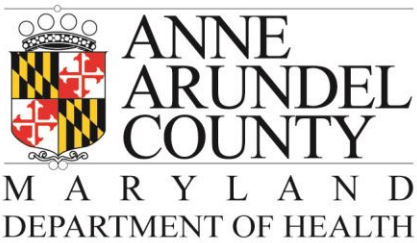

Opioid Misuse Prevention Program (OMPP)

Needs Assessment Report

Submitted by

Anne Arundel County Department of Health

May 28, 2015

Anne Arundel County Department of Health

Opioid Misuse Prevention Program

Contents

Anne Arundel County Department of Health

Opioid Misuse Prevention Program (OMPP)

I. INTRODUCTION

A. BRIEF DESCRIPTION OF YOUR OMPP COMMUNITY

i. Boundaries of the community being assessed

The boundaries of the community being assessed are comprised of Anne Arundel County (AAC)[1] Maryland. AAC is uniquely situated near Baltimore, a major urban U.S. city directly to the north, the bustling Prince George's County to the west, and The Chesapeake Bay, a beautiful and significant coastal waterway to the east.

ii. Rationale definition of this community

Pursuant to the OMPP requirements, this needs assessment addresses AAC as a whole. The rationale used for defining the community is based upon AAC's high prevalence of opioid misuse and high degree of community readiness to address the problem. After a review of the jurisdictional data, significant characteristics of the region include high percentage of those reporting opioids and heroin as primary substance of use, the increasing number of opioid overdoses, opioid overdose fatalities, and the number of residents active in Behavioral Health Administration (BHA) funded treatment for opioid use.

Readiness was demonstrated in past and sustained mobilization efforts by community groups to address ongoing community problems in the region. Organizations working to improve outcomes are three local Maryland Strategic Prevention Framework (MSPF) coalitions: Northern Lights Against Substance Abuse (NLASA), Western Anne Arundel Substance Abuse Prevention Coalition (WASP), and South County Bridges to a Drug Free Community; two emerging localized prevention coalitions in Broadneck and Annapolis; The County-wide Drug Free Community Coalition for Safe Communities (CSC); and several 501 (c) (3) community organizations focused on addressing substance use and the effects on the lives of AAC youth, families and communities.

Opioid Misuse Prevention in AAC became a highly visible, publicly known issue of concern when AAC Executive Steven R. Schuh declared a State of Emergency in AAC due to the Heroin Epidemic (December 2014). This declaration created the impetus for several disparate grass roots groups to seek common forums to join together to publicize and plan to address the growing problem of opioid misuse County-wide.

[1] See **Attachment D** for an Index to Abbreviations used in this document.

iii. Relevant geographic information to describe the community context

AAC is comprised of populous, diverse, mobile communities consisting of both urban and rural locations. The County offers amenities such as access to excellent education, recreation, healthcare and employment. The state capital, Annapolis, is located in AAC. The Nation's capital, the District of Columbia is close as well.

The County is a major thoroughfare, easily accessible from major highways that crisscross the county including Interstate 95, Interstate 97, Interstate 695 (commonly known as the Baltimore Beltway), 895, the Harbor Tunnel Thruway, 195, serving Baltimore-Washington International Airport, and Maryland Route 10, the Arundel Expressway which forms an active bypass connecting the Baltimore Beltway with Ritchie Highway. Route 50 is an east/west route through Annapolis and major route to the Bay Bridge providing access to the Eastern Shore of Maryland and the Atlantic Ocean.

AAC is the home of Baltimore-Washington International Thurgood Marshall Airport (commonly known as BWI) allowing access of direct flights in and out of AAC from different parts of the United States. This location makes AAC geographically beneficial to transient individuals. AAC's waterways create land peninsula formations from which there may only be one highway exiting the area. The waters around AAC provide easy access to Baltimore's industrial shipping lanes. In fact, the county is surrounded by mostly water including The Chesapeake Bay, Magothy River, Severn River, South River, West River and the Patuxent River.

iv. Relevant demographic information to describe the community members

According to the 2013 U.S. Census, AAC has a total population of 556,348 residents. In 2010, AAC had a collective population of 537,656 residents which reflects an increase of 18,692 residents (3.5%) in three years. The 2014 estimated population is 560,133, reflecting another 0.7% increase over 2013. The spikes in total population have implications for AAC to keep pace with its infrastructure including housing, school capacity, employment and healthcare.

The gender of AAC residents is almost equally male and female; 49.5% of residents are male, and 50.5% are female. However, the vast majority of AAC's residents are 18 years old and over. 77.2% are 18 years and over, and 12.7% are 65 years and over with 6.3% under 5 years old.[2]

By race and ethnicity, 70.9% of AAC residents are White, non-Hispanic, 15.8% are Black, non-Hispanic, 6.9% are Hispanic, 3.6% are Asian, non-Hispanic, 0.3% are American Indian and Alaska Native, and 2.5% have other ethnic backgrounds.[3] The Asian population grew by 44% and the Hispanic population grew by 95% in last 10 years from 2004 to 2013, reflecting an increasing trend toward ethnic diversity and possible language challenges[3]

[2] U.S. Census Bureau: State and County Quick Facts, 2015.
[3] Id.

In 2013, the County unemployment rate was 7.0% with several distressed neighborhoods within AAC like Brooklyn Park and Curtis Bay having high unemployment rates of 10% or higher.[4] Major employers in AAC include the National Security Agency, United States Army Ft. George Meade, Northrop Grumman, Anne Arundel Health System, University of Maryland (UM) Baltimore Washington Medical System, Southwest Airlines, and *Maryland Live! Casino*.[5] These employers are physically located mainly in the central, northern and western portions of the county. Public transportation does not serve South County, and is limited in West County making access to major employers and services challenging.

In 2013, the percentage of households earning under $50,000 in AAC was 26%. In 2013, an estimated 5.6% of households received Food Stamp/SNAP benefits in AAC. In areas like Lothian, Glen Burnie (East and West), Brooklyn and Cutis Bay more than 10% of households received Food Stamp/SNAP benefits during 2013.[5] Many adults must work several jobs to keep pace with economic demands of living in AAC leaving youth unsupervised. Young adults find it increasingly hard to find work that generates enough income to live on their own.

In recent years, several detrimental health behaviors among AAC residents have increased and remain higher among the AAC community than Maryland. From 2006 to 2012, 19% of adults in AAC reported excessive drinking compared to 15% of adults in Maryland. In AAC, 38% of driving deaths that occurred between 2009 and 2013 were due to alcohol impaired driving compared to 34% in Maryland during same years. There were 507 violent crimes per 100,000 population in AAC last year, similar to Maryland with 506 violent crimes per 100,000 population.[7]

Even with two full-service hospitals, Anne Arundel Medical Center and Baltimore Washington Medical Center the number of medical care providers has decreased in AAC significantly. The ratio of primary care physicians to patients is 1,452:1 in AAC compared to 1,134:1 in Maryland. The ratio of dentists to patients in AAC is 1,559:1, compared to 1,438:1 in Maryland. Similarly, the ratio of mental health providers to patients is 946:1 in AAC compared to 666:1 in Maryland. Residents of AAC are experiencing longer waiting lists when it comes to receiving medical care.[6]

[4] American Community Survey 5-Year Estimates, 2009-2013.
[5] Anne Arundel Economic Development Corporation, http://www.aaedc.org/, 2015.
[6] County Health Rankings & Roadmaps, http://www.countyhealthrankings.org/app/maryland/2015/rankings/anne-arundel/county/outcomes/overall/snapshot, 2015.

B. COMMUNITY HISTORY

i. Major events and forces that have affected the community

Living and working in AAC has changed over the last decade. The economic downturn has caused an increase in unemployment, drug use and crime. The once close-knit, ethnic-centered communities where everyone knew everyone (and everything), have become divided and less interactive with each other. The economic decline has caused more households to require multiple incomes, leaving more youth unsupervised. The incidence of underage drinking and alcohol-related crashes is higher than the statewide average, thus providing a gateway to the misuse of other substances.

ii. Major events and forces that have influenced the targeted outcomes

According to the Maryland Department of Health and Mental Hygiene (DHMH), there were 70 drug and alcohol-related intoxication deaths in AAC during 2014, a large increase from 51 in 2013.[7] This includes deaths that were the result of recent ingestion or exposure to alcohol or other type of drug, including heroin, cocaine, prescription opioids, benzodiazepines, and other prescribed and un-prescribed drugs. AAC ranks the third highest in the state of Maryland for this statistic, behind Baltimore City and Baltimore County.

Central Maryland includes Anne Arundel County, Baltimore City, Baltimore County, Carroll County, Howard County and Harford County. In 2013, there were 319 heroin-related intoxication deaths in Central Maryland, the highest number in the state of Maryland. 41 of these deaths occurred in AAC, making AAC the third highest county with heroin-related deaths in Maryland. Similarly, AAC had 28 prescription opioid-related intoxication deaths in 2013, the third highest in the state of Maryland.[8]

In April 2014, the presence of Fentanyl was detected in heroin making the illicit drug even more deadly. The high number of overdose deaths in AAC due to this deadly mixture has challenged public agencies and law enforcement. Parents of youth who have died or who are in treatment began to organize and express their frustration to public officials.

Additionally, there has been a recent loss of resources such as "Safe & Drug Free Schools" among public schools located throughout AAC. In January 2015, the change to a single substance abuse Managed Care Organization (MCO), Value Options, has slowed the pace of provider credentialing, patient authorization, service coverage and payment. Some major substance abuse providers have left the County. The public's frustration continues to be expressed in public forums and to elected officials as the County seeks effective, affordable treatment and prevention strategies to address the epidemic.

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[7] Maryland Department of Health and Mental Hygiene, http://dhmh.maryland.gov/vsa/Documents/Report.pdf, 2014.

[8] Id.

Thus, the County Executive formed a Heroin Task Force which operates through several work groups on education, treatment, and community involvement. Currently operating MSPF local coalitions have joined broader County-wide movements and offer coordination with those researching evidence-based strategies and who have access to and rapport with residents and neighborhoods. The Health Officer has mobilized a Fatal Overdose Review Team (FORT) in December 2015 and conducted a major symposium on Opioid Misuse and Overdoses in April 2015. The AAC Police Department has appointed a special Unit solely dedicated to heroin arrests and the AAC State's Attorney has hired a prosecutor dedicated to prosecute heroin cases.

II. METHODS

A. BRIEF DESCRIPTION OF THE DATA COLLECTION TOOLS AND METHODS SELECTED TO CONDUCT THE NEEDS ASSESSMENT

Quantitative and qualitative data collection was completed by the OMPP Needs Assessment Work Group (OMPPNAWG) which was comprised of local and county-wide substance abuse prevention coalition members, AAC Department of Health (DOH) staff and a student intern during a period of time that spanned December, 2014 through April, 2014. The OMPPNAWG collected, reviewed and analyzed all available primary and secondary local and state sources of pre-existing and new quantitative and qualitative data.

The OMPPNAWG was open to anyone who could participate. The OMPPNAWG included representation from the county-wide spectrum of age, gender, urban and rural residents, economic status, professions, educational attainment, race and ethnicity. The following individuals served on the OMPPNAWG:

- Arlene Hall, R.N., M.S.N, CARN, AAC resident
- Mandy Larkins, M.S., Pathways
- TyJuan Thompson, AAC Partnership for Children, Youth, and Families
- Barbara Studer-Baer, B.S.N., R.N., Co-Chair, South County Bridges to a Drug Free Community
- Sandy Smolnicky, M.A., AACDOH
- Katelyn Wilkes, Student Intern, AACDOH
- Sherry D. Medley, Hands of Hope, Inc. and Coordinator, WASP Coalition
- Sgt. Ryan Frashure, Anne Arundel County Police Department (AACPD)
- Sara Gannon, Office of the County Executive, Constituent Services
- Victor Henderson, M.P.A., Office of the County Executive, Constituent Services
- Pamela Brown, Ph.D., AAC Partnership for Children, Youth, and Families
- Derrick Farmer, Chair, WASP Coalition
- Kathy Little, AACDOH
- Angela Gerben, NLASA
- Lauren Greulich, Pathways Student Intern

- Bikash Singh, M.P.H., AACDOH
- Heather Eshleman, M.P.H., AACDOH
-

Data Collection Tools were adopted from the toolkits provided at the State BHA regional needs assessment training on February 18, 2015 and subsequently approved by the OMPPNAWG. Data collection tools included Focus Group Outline, Key Interview Analysis Tool Part 1, Community Readiness Questionnaires and Summary Tool, Focus Group and Key Interview Data Analysis tool Part 2.[9]

B. SOURCES OF QUANTITATIVE AND QUALITATIVE DATA USED IN THE ASSESSMENT

The primary sources of quantitative data used in the assessment to measure consumption included the:

- National Survey on Drug Use and Health (NSDUH) which was administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) and was comprised of 70,000 randomly selected households across the nation (2012): US and MD Consumption of Pain Relievers and Heroin, Age of Users, High School Use, Inpatient Admissions, Intoxication Deaths with Demographics, Source of Pain Relievers.
- Youth Risk Behavior Survey (YRBS) which was administered to 3,616 students in 13 AAC High Schools (2013): AAC and Maryland 30 Day Use, High Schools, Heroin Use with demographic.
- Maryland Public Opinion Survey which was administered on-line to Maryland residents for ages 18 and over, conducted statewide, February 20 - March 15, 2015. The Survey was designed by the UM School of Pharmacy and BHA to explore perceptions, awareness, and use of prescription opioids and heroin in Maryland and its jurisdictions. 1,418 AAC residents responded to the MPOS.
- Consumption and Perceptions among AAC Youth Ages 12-20: Youth Substance Abuse, which was administered to 5,470 AAC youth and young adults County-wide in school year 2012-2013: AAC 30 day Use by substance.

The primary sources of quantitative data used in the assessment to measure consequences include:

- Statewide Maryland Automated Record Tracking (SMART)
- Outpatient Hospital Discharge Data, Maryland Health Services Cost Review Commission (HSCRC)

[9] See **Attachment A** for the Completed Qualitative Data Analysis Tool. See **Attachment B** for the Completed Data Analysis Tool.

- Office of the Chief Medical Examiner (OCME): AAC overdoses, overdose deaths by demographic
- Overdoses and Drug Arrests, AACPD
- Maryland State Department of Education (MSDE), Dangerous Substances Suspensions and Habitual Truants, 2013-2014

Other Sources of quantitative data used in the needs assessment include:

- U.S. Census Population and demographic data
- Behavioral Health Administration (BHA) Overdose data: Number of AAC people in state supported treatment by demographic, drug of choice

The primary sources of qualitative data used in the assessment were collected from people who are misusing opioids or currently receiving substance use disorder treatment, substance abuse disorder prevention and treatment providers, healthcare providers including doctors, nurses and pharmacists, government officials, law enforcement, school personnel, parents, high school youth; parents; law enforcement officials; clergy and faith-based community representatives; community residents; local area social services and mental health service professionals:

- Community Readiness Questionnaires:
    - OMPPNAWG
    - NLASA Coalition
    - WASP Coalition
    - South County Bridges to a Drug Free Community Coalition

- Individual Key Stakeholder Interviews (18 total):
    - North County Pharmacist, March 27, 2015
    - South County Pharmacist, March 28, 2015
    - Emergency Room Doctor, April 7, 2015
    - BWMC Addictions Specialist, March 27, 2015
    - Law Enforcement- Sergeant, March 27, 2015
    - Law Enforcement-Corporal, March 9, 2015
    - Department of Juvenile Services Supervisor, March 25, 2015
    - South County resident, crime victim of drug dealers, March 11, 2015
    - South County resident, parent of young children, March 3, 2015
    - South County resident, medical professional, March 3, 2015
    - South County resident, parent, March 3, 2015
    - South County resident and medical professional, February 27, 2015
    - Substance Abuse Counselor, business owner, parent, February 27, 2015
    - Medical Professional, parent, February 22, 2015
    - South County Treatment provider and faith-based, March 11, 2015
    - Adult in recovery (heroin), March 19, 2015
    - Juvenile in recovery (heroin), March 19, 2015

- Physician, Suboxone approved provider, March 19, 2015 (treatment provider)

- Focus groups (13 total):
  - Recovery Oriented Systems of Care (ROSC), March 2, 2015, 11 participants (treatment providers and people in treatment/recovery)
  - Adult Addictions staff, March 23, 2015, 20 participants (treatment providers)
  - Adult Addictions clients, April 9, 2015, 9 participants (people in treatment/recovery)
  - Police Heroin Task Force, March 25, 2015, 4 participants
  - Muslim Health Fair, March 28, 2015, 20 Doctors
  - Pathways Staff, March 23, 2015, 8 participants (treatment providers)
  - Pathways in-patient focus group, March 19, 2015, 8 participants (people in treatment/recovery)
  - Pathways out-patient March 18, 2015, 8 participants (people in treatment/recovery)
  - Enforcement Work Group, April 16, 2015, 14 participants (law enforcement, prevention and treatment providers)
  - Adults in Recovery, April 19, 2015, 8 participants (people in treatment/recovery)
  - High School Staff, April 14, 2015, 5 participants (school personnel)
  - Teens in Partnership (TIP) youth, April 1, 2015, 6 participants (youth)
  - Heroin Action Team-Moms of children who use(d) Heroin, February 10, 2015

- Town Hall and Community Meetings (13 total)
  - Pasadena Community Forum, November 13, 2014, 15 participants
  - Pasadena Community Forum, February 24, 2015, 30 participants
  - Deale Library Community Forum September 24, 2014, 22 participants
  - Mt Zion United Methodist Church Community Forum, October 18, 2014, 44 participants
  - Southern High School Community Forum, November 18, 2014, 20 participants
  - Edgewater Community Forum, December 12, 2014, 18 participants
  - Cedarhurst Community Forum, January 27, 2015, 22 participants
  - Selby Bay Community Forum, March 10, 2015, 20 participants
  - Behavioral Health Roundtable, June 20, 2014, 13 participants (health providers)
  - Behavioral Health Roundtable, August 11, 2014, 30 participants (health providers)
  - Behavioral Health Roundtable, December 8, 2014, 26 participants (health providers)
  - County Executive's Community Meeting on Treatment, February 20, 2015, 50 participants, (treatment providers and people in treatment/recovery)

- County Executive's Community Meeting on Education, February 20, 2015, 50 participants, (treatment providers and people in treatment/recovery)

- Comments from the Opioid Misuse Prevention Survey[10]

III. CONTEXTUAL RESULTS

A. WHAT

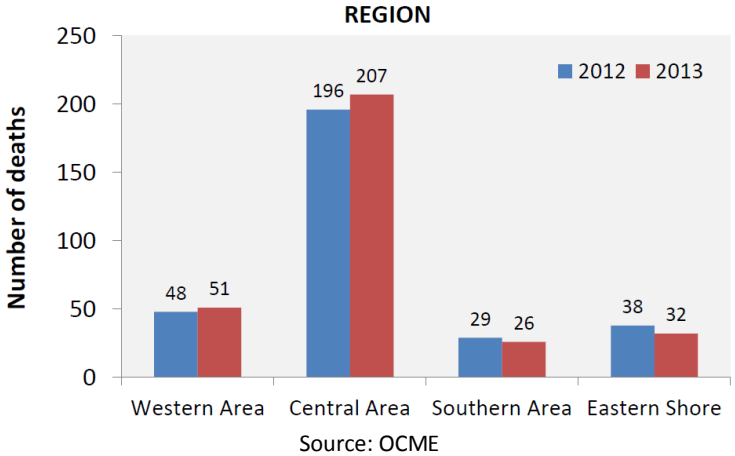
i. Identification of youth, young adult and adult opiate consumption patterns and consequences in the community to be targeted by the coalition's prevention strategies

The reduction of both prescription opioid and heroin misuse among youth and young adults is the selected priority to be targeted by the OMPPNAWG. The OMPPNAWG made this selection after a thorough examination of the data to determine the specific patterns of consumption and their consequences in the community.

The OMPPNAWG found that even though Maryland's non-medical use of opioids paralleled National trends, AAC consumption patterns were higher than Maryland consumption patterns. AAC is the third highest county in Maryland with individuals 12 and older reporting illicit drug use other than marijuana in the past month.[11]

However, according to the OCME, the number of prescription opioid related deaths is highest in the Central Region of Maryland (which includes AAC) than any of the other three regions of the State.

STATE OF MARYLAND OVERDOSES BY REGION 2012-2013



Source: OCME

[10] See **Attachment F** Comments from the Opioid Misuse Prevention Survey.
[11] Maryland Department of Health and Mental Hygiene, http://dhmh.maryland.gov/vsa/Documents/Report.pdf, 2014.

Consumption Patterns

According to NSDUH, Maryland's Patterns of Consumption of the Non-Medical Use of Pain Relievers in the past year ages 18-25 are lower than National Consumption. The following table illustrates the percentage of people who consumed pain relievers for non-medical reasons.

Past Year Non-Medical Use of Pain Relievers MD vs US (%)				
	12 or older	12 - 17	18 - 25	26 and older
US	4.57	6.09	10.43	3.37
Maryland	3.89	4.63	9.13	2.93

Source: NSDUH, 2013

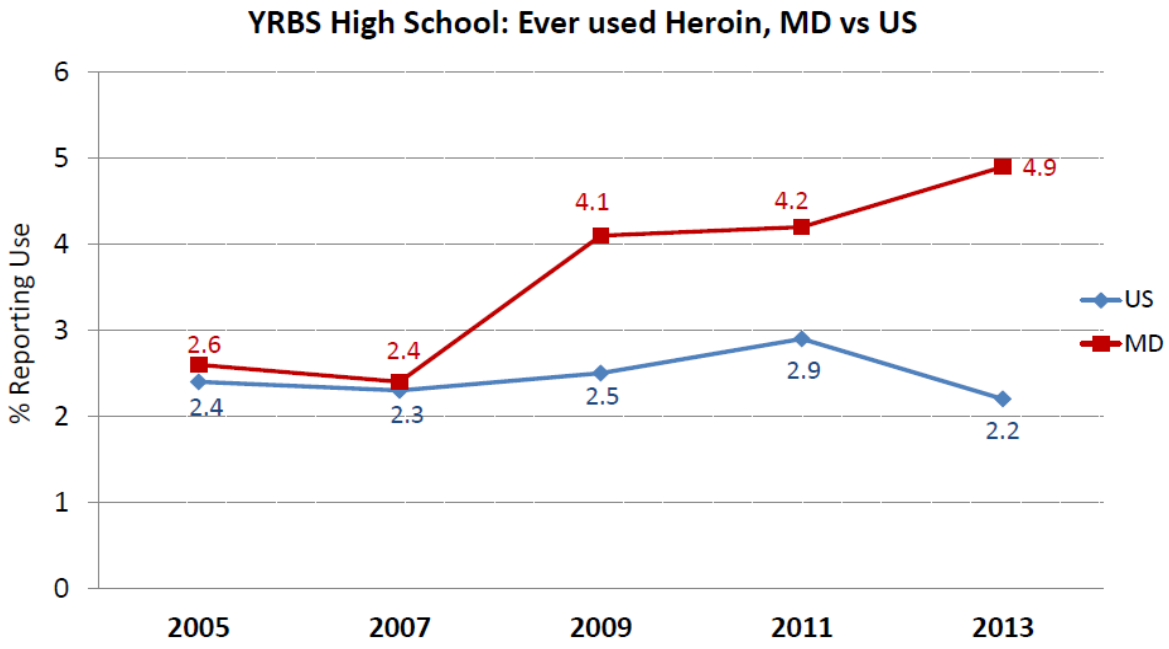
To assess data on a more local level, NSDUH combined survey data collected for years 2010-2012. The table below shows AAC is around the same as the State for drug indicators. Illicit drug use in the last 30 days, age 12 and older was close to 3% for AAC, slightly less than the State. AAC's past year non-medical use of pain relievers among age 12 and older was just over 4%, again slightly higher than the State 3.79%. Both AAC reported drug dependence or abuse in the last year and reported needing but not receiving treatment for illicit drug use in the past year were approximately 2.5% and 2% respectively, slightly lower than the State.

National Survey on Drug Use and Health, 2010, 2011, 2012

	Maryland	Anne Arundel
Illicit Drug Use in the Last 30 Days, age 12 and older	2.75%	2.98%
Past Year Non-Medical Use of Pain Relievers, age 12 and older	3.79%	4.03%
Reported Drug Dependence or Abuse in the Past Year	2.63%	2.53%
Reported Needing but not Receiving Treatment for Illicit Drug Use in the Past Year, age 12 and older	2.30%	2.04%

Source: NSDUH, 2010, 2011, 2012

According to the Youth Risk Behavior Survey (YRBS), between 2009 and 2013, higher percentages of Maryland high school youth reported ever using heroin than high school youth Nationwide. Between 2011 and 2013, data shows a decrease in use nationwide from 2.9% to 2.2%. This is in stark comparison with Maryland for the same period which showed an increase in use from 4.2% to 4.9%.



Grade	State	2005	2007	2009	2011	2013
9th grade	US	2.8	2.6	2.1	2.9	2.0
	MD	1.3	1.4	3.2	3.8	3.9
10th grade	US	2.5	1.8	2.2	2.8	2.0
	MD	1.6	2.1	4.3	3.8	4.3
11th grade	US	1.8	1.8	3.2	2.8	2.4
	MD	2.8	2.2	3.4	3.2	4.9
12th grade	US	2.0	2.6	2.5	2.7	2.1
	MD	5.3	3.1	5.1	4.6	5.2

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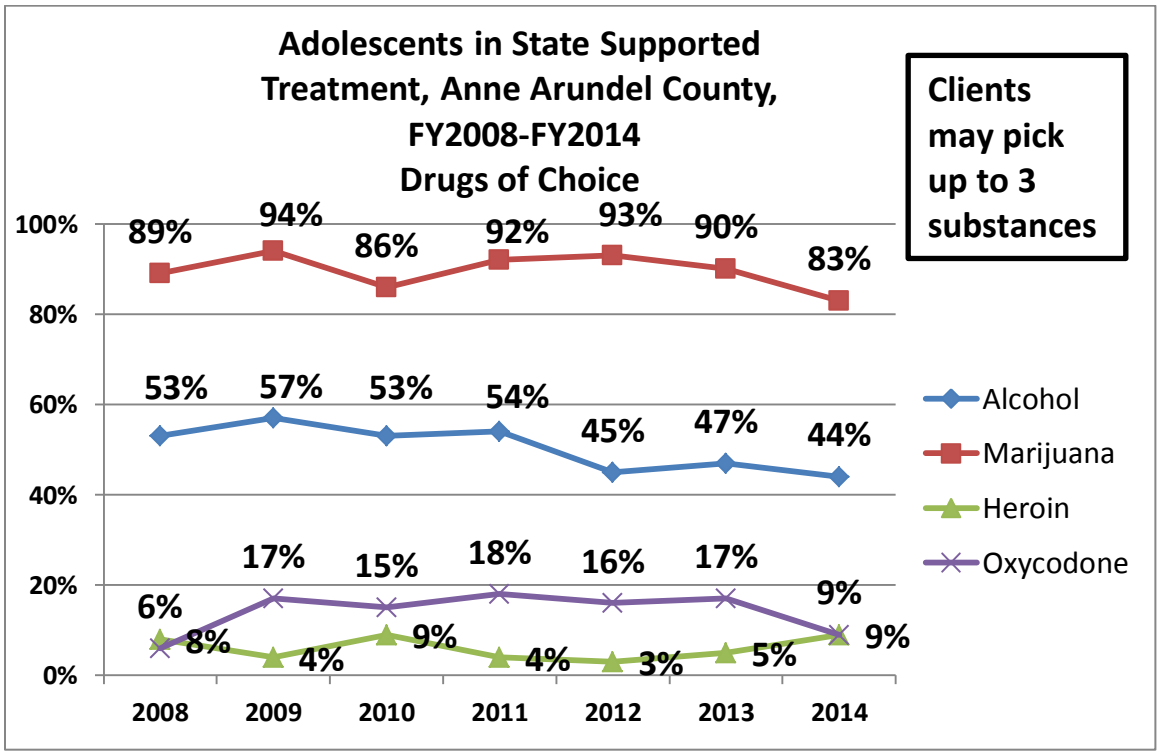
Source: YRBS, 2005-2013

The 2014 YRBS shows AAC's rate is higher compared to Maryland with 5.4% of high school youth reporting ever use of heroin compared to 4.9% for Maryland. AAC percentages of ever use of surveyed drugs are higher than Maryland with the exception of inhalants. The greatest difference is alcohol ever use with over a 4% difference compared to the State.

	Anne Arundel County	Maryland
Alcohol	65.20%	60.90%
Marijuana	36.60%	35.90%
Prescription Drugs	17.30%	15.20%
Inhalants	9.60%	10.40%
Ecstasy	9.40%	8.30%
Cocaine	7.40%	6.50%
Methamphetamines	5.60%	5.00%
Heroin	5.40%	4.90%
Steroids	5.20%	5.10%

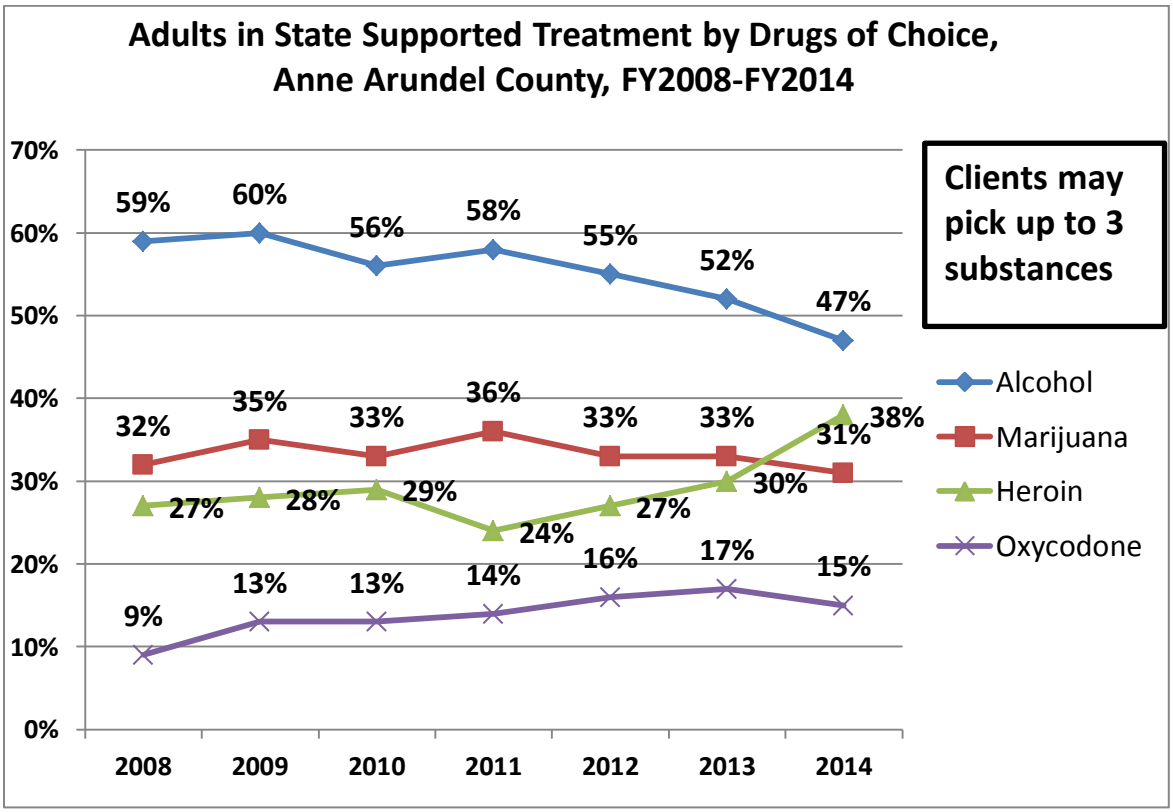
Source YRBS: Anne Arundel County High Schools ever used substances, 2013

According to DHMH, the most commonly mentioned drugs of choice for adolescents in state supported treatment in AAC are alcohol, marijuana, heroin and oxycodone. Although marijuana and alcohol are the top two drugs of choice for adolescents in treatment, their percentages are decreasing. In 2012, 93% of adolescents chose marijuana as one of their drugs of choice and 45% chose alcohol. In 2014, these percentages have dropped to 83% who chose marijuana as a drug of choice and 44% who chose alcohol. The percent of adolescents who chose oxycodone as their drug of choice in 2012 was 16%, which also dropped to 9% in 2014. In contrast, 3% of adolescents chose heroin as one of their drugs of choice in 2012, and this percentage has increased to 9% in 2014. There is an increase in the percentage of adolescents in state supported treatment that mention heroin as a drug of choice.



Source: Behavioral Health Administration, Maryland DHMH

According to DHMH, the drugs of choice for adults in state supported treatment are represented in the chart below. Similar to adolescents in treatment, the percentage of adults who chose marijuana and alcohol as one of their drugs of choice is decreasing. In 2012, 55% of adults chose alcohol as one of their drugs of choice which decreased to 47% in 2014. 33% of adults chose marijuana as one of their drugs of choice in 2012 which dropped to 31% in 2014. Unlike adolescents, a larger percentage of adults chose heroin over oxycodone as one of their drugs of choice. In 2012, a large percentage of adults (27%) chose heroin as one of their drug of choice, more than the 16% who chose oxycodone. In 2014, the percentage of adults who chose oxycodone as one of their drugs of choice dropped by one percent (15%), but the percentage of adults who chose heroin as one of their drugs of choice increased to 38%. In 2014, the second most frequently chosen drug of choice for adults in state supported treatment was heroin (38%), higher than marijuana and oxycodone.

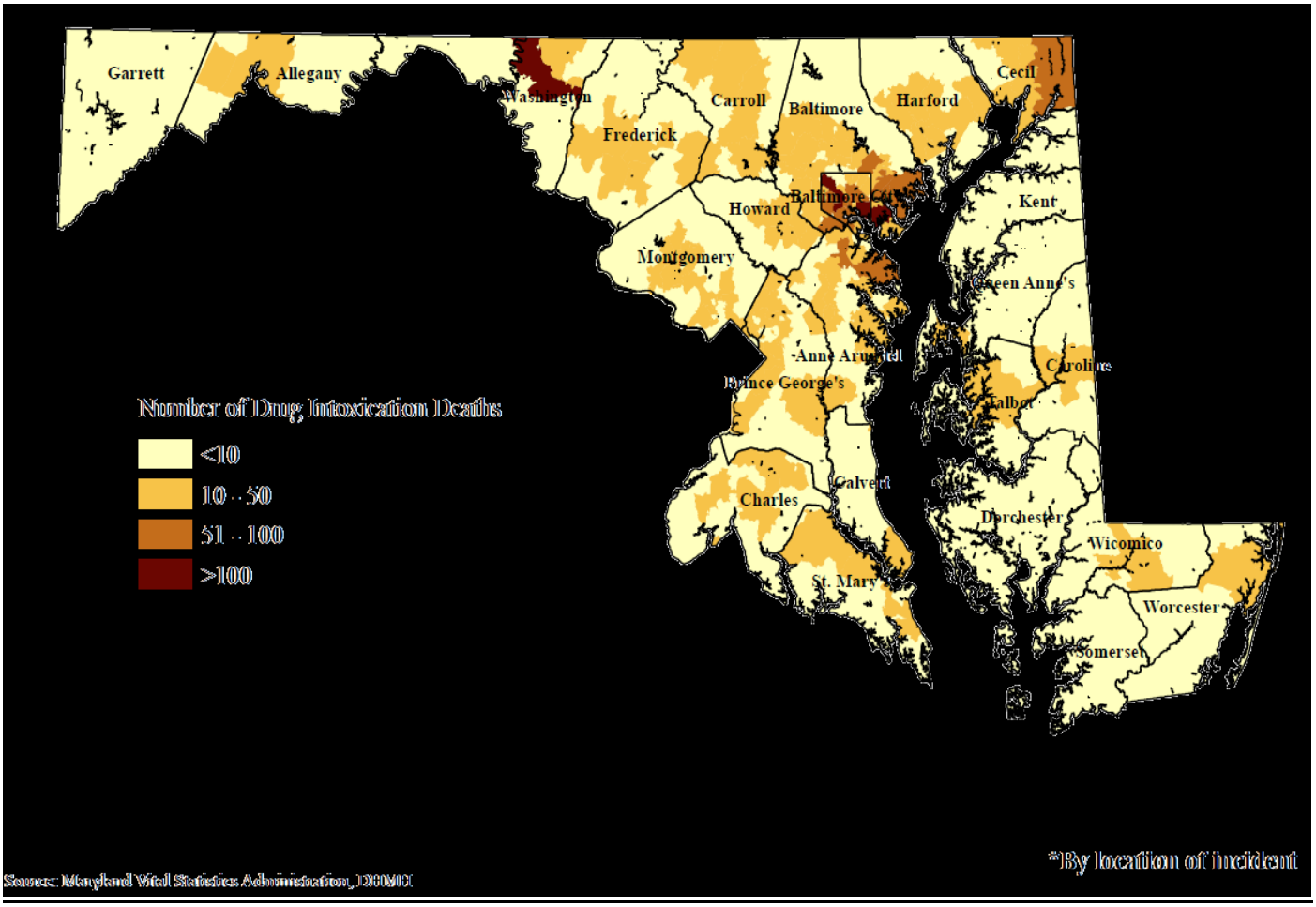


Source: Behavioral Health Administration, Maryland DHMH

Consequences

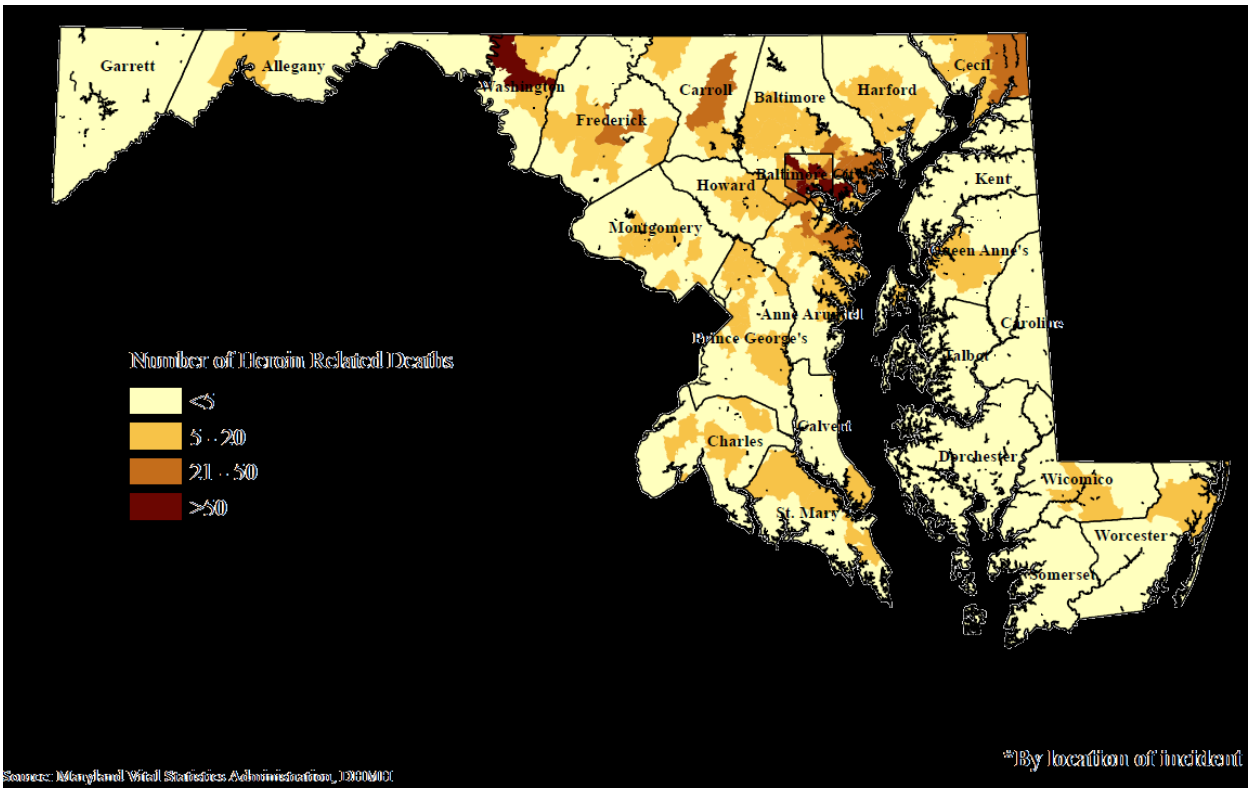
The map below shows drug intoxication deaths by area for the last eight years. Parts of Northern AAC including the areas of Pasadena and Glen Burnie show between 51-100 deaths over the last eight years. The rest of the County shows deaths between 0-50 over the eight year period.

Drug Intoxication Deaths Occurring in Maryland, 2007-2014 (through October)



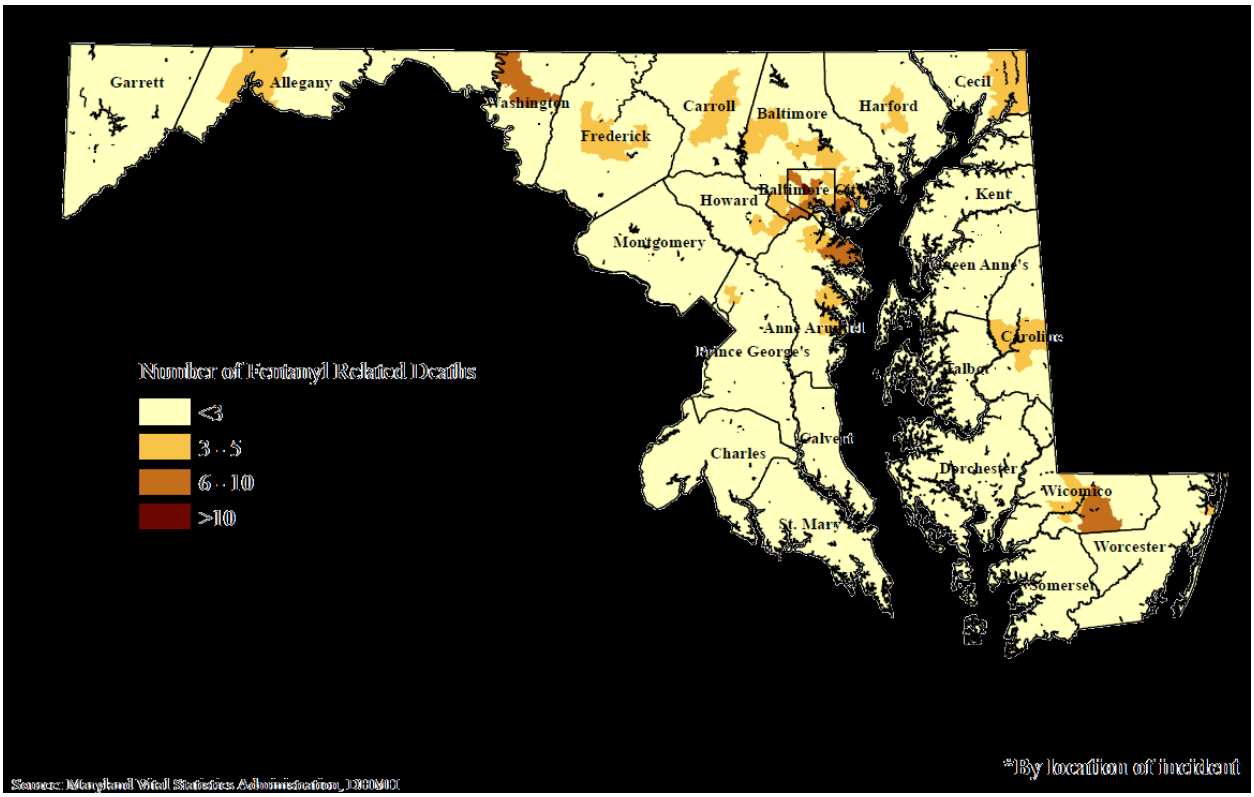
The map below shows the heroin-related deaths during the last eight years. The same areas Pasadena and Glen Burnie show higher numbers of deaths in the range of 21-50. Other parts of the County show number of heroin deaths under 20.

Heroin-Related Deaths Occurring in Maryland, 2007-2014 (through October)



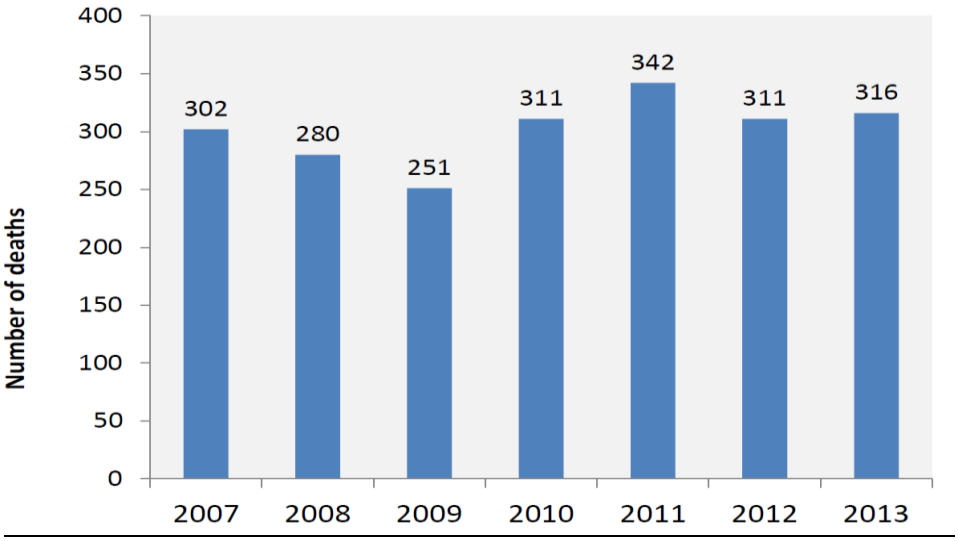
The map below shows the fentanyl-related deaths for the last eight years. The Pasadena area shows the greatest number of fentanyl deaths in the County with between 6-10 deaths. The other areas of the County have 5 or less deaths due to fentanyl.

Fentanyl-Related Deaths Occurring in Maryland, 2007-2014 (through October)



According to data from the OCME, the number of Maryland deaths from opioid-related intoxication is increasing.

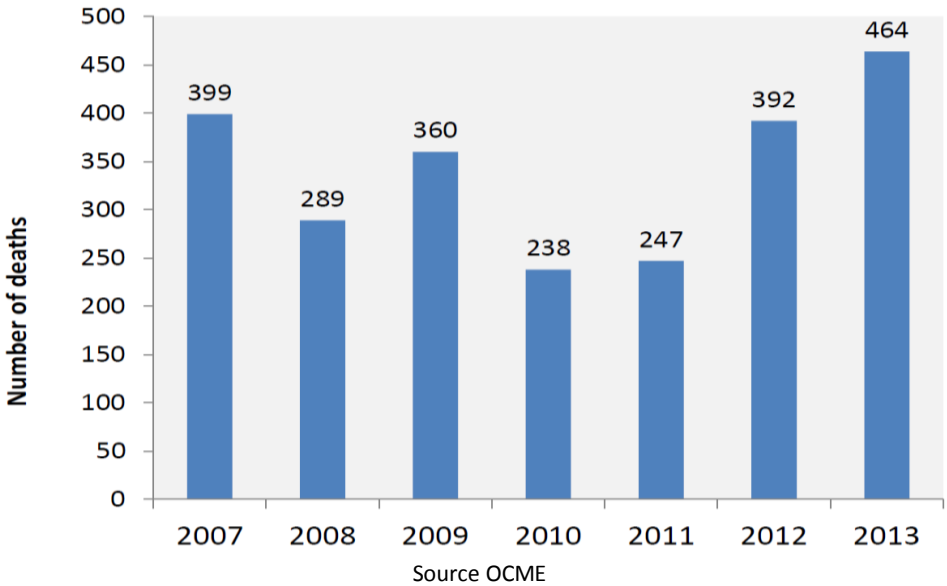
Statewide Opioid-Related Intoxication Deaths in Maryland, 2007-2013



Source: OCME

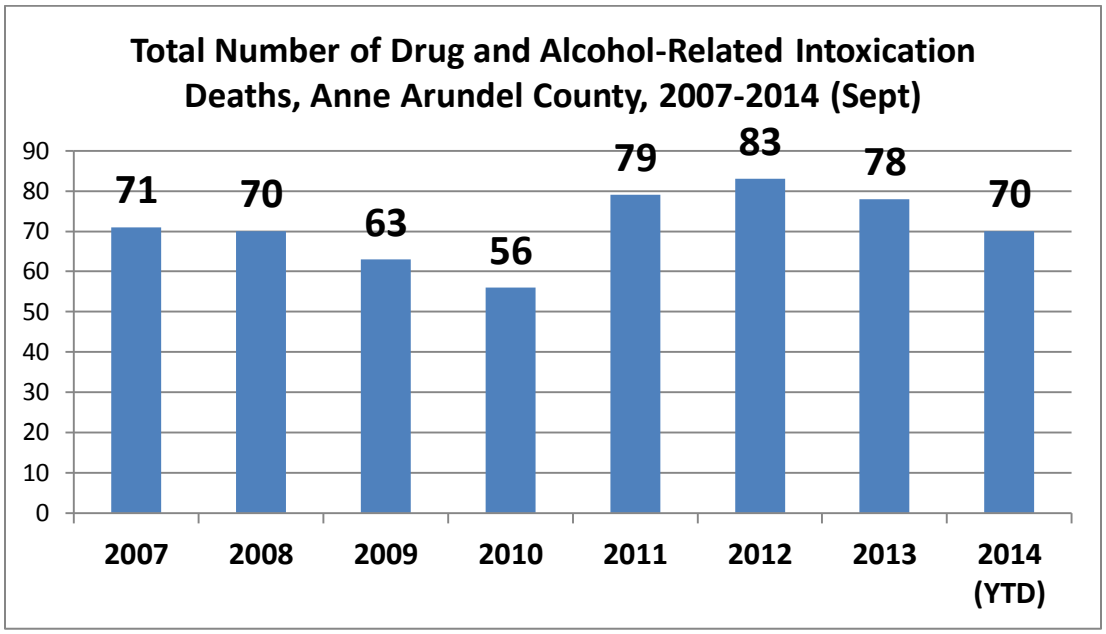
According to data from the OCME, the number of Maryland deaths from heroin-related intoxication is increasing, as well.

Statewide Heroin-Related Intoxication Deaths in Maryland, 2007-2013



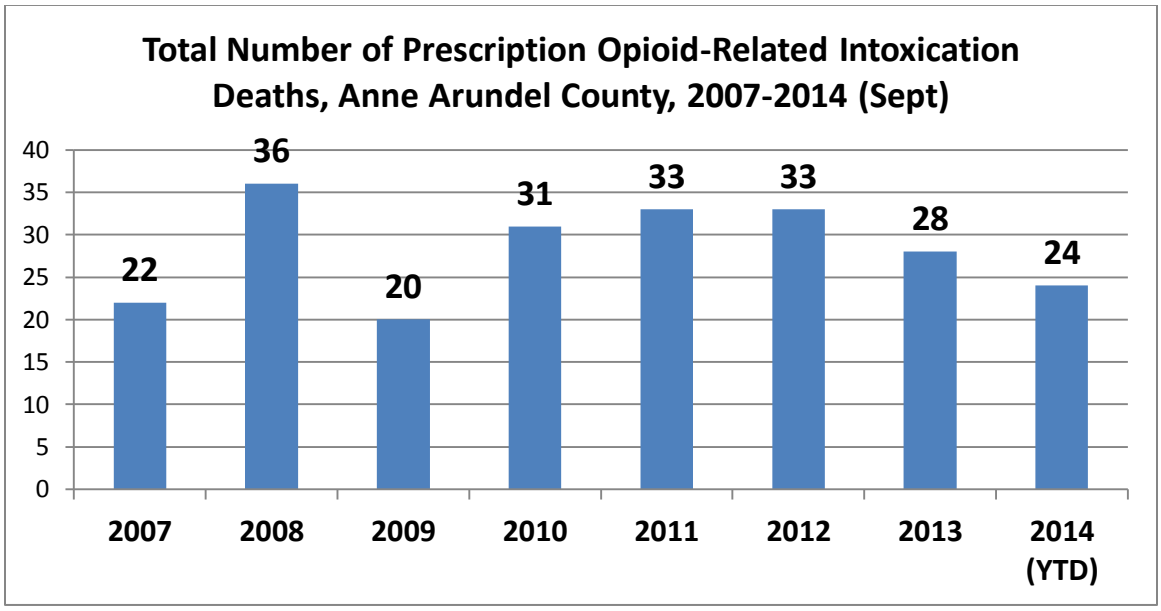
Source OCME

In AAC, according to OCME, the number of drug and alcohol-related intoxication deaths increased in 2011 and 2012 and is on target to be as high or higher in 2014.



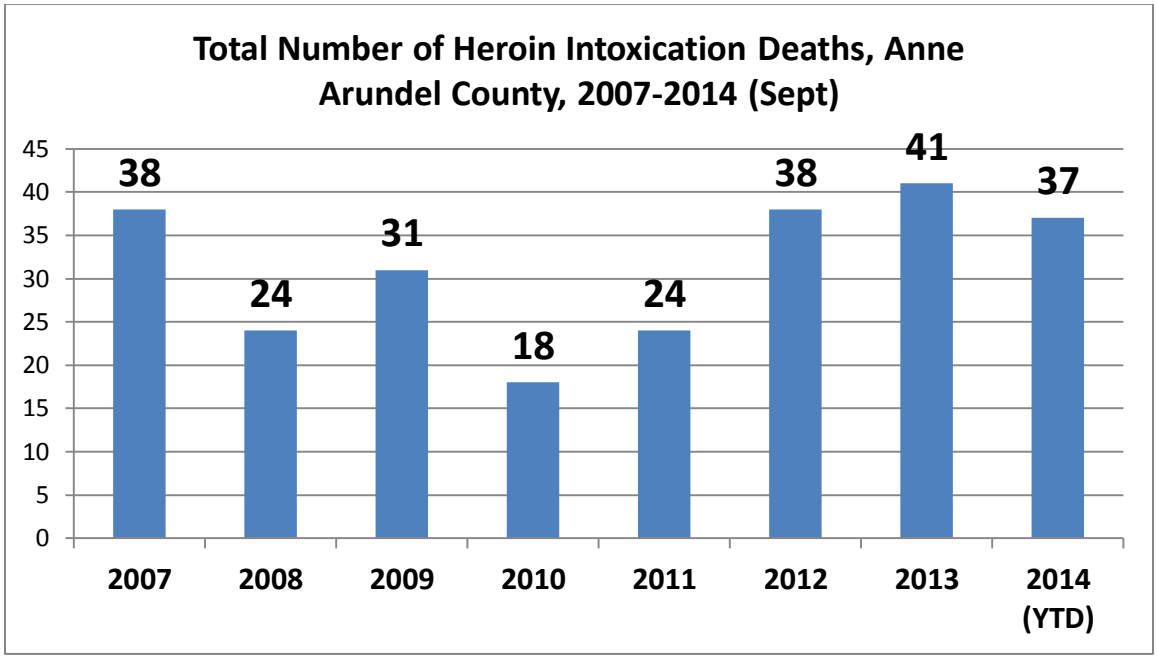
Source: OCME

According to OCME, in AAC prescription opioid deaths were in the low 30's range from 2010-2012. In 2013, they decreased to 28 but are projected to be in the low 30's at the end of 2014.



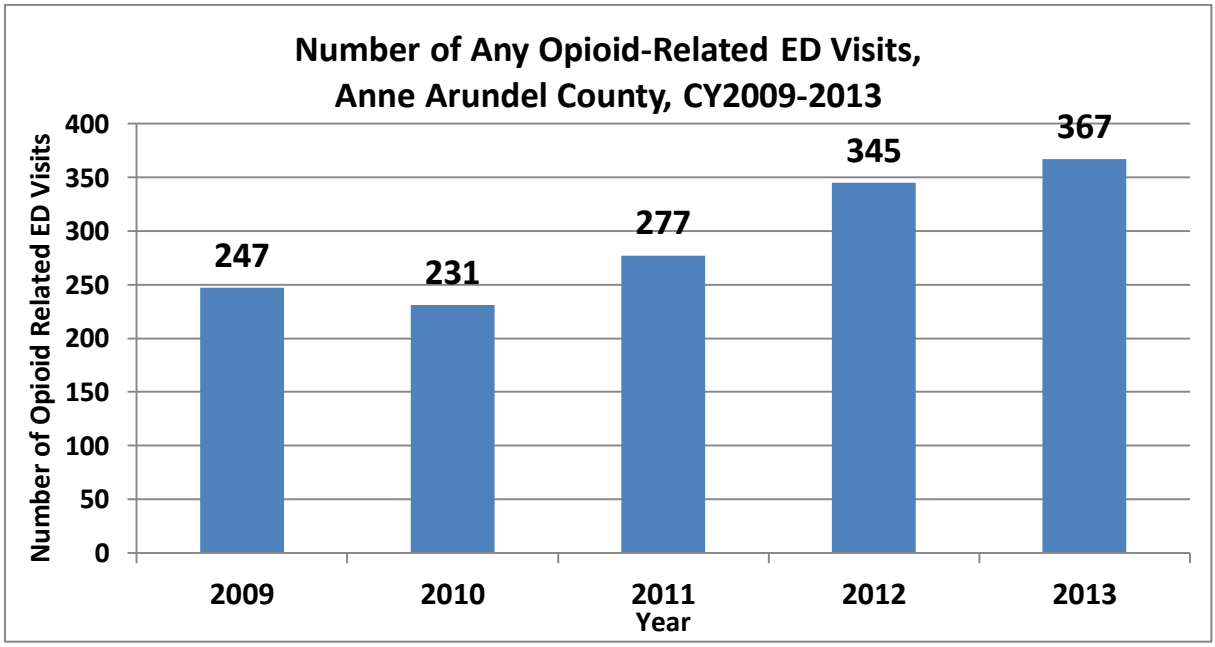
Source: OCME

The total number of heroin intoxication deaths in AAC sharply increased in 2012, doubling the number of deaths in 2010. There were 41 heroin intoxication deaths in 2013. 2014 has 37 deaths in the first 9 months of the year and most likely will surpass the number of deaths in 2013.



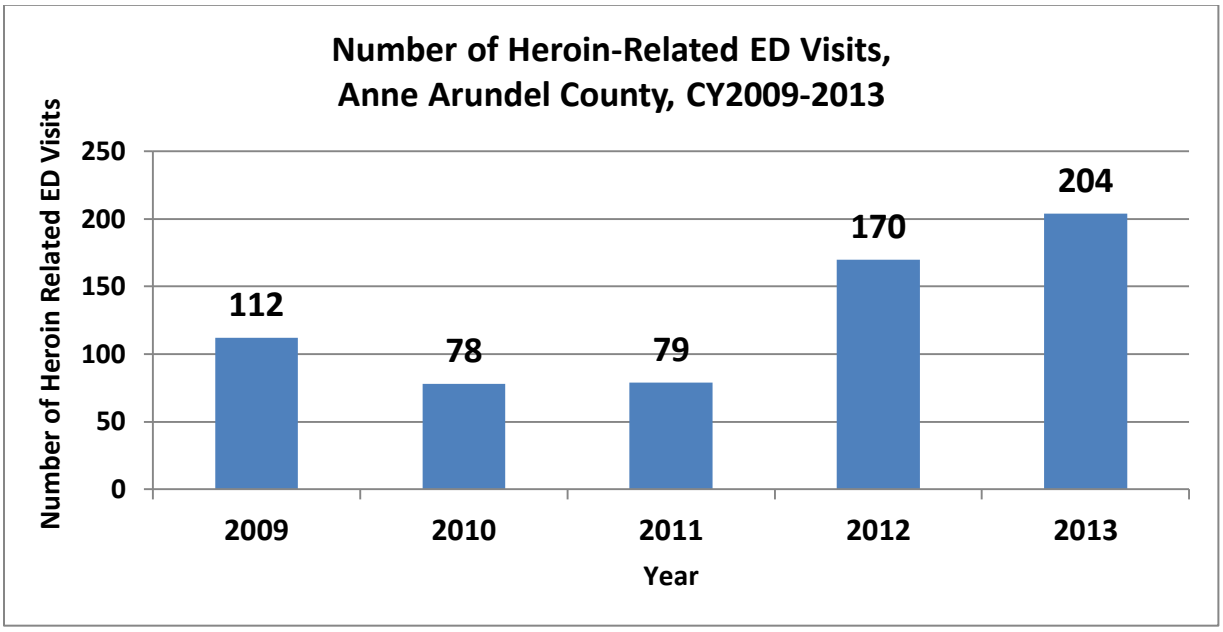
Source: OCME

According HSCRC, the number of any opioid-related emergency department (ED) visits in AAC has increased during the five year period of 2009-2013. As shown in the chart below, there were 247 opioid-related ED visits in AAC in 2009. This number has increased to 345 in 2012 and 367 in 2013.



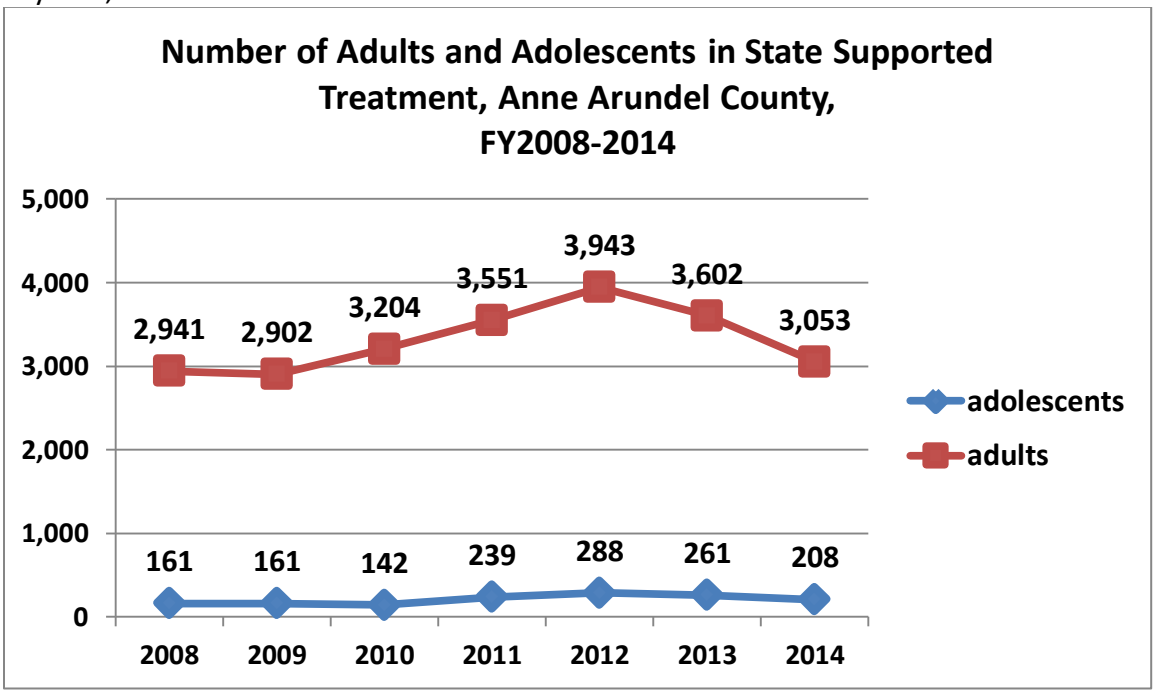
Source: Outpatient Hospital Discharge Data, Maryland Health Services Cost Review Commission

Similarly, the same trend occurs for the number of heroin-related ED visits in AAC from 2009-2013. In 2009, there were 112 heroin-related ED visits in AAC. This number increased 55% from 2009 to 2013, to 204 in 2013.



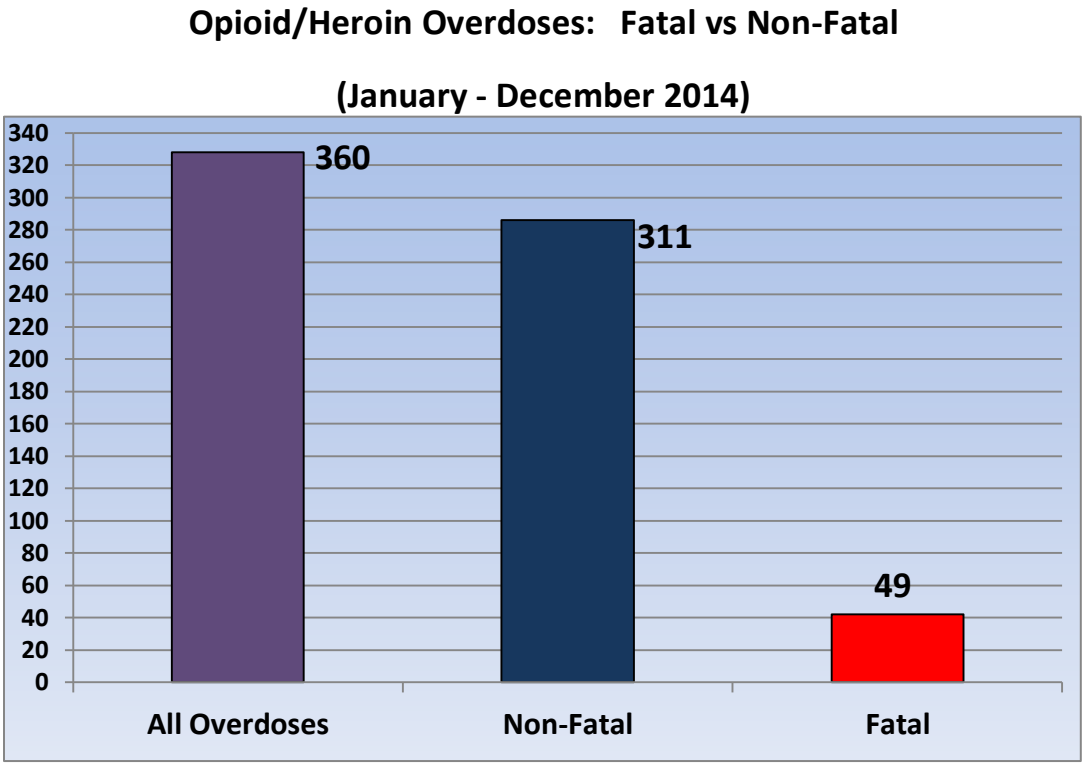
Source: Outpatient Hospital Discharge Data, Maryland Health Services Cost Review Commission

In addition to death and ED visits, another consequence of prescription opioid/heroin misuse is the need for treatment services. According to DHMH, there is a large number of adults, more so than adolescents, who are in state supported treatment in AAC. The chart below indicates a spike in 2012 with 3,943 adults in state supported treatment in AAC. The number has decreased slightly to 3,053 in 2014.



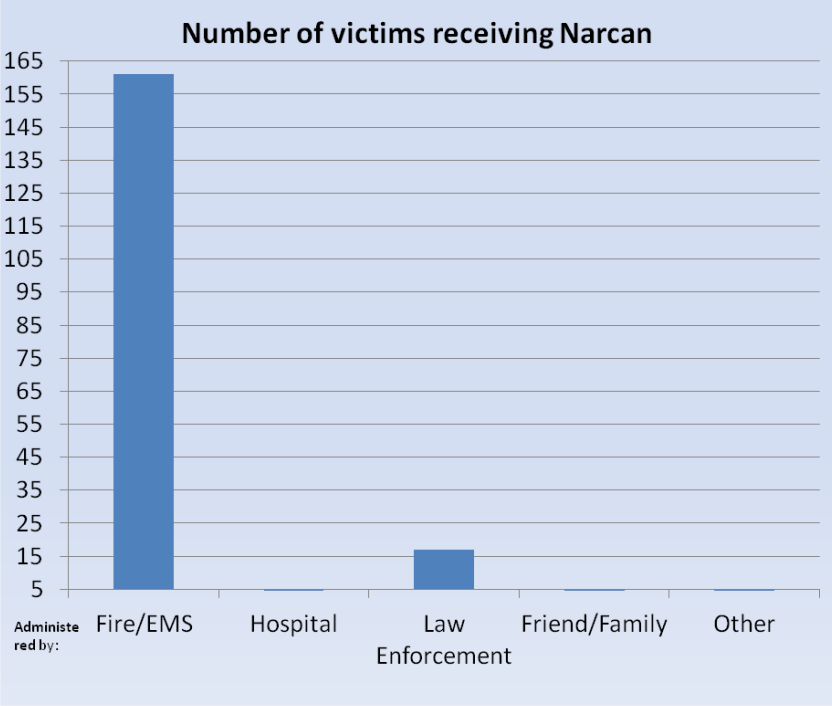
Source: Behavioral Health Administration, Maryland DHMH

In 2014, the AACPD collected data related to opioid and heroin overdoses. Indicated by the chart below, between January-December 2014, there were 360 total opioid and heroin overdoses in AAC. 311 of these overdoses were non-fatal, and 49 were fatal.



Source: AACPD

According to the AACPD, 183 of those overdose victims received Narcan. The charts below represent the number of victims who received Narcan in 2014, along with who administered the Narcan.



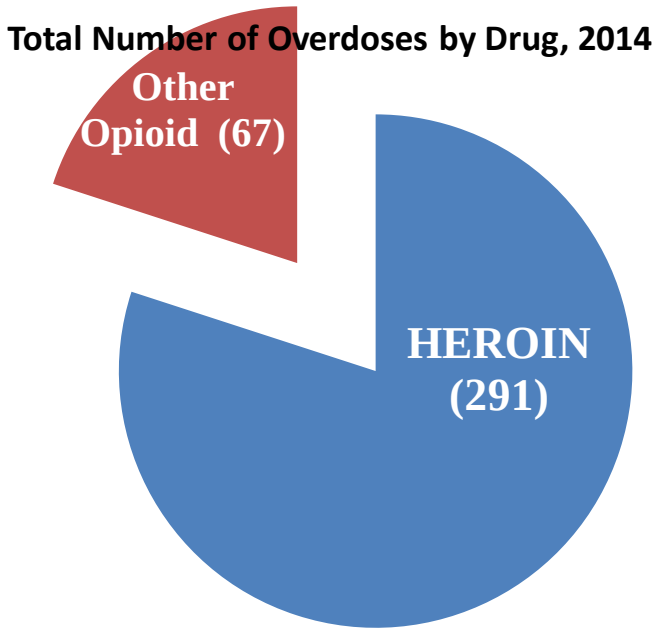
	Number of Victims receiving Narcan
Fire/EMS	161
Hospital	4
Law Enforcement	17
Friend/Family	1
Other	0

Source: AACPD

The Fire/EMS administered the most Narcan to 161 victims. Law enforcement administered Narcan to 17 victims, followed by the hospital who administered Narcan to 4 victims. Only one victim received Narcan from a friend/family member.

From 2014, the AAC police department also provided data for the breakdown of overdoses by substance (fatal and non-fatal). The charts below represent the number of heroin overdoses by district compared to the number of other opioid overdoses by district.

	Heroin	Other Opioid
Eastern	76	19
Northern	99	25
Southern	81	13
Western	35	10



Source: AACPD

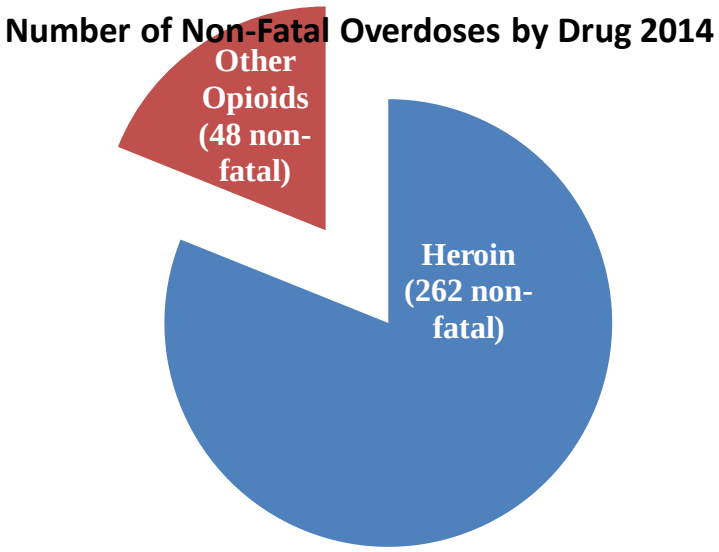
The majority of AAC overdoses in 2014 were due to heroin. 291 of the total overdoses were from heroin, and 67 were from other opioids. In each district, the number of heroin overdoses exceeded the number of other opioid overdoses. In Northern AAC, 99 overdoses were from heroin and only 25 were from other opioids. This trend continues for Eastern AAC with 76 from heroin and 19 from other opioids, Southern AAC with 81 from heroin and 13 from other opioids, and Western AAC with 35 from heroin and 10 from other opioids.

This data is broken down into non-fatal overdoses as well. There are far more heroin non-fatal overdoses than other opioid non-fatal overdoses. 262 of the non-fatal overdoses were due to heroin, and only 48 were due to other opioids. Again, the number of heroin-related non-fatal overdoses exceeded other opioid-related non-fatal overdoses in each district as shown below.

Non-Fatal Overdoses by Police District, 2014

	Heroin	Other opioid
Eastern	65	15
Northern	90	19
Southern	75	8
Western	32	6

Source: AACPD



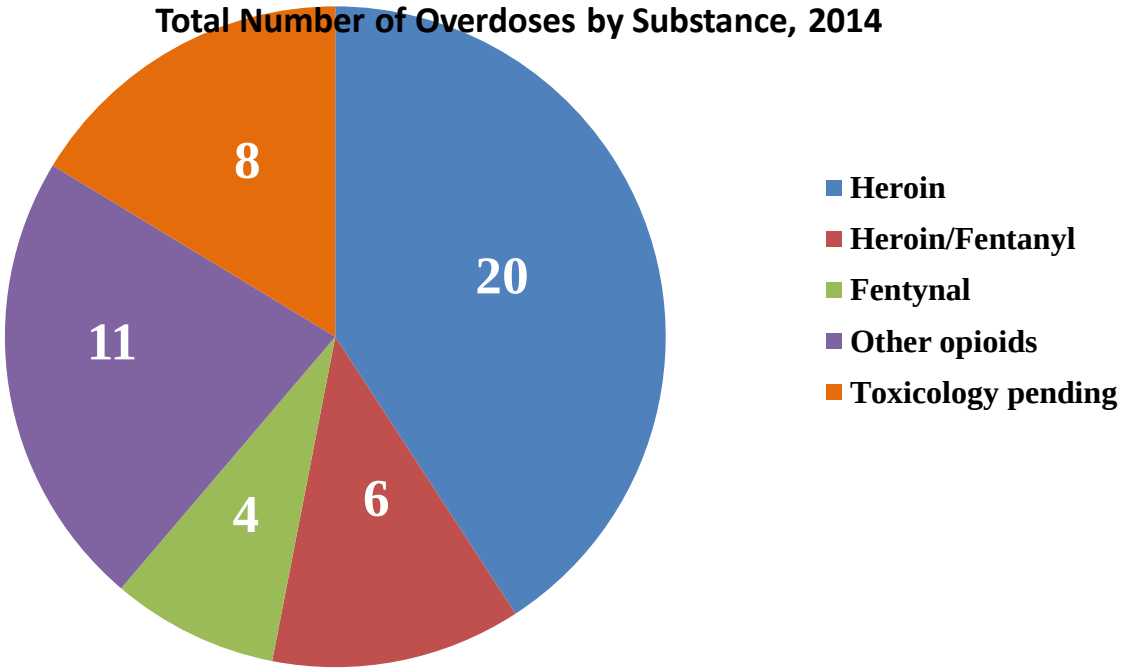
Source: AACPD

The charts below represent fatal overdoses by substance in 2014, according to the AACPD.

Fatal Overdoses by Substance and Police District, 2014

	Eastern	Northern	Southern	Western	Totals
Heroin	8	5	5	2	20
Heroin/Fentanyl	2	1	2	1	6
Fentanyl	2	1	0	1	4
Other opioids	1	3	4	3	11
Toxicology pending	2	6	0	0	8

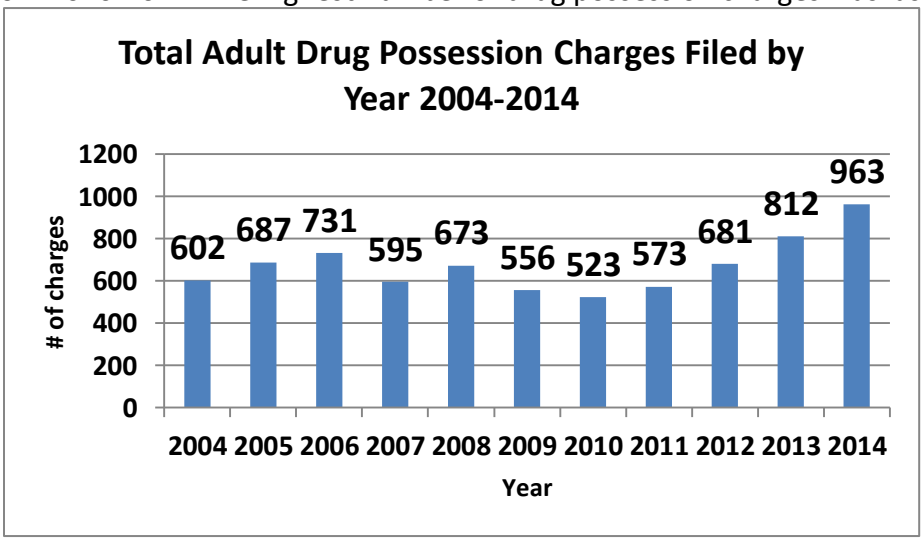
Source: AACPD



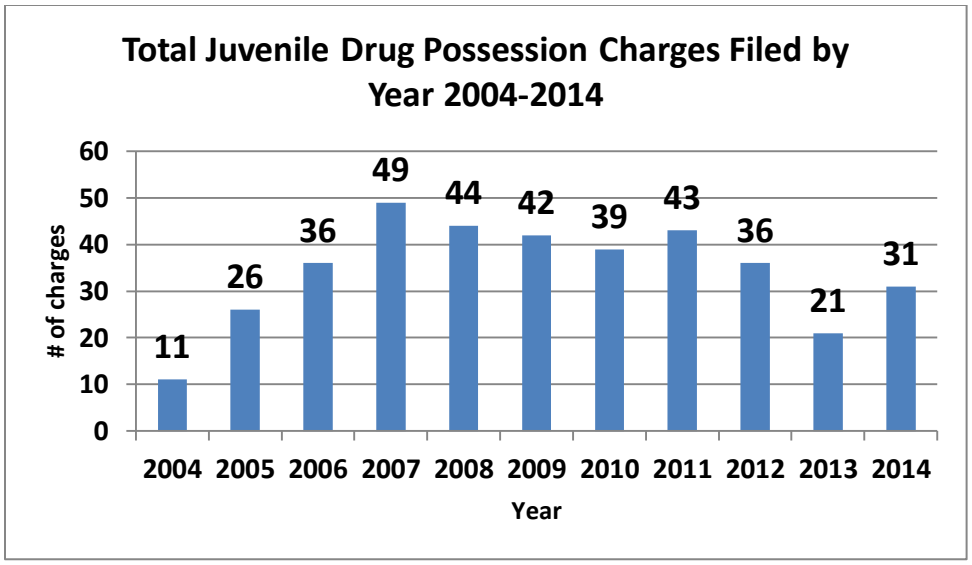
The majority of fatal overdoses in 2014 were from heroin alone, with 20 overdoses. Other opioids caused 11 fatal overdoses, 8 cases are still toxicology pending, 6 were from a mixture of heroin/fentanyl, and 4 were from fentanyl alone.

The AACPD provided data for adult and juvenile drug charges filed from 2004-2014. These drug charges include drug possession and drug sales for adults and juveniles. Below, the next two charts represent the total adult drug possession charges, and the total juvenile drug possession charges. These charts include arrests for all drugs except alcohol and marijuana.

As indicated from the chart below, the total number of adult drug possession charges is steadily increasing from 2010-2014. The highest number of drug possession charges was last year, 963.



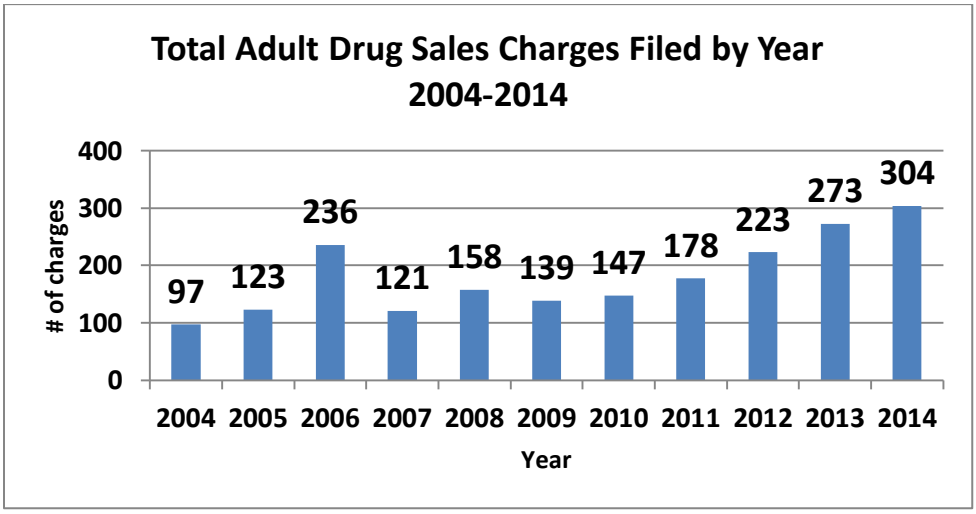
Source: AACPD



Source: AACPD

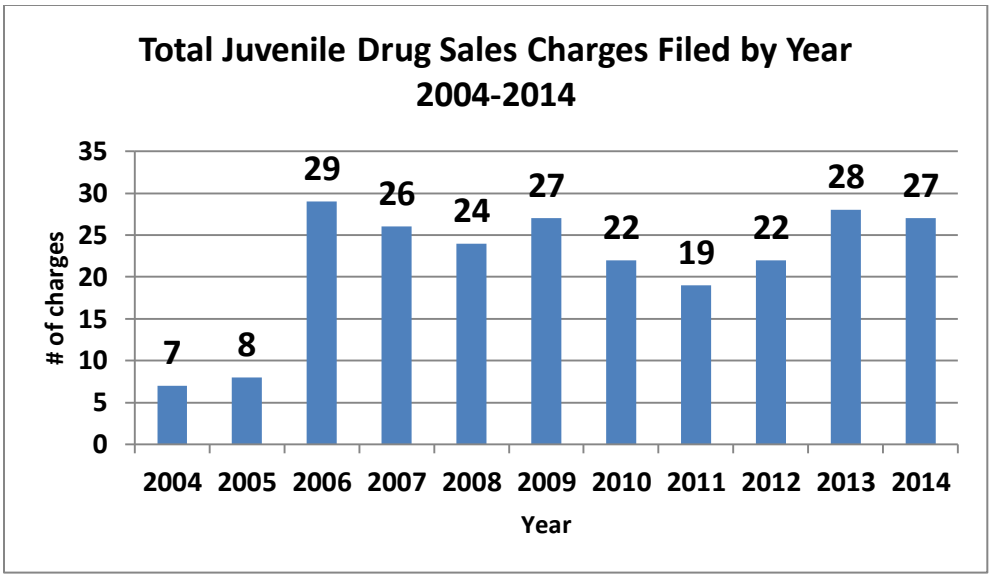
Although the juvenile drug possession charges from 2004-2014 are not as high as the adult drug possession charges, they increased from 2013-2014 by ten charges. Looking at the trend from 2004-2007, the number is likely to continue increasing in the upcoming years. Taking into consideration the number of youth under 18 years of age in AAC, drug charges are very low.

The next two charts below indicate total adult and juvenile drug sales charges filed from 2004-2014. As shown below, charges filed against adults for drug distribution have steadily increased from 2009-2014. The highest number of charges filed was last year with 304 charges.



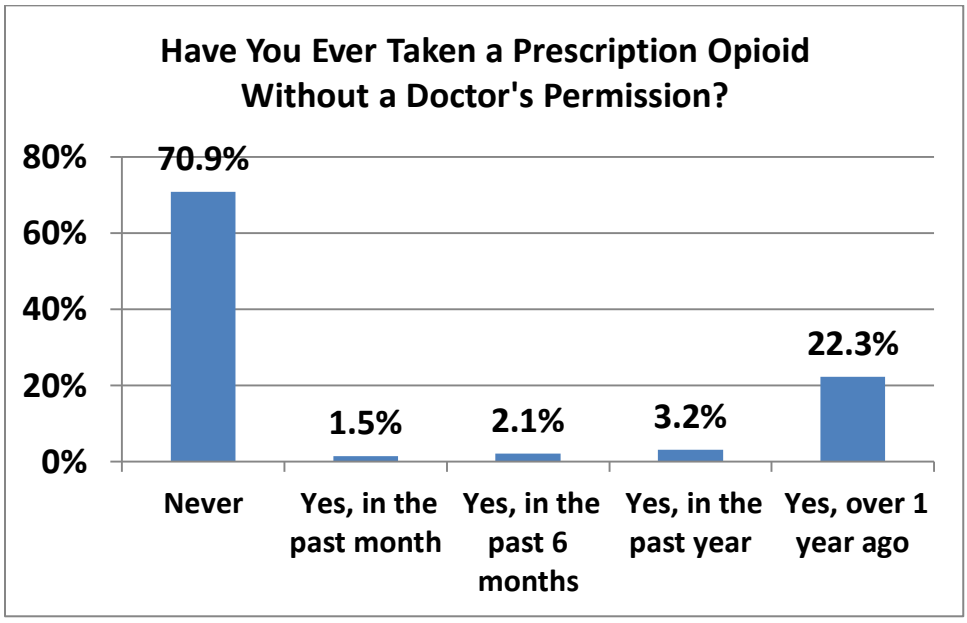
Source: AACPD

The total numbers of juvenile drug sales charges filed from 2004-2014 is represented below. From 2006-2014, between 19 and 29 juveniles were being charged for distributing drugs.



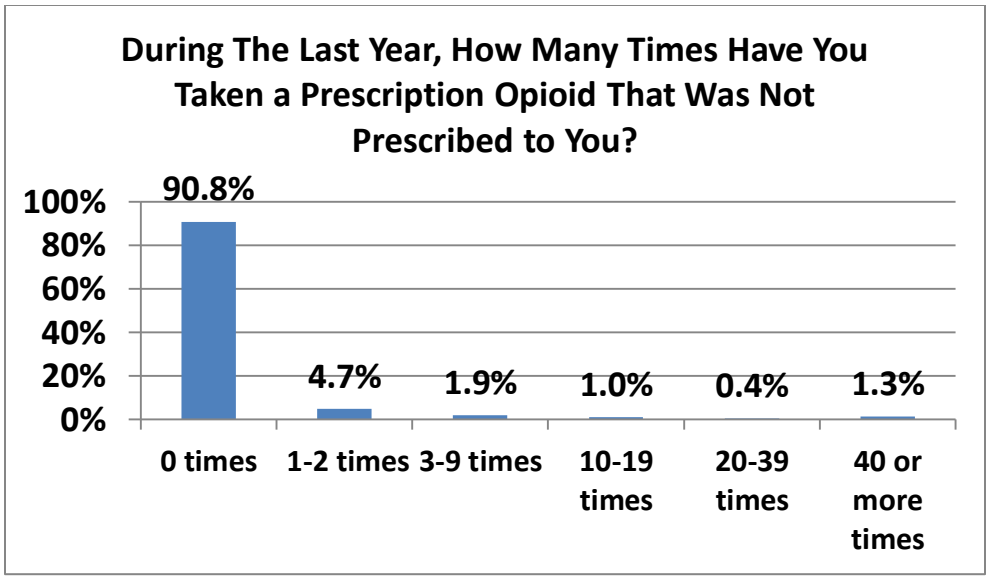
Source: AACPD

In addition to AACPD data, AAC participated in the MPOS. According to the MPOS, of the respondents from AAC who have taken prescription opioids without a doctor's permission, 22.3% took them over one year ago. 70.9% claimed they have never taken a prescription opioid without a doctor's permission. 29% admitted to taking a prescription opioid without a doctor's permission in their life time.



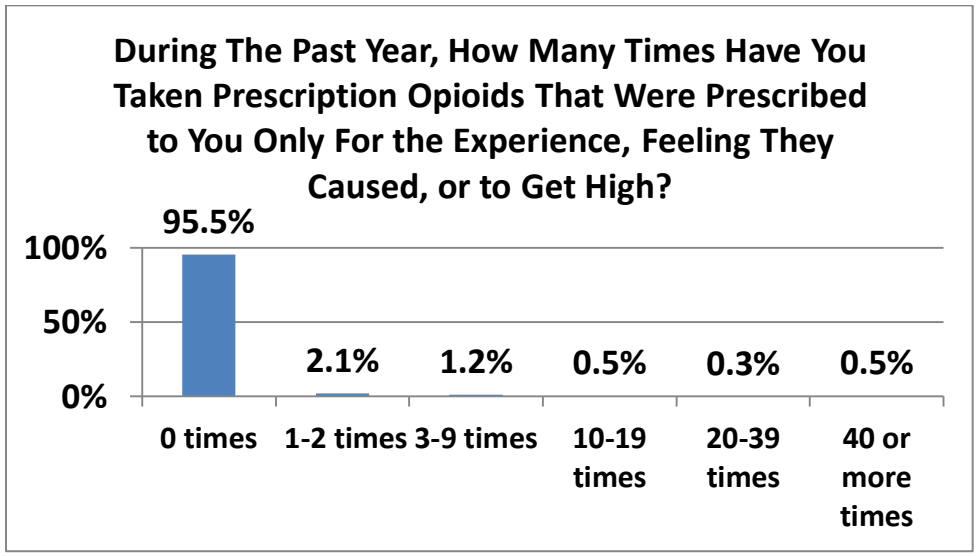
Source: MPOS

The MPOS asked respondents how many times in the last year they took a prescription opioid that was not prescribed to them. 90.8% responded 0 times, 4.7% indicated they had 1-2 times, 1.9% indicated they had 3-9 times, and 1.3% indicated they had taken a prescription opioid that was not prescribed to them 40 or more times.



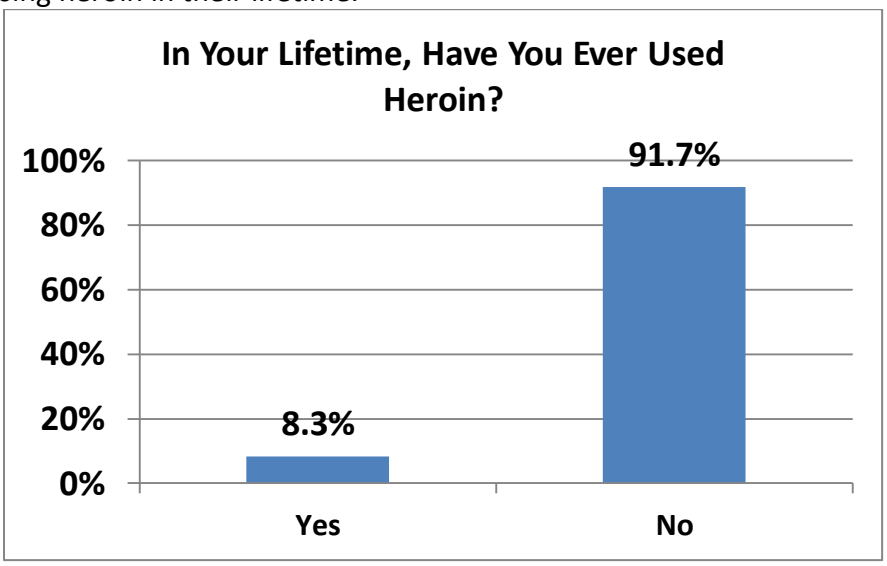
Source: MPOS

The next question concerning consumption asked respondents how many times they have taken prescription opioids that were prescribed to them, but only for the experience, feeling the drug caused, or to get high in the past year. 95.5% responded 0 times, 2.1% claimed 1-2 times, and 1.2% claimed 3-9 times. A small percentage responded they had taken their prescribed opioids for recreational reasons more than 10 times in the past year.



Source: MPOS

The last question from the MPOS related to consumption asked respondents if they have ever used heroin in their lifetime. Although 91.7% said no, 8.3% said yes. Almost 10% of respondents admitted to using heroin in their lifetime.



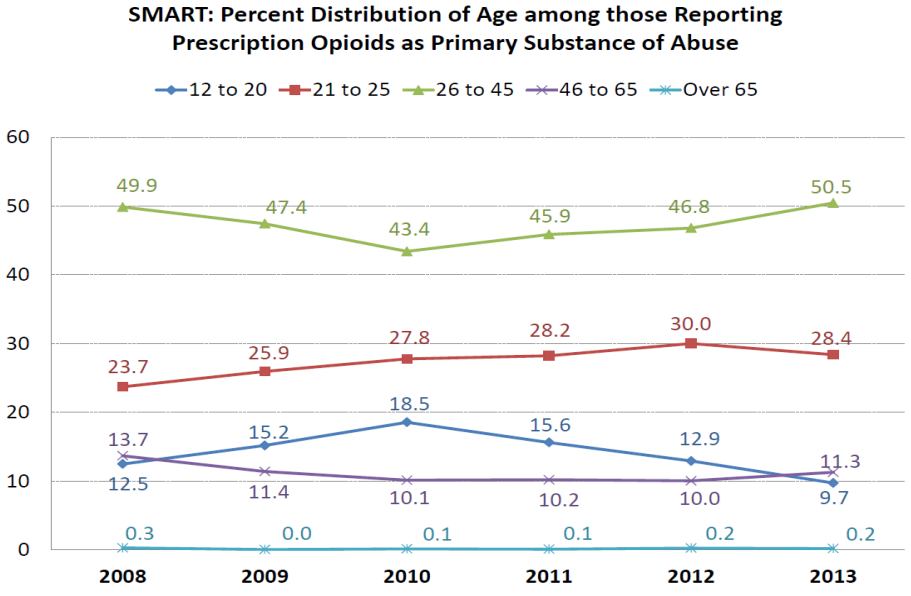
Source: MPOS

B. WHO

i. Identification of specific populations that will be the focus of the coalition's prevention strategies

Consumption Patterns

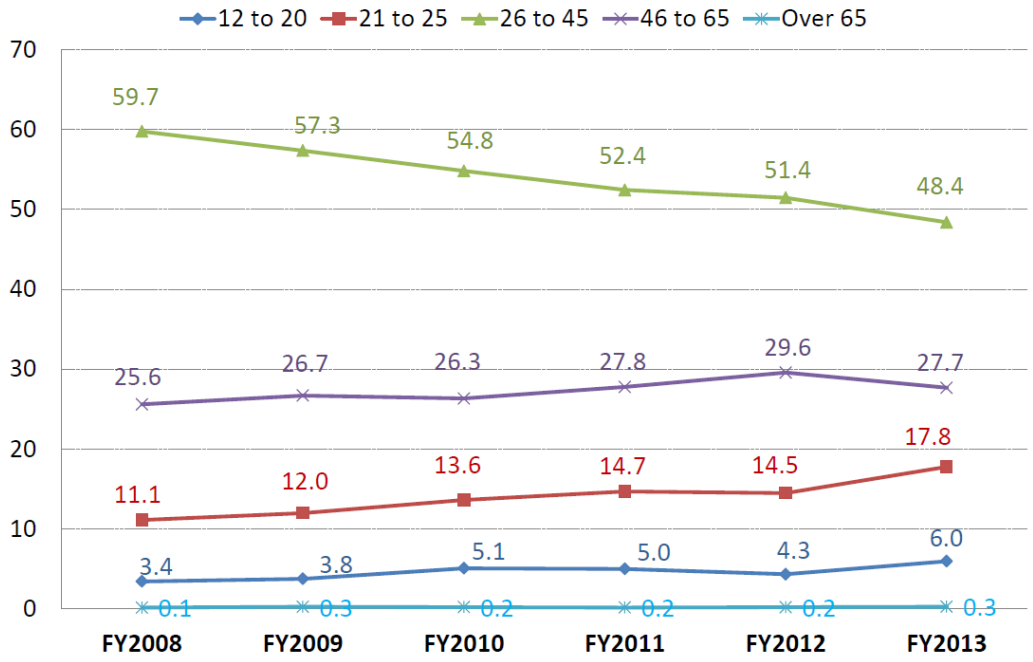
Over the last six years Statewide, the percentage of individuals reporting prescription opioids as their primary substance of abuse has decreased in every age group except for those 26-45 years of age.



Source: SMART, BHA

Additionally, statewide, between 2012 and 2013, there was an increase in the number of people in treatment ages 21-25 reporting heroin as a primary substance of abuse. About half of 26 to 45 year olds have indicated heroin as a primary drug of choice over the six year period.

SMART: Percent Distribution of Age among those Reporting Heroin as Primary Substance of Abuse



Source: SMART, BHA

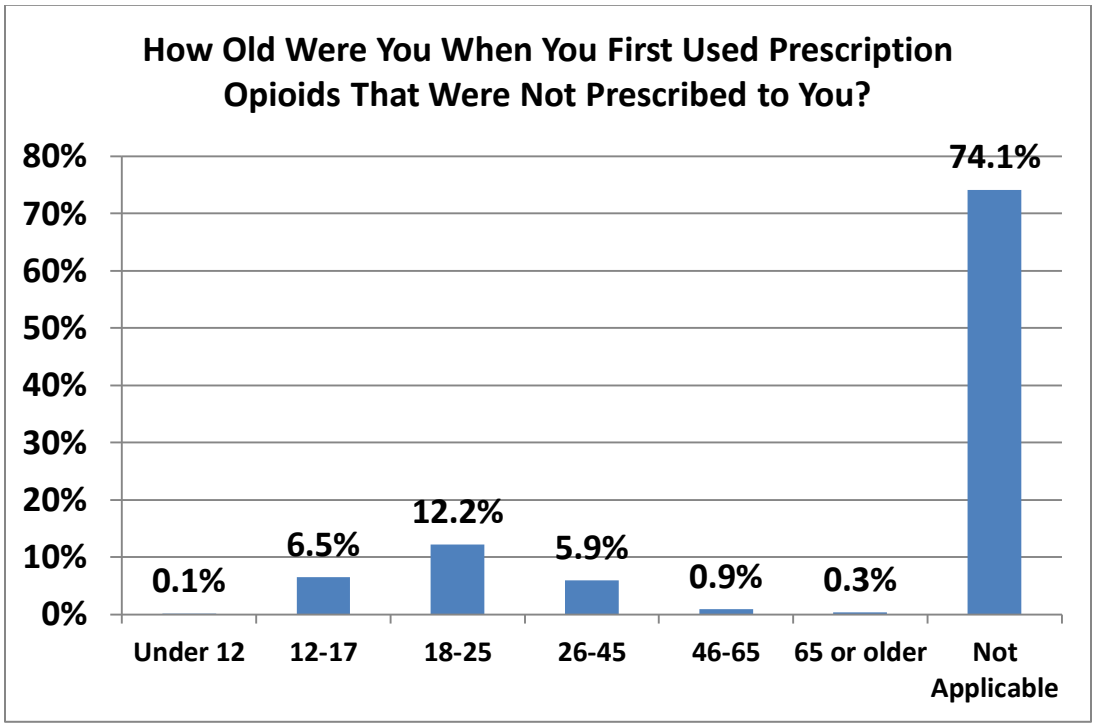
Anne Arundel County Heroin Use by Age, High School Students, 2013

Age in yrs.	Anne Arundel County	Maryland
<15	4.30%	4.80%
16 or 17	5.50%	4.40%
18+	10.70%	7.90%

Source: YRBS

The YRBS table above shows AAC heroin use by age for high school students. There is little use of heroin reported by students under the age of 15. As students age, the percentage of those ever reporting heroin use increases. Those 18 and over reporting heroin use is 3% higher than the State average.

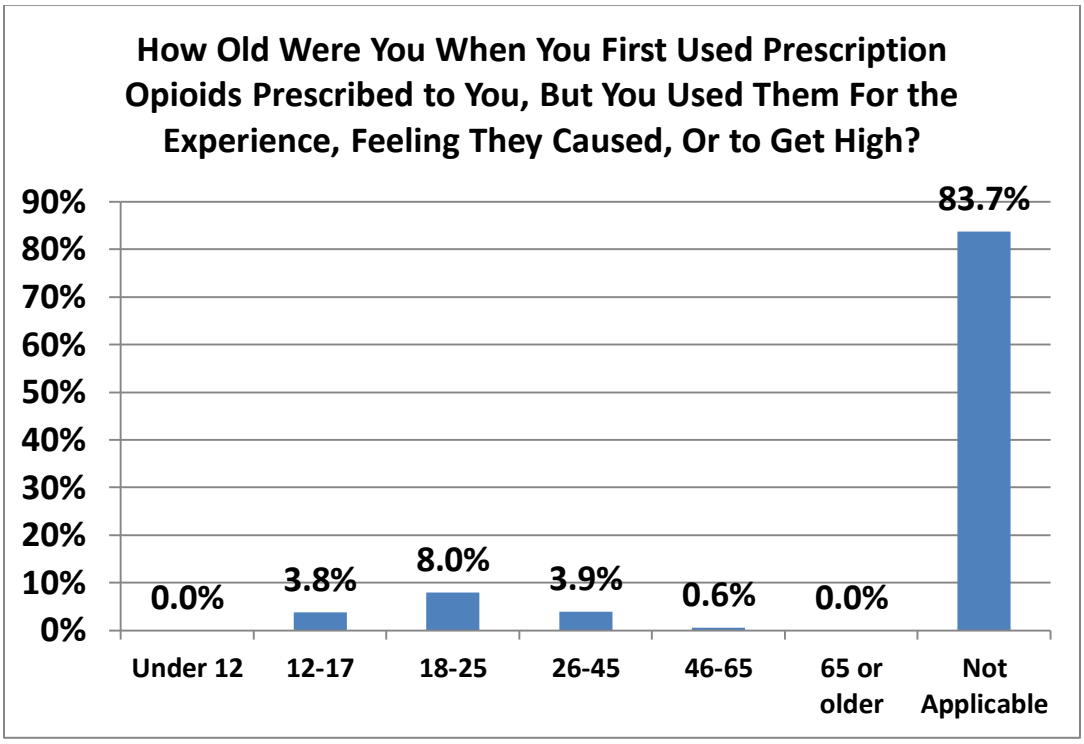
According to the MPOS, AAC residents reported they first misused prescription opioids and heroin when they were between the ages of 18-25. The survey asked respondents how old they were when they first used prescription opioids that were not prescribed to them by a doctor.



Source: MPOS

Although this question was not applicable to 74.1% of respondents, the highest percentage of AAC residents, 12.2%, reported being between the ages of 18-25 when they first used prescription opioids that were not prescribed to them. The second highest reported age of first use were those between the ages of 12-17 with 6.5% and closely after, 5.9% were between the ages of 26-45.

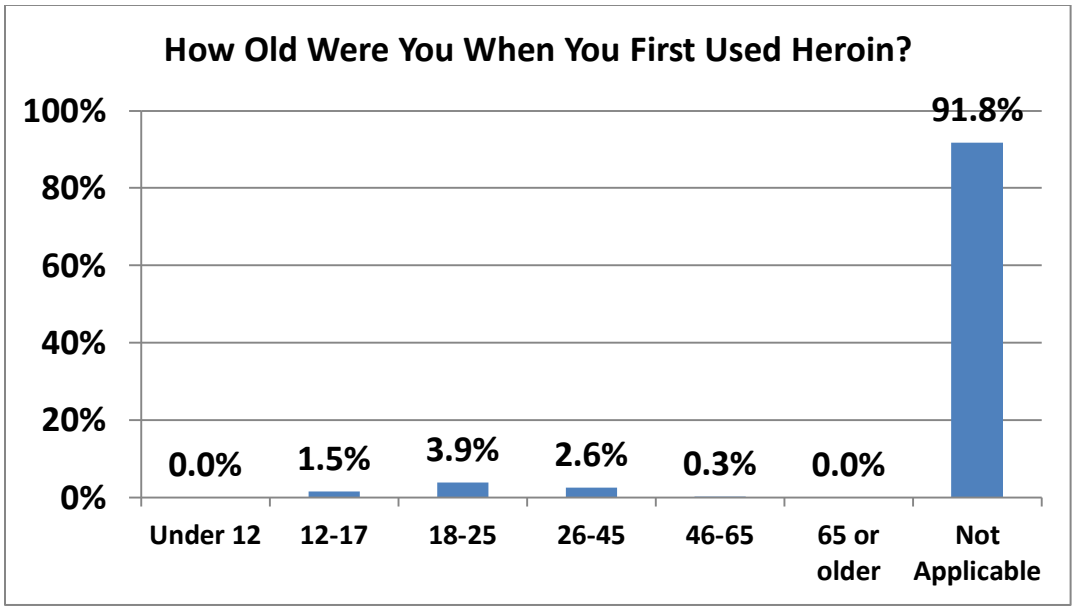
Related to the previous question and who is misusing prescription opioids, the MPOS asked respondents about their age when they first used prescription opioids that were prescribed to them, but used them for the experience, feeling they caused, or to get high.



Source: MPOS

Similarly, this question was not applicable to a large percentage of respondents (83.7%). As seen from the chart above, there is a wide range of when people first started misusing, spanning from 12-17 (3.8%), and 26-45 (3.9%). Similar to the previous question, the highest percentage was between ages 18-25 at 8.0%.

The last MPOS question identifying who is misusing opioids asked respondents how old they were when they first used heroin. This question did not apply to 91.8% of survey respondents. Of those who reported heroin use, the highest percentage, 3.9% reported they were between the ages of 18-25 when they first used. The next highest percentage was between the ages of 26-45 at 2.6%, followed by the 12-17 year old age group at 1.5%.

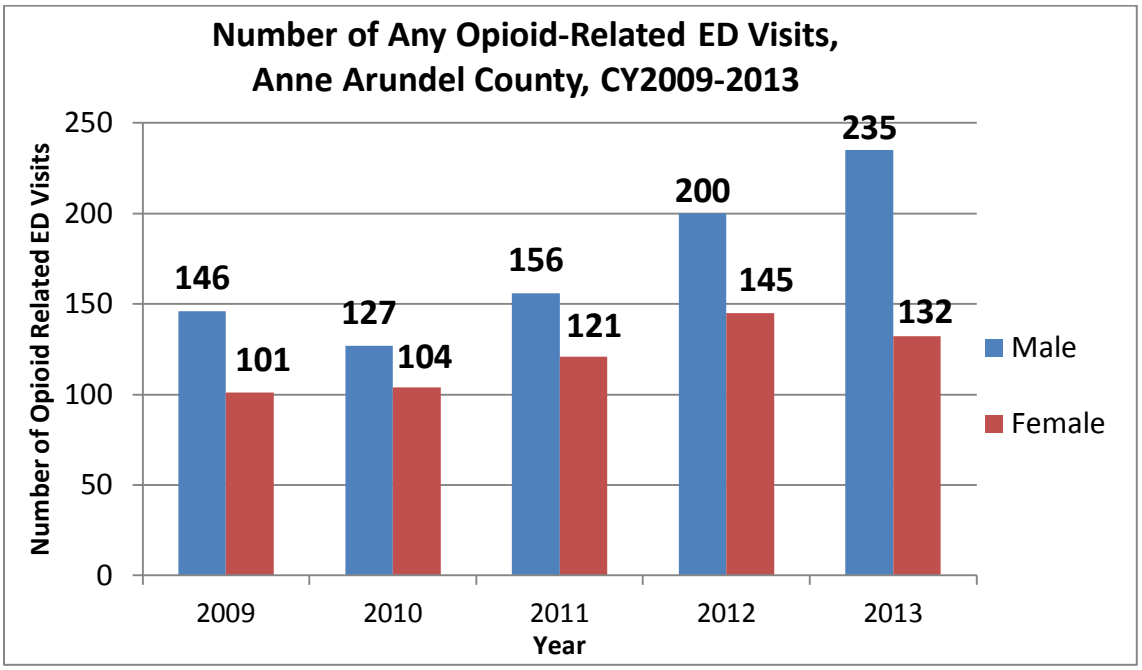


Source: MPOS

There is a common theme from the MPOS that most AAC residents who misuse or have misused prescription opioids and heroin started using when they were between the ages of 18-25.

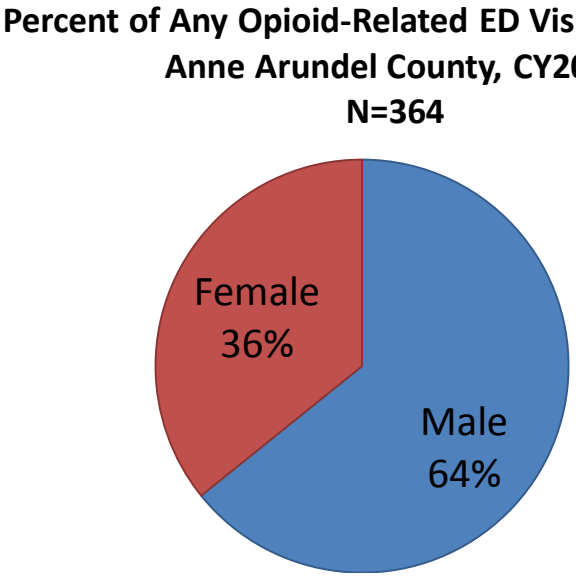
Consequences

The chart below illustrates the number of any opioid-related ED visits in AAC from 2009-2013 by gender. There are consistently more males than females each year who are hospitalized due to opioid misuse. In 2013, there were 235 males and 132 females who had opioid-related ED visits, more than previous years.



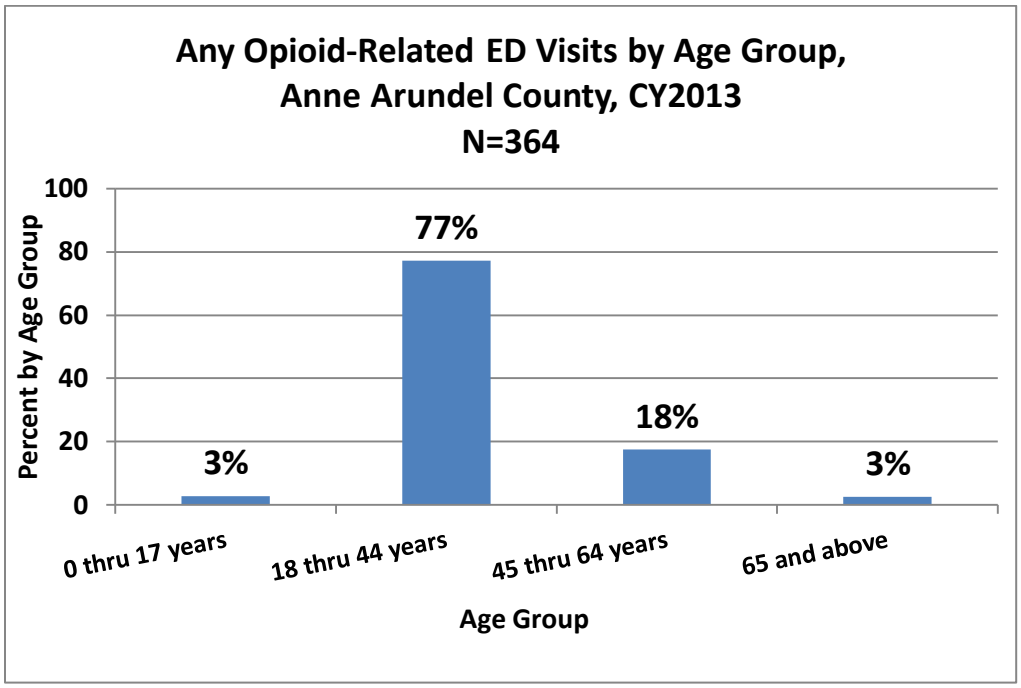
Source: Outpatient Hospital Discharge Data, Maryland Health Services Cost Review Commission

In 2013, of 364 patients who had opioid-related ED visits, 64% were male and 36% were female.



Source: Outpatient Hospital Discharge Data, Maryland Health Services Cost Review Commission

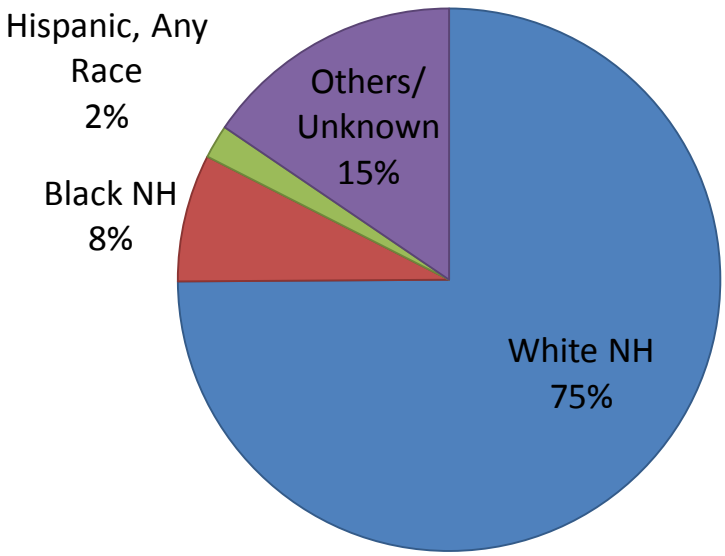
The population of 364 opioid-related ED visits in 2013 distributed by age group is represented below. A large percentage of these ED visits were people between the ages of 18-44 (77%).



Source: Outpatient Hospital Discharge Data, Maryland Health Services Cost Review Commission

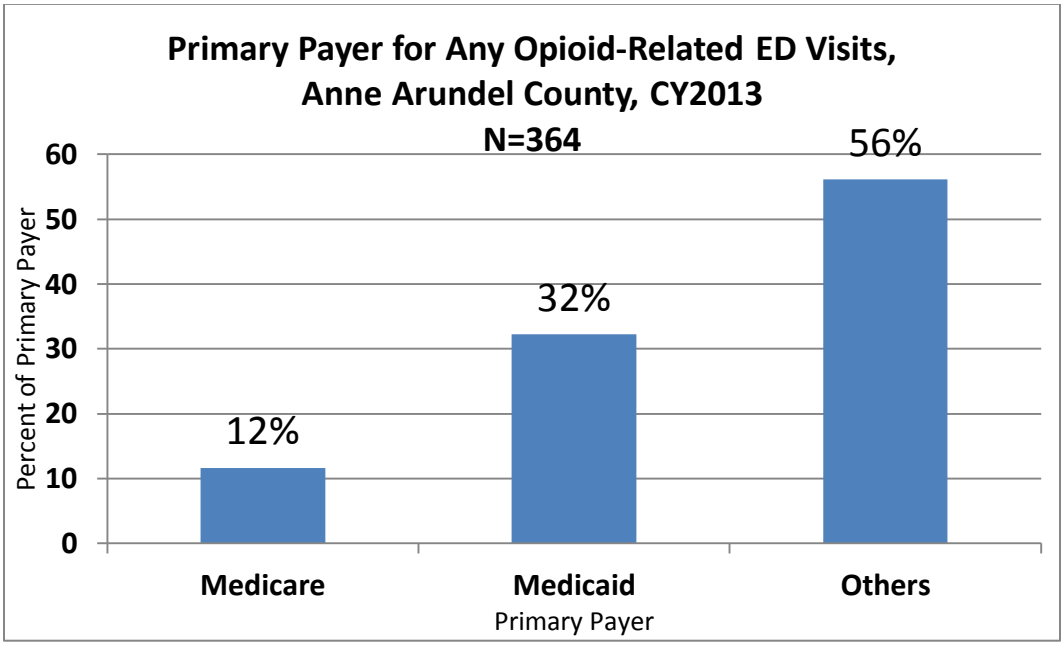
This population of 364 opioid-related ED visits distributed by race is represented in the chart below. The majority of the patients were White, non-Hispanic (75%), 15% were of other/unknown races, 8% were Black, non-Hispanic, and 2% were Hispanic, any race.

Percent of Any Opioid-Related ED Visits by Race/Ethnicity, Anne Arundel County, CY2013
N=364



Source: Outpatient Hospital Discharge Data, Maryland Health Services Cost Review Commission

The Outpatient Hospital Discharge Data also provided results of who the primary payers were for the 364 opioid-related ED visits in 2013. A total of 44% of these ED visits were paid for by either Medicare or Medicaid. The rest of the opioid-related ED visits were paid for by other primary sources (56%). This information is shown in the chart below.

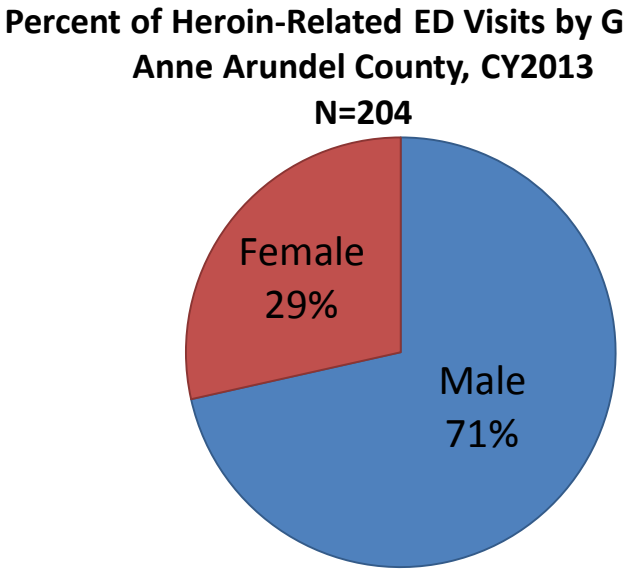


Source: Outpatient Hospital Discharge Data, Maryland Health Services Cost Review Commission

In addition to the data shown above, the same source indicated that 36% (104) of those who had opioid-related ED visits in 2013 had more than one visit.[12]

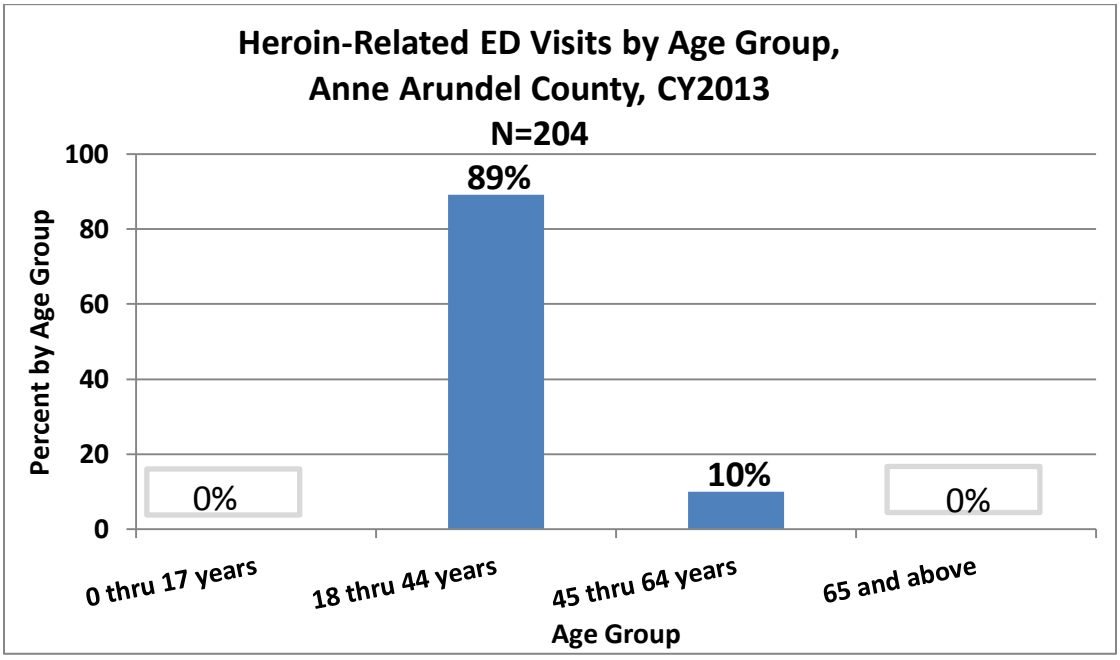
[12] Outpatient Hospital Discharge Data, Maryland Health Services Cost Review Commission

Similarly, the same trends occur for heroin-related ED visits in AAC. In 2013, there were a total of 204 heroin-related ED visits in AAC. The chart below indicates that 71% of these patients were male, and 29% were female.



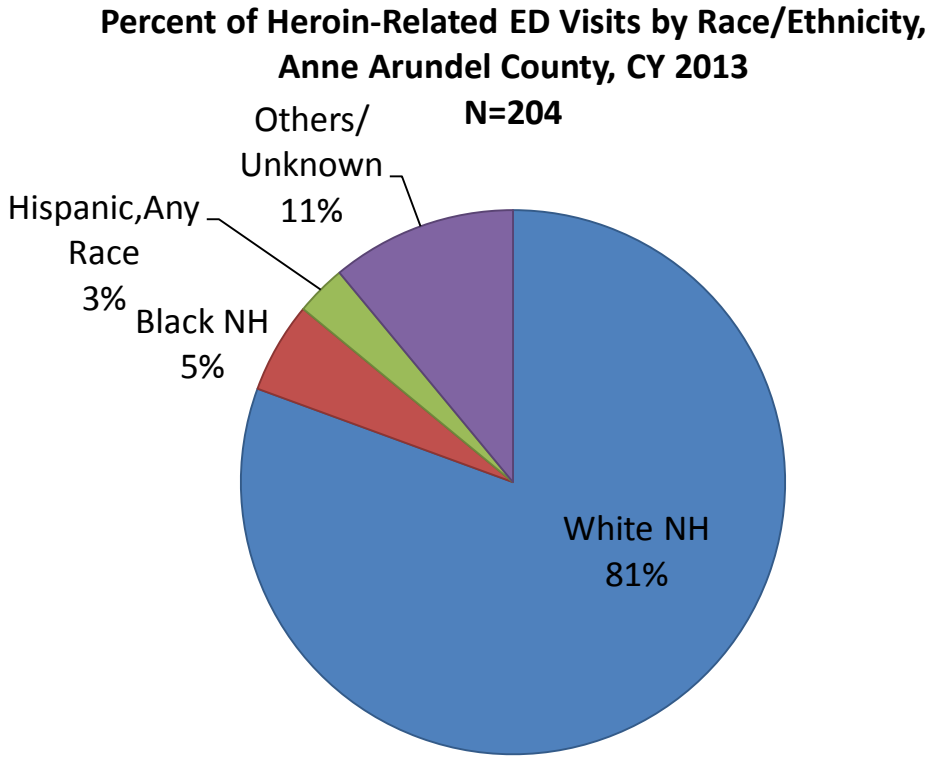
Source: Outpatient Hospital Discharge Data, Maryland Health Services Cost Review Commission

The population of 204 heroin-related ED visits in 2013 distributed by age group is represented below. Like the opioid-related ED visits, a majority of these patients were between the ages of 18-44 (89%).



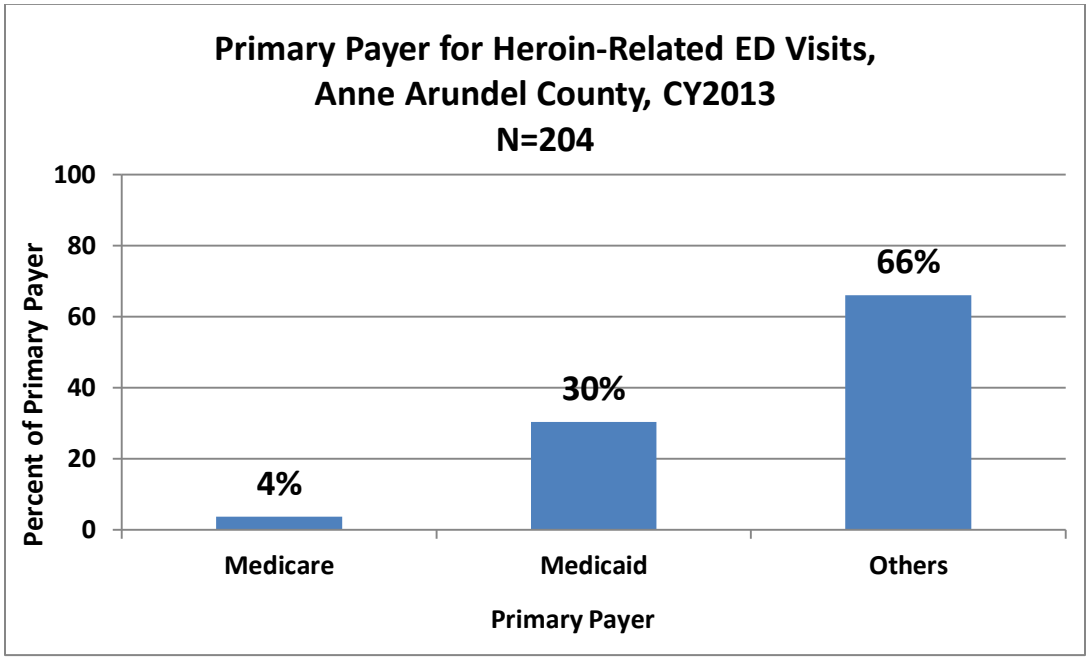
Source: Outpatient Hospital Discharge Data, Maryland Health Services Cost Review Commission

This population is distributed by race in the chart below. Again, with heroin-related ED visits in 2013, a majority of the patients were White, non-Hispanic (81%), 5% were Black, non-Hispanic, and 11% were of other/unknown races, 3% were Hispanic, any race.



Source: Outpatient Hospital Discharge Data, Maryland Health Services Cost Review Commission

This data also provided results of who the primary payers were for the 204 heroin-related ED visits in 2013. A total of 34% of these ED visits were paid for by either Medicare or Medicaid. The rest of the heroin-related ED visits, the majority, were paid for by other primary sources (66%). This information is shown in the chart below.



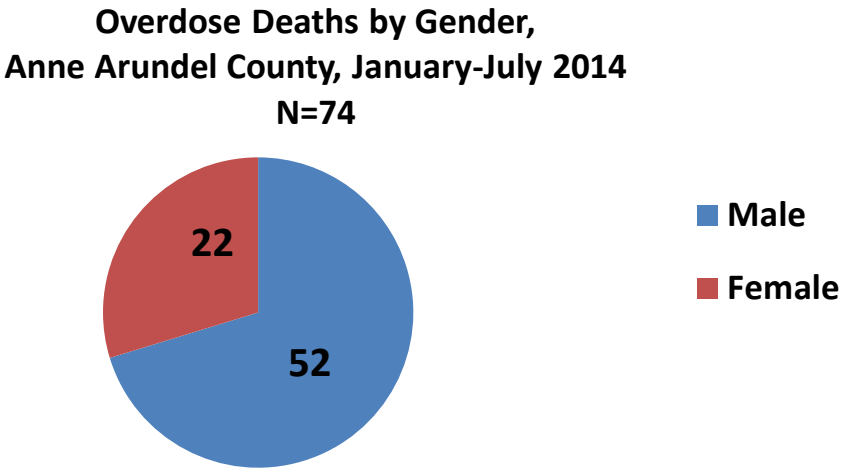
Source: Outpatient Hospital Discharge Data, Maryland Health Services Cost Review Commission

In addition to the data shown above, it was indicated that 37% (58) of those who had heroin-related ED visits in 2013 had more than one visit.[13]

The OCME data provides information about overdoses in AAC. The OCME overdose data includes 74 cases for the period of January-July 2014. This data represents residents of AAC who died in the county, residents of AAC who died out of the county as well as non-residents who died in AAC.

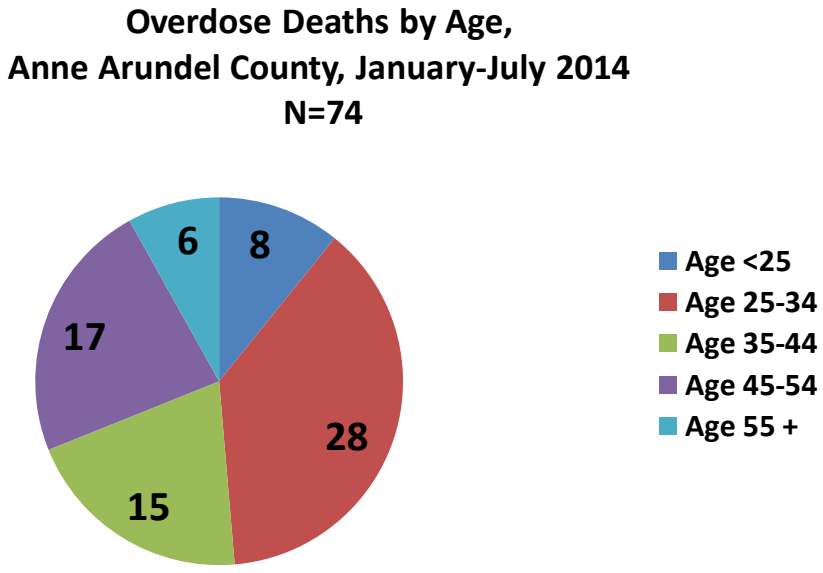
[13] Outpatient Hospital Discharge Data, Maryland Health Services Cost Review Commission

The chart below represents overdose deaths by gender in AAC between January-July of 2014. Out of the 74 overdose deaths, 52 were male and 22 were female.



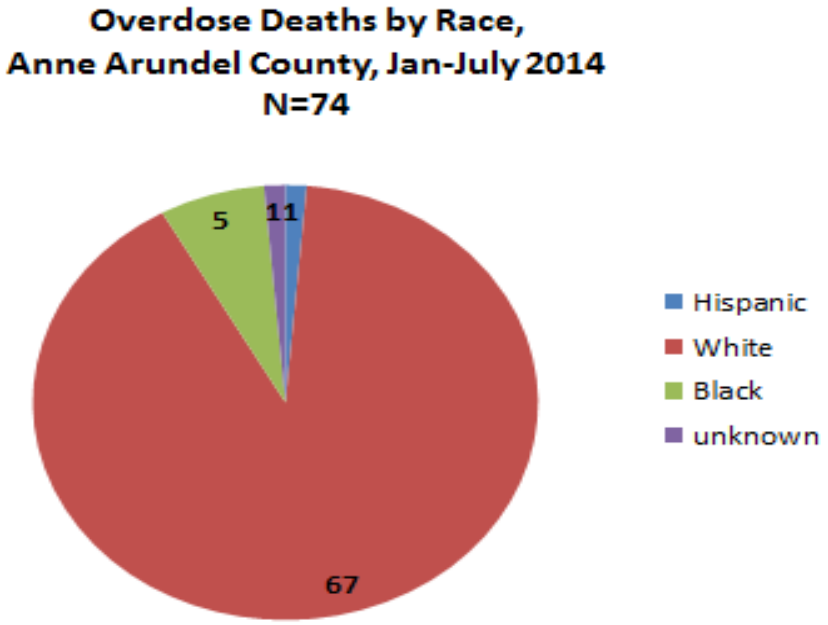
Source: Behavioral Health Administration, Maryland DHMH

The next chart represents the different age groups of the 74 overdose deaths in AAC in 2014. The largest number was among people between the ages of 25-34 with 28 deaths. The next largest number was among people between ages 45-54 with 17 deaths. Following this, the age group of 35-44 had 15 deaths. 8 people were under 25 years old, and 6 people were over 55 years old.



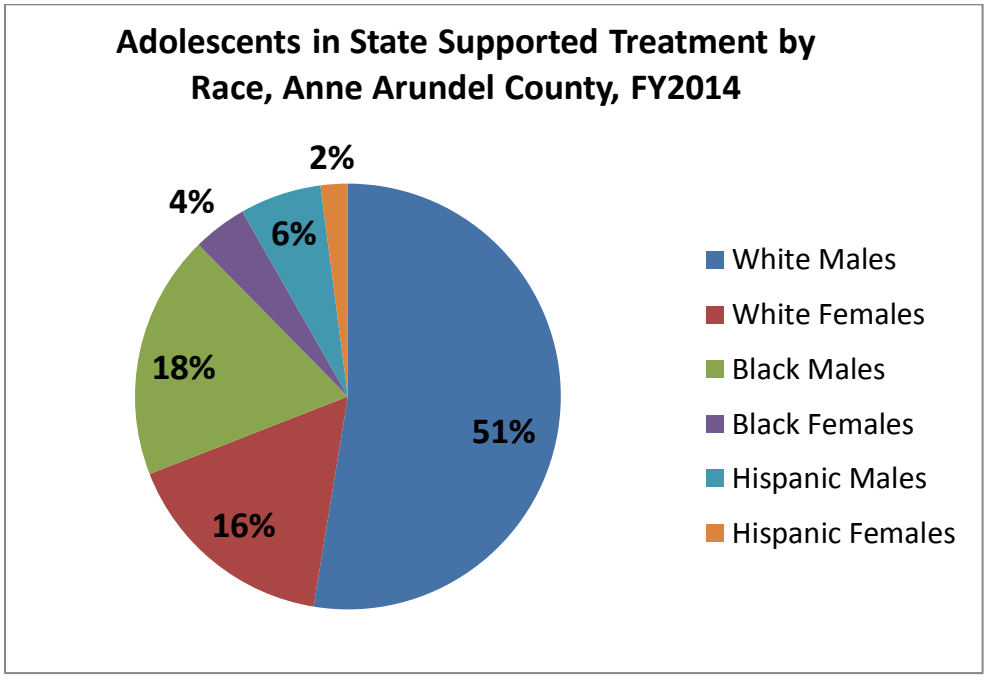
Source: Behavioral Health Administration, Maryland DHMH

Of the 74 overdose deaths between the time period of January-July 2014, 67 of those who died were white. The large majority, 91% were white. Five people who died of an overdose during the first seven months of 2014 were black.



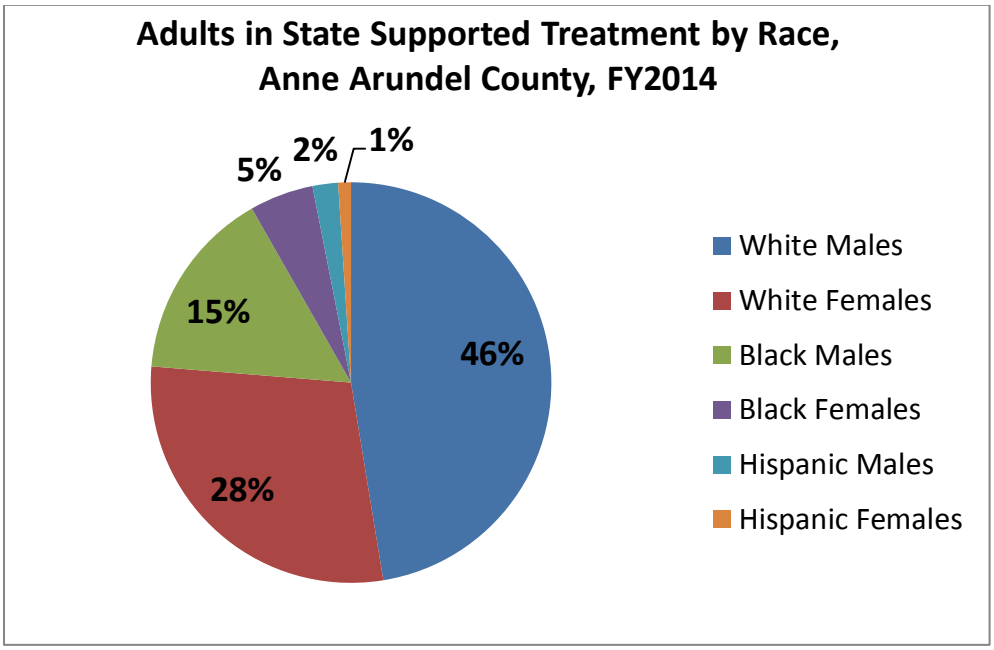
Source: Behavioral Health Administration, Maryland DHMH

The DHMH also provided the representation of adults and adolescents who were in state supported treatment in 2014 by gender and race. These charts are shown below.



Source: Behavioral Health Administration, Maryland DHMH

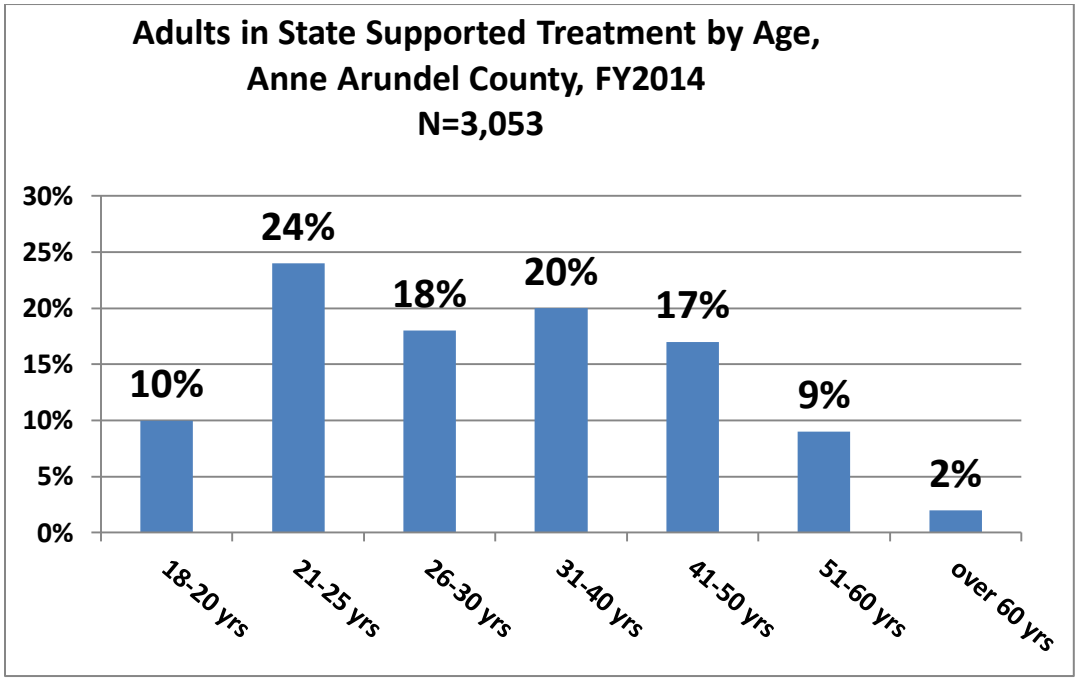
The majority of adolescents in state supported treatment in 2014 were white males (51%). The next highest percentage was black males at 18%, followed by white females at 16%. This chart shows that those adolescents in state supported treatment are predominantly male.



Source: Behavioral Health Administration, Maryland DHMH

The majority of adults in state supported treatment in 2014 were also white males (46%). Unlike the adolescent race pie chart, the next highest percentage was white females at 28%. The third highest category was black males at 15%. This chart shows that adults in state supported treatment in AAC are predominantly white.

The chart below indicates DHMH data of adults in state supported treatment distributed by age. The majority of adults in state supported treatment in 2014 were between the ages of 21-25 years old (24%). 20% of adults in treatment were between the ages of 31-40 years old, 18% were between 26-30 years old, and 17% were between the ages of 41-50. These age groups represent the highest percentages of adults in state supported treatment, with 21-25 years old being the most common age of those in treatment.



Source: Behavioral Health Administration, Maryland DHMH

According to the AACPD, the heroin overdose demographics for the January-December 2014 year are represented in the table below. These numbers indicate the total number of overdoses for 2014, including both fatal and non-fatal.

HEROIN OVERDOSE DEMOGRAPHICS

January 1 through December 31, 2014 (Total Overdoses -- 360 (fatal & non-fatal)

Overdoses by Race & Gender

Total W/M	Total W/F	Total B/M	Total B/F	Other	***Total Overdoses***
243	99	15	3	0	**360**
68%	28%	4%	1%	0%	

Overdoses by Race Only

Both Genders: White	Both Genders: Black	Both Genders: Other	***Total Overdoses***
342	18	0	**360**
95%	5%	0%	

Overdoses by Race, Gender & Age (328 total overdoses)

AGE (count)	W/M	W/F	B/M	B/F	Other	**TOTAL**
Under 18	6	1	0	0	0	**7**
18 - 24	80	42	5	0	0	**127**
25 - 44	128	47	10	3	0	**188**
45 - 64	29	9	0	0	0	**38**
65+	0	0	0	0	0	**0**

AGE (percentage)	W/M	W/F	B/M	B/F	Other	**TOTAL**
Under 18	2%	0%	0%	0%	0%	**2%**
18 - 24	22%	11%	1%	0%	0%	**40%**
25 - 44	36%	13%	3%	1%	0%	**60%**

45 - 64	8%	3%	0%	0%	0%	**12%**
65+	0%	0%	0%	0%	0%	**0%**

As shown in the table, the majority of overdose victims by race and gender in 2014 were white males, 68%. When assessing race only, 95% of overdose victims were white males and females. When assessing age, the majority of overdoses, 60%, in 2014 were people between the ages of 25-44. Furthermore, of the 60% in this age group, 36% were white males. The next most frequent age group for overdose victims was ages 18-24 with 40%. Again, the majority, 36%, in this percentage were white males.

ii. Prioritization process used to identify those populations

In April of 2015, OMPPNAWG members met to discuss data points from the data sources presented above in order to weigh the results and narrow the population focus. It was determined that although there is a wide range of ages misusing opioids/using heroin, the OMPPNAWG would target strategies for youth and young adults in the age ranges of 14-35. It was decided that since the YRBS shows some high school students are misusing prescription opioids and/or heroin, this age group should be targeted by opioid misuse prevention strategies. The OMPPNAWG discussed the importance of targeting younger ages with prevention strategies before they begin using.

C. WHEN

i. If applicable, describe seasonal trends for the selected indicators

Consumption Patterns

No consumption patterns were identified concerning the when.

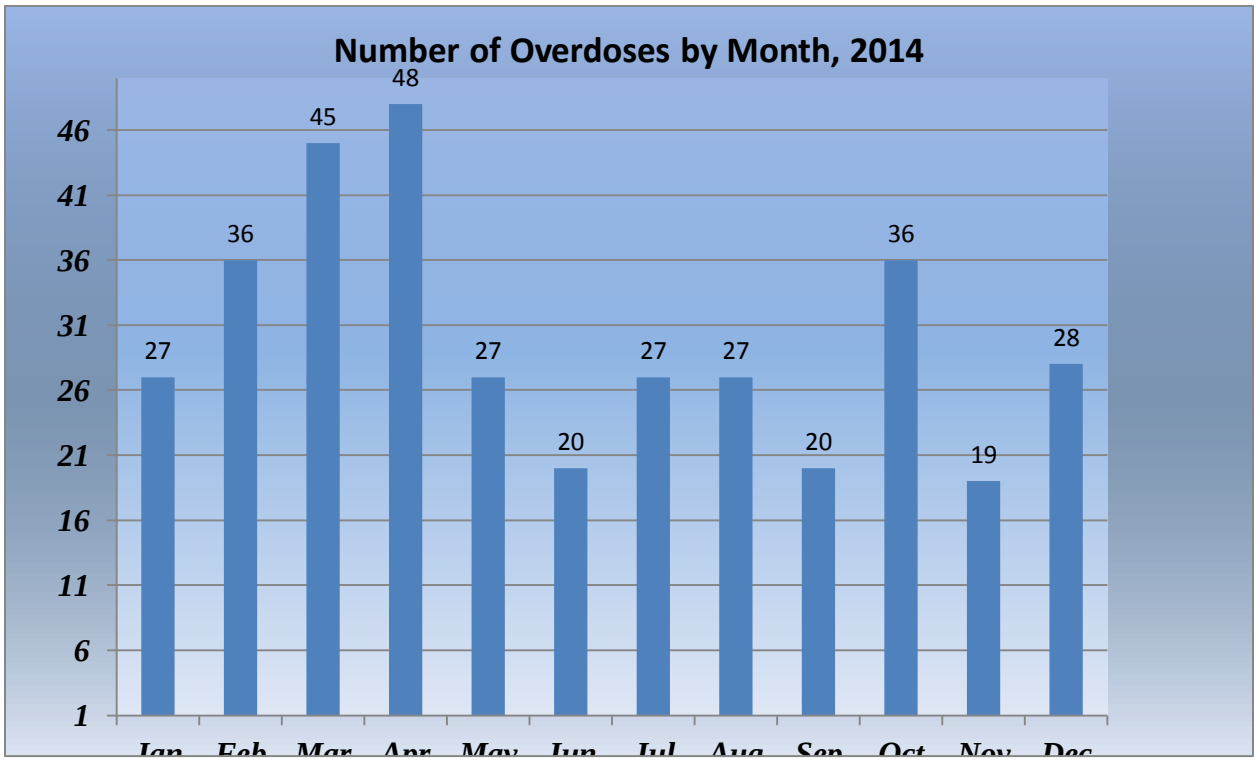
Consequences

For one year (2014) ,the AACPD has been tracking data related to opioid and heroin overdoses. According to the AACPD, the number of overdoses that occurred by month for the year 2014 are represented below. Since the heroin epidemic is new, it is difficult to identify trends with one year's worth of data.

Total Number of Overdoses by Month (through December)

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Number of Overdoses	27	36	45	48	27	20	27	27	20	36	19	28

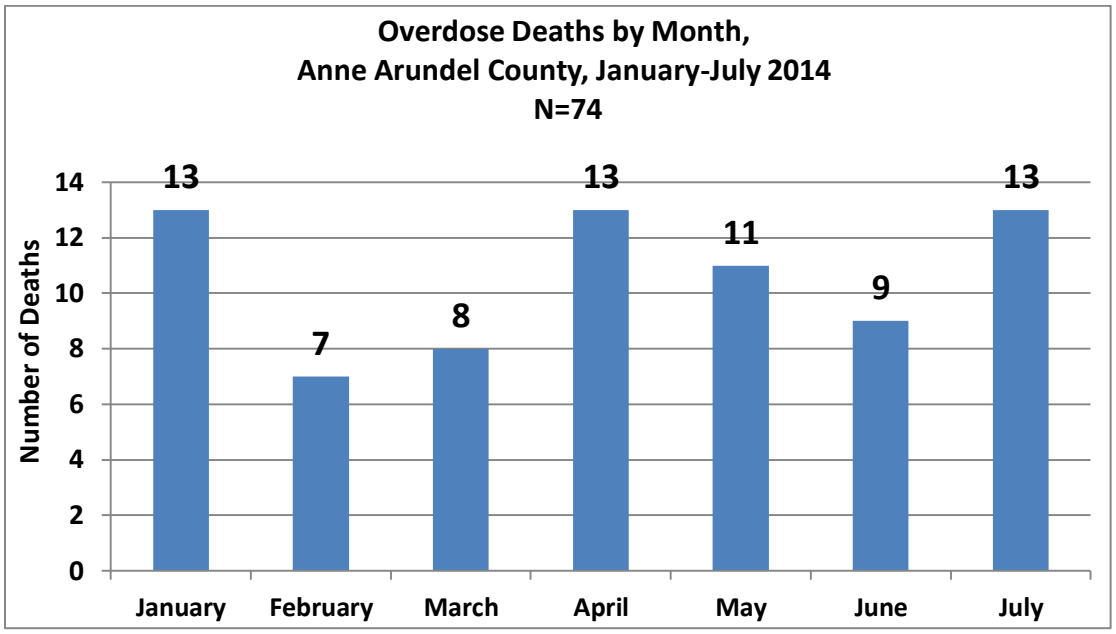
Source: AACPD



Source: AACPD

In 2014, the largest number of overdoses occurred in April (48). March had the second highest number of overdoses with 45. February and October had the same number of overdoses, with 36. As data is collected over the years, more "when" patterns can be identified. According to AACPD and DHMH, the spike in deaths in March and April were due to the heroin laced with fentanyl.

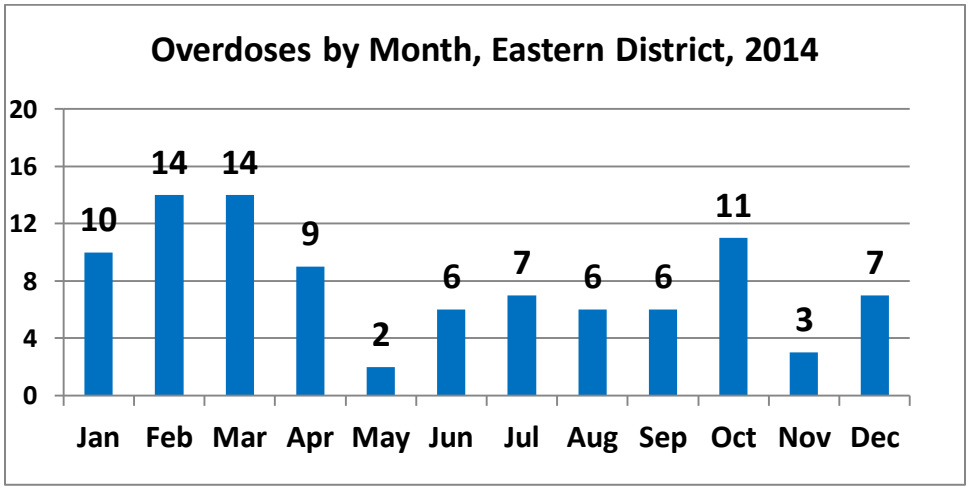
According to the OCME data, there was a spike in overdose deaths every third month from January-July, 2014. This is only one year's worth of data so it is too soon to identify trends.



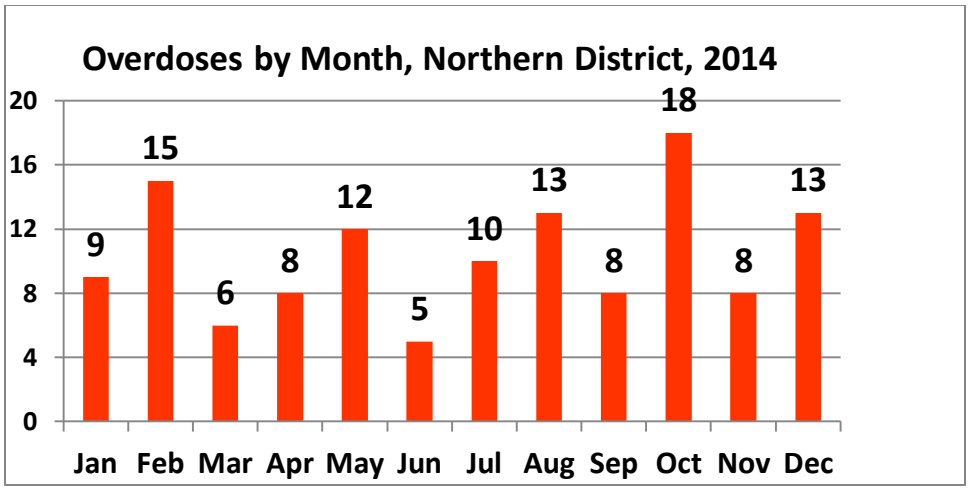
Source: Behavioral Health Administration, Maryland DHMH

In January, there were 13 overdose deaths which decreased to 7 in February followed by 8 in March. In April, the number of deaths increased to 13 when the heroin was found to be laced with fentanyl. July was also a high month for overdoses, with 13 overdoses for the month.

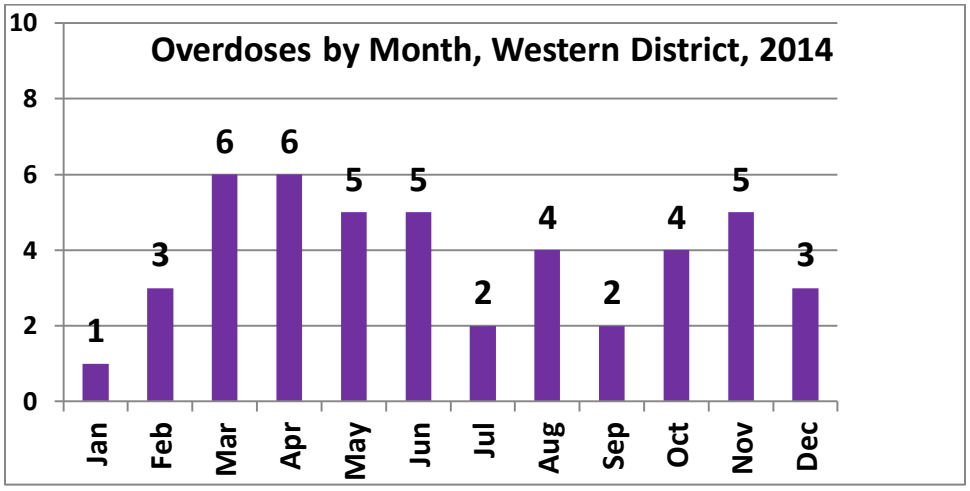
The AACPD provided data for opioid/heroin overdoses by district and month as shown below.



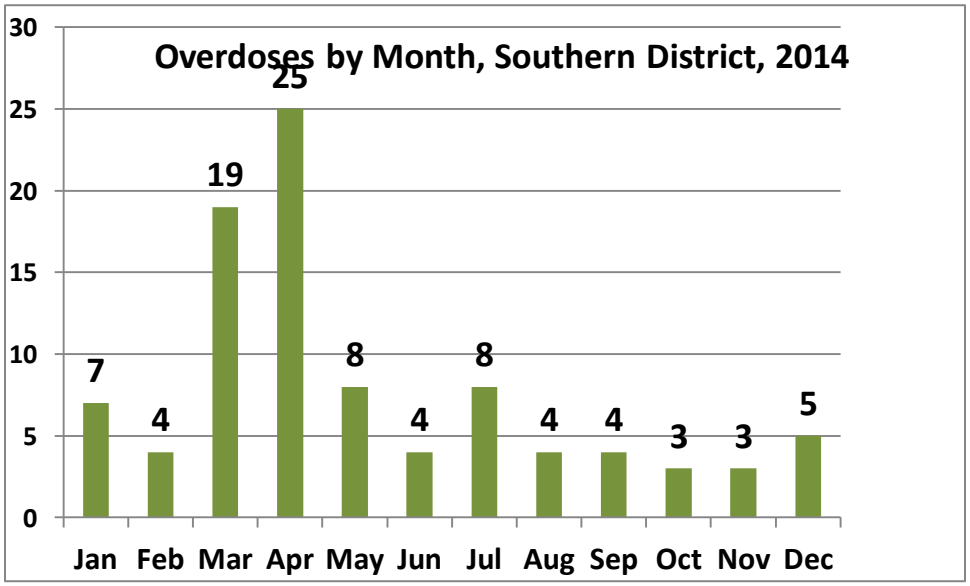
Source: AACPD



Source: AACPD



Source: AACPD



Source: AACPD

Overall, the District with the highest number of overdoses was Northern with a total of 125. The Eastern District had 95 total overdoses and the Southern District had 94. Lastly, the Western District had the least amount of overdoses with 46. The highest number of overdoses by District and month occurred in April in the Southern District with 25.

D. WHERE

i. Identification of specific neighborhoods that will be the focus of the coalition's prevention strategies

Consumption

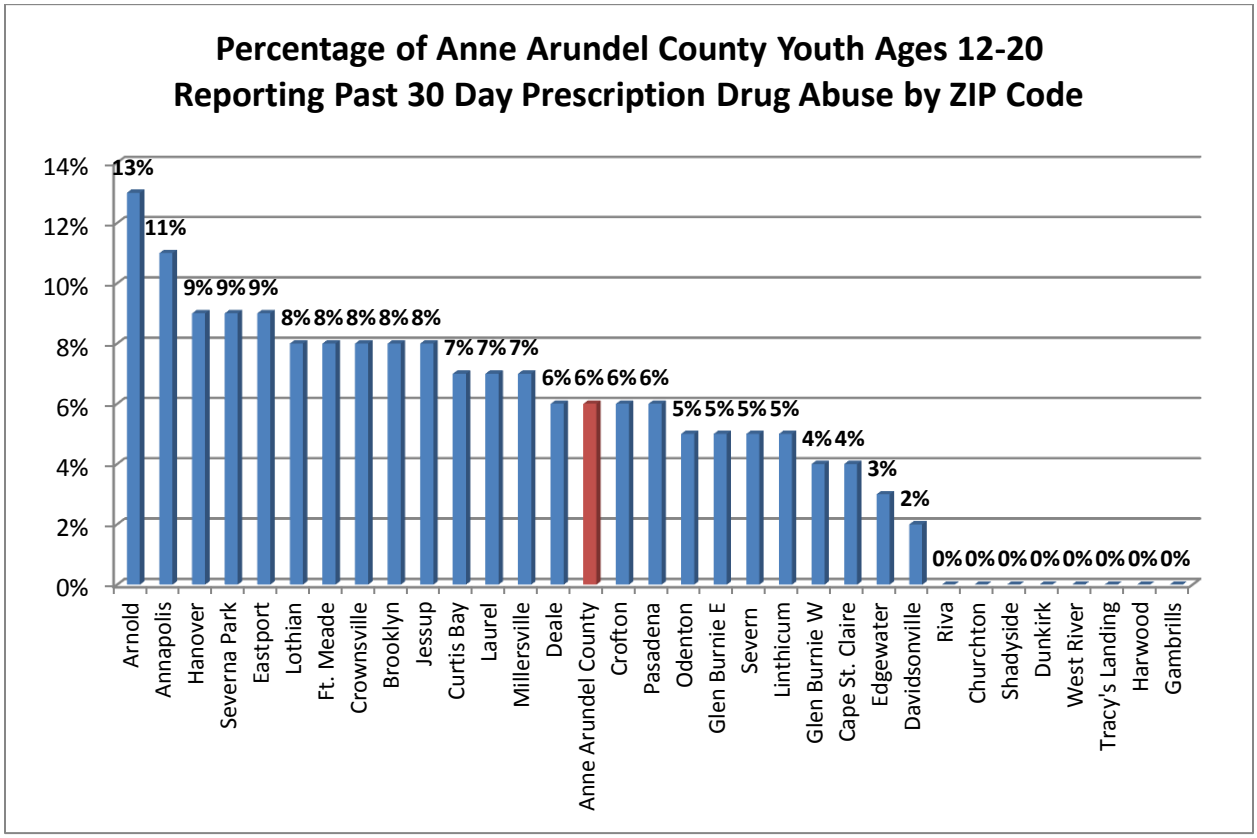
The YRBS table below shows the percentage of students who were sold, offered, or given illegal drugs on school property in 2013. 30.90% of high school students in Anne Arundel County Public Schools (AACPS) were offered, sold, or given illegal drugs on school property. This is more than the Maryland percentage, 29.10%.

Percentage of students who were sold, offered, or given illegal drugs on school property in AAC and Maryland, 2013

	Anne Arundel County	Maryland
% of students offered, sold, given illegal drugs on school property in the last 12 months	**30.90%**	**29.10%**

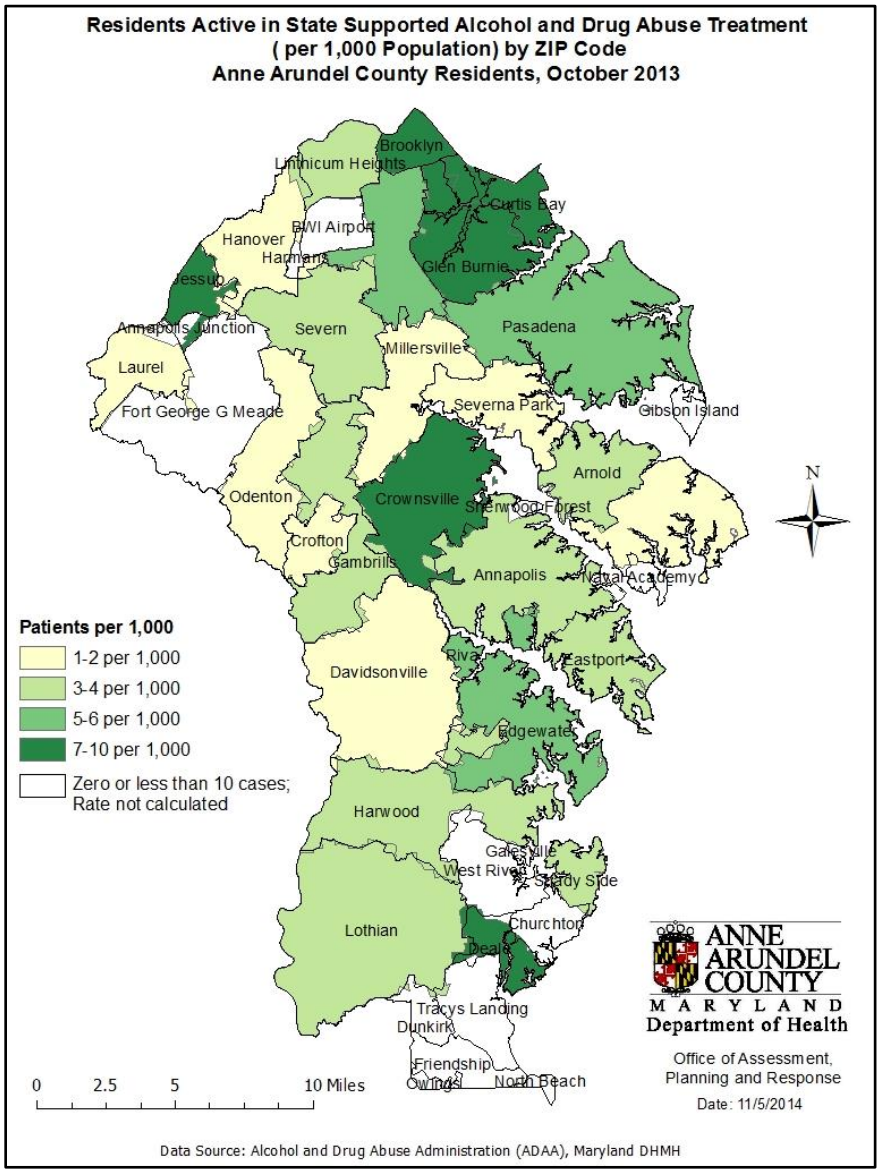
Source: YRBS

In Fall of 2012 through Spring of 2013 a county-wide Youth Substance Use Survey was conducted by the substance abuse prevention coalitions in AAC, including the CSC, NLASA, and WASP. Results below represent the percentage of AAC youth ages 12-20 who reported past 30 day prescription drug abuse according to zip code. One caveat to the survey is sample sizes were smaller in areas that were not part of the WASP or NLASA zip code areas. 6% of AAC youth, county wide, reported past 30 day prescription drug abuse. The top five zip codes in AAC with youth reporting past 30 day prescription drug abuse are Arnold (13%), Annapolis (11%), Hanover (9%), Severna Park (9%), and Eastport (9%).



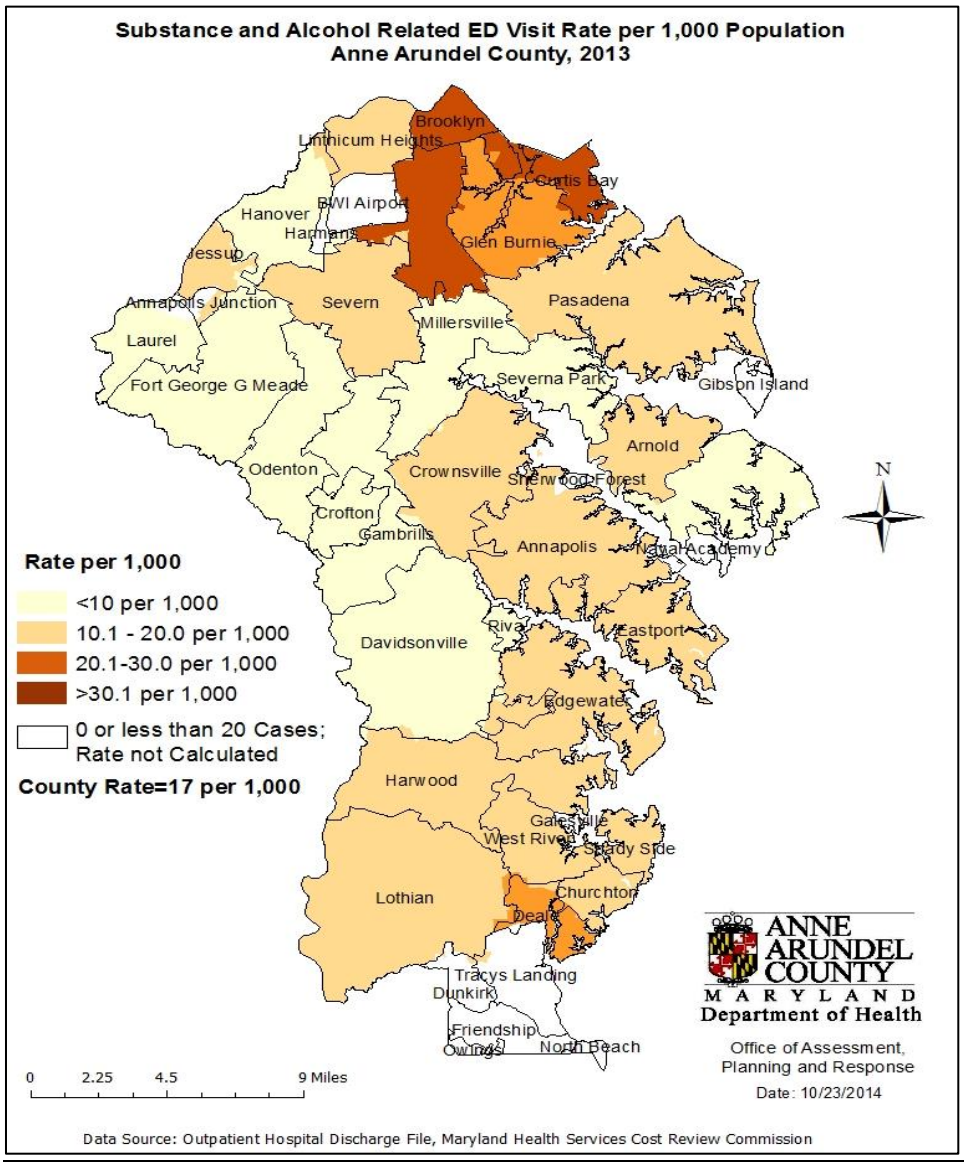
Source: Youth Substance Use Survey, AACDOH

The map below represents AAC residents who were active in state supported alcohol and drug abuse treatment, per 1,000 people, according to zip code. The darker the area is shaded green, the greater the number of people per 1,000 in treatment. In 2013, the top six areas with the highest number of residents in state supported treatment were Brooklyn Park, Curtis Bay, Glen Burnie, Jessup, Crownsville, and Deale. These areas had 7-10 per 1,000 residents who were in active treatment, more than the rest of the County. Two key points to keep in mind about the map are: 1. Those areas in the darker zip codes may have higher numbers of people who abuse substances since more people are seeking treatment, and 2. Those who are represented in this map have access to treatment. Lighter colored areas also may represent no access to treatment. Crownsville has a high concentration of residential treatment that accounts for the darker color on the map. Another limitation of the map is it does not include those who receive treatment through private insurance.



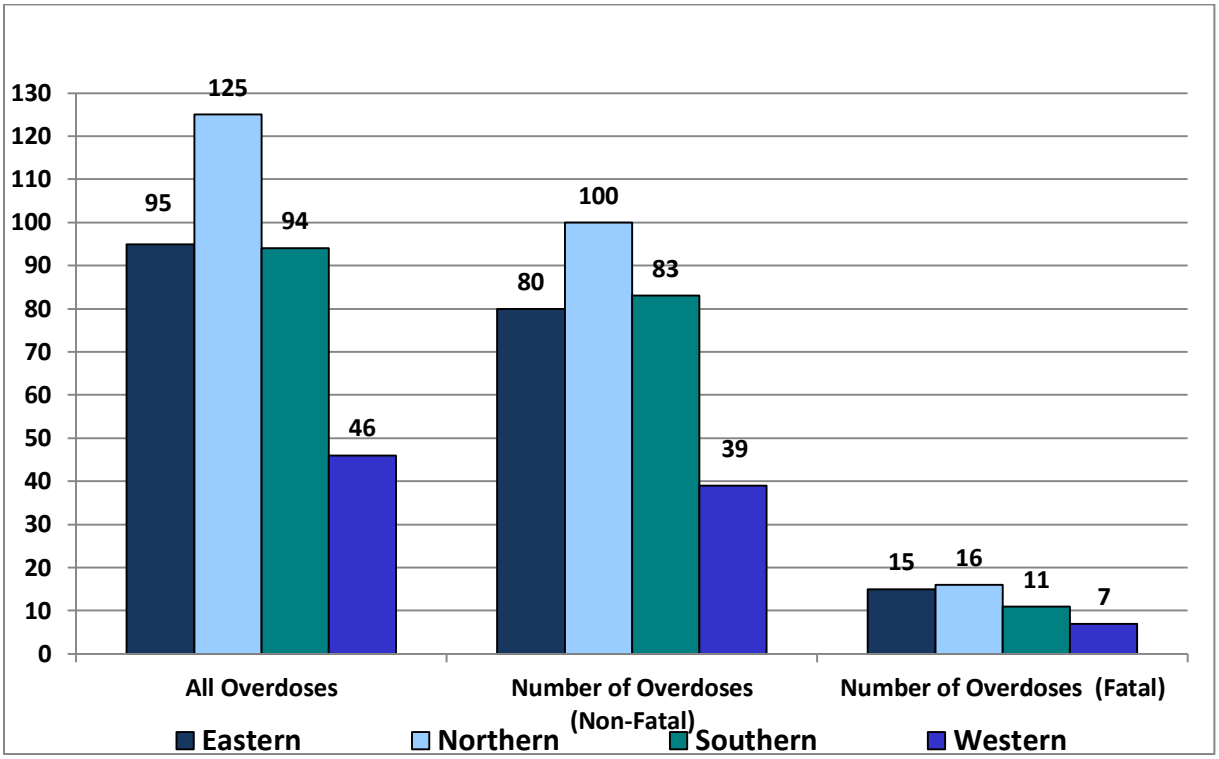
Consequences

The map below represents the rate of substance and alcohol related ED visits, per 1,000 people, according to zip codes in AAC. In 2013, the top four areas with the highest number of ED visits for substance and alcohol abuse were Brooklyn Park, Curtis Bay, Glen Burnie, and Deale. These areas had more than 30.1 ED visits per 1,000, compared to the county rate of 17 per 1,000. If data for opioid and/or heroin ED visits was isolated and analyzed, it would look similar to the picture below.



The AACPD collected data of opioid/heroin overdoses by district which is shown in the chart below. The chart illustrates the total overdoses, total non-fatal overdoses, and the total fatal overdoses.

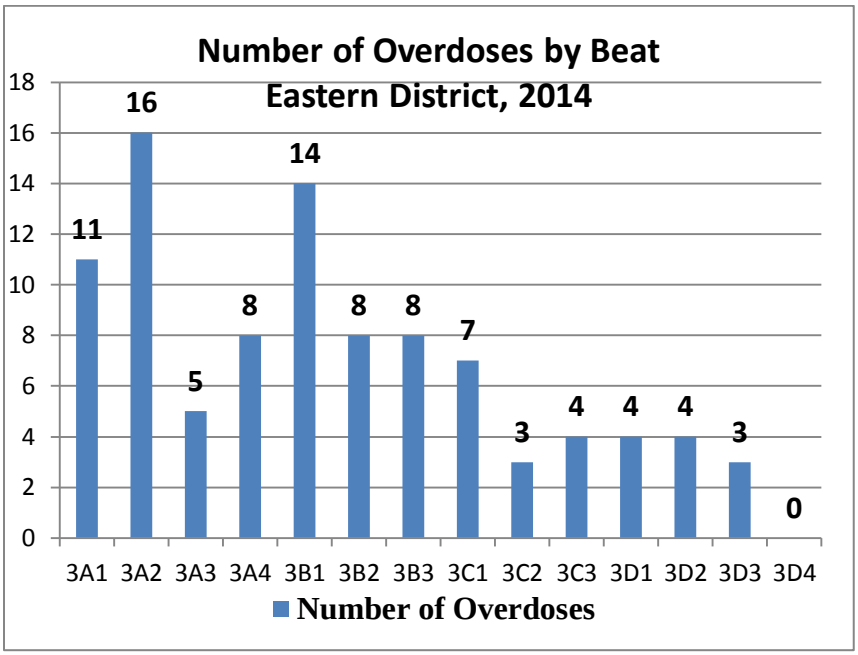
Heroin/Opioid Overdoses by District, 2014



Source: AACPD

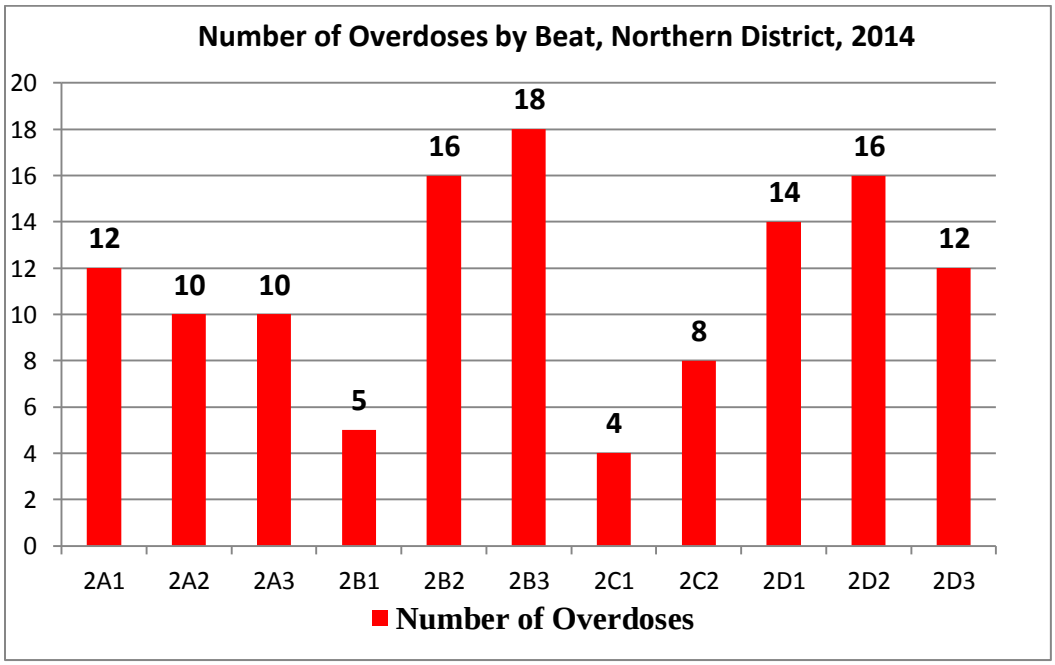
As indicated by the chart, more overdoses occurred in the Northern District in comparison to the other three districts. In Northern AAC, there were 125 total overdoses, 100 non-fatal and 16 fatal overdoses in 2014. The Eastern and Southern Districts had the next highest numbers of overdoses in AAC. There were 95 overdoses in Eastern AAC and 94 in Southern AAC. There were 80 non-fatal and 15 fatal overdoses in Eastern AAC and 83 non-fatal and 11 fatal in Southern AAC. The district with the least amount of overdoses in 2014 was the Western District. In Western AAC, there were 46 overdoses, 39 non-fatal and 7 fatal.

According to the AACPD, the number of opioid/heroin overdoses by beat are represented by each district below.



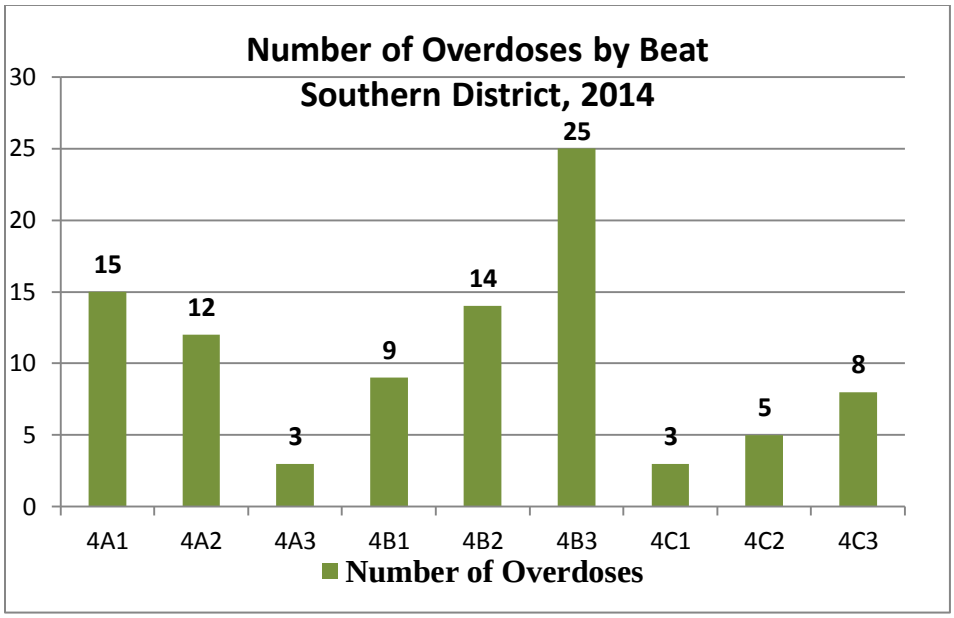
Source: AACPD

In the Eastern District, the areas with the highest number of overdoses were Pasadena (between Ft. Smallwood Road and Mountain Road) 3A2 with 16, Glen Burnie (off Crain Highway) 3B1 with 14, and Curtis Bay (Ft. Smallwood Road, Northern area) 3A1 with 11.



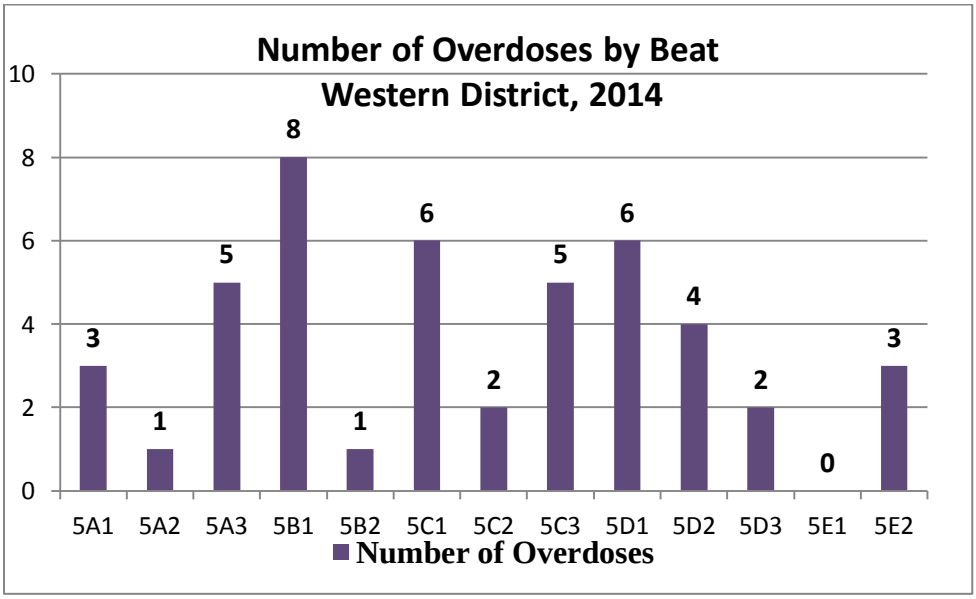
Source: AACPD

In the Northern District, the areas with the highest number of overdoses were Linthicum (between Baltimore & Annapolis Blvd and Andover Road) 2B3 with 18, Linthicum/Brooklyn Park (between Nursery Road and Belle Grove Road) 2B2 and Glen Burnie West (between Crain Highway and Ritchie Highway) 2D2, both with 16, and Glen Burnie West (between Crain Highway and Quarterfield Road) 2D1 with 14.



Source: AACPD

In the Southern District, the areas with the highest number of overdoses were Edgewater (between Central Avenue and Muddy Creek Road) 4B3 with 25, Annapolis (between Bestgate Road and West Street) 4A1 with 15, and Edgewater (between Muddy Creek Road and Solomons Island Road) 4B2 with 14.



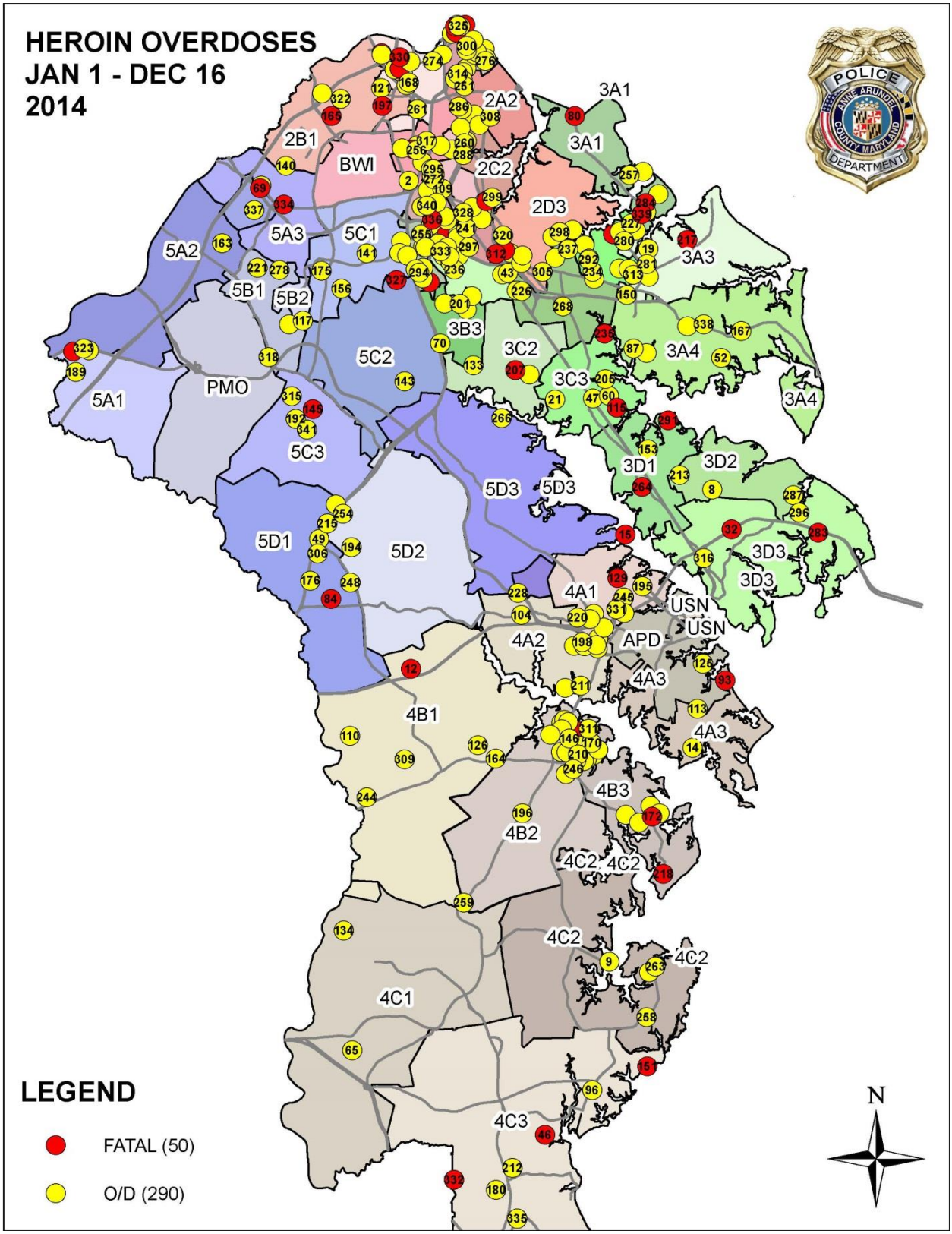
Source: AACPD

In the Western District, the areas with the highest number of overdoses were Severn (between Annapolis Road and Reece Road) 5B1 with 8, Severn Road (between Reece Road and Ridge Road) 5C1 and Crofton (between Crain Highway and Defense Highway) 5D1 with 6, and Hanover (between Arundel Mills Road and Dorsey Road) 5A3 and Odenton (between Crain Highway and Annapolis Road)5C3 with 5.

The top three locations for overdoses (fatal and non-fatal) in AAC for calendar year 2014 were:

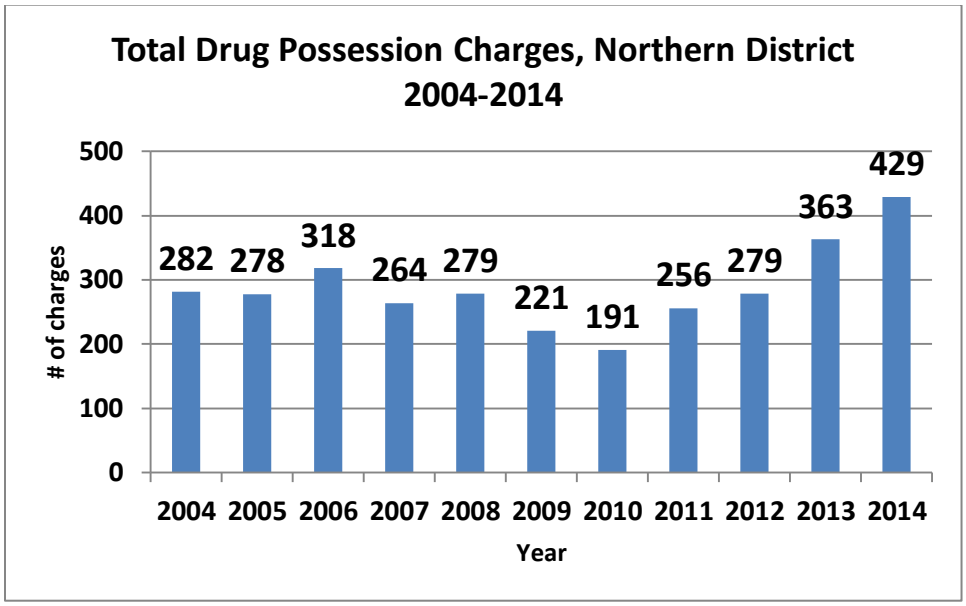
- Edgewater: beat 4B3 between Central Avenue and Muddy Creek Road – Southern District with 25 overdoses
- Linthicum: beat 2B3 between Baltimore and Annapolis Boulevard and Andover Road – Northern District with 18 overdoses
- Linthicum: beat 2B2 between Nursery Road and Belle Grove Road – Northern District with 16 overdoses
- Glen Burnie: beat 2D2 between Crain Highway and Ritchie Highway – Northern District with 16 overdoses
- Pasadena: 3A2 between Fort Smallwood Road and Mountain Road – Eastern District with 16 overdoses

The map below from the AACPD indicates the numbers and locations of fatal and non-fatal overdoses for calendar year 2014 without the last two weeks in December. It is consistent with other data showing areas with greater numbers of overdoses to be the Northern area, Brooklyn Park, Glen Burnie, and Pasadena. Also, greater numbers of overdoses in the South area, Edgewater and Annapolis. This data does not include data from the City of Annapolis Police, so some of the overdoses that occurred in Annapolis may not be included.

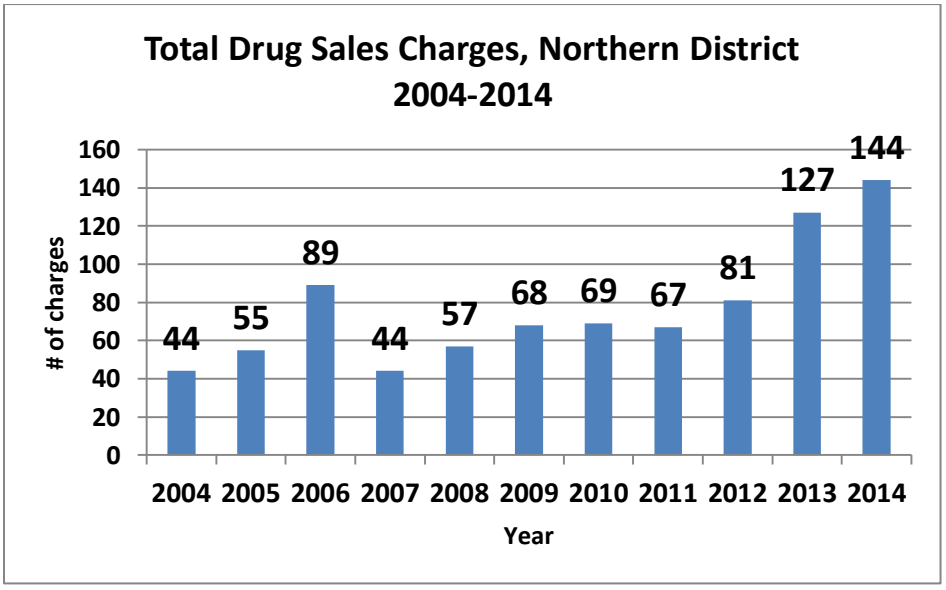

HEROIN OVERDOSES
JAN 1 - DEC 16
2014
POLICE
ANNE ARUNDEL COUNTY MARYLAND
DEPARTMENT
2B1
BWI
2A2
3A1
2C2
2D3
3A3
5A3
5C1
5A2
5B1
5B2
3B3
3C2
3A4
5C2
3C3
PMO
5A1
5C3
3D1
3D2
5D3
5D3
5D1
5D2
3D3
4A1
USN
USN
4A2
APD
4A3
4B1
4A3
4B3
4B2
4C2
4C2
4C2
4C2
4C1
4C3
LEGEND
FATAL (50)
O/D (290)
N

The next 8 charts represent AACPD data for total drug possession charges and total drug sales charges by district. Data includes all drug arrests except alcohol and marijuana related charges. This is analyzed by juvenile (under 18) and adult (18 and over).

In Northern AAC, drug charges for adults and juveniles have been steadily increasing in the past five years. For both drug possession and drug sales, the greatest number of arrests in the last eleven years were made in 2014.

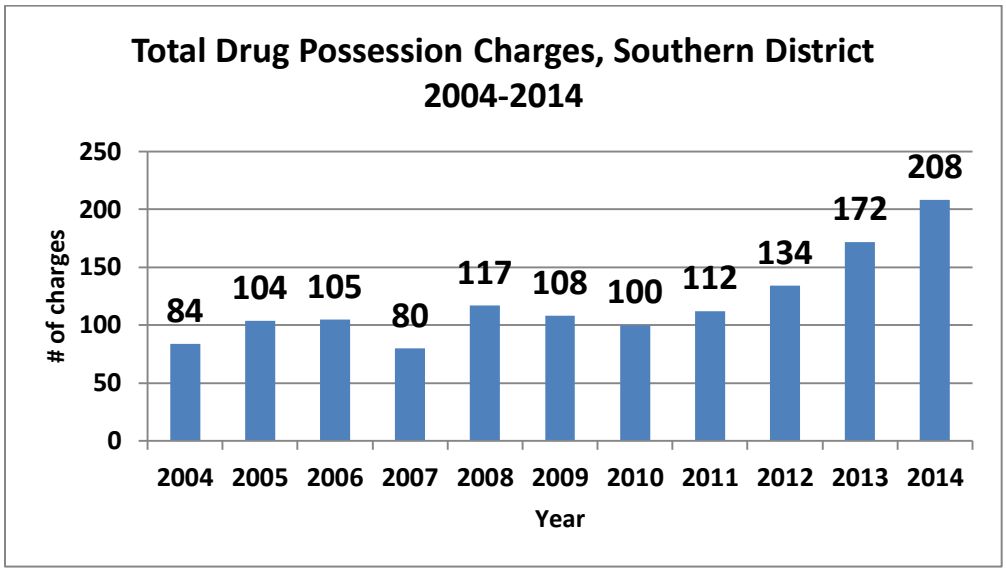


Source: AACPD

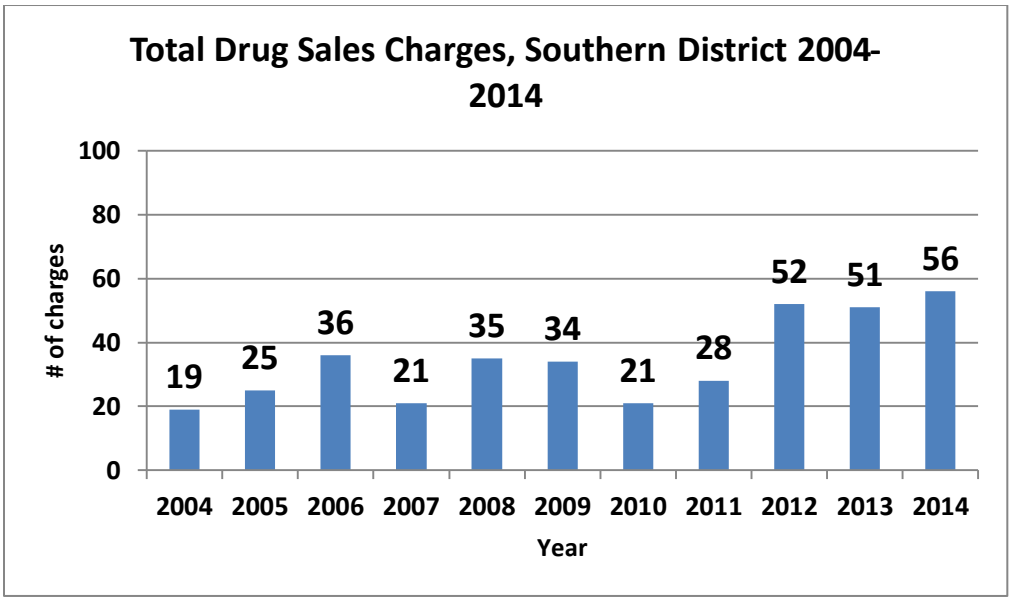


Source: AACPD

In Southern AAC, the total number of drug possession charges have increased steadily from 2010-2014. The total drug sales charges in Southern AAC have the greatest increases during 2012-2014. The greatest numbers of drug arrests in the last eleven years were for possession and sales in 2014.

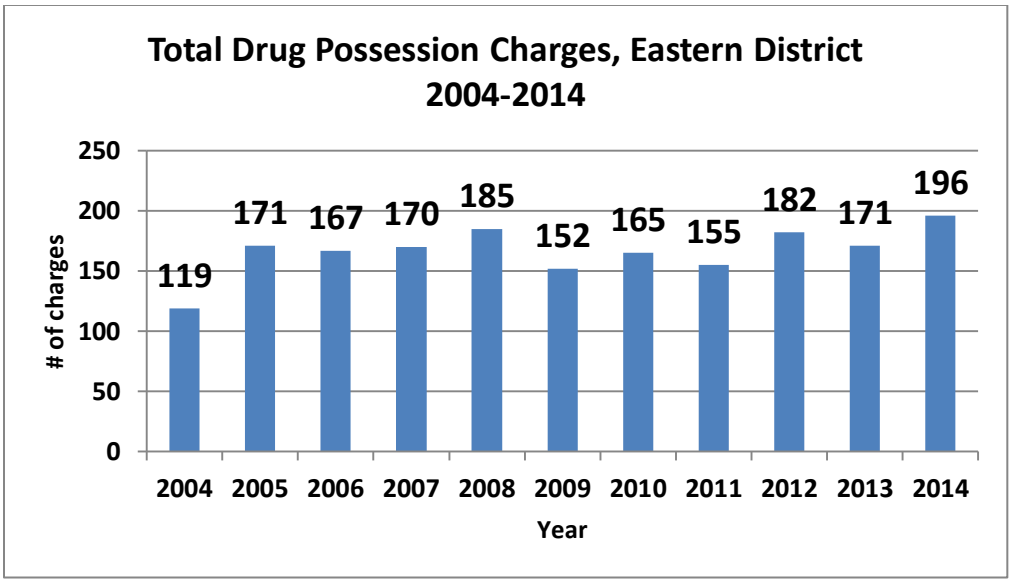


Source: AACPD

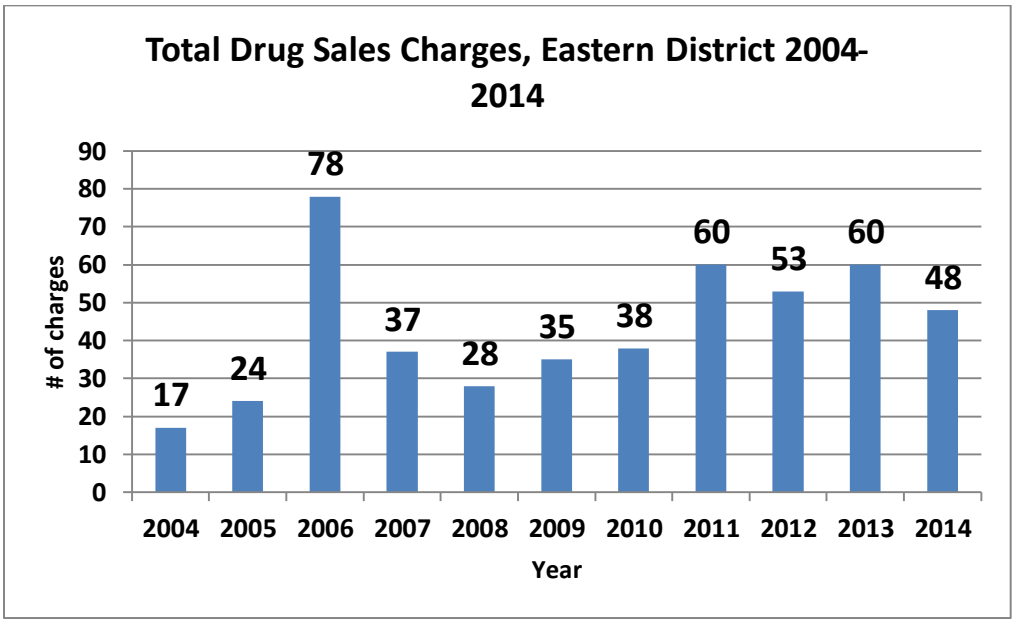


Source: AACPD

In Eastern AAC, the total number of drug possession charges were the highest in 2014 with 196 charges filed. The total number of drug sales charges are slightly higher from 2011-2014 than they have been in the past years, with the exception of 2006 with 78 charges. In Eastern District, the possession charges have not increased as much as Northern and Southern Districts in the last few years.

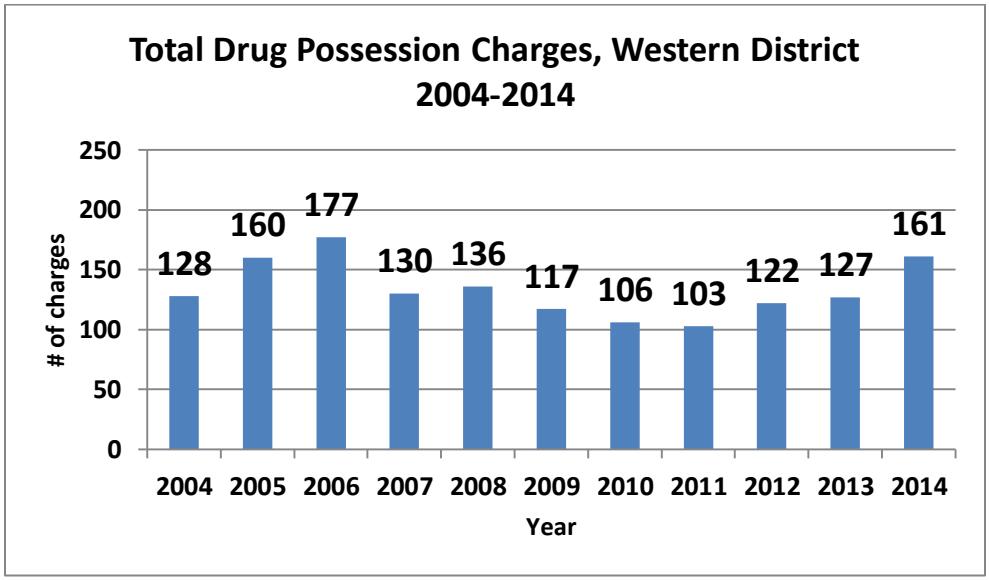


Source: AACPD

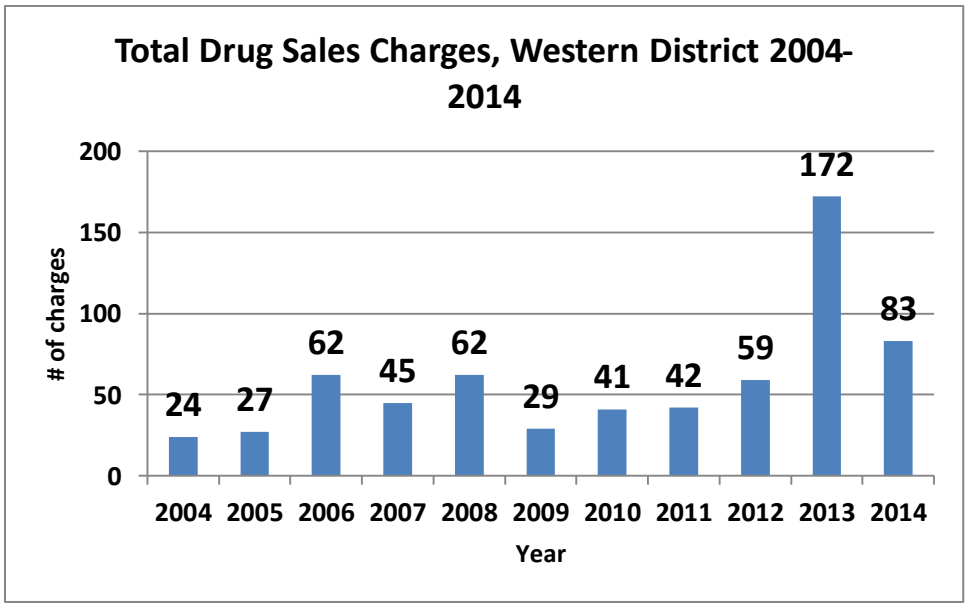


Source: AACPD

In Western AAC, the total number of drug possession charges steadily increased from 103 to 161 from 2011-2014. The total numbers of drug sales charges in Western AAC were the highest they have been in the past ten years during 2013 with 172 charges and 2014 with 83 charges.



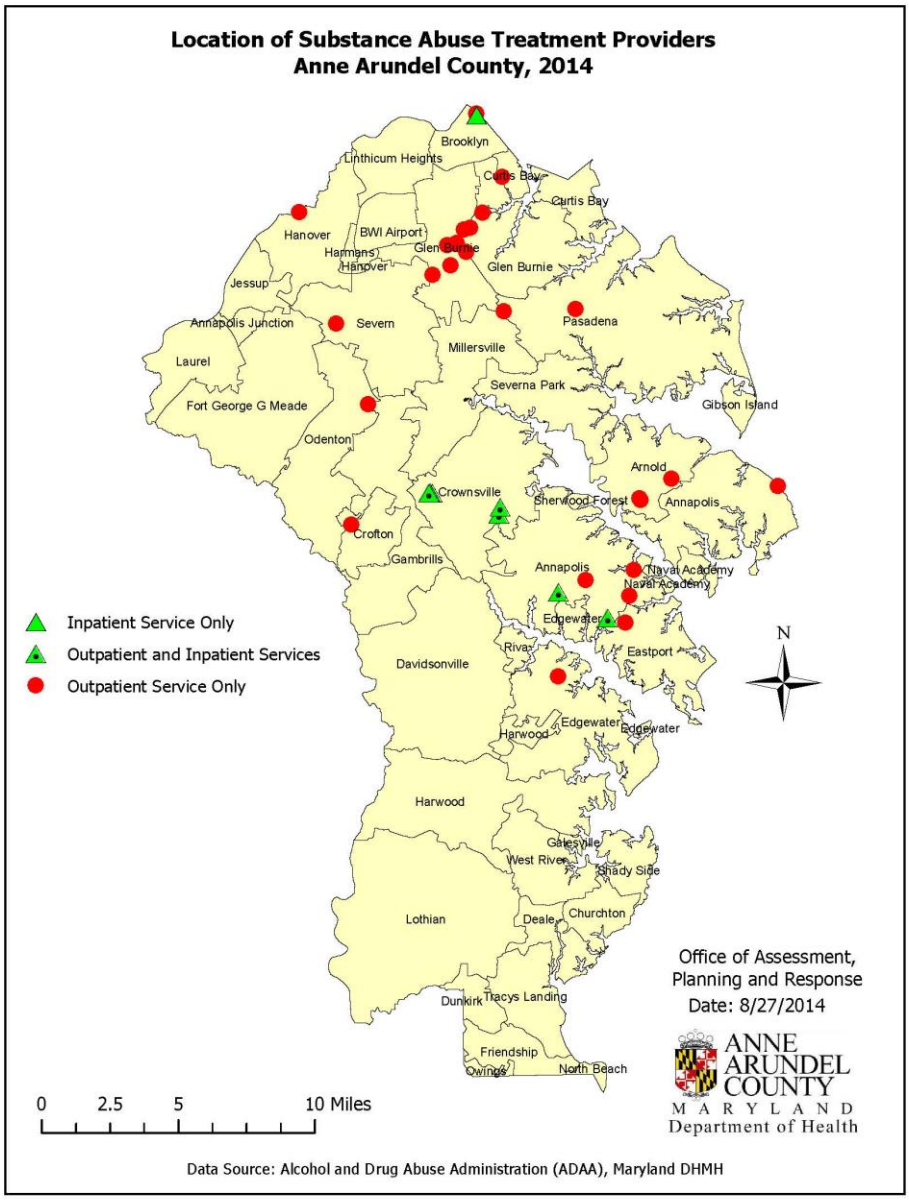
Source: AACPD



Source: AACPD

In assessment of all four districts in AAC, it can be concluded that police are charging adults and juveniles for possession of drugs more frequently than for distribution/sales of drugs. The highest number of charges was filed for drug possession in the Northern District in 2014 with 429 charges.

It is important to include the total number of treatment providers in AAC, levels of treatment, and where treatment centers are located. The map below shows treatment locations by levels of treatment. In 2014, there was one inpatient only treatment center, 5 outpatient and inpatient treatment centers, and 24 outpatient services only treatment centers. There are more treatment centers in the Northern part of AAC. There are no services in AAC south of Edgewater.



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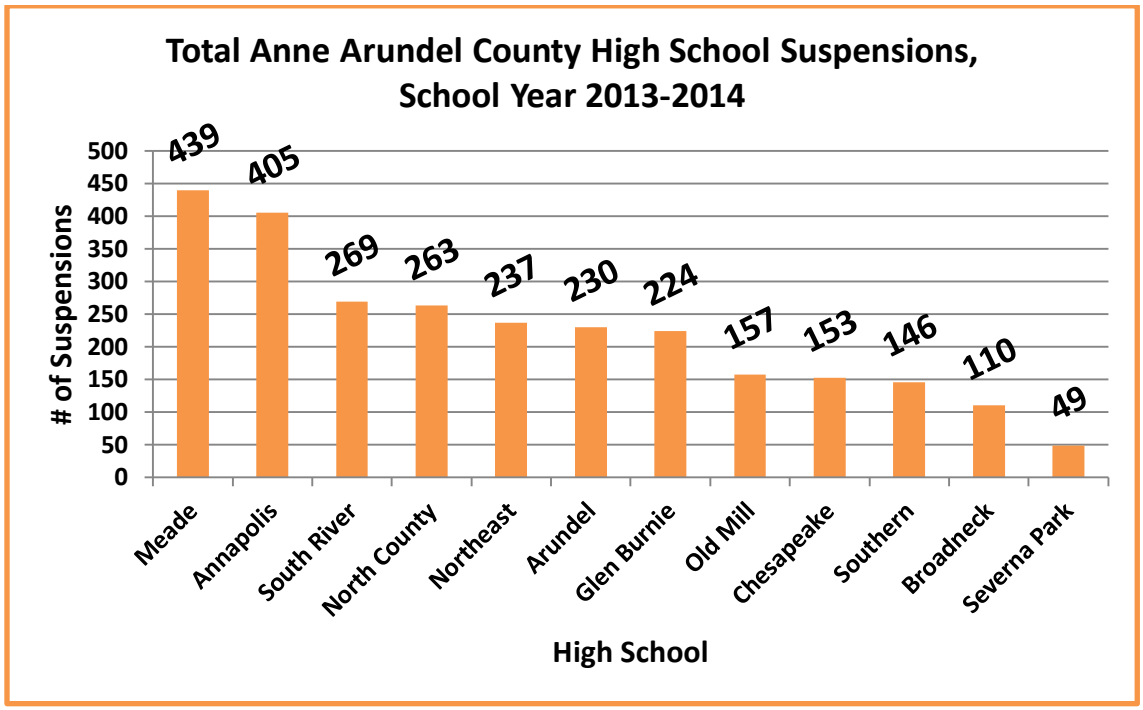
The following charts, from the MSDE, represent school data from 12 high schools in AAC during school year 2013-2014.

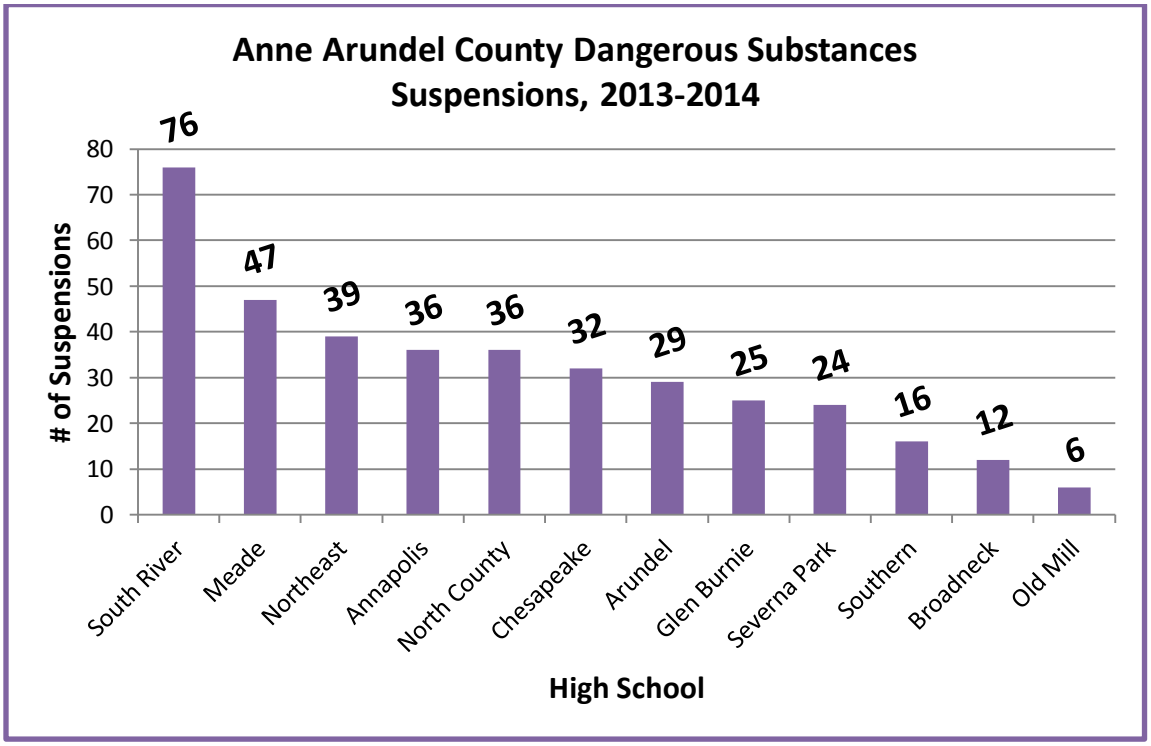


Source: MSDE

As indicated by the chart above for the 2013-2014 school year, the total AAC high school suspensions were the highest at Meade High School with 439 and Annapolis High School with 405. Below, the total suspensions are broken down by dangerous substances suspensions. According to the MSDE, this type of suspension can include incidences involving alcohol, inhalants, drugs, tobacco, selling or soliciting sale of controlled substances, and possessing or using illegal drugs.[14]

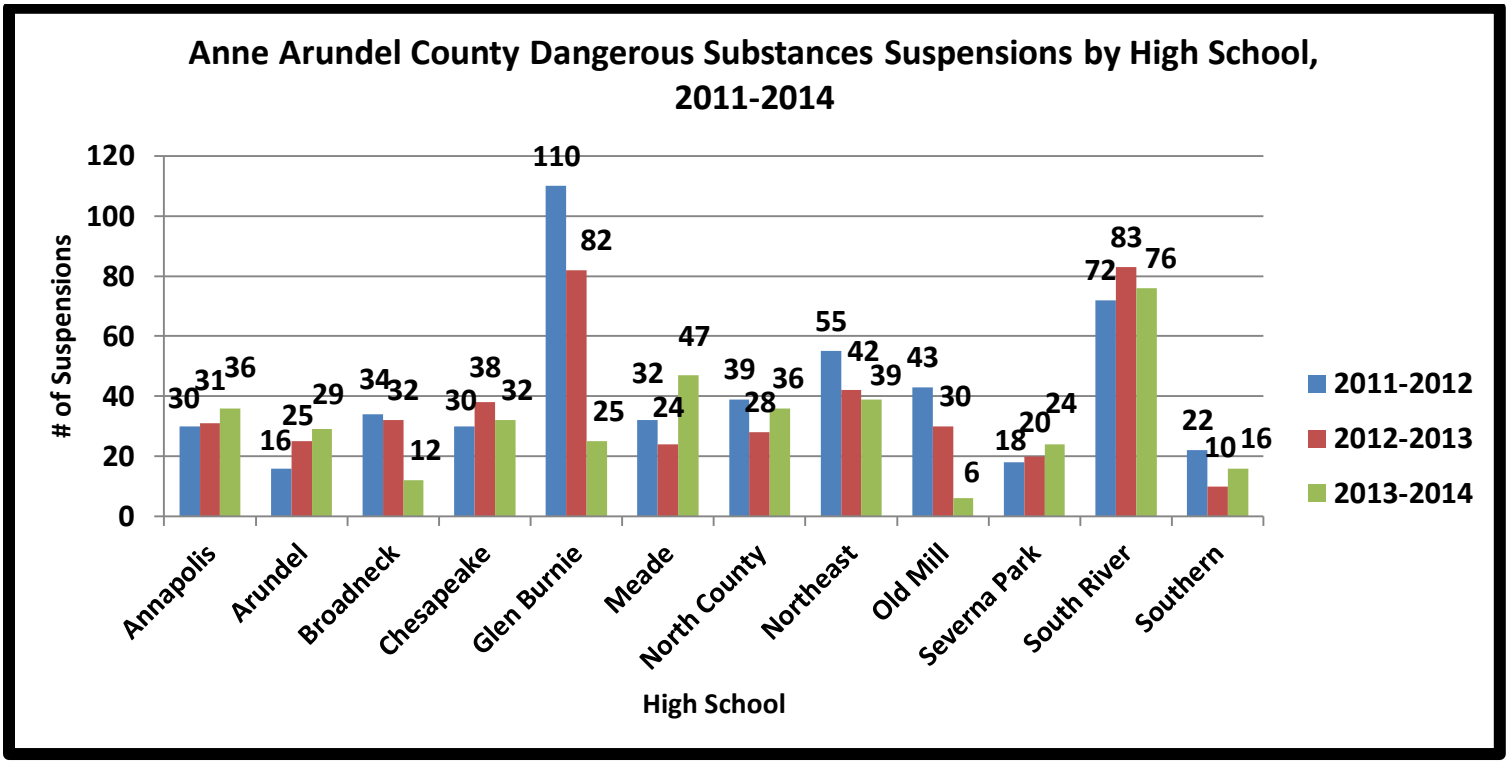
[14] Maryland State Department of Education, http://www.marylandpublicschools.org/MSDE/divisions/planningresultstest/doc/20122013Student/susp13_sch_comb.pdf, 2012-2013.

During the 2013-2014 school year, South River High School had the most dangerous substances suspensions with 76. The second highest was Meade High School with 47. Northeast High School had 39, and Annapolis High School and North County High School both had 36.



Source: MSDE

The chart below represents AAC dangerous substances suspensions by high school for the years 2011-2014. For the 2011-2012 school year, Glen Burnie High School had the most dangerous substances suspensions with 110. This number decreased to 82 for the 2012-2013 school year, and then decreased again to 25 for the 2013-2014 school year. South River High School remains the highest for numbers of dangerous substances suspensions with 72 for the 2011-2012 school year, 83 for the 2012-2013 school year, and 76 for the 2013-2014 school year.



Source: MSDE

These charts show drugs are available in schools and students use substances at school. School substance abuse policies may or may not be enforced based on decisions made by school administrators.

IV. INTERVENING VARIABLES RESULTS

A. RETAIL AVAILABILITY

Retail Availability or access is the amount and ease of obtaining prescription opioids through retail sources. In AAC, data from the MPOS, focus groups and key interviews were used to provide an analysis of retail availability.

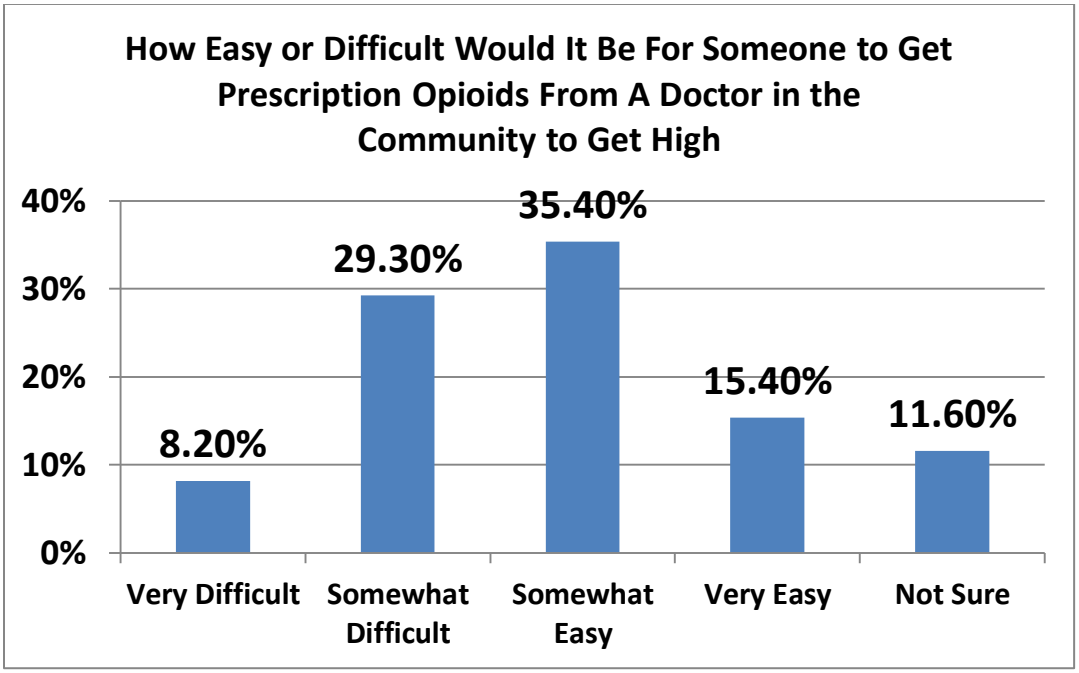
i. Present and discuss the data collected for retail availability that might contribute to opioid misuse consumption patterns and consequences in your community:

Although data from the State Prescription Drug Monitoring Program (PDMP) would have been a helpful source of data for analysis of this variable, it was unavailable at the time this needs assessment was written. The MPOS, focus groups, and key interviews were used to analyze retail availability.

Maryland Public Opinion Survey:

Two questions on the MPOS addressed retail availability. The question that asked, "How do people get their prescription opioids to get high?" three of the choices respondents could select were related to retail availability. 47.5% indicated people get their prescription opioids from doctors. 14.9% indicated fake prescriptions were a way to obtain prescription opioids. 3.8% indicated they could be obtained from pharmacists.

The second question on the MPOS asked about the ease or difficulty in obtaining prescription opioids from a doctor. The chart below shows the responses by category of ease of access.



Source: MPOS

As indicated by the chart, one third of respondents reported it would be somewhat easy to obtain prescription opioids from a doctor in the community to get high. More respondents reported easy or very easy (50.8%) versus somewhat difficult or very difficult (37.5%). About 11% reported they did not know the ease of access of prescription opioids from doctors in the community.

Focus Groups and Key Interviews:

The three most common responses in focus groups and key interviews concerning retail access were doctors overprescribe prescription opioids; youth are prescribed an excess of pain medication for sports injuries and other medical conditions; and doctor shopping is a problem in AAC. Doctors' overprescribing was mentioned in six focus groups and one key interview. Two of four focus groups of people in treatment or recovery (PITR) and two of three of substance abuse treatment providers (SATP) reported doctors overprescribe prescription opioids. Doctors over prescribing opioids was also mentioned as a concern at one of the community meetings, by the youth focus group, and the Department of Juvenile Services (DJS) key interview.

A common theme found in three focus groups and one community provider meeting is youth have an excess of pain medication prescribed to them due to sports injuries and other medical problems. Medical problems could be physical or mental. In addition, car accidents, dental procedures, and surgical procedures were mentioned as causes of youth excess of pain medication. This contributing factor was indicated by 2 of 4 focus groups of PITR, the youth focus group, and one community provider meeting.

According to the National Institute of Health, doctor shopping is defined as seeing multiple treatment providers, either during a single illness episode or to procure prescription medications illicitly.[15] Doctor shopping was mentioned as a problem in AAC by two focus groups of PITR, two focus groups of SATP, the school staff focus group, and one doctor key interview. It was indicated several times that patients lie to doctors to obtain prescription opioids.

Stealing prescription pads from doctors was mentioned as a problem by law enforcement and SATP. One pharmacist key interview revealed that our area is a hub for residents of other counties coming in to fill illegal prescriptions.

The cost of drugs of choice was also indicated repeatedly in all types of focus groups and key interviews as a contributing factor to retail access. Due to more limited access over the years due to controls such as policy changes, formulary changes, and increase use of the PDMP, it has become more difficult and expensive to obtain prescription opioids illegally. According to AACPD, prescription opioids sell for $60 for a high on the streets versus $10 for heroin.

Several times a lapse in insurance or unwillingness of physicians to continue to prescribe prescription opioids was noted. One focus group of SATPs indicated that lapses in insurance coverage cause people who are abusing the drugs to no longer have access to prescription opioids so they use heroin instead. One person in a SATP focus group stated that doctors will

[15] Sansone, Dr. Randy A., Innov Clin Neurosci (2012). Nov-Dec; 9(11-12) pp.42-46. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3552465/, 2015.

stop prescribing pain medications after a period of time but the person is already addicted. Then the person has to turn to drug dealers to purchase their drugs.

Three data sources, one focus group and two key interviews mentioned the use of the PDMP and CRISP. Most that knew about these data bases found them helpful, but slow, redundant, and time consuming. Of the 20 doctors participating in a focus group, some knew about the PDMP and some did not. None of them reported using it because it is so administratively burdensome.

A contributing factor mentioned in one law enforcement focus group and one key interview with a doctor indicated that doctors are likely to prescribe pain medication that is stronger than needed. It is difficult to judge levels of pain. Patient satisfaction is judged according to pain management.

Other key findings mentioned once or twice in focus groups or key interviews included:

- Drugs are available in open air daytime markets (mentioned twice)
- Close proximity and availability of drugs from Baltimore, including access to drugs at Lexington Market (mentioned twice)
- Narcan training has been an important strategy to decrease overdoses and raise awareness of opioid misuse in AAC (mentioned once)
- Doctors do not understand the science of addiction and recovery (mentioned once)
- Doctors have some awareness of the prescription opioid misuse problem (mentioned once)

ii. Discuss the impact of retail availability on opioid misuse consumption patterns and consequences in your community

Consumption

Ease of Access from Doctors

According to the MPOS as well as focus groups and key interviews, people think it is easy to get prescription pain medications from doctors. Since people think they can easily be prescribed these medications, their consumption of opioids increases which can lead to the greater possibility for opioid misuse. If people thought it was hard to obtain a prescription for pain medication from their doctors, consumption of opioids would decrease, therefore decreasing the chance of opioid misuse.

Initial Prescription of Pain Medications for Injuries

Through data collected from focus groups and key interviews, youth are prescribed prescription pain medications for sports injuries and other medical conditions. Instead of being referred to other ways of pain management, youth are initially being prescribed prescription opioids which

increase their consumption of opioids, which increases the opportunity for opioid misuse among youth.

Doctors Overprescribing Prescription Opioids

Findings from focus groups, key interviews, and community meetings indicate that doctors overprescribe prescription opioids. When people are prescribed an excess amount of prescription opioids, they are more likely to consume more. This increases the risk of opioid misuse for people who are overprescribed prescription opioids. If doctors did not overprescribe, the likelihood of opioid misuse would decrease.

Doctors and Pharmacists do not Use the Prescription Drug Monitoring Program (PDMP)

Doctors and pharmacists are unaware of the PDMP or do not have the time to use it. It is cumbersome and not user-friendly.

Cost of Prescription Opioids and Heroin

According to focus groups and key interviews, it is more expensive to get prescription opioids illegally than it is to buy heroin. Those who are addicted to prescription opioids eventually cannot afford them. As a result, they resort to buying heroin which is much cheaper leading to an increase in heroin consumption.

Insurance Lapses

Focus group findings indicate that insurance lapses cause those who are abusing prescription opioids to no longer have access to those drugs. There is an increase in heroin consumption when people switch from prescription opioids to heroin.

Consequences

Doctor Shopping

Through data collected from focus groups and key interviews, doctor shopping is prevalent in AAC. Once people become addicted to prescription opioids, they begin to doctor shop to support their habit. This could lead to an increase in the negative consequences of opioid misuse because people will have large quantities of prescription opioids from several different sources.

Stronger Drugs Being Prescribed by Doctors

According to focus groups and key interviews, doctors prescribe stronger prescription opioids for pain than needed. It was mentioned that since it may be difficult to judge levels of pain among patients, doctors prescribe opioids that are too strong which could lead to patients becoming addicted easily. If doctors prescribed weaker prescription pain medication, the likelihood of patients becoming addicted would decrease.

A. Retail Availability

1. Present the data and explain what do the data for your community reveal

Data Says:	Data Reveals:
Prescription Drug Monitoring Program is unknown or not used by doctors and pharmacists	If Pharmacists and doctors do not use the PDMP, patients have more access to prescription opioids
Residents are unaware that pain medication prescribed for sports injuries, chronic medical conditions, surgeries, etc. can lead to addition	If residents are unaware of the dangers of prescription opioid use youth and young adults are more likely to become addicted to prescription opioids.
Doctors over prescribe medications	If unused medications are not stored properly in the home and/or not returned to a take-back site, youth and young adults have increased access to prescription opioids.
Heroin is cheap	If heroin is cheaper than prescription opioids, youth and young adults who are addicted to prescription opioids will use heroin instead.
Prescription opioids are easy to obtain from doctors.	If prescription opioids are easy to obtain from doctors, those who are addicted will be more likely to doctor shop.
Lapses in insurance lead to the inability to continue to obtain prescription opioids	If prescription opioids are unobtainable due to lapses in insurance, those that are addicted are more likely to obtain prescription opioids or heroin on the street.
People doctor shop.	If someone becomes addicted to prescription opioids they may try to obtain more prescription opioids by use of multiple doctors.

2. Describe how each contributing factor is a main contributor to opioid misuse

- Lack of use of PDMP by pharmacists and doctors: If pharmacist and doctors do not use the PDMP, more people will access prescription opioids and opioid misuse will increase.
- Lack of knowledge that sports injuries, chronic medical conditions, etc. can lead to addiction: If people over use prescription opioids

for pain management, they are more likely to become addicted to prescription opioids.

- Doctors overprescribe prescription opioids: If doctors over prescribe prescription opioids, more people will have access to them and misuse will increase.
- Heroin is cheap: If heroin in cheaper than prescription opioids, those who are addicted to prescription opioids will progress to heroin use when they can no longer afford prescription opioids.
- Ease of access of prescription opioids from doctors: If it is easy to find a doctor to prescribe prescription opioids, it will be easier for those who doctor shop to abuse prescription opioids.
- Lapse in insurance coverage causes a discontinuance of prescription opioids: Those who have become addicted to prescription opioids and have lost insurance will turn to heroin when they can no longer obtain prescription opioids.
- People doctor shop: Those who become addicted to prescription opioids will doctor shop to obtain more prescription opioids.

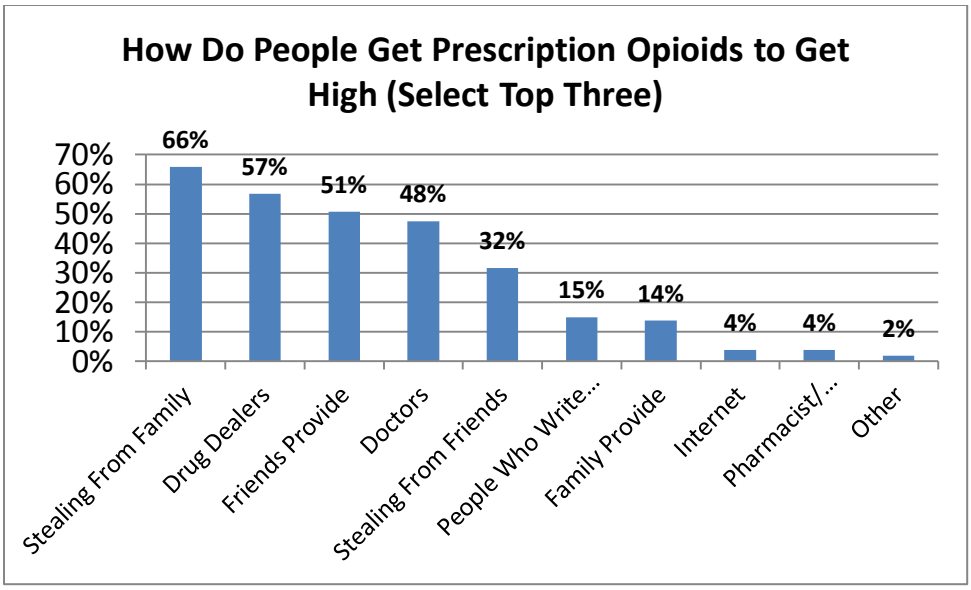
B. Social Availability

i. Present and discuss the data collected for social availability that might contribute to opioid misuse consumption patterns and consequences in your community

Social availability is the access one has to substances through social networks. Data to analyze social availability includes the MPOS, focus groups, key interviews, and the listing of current prescription drug drop boxes in AAC.

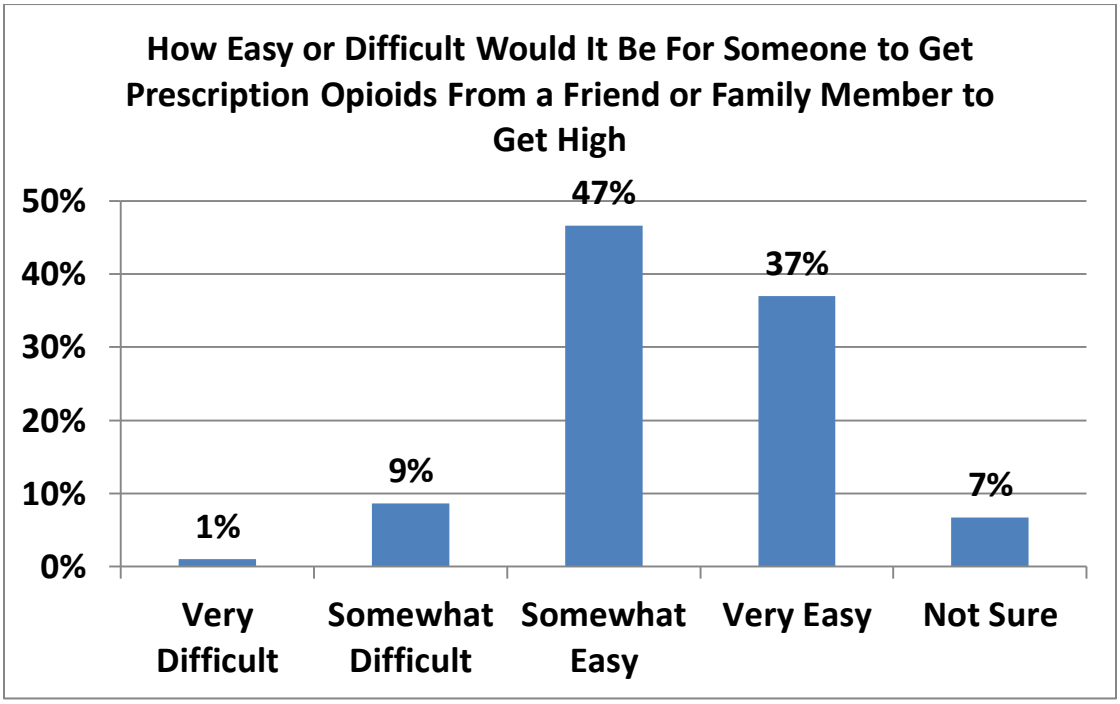
Maryland Public Opinion Survey:

Five questions on the MPOS provided data on social access. The chart below indicates the percentage of responses for answers to, "How do people get prescription opioids to get high?" Respondents could choose up to three responses. In AAC, the most common response was stealing from family with 66% of respondents selecting this answer. The second most frequent answer was drug dealers at 57%, followed by friends provide at 51%.



Source: MPOS

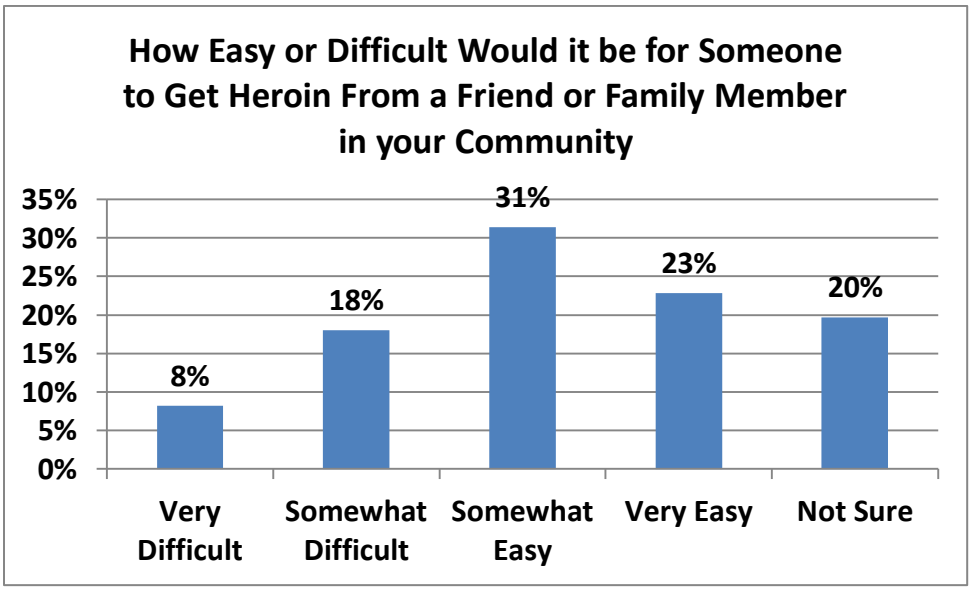
The next question on the MPOS that provided data on social availability was on the topic of ease or difficulty for someone to get prescription opioids from a friend or family member to get high.



Source: MPOS

84% responded that it would be very easy or somewhat easy to obtain prescription opioids from friends or family to get high. Only 8% responded it would be very difficult or somewhat difficult.

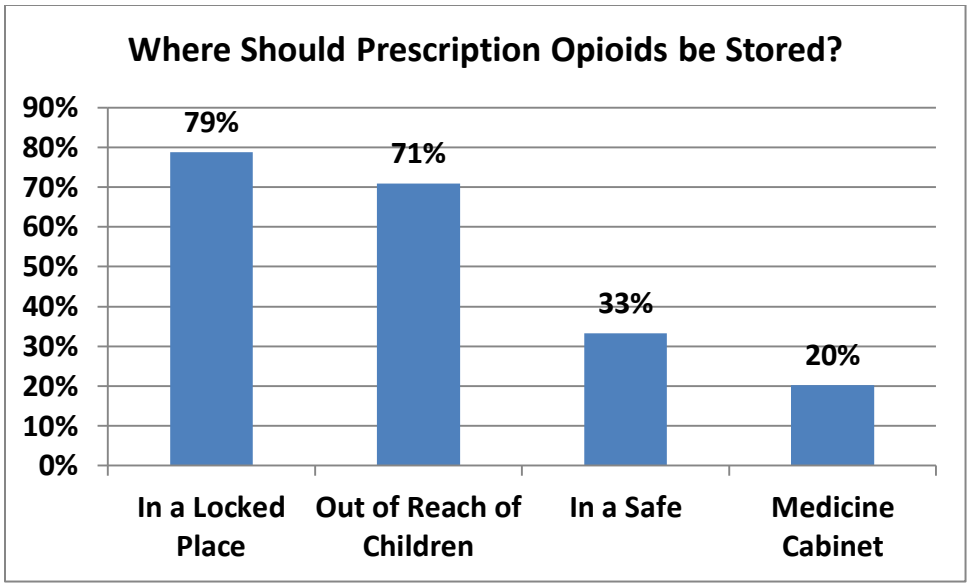
When asked the same question but about heroin instead of prescription opioids, the responses were as follows:



Source: MPOS

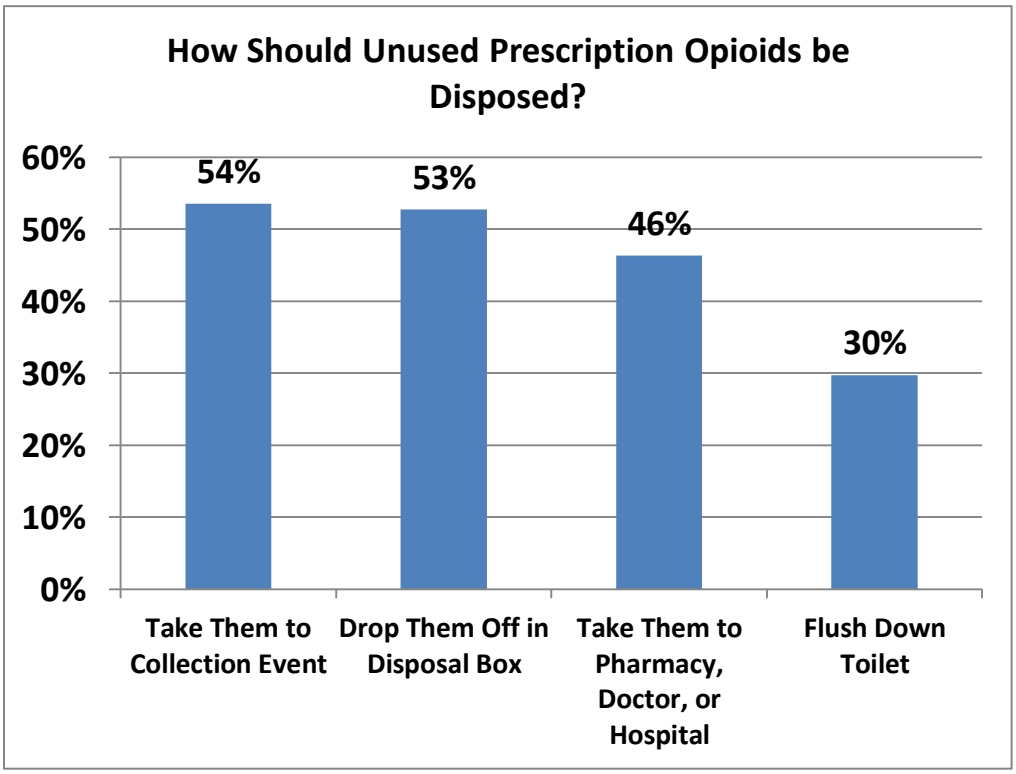
54% responded that heroin would be very easy or somewhat easy to get from a friend or family member. 26% indicated that heroin would be very difficult to somewhat difficult to get. Overall, according to the survey, people reported easier access to prescription opioids versus heroin.

Respondents were asked where prescription opioids should be stored. The survey stated to check all that apply. Four responses were selected by more than 10% of respondents. The most common response was "in a locked place," at 78% of respondents selecting this answer. It was followed by, "out of reach of children," at 70%. Over ¾ of respondents knew prescription opioids should be kept in a locked place.



Source: MPOS

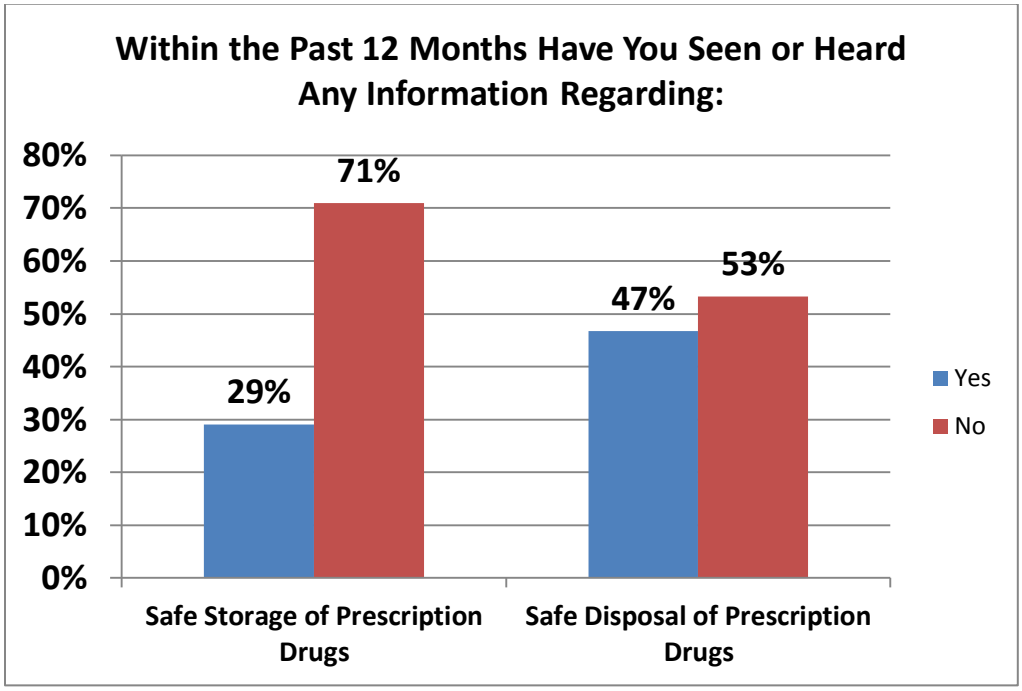
The last question asked respondents about disposal of unused prescription opioids. Respondents were asked to check all that apply.



Source: MPOS

Approximately half of respondents knew to take unused prescription opioids to a collection event. About half of respondents knew to drop them off in a disposal box. Almost half indicated they should be taken back to a pharmacy, doctor, or hospital.

When respondents were asked had they seen or heard any information regarding safe storage or safe disposal of prescription drugs in the past 12 months, more had seen or heard messages on safe disposal. 47% of respondents saw or heard a message on safe disposal of prescription drugs versus 29% for safe storage.



Source: MPOS

Focus Groups and Key Interviews

A common theme, overwhelmingly mentioned the most when asked about social access, was prescription drugs are stolen from family, friends, and neighbors in homes. Stealing of prescription opioids from homes was mentioned during nine focus groups and 3 key interviews. It was mentioned in 3 of 4 PITR focus groups, two SATP focus groups, the youth focus group, school staff focus group, one of the law enforcement focus groups, mothers of addicted children (MAC) focus group, pharmacist key interview, DJS key interview, and doctor key interview. Three sources specifically mentioned obtaining prescription opioids from family members.

The next highest mention on the topic of social access was youth obtaining prescription opioids from "pill parties." Although this was only mentioned during one of the PITR focus groups, it was mentioned by 3 of 4 SATP focus groups. It was also mentioned by the youth focus group, the DJS key interview, and doctor key interview.

It was specifically noted in four focus groups, one key interview, and one community meeting that medications are not stored properly in the home. They are not monitored and/or locked up. One of the law enforcement focus groups discussed and recommended purchasing a safe to lock prescription opioids.

According to the qualitative data collected, access to prescription opioids and heroin is easy to access through drug dealers. One treatment provider indicated that it starts with obtaining prescription opioids from family members, then it becomes stealing from neighbors, then it is turning a drug dealer. In one focus group of PITR, it was mentioned there were as many drug dealers in the County as there are in Baltimore. It is more expensive in County to purchase drugs. In this group, participants all traveled to Lexington Market in Baltimore to purchase their drugs.

The ease of accessing drugs, both prescription opioids and heroin from dealers, was mentioned in three focus groups and one key interview. Easy access of prescription opioids and heroin, in general, was mentioned by two additional qualitative data sources. Two focus groups, the youth and a group of PITR mentioned the easy access of any drug at school.

Drug deals take place in various locations across the County. The most common places mentioned were public places like 7-11, liquor stores, public bathrooms, and malls. Wooded areas and parks were also mentioned as areas where drug dealing takes place, especially in the rural south part of the County. Schools were also mentioned. Most of this data came from law enforcement and medical key interviews and law enforcement focus groups. It was mentioned that thefts are linked to drug activity with people stealing gift cards, lottery tickets, and car parts.

It was also noted in focus groups of law enforcement and PITR that the cell phone has "changed the drug game". The use of cell phones keep people moving and communicating. Due to changes in the law, it has become more difficult for law enforcement to seize cell phones to use as evidence in court.

It was also mentioned, specifically by some of the PITR groups, that people do not know about the drug take back locations. During one PITR group, when asked if they knew where to take back unused prescription drugs, only one of eight knew they could be taken to a police station in AAC.[16]

Some other comments on the subject of social availability mentioned in either one focus group or key interview were:

- Drugs are available in our County jails
- Parents/ adults have no idea of what is going on concerning the abuse of prescription opioids by youth

[16] See **Attachment E** for a list of Prescription Drug Tack Back locations.

- People returning from residential treatment know how to obtain drugs in their communities so it is easy for them to get them
- Youth have too much unsupervised time
- People obtain prescription opioids by using fake prescription pads

ii. Discuss the impact of social availability that might contribute to opioid misuse consumption patterns and consequences in your community

Consumption

Prescription Opioids are Stolen from Homes

By MPOS respondents, 66% indicated they believed those who abuse prescription opioids steal them from family members. This was followed by 57% indicating they believe prescription opioids are purchased from drug dealers, and 51% indicated friends provide prescription opioids to friends. This was also a common theme in key interviews and focus groups.

Youth and Young Adults Obtain Prescription Opioids at Parties

Focus groups and key interview responses indicate the common theme that pills are available at parties through friends. Youth who attend parties where their friends are abusing prescription opioids are more likely to abuse prescription opioids themselves.

Prescription Opioids Can be Purchased and Used in Public Places Including Schools

School data indicates dangerous substances are available at school. The YRBS shows 30.9% of high school students reported being offered, sold, or given illegal drugs on school property in the last 12 months. As indicated through focus groups and key interviews, drugs are being purchased and used in public places such as malls, 7-11's, and gas stations.

Consequences

Prescription Drugs are Not Monitored and Stored Properly in Homes

According to the MPOS, the majority of respondents, 79% know to keep prescription opioids in a locked place. 71% know to keep them out of reach of children. About a third of respondents indicated prescription opioids should be stored in a safe. Lack of monitoring and storage of prescription opioids in the home was mentioned often in focus groups and key interviews.

Unused or Expired Prescription Drugs are not Returned to Disposal Sites

Over 50% of MPOS respondents indicated unused or expired prescription opioids should be returned to a collection event. 53% of respondents indicated prescription opioids should be dropped off in a disposal box and 46% indicated they could be returned to a pharmacy, doctors,

or hospitals. 47% responded they had seen messages on safe disposal of prescription opioids in the last 12 months. It was also mentioned in focus groups and key interviews that people do not know to return unused or expired prescription opioids.

Doctors and Pharmacists do not Talk to Their Patients About the Dangers of Prescription Opioids

As indicated by the MPOS responses, respondents do not see messages or talk to their doctors or pharmacists concerning the dangers of prescription opioids. 23% of respondents reported seeing a message concerning the dangers of prescription opioids at their doctor's offices and 18% reported seeing messages at the pharmacy. 18% reported talking to their doctors about the dangers of prescription opioids and 6% reported talking to their pharmacists.

iii.Describe each contributing factor that you identified

1. Present the data and explain what do the data for your community reveal

Social Availability

Data Says:	Data Reveals:
Doctors and pharmacists do not discuss the dangers of prescription opioids with patients	If doctors and pharmacists do not discuss the dangers of prescription opioids with their patients, they may be unaware and suffer negative consequences due to opioid misuse.
There is a lack of knowledge of and convenience of drug take back sites.	If residents are unaware of prescription take back sites, youth and young adults at risk of addiction will have more access to prescription opioids in homes.
Opioids are available in homes.	If prescription opioids are available in homes, youth and young adults have increased access to stealing prescription opioids in homes.
Youth and young adults steal prescription opioids from homes.	If youth and young adults steal prescription opioids from homes, they are more likely to become addicted and suffer other negative consequences due to misuse.
Prescription opioids are not properly monitored and/or stored in homes.	If prescription opioids are not properly monitored and/or stored in the home, youth and young adults are more likely to misuse them.

Prescription opioids are available at parties and peers use.	If prescription opioids are available at parties, youth are more likely to abuse them, especially if peers are misusing prescription opioids.
Prescription opioids and heroin are purchased and used in public places, including schools.	If prescription opioids and heroin are available in public places, youth and young adults are more likely to purchase and use them.

2. Describe how each contributing factor is a main contributor to opioid misuse

- Doctors and pharmacists do not discuss the dangers of prescription opioids with patients: If patients are unaware of the dangers of prescription opioids they may be more likely to misuse them.
- Lack of knowledge and convenience of drug take back sites: If people do not know the importance of, where to return unused or expired prescription opioids, and/or cannot get to drug take back sites, there will be more prescription opioids available in homes.
- Opioids are available in homes: If prescription opioids are available in homes, there is a greater opportunity for youth and young people to misuse them.
- People steal prescription opioids from homes: If prescription opioids are in homes, youth and young adults have an opportunity to steal them.
- Lack of monitoring/storing of prescription opioids: If prescription opioids are not monitored or locked up, youth and young adults are more likely to misuse them.
- Prescription opioids and other drugs are available at parties, peers use: If prescription opioids are available at parties, youth and young adults are more likely to misuse them, especially if their peers engage in misuse behavior.
- Prescription opioids and heroin are purchased and used in public places: If prescription opioids and heroin are purchased and used in public places, opioid misuse will increase as drugs are easy to obtain.

C. Enforcement and Adjudication

Enforcement is the impact of law enforcement practices on opioid misuse consumption patterns and consequences. This includes the enforcement of rules, laws, and policies regarding substance abuse and its consequences. This intervening variable takes into

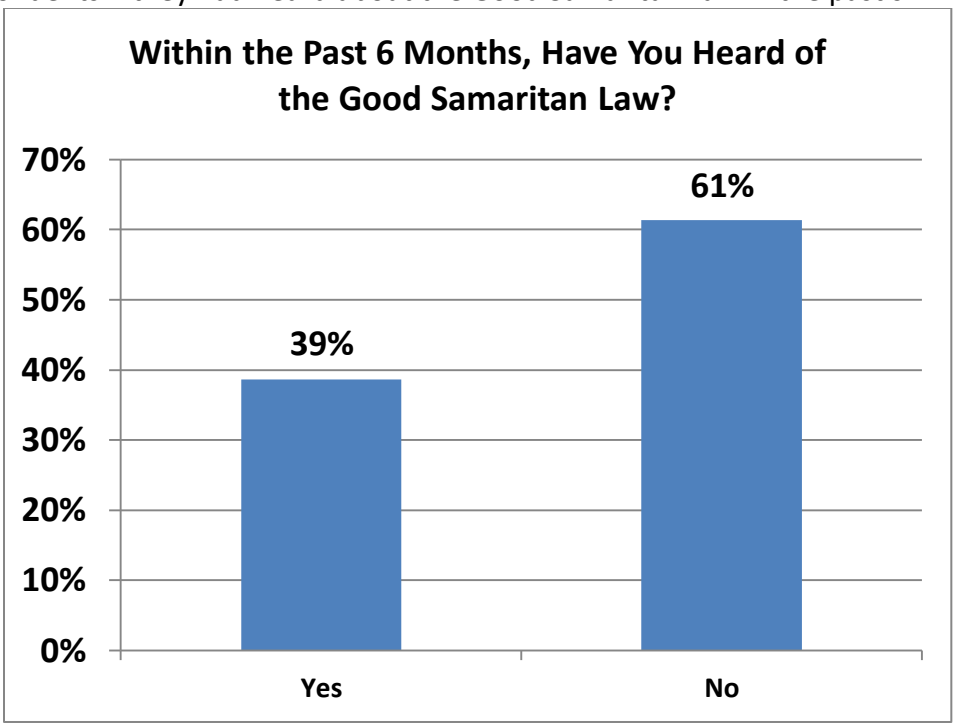
consideration the public's perception of levels of enforcement and how likely people are to believe they will get caught.

i.Present and discuss the data collected for law enforcement and adjudication that might contribute to opioid misuse consumption patterns and consequences in your community

The data used to analyze enforcement include the MPOS, opioid-related drug arrests, school data, focus groups, and key interviews.

Maryland Public Opinion Survey:

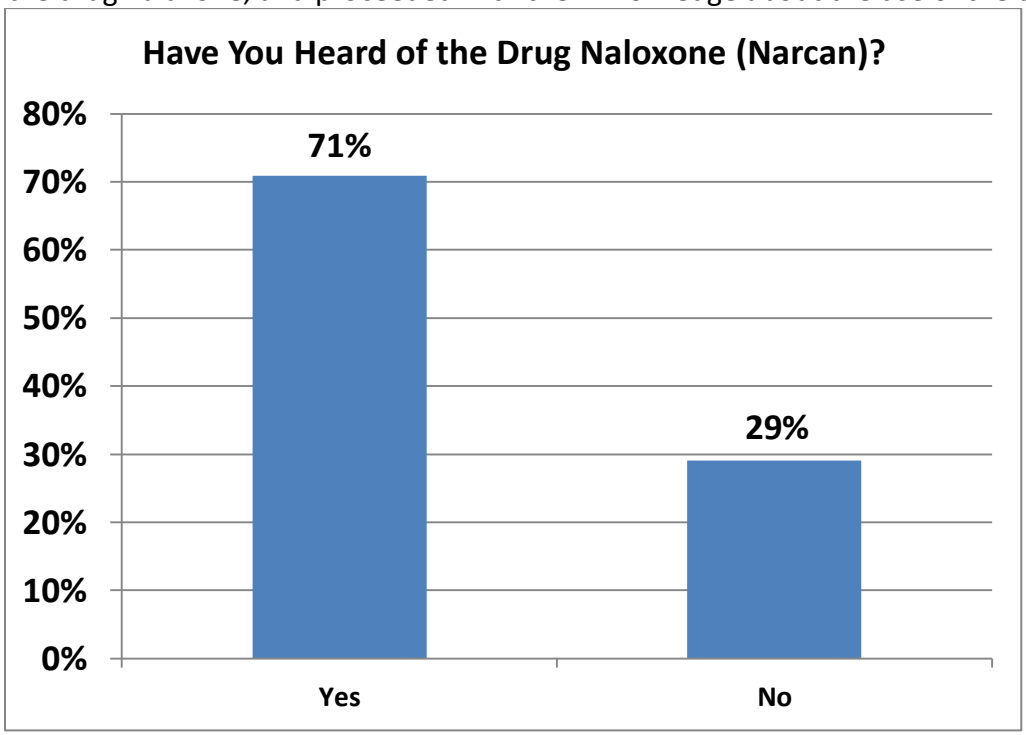
Three questions from the MPOS addressed enforcement and adjudication. The first question asked respondents if they had heard about the Good Samaritan Law in the past six months.



Source: MPOS

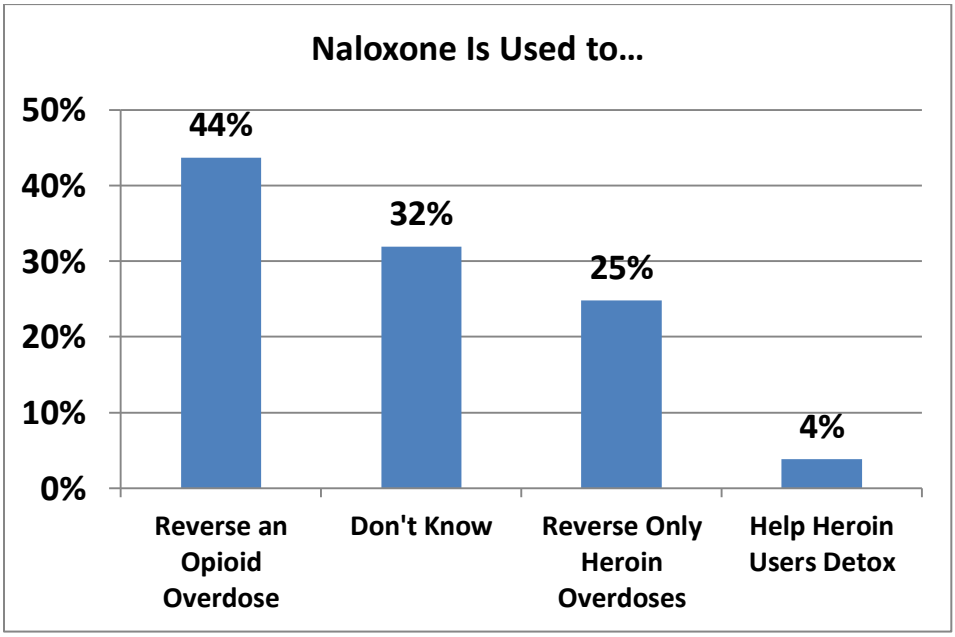
61% of AAC respondents had not heard of the Good Samaritan Law, and only 39% claimed that they had heard of it.

The next two questions from the survey that addressed enforcement asked if respondents have heard of the drug nalaxone, and proceeded with their knowledge about the use of the drug.



Source: MPOS

71% of respondents, almost three-quarters, have heard about the drug nalaxone (Narcan). 29% have never heard of the drug.



Source: MPOS

44%, almost half of the respondents, said that naloxone is used to reverse an opioid overdose followed by 32% who did not know its use. 25% think Naloxone is used to reverse heroin overdoses only.

Opioid Related Drug Arrests: See drug arrests data above.

Other Police Overdose Data: See consequences data above.

School Incident and Discipline Reports: See "where" data, consequences above.

Focus Groups and Key Interviews:

Focus group and key interview findings on the subject of enforcement were not as consistent as the other intervening variables. The enforcement issue mentioned the most was shortage of officers. This was mentioned during 3 focus groups and two key interviews. It was mentioned by law enforcement, youth, and PITR focus groups. There is only one officer in AAC assigned to investigate prescription fraud. One group of PITR mentioned there was too much enforcement. One person said, "the police are on top of it, they are everywhere."

The second most mentioned theme on enforcement was that those that are arrested for possession should be offered treatment instead of punishment. This was mentioned by PITR, one law enforcement officer, and two medical providers. In the PITR focus group, drug court was mentioned as a great alternative to incarceration.

There were a variety of perceptions on who is getting arrested for drug possession and dealing. In one SATP focus group, it was mentioned that people get arrested for possession. Two focus groups clearly mentioned drug dealers were being arrested for selling/ distribution. In another focus group of SATP it was mentioned drug dealers are not being arrested. During a law enforcement focus group, it was discussed that dealers know to sell below 6 grams of heroin to avoid Federal prison. One person in a SATP focus group said police know the hot corners but nothing gets done. In one of the PITR focus groups, a participant stated that police should go after dealers and not users. In a focus group of SATP, one person mentioned that there is a lack of enforcement because they overlook the problem. In a community meeting, one parent said the police do not arrest for drug possession, they call the parent to come pick them up.

In two key interviews of South County residents, it was noted that there has been an increase in police surveillance due to drug activity. It was also noted the creation of the police Heroin Task Force is a good solution to help with the problem of drug use. In two focus groups, one of PITR and the other SATP, it was mentioned that the police do not understand addiction and the community resources that are available to address the problem. This works both ways as throughout the data collection, it was clear that treatment providers do not understand the role of law enforcement in combating the opioid misuse problem in our community.

Additional enforcement topics were mentioned that did not involve the police. Courts and adjudication were mentioned in PITR focus groups. It was mentioned the courts are too strict with no second chances. Also, judges lack the knowledge and understanding of addiction.

In two PITR focus groups it was discussed that doctors and pharmacists should be held accountable for their role in opioid misuse. Schools were mentioned in one key interview. One person said school policies on substance abuse and youth under the influence of a substance at school are not enforced.

Other comments on enforcement mentioned once:

- It is great the police have Narcan
- Anne Arundel County police are more understanding of addiction compared to Baltimore City police
- EMS has stereo types of substance users. Police do not stereotype as much as EMS.
- There is a fear of arrest if unused prescription drugs are returned to police stations.
- Drug dealers know limitations and loop holes in the law to avoid Federal court.
- White people use the drugs and African Americans deal the drugs.
- Drug dealers can be charged with overdose deaths
- Pharmacists work with police and report fake prescriptions
- Petty thefts have increased due to drug addiction.

ii.Discuss the impact of law enforcement and adjudication on opioid misuse consumption patterns and consequences in your community

Consumption

Shortage of Police Officers to Address the Opioid Misuse Problem

Through data collected from focus groups and key interviews, some with law enforcement and some other groups, findings show there is a shortage of police officers to address the opioid misuse problem. Since there is a lack of enforcement, this leads to increase use of opioids as the risk of getting caught decreases. More officers in the community would decrease consumption as it increases the chances of charges for opioid misuse.

Judges are lenient in sentencing of drug offenders

Those who spoke of adjudication, except PITR, stated sentencing for drug offenders is lenient. If those who are charged had stricter sentences or more access to diversion programs such as Drug Court, consumption of opioids would decrease as people would be more fearful of stricter penalties.

Prescription Opioids and Heroin are Purchased and Used in Public Places

Through law enforcement and other key interviews and focus groups, people are purchasing and using prescription opioids and heroin in public places such as the mall, 7-11's, parking lots, etc.

Consequences

Lack of Knowledge of the Good Samaritan Law

According to the MPOS as well as focus groups and key interviews, people did not know about the Good Samaritan Law or have confidence in using it. Some officers from AACPD did not know about the Good Samaritan Law. This could lead to increased negative consequences of opioid misuse as people will not call for help when someone is overdosing.

Lack of Knowledge of Naloxone and Its Use

The MPOS showed there is lack of knowledge of the use of Naloxone. This could lead to increased overdoses as people are not trained to administer it in a situation where it could save the life of a friend or family member.

Use of Substances at School

School data shows there are dangerous substances suspensions at every County high school. This shows there is substance use at every County high school. Use at school results in negative consequences such as poor school performance.

Officers Refer for Treatment or Call Parents Instead of Issuing Juvenile Possession Citations

According to data from AACPD, the number of juvenile drug possession charges are low. Officers are more likely to call crisis response or call a family member than issue a citation. If citations were issued, people would have an increased perceived risk of negative consequences.

Doctor Shopping and "Pill Mills" exist in Anne Arundel County

According to focus groups and key interviews with law enforcement, medical providers, and pharmacists, people doctor shop after they become addicted to prescription opioids. The police investigate doctor shoppers, pharmacists, and doctors for illegal activity related to prescription opioid abuse.

iii.Describe each contributing factor that you identified

1. ***Present the data and explain what do the data for your community reveal***

Enforcement

Data Says:	**Data Reveals:**
Shortage of officers to address the opioid misuse problem	If there is a shortage of officers, those who misuse opioids and/or heroin are less likely to be arrested/charged.
There is a lack of knowledge/confidence in the Good Samaritan law.	If there is a lack of knowledge/confidence in the Good Samaritan law those who are on the scene are less likely to call for help when someone is overdosing.
Police do not charge youth for possession, they call their parents.	If police do not charge youth for drug possession, they may have lower perceived risk of negative consequences of opioid misuse.
Penalties for drug sentencing are not severe enough.	If penalties for drug sentencing are not severe enough, those who are charged with possession and sales will have lower perceived risk of negative consequences.
Drugs are available in schools.	If drug policies are not enforced in schools, youth are more likely to sell, purchase, and use substances at school.
Doctor shoppers, pharmacists, and doctors are sometimes involved in illegal activities related to prescription opioids.	If the police investigate and follow-up on illegal activity due to prescription opioids, such as doctor shopping and "pill mills" these illegal activities will decrease.
The public has a lack of knowledge of Narcan and how to use it. Police and EMS are trained to use Narcan.	If the public is educated on Narcan and how to use it, overdose fatalities would decrease. EMS and the police are trained to use Narcan to save lives.
Prescription opioids and heroin are purchased and used in public places	If prescription opioid and heroin surveillance and patrols are increased in public places, increased enforcement would decrease public drug activity

2. *Describe how each contributing factor is a main contributor to opioid misuse*

- Shortage of police to address the opioid misuse problem: If police surveillance to address opioid misuse was increased, the risk of being caught would increase leading to a decrease in opioid misuse.
- Lack of faith/ knowledge of the Good Samaritan law: If there was a greater knowledge in the Good Samaritan law, those who witness an opioid overdose would be more likely to call for help, thus saving lives.
- Police do not arrest youth for opioid possession, they call their parents: If youth are charged for prescription opioid possession, they would more likely perceive it as risky and would be less likely to misuse opioids.
- Penalties for drug sentencing are not severe enough: If penalties for drug offenders were increased, the perceived risk of negative consequences would increase, decreasing opioid misuse.
- Drugs are available at school: If school policies on drugs are not enforced, youth perceived risk of negative consequences will decrease.
- People doctor shop: If police work with doctors and pharmacists to identify people who doctor shop, prescription opioid misuse would decrease.
- Prescription opioids and heroin are purchased and used in public places: If police increase surveillance and drug patrols, opioid misuse in public places will decrease.
- Lack of knowledge of Narcan and how to use it: If more people are trained to use Narcan, the number of prescription opioid deaths will decrease.

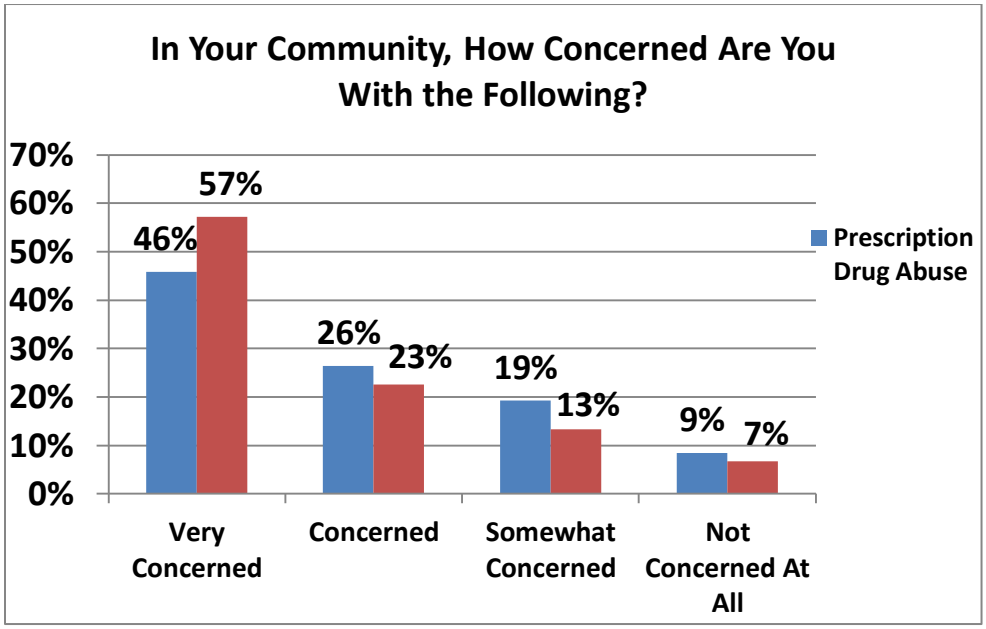
b. Community Norms

Community norms involve the acceptability or unacceptability of opioid misuse in the community. Data used to analyze community norms includes the Public Opinion Survey, focus groups, key interviews, and town hall meetings.

i. **Present and discuss the data collected for community norms that might contribute to opioid misuse consumption patterns and consequences in your community:**

Maryland Public Opinion Survey

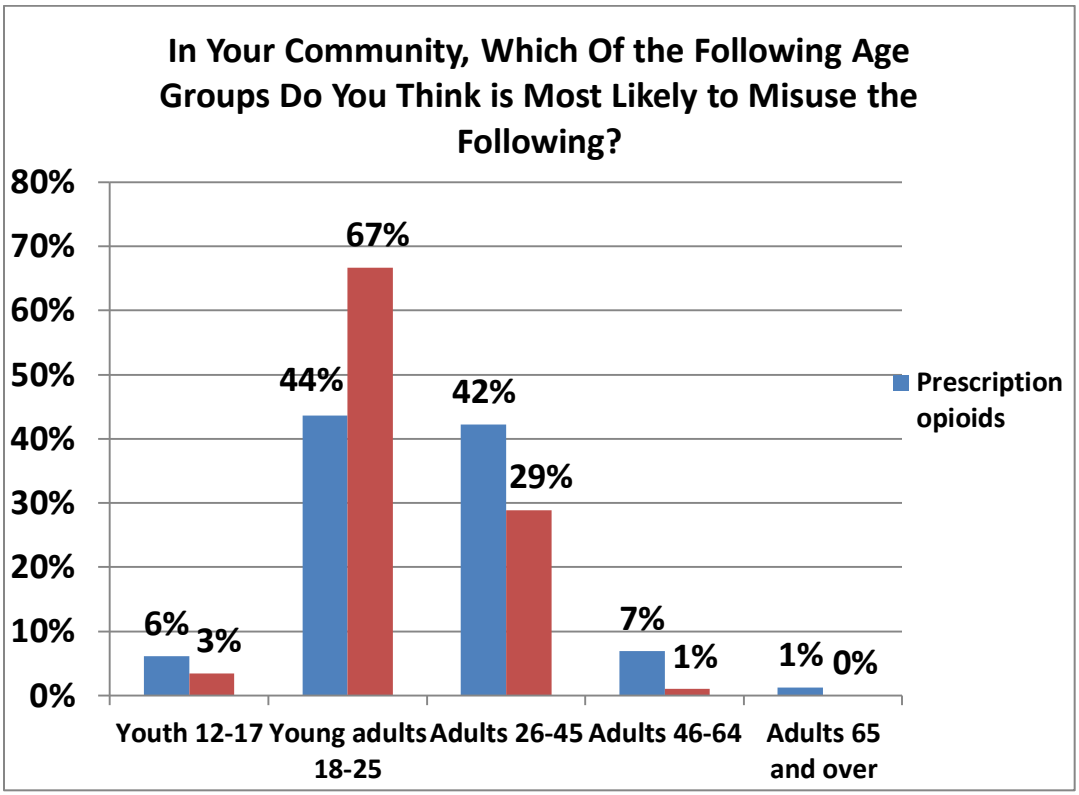
Several questions from the MPOS relate to community norms of opioid misuse. The first question asked respondents about how concerned they are with prescription drug abuse and heroin abuse in the community.



Source: MPOS

57% of the respondents indicated they are very concerned about heroin use, and 46% are very concerned about prescription drug abuse in the community. More than 70% are concerned or very concerned about prescription drug abuse, and 80% are concerned or very concerned about heroin abuse in the community. A very small portion of the respondents are not concerned at all about prescription drug and heroin abuse in the community.

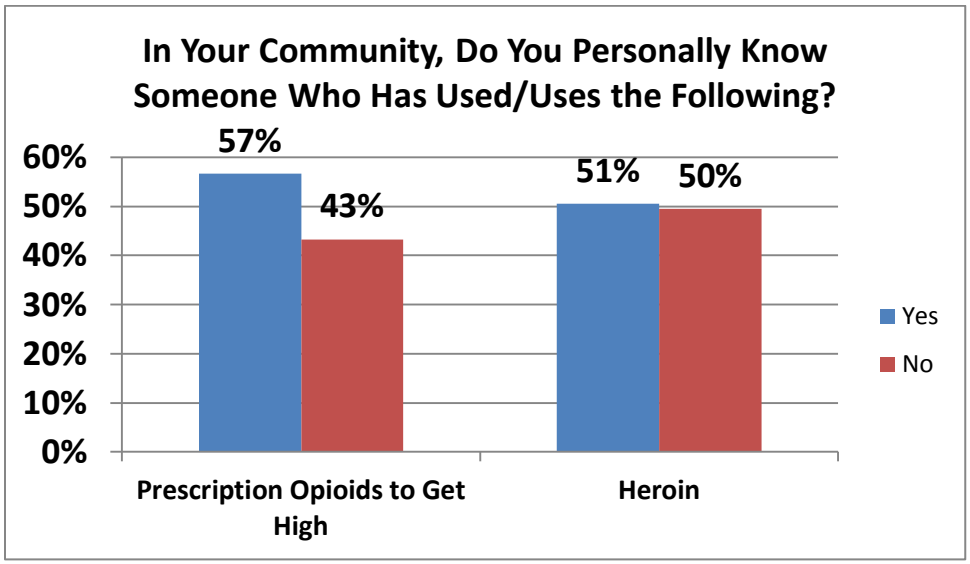
The second question regarding community norms from the survey asked respondents about what age groups are most likely to misuse prescription drugs and heroin.



Source: MPOS

The majority of respondents answered that the age group to most likely misuse prescription drugs and heroin is young adults, ages 18-25, with 67% for heroin, and 44% for prescription opioids. Following this, 42% said adults between the ages of 26-45 were most likely to abuse prescription opioids and 29% for heroin.

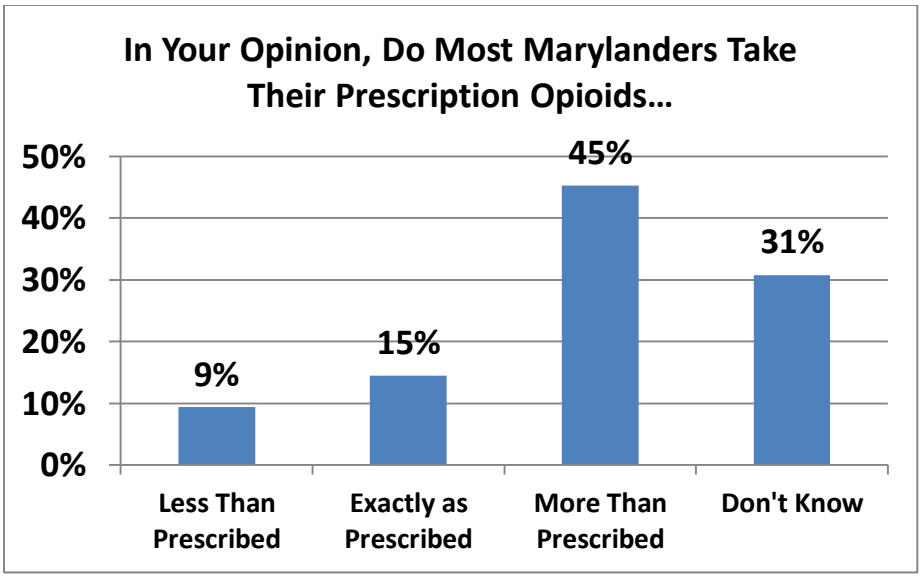
The next question from the survey asked respondents if they personally know someone who has used/uses either prescription drugs to get high or heroin.



Source: MPOS

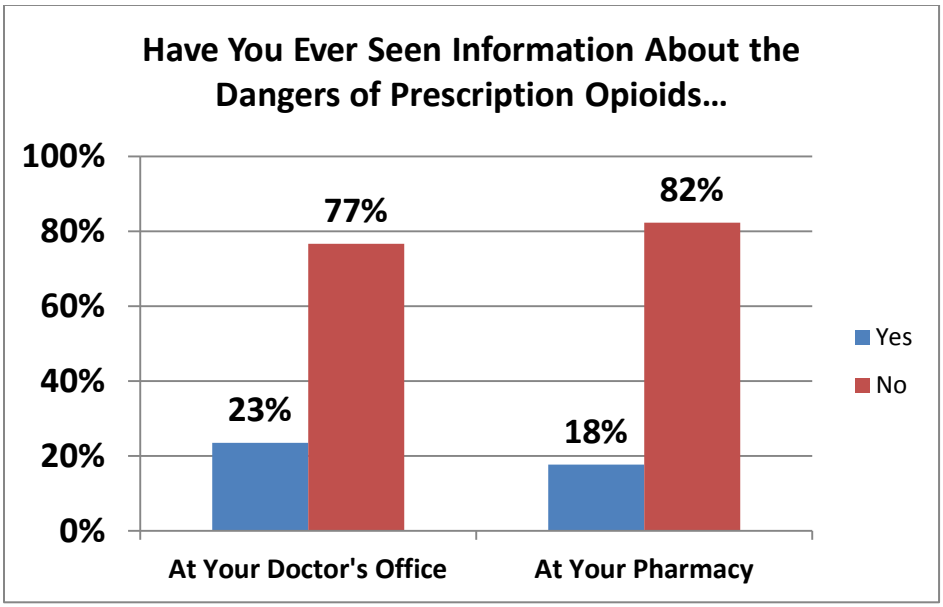
More than half of the respondents know someone who has used/uses prescription opioids to get high or has used/uses heroin. 57% said they know someone who has used prescription opioids to get high, and 51% know someone who has used/uses heroin.

The following question asked the survey respondents about their opinion on how often Marylanders take their prescription opioids when prescribed. 45% selected the response that in their opinion, Marylanders take their prescription opioids more than prescribed. 31% don't know, and only 15% think Marylanders take their prescription opioids exactly as prescribed. Very few respondents think Marylanders take their prescription opioids less than prescribed at 9%.



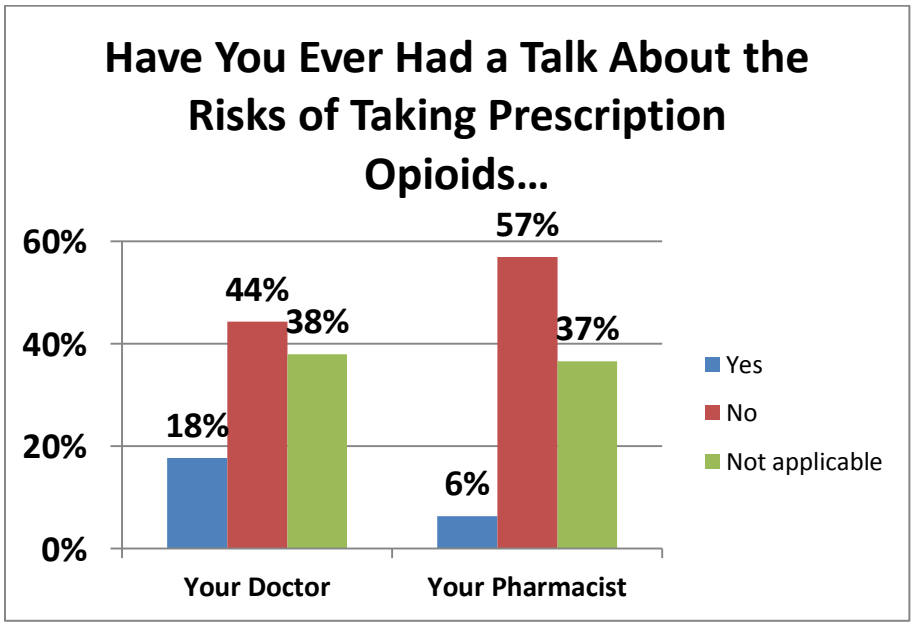
Source: MPOS

The last several questions relating to community norms ask the respondents about their awareness of opioid misuse resources in the community. The next two questions asked respondents if they have seen information about the dangers of prescription opioids at their doctor's offices and pharmacies, and if they have ever had a talk with their doctor or pharmacist about the risks of taking prescription opioids, if applicable.



Source: MPOS

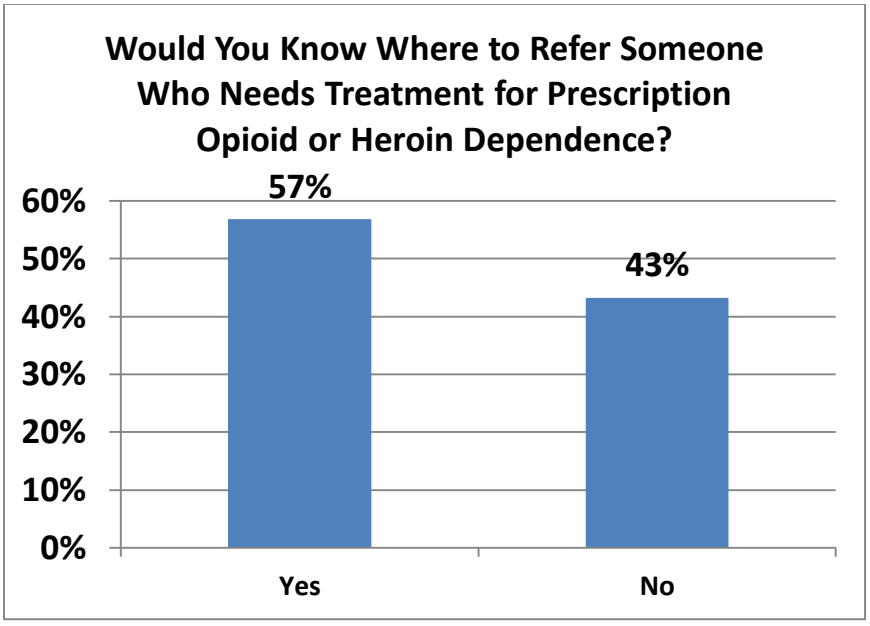
There was a very large percentage of respondents, 77%, who have never seen this information at their doctor's office. 82% have never seen this information at their pharmacy.



Source: MPOS

The majority of respondents answered that they have never talked to their doctor or pharmacist about the risks of taking prescription opioids. 57% have never talked to their pharmacist, and 44% have never talked to their doctor. This question was not applicable to a large percentage of the respondents with 38% from a doctor and 37% from a pharmacist. Very few respondents said they have talked about the risks of prescription opioids, 18% with their doctor, and 6% with their pharmacist.

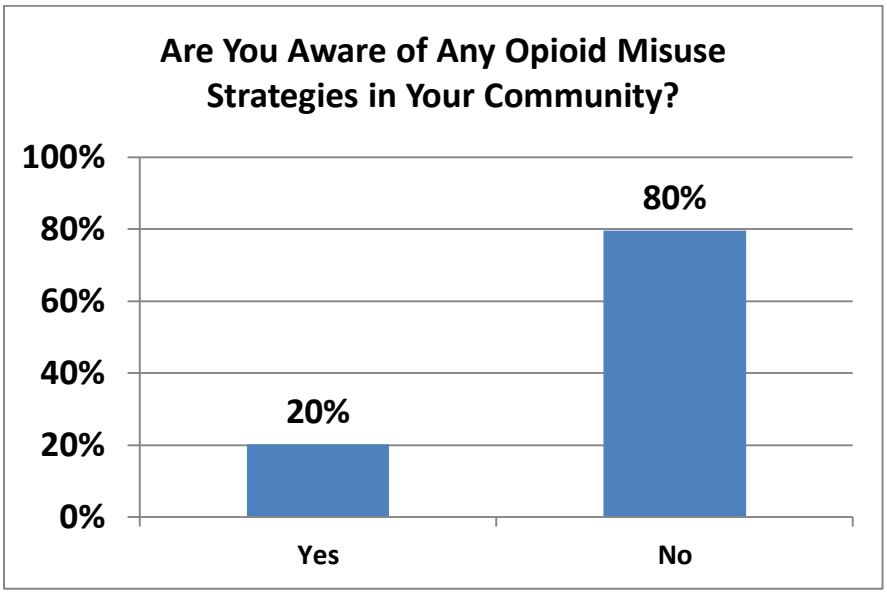
The next question asked respondents if they would know where to refer someone who needs treatment for prescription opioids or heroin dependence. Although the responses were almost half and half, slightly more people said they did know where to refer someone.



Source: MPOS

57% said yes, they did know where to refer someone with prescription opioid or heroin dependence, and 43% said no, they did not know where to refer someone.

The last question from the MPOS on community norms asked respondents about their awareness of opioid misuse strategies in their community, represented in the chart below.



Source: MPOS

A large proportion, 80%, answered that they are not aware of opioid misuse strategies in their community, and only 20% answered that they are aware of opioid misuse strategies in their community.

Focus Groups and Key Interviews:

> "The community doesn't understand. This is not a new problem. This is a public safety issue. We are failing as a society to protect the next generation." Community resident of Southern AAC and suboxone provider.

The most common theme found in the focus groups and key interviews pertaining to the intervening variable of social and community norms is that AAC communities have seen an increase in heroin use in their communities. In twelve focus groups and key interviews it was mentioned that heroin use is on the rise. It was described by several groups as "epidemic", also "very severe". This was mentioned in all four SATP focus groups as well as the youth and MAC focus groups. It was also mentioned in 6 key interviews, from law enforcement to medical staff.

To answer the question of "who" are abusing prescription opioids and heroin, the response was most often "everyone". Some answers specified that youth and young adults ages 14-35 were most likely to abuse prescription opioids and heroin. In key interviews and focus groups, it came up often that users were white and more likely to be middle or upper class than lower class. Law enforcement focus groups and key interviews mentioned these demographic characteristics of opioid users most often with mention in one law enforcement focus group and 4 law enforcement key interviews.

The third most mentioned contributing factor to opioid misuse in the community related to community norms was the lack of treatment or the inaccessibility of treatment. The inaccessibility of treatment includes no treatment options in the area such as in Southern AAC. It could be lack of transportation or long travel times to access treatment. It could also mean it is not affordable or covered by insurance. Navigation to get into treatment is complicated and unknown by many County residents. Issues surrounding treatment were mentioned in seven key interviews and focus groups, including two focus groups, one PITR and the MAC focus group. It was mentioned during two key interviews, one law enforcement and one medical. It was mentioned at three community meetings.

Another contributing factor to opioid misuse is the acceptability that prescription opioids for use and abuse are more acceptable than heroin use. Although it was clear among groups that heroin use has become more acceptable with the younger generations. Someone in the school staff focus group mentioned, "there is a belief because doctors prescribe prescription opioids that they are safe." Three of the PITR focus groups discussed that people think prescription drugs are safer but it is the same as heroin use. They are both highly addictive and dangerous. Prescription opioid abuse was identified as "cleaner" while heroin use was identified as "dirty" and "bottom of the barrel drug use". Two PITR focus groups, one SATP focus group, the school staff focus group, and one medical key interview discussed the prescription opioids versus heroin acceptability issue. The focus group of youth disagreed with the increased acceptability of prescription opioid misuse and heroin use. They said that the majority of youth still think and would say any drug use is "bad", with no difference between prescription drugs or heroin.

The theme of intergenerational use or common use by parents and family members was mentioned as a contributing factor to opioid misuse among the younger generation by three focus groups and 3 key interviews. This contributing factor has been widely confirmed by substance abuse prevention researchers in the literature.[17] Intergenerational use as a contributing factor to opioid misuse was mentioned by one law enforcement focus group, one SATP focus group, and the MAC focus group. It was mentioned by a person in treatment, medical, and DJS key interviews.

The pathways that lead to addiction are not easy to define or understand. In the qualitative data collected for this needs assessment, two pathways leading to opioid addiction were repeated by multiple sources. The first pathway mentioned was prescription opioids prescribed for a legitimate medical condition such as sports injuries, surgeries, car accidents, dental procedures, etc., lead to addiction. The second pathway to opioid addiction was general partying behaviors, including having friends who abuse drugs. Perhaps starting with experimentation of drugs leading to addiction. One key interview of an addiction specialist who works in the ED department in one of our County hospitals said that of the opioid misuse

[17] Fawzy. Fawzy I., et al., *Generational continuity in the use of substances: the impact of parental substance abuse on adolescent substance abuse.* Addictive Behaviors Vol 8, Issue 2, 1983, p. 109-114. http://www.sciencedirect.com/science/article/pii/0306460383900035

patients he sees, “50% started using for legitimate medical reasons and the other 50% started through partying behaviors.” This was mentioned in three focus groups, one SATP group and two PITR groups, as well as three key interviews, one medical and two law enforcement.

Multiple data sources noted that people who use heroin have become younger over the years. More adolescents are using and they do not fear heroin. Heroin use in the general population in AAC has become more acceptable. This was mentioned during three focus groups, one of PITR and two of SATP. It was also mentioned during two key interviews.

Another contributing factor to opioid misuse in the AAC community is the stigma associated with the disease of addiction. Some people still believe only those that are dirty, weak, or from the inner city become addicted to drugs. Some think it is a moral flaw or a choice people make to use. This makes it difficult for people in active drug addiction to seek help and for those in treatment and recovery to speak out about their past addiction. Due to the stigma, lack of education on signs of substance abuse and the disease of addiction, loved ones may choose to ignore or not admit there is a problem for some time. Qualitative data sources mentioned there is general theme of denial that substance abuse exists in AAC communities. Several sources mentioned that the awareness of the problem has been increasing due to County Executive Steven Schuh’s declaration of the heroin state of emergency, a spike in heroin overdose deaths, as well as weekly coverage in the local newspapers, the Annapolis Capital and Maryland Gazette, of the heroin problem in AAC. The stigma and denial of substance abuse problems in the community was mentioned during two focus groups, one SATP focus group and the school staff focus group. It was mentioned during four key interviews. The increased awareness of the problem was mentioned during two key interviews conducted in the Southern area of AAC.

> “If you hear youth mention the word “dope” they are not talking about marijuana…… dope means heroin in Anne Arundel County. “ Anne Arundel County Police Chief Tim Altomare, County Executive’s town hall meeting, March 25, 2015.

Research conducted on substances most commonly abused by youth and often mentioned by someone in treatment as the first drug used such as tobacco, marijuana, and alcohol find it difficult to prove there are “gateway” drugs. In the qualitative data collected for this needs assessment, prescription opioid abuse was mentioned as a gateway drug to heroin use. This was mentioned due to the easy access of heroin and lower price. Two of the PITR focus groups, one SATP focus group, and one law enforcement key interview mentioned the prescription opioid addiction gateway to heroin use.

In other focus groups and key interviews, drugs such as alcohol, tobacco, and marijuana were mentioned as gateway drugs that lead to prescription opioid misuse and/or heroin use. These other gateway drugs were mentioned during two focus groups, MAC and SATP; two key interviews, and one community meeting.

Contributing factors to opioid misuse related to the intervening variable of community norms mentioned by three sources or less included:

- Those who abuse prescription opioids take more than prescribed (3 sources)
- Youth do not know prescription opioids are addictive (3 sources)
- Schools need more education on the subject of substance abuse. Drugs are easily accessible at school. (3 sources)
- People use in public areas (2 sources)
- It is Ok to use someone else's prescription drugs (2 sources)
- It is common prescription opioids are obtained through stealing from family members (2 sources)
- Substance abuse is linked to mental health problems. People use substances to self-medicate for an untreated mental health condition. (2 sources)
- Prescription opioids are kept in homes and are not locked (2 sources)
- Medically assisted treatment is abused. It is replacing one drug for another. There is too much drug replacement. (2 sources)
- There is a stigma to medically assisted treatment. Of the 8 people in the medically assisted PITR focus group, none said they tell people they are on methadone due to the stigma. (1 source)
- People take prescription opioids when not prescribed (1 source)
- The community has a "not in my back yard, nimby" outlook concerning treatment in their communities. (1 source). This has happened several times in the last six months as a proposal for a new methadone clinic in Pasadena was denied and the only substance abuse treatment provider south of Edgewater was rejected by the community and forced to move out of County.

ii.Discuss the impact of community norms on opioid misuse consumption patterns and consequences in your community

Consumption

18-25 Year Olds are Perceived as the Age Most Often Misusing Prescription Opioids and Heroin

Data from the MPOS shows the 18-25 year olds are and are perceived to be the age group who abuse prescription opioids the most. This is indicated in the question asking which age group do you think is most likely to abuse prescription opioids. This age is also indicated as age of first use for prescription opioid and heroin misuse in the MPOS. This community norm of age of first use between the 18-25 years would indicate primary prevention should be done at an age younger than 18.

Community Indicates a General Increase in Heroin Use

Data from focus groups and key interviews have concluded there has been an increase in heroin use in AAC. This agrees with the SMART treatment data that indicates more adults are

seeking treatment for heroin addiction. Hospital data indicates increased emergency department visits for opioids and heroin. Furthermore, this increase in heroin use is indicated in the increase of overdose deaths due to heroin.

Data Indicates Increase in Prescription Opioid Abuse Due to Two Pathways: Pain Management and Partying Behaviors

Focus groups and key interviews conclude that people become addicted to prescription opioids by one of two pathways. The first is due to pain management of sports injuries, surgeries, car accidents, dental procedures, etc. The second pathway to addiction is through beginning drug use through prescription opioids, tobacco, alcohol, and/or marijuana that leads to heroin use. This includes association with friends that use substances.

Heroin Use is Starting at a Younger Age

Focus groups and key interviews indicate that young people that use heroin are starting use at a younger age. According to the YRBS, 5.4% of youth in high school reported using heroin at least once in their life time. When the Maryland Adolescent Survey was done in 2007, this percentage was 2.3%. According to SMART treatment data, over the last 2 years there has been an increase in youth reporting heroin as one of their drugs of choice. This would speak to starting primary prevention of opioid misuse by high school.

Identified Gateway Drugs Lead to Heroin Use

As mentioned in focus groups and key interviews, young people who become addicted to prescription opioids often use tobacco, alcohol, or marijuana before they abuse prescription opioids. The gateway of prescription opioid abuse to heroin was also indicated often during data collection.

Youth and Young Adults Abuse Substances Due to Mental Health Conditions

As mentioned during community meetings, focus groups, and key interviews, those who abuse substances are also likely to have a mental health problem.

Consequences

Community Members Do Not Know Where to Refer Those in Need of Treatment

The MPOS responses indicated 43% do not know how to refer people in need of treatment to treatment services. Similarly, there is a lack of treatment providers in the County with some areas, such as South County, without services.

Prescription Opioid Misuse is More Acceptable Than Heroin Use

Responses from focus groups and key interviews indicated that prescription drug abuse is more acceptable than heroin use. Prescription drug abuse is seen as "safer" and "cleaner". Prescription opioids are prescribed by doctors so they are seen as acceptable. This acceptability of use could encourage drug use among youth.

Intergenerational Use

Responses from focus groups and key interviews indicate that youth see parents and other family members abuse prescription opioids so they see it as acceptable.

Stigma of Opioid Misuse

Focus groups and key interviews indicated there is a community stigma associated with opioid misuse in AAC. This can range from stigma of someone with addiction problems, to someone with a heroin problem, to someone on medically assisted treatment.

Lack of Knowledge of Narcan and Its Use

According to the MPOS, 71% of respondent had heard of Narcan but only 44% knew it was used to reverse an opioid overdose.

iii.Describe each contributing factor that you identified

1. Present the data and explain what do the data for your community reveal

Community Norms

Data Says:	Data Reveals:
Intergenerational abuse of prescription opioids exists in Anne Arundel County	If youth and young adults see parents and other family members abuse prescription opioids and heroin, they are more likely to abuse these substances themselves.
The belief that prescription opioid abuse is more acceptable and safer than heroin.	If there is a belief that prescription opioids are safer than heroin, people are more likely to abuse them first and may progress to heroin use.
There is a lack of treatment options for opioid abuse, knowledge of how to access treatment, and areas with lack of treatment services (South County)	If people cannot access treatment due to barriers, they will continue to use.

People get addicted to prescription opioids because of sports injuries, surgeries, and other pain management situations.	If people do not know that prescription opioids can lead to addiction and other negative consequences, they are more likely to suffer negative consequences.
Prescription opioids are available at parties attended by youth and young adults. Peers abuse prescription opioids.	If youth and young adults attend parties where prescription opioids are being abused, they are more likely to abuse them.
Those who are likely to witness someone overdosing on prescription opioids or heroin may not know about Narcan and/or how to use it.	If community members are trained to use Narcan, they can administer it when someone is overdosing to save a life.
Stigma: There is a stigma in Anne Arundel County of those with substance abuse disorders, those who use heroin, and those who seek medically assisted treatment for opioid misuse	If we can reduce the stigma of substance abuse in Anne Arundel County, more people will seek treatment and be in recovery.
Those who abuse substances are likely to have a mental health problem.	Youth and young adults with untreated mental health conditions are more likely to self-medicate by abusing prescription opioids and/or heroin.
There is a progression of drug use to addiction also referred to as "gateway" drug use.	Youth and young adults start using alcohol, tobacco, and marijuana before using prescription opioids and/or heroin that leads to negative consequences such as addiction. Prescription opioid abuse leads to heroin abuse.

1. Describe how each contributing factor is a main contributor to opioid misuse
    - Intergenerational use: If youth and young adults see family members misusing opioids, they are more likely to do it themselves, increasing opioid misuse.
    - The belief that prescription opioids are safer than heroin: If people do not realize that prescription opioids can lead to addiction and heroin use, they are more likely to misuse them.
    - Lack of treatment centers, knowledge of how to access them, and no treatment in South County: If people do not know how to access treatment or have treatment

available, they are more likely to continue to abuse prescription opioids.

- Lack of knowledge that sports injuries, chronic medical conditions, etc. can lead to prescription opioid addiction: If people do not realize that a common pathway to addiction to prescription opioids is through pain management, opioid misuse will increase.
- Prescription opioids and other drugs are available at parties, peer use: If prescription opioids are available at parties, youth and young adults are more likely to misuse them.
- Lack of knowledge of Narcan and how to use it: If substance abusers and their social networks do not know about Narcan, they will not be able to administer Narcan if a loved one is overdosing, thus increasing opioid overdose deaths.
- Gateway drugs lead to heroin use, progression of addiction: If those misusing substances are unaware that their use may progress to other drugs, they are more likely to misuse opioids. Those who abuse heroin often report a previous addiction to prescription opioids.
- Stigma: Stigma of those with substance abuse disorders, heroin use, and medically assisted treatment: If there is a stigma to substance abuse, heroin use, and medically assisted treatment, those with addictions are less likely to seek treatment.
- Those who abuse substances are likely to have a mental health problem: Those who abuse prescription opioids and/or heroin may have an untreated mental health condition, leading to increased opioid misuse.

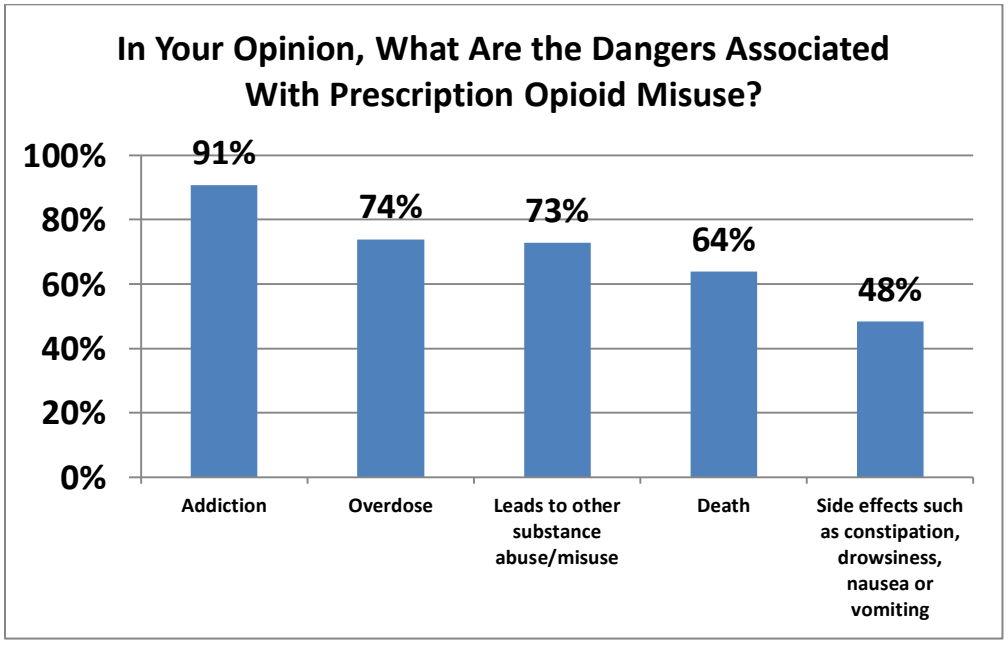
c. Perception of Risk

Perceived risk is an individual's judgement about the characteristics and severity of risk regarding opioid misuse and its consequences. The MPOS, focus groups, and key interviews were used to analyze perception of risk.

i. Present and discuss the data collected for perception of risk that might contribute to opioid misuse consumption patterns and consequences in your community:

Maryland Public Opinion Survey

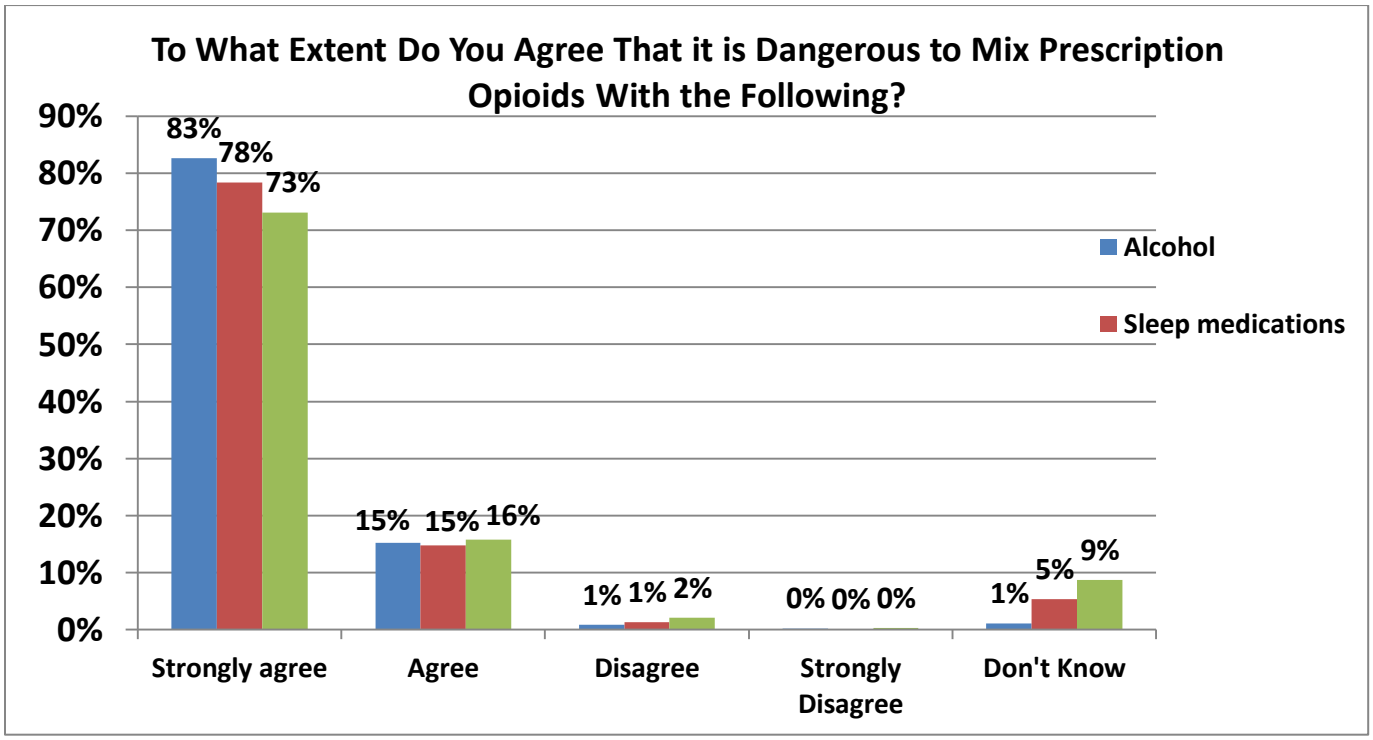
Six questions on the MPOS were related to the perception of risk for opioid misuse in AAC. The first question asked what the respondents' perceptions were regarding the dangers associated with prescription opioid misuse. Respondents were allowed to select more than one response. The selections were as follows:



Source: MPOS

As indicated by the chart, respondents perceive that the most dangerous consequence of prescription opioid misuse is addiction at 91%. 74% responded that overdose is a danger of prescription opioid misuse, followed by the danger that presciption opioid misuse leads to other substance abuse/misuse at 73%. 64% said that prescription opioid misuse leads to death, and 48% said that side effects such as constipation, drowsiness, nausea, or vomiting are a danger of prescription opioid misuse.

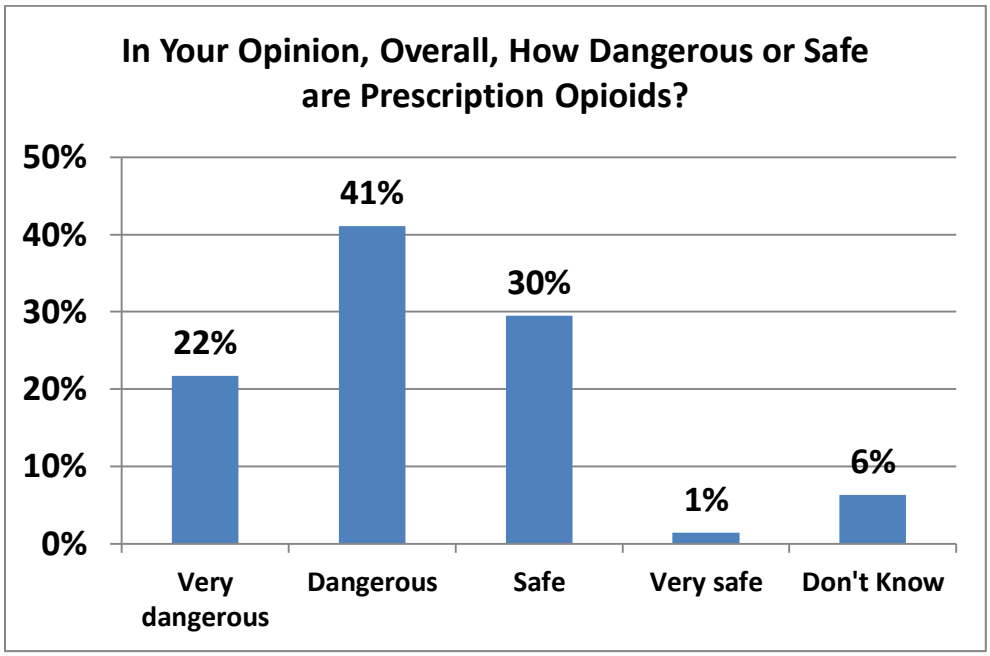
The second question from the survey asked, "To what extent do you agree that it is dangerous to mix prescription opioids with the following?" The respondents selected how strongly they agreed or disagreed about how dangerous it is to mix prescription opioids with alcohol, sleep medications and anti-anxiety medications. The examples of sleep medications given in the survey were Ambien® and Lunesta®, and the examples of anti-anxiety medications were Xanax® and Ativan®.



Source: MPOS

As shown on the chart above, most of the respondents strongly agree that it is dangerous to mix prescription opioids with alcohol (83%), sleep medications (78%), and anti-anxiety medications (73%). Furthermore, 98% agree or strongly agree that it is dangerous to mix prescription opioids with alcohol, 93% agree or strongly agree that it is dangerous to mix prescription opioids with sleep medications, and 89% agree or strongly agree that it is dangerous to mix prescription opioids with anti-anxiety medications. Less than 10% don't know the dangers of mixing prescription opioids with each substance.

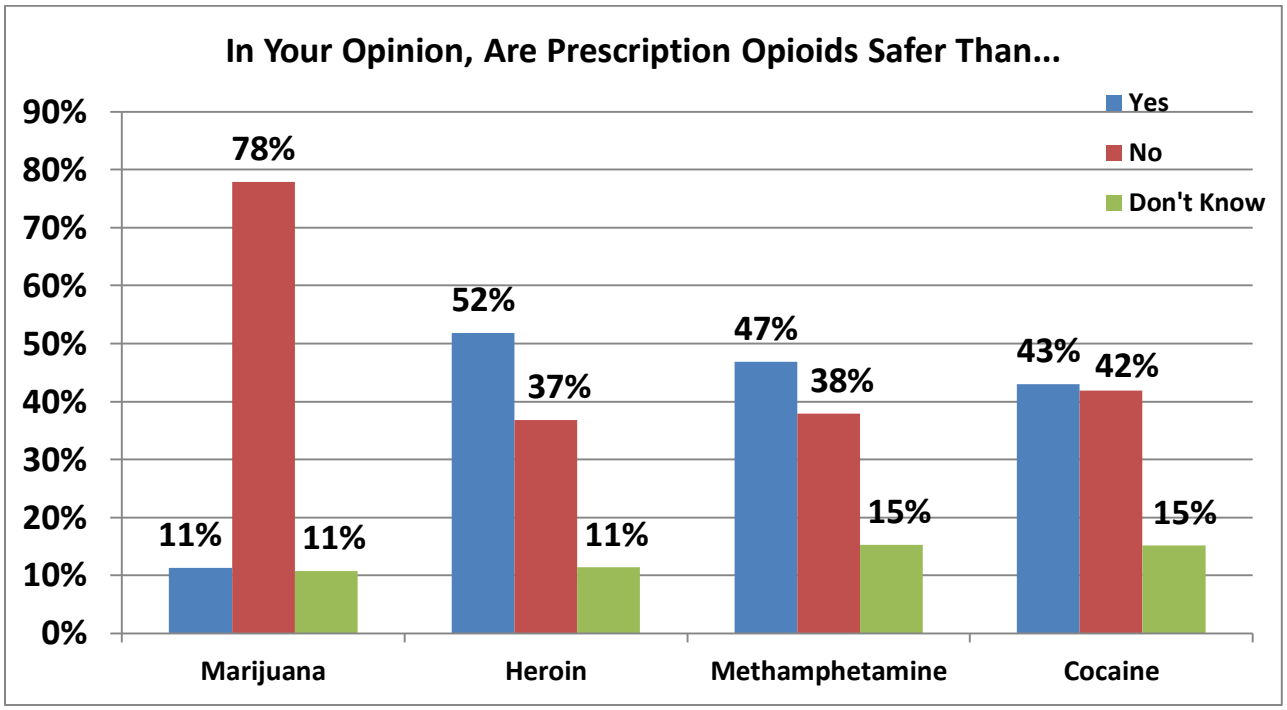
The next survey question on perception of risk asked respondents about the dangers of prescription opioids.



Source: MPOS

63% of the respondents think that prescription opioids are dangerous or very dangerous. 30% think prescription opioids are safe and only 1% thinks they are very safe. 6% reported they do not know about the safety or dangers of prescription opioids.

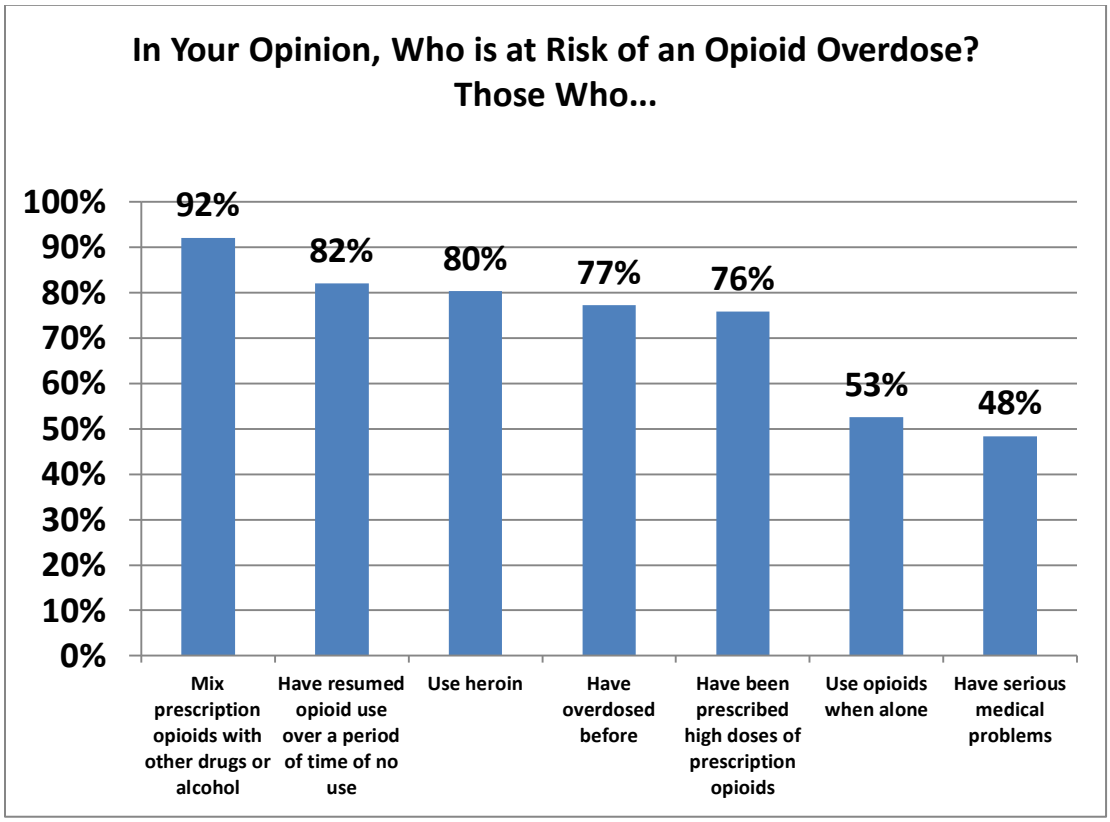
The survey then asked respondents if they think prescription opioids are safer than four other drugs including marijuana, heroin, methamphetamine and cocaine.



Source: MPOS

More respondents think that prescription opioids are safer than heroin (52%), methamphetamine (47%) and cocaine (43%). Conversely, 78% think marijuana is safer than prescription opioids. 15% or less of the respondents do not know if prescription opioids are safer than the other four drugs.

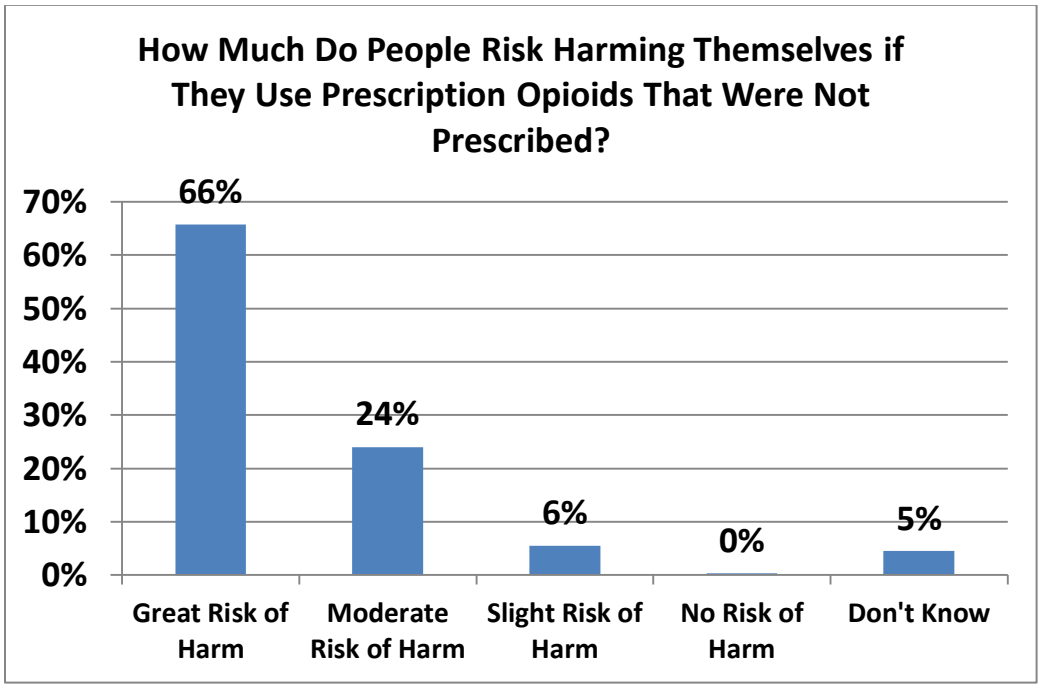
Following the dangers and safety of opioid misuse, the survey asked respondents who they think is at high risk of an opioid overdose. The respondents were allowed to choose more than one answer from the following options:



Source: MPOS

The data indicates that respondents think several populations are at risk of an overdose. As indicated from the chart, most people think those who mix prescription opioids with other drugs or alcohol (92%) are at highest risk of an overdose. Next, 82% think those who have resumed opioid use after a period of time of no use such as those recently released from treatment or prison/jail are at risk of overdosing. Also, 80% think those who use heroin are at high risk of overdosing, 77% think those who have overdosed before are at risk, 76% think those who have been prescribed high doses of prescription opioids are at risk, 53% think those who use opioids when alone are at risk, and 48% think those who have serious medical problems are at risk for an opioid overdose.

The last question from the MPOS on perception of risk asks respondents, "How much do people risk harming themselves (physically or in other ways) if they use prescription opioids that were not prescribed to them to treat their pain?" The results were as follows:



Source: MPOS

As shown from the chart, most people think those who use prescription opioids not prescribed to them are at great risk of harm (66%). 24% think those who use prescription opioids not prescribed to them are at moderate risk of harm, and 6% think those are at slight risk of harm. 5% of the respondents do not know the risk, and no one responded they thought those who use prescription opioids that were not prescribed to them had no risk of harm.

Focus Groups and Key Interviews:

Most of the responses pertaining to perceived risk of opioid misuse answered the question of "What are the risks of opioid misuse"? The most common response mentioned in 16 key interviews and focus groups was the risk of overdose and death. This was discussed in five focus groups including three SATP, youth, and MAC. It was mentioned during 11 key interviews including four residents of South County, three medical, three law enforcement, and one pharmacist. AAC awareness of heroin overdoses has increased with the County Executive declaring a State of Emergency on heroin as well as increased press coverage, community/town hall meetings, and police surveillance.

The second most commonly mentioned risk to opioid misuse was loss of home, family, work, and life. This was mentioned by three focus groups: youth, PIRT, and MAC. It was also mentioned during three key interviews, two residents and one law enforcement.

An increased crime rate, criminal records, and jail time was mentioned during seven key interviews. It was mentioned during three law enforcement interviews and three interviews of South County residents. When the comments were tallied for the MPOS, many indicated crime was a negative consequence of prescription opioid misuse.

The risk of negative health-related consequences was mentioned often during key interviews and focus groups. Negative health-related consequences include Hepatitis C, HIV, Staph infection, abscesses, and endocarditis. Health negative consequences were mentioned during two focus groups, one of SATP and one of PITR as well as two medical key interviews. During one SATP focus group and one medical key interview, increased emergency room visits were mentioned.

Addiction was mentioned as a risk to opioid misuse by the youth focus group and one South County resident key interview.

Other risks to opioid misuse mentioned one time include:

- Mixing drugs can kill you (SATP)
- Decreased performance at school or work (medical key interview)
- Increase risk of drowning (medical key interview)
- Involvement in fights, violence (South County resident key interview)
- Increased car crashes (South County resident key interview)

> "Users don't think they'll get hooked. They don't think about the consequences. They think they are invincible." Member of SATP focus group.

Another topic on perceived risk of opioid misuse that was mentioned frequently was people do not understand the progression of addiction. One police focus group called the progression of addiction "stepping". One progression was explained as snorting to shooting up. Snorting is more acceptable than shooting up. This was discussed during two law enforcement and one PITR focus group. Another group of PITR used the term "gateway" drugs as the progression from marijuana and/or alcohol to heroin. They explain they knew heroin was risky but did not know that other drugs led to the use of heroin.[18] One person in recovery stated, "kids think pills are ok, but don't expect to get addicted to heroin that way."

On the topic of risk of prescription opioid versus heroin, it was noted heroin is not regulated so it is more dangerous than prescription opioids. Prescription opioids are less risky because you know what you are getting. These points were mentioned during one SATP, one law enforcement, and one PITR focus group.

[18] Kirby, T. and Barry AE, Alcohol as a gateway drug: A study of US 12th graders. *J. Sch. Health* (2012) Aug; 82(8) 371-9. http://www.ncbi.nlm.nih.gov/pubmed/22712674

It was mentioned during a PITR and a SATP focus group that when people see their friends and family abuse prescription opioids, they are more likely to think it is not risky as they do not see immediate negative consequences due to opioid misuse. Over the last several years, as discussed during one SATP focus group, there is less fear of using needles to inject drugs. Also, according to one PITR focus group there is an increase in the number of people who think heroin is not dangerous. Purity levels of heroin have increased recently, according to one law enforcement and one SATP focus group. It was mentioned, "the stronger stuff is the better stuff", and "they line up for the stuff that someone od'ed on the day before."

Finally, on the topic of perceived risk, teenagers were mentioned during a PITR focus group and the school staff focus group. The PITR said use is easy to hide at home so you do not think you will get caught. School staff mentioned teenagers think they are invincible and negative consequences due to substance abuse won't happen to them. Also, teenagers do not learn from negative consequences of their peers using.

ii. Discuss the impact of perception of risk on opioid misuse consumption patterns and consequences in your community

Consumption

Prescription Opioids are Safer Than Heroin

As indicated by the MPOS, 52% responded prescription opioids are safer than heroin. Key interviews and focus groups especially of PITR indicate that prescription opioids are not safer pertaining to the risk of addiction.

Addiction to Opioid Drugs is a Progression

Through key interviews and focus groups, drugs such as tobacco, alcohol, and marijuana are "gateway" drugs to prescription opioids and heroin. Prescription opioids are a gateway to heroin use.

Intergenerational Use and Use by Peers Decreases Perceived Risk of Use

As indicated through key interviews and focus groups, young people see family members and peers using without immediate negative consequences and it lowers the perceived risk of use.

Consequences

Dangers of Prescription Opioid Misuse

Through the MPOS, the majority of respondents knew the risks of prescription opioid misuse. Of respondents, 91% indicated addiction was a danger associated with prescription opioid misuse, 74% indicated overdose as a danger, 73% indicated it led to other substance abuse, and 64% indicated death. This was confirmed during focus groups and key interviews.

Mixing Drugs is a Risk

The MPOS asked about the mixing of other drugs with prescription opioids. The majority of respondents indicated they strongly agreed it was dangerous to mix prescription opioids with alcohol (83%), sleep medication (78%), or anti-anxiety medications (73%).

Groups at Risk of Overdose

The MPOS indicated groups of people most at risk of overdose are: those who mix prescription opioids with other drugs or alcohol (92%), those who have resumed opioid use over a period of time with no use (82%), those who use heroin (80%), those who have overdosed before (77%), and those who have been prescribed high doses of prescription opioids (76%).

iii. Describe each contributing factor that you identified

1. **Present the data and explain what do the data for your community reveal**

Perceived Risk

Data Says:	Data Reveals:
Most youth and young adults know prescription opioids and heroin are risky.	If youth and young adults view prescription opioids and heroin as risky, they are less likely to abuse them.
Intergenerational abuse of prescription opioids exists in Anne Arundel County	If youth and young adults see parents and other family members abuse prescription opioids and heroin, they are more likely to see them as less risky.

The belief that prescription opioids are safer than heroin.	If youth and young adults are not aware of the risks of prescription opioid misuse, they are more likely to suffer negative consequences such as addiction and possible progression to heroin.
Gateway drugs lead to heroin use. There is a progression of addiction to heroin from prescription opioids and other drugs such as alcohol, tobacco, and marijuana.	If youth and young adults start abusing drugs they view as less risky, they may progress to other drugs that are viewed as more risky such as heroin.
People believe mixing prescription opioids with other drugs is risky.	If people perceive mixing drugs to be risky, they are less likely to mix multiple prescription drugs or alcohol.
Sub-groups of the population are at greater risk of overdose such as those who mix drugs, those returning from jail or completing treatment, and heroin users.	If those in sub-groups at risk for overdose know about their increased risk, they will be less likely to overdose.

2. Describe how each contributing factor is a main contributor to opioid misuse

- Intergenerational use: If youth and young adult see family misusing prescription opioids, perceived risk will decrease thus increasing opioid misuse.
- The belief that prescription opioids are safer than heroin: If people believe prescription opioids are safer than heroin, they have a lower perception of risk so opioid misuse will increase.
- Gateway drugs lead to heroin use, progression of addiction: If those who abuse drugs do not know about the progression of addiction, their perception of risk will be low and they are more likely to abuse prescription opioids. If those who abuse prescription opioids are not aware that use of prescription opioids may lead to heroin use, their perception of risk is decreased and opioid misuse will increase.
- Use of prescription opioids and/or heroin is a risky behavior: If people do not see prescription opioids and/or heroin use as risky, opioid misuse increases.
- Mixing drugs is a risky behavior: If people do not know mixing prescription opioids such as alcohol or other prescription

opiods is risky, perceived risk is lower and opioid misuse will increase.

- Sub-groups of the population are more at risk for overdose: If those who mix drugs, those who are returning from jail or treatment, and those who abuse heroin do not know they are at increased risk of overdose, their perceived risk is low, and they are more likely to overdose on prescription opioids.

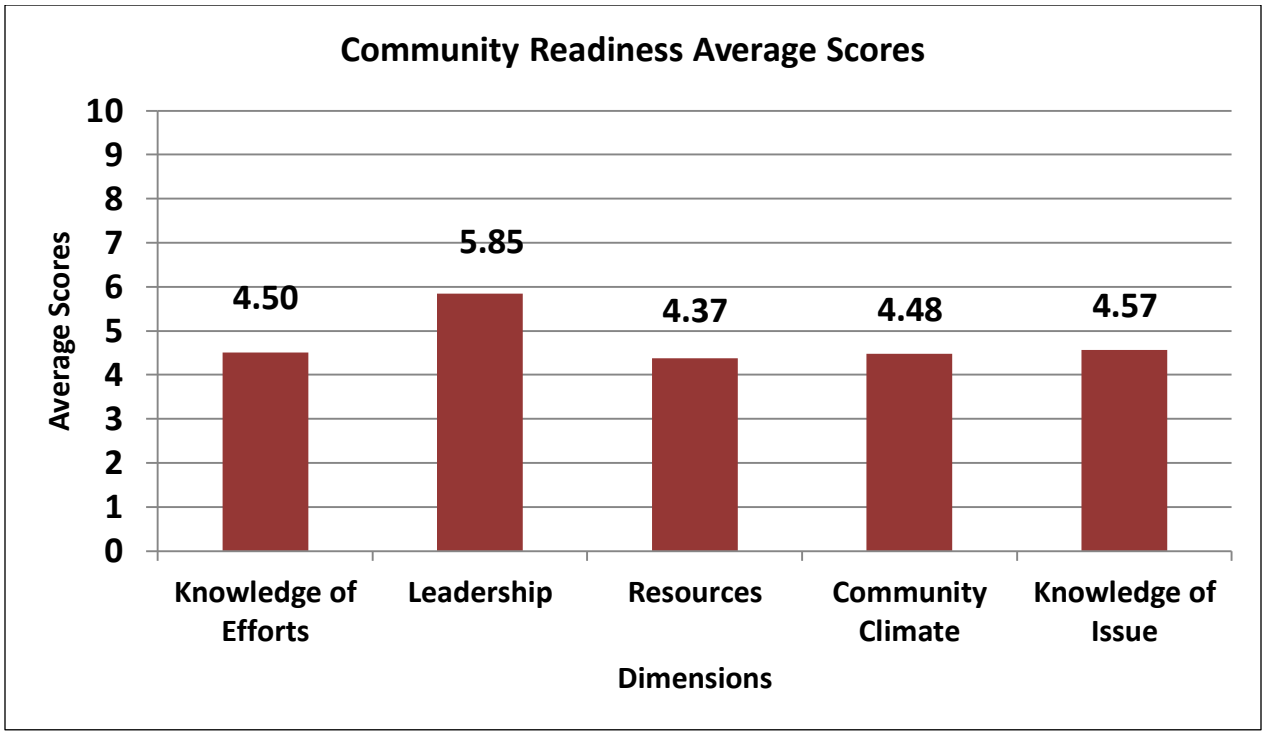
V. ASSESSING COMMUNITY READINESS AND RESOURCES

a. DISCUSS THE RESULTS OF THE COMMUNITY READINESS TOOL TO ASSESS YOUR COMMUNITY READINESS TO TACKLE OPIOID MISUSE

In order to identify the community's level of readiness to tackle opioid misuse, we administered the recommended Community Readiness Survey Tool to four MSPF coalitions during their meetings in March, 2015. These coalitions who completed the Survey Tool were NLASA, WASP, South County Bridges to a Drug Free Community, and the OMPPNAWG. Key members from all over AAC provided their opinions about the levels of community readiness to address opioid misuse in AAC. Sampling included individuals from each of the six sectors: Law, Business, Education, Health, Government, and Involved Citizens. The respondents are all actively engaged in the community and the opioid misuse issue which provided an accurate picture of our community's readiness. Overall, survey respondents stated that the Community Readiness Survey Tool was easy to use and did not require a lot of time to complete. The Community Readiness Assessment reflects cultural competence by involving people of diverse ethnicities throughout the County through the coalitions' representation.

There were a total of 28 surveys collected. The individual survey scores were recorded on the Scoring Sheet provided, and then averages were calculated for each dimension across all respondents. The final averaged scores were all 4 or higher for all five of the Community Readiness Dimensions.[19]

[19] See **Attachment C** Community Readiness Scoring Sheet.



This score places the AAC community between Preplanning and Preparation stages. However, when the individual dimension scores are examined, the Leadership Dimension is placed between Preparation and Initiation stages as it scored slightly higher than the rest of the Dimensions. After analyzing the results from these surveys, we concluded that a substantial number of community members in AAC have heard about local efforts addressing opioid misuse, and leadership including active community members, are supportive in improving current efforts and developing new efforts. The community's attitude about opioid misuse can be improved, and survey respondents agree that this stigma must be changed. Community members have some basic knowledge about causes, consequences, signs and symptoms of opioid misuse which can be improved through education about the issue. There are some resources available that can be used for further efforts to address the issue.

AAC has a higher level of readiness (4+), which may indicate AAC could be focused on presenting messages through one-on-one meetings, small groups, large group presentations, events, traditional media such as posters, TV and radio, social media such as Facebook and Twitter, and on the County-wide prevention website, www.preventsubstanceabuse.org.

Additionally, the MPOS was administered online in Maryland, resulting in 1,418 respondents from AAC alone. One third of these respondents were from ZIP codes in which MSPF local coalitions publicized the survey to community members. The process of administering the survey in and of itself increased the level of awareness of opioid misuse and the contributing factors.

b. DISCUSS THE RESULTS OF YOUR COMMUNITY RESOURCE ASSESSMENT

Throughout AAC, local MSPF coalitions have held community forums to educate the public about opioid misuse and to spread awareness about the issue. These community forums have proven to be successful with high attendance and participation. AAC residents have become very aware of the opioid misuse issue and its recent unfortunate consequences through these forums, AAC Executive Schuh's active role, and recent articles published in local newspapers and blogs.

AAC community members and survey respondents identified several existing resources addressing opioid misuse in AAC, in addition to those mentioned previously, which have helped identify potential resource gaps, build support for prevention activities, and ensure a realistic match between identified needs and available resources. The current opioid misuse resources include:

- 4 local prevention coalitions
    - NLASA
    - WASP
    - South County Bridges
    - CSC
- County Executive's office in conjunction with the Heroin Task Force and its 3 subcommittees:
    - Expanded treatment
    - Enforcement efforts
    - Education in schools
- Police Department Heroin Task Force
- Police dedicated prescription Fraud Unit
- State's Attorney's dedicated Prosecutor
- AAC Crisis Warmline operated by the National Alliance on Mental Illness, 24 hours a day, 7 days a week
- Substance Abuse Treatment Referral Line operated by AACDOH
- Providers
    - Doctors
    - Mental Health
    - Treatment and ASAM levels
        - Outpatient/Intensive Outpatient
        - Residential/Inpatient Treatment
- Adolescent Clubhouses
- Schools
- Faith-based community
- 12 step programs
    - Alcoholics Anonymous, Narcotics Anonymous, NARANON
- Online support programs

- Websites
    - www.preventsubstanceabuse.org
- Facebook Resources
- Upcoming communications campaign

After compiling a list of local resources, there were several gaps in services identified. These gaps include:

- Need for expansion of local prevention coalitions to cover the entire County
- Regulation of medically assisted treatment
- Training/education/knowledge about opioids and treatment options among providers, pharmacists and law enforcement
- Limited treatment in some areas of the county
- Limited access to treatment
- Insurance coverage limitations
- Transportation
- Stigma to access treatment among communities
- Limited emergency care
- Navigation through systems of care
- Funding for prevention services is unstable

c. **INCLUDE ANY INDICATORS NOTED IN THE KEY INFORMANT INTERVIEWS OR FOCUS GROUPS FOR COMMUNITY READINESS**

Several indicators were noted in the key informant interviews and focus groups related to community readiness. Overall, there was a consensus that the general population in AAC is not aware of the Good Samaritan Law. Several focus group participants had very few ideas about what the law states, and many were unaware of exactly what the Good Samaritan Law entails, which could therefore prohibit users from seeking help for fellow users. Furthermore, there is a lack of knowledge among the community about prescription drug take back boxes located at police departments throughout AAC. Because of this, many of those who are prescribed drugs in AAC keep their leftover medications because they are unaware of proper drug disposal.

Most people indicated in focus groups and key informant interviews that they know that opioid misuse is a major problem, they do not know exactly what to do about it, but that something should be done. These indicators correlate with the Community Readiness survey responses showing that the community is aware of the issue but needs more information and encouragement to change their behavior.

VI. PRIORITIZATION

a. COMPLETE THE 2X2 TABLE WITH THE SELECTED CONTRIBUTING FACTORS FOR OPIOID MISUSE IN YOUR COMMUNITY

Through data collection, the OMPPNAWG identified 29 contributing factors to opioid misuse in AAC. Through small group discussion, the group agreed to prioritize six contributing factors the group identified as the most important. These contributing factors were:

- Social availability: Lack of proper monitoring and storage of prescription opioids in the home leading to easy access
- Social availability: Doctors and pharmacist do not discuss the dangers of prescription opioids with their patients.
- Community norms and perceived risk: The belief that prescription opioids are safer than heroin.
- Social availability: People steal prescription opioids from homes.
- Community norms: Lack of treatment, how to access it, and no treatment in South County
- Retail access: Lack of use of PDMP by pharmacists and doctors

	More Important	Less Important
High likelihood to change	1. Lack of proper monitoring and storage of prescription opioids leads to easy access. 2. Doctors and pharmacists do not discuss the dangers of prescription opioids with patients. 3. Belief that prescription opioids are safer that heroin	1. Lack of use of PDMP by doctors and pharmacists
Low likelihood to change	Low Priority 1. Prescription opioids are stolen from homes. 2. Lack of treatment, knowledge of how to access treatment, and no treatment in South County	No Priority

b. DISCUSS RESULTS OF THE CHANGABILITY ASSESSMENT

- Social availability: Lack of proper monitoring and storage of prescription opioids in the home leading to easy access

  Lack of proper monitoring and storage of prescription opioids in the home was prioritized as more important with high likelihood to change by the OMPPNAWG. The data that supports this decision is the MPOS, 65% of respondents indicated that they believe prescription opioids come from stealing from family. Also, 71% indicated that they had not seen a message about proper monitoring and storage of prescription opioids.

- Social availability: Doctors and pharmacists do not discuss the dangers of prescription opioids with their patients.

  Doctors and pharmacists do not discuss the dangers of prescription opioids with their patients was prioritized as more important with high likelihood to change by the OMPPNAWG. The MPOS indicated only 18 % had talked to their doctors concerning prescription opioids and 6% had talked to their pharmacists.

- Community norms and perceived risk: The belief that prescription opioids are safer than heroin.

  The belief that prescription opioids are safer than heroin was prioritized as more important with high likelihood to change by the OMPPNAWG. The MPOS indicated 52% of respondents believed prescription opioids were safer than heroin. Focus groups and key interviews indicated the lack of knowledge that prescription opioids are as dangerous as heroin (in reference to addiction).

- Social availability: People steal prescription opioids from homes.

  People steal prescription opioids from homes was prioritized as more important with low priority. In the MPOS, 65% responded prescription opioids are stolen from family. Key interviews and focus groups indicated people steal prescription opioids from homes. Although the OMPPNAWG prioritized this contributing factor as more important, the group selected it as low priority because it would be difficult to change what goes on in homes.

- Community norms: Lack of treatment, how to access it, and no treatment in South County

  The OMPPNAWG prioritized the contributing factor of lack of treatment, how to access it, and no treatment in South County as more important with low likelihood to change.

Although the MPOS indicated only 57 % of respondents knew how to access treatment and focus groups and key interviews talked about the lack of treatment options, the OMPPNAWG prioritized this contributing factor as low likelihood to change. Other groups and agencies are working on this issue. Also, it is difficult to start a new treatment center due to various reasons discussed previously such as NIMBY, regulations, credentialing of providers, etc.

- Retail access: Lack of use of PDMP by pharmacists and doctors

Lack of use of PDMP by pharmacists and doctors was prioritized as high likelihood to change and less important. Through key interviews and focus groups, medical providers and pharmacists indicated either they did not use the PDMP because they did not know about it or it was time consuming and cumbersome. The OMPPNAWG scored this contributing factor as high likelihood to change with training of pharmacists and physicians. It was scored as less important because other entities such as the State, are working on this.

VII. CONCLUSION

a. SUMMARIZE HOW THE NEEDS ASSESSMENT RESULTED IN THE SELECTION OF SPECIFIC TARGET INTERVENING VARIABLES AND CONTRIBUTING FACTORS

The OMPPNAWG met once a week for six weeks during the months of April and May 2015. The OMPPNAWG collected quantitative and qualitative data for AAC on opioid misuse and analyzed the data for intervening variables and contributing factors. Based on the prioritization process recommended by the State, the OMPPNAWG selected the following contributing factors with high importance and high likelihood to change.

- Social availability: Lack of proper monitoring and storage of prescription opioids in the home leading to easy access
- Social availability: Doctors and pharmacists do not discuss the dangers of prescription opioids with their patients.
- Community norms and perceived risk: The belief that prescription opioids are safer than heroin.

b. DESCRIBE YOUR PROBLEM STATEMENT

i. Use Data about consumption, consequences, readiness, resources and changeability to frame problem statement in specific terms

Prescription opioid misuse among youth and young adults ages 14-35 in Anne Arundel County as indicated by ever use of prescription opioids is related to social availability given lack of proper monitoring and storage of prescription opioids in homes.

Prescription opioid misuse among youth and young adults ages 14-35 in Anne Arundel County as indicated by the Maryland Public Opinion Survey is related to social availability given doctors and pharmacists do not discuss the dangers of prescription opioids with their patients.

Prescription opioid misuse and heroin use among youth and young adults ages 14-35 in Anne Arundel County as indicated by the Maryland Public Opinion Survey and focus groups is related to perceived risk given people believe that prescription opioids are safer than heroin.

one per focus group / Key Interview

Analyzing Focus Group and Key Informant Interviews

You may use this tool to track themes that emerge from each of your focus groups and key informant interviews. This will help you identify the most relevant contributing factors in your community. The second part of the tool (next page) will help you summarize the themes that emerge from all of your qualitative data.

Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	Treatment Providers / DOH Adult Addictions	**Date, Time, Location**	3/25/15
Community	Staff Focus Group	**Number of Participants**	20

Common themes regarding:

Community norms (Using Rx drugs is more acceptable than Heroin) Factors:	- Easy access - More access means more use - Youth doesn't know opioids are addictive - Sports injuries - prescribed meds - become addicted - Frequently w/ high school & college athletes - injuries - Emotional trauma, sleep issues, families who use, large amounts taken for medical surgeries (like wisdom teeth / C-section)
Enforcement	- Police usually get people with possession & attempt to sell. - In So. Co.: more patients come in asking if there will be more treatment centers - Police know where hot corners are, but nothing gets done. - Lot of Narcan trainings
Perceived risk of harm	- Hep-C, HIV, mixing drugs can kill you - Staph infection - No regulation on Heroin, the purity has gone up - ↑ OD's "Stronger stuff is better stuff", "I know it'll kill me, I'm still tempted"
Retail access	- Doctors over-prescribe - Lack of education after someone has injury - Drug dealers ↳ Doctor shop - Drugs are cheap - selling Rx pads - "Candy-Man" Physicians - Pain clinics - very easy to get a script - Insurance lapses - doctor's stop prescribing, so people switch to heroin - Money flow is quick - people will sell & people will buy
Social access	- Close to Baltimore - we are straight beeline from FL to NY. - Heroin - cheaper - pill parties - fish bowls - Everyone knows where hot corners are - Leftover Meds - Jail units - suboxone is snuck in easily - Family members - Neighbors - Lexington Market
What did you learn about your intervening variables and contributing factors?	- "Some people come in that have directly used heroin - but less common" - Progression is mostly from cigarettes, alcohol, marijuana, then drugs → switch to heroin & stick with that. - Percocets - most common, easiest to get
Other pertinent information	- Absolute horror of using IV to get high vs. snorting it. - Users swear they'll never use needles - There's a shock that heroin is being used in middle-class neighborhoods - There needs to be more for kids to do, DARE is non-existent (activities) - There's a lack of education in family units

One per focus group / key interview

Analyzing Focus Group and Key Informant Interviews

You may use this tool to track themes that emerge from each of your focus groups and key informant interviews. This will help you identify the most relevant contributing factors in your community. The second part of the tool (next page) will help you summarize the themes that emerge from all of your qualitative data.

Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	OB Adults in Recovery/Clients	**Date, Time, Location**	4/9/15
Community	Adult Addictions	**Number of Participants**	8
Common themes regarding:			
Community norms	- People take Rx meds when they aren't prescribed, or use more than what's prescribed. - community doesn't know how to properly store medications - People start with Rx pills, then switch to heroin - people think they're better when they use Rx pills because they aren't using heroin but it's the exact same thing. - Misconception in community that pills are better than heroin		
Enforcement	- police are on the ball - A little too much enforcement - court is too strict, no second chances - one and done - judge has no knowledge on addiction - Better equipped to be able to handle a problem in the county as opposed to city cops who just lock you up.		
Perceived risk of harm	- Disease - Depends on the way you do it - can't just snort a "dope pill," and see people shooting up + not want to do it too.		
Retail access	- Doctors over-prescribe / Doctor shop - Doctors cut you off, but you're already addicted		
Social access	- Drugs come from people you know - "If I didn't go to Baltimore, I wouldn't have gotten it." - Parents don't think about storing their meds - People steal meds from neighbors, friends/families houses - Heroin is harder to get in County compared to city, you have to know someone - "If you don't have a phone, you're screwed." There are just as many dealers in co. as in city, it's just more expensive		
What did you learn about your intervening variables and contributing factors?	- Group doesn't know where prescription take-back boxes are - A lot of comparison btwn. County vs. city		
Other pertinent information	- "I was ready to rob a pharmacy when I was hooked on pills, it's just as bad as heroin." - started from being prescribed for injuries, then get cut off, switch to methadone + become addicted - "People don't understand it until they start living it" - people judge you when you say you're an addict, especially when you're pregnant. - until you hit a certain age, consequences don't mean as much to you.		

(All one) Pathways Staff focus Group

Analyzing Focus Group and Key Informant Interviews

You may use this tool to track themes that emerge from each of your focus groups and key informant interviews. This will help you identify the most relevant contributing factors in your community. The second part of the tool (next page) will help you summarize the themes that emerge from all of your qualitative data.

Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	Treatment Providers / Health care	**Date, Time, Location**	3/23/2015 Pathways
Community		**Number of Participants**	8
Common themes regarding:			
Community norms	Heroin is a severe epidemic in our county, state, country ~ about 2½-5yrs ago all percocet, now heroin ~ many adolescents using heroin, a change from about 7-10yrs ago ~ about 50% of users become addicted to pain meds, about 50% use after gateway drugs ~ expectation for pain meds in ED ~ change is driven by economics		
Enforcement	need longer programs / follow up after drug court ~ attitude of police has improved but EMT's have stereotypes / bad attitudes towards addicts ~ sometimes the system works ~ community afraid to be arrested if they take pills to drop box ~ regulation of methadone, suboxone (hard to prescribe), pain management docs		
Perceived risk of harm	users not afraid of needles or of overdose ~ no stigma attached to heroin ~ young people finding family OD and come back to life ~ if withdrawing, can get suboxone on the street ~ scare tactics only work for some		
Retail access	doctors are over prescribing EVERYTHING ~ unethical practices, doctors taking cash ~ ortho, spine, pain, dentist over prescribing ~ ED Docs don't want to deal with addicts ~ if addicted in pain management, cut from program, turn to heroin ~ pharmacy red flags monitored ~ morphine / delated for wks in hosp.		
Social access	patients take from family (mostly older adults), then turn to neighbors, then dealers ~ people don't know about take back locations ~ people dump pills down toilet ~ people don't know how to get rid of meds until family in treatment		
What did you learn about your intervening variables and contributing factors?			
Other pertinent information	Need to holistically treat patients ~ less drugs to treat drugs ~ methadone outdated ~ use electrolytes for detox ~ docs need education and to be more regulated ~ more access to treatment for everyone (lower deductibles & medicaid to pay for detox) ~ suboxone clinics need high regulations ~ patients need access to mental health ~ over prescribing psy meds ~ need to wait 3/6/1 yr to prescribe / diagnose mental health		

Analyzing Focus Group and Key Informant Interviews

You may use this tool to track themes that emerge from each of your focus groups and key informant interviews. This will help you identify the most relevant contributing factors in your community. The second part of the tool (next page) will help you summarize the themes that emerge from all of your qualitative data.

Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	Treatment Providers	**Date, Time, Location**	[redacted] March 23, 2015 12pm pathways
Community		**Number of Participants**	8
Common themes regarding:			
Community norms	Not aware of locking up medication; Stealing from family; Stigma; culture; reaction then prevention; more prevention; more education;		
Enforcement	Attitude has improved with police; EMT have bad attitude toward patients; Every once in awhile the system works; Diverting to treatment instead of Jail (too short); stop legalizing marijuana (sending mixed messages)		
Perceived risk of harm	individualized; drug court (sometimes works sometimes doesn't); death; heroin; needles do not have the same stigma as before; Suboxone will always be a crutch for heroin users		
Retail access	Suboxone (easy to avoid consequences) (more available on the street); individuals from pathways who go to hospital forced to take drugs; hospitals; morphine (pain on a scale of 1-10) orthopedic; dentist		
Social access	Driven by economics; pills to heroin; patients/kids listen to other patients/kids and want to be cool; internet; family members		
What did you learn about your intervening variables and contributing factors?			
Other pertinent information	High Schools should have drug counselors; better system for reporting physicians; doctors; physicians need to be closely monitored; quality of treatment; dr's philosophy not in line with substance treatment. Suicide vs. drug overdose → how do you know		

Analyzing Focus Group and Key Informant Interviews

You may use this tool to track themes that emerge from each of your focus groups and key informant interviews. This will help you identify the most relevant contributing factors in your community. The second part of the tool (next page) will help you summarize the themes that emerge from all of your qualitative data.

Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	Users, People in Treatment	**Date, Time, Location**	March 18, 2015
Community	Outpatient People in Treatment AACo	**Number of Participants**	8 Pathways
Common themes regarding:			
Community norms	Epedemic, touching everyone in someway, community is viewing heroin addicts differently, doesn't discriminate, too late in dealing with epidemic, pills to heroin, pills are safer, trouble finding treatment, mental health plays a huge role in use and self medicating (young, white)		
Enforcement	Longer jail time, increase consequence, offer treatment over punishment, 12 steps or rehab in jail, doctors/pharmacy held accountable		
Perceived risk of harm	severe consequences on home, family, work, life, prescription drugs less risky because you know what you are getting, futures are taken away, knew heroin was dangerous but marijuana/alcohol was their gateway		
Retail access	Doctor shopping (5 doc's at once prescribing different meds) - surgery prescriptions leading to addiction, Pharmacy ignored red flags, unaware of prescription drug take-back		
Social access	School, stealing from medicine cabinet, parents/adults have no education on whats going on		
What did you learn about your intervening variables and contributing factors?			
Other pertinent information	insurance is a problem, need access to treatment, longer treatment coming from streets a problem if they want help. Educate parents on current drug trends and language, mental health counseling (access now and at younger age) Education to patients from doctors after surgery, mental health interventions necessary, gateway drugs started young		

Reduce the stigma and educate families

Analyzing Focus Group and Key Informant Interviews

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Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	Users in treatment Anne Arundel County	**Date, Time, Location**	3/19/15
Community	Inpatient Treatment (Pathways)	**Number of Participants**	8

Common themes regarding:

Community norms	Heroin is not taboo anymore, young people are not afraid of it, stigma towards drugs like heroin has changed, Heroin abuse starts with gateways like alcohol, tobacco, marijuana & pills, drugs should be legalized and more ~~treatment offered, whatever drug is tried first will be~~ The gateway to heroin
Enforcement	police need to go after suppliers not users, doctors should be better regulated, terrorist & ISIS are bringing drugs here on purpose, cops often stereotype, police make fun ~~of heroin addict and offer no resources~~
Perceived risk of harm	more people are thinking heroin is not dangerous, some patients were scared of heroin so they began by snorting and eventually moved to IV- ~~after they did not have access~~.
Retail access	Internet heroin, doctors (particularly hospitals) are over prescribing medications, most stole from older family and neighbors (pills), docs prescribing even with + drug screen for $
Social access	5-6 years ago MD flooded with heroin, can easily get heroin from dealers but pills difficult now Purity changed from white to brown
What did you learn about your intervening variables and contributing factors?	
Other pertinent information	Suboxone is easy to get and abuse Methadone is a 'joke' most people abusing Some combining all ~~Patients need access to care both~~ S.A. and mental health Young people need to know how to make friends and deal with sadness "Addicts are not addicted to mood-altering drugs, they are addicted to ~~their~~ mood"

Anxiety is a problem
Wait 6 months to 1 yr to diagnose mental illness

Analyzing Focus Group and Key Informant Interviews

One per focus group / key interview

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Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews

Demographic Group (eg. youth, users, providers, etc)	Treatment providers	**Date, Time, Location**	4/2/15
Community	ROSC Focus Group	**Number of Participants**	11

Common themes regarding:

Community norms
- People take more than prescribed
- Too much drug replacement - Suboxone + Methadone
- People use due to boredom
- parents are uninformed; Kids are predisposed
- Kids are fearless - White, middle-age, middle-income
- Denial in community, huge stigma

Heroin use: cheaper, doesn't smell, high lasts longer, can't get Rx drugs anymore, glorified/tolerated

Enforcement
- Drug dealers aren't being arrested
- Enforcement is horrible - Don't understand recovery + addiction, Should be more educated
- Lack of Enforcement
- Overlook problem
- "Their hands are tied" - Eventually incarceration will out-do schools

Perceived risk of harm
- Increased ED visits - OD, death, physical addiction, loss of family
- Lack of perceived danger (among users)
- Mixing other drugs w/ Heroin leads to OD, like Xanax, Coke, Nyquil, Tylenol PM, speed-balling
- Narcan won't help when people mix drugs * Users don't think they'll get hooked, don't think about consequences, they're invincible *

Retail access
- Doctor shopping
- Doctors don't understand recovery process
- Start from injuries
- CRISP Program

Social access
- Take meds from medicine cabinets
- A lot of drug dealers
- word of mouth
- parties
- people keep meds in purses - easy access (Not up high + hidden)

What did you learn about your intervening variables and contributing factors?
- Sports injuries, friends are using, depression, chronic pain (All factors) Low self-esteem
- Heroin use is dirty/-only see it on TV, but people have gotten used to it.
- Heroin use is low, bottom of the barrel, inner-city

Other pertinent information
- Parents think kids are just going through a phase
- Addiction is a disease - it's not a phase, it's a sickness
- Now that its accepted, people are admitting that they use.
- "We need to be better marketers than drug dealers"
- ~~"We need to make Recovery attractive"~~
- "We need to focus on life skills + peer support"

Analyzing Focus Group and Key Informant Interviews

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Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	Adults	**Date, Time, Location**	3-19-15 evening
Community	Annapolis Adults in Treatment	**Number of Participants**	7
Common themes regarding:			
Community norms	Its OK to use someone else's prescription. Its OK to lie to Doctors or use more or different than prescribed. Pill addiction isn't as dirty like heroin		
Enforcement	Police should have more power to help. I've seen too many people die because others were scared to call for help.		
Perceived risk of harm	The chances of getting caught depend on where you use. It's easily hidden at home. No Doctor ever talked to me about dangers.		
Retail access	Prescription pain killers from injury. Then shared.		
Social access	Starts by sharing pills & people like the way it feels. Get pills from med. cabents Everyone shares		
What did you learn about your intervening variables and contributing factors?	Started using with friends to overcome grief; when wisdom teeth were removed.		
Other pertinent information	Had no idea pills & heroin were related		

Analyzing Focus Group and Key Informant Interviews

one per focus group / key interview

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Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	Townhall - Parents, Educators	**Date, Time, Location**	2/24/15 6-9
Community	Pasadena	**Number of Participants**	30

Common themes regarding:

Community norms (Kids are naturally curious & will experiment then develop physical dependency)	- Junior prom is worst w/ SA - underage drinking is a gateway - suspension crimes are happening after school hours - Parents would like to see rep. from DJS - Kids get caught up in this lifestyle. - Problems start in middle school, parents want to see MS data
Enforcement	- Youth believe you will get suspended if you have drugs in school, & suspension data is accurate. - Parents are the KEY to stopping substance abuse ↳ First line of defense in substance abuse - Scare tactics don't work
Perceived risk of harm	
Retail access	- Baltimore is heroin capital of the U.S. - Opiates - OxyContin is $75 for one pill, 10 caps of Heroin is $100. (cheap) - There are no labels on street drugs
Social access	- "Parents need to be mindful of Rx meds., because abuse starts there" - "Heroin is becoming the main issue / focus because that's what kids progress to, that's how kids are dying." (seemed as though a greater concern)
What did you learn about your intervening variables and contributing factors?	- Parents are #1 influence in a child's life. - Drug addiction is 100% preventable - Communication & Education are Key.
Other pertinent information	- Parents would like to get more involved in prevention throughout community - Rep. from NARANON spoke - "There is a stigma on heroin use, people are embarrassed so you don't hear about it. - But it's there"

Analyzing Focus Group and Key Informant Interviews

me per focus group / key interview

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Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	Parents / users / providers	**Date, Time, Location**	2/20/15
Community	Focus Group - Heroin Task Force	**Number of Participants**	

Common themes regarding: - 18-30 yr olds - Need younger ppl to engage population

Community norms "Addiction's a disease" $85/week @ Methadone Clinic	- No aftercare or continuum, could only find outpatient treatment - Began @ age 15, got treatment in FL. - Return to community & knew where drugs were - "Need to get away to get treatment" - "Son was sent to PA, & cut off after 12 days because I couldn't afford the $1,000/day, sent to FL on a scholarship & is doing well." - Workforce Development is an issue ✓ - Need for providers to use Evidence-based Programs - Have to design a system to deal w/ co-occurring disorders, trauma as well as SA. ✓ - Discharge plans aren't done right * Waiting lists @ treatment centers ✓✓ - sent son to NC for free treatment, but he can't return to MD
Enforcement - Police didn't arrest my son when he OD'd, they called me instead to come get him.	
Perceived risk of harm	- Addicts can't get jobs bc of charges
Retail access	- Son discharged from facility w/ 13 Rx drug bottles - anti-anxiety, non-narcotic pain relievers, etc. - Insurance is a whole other issue, they should pay & they don't. - Providers aren't getting support from State
Social access	
What did you learn about your intervening variables and contributing factors?	
Other pertinent information	- Need a crisis hotline for parents who are scared for kids. - Kids need to know about AA & 12 step groups

One per focus group/Key Interview

Analyzing Focus Group and Key Informant Interviews

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Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	County Executive's Focus Group - Education	**Date, Time, Location**	2/20/15
Community	Dr. Cicero's Education, Prevention + Awareness Group	**Number of Participants**	50
Common themes regarding:			
Community norms	- Parents have limited access to treatment for children, many children had to go out of state for treatment - Board of Education / schools are becoming more involved - There's a need for a team of parents, professionals to do presentations in the community		
Enforcement			
Perceived risk of harm			
Retail access			
Social access			
What did you learn about your intervening variables and contributing factors?	- Parents should have access to all information regarding their children and substance abuse. - Goal of governor is to bring all counties together (coalition) so each county will understand + know what's going on in each jurisdiction + work together on problem.		
Other pertinent information	- School curriculum is being re-written which will be integrated in 2015 school year 6th Grade - Alcohol 7th Grade - Alcohol + prescription drugs 8th Grade - Marijuana, 10th grade - Heroin		

Analyzing Focus Group and Key Informant Interviews

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Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	Parents / Community Forums	**Date, Time, Location**	9/24 10/18 11/18 12/12 1/27 3/10
Community	~~South Eastern~~ County	**Number of Participants**	75
Common themes regarding:			
Community norms	The schools should do more social media and cell phones are ~~have~~ changing how we view this issue		
Enforcement	increased crime in neighborhoods, appreciation expressed for police presence Many crimes, but only a few people.		
Perceived risk of harm	There is a lack of treatment		
Retail access			
Social access	need more activities in SE Co.		
What did you learn about your intervening variables and contributing factors?			
Other pertinent information			

Analyzing Focus Group and Key Informant Interviews

One per focus group / key interview

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Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	Involved Citizen	**Date, Time, Location**	3/11/15, 12:00pm
Community	Deale - South County	**Number of Participants**	1 (Key Interview)
Common themes regarding:			
Community norms	-users are 18-25, they start younger & become addicted when older, they're starting in high school + middle school. -community is not ready -parents are in denial, they won't admit there's a problem. -The problem interferes with living		
Enforcement	-Heroin Epidemic has helped spread information -I've seen surveillance & cameras (vans) -More enforcement will help problem -police has become more involved -No dialogue/communication from parents @ home.		
Perceived risk of harm	-I've heard gun shots -car crashes -fights -death -jail time -Mental institutions -rehab } If you don't get treatment		
Retail access	Near -Liquor stores - area where kids congregate -7-11		
Social access	-Houses in neighborhood distributing drugs -Kids gather near woods, have easy access		
What did you learn about your intervening variables and contributing factors?			
Other pertinent information	-prevention is MOST important -Faith-based organizations, pastors & elected officials make a difference. -Townhall Meetings, coalitions, presentations all help with prevention/awareness		

Analyzing Focus Group and Key Informant Interviews

One per focus group/key interview

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Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	(Law) Enforcement	**Date, Time, Location**	3/9/15 Southern District Police Station - 2:00
Community	South County	**Number of Participants**	1
Common themes regarding:			
Community norms	-People using ages 18-40 -Anyone can use at any time -Back pain/surgery/injuries/having multiple doctors → factors for use -People in community are not ready -Not enough treatment centers -people don't want treatment centers in their neighborhoods · issue is becoming worse -People are more frequently using in public areas		
Enforcement	-Police Dept. tries to address issue through social media -Attend community events: churches, youth groups, Boy scouts -Heroin Task Force -Locking people up isn't solving the issue		
Perceived risk of harm	-Being caught -seriously injured/harmed -death -↑ crime rate		
Retail access	-Rx drugs have become very expensive (more than ever)		
Social access	-People buy drugs on streets (Heroin) - cheaper -ways to spread more awareness: newspapers, involving celebrities, radio, church groups, youth groups		
What did you learn about your intervening variables and contributing factors?			
Other pertinent information	-Major priority should be informing parents on issue, and ways to communicate w/ their children. -communication is key. -Need to spread awareness/prevention/education at a younger age.		

Analyzing Focus Group and Key Informant Interviews

One per focus group/key interview

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Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	Involved citizen/ Law	**Date, Time, Location**	3/3/15 Northern District Police Station- 11:00
Community	South County	**Number of Participants**	1
Common themes regarding:			
Community norms	- People are becoming more aware of issue - Anyone can use @ any time - People use gateway drugs, get bored, & progress to different level - NIMBY effect - affluent & rural which involves - Impediments: perceptions to chosen ignorance		
Enforcement	- misuse impacts police dept. by adjusting their focus to target suppliers & put larger emphasis on supply and demand. - Heroin Task Force - positive outcome - Rx drug take back boxes		
Perceived risk of harm (consequences)	- Jail time - ↑ crime rate - ↑ Narcan responses		
Retail access			
Social access	- "Gateway" Drugs - Risky behavior		
What did you learn about your intervening variables and contributing factors?			
Other pertinent information	- Coalitions' main focus should be to change perceptions - A tragic event must happen involving heroin to bring community together - Resources are hidden * Need to target different geographic locations		

Analyzing Focus Group and Key Informant Interviews

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Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	prevention, treatment, Faith-based community, resident	**Date, Time, Location**	March 11, 2015 Cedar Grove United Methodist
Community	Deale	**Number of Participants**	1
Common themes regarding:			
Community norms	-Marijuana is a major problem in Deale -Effects family -No recent change of issue, but major problem -Kids btwn. 17-25 -community is NOT ready -People have too much time on their hands -community is becoming more aware		
Enforcement	-No leadership or direction in pursuing constructive outlets for energy -Police have removed paraphenelia		
Perceived risk of harm (consequences)	-users (heroin) either get help or die of overdose		
Retail access			
Social access	-Marijuana is a major problem in Deale. -Drugs ~~being~~ changing hands down by 7-11 + liquor store		
What did you learn about your intervening variables and contributing factors?	-Too much free time- Not enough activites -Declining membership at church -Loss of NA + ~~AA~~ meetings at church		
Other pertinent information	-Need to look @ older adults, especially those who have retired + have new challenges with the amount of time on their hands -church has put up prevention posters -So. Co. Bridges has been a big help in spreading awareness		

★More has to be done to reach kids + drive into them not to do drugs in the first place.

-Church is working on inviting representatives to talk to youth groups (Sunday school + wed. night programs)

★Could interview other pastors/churches

(No info on data collection)

-Church has declined from 450+ to 115

Analyzing Focus Group and Key Informant Interviews

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Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	Adult recovering heroin addict	**Date, Time, Location**	Outpatient treatment center
Community	South County Resident	**Number of Participants**	1
Common themes regarding:			
Community norms	They dont think pills are a problem. They dont think they'll get addicted and then they judge people who do.		
Enforcement	The cops dont care about your problem, they just want to catch you and put you in jail.		
Perceived risk of harm	Death, jail, diseases, loss of job, family... loss of everything		
Retail access	People lie to get prescriptions. They're not hard to get.		
Social access	Pills are all over the place, and they're expensive. Heroin is cheap, but once you have a habit you usually start		
What did you learn about your intervening variables and contributing factors?	dealing or stealing to support it. → Theres NO help in this community. But theres several bars!		
Other pertinent information			

Analyzing Focus Group and Key Informant Interviews

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Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	Suboxone provider	**Date, Time, Location**	South County
Community	South County	**Number of Participants**	1
Common themes regarding:			
Community norms	The community doesnt understand. This is not a new problem. This is a public safety issue, and we are failing as a society to protect the next generation.		
Enforcement	They do what they can, which isnt much because this is a cycle.		
Perceived risk of harm	I dont know how to educate a community. People work hard, theyre busy... We need other treatment modalities besides replacement.		
Retail access	Kids are raiding closets and medicine cabinets. They think using is a badge of maturity.		
Social access	We are no better off now as a society then we were in the 1920s. Kids are "working"/selling.		
What did you learn about your intervening variables and contributing factors?	Economics, people work with no reward. Why are we so burdened by the thought of protecting these kids?		
Other pertinent information	This is All about money, politics and opinions of people with money. If this is an epidemic and it's deemed as so, why not hire people to work towards a solution? (Community health workers)		

Analyzing Focus Group and Key Informant Interviews

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Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	Juvenielle recovering heroin addict	**Date, Time, Location**	Inpatient recovery center
Community	South County Resident	**Number of Participants**	1
Common themes regarding:			
Community norms	"Pills are the new weed in school. Kids don't think theres anything wrong with it. Their parents either dont know, dont care or are using too"		
Enforcement	Cops arrest you for anything, even if youre not doing wrong, they'll find something because youre labled"		
Perceived risk of harm	Kids know heroin is bad, but they dont expect to get addicted by pills.		
Retail access	I know more people who use, or have drugs than dont. I can always talk someone into ~~taking their family members meds for me~~		
Social access	If you have money- its available. Drugs OR treatment, its all about money.		
What did you learn about your intervening variables and contributing factors?	Again, money. My mom needed money and it was easier to sell drugs than work. At		
Other pertinent information	first I didnt use them, but it seemed fun so eventually I did.		

SoCo.

Analyzing Focus Group and Key Informant Interviews

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Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	Resident	**Date, Time, Location**	3-3-15
Community	SoCo	**Number of Participants**	1
Common themes regarding:			
Community norms	an educated community is a safer community		
Enforcement	police should increase monitoring		
Perceived risk of harm	Crime death		
Retail access	inexpensive heroin		
Social access	peer pressure parks could be place to do drugs		
What did you learn about your intervening variables and contributing factors?			
Other pertinent information	- neighborhood associations could pass info out - contact church groups		

Severe & increasing

So Co.

Analyzing Focus Group and Key Informant Interviews

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Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	Medical / Resid	**Date, Time, Location**	3/3/15
Community	So Co.	**Number of Participants**	1
Common themes regarding:			
Community norms	community is split 3ways: causing argue denial PP/ think it won't happen to me		
Enforcement			
Perceived risk of harm	peers listed in paper for possession there are consequences occuring now		
Retail access			
Social access			
What did you learn about your intervening variables and contributing factors?	Stress Breakups medical issues loss of friends mail out information		
Other pertinent information	very personal issue need information & support speak to high school counselors & nurses High Severity go Hen much worse		

So Co

Analyzing Focus Group and Key Informant Interviews

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Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	Medical + Parent Resident	**Date, Time, Location**	2/27/25
Community	~~[illegible]~~ So Co	**Number of Participants**	1
Common themes regarding:			
Community norms	Champion as most affected by the disease Drug addiction is not a choice		
Enforcement			
Perceived risk of harm	addiction excruciating for families		
Retail access	preaching habits need funding for uninsured		
Social access			
What did you learn about your intervening variables and contributing factors?	poor self esteem outreach & education to schools impaired staff lose jobs		
Other pertinent information	Teens & young adults, esp/ally mental health or chronic health issues ; lack of jobs		

very personal issue Severity = Critical getting worse

Very Ready measure

So Co.

Analyzing Focus Group and Key Informant Interviews

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Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	Treatment Provider (Sub Ab)	**Date, Time, Location**	2/27/15
Community	South County	**Number of Participants**	1
Common themes regarding:			
Community norms			
Enforcement			
Perceived risk of harm	increase in ODs increase in ED visits		
Retail access	open air daytime drug markets		
Social access	nurses could begin to educate lock up meds or dispose at police station		
What did you learn about your intervening variables and contributing factors?	prescription drugs are "deeply rooted" need education		
Other pertinent information	Teens & young adults County Executive — Heroin Emergency PaTHways is involved, multi/all agencies are ready Hard to tackle = Severity Very Bad Worse than ever		

So Co

Analyzing Focus Group and Key Informant Interviews

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Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	Medical / Resident	**Date, Time, Location**	2/22/15
Community	So. Co.	**Number of Participants**	1
Common themes regarding:			
Community norms			
Enforcement	step police patrols		
Perceived risk of harm	young man drowned after using drugs		
Retail access			
Social access	Stolen mail for gift cards focus on social networking user groups		
What did you learn about your intervening variables and contributing factors?	Knowledge by no outreach ED Data important		
Other pertinent information	ongoing issue = Steady severity lack of employment contributing factor lack of supervision - contributing factor suggest to increased family involvement speak to community Boards & churches		

MH - Mental Health
SA - Substance Abuse

One per focus group / key interview

Analyzing Focus Group and Key Informant Interviews

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Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	Health Providers	**Date, Time, Location**	June 20, 2019 10:00 a.m - 12:00 p.m.
Community	Anne Arundel Co.	**Number of Participants**	13, Notes by Dr. Chan
Common themes regarding:			
Community norms	As opioid overdoses continue to be highlighted in the media, providers continue to focus on the need for treatment. Providers agree that there is a need for more providers in A.A. county. The demand for treatment is high + everyone is experiencing waiting lists. The DOH admits 4-5 ppl/week + currently has 158 ppl on a waiting list. The Crisis Response Center is also experiencing growing numbers; "we need to have a strong network"
Enforcement	Right now, workforce development is the top priority for providers. Care coordination was identified as 2nd priority, DOH, MH Agency, Office of Aging + Disabilities, + the Partnership for Children, Youth + Families are all working together to identify resources. (List of 68 programs has been identified among these agencies)
Perceived risk of harm	Co-occurring skill develpm't - 3rd priority. Providers expressed the need for training. Providers are encouraged to share info. on training needs.
Retail access	? The DOH is providing training on Narcan/Naloxone which is open to public. ← More Data? Providers should consider enrolling in CRISP system (Health info. system) run by an organization contracted by state for all hospitals - Lack of pharmacies carrying Narcan kits - Costs of kits continue to increase, but should be covered by Medicaid. - MD Pharmacy Program is a resource to access info. on drugs being prescribed.
Social access	
What did you learn about your intervening variables and contributing factors?	
Other pertinent information	

Analyzing Focus Group and Key Informant Interviews

me per focus group / key interview

You may use this tool to track themes that emerge from each of your focus groups and key informant interviews. This will help you identify the most relevant contributing factors in your community. The second part of the tool (next page) will help you summarize the themes that emerge from all of your qualitative data.

Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	BH providers	**Date, Time, Location**	June 20, 2014, 10am-12:00noon August 11, 2014 AACDOH
Community	AA. County	**Number of Participants**	30, 26

Common themes regarding:

Community norms

1st priority: Workforce Development
Needs: Cultural competency - Military personnel → cultural barrier
- More providers for children/adolescents for SA, esp kids & MH
- MD's needed - suboxone providers
- Not enough people in fields

Enforcement

- Need for bilingual professionals (Spanish) → Language barrier
- ~~Constantly~~ ↑ turnover/Burnout → Needs to constantly retrain/rehire, → ↑ stress to staff (cycle) - could be another issue
- Need for more monitors/care coordinators (repeat)
- Involvement of more peer support specialists

Perceived risk of harm

- Need for awareness of services/resources
- Lack of referrals for adolescent SA → need for awareness of referral sources

Retail access

- Language is diff. btwn. MH + SA → levels of care, acronyms (Barrier↓)
- Patients on suboxone can't see another provider of services (co-occurring)

Social access

- Housing → Training → MH vs. SA: cultures/Languages (Barrier?)
- Need for resolution in crisis situations (beds/chairs - ED diversions) for adults & adolescents
- Not enough providers for full continuum → Housing/sober housing (wait 1-2 weeks) for inpatient residential rehab

What did you learn about your intervening variables and contributing factors?

- Need for "good" psychiatrists who accept MA or insurance at all
- Need more physicians who are suboxone certified & take MA
- Need more services to manage elderly (dementia)
  - co-occurring services
  - children & adolescents
  - getting referrals from out of state

Other pertinent information

- Trauma-informed + trauma-specific services in need (esp. among children & adolescents)
- OMI's South of Glen Burnie

→ Transportation
- office locations
- Ability of patients to access care
- Need for in-home services
- Lack of affordable childcare (patients unable to attend sessions)

*Need to explore how to use non-licensed people in recovery

Analyzing Focus Group and Key Informant Interviews

You may use this tool to track themes that emerge from each of your focus groups and key informant interviews. This will help you identify the most relevant contributing factors in your community. The second part of the tool (next page) will help you summarize the themes that emerge from all of your qualitative data.

Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	Law Enforcement	**Date, Time, Location**	3/25/15
Community	AA County	**Number of Participants**	4
Common themes regarding: users hiding pills to get more, wash machine, stolen from cars			
Community norms	Sharing medications okay among youth ~ no relationship between OD and drug use ~ unknown guests steal drugs ~ middle class kids/users think it cool and they are not junkies ~ problem with sports, work, farming injuries leading to pain relievers ~ docs pushing pain meds ~ insurance can get pills		
Enforcement	criminals don't want to go to Fed court and will intentionally calculate in order to stay out ~ arrest 20-30 yr white male/female not many young arrests ~ not african american users more dealers ~ law changed for OD deaths, dealer can be charged (assigned officer)		
Perceived risk of harm parent orientation to address generation gap	~~South county comes to Annapolis for stronger drugs~~ ~ stepping on drugs to make money; don't know how risky drugs are because of stepping, drug dealers change tactics as soon as police change tactics, parking garage at hospital, parking at district court for 30 min ~~dealer became addicted through skin contact~~		community has no clue prevalence of support 3 day training for police
Retail access	call from pharmacists when fake scripts are presented docs prescribe meds to help with withdrawal while waiting for a bed ~ two people in entire county for prescription fraud unit		
Social access	stealing from med cabinets ~ some using with gf/bf and thefts how it starts, some using heroin after injury stealing lottery tickets, folding to footballs, giving to dealers for drugs and dealers use to package		
What did you learn about your intervening variables and contributing factors?			
Other pertinent information	Warning label for "may cause addiction" DOPE = HEROIN = AACo More training and more immediate access to treatment		

College, High, Middle orientation

Analyzing Focus Group and Key Informant Interviews

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Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	Pharmacist	**Date, Time, Location**	Friday, March 27, 2:15pm Weiss, Pasadena, MD
Community	Medical	**Number of Participants**	1
Common themes regarding:			
Community norms	- NOT Acceptable - This is for All Controlled Substance - They do not Like The fact how much it has risen - Need more educational community base programs - Very concerned About having children exposed to people Peddling drugs		
Enforcement	- The Pharmacist works with a police officer when he spots A FAKE prescription - He makes a copy, get License info & pass it to the police - Unaware about the knowledge or feelings of users - Works with Police to Apprehend illegal pads		
Perceived risk of harm	2009 - He use to give syringes up request but due to People using in parking lots & disposing of them in where Children can obtain, Now They MUST have a prescription - death - Brain Damage - Psychological Problems - He does not Talk To clients in the manner to Assume They Are drug users but give Advice About medication)		
Retail access 20 miles Corridor PDMP & CRISP Works Together	There is some Thing called "The channel" In P.G Co, which People from Forrestville, Suitland, & Seat Pleasant get FAKE prescriptions & fill it in Pasadena Area. Go from place to place - (PDMP - Prescription Drug Monitoring Program & CRISP CRISP - Chesapeake Regional Info. System to Track Abusers DO NOT Write Anymore prescriptions for those who Abuse System		
Social access CRISP - CASH MONEY	- They Steal - Fraud (FAKE prescription pads) - Stolen pads - Friends & Family - Create prescription pad (software) - The channel - Call The Pharmacy & Pretend They are doctor office		
What did you learn about your intervening variables and contributing factors?	Social Availability - Someone gave it to them, Stole it from Someone - FAKE ID's LAW Enforcement - NOT enough officers - 1 Heroin Detective Sandra Barnes - AA Co. RETAIL Availability - Use illegal pads, Sell on streets, Steal, Cheap Available		
Other pertinent information What Drug is Commonly over prescribed	What Problem with Prescribing practice: Having to verify Authenticity of prescription with Doctors - Getting drugs covered under insurance plans Pediatric Antibotic - (over prescribed) Opioids not over prescribe it is over used by illicit means The use is continuing rising in Pasadena area		

Analyzing Focus Group and Key Informant Interviews

You may use this tool to track themes that emerge from each of your focus groups and key informant interviews. This will help you identify the most relevant contributing factors in your community. The second part of the tool (next page) will help you summarize the themes that emerge from all of your qualitative data.

Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	Enforcement Mtg. Police, Sheriff	**Date, Time, Location**	4-16-15 11AM Western District PD Odenton
Community	AA County County-Wide	**Number of Participants**	14
Common themes regarding:			
Community norms	Extended families are involved Knows about Crisis Response. Police do take a supp There is no typical addict - [redacted]		
Enforcement	Detectives investigating evidence found in the mail could lead to dealers. 1 Detective is assigned to prescription fraud. Enforcement puts a risk in place Increase in petty thefts and meeting		
Perceived risk of harm	No Teeth! Heroin is their fun Drug; Crack is my emotional drug Never know what is in it. Never thought they'd shoot up but they did.		
Retail access	Prescriptions are stronger than they need to be - try less strong options Difficult to get pills.		
Social access	No one really understands The Good Sam Law: Need a training bulletin. Safe's cost $30. Everyone should get a safe		
What did you learn about your intervening variables and contributing factors?	Pain & Sports Injuries; MH Problems;		
Other pertinent information	A Dentist prescribed Rx to a Juvenile. When the youth returned his parents were asked how many were necessary & what was done with the remainder of the pills		

Analyzing Focus Group and Key Informant Interviews

one per focus group / key int

You may use this tool to track themes that emerge from each of your focus groups and key informant interviews. This will help you identify the most relevant contributing factors in your community. The second part of the tool (next page) will help you summarize the themes that emerge from all of your qualitative data.

Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	Doctor	**Date, Time, Location**	4/7/15
Community	Staff Emergency Medicine	**Number of Participants**	1
Common themes regarding:			
Community norms	-Scale of 1-10, 9 -More OD's than ever -Patient population is more diverse than ever -A lot more younger people, especially using heroin 1st -Most common reason people are misusing opioids is to get high, + they don't want to use needles or obtain heroin marks, it's less conspicuous to use pills 2nd -People use from injuries/accidents + become addicted - people who use usually have a mental disorder - start w/ alcohol/marijuana + progress to Rx drugs → heroin - White: 20s + 30s		
Enforcement	-Needs to be closer monitoring by physicians + family members for people who are prescribed drugs for medical reasons -BWMC sends letters to patients whom they have a concern about, flag their charts, give a warning, send letters to primary physicians -Physicans discuss some counseling points w/ patients who are prescribed opioids		
Perceived risk of harm	-↑ OD's, lead to people becoming brain dead -Death		
Retail access	-Doctor shopping -CRISP is helpful → Experience it every shift -Should be a National Program that monitors opioid use, w/ barcodes -PDMP is very slow + redundant, time-consuming -BWMC uses PDMP every day, about 80% of the time		
Social access	-Most people buy drugs/heroin off the street -People steal from family members/friends -Rx's are stolen - very common -social networking - young people are around users + want to try it + end up addicted very quickly/easily because that's what heroin does.		
What did you learn about your intervening variables and contributing factors?			
Other pertinent information	-People say there's "no high quite like heroin" - it's the next best thing -Rarely see hispanics -Half of users want help, half don't, only half admit they have a problem -Families always want to get help -There should be a continuum of links of medical records from OP providers + hospital providers. - should be a number for people to get help that says 'here are the steps you need to take.' - It's a tragedy, and it's heartbreaking seeing the OD's and young people dying from this issue.		

Analyzing Focus Group and Key Informant Interviews

one per focus group / key interview

You may use this tool to track themes that emerge from each of your focus groups and key informant interviews. This will help you identify the most relevant contributing factors in your community. The second part of the tool (next page) will help you summarize the themes that emerge from all of your qualitative data.

Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	BWMC Addictions Specialist	**Date, Time, Location**	3/27/15
Community	BWMC	**Number of Participants**	1
Common themes regarding:			
Community norms	+Very severe -Generational -start on opiates -female use is increasing +Younger kids & vulnerable brains being exposed +18-28 y.o. -starting younger -Easy access +Fewer resources, not enough prevention -Fewer Tx Beds in community makes discharge planning more lengthy -Admission returns more likely +Take up more ED beds -Addicts say they're suicidal to get admitted & that closes physicians beds to "Real" psych patients		
Enforcement			
Perceived risk of harm	+Absecesses -consequences occur earlier as opposed to consequences from ETOH +endocarditis +kidney failure +↓motivation for school, work +↑OD's -unintentional		
Retail access	+Doctors are getting more verbal in wanting to help stop problem +Insurers - value options changed reimbursement options, now harder to find Tx Beds -Private Methadone clinics		
Social access	+Can get drugs easily from friends/family		
What did you learn about your intervening variables and contributing factors?	+People say they want help, but when it comes to treatment -NIMBY		
Other pertinent information	+BWMC employs Addiction N.P. to care for in-house patients & serve on community wide committees. +BWMC is exploring opportunities for population Health Management & is open to collaboration to avoid ↑ cost unneccessary hospitalization		

Analyzing Focus Group and Key Informant Interviews

one per focus group / key interview

You may use this tool to track themes that emerge from each of your focus groups and key informant interviews. This will help you identify the most relevant contributing factors in your community. The second part of the tool (next page) will help you summarize the themes that emerge from all of your qualitative data.

Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	Law Enforcement	**Date, Time, Location**	3/27/15
Community	So. County Lothian	**Number of Participants**	1
Common themes regarding:			
Community norms	-Affecting every economic status, low income, middle-class, affects every type of family - worse than its ever been. -1-10, 9 (scale) -starts w/ pills, moves to heroin -starts w/ injuries + spirals to addiction -Affects everyone from High school students to senior citizens -connection w/ SSI checks -Abuse is constant because people need it.		
Enforcement	-sentences aren't what they should be -Dealers get out because of over-crowding -Cell phone's make it harder for police		
Perceived risk of harm	-Very successful business owners use + lose their life in 2 years -lose businesses, families -stealing, crime rate ↑, shoplifting, burglaries ↑ - people steal razors + allergy meds, pawn them to support habit -proceeds to violent crime/property crime		
Retail access	-Doctors over-prescribe + look the other way -script fraud -Lack of consequences on passing fraud scripts -misdemeanor + a chance people are willing to take -Dealers are switching to heroin because profit is greater because they can cut it and triple their money		
Social access	-Being close to Baltimore is a factor -Its become huge in Annapolis, comes from St. Mary's Co. People use -Bathrooms at the mall, starbucks bathrooms, public areas -The cellphone has changed the drug game		
What did you learn about your intervening variables and contributing factors?	-Drug use is a huge strain on tax dollars		
Other pertinent information	-Abuse is a loose term, some people abuse more than others but I don't think its any age or race specifically using more.		

Analyzing Focus Group and Key Informant Interviews

You may use this tool to track themes that emerge from each of your focus groups and key informant interviews. This will help you identify the most relevant contributing factors in your community. The second part of the tool (next page) will help you summarize the themes that emerge from all of your qualitative data.

Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	Youth	**Date, Time, Location**	4/1/15 - Partnership
Community	(High School)	**Number of Participants**	6
Common themes regarding:			
Community norms	- They view it as a bad thing - Not good, crazy - It's worse		
Enforcement	- They can only do so much - They should come to the schools and talk about the conseqauences of using and selling. - Very slim cause it can be easily done - If they are shooting up heroin you can see the needle marks		
Perceived risk of harm	- You can get addicted - You can die - You can lose sense of who you are - Put your family through a lot of stress		- ~~Often~~ Just take what's prescribed
Retail access	- Some doctors giving too many pills - Having a injury or if your sick		
Social access	- They get them from friends - They steal them from family members or friends houses - Take them if they are just sitting in the medicine cabinet - At parties and at school		
What did you learn about your intervening variables and contributing factors?	- That drugs are easy to get - Youth need to be made aware of the dangers		
Other pertinent information			

* - Can get anything, drugs at school

Analyzing Focus Group and Key Informant Interviews

You may use this tool to track themes that emerge from each of your focus groups and key informant interviews. This will help you identify the most relevant contributing factors in your community. The second part of the tool (next page) will help you summarize the themes that emerge from all of your qualitative data.

Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)		**Date, Time, Location**	
Community		**Number of Participants**	
Common themes regarding:			
Community norms			
Enforcement			
Perceived risk of harm			
Retail access			
Social access	- Locked away in a safe place - Somewhere that just anyone can't access - You can drop them off at a police station		
What did you learn about your intervening variables and contributing factors?			
Other pertinent information			

Analyzing Focus Group and Key Informant Interviews

You may use this tool to track themes that emerge from each of your focus groups and key informant interviews. This will help you identify the most relevant contributing factors in your community. The second part of the tool (next page) will help you summarize the themes that emerge from all of your qualitative data.

Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	Adults & Children, Docs	**Date, Time, Location**	3-28-15
Community	Muslim Health Fair	**Number of Participants**	120
Common themes regarding:			
Community norms	Drs want training in Pain Mgmt options for people in recovery.		
Enforcement			
Perceived risk of harm	There is a Dr. Educator on staff at the Pain Management Clinic		
Retail access	Drs did not know how to access the PDMP or the Prescription Drug Take Back boxes		
Social access	Parents generally unaware that medications needed to be protected		
What did you learn about your intervening variables and contributing factors?	Education & easier access (the website) are critical in health fair settings		
Other pertinent information			

Analyzing Focus Group and Key Informant Interviews

focus / key

You may use this tool to track themes that emerge from each of your focus groups and key informant interviews. This will help you identify the most relevant contributing factors in your community. The second part of the tool (next page) will help you summarize the themes that emerge from all of your qualitative data.

Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	Department of Juvenile Services	**Date, Time, Location**	3/25/15
Community	AAC	**Number of Participants**	1
Common themes regarding:			
Community norms	Users - Scale of 1-10, 6, maybe higher, pretty serious in South County - Male, female, young kids, people w/ family history, I know of an 11-yr.old who will use anything he can get his hands on. - Most users are white - ↑ use on weekends, after school - opiate use to "be cool" - could be any time - Kids deny that they use - parents in denial		
Enforcement	- We do the best we can to provide services for kids in need. - School system needs to be engaged when kids are younger as far as drugs & dangers - No policy in schools w/ drug use / come in under influence - opiate use is not the main problem, its not a main priority		
Perceived risk of harm	- overdoses - probation - Removal from home & put in program - Getting caught		
Retail access	- Doctors over-prescribe, easy access		
Social access	- Friends - Families deal w/ other issues & don't focus on child who are using - Parties - using marijuana & drinking & introduced to opiates - Experimentation - Heroin is huge in Balt. City - Kids go to parents medicine & steal it		
What did you learn about your intervening variables and contributing factors?	- Lack of transportation to treatment - Needs to be more media attention		
Other pertinent information	- Kids use the "happening drug" & right now its opiates & heroin - There are more kids w/ a problem than programs - No activities for kids or support - "Drugs are a cycle"		

- Treatment IS NOT ACCESSIBLE - INSURANCE - Major issue
- Need for more communication, more affordable programs, more support for families who are battling this

Constituent Services 3/15

Analyzing Focus Group and Key Informant Interviews

You may use this tool to track themes that emerge from each of your focus groups and key informant interviews. This will help you identify the most relevant contributing factors in your community. The second part of the tool (next page) will help you summarize the themes that emerge from all of your qualitative data.

Qualitative Data Analysis Tool: Focus Group and Key Informant Interviews			
Demographic Group (eg. youth, users, providers, etc)	Mothers of addicts	**Date, Time, Location**	2/10/15 9:00am Annapolis
Community	Anne Arundel County residents	**Number of Participants**	5
Common themes regarding:			
Community norms	Opioid use heroin use	Starts young gateway drugs, Middle school age schools, family	
Enforcement	Don't public know as much as they should No face to addiction		
Perceived risk of harm	Death, overdose, withdrawls, Financial burden, broken families		
Retail access	Pharmacy Doctors Prescribers		
Social access	Dealers Social media friends family		
What did you learn about your intervening variables and contributing factors?	there is lack of treatment, Education and Support,		
Other pertinent information			

Qualitative Data Analysis Tool (Part 2)
Now think about ALL the focus groups and key informant interviews you have collected. These will help you with Section IV of your Needs Assessment Report.
Did you notice any differences between different participants/respondents (e.g., providers versus users, or males versus females)? Summarize these differences. The majority of key points were similar throughout focus groups and key informant interviews. The intervening variable with the most differences was enforcement. People in Treatment/Recovery reported the police to be everywhere with the adjudication process strict. Providers and other focus group and key interview participants indicated the police do what they can but there is a shortage of officers to deal with the problem. These groups also indicated adjudication was not strict enough on those who distribute and sell drugs. Another difference was the intervening variable perceived risk. Focus groups and key interview off all participants except the youth indicated youth see heroin use as less risky than previous generations. Use is starting at younger ages and is more culturally acceptable. The youth focus group said that the majority of youth still see heroin use as very risky and dangerous.
What key points resonated with other information you have collected? How did the focus groups and key informant interviews you collect align or not align with the quantitative data you collected? Key interviews and focus groups agreed with the quantitative data that showed the most common age group abusing prescription opioids and heroin are the 14-35 year olds. The law enforcement data aligned with the hospital data and school data indicating that the Northern and Southern parts of the County have higher opioid misuse and overdoses. The OCME overdose data indicates that there are a higher percentage of white males dying of overdoses in Anne Arundel County. SMART data and key interviews and focus groups agree with this. Hospital data agrees with the focus group data that it is not just low income people with opioid misuse problems. There is data to justify that it is also a middle and upper class problem.
What, if any, key points contradict other information you have collected? We found very few data contradictions in the data.

Community: Anne Arundel County **Date: 3/23/15** **Scorer: Katelyn Wilkes**

Community Readiness - Scoring Sheet

	Participant Sector	Knowledge of Efforts	Leadership	Resources	Community Climate	Knowledge of Issue
1		4	8	3	2	5
2		4	5	4	5	4
3		5	4	4	3	3
4	Involved Citizen	5	5			4
5	Involved Citizen	3	4	4	3	5
6		9	8	4	5	2
7		5		4	3	4
8	Involved Citizen/Government/Law	4	6	5	3	5
9		7	5	3	5	5
10	Health	2	8	5	4	4
11	Law	4	6	5	3	4
12	Education	4	7	5	5	6
13	Involved Citizen	3	5	5	5	4
14	Health	5	6	4	6	5
15	Law	3	4	3	3	2
16	Involved Citizen/Health/Business/Education	3	6	4	5	4
17	Government/Health/Education	6	5	6	6	6
18	Business	3	4	3	4	3
19	Health	4	4	4	5	4
20	Involved Citizen	4	6	3	4	4
21	Involved Citizen	5	8	8	9	7
22	Government	5	6	5	5	5
23	Involved Citizen	4	6	5	1	4
24	Government	4	6	4	3	4
25	Involved Citizen/Business/Education	3	8	5	5	6
26	Business	7	4	3	5	5
27	Government	5	6	4	6	7
28	Health	6	8	6	8	7
	Total	126	158	118	121	128
	Average	**4.50**	**5.85**	**4.37**	**4.48**	**4.57**

Abbreviations for Opioid Misuse Prevention Program Needs Assessment

Anne Arundel County

OMPP	Opioid Misuse Prevention Program
AAC	Anne Arundel County
BHA	Behavioral Health Administration
MSPF	Maryland Strategic Prevention Framework
NLASA	Northern Lights Against Substance Abuse
WASP	Western Anne Arundel County Substance Abuse Prevention Coalition
CSC	Coalition for Safe Communities
BWI	Baltimore Washington International Airport
UM	University of Maryland
DHMH	Department of Health and Mental Hygiene
MCO	Managed Care Organization
FORT	Fatal Overdose Review Team
OMPPNAWG	Opioid Misuse Prevention Program Needs Assessment Work Group
AACDOH	Anne Arundel County Department of Health
AACPD	Anne Arundel County Police Department
NSDUH	National Survey on Drug Use and Health
SAMHSA	Substance Abuse and Mental Health Services Administration
AACPS	Anne Arundel County Public Schools
MPOS	Maryland Public Opinion Survey
DJS	Department of Juvenile Services
SMART	Statewide Maryland Automated Record Tracking
HSCRC	Health Services Cost Review Commission
PDMP	Prescription Drug Monitoring Program
OCME	Office of the Chief Medical Examiner
MSDE	Maryland State Department of Education
ROSC	Recovery Oriented Systems of Care
PITR	People in treatment and/or recovery
SATP	Substance abuse treatment providers
MAC	Mothers of addicted children
YRBS	Youth Risk Behavior Survey
ED	Emergency Department

Free Year-Round Prescription Medication Disposal Program

Drop Off Your Expired, Unwanted and Unused Medication Safely in Deposit Boxes at These Locations 24 Hours Daily, 7 Days a Week:

Northern District
939 Hammonds Lane
Baltimore, MD 21225
410.222.6135

Southern District
35 Stepneys Lane
Edgewater, MD 21037
410.222.1961

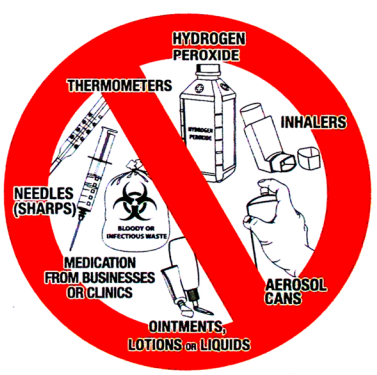
Eastern District
3700 Mountain Road
Pasadena, MD 21122
410.222.6145

Western District
8273 Telegraph Road
Odenton, MD 21113
410.222.6155

YES - Accepted

- Prescriptions
- Prescription Patches
- Prescription Medications
- Prescription Ointments
- Over-the-counter medications
- Vitamins
- Samples
- Medications for pets

STOP These items are **Not-Accepted** in this collection unit.



Remove personal information from original container. No questions asked.

Anne Arundel County Police Department

Program supported in part by the Anne Arundel County Department of Health.

Anne Arundel County
Opioid Misuse Survey Results
Analysis of Comments

Question A8: What are the dangers of opioid use?

- Crime (44)
- Poor Storage leading to abuse by others who can access (8)
- Auto Accidents (8)
- Selling prescriptions, pills to fund the habit (7)
- Doctors overprescribing (5)
- Those who actually need the medication are subject to unjustified obstacles (4)
- Side Effects (4)
- Use of Other Drugs (4)
- Opioids are only dangerous when misused (3)
- Economic Run (3)
- Cost to society (3)
- Employment Issues (3)
- Emotional troubles (2)
- Jail/Institution (2)
- Withdrawal (2)
- Brain Damage (2)
- Impacts others (2)
- Impacts family (2)
- Impacts children/unborn (2)

Question C5: How do people get their opioids?

- All of the above (7)
- I don't know (5)
- Pain clinics(2)
- Robberies of pharmacies (2)
- Traveling to other countries that have them OTC, anyway they can, ER's, buy from someone who has been prescribed the drug, selling their own medication, pill parties (1 each)

Question C5: Where should prescription opioids be stored?

- Depends on the Household (alone or with roommate; if there is a user there (12)
- In a safe or locked box (3)
- In a place only the prescriber knows about (2)
- They should not be stored at all
- In a cool dry area

- It does not matter
- In a make-up bag
- Get rid of prescriptions and legalize marijuana

Question C6: How should unused prescription opioids be disposed?

- Police Station Take Back boxes (9)
- Stored in case of future need (4)
- Throw in garbage crushed and dissolved (2)
- Give them to a person who would take them responsibly
- Eliminate them and legalize marijuana

Question D1: Naloxone is used to….

- Reverse opioids (2)
- Reverse the effect of narcotics or anesthesia (2)
- Block opioid receptors
- Wean people off narcotics like suboxone
- Not sure
- Reverse respiratory depression in an overdose
- Narcan should be OTC

Question D12: Are you are of any opioid misuse prevention strategies?

- DOH Community Coalitions (some specifically mentioned the name of the coalition) (20)
- Police officers and Narcan (14)
- 12 step programs (13)
- We need treatment (12)
- Prevention Education by Pathways (9)
- Methadone (6)
- County Executive Heroin Task Force (4)
- Hotlines (3)
- News articles and public awareness (3)
- Community meeting (3)
- AAC Prevention programs (3)
- The Governor mentioned it as a priority (2)
- Take back boxes (2)
- Website (2)
- DARE, The Impact Society, Strengthening Families, limit prescribing, school programs, community associations

Question F1: What are the biggest substance abuse issues for youth under age 18?

- Not sure (10)
- Methamphetamine(7)
- Tobacco/vapes (6)
- Huffing (3)
- Molly/Ecstasy/MDMA (4)
- Alcohol, OTC, all of the above, heroin, opioids, cocaine synthetic marijuana, cough syrup (1 each)

Question F2: What are the biggest substance abuse issues for youth under age 18-25?

- Not sure (12)
- Methamphetamine (9)
- Molly/Ecstacy/MDMA (4)
- heroin, opioids (2)
- Tobacco (2)
- Alcohol (2)
- PCP, street drugs, acid, Xanax (1 each)

Question F3: What are the biggest substance abuse issues for youth over the age of 25?

- Not sure, I don't know (9)
- Methamphetamine (8)
- Alcohol (7)
- Molly, MDMA (3)
- Drugs are in the city not the county (2)
- Crack, marijuana, all of the above, vaporizers, methadone, Xanax, valium, PDP (1 each)

Question F4: Additional Comments about opioid misuse and abuse….

- It is an epidemic and out of control (19)
- There is no free affordable treatment, we need support an money for those who actually want to get clean Medicaid does not cover in-patient care (11)
- Personally know / seen overdose or death (9)
- Need an awareness campaign about the dangers of painkillers (5)
- Methadone is a revolving door it does not work (5)
- Marijuana is safer it should be legal (4)
- Users are getting younger need to start prevention in 4^{th} and 5^{th} grade (4)
- There are proper uses for opioids to deal with chronic pain. There is a need for a natural safe alternative. There should be more choices (4)
- Expressions of sadness because of the societal issue(4)
- We have been watching people die for years (3)
- Solve this ASAP (3)
- Crime increases (3)
- If people are using drugs and functioning that is fine, we should leave them alone (2)

- It's everywhere in AC, easy to get (2)
- Don't simply put addicts in jail, can't solve a medical problem with criminal laws (2)
- Educate people don't try to change their actions (2)
- People doctor shop and get scores of pills from different doctors very easy to do (2)
- Doctors need penalties and awareness of addictionabout overprescribing (3)
- It is overwhelming (2)
- It is a huge problem (2)
- There should be no Narcan there should be a natural selection for being dumb. Tired of paying tax payer money for their bad decisions. What about veterans and child abuse. Hope they overdose, they are a cancer in our society.
- There are not enough resources for juveniles
- Drug use is glorified in the media
- Heroin is wide spread
- Heron leads to OD
- Heroin used when pharmacies won't give you pills
- Users go downhill fast in college
- Doctors prescribe so freely, prescriptions then they get hooked
- Heroin is a big problem because of the chemicals added
- Vivitrol would be a solution
- South County, Freetown and Pasadena all were specifically mentioned on dire straits
- Police Department is understaffed
- Parents need to be around more
- There are not enough activities for kids
- Need a better way to tackle the dual diagnosis problem (2)
- We should look at harm reduction models.
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