in Maryland.

(3) The Task Force shall submit an interim report no later than six months from the date of this Executive Order on the findings to date relating to the impact of heroin and opioid drug abuse upon public health officials, law enforcement, addiction treatment professionals, families, and other parties.

(4) The Task Force shall submit a final report to the Governor by December 1, 2015 that includes, but is not limited to recommendations for policy, regulations, or legislation to address the following:

(a) Improvement in access to heroin and opioid drug addiction treatment and recovery services across the State, including in our detention and correctional facilities, as well as development of specific metrics to track progress;

(b) Improvement and standardization of the quality of care for heroin and opioid drug addiction treatment and recovery services across the State as well as development of specific metrics to track progress;

(c) Improvement in federal, State, and local law enforcement coordination to address the trafficking and distribution of heroin and opioids throughout the State;

(d) Improvement of coordination between federal, State, county, and municipal agencies to more effectively share public health information and reduce duplicative research and reporting;

(e) Improvement in help available for parents, educators, community groups, and others to prevent youth and adolescent use of heroin and opioids;

(f) Development of alternatives to incarceration for nonviolent offenders whose crimes are driven primarily by their drug addiction; and

(g) Increased public awareness of the heroin and opioid abuse crisis, including ways to remove prejudices associated with persons suffering from substance abuse disorders.

D. Procedures.

(1) The Lieutenant Governor shall chair the Task Force. The Chair shall:

(a) Oversee the implementation of this Executive Order and the work of the Task Force;

(b) Determine the Task Force's agenda; and

(c) Identify additional support as needed.

(2) The Task Force shall convene within 21 days of this Executive Order and meet as frequently as necessary to meet the deadlines established herein.

(3) The Task Force shall conduct regional summits in various parts of the State, including the Eastern Shore, Southern Maryland, Western Maryland, Central Maryland, and the Washington, D.C. Suburbs, to study the impact of heroin and opioid drug abuse in their communities upon public health officials, law enforcement, addiction treatment professionals, families, and other parties.

(4) A majority of the Task Force members shall constitute a quorum for the transaction of any business.

(5) The Task Force may adopt other procedures as necessary to ensure the orderly transaction of business.

GIVEN Under My Hand and the Great Seal of the State of Maryland, in the City of Annapolis, effective this 24th Day of February, 2015.

Lawrence J. Hogan, Jr.
Governor

ATTEST:

John C. Wobensmith
Secretary of State

INTERIM REPORT

HEROIN & OPIOID EMERGENCY TASK FORCE

Lieutenant Governor Boyd K. Rutherford, Chair

AUGUST 24, 2015

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August 24, 2015

Larry Hogan
Governor, State of Maryland
100 State Circle
Annapolis, MD 21401

Dear Governor Hogan:

Through our travels during the 2014 gubernatorial campaign, we heard stories from families, law enforcement, and healthcare professionals of the devastation heroin and opioid abuse has wreaked on communities. As a candidate, you stood alone in publicly recognizing the crisis that has engulfed our State.

I applaud your leadership in creating the Heroin and Opioid Emergency Task Force and thank you for appointing me as Chair. Over the past six months, the Task Force has brought together hundreds of stakeholders in order to develop a plan to tackle this emergency and provide you with holistic and comprehensive recommendations.

Enclosed is our Interim Report, which includes our findings and Task Force workgroup updates. Though final recommendations are not due until later this year, the Interim Report includes 10 recommendations, which can be implemented by the relevant state agency within a few weeks. It also includes 10 funding announcements: seven Department of Health and Mental Hygiene allocations to improve access to treatment and quality of care and three Governor's Office of Crime, Control, and Prevention grants to support law enforcement efforts.

Thank you for your continued leadership and support. We look forward to submitting our Final Report on December 1, 2015.

Sincerely,

Boyd K. Rutherford
Lieutenant Governor, State of Maryland
Chair, Heroin and Opioid Emergency Task Force

I. EXECUTIVE SUMMARY

On February 24, 2015, Governor Hogan issued Executive Order 01.01.2015.12, which created the Heroin and Opioid Emergency Task Force. The Task Force is composed of 11 members with expertise in addiction treatment, law enforcement, education, and prevention. Lieutenant Governor Boyd K. Rutherford serves as the Chair. The Task Force was charged with advising and assisting Governor Hogan in establishing a coordinated statewide and multi-jurisdictional effort to prevent, treat, and significantly reduce heroin and opioid abuse.

In addition, the Task Force must provide recommendations for policy, regulations, or legislation to address the following:

a) Improvement in access to heroin and opioid drug addiction treatment and recovery services across the State, including in our detention and correctional facilities, as well as development of specific metrics to track progress;
b) Improvement and standardization of the quality of care for heroin and opioid drug addiction treatment and recovery services across the State, as well as development of specific metrics to track progress;
c) Improvement in federal, state, and local law enforcement coordination to address the trafficking and distribution of heroin and opioids throughout the State;
d) Improvement of coordination between federal, state, county, and municipal agencies to more effectively share public health information and reduce duplicative research and reporting;
e) Help for parents, educators, community groups, and others to prevent youth and adolescent use of heroin and opioids;
f) Development of alternatives to incarceration for nonviolent offenders whose crimes are driven primarily by their drug addiction; and
g) Increased public awareness of the heroin and opioid abuse crisis, including ways to remove prejudices associated with persons suffering from substance use disorders.

This Interim Report details the Task Force's findings from the regional field summits relating to the impact of heroin and opioid drug use on public health, law enforcement, addiction treatment professionals, families, and communities at large. It is divided into four major sections: Summit Findings, Workgroup Areas of Further Study, Preliminary Recommendations, and Approved Resource Allocations.

The Summit Findings section reflects information provided by the hundreds of stakeholders who testified at the regional summits and in subsequent stakeholder conversations with members of the

Task Force. There are five subsections: a) Access to Treatment; b) Quality of Care; c) Law Enforcement; d) Drug Courts and Reentry; and e) Education and Prevention. Major themes reflected in this section include: insufficient federal, state, and local funding; a critical shortage of residential and outpatient treatment options; inconsistent quality of care standards; an increase in heroin- and opioid-related criminal activity; the promising preliminary outcomes of day reporting centers and jail-based Vivitrol (*i.e.* naltrexone) programs; and the need to raise public awareness and reach young people earlier in more innovative ways.

The Task Force subdivided into five workgroups, which mirrored the five major categories of information provided to the Task Force at the regional summits and through electronic submissions: a) Access to Treatment and Overdose Prevention; b) Quality of Care and Workforce Development; c) Intergovernmental Law Enforcement Coordination; d) Drug Courts and Reentry; and e) Education, Public Awareness, and Prevention. The Workgroup Areas of Further Study section details the objectives, guiding principles, and specific issues under consideration by each workgroup.

The Preliminary Recommendations section details 10 recommendations that can be implemented within a few weeks at little or nominal cost to the relevant state agency. Five recommendations relate to improving prevention and education efforts for youth and adolescents, two relate to law enforcement and the jail-based population, one relates to quality of care in hospital emergency rooms, another relates to highlighting and leveraging faith-based resources, and the last relates to an immediate weeklong public awareness push.

The Approved Resource Allocations section details how $2,000,000 in additional treatment and prevention funding, released by Governor Hogan for fiscal 2016, will be spent. Generally, funds will be spent on naloxone training and distribution to local health departments and local detention centers, overdose survivor outreach programs in hospital emergency departments, prescriber education to improve quality of care, recovery housing for women with children, detoxification services for women with children, and to increase bed capacity at the A.F. Whitsitt Center, a state-operated residential treatment facility on the Eastern Shore. It also details how $189,000 in Governor's Office of Crime Control and Prevention grant funding to local law enforcement will be spent for overtime pay, gang and heroin disruption efforts, and license plate reader technology.

The final report is due on December 1, 2015, and will contain further recommendations.

II. SYNOPSIS OF PRELIMINARY RECOMMENDATIONS

Below are synopses of the Heroin and Opioid Task Force's preliminary recommendations to Governor Hogan that can be implemented within weeks upon authorization.

1. **Earlier and Broader Incorporation of Heroin and Opioid Prevention into the Health Curriculum**
   The Task Force recommends that the Maryland State Department of Education's Division of Curriculum, Assessment, and Accountability develop age-appropriate lessons and resources on heroin and opioid use in support of the Maryland Comprehensive Health Curriculum.

2. **Infusion of Heroin and Opioid Prevention into Additional Disciplines**
   The Task Force recommends that MSDE's Division of Curriculum, Assessment, and Accountability develop Disciplinary Literacy lessons integrating education on heroin and opioid use with College and Career-Ready Standards.

3. **Heroin and Opioid Addiction Integrated into Service Learning Projects**
   The Task Force recommends that MSDE's Service-Learning Office create service learning curriculum-based projects that engage students in addressing the heroin and opioid public health crisis.

4. **Student-based Heroin and Opioid Prevention Campaign**
   The Task Force recommends that MSDE partner with the Office of the Governor and state agencies on a coordinated, multi-tiered public education campaign that discourages students from using heroin or abusing opioids.

5. **Video PSA Campaign**
   The Task Force recommends the recruitment of university film students to develop and produce Public Service Announcements (PSA) to be distributed for broadcast and State social media platforms.

6. **Maryland Emergency Department Opioid Prescribing Guidelines**
   The Task Force recommends that each acute care hospital work with its Emergency Department personnel to implement, as medically appropriate, the opioid prescribing guidelines developed by the Maryland Hospital Association.

7. **Maryland State Police Training on the Good Samaritan Law**
   The Task Force recommends that the Maryland State Police provide training to field and investigative personnel on the legal requirements of the Good Samaritan Law.

8. **Maryland State Police Help Cards and Health Care Follow-Up Unit**

   The Task Force recommends that the Maryland State Police provide heroin and opioid "Help Cards" to all MSP troopers and develop, in conjunction with the Department of Health and Mental Hygiene, a healthcare follow-up unit.

9. **Faith-based Addiction Treatment Database**

   The Task Force recommends that the Governor's Office of Community Initiatives' Interfaith Coordinator develop a comprehensive database of faith-based organizations that provide addiction treatment services.

10. **Overdose Awareness Week**

    The Task Force recommends that the first week of September be declared Maryland Overdose Awareness Week, which will include a conference for Overdose Response Program (ORP) entities and other local events to raise awareness of the addiction and overdose problem.

III. SYNOPSIS OF APPROVED RESOURCE ALLOCATIONS

Below are synopses of approved resource allocations that Governor Hogan, in consultation with the Heroin and Opioid Emergency Task Force, has prioritized in the effort to combat the heroin and opioid public health crisis.

1. **Restoring the A.F. Whitsitt Center to a 40-bed Capacity**

   Governor Hogan will allocate an additional $800,000 in fiscal 2016 to the A.F. Whitsitt Center to restore capacity to 40 beds, allowing an additional 240 patients to receive treatment each year.

2. **Providing Community-Based Naloxone Training and Distribution**

   Governor Hogan has directed $500,000 in supplemental grant awards to Local Health Departments (LHD) to support ORP trainings.

3. **Piloting Overdose Survivor Outreach Program in Hospital Emergency Departments**

   Governor Hogan has directed the Behavioral Health Administration (BHA) to allocate $300,000 towards establishing a pilot Overdose Survivor Outreach Program (OSOP) in Baltimore City.

4. **Piloting Naloxone Distribution to Individuals Screened Positive for Opioid Use Disorder at Release from Local Detention Centers**

   Governor Hogan has directed BHA to provide $150,000 through supplemental awards to three Southern Maryland LHDs - Calvert, Charles, and St. Mary's Counties - to implement overdose education and naloxone distribution programs for individuals released from local detention centers.

5. **Expanding Supportive Recovery Housing for Women with Children**

   Governor Hogan has directed BHA to allocate $100,000 for recovery housing, prioritizing those jurisdictions that currently do not have recovery housing for women with children and those with a significant waiting list.

6. **Supporting Detoxification Services for Women with Children**

   Governor Hogan has directed BHA to make an additional $50,000 available to residential detoxification services with childcare services on site in Baltimore City.

7. **Targeted Outreach and Education to Aberrant/High-Risk Opioid and Other Controlled Substance Prescribers**

   Governor Hogan has directed BHA to allocate $100,000 to conduct targeted outreach and education for practitioners identified as engaging in high-risk prescribing practices.

8. **Overtime for Dorchester County Law Enforcement**

   Governor Hogan, through the Office of Crime Control and Prevention (GOCCP), will provide Dorchester County with $24,700 to provide overtime for law enforcement to address the opioid and heroin epidemic.

9. **Maryland State Police Gang/Heroin Disruption Project**

   Governor Hogan, through GOCCP, will provide Maryland State Police (MSP) with $40,000 to support MSP's Gang/Heroin Disruption Project.

10. **License Plate Reader Technology**

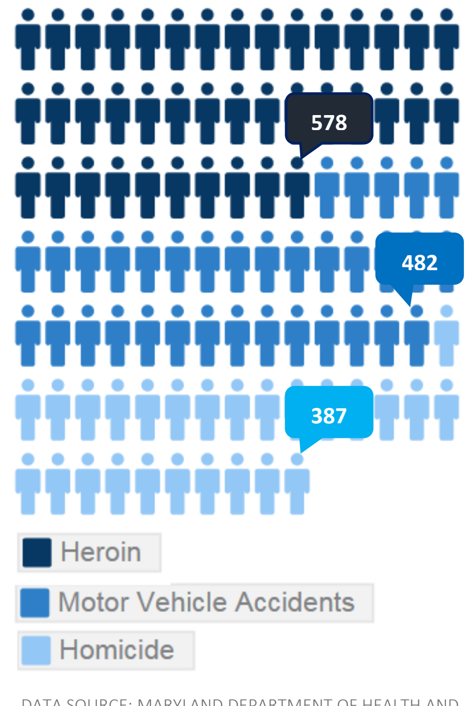
    Governor Hogan, through GOCCP, will provide the Ocean City Police Department with $124,635 to fund license plate reader (LPR) technology at the northern end of Ocean City to target heroin entering Maryland across state lines.

HEROIN & OPIOID EMERGENCY TASK FORCE

INTERIM REPORT

IV. INTRODUCTION

Throughout the 2014 gubernatorial campaign, then-candidates Larry Hogan and Boyd K. Rutherford visited every corner of the State and everywhere they traveled, heard the same tragic stories of how the heroin and opioid epidemic was destroying families and communities. It was clear that it was a public health crisis affecting Marylanders of all walks of life, regardless of socio-economic status, race, religion, education, or any other demographic. The State's prior response focused almost entirely on overdose prevention. Such efforts are important given that fatal overdoses from heroin outpaced the State's homicide rate and deaths from automobile accidents.[1] However, this administration is taking a comprehensive approach through education, treatment, quality of care, law enforcement, alternatives to incarceration, and overdose prevention.



DATA SOURCE: MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 2014 ANNUAL REPORT

On February 24, 2015, after only a month in office, Governor Hogan issued Executive Order 01.01.2015.12, formally creating the Heroin and Opioid Emergency Task Force. The Task Force was authorized to employ every resource available to take a holistic approach to address this public health emergency.

[1] In 2014, there were 578 heroin overdose deaths versus 421 homicides and 511 motor vehicle fatalities. *See* DHMH: Drug- and Alcohol-Related Intoxication Deaths in Maryland, 2014, and DHMH Vital Statistics Administration, Unpublished data, 2015. In 2013, there were 464 heroin overdose deaths versus 387 homicides and 482 motor vehicle fatalities. *See* DHMH: Drug- and Alcohol-Related Intoxication Deaths in Maryland, 2013, and DHMH: Maryland Vital Statistics Annual Report, 2013.

Task Force members include:

- Lieutenant Governor Boyd K. Rutherford, Chair
- Circuit Court Judge Julie S. Solt, Frederick County
- Sheriff Timothy Cameron, St. Mary's County
- Senator Katherine Klausmeier, District 8, Baltimore County
- Delegate Brett Wilson, District 2B, Washington County
- Nancy Whittier Dudley, President, Resilient Soul Services, Inc.
- Elizabeth Embry, Chief of the Criminal Division, Office of the Attorney General
- Dr. Michael B. Finegan, Peninsula Mental Health Services
- Dr. Bankole Johnson, Psychiatry Department Chair, UMD School of Medicine
- Tracey Myers-Preston, Executive Director, MD Addiction Directors Council
- Linda Williams, Executive Director, Addiction Connections Resource, Inc.

Pursuant to the Executive Order, the Task Force is required to submit recommendations on ways to improve public awareness, access to treatment, quality of care, alternatives to incarceration for non-violent drug abusers, and law enforcement coordination. The Task Force held six regional summits throughout the State to hear testimony from persons with substance use disorders, family members, educators, faith leaders, elected officials, law enforcement, addiction treatment professionals, and other stakeholders. The summits were held in Elkton, Baltimore City, Prince Frederick, Hagerstown, Salisbury, and Silver Spring. Participants offered unique perspectives into this public health crisis. An approximate total of 223 people testified before the Task Force—21 elected officials, 31 law enforcement officials, 78 addiction treatment professionals, and 93 members of the general public. In addition, dozens of people submitted written testimony, suggestions, and comments to the Task Force through its Web portal and email address.

> ***"As I travel throughout our State, I hear the devastating stories from our families and friends who hurt from the devastation heroin has wreaked on our communities."***
>
> *–Governor Larry Hogan*

This interim report reflects the Task Force's findings, the ongoing efforts of its workgroups, preliminary recommendations, and approved resource allocations with the understanding that a final report with further recommendations will be submitted to Governor Hogan on December 1, 2015.

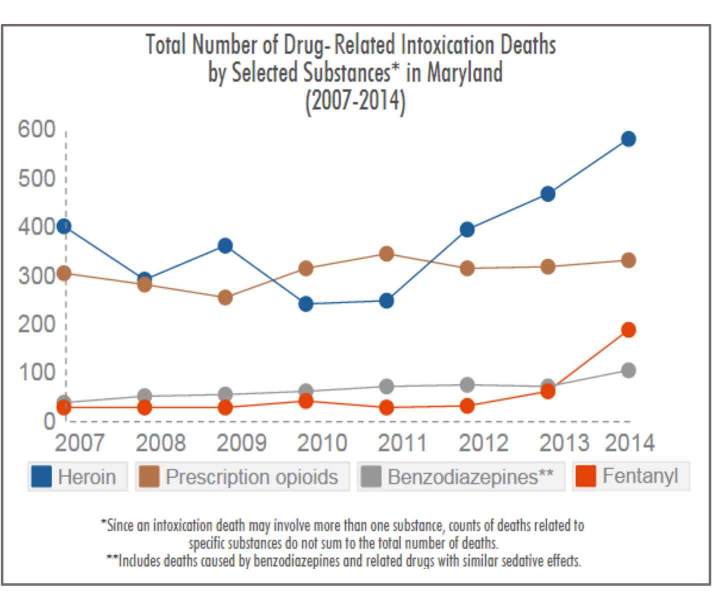
V. SUMMIT FINDINGS

The Heroin and Opioid Emergency Task Force held six regional summits to solicit input and guidance from a wide variety of sources. Testimony delivered at the summits can broadly be categorized into five areas: a) Access to Treatment; b) Quality of Care; c) Law Enforcement; d) Drug Courts and Reentry; and e) Education and Prevention. Below is a summary of the findings from the regional summits.

a. Access to Treatment

A strong recurring theme in the testimony delivered at the summits was the lack of sufficient resources to address the heroin and opioid epidemic and the serious issues Marylanders face as they try to access care. Stakeholders across the State reported a critical shortage of qualified treatment professionals and insufficient capacity at both inpatient and outpatient treatment facilities. The problem is acute in rural counties, where it is difficult to attract and retain treatment professionals. These challenges, among others, highlighted the need to realign and secure additional funding and launch efforts to expand the capacity and collaboration of the treatment system.

At each summit, there was compelling testimony that addressed the overwhelming inability to access treatment immediately. Families consistently reported experiencing multiple and repeated barriers, such as excessively long waiting periods, high deductibles and co-pays, delayed insurance authorization challenges, lack of appropriate levels of care in their respective county or region, among others. Such delays can result in serious consequences including death.



DATA SOURCE: MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 2014 ANNUAL REPORT

Health department and other county officials reported a shortage of long-term residential treatment options, though long-term rehabilitation is not always essential or necessary for every patient. Relatedly, testimony delivered to the Task Force highlighted the need to improve the transition of care for patients when they move from high-intensity residential

treatment to lower-intensity outpatient treatment to ensure high-quality and seamless continuity of patient care.

Stakeholders offered a variety of opinions about the most appropriate treatment needed in the community. Many cited limited or no availability of treatment that includes medication and advocated for the need for additional resources to utilize medication as an important component of treatment. On the other hand, some local parent coalitions were disturbed that medication usage during treatment has seemingly emerged as the sole option to address heroin and opioid dependency and that long-term abstinence-based residential treatment appears to have largely vanished as a valuable treatment option. The testimony also highlighted competing views in the community between those that would like to increase capacity and local treatment options and those that have voiced resistance to new or expanding programs in their communities.

b. Quality of Care

Individuals, families, community groups, and others from the private sector expressed deep concern regarding the increased challenges of providing effective substance use disorder treatment for heroin and opioid dependency. Established standards of care for addiction medicine and practice are not applied at all treatment facilities, resulting in inconsistent quality of care across providers in the State. Currently, notions of quality of care are often based on diagnoses, availability of services, and provider comfort rather than an evidence-based, outcome-driven approach. Additionally, person-centered care is often missing in Maryland's approach to behavioral health, which highlights the active involvement of patients and their families in the design of new care models and in decision-making about individual options for treatment.

Testimony from the public, including parents of children who overdosed and/or died, raised concerns with questionable prescribing practices of some physicians and dentists as well as the quality of some substance use disorder treatment programs, which were not diligent in monitoring the prescribing of opioid replacement medications and providing inadequate medication-only care. At the same time, there appeared to be some confusion by the public as to realistic expectations of the substance use disorder treatment system and what kinds of treatments are best for whom. Finally, there was great dissatisfaction regarding standards of care generally, gaps in communication and collaboration between health care services and law enforcement, and lack of accountability for outcomes.

A broad range of opinions were expressed regarding the use of medications to treat opioid dependency. There was general consensus on the value of Vivitrol (*i.e.* naltrexone), an opioid

antagonist, when dispensed in the context of a comprehensive treatment program. Yet there is concern that the public might be led to believe that naltrexone is a cure-all, which is not yet borne out by sufficient data. Opinions were decidedly mixed regarding opioid replacement interventions, such as methadone and buprenorphine. For example, these medications were described as "an essential component in the long-term treatment of opioid dependency"; "helpful for short-term use only"; "destructive to the patient seeking long-term recovery"; "useful as a 'stabilizing agent' only to prepare the patient to receive treatment"; and "extremely problematic to the operation of treatment programs and other community-based programs since the replacement medications are so often sold by patients for cash to then purchase heroin." A number of people stressed that a key component for addiction treatment and successful recovery is the assumption of personal responsibility. They go on to argue that many patients enter treatment as passive recipients and many treatment regimens involving medication-assisted drug treatment programs fail to promote the theme of personal responsibility.

Nevertheless, there is data on the effectiveness of opioid replacement in the treatment of opioid addiction from decades of research and endorsed by government agencies, including the federal Substance Abuse and Mental Health Services Administration (SAMHSA). According to SAMHSA, opioid replacement therapies have been shown to increase treatment retention while decreasing mortality, criminality, and risk of infectious disease.

Incidents of abuse by both prescribers and patients were reported in most counties. Some recurring concerns that point to the potential for medication diversion or abuse include: the worker's compensation system where medications are reimbursed at 100 percent with no co-pay; in physicians' offices, where medications are marked up at a rate of 500-600 percent; and in some medication-assisted drug treatment programs that maintain patients at higher doses and for a longer period of time than may be medically necessary.

c. Law Enforcement

Though it is evident that we cannot arrest our way out of the State's heroin and opioid problem, law enforcement still plays a very important role in combating this public health crisis. The scale of the heroin and opioid crisis is swamping law enforcement and depleting their resources, leaving local law enforcement ill-equipped to respond to the magnitude of the heroin and opioid problem in Maryland. Sheriffs and police chiefs across the State explained that they are devoting more and more of their resources to fighting heroin trafficking and related crime. In Kent County, 75-80 percent of drug enforcement activity

> ***"We can't arrest our way out of this problem."***
>
> *–St. Mary's County Sheriff Tim Cameron*

focuses on stemming the flow of heroin into the county. In St. Mary's County, 34 percent of all arrests are opioid-related. In Queen Anne's County, heroin is the driving force behind car thefts, thefts from autos, and burglaries. In Calvert County, more than half of all burglaries, sexual assaults, and homicides are related to heroin and opiates. In Allegany County, open-air drug markets are now common. To combat this problem, local jurisdictions have increased the numbers of sheriffs and prosecutors and created new intervention teams.

One of the key strategies presented at the summits is inter-agency collaboration. In Carroll County, prosecutors, sheriffs, members of the health department, and others have formed an overdose response team that focuses on prevention and education, prosecution of repeat drug trafficking offenders, and early intervention for those with minor offenses (treatment and education). They are also adding five detectives to the sheriff's office. Anne Arundel County has a similar collaboration and works closely with Anne Arundel County police and the United States Drug Enforcement Administration to bring cases against distributors and interrupt supply networks. In Caroline County, the Maryland State Police, collaborating with five local police departments, built a 25 co-defendant case. Cecil County has increased funding for their forensic lab. These collaborations were widely praised, but a common theme emerged that additional help is needed with heroin trafficking across State borders.

Some law enforcement officials suggested initiating a criminal investigation in response to every heroin or opioid overdose to identify whether the person who supplied the drugs should be criminally charged and to learn more about the supply network. In the meantime, some counties are referring every fatal overdose to federal authorities for prosecution of the supplier for homicide, since Maryland does not have an equivalent statute that would allow for a homicide charge. On the legislative front, many sheriffs and prosecutors were in favor of a change to Maryland statute to allow for prosecution of suppliers in the case of a fatal overdose and expressed concern about the decriminalization of small amounts of marijuana. The mandatory minimum sentencing laws for repeat offenders were met with mixed reactions. Some wanted stricter mandatory minimums while others praised the General Assembly for relaxing the mandatory minimum sentencing laws. Advocates also praised legislation signed by Governor Hogan that shields certain criminal records to help people obtain housing and employment, and legislation that created the Justice Reinvestment Council.

d. Drug Courts and Reentry

While many of the stakeholders who testified at the summits agreed that incarcerating an offender is not the appropriate way to solve the heroin and opioid epidemic, the criminal justice system does offer an interface to intervene and connect the individual with the resources needed for recovery. Drug courts represent one such opportunity for an offender to

connect with substance use disorder services. Drug court eligibility requirements vary in each jurisdiction, as do the available resources. These programs include needs assessments on arrest, diversion, jail-based substance use disorder treatment, and reentry programs.

Circuit Court Judge Nelson Rupp testified about the extensive conditions for completing the Montgomery County Drug Court program. This program highlighted the value of rapid communication and decisive action by the court and treatment program to deal with non-compliance. The program requires a minimum 30 days in a pre-release center, attending night court weekly, counseling two to three times a week, obtaining a job before moving into a sober home, living in a sober home, and getting slips signed by a sponsor and human services partner. A probation agent also makes periodic home checks. The program takes about two years to complete. Since its inception in 2004, approximately 163 participants have graduated from the Montgomery County Drug Court.

According to Retired Circuit Court Judge Ellen Heller, the Baltimore City Drug Court program includes addiction and mental health treatment, job training, housing, and education. She emphasized the cost savings for treating offenders instead of incarcerating them, but noted that the availability of quality programs, delays in accessing treatment, and the prevalence of co-occurring disorders remain prominent challenges for drug courts. She also identified other alternatives to incarceration for addicted offenders, including pre-charge and pre-booking programs in other jurisdictions.

Howard County State's Attorney Dario Broccolino testified that his county has both a drug court and a reentry program through the Howard County Detention Center. While the reentry program is new, it features drug treatment referral and occupational therapy. Baltimore County State's Attorney Scott Shellenberger identified diversion programs that are being expanded to include offenses other than marijuana. Calvert County State's Attorney Laura Martin noted the sizeable increase in addicted offenders in her county. Calvert County has a drug court; however, it has less than 30 participants. Calvert County is interested in increasing the number of participants because the success of the program makes the community safer. Sheriff Evans from Calvert County noted that forcing addicts into treatment through the criminal justice system is effective.

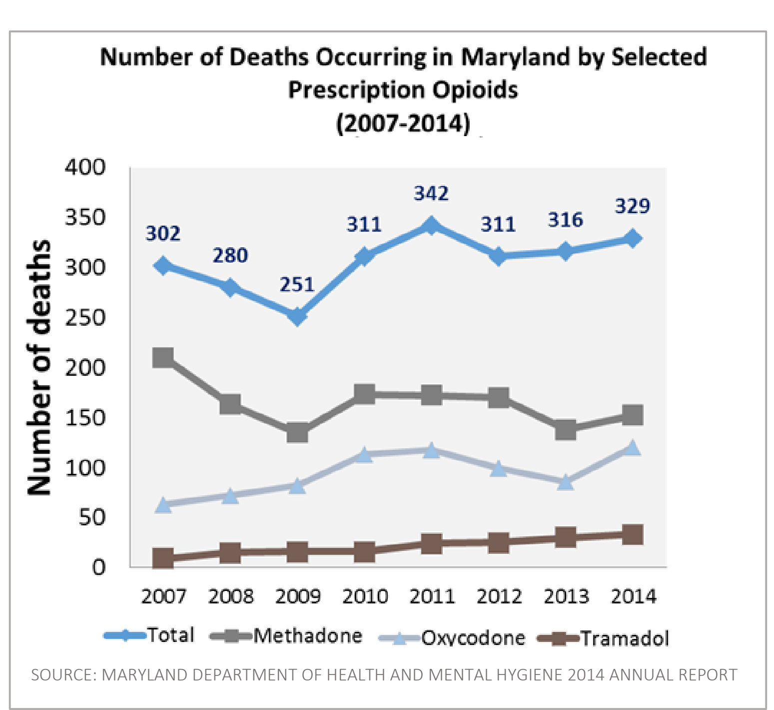
Testimony delivered at the Western Maryland summit discussed the use of Vivitrol (*i.e.* naltrexone) as part of law enforcement treatment options, particularly in Washington County where the Vivitrol pilot program has resulted in zero recidivism or failed tests thus far. Washington County has also been exploring a day reporting center to assist with wraparound services, such as drug and mental health treatment, job training, drug testing, life

skills, and other services, outside of the jail. Frederick County recently received a grant from the Governor's Office of Crime Control and Prevention to include Vivitrol as part of the detention center treatment options. It is important to note, however, that use of extended-release naltrexone in opioid addiction treatment is relatively novel when compared to opioid replacement therapy, and therefore less research exists to describe its effectiveness.

Other stakeholders recommended increased decriminalization efforts, reducing mandatory sentencing, expanding expungement availability, and enhancing reentry services for incarcerated inmates with sentences longer than 18 months. These services include mental health and substance use disorder treatment, housing, and other community benefits. It was also noted that individuals in recovery often have an added hurdle of criminal records to further frustrate employment and housing challenges.

e. Education and Prevention

At each regional summit, people expressed the need to start educating children at a younger age about the dangers of prescription medications, heroin, and other opioids. It was pointed out that there has been a growing problem of young people stealing prescription medications from family members and distributing them at parties (*i.e.* pill parties), with no idea of the medication's prescribed use or effect. Relatedly, it was suggested that parents need to become educated on heroin and opioid abuse, specifically how to talk with their children about drugs and what signs to look for that may indicate drug abuse. Similarly, teachers, law enforcement, judges, and even health care professionals need additional training to more effectively identify substance use disorders.



SOURCE: MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE 2014 ANNUAL REPORT

Stakeholders recommended that the State undertake a large-scale, coordinated media campaign employing all forms of media in order to educate the public and reduce the stigma associated with substance use disorders and addiction treatment. A number of creative ideas

were discussed to involve young people in the development of media campaigns in order to reach target populations. Others suggested that the State should publicize how to safely store and dispose of unused prescription medications.

Earlier this year, Governor Hogan signed legislation to extend civil immunity under the Good Samaritan Act to rescue and emergency care personnel administering medications or treatment in response to an apparent drug overdose. Despite the expanded protections, stakeholders suggested that additional education is needed to clarify the law for the public so that there is no resistance to offer help to a person overdosing on illicit drugs.

Summit participants urged the expansion of peer recovery coaches, resource centers, and naloxone training. It was also recommended that the State do a better job of reaching out to faith-based community organizations because they reach diverse communities and provide counseling services. Such services can be critically important for individuals that are trying to maintain recovery.

VI. WORKGROUP AREAS OF FURTHER STUDY

Following the regional summits, the Task Force subdivided into five workgroups to further study the main areas of concern raised during the summits: a) Access to Treatment and Overdose Prevention; b) Quality of Care and Workforce Development; c) Intergovernmental Law Enforcement Coordination; d) Drug Courts and Reentry; and e) Education, Public Awareness, and Prevention. The policy areas to be studied by each workgroup reflect the duties assigned to the Task Force in the underlying Executive Order. Each workgroup is co-chaired by two Task Force members who solicited the participation of stakeholders interested in the particular subject area. Below are specific issues under consideration by each respective workgroup.

Task Force Workgroups

a) Access to Treatment and Overdose Prevention Workgroup

b) Quality of Care and Workforce Development Workgroup

c) Intergovernmental Law Enforcement Coordination Workgroup

d) Drug Courts and Reentry Workgroup

e) Education, Public Awareness, and Prevention Workgroup

a. Access to Treatment and Overdose Prevention Workgroup

Task Force members Dr. Michael Finegan and Tracey Myers-Preston serve as co-chairs of the Access to Treatment and Overdose Prevention Workgroup. The workgroup is supported by staff from the Department of Health and Mental Hygiene, Department of Human Resources, Maryland Insurance Administration, Department of Juvenile Services, Governor's Office of Crime Control and Prevention, and the Governor's Office of Children. The workgroup is focusing on the challenges individuals and families face with regard to accessing treatment, financial barriers to accessing treatment, and identifying and prioritizing target populations, such as adolescents, pregnant women, and the justice-involved population. Currently, individuals and families lack sufficient information regarding how to access treatment and how best to navigate the treatment system. Further compounding this problem is insufficient access to outpatient and residential treatment, especially for youth and adolescents.

Data provided by the Department of Health and Mental Hygiene indicates that serious deficiencies exist in the treatment system that prevent an individual from accessing the full range of care settings and levels of care. The admission data for fiscal year 2014 by level of care indicates inconsistent use and lack of availability of the full continuum of care in each

part of the State. With the exception of Baltimore City, every county has significant gaps in services. Counties located in Western Maryland and on the Eastern Shore provide the majority of their services in outpatient settings, possess very limited access to residential services, and lack other services across the continuum of care. Furthermore, across the State, there is concern related to transportation, childcare, care for aging parents, and maintaining employment while in treatment.

Another important area of study that the workgroup will examine is the extent to which jurisdictions are funding intervention, assessment, referral, and treatment services beyond traditional business hours, as best practices consistently support the theory that treatment must be readily available. Given the fact that individuals may be uncertain about entering treatment, the system must be positioned to take advantage of any opportunity when an individual expresses a readiness to enter treatment. Treatment must be immediately available and readily accessible. Some facilities have implemented a "no wrong door" approach that includes a 24-hour phone-based hotline, emergency room diversion, screening and referral for treatment, and same-day access to services via walk-in appointments.

The workgroup will identify which programs in the State are offering treatment on demand and providing after-hours services, and will explore methods to incentivize treatment providers to similarly establish urgent care. The workgroup will also determine what technical assistance the State can provide that would allow treatment providers to offer assessments and referrals to treatment beyond traditional business hours.

Care should be individualized, clinically driven, patient-directed, and outcome-informed. Matching the treatment setting, intervention, and services to each individual is critical to achieving positive outcomes. Patients should be afforded the opportunity to receive care at the appropriate level and step up or down in services based on the individual's response to treatment. With this in mind, the workgroup will explore whether the use of outpatient services rather than residential service is truly the result of clinical need or is instead based on availability. Funding clinically inappropriate services is a waste of precious resources, as recovery will not likely be achieved and the patient will continue to cycle in and out of the healthcare system, or worse. The workgroup will also examine whether public dollars are being spent on higher levels of service than what is assessed. For example, a judge could order residential treatment for individuals based upon criminal justice or housing concerns rather than clinical need.

b. Quality of Care and Workforce Development Workgroup

Task Force members Dr. Bankole Johnson and Nancy Dudley serve as co-chairs of the Quality of Care and Workforce Development Workgroup. The workgroup is supported by staff from the Department of Health and Mental Hygiene and Department of Human Resources and will examine a number of factors affecting quality, outcomes, and workforce development.

Standardized quality of care at treatment centers across the State is critically important to ensure that patients have access to evidence-based care. Testimony delivered at the regional summits highlighted inconsistencies across the State. As a result, the workgroup will address inconsistencies in the quality of care across treatment centers and recommend strategies to standardize and enhance quality of care in order to produce the best outcomes for patients. Patient satisfaction surveys and outcome measures will also be explored to ensure patients are treated with the highest quality of care and that patients and their families are actively involved in their treatment plan. The workgroup will also consider ways to bridge the gap in care for individuals with comorbidities, such as chronic pain, psychiatric disorders, and pregnancy. Finally, an adequate supply of treatment professionals is critical to handle the demand demonstrated across the State. As part of its work, the workgroup will identify strategies to cultivate sufficient numbers of qualified, trained, diverse, and competent treatment professionals.

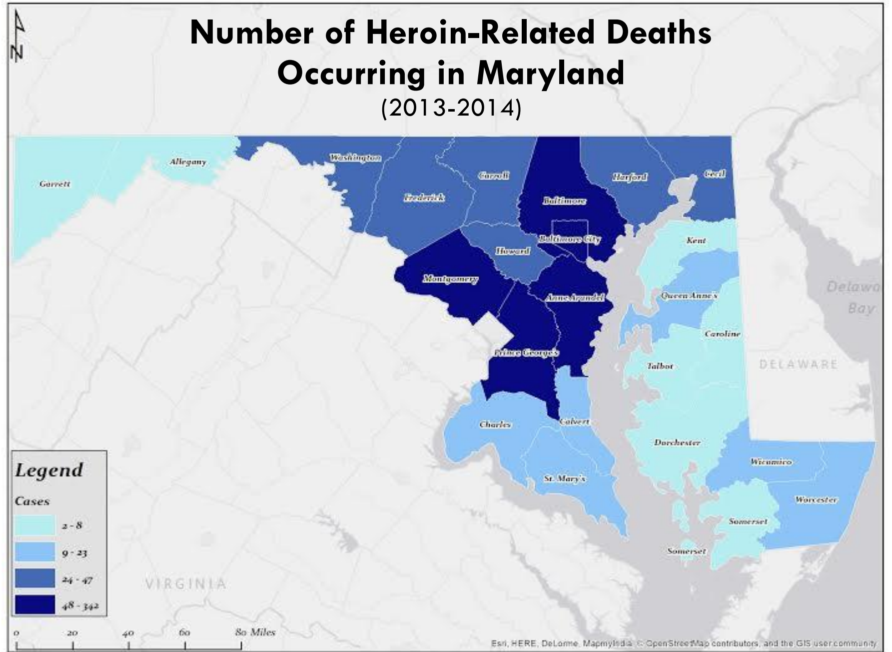
During the course of the regional summits, the workgroup noted deep confusion by the public as to what constitutes effective treatment for heroin and opioid dependency. Effective treatment of individuals with opioid use disorder should be evidence-based, outcome-driven, continuous, comprehensive, compassionate, and based upon integrating both the medical and psychosocial needs of the individual. There is also significant evidence for the efficacy, safety, and life-saving role of medications in the treatment of opioid use disorder. Decisions regarding medication-assisted treatment should be made in collaboration between a patient and a knowledgeable and trained healthcare practitioner. As a corollary, healthcare professionals should provide information to patients about all the different medication options, their pros and cons, and discuss with patients the role of medications as part of individualized treatment planning. Patients should be encouraged to play an active role in their treatment for it to have optimal efficacy and achieve optimal outcomes, including long-term recovery. In short, patients who participate actively in their own treatment have the best outcomes.

c. Intergovernmental Law Enforcement Workgroup

Task Force members Sheriff Tim Cameron and Elizabeth Embry serve as co-chairs of the Intergovernmental Law Enforcement Workgroup. The workgroup is supported by staff from the Governor's Office of Crime Control and Prevention, Maryland State Police, Department of

Human Resources, and Maryland State Department of Education. The workgroup is developing recommendations to improve federal, state, and local law enforcement coordination to address heroin and opioid trafficking across the State. To reach this broad objective, the workgroup developed a work plan covering five core areas: data sharing, intelligence gathering and methods of real-time dissemination, heroin interdiction strategies, prescription drug enforcement and monitoring, and possible legislation that will enable law enforcement to combat the heroin epidemic more effectively.

Improved data sharing among local, state, and federal law enforcement concerning heroin-related enforcement activity is vital for coordinated law enforcement efforts against heroin traffickers in Maryland. While there are structures in place, there are gaps and technological hurdles that need to be addressed. The workgroup will produce specific recommendations to develop a fully functioning, centralized, statewide system used by all local, state, and federal law enforcement to capture data on heroin-related crime.



Similar to the sharing of data, the collection and dissemination of intelligence on heroin trafficking from debriefings, confidential informants, social media, cell phones, and investigations into overdoses occurs inconsistently and may be delayed by protocols designed to protect sensitive information. The workgroup will create recommendations to eliminate unnecessary barriers to the sharing of intelligence among law enforcement agencies and disseminate the best available guidance on how to allocate the responsibility of sharing that information within an agency.

In addition to existing strategies for interdiction, the workgroup will look at allocating additional resources to methods that are underutilized. Partnerships with law enforcement in neighboring states are piecemeal and should be expanded and standardized. The workgroup will develop these recommendations based on proven strategies. Criminal

enforcement of doctors and pharmacies responsible for illegally prescribing or dispensing opiates has been sparse. This is due, in part, to the fact that the transactions occur in private, and in part to the lack of prescription data accessible to law enforcement. The workgroup will explore expanding the usefulness of the Maryland Prescription Drug Monitoring Program (PDMP) to law enforcement through mandatory registration and querying and dedicating investigative and prosecutorial resources to enforcement. Many members of local law enforcement have developed partnerships with local pharmacies so that they are alerted if there is suspicious behavior. In some cases, these initiatives could be replicated and the workgroup will evaluate the feasibility of expanding those partnerships statewide.

Lastly, the workgroup will examine the challenges drug addiction creates in maintaining safety inside correctional facilities. Inmates come up with inventive ways to smuggle contraband drugs inside the facilities. Contraband can be treated as a form of currency, incite violence, and derail an inmate's substance use treatment program. During fiscal year 2015, the Department of Public Safety and Correctional Services (DPSCS) confiscated 187 opiates and approximately 3,350 forms of Suboxone. One of the primary means by which inmates attempt to smuggle contraband is by having their friends and acquaintances conceal it in letters and in the folds of greeting cards. In order to minimize opportunities for introduction of contraband into the facility by mail, especially contraband available in forms visually undetectable, the workgroup will evaluate measures to disrupt smuggling of drugs through inmate personal correspondence mail.

d. Drug Courts and Reentry Workgroup

Task Force members Judge Julie Solt and Delegate Brett Wilson serve as co-chairs of the Drug Courts and Reentry Workgroup. The workgroup is supported by staff from the Department of Public Safety and Correctional Services, Department of Juvenile Services, Governor's Office of Crime Control and Prevention, Department of Human Resources, Maryland State Department of Education, and the Governor's Office of Children. Due to the close correlation between addiction and criminal activity, the criminal justice system, via drug courts and reentry programs, is frequently a gateway to treating heroin- and opioid-addicted offenders.

The workgroup is exploring opportunities with diversion programs, drug courts, day reporting centers, Health General Placements (*i.e.* 8-505/8-507 programs[2]), and reentry programs. The workgroup is currently working with the Maryland State's Attorneys' Association to collect

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[2] 8-505/8-507 programs refer to programs created to give effect to powers granted to the judiciary under MD. CODE ANN., HEALTH–GEN. §8-505 and §8-507 to evaluate a defendant to determine whether, by reason of drug or alcohol abuse, the defendant is in need of and may benefit from treatment and is willing to participate in treatment.

data on which jurisdictions have diversion programs, whether treatment is required where the offender is identified as being heroin- or opioid-addicted, and the recidivism rate for diverted offenders. The workgroup will be exploring recommendations on best practices for successful diversion programs for heroin- and opioid-dependent offenders.

With respect to drug courts, the workgroup is researching how existing programs differ in each jurisdiction. The workgroup will determine whether there is a way to create some uniformity across the various drug court programs with respect to core functions and program requirements. The workgroup has also been in contact with the judiciary regarding the 8-505/8-507 process. It has received information and concerns relating to manipulation of the program to reduce incarceration length, funding issues, delays in treatment, and the appropriate length of treatment.

In addition, the workgroup is examining the merits of day reporting centers, which are designed to operate through the home detention programs available in all Maryland jurisdictions. These centers provide the types of services often needed by addicted offenders, such as drug and mental health treatment, job training, drug testing, life skills, and other services all located under one roof. The workgroup will develop recommendations on how to implement day reporting centers, particularly in areas of the state with fewer local resources. Lastly, the workgroup is gathering data on various reentry programs with the goal of identifying what works, why it works, and which can be duplicated across the state.

e. Education, Public Awareness, and Prevention Workgroup

Task Force members Senator Katherine Klausmeier and Linda Williams serve as co-chairs of the Education, Public Awareness, and Prevention Workgroup. The workgroup is supported by staff from the Maryland State Department of Education, Department of Health and Mental Hygiene, Department of Human Resources, Governor's Office of Community Initiatives, and the Governor's Office of Children. The workgroup is developing recommendations to address ways to engage youth and adolescents, prevention strategies, relapse prevention, overdose death prevention, and the reduction of stigma. Any recommendations will reflect the importance of messaging for specific audiences, including children, parents, families, educators, public health officials, law enforcement, addiction treatment professionals, community groups, and other stakeholders.

> ***"From preventing our kids from using heroin in the first place to increasing and improving access to treatment services for those in recovery, this task force will employ every resource available to take a holistic approach to address this public health emergency."***
>
> *–Governor Larry Hogan*

The workgroup will be studying environmental factors including the broader physical, social, cultural, and institutional forces that contribute to illicit drug use and addiction. It will begin with strategies to stop heroin and opioid abuse before it has a chance to occur. This level of prevention involves education in schools, including use of research-informed curriculum in elementary, middle, and high schools as well as community-based youth services and other nonprofit organizations with a history of providing effective drug education. It also includes the education or re-education of health care professionals about the disease of addiction, the use of screening tools, and problems that can arise from overprescribing opioids.

Next, the workgroup will explore strategies targeted toward those most at risk for problems with heroin or opioids. The workgroup will develop recommendations related to intensive substance abuse education for at-risk and high-risk individuals such as those charged with drug-related offenses or children of addicted parents.[3] In addition, the workgroup will consider the use of social workers or licensed counselors in middle and high schools to provide support as well as screenings, brief intervention, and referrals to treatment (*i.e.* SBIRTs).

The workgroup will pursue strategies to reduce heroin and opioid abuse and support the recovery efforts of people with substance use disorders. The workgroup is exploring ways to provide more supportive environments for young people, such as recovery clubs, recovery high schools, and collegiate recovery centers. It is also developing recommendations for increased naloxone training. The workgroup is focusing on ways to reduce the stigma associated with addiction, including educating the public on the brain science of addiction to clarify that it is a disease rather than a moral weakness. It also agrees that the State should employ a large-scale, coordinated media campaign to educate the public on heroin and opioid abuse.

The Centers for Disease Control and Prevention states that 45 percent of heroin addicts were also addicted to prescription painkillers. The Drug Enforcement Agency has stated that at least 70 percent of new heroin users started with prescription painkillers. Accordingly, the Task Force will explore reintroducing legislation similar to House Bill 3 of 2015 introduced by then-Delegate Kelly Schulz, which will require a prescriber and a dispenser to query the Prescription Drug Monitoring Program (PDMP) to review a patient's prescription monitoring data before prescribing or dispensing a monitored prescription drug. The PDMP was established in 2011 and is housed within the Department of Health and Mental Hygiene (DHMH) to support healthcare providers and their patients in the safe and effective use of prescription drugs. The PDMP collects and stores information on drugs that contain controlled

[3] The workgroup has identified the need for law enforcement, corrections, parole, and probation officers to learn about the disease of addiction and appropriate responses to relapse.

dangerous substances and are dispensed to patients in Maryland. The PDMP also assists in investigations of illegal or inappropriate prescribing, misuse, diversion, or other prescription drug abuse.

Currently, the law does not require prescribers or dispensers to query their patients' PDMP data when prescribing or dispensing controlled substances. As such, the Task Force will explore requiring a prescriber and a dispenser to query the PDMP to review a patient's prescription monitoring data before prescribing or dispensing a monitored prescription drug. Requiring prescribers and dispensers to access PDMP prior to prescribing or dispensing a controlled prescription drug will increase the number of registered PDMP users and the number of inquiries. If legislation is pursued, the Task Force envisions extensive outreach to stakeholders to reach consensus on which healthcare professionals should be required to register and query the PDMP, and under what circumstances. DHMH will also need to increase the technical capabilities of the PDMP to support additional users and increased queries.

In furtherance of its efforts to stem the pipeline of new users, the Task Force will explore possible strengthening of prescriber and pharmacist disclosures. Prescription opioid medications are among the most widely prescribed drugs for the management of moderate to severe chronic pain. The potential for misuse, abuse, or diversion should be concerning for both prescribers and dispensers of opioid prescription medication. There is a role that both prescribers and dispensers can play to ensure the safe use of opioid pain management therapy. Pharmacists are a central point of contact for patients when they fill prescriptions and present an opportunity to further inform patients of any potential adverse side-effects.

The Task Force will explore whether additional, verbal counseling should be required when prescribing or dispensing an opioid prescription drug to patients in Maryland. Prescribers have a responsibility to counsel patients about the specific details of the drugs they are prescribing. They also have a responsibility to monitor patient use, abuse, or diversion of drugs. The Task Force will explore whether prescribers should verbally counsel their patients on how to secure and properly dispose of opioid prescription drugs, as well as the risks of misuse or abuse of opioid prescription drugs. The Task Force will examine the role pharmacists play to ensure that patients understand the risks and benefits of the opioid prescription drugs and whether face-to-face verbal counseling is practical.

VII. PRELIMINARY RECOMMENDATIONS

Though the Task Force is working diligently to develop final recommendations for the December 1, 2015 final report, this interim report includes 10 recommendations with a heavy emphasis on education and prevention strategies targeted toward youth and adolescents.

Recommendation Overview

1. **Earlier and Broader Incorporation of Heroin and Opioid Prevention into the Health Curriculum**
2. **Infusion of Heroin and Opioid Prevention into Additional Disciplines**
3. **Heroin and Opioid Addiction Integrated into Service-Learning Projects**
4. **Student-based Heroin and Opioid Prevention Campaign**
5. **Video PSA Campaign**
6. **Maryland Emergency Department Opioid Prescribing Guidelines**
7. **Maryland State Police Training on the Good Samaritan Law**
8. **Maryland State Police Help Cards and Healthcare Follow-Up Unit**
9. **Faith-based Addiction Treatment Database**
10. **Overdose Awareness Week**

1. Earlier and Broader Incorporation of Heroin and Opioid Prevention into the Health Curriculum

The Task Force heard extensive testimony relating to improving the education of children and adolescents on heroin and opioids at earlier ages. As such, the Task Force recommends that the Maryland State Department of Education's Division of Curriculum, Assessment, and Accountability develop age-appropriate lessons and resources on heroin and opioid use in support of the Maryland Comprehensive Health Curriculum by the MSDE Educational Specialist in Health and Physical Education (PE), Local Education Agency (LEA) Health/PE Coordinators, and Master Teachers. In addition, the Task Force recommends that corresponding professional development and training for school personnel will ensure effective implementation of the materials that are created.

Due to the variety of delivery formats for comprehensive health education amongst the LEAs, lessons and resources will be developed for the traditional focused health classroom as well as cross-curricular resources that can be used by teachers throughout a school. Lessons and resources will be written with consideration given to the age and prior learning of students. Lessons and resources will look at the physical and mental effect heroin and opioid abuse has on a person. In addition, focus will be given to the larger consequence of heroin and opioid

abuse within families and communities. These lessons are ready for dissemination for the 2015-2016 school year.

2. **Infusion of Heroin and Opioid Prevention into Additional Disciplines**
   For students to be fully prepared for the challenges and expectations of college and career, it is critical that they develop literacy skills in all content areas. As a part of Maryland's College and Career-Ready Standards, it is critical that educators in all science, technical subjects, and history/social studies classrooms incorporate content-specific literacy into their instruction. As such, the Task Force recommends that MSDE's Division of Curriculum, Assessment, and Accountability develop Disciplinary Literacy lessons integrating education on heroin and opioid use with College and Career-Ready Standards (English Language Arts and mathematics) through the collaborative efforts of MSDE staff, LEA Content Coordinators, and Master Teachers.

   > ***"Virtually every 3rd grader can tell you that cigarettes are bad for you, but most don't know that taking someone else's prescription drugs is harmful."***
   >
   > *–Lt. Governor Boyd K. Rutherford*

   The use of the heroin and opioid topic as a central theme in social studies, science, fine arts, and other subjects supports the importance of introducing related college and career-ready standards to other disciplines. Since the standards emphasize research skills and the development of point of view related to these skills, this topic will generate interesting and pertinent classroom discussion and assignments in all content areas. The desire to incorporate a disciplinary literacy theme as part of standards-based education requires all subjects and disciplines to align their work with the theme chosen: heroin and opioid addiction. These lessons will be planned for dissemination during the 2015-2016 school year.

3. **Heroin and Opioid Addiction Integrated into Service-Learning Projects**
   Service-learning is a teaching method that combines meaningful service to the community with curriculum-based learning. Through service-learning, students improve their academic, social, and civic skills by applying what they learn in school to the real world. When meaningful reflection is added, students can use the experience to reinforce the link between their service and their learning. All 24 local school systems in Maryland implement service-learning graduation requirements. Each implements the requirements slightly differently because they tailor the specifics of their program to their local community.

   The Task Force recommends that MSDE's Service-Learning Office create service-learning curriculum-based projects that engage students in addressing the heroin and opioid public health crisis. The goal is to provide educators with rigorous and meaningful service-learning

curriculum models and guidance on how to re-engage students in the fight against heroin and opioid abuse. This curriculum will be aligned to newly developed heroin and opioid prevention education infused into course curriculum. To accomplish this task, MSDE's service-learning specialist will conduct meetings with Service-Learning Coordinators in the 24 LEAs. Staff will then work with curriculum specialists to understand relevant areas where these service-learning projects could be best infused. Staff will create the projects and share them at coordinator meetings and via MSDE's website.

4. Student-based Heroin and Opioid Prevention Campaign

The Task Force recommends that MSDE partner with the Office of the Governor and State agencies on a coordinated, multi-tiered public education campaign that discourages students from using heroin or abusing opioids. The campaign will focus on educating students and parents on how to identify and respond to signs of addiction and informing students, parents, and communities on how to access support services. To foster participation at the local level, the campaign will partner with all 24 school systems and youth-serving organizations throughout Maryland to communicate with students and adults during in-school and after-school activities. Target audiences will include students, parents, school personnel, and community and faith-based leaders.

Activities will include the following:

a) Pre- and post-campaign surveys/research to gauge public awareness and success;
b) Fall events at schools with multiple state leaders highlighting a success story or successful local overdose prevention plan that includes the LEA;
c) A student-led contest to design a campaign name, logo, and slogan to support Governor Hogan's overall statewide strategy;
d) Web pages to share key messages and resources, including communication toolkits, downloadable posters, and links to federal, state, and local campaigns, information, and contacts;
e) Focus groups with parents and students to discuss and gain knowledge of prevention and support needs and partner with DHMH and other agencies on health risk communication;
f) Social media campaign by youth to engage youth, led by the student member of the State Board of Education, the Maryland Association of Student Councils, and others; and

g) MSDE and State agencies will pursue earned media focused on prevention, what parents and students are saying, and school services that address the specific needs identified by parents and students.

5. Video PSA Campaign

Though the Education, Public Awareness, and Prevention Workgroup is developing the outlines of a large-scale, coordinated media campaign employing all forms of media, the Task Force recommends the immediate launch of video public service announcements via broadcast and social media throughout Maryland. The Department of Business and Economic Development's Division of Tourism, Film, and the Arts and the Maryland Higher Education Commission will seek students from local higher education institutions to develop and produce 30-second public service announcements. The best PSAs will be featured on State social media platforms and submitted to local broadcast stations for airing. The Governor's Communications Office will direct distribution of approved PSAs.

6. Maryland Emergency Department Opioid Prescribing Guidelines

According to the Centers for Disease Control and Prevention, the strongest risk factor for heroin addiction is addiction to prescription opioid painkillers. As such, hospitals can play an important preventive role in the fight to reduce opioid misuse and abuse. Earlier this summer, the Maryland Hospital Association developed standardized opioid prescribing guidelines for hospital emergency departments.[4] The guidelines are informed by a patient-focused brochure developed by the Maryland Chapter of the American College of Emergency Physicians (MDACEP) that was released in 2014. They were crafted to allow emergency medicine physicians flexibility in prescribing opioids when medically necessary while encouraging best practices in an effort to reduce the risk of opioid addiction. These guidelines, which are endorsed by MDACEP, promote:

> ***"There are some steps that could be taken to better inform doctors, dentists, pharmacists ... about the effects of prescription medications."***
>
> *–Lt. Governor Boyd K. Rutherford*

a) Screening and patient education to help detect and treat existing substance misuse conditions and safeguard patients against unnecessary risks of developing such conditions;

b) Enhanced information sharing among providers using existing tools like the State's health information exchange (CRISP) and the state's prescription drug monitoring program; and

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[4] See Appendix B.

c) Standardized prescribing practices to reduce unnecessary prescriptions (and the amount of pills prescribed) to diminish inadvertent or purposeful misuse of opioids.

The Task Force recommends that each acute care hospital work with its Emergency Department personnel to implement, as medically appropriate, these guidelines and provide the Maryland Hospital Association with periodic updates on the progress of the implementation.

7. Maryland State Police Training on the Good Samaritan Law

The Task Force recommends that the Maryland State Police (MSP) provide training to field and investigative personnel on the legal requirements of the Good Samaritan Law. It is apparent that some confusion exists among law enforcement agencies on what actions they can and cannot take when confronted with a police response that falls under the protection of this law. Unless efforts are taken to remove confusion, valuable intelligence and opportunities to combat this issue could be lost. It is recommended that the State's Attorneys' Association be included in this training, as conformance to this law should be consistent statewide.

8. Maryland State Police Help Cards and Healthcare Follow-Up Unit

The Task Force recommends that the Maryland State Police provide heroin and opioid "Help Cards" to all MSP troopers, with the distribution of the cards beginning in the Western Maryland barracks. The cards should contain health department, treatment, and financial assistance resource information. The cards should be distributed by troopers when encountering heroin- or opioid-related arrests or other encounters. They also can be provided to family members who contact MSP facilities seeking assistance or guidance for addicted family members, friends, or colleagues.

The Task Force also recommends that the Department of Health and Mental Hygiene assist the MSP in developing a healthcare follow-up unit that would be responsive to law enforcement, school personnel, and citizen referrals of persons involved in or at risk of being involved in heroin and opioid use. Often when these contacts occur, persons with substance use disorders are at their most vulnerable state, and quick treatment interaction may be the difference between recovery and continued abuse.

9. Faith-based Addiction Treatment Database

There is a groundswell of passion and commitment among faith groups to help combat the heroin and opioid health crisis. A number of representatives from the faith community, including pastors and members of congregations, stepped forward in support of individuals, families, and programs that are battling heroin and opioid dependency. Such faith-based groups are offering numerous forms of support, including space for 12-step meetings; outreach to individuals and families in crisis due to drug abuse; and non-clinical case

management support for drug dependent individuals who are either waiting to enter treatment, need support during treatment, or who require post-treatment support in order to enter into long-term recovery. Unfortunately, many people with substance use disorders and their families are unaware of the addiction treatment services faith-based organizations in their communities provide. As such, the Task Force recommends that the Governor's Office of Community Initiatives' (GOCI) Interfaith Coordinator develop a comprehensive database of faith-based organizations that provide such services and include contact information, hours of operation, and types of services. The database should be made accessible via GOCI's website and easily navigable by the general public.

10. Overdose Awareness Week

August 31 is International Overdose Awareness Day and September is the SAMHSA-sponsored National Recovery Month. The Task Force recommends that the first week of September be declared Maryland Overdose Awareness Week, which will include a conference for Overdose Response Program (ORP) entities, vigils, and other local events to raise awareness of the addiction and overdose problem.

VIII. APPROVED RESOURCE ALLOCATIONS

In May 2015, Governor Hogan authorized $2 million in additional funding for fiscal year 2016 to combat the heroin and opioid health crisis in Maryland. Over the last six months, the Task Force has had the opportunity to solicit input from well over 300 people on how to best utilize scarce resources to address this public health epidemic. Among the top suggestions received were requests for increased overdose prevention and addiction treatment funding, particularly for the Eastern Shore, ex-offenders, and women with children. Based on the work of the Task Force and the input provided by stakeholders, below are the initial funding announcements approved and authorized by Governor Hogan.

Resource Allocations Overview

1. **Restoring the A.F. Whitsitt Center to a 40-bed Capacity**
2. **Providing Community-Based Naloxone Training and Distribution**
3. **Piloting Overdose Survivor Outreach Program in Hospital Emergency Departments**
4. **Piloting Naloxone Distribution to Individuals Screened Positive for Opioid Use Disorder at Release from Local Detention Centers**
5. **Expanding Supportive Recovery Housing for Women with Children**
6. **Supporting Detoxification Services for Women with Children**
7. **Targeted Outreach and Education to Aberrant/High-Risk Opioid and Other Controlled Substance Prescribers**
8. **Overtime for Dorchester County Law Enforcement**
9. **Maryland State Police Gang/Heroin Disruption Project**
10. **License Plate Reader Technology**

1. Restoring the A.F. Whitsitt Center to a 40-bed Capacity

Established in 1993, the A.F. Whitsitt Center is a 24-hour, seven-day-a-week residential treatment facility for adults suffering from chemical dependency and co-occurring disorders. It also offers a medically monitored detoxification for alcohol-, opiate-, and benzodiazepine-dependent individuals. As a Commission on Accreditation of Rehabilitation Facilities (CARF) accredited residential treatment facility, it offers a wide variety of treatment levels including Level 0.5 early intervention, Level 1 outpatient, Level 2.1 intensive outpatient, Level 3, and 3.7D residential treatment services. Upon completion of the residential program, individuals are connected to a care coordinator through whom they have access to referral and linkage to community-based clinical and recovery support services.

The Center is located in Kent County on the grounds of the former Upper Shore Community Mental Health Center. The catchment area encompasses the entire Eastern Shore of

Maryland. Demographically, Cecil County residents represents 53 percent of the patients, Talbot County represents 10 percent, Queen Anne's County represents 10 percent, Kent County represents 10 percent, Caroline and Dorchester Counties represent 9 precent, and the remaining Lower Shore counties represent 3 percent.

Although individuals can be referred by a physician, the primary source of referrals comes from county detention centers in the Center's catchment area. Judges from the Kent County Circuit and District Court send referrals as well. It treats just under 600 patients annually, prioritizing treatment toward low-income patients and patients requiring medical assistance. These patients tend to have failed outpatient treatment and are high-risk for fatal overdose.

Originally funded for 40 beds with average stay of 30 days, budget cuts in fiscal year 2012 resulted in reduced capacity, shorter lengths of stay, and a longer wait list. Today, the capacity is only 26 beds with an average length of stay of 21 days and an average wait time of four weeks for admission. Due to extraordinary demand and the fact that the Center is the only health department-operated 3.7D residential facility on the Eastern Shore, Governor Hogan has allocated $800,000 in fiscal year 2016 to restore capacity to 40 beds allowing an additional 240 patients to receive treatment each year.

2. **Providing Community-Based Naloxone Training and Distribution**

The Overdose Response Program (ORP) is the State's primary vehicle for training community members on opioid overdose recognition and response and equipping them with naloxone. Although the ORP law only requires the Department of Health and Mental Hygiene to exercise regulatory oversight over local-level entities that conduct naloxone training and distribution, the Behavioral Health Administration (BHA) has historically provided funding to local health departments (LHDs) to promote and expand ORP trainings. Responses to a DHMH survey of ORP training entities conducted in early 2015 showed that many would cease or significantly curtail training and distribution if state funding was not available. As such, Governor Hogan directed $500,000 in supplemental grant awards to LHDs to support ORP trainings. The funding may support the purchase of naloxone and related supplies, personnel time, and promoting and implementing training events.

Applicants will be asked to maximize naloxone funding opportunities from other sources and take advantage of new legal authorities to facilitate wider distribution. BHA will prioritize funding for applications that propose to use standing orders for naloxone prescribing and dispensing as authorized by Chapter 356 of 2015, legislation introduced by Senator Klausmeier to improve the State's ORP program. Standing orders remove the requirement that a healthcare practitioner, such as a doctor or nurse, be physically present for prescribing

and dispensing to occur, which will allow for broader and more efficient naloxone distribution to those most likely to experience, or be in a position to respond to, an opioid overdose. This was a major barrier identified by ORP training entities. In addition, BHA will prioritize funding to LHDs that partner with community-based organizations to expand the number of available trainings. Community-based ORP entities often include highly motivated volunteers with direct connections to high-risk individuals, their families, and friends.

3. **Piloting Overdose Survivor Outreach Program in Hospital Emergency Departments**

In 2014, DHMH issued a report showing that nearly 60 percent of all overdose decedents in 2013 had previously been treated for an overdose at a Maryland hospital in the year prior to death, with almost 10 percent having been treated for overdose five or more times. This indicates an urgent need to improve coordination between hospitals and public health authorities to target the provision of behavioral health treatment, recovery, and harm reduction services for opioid overdose survivors. In response, DHMH announced a new initiative in December 2014 to work with hospitals, local health departments, and behavioral health/addictions authorities to improve information sharing with hospitals and establish effective outreach and care coordination collaborations.

To further these efforts, Governor Hogan has directed BHA to allocate $300,000 toward establishing a pilot Overdose Survivor Outreach Program (OSOP) in Baltimore City. The goal of OSOP will be to coordinate and supplement programs that identify and intervene with addicted individuals in hospital emergency departments to ensure ongoing, in-community follow-up and engagement with overdose survivors after discharge. OSOP will seek to implement peer support services for overdose survivors at multiple points in the continuum of care, including emergency medical services, treatment referral, care coordination, and while enrolled in a treatment program. Overdose education and naloxone distribution services will be incorporated and targeted for opioid overdose survivors. OSOP will also seek to identify and support additional hospitals in Baltimore City and neighboring jurisdictions interested in implementing screening, intervention, and referral protocols and partnering with the local addictions authority to improve care coordination services. Lessons learned from the pilot will inform the State's strategy to expand ED-based interventions to other hospitals throughout the State and be incorporated into technical assistance materials to support implementation.

Funding may be used to support hiring and training peer recovery support specialists, expanding the capacity of Behavioral Health Systems Baltimore (BHSB) to conduct outreach services, training hospital staff, and other necessary services. Importantly, funding will be coordinated to maximize the impact of other existing grant programs, including those focused on implementing Screening, Brief Intervention and Referral to Treatment (SBIRT) in hospitals

and community health centers and expanding access to recovery support services in medication-assisted treatment programs. Other existing funding streams will be leveraged, as available, to provide ongoing recovery support services, including Maryland Recovery Net, a fee-for-service recovery support system overseen by BHA and managed by Value Options that provides access to transportation, housing, peer support, and other services. BHA will work with BHSB and other State and local partners to improve data collection and analysis on survivors receiving services.

4. **Piloting Naloxone Distribution to Individuals Screened Positive for Opioid Use Disorder at Release from Local Detention Centers**

In 2014, the DHMH Vital Statistics Administration (VSA) worked with the Department of Public Safety and Correctional Services to match medical examiner records of overdose deaths with corrections data. Findings from the analysis supported existing research showing that opioid-addicted individuals are at increased risk of overdose immediately following release from incarceration. These findings indicate that targeting overdose education and naloxone distribution to high-risk individuals at the time of release may be an effective strategy for reducing overdose deaths. Models supporting these strategies currently exist across the country. For example, the New York State prison system has recently launched a program to dispense naloxone at the time of release. The Baltimore City Health Department has conducted overdose education trainings in the Baltimore City Detention Center.

Seeking solutions to these challenges, Governor Hogan directed BHA to provide $150,000 through supplemental awards to three Southern Maryland LHDs - Calvert, Charles, and St. Mary's Counties - to implement overdose education and naloxone distribution programs for individuals released from those counties' local detention centers. Focusing the pilot in one region of the state will help maximize impact and evaluation in these three counties that collectively experienced an 88 percent increase in overdose deaths between 2013 and 2014. Historically, these counties have also had limited naloxone distribution through ORPs and there were no opioid treatment programs that received a supply of the Evzio naloxone auto-injector donation. There is an urgent need to target distribution to high-risk individuals in these counties. BHA will work with the LHDs to ensure that those being released are screened for opioid use disorder and that naloxone distribution is targeted accordingly. Detention centers and LHDs will be required to collect and report to BHA information on the individuals served by the program to evaluate impact and estimate the feasibility of expanding the program statewide.

5. **Expanding Supportive Recovery Housing for Women with Children**

Research shows that parental substance use is associated with numerous negative outcomes for children. Parental substance use has been shown to increase the likelihood that a family will experience financial problems, shifting of adult roles onto children, child abuse and neglect, violence, disrupted environments, and inconsistent parenting. Research also shows that a complex and harmful cycle exists in which a history of child abuse and neglect increases a person's risk of substance use later in life and that individuals with substance use disorders are more likely to abuse or neglect their children in turn. In addition, children of parents with substance use disorders are known to have a heightened risk for developing substance use problems themselves. Women, the traditional caregivers, face many obstacles and challenges in engaging in treatment and recovery services that could prevent these negative outcomes. Those obstacles include a lack of collaboration among social service systems, limited options for women who are pregnant, lack of culturally congruent programming, few resources for women with children, fear of loss of child custody, and the stigma of substance use.

In 2012, BHA initiated a series of focus groups to explore substance use among women with children at every women and children's residential treatment program and at several co-ed, intensive outpatient programs. The results were universal: the overarching need identified for women with dependent children was recovery housing that would allow a mother to bring all of her children into recovery with her. Since 2013, BHA has funded recovery houses in Baltimore City and Anne Arundel County. There are currently nine vendors: six in Baltimore City with 11 houses and three in Anne Arundel County with four houses. The houses are in constant demand with waiting lists, as treatment providers are often looking for options similar to these homes when women are ready to be discharged from more intensive treatment.

> ***"We are going to attack this problem from every direction using everything we've got."***
>
> *–Governor Larry Hogan*

As such, Governor Hogan directed BHA to allocate an additional $100,000 for recovery housing, prioritizing those jurisdictions that currently do not have recovery housing for women with children and those with a significant waiting list. The funding will support the lease/rent of a house, furnishing for the building, and a peer house manager to reside in the facility with the families.

6. **Supporting Detoxification Services for Women with Children**

Detoxification is an important, but resource-intensive process. Clients require 24-hour monitoring for assessment and ongoing monitoring of sub-acute biomedical and behavioral conditions related to opioid and alcohol withdrawal. A comprehensive nursing assessment

including client and family history; vital signs; and medication, psychiatric, medical, and substance use history are all provided upon admission to the treatment. Because women historically do better in treatment with their children than without their children, BHA utilizes a model of residential detoxification services with childcare services on site in Baltimore City. This allows mothers to detox in a safe environment and children can receive appropriate wraparound services. These services include, but are not limited to, pediatric and mental health referrals, after-school programming, and recreational activities that are age appropriate.

As such, Governor Hogan will direct BHA to make an additional $50,000 available to continue operation of this program. Treatment programs will have an opportunity to submit a request for the funding and will identify the best practices that they will utilize to move the women into long-term residential treatment or intensive outpatient treatment. BHA will require a yearly report that documents how the program used the funding and the outcomes associated with the funding.

7. Targeted Outreach and Education to Aberrant/High-Risk Opioid and Other Controlled Substance Prescribers

The widespread overprescribing of opioid analgesics for the treatment of pain has been identified as a major driver of the opioid addiction and overdose epidemic. Increased opioid prescribing has refocused the medical community on the lack of strong evidence for the safety and efficacy of long-term opioid therapy for chronic non-cancer pain. However, many providers, including both primary care and pain specialists, may continue to prescribe inappropriately based on outdated or erroneous information about the risks and benefits of opioids for most patients. High-risk prescribing practices, including maintaining patients at high opioid doses, rapid dose escalation, and co-prescribing opioids, benzodiazepines, and other controlled substances, may be common among a relatively small subset of practitioners. This small group may be disproportionately contributing to new cases of addiction, overdose, and diversion.

Aberrant prescribers are at high risk for disciplinary actions by licensing boards and criminal enforcement actions by public safety authorities. These actions can create other unintended consequences when the prescriber's patients are abruptly cut off from their prescriptions. These patients often have multiple co-occurring somatic and behavioral health issues, and a large influx of patients with complex needs can quickly overwhelm a local healthcare system in medically underserved areas.

DHMH has promoted continuing medical education (CME) courses on opioid prescribing provided by MedChi and the Maryland Society of Addiction Medicine and is organizing a live CME training for physicians, nurses, and pharmacists to take place in Maryland in October 2015. The Maryland Board of Physicians has also required a one-hour CME credit on appropriate opioid prescribing as part of its licensing process for all physicians starting in 2015. However, to date there have been no clinical education initiatives narrowly targeted at high-risk prescribers.

As such, Governor Hogan has directed DHMH to allocate $100,000 to conduct targeted outreach and education for practitioners identified as engaging in high-risk prescribing practices. DHMH will develop clinical tools and deploy appropriate personnel to provide direct consultation and support services to improve the quality of treatment provided to patients with chronic pain that are receiving opioid prescriptions. Educational content may also include information on use of the PDMP and CRISP, screening and referral for substance use disorders, buprenorphine, naloxone, and other overdose prevention priorities for the Department. In collaboration with academic partners, practitioner organizations and other stakeholders, DHMH will also investigate establishing an inter-disciplinary pain and addiction medicine collaborative that can provide ongoing clinical consultation to primary care providers across the state.

High-risk practices will be identified by DHMH through analyses of Medicaid claims data, pharmacy inspections/surveys, medical examiner records, and other intra-departmental data sources. DHMH will also conduct an analysis of the PDMP law and regulations to determine whether PDMP data and legal authorities could be used to identify providers or as a means of outreach and education.

8. **Overtime for Dorchester County Law Enforcement**

   Governor Hogan, through the Office of Crime Control and Prevention (GOCCP), will provide Dorchester County with $24,700 to provide overtime for law enforcement to address the opioid and heroin epidemic. Overtime will be used to gather intelligence in conjunction with numerous regional law enforcement agencies to examine the point of origin of the heroin and locations from which drugs are entering Dorchester County. This information will enable law enforcement to target efforts in regards to control and enforcement and will be valuable in prosecuting heroin trafficking cases.

9. **Maryland State Police Gang/Heroin Disruption Project**

   Governor Hogan, through GOCCP, will provide Maryland State Police (MSP) with $40,000 to support MSP's Gang/Heroin Disruption Project. The funds will provide overtime to members

of the MSP Gang Enforcement Unit to conduct home visits with parole and probation officers to Violence Prevention Initiative (VPI) offenders, work beyond scheduled shifts to further heroin investigations, conduct surveillance, and serve arrest warrants. These inter-jurisdictional efforts will help law enforcement arrest street-level drug dealers and those transporting heroin into Maryland.

10. **License Plate Reader Technology**

Governor Hogan, through GOCCP, will provide the Ocean City Police Department with $124,635 to fund license plate reader (LPR) technology at the northern end of Ocean City. The LPR will allow law enforcement to target heroin coming into the State and will be linked into the Maryland Coordination and Analysis Center (MCAC) database.

IX. CONCLUSION

The Heroin and Opioid Emergency Task Force has worked diligently to determine the scale of Maryland's heroin and opioid problem, investigate areas of specific concern and opportunity, and gather a broad coalition of stakeholders to assist in finding solutions. The Interim Report's 10 recommendations and 10 funding disbursements represent the input of hundreds of contributors and will have an immediate positive effect in combating this public health crisis. Even so, the work of the Task Force and its workgroups is nowhere near complete. Over the next four months, the Task Force will continue to leverage all available resources to produce additional recommendations for the Final Report that will span areas ranging from education and prevention to insurance coverage to alternatives to incarceration.

X. ACKNOWLEDGEMENTS

The Task Force is tremendously grateful for the outpouring of support and expertise provided by hundreds of people to help the State combat the heroin and opioid epidemic.

Office of the Governor and Agency Staff

Sam Abed
Richard Alcorta
Irnande Altema
Jon Armiger
Linda Auerback
Julie Ayers
Michael Baier
Diane Banchiere
Gray Barton
Bradley Beard
Paul Beatty
Alberta Brier
Jim Brown
Rianna Brown
Laura Bruner
Shawn Cain
Monique Cheatham
Sara Cherico
Edward Clarke
Joseph Cleary
Kevin Conroy
Michelle Darling
Sandra Davis-Hart
Larry Dawson
Steve DeBoy
Adam Dubitsky
Shawn Eum
Ronald Fisher
Michael Ford
Rebecca Frechard
Andrea Garvey
Debbie Green
Kathleen Green
Deborah Grinnage-Pulley
Jeannie Haddaway-Riccio
James Hedrick
Geoff Hengerer
Christopher Hersl
Amber Ivey
Brandee Izquierdo
Sue Jenkins
Diane Jennings
Henry Johnson
Gayle Jordan-Randolph
Netsanet Kibret
Mary Kwei
Kristina Kyles-Smith
Heather Lageman
Arlene Lee
Kevin Loeb
Marilyn Lorenzo
Mac Love
Sam Malhotra
Renee Markle
Hannah Marr
Steve McAdams
William McCurry
Van Mitchell
Katherine Morris
Stephen Moyer
Sara Muempfer
Mark Newgent
Barry Page
William Pallozzi
Ed Parker
Brad Peganoff
Vertell Porter-Brown
Michael Preston
Terrence Proctor
James Pyles
Al Redmer
Kathleen Rebbert-Franklin
David Ruel
Christopher Shank
Cara Sullivan
Richard A. Tabuteau
Penelope Thornton Talley
Kay Teng
Mishka Terplan
Ann Walker
Dionne Washington
John L. White
Katie Wunderlich

Contributors

Ken Abrams
Wes Adams
Jeff Adams
Uma Ahluwalia
Valerie Albee
Lynn Albizo
Robert Ali
Daniel Alioto
Barbara Allen
John Alverez
Carl Anderton
Dena Anthony
Stefan Antony
Steven Arentz
Jordan Ayres
Deanna Bailey
Jackie Ball
Ron Bateman
Gail Bates
Candy Bathon
Jeannie Beatty
Sean Beatty
Richard Benchoff
Thor Benson
Troy Berry
Chip Bertino
Pam Bezirdijan
Marte Birnbaum
Carol Boyer
Danny Brannon
Lori Brewster
Moe Briggs
Dario Broccolino
Barbara Brookmeyer
Diana Broomell
Heather Brown
Leslie Brown
Richard Brueckner
Ramie Bruguera
Maria Buehler
Jason Burgm
Jacque Burrier
Marie Byers
David Byram
Dewana Campbell
Tina Canter
Gina Carbaugh
Mary Beth Carozza
Charles Casey
Israel Cason
Marvin Cheatham
Theodore Cicero
Martha Clark
Lisa Cleary
Jeff Cline
John Cluster, Jr.
Dan Cochran
James Cockey
Ruth Colbourne
Karl Colder
Byron Conaway
LeeAnn Cook
Jeanne Cooper
Linda Coughlin
Carmela Coyle
Pamela Creekmur
Bill Crotty
Bob Culver
Carmine D'Alessandro
Neil Dampier
Debra Dauer
Ressa Davis
Milton Davis
Louisa Degenhardt
Steward Demond
Sheri Denham
Robert DiCocco
Paul Dietze
Vince Dugan
Kelly Dunn
Kimberly Eaton
Adelaide Eckardt
Laurie Edberg
Pamela Eichelberger
Alisha Ellis
Matthew Ellis
David Engel
Donna Evans
Mike Evans
Ramsey Farah
Marie Finnegan
Mark Fisher
Caressa Flannery
Debbie Fling
Bill Folden
Kirsten Forseth
April Foster
Tony Fowler
Susan Fox
Ryan Frashure
Jim Freeman
Rick Fritz
Kelly Frost
Gary Fry
Bill Gaertner

Bob Galaher
Joe Gamble
Todd Gardner
Jan Gardner
Dirk Gilliam
Robin Gilliam
Penny Glasgow
Barry Glassman
Rodney Glotfelty
Deborah Goeller
Mindy Goodman
Brad Graham
Jonathon Gray
Kathleen Green
Sara Green
Susie Gruber
James Guy
Nanci Hamm
Carlos Hardy
Emily Harman
Ashley Harris
Robert Harsh
Margaret Hawk
Pamela Hay
Ellen Heller
Jim Hendrick
Christie Henzel
Katherine Heverin
Diane Hitchens
Susan Hixon
Gary Hofmann
Rebecca Hogamier
Charles Hotzel
Barbara Hovermill
Mark Howard
Douglas Howard

Theresa Huffines
Babak Imanoel
Lorri Irrgang
Stephanie Iszard
William Jacquis
Sally Jameson
Chuck Jenkins
Rebecca Jenkinson
Melvin Johnson
Henry Jones
William Jones
Basha Jordan Jr.
Kevin Kamenetz
Christina Karrasch
Elizabeth Katz
Paul Katz
Allan Kittleman
Bob Kozloski
Melissa Kramer
Helen Kurtz
Jim Kurtz
Steven Kurtz
Chris LaBarge
Robert Laird
Randy Laird
Randal Landis
Janet Lane
Thomas Lantieri
Briony Larance
Susan Lee
Isiah Leggett
Mike Lewis
David Lidz
Sharan Lindsay
Nicholas Lintzeris
Bryan Lloyd

Mary Logsdon
Christie Long
Lisa Lowe
Matt Maciarello
Joyce Mahoney
Laura Martin
Tracy Marvel
Dorothea Matey
Andrea Mathias
Donald Mathis
Richard Mattick
Bernard McBride
Nicole McCann
John McCarty
Doris McDonald
Brett McKoy
Craig McLochlan
Lisa McLochlan
Charlotte Meck
Wendy Messner
Becky Meyers
Catherine Meyers
Pat Miedusiewski
Dee Miles
Carin Miller
Jacob Miller
Joann Miller
Debbi Mister
Rebecca Mitch-McKee
Laura Mitchell
Karen Mitchell
Bryant Moore
Tari Moore
Alicia Moran
Dan Morhaim
Annette Mrozinski

Douglas Mullendore
Harris Murphy
Peter Murphy
Patrick Musselman
Jennifer Naylor
Claude Nelson
John Newell
Jen Newman
Alvin Nichols
Kathleen O'Brien
Anthony O'Donnell
Yngvild Olsen
Corey Pack
Terry Paddy
Pat Panuska
Samantha Parker
Benjamin Paskus
Dinesh Patil
Gayle Petersen
Laura Pimentel
Lawrence Polsky
Larry Porter
Carol Porto
Susan Powell
Daniel Powell
Christina Price
Brennan Prodey
Deb Prohaska
Ashley Pruski
Sherry Pullen
Richard Raftery
Katlyn Ramey
DeForest Rathbone
Susan Redmer
Patricia Reilly-Ayers
Lisa Rippeon

Craig Robertson
Dawn Rodenbaugh
Ginger Rosela
Nancy Rosen-Cohen
Jamie Rouland
April Rouzer
Nelson Rupp
Joseph Ryan
Ajibike Salako-Akande
Beth Schmidt
Steve Schuh
Regina Sharber
Christopher Shea
Scott Shellenberger
Betty Shifler
Billy Shreve
Kevin Simmers
Charles Smith
Rose Souder
Leland Spencer
Nicole D. Stallings
Eric Sterling
Breta Still
Craig Stofko
Bruce Strazza
Hilary Surratt
Larry Suther
Amy Swartz
Maura Taylor
Mishka Terplan
Tony Torsch
Robert Tousey
Jennifer Tuerke
Allen Twigg
Bill Valentine
Lon Wagner

Valerie Wallace
Sharon Walser
Nancy Waltman
Laura Webb
Tim Weber
Ellen Weber
Josh Webster
Steven Weems
Lisa Welch
Brendan Welsh
Christopher Welsh
Leana Wen
Thomas Werner
Nancy White
Pat White
Pat Whitlock
Summer Widmyer
Dan Williams
John Winslow
Patricia Winters
Catherine Woolley
Gaynell Wright
Dana Wright
Cheryl Wyatt
Jack Young
Karen Young
Julie Zebroski

APPENDICES

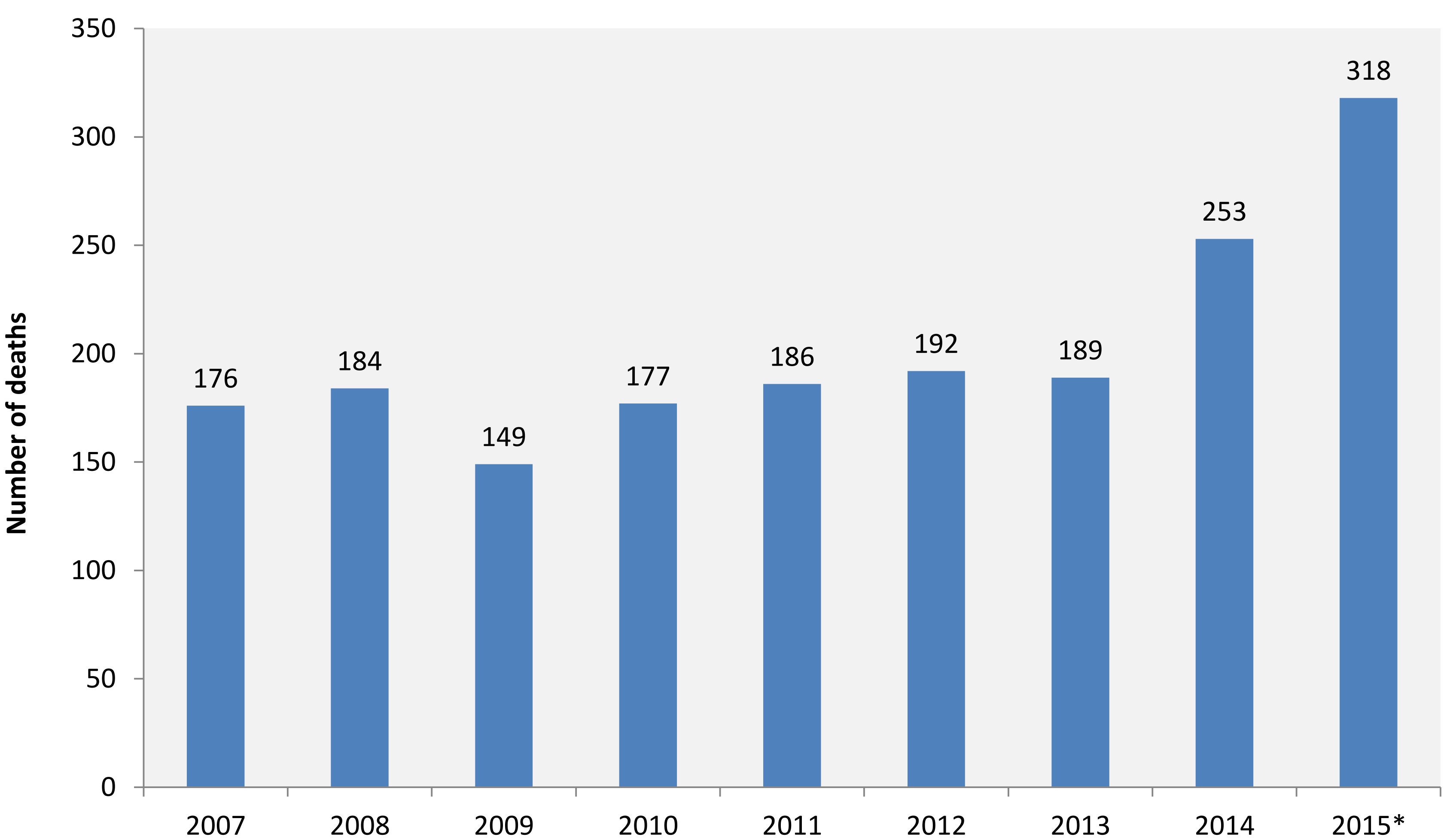
Drug and Alcohol-Related Intoxication Deaths in Maryland

Data update through 1st quarter 2015

This report contains counts of drug and alcohol-related intoxication deaths* occurring in Maryland through the first quarter of 2015, the most recent period for which reasonably complete data are available. Counts are also shown for the same period of 2007-2014 to allow for comparison of trends over time. Counts for 2015 are preliminary and subject to change.

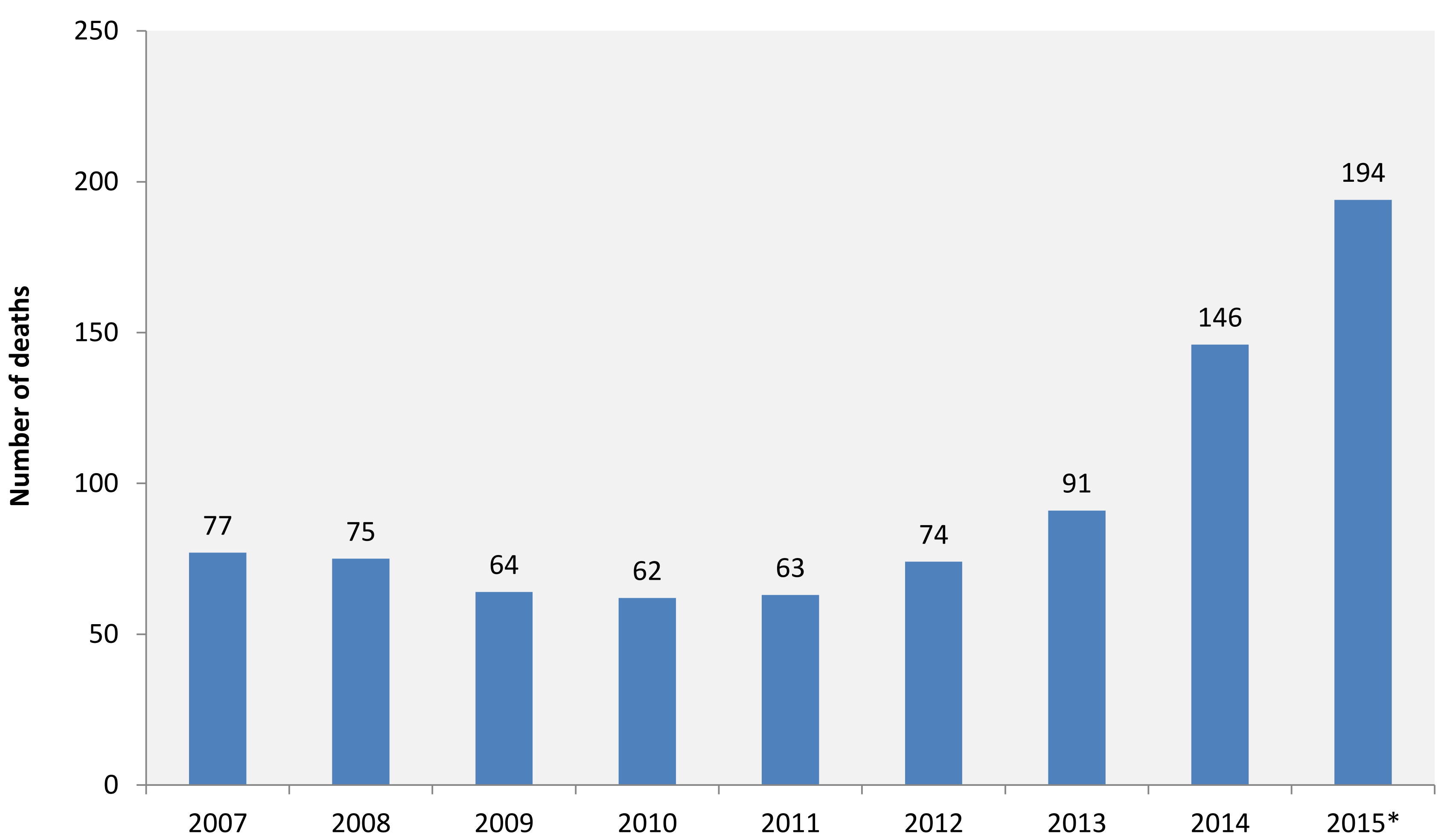
*Deaths resulting from recent ingestion or exposure to alcohol or other types of drugs, including heroin, cocaine, phencyclidine (PCP), prescription opioids, benzodiazepines, methamphetamines and other prescribed and unprescribed drugs.

Figure 1. Total Number of Unintentional Intoxication Deaths Occurring in Maryland from January-March of Each Year.*



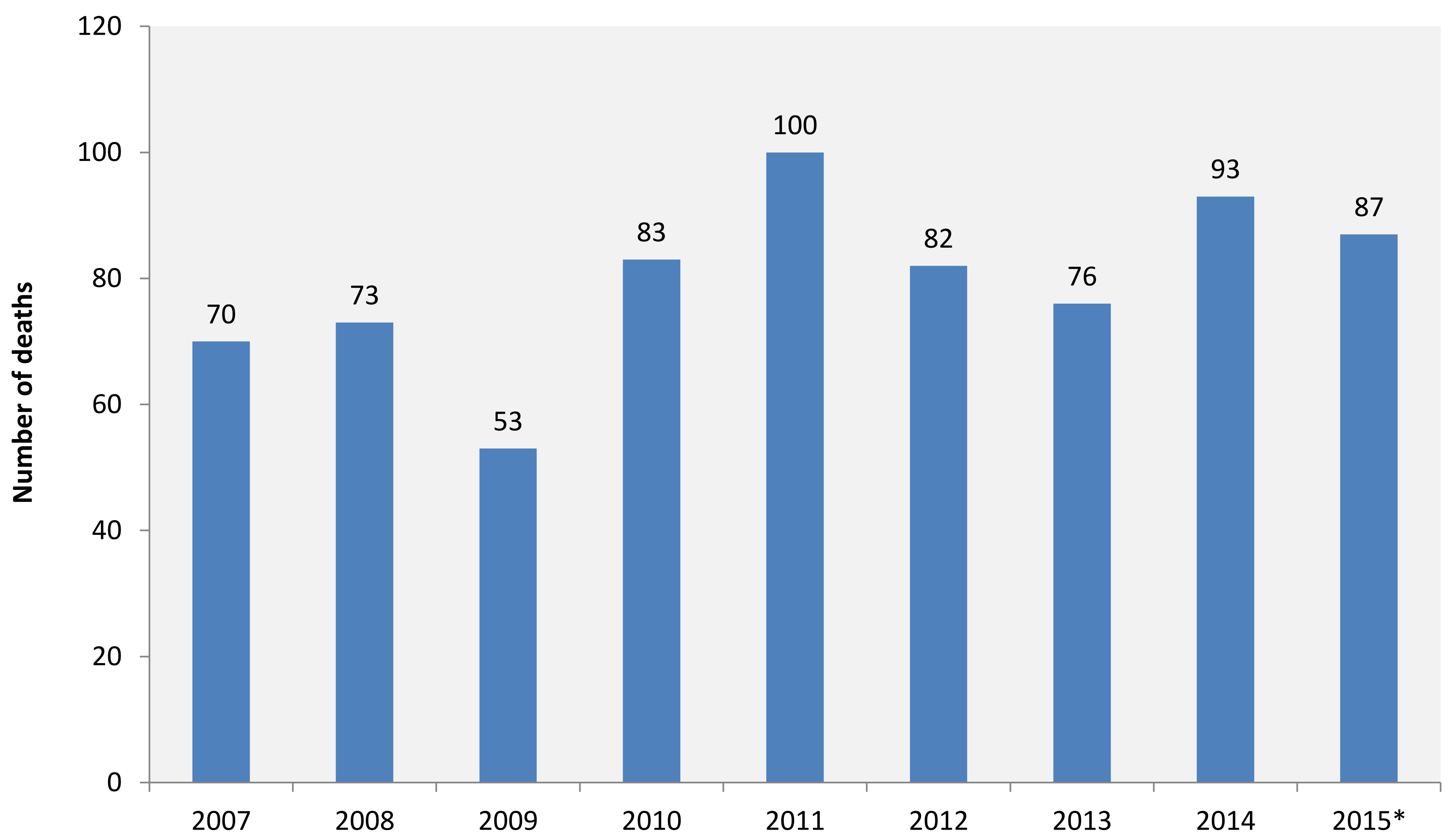
*2015 counts are preliminary.

Figure 2. Number of Heroin-Related Deaths Occurring in Maryland from January through March of Each Year.*



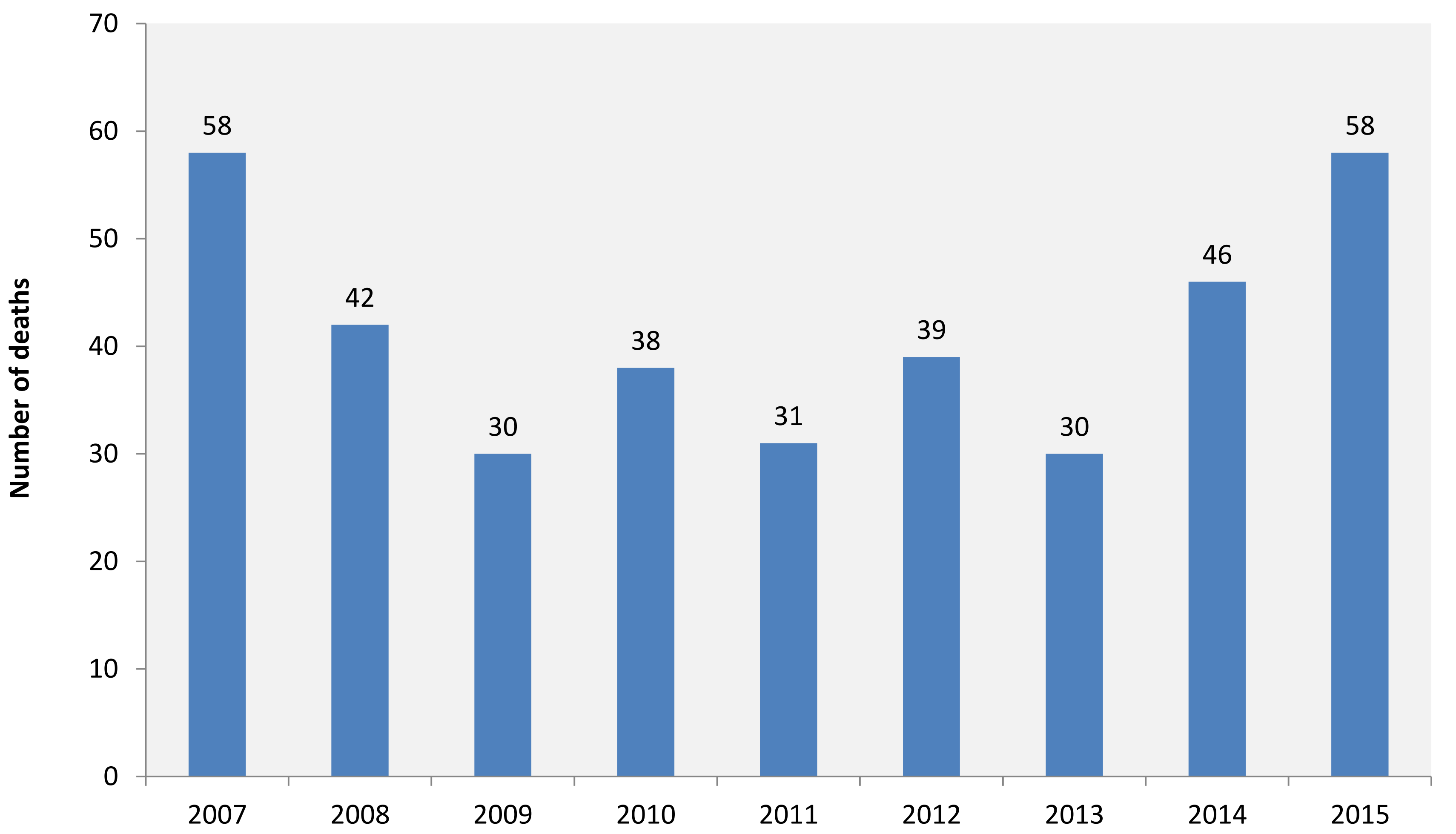
*2015 counts are preliminary.

Figure 3. Number of Prescription Opioid-Related Deaths Occurring in Maryland from January through March of Each Year.*



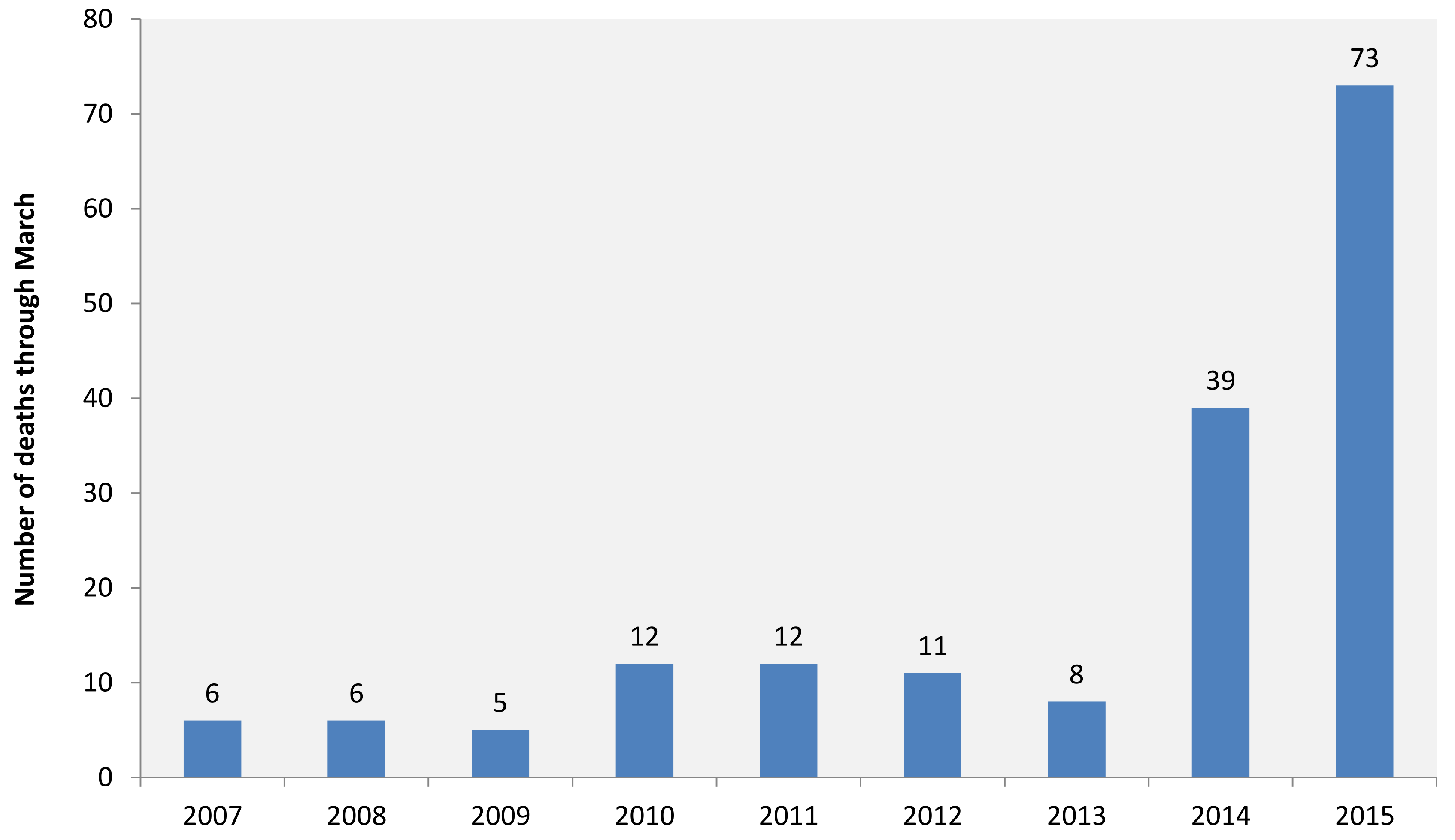
*2015 counts are preliminary.

Figure 4. Number of Cocaine-Related Deaths Occurring in Maryland from January through March of Each Year.*



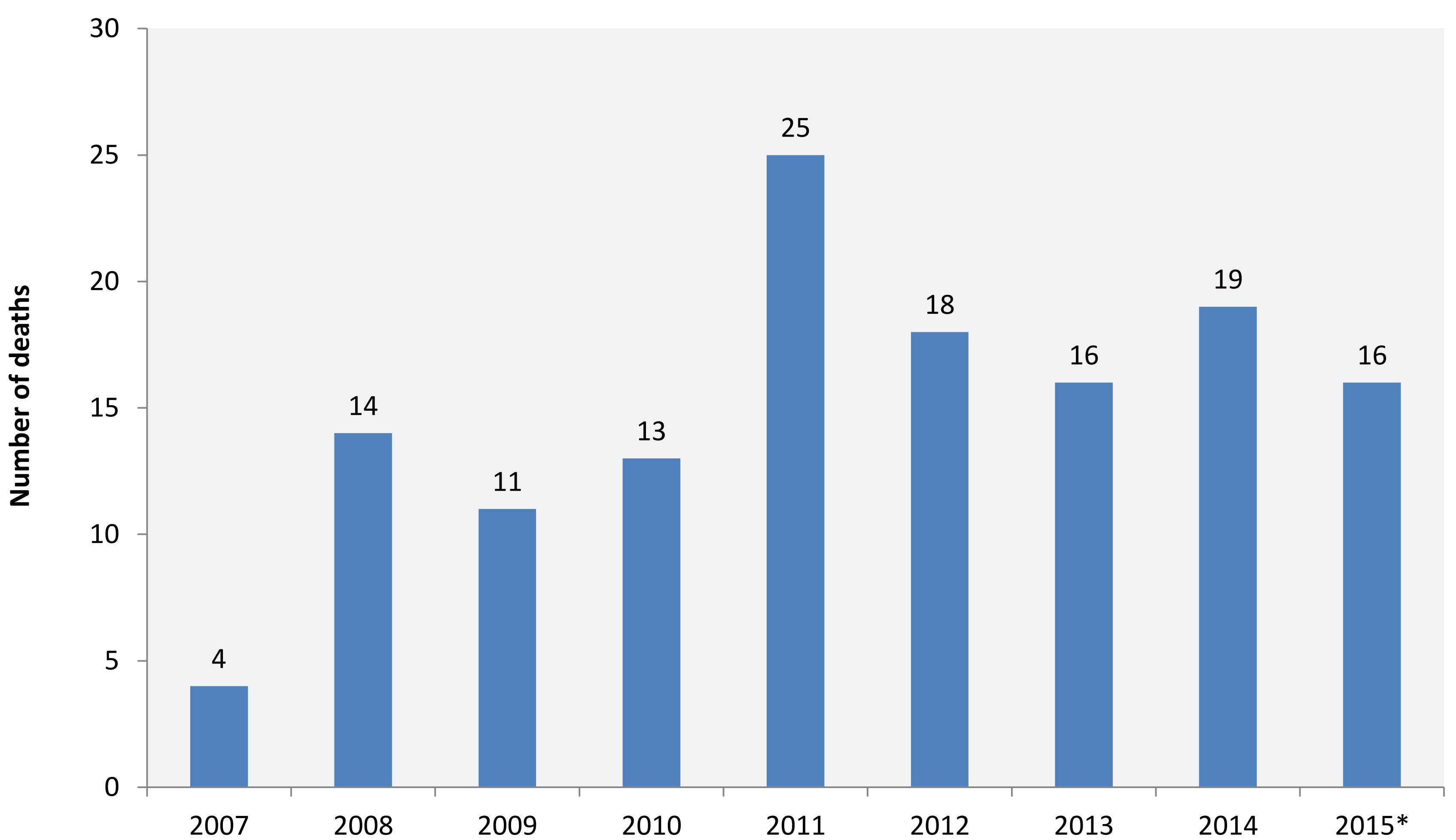
*2015 counts are preliminary.

Figure 5. Number of Fentanyl-Related Intoxication Deaths Occurring in Maryland Through March of Each Year.*



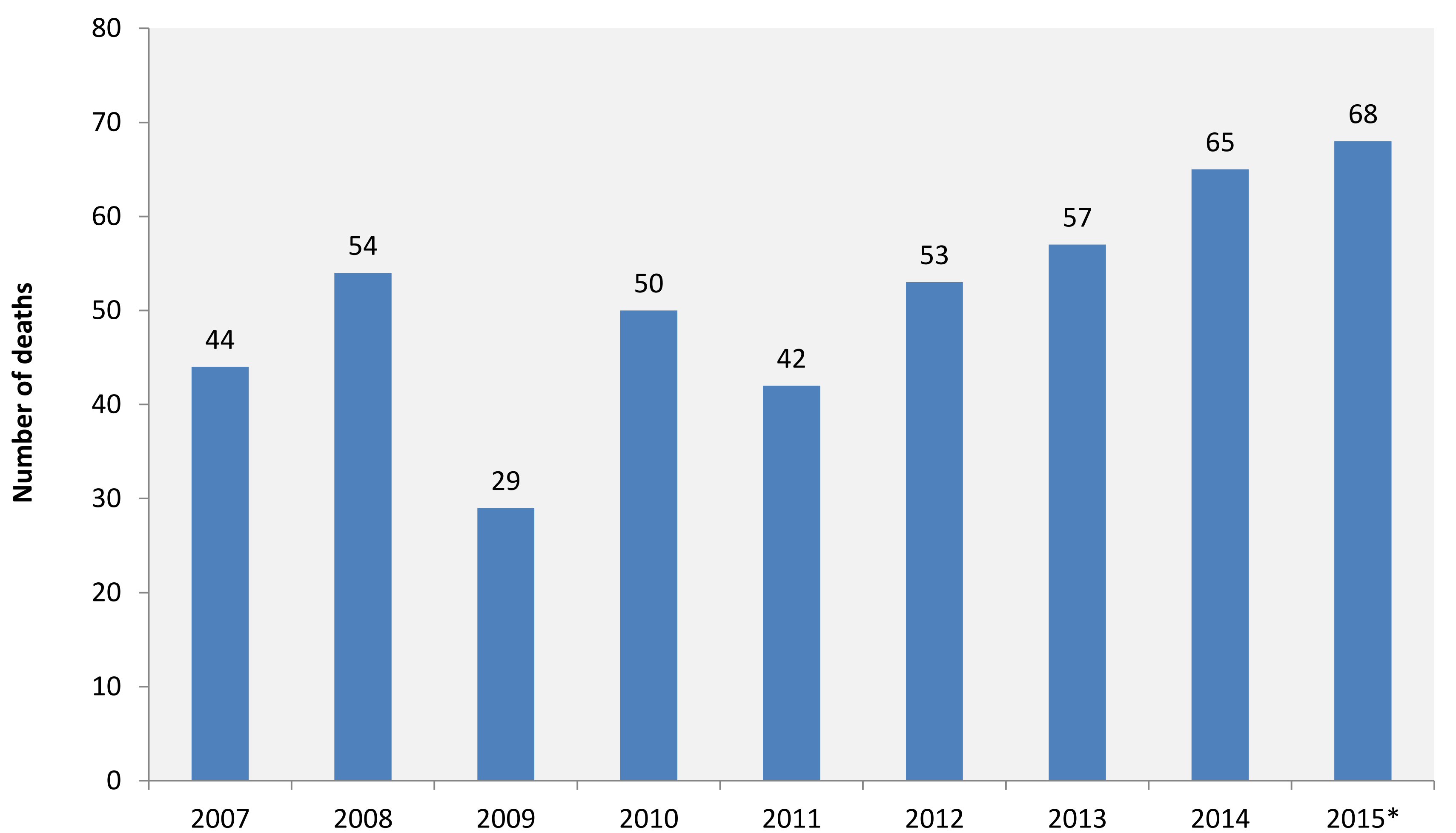
*2014 counts are preliminary and include deaths reported by OCME through March 2014.

Figure 6. Number of Benzodiazepine-Related Deaths Occurring in Maryland from January through March of Each Year.*



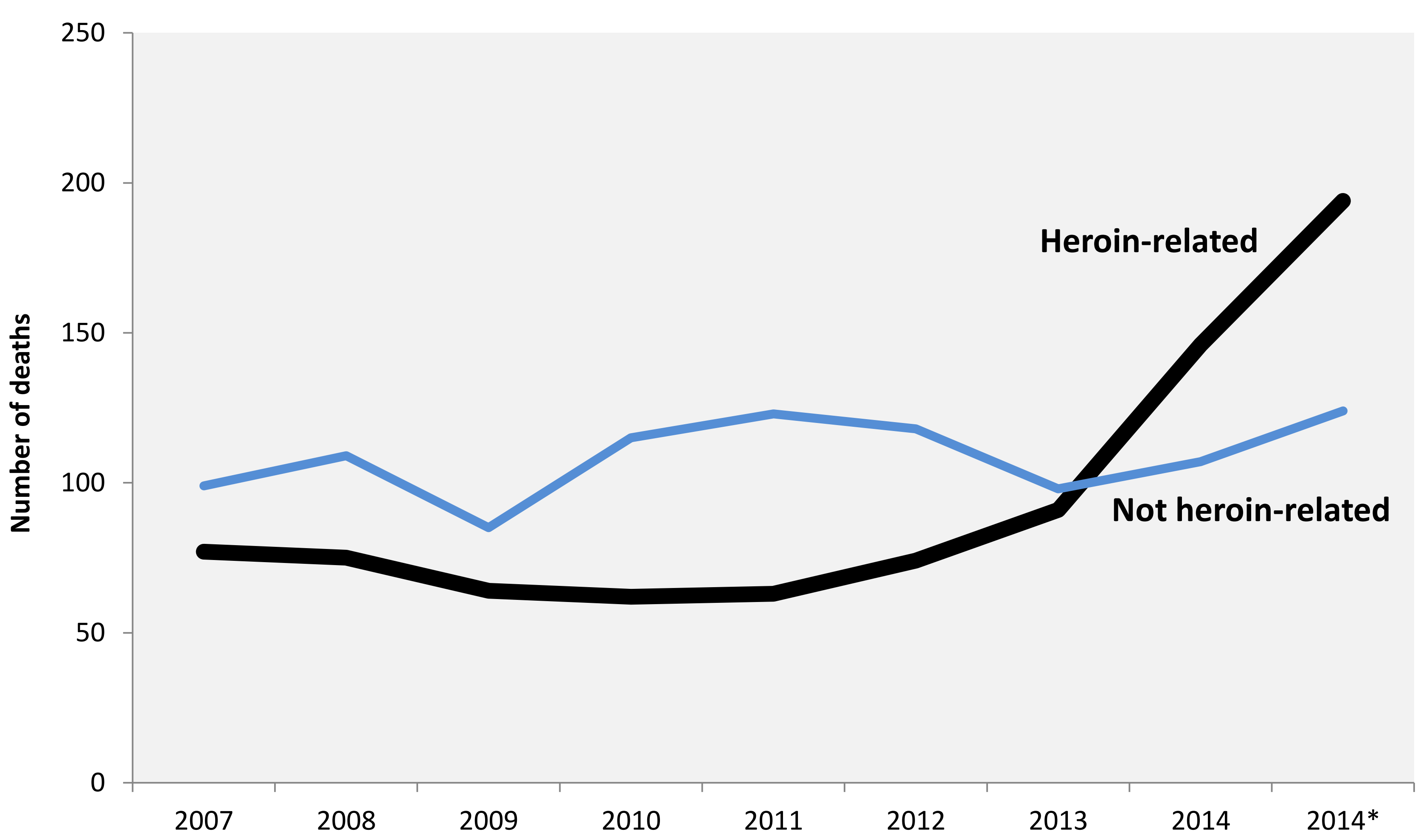
*2015 counts are preliminary.

Figure 7. Number of Alcohol-Related Deaths Occurring in Maryland from January through March of Each Year.*



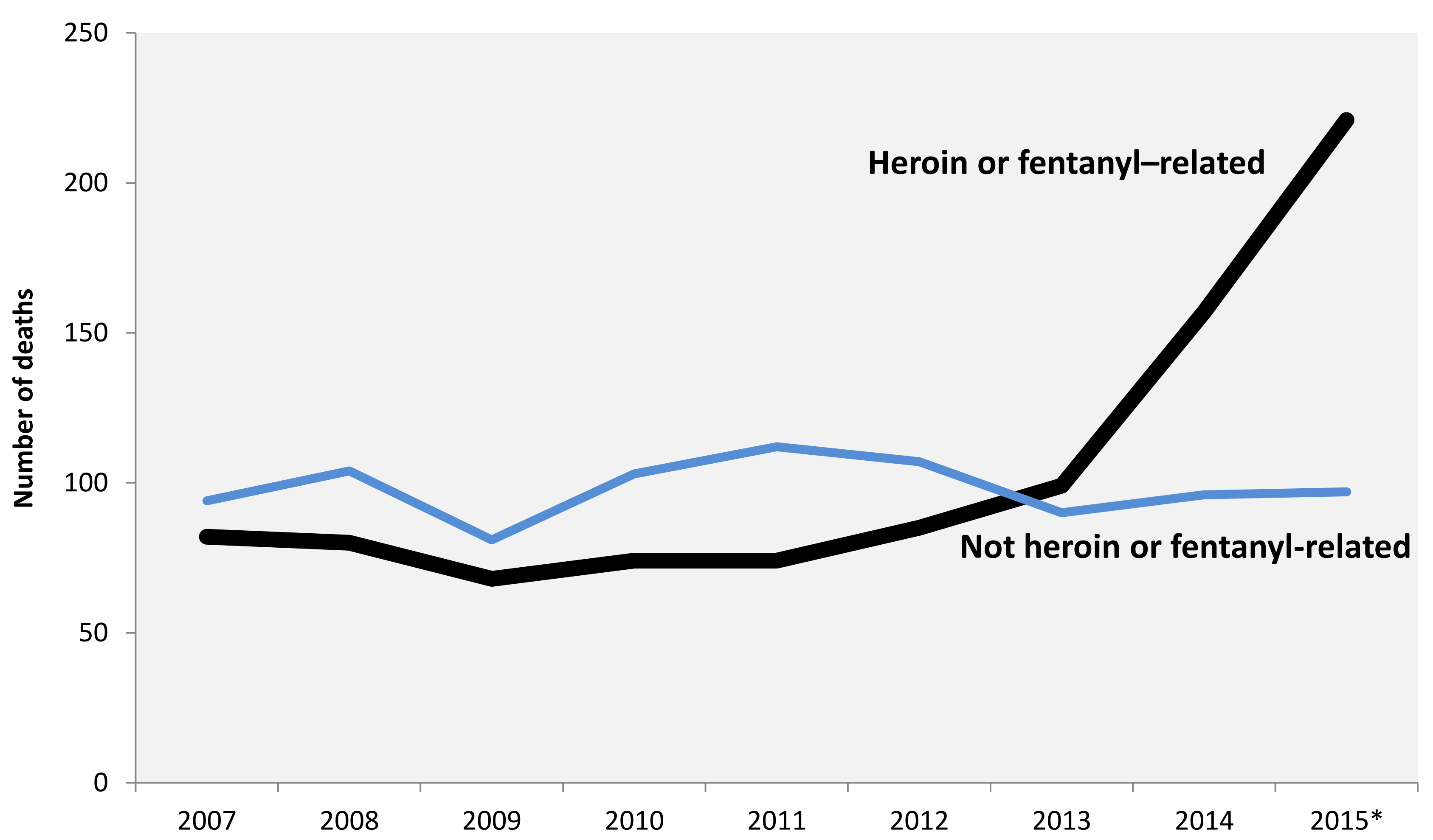
*2015 counts are preliminary.

Figure 8. Number of Drug and Alcohol-Related Intoxication Deaths Involving <u>Heroin</u> Through March of Each Year.*



*2015 counts are preliminary.

Figure 9. Number of Drug and Alcohol-Related Intoxication Deaths Involving Heroin or Fentanyl Through March of Each Year.*



*2015 counts are preliminary.

Figure 10

Total Number of Drug and Alcohol-Related Intoxication Deaths by Place of Occurrence, Maryland. January -- March, 2015 and 2014.

State of Maryland	Drug & Alcohol Intoxication Deaths		2015 vs 2014
COUNTY	Jan. - Mar. 2015	Jan. -Mar. 2014	# DIFFERENCE
Allegany County	5	1	4
A. A. County	27	23	4
Baltimore City	116	74	42
Baltimore County	47	40	7
Calvert County	5	9	-4
Caroline County	0	1	-1
Carroll County	11	14	-3
Cecil County	6	10	-4
Charles County	6	6	0
Dorchester County	0	0	0
Frederick County	3	11	-8
Garrett County	1	1	0
Harford County	9	7	2
Howard County	7	3	4
Kent County	2	0	2
Montgomery County	23	10	13
P.G. County	13	16	-3
Queen Anne's County	1	3	-2
Somerset County	6	1	5
St. Mary's County	3	3	0
Talbot County	2	0	2
Washington County	19	11	8
Wicomico County	4	6	-2
Worcester County	2	3	-1
Total	318	253	65

[1] Includes deaths that were the result of recent ingestion or exposure to alcohol or another type of drug, including heroin, cocaine, prescription opioids, benzodiazepines, and other prescribed and unprescribed drugs.

[2] Includes only deaths for which the manner of death was classified as accidental or undetermined.

[3] Counts for 2015 are preliminary.

TABLE 1. TOTAL NUMBER OF DRUG AND ALCOHOL-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2014 AND YTD 2015 THROUGH MARCH.[1,2,3]

	TOTAL INTOXICATION DEATHS								
	2007	2008	2009	2010	2011	2012	2013	2014	YTD 2015
MARYLAND	815	694	731	649	671	799	858	1,040	318
WESTERN AREA	110	99	97	96	109	115	138	161	51
GARRETT	1	3	3	3	2	0	6	2	1
ALLEGANY	14	9	9	15	12	14	15	12	5
WASHINGTON	16	26	18	20	21	27	28	40	19
FREDERICK	23	15	23	20	30	26	37	42	3
MONTGOMERY	56	46	44	38	44	48	52	65	23
CENTRAL AREA	550	443	479	411	420	519	557	677	217
BALTIMORE CITY	287	184	239	172	167	225	246	304	116
BALTIMORE COUNTY	131	118	106	115	107	119	144	170	47
ANNE ARUNDEL	71	70	63	56	79	83	78	101	27
CARROLL	14	17	22	15	8	29	24	38	11
HOWARD	16	19	16	10	21	24	29	21	7
HARFORD	31	35	33	43	38	39	36	43	9
SOUTHERN AREA	86	94	93	74	73	93	84	110	27
CALVERT	14	9	14	6	12	12	6	17	5
CHARLES	13	16	11	13	11	13	9	21	6
ST. MARY'S	6	11	9	12	8	12	10	9	3
PRINCE GEORGE'S	53	58	59	43	42	56	59	63	13
EASTERN SHORE AREA	69	58	62	68	69	72	79	92	23
CECIL	25	10	24	24	28	25	26	29	6
KENT	3	4	2	5	2	0	4	6	2
QUEEN ANNE'S	4	5	4	4	5	2	8	10	1
CAROLINE	1	4	2	2	11	4	2	7	0
TALBOT	5	4	3	3	1	5	7	4	2
DORCHESTER	4	5	2	6	2	5	5	0	0
WICOMICO	9	13	12	13	11	21	17	20	4
SOMERSET	6	3	4	1	3	3	4	3	6
WORCESTER	12	10	9	10	6	7	6	13	2

1 Includes deaths that were the result of recent ingestion or exposure to alcohol or another type of drug, including heroin, cocaine, prescription opioids, benzodiazepines, and other prescribed and unprescribed drugs.

2 Includes only deaths for which the manner of death was classified as accidental or undetermined.

3 Counts for 2015 are preliminary.

TABLE 2. HERON-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2014 AND YTD 2015 THROUGH MARCH.[1,2,3]

	HEROIN-RELATED DEATHS								
	2007	2008	2009	2010	2011	2012	2013	2014	YTD 2015
MARYLAND	399	289	360	238	247	392	464	578	194
WESTERN AREA	33	35	39	27	34	49	68	86	30
GARRETT	0	0	1	0	1	0	2	1	1
ALLEGANY	3	4	2	3	3	6	3	5	4
WASHINGTON	5	13	11	6	8	11	14	21	11
FREDERICK	8	4	9	6	11	10	21	26	2
MONTGOMERY	17	14	16	12	11	22	28	33	12
CENTRAL AREA	323	203	264	171	165	272	319	379	140
BALTIMORE CITY	200	107	151	93	76	131	150	192	86
BALTIMORE COUNTY	56	51	53	42	38	64	76	86	25
ANNE ARUNDEL	38	24	31	18	24	38	41	53	14
CARROLL	9	5	7	3	2	13	14	16	5
HOWARD	8	8	7	3	10	12	16	9	5
HARFORD	12	8	15	12	15	14	22	23	5
SOUTHERN AREA	28	35	36	25	27	38	38	60	9
CALVERT	5	3	7	1	5	6	2	13	4
CHARLES	2	5	3	6	6	5	5	10	2
ST. MARY'S	1	3	0	4	4	7	6	5	0
PRINCE GEORGE'S	20	24	26	14	12	20	25	32	3
EASTERN SHORE AREA	15	16	21	15	21	33	39	53	15
CECIL	8	4	12	4	8	11	11	15	4
KENT	1	1	0	0	1	0	0	2	1
QUEEN ANNE'S	0	1	3	2	2	2	5	7	0
CAROLINE	0	0	0	0	3	3	2	6	0
TALBOT	1	2	0	0	1	2	2	4	2
DORCHESTER	1	2	0	2	1	3	3	0	0
WICOMICO	1	3	3	5	3	9	11	12	3
SOMERSET	2	1	1	0	1	2	1	1	4
WORCESTER	1	2	2	2	1	1	4	6	1

1 Includes deaths confirmed or suspected to be related to recent heroin use.
2 Includes only deaths for which the manner of death was classified as accidental or undetermined.
3 Counts for 2015 are preliminary.

TABLE 3. PRESCRIPTION OPIOID-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2014 AND YTD 2015 THROUGH MARCH.[1,2,3]

	PRESCRIPTION OPIOID-RELATED DEATHS								
	2007	2008	2009	2010	2011	2012	2013	2014	YTD 2015
MARYLAND	302	280	251	311	342	311	316	329	87
WESTERN AREA	42	38	40	36	58	48	51	52	15
GARRETT	0	2	2	1	1	0	2	2	0
ALLEGANY	9	5	6	8	5	5	8	6	1
WASHINGTON	7	10	4	7	11	9	11	16	7
FREDERICK	6	4	9	6	21	16	14	9	0
MONTGOMERY	20	17	19	14	20	18	16	19	7
CENTRAL AREA	190	189	148	197	212	196	207	216	60
BALTIMORE CITY	95	60	63	61	82	74	86	83	25
BALTIMORE COUNTY	48	51	37	60	68	47	54	59	18
ANNE ARUNDEL	22	36	20	31	33	33	28	32	6
CARROLL	4	11	10	9	5	17	12	15	5
HOWARD	6	6	4	6	9	5	13	7	3
HARFORD	15	25	14	30	15	20	14	20	3
SOUTHERN AREA	25	28	31	33	30	29	26	35	7
CALVERT	8	3	4	3	7	6	3	7	1
CHARLES	6	6	7	4	5	7	5	9	3
ST. MARY'S	3	7	7	9	3	5	4	3	1
PRINCE GEORGE'S	8	12	13	17	15	11	14	16	2
EASTERN SHORE AREA	45	25	32	45	42	38	32	26	5
CECIL	19	6	10	20	20	18	12	12	0
KENT	2	3	2	3	1	0	4	2	1
QUEEN ANNE'S	4	1	1	2	2	0	3	3	1
CAROLINE	0	2	1	2	5	1	0	1	0
TALBOT	2	1	2	2	0	1	4	0	0
DORCHESTER	2	1	1	4	1	3	3	0	0
WICOMICO	5	4	8	7	7	9	4	3	1
SOMERSET	4	3	1	1	3	2	2	1	1
WORCESTER	7	4	6	4	3	4	0	4	1

1 Includes deaths that were related to recent ingestion of one or more prescription opioids.
2 Includes only deaths for which the manner of death was classified as accidental or undetermined.
3 Counts for 2015 are preliminary.

TABLE 4. COCAINE-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2014 AND YTD 2015 THROUGH MARCH.[1,2,3]

	COCAINE-RELATED DEATHS								
	2007	2008	2009	2010	2011	2012	2013	2014	YTD 2015
MARYLAND	248	157	162	135	148	153	154	198	58
WESTERN AREA	29	16	11	12	22	21	26	26	7
GARRETT	0	0	0	1	0	0	0	0	0
ALLEGANY	2	1	1	1	0	2	2	2	2
WASHINGTON	3	1	0	3	3	5	6	6	3
FREDERICK	4	2	3	3	7	2	5	8	1
MONTGOMERY	20	12	7	4	12	12	13	10	1
CENTRAL AREA	178	108	124	93	97	108	102	138	44
BALTIMORE CITY	106	57	72	45	48	59	47	82	27
BALTIMORE COUNTY	30	25	25	23	19	17	27	28	11
ANNE ARUNDEL	26	18	15	13	18	13	12	19	3
CARROLL	2	2	3	6	3	7	7	2	1
HOWARD	6	1	4	1	5	7	5	3	2
HARFORD	8	5	5	5	4	5	4	4	0
SOUTHERN AREA	20	20	15	19	15	16	13	22	4
CALVERT	1	2	1	3	2	3	0	2	0
CHARLES	3	3	2	2	1	1	0	0	0
ST. MARY'S	1	1	1	2	0	2	1	1	1
PRINCE GEORGE'S	15	14	11	12	12	10	12	19	3
EASTERN SHORE AREA	21	13	12	11	14	8	13	12	3
CECIL	5	3	4	3	7	2	5	4	0
KENT	1	2	0	1	0	0	0	1	1
QUEEN ANNE'S	3	0	2	0	1	0	0	0	0
CAROLINE	0	0	1	0	1	1	0	1	0
TALBOT	4	0	1	0	0	0	3	0	1
DORCHESTER	1	1	0	1	1	1	1	0	0
WICOMICO	2	5	2	3	3	4	3	4	1
SOMERSET	1	0	1	1	0	0	0	0	0
WORCESTER	4	2	1	2	1	0	1	2	0

1 Includes deaths that were related to recent use of cocaine.
2 Includes only deaths for which the manner of death was classified as accidental or undetermined.
3 Counts for 2015 are preliminary.

TABLE 5. ALCOHOL-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2014 AND YTD 2015 THROUGH MARCH.[1,2,3]

	ALCOHOL-RELATED DEATHS								
	2007	2008	2009	2010	2011	2012	2013	2014	YTD 2015
MARYLAND	187	175	162	160	161	195	239	270	68
WESTERN AREA	29	34	25	25	32	27	34	45	10
GARRETT	1	2	1	1	1	0	2	1	0
ALLEGANY	5	0	3	4	2	4	2	3	1
WASHINGTON	3	10	4	5	4	3	6	11	3
FREDERICK	5	7	8	5	9	5	11	12	2
MONTGOMERY	15	15	9	10	16	15	13	18	4
CENTRAL AREA	114	96	100	94	99	126	154	166	51
BALTIMORE CITY	56	41	54	39	44	71	86	86	31
BALTIMORE COUNTY	38	23	22	29	22	24	32	39	8
ANNE ARUNDEL	12	12	9	10	21	15	22	18	8
CARROLL	3	4	5	4	4	4	4	9	2
HOWARD	2	7	5	3	4	6	6	6	1
HARFORD	3	9	5	9	4	6	4	8	1
SOUTHERN AREA	31	27	21	22	19	30	29	30	5
CALVERT	3	3	4	0	2	2	1	4	1
CHARLES	5	5	1	4	3	2	4	5	1
ST. MARY'S	2	1	3	2	2	3	2	3	0
PRINCE GEORGE'S	21	18	13	16	12	23	22	18	3
EASTERN SHORE AREA	13	18	16	19	11	12	22	29	2
CECIL	5	4	7	6	3	6	9	5	0
KENT	0	0	0	1	0	0	1	1	0
QUEEN ANNE'S	1	2	0	1	3	0	1	7	0
CAROLINE	1	0	1	0	1	0	1	2	0
TALBOT	0	3	0	0	0	2	2	0	0
DORCHESTER	2	0	0	1	0	1	0	0	0
WICOMICO	1	6	3	4	2	2	6	7	0
SOMERSET	0	0	1	0	1	1	1	2	2
WORCESTER	3	3	4	6	1	0	1	5	0

1 Includes deaths that were related to recent ingestion of alcohol.
2 Includes only deaths for which the manner of death was classified as accidental or undetermined.
3 Counts for 2015 are preliminary.

TABLE 6. FENTANYL-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2014 AND YTD 2015 THROUGH MARCH.[1,2,3]

	FENTANYL-RELATED DEATHS								
	2007	2008	2009	2010	2011	2012	2013	2014	YTD 2015
MARYLAND	26	25	27	39	26	29	58	185	73
WESTERN AREA	5	1	2	7	6	5	7	16	7
GARRETT	0	1	0	0	1	0	0	0	0
ALLEGANY	3	0	1	2	1	1	1	1	0
WASHINGTON	0	0	0	2	1	1	4	1	1
FREDERICK	0	0	0	2	3	1	2	6	0
MONTGOMERY	2	0	1	1	0	2	0	8	6
CENTRAL AREA	14	19	16	20	10	16	35	141	57
BALTIMORE CITY	3	2	4	4	2	4	12	71	40
BALTIMORE COUNTY	6	9	9	6	4	5	11	36	12
ANNE ARUNDEL	3	5	3	5	2	3	6	23	2
CARROLL	0	2	0	2	0	1	2	4	1
HOWARD	1	0	0	0	0	2	3	5	1
HARFORD	1	1	0	3	2	1	1	2	1
SOUTHERN AREA	1	1	4	3	3	2	10	16	5
CALVERT	0	1	1	0	1	0	0	5	1
CHARLES	0	0	0	0	1	1	3	1	1
ST. MARY'S	0	0	1	1	1	0	1	3	0
PRINCE GEORGE'S	1	0	2	2	0	1	6	7	3
EASTERN SHORE AREA	6	4	5	9	7	6	6	12	4
CECIL	2	1	0	2	2	0	0	1	1
KENT	0	0	0	0	0	0	0	1	0
QUEEN ANNE'S	1	0	0	0	0	0	1	1	0
CAROLINE	0	0	0	1	4	0	0	0	0
TALBOT	1	1	0	1	0	1	0	2	1
DORCHESTER	0	0	0	2	0	0	2	0	0
WICOMICO	1	1	3	1	1	4	1	7	0
SOMERSET	1	1	0	1	0	0	2	0	1
WORCESTER	0	0	2	1	0	1	0	0	1

1 Includes deaths that were related to recent use of pharmaceutical or illicitly-produced fentanyl.
2 Includes only deaths for which the manner of death was classified as accidental or undetermined.
3 Counts for 2015 are preliminary.

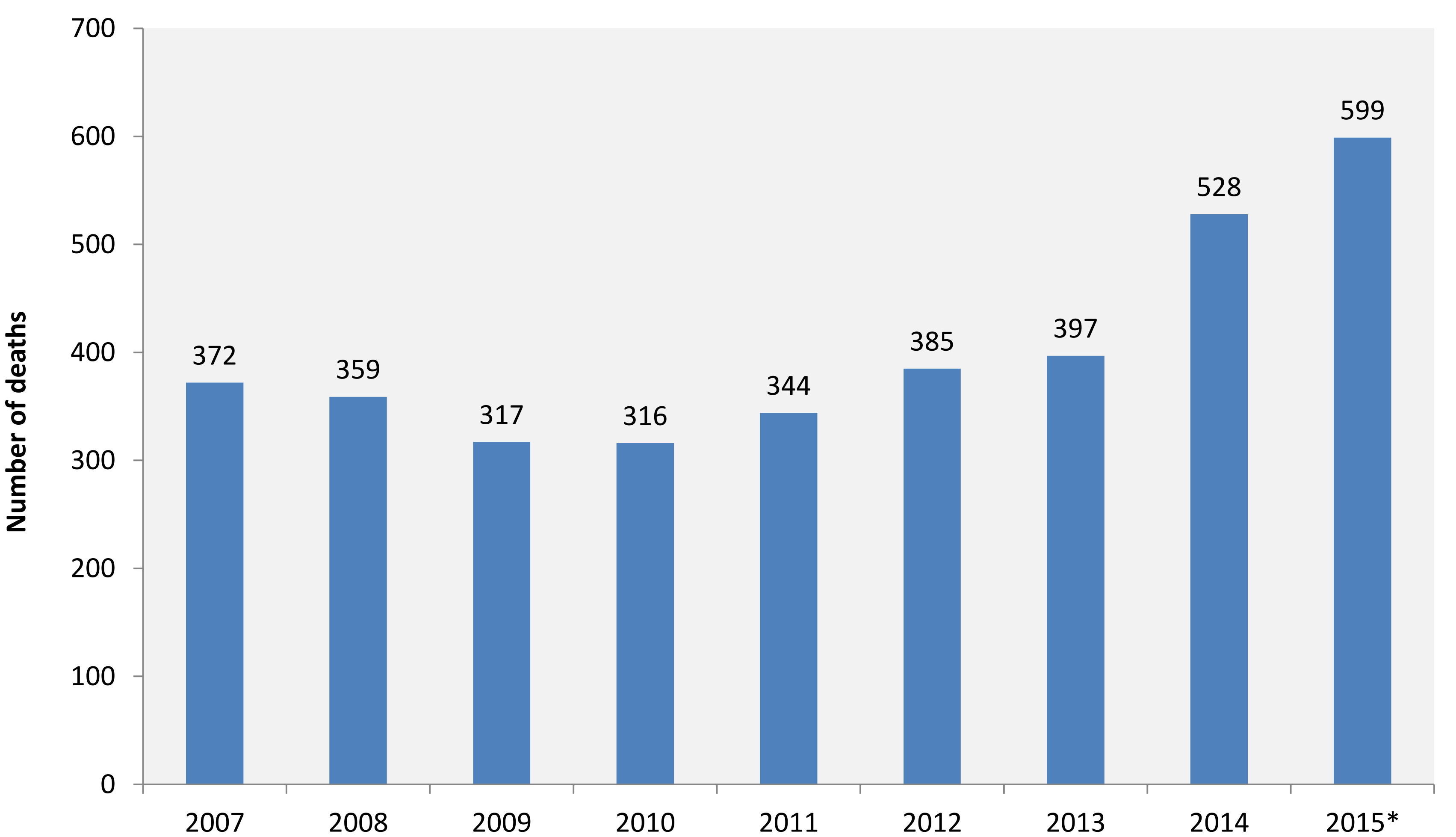
Drug- and Alcohol-Related Intoxication Deaths in Maryland

Data update through 2nd quarter 2015

This report contains counts of drug and alcohol-related intoxication deaths* occurring in Maryland through the second quarter of 2015, the most recent period for which reasonably complete data are available. Counts are also shown for the same period of 2007-2014 to allow for comparison of trends over time. Counts for 2015 are preliminary and subject to change.

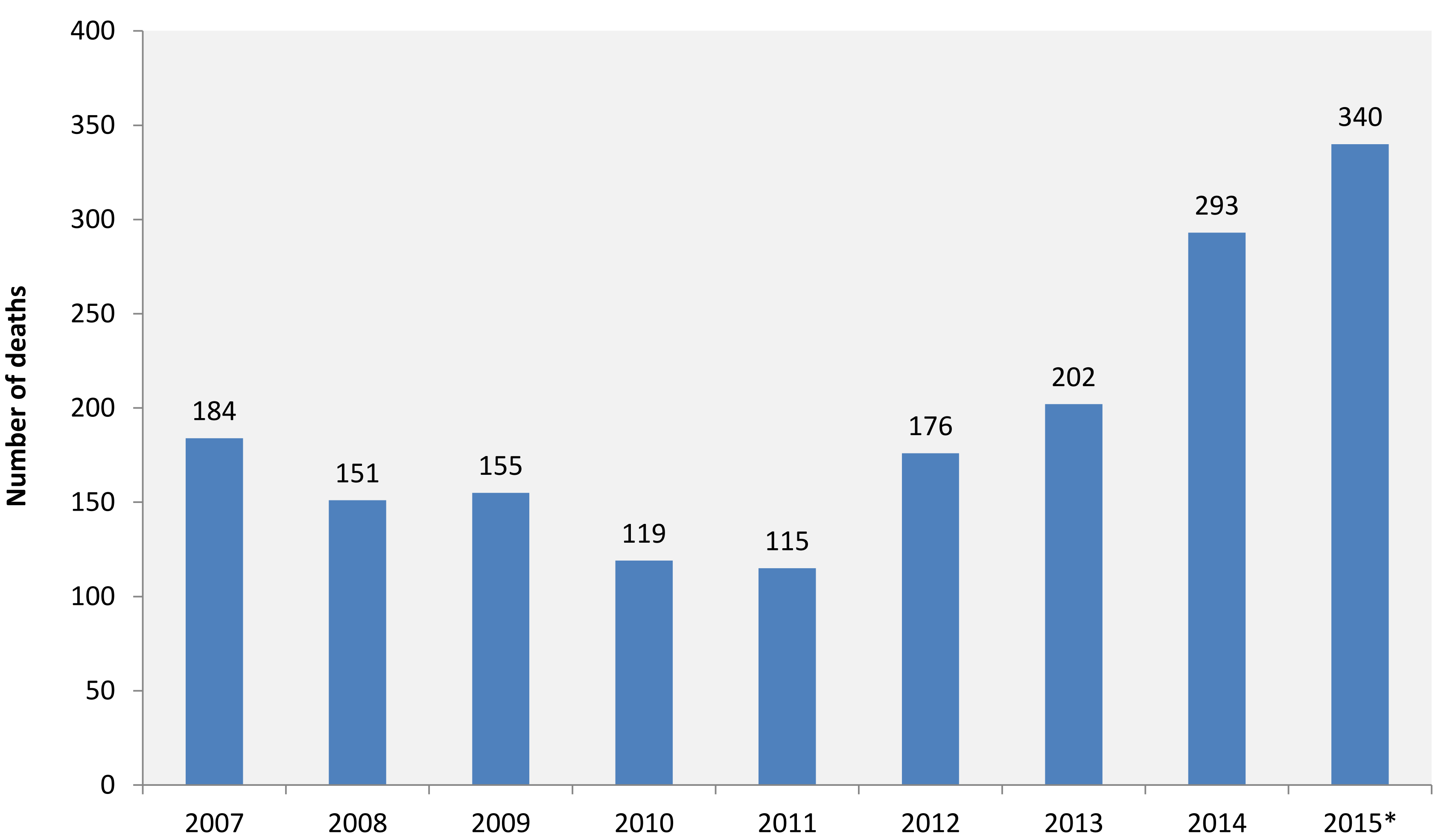
*Deaths resulting from recent ingestion or exposure to alcohol or other types of drugs, including heroin, cocaine, phencyclidine (PCP), prescription opioids, benzodiazepines, methamphetamines and other prescribed and unprescribed drugs.

Figure 1. Total Number of Unintentional Intoxication Deaths Occurring in Maryland from January-June of Each Year.*



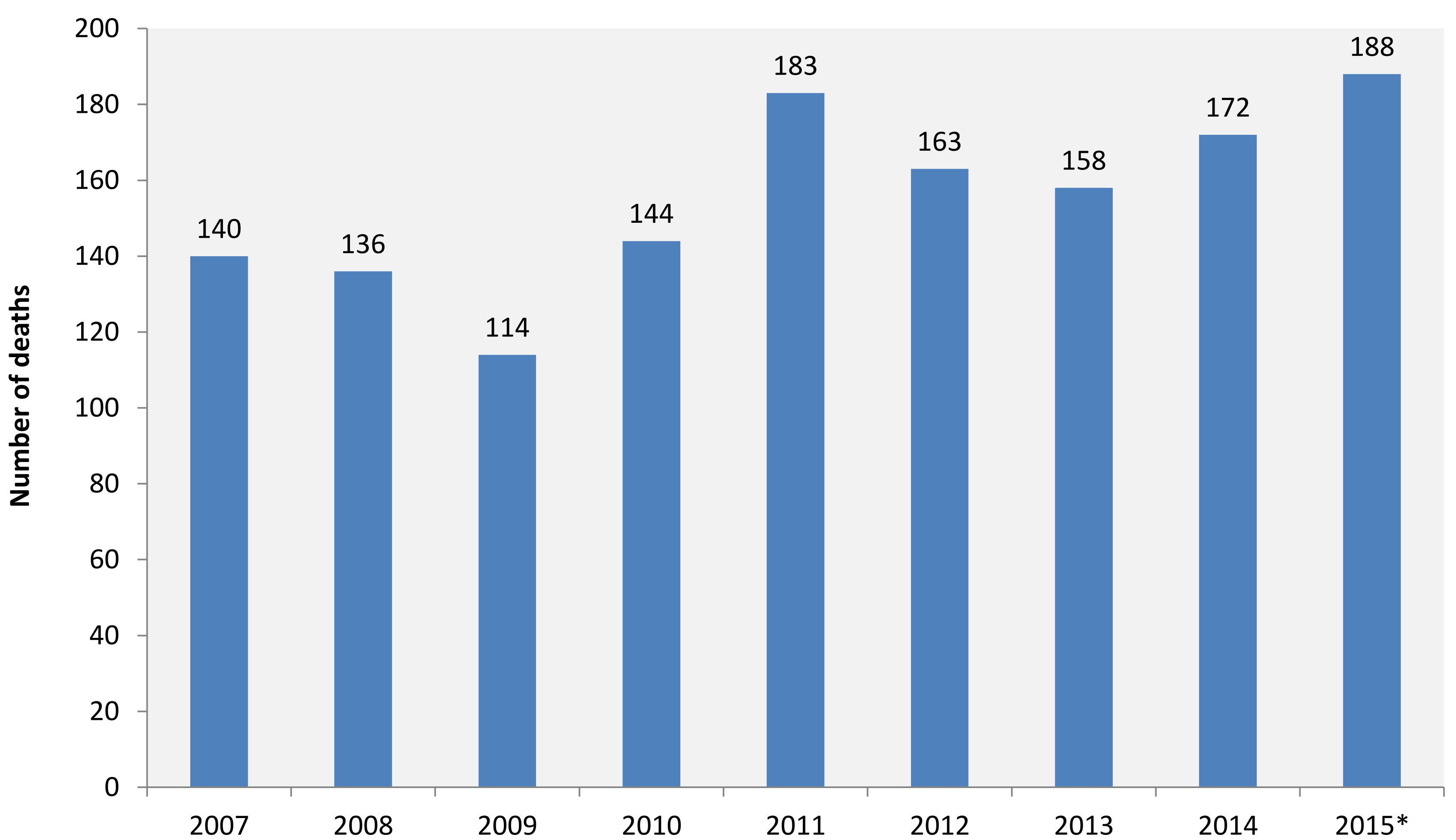
*2015 counts are preliminary.

Figure 2. Number of Heroin-Related Deaths Occurring in Maryland from January through June of Each Year.*



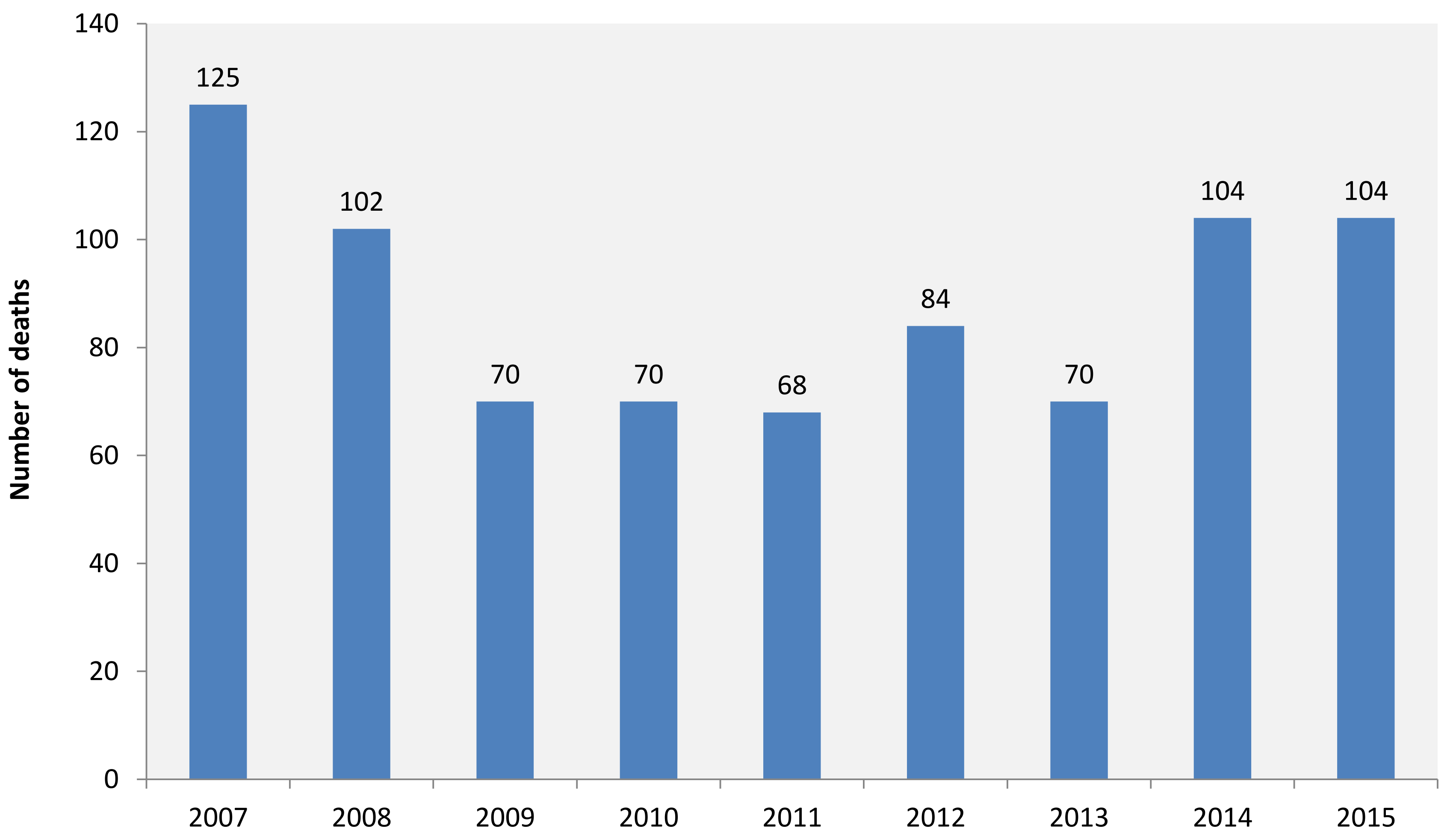
*2015 counts are preliminary.

Figure 3. Number of Prescription Opioid-Related Deaths Occurring in Maryland from January through June of Each Year.*



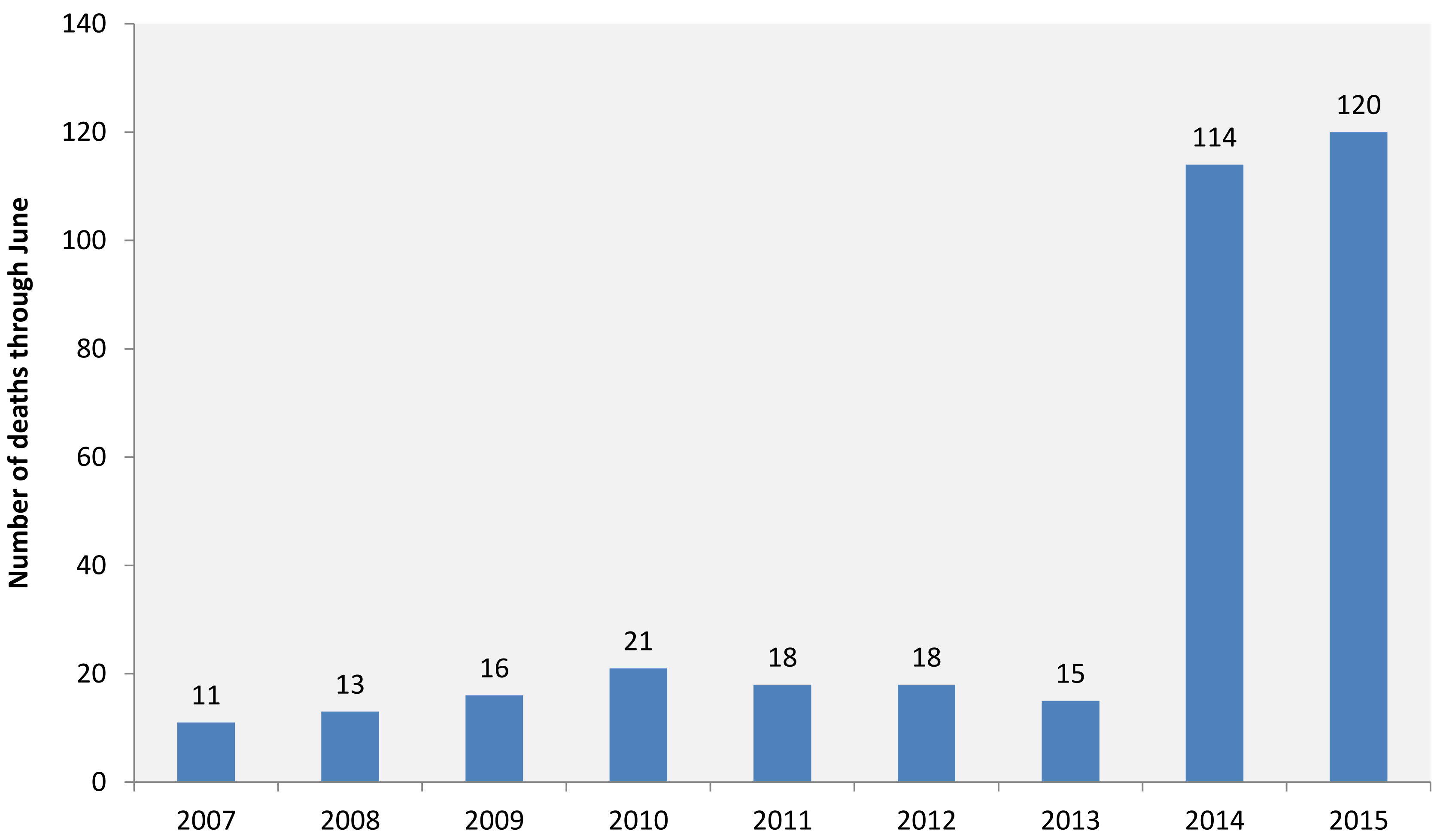
*2015 counts are preliminary.

Figure 4. Number of Cocaine-Related Deaths Occurring in Maryland from January through June of Each Year.*



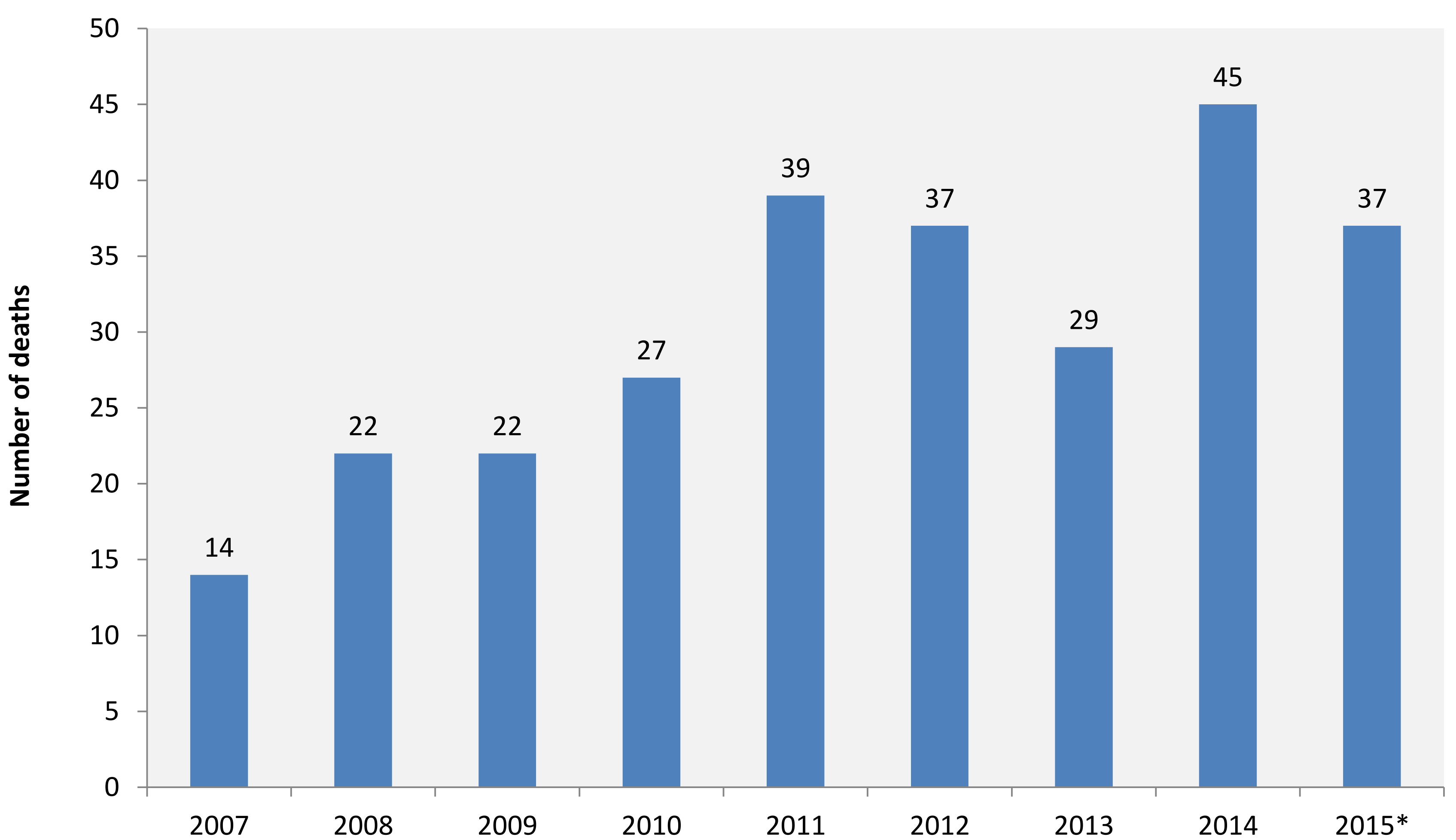
*2015 counts are preliminary.

Figure 5. Number of Fentanyl-Related Intoxication Deaths Occurring in Maryland Through June of Each Year.*



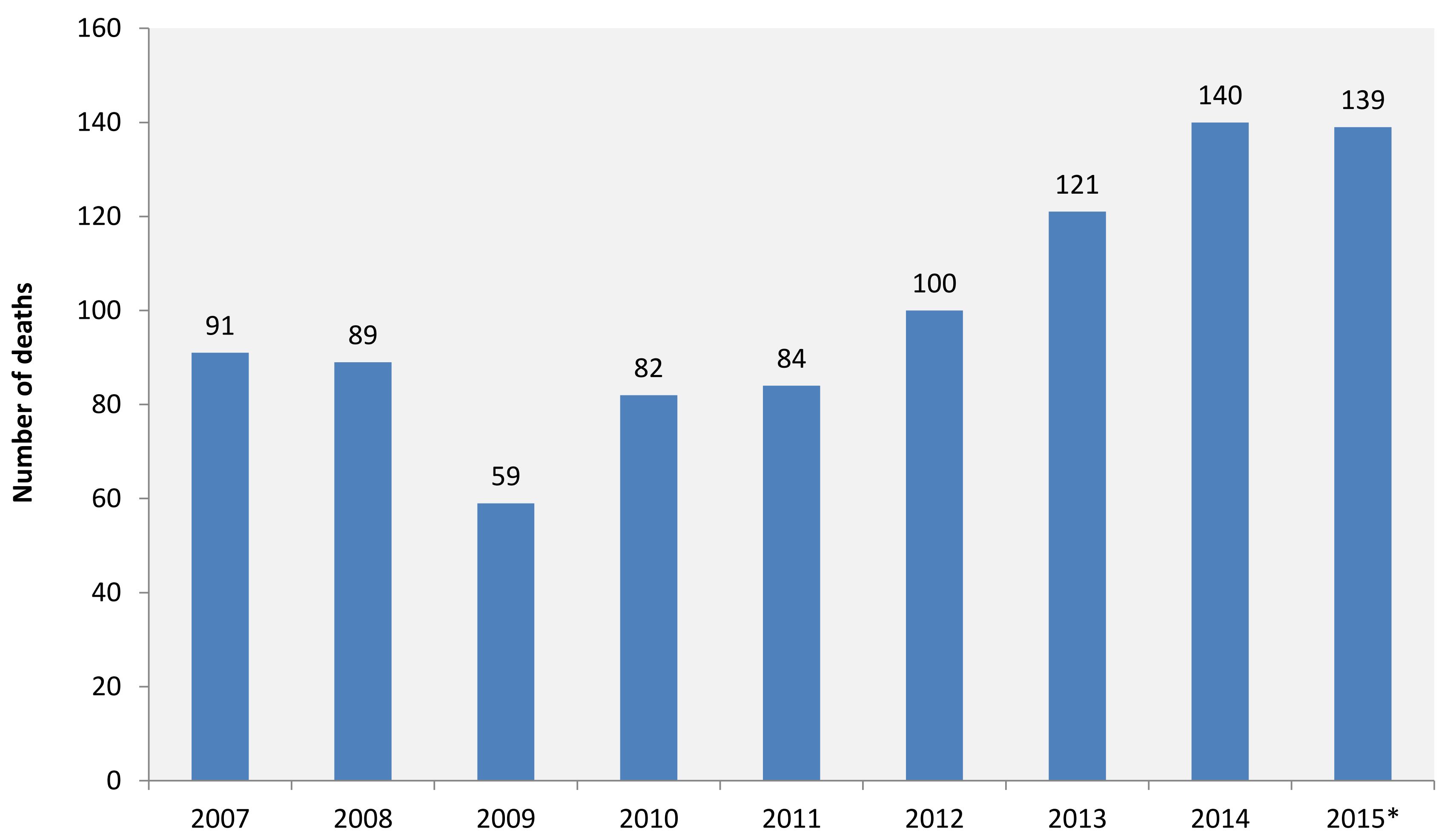
*2015 counts are preliminary.

Figure 6. Number of Benzodiazepine-Related Deaths Occurring in Maryland from January through June of Each Year.*



*2015 counts are preliminary.

Figure 7. Number of Alcohol-Related Deaths Occurring in Maryland from January through June of Each Year.*



*2015 counts are preliminary.

Figure 8

Total Number of Drug and Alcohol-Related Intoxication Deaths by Place of Occurrence, Maryland. January -- June, 2015 and 2014.

State of Maryland	Drug & Alcohol Intoxication Deaths		2015 vs 2014
COUNTY	Jan. - Jun. 2015	Jan. - Jun. 2014	# DIFFERENCE
Allegany County	12	4	8
A. A. County	50	51	-1
Baltimore City	188	162	26
Baltimore County	102	83	19
Calvert County	11	13	-2
Caroline County	0	4	-4
Carroll County	19	22	-3
Cecil County	13	20	-7
Charles County	10	8	2
Dorchester County	0	0	0
Frederick County	18	19	-1
Garrett County	3	1	2
Harford County	22	16	6
Howard County	11	10	1
Kent County	2	2	0
Montgomery County	38	28	10
P.G. County	33	35	-2
Queen Anne's County	2	6	-4
Somerset County	6	1	5
St. Mary's County	10	6	4
Talbot County	2	2	0
Washington County	36	19	17
Wicomico County	7	12	-5
Worcester County	4	4	0
Total	599	528	71

[1]Includes deaths that were the result of recent ingestion or exposure to alcohol or another type of drug, including heroin, cocaine, prescription opioids, benzodiazepines, and other prescribed and unprescribed drugs.

[2]Includes only deaths for which the manner of death was classified as accidental or undetermined.

[3]Counts for 2015 are preliminary.

TABLE 1. TOTAL NUMBER OF DRUG AND ALCOHOL-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2014 AND YTD 2015 THROUGH JUNE.[1,2,3]

	TOTAL INTOXICATION DEATHS								
	2007	2008	2009	2010	2011	2012	2013	2014	YTD 2015
MARYLAND	815	694	731	649	671	799	858	1,041	599
WESTERN AREA	110	99	97	96	109	115	138	161	107
GARRETT	1	3	3	3	2	0	6	2	3
ALLEGANY	14	9	9	15	12	14	15	12	12
WASHINGTON	16	26	18	20	21	27	28	40	36
FREDERICK	23	15	23	20	30	26	37	42	18
MONTGOMERY	56	46	44	38	44	48	52	65	38
CENTRAL AREA	550	443	479	411	420	519	557	678	392
BALTIMORE CITY	287	184	239	172	167	225	246	305	188
BALTIMORE COUNTY	131	118	106	115	107	119	144	170	102
ANNE ARUNDEL	71	70	63	56	79	83	78	101	50
CARROLL	14	17	22	15	8	29	24	38	19
HOWARD	16	19	16	10	21	24	29	21	11
HARFORD	31	35	33	43	38	39	36	43	22
SOUTHERN AREA	86	94	93	74	73	93	84	110	64
CALVERT	14	9	14	6	12	12	6	17	11
CHARLES	13	16	11	13	11	13	9	21	10
ST. MARY'S	6	11	9	12	8	12	10	9	10
PRINCE GEORGE'S	53	58	59	43	42	56	59	63	33
EASTERN SHORE AREA	69	58	62	68	69	72	79	92	36
CECIL	25	10	24	24	28	25	26	29	13
KENT	3	4	2	5	2	0	4	6	2
QUEEN ANNE'S	4	5	4	4	5	2	8	10	2
CAROLINE	1	4	2	2	11	4	2	7	0
TALBOT	5	4	3	3	1	5	7	4	2
DORCHESTER	4	5	2	6	2	5	5	0	0
WICOMICO	9	13	12	13	11	21	17	20	7
SOMERSET	6	3	4	1	3	3	4	3	6
WORCESTER	12	10	9	10	6	7	6	13	4

1 Includes deaths that were the result of recent ingestion or exposure to alcohol or another type of drug, including heroin, cocaine, prescription opioids, benzodiazepines, and other prescribed and unprescribed drugs.

2 Includes only deaths for which the manner of death was classified as accidental or undetermined.

3 Counts for 2015 are preliminary.

TABLE 2. HEROIN-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2014 AND YTD 2015 THROUGH JUNE.[1,2,3]

	HEROIN-RELATED DEATHS								
	2007	2008	2009	2010	2011	2012	2013	2014	YTD 2015
MARYLAND	399	289	360	238	247	392	464	578	340
WESTERN AREA	33	35	39	27	34	49	68	86	60
GARRETT	0	0	1	0	1	0	2	1	1
ALLEGANY	3	4	2	3	3	6	3	5	8
WASHINGTON	5	13	11	6	8	11	14	21	20
FREDERICK	8	4	9	6	11	10	21	26	11
MONTGOMERY	17	14	16	12	11	22	28	33	20
CENTRAL AREA	323	203	264	171	165	272	319	379	233
BALTIMORE CITY	200	107	151	93	76	131	150	192	125
BALTIMORE COUNTY	56	51	53	42	38	64	76	86	58
ANNE ARUNDEL	38	24	31	18	24	38	41	53	22
CARROLL	9	5	7	3	2	13	14	16	8
HOWARD	8	8	7	3	10	12	16	9	8
HARFORD	12	8	15	12	15	14	22	23	12
SOUTHERN AREA	28	35	36	25	27	38	38	60	25
CALVERT	5	3	7	1	5	6	2	13	7
CHARLES	2	5	3	6	6	5	5	10	3
ST. MARY'S	1	3	0	4	4	7	6	5	2
PRINCE GEORGE'S	20	24	26	14	12	20	25	32	13
EASTERN SHORE AREA	15	16	21	15	21	33	39	53	22
CECIL	8	4	12	4	8	11	11	15	7
KENT	1	1	0	0	1	0	0	2	1
QUEEN ANNE'S	0	1	3	2	2	2	5	7	0
CAROLINE	0	0	0	0	3	3	2	6	0
TALBOT	1	2	0	0	1	2	2	4	2
DORCHESTER	1	2	0	2	1	3	3	0	0
WICOMICO	1	3	3	5	3	9	11	12	5
SOMERSET	2	1	1	0	1	2	1	1	4
WORCESTER	1	2	2	2	1	1	4	6	3

1 Includes deaths confirmed or suspected to be related to recent heroin use.
2 Includes only deaths for which the manner of death was classified as accidental or undetermined.
3 Counts for 2015 are preliminary.

TABLE 3. PRESCRIPTION OPIOID-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2014 AND YTD 2015 THROUGH JUNE.[1,2,3]

	PRESCRIPTION OPIOID-RELATED DEATHS								
	2007	2008	2009	2010	2011	2012	2013	2014	YTD 2015
MARYLAND	302	280	251	311	342	311	316	330	188
WESTERN AREA	42	38	40	36	58	48	51	52	31
GARRETT	0	2	2	1	1	0	2	2	1
ALLEGANY	9	5	6	8	5	5	8	6	3
WASHINGTON	7	10	4	7	11	9	11	16	12
FREDERICK	6	4	9	6	21	16	14	9	5
MONTGOMERY	20	17	19	14	20	18	16	19	10
CENTRAL AREA	190	189	148	197	212	196	207	217	128
BALTIMORE CITY	95	60	63	61	82	74	86	84	48
BALTIMORE COUNTY	48	51	37	60	68	47	54	59	39
ANNE ARUNDEL	22	36	20	31	33	33	28	32	17
CARROLL	4	11	10	9	5	17	12	15	11
HOWARD	6	6	4	6	9	5	13	7	4
HARFORD	15	25	14	30	15	20	14	20	9
SOUTHERN AREA	25	28	31	33	30	29	26	35	19
CALVERT	8	3	4	3	7	6	3	7	5
CHARLES	6	6	7	4	5	7	5	9	6
ST. MARY'S	3	7	7	9	3	5	4	3	3
PRINCE GEORGE'S	8	12	13	17	15	11	14	16	5
EASTERN SHORE AREA	45	25	32	45	42	38	32	26	10
CECIL	19	6	10	20	20	18	12	12	3
KENT	2	3	2	3	1	0	4	2	1
QUEEN ANNE'S	4	1	1	2	2	0	3	3	2
CAROLINE	0	2	1	2	5	1	0	1	0
TALBOT	2	1	2	2	0	1	4	0	0
DORCHESTER	2	1	1	4	1	3	3	0	0
WICOMICO	5	4	8	7	7	9	4	3	2
SOMERSET	4	3	1	1	3	2	2	1	1
WORCESTER	7	4	6	4	3	4	0	4	1

1 Includes deaths that were related to recent ingestion of one or more prescription opioids.
2 Includes only deaths for which the manner of death was classified as accidental or undetermined.
3 Counts for 2015 are preliminary.

TABLE 4. COCAINE-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2014 AND YTD 2015 THROUGH JUNE.[1,2,3]

	COCAINE-RELATED DEATHS								
	2007	2008	2009	2010	2011	2012	2013	2014	YTD 2015
MARYLAND	248	157	162	135	148	153	154	198	104
WESTERN AREA	29	16	11	12	22	21	26	26	16
GARRETT	0	0	0	1	0	0	0	0	0
ALLEGANY	2	1	1	1	0	2	2	2	4
WASHINGTON	3	1	0	3	3	5	6	6	8
FREDERICK	4	2	3	3	7	2	5	8	2
MONTGOMERY	20	12	7	4	12	12	13	10	2
CENTRAL AREA	178	108	124	93	97	108	102	138	73
BALTIMORE CITY	106	57	72	45	48	59	47	82	44
BALTIMORE COUNTY	30	25	25	23	19	17	27	28	18
ANNE ARUNDEL	26	18	15	13	18	13	12	19	7
CARROLL	2	2	3	6	3	7	7	2	1
HOWARD	6	1	4	1	5	7	5	3	2
HARFORD	8	5	5	5	4	5	4	4	1
SOUTHERN AREA	20	20	15	19	15	16	13	22	10
CALVERT	1	2	1	3	2	3	0	2	0
CHARLES	3	3	2	2	1	1	0	0	1
ST. MARY'S	1	1	1	2	0	2	1	1	4
PRINCE GEORGE'S	15	14	11	12	12	10	12	19	5
EASTERN SHORE AREA	21	13	12	11	14	8	13	12	5
CECIL	5	3	4	3	7	2	5	4	1
KENT	1	2	0	1	0	0	0	1	1
QUEEN ANNE'S	3	0	2	0	1	0	0	0	0
CAROLINE	0	0	1	0	1	1	0	1	0
TALBOT	4	0	1	0	0	0	3	0	1
DORCHESTER	1	1	0	1	1	1	1	0	0
WICOMICO	2	5	2	3	3	4	3	4	2
SOMERSET	1	0	1	1	0	0	0	0	0
WORCESTER	4	2	1	2	1	0	1	2	0

[1] Includes deaths that were related to recent use of cocaine.
[2] Includes only deaths for which the manner of death was classified as accidental or undetermined.
[3] Counts for 2015 are preliminary.

TABLE 5. ALCOHOL-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2014 AND YTD 2015 THROUGH JUNE.[1,2,3]

	ALCOHOL-RELATED DEATHS								
	2007	2008	2009	2010	2011	2012	2013	2014	YTD 2015
MARYLAND	187	175	162	160	161	195	239	270	139
WESTERN AREA	29	34	25	25	32	27	34	45	26
GARRETT	1	2	1	1	1	0	2	1	1
ALLEGANY	5	0	3	4	2	4	2	3	3
WASHINGTON	3	10	4	5	4	3	6	11	5
FREDERICK	5	7	8	5	9	5	11	12	9
MONTGOMERY	15	15	9	10	16	15	13	18	8
CENTRAL AREA	114	96	100	94	99	126	154	166	98
BALTIMORE CITY	56	41	54	39	44	71	86	86	54
BALTIMORE COUNTY	38	23	22	29	22	24	32	39	21
ANNE ARUNDEL	12	12	9	10	21	15	22	18	12
CARROLL	3	4	5	4	4	4	4	9	4
HOWARD	2	7	5	3	4	6	6	6	2
HARFORD	3	9	5	9	4	6	4	8	5
SOUTHERN AREA	31	27	21	22	19	30	29	30	12
CALVERT	3	3	4	0	2	2	1	4	2
CHARLES	5	5	1	4	3	2	4	5	1
ST. MARY'S	2	1	3	2	2	3	2	3	3
PRINCE GEORGE'S	21	18	13	16	12	23	22	18	6
EASTERN SHORE AREA	13	18	16	19	11	12	22	29	3
CECIL	5	4	7	6	3	6	9	5	0
KENT	0	0	0	1	0	0	1	1	0
QUEEN ANNE'S	1	2	0	1	3	0	1	7	0
CAROLINE	1	0	1	0	1	0	1	2	0
TALBOT	0	3	0	0	0	2	2	0	0
DORCHESTER	2	0	0	1	0	1	0	0	0
WICOMICO	1	6	3	4	2	2	6	7	0
SOMERSET	0	0	1	0	1	1	1	2	2
WORCESTER	3	3	4	6	1	0	1	5	1

1 Includes deaths that were related to recent ingestion of alcohol.
2 Includes only deaths for which the manner of death was classified as accidental or undetermined.
3 Counts for 2015 are preliminary.

TABLE 6. FENTANYL-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2014 AND YTD 2015 THROUGH JUNE.[1,2,3]

	FENTANYL-RELATED DEATHS								
	2007	2008	2009	2010	2011	2012	2013	2014	YTD 2015
MARYLAND	26	25	27	39	26	29	58	186	120
WESTERN AREA	5	1	2	7	6	5	7	16	13
GARRETT	0	1	0	0	1	0	0	0	0
ALLEGANY	3	0	1	2	1	1	1	1	1
WASHINGTON	0	0	0	2	1	1	4	1	3
FREDERICK	0	0	0	2	3	1	2	6	1
MONTGOMERY	2	0	1	1	0	2	0	8	8
CENTRAL AREA	14	19	16	20	10	16	35	142	86
BALTIMORE CITY	3	2	4	4	2	4	12	72	52
BALTIMORE COUNTY	6	9	9	6	4	5	11	36	20
ANNE ARUNDEL	3	5	3	5	2	3	6	23	5
CARROLL	0	2	0	2	0	1	2	4	3
HOWARD	1	0	0	0	0	2	3	5	2
HARFORD	1	1	0	3	2	1	1	2	4
SOUTHERN AREA	1	1	4	3	3	2	10	16	14
CALVERT	0	1	1	0	1	0	0	5	2
CHARLES	0	0	0	0	1	1	3	1	3
ST. MARY'S	0	0	1	1	1	0	1	3	0
PRINCE GEORGE'S	1	0	2	2	0	1	6	7	9
EASTERN SHORE AREA	6	4	5	9	7	6	6	12	7
CECIL	2	1	0	2	2	0	0	1	2
KENT	0	0	0	0	0	0	0	1	0
QUEEN ANNE'S	1	0	0	0	0	0	1	1	0
CAROLINE	0	0	0	1	4	0	0	0	0
TALBOT	1	1	0	1	0	1	0	2	1
DORCHESTER	0	0	0	2	0	0	2	0	0
WICOMICO	1	1	3	1	1	4	1	7	0
SOMERSET	1	1	0	1	0	0	2	0	1
WORCESTER	0	0	2	1	0	1	0	0	3

1 Includes deaths that were related to recent use of pharmaceutical or illicitly-produced fentanyl.
2 Includes only deaths for which the manner of death was classified as accidental or undetermined.
3 Counts for 2015 are preliminary.

Opioid Operational Command Center
Annual Report
January 1, 2018 – December 31, 2018

May 9, 2019

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Message from the Executive Director

Since Governor Hogan declared a state of emergency in response to the opioid crisis in March 2017, Maryland has made tremendous progress in implementing prevention and educational programs, stepping up enforcement, and expanding treatment and recovery programs throughout the state. The Opioid Operational Command Center (OOCC) monitors more than 200 measures pertaining to programs and best practices, and, as you will see in this report, virtually all of those measures are moving in a positive direction.

We have found that the rate of increase in the overall number of opioid-related fatalities has slowed for two years in a row to the slowest rate of growth since 2011. We are seeing sharp declines in the number of heroin-related and prescription opioid-related fatalities.

Despite these encouraging trends, fatalities continue to increase in Maryland. In 2018, 2,114 of our family members, friends, and neighbors died from opioid overdose. The vast majority of these fatalities were caused by fentanyl and its analogs. Fentanyl is a synthetic, heroin-like substance that is immensely powerful and very deadly, and is being mixed with other drugs, like heroin and cocaine.

The OOCC works closely with the opioid intervention teams (OITs) in each of Maryland's 24 local jurisdictions. I am pleased to report that our local partners have made extraordinary progress in adopting best practices.

Working closely with the Maryland Department of Health (MDH), the Governor's Office of Crime Control and Prevention (GOCCP), the Maryland State Department of Education (MSDE), and other state agencies, the OOCC is budgeted to award approximately $56 million in opioid crisis grants in Fiscal Year 2019. The OOCC and these State Partner agencies will support over 100 statewide and local projects in FY19.

Significant opioid-related legislation was passed during the 2018 session of the Maryland General Assembly, including the *Overdose Data Reporting Act* and the *Controlled Dangerous Substances - Volume Dealers Act* as discussed in section VIII of this report.

The governor signed Executive Order 01.01.2018.30 in December 2018. This Executive Order reaffirmed the OOCC's lead role in coordinating the statewide response to the opioid epidemic. The Executive Order also requires all state agencies to remain at the highest level of alert and engagement with respect to the crisis.

With our state partners, local OITs, advocates, and providers throughout the state, we will keep working every day to save the lives of Marylanders.

Steven R. Schuh
Executive Director
Opioid Operational Command Center
Office of the Governor

Executive Summary

The total number of unintentional intoxication deaths from all types of drugs and alcohol in Maryland in 2018 was 2,385, an increase of 4.5 percent as compared to 2017. Opioids accounted for 88.6 percent of all such fatalities.

The number of opioid-related deaths in Maryland in 2018 was 2,114. This was the second consecutive year in which opioid-related fatalities exceeded 2,000. The rate of increase from 2017 to 2018 was 5.2 percent. This is the second year in a row that the rate of increase in opioid-related fatalities was less than 10 percent.

Heroin-related fatalities in 2018 fell by 23.7 percent. 2018 was also the second year in a row that heroin-related fatalities declined in Maryland.

The number of fentanyl-related deaths in Maryland in 2018 was 1,866, an increase of 17.1 percent. Fentanyl and its analogs accounted for approximately 88.3 percent of all opioid-related fatalities in 2018. The rate of increase in the number of fentanyl-related deaths decelerated for the second year in a row.

The number of prescription opioid-related deaths in Maryland also fell for the second year in a row. There were 371 prescription opioid-related deaths in Maryland 2018, a decline of 10.2 percent.

The number of cocaine-related deaths in Maryland increased by 27.9 percent to a total of 784. This is the third straight year of significant increases in the number of cocaine-related fatalities. Approximately 88.7 percent of all cocaine-related fatalities in 2018 was in combination with fentanyl.

Every jurisdiction experienced opioid-related fatalities in 2018. Baltimore City, Baltimore County, and Anne Arundel County experienced the highest number of fatalities, which collectively accounted for 64.5 percent of all opioid-related deaths in Maryland in 2018. Encouragingly, 13 of the 24 local jurisdictions in Maryland experienced a decline in the number of opioid-related fatalities in 2018.

On a population-adjusted basis, the three most heavily impacted jurisdictions in Maryland in 2018 were Baltimore City, Cecil County and Allegany County. The state average was 20.7 fatalities per 100,000 population.

The OOCC's goals and objectives for combating the opioid epidemic were adopted as part of the Inter-Agency Heroin and Opioid Coordinating Plan of October 2018. All goals and objectives align with the governor's three policy priorities of Prevention & Education, Enforcement, and Treatment & Recovery.

Executive Summary

The OOCC works with approximately 20 governmental State Partners to implement the statewide plan. The OOCC tracks 174 state-level metrics (see page 19). Included in this report are the 32 most important metrics, including nine Prevention & Education performance measures, seven Enforcement performance measures, and 16 Treatment & Recovery performance measures.

The OOCC also works with all 24 local jurisdictions in Maryland to implement the statewide plan. The OOCC tracks 36 local-level programs. This report highlights 30 of what we regard as the highest-priority programs and initiatives, including 10 performance measures in the area of Prevention & Education, two in the area of Enforcement, and 18 in the area of Treatment & Recovery.

The OOCC monitors the extent to which OITs have implemented these high-priority programs and initiatives. All jurisdictions are making excellent progress in implementing these programs. All 24 local jurisdictions have implemented at least half of these critical programs.

Two significant opioid-related bills were passed by the Maryland General Assembly during the 2018 legislative session. Those bills were the *Overdose Data Reporting Act*, which led to the creation of the Overdose Map program, and the *Controlled Dangerous Substances -- Volume Dealers Act*, which expands the volume dealer statute to include fentanyl and enables more effective prosecution of high-level drug traffickers.

The State of Maryland has made a major budgetary commitment to combating the opioid epidemic. Total statewide opioid-related spending reached $672 million in FY19 and is proposed to increase to $747 million in FY20. Total opioid-related spending increased by 68 percent since FY17. These figures may not include all opioid-related spending in Maryland.

Within the overall statewide budgetary commitment to combating the opioid epidemic is opioid crisis spending, which represents new funding streams that have been enacted since the governor initiated a state of emergency in March 2017. Opioid crisis funds are forecasted to reach $56.6 million in FY19.

Opioid crisis funds provide funding to support over 100 statewide and local projects. Thirty-six of these grant projects fell into the area of Prevention & Education, nine fell into the area of Enforcement, and 57 fell into the category of Treatment & Recovery.

Of the $56.6 million in fiscal year 2019 opioid crisis spending, $20.9 million was granted to Maryland's 24 local jurisdictions. This figure is preliminary and does not include the federal State Opioid Response (SOR) Grant and other grants that are still in the process of being allocated to sub-recipients.

Note: The fatalities data presented herein are preliminary and subject to change.

Fatalities Data

Fatalities Data

This report contains counts of unintentional drug and alcohol-related intoxication deaths occurring in Maryland through the fourth quarter of 2018, the most recent period for which preliminary data are available. Counts also are shown for the same period of 2009-2017 to allow for review of trends over time.

Unintentional intoxication deaths are fatalities resulting from recent ingestion or exposure to alcohol or other types of drugs, including heroin, prescription opioids, prescribed and illicit forms of fentanyl (including carfentanil), cocaine, benzodiazepines, phencyclidine (PCP), methamphetamines, and other prescribed and unprescribed drugs.

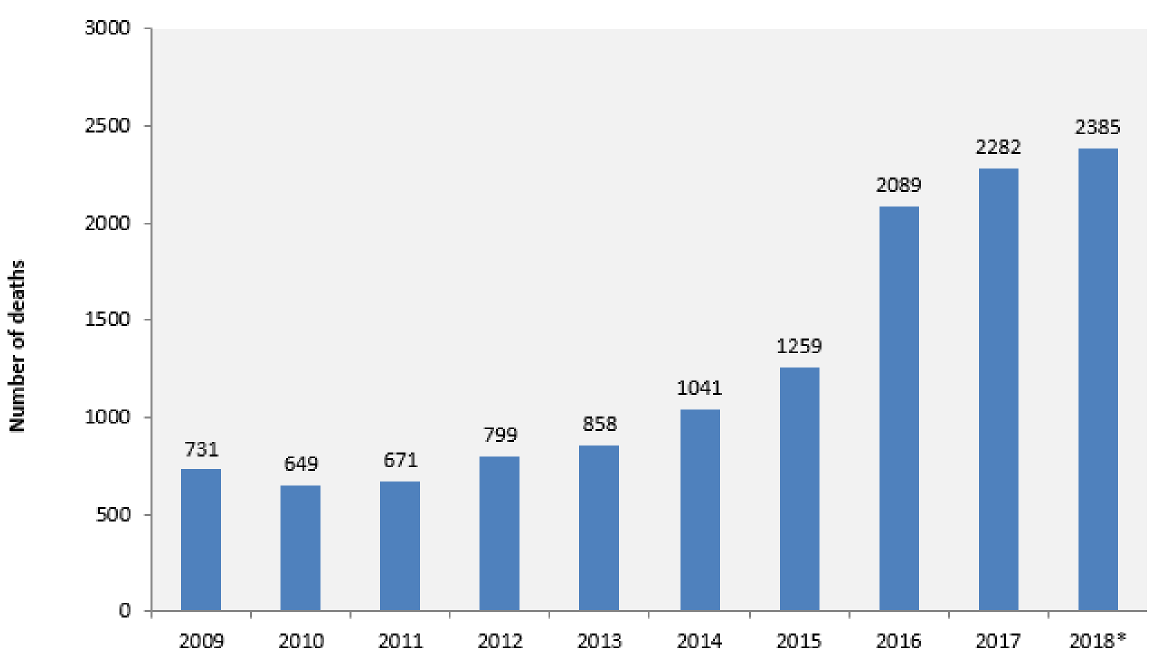
Since an intoxication death may involve more than one substance, counts of deaths related to specific substances do not total to the overall number of deaths.

Note: The fatalities data presented herein are preliminary and subject to change.

Fatalities Data (cont.)

As shown in Figure 1, the total number of unintentional intoxication deaths from all types of drugs and alcohol in Maryland in 2018 increased by 4.5 percent to a total of 2,385. Opioids accounted for 88.6 percent of all unintentional intoxication deaths in Maryland in 2018.

Other causes of unintentional intoxication deaths included alcohol, cocaine, benzodiazepines, and other drugs.



*2018 counts are preliminary.

Fatalities Data (cont.)

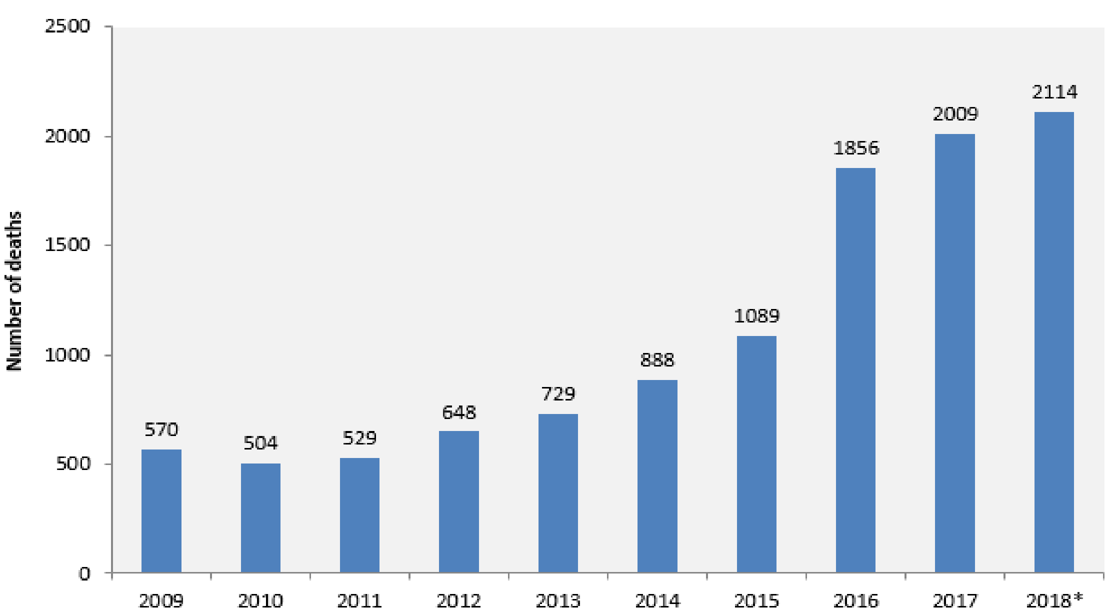
As shown in Figure 2, the number of opioid-related deaths occurring in Maryland in 2018 was 2,114. 2018 was the second year in a row in which opioid-related intoxication deaths exceeded 2,000.

Opioid-related deaths in 2018 increased by 5.2 percent as compared to 2017. This rate of increase was significantly lower than the 8.2 percent rate of increase in 2017 and dramatically lower than the 70.4 percent rate of increase in 2016.

The 2009 to 2011 timeframe was a period of relative stability with respect to the number of opioid-related fatalities in Maryland. The number of fatalities began to increase significantly in 2012 and 2013 as a result of a resurgence in heroin use.

The number of fatalities began to accelerate even more rapidly in the 2014 to 2016 timeframe with the increased availability of synthetic opioids, including fentanyl and its analogs.

Figure 2. Number of Opioid-Related Deaths Occurring in Maryland from January through December of Each Year*

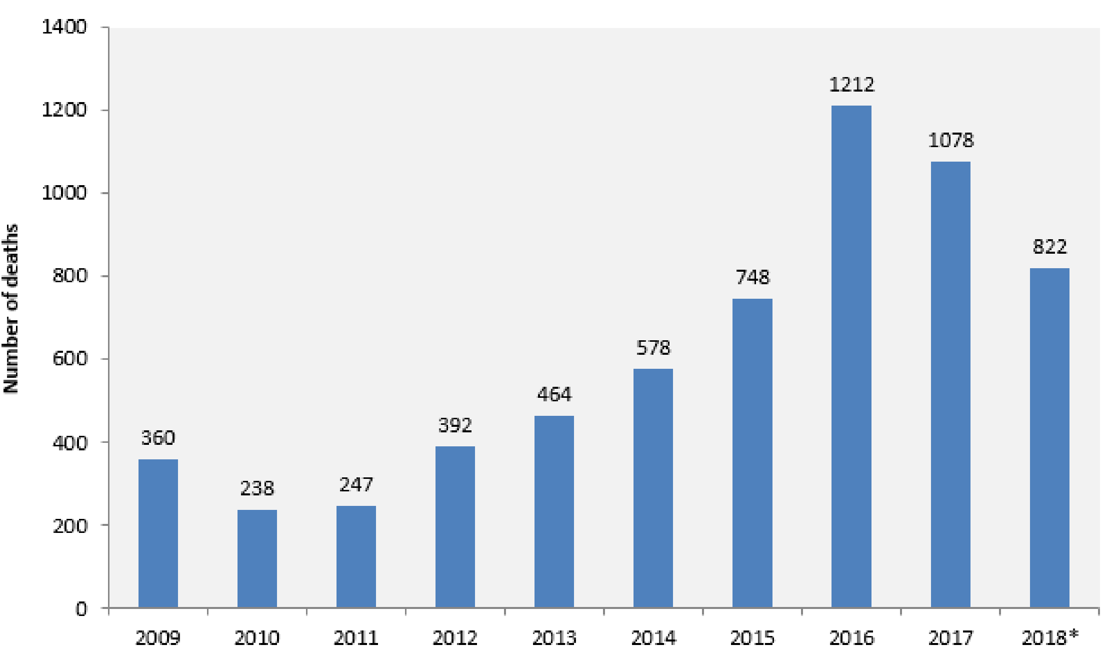


Fatalities Data (cont.)

As shown in Figure 3, the number of heroin-related fatalities fell to 822 in 2018, down 23.7 percent from 2017. 2018 was the second consecutive year of sharp declines in the number of heroin-related deaths.

As noted above, the number of heroin-related fatalities began to surge in 2012 and accelerated dramatically in 2015 and 2016 with the increasingly widespread practice of mixing heroin with synthetic opioids.

We are encouraged by recent declines in the number of heroin-related fatalities, although it must be acknowledged that this may be the result of displacement of heroin for fentanyl as the drug of choice for many users.



*2018 counts are preliminary.

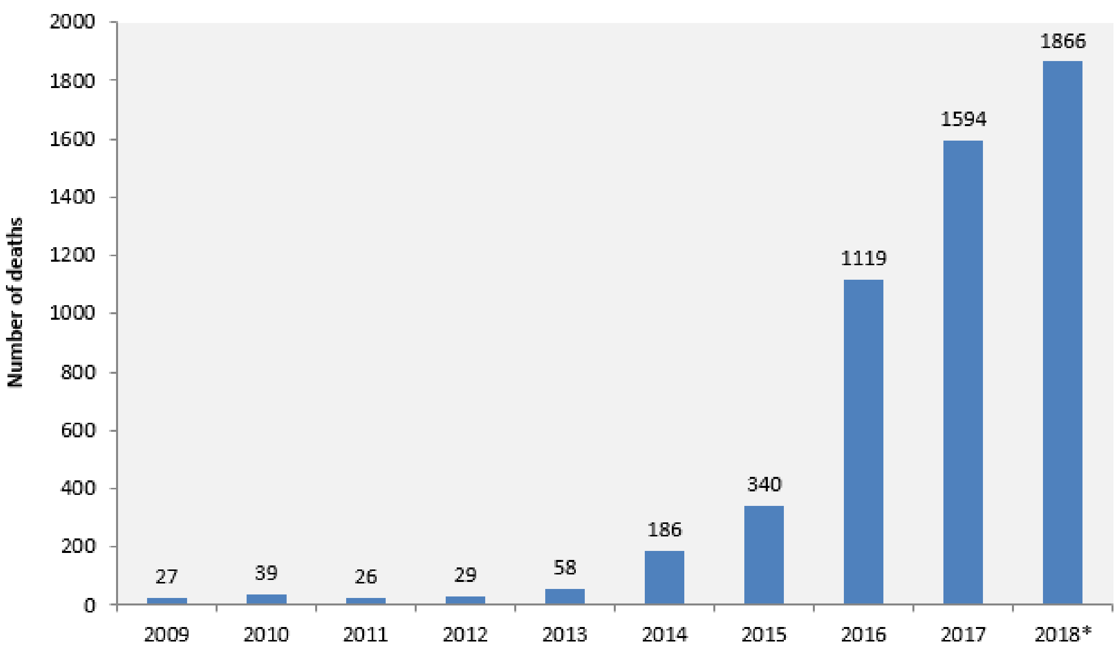
Fatalities Data (cont.)

As shown in Figure 4, the number of fentanyl-related deaths occurring in Maryland was 1,866 in 2018, an increase of 17.1 percent as compared to 2017. This rate of increase represented a deceleration from the prior years' increases of 42.5 percent in 2017 and 229.1 percent in 2016.

Fentanyl accounted for 88.3 percent of all opioid-related fatalities in 2018 versus only 8.0 percent in 2013.

While we are encouraged by what appears to be a slowing in the rate of increase in fentanyl-related fatalities, we remain alarmed by the high toxicity, portability, difficulty of detection, low price, and wide availability of synthetic opioids.

Figure 4. Number of Fentanyl-Related Deaths Occurring in Maryland from January through December of Each Year*

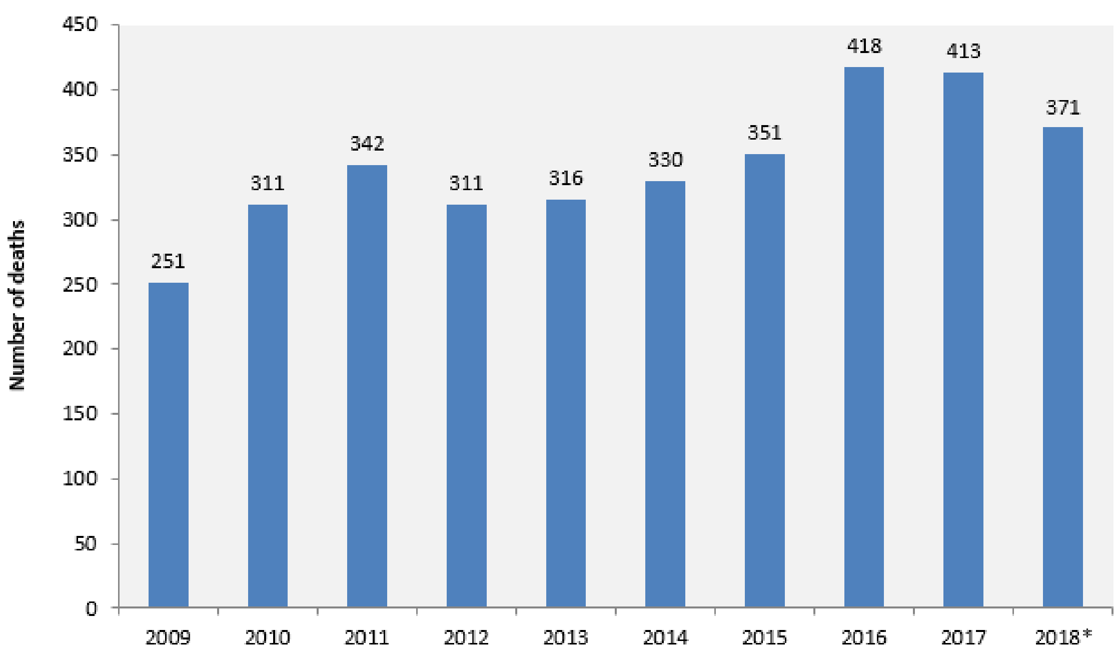


*2018 counts are preliminary.

Fatalities Data (cont.)

As shown in Figure 5, the number of prescription opioid-related deaths in Maryland fell to 371 in 2018, a decrease of 10.2 percent as compared to 2017. 2018 was the second year in a row that the number of prescription opioid-related deaths declined in Maryland.

Despite the declines of the last two years, prescription opioid-related deaths remain at record highs.

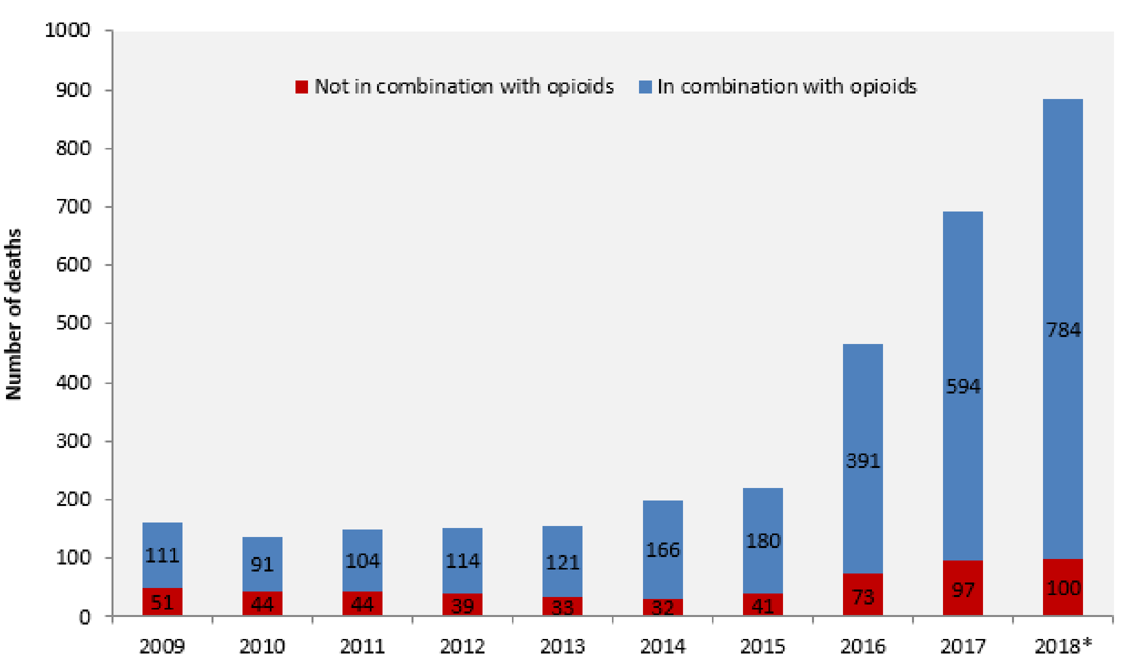


Fatalities Data (cont.)

As shown in Figure 6, the number of cocaine-related deaths in Maryland has accelerated dramatically in the last three years. There were 884 cocaine-related fatalities in 2018, an increase of 27.9 percent as compared to 2017. This rate of increase represented a deceleration from a 48.9 percent increase in 2017 and a 110.0 percent increase in 2016.

The sharp increase in the number of cocaine-related fatalities in recent years was the result of mixing cocaine with fentanyl. Approximately 88.7 percent of all cocaine-related fatalities in 2018 was in combination with fentanyl.

Figure 6. Number of Cocaine-Related Deaths Occurring in Maryland from January through December of Each Year*



*2018 counts are preliminary.

Fatalities Data (cont.)

As shown in Table 1, every local jurisdiction in Maryland experienced opioid-related fatalities in 2018. Baltimore City, Baltimore County, and Anne Arundel County experienced the highest number of fatalities, which collectively accounted for 64.5 percent of all opioid-related deaths in Maryland in 2018.

Thirteen of Maryland's 24 jurisdictions experienced a decline in the number of opioid-related fatalities in 2018, 10 experienced an increase, and one experienced no change. This was the largest number of counties experiencing a decrease in the number of fatalities in any reporting period since the OOCC began tracking this data.

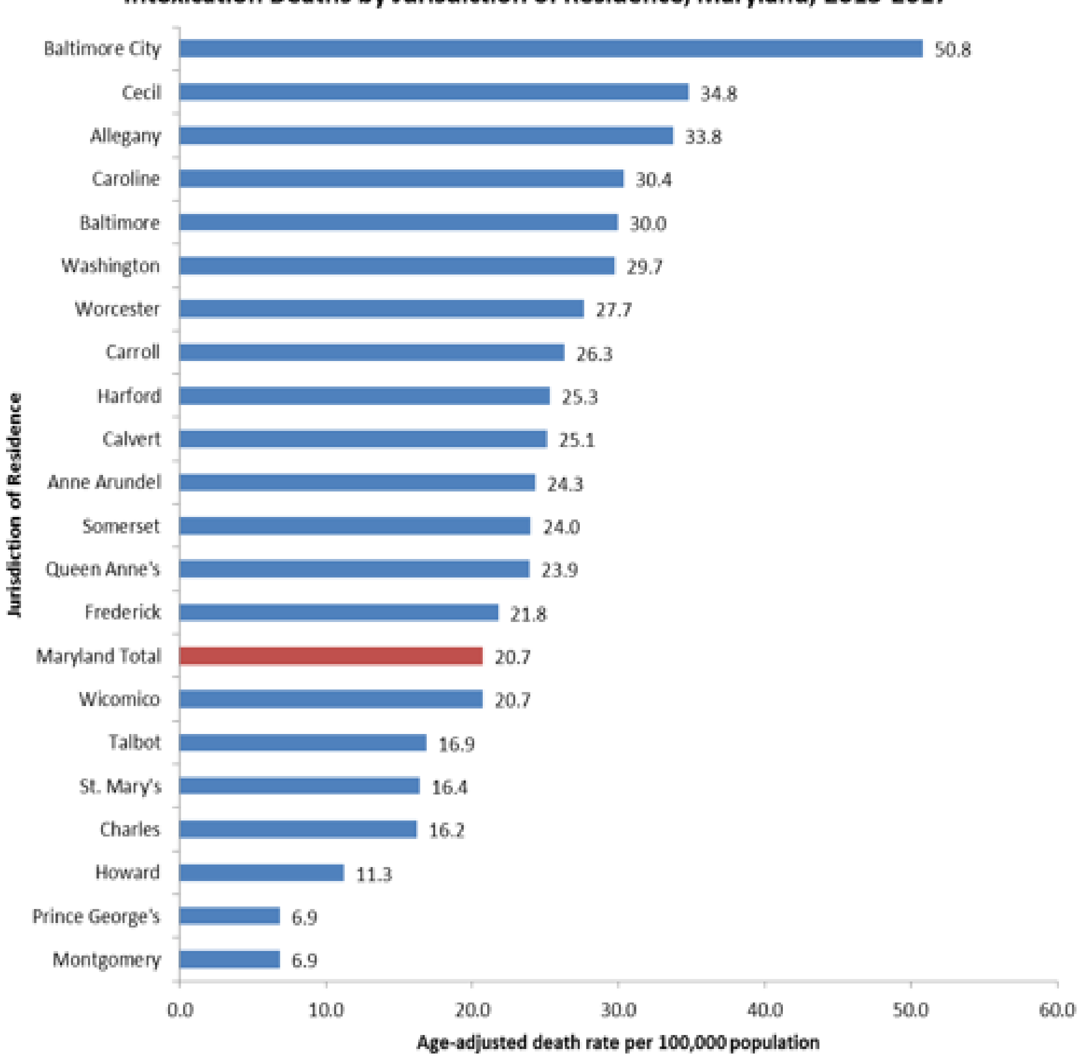
Table 1. Comparison of Unintentional Opioid-Related Intoxication Deaths by Place of Occurrence, Maryland, 2017 and 2018*.

Jurisdiction	Opioid-Related Intoxication Deaths		2017 vs 2018
	2017	2018	# DIFFERENCE
Maryland Total	2009	2114	105
Allegany	36	33	-3
Anne Arundel	198	217	19
Baltimore City	692	798	106
Baltimore County	323	348	25
Calvert	27	24	-3
Caroline	8	7	-1
Carroll	51	67	16
Cecil	57	57	0
Charles	34	19	-15
Dorchester	10	6	-4
Frederick	66	70	4
Garrett	4	3	-1
Harford	93	90	-3
Howard	47	37	-10
Kent	4	2	-2
Montgomery	91	64	-27
Prince George's	124	92	-32
Queen Anne's	6	16	10
Somerset	3	8	5
St. Mary's	33	27	-6
Talbot	8	10	2
Washington	51	80	29
Wicomico	28	29	1
Worcester	15	10	-5

*Counts for 2018 are preliminary.

Fatalities Data (cont.)

As shown in Figure 8, Baltimore City, Cecil County, and Allegany County experienced the highest number of deaths on a population-adjusted basis during the 2013-2017. Baltimore City's population-adjusted death rate for unintentional opioid-related intoxication deaths was 50.8 per 100,000 population, Cecil County's was 34.8, and Allegany County's was 33.8 per 100,000 population. Caroline County and Baltimore County also exceeded 30 deaths per 100,000 population. The average for the State of Maryland was 20.7.



Goals and Objectives

Goals and Objectives

The Inter-Agency Heroin and Opioid Coordination Plan, updated in October 2018, was developed by the OOCC to outline the functions and processes that support Maryland's statewide coordination and collaboration of efforts. The Coordination Plan does not supplant internal, partner-specific procedures, plans, and programs. Rather, the Coordination Plan ensures that partner strategic-planning efforts and program initiatives follow a common statewide vision. The OOCC's original four goals and 16 objectives, developed in collaboration with state and local partners, serve as a framework for the statewide response, strategic planning, analysis, and evaluation.

To accommodate changes to the framework, enable clear reporting, and reflect emerging best practices, the following chart aligns those goals and objectives under Governor Hogan's three-pillar approach to the response.

Prevention & Education	
Original Goals and Objectives	Activity Categories
Goal 1: Prevent new cases of opioid addiction and misuse ● Reduce stigma and improve knowledge and understanding about opioid addiction ● Increase patient, youth, public safety, and general public knowledge of opioid risk and benefits Goal 4: Enhance data collection, sharing, and analysis to improve understanding of and response to the opioid epidemic	Community Awareness Programming Youth & Schools Programming Information Sharing Programming
Enforcement	
Original Goals and Objectives	Activity Categories
Goal 1: Prevent new cases of opioid addiction and misuse ● Reduce illicit opioid supply ● Reduce inappropriate or unnecessary opioid prescribing and dispensing Goal 4: Enhance data collection, sharing, and analysis to improve understanding of and response to the opioid epidemic	Law Enforcement Programming Information Sharing Programming

Treatment & Recovery	
Original Goals and Objectives	Activity Categories
Goal 2: Improve early identification and intervention of opioid addiction ● Build capacity of healthcare system to identify opioid use disorders and link patients to appropriate specialty care ● Improve identification of and provision of services to youth at high-risk for opioid addiction and their families ● Identify and connect individuals to treatment and recovery services at all points of contact with public health systems, public safety, hospitals, social services, and government services ● Implement law enforcement diversion programs to connect low-level drug-involved offenders with treatment services Goal 3: Expand access to services that support recovery and prevent death and disease progression ● Improve access to and quality of opioid addiction treatment in the community ● Enhance criminal justice services for offenders who are opioid-addicted to prevent re-entry and recidivism into the criminal justice system ● Expand access to treatment and recovery services for inmates with substance use disorders in correctional facilities ● Transition inmates leaving incarceration with substance use disorders to outpatient treatment services ● Make overdose education and naloxone distribution available to individuals at high risk for opioid overdose and their families/friends at all contact points with health, safety, and social service systems ● Increase access to naloxone ● Increase access to other harm reduction services for active opioid users (services that reduce the negative health impacts of opioid use) ● Expand access to recovery support services Goal 4: Enhance data collection, sharing, and analysis to improve understanding of and response to the opioid epidemic	Criminal Justice Programming Crisis Intervention Systems Programming Harm Reduction Programming Access to Treatment & Recovery Programming Information Sharing Programming

State Partner Performance Measures

State Partner Performance Measures

The OOCC tracks 174 state-level metrics pertaining to programs that are being implemented by our various state government partners. Thirty of these programs are complete and 10 are in development. This section presents 32 of what we regard as the highest-priority ongoing metrics. Accordingly, this section does not reflect all the efforts of our state government partners. All metrics being followed by the OOCC were developed collaboratively with state partners to best capture departmental response efforts. The state-level performance measures, including the data in this report, are managed by the following governmental state partners:

- Department of Aging (MDoA)
- Department of Disabilities (MdoD)
- Department of Environment (MDE)
- Department of Housing & Community Development (DHCD)
- Department of Human Services (DHS)
- Department of Juvenile Services (DJS)
- Department of Labor, Licensing, and Regulation (DLLR)
- Department of Public Safety & Correctional Services (DPSCS)
- Governor's Office of Community Initiatives - Interfaith Outreach (GOCI)
- Governor's Office of Crime Control & Prevention (GOCCP)
- Maryland Department of Health (MDH)
- Maryland Emergency Management Agency (MEMA)
- Maryland Higher Education Commission (MHEC)
- Maryland Insurance Administration (MIA)
- Maryland Institute for Emergency Medical Services Systems (MIEMSS)
- Maryland State Department of Education (MSDE)
- Maryland State Police (MSP)
- Washington/Baltimore High-Intensity Drug Trafficking Area (W/B HIDTA)

Unless otherwise noted, the chart below provides calendar year 2017 and 2018 data, as well as percent change, where both years' data are available.

Prevention & Education				
Performance Measure	**2017**	**2018**	**Percent Change**	**Reporting Partner**
Number of Public Information Campaigns	18	21	17%	MDH
Number of prescribers registered with Prescription Drug Monitoring Program (PDMP)	40,687	49,579[1]	22%	MDH

[1] In 2018, 87.43% of total prescribers were PDMP registered.

Number of opioid prescriptions (excluding buprenorphine)	3,524,379	3,035,655	-14%	MDH
Number of buprenorphine prescriptions	318,052	383,659	20%	MDH
Number of hospitals with single sign-on PDMP access	32	41	28%	MDH
Pounds of prescription drugs collected	6,342[2]	9,143	44%	MSP
Number of officers, agents, analysts, and support staff who received supported training	781	2,060	164%	W/B HIDTA [3]
Number of Juvenile Services-involved youth receiving prevention education	2,390[4]	2,465[4]	3%	DJS
Number of Local School Systems reporting implemented substance use/behavioral health programs and activities[5]	22[6]	24[7]	9%	MSDE

[2] Based on partial records from July to December 2017.

[3] W/B HIDTA includes 15 counties and 16 cities in Maryland, Virginia, West Virginia and the District of Columbia.

[4] This total may contain duplicates. Some youth may attended multiple educational events.

[5] In January 2017, the Maryland State Department of Education (MSDE) gathered information on strategies that local school systems (LSSs) were doing to address the opioid and heroin epidemic across the state. Each local school system was asked to complete information in three categories: Opioid Use Prevention, Opioid Use Intervention, and Opioid Use Postvention. In May 2017, Governor Hogan approved Senate Bill 1060, Heroin and Opioid Education and Community Action Act of 2017, the Start Talking Maryland Act. Senate Bill 1060 required the establishment of a workgroup for behavioral and substance use disorder programs in public schools in Maryland. A major task of the workgroup was to evaluate programs and services that provide behavioral and substance use services in public schools in Maryland. A survey was created to evaluate programs.

[6] MSDE reports based on school year. The 2017 measure includes the 2016-2017 school year, and the 2018 includes the 2017-2018 school year.

[7] All 24 LSSs reported having at least one substance use/behavioral health program being implemented in their jurisdiction. The Start Talking Maryland Report identified 52 substance use/behavioral health programs being implemented throughout Maryland schools.

Enforcement				
Performance Measure	**2017**	**2018**	**Percent Change**	**Reporting Partner**
Number of Office of Controlled Substances Administration (OCSA) inspections to identify providers with inappropriate prescribing practices	649	1,347	108%	MDH
Number of OCSA investigations based on red flags or complaints	106	254	140%	MDH
Kilograms of heroin seized	146	188[8]	29%	W/B HIDTA
Kilograms/Dosage units of fentanyl seized	40 kilograms 116 dosage units	45 kilograms 3,097 dosage units[8]	45% 2,570%	W/B HIDTA
Kilograms/Dosage units of prescription narcotics seized	4.1 kilograms 3,409 dosage units	2.1 kilograms 1,957 dosage units[8]	-49% -43%	W/B HIDTA
Number of drug trafficking organizations (DTOs) and money laundering organizations (MLOs) successfully disrupted or dismantled	146	125[8]	-14%	W/B HIDTA
Number of investigations for which HIDTA analysts provided analytical support	280	357[8]	28%	W/B HIDTA

[8] W/B HIDTA 2018 numbers are preliminary.

Treatment & Recovery				
Performance Measures	**2017**	**2018**	**Percent Change**	**Reporting Partner**
Number of Crisis Hotline calls	983[9]	1,495[9]	52%	MDH
Number of new institutions trained in SBIRT[10]	12	34	183%	MDH
Number of individuals who received SBIRT services	27,675	46,831	69%	MDH
Number of SBIRT Brief Interventions (BI) provided by funded Peer Support Specialists	337,250	594,281	76%	MDH
Number of Peer Support Specialists working within the public behavioral health system	235	308	31%	MDH
Number of individuals trained by state-authorized Overdose Response Program (ORP) training organizations	37,234	35,008	-6%	MDH
Number of naloxone doses dispensed to community members through state authorized ORP training organizations, including the Overdose Education and Naloxone Distribution (OEND) grant funding program	47,611	41,952	-12%	MDH

[9] These are for fiscal years 2017 and 2018 and include only Maryland Crisis Hotline calls. 2-1-1, press 1 figures are not included here.
[10] SBIRT stands for Screening, Brief Intervention, Referral to Treatment.

Number of layperson naloxone administrations reported to the state (Maryland Poison Control Center and/or other reports faxed to state)	724	988	37%	MDH
Number of naloxone doses purchased with OIT Grants[11]	7,949	39,546	398%	MDH
Number of patients receiving naloxone from EMS providers[12]	14,215	13,307	-6%	MIEMSS
Number of naloxone administrations by state troopers	129	112	-13%	MSP
Number of individuals served by state- and federally-supported crisis treatment centers and residential crisis service providers[13]	594	2,092	252%	MDH
Number of certified recovery residences	172	252	47%	MDH
Number of beds/capacity of certified recovery residences	1,622	2,333	44%	MDH
Number of individuals that received SUD residential treatment services under the Medicaid 1115 Waiver in accordance with legislation	4,803	10,993	129%	MDH
Number of jurisdictions with Syringe Service Programs approved	1	4	300%	MDH

[11] OIT funding began in Fiscal Year 2018.
[12] If an EMS patient received multiple administrations, the patient is counted only once.
[13] Counts for 2017 and 2018 are fiscal year.

Opioid Intervention Team (OIT) Performance Measures

OIT Performance Measures

The OOCC tracks 36 local-level programs and initiatives implemented by our various local partners through the Opioid Intervention Teams (OITs). This section presents 30 performance measures that we regard as the highest priority programs and initiatives. Accordingly, this section does not reflect all the efforts of our local partners. All metrics followed by the OOCC were developed collaboratively with our local partners to best capture local response effort. Unless otherwise noted, the chart below provides baseline and 2018 data, as well as percent change, where data points are available. For purposes of this report, baseline data includes programming available prior to the emergency declaration on March 1, 2017. The information contained in this report was submitted through local OIT leadership and their partners. OIT leadership reported on the status of various programs in their jurisdiction as of as of December 10, 2018.

Prevention Education			
Performance Measure	**Baseline (prior to March 2017)**	**12/31/2018**	**Percent Change**
Number of jurisdictions reporting implementing information campaigns aimed at prevention and stigma reduction	11	24	118.18%
Number of jurisdictions reporting implementing information campaigns that educate individuals on how to access resources available in the area	15	24	60%
Number of jurisdictions reporting implementing programs to encourage safe disposal of prescription medications	21	24	14.29%
Number of jurisdictions reporting implementing locally-led programs to educate prescribers about best practices in prescribing opioids or pain medications	7	18	157.14%
Number of jurisdictions reporting implementing programs to increase employer support for individuals seeking treatment and those in recovery	2	13	550%

Number of jurisdictions reporting implementing programs to address to compassion fatigue with partners	3	15	400%
Number of jurisdictions reporting implementing evidence-based substance use addiction & prevention curriculum	17	24	41.18%
Number of school systems that identify and support youth who use substances	5	22	340%
Number of jurisdictions reporting implementing youth-focused substance use addiction & prevention programs outside of school hours	13	15	15.38%
Number of jurisdictions reporting implementing programs to support youth impacted by overdose or addiction in their homes	6	14	133.33%
Number of jurisdictions reporting processes to share information between local agencies to identify high-risk individuals	3	23	666.67%
Number of jurisdictions reporting processes to monitor and evaluate programs in jurisdiction	14	19	35.71%
Number of jurisdictions registered to receive Spike Alerts via ODMAP	20	20	0%
Law Enforcement Programming			
Performance Measure	**Baseline (prior to March 2017)**	**12/31/2018**	**Percent Change**
Number of jurisdictions reporting implementing the heroin coordinator program	15	20	33.33%

Number of jurisdictions reporting implementing police-led programs where officers can refer individuals to care at various points along the sequential intercept	4	8	100%
Treatment and Recovery Programming			
Performance Measure	**Baseline (prior to March 2017)**	**12/31/2018**	**Percent Change**
Number of jurisdictions reporting implementing some level of pretrial substance abuse screening	7	19	171.43%
Number of jurisdictions reporting implementing at least one type of Medication-Assisted Treatment available in the correctional facility for individuals while incarcerated	12	17	41.67%
Number of jurisdictions reporting implementing at least one type of Medication-Assisted Treatment induction available upon release from a correctional facility	13	18	38.46%
Number of jurisdictions reporting other types of treatment available for individuals with substance use disorder within the correction facility	19	19	0%
Number of jurisdictions reporting a facilitated approach to referral treatment upon release from a correctional facility	10	22	120%
Number of jurisdictions reporting programs to support transitions to recovery housing and employment services upon release from a correctional facility	10	19	90%

Number of jurisdictions reporting implementing mobile crisis teams for substance use disorder	10	16	60%
Number of jurisdictions reporting implementing walk-in crisis services for substance use disorder	13	14	7.69%
Number of jurisdictions reporting Crisis Stabilization outside of the Hospital ER	1	5	400%
Number of jurisdictions reporting having Peer Recovery Specialists in at least one of these areas: emergency departments, OSOP, OB/GYN offices, other healthcare settings, recovery centers, street outreach, crisis response, stabilization centers, partnering with law enforcement or corrections, schools, CBOs, Dept. of Health, Fire & Rescue, treatment centers, and / or Dept. of Social Services	18	24	33.33%
Number of jurisdictions reporting employment training and/or workforce development resources for individuals in recovery	8	11	38%
Number of jurisdictions reporting implementing naloxone training & distribution	19	23	21.05%
Number of jurisdictions reporting implementing harm reduction programs	8	12	50%
Number of jurisdictions reporting implementing EMS Leave Behind	n/a	10	n/a
Number of jurisdictions reporting implementing case management support for individuals in treatment	16	21	31.25%

Local Best Practices

Local Best Practices

This section describes and outlines current implementation at the local level of research-based strategies and programs identified collaboratively with state and local partners as effective practices. OITs reported their current state of program implementation via the Situation Report process as of December 31, 2018. The OITs self-assessed program implementation under the following eight program areas and 30 programs. No local jurisdiction has implemented all 30 programs. Ten jurisdictions have implemented more than 22 of the practices, and 14 jurisdictions have implemented 22 or fewer of the practices.

1. Community Awareness Programming
    a. Information campaigns aimed at prevention and stigma reduction (e.g., Going Purple, Good Samaritan Law information)
    b. Information campaigns to educate individuals on how to access resources available in your area
    c. Programs to encourage safe disposal of prescription medications (e.g., community take-back events, drop boxes, pill disposal systems)
    d. Locally-led programs to educate prescribers about best practices in prescribing opioids or pain medications (e.g., academic detailing)
    e. Increase employer support for individuals seeking treatment and those in recovery (e.g., informational materials, employer seminars)
    f. Programs to address compassion fatigue with response partners (EMS, law enforcement, 911 call-takers, ED, & health) (e.g., first responders recognition events, visits/thank you messages from those in recovery, success stories)

2. Youth & Schools Programming
    a. Evidence-based substance use addiction and prevention curriculum in the school system
    b. School system programs to identify and support youth who use substances
    c. Youth-focused substance use addiction and prevention programs that take place outside of school hours
    d. Programs to support youth impacted by overdose or addiction in their homes (e.g., art or recreational programs, programs that alert educators when a student has seen/experienced substance-related trauma in the home, other school services)

3. Law Enforcement Programming
    a. Participation in the Heroin Coordinator program
    b. Law enforcement has a diversion program by which officers can refer an individual to treatment or resources rather than arrest

4. Criminal Justice Programming
    a. Pretrial substance abuse screening through your correctional facility
    b. Medication-Assisted Treatment programs in correctional facilities for individuals while incarcerated
    c. Medication-Assisted Treatment induction available upon release from a correctional facility

Local Best Practices (cont.)

a. Other types of treatment available for individuals with substance use disorder within correctional facilities
b. Facilitated approach to referral to treatment upon release from a correctional facility (e.g., care coordination)
c. Programs to support transitions to recovery housing and employment services upon release from a correctional facility

5. Crisis Intervention Systems Programming
    d. Mobile crisis teams for substance use disorder (community-based mobile crisis services that provide face-to-face professional and peer intervention, deployed in real time to the location of a person in crisis to begin the process of assessment and definitive treatment)
    e. Walk-in crisis services for substance use disorder (a program that provides assistance to individuals in crisis without an appointment or referral)
    f. Outside of the ED, a crisis stabilization center that includes medical stabilization for substance use emergencies and linkages to treatment options
    g. Peer Recovery Specialists working in at least one of these areas: emergency departments, OSOP, OB/GYN offices, other healthcare settings, recovery centers, street outreach, crisis response, stabilization centers, partnering with law enforcement or corrections, schools, CBOs, LHD, Fire & Rescue, treatment centers, and/or Dept. of Social Services

6. Harm Reduction Programming
    a. Employment training/workforce development resources targeted at individuals in recovery (e.g., skills training, resume assistance)
    b. Naloxone training and distribution in your community
    c. Other harm reduction programs
    d. EMS Leave Behind Program

7. Access to Treatment & Recovery Programming
    a. Case management support for individuals in treatment (e.g., supporting transitions, connection with other services)

8. Information Sharing Programming
    a. Process to share information between local agencies to identify high-risk individuals (e.g., EMS sharing nonfatal refusals with LHDs / OSOPs)
    b. Process for monitoring and evaluating programs in your jurisdiction (e.g., regular reporting, data analysis & follow-up)
    c. Signed up to receive spike alerts via ODMap

1. Community Awareness Programming	Allegany	Anne Arundel/Annapolis	Baltimore City	Baltimore County	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garret	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	Somerset	St. Mary's	Talbot	Washington	Wicomico	Worchester
a. Information Campaigns/Anti Stigma																								
b. Information Campaigns/ Access																								
c. Safe Disposal Programs																								
d. Prescriber Education																								
e. Employer Support Programs																								
f. Compassion/Fatigue Prevention																								
2. Youth & School Programming																								
a. Substance-Use and Prevention Curriculum																								
b. Youth Identification & Support Programs																								
c. Safe Disposal Programs																								
d. Youth Impact Programs																								
3. Law Enforcement Programming																								
a. Heroin Coordinator Programs																								
b. Law Enforcement Diversion																								
4. Criminal Justice Programming																								
a. Pre-Trial Screening[1]																								
b. MAT While Incarcerated[2]																								
c. MAT Upon Release[2]																								
d. Other Treatment While Incarcerated																								
e. Facilitated Referral Upon Release[3]																								
f. Recovery-Housing Transition Support																								

[1] For this practice, red indicates no screening, light green indicates selective, and dark green is universal.

[2] Red is none, and green is at least one medication assisted treatment.

[3] Red is none, light green indicates yes, unless released pretrial, and dark green is yes, for all inmates including those released pretrial.

5. Crisis Intervention Systems	Allegany	Anne Arundel/Annapolis	Baltimore City	Baltimore County	Calvert	Caroline	Carroll	Cecil	Charles	Dorchester	Frederick	Garret	Harford	Howard	Kent	Montgomery	Prince George's	Queen Anne's	Somerset	St. Mary's	Talbot	Washington	Wicomico	Worchester
a. Mobile Crisis Teams[4]																								
b. Walk-In Crisis Services																								
c. Crisis Stabilization (outside ED)																								
d. Peer-Recovery Specialists																								
6. Harm Reduction Programming																								
a. Employement Training																								
b. Naloxone Training and Distribution																								
c. Other Harm-Reduction Strategies																								
d. EMS Leave Behind Program																								
7. Access to Treatment & Recovery																								
Case-Management Support																								
8. Information Sharing Programming																								
a. Local Agency Communication																								
b.Program Monitoring and Evaluation																								
c. Spike Alerts																								

Legend

- Yes, fully implemented
- Yes, beginning to implement
- No, but planning to implement
- No, no plans to implement
- No answer provided

[4] Red is no team present, light red is no team present, but planning to implement, light green is yes with limited hours, and dark green is yes with 24/7 coverage.

2018 Opioid-Related Legislation

Opioid-Related Legislation

The OOCC monitors all opioid-related legislation under consideration by the General Assembly, assists state agencies in developing opioid-related legislation, and provides testimony in connection with such legislation.

Two significant opioid-related bills were passed by the Maryland General Assembly during the 2018 Legislative Session, and both bills were signed into law by Governor Hogan. The bills were as follows:

The **Overdose Data Reporting Act** allows EMS providers and law enforcement officials to input and share data about opioid overdoses. This enables first responders to track this information and allocate resources, including naloxone, in near real-time to respond to an extremely potent batch of opioids in a specific area. The legislation makes Maryland one of 27 states and nearly 300 agencies to use this technology to inform first responders, identify national trends, and prevent overdose deaths.

The **Controlled Dangerous Substances – Volume Dealers Act** expands the volume dealer statute to include fentanyl and its analogs and allows for more effective prosecution of high-level drug traffickers who deal in large quantities of controlled substances. It also amends how the existing volume dealer statute deals with mixtures containing heroin.

Additionally, in December 2018, the governor signed Executive Order 01.01.2018.30, which named Lt. Governor Boyd Rutherford as chair of the Inter-Agency Heroin and Opioid Coordinating Council, formalized the structure of the OOCC and established it within MEMA, and designated the 24 OITs that have been developed in each jurisdiction as the mechanism for distributing funds provided through the OOCC.

Opioid-Related State Spending

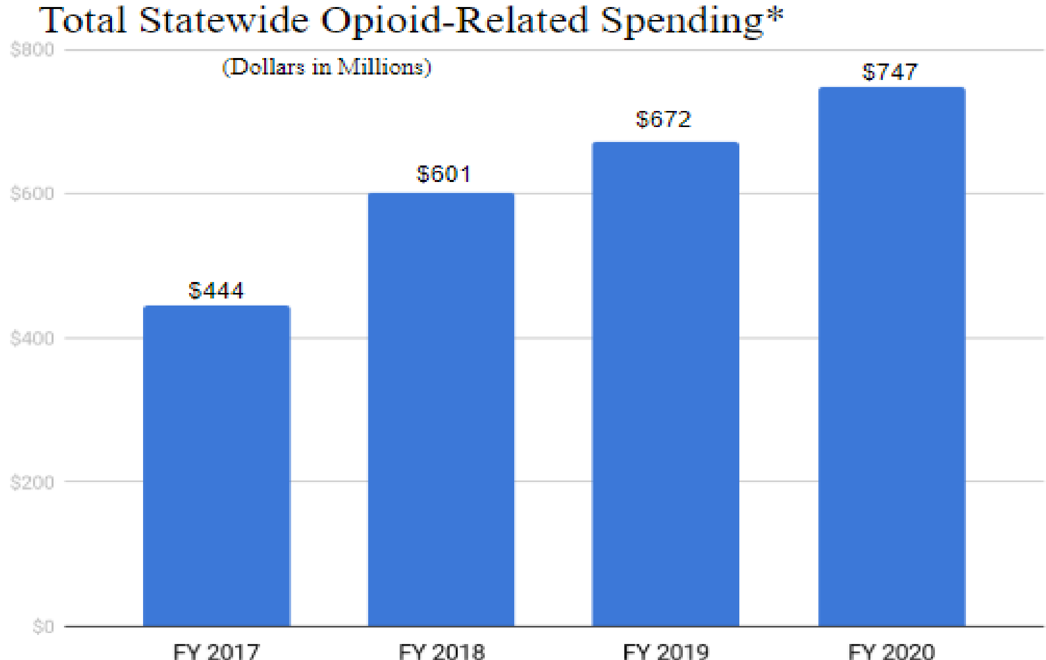
Opioid-Related State Spending

The State of Maryland has made a major budgetary commitment to combating the opioid epidemic. That commitment includes a dramatic expansion of existing programs and authorization of incremental opioid crisis funds. This funding supports a wide range of direct programs and services as well as grants to local jurisdictions in support of programs and services offered at the local level.

a. Total Statewide Spending

As shown in the chart below, total statewide opioid-related spending reached $672 million in FY19 and is proposed to increase to $747 million in FY20. By FY20, total statewide opioid-related spending will have increased by 68 percent since FY17 when the governor declared a state of emergency related to heroin and opioids.

The figure for statewide spending includes programmatic and grant-making expenditures for MDH, GOCCP, and the OOCC. These figures do not include other agencies of state government that may also operate opioid-related programs. One of the goals for the OOCC in the coming year is to develop a comprehensive estimate of all opioid-related spending throughout state government.



*Source: Department of Budget and Management

Opioid-Related State Spending (cont.)

b. Opioid Crisis Spending

When Governor Hogan initiated a state of emergency pertaining to opioids in early 2017, he authorized the allocation of several new funding streams to address the crisis. Those incremental opioid crisis funding streams include the federal 21st Century Cures Act, state general funds that are allocated through the OOCC, and funding from GOCCP.

Opioid crisis funds are budgeted at $56.6 million in FY19 and are proposed at $63.7 million for fiscal year 2020.

Streams of Opioid Crisis Funding			
	FY2018	**FY2019 Working**	**FY2020 Proposed**
OOCC[14]	$10,513,712	$10,900,981	$10,805,547
GOCCP[15]	$2,181,489	$1,168,900	$1,400,000
MDH-Cures[16]	$10,036,845	$10,036,784	
MDH-SOR[17]		$33,169,407	$50,169,407
DLLR[18]		$1,312,543	$1,312,543
Total	**$22,732,046**	**$56,588,615**	**$63,687,497**

[14] Excludes provider rate increase in FY2019 of $5.3 million.
[15] In June 2018, GOCCP announced $1.2 million in funding for the opioid crisis (includes Heroin Coordinators, LEAD and Peer Specialist programs only). The Peer Specialist program was reduced from $140,000 to $86,900 later in the fiscal year. However, GOCCP funds other opioid-related programs that would not be included in the definition of "opioid crisis funding" as was previously explained. The FY2020 funding figure is an approximation of the cost of continuing these three programs in the next fiscal year.
[16] Cures funding only applied to FY18 and FY19
[17] SOR grant award is $33.2 million in years 1 and 2 (Year 1: September 30, 2018 - September 30, 2019). An additional $17 million is anticipated for year 1, but has been designated for use in FY2020.
[18] Full grant award is $1,975,085 and $650,000 for the award period of 07/01/2018 - 06/30/2020.

Opioid Crisis Grants

Opioid Crisis Grants

The table below presents the various programs that are being funded by opioid crisis grants. The grants are organized into the governor's three policy priorities of Prevention & Education, Enforcement, and Treatment & Recovery. The OOCC will also be making several new grant awards with repurposed funds prior to the close of FY2019.

OPIOID CRISIS GRANTS FY2019			
Funding Amount	**Funding Source (1)**	**Initiative Overview**	**Implementing Partner**
PREVENTION & EDUCATION			
$1,000,000	Federal Cures Grant	Continuation of public awareness campaigns to reduce stigma and increase patient-physician communication	MDH, OOCC
$700,000	Federal Cures Grant	Establishes harm reduction outreach teams	Lead Agency: MDH
$200,000	Federal Cures Grant	Continuation of a program that creates school-based teams for early identification of the problems related to substance use disorders [b]	Lead Agency: MDH; Supporting Partner: MSDE
$35,400	OOCC General Funds	Supports the Carroll County Drug and Violence Expo - Carroll County Chamber of Commerce [b]	Lead Agency: Carroll County Chamber of Commerce; Supporting Partners: GOCCP
$10,000	OOCC General Funds	Supports faith-based education and stigma reduction initiatives - Maryland Faith Health Network [b]	Lead Agency: Maryland Faith Health Network; Supporting Partners: OOCC, Governor's Office of Community Initiatives - Interfaith Outreach

$1,656,000	Federal SOR Grant	Media campaign to improve doctor-patient communication regarding the harmful effects of opioid drug use	Lead Agency: MDH
$54,973	Federal SOR Grant	Healthy Beginnings program to support pregnant women/children	Lead Agency: MDH
$120,938	Federal SOR Grant	Adolescent Community Reinforcement Approach (A-CRA) - intervention that support adolescents in recovery by increasing family, social, and education/vocational reinforcers	Lead Agency: MDH
$87,844	Federal SOR Grant	Start Talking Teacher Training	Lead Agency: MDH
$1,743,343	Federal SOR Grant	Project management funding (mandatory) for Substance Abuse and Mental Health Services Administration (SAMHSA)	Lead Agency: MDH
$145,611	Federal SOR Grant	Student Assistance Program that creates school-based teams for early identification of the problems related to substance use disorders in partnership with the University of MD, School of Medicine	Lead Agency: MDH
$965,083	OOCC General Funds	Prevention & education efforts of all 24 OITs [(e)]	Lead Agency: OOCC; Supporting Partner: MDH

ENFORCEMENT			
$897,000	GOCCP General Funds	Continuation of the heroin coordinator program, which helps to make the link between law enforcement and treatment	Lead Agency: GOCCP
$162,500	OOCC General Funds	Expands the Heroin Coordinator Program statewide	Lead Agency: GOCCP; Supporting Partners: Local jurisdiction law enforcement
$195,000	OOCC General Funds	Expands law enforcement assisted diversion (LEAD) to treatment programs [b]	Lead Agency: GOCCP
$185,000	Federal: Byrne Justice Assistance Grant	Expands law enforcement assisted diversion (LEAD) to treatment programs [b]	Lead Agency: GOCCP
$370,000	OOCC General Funds	Increases monitoring and regulatory oversight of controlled substances prescribers and dispensers [b]	Lead Agency: MDH
$39,000	OOCC General Funds	Continuation of law enforcement investigation support [b]	Lead Agency: W/B HIDTA; Supporting Partners: GOCCP,(MSP)
$163,184	OOCC General Funds	Supports the Analytical Testing Initiative - Howard County Police Department [b]	Lead Agency: Howard County Police Department; Supporting Partner: GOCCP

$71,800	OOCC General Funds	Supports Enforcement efforts for all 24 OITs [e]	Lead Agency: OOCC; Supporting Partner: MDH

TREATMENT & RECOVERY			
$2,810,000	Federal Cures Grant	Expands access to crisis beds and residential treatment services statewide	Lead Agency: MDH
$3,803,947	Federal SOR Grant	Expands access to crisis beds in Allegany, Anne Arundel, Baltimore City, Mid-Shore and Worcester Counties	Lead Agency: MDH
$8,800,569	Federal SOR Grant	Crisis walk-in centers, including Anne Arundel, Baltimore City, Calvert, Carroll, Cecil, Howard, Harford (adding peer support), Washington County, etc.	Lead Agency: MDH
$1,891,081	Federal SOR Grant	Safe Stations in Anne Arundel, Mid-Shore and Worcester Counties	Lead Agency: MDH
$920,000	OOCC General Funds	Improves access to naloxone statewide	Lead Agency: MDH; Supporting Partner: MIEMSS
$1,300,000	Federal Cures Grant		
$2,690,820	Federal SOR Grant		
$2,000,000	Federal Cures Grant	Supports implementation of 24-hour crisis stabilization center in Baltimore City	Lead Agency: MDH

$660,000	OOCC General Funds	Supports peer support specialist and SBIRT services, with a focus on hospitals, correctional facilities, and other high-risk populations [c]	Lead Agency: MDH; Supporting Agencies: DPSCS, Maryland Hospital Association (MHA), Maryland Correctional Administrators Association (MCAA)
$800,000	Federal Cures Grant		
$86,900	GOCCP General Funds [d]		
$613,100	OOCC General Funds	Increases access to medications that support recovery from substance use disorders ($250,000 to Correctional Facilities; $363,100 to WellMobile)[b]	Lead Agency: MDH
$900,000	Federal Cures Grant	Training and consultation/technical assistance for prescribers of medications that support recovery	Lead Agency: MDH
$499,804	Federal SOR Grant		
$2,174,714	Federal SOR Grant	Increase access to medications that support recovery from substance use. Focus areas include Baltimore County, Calvert, Harford, Howard, Prince George's, Caroline, Queen Anne's, Cecil, and St. Mary's	Lead Agency: MDH
$817,500	Federal SOR Grant	SBIRT services for K-12 ($100,000), OB/GYN ($682,500), and College ($35,000)	Lead Agency: MDH
$350,000	OOCC General Funds	Expands and improves the statewide crisis hotline	Lead Agency: MDH

$200,000	OOCC General Funds	Supports the Montgomery County School System recovery and academic program (g)	Lead Agency: MSDE
$750,000	OOCC General Funds	Supports the Farming4Hunger Food Center in Caroline County (b)	Lead Agency: Farming4Hunger; Supporting Partner: GOCCP
$250,000	OOCC General Funds	Supports Brooke's House recovery house for women in Washington County (b)(g)	Lead Agency: Brooke's House; Supporting Partners: OOCC, MDH
$80,922	OOCC General Funds	Supports the Project Realize! youth mentoring program - Horizon Goodwill Industries in Washington County (b)	Leading Agency: Horizon Goodwill Industries; Supporting Partner: GOCCP
$75,310	OOCC General Funds	Supports the CrossRoads Freedom Center Addiction Wellness Program in Frederick County (b)	Leading Agency: CrossRoads Freedom Center; Supporting Partner: GOCCP
$2,863,250	Federal SOR Grant	Overdose Survivor Outreach Program expanded to nine hospitals	Lead Agency: MDH
$138,999	Federal SOR Grant	Supports sign Language Interpreters to address gap in addiction services	Lead Agency: MDH
$298,395	Federal SOR Grant	Recovery housing for transition-age youth	Lead Agency: MDH
$1,536,395	Federal SOR Grant	Recovery housing for adults	Lead Agency: MDH
$3,580,224	Federal SOR Grant	Harm reduction program	Lead Agency: MDH
$265,000	Federal SOR Grant	Hospital pilot project that will engage patients with substance use disorders in MAT program	Lead Agency: MDH

$987,543	Federal WIA/ WIOA Dislocated Worker Nation Reserve Demonstration Grant [f]	Supporting treatment & recovery programs, including the Opioid Workforce Innovation Fund which will allow for monies to be available to organizations working on addressing the opioid crisis to seed innovative and promising programs	Lead Agency: DLLR
$325,000	Federal WIA/ WIOA Dislocated Worker Nation Reserve Demonstration Grant [f]	Supporting treatment & recovery programs, including a program to provide funding to organizations that seek to serve women impacted by the opioid crisis	Lead Agency: DLLR
$2,819,097	OOCC General Funds	Supports Treatment & Recovery efforts for all 24 Opioid Intervention Teams [e]	Lead Agency: OOCC; Supporting Partner: MDH

OTHER			
$144,740	OOCC General Funds	Supports the administration of $4 million in OIT grants [e]	Lead Agency: OOCC; Supporting Partner: MDH
$950,000	OOCC General Funds	Supports OOCC Administrative Costs	Lead Agency: OOCC
$270,000	Federal Cures Grant	Supports Cures Administrative Costs	Lead Agency: MDH

[a] Federal SOR Grant: September 30, 2018 through September 29, 2019
[b] Projects pending (approved by OOCC, but grant funds have not yet been disbursed)
[c] SBIRT Hospital $522,725; SBIRT Corrections $141,000 (Reduced from initial budgeted amount of $760,000)
[d] Supports 3 peer specialist in Frederick, Washington and Wicomico. Reduced from $144,287.
[e] More information about the Opioid Intervention Team (OIT) grants are contained in the jurisdiction breakdown. Garrett County's OIT allocation of $65,304 was allocated to Prevention & Education until confirmation of breakdown is obtained.
[f] Full grant award is $1,975,085 and $650,000 for the award period of 07/01/2018 -- 06/30/2020.
[g] Assumes OOCC is able to encumber the balance of the award in FY2019.

**Other Youth Focused Prevention of $733,363 excluded from the above table. This is an unapproved project funded out of the federal Cures grant.

Local Jurisdiction Grants

Local Jurisdiction Grants

The table below provides preliminary information regarding grants to local jurisdictions. The figures include certain opioid-related funding that is over and above opioid crisis funds. The figures do not include federal SOR grants and other grants that are still in the process of being allocated to sub-recipients.

SUMMARY OF OPIOID CRISIS SPENDING BY JURISDICTION

Jurisdiction		Amount	% of Total
Allegany County		$ 845,765	3.9%
Anne Arundel County/City of Annapolis		$ 2,840,271	13.0%
Baltimore City		$ 6,015,237	27.5%
Baltimore County		$ 979,510	4.5%
Calvert County		$ 344,830	1.6%
Caroline County		$ 1,578,959	7.2%
Carroll County		$ 556,881	2.5%
Cecil County		$ 696,579	3.2%
Charles County		$ 190,636	0.9%
Dorchester County		$ 422,892	1.9%
Frederick County		$ 721,138	3.3%
Garrett County		$ 92,307	0.4%
Harford County		$ 589,121	2.7%
Howard County		$ 467,045	2.1%
Kent County		$ 386,721	1.8%
Montgomery County		$ 558,808	2.6%
Prince George's County		$ 843,162	3.8%
Queen Anne's County		$ 88,988	0.4%
Somerset County		$ 136,538	0.6%
St. Mary's County		$ 141,738	0.6%
Talbot County		$ 159,344	0.7%
Washington County		$ 1,172,564	5.4%
Wicomico County		$ 814,928	3.9%
Worcester County/Ocean City		$ 295,186	1.3%
TOTAL		**$ 20,939,148**	

Below is a more detailed summary of the breakdown of preliminary heroin and opioid grant funds by jurisdiction.

ALLEGANY COUNTY

Amount	Project Title	Project Description	Funding Source
		State OIT Grant Funding	
$ 115,759	Reduce Illicit Supply of Opioids	Allegany Co. Sheriff's Office, Cumberland Police, and MSP will coordinate and implement drug interdiction events in order to reduce the supply of illicit opioids	OOCC
	Increase community supply of Naloxone	Funding to purchase Naloxone for first responders	
	Outreach and Education	Prescribe Change Allegany campaign to educate on opioid addiction, naloxone, proper storage and disposal of medication, addiction treatment resources, and overdose deaths. Will involve public website, community events, radio ads, billboards	
	Supporting Recovery Services	Support and connect those in need with opioid-related recovery services at Fort Recovery	
	Staff Training	Send three Allegany Co. Health Department staff to National Rx Drug Abuse and Heroin Summit	
		OTHER STATE AND EMERGENCY FUNDING	
$ 8,024	Correctional Facility SBIRT	Integrate SBIRT into Allegany County Detention Center processes to identify individuals at risk for substance use in the criminal justice system and connect them with treatment resources	OOCC/MDH

$ 32,989	Peer Recovery Support Specialists	Peer Recovery Specialist programs to support and connect individuals to appropriate resources	Cures
$ 61,544	Naloxone Saturation	Support Dept. of Health Overdose Education and Naloxone Distribution community naloxone efforts	Cures/OOCC/BHA
$ 5,516	Student Assistance Program (SAP)	School-based brief intervention and referral to treatment	Cures
$ 164,447	3.1 Crisis Treatment Expansion	Continuation from 2018	Cures
$ 111,616	3.7D Crisis Treatment Expansion	Continuation from 2018	Cures
$ 3,400	Law Enforcement Investigation Support		OOCC/HIDTA
$ 56,066	Heroin Coordinators	One individual from a law enforcement agency responsible for local consolidation and analysis of drug overdose information for targeted prosecution, drug supply reduction, and public health coordination	GOCCP
$ 286,404	MD Criminal Intelligence Network	Coalition of criminal justice agencies that collaborates and coordinates tactics, resources, and intelligence through data sharing, partnerships, policies, and technologies	GOCCP
Total $ 845,765			

ANNE ARUNDEL COUNTY

State OIT Grant Funding			
$ 289,613	Sustaining Expanded Mobile Crisis Response- Continued Support of Safe Stations Program	Funds will be used to provide continued support and expand MCTs and Safe Station Program	OOCC
	Sustaining Existing and Developing New Prevention and Outreach Campaigns	Enhance and sustain public awareness campaigns Denial is Deadly, Not My Child, and the D.A.R.E program	
Other State and Emergency Funding			
$ 55,024	Corrections SBIRT	Continuation from FY18	OOCC/MDH
$ 20,220	Police-led Youth Prevention Program		OOCC
$ 43,682	Peer Recovery Support Specialists	Peer Recovery Specialist programs to support and connect individuals to appropriate resources	Cures
$ 5,516	Student Assistance Program (SAP)	School-based brief intervention and referral to treatment	Cures
$ 363,110	WellMobile	Continuation from FY18	OOCC
$ 150,000	3.1 Crisis Bed Expansion	Continuation from FY18	Cures
$ 726,641	3.7D Crisis Bed Expansion	Continuation from FY18	Cures
$ 199,005	Naloxone Saturation	Support Dept. of Health Overdose Education and Naloxone Distribution community naloxone efforts	Cures/OOCC/BHA
$ 80,000	Harm Reduction Outreach Teams	Establish capacity of harm reduction outreach teams to reach people at high risk for overdose to identify appropriate referrals to crisis centers and SUD treatment	Cures

$ 70,800	Heroin Coordinators	One individual from a law enforcement agency responsible for local consolidation and analysis of drug overdose information for targeted prosecution, drug supply reduction, and public health coordination	GOCCP
$ 836,660	MD Criminal Intelligence Network (MCIN)	Coalition of criminal justice agencies that collaborates and coordinates tactics, resources, and intelligence through data sharing, partnerships, policies, and technologies	GOCCP
Total $ 2,840,271			

BALTIMORE CITY

State OIT Grant Funding			
$ 854,732	Hub & Spokes Network of Buprenorphine Treatment	Funds will be used to expand and enhance services to allow walk-in intake on weekends as well as offering buprenorphine treatment to walk-in STD patients	OOCC
	Levels of Care for Baltimore City Hospitals	Funds will be used to support a part-time consultant who will assist with the development of the Levels of Care and provide technical assistance to hospital systems in developing opioid-related protocols	
	Street Outreach and Overdose Spike Response	Funding to support 2.5 peer recovery specialists and a supervisor	
Other State and Emergency Funding			
$ 1,678,917	Crisis Treatment Center (Tuerk House)		Cures
$ 5,516	Student Assistance Program (SAP)	School-based brief intervention and referral	Cures
$ 87,500	Hospital SBIRT	St. Agnes Hospital	OOCC
$ 55,556	Peer Support Specialists	Peer Recovery Specialist programs to support and connect individuals to appropriate resources	Cures
$ 577,774	3.7D Crisis Treatment Expansion	Continued from FY18	Cures
$ 589,137	Harm Reduction Outreach Teams	Establish capacity of harm reduction outreach teams to reach people at high risk for overdose to identify appropriate referrals to crisis centers and SUD treatment	Cures
$ 183,678	Law Enforcement Assisted Diversion (LEAD)	GOCCP supports Baltimore City LEAD	GOCCP

$ 963,391	Naloxone Saturation	Support Dept. of Health Overdose Education and Naloxone Distribution community naloxone efforts. ($722,605 to Health Dpt., $240,786 to BHS-B)	Cures/OOCC/BHA
$ 3,400	Law Enforcement Investigation Support		OOCC/HIDTA
$ 859,394	MD Criminal Intelligence Network (MCIN)	A coalition of criminal justice agencies that collaborates and coordinates tactics, resources, and intelligence through data sharing, partnerships, policies, and technologies	GOCCP
$ 87,542	HITDA Heroin Coordinator		University of Baltimore, College of Public Affairs
$ 68,700	Heroin Coordinators	One individual from a law enforcement agency responsible for local consolidation and analysis of drug overdose information for targeted prosecution, drug supply reduction, and public health coordination	GOCCP
Total $ 6,015,237			

BALTIMORE COUNTY

State OIT Grant Funding			
$ 465,682	Media Campaign - Public Health Issues Related to Opioid Epidemic	Increase media campaign outreach efforts regarding opioid use and misuse to include social media activities, media campaigns, web content, education, and outreach events	OOCC
	Expansion of Peer Recovery Support Services	Funding to continue support and enhance Peer Recovery Support Services for overnights, weekends, and evenings	
Other State and Emergency Funding			
$ 175,000	Hospital SBIRT OSOP	Continuation of FY18	OOCC/SAMSHA
$ 70,304	Naloxone Saturation	Support Dept. of Health Overdose Education and Naloxone Distribution community naloxone efforts.	Cures/OOCC/BHA
$ 5,516	Student Assistance Program (SAP)	School-based brief intervention and referral to treatment	Cures
$ 3,400	Law Enforcement Investigation Support		OOCC/HIDTA
$ 42,608	Heroin Coordinators	One individual from a law enforcement agency responsible for local consolidation and analysis of drug overdose information for targeted prosecution, drug supply reduction, and public health	GOCCP
$ 217,000	MD Criminal Intelligence Network (MCIN)	A coalition of criminal justice agencies that collaborates and coordinates tactics, resources, and intelligence through data sharing, partnerships, policies, and technologies	GOCCP
Total $ 979,510			

CALVERT COUNTY

State OIT Grant Funding			
$ 100,256	Calvert County Expanded Access to Clinical Services and MAT	Funding for retention of psychiatric nurse at Calvert County Behavioral Health Center and support access to substance use and medication assisted treatment	OOCC
	Calvert County Peer Recovery Specialist Program	Funding to expand peer recovery support program	
	MAT/Crisis Coordination Initiative	Funding to support a MAT coordinator	
	Calvert County Opioid Abuse Awareness and Health Promotion Campaign	Increase community awareness of opioid use, misuse, diversion, overdose prevention, response, and services that aid in preventing opioid use. Will include a mixture of traditional and social media outputs, advertisements, PSAs, and website	
Other State and Emergency Funding			
$ 103,717	Peer Recovery Support Specialists	Peer Recovery Specialist programs to support and connect individuals to appropriate resources	Cures
$ 84,966	Naloxone Saturation	Support Dept. of Health Overdose Education and Naloxone Distribution community naloxone efforts.	Cures/OOCC/BHA
$ 5,516	Student Assistance Program (SAP)	School-based brief intervention and referral to treatment	Cures
$ 3,400	Law Enforcement Investigation Support		OOCC/HIDTA
$ 46,975	Heroin Coordinators	One individual from a law enforcement agency responsible for local consolidation and analysis of drug overdose information for targeted prosecution, drug	GOCCP

		supply reduction, and public health	
Total **$ 344,830**			

CAROLINE COUNTY

State OIT Grant Funding			
$ 77,002	Enhanced Data for Enhanced Response	Funding to hire statistician to work with community stakeholders to improve accuracy of data collection and analysis	OOCC
	Decrease Opioid Growth / Continuation from FY18 and Illicit Opiate Program	Funding to purchase two K9 first aid kits & Kevlar vests. Additional funding for drug-related tips for possession and distribution of opiates	
	Treatment Pays	If individuals within the buprenorphine program samples are deemed acceptable, they will be provided a fifty-dollar Walmart gift card - an incentive based buprenorphine program	
Other State and Emergency Funding			
$ 750,000	Farming 4 Hunger	Provide job training in crop production and agricultural management to inmates who have qualified for work release. (Grant approved/pending)	OOCC/BHA
$ 286,002	Local Addiction Authority	General funds, $5,000 specifically dedicated to Local Drug & Alcohol Abuse Council activities.	BHA
$ 48,179	General Funds Service Grant	General funds, including Buprenorphine Initiative ($20,080) and Halfway House ($5,590).	BHA
$ 49,355	Naloxone Saturation	Support Dept. of Health Overdose Education and Naloxone Distribution community naloxone efforts.	Cures/OOCC/BHA
$ 368,421	MAT Community Provider		BHA/SOR
Total $ 1,578,959			

CARROLL COUNTY

State OIT Grant Funding			
$ 132,739	Mobile Crisis and Crisis Stabilization Services	Increase Mobile Crisis Services from 8 hours to a minimum of 14 hours. Add requirements for vendor to be a provider of services in the Public Behavioral Health System	OOCC
Other State and Emergency Funding			
$ 91,825	Naloxone Saturation	Support Dept. of Health Overdose Education and Naloxone Distribution community naloxone efforts.	Cures/OOCC/BHA
$ 5,516	Student Assistance Program (SAP)	School-based brief intervention and referral to treatment	Cures
$ 35,400	Carroll County Chamber of Commerce Drug and Violence Expo	A community opportunity to learn about various issues and available resources	OOCC
$ 291,401	MD Criminal Intelligence Network (MCIN)	A coalition of criminal justice agencies that collaborates and coordinates tactics, resources, and intelligence through data sharing, partnerships, policies, and technologies	GOCCP
Total $ 556,881			

CECIL COUNTY

State OIT Grant Funding			
$ 124,618	Peer Recovery Specialist Expansion for Hospital and Overdose Outreach	Expansion of peer recovery program - hiring of one full time peer recovery specialist and additional hours for services	OOCC
	Drug Free Cecil - Youth Leadership Project	Funding to support the two-day Leadership Summit and one day dialogue event. Funding will also support development, advertising, promotion of student created PSAs	
	Transportation Assistance to Reduce Barriers and Expand Access to Services	Funding for transportation vouchers for low income individuals with behavioral health needs, those in recovery, and those who are opioid dependent	
	Cecil County Consultant to Guide Behavioral Health Crisis Response Systems	Consultant to develop plan of action for coordinating and expanding local community behavioral health crisis response systems	
Other State and Emergency Funding			
$ 91,836	Naloxone Saturation	Support Dept. of Health Overdose Education and Naloxone Distribution community naloxone efforts.	Cures/OOCC/BHA
$ 5,516	Student Assistance Program (SAP)	School-based brief intervention and referral to treatment	Cures
$ 51,504	Heroin Coordinators	One individual from a law enforcement agency responsible for local consolidation and analysis of drug overdose information for targeted prosecution, drug supply reduction, and public health coordination	GOCCP

$ 20,680	Correctional Facility MAT	Continuation from FY18	GOCCP/OOCC
$ 402,425	Mobile Crisis Team Support	To serve adults under the influence of drugs/alcohol or recently revived from an overdose and does not need emergency medical care and can be safely served in a community setting.	SOR/BHA
Total $ 696,579			

CHARLES COUNTY

State OIT Grant Funding			
$ 107,270	Opioid Outreach and Awareness Public Events	Funding will be used to support and facilitate 6 opioid outreach events to educate community on substance use disorders and how to get involved	OOCC
	Staff Supervision	Funding to provide training and supervision of already established peer recovery specialists and alcohol/drug counselors	
	Charles County Welcome Wagon	Development of welcome wagon that canvasses vulnerable communities and educates people on high risk behaviors. Welcome Wagon will provide supplies and educational materials that assist those with substance use disorders	
	First Responder Narcan Availability	Funding to purchase and procure doses for Narcan for Charles Co. first responders and other Charles Co. agencies and organizations	
	Charles County Increased Overdose Response Capacity	Provide funding support for Charles County Dept. of Health And Hospice of Charles County partnership to provide grief counseling to children and those affected by opioid overdose	
	Charles County Increased Overdose Response Capacity	Hire an additional alcohol and drug counselor at the Charles County Dept. of Health's Substance Use Services Clinic	

Other State and Emergency Funding			
$ 24,450	Naloxone Saturation	Support Dept. of Health Overdose Education and Naloxone Distribution community naloxone efforts.	Cures/OOCC/BHA
$ 5,516	Student Assistance Program (SAP)	School-based brief intervention and referral to treatment	Cures
$ 3,400	Law Enforcement Investigation Support		OOCC/HIDTA
$ 50,000	Heroin Coordinators	One individual from a law enforcement agency responsible for local consolidation and analysis of drug overdose information for targeted prosecution, drug supply reduction, and public health coordination	GOCCP
Total $ 190,636			

DORCHESTER COUNTY

State OIT Grant Funding			
$ 74,418	Youth Action Council Play Days	Funding to host, facilitate, and support ten Play Days throughout Dorchester County. These Play Days provide drug-free, fun, challenging, and structured activities to youth and young adults	OOCC
	OIT Coordinator	Hire an OIT coordinator/analyst to assist coordinating local partners and improve opioid-related efforts and initiatives	
	Wellness in the Storm	Anti-stigma and public awareness art project targeting any individual affected by opioid/substance use, trauma, mental health, and poverty	
	Peer Recovery Support Services	Funding for Overdose Victims Support Program that will respond to overdose emergencies during off work hours and offer treatment and recovery services to individuals of overdose, family members, and significant others	
Other State and Emergency Funding			
$ 83,198	Naloxone Saturation	Support Dept. of Health Overdose Education and Naloxone Distribution community naloxone efforts.	Cures/OOCC/BHA
$ 47,000	Correctional SBIRT & Case Manager	SBIRT and case manager, continuation of FY18	Cures
$ 5,516	Student Assistance Program (SAP)	School-based brief intervention and referral to treatment	GOCCP

$ 48,700	Heroin Coordinators	One individual from a law enforcement agency responsible for local consolidation and analysis of drug overdose information for targeted prosecution, drug supply reduction, and public health coordination	GOCCP
$ 164,060	MD Criminal Intelligence Network (MCIN)	A coalition of criminal justice agencies that collaborates and coordinates tactics, resources, and intelligence through data sharing, partnerships, policies, and technologies	GOCCP
Total $ 422,892			

FREDERICK COUNTY

State OIT Grant Funding			
$ 157,839	Frederick County Peer Support Expansion Continuation	Funding to continue support and expand peer support services	OOCC
Other State and Emergency Funding			
$ 45,100	Naloxone Saturation	Support Dept. of Health Overdose Education and Naloxone Distribution community Naloxone efforts.	Cures/OOCC/BHA
$ 75,383	3.1 Crisis Treatment Expansion	Continuation from FY18	Cures
$ 5,516	Student Assistance Program (SAP)	School-based brief intervention and referral to treatment	GOCCP
$ 26,102	Heroin Coordinators	One individual from a law enforcement agency responsible for local consolidation and analysis of drug overdose information for targeted prosecution, drug supply reduction, and public health coordination	GOCCP
$ 247,469	MD Criminal Intelligence Network (MCIN)	A coalition of criminal justice agencies that collaborates and coordinates tactics, resources, and intelligence through data sharing, partnerships, policies, and technologies	OOCC
$ 75,310	CrossRoads Freedom Center Addiction Wellness Program	Enhances traditional recovery practices by integrating wellness therapies to support emotional, psychological, and physical health outcomes for clients. (Grant approved/pending)	GOCCP

$ 38,419	Correctional MAT	These programs are a partnership between local Detention Centers and Public Health Agencies which incorporates Vivitrol as a tool in a Medication Assisted Treatment program for persons leaving Detention Centers. A Vivitrol injection is administered approximately 10 days prior to release from incarceration and the person is assigned to counseling and wrap around services. A schedule for the monthly injections is also implemented.	GOCCP
$ 50,000	Peer Specialist	Screening, Brief Intervention, and Referral to Treatment services, with a focus on hospitals, correctional facilities, and other high-risk populations	
Total $ 721,138			

GARRETT COUNTY

State OIT Grant Funding			
$ 71,834	Garrett County Opioid and Drug Abuse Call to Action	Funding to host and support a Call to Action event and subsequent speakers	OOCC
	Mini-SBIRT and Treatment Resources Training	Funding for training of medical offices in 'mini' SBIRT training	
	ER Based Naloxone Education and Distribution	Funding provides education to patients and family members presenting in Garrett Regional Medical Center ER. They will also receive Naloxone. Hospital staff will be taught how to train the lay person for response to overdose	
Other State and Emergency Funding			
$ 14,957	Naloxone Saturation	Support Dept. of Health Overdose Education and Naloxone Distribution community naloxone efforts.	Cures/OOCC/BHA
$5,516	Student Assistance Program (SAP)	School-based brief intervention and referral to treatment	Cures
Total $ 92,307			

HARFORD COUNTY

State OIT Grant Funding			
$ 171,496	Harford County's Central Intake, Navigation and Recovery Team (CINRT)	Funding for peer specialists and healthcare professionals that provide screening to individuals in crisis, assist with navigation through the treatment system, and follow up with recovery support and care coordination. Will eventually lead to a community-based crisis center.	OOCC
Other State and Emergency Funding			
$ 5,516	Student Assistance Program (SAP)	School-based brief intervention and referral to treatment	Cures
$ 87,500	Hospital SBIRT OSOP	Continuation from FY18	OOCC
$ 185,145	Naloxone Saturation	Support Dept. of Health Overdose Education and Naloxone Distribution community naloxone efforts.	Cures/OOCC/BHA
$ 78,646	Heroin Coordinators	One individual from a law enforcement agency responsible for local consolidation and analysis of drug overdose information for targeted prosecution, drug supply reduction, and public health coordination	GOCCP
$ 60,818	Correctional Facility MAT	Vivitrol treatment and pre-reentry case manager	GOCCP- OOCC
Total $ 589,121			

HOWARD COUNTY

State OIT Grant Funding			
$ 124,249	Howard County SUD Screening Portal	Funding to provide continued support and expand Grassroots staffing capacity to strengthen SUD screening, referral, and warm handoff process for those who need SBIRT	OOCC
Other State and Emergency Funding			
$ 33,709	Naloxone Saturation	Support Dept. of Health Overdose Education and Naloxone Distribution community naloxone efforts.	Cures/OOCC/BHA
$ 5,516	Student Assistance Program (SAP)	School-based brief intervention and referral to treatment	Cures
$ 163,184	Howard County Police Department	Fight against heroin use through analytical testing (Grant approved/pending)	OOCC
$ 66,130	Correctional MAT	These programs are a partnership between local Detention Centers and Public Health Agencies which incorporates Vivitrol as a tool in a Medication Assisted Treatment program for persons leaving Detention Centers. A Vivitrol injection is administered approximately 10 days prior to release from incarceration and the person is assigned to counseling and wrap around services. A schedule for the monthly injections is also implemented.	GOCCP
$ 74,257	Heroin Coordinators	Continuation from FY18	GOCCP
Total $ 467,045			

KENT COUNTY

State OIT Grant Funding			
$ 73,311	Opioid Community Intervention Project	Funding to retain two full time peer recovery specialists and their certifications.	OOCC
Other State and Emergency Funding			
$ 285,394	3.7 Crisis Bed Expansion	Continuation from FY18	Cures
$ 22,500	Naloxone Saturation	Support Dept. of Health Overdose Education and Naloxone Distribution community naloxone efforts.	Cures/OOCC/BHA
$ 5,516	Student Assistance Program (SAP)	School-based brief intervention and referral to treatment	Cures
Total $ 386,721			

MONTGOMERY COUNTY

State OIT Grant Funding			
$ 185,892	Save a Life Montgomery: Opioid and Substance Abuse Community Forums	Funding to provide 3-5 community forums in distinct geographic areas to address unique issues among parents, caregivers, and youth participants	OOCC
	Public Awareness Campaign (focus on Opioid Prevention to Adults)	Funding to expand the public awareness campaign tailored to Montgomery County. Project will provide advertisement in several locations for website	
	Police, Fire & Rescue & Targeted Community Access to Naloxone and other Harm Reduction activities	Funding to support identification and distribution of Narcan in high-risk communities. Funding will also be used to explore other health safety activities like needle exchange, safe medication disposal, and street outreach	
	Stop Triage Engage Educate Rehabilitate (STEER) - Supervision	Funding will be used to expand STEER program and outreach teams to provide services 24 hours a day, 7 days a week.	
Other State and Emergency Funding			
$ 50,000	Naloxone Saturation	Support Dept. of Health Overdose Education and Naloxone Distribution	Cures/OOCC/BHA
$ 5,516	Student Assistance Program (SAP)	School-based brief intervention and referral to treatment	Cures
$ 60,000	Heroin Coordinators	One individual from a law enforcement agency responsible for local consolidation and analysis of drug overdose information for targeted prosecution, drug supply reduction, and public health coordination	GOCCP

$ 257,400	MD Criminal Intelligence Network (MCIN)	A coalition of criminal justice agencies that collaborates and coordinates tactics, resources, and intelligence through data sharing, partnerships, policies, and technologies	GOCCP
Total $ 558,808			

PRINCE GEORGE'S COUNTY

State OIT Grant Funding			
$ 198,442	Community Outreach	Funding to provide continued support of partnership between Health Dept. and Community Police Division for community outreach and follow up on houses that had been dispatched for overdose	OOCC
	Educational and Stigma Reduction Campaign	Funding for continued support of campaign that promotes recovery from prescription drug and illicit drug misuse. Plan also includes opioid overdose risk education materials, treatment cards, and information packets	
	Increase Police and Community Naloxone Training and Distribution	Funds to provide continued training and distribution of Naloxone to peer recovery specialists and law enforcement	
Other State and Emergency Funding			
$ 5,516	Student Assistance Program (SAP)	School-based brief intervention and referral to treatment	Cures
$ 50,128	Naloxone Saturation	Support Dept. of Health Overdose Education and Naloxone Distribution community naloxone efforts.	Cures/OOCC/BHA
$ 6,800	Law Enforcement Investigation Support		OOCC/HIDTA
$ 582,276	MD Criminal Intelligence Network (MCIN)	A coalition of criminal justice agencies that collaborates and coordinates tactics, resources, and intelligence through data sharing, partnerships, policies, and technologies	GOCCP
Total $ 843,162			

QUEEN ANNE'S COUNTY

State OIT Grant Funding			
$ 78,478	Peer Support Specialist/Services	Funding for hiring, training, and certification of peer recovery specialist	OOCC
Other State and Emergency Funding			
$ 4,994	Correctional Facility MAT	Vivitrol treatment and pre-reentry case manager	GOCCP/OOCC
$ 5,516	Student Assistance Program (SAP)	School-based brief intervention and referral to treatment	Cures
Total $ 88,988			

SOMERSET COUNTY

State OIT Grant Funding			
$ 93,981	Peer Recovery Support Specialist	Funding to retain peer recovery support specialist	OOCC
	Somerset County Opioid United Team (SCOUT) Initiative	Funding for mailing, advertising, and printing of materials. It will also fund educational events and educational resource materials for opioid issues	
	Law Enforcement Support	Funding will provide continued support for law enforcement agencies to expand their current capacity in investigations and enforcement	
Other State and Emergency Funding			
$ 37,041	Naloxone Saturation	Support Dept. of Health Overdose Education and Naloxone Distribution community naloxone efforts.	Cures/OOCC/BHA
$ 5,516	Student Assistance Program (SAP)	School-based brief intervention and referral to treatment	Cures
Total $ 136,538			

ST. MARY'S COUNTY

State OIT Grant Funding			
$ 73,680	Encouraging treatment to those experiencing nonfatal opioid overdose	Funding to provide continued outreach to those discharged from hospital that experienced non-fatal opioid overdose but refused substance use services	OOCC
	Level 3.5 treatment services for St. Mary's County Detention Center	Funding to provide continued assurance that those incarcerated have access to level 3.5 substance use treatment regardless of health insurance coverage	
	Increasing Local Capacity for Non-Opioid Pain Management	Funding to provide training for local healthcare providers on non-opioid pain management modalities and establishing referral mechanisms	
Other State and Emergency Funding			
$ 50,892	Naloxone Saturation	Support Dept. of Health Overdose Education and Naloxone Distribution community naloxone efforts.	Cures/OOCC/BHA
$ 5,516	Student Assistance Program (SAP)	School-based brief intervention and referral to treatment	Cures
$ 3,400	Law Enforcement Investigation Support		OOCC/HIDTA
$ 8,250	Correctional Facility MAT		GOCCP/OOCC
Total $ 141,738			

TALBOT COUNTY

State OIT Grant Funding			
$ 78,848	Strengthening Recovery	Funding to provide temporary safe housing and support for those after opioid detoxification	OOCC
	Building a Volunteer Recovery Network	Funding to enhance linkage of clients with long term peer support including transportation to center	
	Prevention and Intervention for High Risk students/families	Funding to provide social worker to engage in identified high risk students and their families for comprehensive support	
	Naloxone Access	Funding for Narcan training and distribution in community	
Other State and Emergency Funding			
$ 22,956	Naloxone Saturation	Support Dept. of Health Overdose Education and Naloxone Distribution	Cures/OOCC/BHA
$ 5,516	Student Assistance Program (SAP)	School-based brief intervention and referral to treatment	Cures
$ 8,024	Corrections SBIRT	Continuation from FY18 (Talbot County Detention Center; SBIRT only)	OOCC/MDH
$ 44,000	Heroin Coordinators	One individual from a law enforcement agency responsible for local consolidation and analysis of drug overdose information for targeted prosecution, drug supply reduction, and public health coordination	GOCCP
Total $ 159,344			

WASHINGTON COUNTY

State OIT Grant Funding			
$ 150,087	Community Overdose Response for Direct Services	Funds to provide continued support of opioid crisis response team that include peer support, law enforcement, and local medical providers	OOCC
	Washington Goes Purple	Funding to support projects in community that focus on education in school system and promoting discussion with students and their parents about prescription medication. Modeled after 'Talbot Goes Purple' initiative	
Other State and Emergency Funding			
$ 87,500	Hospital SBIRT OSOP	Continuation from FY2018	OOCC
$ 64,541	Naloxone Saturation	Support Dept. of Health Overdose Education and Naloxone Distribution community naloxone efforts.	Cures/OOCC/BHA
$ 5,516	Student Assistance Program (SAP)	School-based brief intervention and referral to treatment	Cures
$ 100,000	3.1 Crisis Treatment Expansion	Continuation from FY2018	Cures
$ 153,998	MD Criminal Intelligence Network (MCIN)	A coalition of criminal justice agencies that collaborates and coordinates tactics, resources, and intelligence through data sharing, partnerships, policies, and technologies	GOCCP
$ 270,000	Adult Day Reporting Center	The Washington County Sheriff's Office Adult Day Reporting Center offers a minimum-security alternative to traditional incarceration for offenders who meet the criteria for the program. The program provides community based	GOCCP

		services and treatment to offenders under probation, pretrial supervision, and those sentenced directly to the Day Reporting Center. It also provides Cognitive Behavioral Therapy in group and individual settings along with Medication Assisted Treatment incorporating Vivitrol in order to reduce recidivism, jail population and corrections related costs.	
$ 80,922	Horizon Goodwill Industries PROJECT REALIZE!	A mentoring program for youth involved in the justice system. (Grant approved/pending)	OOCC
$ 250,000	Brooke's House	Long-term sober living facility for women in Washington County (Grant approved/pending)	OOCC
$ 10,000	Peer Specialist	Screening, Brief Intervention, and Referral to Treatment services, with a focus on hospitals, correctional facilities, and other high-risk populations	GOCCP
Total $1,172,564			

WICOMICO COUNTY

State OIT Grant Funding			
$ 110,222	Education, Training and Informational Campaign	Funding to provide continued opioid forums throughout county to provide education to public and solicit feedback, naloxone trainings, and distribution of resource guides	OOCC
	Wicomico Opioid Coordinator	Funding to retain opioid coordinator	
Other State and Emergency Funding			
$ 74,865	Naloxone Saturation	Support Dept. of Health Overdose Education and Naloxone Distribution	Cures/OOCC/BHA
$ 5,516	Student Assistance Program (SAP)	School-based brief intervention and referral to treatment	Cures
$ 47,000	Corrections SBIRT	Continuation from FY18	OOCC-MDH
$ 40,662	Heroin Coordinators	One individual from a law enforcement agency responsible for local consolidation and analysis of drug overdose information for targeted prosecution, drug supply reduction, and public health coordination	GOCCP
$ 431,786	MD Criminal Intelligence Network (MCIN)	A coalition of criminal justice agencies that collaborates and coordinates tactics, resources, and intelligence through data sharing, partnerships, policies, and technologies	GOCCP
$ 78,000	Medically Assisted Treatment (MAT)	Partnership between local Detention Centers and Public Health Agencies which incorporates Vivitrol as a tool in MAT program for persons leaving Detention Centers.	GOCCP

$ 26,877	Peer Specialist	Screening, Brief Intervention, and Referral to Treatment services, with a focus on hospitals, correctional facilities, and other high-risk populations	GOCCP
Total **$ 814,928**			

WORCESTER COUNTY

State OIT Grant Funding			
$ 89,552	Placement of Recovery Specialists in Hospital Emergency Department	Peer recovery specialist assignment in hospital ERs to serve as treatment resource. They will also assist in development and monitoring of Naloxone distribution	OOCC
Other State and Emergency Funding			
$ 103,962	Naloxone Saturation	Support Dept. of Health Overdose Education and Naloxone Distribution	Cures/OOCC/BHA
$ 5,516	Student Assistance Program (SAP)	School-based brief intervention and referral to treatment	Cures
$ 45,541	3.1 Crisis Treatment Expansion	Continuation from FY2018	Cures
$ 50,615	Heroin Coordinators	Continuation from FY2018	GOCCP
Total $ 295,186			

PREVENTION • TREATMENT • RECOVERY
Before it's too late.

Maryland Inter-Agency Heroin and Opioid Coordination Plan

Developed by the Opioid Operational Command Center
FY19 Mid-Year Update

From the Executive Director:

Since Governor Larry Hogan declared a State of Emergency to combat the heroin and opioid crisis in March 2017, Maryland's Opioid Operational Command Center has been working with state agencies and local jurisdictions to address the epidemic.

Every day, the state and its federal and local partners are working hard to save the lives of the Marylanders caught in the grips of addiction. We've made progress in expanding access to treatment and recovery services, disrupting and dismantling drug trafficking organizations, and beginning to re-educate our youth on the dangers of drug use – but there is still work to be done in fighting this destructive crisis that is evolving daily.

The Inter-Agency Heroin and Opioid Coordination Plan that follows ensures that partner priorities, strategic planning efforts, and program initiatives are working toward a common statewide vision and shared goals.

We thank our state and local partners, opioid intervention teams, advocates, first responders, law enforcement, and local health departments, as well as the countless Marylanders who have stepped up to fight this crisis.

Clay B. Stamp

Clay B. Stamp
Executive Director, Opioid Operational Command Center
Senior Emergency Management Advisor to the Governor and Chair of the Governor's Emergency Management Advisory Council

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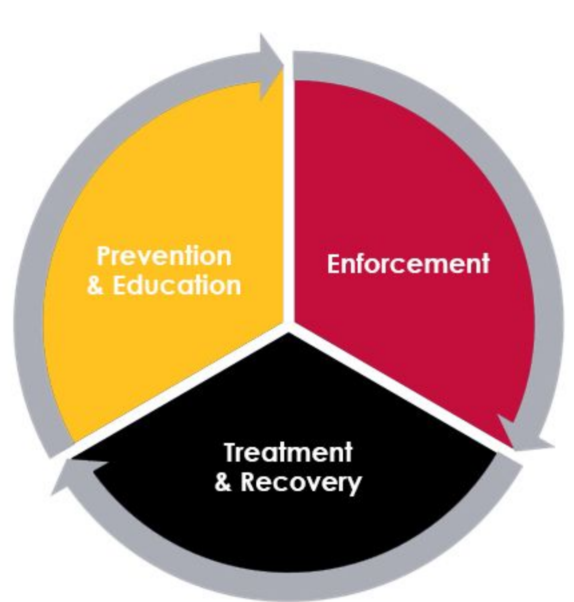
Introduction

The heroin and opioid overdose crisis in Maryland cuts across all demographics and geographical settings. Fentanyl, heroin, and prescription opioids have ignited an urgent and growing public health crisis that poses a serious threat to the security and economic well-being of the state. The goal of Maryland's comprehensive heroin and opioid response is to reduce heroin and opioid-related overdoses and overdose fatalities[1] through coordinated prevention, education, enforcement, treatment, and recovery efforts. The Inter-Agency Heroin and Opioid Coordination Plan was developed by the Opioid Operational Command Center (OOCC) to outline the functions and processes that support Maryland's statewide coordination and collaboration of efforts.



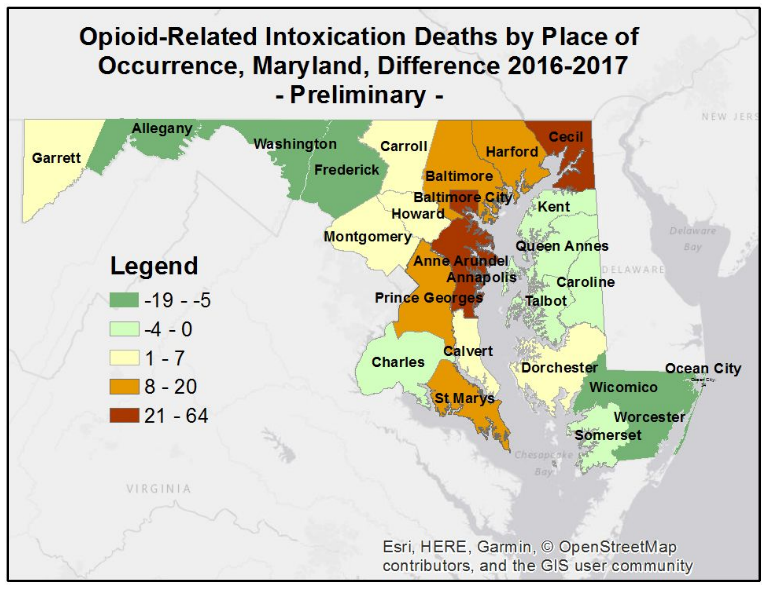
The Coordination Plan does not supplant internal partner-specific procedures, plans, and programs. Rather, the Coordination Plan ensures that partner priorities, strategic planning efforts, and program initiatives are working toward a common statewide vision and shared goals. As an emergency management body, the Opioid Operational Command Center provides centralized direction and control to coordinate statewide response efforts and information-sharing initiatives. The Coordination Plan has been developed by the OOCC with the full collaboration of OOCC strategic partners.

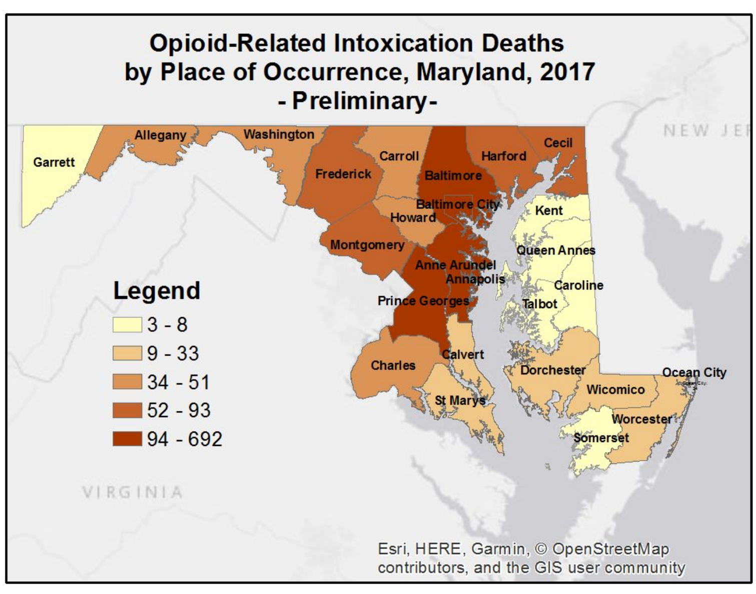
This Coordination Plan seeks to (1) clearly communicate the mission of Maryland's centralized, coordinated response, (2) outline roles and responsibilities of partnering state and local organizations, and (3) provide an overview of statewide response goals, objectives, and performance measures.

[1] Maryland Department of Health. (June 2018). *Unintentional Drug- and Alcohol-Related Intoxication Deaths in Maryland Annual Report 2017*.

Heroin and Opioid Overdose Trends

The Maryland Department of Health's *Unintentional Drug- and Alcohol-Related Intoxication Deaths in Maryland Annual Report*[2] shows Maryland had 2,282 drug and alcohol-related intoxication deaths in 2017 (a nine percent increase from 2016). Of those deaths, 2,009 (88%) were related to opioids including heroin, prescription opioids, and fentanyl. Fentanyl-related deaths continue to rise, increasing from 1,119 in 2016 to 1,594 in 2017 (+42%). Cocaine-related deaths are also up from 464 in 2016 to 691 in 2017 (+49%). The number of heroin-related and prescription drug-related deaths dropped slightly in 2017 when compared to 2016 (-11% and -1% respectively).





[2]Maryland Dept. of Health. 2017. *Unintentional Drug- and Alcohol-Related Intoxication Deaths in Maryland Annual Report 2017.*

Core Principles

The following core principles reflect overarching values that should be incorporated into all statewide response strategies and tactics:

- **Whole community engagement**[3]
- **Culturally competent**[4]
- **Sustainable**
- **Data Informed**
- **Person First focus**

FEMA's Whole Community Planning approach provides a foundation for increasing individual and community engagement in the policy and planning process by actively valuing the voices of community-members in matters that affect their health and communities. Benefits of the whole community approach include:

- Developing a shared understanding of needs and capabilities
- Fostering collective learning
- Empowering the community directly affected by policy and planning
- Integrating community resources and voices

Background

In 2015, recognizing the increasing severity of the heroin and opioid overdose crisis, Governor Larry Hogan established the Heroin and Opioid Emergency Task Force (Task Force) and the Inter-Agency Heroin and Opioid Coordinating Council (Coordinating Council). Governor Hogan charged the Task Force with developing initial recommendations for action; the Task Force concluded its work and published its final report in December of 2015. The Coordinating Council continues to serve as the subcabinet of the Governor responsible for oversight of the statewide response.

In January of 2017, Governor Larry Hogan established the Opioid Operational Command Center (OOCC) within the Coordinating Council and established Opioid Intervention Teams (OITs) in each jurisdiction. Based on the initial findings of the OOCC, the administration signed an executive order on March 1, 2017, declaring a State of Emergency for the Heroin and Opioid Crisis. The State of Emergency activated the Governor's emergency management authority, authorized the OOCC Executive Director to direct the state agency response, and spurred rapid coordination between state agencies and local jurisdictions. *See Appendix A: Executive Orders*.

[3] FEMA. (2011). *A Whole Community Approach to Emergency Management: Principles, Themes, and Pathways for Action* (FDOC 104-008-1).
[4] SAMHSA's Strategic Prevention Framework. (n.d.). Retrieved from https://www.samhsa.gov/capt/applying-strategic-prevention/cultural-competence.

Statewide Response Goals

The Coordination Plan guides the statewide response to the heroin and opioid overdose crisis by aligning the efforts of many diverse stakeholders around agreed-upon goals and objectives. The statewide goals are organized around the levels of public health prevention and were collaboratively developed based on the Task Force recommendations and input from subject matter experts in the areas of prevention, education, enforcement, treatment, and recovery.

Guided by the four operational goals, OOCC partners identified agency-specific objectives, deliverables, timelines, and performance measures in order to report progress and promote accountability. The Administration's focus on prevention, education, enforcement, treatment, and recovery are integrated throughout the statewide goals. *See Appendix B: Statewide Goals & Objectives.*

Concept of Statewide Operations

The response framework developed by the Governor's executive orders emphasizes a multidisciplinary, multi-agency incident management structure to mobilize and coordinate state and local stakeholders under four common, collaboratively-created goals. The OOCC Executive Director has the authority of the Governor to direct the Coordinating Council and all State agencies to assist, engage, deploy, and coordinate available resources to address the opioid crisis.

Management Structures

Inter-Agency Heroin and Opioid Coordinating Council (Coordinating Council)

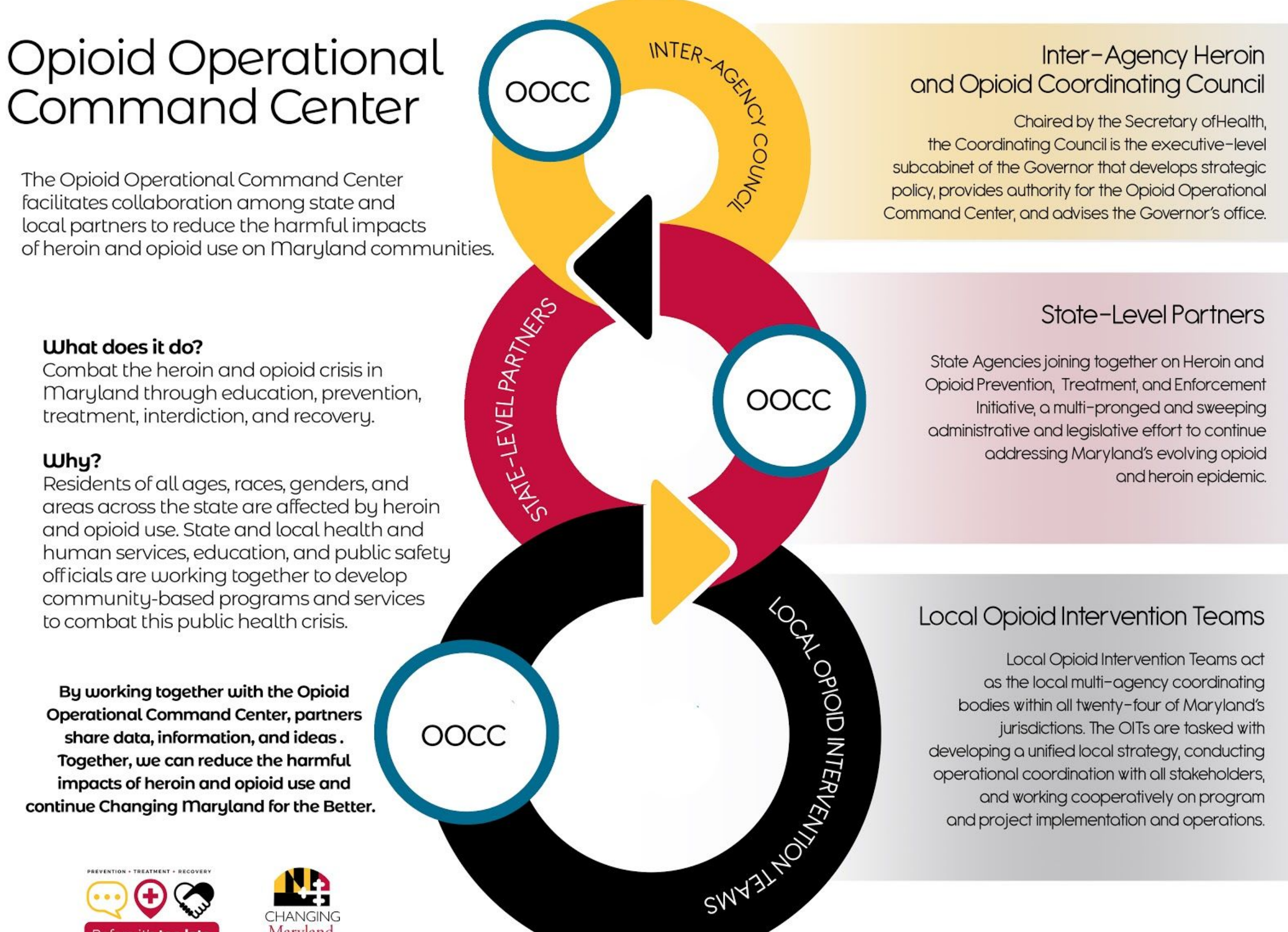
The Coordinating Council is the executive-level subcabinet of the Governor that develops strategic policy, provides authority for the Opioid Operational Command Center, and advises the Governor's office. The Coordinating Council, chaired by the Secretary of the Maryland Department of Health, includes representatives from law enforcement and public safety, education, emergency services, and other human and social service departments.

Opioid Operational Command Center (OOCC)

The OOCC serves within the Coordinating Council to coordinate the statewide response using the principles of the National Response Framework. As an emergency management body, the OOCC connects with state and local response partners from all sectors to identify challenges, establish system-wide priorities, and capitalize on opportunities for collaboration.

The OOCC's Core Functions include:

- Coordination & Enhancement of Partner Activities
- Data Collection & Analysis Data
- Funding Oversight
- Communications
- Reporting



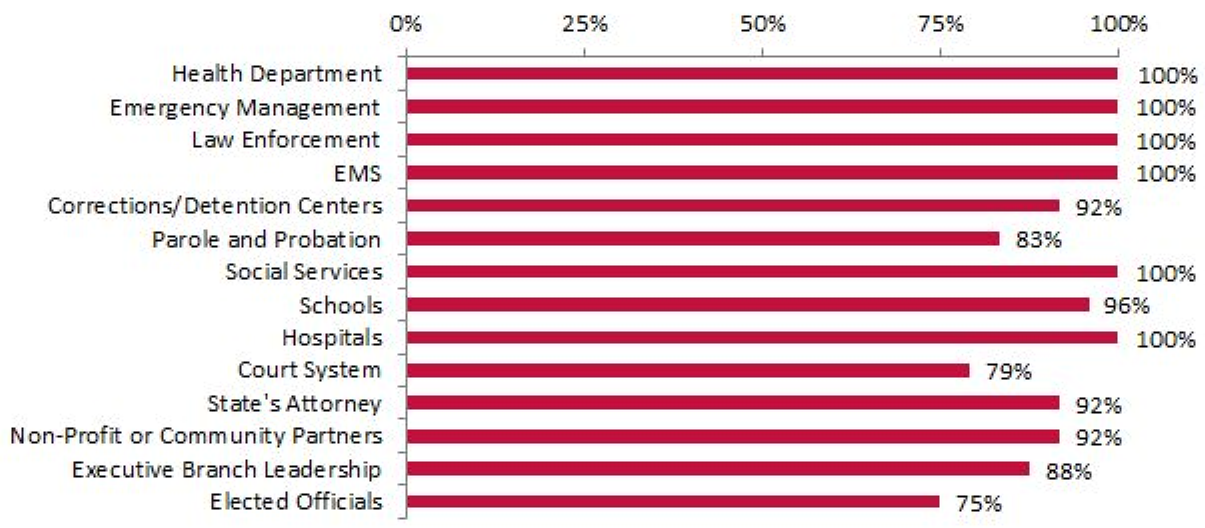
State-Level Partner Roles and Responsibilities

The OOCC coordinates the statewide heroin and opioid crisis response through state partner agencies from health, human services, education, law enforcement / public safety, and emergency services. State partners serve as subject matter experts on collaborative initiatives and are responsible for program development and implementation, within their agencies. *See Appendix C: Partner Functions*. Non-governmental partners, including healthcare systems and associations, community and faith-based organizations, professional associations, and nonprofits and businesses, play a pivotal role in Maryland's whole community approach.

Local Opioid Intervention Teams

A key element of the statewide strategy is encouraging multidisciplinary collaboration and coordination among all levels of government. To provide direction and coordination among stakeholders on a local level, all twenty-four jurisdictions set up Opioid Intervention Teams, which are the local jurisdiction multi-agency coordination bodies. The purpose of an OIT is to bring together representatives from different local agencies to identify gaps and opportunities, coordinate resources. OITs are led jointly by the jurisdiction's health officer and emergency manager and include local government and community partners from local agencies, advocates, and community groups.

OITs are responsible for developing a community strategy to address opioid addiction and misuse in their community, identifying priority areas for programming, and allocating OIT grant funding to those areas. Most OITs meet on a monthly or quarterly basis to discuss progress in priority areas and gaps that need to be addressed. *See Appendix B.*



Information Sharing

A primary function of the OOCC is enhancing communication and information sharing among all response partners. State partners and local OIT members have specialized expertise, capabilities, and data that can be shared to inform a stronger and more coordinated statewide response.

The OOCC implements a variety of communication and information sharing strategies, including:

- **Alerts** - Time-sensitive and health/safety-related information
- **Stakeholder Notifications** - Informational resources, funding opportunities, and upcoming events
- **Data Collection & Resources** - Processes and tools that help partners understand the crisis, target resources, and measure their impact
- **Education and Training** - Efforts to improve understanding of the statewide response and share resources available to partner organizations
- **Partner-specific Projects** - Efforts to help partners close identified information gaps

See Appendix D: Information Sharing Calendar which includes details about operational staff meetings, webinars, quarterly Council meetings, reporting requirements, and other information sharing strategies.

Collaborative Multidisciplinary Stakeholder Engagement

Building on the framework of the operational goals and partner-specific objectives, the OOCC facilitates strategy-development sessions, workgroups, and workshops to share state and local evidenced-based best practices and develop strategies to support the statewide goals and objectives. The OOCC holds regular multidisciplinary coordination sessions as well as focused collaboration sessions when a specific need has been identified or upon request of a partner. The goals of these sessions may include:

- Sharing and maintaining multidisciplinary and multi-jurisdictional situational awareness,
- Identifying specific evidence-based practices and programmatic gaps in the statewide response,
- Developing specific, actionable recommendations to address short-term response gaps, and
- Highlighting long-term strategic priorities.

Appendices

Appendix A: Executive Order Mandates

Appendix B: Statewide Goals & Objectives

Appendix C: Partner Functions

Appendix D: Information Sharing Calendar

Appendix A: Executive Order Mandates

Inter-Agency Heroin and Opioid Coordinating Council

Pursuant to EO 01.01.2015.13, the Council shall update the Governor on each agency's efforts to address the heroin and opioid crisis. The Secretary of MDH chairs the Council overseeing the implementation of the EO and the work of the Council. The specific duties tasked to the Council by mandate are as follows:

- The member state agencies previously listed shall seek opportunities to share data with one another and with the Office of the Governor for the purpose of supporting public health and public safety responses to the heroin and opioid epidemic. The agencies shall share the data in their possession relevant to the epidemic;
- The Council shall develop recommendations for policy, regulations, or legislation to facilitate improved sharing of public health and public safety information among state agencies; and
- On behalf of the Council, MDH shall submit an annual report to the Governor and the public in the form of the Inter-Agency Heroin and Opioid Coordination Plan.

Opioid Operational Command Center

The OOCC facilitates collaboration among state and local departments, agencies, and offices across health, human services, education, and public safety entities to reduce the harmful impacts of opioid addiction on Maryland communities. Pursuant to EO 01.01.2017.01, the OOCC serves as the operational coordination entity across the state tasked to:

- Develop operational strategies to continue implementing the 33 recommendations of the Heroin and Opioid Emergency Task Force authorized by EO 01.01.2015.12.
- Collect, analyze, and facilitate the sharing of data relevant to the epidemic from state and local sources, while maintaining the privacy and security of sensitive personal information.
- Develop a memorandum of understanding among state and local agencies that provides for the sharing and collection of health and public safety information and data related to the heroin and opioid epidemic.
- Assist and support local agencies in the creation of OITs that will share such data.
- Coordinate the training of and provide resources for state and local agencies addressing the threat to the public health, security, and economic well-being of the State of Maryland.

The following are additional responsibilities the Governor assigned to an individual in the Executive Branch to the MEMA, currently serving as the OOCC executive director. This individual is designated to administer the Governor's authority under the Maryland Emergency Management Agency Act and operationally address the heroin and opioid crisis pursuant to EO Declaration of Emergency [01.01.2017.02], including:

- Directing MEMA, MSP, MDH, the Governor's Office of Crime Control and Prevention (GOCCP), and/or any other appropriate state department, agency, and office, including the Heroin and Opioid Emergency Task Force, the Council, and the OOCC, to assist, engage, deploy, and coordinate available resources to address the crisis;
- Coordinating the preparation of plans, programs, and infrastructure for emergency management operations of the local political subdivisions of the state, employing their social service, law enforcement, and public health functions;
- Instituting public information and awareness programs;
- Authorizing the procurement of supplies and equipment necessary to control and eliminate the crisis; and
- Taking other necessary steps to address the opioid crisis.

Appendix B: Statewide Goals & Objectives

Goal 1: Prevent New Cases

1.1: Reduce inappropriate or unnecessary opioid prescribing and dispensing

1.2: Reduce supply of illicit opioids

1.3: Increase patient knowledge of opioid risk and benefits

1.4: Increase family and youth knowledge of opioid risk and benefits

1.5: Increase public safety knowledge of opioid risk and benefits

Goal 2: Improve Early Identification and Intervention

2.1: Reduce stigma and improve knowledge and understanding about opioid addiction

2.2: Build capacity of healthcare system to identify behavioral health disorders and link patients to appropriate specialty care

2.3: Improve identification of and provision of services to youth at high-risk for opioid addiction and their families

2.4: Identify and target individuals at high risk for fatal overdose for treatment and recovery support services at all contact points with health, safety, and social service systems, with a specific focus upon entry to an emergency department

Goal 3: Expand Access to Treatment & Recovery Services

3.1: Improve access to and quality of evidence-based opioid addiction treatment in the community

3.2: Make overdose education and naloxone distribution available to individuals at high risk for opioid overdose and their families/friends at all contact points with health, safety, and social service systems

3.3: Increase access to harm reduction services to active opioid users

3.4: Expand access to recovery support services

3.5: Enhance criminal justice services for offenders who are opioid-addicted to prevent re-entry and repeat recidivism into the criminal justice system

Goal 4: Enhance data collection, sharing, & analysis

4.1: Improve understanding of population- and individual-level risk and protective factors to inform prevention initiatives

4.2: Establish a public health surveillance system to monitor indicators of opioid-related morbidity and mortality for informed rapid and actionable response

4.3: Improve prevention program operations and initiatives through data sharing and analysis projects

4.4: Conduct ongoing monitoring and evaluation of response initiatives to ensure successful implementation and outcomes

Appendix C: Partner Functions

Department/Agency	Prevention & Response Roles and Responsibilities
Maryland Emergency Management Agency (MEMA)	Provide operational statewide coordination and support for the overall heroin and opioid response and planning process ● Via the OOCC, coordinate the overall emergency planning, preparedness, and response of all state departments, agencies, and offices in an emergency, with support from MDH. ● Support local government and state department, agency, and office emergency operations planning. ● Facilitate any Emergency Management Assistance Compact (EMAC) requests. ● Support communications via an in-person or virtual Joint Information Center (JIC) as appropriate.
Maryland Department of Health (MDH)	Provide overarching leadership and coordination for overall heroin and opioid crisis response as lead of the Public Health and Medical State Coordinating Function (SCF). ● Coordinate public health surveillance and investigation, including prescription drug monitoring, syndromic and disease outbreak surveillance with appropriate laboratory testing, analysis, and result sharing with federal, state, and local partner agencies. ● Provide technical guidance and resources to the state heroin and opioid coordinating body and LHDs to prevent, respond to, and recover from an opioid-related public health emergency. ● Provide technical guidance and resources to healthcare facilities including hospitals, federally qualified healthcare centers, long term care facilities, and primary care facilities. ● Assess heroin and opioid-related threats/hazards impacting public health and medical partners, as well as the public. ● Communicate with the public to educate Marylanders on public health preparedness steps they can take to prevent, respond to, or recover from an opioid-related emergency. ● Maintain vital records, such as a records of all overdose deaths that occur in Maryland, including toxicology results. ● Maintain health coverage programs, such as Medicaid and substance use disorder treatment services. ● Create and maintain mental and behavioral health

	programs for the treatment of behavioral health conditions, and the prevention, treatment, and recovery from substance use disorders. ● Ensure healthcare professionals are licensed and credentialed, such as enrolled in the controlled dangerous substances registration. ● Regulate healthcare facilities, including hospitals, clinics, nursing homes, primary care, etc. ● Investigate unusual or unattended deaths, properly store deceased remains, and maintain the capacity to surge in the event of mass fatality. ● Coordinate public health and medical volunteer management to support the response as directed. ● Prepare to enhance operations, including activation of the State Emergency Operations Center.
Governor's Office of Crime Control and Prevention (GOCCP)	● Support Heroin Coordinators program to facilitate information sharing between law enforcement, LHDs, fire/emergency medical services (EMS), and parole and probation. ● Support medication-assisted treatment re-entry programs in correctional facilities. ● Support law enforcement assisted diversion tools for planning, implementation, and evaluation.
Maryland State Police (MSP)	● Coordinate federal, state, and local law enforcement activities as they relate to the opioid crisis through the HIDTA. ● Facilitate training for personnel available to assist with activities such as overdose education and naloxone distribution. ● Facilitate education of law enforcement partners, probation officers, prosecutors, and the public about the Good Samaritan Law.
Department of Juvenile Services (DJS)	● Develop and implement comprehensive heroin and opioid abuse screening and control measures to prevent the introduction and spread of heroin and opioid-related abuse within juvenile detention facilities. ● Develop strategies to reduce recidivism of substance abusers upon release.
Department of Public Safety and Correctional Services (DPSCS)	● Develop strategies to reduce recidivism of substance abusers upon release. ● Develop and implement control measures to prevent the introduction and spread of opioid-related abuse within correctional facilities, to include policies and procedures for strengthening counter-smuggling efforts, expanding segregation addiction programs, and

	establishing a recovery unit in facilities.
Maryland State Department of Education (MSDE)	• Provide guidance to school systems promoting evidence-based prevention strategies that develop refusal skills among students. • Coordinate with MDH to develop communication protocols between school systems and public health entities at the State and local levels. • Coordinate with MDH to develop protocols for the training of school faculty and staff to identify signs of addiction and to access support services.
Maryland Institute for Emergency Medical Services Systems (MIEMSS)	• Provide guidance to EMS operational programs, medical directors and individual EMS providers on the proper care and treatment of patients, including personal protective practices, transportation, and resources available for this response. • Ensure there are personnel trained and available to deploy to public health emergency incident sites, or impacted counties, to assist with situational awareness and coordination of resources, as necessary. • Ensure there are adequate EMS resources, including for mass casualty events and evacuation of health/medical facilities, when requested. • Utilize the statewide EMS electronic patient care reporting system (eMEDS) to collect, compile and analyze statistics to identify injury and illness patterns and trends.
Maryland Higher Education Commission (MHEC)	• Develop strategies to incentivize colleges and universities to create collegiate recovery programs. • Coordinate with MDH to support curriculum development for substance use disorder prevention/treatment to be built into advanced professional education.
Office of the Attorney General (OAG)	• Provide legal advice and opinions in support of MDH heroin and opioid-related operations, to include preparing and reviewing proclamations and special regulations issued by the Governor. • Prepare memos and/or legal orders for and represent the state on legal issues for heroin and opioid-related public health measures.

Department of Human Services (DHS)	● Coordinate the provision of human services and collaborate with MDH to ensure eligible clients are able to register for health coverage and services, such as Medicaid and Medicare. ● Create and maintain a communications network with local departments of social services, which can push prevention messaging to partners. ● Coordinate human services training for Volunteer Organizations Active in Disasters.
Maryland Insurance Administration (MIA)	● Provide technical assistance regarding commercial insurance . ● Review actions of commercial insurers to make certain that they are in compliance with Maryland law. ● Provide information to consumers and providers regarding how the Maryland Insurance Administration can assist with the claims process.
High Intensity Drug Trafficking Washington/Baltimore Area (HIDTA)	● Support partnerships between public health and public safety agencies in order to increase collaborative solutions and data sharing. ● Support efforts to act as the Central Repository for Maryland Drug Intelligence as designated by the Lt. Governor's Task Force Recommendations.

Appendix D: Information Sharing Calendar

Frequency	Activities
Quarterly	● Inter-Agency Heroin and Opioid Coordinating Council Meetings ● Executive Reports (including both state and local performance measures) ● OIT Grant Report ● Joint Chairmen's Report
Monthly	● Operational Period Briefings ● Webinars ● Lieutenant Governor’s Report ● State partner & OIT Situation Check-ins
Bi-weekly	● Governor’s Report
Ongoing / As Necessary	● BeforeItsTooLate Resource Hub ● Stakeholder Notifications & Alerts ● Stakeholder Workgroups ● Information-sharing Forums ● Press Releases

Maryland Opioid Rapid Response
Statewide Needs Assessment

Maryland Department of Health
Behavioral Health Administration

July 2017

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I. Introduction

The Maryland Opioid Rapid Response (M.O.R.R.) initiative is designed to take a strategic and comprehensive approach to increasing access to and enhancing services for individuals with an Opioid Use Disorder (OUD) through targeting high risk regions and populations and reducing gaps in service throughout the Public Behavioral Health System (PBHS) and the state. The goal is to utilize a public health framework of prevention, treatment and recovery services to reduce unmet treatment needs and opioid related deaths. The priorities of the M.O.R.R. Initiative are to:

- Prevent opioid misuse and abuse through enhanced prescriber practices and public awareness;
- Treat opioid dependence by expanding treatment and increasing quality;
- Prevent overdose fatalities through naloxone expansion; and
- Expand recovery supports in the community.

This needs assessment used multiple information sources to assess and map the current capacity and need for opioid treatment in Maryland. This analysis builds on and expands the findings of a recent Opioid Treatment Program (OTP) Needs Assessment Report conducted by the University of Maryland, Baltimore in 2016 **[1]** and will be used to help inform the development of the M.O.R.R. initiative strategic plan and guide State and local planning and system development efforts to increase system capacity where it is most needed.

II. Needs Assessment Approach and Methodology

II-A. Data Sources and Descriptions: This needs assessment is based on multiple data and information sources, including:

- National Survey on Drug Use and Health (NSDUH) **[2]**: Annual comprehensive national survey administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) that asks people 12 years and older about their drug use. SAMHSA releases the data to the public for use in research and planning.
- Office of Maryland Chief Medical Examiner (OCME) – Overdose Death Data: Tracks all deaths occurring in the state that result from violence, suicide, casualty, or take place in a suspicious, unexpected or unusual manner.
- US Census Bureau, American Community Survey (ACS) **[3]:** National continuous survey that is designed to provide demographic, housing, social, and economic data on communities across the country. This data was used to derive estimates of Maryland's total population, age 12 years and older.
- Maryland Public Behavioral Health System Paid Claims Data: Contains service use and expenditure data for behavioral health services. Service claims for Opioid Treatment Programs (OTP) were obtained for CY 2016.
- Maryland Prescription Drug Monitoring Program (PDMP): Established by the Maryland Department of Health and Mental Hygiene (DHMH), Behavioral Health Administration (BHA), the PDMP collects and securely stores information on drugs that contain controlled substances and are dispensed to patients in Maryland.
- Opioid Treatment Program Provider Census Survey: Point in time survey of all OTP providers conducted in June and July of 2016 by the University of Maryland, System Evaluation Center. Data contains OTP provider estimates of the current number of patients in treatment and the maximum number of patients that could be treated within existing resources.

- Overdose Response Program (ORP) Administrative Tracking System: Maintained by BHA and contains data on the number of naloxone distribution sites, trainings conducted, persons trained, and naloxone doses administered statewide.

II-B. Estimating Need for Treatment:

The methodology for estimating the need for opioid treatment was based on a recent publication that tested this methodology in New York City **[4]**. This methodology was originally used in the City of Baltimore's Mayor's Heroin Treatment & Prevention Task Force Report **[5]** for estimating the need for opioid treatment in the city and later used by the University of Maryland in the 2016 Opioid Needs Assessment **[1]**. The methodology involves combining multiple datasets, then providing a range of estimates that are based on potential overlap among the datasets. Three data sets were used to derive these estimates including: the SAMHSA National Survey on Drug Use and Health Survey (NSDUH) **[6]**, Opioid Related Overdose Death data from the Maryland Office of the Chief Medical Examiner, and public behavioral health service Claims data on the number of individuals treated by Opioid Treatment Program providers in CY 2016. This methodology was applied across the jurisdictions and regions of Maryland using available data.

Maryland population estimates (2010 – 2014) for age 12 years and older were derived from the American Community Survey **[3]** data obtained from the Maryland Department of Planning, and estimates for drug or alcohol dependence were derived from the NSDUH data obtained from SAMHSA [6]. The adjusted NSDUH estimate for dependence or abuse of opioids only was calculated by multiplying the NSDUH percentages of any substance dependence or abuse by 0.1166 (11.66%), which is the national percentage of people with a heroin or prescription painkiller use disorder out of all people with any kind of substance use disorder. While the NSDUH data was used to estimate the need for OUD treatment in this assessment, it has limitations, including its focus on anon-institutionalized civilian population only and that it relies exclusively on a telephone survey methodology, which may exclude individuals with limited access to telephones. Despite these limitations, the NSDUH data is the most comprehensive national survey of substance use in individuals 12 years and older and is used extensively for policy planning at the federal and state levels.

Need estimates were derived by combining the three data sets mentioned above. Since the degree of overlap across the datasets could not be determined, the methodology provides three estimates that account for varying levels of overlap across the datasets from Restrictive – assuming 100% overlap to Expansive assuming no overlap across the datasets. The average of the two estimates is calculated to derive a Midpoint Estimate. The Midpoint Estimate was used to generate statewide and county estimates of individuals in need of OTP treatment.

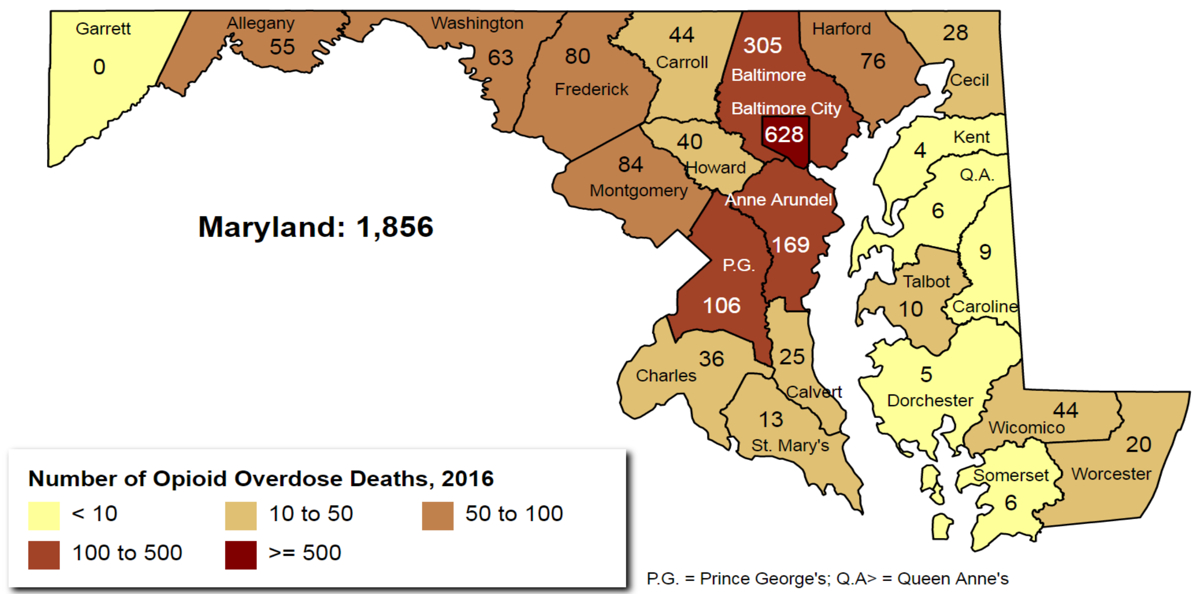
II-C. Estimating Treatment Capacity:

Opioid Treatment Program capacity was based on a point in time telephone survey of OTPs in Maryland (see survey description above). The estimated treatment capacities reported by each OTP were summed in a given jurisdiction for both methadone and buprenorphine patients to derive county level capacity estimates. This total capacity reflects the overall capacity of the OTPs at the time of the call. It is important to note that this data only represents persons receiving buprenorphine from an OTP provider; this is a known under-representation of the population treated with buprenorphine, as many persons receive buprenorphine outside of OTPs through physician office based opioid providers.

III. Needs Assessment Findings

III-A. Opioid Involved Overdose Deaths in Maryland

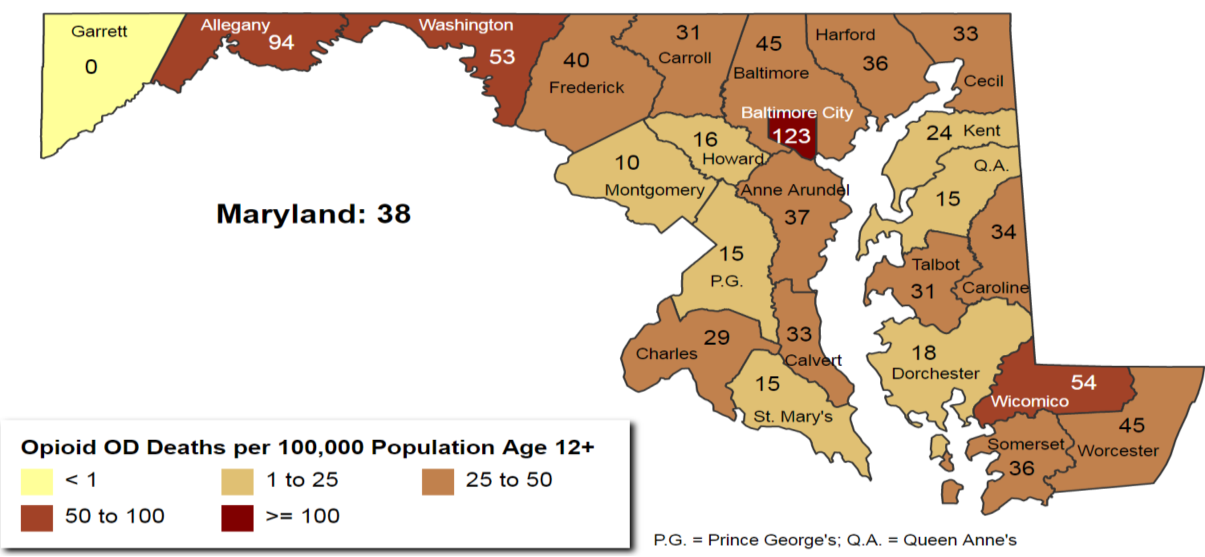
Figure 1. Total Number of Opioid Related Overdose Deaths by Maryland Jurisdiction, 2016



Notes: Based on 2016 data from the Maryland Office of the Chief Medical Examiner (OCME). Numbers are based on location of occurrence, so all deaths may not reflect Maryland residents.

- In 2016, a total of 1,856 opioid related overdose deaths occurred in Maryland, which translates to an average of five deaths per day;
- The highest number of opioid related overdose deaths occurred in Baltimore City (628), Baltimore County (305), Anne Arundel County (169) and Prince Georges County (106). These four jurisdictions account for nearly two-thirds (65%) of all opioid related overdose deaths in the state.

Figure 2. Rate of Opioid Related Overdose Deaths per 100,000 Population, Age 12 Years and older



Notes: Based on 2016 data from the Maryland Office of the Chief Medical Examiner (OCME). Numbers are based on location of occurrence, so all deaths may not reflect Maryland residents.

- The statewide opioid related overdose death rate was 38 deaths per 100,000 population in 2016.

- As shown in Figure 2, seven jurisdictions had overdose death rates that were higher than the state rate, including: Baltimore City (123), Allegany county (94), Wicomico County (54), Washington county (53), Baltimore County (45), Worcester County (45) and Frederick County (40).
- The death rate in Baltimore City was 3.2 times higher than the state overall, followed by Allegany County which was 2.5 times higher than the state rate.

Analysis and Identification of High-Risk Areas and Populations of Focus

Opioid use disorders and opioid related overdose deaths have become a serious public health challenge in Maryland and across the country. Maryland's age adjusted 2015 death rate per 100,000 population involving all drugs (20.9) and involving Opioids (17.7) are well above the national rates of 16.3 and 10.4 respectively **[7].** The number of opioid related overdose deaths in Maryland has increased nearly two fold (187%) between 2012 (646) and 2016 (1856). Since 2014, Maryland has seen a substantial uptick in overdose deaths over previous years, as demonstrated by a 23% increase between 2014 and 2015 and a 70% increase between 2015 and 2016.

In 2016, the opioid related overdose death rate in Maryland was 38 per 100,000 population which is up from 21 per 100,000 in 2015. As shown in Figure 2, opioid overdose death rates vary substantially across Maryland jurisdictions ranging from zero in Garrett County to 123 in Baltimore City. While seven jurisdictions had opioid related death rates higher than the state rate, four jurisdictions (Baltimore City, Allegany County, Washington County, and Wicomico County) had rates over 50 per 100,000 population, indicating areas with higher risk and potential areas to target treatment and prevention efforts. The Baltimore metro area (Baltimore City, and Baltimore, Anne Arundel, Carroll, Harford, and Howard Counties) have had the highest rates historically and over the past few years, rates have been increasing faster than most other areas in the state. Overdose deaths in Western Maryland (Garrett, Allegany, Washington, and Frederick Counties) have increased nearly fourfold over the past six years. In this analysis, two jurisdictions stand out as being at particularly high risk for overdose deaths with rates 2.5 times (Allegany County) and 3.2 times (Baltimore City) higher than the overall state rate. Further analysis of the data shows that in 2016, the gender specific opioid-related death rates for Males, 61.5 per 100,000, was nearly three times the rate for females (21.5). Age specific opioid related death rates were greatest for those individuals 45 to 54 years (64.3) and 25 to 34 years (62.9). There were fewer opioid related deaths to those under 25 years (16.1) and the age specific rate for those over 54 years was 25.4 per 100,000.

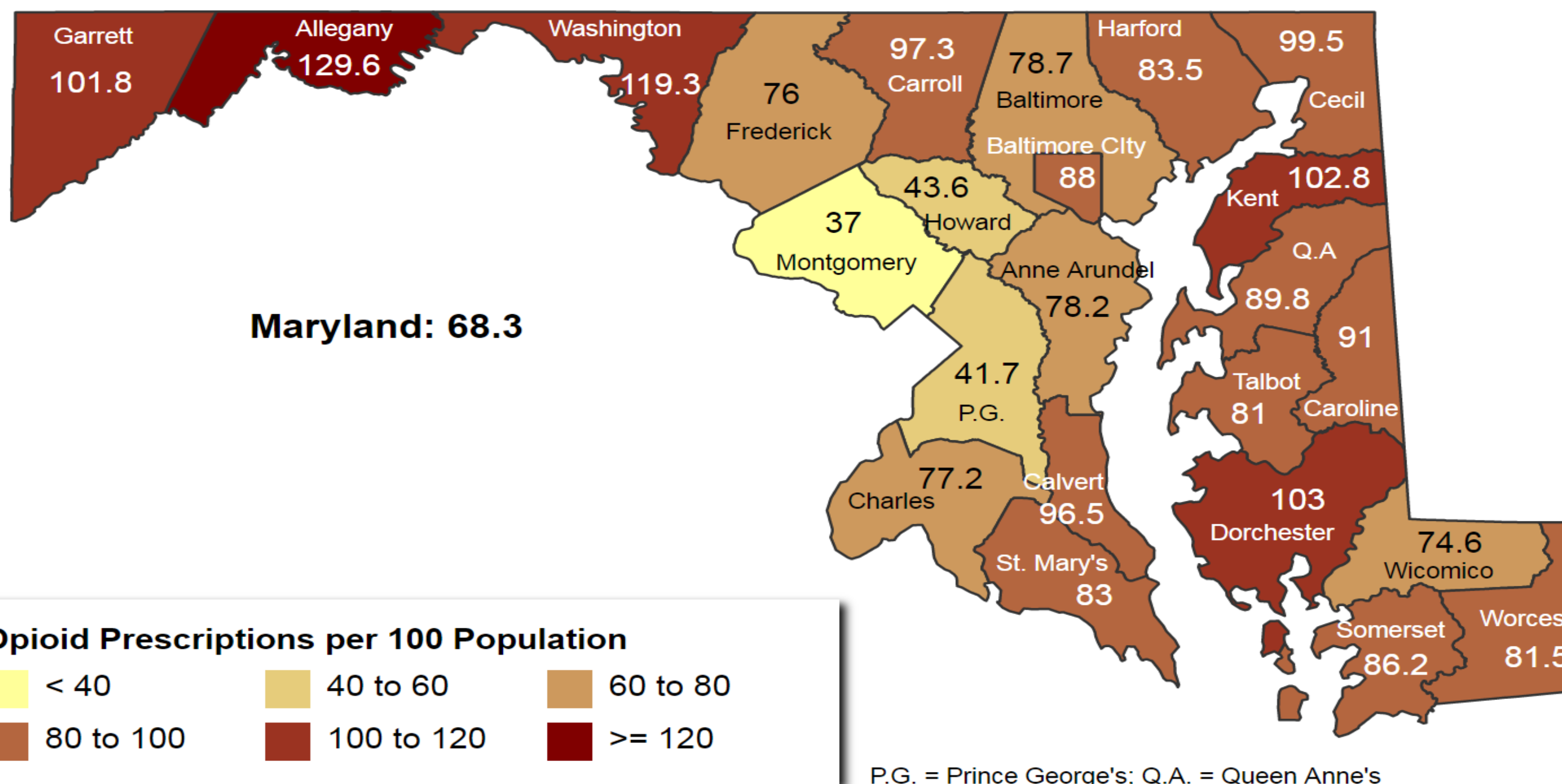
The Maryland Department of Health, Behavioral Health Administration (MDH BHA) is developing an overdose predictive risk model. The model is based on data from multiple data sets and designed to identify key risk factors that can be provided to treatment providers, local behavioral health authorities and other stakeholders to assist them in targeting high-risk individuals in the populations they serve and intervening early to prevent overdoses and overdose deaths. The BHA PDMP also has new staff and software capacity to conduct cluster analyses based upon overdose incidence, CDS prescriptions filled, dangerous co-prescribing of medications and other relevant factors associated with management of patients receiving opioids.

III-B. Prescription Opioids and Benzodiazepines: Summary of PDMP Data

Opioid Prescriptions

Statewide, a total of 4,108,230 opioid pain medication prescriptions were dispensed in CY 2016. The number of opioid prescriptions dispensed varied substantially across jurisdictions, ranging from 20,278 in Kent County to 653,626 in Baltimore County. The highest number of opioid pain prescriptions were dispensed in the five most populated jurisdictions, including: Baltimore County (653,626), Baltimore City (540,669), Anne Arundel County (444,489), Montgomery County (385,957) and Prince Georges County (378,284). These jurisdictions represent more than one-half (58%) of all opioid pain prescriptions dispensed statewide.

Figure 3. Rate of Opioid Prescriptions Dispensed per 100 Population by Jurisdiction



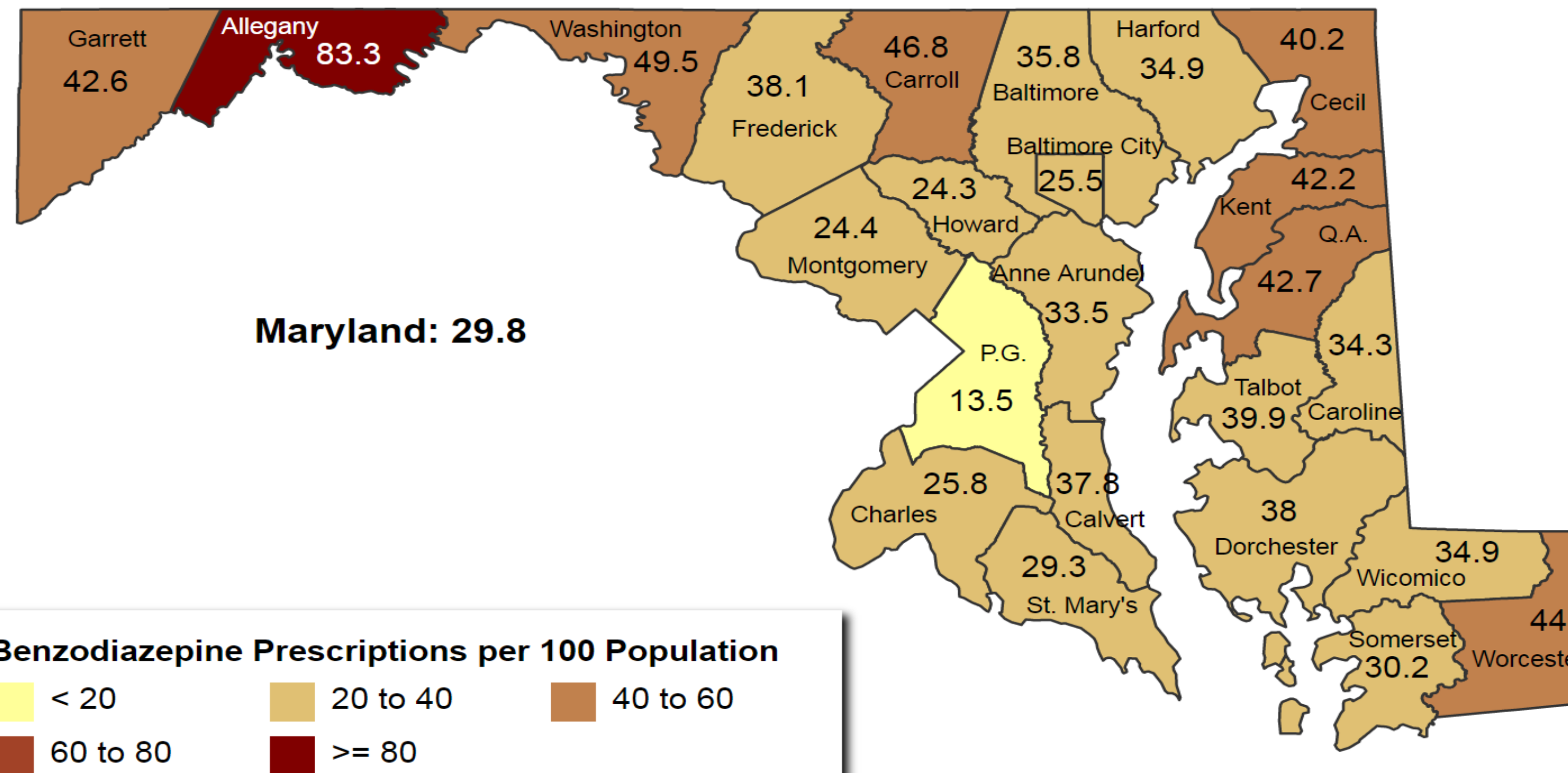
Notes: The numbers are based on PDMP data and represent the rate of opioid pain prescriptions dispensed to Maryland residents per 100 population during CY 2016. Rates are based on the number of prescriptions dispensed and not the number of people.

- As shown (Figure 3) above 68.3 opioid pain medication prescriptions were dispensed for every 100 Maryland citizens in CY 2016.
- Opioid pain prescription rates showed considerable variation across jurisdictions ranging from a low of 37 in Montgomery County to 129.6 per 100 Maryland population in Allegany County.
- Opioid pain medication prescribing rates in Allegany (129.6) and Washington (119.3) Counties standout as being particularly high, with rates nearly two times the state rate.

Benzodiazepine Prescriptions

In CY 2016, a total of 1,789,631 benzodiazepine prescriptions were dispensed statewide. The number of benzodiazepine prescriptions dispensed were highest in the same five jurisdictions that had the highest number of opioid pain prescriptions.

Figure 4. Rate of Benzodiazepine Prescriptions Dispensed by Jurisdiction



Notes: The numbers are based on PDMP data and represent the rate of benzodiazepine prescriptions dispensed to Maryland residents per 100 population during CY 2016. Rates are based on the number of prescriptions dispensed and not the number of people.

- As shown above, 29.8 benzodiazepine prescriptions were dispensed for every 100 Maryland citizens in CY 2016.
- Benzodiazepine prescription rates varied substantially across jurisdictions ranging from 13.5 in Prince Georges County to 83.3 per 100 population in Allegany County.
- Mirroring the opioid prescription rates, both Allegany (83.3) and Washington (49.5) Counties had the highest rates of benzodiazepine prescriptions: 2.8 and 1.7 times higher than the statewide rate respectively.

Analysis and Identification of High-Risk Areas and Populations of Focus

The five most populated jurisdictions had the highest volume of prescriptions dispensed for both opioid pain medication and benzodiazepines. Statewide, the prescribing rate for opioid pain medications and benzodiazepines in 2016 was 68.3 and 29.8 respectively per 100 population. Consistent with national trends, opioid pain medication prescription rates vary widely across Maryland jurisdictions ranging from 37 in Montgomery County to 129.6 in Allegany County. This analysis identified two jurisdictions with particularly high opioid prescribing rates nearly twice the statewide rate (See Figure 3). Prescribing rates for benzodiazepines across the jurisdictions tended to be higher in less populated areas. The findings

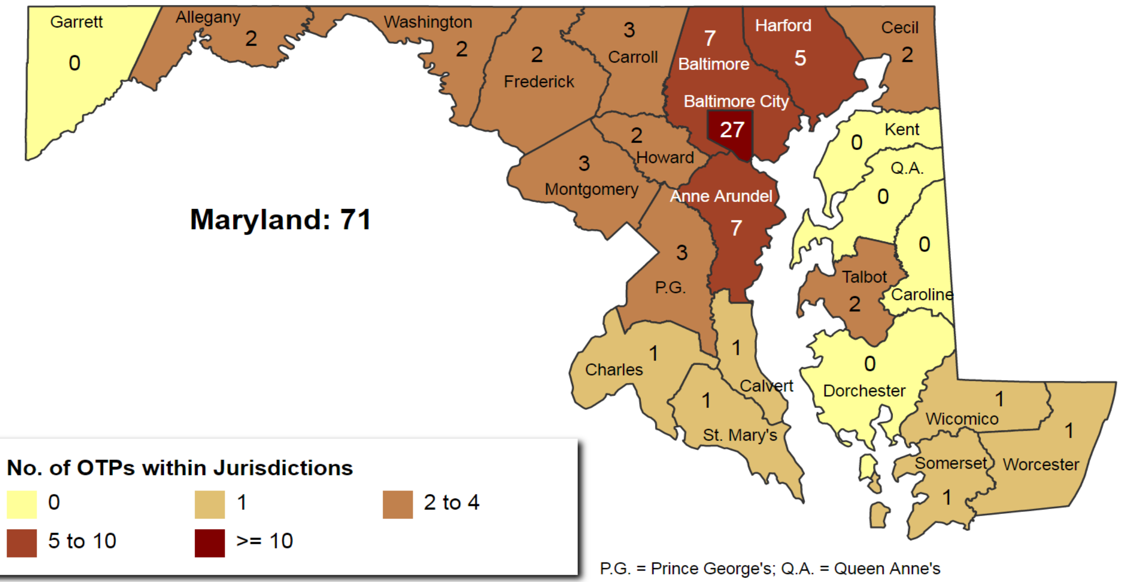
mirrored that of the opioid prescriptions for both Allegany County (83.3) and Washington County (49.5) that have the highest prescribing rates 2.8 and 1.7 times higher than the statewide rate respectively. As noted earlier, both of these counties also have high rates of opioid related overdose deaths compared to the state as a whole.

MDH BHA is using epidemiological and PDMP data to further efforts in reducing overprescribing practices across the state. The Maryland PDMP provides unsolicited reporting notifications to prescribers and pharmacists, and is engaged in a High-Risk Flag Development project, designed to detect prescriber outlier behavior based on CDS prescribing best practices and applying "red flags" to PDMP data.

III-C. Location and Availability of Opioid Treatment Services

Treatment services in Maryland for individuals diagnosed with opioid use disorders consist of Opioid Treatment Programs (OTP), Office Based Opioid Therapy (OBOT), and abstinence based residential and outpatient services. The data presented in this needs assessment is focused upon Medication Assisted Treatment, in recognition of the considerable evidence supporting improved outcomes for MAT for individuals with OUD. Gaps in treatment for this population consist not only of geographic lack of access to OTPs and OBOT, but also in residential treatment such as ASAM Level 3.7 and Level 3.1 residential programs. Additionally, there are currently no walk-in crisis centers in the state that provide treatment on demand.

Figure 5. Number of Certified Opioid Treatment Programs by Maryland Jurisdiction.



Notes: Data based on 2016 OTP Provider Survey. Wicomico, Somerset, and Worcester counties were assigned a "1", since Wicomico County has a mobile treatment van that provides services to the three county area.

- In 2016 there were a total of 71 certified OTP providers delivering Opioid Maintenance Therapy services in Maryland. More than one-half (58%) are located in three jurisdictions in the Metro-Baltimore region, including Baltimore City (27), Baltimore County (7), and Anne Arundel County (7).

Figure 6. Number of Office Based Certified Buprenorphine Providers by Jurisdiction

P.G. = Prince George's; Q.A. = Queen Anne's

Notes: Data based on PDMP, 1/1/2016 – 4/30/2017. Numbers include providers waivered at the 30, 100, and 275 levels.

- In addition to the treatment capacity provided by OTP providers, there are a total of 658 Data Waivered physicians registered to provide buprenorphine across the state.
- Nearly one-half (49%) of these practices are in Baltimore City or in Baltimore County.
- Out of the 658 providers, 263 are waivered for 100 patients, 75 at 275 patients and 320 at 30 patients. If all providers were treating up to their waivered limit, there would be a capacity to treat 56,525 patients. Data is not currently available on the extent to which these providers are treating up to their waivered capacity. However, a recent study by Stein and colleagues (2016) **[9]** on buprenorphine treatment use and capacity across six states with the highest number of buprenorphine waivered physicians, found that monthly patient censuses for buprenorphine providers were well below capacity with more than 20% of practices treating three or fewer patients and fewer than 10% treating more than 75 patients. In Maryland, office based opioid therapy is provided in the context of medical practices that also provide a full array of medical services in addition to Substance Use Disorder treatment.
- Providing psychological counseling in conjunction with MAT is recognized as best practice and has been shown to improve treatment outcomes for individuals with opioid use disorder **[10]**. In Maryland all OTP providers are required to provide psychological counseling and other psychosocial support services to individuals receiving Medication Assisted Treatment. There is currently no data available that identifies the number of OTP providers that provide psychosocial interventions in compliance with the state requirement. However, Maryland Medicaid has recently re-bundled the MAT services reimbursement rate allowing outpatient counseling services to be billed separately. This change will enable data to be collected on individuals receiving outpatient counseling from OTP providers effective May 15, 2017.Maryland Medicaid will provide a re-bundled methadone reimbursement rate to include a $63 per week per patient bundle for methadone maintenance (or $56 for buprenorphine maintenance since the drug itself is paid for through the Medicaid pharmacy program) and the ability for OTPs to bill for outpatient counseling separately, as clinically necessary. Additionally, OTPs will be reimbursed separately for Medication Assisted Treatment (MAT) induction, periodic medication management visits, and guest dosing services provided by the home OTP and guest OTP as clinically indicated.

III-D. Current Opioid Treatment Programming Capacity

Figure 7. Number of People Treated in Publicly Funded OTPs by Jurisdiction in 2016

P.G. = Prince George's; Q.A. = Queen Anne's

Notes: Data based on CY 2016 Public Behavioral Health System service claims data for individuals receiving both Methadone and Buprenorphine treatment in Opioid Treatment Programs. Counts are based on location of patient residence.

- In CY 2016, a total of 32,079 individuals received publicly funded OTP treatment services in Maryland. This translates to a statewide treatment rate of 665.6 individuals per 1000 Maryland population dependent on or abusing opioids.
- As shown in Figure 7, Baltimore City (13,000), Baltimore County (5,300) and Anne Arundel County (3,300) had the highest numbers of individuals receiving OTP services, accounting for slightly over two-thirds (67%) of all individuals served statewide.
- These numbers likely underrepresent the total number of individuals who receive Medication Assisted Treatment in Maryland since they do not include private pay (self-pay or private insurance). This data is not currently available.

III-E. Availability and Location of Overdose Prevention and Recovery Initiatives

The Maryland Department of Health, Behavioral Health Administration (MDH BHA) currently administers the Overdose Response Program (ORP), which was authorized by law in 2013. The ORP is Maryland's statewide program for community-based overdose education and naloxone distribution (OEND). Under ORP, MDH BHA authorizes state and local public and private organizations to conduct education and training on opioid overdose recognition and response. Training includes recognizing and responding to the signs and symptoms of an opioid overdose with the use of naloxone.

As of June 30, 2017, there are a total of 78 Opioid Response Programs (ORP) operating across the state with a concentration in Baltimore City and surrounding jurisdictions. These programs are operated at a variety of organizations, including all Local Addiction Authorities (LAAs) and multiple community-based organizations, healthcare providers, police and EMS agencies, state agencies and others. These organizations provide a variety of opioid response services, including naloxone training and administration. Since 2014, a total of 86,955 doses of naloxone have been dispensed by ORP sites with 52,959 doses dispensed in SFY 2017 alone. **[11]**

MDH BHA has provided over $3 million in competitive grants to LAAs for start-up and expansion of their programs since SFY 2014. Beginning in 2015, additional funding was allocated for training and naloxone distribution in local detention centers, which was expanded to eight jurisdictions in FY2017. A total of $2.7 million to expand naloxone access statewide was made available through the Governor's Office on Crime Control, the Opioid Operations Command Center and the 21st Century Cures Act grant.
Since the launch of the ORP, a total of 56,221 individuals have received training in overdose response and the administration of naloxone. Training increased significantly in the last two years with 21,973 and 23,661 individuals trained in SFY 2016 and SFY 2017 respectively.

There continue to be training and access gaps outside of the Baltimore Metro area. Many LAAs are working to address these gaps by incorporating novel naloxone training and distribution models such as street-based outreach and prioritizing peer-delivered training. In addition, naloxone is not readily available in all Maryland pharmacies. MDH BHA made changes to the State's standing order law for naloxone during the 2017 legislative session and issued an updated standing order in June of 2017. These changes expand the number of individuals who can access naloxone from a pharmacist without a prescription, which will increase demand and availability of the drug.

III-F. Policy/Legislative Initiatives

In an effort to address the opioid crisis in the State, a number of policy and legislative initiatives have been implemented, including:

Good Samaritan Laws: Maryland's Good Samaritan law became effective October 1, 2015. This law provides protection from arrest as well as prosecution for specific crimes and expands the charges from which people assisting in an emergency overdose situation are immune from arrest and prosecution, with the goal of increasing the availability and access of Naloxone.

PDMP: The Maryland PDMP was fully launched in December 2013. Legislation enacted in 2016 requires mandatory registration of all prescribers as of 7/1/17, and mandatory reporting by 7/1/18.

Naloxone: The Maryland General Assembly passed a law that went into effect on 10/1/15 that expanded public access to naloxone by allowing training entities to provide naloxone to Marylanders. A statewide standing order was later issued to all pharmacies by the Deputy Secretary of the Maryland Department of Health, and in 2017 a previous statute requiring naloxone prescription recipients to complete training was revised to remove the training requirement. These changes further increase access by allowing pharmacists to dispense naloxone to anyone upon request.

New funding: New state general funds totaling approximately $1.9 million have been allocated for SFY 2018 to specifically increase naloxone distribution.

Public regulatory agency developments and practices: New integrated community behavioral health program regulations became effective 10/1/16 that included regulatory language prohibiting exclusion or discrimination in the provision of services toward persons receiving opioid treatment services. The aim of this regulation is to eliminate the denial of services, for example residential treatment and recovery housing, to persons participating in methadone maintenance treatment.

State funding language: Standard contract language for state or Substance Abuse Block Grant funded treatment contracts includes a requirement that pharmacotherapy be offered, directly or through referral, to all patients with an opioid use disorder. In addition, conditions of treatment contract award have specified for several years that an overdose prevention plan be developed as part of the patient treatment plan for each patient with an opiate use disorder.

Public payer reimbursement practices: Medicaid reimbursement for OTPs has been recently revised to a reimbursement structure that encourages flexibility in the delivery of intensive counseling services. The previous reimbursement structure compensated providers at a bundled weekly rate for all services provided, regardless of the actual frequency or amount of services within a given week. The new structure separates the reimbursement for medication management from counseling services, so that they are separately billed. This "unbundling" is intended to encourage the provision of clinical support services.

Task forces to address the opioid crisis: In 2015 Maryland's Governor Larry Hogan created the Heroin and Opioid Emergency Task Force, chaired by Lt. Governor Boyd Rutherford. The Task Force developed 33 recommendations to aggressively combat the opioid and heroin crisis, focusing on prevention, treatment and enforcement. The Inter-Agency Heroin and Opioid Coordinating Council was created early this year, and was authorized establish the Opioid Operational Command Center (OOCC). The center is facilitating greater collaboration among state and local behavioral health, public health, human services, and public safety entities to reduce the harmful impacts of opioid addiction on Maryland communities.

Other legislation: Legislation passed in spring 2017 (Heroin and Opioid Prevention Effort and Treatment Act of 2017) expanded drug court programs for Fiscal Year 2019; requires that prescribers not registered in the PDMP be denied Controlled Dangerous Substance (CDS) registration renewal; expands local overdose fatality review team scope of review to nonfatal overdoses; requires the establishment of a walk-in crisis center; requires improvements to the statewide crisis hotline system; requires that evidence-based opioid use disorder treatment and recovery support information be provided to health care providers, individuals with opioid use disorders and their families; requires increased availability of buprenorphine providers within health care facilities; requires that co-prescribing guidelines be established for opioid reversal drugs for patients at elevated risk for overdose; requires rate increases for community providers in future years; requires hospitals to develop protocols for discharging patients who have overdosed or been diagnosed with a substance use disorder; requires the Maryland Hospital Association to conduct a study that identifies opportunities to support a comprehensive treatment continuum for individuals with substance use disorders in hospitals; and requires that insurers include an opiate antagonist that does not require pre-authorization on their formularies.

III-G. Evidence-based, Evidence-Informed and Promising Prevention Practices

Maryland recognizes that prevention efforts are a key component of a comprehensive approach for effectively addressing the opioid crisis. MDH BHA has made a significant investment in prevention and has initiated a number of statewide evidence-supported prevention efforts, including:

The Opioid Misuse Prevention Program (OMPP). This program is administered by the MDH BHA Office of Health Promotion and Prevention and utilizes the Strategic Prevention Framework (SPF) process. There are 18 jurisdictions receiving grant funding for the OMPP project. One of the 18 jurisdictions is a regional collaborative made up of five counties known as the Mid-Shore (Caroline, Dorchester, Kent, Queen Anne's, and Talbot). The only jurisdictions in Maryland not participating in the grant program are Charles and Prince George's counties. The funds are provided to strengthen and enhance local overdose prevention plans and to implement evidence-based opioid misuse prevention strategies. The purpose of this program is to reduce opioid misuse, overdoses, and overdose fatalities. Jurisdictions are required to work through the five stages of SAMHSA's Strategic Prevention Framework process (assessment, capacity, planning, implementation, and evaluation) in order to implement their evidence-based strategies.

Substance Abuse Block Grant (SABG) Prevention Set-Aside Program. Maryland provides SABG prevention grant funding to all 24 jurisdictions and four regional college Alcohol Tobacco and Other Drug (ATOD) Prevention Centers. SABG prevention funds are used for primary prevention activities for those who have not been identified as having a substance abuse problem and are used in Maryland to support evidence based prevention programs and best practices. There are currently no evidence-based primary prevention programs that specifically address opioids misuse and addiction. Instead, to assist with efforts to prevent eventual opioid misuse, Maryland provides funding to support primary prevention activities that are designed to prevent the misuse of any and all substances. This includes direct service programs that educate youth about the harms and risks of substance use while strengthening their skills in areas such as decision making, goal setting, problem solving, conflict resolution and drug refusal techniques. Direct services are also provided that strengthen family communications and bonding and parents' ability to discuss drug use issues with their children and to model appropriate anti-substance use behaviors. This grant also supports evidence-based strategies designed to change community conditions (retail and social availability of substances, low perceptions of harm and risk of drug misuse, community norms, enforcement of drug laws and policies, etc.) that contribute to and/or foster substance misuse.

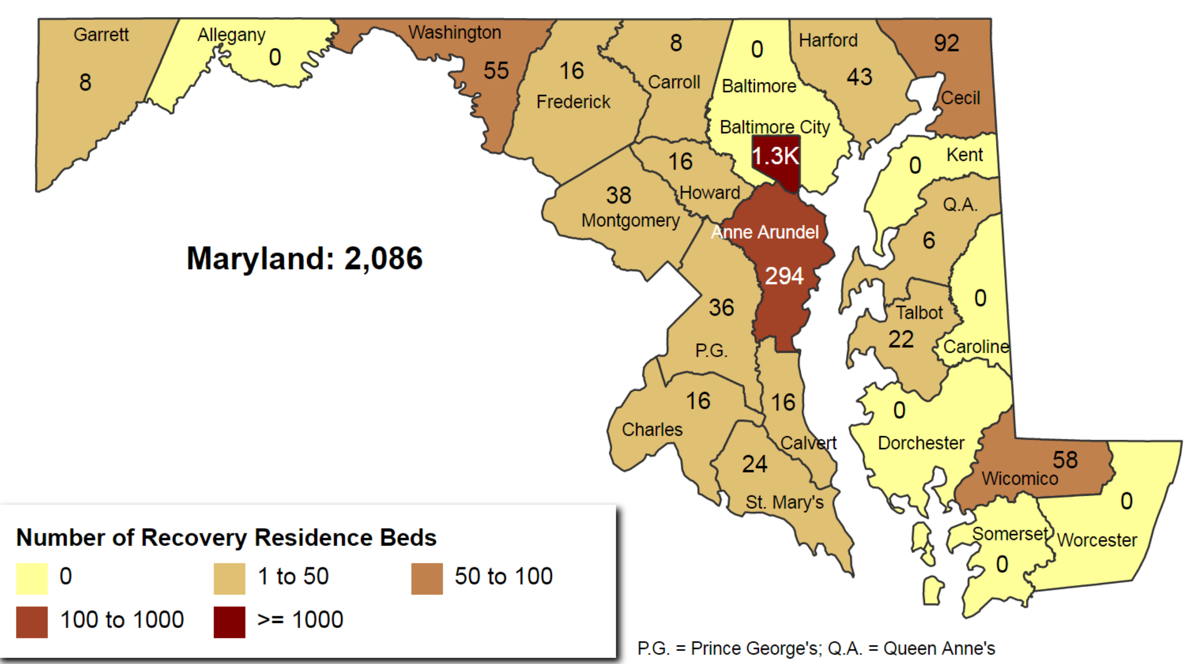
Strategic Prevention Framework (SPF) - Rx Grant. The Maryland SPF-Rx initiative has two primary goals: 1) to reduce youth and adult non-medical use of prescription drugs (NMUPD), including opioids, by providing technical assistance and training to local jurisdictions and 2) to strengthen state and local capacity to address overprescribing through the dissemination of state PDMP and State Epidemiological Outcomes Workgroup (SEOW) data to state and local prevention, intervention and treatment authorities, and to providers. Maryland is currently utilizing year one SPF-Rx funding to conduct a required state needs assessment. This assessment will determine high risk populations and geographic areas to target for the state's future NMUPD prevention efforts; the data needs of local communities and their capacity to use data for prevention planning; and the capacity of the state PDMP and SEOW to produce data in formats that state and local authorities can effectively use in their system planning and management, and for service provision within their jurisdiction. In year-2 and beyond, the SPF-RX

project will, based on this needs assessment, provide technical assistance and training to local jurisdictions to assist them to provide prescription drug misuse prevention activities and education to schools, communities, parents, prescribers and their patients.

Public Awareness and Education: Recent statewide media campaigns have focused on three subject areas and target the general public. The three areas of focus were 1) Anti – Stigma, 2) Naloxone, and 3) the Good Samaritan Law. These efforts in educating the general public around all three areas of focus were initiated through a series of PSAs that included an NFL football player talking about the stigma associated with SUDs. The PSAs aired on all of the major local stations and in select movie theaters across the state. The "Naloxone Works" campaign highlighted real Marylanders who had saved a life by administering naloxone. Photos and information appeared on transit and billboards throughout the state showing these life-savers in various settings that represented different geographical areas of the state. MDH-BHA also worked with state advocates to create an Ambassador program, which entailed family members reaching out to communities in an effort to educate them about the state's Good Samaritan law. In addition, BHA worked closely with Maryland Public Television to develop "Breaking Heroin's Grip, Road to Recovery," an hour long program that featured stories of Marylanders and highlighted Maryland's Crisis Hotline team. BHA also has a heavy presence in social media and hosted three successful Twitter storms that trended throughout the state on the three areas of focus.

III-H. Recovery Support Initiatives

Figure 8. Number of Approved Recovery Residence Beds by Maryland Jurisdiction



Notes: Map is based on Maryland State Association of Recovery Residences (M-SARR) membership data from the Maryland Recovery Connecting Committee (M-ROCC) and reflects the number of approved recovery residences, as of June 15, 2017.

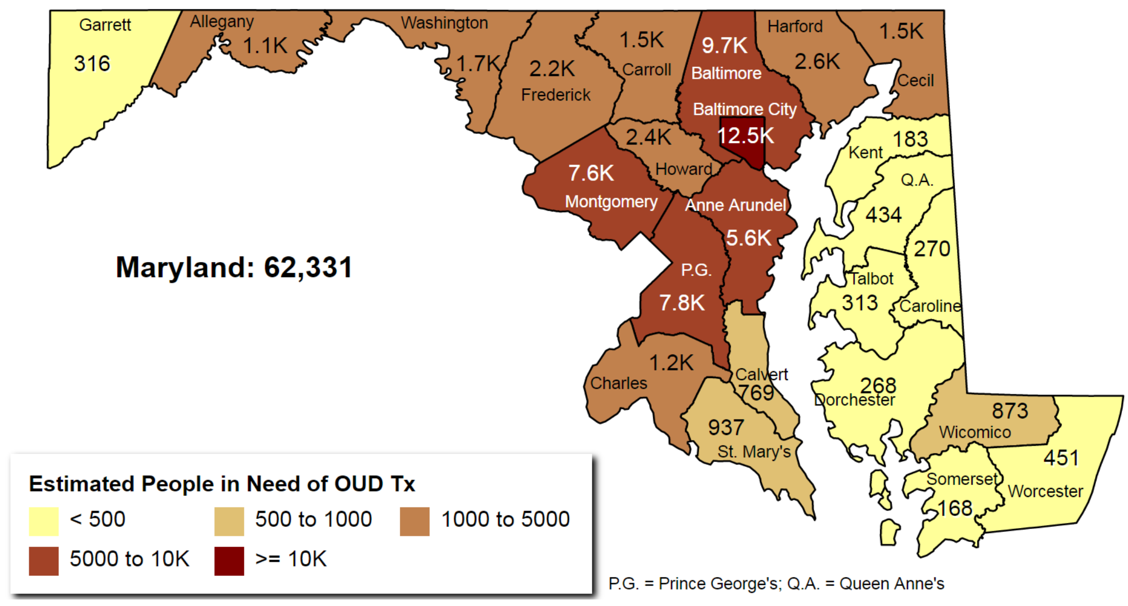
- Certified Recovery Residences are a key component of the Substance Related Disorder (SRD) treatment and recovery continuum in Maryland and support individuals and their families in their recovery and re-entering the community.

- As shown in Figure 8, there are currently 2,086 Certified Recovery Residence beds in Maryland. The majority 1,594 (76%) are located in Baltimore City (1,300) and Anne Arundel County (294).
- The 2,086 Recovery Residence beds are distributed across 213 Recovery Residence providers statewide.

Maryland has developed a robust statewide peer support and recovery network that plays an integral role in helping individuals navigate the system and supporting individual recovery. In addition to recovery housing, peer support and recovery coaching is provided in all 24 jurisdictions. Maryland also supports Recovery Community Centers (RCC). MDH BHA currently provides funding for 20 centers across the state. Recovery Community Centers are designed to be a safe haven for those in recovery to convene and where individuals interested in recovery can be linked to a number of services and supports that promote wellness and recovery, including 12-step support meetings, peer support and recovery coaching, education on health and wellness, and linking individuals to physical health, behavioral health and self-help services. Care coordinator positions are available in each jurisdiction and care coordination is available for individuals who access residential treatment services (3.3, 3.5, 3.7) utilizing BHA funds. There are 27 care coordination service providers statewide who function as system navigators linking individuals with community based recovery supports upon discharge from residential treatment. In SFY 2016, a total of 5,279 individuals received care coordination services statewide.

III-I Estimated Current Treatment Need and Capacity

Figure 9. Estimated Number of People in Need of Treatment for OUD (Age 12 or Older)



Notes: Need estimates are derived from combining three data sets, including the NSDUH data for 2012-2014 on past year alcohol or drug abuse or dependence, overdose deaths and PBHS service claims for OTP services (See section II-B, p. 4).

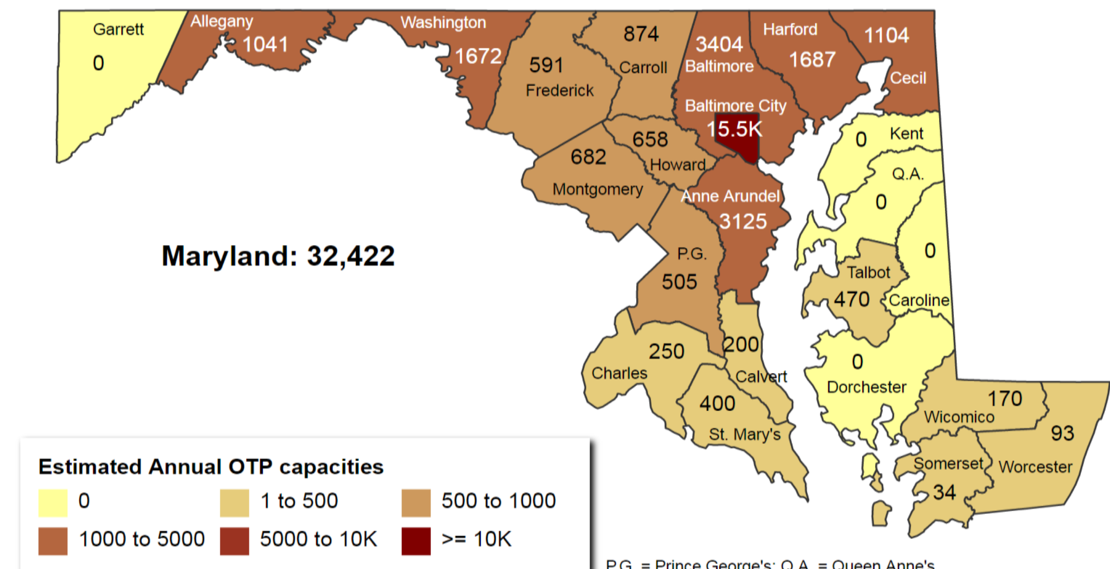
- It is estimated that between 48,198 (Restrictive) and 76,458 (Expansive) Maryland citizens age 12 and older are in need of treatment for an opioid use disorder. The midpoint of this range, 62,331 is used as the needs estimate in this assessment and represents 1.3% of the population 12 years of age or older.

- As shown in Figure 9, five jurisdictions have more than 5,000 individuals in need of OTP treatment, including Baltimore City (12,500), Baltimore County (9,686), Prince Georges County (7,792), Montgomery County (7,571), and Anne Arundel County (5,606). Together, these jurisdictions account for 69 percent (43,155) of the total number (62,331) of people estimated to be in need of OUD treatment.

While multiple data sets were used to improve the estimates of the need for opioid treatment, the methodology has a number of limitations, of note:

- NSDUH is a point-in-time survey based on a selected subpopulation of the individuals in need, including non-institutionalized individuals 12 years and older who have access to telephones that likely underestimates the actual number of people in need.
- While data from multiple data sources were used, the degree of overlap (the same individuals being counted across the data sets) could not be accurately determined. Additionally, the selected data sources used to supplement the NSDUH estimates (overdose deaths, OTP service users) do not capture the full spectrum of individuals in need of services, especially those who receive opioid related services outside of publicly funded OTP services, such as from physician based practices, hospital inpatient and emergency departments.
- Need estimates vary widely depending on the data sets selected to estimate the number of individuals in need of treatment, the estimation assumptions made, and the approach to managing the overlap between the different data sets. For instance the needs assessment conducted in Baltimore City by Behavioral Health System Baltimore used the need estimate from the Baltimore City Mayor's Heroin Task Force (HTF) report. The HTF used three publicly maintained data sets, including: Medicaid transactions; opioid treatment clinic services supported by state or federal block grant funds; and hospital inpatient and emergency department discharge transactions to supplement the NSDUH estimates **[4].**
- Using the above data sources and the HTF estimation methodology, the Behavioral Health System Baltimore, estimated that 24,887 individuals were in need of opioid treatment services in the city, nearly double the estimate in this report. Based on the method used in this assessment, it was estimated that between 6,364 and 18,644 individuals were dependent on or abusing opioids in Baltimore City. Given that this methodology underestimates the level of need, the more expansive estimate may provide a better representation of the actual need. The discrepancies between need estimates underscores the importance for the development of a more comprehensive method to assess treatment need that takes into account local area risk factors and social determinants of health.

Figure 10. Estimated Patient Capacities of Opioid Treatment Programs by Jurisdiction



Note: OTP annual capacity estimates are based on estimates derived from a survey of all OTP providers conducted in June-July 2016. See Section II C – Estimating Treatment Capacity, page 3. Total capacity is based on OTP provider estimates of their maximum treatment capacity given their current resources and staffing. Note that the Wicomico County treatment van serves Wicomico, Worchester, and Somerset counties, so while Worchester and Somerset counties have no OTPs, they end up having OTP capacity.

- OTP providers across Maryland estimated that they could treat a maximum of 32,422 with OUD at any given time. This translates to a treatment rate of 6.7 persons per 1,000 population and a statewide capacity to treat 52% of all individuals in need of treatment.
- As shown in Figure 10, OTP treatment capacity varies widely across the state with the greatest capacity occurring in three jurisdictions, including: Baltimore City (nearly 15,500), Baltimore County (3,404) and Anne Arundel County (3,125). These three jurisdiction account for more than two-thirds (68%) of the total statewide OTP capacity and have the capacity to treat 806 individuals per every 1000 people in need of OUD treatment across the three jurisdictions.
- Four jurisdictions located in the eastern part of the state (Kent County, Queen Anne County, Caroline County, and Dorchester County) and one jurisdiction (Garrett County) in the far western end of the state have no treatment capacity. These jurisdictions are less populated and have fewer individuals in need of OUD treatment. It is likely that individuals needing OTP treatment in these jurisdictions access services available in neighboring counties on the eastern shore (Talbot, Wicomico, Cecil) or in neighboring states for Garrett County.

III-J. Opioid and Substance Use Prevention, Treatment and Recovery Activities and Funding Sources

Table 1. Funding Sources for Treatment and Recovery Activities

Funding Source	Primary Activities
SAPT Block Grant	Primary Prevention emphasizing environmental strategies with all substances, Data Collection
SPF Rx Grant (strategic planning underway)	Providing PDMP data reports to local prevention entities, targeted interventions to reduce non-medical use of prescription drugs in high need areas
State Federal Funds (Opioid Misuse Prevention Program)	Local strategic plan implementation based on SPF process, primary and secondary prevention to impact opioid misuse
SBIRT Grant	Implementing SBIRT in somatic health care facilities
State General Funds	Public Awareness Activities: Ambassador Program, general campaign covering anti-stigma, Good Samaritan Law, Naloxone, Fentanyl, MAT
Harold Rogers Grant 2015	Several (2-4) Local Overdose Fatality Review Teams
SAPT Block Grant	Overdose Fatality Review TA, Overdose Response Program TA, buprenorphine provider expansion
State General Funds	PDMP, Overdose Response Program (Naloxone training and distribution), Detention Center Naloxone Pilot, Overdose Survivors Outreach Project, PDMP public awareness activities
CDC Grant	PDMP Enhancement, Prescriber Education
Harold Rogers Grant	Overdose predictive risk model
SAPT Block Grant	Peer workforce training subsidies
SAPT Block Grant	AVATAR – virtual reality patient treatment
SAPT Block Grant	Family Navigators
SAPT Block Grant	Treatment services (full continuum) for uninsured; non- MA reimbursed services for Adult Levels 3.7, 3.5, 3.3 and 3.1.
State General funds	Treatment services (full continuum) for uninsured; non- MA reimbursed services for Adult Levels 3.7, 3.5, 3.3 and 3.1.
Funding Source	**Primary Activities**
State General Funds	Buprenorphine Initiative – Physician time, medication
MAT-PDOA Grant	MAT service support for patients coming from hospital EDs and Level 3.7 induction treatment
MD- BHAY Grant	Adolescent treatment services within school settings, including training and dissemination of the evidence-based Adolescent Community Reinforcement Approach (A-CRA).
Cigarette Restitution Funds	Ambulatory Treatment Services
State General and Reimbursable Funds	Drug Court Support
MD CABHI Grant	Evidence-based treatment and recovery services to homeless individuals to support access to housing
SAPT Block Grant	Care Coordination
State General Funds	Recovery support services: recovery housing, transportation, gap services, halfway house, adolescent and adult recovery community centers, peer recovery support specialists

IV. Summary, Conclusions and Recommendations

Opioid Use and Misuse Prevention: The results of this assessment indicate that the volume of opioid and benzodiazepine prescriptions is concentrated in Maryland's five most populated jurisdictions. While opioid and benzodiazepine prescribing rates vary widely across the state, Allegany and Washington counties have particularly high prescribing rates for both medications that warrant further investigation and may benefit from targeted prevention interventions. This data supports the need for statewide media campaigns (social marketing and stigma reduction). However, interventions targeting prescribers and patients such as "Talk to Your Doctor, Talk to Your Patient" will be emphasized in those jurisdictions experiencing the highest prescribing rates. The assessment findings indicated that males were nearly three times more likely than females to die as a result of an opioid related overdose and individuals between the ages of 25 to 34 years and 45 to 54 years were also at significantly higher risk. While prevention efforts will continue to be directed toward all Maryland citizens, these finding suggest a need to examine and potentially adapt media campaigns and outreach efforts to specifically target these subpopulations.

Overdose/Overdose Death Prevention: The highest number of opioid related overdose deaths occurred in four of the five most populous jurisdictions, including Baltimore City, and Baltimore, Anne Arundel, and Prince Georges Counties. Overdose death rates varied substantially across jurisdictions with the highest rates occurring in four jurisdiction including Baltimore City and Allegany, Washington and Wicomico Counties. While additional analysis is needed, the high rates of opioid and benzodiazepine prescriptions appear to be associated with the higher rate of opioid related overdose deaths in both Allegany and Washington Counties. While overdose response and naloxone training has increased dramatically over the past couple of years, OPR training efforts have been concentrated in Baltimore City and surrounding jurisdictions. There continue to be naloxone training access gaps outside of the Baltimore Metro area. MDH BHA is working with local addiction authorities to address these gaps by incorporating novel training and distribution models such as street-based outreach and prioritizing peer-delivered training.

Treatment and Recovery Support: Based on the need estimation methodology summarized in section II-B of this report, it is estimated that between 48,198 and 76,458 Maryland citizens are in need of treatment for an opioid use disorder. Using this methodology, it was estimated that 62,331 individuals were in need of opioid treatment statewide. Five jurisdictions (Baltimore City and Baltimore, Anne Arundel, Montgomery, and Prince Georges Counties) were identified as having the highest number of people in need of treatment accounting for more than two-thirds (69%) of the statewide treatment need. In this analysis, it was estimated that Maryland's Opioid Treatment Program (OTP) currently has the capacity to treat 32,422 individuals at a given point in time representing just over one-half (52%) of the estimated need. However, this treatment capacity varied widely across the state and is concentrated in three jurisdictions in the Baltimore metro area (Baltimore City, and Baltimore and Anne Arundel Counties). These jurisdictions account for slightly over two-thirds (68%) of the statewide treatment capacity. The capacity estimates used in this report focused on the OTP providers only and did not include the OBOT providers and therefore under estimate the actual treatment capacity. Maryland has a total of 658 Data Waivered providers with the largest concentration located in Baltimore City and surrounding jurisdictions. While the number of OBOT providers and their waivered capacity is known, Maryland currently is not able to reliably determine the extent to which these providers are treating up to their authorized capacity and therefore are unable to accurately determine the additional treatment capacity provided by these providers.

As detailed in the Policy section of this report, the Maryland Department of Health has worked to remove impediments to reimbursement for OTP treatment services. These changes are expected to result in an expansion of OMT capacity across the state; therefore, the grant proposal does not reflect a request for direct expansion of OMT programs. In recognition of the important role that peers play in supporting the recovery process, Maryland proposed adding peer recovery support specialists to OMT programs, with the goal of increasing treatment retention and enhancing wellbeing and community re-integration.

The flexibility of office based buprenorphine treatment makes it an appealing alternative and adjunct to OMT programs, and the grant proposal reflects Maryland's intent to support the expansion of office based buprenorphine services through physician consultation and support using an adaptation of Maryland's Behavioral Health Integration in Pediatric Primary Care model (B-HIPP) as outlined in the M.O.R.R. Grant.

The MDH BHA recently conducted a substance related disorder needs assessment that attempted to estimate treatment need across the entire substance related services continuum of care, inclusive of both residential and outpatient services. This analysis identified a need for additional capacity in all levels of care. However, a number of treatment areas were identified as lacking sufficient capacity to address current treatment needs, including: Outpatient (Level 2), Short-Term Residential (Level 3.7), and Long-Term Residential (Levels 3.1, 3.3 and 3.5) and OMT.

Access to all levels of care in the continuum is important; however, because short-term residential care (Level 3.7) is utilized by patients with the most severe disorders and was identified by the needs assessment as having the largest gap between need and capacity, increasing capacity and immediate access to this level of care was determined to be a top priority. Additional lower intensity residential treatment and supportive living environments are a critical next step for many patients discharged from this level of care; however the needs assessment identified that the current capacity of long term residential care as meeting only 24% of the identified need. Thus, expanding Level 3.1 low intensity residential care was also identified as a priority.
The M.O.R.R. grant proposal reflects Maryland's intent to prioritize the development of crisis beds (level 3.7) and increase capacity in Level 3.1 programs.

This need assessment finding underscore the importance of data to inform and target interventions to address the opioid crisis in Maryland. For example, MDH BHA is working on a predictive risk model to identify key risk factors that contribute to opioid related overdoses and deaths to proactively identify at risk individuals and groups to more effectively target interventions and outreach efforts. Further analysis is needed using the PDMP and other epidemiological data to better understand the factors driving the high opioid and benzodiazepine prescribing rates and practices as well as the extent to which they contribute to high overdose mortality in the identified high risk jurisdictions.

End Notes:

1. Opioid Treatment Programs in Maryland, Needs Assessment Report. University of Maryland Baltimore, Unpublished Report prepared for Maryland Behavioral Health Administration, September, 2016.

2. United States Substance Abuse and Mental Health Services (SAMHSA), Results from the 2014 national survey on drug use and health; detailed tables. September 10, 2015. http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH-DetTabs2014.pdf

3. United States Census Bureau, American Community Survey. https://www.census.gov/programs-surveys/acs/.

4. McNeely, J., Gourevetch, M.N., Paone, D., Shah, S., Wright, S., and Heller, D. (2012). Estimating the prevalence of illicit opioid use in New York City using multiple data sources, BMC Public Health, 12:443.

5. Baltimore City Mayor's Heroin Treatment & Prevention Task Force Report, http://health.baltimorecity.gov/opioid-overdose/mayors-heroin-treatment-and-prevention-task-force; July 2015.

6. United States Substance Abuse and Mental Health Administration, National Survey on Drug Use and Health, National Survey on Drug Use and Health: Comparison of 2010-2012 and 2012-2014 Population Percentages (Sub-State Regions). http://www.samhsa.gov/data/sites/default/files/NSDUHsubstateChangeTabs2014/NSDUHsubstateChangeTabs2014.htm

7. The Henry J. Kaiser Family Foundation - http://www.kff.org/other/state-indicator/opioid-overdose-death-rates/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%

8. Guy,G.P., Zhang, K., Bohm, M.K., Losby, J., Lewis, B., Young, R., Murphy, L.B., Dowell, D. (July 2017). Vital Signs: opioid prescribing in the United States, 2006-2105. https://www.cdc.gov/mmwr/volumes/66/wr/mm6626a4.htm

9. Stein, B.V., Sarbaro, M., Dick, A.W., Pecura, R.L., Burns, R., & Gordon, A., (2016). Physician capacity to treat opioid use disorder with buprenorphine assisted treatment. JAMA, 316(11), p. 1211.

10. Rieckmann, T., Kovas, A. E., & Rutkowski, B. A. (2010). Adoption of Medications in Substance Abuse Treatment: Priorities and Strategies of Single State Authorities. *Journal of Psychoactive Drugs*, Suppl 6, 227–238.

11. MDH-BHA Opioid Response Program Naloxone Tracking Data System.
Opioid Treatment Programs in Maryland, Needs Assessment Report. University of Maryland Baltimore, Unpublished Report prepared for Maryland Behavioral Health Administration, September, 2016.

Federal Opiod Grants-BHA

BHA Federal Opioid Grant Awards

Award Number	Project Name	Project Period	# Yrs	Total Project Amount	Sub-Receipient	(Federal Fiscal Year) Funding 2016	(Federal Fiscal Year) Funding 2017	(Federal Fiscal Year) Funding 2018	(Federal Fiscal Year) Funding 2019	(Federal Fiscal Year) Funding 2020	Remainder	Total Funding to Receipient	Purpose for Allocating Fund
2015-PM-BX-K002	PDMP - High Risk Prescription Drug Users	10/1/15 - 9/30/18	3	$743,566.00	CRISP/The Johns Hopkins Center for Population Health Information Technology - CPHIT	408,240.00	174,053.00	139,223.00	-	-		721,516.00	Prevention/Treatment
2015-PM-BX-K002	PDMP - High Risk Prescription Drug Users	10/1/15 - 9/30/18	3		BHA Program Staff Travel/Supplies	5,690.00	8,180.00	8,180.00	-	-		22,050.00	Admin/Infrastructure
					SUBTOTAL	**413,930.00**	**182,233.00**	**147,403.00**	**-**	**-**		**743,566.00**	
2016-PM-BX-K004	Overdose Fatality Review Enhancement	10/1/16 - 9/30/19	3	$600,000.00	CRISP- Chesapeake Regional Information for our Patients	-	106,162	29,912	29,912	-		165,985.94	Prevention
2016-PM-BX-K004	Overdose Fatality Review Enhancement	10/1/16 - 9/30/19	3		University of Maryland - Evaluation	-	25,199	25,199	25,199	-		75,597.00	Evaluation
2016-PM-BX-K004	Overdose Fatality Review Enhancement	10/1/16 - 9/30/19	3		Local Overdose Fatality Review Coordinators	-	-	159,466	162,656	-		322,121.80	Treatment/Recovery
2016-PM-BX-K004	Overdose Fatality Review Enhancement	10/1/16 - 9/30/19	3		BHA Program staff- Travel/Supplies/Other	-	10,856	14,156	11,283	-		36,295.26	Admin/Infrastructure
					SUBTOTAL	**-**	**142,217.00**	**228,732.86**	**229,050.14**	**-**		**600,000.00**	
2018-PM-BX-K098	FY18 COAP Category 6 - Comprehensive Opioid Abuse Site-	10/01/18 - 09/30/21	3	$994,523.00	TBD- SUBTOTAL	-	-	-	-	-	**994,523.00**	**994,523.00**	
5H79TI081459-02	MAT-PDOA Prescription Drug and Opioid Addiction	09/30/18 - 09/29/21	3	$1,574,010.00	Anne Arundel County	-	-	-	362,654	370,304.00		732,958.00	Recovery-Family Peer Support Specialist to provide outreach engagement and wrap around services
5H79TI081459-02	MAT-PDOA Prescription Drug and Opioid Addiction	09/30/18 - 09/29/21	3		University of Maryland	-	-	-	79,634	79,634.00		159,268.00	Evaluation to conduct local performance assessement
5H79TI081459-02	MAT-PDOA Prescription Drug and Opioid Addiction	09/30/18 - 09/29/21	3		Program staff- Admin/Travel/Other	-	-	-	82,382.00	74,732.00		157,114.00	Admin/Infrastructure
5H79TI081459-02	MAT-PDOA Prescription Drug and Opioid Addiction	09/30/18 - 09/29/21	3		TBD					0.00	524,670.00	524,670.00	
					SUBTOTAL	**-**	**-**	**-**	**524,670.00**	**524,670.00**	**524,670.00**	**1,574,010.00**	
5U79SP022085-04	SPF-Rx - Strategic Targeting of Prescription Drug Misuse in Maryland Communities	9/1/16 - 8/31/21	5	$1,742,047.00	University of Maryland - Evaluation/Operation	-	315,692.78	321,472.00	285,636.00	83,000.00		1,005,800.78	Evaluation/Operation
5U79SP022085-04	SPF-Rx - Strategic Targeting of Prescription Drug Misuse in Maryland Communities	9/1/16 - 8/31/21	5		LHD (AA, Balto Co, Calvert, Frederick, Howard, St Mary's, Somerset, Washington, Wicomico)	-	-	-	0.00	78,470.00		78,470.00	Prevention/Treatment
5U79SP022085-04	SPF-Rx - Strategic Targeting of Prescription Drug Misuse in Maryland Communities	9/1/16 - 8/31/21	5		BHA - Admin/Travel/Other	-	19,645.22	18,277.00	75,406.00	-		113,328.22	Admin/Infrastructure
5U79SP022085-04	SPF-Rx - Strategic Targeting of Prescription Drug Misuse in Maryland Communities	9/1/16 - 8/31/21	5		TBD						544,448.00	544,448.00	
					SUBTOTAL	**-**	**335,338.00**	**339,749.00**	**361,042.00**	**161,470.00**	**544,448.00**	**1,742,047.00**	
6 NU17CE002723-03-01	CDC - Maryland Prescription Drug Overdose Prevention for States	3/1/16 - 8/31/19	3	$5,953,195.00	BHA Program staff- Admin/Travel/Other	-	30,168.01	100,706.00	245,941.00	-		376,815.01	Admin/Infrastructure

Federal Opiod Grants-BHA

Award Number	Project Name	Project Period	# Yrs	Total Project Amount	Sub-Receipient	(Federal Fiscal Year) Funding 2016	(Federal Fiscal Year) Funding 2017	(Federal Fiscal Year) Funding 2018	(Federal Fiscal Year) Funding 2019	(Federal Fiscal Year) Funding 2020	Remainder	Total Funding to Receipient	Purpose for Allocating Fund
6 NU17CE002723-03-01	CDC - Maryland Prescription Drug Overdose Prevention for States	3/1/16 - 8/31/19	3		UMB, School of Pharmacy SoP & PHSR	-	-	102,775.00	166,845.00	-		269,620.00	Evaluation of PFS-funded pharmacy naloxone outreach
6 NU17CE002723-03-01	CDC - Maryland Prescription Drug Overdose Prevention for States	3/1/16 - 8/31/19	3		UMB System Evaluation Center ("SEC")	-	-	145,262.00	134,293.00	-		279,555.00	Evaluation
6 NU17CE002723-03-01	CDC - Maryland Prescription Drug Overdose Prevention for States	3/1/16 - 8/31/19	3		UMB School of Pharmacy SoP (DiPaula)	-	-	196,986.00	337,059.00	-		534,045.00	Prevention
6 NU17CE002723-03-01	CDC - Maryland Prescription Drug Overdose Prevention for States	3/1/16 - 8/31/19	3		University of Maryland Baltimore County - MIPAR	-	106,164.57	165,009.00		-		271,173.57	Contractual staff to implement program
6 NU17CE002723-03-01	CDC - Maryland Prescription Drug Overdose Prevention for States	3/1/16 - 8/31/19	3		UMB School of Phamacy ("SoP PRC")	-	-	163,869.00		-		163,869.00	Prevention
6 NU17CE002723-03-01	CDC - Maryland Prescription Drug Overdose Prevention for States	3/1/16 - 8/31/19	3		MD Poison Center	-	-	199,976.00	211,969.00	-		411,945.00	Treatment/Recovery
6 NU17CE002723-03-01	CDC - Maryland Prescription Drug Overdose Prevention for States	3/1/16 - 8/31/19	3		Maryland Public Television (MPT) Public Awareness	-	-	200,000.00		-		200,000.00	Prevention- Public Awareness
6 NU17CE002723-03-01	CDC - Maryland Prescription Drug Overdose Prevention for States	3/1/16 - 8/31/19	3		CRISP/Medchi	-	124,612.42	1,225,285.00	1,347,735.00	-		2,697,632.42	Prevention
6 NU17CE002723-03-01	CDC - Maryland Prescription Drug Overdose Prevention for States	3/1/16 - 8/31/19	3		Anne Arundel Co & Mosaic Group - Overdose Survivor's Outreach	-	-	241,946.00	151,397.00	-		393,343.00	Treatment/Recovery
6 NU17CE002723-03-01	CDC - Maryland Prescription Drug Overdose Prevention for States	3/1/16 - 8/31/19	3		Fredrick Co - Overdose Survivor's Outreach	-	-	90,000.00	54,202.00	-		144,202.00	Treatment/Recovery
6 NU17CE002723-03-01	CDC - Maryland Prescription Drug Overdose Prevention for States	3/1/16 - 8/31/19	3		Worcester Co - Overdose Survivor's Outreach	-	-	90,000.00	120,995.00	-		210,995.00	Treatment/Recovery
					SUBTOTAL	**-**	**260,945.00**	**2,921,814.00**	**2,770,436.00**	**-**	**-**	**5,953,195.00**	
1H79TI080252	MORR - Maryland Opioid Rapid Response "STR"	5/1/2017 - 4/30/2019	2	**$20,073,627.00**	Allegany County Health Department	-	-	598,703.00	385,840.00	-		984,543.00	Treatment-Residential Asam level 3.1 care
1H79TI080252	MORR - Maryland Opioid Rapid Response "STR"	5/1/2017 - 4/30/2019	2		Anne Arundel County Dept. of Health	-	-	399,228.76	2,317,885.00	-		2,717,113.76	Treatment/Recovery-Crisis Services, Peer support Services and Asam levels of care
1H79TI080252	MORR - Maryland Opioid Rapid Response "STR"	5/1/2017 - 4/30/2019	2		BHSB -Behavioral Health Systems Baltimore	-	-	1,158,157.18	4,608,282.00	-		5,766,439.18	Prevention/Treatment/Recovery-Harm Reduction, Crisis Services, Overdose Education and Naloxone
1H79TI080252	MORR - Maryland Opioid Rapid Response "STR"	5/1/2017 - 4/30/2019	2		Baltimore City Health Department	-	-	406,477.00	0.00	-		406,477.00	Prevention-Naloxone
1H79TI080252	MORR - Maryland Opioid Rapid Response "STR"	5/1/2017 - 4/30/2019	2		Baltimore County Health Department	-	-	70,304.00	70,304.00	-		140,608.00	Prevention-Overdose Education and Naloxone
1H79TI080252	MORR - Maryland Opioid Rapid Response "STR"	5/1/2017 - 4/30/2019	2		UMB-MD BHIPP - Buprenorphine	-	-	442,709.00	537,937.00	-		980,646.00	Treatment/Recovery
1H79TI080252	MORR - Maryland Opioid Rapid Response "STR"	5/1/2017 - 4/30/2019	2		Calvert Co Health Department	-	-	216,902.00	221,256.00	-		438,158.00	Prevention/Recovery-Peer Services and Naloxone
1H79TI080252	MORR - Maryland Opioid Rapid Response "STR"	5/1/2017 - 4/30/2019	2		Caroline Co Health Department	-	-	49,335.00	49,355.00	-		98,690.00	Prevention-Naloxone
1H79TI080252	MORR - Maryland Opioid Rapid Response "STR"	5/1/2017 - 4/30/2019	2		Cecil Co Health Department	-	-	93,906.00	91,836.00	-		185,742.00	Prevention-Naloxone
1H79TI080252	MORR - Maryland Opioid Rapid Response "STR"	5/1/2017 - 4/30/2019	2		Frederick County Dept. of Health	-	-	181,734.00	168,915.00	-		350,649.00	Treatment-Residential Asam Level 3.1 expansion services

Award Number	Project Name	Project Period	# Yrs	Total Project Amount	Sub-Receipient	(Federal Fiscal Year) Funding 2016	(Federal Fiscal Year) Funding 2017	(Federal Fiscal Year) Funding 2018	(Federal Fiscal Year) Funding 2019	(Federal Fiscal Year) Funding 2020	Remainder	Total Funding to Receipient	Purpose for Allocating Fund
1H79TI080252	MORR - Maryland Opioid Rapid Response "STR"	5/1/2017 - 4/30/2019	2		Harford Co Health Department	-	-	215,519.00	185,145.00	-		400,664.00	Prevention-Naloxone
1H79TI080252	MORR - Maryland Opioid Rapid Response "STR"	5/1/2017 - 4/30/2019	2		Howard County Department of Health	-	-	33,709.00	33,709.00	-		67,418.00	Prevention-Overdose Education and Naloxone
1H79TI080252	MORR - Maryland Opioid Rapid Response "STR"	5/1/2017 - 4/30/2019	2		Kent Co. H.D.	-	-	37,500.00	22,500.00	-		60,000.00	Prevention-Overdose Education and Naloxone
1H79TI080252	MORR - Maryland Opioid Rapid Response "STR"	5/1/2017 - 4/30/2019	2		Mid Shore Behavioral Health	-	-	297,063.00	453,649.00	-		750,712.00	Treatment/Recovery
1H79TI080252	MORR - Maryland Opioid Rapid Response "STR"	5/1/2017 - 4/30/2019	2		Prince George's	-	-	50,128.00	50,128.00	-		100,256.00	Prevention-Overdose Education and Naloxone
1H79TI080252	MORR - Maryland Opioid Rapid Response "STR"	5/1/2017 - 4/30/2019	2		Talbot Co H.D	-	-	38,150.00	22,956.00	-		61,106.00	Prevention-Overdose Education and Naloxone
1H79TI080252	MORR - Maryland Opioid Rapid Response "STR"	5/1/2017 - 4/30/2019	2		Washington Co Health Department	-	-	170,500.00	150,000.00	-		320,500.00	Prevention-Overdose Education and Naloxone
1H79TI080252	MORR - Maryland Opioid Rapid Response "STR"	5/1/2017 - 4/30/2019	2		Wicomico County Health Department	-	-	74,865.00	74,865.00	-		149,730.00	Prevention-Overdose Education and Naloxone
1H79TI080252	MORR - Maryland Opioid Rapid Response "STR"	5/1/2017 - 4/30/2019	2		Worcester Co Health Department	-	-	175,544.00	156,325.00	-		331,869.00	Prevention/Treatment-Overdose Education and Naloxone, and Expansion of Residential 3.1 Asam level of care
1H79TI080252	MORR - Maryland Opioid Rapid Response "STR"	5/1/2017 - 4/30/2019	2		Maryland Public Television	-	-	855,873.00	725,000.00	-		1,580,873.00	Prevention-Public Awareness
1H79TI080252	MORR - Maryland Opioid Rapid Response "STR"	5/1/2017 - 4/30/2019	2		University of Baltimore	-	-	120,000.00	135,000.00	-		255,000.00	Evaluation-Talk to your Doctor campaign
1H79TI080252	MORR - Maryland Opioid Rapid Response "STR"	5/1/2017 - 4/30/2019	2		Vector Media Holding Corp	-	-		48,965.00	-		48,965.00	Public Awareness Media Campaign
1H79TI080252	MORR - Maryland Opioid Rapid Response "STR"	5/1/2017 - 4/30/2019	2		SCREENVISION	-	-	16,094.00	81,286.00	-		97,380.00	Prevention-Media Campaign
1H79TI080252	MORR - Maryland Opioid Rapid Response "STR"	5/1/2017 - 4/30/2019	2		UMB - National Cinemedia LLC	-	-		81,666.00	-		81,666.00	Prevention-Media Campaign
1H79TI080252	MORR - Maryland Opioid Rapid Response "STR"	5/1/2017 - 4/30/2019	2		BHSB - Harm Reduction Outreach Teams	-	-	706,964.00	706,964.00	-		1,413,928.00	Prevention/Treatment-Harm Reduction, Crisis Services, Overdose Education and Naloxone
1H79TI080252	MORR - Maryland Opioid Rapid Response "STR"	5/1/2017 - 4/30/2019	2		UMB - SAP (Student Assistance Program)	-	-	200,000.00	347,000.00	-		547,000.00	Prevention
1H79TI080252	MORR - Maryland Opioid Rapid Response "STR"	5/1/2017 - 4/30/2019	2		University of Maryland-System Evaluation Center	-	-	0.00	51,000.00	-		51,000.00	Prevention-Evaluation-Data and Quality Improvement
1H79TI080252	MORR - Maryland Opioid Rapid Response "STR"	5/1/2017 - 4/30/2019	2		BHA Program Staff - Admin/Travel/Other Infrastructure	-	-	44,269.21	162,534.00	-		206,803.21	Admin
`	MORR - Maryland Opioid Rapid Response "STR"	5/1/2017 - 4/30/2019	2		TBD			0.00	1,479,690.85			1,479,690.85	Prevention - Naloxone
					SUBTOTAL	-	-	**6,653,634.15**	**13,419,992.85**	-	-	**20,073,627.00**	
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2	**$83,653,244.00**	Allegany Co Health Department	-	-	-	111,255.00			111,255.00	Treatment/Recovery- Crisis Beds
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Anne Arundel Co Mental Health Agency, Inc.	-	-	-	995,101.00			995,101.00	Treatment/Recovery- Safe Stations
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Anne Arundel County Department of Health	-	-	-	1,545,581.00			1,545,581.00	Treatment/Recovery-Crisis Stabilization Centers, Crisis Beds, Recovery Houses, and Harm Reduction
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Behavioral Health System Baltimore, Inc.	-	-	-	1,376,373.00			1,376,373.00	Treatment/Recovery- Crisis Walk in Centers, Crisis Beds, and Harm Reduction

Award Number	Project Name	Project Period	# Yrs	Total Project Amount	Sub-Receipient	(Federal Fiscal Year) Funding 2016	(Federal Fiscal Year) Funding 2017	(Federal Fiscal Year) Funding 2018	(Federal Fiscal Year) Funding 2019	(Federal Fiscal Year) Funding 2020	Remainder	Total Funding to Receipient	Purpose for Allocating Fund
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Baltimore Co Department of Health	-	-	-	930,232.00			930,232.00	Treatment/Recovery- Criminal Justice population reentry
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Calvert Co Health Department	-	-	-	1,782,259.00			1,782,259.00	Treatment/Recovery- Crisis Stabilization Center, Recovery Houses, and Criminal justice reentry
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Caroline Co Health Department	-	-	-	378,073.00			378,073.00	Treatment/Recovery
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Carroll Co Health Department	-	-	-	1,401,177.00			1,401,177.00	Treatment/Recovery- Crisis Stabilization Center and Crisis Beds
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Cecil Co Health Department	-	-	-	514,295.00			514,295.00	Treatment/Recovery- Crisis Stabilization Center and Criminal justice population reentry
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Frederick Co H.D	-	-	-	97,768.00			97,768.00	Treatment/Recovery- Recovery Houses
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Harford Co Health Department	-	-	-	735,186.00			735,186.00	Treatment/Recovery-Crisis Stabilization Center
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Howard County Department of Health	-	-	-	1,192,423.00			1,192,423.00	Treatment/Recovery-Crisis Stabilization Center, Recovery Houses and Criminal Justice population reentry
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Kent Co. H.D.	-	-	-	96,906.00			96,906.00	Treatment/Recovery- Recovery Houses
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Mid Shore Behavioral Health, Inc.	-	-	-	2,070,410.00			2,070,410.00	Treatment/Recovery- Crisis Beds, Safe Stations, and Recovery Houses
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Montgomery County Health Department	-	-	-	97,768.00			97,768.00	Treatment/Recovery- Recovery Houses
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		PG Co Health Department	-	-	-	176,000.00			176,000.00	Treatment/Recovery- Criminal Justice population reentry
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Queen Anne's Co Health Department	-	-	-	3,995.00			3,995.00	Treatment/Recovery-Criminal Justice population reentry
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Somerset County Health Department	-	-	-	0.00			-	Treatment/Recovery
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		St. Mary's Co Health Department	-	-	-	110,968.00			110,968.00	Treatment/Recovery-Criminal Justice population reentry and Recovery Houses
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Talbot Co H.D	-	-	-	183,920.00			183,920.00	Treatment/Recovery-Recovery Houses
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Washington Co Health Department	-	-	-	1,242,400.00			1,242,400.00	Treatment/Recovery-Crisis stabilization Center
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Worcester Co Health Department	-	-	-	98,613.00			98,613.00	Treatment/Recovery-Safe Stations and Recovery Houses
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		SBIRT - MOSAIC	-	-	-	3,680,750.00			3,680,750.00	Treatment/Recovery-SBIRT activities in Primary Care Network Practices, K-12 Schools, Colleges and Counseling Centers
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		University of Maryland Baltimore-/BHIPP	-	-	-	280,000.00			280,000.00	Treatment/Recovery- Expansion of Consulation and Technical Assistance for Health Care Providers
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Sign Language Interpreter (DASAM)	-	-	-	111,000.00			111,000.00	Treatment/Recovery

Federal Opiod Grants-BHA

Award Number	Project Name	Project Period	# Yrs	Total Project Amount	Sub-Receipient	(Federal Fiscal Year) Funding 2016	(Federal Fiscal Year) Funding 2017	(Federal Fiscal Year) Funding 2018	(Federal Fiscal Year) Funding 2019	(Federal Fiscal Year) Funding 2020	Remainder	Total Funding to Receipient	Purpose for Allocating Fund
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Behavioral Health System Baltimore, Inc.	-	-	-	142,730.00			142,730.00	Treatment/Recovery-Medical Patient Engagement
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		University of Maryland	-	-	-				-	Treatment/Recovery-Workforce Development MAT Training
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Adolescent Community Reinforcement Approach (A-CRA)	-	-	-	120,938.00			120,938.00	Treatment/Recovery
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Harm Reduction Grants- 18 jurisdictions and Non profits	-	-	-	1,235,607.61			1,235,607.61	Prevention- Harm Reduction
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Local Health Departments and Non profits	-	-	-	2,545,582.89			2,545,582.89	Prevention- Naloxone
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Start Talking Teacher Training (MSDE)	-	-	-	87,844.00			87,844.00	Prevention
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		University of Maryland- School Of Medicine	-	-	-	145,611.00			145,611.00	Prevention- Student Assistance Program
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Public Service Network, LLC	-	-	-	348,905.00			348,905.00	Prevention- Public Awareness
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Maryland Public Television (MPT)	-	-	-	2,096,000.00			2,096,000.00	Prevention-Media Campaign expansion
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Vector Media	-	-	-	69,850.00			69,850.00	Prevention- Public Awareness
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Maryland Higher Education Commission (MHEC)	-	-	-	200,000.00			200,000.00	Prevention-Public Awareness
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Department of Public Safety & Correctional Services	-	-	-				-	Treatment/Recovery- Criminal Justice population reentry
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Grants to 14 Local Detention Centers- TBD	-	-	-				-	Treatment/Recovery- Criminal Justice population reentry
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Care Coordination Grants - LHDs - Kent, Frederick, and Baltimore City	-	-	-	22,430.00			22,430.00	Treatment/Recovery
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Grants to Nonprofits and Faith-based Orgranizations (LHD)	-	-	-	-	-		-	Treatment/Recovery
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		Assistance (18 non-profit & training; project	-	-	-	-	-		-	Treatment/Recovery
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		University of Maryland Baltimore - **Grant Evaluation**	-	-	-	640,971.00			640,971.00	Evaluation
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		BHA - Admin/Travel/Other Infrastructure	-	-	-	1,102,372.00			1,102,372.00	Admin/Infrastructure
5H79TI081721	MD-SOR/SUPPLEMENTAL - State of Maryland Opioid Response	09/30/18 - 09/29/20	2		TBD						55,681,949.50	55,681,949.50	
					SUBTOTAL	-	-	-	**27,971,294.50**	-	**55,681,949.50**	**83,653,244.00**	
1 NU90TP921986	CDC COAG - Public Health Crisis Response	09/01/18 - 08/31/19	1	$825,672.00	Behavioral Health System Baltimore	-	-		192,249.00	-	$633,423.00	192,249.00	Prevention - Harm Reduction (only a portion belongs to BHA rest is PH)
					SUBTOTAL				**192,249.00**		**$633,423.00**	**192,249.00**	
					TOTAL	**413,930.00**	**920,733.00**	**10,291,333.01**	**45,468,734.49**	**686,140.00**	**58,379,013.50**	**115,526,461.00**	

Maryland Department of Health
Larry Hogan, Governor – Boyd Rutherford, Lt. Governor – Robert R. Neall, Secretary

May 2019

Unintentional Drug- and Alcohol-Related Intoxication Deaths in Maryland, 2018

Number of deaths

3000
2500
2000
1500
1000
500
0

815 694 731 649 671 799 858 1041 1259 2089 2282 2406

2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018

Total Opioid-related Not Opioid-related

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METHODS

Introduction

The purpose of this report is to describe trends in the number of unintentional drug- and alcohol-related intoxication deaths occurring in Maryland during the period 2007-2018. Trends are examined by age at time of death, race/ethnicity, gender, place of death, and substances related to death.

This report was prepared using drug and alcohol intoxication data housed in a registry developed and maintained by the Vital Statistics Administration (VSA) of the Maryland Department of Health (MDH). The methodology for reporting on drug-related intoxication deaths in Maryland was developed by VSA with assistance from the MDH Behavioral Health Administration, the Office of the Chief Medical Examiner (OCME) and the Maryland Poison Control Center. Assistance was also provided by authors of a Baltimore City Health Department report on intoxication deaths.[1]

Sources of data

The data included in this report were obtained mainly from the OCME. Maryland law requires the 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, review of 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 drug or alcohol intoxication.

A small number of death records involving intoxication deaths were filed by sources other than OCME and were identified through death records maintained by VSA. This included records filed by medical facilities rather than OCME, and records filed by federal investigators following deaths involving U.S. military personnel. Information available on these cases was included in the registry.

Information on place of death and race/ethnicity was missing for a small number of records provided by OCME and was obtained through death certificate data. Death certificate data were also used to update demographic information on records that were amended after the records were filed with the Division of Vital Records.

[1] 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 drug-related intoxication deaths

For the purpose of this report, an intoxication death was defined as a death that was the result of recent ingestion or exposure to alcohol or another type of drug, including heroin, fentanyl, cocaine, prescription opioids, benzodiazepines, phencyclidine (PCP), methamphetamines, and other prescribed and unprescribed drugs. OCME provided all records to VSA for which the text of the cause of death included one or more of the following terms: poisoning, intoxication, toxicity, inhalation, ingestion, overdose, exposure, chemical, effects, or use. Any records provided by OCME that were not unintentional drug-related intoxication deaths, such as deaths due to smoke inhalation, carbon monoxide intoxication, cold exposure, and chronic use of alcohol or other drugs, were excluded in the registry. Also excluded from the registry were deaths for which the manner of death was determined to be natural, suicide, or homicide.

Analyses

Trends in the number of unintentional drug- and alcohol-related intoxication deaths occurring in Maryland during the years 2007-2018 were analyzed by age group, race/ethnicity, gender, place of occurrence of death, and substances related to the death. Changes over time were examined for deaths related to the following substances:

1. Opioids
    a. Heroin
    b. Prescription opioids
    c. Fentanyl (prescribed and illicit)
2. Cocaine
3. Benzodiazepines and related drugs
4. Methamphetamine
5. Alcohol

The number of deaths by place of occurrence was computed by jurisdiction and by region, categorized as follows:

Northwest Area	Baltimore Metro Area	National Capital Area	Southern Area	Eastern Shore Area
Garrett Co. Allegany Co. Washington Co. Frederick Co.	Baltimore City Baltimore Co. Anne Arundel Co. Carroll Co. Howard Co. Harford Co.	Montgomery Co. Prince George's Co.	Calvert Co. Charles Co. St. Mary's Co.	Cecil Co. Kent Co. Queen Anne's Co. Caroline Co. Talbot Co. Dorchester Co. Wicomico Co. Somerset Co. Worcester Co.

Trends in deaths for the period 2007-2018 are shown in Figures 1 through 38. Data on intoxication deaths related to a combination of substances are shown in Figures 39

through 45. Counts of the number of total deaths and deaths related to classes of substances or specific substances by place of occurrence are shown in Tables 1 through 11.

Age-adjusted death rates

Age-adjusted death rates by place of residence are shown in Figure 46. Age-adjusted death rates were calculated in order to allow for the comparison of drug death rates among Maryland jurisdictions. Unlike all other data included in this report, these rates are based on place of residence of the decedent rather than place where the drug-related incident occurred. Since out of state data are generally not available until approximately six months after the close of a calendar year, only data through 2017 were available at the time this report was prepared. Therefore, age-adjusted rates cover the period 2013 through 2017. Since the number of drug deaths is relatively small in many Maryland jurisdictions, it was necessary to calculate rates for a five year period in order to obtain counts that were large enough to be used to calculate stable rates.

Drug death information received from other states is far less detailed than the data available from OCME and often does not include information on the substances involved in a death. For that reason, rates could only be calculated for total deaths and not deaths related to individual substances.

Since an intoxication death may involve more than one substance, counts of deaths related to specific substances do not sum to the total number of deaths in this report.

Opioid-related deaths

Opioids include heroin and prescription opioid drugs such as oxycodone, hydrocodone, hydromorphone, methadone, tramadol and codeine, and prescribed and illicit fentanyl. In this report, an opioid was considered to be associated with a death if a specific opioid drug was indicated in the cause of death. If the cause of death did not identify a specific drug (e.g., the cause of death indicated "Narcotic Intoxication"), OCME toxicology results were reviewed to determine whether the presence of any opioid drug was detected. If so, the cause of death was considered to be opioid-related, regardless of the level of the drug. Scene investigation notes were also reviewed in an attempt to better categorize death records with non-specific causes of death.

Since heroin is rapidly metabolized into morphine, the records of many deaths that are likely to be heroin-related do not list "heroin" as a cause of death, and therefore cannot be identified using only information listed in the cause of death. Therefore, a combination of information contained in the cause of death field, toxicology results, and scene investigation notes is used to identify heroin-related deaths. In this report, a death was considered to be heroin-related if:

1. “Heroin” was mentioned in the cause of death; or
2. The toxicology screen showed a positive result for 6-monacetylmorphine; or
3. The toxicology screen showed positive results for both morphine and quinine; or
4. The cause of death was nonspecific and the scene investigation notes indicated that heroin was likely to have been involved in the death; or
5. The death was associated with morphine through either cause of death information or toxicology results, unless information contained in the investigation notes did not support this assumption.

A record was not coded as heroin-related, despite the presence of morphine, if OCME determined that another substance caused the death.

Prescription opioid-related deaths were defined as deaths that involve one or more prescription opioids, as identified through cause of death information when a specific drug was indicated and through toxicology results when the cause of death was nonspecific. Prescription opioids include buprenorphine, codeine, hydrocodone, hydromorphone, meperidine, methadone, morphine, oxycodone, pentazocine, propoxyphene, tramadol and prescribed fentanyl. Prescribed fentanyl is an opioid analgesic approved for patient use to manage severe or chronic pain. There is also a form of fentanyl that is produced illicitly in clandestine laboratories and mixed with (or substituted for) heroin or other illicit drugs. Although in some cases it was difficult to determine whether a prescribed or illicit form of fentanyl was related to a death, the count of prescription opioid-related drugs in this report includes only fentanyl deaths in which a prescription form of the drug was clearly involved.

Fentanyl-related deaths began increasing in late 2013 as a result of overdoses involving nonpharmaceutical fentanyl, that is, nonprescription fentanyl produced in clandestine laboratories and mixed with, or substituted for, heroin or other illicit substances. Nearly all fentanyl-related deaths occurring in recent years have involved the use of nonpharmaceutical fentanyl. Fentanyl is many times more potent than heroin, and greatly increases the risk of an overdose death. Carfentanil, an extremely potent analog of fentanyl, was first detected in Maryland drug intoxication death cases in 2017, and is reported separately in Figures 21 and 22.

Benzodiazepine-related deaths

Benzodiazepines are a class of depressants that include drugs such as alprazolam, clonazepam, diazepam, and multiple related drugs. The category of benzodiazepine-related drugs in this report includes both benzodiazepines and related drugs, such as zolpidem, which have similar sedative effects.

Cocaine-related deaths

Cocaine is a highly addictive stimulant drug derived from coca leaves. It is frequently mixed with other non-psychoactive substances, such as cornstarch or talcum powder, to dilute its potency, however in the last few years, it has been mixed with fentanyl.

Methamphetamine-related deaths

Methamphetamine is another highly addictive stimulant drug. Illicit forms of methamphetamine have also been found to be mixed with fentanyl or other opioids.

SUMMARY OF TRENDS IN DRUG INTOXICATION DEATHS—2007 TO 2018

Total alcohol and drug intoxication deaths

- The number of drug- and alcohol-related intoxication deaths occurring in Maryland increased in 2018 for the eighth year in a row, reaching an all-time high of 2,406 deaths. This represented a 5% increase over the number of deaths (2,282) in 2017. However, this increase was less than the 9% increase between 2016 and 2017, and substantially less than the 66% increase that occurred between 2015 and 2016, which was the largest single year increase that has been recorded.
- Between the years 2011 through 2016, intoxication deaths increased among all age groups, and were highest among those aged 45-54 years old. In 2017, deaths in this age group were surpassed by those aged 25-34 years old. The number of deaths among those aged <25 years decreased in 2017. In 2018, deaths continued to decrease among those <25 years, and also decreased among those 25-34 years. Deaths increased in the older age groups in 2018, and were highest among those 55 years and older.
- The number of deaths decreased by 2% among Whites, but continued to increase among Blacks (20%), and among Hispanics (14%) between 2017 and 2018.
- Deaths decreased by 2% among women between 2017 and 2018, but continued to increase among men (9%). Intoxication deaths were 2.8 times higher among men than women.
- Although there continued to be substantial increases in the number of deaths occurring in many jurisdictions of the state: Baltimore City, Baltimore County, Anne Arundel, Washington, Carroll, Queen Anne's, and Somerset Counties, there were more counties that had declines in the number of deaths in 2018 compared to 2017; Garrett, Howard, Montgomery, Prince George's, Calvert, Charles, St. Mary's, Kent, Caroline, Talbot, Dorchester, and Worcester.

Opioid-related deaths

- Eighty-nine percent of all intoxication deaths that occurred in Maryland in 2018 were **opioid**-related. **Opioid**-related deaths include deaths related to **heroin**, **prescription opioids**, and nonpharmaceutical **fentanyl**.
- The number of **opioid**-related deaths increased by 7% between 2017 and 2018, slightly less than the 8% increase between 2016 and 2017. Non opioid-related drug deaths decreased for the first time since 2013.
- Large increases in the number of **fentanyl**-related deaths continued to drive the overall rise in opioid-related deaths. Between 2017 and 2018 the number of **fentanyl**-related deaths increased by 18% (from 1594 to 1888). The number of **heroin**-related deaths declined by 11% between 2016 and 2017 (from 1212 to 1078) and continued to decline in 2018 by 23% to 830 deaths. The number of **prescription opioid**-related deaths decreased by 8% between 2017 and 2018 (from 413 to 379); 65% of these deaths occurred in combination with heroin and/or fentanyl.
- **Heroin**-related deaths continued to decrease in 2018 among all age groups, and among both sexes, as they did in 2017. **Heroin**-related deaths also declined among non-Hispanic Whites and Non-Hispanic Blacks in 2018, but rose slightly among Hispanics.

In 2018, **heroin** deaths declined in 16 jurisdictions, remained the same in 2 counties, and increased in 6 jurisdictions.

- Eighty-seven percent of **heroin**-related deaths in 2018 occurred in combination with **fentanyl,** 39% in combination with **cocaine**, 15% in combination with **prescription opioids**, and 13% in combination with **alcohol**.
- The number of **prescription opioid**-related deaths had been rising since 2013, but declined slightly in 2017 and declined again in 2018. The number of **prescription opioid**-related deaths declined among all age groups except among those 55 years and older, which increased by 22% between 2017 and 2018. Deaths decreased among non-Hispanic Whites and Hispanics, but increased by 14% among non-Hispanic Blacks. Deaths related to **prescription opioids** were stable among men, but decreased by 20% among women in 2018.
- **Fentanyl**-related deaths have increased rapidly since 2013, but the 18% increase between 2017 and 2018 was diminished compared with the dramatic increases between 2015 and 2016 (229%) and between 2016 and 2017 (42%).
- In 2018, **Fentanyl**-related deaths continued to increase among all age groups except those under 25 years. **Fentanyl**-related deaths increased among non-Hispanic Whites, non-Hispanic Blacks, and Hispanics and among both men and women. In 2018, **fentanyl** deaths increased in 12 jurisdictions, declined in 9 counties, and remained the same in 3 counties.
- Thirty-nine percent of **fentanyl**-related deaths in 2018 occurred in combination with cocaine, 38% in combination with **heroin**, and 18% in combination with **alcohol**.
- Deaths related to **carfentanil** (a **fentanyl** analog) were first identified in 2017 (testing began in 2016). There were 60 **carfentanil**-related deaths in 2017, however this number dropped to 2 in 2018.

Cocaine-related deaths

- The number of **cocaine**-related deaths remained relatively stable between 2008 and 2013, and began rising in 2014. The number of **cocaine**-related deaths increased 110% between 2015 and 2016, increased 49% between 2016 and 2017, and increased by 29% between 2017 and 2018.
- **Cocaine**-related deaths increased in 2018 among all age groups except those under 25 years, among non-Hispanic Whites, non-Hispanic Blacks, and Hispanics, and among both sexes.
- The overall increase in **cocaine**-related deaths is largely the result of deaths occurring in combination with opioids. Eighty-two percent of **cocaine**-related deaths in 2018 occurred in combination with **fentanyl**, and 36% in combination with **heroin**.

Benzodiazepine-related deaths

- The number of **benzodiazepine**-related deaths decreased by 13% between 2017 and 2018.
- **Benzodiazepine**-related deaths declined in 2018 among all age groups except those 55 years and older. Deaths decreased among non-Hispanic Whites, but increased among

non-Hispanic Blacks and Hispanics. Decreases were seen among both men and women.

- Ninety-one percent of **benzodiazepine**-related deaths in 2018 were in combination with **opioids**. Fifty-six percent of all **benzodiazepine**-related deaths occurred in combination with **fentanyl,** 44% in combination with **prescription opioids,** and 37% in combination with **heroin**.

Methamphetamine-related deaths

- The number of **methamphetamine**-related deaths has been rising since 2015. These deaths increased by 14% between 2017 and 2018.
- **Methamphetamine**-related deaths increased among those aged 25-34 years, but were steady among all other age groups. Deaths increased among non-Hispanic Whites, but decreased among non-Hispanic Blacks. There were no deaths among Hispanics. Deaths increased among both sexes.
- Eighty-eight percent of **methamphetamine**-related deaths in 2018 were in combination with **opioids**. Eighty-one percent of all **methamphetamine**-related deaths occurred in combination with **fentanyl,** 47% in combination with **heroin,** and 9% in combination with **prescription opioids**.

Alcohol-related deaths

- The number of **alcohol**-related deaths decreased by 9% in 2018.
- **Alcohol**-related deaths in 2018 declined among those less than 35 years of age, increased among those 35-44 years, decreased among those 45-54 years and was stable among those 55 years and older. Deaths decreased among non-Hispanic Whites and Hispanics, but increased among non-Hispanic Blacks. Deaths decreased in 2017 among both men and women.
- Eighty percent of acute **alcohol**-related deaths in 2018 occurred in combination with opioids. Seventy-two percent occurred in combination with **fentanyl**, and 23% occurred in combination with **heroin**.

Age-adjusted death rates

- Age-adjusted death rates for the period 2013-2017 ranged from lows of 8.5 and 9.7 per 100,000 population in Montgomery and Prince George’s Counties, respectively, to a high of 56.6 per 100,000 population in Baltimore City. The Maryland state age-adjusted mortality rate for deaths related to unintentional intoxication was 23.8 deaths per 100,000 population over the five year period.

TOTAL INTOXICATION DEATHS

Figure 1. Total Number of Drug- and Alcohol-Related Intoxication Deaths Occurring in Maryland, 2007-2018.

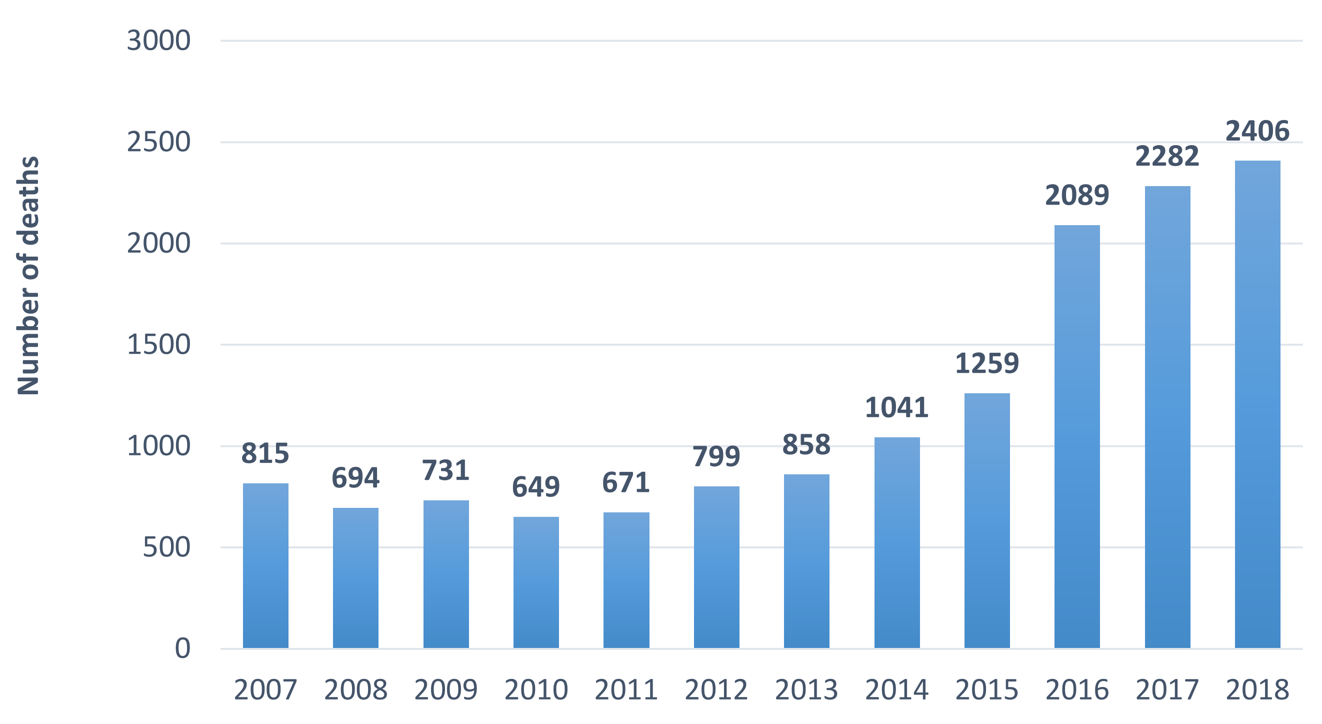


Figure 2. Total Number of Intoxication Deaths Occurring in Maryland by Place of Occurrence, 2018.

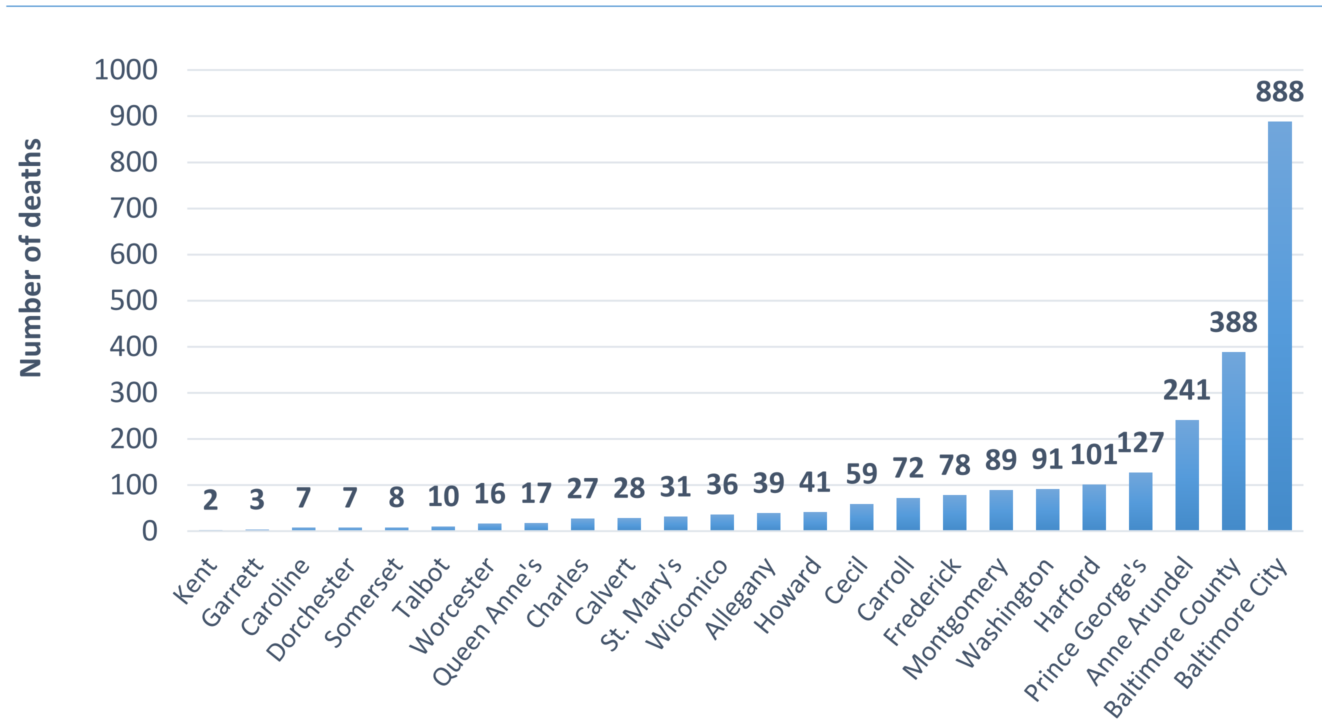


Figure 3. Total Number of Drug- and Alcohol-Related Intoxication Deaths Occurring in Maryland by Age Group, Race/Ethnicity and Gender, 2007-2018.

AGE (years)

Number of deaths

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
<25 years	75	65	73	71	76	87	79	97	99	161	154	131
25-34 years	127	112	142	142	167	169	216	234	297	525	588	561
35-44 years	257	190	167	153	128	171	175	217	281	428	461	513
45-54 years	263	222	241	197	209	243	246	290	339	550	560	582
55+ years	93	105	108	86	91	129	141	203	241	424	517	618

RACE/ETHNICITY

Number of deaths

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
NH White	542	493	504	469	505	590	611	702	868	1349	1505	1479
NH Black	253	187	210	149	132	183	214	298	350	654	687	823
Hispanic	18	11	16	24	23	18	21	30	21	53	59	67

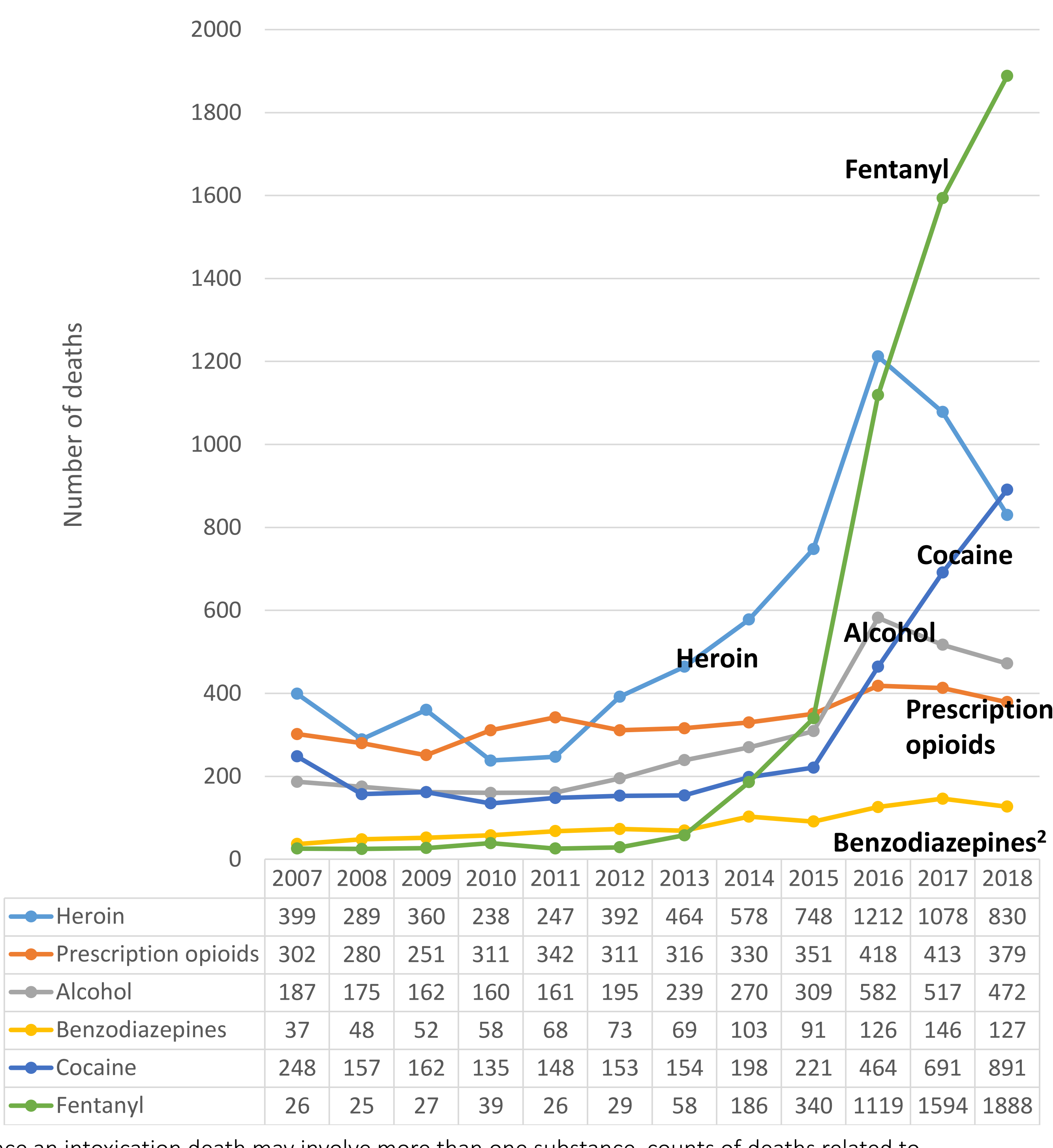
GENDER

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Male	584	481	522	427	449	548	584	743	893	1513	1626	1766
Female	231	213	209	222	222	251	274	298	365	574	656	640

Figure 4. Total Number of Drug- and Alcohol-Related Intoxication Deaths by Place of Occurrence, Maryland, 2007-2018.

DRUG- AND ALCOHOL-RELATED INTOXICATION
DEATHS BY SUBSTANCE

Figure 5. Total Number of Drug- and Alcohol-Related Intoxication Deaths by Selected Substances[1], Maryland, 2007-2018.



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Heroin	399	289	360	238	247	392	464	578	748	1212	1078	830
Prescription opioids	302	280	251	311	342	311	316	330	351	418	413	379
Alcohol	187	175	162	160	161	195	239	270	309	582	517	472
Benzodiazepines	37	48	52	58	68	73	69	103	91	126	146	127
Cocaine	248	157	162	135	148	153	154	198	221	464	691	891
Fentanyl	26	25	27	39	26	29	58	186	340	1119	1594	1888

[1]Since an intoxication death may involve more than one substance, counts of deaths related to specific substances do not sum to the total number of deaths.

[2]Includes deaths caused by benzodiazepines and related drugs with similar sedative effects.

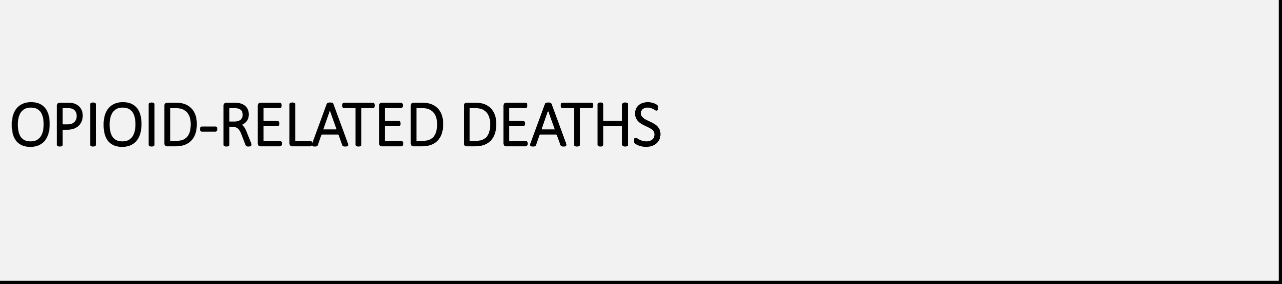
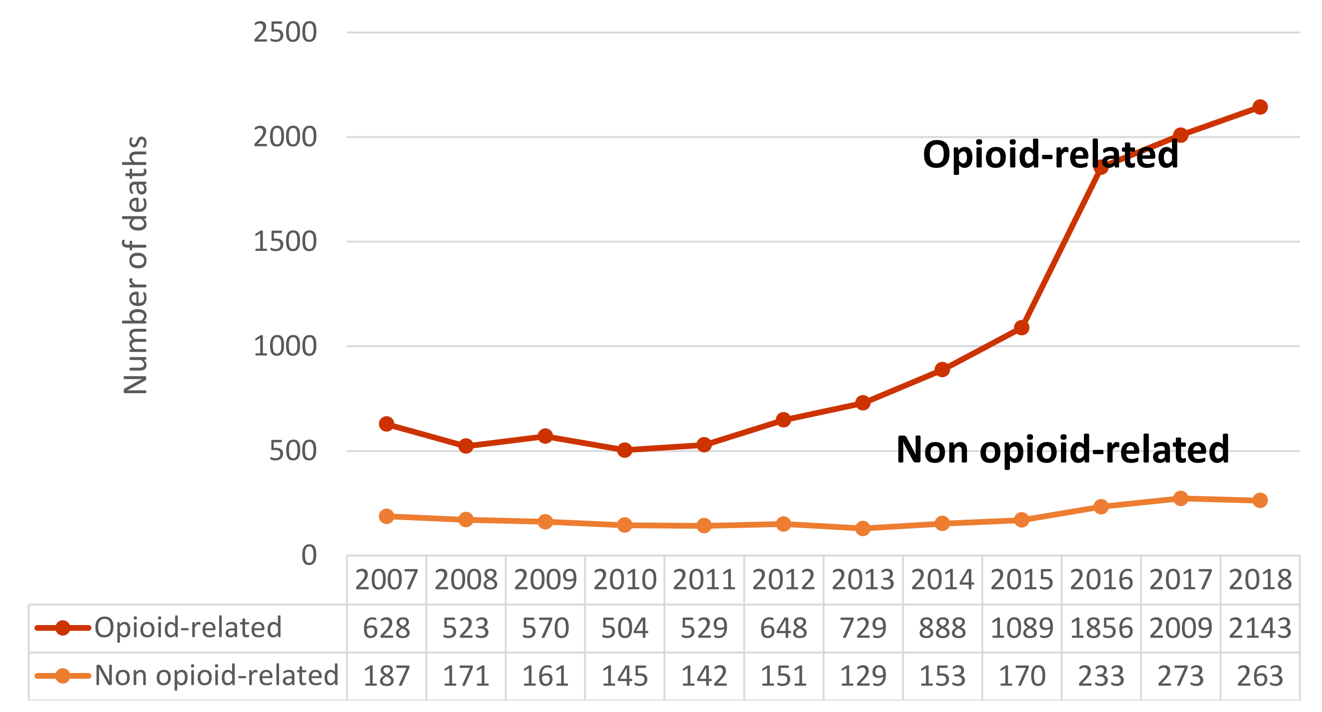
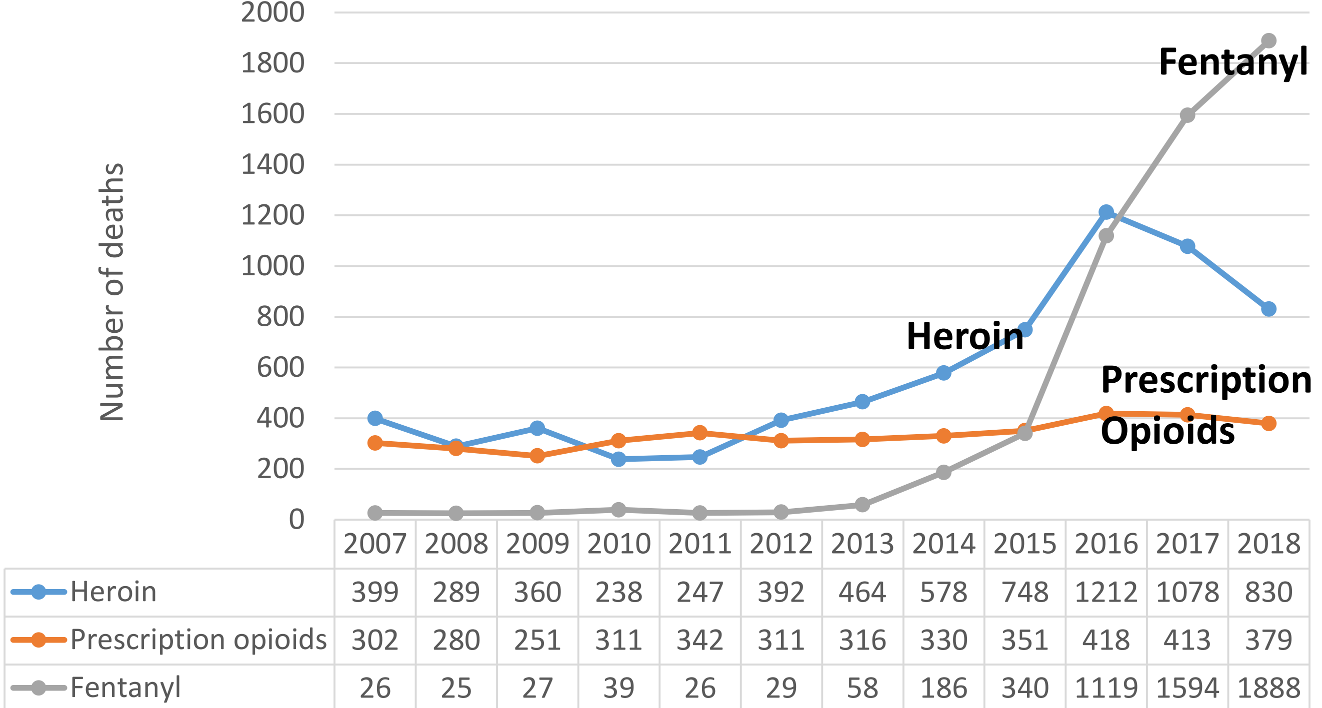

OPIOID-RELATED DEATHS

Figure 6. Total Number of Opioid* and Non-Opioid-Related Deaths Occurring in Maryland, 2007-2018.



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Opioid-related	628	523	570	504	529	648	729	888	1089	1856	2009	2143
Non opioid-related	187	171	161	145	142	151	129	153	170	233	273	263

Figure 7. Number of Opioid-Related Deaths Occurring in Maryland by Substance, 2007-2018.



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Heroin	399	289	360	238	247	392	464	578	748	1212	1078	830
Prescription opioids	302	280	251	311	342	311	316	330	351	418	413	379
Fentanyl	26	25	27	39	26	29	58	186	340	1119	1594	1888

*Total opioids include heroin, prescription opioids, and illicit forms of fentanyl.

Figure 8. Number of Heroin-Related Deaths Occurring in Maryland, 2007-2018.

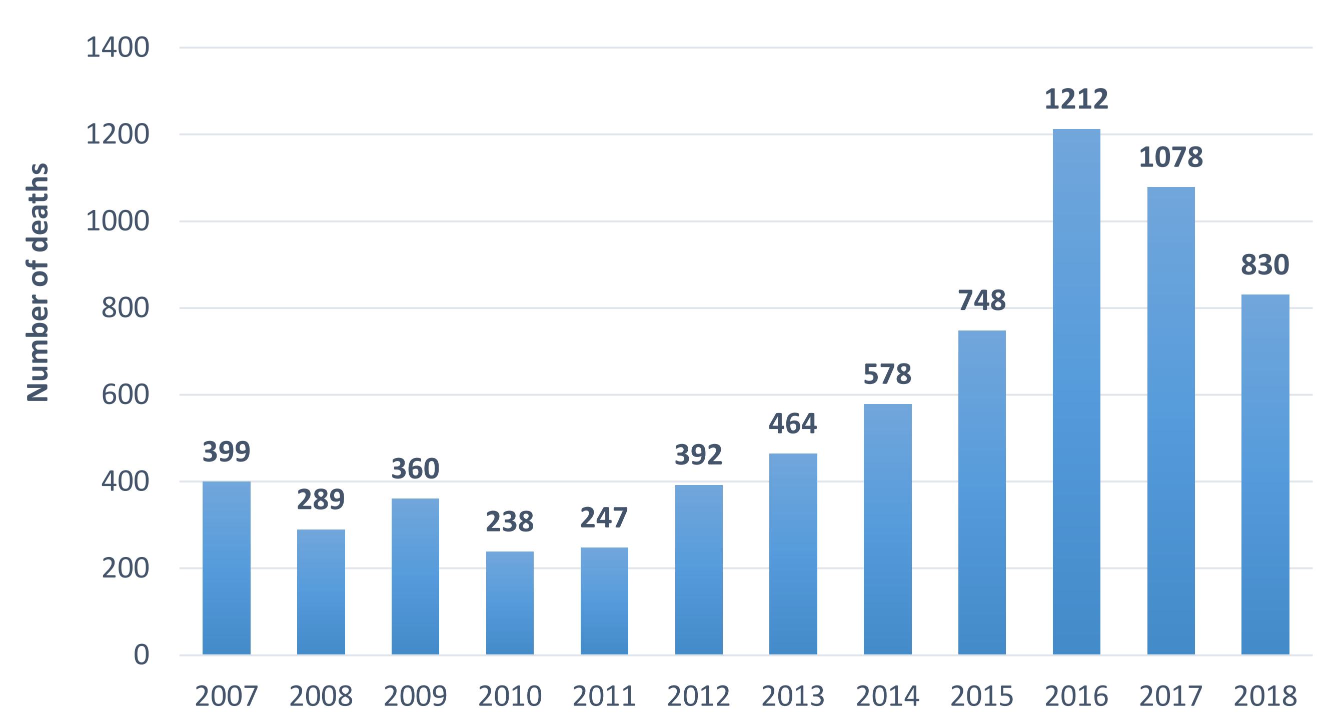


Figure 9. Number of Heroin-Related Deaths Occurring in Maryland by Place of Occurrence, 2018.

Number of deaths (axis: 0, 100, 200, 300, 400)

Place of Occurrence	Number of deaths
Garrett	1
Caroline	3
Dorchester	3
Talbot	4
Somerset	5
Worcester	6
Worcester	6
Calvert	8
Queen Anne's	8
Charles	11
St. Mary's	12
Wicomico	12
Allegany	15
Howard	15
Frederick	23
Washington	29
Carroll	34
Montgomery	34
Cecil	40
Harford	43
Prince George's	44
Anne Arundel	75
Baltimore County	119
Baltimore City	286

Figure 10. Number of Heroin-Related Deaths Occurring in Maryland by Age Group, Race/Ethnicity and Gender, 2007-2018.

AGE (years)

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
<25 years	32	29	31	24	28	53	54	61	69	100	86	55
25-34 years	59	50	83	45	67	87	129	148	202	312	278	200
35-44 years	141	77	81	62	52	81	83	118	165	229	226	196
45-54 years	133	91	121	74	67	124	133	157	178	335	277	205
55+ years	34	42	44	33	33	47	65	94	133	235	210	174

RACE/ETHNICITY

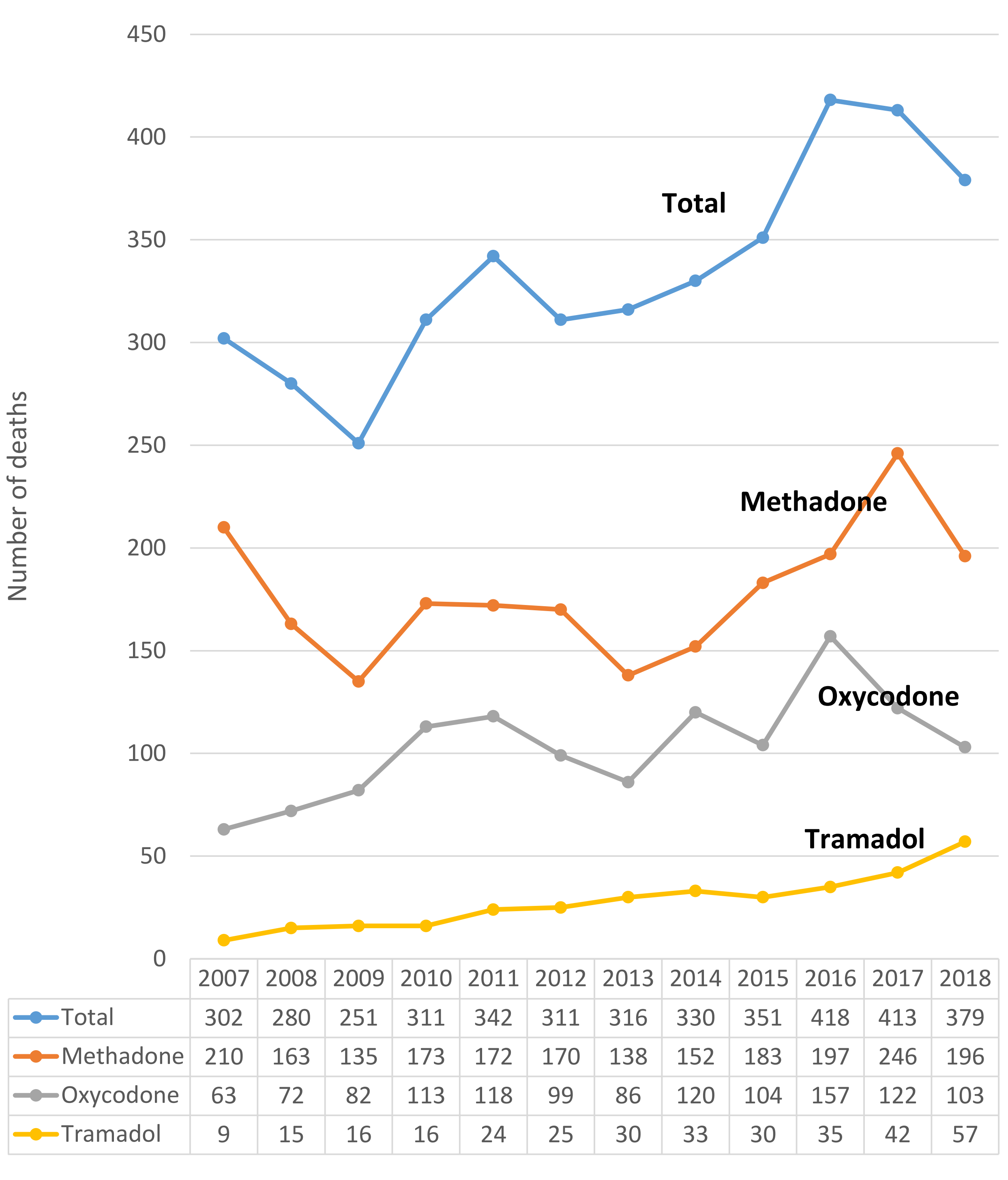
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
NH White	239	190	238	149	178	285	321	379	520	772	742	536
NH Black	158	98	119	79	62	100	131	188	204	397	309	269
Hispanic	2	1	3	7	6	2	8	8	8	25	17	18

GENDER

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2108
Male	305	216	283	178	178	294	344	454	588	897	821	615
Female	94	73	77	60	69	98	120	124	159	314	257	215

Figure 11. Number of Heroin-Related Deaths by Place of Occurrence, Maryland, 2007-2018.

Figure 12. Number of Deaths Occurring in Maryland by Selected Prescription Opioids, 2007-2018.



	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Total	302	280	251	311	342	311	316	330	351	418	413	379
Methadone	210	163	135	173	172	170	138	152	183	197	246	196
Oxycodone	63	72	82	113	118	99	86	120	104	157	122	103
Tramadol	9	15	16	16	24	25	30	33	30	35	42	57

Figure 13. Number of Prescription Opioid-Related Deaths Occurring in Maryland, 2007-2018.

Number of deaths

450
400
350
300
250
200
150
100
50
0

2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
302	280	251	311	342	311	316	330	351	418	413	379

Figure 14. Number of Prescription Opioid-Related Deaths Occurring in Maryland by Place of Occurrence, 2018.

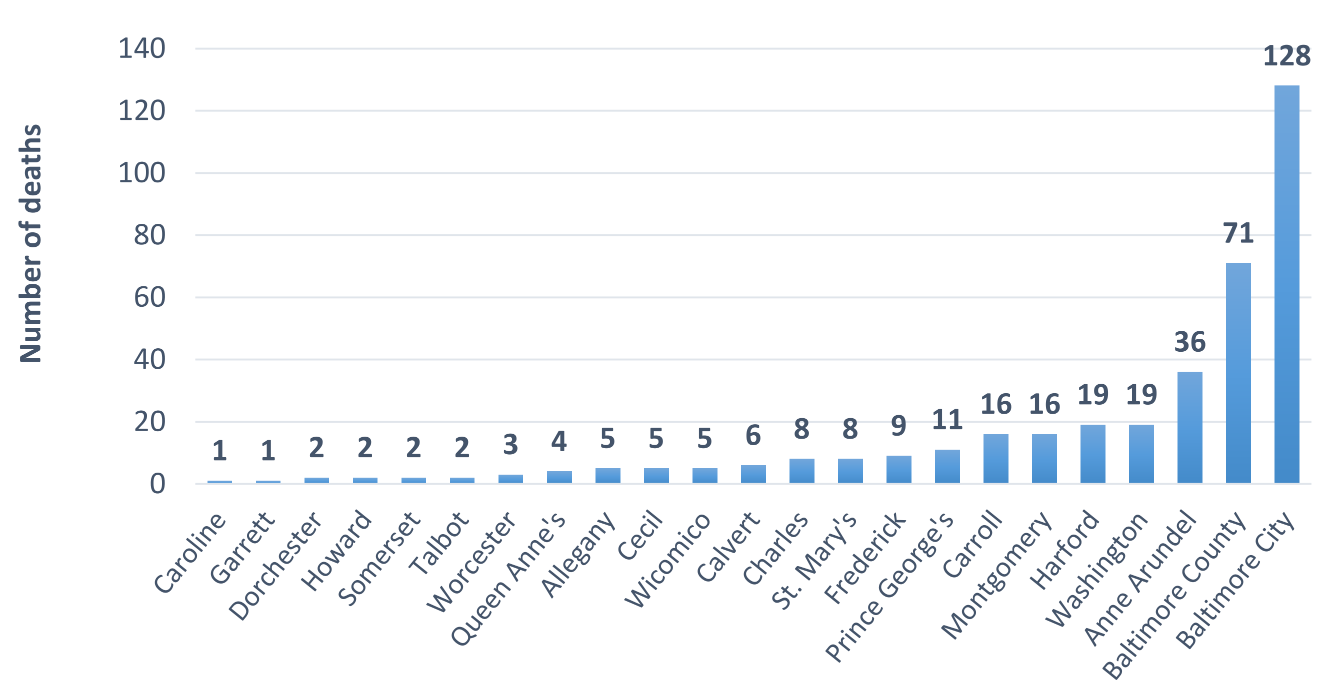


Figure 15. Number of Prescription Opioid-Related Deaths Occurring in Maryland by Age Group, Race/Ethnicity and Gender, 2007-2018.

AGE (years)

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
<25 years	36	32	31	47	50	29	26	21	16	23	20	14
25-34 years	59	48	52	79	88	83	84	69	71	92	90	65
35-44 years	87	84	60	69	58	67	68	66	83	98	95	82
45-54 years	90	87	74	83	111	80	89	91	107	114	113	101
55+ years	30	29	34	33	35	52	49	83	74	91	95	116

RACE/ETHNICITY

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
NH White	232	229	198	264	278	258	247	256	265	308	306	263
NH Black	67	47	51	40	52	46	63	66	80	105	95	108
Hispanic	3	2	1	6	9	4	3	6	3	2	7	5

GENDER

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Male	201	186	168	177	218	187	178	199	206	258	238	239
Female	101	94	83	134	124	124	138	131	145	160	175	140

Figure 16. Number of Prescription Opioid-Related Deaths by Place of Occurrence, Maryland, 2007-2018.

Figure 17. Number of Fentanyl-Related Deaths Occurring in Maryland, 2007-2018.

Number of deaths

2000
1800
1600
1400
1200
1000
800
600
400
200
0

26 25 27 39 26 29 58 186 340 1119 1594 1888

2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018

Figure 18. Number of Fentanyl-Related Deaths Occurring in Maryland by Place of Occurrence, 2018.

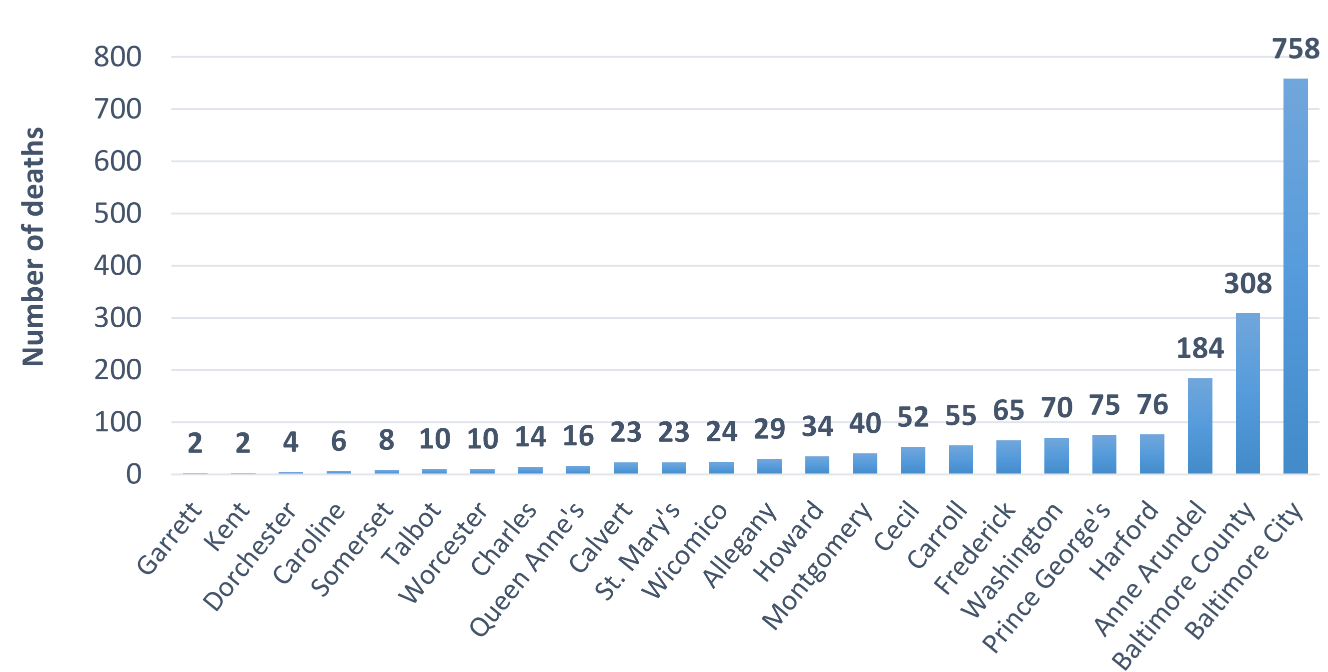


Figure 19. Number of Fentanyl-Related Deaths Occurring in Maryland by Age Group, Race/Ethnicity and Gender, 2007-2018.

AGE (years)

Number of deaths

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
<25 years	2	2	2	6	1	1	7	28	27	93	118	115
25-34 years	4	4	2	10	6	6	18	48	93	313	454	467
35-44 years	9	9	9	9	9	10	10	38	72	221	333	414
45-54 years	8	8	11	12	9	5	13	49	91	292	380	454
55+ years	3	2	3	2	1	7	10	23	57	200	307	437

RACE/ETHNICITY

Number of deaths

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
NH White	22	24	25	34	25	27	43	103	234	729	1061	1143
NH Black	3	1	2	4	0	2	14	75	102	350	483	670
Hispanic	1	0	0	0	1	0	0	6	2	24	29	43

GENDER

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Male	18	17	20	17	15	18	42	148	259	836	1184	1413
Female	8	8	7	22	11	11	16	38	81	282	410	475

Figure 20. Number of Fentanyl-Related Deaths by Place of Occurrence, Maryland, 2007-2018.

REGION

Number of deaths

1600
1400
1200
1000
800
600
400
200
0

2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018

Northwest
Baltimore Metro
Southern
Eastern Shore
National Capital

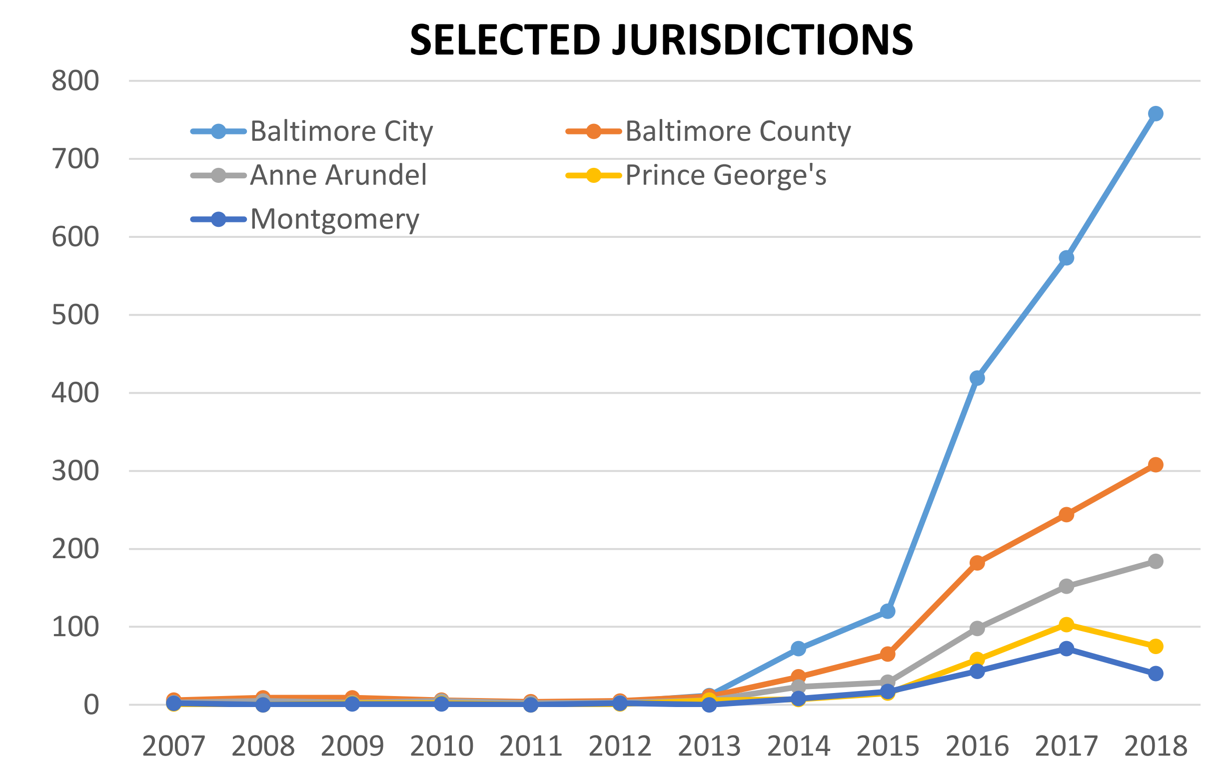


Figure 21. Number of Carfentanil-Related Deaths Occurring in Maryland, 2007-2018.

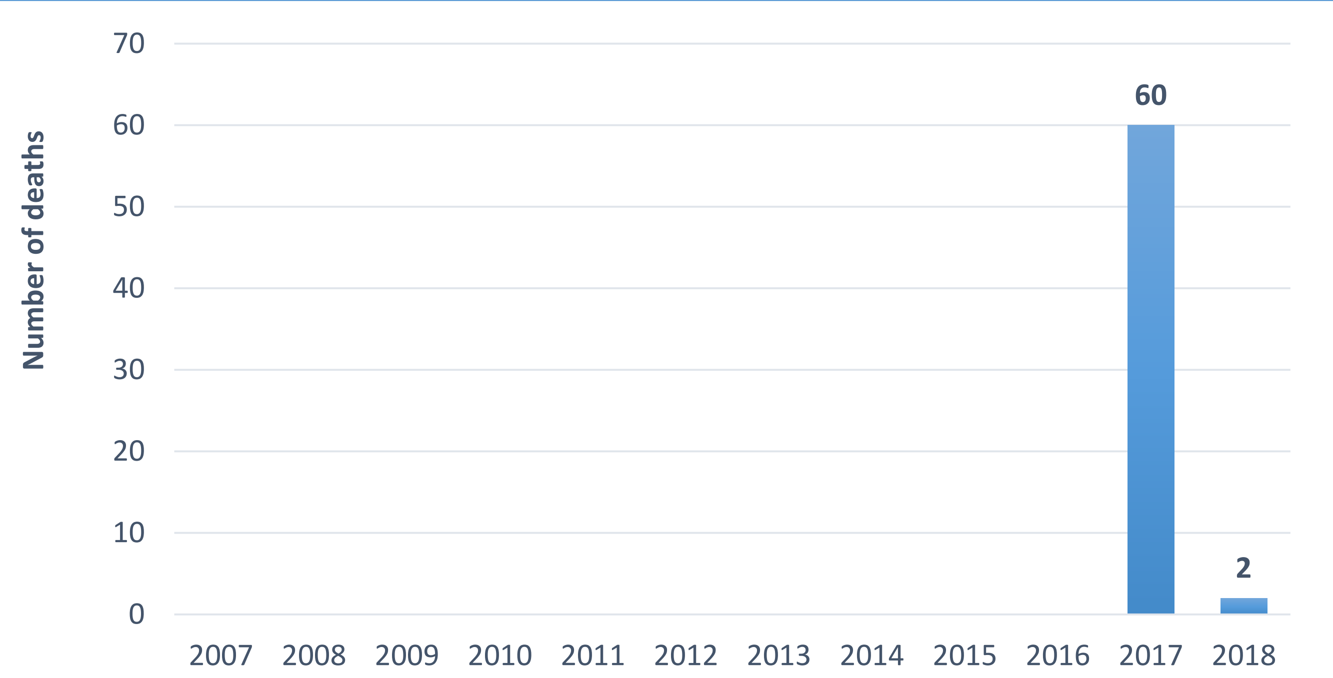


Figure 22. Number of Carfentanil-Related Deaths Occurring in Maryland by Age Group, Race/Ethnicity, and Gender, 2017-2018.

Number of deaths
50
45
40
35
30
25
20
15
10
5
0
4
17
2
14
15
10
40
19
2
44
2
16
< 25
25-34
35-44
45-54
55+
White
Black
Hispanic
Male
Female
Age Group
Race/Ethnicity
Gender
2017
2018

COCAINE-RELATED DEATHS

Figure 23. Number of Cocaine-Related Deaths Occurring in Maryland, 2007-2018.

NUMBER OF DEATHS

Year	In combination with opioids	Not in combination with opioids
2007	182	66
2008	101	56
2009	111	51
2010	91	44
2011	104	44
2012	114	39
2013	121	33
2014	166	32
2015	180	41
2016	391	73
2017	594	97
2018	792	99

Figure 24. Number of Cocaine-Related Deaths Occurring in Maryland by Place of Occurrence, 2018.

NUMBER OF DEATHS

Place of Occurrence	Number of Deaths
Caroline	1
Kent	1
Dorchester	3
Calvert	3
Talbot	3
Worcester	5
Queen Anne's	5
Somerset	6
Allegany	15
Charles	18
Wicomico	17
Cecil	14
St. Mary's	20
Montgomery	22
Howard	23
Carroll	25
Frederick	24
Prince George's	40
Washington	34
Harford	48
Anne Arundel	96
Baltimore County	144
Baltimore City	423

Figure 25. Number of Cocaine-Related Deaths Occurring in Maryland by Age Group, Race/Ethnicity and Gender, 2007-2018.

AGE (years)

Number of deaths

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
<25 years	19	7	10	7	9	8	7	8	9	20	38	36
25-34 years	32	26	29	38	34	34	29	33	46	113	175	208
35-44 years	103	52	33	38	39	30	35	49	54	97	137	193
45-54 years	73	52	70	39	45	57	54	69	76	146	202	239
55+ years	21	20	20	13	21	24	29	39	36	88	138	214

RACE/ETHNICITY

Number of deaths

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
NH White	160	95	96	80	101	92	97	112	134	274	429	532
NH Black	87	62	65	50	43	55	51	79	81	172	244	326
Hispanic	1	0	1	2	4	3	3	4	3	12	9	21

GENDER

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Male	186	122	119	93	106	103	110	149	170	347	485	656
Female	62	35	43	42	42	50	44	49	51	117	206	235

Figure 26. Number of Cocaine-Related Deaths by Place of Occurrence, Maryland, 2007-2018.

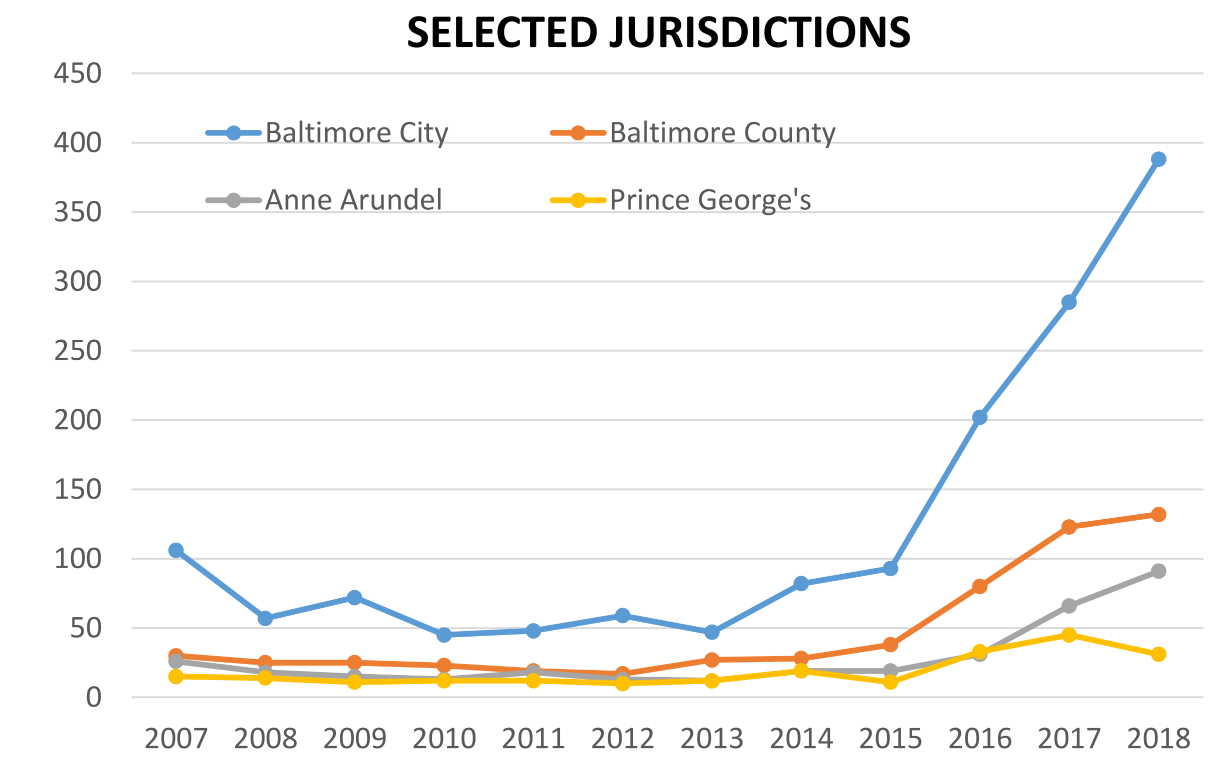
REGION

Northwest
Baltimore Metro
Southern
Eastern Shore
National Capital

Number of deaths

800
700
600
500
400
300
200
100
0

2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018



BENZODIAZEPINE-RELATED DEATHS

Figure 27. Number of Benzodiazepine-Related Deaths Occurring in Maryland, 2007-2018.

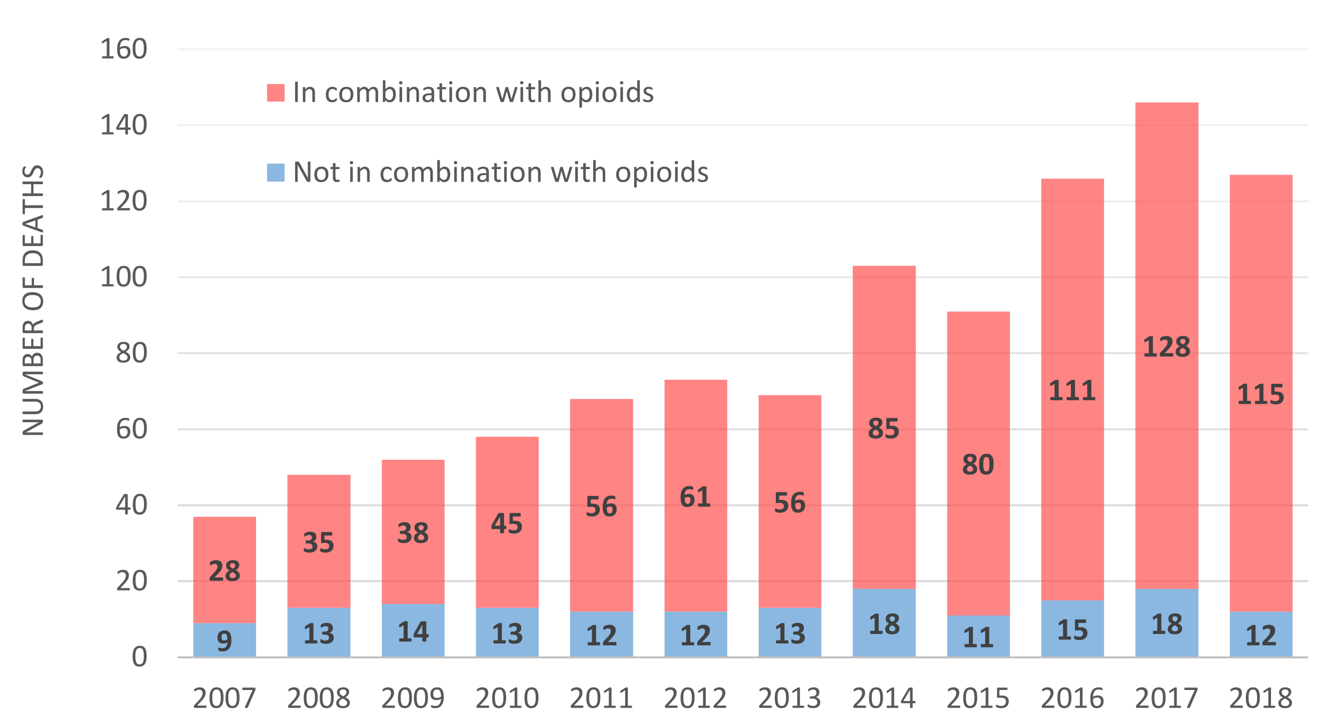


Figure 28. Number of Benzodiazepine-Related Deaths Occurring in Maryland by Place of Occurrence, 2018.

NUMBER OF DEATHS

35
30
25
20
15
10
5
0

Place of Occurrence	Number of Deaths
Allegany	1
Charles	1
Howard	1
St. Mary's	1
Wicomico	1
Calvert	2
Cecil	2
Worcester	2
Queen Anne's	3
Carroll	4
Washington	4
Frederick	5
Prince George's	6
Harford	9
Montgomery	9
Anne Arundel	16
Baltimore City	28
Baltimore County	32

Figure 29. Number of Benzodiazepine-Related Deaths Occurring in Maryland by Age Group, Race/Ethnicity and Gender, 2007-2018.

AGE (years)

Number of deaths

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
<25 years	3	3	11	8	7	8	3	8	5	12	15	12
25-34 years	8	10	12	14	21	18	21	30	23	33	42	33
35-44 years	9	13	11	15	13	15	16	18	25	28	31	26
45-54 years	9	14	13	14	19	24	18	25	25	28	27	23
55+ years	8	8	5	7	8	8	11	22	13	25	31	33

RACE/ETHNICITY

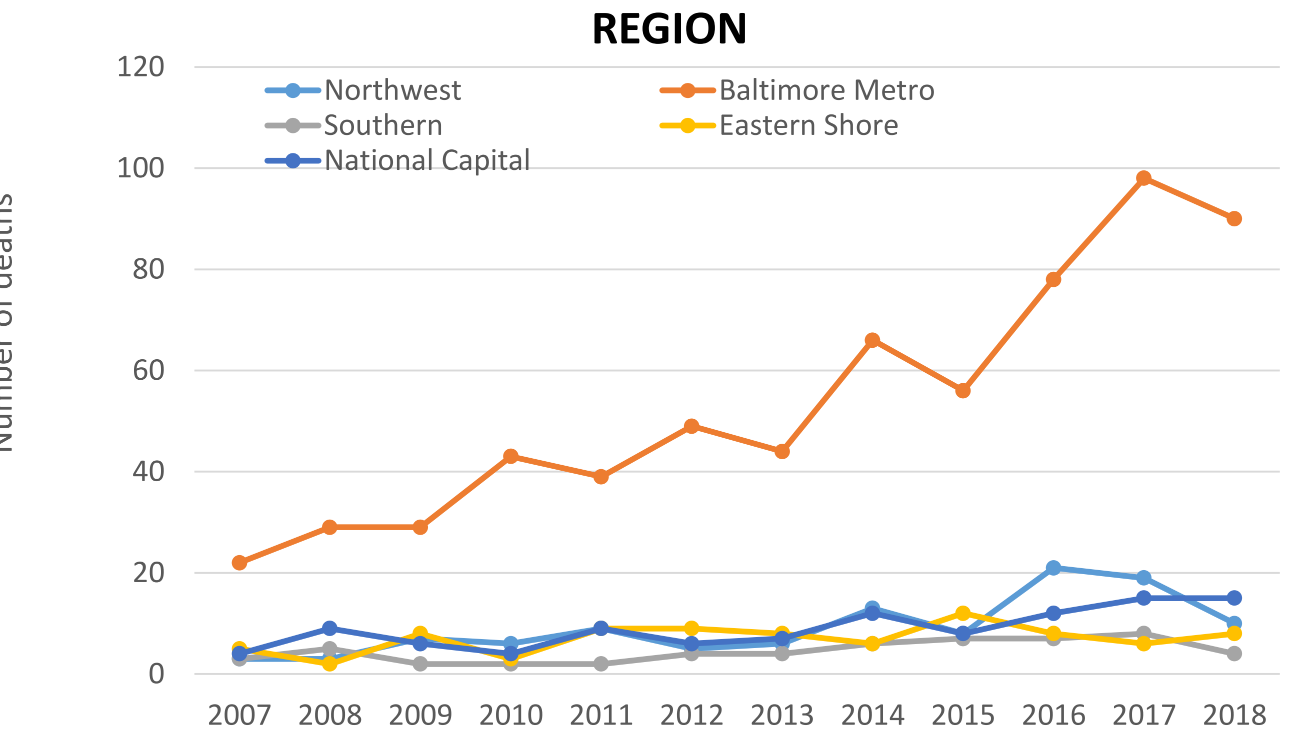
Number of deaths

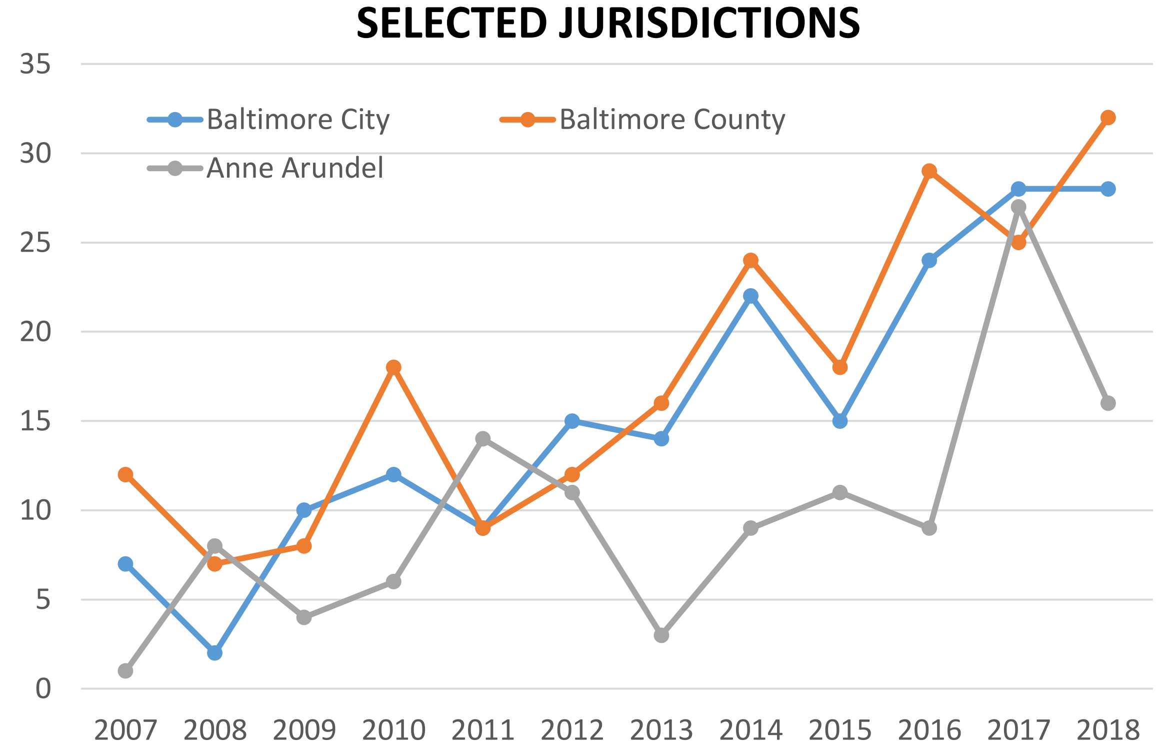
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
NH White	34	44	48	54	60	67	59	82	79	106	130	102
NH Black	2	2	4	3	3	6	8	16	9	17	15	20
Hispanic	1	1	0	0	2	0	1	2	1	2	0	3

GENDER

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Male	26	30	37	32	37	44	39	67	50	77	82	78
Female	11	18	15	26	31	29	30	36	41	49	64	49

Figure 30. Number of Benzodiazepine-Related Deaths by Place of Occurrence, Maryland, 2007-2018.





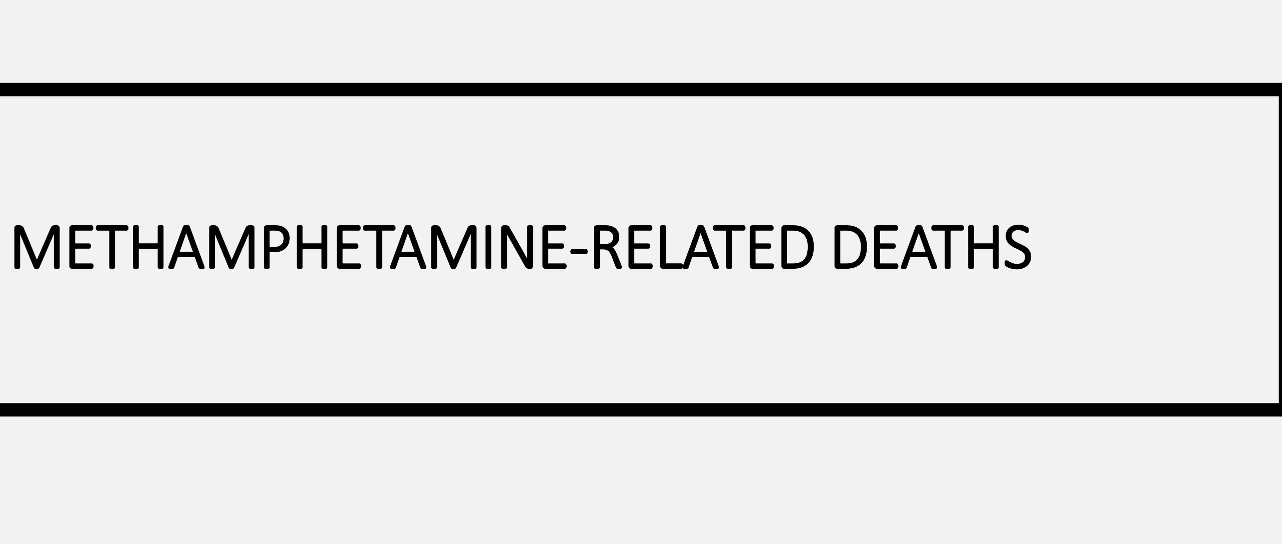

METHAMPHETAMINE-RELATED DEATHS

Figure 31. Number of Methamphetamine-Related Deaths Occurring in Maryland, 2007-2018.

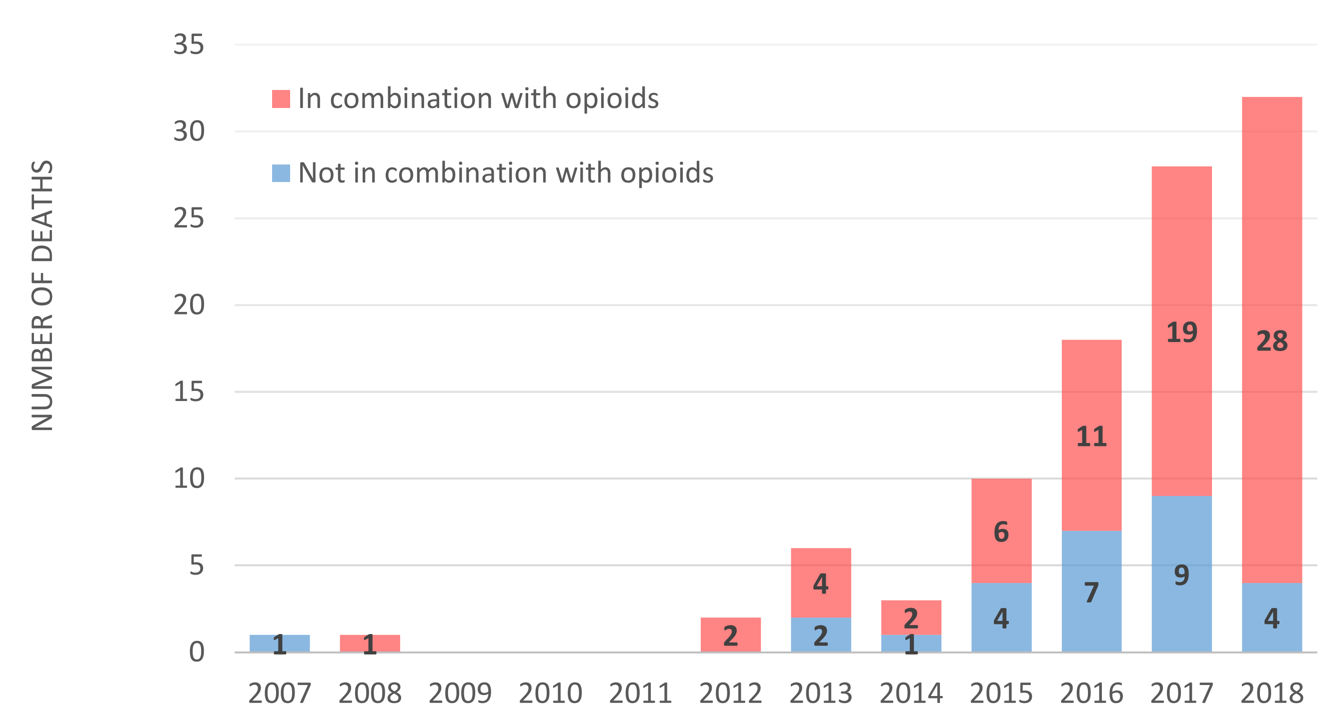


Figure 32. Number of Methamphetamine-Related Deaths Occurring in Maryland by Place of Occurrence, 2018.

NUMBER OF DEATHS

7
6
5
4
3
2
1
0

1 1 1 1 1 1 2 2 3 3 4 5 6

Calvert
Carroll
Howard
Montgomery
Wicomico
Worcester
Allegany
Anne Arundel
Prince George's
Washington
Baltimore County
Baltimore City
Cecil

Figure 33. Number of Methamphetamine-Related Deaths Occurring in Maryland by Age Group, Race/Ethnicity and Gender, 2007-2018.

AGE (years)

Number of deaths

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
<25 years	0	1	0	0	0	1	1	0	1	0	4	4
25-34 years	1	0	0	0	0	0	2	1	4	10	9	14
35-44 years	0	0	0	0	0	1	0	1	3	4	8	8
45-54 years	0	0	0	0	0	0	2	1	2	3	4	4
55+ years	0	0	0	0	0	0	1	0	0	1	2	2

RACE/ETHNICITY

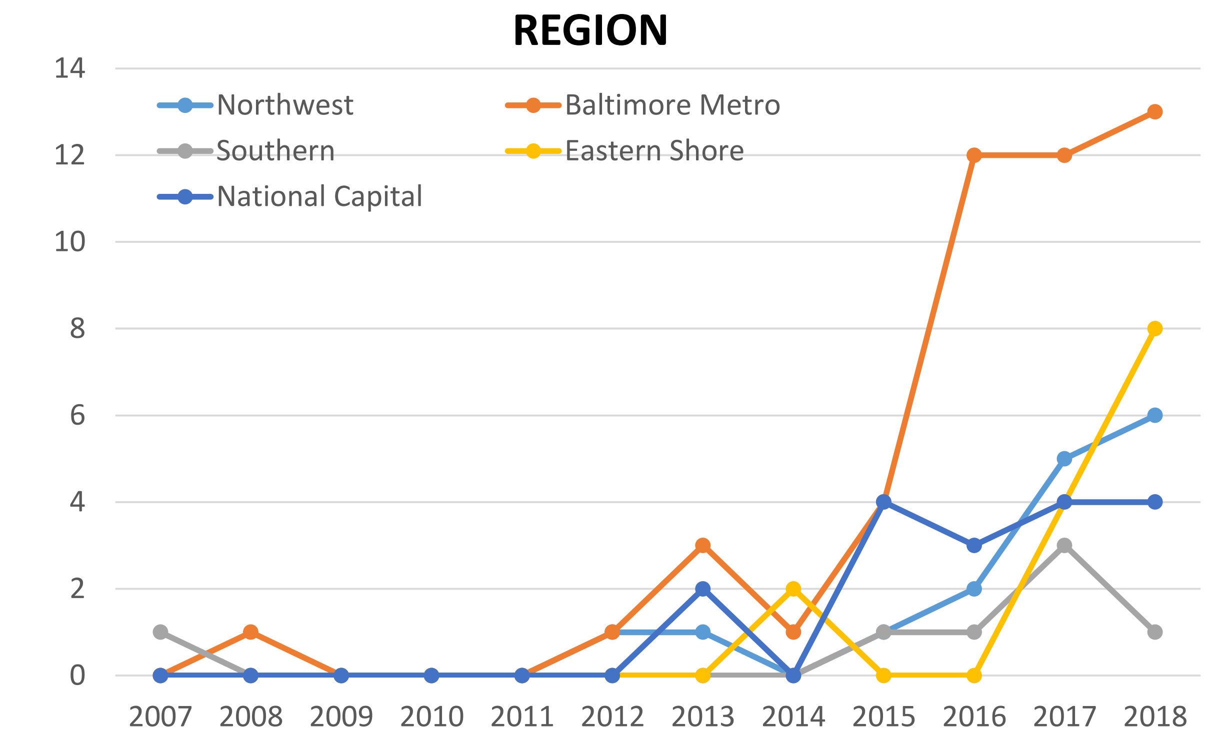
Number of deaths

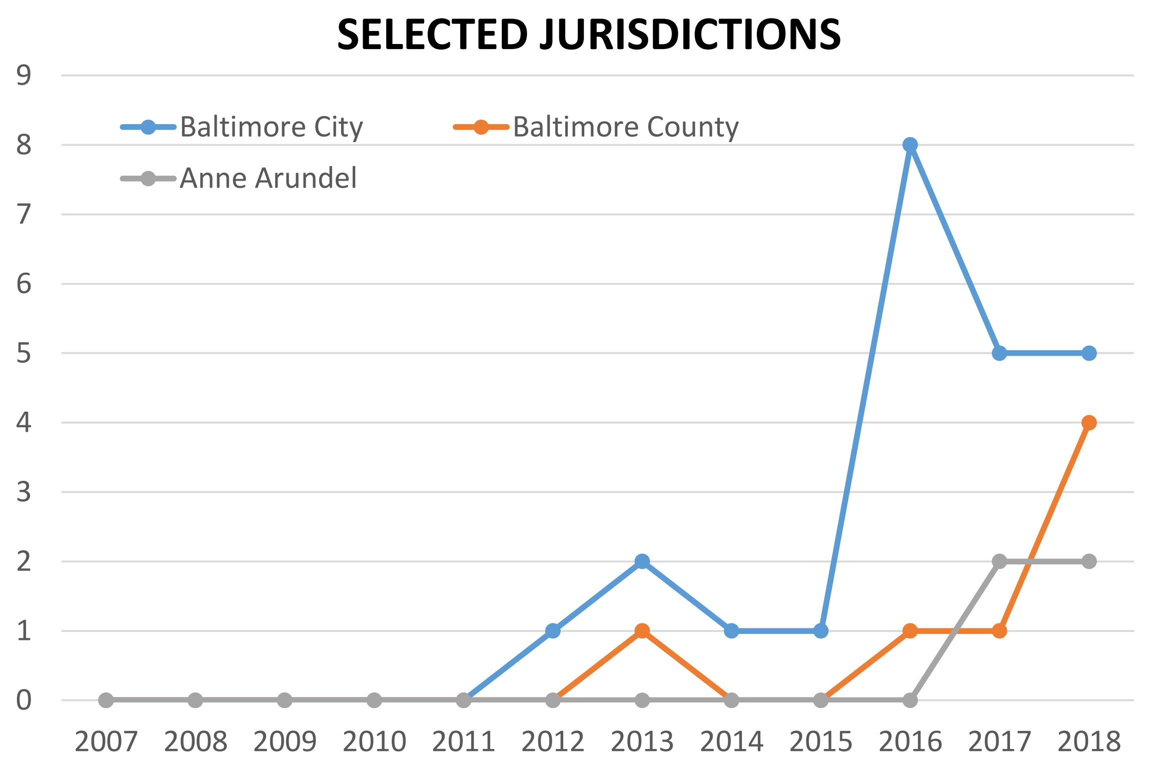
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
NH White	1	1	0	0	0	2	3	3	6	11	22	28
NH Black	0	0	0	0	0	0	3	0	3	6	5	4
Hispanic	0	0	0	0	0	0	0	0	1	0	0	0

GENDER

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Male	1	1	0	0	0	2	3	3	8	13	24	27
Female	0	0	0	0	0	0	3	0	2	5	4	5

Figure 34. Number of Methamphetamine-Related Deaths by Place of Occurrence, Maryland, 2007-2018.





ALCOHOL-RELATED DEATHS

Figure 35. Number of Alcohol-Related Deaths Occurring in Maryland, 2007-2018.

Figure 36. Number of Alcohol-Related Deaths Occurring in Maryland by Place of Occurrence, 2018.

Figure 37. Number of Alcohol-Related Deaths Occurring in Maryland by Age Group, Race/Ethnicity and Gender, 2007-2018.

AGE (years)

Number of deaths

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
<25 years	16	10	13	9	18	10	9	12	15	25	23	13
25-34 years	28	27	31	33	37	26	35	51	52	115	97	85
35-44 years	57	48	36	31	31	46	56	55	73	123	102	110
45-54 years	64	61	65	64	56	77	88	104	109	195	154	123
55+ years	24	30	18	24	19	36	50	48	61	124	141	141

RACE/ETHNICITY

Number of deaths

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
NH White	116	119	114	107	116	128	146	161	201	348	298	240
NH Black	58	46	36	37	32	54	77	87	95	203	174	193
Hispanic	13	9	13	15	11	11	13	18	12	26	36	32

GENDER

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Male	159	136	125	127	127	150	181	219	256	452	399	372
Female	30	40	38	34	34	45	58	51	54	130	118	100

Figure 38. Number of Alcohol-Related Deaths by Place of Occurrence, Maryland, 2007-2018.

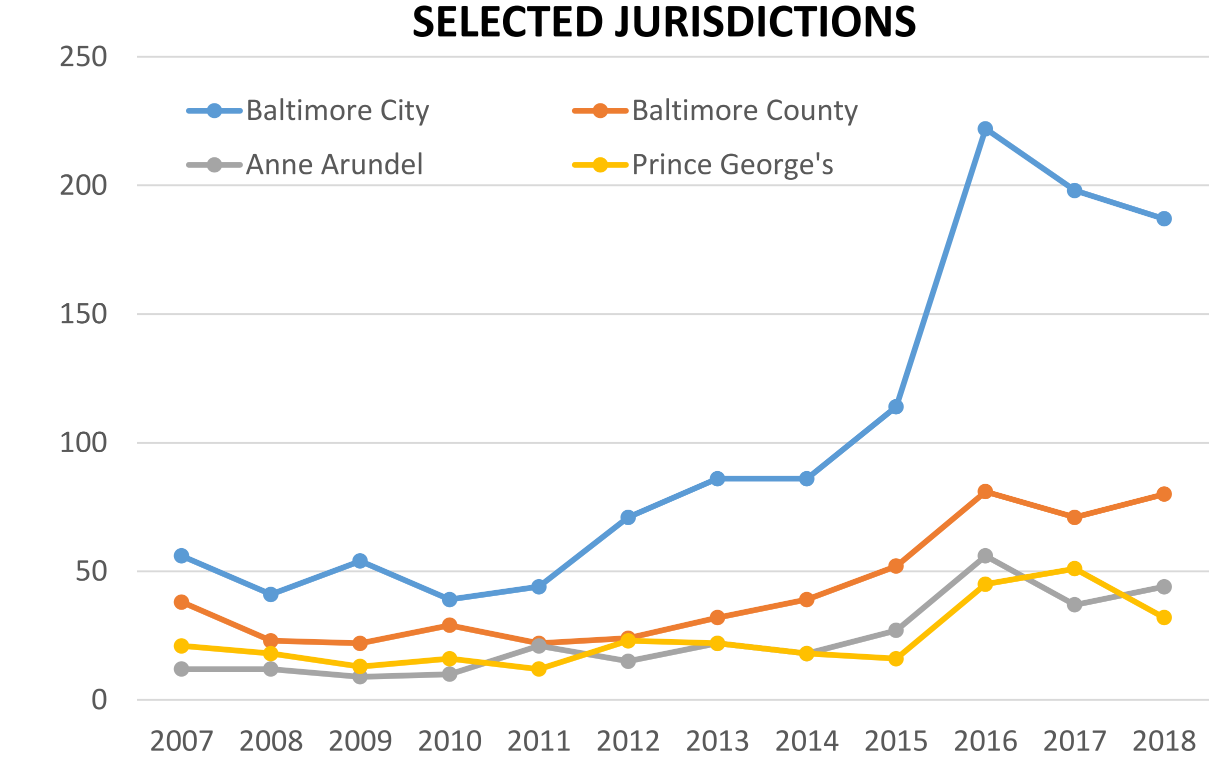
REGION

Northwest
Baltimore Metro
Southern
Eastern Shore
National Capital

Number of deaths

450
400
350
300
250
200
150
100
50
0

2007 2008 2009 2010 2011 2012 2013 2014 2015 2016 2017 2018



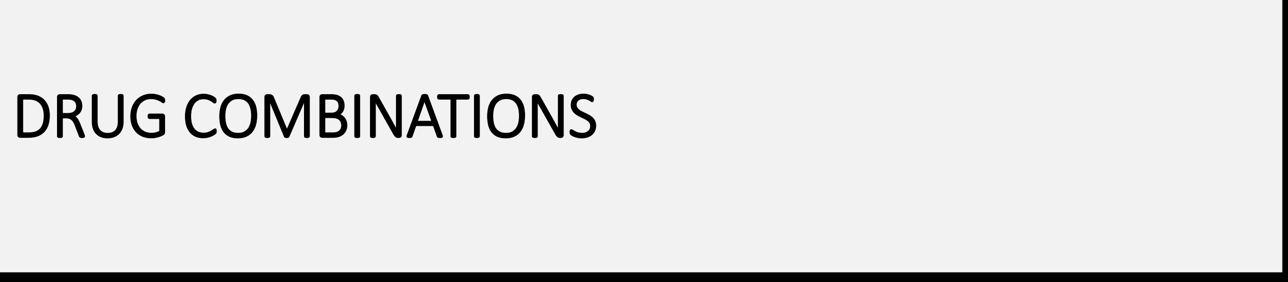

DRUG COMBINATIONS

Figure 39. Number of Drug- and Alcohol-Related Intoxication Deaths Involving Opioids, 2007-2018.

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Total deaths	815	694	731	649	671	799	858	1041	1259	2089	2282	2406
Opioid-related	628	523	570	504	529	648	729	888	1089	1856	2009	2143
Not opioid-related	187	171	161	145	142	151	129	153	170	233	273	263

Figure 40. Number of Intoxication Deaths by Presence of Heroin and/or Fentanyl, 2007-2018.

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Total deaths	815	694	731	649	671	799	858	1041	1259	2089	2282	2406
Both Heroin and fentanyl	3	2	3	6	5	2	24	101	220	705	844	718
Either Heroin or Fentanyl	422	312	384	271	268	419	498	663	868	1626	1828	2000
Neither Heroin or Fentanyl	393	382	347	378	403	380	360	378	391	463	454	406

Figure 41. Number of Prescription Opioid-Related Intoxication Deaths Involving Heroin or Fentanyl, 2007-2018.

Number of deaths

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Total deaths	302	280	251	311	342	311	316	330	351	418	413	379
In combination with heroin or fentanyl	96	69	65	78	81	82	85	105	130	213	244	246
Not in combination with heroin or fentanyl	206	211	186	233	261	229	231	225	221	205	169	133

Figure 42. Number of Cocaine-Related Intoxication Deaths Involving Heroin or Fentanyl, 2007-2018.

Number of deaths

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Total deaths	248	157	162	135	148	153	154	198	221	464	691	891
In combination w/heroin or fentanyl	150	72	85	50	64	82	95	143	170	365	554	770
Not in combination w/heroin or fentanyl	98	85	77	85	84	71	59	55	51	99	137	121

Figure 43. Number of Benzodiazepine-Related Intoxication Deaths Involving Heroin or Fentanyl, 2007-2018.

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Total deaths	37	48	52	58	68	73	69	103	91	126	146	127
In combination with heroin or fentanyl	8	6	13	12	13	20	16	36	45	77	91	83
Not in combination with heroin or fentanyl	29	42	39	46	55	53	53	67	46	49	55	44

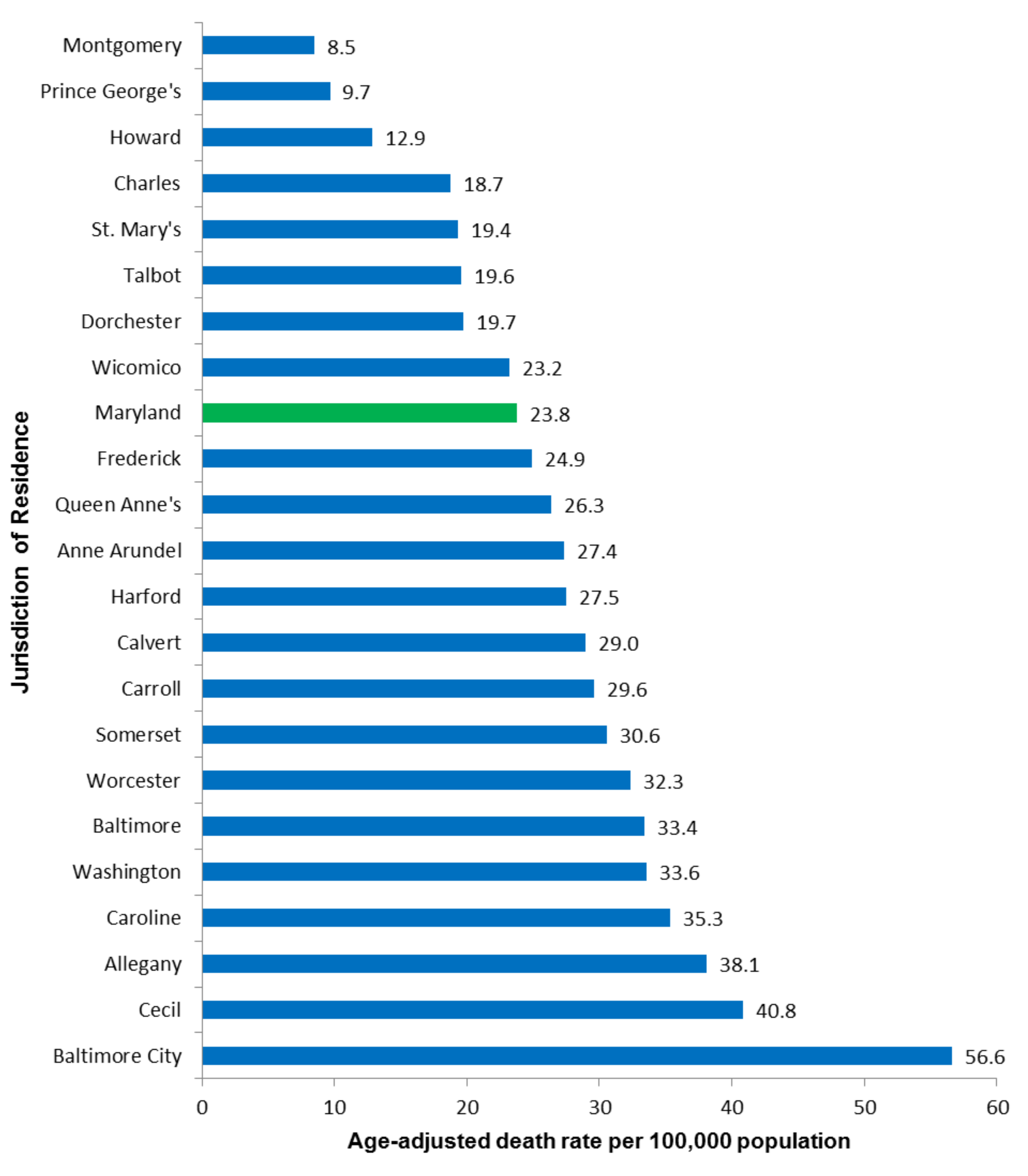
Figure 44. Number of Alcohol-Related Intoxication Deaths Involving Heroin or Fentanyl, 2007-2018.

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Total deaths	189	176	163	161	161	195	239	270	310	582	517	472
In combination with heroin or fentanyl	76	51	74	53	46	95	137	162	207	438	364	356
Not in combination with heroin or fentanyl	113	125	89	108	115	100	102	108	103	140	153	116

Figure 45. Combinations of Substances Related to Unintentional Drug- and Alcohol-Related Intoxication Deaths, Maryland, 2018.

		Number	Percent
Fentanyl			
	Total	1888	
	In combination		
	With cocaine	737	39.0
	With heroin	718	38.0
	With alcohol	339	18.0
	With prescription opioids	222	11.8
	With benzodiazepines	71	3.8
Cocaine			
	Total	891	
	In combination		
	With fentanyl	727	81.6
	With heroin	324	36.4
	With alcohol	134	15.0
	With prescription opioids	109	12.2
	With benzodiazepines	32	3.6
Heroin			
	Total	830	
	In combination		
	With fentanyl	718	86.5
	With cocaine	324	39.0
	With prescription opioids	128	15.4
	With alcohol	110	13.3
	With benzodiazepines	47	5.7
Alcohol			
	Total	472	
	In combination		
	With fentanyl	339	71.8
	With cocaine	134	28.4
	With heroin	110	23.3
	With prescription opioids	50	10.6
	With benzodiazepines	21	4.4
Prescription opioids			
	Total	379	
	In combination		
	With fentanyl	222	58.6
	With heroin	128	33.8
	With cocaine	109	28.8
	With benzodiazepines	56	14.8
	With alcohol	50	13.2
Benzodiazepines			
	Total	127	
	In combination		
	With fentanyl	71	55.9
	With prescription opioids	56	44.1
	With heroin	47	37.0
	With cocaine	32	25.2
	With alcohol	21	16.5

Figure 46. Age-Adjusted Mortality Rates[1,2] for Total Unintentional Intoxication Deaths by Place of Residence,[3] Maryland, 2013-2017.



[1]Age-adjusted to the 2000 U.S. standard population by the direct method.
[2]Since 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 five-year period.
[3]Rates are based on place of residence, not place of occurrence.

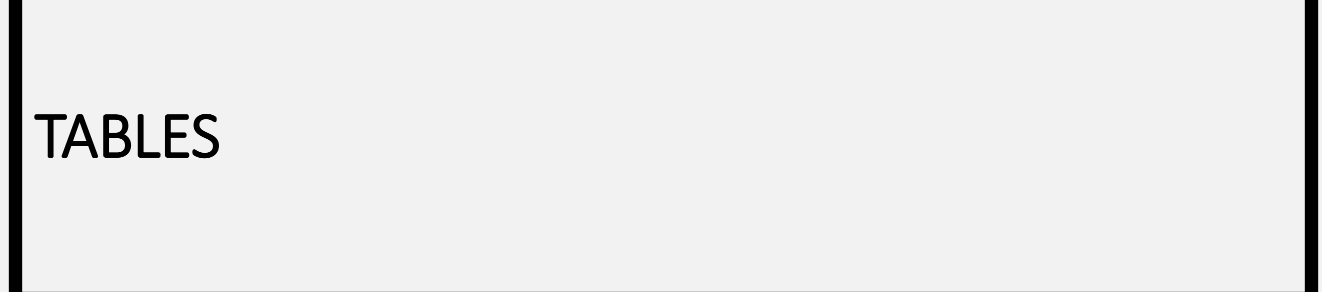

TABLES

TABLE 1. TOTAL NUMBER OF DRUG AND ALCOHOL-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2018.[1,2]

REGION AND POLITICAL SUBDIVISION	TOTAL INTOXICATION DEATHS												
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	TOTAL
MARYLAND	815	694	731	649	671	799	858	1,041	1,259	2,089	2,282	2,406	14,294
NORTHWEST AREA	54	53	53	58	65	67	86	96	131	214	183	211	1,271
GARRETT	1	3	3	3	2	0	6	2	5	1	8	3	37
ALLEGANY	14	9	9	15	12	14	15	12	22	59	38	39	258
WASHINGTON	16	26	18	20	21	27	28	40	64	66	59	91	476
FREDERICK	23	15	23	20	30	26	37	42	40	88	78	78	500
BALTIMORE METRO AREA	550	443	479	411	420	519	557	678	841	1,402	1,549	1,731	9,580
BALTIMORE CITY	287	184	239	172	167	225	246	305	393	694	761	888	4,561
BALTIMORE COUNTY	131	118	106	115	107	119	144	170	220	336	367	388	2,321
ANNE ARUNDEL	71	70	63	56	79	83	78	101	112	195	214	241	1,363
CARROLL	14	17	22	15	8	29	24	38	40	47	55	72	381
HOWARD	16	19	16	10	21	24	29	21	26	46	51	41	320
HARFORD	31	35	33	43	38	39	36	43	50	84	101	101	634
NATIONAL CAPITAL AREA	109	104	103	81	86	104	111	128	140	231	283	216	1,696
MONTGOMERY	56	46	44	38	44	48	52	65	70	102	116	89	770
PRINCE GEORGE'S	53	58	59	43	42	56	59	63	70	129	167	127	926
SOUTHERN AREA	33	36	34	31	31	37	25	47	59	88	103	86	610
CALVERT	14	9	14	6	12	12	6	17	20	28	32	28	198
CHARLES	13	16	11	13	11	13	9	21	22	45	37	27	238
ST MARY'S	6	11	9	12	8	12	10	9	17	15	34	31	174
EASTERN SHORE AREA	69	58	62	68	69	72	79	92	88	154	164	162	1,137
CECIL	25	10	24	24	28	25	26	29	32	30	59	59	371
KENT	3	4	2	5	2	0	4	6	3	6	5	2	42
QUEEN ANNE'S	4	5	4	4	5	2	8	10	4	8	8	17	79
CAROLINE	1	4	2	2	11	4	2	7	3	10	11	7	64
TALBOT	5	4	3	3	1	5	7	4	5	10	11	10	68
DORCHESTER	4	5	2	6	2	5	5	0	1	6	12	7	55
WICOMICO	9	13	12	13	11	21	17	20	18	48	35	36	253
SOMERSET	6	3	4	1	3	3	4	3	6	8	4	8	53
WORCESTER	12	10	9	10	6	7	6	13	16	28	19	16	152

1 Includes deaths that were the result of recent ingestion or exposure to alcohol or another type of drug, including heroin, cocaine, prescription opioids, benzodiazepines, and other prescribed and unprescribed drugs.
2 Includes only deaths for which the manner of death was classified as accidental or undetermined.

TABLE 2. TOTAL NUMBER OF OPIOID-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2018.[1,2]

REGION AND POLITICAL SUBDIVISION	OPIOID-RELATED DEATHS												
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	TOTAL
MARYLAND	628	523	570	504	529	648	729	888	1,089	1,856	2,009	2,143	12,116
NORTHWEST AREA	35	37	41	37	53	53	74	81	118	198	157	189	1,073
GARRETT	0	2	3	1	1	0	4	2	4	0	4	3	24
ALLEGANY	12	7	6	11	8	10	11	11	20	55	36	33	220
WASHINGTON	11	21	14	13	16	20	26	34	57	63	51	83	409
FREDERICK	12	7	18	12	28	23	33	34	37	80	66	70	420
BALTIMORE METRO AREA	455	362	382	337	341	437	485	591	742	1,262	1,404	1,578	8,376
BALTIMORE CITY	256	154	199	139	142	189	212	275	354	628	692	814	4,054
BALTIMORE COUNTY	95	92	83	95	93	104	125	146	195	305	323	352	2,008
ANNE ARUNDEL	54	57	45	44	53	68	67	85	89	169	198	218	1,147
CARROLL	12	15	16	12	7	27	21	29	34	44	51	68	336
HOWARD	14	13	11	9	18	17	26	18	25	40	47	36	274
HARFORD	24	31	28	38	28	32	34	38	45	76	93	90	557
NATIONAL CAPITAL AREA	62	62	69	52	52	66	78	101	104	190	215	158	1,209
MONTGOMERY	35	29	31	25	28	36	40	53	59	84	91	64	575
PRINCE GEORGE'S	27	33	38	27	24	30	38	48	45	106	124	94	634
SOUTHERN AREA	23	24	28	23	26	32	24	40	48	74	94	71	507
CALVERT	12	6	11	4	10	11	5	16	19	25	27	25	171
CHARLES	8	9	10	9	10	12	9	16	17	36	34	19	189
ST MARY'S	3	9	7	10	6	9	10	8	12	13	33	27	147
EASTERN SHORE AREA	53	38	50	55	57	60	68	75	77	132	139	147	951
CECIL	23	9	21	21	24	22	22	25	26	28	57	58	336
KENT	2	4	2	3	1	0	4	3	3	4	4	2	32
QUEEN ANNE'S	4	2	3	4	4	2	7	9	4	6	6	16	67
CAROLINE	0	2	1	2	8	4	2	7	3	9	8	7	53
TALBOT	3	3	2	2	1	3	6	4	5	10	8	10	57
DORCHESTER	2	3	1	6	2	5	5	0	1	5	10	6	46
WICOMICO	6	7	10	10	10	17	14	15	17	44	28	30	208
SOMERSET	5	3	2	1	3	2	4	2	4	6	3	8	43
WORCESTER	8	5	8	6	4	5	4	10	14	20	15	10	109

1 Includes deaths confirmed or suspected to be related to recent ingestion of opioids.
2 Includes only deaths for which the manner of death was classified as accidental or undetermined.

TABLE 3. TOTAL NUMBER OF HEROIN-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2018.[1,2]

REGION AND POLITICAL SUBDIVISION	HEROIN-RELATED DEATHS												
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	TOTAL
MARYLAND	399	289	360	238	247	392	464	578	748	1,212	1,078	830	6,835
NORTHWEST AREA	16	21	23	15	23	27	40	53	80	119	72	68	557
GARRETT	0	0	1	0	1	0	2	1	3	0	1	1	10
ALLEGANY	3	4	2	3	3	6	3	5	13	34	14	15	105
WASHINGTON	5	13	11	6	8	11	14	21	38	39	22	29	217
FREDERICK	8	4	9	6	11	10	21	26	26	46	35	23	225
BALTIMORE METRO AREA	323	203	264	171	165	272	319	379	519	858	772	572	4,817
BALTIMORE CITY	200	107	151	93	76	131	150	192	260	454	380	286	2,480
BALTIMORE COUNTY	56	51	53	42	38	64	76	86	134	208	170	119	1,097
ANNE ARUNDEL	38	24	31	18	24	38	41	53	60	105	118	75	625
CARROLL	9	5	7	3	2	13	14	16	22	25	28	34	178
HOWARD	8	8	7	3	10	12	16	9	16	24	23	15	151
HARFORD	12	8	15	12	15	14	22	23	27	42	53	43	286
NATIONAL CAPITAL AREA	37	38	42	26	23	42	53	65	69	115	104	78	692
MONTGOMERY	17	14	16	12	11	22	28	33	37	48	52	34	324
PRINCE GEORGE'S	20	24	26	14	12	20	25	32	32	67	52	44	368
SOUTHERN AREA	8	11	10	11	15	18	13	28	29	48	45	31	267
CALVERT	5	3	7	1	5	6	2	13	15	17	17	8	99
CHARLES	2	5	3	6	6	5	5	10	8	22	16	11	99
ST MARY'S	1	3	0	4	4	7	6	5	6	9	12	12	69
EASTERN SHORE AREA	15	16	21	15	21	33	39	53	51	72	85	81	502
CECIL	8	4	12	4	8	11	11	15	16	19	37	40	185
KENT	1	1	0	0	1	0	0	2	1	1	1	0	8
QUEEN ANNE'S	0	1	3	2	2	2	5	7	1	4	5	8	40
CAROLINE	0	0	0	0	3	3	2	6	2	6	4	3	29
TALBOT	1	2	0	0	1	2	2	4	3	4	3	4	26
DORCHESTER	1	2	0	2	1	3	3	0	1	3	4	3	23
WICOMICO	1	3	3	5	3	9	11	12	13	21	20	12	113
SOMERSET	2	1	1	0	1	2	1	1	3	3	2	5	22
WORCESTER	1	2	2	2	1	1	4	6	11	11	9	6	56

1 Includes deaths confirmed or suspected to be related to recent heroin use.
2 Includes only deaths for which the manner of death was classified as accidental or undetermined.

TABLE 4. TOTAL NUMBER OF PRESCRIPTION OPIOID-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2018.[1,2]

REGION AND POLITICAL SUBDIVISION	PRESCRIPTION OPIOID-RELATED DEATHS												
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	TOTAL
MARYLAND	302	280	251	311	342	311	316	330	351	418	413	379	4,004
NORTHWEST AREA	22	21	21	22	38	30	35	33	39	56	35	34	386
GARRETT	0	2	2	1	1	0	2	2	1	0	1	1	13
ALLEGANY	9	5	6	8	5	5	8	6	6	15	9	5	87
WASHINGTON	7	10	4	7	11	9	11	16	20	23	8	19	145
FREDERICK	6	4	9	6	21	16	14	9	12	18	17	9	141
BALTIMORE METRO AREA	190	189	148	197	212	196	207	217	233	265	298	272	2,624
BALTIMORE CITY	95	60	63	61	82	74	86	84	105	113	123	128	1,074
BALTIMORE COUNTY	48	51	37	60	68	47	54	59	62	67	87	71	711
ANNE ARUNDEL	22	36	20	31	33	33	28	32	27	48	43	36	389
CARROLL	4	11	10	9	5	17	12	15	14	15	13	16	141
HOWARD	6	6	4	6	9	5	13	7	9	6	13	2	86
HARFORD	15	25	14	30	15	20	14	20	16	16	19	19	223
NATIONAL CAPITAL AREA	28	29	32	31	35	29	30	35	36	42	33	27	387
MONTGOMERY	20	17	19	14	20	18	16	19	23	26	19	16	227
PRINCE GEORGE'S	8	12	13	17	15	11	14	16	13	16	14	11	160
SOUTHERN AREA	17	16	18	16	15	18	12	19	19	25	26	22	223
CALVERT	8	3	4	3	7	6	3	7	6	11	5	6	69
CHARLES	6	6	7	4	5	7	5	9	8	10	11	8	86
ST MARY'S	3	7	7	9	3	5	4	3	5	4	10	8	68
EASTERN SHORE AREA	45	25	32	45	42	38	32	26	24	30	21	24	384
CECIL	19	6	10	20	20	18	12	12	10	8	8	5	148
KENT	2	3	2	3	1	0	4	2	2	0	2	0	21
QUEEN ANNE'S	4	1	1	2	2	0	3	3	3	2	2	4	27
CAROLINE	0	2	1	2	5	1	0	1	0	4	1	1	18
TALBOT	2	1	2	2	0	1	4	0	2	3	4	2	23
DORCHESTER	2	1	1	4	1	3	3	0	0	2	2	2	21
WICOMICO	5	4	8	7	7	9	4	3	5	7	0	5	64
SOMERSET	4	3	1	1	3	2	2	1	1	0	1	2	21
WORCESTER	7	4	6	4	3	4	0	4	1	4	1	3	41

[1] Includes deaths confirmed or suspected to be related to recent ingestion of one or more prescription opioids.
[2] Includes only deaths for which the manner of death was classified as accidental or undetermined.

TABLE 5. TOTAL NUMBER OF OXYCODONE-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2018.[1,2]

REGION AND POLITICAL SUBDIVISION	OXYCODONE-RELATED DEATHS												
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	TOTAL
MARYLAND	63	72	82	113	118	99	86	120	104	157	122	103	1,239
NORTHWEST AREA	4	7	9	7	11	13	12	10	11	25	16	13	138
GARRETT	0	1	0	0	0	0	1	0	0	0	0	0	2
ALLEGANY	3	0	1	2	0	2	3	3	2	7	3	2	28
WASHINGTON	0	4	3	2	5	2	5	5	6	11	2	7	52
FREDERICK	1	2	5	3	6	9	3	2	3	7	11	4	56
BALTIMORE METRO AREA	31	44	34	59	63	51	44	69	56	77	73	67	668
BALTIMORE CITY	7	6	10	5	15	15	11	20	18	22	23	21	173
BALTIMORE COUNTY	8	14	14	21	22	12	14	22	16	22	21	20	206
ANNE ARUNDEL	5	9	4	9	14	11	9	10	12	23	15	15	136
CARROLL	2	3	3	6	3	6	3	4	3	3	4	7	47
HOWARD	3	2	0	4	2	2	4	4	4	2	5	0	32
HARFORD	6	10	3	14	7	5	3	9	3	5	5	4	74
NATIONAL CAPITAL AREA	10	10	14	15	14	11	13	17	16	25	13	7	165
MONTGOMERY	7	8	10	7	9	8	7	11	8	16	8	4	103
PRINCE GEORGE'S	3	2	4	8	5	3	6	6	8	9	5	3	62
SOUTHERN AREA	9	7	11	7	10	10	6	11	13	13	14	10	121
CALVERT	3	1	2	2	4	5	3	3	3	7	3	1	37
CHARLES	5	3	4	2	4	3	1	5	8	4	7	5	51
ST MARY'S	1	3	5	3	2	2	2	3	2	2	4	4	33
EASTERN SHORE AREA	9	4	14	25	20	14	11	13	8	17	6	6	147
CECIL	3	0	3	13	9	4	6	6	3	2	2	0	51
KENT	0	0	1	2	0	0	1	0	1	0	0	0	5
QUEEN ANNE'S	1	0	1	1	1	0	1	1	2	1	0	1	10
CAROLINE	0	0	1	1	0	0	0	0	0	3	0	1	6
TALBOT	0	0	0	1	0	1	1	0	0	2	2	0	7
DORCHESTER	1	0	0	2	1	1	0	0	0	2	1	1	9
WICOMICO	1	2	4	2	5	5	1	2	1	5	0	2	30
SOMERSET	0	0	1	1	2	1	1	1	0	0	0	1	8
WORCESTER	3	2	3	2	2	2	0	3	1	2	1	0	21

[1] Includes deaths confirmed or suspected to be related to recent ingestion of oxycodone.
[2] Includes only deaths for which the manner of death was classified as accidental or undetermined.

TABLE 6: TOTAL NUMBER OF METHADONE-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2018.[1,2]

REGION AND POLITICAL SUBDIVISION	METHADONE-RELATED DEATHS												
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	TOTAL
MARYLAND	210	163	135	173	172	170	138	152	183	197	246	196	2,135
NORTHWEST AREA	15	9	7	8	14	14	8	20	14	12	11	14	146
GARRETT	0	0	1	1	0	0	1	1	0	0	0	0	4
ALLEGANY	3	4	2	3	4	1	1	3	2	4	3	2	32
WASHINGTON	6	4	0	3	5	4	3	10	6	5	4	10	60
FREDERICK	6	1	4	1	5	9	3	6	6	3	4	2	50
BALTIMORE METRO AREA	141	118	97	128	128	122	110	112	145	158	198	155	1,612
BALTIMORE CITY	80	47	50	53	65	54	57	54	78	82	87	85	792
BALTIMORE COUNTY	34	29	18	37	32	28	29	31	34	36	63	37	408
ANNE ARUNDEL	15	19	13	17	17	15	6	14	9	21	23	12	181
CARROLL	1	7	4	2	2	12	7	5	9	9	6	6	70
HOWARD	2	1	4	2	5	1	5	2	5	2	8	1	38
HARFORD	9	15	8	17	7	12	6	6	10	8	11	14	123
NATIONAL CAPITAL AREA	11	16	12	12	13	13	7	6	9	13	14	7	133
MONTGOMERY	8	8	7	5	6	7	3	5	6	7	6	4	72
PRINCE GEORGE'S	3	8	5	7	7	6	4	1	3	6	8	3	61
SOUTHERN AREA	9	7	7	7	3	5	2	7	6	6	9	7	75
CALVERT	5	0	2	1	2	2	0	2	3	2	3	4	26
CHARLES	2	4	2	1	0	1	1	4	2	2	3	2	24
ST MARY'S	2	3	3	5	1	2	1	1	1	2	3	1	25
EASTERN SHORE AREA	34	13	12	18	14	16	11	7	9	8	14	13	169
CECIL	16	3	6	9	9	10	4	4	3	3	4	5	76
KENT	2	2	1	2	1	0	2	1	1	0	2	0	14
QUEEN ANNE'S	2	1	1	1	1	0	1	0	1	1	2	3	14
CAROLINE	0	0	0	1	1	1	0	1	0	2	1	0	7
TALBOT	2	0	2	1	0	1	2	0	1	1	2	1	13
DORCHESTER	1	1	0	0	0	1	0	0	0	0	2	1	6
WICOMICO	3	2	1	3	1	1	2	0	2	0	0	1	16
SOMERSET	3	2	0	0	1	0	0	0	1	0	1	0	8
WORCESTER	5	2	1	1	0	2	0	1	0	1	0	2	15

1 Includes deaths confirmed or suspected to be related to recent ingestion of methadone.
2 Includes only deaths for which the manner of death was classified as accidental or undetermined.

TABLE 7: TOTAL NUMBER OF FENTANYL-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2018.[1,2]

REGION AND POLITICAL SUBDIVISION	FENTANYL-RELATED DEATHS												
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	TOTAL
MARYLAND	26	25	27	39	26	29	58	186	340	1,119	1,594	1,888	5,357
NORTHWEST AREA	3	1	1	6	6	3	7	8	32	109	119	166	461
GARRETT	0	1	0	0	1	0	0	0	2	0	2	2	8
ALLEGANY	3	0	1	2	1	1	1	1	5	29	29	29	102
WASHINGTON	0	0	0	2	1	1	4	1	14	31	39	70	163
FREDERICK	0	0	0	2	3	1	2	6	11	49	49	65	188
BALTIMORE METRO AREA	14	19	16	20	10	16	35	142	248	792	1,118	1,415	3,845
BALTIMORE CITY	3	2	4	4	2	4	12	72	120	419	573	758	1,973
BALTIMORE COUNTY	6	9	9	6	4	5	11	36	65	182	244	308	885
ANNE ARUNDEL	3	5	3	5	2	3	6	23	29	98	152	184	513
CARROLL	0	2	0	2	0	1	2	4	11	20	40	55	137
HOWARD	1	0	0	0	0	2	3	5	7	27	36	34	115
HARFORD	1	1	0	3	2	1	1	2	16	46	73	76	222
NATIONAL CAPITAL AREA	3	0	3	3	0	3	6	15	32	101	175	115	456
MONTGOMERY	2	0	1	1	0	2	0	8	17	43	72	40	186
PRINCE GEORGE'S	1	0	2	2	0	1	6	7	15	58	103	75	270
SOUTHERN AREA	0	1	2	1	3	1	4	9	9	32	74	60	196
CALVERT	0	1	1	0	1	0	0	5	2	11	22	23	66
CHARLES	0	0	0	0	1	1	3	1	4	17	26	14	67
ST MARY'S	0	0	1	1	1	0	1	3	3	4	26	23	63
EASTERN SHORE AREA	6	4	5	9	7	6	6	12	19	85	108	132	399
CECIL	2	1	0	2	2	0	0	1	7	9	44	52	120
KENT	0	0	0	0	0	0	0	1	0	3	3	2	9
QUEEN ANNE'S	1	0	0	0	0	0	1	1	0	4	5	16	28
CAROLINE	0	0	0	1	4	0	0	0	1	3	7	6	22
TALBOT	1	1	0	1	0	1	0	2	2	7	3	10	28
DORCHESTER	0	0	0	2	0	0	2	0	1	3	7	4	19
WICOMICO	1	1	3	1	1	4	1	7	1	34	24	24	102
SOMERSET	1	1	0	1	0	0	2	0	1	6	3	8	23
WORCESTER	0	0	2	1	0	1	0	0	6	16	12	10	48

1 Includes deaths confirmed or suspected to be related to recent ingestion or exposure to pharmaceutical or nonpharmaceutical fentanyl.
2 Includes only deaths for which the manner of death was classified as accidental or undetermined.

TABLE 8: TOTAL NUMBER OF COCAINE-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2018.[1,2]

REGION AND POLITICAL SUBDIVISION	COCAINE-RELATED DEATHS												
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	TOTAL
MARYLAND	248	157	162	135	148	153	154	198	221	464	691	891	3,622
NORTHWEST AREA	9	4	4	8	10	9	13	16	20	27	43	67	230
GARRETT	0	0	0	1	0	0	0	0	1	0	1	0	3
ALLEGANY	2	1	1	1	0	2	2	2	5	9	13	12	50
WASHINGTON	3	1	0	3	3	5	6	6	10	9	10	31	87
FREDERICK	4	2	3	3	7	2	5	8	4	9	19	24	90
BALTIMORE METRO AREA	178	108	124	93	97	108	102	138	167	348	522	693	2,678
BALTIMORE CITY	106	57	72	45	48	59	47	82	93	202	285	388	1,484
BALTIMORE COUNTY	30	25	25	23	19	17	27	28	38	80	123	132	567
ANNE ARUNDEL	26	18	15	13	18	13	12	19	19	31	66	91	341
CARROLL	2	2	3	6	3	7	7	2	6	8	14	23	83
HOWARD	6	1	4	1	5	7	5	3	6	7	16	19	80
HARFORD	8	5	5	5	4	5	4	4	5	20	18	40	123
NATIONAL CAPITAL AREA	35	26	18	16	24	22	25	29	16	44	62	49	366
MONTGOMERY	20	12	7	4	12	12	13	10	5	11	17	18	141
PRINCE GEORGE'S	15	14	11	12	12	10	12	19	11	33	45	31	225
SOUTHERN AREA	5	6	4	7	3	6	1	3	6	8	19	33	101
CALVERT	1	2	1	3	2	3	0	2	0	2	3	3	22
CHARLES	3	3	2	2	1	1	0	0	2	4	10	13	41
ST MARY'S	1	1	1	2	0	2	1	1	4	2	6	17	38
EASTERN SHORE AREA	21	13	12	11	14	8	13	12	12	37	45	49	247
CECIL	5	3	4	3	7	2	5	4	3	3	15	14	68
KENT	1	2	0	1	0	0	0	1	1	0	1	1	8
QUEEN ANNE'S	3	0	2	0	1	0	0	0	0	1	2	5	14
CAROLINE	0	0	1	0	1	1	0	1	0	5	2	1	12
TALBOT	4	0	1	0	0	0	3	0	1	2	2	3	16
DORCHESTER	1	1	0	1	1	1	1	0	0	1	7	2	16
WICOMICO	2	5	2	3	3	4	3	4	7	13	7	13	66
SOMERSET	1	0	1	1	0	0	0	0	0	4	2	6	15
WORCESTER	4	2	1	2	1	0	1	2	0	8	7	4	32

1 Includes deaths confirmed or suspected to be related to recent use of cocaine.
2 Includes only deaths for which the manner of death was classified as accidental or undetermined.

TABLE 9: TOTAL NUMBER OF BENZODIAZEPINE-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2018.[1,2]

REGION AND POLITICAL SUBDIVISION	BENZODIAZEPINE-RELATED DEATHS												
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	TOTAL
MARYLAND	37	48	52	58	68	73	69	103	91	126	146	127	998
NORTHWEST AREA	3	3	7	6	9	5	6	13	8	21	19	10	100
GARRETT	0	0	1	0	0	0	1	0	1	0	2	0	5
ALLEGANY	1	0	1	3	1	0	1	3	1	6	5	1	23
WASHINGTON	1	2	2	2	4	3	2	5	3	6	2	4	36
FREDERICK	1	1	3	1	4	2	2	5	3	9	10	5	46
BALTIMORE METRO AREA	22	29	29	43	39	49	44	66	56	78	98	90	553
BALTIMORE CITY	7	2	10	12	9	15	14	22	15	24	28	28	186
BALTIMORE COUNTY	12	7	8	18	9	12	16	24	18	29	25	32	210
ANNE ARUNDEL	1	8	4	6	14	11	3	9	11	9	27	16	119
CARROLL	0	4	3	3	0	1	3	3	4	1	4	4	30
HOWARD	1	2	2	2	4	2	5	0	6	8	5	1	38
HARFORD	1	6	2	2	3	8	3	8	2	7	9	9	60
NATIONAL CAPITAL AREA	4	9	6	4	9	6	7	12	8	12	15	15	92
MONTGOMERY	1	5	4	4	6	4	4	10	7	7	8	9	69
PRINCE GEORGE'S	3	4	2	0	3	2	3	2	1	5	7	6	38
SOUTHERN AREA	3	5	2	2	2	4	4	6	7	7	8	4	50
CALVERT	1	1	1	1	1	1	1	3	1	1	2	2	16
CHARLES	1	3	1	0	0	2	1	2	4	4	4	1	23
ST MARY'S	1	1	0	1	1	1	2	1	2	2	2	1	15
EASTERN SHORE AREA	5	2	8	3	9	9	8	6	12	8	6	8	76
CECIL	4	0	3	2	6	7	3	3	5	2	1	2	38
KENT	0	0	0	0	0	0	0	0	0	1	2	0	3
QUEEN ANNE'S	0	0	0	1	1	0	0	0	1	1	0	3	7
CAROLINE	0	0	0	0	0	0	0	0	0	0	1	0	1
TALBOT	0	1	0	0	0	0	3	0	1	1	1	0	7
DORCHESTER	0	0	1	0	0	1	1	0	0	1	0	0	4
WICOMICO	0	0	0	0	1	0	0	1	2	1	0	1	6
SOMERSET	1	0	1	0	0	1	1	0	0	0	0	0	4
WORCESTER	0	1	3	0	1	0	0	2	3	1	1	2	14

1 Includes deaths confirmed or suspected to be related to recent ingestion of a benzodiazepine or related drug with sedative effects.
2 Includes only deaths for which the manner of death was classified as accidental or undetermined.

TABLE 10: TOTAL NUMBER OF METHAMPHETAMINE-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2018.[1,2]

REGION AND POLITICAL SUBDIVISION	METHAMPHETAMINE-RELATED DEATHS												
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	TOTAL
MARYLAND	1	1	0	0	0	2	6	3	10	18	28	32	101
NORTHWEST AREA	0	0	0	0	0	1	1	0	1	2	5	6	16
GARRETT	0	0	0	0	0	0	0	0	0	0	2	1	3
ALLEGANY	0	0	0	0	0	0	1	0	0	1	0	2	4
WASHINGTON	0	0	0	0	0	0	0	0	1	1	1	3	6
FREDERICK	0	0	0	0	0	1	0	0	0	0	2	0	3
BALTIMORE METRO AREA	0	1	0	0	0	1	3	1	4	12	12	13	47
BALTIMORE CITY	0	0	0	0	0	1	2	1	1	8	5	5	23
BALTIMORE COUNTY	0	0	0	0	0	0	1	0	0	1	1	4	7
ANNE ARUNDEL	0	0	0	0	0	0	0	0	0	0	2	2	4
CARROLL	0	0	0	0	0	0	0	0	1	0	1	1	3
HOWARD	0	0	0	0	0	0	0	0	2	2	1	1	6
HARFORD	0	1	0	0	0	0	0	0	0	1	2	0	4
NATIONAL CAPITAL AREA	0	0	0	0	0	0	2	0	4	3	4	4	17
MONTGOMERY	0	0	0	0	0	0	0	0	0	1	2	1	4
PRINCE GEORGE'S	0	0	0	0	0	0	2	0	4	2	2	3	13
SOUTHERN AREA	1	0	0	0	0	0	0	0	1	1	3	1	7
CALVERT	0	0	0	0	0	0	0	0	0	0	1	1	2
CHARLES	1	0	0	0	0	0	0	0	1	1	2	0	5
EASTERN SHORE AREA	0	0	0	0	0	0	0	2	0	0	4	8	14
CECIL	0	0	0	0	0	0	0	0	0	0	4	6	10
CAROLINE	0	0	0	0	0	0	0	1	0	0	0	0	1
WICOMICO	0	0	0	0	0	0	0	1	0	0	0	1	2
WORCESTER	0	0	0	0	0	0	0	0	0	0	0	1	1

1 Includes deaths confirmed or suspected to be related to recent ingestion of methamphetamine.
2 Includes only deaths for which the manner of death was classified as accidental or undetermined.

TABLE 11: TOTAL NUMBER OF ALCOHOL-RELATED INTOXICATION DEATHS BY PLACE OF OCCURRENCE, 2007-2018.[1,2]

REGION AND POLITICAL SUBDIVISION	ALCOHOL-RELATED DEATHS												
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	TOTAL
MARYLAND	189	176	163	161	161	195	239	270	310	582	517	472	3,435
NORTHWEST AREA	14	19	16	15	16	12	21	27	30	47	31	0	282
GARRETT	1	2	1	1	1	0	2	1	1	1	2	1	14
ALLEGANY	5	0	3	4	2	4	2	3	6	14	4	7	54
WASHINGTON	3	10	4	5	4	3	6	11	10	17	14	15	102
FREDERICK	5	7	8	5	9	5	11	12	13	15	11	11	112
BALTIMORE METRO AREA	114	96	100	94	99	126	154	166	215	403	334	0	2,240
BALTIMORE CITY	56	41	54	39	44	71	86	86	114	222	198	187	1,198
BALTIMORE COUNTY	38	23	22	29	22	24	32	39	52	81	71	80	513
ANNE ARUNDEL	12	12	9	10	21	15	22	18	27	56	37	44	283
CARROLL	3	4	5	4	4	4	4	9	6	12	9	10	74
HOWARD	2	7	5	3	4	6	6	6	5	14	7	5	70
HARFORD	3	9	5	9	4	6	4	8	11	18	12	13	102
NATIONAL CAPITAL AREA	38	34	23	27	28	38	35	36	32	67	86	0	495
MONTGOMERY	17	15	9	10	16	15	13	18	15	22	35	19	204
PRINCE GEORGE'S	21	19	14	17	12	23	22	18	17	45	51	32	291
SOUTHERN AREA	10	9	8	6	7	7	7	12	11	22	24	0	140
CALVERT	3	3	4	0	2	2	1	4	3	7	4	9	42
CHARLES	5	5	1	4	3	2	4	5	4	12	9	3	57
ST MARY'S	2	1	3	2	2	3	2	3	4	3	11	5	41
EASTERN SHORE AREA	13	18	16	19	11	12	22	29	22	43	42	0	278
CECIL	5	4	7	6	3	6	9	5	8	8	12	10	83
KENT	0	0	0	1	0	0	1	1	0	1	1	0	5
QUEEN ANNE'S	1	2	0	1	3	0	1	7	0	2	4	3	24
CAROLINE	1	0	1	0	1	0	1	2	0	5	4	1	16
TALBOT	0	3	0	0	0	2	2	0	0	0	5	4	16
DORCHESTER	2	0	0	1	0	1	0	0	1	1	2	1	9
WICOMICO	1	6	3	4	2	2	6	7	3	12	9	8	63
SOMERSET	0	0	1	0	1	1	1	2	2	3	1	0	12
WORCESTER	3	3	4	6	1	0	1	5	8	11	4	4	50

1 Includes deaths confirmed or suspected to be related to recent ingestion of alcohol.
2 Includes only deaths for which the manner of death was classified as accidental or undetermined.

Unintentional Drug- and Alcohol-Related Intoxication Deaths* in Maryland

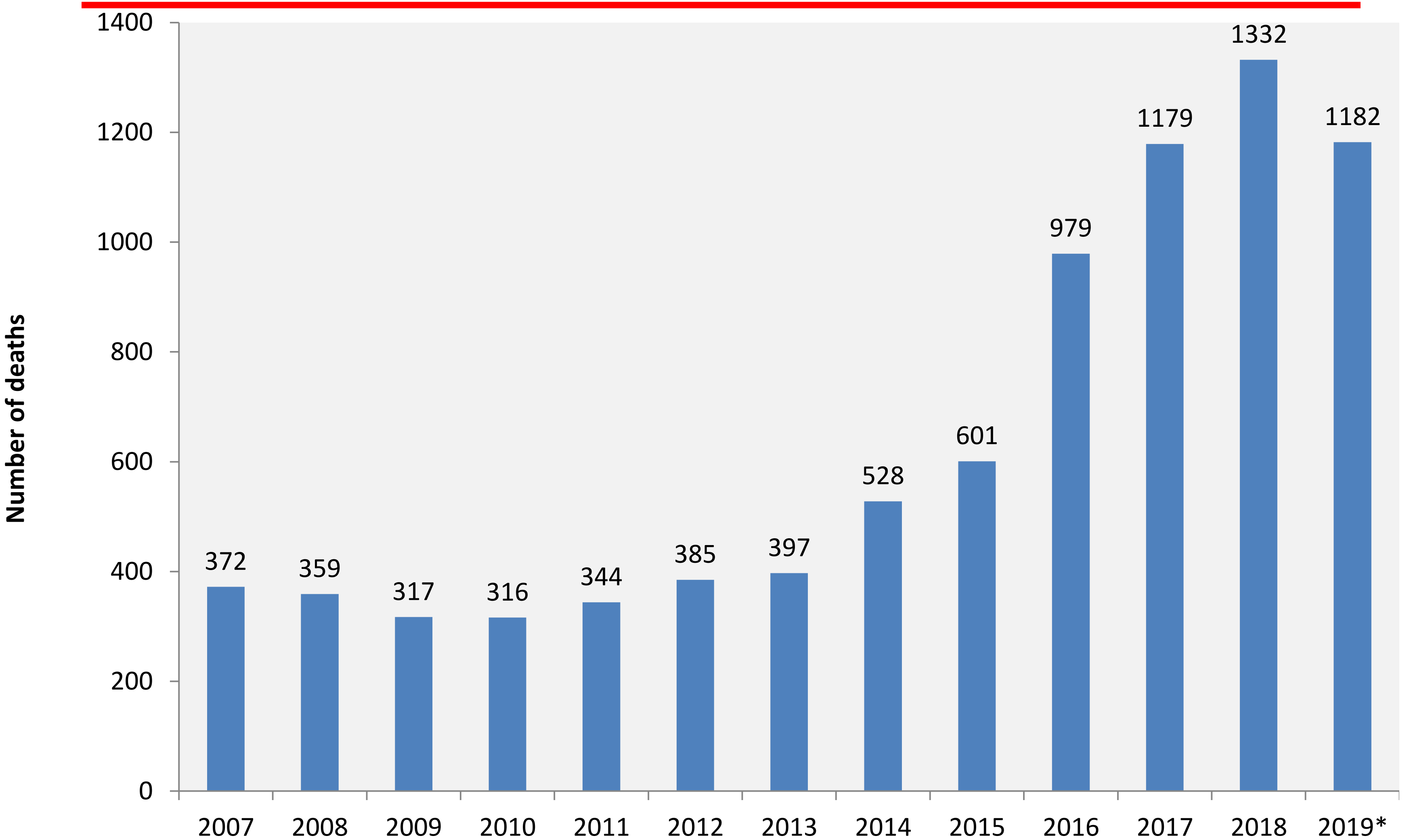
Preliminary Data update through 2nd quarter 2019

This report contains counts of unintentional drug- and alcohol-related intoxication deaths* occurring in Maryland through the 2nd quarter of 2019, the most recent period for which preliminary data are available. Counts are also shown for the same period of 2007-2018 to allow for review of trends over time. Counts for 2019 are not complete and are subject to change.

Since an intoxication death may involve more than one substance, counts of deaths related to specific substances do not sum to the total number of deaths.

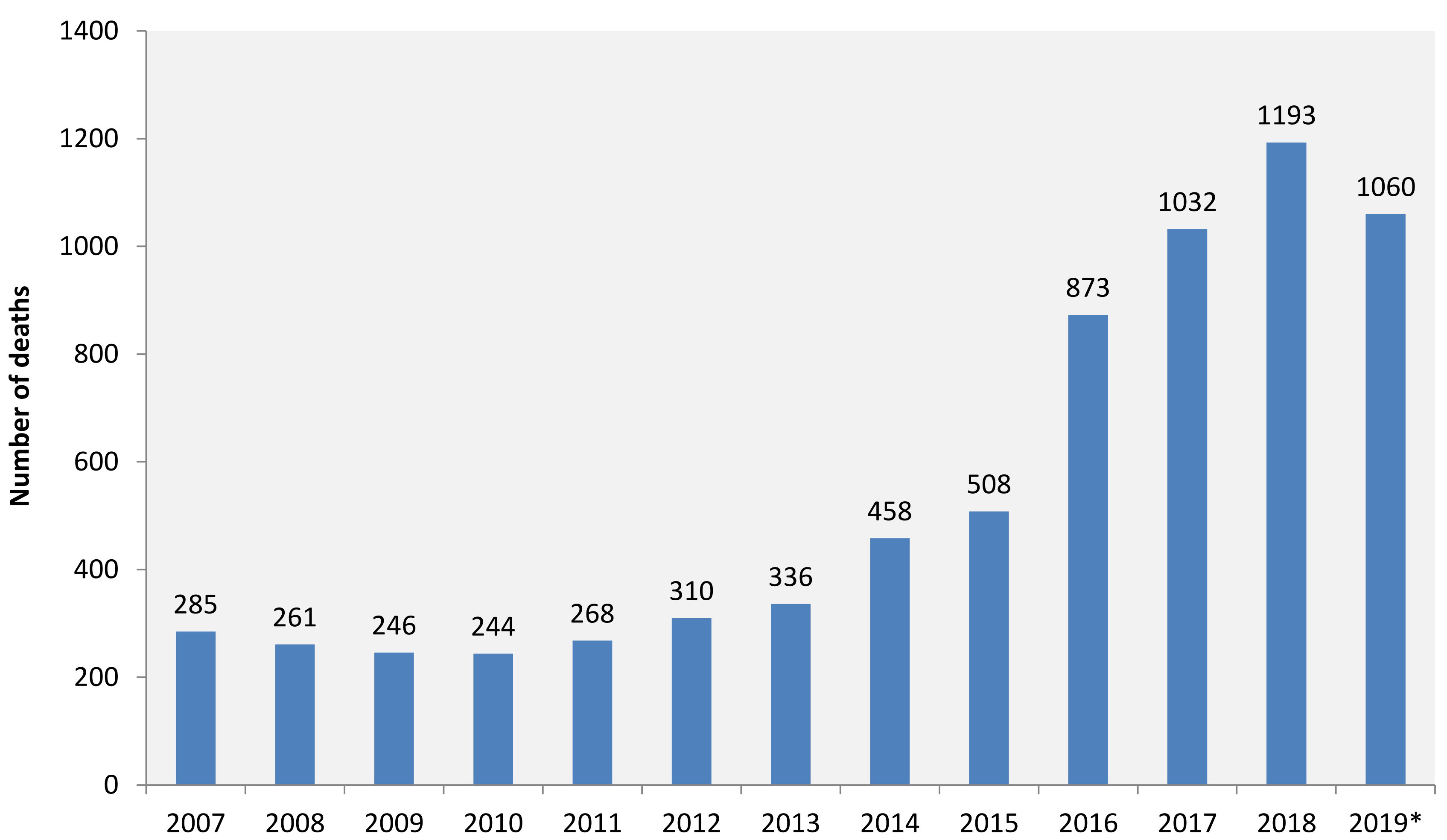
*Deaths resulting from recent ingestion or exposure to alcohol or other types of drugs, including heroin, prescription opioids, prescribed and illicit forms of fentanyl (including carfentanil), cocaine, benzodiazepines, phencyclidine (PCP), methamphetamines and other prescribed and unprescribed drugs.

Figure 1. Total Number of Unintentional Intoxication Deaths Occurring in Maryland from January-June of Each Year.*



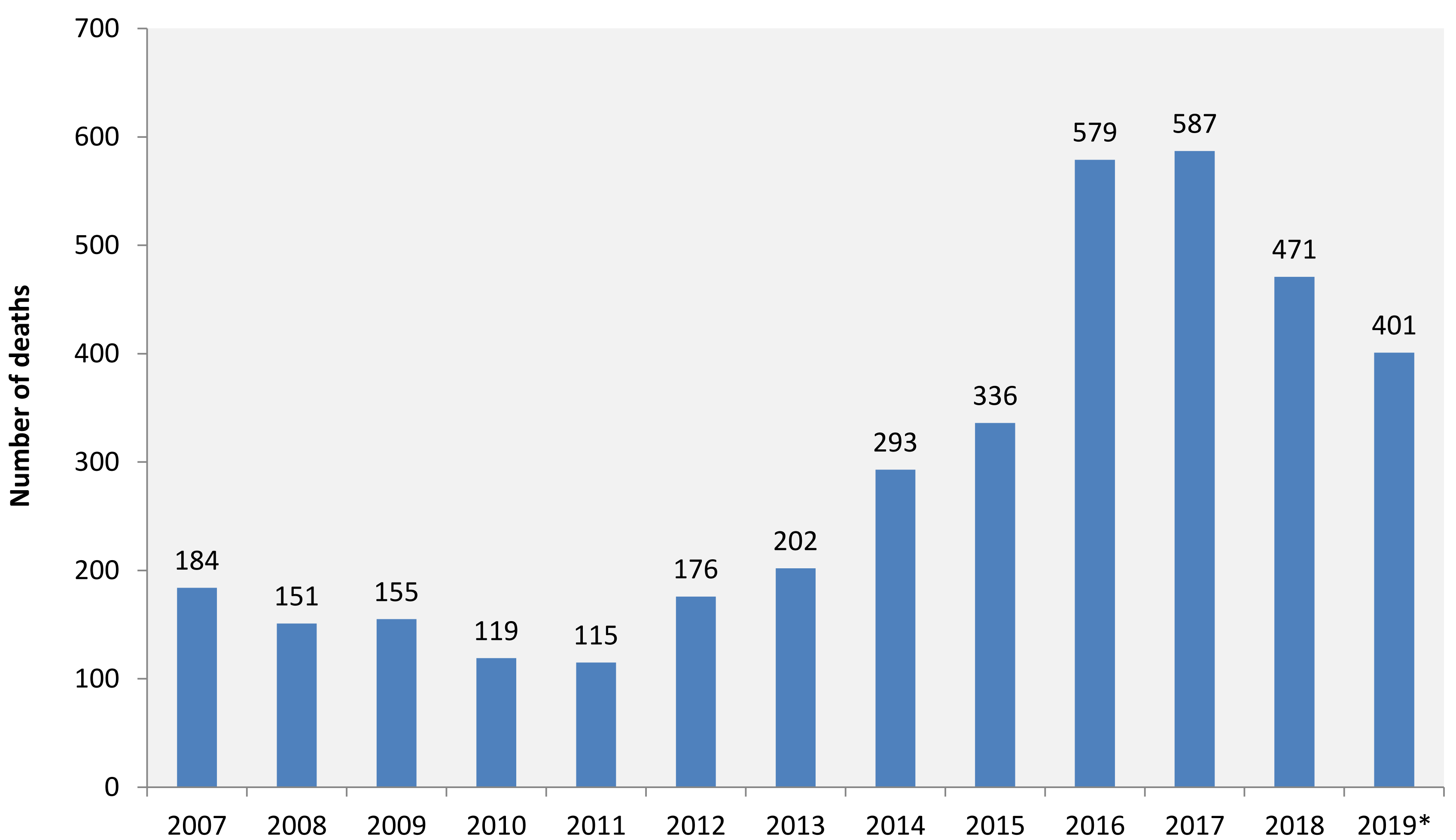
*2019 counts are preliminary.

Figure 2. Number of Opioid-Related Deaths Occurring in Maryland from January through June of Each Year.*



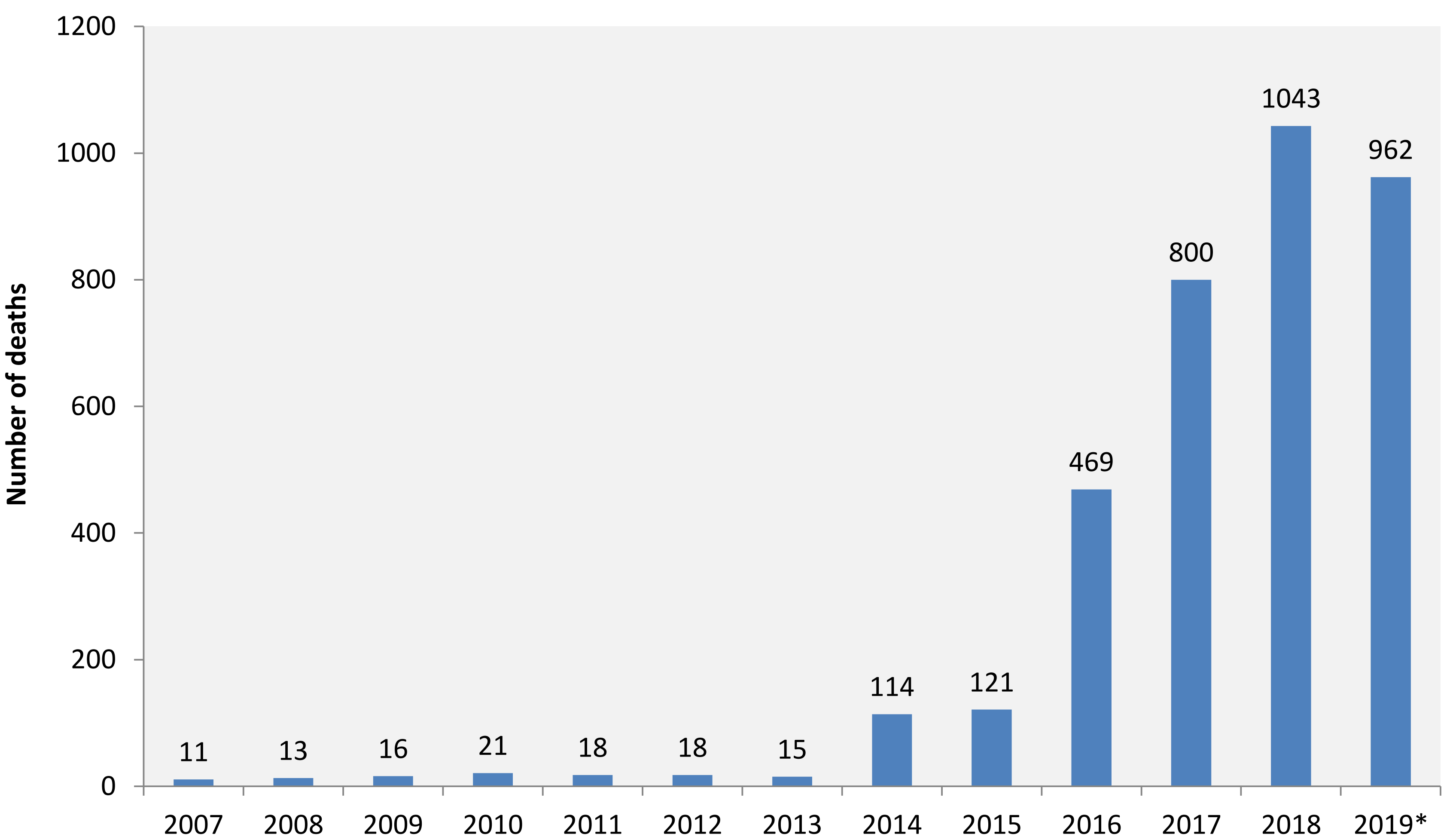
*2019 counts are preliminary.

Figure 3. Number of Heroin-Related Deaths Occurring in Maryland from January through June of Each Year.*



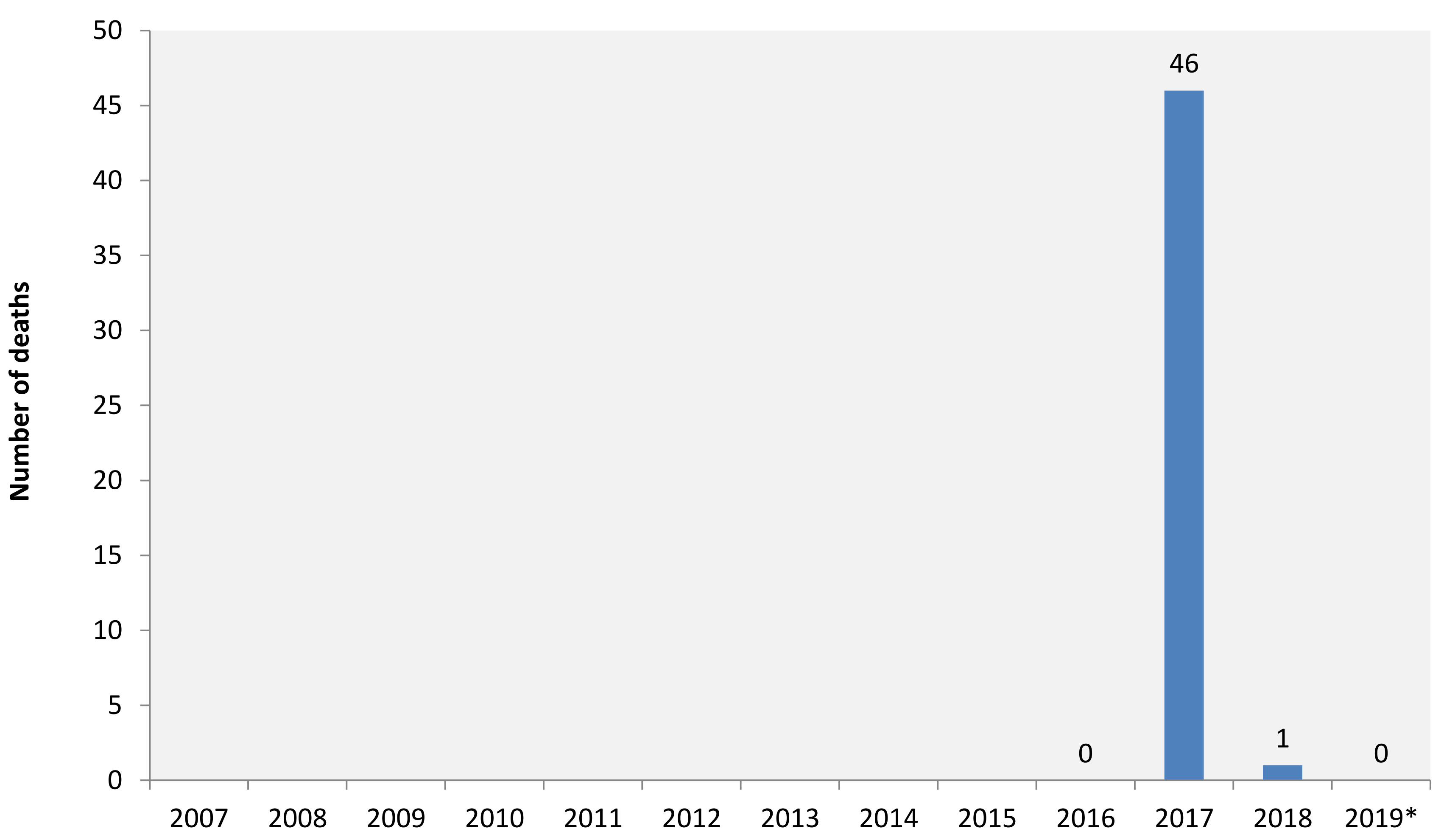
*2019 counts are preliminary.

Figure 4. Number of Fentanyl-Related Deaths Occurring in Maryland from January through June of Each Year.*



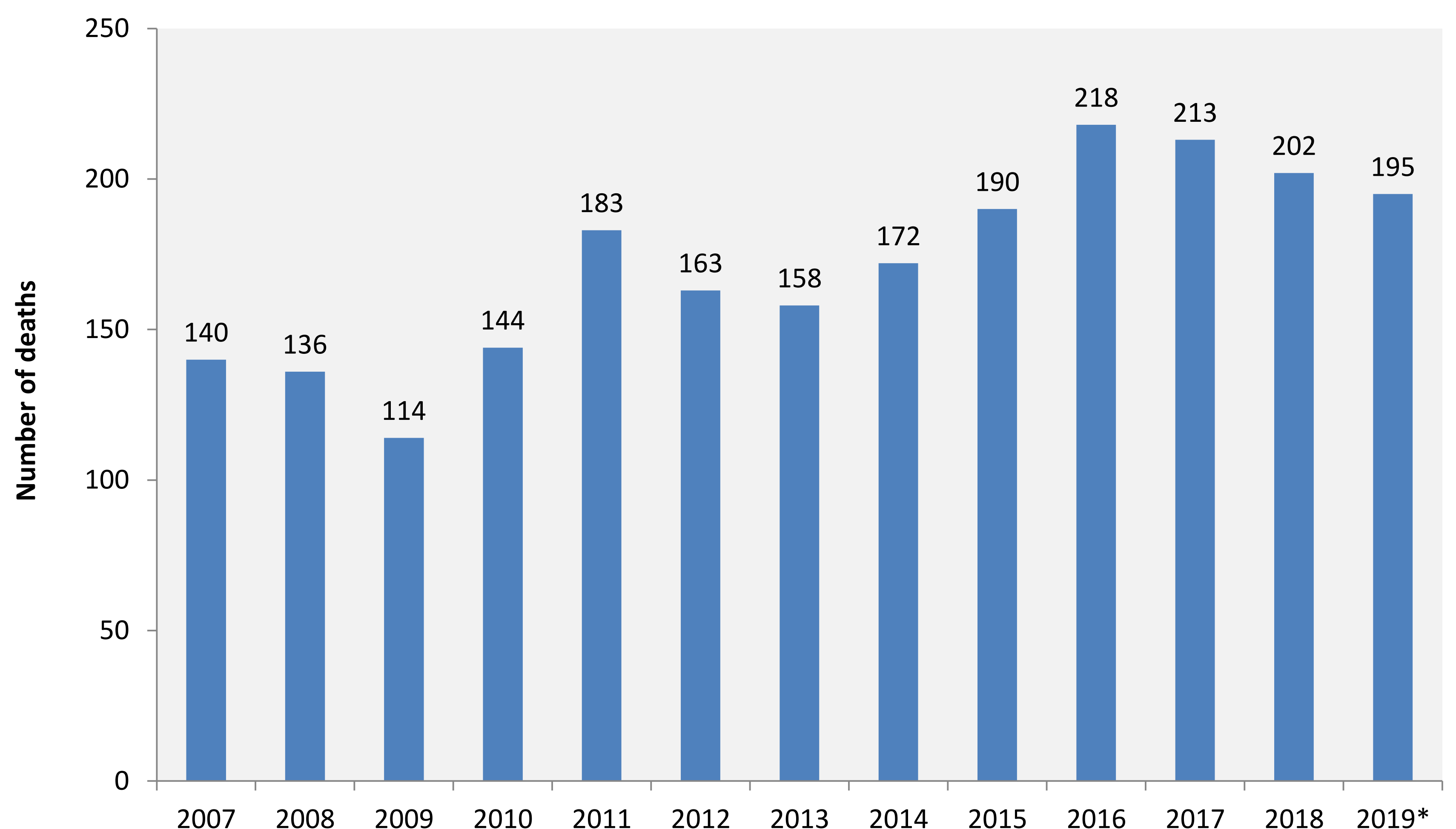
*2019 counts are preliminary.

Figure 5. Number of Carfentanil-Related Deaths Occurring in Maryland from January through June of Each Year.*



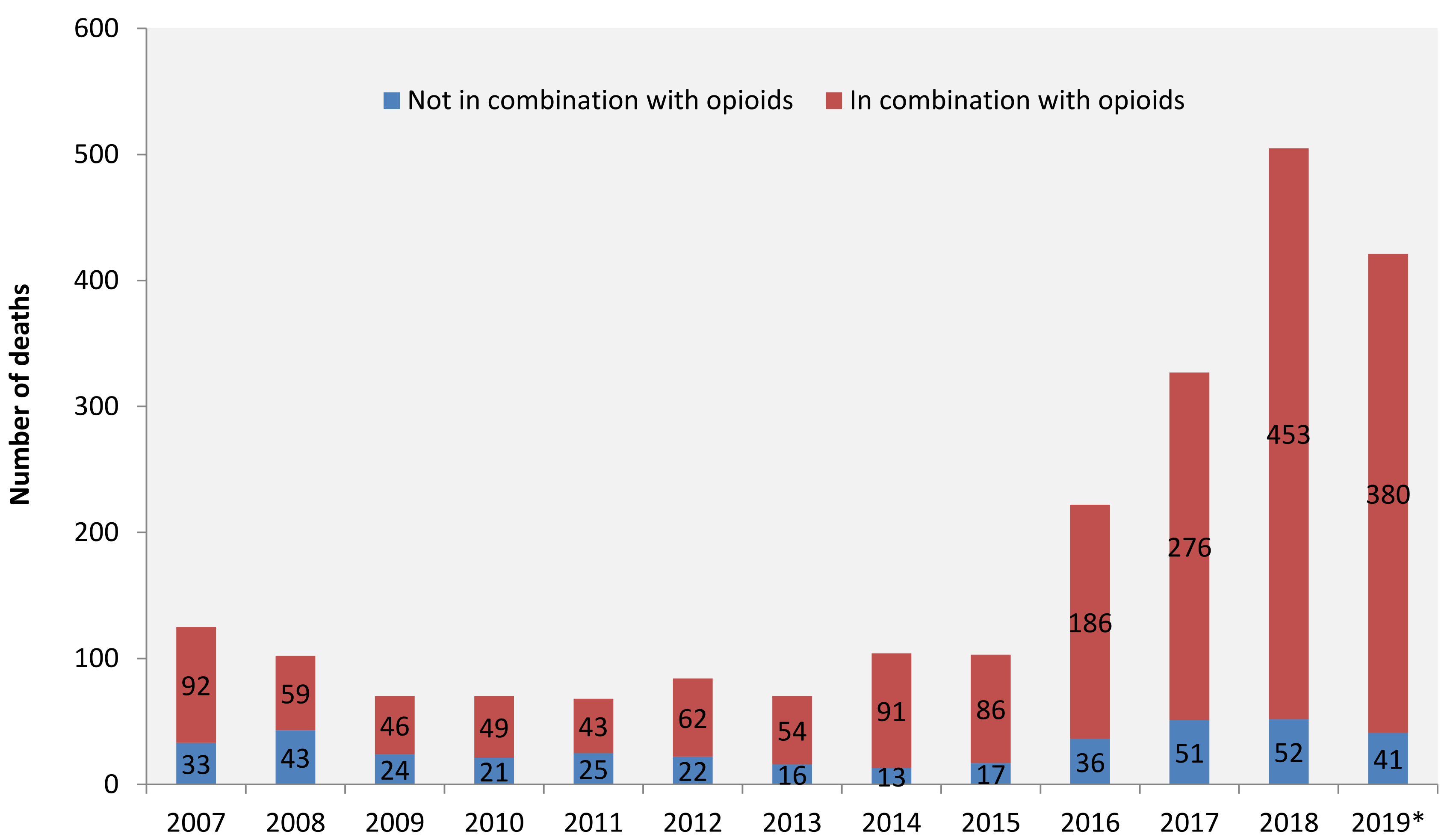
*2019 counts are preliminary.
** Screening for Carfentanil began in 2016, first detected in 2017

Figure 6. Number of Prescription Opioid-Related Deaths Occurring in Maryland from January through June of Each Year.*



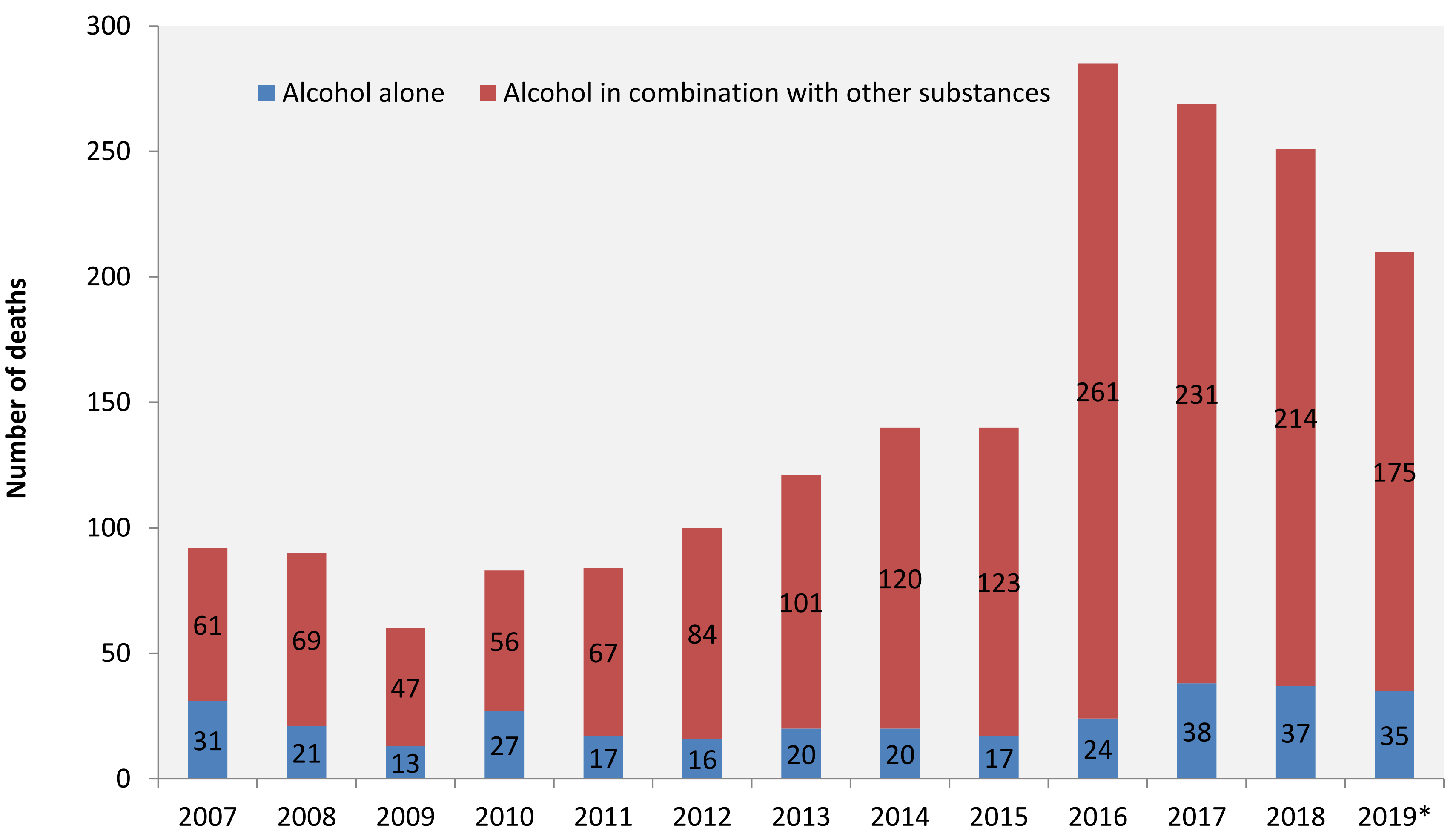
*2019 counts are preliminary.

Figure 7. Number of Cocaine-Related Deaths Occurring in Maryland from January through June of Each Year.*



*2019 counts are preliminary.

Figure 8. Number of Alcohol-Related Deaths Occurring in Maryland from January through June of Each Year.*



*2019 counts are preliminary.

Table 1. Comparison of Total Drug and Alcohol-Related Intoxication Deaths[1,2] by Place of Occurrence, Maryland, January -- June, 2019[3] and 2018.

Jurisdiction	Drug & Alcohol Intoxication Deaths		2019 vs 2018
	Jan. - Jun. 2019	Jan. - Jun. 2018	# DIFFERENCE
Maryland Total	1182	1332	-150
Allegany	15	19	-4
Anne Arundel	104	142	-38
Baltimore City	484	483	1
Baltimore County	187	215	-28
Calvert	17	13	4
Caroline	7	3	4
Carroll	23	48	-25
Cecil	25	33	-8
Charles	13	12	1
Dorchester	5	5	0
Frederick	34	48	-14
Garrett	3	2	1
Harford	44	53	-9
Howard	17	23	-6
Kent	6	1	5
Montgomery	46	55	-9
Prince George's	53	70	-17
Queen Anne's	7	4	3
Somerset	1	5	-4
St. Mary's	11	18	-7
Talbot	9	3	6
Washington	41	46	-5
Wicomico	18	18	0
Worcester	12	13	-1

[1]Includes deaths that were the result of recent ingestion or exposure to alcohol or another type of drug, including heroin, cocaine, prescription opioids, benzodiazepines, and other prescribed and unprescribed drugs.

[2]Includes only deaths for which the manner of death was classified as accidental or undetermined.

[3]Counts for 2019 are not complete.

Table 2. Comparison of Opioid-Related Intoxication Deaths[1,2] by Place of Occurrence, Maryland, January -- June, 2019[3] and 2018.

Jurisdiction	Opioid Intoxication Deaths		2019 vs 2018
	Jan. - Jun. 2019	Jan. - Jun. 2018	# DIFFERENCE
Maryland Total	1060	1193	-133
Allegany	13	16	-3
Anne Arundel	91	132	-41
Baltimore City	449	444	5
Baltimore County	168	195	-27
Calvert	13	11	2
Caroline	7	3	4
Carroll	23	46	-23
Cecil	22	32	-10
Charles	12	8	4
Dorchester	5	4	1
Frederick	33	44	-11
Garrett	2	2	0
Harford	38	46	-8
Howard	14	21	-7
Kent	6	1	5
Montgomery	37	41	-4
Prince George's	37	52	-15
Queen Anne's	7	4	3
Somerset	1	5	-4
St. Mary's	11	17	-6
Talbot	9	3	6
Washington	38	44	-6
Wicomico	15	14	1
Worcester	9	8	1

[1]Includes deaths that were the result of recent ingestion or exposure to any opioid, prescribed or illicit.

[2]Includes only deaths for which the manner of death was classified as accidental or undetermined.

[3]Counts for 2019 are not complete.

Table 3. Comparison of Heroin-Related Intoxication Deaths[1,2] by Place of Occurrence, Maryland, January -- June, 2019[3] and 2018.

Jurisdiction	Heroin Intoxication Deaths		2019 vs 2018
	Jan. - Jun. 2019	Jan. - Jun. 2018	# DIFFERENCE
Maryland Total	401	471	-70
Allegany	3	3	0
Anne Arundel	30	47	-17
Baltimore City	168	158	10
Baltimore County	67	67	0
Calvert	6	5	1
Caroline	4	2	2
Carroll	7	23	-16
Cecil	7	24	-17
Charles	8	4	4
Dorchester	1	3	-2
Frederick	14	16	-2
Garrett	0	1	-1
Harford	13	20	-7
Howard	5	8	-3
Kent	2	0	2
Montgomery	18	23	-5
Prince George's	18	23	-5
Queen Anne's	2	1	1
Somerset	1	3	-2
St. Mary's	3	10	-7
Talbot	3	2	1
Washington	13	18	-5
Wicomico	5	6	-1
Worcester	3	4	-1

[1]Includes deaths that were the result of recent ingestion or exposure to heroin.

[2]Includes only deaths for which the manner of death was classified as accidental or undetermined.

[3]Counts for 2019 are not complete.

Table 4. Comparison of Fentanyl-Related Intoxication Deaths[1,2] by Place of Occurrence, Maryland, January -- June, 2019[3] and 2018.

Jurisdiction	Fentanyl Intoxication Deaths		2019 vs 2018
	Jan. - Jun. 2019	Jan. - Jun. 2018	# DIFFERENCE
Maryland Total	962	1043	-81
Allegany	11	13	-2
Anne Arundel	82	111	-29
Baltimore City	426	415	11
Baltimore County	148	169	-21
Calvert	13	10	3
Caroline	5	3	2
Carroll	22	35	-13
Cecil	20	27	-7
Charles	11	7	4
Dorchester	4	3	1
Frederick	29	42	-13
Garrett	2	1	1
Harford	28	38	-10
Howard	11	19	-8
Kent	6	1	5
Montgomery	33	26	7
Prince George's	31	41	-10
Queen Anne's	6	4	2
Somerset	1	5	-4
St. Mary's	9	14	-5
Talbot	8	3	5
Washington	33	37	-4
Wicomico	14	11	3
Worcester	9	8	1

[1]Includes deaths that were the result of recent ingestion or exposure to fentanyl.

[2]Includes only deaths for which the manner of death was classified as accidental or undetermined.

[3]Counts for 2019 are not complete.

Table 5. Total Number of Drug and Alcohol-Related Intoxication Deaths[1,2] by Place of Occurrence, Maryland, 2007-2018 and YTD 2019 Through June.[3]

Jurisdiction	Drug & Alcohol Intoxication Deaths												
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019 YTD
Maryland Total	815	694	731	649	671	799	858	1,041	1,259	2,089	2,282	2,406	1,182
Allegany	14	9	9	15	12	14	15	12	22	59	38	39	15
Anne Arundel	71	70	63	56	79	83	78	101	112	195	214	241	104
Baltimore City	287	184	239	172	167	225	246	305	393	694	761	888	484
Baltimore County	131	118	106	115	107	119	144	170	220	336	367	388	187
Calvert	14	9	14	6	12	12	6	17	20	28	32	28	17
Caroline	1	4	2	2	11	4	2	7	3	10	11	7	7
Carroll	14	17	22	15	8	29	24	38	40	47	55	72	23
Cecil	25	10	24	24	28	25	26	29	32	30	59	59	25
Charles	13	16	11	13	11	13	9	21	22	45	37	27	13
Dorchester	4	5	2	6	2	5	5	0	1	6	12	7	5
Frederick	23	15	23	20	30	26	37	42	40	88	78	78	34
Garrett	1	3	3	3	2	0	6	2	5	1	8	3	3
Harford	31	35	33	43	38	39	36	43	50	84	101	101	44
Howard	16	19	16	10	21	24	29	21	26	46	51	41	17
Kent	3	4	2	5	2	0	4	6	3	6	5	2	6
Montgomery	56	46	44	38	44	48	52	65	70	102	116	89	46
Prince George's	53	58	59	43	42	56	59	63	70	129	167	127	53
Queen Anne's	4	5	4	4	5	2	8	10	4	8	8	17	7
Somerset	6	3	4	1	3	3	4	3	6	8	4	8	1
St. Mary's	6	11	9	12	8	12	10	9	17	15	34	31	11
Talbot	5	4	3	3	1	5	7	4	5	10	11	10	9
Washington	16	26	18	20	21	27	28	40	64	66	59	91	41
Wicomico	9	13	12	13	11	21	17	20	18	48	35	36	18
Worcester	12	10	9	10	6	7	6	13	16	28	19	16	12

[1]Includes deaths that were the result of recent ingestion or exposure to alcohol or another type of drug, including heroin, cocaine, prescription opioids, benzodiazepines, and other prescribed and unprescribed drugs.

[2]Includes only deaths for which the manner of death was classified as accidental or undetermined.

[3]Counts for 2019 are not complete.

Table 6. Number of Opioid-Related Intoxication Deaths[1,2] by Place of Occurrence, Maryland, 2007-2018 and YTD 2019 Through June.[3]

Jurisdiction	Opioid Intoxication Deaths												
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019 YTD
Maryland Total	628	523	570	504	529	648	729	888	1,089	1,856	2,009	2,143	1,060
Allegany	12	7	6	11	8	10	11	11	20	55	36	33	13
Anne Arundel	54	57	45	44	53	68	67	85	89	169	198	218	91
Baltimore City	256	154	199	139	142	189	212	275	354	628	692	814	449
Baltimore County	95	92	83	95	93	104	125	146	195	305	323	352	168
Calvert	12	6	11	4	10	11	5	16	19	25	27	25	13
Caroline	0	2	1	2	8	4	2	7	3	9	8	7	7
Carroll	12	15	16	12	7	27	21	29	34	44	51	68	23
Cecil	23	9	21	21	24	22	22	25	26	28	57	58	22
Charles	8	9	10	9	10	12	9	16	17	36	34	19	12
Dorchester	2	3	1	6	2	5	5	0	1	5	10	6	5
Frederick	12	7	18	12	28	23	33	34	37	80	66	70	33
Garrett	0	2	3	1	1	0	4	2	4	0	4	3	2
Harford	24	31	28	38	28	32	34	38	45	76	93	90	38
Howard	14	13	11	9	18	17	26	18	25	40	47	36	14
Kent	2	4	2	3	1	0	4	3	3	4	4	2	6
Montgomery	35	29	31	25	28	36	40	53	59	84	91	64	37
Prince George's	27	33	38	27	24	30	38	48	45	106	124	94	37
Queen Anne's	4	2	3	4	4	2	7	9	4	6	6	16	7
Somerset	5	3	2	1	3	2	4	2	4	6	3	8	1
St. Mary's	3	9	7	10	6	9	10	8	12	13	33	27	11
Talbot	3	3	2	2	1	3	6	4	5	10	8	10	9
Washington	11	21	14	13	16	20	26	34	57	63	51	83	38
Wicomico	6	7	10	10	10	17	14	15	17	44	28	30	15
Worcester	8	5	8	6	4	5	4	10	14	20	15	10	9

[1]Includes deaths that were the result of recent ingestion or exposure to prescription and illicit opioids.

[2]Includes only deaths for which the manner of death was classified as accidental or undetermined.

[3]Counts for 2019 are not complete.

Table 7. Number of Heroin-Related Intoxication Deaths[1,2] by Place of Occurrence, Maryland, 2007-2018 and YTD 2019 Through June.[3]

Jurisdiction	Heroin Intoxication Deaths												
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019 YTD
Maryland Total	399	289	360	238	247	392	464	578	748	1,212	1,078	830	401
Allegany	3	4	2	3	3	6	3	5	13	34	14	15	3
Anne Arundel	38	24	31	18	24	38	41	53	60	105	118	75	30
Baltimore City	200	107	151	93	76	131	150	192	260	454	380	286	168
Baltimore County	56	51	53	42	38	64	76	86	134	208	170	119	67
Calvert	5	3	7	1	5	6	2	13	15	17	17	8	6
Caroline	0	0	0	0	3	3	2	6	2	6	4	3	4
Carroll	9	5	7	3	2	13	14	16	22	25	28	34	7
Cecil	8	4	12	4	8	11	11	15	16	19	37	40	7
Charles	2	5	3	6	6	5	5	10	8	22	16	11	8
Dorchester	1	2	0	2	1	3	3	0	1	3	4	3	1
Frederick	8	4	9	6	11	10	21	26	26	46	35	23	14
Garrett	0	0	1	0	1	0	2	1	3	0	1	1	0
Harford	12	8	15	12	15	14	22	23	27	42	53	43	13
Howard	8	8	7	3	10	12	16	9	16	24	23	15	5
Kent	1	1	0	0	1	0	0	2	1	1	1	0	2
Montgomery	17	14	16	12	11	22	28	33	37	48	52	34	18
Prince George's	20	24	26	14	12	20	25	32	32	67	52	44	18
Queen Anne's	0	1	3	2	2	2	5	7	1	4	5	8	2
Somerset	2	1	1	0	1	2	1	1	3	3	2	5	1
St. Mary's	1	3	0	4	4	7	6	5	6	9	12	12	3
Talbot	1	2	0	0	1	2	2	4	3	4	3	4	3
Washington	5	13	11	6	8	11	14	21	38	39	22	29	13
Wicomico	1	3	3	5	3	9	11	12	13	21	20	12	5
Worcester	1	2	2	2	1	1	4	6	11	11	9	6	3

[1]Includes deaths that were the result of recent ingestion or exposure to heroin.

[2]Includes only deaths for which the manner of death was classified as accidental or undetermined.

[3]Counts for 2019 are not complete.

Table 8. Number of Fentanyl-Related Intoxication Deaths[1,2] by Place of Occurrence, Maryland, 2007-2018 and YTD 2019 Through June.[3]

Jurisdiction	Fentanyl Intoxication Deaths												
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019 YTD
Maryland Total	26	25	27	39	26	29	58	186	340	1,119	1,594	1,888	962
Allegany	3	0	1	2	1	1	1	1	5	29	29	29	11
Anne Arundel	3	5	3	5	2	3	6	23	29	98	152	184	82
Baltimore City	3	2	4	4	2	4	12	72	120	419	573	758	426
Baltimore County	6	9	9	6	4	5	11	36	65	182	244	308	148
Calvert	0	1	1	0	1	0	0	5	2	11	22	23	13
Caroline	0	0	0	1	4	0	0	0	1	3	7	6	5
Carroll	0	2	0	2	0	1	2	4	11	20	40	55	22
Cecil	2	1	0	2	2	0	0	1	7	9	44	52	20
Charles	0	0	0	0	1	1	3	1	4	17	26	14	11
Dorchester	0	0	0	2	0	0	2	0	1	3	7	4	4
Frederick	0	0	0	2	3	1	2	6	11	49	49	65	29
Garrett	0	1	0	0	1	0	0	0	2	0	2	2	2
Harford	1	1	0	3	2	1	1	2	16	46	73	76	28
Howard	1	0	0	0	0	2	3	5	7	27	36	34	11
Kent	0	0	0	0	0	0	0	1	0	3	3	2	6
Montgomery	2	0	1	1	0	2	0	8	17	43	72	40	33
Prince George's	1	0	2	2	0	1	6	7	15	58	103	75	31
Queen Anne's	1	0	0	0	0	0	1	1	0	4	5	16	6
Somerset	1	1	0	1	0	0	2	0	1	6	3	8	1
St. Mary's	0	0	1	1	1	0	1	3	3	4	26	23	9
Talbot	1	1	0	1	0	1	0	2	2	7	3	10	8
Washington	0	0	0	2	1	1	4	1	14	31	39	70	33
Wicomico	1	1	3	1	1	4	1	7	1	34	24	24	14
Worcester	0	0	2	1	0	1	0	0	6	16	12	10	9

[1]Includes deaths that were the result of recent ingestion or exposure to prescription or illicit fentanyl.

[2]Includes only deaths for which the manner of death was classified as accidental or undetermined.

[3]Counts for 2019 are not complete.

Table 9. Number of Prescription Opioid-Related Intoxication Deaths[1,2] by Place of Occurrence, Maryland, 2007-2018 and YTD 2019 Through June.[3]

Jurisdiction	Prescription Opioid Intoxication Deaths												
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019 YTD
Maryland Total	302	280	251	311	342	311	316	330	351	418	413	379	195
Allegany	9	5	6	8	5	5	8	6	6	15	9	5	2
Anne Arundel	22	36	20	31	33	33	28	32	27	48	43	36	13
Baltimore City	95	60	63	61	82	74	86	84	105	113	123	128	72
Baltimore County	48	51	37	60	68	47	54	59	62	67	87	71	37
Calvert	8	3	4	3	7	6	3	7	6	11	5	6	2
Caroline	0	2	1	2	5	1	0	1	0	4	1	1	3
Carroll	4	11	10	9	5	17	12	15	14	15	13	16	5
Cecil	19	6	10	20	20	18	12	12	10	8	8	5	2
Charles	6	6	7	4	5	7	5	9	8	10	11	8	4
Dorchester	2	1	1	4	1	3	3	0	0	2	2	2	2
Frederick	6	4	9	6	21	16	14	9	12	18	17	9	7
Garrett	0	2	2	1	1	0	2	2	1	0	1	1	0
Harford	15	25	14	30	15	20	14	20	16	16	19	19	10
Howard	6	6	4	6	9	5	13	7	9	6	13	2	4
Kent	2	3	2	3	1	0	4	2	2	0	2	0	0
Montgomery	20	17	19	14	20	18	16	19	23	26	19	16	7
Prince George's	8	12	13	17	15	11	14	16	13	16	14	11	8
Queen Anne's	4	1	1	2	2	0	3	3	3	2	2	4	0
Somerset	4	3	1	1	3	2	2	1	1	0	1	2	0
St. Mary's	3	7	7	9	3	5	4	3	5	4	10	8	5
Talbot	2	1	2	2	0	1	4	0	2	3	4	2	3
Washington	7	10	4	7	11	9	11	16	20	23	8	19	6
Wicomico	5	4	8	7	7	9	4	3	5	7	0	5	2
Worcester	7	4	6	4	3	4	0	4	1	4	1	3	1

[1]Includes deaths that were the result of recent ingestion or exposure to prescription opioids.

[2]Includes only deaths for which the manner of death was classified as accidental or undetermined.

[3]Counts for 2019 are not complete.

Table 10. Number of Cocaine-Related Intoxication Deaths[1,2] by Place of Occurrence, Maryland, 2007-2018 and YTD 2019 Through June.[3]

Jurisdiction	Cocaine Intoxication Deaths												
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019 YTD
Maryland Total	248	157	162	135	148	153	154	198	221	464	691	891	421
Allegany	2	1	1	1	0	2	2	2	5	9	13	12	2
Anne Arundel	26	18	15	13	18	13	12	19	19	31	66	91	38
Baltimore City	106	57	72	45	48	59	47	82	93	202	285	388	196
Baltimore County	30	25	25	23	19	17	27	28	38	80	123	132	72
Calvert	1	2	1	3	2	3	0	2	0	2	3	3	5
Caroline	0	0	1	0	1	1	0	1	0	5	2	1	0
Carroll	2	2	3	6	3	7	7	2	6	8	14	23	12
Cecil	5	3	4	3	7	2	5	4	3	3	15	14	4
Charles	3	3	2	2	1	1	0	0	2	4	10	13	5
Dorchester	1	1	0	1	1	1	1	0	0	1	7	2	2
Frederick	4	2	3	3	7	2	5	8	4	9	19	24	3
Garrett	0	0	0	1	0	0	0	0	1	0	1	0	1
Harford	8	5	5	5	4	5	4	4	5	20	18	40	12
Howard	6	1	4	1	5	7	5	3	6	7	16	19	4
Kent	1	2	0	1	0	0	0	1	1	0	1	1	2
Montgomery	20	12	7	4	12	12	13	10	5	11	17	18	10
Prince George's	15	14	11	12	12	10	12	19	11	33	45	31	18
Queen Anne's	3	0	2	0	1	0	0	0	0	1	2	5	3
Somerset	1	0	1	1	0	0	0	0	0	4	2	6	0
St. Mary's	1	1	1	2	0	2	1	1	4	2	6	17	6
Talbot	4	0	1	0	0	0	3	0	1	2	2	3	4
Washington	3	1	0	3	3	5	6	6	10	9	10	31	12
Wicomico	2	5	2	3	3	4	3	4	7	13	7	13	10
Worcester	4	2	1	2	1	0	1	2	0	8	7	4	0

[1]Includes deaths that were the result of recent ingestion or exposure to cocaine.

[2]Includes only deaths for which the manner of death was classified as accidental or undetermined.

[3]Counts for 2019 are not complete.

Table 11. Number of Alcohol-Related Intoxication Deaths[1,2] by Place of Occurrence, Maryland, 2007-2018 and YTD 2019 Through June.[3]

Jurisdiction	Alcohol Intoxication Deaths												
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019 YTD
Maryland Total	189	176	163	161	161	195	239	270	310	582	517	472	210
Allegany	5	0	3	4	2	4	2	3	6	14	4	7	3
Anne Arundel	12	12	9	10	21	15	22	18	27	56	37	44	16
Baltimore City	56	41	54	39	44	71	86	86	114	222	198	187	87
Baltimore County	38	23	22	29	22	24	32	39	52	81	71	80	26
Calvert	3	3	4	0	2	2	1	4	3	7	4	9	2
Caroline	1	0	1	0	1	0	1	2	0	5	4	1	1
Carroll	3	4	5	4	4	4	4	9	6	12	9	10	3
Cecil	5	4	7	6	3	6	9	5	8	8	12	10	2
Charles	5	5	1	4	3	2	4	5	4	12	9	3	3
Dorchester	2	0	0	1	0	1	0	0	1	1	2	1	2
Frederick	5	7	8	5	9	5	11	12	13	15	11	11	9
Garrett	1	2	1	1	1	0	2	1	1	1	2	1	1
Harford	3	9	5	9	4	6	4	8	11	18	12	13	4
Howard	2	7	5	3	4	6	6	6	5	14	7	5	3
Kent	0	0	0	1	0	0	1	1	0	1	1	0	1
Montgomery	17	15	9	10	16	15	13	18	15	22	35	19	11
Prince George's	21	19	14	17	12	23	22	18	17	45	51	32	14
Queen Anne's	1	2	0	1	3	0	1	7	0	2	4	3	0
Somerset	0	0	1	0	1	1	1	2	2	3	1	0	0
St. Mary's	2	1	3	2	2	3	2	3	4	3	11	5	1
Talbot	0	3	0	0	0	2	2	0	0	0	5	4	2
Washington	3	10	4	5	4	3	6	11	10	17	14	15	10
Wicomico	1	6	3	4	2	2	6	7	3	12	9	8	7
Worcester	3	3	4	6	1	0	1	5	8	11	4	4	2

[1]Includes deaths that were the result of recent ingestion or exposure to alcohol.

[2]Includes only deaths for which the manner of death was classified as accidental or undetermined.

[3]Counts for 2019 are not complete.

MARYLAND'S INTER-AGENCY OPIOID COORDINATION PLAN

Inter-Agency Heroin and Opioid Coordinating Council

January 2020

Message from the Lieutenant Governor

Since January 2015, the Hogan-Rutherford administration has been laser-focused on implementing a comprehensive, holistic approach to addressing Maryland's ongoing opioid and addiction crisis. Recognizing that this epidemic is a complex issue encompassing many different actors and stakeholders, the administration's efforts have focused on three major policy priorities: *Prevention & Education, Enforcement & Public Safety,* and *Treatment & Recovery.*

It was determined that improved communication and coordination was necessary not only among the various state agencies responding to the epidemic, but their counterparts on the county and municipal levels as well. In 2017, Governor Hogan established the Opioid Operational Command Center (OOCC) in order to improve collaboration between state and local public health, human services, education, and public safety entities to reduce the harmful impacts of the opioid epidemic and substance use disorder on Maryland communities.

As Chair of the Maryland Heroin and Opioid Emergency Task Force and the Inter-Agency Heroin and Opioid Coordinating Council (IACC), I have seen first-hand the hard work and dedication by many individuals in state government to address this crisis and save lives. As part of the IACC, the OOCC is responsible for coordinating with approximately 20 state agencies and all 24 local jurisdictions and Opioid Intervention Teams to ensure that their efforts are aligned with the administration's policy priorities. The following Inter-Agency Opioid Coordination Plan includes detailed descriptions of the State's current programs and initiatives as well as the goals of the Coordination Plan and what efforts will be implemented in order to achieve those goals.

The opioid epidemic is a nationwide public health crisis, the effects of which will be felt for generations to come. In Maryland, for the first time in over a decade, we have finally seen a decline in the number of opioid-related intoxication deaths across the state. While this does give us hope that our efforts are on the right track, more than anything it tells us we must continue with a well-funded, strategic, and comprehensive plan in order to keep making progress.

Boyd K. Rutherford

Lieutenant Governor

Message from the Executive Director of the OOCC

On behalf of the Inter-Agency Opioid Coordinating Council, the Opioid Operational Command Center is pleased to present the 2020 Maryland Inter-Agency Opioid Coordination Plan. The plan provides an overview of the opioid crisis, its effect on Maryland, and our state's response. Most importantly, the plan outlines the goals, strategies and objectives that will guide our response to the opioid epidemic in the coming year.

Opioids have presented Maryland with a dire and unprecedented crisis – a crisis that stole the lives of more than 2,000 citizens in both 2017 and 2018. The effects of opioids on our state have been far reaching, and no jurisdiction or citizen has been spared from their wrath. We are thankful that 2019 brought Maryland the first six-month decline in opioid fatalities in over a decade. However, we must bear in mind that fatalities are still running near all-time highs.

The coordination plan is an integral component of our state's coordinated response to the epidemic – a response that has been viewed as a model for other states facing the same devastating effects of the opioid tragedy. The administration of Governor Larry Hogan started this work in 2015 under the leadership of Lt. Governor Boyd Rutherford with a focus on three key policy priorities: *Prevention & Education*, *Enforcement & Public Safety,* and *Treatment & Recovery.* These policy areas form the basis of our approach, and they drive each of the goals in this plan.

The IACC and OOCC will use this plan to guide our ongoing response to the most- important public health issue of our time. We also encourage local jurisdictions to use this plan as the basis for their own coordination plans.

I would like to acknowledge the efforts of our state partners and local Opioid Intervention Teams for their assistance in developing this plan. As each of us undertakes our work, we will do so driven by the hope of eliminating suffering from substance use disorder.

Thank you,

Steven R. Schuh

Executive Director, Opioid Operational Command Center

Acknowledgements

The Opioid Operational Command Center would like to thank our state and local partners who contributed their time and expertise to Maryland's Inter-Agency Opioid Coordination Plan. Addressing the opioid epidemic in a comprehensive manner requires an all-hands-on-deck approach, and we are grateful for the insight provided by our partners.

State Partners:

Governor's Office on Crime Control & Prevention of Maryland (GOCCP)
Governor's Office on Homeland Security (GOHC)
High Intensity Drug Trafficking Agency (HIDTA)
Maryland Center for School Safety (MCSS)
Maryland Community Health Resources Commission (CHRC)
Maryland Department of Aging (DOA)
Maryland Department of Budget and Management (DBM)
Maryland Department of Health (MDH)
Maryland Department of Housing and Community Development (DHCD)
Maryland Department of Human Services (DHS)
Maryland Department of Information Technology (DoIT)
Maryland Department of Juvenile Services (DJS)
Maryland Department of Labor (MDOL)
Maryland Department of Public Safety and Correctional Services (DPSCS)
Maryland Emergency Management Agency (MEMA)
Maryland Governor's Grants Office (GGO)
Maryland Higher Education Commission (MHEC)
Maryland Insurance Administration (MIA)
Maryland Institute for Emergency Medical Services Systems (MIEMSS)
Maryland State Department of Education (MSDE)
Maryland State Police (MSP)
Motor Vehicle Administration (MVA)

Jurisdictional Partners:

Allegany County Health Department
Anne Arundel County Health Department
Baltimore City Health Department
Baltimore County Health Department
Calvert County Health Department
Caroline County Health Department
Carroll County Health Department
Cecil County Health Department
Charles County Health Department
Dorchester County Health Department
Frederick County Health Department
Garrett County Health Department
Harford County Health Department
Howard County Health Department
Kent County Health Department
Montgomery County Health Department
Prince George's County Health Department
Queen Anne's County Health Department
Somerset County Health Department
St. Mary's County Health Department
Talbot County Health Department
Washington County Health Department
Wicomico County Health Department
Worcester County Health Department

Academic & Community Partners:

Baltimore Harm Reduction Coalition (BHRC)
Bmore POWER
Episcopal Diocese of Maryland
James Place, Inc.
Lifespan Network
Maryland Association for the Treatment of Opioid Use Disorder (MATOD)
Maryland Hospital Association (MHA)
Maryland State Medical Society: MedChi

Opioid Crisis Overview

Since Governor Larry Hogan declared a state of emergency in 2017 in response to the opioid epidemic, state agencies, local jurisdictions, and community organizations have made tremendous strides in addressing the crisis. The formation of the Opioid Operational Command Center (OOCC) has facilitated cross-organizational coordination of resources, and the establishment of local Opioid Intervention Teams (OITs) has brought together stakeholders from multiple disciplines to identify programs and practices that best fit each local community.

Since the declaration of the state of emergency, the rate of opioid-related fatalities in Maryland has shown signs of stabilization. Opioid-related fatalities declined in the first six months of 2019 when compared to the same time period in 2018. While the decline in opioid-related fatalities is welcome news, the state's work is far from over. Opioid misuse, opioid-related overdoses, and deaths continue to present an urgent public health crisis that requires an equally urgent response.

Opioid Fatality Data

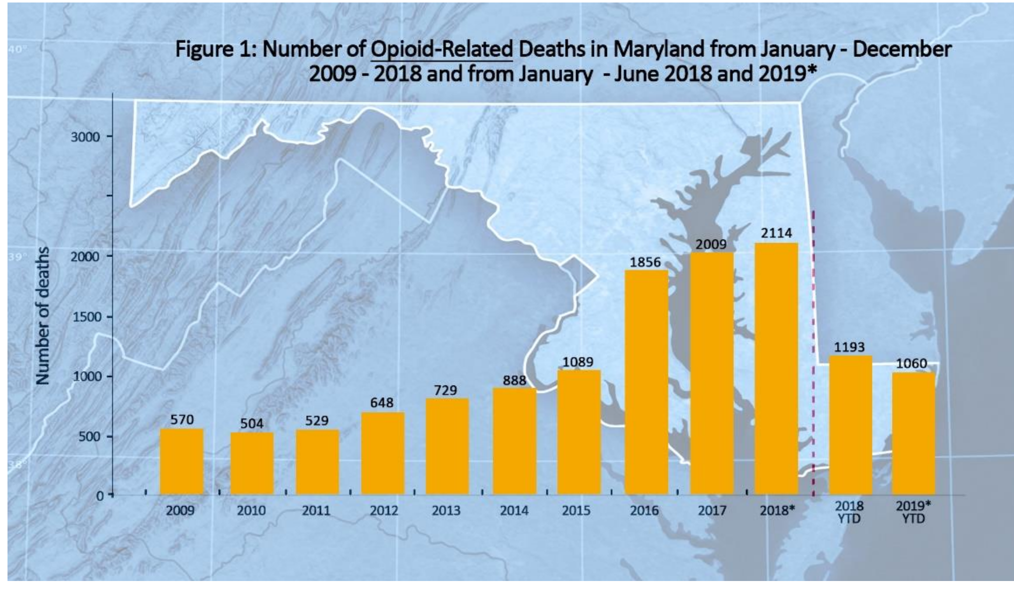
Shown below are counts of opioid-related intoxication deaths occurring in Maryland through June 2019, the most recent period for which preliminary data are publicly available.

Unintentional opioid intoxication deaths are fatalities resulting from recent ingestion or exposure to opioids, including heroin, prescription opioids, prescribed and illicit forms of fentanyl, and cocaine, benzodiazepines, phencyclidine (PCP), methamphetamine, and other drugs in combination with opioids.

Note: The fatalities data presented herein are preliminary and subject to change.

As shown in Figure 1 below, there were 1,060 opioid-related deaths in Maryland in the first six months of 2019. This represents a decrease of 11.1% when compared to the same time period in 2018.

The years 2009 through 2011 were a period of relative stability in the number of opioid-related fatalities in Maryland. The number of fatalities began to increase significantly in 2012 and 2013 as a result of a resurgence in heroin use.



The number of fatalities began to accelerate even more rapidly during the 2014 to 2016 timeframe with the increased availability of illicit synthetic opioids, including fentanyl and its analogs. The period of 2017-2018 witnessed a slowing in the growth rate of fatalities. There was a decline in fatalities during the first half of 2019 as compared to the first half of 2018.

Figure 2. Number of Opioid-Related Drug Intoxication Deaths 2019 v. 2018 Year-to-Date

Number of Deaths Related to:	2018 1st Half (Jan. - Jun.)	2019 1st Half (Jan. - Jun.)	Percent Difference
All Opioids	1,193	1,060	-11.1%
Fentanyl	1,043	962	-7.8%
Cocaine	453	380	-16.1%
Heroin	471	401	-14.9%
Prescription Opioids	202	195	-3.5%
Alcohol	201	168	-16.4%

As shown in Figure 2, in addition to declines in overall opioid-related fatalities, there were declines in deaths related to fentanyl, cocaine in combination with opioids, heroin and prescription opioids through the first half of 2019.

Of the 24 jurisdictions in Maryland, 13 experienced declines in the number of opioid-related deaths in the first half of 2019.

*2019 data are preliminary

Background

In 2015, recognizing the increasing severity of the heroin and opioid overdose crisis, Governor Larry Hogan established the Heroin and Opioid Emergency Task Force and the Inter-Agency Heroin and Opioid Coordinating Council (IACC). Governor Hogan charged the task force with developing initial recommendations for addressing the crisis. The task force's final report in December of 2015 identified 33 recommendations, nearly all of which have been implemented. The IACC continues to meet quarterly as a subcabinet organization responsible for oversight of the statewide response.

In January of 2017, Governor Hogan established the OOCC within the IACC, and he established OITs in each local jurisdiction. Due to the accelerating rate of opioid-related fatalities, Governor Hogan signed an executive order on March 1, 2017 that declared a state of emergency related to the heroin and opioid crisis. The state of emergency activated the Governor's emergency-management authority, authorized the OOCC's executive director to direct the state-agency response, and spurred rapid coordination between state agencies and local jurisdictions. Additionally, Governor Hogan made a five-year, $50 million general-fund budgetary commitment to address the crisis. This funding is used to support programs aligning with the Hogan Administration's policy priorities for combatting the crisis, which are: *Prevention* & *Education*, *Enforcement* & *Public Safety*, and *Treatment & Recovery.*

Recognizing that the opioid-epidemic was a long-term public health threat, Governor Hogan signed Executive Order 01.01.2018.30 in December 2018. This latest executive order replaced the original executive order and requires that state agencies and local jurisdictions continue to operate under a heightened response framework over the long term. See Appendix A.

Opioid Operational Command Center

The OOCC serves as the primary coordinating office for the state's response to the opioid crisis. As outlined in the February 2017 declaration of emergency and reiterated in the December 2018 executive order, the OOCC is responsible for coordinating with approximately 20 state agencies and all 24 local jurisdictions and OITs to ensure that their efforts are aligned with Governor Hogan's established policy priorities: *Prevention* & *Education*, *Enforcement* & *Public Safety*, and *Treatment* & *Recovery*.
The OOCC is an extension of the Office of the Governor, and the OOCC Executive Director is a cabinet-level officer. Operationally, the OOCC is part of the Maryland Emergency Management Agency (MEMA) within the Military Department.

OOCC Vision and Mission

Vision: The OOCC's vision is that Maryland will be a healthier place where no one else falls victim to substance use disorder, where anyone impacted by substance use disorder can get the help they need, and where there is no more suffering from the misuse of substances.

Mission: Under the guidance of the Inter-Agency Heroin and Opioid Coordinating Council, the OOCC will pursue the following mission elements to make our vision a reality:

I. Develop the *Inter-Agency Opioid Coordination Plan*;
II. Coordinate the opioid-related efforts of approximately 20 state agencies, our community partners, and all 24 local jurisdictions throughout the state;
III. Identify "promising practices" that can be implemented throughout Maryland;
IV. Assess gaps in statewide and local efforts to combat the opioid epidemic and work to fill those gaps;
V. Facilitate communications and collect relevant data;
VI. Provide financial support to assist local jurisdictions, state agencies, and community organizations to advance their efforts to combat the opioid crisis; and
VII. Evaluate all opioid-related legislation and opioid crisis-related budget proposals.

State-Level Partner Roles and Responsibilities

The OOCC coordinates the statewide opioid crisis response through state partner agencies in the areas of health, human services, education, law enforcement/public safety, and emergency services. State partners serve as subject-matter experts on collaborative initiatives and are responsible for program development and implementation within their agencies. Non-governmental partners, including health care systems and associations, community and faith-based organizations, professional associations, and nonprofits and businesses, play a vital role in Maryland's whole-community approach.

Local Opioid Intervention Teams (OITs)

A key element of the statewide strategy is encouraging multidisciplinary collaboration and coordination among all levels of government. To provide direction and coordination among stakeholders at the local level, all 24 jurisdictions have established OITs, which function as local jurisdictional, multi-agency coordinating bodies. The purpose of an OIT is to bring together representatives from different local agencies to advance local programming, to identify gaps and opportunities and to coordinate resources. OITs are led jointly by each jurisdiction's health officer and emergency manager and include governmental and community partners from local agencies, providers, and community groups.

OITs are responsible for developing a community strategy to address opioid addiction and substance use disorder (SUD) in their community. OITs also identify priority areas for programming and allocate OIT grant funding to those areas. Most OITs meet on a monthly or quarterly basis to discuss progress in priority areas and gaps that need to be addressed.

Opioid Operational Command Center

The Opioid Operational Command Center facilitates collaboration among state and local partners to reduce the harmful impacts of heroin and opioid misuse on Maryland communities.

What does the OOCC do?
Combat the heroin and opioid crisis in Maryland through education, prevention, treatment, interdiction, and recovery.

Why?
Residents of all ages, races, genders, and areas across the state are affected by heroin and opioid misuse. State and local health and human services, education, and public safety officials are working together to develop community-based programs and services to combat this public health crisis.

By working together with the Opioid Operational Command Center, partners share data, information, and ideas. Together, we can reduce the harmful impacts of heroin and opioid use and continue *changing Maryland for the Better.*

OOCC

INTER-AGENCY COUNCIL

STATE-LEVEL PARTNERS

LOCAL OPIOID INTERVENTION TEAMS

Inter-Agency Heroin and Opioid Coordinating Council

Chaired by Lt. Governor Boyd K. Rutherford, the Coordinating Council is the executive-level subcabinet of the Governor that develops strategic policy, provides authority for the Opioid Operational Command Center, and advises the governor's office.

State-Level Partners

The OOCC coordinates with approximately 20 state agencies to ensure that efforts align with the Hogan Administration's policy priority areas: *Prevention & Education, Enforcement & Public Safety* and *Treatment & Recovery.*

In addition to partnering with state agencies, the OOCC coordinates with non-governmental partners to execute Maryland's whole-community approach to addressing the opioid crisis.

Local Opioid Intervention Teams

Local Opioid Intervention Teams act as the local multi-agency, coordinating bodies within each of Maryland's 24 jurisdictions. The OITs are tasked with developing a unified local strategy, conducting operational coordination with all stakeholders, and working cooperatively on program and project implementation and operations.

Hogan Administration Policy Priorities

To address the opioid crisis in a comprehensive and systematic manner, Governor Hogan identified the following policy priorities: *Prevention* & *Education, Enforcement* & *Public Safety,* and *Treatment & Recovery*.

Prevention & Education

In order to protect the current and future health and wellness of Marylanders, the OOCC supports programs and strategies that prevent current and future substance use and mitigates the consequences associated with SUD.

The OOCC categorizes prevention strategies as either *primary prevention* or *harm reduction*. Primary prevention strategies aim to reduce individual and environmental risk factors while increasing protective factors to prevent or delay the onset of drug use. Examples of primary prevention strategies include public health messaging campaigns, school curricula that address the risks associated with substance use, and initiatives that support the safe storage and disposal of prescription drugs.

Harm reduction strategies aim to meet drug users where they are by offering a spectrum of services. These services range from mitigating the negative health effects of drug use to abstinence programs.[1] Strategies that reduce harm related to drug use provide an opportunity for individuals who use drugs to engage with systems of care in a dignified and humane manner. Examples of harm reduction programming in Maryland include targeted naloxone distribution through the Maryland Department of Health's supported Overdose Response Programs (ORPs) and emergency medical systems (EMS) naloxone leave-behind programs. Additionally, local jurisdictions and community organizations have begun expanding access to harm reduction services through the provision of wound-care treatment and by distributing harm reduction tools such as fentanyl test strips.

Enforcement & Public Safety

Law enforcement and public safety officials play a critical role in addressing the opioid crisis. Reducing the supply of illicit drugs remains a priority, and law enforcement agencies are using innovative technologies to identify, arrest, and prosecute large-scale drug traffickers.

While reducing the drug supply is a high priority, the OOCC does not believe that the

[1]Source: Harm Reduction Coalition

opioid crisis can be solved by a focus on arrests alone. Public safety officials are in a unique position to help individuals at what may be their lowest points by diverting or deflecting arrests and by connecting those in need with treatment and other resources. Two jurisdictions in Maryland have established pre-arrest diversion programs, and several others have expressed interest in creating such programs.

In many ways, the opioid crisis has encouraged public health and public safety officials to work closer together to identify opportunities to treat people in need of addiction services and to coordinate community services for individuals upon release. Local detention centers often encounter individuals in need of SUD services, and the opioid crisis has encouraged local health departments to provide resources to detention centers to assist in screening and identifying individuals in need of treatment. Through screenings, incarcerated individuals can be connected to various levels of treatment, either in the detention center or in the community. Additionally, many health departments have found it beneficial to place peer recovery support specialists in the detention centers to serve as an access point to resources.

Treatment & Recovery

SUD is a complex disease, and no single treatment is appropriate for everyone. Treatment for SUD should be individualized to meet the needs of the person. SUD treatment services, interventions, and care settings should be tailored to provide individuals with the greatest opportunity for successful outcomes[2].

Individuals should be able to access all levels of substance use treatment, ranging from outpatient services to medically managed, intensive residential care. Gaps in treatment services exist throughout Maryland, and the state is working tirelessly to identify opportunities to expand services to all geographic regions.

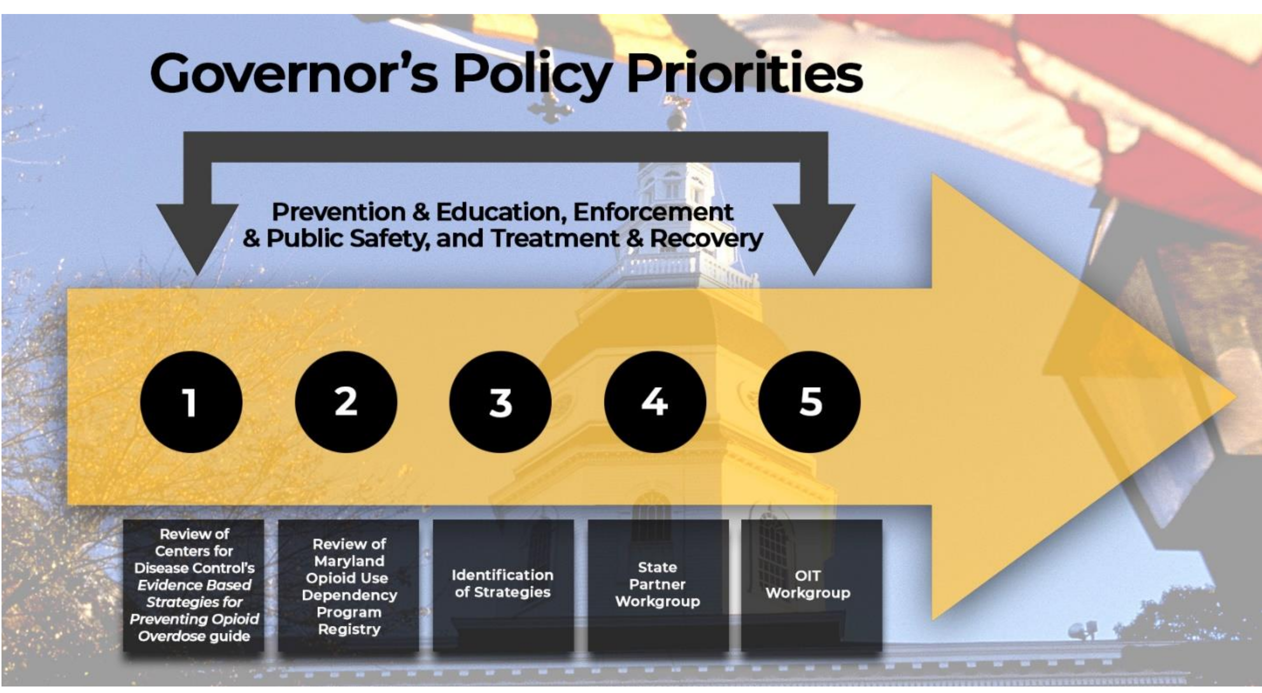
Although there are gaps, there are many efforts underway to expand treatment options for Marylanders. The Maryland Department of Health has actively promoted a model known as *Screening, Brief Intervention and Referral to Treatment* (SBIRT). SBIRT is a system for health care providers to identify individuals who may be in need of behavioral health services and to connect those individuals to the appropriate level of care. The OOCC is partnering with the Maryland Behavioral Health Administration (BHA) to inventory treatment capacity at multiple levels of care to identify counties around the state in the greatest need of service expansion. Additionally, state health care leaders are identifying mechanisms for recruiting and retaining behavioral health workers.

The OOCC recognizes that, in order to provide a full continuum of care for individuals leaving SUD treatment, there needs to be stable housing to support long-term recovery. Additionally, the OOCC supports initiatives that provide care coordination for individuals in recovery, including services that range from enrolling individuals into health insurance plans to helping individuals identify employment opportunities.

[2]Source: National Institute on Drug Abuse, Principles of Drug Addiction Treatment: A Research Based Guide (Third Edition)

Coordination Planning Process

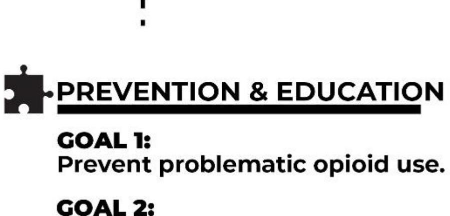
To develop Maryland's 2019 *Inter-Agency Coordination Plan*, the OOCC used Governor Hogan's policy priorities of *Prevention* & *Education, Enforcement* & *Public Safety,* and *Treatment* & *Recovery* as a foundation. The OOCC also reviewed the Centers for Disease Control's *Evidence Based Strategies for Preventing Opioid Overdose* guide and the OOCC's *Substance Use Program Inventory* to develop a list of priority goals, strategies and implementation partners. These goals and strategies were presented to leaders of state agencies and local OITs. During these coordination planning sessions, partners provided critical feedback on language, feasibility, and historical context for each of the proposed strategies.



Coordination Plan Overview

Shown below is an overview of the coordination plan. This overview outlines the nine goals identified in the plan based on policy priority. Following the overview is the comprehensive coordination plan that lists goals, strategies, tactics and implementation partners. For clarity, this coordination plan defined a **goal** as a broad, desired outcome; a **strategy** as an approach that will be taken to achieve a goal; and a **tactic** as the specific actions that will be taken to implement a strategy.

Coordination Plan Overview



PREVENTION & EDUCATION

GOAL 1:
Prevent problematic opioid use.

GOAL 2:
Reduce opioid-related morbidity & mortality.

GOAL 3:
Enhance statewide systems to inform strategy.

Before It's Too Late is the statewide effort to bring awareness to the rapid escalation of the heroin, opioid, and fentanyl crisis in Maryland, and to mobilize all available resources for effective prevention, treatment, and recovery *before it's too late*.

ENFORCEMENT & PUBLIC SAFETY

GOAL 1:
Reduce Illicit drug-supply.

GOAL 2:
Expand access to SUD treatment in criminal justice system.

GOAL 3:
Expand alternatives to incarceration for individuals with SUD.

TREATMENT & RECOVERY

GOAL: 1
Ensure access to SUD treatment.

GOAL 2:
Expand the behavioral health workforce and increase workforce competencies.

GOAL 3:
Ensure access to recovery support services.

Coordination Plan:

Goals, Strategies, Tactics and Implementation Partners

Prevention & Education

Goal 1: Prevent Problematic Opioid Use

Strategies		Tactics	Implementation Partners

1.1	**Promote proven and promising SUD prevention programs for youth and adults.**	*Expansion of evidence-based/promising programming:*
		
		Funding:
		• Identify funding streams that can support primary prevention programming across agencies
		  ○ Example: Substance Abuse Block Grant Funding (MDH)
		  ○ Family First Program (DHS)
		
		Partnerships:
		• Coordinate meetings among relevant agencies to strengthen partnerships and collaborations.
		
		Program Implementation:
		• Identify opportunities for program implementation across various state agencies.
			MDH, MSDE, DHS, DOL, DHCD, MHEC, DOA, DPSCS, MEMA, Local Jurisdictions.

Prevention & Education

Goal 1: Prevent Problematic Opioid Use

<table>
<tr><th colspan="2">Strategies</th><th>Tactics</th><th>Implementation Partners</th></tr>
<tr><td>1.1 Cont’d</td><td></td><td><u>Barriers</u>:
Identify barriers to program implementation and make adaptations as needed to facilitate enhanced coordination.
Student Programming:
<u>Collaboration</u>:
Collaborate with local prevention coordinators and local school systems.
<u>Prevention Clubs</u>:
Identify schools without prevention-club programming (e.g. SADD) and determine the need to establish programming.
<u>Partnerships</u>:
Partner with prevention coordinators and local school systems to support the establishment and expansion of school-based prevention clubs.</td><td>MDH, MSDE, DHS, MHEC, Local Jurisdictions.</td></tr>
</table>

Prevention & Education

Goal 1: Prevent Problematic Opioid Use

Strategies		Tactics	Implementation Partners
1.2	**Promote public awareness efforts on topics including:** • **Risks of opioid use.** • **Naloxone administration.** • **Risks of fentanyl.** • **Stigma.** • **Crisis hotlines.** • **Good Samaritan Law.** • **Other substances.** • **Trauma and mental health.** • **Proper storage and disposal of medications.**	*Public-Awareness Campaigns:* **Resources:** • Provide resources to state agencies for the development and production of awareness campaigns on priority topics. **Dissemination:** • Disseminate educational campaigns produced by state partners. **Campaign Development**: • Develop campaigns as needed to address other relevant issues as they arise, including emerging substance use trends. *Public-Awareness Events:* **Events:** • Promote the benefits of hosting regularly occurring, multi-disciplinary, awareness events that address the risks associated with opioid use, overdose response, and other topics.	MDH, MHEC, MSDE, MDOT, DOA, DOL, MEMA, MSP, DJS, Local Jurisdictions.

Prevention & Education

Goal 1: Prevent Problematic Opioid Use

<table>
<tr><th colspan="2">Strategies</th><th>Tactics</th><th>Implementation Partners</th></tr>
<tr><td>1.3</td><td>Promote prescription opioid prescribing best practices among health care providers:
Prescription Drug Monitoring Program (PDMP) utilization.
Academic detailing.
Co-prescribing of naloxone.</td><td>Prescription Drug Monitoring Program:

<u>Best Practices</u>:
Identify best practices for presenting PDMP data to inform clinical decision making.
<u>Integration with CRISP</u>:
Collaborate with CRISP to integrate PDMP data into electronic medical records.
<u>Accessibility</u>:
Ensure data are presented in a manner that is accessible to prescribers.
<u>Reports</u>:
Develop reports that provide insight into prescriber practices.
<u>Enforcement</u>:
Use PDMP data to identify problematic prescribers and enforce sanctions as appropriate.</td><td>MDH, MedChi, MHEC, DOA, Payers, Hospitals, CRISP, Local Jurisdictions.</td></tr>
</table>

Prevention & Education

Goal 1: Prevent Problematic Opioid Use

<table>
<tr><th colspan="2">Strategies</th><th>Tactics</th><th>Implementation Partners</th></tr>
<tr><td>1.3 Cont'd</td><td></td><td>Academic Detailing:

<u>MDH Pilot</u>:
• Provide technical assistance to nine jurisdictions participating in MDH's pilot program as they deliver targeted messages on: 1) Using non-opioid treatment as first line therapy for acute or chronic pain, 2) If opioids are needed, starting at the lowest effective dose, 3) Using the PDMP data to determine if patients have previously filled CDS, 4) Ensuring patient safety by avoiding concurrent prescribing of opioids and other sedating drugs, and 5) Referring patients to treatment with SUD.

Co-Prescribing Naloxone:

<u>Fact Sheet</u>:
• Develop a fact sheet on CDC recommendations for co-prescribing naloxone.

<u>CRISP Integration</u>:
• Integrate information on co-prescribing naloxone into the CRISP portal.</td><td>MDH, MedChi, MHEC, DOA, Payers, Hospitals, CRISP, Local Jurisdictions.</td></tr>
</table>

Prevention & Education

Goal 1: Prevent Problematic Opioid Use

Strategies		Tactics	Implementation Partners
1.3 Cont'd		**Co-Prescribing**: • Explore strategies for targeting messages about co-prescribing naloxone to prescribers.	MDH, MedChi, MHEC, DOA, Payers, Hospitals, CRISP, Local Jurisdictions.
1.4	**Promote mechanisms for safe drug disposal.**	**Safe Disposal**: • Support local jurisdictions and state agencies that identify a need for drug disposal options with technical assistance and resources to facilitate safe storage and disposal of prescription medications. **Program Expansion**: • Reach out to additional partners to explore opportunities for expanding drug-disposal opportunities.	MDH, MSDE, Law Enforcement, DOA, Pharmacies, Local Jurisdictions.

Prevention & Education

Goal 1: Prevent Problematic Opioid Use

<table>
<tr><th colspan="2">Strategies</th><th>Tactics</th><th>Implementation Partners</th></tr>
<tr><td>1.5</td><td>Care coordination and data sharing to identify at-risk and impacted youth.</td><td>Handle with Care Program:

<u>Awareness</u>:
Raise awareness of the Handle with Care Program among relevant partners.
<u>Program Expansion</u>:
Assist in the expansion of Handle with Care programming.
Protocols and Care Systems for Newborns Exposed to Opioids:

<u>Existing Protocols</u>:
Identify jurisdictions with protocols for responding to newborns exposed to opioids.
Review protocols and systems that effectively link newborns and mothers to resources and care.
<u>Program Expansion</u>:
Promote effective protocols and program expansion to other jurisdictions.
Facilitate information sharing among jurisdictions as they develop effective protocols and resource systems.</td><td>MDH, MSDE, DJS, MSDE, GOCCP, Local Jurisdictions.</td></tr>
</table>

Prevention & Education

Goal 1: Prevent Problematic Opioid Use

Strategies		Tactics	Implementation Partners
1.5 Cont'd		*Screening for Adverse Childhood Experiences (ACEs):* **Training**: • Promote professional learning opportunities around ACEs. **Application**: • Identify ways in which ACEs can inform programmatic decision making.	MDH, MSDE, DJS, MSDE, GOCCP, Local Jurisdictions.
1.6	**Vocational opportunities for individuals in areas heavily-impacted by substance use disorder.**	**Needs Assessment**: • Identify areas around Maryland that have been heavily impacted by substance use disorder and have higher than average rates of unemployment. **Training**: • Promote supportive employment programs that educate employers on how to retain and support those who suffer from SUD.	DOL, MDH, DOD. DOL, MDH, DOD.

Prevention & Education

Goal 1: Prevent Problematic Opioid Use

Strategies		Tactics	Implementation Partners
1.6 Cont'd		• Support the implementation of vocational programs for individuals in underserved communities, such as those offered through the Opioid Workforce Innovation Fund.	

Prevention & Education

Goal 2: Reduce Opioid-Related Morbidity and Mortality

Strategies		Tactics	Implementation Partners
2.1	**Emphasize targeted naloxone distribution in all Maryland jurisdictions.**	**<u>Overdose-Response Training</u>:** • Provide resources to local jurisdictions and community-based organizations that provide overdose-response training with an emphasis on educating individuals who use drugs, their friends, family and associates. **<u>Correctional Facilities</u>:** • Equip local detention centers with resources and technical assistance to provide naloxone kits to individuals leaving incarceration. **<u>Overdose Scenes</u>:** • Encourage all jurisdictions in Maryland to partner with emergency medical systems to provide naloxone kits on the scene of an overdose. Kits should include: ○ Naloxone ○ Protective face mask and gloves ○ Information on how to access local substance use treatment and harm reduction resources	MDH, MIEMSS, Prescribers, Pharmacies, MSDE, Local Jurisdictions.

Prevention & Education			
Goal 2: Reduce Opioid-Related Morbidity and Mortality			
Strategies		**Tactics**	**Implementation Partners**
2.2	**Support the implementation of harm reduction services.**	**<u>Funding</u>:** • Develop and disseminate requests for proposals (RFPs) for funding available to community-based organizations and local governments that provide harm reduction services. • Promote use of appropriate harm reduction materials, including: fentanyl test strips, wound-care supplies, resource guides, etc. **<u>Barriers</u>:** • Understand barriers to implementing harm reduction services. **<u>Effective Distribution</u>:** • Provide technical assistance to jurisdictions and community-based organizations that implement harm reduction programming (including syringe-services programs (SSPs), fentanyl test strips, wound-care supplies, resource guides, etc.) to ensure resources are distributed effectively to individuals who are in greatest need.	MDH, Law Enforcement, Judiciary, DHCD, MHEC, Local Jurisdictions.

Prevention & Education

Goal 3: Enhance Statewide Systems to Inform Strategy

<table>
<tr><th colspan="2">Strategies</th><th>Tactics</th><th>Implementation Partners</th></tr>
<tr><td>3.1</td><td>Facilitate statewide data sharing of opioid indicators by jurisdiction.</td><td><u>Promising Practices</u>:
• Identify the most promising outcome indicators and processes that will help inform opioid-related policy and programmatic decision making.

<u>Dashboards</u>:
• Research opioid dashboards in other and states that could serve as a model for Maryland's data-sharing initiatives.

<u>Chapter 211</u>:
• Carry out requirements of Chapter 211 legislation by convening relevant state-agency partners and enabling cross-agency data sharing.</td><td>MDH, MIEMSS, MSP, DHS, GOCCP, HIDTA, DPSCS, MHA, Poison Control.</td></tr>
<tr><td>3.2</td><td>Streamline statutory requirements for SUD-related workgroups and administrative structures.</td><td><u>Boards</u>:
• Catalogue all alcohol- and drug-related boards currently required in statute.
• Assess agency involvement in SUD workgroups/boards.

<u>Redundancies</u>:
• Identify redundancies in scopes of work to make recommendations for workgroup/board consolidations as appropriate.</td><td>OOCC, MDH, Legislature.</td></tr>
</table>

Enforcement & Public Safety			
Goal 4: Reduce Illicit Drug Supply			
Strategies		**Tactics**	**Implementation Partners**
4.1	**Expand heroin/overdose coordinator program to cover all Maryland jurisdictions.**	**<u>Gaps</u>:** • Identify jurisdictions without HIDTA overdose-coordinator coverage to all jurisdictions. **<u>Barriers</u>:** • Identify barriers to bringing overdose coordinator program to areas of need. **<u>Expansion</u>:** • Expand heroin/overdose coordinator program to all jurisdictions. • Encourage collaboration among overdose coordinators and public health and behavioral health professionals.	GOCCP, HIDTA, MSP, Local Jurisdictions.

Enforcement & Public Safety			
Goal 4: Reduce Illicit Drug Supply			
4.2	**Promote drug take-back initiatives.**	*Drug Take- Back Day:* **<u>Events</u>:** • Identify semi-annual Drug Enforcement Agency (DEA) National Drug Take- Back Days. **<u>Local Initiatives</u>:** • Encourage local law enforcement agencies to participate in conducting local initiatives. **<u>Publicity</u>:** • Publicize drug take-back initiatives. *Permanent Drop Boxes:* **<u>Drop-Box Inventory</u>:** • Review current list of permanent drop boxes and update semi-annually. **<u>Promotion</u>:** • Promote the locations of permanent drop boxes via website and social media.	MDH, GOCCP, MSP, Local Jurisdictions.

Enforcement & Public Safety

Goal 5: Expand Access to SUD Treatment in the Criminal Justice System

Strategies		Tactics	Implementation Partners
5.1	**Support correctional facilities with the implementation of MAT programs, including all three FDA-approved medications for treating SUD.**	**HB 116 Implementation**: • Identify needs of correctional facilities participating in the first phase of implementing House Bill 116. • Explore opportunities for diversion and community-based treatment associated with the requirements of HB 116. **Assistance**: • Provide technical assistance to jurisdictions based on identified needs. **Resources**: • Provide resources to jurisdictions to support the expansion of MAT programs within local detention centers.	GOCCP, MDH, Local Jurisdictions.

Enforcement & Public Safety Goal 5: Expand Access to SUD Treatment in the Criminal Justice System			
Strategies		**Tactics**	**Implementation Partners**
5.2	**Promote various levels of clinical counseling within detention centers.**	**<u>Gaps</u>:** • Conduct a jurisdictional gap analysis of levels of clinical care for SUD. **<u>Funding</u>:** • Identify funding opportunities for expanding clinical care. **<u>Technical Assistance</u>:** • Provide technical assistance and resources to jurisdictions as they expand clinical-care services.	GOCCP, MDH, DJS, Local Jurisdictions.

Enforcement & Public Safety

Goal 6: Expand Alternatives to Incarceration for Individuals with SUD

Strategies		Tactics	Implementation Partners
6.1	**Expand diversion and deflection programs in local jurisdictions.**	**Relationships:** • Expand relationships with law enforcement and judicial offices in local jurisdictions. **Technical Assistance:** • Provide technical assistance to jurisdictions interested in implementing diversion and deflection programs.	GOCCP, MDH, DJS, Local Jurisdictions.
6.2	**Facilitate more-coordinated relationships between problem-solving courts, criminal justice and behavioral health partners.**	**Gaps:** • Explore state and local system-level gaps between criminal justice and behavioral health partners. **Partnerships:** • Identify opportunities to enhance partnerships in order to create a more comprehensive system of care. **Technical Assistance:** • Provide technical assistance and resources to partners to facilitate coordination.	MD Judiciary, DJS, MDH, Local Jurisdictions.

Enforcement & Public Safety

Goal 6: Expand Alternatives to Incarceration for Individuals with SUD

Strategies		Tactics	Implementation Partners
6.3	**Expand care coordination services for individuals engaged with the criminal-justice system:** • **Screening & assessment at intake.** • **Life-skills training.** • **Care coordination to community providers.** • **Re-entry services.**	**Needs Assessment:** • Complete an assessment of care coordination services by local detention center and juvenile services facilities. **Best Practices:** • Identify jurisdictions with robust care-coordination and wrap around services for individuals incarcerated and for those reentering the community. **Training:** • Provide learning opportunities for local detention centers on how to expand wrap-around services for individuals incarcerated and for those reentering the community. **Step-Down Programs:** • Encourage step-down opportunities for individuals leaving state correctional facilities (e.g., The Direct Reentry Program).	DPSCS, GOCCP, DJS, Local Jurisdictions.

Enforcement & Public Safety			
Goal 6: Expand Alternatives to Incarceration for Individuals with SUD			
Strategies		**Tactics**	**Implementation Partners**
6.3 Cont'd		**<u>Program Expansion</u>:** • Provide resources and technical assistance to expand services for local detention centers and state correctional facilities.	DPSCS, GOCCP, DJS, Local Jurisdictions.

Treatment & Recovery

Goal 7: Ensure Access to SUD Treatment

Strategies		Tactics	Implementation Partners
7.1	**Build capacity of professionals in all settings to screen for substance use risk and to refer patients to substance use providers.**	<u>**Program Expansion**</u>: • Expand screening and referral programming in a variety of settings including: ○ Primary care facilities ○ Federally Qualified Health Care Centers (FQHC) ○ Hospitals/ Emergency Departments ○ Detention centers ○ Department of Social Services ○ Offices of Parole & Probation	MDH, MDPCP, MHA, DHS, MHEC, MedChi, MIA, Local Jurisdictions.
7.2	**Expand crisis-response system to cover all Maryland jurisdictions:** • **211, Press 1.** • **Stabilization/walk-in facilities.** • **Mobile crisis services.** • **Assessment and referral centers.**	<u>**Needs Assessment:**</u> • Identify gaps in crisis services by jurisdiction. <u>**Minimum Service Components**</u>: • Identify the minimum crisis service components that should be available to individuals in need of crisis services. <u>**Program Expansion**</u>: • Identify opportunities and mechanisms for expanding crisis-services programs.	MDH, MIEMMS, Commission to Study Mental and Behavioral Health, Local Jurisdictions.

Treatment & Recovery

Goal 7: Ensure Access to SUD Treatment

Strategies		Tactics	Implementation Partners
7.3	**Promote continuum of care for SUD services in all Maryland jurisdictions.**	**<u>Needs Assessment</u>:** • Identify and map treatment needs. **<u>Program Expansion</u>:** • Promote program expansion and identify funding sources, financial incentives, and new technologies to support expansion efforts. • Promote parity laws. **<u>Barriers</u>:** • Support programs that remove barriers to treatment (e.g., Medicaid enrollment, transportation services, etc.).	MDH, MIA, Local Jurisdictions.

Treatment & Recovery

Goal 7: Ensure Access to SUD Treatment

Strategies		Tactics	Implementation Partners
7.4	**Promote promising hospital practices for combatting SUD.**	**Buprenorphine Induction:** • Promote buprenorphine induction in emergency department settings. **Peers:** • Utilize peers to ensure care coordination for individuals leaving the emergency department.	MHA, MedChi, MDH, MHEC.
7.5	**Support Peer Recovery Support Specialists programs in multi-disciplinary settings to cover all Maryland jurisdictions.**	**Agency Points of Contact:** • Identify public-serving agencies that encounter individuals who may be at-risk for SUD. **Alternative Locations:** • Encourage memoranda of understanding (MOUs) between agencies who employ peers and partnering agencies to place Peers in alternative locations.	MDH, MIEMSS, DHS, DPSCS, MHA, EMS, DOL, Local Jurisdictions.

Treatment & Recovery			
Goal 7: Ensure Access to SUD Treatment			
Strategies		**Tactics**	**Implementation Partners**
7.5 Cont'd		**Peer Services**: • Enable Peers to conduct motivational interviewing, and to provide other resources for individuals in need of substance use treatment. **Funding**: • Explore payer reimbursement for Peer services.	MDH, MIEMSS, DHS, DPSCS, MHA, EMS, DOL, Local Jurisdictions.
7.6	**Expand access to medication assisted treatment (MAT) to cover all Maryland jurisdictions.**	**Waivers**: • Support prescribers in obtaining DATA 2000 waiver. **Technical Assistance**: • Identify areas of need for technical assistance for waived prescribers. **Prescriber Supports**: • Link waived providers with existing supports to prescribe buprenorphine (e.g., MACS). **Mobile Treatment**: • Encourage jurisdictions to expand access to MAT by establishing mobile treatment options.	MDH, MIA, Maryland Addiction Consultants (MACS), Maryland Primary Care Program, Prescribers.

Treatment & Recovery			
Goal 7: Ensure Access to SUD Treatment			
Strategies		**Tactics**	**Implementation Partners**
7.6 Cont'd		**MD Primary Care**: • Promote Maryland Primary Care Program. **Barriers**: • Explore barriers to expanding MAT providers. • Explore eliminating prior- authorization for all formulations of buprenorphine.	MDH, MIA, Maryland Addiction Consultants (MACS), Maryland Primary Care Program, Prescribers.

Treatment & Recovery

Goal 8: Expand the Behavioral Health Workforce and Increase Workforce Competencies

Strategies		Tactics	Implementation Partners
8.1	**Collaborate with universities, professional schools and licensing boards to incentivize individuals to pursue behavioral-health professions.**	**Models for Workforce Expansion**: • Research other national and state models for expanding the behavioral health workforce. **Incentives**: • Identify opportunities for encouraging students to pursue careers in behavioral health.	MDH, MHEC, MIA.
8.2	**Assess reciprocity standards for professional counselors and therapists and identify opportunities to allow out-of-state practitioners to work in Maryland.**	**Barriers**: • Explore barriers for allowing reciprocity for counselors licensed in other states to practice in Maryland.	OOCC, MDH, Board of Professional Counselors.

Treatment & Recovery

Goal 8: Expand the Behavioral Health Workforce and Increase Workforce Competencies

Strategies		Tactics	Implementation Partners
8.3	**Explore mechanisms to encourage the behavioral-health workforce to participate in topic-specific training opportunities.**	**Continuing Education:** • Identify areas within the behavioral-health workforce that could benefit from continuing-education opportunities. • Identify and promote opportunities for providing Continuing Education Units (CEUs) to behavioral health professionals.	MDH, MHEC, MedChi.
8.4	**Support wellness initiatives for individuals who work in the behavioral health field in all Maryland jurisdictions.**	**Acknowledgement:** • Promote acknowledgement ceremonies for first responders and the behavioral health workforce. **Wellness:** • Encourage local jurisdictions to sponsor events for staff that encourage wellness (e.g. Mental Health First Aid).	MDH, DOL, First Responders, Local Jurisdictions.

Treatment & Recovery

Goal 9: Ensure Access to Recovery-Support Services

Strategies		Tactics	Implementation Partners
9.1	**Equip local jurisdictions with resources to operate comprehensive care coordination for individuals moving through levels of treatment.**	**<u>Barriers</u>:** • Identify barriers to keeping individuals engaged in treatment. **<u>Local Partnerships</u>:** • Identify opportunities for partnerships between local agencies and treatment providers. **<u>Peer Support</u>:** • Promote the use of and expand the utilization of Peers to serve as outreach specialists for individuals transitioning among various levels of SUD treatment. • Promote peer resources for families impacted by SUD. **<u>Best Practices</u>:** • Investigate best practices in case management for other chronic conditions to identify systems that could be transferrable for individuals with SUD.	MDH, DHS, DPSCS, MIA, MHEC.

Treatment & Recovery

Goal 9: Ensure Access to Recovery-Support Services

Strategies		Tactics	Implementation Partners
9.1 Cont'd		**Care Managers:** • Promote the services of care managers available through the Maryland Primary Care Program.	MDH, DHS, DPSCS, MIA, MHEC.
9.2	**Explore the expansion of wellness and recovery centers.**	**Models:** • Identify model wellness and recovery centers in the state that provide connections to social support, mental health, housing and employment services. **Needs Assessment:** • Assess the need for additional wellness and recovery centers in other jurisdictions. **Expansion:** • Promote opportunities for expansion of recovery centers. **Assistance:** • Support wellness and recovery centers with technical assistance and other resources.	MDH.

Treatment & Recovery			
Goal 9: Ensure Access to Recovery-Support Services			
Strategies		**Tactics**	**Implementation Partners**
9.3	**Support sober-living housing in all Maryland jurisdictions.**	**Barriers**: • Identify barriers to establishing sober-living residences. **Assistance**: • Partner with BHA to identify policies and regulations that would encourage the expansion of sober-living residences.	MDH.

Outcomes

Outcomes

Measuring the progress of each goal is a critical component of the coordination plan. Primary health outcomes and secondary outcomes have been identified to track Maryland's progress in addressing the opioid crisis. Primary health outcomes are those that directly relate to an individual's health. Secondary outcomes are those that support the objective of improving primary health outcomes. Below please find a chart outlining primary health outcomes and secondary health outcomes that will be tacked throughout the next four years.

Primary Health Outcomes			
Goal	**Outcome**	**Data Source**	**Frequency**
Goal 1: Prevent Problematic Opioid Use	Reduce non-medical use of prescription drugs for individuals 12+ in Maryland.	National Survey on Drug Use and Health (NSDUH)	Biannually
	Reduce the number of Maryland youth reporting non-medical use of prescription-drugs.	Youth Risk Behavior Survey (YRBS)	Biannually
	Reduce heroin use for individuals 12+ in Maryland.	NSDUH	Biannually
	Reduce the number of youth in Maryland reporting lifetime heroin use.	YRBS	Biannually
Goal 2: Reduce Opioid-Related Morbidity, Mortality and Trauma	Reduce the number of opioid-related fatalities.	Maryland Vital Statistics Administration	Quarterly
	Reduce the number of opioid-related emergency department visits.	CRISP	Quarterly
	Reduce the percentage of substance-exposed newborns placed into foster care within 90 days of birth.	Department of Human Services (DHS)	Annually
	Reduce the incidence of hepatitis C transmission.	MDH	Annually
Goal 7: Ensure Access to SUD Treatment	Increase the number of individuals connected to SUD treatment.	Substance Abuse and Mental Health Services (SAMHSA)	Annually

Secondary Outcomes			
Goals	**Secondary Outcomes**	**Data Source**	**Frequency**
Goal 3: Enhance Statewide Systems to Inform Strategy	Develop a public-facing data dashboard.	OOCC Tracking	Annually
	Recommendations submitted to legislature for workgroup/board consolidation.	OOCC Tracking	Annually
Goal 4: Reduce Illicit Drug Supply	Increase coverage of HIDTA sponsored heroin/overdose coordinator program.	HIDTA/Local OIT Reporting	Quarterly
Goal 5: Expand Access to SUD Treatment in the Criminal Justice System	Local detention centers will comply with the requirements outlined in HB 116.	GOCCP/Local OIT Reporting	Annually
Goal 6: Expand alternatives to Incarceration for Individuals with SUD	Increase the number of diversion and deflection programs.	GOCCP	Annually
Goal 8: Expand the Behavioral Health Workforce and Increase Workforce Competencies	Increase the number of licensed behavioral health professionals practicing in Maryland.	BHA	Annually
Goal 9: Ensure Access to Recovery Support Services	Increase the number of sober-living residences in Maryland.	BHA	Annually

Appendices

Appendix A: Executive Order

Executive Order
01.01.2018.30

Inter-Agency Heroin and Opioid Coordinating Council
(Amends Executive Order 01.01.2017.01)

WHEREAS, The State of Maryland faces a heroin and opioid epidemic;

WHEREAS, Heroin and opioid drug dependency surged in Maryland over the last decade, resulting in a dramatic increase in heroin-related emergency room visits;

WHEREAS, The rise in the number of heroin and opioid overdose deaths represents an urgent and growing public health threat, cutting across all demographics and geographical settings in Maryland, and also represents a serious threat to the security and economic well-being of the State;

WHEREAS, Maryland State agencies have different expertise, capabilities, and data that, when shared, can better inform a coordinated, statewide response to the opioid overdose epidemic;

WHEREAS, Coordinated action among State agencies has made a greater impact in reducing abuse and overdose deaths; **[**and**]**

WHEREAS, Local collaboration in the sharing of data, expertise, and capabilities, and in the delivery of services, can further reduce abuse and overdose deaths**[**.**];**

WHEREAS, FOLLOWING THE MARCH 1, 2017, DECLARATION OF A STATE OF EMERGENCY IN RESPONSE TO THE HEROIN, OPIOID, AND FENTANYL CRISIS, THE OPIOID OPERATIONAL COMMAND CENTER ESTABLISHED A RESPONSE FRAMEWORK THAT EMPHASIZED A MULTIDISCIPLINARY, MULTIAGENCY INCIDENT MANAGEMENT STRUCTURE TO MOBILIZE AND COORDINATE STATE AND LOCAL STAKEHOLDERS; AND

WHEREAS, **THE HEROIN, OPIOID, AND FENTANYL CRISIS REQUIRES THE CONTINUATION OF THIS HEIGHTENED RESPONSE FRAMEWORK AND ONGOING COOPERATION AND MOBILIZATION OF STATE AND LOCAL STAKEHOLDERS;**

NOW, THEREFORE, I, LAWRENCE J. HOGAN, JR., GOVERNOR OF THE STATE OF MARYLAND, BY VIRTUE OF THE AUTHORITY VESTED IN ME BY THE CONSTITUTION AND LAWS OF MARYLAND, HEREBY AMEND EXECUTIVE ORDER 01.01.2017.01 AND PROCLAIM THE FOLLOWING EXECUTIVE ORDER, EFFECTIVE IMMEDIATELY:

A. Establishment. There is a Governor's Inter-Agency Heroin and Opioid Coordinating Council (**THE** "Council").

B. Membership.

(1) The Council is a subcabinet of the Governor and shall consist of the heads of the following State **UNITS** [agencies] or their designeeS and such other [e]**E**xecutive **B**[b]ranch **UNITS** [agencies] as the Governor may designate:

(a) The Department of Health [and Mental Hygiene];

(b) The Department of State Police;

(c) The Department of Public Safety and Correctional Services;

(d) The Department of Juvenile Services;

(e) The Institute for Emergency Medical Services Systems; [and]

(f) The Maryland State Department of Education; **AND**

(G) THE MARYLAND EMERGENCY MANAGEMENT AGENCY.

(2) Staff members from the Offices of the Governor and Lieutenant Governor, including the Governor's Office of Crime Control and Prevention [and the Office of Problem Solving Courts], will also be regular participants.

(3) Other State **UNITS** [agencies] may be asked to participate at the invitation of the Chair.

C. Duties.

(1) The [member] State **UNITS** [agencies (Agencies)] listed in Paragraph B (1) **(THE "AGENCIES")** shall seek opportunities to share data with one another and with the Office of the Governor for the purpose of supporting public health and public safety responses to the heroin and opioid epidemic. The Agencies shall share the data in their possession relevant to the epidemic to the maximum extent permitted by law.

(2) The Council shall develop recommendations for policy, regulations, or legislation to facilitate improved sharing of public health and public safety information among State **UNITS** [agencies].

(3) The Council shall update the Governor within 45 days of the date of this Executive Order, and biannually thereafter, on **THE AGENCIES'** [each agency's] efforts to address heroin and opioid education, treatment, interdiction, overdose, and recovery.

(4) On behalf of the Council, the [Department of Mental Health and Hygiene] **OPIOID OPERATIONAL COMMAND CENTER** shall submit an annual report to the Governor and the public in the form of the Inter-Agency Heroin and Opioid Coordination Plan.

D. Procedures.

(1) The [Secretary of the Department of Health and Mental Hygiene] **LIEUTENANT GOVERNOR** shall chair the Council. The Chair shall:

(a) Oversee the implementation of this Executive Order and the work of the Council;

(b) Determine the Council's agenda; and

(c) Identify additional support as needed.

(2) The Council shall meet on a quarterly basis, or more frequently if the members deem appropriate.

(3) In advance of each meeting of the Council, each of the Agencies shall provide updates to the Chair regarding **ITS** [the agency's] efforts to share public safety and public health information relating to the heroin and opioid epidemic.

(4) A majority of the Council members shall constitute a quorum for the transaction of any business.

(5) The Council may adopt other procedures as necessary to ensure the orderly transaction of business.

E. Opioid Operational Command Center.

(1) **TO REFLECT THE NEED FOR AN ONGOING HEIGHTENED RESPONSE FRAMEWORK TO THE HEROIN, OPIOID, AND FENTANYL CRISIS,** [T]There is an Opioid Operational Command Center (**THE** "Center") within the [Council] **THE MARYLAND EMERGENCY MANAGEMENT AGENCY**.

(2) THE CENTER SHALL BE MANAGED BY AN EXECUTIVE DIRECTOR, WHO SHALL BE PRIMARILY RESPONSIBLE FOR COORDINATING INTERAGENCY ACTIVITIES IN RESPONSE TO THE HEROIN, OPIOID, AND FENTANYL CRISIS THROUGHOUT THE STATE AND SHALL BE THE STATE'S PRINCIPAL COORDINATOR WITH LOCAL, REGIONAL, AND FEDERAL COUNTERPART ORGANIZATIONS ON ISSUES RELATED TO THE HEROIN, OPIOID, AND FENTANYL CRISIS.

(3) THE EXECUTIVE DIRECTOR IS RESPONSIBLE FOR THE DAILY OPERATION AND ADMINISTRATION OF THE CENTER. THE EXECUTIVE DIRECTOR SHALL SERVE AT THE PLEASURE OF THE GOVERNOR.

(4) The Center shall:

(a) Develop operational strategies to continue implementing the recommendations of the Heroin and Opioid Emergency Task Force authorized by Executive Order 01.01.2015.12;

(b) **CONTINUE TO CARRY OUT MARYLAND'S CENTRALIZED, COORDINATED RESPONSE TO THE HEROIN, OPIOID, AND FENTANYL CRISIS THROUGH THE IMPLEMENTATION OF THE INTER-AGENCY HEROIN AND OPIOID COORDINATION PLAN REQUIRED BY PARAGRAPH (C)(4);**

([B]**C**) Collect, analyze, and facilitate the sharing of data relevant to the epidemic from state and local sources while maintaining the privacy and security of sensitive personal information;

([C]**D**) Develop [a] memorand**A**[um] of understanding among state and local agencies that provide[s] for the sharing and collection of health and public safety information and data

relating to the heroin [and], opioid, **AND FENTANYL** epidemic;

([D]**E**) Assist and support local agencies in the creation of Opioid Intervention Teams that will share such data; [and]

([E]**F**) Coordinate the training of and provide resources for **UNITS OF** state and local **GOVERNMENT** [agencies] addressing the threat to the public health, security, and economic well-being of the State **POSED BY THE HEROIN, OPIOID, AND FENTANYL CRISIS**[.]; **AND**

(G) PROVIDE STAFF TO THE COUNCIL.

F. OPIOID INTERVENTION TEAMS.

(1) PRIOR TO RECEIVING FUNDS FROM THE CENTER, EACH COUNTY AND THE CITY OF BALTIMORE ("COUNTIES") SHALL ESTABLISH AN OPIOID INTERVENTION TEAM. AN OPIOID INTERVENTION TEAM SHALL INCLUDE, BUT IS NOT LIMITED TO, INDIVIDUALS WITH EXPERIENCE IN:

(A) EMERGENCY MANAGEMENT;

(B) HEALTH;

(C) LAW ENFORCEMENT;

(D) SOCIAL SERVICES;

(E) EDUCATION; AND

(F) PRIVATE SECTOR, NON-PROFIT, COMMUNITY, AND FAITH-BASED ORGANIZATIONS.

(2) A COUNTY MAY DESIGNATE MULTIDISCIPLINARY AND MULTIAGENCY DRUG OVERDOSE FATALITY REVIEW TEAMS AS ESTABLISHED UNDER HEALTH -- GENERAL ARTICLE § 5-902, LOCAL ADDICTION AUTHORITIES AS DEFINED IN HEALTH -- GENERAL ARTICLE § 7.5-101, OR LOCAL BEHAVIORAL HEALTH AUTHORITIES AS DEFINED IN HEALTH -- GENERAL ARTICLE § 7.5-101 AS THE OPIOID INTERVENTION TEAM.

(3) OPIOID INTERVENTION TEAMS WILL DISTRIBUTE ANY FUNDS THE CENTER PROVIDES TO LOCAL

GOVERNMENTS AND UNITS AS PROVIDED FOR IN THE STATE BUDGET.

G. OPIOID SPENDING PLANS.

(1) EACH UNIT OF STATE GOVERNMENT SUBJECT TO THE SUPERVISION AND DIRECTION OF THE GOVERNOR THAT SPENDS FUNDS TO ADDRESS THE HEROIN, OPIOID, AND FENTANYL CRISIS SHALL SUBMIT TO THE CENTER:

(A) BY SEPTEMBER 1 OF EACH YEAR, AN ANNUAL SPENDING PLAN FOR ALL FUNDING USED TO ADDRESS THE HEROIN, OPIOID, AND FENTANYL OVERDOSE CRISIS;

(B) ALTERATIONS TO THE PLAN THAT EXCEED $2 MILLION; AND

(C) ACCOUNTS OF NEW SPENDING OF FUNDS THAT EXCEED $2 MILLION USED TO ADDRESS THE HEROIN, OPIOID, AND FENTANYL CRISIS.

(2) THE CENTER SHALL PROVIDE ADVICE AND CONSENT ON EACH ANNUAL PLAN, ALTERATIONS TO THE PLAN THAT EXCEED $2 MILLION, AND NEW SPENDING OF FUNDS THAT EXCEED $2 MILLION.

GIVEN Under My Hand and the Great Seal of the State of Maryland, in the City of Annapolis, this 12th Day of December 2018.

Lawrence J. Hogan, Jr.
Governor

ATTEST:

John C. Wobensmith
Secretary of State

Appendix B: Glossary of Terms

Addiction: The most severe form of substance use disorder, associated with compulsive or uncontrolled use of one or more substances.[3]

Adverse Childhood Experiences (ACEs)[4]: Potentially traumatic events that occur in childhood such as experiencing violence, abuse, or neglect; witnessing violence in the home; and having a family member attempt or die by suicide. ACEs have been linked to risky health behaviors, chronic health conditions, low life potential, and early death.

Buprenorphine: An FDA-approved medication used to treat opioid use disorder, specifically for opioid detoxification, induction or maintenance.

Evidence-Based Practice: Process of integrating evidence from scientific research and practice to improve the health of the target population. [5]

Fentanyl: A synthetic opioid approximately 50 times more potent than heroin and 100 times more potent than morphine. Fentanyl has been produced pharmaceutically and prescribed for the treatment of severe pain, but in recent years fentanyl has increasingly been produced and sold illegally.

Harm Reduction: A set of practical strategies and ideas aimed at reducing the negative consequences associated with drug use.

Medication Assisted Treatment (MAT): The combination of behavioral interventions and medications to treat substance use disorders.[1]

Methadone: An FDA-approved OAT medication used to treat opioid use disorder, specifically for opioid detoxification or maintenance.

Naloxone: An FDA-approved medication that displaces opioids and reverses the effects of an opioid overdose (e.g., difficulties breathing).

Naltrexone: an FDA-approved medication used to treat alcohol use disorder and opioid use disorder.

Opioid: A class of substances that bind to opioid receptors in the brain. Opioids block pain and produce effects such as elevated mood and drowsiness. Common opioids include prescription opioids, heroin, and fentanyl.

Opioid Agonist Therapy (OAT): Long-acting medications that bind to opioid receptors and help manage opioid withdrawal symptoms and cravings (e.g., methadone and buprenorphine).

Opioid Intervention Teams: Local multi-agency coordinating bodies within each of Maryland's 24 jurisdictions. OITs are tasked with developing unified local strategy, conducting operational coordination

[3] U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*. Washington, DC: HHS, November 2016.

[4]The Centers for Disease Control and Prevention:
https://www.cdc.gov/violenceprevention/childabuseandneglect/acestudy/aboutace.html

[5] Vanagas, G., Bala, M., & Lhachimi, S. K. (2017). Evidence-Based Public Health 2017. *BioMed research international, 2017, 2607397. doi:10.1155/2017/2607397*

with all stakeholders, and working cooperatively on program and project implementation and operations.

Opioid Use Disorder (OUD): A substance use disorder involving the problematic use of opioids.

Peer: A person with lived experience around drug use, who is in recovery and is actively involved in counseling others.

People Who Use Drugs (PWUD): A person who actively uses drugs or has recently used drugs. Preferred over stigmatizing terms such as “abuser,” “addict,” “junkie,” or “user.”

Opioid Misuse: Non-medical use of opioids associated with negative health risks (e.g., overdose) or social consequences (e.g., poor performance at work or school).

Promising Practices: Policy or programmatic interventions that have been evaluated by the OOCC and are believed to be effective. Some, but not all of these practices are evidence-based.

Recovery: A process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential.[6]

Screening, Brief Intervention and Referral to Treatment (SBIRT): An evidence-based practice used to identify, reduce, and prevent problematic use, misuse, and dependence on alcohol and illicit drugs.[7]

Substance Use Disorder (SUD): A medical illness caused by repeated misuse of a substance or substances. Substance use disorders are characterized by clinically significant impairments in health, social function, and ability to control substance use and are diagnosed through assessing cognitive, behavioral, and psychological symptoms. Substance use disorders range from mild to severe and from temporary to chronic.[1]

Synthetic Opioid: A class of opioids that are designed to provide pain relief, and that mimic naturally occurring opioids, such as codeine and morphine. Synthetic opioids tend to be highly potent, which means only a small amount of the drug is required to produce a given effect and include drugs like tramadol and fentanyl.[8]

Trauma: Exposure to actual or threatened death, serious injury, or sexual violence, including experiencing, witnessing and learning about violence.[9]

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[6] Substance Abuse and Mental Health Services Administration (SAMHSA) https://www.samhsa.gov/find-help/recovery
[7] Substance Abuse and Mental Health Services Administration (SAMHSA) https://www.integration.samhsa.gov/clinical-practice/sbirt
[8] The Centers for Disease Control and Prevention https://www.cdc.gov/drugoverdose/data/fentanyl.html
[9] American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA