PUBLIC TESTIMONY TO THE WORK GROUP ON

DRUG TREATMENT ACCESS & NEIGHBORHOOD RELATIONS

Hosted by the Baltimore City Health Department

12/14/2016: Meeting One Treatment Providers & Community Organizations
12/16/2016: Meeting Two Individuals in Recovery & Community Organizations
12/20/2016: Meeting Three National Policy Leaders & Hospital/University Leaders

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Baltimore City Health Department
Leana Wen, MD, MSc, *Commissioner of Health*

INTRODUCTION

Baltimore City is in the midst of a public health emergency: in 2015, 393 people in Baltimore died from overdose – more than died from homicide. While Baltimore has become a national leader in expanding access to the life-saving overdose antidote, naloxone, only 11 percent of Americans with addiction are able to get the long-term treatment that they need.

At the same time, some community leaders have expressed concerns about the effects of drug treatment centers on their communities. Solutions to the problem of unmet need must take into account these neighborhood concerns, but they must also take into account the protections afforded to treatment centers and their clients by the Americans with Disabilities Act, Fair Housing Act, and Rehabilitation Act.

The solutions, in other words, must be comprehensive. That's why, as a follow-up to the Mayor's Heroin Taskforce Report, the Baltimore City Health Department has convened a Workgroup on Drug Treatment Access and Neighborhood Relations. The workgroup was formed with the following three goals:

1. Engage partners in conducting a comprehensive, strategic planning process from a city-level perspective, including questions around siting, certifications, and transportation;
2. Propose community-wide financial and regulatory incentive mechanisms to ensure the construction of neighborhood-friendly drug treatment centers;
3. Pursue legislative and regulatory efforts to support the first two goals, with the intention of creating a best practice model to address this issue on the state and national levels.

In order to engage community stakeholders and make full use of the local knowledge that must inform any solution to these issues, the workgroup is hosted three community listening and public testimony sessions from 5 – 8 p.m. on December 14, 16, and 20. The sessions featured testimony from experts across the drug treatment landscape. Testimony was also open to the public.

MEMBERS OF THE WORKGROUP ON
DRUG TREATMENT ACCESS AND NEIGHBORHOOD RELATIONS

Co-chairs:

- Don Fry, President & CEO of the Greater Baltimore Committee
- Bill McCarthy, Executive Director of Catholic Charities
- Dr. Leana Wen, Baltimore City Health Commissioner

Members:

- Tony Brown, Director of Safety Services, Charles Village Benefits District
- John Bullock, Assistant Professor, Towson University
- Kevin Davis, Police Commissioner, Baltimore City
- Pamela Davis, Director of Police Development and Training Academy, BPD
- Andy Frank, Special Advisor to the President on Economic Development, The Johns Hopkins University
- Matt Gallagher, President & CEO, Goldseker Foundation
- Nancy Jordan-Howard, COO, Baltimore Development Corporation
- Jon Laria, Managing Partner, Ballard Spahr LLP
- Alyssa Domzal, Association, Ballard Spahr LLP
- J.R. Lee, Public Safety Committee Chair, Southwest Partnership
- Alan Mlinarchik, Central Baltimore Partnership; Charm City Group, LLC
- Dr. Sam Ross, CEO, Bon Secours Health System
- Vickie Walters, Executive Director, IBR/REACH Health Services
- Kathy Westcoat, President and CEO, Behavioral Health System Baltimore
- Adrienne Breidenstine, Vice President of Policy and Communications, BHSB

TESTIMONY SESSIONS

12/14/2016: Meeting One

Treatment Providers

- Karen Reese, Executive Director, Man Alive, Inc.
- Debbie Rock, Executive Director, LIGHT Health and Wellness, Inc.
- Lillian Donnard, Executive Director, Glenwood Life Counseling Services
- Vickie Walters, Executive Director, IBR/REACH Health Services

Community Organizations

- Saleem Gauhar, Executive Director, Manna House, Inc.

12/16/2016: Meeting Two

Individuals in Recovery

- Carlos Hardy, Founder and CEO, M-ROCC

Community Organizations

- Edna Mann-Lake and Timothy Bridges, President and Vice President, Fayette Street Outreach Organization, Inc.

12/20/2016: Meeting Three

National Policy Leaders

- Dr. Wilson Compton, Deputy Director, National Institute on Drug Abuse (NIDA)
- Dr. Yngvild Olsen, Director-at-Large and Chair of Public Policy Committee, American Society of Addiction Medicine (ASAM)

Anchor Institutions: Hospital/University Leaders

- Dr. Aliya Jones, Chair, Department of Behavioral Health, Bon Secours Health System
- Dr. Chris Welsh, Medical Director, Substance Abuse Consultation Service and Comprehensive Recovery Program, University of Maryland Medical Center

12/14/16 Panel 1: Treatment Providers

KAREN REESE
Executive Director of Man Alive/ Lane Treatment Center

Good evening, I'm Karen Reese, Executive Director of Man Alive/Lane Treatment Center. I appreciate the opportunity to discuss issues related to expansion of evidence based treatment centers and relationships between the centers & stakeholders;

For more than four decades, our organization has resided in the 21218 zip code and I have institutional knowledge of the challenges and best practices;

In terms of evidence based practices, since 2004, all medication-assisted treatment programs are mandated to have national accreditation by either CARF or JACHO and are re-credentialed every three years;

Simply stating these centers need to demonstrate conformance to meeting accreditation standards;

As with any health care facility, please bear in mind that our treatment centers are staffed with medical and clinical professionals who diagnose and develop treatment plans for individuals with substance use and mental health disorders;

From a neighborhood perspective, it is critical for us to have an open dialogue and engagement with all stakeholders in the area;

Education, transparency and common goal commitments should be the cornerstone for all those individuals living and working in their communities;

I've personally served on many of the community association boards or have had representatives from the agency attend such meetings; these associations have had my cell phone number to contact me at anytime;

By working alongside the stakeholders, changes have been made to satisfy all parties;

Both IBR/REACH and Man Alive have contracted with a security guard agency to employ two guards during our business hours; this has been most beneficial in terms of addressing loitering and/or drug activity;

In addition to implementation of security measures, we have worked with the community on improvement projects, i.e., we adopted a local abandoned lot for greening and staff and clients participated in this endeavor;

We maintain an aesthetically pleasing exterior of the building; we also clean up our tree wells, pick up trash in the front and back and plant flowers in the springtime;

In terms of clinic expansions, it is important to pin point areas of need and open up centers where treatment services are not available. This could address the issue of over-saturation of clinics in a designated area….

But clients should have access and choice, just like any other consumer in the healthcare industry;

Forty plus years later, stigma still haunts this industry. Despite all the scientific evidence supporting the disease model of addiction, our society is hard-wired into discussing it as a moral failing which belongs in the criminal justice system;

However, I see progressive leaders, such as Surgeon General Dr. Vivek Murthy and Baltimore's own Health Commissioner Dr. Leana Wen, changing and moving the dialogue into the public health arena…….once this becomes a standardized conversation, forums such as these may not be needed…….as our clients would be seen as any other individual suffering from a chronic disease.

Thank you for your time.

DEBBIE ROCK
CEO and Founder of LIGHT Health and Wellness Comprehensive Services, Inc.

Good Evening, my name is Debbie Rock and I am the founder and CEO of LIGHT Health and Wellness Comprehensive Services, Inc.

I am honored to have been asked to provide testimony as a community based organization serving the citizens of Baltimore City and the surrounding counties. For the past 20 years, I've been serving women, children and families impacted by HIV, substance abuse, mental health/trauma and poverty. We have served over 20,000 individuals and work with over 300 families per year.

In preparing for this, I sought several of my mentor's opinions as to how to write this. I think the best advice I received was to share my journey and what has best worked for the many families we've served.

I was told to stay broad, making sure that what I come up with could be in the best interest/or best practices inclusive of all of Baltimore, hitting on the social and health determinants.

The Content Matters

This became a challenge for me because I've found that treating families holistically has been the key to the success of many of our families. No one walked in our doors having just one issue whether it was HIV or substance abuse; actually we always had a game plan to help them to break multi-generational poverty.

If they felt it was hard to change their behavior for themselves, the hook was the children; and having a nurturing child care facility that could provide a daily safe haven. The other hook was recognizing multiple community agencies that we work with to provide services to complement our services.

For example, we collaborate with University of Maryland Medical Systems, Johns Hopkins Hospital, Morgan State University and The Center for Urban Families.(see attached CFUF)
As a result of our intense collaborations many of our parents have successfully become drug free, gone back to school while their children were in our child care program. Some have obtained their GED's, master's degrees and are presently employed at establishments, like Walmart and the Baltimore City Health Department, as Addiction Counselors and nurses. Children who were infected by HIV are no longer dying, but growing up to graduate from universities, such as Spellman, St. Mary's College, Morgan and Coppin State Universities. They are now gainfully employed today and are our success stories.

We also provide support to grandparents and other relative caregivers who have had to take on the responsibility of caring for their grandchildren or nieces/nephews, etc. We showed them how to deal with their health issues and the lack of adequate funding as they raise multiple children in their households while parents were getting their act together.
One of our younger moms "Charmaine", HIV infected at 15 years old (now 29 and married with 5 children) benefitted from our childcare and counseling services and has also utilized the support services offered by Center For Urban Families for life skills, as well as Mentoring Male Teens in the Hood tutor/mentor program for boys. Because of these partnerships, this family is successful today, both holding down full time jobs and their children are all doing well in school. This was all being done while Charmaine's mom battled drug addiction. Charmaine is now an outreach/health education and risk reduction specialist.

In order for you to put faces to the research data that you have heard or will hear from my colleagues, let me bring it closer to home.

For 15 years, Angela was a substances abuser, a drug dealer, and a prostitute. She became homeless and was incarcerated several times. On top of that she was diagnosed with HIV.
Just hearing this, you may be thinking, "I would not want that type of person in my community receiving treatment."

But, that is not how the story ends; Angela is now 19 years in recovery. She has been living with HIV for 31 years. The story gets better; she is the author of three books, a licensed minister, and a home owner. She has three degrees, associate bachelors and masters in psychology and is working on her doctorate. On top of that, she has been a part of our program for 16 years. Her

youngest daughter graduated from our childcare program and is now in the 12th grade with a 4.0 grade point average. She also has been awarded two college scholarships where she will study to become an EMT.

Angela went from being a prostitute, dependent on heroin and cocaine, to a vibrant successful mother, community member and health educator providing support to other men and women in similar situations.

I could site numerous stories of families in similar situations that have moved from being substance abuser to positive role models. But, I only have five minutes.

But, none of this would have happen if Angela and countless others like her weren't able to receive access to both acute (on demand) and continuous long-term treatment and support services for themselves and their children in their "communities." Issues such as substance abuse, HIV, trauma and violence do not happen in isolation of the community. They happen in the community and that is where interventions should be developed and received. Providing intervention services for individuals and their families where they live and work can create positive effects, as mentioned above.

IMAGINE if we could do citywide holistic treatment services that could be replicated throughout the counties.

IMAGINE receiving treatment instead of being penalized and imprisoned.

IMAGINE being able to provide first responders, i.e., firemen, police officers, etc., with effective training to deescalate volatile situations and assist families.

IMAGINE if we could strengthen our community partnerships and provide support collectively to our citizens in their communities.

Look what we've done with little or no funding; imagine what we could do with sufficient funding and resources and everyone did not work in silos.

So, how do we resolve this issue, we recognize that we cannot serve our children and families in a vacuum. We must:

- Develop successful community partnerships where information can be shared and treatment facilities are welcomed as community asset and not a liability.
- Provide adequate funding to community-based organizations, which are the heart of the community, that serve the needs of our most vulnerable citizens.
- Develop treatment centers that tend to the holistic needs of individuals and their families, not just his or her drug abuse. To be effective, treatment must address the individual's drug abuse and any associated medical, psychological, social, vocational, and legal problems.

- Continue to keep the lines of communication open between concerned citizens in the community and administrators to address concerns.
- Involve former clients as a part of the advisory committees or planning team to ensure new treatment programs meet the needs of individuals and families.
- Provide treatment centers that will allow the parents to bring their children to the facilities with childcare.

I want to thank you for this opportunity to speak. If you would like more information on LIGHT Health and Wellness Comprehensive Services, please visit http://www.lighthealth.org/

LILLIAN DONNARD, LSW
Director of Glenwood Life Counseling Center

Good evening, my name is Lillian Donnard; I am a social worker and the director of Glenwood Life Counseling Center.

GLCC has been in operation since April of 1971. We were among the first medication assisted programs to open in the state of Maryland. We have been in the Woodbourne McCabe neighborhood of North Baltimore for all of our 45 years of existence. We occupy a renovated commercial building just off of York Road that had served as a plumbing supply warehouse. We are a CARF and state of Maryland certified program and we currently serve approx. 650 opiate addicted patients and their families. Since we are just a half block from York road right near the #8 bus stop, most of our patients take one bus ride to our clinic.

Last year, I participated in the **Neighborhood Work group** of the Mayor's Task force. I had the pleasure of working with several business owners and community activist who I found, much to my delight to be not just reluctant "victims" of living with a drug treatment facility in their communities but rather whole heartedly supportive of the need for community based programs such as ours. We found very little to disagree about. We agreed on the importance of everyone being "good neighbors ", if we were to live and work in such close proximity to each other.

We agreed on the need to clean in front of your business, to hire security both to protect our patients from the drug dealers who prey on them, but also to give our neighbors a sense of "safe passage" to and from their homes. We agreed that any business with many customers has to be mindful of traffic, noise, litter and congestion. We all understand the importance of a community representative on our board of directors and of clinic representation in our community meetings. It was easy enough for us, to agree with reasonable, well thought out recommendations for being a good neighbor, because for the most part we have tried very hard to be just that.

To that end, although I will concede that this "being a good neighbor" is always a "work in progress", Glenwood has adopted several best practices that attempts to do just that:

- We have a part time security guard
- We have clients who sweep our block every day.
- We have a neighbor who we've hired to mow, landscape and mulch our shrubs and flowers.
- We built a small playground for our client's and neighborhood children.
- We house the monthly Woodbourne-McCabe community meeting in our building.
- We have peer case managers who provide entitlement, education, vocational information and referral to both our clients and neighbors.
- We have limited the number of clients we serve despite the fact that this presents a financial hardship to us that the much larger clinics do not experience.
- We are open until 6:30 pm to "spread out" visits to the clinic.
- We have 25 clinic groups and NA meetings throughout the week to keep our clients "busy"
- We have a loitering policy that both our security guard and other staff work very hard to enforce. We have an administrative review meeting to address repeat loiterers or suspected drug dealers.
- We have 16 cameras in and outside of our building that operate 24/7 which the police have used on any number of occasions to gather information on an incident.
- We have a very active CLIENT ADVOCACY TEAM that has been involved with neighbor activities such as back to school cook outs, Habitat work, holiday food baskets for our neighbors, Toys for Tots, the mayors clean up, & *National Night out*
- We have always had a community member on our board; we patronize the auto mechanic on our block, the Corner carry out, the dry cleaner, pizza place, CVS and Subway shop on York road. We don't however, patronize the 4 liquor stores within two blocks of our building and strongly discourage our clients from doing so as well . Alcohol and medication do not mix!
- We call 311 every 6 months to complain about and work with the cleanup of the dumping behind our building on a neighbor's property.
- We have had the debris and overgrowth cleaned up behind our playground and planted a community garden with 8 beds which yielded 200 pounds of produce this past season.

Our clinic is in a residential neighborhood that is experiencing revitalization due to the work of Habitat for Humanity on 30 or more homes. We have been actively involved with H for H and with Rebuilding Together Baltimore to help insure that we are an asset to and not a drain on our community.

I thank you for the opportunity to speak with you this evening. It's been an honor.

VICKIE WALTERS
IBR/REACH Health Services:

Good evening and thank you for being here at the first community forum. I appreciate your willingness to be open to providers in the community and I would like to take a few minutes to talk about several issues in the few minutes I have available to me this evening.

First, substance use disorders are a chronic, relapsing disease that require effective treatment with a view toward long-term management. What I mean by this is that addiction is not usually treated quickly and that effective treatment for substance use disorders, particularly opioid addiction, often includes medications like buprenorphine and methadone coupled with evidence-based behavioral treatments like individual and group counseling which together improve medical and mental health outcomes and reduce relapse and recidivism. We know from lots of verified research in the field that treatment works and people do recover and get better and become productive members of society but it doesn't work overnight. Just like diabetes and high blood pressure are not "cured." People learn to manage these diseases through lifestyle changes and by taking the appropriate medications. Behavior change is hard and it takes time and work. It also includes ups and downs and many people come in and out of treatment over time and it may take several attempts before they "get it right." As providers, we keep the door open and we strongly believe that recovery is possible.

As members of the community, we as treatment providers want to be a part of the community in which we provide services and want the community to be a safe place for our patients to come to access quality treatment. Many of our staff and our patients live in the community and the surrounding area and we frequent the many businesses in the community. To that end, we are willing to work with the community to make it a safe and inviting place for all of us to live and work in. To that end, facilities should be willing to follow the SAMHSA guidelines for good community relations which include:

- Maintaining a clean and orderly facility that does not impede pedestrian or traffic flow.
- Identifying and maintaining communication with community leaders for the purpose of fostering good community relations.
- Development and implementation of a community relations plan that is specific to the configuration and needs of the program within its community and includes but is not limited to the following actions:
    - Establish a liaison with community representatives to share information about the program, the community, and mutual concerns and issues.
    - Identify program personnel who will function as community relations coordinators.
    - Serve as a community resource on substance use and related health and social issues.
    - Develop program policies and procedures to effectively address or resolve community problems (including patient loitering and medication diversion).

- Document community contacts and community relations efforts and evaluate the effectiveness of these activities.

This is not a complete and comprehensive list but just some of the things that programs in the community are doing and are willing to expand upon with your input and suggestions.

I would also like to stress the importance of patient choice in choosing a treatment program and the long legacy of the community's openness to behavioral health clinics in the area and the idea that having people access medical care only in their zip code is not tenable. As a consumer of health care, and the treatment of addiction is healthcare, I have the right to choose a provider wherever I like. I may choose a provider based on referral from friends, family, the fact that it is not in my neighborhood and I don't have to see my neighbor when I go into my treatment program, and that is my right. There are also providers that are contracted with private insurance companies and they refer to only those providers and that limits choices for some consumers. And providers offer different treatment modalities and the quality of treatment may be different with different providers and consumers have the right to choose the treatment that works best for them.

Thank you for your time and attention.

12/14/16 Panel 2: Community Organizations

SALEEM GAUHAR
Executive Director at Manna House, Inc.

My name is Saleem Gauhar. I have been a volunteer at Manna House Inc. since the early eighties, on staff since 2004 and have been the Executive Director for the last five years. Our aim is to provide the homeless and poor of the City with goods and services to move them towards independence.

Manna House is fifty years old and this year we are celebrating half a century of service to the poor and homeless of Baltimore City. Lovely Lane, the mother church of Methodism in the United States, in which we are now seated, was one of its founding members. We operate a day shelter on week days where clients can access the wide array of services we have to offer, including case management, showers, clothes, mail etc. and a light meal in the afternoon. We also serve a hot breakfast every day, three hundred and sixty-five days a year. With the reallocation of resources by HUD, Manna House has lost seventy-eight thousand dollars of funding it has received for the last twelve years, the greater part of which, went to employ a case manager.

Concerted Care Group opened across the street from Manna House in 2104.

Patients come out of CCG and those who need it, see free hot breakfast across the street and they come to eat. Since CCG opened, the number of breakfasts served annually has gone up by more than ten thousand. That is fine, because that is what we are here for and the additional expense is our responsibility. However, there have been unintended consequences. We now have a higher concentration of drug addicted clients at the agency. They act up, are often unable to understand why services they want are not available or why they are not instantly available on demand. This often results in shouts and threats. This behavior spills over to some of the other clients and the result is that we have out of control situations develop well before the police or security help from CCG can arrive. We are having serious problems with service delivery. We have had our tires slashed, our cars keyed and one windshield smashed. We have drug dealing on our parking lot and on the sidewalk outside on 25th street. Rude and unacceptable behavior aside, we have had two cases of female counselor staff being physically assaulted. Some of this we have on film. The staff no longer feels safe at work. As I said, we are a fifty year old agency and have never felt the need of hiring security until CCG opened across the street from us. There have been plusses. When they first opened, we gave them the use of our facilities until they were up and running. On a personal level, we have a good relationship with them. We have recently collaborated on a health fair held on our premises and those addicted to drugs get much needed treatment.

However, the security problems are very real evidenced by the fact that CCG itself has two high quality security staff on their premises. That is why the drug dealing goes on in our parking lot and on our sidewalk on 25th street instead of at CCG. This is why the physical assaults take place at our agency. We installed security cameras and CCG has made available to us their security personnel by phone call. That has turned out to be wholly inadequate. By the time they arrive, the miscreants are long gone. We absolutely need on site security. I have appealed to CCG to provide it since our security problem is consequent to their opening, but that has not worked out. We do not have the funds for needed counselor or kitchen staff. We do not have the funds needed to engage security. I do not see why we should need to, when the problem is not of our making. It is unacceptable for Manna House staff to feel unsafe at work. It is unacceptable that a sixty year old female case manager should be beaten to the ground. My fear is that something more than a physical assault is likely to occur and we need CCG or other authorities to help.

Thank you for listening. I have long wanted to bring this issue to a forum that may be of assistance before something tragic occurs.

12/16/16 Panel 1: Individuals in Recovery

CARLOS HARDY
CEO of the Maryland Recovery Organization Connecting Communities (M-ROCC)

Good evening ladies and gentlemen, I would like to open my brief comments by thanking the committee for your willingness to take on the issues of increased access to treatment and neighborhood or community relations.

My name is Carlos Hardy and I currently serve as CEO of the Maryland Recovery Organization Connecting Communities (M-ROCC), a company I founded in 2012. I am also a person with 23 years in long term recovery.

Resources or funding aside I strongly believe the biggest challenge to expanding community based treatment and recovery residences to be the entrenchment of N.I.M.B.Y (Not in My Back Yard) attitudes. A less familiar acronym, but effective just the same would be B.A.N.A.N.A (Build Absolutely Nothing Anywhere Near Anything)
I first experienced this phenomenon, and to just what lengths communities were willing to go to stop programs from opening, in 2002 when I was hired as a Drug Treatment Organizer with the Citizens Planning and Housing Association (CPHA).

My 5 years spent as a drug treatment organizer taught me the most about the relationship or dynamic of treatment, recovery and communities….

My limited time does not allow me to discuss my experiences in detail, but they can be best summarized as follows:
Whenever meeting with community leaders, I was guarantee to get the following question. Where do you live…. Upon answering the question, the community response was pretty much guaranteed to be “well put it in your neighborhood”.

Ask each member of this distinguished panel to visualize this scenario… You go to bed at night and wake up in the morning with a treatment or recovery house program as your next-door neighbor… What would you think and how would you respond? What would your neighbors think, and how would THEY respond?

12/16/16 Panel 2: Community Organizations

EDNA MANN-LAKE, President of Fayette Street Outreach Organization, INC.
TIM BRIDGES, Vice President of Fayette Street Outreach Organization, INC.

The question how you can expand access to evidence-based drug treatment while maintaining and where necessary repairing relationships between treatment centers and their neighborhoods.

- Treatment centers need to meet with the communities to give an up-date on what their plans are if any.
- To make sure that their clients respect the communities in which they are receiving their treatment. Such as not staying around in that area after getting their treatment.
- Connect with the communities that have a workforce development programs for the clients that may need help in getting back in the work force.
- Have an open dialogue on any changes that may take place and can cause any direct changes that would have an effect on the communities.
- Make the communities feel that they play an important part in the program.
- To help educate communities on steps in the drug treatment program, and the different drugs that are being used.

Our overall hope is that the treatment programs will work with communities as a whole without any negative outcomes on either side.

KAREN STOKES
CEO of Strong City Baltimore

I am writing as CEO of Strong City Baltimore, a 48 year-old nonprofit organization whose mission is to build and strengthen neighborhoods and people.

Thank you for the opportunity to comment regarding the community impact of drug treatment. Strong City Baltimore has its roots in North and Central Baltimore, the location of many drug treatment facilities. In fact, we believe that the area within a quarter mile of 24th and Saint Paul Streets has the nation's highest concentration of drug treatment facilities. This area contains three major Methadone Clinics and several smaller treatment facilities.

Even though there is a concentration of treatment facilities in this area, they are not located on a campus with strict security in a way that hospital based facilities usually are. Instead, the area's clinics are located in a residential neighborhood and are responsible for security inside their building, on the street directly in front of their building, and in the employee parking lot. Also, facilities in this area provide little or no parking for their patients. This limited scope of

security keeps operating costs low and pushes any trouble with the patients into the public realm where community members, nearby businesses, and the police are held responsible.

Most patients receiving drug treatment cause no problems for the community around the treatment facility. They get their treatment and go. Unfortunately, a minority of patients, particularly those who are struggling with the treatment program, continue to use illegal drugs while they are in treatment. Relapse is common and many patients need multiple periods in treatment before they succeed. Methadone patients, in particular, are drawn to the Benzodiazepine class of anti-anxiety medication which, when combined with Methadone in a practice known as "Boosting," can give the patient an effect something like the Heroin that many of them were formerly using.

Non-prescribed Benzodiazepines are the predominant drug sold around treatment facilities even though they are not a major street drug in other parts of the city. In fact, 70% of the 44 dealers arrested near the Maryland Avenue treatment facilities and sent to District Court in 2014 were arrested for selling Benzodiazepines. A casual visitor to the area will see open air drug dealing in the 1900 and 2000 blocks of Maryland Avenue and nearby on North Avenue morning and afternoon.

We realize that drug dealing takes place in many parts of Baltimore City. Nonetheless, the drug activity around treatment facilities, particularly Methadone treatment facilities, has distinct differences (in the hours of operation and the illicit drugs offered) from drug dealing elsewhere. We realize that this drug activity harms the patients attempting to stick with their treatment program goals more than it harms nearby residents and business.

The clinics here in Central Baltimore pose significant community impact. We know that there are solutions, but there must be a commitment to working toward those solutions.

12/20/16 Panel 1: National Policy Experts

DR. WILSON COMPTON
Deputy Director of NIDA

Good evening. Thank you for inviting the National Institute on Drug Abuse (NIDA), a component of the National Institutes of Health (NIH), to participate in this important session and provide an overview of what science tells us about the neurobiology of substance use disorders and how science can drive the development of solutions to prevent and treat substance misuse and addiction, and related health consequences.

Background

Substance misuse and addiction are serious national problems that affect public health as well as social and economic welfare. In 2015, 21 million people in the United States suffered from a substance use disorder[i] and over 52,000 people died of a drug overdose, with over 60 percent of those deaths resulting from misuse of opioids.[ii] The consequences of this public health crisis go beyond addiction and overdoses and include the rising incidence of neonatal abstinence syndrome and the increased spread of infectious diseases such as HIV and hepatitis C (HCV).

While evidence based prevention and treatment strategies exist, they are highly underutilized across the United States; few communities implement proven prevention approaches and only a fraction – about 10 percent – of people with substance use disorders receive treatment.[i] Even those who can access treatment often find themselves in programs that do not use evidence-supported treatments, such as buprenorphine or methadone for opioid addiction. This is often the result of misconceptions about the medical nature of addiction.

As highlighted in the recently released Surgeon General's Report on Alcohol, Drugs, and Health, many people still believe that addiction is a moral failing that could be solved with willpower. But the science is clear: Addiction is a chronic, relapsing neurobiological disorder caused by changes in the brain that make controlling drug use extremely difficult, even when an individual recognizes the negative impact substance use has on his or her life and wants to stop.

Over the last few decades research advances – driven by advances in scientific technologies – have revealed the neurobiological underpinnings of addiction. For example, functional MRI has allowed us to look inside the brains of people with drug addictions and shown us that people with drug addictions have reduced metabolic activity in areas of the frontal cortex including the orbitofrontal cortex, anterior cingulate gyrus, and dorsolateral prefrontal cortex, brain regions that are essential in decision-making.

Other brain imaging and molecular biology research has shown us that addiction is associated with disruptions in multiple brain circuits. For example, brain reward circuits adapt to repeated drug-induced surges of the neurotransmitter dopamine by becoming less sensitive to it, a process called receptor downregulation. The result of this downregulation is that the person no longer experiences pleasure in response to natural rewards – such as food, sex, or positive social interactions.

At the same time, drug use has similar disrupting effects on other brain circuits that control the stress response, impulse control, memory, and other functions. These changes make it harder for someone with an addiction to manage their stress, control their impulses, and make the healthy choice to stop drug-seeking and use.

Often people do not understand that - because of these changes in brain circuitry - for someone with an addiction, drug use is not a matter of "getting high" but of briefly gaining some relief from the almost unbearable distress caused by withdrawal.

It is also important to understand that the brain disorder model of addiction fits within the larger biopsychosocial framework. Addiction involves lasting changes to the brain that arise from a mix of psychosocial factors arising from a person's unique history, personality, and social environments that either increase the risk of drug use – such as poverty or early exposure to drugs – or that provide buffers against those risks – such as strong family and social supports.

These factors also interact with an individual's genetic propensities for impulsive behavior and for developing dependence and addiction. Similar to other medical conditions with a behavioral component such as diabetes or cardiovascular disorder, patients benefit from treatment with a combination of behavioral counseling and medications when they are available.

Science Driven Solutions

In the midst of an ongoing epidemic of opioid overdose deaths, the U.S. Department of Health and Human Services launched a major initiative to address the complex problem of prescription opioid and heroin misuse in this country. The three pillars of this initiative include: (1) improving opioid prescription practices, (2) wide deployment of the opioid overdose reversal drug naloxone, and (3) increasing access to medication-assisted treatment to treat opioid use disorders.[iii]

Improving prescribing practices

Recent research has shown that doctors continue to prescribe opioids to patients even after non-fatal overdoses. One study found doctors continued prescribing opioids to 91 percent of patients following an overdose. Of these patients, 63 percent remained on a high dose of prescription opioids 1-3 months after overdosing and 17 percent of patients who continued to receive high doses of prescription opioids overdosed again within two years.[iv]

Prescription opioid medications can help treat and manage severe pain but may pose risks for addiction, overdose, and death. Prescribers must balance the benefits and risk for individual patients. However, clinicians across the country typically receive insufficient education on pain treatment.[v,vi] The CDC recently released guidelines for the use of opioids in the treatment of chronic, non-cancer pain in primary care.[vii] Implementation of these clinical practice guidelines are an important step for promoting safer, more effective chronic pain treatment while reducing the number of people who misuse opioids, develop an opioid use disorder, or overdose from these powerful drugs.

Combatting Overdoses with Naloxone

Naloxone can quickly restore normal breathing and save the life of a person who is overdosing on opioids. In 2015, the FDA approved the first naloxone nasal spray, NARCAN® a user-friendly naloxone formulation developed as a result of NIDA-funded research. Naloxone is also available as a user-friendly auto injector, EVZIO®, that provides verbal step-by-step instructions on administering the opioid antidote. Naloxone distribution programs provide these user-friendly naloxone formulations to opioid users, their friends and families, and others who may find themselves in a position to save the life of someone at risk of an opioid overdose. A naloxone

distribution program in Massachusetts reduced opioid overdose deaths by an estimated 11% in the 19 communities that implemented it, without increasing opioid use.[viii]

However, in a survey given to chronic pain patients receiving prescription opioids, only 3 percent of patients reported having a naloxone prescription or being trained to deliver naloxone. Yet, nearly 40 percent had witnessed an overdose.[ix] Another study among persons with opioid use disorder found 68 percent of participants had witnessed an overdose but only 17 percent had a prescription for naloxone.[x] These data highlight the need to increase the distribution of naloxone to high risk populations.

Increasing Access to Medications for Opioid Addiction
Research has clearly demonstrated that medications such as methadone, buprenorphine, and extended release naltrexone – used to treat opioid addiction – decrease opioid use, opioid-related overdose deaths, and infectious disease transmission while improving a patient's social functioning. Right here in Baltimore, after buprenorphine became available, heroin overdose deaths decreased by 37% demonstrating the potential life-saving aspects of medication treatments of opioid use disorders.[xi]

In May of this year the FDA approved a new long-acting buprenorphine implant called Probuphine. This subdermal implant delivers a constant low dose of buprenorphine for six-months. Buprenorphine has previously only been available in pill form or as a sublingual film that must be taken daily. The main studies of Probuphine implant showed that it had excellent treatment compliance, and should minimize the potential for diversion and misuse.[xii]

Despite the efficacy of these medications, they remain underused. Recent research has highlighted some strategies for increasing their implementation among high risk populations. For example, patients who were initiated on buprenorphine in the emergency department were more than twice as likely to remain engaged in treatment compared to patients referred for treatment,[xiii] and initiating treatment with extended-release naltrexone in adults on probation or parole who had opioid dependence reduced relapse rates.[xiv]

A common misconception is that treating addiction with medication is substituting one addiction with another. When someone is treated for an opioid addiction the dosage of medication used does not get them high, it helps to reduce opioid cravings and withdrawal. These medications restore balance to the brain circuits affected by addiction, allowing the patient to work towards recovery.

Another important focus for expanding access to these medications is opioid-using pregnant women. Between the years 2000-2012, there was a five-fold increase in the number of babies born with neonatal abstinence syndrome.[xv] This increase was driven in part by the high rate of opioid prescriptions being given to pregnant women and to the overall increasing rates of opioid use disorders in the population. An estimated 14.4 percent of pregnant women with private insurance and 21.6 percent of Medicaid enrolled pregnant women filled prescriptions for an opioid during their pregnancy between 2000 and 2007.[xvi] Despite the risk for producing

neonatal abstinence syndrome, there is clear evidence that treatment of opioid dependent pregnant women with methadone or buprenorphine improves outcomes for their babies; reducing symptoms of neonatal abstinence syndrome and length of hospital stay. These treatments remain highly underused but they present the best opportunities to treat opioid use disorder in pregnancy.[xvii,xviii]

Another concern is the transmission of infectious diseases such as HIV and HCV due to injection of heroin or prescription opioids, which has risen as the number of individuals injecting opioids has increased. 2015 saw one of the fastest-spreading outbreaks of HIV in the U.S. since the inception of the epidemic with 184 cases reported in a small rural county in southeastern Indiana.[xix] This outbreak was driven by injection drug use—specifically, abuse of the opioid painkiller Opana (oxymorphone). One policy that has been shown effective for reducing the spread of infectious diseases is sterile syringe exchange. A prospective study of a syringe exchange program in New York City found a 70 percent reduction in the transmission of HIV and an overall 33 percent decrease in the prevalence of HIV, as well as a 29 percent decrease in the prevalence of hepatitis C injection among people who inject drugs. [xx] [xxi] In addition to reducing infectious disease transmission, these programs also offer counseling services, HIV testing, and serve as an important facilitator to engage people in substance use disorder treatment.

Conclusion

There are many evidence-based strategies that can be brought to bear on the ongoing crisis of drug use and addiction. Overcoming the misconceptions and societal stigma that have hindered implementation of these strategies is critical. As highlighted by the Surgeon General, how we respond to this crisis is a moral test for our country. We must be guided by the best available science to develop pragmatic solutions to reduce drug use, addiction, and related public health consequences.

DR. YNGVILD OLSEN
Chair of Public Policy Committee, ASAM; Medical Director for IBR/REACH Health Services

1. Here on behalf of ASAM where I chair the Public Policy Committee
2. Also Medical Director for the Institutes for Behavior Resources here in Baltimore

Two areas I would like to address:

Access and quality

First – on access.

We need broad access to effective addiction treatment because we have a serious epidemic in Baltimore – and unfortunately, despite tremendous efforts, it's not getting better.

Through June 2016, Baltimore City counted 290 OD deaths, 205 of which were heroin related, and 149 determined to be related to fentanyl. In all of 2015, Baltimore City counted 393 OD deaths, 120 of which were fentanyl related; and that was an increase of 67% from 2014, and a 900% increase from 2013. At this rate, this year, the number of people lost to OD would fill Camden Yards press box almost 6 times over.

But we all know that addiction also has other deleterious effects. When substance use and addiction become widespread in a community, these consequences are felt collectively. Addiction is costly to community and local businesses; the economic cost of addiction in the United States was estimated at $193 billion in 2007 (the last available estimate), including $120 billion in lost productivity.[xxii]

Fortunately, we know what works and what doesn't in addressing addiction. Decades of scientific research has proven that addiction is a chronic brain disease affecting neurocircuitry, with some people more susceptible than others.

Years of experience have shown us that supply-side interventions – trying to limit drugs in the community through law enforcement actions – are not sufficient to fully ameliorate the consequences of addiction in the community. From years of research and through numerous well-respected sources, like the Surgeon General's recent report on addiction, NIDA, and the World Health Organization, we have conclusive evidence that treatment that includes a medication leads to the best outcomes for most people with an opioid use disorder.

Unfortunately, there are many barriers to accessing evidence-based addiction treatment, even in Baltimore. While the lack of perceived need for treatment is by far the most common reason people don't receive care, we know that stigma plays a large part, particularly for people with opioid use disorder. They must deal with the stigma of their disease as well as stigma often related to treatment. And despite the perceived availability of treatment in Baltimore, it is not always available when people finally make the decision to access it. National statistics estimate that only about 10% of those in need of treatment receive it.

And treatment isn't treatment isn't treatment – that's where the quality comes in.

As an addiction specialist physician, I've seen how people can recover from addiction when they have access to high-quality care. I've also seen what happens when treatment is not delivered in accordance with best practices – stigma is perpetuated, people give up, and disease consequences continue. ASAM applauds the work that Maryland, and Baltimore City, has done and continues to do in improving the quality of addiction treatment being provided for those with opioid use disorder.

The problem we must solve is how to connect more people who need treatment with the comprehensive medical care that can help them learn to manage their disease, achieve remission, and sustain recovery. And treatment and neighborhood development are not mutually exclusive. When persons with addiction are in remission, they are less likely to commit crimes and more likely to be able to sustain employment and provide for themselves and their families. When communities can access high-quality care, the positive social consequences have ripple effects for the entire community, boosting safety and economic productivity in the short run and promoting protective factors that may prevent drug use and the onset of addiction in younger generations.

To achieve this win-win for everyone, ASAM recommends:

1. Working with insurers, including Medicaid, and DHMH to recognize and incentivize the provision of comprehensive, high quality, evidence-based treatment. The American Society of Addiction Medicine has practice guidelines that can inform this process.
2. Supporting physicians, nurse practitioners and PAs who are interested and willing to offer addiction treatment services as part of their practice. Many clinicians who are not addiction specialists feel they don't have the support they need to treat these complex patients. Offering them mentorship and ensuring they are paid appropriately for treating addiction, can increase access to care from clinicians who are already established in the community.
3. Consider co-locating addiction treatment services with other services that patients need, such as primary and mental health care, housing support, job training services, WIC programs, etc.

These are a few initial thoughts and I'm happy to take questions.

12/20/16 Panel 2: Anchor Institutions: Hospital/University Leaders

DR. ALIYA JONES
Chief of Psychiatry and Chair of the Department of Behavioral Health
Bon Secours Hospital Baltimore

Good Evening, my name is Aliya Jones, MD and I am the Chief of Psychiatry and the Chair of the Department of Behavioral Health at Bon Secours Hospital Baltimore, a not-for-profit Catholic Healthcare Ministry charged with a mission of being good help to those in need. Welcome to Bon Secours Community Works, the arm of our ministry that works to enrich West Baltimore communities with programs and services that address social determinants of health and contribute to the long-term economic and social viability of neighborhoods.

Our CEO, Dr. Samuel Ross, is a member of your work group. In his absence, I am honored to have been asked to provide testimony on the behalf of Bon Secours Baltimore an anchor institution in southwest Baltimore. The Sisters of Bon Secours have been serving the citizens of southwest Baltimore since 1881 when they arrived to our shores to do home nursing, and they went on to found Bon Secours Hospital in 1919.

Bon Secours has an extensive number of behavioral health programs, in addition to emergency, primary care and specialty services. Included in our range of services are 3 JCAHO accredited substance abuse programs – New Hope and ADAPT Cares (Opioid Maintenance Therapy) and Next Passage (IOP, Buprenorphine, medication-free treatment). Personally, I am an addiction psychiatrist who has been practicing in the Baltimore metro area for the past 15 years.

I have been asked to discuss how we can expand access to treatment while maintaining positive relationships between providers and the neighborhoods in which they operate, and to do this in 5 minutes. The short answer is, there are no short answers, and that this is very difficult work that must be done intentionally, determinedly, and persistently.

One of the most important first steps is to have leadership that appreciates the importance of partnering with the communities wherein their programs are located. This acknowledgment and demonstration of respect towards communities is critical to the development of a relationship that can strengthen and grow over time.

Secondly, treatment organizations must see the community as a potential ally, and must try to help the community to see the organization as an ally. Working together to try to develop mutual positive regard will help both entities be poised to identify opportunities for collaboration and mutual support. We need to create win-win partnerships. Treatment organizations need the communities they are imbedded within to be supportive of the work that they do, as a negative impression of a local treatment program can affect referrals from the very community we are trying to help. In turn, treatment programs need to be good neighbors, who respect the legitimate concerns raised by the local community, and they need to be quickly responsive, and keep any resultant promises made (ie. loitering).

Our programs need to engage the community by truly listening to their concerns. We have to move beyond just "tolerating" each other's presence, and truly seek to "understand" the

mutual needs and values. We need to move from asking\telling the community "what's the matter with you" and instead ask "what matters to you" as a neighbor.

The "listening" can occur in multiple ways. It can be as simple as informal meetings with immediate neighbors, and attending their more formal community association meetings and activities, for purposes of relationship building, and providing information about services provided that may be useful to the neighbors and those they are connected to.

In our case an additional way of determining how to best partner with your local community is by performing a comprehensive Community Health Needs Assessment. Bon Secours, like other non-profit organizations, is required to perform such an assessment every three years, and we just completed our latest CHNA a few months ago. Implementation plans include establishing a Community Advisory Board and membership must include representatives from the neighborhood.

Providing the community education about the benefit of services is important. However, it is has been stated that "education is necessary but insufficient to create meaningful change". This is particularly true when talking about substance abuse services, which are highly stigmatized, as is substance use itself. Treatment programs must counter stigma with truth, and tell real stories about real people, real neighbors, that demonstrate the effectiveness of your programs. The community needs to see that there is someone in their very home who could, or could have, benefited from the provided services. They need to feel connected to their very neighbors that they would rather not see, they need to be convinced of the potential in the life rescued from the scourge of addiction. They need to know and be reminded that treatment works and that recovery is possible. Leaders need to invite the community in, to check out their programs and see "what's goin' on in there". They need to see how ordinary the workplace is,

to hear the laughter that comes from being in a safe environment, to see the smile returned for a smile extended, to hear people greet one another as old friends who respect and care for each other. We need to take away the mystery, which lends itself towards negative fantasies. Program leaders need to meet with the community when there is no crisis, when there is nothing to gain but an improved relationship and shared understanding. We also need to evaluate how we can better engage the media as a partner to help tell our stories.

Treatment programs need to intentionally provide greater outreach to communities of faith, on social media outlets, and likely develop more creative opportunities (like providing information at popular local community events, festivals, concerts, etc.) for there are too few people in the community that are aware of treatment options for common substance use problems, which is devastating news for a community wherein substance use abounds.

In conclusion, what do we know? We know that there are 20,000 persons in the city of Baltimore that are in need of substance use treatment. We know that there is current capacity for only approximately 7,000 citizens at any given moment. We know that people who are dependent upon substances are at great risk themselves to trauma, criminal activities, and physical illness including infectious diseases, overdose and death, amongst many other woes.

We know that neighborhoods/cities with high rates of substance use also have high crime rates, high rates of violence, and high rates of transmission of infectious diseases, amongst many other challenges. We know that treating individuals with substance use disorders improves the quality of life for the individual, their family, their children, their neighborhood, and in our case our entire city.

Finally, we know treatment programs can't do it alone. We know we must partner with our community stakeholders. We know we must earn and retain their respect. We know we must listen and respond to their concerns and needs. We know we must combat the stigma that binds our hands and causes us to watch our neighbors, our family and our friends needlessly die.

DR. CHRISTOPHER WELSH
Addiction Psychiatrist at the University of Maryland Medical Center

My name is Christopher Welsh. I am an addiction psychiatrist at the University of Maryland Medical Center and have been one of the providers in our mental health and addiction treatment services programs for almost 20 years. In addition, I have collaborated with the Baltimore City Health Department and Behavioral Health Systems Baltimore (BHSB, formerly SSAS) on various projects including the Baltimore Buprenorphine Initiative (BBi), Staying Alive Overdose Prevention Program, Screening Brief Intervention and Referral to Treatment (SBIRT) in primary care initiative and Preventing Substance Exposed Pregnancies (PSEP) initiative. I also serve on the Baltimore City Needle Exchange Advisory Committee.

For generations, the University of Maryland Medical Center and its partners in the University of Maryland School of Medicine as well as the Schools of Social Work, Law, Nursing and Pharmacy have been active in providing behavioral health care, including addiction treatment services in Baltimore. As Baltimore anchor institutions, the Hospital and the University are committed to improving the health of our neighbors in Baltimore through patient/provider relationships and through a variety of community-benefit activities that a dress health and its social determinants.

So what do we know?

Human biology is susceptible to addiction. Over the past few decades, brain imaging and other research has helped us learn that the same basic brain systems that are involved with rewarding/reinforcing behaviors that are essential for survival also play a key role in addiction. From other biological research, we also know that there is a strong genetically inherited component to addiction. These and other factors have led us to realize that addiction is best understood and treated as a chronic, multifactorial health issue not unlike other conditions in which behavior plays a large role in maintenance of the symptoms as well as management of those symptoms. As a part of this, evidence based treatments such as the use of medications (currently FDA approved for opioid, alcohol and tobacco use disorders) have been shown to be very effective in helping patients manage their disease.
Sounds like this shouldn't be such a difficult thing to do. However, addiction rarely occurs in isolation and many of our patients in West Baltimore (as with patients in every other area of the world) are also likely to suffer from multiple other behavioral health problems as well as poor physical health relative to their non-addicted peers. In addition, arguably, more than any other health issue, addiction is also a social (and political) issue significantly contributing to and impacted by poverty, unemployment, homelessness, violence, crime, trauma, racism and community and family dysfunction. It is also heavily influenced by negative public perception. These factors and the resultant disparities make the problem very difficult to adequately address.

For decades, the University of Maryland Medical Center tried to increase our efforts to work with individuals suffering from addiction, establishing a specific addiction consultation service in the 1980s. More recently, we have expanded this by placing peer recovery coaches in the emergency department (ED), and are preparing, with state and 0Sl funding, to initiate medication assisted treatment with buprenorphine in the ED (at UMMC and several other city hospitals). We are also engaged in a NIDA-funded study (called NAVSTAR) looking at the effectiveness of using social workers as navigators to help patients connect to various services following a substance-related hospitalization.

In our community addiction treatment programs, both east and west of Martin Luther King Boulevard, we have always tried to engage the community in our efforts. We have also worked to provide enhanced services for our patients, establishing our methadone program as a health

home and collaborating with HealthCare Access Maryland and Paul's Place to increase access to social services we cannot easily offer within the programs.

What have we learned and where are we going?

So, as we look back over our decades of involvement in treating substance use disorders, we feel that a great deal more could be done to improve the total health and well-being of our neighbors in Baltimore while building a stronger, healthier community. In some ways, the future involves returning to a version of the "family doc" model of care where the whole person is evaluated and treated. However, the updated version of the chronic care model involves the use of an integrated, multi-specialty team, not a single heroic individual. And similar to what some in the room remember (or have seen on old television shows) the providers come to us - we are not going to a hospital or an emergency room for care.

In the case of the University of Maryland Medical Center, we are planning what we are currently calling the Champion Center, based on the word "campio," one who supports or who fights on behalf of others. The Center is imagined as a "front door'' for the community to University and Medical Center resources. The center will bring together a set of diverse and complementary services under one roof including:

- Health care delivery services (adult and pediatric primary care, adolescent medicine, community psychiatry, addiction treatment, "rotating" adult and pediatric specialty care, obstetrics and well-woman care, and physical rehabilitation)
- Health care services (preventative care, health education, trauma-in formed treatment, parent coaching/mentoring, health screening, promotion, telemedicine, pharmacy services)
- Community support services (community rooms, community partner organizations, child care, and recreation for young adults, life skills training, social support services including synchronized "inter- disciplinary" consults and intervention with our other partners from the University of Maryland Baltimore.)

All of these services would be provided in a center located not on the campus of the Medical Center or University for the convenience of the medical professionals but in the community; closer to where the patients live. We are very excited by the possibilities of this integrated approach we hope you share our optimism.

Thank you for spending your time to help our city address this important issue.

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