MARYLAND OVERDOSE RESPONSE

ADVISORY COUNCIL

Citizen Advisory Workgroup

Recommendations

Released: September 2026

Introduction

The Maryland Overdose Response Advisory Council (MORAC) was established by Executive Order 01.01.2023.21 and is chaired by Lt. Governor Aruna Miller. The Council brings together representatives from 18 state agencies to coordinate efforts to reduce overdose morbidity and mortality in Maryland. Its work includes sharing data related to the overdose crisis across agencies and providing strategic guidance on expanding access to substance use care and addressing disparities in overdose outcomes.

Recognizing that an effective overdose response must be informed not only by state agencies, but also by the people and communities most directly affected, MORAC has made community engagement an important part of its work. Members of the public are invited to attend Council meetings, and time is reserved on each agenda for public comment. At the June 2025 MORAC meeting, Lt. Governor Miller announced that the Maryland Office of Overdose Response (MOOR) would establish the Council's first Citizen Advisory Workgroup (CAW). The CAW was created to bring additional community perspectives into the state's overdose response and to help inform efforts by MORAC and participating state agencies to reduce overdoses and expand pathways to substance use recovery.

Membership

In fall 2025, the Maryland Office of Overdose Response (MOOR) opened applications for Marylanders interested in serving on the CAW. Applicants were required to identify as one or more of the following: a person with lived experience with substance use, a family member of an individual with substance use, or a substance use care provider in Maryland. MOOR received more than 100 applications and selected members based on their personal statements, geographic diversity, and the unique experiences and perspectives they would bring to the workgroup.

The CAW began meeting in January 2026. During the first several months, it became clear that some members were unable to continue participating because of personal or professional conflicts. To maintain a strong and representative workgroup, MOOR conducted a second round of recruitment in May 2026, with the newly selected members joining the CAW in June. The CAW now consists of 14 members representing all five regions of Maryland: Capital, Central, Eastern, Southern, and Western. Together, members bring a broad range of lived, family, and professional experiences with substance use and the systems that serve people who use drugs.

Process

The CAW began its work by focusing on the priorities, perspectives, and experiences of individual members. Throughout their early meetings, members worked together to identify and organize the issues they believed were most important for the workgroup to address, ultimately developing a detailed outline to guide its discussions. The CAW then dedicated individual meetings to each major section of the outline. For each topic, one or more members volunteered to prepare a background presentation, facilitate the group's discussion, and develop a written summary afterward. These summaries captured the key themes raised during the discussion and the recommendations that emerged from the group's deliberations. This member-led process ensured that the CAW's work was grounded in the knowledge and experiences of its members while providing a consistent structure for developing the recommendations included in this report.

Preparation of this Report

This report was developed from the written summaries prepared following each of the CAW's topic discussions, along with this introduction providing context for the workgroup and its process. Because the individual sections were prepared by different members, they varied in structure, style, and level of detail. Artificial intelligence (AI) was used as an editorial tool to organize the material into a consistent format and create a more uniform voice across the report. The goal was to improve clarity and consistency while preserving the substance and, wherever possible, the original language of the member-authored summaries. Members who had prepared the original summaries then reviewed their sections to ensure that the editing process had not introduced substantive changes and that the final text accurately reflected the discussions, perspectives, and recommendations of the CAW.

Next Steps

The breadth of issues identified by the CAW exceeded what could be fully addressed within the timeframe for this report. As a result, several topics included in the workgroup's original outline remain for further discussion, including recovery as a lifelong process, medications for opioid use disorder (MOUD), and the vital role of peers in the recovery continuum. The CAW will continue meeting through the end of 2026 to complete this work and consider additional priorities.

Acknowledgments

This report reflects the collective work, perspectives, and recommendations of the entire CAW. Several members, however, made substantial contributions to its preparation. Thomas Higdon and Barbara Allen served as the lead editors of the report, helping bring the individual sections together into a cohesive final document. The CAW also recognizes the members who prepared the original topic summaries that form the foundation of the report: Sean Baker (Recovery); Malik Burnett (Treatment); Johanna Dolan (Data); Jessie Dunleavy (Criminal System, Harm Reduction, Myths, and Prevention); Thomas Higdon (Prevention, Quality, Representation, and Stigma); Megan Murnane (Harm Reduction); Yngvild Olsen (Treatment); and Joe Rogers (PHP with a Pillow). Their work in documenting the CAW's discussions and recommendations was essential to the development of this report.

Statement on Consensus and Independence

The CAW voted unanimously to approve this report and its recommendations. This report represents the work and recommendations of the CAW itself. Its contents do not necessarily reflect the views, policies, or positions of the Maryland Overdose Response Advisory Council (MORAC) or the Maryland Office of Overdose Response (MOOR).

Prevention

Maryland's substance use prevention and education efforts appear fragmented across agencies, jurisdictions, schools, and community organizations. The absence of a statewide strategic plan establishing effective prevention measures makes it difficult to identify priorities, coordinate programs and policies, measure outcomes, and ensure widespread understanding of substance use and its harms.

Key themes

Youth. Effective prevention education must begin in elementary school and continue through high school using an age-appropriate curriculum that emphasizes safety, risk reduction, equity, and overall well-being. Successful programs foster resilience, decision-making, and trust, while reducing the societal and individual costs of drug use. The curriculum should provide honest science-based information regarding substances, long-term harms (including overdose and legal consequences), and initiatives such as naloxone that reduce the harms of drug use. Programming should also equip youth with knowledge of drug policies, including protections like Maryland's Good Samaritan Law. Young people respond best to accurate information that bolsters their knowledge base rather than ineffective fearmongering tactics. Engaging youth in leadership roles in developing and delivering prevention messaging enhances program credibility while encouraging sustained conversations within schools and communities. Selective programming for students identified at high risk has proven effective in schools when coordinated with community interventions.

Community. Health-centered factual information on drugs equips people to make informed decisions that prevent or minimize the harms of drug use. Public messaging must be entirely factual, non-stigmatizing, broadly accessible, and user-friendly. Program development should focus on disseminating beneficial information for adults of all ages, with adaptations that enable culturally sensitive strategies for specific high-risk demographics (e.g., Black males over age 55). Among those in need of factual information and practical support are family members and caretakers who struggle in isolation, unsure of their roles and reluctant to seek help due to stigma. Tailored outreach programs and dissemination of fact-based resources can bridge this gap and minimize the stigma that hinders effective support.

Consistency. Uneven implementation of prevention education programs, reliance on non-evidence-based practices, and conflicting messages constitute an urgent concern. Resistance to proven, effective measures persists within schools, communities, and health care systems. This resistance underscores the need to invest heavily in science-based policies that maximize health outcomes. Inundating teens or adults with negative messaging and sensational stories is demonstrably ineffective. Long-held beliefs often stymie progress; for instance, an over-focus on abstinence-only models frequently undermines the primary goal of saving lives.

The challenge. The primary challenge lies in ensuring that publicly available information remains current, evidence-based, universally accessible, and free of conflicting messages. While Maryland's Stop Overdose website is full of invaluable information, with video clips on medications, stigma, and the Good Samaritan Law as excellent examples of crucial public service messaging, the same platform lists "Public Awareness Toolkits" with broken, inaccessible links. More concerning, various county health departments disseminate public announcements regarding drug trends that often reflect factual

inaccuracies, outdated data, or stigmatizing language. Because mainstream media tends to highlight sensational stories that counter public understanding, state and county governments must be doubly vigilant in establishing clear expectations for public education and in fostering stakeholder collaboration.

Recommendations

1. **Implement evidence-based prevention education** across all public-school grade levels, complete with established criteria and standardized assessment strategies.

2. **Develop a comprehensive statewide prevention and education strategy** that aligns state agencies, local jurisdictions, schools, and community organizations to set measurable priorities and integrate programs and public policy.

3. **Promote honest, developmentally appropriate prevention education across the lifespan** to address the distinct, evolving needs of youth, parents, caregivers, and older adults.

4. **Strengthen accountability for prevention practices** by prioritizing evidence-based approaches, rigorously evaluating outcomes, replicating effective models and eliminating activities that lack empirical evidence or measurable value.

Harm Reduction

Harm reduction refers to a range of initiatives that have proven to reduce overdose and infectious disease transmission. Grounded in justice and human rights, harm reduction is a belief system that prioritizes health and well-being in a non-judgmental and non-coercive environment, without requiring abstinence as a precondition for support. This approach transcends shame and stigma, helping people to take care of themselves and make healthy choices. Harm reduction services are practical, safe, and cost-effective.

The current federal administration undermines support for harm reduction with unsubstantiated claims that it encourages substance use. This position has often prompted the use of alternative terms in lieu of curtailing services. Regardless, states hold the jurisdiction to protect public health and safety and can continue to implement harm reduction strategies.

In general, harm reduction is pervasive in U.S. society. Some aspects are regulated by law (seat belts, helmets, fences around pools, and pen caps) and others by common sense (sunscreen, designated drivers, nicotine patches, and condoms). Harm reduction recognizes that human beings take risks and that lowering the consequences of those risks is often more realistic than demanding immediate change in human behavior.

Identified by MOOR as a high priority, harm reduction services have grown in Maryland, evidenced by expanded access to naloxone, drug checking supplies, and Syringe Service Programs (SSPs). Even so, gaps in these services and disparities in access, particularly in high-mortality communities, along with fear of

criminalization for possession of safe-use supplies, prevent these programs from achieving their significant financial and life-sustaining potential.

Key themes

Public health and recovery from substance use disorder are shared goals among stakeholders. The fact that more than 75% of those who suffer from addiction do not receive any formal treatment or recovery support underscores the critical need for harm reduction services that keep people at risk from falling through the cracks. In providing basic health care in a non-threatening environment, harm reduction services build relationships, establish trust, restore participants' sense of self-worth, and have proven to increase the likelihood of voluntary treatment.

Harm reduction rationale undergirds hope for a future that is healthier and more humane. Beyond reducing overdose deaths and the spread of blood-borne diseases such as HIV and hepatitis, it moves drug use out of back alleys into safe spaces, reduces neighborhood trash and crime, dismantles systems of oppression and isolation, and complements the approach to treatment.

Criminalization creates hurdles in nearly every system designed to help. Incarceration and its consequences often do more harm than the behavior it professes to change. Criminalizing drug use is not only a formidable barrier to efforts to reduce stigma but also, by harming the very people who need help, a primary driver that keeps people locked in poverty, hopelessness, and addiction.

Racism and other inequities are significant barriers to needed health-focused initiatives. Extreme racial disparities in criminal justice practices result in shameful incarceration percentages. Marginalized communities are targeted for arrests, while privileged individuals are more often able to reduce the risks of drug use and avoid harsh penalties. Exacerbating this discrimination, services that mitigate harm and promote health are often absent in areas where the death toll is highest, including in rural communities where inadequate transportation is a barrier.

Reluctance to embrace health-centered legislation is an impediment. Too many lawmakers remain uncomfortable accepting substance use disorder (SUD) as a medical condition. Bias toward established laws or fear of appearing "soft on crime" often results in opposition to sensible legislation and a seeming disregard for scientific evidence and research findings on health and economic benefits. Fortunately, there are lawmakers whose tireless efforts to advance needed reform have enabled progress, providing hope for seeing an end to the quagmire of over-incarceration and preventable deaths.

Overdose Prevention Centers (OPCs) are supported by global evidence. Staffed with trained professionals, OPCs are facilities where people can use previously purchased drugs and, if necessary, an overdose can be reversed. They offer safe-use supplies, hygiene necessities, food, and connections to community resources such as employment. Bringing users out of the shadows into a caring environment inspires healthier choices including SUD treatment. They also provide public service, preventing infections, reducing crime, and keeping drug use indoors. Economic evaluations report favorable cost-benefit ratios with benefits far outweighing expenses. Over 150 OPCs operate elsewhere in the world, some for 40 years, and none with an overdose fatality.

The U.S. is the world leader in overdose fatalities by a substantial margin. Countries with robust, comprehensive harm reduction services—such as overdose prevention centers (OPCs) and widespread

access to safe-use resources—consistently maintain significantly lower rates of fatal drug overdose than nations with fragmented or criminalization-heavy policies.

Recommendations

1. **Promote harm reduction principles in all Maryland communities.**
    - Recognize that drug use does not warrant inhumane handling.
    - Affirm that people who use drugs do not forfeit the right to be treated with dignity.
    - Acknowledge that people who use drugs are capable of making decisions about their own health care.
    - Value the importance of any positive change on an individual's path to wellness.
    - Counter the societal assault of stigmatization and criminalization.

2. **Expand access to safe-use supplies.**
    - Continue expanding SSPs to guarantee low-barrier access in every jurisdiction.
    - Expand access to include safe-smoking supplies.
    - Ensure harm reduction services are located where potential harm and overdose mortality are greatest.
    - Decriminalize possession of safe-use supplies and drug paraphernalia.

3. **Maximize access to overdose reversal drugs.**
    - Saturate public and medical spaces with naloxone, including doctors' offices, emergency rooms, hospitals, pharmacies, schools, libraries, music venues, and other appropriate locations.
    - Ensure that people understand proper naloxone use and dosage.

4. **Expand drug checking services.**
    - Increase broad access to drug checking resources.
    - Deploy advanced spectroscopy testing tools where appropriate.
    - Reduce reporting times for people using drug checking services.
    - Strategically place drug checking services based on regional needs.

5. **Pass state legislation authorizing Overdose Prevention Centers in strategic locations.**
    - Embrace proven effectiveness of OPCs in preventing overdose deaths, infectious disease transmission, and public drug use while minimizing the compounded misery of arrests and incarceration.
    - Understand the value of compassion for people who struggle, the human connections that bolster self-care, and hope for a healthy future.

6. **Address racial and socioeconomic inequities.**
    - Formally acknowledge existing systemic racism within drug policy.
    - Shift the mindset away from punishment to a culture of care.
    - Increase harm reduction services in Black communities, rural communities, and all high-mortality areas.
    - Bolster community engagement and enlist trusted community members to provide harm reduction resources.

7. **Increase understanding and support for harm reduction among policymakers, law enforcement, health care professionals, and the public.**
    - Educate communities that addiction is a highly treatable medical condition, not a criminal justice issue.
    - Highlight immediate financial savings from reductions in emergency room visits, hospital stays, infectious disease, incarceration, and chronic disease management.
    - Promote shared public health benefits, including reduced overdose, lower disease transmission, reduced public debris, and increased community productivity.

8. **Ensure that all policies are guided by the primary goal of saving lives.**
    - Include people with lived experience in policymaking.
    - Continue to reject punitive and counterproductive drug-induced homicide laws.

Treatment

Treatment for substance use disorders encompasses a broad range of therapies, including medications and behavioral interventions, in individualized ways that account not only for the types of substance use disorders people may have but also for their severity, whether mild, moderate, or severe. While people with SUD can initiate, receive, and continue treatment, particularly with medications, in primary care, emergency departments, and hospital settings, those with the most severe forms of SUD often are served in the specialty behavioral health system.

The regulatory oversight and payment frameworks for Maryland's specialty addiction treatment system are currently based on the American Society of Addiction Medicine (ASAM) Criteria 3rd Edition. This framework has become outdated and falls short of the latest edition of the ASAM Criteria, the 4th Edition, leaving unnecessary complexity and opportunities for inappropriate care and oversight within the state's specialty addiction treatment system.

Additionally, the current treatment system lacks uniform standards for evaluating progress within the context of treatment and leaves patients unable to objectively determine which facilities provide the best care for their needs. This is particularly the case for people with opioid use disorder (OUD) given that the standard of care for this condition—medications for opioid use disorder (MOUD)—is not universally accessible across different settings in which patients with OUD find themselves.

MOUD is the terminology that describes the FDA-approved medications for opioid use disorder, separating them out from other non-pharmacological treatment modalities for OUD to reduce stigma and more accurately describe the different treatment components that make up the more stigmatizing term "medication-assisted treatment." Two forms of MOUD, methadone and buprenorphine, are long-standing FDA-approved medications recognized as the most effective way to help people stop or reduce opioid use and play significant roles in curbing the overdose epidemic in the U.S. Multiple studies demonstrate that these medications reduce the risk of opioid-related overdose death by over 50%, with long-term use providing the best outcomes. Methadone and buprenorphine are safe and effective during pregnancy as well. However, fewer than 1 in 5 people with OUD receive these medications according to national estimates from SAMHSA.

Naltrexone is a third FDA-approved medication for OUD that also treats alcohol use disorder, but it does not have the duration of evidence supporting its efficacy or mortality-reducing effect for people with OUD. Maryland law requires all three forms of MOUD to be available in carceral settings, although compliance with this is mixed. Maryland's legislature in 2026 also passed a law (HB 1249) prohibiting certified recovery residences from denying admission or services to people taking any form of MOUD or requiring that they lower their dose or switch from one form of MOUD to another.

While measures such as these are designed to improve access to MOUD, more work is needed. Some of the barriers to MOUD expansion rest at the federal level but Maryland can do its part. That includes ensuring that statewide improvement efforts are implemented as intended and supporting the integration of MOUD across the specialty behavioral health treatment system in alignment with the ASAM Criteria 4th Edition.

An additional consideration for SUD treatment more broadly is found in the concept of measurement-based care. When measurement-based care is coupled with an emphasis on recovery-oriented outcomes, it can provide a framework for both providers and patients to objectively assess progress in treatment settings and determine whether additional or alternative interventions are required.

Given the evolution of the SUD landscape and the expansion of treatments, the regulatory and licensing bodies within the Maryland Department of Health (MDH), Behavioral Health Administration (BHA), and local agencies are ill-equipped to provide the requisite oversight and technical assistance to treatment programs and facilities to ensure that state-of-the-art, evidence-based treatment is routinely being provided.

Key themes

Maryland should modernize its treatment framework by adopting the ASAM Criteria 4th Edition. BHA's regulatory oversight and training capacity should be strengthened to ensure that the ASAM Criteria 4th Edition are incorporated into licensing, regulatory, and reimbursement systems across the Maryland treatment landscape.

Treatment systems need objective ways to measure patient progress. Measurement-based care focused on recovery-oriented outcomes should be incorporated into treatment environments to establish objective criteria around which patients and providers can assess progress and ensure that appropriate progress is being made.

BHA needs sufficient capacity to provide effective oversight and technical assistance. Effective implementation of updated treatment standards will require regulatory and licensing bodies at the state and local levels to have the resources, training, and capacity necessary to ensure that evidence-based treatment is routinely provided.

MOUD acceptance and expansion are critical to Maryland's efforts to reduce harm from fentanyl and prevent a resurgence of opioid-related overdose mortality. While Maryland has done a lot of work to ensure access to buprenorphine, methadone, and naltrexone, more work is needed across criminal justice settings, emergency departments, hospitals, primary care, and throughout the specialty behavioral health system.

Recommendations

1. **Provide BHA with sufficient resources to evaluate and lead the development of a strategic plan for adoption of the ASAM Criteria 4th Edition.** The plan should address how the updated criteria will be incorporated into Maryland's licensing, regulatory, reimbursement, workforce training, and quality-assurance systems. It should also clarify how the ASAM Criteria will interact with other standards across the recovery continuum, including National Alliance for Recovery Residences (NARR) standards for recovery residences. Incorporating NARR standards into this broader framework would help ensure that recovery housing is governed by appropriate, nationally recognized standards while remaining clearly distinguished from licensed substance use disorder treatment.

2. **Incorporate the latest version of the ASAM Criteria into relevant MDH regulations and payment systems, with a go-live date for the 4th Edition within three years.** MDH should establish a clear implementation timeline, provide technical assistance and training to providers and payers, and allow sufficient transition time for treatment programs to update clinical practices, documentation, staffing, and billing systems before the new requirements take effect.

3. **Require access to all forms of MOUD as part of the transition to the ASAM Criteria 4th Edition for all specialty behavioral health settings, including recovery residences**. MDH should fully align its standards with the ASAM Criteria 4th Edition and Maryland law regarding the inclusion of MOUD.

4. **Ensure all carceral settings are equipped to provide all forms of MOUD, whether initiating or continuing medication, based on individual need.** Maryland has convened a workgroup to assess the impact and sustainability of HB 116, passed in 2019 to require OUD treatment in all of the state's jails and detention centers. Maintaining access to MOUD for incarcerated populations is an important outcome for this workgroup.

5. **Adopt measurement-based care frameworks focused on recovery-oriented outcomes as part of Maryland's regulatory, licensing, and funding framework for the treatment of substance use disorders.** Maryland should establish consistent expectations for the routine use of validated measures that allow patients and providers to assess progress over time and adjust treatment when needed. Measures should reflect a broad range of recovery-oriented outcomes, including physical and behavioral health, quality of life, functioning, housing stability, treatment engagement, reduction in substance-related harms, and progress toward goals identified by the patient. MDH should provide guidance, training, and technical assistance to support implementation and should ensure that measurement-based care is used to improve clinical decision-making and quality of care, rather than relying solely on abstinence or other narrow measures of treatment success.

6. **Maryland should leverage federal changes to methadone treatment access.** Maryland should ensure alignment with the 2024 revisions to federal Opioid Treatment Program (OTP) regulations at the state level, evaluate the uptake and impact of new flexibilities and provisions on access, care integration, and treatment outcomes, and assess patient-reported outcomes including perceptions of OTP clinic culture and climate. Maryland should also support changes that may

occur with passage of the Modernizing Opioid Treatment Access Act (MOTAA 2.0) currently being considered by Congress.

Criminal System

The issue is twofold. First, criminalizing drug use creates more problems than it solves. In addition to staggering costs, it depletes health care resources and is a barrier to proven life-saving initiatives while failing to reduce the availability of drugs, the demand for drugs, or the number of addictions. Second, the criminal system is rooted in racial discrimination and moralistic class warfare, justifying inhumane treatment, eroding human rights, and trapping people in addiction and poverty.

Key themes

Racial disparities are deeply embedded in the criminal system. Maryland is keenly aware of the law enforcement biases and racism that bred the shameful distinction of a prison population that is over 70% Black. Of those arrested on drug charges, the overwhelming majority are Black, yet the rate of drug use among Black and white people is virtually the same. The state is also working to address racial disparities in overdose deaths, with the rate for Black fatalities reported as 61% higher than for whites, representing an increase over the recent past.

Criminalization creates barriers to stability and recovery. The hardships inflicted by routine dehumanization, along with a criminal record, imperil liberties and challenge a stable life. Restricted access to employment, housing, food, health care, and other life-sustaining benefits perpetuates poverty, hopelessness, and recidivism.

People who use drugs need support, not punishment. While there is increased understanding of substance use disorder as a medical condition, criminalizing the very people who need help continues. Common-sense, science-backed, and humanistic principles behind pleas for reform, such as decriminalizing paraphernalia, often fall short. There is recognition of meaningful progress, with Governor Moore's historic number of pardons for cannabis convictions and the Expungement Reform Act of 2025, as prime examples. Also, the state deserves much credit for continuing to avoid passing legislation like drug-induced homicide laws.

Misinformation and stigma continue to impede reform. Maryland urges public buy-in for destigmatizing substance use disorder, with campaigns that include video messaging and TV spots that are well done and impactful. This effort has made a difference, but the goal of destigmatizing behavior that remains criminalized will continue to be a challenge.

Recommendations

1. **Stop punishing people for drug use and adopt a health-minded framework instead.** Support access to health-oriented resources in lieu of criminalizing drug possession.

2. **Expand and maximize diversion programs, including Law Enforcement Assisted Diversion (LEAD),** that promote alternatives to criminalization and redirect people to services focused on improved health outcomes.

3. **Support decriminalization of possession of drugs for personal use and drug paraphernalia** to minimize criminalization and reduce risk factors for people who use drugs.

4. **End discriminatory practices that target marginalized communities** to eliminate disparities in arrests, bail and pretrial release, sentencing, and parole conditions or sanctions that undergird the cycle of recidivism and perpetuate known risk factors for substance use.

5. **Continue to expunge criminal records and issue pardons for drug-related convictions,** extending beyond cannabis possession, to restore human rights and equal opportunities for employment, housing, food, and other life-sustaining benefits and to reduce risk factors for substance use**.**

6. **Ensure compliance with state law mandating that people with substance use disorder who must be incarcerated have easy access to medications** that are the gold standard for treatment, promoting treatment as prevention against recidivism and overdose.

7. **Ensure that Maryland drug courts base all treatment placements on medical diagnosis from independent health care professionals rather than judicial or law enforcement discretion,** ensuring care matches individual needs and reduces recidivism.

8. **Promote facts and challenge myths that impede reform.** Public policy should reflect understanding of facts such as: addiction is a treatable medical condition; the majority of people do recover; return to use is common and not a failure; punishment has not proven effective as treatment for substance use disorder; and the known benefits of medications for opioid use disorder (MOUD) far outweigh perceived concerns.

Recovery

Recovery is a critical piece of the substance use disorder continuum and one that the CAW robustly discussed and considered; however, a comprehensive set of recommendations regarding this broader topic was not ready by the time of this report's submission. The CAW believes this is a critical topic for review and that MORAC is uniquely positioned to address the issues that the CAW raised. The CAW therefore plans to submit a subsequent report covering recovery, Maryland RecoveryNet (MDRN), and recommendations for improving recovery housing for Marylanders.

PHP with a Pillow

The CAW examined the challenges of the Partial Hospitalization Program, or PHP, in which a person may spend much of the day receiving treatment but lives somewhere else at night. The 4th Edition of the American Society of Addiction Medicine (ASAM) changes the name of Partial Hospitalization (PHP) to "High Intensity Outpatient" to further clarify that this level of care is outpatient and should not be associated with housing.

Concerns have been raised that Maryland's Medicaid reimbursement and recovery housing systems may unintentionally encourage providers to use PHP even when another level of care may better meet a person's needs. The concern is not with PHP itself, which is an important part of the treatment system. Rather, treatment decisions should be based on what is most appropriate for the individual, not on which combination of services generates the greatest reimbursement.

Key themes

Financial incentives should not drive treatment decisions. Maryland Medicaid currently pays more for six or more hours of PHP outpatient treatment each day than it pays for Level 3.5 residential treatment, including room and board. PHP providers may also receive payment for certain additional services that are bundled into the reimbursement rates set for licensed residential treatment providers. This creates a financial incentive to provide intensive outpatient treatment rather than residential treatment, even when residential care may be more appropriate.

The widespread use of the higher PHP payment raises concerns. According to Maryland Medicaid claims data presented to the workgroup, approximately 93.5 percent of PHP claims used the higher payment modifier available when treatment is provided for six or more hours per day. Such widespread use raises questions about whether this enhanced payment is being used as originally intended.

Outpatient and residential treatment serve different purposes. PHP is intensive outpatient treatment. Residential treatment provides both treatment and a structured living environment. Maryland's payment system should reinforce these distinctions and help people receive the type and intensity of care that best meets their needs. When a potential patient is screened and needs that level of treatment intensity, but also needs housing, the proper placement is not pairing PHP with recovery housing. That person should be placed in a licensed residential treatment program based on ASAM scoring criteria.

Recovery housing should not be used to steer people into a particular treatment program. Some treatment providers also operate, are affiliated with, or have relationships with recovery housing. These arrangements become problematic when a person's ability to remain housed depends on continuing treatment with a particular provider. People should be able to choose or change treatment providers without putting their housing at risk.

Recovery housing is not intended to function as a place to keep people attending treatment. Recovery housing is about connecting individuals to their community, teaching them life skills, modeling how to handle various challenges, rebuilding familial relationships, and fostering a routine that enables them to become a productive member of society. When individuals are housed with PHP providers, none of this happens. Often, clients in these situations cannot use their phones, have dinner with their families, or get jobs, and many are not even allowed to leave the property. That is not recovery housing; it is the antithesis of it.

Recovery housing and treatment should remain distinct services. Maryland RecoveryNet (MDRN) is intended to help people access recovery housing when they lack other resources to pay for it. Combining publicly funded recovery housing with intensive outpatient treatment in ways that function like residential treatment can blur the distinction between the two systems and create opportunities for inappropriate billing. Allowing funds to be used while in PHP robs the consumer of their funding for when they most need it, as they begin their journey to support themselves without the guardrails of treatment in a true recovery residence setting.

The current payment structure may result in substantial unnecessary Medicaid spending. The analysis presented to the workgroup estimated that eliminating the enhanced modifier payment for six or more hours of PHP treatment could reduce Medicaid spending by approximately $35 million to $50 million annually. These estimates warrant further review, but the potential fiscal impact is significant enough to justify closer examination of the current reimbursement structure.

Recommendations

1. **Eliminate the enhanced Medicaid payment for six or more hours of PHP treatment per day.** Currently billed using Modifier 22, this higher rate creates a financial incentive to provide extended PHP services. Eliminating it would help ensure that decisions about the intensity and setting of treatment are based on patient needs rather than reimbursement.

2. **Prevent treatment providers from using recovery housing to steer or retain patients.** Maryland should prohibit arrangements in which access to MDRN-funded recovery housing is conditioned on receiving treatment from a particular provider or affiliated entity. Financial relationships between treatment providers and recovery housing providers should be transparent and subject to appropriate oversight. If a provider is found to be committing fraud involving state funds, they should be banned from accessing those state funding sources in the future.

3. **Protect a person's ability to choose treatment and housing independently.** People receiving MDRN-funded housing should be free to choose or change treatment providers without losing their housing. Policies should also prevent treatment or housing providers from using financial incentives, referrals, or other arrangements that improperly limit patient choice.

4. **Prohibit coterminous billing for PHP and MDRN.** MDRN funding is intended to be a benefit to the consumer in the early stages of recovery, typically after completion of a licensed residential treatment program, where they can have the rent paid during the first couple of months of their stay in an independent recovery house while they work to find a job to be able to continue to pay rent. Providers should not use a consumer's MDRN funding while the consumer is in a PHP program receiving six hours per day of treatment, because the consumer is not at an appropriate point in their recovery journey to use this benefit. No clinician in the State of Maryland should support this combination of services.

5. **Strengthen oversight of treatment placement and billing.** Maryland should regularly examine Medicaid claims and other data to identify unusual patterns in the use of PHP, determine whether people are receiving the level of care that best meets their needs, and ensure that Medicaid and recovery housing funds are being used appropriately.

Cross-Cutting Themes

Stigma

Stigma associated with substance use remains a major driver of preventable harm, including deaths, in Maryland's overdose response and behavioral health systems. Stigma affects whether people feel safe asking for help, whether they are treated with dignity when they do ask for help, and whether public policy prioritizes health, autonomy, and survival over punishment, exclusion, and control.

Stigma is especially damaging in the systems that people who use drugs must navigate most often, including emergency departments, hospitals, treatment programs, recovery settings, social services, law enforcement, courts, jails, prisons, and reentry systems. People who use or have used drugs commonly report being treated as dishonest, manipulative, dangerous, irresponsible, or less worthy of care. These experiences, along with fear of arrest, can lead people to use alone, delay medical treatment, avoid calling for help during emergencies, decline behavioral health services, leave treatment early, or disengage from systems that feel unsafe or dehumanizing.

Key Themes

Stigma is more than offensive language or negative attitudes. Stigma shows up in concrete decisions and practices, including whether a person's pain is taken seriously, whether a return to use is treated as a clinical concern or a moral failure, whether parents are threatened with family separation, whether people are discharged from programs for symptoms of the condition being treated, and whether policymakers listen to people with lived and living experience.

Stigma can discourage people from seeking care. People may avoid emergency departments because they expect to be judged or denied adequate care. People seeking help for pain, withdrawal, or mental health needs may be labeled as "drug-seeking," while people taking medications such as methadone or buprenorphine may be shamed for receiving evidence-based treatment.

People may feel pressure to appear "recovered enough" to be treated as credible. People who use or have used drugs may feel that they must present themselves as abstinent, compliant, or otherwise acceptable to receive respectful treatment or have their perspectives taken seriously. These experiences are especially harmful for people who are still using drugs, are experiencing homelessness, or have criminal records.

Stigma is structural. Stigma can be embedded in program rules, funding decisions, public messaging, eligibility criteria, and accountability systems. Anti-stigma work therefore must go beyond awareness campaigns and address the policies and practices that affect how people are treated. The biggest hurdle in overcoming stigma is that drug possession, even for personal use, is a punishable crime.

Anti-stigma efforts should be connected to service quality and safety. Reducing stigma should be treated as part of service quality, workforce development, patient safety, overdose prevention, and civil rights, rather than as a separate communications or public education initiative.

Recommendations

1. **Require recurring anti-stigma training in systems where stigma creates the greatest risk of harm**, including emergency departments, hospitals, behavioral health programs, recovery support services, the criminal system, and social service agencies.

2. **Ensure that anti-stigma training is co-designed and co-led by people with lived and living experience of substance use**, including people who currently use drugs.

3. **Focus anti-stigma training on practical behavior changes rather than general awareness alone.** Training should help participants apply evidence-based, person-centered practices in real-world settings. For example, it should reinforce patient autonomy by supporting individuals in making informed decisions about their care, and it should address return to use as a common part of the recovery process that calls for reassessment, continued engagement, and appropriate support rather than punishment or exclusion from services.

4. **Address structural stigma in policies and practices.** Organizations should review whether their rules and procedures create unnecessary barriers to care or penalize people because of substance use. For example, programs should avoid discharging or excluding someone solely because of a return to use, and eligibility requirements should not prevent access to services when a person is actively using substances. Anti-stigma principles should also be incorporated into quality improvement and accountability efforts so that these practices can be monitored and addressed.

Quality

People seeking help for substance use should receive high-quality, evidence-based services delivered with dignity and respect. Instead, people often encounter a fragmented system with wide variation in quality. These concerns arise across multiple settings, including emergency departments, treatment programs, recovery residences, peer support services, crisis services, correctional settings, and reentry services.

Accountability is complicated by the fact that different complaints may need to go to different entities depending on the setting, provider type, license, funding source, or nature of the concern. For consumers and families in crisis, this fragmentation can make the system feel inaccessible and unresponsive.

Key Themes

People often do not know where to turn when something goes wrong. Even when a formal complaint process exists, it may be difficult to understand, intimidating to use, slow to respond, or unclear about outcomes. Often, the issue is not knowing where to begin finding the “report here” location when needed.

People may fear retaliation for raising concerns. People currently receiving services may worry that complaining could result in discharge, loss of housing, loss of medication, loss of child custody, or being labeled “difficult.” These risks can discourage people from reporting unsafe or inappropriate care.

Quality concerns extend across the continuum of care. Commonly reported experiences include people being discharged from programs after a return to use; being pressured into treatment or recovery pathways that do not match their needs; being denied services or discouraged from using medications for opioid use disorder; being required to participate in specific mutual-aid or spiritual programs as a condition of housing or services; and being placed in unsafe or poorly supervised recovery housing.

Accountability should focus on prevention and system improvement, not only punishment after harm occurs. Maryland needs a stronger consumer protection infrastructure that helps people understand their rights, identifies patterns across providers and systems, and uses complaint data to improve quality statewide.

Consumers and families need clear information about their rights. Plain-language information about consumer rights, anti-retaliation protections, and how to report a problem can make accountability systems more accessible and help people advocate for themselves and their loved ones.

Recommendations

1. **Create an independent behavioral health ombudsman for people receiving or seeking services across the continuum of care**, including harm reduction, treatment, mental health, recovery housing, and other recovery supports.

2. **Establish the ombudsman as a single point of entry for complaints and concerns**, regardless of which agency, board, accreditor, payer, or licensing body ultimately has authority to address the complaint. The ombudsman should help people understand their rights, document complaints, route concerns to the appropriate entity, track progress, and follow up with consumers and families.

3. **Prioritize urgent complaints involving immediate harm or retaliation**, including complaints involving safety risks, denial of medication, unsafe housing, discharge from a program, or other circumstances that could jeopardize a person's health or well-being.

4. **Use complaint data to improve quality statewide**. The ombudsman should issue regular public reports using de-identified data on complaint trends, recurring quality problems, response times, referral outcomes, and systemic gaps. These findings should inform oversight, training, funding decisions, and consumer protection.

5. **Develop and distribute plain-language consumer rights materials** for harm reduction, treatment, recovery housing, and other recovery support settings. These materials should explain consumer rights, anti-retaliation protections, and how to report a problem, and should be made available to people receiving services and impacted family members.

Representation

People closest to the harms of substance use, overdose, treatment barriers, criminalization, homelessness, and recovery systems are often not meaningfully represented in the bodies that shape policy and funding decisions.

Maryland has many advisory bodies that influence substance use, behavioral health, public safety, housing, health care, and social service policy. However, people with lived experience of substance use are often underrepresented, and people with living experience, meaning people who currently use drugs, are even more likely to be excluded.

When people with lived experience are included, they are often people who now work within provider systems. Their perspectives are valuable, but they do not substitute for the voices of people who are not professionally connected to the systems being discussed. Without balanced representation, advisory bodies may unintentionally reproduce the assumptions of providers, funders, and agencies while missing the day-to-day realities of people who rely on, avoid, or are harmed by those systems.

Key Themes

Lived experience is not monolithic. The experiences of a person in long-term recovery, a person currently using drugs, and a parent or loved one may overlap, but they are not interchangeable. Advisory bodies need a broader range of perspectives to understand how policies and systems function in real life.

People with living experience are particularly likely to be excluded. People who currently use drugs may be viewed as unstable, unreliable, or not “ready” to participate. Excluding these voices means that decisions affecting people who use drugs may be made without meaningful participation from the people most directly affected.

Professional lived experience does not substitute for independent community voices. People with lived experience who work within treatment, recovery, behavioral health, or other provider systems bring important perspectives. At the same time, their experiences may differ from those of people who are not professionally connected to those systems. Meaningful representation requires both.

Representation must be distinguished from tokenism. People with lived experience commonly report being invited to tell their stories but not to shape decisions, or being treated as symbolic participants rather than equal contributors. Meaningful representation requires clear roles, transparency about how input will be used, and genuine opportunities to influence recommendations and decisions.

The structure of participation can itself create barriers. Daytime meetings, technical language, unpaid participation, and expectations that members already understand government processes tend to favor professionals. Participation should not be limited to people who can afford to volunteer or who are being compensated by an employer to attend.

Meaningful participation requires support. Accessible meetings, plain-language materials, orientation and preparation, compensation for time and expertise, and feedback showing how community input affected final recommendations can help people participate as equal contributors rather than symbolic representatives.

Recommendations

1. **Strengthen representation on relevant advisory bodies by reserving seats for people with lived and living experience of substance use**, including people who currently use drugs.

2. **Ensure that representation includes people who are independent of service-provider systems**. Some designated seats should be reserved for people who are not employed by, do not own, and do not have a financial stake in behavioral health, treatment, recovery residence, or related service providers. This should complement, not replace, participation by people with lived experience who work in the field.

3. **Provide stipends and other accommodations that make participation accessible**. People with lived or living experience should be compensated for their time and expertise when appropriate, so participation is not limited to people who can afford unpaid civic labor or whose employers pay them to attend.

4. **Adopt practices that support meaningful participation rather than tokenism**, including plain-language materials, orientation for new members, accessible meeting structures, transparent decision-making processes, and feedback loops showing how community input affected final recommendations.

Data

Data is a cross-cutting element of every priority identified in this report. Maryland cannot determine whether prevention strategies are effective, whether treatment quality is improving, whether harm reduction services are reaching communities with the greatest need, whether criminal-system reforms are producing better outcomes, or whether disparities are narrowing without consistent and meaningful measurement. Data should therefore be understood not as a separate program area, but as essential infrastructure for accountability, learning, continuous improvement, and policy development.

Maryland collects significant amounts of data regarding prevention, treatment, harm reduction, recovery support, overdose response, and related systems. Much of this data, however, focuses on services delivered rather than whether those services result in meaningful improvements in people's lives. Measures such as program participation, treatment admissions, program completions, service encounters, arrests, and overdose deaths provide important information, but they do not fully capture whether people are safer, healthier, more connected, more stable, or experiencing an improved quality of life.

A broader "data-to-action" gap also remains. Data is often collected inconsistently across programs and agencies, data sharing between government entities remains difficult, and changes in reporting systems can interrupt long-term tracking. These challenges make it harder to identify gaps, ensure accountability, evaluate programs and policies, and use data to drive policy change.

Key themes

Measure outcomes, not only outputs. The focus should shift from merely tracking service delivery to measuring meaningful improvements in people's lives. Recovery capital is one useful framework because it looks beyond binary measures such as "sober versus not sober" and considers factors such as housing,

employment, health, social connection, access to health care, and community support. These measures should be complemented by broader quality-of-life indicators that capture whether people are building lives characterized by greater stability, health, connection, opportunity, autonomy, and well-being.

Use both leading and lagging indicators. Lagging indicators, such as overdose deaths, arrests, incarceration, and program completion, should be considered alongside leading indicators, such as naloxone access, transportation availability, housing stability, recovery support engagement, and community connectedness. Leading indicators may provide opportunities to intervene before negative outcomes occur.

Create greater consistency across data systems. Data collection lacks consistency across providers and over time, and changes in federal reporting systems can interrupt long-term tracking. A core set of critical data elements should remain consistent despite changes in individual reporting tools or systems.

Improve data integration and sharing. Data collection alone is not sufficient if information remains siloed among agencies and providers. Establishing and implementing data-sharing agreements between government agencies can be difficult, and MORAC may be well-positioned to help address these barriers.

Better evaluate long-term outcomes and program effectiveness. Measures such as program completion do not necessarily show whether a program improved a person's life over time. Better longitudinal data are needed on treatment, harm reduction, diversion programs, drug courts, and other criminal system interventions.

Ensure that lived experience and diverse recovery pathways inform data collection. Stigma and narrow definitions of success can affect data collection and interpretation. Lived experience should inform data collection, and information should reflect different populations, experiences, and pathways to recovery.

Recommendations

1. **Expand statewide measurement beyond service delivery metrics to include meaningful outcome measures**, including measures of health, wellness, stability, quality of life, and recovery capital.

2. **Establish a core set of critical data elements and shared definitions of success** developed with meaningful participation from people with lived and living experience, across prevention, treatment, harm reduction, and recovery support efforts, so that key outcomes can be measured consistently over time.

3. **Improve the integration and responsible sharing of data across agencies and systems**, including identifying and addressing legal, technical, and administrative barriers to data sharing.

4. **Increase the use of leading indicators and longitudinal data** to identify opportunities for intervention before crises occur and to better understand whether programs and policies produce meaningful improvements over time.

5. **Strengthen Maryland's ability to examine outcomes across time and across systems** rather than relying primarily on outcomes measured at discharge, program completion, or a single point in

time, as a program's immediate outcome may differ substantially from its outcome six months or a year later.

6. **Improve transparency and equity through meaningful disaggregation of data.** Where legally and methodologically appropriate, reporting should allow Maryland to examine differences by relevant demographic, geographic, socioeconomic, housing, disability, and criminal-system characteristics, including race, ethnicity, sexual orientation, and gender identity, where those data can be collected safely and appropriately, so the state can identify disparities, understand who is benefiting from services, and determine who may be left behind.

7. **Create mechanisms for translating data into action.** Maryland should establish routine processes for reviewing outcome data with policymakers, agencies, providers, researchers, and people with lived and living experience; identifying disparities and emerging concerns; and using findings to inform policy, funding, oversight, program improvement, and future MORAC recommendations.

8. **Review and build upon existing Maryland data initiatives before creating new data requirements**, including the state data inventory and related projects, to identify gaps, duplication, opportunities for coordination, and ways to use existing data more effectively.

Appendix

Myths that Impede Reform

Citizens with lived experience know that policy is only as effective as the truth it is built upon. Common misunderstandings about substance use remain pervasive across Maryland, presenting barriers to desperately needed change. Solutions to reduce the harms of addiction require factual understanding to inform sensible statewide policies. Establishing shared knowledge among lawmakers, health care providers, educators, social workers, law enforcement and judicial officials, and neighbors is a vital effort. It can create powerful inroads into barriers to much-needed reform.

Knowing that the U.S. has the highest overdose fatality rate in the world, regardless of recent declines in death totals, and has the highest number of prisoners, is a starting point for rethinking priorities. Maryland has made progress but must focus on a comprehensive plan to promote effective health care in lieu of fragmented policies that often work at cross purposes.

Reframing the condition

- **MYTH:** Addiction is a moral failure, representative of a character flaw.

  TRUTH: Addiction is a complex medical condition as defined in the Diagnostic and Statistical Manual (DSM-5), with susceptibility rooted in underlying genetic predisposition, mental health disorders, trauma, or deprivation.

- **MYTH:** Addiction is a simple choice requiring only willpower to overcome.

  TRUTH: Addiction alters brain circuits tied to choice, reward, and impulse control, and it requires a comprehensive and individualized process to overcome.

- **MYTH:** The drug itself is the sole driver of addiction; any use inevitably leads to addiction.

  TRUTH: Ten years of data reveal that between 80% and 90% of those who use addictive drugs do not develop a problem with them.

- **MYTH:** Return to use represents a failure.

  TRUTH: Addiction is defined as a chronic, relapsing medical condition, and return to use (relapse) is a common, expected milestone on the nonlinear path to recovery.

- **MYTH:** An individual must hit “rock bottom” in order to seek recovery.

  TRUTH: Waiting for someone to hit “rock bottom” often means waiting for them to die, especially in the era of potent synthetic drugs. Intervention and support can be highly effective at any stage of a substance use disorder.

- **MYTH:** Abstinence is the only true measure of successful recovery.

  TRUTH: Recovery is a deeply personal process. Success can be measured by reduced use, fewer emergency room visits, stable housing, and holding a job.

Public health

- **MYTH:** Harm reduction programs enable and encourage drug use.

  TRUTH: Decades of data show there is no evidence to support this claim. Instead, these services keep people alive, build human connections, and significantly increase the likelihood that a person will enter treatment.

- **MYTH:** Medication to treat addiction just substitutes one drug for another.

  TRUTH: FDA-approved medications like buprenorphine and methadone stabilize brain chemistry, reduce cravings, and have proven to cut overdose mortality rates in half, with long-term use most successful.

- **MYTH:** Forced or mandated treatment is effective for people who refuse help.

  TRUTH: Studies show that compulsory treatment does not improve long-term recovery outcomes, and that forcing people into treatment has increased the risk of fatal overdose upon release.

- **MYTH:** Drug education programs that use scare tactics are effective at preventing youth drug use.

  TRUTH: Studies consistently show that fear-based education does not deter youth substance use and often erodes trust in public health messaging. Honest, accurate, and harm-reduction-focused youth education is vastly more effective.

System Waste and Macroeconomics

- **MYTH:** Fentanyl exposure can cause a fatal overdose just by touching it or breathing ambient air.

  TRUTH: Major medical and toxicological societies confirm it is scientifically impossible to overdose from accidental skin contact or breathing residual air near fentanyl. This myth has caused panic, delays in life-saving care, and unnecessary criminal charges, with wasted resources for high-cost equipment for police departments such as hazmat suits, detection scanners, and respirators.

- **MYTH:** Criminalization and tough-on-crime policing are effective solutions to the drug crisis.

TRUTH: Decades of mass incarceration have failed to reduce drug availability, addictions, or overdose deaths. Treating a public health crisis through the criminal justice system depletes financial resources and worsens outcomes. Data from the Maryland State Archives show that the state has approximately 1,500 people incarcerated for drug offenses, at a cost per inmate of $5,000 per month, or $60,000 per year.

- **MYTH:** A drug-free society is a realistic goal, justifying the $44 billion federal drug control budget.

  TRUTH: Humans have been using mind-altering substances for relief, ritual, or pleasure for thousands of years. It is part of human nature, and expecting zero usage is unrealistic. Effective policies focus on reducing the preventable harms of drug use.

- **MYTH:** Expanding Syringe Service Programs (SSPs) is unaffordable.

  TRUTH: Expanding SSPs is highly cost-effective. The CDC notes that every dollar invested in an SSP yields an estimated $7.58 return on investment, substantiated by averting the high costs of treatment for HIV and hepatitis.

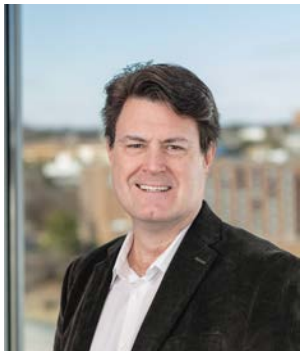
- **MYTH:** The largest economic cost of the drug crisis is measured in expenditures like health care, treatment, and harm reduction services.

  TRUTH: The single largest economic drain is on lost workforce productivity with two main drivers: (a) loss of productivity (unemployment, absenteeism) among those afflicted with addiction is $107 billion annually; (b) loss of productivity due to premature overdose death is $92 billion annually. The combined total loss of productivity is $199 billion annually.

Member Biographies

Barbara Allen (Co-Chair)

As Executive Director of James' Place Inc., a nonprofit in Maryland, Barbara focuses in two key areas of all things related to substance use and mental health. First is the joy of financially helping those transitioning from SUD treatment into recovery housing. Regardless if it's a first or fifth time in treatment, collaborating with providers, house managers, sponsors and probation/parole, this fuels her focus. Second, after the SUD related deaths of her son, Jim, brothers Bill and Tom, and niece Amanda, she is a policy advocate at the local and state level. Knowing first hand of the needs and failures of the system of care, she invests time heavily in numerous local, state and federal organizations working to save lives and provide hope for those who suffer this disease and their families.



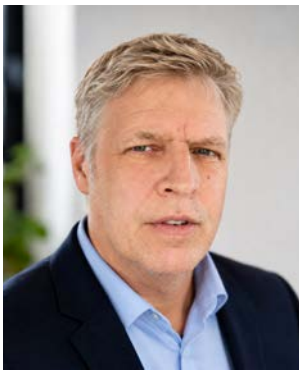
Thomas Higdon, (Co-Chair)

Thomas Higdon is the founder and Executive Director of the Maryland Alliance for Sensible Drug Policy, where he works to advance policies that treat people who use drugs with dignity, not punishment.

His motivation is deeply personal. After more than two decades of drug use, Thomas lived through the fallout: broken relationships, unemployment, homelessness, and repeated encounters with the criminal legal system. He also cycled through more than a dozen treatment programs, some of which left him feeling more harmed than helped.

Over time, he came to a hard truth: his drug use had caused real harm, but the systems meant to help often made recovery harder. In rebuilding his life, he found a deeper purpose in pushing for change. Alongside his lived experience, Thomas brings a broad range of professional expertise in organizing, program management, and public policy. Across his work, he has focused on building practical solutions for people and communities too often left behind. Thomas is also active in state and local efforts to reform drug policy and strengthen recovery support systems in Maryland. He is Co-Chair of the Maryland Overdose Response Advisory Council's Citizen Advisory Workgroup and a member of the Opioid-Associated Disease Prevention and Outreach Program Standing Advisory Committee. At the local level, he chairs the Baltimore County Behavioral Health Advisory Council and serves on the leadership team of Baltimore County's Recovery Oriented Systems of Care.

He holds a B.A. in Political Science from Eckerd College and a Juris Doctor from Tulane University. Thomas lives in Baltimore County with his wife, Kathryn, his stepson, Parker, and their dog, Luna. Outside of work, he enjoys reading, spending time outdoors, and exploring Baltimore.



Sean Baker

Sean Baker is a person in long-term recovery and the founder and Executive Director of Awaken Recovery Foundation, a nonprofit providing certified recovery housing and support services for women on Maryland's Eastern Shore. Since 2019, he has led the organization's growth and the development of programs focused on peer support, transportation, employment, financial literacy, wellness, and independent living. A former attorney with experience in nonprofit leadership and advocacy, Sean is dedicated to strengthening recovery housing and expanding practical pathways to long-term recovery.

Malik Burnett

As a physician, entrepreneur, and drug policy expert, Dr. Malik Burnett works to advance the broader drug policy reform agenda with the goal of shifting US drug policy from a framework based on criminal justice to one based on public health. Dr. Burnett currently serves as an Assistant Professor in Addiction Medicine at the University of Maryland Midtown Campus, a consultant for the Maryland Addiction Consultation Service and as medical director of several community opioid treatment programs. Additionally, he serves as a Vice Chair of the American Society of Addiction Medicine Legislative and Public Policy Committee.

He previously served as the Medical Director for the Center for Harm Reduction Services for the Maryland Department of Health, where he oversaw the statewide naloxone distribution and syringe service programs.

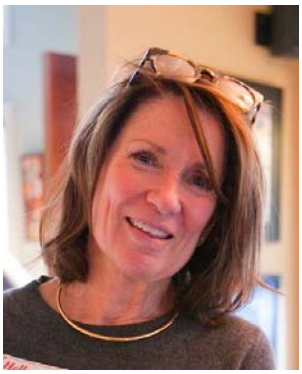
He attended Duke University where he completed undergraduate, medical, and business training. He earned his MPH from Johns Hopkins Bloomberg School of Public Health and completed his residency training in general preventive medicine at Johns Hopkins Hospital and his addiction medicine fellowship at the University of Maryland Medical Center.

Tammy Collins

Tammy Collins serves as Operations Director for Serenity Sistas, where she combines professional leadership with the powerful perspective of lived experience. Her personal journey with addiction and recovery fuels her commitment to advocacy, reducing stigma, and ensuring that the voices and experiences of those affected by addiction are heard and valued.

Johanna M. Dolan

Johanna M. Dolan is the founder of Dolan Research International, a consulting firm focused on workforce development, organizational effectiveness, and recovery support services. She holds a master's degree in Industrial/Organizational Psychology and is a Board Certified Coach. Johanna brings both professional expertise and lived experience in long-term recovery to her work, with particular interests in recovery capital, outcomes measurement, peer and recovery workforce development, and building systems that improve quality of life. She has contributed to state and national behavioral health initiatives. She is committed to ensuring that people with lived and living experience meaningfully inform the policies, programs, and systems that affect their lives.



Jessie Dunleavy

Motivated by all she learned through her son's struggles—from learning disabilities to a mental health diagnosis and ultimately drug addiction—Jessie Dunleavy is an advocate for drug policy reform. In opposition to the devastation inflicted by the war on drugs—particularly for vulnerable populations—she champions policies based on human rights and scientific research and is committed to combating stigma and other impediments to humane and effective strategies to reduce the harms of drug use.In coming to terms with the loss of her son, the injustices he endured, and the realization that his death was preventable, she found solace in connecting with others whose advocacy preceded hers. Grounded in science and dedicated to justice, these researchers, journalists, physicians, and human rights workers restored her hope, a hope that humanity and compassion could triumph over the criminalization and marginalization of those who suffer.

Beyond lending her voice through opinion editorials, speaking engagements, broadcast interviews, and social media, she has joined forces with like-minded groups at the national, state, and local levels including the Drug Policy Alliance, the Maryland Alliance for Sensible Drug Policy, and NCADD-Maryland's Addiction Treatment Advocates Committee. Working within her local health department, she is a member of the Senior Policy Team, the Overdose Prevention Team, and the Risk Reduction Advisory Council. She collaborates with organizations such as the Baltimore Harm Reduction Coalition and she lobbies for her cause within the Maryland General Assembly.

She has a master's degree in library and information science and served as an academic librarian for a decade at the outset of her career. Subsequently, she spent thirty years as an administrator in a pre-kindergarten through grade twelve college preparatory school.

She is the author of *Cover My Dreams in Ink, A Son's Unbearable Solitude, A Mother's Unending Quest*—an award winning memoir that portrays the journey of her son with the aim of inspiring sensitivity for those who are different and compassion for those whose battles arise from uncontrollable circumstances rather than faults of character. She lives in her hometown, Annapolis, Maryland.

Megan Murnane

Megan Murnane is a Davidsonville native and a person in recovery. A former special education teacher, she holds a Master of Arts in Leadership in Teaching from Notre Dame of Maryland University and is currently pursuing certification as a substance abuse counselor. She serves on the Harm Reduction Advisory Council for Anne Arundel County, and her focus is on helping women find purpose and build the tools to sustain long-term recovery.

She believes that recovery looks different for every person, that stigma can have dangerous consequences, and that MOUD saves lives. It's this focus, and these beliefs, that led her to found Sober Glow in March of 2025, a nonprofit working to create housing for women in recovery. As of July 2026, The Recovery Launch Pad, its recovery housing program in the heart of Annapolis, began the certification process with MCORR, and Megan hopes to be serving women within the next few months. She believes policy shaped by lived experience will always lead to the most commonsense solutions, and she is committed to making sure that experience has a real voice in the room.

Malik Mines

Malik Mines is the Recovery Friendly Advisor and a Peer Support Specialist with the St. Mary's County Health Department within the Behavioral Health Division. Leveraging his lived experience, Malik plays a vital role in the Recovery Friendly Workplace Initiative, led by the Maryland Department of Labor, where he helps businesses create supportive environments for individuals in recovery. He provides essential services tied to the Recovery Friendly Workplace designation, along with peer support and workforce development for individuals facing substance use disorders, mental health challenges, and co-occurring conditions—empowering both local workplaces and the broader community toward recovery and resilience.

Jim Raley

Jim Raley is a resident of Garrett County Maryland. He holds a Bachelor's Degree from California University of Pennsylvania and a Master's Degree from Frostburg State University in Educational Supervision. Jim had a career in public education for 31 years as a teacher and administrator, and during that time spent 14 years as an elected School Board Member in Garrett County. He retired in 2011 to pursue a career in politics, and in 2010, he was elected County Commissioner in Garrett County. Following the 2014 election, Jim took a position with the Office of Consumer Advocates in a peer based program operating programs in Allegany, Garrett, and Washington Counties. He left that position in April of 2019 to serve in the capacity of Executive Director of Archway Station in Cumberland Maryland, which is a psychiatric rehabilitation program in Allegany and Garrett County, Maryland. He has been successful at securing funding to open recovery-based programming and recently opened a recovery housing program for women with children in cooperation with the Behavioral Health Administration and Department of Housing and Community Development. That project is slated to expand into a $2.5 million renovated facility in 2027 that will house additional mothers and children. Jim

has secured funding from the Appalachian Regional Commission to launch a program called Housing Opportunities Made Easy (HOME) that will have low barrier affordable transitional housing located in the City of Cumberland.

Jim has served on numerous commissions and boards over the years. He was a member of the Governor's Safe Drilling Initiative from 2011-2014 studying the development of Shale Gas in Western Maryland. He has been a member of the Board for On Our Own of Maryland, Resources for Independence Center for Independent Living, the Thomas B. Finan Citizen Advisory Board, and the Dove Center Domestic Violence Shelter. He is a 2023 graduate of the Appalachian Regional Commission Leadership Institute. Jim is a lifelong member of the Eastern Garrett County Volunteer Fire and Rescue Department and is a Maryland EMT-B. He and his spouse share two adult daughters and two grandchildren.

Joe Rogers

Joe Rogers joined Project Chesapeake full-time as a partner in 2016 and has played a pivotal role in the organization's transformation into one of Maryland's leading providers of behavioral health services. Drawing on his experience managing more than $300 million in development projects and his expertise in investment strategy, finance, and business development, Rogers has helped drive Project Chesapeake's strategic growth, expanding its footprint across the state and increasing access to high-quality Substance Use Disorder treatment and mental health counseling for individuals and families in underserved communities. His leadership has strengthened the organization's operational capacity, supported the development of new facilities and programs, and positioned Project Chesapeake for continued statewide impact. Rogers is a graduate of the University of Maryland, College Park, where he earned a Bachelor of Arts in Journalism.

Jacqualine Salb

Jackie is a person in long-term recovery, a certified peer, a mom, and someone who has lost loved ones to substance use. These experiences shape her deep commitment to harm reduction, community safety, and judgment-free support. Before her current role, Jackie worked for many years as a critical care nurse, a background that helps her translate complex information into language that feels clear, practical, and accessible.

Jackie currently serves as the Overdose Prevention Coordinator at Mid Shore Behavioral Health, where she leads naloxone trainings and safety initiatives across the region. As someone who is neurodivergent, she approaches outreach with creativity, clarity, and a focus on reducing barriers so people can access the support they need.

Jackie has a strong belief in dignity, compassion, and meeting people exactly where they are. Her values are rooted in lived experience, through the people she has loved and lost, and in the belief that every person deserves safety and support without judgment.

Yngvild Olsen

Dr. Yngvild Olsen is a nationally recognized leader in addiction medicine, public health policy, and clinical care integration who currently provides care to patients with Opioid Use Disorder (OUD) and other Substance Use Disorders (SUDs) in Baltimore City and serves as a National Advisor for Manatt Health. Dr. Olsen has over two decades of experience across clinical, academic and governmental roles at the local, state and federal level, including leadership at REACH Health Services, Johns Hopkins, the Baltimore Substance Abuse System, and, most recently, as the Director for the Center for Substance Abuse Treatment at the Substance Abuse and Mental Health Services Administration (SAMHSA).

Dr. Olsen has held leadership roles at the American Society of Addiction Medicine (ASAM), and previously served in a consultant capacity to the Maryland Behavioral Health Administration (BHA). Dr. Olsen is board-certified in addiction medicine, trained in general internal medicine and is widely respected for her contributions to advancing addiction treatment and recovery nationwide.

Amy Young

Amy Young uses her lived experience to inspire, educate, and empower others. Having navigated the challenges of loving a child through addiction, incarceration, recovery, and having endless hope, she draws upon those experiences to support families facing similar struggles.

Amy believes that while individuals living with addiction deserve the opportunity for recovery, so do the people who love them. She recognizes that those recoveries are often not parallel and that family members need their own support, healing, and hope. Driven by that belief, Amy founded PABA (Parents Affected by Addiction), a grassroots support group in Southern Maryland dedicated to helping families impacted by a loved one's substance use. Through this work, she built strong partnerships with community organizations and became a trusted advocate for families navigating addiction and recovery.

Today, Amy serves as a Family Partner with Parents Place of Maryland, a nonprofit organization that provides support, resources, education, and empowerment to families. Drawing from both her personal journey and professional experience, she helps others realize they are not alone. Amy provides compassionate guidance, practical resources, and the reassurance that healing is possible—even when the path is difficult.

Amy is passionate about helping families discover the strength and courage they never knew they possessed. She often says that supporting others “feeds her soul” and her commitment to walking alongside families with empathy, authenticity, and hope is at the heart of everything she does.