

Executive Summary:

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

Montgomery County's Department of Health & Human Services (DHHS) in conjunction with the Department of Health and Mental Hygiene (DHMH) is coordinating a number of key initiatives to help reduce opioid-related overdoses in Montgomery County. Several of the activities identified in this plan are already in operation or planned for in the FY-14 budget cycle. Still others are in development by various County departments or providers. Finally there are several elements that either require additional funding or State action before they can be implemented. As is always the case implementation of the various elements in this plan is dependant on the availability of funding or other resources.

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

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

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

I. Review and Analysis of Data

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

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

Preliminary findings include:

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

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

II. Interventions: Primary, Secondary, Tertiary

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

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

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

Raising Awareness

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Effective screening processes in treatment settings.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

III. Additional Considerations

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

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

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

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

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

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

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

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

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

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

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

Summary of Stakeholder Input

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

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

Performance Metrics

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

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

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

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

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

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

V. Attachments

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

Stakeholder Recommendations for Montgomery County Overdose Prevention Plan

Section 2: Planned Interventions and Initiatives

Section 3: Performance Metrics

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

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

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

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

Section 2: Planned Interventions and Initiatives

A. Education/Training/Expansion of the Clinical Community

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

D. Other Interventions / Initiatives

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

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

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

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

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

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

Section 3: Performance Metrics

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

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

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

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

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

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

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

OPIOID OVERDOSE PREVENTION PLAN- PERFORMANCE METRICS

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

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

OPIOID OVERDOSE PREVENTION PLAN- PERFORMANCE METRICS

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

OPIOID OVERDOSE PREVENTION PLAN- PERFORMANCE METRICS

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

OPIOID OVERDOSE PREVENTION PLAN- PERFORMANCE METRICS

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

Opioid Overdose Prevention Plan Committee Roster

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