THE JUNE 2017 RICARES REPORT TO THE COMMUNITY GAVE AN OVERVIEW OF THE EVENTS LEADING, AND ACTIONS TAKEN, TO ADDRESS THE ACCIDENTAL OPIOID OVERDOSE DEATH EPIDEMIC IN OUR STATE. THIS SECOND REPORT WILL LIST SOME NEW ACTIONS TAKEN BY THE GOVERNOR'S OVERDOSE PREVENTION AND INTERVENTION TASK FORCE. WE WILL STATE OUR PERSPECTIVE OF SOME PROBLEMATIC ASPECTS OF THE PRESENT TREATMENT LANDSCAPE.

RICARES REPORT TO THE COMMUNITY

PART II

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RICARES Report to the Community
Part II
November 2017

The present opioid overdose epidemic is the result of an infection that has been allowed to fester in our social fabric for too many years. We feel it every day.
We continue to be moved and inspired by the family members of victims who have decided to speak out and fight back. They are reaching out to each other to form support groups. They are speaking in public about the sons, daughters, sisters and brothers that they have lost. William White writes, "Through their stories, they are debunking the myth that only bad people from bad families die of drugs. They are saying to their lost loved one, 'We will not let stigma and shame silence the speaking of your name; we will honor what you meant to us and turn our grief into something of great value to others.' "**(1)**
We must strive to match their courage and their resolve. There are few of us that have not been affected. We must continue to work together.

We believe that our present task is to continue to actively focus on mitigating the effects of our state's opioid infection. At the same time, we must continue to discuss, plan and work together about how to address our state's addiction epidemic issue and to address the societal issues that prolong and intensify it. The devastating effects of the addiction epidemic on the people of our state continue to among the most severe in the nation.

The June 2017 *RICARES Report to the Community* gave an overview of the events leading, and actions taken, to address the accidental opioid overdose death epidemic in our state.
This second report will list some new actions taken by the Governor's Overdose Prevention and Intervention Task Force (GTF).
We will state our perspective of some problematic aspects of the present treatment landscape.
We will urge the GTF to rapidly add to and enhance the existing harm reduction efforts and will list a range of specific recommendations.

Some of the actions that have been taken to date:

- Aggressive and ongoing Naloxone training and kit distribution (including a collaborative practice agreement with many, but not all, pharmacies)
- RI is a national leader in the establishment of Public Naloxone Boxes
- Good Samaritan legislation (initial and enhanced)
- Additional Prescription Drug Monitoring Program rules from the Department of Health
- A long term Methadone Maintenance Treatment program in the Department of Corrections that also includes induction prior to release
- New Department of Health guidelines for opioid prescribing
- Regular medication take-back days and the existence of medication disposal lockboxes in virtually every police station in the state
- Attempts to increase access to medication assisted treatment
- Targeted overdose education
- Recovery Coaches in every hospital emergency department in the state
- Recommendations for additional substance-use specific education across the continuum of medical education
- At least one academic detailing study related to Naloxone
- A privately funded DOH public awareness campaign
- An outreach initiative
- On-going establishment of Centers of Excellence
- Legislation that authorized licensed chemical dependency professionals to perform auricular acudetox in their practice (in accordance with the protocol established by the National Acupuncture Detoxification Association)

Some of what has happened since the RICARES June Report to the Community:

In July, the Governor issued an Executive Order (17-07) *"Taking Further Actions to Address the Opioid Crisis."* The order enhanced the four existing Task Force strategies. For example:

- **Prevention**: established a Family Task Force
- **Rescue**: encouraged all the hospitals to adopt best practice Levels of Care for the treatment of overdoses and opioid use disorder; required

DOH and BHDDH to propose a "comprehensive harm reduction strategy"

- **Treatment**: encouraged all local law enforcement to implement pre-arrest diversion programs (one has been implemented in West Warwick)
- **Recovery**: worked to expand access to alcohol and drug free residences (i.e., Recovery Housing)

Other positive developments include:

- The dashboard at PreventOverdoseRI.org (PORI) continues to be an updated and valuable information resource
- Thanks to the relentless effort and leadership of Michelle McKenzie of PONI and her teams since 2015, over 14,000 Naloxone kits have been distributed in every RI community except Portsmouth (PORI)
- The implementation of Community Overdose Engagement (CODE) alerts and community informational meetings (as indicated in response to public health advisories of a concentration of overdose activity in a specific area)
- Private insurers were requiring prior authorization for MAT; an effort lead by community advocates such as Sue Jacobsen from Thundermist resulted in a reversal of that policy
- Brandon Marshall, PhD, is currently leading a study in which he and his team have asked 90 participants to test their drugs for the presence of fentanyl, using special test strips, and to report back their findings.
- The number of patients on Methadone continues to steadily rise: in January there were 5368, in September there were 5491
- The number of patients receiving Buprenorphine has increased slightly: in January there were 4442, in September there were 4577

  > However, there are no waivered physicians in roughly half the state (PORI). Medical epidemiologist Jay Unick of the University of Maryland said, "Any physician in this country can prescribe oxycodone in high doses, but they can't prescribe buprenorphine unless they have special training…You just don't have easy access to buprenorphine. And that's crazy in a world flooded with opioids." **(2)**

  This prompts the question, "Does that mean that it is easier to get Fentanyl than Buprenorphine?"

This breadth, depth and diversity of initiatives should not be underestimated. Our state has been bold and innovative in the consideration and implementation of strategies to attempt to minimize the morbidity and mortality associated with opioid misuse and addiction. A prime example is the expansion of Medication Assisted Treatment, including selected pre-release induction, in the Department of Corrections. This action can only have a positive effect.

What is the present situation?

The stated main goal of the Governor's Task Force is "Decrease the number of Overdose Deaths" (PORI).
In 2016, 336 friends and family members died.
In the first half of 2017, 172 of our friends and family members have died (PORI). The mortality rate is increasing.

It is clear to us that the strategies of the GTF continue to be comprehensive and consistent with the appropriate public health approach to the epidemic, and that our state continues to be among the nations' leaders in our response to the epidemic.
But the mortality rate is increasing.

It is clear to us that the leadership of the GTF continues to be informed, committed, and willing to innovate. The members and stakeholders of the GTF continue to be collaborative, involved, and concerned.
But our friends and family members continue to die at an increasing rate.
It is frustrating and heartbreaking.

WHY?

We don't have the definitive answer –the etiology of the long-standing addiction epidemic is multi-variable and very complex. We are now experiencing another acute and painful symptom of that epidemic.
The epidemic has been almost two decades in the making and will probably not end quickly enough for any of us.
Perhaps one factor is what drug policy experts call the 'balloon effect.' When a drug's supply is limited, users and traffickers don't give up - they find other ways. It's like pushing down on a half-inflated balloon; the air doesn't vanish, but instead moves to another part of the balloon.
The result of the (appropriate and necessary) crackdown on prescription

opioids resulted in increased use of cheaper and more easily obtained heroin. Soon thereafter the availability of Fentanyl and its analogues (much cheaper than heroin to produce) rapidly expanded to dominate the illicit opioid drug supply. Fentanyl analogues such as U-47700 ('pink') can be ordered on line (on the dark web) for as little as $40/gram (CNN.com, Nov. 2016), or made at home with easily obtained ingredients (WSJ.com, Oct.2016). In addition, such street-designed drugs as Krokodile (an injectable mess of codeine, iodine and solvents such as gasoline or hydrochloric acid – it is cheaper than heroin) and 'grey death' (a mix of several opioids e.g., heroin, fentanyl, carfentanyl, that has the appearance of concrete mix) are just two examples of many available drugs in which the ingredients and concentrations are unknown. The result is that the illicit drug supply is more deadly than ever.

Another factor may be that the on-going supply interdiction efforts appear to be ineffective (if the actual goal of interdiction is to limit supply and thus increase cost to a prohibitive level).

A third factor may be that demand does not appear to have diminished – the steady state of demand is a vexing and difficult issue to address. Rhode Island is part of the national $60 billion drug market. **(3)**

Another major factor is that our state's high concentration of the social determinants that are associated with addiction prevalence has lead to Rhode Island having the highest national rate of deaths from alcohol, drugs and suicide for adults ages 25-34, from 2011-2015. **(4)**

Our Treatment Perspective:

During her remarks at the signing of the executive order, the Governor stated the intention that "all roads lead to treatment." In a recent interview, Dr. Alexander Scott stated that, "...our focus and approach is treatment [to promote] living a life of recovery" (ConvergenceRI, October 2017).

"All roads lead to treatment" is a more effective and appropriate route than the historically ineffective and dead-end roads that lead to the criminal justice system.

These are some of the issues that we believe are important to consider as we continue to rely (appropriately and necessarily) on the Treatment strategy.

WOMEN AND TREATMENT

(This is an excerpt from the RICARES June Report to the Community):
"*The White Paper: Opioid Use, Misuse, and Overdose in Women released in 2016 from the DHHS Office on Women's Health notes the significantly different biological pathways and social pathways to opioid use disorder (and all substance use disorders) for women.*
A 2011 study by Traci Green, PhD states that, "Often, women who abuse prescription painkillers may have a history of physical, emotional or sexual trauma. Biologically, people who experience a traumatic event respond to pain differently. They are 'rewired' by that traumatic experience, they may feel pain very differently, and require different prescribing approaches."

In addition, we know that recovery for women is qualitatively different than for men.
Our impression is that the prevention, treatment and recovery continuum continues to minimize the unique experience of women in favor of a one-size fits all approach. We believe that this is a major contributor to the on-going generational cycle of addiction.
We recommend that the Governor's Task Force develop an additional element that focuses on primary prevention, treatment and recovery for women.
We are not aware of any response to the reference to women in Dr. Green's 2011 study **(5)** or to the preceding statement.

There is no cohort with substance use disorders whose condition is more severe and complex than women with Opioid Use Disorder.

If we want to assure the continued intergenerational cycle of addiction, we should continue to use the same treatment model for women as for men.

If we want to assure the continued cycle of intergenerational trauma, we should continue to use the same treatment model for women as for men.

Traci Green has noted the 'feminization of the opioid crisis' (at Rhode Island College Forum, October 2017).
We know that the addiction trajectory for women is different than for men, biologically, psychologically and socially.
Some examples:

- 1999 – 2010: Overdose death rates from prescribed opioids increased by 400% for women v. 237% for men
- 2002-2013: Heroin use rate increased 100% for women v. 50% for men
- 2010 – 2014: New cases of Hepatitis C in women increased more than 260% (with the increased risk of perinatal transmission)
- Women become physically dependent on opioid pain medications more quickly than men ('telescoping' - the progression of time from first use to physical dependence) and tend to need smaller amounts of drugs in that shorter time to become dependent
- Women may be more sensitive to cravings than men (indicated in studies with cocaine, cigarettes and opioids)

- and -

- Psychological and emotional distress are risk factors for hazardous prescription opioid use for women, but not for men
- Women are more likely to be introduced to hazardous use by a partner; men by a peer
- Psychological and emotional distress are risk factors for opioid nonmedical use for women, but not for men
- Drug misuse following PTSD from trauma is more common in women than in men
- The lifetime trauma history of women who misuse substances is 55%-99% -versus- 36% - 51% of women in the general population
- Women are more likely then men to have co-occurring disorders (the most common are a substance use disorder with anxiety disorders or depression **[all cites from (6)]**

Note: A disturbing trend is noted in the current PORI data graph titled, "About 3 in 4 people who die of an overdose are men." From 2014 – 2016, 71% of the fatalities were men and 29% were women. For first half of 2017, the fatality ratio is 59% men and 41% women: a significant 12% increase for women.

We again ask the Governor's Task Force to facilitate the development of an additional strategy that focuses on primary prevention, on treatment, and on recovery for women.

Addiction recovery is also different for women than for men - and by 'different' we mean more difficult and more complex. As Dr. Green noted in her 2011 study, from a neuropsychological point of view, women are very vulnerable in the early stages of recovery. Women in

recovery from opioid use disorder also tend to have to deal with a wider range of physical co-morbidities and co-occurring mental health conditions, lack of a high school diploma, and lack of income (2011 TEDS). In other words, most women with opioid use disorder enter recovery with higher personal vulnerability, including a history of trauma that must be addressed at some point, and with lower recovery capital.

TREATMENT IS NOT EMBRACED

- Only about 10 percent of people with a substance use disorder receive any type of specialty treatment. Over 40 percent of people with a substance use disorder also have a mental health condition, yet fewer than half (48%) receive treatment for either disorder. **(7)**
- 73 % of the people who meet criteria for needing treatment for drugs perceive no need for treatment. **(8)**

AS EFFECTIVE AS IT IS, MAT IS NOT ALWAYS EFFECTIVE

- Methadone, often referred to as the 'gold standard' of opioid use disorder treatment, has clearly been shown to reduce the major risks associated with untreated opioid dependence in patients who are willing to undergo and are successfully retained in treatment. However, between 15% to 25% (New England Journal of Medicine, August 2009) and up to 40% **(9)** of the most adversely affected patients do not have a good response to this treatment. Such persons are either not retained in methadone maintenance treatment for very long or continue to use illicit opioids while in treatment.
- Due to the restrictions on providers and the nature of Methadone Maintenance Treatment (MMT) delivery, recovery for patients in MMT is often a challenge and cannot be assumed. For example, patients must daily go to the clinic to receive their medication in the early morning. No treatment for any other chronic medical condition requires this level of commitment, stamina and personal difficulty.

- Many patients simply want to “dose and go.” This choice must be honored. However, our lived experience is that the removal of immediate negative consequences, with no ancillary services, is necessary, but not sufficient, for successful recovery.
- Well educated, well trained, caring, committed, and hard working experienced professionals staff the Opioid Treatment Programs (OTP) in the state. They work in a modality subject to extraordinary oversight. One Executive Director estimated that between BHDDH and Department of Health regulations, Drug Enforcement Agency regulations, federal confidentiality requirements such as 42CFR and HIPAA, mandatory national accreditation standards, various corporate compliance standards, etc., the OTP’s have to be aware of and comply with over 4000 regulations and standards.

This prompts the question: to what extent is this load of oversight a barrier to optimal treatment delivery?

Traumatic Brain Injury and Substance Use Disorder Treatment

At a recent RICARES interview, staff at a residential treatment program stated that that they are feeling “outgunned.” **(10)** Specifically, they feel that they are seeing multiple patients with obvious cognitive deficiencies that are a barrier to maximizing the benefits of treatment at best, and are a cause of the inability to absorb and retain treatment knowledge and insights at worst. Based on the history that patients give, staff believes that a significant number of these patients are suffering from undiagnosed and untreated traumatic brain injuries, and that the existing assessment protocol does not have the capacity to identify the condition. This real possibility is consistent with the experience of people in recovery who during their addiction careers were commonly in car accidents, fights, passing out and hitting the ground, beatings while incarcerated, etc. The staff feels that this condition is especially prevalent in patients with serial treatment episodes (very common in methadone maintenance treatment), with patients who are referred from the criminal justice system, and with patients who are opioid overdose survivors.

There is no evidence that MAT staff conducting assessments have been trained to recognize signs of potential TBI/CTE symptoms. There is little evidence that patients with serial treatment episodes are screened for

potential cognitive deficits that contribute to an inability to complete treatment, or to sustain recovery.
Rhode Island has no mental health programs (or specialized addiction programs) offering specialized services for traumatic brain injury. **(11)** This situation exists despite the long-standing existence in Rhode Island of a neuropsychological questionnaire/clinical interview protocol and of developed practical neurological rehabilitation strategies for treatment planning for persons with behavioral healthcare conditions.

A Major Barrier: In Rhode Island we Kick Patients out of Addiction Treatment

In Rhode Island, as is the case nationally, patients get thrown out of addiction treatment. The treatment termination is often called 'administrative discharge,' a practice that has a long history in addiction treatment (but is relatively unknown in the treatment of any other medical condition). It is the adversarial termination of services due to a patient's failure to comply with program rules and expectations. The BHDDH Licensing Regulations sanction this practice in three different sections:

- "…being asked to leave a program or service for not fulfilling the responsibilities of such program or service" (Section 15.3.7, A.)
- for "…not participating adequately in a particular service or program…" (Section 28.4)
- for 'involuntary withdrawal of treatment." (Section 45.17; 'treatment' refers to opioid replacement medication)

The primary reasons that patients are administratively discharged are they either they confirm their diagnosis (continued alcohol/other drug use) or they violate rules that often have little nexus to addiction recovery. It is clear to us that abstinence and the ability to follow rules (not a strength or priority of people with active addictions) are excellent treatment goals, but should <u>not</u> be a prerequisite for treatment.
These are some of the problems with the administrative discharge process:

- Ignores our knowledge that chronic exposure to opioids results in structural and functional changes in regions of the brain that mediate affect, impulse, reward, and motivation. **(12)**
- The Methadone Maintenance Treatment level of care typically

treats patient with the most severe, complex and chronic conditions. These conditions include co-occurring mental health disorders, other co-morbidities (e.g. Hepatitis C), a wide range of problematic social determinants, and the least amount of recovery capital.

- Those who are struggling with treatment, for multiple reasons related to their personal history and the consequences of their addiction trajectories, are the most medically compromised patients
- Flows from the historical substance use disorder treatment model that requires patients to fit the treatment program rather than the program fitting the patient (otherwise the patient is considered 'not ready' for treatment)
- Puts the blame for treatment failure on the patient; not on the treatment technologies, not on a clinician's problems in implementing the technology, not on a failure to meet the patient's needs - but on the sick patient
- Pretty much guarantees that when patients are rapidly detoxed and thrown out of treatment they will simply return to the drug subculture. Return to drug use increases the possibility of incarceration. While longer treatment retention is associated with a greater likelihood of abstinence, incarceration is negatively related to subsequent abstinence. **(13)**

WHAT DOES THIS MEAN?

- From 2006 - 2014 the national 'terminated by facility'[1] rate was 7.0% **(14)**
- In Rhode Island from 2006-2014: 14.35% of patients were administratively discharged. For this time period, Rhode Island had the third highest 'terminated by facility' rate in the nation (all treatment modalities). **(14)**
- By service, the highest national rates of 'administrative discharge' are in Opioid Replacement Therapy (30.7%), long-term residential (24.8%), and Out Patient (23.7%) [2002 TEDS]
- Presently 5491 patients are receiving Methadone Maintenance Treatment in the state [2] (PORI, September 2017).
- A recent representative sample of RI Opioid Treatment Programs shows that the gender patient ratio is consistently around 60% men and 40% women.
- Patients aged 18-29 are the highest risk age group for administrative discharge (2011 TEDS)
- Socioeconomically, the highest risk groups are those with no high school diploma and no income (2011 TEDS)

This prompts at least two questions:

How many patients with undiagnosed and untreated traumatic brain injuries are being kicked out of treatment for failure to 'participate adequately' in treatment?

How many patients with co-occurring mental health disorders are being kicked out of treatment for failure to 'participate adequately' in treatment?

[1] Defined in TEDS-D as: "Treatment terminated by action of facility, generally because of client non-compliance or violation of rules, laws, or procedures (not because client dropped out of treatment, client incarcerated, or other client motivated reason)." In Rhode Island, we call this 'administrative discharge."

[2] In one RI OTP from 2011-2016 the admin discharge range was 5% - 24%; in another RI OTP for 2016 the admin discharge rate was 17%

Additional Intervention Strategies (aka 'harm reduction')

The Governor's Task Force has clearly identified the generally accepted three broad areas of initiatives to decrease fatal opioid overdose: primary prevention; increasing access to effective treatment; and harm reduction strategies **(15).**

However, the effect of the introduction of fentanyl and its analogues into the illicit drug market and the resulting increase in opioid overdose deaths highlights the immediate need for additional innovative intervention strategies to enhance the current efforts.

There is no universally accepted definition of harm reduction; thus, there is significant misunderstanding and confusion around the term. We propose using two concepts to guide us.

"The broad purpose of preventive measures should be to prevent or reduce the severity of problems associated with the non-medical use of dependence-producing drugs. This goal is at once broader, more specific, and with respect to certain drugs in many countries, more realistic than the prevention of-non-medical use *per se*." **(16)**

–and-

"Harm reduction refers to interventions aimed at reducing the negative effects of health behaviors without necessarily extinguishing the problematic health behaviors completely." **(17)**

Supervised consumption sites: a successful strategy in many countries and being seriously considered nationally in California, Maryland, Vermont, Massachusetts, and in the cities of Ithaca and Seattle. Experts from the Governor's Task Force have also cited its potential. **(18)**

Successful supervised consumption facilities include the presence of, but not forcing of, treatment exposure and related resources. We urge the GTF to develop supervised consumption sites in the state.

Additional substance-related strategies: include other drugs as possible substitutes for the opiate/opioid agonists. (*As previously noted, 15% to 40% of the most adversely affected persons do not have a good response to this treatment. Typically, their treatment is terminated or they continue to use other substances while in treatment*).

Alternative treatment-related substances used and/or proposed internationally include:

- Treatment with Diacetylmorphine, (i.e., Heroin Assisted Treatment) (used in at least 7 countries and presently being considered in Maryland, Nevada and New Mexico)
- Treatment with Hydromorphone (Dilaudid)
- Treatment with Cannabis
- Ibogaine Detoxification
- Treatment with slow-release morphine or codeine as an opioid substitution

All these variations of medication-assisted treatment for opioid use disorder have been used or tested and results are in the literature. We urge the GTF to consider the implementation of any or all treatments via a pilot program(s).

Naloxone: the education and distribution effort has been very successful. A possible enhancement could be the adoption of the program of the Chicago Recovery Alliance that distributed Naloxone through a mobile van-based harm reduction program.

Decriminalization: The long time position of harm reduction advocates is that the criminalization of drug use and possession creates more harm than the harm it seeks to prevent. Repressive drug laws and policies perpetuate stigma, risky forms of drug use, and negative health and social consequences, not only for drug users but for the wider community as well. Harm reduction efforts are hampered by the existence of criminal laws.
In 2012, the UN Commission on HIV and the Law called for the decriminalization of drug use, needles and the personal possession of drugs. Also, in 2012, the Global Commission on Drug Policy recommended the decriminalization of drug use. The existence of criminal laws, disproportionate penalties, and law enforcement hampers harm reduction.

Recovery Housing: We are grateful for the increased effort being made by the Department of BHDDH toward expanding recovery housing in the state, and the work of Senator Josh Miller in establishing a recovery housing certification process.
Additional actions are required to strengthen this critical recovery support service.
We again (see the June report) note these housing recommendations from

The Society of Community Research and Action:

- Single State Authorities on alcohol and other drug problems to establish loan funds and other mechanisms that will support the development of recovery residences where the need for such resources has been established. (NOTE: Rhode Island did have a revolving loan fund for years – it disappeared). An RFP for NARR Level II and Level III housing has been issued. This is welcome but limited. Actions such as a revolving loan fund will open more opportunities for a larger range of housing providers.
- Funding for critical research related to recovery residences.
- Strategies to educate and train addiction treatment professionals and allied health and human services professionals on the value of recovery homes.
- Public education strategies that will address the stigma and misconceptions often attached to recovery homes and their residents.
- An additional action should be an Emergency Recovery Housing Respite option: safe and very temporary housing for residents who have had a one or two day episode of resumed use to stay until they are allowed back in their recovery house.

Some other plausible and do-able strategies include:

- Route-transition interventions: e.g., promote smoking heroin rather than injecting
- Outreach and education programs that can involve assistance with access to services, peer mentoring or treatment, provision of educational materials on harm reduction, safe drug use, or safe sex
- A mobile assessment unit
- Access to justice: evidence suggests that access to legal aid, paralegal services and legal empowerment can greatly enhance the health of drug users
- Access to medical services: people who inject drugs are deterred from accessing services for a variety of reasons, including experience of discrimination and judgment

We need to remember: that the authorities on the efficacy of various harm reduction strategies include both the patients in medication-assisted recovery and the active users still in the community who incorporated many personal harm reduction practices into their daily lives. The public health conceptions of harm reduction do not tend to include the range of strategies

used by people who use drugs. We know that these folks can provide essential and valuable input. We have seen examples in the focus group results in the June *RICARES Report to the Community* **(19)**, in the study by Carroll et al, **(20)** and in the study by Boucher, et al. **(21)**
While we appreciate the presence of at least two persons with lived experience presently on the GTF, we urge the GTF to significantly expand the voice and utilize the knowledge and creativity of people with lived experience in the conceptualization and implementation of harm reduction interventions.
We urge the GTF to consider: a formal and comprehensive set of principles for harm reduction has recently been developed, including a description of how interventions based on the principles can be delivered in healthcare settings. **(17)** We recommend that this knowledge be incorporated into a targeted and expanded harm reduction strategy in the state.

Final comments

If we can say that there is any kind of positive outcome associated with the present epidemic, it is our state's response as exemplified by a range of almost unprecedented collaborations.
It is the recognition that opioid misuse and addiction is no longer someone else's problem.
In virtually every town and city, coalitions such as the Prevention Task Forces, informal groups of family members and friends of victims, and other simply concerned people continue to work together.
The extraordinary range of family members, treatment providers, community advocates, law enforcement, academia, first responders, state agency representatives, and legislators, to name just a few, continue to be passionate, collaborative and committed to the work.
Hope is a prerequisite for recovery. Our past and present work, effort and commitment is the source of our hope and of our conviction that our state and our communities will recover soon from this epidemic.

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