final minutes

Opioid Advisory Commission (OAC) Meeting
10:00 a.m. • December 14, 2023
Legislative Conference Room • 3rd Floor Boji Tower Building
124 W. Allegan Street • Lansing, MI

Members Present:
Judge Linda Davis
Katharine Hude
Mona Makki
Scott Masi
Mario Nanos
Patrick Patterson
Kyle Rambo

Members Excused:
Sheriff Daniel Abbott
Brad Casemore
Dr. Cara Poland
Dr. Sarah Stoddard

Mr. Patrick Patterson served as Chair in Dr. Poland's absence.

Ms. Tara King serving as Program Coordinator to the Commission was in attendance.

Ms. Jennifer Dettloff serving as ex-officio to the Commission was in attendance.

I. Call to Order
The Chair called the meeting to order at 10:07 a.m.

II. Roll Call
The Chair asked the clerk to take roll. The clerk reported a quorum was present. The Chair asked for absent members to be excused.

III. Approval of the November 16, Meeting Minutes
The Chair directed attention to the proposed minutes of the November 16, 2023, meeting and asked if there were any changes. **The Chair asked the meeting minutes to reflect change to add "OAC efforts" at the end of Mr. Gladstone's workgroup update.** No other changes were discussed. **Ms. Hude moved, supported by Judge Davis to approve the minutes of the November 16, 2023, meeting to include a change to add "OAC efforts" at the end of Mr. Gladstone's workgroup update. There was no further discussion and the Chair asked for a roll call vote. The motion failed and the meeting minutes were not approved.**

IV. Public Comment

The Chair asked if there were any comments from the public.

Annie Moran representing Velocity Biogroup/Hikema Specialty expressed a need to make available tools to prevent overdose deaths, specifically the medication naloxone.

Dr. Arun Gupta discussed material provided to Commission members. Enclosed.

V. Community Engagement and Planning Collaborative (CEPC) Updates

The Chair directed attention to Ms. King to open discussion around CEPC updates.

Ms. King directed attention to Mr. Dominick Gladstone for an update of the Community Engagement & Planning Committee.

Mr. Gladstone reported the committee has met and are continuing efforts in developing a comprehensive work plan. Mr. Gladstone provided a copy of his report for the Commission. Enclosed.

Ms. King provided an update for the Health Equity Subcommittee in Ms. Amy Dolinky's absence. Ms. King reported the subcommittee is continuing efforts in developing a work plan to include working to identify key terms as well as developing a comprehensive definition of key terms.

The Commission recessed for break at 11:03 a.m.

The Chair called the meeting to order at 11:13 a.m. The Chair asked the clerk to take roll. The clerk reported a quorum was present. The Chair asked for absent members to be excused.

Members Present:	**Members Excused:**
Judge Linda Davis	**Sheriff Daniel Abbott**
Katharine Hude	**Brad Casemore**
Mona Makki	**Dr. Cara Poland**
Scott Masi	**Dr. Sarah Stoddard**
Mario Nanos	
Patrick Patterson	
Kyle Rambo	

VI. Key Activities of the Opioid Advisory Commission (OAC)

The Chair directed attention to Ms. King to open discussion around key items and activities.

Ms. King provided materials for Commission discussion.

- General Updates

The Commission recessed for break at 11:22 a.m.

The Chair called the meeting to order at 11:28 a.m. The Chair asked the clerk to take roll. The clerk reported a quorum was present. The Chair asked for absent members to be excused.

Members Present:	**Members Excused:**
Judge Linda Davis	**Sheriff Daniel Abbott**
Katharine Hude	**Brad Casemore**
Mona Makki	**Dr. Cara Poland**
Scott Masi	**Dr. Sarah Stoddard**
Mario Nanos	
Patrick Patterson	
Kyle Rambo	

The Chair directed attention to Ms. King to continue discussion around key items and activities.

Ms. King referenced to materials provided to Commission members.

- "Community Voices" Initiative
  - Michigan Opioid Settlement Funds: Community Impact Survey
  - Community Listening Sessions
  - Engagement Efforts/Community Drop-Ins/Partner Roundtables
- 2024 Annual Report – Planning and Development

VII. Workgroup Member Comment

The Chair asked if there were any comments from members of the Community Engagement & Planning Collaborative.

Mr. Gladstone expressed a lack of availability for long term treatment program and recommends the use of recovery capital management, collecting data and utilizing toward long term treatment.

VIII. Commission Member Comment

The Chair asked if there were any comments from members of the Commission.

Mr. Rambo expressed recommendation needed for long term workforce development noting specifically the Upper Peninsula does not have the workforce for long term programs.

The Commission discussed and unanimously agree to support the need for long term workforce development along with on-going training for existing workforce.

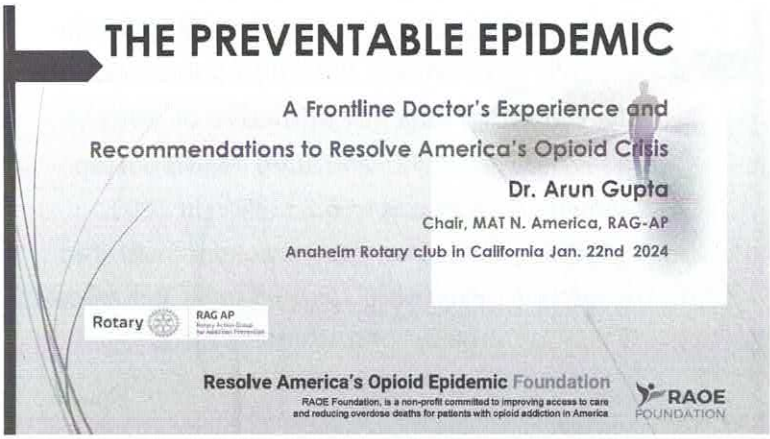
IX. Next Meeting Date: Thursday, January 11, 2024

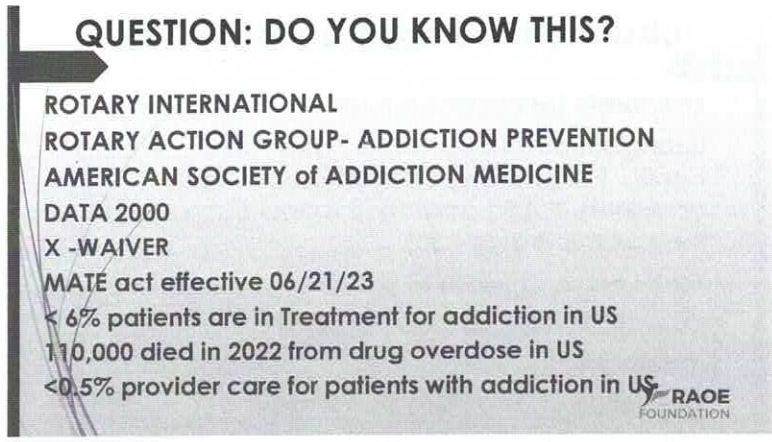
The Chair announced the next meeting date for Thursday, January 11, 2024, at 10:00 a.m.

The Chair reminded Commission members a majority of seven (7) Commission members in attendance is required to conduct Commission business and instructed Commission members to let the clerk know if availability has changed.

X. Adjournment

There being no further business before the Commission the Chair adjourned the meeting at 12:00 p.m. with unanimous support.


THE PREVENTABLE EPIDEMIC
A Frontline Doctor's Experience and
Recommendations to Resolve America's Opioid Crisis
Dr. Arun Gupta
Chair, MAT N. America, RAG-AP
Anaheim Rotary club in California Jan. 22nd 2024
Rotary
RAG AP
Resolve America's Opioid Epidemic Foundation
RAOE Foundation, is a non-profit committed to improving access to care and reducing overdose deaths for patients with opioid addiction in America
RAOE
FOUNDATION


QUESTION: DO YOU KNOW THIS?
ROTARY INTERNATIONAL
ROTARY ACTION GROUP- ADDICTION PREVENTION
AMERICAN SOCIETY of ADDICTION MEDICINE
DATA 2000
X -WAIVER
MATE act effective 06/21/23
< 6% patients are in Treatment for addiction in US
110,000 died in 2022 from drug overdose in US
<0.5% provider care for patients with addiction in US
RAOE
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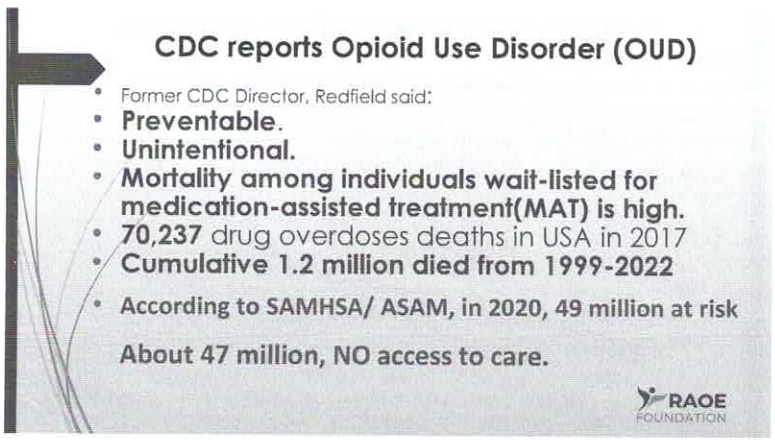
CDC reports Opioid Use Disorder (OUD)
Former CDC Director, Redfield said:
Preventable.
Unintentional.
Mortality among individuals wait-listed for medication-assisted treatment(MAT) is high.
70,237 drug overdoses deaths in USA in 2017
Cumulative 1.2 million died from 1999-2022
According to SAMHSA/ ASAM, in 2020, 49 million at risk
About 47 million, NO access to care.
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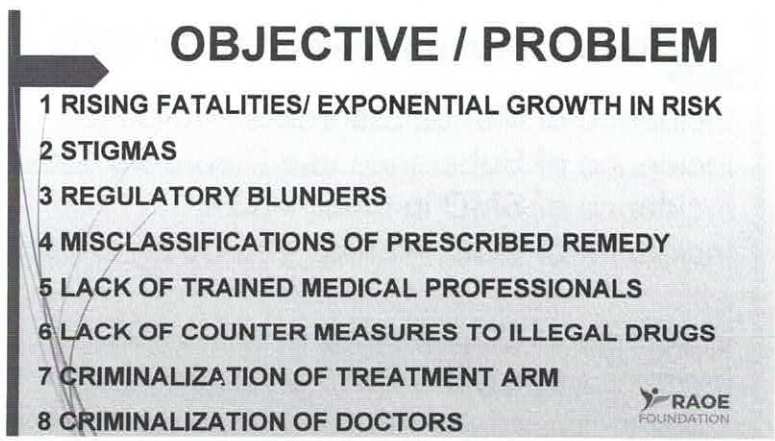
OBJECTIVE / PROBLEM
1 RISING FATALITIES/ EXPONENTIAL GROWTH IN RISK
2 STIGMAS
3 REGULATORY BLUNDERS
4 MISCLASSIFICATIONS OF PRESCRIBED REMEDY
5 LACK OF TRAINED MEDICAL PROFESSIONALS
6 LACK OF COUNTER MEASURES TO ILLEGAL DRUGS
7 CRIMINALIZATION OF TREATMENT ARM
8 CRIMINALIZATION OF DOCTORS
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Substance use expense to society

Economic loss Direct & Indirect= 500 =>750 Billion

Intangible cost to Society & harm = 3.23 T (include Health, Productivity, Criminal justice, Traffic accidents, Public assistance & Social service, Fire, Research & Prevention)

Total Loss 3.73 Trillion till 2019

Expected to rise 10 Trillion by 2030

Treatment cheaper than Incarceration $1vs $12

Prevention of addiction $1 Saves $7

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Purdue marketed and promoted OxyContin

OxyContin approved in 1995, non cancer pain

Mislabeling, was not addictive or abusive.

Representatives =2000, and lured **94,000** doctors

Annual prescriptions to 6.2 million in 2002.

No DCP (diversion control plan) was ever instituted.

2010 Oxycontin & Opana were required to be abuse-proof.

$ 4 billion settlement no criminal charges

GAO-04-110 Report 2003

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Relationship between SUD/ SMD

Incidence of Mental Disorders >40-50%
Incidence of Substance use Disorders 12%
Incidence of SMD in office >50%
Incidence of SUD in office >15-50%

Incidence of SUD & SMD in office 60%
Incidence of SUD & SMD in ER 80%

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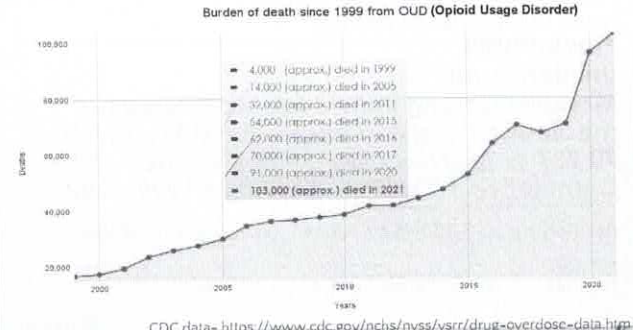
Number of Opioid Usage Deaths in The Past 22 years



CDC data- https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm

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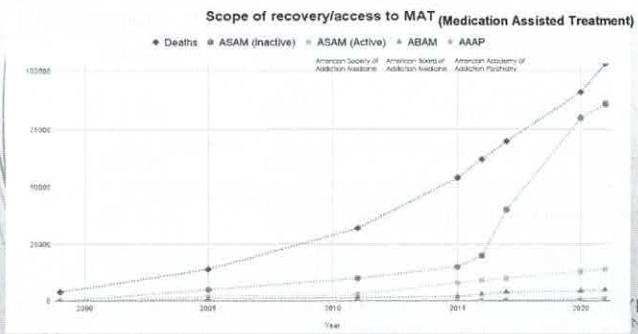
Number of Deaths in Past 22 years Vs Doctors available in America



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Maximally Disruptive Care?

- Since 2000, USA consumed 93% of all world narcotics.
- **60% reduction on narcotic manufacturing in US from 2016.**
- **99% US doctors have no training in pain or addiction medication.**
- > 1,000 doctors shut down in last 20 years, scaring the rest.
- **Fentanyl, Xylazine,Heroin, meth, and cocaine >90% of deaths.**
- Addiction doctors have unnecessary, limits, regulation, and oversight because of which they cannot prescribe remedies.
- Street drugs are cheaper, deadlier and easy to find(snapchat)

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Maximally Disruptive Care? Who studies at Medical Schools?

Doctors, NPs, PAs

Lawyers

Insurance Companies,

Politicians,

MBAs

Bureaucrats

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Criminalization of the Treatment Arm

- DATA 2000
- X- waiver
- Diversion control plan (DCP) in 2005 on Rx
- Never DCP on Narcotics
- Reckitt Benckiser 2018
- Indivior 2020
- Dangerous street drugs, easily available

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Criminalization of Doctors

Doctors can't be in Treatment & work.
>1000 providers apprehended.
Dentists can be in Treatment & work.
Lawyers can be in Treatment & work.
Pilot can be in Treatment & work.
Politicians can be in Treatment & work.
Medical professional can be at risk.

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CDC Reports Overdose Deaths 2021 in America

DRUG TYPE	(DEATHS 2021)	(DEATHS 2020)
Synthetic Opioids (fentanyl)	71,238	57,834
Psychostimulants (meth)	32,856	24,576
Cocaine	24,538	19,927
Natural/semi-synthetic (prescription)	13,503	13,722

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>1,200,000 dead from 1999-2022,
91,000 in 2020, & 108,000 in 2021

Effective treatment Buprenorphine available since 2002

Lack of Access
9 out of 10 patients with OUD don't have access to treatment
Inability to Deliver Life Saving Medicine
Only 1% of doctors actively prescribe MAT (Medication Assisted Treatment)
No formal education
Addiction is not taught in medical school and residency in USA
Federal Regulations
Unnecessary regulations, limits, and oversight in addiction medicine

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WHERE ARE ALL THE ADDICTION DOCTORS?

None of 179 (132+47) medical schools or 8887 residency programs in US teach addiction
Less than 15 doctors were getting trained per year in addiction until year 2010 in the USA
~1700 addiction doctors in 2011
~4,000 addiction doctors in 2011
~ <20,000 active addiction providers in 2021

106,000 providers have ability to treat addiction
MAT (but very limited & regulated for 21 years)

Doctors Lack Addiction Training

Why do the remaining 980,000 US doctors refuse to treat addiction??

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PSYCHIATRIST AS ADDICTION DOCTORS

- **Anxiety disorders**, including generalized anxiety disorder (GAD), obsessive-compulsive disorder (OCD), panic disorder (PD), phobias, and social anxiety disorder (SAD)
- **Eating disorders**, including anorexia nervosa (AN), binge eating and bulimia nervosa (BN)
- **Mood disorders**, including bipolar disorder (BD), major depressive disorder (MDD), and substance-induced mood disorder (SIMD)
- **Personality disorders**, including borderline personality disorder (BPD), narcissistic personality disorder (NPD), obsessive-compulsive personality disorder (OCPD). and paranoid personality disorder (PPD)
- **Psychotic disorders**, including bipolar psychosis, schizophrenia, schizoaffective disorder, and substance-induced psychotic disorder (SIPD)
- **Specific learning disorders**, including attention-deficit hyperactivity disorder (ADHD) and dyslexia
- **,000 members(total 38,000), American Academy of Addiction Psychiatry (AAAP).**

Psychiatry No Addiction Training

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Available Treatment For Narcotics

1:**Buprenorphine**, Class 3 sublingual daily available since 09/ 2002 Doctors can prescribe only (Suboxone,Zubsolv,Subutex,Bunavail,sublingual, Inj Sublocade Monthly Injection

2:**Methadone** (OTPs) Class 2 - Doctors Can't Rx

3:**Vivitrol** (non Restricted)monthly injection

- Counseling
- Gradual withdrawal
- **Harm reduction policies (HRP)**

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Opioid epidemic and crisis in the USA

ata 2000 passed **H.R.2634** 106th Congress in **(1999-2000)**

- "Authorizes the Secretary and the Attorney General, for three years, to make determinations regarding whether:
- (1) treatments provided under such waivers have been effective forms of maintenance and detoxification treatment in clinical settings;
- (2) such waivers have significantly increased the availability of such treatment; and
- 3) such waivers have adverse public health consequences.
- **Buprenorphine rescheduled to CIII,October 7, 2002**

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Drug Addiction Treatment Act of 2000

- 30 - 100 Patient Limit .
- This same law, void of any supporting science, caps the number of addicted patients a physician can treat 30/ month through the first year.
- Expandable to 100/month patients thereafter.
- **No other medications have such restrictions, including the prescription drugs people get addicted to and die from.**
- **Like many well-intentioned laws, the unintended consequences are significant.**

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A review of DATA 2000 was done in 2005

Usefulness of the program noted,

Concerns raised about diversion.

Diversion rarely: drug of abuse.

Primarily relief of withdrawal.

No one was dying from it.

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DIVERSION CONTROL 42 CFR 8.12(c) (2).

Diversion Control Plan" (DCP) as part of its quality assurance program.

Goal of DCP = reduce the scope/ significance of diversion and its impact on communities.

CRIMINALIZATION OF TREATMENT

Never (DCP) on Prescription Narcotics

We are not addressing OD deaths & Opioid crisis in America". By Dr Arun

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Misdirection against Indivior, Reckitt

- Government makes 2 main claims against the company: that it aided careless & clinically unwarranted prescribing by doctors of SUBOXONE products to too many people & in too high dosages;
- **Indivior Solutions Sentenced as Part of $2 Billion**
- Suboxone (Buprenorphine) not in top 20 drugs in OD
- It is not killing people, why bother.
- Lack of Suboxone access => increase in diversion.
- Lack of Suboxone => relapse & death

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The Link Between Misconceptions About Opioid Use Disorders and Current Policies

Clinical Pain Advisor Contributing Writer August 1, 2019

Harrison Narcotics Tax Act in 1914 and later rulings, the perception of opioid misuse changed.[2] Opioid addiction was no longer viewed as a treatable disease, and individuals with opioid use disorders (OUD) were perceived as responsible for their condition and as lacking moral fiber.[2] The Supreme Court supported this view until 1962, when it ruled that addiction was a disease.[2]

Attempts to limit supply by getting tough on large-volume prescribers have been unsuccessful.

An estimated 20 million people in the United States meet the criteria for substance use disorder. In 2015 alone, the opioid epidemic cost an estimated $504 billion in health care, criminal justice, and lost productivity.

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Federal Legislation impacting OUD

- **Harrison Narcotic and Tax Act of 1914** legislated psychoactive
- drugs and prohibited doctors from prescribing those drugs.
- **Addiction is a moral failing,** not treatable
- **A physician cannot prescribe another addictive drug for any addictive condition.**
  - Methadone is Class 2
  - Suboxone/Buprenorphine is Class 3

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FAILED OPIOID RELATED REGULATIONS IN THE LAST DECADE

Since 2010, 16, states introduced around 1,300 opioid-related bills and enacted around 500.

CDC guidelines on opioid prescribing many of these laws are based on, have been **controversial,** and are often described as "**blunt instruments.**"

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Reference: Rebecca L. Haffajee, JD, PhD, MPH, a U-M assistant professor of Health Management & Policy

Michigan Department of Licensing and Regulatory Affairs website

if you have additional questions, please contact Stacey P. Hettiger, MSMS Director of Medical and Regulatory Policy at 517-336-5766.

- R 338.3125 - **Gabapentin has been added to the schedule 5 drug** list as a controlled substance. As a result of this change, any prescribers prescribing gabapentin must be registered with the Michigan Automated Prescription System (MAPS). Prescribers must also obtain and review the patient's **MAPS report if prescribing a quantity that exceeds a 3-day** supply, unless dispensed and administered to a patient within a hospital or freestanding surgical outpatient facility.

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SUPREME COURT OF THE UNITED STATES

No. 20–1410. Argued March 1, 2022—**Decided June 27, 2022**[1]

Held: Section 841's "knowingly or intentionally" mens rea applies to the statute's "except as authorized" clause. Once a defendant meets the burden of producing evidence that his or her conduct was "authorized," the Government must prove beyond a reasonable doubt that the defendant knowingly or intentionally acted in an unauthorized manner. Pp. 4–16.

Finally, the Government argues that requiring it to prove that a doctor knowingly or intentionally acted not "as authorized" will allow bad-apple doctors to escape liability by claiming idiosyncratic views about their prescribing authority. But the Court has often rejected this kind of argument, see, e.g., Rehaif, 588 U. S., at ___, and does so again here. Pp. 9–15.

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SUPREME COURT OF THE UNITED STATES

Except 'Pill Mill' Docs, You May Be in for a Big Scare Two recent Supreme Court cases have major implications for physician practice by Aron Solomon, JD October 27, 2022
Last week, in an otherwise unremarkable order list, the Supreme Court remanded a case involving a "pill mill" doctor to a lower court for further consideration, in a move that could impact previous precedent-setting decisions on prescribing liability.

The ultimate decision in the case, Santos, Medardo Q. v. United States (Santos), will have important implications for care

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BARRIERS IN TREATMENT MUST BE REMOVED

Barrier #2 : STIGMA: (Vs implicit bias)
Addiction has been incorrectly seen as moral failing.

Despite Supreme Court's ruling in 1962," Addiction is a chronic treatable disease , not a moral failing
*Stigma towards disease of addiction
*Stigma towards treatment
*Stigma towards success of treatment
94% of patients do not access to MAT/ MOUD

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HOW TO REDUCE STIGMA

Just saying : STOP STIGMA : Will not WORK
MANDATORY EDUCATION
MEDICAL PROFESSIONALS, Policy makers, Insurance:
ADDICTION
BETTER VOCABULARY,
EMPATHY
HUMANITY

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BARRIERS IN TREATMENT MUST BE REMOVED

.Barrier #3 Diversion of Suboxone:

CRIMINALIZATION OF TREATMENT ARM, since 2005 (Diversion Control Plan)
Indivior Solutions Sentenced as Part of $2 Billion Resolution of False Safety Claims Concerning Suboxone

Decriminalize Treatment Arm

- It is meant to save live... not addictive... proven effective to keep people in Remission , prevent relapse & death
94% of patients do not access to MAT/ MOUD

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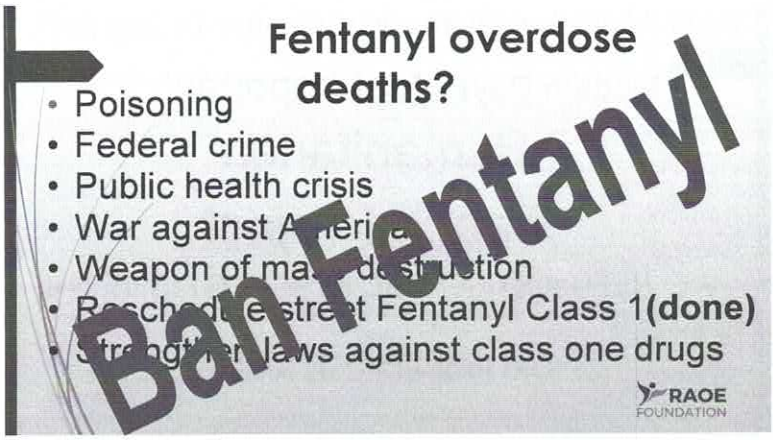
Fentanyl overdose deaths?
• Poisoning
• Federal crime
• Public health crisis
• War against America
• Weapon of mass destruction
• Reschedule street Fentanyl Class 1(done)
• Strengthen laws against class one drugs
Ban Fentanyl
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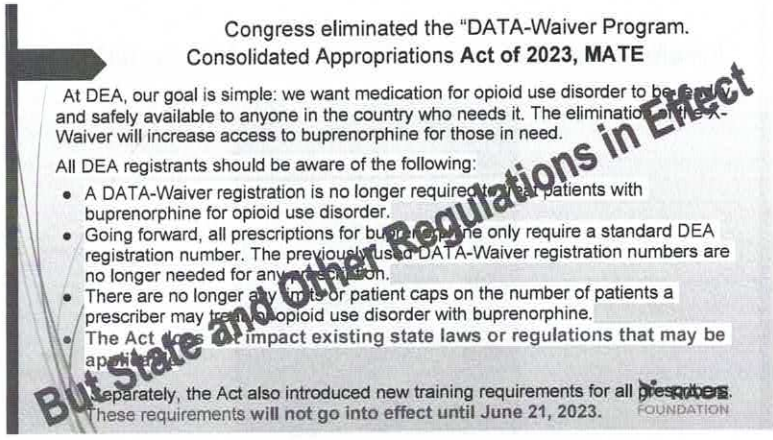
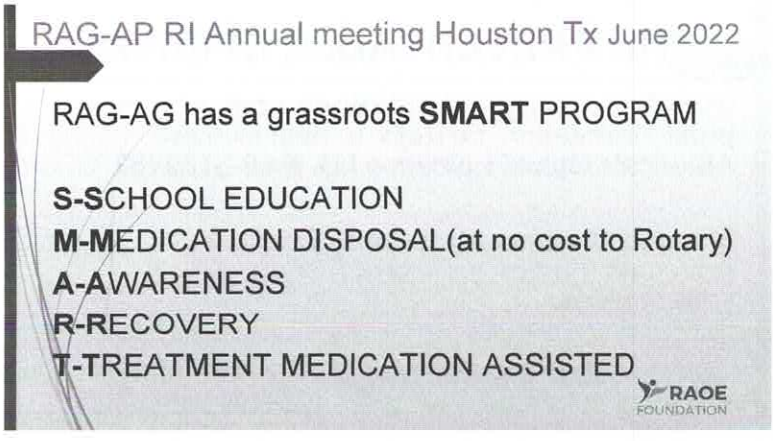
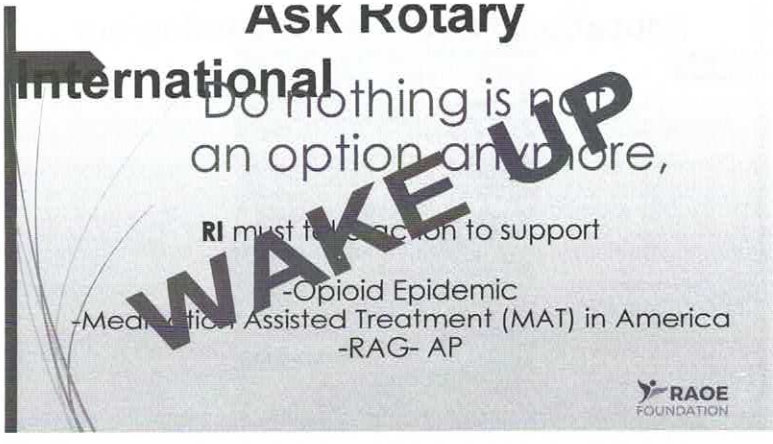

Congress eliminated the "DATA-Waiver Program.
Consolidated Appropriations Act of 2023, MATE
At DEA, our goal is simple: we want medication for opioid use disorder to be fully and safely available to anyone in the country who needs it. The elimination of the X-Waiver will increase access to buprenorphine for those in need.
All DEA registrants should be aware of the following:
• A DATA-Waiver registration is no longer required to treat patients with buprenorphine for opioid use disorder.
• Going forward, all prescriptions for buprenorphine only require a standard DEA registration number. The previously used DATA-Waiver registration numbers are no longer needed for any prescription.
• There are no longer any limits or patient caps on the number of patients a prescriber may treat for opioid use disorder with buprenorphine.
• The Act does not impact existing state laws or regulations that may be applicable.
Separately, the Act also introduced new training requirements for all prescribers. These requirements will not go into effect until June 21, 2023.
But State and other regulations in Effect
FOUNDATION


RAG-AP RI Annual meeting Houston Tx June 2022
RAG-AG has a grassroots SMART PROGRAM
S-SCHOOL EDUCATION
M-MEDICATION DISPOSAL(at no cost to Rotary)
A-AWARENESS
R-RECOVERY
T-TREATMENT MEDICATION ASSISTED
RAOE FOUNDATION


ASK Rotary International
Do nothing is not an option anymore,
RI must take action to support
-Opioid Epidemic
-Medication Assisted Treatment (MAT) in America
-RAG- AP
WAKE UP
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Installation of Kiosk at my office with Erin Dobbins 032122

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RAG-AP RI Annual meeting Houston Tx June 2022

Modern Days Most Important Humanitarian Peace Project

WE NEED A STRATEGIC RESET TO FIGHT THE OPIOID EPIDEMIC IN AMERICA,

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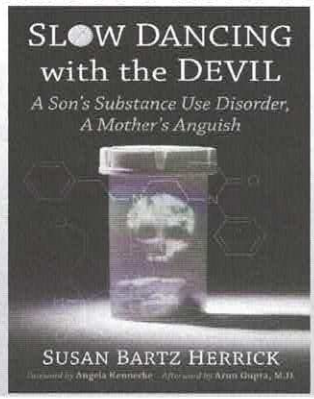
Educational Book/ Movie coming out



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THE PREVENTABLE EPIDEMIC

SOS Serious Opioid solutions.com, is a non-profit **Foundation** 501(c)3 to help Resolve America's Opioid Epidemic I.D. # 88-3739782

Mission & vision statement: Educate & Advocate the policy makers & support local communities.

Committed to improving access to care and reducing overdose deaths for patients with opioid addiction in America

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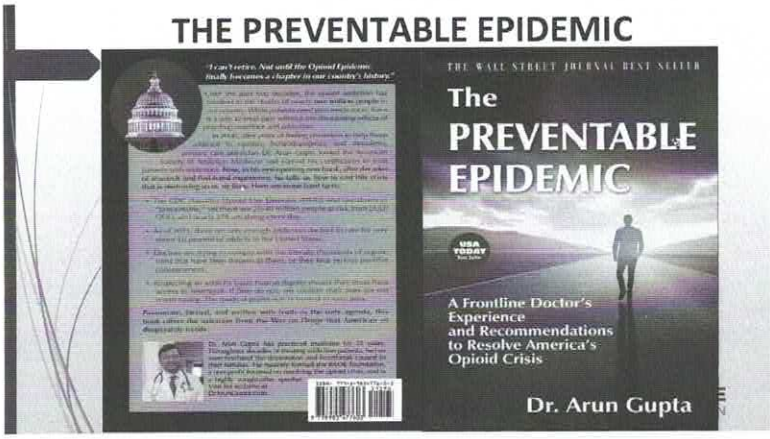
THE PREVENTABLE EPIDEMIC
THE WALL STREET JOURNAL BEST SELLER
The
PREVENTABLE
EPIDEMIC
USA TODAY
A Frontline Doctor's Experience and Recommendations to Resolve America's Opioid Crisis
Dr. Arun Gupta

Opioid Advisory Commission (OAC) – Community Engagement & Planning Committee (CEPC)

ACTIVITY REPORT

December 14, 2023

The Community Engagement workgroup met on December 7th, 2023. We continued our efforts in generating a comprehensive work plan for 2024.

Our current activities include whiteboarding the barriers and proposed solutions to true community engagement. We have defined engagement as creating two-way communication with all stakeholders and audiences.

We also have begun prioritizing low-hanging fruit in our goal setting. We know there are many barriers, some of which are out of our control, but if we can demonstrate that our strategies will work with a few short-term "wins", we believe more doors will be opened to the more complex issues.

Some Key Points for Consideration—

- Meet legislative requirements while addressing emerging urgent issues.
- Promoting better, more inclusive, conversations with a wide range of audiences.
- Exploring ways to be catalysts for collaboration, breaking down silos.
- Reducing stigma and bias.

Our group has a great deal of experience and dynamic input; however, we seem to run short on time at each meeting. We are planning an extra meeting time early in 2024. We also plan to create a shared file system for input between meetings. Finally, we plan to interact with the Health Equity group, so as not to duplicate mutually relevant information.

2024 State Opioid Settlement Investments

Prevention FY24 Estimated Budget Allocation: $3.9 million*[1]

Injury and Violence Prevention Section Programming: $2.4 million

- Funds will allow the MDHHS Injury and Violence Prevention Section to continue prevention programming that will address risk factors, such as Adverse Childhood Experiences (ACEs), and promote protective factors that are connected to substance use/misuse, and substance use disorder (SUD). Efforts include:

- Greater Flint Health Coalition Faith Based Engagement Project will utilize strategies outlined in the U.S. Department of Health and Human Services the Partnership Center for Faith and Opportunity Opioid Crisis Practical Toolkit to build a faith-based coalition led by community leaders in Genesee County to address overdose response efforts to prevent overdoses.

- Corewell Health Youth and Family Engagement Project will implement evidence-based prevention programming, including Nurturing Parenting, Prime for Life, Botvin's Life Skills, peer-to-peer efforts, and other programming meant to mitigate Adverse Childhood Experiences (ACEs) and build resiliency. Programming will be made available to selective and indicated adolescents, including supports for LGBTQ+ youth, pregnant and parenting teens, and students identified as high risk.

- The Injury and Violence Prevention Section will collaborate with the Early Childhood Investment Corporation to host 10 in-person training workshops across diverse communities in Michigan to educate and create awareness of the Healthy Outcomes Positive Experience (HOPE) Framework from Tufts Medicine. HOPE identifies ways that our communities and systems of care can better address ACEs and ensure that children have more positive experiences and that families have support to nurture their strengths.

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- Michigan Model for Health (MiMH) will utilize funds to maintain licenses for educators that are due to expire (licenses expire every two years) and on-going maintenance including fees to support the on-line platform, which supports educators, families, and communities and across Michigan to build skills for youth and help build positive lifestyle behaviors in students. Topics addressed by MMH include alcohol, tobacco, and other drug use prevention, including skills-based instruction in opioid misuse prevention; social and emotional health; personal health and wellness; and safety.

- Funds will support 10 Quick Response Teams (QRTs) in communities throughout Michigan. QRTs utilize a multi-disciplinary approach of trained professionals including first responders, case managers, and peer mentors who go to a person's home and address any post-overdose needs and connect to supports. The primary aim is to prevent further harm or death by linking individuals/families who use substances to person-centered supportive services, such as treatment, education, peer support, housing, work force development and other needed resources.

- Funds will support Michigan Overdose Fatality Review (MiOFR) which strives to reduce overdoses by reviewing fatal overdose events and identifying touchpoints throughout a decedent's life that may have been a point of intervention or prevention. Overdose fatality review (OFR) is nationally recognized model that employ teams that are multidisciplinary and include individuals who share information about a decedent or contribute to analysis of available data to make recommendations that will prevent future overdoses. OFRs increase communities' overall capacity to prevent future overdose deaths by leveraging resources from multiple agencies and sectors to increase system-level response. By conducting a series of OFRs, jurisdictions begin to see patterns of need and opportunity, not only within specific agencies but across systems.

Opioid Coalition Training: $500K

Community coalitions have proven effective in raising awareness and galvanizing community efforts around a variety of topics surrounding substance misuse, including syringe exchanges and naloxone distribution, as well as youth substance use. Funds will allow Michigan coalitions in various stages of coalition development to apply for a sponsored membership to a national coalition organization that provides training, resources, and support to substance use prevention organizations. Funds would also give selected coalitions the opportunity to attend a 3-week virtual coalition academy and receive follow up support. This opportunity would give

communities the tools to develop and sustain impactful grassroots efforts to prevent and address substance use disorder and opioid misuse/disorder in their communities. Planning efforts are currently underway for this investment. Sign up for MDHHS email updates to receive press release announcements for open funding opportunities here.

Prevention Request for Proposals: $1 million

A primary prevention RFP will allow community organizations within Michigan the competitive opportunity to apply for funds to implement innovative, evidence-driven primary prevention efforts that are selected through the application of SAMHSA's Strategic Prevention Framework and delivered to priority populations. Planning efforts are currently underway for this investment. Sign up for MDHHS email updates to receive press release announcements for open funding opportunities here.

Treatment FY24 Estimated Budget Allocation: $9.8 million*[2]

Emergency Department (ED) Medications for Opioid Use Disorder (MOUD) Initiative: $1 million

Hospitals, especially emergency departments, are a critical intervention point to reach and treat those with opioid use disorder (OUD), increase access to MOUD, and provide equitable care. The emergency department is often the only contact individuals with OUD have with the healthcare system, and it's 24-hour, 365-day accessibility positions it well to help close the treatment gap. The Michigan Opioid Partnership (MOP) will implement the ED MOUD Initiative with the objective to clearly identify barriers to sustainability, assist with removing those barriers, and identify what emergency departments need in order to set up and sustain ED MOUD protocols. The primary focus of the project will be on engaging successful hospitals who have embedded and sustained ED MOUD protocols, building on MOP's existing partnership with a local racial equity organization to ensure disparities in healthcare are addressed, and not limited to, funding, state policies, billing and reimbursement, outpatient landscape, culture, etc. Emphasis will be on hosting peer-to-peer learning engagements and engaging with clinical champions across the state to equip others with the knowledge and skillset to begin an ED MOUD program in their hospital.

Medicaid Recovery Incentives (Contingency Management) Pilot: $3 million

Michigan is seeing a rise in methamphetamine use, polysubstance use, and the presence of fentanyl in the illicit methamphetamine supply. To address the substance use crisis in Michigan, MDHHS is launching the Recovery Incentives Pilot to provide contingency management to eligible Medicaid beneficiaries with a stimulant use disorder (StimUD) and/or OUD. Contingency management is an evidence-based practice that provides motivational incentives to individuals living with substance use disorder (SUD) for meeting treatment goals. The pilot period will last for two years, and its goals are to: 1) Improve access to effective community-based SUD treatment and recovery services. 2) Address the SUD crisis in Michigan through a new evidence-based treatment. 3) Improve the health and well-being of Medicaid beneficiaries living with StimUD and OUD. 25% of the project budget will be funded through Settlement dollars. Funds will cover the cost of the service and startup costs for qualifying providers, the recovery incentives, training and TA for providers, and a web-based incentive vendor that will develop the system to log and deliver incentives to beneficiaries. Planning efforts are currently underway for this investment. Sign up for MDHHS email updates to receive press release announcements for open funding opportunities here.

Michigan Opioid Treatment Access (MIOTA) Loan Repayment Program 2.0: $1 million

Provider organizations cite staffing as one of the largest barriers to providing SUD treatment services. However, federal funders have historically prohibited the use of funds for workforce development programs. This funding will continue to support the second year of the award period for awards made

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under the Michigan Opioid Treatment Access Loan Repayment Program (MIOTA LRP 2.0) that provides loan payment support to incentivize their commitment to providing SUD services for a period of two years. Awardees include those that provide MOUD or SUD counseling services, including physicians or psychiatrists (MDs or DOs), psychologists, nurse practitioners, physician assistants, and SUD counselors.

SUD Treatment and Recovery Provider Infrastructure Support: $1 million

PIHPs and SUD provider organizations face physical infrastructure challenges to adequately serve clients, limiting access to services in Michigan. Grant funding to make infrastructure improvements is not possible through other sources of grant funding. Carry over funding will allow for grantees awarded under the FY 2023 Infrastructure RFP to complete their approved projects. The goals of the projects are to expand, increase, or enhance the physical treatment and recovery services infrastructure to ultimately increase or expand the availability of treatment for OUD and any co-occurring SUD/Mental Health conditions, including all forms of MOUD, to better meet the demand for services.

Transportation Services for Substance Use Disorder Treatment and Recovery Services: $2.8 million

Feedback from beneficiaries and providers indicates that the lack of reliable transportation is the most significant barrier to treatment access and retention. Settlement funds will provide one-time grant funding to grantees to expand or increase the availability of transportation services for individuals seeking or receiving SUD treatment or recovery services. Through transportation service expansion, grants are intended to encourage treatment and recovery service access and retention by serving target communities and underserved populations in need of services and support.

Treatment Request for Proposals: $1 million

Funds will be directed to provide additional innovative treatment-related supports that will likely be made possible to providers through a competitive RFP. Planning efforts are currently underway for this investment. Sign up for MDHHS email updates to receive press release announcements for open funding opportunities here.

Recovery FY24 Estimated Budget Allocation: $6.2 million*[3]

Recovery Community Organizations: $1.4 million

Recovery supports were the highest identified need of the respondents of the 2021-22 MDHHS Opioids Settlement Prioritization Survey. Priorities that have been addressed over the last four years have included supporting peer recovery coaches and providing training and support for recovery-friendly workplaces. Continued support is still needed to offer robust recovery supports, especially where other funding sources aren't able to fully cover, such as funding for recovery community organizations (RCOs). An RCO is an independent, non-profit organization led and governed by representatives of local communities of recovery. These organizations organize recovery-focused policy advocacy activities, carry out recovery-focused community education and outreach programs, and/or provide peer-based recovery support services. Funds will provide funding support to awarded RCO grantees.

Recovery Housing: $4 million

Housing insecurity serves as a risk factor for OUD and overdose death. The risk of death from an opioid overdose is 30 times higher for those that have experienced homelessness. Individuals recovering from an SUD consider housing one of their primary needs following treatment. MDHHS is working with the Michigan State Housing Development Authority (MSHDA) to plan a competitive opportunity to fund recovery residences, with a focus on fostering new recovery housing sites in areas of the state where recovery beds are most needed. Current funding streams restrict the use of funds to subsidizing or expanding recovery housing within existing housing stock. These funds would promote the establishment of new recovery housing sites through loans, similar to other MSHDA initiatives to expand recovery housing. Planning efforts are currently underway for this investment. Sign up for MDHHS email updates to receive press release announcements for open funding opportunities here.

Recovery Supports: $280K

Given the high need for community-based recovery supports, additional funds will be directed to support an additional innovative community-based recovery support service. Planning efforts are currently underway for this investment. Sign up for MDHHS email updates to receive press release announcements for open funding opportunities here

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Harm Reduction FY24 Estimated Budget Allocation: $10 million*[4]

Narcan Direct: $5 million

Widespread distribution of naloxone, a medication that rapidly reverses an opioid overdose, is an evidence-based way to reduce the number of overdose deaths. Funding will continue to support the purchase of intranasal Narcan to operate Narcan Direct, the MDHHS naloxone portal. Michigan is an innovator within the nation in launching this online portal for bulk order naloxone for community organizations to order at no-cost. Widespread dissemination of naloxone is essential to reversing the tide of overdose, especially given the prevalence of strong opioids like fentanyl in the illicit drug supply. The availability of intranasal naloxone through Narcan Direct has enabled the distribution of over 730K naloxone kits into Michigan communities, resulting in an estimated 6,637 overdose reversals (as of September 2023) since the Portal's launch in 2020. MDHHS is also exploring the potential of making intramuscular naloxone available through the Portal.

Syringe Service Programs (SSPs): $5 million

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Criminal-Legal FY24 Estimated Budget Allocation: $5 million*[5]

Medications for Opioid Use Disorder (MOUD) Implementation in Michigan Dept. of Corrections (MDOC) Facilities: $2.5 million

Research has shown that individuals who are incarcerated are at significant risk of experiencing both non-fatal and fatal overdose post-incarceration. Increased risk for overdose in the incarcerated population is partially attributed to the sporadic use or total abstinence of opioids while incarcerated, resulting in a lower tolerance to opioids, putting the individual at significant risk of overdose if they attempt to consume the same amount of substances that they were using pre-incarceration. Michigan has been working to expand MOUD treatment in jails and prisons and improve connections to the community after release. Increasingly litigation and federal rulings have required the provision of OUD services. This would offset the cost of these medications (which can be as high as $1800 per dose) to support MDOC prisons in providing MOUD.

MOUD Implementation in Jail Settings: $1.5 million

A contracted TA and Training project administrator will recruit county jails to participate in individualized technical assistance and training to implement or expand access to MOUD. While training and technical assistance needs may vary by participating jails, technical assistance will include: 1) Implementing or expanding a MOUD continuum-of-care model from jail to release to the community. 2) Identifying incarcerated individuals with OUD. 3) Providing evidence-based treatment within the jail. 4) Establishing reentry to ensure continuity in medication and supportive services after release from incarceration. 5) Participating county jails will receive a stipend that must be used to cover the costs associated with MOUD programs, such as medications that can cost up to $1,800 per dose.

Medicaid 1115 Waiver Demonstration for Incarcerated Population: $500K

On April 17, 2023, CMS issued guidance on designing an 1115 waiver demonstration project to improve care transitions for individuals who are incarcerated and soon to be released from a non-federal correctional institution, providing a unique opportunity to use Medicaid dollars to cover certain healthcare costs for individuals who have historically been excluded from such coverage due to the Medicaid Inmate Exclusion Policy (MIEP). The demonstration would not only allow, but require, that medication assisted treatment be included in the pre-release benefit package, including the three FDA-approved medications to treat opioid use disorder which include methadone, buprenorphine, and long-extended naltrexone, two of which have shown to be effective in reducing opioid overdose. Opioid settlement funds would be utilized to help cover the costs associated with design development and/or drafting an 1115 waiver submission to CMS, including the cost of working with a consultant with specific subject matter expertise, and required community engagement work to inform the effort. Planning

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efforts are currently underway for this investment. Sign up for MDHHS email updates to receive press release announcements for open funding opportunities here.

Offender Success Programming Supports: $500K

Offender Success is a statewide program implemented by MDOC and assists individuals with a successful transition back into our communities. Their programs focus on job placement, residential stability, social supports, and health/behavioral health, including SUD treatment services. Providing supervision and support during this period of transition for individuals is vital for decreasing recidivism rates and overdoses. Funding will support the program by providing funding to support individuals receive supports for their treatment and recovery, including transportation access. Planning efforts are currently underway for this investment.

Pregnant and Parenting FY24 Estimated Budget Allocation: $3.4 million*[6]

Rooming In: $906K

Support is needed for pregnant individuals and their children. From Fiscal Year 2012 to Fiscal Year 2021, diagnosis of OUD during pregnancy doubled (from 1.3% to 2.8%). Rooming-in integrates non-pharmacological methods for post-delivery care for an infant with Neonatal Abstinence Syndrome (NAS). MDHHS has previously funded 3 hospitals for rooming-in care and hire specialized staff to provide rooming-in care. All hospitals have hired staff, identified rooms that will be converted, and are beginning to ordered specialized materials for care. This funding would expand this effort to additional hospitals within the state to promote family unification and support the health of mothers and babies affected by substance use.

High Touch High Tech:; $400K

Settlement investments will help support the implementation of High Touch High Tech (HT2), a program that uses tablet-administered screening tools, via an app, to screen expectant mothers for mental health and substance use-related risk. The program is designed for easy uptake by new clinics. It is also designed to easily fit into the workflow of prenatal clinics and has resources built into the programming to allow for easy resource distribution. It has been shown to be effective at identifying an SUD need in pregnant individuals, thus allowing them to connect with necessary care. These funds will expand of this program across the state.

Substance Use Disorder Family Support Program and Peer Supports: $2.1 million

US Dept. of Health and Human Services Adoption and Foster Care Analysis and Reporting System (AFCARS) FY 2021 data indicates that 3,837 children entered foster care during FY2021. 38% of those circumstances involved "drug abuse" of parent. Further, studies indicate that there is substantial overlap between parents involved in the child welfare and substance use treatment systems. Funding will invest in the SUD Family Support Program and peer supports for families vulnerable to child removal due to involvement with substance use, with the goal of reducing the rate of children removed from family homes, supporting family recovery and family reunification, and providing parents will parenting skills and tools to lead healthy families and stay engaged in treatment/recovery.

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Equity FY24 Estimated Budget Allocation: $2.5 million[7]

A continued focus on equity, specifically on addressing racial disparities in treatment access and delivery, must be emphasized in every project moving forward. While efforts have been made to improve access to treatment and remove barriers, our data shows us that treatment may still not be reaching those who need or want it. Work must intentionally focus on removing barriers and addressing racial disparities to ensure equitable access and delivery of SUD/OUD treatment services. Equity work will advance efforts to address racial inequities contributing to overdoses in Michigan. Activities include piloting a faith-based learning collaborative with faith-based leaders and expanding Neighborhood Wellness sites services for training and naloxone distribution. Additional work focusing on equitable internal processes and evaluation measures will be implemented.

[7] https://www.michigan.gov/opioids/opioidsettlements/settlement-spending

Data FY24 Estimated Budget Allocation: $1.5 million*[8]

Representatives from MDHHS Epidemiology (Opioids and Emerging Drugs or OED Unit), Viral Hepatitis Unit, Bureau of Emergency, Trauma and Preparedness (BETP), Licensing and Regulatory Affairs (LARA), Michigan State Police (MSP), and Behavioral and Physical Health and Aging Services Administration (BPHASA) worked together to assess opioid overdose and substance use disorder (SUD) related data needs and will be utilizing funds to support overdose data surveillance platforms that are integral in determining issues, trends, and needs across the state.

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Maximizing Impact: $2.8 million + 5% Administration cap*[9]

Administration: 5% cap It is critical to maximize the amount of this funding going to services. However, sufficient staffing is required to successfully implement programs to ensure appropriate program oversight to successfully implement funded efforts, as well as issuing and overseeing grant and contract opportunities, and providing communications regarding settlement investments. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) has a five percent cap on admin for grants and this provides the right balance of funding for services, while providing sufficient staffing. Likewise, this funding would adhere to the 5% cap standard set by SAMHSA.

Communications: $100K

Communications with stakeholders is vital in ensuring that MDHHS develops opioid settlement spend plans that are responsive to the needs of communities. It is also necessary for MDHHS to adequately share communicate with stakeholders regarding settlement investments and associated impact, as well as opportunities for funding. Funding for communications would provide MDHHS with expert consultation that would assist in messaging, effective communication modalities and practices, and information sharing.

Evaluation of Settlement Investments: $500K

To determine program effectiveness and impact, an evaluator with specific expertise and experience is necessary to ensure settlement investments are impactful in addressing the opioids crisis in Michigan. Funding would allow MDHHS to procure an expert evaluator that will guide programming efforts in developing measurable short term and long-term outcomes and would lead in the monitoring of funded efforts' impact, which will assist in future spend plan development and determining how funds have helped reduce opioid-related harms and overdoses, as well as providing metrics on investment efforts to the public. Planning efforts are currently underway for this investment. Sign up for MDHHS email updates to receive press release announcements for open funding opportunities here.

Local Governments Incentives: $1 million

Presently, the national opioid settlements only require reporting on funds that are not used for purposes of opioid remediation. This reporting requirement applies to both state and local recipients. There is no requirement for local governments to report on their opioid remediation investments. Incentives for local governments would encourage reporting out on investments, as well as incentivize investments into evidence-based efforts to address the opioids crisis. Funds would provide financial incentives to local governments for their settlement investment in best practices/evidence-based

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interventions, as well as reporting on investments. This will encourage the sharing of information to help better inform state-wide strategy to address the opioids crisis and the utilization of funds for evidence-informed efforts.

Technical Assistance Collaborative for Local Governments: $1.25 million

Local governments/subdivisions will receive a portion of the 50% local share of the $776 million coming to Michigan over the next 18 years as a result of the nationwide Opioids Settlement with the three largest opioid distributors and manufacturer, Janssen. The State of Michigan and local governments in receipt of Settlement funds must follow Settlement documentation Exhibit E: List of Opioid Remediation Uses as they allocate funds towards programming. Local governments may need technical assistance consultation to assist in planning and implementation of approved opioid remediation programming in their community. The Technical Assistance Collaborative, which is comprised of MDHHS, Michigan State University, the University of Michigan, and Wayne State University, will provide information and assistance on evidence-based practices suited to address the opioid crisis to ensure impact of funding. Individualized technical assistance to requesting counties, informational webinars, and resource sharing will be included in the Technical Assistance plan

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Fund 1584
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Grantee	Project Code	Performance Period	Current Contract Amount	MI Opioid Healing and Recovery Expenditures as of 11.15.23 1584	*Expenditure Totals Per Category*
Treatment (491EG8097) (491EG8250MA MATCH)					***1,104,754***
Arab Community Center for Economic and Social Services (ACCESS)	SUDTR-2023	06/23-09/23	450,000	232,117	
Hegira Health, Inc	SUDTR-2023	06/23-09/23	173,175	71,388	
Lakeshore Regional Entity	SUDTR-2023	06/23-09/23	495,000	495,000	
List Psychological Services, PLC	SUDTR-2023	06/23-09/23	495,000	101,432	
Munson Medical Center	SUDTR-2023	06/23-09/23	68,334	29,414	
Sacred Heart Rehabilitation Center, Inc	SUDTR-2023	06/23-09/23	-	-	
Salvation Army Harbor Light Center	SUDTR-2023	06/23-09/23	494,848	121,194	
Summit Pointe	SUDTR-2023	06/23-09/23	405,123	54,208	
Prevention (491EG8098)					***396,649***
Flint Odyssey House	MOSP-2023	03/23-09/23	100,000	50,544	
DTMB Monthly Charges				75	
Greater Flint Health Coalition	MOSP-2023	03/23-09/23	100,000	971	
Home of New Vision - Wraparound Systems	MOSP-2023	03/23-09/23	100,000	72,372	
Michigan Public Health Institute - MI Opioid Settlement P	MOSP-MP	05/23-09/23	680,150	42,150	
Oakwood Healthcare Inc - Youth Resiliency	MOSP-2023	03/23-09/23	300,000	90,537	
Arab Community Center for Economic and Social Services - Implementation efforts	OSSPP-AC	05/23-09/23	150,000	140,000	

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Harm Reduction (491EG8183)					***10,343,501***
Benzie-Leelanau District Health Department	HRSS	10/22-09/23	35,001	35,001	
Calhoun County Health Department	HRSS	10/22-09/23	73,751	73,751	
Central Michigan District Health	HRSS	10/22-09/23	68,751	68,751	
Chippewa County Health Department	HRSS	10/22-09/23	61,751	61,751	
Dickinson-Iron District Health Department	HRSS	10/22-09/23	61,251	61,251	
District Health Department #10	HRSS	10/22-09/23	62,501	62,501	
District Health Department #2	HRSS	10/22-09/23	43,750	43,750	
District Health Department #4	HRSS	10/22-09/23	65,750	65,750	
Health Department of Northwest Michigan - Harm Reduction Services	HRSS	10/22-09/23	63,750	63,750	
Luce-Mackinac-Alger-Schoolcraft DHD - Harm Reduction	HRSS	10/22-09/23	66,751	66,751	
Marquette County Health Department - Harm Reduction S	HRSS	10/22-09/23	145,001	145,001	
Oakland County DHHS Health Division - Harm Reduction	HRSS	10/22-09/23	229,500	229,500	
Public Health, Delta & Menominee Counties - Harm Reduction Support Services	HRSS	10/22-09/23	73,502	73,501	
Saginaw County Health Department - Harm Reduction Support Services	HRSS	10/22-09/23	42,501	42,501	
Shiawassee County Health Department - Harm Reduction Support Services	HRSS	10/22-09/23	7,501	7,501	

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St. Clair County Health Department - Harm Reduction Support Services	HRSS	10/22-09/23	70,001	70,001	
Western Upper Peninsula Health Department - Harm Reduction Support Services (Houghton County)	HRSS	10/22-09/23	50,251	50,251	
Community Outreach Prevention and Education Network	HRSS-CN	10/22-09/23	111,644	111,416	
Detroit Recovery Project	HRSS-DR	10/22-09/23	5,000	5,000	
Families Against Narcotics	HRSS-FA	10/22-09/23	214,682	214,840	
Grand Rapids Red Project - Southwest Michigan Harm Reduction Services	SWMHARM-GR	10/22-09/23	395,205	395,205	
Grand Rapids Red Project - Syringe Services Program Technical Assistance	SSPTA-GR	10/22-09/23	35,811	34,440	
Harm Reduction Michigan	HRSS-HR	10/22-09/23	294,705	294,705	
Home of New Vision - Harm Reduction Support Services	HRSS-HNV	10/22-09/23	126,607	126,607	
JXN Harm Reduction	HRSS-JX	10/22-09/23	18,789	18,789	
Oakwood Healthcare Inc (IVP with Corewell Health)	HRSS-OA	10/22-09/23	10,777	10,777	
Punks with Lunch Lansing	HRSS-PL	10/22-09/23	81,821	81,821	
Randy's House	HRSS-RG	10/22-09/23	64,740	64,740	
Salvation Army Harbor Light Center	HRSS-HL	10/22-09/23	120,863	120,863	
SOOAR - Harm Reduction Services	HRSS-SO	10/22-09/23	80,720	80,720	
Wellness AIDS Services, Inc	HRSS-WA	10/22-09/23	128,776	107,001	

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Wellness Networks, Inc. dba UNIFIED HIV Health and Beyond	HRSS-WN	10/22-09/23	85,461	66,715	
Arab Community Center for Economic and Social Service	HRSS-AC	10/22-09/23	100,000	100,000	
Community Health Awareness Group	HRSS-CH	10/22-09/23	30,000	30,000	
Wayne State University	SSP-WS	10/22-09/23	69,787	69,787	
Michigan Public Health Institute - Ending HIV Epidemic H	EHIVHR-MP	10/22-09/23	41,196	31,053	
Michigan Public Health Institute - Harm Reduction Servic	HRSVS-MP	10/22-09/23	166,059	158,340	
Emergent Devices	DO 23*1031 / JV1 23*13363	10/22-09/23	7,000,075	6,999,422	
Criminal and Legal (491EG8101)					***2,500,000***
IADOC23-99022	MDOC	01/23-09/23	2,500,000	2,500,000	
Pregnant and Parenting (491EG8102)					***818,441***
Covenant Rooming In Expansion	HRIP-2023	04/23-09/23	250,000	170,000	
Michigan State Unviersity - Regional Perinatal Collaborative (now High Touch High Expansion)	RPC-MS	10/22-09/23	400,000	400,000	
Upper Peninsula Healthcare Solutions	RPC-2023	10/22-09/23	250,000	248,441	
Recovery (491EG8096)					***482,130***
Community Assessment Referral & Education - CARE	RSSC-2023	01/23-09/23	104,269	104,269	
Recovery Advocates in Livingston Inc	RSSC-2023	01/23-09/23	91,995	91,995	
Serenity Houe of Flint	RSSC-2023	01/23-09/23	149,998	140,611	

Section 110
Opioid Response Activities
Appropriation #57467
Fund 1584
FY 2023 Spending Plan

Grantee	Project Code	Performance Period	Current Contract Amount	MI Opioid Healing and Recovery Expenditures as of 11.15.23 1584	*Expenditure Totals Per Category*
WAI-IAM Inc	RSSC-2023	01/23-09/23	145,255	145,255	
Data (491XX3555)					***11,913***
Data (IA for LARA)		1/23-12/23	324,000		
DTMB Invoice from MODA (MICelerity)				9,413	
DTMB Invoices (MiCelerity)				2,500	
MDHHS-ENT-DW ADT Data to BioSpatial EMS-DEV			57,436		
Admin Contract Staff (491EG8186)					***25,000***
MPHI Salaries	OPSS-MP	5/23-09/24	125,000	25,000	
Equity (491EG8184)					***106,921***
Michigan Public Health Institute - OTF Racial Equity Workgroup (RWEG)	REW-MP	8/23-09/23	148,668	90,045	
Michigan Public Health Institute - Faith Based Learning	OFBLC-MP	05/23-09/23	250,000	16,876	
Admin 5% CAP (491EG8099)					***355,296***
Michigan Public Health Institute - Opioids Settlement Website and Technical Assistance Program Support	OSWTAP-MP	01/23-09/23	680,183	347,887	
DTMB Invoices and Travel Admin Expenses		10/23-09/23	-	7,409	
			19,892,414		
			Direct Contracts:	**16,144,606**	

OPIOID ADVISORY COMMISSION (OAC)

Grief Recovery After a Substance Passing (GRASP) Mid-Michigan Chapter

Session Date: 11/2/2023

Summary

A 90-minute listening session was held on November 2, 2023, with the regional support group Grief Recovery After a Substance Passing[1] (GRASP—Mid-Michigan Chapter); GRASP "was created to offer understanding, compassion, and support for those who have lost someone they love through addiction and overdose"[2]. The Mid-Michigan chapter offers a monthly in-person support group, of same or similar meeting duration.

The session was held in East Lansing, Michigan, at the group's standing meeting location; 18 attendees were present.

Attendees were provided with the following discussion considerations in advance of November 2, 2023, and were given approximately five (5) minutes each, to share (voluntarily) during the session; session format and facilitation was similarly aligned with the group's regularly scheduled meetings.

The Opioid Advisory Commission (OAC) is hoping to learn more about the following:

- *The experiences of family members who have had a loved one die from overdose, substance-related death, or suicide.*
- *Any supports that helped them [members] following their loss.*
- *Any supports that they [members] sought, but had difficulty accessing, following their loss.*
- *Any information about the experience of their loved one.*
- *Any information about supports that helped their loved one.*
- *Any information about supports that their loved one had difficulty accessing.*
- *Any thoughts or recommendations for how state opioid settlement funds should be used.*
- *Any thoughts or recommendations for existing services and supports that could be improved or expanded.*
- *Any thoughts or recommendations for supports and services for family members who have lost a loved one to overdose, substance-related death, or suicide.*
- *Any other areas that are not included but should be considered.*

The following themes were identified from the personal and familial accounts of participating attendees. Categories for "Recommendations" and "Experiences" were developed by OAC staff to capture thematic elements shared during the GRASP session.

[1] https://grasphelp.org/m/
[2] https://grasphelp.org/about-us/

Recommendations

Improve early identification and intervention

Recommendations were made for increasing supports within the K-12 system, for education, training, and resource allocation, to improve early identification and response measures for mental health conditions, learning disabilities, substance use disorders, co-occurring disorders, and trauma, among youth.

Improve education, youth prevention, and anti-stigma efforts

Recommendations were made to improve education and outreach efforts for youth within the K-12 system, including earlier delivery of educational and prevention programming, expansion of prevention services beyond primary prevention initiatives, and intentional efforts to reduce stigma associated with substance use disorders and mental health conditions.

Specific strategies for education/prevention were discussed by participants, including but not limited to:

- Education on the harms associated with substance contamination (e.g. presence of fentanyl in various substances).
- Education on fentanyl and associated risks, including mortality.
- Education on mental health conditions, substance use, substance use disorders, and trauma.
- Education on resources available for youth and families interested in support for mental health conditions, learning disabilities, substance use, substance use disorders, and trauma.

Increase supports for co-occurring disorders and complex needs

Recommendations were made for increasing services and supports that address co-occurring substance use and mental health disorders and complex needs, including but not limited to housing instability, medical and/or physical health needs, involvement in the criminal-legal system, and trauma/complex trauma.

Specific strategies that may support co-occurring and complex needs were discussed by participants, including but not limited to:

- Integrated care and co-location of mental health professionals within key systems/sectors.
- Increased education, training, and support for mental health needs and co-occurring. disorders—particularly within key systems/sectors that may encounter or provide services to impacted individuals.
- Enhanced coordination across key systems/sectors including emergency services, medical, health, behavioral health, court/carceral, and recovery.
- Increased education, training, and services to support trauma-informed care.
- Representation and inclusion of individuals with lived experience in key systems/sectors; increased integration of peer recovery and peer support professionals.
- Inclusion of systems navigators or coordinators; professionals to assist individuals in navigating multiple systems and making linkages to care.

- Expansion of specialized, wraparound teams that may provide a variety of supportive and/or clinical services.

Increase whole-person care and supports for basic needs

Recommendations were made to increase supports that address the whole person and provide for an individual's basic needs.

Specific strategies that may support whole person care and basic needs were discussed by participants, including but not limited to:

- Access to housing; increasing emergency, transitional, recovery, and/or supportive housing options.
- Access to transportation; increasing availability of and access to transportation that supports linkage to necessary services.
- Access to essentials; increasing support and low barrier paths for individuals to obtain essential items (food, clothing, etc.) at any point in their recovery process.
- Representation and inclusion of individuals with lived experience in key systems/sectors; increased integration of peer recovery and peer support professionals.
- Inclusion of systems navigators or coordinators; professionals to assist individuals in navigating multiple systems and making linkages to care.

Increase supports for justice-impacted individuals

Recommendations were made for increased and enhanced supports, specific to justice-impacted persons.

Specific strategies that may improve response efforts for justice-impacted individuals were discussed by participants, including but not limited to:

- Expanding embedded clinical and/or peer staff within law enforcement teams and/or first-responder agencies.
- Increasing diversion pathways for individuals with substance use disorders, mental health conditions, and/or co-occurring needs.
- Increasing transitional supports for individuals transitioning into the community from carceral (county jail or state/federal correctional) settings.
- Increasing supports for substance use disorders, mental health conditions, and transitional services, in carceral settings.
- Expanding specialized community support services for individuals with current justice-involvement.
- Representation and inclusion of individuals with lived experience (including experience with the criminal-legal system); increased integration of peer recovery and peer support professionals.
- Inclusion of systems navigators or coordinators; professionals to assist individuals in navigating multiple systems and making linkages to care

Expand supports delivered at critical times and critical intervention points
Recommendations were made for improving/expanding supports for delivery at critical times (e.g., transitions from treatment or carceral settings; post-incident/post-overdose) and at critical intervention points (e.g., embedded staff with law enforcement and/or first-responder teams; emergency departments; crisis residential and/or engagement centers; emergency housing providers; recovery organizations).

Improve immediate access to care and extended stays
Recommendations were made for improving immediate access to necessary health, behavioral health, and/or housing services including but not limited to acute detoxification programs, sub-acute detoxification programs, residential/inpatient SUD/COD treatment facilities, psychiatric inpatient facilities, engagement centers, crisis residential centers, community mental health providers, Medication for Opioid Use Disorder (MOUD)/Medication Assisted Treatment (MAT) providers, and emergency housing providers.

Recommendations were also made to extend program duration for detoxification services, and long-term residential/inpatient SUD/COD programming, including accessible options that extend beyond 6+ months.

Ensure supports for (and representation of) impacted families
Recommendations were made for increasing supports for impacted families including but not limited to (1) financial support for family members of decedents (e.g. funding to cover or offset burial/memorial costs), (2) financial support for children of decedents and/or funding to support kinship care (e.g. funding to assist with costs of living, childcare, college tuition/scholarship), and (3) general supports for impacted families (e.g. clinical/community support services for family members impacted by the loss of a loved one to overdose, substance-related death, and/or suicide).

Recommendations were also made to support meaningful inclusion and representation of impacted families in advisory and/or community planning spaces. Specifically, intentional representation of individuals who have experienced the loss of a family member due to overdose, substance-related death, and/or suicide.

Experiences

Familial lived experience
All attending individuals shared lived experience in the loss of a family member(s) due to overdose, substance-related death, suicide, and/or associated causes.
Noting additional experiences shared regarding family member(s) in current/active use, and those experiencing substance use disorders (SUD), and/or co-occurring mental health disorders (COD), presently.

Stigma
The theme of "stigma" was identified based on prevalent report of experiences of stigma, including but not limited to negative interactions, inequitable response measures, and/or unfair or false beliefs expressed to family members (and decedents), by first responders/law enforcement, behavioral health professionals, medical professionals, and/or educational professionals, regarding substance use, substance use disorder, mental health disorders, co-occurring disorders, involvement with the criminal-legal system, and/or overdose.

Co-occurring needs
The theme of "co-occurring needs" was identified based on prevalent report of a family member (decedent) experiencing a mental health condition(s) and co-occurring substance use disorder(s) and/or participant reference to the need for mental health services/supports.

Complex needs
The theme of "complex needs" was identified based on prevalent report of a family member (decedent) experiencing housing instability, multi-systems involvement, medical/physical conditions, co-occurring disorders and/or participant reference to the need for associated services/supports.

Early intervention
The theme of "early intervention" was identified based on prevalent report of a family member (decedent) experiencing a mental health condition(s) and/or additional learning needs, in early/middle childhood or adolescence, and/or participant reference to services/supports/training needed/lacking within the K-12 system.

Access to care
The theme of "access to care" was identified based on prevalent report of a family member (decedent) experiencing significant barriers (often repeated) to accessing necessary health, behavioral health, and/or housing services.

Justice-involvement
The theme of "justice-involvement" was identified based on prevalent report of a family member (decedent) experiencing involvement with the criminal-legal system, including but not limited to prior arrest and/or court involvement, experience in carceral/correctional settings, and/or experience on community supervision (probation/parole).

Additional Considerations

The following items represent additional considerations and recommended strategies/services shared by participants:

- Policy: Drug Decriminalization
- Policy and Program Development: Safe Use Sites/Supervised Consumption Services
- Utilization of Housing First models
- Improved service coordination (across key systems)
- Step-down models and structured/phased approaches to transitioning individuals out of care or carceral settings.
- Assisted Outpatient Treatment (AOT)[3] and/or court-determined therapeutic mandates.
- Emphasis on wraparound, case management, and/or peer support as critical services
- Expansion/development of SUD/COD residential treatment facilities.
- Increasing/enhancing research efforts around substance use, substance use disorders, mental health conditions, and co-occurring needs.

[3] https://behaviorhealthjustice.wayne.edu/aot#:~:text=Assisted%20outpatient%20treatment%20(AOT)%20is,at%20risk%20for%20negative%20outcomes.

OPIOID ADVISORY COMMISSION (OAC)

Tuscola County Overdose Fatality Review (OFR) Team

Session Date: 11/2/2023

Summary

A 90-minute listening session was held on November 2, 2023, with the Tuscola County Overdose Fatality Review team; "Overdose Fatality Review (OFR) teams are multidisciplinary and include individuals who can share information about a decedent or contribute to the analysis of available data to make recommendations that will prevent future overdose deaths."[1]

The session was held at the group's standing meeting time and offered virtually, to align with the team's existing meeting platform; 8 attendees were present.

Attendees were provided a brief overview of the Opioid Advisory Commission (OAC), the Community Voices initiative, and the format for the virtual session. Session structure was flexible, allowing for roundtable discussion, with voluntary participation, as desired. Clarifying questions from the OAC facilitator were permitted by the group. Attendees were provided with the following considerations for discussion:

Your experience—*what would you like to share about your experience(s)? Professionally and/or personally*

Your observations—*what are you seeing in your community? Strengths/Benefits; Needs/Gaps*

Your input—*how should the State be spending [state share] opioid settlement dollars?*

Your questions—*what questions do you have for the Opioid Advisory Commission or state government officials?*

The following themes were identified from discussion with participating attendees. The "Recommendations" category was developed by OAC staff to capture thematic elements shared during the Tuscola OFR session.

[1] https://michiganofr.org/

Recommendations

Expand treatment options and improve immediate access to care
Recommendations were made for expanding treatment options for substance use disorders (SUD), mental health conditions, and co-occurring disorders (COD), specifically inpatient/residential services. Regional limitations were noted in the lack of (1) withdrawal management programs, (2) SUD inpatient/residential treatment facilities, and (3) limited bed availability for both emergency and psychiatric inpatient services, within the Thumb Region.[2]

The absence of a local (regional) residential treatment facility, requires individuals seeking supports for withdrawal management and/or inpatient/residential SUD programming, to utilize services outside of the Thumb Region; this presents additional barriers for service access and increases the need for ancillary resources (transportation) to support admission. Noting additional needs identified in limited adolescent inpatient psychiatric services ("bed availability") and adolescent SUD treatment options.

Expand supports delivered at critical times and critical intervention points
Recommendations were made for improving/expanding supports at critical times (e.g. transitions from treatment or carceral settings; post-incident/post-overdose) and at critical intervention points (e.g. embedded staff with law enforcement and/or first-responder teams; emergency departments; crisis residential and/or engagement centers; emergency housing providers; recovery community organizations).

Participants identified opportunities for strategic outreach/engagement, as a means to improving resource-linkages and optimizing service-delivery. Current efforts, including strategic placement of peer recovery coaches, were discussed, with recommendations to expand existing services, especially those utilizing peer professionals in key sectors, at critical times and critical intervention points.

Increase housing and transportation supports
Recommendations were made to increase funding for transportation and housing supports; both were identified as enduring needs within the Thumb region.

Transportation
While public transportation options were referenced, significant limitations were noted in regional accessibility; noting that the Thumb is a predominantly rural community[3]. Further needs were noted in limited transportation options to support immediate linkage to necessary services.

Alternative transportation options presently available include utilization of peer professionals via Recovery Community Organizations (RCOs); transportation services offered in this capacity were identified as vital to the community and regularly utilized. However additional recommendations were

[2] "Thumb Region" is intended to describe the communities of Tuscola, Huron, and Sanilac counties.

[3] https://www.ers.usda.gov/webdocs/DataFiles/53180/25577_MI.pdf?v=0

made for (1) service expansion, and (2) increasing options for transportation at critical times, including admission to/discharge from crisis programming (SUD and/or mental health), discharge from carceral settings (community re-entry), discharge from the emergency medical/psychiatric settings (hospital discharge), withdrawal management and/or inpatient/residential SUD programming, and emergency housing admission/discharge.

Noting additional needs identified for transport to non-emergent (routine), necessary community-based services including but not limited to mental health and/or SUD treatment (including medication for treatment of opioid use disorder; MOUD services), primary and/or specialty medical care, court and/or required programming of the criminal-legal system, recovery programming, social services and/or organizations utilized to obtain necessary resources (food, clothing, etc.).

Housing

The need for housing was similarly emphasized, noting limited supportive housing options available in the Thumb region. Participants identified the need for general service development and expansion to address community needs, including but not limited to emergency housing, transitional housing, recovery housing ("sober living"), specialized supportive housing (e.g. justice-impacted individuals; families) and/or permanent supportive housing.

Increase supports for co-occurring disorders and complex needs

Recommendations were made to increase services and supports for co-occurring substance use and mental health disorders, and complex needs, including but not limited to medical, housing, transportation, education, employment, financial, familial/interpersonal, and legal.

Improve whole-person care and increase supports for basic needs

Recommendations were made to increase supports that address the whole person and provide for an individual's basic needs.

Strategies were identified to support whole-person care and resources to address basic needs, including but not limited to:

- Increasing funding for and access to essentials; increasing support and low barrier paths for individuals to obtain essential items (food, clothing, etc.) at any point in their recovery process
- Maintaining alignment and cross-sector collaboration to improve needs identification and response measures.
- Strategic placement of systems navigators/coordinators; professionals to assist individuals in navigating multiple systems and making linkages to care.
- Inclusion and utilization of peer professionals (individuals with lived experience) in all settings; ensuring representation of individuals with lived experience in key sectors.

Expand supports for justice-involved individuals

Recommendations were made to expand and enhance supports for justice-impacted persons. Community strengths were identified in existing diversion initiatives (specialty court programming). Gaps were identified in in medication-linkage and transitional services, however participants identified local efforts underway to improve medication and resource-linkage within carceral settings.

Strategies were identified to support justice-impacted individuals, including but not limited to:

- Increasing access to necessary medications in local carceral settings (county jail), including but not limited to medications for treatment of opioid use disorder (MOUD) and other substance use disorders; medications for treatment of mental health disorders.
- Increasing transitional supports for individuals re-entering the community from local carceral (county jail) settings; supports to be offered both in carceral settings and in the community, post-release.
- Increasing general supports for substance use disorders, mental health conditions, and transitional services, in carceral settings.
- Expanding specialized community support services for individuals with current justice-involvement.
- Maintaining strategic, cross-sector partnerships to support collaborative interventions for populations with complex needs.

Additional Considerations

The following items represent additional considerations and recommended strategies/services shared by participants:

- Increasing provider education and training around trauma ("trauma-informed care").
- Increasing funding for supports and services to address trauma and complex trauma, in multiple systems.
- Ensuring mental health and substance use disorder parity, in Michigan[4]; developing a comprehensive plan to support mental health and substance use disorder parity, including supports for integration/transition at the local level.
- Expanding coverage for fentanyl testing at local hospitals and treatment via LC/MS, GC/MS, or other valid, confirmatory processes; ensuring Medicaid reimbursement/coverage for fentanyl testing.
- **Experience:** Secondary trauma and professional "burnout" in key sectors.
  Recommendation: Development of a provider support network, facilitated at the regional and/or state level to support the following aims:
  - Development of a professional community, with inclusion of local/regional providers (and staff).

[4] https://www.cms.gov/marketplace/private-health-insurance/mental-health-parity-addiction-equity

- General support to address secondary trauma and/or professional burnout of direct service providers.
- Provider learning network, to exchange ideas/strategies/experiences with other providers/professionals.
- Planning and development: community planning for program planning and development.

OPIOID ADVISORY COMMISSION (OAC)

Jackson, Michigan—Jackson Area Recovery Community (JARC)

Session Dates: 11/7/2023; 11/10/2023

Summary

Two (2) public listening sessions were held in Jackson, Michigan on November 7, 2023, and November 10, 2023, respectively. Sessions were open to the public and were promoted as "listening sessions on the use of state opioid settlement funds".[1]

Both sessions were held at the Jackson Area Recovery Community (JARC), a recovery community organization (RCO)[2] with the following mission: "...to create a community that is free from stigma towards substance use disorder by bridging the gap between addiction and recovery through education, advocacy, and awareness. JARC aims to be a strong voice for the individuals and families in long-term recovery, ensuring a strong, healthy, and productive community"[3]; JARC is affiliated with Home of New Vision, a CARF[4]-accredited substance use disorder service-provider.[5]

Sessions were each 120-minutes in length and held at times that aligned with the existing "community drop-in" schedule at JARC; 17 total attendees were present.

Attendees were provided a brief overview of the Opioid Advisory Commission (OAC) and the Community Voices initiative. Facilitation format and participation expectations were discussed at the beginning of each session. Session structure was flexible, allowing for roundtable discussion, with voluntary participation, as desired. Clarifying questions from the OAC facilitator were permitted by the group. Attendees were provided with the following considerations for discussion:

Your experience—*what would you like to share about your experience(s)? Professionally and/or personally*

Your observations—*what are you seeing in your community? Strengths/Benefits; Needs/Gaps*

Your input—*how should the State be spending [state share] opioid settlement dollars?*

Your questions—*what questions do you have for the Opioid Advisory Commission or state government officials?*

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[1] https://council.legislature.mi.gov/Content/Files/OAC/JARC%20Final%20Flyer.pdf
[2] https://facesandvoicesofrecovery.org/wp-content/uploads/2023/03/070623_National-Standards-for-RCOs.pdf
[3] http://homeofnewvision.org/jarc/
[4] https://carf.org/
[55] http://homeofnewvision.org/

The following themes were identified from discussion with participating attendees. The "Recommendations" category was developed by OAC staff to capture thematic elements shared during the JARC community sessions.

Recommendations

Direct dollars to community organizations; create low barrier funding opportunities
Recommendations were made to invest state settlement funds back into the community; this would be achieved by directing dollars to community-based organizations, specifically nonprofit provider organizations. Participants reported funding limitations as the primary barrier in expanding/enhancing existing services for recovery, harm reduction/overdose prevention, behavioral health care, and housing.

Recommendations were also made to create low barrier funding opportunities for community-based organizations, specifically organizations serving disproportionately impacted populations. Considerations were suggested, including increasing communication with the public and evaluating how information about funding opportunities is currently provided (to communities). Recommendations for ensuring that funding opportunities be low barrier in ease of access, and application and reporting processes, were made.

Expand recovery supports for assertive outreach and engagement
Recommendations were made to increase support for direct engagement activities—specifically "assertive outreach"[6] efforts by peer professionals and expansion of engagement centers and mobile/community outreach teams.

Participants emphasized the importance of engagement, especially with the most vulnerable populations—individuals often considered hard-to-reach due to multiple, complex needs and environmental barriers (e.g., housing instability, active substance use, co-occurring mental health disorders, and involvement with the criminal-legal system). Populations served by assertive outreach activities were identified as individuals most "in-need" of resources and/or support services.

Participants also identified current assertive outreach efforts within the community and critical linkages to care, being provided by the following:

- Peer professionals
- Recovery Community Organizations (RCO)
- Engagement Centers
- Mobile harm reduction teams/harm reduction organization

[6] "Assertive outreach" is intended to include community outreach activities, delivered strategically, at specific times, locations, or settings, where the chance for contact/engagement with a target population is greatest, while environmental barrier(s) for contact/engagement, are lowest. Assertive outreach activities involve targeted efforts to engage with the most hard-to-reach populations, for the purpose of providing education, linking an individual to community resources, and/or delivering a specific service.

Increase housing and transportation supports

Recommendations were made to increase housing and transportation supports.

Significant housing needs were noted by participants, with service gaps identified around emergency, transitional, and recovery housing services; limited availability of "structured"/"Step Down" programming, was also identified. Beyond limited local providers, exclusionary policies, including narrow admission/eligibility criteria, lengthy "bans" following program infractions, and limited options for families, were discussed as contributive factors to current housing needs.

Participants also discussed the need for transportation to support critical linkages to care, including withdrawal management programs ("detox"), inpatient/residential substance use disorder (SUD) treatment, and outpatient MOUD[7] services. Barriers were discussed in the lack of on-call transportation options, that if available, may better support immediate access to care. Out-of-county/regional transports were identified as a significant need, given limited local service/provider options (residential SUD treatment), with current transportation options being provided by peer professionals through the local RCO, with noted limited capacity.

Increase supports delivered at critical times and critical intervention points

Recommendations were made to increase supports delivered at critical times (e.g. transitions from carceral or treatment settings; post-incident/post-overdose) and at critical intervention points (e.g. recovery community organizations, carceral settings, crisis residential and/or engagement centers; emergency housing).

Participants discussed existing efforts for critical time intervention, including services delivered through the local recovery community organization (RCO), engagement center, mobile harm reduction program/team, and emergency department/hospital. Existing services were regarded as essential to individual engagement and vital in supporting further linkages to care, including health and behavioral health services. Existing efforts were reported to be primarily delivered by peer professionals, positioned in various sectors/organizations. Recommendations were made to expand existing supports in order to meet (estimated) community need and enhance present efforts.

Expand and optimize existing services

Recommendations were made to (1) increase funding for expansion of existing community services and to (2) increase/enhance strategic partnerships for optimized service delivery.

Participants discussed community strengths, including services provided by the local engagement center, RCO, harm reduction organization, hospital, and county health department. Recommendations were made to increase funding to expand existing services, especially those which span multiple systems and provide critical linkages to care.

[7] "MOUD": Medications for opioid use disorder; https://www.samhsa.gov/medications-substance-use-disorders

Significant gaps were identified around critical services, previously offered, but not currently provided. Support for justice-impacted populations was emphasized, specifically MOUD services in carceral (jail) settings; jail-based MOUD was identified as an enduring need, previously, but not presently, addressed. Participants discussed how collaboration and strategic community partnerships may best support coordination, program development, optimization, and sustainability, especially around supports for populations with multi-systems involvement and complex needs (e.g., justice-involved individuals).

Ensure representation of individuals with lived experience; increase workforce development of peer professionals

Recommendations were made to ensure representation of individuals with lived experience in key sectors and to support broader workforce development of peer professionals.[8]

Participants discussed representation of individuals with lived experience as both a best practice and necessity, in providing culturally responsive services for those seeking support for SUD. Individuals with lived experience who serve as peer professionals, clinicians, community advocates, and in other various (service/community) roles, were regarded by participants as vital in helping build trust, develop meaningful engagement, and support service retention, among individuals seeking support for SUD.

Recommendations were made to ensure representation of individuals with lived experience in key sectors and systems, with additional funding and policy/messaging needed to best support widespread adoption.

Workforce development of peer professionals was also noted as essential, to addressing the need (reported) for more peer professionals in key sectors and supporting professional development opportunities for individuals in recovery. Strategies for workforce development were identified around increasing training/certification tracks, providing organizational incentives for development/utilization of peer positions, and increasing reimbursement rates for peer-delivered services.

[8] "Peer professionals" is intended to include both certified and non-certified professionals, who have lived experience with substance use disorders (SUD), and are presently in recovery, working in a peer-to-peer capacity; peer professionals work in a variety of settings including but not limited to prevention, treatment, recovery, harm reduction, health/medical, behavioral health, housing, and the criminal-legal system.

Additional Considerations

The following items represent additional considerations and recommended strategies/services shared by participants:

- Increase provider education around co-occurring disorders; increase funding to support co-occurring needs across key sectors.
- Increase funding to address stigma around SUD and mental health disorders; develop an anti-stigma campaign that challenges assumptions/stereotypes of addiction.
- Increase funding for engagement centers (specifically); explore opportunities to increase service duration (length of stay) to improve engagement and promote further linkages to care.
- Increase provider education and training around trauma.
- Explore variations of existing integrated/comprehensive housing programming (e.g. HOPWA[9]), that may be adapted to support populations with SUD and/or co-occurring disorders (COD).
- Increase funding for smoking supplies offered by harm reduction organizations.
- Collect and use local data to craft tailored interventions/resources that support engagement with different communities.
- Ensure inclusion of/coordination with local communities when collecting/analyzing data and determining Substance Use Burden, Substance Use Resources, and Social Vulnerability.[10]
- Ensure support and consideration for families (in recovery), specifically in supportive housing opportunities.

[9] https://www.hudexchange.info/programs/hopwa/
[10] https://www.michigan.gov/opioids/category-data

OPIOID ADVISORY COMMISSION (OAC)

Lansing, Michigan—Lifeboat Addiction Recovery Services (Lifeboat)

Session Date: 11/20/2023

Summary

A listening session was held in Lansing, Michigan on November 20, 2023. The session was open to the public and promoted as a "listening session on the use of state opioid settlement funds".[1]

The session was held at Lifeboat Addiction Recovery Services (Lifeboat), a recovery community organization (RCO)[2] and "... a Mid-Michigan, registered non-profit organization, certified in providing support services, to the addiction recovery community" with the following mission: "To provide community and peer support to all who seek recovery from substance use disorder and their loved ones. To end the stigma surrounding addiction and create a more recovery-positive culture".[3]

The listening session was 90-minutes in duration and held at a time that aligned with the existing "community drop-in" schedule at Lifeboat; 13 totals attendees were present.

Attendees were provided a brief overview of the Opioid Advisory Commission (OAC) and the Community Voices initiative. Facilitation format and participation expectations were discussed at the beginning of each session. Session structure was flexible, allowing for roundtable discussion, with voluntary participation, as desired. Clarifying questions from the OAC facilitator(s) were permitted by the group. Attendees were provided with the following considerations for discussion:

Your experience—*what would you like to share about your experience(s)? Professionally and/or personally*

Your observations—*what are you seeing in your community? Strengths/Benefits; Needs/Gaps*

Your input—*how should the State be spending [state share] opioid settlement dollars?*

Your questions—*what questions do you have for the Opioid Advisory Commission or state government officials?*

[1] https://council.legislature.mi.gov/Content/Files/OAC/Lifeboat%20Final%20Flyer.pdf
[2] https://facesandvoicesofrecovery.org/wp-content/uploads/2023/03/070623_National-Standards-for-RCOs.pdf
[3] https://lifeboataddictionrecovery.org/services

The following themes were identified from discussion with participating attendees. The "Recommendations" category was developed by OAC staff to capture thematic elements shared during the Lifeboat community session.

Recommendations

Increase supports for individuals with multi-systems involvement

Recommendations were made to increase supports for individuals involved in multiple systems (e.g., public SUD, criminal-legal, community mental health, emergency housing). Specific recommendations were made to support workforce development of system navigators, envisioned as professionals with unique knowledge of multiple, public systems, who could provide comprehensive support through systems navigation, resource-linkage, and general service coordination.

Participants identified significant gaps around information accessibility, low barrier access points, and limited service coordination. The lack of easily accessible information around critical processes, potential resources, eligibility requirements, and ancillary services, was identified as a significant barrier to service access and utilization. Participants also described how barriers for one system/service are exacerbated by the lack of coordinated efforts across multiple systems/services—presenting a significant challenge for any individuals seeking services—especially those most vulnerable, who present with the greatest need, the least resources, and the highest degree of systems involvement.

Increase supports for housing, transportation, and employment

Recommendations were made to increase funding for housing, transportation and employment supports.

Participants discussed the necessity of expanding housing supports to address emergent, transitional, recovery, and long-term (housing) needs. Consideration was made for the development of supportive/recovery housing options/communities, that provided safe and quality housing, in strategic (geographic) locations with limited access to drugs and alcohol.

Participants also discussed the enduring need for transportation, especially for accessing and maintaining engagement with health, behavioral health, recovery support services, MOUD services[4], maintaining adherence with legal requirements, and maintaining employment.

Recommendations were also made to expand/enhance employment services, especially those provided during critical transition periods and those built into existing supportive housing or court programming.

[4] "MOUD": Medications for opioid use disorder; https://www.samhsa.gov/medications-substance-use-disorders

Increase supports delivered at critical times and critical intervention points

Recommendations were made to increase supports delivered at critical times (e.g., transitions from carceral or treatment settings; post-incident/post-overdose) and at critical intervention points (e.g., recovery community organizations, carceral settings, crisis residential and/or engagement centers; emergency housing).

Participants discussed the need for increased (and adequate) supports to assist with systems navigation, resource-linkage, care/service coordination, housing, transportation, and employment—all deemed necessary for successful transition back into the community.

Significant gaps were identified in the lack of transitional support around:

- Discharge from inpatient/residential SUD treatment facilities and,
- Community re-entry from correctional facilities (carceral settings).

Further recommendations were made to expand transitional support services provided within key systems (e.g., jails, prisons, and residential treatment facilities), while also ensuring adequate support and "follow-up" during an individual's transition period.

Ensure representation, culturally responsive supports, and consumer choice

Recommendations were made to ensure that key sectors and systems are inclusive and representative of BIPOC communities,[5] including professional training and direct representation of BIPOC professionals within provider agencies. Considerations were discussed for developing culturally responsive services and ensuring that consumers/recipients have a choice in who is providing their care. Participants identified the ways in which feeling comfortable with a support worker/service provider (e.g., clinician, peer recovery coach, physician) may play a crucial role in initial trust-building and service-engagement/utilization.

Ensure provider accountability; develop a state oversight board for public SUD service providers

Recommendations were made to increase accountability for and oversight of public SUD service providers, to ensure the delivery of quality care and consumer protection. Participants discussed the need for a state-level oversight board to develop/enhance standards and practices related to SUD services, monitor providers for adherence, and manage consumer complaints. Participants discussed how a state-level oversight board may also serve as a centralized point for receiving and investigating concerns about SUD service-providers; noting uncertainty around current state-level resources to address consumer concerns.

Expand assertive outreach and engagement

[5] "BIPOC": Black, Indigenous, and People of Color

Recommendations were made to increase support for direct engagement and assertive outreach[6] as a means to reducing barriers to care.

Participants emphasized the importance of engagement, especially with individuals considered hard-to-reach due to multiple, complex needs, and environmental barriers (e.g., housing instability, active substance use, co-occurring mental health disorders, and involvement with the criminal-legal system).

Participants described current processes for accessing care that often presented additional burden on the individual. Services with lengthy requirements and determination processes with multiple, complicated steps, were discussed as a significant barrier to linking individuals with supportive services.

Additional Considerations

The following items represent additional considerations and recommended strategies/services shared by participants:

- Increase education, advocacy, and funding to support development of supervised consumption services/safe use sites.[7]
- Expand existing supports for life skills/support services, including but not limited to budgeting/financial management.
- Reduce compartmentalization ("siloing") of support services and key systems; develop regional/local access points to assist individuals in navigating services and systems.
- Increase SUD and mental health services offered in carceral settings; ensure that services are in place for continuation of necessary medications in carceral settings, including psychiatric medications and MOUD.

[6] "Assertive outreach" is intended to include community outreach activities, delivered strategically, at specific times, locations, or settings, where the chance for contact/engagement with a target population is greatest, while environmental barrier(s) for contact/engagement, are lowest. Assertive outreach activities involve targeted efforts to engage with the most hard-to-reach populations, for the purpose of providing education, linking an individual to community resources, and/or delivering a specific service.

[7] https://harmreduction.org/issues/supervised-consumption-services/

Recognizing Principles in Action, Promising Partnerships, and Community Innovations

The Opioid Advisory Commission (OAC) is partnering with the Michigan Association of Counties, Michigan Municipal League, and Michigan Townships Association, to spotlight local governments that are demonstrating promising practices, in alignment with national guidance.

The Opioid Litigation Principles from the Johns Hopkins Bloomberg School of Public Health (coalition) provide guidance on the spending of opioid settlement funds, for all jurisdictions. The principles are nationally recognized and have been endorsed by over 60 organizations from across the country.

The Principles

Principle 1. Spend the Money to Save Lives
Principle 2. Use Evidence to Guide the Spending
Principle 3. Invest in Youth Prevention
Principle 4. Focus on Racial Equity
Principle 5. Develop a Fair and Transparent Process for Deciding Where to Spend Funds

Nomination Process

Individuals can nominate their local government (jurisdiction) for recognition by the OAC, within quarterly and annual reports of the Commission—completion of this form allows for nomination of a jurisdiction.

Through nomination, the work of local governments may also be shared with the National Association of Counties (NACo.) Opioid Solutions Center for recognition on their website or within publications and Johns Hopkins Bloomberg School of Public Health as nomination for Awards for Excellence in the Application of the Opioid Litigation Principles.

Data collected from this survey will be housed with the OAC and shared with the Michigan Association of Counties, Michigan Townships Association, and Michigan Municipal League.

For more information, please contact oac@legislature.mi.gov.

Nomination

Please complete the following sections to help us with notification.

*Required items

1. **Nominator name and title***

2. **Nominator email***

3. **Are you nominating:**

- ◯ A jurisdiction or organization you work for
- ◯ A jurisdiction or organization you know of
- ◯ Other (please specify)

4. **Jurisdiction name***

5. **What type of jurisdiction are you nominating?***

- ◯ City/Town
- ◯ Township
- ◯ County

6. **Please provide a point of contact for the jurisdiction you are nominating.***

Point of Contact Name

Point of Contact Email

Decision-making process

Help us understand the process(es) this jurisdiction is using to determine how to spend opioid settlement funds.

7. **Please give an overview of the process used in this jurisdiction to determine how to spend the funds from the opioid settlement.**
Select all items that apply

- [ ] Collaborative community-wide strategic planning process
- [ ] Community listening sessions, roundtables, and/or town halls
- [ ] Community assessment (surveys and/or focus groups)
- [ ] Landscape analysis and/or gap inventory
- [ ] Creation of advisory council or steering committee
- [ ] Other (please specify)

Community Innovations

8. **Please share information on any innovative practices or strategies that were used through planning efforts.**

9. **Please share information on any innovative practices or strategies that were, or will be, funded.**

Promising Partnerships

10. **Please share information on any promising partnerships or community-inclusion efforts that the jurisdiction engaged in throughout the planning process.**

Principles in Action

The Bloomberg-Hopkins Principles lay out an approach to determine how to spend the dollars. Please identify which strategies this jurisdiction has implemented, that support adoption of the Principles.

11. **Principle 1. Spend the money to save lives**
Select all items that apply

- [ ] Establishing a dedicated fund
- [ ] Supplementing rather than supplanting existing funding
- [ ] Not spending all the money at once
- [ ] Reporting to the public on where the money is going
- [ ] Other (please explain)

12. **Principle 2. Use evidence to guide spending**
Select all items that apply

- [ ] Directing funds to programs supported by evidence
- [ ] Removing policies that may block adoption of programs that work
- [ ] Building data collection capacity
- [ ] Other (please explain)

13. **Principle 3. Invest in youth prevention**

Select all items that apply

- [ ] Directing funds to evidence-based interventions
- [ ] Other (please specify)

14. **Principle 4. Focus on racial equity**

Select all items that apply

- [ ] Investing in communities affected by discriminatory policies
- [ ] Supporting diversion from arrest and incarceration
- [ ] Funding anti-stigma campaigns
- [ ] Involving community members in solutions
- [ ] Other (please specify)

15. **Principle 5. Develop a fair and transparent process for deciding where to spend funds**

Select all items that apply

- [ ] Determining areas of need
- [ ] Receiving input from groups that touch different parts of the epidemic to develop the plan
- [ ] Ensuring that there is representation that reflects the diversity of affected communities when allocating fund
- [ ] Other (please specify)

16. **Please describe how the jurisdiction implemented the Principles (strategies) selected above.**

(Less than 500 words)

Key Takeaways

17. **In deciding how to spend money from the opioid litigation, what can other localities learn from the approach that was used in this jurisdiction?**
(Less than 500 words)

18. **What else should we know about the process to spend the opioid litigation funds in this jurisdiction?**
(Less than 500 words)

Opioid Advisory Commission
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