final minutes

Opioid Advisory Commission (OAC) Meeting
10:00 a.m. • July 20, 2023
Legislative Conference Room • 3rd Floor Boji Tower Building
124 W. Allegan Street • Lansing, MI

Members Present:
Mr. Brad Casemore
Judge Linda Davis
Ms. Katharine Hude
Ms. Mona Makki
Mr. Patrick Patterson
Dr. Cara Poland
Mr. Kyle Rambo
Dr. Sarah Stoddard

Members Excused:
Ms. Kelly Ainsworth
Mr. Scott Masi
Mr. Mario Nanos
Dr. Cameron Risma

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

Mr. Jared Welehodsky serving as a representative from the Michigan Department of Health and Human Services was in attendance.

Mr. Mario Nanos joined in-person at 10:02 a.m.

I. Call to Order
The Chair called the meeting to order at 10:00 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 May 11, 2023, Meeting Minutes
The Chair directed attention to the proposed minutes of the May 11, 2023, meeting and asked if there were any changes. **Judge Davis moved, supported by Mr. Patterson to approve the minutes of the May 11, 2023, meeting minutes. There was no further discussion and the Chair asked for a roll call vote. The motion prevailed and the minutes were approved.**

IV. Committee Member Appointments Update
The Chair indicated the Commission has not yet received confirmation of appointments to those members of the Commissions whose terms expire in July and expressed members currently in place will remain. The clerk will alert the Commission when confirmation is received from leadership.

V. Public Comment

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

- Mr. Brand Newlin representing the Billion Pill Pledge Program, materials provided.
- Ms. Brandy Novicka representing the disabled chronic pain population encouraging the Commission to include this population in discussions bringing attention to the Commission the harms that opioid prohibition has caused chronic pain patients (CPPs) and asked for support in correcting the problem.
- Ms. Darlene Berger, representing the chronic pain community, materials provided.
- Dr. Deborah Smith representing Wellness, InX introducing services as a provider of substance disorder assessment, diagnosis, evaluations, community case management, peer support and training for peer recovery.
- Dr. Lori Burke and Dr. Jennifer Hoffman representing ConnectHealth introducing services as changing patient behavior and improve patient outcomes that multiplies the effectiveness of medical professionals.
- Ms. Diana Arnold, a pain patient expressing the need to help individuals with chronic pain.
- Ms. Claudia Remenar representing Grief Recovery After a Substance Passing (GRASP), materials provided.
- Mr. Robert Marks, a pain patient expressing the need to include the DEA and doctors in future Commission discussions.

VI. Key Items and Activities

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

- Recommendations to state legislature
- Quarterly reports
- Regional listening and informational sessions
- Community Engagement and Planning Collaborative (advisory workgroup)
- Opioid Settlement State-Local workgroup
- Inclusion/representation of Tribal partners (preliminary outreach plan)

VII. Michigan Department of Health and Human Services (MDHHS): Department Updates.

The Chair welcomed Mr. Welehodsky and opened the floor for MDHHS to discuss updates.

VIII. Commission Member Comment

The Chair noted the Commission Member comments were discussed during MDHHS updates.

- Mr. Casemore inquired on the OAC proposed meeting schedule handout. Ms. King expressed the dates were provided to Commissioners to allow time to confirm availability and will be discussed at the September meeting.
- Mr. Rambo expressed interest in how the Attorney General's office will spend the opioid funds received. Ms. Hude supports. Ms. King will follow up on Mr. Rambo's inquiry.

IX. Next Meeting Date: Thursday, September 14, 2023.

The Chair announced the next meeting date for Thursday, September 14, 2023, 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 11:51 a.m. with unanimous support.

OPIOID ADVISORY COMMISSION (OAC)
PROPOSED MEETING SCHEDULE
NOVEMBER 2023 – MAY 2024

Thursday, November 16, 2023
10:00a – 12:00p

Thursday, December 14, 2023
10:00a – 12:00p

Thursday, January 11, 2024
10:00a – 12:00p

Thursday, February 8, 2024
10:00a – 12:00p

Thursday, March 14, 2024
10:00a – 12:00p

Thursday, April 18, 2024
10:00a – 12:00p

Thursday, May 16, 2024
10:00a – 12:00p

OPIOID ADVSORY COMMISSION (OAC)
Q1 Fiscal Year 2023-2024
Progress Report—Outline

I. EXECUTIVE SUMMARY

II. OPIOID SETTLEMENTS AND STATE SPENDING

a. Settlement tracking
b. Expenditure reports (boilerplate Sec. 917)
c. Spending Plans (boilerplate Sec. 917)
d. Policy/legislation tracking

III. REGIONAL/STATE STATS

a. MODA Dashboard and CDC stats
    - Fatal and non-fatal overdose by geographic location
    - Fata and non-fatal overdose by race/ethnicity
    - MI-SUVI data
b. State and/or regional data
    - Co-occurring Disorders
    - Justice-Involvement
    - SDOH

IV. OAC INITIATIVES

a. Listening Sessions
    - Overview
    - Implementation
    - Qualitative data analysis
    - Key Takeaways
b. Community Engagement and Planning Collaborative (advisory workgroup)
    - Overview
    - Status updates
c. Efforts to support equity and community inclusion
    - Disproportionately impacted populations and communities
    - Individuals and families with lived experience with SUD, COD, and/or involvement in the criminal-legal system
d. Policy considerations

V. OAC COMMUNITY ENGAGEMENT AND PLANNING COLLABORATIVE

a. Summary of charter and key tasks
b. Current work
c. Recommendations

VI. STATE INITIATIVES

a. DHHS initiatives
    - Key projects
    - Equity initiatives
b. Opioids Task Force updates

VII. LOCAL INITIATIVES

a. Local trends
b. Bloomberg/Hopkins Principles: Community Spotlights
c. State-Local collaboration

VIII. SCORECARD

a. Scorecard
b. Methodology
c. Key Takeaways

IX. NEXT STEPS

Note: Standing section for Tribal partners (including recommendations) to be explored with Tribal leaders.

OPIOID ADVISORY COMMISSION (OAC)
REGIONAL LISTENING SESSIONS

PURPOSE
To increase meaningful community inclusion in discussion around planning and use of state opioid settlement funds. To solicit and use input[i] from community members, specifically those who have been directly and/or disproportionately impacted, when developing recommendations for funding and policy initiatives to the state legislature.

OBJECTIVES
Encourage and utilize community input to enhance OAC/legislative understanding of community (i) needs, (ii) priorities, (iii) service gaps, (iv) cultural considerations, (v) planning and implementation considerations, (vi) funding recommendations and (vii) funding priorities, as related to state opioid settlement funds.

a. Accessibility: Establish easily accessible "listening" spaces that are available to the public and geographically equitable.
b. Inclusivity: Increase opportunities for community stakeholders and individuals and families impacted by Michigan's opioid epidemic to provide direct input to the OAC.
c. Equity: Increase opportunities for communities that have been disproportionately impacted by Michigan's opioid epidemic to discuss needs, priorities, and solutions.
d. Utility: Utilize community input when developing recommendations for funding and policy initiatives; publicly inform community members how input from "listening sessions" will be used by the OAC.

"Listening Session": a facilitated discussion with a group of individuals, aimed at collecting information about their experience, observations, and recommendations.

TARGET ATTENDEES
Individuals and families with "lived experience", consumers of public SUD, SSP and community mental health services, community stakeholders, Tribal partners, state legislators.

"Lived Experience" as defined by personal or familial experience of substance use, substance use disorder(s) (SUD), co-occurring disorder(s) (COD), and/or involvement in the criminal-legal system.

Community Stakeholders

Health Providers

- Community Health Departments *Representatives affiliated with overdose reporting, Syringe Service Programs and/or Community Health Workers (CHW)*
- Local Hospitals *Representatives from emergency departments*
- Primary and Specialty Medical Providers
- FQHCs and Integrated Care Facilities
- Mobile Treatment Providers
- Prevention Programs/Specialists

Behavioral Health Treatment Providers

- Regional Stakeholders
  - PIHP/CMHEs

- SUD Treatment Providers
  - Residential
  - Outpatient
  - MOUD/MAT/MAR
  - OHH
  - Carceral/Jail-Based MOUD Providers
  - Prevention Programs/Specialists

- Mental Health Treatment Providers
  - Community Mental Health Agencies
  - CCBHCs
  - Crisis Residential Centers
  - Carceral/Jail-Based Mental Health Providers
  - Prevention Programs/Specialists

Recovery Service Providers

- Recovery Community Organizations (RCOs)
- Peer Support Specialists
- Peer Recovery Coaches
- AA/NA/Smart Recovery Providers (12-Step Community)
- Recovery Housing Providers
- Drop-In Centers

Supportive Service Providers

- Emergency/Transitional Housing Providers
- Youth Emergency Housing Providers
- Emergency Food/Clothing Providers
- Outreach Teams/Community Engagement Specialists
- Adult Educational/Vocational Programs
- Organizations serving justice-involved individuals

Emergency Services

- EMS
- Law Enforcement (City/County/MSP)
- Quick Response/Post-Incident Response Teams
- Crisis Intervention Teams

Criminal-Legal

- MDOC Field Offices (Probation/Parole Departments)
- District Probation Offices
- Treatment Courts (Drug Court, Sobriety Court, Mental Health Court, Wellness Courts, Veterans Treatment Courts, etc.)
- District/Circuit Courts

- County Jails
- Juvenile Detention
- Juvenile Probation Offices
- Engagement Teams/Providers

Faith-Based Communities

- Churches/Congregations
- Faith-Based Service Organizations

Education K-12

- Intermediate School District (ISD) *Representatives/staff providing specialized/ancillary support (social work, counseling, juvenile diversion programming, prevention programming, etc.)*
- Local Middle/High Schools

Local Government

- County/Municipal/Township BOC
- Elected Officials

PLANNING CONSIDERATIONS

1. **Inclusion of individuals directly impacted:** Meaningful attempts should be made to engage and include individuals who have been directly impacted by Michigan's opioid epidemic.
   Priority populations may include, but are not limited to:
   - *Individuals with lived experience, as it relates to substance use disorder(s)(SUD) and/or co-occurring mental health condition(s) (COD)*
   - *Families with lived experience, as defined by a family member with a substance use disorder(s) (SUD) and/or co-occurring mental health condition(s) (COD)*
   - *Individuals with current and/or prior lived experience in the criminal-legal system*
   - *Families with lived experience, as defined by a family member with current and/or prior involvement in the criminal-legal system*
   - *Individuals with current and/or prior involvement in the public SUD and/or mental health treatment systems*
   - *Individuals with current and/or prior utilization of Syringe Service Programs (SSP) or other harm reduction services*
   - *Individuals with current and/or prior utilization of community-based recovery services*

2. **Inclusion of disproportionately impacted communities:** Additional attempts should be made to engage and include communities that have been disproportionately impacted by Michigan's opioid epidemic.
   Priority communities may include, but are not limited to:
   - *Geographic communities that fall within the 75th -100th percentile on the Michigan Substance Use Vulnerability Index (MI-SUVI)*
   - *Geographic communities with highest rates of fatal and/or non-fatal overdose*
   - *Racial/Ethnic communities with disproportionate rates of fatal and non-fatal overdose*

- *Tribal communities—noting further discussion with Tribal leaders to determine (a) interest and (b) recommendations for community listening sessions.*

3. **Inclusion of legislative members:** Efforts should be made to involve legislative members in OAC regional listening sessions. Considerations of the legislative calendar (session vs. non-session days) will be made to support legislative inclusion.

   - *District maps by county*
     https://www.michigan.gov/micrc/mapping-process/final-maps/district-maps-by-county
   - *House and Senate statewide district maps*
     https://www.michigan.gov/micrc/mapping-process/final-maps
   - *List of Representatives*
     https://www.house.mi.gov/AllRepresentatives
   - *List of Senators*
     https://senate.michigan.gov/senators/senatorinfo_complete.html

4. **Efforts to support equitable access:** Efforts should be made to support equitable access to OAC listening sessions, for those who may not have personal access to technological resources and/or those who may not feel comfortable with public speaking.
   - ***Consider hybrid sessions:*** *While listening sessions may be held virtually, offer in-person, community-based options that are publicly accessible, to support equitable opportunities for participation. Identify at least one (1) organization, per region, to serve as community host for in-person sessions.*
   - ***Consider supplemental options for input/feedback:*** *Develop a simple, easily accessible, community-based survey that can be distributed as an alternative to community listening sessions. Survey to be offered in multiple forms (electronic/web-based and hard-copy). Coordinate with host and/or participating organization(s) to assist with distribution and collection.*

5. **Collaboration with workgroup members:** Project collaboration with members of the Community Engagement and Planning Collaborative (advisory workgroup) may help expand outreach and engagement efforts with community stakeholders, optimize operations of the listening and information sessions, and enhance partnership between members of the Collaborative and members of the OAC.*
   **Noting further exploration of opportunities for collaboration following initial convening of the Collaborative (advisory workgroup) in September 2023.*

REGIONAL COORDINATION

The following items (proposed) are intended to support coordination efforts for regional listening and/or information sessions:

Listening Sessions
Frequency: Monthly
Schedule: Last Monday of the month
Session Time: 4:00-6:00p
Session Duration: 2 hours (120 mins)

Session Type: Hybrid (Virtual and In-Person)

Information Sessions *Proposed*

Frequency: Monthly

Schedule: 3rd Monday of the month following regional listening session

Session Time: 11:00a-1:00p

Session Duration: 2 hours (120 mins)

Session Type: Hybrid (Virtual and In-Person)

Purpose – To create and maintain two-way direct collaboration between the Opioid Advisory Commission (OAC) and Stakeholders.

Objectives – To inform communities on status of OAC efforts and remediation plans. To synchronize efforts of Opioid Advisory Commission (OAC), Opioids Task Force (OTF), Michigan Department of Health and Human Services (MDHHS), Michigan Department of Attorney General (AG), Prepaid Inpatient Health Plans (PIHPs)/Community Mental Health Entities (CMHEs) and communities involved in opioid settlement funds "distribution".

Key Offices – TBD

LISTENING SESSIONS—SUGGESTED TIMELINE AND COORDINATION STEPS

45-60 days prior to event(s):

- ☐ Identify community stakeholders; engage with community stakeholders
- ☐ Identify key legislators by Senate and House districts within region; engage with key legislative offices
- ☐ Identify community host(s) for hybrid (in-person) session
- ☐ Identify technology needs
- ☐ Identify support staff to assist with event coordination
- ☐ Identify engagement and inclusion strategies for priority populations
- ☐ Identify capacity limitations
- ☐ Develop event announcement/flyer (modify template)
- ☐ Optional: Explore event registration process

30-45 days prior to event(s):

- ☐ Distribute announcement/flyer to community stakeholders; continue engagement efforts
- ☐ Distribute announcement/flyer to key legislative offices; continue engagement efforts
- ☐ Optional: Open event registration
- ☐ Engage priority populations through identified strategies
- ☐ Confirm technology needs and supports
- ☐ Confirm staff needs and supports
- ☐ Develop plan for distribution and collection of survey; discuss with community host(s)

14 days prior to event(s):

- ☐ Send event reminder including announcement/flyer to community stakeholders; continue engagement efforts
- ☐ Send event reminder including announcement/flyer to key legislative offices; continue engagement efforts

- ☐ Continue to engage priority populations through identified strategies
- ☐ Confirm plan for distribution and collection of survey; coordinate with community host(s)

7 days prior to event(s):

- ☐ Send event reminder including announcement/flyer to community stakeholders; continue engagement efforts
- ☐ Send event reminder including announcement/flyer to key legislative offices; continue engagement efforts
- ☐ Continue to engage priority populations through identified strategies
- ☐ Tech walk-through with support staff and community host(s)

1 day prior to event(s):

- ☐ Send event reminder including announcement/flyer to community stakeholders; continue engagement efforts
- ☐ Send event reminder including announcement/flyer to key legislative offices; continue engagement efforts
- ☐ Continue to engage priority populations through identified strategies
- ☐ Final walk-through/confirmation with community host(s)

DAY OF EVENT: LISTENING SESSION HELD

1 day following event(s):

- ☐ Send summary and thank you notice to community stakeholders; continue engagement efforts
- ☐ Send summary and thank you notice to key legislative offices; continue engagement efforts
- ☐ Send summary and thank you notice to community host(s)
- ☐ Send summary and thank you notice to participating legislative offices
- ☐ Begin collection efforts of survey responses from community host(s); confirm deadline for final submission (1 week/7 days)

7 days following event(s):

- ☐ Collect remaining survey responses from community host(s)

IF HOLDING INFORMATIONAL SESSION

- ☐ If applicable: Distribute announcement/flyer to community stakeholders; continue engagement efforts
- ☐ If applicable: Distribute announcement/flyer to key legislative offices; continue engagement efforts
- ☐ Optional: Open event registration
- ☐ Engage priority populations through identified strategies
- ☐ Confirm technology needs and supports
- ☐ Confirm staff needs and supports

TEMPLATES

Items to be created by OAC Coordinator (proposed) for standardized use in all listening sessions and information sessions

Listening Session (materials)

- Event Announcement: Language and Flyer
- Community Survey
- Facilitation guide and visual aids (slide deck)
- Disclaimer for recording (Zoom)
- Description of how community member input will be used in OAC activities
- Event Summary
- "Thank You" Letter (partners)
- "Thank You" Letter (legislative offices)

Information Session (materials)

- Event Announcement: Language and Flyer
- Slide Deck *To be created in collaboration with other key offices*
- Disclaimer for recording (Zoom)
- Description of how community member input will be used in OAC activities
- Event Summary
- "Thank You" Letter (partners)
- "Thank You" Letter (legislative offices)

SESSION FACILITATION

Considerations for facilitation of regional listening sessions

Consider utilizing visual aids (slide deck) that cover all information as part of 10-15 min introduction and session overview.

Session Facilitator(s): Designate a session facilitator and determine role/responsibilities. The facilitator's role and responsibilities should be simply and clearly communicated to participants at the start of the meeting as should role/responsibilities of any support staff (community host) assisting with event operations.
*Suggested facilitation by OAC Coordinator and/or Commission Lead**
**Noting potential inclusion of workgroup member(s) to assist with session facilitation—TBD*

Purpose, Parameters and Participation Expectations: The purpose of the listening session, parameters for session operations, and participation expectations should be simply and clearly communicated to all participants at the start of the meeting.
Participation expectations should also include time limits for public comment (5 mins) and what participants can expect if time is exceeded.

Participants should be informed about what to expect in terms of session management:

- How are individuals selected to speak?
- Who is assisting with managing the session?

- How long does each individual have to speak? (5 mins)
- What occurs if comment time limit is exceeded?
- What occurs if session is scheduled to conclude and there are still attendees waiting to speak?
- What options/alternatives are there to provide input?

Introduction and Purpose of Survey
Brief introduction of survey, purpose, and how participants can access and submit survey should also be simply and clearly communicated.
Survey access and submission should be reviewed again at conclusion of the listening session.

Disclaimer and Explanation of Information Use: A disclaimer about any session recordings (virtual session) and an explanation of how community input/information communicated during the listening session will be used by the OAC, should be simply and clearly communicated to all participants at the start of the meeting.

Focus Areas: Guidance should be provided on what specific input is being solicited from participants. For virtual sessions, consider displaying slide for session duration with visual prompts for participants, including but not limited to:

- First name
  What is your first name?

- County (or Tribal community) of residence
  What County or Tribal community do you live in?

- If applicable: Organizational affiliation
  If applicable, what organization are you affiliated with?

- Personal and/or experience
  What would you like to share about your personal and/or professional experience?

- Observations of community need(s)
  What needs do see in your community? What do you believe should be a priority?

- Suggestions for use of opioid settlement funds
  What recommendations do you have for the OAC/state legislature for how state opioid settlement funds should be used?

- Suggestions for planning/implementation considerations
  What recommendations do you have for the OAC/state legislature for how programs funded with settlement dollars should be planned for, developed, and/or implemented in your community?

- Questions for the OAC
  What questions do you have for the OAC?
  REMINDER that questions will not be answered at the listening session but will be taken for further consideration.

[i] https://opioidprinciples.jhsph.edu/the-principles/

Bloomberg/Hopkins Principle 5: Develop a fair and transparent process for deciding where to spend the funding.
This process should be guided by public health leaders with the active engagement of people and families with lived experience, as well as other key groups

Receive input from groups that touch different parts of the epidemic to develop the plan.

Jurisdictions should draw upon public health leaders with expertise in addiction and substance use to guide discussions and determinations around the use of the dollars. They should also include groups with firsthand experience working with youth and people who use drugs—including prevention and treatment providers, law enforcement personnel, recovery community organizations, social service organizations, and others—who have insights into strategies that are working, those that need to be revised, and areas where new investments are needed.

Once a jurisdiction has conducted an initial assessment of areas where additional resources would be helpful, it should solicit and integrate broad feedback to design a plan that will meet the needs of the local community.

Jurisdictions should be sure to include people with lived experience, including those receiving medications as part of their treatment, as part of the decision-making process. The Ryan White Program, which distributes HIV funds to affected communities, demonstrates one way to do this; at least one-third of the members of the community Planning Councils that allocate funds to treatment providers must receive program services themselves. **In addition to the groups from which a jurisdiction may formally seek input, they should also solicit and use input from the public. This will help raise the profile of the newly developed plan and give those with particular insights—such as families and other members of the recovery community—a chance to weigh in.**

REGIONAL LISTENING SESSIONS
PLANNING DOCUMENT

Session (Listening or Information)_____
Commissioner Lead_____
Co-Lead(s)_____

Tentative Date (Listening Session):_____
Tentative Date (Informational Session):_____
Region:_____
Counties in Region:_____

Key Legislative Offices:_____

Community Host(s):_____

Community Stakeholders

a. Health Providers:

- Community Health Departments *Representatives affiliated with overdose reporting, Syringe Service Programs and/or Community Health Workers (CHW)*
- Local Hospitals *Representatives from emergency departments*
- Primary and Specialty Medical Providers
- FQHCs and Integrated Care Facilities

- Mobile Treatment Providers
- Prevention Programs/Specialists

Community Stakeholders

b. Behavioral Health Treatment Providers:

- Regional Stakeholders
  - PIHP/CMHEs
- SUD Treatment Providers
  - Residential
  - Outpatient
  - MOUD/MAT/MAR
  - OHH
  - Carceral/Jail-Based MOUD Providers
  - Prevention Programs/Specialists
- Mental Health Treatment Providers
  - Community Mental Health Agencies
  - CCBHCs
  - Crisis Residential Centers
  - Carceral/Jail-Based Mental Health Providers
  - Prevention Programs/Specialists

Community Stakeholders

c. Recovery Service Providers

- Recovery Community Organizations (RCOs)
- Peer Support Specialists
- Peer Recovery Coaches
- AA/NA/Smart Recovery Providers (12-Step Community)
- Recovery Housing Providers
- Drop-In Centers

Community Stakeholders

d. Supportive Service Providers

- Emergency/Transitional Housing Providers
- Youth Emergency Housing Providers
- Emergency Food/Clothing Providers
- Outreach Teams/Community Engagement Specialists
- Adult Educational/Vocational Programs
- Organizations serving justice-involved individuals

Community Stakeholders

e. Emergency Services

- EMS
- Law Enforcement (City/County/MSP)
- Quick Response/Post-Incident Response Teams
- Crisis Intervention Teams

Community Stakeholders

f. Criminal-Legal

- MDOC Field Offices (Probation/Parole Departments)
- District Probation Offices
- Treatment Courts (Drug Court, Sobriety Court, Mental Health Court, Wellness Courts, Veterans Treatment Courts, etc.)
- District/Circuit Courts
- County Jails
- Juvenile Detention
- Juvenile Probation Offices
- Engagement Teams/Providers

Community Stakeholders

g. Faith-Based Communities

- Churches/Congregations
- Faith-Based Service Organizations

Community Stakeholders

h. Education K-12

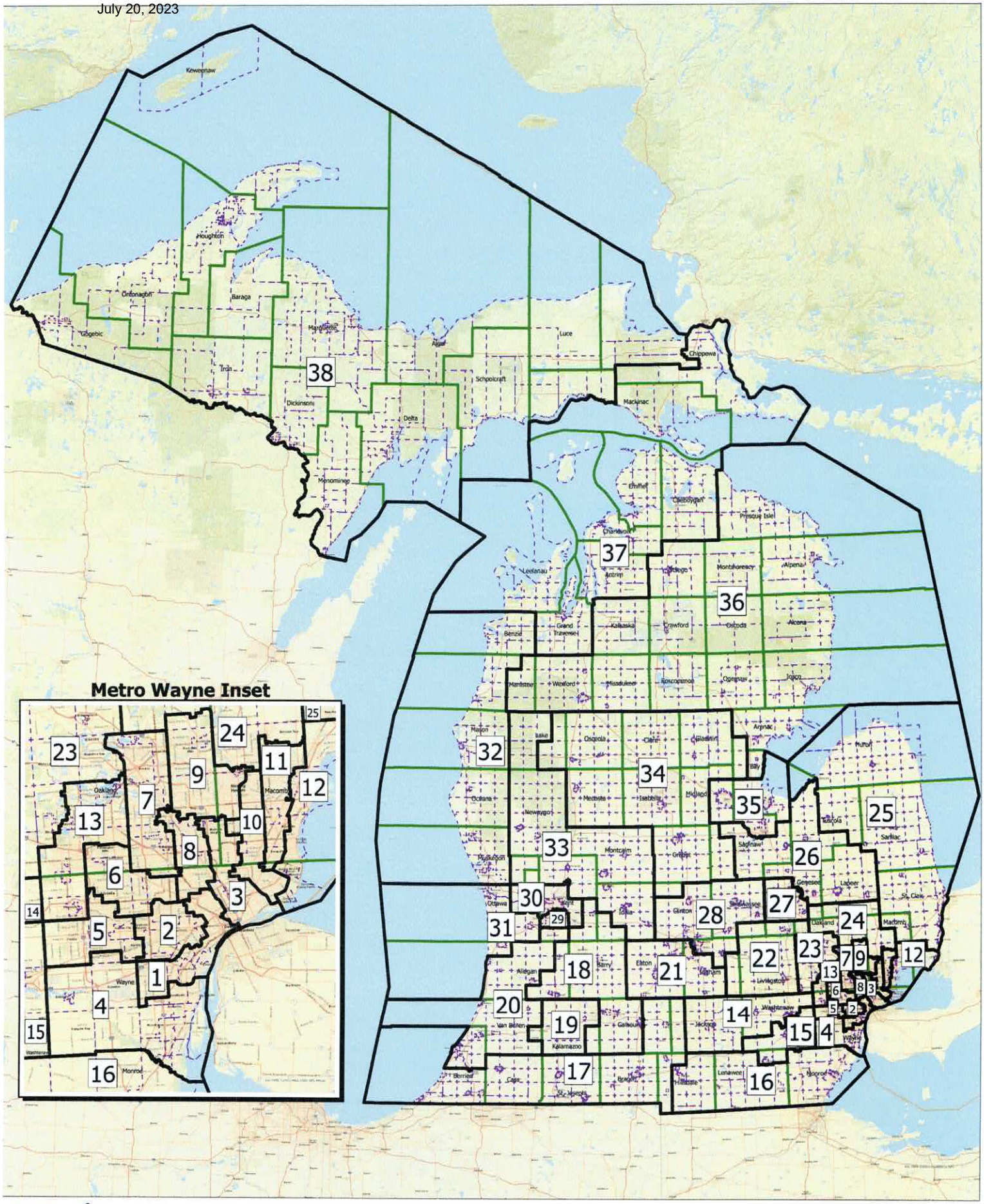
- Intermediate School District (ISD) *Representatives/staff providing specialized/ancillary support (social work, counseling, juvenile diversion programming, prevention programming, etc.)*
- Local Middle/High Schools

Community Stakeholders

i. Local Government

- County/Municipal/Township BOC
- Elected Officials

2022 Michigan State Senate Districts (Linden)

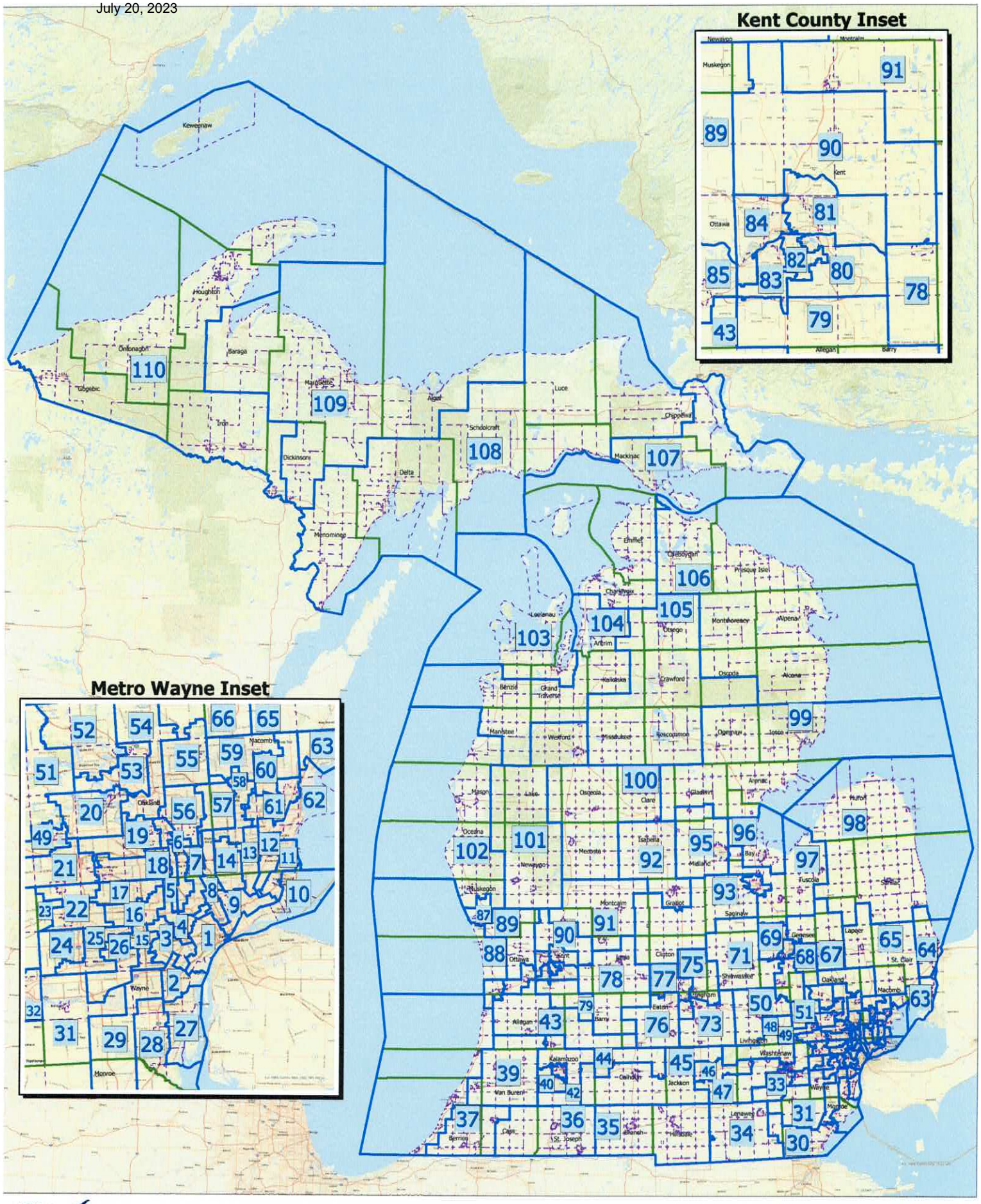


MICHIGAN INDEPENDENT CITIZENS REDISTRICTING COMMISSION

Election Data Services

Linden Senate Districts | Counties | Townships

2022 Michigan State House Districts (Hickory)



MICHIGAN INDEPENDENT CITIZENS REDISTRICTING COMMISSION

Election Data Services

Hickory House Districts | Counties | Townships

BILLION
PILL PLEDGE

AN OPIOID PREVENTION PROGRAM ELIGIBLE FOR SUPPORT FROM OPIOID LAWSUIT SETTLEMENTS

What is the Billion Pill Pledge?

The Billion Pill Pledge program, powered by Goldfinch Health, recently launched to support primary prevention efforts through the opioid settlements. The Billion Pill Pledge program aims to remove +1B opioid pills from medicine cabinets in the US.

The program is designed to support community hospitals in enhancing surgical care with evidence based protocols and opioid prescribing. These widely supported, but underutilized approaches have been shown to improve patient outcomes, reduce healthcare costs and dramatically decrease the need for opioids.

How does the program work?

Goldfinch Health helps hospitals overcome implementation challenges and establish a new baseline of optimized approaches. The program works in the following ways:

- Peer-to-peer **clinical education**
- **Personalized pain management** to reduce opioids
- **Nurse support** and **Prepared for Surgery Tool Kit**

Where does primary prevention fit?

A recent study indicated **11%** of opioid settlement funds should be allocated to prevention. Prevention efforts include:

- Prescriber education
- Research
- Community education

Naloxone is an important initiative, but it does not prevent misuse or diversion. A true primary prevention strategy helps ensure we stop creating new long-term opioid users immediately. Doing so frees up more funds in future years to support those with substance use disorder.

Program results:

89%

of patients needed fewer than 10 opioids after surgery

www.billionpillpledge.com

meredith.allan@goldfinchhealth.com

My public comments to
The Michigan Opioid Advisory Commission Meeting
July 20, 2023, 9:00 am to 12:00 pm

Good morning, thank you for allowing me to speak.

My name is Darlene Berger, I'm a Michigan chronic pain patient since 2011. I live in Ferndale, Michigan.

I'm part of a group of nearly 1000 Michigan residents who are active on the FaceBook group, the Michigan Doctor Patient Forum. The Michigan Doctor Patient Forum is part of a larger national group of the same name with 25,000 members.

I'm going to share a few posts that illustrate how opioid prohibition and fear mongering are torturing pain patients in Michigan and driving some of them to suicide.

Jenelle from **Escanaba, Michigan**, who's family doctor moved, can't find a new doctor to manage her chronic knee pain. The closest doctor she could find won't accept her because she lives too far away. On Feb 17, 2022 , she wrote, "I'm not in withdrawal, just a lot of pain, and now I have inspections on the 22nd, which I cannot clean for, because I can barely walk now, so I'll end up losing my housing. I can't get up my stairs to take a shower or sleep in my own bed. I can't get downstairs to the basement to do my laundry. I am running out of food but can't do any grocery shopping or even cook. I now have to rehome my cats because I can no longer take care of them. I am lucky I can still get up to use the bathroom. I haven't eaten in days because I can't stand long enough to cook anything, and I'll have to send my daughter to live with my mother because I can't properly take care of her. I can't do this anymore. I was good on 40 mg of Percocet a day until my doctor left, and now no one will prescribe. I have no life now, so what's the point. I am done fighting. I have no one to fight for me. I can't and won't live like this anymore."

On March 27, 2022, **Charlene** in **Trenton, Michigan**, said "I need help. I am in the hospital. I broke my left leg. My right foot and ankle were also broken. I have a lisfranc fracture. They put in a plate and screws. My legs are burning so bad. My pain management doctors are handling my case in the hospital and are not very kind. They are saying that when I am released, they will be cutting my meds, that my tolerance is too high because the [dosage of the] meds they have been prescribing for years is too high, and that is why I am in pain. I have catastrophic injuries and will be in wheelchair for at least 6 months to a year. And it is still possible I will never walk again. I can't believe they are trying to reduce my meds while recovering from such severe injuries. The hospital has said they want me to go to a rehab/nursing home but I can't [because if I do] I will lose my senior alliance help and I can't live without that. I am in South Eastern Michigan. At Beaumont South Shore hospital located in Trenton." Yesterday she said, "I still can't walk...," and "I think of having my left leg amputated every day. Just putting on socks can make me scream out in pain."

On November 14th, 2022, **Shalyn Manson,** a woman from **Lansing, Michigan** threw herself into the freezing Grand River after being forced to taper her pain medication for unknown reasons. She was a marathon runner who developed a pain syndrome resulting from a foot injury. She was on pain medicine for years before she was forced off her medication. In her suicide note, which she shared on social media, she described her feelings of being in, "a living hell with no way out."

I know you're probably thinking this isn't the Commission's job to be concerned about chronic pain patients. You think your only obligation is to the addiction and recovery community, but we disagree.

The DEA (cops, not licensed doctors) has taken a bogus and supposedly optional guideline from the CDC, weaponized it, and used it to justify the arrest of doctors who have done nothing more than prescribe opioids for pain. Look up the story of Dr. Lesly Pompy (https://ronaldwchapman.com/blog/leslypompyacquittal#:~:text=Lesly%20Pompy%20Acquitted%20of%20All%2038%20Counts,Trafficking%20and%20Health%20care%20Fraud&text=A%20federal%20jury%20acquitted%20Dr,after%20a%20month%20long%20trial.). He fought back and was acquitted of all charges. It took him 6 years, and he is still not in clinical practice again.

We deserve a seat at this table because we have an opioid problem, too; as in we can't get any for our pain, and that is torture. And I know you don't believe me, because the party line from organizations like PROP and Michigan OPEN is that no one needs opioids for any reason, and unfortunately, this lie is being repeated so frequently, most people believe it.

You probably don't believe that withholding opioid medication for pain relief is torture, because that lie is also on perpetual repeat. But I want to let you know the United Nations agrees with us that it is. (https://www.practicalpainmanagement.com/treatments/pharmacological/opioids/united-nations-says-untreated-pain-inhumane-cruel; see also below).

The prohibition has gone too far and made life a living hell for Michiganders in pain.

We deserve a seat at this table, we deserve to be heard, and we deserve to have a say in how you advise congress to use this money to manage the availability, or not, of opioid medication for medical use.

We want our opioids back. We want our pain medication back. We want our government to stop imprisoning our doctors for prescribing opioids.

The Commission talks about medication assisted therapy to treat addiction with opioids. All we are asking for is the same consideration. That opioids be available to treat pain patients, and right now, because of the aforementioned actions of law enforcement, they are virtually unavailable for treatment of pain.

We want you to tell congress, along with whatever else you have to say about harm reduction, to pass a law that protects who prescribe opioids for pain from harassment and imprisonment by the DEA, State Attorney General, and State Medical Boards.

Enough is enough.

Thank you.

Sincerely,

Darlene Berger

PS: This quote is from a UN General Assembly, February 1, 2013.
"When the failure of States to take positive steps, or to refrain from interfering with health-care services, condemns patients to unnecessary suffering from pain, States not only fall [a]foul of the right to health, but may also violate an affirmative obligation under the prohibition of torture and ill-treatment." And "the failure to ensure access to controlled medicines for the relief of pain and suffering threatens fundamental rights to health and to protection against cruel, inhuman and degrading treatment. Governments must guarantee essential medicines – which include, among others, opioid analgesics – as part of their minimum core obligations under the right to health, and take measures to protect people under their jurisdiction from inhuman and degrading treatment" (page 12, https://www.ohchr.org/sites/default/files/Documents/HRBodies/HRCouncil/RegularSession/Session22/A.HRC.22.53_English.pdf).

Losing a Child to Fentanyl

by Claudia Remenar

On May 7, 2021 I lost my beautiful and accomplished daughter Marianne Deschaine, 35, to an accidental overdose of fentanyl and methamphetamine. Marianne grew up in Haslett, attended Michigan State and the University of Michigan, and appeared to be a typical young person. She went on to a career in social work, administering programs for homeless veterans in northern California. But slowly, over time, unbeknownst to us, she fell prey to an addiction to opioids.

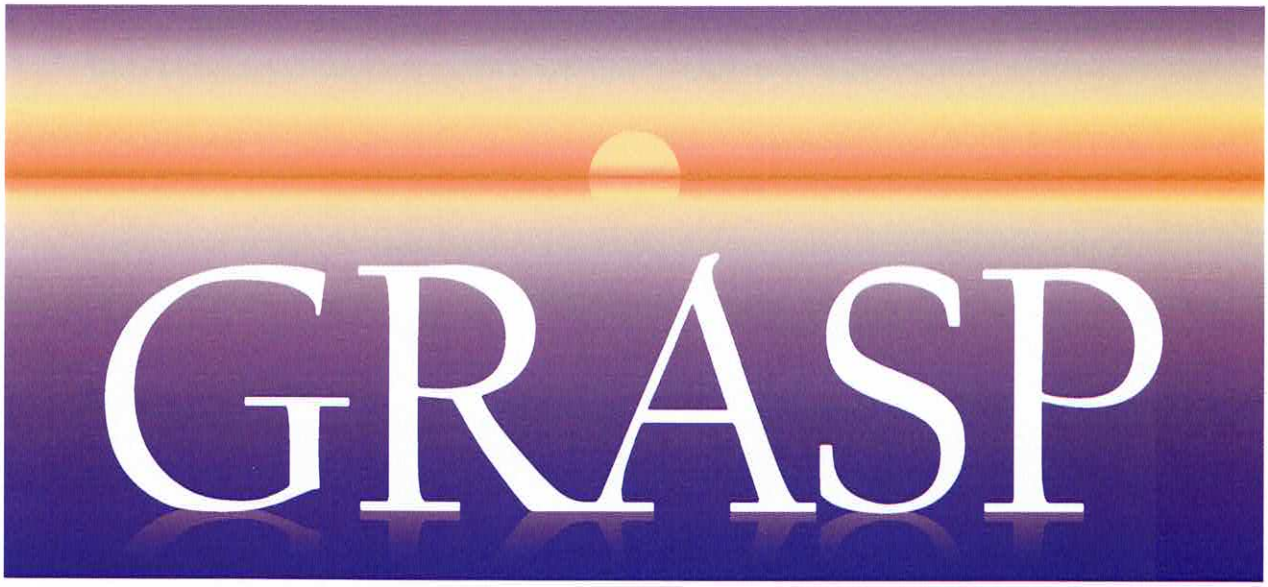
When a tragedy like this happens, you feel like you're the only one experiencing it. But drug overdoses have reached alarming levels. It is now the leading cause of death in America for adults under 50. Each year over 100,000 Americans die from overdoses. That's far above the number of car accident and suicide deaths *combined*. One person fatally overdoses every five minutes in America. How many are dying in our community? Read the obituaries and you'll notice almost daily listings of young people. Not all are overdoses, but some are. Mention drug addiction to people and most likely they will have a similar story about a relative or acquaintance.

The increase in deaths is largely due to fentanyl. This synthetic opioid has been used to create counterfeit pills that look like Oxycodone, Adderall, or Xanax and has been added to other drugs like heroin, methamphetamine, or cocaine. Fentanyl is fifty times stronger than heroin. It's potent and cheap—an amount as small as four grains of sand can kill and it has flooded the drug supply. Any drug bought on the street or from a dealer can be tainted and should be considered deadly.

As parents, we can never, ever move on from the grief of losing a child. But we can pick ourselves up and move *forward*. We want to end the stigma and tell the world that opioid addiction is an acquired brain disease, not a character flaw or lack of willpower. Marianne experienced that stigma, causing her to keep the secret of her addiction all the way to the grave. Four years before dying, she wrote in her journal, "I want off this impossible treadmill. I want out but I have no idea how. I've never felt so trapped."

To honor my daughter's struggle and to help myself and others, I organized a Michigan chapter of the national group GRASP--which stands for Grief Recovery After a Substance Passing. We began meeting in East Lansing in May of 2022. Despite barely getting the word out, at our first meeting 14 people walked through the door, all parents who had lost an adult child, mostly due to fentanyl. Some drive in from two and three hours away. Obviously, this kind of grief support has been needed. Grief that is witnessed in a safe environment can begin to heal.

If the absolute worst thing happens and you lose a loved one to overdose, support is here: GRASPhelp.org. Our East Lansing chapter meets the first Thursday of every month. Call 517-339-4156 for details.



Grief Recovery After a Substance Passing®

GRASP provides help, compassion, and most of all understanding for individuals who have had someone they love die as a result of substance use.

Mid-Michigan GRASP Chapter

Meets on the first Thursday of each month

From 6 to 7:30 pm

at Gorsline-Runciman

1730 East Grand River, East Lansing

There is no cost to attend but pre-registration is required prior to first meeting.

Contact Claudia Remenar

517-339-4156

MidmiGRASP@gmail.com

Visit the GRASP website: www.grasphelp.org

CADCA®

cadca.org

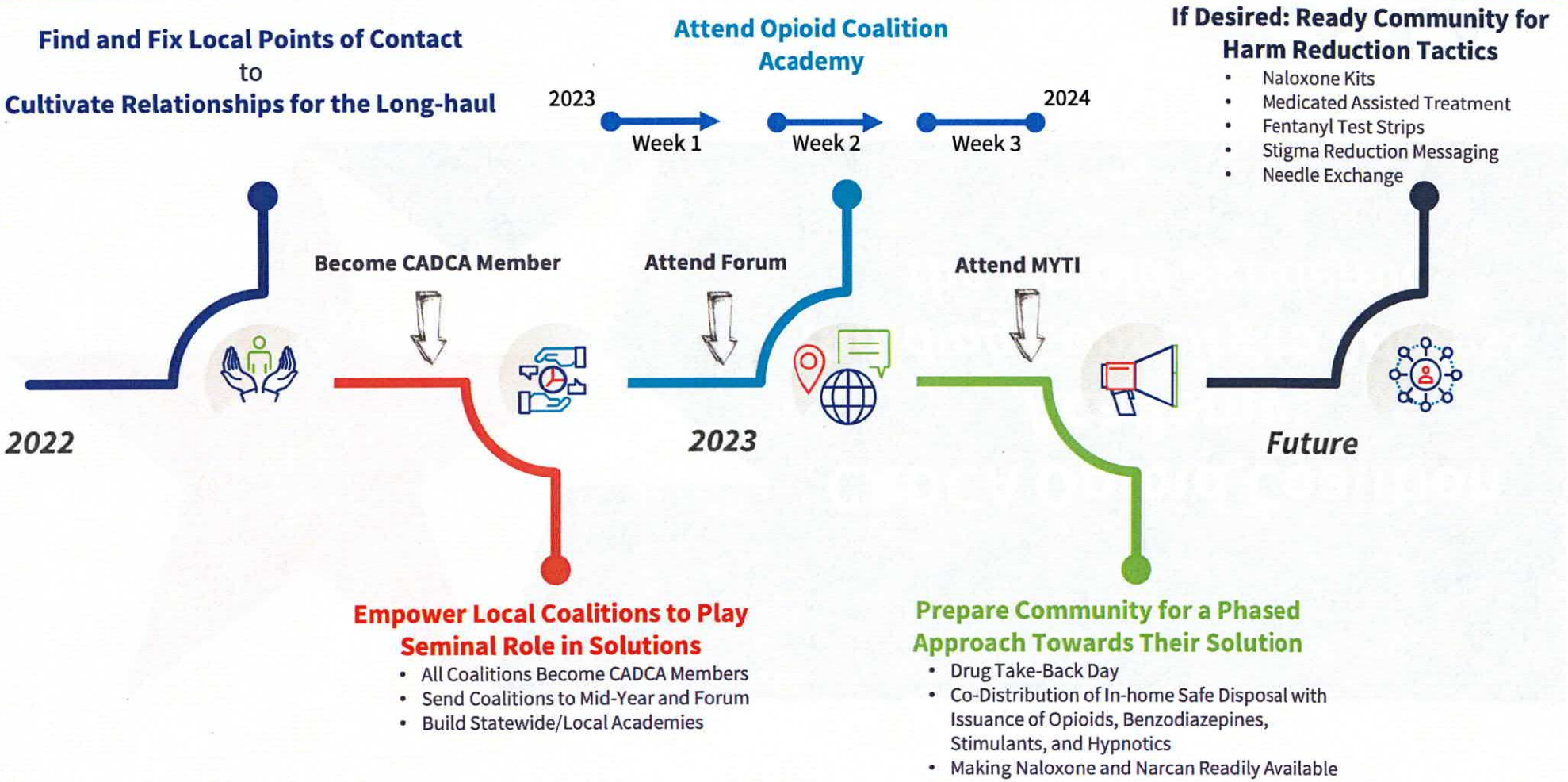
GLOBAL | COLLABORATIVE | INNOVATIVE | PASSIONATE | LEADER

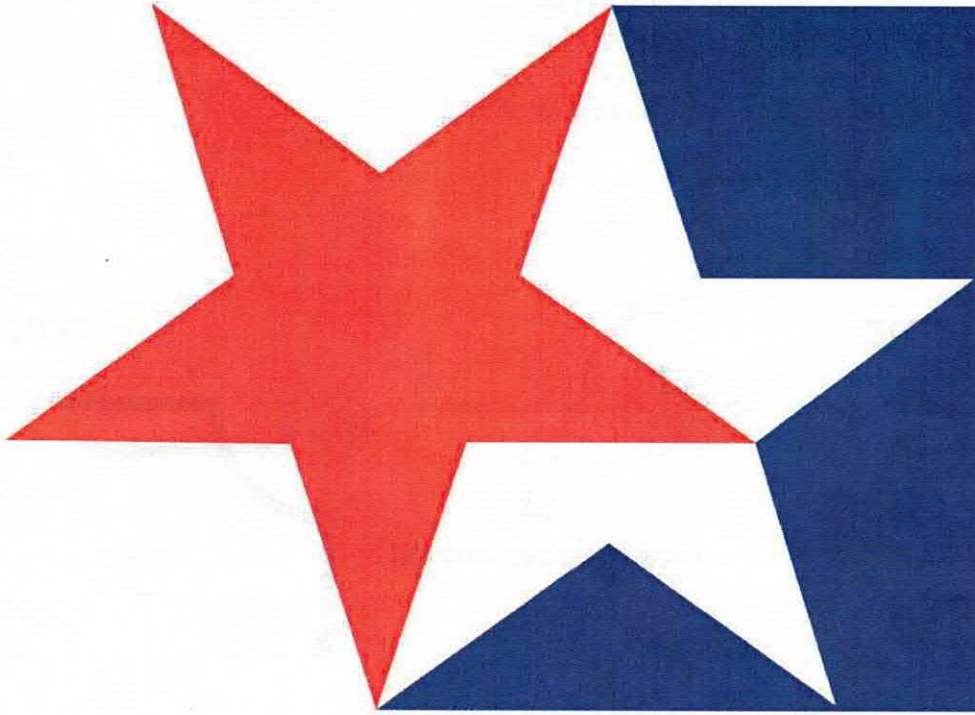
CADCA's Coalition Model

Essential Sectors

CADCA's Approach to Opioid Settlement Dollars

Goal: Provide States, Counties and Cities with Sustainable Solutions to Build Sustainable Coalitions





CADCA Opioid Coalition Academy:
Building Capacity to Address the Opioid Syndemic

CADCA®
Building Drug-Free Communities

cadca.org

GLOBAL | COLLABORATIVE | INNOVATIVE | PASSIONATE | LEADER

C ommunity–Based

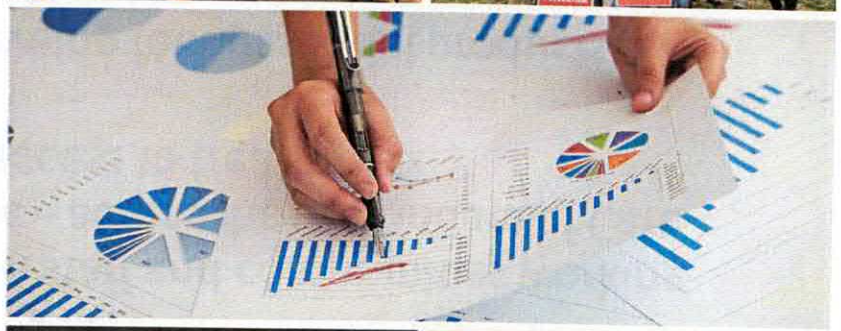
A dvocacy–Focused

D ata–Driven

C oalition–Building

A ssociation

CADCA®



Purpose of the Opioid Coalition Academy (OCA)

The OCA is designed specifically for coalition staff and communities working to reduce the impact of the opioid syndemic – across the Continuum of Care including prevention, harm reduction and access to treatment.

By the end of the training, coalitions will develop four essential products:

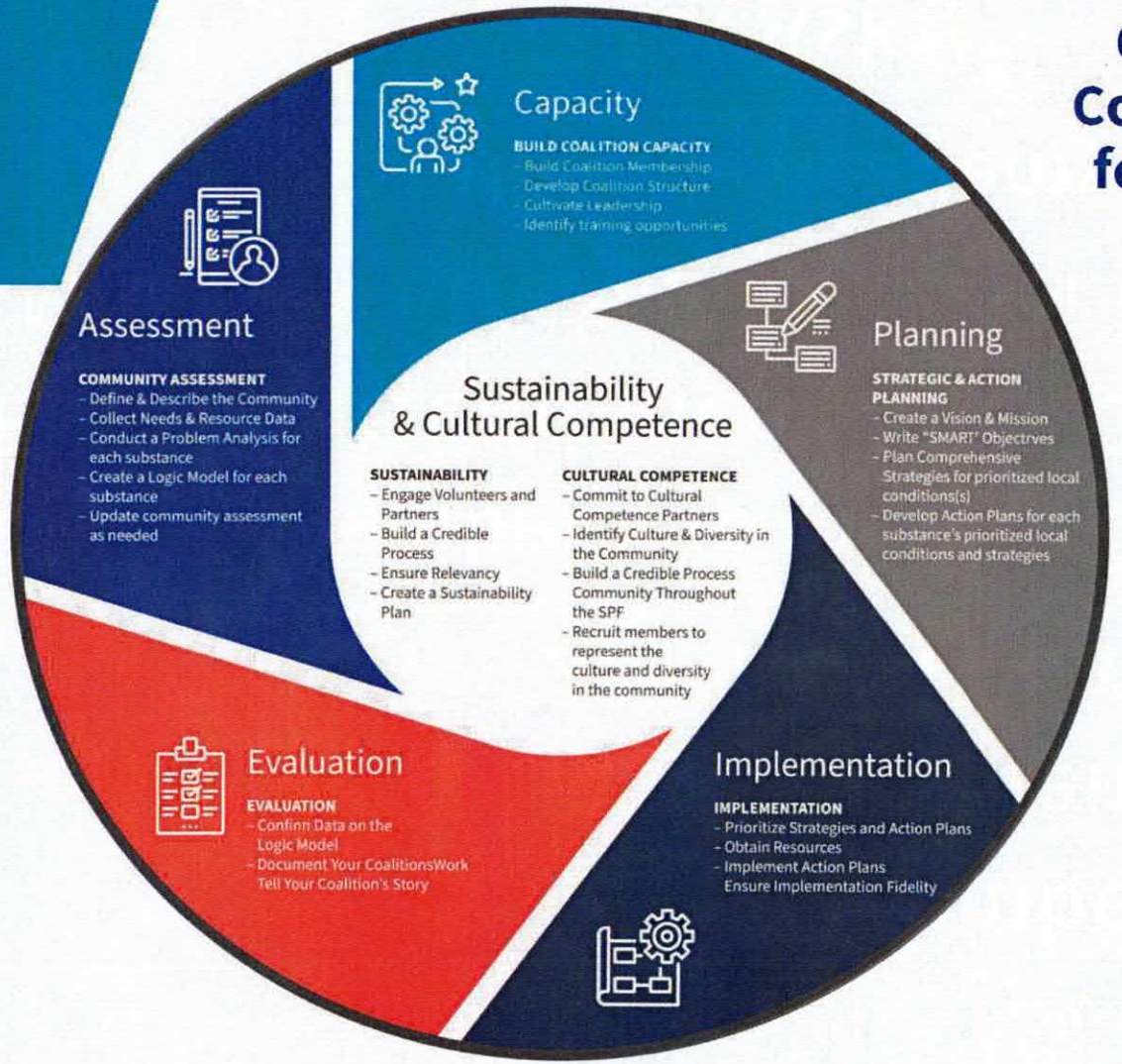
1. Opioid Community Assessment,
2. 3 Tier Logic Model – Prevention; Harm Reduction; Access to Treatment,
3. Strategic and Action Plan
4. Evaluation Plan

Agenda At A Glance

Week One	Week Two	Week Three
Public Health Approach Continuum of Care and the Opioid Syndemic CADCA's Model for Community Change	Review Community Assessment	Review Weeks 1 & 2
The Opioid Syndemic in America Health Equity and Health Disparities	Problem Analysis:	SPF: Evaluation
Opioid Specific considerations through the SPF	Three Tiered Logic Model: Prevention; Harm Reduction; Treatment	Policy and Environmental Strategies
SPF: Community Assessment Conducting a Community Assessment Across the Continuum of Care	Strategic & Action Planning: Health Equity Considerations in Planning	SPF: Sustainability
SPF: Understanding Risk & Protective Factors	SPF: Health Equity Considerations in Implementation	SPF: Cultural Competence
SPF: Capacity: Engaging Stakeholders	SPF: Capacity: Leadership	Taking it Home

CADCA Opioid Coalition Academy Objectives

- Share key concepts with their coalitions and communities (e.g., health equity, public health approach, SPF, community level change, role of the coalition)
- Discuss the opioid syndemic considering the Continuum of Care
- Understand Risk & Protective Factor Theory
- Build capacity to address the opioid syndemic
- Develop a data driven strategic and action plan
- Implement effective environmental strategies and policies
- Develop a three-tier opioid logic model to address prevention, harm reduction and access to treatment

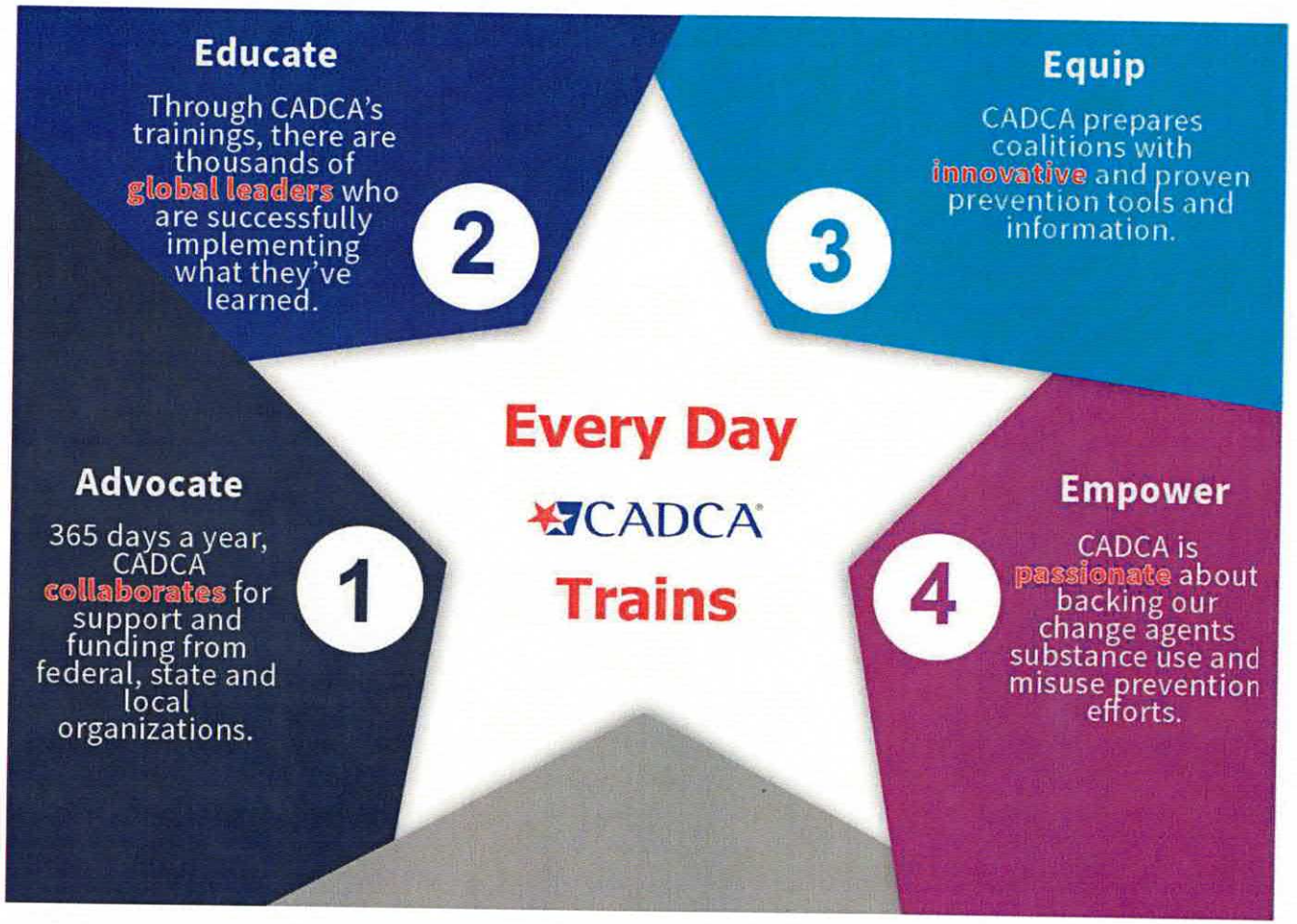


OCA incorporates CADCA's Coalition Skills and Processes for the Strategic Prevention Framework (SPF)

Who Should Attend?

- Coalitions
- Communities Starting Coalition
- Health Care Systems
- Public Health Leaders
- State-Level Leaders


The Ask
47 Members
180 Non-Members
227 Total Coalitions
CADCA Membership for All 227 Coalitions: $61,290
Forum Attendance (2 Per Coalition): $338,230
Mid-Year Attendance (2 Per Coalition): $338,230
Statewide Academy: $2,400,000
Total Ask: $3,137,750


Educate
Through CADCA's trainings, there are thousands of global leaders who are successfully implementing what they've learned.
2
Equip
CADCA prepares coalitions with innovative and proven prevention tools and information.
3
Every Day
CADCA
Trains
Advocate
365 days a year, CADCA collaborates for support and funding from federal, state and local organizations.
1
Empower
CADCA is passionate about backing our change agents substance use and misuse prevention efforts.
4

Love Detroit Prevention Coalition
The Youth Connection
4777 E. Outer Drive; Suite 1340
Detroit, MI 48234-3241
Phone: (313) 826-7099

Date: May 11,2023
Meeting Participants: CADCA, Michigan Department of Health and Human Services, The Youth Connection/Love Detroit Prevention Coalition

CADCA

MAJOR GENERAL BARRYE PRICE, PHD. (RET.)

General Price is the President & CEO of CADCA. Price has a distinguished military career and public service experience that includes serving on multiple federal task forces. General Price was named President and CEO of CADCA in July 2020. He has served as CADCA's executive vice president and chief operating officer since 2016. Price succeeds General Arthur T. Dean who will retire in 2021 after 23 years of serving CADCA and its coalitions.

Price served in the US Army for 31 years with duty both domestically and abroad. His military awards and decorations include the Distinguished Service Medal; Defense Superior Service Medal; three Legions of Merit; Bronze Star Medal; Defense Meritorious Service Medal; five Meritorious Service Medals; Joint Commendation Medal; two Army Commendation Medals; two Army Achievement Medals; National Defense Service Medal; Overseas Service Medal; Outstanding Volunteer Medal; Kuwait Liberation Medal; Southwest Asia Service Medal; Global War on Terrorism Service Medal; Army Staff Badge; and the Airborne and Air Assault Badges.

He served on the President and First Lady's Task Force on "Raising Responsible and Resourceful Teenagers" in 2000 as well as President Clinton's "Mississippi Delta Task Force," which sought to revitalize the 207-county, seven-state region that comprises the Mississippi River flood plain from 1999 through 2000. Price has authored two books: "Against All Enemies Foreign and Domestic: A Study of Urban Unrest and Federal Intervention Within the United States" and "Life on the Other Side of You."

He is a Distinguished Military Graduate of the University of Houston's College of Business Administration. He earned a Master of Arts in History from Texas A&M University and became the first African American to obtain a doctorate from the Department of History in the university's 140-year history. He also earned a Master of Science in National Security Strategy from the National Defense University.

The Youth Connection/Love Detroit Prevention Coalition

Grenae Dudley, Ph.D.
A professional advocate of children's welfare, Dr. Grenaé D. Dudley is President and Chief Executive Officer of The Youth Connection, whose goal is to connect youth to brighter futures. A licensed clinical psychologist, she has designed, developed, and implemented nationally recognized programs that address the needs of children and their families.

She serves as the Chair of The Love Detroit Prevention Coalition which received the Community Anti-Drug Coalitions of America's 2019 Chairman's Award. In 2012 Dr. Dudley received the FBI Director's Community Leadership Award In Recognition of Outstanding Contributions to our Nation's Communities through unselfish dedication and leadership and was the 2018 Preventionist of the Year which she received from The Michigan Department of Health and Human Services Office of Recovery Oriented Systems of Care. She was selected by the Greater Detroit Area Health Council to receive the 2019 Sy Gottlieb Award. The award recognizes an outstanding health care professional who has demonstrated sustained visionary leadership in southeastern Michigan. Dr. Dudley is also very proud of being a "Distinguished Clown for Detroit's annual Thanksgiving Day Parade.

Jeffrey Griffith, BA
is the Chief Operating Officer for The Youth Connection, Inc., a 501(c)(3) non-profit organization located on the east side of Detroit. In his role, Mr. Griffith acts as the director of Substance Abuse Prevention programs for the agency and has over 13 years of experience in the field. He has been working with The Youth Connection since 2001.

His work to reduce underage tobacco sales in Detroit has brought the underage sales rate down by 33% and The Youth Connection's social media communications campaigns have reached hundreds of thousands of people in Detroit in the past 3 years.

Prior to his work with The Youth Connection, Mr. Griffith was involved in working on local and national political campaigns. He has worked for various political entities including state parties, federal, state, and local candidates for office as well as on a statewide ballot initiative.

He currently serves as the Treasurer for the nationally recognized, award-winning Love Detroit Prevention Coalition, Co-Chair of the Michigan Prevention Association, and Designated Youth Tobacco Use Representative for Wayne County. He holds a Bachelor of Arts degree from Michigan State University (Go Green!)

Michigan Department of Health and Human Services

Jared Welehodsky is the state assistant administrator to Michigan's Chief Medical Executive. In this role, Jared leads Michigan's opioid response and supports the Chief Medical Executive's efforts to reduce gun violence, reduce lead exposure in children, and promote immunizations. Jared has worked at the Michigan Department of Health and Human Services (MDHHS) for over eight years. Jared previously worked in MDHHS Policy leading implementation of MDHHS' opioid response and the implementation of the recommendations of Michigan's Mental Health and Wellness Commission. Prior to working at MDHHS, Mr. Welehodsky worked in the Michigan State Senate for five years.

Dr. Natasha Bagdasarian, MD, MPH, FIDSA, was named the Chief Medical Executive for the State of Michigan in 2021. In this role she provides overall medical guidance for the State of Michigan as a cabinet member of the Governor. She is board certified by the American Board of Internal Medicine in both Internal Medicine and Infectious Diseases and is a Fellow of the Infectious Diseases Society of America.

From 2020-2021 Dr. Bagdasarian served the State of Michigan in the role of Senior Public Health Physician, where she oversaw the SARS-CoV-2 testing strategy for the state and helped bring rapid testing technologies to vulnerable populations. Since early 2020 she has served as a consultant/technical advisor for the World Health Organization (WHO), providing guidance on outbreak preparedness and COVID-19.

She has worked in Michigan and internationally (Singapore, Bangladesh), and has over 40 publications on topics in infectious diseases and public health, including guidance on infection prevention and control of the SARS-CoV-2 virus which causes COVID-19. She has held teaching appointments at the University of Michigan, Wayne State University, and the National University of Singapore, and is currently an Adjunct Clinical Professor in Epidemiology at the University of Michigan School of Public Health.

Dr. Bagdasarian completed medical school at Wayne State University; internal medicine residency and infectious diseases fellowship at the University of Michigan; and she received a Master's in Public Health degree in hospital and molecular epidemiology, from the University of Michigan School of Public Health.

Angie Smith-Butterwick is the manager of the Substance Use, Gambling and Epidemiology section within MDHHS. She has 20 years' experience working with women and their children and served as the Women's Treatment Specialist for the state of Michigan for 11 years. Angie obtained her Master of Social Work degree in 2005 with a concentration in Law and Child Welfare and completed SAMHSA's Women's Addiction Services Leadership Institute in 2016. She has used that knowledge to help shape and develop standards of service for women and men with a substance use disorder and their children in the state of Michigan, and as a bridge to working cooperatively with child welfare services to improve outcomes for families. Angie's advocacy efforts have increased the array and availability of services in Michigan by improving the quality of services available and developing new services to meet emerging needs. Angie has been involved with the Women's Services Network and National Treatment Network of NASADAD since 2006 and has served the membership on various committees and in multiple roles.

Lisa Coleman received her B.A. in Social Justice and has worked in the behavioral health field, mainly prevention, for the past 24 years. She is the PDO and PFS Project Director and Departmental Prevention Specialist for the Michigan Department of Health and Human Services, Substance Use, Gambling, and Epidemiology Section. Her various responsibilities involve writing grants, administering SUD prevention services (including coalition efforts) and prevention discretionary grant projects, offering technical assistance, managing the prevention training schedule, and leading state level groups. Furthermore, she is the National Prevention Network (NPN) representative for the state of Michigan and NPN Central Region Rep, as well as a member of the Great Lakes Prevention Technology Transfer Center (PTTC) Advisory Board.

Maricruz Moya
is a seconded staff for the Michigan Department of Health and Human Services (MDHHS) advancing racial equity efforts to reduce overdose in the community. As a graduate from Wayne State University (B.S in Community Health Education), she has dedicated her efforts to addressing social determinants of health such as access to services. In the past, she has also worked with the City of Detroit to support constituents and citywide policy efforts."

EXHIBIT E

List of Opioid Remediation Uses

Schedule A
Core Strategies

States and Qualifying Block Grantees shall choose from among the abatement strategies listed in Schedule B. However, priority shall be given to the following core abatement strategies ("*Core Strategies*").[14]

A. **NALOXONE OR OTHER FDA-APPROVED DRUG TO REVERSE OPIOID OVERDOSES**

1. Expand training for first responders, schools, community support groups and families; and

2. Increase distribution to individuals who are uninsured or whose insurance does not cover the needed service.

B. **MEDICATION-ASSISTED TREATMENT ("*MAT*") DISTRIBUTION AND OTHER OPIOID-RELATED TREATMENT**

1. Increase distribution of MAT to individuals who are uninsured or whose insurance does not cover the needed service;

2. Provide education to school-based and youth-focused programs that discourage or prevent misuse;

3. Provide MAT education and awareness training to healthcare providers, EMTs, law enforcement, and other first responders; and

4. Provide treatment and recovery support services such as residential and inpatient treatment, intensive outpatient treatment, outpatient therapy or counseling, and recovery housing that allow or integrate medication and with other support services.

[14] As used in this Schedule A, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs.

C. **PREGNANT & POSTPARTUM WOMEN**

1. Expand Screening, Brief Intervention, and Referral to Treatment ("*SBIRT*") services to non-Medicaid eligible or uninsured pregnant women;

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for women with co-occurring Opioid Use Disorder ("*OUD*") and other Substance Use Disorder ("*SUD*")/Mental Health disorders for uninsured individuals for up to 12 months postpartum; and

3. Provide comprehensive wrap-around services to individuals with OUD, including housing, transportation, job placement/training, and childcare.

D. **EXPANDING TREATMENT FOR NEONATAL ABSTINENCE SYNDROME ("*NAS*")**

1. Expand comprehensive evidence-based and recovery support for NAS babies;

2. Expand services for better continuum of care with infant-need dyad; and

3. Expand long-term treatment and services for medical monitoring of NAS babies and their families.

E. **EXPANSION OF WARM HAND-OFF PROGRAMS AND RECOVERY SERVICES**

1. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments;

2. Expand warm hand-off services to transition to recovery services;

3. Broaden scope of recovery services to include co-occurring SUD or mental health conditions;

4. Provide comprehensive wrap-around services to individuals in recovery, including housing, transportation, job placement/training, and childcare; and

5. Hire additional social workers or other behavioral health workers to facilitate expansions above.

F. **TREATMENT FOR INCARCERATED POPULATION**

1. Provide evidence-based treatment and recovery support, including MAT for persons with OUD and co-occurring SUD/MH disorders within and transitioning out of the criminal justice system; and

2. Increase funding for jails to provide treatment to inmates with OUD.

G. **PREVENTION PROGRAMS**

1. Funding for media campaigns to prevent opioid use (similar to the FDA's "Real Cost" campaign to prevent youth from misusing tobacco);

2. Funding for evidence-based prevention programs in schools;

3. Funding for medical provider education and outreach regarding best prescribing practices for opioids consistent with the 2016 CDC guidelines, including providers at hospitals (academic detailing);

4. Funding for community drug disposal programs; and

5. Funding and training for first responders to participate in pre-arrest diversion programs, post-overdose response teams, or similar strategies that connect at-risk individuals to behavioral health services and supports.

H. **EXPANDING SYRINGE SERVICE PROGRAMS**

1. Provide comprehensive syringe services programs with more wrap-around services, including linkage to OUD treatment, access to sterile syringes and linkage to care and treatment of infectious diseases.

I. **EVIDENCE-BASED DATA COLLECTION AND RESEARCH ANALYZING THE EFFECTIVENESS OF THE ABATEMENT STRATEGIES WITHIN THE STATE**

Schedule B
Approved Uses

Support treatment of Opioid Use Disorder (OUD) and any co-occurring Substance Use Disorder or Mental Health (SUD/MH) conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

PART ONE: TREATMENT

A. TREAT OPIOID USE DISORDER (OUD)

Support treatment of Opioid Use Disorder ("*OUD*") and any co-occurring Substance Use Disorder or Mental Health ("*SUD/MH*") conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:[15]

1. Expand availability of treatment for OUD and any co-occurring SUD/MH conditions, including all forms of Medication-Assisted Treatment ("*MAT*") approved by the U.S. Food and Drug Administration.

2. Support and reimburse evidence-based services that adhere to the American Society of Addiction Medicine ("*ASAM*") continuum of care for OUD and any co-occurring SUD/MH conditions.

3. Expand telehealth to increase access to treatment for OUD and any co-occurring SUD/MH conditions, including MAT, as well as counseling, psychiatric support, and other treatment and recovery support services.

4. Improve oversight of Opioid Treatment Programs ("*OTPs*") to assure evidence-based or evidence-informed practices such as adequate methadone dosing and low threshold approaches to treatment.

5. Support mobile intervention, treatment, and recovery services, offered by qualified professionals and service providers, such as peer recovery coaches, for persons with OUD and any co-occurring SUD/MH conditions and for persons who have experienced an opioid overdose.

6. Provide treatment of trauma for individuals with OUD (*e.g.*, violence, sexual assault, human trafficking, or adverse childhood experiences) and family members (*e.g.*, surviving family members after an overdose or overdose fatality), and training of health care personnel to identify and address such trauma.

7. Support evidence-based withdrawal management services for people with OUD and any co-occurring mental health conditions.

[15] As used in this Schedule B, words like "expand," "fund," "provide" or the like shall not indicate a preference for new or existing programs.

8. Provide training on MAT for health care providers, first responders, students, or other supporting professionals, such as peer recovery coaches or recovery outreach specialists, including telementoring to assist community-based providers in rural or underserved areas.

9. Support workforce development for addiction professionals who work with persons with OUD and any co-occurring SUD/MH conditions.

10. Offer fellowships for addiction medicine specialists for direct patient care, instructors, and clinical research for treatments.

11. Offer scholarships and supports for behavioral health practitioners or workers involved in addressing OUD and any co-occurring SUD/MH or mental health conditions, including, but not limited to, training, scholarships, fellowships, loan repayment programs, or other incentives for providers to work in rural or underserved areas.

12. Provide funding and training for clinicians to obtain a waiver under the federal Drug Addiction Treatment Act of 2000 ("*DATA 2000*") to prescribe MAT for OUD, and provide technical assistance and professional support to clinicians who have obtained a DATA 2000 waiver.

13. Disseminate of web-based training curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service–Opioids web-based training curriculum and motivational interviewing.

14. Develop and disseminate new curricula, such as the American Academy of Addiction Psychiatry's Provider Clinical Support Service for Medication–Assisted Treatment.

B. SUPPORT PEOPLE IN TREATMENT AND RECOVERY

Support people in recovery from OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the programs or strategies that:

1. Provide comprehensive wrap-around services to individuals with OUD and any co-occurring SUD/MH conditions, including housing, transportation, education, job placement, job training, or childcare.

2. Provide the full continuum of care of treatment and recovery services for OUD and any co-occurring SUD/MH conditions, including supportive housing, peer support services and counseling, community navigators, case management, and connections to community-based services.

3. Provide counseling, peer-support, recovery case management and residential treatment with access to medications for those who need it to persons with OUD and any co-occurring SUD/MH conditions.

4. Provide access to housing for people with OUD and any co-occurring SUD/MH conditions, including supportive housing, recovery housing, housing assistance programs, training for housing providers, or recovery housing programs that allow or integrate FDA-approved mediation with other support services.

5. Provide community support services, including social and legal services, to assist in deinstitutionalizing persons with OUD and any co-occurring SUD/MH conditions.

6. Support or expand peer-recovery centers, which may include support groups, social events, computer access, or other services for persons with OUD and any co-occurring SUD/MH conditions.

7. Provide or support transportation to treatment or recovery programs or services for persons with OUD and any co-occurring SUD/MH conditions.

8. Provide employment training or educational services for persons in treatment for or recovery from OUD and any co-occurring SUD/MH conditions.

9. Identify successful recovery programs such as physician, pilot, and college recovery programs, and provide support and technical assistance to increase the number and capacity of high-quality programs to help those in recovery.

10. Engage non-profits, faith-based communities, and community coalitions to support people in treatment and recovery and to support family members in their efforts to support the person with OUD in the family.

11. Provide training and development of procedures for government staff to appropriately interact and provide social and other services to individuals with or in recovery from OUD, including reducing stigma.

12. Support stigma reduction efforts regarding treatment and support for persons with OUD, including reducing the stigma on effective treatment.

13. Create or support culturally appropriate services and programs for persons with OUD and any co-occurring SUD/MH conditions, including new Americans.

14. Create and/or support recovery high schools.

15. Hire or train behavioral health workers to provide or expand any of the services or supports listed above.

C. CONNECT PEOPLE WHO NEED HELP TO THE HELP THEY NEED (CONNECTIONS TO CARE)

Provide connections to care for people who have—or are at risk of developing—OUD and any co-occurring SUD/MH conditions through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Ensure that health care providers are screening for OUD and other risk factors and know how to appropriately counsel and treat (or refer if necessary) a patient for OUD treatment.

2. Fund SBIRT programs to reduce the transition from use to disorders, including SBIRT services to pregnant women who are uninsured or not eligible for Medicaid.

3. Provide training and long-term implementation of SBIRT in key systems (health, schools, colleges, criminal justice, and probation), with a focus on youth and young adults when transition from misuse to opioid disorder is common.

4. Purchase automated versions of SBIRT and support ongoing costs of the technology.

5. Expand services such as navigators and on-call teams to begin MAT in hospital emergency departments.

6. Provide training for emergency room personnel treating opioid overdose patients on post-discharge planning, including community referrals for MAT, recovery case management or support services.

7. Support hospital programs that transition persons with OUD and any co-occurring SUD/MH conditions, or persons who have experienced an opioid overdose, into clinically appropriate follow-up care through a bridge clinic or similar approach.

8. Support crisis stabilization centers that serve as an alternative to hospital emergency departments for persons with OUD and any co-occurring SUD/MH conditions or persons that have experienced an opioid overdose.

9. Support the work of Emergency Medical Systems, including peer support specialists, to connect individuals to treatment or other appropriate services following an opioid overdose or other opioid-related adverse event.

10. Provide funding for peer support specialists or recovery coaches in emergency departments, detox facilities, recovery centers, recovery housing, or similar settings; offer services, supports, or connections to care to persons with OUD and any co-occurring SUD/MH conditions or to persons who have experienced an opioid overdose.

11. Expand warm hand-off services to transition to recovery services.

12. Create or support school-based contacts that parents can engage with to seek immediate treatment services for their child; and support prevention, intervention, treatment, and recovery programs focused on young people.

13. Develop and support best practices on addressing OUD in the workplace.

14. Support assistance programs for health care providers with OUD.

15. Engage non-profits and the faith community as a system to support outreach for treatment.

16. Support centralized call centers that provide information and connections to appropriate services and supports for persons with OUD and any co-occurring SUD/MH conditions.

D. ADDRESS THE NEEDS OF CRIMINAL JUSTICE-INVOLVED PERSONS

Address the needs of persons with OUD and any co-occurring SUD/MH conditions who are involved in, are at risk of becoming involved in, or are transitioning out of the criminal justice system through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Support pre-arrest or pre-arraignment diversion and deflection strategies for persons with OUD and any co-occurring SUD/MH conditions, including established strategies such as:

    1. Self-referral strategies such as the Angel Programs or the Police Assisted Addiction Recovery Initiative ("*PAARI*");

    2. Active outreach strategies such as the Drug Abuse Response Team ("*DART*") model;

    3. "Naloxone Plus" strategies, which work to ensure that individuals who have received naloxone to reverse the effects of an overdose are then linked to treatment programs or other appropriate services;

    4. Officer prevention strategies, such as the Law Enforcement Assisted Diversion ("*LEAD*") model;

    5. Officer intervention strategies such as the Leon County, Florida Adult Civil Citation Network or the Chicago Westside Narcotics Diversion to Treatment Initiative; or

    6. Co-responder and/or alternative responder models to address OUD-related 911 calls with greater SUD expertise.

2. Support pre-trial services that connect individuals with OUD and any co-occurring SUD/MH conditions to evidence-informed treatment, including MAT, and related services.

3. Support treatment and recovery courts that provide evidence-based options for persons with OUD and any co-occurring SUD/MH conditions.

4. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are incarcerated in jail or prison.

5. Provide evidence-informed treatment, including MAT, recovery support, harm reduction, or other appropriate services to individuals with OUD and any co-occurring SUD/MH conditions who are leaving jail or prison or have recently left jail or prison, are on probation or parole, are under community corrections supervision, or are in re-entry programs or facilities.

6. Support critical time interventions ("*CTI*"), particularly for individuals living with dual-diagnosis OUD/serious mental illness, and services for individuals who face immediate risks and service needs and risks upon release from correctional settings.

7. Provide training on best practices for addressing the needs of criminal justice-involved persons with OUD and any co-occurring SUD/MH conditions to law enforcement, correctional, or judicial personnel or to providers of treatment, recovery, harm reduction, case management, or other services offered in connection with any of the strategies described in this section.

E. ADDRESS THE NEEDS OF PREGNANT OR PARENTING WOMEN AND THEIR FAMILIES, INCLUDING BABIES WITH NEONATAL ABSTINENCE SYNDROME

Address the needs of pregnant or parenting women with OUD and any co-occurring SUD/MH conditions, and the needs of their families, including babies with neonatal abstinence syndrome ("*NAS*"), through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, those that:

1. Support evidence-based or evidence-informed treatment, including MAT, recovery services and supports, and prevention services for pregnant women—or women who could become pregnant—who have OUD and any co-occurring SUD/MH conditions, and other measures to educate and provide support to families affected by Neonatal Abstinence Syndrome.

2. Expand comprehensive evidence-based treatment and recovery services, including MAT, for uninsured women with OUD and any co-occurring SUD/MH conditions for up to 12 months postpartum.

3. Provide training for obstetricians or other healthcare personnel who work with pregnant women and their families regarding treatment of OUD and any co-occurring SUD/MH conditions.

4. Expand comprehensive evidence-based treatment and recovery support for NAS babies; expand services for better continuum of care with infant-need dyad; and expand long-term treatment and services for medical monitoring of NAS babies and their families.

5. Provide training to health care providers who work with pregnant or parenting women on best practices for compliance with federal requirements that children born with NAS get referred to appropriate services and receive a plan of safe care.

6. Provide child and family supports for parenting women with OUD and any co-occurring SUD/MH conditions.

7. Provide enhanced family support and child care services for parents with OUD and any co-occurring SUD/MH conditions.

8. Provide enhanced support for children and family members suffering trauma as a result of addiction in the family; and offer trauma-informed behavioral health treatment for adverse childhood events.

9. Offer home-based wrap-around services to persons with OUD and any co-occurring SUD/MH conditions, including, but not limited to, parent skills training.

10. Provide support for Children's Services—Fund additional positions and services, including supportive housing and other residential services, relating to children being removed from the home and/or placed in foster care due to custodial opioid use.

PART TWO: PREVENTION

F. PREVENT OVER-PRESCRIBING AND ENSURE APPROPRIATE PRESCRIBING AND DISPENSING OF OPIOIDS

Support efforts to prevent over-prescribing and ensure appropriate prescribing and dispensing of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Funding medical provider education and outreach regarding best prescribing practices for opioids consistent with the Guidelines for Prescribing Opioids for Chronic Pain from the U.S. Centers for Disease Control and Prevention, including providers at hospitals (academic detailing).

2. Training for health care providers regarding safe and responsible opioid prescribing, dosing, and tapering patients off opioids.

3. Continuing Medical Education (CME) on appropriate prescribing of opioids.

4. Providing Support for non-opioid pain treatment alternatives, including training providers to offer or refer to multi-modal, evidence-informed treatment of pain.

5. Supporting enhancements or improvements to Prescription Drug Monitoring Programs ("*PDMPs*"), including, but not limited to, improvements that:

1. Increase the number of prescribers using PDMPs;

2. Improve point-of-care decision-making by increasing the quantity, quality, or format of data available to prescribers using PDMPs, by improving the interface that prescribers use to access PDMP data, or both; or

3. Enable states to use PDMP data in support of surveillance or intervention strategies, including MAT referrals and follow-up for individuals identified within PDMP data as likely to experience OUD in a manner that complies with all relevant privacy and security laws and rules.

6. Ensuring PDMPs incorporate available overdose/naloxone deployment data, including the United States Department of Transportation's Emergency Medical Technician overdose database in a manner that complies with all relevant privacy and security laws and rules.

7. Increasing electronic prescribing to prevent diversion or forgery.

8. Educating dispensers on appropriate opioid dispensing.

G. PREVENT MISUSE OF OPIOIDS

Support efforts to discourage or prevent misuse of opioids through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Funding media campaigns to prevent opioid misuse.

2. Corrective advertising or affirmative public education campaigns based on evidence.

3. Public education relating to drug disposal.

4. Drug take-back disposal or destruction programs.

5. Funding community anti-drug coalitions that engage in drug prevention efforts.

6. Supporting community coalitions in implementing evidence-informed prevention, such as reduced social access and physical access, stigma reduction—including staffing, educational campaigns, support for people in treatment or recovery, or training of coalitions in evidence-informed implementation, including the Strategic Prevention Framework developed by the U.S. Substance Abuse and Mental Health Services Administration ("*SAMHSA*").

7. Engaging non-profits and faith-based communities as systems to support prevention.

8. Funding evidence-based prevention programs in schools or evidence-informed school and community education programs and campaigns for students, families, school employees, school athletic programs, parent-teacher and student associations, and others.

9. School-based or youth-focused programs or strategies that have demonstrated effectiveness in preventing drug misuse and seem likely to be effective in preventing the uptake and use of opioids.

10. Create or support community-based education or intervention services for families, youth, and adolescents at risk for OUD and any co-occurring SUD/MH conditions.

11. Support evidence-informed programs or curricula to address mental health needs of young people who may be at risk of misusing opioids or other drugs, including emotional modulation and resilience skills.

12. Support greater access to mental health services and supports for young people, including services and supports provided by school nurses, behavioral health workers or other school staff, to address mental health needs in young people that (when not properly addressed) increase the risk of opioid or another drug misuse.

H. PREVENT OVERDOSE DEATHS AND OTHER HARMS (HARM REDUCTION)

Support efforts to prevent or reduce overdose deaths or other opioid-related harms through evidence-based or evidence-informed programs or strategies that may include, but are not limited to, the following:

1. Increased availability and distribution of naloxone and other drugs that treat overdoses for first responders, overdose patients, individuals with OUD and their friends and family members, schools, community navigators and outreach workers, persons being released from jail or prison, or other members of the general public.

2. Public health entities providing free naloxone to anyone in the community.

3. Training and education regarding naloxone and other drugs that treat overdoses for first responders, overdose patients, patients taking opioids, families, schools, community support groups, and other members of the general public.

4. Enabling school nurses and other school staff to respond to opioid overdoses, and provide them with naloxone, training, and support.

5. Expanding, improving, or developing data tracking software and applications for overdoses/naloxone revivals.

6. Public education relating to emergency responses to overdoses.

7. Public education relating to immunity and Good Samaritan laws.

8. Educating first responders regarding the existence and operation of immunity and Good Samaritan laws.

9. Syringe service programs and other evidence-informed programs to reduce harms associated with intravenous drug use, including supplies, staffing, space, peer support services, referrals to treatment, fentanyl checking, connections to care, and the full range of harm reduction and treatment services provided by these programs.

10. Expanding access to testing and treatment for infectious diseases such as HIV and Hepatitis C resulting from intravenous opioid use.

11. Supporting mobile units that offer or provide referrals to harm reduction services, treatment, recovery supports, health care, or other appropriate services to persons that use opioids or persons with OUD and any co-occurring SUD/MH conditions.

12. Providing training in harm reduction strategies to health care providers, students, peer recovery coaches, recovery outreach specialists, or other professionals that provide care to persons who use opioids or persons with OUD and any co-occurring SUD/MH conditions.

13. Supporting screening for fentanyl in routine clinical toxicology testing.

PART THREE: OTHER STRATEGIES

I. FIRST RESPONDERS

In addition to items in section C, D and H relating to first responders, support the following:

1. Education of law enforcement or other first responders regarding appropriate practices and precautions when dealing with fentanyl or other drugs.

2. Provision of wellness and support services for first responders and others who experience secondary trauma associated with opioid-related emergency events.

J. LEADERSHIP, PLANNING AND COORDINATION

Support efforts to provide leadership, planning, coordination, facilitations, training and technical assistance to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, the following:

1. Statewide, regional, local or community regional planning to identify root causes of addiction and overdose, goals for reducing harms related to the opioid epidemic, and areas and populations with the greatest needs for treatment

intervention services, and to support training and technical assistance and other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

2. A dashboard to (a) share reports, recommendations, or plans to spend opioid settlement funds; (b) to show how opioid settlement funds have been spent; (c) to report program or strategy outcomes; or (d) to track, share or visualize key opioid- or health-related indicators and supports as identified through collaborative statewide, regional, local or community processes.

3. Invest in infrastructure or staffing at government or not-for-profit agencies to support collaborative, cross-system coordination with the purpose of preventing overprescribing, opioid misuse, or opioid overdoses, treating those with OUD and any co-occurring SUD/MH conditions, supporting them in treatment or recovery, connecting them to care, or implementing other strategies to abate the opioid epidemic described in this opioid abatement strategy list.

4. Provide resources to staff government oversight and management of opioid abatement programs.

K. TRAINING

In addition to the training referred to throughout this document, support training to abate the opioid epidemic through activities, programs, or strategies that may include, but are not limited to, those that:

1. Provide funding for staff training or networking programs and services to improve the capability of government, community, and not-for-profit entities to abate the opioid crisis.

2. Support infrastructure and staffing for collaborative cross-system coordination to prevent opioid misuse, prevent overdoses, and treat those with OUD and any co-occurring SUD/MH conditions, or implement other strategies to abate the opioid epidemic described in this opioid abatement strategy list (*e.g.*, health care, primary care, pharmacies, PDMPs, etc.).

L. RESEARCH

Support opioid abatement research that may include, but is not limited to, the following:

1. Monitoring, surveillance, data collection and evaluation of programs and strategies described in this opioid abatement strategy list.

2. Research non-opioid treatment of chronic pain.

3. Research on improved service delivery for modalities such as SBIRT that demonstrate promising but mixed results in populations vulnerable to opioid use disorders.

4. Research on novel harm reduction and prevention efforts such as the provision of fentanyl test strips.

5. Research on innovative supply-side enforcement efforts such as improved detection of mail-based delivery of synthetic opioids.

6. Expanded research on swift/certain/fair models to reduce and deter opioid misuse within criminal justice populations that build upon promising approaches used to address other substances (*e.g.*, Hawaii HOPE and Dakota 24/7).

7. Epidemiological surveillance of OUD-related behaviors in critical populations, including individuals entering the criminal justice system, including, but not limited to approaches modeled on the Arrestee Drug Abuse Monitoring ("*ADAM*") system.

8. Qualitative and quantitative research regarding public health risks and harm reduction opportunities within illicit drug markets, including surveys of market participants who sell or distribute illicit opioids.

9. Geospatial analysis of access barriers to MAT and their association with treatment engagement and treatment outcomes.

AG

Michigan's $81 Million Opioid Settlement Distribution Set to Begin

January 13, 2023

AG Press
agpress@michigan.gov

LANSING – Michigan Attorney General Dana Nessel announced that participating local governments throughout Michigan can expect to see funds as soon as later this month a result of the Department's participation in two multi-state opioid settlements.

"I am relieved the court ruled in accordance with the law, and I thank the judge for the keen attention she paid to this important matter," said Nessel. "It's critical that communities throughout Michigan are indemnified for the harm they suffered due to the recklessness of the opioid manufacturers and distributors. The frivolous challenge by Ottawa County delayed millions of dollars from being put to good use to help Michigan residents our communities recover."

The settlement money's distribution was expected to begin in the fourth quarter of 2022 but was held up by legal challenges brought by the Ottawa County Commission. This morning, Wayne County Circuit Judge Patricia Fresard granted the Attorney General's request for summary disposition, clearing any roadblocks with the settlement distributions, which could now start by January 31.

The $81 million that will be available later this month encompasses the first three payments of these settlements. Since September, the National Settlement Administrator has provided three Notices of Payment totaling about $81.6 million.

Ottawa County had disputed all three payments, which held up payments to all local governments.

Michigan is anticipating over $1.45 billion from opioid settlements. This includes some settlements that are still in process. The opioid settlement funds that the State of Michigan receives will be directed to the Michigan Opioid Healing and Recovery Fund (MCL 12.253). This fund was created by the Legislature in 2022. The Legislature also created the Opioid Advisory Commission (MCL 4.1851) to make recommendations on the State's opioid fund.

ADDITIONAL SETTLEMENT BACKGROUND

State negotiations were led by Attorneys General Josh Stein (NC), Herbert Slatery (TN) and the attorneys general from California, Colorado, Connecticut, Delaware, Florida, Georgia, Louisiana, Massachusetts, Michigan, New York, Ohio, Pennsylvania, and Texas. The agreement in principle was reached by all parties in October of 2019 and the parties have been working on the particulars of the settlement since then.

Funding Overview:

- The three distributors collectively will pay up to $21 billion over 18 years.
- Johnson & Johnson will pay up to $5 billion over nine years with up to $3.7 billion paid during the first three years.
- The total funding distributed will be determined by the overall degree of participation by both litigating and non-litigating state and local governments.
- The substantial majority of the money is to be spent on opioid treatment and prevention.
- Each state's share of the funding has been determined by agreement among the states using a formula that takes into account the population of the state along with the impact of the crisis on the state - the number of overdose deaths, the number of residents with substance use disorder, and the number of opioids prescribed.

Injunctive Relief Overview:

- Requires Cardinal, McKesson, and AmerisourceBergen, through court orders, to:
    - Establish a centralized independent clearinghouse to provide all three distributors and state regulators with aggregated data and analytics about where drugs are going and how often, eliminating blind spots in the current systems used by distributors.
    - Use data-driven systems to detect suspicious opioid orders from customer pharmacies.

- Terminate customer pharmacies' ability to receive shipments, and report those companies to state regulators, when they show certain signs of diversion.
- Prohibit shipping of and report suspicious opioid orders.
- Prohibit sales staff from influencing decisions related to identifying suspicious opioid orders.
- Require senior corporate officials to engage in regular oversight of anti-diversion efforts.

- Requires Johnson & Johnson, through court orders, to:
  - Stop selling opioids.
  - Not fund or provide grants to third parties for promoting opioids.
  - Not lobby on activities related to opioids.
  - Share clinical trial data under the Yale University Open Data Access Project.

A breakdown of how the settlement money is to be spent on opioid treatment and prevention is available here.

A national website has been created to provide additional information on the settlement.

If you or a loved one need opioid addiction treatment, there are resources to help.

###

Attorney General MI Newswire Press Release

Related News

AG Nessel Announces Distribution of $141 Million Settlement to Millions of Low-Income Americans Deceived by TurboTax Owner Intuit

Consumers to Receive Checks in the Mail from Multistate Settlement Without Needing to File a Claim

Steven Decker Sentenced for Defrauding U.S. Department of

Veterans Affairs and MI Treasury

AG Nessel Joins 22 States to Protect Patients Against Texas' Attempt to Exclude Abortion from Emergency Healthcare

Michigan Municipalities Still Able to Participate in Opioid Settlement as Deadline Extended to May 9

AG Nessel Concludes Investigation of Intoxalock After Sufficient Changes to Misleading Mailer

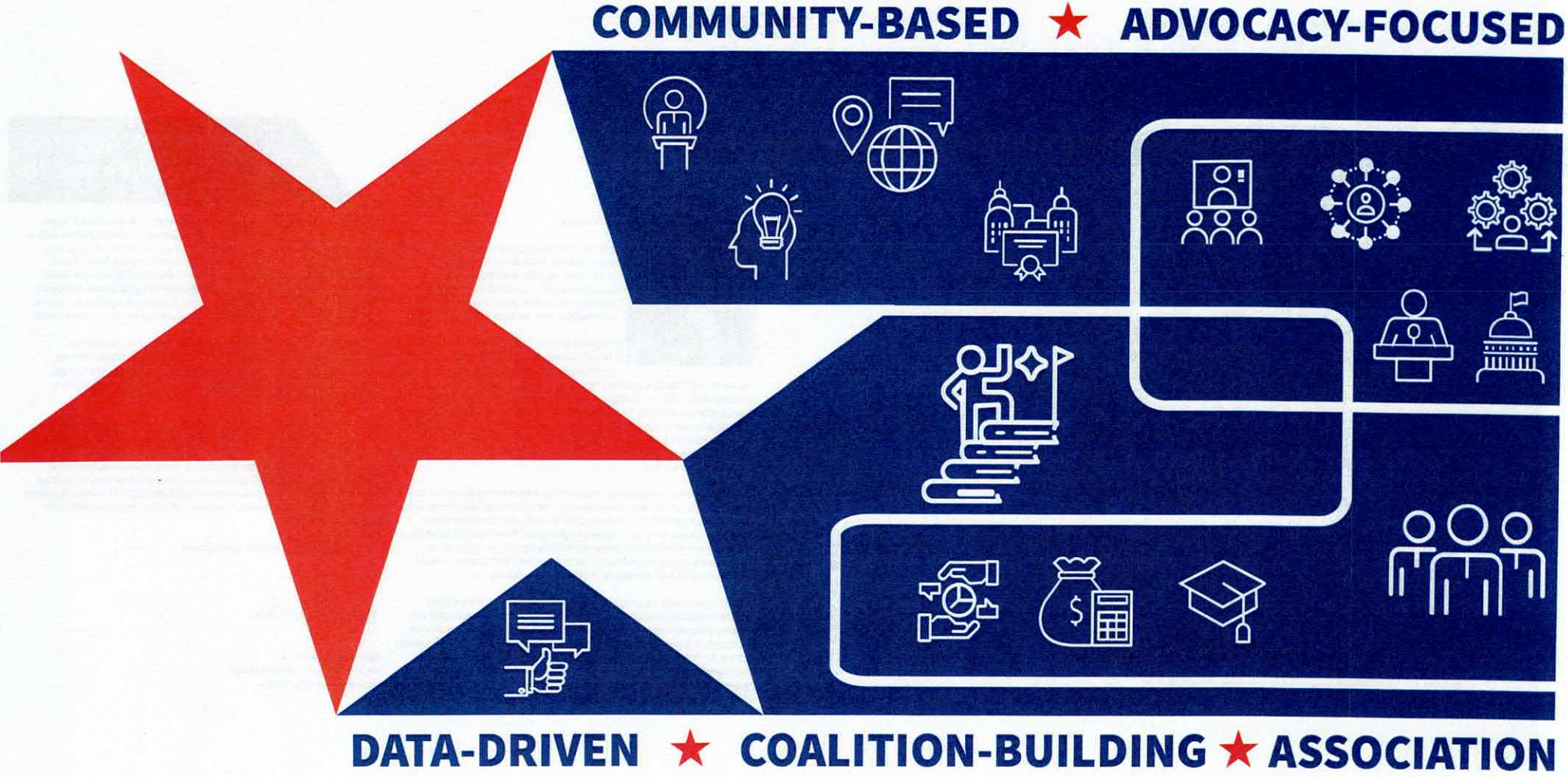
Trial to Proceed in 1982 Disappearance and Homicide of Ann Arbor Infant

Ottawa County Sanctioned by Third Circuit Court for Encumbering Opioid Settlement

Ten Years After Campus Rape, Charges Brought by Kalamazoo Sexual Assault Initiative

AG Nessel Joins Multistate Coalition Opposing Restrictions to Title X Family Planning Program

Michigan Assistant Attorney General John Pallas Receives International Prosecutor of the Year Award



CADCA

cadca.org

TOGETHER TOWARD TOMORROW

ANNUAL REPORT 2022

TABLE OF CONTENTS

MESSAGE FROM THE PRESIDENT AND CEO

Dear Friends,

As we embark on a new year and set out to continue our honorable and worthy fight in creating safe, healthy and drug-free communities, I would like to take the opportunity to reflect and acknowledge the remarkable strides we have made as a field.

This past years has been characterized as a period of great uncertainty and strife. We experienced a worldwide pandemic; have noted a rise in mental health concerns - especially among our youth; and witnessed the harrowing trends in overdose deaths. Yet, as I reflect on this stretch of time, I am not struck with feelings of defeat or discouragement. I see more than what we are up against; I see revealed the true strength of a movement that, no matter what challenges may arise, will persevere and adapt accordingly. I see the power of our collective efforts and the endless potential of our future endeavors.

2022 was a year of transitioning, reassembling and reuniting in person. It was a year to round up the lessons we have learned and thoughtfully incorporate them into our plan for the upcoming year. In 2023, you can expect more intentional accessibility and support for your work from the CADCA family, even more relevant keynote speakers and training session topics at our premier training events, and you will see us pursue more opportunities to ensure that your coalition can be as effective as possible.

This fall, I have begun a long and worthwhile journey to visit each state and territory to advocate for the allocation of Opioid Settlement dollars to support your prevention efforts. I believe whole-heartedly that you are the solution to this epidemic, and that you will be the agents of change necessary to turn the tide in overdose deaths. I hope that by serving as your voice and your devoted ally, you will see more funding to increase your coalition capacity, sustainability and outcomes.

CADCA has also recently undergone a brand refresh. Upon conducting an external survey of our stakeholders and meditating on what our organization truly represents, five pillars have emerged that we feel best encapsulates what we stand for: Community-Based, Advocacy-Focused, Data-Driven, Coalition-Building, Association. We are more than the letters in our name, which is why we have replaced Community Anti-Drug Coalitions of America with simply: CADCA. This transition signifies that we are a global movement and shines a light on the true representation of who we are and what we do.

We are entering a period of growth and exploring new opportunities to expand beyond serving as an umbrella organization. We are braving new grounds and revising our strategic plan, not for the sake of change, but in pursuit of becoming a more expansive and valuable resource for communities worldwide.

As you look through this report, I ask that you join me in celebrating the successes we have shared. The highlights we have gathered are structured around CADCA's Five Strategic Priorities – to increase the number of coalitions in the U.S. and globally, increase capacity and effectiveness of coalitions, increase capacity and effectiveness of youth and adult coalition leaders and members, increase brand recognition of CADCA and our coalition model and create and enhance a powerful, effective legislative and policy environment.

Thank you for your continued commitment.

Sincerely,

Barrye L. Price

Barrye L. Price, Ph.D.
Major General, U.S. Army Retired
President and CEO, CADCA

NUMBER OF ADULTS AND YOUTH TRAINED

16,579

IN ALL 50 STATES AND PUERTO RICO

NUMBER OF COALITIONS TRAINED OVERALL

4,461

ADULTS

TRAINED
13,575
FROM
4,461
COALITIONS
FROM
39
STATES
FOR TOTAL NUMBER OF
1,234
TRAINING HOURS

YOUTH

TRAINED
3,200
FROM
26
STATES AND PUERTO RICO

INCREASE THE NUMBER OF COALITIONS IN THE US AND GLOBALLY

Coalition Development Support (CDS)

REQUESTS **1652** HOURS **1264**

48
STATES PLUS GUAM AND PUERTO RICO

OF COALITIONS PARTICIPATING IN "BEYOND THE NCA" INITIATIVE
64

Outreach

OF CONTACTS MADE
1,233

Publications

OF PRACTICAL THEORIST DOWNLOADS
279
PRACTICAL THEORIST REQUESTS FOR PT HARDCOPIES
500

Primer Requests

PRIMER REQUESTS FOR HARD COPY
400
DIGITAL DOWNLOAD FROM WEBSITE
158

What's Trending

COUNTERFEIT PILLS
128
VIEWS
106
DOWNLOADS

DELTA-8
128
VIEWS
106
DOWNLOADS

OPIOIDS AND THE PANDEMIC: A DEADLY MIX
DOWNLOADS
69
VIEWS
50

Got Outcomes

OF APPLICATIONS
55
APPLICATIONS THIS YEAR FROM
27
STATES

Annual Survey

SURVEY RESPONDENTS
554
FROM
49
STATES

Evaluation

COALITION TECHNICAL SUPPORT AND DEA 360 EVALUATION COMPLETED
32
TRAININGS/EVALUATION

Webinars

TOTAL WEBINARS
16
TOTAL WEBINAR PARTICIPANTS
2,810
OF UNIQUE COALITIONS
1,926

YOUTH AND ADVANCED TRAININGS

DEA Operation Engage/ Customized Service Training

ADULTS TRAINED
630

YOUTH TRAINED
400

HOURS OF TRAINING
625

CADCA Youth Leadership Initiative (CYLI) Training

OF CYLI TRAININGS
23

FROM # OF STATES
26

NUMBER OF ADULT ADVISORS TRAINED
120

Graduate Coalition Academy

OF GCA PARTICIPANTS
24

FROM # OF COALITIONS
10

National Coalition Academy

OF NCA ATTENDEES
390

OF REPRESENTED COALITIONS
192

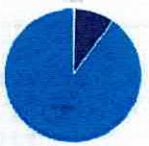
FROM # OF STATES
39

OF COALITIONS GRADUATED FROM 2021 NCA
163

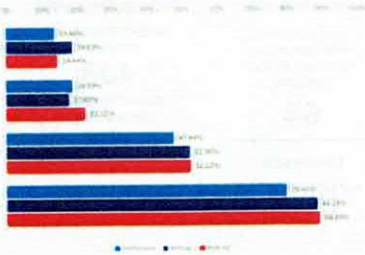
OF CHAIRMAN'S AWARD APPLICANTS
17

Responses from the 2022 National Coalition Academy (NCA) evaluations were compiled for overall satisfaction of training and training transfer, the ways in which the CADCA model was shared with coalition members by NCA attendees.

"In General, How Satisfied Are You with the Training You Received?"



"With How Many Other Members of Your Coalition Did You Share Information You Learned and/or Resources from the NCA Trainings?"



International

In 2022,

CADCA's International Department continued to mobilize communities to establish, strengthen and maintain community coalitions in the fight to prevent substance misuse.

Global network of
353
community coalitions in
28
countries

42
new coalitions established in 2022

Trained volunteer network of over
12,400
coalition leaders worldwide

10
national associations of community coalitions formed on four continents

Operated in
21
countries in 2022 and reached
223
coalitions through training and technical assistance

COALITIONS

255
TRAININGS TO COALITIONS

7
TRAINER-LED WEBINARS

In 2022, CADCA's International Department had 544 engagement activities with coalitions in Latin America, Africa, Europe, Central & Southeast Asia through

181
TECHNICAL ASSISTANCE SESSIONS

83
ONE ON ONE COALITION DEVELOPMENT CONSULTATIONS

18
REGIONAL/NATIONAL COALITION ENGAGEMENT EVENTS

In 2022, CADCA's International Programs engagement activities resulted in

1,163
TOUCH POINTS TO COALITIONS GLOBALLY TO TRAIN ADULT AND YOUTH MEMBERS

8,627
ADULT AND YOUTH COALITION LEADERS TRAINED

TRAINING AND TECHNICAL SUPPORT DELIVERED IN

7
LANGUAGES

In 2022, CADCA's International Programs contributed to the 20th Mid-Year Training Institute with

88
REGISTERED ATTENDEES FROM

10
TRAINING SESSIONS IN

21
COUNTRIES

3
LANGUAGES

SIMULTANEOUS INTERPRETATION OFFERED IN

3
LANGUAGES

REGIONAL NETWORKING SESSIONS FOR COALITIONS FROM

3
CONTINENTS

5 BUREAU OF INTERNATIONAL NARCOTICS AND LAW ENFORCEMENT AFFAIRS (INL) OFFICES REPRESENTED

EFFECTIVENESS OF COALITIONS

DFKC Awards

CADCA's 24th Annual Drug-Free Kids Campaign Awards was held in-person at the Gaylord National Riverview Ballroom.

MAJOR GENERAL ARTHUR T. DEAN HUMANITARIAN AWARD
Amerisource Bergen

CHAMPION FOR DRUG-FREE KIDS
Faegre Drinker Consulting

NATHANIEL J. SUTTON ADVOCACY IN THE ARTS AWARD
The Mark & Brenda Moore Foundation

MASTER OF CEREMONIES
Anita Brikman, Senior Vice President, Communications & Public Affairs, Consumer Healthcare Products Association (CHPA) and Executive Director, CHPA Educational Foundation

CHAIR
Roger Krone, Chairman and Chief Executive Officer, Leidos

VICE-CHAIR
Jason Sundby, Chairman and Chief Executive Officer, Verde Technologies

MUSICAL PERFORMANCE
Sean Ardoin

INVOCATION
Bishop James Watson

CONGRESSIONAL SPECIAL GUEST
The Honorable Madeleine Dean (D/PA 4th)

YOUTH HONOREES
Jaleyna Lawes, Broward Youth Coalition
Sofia Ferreiro, Levittown Community Action Coalition

252 CONGRESSIONAL HOST COMMITTEE MEMBERS

#? LEADERSHIP TEAM MEMBERS

Mid-Year Attendance
2,137

Forum Attendance
2,024

INCRASE BRAND RECOGNITION OF CADCA AND OUR COALITION MODEL

PERCENT INCREASE IN FOLLOWERS

1.1%	20.5%	1.2%	25.3%

106
VIDEOS CREATED IN 2022

27,271
TOTAL VIDEO VIEWS IN 2022

310
TOTAL EMAILS SENT

33.2%
EMAIL OPEN RATE

FY 2022 APPROPRIATIONS

CADCA's Public Policy Team has worked to save and increase funding for all the core federal programs that support the substance use prevention field in the United States and around the world. Since FY 1994, CADCA has been responsible for the restoration of cuts or funding increases of over $4.72 billion. While Fiscal Year (FY) 2022 numbers are final, FY 2023 numbers are still being debated in Congress.

The Drug-Free Communities (DFC) program was funded at a record high level of **$106 million** (+$4 million above the final FY 2021 appropriated amount), to include **$2.5 million** (level with the final FY 2021 appropriated amount) for the National Community Anti-Drug Coalition Institute, a grant to CADCA that provides the Technical Assistance and Training for the DFC program.

The Comprehensive Addiction and Recovery Act (CARA) enhancement grants, that only current and former DFC coalitions are eligible to compete for, to do more with more intensity around opioid and stimulant issues, were funded at a record level of **$5.2 million** (+$200 thousand above the final FY 2021 appropriated amount of $5 million).

The Sober Truth on Preventing Underage Drinking (STOP) Act programs were funded at a record **$12 million** (+$2 million above the final FY 2021 appropriated amount of $10 million), to include:

- **$9 million** for the STOP Act enhancement grants (+$2 million above the final FY 2021 appropriated amount of $7 million).
- **$2 million** for the Adult-Oriented National Media Campaign (level with the final FY 2021 appropriated amount).
- **$1 million** for the Interagency Coordinating Committee for the Prevention of Underage Drinking (level with the final FY 2021 appropriated amount).

SAMHSA's Center for Substance Abuse Prevention (CSAP) was funded at **$218.219 million**, ($10 million above the final FY 2021 appropriated amount of $208.219 million) and, within that amount, the Strategic Prevention Framework/Partnership for Success (SPF/PFS) grant program was funded at **$127.484 million** (+$8 million above the final FY 2021 appropriated amount of $119.484 million).

The Substance Abuse Prevention and Treatment Block Grant within SAMHSA's Center for Substance Abuse Treatment (CSAT) was funded at **$1.908 billion** (+$50.079 million above the final FY 2021 appropriated amount of $1.858 billion). This includes the 20% prevention set-aside of $381.6 million (+$10 million above the FY 2021 prevention set aside of $371.6 million).

The State Department's International Narcotics Control and Law Enforcement (INL) Demand Reduction program was funded at **$20 million** (+$5 million above the final FY 2021 appropriated amount of $15 million).

The DFC Pandemic Relief Act

In March 2022, President Biden signed the DFC Pandemic Relief Act into law. This legislation allows the Office of National Drug Control Policy (ONDCP) to waive, on a case-by-case basis, all or part of the DFC program's local matching requirements for coalitions impacted by COVID-19. CADCA successfully advocated to see that this bill became law.

STOP Act Reauthorization

CADCA is working with a bipartisan, bicameral group of Congresspeople to support the reauthorization of the Sober Truth on Preventing (STOP) Underage Drinking Act. This bill would reauthorize STOP Act programs including the Community-Based Coalition Enhancement Grants, to current and former DFC coalitions to do more about underage drinking.

Bruce's Law

CADCA worked with a bipartisan, bicameral group of Congresspeople to support the introduction of Bruce's Law in both the Senate and the House. This legislation includes a provision for a new grant program for current and former DFCs to compete for funding specifically to focus on the dangers of fentanyl contamination.

Other Public Policy Successes

CADCA's Public Policy Team continuously works to create new relationships and champions for the substance use prevention field in Congress.

Legislative Alerts

In calendar year 2022, respondents to CADCA's legislative alerts sent nearly **4,012** messages to their members of Congress about increased funding for prevention programs, as well as in support of or opposition to specific bills.

DFKC Awards

252 members of Congress signed onto the Congressional Host Committee for the Drug-Free Kids Campaign Awards Dinner.

National Leadership Forum

In February 2022, CADCA held another successful virtual Capitol Hill Day. 800 people attended 205 Capitol Hill meetings.

Geographic Health Equity Alliance

A CADCA Initiative

SUPPORTED FIFTEEN STATE PROGRAMS

1. Tobacco Control Programs: MO, VA, KS, IN, FL, AR, TX, ID, SC, KY, IL
2. Comprehensive Tobacco Control Programs: KS, IN, FL, OK, RI, WV, IL

HOSTED TWO LEARNING COLLABORATIVES

These two year-long training and technical assistance programs were offered to 9 state National Tobacco Control and Comprehensive Cancer Control programs.

1. Geographic/Policy Surveillance Learning Collaborative
2. HPV Vaccination Policy Learning Collaborative

HOSTED THIRTEEN WEBINARS

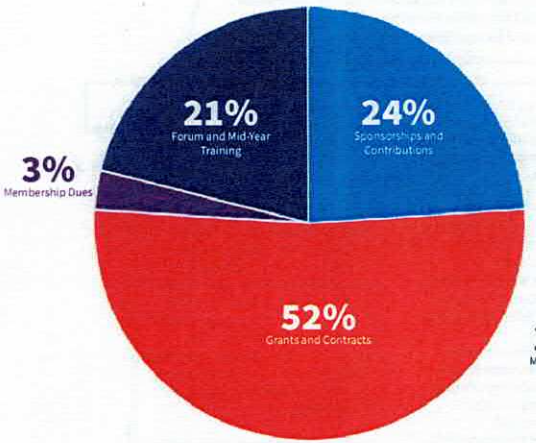
This year, GHEA took a deep dive into three topics relevant to tobacco- and cancer-control. Topics and highlights include:

1. Rural Inclusion in Comprehensive Cancer Control Planning
2. Local Control (of public health decision making)
3. HPV Vaccination Policy, Systems and Environmental Change Strategies
4. E-Cigarette Collection and Disposal in Schools: ABC and FAQs
5. Youth Indoor and Outdoor Exposure to Secondhand Smoke and Aerosol

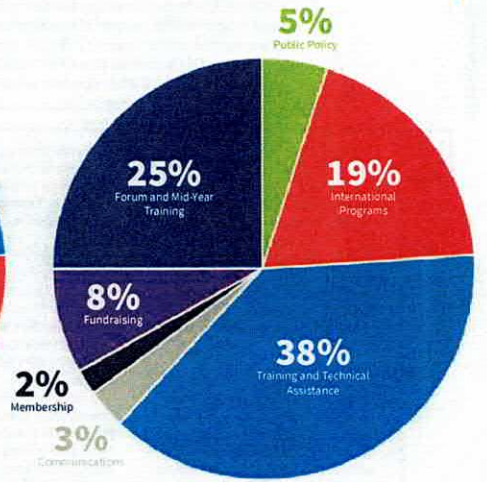
HOSTED SEVEN TOTAL SESSIONS AT FORUM AND MID-YEAR

FINANCIALS

REVENUE



EXPENSES




CADCA
cadca.org
CADCA
CADCA
CADCAcoalitions
CADCAcoalitions
CADCA
CADCAOrg
community.cadca.org

PARTNERS

*The mark "CDC" is owned by the US Dept. of Health and Human Services (HHS) and is used with permission. Use of this logo is not an endorsement by HHS or CDC of any particular product, service, or enterprise.

CADCA Community

15,000 MEMBERS

7,000 DISCUSSIONS

600 LIBRARY RESOURCES

Premier
National Institute on Alcohol Abuse and Alcoholism (NIAAA)
Drug Enforcement Administration (DEA)

Executive
Snap Inc.
Alkermes

Platinum
Strategic Resources Inc. (SRI)
National Institute on Drug Abuse (NIDA)
Gaylord Palms
Consumer Healthcare Products Association (CHPA)
Inspire Event Solutions
IMN Solutions
National Alcohol Beverage Control Association (NABCA)
Tower Foundation

Gold
Ina Kay Foundation
Healthcare Distribution Alliance
The Mark and Brenda Moore Foundation
Oracle Cerner

Silver
Gaylord National Resort & Convention Center
Aetna
Health and Hope West Virginia
Hilarity for Charity

Bronze
Barrye and Dr. Tracy Price
Mother's Against Prescription Drug Abuse (MAPDA)
National Basketball Association (NBA)
Nolen Bivens
PenFed Foundation
Xomad
RWFJ Special Contributions Fund of the Princeton Area Community Foundation
Faegre Drinker Consulting
AEGIX Global, LLC
Dooner Social Ventures
Penn Quarters Partners
Major General & Mrs. Arthur T. Dean
Donald and Beverly Truslow
NIMCO, Inc.
The Honorable Mary Bono and Rear Admiral Steve Oswald, USN (Ret.), NASA Astronaut Nolen Bivens
Colonel Bill Smith (In Honor of Carl David Holmes)
R. Lynch Enterprise, LLC
James Milano
Antonio Coleman
Frank and Vera Clark
World Services, LLC
Michael Harrison
Alonzo Fulgham
The Roberts Family in memory of Vaughn and Gwendolyn Roberts and Joshua and Dorothy Thompson
Zensights
Dr. and Mrs. Albert Terrillion
Caron Treatment Centers
Bank of America Merrill Lynch (Peter Dunne & Winship Ross)
CADCA Communications & Meetings Team (Angelique, Relja, Kahlee, Natalie, Catalina, Ebony)
Valentino and Terri Murphy
James and Christine Borger
Thau Family Trust
Pat Castillo
Raiko Mendoza
Andrew and Karen Drexler
Bill Davis
Colonel Norvel Dillard
William and Margaret Chow
Colonel Robert Whaley
USI Insurance Services
ZRG Partners
Truth Initiative
Idea Engineering
Campaign for Tobacco-Free Kids

CADCA Board of Directors

THE HONORABLE MARY BONO
Chairman
Former Member of U.S. Congress
Integridas by Bono LLC
President and Founder

GREGORY PUCKETT
Secretary
County Commissioner, Mercer County, West Virginia
Executive Director, Community Connections, Inc.

LARRY P. COTE, ESQUIRE
Vice Chairman
Founding Partner, Cote Law PLLC

DONALD K. TRUSLOW
Treasurer
Retired Banking Executive

Board Members

MICHAEL A. BRAUN
President, SAVA Workforce Solutions, LLC
DEA Chief of Operations (Retired)

ANITA BRIKMAN
Senior Vice President, Communications & Public Affairs, Consumer Healthcare Products Association (CHPA) and Executive Director, CHPA Educational Foundation

ESTHER T. BENJAMIN
Chief Executive officer and Executive Director
World Education Services, Inc.

MONTY BURKS, PH.D.
Director of Faith-Based Initiatives for the Tenessee Department of Mental Health and Substance Abuse Services

KAREN DREXLER, M.D.
Associate Professor, Dept. of Psychiatry and Behavioral Sciences, Emory University School of Medicine Atlanta VAMC

RUDOLPH ESTRADA
Chief Executive Officer
Estradagy Business Advisors, LLC

FRAN FLENER
Former Arkansas Drug Director

JAMES J. (JAY) GALEOTA JR.
President and CEO
Kallyope

JUAN GARCIA
Managing Director, Defense, Security & Justice Sector
Deloitte Consulting LLP

MARK S. GOLD, M.D.
Professor, Distinguished Professor, Eminent Scholar, Chief, Chairman, Emeritus Eminent Scholar & Distinguished Alumni Professor (1990-2015)
Professor (Adjunct) Washington University in St. Louis, School of Medicine

LIEUTENANT GENERAL (RET.) PATTY HOROHO
Chief Executive Officer
Optum Serve
43rd Army Surgeon General

JEANNIE HOVLAND
Member of the Flandreau Santee Sioux Tribe

MICHELLE KLEY
Executive Vice President
General Counsel and Secretary
Volta, Inc.

THE HONORABLE MICHAEL KRAMER
Judge of the Noble Circuit Court
33rd Judicial Circuit of Indiana

KIRK R. LANE
Director
Arkansas Opioid Recovery Partnership

CHET D. LINTON
Chief Executive Officer
AEGIX Global USDGI

WILLIE MITCHELL
Board President/Executive Director
San Antonio Fighting Back, Inc.

BRIGITTE NETTESHEIM
President, Territory Leader, North Central Territory & Joint Venture Markets

THOMAS J. REDDIN
Managing Partner
Red Dog Ventures, LLC

RONALD S. ROCHON, PH.D.
President
University of Southern Indiana

AARON S. WILLIAMS
Senior Advisor - Emeritus
International Development & Governmental Relations
RTI International

DAVE ZOOK
Partner
Faegre Drinker Biddle & Reath LLP

EMERITUS

NEIL AUSTRIAN
Former Chairman and CEO
Office Depot, Inc.
Former President
The NFL

GENERAL ARTHUR T. DEAN
Former Chairman and CEO
CADCA Board of Directors

Coalition Advisory Committee

VIRGIL BOYSAW, JR.
Director
Cecil County Drug Free Communities Coalition
Cecil County Health Department

SAM BRADSHAW, BSW, CPS
Director of Prevention Services
Cherokee Nation Behavioral Health
Tahlequah, Oklahoma

REVEREND SHANE BRITT
Founder and Executive Director
The Scottsville Allen County Faith Coalition, Inc.

JORDAN S. ESSER
Community Initiatives Coordinator
DuPage County Health Department

MERILEE FOWLER
Executive Director
MATFORCE and Community Counts

AMY R.H. HASKINS, M.A.
Administrator & Sanitarian
Jackson County Health Department
Project Director
Jackson County Anti-Drug Coalition

CINDY C. HAYFORD
Director
Deerfield Valley Community Partnership

BEVERLY H. JOHNSON, MPA
Director of Prevention Services
Alabama Department of Mental Health

MIKE LOPEZ
Program Manager
Youth Services
Los Angeles LGBT Center

KEVIN MCCLOSKEY
Director of Community-Based Programs
Youth Services
Los Angeles LGBT Center

MICHAEL J. NOZILE, SR.
President & CEO
Gang Alternative, Inc.

JOSE D. PIETRI
Project Director
Coalition for the Management and Prevention of Substance Abuse of Sabana Grande (COMPASS)

STEPHANIE RHINEHART, LMSW
Prevention Program Manager
Kansas Department for Aging and Disability Services/Behavioral Health Services

GAIL M. TAYLOR, M.E.D.
Director
Behavioral Health Wellness
Virginia Department of Behavioral Health and Developmental Services

Executive Team

MAJOR GENERAL (RETIRED) BARRYE L. PRICE, PH.D.
President and CEO

VALENTINO MURPHY MBA, SHRM-SCP, SPHR
Chief of Staff

JAMES BORGER
Vice President, Finance and CFO

PAT CASTILLO, B.A., EMPA
Vice President, Training & Operations
Director, National Coalition Institute

RAIKO MENDOZA
Vice President, Business Development and Membership

ERIC SIERVO, M.ED.
Vice President, International Programs

ANGELIQUE WILKINS
Vice President, Communications & Meetings

SUE THAU
Public Policy Consultant

Future CADCA Events

2023

January 30 - February 2
National Leadership Forum
Gaylord National Hotel
National Harbor, MD

July 16 - July 20
Mid-Year Training Institute
Gaylord Texan
Dallas, TX

October 12, 2023
25th Annual Drug-Free Kids Campaign Awards Dinner
Riverview Ballroom, Gaylord National Hotel
National Harbor, MD

Reducing Drug Use, One Community At a Time

Since 1992, CADCA has demonstrated that when all sectors of a community come together, social change happens. CADCA represents over 5,000 community coalitions that involve individuals from key sectors including schools, law enforcement, youth, parents, healthcare, media, tribal communities and others. We have members in every U.S. state and territory and more than 30 countries around the world. The CADCA coalition model emphasizes the power of community coalitions to prevent substance misuse through collaborative community efforts. We believe that prevention of substance use and misuse before it starts is the most effective and cost-efficient way to reduce substance use and its associated costs.

In addition to supporting our member coalitions by providing resources and materials designed to help our coalitions be effective and sustainable, CADCA also offers customized trainings for coalitions across the world. Through our International Programs, Youth Leadership and Training teams, we are able to reach and empower thousands of change advocates per year. CADCA also offer signature events each year, including the National Leadership Forum, Mid-Year Training Institute and Drug-Free Kids Campaign Awards Dinner, which help our members network, share ideas and learn from some of the most influential substance misuse professionals in the world. Through these efforts, we stand by our slogan of "Everyday CADCA Trains." We believe our ongoing training efforts help address the current substance misuse epidemic, and those outcomes will change the world.

29

YEAR EXPERIENCE

305

COMMUNITY COALITIONS

14,000

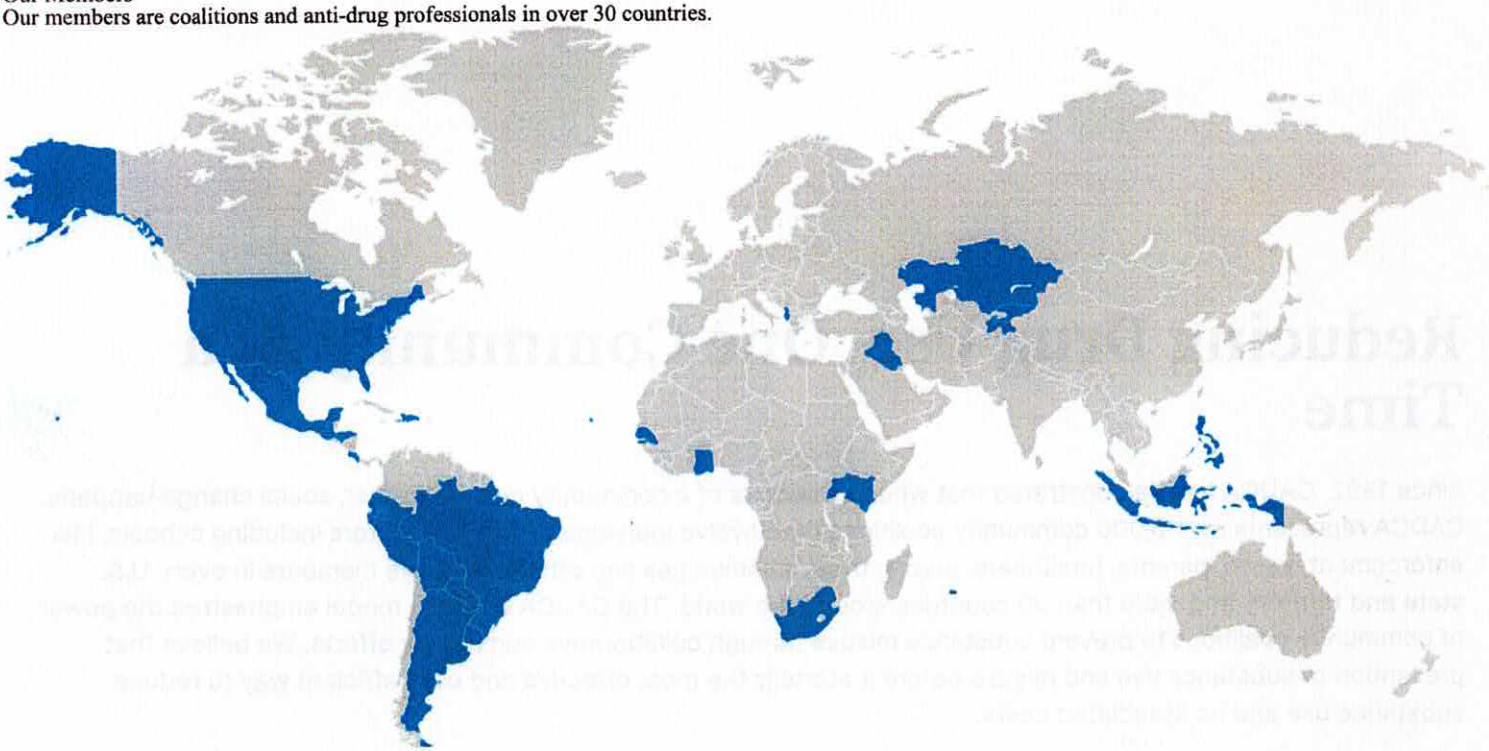
PROFESSIONALS TRAINED

28

COUNTRIES

Our Members

Our members are coalitions and anti-drug professionals in over 30 countries.



We are in this together

Partnership Opportunities

Leadership & Governance

The members of our senior management team come from all walks of life and are among the most diverse in America today.

For the Media

The Media Relations team at CADCA welcomes inquiries and interview requests from members of the media.

Awards

Our awards recognize coalitions that achieve measurable success in community-level substance misuse related outcomes by implementing a comprehensive and feasible plan guided by local data.

Keep Up With All Things CADCA