Chicago-Cook Task Force on Heroin

Final Report

October 6, 2016

EXECUTIVE SUMMARY

In light of the growing heroin epidemic nationwide, Mayor Rahm Emanuel, Cook County President Toni Preckwinkle, Chicago Alderman Ed Burke, and Cook County Commissioner Richard Boykin launched the Chicago-Cook Task Force on Heroin. The task force has aimed to identify reforms that can be undertaken at a local level to improve prevention and response to heroin use and addiction. The task force has examined the issue from several angles: (1) education of community members, (2) education of healthcare professionals, (3) data, (4) treatment, (5) trafficking, and (6) overdose reversal. After months of research and deliberation, the task force proposes recommendations in each area to enhance heroin policies and programs in Chicago and Cook County. Those recommendations include:

Education of Community Members

1. Work with pharmacies to develop and disseminate information to patients about accessing naloxone, the risks of opioid use, and contacting a potential help line.
2. Create a county-wide public awareness campaign related to the prevention, treatment, and de-stigmatization of opioid addiction. Elements could include:
    a. Engaging community organizations, faith-based groups, and the general public on navigating the treatment process and on the benefits of medication-assisted treatment and naloxone.
    b. Utilizing digital ads and social media to combat online misinformation about opioids and directing patients to evidence-based services and naloxone providers.
    c. Increasing public knowledge of drop-off centers where excess or expired prescription medication can be disposed.
    d. Providing workshops to educate parents and caretakers of all ages on identifying and addressing opioid use, including on proper disposal of medication.
    e. Educating individuals with opioid use disorder on strategies for harm reduction and navigating the treatment process.
3. Create and implement an education program for criminal justice professionals to de-stigmatize medication-assisted treatment.
4. Review current prevention programs in Chicago and Cook County public schools and police departments to identify ways to expand social emotional learning and evidence-based practices.

Education of Healthcare Professionals

1. Develop and disseminate a toolkit for health care providers, prescribers, pharmacists, and first responders to use to communicate with patients about opioids and obtain a history of substance use disorder.
2. Promote the Centers for Disease Control and Prevention (CDC) guidelines on opioid prescribing to all clinicians in Cook County.
3. Create “Safe Prescribing” recognition for hospitals and clinics that utilize safe opioid prescribing practices.
4. Encourage hospitals, clinics, and physicians to use the Illinois Prescription Drug Monitoring Program (PDMP) and to connect PDMP data to electronic health records; work with vendors to develop tools that seamlessly integrate such data.
5. Encourage pharmacies to train staff to be able to provide naloxone without a prescription.

Data

1. Create a working group of stakeholders to share data and recommend improved methods of data collection and dissemination across departments and organizations.
2. Encourage the data working group to capture and evaluate data from a variety of City and County sources to identify any gaps in current emergency and pre-emptive naloxone deployment protocols and strategy, and recommend locations where naloxone should be placed and distributed.
3. Ensure more middle and high schools in Chicago participate regularly in the Illinois Youth Survey and ensure the survey contains sufficient questions on opioid use.
4. Identify treatment deserts in Chicago to help assure that new resources are allocated in communities with the greatest need.

Treatment

1. Create a coordinated intake and referral line to help individuals, primary care facilities, and emergency departments navigate the system of treatment providers and match patients to the appropriate level of addiction treatment services within their insurance network.
2. Ensure pharmacies and/or drug companies create additional drop-off centers across Chicago and Cook County for expired and unused medication.
3. Increase funding for access to medication-assisted treatment in Chicago, particularly in neighborhoods where the need for services exceeds the availability of services.
4. Provide technical assistance to health centers in Chicago to create, expand, and/or enhance medication-assisted treatment programs, including centers that recently received a Health Resources and Services Administration (HRSA) grant for implementing such programs.
5. Incorporate the CDC guidelines on opioid prescribing into the employee benefits of the City of Chicago, Cook County, and sister agencies.
6. Foster collaboration between Cook County and community providers to develop and implement a seamless system of transitional care post-detention and post-incarceration by connecting patients with long-term services.
7. Conduct regular outreach missions to locations in Chicago where individuals are housed in unlicensed, sub-standard treatment programs; inspect the buildings and connect the individuals to adequate shelter and appropriate services when feasible; frequently update the list of locations.
8. Advocate for Medicaid coverage for certified recovery support specialists; encourage the state to create a licensure for them and encourage an active network of recovery coaches to model successful long-term treatment.
9. Advocate for the federal Medicaid Coverage for Addiction Recovery Expansion Act (S.2605), which would let states expand access to care by having Medicaid cover facilities with more than 16 beds.
10. Advocate for Medicaid coverage of treatment services for patients in pre-trial detention.
11. Advocate at the federal level to ease restrictions on methadone to allow expanded prescribing.
12. Advocate at the federal level to further ease restrictions on physicians prescribing buprenorphine.
13. Advocate for significantly increased funding of the federal Comprehensive Addiction and Recovery Act (CARA) to expand treatment capacity and other measures to fight the opioid crisis.

Trafficking

1. Encourage law enforcement representatives to regularly update service providers on trafficking patterns and market trends in order to prepare for future upticks in drug usage or the introduction of new drugs.
2. Expand CPD and HIDTA's diversion pilot program allowing some individuals involved in low-level narcotics offenses to access treatment in lieu of an arrest.
3. Develop innovative anti-trafficking prosecution strategies in partnership with federal and state prosecutors.

Overdose Reversal

1. Expand naloxone deployment to entire CFD fleet, ensuring that all Basic Life Support (BLS) vehicles and command vehicles, in addition to the existing Advanced Life Support (ALS) vehicles, will have naloxone available.
2. Facilitate widespread access to affordable naloxone by encouraging pharmaceutical companies to lower the cost of their products, identify new forms of funding to purchase additional supplies, and increase purchasing power by combining government purchase of naloxone across the county.
3. Provide naloxone upon release from jail, medical detox, treatment programs for substance use disorder, and other settings where patients are likely to have decreased opioid tolerance and be vulnerable to overdose.
4. Encourage treatment providers that receive City or County funding to provide naloxone to patients upon release from treatment programs for substance use disorder.
5. Review current regulatory obstacles to prescribing naloxone and training patients on how to use it; advocate for any needed streamlining to simplify the process for physicians.
6. Provide information to all City of Chicago and Cook County employees about opportunities to receive off-duty naloxone deployment training and how to recognize signs of an overdose.
7. Ensure all drug education programs to which the Cook County Circuit Court refers a defendant include a naloxone education component.

TASK FORCE MEMBERS

City of Chicago

- Chairman Ed Burke, 14th Ward
- Alderman Pat Dowell, 3rd Ward
- Alderman Leslie Hairston, 5th Ward
- Alderman George A. Cardenas, 12th Ward
- Alderman Willie B. Cochran, 20th Ward
- Alderman Ariel E. Reboyras, 30th Ward
- Alderman Emma A. Mitts, 37th Ward
- Julie Morita, MD, Commissioner, Chicago Department of Public Health
- Jesse Lava, MPP, Director of Policy, Chicago Department of Public Health
- Chief Anthony Riccio, Organized Crime Bureau, Chicago Police Department
- Mary Sheridan, Assistant Deputy Fire Commissioner, Chicago Fire Department
- Leslee Stein-Spencer, RN, MS, Director of Medical Administration and Regulatory Compliance, Chicago Fire Department
- Dionne Tate, Deputy Director, Police and Fire Dispatch, OEMC
- Marty Doyle, Director of Training for 911 Operations
- Jane E. Notz, JD, First Assistant Corporation Counsel, Chicago Department of Law
- Matt Fischler, Former Director of Policy Planning, Mayor's Office
- Helena Swanson-Nystrom, Former Policy Associate, Mayor's Office

Cook County

- Commissioner Richard Boykin, 1st District
- Lori Roper, JD, Attorney Supervisor, Specialty Courts, Law Office of the Cook County Public Defender
- Amy Campanelli, JD, Cook County Public Defender
- Beverly Butler, Office of the Cook County Chief Judge
- Garvin Ambrose, Chief of Staff, Office of the Cook County State's Attorney
- Philip Roy, Policy Advisor, Office of the Cook County State's Attorney
- Katie Dunne, Assistant to the Sheriff, Office of the Cook County Sheriff
- Brian White, First Deputy Chief of Police, Cook County Sheriff's Police Department
- Letitia Close, Chief of Staff to the CEO, Cook County Health and Hospitals System
- Rebecca Janowitz, JD, MPA, Special Assistant for Legal Affairs, Cook County Justice Advisory Council
- Patrick Carey, Former Special Assistant, Governmental and Legislative Affairs, Office of President Preckwinkle
- Emilie Junge, JD, Member, Board of Directors, Cook County Health and Hospitals System
- Steven Aks, DO, FACMT, FACEP, Director, the Toxikon Consortium; Attending Physician, Department of Emergency Medicine, Cook County Health and Hospitals System

Over approximately four months, the Chicago-Cook Task Force on Heroin met three times in public sessions where expert witnesses gave testimony and presented evidence. These experts included physicians, academics, advocates, and service providers. The task force also met three times privately to discuss the evidence it had heard and create recommendations. Testifying organizations and individuals included:

- Steven Aks, DO, FACMT, FACEP, Director, the Toxikon Consortium; Attending Physician, Department of Emergency Medicine, Cook County Health and Hospitals System

- Dan Bigg, Director, Chicago Recovery Alliance
- Eddy Borrayo, MSW, CADC, MI/SA II, Executive Director, Rincon Family Services
- Tom Britton, DrPH, President and CEO, Gateway Foundation
- Stephen Cina, MD, Former Chief Medical Examiner, Cook County
- Ruth Coffman, MPP, MDiv, Executive Director, University of Chicago Urban Health Lab
- Melody Heaps, MA, President, MMH & Associates; Founder and Former President, Treatment Alternatives for Safe Communities (TASC) of Illinois
- Juan Hernandez, Chief, Chicago Fire Department
- Richard Jorgenson, MD, FACS, Coroner, DuPage County
- Emilie Junge, JD, Member, Board of Directors, Cook County Health and Hospitals System
- Steve and Pam Kamenicky, Volunteers, Chicago Recovery Alliance
- Kathie Kane-Willis, MA, Director, Illinois Consortium on Drug Policy, Roosevelt University
- Sara Moscato Howe, MS, CHES, CEO, Illinois Alcoholism and Drug Dependence Association
- Kate Mahoney, MSW, LCSW, Executive Director, PEER Services
- R.J. McMahon, MBA, Executive Director, Robert Crown Centers for Health Education
- Julie Morita, MD, Commissioner, Chicago Department of Public Health
- Suzanne Carlberg Racich, PhD, Assistant Professor, DePaul University; Volunteer, Chicago Recovery Alliance
- Anthony Riccio, Chief of Bureau of Organized Crime, Chicago Police Department
- Pamela Rodgriguez, MS, President and CEO, TASC of Illinois
- Nicholas Roti, Executive Director, High-Intensity Drug Trafficking Area (HIDTA) Chicago
- Elizabeth Salisbury-Afshar, MD, Medical Director, Heartland Health Outreach
- Mary Sheridan, Assistant Deputy Fire Commissioner, EMS Operations, Chicago Fire Department

Additional experts contributed to the task force's work by offering guidance through meetings, phone calls, and emails. These contributors included Dr. Dan Lustig of Haymarket Center, Maya Doe-Simkins of Heartland Alliance, Marco Jacome of Healthcare Alternative Systems, Richard Weisskopf of the Illinois Department of Human Services, and numerous others.

ISSUE BACKGROUND

Heroin is an opioid, a class of drugs stemming from the opium poppy.[1] Examples of prescription opioids are hydrocodone (like Vicodin), oxycodone (like OxyContin and Percocet), morphine (like Kadian and Avinza), and codeine.[2] Opioids reduce the intensity of pain by targeting receptors in the brain, spinal cord, and other organs. Such drugs can produce euphoric states, along with side effects such as constipation and nausea.[3] Although prescription opioids can be beneficial in circumstances such as cancer, the period following surgery, and short-term instances of severe pain,[4] they can also be addictive and are frequently used for non-medical purposes. Signs of addiction—medically recognized as opioid use disorder—include failure to fulfill major life obligations, unsuccessful efforts to cut down use, and spending significant time

[1] Although opioids and opiates are technically different, we will refer to both in this report as opioids to avoid confusion.
[2] National Institute on Drug Abuse (2014). Prescription Drug Abuse: What Are Opioids? https://www.drugabuse.gov/publications/research-reports/prescription-drugs/opioids/what-are-opioids
[3] National Institute on Drug Abuse (2014). Prescription Drug Abuse: How Do Opioids Affect the Brain and Body? https://www.drugabuse.gov/publications/research-reports/prescription-drugs/opioids/how-do-opioids-affect-brain-body
[4] See, for instance, Dowell, D. et al (2016). "CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016." Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, March 18, 2016 / 65(1); 1–49. http://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm.

on activities to obtain or use opioids.[5] High doses can depress the respiratory system and lead to a coma or death, especially when used in combination with other drugs, including sedatives such as alcohol.[6]

Opioid overdoses have shot up in recent years. Between 2001 and 2014, deaths in the United States from prescription opioids more than tripled—and deaths from heroin rose six-fold.[7] Indeed, opioids are involved in at least half of this nation's lethal drug overdoses.[8] In a national survey of drug use and health, the National Institutes of Health reported that the overall user rate for heroin was 2% for those age 18 years and older,[9] and the U.S. Department of Health and Human Services found that the number of persons with heroin dependence or abuse[10] was 467,000 in 2012 (twice what it was a decade earlier) and 2.1 million for pain relievers.[11] In all, the United States had an estimated 8,257 heroin deaths and 16,235 prescription opioid deaths in 2013.[12]

One cause of the rise in opioid use disorder and overdose has been excessive prescribing by physicians, some of whom have been misled by drug company representatives downplaying the risks of opioids.[13] Federal data says 79.5% of individuals who reported starting heroin use in recent years had previously abused pain medication—suggesting painkillers are a gateway to greater abuse.[14] Another cause of the uptick has been drug traffickers' increasingly aggressive and creative efforts to get people hooked.[15] Heroin is cheaper and often easier to obtain than prescription painkillers. And when individuals with a painkiller addiction cannot access prescription opioids, they often turn to heroin.[16]

Although treatment for opioid use disorder is available, the stigma surrounding drug addiction remains strong, discouraging many from seeking treatment. In fact, negative attitudes about addiction surpass those about mental illness.[17]

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[5] Substance Abuse and Mental Health Services Administration (2015). Substance Use Disorders: Opioid Use Disorder: http://www.samhsa.gov/disorders/substance-use.
[6] World Health Organization (2014). Information Sheet on Opioid Overdose. http://www.who.int/substance_abuse/information-sheet/en/.
[7] National Institute on Drug Abuse: National Center for Health Statistics (2015) CDC Wonder Data: National Overdose Rates. https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates.
[8] Centers for Disease Control and Prevention. Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2016. Available at http://wonder.cdc.gov and http://www.cdc.gov/drugoverdose/data/overdose.html.
[9] National Survey of Drug Use and Health (2012-2014). National Survey on Drug Use and Health: Trends in Prevalence of Various Drugs for Ages 12 or Older, Ages 12 to 17, Ages 18 to 25, and Ages 26 or Older; 2012 – 2014. https://www.drugabuse.gov/national-survey-drug-use-health.
[10] "Abuse" is no longer a medically-preferred term, but it will appear sporadically in this report when referring to older studies or other materials that use the term.
[11] US Department of Health and Human Services. Results from the 2012 National Survey on Drug Use and Health: Summary of Findings. http://www.samhsa.gov/data/sites/default/files/NSDUHresults2012/NSDUHresults2012.pdf.
[12] Centers for Disease Control, Data Brief 190: Drug-poisoning Deaths Involving Heroin: United States, 2000–2013. http://www.cdc.gov/nchs/data/databriefs/db190_table.pdf#1.
[13] Quinones, S. (2015) Dreamland: The True Tale of America's Opiate Epidemic. New York, NY: Bloomsbury Press.
[14] Muhuri, J., et al (2013). "Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States." CBHSQ Data Review. http://www.samhsa.gov/data/sites/default/files/DR006/DR006/nonmedical-pain-reliever-use-2013.htm. See also: Kuehn, B.M. (2012) "SAMHSA: Pain Medication Abuse a Common Path to Heroin, Experts Say This Pattern Likely Driving Heroin Resurgence." Medical News and Perspectives. JAMA Vol. 310. 1433.
[15] Quinones (2015).
[16] Substance Abuse and Mental Health Services Administration (2016). Opioids: Heroin. http://www.samhsa.gov/atod/opioids.
[17] Barry, C. et al (2014). "Stigma, Discrimination, Treatment Effectiveness, and Policy: Public Views about Drug Addiction and Mental Illness." Psychiatric Services Vol. 65 No. 10.

HEROIN IN THE CHICAGO AREA

The opioid epidemic has hit Chicago and the surrounding areas hard. As of 2011, this area led the nation in heroin-related emergency department visits with 24,627—and was second only to the Boston area in visits per capita.[18] In fact, the Chicago area's per-capita rate of heroin-related emergency department visits was more than three times the national average.[19] Opioid use is especially prevalent among those caught up in the criminal justice system: 14% of adult male arrestees tested positive for opioids in 2013.[20] And youth are not exempt from the epidemic: an estimated 4.1% of Chicago high school students have used heroin.[21]

The Cook County Medical Examiner's figures show that in 2015, there were at least 609 opioid-related overdose deaths in Cook County, 403 of which were in Chicago. The numbers for heroin specifically were 424 in Cook County and 285 in Chicago alone.[22] Increasingly, overdose deaths are coming from heroin laced with fentanyl, a powerful synthetic opioid.[23] The Chicago Fire Department responded to 2,734 suspected overdoses in 2015.[24] A disproportionate share of the overdoses and deaths happened on Chicago's west side, near the so-called "heroin highway" where heroin trafficking is prominent.[25] According to a study from Roosevelt University, 35% of Chicago's hospitalizations for opioids in 2013 occurred on the west side. That figure was 7% for the north side and 20% for the south side.[26]

Indeed, many community areas could be classified as treatment deserts where the need is greater than the availability of services. Such areas would likely include Austin, East and West Garfield Park, the Near West Side, Humboldt Park, and West Englewood, among others.[27]

Law enforcement officials, who widely see heroin as a catalyst for other crime, have also faced an increasing problem. In 2011, the U.S. Department of Justice's National Drug Intelligence Center stated the availability of heroin in the Chicago area had "increased sharply over the past few years because of greater control by Mexican drug trafficking organizations" and would likely continue to rise.[28] From 2006 to 2009, the quantity of illicit drug seized in a year by the Cook County Sheriff's Office increased from 7.9 kilograms to 59.8 kilograms.[29] Neighborhood disparities occur in heroin possession arrests as well, with Chicago's highest rates being in community areas on the west side.[30]

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[18] Office of National Drug Control Policy. "National Drug Control Safety Data Supplement 2014." Accessed 6/22/2015. https://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/ndcs_data_supplement_2014.pdf
[19] US Department of Justice. "Chicago High Intensity Trafficking Area Drug Market Analysis 2011." Accessed 6/22/2015.http://www.justice.gov/archive/ndic/dmas/Chicago_DMA-2011(U).pdf
[20] Office of National Drug Control Policy. "National Drug Control Safety Data Supplement 2014." Accessed 6/22/2015. https://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/ndcs_data_supplement_2014.pdf
[21] Centers for Disease Control and Prevention (2013 data). Youth Risk Behavior Surveillance System report. See https://nccd.cdc.gov/youthonline/App/Results.aspx?LID=CH.
[22] Calculations from Stephen Cina, MD, Chief Medical Examiner of Cook County, delivered April 22, 2016.
[23] Briscoe, T. and Gorner, J. "Fentanyl-related deaths spike in Cook County in 2015, reports show," Chicago Tribune, December 22, 2015.
[24] Chicago Fire Department (2016). Electronic Reporting System data.
[25] Chicago Department of Public Health (2016), "Opioid Overdose Rate, Chicago Community Areas 2014," prepared by Reina, M. This analysis used the Chicago Fire Department's 2016 data.
[26] Kane-Willis, K., and Metzger, S. "Hidden in Plain Sight: Heroin's Impact on Chicago's West Side." Illinois Consortium on Drug Policy at Roosevelt University, August 2016.
[27] See Appendix III on page 20 of this report.
[28] US Department of Justice.
[29] US Department of Justice.
[30] Kane-Willis, K., and Metzger, S.

RECENT STATE AND FEDERAL EFFORTS

In 2015, Illinois lawmakers passed the Heroin Crisis Act, a sweeping piece of legislation that addresses issues such as reversing overdoses, reimbursing for more treatment, educating stakeholders, and improving data collection—some of the very issues being reviewed by the Chicago-Cook Task Force on Heroin.[31] Among other things, the bill:

- Requires Medicaid to cover methadone (an evidence-based treatment), buprenorphine (another evidence-based treatment) for long term use, and naloxone (an overdose antidote).
- Requires Medicaid and private insurers to treat substance use disorder like other medical conditions.
- Promotes the use of naloxone at schools and by law enforcement. The bill also provides for pharmacist training in naloxone, authorizes pharmacists and other healthcare professionals to prescribe it, and expands liability protections for those who administer it.
- Requires the reporting of opioid overdoses and education efforts to the Illinois Department of Public Health.
- Enhances the Prescription Drug Monitoring Program so healthcare professionals know more about patients' drug histories.
- Increases access to drug courts as an alternative to incarceration.

Illinois and the Chicago area are also affected by what happens at the federal level, and the Obama administration has taken important steps over the last year alone to combat opioid addiction. In February 2016, the White House proposed a 2017 budget that would include substantial new funding to expand access to treatment for prescription drug abuse and heroin use and improve state-level overdose prevention strategies. This announcement came on the heels of the federal government mobilizing several public and private sector partnerships in October 2015 to produce a response on overdose and community prevention.[32]

In July 2016, President Obama signed the Comprehensive Addiction and Recovery Act, which takes action on prevention and education, treatment, law enforcement efforts, and recovery. The President made clear the bill needed significantly more funding behind it to turn the tide on the opioid epidemic. Yet the Obama administration has been able to take action on its own. The Centers for Disease Control and Prevention (CDC) has recently released guidelines and educational resources on opioid prescribing[33] and announced plans to allocate $8.5 million to the development of tools and resources to help inform physicians about appropriate prescribing practices.[34] In addition, the U.S. Department of Health and Human Services has raised the limit on the number of patients that eligible physicians can treat with buprenorphine, an evidence-based medication for opioid use disorder.[35]

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[31] See the text of the bill at the Illinois General Assembly website at http://www.ilga.gov/legislation/99/HB/09900HB0001enr.htm. For a summary, see Rabbit, D. "The Heroin Crisis Act: What You Need to Know about the New Law." Heartland Alliance for Human Rights and Human Needs. November 16, 2015. http://www.issuelab.org/resource/heroin_crisis_act_what_you_need_to_know_about_the_new_law_the

[32] The White House: The Office of the Press Secretary. "Fact Sheet: Obama Administration Announces Public and Private Sectors Efforts to Address Prescription Drug Abuse and Heroin Use". Accessed 4/26/16 https://www.whitehouse.gov/the-press-office/2015/10/21/fact-sheet-obama-administration-announces-public-and-private-sector

[33] Centers for Disease Control and Prevention (2016). Injury Prevention and Control: Opioid Overdose: CDC Guideline for Prescribing Opioids for Chronic Pain. http://www.cdc.gov/drugoverdose/prescribing/guideline.html.

[34] The White House: The Office of the Press Secretary.

[35] Substance Abuse and Mental Health Services Administration. "Final rule expanding access to medication-assisted treatment," July 11, 2016. http://blog.samhsa.gov/2016/07/11/final-rule-expanding-access-to-medication-assisted-treatment/#.V9bCDFsrJD8.

CURRENT EFFORTS

Despite the important work being done at the state and federal level, Chicago and Cook County still have a strong role to play in addressing heroin and other opioids.

Chicago

Mayor Emanuel is committed to curbing the opioid epidemic and protecting residents' health through every means available. The City of Chicago is implementing numerous interventions to address the issue.

- In 2016, the Chicago Department of Public Health (CDPH) is investing $1.75 million on prevention and treatment of substance use disorders, partnering with the Public Health Institute of Metropolitan Chicago to manage the investments. This investment represents an increase over the previous year.
- The City of Chicago reached an agreement with the drug company Pfizer in July 2016 to commit the company to strict standards for the marketing and promotion of prescription opioids.
- In 2015, CDPH educated healthcare providers by sending a letter on appropriate opioid prescribing practices to 11,000 physicians in the city.
- In 2014, the City of Chicago filed a lawsuit against five opioid manufacturers who misrepresented opioid benefits while minimizing health risks, leading to more addiction, overdoses, and deaths.
- CDPH annually participates in National Prevention Week and coordinates the Recovery Walk.
- CPD fights heroin trafficking through citywide policing efforts, including through the Narcotics Unit.
- CPD has drop-off boxes at all police stations where residents can deposit expired prescriptions and other drugs.
- CPD and HIDTA, in collaboration with the University of Chicago's Crime Lab and Health Lab, have begun implementing a diversion pilot program allowing some individuals involved in low-level narcotics offenses to access treatment in lieu of an arrest.
- In 2015, the Chicago Department of Family and Support Services (DFSS) conducted outreach missions to buildings suspected of housing unlicensed heroin treatment facilities where residents, many from Puerto Rico, were staying and receiving sub-standard care. The Department of Buildings inspected these facilities as well.
- DFSS invests in clinical treatment and wraparound services for residents who are homeless or formerly homeless. Many of these residents face substance use disorders, including opioid use disorder.
- The Chicago Fire Department (CFD) is armed with naloxone to reverse suspected overdoses. Seventy-five ambulances, 72 fire companies, and all eight paramedic field chiefs who are on duty 24/7 carry naloxone. CFD also maintains data on overdose Emergency Medical Services calls and transports in order to help the City assess hot spots and evaluate the overdose problem.
- Mayor Emanuel is planning to convene a Chicagoland summit to help develop a regional response to the opioid epidemic.

Cook County

Cook County government, for its part, undertakes a variety of efforts:

- Cook County Health and Hospitals System (CCHHS) delivers and continues to expand medication services in hospital and outpatient clinics to combat addiction.
- In 2012, CCHHS began the first hospital-based naloxone training program in Illinois.

- CCHHS and the Cook County Medical Examiner communicate on opioid overdoses so providers can adapt to emerging trends of drug use.
- In 2016 CCHHS has partnered with the Orland Police Department to help them administer naloxone as first responders.
- CCHHS has partnered with the Cermak Health Services, which operates in the Cook County Jail and Cook County Sheriff's Office, to enhance addiction services for detainees and to develop a naloxone distribution program for those with substance use disorder upon release.
- CCHHS is a partner with the Illinois Poison Center and the University of Illinois and has been monitoring opioid use patterns throughout the County and State since 1988 as the Toxikon Consortium.
- The Cook County State's Attorney's Office has implemented programs to divert justice-involved drug users to education and treatment services. Programs include Drug School, the Veterans Treatment Court, the Drug Deferred Prosecution Program, the Chicago Prostitution and Trafficking Intervention Court, and Drug Treatment Court. In 2015, over 2,500 drug users were diverted to services in lieu of traditional prosecution and sentencing.
- The Cook County Sheriff's Office is the fiduciary of the HIDTA under the White House's Office of National Drug Control Policy and allocates staffing and other resources to the program as part of a coordinated, multi-disciplinary approach to addressing drug trafficking.
- The Cook County Department of Corrections offers numerous mental health and drug treatment initiatives. These initiatives include treatment programs for men and women in custody, individualized discharge planning for those reentering their communities, operation of several community-based services for individuals who wish to continue treatment after incarceration, and contracting with community-based providers that offer alternatives to detainment for pregnant women and homeless individuals in need of mental health and drug treatment.
- The Sheriff's Court Services Department has a social service unit that assists residents who are in distress during the eviction process or other civil proceedings. This assistance includes making placements into treatment or alternative housing for residents in need.
- The Cook County Sheriff's Police Department (CCSPD) is the primary police agency for unincorporated Cook County and provides specialized support to other law enforcement agencies within the county. CCSPD has several units and initiatives focused on drug suppression and enforcement, provides Crisis Intervention Training (CIT) to its officers, and will be offering CIT training to police officers from agencies around Cook County.

These efforts provide a strong foundation for preventing and responding to opioid use disorder in our area. Yet given the magnitude of the task, more must be done. The Chicago-Cook Task Force on Heroin has examined several areas for enhanced efforts: (1) education of community members, (2) education of healthcare professionals, (3) data, (4) treatment, (5) trafficking, and (6) overdose reversal.

RECOMMENDATIONS: EDUCATION OF COMMUNITY MEMBERS

Residents of Chicago and suburban Cook County need quality information to do their part in fighting the heroin epidemic. Stigma, lack of information, and outright misinformation have served as obstacles in the effort to reduce addiction and overdoses. As mentioned, negative attitudes about drug addiction are worse than they are for mental illness. Many patients are unaware of how addictive opioids really are. And many residents either don't know where to go for treatment or are led astray by marketing that promotes inadequate treatment.[36] Data shows parents have a strong influence on their kids' substance use habits,[37] but many are unsure how best to help. The Illinois Heroin Crisis Act of 2015 does include provisions related to community education, including on educational materials for patients, informational signage at pharmacies, public awareness of medication drop-off points, education of drug court prosecutors and public defenders, and a school prevention program with educational materials. Nevertheless, work must also occur at a local level to ensure sufficient community education on opioids.

The Chicago-Cook Task Force on Heroin therefore makes the following recommendations:

1. Work with pharmacies to develop and disseminate information to patients about accessing naloxone, the risks of opioid use, and contacting a potential help line.
2. Create a county-wide public awareness campaign related to the prevention, treatment, and de-stigmatization of opioid addiction. Elements could include:
    a. Engaging community organizations, faith-based groups, and the general public on navigating the treatment process and on the benefits of medication-assisted treatment and naloxone.
    b. Utilizing digital ads and social media to combat online misinformation about opioids and directing patients to evidence-based services and naloxone providers.
    c. Increasing public knowledge of drop-off centers where excess or expired prescription medication can be disposed.
    d. Providing workshops to educate parents and caretakers of all ages on identifying and addressing opioid use, including on proper disposal of medication.
    e. Educating individuals with opioid use disorder on strategies for harm reduction and navigating the treatment process.
3. Create and implement an education program for criminal justice professionals to de-stigmatize medication-assisted treatment.
4. Review current prevention programs in Chicago and Cook County public schools and police departments to identify ways to expand social emotional learning and other evidence-based practices.

RECOMMENDATIONS: EDUCATION OF HEALTHCARE PROFESSIONALS

In recent decades, drug companies have deliberately misrepresented opioids' risks and benefits to induce doctors to give out more prescriptions. This effort has helped fuel the opioid epidemic by clouding physicians' understanding of the science.[38] In addition to the human cost of such deception, local governments have ended up spending large amounts of money through insurance claims and workers

[36] Testimony of Kathie Kane-Willis, Roosevelt University. Task Force on Heroin public meeting, February 26, 2016.
[37] See, for instance, Partnership for a Drug-Free America (2009). "Partnership Attitude Tracking Study. http://www.drugfree.org/wp-content/uploads/2011/04/Full-Report-FINAL-PATS-Teens-2008_updated.pdf.
[38] Quinones (2015).

compensation on public employees who are prescribed opioids. Between 2005 and 2015, the City of Chicago spent about $13.9 million on opioid prescriptions alone, not counting additional costs on things like doctors' visits, toxicology screens, and the ripple effects of overdose and addiction.[39] The CDC's research and recently-released prescribing guidelines clearly refute the drug companies' narrative. Physicians and other healthcare professionals must be educated on the CDC guidelines and be encouraged to follow them. Unfortunately, federal agencies have found that "most prescribers receive little training on the importance of appropriate prescribing and dispensing of prescription pain relievers, on how to recognize substance misuse and abuse in their patients, or on treating pain."[40] Education on pain tends to be limited in medical school as well.[41] However, there are options for educating providers. Prescribing guidelines, for instance, have been shown to be effective in cutting misuse and overdose deaths.[42]

The task force therefore recommends the following:

1. Develop and disseminate a toolkit for health care providers, prescribers, pharmacists, and first responders to use to communicate with patients about opioids and obtain a history of substance use disorder.
2. Promote the CDC guidelines on opioid prescribing to all clinicians in Cook County.
3. Create "Safe Prescribing" recognition for hospitals and clinics that utilize safe opioid prescribing practices.
4. Encourage hospitals, clinics, and physicians to use the Illinois Prescription Drug Monitoring Program (PDMP) and to connect PDMP data to electronic health records; work with vendors to develop tools that seamlessly integrate such data.
   ➔ This effort would complement pilot initiatives the Illinois Department of Human Services will be undertaking with hospitals to link the PDMP to electronic health records.
5. Encourage pharmacies to train staff to be able to provide naloxone without a prescription.

RECOMMENDATIONS: DATA

Good data is the basis for understanding the heroin epidemic on a wide scale—and knowing whether efforts to fight it are working. Government institutions in Chicago and suburban Cook County can do more to generate and mutually share the data needed to make sound policy decisions. Such efforts would also allow government agencies to report trends to the public and create an early warning system to help providers and law enforcement officials respond to the epidemic in targeted, effective ways.

The task force therefore recommends the following:

1. Create a working group of stakeholders to share data and recommend improved methods of data collection and dissemination across departments and organizations.
2. Encourage the data working group to capture and evaluate data from a variety of City and County sources to identify any gaps in current emergency and pre-emptive naloxone deployment

[39] City of Chicago (2015), Second Amended Complaint, United States District Court for the Northern District of Illinois, Eastern Division. Case No. 14-cv-04361.
[40] U.S. Government Accountability Office (2011). "Prescription Pain Reliever Abuse." GAO-12-115. http://www.gao.gov/assets/590/587301.pdf.
[41] Mezei, L and Murinson, BB (2011). "Pain Education in North American Medical Schools," Journal of Pain.
[42] National Safety Council (2015). Prescription Drug Community Action Kit: Engaging the Medical Community. http://www.nsc.org/RxDrugOverdoseDocuments/Rx%20community%20action%20kit%202015/CAK-Engaging-Medical-Community.pdf.

protocols and strategy, and recommend locations where naloxone should be placed and distributed.
3. Ensure more middle and high schools in Chicago participate regularly in the Illinois Youth Survey and ensure the survey contains sufficient questions on opioid use.
4. Identify treatment deserts in Chicago to help assure that new resources are allocated in communities with the greatest need.

RECOMMENDATIONS: TREATMENT

Opioid use disorder is a medical condition. The evidence is clear that effective treatments are available to help patients reduce or eliminate their drug use and be less likely to overdose. Methadone has been shown to be more effective than drug-free approaches at keeping patients in treatment and reducing criminal activity and deaths.[43] Buprenorphine has also proved to be an effective treatment,[44] and because it is less tightly regulated at the federal level, more opportunities exist for expanding use of this medication to a variety of settings. Yet more must be done to coordinate among treatment providers while improving and expanding the services available in the Chicago area—especially in treatment deserts, where more people need help than can readily access it. Some individuals have been sent to unlicensed and substandard Chicago facilities based on false promises of quality treatment.[45] There should also be improved support for residents leaving incarceration, as research shows coordination for this group can lead to better health, fewer emergency department visits, and lower recidivism.[46]

The task force therefore recommends the following:

1. Create a coordinated intake and referral line to help individuals, primary care facilities, and emergency departments navigate the system of treatment providers and match patients to the appropriate level of addiction treatment services within their insurance network.
2. Ensure pharmacies and/or drug companies create additional drop-off centers across Chicago and Cook County for expired and unused medication.
3. Increase funding for access to medication-assisted treatment in Chicago, particularly in neighborhoods where the need for services exceeds the availability of services.
4. Provide technical assistance to health centers in Chicago to create, expand, and/or enhance medication-assisted treatment programs, including centers that recently received a HRSA grant for implementing such programs.
5. Incorporate the CDC guidelines on opioid prescribing into the employee benefits of the City of Chicago, Cook County, and sister agencies.

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[43] Breen, C, et al (2009). "Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence," the Cochrane Collaboration.

[44] See, for instance, Ling W, et al. "Buprenorphine maintenance treatment of opiate dependence: a multicenter, randomized clinical trial." Addiction 1998; 93:475-86. Johnson RE, et al. "A controlled trial of buprenorphine treatment for opioid dependence." JAMA 1992; 267:2750-5. Johnson RE, et al. "A placebo controlled clinical trial of buprenorphine as a treatment for opioid dependence. Drug Alcohol Depend 1995; 40:17-25." Racich, DW, et al. "Opioid Dependence Treatment, Including Buprenorphine/Naloxone," Annals of Pharmacotherapy, 2002 Feb; 36(2):312-21.

[45] Cardona-Maguidad, Adriana (2015). "Puerto Rico exports its drug addicts to Chicago," WBEZ report. https://www.wbez.org/shows/wbez-news/puerto-rico-exports-its-drug-addicts-to-chicago/ee2c2bc5-8410-4dfa-b2fd-5a5f4aa119ee.

[46] Held, M. L., et al. "Integrated Primary and Behavioral Health Care in Patient-Centered Medical Homes for Jail Releases with Mental Illness." Criminal Justice and Behavior 39, no. 4 (2012): 533-551. See also Wang, E. et al. "Engaging Individuals Recently Released from Prison into Primary Care: a Randomized Trial." American Journal of Public Health. 102, no 9 (2012): e22-9.

6. Foster collaboration between Cook County and community providers to develop and implement a seamless system of transitional care post-detention and post-incarceration by connecting patients with long-term services.
7. Conduct regular outreach missions to locations in Chicago where individuals are housed in unlicensed, sub-standard treatment programs; inspect the buildings and connect the individuals to adequate shelter and appropriate services when feasible; frequently update the list of locations.
8. Advocate for Medicaid coverage for certified recovery support specialists; encourage the state to create a licensure for them and encourage an active network of recovery coaches to model successful long-term treatment.
   ➔ People with arrests and criminal convictions related to substance use should be eligible for such a license.
9. Advocate for the federal Medicaid Coverage for Addiction Recovery Expansion Act (S.2605), which would let states expand access to care by having Medicaid cover facilities with more than 16 beds.
10. Advocate for Medicaid coverage of treatment services for patients in pre-trial detention.
11. Advocate at the federal level to ease restrictions on methadone to allow expanded prescribing.
12. Advocate at the federal level to further ease restrictions on physicians prescribing buprenorphine.
13. Advocate for significantly increased funding of the federal Comprehensive Addiction and Recovery Act (CARA) to expand treatment capacity and other measures to fight the opioid crisis.

RECOMMENDATIONS: TRAFFICKING

Reducing the supply of heroin is critical to keeping down use. Heroin dealers have been finding new ways to get their product into residents' hands, and law enforcement agencies must meet these efforts with effective means of disrupting the supply chain. Yet traditional criminal justice strategies are not enough. Addiction is a public health issue, and law enforcement has an opportunity to collaborate with the health community to ensure a coordinated approach to reducing heroin use and overdose deaths.

The task force therefore recommends the following:

1. Encourage law enforcement representatives to regularly update service providers on trafficking patterns and market trends in order to prepare for future upticks in drug usage or the introduction of new drugs.
2. Expand CPD and HIDTA's diversion pilot program allowing some individuals involved in low-level narcotics offenses to access treatment in lieu of an arrest.
3. Develop innovative anti-trafficking prosecution strategies in partnership with federal and state prosecutors.

RECOMMENDATIONS: OVERDOSE REVERSAL

Naloxone is a lifesaving medication that serves as an antidote to opioid overdoses. Also known by the brand name Narcan, this medication must be more available to prevent overdose deaths. Research is clear that training laypeople in administering naloxone is effective.[47] Moreover, supplying the medication to opioid users and those at high risk for overdose—including those leaving incarceration, emergency departments, and detox—can save lives.[48] While Illinois is making great strides in expanding naloxone availability through the 2015 Heroin Crisis Act, numerous actions can be taken locally to increase use of the medication.

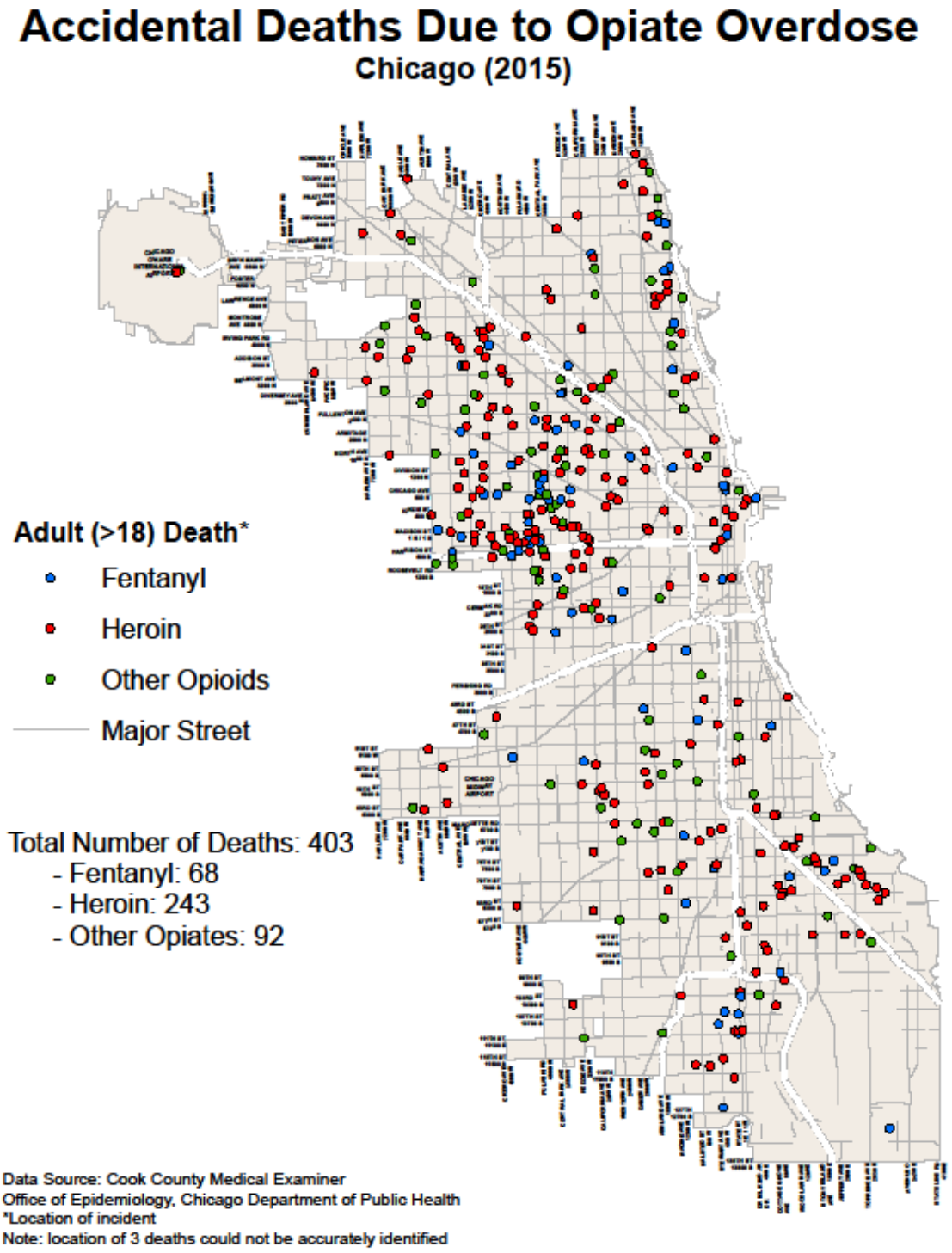
The task force therefore recommends the following:

1. Expand naloxone deployment to entire CFD fleet, ensuring that all Basic Life Support (BLS) vehicles and command vehicles, in addition to the existing Advanced Life Support (ALS) vehicles, will have naloxone available.
2. Facilitate widespread access to affordable naloxone by encouraging pharmaceutical companies to lower the cost of their products, identify new forms of funding to purchase additional supplies, and increase purchasing power by combining government purchase of naloxone across the county.
3. Provide naloxone upon release from jail, medical detox, treatment programs for substance disorder, and other settings where patients are likely to have decreased opioid tolerance and be vulnerable to overdose.
4. Encourage treatment providers that receive City or County funding to provide naloxone to patients upon release from treatment programs for substance use disorder.
5. Review current regulatory obstacles to prescribing naloxone and training patients on how to use it; advocate for any needed streamlining to simplify the process for physicians.
6. Provide information to all City of Chicago and Cook County employees about opportunities to receive off-duty naloxone deployment training and how to recognize signs of an overdose.
7. Ensure all drug education programs to which the Cook County Circuit Court refers a defendant include a naloxone education component.

[47] Green, T, et al (2008). "Distinguishing signs of opioid overdose and indication for naloxone." Addiction. 103(6): 979-989. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3163671/.

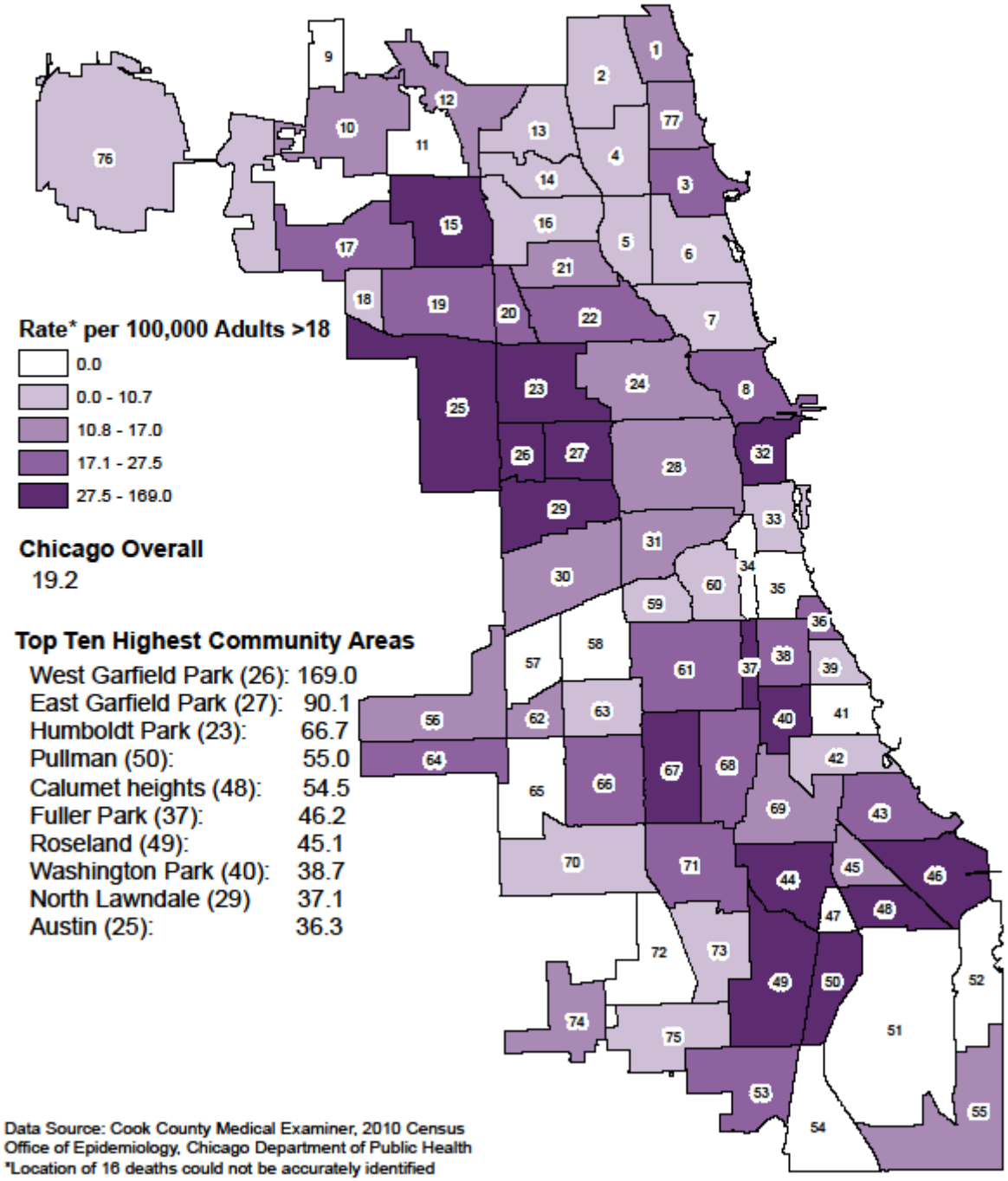
[48] See, for instance, the following: Bohnert, A, et al (2012). "Characteristics of drug users who witness many overdoses: Implications for overdose prevention." Drug and Alcohol Dependence. 120(1-3): 168-173. Wheeler, E, et al (2015). "Opioid Overdose Prevention Programs Providing Naloxone to Laypersons—United States, 2014. Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report. 64(23); 631-635. Binswanger, I, et al (2012). "Return to drug use and overdose after release from prison: a qualitative study of risk and protective factors." Addiction Science & Clinical Practice. 7(1): 3. Wakeman, S, et al (2009). "Preventing Death Among the Recently Incarcerated: An Argument for Naloxone Prescription Before Release." Journal of Addictive Diseases. 28(2): 124-129.

APPENDIX I: CHICAGO OPIOID OVERDOSE MAPS



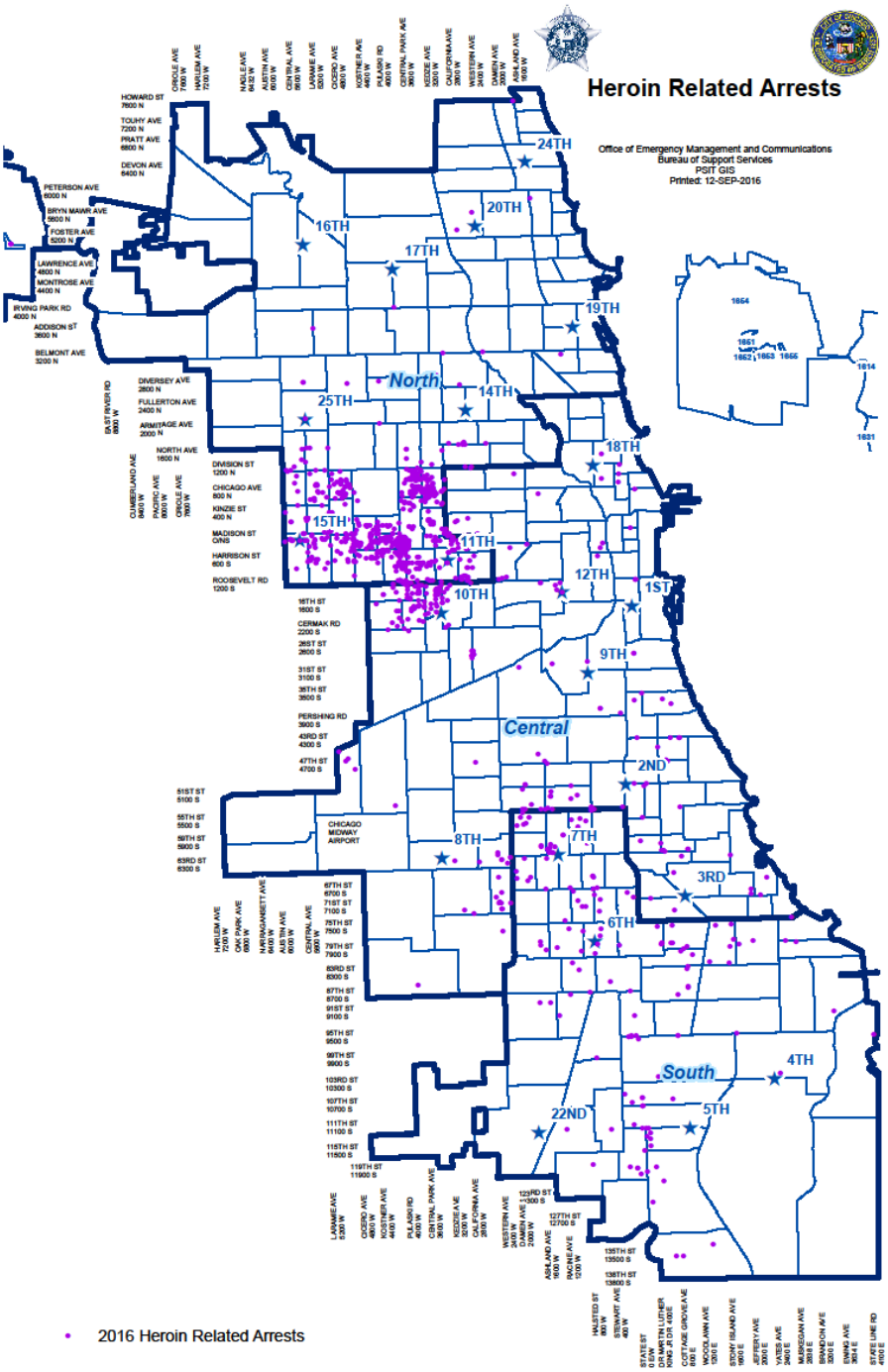
Accidental Death Rate Due to Opiate Overdose

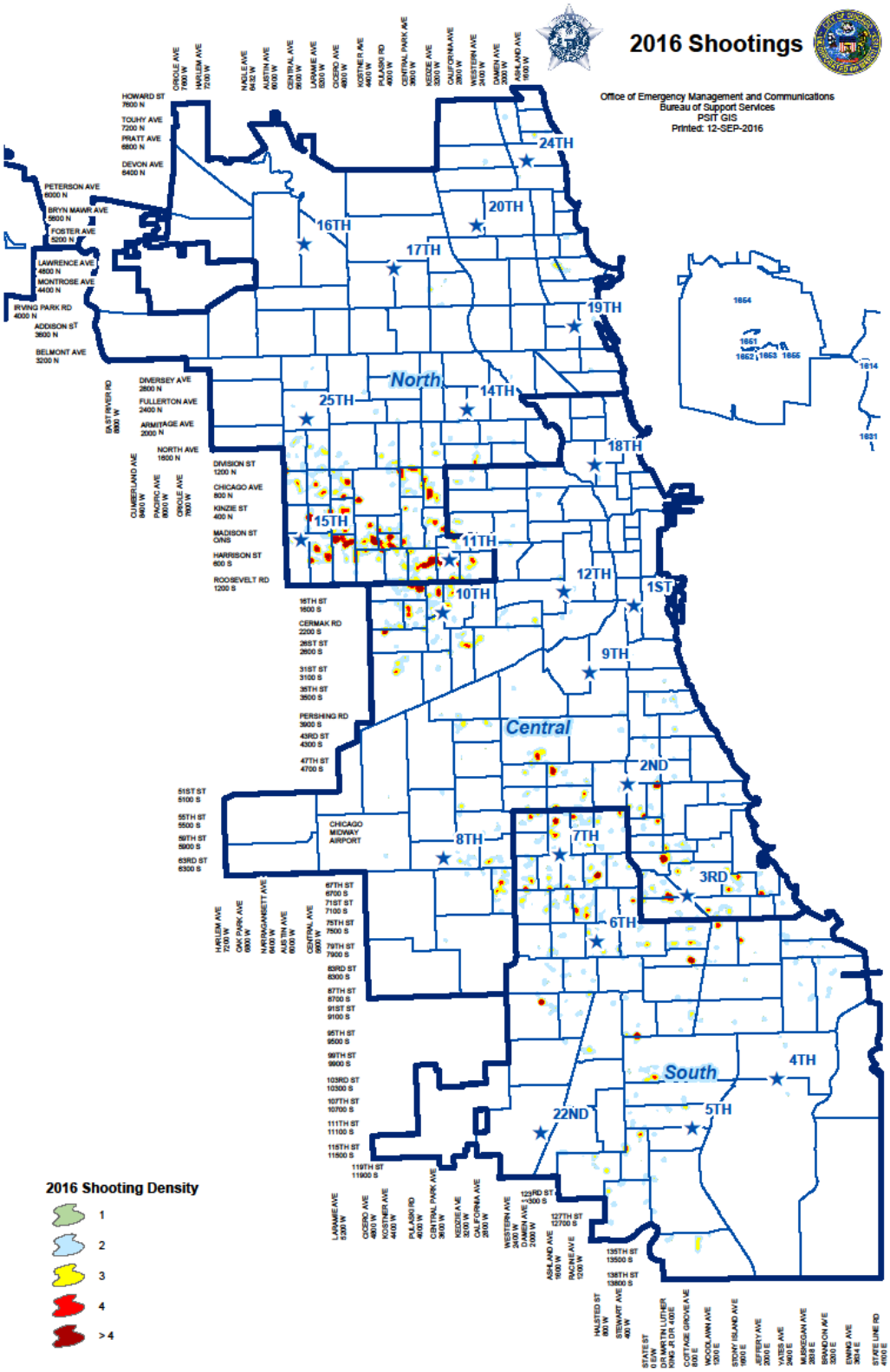
Community Area, Chicago (2015)



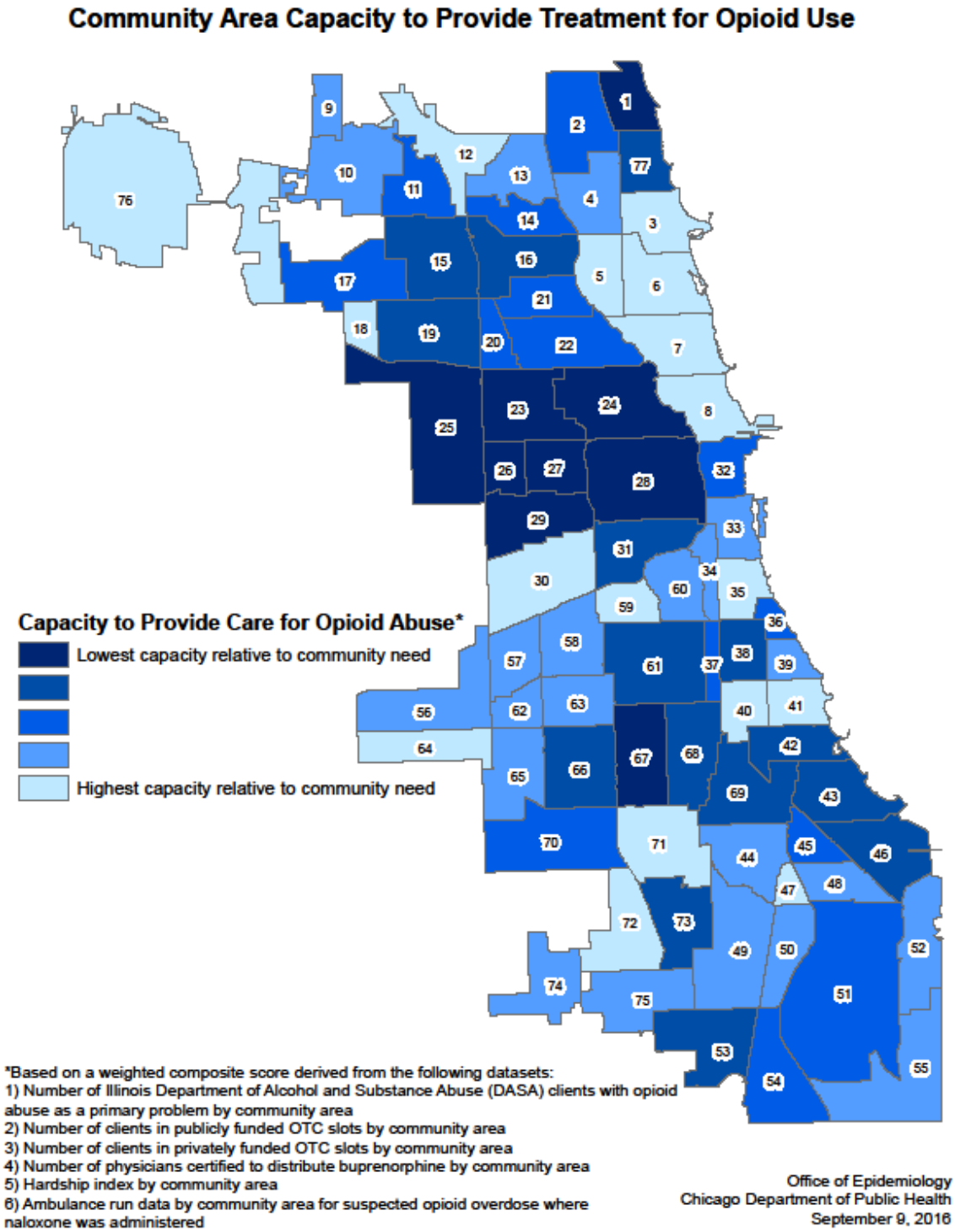
Data Source: Cook County Medical Examiner, 2010 Census
Office of Epidemiology, Chicago Department of Public Health
*Location of 16 deaths could not be accurately identified

APPENDIX II: MAPS OF HEROIN AND SHOOTING IN CHICAGO (1/1 to 9/11, 2016)




2016 Shootings
Office of Emergency Management and Communications
Bureau of Support Services
PSIT GIS
Printed: 12-SEP-2016
North
Central
South
24TH
20TH
16TH
17TH
19TH
25TH
14TH
18TH
15TH
11TH
12TH
1ST
10TH
9TH
2ND
8TH
7TH
3RD
6TH
4TH
22ND
5TH
CHICAGO MIDWAY AIRPORT
2016 Shooting Density
1
2
3
4
>4

APPENDIX III: HIGH-NEED AREAS IN CHICAGO



APPENDIX IV: COOK COUNTY OPIOID OVERDOSE MAP