

**WV Strategic Prevention Framework  
for Prescription Drugs  
(WV SPF-Rx)  
Needs Assessment**



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## Purpose

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This report is to inform programmatic prevention efforts across the state by the regional prevention specialists and other stakeholders working on the West Virginia Strategic Prevention Framework for Prescription Drugs (WV SPF-Rx). This assessment contains prevalence data on prescription and other opioid illicit drug misuse and related consequences, risk and protective factors related to prescription drug misuse, and prevention capacity resources to address prescription drug misuse in the state. The data can be used to examine trends in prescribing and overdose rates over time and by county. In addition, this report contains information on Prescription Drug Monitoring Programs that can assist with informing prevention practice at the policy level.

## Introduction and Background

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The West Virginia Department of Health and Human Resources (WV DHHR) Bureau for Behavioral Health (BBH) is the federally designated single state agency responsible for planning, carrying out, and evaluating activities to prevent and treat substance misuse and related activities (42 U.S.C. 300x-30 and 45 CFR 96.121). The Bureau for Behavioral Health (BBH) supports evidence-based practices that promote social and emotional wellbeing, prevention approaches, person-centered interventions, and self-directed and/or recovery driven support services. The Substance Abuse and Mental Health Services Administration (SAMHSA) is the federal agency within the U.S. Department of Health and Human Services that leads efforts to increase behavioral health across the nation. SAMHSA works with states and local communities to provide prevention activities to educate and support individuals and their families and communities to prevent the misuse of substances and the development of a substance use disorder. Prevention services are divided into three population categories based on the Institute of Medicine (IOM) model of care: universal, selective, and indicated. The goal of prevention is to prevent the onset of mental, emotional, behavioral, and substance use related problems. Prevention services include: Information Dissemination, Education, Alternatives, Problem Identification (ID) & Referral, Community Based Processes, and Environmental Strategies.

In 2016, SAMHSA awarded the WV DHHR BBH a five-year Strategic Prevention Framework Prescription Drug (SPF Rx) grant. The SPF Rx is funded around \$371,000 per year for five years. **The goals of the West Virginia Strategic Prevention Framework for Prescription Drugs (WV SPF Rx) program are to 1) enhance and expand infrastructure to address prescription drug misuse for youth (ages 12-17) and adults (18 and older) and 2) prevent and reduce prescription drug and illicit opioid misuse.**

Additional objectives of the project include: conducting a needs assessment; developing a data driven strategic plan to address prescription drug misuse; evaluating the PDMP to make service and policy level recommendations to improve usage; implementing prevention activities; implementing efforts to increase the use of the PDMP and best practices when prescribing opioids; increasing the capacity of the workforce to address prescription drug misuse; and developing a local evaluation plan to assess prevention efforts.

## Strategic Prevention Framework

The SPF Rx project relies upon the Strategic Prevention Framework (SPF) from SAMHSA. The SPF model (2019) provides guidelines for communities to examine prevention needs and efforts to address substance misuse. The steps of the SPF framework include the following:

- **Assessment** – Identify prevention needs based on data.
- **Capacity** – Build resources and readiness to address the needs.
- **Planning** – Use data to develop a strategic plan.
- **Implementation** – Deliver evidenced-based programs, policies, and practices.
- **Evaluation** – Evaluate the prevention efforts for outcomes.

In addition, the SPF models embraces cultural competency among members by identifying cultural and training needs. The model also works to create a sustainability plan (SAMHSA, 2019).

Figure 1: SPF Model



## Problems and Related Behaviors

Prescription drug misuse is a serious public health concern, with an estimated 6% of the population or 18 million people (ages 12 and older) reporting medication misuse at least once over the past year in 2017 (Center for Behavioral Health Statistics and Quality, 2018). The National Institute of Drug Abuse (NIDA) (2018), defines prescription drug misuse as taking a medication in a manner or dose other than prescribed; taking someone else's prescription; or taking a medication to feel euphoria (i.e., to get high). The most commonly misused medications are opioids, Central Nervous System (CNS) depressants that treat anxiety (i.e., benzodiazepines) or sleep disorders (i.e., zolpidem), and stimulants (NIDA, 2018).

National data suggests that young adults (ages 18-25) are most at risk for prescription drug misuse (Monitoring the Future, 2017) with over 14% reporting non-medical use in the past year; however, it can affect anyone. Studies also suggest that youth and older adults are at risk. Nationally, youth (ages 12-17) reported 4.9% of non-medical use in the past year (Monitoring the Future, 2017). Studies on older adults (ages 57-85) suggest that over half take 5 or more medications or supplements a day (Qato et al. 2008), which can increase unintentional use or intentional misuse leading to poor health outcomes and consequences. Prescription drug misuse can differ by age or gender, by ease of access (Manchikanti, et al, 2010), and due to the perception that prescription drugs may be safer or less harmful than illicit drugs (Webster, 2012).

Prescription drug misuse can lead to serious health related consequences, including overdose and overdose death. Nationally, over the last two decades as the number of individuals prescribed opioids increased, so did the number of overdoses and deaths from prescription opioids (CDC, 2020). In the United States, over 232,000 people have died from overdoses involving prescription opioids between 1999 and 2018. Furthermore, overdose deaths involving a prescription opioid were more than four times higher in 2018 than in 1999.

In West Virginia, multiple factors have contributed to the increased rates of prescription opioid and illicit opioid misuse, including increased access due to the large numbers of opioid prescriptions in the state over the past decade. According to the National Institute on Drug Abuse

(NIDA), in 2017 West Virginia providers wrote 81.3 prescriptions for every 100 persons as compared to the national average of 58.7 prescriptions. Prescriptions decreased in 2018 in West Virginia, with providers writing 69.3 opioid prescriptions for every 100 persons, compared to the national rate of 51.4 prescriptions (NIDA, 2018). It is important to note that this rate was still among the top 10 in the nation, but it was the lowest number for West Virginia since 2006 (CDC, 2019). Other demographic factors that can contribute to substance misuse, along with poor health and behavioral health outcomes, include disparities in family income, socioeconomic status, employment, and educational attainment (Marshall *et al.*, 2017).

### Consumption and Other Related Data for Youth (ages 12-17)

The following table contains data from the WV School Climate Survey from youth (ages 12-17) on prescription drug misuse, perception of harm, and parental approval in regards to misusing prescription drugs. Both perception of harm and parental approval are related factors to substance misuse. Lowered perceptions of harm can lead to increases in risk of substance misuse. In addition, parental disapproval is linked to lower rates of substance misuse. Risk and protective factors are discussed further in another section in this report. School Climate data was similar across the prevention regions. The majority of students, 96% and higher reported not using a prescription without a doctor's order in the past 30 days.

Table 1 WV School Climate Survey Data: 2018-2019 School Year

WV School Climate Survey Data: 2018-2019 School Year							
During the past 30 Days, on how many days did you use prescription pills or medications without a doctor's order?							
Region	0 Days	1 Day	2 Days	3-9 Days	10-19 Days	20-30 Days	Non-Response
1	96.76%	1.00%	0.47%	0.61%	0.33%	0.39%	0.44%
2	96.50%	1.13%	0.68%	0.49%	0.23%	0.49%	0.48%
3	96.87%	1.43%	0.64%	0.46%	0.18%	0.18%	0.24%
4	96.64%	1.05%	0.54%	0.39%	0.23%	0.64%	0.51%
5	97.11%	1.08%	0.44%	0.47%	0.17%	0.38%	0.35%
6	96.77%	1.39%	0.61%	0.44%	0.14%	0.41%	0.24%
How much do people risk harming themselves physically and in other ways when they do the following? Use prescription drugs that are not prescribed to them.							
Region	Great Risk or Harm	Moderate Risk or Harm	Slight Risk or Harm	No Risk or Harm	Non Response	Low Risk Total	
1	70.16%	15.38%	4.97%	7.20%	2.29%	12.17%	
2	64.83%	16.53%	6.48%	9.04%	3.12%	15.52%	
3	70.28%	14.86%	6.78%	7.26%	0.82%	14.04%	
4	68.17%	16.75%	6.04%	7.10%	1.94%	13.14%	
5	69.64%	15.13%	5.81%	7.80%	1.62%	13.61%	
6	69.10%	14.88%	6.48%	7.87%	1.67%	14.35%	
How wrong do your parents feel it would be for you to use prescription drugs not prescribed to you?							
Region	Not Wrong at All	A Little Bit Wrong	Wrong	Very Wrong	Non-Response	Low Disapproval Total	
1	1.51%	1.73%	5.50%	89.14%	2.12%	3.24%	

<b>2</b>	<b>1.09%</b>	<b>1.88%</b>	<b>5.95%</b>	<b>88.14%</b>	<b>2.94%</b>	<b>2.97%</b>
<b>3</b>	<b>1.15%</b>	<b>1.91%</b>	<b>6.44%</b>	<b>89.36%</b>	<b>1.14%</b>	<b>3.06%</b>
<b>4</b>	<b>1.16%</b>	<b>1.63%</b>	<b>6.15%</b>	<b>88.96%</b>	<b>2.10%</b>	<b>2.79%</b>
<b>5</b>	<b>1.47%</b>	<b>1.53%</b>	<b>5.53%</b>	<b>88.98%</b>	<b>2.49%</b>	<b>3.00%</b>
<b>6</b>	<b>1.61%</b>	<b>2.31%</b>	<b>5.96%</b>	<b>88.34%</b>	<b>1.78%</b>	<b>3.92%</b>

\*Note: This data was released by the WVDOE to the MU COE for Evaluation Purposes only.

**Consumption Data for Young Adults (ages 18 and up) on WV Higher Education Campuses**

The following data is from the American College Health Association’s National College Health Assessment (NCHA) II, which is conducted every other year in West Virginia to examine substance use, mental health and other health related behaviors among students on campuses in West Virginia. Not every institution participates in the survey. In 2018, the survey was administered online during the Spring of 2018. Males and females reported similar pain killer misuse, but females reported higher sedative prescription drug misuse, while males reported higher stimulant use. It is important to note that the percentages of students in WV reporting prescription drug misuse were higher in every category when compared to the national percentage rates. Students reported the following prescription drug misuse:

*Table 2 Executive Summary*

Percent of College Students who reported using Prescription Drugs that were not prescribed to them within the last 12 months:			
Percentages (%)	Male	Female	Total
Pain Killers	4.0%	3.9%	4.0%
Sedatives	2.6%	3.4%	3.3%
Stimulants	5.8%	4.9%	5.2%

\*Data from WV Executive Summary Report, Spring 2018, ACHA-NCHA II.

**Consumption Data for Youth (ages 12-17), Young Adults (ages 18-25) and Older Adults (ages 26 and older)**

The National Survey on Drug Use and Health (NSDUH) is conducted every year by interview with around 70,000 participants. It is overseen by SAMHSA’s Center for Behavioral Health and Statistics Quality. The following tables include data from the NSDUH on pain reliever misuse and heroin use in the past year. The tables reflect pain reliever misuse and heroin use data from the populations of focus: youth (ages 12-17) and adults (ages 18 and up). The NSDUH provides estimates and comparisons between state and national prevalence rates. Pain reliever misuse rates in West Virginia are lower or similar to the national rates. However, the rates of heroin use in the past year are higher in almost every age range category and year (except for 2016-2017 ages 12-17) in West Virginia when compared to the national estimates.



Table 3 National Survey on Drug Use and Health (NSDUH): 2016-2017 and 2017-2018 Data

National Survey on Drug Use and Health (NSDUH)										
	2016-17	2017-18	2016-17	2017-18	2016-17	2017-18	2016-17	2017-18	2016-17	2017-18
<b>Pain Reliever Misuse in the Past Year</b>	<b>12 or Older Estimate</b>		<b>12-17 Estimate</b>		<b>18-25 Estimate</b>		<b>26 or Older Estimate</b>		<b>18 or Older Estimate</b>	
US	4.17%	3.85%	3.31%	2.93%	7.13%	6.32%	3.79%	3.56%	4.26%	3.94%
West Virginia	4.06%	3.82%	2.86%	2.89%	7.19%	6.35%	3.73%	3.55%	4.17%	3.90%
<b>Heroin Use in the Past Year</b>	<b>12 or Older Estimate</b>		<b>12-17 Estimate</b>		<b>18-25 Estimate</b>		<b>26 or Older Estimate</b>		<b>18 or Older Estimate</b>	
US	0.34%	0.31%	0.05%	0.05%	0.64%	0.54%	0.32%	0.30%	0.37%	0.34%
West Virginia	0.69%	0.50%	0.05%	0.07%	1.45%	0.89%	0.64%	0.49%	0.75%	0.54%

\*2016-2017 and 2017-2018 NSDUH Survey

### Prescription Drug Monitoring Programs (PDMP) Data

PDMPs are state-run electronic databases that can be used to track prescribing and dispensing of controlled substances. They are also tools that can be used to identify patients who may be misusing prescriptions and track problematic prescribing practices. In West Virginia, the West Virginia Board of Pharmacy operates the PDMP, which operates similar to other state database programs. All licensees who dispense Schedule II, III and IV controlled substances to residents of West Virginia must provide the dispensing information to the West Virginia Board of Pharmacy (BOP) during each 24-hour period basis. They must also include in their reporting Schedule V controlled substances (e.g. pseudoephedrine) dispensed as a prescription, Gabapentin-containing products and Naloxone-containing opioid-reversing agents (e.g. Narcan®). There are some exceptions allowed by state code. Requests for de-identified information for research or evaluation purposes can be made to the West Virginia Board of Pharmacy.

Recently, the West Virginia Office of Drug Control Policy (ODCP) created a new PDMP data platform for prescription drug information. The platform contains information on several prescriptions at the county level, including controlled substances, opioids, benzodiazepines,



stimulants, naloxone prescriptions, and morphine equivalents. In terms of potency, opioid medications can be measured to each other based on milligrams (mg) of Morphine Equivalents (MME). Prescriptions over 90 mg Morphine Equivalents per day are considered high dose opioids. There are many instances that this may be appropriate use such as terminal illness or cancer related pain, but the PDMP does not provide sufficient details to determine how many of these episodes represent appropriate uses of opioids. Over the past three years, there have been decreases in the number of prescription opioids in the state. Statewide, there have also been reductions in benzodiazepines and stimulants. In addition, regional data also shows decreases in the number of opioids prescribed over the last three years in West Virginia. The data also shows the increases in Naloxone prescriptions throughout the state. For county specific data, please see Attachment B in this report.

*Table 4 Office of Drug Control Policy PDMP Statewide Data*

<b>Statewide Prescription Dose Totals: Benzodiazepines, Opioids, and Stimulants</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>Benzodiazepines</b>	<b>67,977,369</b>	<b>54,164,485</b>	<b>45,662,885</b>
<b>Opioids</b>	<b>117,790,946</b>	<b>101,337,135</b>	<b>86,310,691</b>
<b>Stimulants</b>	<b>17,824,063</b>	<b>16,584,213</b>	<b>14,739,170</b>
<b>Statewide Prescriptions Greater/Equal 90 Morphine Milligram Equivalent (MME) (Estimates)</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>&gt;=90 MME</b>	<b>154,800</b>	<b>118,600</b>	<b>90,800</b>
<b>Statewide Naloxone Prescriptions Dispensed</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>Naloxone</b>	<b>4,566</b>	<b>10,573</b>	<b>14,662</b>

\*Data from West Virginia Controlled Substance Monitoring Program 2014 to 2018 Dashboard. See Attachment A in this report for a list of drugs reported in each classification.

*Table 5 Office of Drug Control Policy PDMP Regional Data*

<b>Region 1 Prescription Dose Totals: Benzodiazepines, Opioids, and Stimulants</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>Benzodiazepines</b>	<b>6,537,050</b>	<b>4,022,558</b>	<b>3,188,456</b>
<b>Opioids</b>	<b>9,398,947</b>	<b>7,756,597</b>	<b>6,490,662</b>
<b>Stimulants</b>	<b>1,036,026</b>	<b>983,176</b>	<b>847,234</b>
<b>Region 1 Prescriptions Greater/Equal 90 Morphine Milligram Equivalent (MME) (Estimates)</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>&gt;=90 MME</b>	<b>14,200</b>	<b>10,700</b>	<b>8,200</b>
<b>Region 1 Naloxone Prescriptions Dispensed</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>Naloxone</b>	<b>208</b>	<b>330</b>	<b>483</b>
<b>Region 2 Prescription Dose Totals: Benzodiazepines, Opioids, and Stimulants</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>Benzodiazepines</b>	<b>7,251,098</b>	<b>5,137,383</b>	<b>4,225,899</b>
<b>Opioids</b>	<b>15,575,940</b>	<b>13,320,855</b>	<b>11,721,012</b>
<b>Stimulants</b>	<b>2,284,606</b>	<b>2,191,916</b>	<b>1,984,267</b>

<b>Region 2 Total Prescriptions Greater/Equal 90 Morphine Milligram Equivalent (MME) (Estimates)</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>&gt;=90 MME</b>	<b>37,744</b>	<b>27,904</b>	<b>20,224</b>
<b>Region 2 Naloxone Prescriptions Dispensed</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>Naloxone</b>	<b>1,133</b>	<b>2,495</b>	<b>2,860</b>
<b>Region 3 Prescription Dose Totals: Benzodiazepines, Opioids, and Stimulants</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>Benzodiazepines</b>	<b>5,988,925</b>	<b>4,652,497</b>	<b>3,597,320</b>
<b>Opioids</b>	<b>10,298,570</b>	<b>8,258,102</b>	<b>6,712,541</b>
<b>Stimulants</b>	<b>1,718,289</b>	<b>1,608,529</b>	<b>1,395,093</b>
<b>Region 3 Prescriptions Greater/Equal 90 Morphine Milligram Equivalent (MME) (Estimates)</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>&gt;=90 MME</b>	<b>10,997</b>	<b>7,865</b>	<b>5,861</b>
<b>Region 3 Naloxone Prescriptions Dispensed</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>Naloxone</b>	<b>191</b>	<b>924</b>	<b>1,055</b>
<b>Region 4 Prescription Dose Totals: Benzodiazepines, Opioids, and Stimulants</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>Benzodiazepines</b>	<b>12,934,561</b>	<b>9,895,839</b>	<b>8,213,001</b>
<b>Opioids</b>	<b>22,948,311</b>	<b>18,927,584</b>	<b>15,948,778</b>
<b>Stimulants</b>	<b>3,450,654</b>	<b>3,162,658</b>	<b>2,862,479</b>
<b>Region 4 Prescriptions Greater/Equal 90 Morphine Milligram Equivalent (MME) (Estimates)</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>&gt;=90 MME</b>	<b>28,372</b>	<b>23,690</b>	<b>17,973</b>
<b>Region 4 Naloxone Prescriptions Dispensed</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>Naloxone</b>	<b>780</b>	<b>1,865</b>	<b>3,302</b>
<b>Region 5 Prescription Dose Totals: Benzodiazepines, Opioids, and Stimulants</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>Benzodiazepines</b>	<b>20,135,428</b>	<b>19,313,966</b>	<b>15,275,290</b>
<b>Opioids</b>	<b>35,199,482</b>	<b>32,937,212</b>	<b>28,639,134</b>
<b>Stimulants</b>	<b>6,518,451</b>	<b>6,211,408</b>	<b>5,587,459</b>
<b>Region 5 Prescriptions Greater/Equal 90 Morphine Milligram Equivalent (MME) (Estimates)</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>&gt;=90 MME</b>	<b>35,046</b>	<b>26,500</b>	<b>20,783</b>
<b>Naloxone Prescriptions Dispensed</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>Naloxone</b>	<b>1,258</b>	<b>2,209</b>	<b>3,206</b>
<b>Region 6 Prescription Dose Totals: Benzodiazepines, Opioids, and Stimulants</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>Benzodiazepines</b>	<b>15,130,307</b>	<b>11,142,242</b>	<b>11,162,919</b>
<b>Opioids</b>	<b>24,369,696</b>	<b>20,136,785</b>	<b>16,798,564</b>

<b>Stimulants</b>	<b>2,816,037</b>	<b>2,426,526</b>	<b>2,062,638</b>
<b>Region 6 Prescriptions Greater/Equal 90 Morphine Milligram Equivalent (MME) (Estimates)</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>&gt;=90 MME</b>	<b>28,282</b>	<b>22,122</b>	<b>17,607</b>
<b>Region 6 Naloxone Prescriptions Dispensed</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>Naloxone</b>	<b>1,747</b>	<b>2,750</b>	<b>3,756</b>

\*Data from West Virginia Controlled Substance Monitoring Program 2014 to 2018 Dashboard. See Attachment A in this report for a list of drugs reported in each classification.

**Consequence Data**

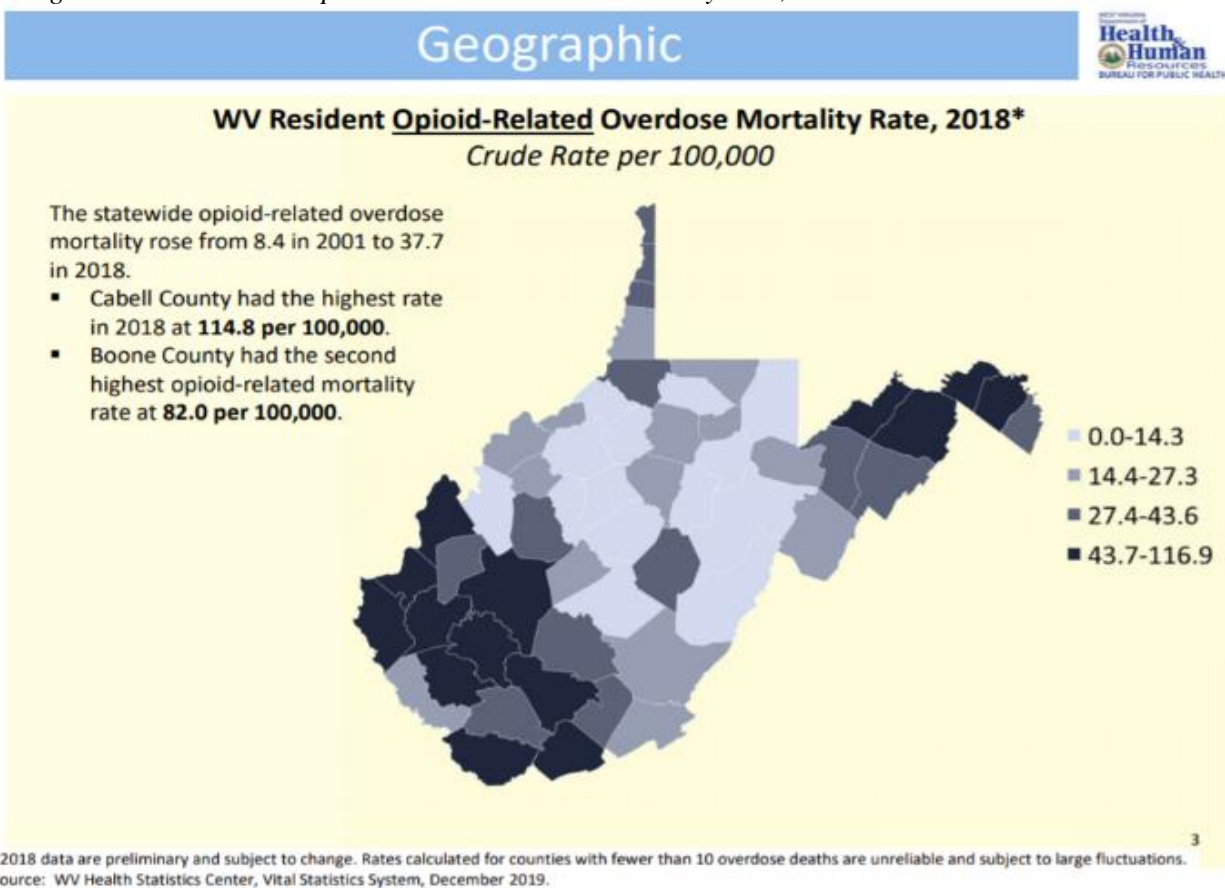
Prescription drug misuse can lead to serious health and behavioral health outcomes, such as increased emergency room visits, development of substance use or opioid use disorders that need treatment, overdose, and overdose deaths.

The 2017-2018 NSDUH survey estimates that 4.08% of West Virginian youth (ages 12-17) experienced a substance use disorder in the past year, compared to 3.83% nationally; however, estimates for other age groups (ages 18-25 and 26+) were lower than the national rates this past year. The 2017-2018 NSDUH survey estimates 0.45% (ages 12-17), 1.11% (ages 18-25 years of age), and 0.73% (ages 26+) experienced a pain reliever use disorder in the past year, when compared to 0.41% (ages 12-17), 0.86% (ages 18-25), and 0.60% (ages 26+) nationally.

Individuals with a substance use or opioid use disorder are at an increased risk of experiencing an overdose or an overdose death. Overdose morbidity data is the incidence of a disease in a population, while the overdose mortality data is the incidence of death from a disease in a population. According to the CDC, provisional data for West Virginia and the nation show declines in overdose death rates in the beginning of 2019 (Ahmad, F. et al., 2020). However, prior to 2019, West Virginia led the nation in overdose death rates at 57.8 per 100,000 (Scholl, L. et al., 2018). The SPF Rx project is examining overdose morbidity and mortality data by gender, age, and other important different demographics such as race and ethnicity when available. Data for cross-site evaluation is collected from the CDC Wonders and ESSENCE database. For the purposes of this report, easily accessible extant data from offices within WV DHHR are being used in order to increase the sustainability of the project. The evaluation team will train the prevention specialists to locate local community and regional data related to prescription drugs and overdoses.

The State Epidemiological Outcomes Workgroup (SEOW) is overseen by the WV Bureau for Behavioral Health. The SEOW can identify and analyze substance use data to inform policy and program related decisions on prevention efforts. The SEOW is comprised of multiple organizational and individual partners who assist and share expertise. The SEOW can inform and assist with coordinating prevention efforts. The SEOW works to provide quarterly presentations, which are located on the WV DHHR website. The following image is on WV Fatal Drug Overdoses from the meeting on January 13, 2020 and provides a ‘snapshot’ of the counties that lost residents to fatal opioid-related overdoses.

Figure 2: WV Resident Opioid-Related Overdose Mortality Rate, 2018



Finally, the WV Office of Drug Control Policy (ODCP) has developed two new dashboards to provide timely county-level information on overdoses. One dashboard presents information on the number of West Virginia hospital Emergency Room (ER) visits from an overdose, while the other dashboard provides the number of Emergency Medical Services (EMS) runs for a suspected overdose event. The platforms can help inform the prevention specialists and community stakeholders by providing up-to-date relevant overdose information to inform real time activities.

According to the ODCP, the ER visit dashboard provides information on the number of ER visits associated with an overdose event. Currently, the dashboard obtains data from 46 ERs in West Virginia. The data is provided by the Centers for Disease Control and Prevention’s (CDC) National Syndromic Surveillance Program (NSSP) BioSense Platform Essence and the West Virginia Hospital Association. The data on the dashboard is generated from information from ER medical records, which either classify the incident as accidental overdose or suicide-related overdose events. The treating ER physician determines an overdose by using the International Classification of Disease, tenth revision Clinical Modification (ICD-10-CM) codes as either a primary or a secondary diagnosis (State of WV, 2020).

Table 6 Office of Drug Control Policy Emergency Room (ER) Information

<b>Statewide Emergency Room Overdose (Morbidity and Mortality) Data</b>	
<b>Month and Year</b>	<b>Number</b>
January 2019	529
February 2019	499
March 2019	617
April 2019	601
May 2019	596
June 2019	576
July 2019	520
August 2019	609
September 2019	615
October 2019	561
November 2019	525
December 2019	550
January 2020	582
February 2020	566
March 2020	550
<b>Total to Date</b>	<b>8,496</b>
<b>Overdoses by Age Group</b>	
0-19	1,252
20-29	1,819
30-39	2,056
40-49	1,359
50-59	960
60-69	602
70+	446
Unknown	1-6
<b>Overdoses by Sex</b>	
Females	4,070
Males	4,349
Unknown	77

\*Data from WV Office of Drug Control Policy Emergency Room (ER) Overdose Dashboard 2020.

According to the ODCP, the EMS data displayed in the tables and graphs are generated from data from EMS run sheets, which is an electronic report generated by EMS responders (paramedics and emergency medical technicians (EMTs)) when an ambulance is dispatched to a scene. The sheet contains information about the call, information about the patient, circumstances surrounding the event, treatment rendered, and if the patient was transferred to a hospital. EMS personnel do not diagnose patients; they assess the patient and generate a “field impression” of the condition of the patient (State of WV, 2020).

Table 7 Office of Drug Control Policy Emergency Medical Services (EMS) Information

<b>Statewide EMS Overdose (Morbidity and Mortality) Data</b>	
<b>Month and Year</b>	<b>Number</b>
January 2019	630
February 2019	441
March 2019	608
April 2019	648
May 2019	651
June 2019	655
July 2019	582
August 2019	461
September 2019	528
October 2019	584
November 2019	608
December 2019	633
January 2020	704
February 2020	534
March 2020	550
<b>Total to Date</b>	<b>8,817</b>
<b>Overdoses by Age Group</b>	
0-19	708
20-29	1,879
30-39	2,396
40-49	1,580
50-59	1,023
60-69	634
70+	426
Unknown	171
<b>Overdoses by Sex</b>	
Females	3,638
Males	4,962
Unknown	217
<b>Naloxone (Narcan) Given</b>	
Yes	4,017
No	4,800

\*Data from WV Office of Drug Control Policy Emergency Medical Service (EMS) Overdose Dashboard 2020.

## Risk and Protective Factors

Multiple contributing factors can affect an individual’s risk of substance misuse. Risk factors are ones that increase the likelihood of someone misusing substances, while protective factors counter an individual’s risk. Risk and protective factors can be variable or fixed; they can accumulate over a person’s life; and they can exist in multiple contexts, such as individual, relational, community or societal (SAMHSA, n.d.). The Socio-ecological model is a developmental framework to examine an individual’s risk and protective factors through these multiple contexts and different settings as individual’s age. The contexts include:

- **Individual:** These factors include a person’s age, education, income, genetics, health, and psychosocial strengths.
- **Relationship:** These factors include an individual’s family members, peers, teachers, and other close relationships that affect their experiences and can influence their behavior.
- **Community:** These include settings where social relationships occur, such as schools, workplaces, online communities, and neighborhoods.
- **Societal:** These factors, often called the social determinants of health, include historical trauma, discrimination, social constructions of gender, laws limiting access to substances, and media portrayal of substance use (SAMHSA, 2019).

Figure 3: Socio-ecological Model



It is important to examine these contextual factors when planning prevention efforts in communities. The following information is a systematic review of studies that examine risk and protective factors related to prescription drug misuse through the socio-ecological lens (Nargiso *et al.*, 2014). Most of the prevention research on risk and protective factors related to prescription drug misuse has examined youth (ages 12-17) and young adults (ages 18-25).

Table 8: Risk and Protective Factors Associated with Prescription (Rx) Drug Misuse

Risk and Protective Factors Associated with Prescription (Rx) Drug Misuse		
Populations of Focus: Adolescents (ages 12-17) and Adults 18 and older		
Socio-Ecological Domain	Risk Factors	Protective Factors
Individual	There is an inverse relationship between perceived harm in Rx drug use and Rx Drug misuse. This means that when individuals or local communities believe there is no real harm, Rx drug misuse is higher.	Education regarding harms associated with Rx drug misuse lowers individual risk for misuse.  Increased religious attendance reduced risk of Rx drug misuse.



	<p>Many studies show an extreme overlap between tobacco and e-cigarette use and Rx drug misuse.</p> <p>Risk takers have higher rates of Rx drug misuse.</p>	
Interpersonal /family	<p>Youth of parents that are ‘tolerant’ of drug use <u>or</u> those with family history of drug misuse are at a significant risk of misuse themselves.</p>	<p>Friend/peer disapproval of Rx drug use markedly decreases risk for Rx drug misuse.</p> <p>Parental monitoring and involvement reduced risk for Rx drug misuse.</p>
School	<p>There is a significant association between Rx misuse and educational attainment.</p> <p>In High school, Rx misuse is correlated with lower GPAs and dropping out of school.</p>	<p>Family and parental involvement in education and behaviors at school may protect against risk of Rx misuse.</p>
Community	<p>Community environments that include Rx drug misuse or tolerant attitudes toward Rx misuse increase the risk for Rx drug misuse.</p> <p>Availability of Rx drugs relates to misuse. This is attributable to development of new drugs and prescribing practices.</p>	<p>Education on a community-wide level regarding harms associated with Rx drug misuse lowers Rx misuse.</p> <p>Community connectedness</p>
Societal	<p>Low socioeconomic status, poverty, homelessness, and incarceration are risk factors for substance misuse.</p>	<p>Access to health care</p>

\*Nargiso et al., 2014

In reviewing the studies, it is important to note that certain factors influence risk for prescription drug misuse across multiple domains (individual, interpersonal, school, community and societal). As noted earlier, perception regarding the potential harm of a substance is associated with risk of misuse. When perceptions of harm are low, then the risk for prescription drug misuse is higher. The relationship between perceived harm and prescription drug misuse can affect one at the individual, interpersonal, and community level. To protect against this risk factor, many communities have adopted community-wide training to not only educate about the potential harm of prescription drug misuse (physical and mental dependence, potential for overdosing), but they also include training that addresses stigmatization of individuals who misuse prescription drugs. This is necessary as stigmatization can compound substance misuse in communities and prevent individuals from seeking treatment.

Another significant component that affects multiple domains is family and parental involvement. A lack of parental involvement can put adolescents at a higher risk for misusing prescription drugs. Furthermore, if parents or family members are misusing prescription drugs or are more ‘tolerant’ of substance misuse, then adolescents (and adults) are at a higher risk to misuse prescription drugs. On the other hand, family involvement is a protective factor in reducing prescription drug misuse.

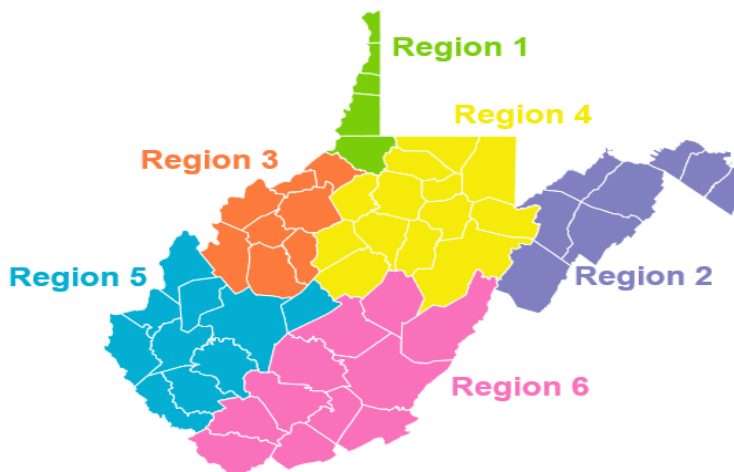
## Prevention Capacity

West Virginia, often referred to as the Heart of Appalachia, is the only state that falls entirely within the federally designated Appalachian Region of the United States. Geographically, the state is rural and population centers are remote and small in comparison with other states. Appalachians’ strong cultural values, such as Neighborliness, Personalism, Solidarity, and a Strong sense of Family are great sources of strengths that can assist in prevention activities and mobilization efforts. Other cultural values include: Individualism, Self-Reliance and Self-Pride, Traditionalism, Modesty, Patriotism, and Strong Religious Beliefs. (Jones, 1994).

The capacity of the state and communities to address prescription drug misuse includes a multitude of resources, people, expertise, infrastructure, funding, and awareness of the issue. It also includes training and workforce needs. Information regarding needs for prevention capacity came from extant data, focus groups with coalition members and key stakeholders, surveys with prevention leads, and discussions with DHHR staff.

The Bureau for Behavioral Health has designated six behavioral health regions that provide prevention services to the counties within the region. Each region has a prevention lead organization (PLO) and a lead contact who assists in providing services, programs, training, and technical assistance related to prevention. The prevention lead organizations include comprehensive behavioral health centers and other non-profit service groups, such as Family Resource Networks (FRNs). All counties are required to use SAMHSA’s Strategic Prevention Framework planning model to identify needs and match evidence-based programs and practices. Prevention practitioners are encouraged to support community mobilization through local coalitions, provide prevention education to populations in need of prevention interventions and create nurturing, drug-free environments through environmental strategies. The majority of the counties have local, active coalitions. The prevention leads reported not having coalitions in a few counties, but engaging with those communities through community based prevention projects.

Figure 4: WV Behavioral Health Regions



The Prevention Lead Organizations and their contacts are as follows:

*Table 9: Prevention Lead Organizations*

<b>Region</b>	<b>Counties</b>	<b>Organization</b>	<b>Contact Information</b>
<b>1</b>	<b>Hancock, Brooke, Ohio, Marshall, Wetzel</b>	<b>Youth Services System, Inc.</b>	<b>Lori Bumba 304-233-2045 <a href="mailto:Lori.impactov@gmail.com">Lori.impactov@gmail.com</a></b>
<b>2</b>	<b>Pendleton, Grant, Hardy, Mineral, Hampshire, Morgan, Jefferson, Berkeley,</b>	<b>Potomac Highlands Guild</b>	<b>Paige Mathias 304-257-1155 <a href="mailto:paigem@potomachighlandsguild.com">paigem@potomachighlandsguild.com</a></b>
<b>3</b>	<b>Tyler, Pleasants, Wood, Ritchie, Jackson, Wirt, Roane, Calhoun</b>	<b>Westbrook Health Services</b>	<b>Shelly Mize 304-927-5200 extension 410 <a href="mailto:smize@westbrookhealth.com">smize@westbrookhealth.com</a></b>
<b>4</b>	<b>Monongalia, Preston, Marion, Doddridge, Harrison, Taylor, Barbour, Tucker, Gilmer, Lewis, Upshur, Randolph, Braxton</b>	<b>West Virginia Prevention Solutions</b>	<b>Elizabeth Shahan 304-423-5049 <a href="mailto:wvpsdirector@gmail.com">wvpsdirector@gmail.com</a></b>
<b>5</b>	<b>Mason, Putnam, Kanawha, Clay, Cabell, Wayne, Mingo, Logan, Lincoln, Boone</b>	<b>Prestera Center</b>	<b>Kim Shoemake 304-412-7036 <a href="mailto:Kimberly.Shoemake@prestera.org">Kimberly.Shoemake@prestera.org</a></b>
<b>6</b>	<b>Webster, Pocahontas, Nicholas, Fayette, Greenbrier, Raleigh, Summers, Monroe, Wyoming, Mercer, McDowell</b>	<b>Community Connections</b>	<b>Greg Puckett 304-913-4956 <a href="mailto:drugfree@strongcommunities.org">drugfree@strongcommunities.org</a></b>

\*Data from BBH

The WV Bureau for Behavioral Health (BBH) provides the majority of the state’s prevention funding, which is used for primary prevention activities around the state. The funding was around \$8.25 million in federal fiscal year 2018. In the federal fiscal year 2019, the funding was around \$6.4 million. The funding sources include SAMHSA’s Substance Abuse Prevention and Treatment Block grant, which is a non-competitive federal grant to address substance misuse and mental health prevention and treatment. SAMHSA’s SAPT funding is based on the state’s population. The state allocates about \$1.9 million per year for universal prevention activities and prevention infrastructure in the state. This is about 20% of the SAPT grant. The funding supports the Prevention Lead Organizations who house and fund the lead prevention contact in each region and who in turn provide sub-grants to county coalitions for prevention activities.

In addition, the Bureau for Behavioral Health has two other competitive federal grants funded by SAMHSA, the Strategic Prevention Framework for Prescription Drug Misuse (SPF Rx) and the Strategic Prevention Framework Partnerships for Success (SPF PFS) grant. The SPF Rx grant provides approximately \$22,500 in funding to the prevention regions to implement prevention activities focused on reducing prescription opioid drug misuse and other illicit opioid use. Prevention activities include increasing prescriber education and use of the PDMP,

education on safe medication disposal and providing safe drug disposal kits, health literacy on prescription drugs, including opioids, and education to reduce stigma which is a barrier for those seeking assistance for substance misuse and substance use disorders. Additional funding is provided to Marshall University for evaluation and prescriber/dispenser education. Community Access assist with website, media and prevention related communication. BBH also recently provided around \$12,800 in additional funding to support the purchase and dissemination of more safe drug disposal kits in each region.

The SPF PFS grant has been a large boost to prevention capacity in the state. The SPF PFS provides around \$300,000 in funding per year to each PLO. The funding supports prevention coordinators in each region for a total of 19. Most regions support three coordinators, with one region supporting four coordinators with their portion of the funding. The prevention coordinators assist with providing selective and indicated evidence-based prevention services to youth who are 9 to 20 years of age around the state. The funding also provides funding to Marshall University for evaluation and technical assistance.

In addition, the state was awarded a State Opioid Response (SOR) grant from SAMSHA. The total grants were \$28 million in federal fiscal year 2018 and 2019. The majority of these funds are being primarily used for treatment, but BBH is also using SOR funding to fund a coalition engagement specialist to work with all the county coalitions in each region (total of six). The engagement specialists are working to assist the coalitions in community mobilization. BBH anticipates \$300,000 in additional SOR funding in the 2020 calendar year to increase prevention services.

All four grants are working to prevent substance misuse by building capacity and increasing evidenced based prevention activities. Other prevention funding in the state includes funding from the WV Department of Education, the West Virginia's Governor's Highway Safety Program, the WV Bureau for Public Health, the WV Department of Military Affairs & Public Safety, and additional local philanthropic funding.

Several county coalitions have received funding from the Drug-Free Communities (DFC) grant program. These grants were administered by SAMHSA, but will be overseen by the Centers for Disease Control and Prevention (CDC) moving forward. DFC grants use similar approaches to the SPF model by identifying substance use problems in a community and identifying evidenced based solution to address it. DFC funding in the state currently includes: Brooke Hancock Family Resource Network, Cabell County Substance Abuse Prevention Coalition, Community Connections in Mercer County, Morgan County Partnership, Inc., and S.T.O.P. Strong Through Our Plan in Mingo County. Putnam County has completed five years of DFC funding. In addition, Jackson and Ohio Counties have also been the recipients of DFC funding and have completed their ten years of prevention funding. Other communities have applied for further funding to assist with prevention activities. This funding includes SAMHSA and HRSA funding received directly by local agencies and includes: CARA Local Drug Crises Grants, the STOP Act Grant, a local SPF PFS grant, and several HRSA Rural Opioid Planning grants for prevention, treatment and recovery services have been awarded in rural counties around the state over the past two years.

West Virginia also recognizes the need to fund prevention activities on higher education campuses. In 2002, the West Virginia Collegiate Initiative to Address alcohol and other drug misuse (WVCIA) was formed to assess substance misuse among college age students (18 and older) and to implement evidenced based prevention practices and activities. WVCIA is primarily funded by BBH and the WV Governor’s Highway Safety Program. The funding is used to provide a statewide assessment every other year and to build prevention capacity through training during the other years. Funding is also used to help campuses offset cost for prevention activities and programs whenever possible.

Workforce is another critical component of the SPF model. In addition to the funding provided to the prevention leads to hire additional staff to implement prevention activities, both the SPF Rx and SPF PFS grants are working to increase prevention workforce capacity through training. Two individuals held a current certified prevention specialists 1 credential in the state and seven held an active certified prevention specialist 2 credential during fiscal year 2019. The prevention specialists who are certified will increase over time with support from DHHR and funding from these grants, primarily the SPF PFS. In West Virginia, individuals are certified through the West Virginia Board of Addiction and Prevention Professionals (WVCBAPP). The WVCBAPP certifies the competencies and qualifications of professionals involved in prevention, treatment and recovery services in the state. WVCBAPP is a member of the International Certification & Reciprocity Consortium on Alcohol and Other Drug Abuse (IC & RC), which adheres to international requirements for certification of prevention specialists. The Prevention Specialist credential requires professionals to demonstrate competency through experience, education, supervision, and the passing of a rigorous examination. The Prevention Specialist Credentials are as follows:

*Table 10: Prevention Specialists Qualifications*

<b>Level</b>	<b>Experience</b>	<b>Education</b>	<b>Prevention Education/Training</b>	<b>Ethics</b>
WV Certified Prevention Specialists 1	Two years qualifying work experience and one year in direct service	Minimum two year college degree or 60 credit hours from an accredited college or university in a community health, education or related field, which 12 credit hours must be in the prevention content domains	180 hours of prevention specific education and training. Prevention specialist must pass the IC&RC International Prevention Specialist Examination	Must adhere to a prevention code of ethics
WV Certified Prevention Specialists 2	Four years qualifying work experience	Minimum of a Bachelor’s Degree from an accredited college or university, which 24 credit hours must be in the prevention content domains	300 hours of education/training (240 must be prevention specific hours)	Must adhere to a prevention code of ethics
<i>To maintain a credential, an individual must live or work 51% of the time in WV and re-certify every two years by completing 40 hours of continuing education, with 6 hours of addiction or prevention ethics</i>				

\*WVCBAPP at <https://www.wvcbapp.org>

In addition to these resources, capacity also includes information on a communities' readiness to address the problem, including knowledge of the problem, attitudes about the problem, support of local leaders, and resources. Prevention leads are currently working toward community readiness assessments. Two prevention leads have completed readiness assessments and three are in the process.

The evaluation team also conducted a confidential, online qualitative survey through Qualtrics with the prevention leads to examine resources, gaps, risk and protective factors related to prescription drug misuse and other related information regarding some of the prevention activities that could strengthen or challenge prevention activities around the state. Five of the six prevention leads completed the survey. The survey questions and findings are as follows:

*What are the data sources to which you have access that help guide you with decreasing prescription drug misuse or other illicit opioid use? (i.e., including hospital assessments, county health improvements, National College Health Association, and local school climate data). If you don't have access to prescription drug data or other illicit opioid use data sources, what types of data would help you be more effective in your job?*

- 3 out of 5 reported using the Office of Drug Control Policy Dashboards
- 2 out of 5 reported using the State Epidemiological Outcomes Workgroup, the School Climate Survey, Hospital data or data plans, county health plans or health department data
- Other data sources that are used included the college assessment data (1), 911 data (1) local crime data (1), and using federal sources such as SAMHSA, NIH, and OJJDP for data (1)
- Data sources needed included information on homelessness (1), poverty (1), police reports (1), economic data (1), and overdose mapping (1)
- One participant reported wanting the school climate data shared and 2 out of five stated any additional substance use data shared with them would be helpful in their prevention efforts

*What do you see as the biggest protective factor in your region in terms of reducing prescription drug and other illicit opioid use in your region? (with youth ages 12- 17 and with adults 18 and older)*

- 3 out of 5 reported activities in their communities (youth and adults), including after school activities, alternative activities, physical fitness, parks and recreational activities
- 2 out of 5 reported parental involvement
- 2 out of 5 reported parental and youth healthy support groups
- 2 out of 5 reported the healthcare and behavioral health including expanded school based mental health
- 1 out of 5 reported investments from the community for youth and adults
- 1 out of 5 reported evidence based programs

- 1 out of 5 reported education for youth and adults

*What do you see as the biggest risk factor in your region in terms of reducing prescription drug and other illicit opioid use in your region? (with youth ages 12-17 and with adults 18 and older) What about other substance misuse?*

- 4 out of 5 responded poverty, poor economic conditions and loss of jobs
- 1 out of 5 reported low education attainment
- 1 out of 5 reported a lack of community support
- 2 out of 5 reported risks related to their populations; older population who is still sharing medications, employed individuals experiencing injury, and younger populations who may be engaging in risk-taking behaviors

*Please share how your prevention work intersects with health or behavioral health care in your region.*

- 5 out of 5 mentioned specific programs and supports provided by health and behavioral health care in their regions (behavioral health centers, hospitals, providers, and health departments)
- 3 out of 5 mentioned the “continuum of care” and prevention’s role in it
- 3 out of 5 mentioned partners participating in coalition meetings and training
- 2 out of 5 mentioned information and referral and their role connecting individuals to treatment sources
- 2 out of 5 stated prevention was a “top priority” for providers
- Other items mentioned included naloxone training (1), support for drug take backs (1), permanent drug boxes (1), harm reduction (1), needle exchange (1), quick response teams (1), and pregnancy prevention (1)

*What types of activities do you think would help with substance use disorder stigma reduction in your region?*

- 4 out of 5 reported more community wide trainings and education is needed
- 3 out of 5 reported more training on the “science of addiction” and 2 out of 5 reported training on “addiction as a brain disease”
- 1 out of 5 reported the need for professional development in the regions as it relates stigma and preventing individuals from seeking treatment
- 1 out of 5 reported the need for a media campaign to address stigma
- 1 out of 5 reported prevention’s role to address basic needs and to connect to treatment services, such as information and referral

*What groups would be important to focus substance use disorder stigma reduction efforts on in your communities?*

- 4 out of 5 reported training needs for faith based groups in their communities, many are using ineffective prevention messages



- 2 out of 5 reported the need to train law enforcement and getting them to participate in prevention not only enforcement
- Other areas reported included the need to train judges (1), lawyers (1), child case workers (1), recover centers (1), parents (1), schools (1), and civic organizations (1)
- 1 out of 5 reported the need to engage all of the “12 sectors for prevention”

*What role do you think health literacy around prescription drugs might play with individuals in your communities?*

- 4 out of 5 saw health literacy as an opportunity to increase awareness and knowledge which may decrease misuse
- 1 out of 5 participants reported the need to make the information more holistic, focusing on multiple substances including alcohol and tobacco and how it affects health
- 1 out of 5 reported the training could assist with reducing stigma and reducing barriers to treatment

*What resources would help you be more effective with decreasing prescription drug misuse or other illicit opioid use in your region?*

- Many reported the need for more drug disposal items with 3 out of 5 wanted more safe drug disposal kits; 2 out of 5 wanted more permanent drug disposal boxes; 2 out of 5 wanted drug safety lock boxes for individuals in their communities; 1 wanted more community drug take back events
- Many reported the need for more information: 2 out of 5 wanted to promote Health and Hope more; 2 out of 5 asked for tools to help with information dissemination methods and media; 2 out of 5 wanted resources on other drugs (stimulants, benzodiazepines, and other substances); 1 out of 5 reported broadband needs to disseminate information
- 1 out of 5 reported the need for professional trainings

*What other types of substance misuse are you concerned about in your communities? Please share your thoughts on this as it relates to different populations of focus, such as youth, transitioning adults (18-25), adults, and older adults (65 and older) or different types of counties in your region, such as urban vs. rural.*

- 3 out of 5 reported concerns about stimulants
- 3 out of 5 reported concerns about alcohol misuse
- 2 out of 5 reported concerns about marijuana use, particularly with medical marijuana
- 2 out of 5 reported concerns about tobacco
- 2 out of 5 reported needs and training related to addressing substances in urban vs rural settings
- 1 out of 5 reported needs for training on benzodiazepines

- 1 out of 5 reported concerns related to veterans and older populations in their communities
- 1 out of 5 reported the need to address deeper areas related to substance misuse, such as poverty, lack of opportunities, local economics as it relates substance use

*Do you have any other thoughts that you'd like to share regarding the SPF Rx project?*

- 2 out of 5 reported the need to look at this from the community “lens”
- 2 out of 5 wanted to survey the community for what they think the problem is or to conduct a statewide survey with communities to ask about prescription drugs and what they see as the problem
- 1 out of 5 wanted to focus on larger issues and to take a “deeper dive” into health policy and addressing community basic needs such as poverty
- 1 out of 5 saw the need for more training to address stigma

### **Other Important Policy Related Findings**

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This assessment report also presents findings regarding PDMPs in order to inform stakeholders about important policy level information. A number of studies regarding the use and effects of PDMPs have been conducted across the nation. While results regarding the effects are mixed, possibly reflecting the individualized nature in which state-level PDMPs function, there are several promising lines of research outcomes. For example, there is evidence that consistent prescriber use of the PDMP for monitoring of trends in prescribing patterns can be used to reduce over-prescription of substances such as opioids (Elder et al., 2018). Such surveillance has also been successfully used to document emerging trends that may signal the next substance crisis, thus allowing states to anticipate and put prevention measures in place (Kaye et al., 2017a; Kaye et al., 2017b). There are a number of promising innovative practices, such as improving efficiency and ease of access, that demonstrate increases in use of the PDMP by providers (National Alliance for Model State Drug Laws, 2017; Rutkow et al., 2017). These innovative practices include: integrating electronic health records with the PDMP, especially for emergency departments (Rutkow et al., 2017; Elder et al., 2018); integrating training/education for updated guidelines for prescribing into the PDMP (Rutkow et al., 2017); and allowing access to data from neighboring states (Elder et al., 2018). Thus, PDMPs do offer promising options to reduce the overuse and misuse of prescription medication.

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**Attachment A. Classification of Medications in PDMP Report**

Classification	Description	Agents Included
Benzodiazepines	Sedative agents which are used to treat anxiety and seizures.	Alprazolam, Chlordiazepoxide, Clobazam, Clonazepam, Clorazepate, Diazepam, Estazolam, Flurazepam, Lorazepam, Oxazepam, Temazepam, Triazolam,
Opioids	Pain agents used to treat a wide variety of pain conditions.	Butorphanol, Codeine, Dihydrocodeine, Fentanyl, Hydrocodone, Hydromorphone, Merperidine, Methadone, Morphine, Opium, Oxycodone, Oxymorphone, Pentazocine, Tapentadol, Tramadol,
Stimulants	Agents that stimulate the Central Nervous System. Often used for Attention Deficit Disorder and weight loss.	Amphetamine, Dexmethylphenidate, Dextroamphetamine, Lisdexamfetamine, Methylphenidate,

\*Other medications included in the PDMP dashboard include naloxone and buprenorphine, which were pulled out separately. Other medications included in the dashboard not included in this report are baclofen, carisoprodol (Soma), gabapentin and zolpidem (Ambien).

## Attachment B. County Data

### Region 1 Brooke, Hancock, Marshall, Ohio, and Wetzel

<b>Brooke</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	713,554	605,836	465,894
Opioids	1,495,879	1,281,565	1,062,238
Stimulants	134,404	127,269	114,741
<b>Hancock</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	1,227,540	1,107,049	884,539
Opioids	2,112,213	1,827,340	1,550,589
Stimulants	241,384	236,160	203,598
<b>Marshall</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	2,993,271	885,483	694,066
Opioids	2,329,283	1,828,980	1,546,219
Stimulants	211,441	185,522	150,936
<b>Ohio</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	1,030,584	931,456	737,227
Opioids	2,338,371	1,931,165	1,659,343
Stimulants	363,606	344,419	296,496
<b>Wetzel</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	572,101	492,734	406,730
Opioids	1,123,201	887,547	672,273
Stimulants	85,191	89,806	81,463
<b>Region 1 totals</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	6,537,050	4,022,558	3,188,456
Opioids	9,398,947	7,756,597	6,490,662
Stimulants	1,036,026	983,176	847,234

\*Data from West Virginia Controlled Substance Monitoring Program 2014 to 2018 Dashboard. See Attachment A in this report for a list of drugs reported in each classification.

<b>Region 1 Prescriptions Greater/Equal 90 MME (Estimates)</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
Brooke	2,200	1,600	1,000
Hancock	2,900	2,200	1,700
Marshall	4,100	3,100	2,400
Ohio	4,000	3,000	2,600
Wetzel	995	803	469
<b>Region 1 Totals</b>	<b>14,200</b>	<b>10,700</b>	<b>8,200</b>

\*Data from West Virginia Controlled Substance Monitoring Program 2014 to 2018 Dashboard.

<b>Region 1 Naloxone Prescriptions</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
Brooke	90	80	84
Hancock	48	93	106
Marshall	56	49	113
Ohio	8	58	106
Wetzel	6	50	74
<b>Region 1 Totals</b>	<b>208</b>	<b>330</b>	<b>483</b>

\*Data from West Virginia Controlled Substance Monitoring Program 2014 to 2018 Dashboard.

<b>Region 1 Buprenorphine Prescriptions</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>Brooke</b>	<b>146,030</b>	<b>159,862</b>	<b>149,177</b>
<b>Hancock</b>	<b>199,426</b>	<b>259,572</b>	<b>285,144</b>
<b>Marshall</b>	<b>181,977</b>	<b>166,054</b>	<b>149,168</b>
<b>Ohio</b>	<b>231,014</b>	<b>214,062</b>	<b>194,051</b>
<b>Wetzel</b>	<b>64,067</b>	<b>58,613</b>	<b>46,194</b>
<b>Region 1 Totals</b>	<b>822,514</b>	<b>858,163</b>	<b>823,734</b>

\*Data from West Virginia Controlled Substance Monitoring Program 2014 to 2018 Dashboard.

<b>Region 1 ER Overdose Data (Morbidity and Mortality)</b>					
<b>County</b>	<b>Total Overdoses</b>	<b>Highest Overdoses by Age group</b>	<b>Sex</b>		
			<b>M</b>	<b>F</b>	<b>U</b>
<b>Brooke</b>	<b>Not Reported</b>	<b>--</b>	<b>--</b>	<b>--</b>	<b>--</b>
<b>Hancock</b>	<b>146</b>	<b>30-39 (44)</b>	<b>73</b>	<b>73</b>	<b>0</b>
<b>Marshall</b>	<b>106</b>	<b>30-39 (24)</b>	<b>63</b>	<b>43</b>	<b>0</b>
<b>Ohio</b>	<b>382</b>	<b>30-39 (100)</b>	<b>184</b>	<b>198</b>	<b>0</b>
<b>Wetzel</b>	<b>70</b>	<b>20-29 (28)</b>	<b>9</b>	<b>7</b>	<b>54</b>
<b>Region 1 Totals</b>	<b>704</b>	<b>30-39 (mode)</b>	<b>329</b>	<b>321</b>	<b>54</b>

\*Data from West Virginia Office of Drug Control Policy ER Overdose Data Dashboard.

<b>Region 1 EMS Overdose Data (Morbidity and Mortality)</b>							
<b>County</b>	<b>Total Overdoses</b>	<b>Highest Overdoses by Age group</b>	<b>Sex</b>			<b>Naloxone Given</b>	
			<b>M</b>	<b>F</b>	<b>U</b>	<b>Y</b>	<b>N</b>
<b>Brooke</b>	<b>78</b>	<b>30-39 (18) 40-49 (18)</b>	<b>51</b>	<b>27</b>	<b>0</b>	<b>49</b>	<b>29</b>
<b>Hancock</b>	<b>90</b>	<b>30-39 (29)</b>	<b>48</b>	<b>33</b>	<b>9</b>	<b>69</b>	<b>21</b>
<b>Marshall</b>	<b>51</b>	<b>20-29 (13)</b>	<b>30</b>	<b>18</b>	<b>S</b>	<b>28</b>	<b>23</b>
<b>Ohio</b>	<b>103</b>	<b>30-39 (38)</b>	<b>60</b>	<b>41</b>	<b>S</b>	<b>45</b>	<b>58</b>
<b>Wetzel</b>	<b>75</b>	<b>30-39 (22)</b>	<b>37</b>	<b>35</b>	<b>S</b>	<b>28</b>	<b>47</b>
<b>Region 1 Totals</b>	<b>397</b>	<b>30-39 (mode)</b>	<b>226</b>	<b>154</b>	<b>9</b>	<b>219</b>	<b>178</b>

\*Data from West Virginia Office of Drug Control Policy EMS Data Dashboard.



**Region 2 Berkeley, Grant, Hampshire, Hardy, Jefferson, Mineral, Morgan, and Pendleton**

<b>Berkeley</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	2,215,312	1,919,667	1,563,719
Opioids	7,012,240	6,139,168	5,331,069
Stimulants	985,283	977,703	882,883
<b>Grant</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	383,382	351,150	279,910
Opioids	684,285	588,083	471,412
Stimulants	95,188	87,826	72,444
<b>Hampshire</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	577,222	494,313	415,257
Opioids	1,218,227	1,019,622	965,903
Stimulants	134,033	125,265	132,965
<b>Hardy</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	300,556	278,196	236,752
Opioids	567,259	486,747	414,948
Stimulants	133,870	116,962	81,976
<b>Jefferson</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	971,860	838,753	676,792
Opioids	3,049,652	2,516,756	2,217,115
Stimulants	565,886	542,945	499,435
<b>Mineral</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	2,295,980	814,938	652,468
Opioids	1,497,746	1,282,060	1,193,207
Stimulants	228,810	207,987	200,166
<b>Morgan</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	299,267	265,324	250,319
Opioids	1,127,109	982,960	871,391
Stimulants	88,820	80,380	63,959
<b>Pendleton</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	207,519	175,042	150,682
Opioids	419,422	305,459	255,967
Stimulants	52,716	52,848	50,439
<b>Region 2 totals</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	7,251,098	5,137,383	4,225,899
Opioids	15,575,940	13,320,855	11,721,012
Stimulants	2,284,606	2,191,916	1,984,267

\*Data from West Virginia Controlled Substance Monitoring Program 2014 to 2018 Dashboard. See Attachment A in this report for a list of drugs reported in each classification.

<b>Region 2 Prescriptions Greater/Equal 90 MME (Estimates)</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
Berkeley	18,500	13,800	9,900
Grant	576	430	244
Hampshire	3,300	2,300	1,800
Hardy	668	567	463
Jefferson	9,200	6,400	4,400
Mineral	1,800	1,400	1,100
Morgan	3,000	2,400	1,800

Pendleton	700	607	517
<b>Region 2 Totals</b>	<b>37,744</b>	<b>27,904</b>	<b>20,224</b>

\*Data from West Virginia Controlled Substance Monitoring Program 2014 to 2018 Dashboard.

Region 2 Naloxone Prescriptions			
	2017	2018	2019
Berkeley	581	1,150	1,359
Grant	16	34	72
Hampshire	65	288	217
Hardy	30	61	60
Jefferson	330	580	704
Mineral	48	174	148
Morgan	51	166	250
Pendleton	12	42	50
<b>Region 2 Totals</b>	<b>1,133</b>	<b>2,495</b>	<b>2,860</b>

\*Data from West Virginia Controlled Substance Monitoring Program 2014 to 2018 Dashboard.

Region 2 Buprenorphine Prescriptions			
	2017	2018	2019
Berkeley	342,259	385,144	394,724
Grant	8,180	9,890	14,345
Hampshire	37,388	55,025	57,407
Hardy	10,830	9,575	8,409
Jefferson	136,555	157,343	170,226
Mineral	43,844	84,190	77,232
Morgan	20,382	32,734	38,953
Pendleton	5,253	5,076	3,835
<b>Region 2 Totals</b>	<b>614,791</b>	<b>738,977</b>	<b>765,131</b>

\*Data from West Virginia Controlled Substance Monitoring Program 2014 to 2018 Dashboard.

Region 2 ER Overdose Data (Morbidity and Mortality)					
County	Total Overdoses	Highest Overdoses by Age group	Sex		
			M	F	U
Berkeley	666	20-29 (167)	363	298	S
Grant	48	0-19 (11), 20-29 (11), 30-39 (11)	25	23	0
Hampshire	83	20-29 (24)	56	26	S
Hardy	NA	--	--	--	--
Jefferson	200	30-39 (54)	107	92	S
Mineral	55	0-19 (16)	29	26	0
Morgan	68	0-19 (17)	37	31	0
Pendleton	NA	--	-	-	-
<b>Region 2 Totals</b>	<b>1,120</b>	<b>0-19, 20-29 (mode)</b>	<b>617</b>	<b>496</b>	<b>S</b>

\*Data from West Virginia Office of Drug Control Policy ER Overdose Data Dashboard.

<b>Region 2 EMS Overdose Data (Morbidity and Mortality)</b>							
<b>County</b>	<b>Total Overdoses</b>	<b>Highest Overdoses by Age group</b>	<b>Sex</b>			<b>Naloxone Given</b>	
			<b>Male, Female, Unknown</b>	<b>M</b>	<b>F</b>	<b>U</b>	<b>Y</b>
<b>Berkeley</b>	<b>765</b>	<b>30-39 (205)</b>	<b>451</b>	<b>304</b>	<b>10</b>	<b>349</b>	<b>416</b>
<b>Grant</b>	<b>24</b>	<b>S</b>	<b>13</b>	<b>11</b>	<b>0</b>	<b>1</b>	<b>23</b>
<b>Hampshire</b>	<b>87</b>	<b>20-29 (26)</b>	<b>57</b>	<b>22</b>	<b>8</b>	<b>45</b>	<b>42</b>
<b>Hardy</b>	<b>31</b>	<b>20-29 (11)</b>	<b>17</b>	<b>14</b>	<b>0</b>	<b>4</b>	<b>27</b>
<b>Jefferson</b>	<b>252</b>	<b>30-39 (73)</b>	<b>150</b>	<b>98</b>	<b>S</b>	<b>137</b>	<b>115</b>
<b>Mineral</b>	<b>64</b>	<b>30-39 (17)</b>	<b>42</b>	<b>22</b>	<b>0</b>	<b>32</b>	<b>32</b>
<b>Morgan</b>	<b>70</b>	<b>30-39 (22)</b>	<b>45</b>	<b>25</b>	<b>0</b>	<b>35</b>	<b>35</b>
<b>Pendleton</b>	<b>12</b>	<b>S</b>	<b>S</b>	<b>S</b>	<b>S</b>	<b>4</b>	<b>8</b>
<b>Region 2 Totals</b>	<b>1,305</b>	<b>30-39 (mode)</b>	<b>775</b>	<b>496</b>	<b>18</b>	<b>607</b>	<b>698</b>

\*Data from West Virginia Office of Drug Control Policy EMS Overdose Data Dashboard.

**Region 3 Calhoun, Jackson, Pleasants, Ritchie, Roane, Tyler, Wirt and Wood**

<b>Calhoun</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	155,776	131,746	101,942
Opioids	425,675	344,236	272,559
Stimulants	38,342	33,222	27,451
<b>Jackson</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	867,153	751,625	657,545
Opioids	1,797,789	1,389,538	1,075,761
Stimulants	252,770	251,160	222,959
<b>Pleasants</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	224,134	191,145	172,738
Opioids	453,833	349,229	295,760
Stimulants	56,236	56,197	48,172
<b>Ritchie</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	314,401	281,145	230,896
Opioids	663,914	541,687	484,784
Stimulants	88,733	73,369	61,888
<b>Roane</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	397,694	343,706	275,737
Opioids	961,519	835,694	692,463
Stimulants	96,770	77,512	77,546
<b>Tyler</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	219,810	185,065	155,369
Opioids	470,947	364,866	296,327
Stimulants	40,862	40,874	36,326
<b>Wirt</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	157,671	142,603	115,314
Opioids	392,760	339,136	281,329
Stimulants	47,898	48,770	43,838
<b>Wood</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	3,652,286	2,625,462	1,887,779
Opioids	5,132,133	4,093,716	3,313,558
Stimulants	1,096,678	1,027,425	876,913
<b>Region 3 totals</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	5,988,925	4,652,497	3,597,320
Opioids	10,298,570	8,258,102	6,712,541
Stimulants	1,718,289	1,608,529	1,395,093

\*Data from West Virginia Controlled Substance Monitoring Program 2014 to 2018 Dashboard. See Attachment A in this report for a list of drugs reported in each classification.

<b>Region 3 Prescriptions Greater/Equal 90 MME (Estimates)</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>Calhoun</b>	422	321	249
<b>Jackson</b>	1,900	1,100	754
<b>Pleasants</b>	646	396	232
<b>Ritchie</b>	745	443	352
<b>Roane</b>	804	624	384
<b>Tyler</b>	507	293	239
<b>Wirt</b>	473	288	151

Wood	5,500	4,400	3,500
<b>Region 3 Totals</b>	<b>10,997</b>	<b>7,865</b>	<b>5,861</b>

\*Data from West Virginia Controlled Substance Monitoring Program 2014 to 2018 Dashboard.

Region 3 Naloxone Prescriptions			
	2017	2018	2019
Calhoun	0	47	32
Jackson	92	162	176
Pleasants	2	20	24
Ritchie	4	60	24
Roane	20	130	144
Tyler	2	35	20
Wirt	4	50	23
Wood	67	420	612
<b>Region 3 Totals</b>	<b>191</b>	<b>924</b>	<b>1,055</b>

\*Data from West Virginia Controlled Substance Monitoring Program 2014 to 2018 Dashboard.

Region 3 Buprenorphine Prescriptions			
	2017	2018	2019
Calhoun	7,973	6,068	3,396
Jackson	186,031	172,894	155,994
Pleasants	4,580	5,460	8,384
Ritchie	10,494	12,564	17,953
Roane	33,601	34,336	35,674
Tyler	17,286	15,183	15,540
Wirt	9,100	9,825	10,535
Wood	145,594	176,573	189,967
<b>Region 3 Totals</b>	<b>414,659</b>	<b>432,903</b>	<b>437,443</b>

\*Data from West Virginia Controlled Substance Monitoring Program 2014 to 2018 Dashboard.

Region 3 ER Overdose Data (Morbidity and Mortality)					
County	Total Overdoses	Highest Overdoses by Age group	Sex		
			M	F	U
Calhoun	NA	--	--	--	--
Jackson	19	S	10	9	0
Pleasants	NA	--	--	--	--
Ritchie	24	S	17	7	0
Roane	23	S	13	10	0
Tyler	NA	--	--	--	--
Wirt	NA	--	--	--	--
Wood	480	30-39(150)	267	212	S
<b>Region 3 Totals</b>	<b>546</b>	<b>30-39</b>	<b>307</b>	<b>238</b>	<b>0</b>

\*Data from West Virginia Office of Drug Control Policy ER Overdose Data Dashboard.

<b>Region 3 EMS Overdose Data (Morbidity and Mortality)</b>							
<b>County</b>	<b>Total Overdoses</b>	<b>Highest Overdoses by Age group</b>	<b>Sex</b>			<b>Naloxone Given</b>	
			<b>Male, Female, Unknown</b>	<b>M</b>	<b>F</b>	<b>U</b>	<b>Y</b>
<b>Calhoun</b>	<b>6</b>	<b>S</b>	<b>S</b>	<b>S</b>	<b>S</b>	<b>3</b>	<b>3</b>
<b>Jackson</b>	<b>74</b>	<b>20-29 (13), 50-59 (13)</b>	<b>49</b>	<b>24</b>	<b>S</b>	<b>43</b>	<b>31</b>
<b>Pleasants</b>	<b>9</b>	<b>S</b>	<b>S</b>	<b>S</b>	<b>0</b>	<b>7</b>	<b>2</b>
<b>Ritchie</b>	<b>10</b>	<b>S</b>	<b>S</b>	<b>S</b>	<b>0</b>	<b>2</b>	<b>8</b>
<b>Roane</b>	<b>31</b>	<b>50-59 (8)</b>	<b>13</b>	<b>18</b>	<b>0</b>	<b>14</b>	<b>17</b>
<b>Tyler</b>	<b>13</b>	<b>S</b>	<b>13</b>	<b>0</b>	<b>0</b>	<b>3</b>	<b>10</b>
<b>Wirt</b>	<b>14</b>	<b>S</b>	<b>14</b>	<b>0</b>	<b>0</b>	<b>9</b>	<b>5</b>
<b>Wood</b>	<b>678</b>	<b>30-39 (229)</b>	<b>381</b>	<b>276</b>	<b>21</b>	<b>390</b>	<b>288</b>
<b>Totals Region 3</b>	<b>835</b>	<b>50-59 (mode)</b>	<b>470</b>	<b>318</b>	<b>21</b>	<b>471</b>	<b>364</b>

\*Data from West Virginia Office of Drug Control Policy EMS Data Dashboard.

**Region 4 Barbour, Braxton, Doddridge, Gilmer, Harrison, Lewis, Marion,  
Monongalia, Preston, Randolph, Upshur, Taylor and Tucker**

<b>Barbour</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	468,182	429,202	385,834
Opioids	1,134,020	964,559	773,109
Stimulants	109,256	107,712	87,201
<b>Braxton</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	350,075	311,798	247,639
Opioids	881,457	760,019	629,582
Stimulants	79,273	60,732	61,262
<b>Doddridge</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	146,847	130,555	104,765
Opioids	284,096	233,419	200,986
Stimulants	25,422	21,254	17,950
<b>Gilmer</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	145,900	133,480	111,442
Opioids	350,746	290,157	234,731
Stimulants	33,811	30,631	29,782
<b>Harrison</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	3,952,829	3,026,468	2,512,054
Opioids	5,640,399	4,836,633	4,120,999
Stimulants	730,493	660,500	595,866
<b>Lewis</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	666,351	603,313	490,256
Opioids	1,218,747	1,054,807	898,116
Stimulants	131,141	109,258	89,004
<b>Marion</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	2,698,099	1,710,845	1,399,682
Opioids	3,178,533	2,493,442	2,178,735
Stimulants	575,555	525,366	519,361
<b>Monongalia</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	1,992,433	1,264,219	1,028,611
Opioids	3,733,641	2,645,899	2,185,427
Stimulants	977,711	927,346	813,222
<b>Preston</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	739,424	665,808	573,517
Opioids	2,163,000	1,922,486	1,615,736
Stimulants	340,552	286,761	251,851
<b>Randolph</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	784,178	707,159	580,787
Opioids	2,083,485	1,760,176	1,408,399
Stimulants	135,685	139,208	125,851
<b>Upshur</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	432,110	398,562	335,264
Opioids	1,027,091	855,048	742,915
Stimulants	143,422	141,836	122,659
<b>Taylor</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	431,672	398,632	345,927
Opioids	933,886	829,306	722,927



Stimulants	130,400	110,407	108,482
<b>Tucker</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	126,461	115,798	97,223
Opioids	319,210	281,633	237,116
Stimulants	37,933	41,647	39,988
<b>Region 4 totals</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	12,934,561	9,895,839	8,213,001
Opioids	22,948,311	18,927,584	15,948,778
Stimulants	3,450,654	3,162,658	2,862,479

\*Data from West Virginia Controlled Substance Monitoring Program 2014 to 2018 Dashboard. See Attachment A in this report for a list of drugs reported in each classification.

<b>Region 4 Prescriptions Greater/Equal 90 MME (Estimates)</b>			
	2017	2018	2019
Barbour	1,400	1,200	741
Braxton	919	622	550
Doddridge	387	348	278
Gilmer	377	296	283
Harrison	6,700	5,800	4,700
Lewis	1,500	1,300	962
Marion	3,500	2,800	2,400
Monongalia	4,900	4,100	3,000
Preston	3,300	2,900	2,100
Randolph	2,700	2,300	1,400
Upshur	1,300	932	636
Taylor	1,100	862	724
Tucker	289	230	199
<b>Region 4 Total</b>	<b>28,372</b>	<b>23,690</b>	<b>17,973</b>

\*Data from West Virginia Controlled Substance Monitoring Program 2014 to 2018 Dashboard.

<b>Region 4 Naloxone Prescriptions</b>			
	2017	2018	2019
Barbour	10	52	102
Braxton	76	127	150
Doddridge	2	6	10
Gilmer	6	26	38
Harrison	146	295	459
Lewis	28	97	184
Marion	111	161	400
Monongalia	238	729	1,123
Preston	79	100	412
Randolph	20	96	170
Upshur	22	108	130
Taylor	26	62	104
Tucker	16	6	20
<b>Region 4 Totals</b>	<b>780</b>	<b>1,865</b>	<b>3,302</b>

\*Data from West Virginia Controlled Substance Monitoring Program 2014 to 2018 Dashboard.

<b>Buprenorphine Prescriptions Region 4</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>Barbour</b>	<b>30,852</b>	<b>35,559</b>	<b>39,134</b>
<b>Braxton</b>	<b>46,640</b>	<b>52,228</b>	<b>52,673</b>
<b>Doddridge</b>	<b>7,211</b>	<b>5,867</b>	<b>4,693</b>
<b>Gilmer</b>	<b>6,942</b>	<b>7,986</b>	<b>9,394</b>
<b>Harrison</b>	<b>340,429</b>	<b>310,499</b>	<b>313,780</b>
<b>Lewis</b>	<b>75,009</b>	<b>72,756</b>	<b>64,646</b>
<b>Marion</b>	<b>240,877</b>	<b>226,473</b>	<b>222,502</b>
<b>Monongalia</b>	<b>308,477</b>	<b>312,984</b>	<b>255,266</b>
<b>Preston</b>	<b>196,193</b>	<b>193,517</b>	<b>170,548</b>
<b>Randolph</b>	<b>44,597</b>	<b>39,256</b>	<b>57,582</b>
<b>Upshur</b>	<b>60,181</b>	<b>63,242</b>	<b>58,367</b>
<b>Taylor</b>	<b>7,574</b>	<b>6,135</b>	<b>8,984</b>
<b>Tucker</b>	<b>44,266</b>	<b>44,361</b>	<b>47,851</b>
<b>Region 4 Totals</b>	<b>1,409,248</b>	<b>1,370,863</b>	<b>1,305,420</b>

\*Data from West Virginia Controlled Substance Monitoring Program 2014 to 2018 Dashboard.

<b>Region 4 ER Overdose Data (Morbidity and Mortality)</b>					
<b>County</b>	<b>Total Overdoses</b>	<b>Highest Overdoses by Age group</b>	<b>Sex</b>		
			<b>M</b>	<b>F</b>	<b>U</b>
<b>Barbour</b>	<b>NA</b>	<b>--</b>	<b>--</b>	<b>--</b>	<b>--</b>
<b>Braxton</b>	<b>20</b>	<b>20-29 (8)</b>	<b>9</b>	<b>11</b>	<b>0</b>
<b>Doddridge</b>	<b>NA</b>	<b>--</b>	<b>--</b>	<b>--</b>	<b>--</b>
<b>Gilmer</b>	<b>NA</b>	<b>--</b>	<b>--</b>	<b>--</b>	<b>--</b>
<b>Harrison</b>	<b>439</b>	<b>30-39 (100)</b>	<b>198</b>	<b>241</b>	<b>0</b>
<b>Lewis</b>	<b>77</b>	<b>0-19 (26)</b>	<b>31</b>	<b>46</b>	<b>0</b>
<b>Marion</b>	<b>215</b>	<b>30-39 (64)</b>	<b>115</b>	<b>100</b>	<b>0</b>
<b>Monongalia</b>	<b>762</b>	<b>20-29 (183)</b>	<b>406</b>	<b>356</b>	<b>0</b>
<b>Preston</b>	<b>42</b>	<b>30-39 (12)</b>	<b>20</b>	<b>22</b>	<b>0</b>
<b>Randolph</b>	<b>94</b>	<b>0-19 (31)</b>	<b>46</b>	<b>48</b>	<b>0</b>
<b>Upshur</b>	<b>105</b>	<b>0-19 (34)</b>	<b>44</b>	<b>61</b>	<b>0</b>
<b>Taylor</b>	<b>28</b>	<b>0-19 (7)</b>	<b>13</b>	<b>15</b>	<b>0</b>
<b>Tucker</b>	<b>NA</b>	<b>--</b>	<b>--</b>	<b>--</b>	<b>--</b>
<b>Region 4 Totals</b>	<b>1,782</b>	<b>0-19 30-39 modes</b>	<b>882</b>	<b>900</b>	<b>0</b>

\*Data from West Virginia Office of Drug Control Policy ER Overdose Data Dashboard.

<b>Region 4 EMS Overdose Data (Morbidity and Mortality)</b>							
<b>County</b>	<b>Total Overdoses</b>	<b>Highest Overdoses by Age group</b>	<b>Sex</b>			<b>Naloxone Given</b>	
			<b>Male</b>	<b>Female</b>	<b>Unknown</b>	<b>Y</b>	<b>N</b>
<b>Barbour</b>	<b>23</b>	<b>S</b>	<b>15</b>	<b>8</b>	<b>0</b>	<b>14</b>	<b>9</b>
<b>Braxton</b>	<b>30</b>	<b>30-39 (8)</b>	<b>16</b>	<b>14</b>	<b>0</b>	<b>17</b>	<b>13</b>
<b>Doddridge</b>	<b>20</b>	<b>S</b>	<b>20</b>	<b>0</b>	<b>0</b>	<b>6</b>	<b>14</b>
<b>Gilmer</b>	<b>9</b>	<b>S</b>	<b>NR</b>	<b>NR</b>	<b>NR</b>	<b>4</b>	<b>5</b>
<b>Harrison</b>	<b>339</b>	<b>30-39 (88)</b>	<b>175</b>	<b>153</b>	<b>11</b>	<b>131</b>	<b>208</b>
<b>Lewis</b>	<b>79</b>	<b>20-29 (21)</b>	<b>38</b>	<b>41</b>	<b>0</b>	<b>22</b>	<b>57</b>
<b>Marion</b>	<b>243</b>	<b>30-39 (68)</b>	<b>132</b>	<b>111</b>	<b>0</b>	<b>107</b>	<b>136</b>
<b>Monongalia</b>	<b>456</b>	<b>20-29 (139)</b>	<b>271</b>	<b>185</b>	<b>0</b>	<b>121</b>	<b>335</b>
<b>Preston</b>	<b>93</b>	<b>30-39 (24)</b>	<b>47</b>	<b>46</b>	<b>0</b>	<b>41</b>	<b>52</b>
<b>Randolph</b>	<b>71</b>	<b>40-49 (16)</b>	<b>31</b>	<b>40</b>	<b>0</b>	<b>32</b>	<b>39</b>
<b>Upshur</b>	<b>112</b>	<b>20-29 (26)</b>	<b>53</b>	<b>59</b>	<b>0</b>	<b>34</b>	<b>78</b>
<b>Taylor</b>	<b>21</b>	<b>S</b>	<b>9</b>	<b>12</b>	<b>0</b>	<b>5</b>	<b>16</b>
<b>Tucker</b>	<b>9</b>	<b>S</b>	<b>NR</b>	<b>NR</b>	<b>NR</b>	<b>3</b>	<b>6</b>
<b>Region 4 Totals</b>	<b>1505</b>	<b>30-39 (mode)</b>	<b>807</b>	<b>669</b>	<b>11</b>	<b>537</b>	<b>968</b>

\*Data from West Virginia Office of Drug Control Policy EMS Data Dashboard.

**Region 5 Boone, Cabell, Clay, Kanawha, Mason, Mingo, Putnam, Lincoln, Logan, and Wayne**

<b>Boone</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	1,471,440	1,279,147	1,033,699
Opioids	2,588,664	2,232,433	1,936,413
Stimulants	254,874	234,909	203,397
<b>Cabell</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	4,139,698	3,502,914	2,576,471
Opioids	7,457,948	6,418,959	5,747,377
Stimulants	1,615,353	1,476,125	1,378,402
<b>Clay</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	250,919	205,800	168,495
Opioids	812,761	714,820	635,102
Stimulants	63,331	61,675	66,277
<b>Kanawha</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	7,578,208	6,536,255	5,089,505
Opioids	12,582,076	10,446,895	8,932,613
Stimulants	2,787,965	2,550,650	2,195,232
<b>Mason</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	968,390	812,231	680,347
Opioids	1,525,168	1,284,368	1,154,764
Stimulants	246,580	212,761	193,803
<b>Mingo</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	887,645	1,077,212	887,645
Opioids	1,287,908	1,547,206	1,287,908
Stimulants	75,121	77,210	75,121
<b>Putnam</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	1,415,132	1,814,042	1,415,132
Opioids	2,423,085	2,797,156	2,423,085
Stimulants	781,704	848,799	781,704
<b>Lincoln</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	773,800	930,245	773,800
Opioids	1,831,091	2,097,727	1,831,091
Stimulants	200,618	213,166	200,618
<b>Logan</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	2,039,139	2,343,858	2,039,139
Opioids	3,237,017	3,717,867	3,237,017
Stimulants	267,523	300,604	267,523
<b>Wayne</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	611,057	812,262	611,057
Opioids	1,453,764	1,679,781	1,453,764
Stimulants	225,382	235,509	225,382
<b>Region 5 totals</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	20,135,428	19,313,966	15,275,290
Opioids	35,199,482	32,937,212	28,639,134
Stimulants	6,518,451	6,211,408	5,587,459

\*Data from West Virginia Controlled Substance Monitoring Program 2014 to 2018 Dashboard. See Attachment A in this report for a list of drugs reported in each classification.

<b>Region 5 Prescriptions Greater/Equal 90 MME (Estimates)</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>Boone</b>	2,600	1,800	1,300
<b>Cabell</b>	5,900	4,500	3,800
<b>Clay</b>	646	457	497
<b>Kanawha</b>	12,300	9,200	6,800
<b>Mason</b>	1,200	943	847
<b>Mingo</b>	1,500	1,000	739
<b>Putnam</b>	3,400	2,800	2,200
<b>Lincoln</b>	2,200	1,700	1,400
<b>Logan</b>	3,300	2,600	2,200
<b>Wayne</b>	2,000	1,500	1,000
<b>Region 5 Totals</b>	<b>35,046</b>	<b>26,500</b>	<b>20,783</b>

\*Data from West Virginia Controlled Substance Monitoring Program 2014 to 2018 Dashboard.

<b>Region 5 Naloxone Prescriptions</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>Boone</b>	39	127	94
<b>Cabell</b>	119	377	748
<b>Clay</b>	18	46	109
<b>Kanawha</b>	156	839	1,129
<b>Mason</b>	32	146	232
<b>Mingo</b>	126	84	126
<b>Putnam</b>	256	250	256
<b>Lincoln</b>	166	132	166
<b>Logan</b>	182	133	182
<b>Wayne</b>	164	75	164
<b>Region 5 Totals</b>	<b>1,258</b>	<b>2,209</b>	<b>3,206</b>

\*Data from West Virginia Controlled Substance Monitoring Program 2014 to 2018 Dashboard.

<b>Region 5 Buprenorphine Prescriptions</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>Boone</b>	248,544	244,485	209,291
<b>Cabell</b>	475,765	595,941	629,217
<b>Clay</b>	35,039	33,537	36,044
<b>Kanawha</b>	654,491	684,746	721,076
<b>Mason</b>	99,976	98,196	109,872
<b>Mingo</b>	192,420	208,762	192,420
<b>Putnam</b>	133,262	149,211	133,262
<b>Lincoln</b>	165,123	179,545	165,123
<b>Logan</b>	517,515	596,687	517,515
<b>Wayne</b>	156,662	170,845	156,662
<b>Region 5 Totals</b>	<b>2,678,797</b>	<b>2,961,955</b>	<b>2,870,482</b>

\*Data from West Virginia Controlled Substance Monitoring Program 2014 to 2018 Dashboard.

<b>Region 5 ER Overdose Data (Morbidity and Mortality)</b>					
County	Total Overdoses	Highest Overdoses by Age group	Sex		
			M	F	U
Boone	NA	--	--	--	--
Cabell	885	30-39 (239)	475	400	10
Clay	NA	--	--	--	--
Kanawha	1291	30-39 (337)	662	629	0
Mason	471	30-39 (112)	218	253	0
Mingo	14	--	0	14	0
Putnam	100	30-39 (30)	65	35	0
Lincoln	NA	--	--	--	--
Logan	234	30-39 (62)	122	112	0
Wayne	NA	--	--	--	--
<b>Region 5 Totals</b>	<b>2995</b>	<b>30-39 (mode)</b>	<b>1542</b>	<b>1443</b>	<b>10</b>

\*Data from West Virginia Office of Drug Control Policy ER Overdose Data Dashboard.

<b>Region 5 EMS Overdose Data (Morbidity and Mortality)</b>							
County	Total Overdoses	Highest Overdoses by Age group	Sex Male, Female, Unknown			Naloxone Given	
			M	F	U	Y	N
Boone	158	40-49 (39)	85	63	10	62	96
Cabell	835	30-39 (278)	503	316	16	476	359
Clay	2	S	S	S	--	0	2
Kanawha	1331	30-39 (427)	777	524	30	787	544
Mason	103	30-39 (36)	65	37	S	51	52
Mingo	100	30-39 (21)	53	47	0	24	76
Putnam	184	30-39 (51)	108	75	S	109	75
Lincoln	73	40-49 (25)	37	31	S	50	23
Logan	101	40-49 (37)	53	47	S	1	100
Wayne	222	30-39 (58)	127	84	11	101	121
<b>Region 5 Totals</b>	<b>2951</b>	<b>30-39 (mode)</b>	<b>1,808</b>	<b>1,224</b>	<b>67</b>	<b>1,661</b>	<b>1,448</b>

\*Data from West Virginia Office of Drug Control Policy EMS Data Dashboard.

**Region 6 Fayette, Greenbrier, McDowell, Mercer, Monroe, Nicholas, Pocahontas, Raleigh, Summers, Webster and Wyoming**

<b>Fayette</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	2,137,728	1,460,253	1,455,547
Opioids	3,054,790	2,497,647	2,084,424
Stimulants	434,547	376,842	321,806
<b>Greenbrier</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	1,303,573	1,038,723	991,275
Opioids	2,560,171	2,177,072	1,877,508
Stimulants	340,087	299,960	257,038
<b>McDowell</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	1,121,546	962,861	843,578
Opioids	1,768,100	1,569,604	1,136,661
Stimulants	79,979	71,059	67,430
<b>Mercer</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	2,900,382	2,218,354	2,114,422
Opioids	4,583,487	3,662,454	2,953,422
Stimulants	429,134	350,427	292,489
<b>Monroe</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	333,520	239,978	239,443
Opioids	651,027	520,354	438,097
Stimulants	62,362	42,759	44,882
<b>Nicholas</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	1,179,794	853,733	830,194
Opioids	2,320,988	2,003,020	1,689,813
Stimulants	164,626	155,809	141,422
<b>Pocahontas</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	206,273	176,604	150,995
Opioids	448,918	411,101	359,889
Stimulants	33,261	34,214	32,145
<b>Raleigh</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	3,781,126	2,675,611	2,819,734
Opioids	4,835,475	3,848,404	3,249,754
Stimulants	898,133	778,539	652,773
<b>Summers</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	504,678	382,103	399,495
Opioids	1,119,267	903,779	846,768
Stimulants	75,593	65,886	56,360
<b>Webster</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	243,599	172,535	185,858
Opioids	965,798	859,521	780,030
Stimulants	49,292	42,438	40,042
<b>Wyoming</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	1,418,088	961,487	1,132,378
Opioids	2,061,675	1,683,829	1,381,920
Stimulants	249,023	208,593	156,251
<b>Region 6 totals</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>
Benzodiazepines	15,130,307	11,142,242	11,162,919
Opioids	24,369,696	20,136,785	16,798,564

<b>Stimulants</b>	<b>2,816,037</b>	<b>2,426,526</b>	<b>2,062,638</b>
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\*Data from West Virginia Controlled Substance Monitoring Program 2014 to 2018 Dashboard. See Attachment A in this report for a list of drugs reported in each classification.

<b>Region 6 Prescriptions Greater/Equal 90 MME (Estimates)</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>Fayette</b>	<b>3,300</b>	<b>2,500</b>	<b>2,000</b>
<b>Greenbrier</b>	<b>3,900</b>	<b>2,900</b>	<b>2,200</b>
<b>McDowell</b>	<b>2,000</b>	<b>1,800</b>	<b>1,300</b>
<b>Mercer</b>	<b>5,200</b>	<b>4,300</b>	<b>3,800</b>
<b>Monroe</b>	<b>1,100</b>	<b>862</b>	<b>718</b>
<b>Nicholas</b>	<b>2,400</b>	<b>1,700</b>	<b>1,200</b>
<b>Pocahontas</b>	<b>695</b>	<b>668</b>	<b>490</b>
<b>Raleigh</b>	<b>5,800</b>	<b>4,300</b>	<b>3,200</b>
<b>Summers</b>	<b>1,300</b>	<b>843</b>	<b>856</b>
<b>Webster</b>	<b>887</b>	<b>649</b>	<b>543</b>
<b>Wyoming</b>	<b>1,700</b>	<b>1,600</b>	<b>1,300</b>
<b>Region 6 Totals</b>	<b>28,282</b>	<b>22,122</b>	<b>17,607</b>

\*Data from West Virginia Controlled Substance Monitoring Program 2014 to 2018 Dashboard.

<b>Region 6 Naloxone Prescriptions</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>Fayette</b>	<b>138</b>	<b>453</b>	<b>557</b>
<b>Greenbrier</b>	<b>118</b>	<b>245</b>	<b>245</b>
<b>McDowell</b>	<b>250</b>	<b>208</b>	<b>403</b>
<b>Mercer</b>	<b>558</b>	<b>665</b>	<b>782</b>
<b>Monroe</b>	<b>50</b>	<b>77</b>	<b>72</b>
<b>Nicholas</b>	<b>26</b>	<b>137</b>	<b>201</b>
<b>Pocahontas</b>	<b>14</b>	<b>72</b>	<b>61</b>
<b>Raleigh</b>	<b>410</b>	<b>553</b>	<b>935</b>
<b>Summers</b>	<b>68</b>	<b>56</b>	<b>111</b>
<b>Webster</b>	<b>24</b>	<b>40</b>	<b>69</b>
<b>Wyoming</b>	<b>91</b>	<b>244</b>	<b>320</b>
<b>Region 6 Totals</b>	<b>1,747</b>	<b>2,750</b>	<b>3,756</b>

\*Data from West Virginia Controlled Substance Monitoring Program 2014 to 2018 Dashboard.



<b>Region 6 Buprenorphine Prescriptions</b>			
	<b>2017</b>	<b>2018</b>	<b>2019</b>
<b>Fayette</b>	<b>195,113</b>	<b>201,688</b>	<b>230,692</b>
<b>Greenbrier</b>	<b>95,448</b>	<b>100,646</b>	<b>100,923</b>
<b>McDowell</b>	<b>214,646</b>	<b>258,944</b>	<b>226,950</b>
<b>Mercer</b>	<b>218,246</b>	<b>329,257</b>	<b>379,625</b>
<b>Monroe</b>	<b>28,255</b>	<b>33,124</b>	<b>29,675</b>
<b>Nicholas</b>	<b>184,331</b>	<b>192,098</b>	<b>152,146</b>
<b>Pocahontas</b>	<b>20,709</b>	<b>16,822</b>	<b>21,101</b>
<b>Raleigh</b>	<b>456,685</b>	<b>526,121</b>	<b>466,861</b>
<b>Summers</b>	<b>51,886</b>	<b>69,267</b>	<b>63,414</b>
<b>Webster</b>	<b>43,077</b>	<b>44,841</b>	<b>42,122</b>
<b>Wyoming</b>	<b>248,768</b>	<b>284,379</b>	<b>250,086</b>
<b>Region 6 Totals</b>	<b>1,757,164</b>	<b>2,057,187</b>	<b>1,963,794</b>

\*Data from West Virginia Controlled Substance Monitoring Program 2014 to 2018 Dashboard.

<b>Region 6 ER Overdose Data (Morbidity and Mortality)</b>					
<b>County</b>	<b>Total Overdoses</b>	<b>Highest Overdoses by Age group</b>	<b>Sex</b>		
			<b>M</b>	<b>F</b>	<b>U</b>
<b>Fayette</b>	<b>136</b>	<b>30-39 (30)</b>	<b>83</b>	<b>53</b>	
<b>Greenbrier</b>	<b>182</b>	<b>0-19 (41)</b>	<b>85</b>	<b>97</b>	
<b>McDowell</b>	<b>3</b>	<b>S</b>	<b>S</b>	<b>S</b>	
<b>Mercer</b>	<b>460</b>	<b>30-39 (95)</b>	<b>234</b>	<b>236</b>	
<b>Monroe</b>	<b>NA</b>	<b>--</b>	<b>--</b>	<b>--</b>	
<b>Nicholas</b>	<b>136</b>	<b>40-49 (31)</b>	<b>81</b>	<b>54</b>	
<b>Pocahontas</b>	<b>17</b>	<b>30-39 (103)</b>	<b>S</b>	<b>12</b>	
<b>Raleigh</b>	<b>408</b>	<b>S</b>	<b>216</b>	<b>192</b>	
<b>Summers</b>	<b>NA</b>	<b>--</b>	<b>--</b>	<b>--</b>	
<b>Webster</b>	<b>NA</b>	<b>--</b>	<b>--</b>	<b>--</b>	
<b>Wyoming</b>	<b>NA</b>	<b>--</b>	<b>--</b>	<b>--</b>	
<b>Region 6 Totals</b>	<b>1,339</b>	<b>30-39 (mode)</b>	<b>699</b>	<b>644</b>	

\*Data from West Virginia Office of Drug Control Policy ER Overdose Data Dashboard.

<b>Region 6 EMS Overdose Data (Morbidity and Mortality)</b>							
<b>County</b>	<b>Total Overdoses</b>	<b>Highest Overdoses by Age group</b>	<b>Sex</b>			<b>Naloxone Given</b>	
			<b>Male, Female, Unknown</b>	<b>M</b>	<b>F</b>	<b>U</b>	<b>Yes</b>
<b>Fayette</b>	<b>103</b>	<b>30-39 (28)</b>	<b>47</b>	<b>52</b>	<b>S</b>	<b>4</b>	<b>99</b>
<b>Greenbrier</b>	<b>132</b>	<b>20-29 (35)</b>	<b>80</b>	<b>52</b>	<b>--</b>	<b>55</b>	<b>77</b>
<b>McDowell</b>	<b>49</b>	<b>40-49 (17)</b>	<b>27</b>	<b>22</b>	<b>--</b>	<b>2</b>	<b>47</b>
<b>Mercer</b>	<b>498</b>	<b>20-29 (107)</b> <b>30-39 (107)</b>	<b>233</b>	<b>255</b>	<b>10</b>	<b>124</b>	<b>374</b>
<b>Monroe</b>	<b>52</b>	<b>40-49 (15)</b>	<b>28</b>	<b>23</b>	<b>S</b>	<b>34</b>	<b>18</b>
<b>Nicholas</b>	<b>58</b>	<b>40-49 (14)</b>	<b>25</b>	<b>32</b>	<b>S</b>	<b>16</b>	<b>42</b>
<b>Pocahontas</b>	<b>33</b>	<b>40-49 (10)</b>	<b>18</b>	<b>15</b>	<b>--</b>	<b>22</b>	<b>11</b>
<b>Raleigh</b>	<b>285</b>	<b>30-39 (80)</b>	<b>163</b>	<b>107</b>	<b>15</b>	<b>24</b>	<b>261</b>
<b>Summers</b>	<b>39</b>	<b>20-29 (9)</b> <b>30-39 (9)</b> <b>50-59 (9)</b>	<b>22</b>	<b>17</b>		<b>20</b>	<b>19</b>
<b>Webster</b>	<b>20</b>	<b>S</b>	<b>S</b>	<b>13</b>	<b>S</b>	<b>10</b>	<b>10</b>
<b>Wyoming</b>	<b>41</b>	<b>40-49 (11)</b>	<b>23</b>	<b>18</b>	<b>--</b>	<b>6</b>	<b>35</b>
<b>Region 6 Totals</b>	<b>1,310</b>	<b>40-49 (mode)</b>	<b>666</b>	<b>606</b>	<b>25</b>	<b>317</b>	<b>993</b>

\*Data from West Virginia Office of Drug Control Policy EMS Data Dashboard.