Meeting Discussion Summary

PURPOSE OF THE MEETING
The purpose of the meeting was to:
• collect information from experienced practitioners who are engaged in addressing the opioid crisis on a daily basis
• assess the efforts that were already underway to combat the prescription drug and heroin abuse issue in the Southern Illinois region
• explore ways to coordinate efforts to address the opioid crisis
• compile information to formulate a Regional Action Plan that will reduce the threat of opioid abuse and its consequences in southern Illinois communities

ATTENDEES
The meeting was attended by 70 professionals from the lower 33 counties of Illinois. Professions represented at the event included substance abuse treatment clinicians and administrators, physicians, pharmacists, state and local health department representatives, federal, state, and local law enforcement officials, hospital and health administrators, educators and health educators and representatives of political leaders.

Organizational representation included: 9 county health departments (representing 17 counties), 6 hospitals, 3 FQHC/Rural Health Centers, 7 behavioral health service providers, 5 state agencies/departments, two federal agencies, and other agencies, educational institutions, non-governmental organizations, and associations.

DISCUSSION SUMMARY REPORTING
This summary consists mostly of the “raw information” presented during the meeting’s “report out” sessions, as documented by each group’s facilitator. It is organized by the response to each discussion question, by each of the five groups in the morning and afternoon sessions.

No attempt was made to analyze/summarize these observations or to make further recommendations at this time.
MORNING SESSION
Participants were organized (roughly) by profession; law enforcement representatives were included in each group.

WHAT EVIDENCE OF THE PRESCRIPTION DRUG/OPIOID ABUSE ISSUE IS YOUR ORGANIZATION SEEING OR DEALING WITH?

Physicians/PAs/Pharmacists/PDMP Administrators
- MAT physicians report long waiting list of patients for treatment, and individual patient panels are full. Estimate they turn away at least a 1,000 patients a year
- Inpatient residential treatment beds are always full. Estimate 100 people on the waiting list for residential treatment
- Adults males are seeking residential treatment in high numbers
- One physician estimates 30-40% increase over 2 years in his practice for patients using heroin.
- Some patients still seeking treatment have 5 – 15 years of opioid use; durable problem
- Patients seeking services in ED – Patients/family coming to ED looking for services, and patients being treated for overdoses
- Southern IL is seeing an increase in the concomitant use of opiates and benzodiazepines
- Among all states IL ranks low in opioid use but high in benzodiazepine use

Behavioral Health Clinicians
- Increase in:
  - deaths due to overdoses
  - overdoses seen in EDs
  - detoxification admissions
  - referrals to medical detox
  - families requesting help
  - ‘chronic pain’ complaints
  - indictments for illegal distribution of prescription drugs
  - treatment for pregnant women who are addicted to opioids
- Overprescribing of opioids
- High schools requesting drug tests for students

Educators/Health Educators
- Increase in:
  - death rate due to heroin overdose; more publicized deaths
  - drug use overall; use/abuse by students of all ages
  - availability in universities; presence of very organized gangs in region
- More pharmacy, doctor, and veterinarian office break-ins (e.g., Herrin, Metro-East, Salem)
• Use has approximately doubled from 8th grade to 10th grade (Massac Co. Illinois Youth Survey)
• Increased unemployment in area likely to cause increase in dealers

**Health & Behavioral Health Administrators**
• Increase in:
  - overdoses & overdose deaths
  - arrest/prosecutions for opioid/heroin possession and distribution
  - fraudulent prescriptions sold over the internet
  - drug abuse counseling clients
  - non-drug crime perpetrated by drug abusers
  - needlestick, blood borne diseases (4x increase in hepatitis in one county)
• Hospital emergency department visits, hospitalizations, and length of stay
• Overprescribing of meds

**Health Departments**
• Increase in:
  - overdose cases in hospital emergency departments (heroin, meth, prescription pills)
  - treatment admissions, most for heroin and opiate prescription addiction
  - requests for treatment of addiction among high-school aged adolescents
  - importation of heroin at the Mexican-U.S. border
  - ease of obtaining drugs by addicts throughout southern Illinois
• Heroin has become the drug of choice for dealers to market in Southern Illinois
• Evidence of overprescribing: patient testimony and drug monitoring data
• Broadening demographic profile of heroin and prescription opioid abuser: no longer able to describe the “typical abuser”

**WHAT PREVENTION AND OVERDOSE RESPONSE EFFORTS ARE CURRENTLY UNDERWAY? WHO IS INVOLVED?**

**Physicians/PAs/Pharmacists/PDMP Administrators**
• Patients/family are presenting to ED requesting outpatient services and they are referred to local behavioral health agencies
• At-risk patients/families are prescribed Narcan with written instructions on use if present to the ED
• One physician present trains 1st responders on Narcan administration
• Patients presenting to ED who have overdosed are given Narcan and are monitored in the ED until stable or admitted as indicated.
• All patients seen in ED are prescribed Narcan at discharge, provided instructions on using, and referred to addiction counseling
EDs are seeing “drug seekers” and patients who are “traveling” across Illinois seeking drugs
EDs have a written policy for treatment of opioid addiction

**Behavioral Health Clinicians**
- Narcan/Naloxone availability and utilization by law enforcement, doctors, pharmacies, EMS
- Education of law enforcement and EMS in Narcan/Naloxone
- Good Samaritan Laws in place (except are police, EMS, and first-responders exempt?)
- Required inclusion in school education?
- Needle Exchange program

**Educators/Health Educators**
- After-school programs/character education classes, youth programs (such as 4-H, classroom and community education programs)
- Overdose response efforts
  - troopers & EMTs carrying NARCAN (anti-opiate reversal medication kits); DCFS has kits available; some schools have emergency kits
  - insurance carriers will cover prescriptions for families to obtain
- Prevention program grant is available for 6th, 8th, and 10th grades
- Continued education with access to evidence based education to continue teaching in classrooms beyond this. Fellowship House is currently doing this in 5th grade through a grant, in the hopes that future health educators will continue the education process.

**Health & Behavioral Health Administrators**
- TASC (Treatment Alternatives for Safe Communities): Education for clients/parents regarding Nilox via social media
- Centerstone: Crisis Service Center
- Egyptian Health Department: Prevention specialists
- Prescription Monitoring Program
- Drug take-back events in communities, often sponsored by Sheriff’s Offices
- Primary care physicians referring patients to pain mgmt. resources to coordinate prescription usage
- Decrease in prescription dosages by SOME emergency departments
- DEA making undercover purchases on the internet
- Some schools including prevention education into curriculum
- Naloxone distributed by some EMS and law enforcement agencies

**Health Departments**
- Egyptian HD: DASA (Division of Alcoholism and Substance Abuse)-certified overdoes prevention program: physicians and health departments work law enforcement to proliferate Naloxone use
- Egyptian HD: DHS-funded drug prevention programming in schools for 4th/5th graders
- DASA: committed to partnering with health departments and other public health providers to train first responders and community in use of Naloxone
- CONSENSUS FROM GROUP THAT PREVENTION PROGRAMMING AND OTHER EFFORTS ARE THE REGION’S LARGEST GAP IN ADDRESSING OPIOID/HEROIN ABUSE

WHAT TREATMENT EFFORTS ARE CURRENTLY UNDERWAY? WHO IS INVOLVED

**Physicians/PAs/Pharmacists/PDMP Administrators**

- Severe access to care and treatment disparity in the region
- Only 5 Medication Assisted Treatment (MAT) certified physicians in southern 16 counties
- Patients travel at least 1 hour for Methadone
- Suboxone treatment effective for heroin addiction
- Physicians discussed various approaches to care and treatment:
  - providing counseling in addition to MAT for patients addicted to opioids
  - the duration of treatment: intense initiation/short duration residential treatment, 1 year or less suboxone taper, or suboxone taper of up to 2 years
  - providing care that is patient driven, what the “patient wants”, versus providing prescriptive care that the “patient needs”.
  - requiring a patient-doctor contract
- Adult male patients are looking for intense initiation treatment in a residential setting
- Families are desperately seeking treatment for addicted individuals who are not interested in treatment
- Patients hide their addiction when making a medical appointment and reveal the true reason for their visit during a one-on-one with the physician
- All physicians agreed on the usefulness of urine drug testing as a diagnostic tool
- General agreement that patients do not follow-up well with counseling
- DASA is underfunded and critical treatment will not be available very soon without funding
- Residential centers need more flexibility for allocation of beds – surplus of adolescent beds and shortage of adult male beds
- Need to expand scope of practice for PA/NP to become MAT certified providers

**Behavioral Health Clinicians**

- Vivitrol treatment
- Medically Assisted Treatment alone
- Medically Assisted Treatment, counseling and follow-up
- Cognitive Behavior Therapy/Dialectical Behavior Therapy
- Faith Based *Celebrate Recovery* events
- AA/NA
• **Who is involved?**
  o Physicians
  o Law Enforcement
  o Hospitals
  o Pharmacists

_Educators/Health Educators_
• Gateway has youth program currently available with one week or less waiting period
• Hospitals have inpatient areas, but very limited space
• Programs with judge and local health departments for referrals of drug related crimes (Drug Courts)
• PMP – but currently ineffective – needs to be “real time”, with full participation

_Health & Behavioral Health Administrators_
• Gateway: Vivitrol provides 30-day extended release ($1500/injection)
• Substance abuse counseling: TASC, Gateway, EHD, Centerstone, VA, Family Counseling Center, Community Resource Center, Fellowship House
• Centerstone: halfway house; mentorship programs
• Churches: Celebrate Recovery; AL-ANON; Narcotics Anonymous
• Inpatient Treatment: Gateway, Vantage Point, VA
• Some Suboxone treatment in the region

_Health Departments_
• Egyptian HD: working with health care providers to provide medication-assisted treatment (MAT) for opiate addiction
• Centerstone: Health Home Illinois program; Crisis Service Center
• Some suboxone treatment in the region, although it’s effectiveness is questionable

**WHAT ENFORCEMENT AND SUPPLY REDUCTION EFFORTS ARE CURRENTLY UNDERWAY? WHO IS INVOLVED?**

_Philicians/PAs/Pharmacists/PDMP Administrators_
• General agreement that Prescription Drug Monitoring Program (PDMP) works well
• Physicians are making queries to the program; this is time consuming, but not a burden
• General agreement that expanding the delegates who can access the system would improve care efficiency
• General agreement that Missouri should adopt a PMP
• General agreement that Providers should be able to access other state’s PMP
• Not mandating use of PDMP limits its effectiveness
• PDMP now has a Peer Review Committee
• Enhancements planned for the PDMP – PMP is now an almost “real time” view, integrating PDMP data into patient EHRs, intensive analysis of PMP data to include trending, plans for each individual physician to receive a practice and patient profile report, State legislating to increase the delegates who can view the PMP – will likely only be licensed personnel acting under the direction of a physician.
• Primary care providers are poorly informed about drug “take back” events in the community and sites for drug disposal
• 50% of opioid users get their supply from family/friend unused prescriptions
• Pharmacies cannot “take back” opioid drugs

**Behavioral Health Clinicians**
• Take Back Day/Drop Boxes for Prescription Drugs
• PMP utilization/Pill counts/Drug testing

**Educators/Health Educators**
• Take Back” programs by community, law enforcement, and DEA
• Needle exchanges
• Use PMP to manage prescriptions
• Law enforcement task force specifically dedicated to the problem
• Changing the laws to protect “reporters” and those who choose to get help (good Samaritan)
• WHO: Law enforcement, judicial system, DEA, local health departments, health coalitions, schools

**Health & Behavioral Health Administrators**
• DEA: internet monitoring
• DHS: Prescription Monitoring Program
• Hospital emergency departments: decreasing dosages
• Drug take-back programs
• Media: Education to public; encouraging public participation in solution
• Restrictions on who can pick-up prescription from pharmacy

**Health Departments**
• Prescription Monitoring Program, but it must be more “real time”
• Sudafed Monitoring Program should be more “real time”
• Law Enforcement: Drug Enforcement Administration, Southern Illinois Enforcement Group, Drug Task Force
WHO NEEDS TO BE ENGAGED THAT ARE NOT?

**Physicians/PAs/Pharmacists/PDMP Administrators**
- Need to increase the number of Medication Assisted Treatment certified physicians in Southern Illinois
- Need to increase the number of treatment facilities or expand their scope – both inpatient and outpatient services
- State - Need for Resources (money) to fund services

**Behavioral Health Clinicians**
- Recovering Individuals
- Business Community
- Media
- Parents
- Youth
- Faith community
- State and local government
- Need to think about the evidence-based 12 sector model from Drug Free Communities that is currently being used in local regions for teen drinking reduction (see Handbook for Community Anti-Drug Coalitions - http://www.cadca.org/resources/handbook-community-anti-drug-coalitions) - grants come out each year in January from Prevention 1st

**Educators/Health Educators**
- Chambers of Commerce
- Business owners of low wage employers
- Successful recovery individuals
- Faith community
- Youth leaders (e.g., 4-H agents, Boys and Girls Club workers, scout leaders, teachers, youth ministers)

**Health & Behavioral Health Administrators**
- Attorneys
- Prosecutors
- Local police/sheriffs
- Educators
- Students
- IL Primary Care Association
- Churches/ministerial alliances
- Individual physicians
Health Departments

- Physicians!!
- SIU School of Medicine: Teach addiction treatment and protocols to students
- Employers, through wellness programs
- Insurance companies/managed care organizations (MCOs)

WHAT IS THE MOST IMPORTANT OBJECTIVE FOR YOUR INDIVIDUAL ORGANIZATION/PROFESSION REGARDING THIS ISSUE?

Physicians/PAs/Pharmacists/PDMP Administrators

- Reduce opioid addiction
- Improve access to care and treatment for opioid addiction
- Increase the number of Medication Assisted Treatment certified physicians

Behavioral Health Clinicians

- Effective and timely treatment
- Engaging the community
- Prevention of the addiction
- Availability of treatment beds within hospitals
- Availability of Detox beds
- Education in schools
- Understand the full picture
- Education of adults
- Education for pregnant population
- Change prescription doses and methods
- Establishing a cohesive message for patients

Educators/Health Educators

- PREVENTION is most important!
- Education of youth and adults
- Communication as a coordinated effort between multiple agencies
- Break down stigma associated with drug use (especially in small towns)
- Gain better understanding of the treatment process
- Find funding opportunities/community resources
- Need multiple educational opportunities, not just one-time deals for communities
- Gain media attention
- Address the effects of poverty on the community/family/individual
Health & Behavioral Health Administrators

- EHD: #1 priority is prevention and treatment
- All LADs:
  - promote PMP
  - decrease communicable diseases
- TASC: Decrease intakes into criminal justice system
- SIH: Routine screening and referral by physicians
  - address mental health needs
  - more community/referral resources
  - education of staff

Health Departments

- More prevention programming
- MAT – followed to fidelity
- Disrupt flow of heroin from Mexican border to Southern Illinois neighborhoods
- Less overprescribing of opiates
- Training United Way 211 staff to properly refer for real-time help to abusers
- Focus criminal penalties on dealers, rather than users

COMMUNITY READINESS SURVEY

Meeting participants were asked to rate the status of their communities’ readiness to address opioid and heroin abuse issues. Participants could rate their community’s knowledge and climate/attitude on a seven point scale. Approximately 60% of attendees participated in the survey. More than 90% of the ratings were at the level of 4 or less on both scales, suggesting that participants believe that their communities are poorly prepared to begin to address the opioid crisis in the region.

Knowledge Scale

1. Community members HAVE NO KNOWLEDGE about opioid abuse or its impact on their community.
2. ONLY A FEW community members HAVE ANY KNOWLEDGE about opioid abuse in the community. Most community members are completely uniformed. There are many misconceptions about how and where opioid abuse occurs, and if it is a problem locally.
3. Community members HAVE ONLY VAGUE KNOWLEDGE about opioid abuse in the community. They have some awareness that opioid abuse is a problem and why it may occur. There may be misconceptions about opioid abuse, and why it needs to be addressed in the community.
4. HAVE LIMITED KNOWLEDGE about opioid abuse. They are aware that opioid abuse can be a problem and have some information about causes, consequences, signs and symptoms. There is no knowledge about how much it occurs locally and what can be done to address it.

5. Community members HAVE BASIC KNOWLEDGE about opioid abuse. They are aware of why opioid abuse is a problem, and have a basic knowledge about causes, consequences, signs and symptoms. They have some knowledge about how much it occurs locally and what can be done to address it.

6. Community members HAVE MORE THAN BASIC KNOWLEDGE about opioid abuse. They understand the causes, consequences, signs and symptoms of opioid abuse. They have significant knowledge about local prevalence, its effect on the community, and what can be done to address it.

7. Community members HAVE DETAILED KNOWLEDGE about opioid abuse, its effect on the community, local prevalence, and actions that can be taken to address it. Community members are prepared to dedicate community resources to prevention and treatment efforts in their community.

8. 

Table 1. Community Readiness: Knowledge (n=45)

| Community Knowledge: Prescription Drug Abuse and Heroin Addiction |
|------------------|------------------|------------------|------------------|------------------|
| (1) Have No knowledge | 0                | 0                | 0                | 0                |
| (2) A few have knowledge | 0                | 0                | 0                | 0                |
| (3) Have vague knowledge | 0               | 0                | 0                | 0                |
| (4) Have limited knowledge | 3               | 3                | 3                | 3                |
| (5) Have basic knowledge | 12              | 12               | 12               | 12               |
| (6) Have more than basic knowledge | 17              | 17               | 17               | 17               |
| (7) Have detailed knowledge | 0               | 0                | 0                | 0                |

Attitude/Community Climate Scale

1. The community DOES NOT BELIEVE THAT THERE IS AN OPIOID ABUSE PROBLEM in their community. Attitude is “only ‘those’ people do that.”

2. There is LITTLE OR NO RECOGNITION THAT OPIOID ABUSE is a community problem. Prevailing attitudes are “there’s nothing we can do” or “it’s just the way things are.”

3. The attitude in the community is STARTING TO ACKNOWLEDGE THE PROBLEM of opioid abuse. "We have to do something but don't know what to do."
4. The attitude in the community is “we are concerned about this”. Some community members SUPPORT MODEST EFFORTS to seek out programs to identify and address opioid abuse.

5. The attitude in the community is “This is our responsibility”. COMMUNITY BEGINNING TO ENGAGE in programs that prevent and treat opioid abuse.

6. The majority of the community generally ACCEPTS PROGRAMS, ACTIVITIES, AND POLICIES. Support may be somewhat passive.

7. All major segments of the community are HIGHLY SUPPORTIVE, and community members are ACTIVELY ENGAGED in evaluating and improving prevention and treatment efforts.

Table 2. Community Readiness: Attitude/Climate (n=43)

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<th>Community Attitudes: Prescription Drug Abuse and Heroin Addiction</th>
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<tr>
<td>(1) &quot;Only those people do that&quot;</td>
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<td>(2) &quot;there is nothing that we can do&quot;</td>
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<td>(3) &quot;we have to do something but don't know what to do&quot;</td>
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<td>(4) &quot;we are concerned about this&quot;</td>
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<td>(5) &quot;this is our responsibility&quot;</td>
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<td>(6) Majority accepts programs, activities, policies</td>
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<td>(7) Community is highly supportive and engaged</td>
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**AFTERNOON SESSION**
The afternoon session grouped participants based (roughly) on the county they live and/or provide service to.

*County clusters*
Blue (Ruth) – Bond, Marion, Saline, Sangamon, Wayne, Wabash
Yellow (Kim) – Johnson, Union
Pink (Jeff) – Perry, Randolph, Washington
Light Green (Angie) - Jackson
Dark Green (Dennis) – Franklin, Williamson

**WHAT ARE THE TOP THREE INITIATIVES WE CAN LAUNCH OR EXPAND IN OUR REGION WITH NO ADDITIONAL RESOURCES?**

*Blue*
*Saline County*
1) Increase the involvement of our coalitions in the issue of Opioid Prescription Drug Abuse and Heroin Addiction, both our health coalition and our substance use coalition
2) Increase distribution of Naloxone and increase the number of persons trained in administering – such as law enforcement, physicians
3) Expand take back programs

*Marion County*
1) Develop a plan for a community coalition – Health Department take lead
2) Develop a plan for training 1st responders in naloxone administration – Health Department take lead
3) Develop a plan for take-back programs – Health Department take lead

*Yellow*
1) Hold community forums to increase awareness and educate
2) Engage the media
3) Utilize Community Health Coalitions to focus on Opioid issues and engage other sectors
4) Talk to low wage employers to educate on the depth of the problem and engage them in a solution
5) Educate Chambers of Commerce, Rotary Clubs, Kiwanis Clubs, and fire departments
6) Launch a social media campaign to educate and promote awareness
7) Bring the issue up at all consortium meetings
8) Enroll in DASA’s Overdose Prevention Program
9) Advocate for tougher laws
**Pink**
1) Increase evidence-based prevention-education and public awareness campaigns
   a. especially peer-to-peer
   b. especially with younger groups
   c. start with alcohol education
   d. include faith communities
   e. employ social media
2) Pursue grant/funding to hire Prevention Educator to work with communities/schools
3) Improve PMP
4) Lobby for funding to increase access to treatment and detox
5) Work with DCFS to improve treatment plans for families – focus on impacts of addiction on children

**Light Green**
1) Public education/awareness
2) Responsible prescribing practices
3) More real-time data from Prescription Monitoring Program

**Dark Green**
1) Emphasis on public education about resources that are CURRENTLY available, as well as producing a “substance abuse resource guide” for public consumption.
2) Emphasis on education to patients, especially regarding drug “take-back” events; managing patient expectations about what medications they NEED, as opposed to what medications they BELIEVE that they should receive.
3) Education of primary care providers, regarding prescribing guidelines, Medication Assisted Treatment (MAT), and sharing of MAT best practices

**What are the assets and barriers (cultural, social, economic, etc.) to these initiatives?**

**Blue**

**Assets**
- Saline county has a health coalition and a substance use coalition
- Local physician in Saline county providing 1st responder training on the use of Narcan
- In Saline county the local coalition raised the money themselves to purchase the naloxone kits
- Both Saline and Marion county Health Departments’ IPLANs have identified substance use as a priority problem
- Local speakers willing to share their story of addiction

**Barriers**
- Community Leadership needed to move this project forward
• Marion and Wayne counties have no health coalitions
• Wayne county community has low awareness about Opioid Prescription Drug Abuse and Heroin Addiction
• Marion and Wayne counties – 1st responders not trained to administer Narcan
• Marion and Wayne counties do not have take back programs
• Marion county sheriff department says it is against the law for them to have a take back program
• Poor access to treatment
• Shortage of physicians MAT certified
• Pharmacist from Wayne county is not seeing prescriptions for Narcan being written at the hospital
• In Marion county the Coroner shared a personal story of addiction
• Cost of naloxone kits ($50 each) prohibitive of their routine use

Yellow
• Lack of:
  o staff, resources and time
  o travel budget
  o treatment options
  o education
  o transportation
• Poor economy
• Bureaucracy

Pink
No unique responses

Light Green
Assets
• PMP already in operation
• Many prescribers and pharmacists now have access to PMP
• Some education in place
• Issue of overprescribing is now in forefront of discussion
• Good network of coalitions/planning networks
• Electronic prescriptions
• Limited # of refills

Barriers
• Absence of real-time data from PMP
• No or inaccurate date from neighboring states
• PMP is not mandatory in Illinois
• Patient expectations to be 100% pain-free
• Hospital/health care provider patient satisfaction based upon “pain free”
• Joint Commission “pain free” standards
• No assessment of drug abuse patients for past Suboxone abuse
• Alternative pain relief therapies not paid by insurance

**Dark Green**

**Assets**
• Region replete with experienced educators
• Existing resource guides can be used as templates

**Barriers**
• Lack of consensus on most effective prescribing guidelines
• Misunderstanding of MAT by physicians
• Inadequate data
• Lack of community resiliency
• Community view of addiction as moral issue, as opposed to disease
• Fear by community members to confront issues that are propagated by the epidemic
• Patients often won’t seek treatment
• Stigma, on the part of the community towards the abuser, as well as towards communities with a significant abuse rate.

**IF ADDITIONAL RESOURCES WERE AVAILABLE, WHAT ARE THE TOP THREE INITIATIVES THAT COULD HAVE THE MOST IMPACT IN OUR REGION?**

**Blue**
Essentially same initiative but now have ability to implement with MONEY
1) Purchase naloxone kits
2) Purchase receptacles used for “take back” – these are expensive
3) Provide naloxone training for 1st responders
4) Provide services

**Yellow**
1) Improve treatment options
2) Training

**Pink**
No unique responses
**Light Green**
1) Increase treatment resources (mental health, pain addiction)
2) Education (public, patients, health care providers)
3) Support law enforcement efforts with more staff, resources

**Dark Green**
1) Patient-centered care for substance abuse patients
2) Evidence-based education in K-12 schools
3) Mid-level providers should be permitted to administer opioid treatment: requires regulatory/statutory changes in protocols and scopes of practice

**WHAT ARE THE ASSETS AND BARRIERS (CULTURAL, SOCIAL, ECONOMIC, ETC.) TO THESE INITIATIVES?**

**Blue**

Barriers remaining despite money
- Many youth feel hopeless, they have no transportation, there are no jobs and even if there were jobs they could not get to them
- Once you have a criminal history for drug abuse your chances for finding a decent job are very low

Other programming needed or expanded
- Provide preventive education in schools – develop open lines of communication with schools
- Harm reduction programs – needle exchange programs
- Community education on Amnesty programs and Good Samaritan Law
- Engage neighborhood watch groups to work on this issue
- Education on use of naloxone
- More providers trained for MAT
- Expand use of the PMP

**Yellow**
- Poor economic conditions
- Territorial issues
- Lack of accountability of the target population
- Bureaucracy
- Denial of the problem
- Ability to engage law enforcement in prevention and treatment efforts
No unique responses

**Light Green**

**Assets**
- Treatment: evidence that it works
- Referral process improving
- PMP is becoming more effective
- Some law enforcement “safe harbors” exist

**Barriers**
- Public not aware of treatment resources
- Treatment resources are limited
- Treatment program re-lapses are common
- Cost of treatment
- Risks of abuse of Suboxone
- Not all law enforcement involved in “safe harbor” programs
- Frustration by criminal justice system: chronic, myriad-repeating offenders with little or no consequences for offenses

**Dark Green**

**Barriers**
- Uniformed legislators: Legislation that is well-meaning, but ineffective and/or inefficient

**Assets**
- CATCH program at CRHSSD
- A national movement to patient-centered medical care

**WHAT IS THE MOST IMPORTANT OBJECTIVE FOR YOUR REGION REGARDING THIS ISSUE?**

**Blue**
- Create a regional plan to address Opioid Prescription Drug Abuse and Heroin Addiction – streamline communication and education
- Improve access to care and treatment for opioid addiction

**Yellow**
- To build our own regional capacity
Pink
No unique responses

Light Green
• Coordinate effort with a Plan
  o real goals/objectives
  o timeline
  o maintain cross-domain interaction
  o community meetings
  o measure effectiveness of programming

Dark Green
• Education to physicians (and other treatment providers), patients, and the public

LOGICAL NEXT STEPS?

Blue
• Adopt the Regional Plan at the August 31st Summit

Yellow
• Invest economically in our region
• Increase education and awareness
• Coordinate our efforts
• Form strategic partnerships
• Engage all sectors

Pink
No unique responses

Light Green
• Create a regional plan

Dark Green
• Continue momentum and meaningful networking between domains represented at the 06/06 meeting, and continue momentum into, and beyond, the August summit.

SETTING PRIORITIES AND NEXT STEPS (Wrap-up)

What would success look like 3 years from now?

What are the critical components to address now?
Are there immediate actions that can be taken?
What does success look like:

- Addicts can walk into “anywhere” (police, hospital, doctor’s office, homeless shelter, etc.) and find a quick path to treatment
- Number of drug overdoses and deaths are drastically reduced
- **ALL** Illinois primary and secondary schools will participate in the Illinois Youth (behavioral) Survey (https://iys.cprd.illinois.edu/) and results will show that all students believe that all illicit drug use is dangerous
- There will be full participation by all prescribers in the Illinois Prescription Drug Monitoring Program (PMP)
- Immediate access to treatment is available when addicts are ready for it
- Universal screening for opioids by all providers prior to treatment for chronic pain
- More family involvement in opioid addiction treatment
- No overdosed kids being taken to the Emergency Room by their friends

What are the critical components to address now/Are their immediate actions that can be taken:

- Coherent/consistent Educational message
- Public awareness (with consistent message)
- Complete and consistent message (about risks) to patients when dispensing opioid pain relievers
- Develop and implement “informed consent” template/packet to be signed by patients acknowledging the side-effects and impacts of opioid pain treatment; becomes part of medical record
- Better communication across organizations during treatment; address any HIPPA constraints to information sharing
- Identify and engage other people/organizations who need to “be at the table” (e.g., employers)