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Bridging the Gap

Examining Access to Medication Assisted Treatment and Opioid Withdrawal Care in Montgomery County, Maryland

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About the Fellow

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Executive Summary

In 2023, Healthy Montgomery's Health Needs Assessment provided community feedback on recommendations to close gaps in behavioral healthcare in Montgomery County. The main concern was the need for affordable drug and alcohol rehabilitation programs.[1] One type of program is Medication Assisted Treatment (MAT) program, which is considered the gold standard for opioid use disorder care. MAT combines medications and therapy to help patients enjoy a higher quality of life without withdrawal symptoms and addiction cravings. As the opioid crisis worsened, MAT was expanded in certain areas, which showed a high success rate in overdose prevention and increased chances of maintaining care. However, MAT can cause significant financial strain, making accessibility low and preventing initiation of treatment. While Montgomery County has MAT options, all but one clinic are private entities, and the majority of private clinics have hours limited to the work week during work hours. When someone decides to seek treatment, it is essential to take advantage of the opportunity to initiate care, as this is often fleeting. If the desire arises during the weekend or the middle of the night, where can residents turn to? What are their options in Montgomery County? Can residents receive the proper resources at the MAT locations, or must they seek out different services at different locations to meet their mental health and substance use needs? These considerations of potential gaps are important in ensuring that all residents can equitably access effective opioid use disorder care at any point in time. Based on other county models around the United States, potential options to expand access include

- **evaluating a Safe Station program**
- **extending hours and days of the public MAT clinic**
- **equipping current public resources with MAT capabilities**
- **promoting MAT for qualifying adolescents**

The county's behavioral healthcare system has made great strides and risen to address the opioid crisis in the region, but examining potential gaps and remedies is essential to ensure the system is effective.

Background

Definitions

Cooccurring disorders: a combination of substance-use disorder and mental disorders included in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition. Any combination and number of mental and substance use disorders qualify as cooccurring.[2]

Medication Assisted Treatment (MAT): treatment that uses medications, counseling, behavioral therapy, and sometimes psychiatric medications to treat substance use disorders. The medication assists withdrawal symptoms, reestablishes regular brain function, and prevents relapse.[3]

Opioid use disorder (OUD): The chronic use of opioids that causes physical and psychological dependence on opioids, making it difficult to quit without withdrawal symptoms.[4]

Opioid withdrawal: a set of symptoms that occur in someone who is physiologically dependent on opioids when there is a sudden reduction of opioids after using heavily and for an extended time period. Opioid withdrawal syndrome can be life-threatening and can lead someone to retake opioids to prevent the withdrawal.[5]

Point of entry: a program where a patient can initiate long-term care, information, testing, needs assessment, support coordination, and connection to proper resources.[6]

Peer recovery specialists: those who have had successful experiences in recovery, enabling them to provide mutual understanding and support to help maintain treatment and prevent relapse.[7]

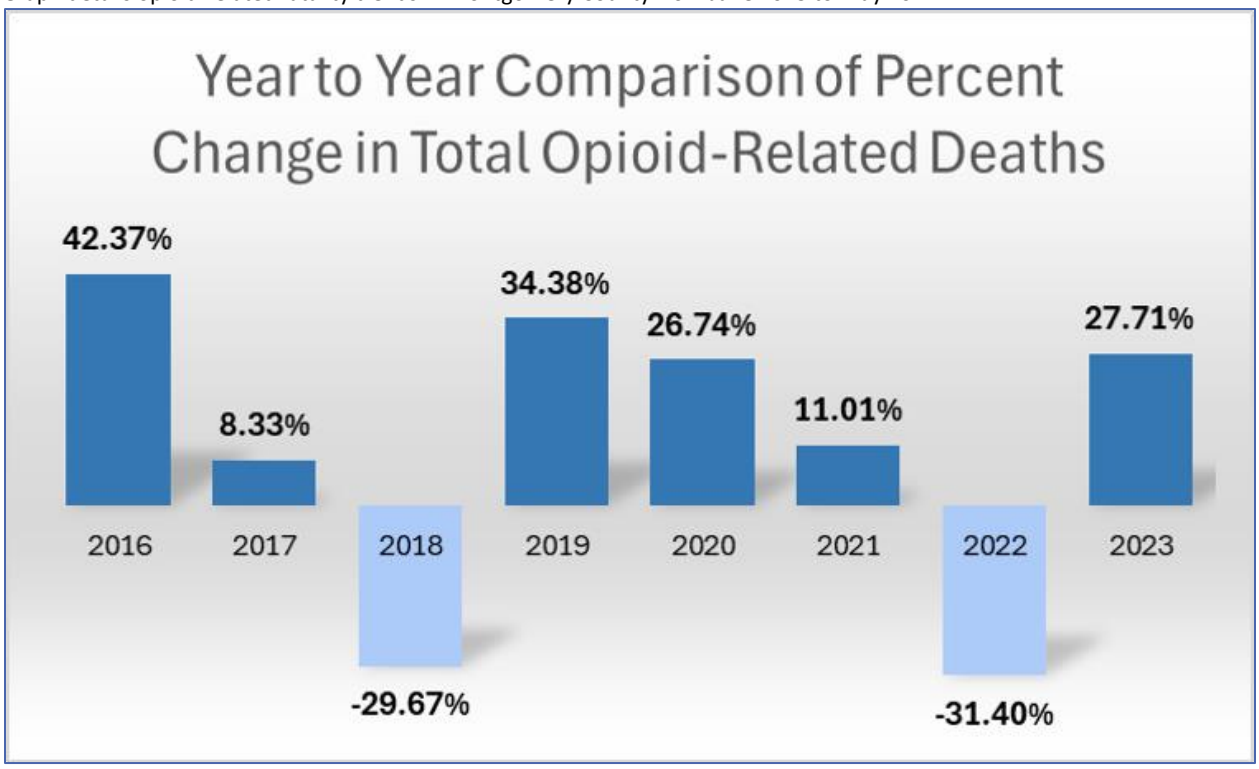
Safe Stations: a program for individuals dealing with addiction and substance use disorders that provides the opportunity to seek assistance at any time at a fire station. Medical evaluation is carried out and connection to proper resources facilitated by specialists occurs.[8]

National, state, and local trends

Two million people in the United States have an opioid use disorder,[9] and there were approximately 107,500 opioid-related deaths in 2023.[10] While the number of opioid-related deaths exponentially rose until 2021, improvement on a national and state level has emerged with the U.S. having a reduction in deaths by 6.7% from 2023 to 2024 and Maryland having a reduction in deaths by 2.28%.[11] This decrease in fatal opioid overdoses can partly be attributed to the wide distribution of Naloxone and fentanyl testing strips and an increase in the availability of MAT through clinics or physicians.[12] Also, the prescription drug monitoring program has been influential in reducing the number of prescription opioid-related overdose fatalities.[13]

In Montgomery County, from 2012 to 2023, overdose fatalities rose by 188%.[14] During the pandemic, 2020 rates increased by 26.74% from 2019, and 2021 saw an increase of 11.01%, which were the highest levels that the county has experienced.[15] 2022 saw a decrease of 31.40%, while 2023 saw an increase of 27.71% for opioid-related deaths.[16] In comparison, the state had a 11.7% decrease in 2022 and a 2.25% decrease in 2023.[17] In summary, while the state's rates were slowly decreasing, Montgomery County experienced high percentage decreases and then high percentage increases. The reasons for this difference in 2023 are difficult to pinpoint at this time, but some factors involved are the higher percentage of opioid overdoses in Montgomery County are people of color in comparison to the state level.[18]

Graph details opioid-related fatality trends In Montgomery County from June 2023 to May 2024.[19]



Source: MDH Interactive Dashboards on Overdose Related Data

In Montgomery County from June 2023 to May 2024, opioid-related overdoses are the most common type of fatal overdoses.[20] While fentanyl is the most common cause of overdoses, polysubstance, which is when two or more psychoactive substances are ingested at once intentionally or unintentionally, is a significantly increasing cause of overdoses in 2024.[21] Despite this, preliminary data on Montgomery County opioid-related fatalities show a significant decrease during the first five months of 2024.[22] This is a new development and requires increased observance to understand the changes seen in fentanyl and other substances that may be connected to the reduced fatality rate.[23]

MAT Standards and Practices

There are three FDA approved MAT medications:

- Buprenorphine – Helps manage OUD, prevents withdrawal, and works as a partial mixed opioid agonist at receptors in the brain. It is dosed daily through tablet, injection, or with Naloxone (Narcan).[24]
- Methadone – Treats OUD for those with a confirmed diagnosis by reducing opioid cravings and withdrawals and blocking the effects of opioids. It is long-acting and can also be used for pain management. It is administered through liquid, powder, or tablet.[25]
- Naltrexone (Vivitrol) – It is available in pill form for alcohol use disorder and long-lasting injectable for OUD and alcohol addiction. Naltrexone blocks opioid receptors to prevent euphoric effects and reduces opioid cravings.[26]

Prescription treatment aspects of MAT

Receiving MAT through a primary care physician is considered one of the best ways to increase access to MAT and provide personalized care to meet the variety of needs for different patients, but there have been barriers in the past to prescribing the medications.[27] MAT is available through primary physicians and access to prescriptions has been expanded with the elimination of the X-Waiver in 2022, which allowed for doctors who completed the time-consuming application, an 8-hour minimum training, and federal certification to prescribe Buprenorphine. Unfortunately, the waiver created more stigma around prescribing MAT in comparison to prescribing opioids, because physicians were limited on the number of patients they could prescribe MAT for annually, but no restrictions existed for prescribing opioids.[28] With the elimination, a provider is only required to have a Drug Enforcement Agency (DEA) certificate with Schedule III Authority to prescribe buprenorphine for OUD.[29] Providers who did not previously have an X-Waiver before the elimination are required to submit a supplemental application and upload certain documents to prescribe.[30] However, even with the X-Waiver elimination, the number of physicians providing medicated opioid treatment has not grown significantly as expected with an increase of only 2% in 2019 to 8% in 2023 on a national average.[31] However, only 27% of those who would benefit from a prescription of Buprenorphine, Methadone, or Naltrexone actually receive one.[32] Before it was eliminated, the waiver created more stigma around prescribing MAT in comparison to prescribing opioids, because physicians were limited on the number of patients they could prescribe MAT for annually, but no restrictions existed for prescribing opioids.[33] This is primarily due to stigma and fear that prescriptions will be diverted to others, but studies show that diverted buprenorphine is helpful in preventing opioid-related overdoses and serves as a form of harm reduction. This should not

be a reason for providers to abstain from prescribing.[34] The other means of receiving MAT medications and other necessary care include clinics, drug rehabilitation programs, mobile methadone treatment facilities, and telemedicine.[35] The majority of substance use treatment centers do not provide MAT and do not have the correct classifications to offer it.[36] Approximately 18% of substance use programs have the resources to appropriately treat co-occurring disorders.[37]

Mental health aspects of substance use and treatment

As part of MAT, mental health treatment is a required part of the program. Medication treatment cannot be the only form of assistance provided, whether or not a patient has a cooccurring order. Therapy is still important for those without cooccurring disorders because the psychological parts of addiction still need to be addressed and cannot be fixed by only altering the chemical balance with medications.[38] Many who use opioids have had experiences with other addictive experiences in the past and having treatment like MAT allows them to work on breaking from the cycle of addiction that can continue in the forms of other substances without therapy. For those with cooccurring disorders, the therapy part of MAT provides opportunities to address multiple disorders that may be contributing to each other, requiring an integrated care model. It is quite common for those with OUD to also have at least one mental health disorder with at least 65% of those with an OUD qualify as having a cooccurring disorder,[39] but this number could also be as high as 80%. Post-traumatic stress disorder (PTSD) and a history of experiencing abuse are particularly prevalent among those with OUD.[40]

Therapy is half of the treatment process involved in MAT. However, most Buprenorphine patients do not receive psychosocial or behavioral therapy.[41] The medications and therapy are meant to work with one another to help the patient handle their addiction and increase quality of life while receiving treatment if possible. Providing psychosocial and behavioral therapy can result in better treatment outcomes.[42] Detoxification and rehabilitation facilities are well-equipped to handle patients with SUD and OUD, but these facilities cannot always provide mental health care for mental disorders and distress that could be driving the patient to seek opioids and other substances to self-medicate.[43] This can leave patients with incomplete care or can lower their chances of retention.[44]

Status Quo

Unaffordability of MAT

Private drug and alcohol rehabilitation is a profitable $42 billion industry in the U.S. that often fails to show effectiveness of their programs.[45] The national average costs to receive private treatment will vary extensively depending on location, services used, and insurance status. Based on the national

average, basic treatment for Methadone, Buprenorphine, and Naltrexone with medication, administration, and psychosocial support services each cost:[46]

MEDICATION	PER WEEK	PER YEAR
METHADONE	$126	$6,552
BUPRENORPHINE (2X A WEEK)	$115	$5,980
NALTREXONE	$271	$14,112

These high costs also disrupt the chance of initiation for treatment because costs were one of the major reasons people did not pursue MAT.[47] Even with insurance, it can be difficult. Medicaid is the largest payer for MAT services, and the reimbursement rate is typically quite low, which discourages private clinics from accepting patients on Medicaid.[48] While Maryland Medicaid is required to cover medications in MAT, it still requires authorization from the Department or its designee prior to receiving services based on medical needs, which can delay treatment or prevent people from remaining invested in receiving treatment.[4950] Among those receiving MAT, psychosocial concerns affect a significant portion of the population with 54% experiencing unemployment, 75% being low-income, 51% experiencing food insecurity, and 64% lacking reliable transportation.[51] These factors complicate access to MAT and the affordability of entering and maintaining treatment.

Equity Concerns

The social determinants of health, such as income, environment, healthcare literacy and access, educational attainment, and discrimination can determine the risk of someone developing a substance use disorder.[52] In Maryland and other states, as the rates of opioid overdoses increased among minorities, access to treatment has not increased alongside the rates.[53] There is less residential access because of the disparities in clinic distribution, which are more likely to be placed in areas with a smaller racial minority population.[54] If someone is a racial minority, there is a less likelihood of receiving a follow-up appointment for non-fatal overdoses, which contributes to the care disparities along racial lines.[55] African American patients are less likely to receive a prescription for OUD in comparison to white people with an OUD.[56] Even though overdose deaths rose by 64.5% for African American Marylander and 15.3% for White Marylanders, relative to population White Marylanders proportionally receive more prescriptions for OUD than African American Marylanders.[57] Other social determinants of health that impact minority communities in Maryland also contribute to the barriers in receiving MAT, such as education quality in minority majority neighborhoods, inequities in healthcare, and employment opportunities.[58] Racialized drug policies carried out for decades has created generational trauma and caused mass incarceration among African American Marylanders, which further exacerbates negative

social determinants of health.[59] Behavioral health services are an important part of combatting OUD but are often scarce in minority communities due to stigma, cultural practices, neighborhood segregation, and language barriers.[60] For example, when comparing Louisiana Medicaid recipients of all races, white recipients had higher rates of receiving MAT in comparison to Black and Hispanic recipients.[61] When looking at different ZIP codes in Louisiana, more racially and ethnically diverse ZIP codes had significantly less access than white dominated ZIP codes.[62] During the Covid-19 pandemic, disparities improved due to MAT clinics receiving state permission to provide telehealth appointments, but significant differences in care still remain.[63]

In Montgomery County, the demographics of fatal overdose victims have significantly changed as whites historically made up the majority of opioid overdose victims, and this has significantly decreased in recent years. However, the increase of fatal overdoses in 2023 can be attributed to the disproportionate increase in fatalities among Hispanic and Black residents in 2020 and 2022 respectively.[64] Also, older adults in the over fifty-five and under twenty-two age groups also contributed to the increase in overdoses in the county.[65] Accessing MAT requires allocating significant personal funds and time. If an individual is uninsured or underinsured for MAT and must continue to work while receiving treatment, treatment options are slim for treatment initiation. This can have a significant impact on immigrant or undocumented residents who may not have easy access to sufficient insurance, may work long hours, or have multiple jobs.[6667] Because Hispanic residents are among the populations in the county who are experiencing a rise in overdoses, consideration for challenges Hispanic residents experience must be included in public policies.

The Montgomery County youth population is another vulnerable population that does not have equal access to affordable MAT. From 2021 to 2022, there was a 150% increase in overdose-related emergency room visits among youth.[68] The decline in opioid-related deaths was seen in the twenty-two and older age groups, but fatalities in youth under twenty-two have remained at the same levels since 2023.[69] Due to a lack of understanding of the dangers of opioids and the methods used by dealers to create addiction, youth are particularly susceptible to unintentional overdoses because of disguised pills that look similar to Adderall or Percocet but really contain highly potent substances and create addictive symptoms after the first use.[70]

What does MAT currently look like in Montgomery County?

The Department of Health and Human Services (DHHS)-run MAT clinic operates a variety of essential programs under one roof, including the drug court program, Methadone dosages, psychiatric

care, and therapy. The DHHS clinic allows for people to work and maintain a routine for the most part while receiving treatment. If the patient is unable to pay, sliding scales are available at the public MAT clinic and at several of the private treatment centers, and the scale is based on income and services used. For current clients, the DHHS clinic is flexible with scheduling therapy appointments and telehealth therapy even though official hours end at 5:00 pm. Also, if a current client has not been approved for taking dosages home over the weekends, they can visit the clinic on weekends to receive their dosage.[71]

For private Medication Assisted Treatment programs, there are approximately ten clinics according to the Substance Abuse and Mental Health Services Administration (SAMHSA)'s directory, and only two operate 24-hour per day, seven days per week residential programs.[72] The centers offer a variety of resources and programs in addition to MAT, such as housing services, cooccurring disorders care, and group and individual therapy. A more intense program like inpatient rehabilitation provided by two of the private centers is not accessible to those who cannot miss work, as this would make it more difficult to pay and sustain themselves and/or their families.[73]

Summary of MAT programs that offer services within the Public Behavioral Health System (PBHS): ("No available info" indicates that this information was not made available via online contact)[74]

Name	Operation hours	Dosing hours	Services	Location	Access	Payment	Age
DHHS run (Montgomery County Outpatient Addiction Services)	M-F 8:30am-5:00pm	M-F 7:30am-5:00am	• Outpatient treatment for addiction to narcotics & opiates • Methadone • Buprenorphine • Psychiatric evaluation • Cooccurring treatment • Medication management • Group counseling • Individual counseling • Drug court • Drug testing	Rockville	Description of directions by bus, metro, and care available online; 4 min walk from bus station	Sliding scale, all insurance	18+

Another Way	M-F 5:30am-1:30pm; Sat 7-10am; Sun closed	M-F 5:30am-11:00aam; Sat 7-10am; Sun closed	• Detoxification • Methadone • Buprenorphine maintenance and detoxification • Individual counseling • Group counseling • Urinalysis drug screening • Referral services	Takoma Park	Near Langley Park Plaza's bus stops	Info Unavailable	Info unavailable
Maryland Treatment Center -Avery Road (contracted out by county)	M-F 8:00-4:30; Sat and Sun closed	Info Unavailable	• Detoxification • Buprenorphine • Vivitrol • Inpatient programs • Intensive outpatient • Long-term residential programs	Rockville	Bus system outside of Rockville stops by close	Private, Medicaid, state family services, private insurance	21+
Born Free Wellness	M-F 5:45am-1:00pm; Sat 7-0:30am; Sun closed	M-F 5:45am-10:00am; Sat 7-9:30am; Sun closed	• Methadone • Buprenorphine • Vivitrol • Cooccurring • Holistic well-being • Case management • Referral services • Confidential consultation • Drug screens • Testing & prevention.	Germantown	Near Seneca Valley Highschool's bus stop	Info unavailable	18+
MD Wellness and Recovery	Info Unavailable	Info Unavailable	• Intensive outpatient • Buprenorphine • Vivitrol • Cooccurring • Partial hospitalization program • Community housing program	North Bethesda	15 min walk from North Bethesda metro station	Info Unavailable	18+

Montgomery Recovery Services	M-F 5:30am-1:00pm; Sat closed; Sun closed	M-F 5:45-11:30am; Sat closed; Sun closed	• Methadone • Buprenorphine, • Cooccurring treatment • Individual counseling, • Group counseling • Referrals	Rockville	4 min walk from E Gude Dr and Rothgeb Dr bus stop	Medicare, Medicaid, cash, self-payment	18+

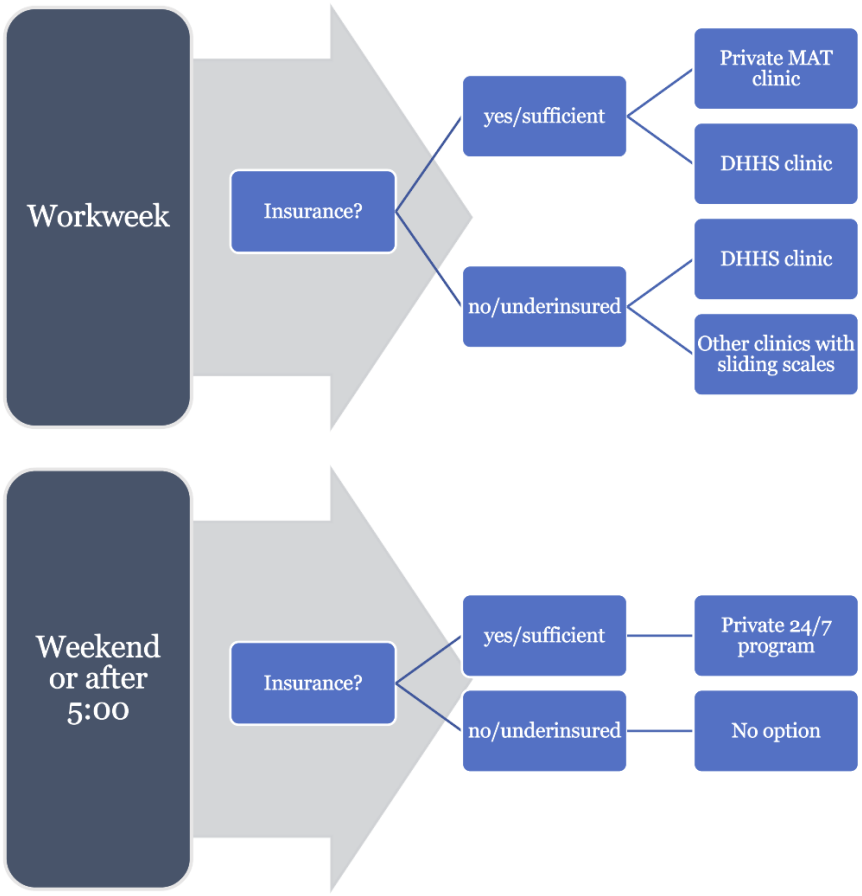
Other public services addressing behavioral health issues

The Crisis Center and the pending Diversion Center also support opioid withdrawal care in certain aspects. For the Crisis Center, it can provide temporary monitoring in the stabilization room if there are no high-risk medical complications, otherwise the individual would need transportation to Suburban or Medstar hospitals, which provide inpatient detoxification on an acute level. The Crisis Center does not initiate MAT because the Crisis Center is only intended to house patients for up to 23 hours, which is not sufficient time to ensure medication can be distributed again. The Crisis Center also already operates the mobile crisis team, connection to resources including housing, connection to resources for those undocumented, outreach, peer support, therapy, and many other services.[75] Expected to open in September of 2026, the Diversion Center will treat individuals experiencing a mental health or substance use crisis to reduce the numbers in emergency rooms and jail.[76]

Source: "Montgomery County Crisis Center works to fill vacant positions, address community needs". Photograph Abc7News, April 2024.

The Gaps in Care:

Graph on MAT options during workweek, weekends, and after closing hours based on insurance status.



A major concern in the current system is the issue of sufficient entry-points. From July 2023 to July 2024, 70% of the 519 emergency calls occurred on weekends and outside of working hours 7am-5:00pm.[77] When someone decides to initiate treatment on a Saturday or any evening during the weekdays, where can they go? Currently, as illustrated above, there is not a clear answer. If they have robust insurance, there are private rehabilitations programs they can enroll in that may accept Medicaid. If these options are unattainable for any variety of reasons, residents do not have an option beyond the public MAT clinic, but only during the workday. As someone moves to different resources for the most appropriate treatment, the continuum of care between resources has gaps in ensuring MAT retention, and the DHHS clinic has expressed concern regarding those who fall off the grid without certain transition points.

Certain populations, such as children, have no public treatment options and private options are scarce in the county. Montgomery County leaders have requested the state for funds for a residential

substance use treatment center for youths due to the rates of fatal overdoses among youth.[78] Currently, nowhere in the state is there a medical facility that focuses on youth overdose stabilization.[79] The county is in need of a service that provides this and planning for continuum of care through community-based, inpatient, and outpatient services.[80] There are currently local organizations, such as Montgomery Goes Purple, that focus on outreach and awareness of overdoses for youth and their families through forums or other events at Montgomery County schools.[81] The Federal Drug Administration has only approved Buprenorphine for those over the age of sixteen, but there are recommendations from medical professionals to expand this to youth with OUD under the age of sixteen.[82] Even though the American Academy of Pediatrics recommends prescribing Buprenorphine to youth with OUD, only 6% of U.S. pediatricians have prescribed Buprenorphine.[83] While the number of children between 10 and 19 who died from an overdose has doubled in recent years, buprenorphine prescription distributions for this age group declined.[84] In Montgomery County, there are 156 providers who can prescribe Buprenorphine out of 2,961 physicians (5.2% of doctors prescribe Buprenorphine, which is a similar rate to the state level). There are 515 pediatricians in Montgomery County, but there is no explicit record of which ones prescribe Buprenorphine.[85]

Part of these gaps is a lack of detoxification options that could create entry-points for care. Currently, in Montgomery County, when someone is in need of detoxification and monitoring, they are taken to the closest hospital regardless of the special amenities. If Suburban or Medstar hospitals are within close proximity, that is the most ideal situation, as both hospitals provide inpatient detoxification in medically high-risk situations. The Crisis Center's Stabilization Room can serve as a place for sobering if there is space available, but it cannot provide detoxification due to the medical risks and the amount of time required for detoxification. The Crisis Center is limited on space and staff, and the DHHS MAT clinic struggles to recruit staff due to the nature of the work, which is exhausting for current staff.[86] Besides the long wait times at the emergency room, there are no other easily accessible options for detoxification, until the Diversion Center is built in 2026, but capacity is still being determined.[87]

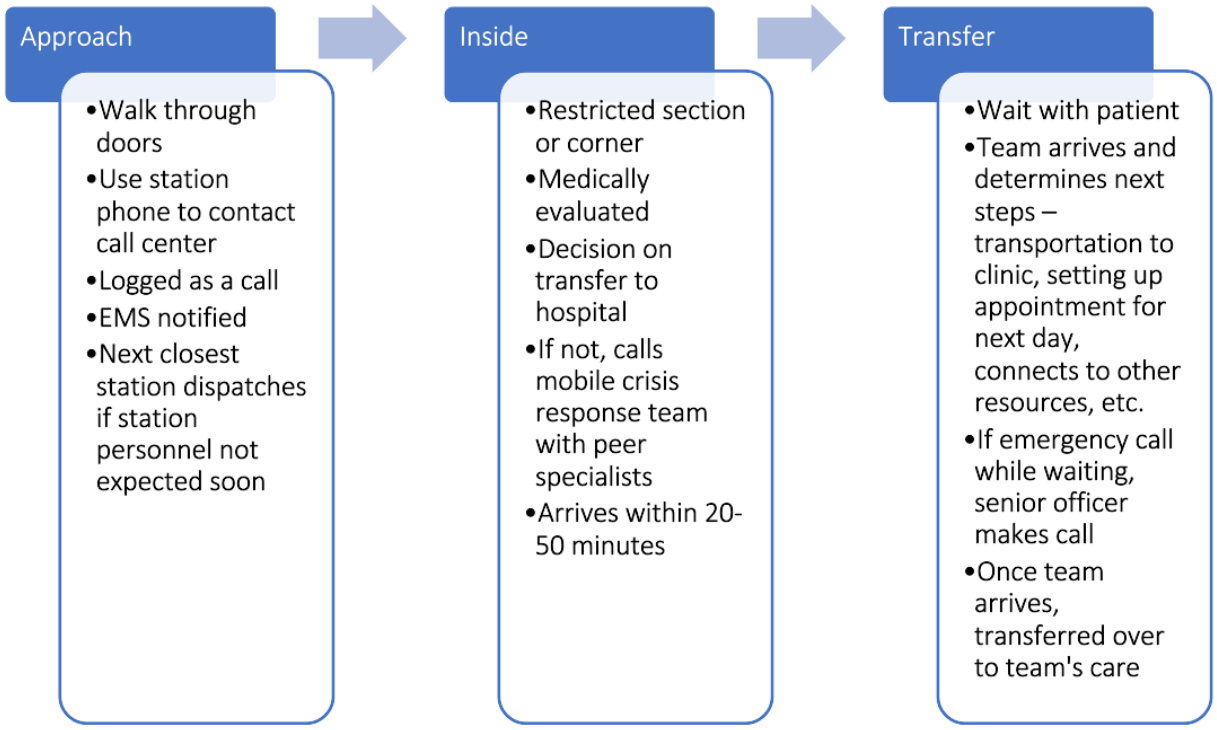
How Other Jurisdictions Have Handled These Gaps: Case Studies

Safe Stations

Anne Arundel County: In response to the rise in opioid-related overdoses in 2014, Anne Arundel County developed plans to establish a safe station program at 39 of their fire stations. Within a month of receiving approval, the program was launched, and within an hour after the press conference that informed the community, the first participant showed up at a fire station. Initially, there was

apprehension around safety concerns, but there were no violent episodes, and the participants were those interested in merely seeking help. Within three months of launching the program, the number of participants in Safe Stations passed the number of emergency calls for overdoses. When someone approached the station, they could notify the first responders through the large open doors, or they could wring a bell by a SOS plaque that designated the station as a Safe Station.[88] If the station is empty, the individual has the ability to use the station telephone outside and contact the call center, who will then log it as an emergency call, notify EMS, and take the responding personnel out of service for other calls besides serious cases.[89] If the station's paramedics are not expected back shortly, the closest station can dispatch their paramedics to the call at the Safe Station.

Once the participant enters the Safe Station, medics will evaluate the patient in a restricted section or corner of the station and determine if transportation to a hospital is necessary. If the patient does not require advanced medical attention, the medics call the mobile crisis response team of Anne Arundel County, which was brought together by internal and external organizations. On average, the crisis team arrives around 20-50 minutes after receiving the call, and the medic will continue to sit and talk with the participant. The Safe Station call is logged as an official call and those helping the participant are considered to be out-of-service for further calls, but a nearby major emergency that requires all personnel would take precedent. If this type of call occurs before the crisis team arrives, the senior fire officer makes the judgement call on how to handle the situation depending on the emergency and the status of the participant. While paramedics respond to the new emergency, the participant, if stable, can wait for the crisis team to arrive, or a call can be sent to a further away station to meet the participant at the Safe Station. Upon arrival of the crisis team, the participant will be switched to their care, and the team will determine the next options based on the case. Sometimes, this can involve making an appointment for the individual at a substance use disorder clinic for the morning or transporting to other appropriate services.[90] The crisis team takes into account mental health crises along with substance use disorders. If there are no available beds or the best-suited facility is closed when the team responds, the patient can wait at home or receive supervised housing directed by the crisis team.[91] If the crisis team is worried about their safety with the individual, a firefighter would remain with the team, while this is a rare occurrence, the safeguard is available.[92] In 60% of Anne Arundel County Safe Station calls, the police are included in the process, but the police do not arrest individuals seeking help at a Safe Station.[93]



Description: Flow chart on the steps in each of the three stages of the Safe Station response process for individuals who seek treatment.

This Safe Station system provides certain advantages despite the additional time it can take from first responders. With the safe station program, people can opt to walk to their local station rather than calling emergency services to travel to them. When a patient approaches the Safe Station, a unit still becomes unavailable, as it would during regular calls that require travel to on-scene. However, having the patients go to the station allows for personnel to still respond to serious calls even when they are managing a safe station call. Personnel no longer need to run as many calls to typically unsafe areas, since those in need are seeking them out. Further, this provides a space where people can initiate care at any time with no cost. In Anne Arundel County, from April 2017 to December 2019, 1,287 individuals sought treatment through the Safe Station program, and there was a 55% recovery rate among those who were past participants before receiving care.[94] Because of the variety of resources for combatting the opioid epidemic that increased around the same time, Safe Stations cannot be pinpointed as the main contributor to success, nor can it be determined how much it helped. Either way, it created a door for people to walk through to seek treatment at any point during the day.[95]

Manchester and Nashua, New Hampshire: In May 2016, Manchester established a Safe Station program that has since ceased because a new 24-hour program for opioid withdrawal care was established. This new program is the Doorway Program, which is a network of nine locations in the

region that are available 24/7 to provide substance use care and connections to resources.[96] During the five years Manchester ran their Safe Station program, they received 8,000 participants.[97] The City of Nashua also ran a Safe Station program that has ceased due to the Doorway Program now providing similar services during the same hours.[98] Nashua partnered with the Mental Health Mobile Crisis Team run by Harbor Homes, a non-profit that provides healthcare and housing for low-income residents, to perform Safe Station functions.[99] The Nashua Safe Stations received 3,600 participants.[100] There have been concerns expressed by emergency personal in New Hampshire with Safe Station programs regarding safety concerns when an agitated patient approaches the station. Also, politicians have wanted unavailable evidence for effectiveness of the program.[101]

Providence, Rhode Island: Providence's Safe Station program was launched in January of 2018 to reduce drug overdose-related deaths. Their program was based off of New Hampshire and Anne Arundel County's programs, and Providence published a document that guides and provides recommendations to other municipalities interested in establishing a Safe Station program.[102] The Providence Safe Stations partners with the Providence Center, which is a mental health and drug treatment provider, and local recovery providers to ensure transfer of care. After the participant calls or walks by to determine if the fire station is staffed, paramedics lead the participant to a private area where they will determine if their vitals are stable and remove any drugs or paraphernalia, which are placed in a locked drop box.[103] Once the Safe Station personnel call peer recovery specialists, they will wait with the participant and fill out a Safe Station intake form and standard electronic records.[104] The average time the patient will be in the Safe Station is less than 30 minutes, and two peer recovery specialists arrive within 15 minutes of receiving the call from the Safe tation notifying them of the participant.[105] When the specialists arrive, they will discuss with the participant their needs, options for treatment, next steps, and plan for follow-up as part of the peer support organization plan.[106] Some recommendations from Providence include installation of signs for Safe Stations, a phone number for participants to call, sharp box, tables and chairs, and intake forms for materials. Other components to consider including are a unique overdose indicator in EMS electronic records for tracking the number of participants and a female-identifying first responder should be one of the personnel responding to a female-identifying participant.[107]

Safe Station Analysis

- Similarities to current Montgomery County practices: Montgomery County Fire Stations have had the Safe Haven program for babies for many decades, which allows infant drop-offs at any

station. Residents are allowed to approach the station already for assistance on other concerns, such as checking blood pressure or medically evaluating a patient to determine necessity of transportation to a hospital, and these instances are logged into the Computer Aided Dispatch (CAD) system (7/24).[108]

- Differences: Montgomery County Fire Stations do not currently allow individuals to enter the station for substance use crises. The Montgomery Mobile Crisis Team does not pick up patients from the fire stations, but EMS can drop off patients at the Crisis Center.[109]
- Benefits: The program takes advantage of the small window of motivation those with substance use disorders have to seek treatment, as stations are available at any time and are geographically accessible.[110]
- Challenges: Looking at these four examples, safety concerns, overwhelming personnel, collaboration among entities, expense, and uncertain effectiveness all complicate the program.[111] More questions need to be answered on the program's effectiveness, such as whether or not the program reaches individuals who would not seek treatment otherwise or if the program decreases the level of substance-related harm.[112]

Crisis Centers, Public MAT Clinics, and Detoxification

Phoenix, AZ: In 2017, Arizona opened the first 24/7 MAT clinic in the United States in response to the increase in opioid-related overdoses in the Northern Phoenix region.[113] This became known as the "Arizona Model".[114] The Clinic's establishment targets those who could not seek treatment without extended hours available to them due to school and work. Another part of the population the center serves is those being released from the emergency room or incarceration at later hours of the day and are in need of initiating care.[115] Many patients also sought out the clinic because they experienced barriers at other treatment centers due to insurance complications or long waiting lists.[116] The Center is run by Community Medical Service (CMS), which provides MAT programs at 32 centers across nine states through the 21st Century Cures Act,[117] and they are the largest provider that can distribute MAT in Arizona.[118]

A major component of the Arizona model is the Recovery Response Clinic also in Northern Phoenix. It serves as a crisis clinic where individuals can seek a variety of services, such as medication management, detoxification, and EMS/Police drop-off. Because of the center, fewer individuals experiencing a crisis are sent to wait hours and days in the emergency room without support or are sent to jail.[119] Arizona has also seen economic benefits, as the Phoenix crisis center analyzed data to

determine that for every dollar invested in crisis care $1.60 was saved in medical costs, and the time saved for law enforcement officials was equal to 37 full-time officials.[120] While the Recovery Response Clinic is prepared for transportation of patients to hospitals when medically necessary, only 1% of admitted patients have required a hospital visit.[121] When patients enter the center, they complete a drug test, assigned a reclining chair, and receive therapy, prescription medications, and referrals.[122] Most patients are only held no more than the first 24 hours, but 72-hour stays are available and include a stay in one of the twenty long-term beds, which frees up one of the 25 short-term beds.[123] At a different psychiatric urgent care center, patients can receive temporary prescriptions for psychiatric medications with a walk-in. This has reduced the number of patients escorted by police to the center. In 2020, plans were made to begin providing MAT, and it appears that this has been established, but its experience with MAT is not available.[124] It operates next to the 24/7 Methadone clinic, which likely established a partnership. Such a partnership would allow for collaboration on appropriate treatments for patients and ensure continuum of care from a crisis clinic to post-visit MAT.

- Similarities: The 24/7 MAT clinic is contracted out like Avery Road. The Recovery Response Clinic operates similarly to Montgomery County's Crisis Center operated by DHHS, as the Center also provides mental health crisis services, referrals, stabilization, and a mobile unit.
- Differences: The Phoenix example has MAT services within the same complex, provides first dosage for MAT, and can keep patients up to 72 hours. The Montgomery Crisis Center does not initiate MAT or have the current capabilities, keeps patients for up to 23 hours, and does not provide detoxification services.[125]
- Benefits: The combined care with MAT and a crisis clinic helps ensure continuum of care and creates easier transition points. Also, it provides comprehensive care for those with cooccurring disorders.
- Challenges: The Montgomery County Crisis Center already serves as a "one-stop shop" for a variety of mental health and social services. The space in the Crisis Center is already limited, and there are plans to expand to meet their current needs. Adding MAT as a capability, would require more space, beds, and specialists.[126]

Fairfax County, VA: The Community Services Board (CSB) is a public agency that organizes and provides for adults and youth with substance use disorders, mental illness, and developmental disorders, and the Addiction Medicine Clinic serves those over 18.[127] The Fairfax CSB is one of the 40 CSBs required in every Virginian jurisdiction and operates within their Department of Health and Human

Services.[128] A major part of the MAT offered there is officed-based opioid treatment (OBOT), which is designed for those with a past or present opioid use disorder and includes medication management, case management, supports from a Peer Recovery Specialist, optional group or individual therapy, and treatment for cooccurring disorders.[129] Like many other public substance misuse clinics, the Fairfax clinic uses a sliding scale to determine affordable service fees based on income, services used, and household size. The Fairfax Detoxification Center is a short-term residential program allows for residents over the age of 18 to detoxify and stabilize from drugs and/or alcohol.[130] The Center is monitored by trained staff and provides pain health and wellness services, referral services for follow-up and correct care, and education.[131]

- Similarities: The Montgomery County Crisis Center also has peer recovery specialists support and therapy. The DHHS MAT clinic also provides a sliding scale for payment and treatment for cooccurring disorders. In Maryland, like Virginia, every county is required to have a drug and alcohol abuse advisory council.[132]
- Differences: Fairfax has youth substance use services and a detoxification center.
- Benefits: Public youth substance use services would help youth initiate treatment at a low-cost. The Fairfax model combines MAT with mental health treatment to ensure that both needs are being met, especially for those with cooccurring disorders.
- Challenges: Because Fairfax is using a state mandated model, there is more guidance and funding for their operations. CSB is housed in a variety of centers spread throughout the county, and the board runs several residential treatment services, detoxification services, developmental disabilities services, an addiction medicine clinic, and other services, which is difficult for most counties to maintain without support.[133]

Seattle, WA: The pending post-overdose recovery facility and increased mobile addiction treatment services in Seattle will aid those experiencing non-fatal overdoses. This will allow patients to receive treatment to alleviate the withdrawal symptoms and to connect them to recovery services, such as MAT. The Seattle Fire Department's overdose response team will transport patients to the facility to increase accessibility of recovery.[134] The center will keep clients for up to 23 hours and intends to provide within that time-frame post-overdose stabilization, initiation into evidence-based medication treatments, and connection to behavioral health care.[135] As part of this project, there will be mobile medical units that will provide medication to vulnerable populations in Seattle and the surrounding county.[136]

- Similarities: The Montgomery County Crisis Center also keeps clients up to 23 hours, provides connections to behavioral health care, and operates a mobile crisis team.
- Differences: The Seattle model will provide a mobile addiction treatment service that has the capabilities to assist non-fatal overdoses, transportation to appropriate facilities for substance use treatment, and administer medications to vulnerable populations to initiate MAT.
- Benefits: The Seattle model will use emergency services to provide appropriate care, resources, and transportation which will help ensure that patients are directed to long-term treatment options and receive care fast. Medical units will directly outreach to areas with higher rates of overdoses for preventative measures and equitable outreach.
- Challenges: Use of emergency services is expensive and can detract from other more serious emergencies and from the number of available units at a time. In Maryland, paramedics that are part of Mobile Integrated Health teams are the only personnel permitted to administer Buprenorphine.

Palm Beach County, FL: In 2020, the JFK Medical Center and the Palm Beach County Commission announced a public-private partnership opening a first-time Addiction Stabilization Unit.[137] It is an "attempt to medicalize addiction and treat it like other medical illnesses".[138] With the new unit, EMS have been allowed to skip the emergency rooms and drop overdose patients off at the facility that provides specialized care. Patients that have experienced an overdose are initiated into MAT after a few hours, which helps the patient follow longer-term treatment plans after their stay.[139] After stabilization, patients willing to seek help are typically transferred to the local MAT clinic where they will be treated by psychiatrists, primary-care physicians, addiction counselors, individual and group therapy, psychiatric services, care coordination, pharmacy services, and social services.[140]

- Similarities: Detoxification already exists at Suburban and MedStar Montgomery hospitals. Further, the Diversion Center set to be finished in 2026 will offer detoxification for transports.
- Differences: This is a public-private partnership in a hospital setting, and it ensures patients that need MAT will receive it due to proximity and system of easy transition of care. MAT is not given at Suburban and MedStar Montgomery hospitals. Also, Montgomery EMS cannot bypass the emergency department to deliver patients to the detoxification services at Suburban and MedStar Montgomery hospitals.

- Benefits: This model allows for EMS to bypass the emergency room drop-off wait times and bring patients directly to the unit, and the model provides an opportunity to quickly transfer patients to the MAT clinic nearby, ensuring initiation of care.
- Challenges: The cost to operate a facility with a private entity in a hospital setting requires extensive budgeting and collaboration. Further, the Diversion Center will hopefully fulfill this function.

North Carolina: The hours for the SouthLight Opioid Treatment Program in North Carolina are particularly notable. The center is the first to offer MAT during evening hours. During the weekdays, the hours are split up with 5:30am to 12:30pm being the morning hours and 4:00pm to 7:00pm are the evening hours. For weekends and holidays, the morning hours remain the same, while the evening hours are 4:00pm to 6:00pm. This has assisted with patients experiencing barriers to receiving treatment due to work hours and school hours for their children.[141]

- Similarities: Open for a similar number of weekday hours to the DHHS MAT clinic.
- Differences: This is run by a non-profit with multiple locations across states. The hours are split up into two sections, while most clinics have consecutive operating hours for clinics. The North Carolina clinic publicly operates for limited hours on weekends.
- Benefits: This addresses those unable to receive MAT before 5:00. It also ensures initiation of care availability on weekends.
- Challenges: There would be issues with finding staff willing to work the odd hours or have two different shifts, which could be expensive.

New Mexico: In New Mexico, the state legislator has advocated for expanding access to MAT for minors with a substance use disorder by funding programs that support it and remove funding for programs that restrict it.[142] The American Academy of Pediatrics approval of access to MAT and other evidence that suggests treatment without medication can be counterproductive has spurred the advocacy from New Mexico legislators.[143] However, in the 2024 session, the bills, which would prevent the restriction of MAT for minors in inpatient and outpatient substance abuse treatment facilities and programs funded by the state, in the House and the Senate died. If the bill was passed, facilities that received public funds and served adolescents for rehabilitation but refused to provide MAT would no longer receive public funding.

- Similarities: The Montgomery County Government has appealed to the Maryland State Government to fund youth substance use centers, but everything still remains in the elementary stages of discussions with the Maryland Governor.[144]
- Differences: The New Mexico legislature was working on a bill for reducing restrictions on MAT for youth, rather than a treatment center, which was the focus of the Montgomery County appeal.
- Benefits: MAT for adolescents is promoted by pediatric medical academics, and this would remove a barrier to MAT if entities with public funding were no longer permitted to refuse MAT.
- Challenges: There is no implemented program to model after, and there is limited research on Buprenorphine treatment in adolescents. There is no MAT clinic for adolescents in the state of Maryland, so implementation legislation that prevents refusal of MAT to adolescents or creates a MAT clinic for adolescents would not have a previous local model to build off of.

Policy Options:

1. Conduct an evaluation on the possibility of implementing a Safe Station program

An evaluation would require the Fire and Rescue Services to consider the usefulness of a Safe Station program and determine if it is feasible financially and timewise. The other main entity that would need to be heavily involved is the Montgomery County Crisis Center and their mobile crisis team. Analysis of emergency call data can help determine when overdose-related calls are the most common and if there is a need for a Safe Station program. Out of the 519 overdoses that occurred from July 2023 to July 2024, 70% happened outside of regular MAT clinic hours. Further, not all stations necessarily have to implement this program, but those with the most overdose calls to local areas should consider becoming Safe Stations. Choosing only specific stations to be Safe Stations would help with freeing up crews that are not devoted to Safe Station calls, but the negative side effects could be restricting residents in certain areas from using this service and overwhelming stations that are designated as Safe Stations.

A portion of the evaluation should consider the Save Haven Law for surrendered babies program implemented in Montgomery County to help measure time devoted to answering calls where an individual is brought to the station and how the transfer process occurs.[145] A potential Safe Station program would involve designating an area of the station, relaying changes and procedures to crews ahead of the implementation, setting up phones or bells at stations that do not already have them, setting up signs that indicate Safe Stations. A Safe Station program would build on the current

infrastructure, use the same call system that already exists, and maintain the current EMS response process. A unit would not transport patients unless the hospital is required or requested, or if the mobile crisis team will be delayed in arriving, a unit will transport the patient to the Crisis Center instead. This would save money on fuel and transportation time. However, there are important implications that must be considered, such as the feasibility of it, necessity of it in consideration of Montgomery County's current opioid overdose rates, and disruption of duties. Having a unit unavailable for an undetermined and possibly lengthy amount of time until the mobile crisis team responds can delay responses to other emergencies if a further fire station has to dispatch a unit to an emergency instead. Another concern is the possibility of high utilizers of the program who will regularly visit the Safe Station but will not follow through with treatment provided. This could create another avenue for high utilizers of emergency services to continually return to the station and repeat the cycle upon release from the call.

2. Evaluate equipping the Crisis Center and Mobile Crisis Team to initiate MAT

Conduct an evaluation on feasibility of the Crisis Center providing the first dosage of MAT for those who need care from resources under the roof of the Crisis Center. If the patient is ready to begin MAT, the clinic would direct them to the public MAT clinic down the road for their second dosage and a plan to seek treatment. However, the Crisis Center already operates as a one-stop shop, and additional responsibilities would overwhelm the Center and their current system. MAT can also only be provided after a certain number of hours since an overdose. If a patient experiences an overdose, MAT administration would be delayed, and the patient may not be with the Crisis Center by the time that would be necessary. Despite this, equipping the Crisis Center to provide MAT would close gaps between providing mental health care and substance use disorder to patients simultaneously.

3. Extending hours of the public MAT clinic to allow weekend initial appointments

Since the DHHS MAT clinic already provides weekend dosages for current patients, the clinic can advertise specific hours to allow for initiation by new patients. These hours can be based around when the clinic is already dispensing medications to patients and providing therapy to not disrupt already functioning hours. These new hours should be advertised online and made publicly known. These limited weekend hours can be dedicated to dosage and a certain number of therapy patients. The clinic should still encourage eligible patients to receive take-home dosages for the weekend to prevent overwhelming the clinic during weekend hours.

4. Make known which pediatricians prescribe MAT

Unfortunately, establishing a MAT clinic for youth would be too costly without state support. The request by the County Council and County Executive for youth substance use clinics is progress, but MAT should also be included in these discussions as a main form of treatment. MAT would be limited in a youth clinic because prescriptions can only be given to a small portion of the population from 16–18-year-olds due to FDA prohibition of providing MAT to those under 16. Another way of increasing access to MAT among youth is through pediatricians, who can also prescribe MAT. To help families and youth connect with healthcare providers that prescribe MAT, the county should maintain a page on the DHHS website that provides updated information on the pediatricians who prescribe MAT and their accepted insurance. This could be modeled after DHHS's webpage on MAT clinics in Montgomery County that provides details on the pediatrician who provides MAT, including contact information, insurance plans accepted, and medications prescribed. Determining which pediatricians prescribe MAT could be done in two different ways. The first option is to use SAMHSA's site that lists all of the physicians who prescribe MAT in each city in the country, but the physicians' specialties is not listed with their names.[146] This would require searching up each provider who prescribes MAT according to SAMHSA to determine which physicians are pediatricians. The second option is to call each pediatrician's office directly and inquire if the pediatrician would consent to their information being added to a list of pediatrician MAT prescribers. On the webpage, include an email to allow providers to request to be added to the list with provision of proof. This could encourage more physicians to prescribe Buprenorphine if their prescribing practices are made more publicly known, but it also carries the risk of discouraging physicians from prescribing due to stigma and fears that families will not want to take their children to doctors who prescribe medication for addiction.

Racial Equity and Social Justice Progress

These recommendations aim to help improve the lack of healthcare equity and access, which disproportionally impacts people of color. As discussed previously, Hispanic and Black residents have experienced a significant increase in fatal overdoses in the past several years, and these recommendations would increase access to opioid use disorder care. These recommendations also encourage more low-income residents to seek treatment, and the two largest racial and ethnic groups that make up the low-income population are Black and Hispanic.[147] Since people of color are disproportionally refused a prescription for MAT through primary physicians, these recommendations create other avenues to seek care in places where care cannot be refused, such as at fire stations.

Unfortunately, there is no clear evidence if these recommendations will mitigate healthcare racial inequities, but they intend to open access to all residents no matter their socioeconomic status.

Each recommendation could potentially reduce inequities in Montgomery County through various avenues. The first recommendation provides free opportunities to initiate MAT. The mobile crisis team can determine the most appropriate resources for the patient based on income status or direct patients to services with a more diverse workforce for comfort if that is a patient concern. The second recommendation will help increase initiation of MAT, which people of color have been disproportionally refused by primary physicians, creating another alternative to initiation of MAT. The third recommendation will create more flexibility for those with longer work hours or multiple jobs, who are typically low-income residents. The fourth recommendation increases access to pediatricians who prescribe MAT and help families determine which pediatricians would be most suitable based on insurance, language, and other concerns. Because an increasing number of residents who experience fatal overdoses are people of color, increasing resources to match the need is important in furthering racial equity and social justice.

The Wider Impact

The opioid crisis has a rooted influence in many areas of society, the economy, and personal lives. For some people, the opioid crisis and whether or not they can access treatment is a life-or-death situation. The case studies and proposals would have a much wider impact than a few lives. It would reduce the number of emergency room visits, possibly saving time and lives in the emergency rooms. Expanding access to MAT also expands access to mental health treatment with the therapy requirements in MAT and the opportunities to connect people to proper resources and psychiatric medications. While Montgomery County has advanced substance use disorder care, not everyone can access this care at any time or in any financial situation, and the county should strive to improve equitable access with current resources and new ideas. Although MAT is a band-aid solution to the major looming issue of mental and behavioral health problems that often give way to opioid use, MAT is the gold standard of care for those with an opioid use disorder and can help manage current struggles.

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