

Baltimore Mayor's Heroin Treatment & Prevention Task Force Report

JULY 2015



Leana Wen, M.D.
Health Commissioner



Stephanie Rawlings-Blake
Mayor



Behavioral Health System
Baltimore



Acknowledgements

The City of Baltimore, the Baltimore City Health Department and Behavioral Health System Baltimore would like to thank all of the partners and stakeholders who participated in this process and made this document possible. A wide variety of people contributed to this report, from peer support advocates to heads of federal, state and local agencies. We are grateful for all of your contributions.

Thank you also to the Hatcher Group for the graphic design of this report.

INTRODUCTION

Communities across the nation have been experiencing troubling increases in opioid overdose deaths – a critical problem causing an epidemic in America. Opioids include heroin and prescription drugs such as oxycodone, hydrocodone, hydromorphone, fentanyl, codeine, etc. Opioid misuse and addiction affects people from all walks of life and all age groups. Although opioid addiction can have devastating consequences, it is important to recognize that addiction is a treatable illness that can be managed – recovery is possible!¹

Addressing heroin addiction is a critical priority of Mayor Stephanie Rawlings-Blake, who convened the Heroin Treatment and Prevention Task Force to come up with urgent and actionable strategies. The Task Force members are united in our commitment to free residents and families from the overwhelming influence of heroin and other opioids.

We envision a city where people live and thrive in communities that promote and support health and wellness. We believe that all Baltimore residents should have the opportunity to achieve their full potential. We ensure that the care provided throughout Baltimore is of the highest quality, comprehensive and person-centered, and that providers work in true partnership with those who seek care. We collaborate with community leaders and residents to advocate for and promote policies, values and norms that are supportive of behavioral health and wellness.

And we do this with the urgency that this issue deserves. Nearly every day, one resident in our city dies because of overdose. Many thousands more suffer from untreated addiction. This is a life and death issue, one that affects our friends, our neighbors, and our family members.

These values have guided the work of this Task Force. This report outlines the recommendations and the work that must continue in order to address this life-and-death issue.

¹ Although the focus of the Task Force was heroin, it is worth noting that many of the recommendations throughout this report are applicable to the broader opioid treatment system.



Letter from Mayor Stephanie Rawlings-Blake

Baltimore City has the building blocks for a bright future, including strong neighborhoods, a rich history, thriving anchor institutions and vibrant cultural activities. But we also face major challenges, including problems stemming from heroin. For decades, heroin and, more recently, other opioids like prescription narcotics, have disrupted the lives of too many of our residents and damaged our communities. While we have made progress in recent years, we continue to face an urgent public health challenge.

Last year, I formed the Heroin Treatment and Prevention Task Force to closely examine the problem, measure its scope, identify shortcomings in our treatment system, and develop smart responses. After months of hard work by the Task Force, I am pleased to share this report outlining its findings and recommendations.

Most directly, heroin and the misuse of other opioids harm users, sometimes with deadly results. Those with substance use problems may struggle to work or be good parents. They often lose their homes and develop other health problems.

But all of us are affected. Abuse of these drugs generates crime, strains our healthcare system and harms the quality of life for residents in many communities. In short, heroin and opioid abuse threatens all aspects of Baltimore's future.

As a city, we are focused on creating new economic opportunities and growing our population. But we cannot maintain this progress unless we give all residents the opportunity to lead healthy lives. That includes providing access to the best possible substance use treatment for those who need it. These recommendations will strengthen our treatment system and help many more of our friends, neighbors and relatives move into recovery and healthy lives.

I applaud the members of the Task Force and its co-chairs, Dr. Samuel L. Ross and Bernard J. McBride, for accepting the assignment and producing this valuable document. And Baltimore City Health Commissioner Dr. Leana Wen has provided strong leadership, impetus, and vision for our ongoing efforts.

I pledge to maintain the City's focus on this critically important issue and will work closely with our many partners and stakeholders to implement the recommendations in this report. Together, we will make Baltimore a healthier city for all.

Sincerely,



Stephanie Rawlings-Blake
Mayor of Baltimore

Letter from Baltimore Health Commissioner Dr. Leana Wen

As an ER doctor, I have seen the ravages of heroin addiction firsthand. My patients have suffered lasting consequences of addiction; many die from heroin overdose. As the city's doctor, I have seen how heroin ties into the very fabric of Baltimore. It is impossible to separate heroin use from problems of poverty, violence, incarceration, homelessness, and ill physical and mental health.

These issues contribute to rampant health disparities that divide our city—disparities that were unveiled to all in the wake of the civil unrest that followed the tragic death of Freddie Gray. In order to heal our city, we must address the underlying problem: substance addiction, and in particular, the heroin epidemic that has and is continuing to ravage Baltimore.

The Baltimore City Health Department has a mandate to protect the health and improve the well-being of all of our residents. There are many issues we must address, but none of them are more urgent than the heroin epidemic. This is why we are so proud of our Mayor, Stephanie Rawlings-Blake, for taking on this critical public health issue and demanding citywide attention and action to it.

There are three principles we commit to in issuing this report. First, this report is all about action. The last thing our city needs is another report that will sit unused on a shelf. Every single recommendation is an action item that we can believe can be implemented immediately. Some are so urgent that work has already begun—for example, the alarming rate of overdose deaths prompted us to launch a citywide Overdose Prevention and Treatment Plan.² In just two months, we have already increased naloxone distribution by 200% so that we do not wait to save the lives of our citizens.

Second, we intend for the recommendations to be a blueprint and a call to action for many stakeholders. Governor Hogan has convened a statewide task force on the opioid epidemic; we hope the Governor will embrace our recommendations so that together we can move the needle in Maryland. Our federal partners are assisting Baltimore with recovery; we hope they will use this document to guide their funding priorities.

Third, Baltimore and Mayor Rawlings-Blake have never taken a back seat to public health and we are not going to do so now. This is the time for bold and decisive action. This report proposes solutions that are difficult and are not going to be straightforward. We do not shy away from such a challenge. We are at a turning point in Baltimore's history. Our recommendations on fighting the underlying scourge of heroin are one critical step to build Baltimore into a healthier and more equitable community.

The Baltimore City Health Department is pleased to join Mayor Rawlings-Blake and our partners across the city to issue this important report to protect health, eliminate disparities, and advocate for equity and justice.

Sincerely,



Leana Wen, M.D., M.Sc.
Baltimore City Health Commissioner

² <http://www.baltimoresun.com/news/opinion/oped/bs-ed-wen-0524-20150523-story.html>

Letter from the Task Force Co-Chairs

We have been honored to serve as the co-chairs of the Mayor's Heroin Treatment and Prevention Task Force. As long-time leaders in healthcare, we know all too well the devastation that heroin and other opioids cause throughout the Baltimore community. Addressing those problems requires strong central leadership and broad community-wide effort, and the work of the Task Force has been exactly that.

This group brought together dozens of people with diverse experience dealing with substance use – nonprofit leaders, academics, medical experts, public safety officials, faith leaders, business people, elected officials and community leaders. We were pleased to include state partners in all aspects of the Task Force efforts, and members of the community, including people in recovery, had opportunities to share their views, experience and recommendations.

This inclusive process gave Task Force members a full view of the challenge and allowed us to accurately document the scope of the problem and identify what we're doing well and where we need to improve our efforts.

We are confident that this report's thoughtful recommendations provide a reliable blueprint for tackling Baltimore's substance use problems. We also look forward to linking our efforts with those of Maryland's Heroin and Opioid Emergency Task Force. Though other parts of the state may face unique problems, we hope that our lessons and action items will be useful to the Governor and Lieutenant Governor as they shape their recommendations.

Finally, we offer our deep appreciation to the members of our Task Force and its work groups as well as the staff at Behavioral Health System Baltimore who provided vital support. Together we have made progress in addressing one of Baltimore's most pressing challenges.

Sincerely,



Dr. Samuel L. Ross
Chief Executive Officer
Bon Secours Baltimore Health System



Bernard J. McBride
President and Chief Executive Officer
Behavioral Health System Baltimore



EXECUTIVE SUMMARY

In October 2014, Mayor Stephanie Rawlings-Blake convened the Heroin Treatment and Prevention Task Force to address the critical problem of opioid addiction in Baltimore City. The goal of the Task Force was to study the problem of heroin addiction and to propose solutions for improving access to effective treatment and neighborhood compatibility. The Task Force engaged many key stakeholders and partners throughout this process to study the best practices available to address this critical issue.

The work of the Task Force was divided into four workgroups: Data, Access to Care, Practice Standards, and Neighborhoods. The workgroups were comprised of national and local experts, community stakeholders, providers, and representatives from state and local government. Each engaged in a process to review the relevant literature, gather information about the existing systems, review national models, and develop recommendations to address the unique needs of Baltimore City.

The Mayor and Health Commissioner also convened community meetings to solicit feedback from interested community members. The ten recommendations contained in this report represent the culmination of this work, along with input from a broad spectrum of stakeholders and community members.

These recommendations will help guide the work of the [Baltimore City Health Department](#) and [Behavioral Health System Baltimore](#) in addressing the issue of heroin and opioid misuse and overdose over the next several months and years. We hope these action items can also spur action for state and federal partners to assist Baltimore with recovery and healing, and building our city into a model for others to follow.

SUMMARY OF RECOMMENDATIONS

- 1 Develop dashboard for ongoing monitoring** to obtain real-time data for number of people with substance use disorders, near-fatal and fatal overdoses, and capacity for treatment.
- 2 Implement citywide heroin overdose plan** to save lives of our citizens. This plan includes developing targeted treatment and preventive interventions for those at highest risk for overdose and ensuring widespread dissemination of the opioid antidote, naloxone.
- 3 Develop a centralized, easy-to-access intake that is 24/7**, with immediate access to an addiction counselor or social worker, and publicize to all (including emergency departments, emergency personnel, peer networks, and community members).
- 4 Increase data-driven, high-impact options for treatment.** This includes universal case management and access to treatment for most vulnerable individuals in the city such as inmates and the recently incarcerated, as well as increasing availability of evidence-based treatment, such as buprenorphine.
- 5 Ensure treatment on demand.** This includes work towards a 24/7, “no wrong door” treatment center for addiction and full capacity for treatment in both intensive inpatient and low-intensity outpatient settings.
- 6 Develop voluntary certification and review for substance use providers** based on core standards of care. This includes a pilot to test and refine best practice standards with key volunteer providers in Baltimore City.
- 7 Facilitate an ongoing partnership and collaboration** among key stakeholders to pilot programs, test economic incentives, and discuss integration with state/federal systems of care.
- 8 Develop standardized good neighbor agreement and establish best practices for substance use disorder providers and community members** (including issues such as loitering, cleanliness, security, community advisory committee, and voluntary agreements).
- 9 Coordinate efforts with treatment providers and law enforcement.** This includes preventing targeted drug sales to vulnerable individuals undergoing addiction treatment; working collaboratively to obtain help for people with behavioral health disorders; and increasing support for Drug Treatment Courts and other diversion programs.
- 10 Implement comprehensive strategy to educate and inform residents, businesses, and other key stakeholders** about substance addiction to help reduce fear and combat stigma. This includes launching a campaign to educate citizens that addiction is a chronic disease and to encourage individuals to see treatment.

TASK FORCE OVERVIEW AND HISTORY

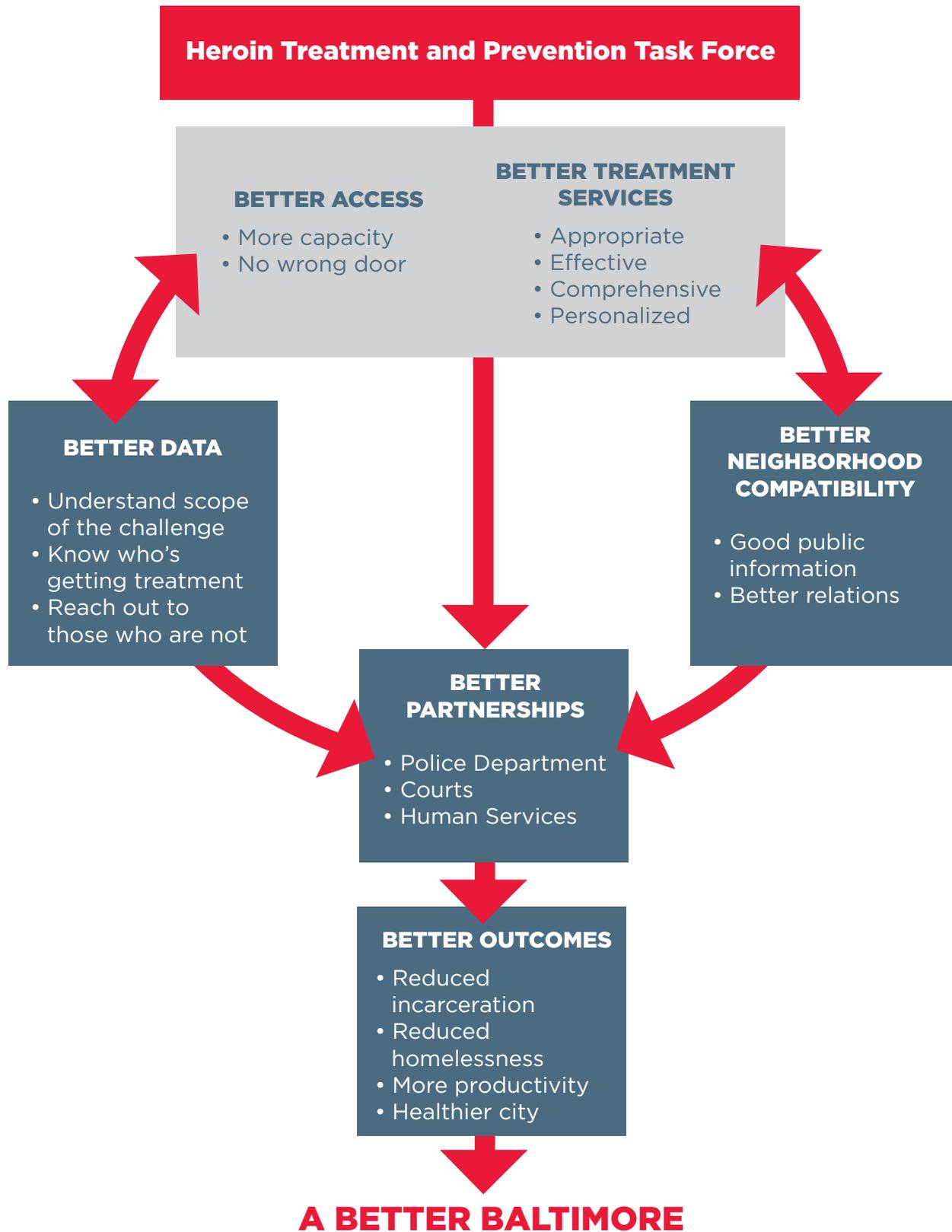
In October 2014, Mayor Stephanie Rawlings-Blake convened the Heroin Treatment and Prevention Task Force to address the critical problem of opioid addiction in Baltimore City. In January 2015, the new Baltimore City Health Commissioner, Dr. Leana Wen, was appointed with the specific mandate to prioritize substance use and to provide bold vision and leadership on this critical issue.

Bernard McBride, President and CEO of Behavioral Health System Baltimore (BHSB), and Dr. Samuel Ross, CEO of Bon Secours Baltimore Health System, co-chaired the Task Force.³ Bon Secours Baltimore Health System is a large health care organization in west Baltimore, with a strong investment in this issue. BHSB is the behavioral health authority for Baltimore City. As such, BHSB oversees Baltimore City's public behavioral health system – the system of care that addresses emotional health and well-being, which includes services for substance use and mental health disorders.

Outpatient services are the foundation of effective behavioral health systems of care. Therefore, much of the Task Force activities focused on ensuring that Baltimore City residents have access to effective outpatient services in order to reduce the harmful outcomes associated with untreated substance use disorders, the most devastating of which is overdose death.

The Task Force has held multiple public meetings and convened stakeholders across a broad array of representative groups. These recommendations are released in July 2015. Due to the urgency of the heroin epidemic, some recommendations have already been implemented under Mayor Rawlings-Blake and Health Commissioner Dr. Wen's leadership.

³ A complete list of Task Force members is located in the Appendix.



WORKGROUP REPORTS

Each of the four workgroups (Data, Access to Care, Practice Standards, and Neighborhoods) had a defined set of goals and objectives to guide their work, and operated under the direction of the Task Force co-chairs. A minimum of three Task Force members were assigned to each workgroup, along with additional members who were not members of the Task Force, as needed.

The workgroups held multiple working sessions to (i) examine issues surrounding substance use and opioid overdose; (ii) solicit input from experts and other stakeholders; (iii) review data, research, and best practices; (iv) formulate the next steps; and (v) develop recommendations for further system improvements. This report summarizes their findings and recommendations for strengthening Baltimore City's behavioral health system of care.

I. Data Workgroup Report

Recognizing the importance of using data to inform decision-making, the Data Workgroup collected, reviewed, analyzed, and presented data to guide the Task Force. Substance use disorder epidemiology, like other public health problems, quantifies the magnitude of the problem. Measuring substance use presents inherent challenges because human behavior is individualized and frequently changes, making it difficult to quantify. It required us to ask the question, "How will an individual behave on any one day at any one time?"

Another inherent challenge in the field of substance use epidemiology is that data sources do not always use the same data points, making it difficult to compile results from different data sources. For example, are we measuring people or treatment admissions; all substances or illicit substances or heroin; (dependence or abuse) or (use or disorder)? Taking into account the differing terminology is critical to the success of any data analysis of substance use disorder.

Further complicating measurement in the field of substance use is the fact that substance use is hidden by users due to social stigma and the legal consequences of use. Surveys also typically under-count individuals who use heroin or other illegal substances because they are less likely to have stable homes, be institutionalized or otherwise not well represented in population-based surveys. Therefore, a point in time estimate is not static, but changes as individual behavior changes.

The Data Workgroup reviewed several sources to help make decisions about the best way to estimate prevalence for this report, such as *What is the Scope of the Heroin Problem in the United States* (National Institute on Drug Abuse) and *The Extent of Alcohol and Drug Abuse in the State of Maryland* (Behavioral Health Administration, formerly the Maryland Alcoholism Control/Drug Abuse Administration). Where there are specific references made, a footnote is used.

Estimating Heroin Use in Baltimore City

Over the years, estimates of the number of people using heroin in Baltimore City have varied widely. The Data Workgroup examined the available data and developed an updated good-faith estimate of the number of people using heroin in Baltimore City – a first step to identifying unmet needs in the City’s behavioral health treatment system.

Based on calculations that build on federal survey and state data, the Data Workgroup estimates that 18,916 people have used heroin in the past year in Baltimore City.

Available Data

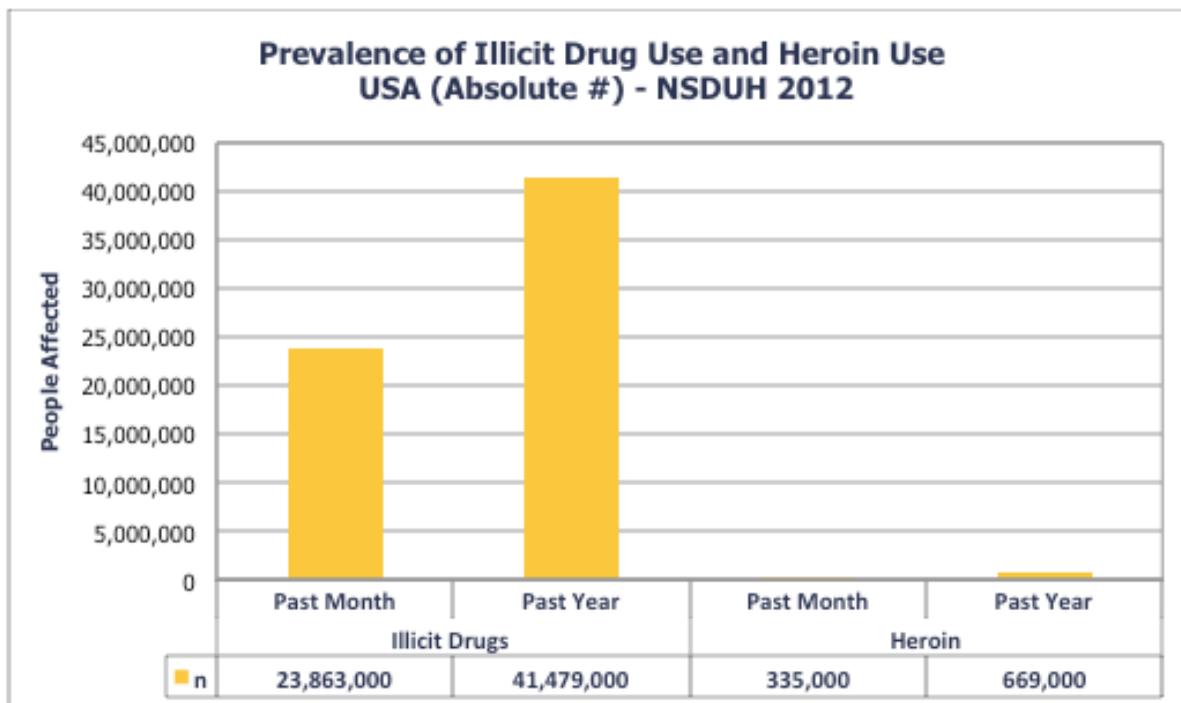
The National Survey of Drug Use and Health (NSDUH), a population-based survey, was used as the basis for the preliminary estimate provided. However, there are limitations with the use of NSDUH data since it only represents the civilian, non-institutionalized population and the data is collected through a phone survey, which is a small sample size and limited to individuals with phone access. Additionally, the survey results report the percentage of the population surveyed. To use the data effectively, the percentages must be applied to the U.S. population and the data points are not always specific to Baltimore City and/or heroin use. Although there are limitations to the data collection and use of NSDUH data, it is still the most comprehensive study of substance use available and is used extensively for policy planning at the federal level.

The following is summary data the workgroup reviewed and used as the basis for the analysis:

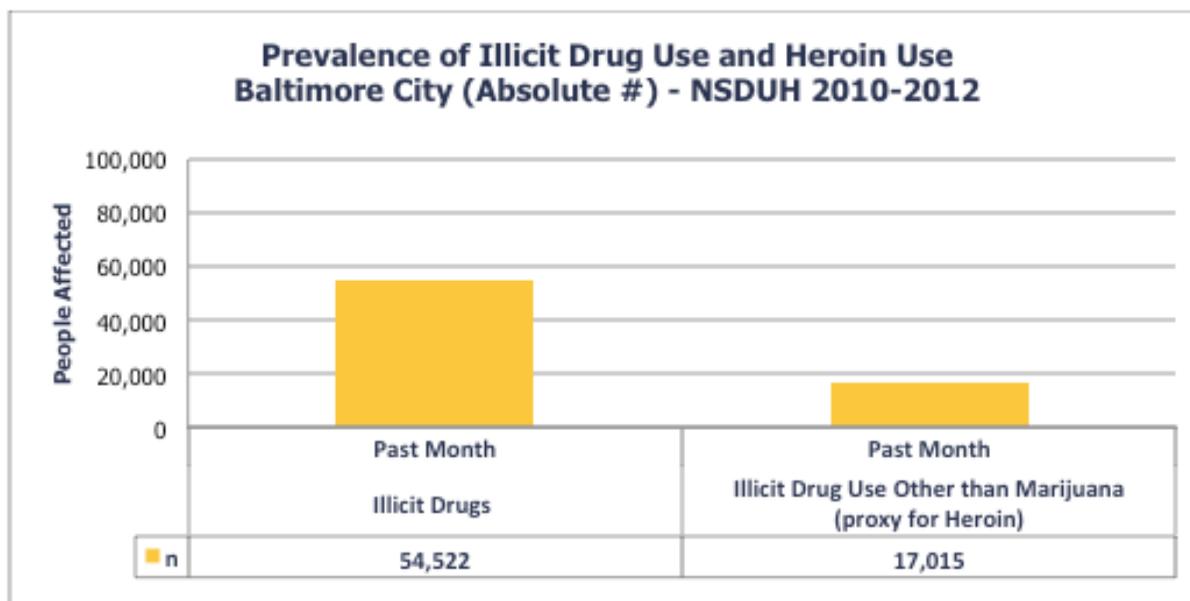
Data Source	National Survey of Drug Use and Health (NSDUH) for individuals age 12 or older, Nationwide	National Survey of Drug Use and Health (NSDUH) for individuals age 12 or older, Nationwide	National Survey of Drug Use and Health (NSDUH) for individuals age 12 or older, Baltimore City	SMART – Behavioral Health Administration (BHA) publicly funded treatment data
Measure	2012 heroin use within the last 30 days	2012 heroin use within the last year	2010 – 2012 Illicit substance use other than marijuana within the last 30 days	FY 12 treatment admissions
Statistic(s)	335,000 people (0.13%)	669,000 people (0.26%)	17,015 people (3.28%)*	<ul style="list-style-type: none"> ▪ 16,679 uninsured individuals or Medicaid recipients admitted ▪ 47.13% reported heroin as a primary substance ▪ 56.62% reported heroin used as any substance
Limitations	<ul style="list-style-type: none"> ▪ Civilian, non-institutionalized population ▪ Civilian, non-institutionalized population ▪ Phone survey ▪ Reports percentage of population surveyed which is applied to the U.S. population to calculate the number 			<ul style="list-style-type: none"> ▪ Not people, only admissions ▪ Treatment engagement ▪ Not specific to heroin

*95% confidence level indicates a range of 2.25% - 4.77% which equals a range of 11,672 – 24,746 people aged 12 years or older in Baltimore City with illicit substance use within the last 30 days

In the United States more than 41 million people (16%) report using any illicit drug in a one-year time period with 1.6% of these individuals using heroin.



The prevalence of use specific to heroin is not available in the NSDUH data for Baltimore City. NSDUH does measure for Baltimore City the number of people using illicit drugs in the last 30 days with a breakdown of the data to document the number of people using illicit drugs other than marijuana. The 17,015 individuals using illicit drugs other than marijuana is the closest proxy available in NSDUH for heroin use.



Methodology

NSDUH data was used as the base number to calculate the preliminary estimate of 18,916 people using heroin in the past year in Baltimore City. Since the methodology used for the NSDUH survey likely undercounts homeless individuals (who are more likely to be using drugs than the general public), a proxy data source for this population was needed. The Baltimore City 2013 Homeless Point in Time count documented 2,638 homeless people in Baltimore City with 36% of those individuals identified as having a history of chronic substance misuse and addiction. Applying 36% to the total number of people counted yields 950 homeless individuals to add to any estimate generated from the analysis of the NSDUH data. This methodology was substantiated by a study conducted in New York State⁶ and will be used to further refine the estimate by combining additional data sources to the NSDUH data.

The workgroup looked initially at the percentage of people reported by NSDUH as using heroin in the last year which was 0.26% (NSDUH 2012). Applying this percentage to the Baltimore City population of people age 12 years or older (518,769 from NSDUH) yielded 1,349 individuals. After accounting for the homeless population by adding 950 people, 2,299 people aged 12 or older were identified as using heroin in Baltimore City in the last year. It was unanimously agreed that this estimation was too low and that it would be better to use data specific to Baltimore City.

Specifically, NSDUH data estimates that 17,015 people age 12 or older reported using an illicit substance other than marijuana in Baltimore City in the last 30 days. This number includes the use of multiple illicit drugs such as heroin and cocaine. It is a challenge to determine how many of those people specifically use heroin. One way to do this is by inferring from treatment data which shows that between 47-56% of treatment admissions (SMART) to publicly funded treatment programs are for heroin use. The workgroup took the mid-point of that range - 50% - to calculate that of the 17,015 people who reported illicit substance use, 8,508 people used heroin in Baltimore City in the last 30 days. Accounting for homeless individuals by adding 950 people to the number estimates 9,458 people using heroin in the last 30 days in Baltimore City.

Worldwide, most surveys include three prevalence indicators (lifetime prevalence, last year prevalence (current use), last month prevalence (recent use)). The workgroup questioned which indicator is the correct time period for policy decisions and found that when looking at a one-year time period as compared to 30 days, the rate of use doubled (0.13% vs. 0.26%, NSDUH).

In addition, lifetime prevalence is a cumulative indicator and would not be good for policy decisions because a person using five or ten years ago is much different than someone using within the last year. It was agreed that current use (within the last year) should be employed to monitor levels of drug use in the general population, rather than use in the last 30 days or lifetime prevalence.

⁶ McNeely et al. (2012): Estimating the prevalence of illicit opioid use in New York City using multiple data sources, BMC Public Health, 12:443.

Because of this decision, the Data Workgroup adjusted the estimate to one year by doubling the figure for use within the last 30 days, estimating that the number of individuals age 12 years or older using heroin in Baltimore City during a one-year timeframe is 18,916:

	17,015 people with illicit substance use in Baltimore City in the past month (NSDUH)
x	50% of admissions to treatment involve heroin (BHA SMART)
	8,508 people
+	950 homeless individuals not adequately represented in the NSDUH survey
	9,458 people in Baltimore City age 12 years or older using heroin in the last 30 days
x	2
	18,916 people in Baltimore City aged 12 years or older using heroin within the last year

Providing real-time estimates is an ongoing process. In the work ahead, this workgroup plans to further refine the estimate of 18,916 by adding additional data sources and applying additional analytic methods. There are several points of contact between the health and addiction treatment systems and users of heroin where individuals can be counted. For example, emergency rooms, hospitals, and addiction treatment facilities seek reimbursement for services for users of heroin and other illicit drugs whether insured or uninsured. The workgroup will be focusing on users within the public system and will use Medicaid, hospital and state-funded treatment data to further refine the estimate. The workgroup's access to diagnostic and treatment data for individuals with private health insurance is limited to HSCRC-regulated hospitals or to clinics certified by the state's public-supported treatment system.

The below matrix uses the framework outlined by McNeely et al, (2012) and identifies the potential sources of data the workgroup is using to provide the best analysis.

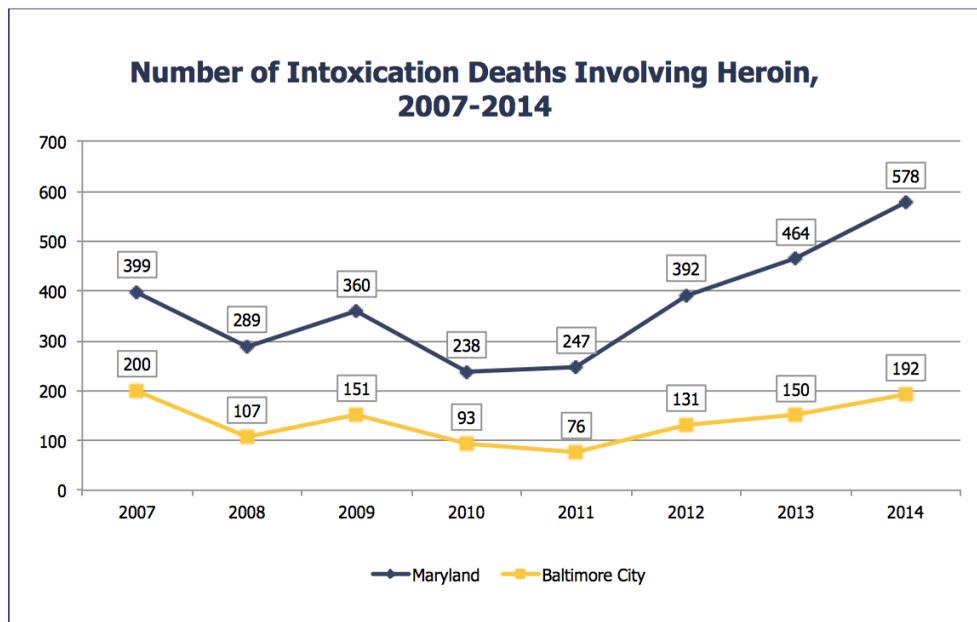
Population Captured	Subpopulation Cluster assigned by McNeely et al.	Dataset
Household survey	General population	NSDUH
Inmates receiving methadone or other services for heroin use	General population	In need of this data
Overdose deaths	General population	Vital records
Homeless	Not specifically enumerated by McNeely	Baltimore City 2013 Homeless Point in Time Count
Injection drug users	Not specifically enumerated by McNeely	Needle exchange data
Detox and other addiction treatment programs	Addiction services	Behavioral Health Administration addiction treatment data for state funded treatment services (SMART) Medicaid claims data Health Services Cost Review Commission (HSCRC) hospital data
Opioid treatment with a medication	Addiction services	Medicaid claims data
Hospital admissions	Medical services	Health Services Cost Review Commission (HSCRC) hospital data
Emergency room admissions	Medical services	Medicaid claims data Health Services Cost Review Commission (HSCRC) hospital data

The workgroup will be looking at a minimum of one year of data and will ideally use unique IDs to cross-link the differing datasets. When cross-linking is not possible, separate estimates will be generated, taking into consideration the expansive and restrictive estimates for each data point and how the individual estimates may overlap.

The data sources available to the workgroup only provide a snapshot of a subset of individuals because only a finite number of individuals go to the emergency room, are hospitalized for drug use, choose to enter addiction treatment, or are incarcerated or homeless. Fortunately, there is literature detailing the rate of overdose, addiction treatment and mortality for individuals using heroin. These rates can be used to estimate the total population at risk for a given amount of individuals presenting in emergency rooms or addiction treatment facilities. For each of the data sources where the number of heroin and illicit opiate users can be counted, a back-calculation method will be used to create a best estimate of the number of individuals at risk and a range of estimates that are reasonable given the data. Furthermore, these calculations can get more precise with the use of age and demographically adjusted estimates of risk.

Heroin Overdose Data

In Maryland, the number of overdose deaths associated with heroin increased by 21% (from 464 to 578) between 2013 and 2014. Baltimore City experienced a 28% increase (from 150 to 192) over the same time period.⁷ These numbers represent one of the most devastating outcomes of addiction and highlight the importance of this issue right now.



In response to these numbers, the Baltimore City Health Department, in collaboration with BHSB and other partners in the city, has begun to implement a comprehensive citywide overdose prevention plan. Some of the overdose prevention interventions are described later in this document, as they relate to the work and recommendations of the workgroups.

General Recommendations

A long-term goal of this workgroup, which intersects with the goals of several other workgroups, is to create a tool that will allow the Baltimore City Health Department and BHSB to regularly monitor several data points in a timely fashion. This type of monitoring will allow the city's health care system to be more responsive to the needs of people with opioid use disorders.

Another critical step is to establish the total number of Baltimore City residents receiving treatment services for an opioid use disorder in order to begin to understand the amount of unmet need in Baltimore City. In other words, the workgroup will estimate the number of people with an opioid use disorder who are in need of treatment or otherwise at risk of heroin overdose, but are not receiving treatment for a variety of reasons.

⁷ Drug- and Alcohol-Related Intoxication Deaths in Maryland, 2014; Maryland Department of Health and Mental Hygiene; May, 2015.

RECOMMENDATION #1

Develop a dashboard for ongoing monitoring to obtain real-time data for number of people with substance use disorders, near-fatal and fatal overdoses, and provider capacity for treatment.

Knowing this number will help determine if there is a need for additional system capacity, and will inform system-level interventions to close the gap between the number of people who need treatment and the number of people receiving treatment. Task force members have received anecdotal reports of insufficient treatment slots, particularly from providers stretched to do more with fewer resources. The city can play an important role in assessing this number as well as seeking out other avenues of funding. This is why a dashboard for ongoing monitoring will be of great use, and is the Task Force's first recommendation.

The availability of data about the scope of the problem, including overdoses, as well as our capacity to respond and the degree to which we are effectively responding, will give us the ability to plan, respond, assess and improve on our response.

Immediate Next Steps

- Provide an updated estimate by the end of 2015 of the number of individuals in Baltimore City using heroin each year.
- Provide an estimate of the number of people engaged in substance use disorder treatment who use heroin.
- Determine methodology for defining need, i.e. does every individual who uses need treatment.
- Provide an estimate of the number of people with unmet treatment needs.
- Determine how often these data points can be obtained and how.
- Formulate information needed to have real-time provider capacity for treatment.

II. Access to Care Workgroup Report

People enter substance use disorder treatment through a variety of pathways and barriers can prevent entry into treatment at various points throughout the system. Recognizing this issue, the Access to Care Workgroup focused its efforts on understanding the locations of these barriers and identifying opportunities to strengthen access points and minimize barriers. Additionally, because non-fatal overdoses represent a unique opportunity to link individuals to treatment, this workgroup also explored opportunities for overdose prevention interventions.

Substance Use Service System

Baltimore City has a public behavioral health system that provides substance use disorder services across the full continuum of care - prevention, early identification, intervention, treatment, and recovery support. Recognizing that care needs to be accessible, services are offered in a variety of settings, including, but not limited to: hospitals, residential programs, community-based programs, schools, homeless shelters, community centers, and on the streets.

Treatment approaches are tailored to address substance use patterns and substance-related medical, psychiatric, and social problems. Treatment programs often last for several weeks, months, or years, and can serve people at different levels of intensity to meet their needs. Methadone and buprenorphine are medications that assist with opioid treatment, and are effective, evidence-based options that help many people recover from opioid addiction. Effective treatment also requires mental health and physical health wrap-around services.

It is important to note that while many people are able to attain recovery and abstain from substance misuse, some do experience relapse. Relapse rates among people with substance use disorders are similar to those for other chronic medical conditions such as diabetes, hypertension, and asthma, which also have both physiological and behavioral components. Treatment of chronic conditions often involves changing deeply embedded behaviors, which is very challenging.

Baltimore City works in collaboration with the state's Department of Health and Mental Hygiene's Behavioral Health Administration to fund and oversee publicly (both Medicaid and grant) funded substance use disorder services in the city each year. Maryland's Department of Health and Mental Hygiene issues licenses and certifications for substance use disorder treatment programs and counselors, and the Behavioral Health Administration sets policy in this area.

Intake System

In order to better understand the current state of the intake system in Baltimore City, the workgroup started by gathering information about people's experience accessing opioid treatment in Baltimore City by:

- **Reviewing call data from the City's two behavioral health call centers.**
 - o The City's "Information and Referral" call center reported that for individuals seeking all types of substance use disorder treatment (including non-opioid treatment), the average time between the call and the first appointment was 5 days.
 - o However, the "Information and Referral" line only operates during business hours. A convening of Emergency Department leadership across the city showed that none knew about this line, as a result of its limited hours and outreach across the city.

- **Reviewing opioid treatment data (SMART) that shows how long it takes to access treatment.**
 - o This data shows that in 2013, the average wait for opioid treatment was 4 days.
 - o It is important to note that first appointments do not always include a medical evaluation or treatment. Often first appointments are used to gather patient information and formally admit the person into the program. Often a follow-up appointment is scheduled for more thorough evaluation and treatment.

- **Making "secret shopper" calls to opioid treatment programs to set up appointments.**
 - o The workgroup found that approximately 45-65% of callers were able to schedule an appointment with 48 hours. The time to appointment ranged from 24 hours to two weeks.
 - o However, there was no central intake system. Multiple phone numbers are advertised for individuals seeking treatment to call. Many are non-working; others work only during limited hours. Few physicians and social workers in an anecdotal sample knew any of the numbers.

- **Surveying people in treatment about their experiences accessing care.**
 - o Qualitative surveys and anecdotal experiences show that many have difficulty accessing care or knowing how to do so. There are no billboards or advertisements that encourage seeking care, and no centralized process to do so. This is compounded by the stigma that often exists for those seeking treatment.

Overdose Prevention and Intervention

As mentioned previously, opioid overdose death, the most devastating consequence of substance misuse, has been rising in Maryland and Baltimore City at alarming rates. There are opportunities to prevent overdoses and to intervene following non-fatal overdoses that will save lives.

One recommendation that was to result from this Task Force is a citywide plan to prevent overdose deaths. Because of the urgency of the issue, Health Commissioner Dr. Wen developed and led the implementation of

the citywide plan ahead of report’s release. The main goal of this plan is to decrease the number of nonfatal and fatal opioid-related overdoses in Baltimore City in order to save lives. The first objective is to increase access to naloxone, an opioid overdose antidote, in neighborhoods and among communities with the highest risk of overdose. Community members are being trained to identify the signs of opioid overdose and to administer naloxone. Some of the target communities include:

- Geographic areas known for drug sales and/or have high numbers of overdose deaths.
- People at risk of overdose (e.g., people who use opioids non-medically, people who have experienced an overdose, etc.)
- Public agency and service provider staff who interact with people at risk of overdose.
- Friends and family members of people at risk of overdose.

Eventually, the plan calls upon every citizen to be trained to use naloxone to save the life of fellow residents.

Another objective is to improve public knowledge around recognizing opioid overdose, using naloxone to save lives, and accessing treatment, recovery, and supportive services. This information will be disseminated both widely and targeted to groups most in need of this information. This includes the provider community. Best practice letters have already been sent out to medical doctors, dentists, specialists, and pharmacies to strongly encourage co-prescribing naloxone for every patient who is taking opioids or could be at risk for overdose.

The overdose plan also includes the use of “public health detailers” to teach providers about judicious prescription of opioids and the necessity of co-prescribing naloxone. In addition, there is a component emphasizing a public education campaign to reach citizens about the need for carrying naloxone and saving lives. This campaign has already been developed and is set to be launched the day of the release of this Task Force report.

Finally, the plan calls on the Health Department and BHSB to build and strengthen the linkages with treatment and recovery support services for people who are at risk of overdose and to prevent future overdose. Peers can be powerful advocates and need to be trained and incorporated in overdose prevention and treatment. This part of the effort has also been launched with training for community health workers to serve as critical partners. Under Mayor Rawlings-Blake and Dr. Wen’s leadership, the citywide overdose prevention plan is already underway and has already convened dozens of entities around the city to address this critical life-saving problem.

RECOMMENDATION #2

Implement citywide heroin overdose plan to save lives of our citizens. This plan includes developing targeted treatment and preventive interventions for those at highest risk for overdose and ensuring widespread dissemination of the opioid antidote, naloxone.

Intake: 24/7 Access

The workgroup also reviewed access standards used by other states' managed care organizations and insurance companies to get a broad view of access standards across other systems. In general, it was determined that access to opioid use disorder treatment for non-emergencies (i.e., non-overdose issues) should be considered urgent, and ideally, individuals seeking treatment should be able to access it within 48 hours.

Not only should people be able to get an appointment at that time, but they should also be able to receive a thorough medical evaluation and any needed immediate treatment, not just an intake assessment. It should also be easy for people to identify who to call and how to call—confusion about numbers and times of the day can lead to many individuals not seeking treatment at all.

As a result of the review of the literature and based on the “secret shopper” surveys, it was recommended that the multiple existing call centers be centralized into an easy-to-access intake system that is available 24 hours per day, 7 days per week, 365 days per year (24/7/365) to facilitate timely appointment scheduling. This was another recommendation that did not need to wait: the Health Department and BHSB are already starting to work with the existing call centers to implement this recommendation. The combined 24/7 line is set to launch in Fall 2015. There is a planned media and outreach campaign around the launch of this line so that all emergency department staff, social workers, peer recovery specialists, and community groups will be able to disseminate information about this line.

RECOMMENDATION #3

Develop a centralized, easy-to-access intake that is 24/7, with immediate access to an addiction counselor or social worker, and publicize to all (including emergency departments, emergency personnel, peer networks, and community members).

Treatment Entry

Ideally, the behavioral health system should provide multiple “low threshold” entry points. Low threshold means that there are very few demands placed on the person trying to access care. One way to promote this type of system is for providers to use an “open access” clinic-scheduling model. The workgroup reviewed literature on these models, which allow for immediate access to care including screening, assessment, medical evaluation, and often even prescriptions during the first visit. Built into these open access models are the measurement of treatment slots, treatment demand, usage, effectiveness, and cost.

Although developed initially within primary care settings, open access scheduling has been implemented in behavioral health settings. This type of immediate access to treatment can be extremely beneficial for individuals with behavioral health conditions as the motivation for treatment may decrease over time. In other words, this model of clinic scheduling allows one to more readily accommodate individuals at critical moments of motivation for change.

The workgroup developed several recommended components for programs looking to adopt an open access model:

- Well-distributed, walk-in appointment capacity to see new clients, which allows people to access care as soon as they are ready.
- First appointment includes screening, assessment, evaluation, and prescriptions, if needed.
- Offer a variety of treatment options to meet a range of needs across the spectrum of addiction severity.
- Help people navigate their treatment options, taking into account personal preferences, clinical needs, and mitigating factors (e.g., cost, wait time, distance, etc.)
- Follow-up appointments scheduled within 3-5 days.
- Capacity to measure treatment slots, demand, usage, effectiveness, and cost.
- Low threshold/low demand – minimal demands on the person seeking services in order to encourage service use; no requirement to abstain from substance use as a condition of service access; use of harm-reduction programming.
- Cultural and linguistic competence to increase people’s ability to meaningfully engage in treatment that acknowledges and is respectful of cultural differences.
- Prioritization of rapid treatment reentry in the event of premature dropout or post-treatment relapse.

It is not sufficient to have treatment if the individual is unable to access it. Research shows that individuals who are the most vulnerable often do not know how to connect to care. For those in jail, eight out of ten individuals have a substance use disorder and four out of ten have diagnosed mental illness. Case management for all those who are released from jail will help to connect those most in need with the services they require. There is already a model of this through Baltimore Crisis Response Inc.; this model is evidence-based and needs to be expanded to provide case management for all.⁸ The Task Force also encourages other efforts by the Mayor’s office and city agencies to increase mental health and substance use outreach services. For example, the Police Department together with the Health Department and BHSB have been working on a pilot for plain-clothed officers to partner with a mental health worker in conducting outreach. Such efforts can further assist in connecting vulnerable individuals to needed treatment.

RECOMMENDATION #4

Increase data-driven, high-impact options for treatment. This includes universal case management and access to treatment for most vulnerable individuals in the city such as inmates and the recently incarcerated, as well as increasing availability of evidence-based treatment, such as buprenorphine.

The workgroup also reviewed specifically access to buprenorphine for individuals with opioid use disorders. Although buprenorphine has been integrated into “traditional” substance treatment facilities (including methadone practices), the primary model of buprenorphine is office-based. Traditionally induction and

⁸ http://www.washingtonpost.com/opinions/a-prescription-for-baltimores-health/2015/05/22/582cbb4c-fa83-11e4-9030-b4732caefe81_story.html

maintenance are done in the same facility. The workgroup discussed uncoupling induction from maintenance as some office-based practices may not always be well equipped to deal with both the initial medication management and the complex other issues that individuals new to treatment might have. This could be accomplished in the 24/7-treatment center. Once stabilized, individuals would be referred to an office-based practice for maintenance. The workgroup also discussed the criminal justice population and current difficulties in providing medication-assisted treatment (MAT) in general in jail settings. All agreed regarding the heightened importance of developing enhanced access for criminal justice system involved individuals, including ready access to buprenorphine when indicated.

RECOMMENDATION #5

Ensure treatment on demand. This includes work towards a 24/7, “no wrong door” treatment center for addiction and full capacity for treatment in both intensive inpatient and low-intensity outpatient settings.

An even more aspirational concept is the idea of the 24/7, “no wrong door” resource center for addiction treatment. In the 2015 Maryland General Assembly session, state Delegate Peter A. Hammen lead efforts to successfully obtain \$3.6 million towards a stabilization (also known as “sobering”) center in Baltimore. This center would divert patients with substance use disorders away from ERs into a specialized location for treating individuals at highest risk for addiction. A model for the stabilization center that exists in San Antonio has found that this increases access to treatment and assists with reducing ER visits. This should be developed and further expanded into a “no wrong door” ER for all comers to receive immediate substance use and mental health treatment. The Task Force hopes that federal funding can be leveraged to develop this 24/7 behavioral health ER, while in the meantime, encouraging work on the stabilization center.

Immediate Next Steps

- Continue work on a 24/7 phone intake system and plan to launch this fall.
- Work on stabilization center while looking for funding for developing full 24/7-treatment center.
- Raise funding for universal case management system for most vulnerable individuals.
- Work with state partners to ensure all those incarcerated receive access to medications, in particular buprenorphine.
- Develop pilots to increase access to buprenorphine including immediate access to buprenorphine, induction in jail, and increased training of providers.
- Work with one or more opioid treatment programs in Baltimore City to pilot an “open access” models described above.
- Develop factors needed to restart DrugStat to monitor, in real-time, localized (by zip code or sub-zip code) demand and capacity for outpatient and inpatient treatment as well as annual performance of each treatment center against previous DrugStat metrics on treatment program success.

III. Practice Standards Workgroup Report

The Practice Standards Workgroup led the effort to identify solutions for improving the quality and effectiveness of treatment services for individuals with substance use disorders with the goal of improving treatment outcomes.

Existing Standards

Evidence-based practices have become part of the specialty behavioral health system landscape. As issues related to quality of care and system accountability receive more emphasis through health care reform, the inherent effectiveness of evidence-based practices is attractive to policymakers and purchasers of services. This trend parallels a similar trend in general health care in which there is increasing emphasis on healthcare outcomes. National trends and outcome measurement require the establishment of standards of practice that are measured with the use of clinical outcome data. SAMHSA has developed national outcome measures for behavioral health services that include important service considerations such as the use of hospital inpatient care, use of evidence-based practices, and overall program cost-effectiveness. SAMSHA is encouraging the use of key outcome measures which include decreased symptomatology, improved functionality at work or school, improved stability/functionality at home, client perception of care, abstinence from drug and alcohol use, decreased criminal justice involvement, reduced use of inpatient beds, use of evidence based practices, and cost effectiveness.

Currently there is no comprehensive system of reporting, analysis, and improvement in existence. By leveraging current quality improvement processes at the Behavioral Health Administration, Medicaid, the City, and provider levels, it is hoped that such a system can be developed. Outcome reporting will allow the identification of strengths and opportunities for improving care across the domains of opioid use disorder treatment. In addition, practice standards can define the metrics for treatment success; measures of treatment effectiveness; and a data infrastructure system for monitoring providers. These findings will inform quality improvement and ensure consistent, high quality, and fiscally effective services are delivered to the citizens of Baltimore.

In Maryland, most behavioral health programs are required to adhere to minimum standards set forth by the Code of Maryland Regulations. These delineate governance structures, staffing requirements, and minimum clinical care standards. Opioid Treatment Programs in addition are required to be approved and certified by the Federal Center for Substance Abuse Treatment and licensed by the Drug Enforcement Administration to operate. To receive federal approval, CSAT in turn requires that all OTPs receive accreditation by an authorized, national accrediting body such as Commission for Accreditation of Rehabilitation Facilities or Joint Commission on Accreditation of Healthcare Organizations. Within the last two years, the Behavioral Health Administration in Maryland's Department of Health and Mental Hygiene (DHMH) decided to require all behavioral health programs, not just OTPs, to be accredited by an approved accrediting body. Historically, accreditation standards have been higher, though still in line with, Maryland's regulations. It is anticipated that requiring behavioral health providers to seek accreditation will result in better treatment outcomes.

Recommended Framework

The practice standards workgroup began by identifying existing standards for addiction treatment, including those that are federally and state mandated (through SAMHSA and COMAR, respectively), accreditation standards through CARF and JCAHO, and ASAM standards that became available in late winter (standards for the addiction medicine physician and performance measures for addiction medicine physicians).

The workgroup then focused on filling in gaps in the existing standards as it identified them, either because there was not sufficient focus on outcomes of treatment, because evidence based practices were not sufficiently included, or because key elements get lost in practice.

The group also considered what data sources exist for potentially measuring and monitoring additional practice standards. In formulating additional standards that could be practically operationalized, the group reviewed different models for behavior change and different existing treatment system frameworks. The group relied on two key models of behavior change, including the adaptive stepped care model⁹ and the trans-theoretical model of behavior change,^{10,11} and two key frameworks, the Recovery Oriented Systems of Care¹² and the National Committee on Quality Assurance. In addition, the group reviewed the Assertive Community Treatment model, an existing behavioral health service in Maryland that uses a quality driven financial incentive system.

The full set of preliminary practice standards developed by the workgroup is attached as an Appendix to this report. These standards are meant for treatment providers, and are highly technical. However, several themes emerged regarding the intent behind the standards, including:

- **Adaptive Care** – All treatment should be individualized based on the needs of the person and adapt to a person’s changing needs as they progress through treatment. If one course of treatment is not effective, the program should reassess its approach and adapt to better meet the person’s needs. Treatment non-adherence should not be considered a failure on the person’s part, but an indication that the program should reassess its approach to avoid premature discharge or program dropout.
- **Variety in Programming** – Programs should offer a wide variety of treatment and skill-building options based on the person’s unique strengths and challenges. Services should address the person’s life

RECOMMENDATION #6

Develop voluntary certification and inspection for substance use providers based on core standards of care. This includes a pilot to test and refine best practice standards with key volunteer providers in Baltimore City.

⁹ <http://www.ncbi.nlm.nih.gov/pubmed/18468359>

¹⁰ Prochaska, J.O. and DiClemente, C.C. (1984). *The transtheoretical approach: Crossing the traditional boundaries of therapy*. Melbourne, Florida: Krieger Publishing Company.

¹¹ Prochaska, J. O., & Norcross, J. C. (2006). *Systems of psychotherapy: A transtheoretical analysis (Sixth Edition)* Pacific Grove, CA: Brooks-Cole.

¹² http://www.samhsa.gov/sites/default/files/partnersforrecovery/docs/Guiding_Principles_Whitepaper.pdf

domains (e.g., engagement in meaningful activities, life skills, stress/anger/conflict management, etc.), and should encourage healthy natural supports (e.g., relationships with family and friends).

- **Proactive Engagement** – Programs should actively engage people to prevent premature discharge or dropout. Along with providing adaptive care, programs should assess people’s level of motivation and readiness for change, which might mean referring individuals to other programs.
- **Increased Access to Medical Staff** – Opioid misuse has serious medical implications, and people going through opioid treatment should have access to medical staff (e.g., physician, nurse practitioner) when needed to help manage their health and recovery.

The group made several assumptions about how a set of practice standards might be adopted by providers towards the goal of improving quality of care. These included:

- Providers need to see value in adopting new practice standards and participating in a certification process. Tying certification to an incentive component could help ensure this.
- While sanctions based on regulatory non-compliance can identify and remediate low performing providers, it is not very useful by itself in improving quality of care across a system or network of healthcare providers. For this to happen, positive incentives are needed.
- Positive incentives do not all need to be financial but might include relief from multiple regulatory audits or waivers from administrative paperwork. Financial incentives also need to be available.
- For a given provider, adoption of a new set of practice standards functions best if staged, rather than an “all or nothing” approach. This means any certification system needs to have defined stages with benchmarks to meet for each stage.
- Implementation of a new set of practice standards across different healthcare settings functions is best done in phases. As such, a voluntary certification process would need to proceed according to a delineated plan with training and technical assistance for each phase.

Implementation

With a comprehensive set of standards, the development and implementation of an outcome reporting system could provide ways to measure the performance of specialty behavioral health care providers in order to create a system of ongoing quality improvement which could include performance outcome system reporting, an infrastructure of technology, expert workgroups, training, performance outcome system protocols and quality improvement plans.

In discussing how the identified practice standards could be operationalized, the workgroup looked to the Assertive Community Treatment (ACT) model as an example. The ACT model provides a comprehensive set of services for people with serious mental illness and the highest levels of need. A large focus is on case management, support, and coordinating and communicating between a multi-disciplinary clinical team and other health care providers. A major goal of this model is to help keep people as healthy as possible and avoid unnecessary emergency department visits or hospitalizations.

To make sure the team is functioning at its best, each ACT team in Maryland is reviewed every year and their performance graded on a standardized scale. As long as the team gets above a certain score, they can receive a higher amount of state funding to pay for all the services they provide. If they fall below this score, then they lose their designation as an ACT team and are no longer eligible for the extra money. At that point, they go back to receiving only a base minimum amount of funding, have to lay off staff, and transfer participants to other ACT teams.

RECOMMENDATION #7

Facilitate an ongoing partnership and collaboration among key stakeholders to pilot programs, test economic incentives, and discuss integration with state/federal systems of care.

The ACT model has been tested in several studies and evaluated in states across the country and has been found to help keep people in their homes in the community and out of emergency departments and hospitals. A slightly newer model, the Integrated Dual Disorders Treatment (IDDT) model, specifically incorporates substance use disorder services into the ACT model. Like ACT, IDDT has also been found to be successful in studies and in other states.

Given the narrow eligibility criteria for ACT and IDDT, these models are unfortunately not applicable to all the levels of care considered by the workgroup. However, the workgroup embraced the concept of establishing a scoring system based on a defined scale and using that as the basis for a voluntary certification process.

Immediate Next Steps

- Test and refine the best practice standards in a pilot of volunteer providers in Baltimore City.
- Present results of the pilot to the Maryland Department of Health and Mental Hygiene and Medicaid as part of an incentivized certification proposal.

IV. Neighborhood Workgroup Report

Recognizing the importance of positive relationships between substance use disorder treatment programs and the surrounding neighborhoods, this workgroup brought together program staff, neighborhood residents, community association members, and other interested and experienced partners. The goal was to identify best practices and standards for operating substance use treatment programs in communities, increase public understanding of addiction, and promote positive interactions between programs and neighbors. It operated using three key principles:

- Accessible and geographically-distributed substance use treatment with walk-in appointment capacity is vital for the health of city residents.
- Neighborhoods have a right to acceptable living conditions.
- Location and neighborhood conditions should not act as barriers to treatment or contribute to prejudice against people seeking treatment.

Participation and Meetings

The Neighborhood Workgroup held meetings in community locations to facilitate community participation and so that workgroup members could see various neighborhoods and programs. The group met in Park Heights, the York Road corridor, Hollins Market, and Broadway East. In addition to the standard workgroup meetings, this workgroup also hosted open community meetings to gather additional input from community stakeholders. These meetings were facilitated by Mayor Rawlings-Blake and Health Commissioner Dr. Wen. Partners in attendance at the workgroup and community meetings included:

- Baltimore Police Department
- Behavioral Health Administration (BHA)
- Bon Secours Outpatient Substance Use Disorder Programs
- Center for Addiction Medicine
- Central Baltimore Partnership
- Downtown Partnership
- East Baltimore Development, Inc.
- Gaudenzia Treatment and Recovery Services
- Hampden Merchants Association
- Hollins Roundhouse Association
- Johns Hopkins University
- Lexington Market
- LIGHT Health and Wellness Comprehensive Services
- Maryland Peer Advisory Council
- Maryland Poison Center
- Maryland Recovery Organization Connecting Communities (M-ROCC)
- Mayor's Office on Criminal Justice
- MedStar Union Memorial Hospital
- Midtown Community Benefits District
- OSI-Baltimore
- Park Heights Community Health Alliance
- Park Heights Renaissance
- Penn-North Recovery
- Sinai Hospital
- University of Maryland Medical Center
- Various Media Outlets
- Various Other Peer Advocates
- Various Residents

Good Neighbor Agreement

One of the main goals of this workgroup was to develop a “good neighbor” agreement that establishes best practices for operating substance use disorder treatment programs. Similar agreements have been recommended by the national Substance Abuse and Mental Health Administration (SAMHSA), through their Treatment Improvement Protocol for Medication-Assisted Treatment.^{13,14} This agreement, meant to facilitate productive conversations between treatment programs and community members, outlines several specific recommended practices:

RECOMMENDATION #8

Develop standardized good neighbor agreement and establish best practices for substance use disorder providers and community members (including issues such as loitering, cleanliness, security, community advisory committee, and voluntary agreements).

- **Community Liaising** – Partners (i.e., treatment programs and community/business associations) should each identify representatives to attend meetings and sit on boards. This is meant to facilitate strong relationships and problem solving among partners.
- **Physical Facility Management** – Treatment programs should be expected to maintain clean and orderly facilities with regular, posted hours.
- **Loitering** – Programs should maintain and enforce pre- and post-treatment loitering policies that include having sufficient indoor space to accommodate clients who are waiting for treatment.
- **Sanitation** – Similar to physical facility management, programs should regularly patrol their premises to ensure it is reasonably free of litter and trash on the sidewalk and streets.
- **Safety/Security** – Programs should maintain and enforce safety and security policies that include expected conduct, use of cameras and lights to monitor the exterior of the program’s building, and having trained staff available to intervene in cases of misconduct.
- **Improved Geographic Distribution** – Prospective or expanding treatment programs should locate in neighborhoods and areas where unmet demand for treatment exists to (1) avoid over-concentration of treatment in specific communities and (2) address “treatment deserts” in other areas of the city.
- **Long Range Planning/Ongoing Problem Solving** – Programs and communities should commit to engage in ongoing discussions and to collaboratively address problems as they arise.

The Baltimore City Good Neighbor Agreement template developed by this workgroup is available as an Appendix to this report and can be used by communities and programs. This agreement was largely based on the experience of the Charles North, Charles Village, and Old Goucher neighborhoods, which have implemented a similar agreement with programs in their communities.

¹³ Center for Substance Abuse Treatment. *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*. Treatment Improvement Protocol (TIP) Series 43. DHHS Publication No. (SMA) 05-4048. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

¹⁴ <http://www.crimesolutions.gov/programdetails.aspx?ID=208>

Working with Law Enforcement

Another goal of this workgroup was to coordinate efforts with treatment programs and law enforcement.

One major goal is to prevent targeted drug sales to vulnerable people engaged in substance use disorder treatment. The National Institute of Justice promotes two best practices that were consulted in the development of these programs: High Point Drug Market Intervention and Hot Spots Policing¹⁵. With assistance and coordination from the Mayor's Office on Criminal Justice, the workgroup is piloting a collaboration with a medication assisted substance use disorder treatment program and the Northern District Baltimore Police Department (BPD) in the York Road Corridor.

This pilot collaboration involves several components:

- Establishment of direct lines of communication between the treatment provider and police.
 - o The provider will provide the BPD with a direct contact person to address concerns within the treatment program footprint and BPD will have one contact within the department that the treatment provider can call when/if they notice drug distribution or other criminal activity around treatment program.
 - o Police assessment of building security leading to recommendations to address vulnerabilities - BCPD will assess the area surroundings and within the treatment program for possible improvements and will make recommendations to the identified treatment provider to decrease potential vulnerable areas that could unwillingly attract criminal activity (e.g., roads, public spaces, and other area businesses).
- The Department of Transportation will complete an assessment of specific areas regarding traffic flow and possible parking, i.e., parking changes. These minor changes have proven to have a large impact in other areas impacted by high volumes of illicit drug sales, such as Lexington Market.
- Police orientation for new clients to help them avoid being targets for drug sales.
- MTA Police to discuss increasing patrols at the bus stop and increasing the buses on the routes near the treatment provider during peak hours of treatment services.

Other pilots include the police and mental health partnership as described in the previous section. There has also been a successful Drug Treatment Court developed in collaboration with the Public Defender, State's Attorney, and other law enforcement offices. The Task Force encourages the development and promotion of such efforts. By continuing to pilot and evaluate these programs, the workgroup hopes to establish a standard protocol that can be used by programs across Baltimore City.

¹⁵ <http://www.crimesolutions.gov/programdetails.aspx?ID=361>

RECOMMENDATION #9

Coordinate efforts with treatment providers and law enforcement. This includes preventing targeted drug sales to vulnerable individuals undergoing addiction treatment; working collaboratively to obtain help for people with behavioral health disorders; and increasing support for Drug Treatment Courts and other diversion programs.

Reducing Stigma

Finally, this workgroup discussed the critical issue of stigma surrounding substance use disorders. Many communities still have negative attitudes toward people with substance use disorders, despite the fact that all major medical associations define substance use disorders as a disease of the brain – not a statement on a person’s character or willpower. This stigma has the effect of deterring people from seeking treatment, impeding their ability to recover from their illness, and perpetuating myth and misunderstanding. By making treatment options more accessible while reducing stigma, our goal is to ensure everyone who needs and wants treatment will be able to obtain it. Such efforts to combat stigma may reduce the number of users who do not want treatment or for whom treatment has not been successful in the past.

Research shows that an effective way to change the way the public thinks about people with substance use disorders is by showing real people who are in recovery and sharing their stories.¹⁶ The workgroup recommends that this powerful strategy be part of a broader awareness and educational campaign. Indeed, this recommendation is one that is so urgent that Mayor Rawlings-Blake and Health Commissioner Dr. Wen have said they cannot wait to implement it. The first part of the campaign is being launched in July 2015, showing the human side of addiction and the need for treatment. Such a campaign can unite Baltimore around the common goal of promoting a vision for the city where people live and thrive in communities that support physical and behavioral health and wellness.

Immediate Next Steps

- Disseminate the Service Agency Good Neighbor Agreement to treatment programs throughout Baltimore City and use the agreement as the beginning of discussions between neighborhood associations and treatment facilities.
- Complete the pilot program to coordinate treatment programs and local police districts.
- Start pilot for mental health/police unit.
- Explore funding opportunities to increase pre-court diversion programs such as Drug Treatment Courts.
- Reduce stigma by launching a campaign that shares the success of real people in recovery.

RECOMMENDATION #10

Implement comprehensive strategy to educate and inform residents, businesses, and other key stakeholders about substance addiction to help reduce fear and combat stigma. This includes launching a campaign to educate citizens that addiction is a chronic disease and that to encourage individuals to see treatment.

¹⁶ Luty J., Rao H., Arokiadass S. M. R., Easow J. M., Sarkhel A. The repentant sinner: methods to reduce stigmatized attitudes towards mental illness. *Psychiatric Bulletin* 2008; 32: 327-32.

Conclusion: A Call to Action

The Baltimore Mayor's Heroin Treatment and Prevention Task Force worked diligently to develop this plan for responding to the heroin epidemic that cripples lives and contributes to so many of Baltimore City's problems.

The recommendations included in this report rely on the insights of experts and the views of members of the community. These action steps are thoughtful, doable and urgently needed. It is the Task Force's expectation that all of them will be fully implemented, and indeed, some are already in the works. Our hope is that the items in this report are actionable rather than rhetorical. At the nexus of physical, mental, and community health, addiction requires a multitude of approaches that take into account the complexity of its social factors in both disease and treatment. Only as a city, working in tandem with community stakeholders, will we be able to successfully treat and prevent heroin misuse and addiction.

It is critical that our partners at the state and federal levels work with Baltimore City leaders to help implement these recommendations. This challenge is enormous; combatting it requires an effective, community-wide response.

Working together to implement this plan, we can make real progress in combatting heroin use, undo the health disparities that divide our city, and make Baltimore a healthier and more equitable and just community for all.



APPENDICES

- I.** Task Force and Workgroup Membership
- II.** Task Force and Workgroup Meeting Dates
- III.** Service Agency Good Neighborhood Agreement
- IV.** Suggested Practice Standards

APPENDIX I. Task Force and Workgroup Membership

Heroin Treatment and Prevention Task Force and Workgroup Members

Task Force Member	Title & Affiliation
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Continued on the next page.

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Access to Care Workgroup

Workgroup Members	Title & Affiliation
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<i>Robert Curran</i>	Councilman 3rd District, Baltimore City Council
<i>Franklin Dyson</i>	Treatment Compliance Evaluator, DHMH, Behavioral Health Administration
<i>Jan Gryczynski, PhD</i>	Research Scientist, Friends Research Institute
<i>Traci Kodeck, MPH</i>	Vice President, Programs, HealthCare Access Maryland
<i>Tesha Milton, LCSW-C</i>	Director, Provider & Consumer Management, BHSB
<i>Alan Mlinarchik</i>	Central Baltimore Partnership; Principal, Charm City Group, LLC
<i>Scott Nolen</i>	Director, Drug Addiction Treatment, Open Society Institute-Baltimore
<i>Judy Simmons</i>	Alumni, The Family Recovery Program, Inc.
<i>Christina Trenton</i>	Vice President, Program Operations, BHSB
<i>Michelle Tuten, PhD</i>	Assistant Professor, University of Maryland, School of Social Work
<i>Vickie L. Walters, LCSW-C</i>	Executive Director, Institutes for Behavior Resources, Inc.
<i>Connie Wozny</i>	Clinical Trainer, ValueOptions Maryland

Neighborhood Workgroup

Workgroup Members	Title & Affiliation
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<i>Jane Buccheri</i>	President, Hollins Roundhouse Association
<i>Robert Curran</i>	Councilman 3rd District, Baltimore City Council
<i>Marvelle “Kheninh” Daniels, BSW, CAC-AD</i>	Director of Programming, Maryland Recovery Organization Connecting Communities (M-ROCC)
<i>Lillian M. Donnard, MSW</i>	Executive Director, Glenwood Life Counseling Center
<i>Jacquelyn Jones</i>	Hampden Merchant
<i>Alan Mlinarchik</i>	Central Baltimore Partnership; Principal, Charm City Group, LLC
<i>Leon F. Pinkett</i>	Assistant Deputy Mayor, Office of Economic and Neighborhood Development
<i>Debbie J. Rock</i>	Executive Director, LIGHT Health and Wellness Comprehensive Services, Inc.
<i>Tiffinee Scott</i>	Chair, Maryland Peer Advisory Council
<i>Judy Simmons</i>	Alumni, The Family Recovery Program, Inc.
<i>Barry Waters</i>	Compliance Quality Administrator, BHSB
<i>Tom Yeager</i>	Executive Vice President, Public Safety & Community Services, Downtown Partnership
<i>Michelle Wirzberger, Esq.</i>	Executive Director, Midtown Community Benefits District

Practice Standards Workgroup

Workgroup Members	Title & Affiliation
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<i>Lisa Hadley, MD, JD</i>	Clinical Director, DHMH, Behavioral Health Administration
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<i>Jacquelyn Jones</i>	Hampden Merchant
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Data Workgroup

Workgroup Members	Title & Affiliation
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<i>Jose Arbelaez, MD, MHS, PhD</i>	Workgroup Co-Chair; Director, Epidemiology and Evaluation, BHSB
<i>Michael T. Abrams, MPH</i>	Senior Research Analyst, The Hilltop Institute
<i>Momen Abukhdeir</i>	CitiStat Analyst, Office of the Mayor
<i>Aruna Chandran, MD</i>	Associate Scientist, Chief of Epidemiologic Services, Baltimore City Health Department at Johns Hopkins Bloomberg School of Public Health
<i>Timothy Santoni, MA</i>	Administrator for Data Management, University of Maryland School of Medicine
<i>Mishka Terplan, MD, MPH, FACOG Diplomate ABAM</i>	Medical Director, BHSB
<i>Jay Unick, MSW, PhD</i>	Assistant Professor, School of Social Work, University of Maryland

APPENDIX II. Task Force and Workgroup Meeting Dates

Task Force Meetings

Thursday, October 16, 2014, Noon-1:30 pm
 Thursday, November 20, 2014, Noon-1:30 pm
 Thursday, January 15, 2015, Noon-1:30 pm
 Thursday, July 23, 2015, Noon-1:30 pm

Data Workgroup held at BHSB

Thursday, October 2, 2014, 3:00-4:00 pm
 Thursday, October 30, 2014, 9:00-10:00 am
 Thursday, November 13, 2014, 3:00-4:00 pm
 Wednesday, December 17, 2014, 11:30 am-12:30 pm
 Monday, January 12, 2015, 10:00-11:00 am
 Monday, February 9, 2015, 10:00-11:00 am
 Monday, March 9, 2015, 10:00-11:00 am
 Monday, April 13, 2015, 10:00-11:00 am
 Monday, May 11, 2015, 10:00-11:00 am
 Monday, July 13, 2015, 10:00-11:00 am

Access to Care Workgroup held at BHSB

Thursday, October 6, 2014, 3:00-4:00 pm
 Wednesday, November 12, 2014, 9:00-10:00 am
 Wednesday, December 10, 2014, 4:00-5:00 pm
 Wednesday, January 14, 2015, 9:00-10:00 am
 Wednesday, February 11, 2015, 9:00-10:00 am
 Wednesday, March 11, 2015, 9:00-10:00 am
 Wednesday, April 8, 2015, 9:00-10:00 am
 Wednesday, July 22, 2015, 9:00-10:00 am

Practice Standards Workgroup held at BHSB

Thursday, October 9, 2014, 4:00-5:00 pm
 Wednesday, October 29, 2014, 3:00-4:00 pm
 Monday, November 17, 2014, 1:00-2:00 pm
 Tuesday, December 2, 2014, 4:00-5:00 pm
 Tuesday, January 13, 2015, 4:00-5:00 pm
 Tuesday, February 3, 2015, 3:00-4:00 pm
 Tuesday, February 24, 2015, 3:00-4:00 pm
 Tuesday, March 17, 2015, 4:00-5:00 pm
 Tuesday, April 24, 2015, 4:00-5:00 pm
 Tuesday, May 26, 2015, 4:00-5:00 pm

Neighborhood Workgroup

held at various community locations

Monday, October 20, 2014, 10:00-11:00 am
 Tuesday, November 18, 2014, 10:00-11:00 am
 Tuesday, December 16, 2014, 10:00-11:00 am
 Tuesday, January 20, 2015, 10:00-11:00 am
 Tuesday, March 17, 2015, 10:00-11:00 am
 Monday, April 13, 2015, 1:00-2:00 pm
 Thursday, April 16, 2015, 3:00-4:00pm
 Wednesday, April 29, 2015, 9:30-10:30am

APPENDIX III. Service Agency Good Neighborhood Agreement

Introduction

This document is meant to facilitate a discussion and agreement between behavioral health care service provider agencies (referred to as “Service Agencies” throughout) and various community entities such as Neighborhood Associations, Business Associations, or other combinations of community representatives (referred to as the “Community” throughout). Fill in the blanks throughout this document to complete it before signing.

By engaging in constructive discussions, Community representatives can establish partnerships with participating Service Agencies and address specific issues and conditions in the area around the Service Agency, which may have a negative impact on client safety, treatment outcomes, Service Agency staff, and the quality of life enjoyed by Community residents and business owners.

By participating in this agreement, Service Agencies intend to address the Community’s concerns, join the partnership that the Community intends to establish, and support the Community’s efforts to make the Community clean and safe for everyone, including staff and clients of the Service Agencies.

By signing this agreement, Community representatives and participating Service Agencies will enter into a partnership as described above, by 1) pledging to understand each other’s concerns, work together in a respectful, collaborative manner to find mutually beneficial common ground, share valuable resources and information promptly as needed, and move swiftly to identify and resolve problems; and 2) setting forth below the terms and conditions to which they agree to be bound.

Upon execution of this agreement, the Community will agree to provide letters of support to the Service Agency for various activities for which such letters would be useful.

The participating Service Agency agrees to do the following:

COMMUNITY LIAISING:

1. Allow for the appointment by each affected Community and Business Association of one member to sit on a Community Advisory Committee which would meet regularly with all participating Service Agencies to address ongoing Community issues and to facilitate a partnership with the Community;
2. Provide to Community representatives contact information for the Director, his or her designated agent, and his or her successors, for the purpose of being available during operating hours in the event of any non-emergency Community concerns or problems arising from the operation of the participating Service Agency or the behavior of its clients in the Community;
3. Consider inviting Community representatives to serve on the Board of Directors of the participating Service Agency;

4. Make a contribution to the operating budget of the Community organization or its successor, in an amount reasonably commensurate with the amount of benefits district tax the building housing the facility would pay, if it did not have a non-profit exemption from City Real Property Tax; and, if the building owner is currently paying a benefits district tax, in an amount commensurate with the value of any additional safety and security services being requested.

PHYSICAL FACILITY MANAGEMENT:

1. Follow all applicable government regulations and clinical guidelines and standards for services provided, including but not limited to those regarding staff to client/patient ratios and numbers of clients/patients served.
2. Maintain hours of _____. However, provided that Participating Service Agency consults in advance with representatives to the Community Advisory Committee (see #A-1 above) and fully considers community input before doing so, participating Service Agency reserves the right to modify these hours in the future to best meet the needs of its client population;
3. Participating Service Agency shall not operate a residential program or an outpatient program at this location if not already properly designated as such at the time this Agreement is signed.
4. Maintain a neat, clean and orderly facility. Arrange for regular trash pickup by private contractors if so required by applicable Baltimore City Sanitation Ordinances currently in effect;
5. Follow all applicable local, state, and federal guidelines for services provided, including but not limited to any applicable SAMHSA 2012 Guidelines for Treatment Improvement Protocol: Medication-Assisted Treatment for Opioid Addiction.

LOITERING:

1. Prevent lines of clients which spread outdoors by (a) providing adequate indoor waiting area for clients served during hours of operation; and (b) discouraging clients from arriving before opening and remaining outside after closing;
2. Patrol the ____ (enter number) square block area surrounding the premises of the participating Service Agency at least ____ (enter number) times per day during hours of operation to prevent loitering in the area by clients of participating Service Agency and to provide a demonstrated presence in the area; and document client loitering patterns;
3. Maintain an area within the facility designated for client socialization with adequate square footage and amenities in order to discourage loitering outside of the facility; and/or refer clients to recovery support services outside of the participating Service Agency to promote recovery and discourage loitering.

SANITATION:

1. Patrol the ____ (enter number) square block area surrounding the premises of the participating Service Agency at least ____ (enter number) times a day during hours of operation to keep it reasonably free of litter by picking up trash on streets and sidewalks;
2. Meet regularly with the Sanitation Team of the Community's organization, or its successor, to discuss any sanitation issues that may arise and collect information about trash rules and enforcement.

SAFETY/SECURITY:

1. Install, maintain, and monitor working security cameras and exterior lighting (on or on motion sensor from dusk to dawn lighting) in front and back of the building;
2. Maintain trained staff to monitor client behavior during hours of operation, specifically but not limited to, at the exterior of the participating Service Agency for one hour before and after closing to discourage loitering and other misconduct;
3. Draft and enforce a policy sufficient to convey a standard of behavior which encourages good behavior by clients when they enter the Community; and which discourages misconduct (including loitering, drug use, drug dealing, violence, or noise disturbance of neighbors) by clients. Communicate the policy and sanctions clearly to clients upon admission and provide them with a copy. The policy should contain guidelines to prevent repeat offenders from obtaining services from the participating Service Agency or any other Service Agency in the Community.

LONG RANGE PLANNING/ONGOING PROBLEM SOLVING:

1. Participate in further discussions about taking a campus approach whereby the participating Service Agency agrees to participate in developing solutions to address issues of safety and security throughout the community;
2. Support the Community’s initiative to address the saturation of Service Agencies by preventing the introduction into the Community of any additional Service Agencies; notify Community before expanding current program(s), transferring operation of current program(s) to a third party, and/or supporting the addition of new service providers to the Community.

ENFORCEMENT: Should participating Service Agency fail to abide by one or more of the above terms and conditions, the Community agrees to express and clarify its concern(s) at a meeting with the Director of the participating Service Agency, and, if a resolution cannot be reached at this meeting or the Director refuses such a meeting, the Community reserves the right to withdraw its support and to actively oppose the operation of the participating Service Agency, including but not limited to, contacting the landlord of the building, the appropriate city, state, and federal officials, and funding sources.

Acknowledged and Agreed this ____ day of _____, 20____ by:
Participating Service Agency

By: _____
(name, title)

Acknowledged and Agreed this ____ day of _____, 20____ by:
Community and/or Business Association

By: _____
(name, title)

Acknowledged and Agreed this ____ day of _____, 20____ by:
Community and/or Business Association

By: _____
(name, title)

APPENDIX IV. Suggested Practice Standards

Below are the suggested standards that be used by various levels of treatment in order to improve the quality and effectiveness of treatment services for individuals with substance use disorders with the goal of improving treatment outcomes. These suggestions are the product of many hours of discussion by the Practice Standards Workgroup

Early Intervention (Level 0.5)

PRINCIPLES OF SERVICE DELIVERY:

- A. Targets early detection of high risk substance use.
- B. Prevention of further progression of substance use.
- C. Services may include brief intervention counseling, primary care monitoring, group and/or family therapy.
- D. A comprehensive assessment drives the placement decision.
- E. All services offered are individualized and strengths based.
- F. Goal of all services should be to strengthen motivation towards change.
- G. Interventions delivered based on individual preferences and individual needs.
- H. Menus of options are presented and individuals are afforded the opportunity to select from supports and services that correspond to their personal interest and goals.
- I. Linkages with community support systems are developed to assist students with achievement of their goals.

ELEMENTS OF SERVICE DELIVERY:

Individual sessions

- | | |
|---|---|
| A. Exploration of interpersonal issues and characteristics of the individual and family | I. Anger management & conflict resolution |
| B. Favorable attitudes toward substance use | J. Relationship skills |
| C. Family conflict | K. Peer Issues |
| D. Parental drug and alcohol abuse | L. Risk Behaviors |
| E. School performance | M. Didactic education about the use of substances and their effects as well as addiction and recovery |
| F. Decision making | N. Activity engagement strategies |
| G. Problem solving | |
| H. Coping Skills | |

ELEMENTS OF SERVICE DELIVERY:

Group sessions

- | | |
|---|-----------------------------------|
| A. Exploration of interpersonal issues | D. Activity engagement strategies |
| B. Games & Activities | E. Parental Drug and Alcohol use |
| C. Didactic education about the use of substances and their effects as well as addiction and recovery | F. Risk Behaviors |

Family sessions

Exploration of the following:

- | | |
|--------------------------------|----------------------------------|
| A. Family patterns & dynamics | D. Parental drug and alcohol use |
| B. Healthy family functioning | E. Family conflict |
| C. Communication in the family | |

Peer Supports:

- A. Self-selected peer supports
- B. Support groups
- C. 12-step fellowship groups

Outpatient/Intensive Outpatient (Level 1 & 2.1), Residential (Levels 3.7-3.1) and Opioid Treatment Program (OTP)

Note: the recommended practice standards outlined below are the same for these three levels of treatment.

- I. Focus on patient life domains (employment, volunteer work, family, relationships). Same for Residential and OTP.
- II. Family involvement and other supportive individuals-Engagement of non-alcohol/drug using supports.
- III. Adaptive care is provided based on outcome and individual response. Changes in doses of all of these should be guided by two or more objective continuous performance measures of treatment response (e.g., substance use, counseling attendance, unemployment, lack of substance-negative support in social network of patients, or others).
 - A. Incorporates the use of a wide range of doses in the use of available medications in treating substance use disorders.
 - B. Varying doses of both individual and group based verbal therapies (i.e., standard schedules to IOP levels and beyond).
 - C. Different types of interventions (e.g., cognitive-behavioral, motivational, psychoeducational, supportive-expressive therapies, toxicology testing) over the course of a treatment episode.

- IV. Provides combination treatment that includes bringing together pharmacotherapies and verbal-based therapies with behavior reinforcement interventions to improve overall patient adherence:
 - A. Patients must be offered all available SUD medications (methadone, buprenorphine, Vivitrol, Antabuse, etc.)
 - B. Concurrent treatment for multiple substances, addresses all alcohol and drug use.
- V. Patients must be offered a menu of services that include client centered offerings such as anger management, stress management, parenting, life skills, conflict management, budgeting, etc.
- VI. Transfer patients to a program that meets the patient needs.
- VII. Program that supports adherence behavior and individualized responses to non-adherence behavior.
- VIII. Increase transparency: care scheduled versus care.
- IX. Medical coverage with rapid responsiveness to patient needs.
- X. Provider commits time and resources to effective clinical supervision.
- XI. Provider commits time and resources to creation of multidisciplinary team-based care (comprised of allied health provider, counselor, peer).
- XII. Access standard-patients are admitted, when appropriate, within 24-48 hours of request.
- XIII. Program uses incentives to encourage engagement in care.
- XIV. Coordinates care and share information between MH, primary care, and SUD providers.
- XV. Initiate and maintain contacts with the community to assess and address community needs or concerns.
- XVI. Performance measures listed below will be tracked and used to make adjustments to practice standards:
 - A. Percent of patients prescribed a medication for alcohol use disorder
 - B. Percent of patients prescribed a medication for opioid use disorder
 - C. Presence of screening for psychiatric disorder
 - D. Presence of screening for tobacco use disorder
 - E. Follow-up with primary care physician
 - F. Percent of patients who are re-admitted to a hospital or residential placement within 6 months

Community-based Withdrawal Management (Level 3.7D)

Note: some of the same practice standards suggested for Outpatient/Intensive Outpatient), Residential and Opioid Treatment Program are also suggested for this level of care, as noted below, as well as some additional suggested standards.

- II. Same involvement as all other levels.
- IV. Same combination treatment as all other levels.
- VI. Same Transfer as all other levels.
- VII. Same Adherence as all other levels.
- VIII. Same Transparency as all other levels.
- IX. Full time medical coverage with rapid responsiveness to patient needs.
- X. Same clinical time and resource commitments as all other levels.
- XI. Same multi-disciplinary commitments as all other levels.
- XII. Same Access as all other levels.
- XIV. Same Coordination as all other levels.
- XV. Same Community contacts as all other levels.
- XVI. Same Performance Measures as all other levels.
- XVII. Development of admission protocols that do not screen out those on high doses of methadone.
- XVIII. Use of clinical withdrawal management scales, urine toxicology screens and breathalyzer results as part of the admission and ongoing management of patient stability.
- XIX. The setting in which detoxification is carried out should be appropriate for the medical conditions present and should be adequate to provide the degree of monitoring needed to ensure safety Acute conditions need to be addressed concurrently with the withdrawal process. Hospital based detox services may be needed for some patients.
- XX. Admission criteria for detox services include patients with alcohol, sedative-hypnotic, and opioid withdrawal syndromes.

