final minutes

Opioid Advisory Commission (OAC) Meeting
10:00 a.m. • Thursday, December 8, 2022
Legislative Conference Room • 3rd Floor Boji Tower Building
124 W. Allegan Street • Lansing, MI

Members Present:
Ms. Kelly Ainsworth
Mr. Brad Casemore
Judge Linda Davis
Ms. Katharine Hude
Mr. Scott Masi
Mr. Mario Nanos
Mr. Patrick Patterson
Dr. Cara Poland
Mr. Kyle Rambo
Dr. Sarah Stoddard

Members Excused:
Ms. Mona Makki
Dr. Cameron Risma

Dr. Risma joined virtually; therefore, was unable to be counted present for the purposes of quorum or act on voting items before the Commission per the Open Meetings Act.

Dr. Stoddard arrived in-person at 10:28 a.m.

Ms. Dettloff serving as an Ex-officio member to the Commission was in attendance.

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

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 November 10, 2022 Meeting Minutes
The Chair directed attention to the proposed minutes of the November 10, 2022 meeting and asked if there were any changes. **Judge Davis moved, supported by Mr. Casemore to approve the minutes of the November 10, 2022 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. Meeting Duration Discussion
Based on the desire from Commission members, the Chair proposed to adjust the January, February, and March meeting times to reflect a new duration of 9:00 a.m. – 12:00 p.m. There was agreement amongst Commission members.

V. Commission Report Discussion

The Chair expressed gratitude to Commission members and Ms. King for collaboration in the development of the Commission's report. The Chair directed attention to Ms. King for further action items.

- Review plan for group discussion
- Review OAC supplemental handouts
- Review Annual Report: Draft outline
    - Core Documents & Supplementary Materials
    - Guiding Principles
    - Strategic Priorities

The Chair called for a lunch break at 12:15 p.m. and excused herself for the remainder of the meeting announcing Vice Chair Patterson will serve as Chair to resume the meeting after the lunch break.

The Chair called the meeting to order at 12:45 p.m. The Chair asked the clerk to take roll. The clerk reported a quorum was present. The Chair asked for absent members to be excused.

Members Present:
Ms. Kelly Ainsworth
Mr. Brad Casemore
Judge Linda Davis
Ms. Katharine Hude
Mr. Scott Masi
Mr. Mario Nanos
Mr. Patrick Patterson
Mr. Kyle Rambo
Dr. Sarah Stoddard

Members Excused:
Ms. Mona Makki
Dr. Cara Poland
Dr. Cameron Risma

VI. Presentations to the Commission

- Michigan Overdose Prevention Coalition
    - Justin Fast, Public Sector Consultants
    - Pamela Lynch, Harm Reduction Michigan
    - Steve Aslum, The Grand Rapids Red Project
- Michigan Opioid Collaborative
    - Dr. Amy Bohnert, University of Michigan
    - Dr. Allison Lin, University of Michigan
- Perinatal Opioid Use
    - Dr. Claire Margerison, Michigan State University
- Medications for Opioid Use Disorder in the Carceral Setting
    - Mr. Matthew Costello, Wayne State University
    - Ms. Katharine Hude, Michigan Association of Treatment Court Professionals
- Families Against Narcotics
    - Judge Linda Davis, Families Against Narcotics

VII. Commission Member Comment

The Chair asked if there were additional comments from Commission members. Mr. Nanos distributed a news article published in Crain's Detroit Business titled "Adolescent addiction recovery site will serve those without insurance"

VIII. Public Comment

The Chair asked if there were any comments from the public. There was none.

IX. Next Meeting Date: Thursday, January 12, 2023 at 9:00 a.m.

The Chair announced the next meeting date for Thursday, January 12, 2022 at 9:00 a.m. The Chair reminded Commission members a majority of seven 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 3:46 p.m. with unanimous support.

Michigan Overdose Prevention Coalition

Michigan Overdose Prevention Coalition

Steve Alsum
Grand Rapids Red Project, steve@redproject.org

Pam Lynch
Harm Reduction Michigan, pam@harmreductionmi.org

Justin Fast
Public Sector Consultants, jfast@publicsectorconsultants.com

Vision

Substance use and overdose are understood as public health issues. Public policy, health systems, and social services are healing-focused and compassionate to people who use drugs.

Mission

The Michigan Overdose Prevention Coalition will equip its members to educate decisionmakers, advocate for public policy change, and improve service delivery systems for people who use drugs.

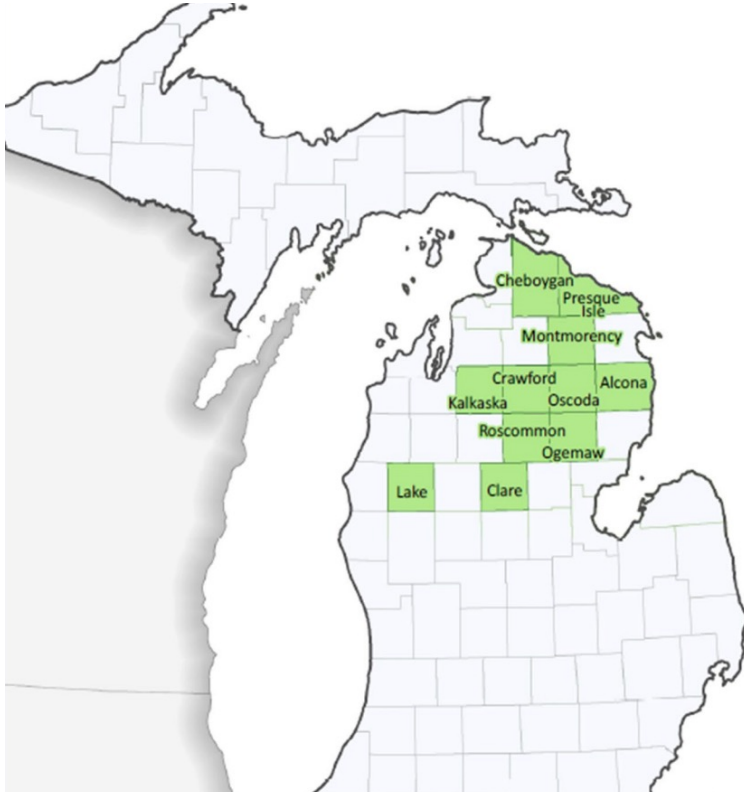
Harm Reduction Education

What we mean when we say harm reduction…

Harm reduction is a public health approach that aims to reduce the negative impacts of substance use. It means meeting people where they are and linking them to life-sustaining health services, including:

- Community-based access to naloxone
- Syringe service programs
- Education and counseling
- Planning and prevention resource
- Recovery resources
- Minor medical treatments

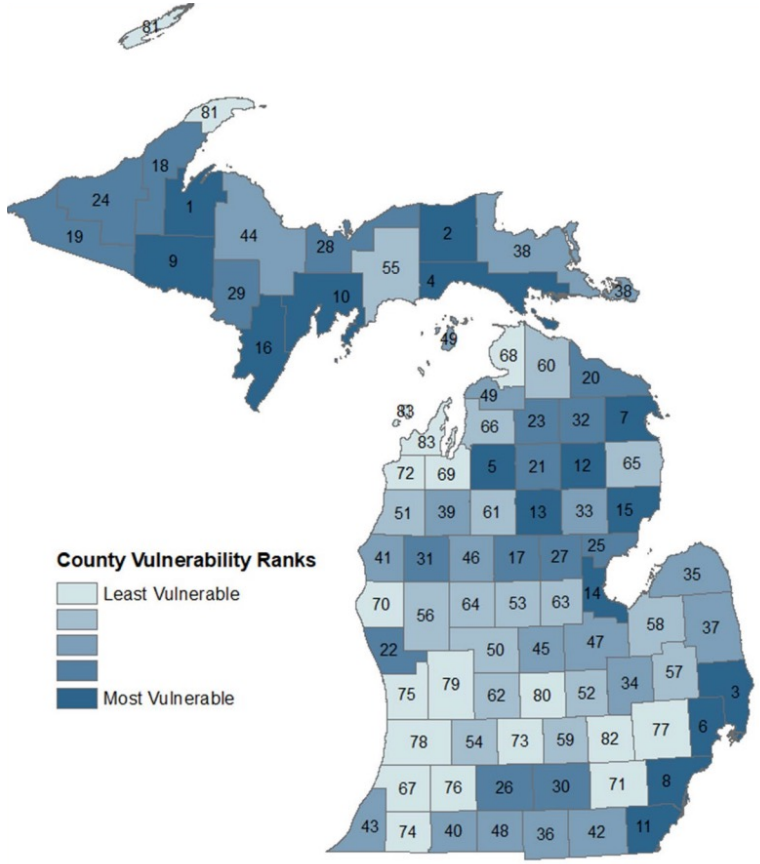
Harm Reduction Needs in Michigan



CDC Evaluation

The CDC has identified 11 counties in Michigan's northern Lower Peninsula as having an elevated risk of an injection-fueled HIV outbreak.

The Michigan Department of Health and Human Services identified 14 additional vulnerable counties.



MDHHS Evaluation

Naloxone Access

Expanding Access to Naloxone in Michigan

- Naloxone—also known as Narcan®—is a safe medication designed to rapidly reverse the effects of opioid overdoses and prevent fatalities.
- In 2021, Michigan SSPs saved at least 3,000 lives with naloxone.
- Fewer preventable deaths and more lives saved.
- Statewide standing order in place to ensure access.

PA 176 of 2022

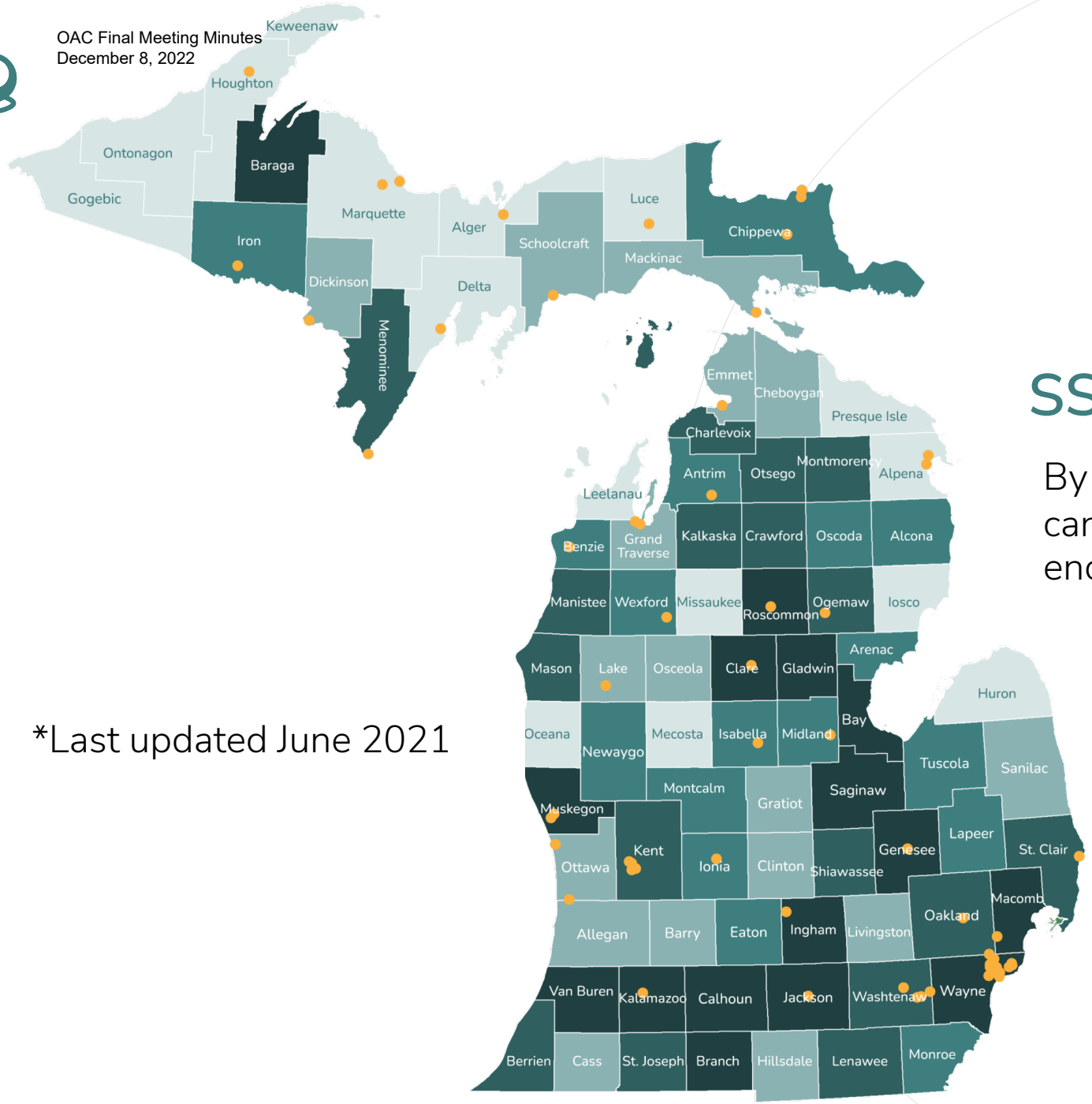
Bipartisan legislation expanded access to naloxone to reduce overdose fatalities

- Expanded access to naloxone, especially at a grassroots level.
- Allows for the distribution of naloxone by community-based organizations under the statewide standing order and protects them from liability.
- Enables the Michigan Department of Health and Human Services chief medical executive to expand access to naloxone.

Syringe Service Program Access

What Services Do SSPs Provide?

- Training in overdose prevention and response with access to Narcan/naloxone
- Hepatitis A and B vaccines
- HIV and Hepatitis C testing and linkage to care
- Connect people to substance use treatment
- Assistance in accessing medical care
- Basic wound care that reduces emergency room visits and hospitalizations from untreated minor injuries
- Access to safer sex education and supplies
- Access to and disposal of sterile syringes and injection equipment.



SSPs in Michigan

By expanding SSPs statewide, counties can provide more resources and encourage safer, healthier communities.

*Last updated June 2021

Public Health Benefits of SSPs

- SSPs reduce HIV prevalence by as much as 50 percent
- SSPs reduce Hepatitis C prevalence by as much as 50 percent
- SSP participants have been shown to be up to five times more likely to access substance use disorder and recovery services, and stay enrolled in those services, than people injecting drugs and not utilizing an SSP

Syringe Service Program Barriers

- Inconsistent laws across the state
- Stigma
- Not in my backyard
- Burnout and grief
- Funding

How are Syringe Service Programs Funded?

There are no dedicated funding streams.

- According to the CDC, The Consolidated Appropriations Act of 2018 permits use of funds from DHHS, under certain circumstances, to support SSPs. This is with the exception that funds may not be used to purchase needles or syringes.
- Majority of funds provided by private foundations/other funding methods due to the Consolidated Appropriations Act of 2018
- MDHHS has offered services, such as staffing
- Foundation partnerships are key to funding SSPs

SSPs will save our state money.

- Hospitalizations due to substance-use related infections resulted in $1.3 Billion in healthcare costs.
- The price of one new syringe, which can prevent transmission of infections, costs only 6 cents.

- They do not only prevent infection between users, but also reduce needlestick injuries among first responders and law enforcement by 66%.

- The estimated lifetime cost savings of someone living with HIV would be $400,000 per person.

- For FY 2018-19 $79.8 million was spent on drugs designed to cure Chronic Hepatitis, $34.8 million was spent on those treated through traditional Medicaid, and $45 million was spent on those treated through the Healthy Michigan Plan.

SSPs decrease drug use and crime.

- Studies show that in areas where SSPs operate, clients are five times more likely to enter a drug treatment program than those who do not seek services at SSPs.
- HIV infections have decreased by 80% since the implementation of the first SSPs in the 1980s.
- About 1 in 4 Michigan SSP clients that have been referred to substance use treatment centers received treatment.
- Studies of cities that have implemented needle exchange programs found that there was not a corresponding increase in crime.

The problem is in our backyards. The solution needs to be, too.

- There are currently 35 programs with 64 sites operating across the state. By expanding SSPs statewide, districts will have more resources for users and will encourage safer and cleaner communities.
- The CDC found that within two similar cities, when compared, the city with an SSP had 86% fewer syringes in public places like parks and sidewalks.

Next Steps

Solutions

1. Support legislation in the 2023 legislative session that clarifies the operation of SSPs in Michigan.

2. Clarify that equipment provided by SSPs, such as needles and syringes, are not considered drug paraphernalia under state or local law.

3. Protect individuals obtaining or returning syringes from arrest, prosecution, charges, or convictions.

4. Create a consistent, reliable funding stream for statewide harm reduction services that meet people where they are.

Questions?

Michigan Overdose Prevention Coalition

Together, we can reduce overdose fatalities in Michigan.

mioverdoseprevention.com

WHAT IS HARM REDUCTION?

Harm reduction is a public health approach that aims to reduce the negative impacts of substance use.

This includes linking people to life-sustaining health services, enabling access to naloxone—medicine that reverses the effects of an opioid overdose—and making public health equipment like sterile syringes available through syringe service programs (SSPs) to prevent the spread of HIV and viral hepatitis.

We participate in different forms of harm reduction almost every day, like wearing helmets and seat belts, applying sunscreen, or carrying first aid kits. At its core, harm reduction keeps us safe and alive.

WHAT IS NALOXONE?

Naloxone—also known as Narcan®—is a safe medication designed to rapidly reverse the effects of opioid overdoses and prevent fatalities.

Learn more about naloxone at **mioverdoseprevention.com**.

In 2020, Michigan syringe service programs saved at least 2,000 lives with naloxone.

KNOW THIS ABOUT NALOXONE

Naloxone availability does not encourage drug use.

Expanded access to naloxone means fewer preventable deaths and more lives saved. Michigan pharmacies have dispensed naloxone under a single statewide prescription by the Michigan Department of Health and Human Services' chief medical executive since 2016. Yet community-based organizations still can't purchase or distribute naloxone under this order, restricting access to those who need it.

Naloxone poses no risk of harm.

Naloxone is a safe medication used by medical professionals and first responders of all types to prevent opioid overdose deaths. It carries no risk of abuse and has no effect on people who do not already have opioids in their systems.[1]

Naloxone enables faster first response when and where it's needed.

Nationwide, more than 80 percent of overdose reversals with naloxone were carried out by other substance users.[2] By equipping and training the people most likely to witness an overdose how to respond, more lives can be saved in seconds.

Nationwide, more than 80 percent of overdose reversals with naloxone were carried out by other substance users.

ACTIVE LEGISLATION

House Bill 5166 of 2021 and Senate Bill 0578 of 2021

Background

- Legislation from 2016 codified a statewide standing order for naloxone issued by the Michigan Department of Health and Human Services' chief medical executive.
- Pharmacies currently dispense naloxone under a standing order and individuals do not need a unique prescription to receive the medication.
- Community-based organizations cannot currently purchase and distribute naloxone under the standing order, restricting access to those who need it.

Solution

Permit community-based organizations to purchase and distribute naloxone under the standing order.

Impact

- Expanded access to naloxone, especially at a grassroots level
- Fewer preventable deaths and more lives saved
- More cost savings attributed to comprehensive care
- No fiscal impact on state budget

WHAT ARE SYRINGE SERVICE PROGRAMS?

A syringe service program (SSP) is a community-based prevention program that connects people who use substances with comprehensive care and resources.

These resources include linkage to substance use treatment; access to and disposal of sterile syringes and injection equipment; and vaccination, testing, and linkage to care and treatment for HIV and hepatitis C (HCV).

Learn more about syringe service programs at **mioverdoseprevention.com**.

Because SSPs facilitate the safe disposal of used syringes, this reduces accidental needlesticks among law enforcement by 66 percent.

KNOW THIS ABOUT SSPS

Our communities and our neighbors need SSPs.

Eleven counties in Michigan's northern Lower Peninsula have been identified as having an elevated risk of an injection-fueled HIV outbreak by the Centers for Disease Control and Prevention (CDC).[3] The Michigan Department of Health and Human Services identified 14 additional vulnerable counties. By expanding SSPs statewide, counties can provide more resources and encourage safer, healthier communities.

SSPs save lives and millions of taxpayer dollars.

Life is priceless. The cost of one new syringe is $1.[4] The average lifetime cost of treating one person with HIV is almost $450,000. Healthcare costs in Michigan associated with skin, soft tissue, and vascular infections from substance use are estimated at more than $400 million per year.[5] SSPs save lives and millions of taxpayer dollars.

SSPs effectively protect individuals and their communities from harm.

SSPs are associated with an estimated 50 percent reduction in HIV and HCV incidence. When combined with medications that treat opioid dependence (also known as medication-assisted treatment), HCV and HIV transmission is reduced by over two-thirds. SSP participants are five times more likely to enter treatment programs than those who do not seek SSP services.[6]

Additionally, studies of cities that have implemented syringe service programs found no corresponding increase in crime. Because SSPs facilitate the safe disposal of used syringes, this reduces accidental needlesticks among law enforcement by 66 percent.

SOURCES

[1] Centers for Disease Control and Prevention. 2018. *Evidence-based Strategies for Preventing Opioid Overdose: What's Working in the United States*. Atlanta: CDC. Accessed June 16, 2021. https://www.cdc.gov/drugoverdose/pdf/pubs/2018-evidence-based-strategies.pdf

[2] CDC, *Evidence-based Strategies.*

[3] North America Syringe Exchange Network. n.d. "SSP Locations." *North America Syringe Exchange Network*. Accessed June 16, 2021. https://nasen.org/map

[4] Laura Pegram. March 2020. "Syringe Services Programs (SSPs): Funding and Sustainability." Presentation. Accessed June 16, 2021. https://www.michigan.gov/documents/mdhhs/MI_Vital_Strategies_Funding_3-26-20_685204_7.pdf

[5] Paul Farnham, Chaitra Gopalappa, Stephanie Sansom, Angela Hutchinson, John Brooks, Paul Weidle, Vincent Marconi, and David Rimland. October 2013. "Updates of Lifetime Costs of Care and Quality-of-life Estimates for HIV-infected Persons in the United States." *Journal of Acquired Immune Deficiency Syndrome* 64 (2): 183–189. Accessed June 16, 2021. 10.1097/QAI.0b013e3182973966

[6] Holly Hagan, James McGough, Hanne Thiede, Sharon Hopkins, Jeffrey Duchin, and E. Russell Alexander. October 2000. "Reduced Injection Frequency and Increased Entry and Retention in Drug Treatment Associated with Needle-exchange Participation in Seattle Drug Injectors." *Journal of Substance Abuse Treatment* 19 (3): 247–252. Accessed June 16, 2021. https://doi.org/10.1016/S0740-5472(00)00104-5

OAC Final Meeting Minutes
December 8, 2022

Michigan Overdose Prevention Coalition
c/o RWC Advocacy
106 W. Allegan St., Ste. 600
Lansing, MI 48933

March 11, 2022

Natasha Bagdasarian, Chief Medical Executive
Michigan Department of Health and Human Services
333 S. Grand Ave., PO Box 30195
Lansing, MI 48909

Dear Dr. Bagdasarian,

Thank you again for your recent efforts to solicit input from Michigan harm reduction practitioners on how to prioritize opioid settlement expenditures. We understand that the terms of this settlement impose strict limitations on the Michigan Department of Health and Human Services's (MDHHS) investment of these funds.[1] However, it is also our belief that an inclusive and transparent approach to investment in reduced overdose and drug poisoning is a necessary first step to preventing unnecessary deaths statewide.

In February 2022, Michigan Overdose Prevention Coalition's (MOPC) steering committee, with support from Public Sector Consultants, reviewed and prioritized best practice recommendations for the use of opioid settlement dollars published in three nationally recognized white papers, including the Harvard University Center for Health and Human Rights, Harvard University Medical School, and Johns Hopkins Bloomberg School of Public Health.[2,3,4] We then crosswalked this shortlist of recommendations with the

[1] State of Michigan. September 18, 2021. *Distribution Settlement Agreement.* Accessed December 10, 2021. https://www.michigan.gov/documents/ag/Final-Distributor-Settlement-Agreement-9.18.21_736721_7.pdf

[2] FXB Center for Health and Human Rights at Harvard University. December 2020. *From the War on Drugs to Harm Reduction: Imagining a Just Overdose Crisis Response.* Boston: FXB Center for Health and Human Rights at Harvard University. Accessed December 10, 2021. https://cdn1.sph.harvard.edu/wp-content/uploads/sites/2464/2020/12/Opioid-Whitepaper-Final-12-2020.pdf#page=9

[3] Michael Barnett et. al. 2020. *Evidence Based Strategies for Abatement of Harms from the Opioid Epidemic.* Boston: Harvard Medical School, Blavatnik Institute for Health Care Policy. Accessed December 10, 2021. https://www.dhhs.nh.gov/dcbcs/bdas/documents/the-opioid-epidemic-v3.pdf

[4] Johns Hopkins Bloomberg School of Public Health. n.d. *Principles for the Use of Funds from the Opioid Litigation.* Baltimore: Johns Hopkins Bloomberg School of Public Health. Accessed December 10, 2021. https://opioidprinciples.jhsph.edu/wp-content/uploads/2021/01/Litigation-Principles.pdf

State of Michigan's core abatement strategies (MDHHS Schedule A) and conducted a statewide survey to solicit harm reduction practitioners' priorities for supporting and expanding upon these strategies.

Seventy people participated in this exercise from an array of backgrounds, including people who use opioids and people who use other drugs. Appendix A has a full breakdown of survey respondents and their recommendations. Together, this statewide network identified funding priorities by weighting and rank-ordering national and state recommendations according to both efficacy and feasibility, with an emphasis on actions that will save lives in both the short and long terms.

Based on this process, and in addition to its earlier request that people with lived experience using drugs and harm reduction practitioners be included in formal decision-making bodies, the MOPC steering committee also respectfully submits the following recommendations:

1. **Fund comprehensive harm reduction services that are inclusive; are culturally appropriate; provide low-barrier, non-coercive services; and are led by and for people who use drugs** (This recommendation corresponds to MDHHS core abatement strategies A, B, C, D, and E. See Appendix A, "Impact and Feasibility of Recommendations," for a more detailed crosswalk of these recommendations).

2. **Prevent future harms by addressing structural and systemic inequities for people who use drugs—specifically removing punitive practices and policies to address substance use as a health issue**. (This recommendation corresponds to MDHHS core abatement strategies F, G, and H. See Appendix A, "Impact and Feasibility of Recommendations," for a more detailed crosswalk of these recommendations).

3. **Update policies and standardize related utilization of medications for opioid use disorder and substance use disorder treatment based on the most up-to-date scientific evidence that complies with Americans with Disabilities Act compliance guidelines and human rights.** (This recommendation corresponds to MDHHS core abatement strategies I, J, K, and L. See Appendix A, "Impact and Feasibility of Recommendations," for a more detailed crosswalk of these recommendations).

Our membership stands ready to assist and support you in this important work. Please do not hesitate to contact us with further questions.

Thank you for your consideration.

Sincerely,

Michigan Overdose Prevention Coalition Steering Committee

Cc

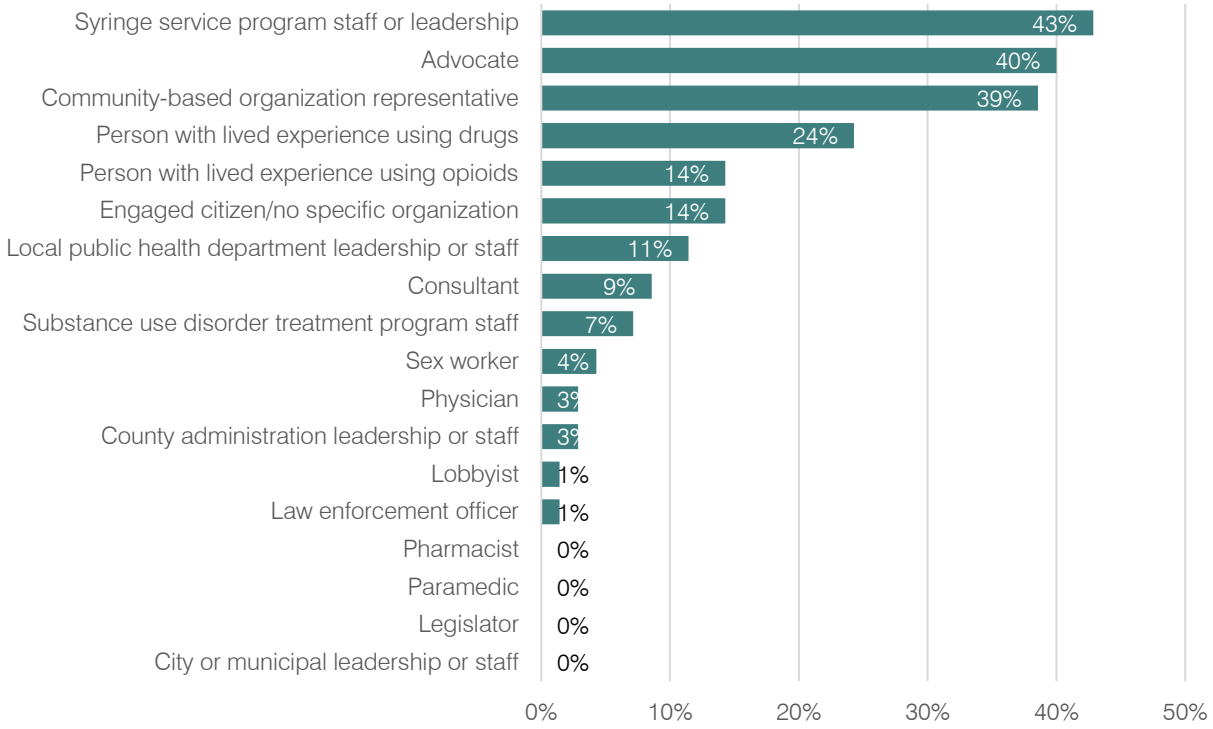
Senator Curt VanderWall
Senator Winnie Brinks
Representative Angela Witwer
Representative Mary Whiteford
Attorney General Dana Nessel

Formed in 2020, MOPC is a statewide network supporting expanded access to naloxone and syringe service programs in Michigan. Our 50 plus members have lived experience related to substance use and overdose—both personal and professional—via the healthcare system, syringe service programs, treatment programs, county associations, law enforcement, familial relationships, and harm reduction organizations. To learn more, visit our website at https://mioverdoseprevention.com/ or contact us any time.

MOPC Opioid Settlement Fund Survey

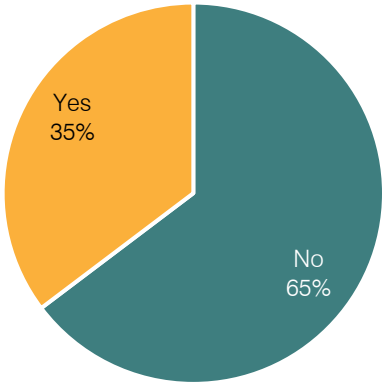
February 24, 2022

Which of the following describe you? Select all that apply.



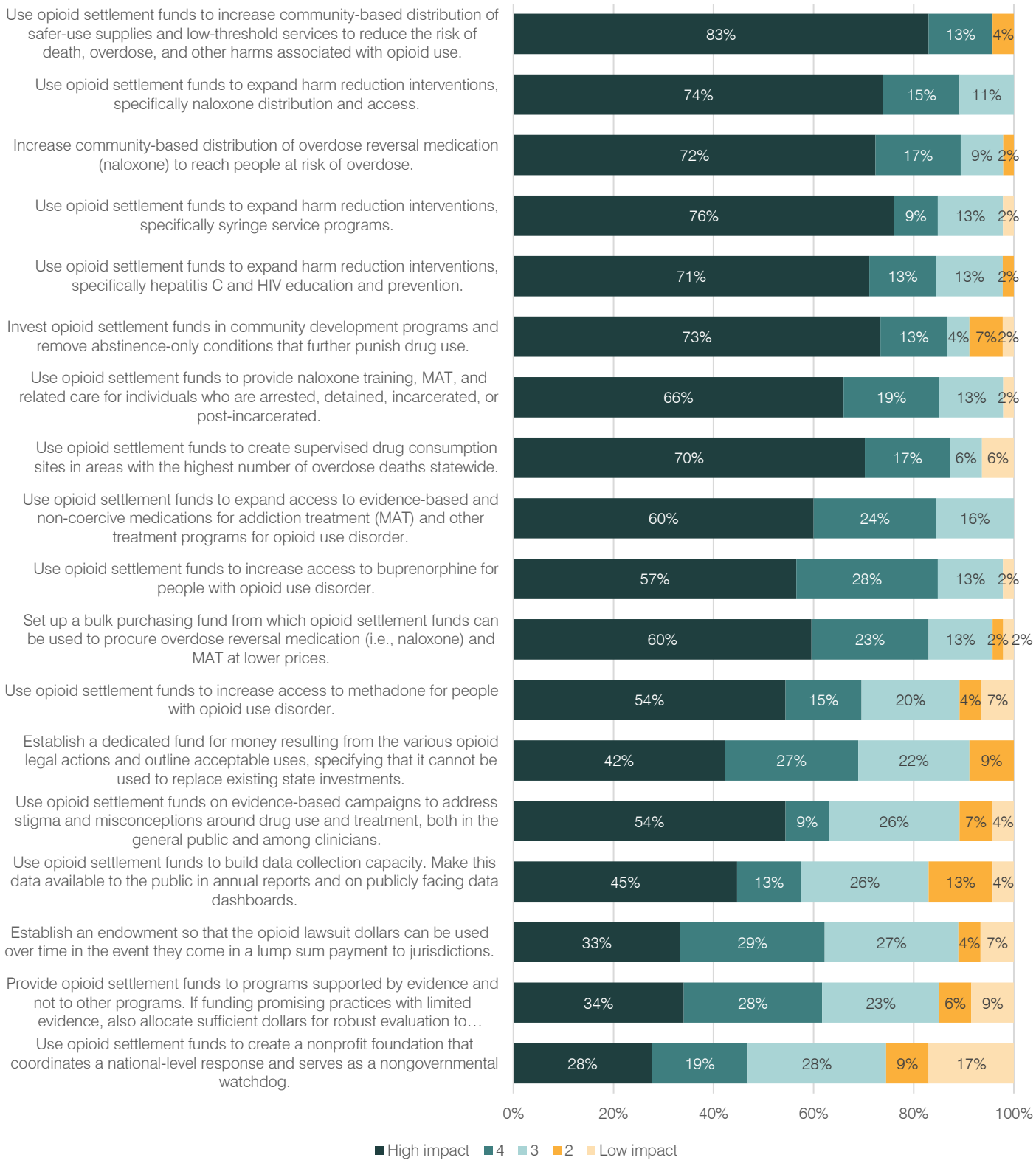
N = 70.
Note: Percentages total more than 100 because respondents could select more than one choice.

Have you participated in any Michigan Opioid Prevention Coalition monthly meetings?



N = 68.

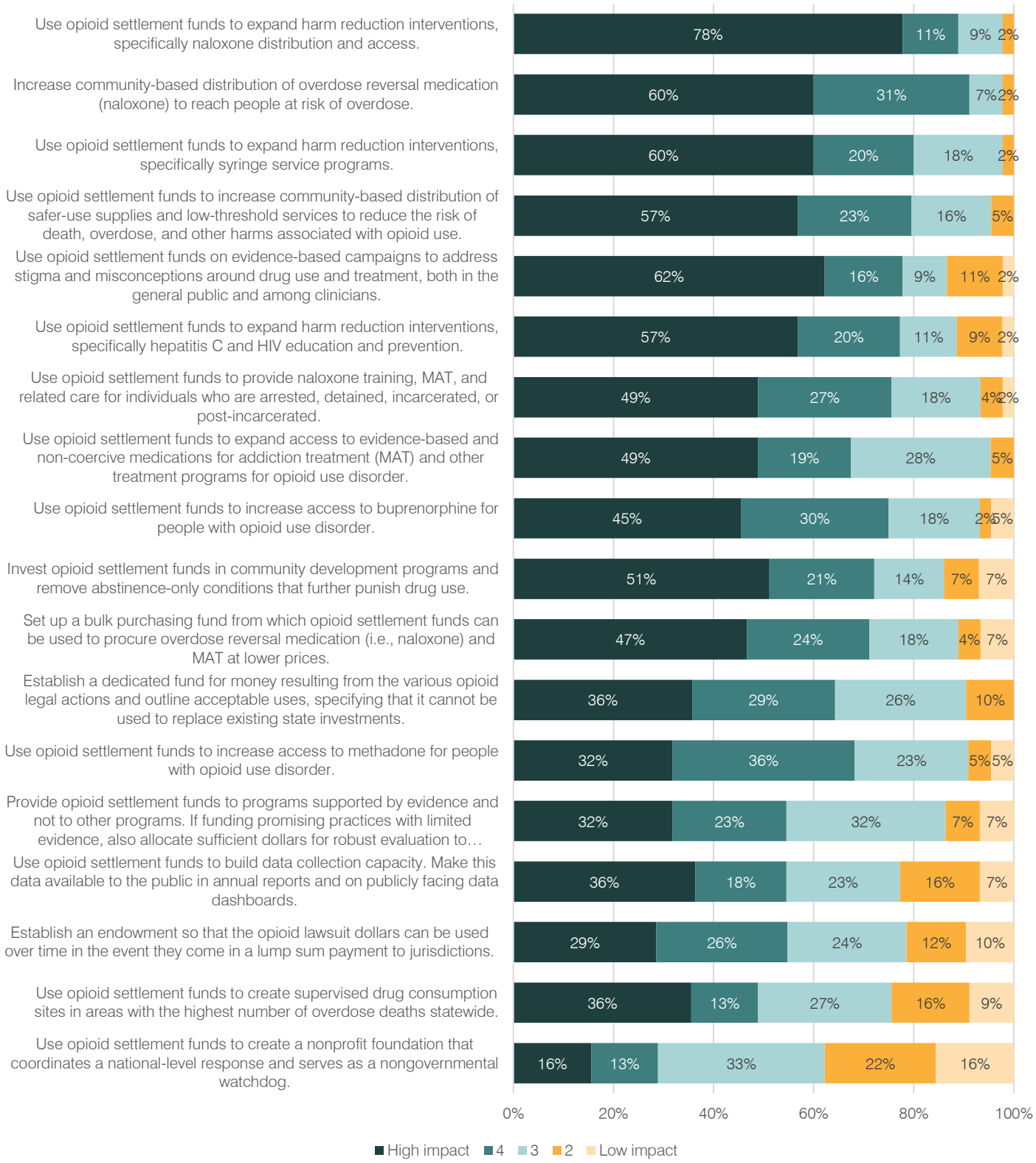
Impact of Recommendations



N varied by response—see table below.

Recommendation	Minimum	Maximum	Mean	Count
Use opioid settlement funds to increase community-based distribution of safer-use supplies and low-threshold services to reduce the risk of death, overdose, and other harms associated with opioid use.	2.00	5.00	4.74	47
Use opioid settlement funds to expand harm reduction interventions, specifically naloxone distribution and access.	3.00	5.00	4.63	46
Increase community-based distribution of overdose reversal medication (naloxone) to reach people at risk of overdose.	2.00	5.00	4.60	47
Use opioid settlement funds to expand harm reduction interventions, specifically syringe service programs.	1.00	5.00	4.57	46
Use opioid settlement funds to expand harm reduction interventions, specifically hepatitis C and HIV education and prevention.	2.00	5.00	4.53	45
Invest opioid settlement funds in community development programs and remove abstinence-only conditions that further punish drug use.	1.00	5.00	4.49	45
Use opioid settlement funds to provide naloxone training, MAT, and related care for individuals who are arrested, detained, incarcerated, or post-incarcerated.	1.00	5.00	4.47	47
Use opioid settlement funds to create supervised drug consumption sites in areas with the highest number of overdose deaths statewide.	1.00	5.00	4.45	47
Use opioid settlement funds to expand access to evidence-based and non-coercive medications for addiction treatment (MAT) and other treatment programs for opioid use disorder.	3.00	5.00	4.44	45
Use opioid settlement funds to increase access to buprenorphine for people with opioid use disorder.	1.00	5.00	4.37	46
Set up a bulk purchasing fund from which opioid settlement funds can be used to procure overdose reversal medication (i.e., naloxone) and MAT at lower prices.	1.00	5.00	4.36	47
Use opioid settlement funds to increase access to methadone for people with opioid use disorder.	1.00	5.00	4.07	46
Establish a dedicated fund for money resulting from the various opioid legal actions and outline acceptable uses, specifying that it cannot be used to replace existing state investments.	2.00	5.00	4.02	45
Use opioid settlement funds on evidence-based campaigns to address stigma and misconceptions around drug use and treatment, both in the general public and among clinicians.	1.00	5.00	4.02	46
Use opioid settlement funds to build data collection capacity. Create new systems to measure variables for which there currently is no assessment. These systems might collect statewide data on harm reduction services that are not tracked in administrative databases because the services are not run by government agencies (e.g., staffing, services provided, and individuals participating in such services as syringe exchange programs, fentanyl strip distribution programs, and naloxone distribution initiatives). Make this data available to the public in annual reports and on publicly facing data dashboards.	1.00	5.00	3.81	47
Establish an endowment so that the opioid lawsuit dollars can be used over time in the event they come in a lump sum payment to jurisdictions. (i.e., don't exchange future payments for an upfront lump sum payment, as happened in many states with dollars from the tobacco settlements.	1.00	5.00	3.78	45
Provide opioid settlement funds to programs supported by evidence and not to other programs (see the Johns Hopkins resources page for examples). If funding promising practices with limited evidence, also allocate sufficient dollars for robust evaluation to confirm their effectiveness.	1.00	5.00	3.72	47
Use opioid settlement funds to create a nonprofit foundation that coordinates a national-level response and serves as a nongovernmental watchdog.	1.00	5.00	3.32	47

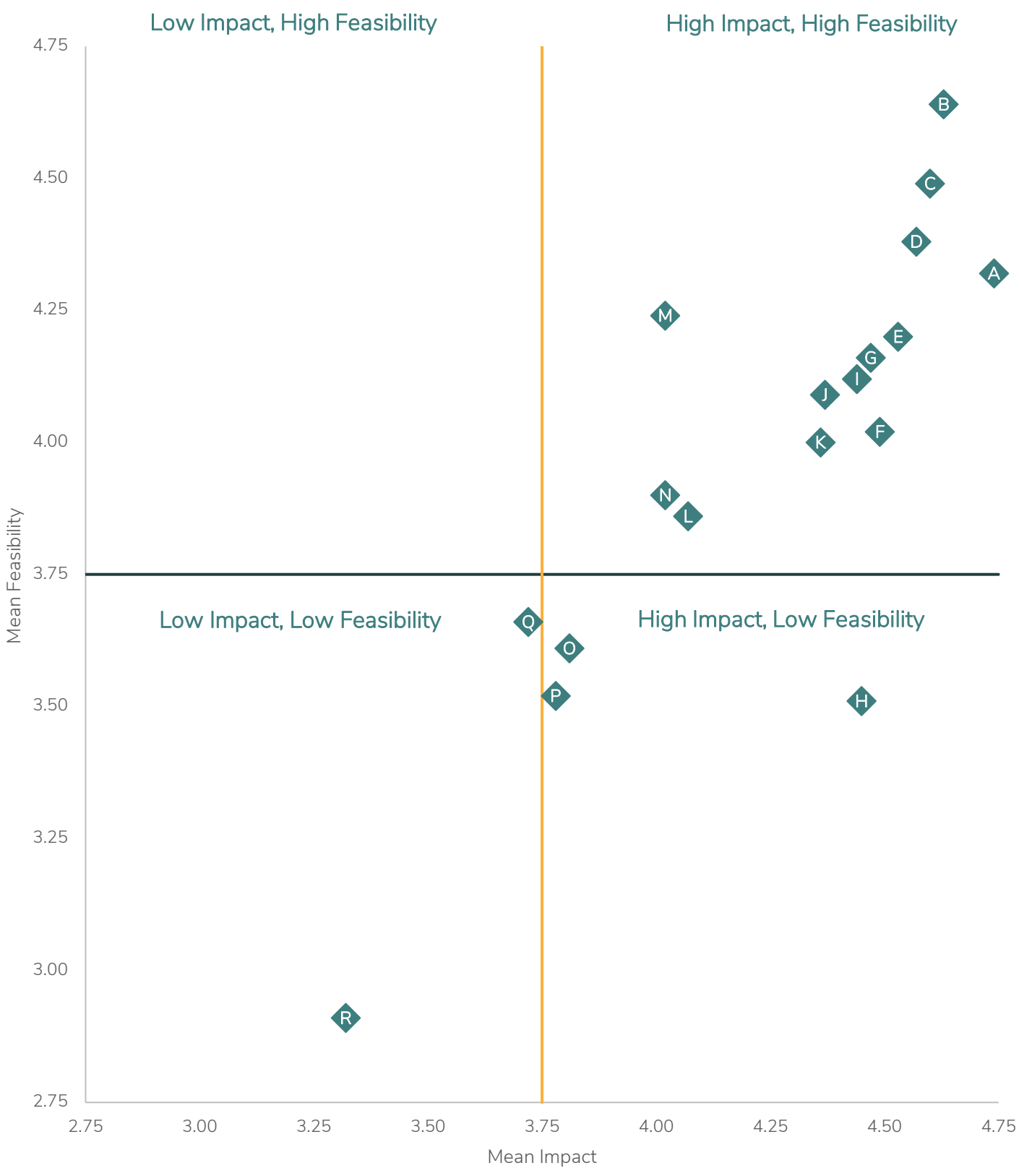
Feasibility of Recommendations



N varied by response—see table below.

Recommendation	Minimum	Maximum	Mean	Count
Use opioid settlement funds to expand harm reduction interventions, specifically naloxone distribution and access.	2.00	5.00	4.64	45
Increase community-based distribution of overdose reversal medication (naloxone) to reach people at risk of overdose.	2.00	5.00	4.49	45
Use opioid settlement funds to expand harm reduction interventions, specifically syringe service programs.	2.00	5.00	4.38	45
Use opioid settlement funds to increase community-based distribution of safer-use supplies and low-threshold services to reduce the risk of death, overdose, and other harms associated with opioid use.	2.00	5.00	4.32	44
Use opioid settlement funds on evidence-based campaigns to address stigma and misconceptions around drug use and treatment, both in the general public and among clinicians.	1.00	5.00	4.24	45
Use opioid settlement funds to expand harm reduction interventions, specifically hepatitis C and HIV education and prevention.	1.00	5.00	4.20	44
Use opioid settlement funds to provide naloxone training, MAT, and related care for individuals who are arrested, detained, incarcerated, or post-incarcerated.	1.00	5.00	4.16	45
Use opioid settlement funds to expand access to evidence-based and non-coercive medications for addiction treatment (MAT) and other treatment programs for opioid use disorder.	2.00	5.00	4.12	43
Use opioid settlement funds to increase access to buprenorphine for people with opioid use disorder.	1.00	5.00	4.09	44
Invest opioid settlement funds in community development programs and remove abstinence-only conditions that further punish drug use.	1.00	5.00	4.02	43
Set up a bulk purchasing fund from which opioid settlement funds can be used to procure overdose reversal medication (i.e., naloxone) and MAT at lower prices.	1.00	5.00	4.00	45
Establish a dedicated fund for money resulting from the various opioid legal actions and outline acceptable uses, specifying that it cannot be used to replace existing state investments.	2.00	5.00	3.90	42
Use opioid settlement funds to increase access to methadone for people with opioid use disorder.	1.00	5.00	3.86	44
Provide opioid settlement funds to programs supported by evidence and not to other programs (see the Johns Hopkins resources page for examples). If funding promising practices with limited evidence, also allocate sufficient dollars for robust evaluation to confirm their effectiveness.	1.00	5.00	3.66	44
Use opioid settlement funds to build data collection capacity. Create new systems to measure variables for which there currently is no assessment. These systems might collect statewide data on harm reduction services that are not tracked in administrative databases because the services are not run by government agencies (e.g., staffing, services provided, and individuals participating in such services as syringe exchange programs, fentanyl strip distribution programs, and naloxone distribution initiatives). Make this data available to the public in annual reports and on publicly facing data dashboards.	1.00	5.00	3.61	44
Establish an endowment so that the opioid lawsuit dollars can be used over time in the event they come in a lump sum payment to jurisdictions. (i.e., don't exchange future payments for an upfront lump sum payment, as happened in many states with dollars from the tobacco settlements.	1.00	5.00	3.52	42
Use opioid settlement funds to create supervised drug consumption sites in areas with the highest number of overdose deaths statewide.	1.00	5.00	3.51	45
Use opioid settlement funds to create a nonprofit foundation that coordinates a national-level response and serves as a nongovernmental watchdog.	1.00	5.00	2.91	45

Impact and Feasibility of Recommendations



Note: See table below for letter key.

	Recommendation	Reference	Schedule A Core Strategy
A	Use opioid settlement funds to increase community-based distribution of safer-use supplies and low-threshold services to reduce the risk of death, overdose, and other harms associated with opioid use.	Harvard pp. 12–13	H.1
B	Use opioid settlement funds to expand harm reduction interventions, specifically naloxone distribution and access.	LAC pp. 29–31, 65	A.1 and A.2
C	Increase community-based distribution of overdose reversal medication (naloxone) to reach people at risk of overdose.	Harvard pp. 11–12	A.1 and A.2
D	Use opioid settlement funds to expand harm reduction interventions, specifically syringe service programs.	LAC pp. 29–31	H.1
E	Use opioid settlement funds to expand harm reduction interventions, specifically hepatitis C and HIV education and prevention.	LAC p. 34	H.1
F	Invest opioid settlement funds in community development programs and remove abstinence-only conditions that further punish drug use.	Harvard pp. 22–23	B2 (?)
G	Use opioid settlement funds to provide naloxone training, MAT, and related care for individuals who are arrested, detained, incarcerated, or post-incarcerated.	Harvard p. 15	A.1, B.1, B.2, B.3, E.1, F.1, F.2, and G.5.
H	Use opioid settlement funds to create supervised drug consumption sites in areas with the highest number of overdose deaths statewide.	LAC p. 34	
I	Use opioid settlement funds to expand access to evidence-based and non-coercive medications for addiction treatment (MAT) and other treatment programs for opioid use disorder.	Harvard pp. 14	A.1, B.1,, B.2, B.3, C.2, E.1, F.1, F.2, and G.5.
J	Use opioid settlement funds to increase access to buprenorphine for people with opioid use disorder.	LAC pp. 8–13	A.1, B.1,, B.2, B.3, C.2, E.1, F.1, F.2, and G.5.
K	Set up a bulk purchasing fund from which opioid settlement funds can be used to procure overdose reversal medication (i.e., naloxone) and MAT at lower prices.	Harvard pp. 9–11	A.1, B.1, B.2, B.3, C.2, E.1, F.1, F.2, and G.5.
L	Use opioid settlement funds to increase access to methadone for people with opioid use disorder.	LAC pp. 8–13	A.1, B.1, B.2, B.3, C.2, E.1, F.1, F.2, and G.5.
M	Use opioid settlement funds on evidence-based campaigns to address stigma and misconceptions around drug use and treatment, both in the general public and among clinicians.	Harvard pp. 18–19 Johns Hopkins p. 7	G.1.
N	Establish a dedicated fund for money resulting from the various opioid legal actions and outline acceptable uses, specifying that it cannot be used to replace existing state investments.	Johns Hopkins p. 4	
O	Use opioid settlement funds to build data collection capacity. Create new systems to measure variables for which there currently is no assessment. These systems might collect statewide data on harm reduction services that are not tracked in administrative databases because the services are not run by government agencies (e.g., staffing, services provided, and individuals participating in such services as syringe exchange programs, fentanyl strip distribution programs, and naloxone distribution initiatives). Make this data available to the public in annual reports and on publicly facing data dashboards.	LAC p. 62 Johns Hopkins p. 5	Core Strategy I
P	Establish an endowment so that the opioid lawsuit dollars can be used over time in the event they come in a lump sum payment to jurisdictions. (i.e., don't exchange future payments for an upfront lump sum payment, as happened in many states with dollars from the tobacco settlements.	Johns Hopkins p. 4	
Q	Provide opioid settlement funds to programs supported by evidence and not to other programs (see the Johns Hopkins resources page for examples). If funding promising practices with limited evidence, also allocate sufficient dollars for robust evaluation to confirm their effectiveness.	Johns Hopkins p. 5	Core Strategy I
R	Use opioid settlement funds to create a nonprofit foundation that coordinates a national-level response and serves as a nongovernmental watchdog.	Harvard pp. 23–25	

Michigan Harm Reduction Legislation Summaries

Syringe Service Program Legislation

Draft

What is a syringe service program?

A syringe service program (SSP) is a community-based prevention program that can prevent the spread of HIV and hepatitis C through vaccination, testing, and links to care and treatment; reduce healthcare costs; connect people to substance use treatment; and provide access to and disposal of sterile syringes and injection equipment.

Background

According to the Centers for Disease Control and Prevention, there is a high risk of an HIV outbreak among people who inject drugs in **11 counties** in Michigan's northern Lower Peninsula.

Healthcare costs associated with skin, soft tissue, and vascular infections as well as substance use are estimated at more than **$400 million per year** in Michigan.

Under state law, syringes and other equipment provided by health programs are not classified as drug paraphernalia. However, many localities criminalize activities related to drug paraphernalia without exemptions for public health services.

SSP staff, participants, and persons attempting to discard used needles safely can face criminal charges for activities that protect public health.

Safely discarding used needles at SSPs is proven to reduce needle-stick injury to law enforcement by 66 percent.

SSPs reduce HIV and hepatitis C transmission rates.

Impact

- Fewer cases of HIV and hepatitis C.
- More cost savings attributed to comprehensive care.
- More SSPs to provide life-saving resources.
- More connections to comprehensive care, supports, and services, including substance use treatment.
- Fewer needle-stick injuries.
- No fiscal impact on state budget.

Solution

- Support and pass legislation in the 2023 legislative session authorizing the establishment and operation of SSPs in Michigan.
- Clarify that equipment provided by SSPs, such as needles and syringes, are not considered drug paraphernalia under state or local law.
- Protect individuals obtaining or returning syringes from arrest, prosecution, charges, or convictions.
- Reduce the transmission of viral hepatitis, HIV, and other infections.

New users of SSPs are five times more likely to enter drug treatment and three times more likely to stop using drugs than those who don't use the programs.

Naloxone Legislation

Passed in July 2022

What is naloxone?

Naloxone is a safe medication designed to rapidly reverse opioid overdoses.

Background

- Enables the Michigan Department of Health and Human Services chief medical executive to expand access to naloxone for individuals experiencing an opioid overdose.
- Permits community-based organizations to purchase and distribute naloxone under a standing order.

Impact

- Expanded access to naloxone, especially at a grassroots level.
- Fewer preventable deaths and more lives saved.
- More cost savings attributed to comprehensive care.
- No fiscal impact on state budget.

Legislation expands access to naloxone to reduce overdose fatalities.

Michigan Overdose Prevention Coalition

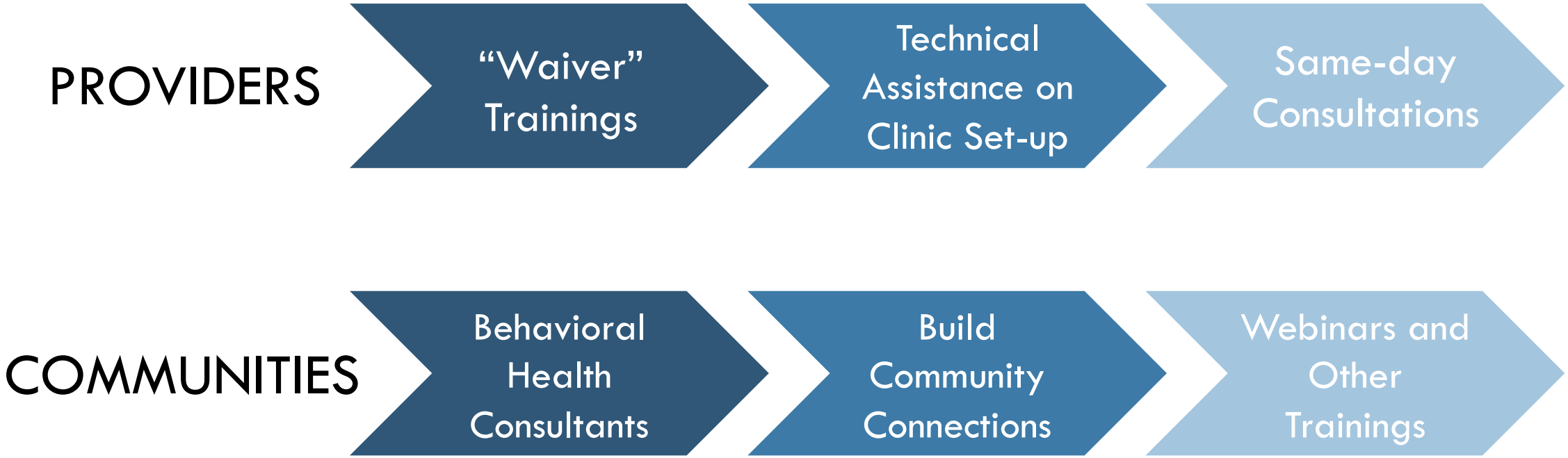
mioverdoseprevention.com

MICHIGAN OPIOID COLLABORATIVE

Project Support and Overview

WHAT WE DO

WHAT WE DO


PROVIDERS
"Waiver" Trainings
Technical Assistance on Clinic Set-up
Same-day Consultations
COMMUNITIES
Behavioral Health Consultants
Build Community Connections
Webinars and Other Trainings

TEAM ROLES

- **Addiction Physicians**
  - X-waiver trainings and webinars on different MOUD/SUD topics
  - Same-day consultations & general support

- **Peer Recovery Coordinator**
  - Provider/Community outreach
  - Address stigma around MAT/SUDs

BHC ROLE

- Coordinate consults
- Community referrals
- Participate in local coalitions
- Presentations and “round tables”
- Outreach to providers
- Outreach to pharmacies
- Outreach to public safety and criminal justice

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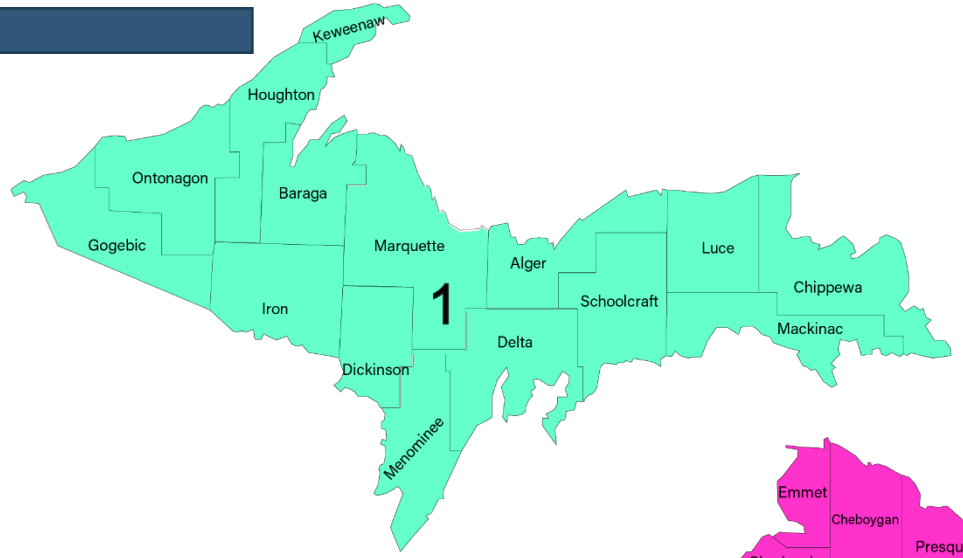
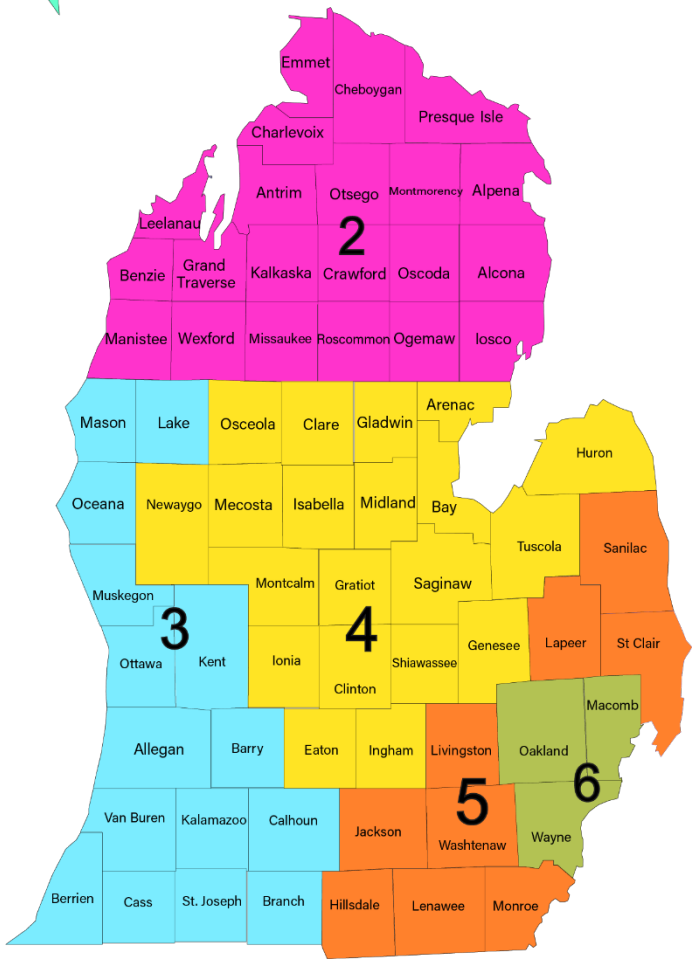




TARGETED OUTREACH

- GREAT MOMS – model of care
- HIV prevention and treatment
- Low barrier treatment
- Hepatitis C treatment
- Chronic pain and OUD support
- Treatment Gap Counties
- Overdose Priority
- Underserved areas/populations
- Pharmacy collaborations

MOC PROVIDER SUPPORT – EASY AS 1, 2, 3

Michigan Opioid Collaborative

MEDICATIONS FOR OUD

GOALS OF USING MEDICATIONS FOR OPIOID USE DISORDER (MOUD)

Reduce cravings and withdrawal symptoms

Block the euphoric effect of other opioids

Interrupt the cycle of seeking, using, and recovering from drug use

Improve rates of engagement in treatment

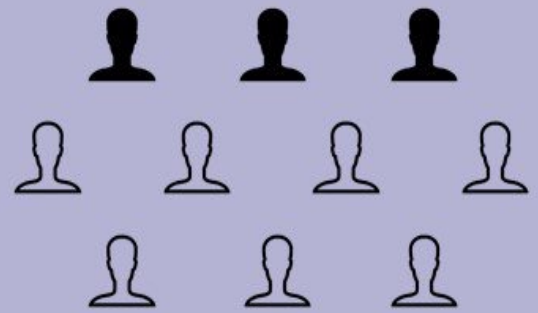
Restore the normal reward pathway

Methadone And Buprenorphine Are Associated With Reduced Mortality After Nonfatal Opioid Overdose

RETROSPECTIVE COHORT, MASSACHUSETTS PUBLIC HEALTH DATASET, 2012-2014

17,568 opioid overdose survivors
with ambulance or hospital encounter

Only 3 in 10 receive MOUD*
over 12 months of follow-up



*Medication for Opioid Use Disorder

Mortality at 12 months:
4.7 deaths / 100 person-yrs

Association of MOUD* with mortality:

Methadone	↓ 53%
Buprenorphine	↓ 37%
Naltrexone**	↔

** *limited by small sample*

Larochelle et al. *Annals of Internal Medicine*. 2018.

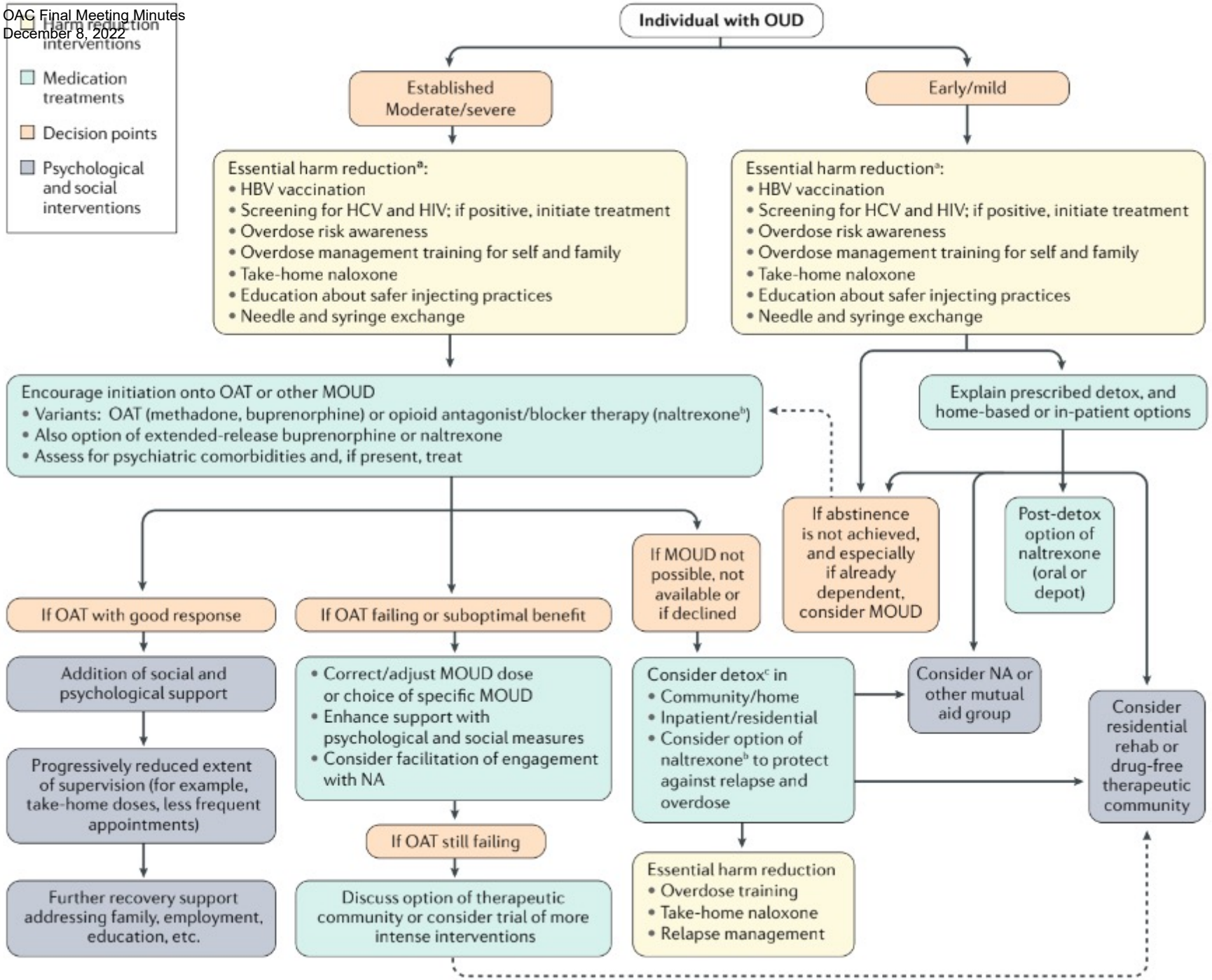
Boston Medical Center

Grayken Center for Addiction
Boston Medical Center

CARE
Clinical Addiction Research and Education

Boston University School of Medicine

From:
"Opioid Use Disorders"
Strang et al., 2020
Nature Reviews



Michigan Opioid Collaborative

IMPACT

PATIENT/CLINIC CASE

MOC EXPANSION MAP

Year 1

Year 2

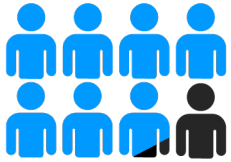
Year 3

Michigan Opioid Collaborative

MICHIGAN OPIOID COLLABORATIVE

IMPACT IN 2021

390
people trained



at the 13 MOUD Trainings MOC hosted. 336 of the 390 attendees were prescribers.

1,427
consults

delivered to providers and clinics across Michigan.

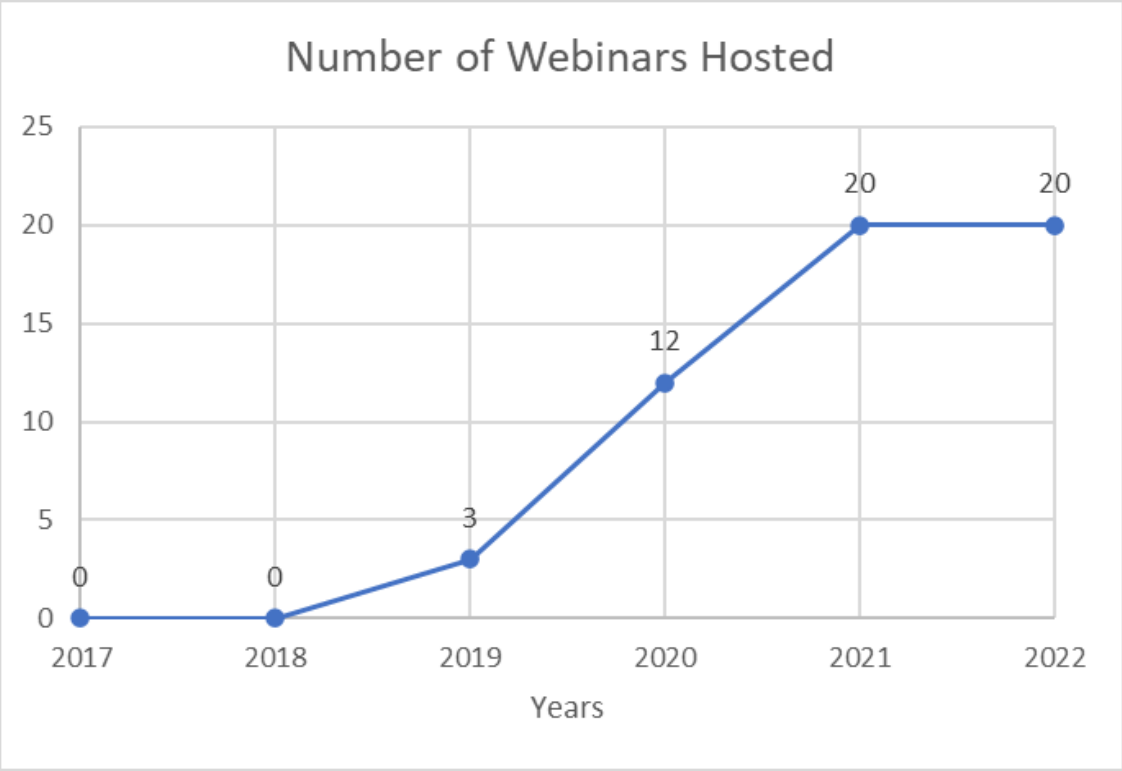
159
patient consultations

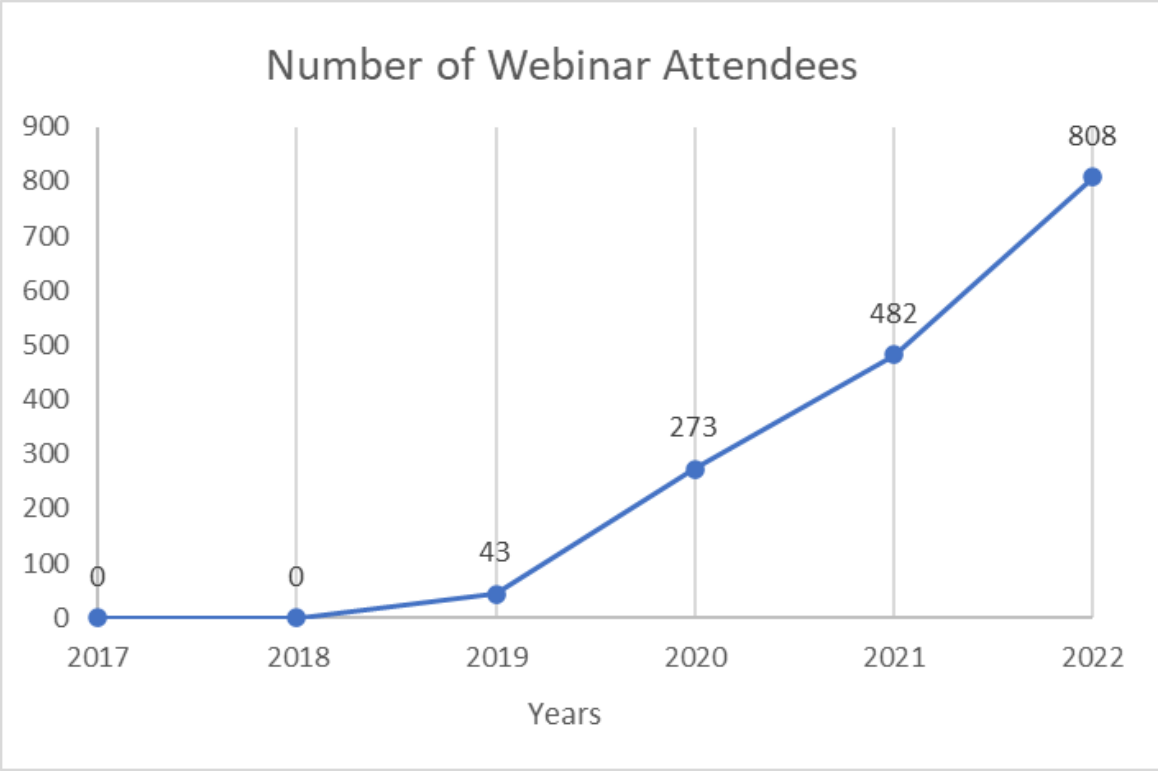
delivered to Michigan prescribers from MOC's team of physicians.

34
Hepatitis C patient consultations

provided by MOC's Hepatitis C Virus specialist.

WEBINARS


Number of Webinars Hosted
25
20
15
10
5
0
0
0
3
12
20
20
2017
2018
2019
2020
2021
2022
Years


Number of Webinar Attendees
900
800
700
600
500
400
300
200
100
0
0
0
43
273
482
808
2017
2018
2019
2020
2021
2022
Years

ADDITIONAL IMPACTS

From None to Five

Getting access to office-based OUD care remains a barrier for patients in Michigan's Upper Peninsula. The region needs more providers delivering this critical care.

Our Upper Peninsula Behavioral Health Consultant identified underserved areas. We first started regularly assisting the Newberry clinic in early 2020. At the time, the clinic had no patients taking buprenorphine.

After 31 consultations and meetings from the MOC team, this clinic now has 5 waivered providers, 12 patients on buprenorphine, ***and is the only clinic prescribing in the entire County.***

MICHIGAN OPIOID COLLABORATIVE

IMPACT IN 2021

I believe MOC is a great resource not only for physicians seeking support to start providing MAT for OUD but of course for the huge unmet need of OUD patients in Michigan. I believe that MOC is also a great example for other locations in Michigan and for other states and cities to start.

Working in a rural community, having the opportunity to learn from and interact with practitioners with a broad range of knowledge and experience has been invaluable. I have gained valuable knowledge in the areas of opioid agonist therapy, Hepatitis C management as well as treating patients with other intercurrent mental health and medical problems. I am very grateful for the continued support of the Michigan Opioid Collaborative.

OUR NEXT STEPS

OUR TEAM

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Michigan Medicine
Co-PI

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Michigan Medicine
Co-PI

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Michigan Medicine

Chris Frank, MD
Michigan Medicine

Robert McMorrow, DO
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Ponni Perumalswami, MD
Michigan Medicine

Cara Poland, MD
Michigan State University

Sheba Sethi, MD
Michigan Medicine

Avani Sheth, MD, MPH
Wayne County Health Department

THE MICHIGAN OPIOID COLLABORATIVE IS FUNDED BY:

Blue Cross® Blue Shield® of Michigan

Michigan Department of Health and Human Services

M | ANESTHESIOLOGY

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

M | MICHIGAN MEDICINE UNIVERSITY OF MICHIGAN

MOC Michigan Opioid Collaborative

FUTURE OF FUNDING

1. Current funding ends Sept (SOR) and December (BCBS) 2023
2. Need for multi-year funding, with annual benchmarks, to retain experts

THANK YOU & QUESTIONS?

CONTACT THE MOC:
MOC-ADMINISTRATION@UMICH.EDU

PERINATAL OPIOID USE: CONSEQUENCES AND OPPORTUNITIES

Presentation to Opioid Advisory Commission
December 8, 2022

Claire Margerison, MPH PhD

CONTACT INFORMATION

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Associate Professor

Department of Epidemiology & Biostatistics

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OUTLINE

- Perinatal opioid burden
- Trends and Inequities
- Pregnancy as a window of opportunity
- Opportunities and barriers

MEASURES OF PERINATAL OPIOID BURDEN

Pregnancy-associated death (PAD)

- "A death during or within one year of pregnancy, **regardless of the cause.** " (Review to Action)[1]
- Includes deaths due to opioid overdose

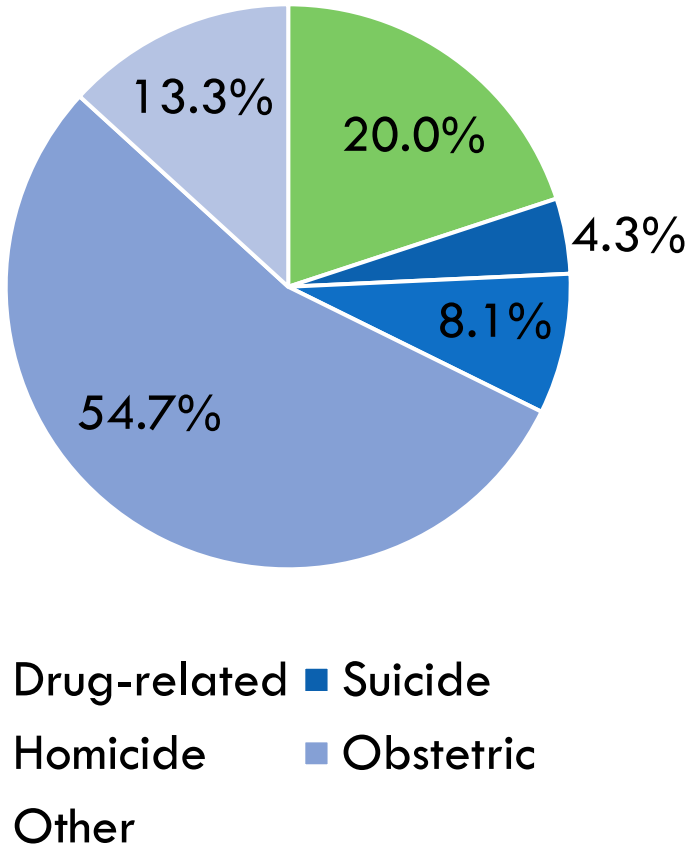
Neonatal Abstinence Syndrome (NAS)

- "Group of conditions caused when a baby withdraws from certain drugs they are exposed to in the womb before birth" (March of Dimes)[2]

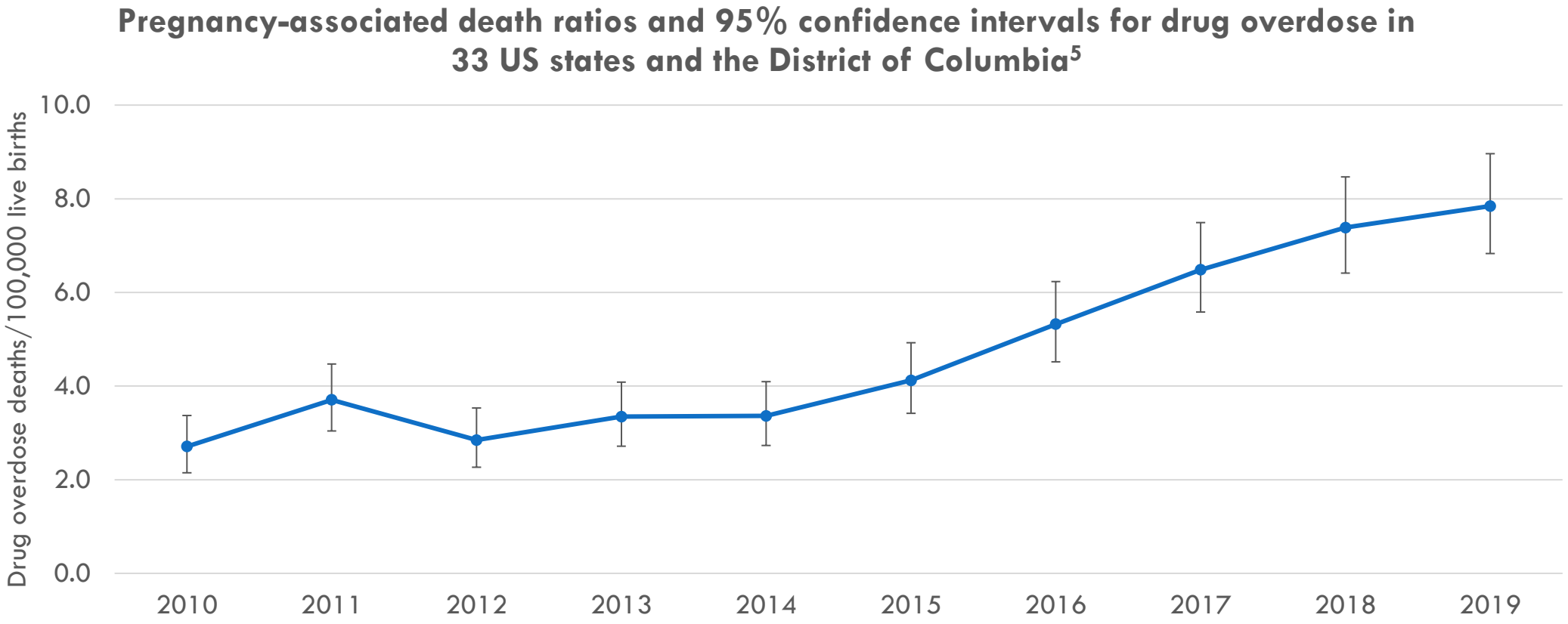
DRUG OVERDOSE IS THE LEADING SINGLE CAUSE OF PREGNANCY-ASSOCIATED DEATH

- In the US in 2020, drug overdose made up almost 20% of all pregnancy-associated deaths (Margerison et al., under review)[3]
- Between 2008-2018, drug overdose deaths made up 25% of all pregnancy-associated deaths in Michigan[4]

Pregnancy-associated death by cause, United States, 2020[3]



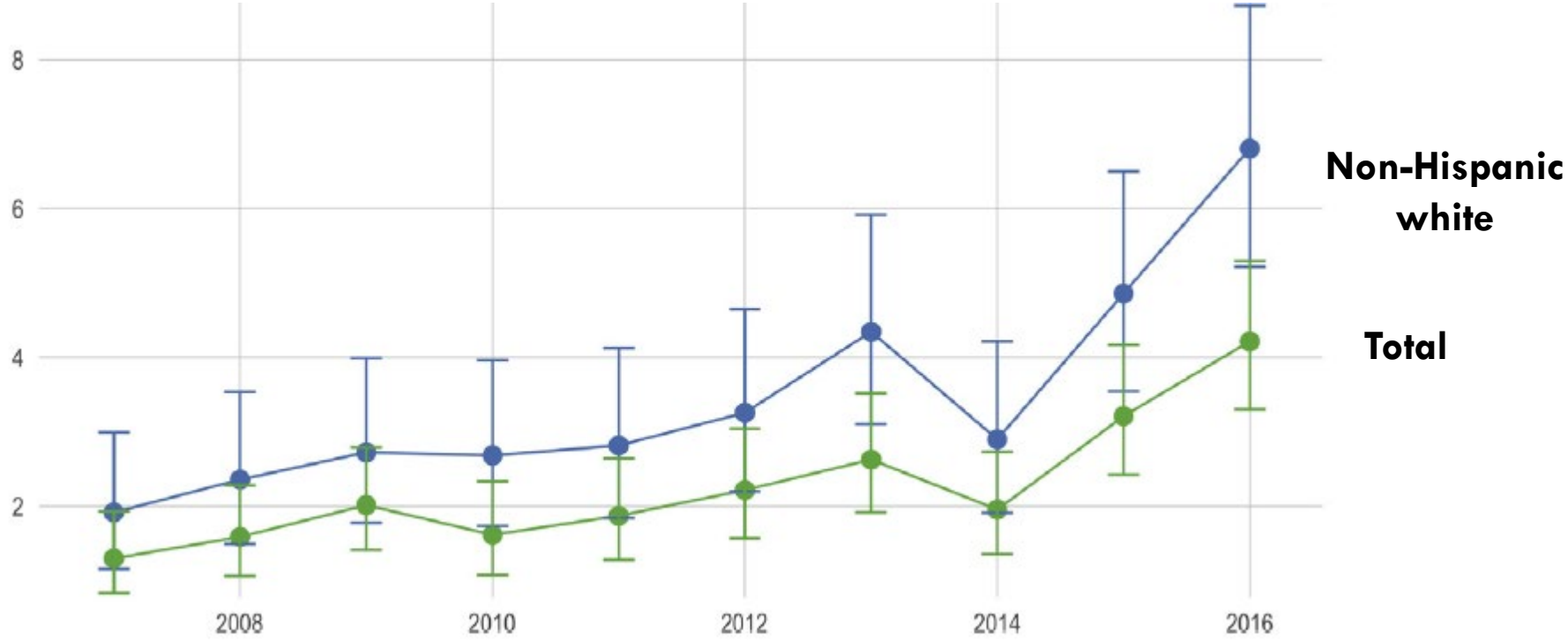
PREGNANCY-ASSOCIATED DRUG OVERDOSE DEATHS ARE INCREASING



[5]Margerison CE et al. Pregnancy-Associated Deaths Due to Drugs, Suicide, and Homicide in the United States, 2010-2019. Obstet Gynecol. 2022 Feb 1;139(2):172-180.

PREGNANCY-ASSOCIATED OPIOID OVERDOSE DEATHS ARE INCREASING

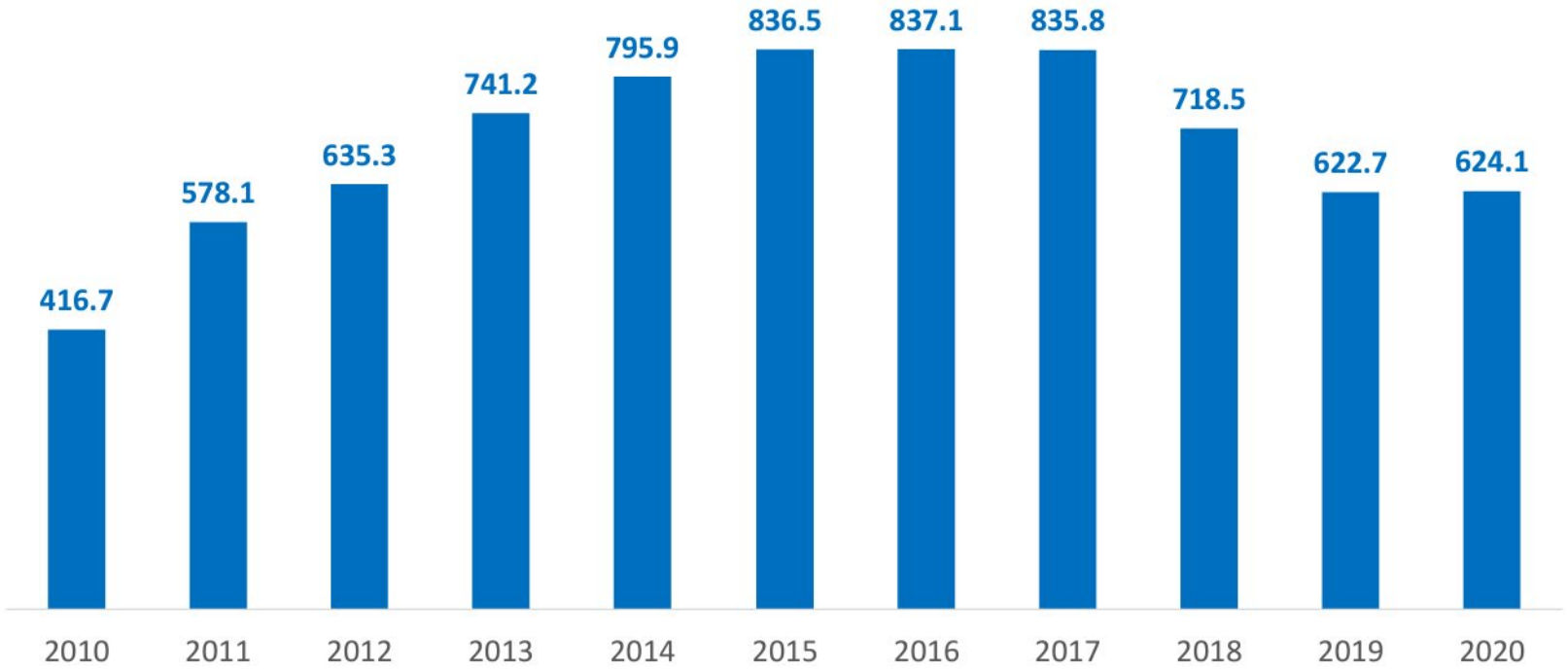
US Pregnancy-associated deaths due to opioids per 100,000 live births[6]



[6]Gemmill A, Kiang MV, Alexander MJ. Trends in pregnancy-associated mortality involving opioids in the United States, 2007-2016. Am J Obstet Gynecol. 2019 Jan;220(1):115-116.

NEONATAL ABSTINENCE SYNDROME PEAKED 2016, DECREASING SLOWLY

Michigan NAS Incidence Rate per 100,000 Live Births[7]

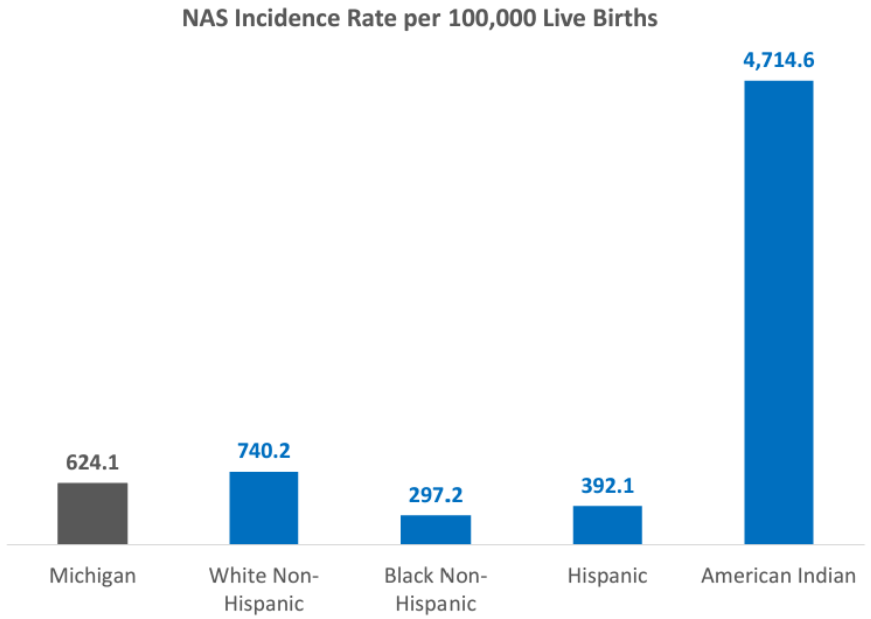


Note: 2010-2015: 779.5 (drug withdrawal syndrome in newborn) and 2016-current: P96.1 (neonatal withdrawal symptoms from maternal use of drugs of addiction)
Data source: Michigan Resident Live Birth Files Linked with Michigan Hospital Discharge Data, Division for Vital Records and Health Statistics, MDHHS

RACIAL AND ETHNIC INEQUITIES IN NEONATAL ABSTINENCE SYNDROME

Neonatal Abstinence Syndrome by Maternal Race and Ethnicity, Michigan, 2020[6]

Race/Ethnicity	Cases	Births	Rate
Michigan (All)	650	104,149	624.1
White Non-Hispanic	519	70,113	740.2
Black Non-Hispanic	57	19,180	297.2
Hispanic	28	7,141	392.1
American Indian	19	403	4,714.6

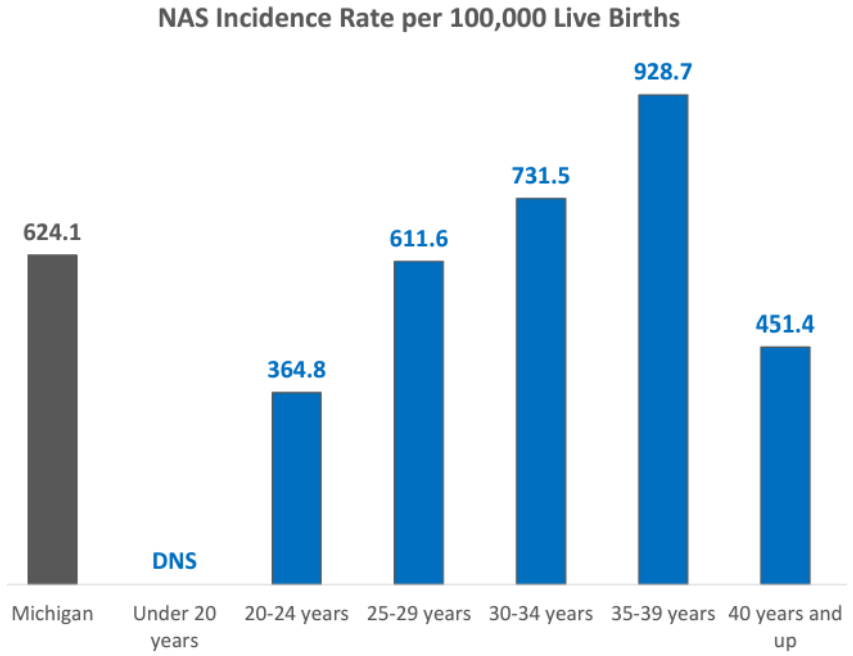


Note: 2010-2015: 779.5 (drug withdrawal syndrome in newborn) and 2016-current: P96.1 (neonatal withdrawal symptoms from maternal use of drugs of addiction)
Data source: Michigan Resident Live Birth Files Linked with Michigan Hospital Discharge Data, Division for Vital Records and Health Statistics, MDHHS

AGE-RELATED INEQUITIES IN NEONATAL ABSTINENCE SYNDROME

Neonatal Abstinence Syndrome by Maternal Age, Michigan, 2020[6]

Age Group (years)	Cases	Births	Rate
Michigan (All)	650	104,149	624.1
<20	DNS	4,233	DNS
20-24	70	19,190	364.8
25-29	197	32,211	611.6
30-34	232	31,176	731.5
35-39	129	13,891	928.7
40+	13	2.89	451.5

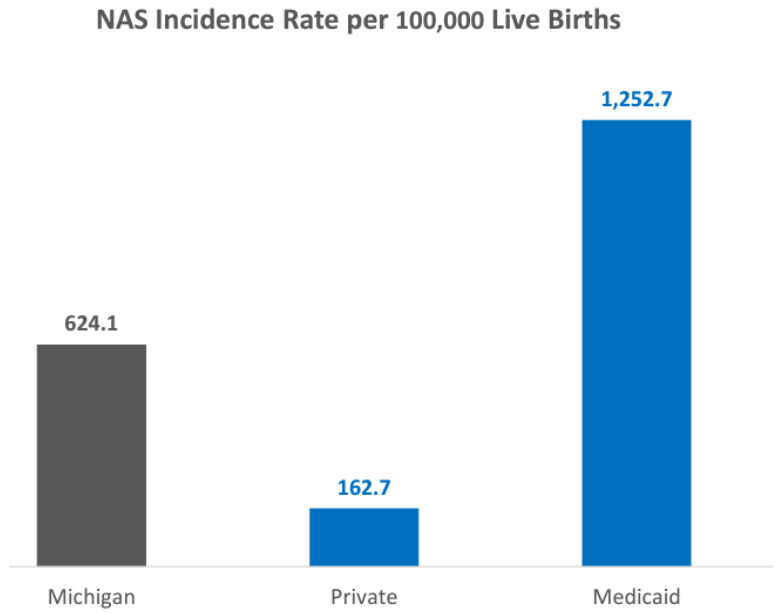


Note: 2010-2015: 779.5 (drug withdrawal syndrome in newborn) and 2016-current: P96.1 (neonatal withdrawal symptoms from maternal use of drugs of addiction)
Data source: Michigan Resident Live Birth Files Linked with Michigan Hospital Discharge Data, Division for Vital Records and Health Statistics, MDHHS

INCOME-RELATED INEQUITIES IN NEONATAL ABSTINENCE SYNDROME

Neonatal Abstinence Syndrome by Payment Source, Michigan, 2020[6]

Payment Source	Cases	Births	Rate
Michigan (All)	650	104,149	624.1
Private	96	59,015	162.7
Medicaid	517	41,21	1,252.7

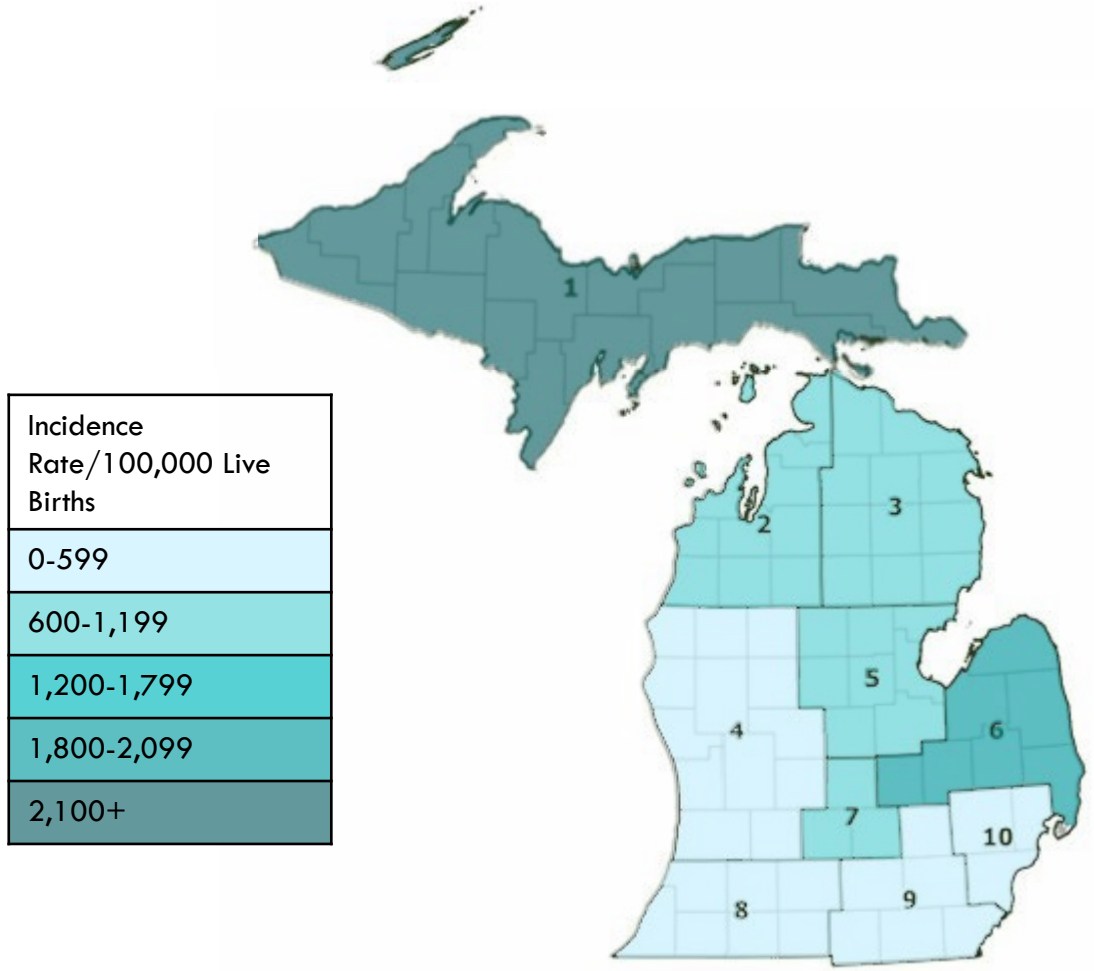


Note: 2010-2015: 779.5 (drug withdrawal syndrome in newborn) and 2016-current: P96.1 (neonatal withdrawal symptoms from maternal use of drugs of addiction)
Data source: Michigan Resident Live Birth Files Linked with Michigan Hospital Discharge Data, Division for Vital Records and Health Statistics, MDHHS

GEOGRAPHIC INEQUITIES IN NEONATAL ABSTINENCE SYNDROME

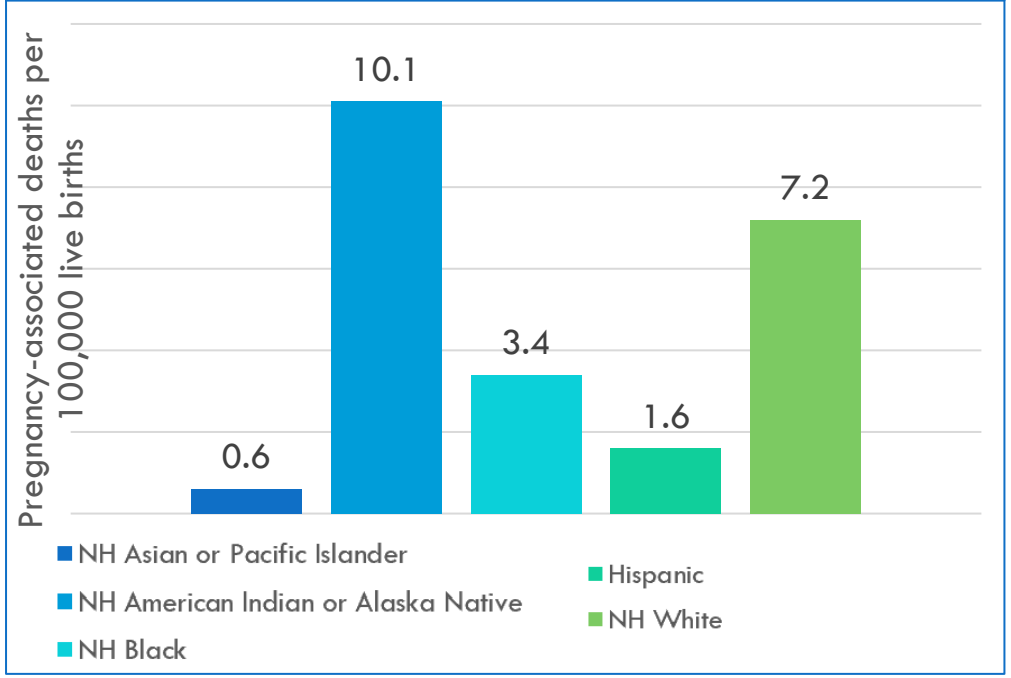
Neonatal Abstinence Syndrome by Prosperity Region, Michigan, 2020[7]

Region	Cases	Births	Rate
Michigan (All)	650	104,149	624.1
1	67	2,489	2,691.8
2	23	2,680	858.2
3	17	1,616	1,053.9
4	53	18,104	292.8
5	59	5,333	1,106.3
6	102	8,433	1,209.5
7	32	4,653	687.7
8	33	8,298	397.7
9	42	9,660	434.8
10	222	42,878	517.7

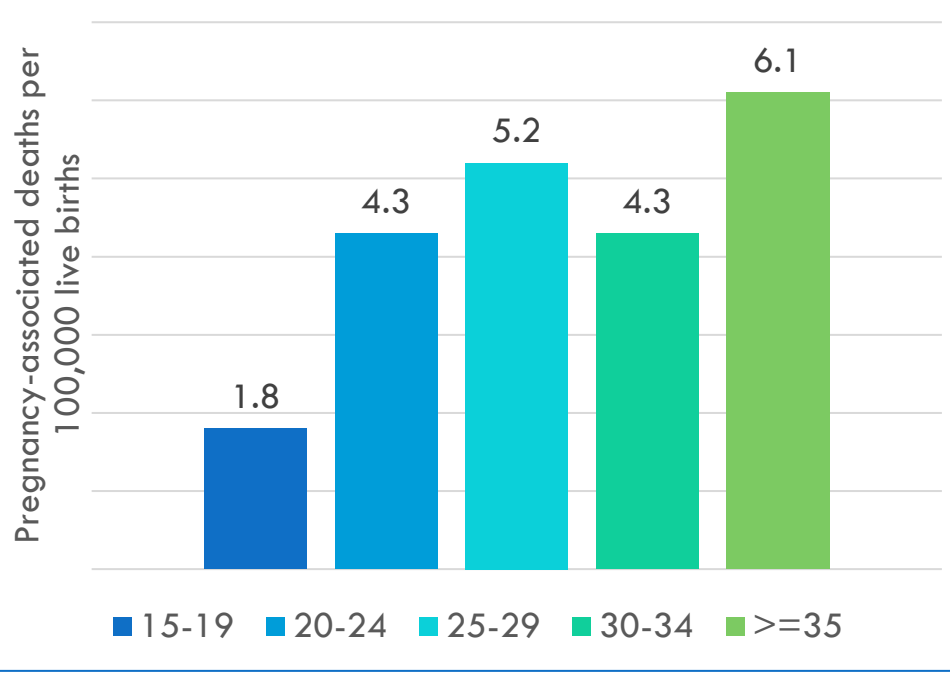


INEQUITIES IN PREGNANCY-ASSOCIATED DRUG OVERDOSE DEATH[5]

Race and Ethnicity



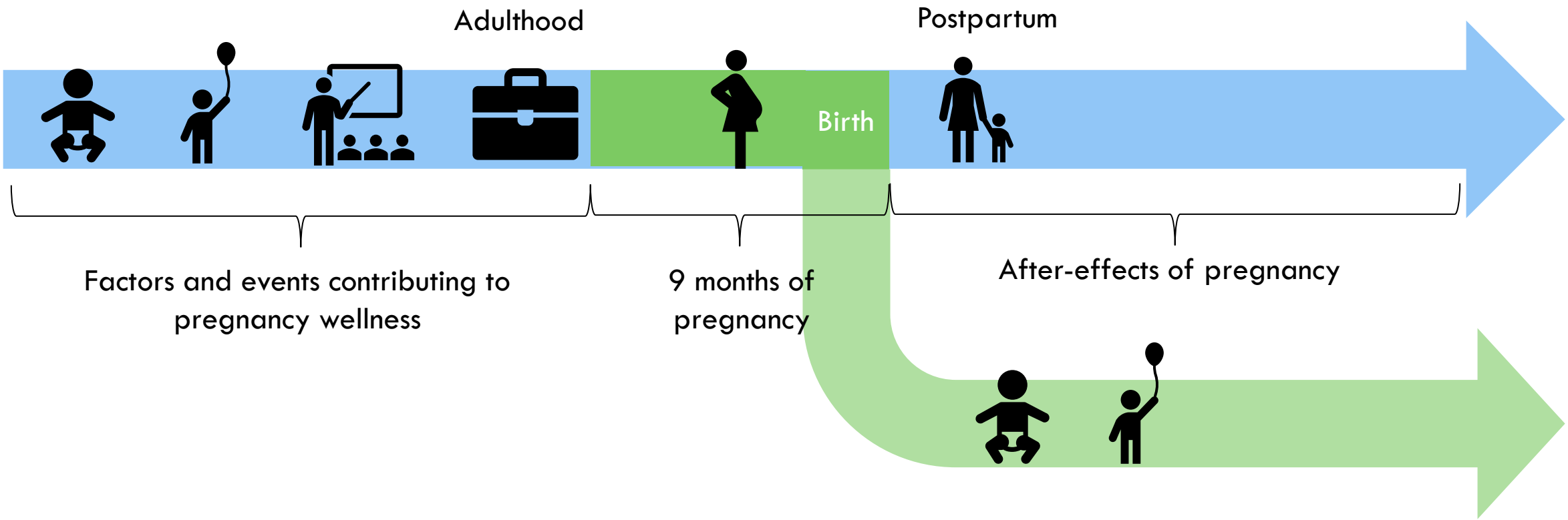
Age



Data from United States vital statistic mortality files for 33 states + DC, 2010-2019

[5]Margerison CE et al. Pregnancy-Associated Deaths Due to Drugs, Suicide, and Homicide in the United States, 2010-2019. Obstet Gynecol. 2022 Feb 1;139(2):172-180.

WHY DOES PREGNANCY MATTER?
SMALL BUT CRITICAL WINDOW OF OPPORTUNITY



SCREENING & INTERVENTION DURING PREGNANCY

Opportunities

- Highly motivated to make behavior change[8]
- Highly engaged with healthcare system
  - 98% receive prenatal care[9]
  - 94% of people receive this care by the second trimester[9]

Gaps

- Regardless of access, care for substance use is often not optimal
- Most drug overdose deaths occur in postpartum[5]
- Less engagement in healthcare during postpartum period

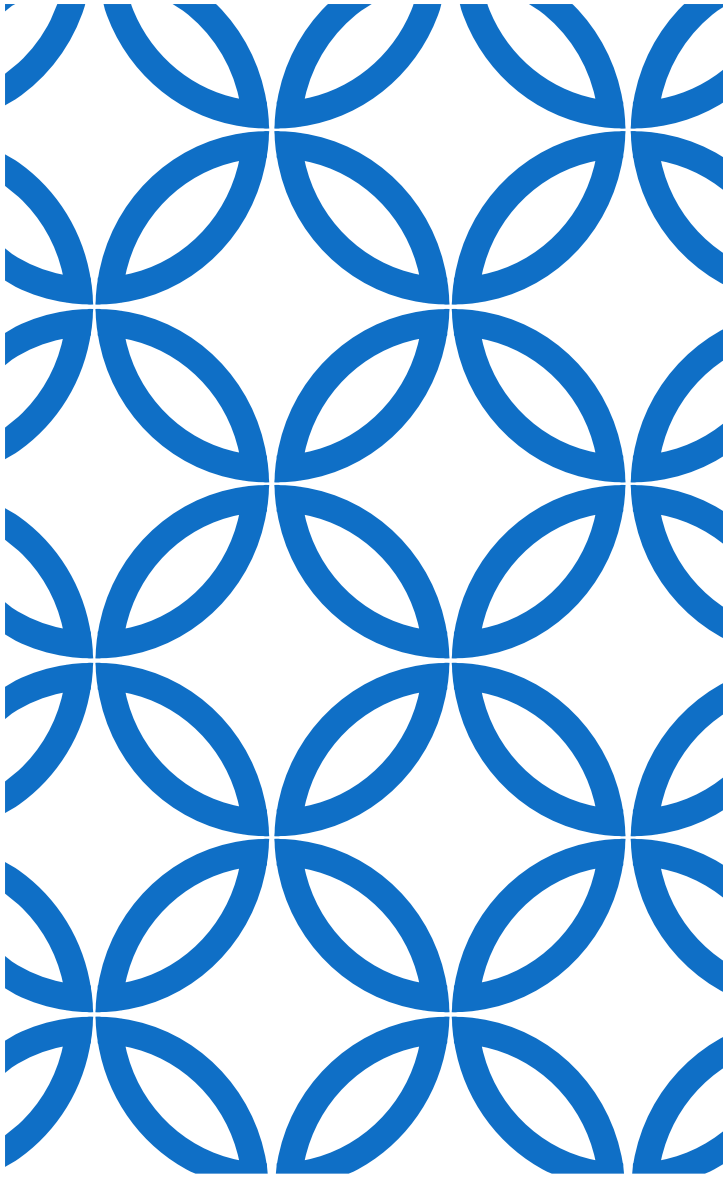
MISSED OPPORTUNITIES FOR SCREENING & INTERVENTION

71% of pregnancy-associated deaths due to drug overdose had a known history of substance use disorder

- Only 27% of those received medication assisted treatment
- Of those, 11% discontinued treatment during last trimester of pregnancy or postpartum[4]

Among pregnancy-associated deaths due to drug overdose:

- 43% had an opioid prescription (not associated with cesarean delivery)
- 44% had a benzodiazepine prescription
- 33% had a prescription for both[4]



"PREGNANT AND POSTPARTUM INDIVIDUALS WERE NOT OPTIMALLY TREATED FOR THEIR SUBSTANCE USE DISORDER OR MENTAL ILLNESS DESPITE HAVING MULTIPLE RISK FACTORS ACKNOWLEDGED IN THEIR MEDICAL RECORDS." (KOUNTANIS ET AL., 2022)[4]

OPPORTUNITIES FOR SCREENING, INTERVENTION, & PREVENTION

Screening

- Identify those needing services
- Passive (existing prenatal and postpartum visits) or active (extend postpartum care, coordinate with pediatric care, outreach outside of medical care)

Treatment

- Immediate access to:
  - Medication
  - Counselling
- Coordination of care

Resources

- Long-term connection to resources for
  - Substance use treatment
  - Social determinants of health: food assistance, job security, childcare, transportation, housing

BARRIERS TO SCREENING, INTERVENTION, & PREVENTION

Lack of programs specifically for pregnancy and postpartum

Availability

- Programs do not exist
- Not enough providers
- Long appointment wait times

Accessibility

- Qualification criteria
- Cost, missing work
- Transportation
- Childcare

Already missing work due to prenatal care and parent leave

May no longer have insurance after birth

Fear of CPS involvement, loss of child

Acceptability

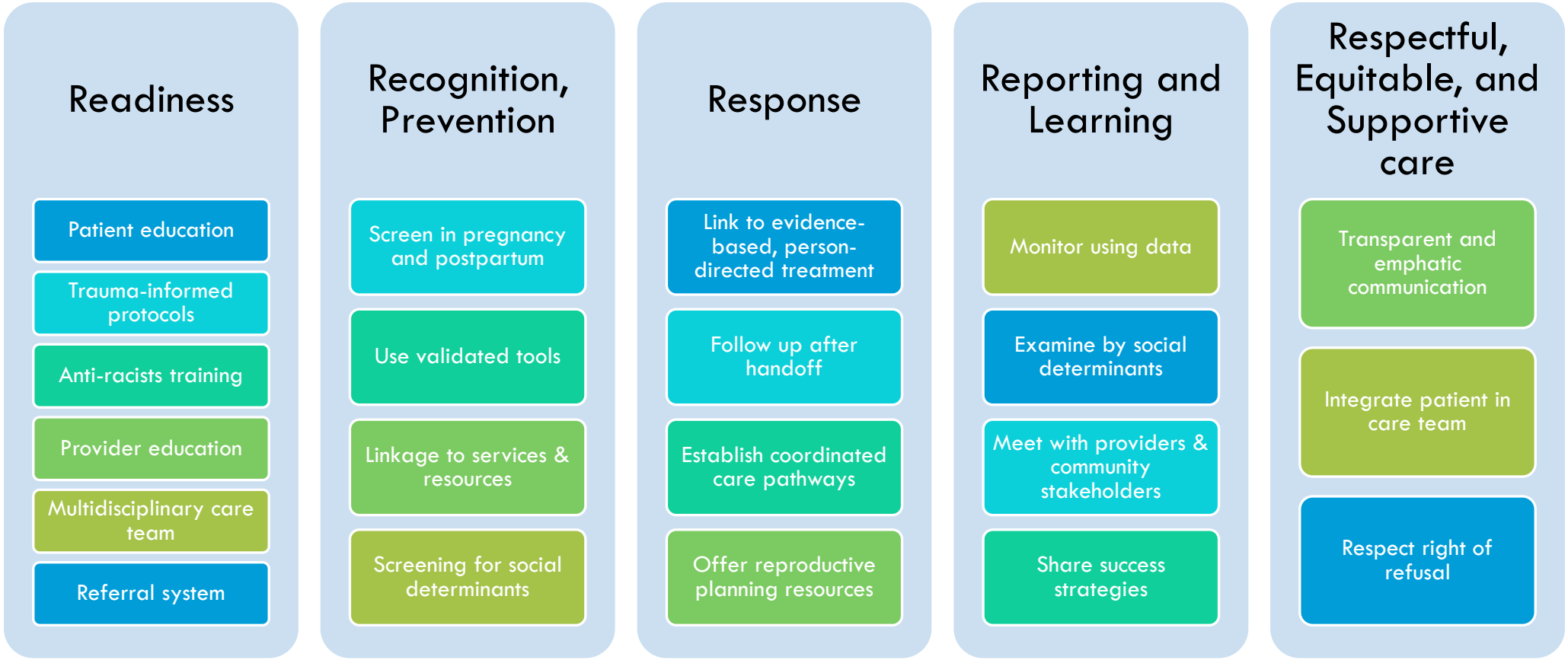
- Mistrust of medical system
- Fear of stigma or punitive measures

Effectiveness

- Quality of care
- Coordination with existing care
- Cultural relevance

Themes modified from Tanahashi model[10]

SPECIFIC RECOMMENDATIONS



"Care for Pregnant and Postpartum People with Substance Use Disorder Patient Safety Bundle" (Alliance for Innovation on Maternal Health. https://saferbirth.org/wp-content/uploads/CPPSUD_PSB_Final_V1_2021.pdf)[11]

PREGNANCY AS WINDOW FOR REDUCING DISPARITIES

PREGNANCY AS WINDOW FOR REDUCING INEQUITIES

- DO address injustice in everyday practices of institutions, laws, and policies
- DON'T assume that individuals are solely responsible for poor health outcomes or behaviors
- DO examine the role that society and institutions play in shaping conditions that lead to behavior and health outcomes
- DO take a strengths-based approach to amplifying existing strengths in communities to solve public health problems
- DO focus on systemic change over individual-level interventions

KEY TAKE-AWAYS

1. Drug overdose is the leading non-obstetric cause of pregnancy-associated death

Pregnancy-associated drug overdose deaths are increasing

Inequities exist in perinatal drug overdose death

Pregnancy is a critical window of opportunity

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QUESTIONS & COMMENTS

Medications for Opioid Use Disorder in Carceral Settings

WAYNE STATE
School of Social Work
Center for Behavioral Health and Justice

WAYNE STATE
School of Social Work
Center for Behavioral Health and Justice

We envision communities in which **research**, **data**, and **best practices** are used by multiple stakeholders to *enhance the optimal well-being of individuals with mental illness and/or substance use disorders who come in contact with the criminal/legal system*.

We work with local communities, organizations, and behavioral health and law enforcement agencies across Michigan to provide

EXPERTISE, EVALUATION, TRAINING, and TECHNICAL ASSISTANCE

to optimize diversion of individuals with mental health or substance use disorders from jail or prison.

We Help Stakeholders…

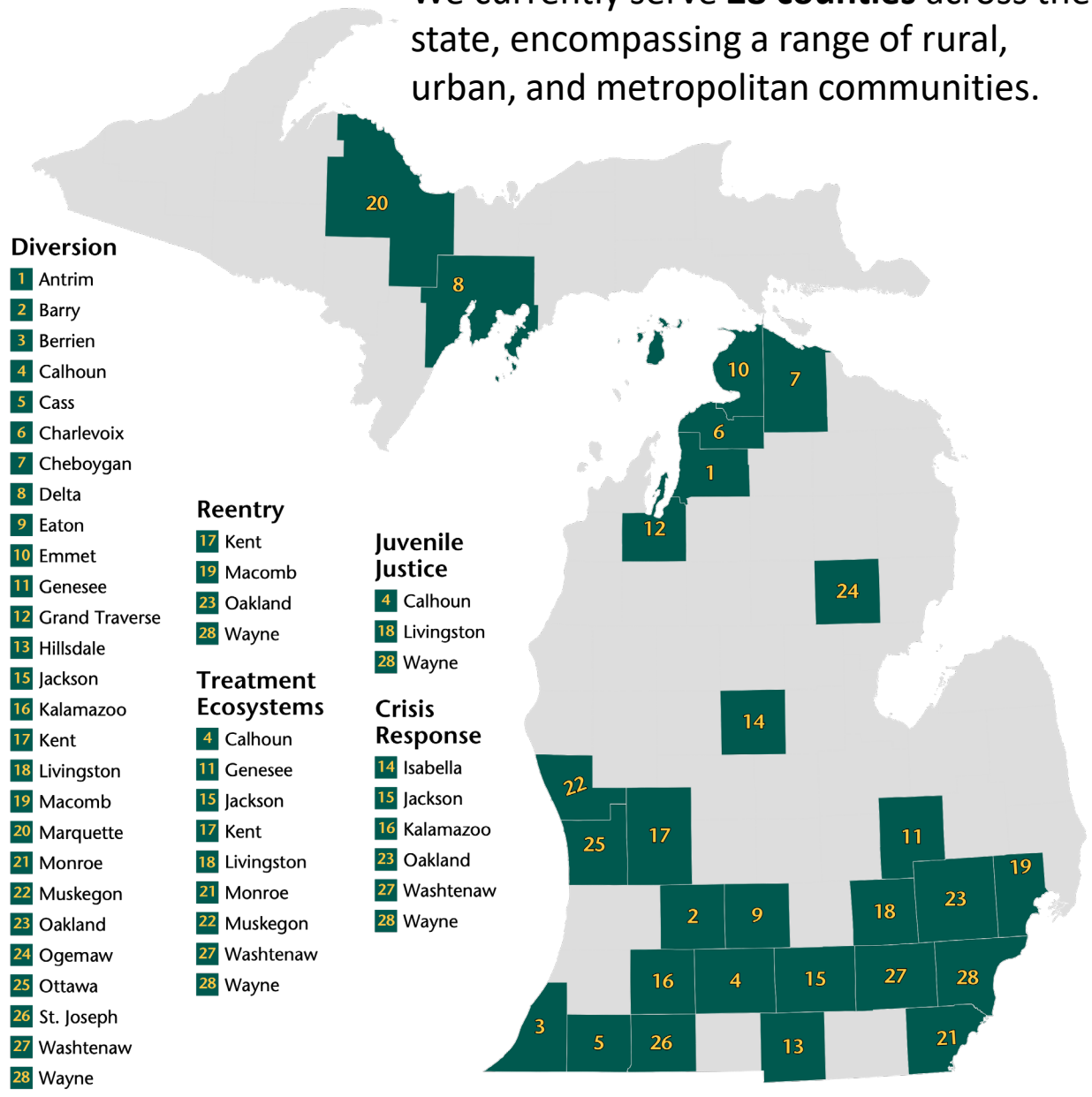
Implement best and innovative practices at every intercept of the criminal/legal continuum.

Collect and use data to drive decisions.

Create linkages to solve problems.

Develop action plans to achieve goals and sustain initiatives.

We currently serve **28 counties** across the state, encompassing a range of rural, urban, and metropolitan communities.



Diversion
- 1 Antrim
- 2 Barry
- 3 Berrien
- 4 Calhoun
- 5 Cass
- 6 Charlevoix
- 7 Cheboygan
- 8 Delta
- 9 Eaton
- 10 Emmet
- 11 Genesee
- 12 Grand Traverse
- 13 Hillsdale
- 15 Jackson
- 16 Kalamazoo
- 17 Kent
- 18 Livingston
- 19 Macomb
- 20 Marquette
- 21 Monroe
- 22 Muskegon
- 23 Oakland
- 24 Ogemaw
- 25 Ottawa
- 26 St. Joseph
- 27 Washtenaw
- 28 Wayne

Reentry
- 17 Kent
- 19 Macomb
- 23 Oakland
- 28 Wayne

Treatment Ecosystems
- 4 Calhoun
- 11 Genesee
- 15 Jackson
- 17 Kent
- 18 Livingston
- 21 Monroe
- 22 Muskegon
- 27 Washtenaw
- 28 Wayne

Juvenile Justice
- 4 Calhoun
- 18 Livingston
- 28 Wayne

Crisis Response
- 14 Isabella
- 15 Jackson
- 16 Kalamazoo
- 23 Oakland
- 27 Washtenaw
- 28 Wayne

Current Initiatives

Across the Sequential Intercept Model

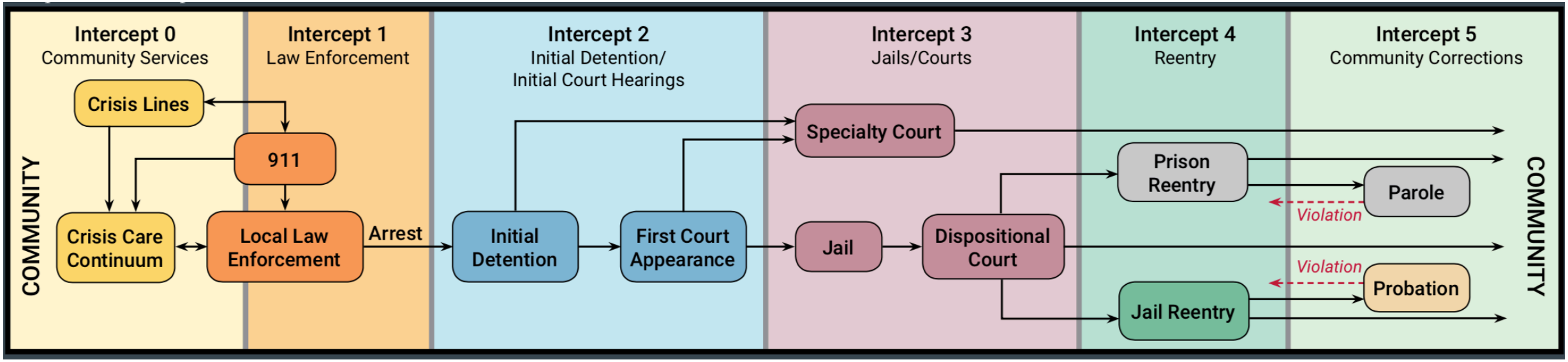
Juvenile Justice

Jail Diversion

Treatment Ecosystems

Crisis Response

Wayne County Jail/Mental Health Initiative



SAMHSA'S GAINS Center (2013), *Developing a comprehensive plan for behavioral health and criminal justice collaboration: The Sequential Intercept Model (3rd ed.). Delmar, NY: Policy Research Associates, Inc.*

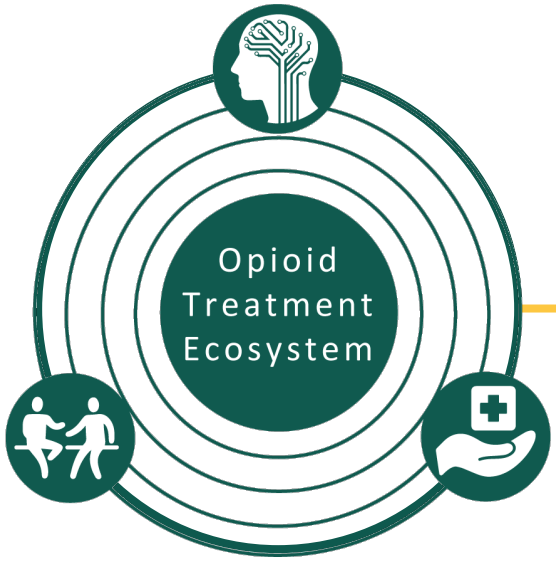
The need for an opioid treatment ecosystem

Most drug overdose deaths involve opioids

High risk of overdose following release from jail

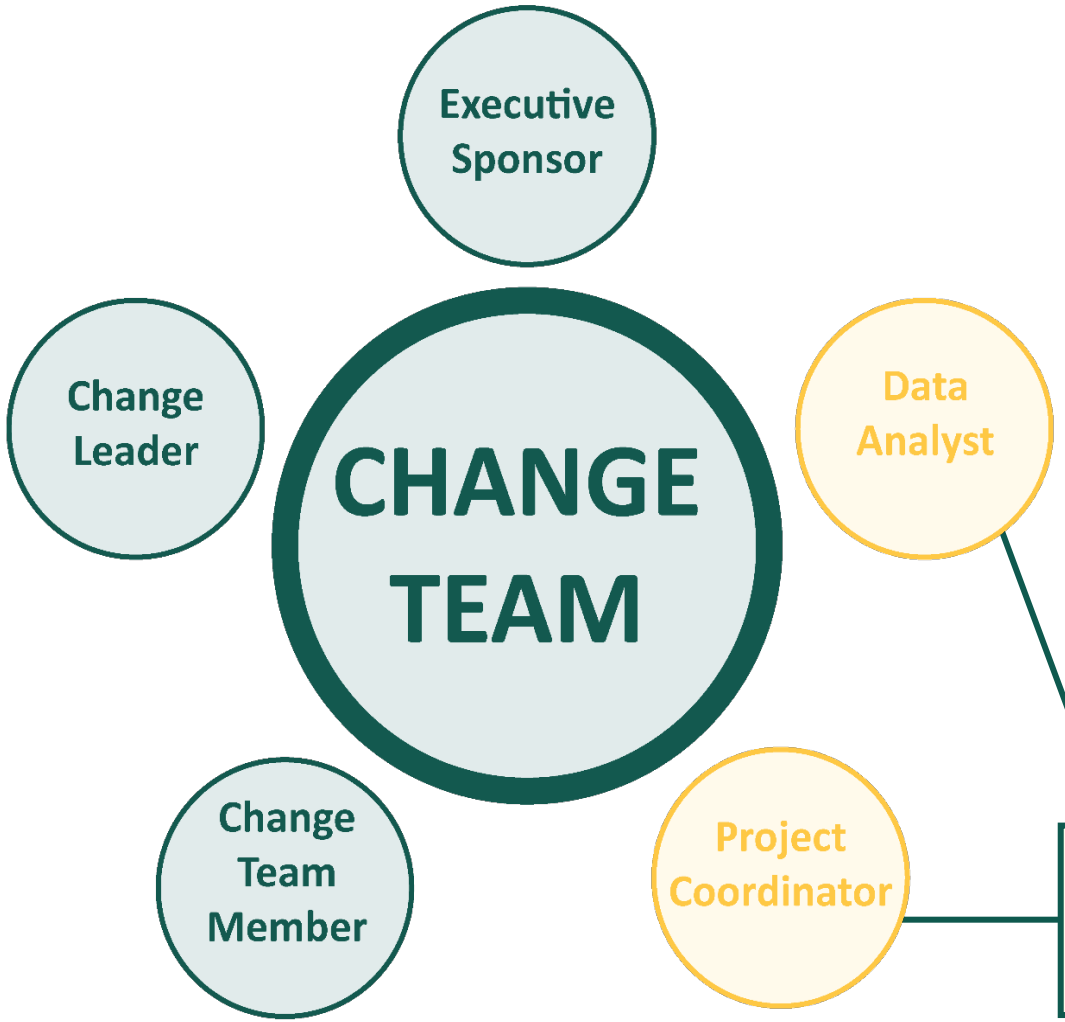
Medications for opioid use disorder (MOUD) is gold standard treatment

Very few jails provide any form of MOUD



The need for an Opioid Treatment Ecosystem

County-level change teams



- Includes jail command staff, jail medical, PIHP/CMH and community providers
- Monthly Change Team meetings
- Data review, implementation barriers, and shared learning

CBHJ MOUD in jail model

Implementation of a validated screening tool

- **RODS**
- **TCUDS**
  with opioid supplement

- Standard screening at booking helps identify who needs treatment
- Goal is to screen 100% of everyone booked
- Works best when captured electronically – easily share screening results with jail medical team and other providers

Development of baseline data using the RODS

Rapid Opioid Dependence Screen (RODS) **Inmate ID: _____**

Please complete the screen below on all bookings except for US Marshals and ICE bookings.

Instructions (to be read aloud): When individuals stop using opioids, there may be physical withdrawal symptoms that require medical attention. We want to better understand the need for services for opioid use or withdrawal. To help with this, I am going to ask a few questions about opioid use in the last 12 months. This should take less than 2 minutes to complete. Your answers will only be used to help us determine the need for programs and services and will NOT impact any charges or probation or parole violations.

1a. Have you used heroin in the last 12 months?	◯ Yes	◯ No	
1b. In the last 12 months, have you abused or misused any of the following prescription drugs? (Abuse/misuse means taking without a prescription or taking more than prescribed.)			
◦ Vicodin	◯ Yes	◯ No	
◦ Norco	◯ Yes	◯ No	
◦ Oxycodone/Oxycontin ("Oxy")	◯ Yes	◯ No	
◦ Percocet	◯ Yes	◯ No	
◦ Other opioids such as morphine, Fentanyl, Dilaudid, Lortab, Codeine, or Tramadol	◯ Yes	◯ No	
1c. In the last 12 months, have you used any of the following?			
◦ Buprenorphine? (also known as Suboxone, Subutex, or Zubsolv)	◯ Yes	◯ No	

Development of baseline data using the RODS

IF YES, have you abused/misused it?	◯ Yes	◯ No	◯ NA
◦ Methadone	◯ Yes	◯ No	
IF YES, have you abused/misused it?	◯ Yes	◯ No	◯ NA
1d. Are you currently taking any prescribed medication assisted treatment (MAT) to help treat your opioid use disorder? (If yes, which one?)	◯ Yes	◯ No	
◦ Buprenorphine/Suboxone/Subutex/Zubsolv	◯		
◦ Methadone	◯		
◦ Naltrexone/Vivitrol	◯		
If there are any "Yes" responses to 1a, 1b, or 'abuse/misuse' in 1c, please complete the questions below. If 1a, 1b, and 1c abuse/misuse items are all "No", stop the screen here.			
In the last 12 months…			
2. Did you ever need to use more opioids to get the same high as when you first started using opioids?	◯ Yes	◯ No	
3. Did the idea of missing a dose (or fix) ever make you anxious or worried?	◯ Yes	◯ No	
4. In the morning, did you ever use opioids to keep you from feeling "dope sick" or did you ever feel "dope sick"?	◯ Yes	◯ No	
5. Did you worry about your use of opioids?	◯ Yes	◯ No	
6. Did you find it difficult to stop or not use opioids?	◯ Yes	◯ No	
7. Did you ever need to spend a lot of time/energy on finding opioids or recovering from feeling high?	◯ Yes	◯ No	
8. Did you ever miss important things like doctor's appointments, family/friend activities, or other things because of opioids?	◯ Yes	◯ No	

CBHJ MOUD in jail model

Access to all forms of MOUD

- **Methadone**
- **Buprenorphine**
- **Naltrexone**

- Reduces drug use and criminal behavior
- Following lawsuits in Maine, Massachusetts, and Washington, federal courts ruled that withholding treatment is a violation of the 8th Amendment and the ADA (Arnold, 2019; Taylor, 2018; Associated Press, 2019)
- ADA defines OUD as a disability (DHHS, 2018)
- Best practice is to provide access to all three forms of medications for OUD

CBHJ MOUD in jail model

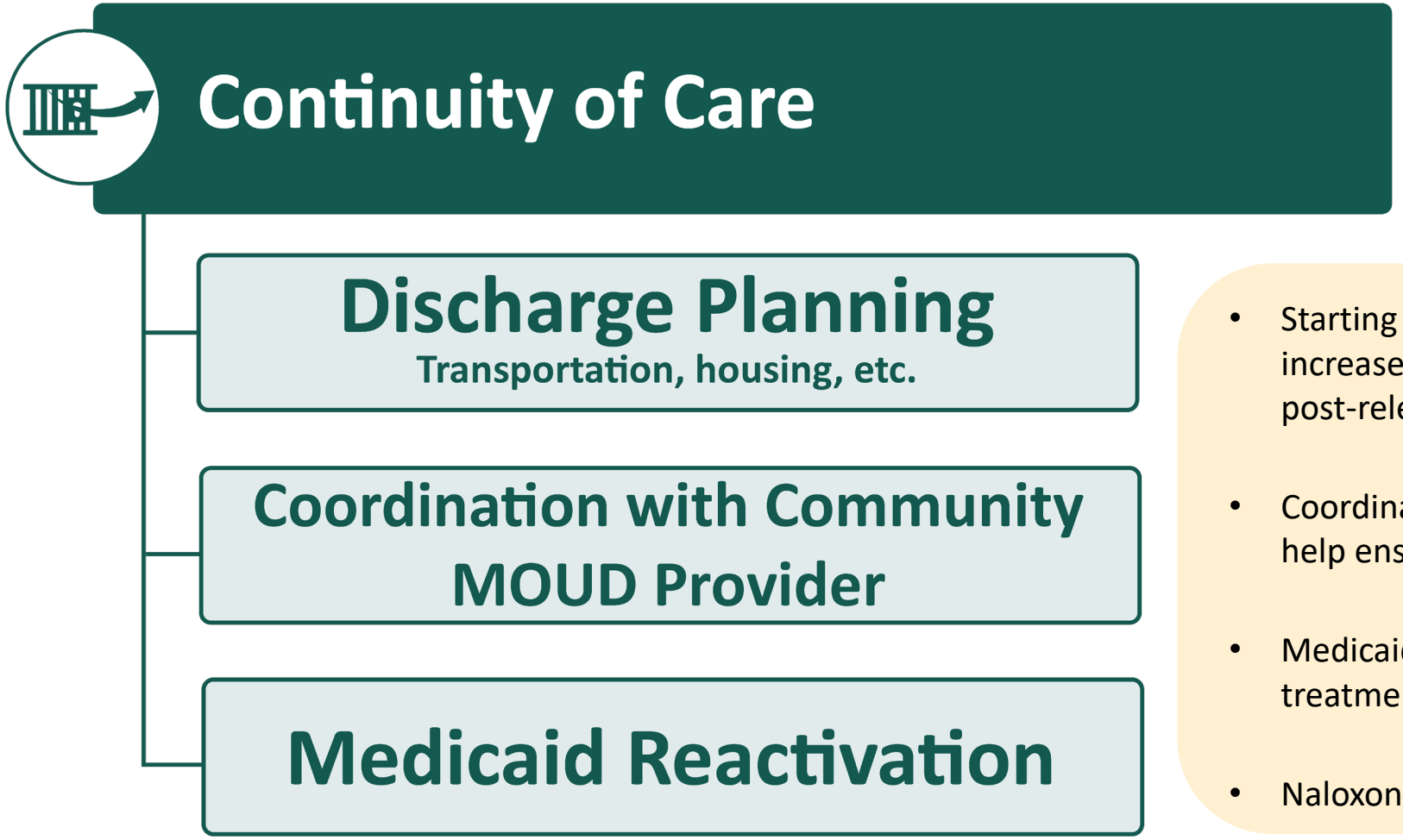
Psychosocial services

Group/individualized therapy

OUD targeted offerings
(Relapse prevention, MRT class, etc).

- Psychosocial services should be provided in conjunction with MOUD to treat the whole person
- May be required for patients receiving treatment from an OTP
- Counseling via telehealth can be very effective

CBHJ MOUD in Jail Model



- Starting treatment while incarcerated increases likelihood of treatment engagement post-release
- Coordination with community providers can help ensure treatment continues
- Medicaid reactivation prevents gaps in treatment services following release
- Naloxone distribution saves lives

Thank you

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Introduction to Treatment Courts in Michigan

Presented to the Opioid Advisory Commission December 8, 2022 by

Michigan Association of Treatment Court Professionals

What are Treatment Courts?

Referred to as Problem-Solving Courts by the State Court Administrative Office (SCAO), the administrative arm of the Michigan Supreme Court (MSC)

SCAO has a Problem-Solving Courts division and a MSC justice is assigned as a PSC-liaison

from State Court Administrative Office FY2021 Problem-Solving Courts Annual Report

Problem-solving courts (PSCs), or treatment courts, use therapeutic jurisprudence models, which combine intense supervision and monitoring with treatment for substance use disorders (SUD) and mental illness. The models for the various types of PSCs have undergone decades of research-based evaluation to determine which components result in positive change among individuals entering a PSC. The models were developed to address underlying reasons why some individuals continually return to crime. For example, individuals suffering with drug or alcohol addiction do not benefit from jail or a standard probation term when they are not required to engage in treatment for their SUD. Similarly, individuals who suffer with untreated mental illness do not benefit from jail or other punitive measures when their mental illness goes unaddressed or even unrecognized. **Ignoring the underlying reasons why people commit crime in the first place often results in a cycle of continuous criminal activity.**

Historically, the two fields — criminal justice and behavioral health treatment — have operated separately with little interaction between them. Even when the two fields did communicate with one another, typically neither field had extensive experience and knowledge of the other field's terminology and processes. This resulted in courts not understanding addiction and mental illness and how therapy works, and therapists not understanding criminal justice processes and ideologies associated with probation and jail sanctioning.

PSCs make these two fields interdependent by requiring treatment services that address the behaviors that lead to crime as part of a structured court program. **Thus, court personnel and therapists work together as a team to bridge the gaps between the two fields by regularly communicating with one another to ensure that participants are compliant and progressing in their treatment.**

While defendants on standard probation must comply with standard probation terms, such as showing up for probation appointments, PSC participants have additional supervision, monitoring, and resources to help them change their way of life. This is especially difficult for a person struggling with addiction and/or mental illness. Participants in a treatment court must attend therapy, frequent court review hearings, and complete frequent and random drug testing to determine abstinence or medication compliance. They also have access to ancillary services, such as community support groups, education services, and employment assistance. **Participants are also held accountable for their actions and are subjected to a higher level of monitoring and supervision than standard probation.** Home checks and employment checks by law enforcement, probation officers, or case managers are conducted, as well as frequent probation and/or case manager appointments. Rewards are given for positive behaviors such as breakthroughs in treatment, helping in the community or fellow participants, finding employment, or even making it through a

TREATMENT COURTS

SAVE LIVES

REDUCE CRIME

AND SAVE MONEY

SAVE LIVES

- The average success rate for treatment courts addressing drug & alcohol use disorder is 65%
- Drug / Sobriety Court graduates achieved an average 338 consecutive days of sobriety at the time of their discharge.
- On average, 13% of drug court participants were able to improve their education level while in a drug court.

REDUCE CRIME

- 78% of Drug Court graduates in Michigan remain arrest-free at least 3 years after leaving the program.

SAVE MONEY

- Drug Courts save as much as $27 for every $1 invested.

Of the **2,482** participants discharged from a drug or sobriety court program in FY2021,

69%

Successfully completed the program

from State Court Administrative Office
Problem-Solving Courts Website

Current Number of Problem-Solving Courts in Michigan

(as of August 9,2022)

Drug/Sobriety Courts:

Hybrid DWI/Drug	DWI	Juvenile	Adult Drug Court	Family Dependency	Tribal	Total
58	38	11	13	8	9	137

Mental Health Courts:

Adult	Juvenile	Total
35	7	42

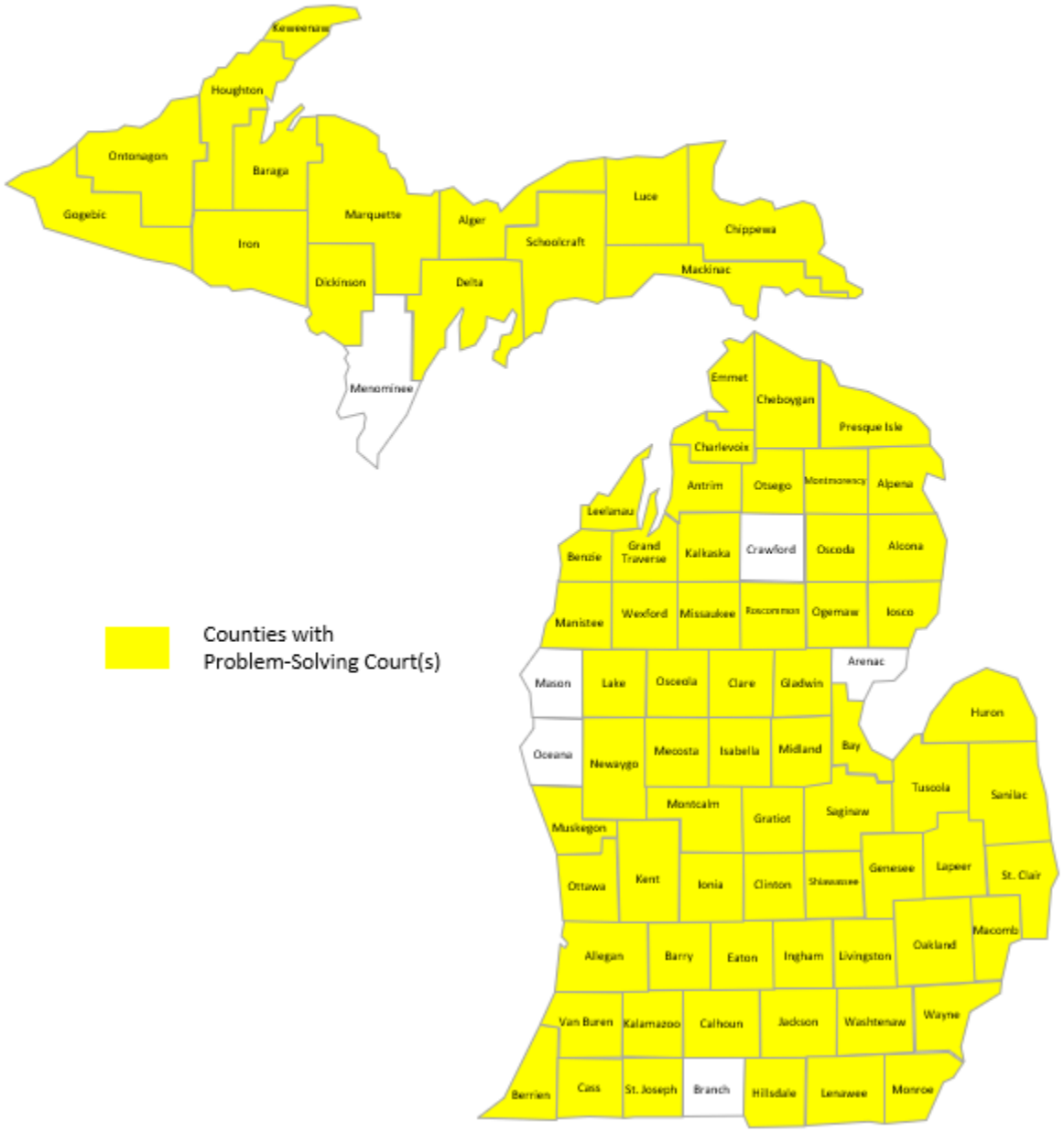
Veterans Treatment Courts:

Total
29

208

Total # of MI PSCs

Michigan's Problem-Solving Courts by County
All Problem-Solving Courts
Fiscal Year 2021



137

Total # of Drug/Sobriety Treatment Courts

Hybrid DWI/Drug = 58

DWI = 38

Juvenile Drug = 11

Adult Drug = 13

Family Dependency = 8

Tribal Healing-to-Wellness = 9

Court Name	Type	County	City	Phone
1st Circuit Court	Family Dependency Court	Hillsdale	Hillsdale	517-437-4643
2nd Circuit Court	Hybrid DWI/Drug Court	Berrien	St. Joseph	269-983-7111
3rd Circuit Court	Hybrid DWI/Drug Court	Wayne	Detroit	313-224-2506
3rd Circuit Court	Juvenile Drug Court	Wayne	Detroit	313-224-2506
4th Circuit Court	Hybrid DWI/Drug Court	Jackson	Jackson	517-788-4365
5th Circuit Court	Hybrid DWI/Drug Court	Barry	Hastings	269-945-1404
6th Circuit Court	Hybrid DWI/Drug Court	Oakland	Pontiac	248-452-2154
6th Circuit Court	Juvenile Drug Court	Oakland	Pontiac	248-452-2154
7th Circuit Court	Hybrid DWI/Drug Court	Genesee	Flint	810-424-4355
7th Circuit Court	Family Dependency Court	Genesee	Flint	810-424-4355
7th Circuit Court	Juvenile Drug Court	Genesee	Flint	810-424-4355
8th Circuit Court	Adult Drug Court Drug	Ionia	Ionia	616-527-5315
9th Circuit Court	Family Dependency Court	Kalamazoo	Kalamazoo	269-383-6469
9th Circuit Court	Hybrid DWI/Drug Court	Kalamazoo	Kalamazoo	269-383-6469
9th Circuit Court	Hybrid DWI/Drug Court	Kalamazoo	Kalamazoo	269-383-6469
9th Circuit Court	Juvenile Drug Court	Kalamazoo	Kalamazoo	269-383-6469
10th Circuit Court	Adult Drug Court	Saginaw	Saginaw	202-735-4506
14th Circuit Court	Hybrid DWI/Drug Court	Muskegon	Muskegon	231-724-6251
15th Circuit Court	Family Dependency Court	Branch	Coldwater	517-279-4304
16th Circuit Court	Adult Drug Court	Macomb	Mt. Clemens	586-469-5164
16th Circuit Court	DWI Sobriety Court	Macomb	Mt. Clemens	586-469-5146
18th Circuit Court	Adult Drug Court	Bay	Bay City	989-895-4265
18th Circuit Court	Family Dependency Court	Bay	Bay City	989-895-4265
18th Circuit Court	Juvenile Drug Court	Bay	Bay City	989-895-4265
19th Circuit Court	Adult Drug Court	Benzie Manistee	Beulah	231-723-6664
20th Circuit Court	Hybrid DWI/Drug Court	Ottawa	Grand Haven	616-846-8320
21st Circuit Court	Hybrid DWI/Drug Court	Isabella	Mt. Pleasant	989-772-0911
21st Circuit Court	Juvenile Drug Court	Isabella	Mt. Pleasant	989-772-0911
22nd Circuit Court	Hybrid DWI/Drug Court	Washtenaw	Ann Arbor	734-222-6915
22nd Circuit Court	Juvenile Drug Court	Washtenaw	Ann Arbor	734-222-6900
23rd Circuit Court	Hybrid DWI/Drug Court	Alcona	Harrisville	989-724-9474
25th Circuit Court	Adult Drug Court	Marquette	Marquette	906-225-8277
25th Circuit Court	Juvenile Drug Court	Marquette	Marquette	906-225-8277
29th Circuit Court	Adult Drug Court	Clinton/Gratiot	St. Johns	989-224-5132
30th Circuit Court	Family Dependency Court	Ingham	Lansing	517-483-6500
33rd Circuit Court	Juvenile Drug Court	Charlevoix	Charlevoix	231-547-7214

42

Total # of Mental Health Treatment Courts

Adult = 35

Juvenile = 7

Updated 8/9/22

Court Name	Type	County	City	Phone
2nd Circuit Court	Adult Mental Health Court	Berrien	St. Joseph	269-983-7111
3rd Circuit Court	Adult Mental Health Court	Wayne	Detroit	313-224-2506
3rd Circuit Court	Juvenile Mental Health Court	Wayne	Detroit	313-224-2506
6th Circuit Court	Juvenile Mental Health Court	Oakland	Pontiac	248-858-0345
7th Circuit Court	Adult Mental Health Court	Genesee	Flint	810-424-4355
7th Circuit Court	Juvenile Mental Health Court	Genesee	Flint	810-424-4355
9th Circuit Court	Juvenile Mental Health Court	Kalamazoo	Kalamazoo	269-383-6469
16th Circuit Court	Adult Mental Health Court	Macomb	Mt. Clemens	586-469-5164
17th Circuit Court	Adult Mental Health Court	Kent	Grand Rapids	313-387-2790
17th Circuit Court	Juvenile Mental Health Court	Kent	Grand Rapids	616-632-5220
30th Circuit Court	Adult Mental Health Court	Ingham	Lansing	517-483-6500
35th Circuit Court	Adult Mental Health Court	Shiawassee	Corunna	989-743-2239
36th Circuit Court	Adult Mental Health Court	Van Buren	Paw Paw	269-657-8200
36th Circuit Court	Juvenile Mental Health Court	Van Buren	Paw Paw	269-657-8200
42nd Circuit Court	Adult Mental Health Court	Midland	Midland	989-832-6657
43rd Circuit Court	Adult Mental Health Court	Cass	St. Joseph	269-983-7111
44th Circuit Court	Adult Mental Health Court	Livingston	Howell	517-548-1000
45th Circuit Court	Juvenile Mental Health Court	Saint Joseph	Centreville	269-467-5500
54th Circuit Court	Adult Mental Health Court	Tuscola	Caro	989-673-3330
1st District Court	Adult Mental Health Court	Monroe	Monroe	734-240-7075
2A District Court	Adult Mental Health Court	Lenawee	Adrian	517-437-7329
8th District Court	Adult Mental Health Court	Kalamazoo	Kalamazoo	269-384-8171
10th District Court	Adult Mental Health Court	Calhoun	Battle Creek	269-969-6726
15th District Court	Adult Mental Health Court	Washtenaw	Ann Arbor	734-794-6764
27th District Court	Adult Mental Health Court	Wayne	Wyandotte	734-324-4475
29th District Court	Adult Mental Health Court	Wayne	Wayne	734-722-5220
30th District Court	Adult Mental Health Court	Wayne	Highland Park	313-252-0300
32A District Court	Adult Mental Health Court	Wayne	Harper Woods	313-343-2590
36th District Court	Adult Mental Health Court	Wayne	Detroit	313-965-2200
41B District Court	Adult Mental Health Court	Macomb	Clinton Twp	586-469-1254
45th District Court	Adult Mental Health Court	Oakland	Oak Park	248-691-7532
52nd District Court	Adult Mental Health Court	Oakland	Troy	248-528-0400
55th District Court	Adult Mental Health Court	Ingham	Mason	517-676-8400
57th District Court	Adult Mental Health Court	Allegan	Allegan	269-673-0400
58th District Court	Adult Mental Health Court	Ottawa	Holland	616-392-6991
60th District Court	Adult Mental Health Court	Muskegon	Muskegon	231-724-6283
65B District Court	Adult Mental Health Court	Gratiot Clinton Ionia Montcalm	Ithaca	989-875-5240

29

Total # of Veterans Treatment Courts

Court Name	Type	County	City	Phone
3rd Circuit Court	Veterans Treatment Court	Wayne	Detroit	313-224-2506
6th Circuit Court	Veterans Treatment Court	Oakland	Pontiac	248-452-2154
7th Circuit Court	Veterans Treatment Court	Genesee	Flint	810-424-4355
16th Circuit Court	Veterans Treatment Court	Macomb	Mt. Clemens	586-469-5164
39th Circuit Court	Veterans Treatment Court	Lenawee	Adrian	517-264-4597
56th Circuit Court	Veterans Treatment Court	Eaton	Charlotte	517-543-2999
1st District Court	Veterans Treatment Court	Monroe	Monroe	734-240-7075
10th District Court	Veterans Treatment Court	Calhoun	Battle Creek	269-969-6726
15th District Court	Veterans Treatment Court	Washtenaw	Ann Arbor	734-794-6764
17th District Court	Veterans Treatment Court	Wayne	Redford	313-387-2790
19th District Court	Veterans Treatment Court	Wayne	Dearborn	313-943-2060
28th District Court	Veterans Treatment Court	Wayne	Southgate	734-258-3068
36th District Court	Veterans Treatment Court	Wayne	Detroit	313-965-3721
41B District Court	Veterans Treatment Court	Macomb	Clinton Township	586-469-9300
45th District Court	Veterans Treatment Court	Oakland	Oak Park	248-691-7532
51st District Court	Veterans Treatment Court	Oakland	Waterford	248-674-4655
52-1 District Court	Veterans Treatment Court	Oakland	Novi	248-305-6144
53rd District Court	Veterans Treatment Court	Livingston	Howell	517-548-1000
54B District Court	Veterans Treatment Court	Ingham	East Lansing	517-351-7000
57th District Court	Veterans Treatment Court	Allegan Ottawa Van Buren	Allegan	269-673-0400
60th District Court	Veterans Treatment Court	Muskegon	Muskegon	231-724-6283
62A Disrict Court	Veterans Treatment Court	Kent	Wyoming	616-530-7385
64A District Court	Veterans Treatment Court	Ionia	Ionia	616-527-5344
70th District Court	Veterans Treatment Court	Saginaw	Saginaw	989-790-5363
80th District Court	Veterans Treatment Court	ClareGladwin	Harrison	989-539-7173
88th District Court	Veterans Treatment Court	Montmorency	Atlanta	989-785-8035
90th District Court	Veterans Treatment Court	Emmet	Petoskey	231-348-1750
95B District Court	Veterans Treatment Court	Dickinson	Iron Mountain	906-774-0506

What are Treatment Courts NOT?

- They are NOT separate Courts! They are specialized dockets that Judges at both the District Court and Circuit Court-level maintain in addition to their normal civil and criminal dockets.

- Not all Specialty Courts are Treatment Courts – there are a number of specialty court programs throughout the state (e.g., Human Trafficking Court in Washtenaw County; Baby Court in Genesee County) that are not treatment courts – treatment courts are concerned with both crimes involving drugs/alcohol and/or crimes committed by individuals with a SUD and/or mental health disorder.

The Defendant

Is referred to as the **Participant** in a Treatment Court.

Treatment Courts accept those with **High Risk/High Needs** – not everyone charged with a substance use offense is eligible for or should be in a treatment court (in fact, national research shows that those with low risk and/or low needs can be detrimental to the HRHN participants).

"[M]ixing participants with different levels of risk or need in the same treatment groups or residential programs has been found to increase crime, substance use, and other undesirable outcomes, because it exposes low-risk participants to antisocial peers and values (e.g., Lloyd et al., 2014; Lowenkamp & Latessa, 2004; Lowenkamp et al., 2005; Welsh & Rocque, 2014; Wexler et al., 2004).

Generally, a participant has already been convicted of a crime and is sentenced to intensive supervision by a treatment court.

The Team

CRIMINAL		FAMILY
Judge		Judge
Prosecutor & Defense attorney		Prosecutor & Parents' attorneys
Treatment providers		Treatment providers
Coordinator		Coordinator
Case Managers		Case Managers
Probation & DOC		Probation & DOC
Community Corrections		Community Corrections
Law Enforcement		Law Enforcement
Evaluator		Evaluator
Community Members		Community Members
Peer supports		Peer supports
		DHHS
		LGAL
		CASA

The team meets weekly to discuss participant progress – referred to as team meetings or staffings.

The Team – Participating Judges

Judicial Participation	Recidivism reduction*
The judges spends an average of 3 minutes or more per participant during status review hearings	>153% (& cost savings of >36%)
The judge's term is indefinite	>35% (& cost savings of >17%)
The judge was assigned to treatment court on a voluntary basis	>84% (& cost savings of >4%)

*Recidivism reduction & cost savings compared to courts that do not follow these practices

NPC Research Key Components Study 2008

Participant Services

Integrate alcohol and other drug treatment services with justice system case-processing. Examples of rehabilitative services include:

- Drug testing
- Outpatient treatment
- Medication for Opioid Use Disorder (MOUD)
- Case service planning
- AA/NA/Smart Recovery/12 Step Programs
- Peer Recovery Coaches
- Therapy
- Trauma-based care
- Child Assessment & Treatment
- Parenting classes
- Sober interactions & activities
- Education assistance
- Job training/assistance
- Housing assistance
- Physical/dental/health care

Services should be more than simply satisfying a checklist – they need to be individualized to the needs of the participant.

The Phases

Typically, treatment court programs follow three separate Phases. Each phase lasts approximately 4 months, with most program completions occurring between 12-18 months (sometimes longer depending on the needs of the participant).

During Phase I, participants are meeting with their probation officer and appearing before the judge weekly. As a participant moves through the phases, services continue but they may not have to appear in front of the judge as frequently.

Completion of a treatment court program culminates in a graduation.

Hon. Susan Jordan & participants during Jackson County Adult Treatment Court graduation.

Certification of Problem-Solving Courts

In 2013 and 2015, the National Association of Drug Court Professionals (NADCP) published the "Adult Drug Court Best Practices Standards Volumes I and II," which have been a blueprint for how treatment courts should operate to improve outcomes for offenders with SUD or mental illness.
Drawing heavily from these manuals and their resources, SCAO collaborated with the Michigan Association of Treatment Court Professionals in 2016 to determine which best practices for Michigan's drug courts were required in order to achieve the level of certification, and subsequently published the "Michigan Adult Drug Court Standards, Best Practices, and Promising Practices" in March 2017.
In 2018, SCAO developed and published the required best practices and standards for veterans treatment courts and mental health courts.

To certify a court, SCAO's team of PSC analysts conduct a process evaluation of programs to ensure operations adhere to all required best practices and standards. Prior to the pandemic, analysts conducted on-site evaluations of each court, spending one to two days with the team, but evaluations are now conducted via Zoom. PSC analysts observe courtroom procedures and staffing meetings, conduct interviews with all team members, review policy and procedures manuals and other materials, and evaluate program data.

An official report containing SCAO's findings and operations that do not meet best practices or standards is sent to the court. Teams are given time to revise any necessary program operations, and once in compliance, they are officially awarded certification for four years. Courts that are awaiting their official site visit are granted provisional certification until their programs are officially reviewed. As of September 30, 2020, 55 drug courts had received certification. In addition, 7 veterans treatment courts and 7 mental health courts became certified. To view the standards and best practices manuals for each type of PSC, please visit courts.mi.gov/PSCresources. *

** From SCAO FY 2020 Problem-Solving Courts Annual Report*

Certification of a MI treatment court required to receive state grant funding.

Certification of Problem-Solving Courts

BEST PRACTICE

Drug courts enjoy significantly greater reductions in recidivism and significantly higher cost savings when all of the above-mentioned team members regularly participate in staffing meetings and hearings.

(Carey, Mackin & Finigan et al., 2012)

STANDARD

The drug treatment court shall cooperate with, and act in a collaborative manner with, the prosecutor, defense counsel, treatment providers, the local substance abuse coordinating agency for that circuit or district, probation departments, and, to the extent possible, local law enforcement, the department of corrections, and community corrections agencies.

MCL 600.1070(3)

TREATMENT COURT STATUES

REVISED JUDICATURE ACT OF 1961 (EXCERPT)
Act 236 of 1961

CHAPTER 10A. DRUG TREATMENT COURTS (600.1060...600.1088)

CHAPTER 10B. MENTAL HEALTH COURT (600.1090...600.1099a)

CHAPTER 10C JUVENILE MENTAL HEALTH COURTS (600.1099b...600.1099m)

CHAPTER 12 VETERANS TREATMENT COURTS (600.1200...600.1297)

ABOUT US

MICHIGAN ASSOCIATION OF TREATMENT COURT PROFESSIONALS

MATCP is a 501c4 nonprofit, founded by the first drug and sobriety court members. The first drug court in Michigan was started in Kalamazoo County Circuit Court.

The Michigan Association of Treatment Court Professionals (MATCP) was founded in 1996 and held its 1st annual conference for treatment court personnel in 1999. In 2022, MATCP's 22nd Annual Conference in Lansing, Michigan attracted over 800 treatment court professionals from across the state.

MATCP provides training through its annual conference, Upper Peninsula training, and other educational events; serves as a voice for treatment courts in the state and federal legislature; and works with the public and private sectors on educating and advancing treatment courts and other criminal justice and substance use/healthcare reforms.

MISSION

The mission of the Michigan Association of Treatment Court Professionals (MATCP) is to provide leadership to treatment courts in the State of Michigan.

GOAL

Our goal is to advance the cost savings and lifesaving philosophies of treatment courts: this model of justice succeeds where traditional probation and jail sentences have not.

2022 - 2023
MATCP BOARD OF DIRECTORS

EXECUTIVE COMMITTEE

President: Hon. Jocelyn Fabry, Sault St. Marie Chippewa Tribal Court

Vice President: David Wallace, Chief Assistant Prosecuting Attorney, Huron County

Secretary: Hon. Carrie Fuca, 41B Veterans Treatment Court Presiding Judge

Treasurer: Mark Witte, Executive Director, OnPoint *(formerly known as Allegan County Community Mental Health Services)*

Past President: Alma Valenzuela, Director of Probation & Community Corrections, Ottawa County

2022 - 2023
MATCP BOARD OF DIRECTORS

MEMBERS-AT-LARGE

John Andrews, Michigan Association of Substance Abuse Coordinating Agencies (retired)
Jamaine Atkins, Certified Peer Recovery Coach, Growth Works, Inc.
Alexandra Black, Court Administrator, 52-1District Court, Oakland County
Hon. Robert Cooney, 86th District Court, Grand Traverse County
Hon. Linda Davis (ret.), Families Against Narcotics (F.A.N.) Executive Director
Sheila Day, LMSW, Truism Center
Hon. Susan Dobrich* (ret.), Cass County Probate Court
Hon. John Hallacy, 37th Circuit Court Presiding Judge, Calhoun County
Barbara Hankey*, Oakland County Director of Public Services
Hon. Shannon Holmes, 36th District Court Presiding Judge, Wayne County
Hon. Susan Jonas (ret.), 58th District Sobriety Court Presiding Judge, Ottawa County
Hon. Karen Khalil, 17th District Veterans Court Presiding Judge, Wayne County
Andrea Krause, Prosecuting Attorney, Montcalm County
Hon. Laura Mack (ret.), 29th District Mental Health Court Presiding Judge, Wayne County
Hon. Maureen McGinnis, 52nd District Court Presiding Judge, Oakland County
Hon. Phyllis McMillen*, 6th Circuit Drug Court Presiding Judge, Oakland County
Hon. Geno Salomone* (ret.), 23rd District Sobriety Court Presiding Judge, Wayne County
Hon. Patrick Shannon (ret.), Tribal Prosecutor, Little Traverse Bay Bands of Odawa Indians
Carol Smith, Behavioral Health Director, Catholic Human Services (retired)
Robert Steinhoff, Prosecuting Attorney, Alger County
Patrick Stropes, CPRM, CPRC, RCSS
Brian Wagner, Program Director of Problem-Solving Courts, 65B District Court, Gratiot County

*** Former Board President**

Public Partners

Office of Governor Gretchen Whitmer

Michigan Department of Attorney General

Michigan Department of State

Michigan Department of Health and Human Services

Michigan Department of Corrections

Michigan State Police

Office of Highway Safety Planning

Michigan State Housing Development Authority

Michigan Supreme Court

State Court Administrative Office

Michigan Judicial Institute

Criminal Defense Attorneys of Michigan

Prosecuting Attorneys Association of Michigan

Michigan Judges Association

Michigan District Judges Association

Michigan Probate Judges Association

Michigan Sheriffs' Association

Michigan Association of Chiefs of Police

Community Mental Health Association of Michigan

Michigan State Medical Society

National Association of Drug Court Professionals

National Center for State Courts

Center for Court Innovation

Center for Children & Family Futures

Regional Cross Training

CONNECTING TREATMENT COURTS AND HEALTH PROFESSIONALS

MDHHS Michigan Department of Health & Human Services

Michigan Psychiatric Society

MATCP Michigan Association of Treatment Court Professionals

MOA Michigan Osteopathic Association

MSMS Michigan State Medical Society

Current Legislative Bills We are Tracking

State House & Senate

HB 5340, to create the Family Treatment Court Act. **MATCP SUPPORTS**

Federal

S.2673 Treatment Court, Rehabilitation, and Recovery Act - will replace the Drug Court Discretionary Grant program with more than 30 years of research, codifying best practices, and meeting the current needs of treatment courts. **MATCP SUPPORTS**

Current State Legislative Bills We are Working On

3-Bill Package:

HB 5482 – All **other Treatment Court Violent Offenders** – would amend MCL 600.1066(d); same approach as above. SCAO & PAAM are supportive.

HB 5483 – **Mental Health Court Violent Offenders** – would amend MCL 600.1093(1) to allow violent offenders into MHC by discretion of Judge and Prosecutor after consultation with victim. SCAO & PAAM are supportive.

HB 5484 – **New Felonies Bill** – would amend MCL 600.1074 (2), which provides mandatory termination when participants is convicted of felony after admission into treatment court. New language would allow for judicial discretion to continue the participant in the program. SCAO & PAAM are supportive.

SB 810 – **Mental Health Court/Veterans Court Interlock Program** – would amend MCL 1084 & 257.304. Adds to the existing Ignition Interlock/Restricted License Program. SCAO, PAAM, and MDOS (Sec. of State) are supportive.

State Legislative Successes During 2021-2022 Legislative Session

HB 5512 MMMA/TC bill – as a result of the *People v Thue* CoA decision, this bill amended the Michigan Medical Marihuana Act (MMMA) to remove the TC statutes from control under the MMMA. Required 2/3 vote to pass. Passed the Michigan House of Representatives 87-16 (3 not voting) and passed the Michigan Senate 30-8. It was signed into law on July 25, 2022.

Treatment Court Housing Pilot for Opioid Use Disorder (OUD)/Substance Abuse Disorder (SUD) Participants

The idea for the Housing Pilot arose from the 2016 MATCP Public Partner Summit. Governor Rick Snyder and his staff were supportive of moving this pilot forward.

In 2017, MSHDA created a new class of Permanent Supportive Housing to meet the needs of persons in recovery from OUDs/SUDs. Recovery Housing is a marriage between the Treatment Courts and Permanent Supportive Housing. The target population for Recovery Housing are persons in Treatment Courts with a SUD, with a focus on persons with an OUD. The Treatment Courts refer potential residents to the Recovery Housing community. They continue to make use of their existing treatment service providers and funding, while maintaining oversight and control of the residents through Treatment Court methodology. A key factor of this program is that residents can stay in Recovery Housing for as long as they like. Short term stays in jails, residential facilities or short-term housing do not provide the long-term safety and stability needed to achieve recovery from opioid issues.

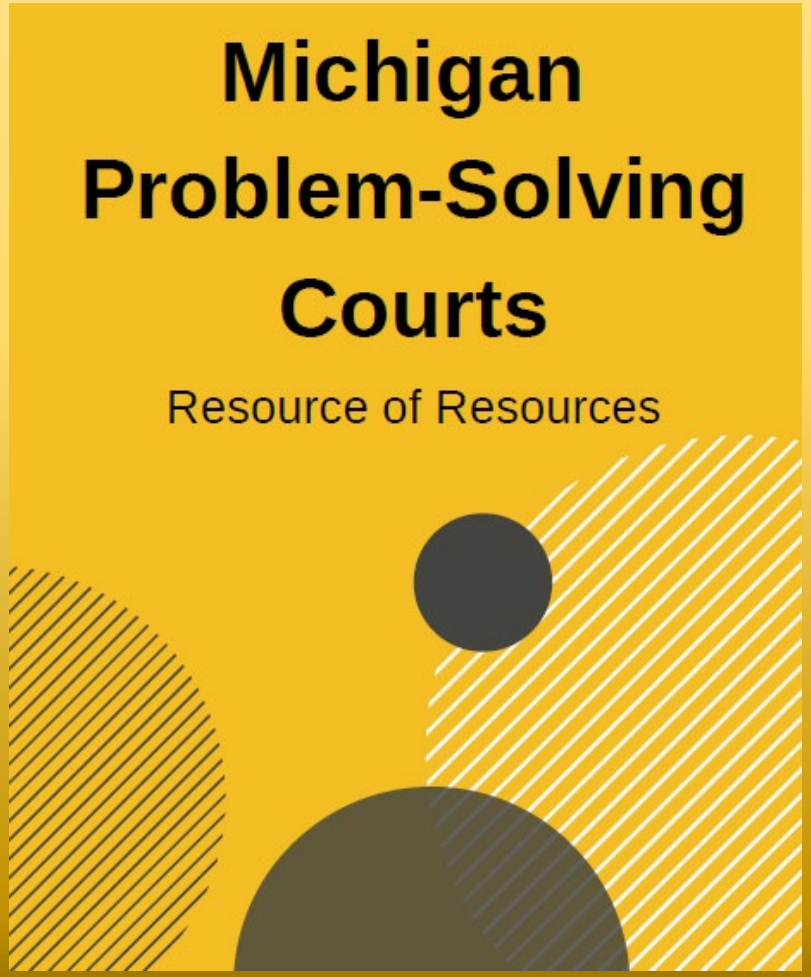
MSHDA sought to develop three Recovery Housing projects as the initial pilot for the program. Andy's Place, a fifty-unit development in Jackson County, invited its first residents in 2021. The second development, which is located in Southfield will have eighty units. It has secured the land, has support from the local government and has submitted its formal application for Low Income Tax Credits. Discussions are ongoing for the third Recovery Housing project to be located in West Michigan (Kent, Ottawa, and Muskegon counties), Southwest Michigan (Kalamazoo) or Mid-Michigan (Midland, Saginaw, Bay, and Isabella counties). Efforts are currently underway to seek support from local community leaders, to begin looking for land and to secure support from local strategic partners.

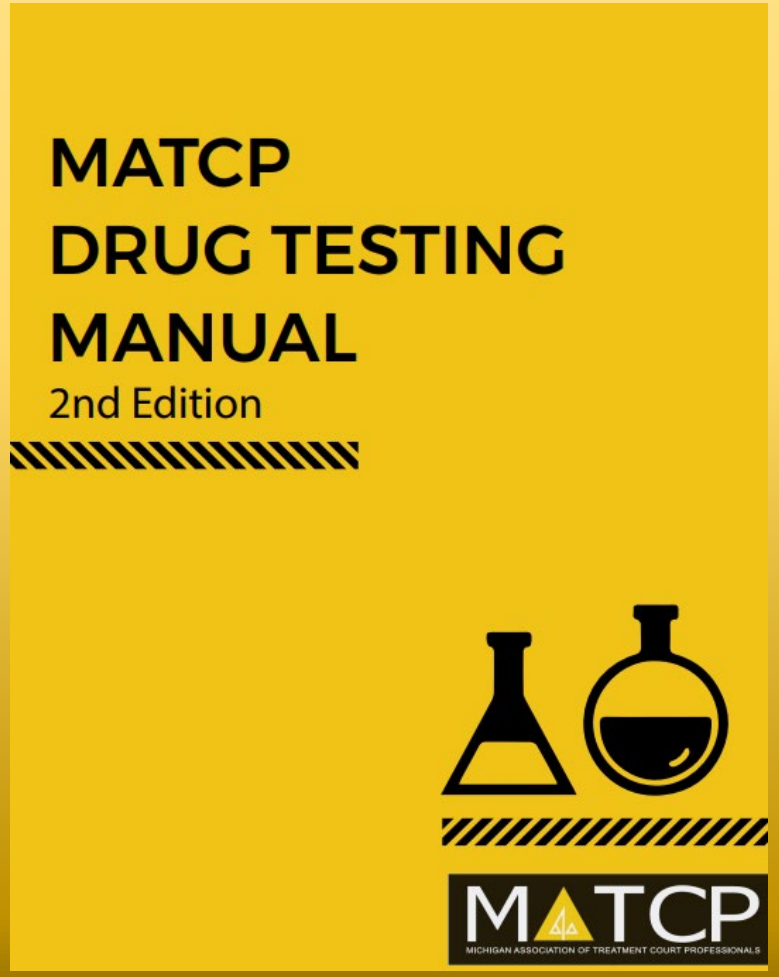
Andy's Place

Jackson, MI

HOUSING PROJECT | MATCP

RESOURCES





Available for download on our website, matcp.org, under Resources, MATCP Resources

EDUCATION

Conference topics include: drug trends & testing; assisted-outpatient therapy for mental health needs; MOUD; trauma-informed practices; motivational interviewing; use of peer recovery coaches; treatment court fundamentals, and more!

MATCP ALSO:

- Travels annually to the U.P. to present to treatment court professionals from the U.P. and upper-lower peninsula.
- Does trainings at the request of courts in Mt. Pleasant, Saginaw, Taylor, Lincoln Park and more.

We are available for informal meetings, community presentations, or a more structured training.

MATCP 23rd Annual Conference
February 28 – March 1, 2023
DeVos Place, Grand Rapids, Michigan

Visit matcpconference.org for more conference information

MATCP
MICHIGAN ASSOCIATION OF TREATMENT COURT PROFESSIONALS

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info@matcp.org
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Kate Hude
Executive Director
kate@matcp.org

Hon. Harvey Hoffman (ret.)
Legislative Director
judgehoffman@gmail.com

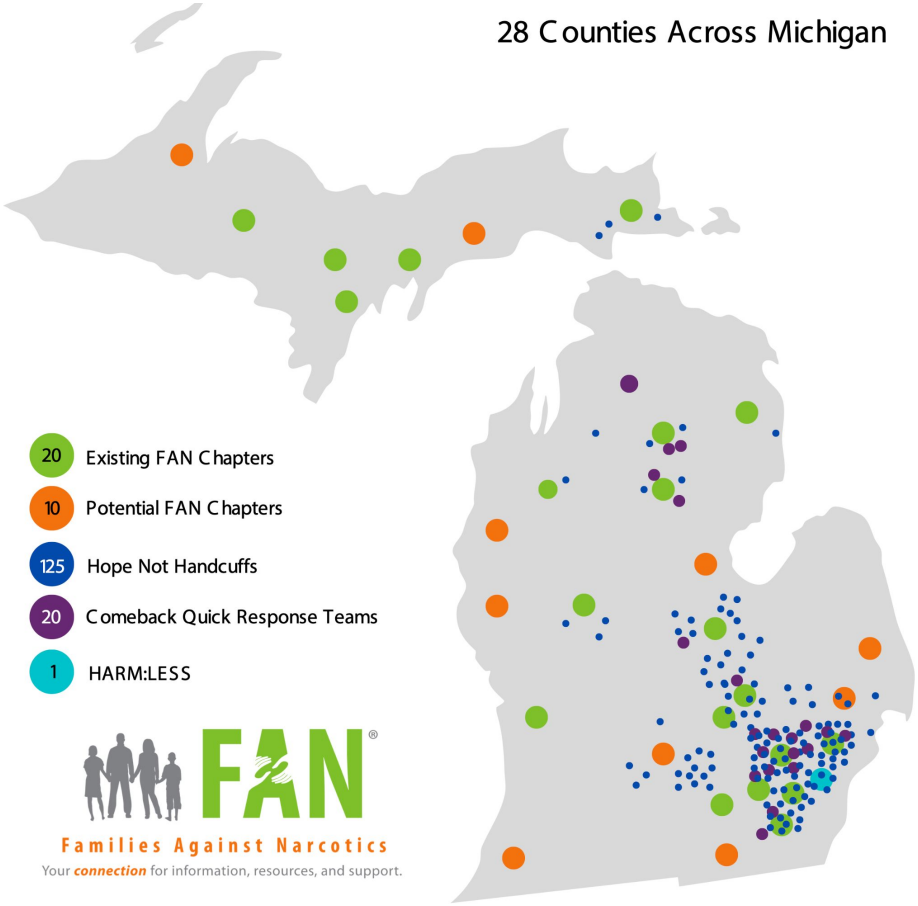
OAC Final Meeting Minutes
December 8, 2022

FAN®

Families Against Narcotics

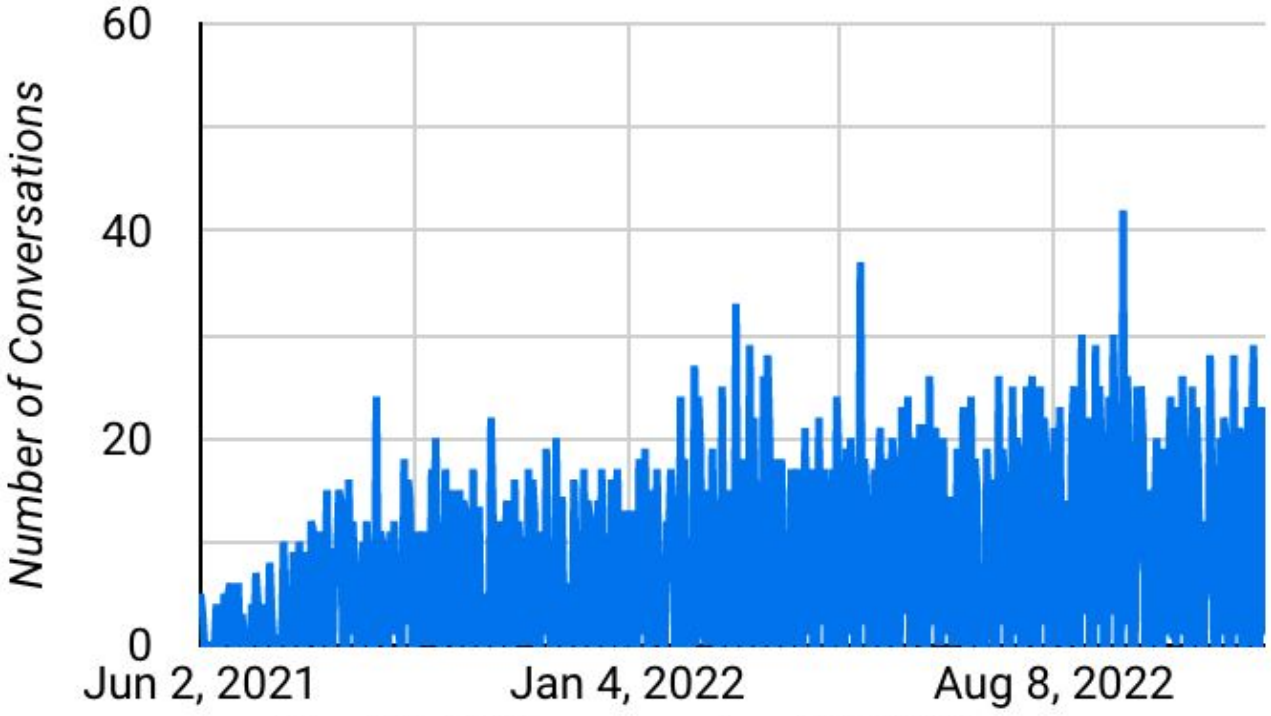
Your ***connection*** for information, resources, and support.

28 Counties Across Michigan



HARM:LESS
Harm Reduction Support Team

STARTED: **June 2021**
TOTAL CONVERSATIONS: **3,805**
NUMBER OF INDIVIDUALS: **766**



HARM:LESS
Harm Reduction Support Team

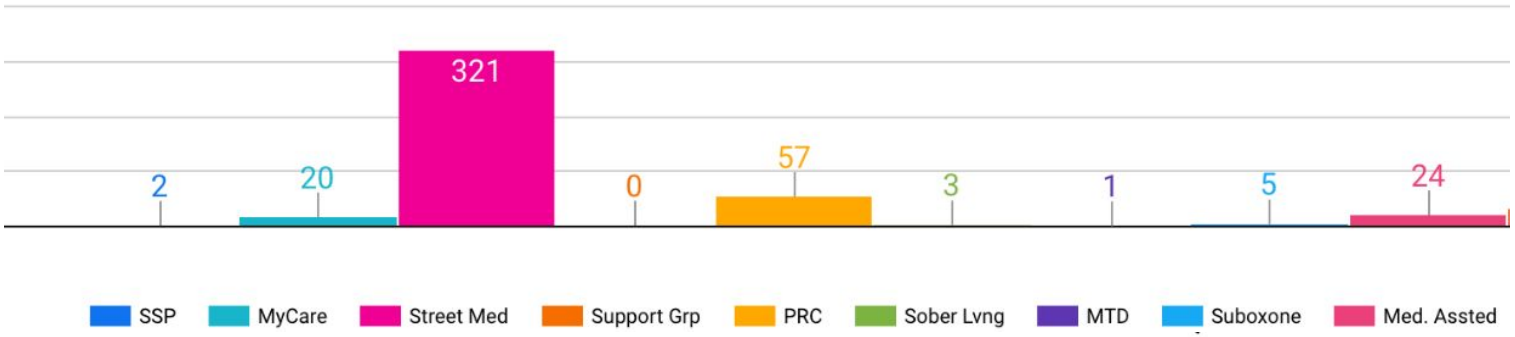
51.74%

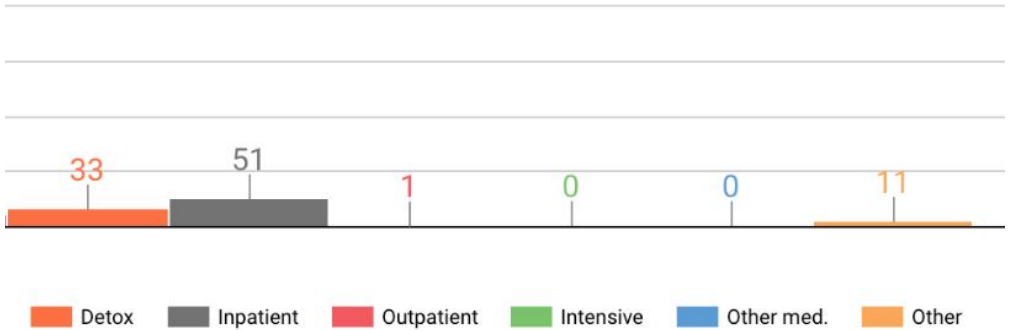
of individuals experienced homelessness in the last

7 days

HARM:LESS
Harm Reduction Support Team

SERVICES REFERRED TO:

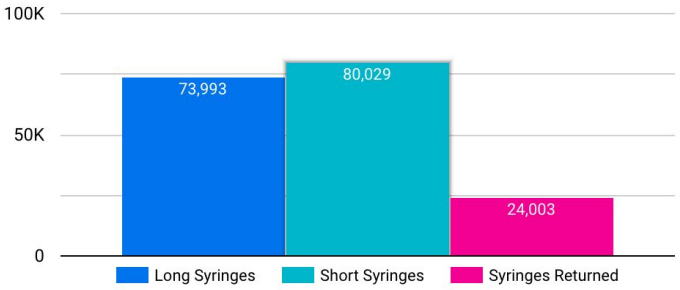




HARM:LESS
Harm Reduction Support Team

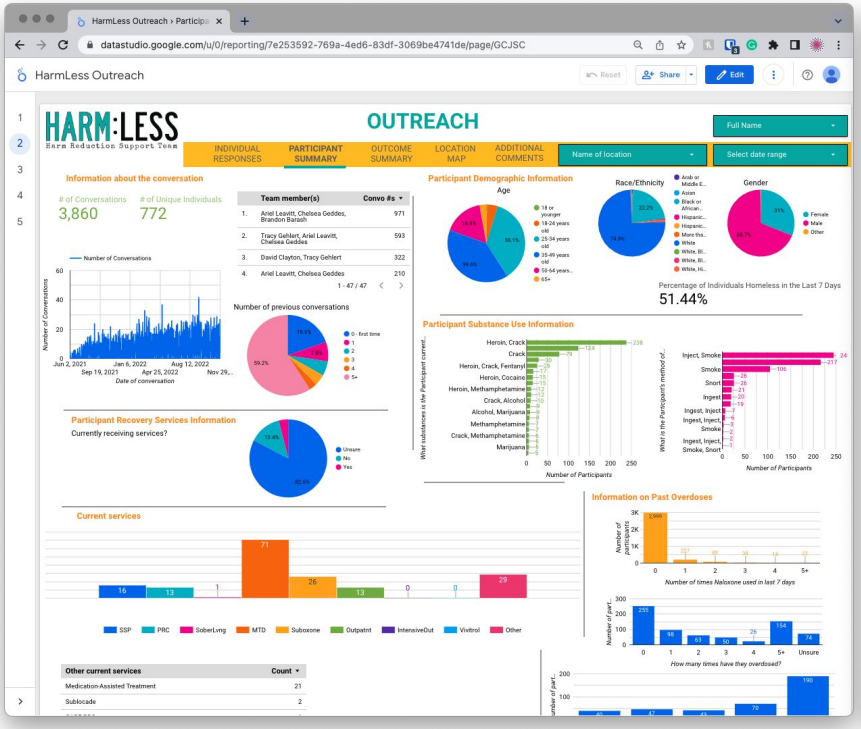
HARM REDUCTION SUPPLIES:

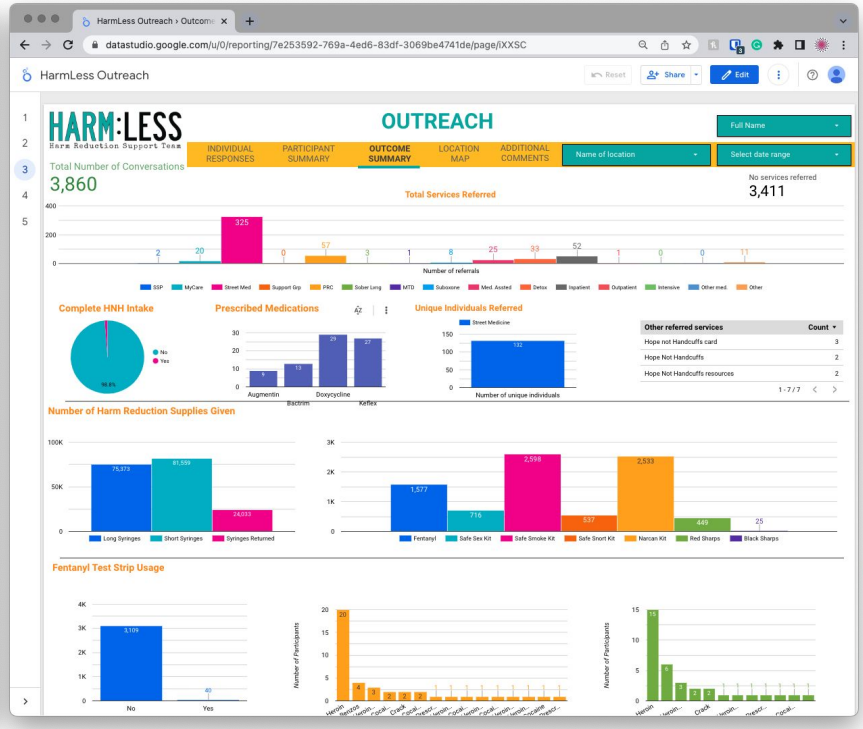
^ STARTING 11/2/22



OAC Final Meeting Minutes
December 8, 2022

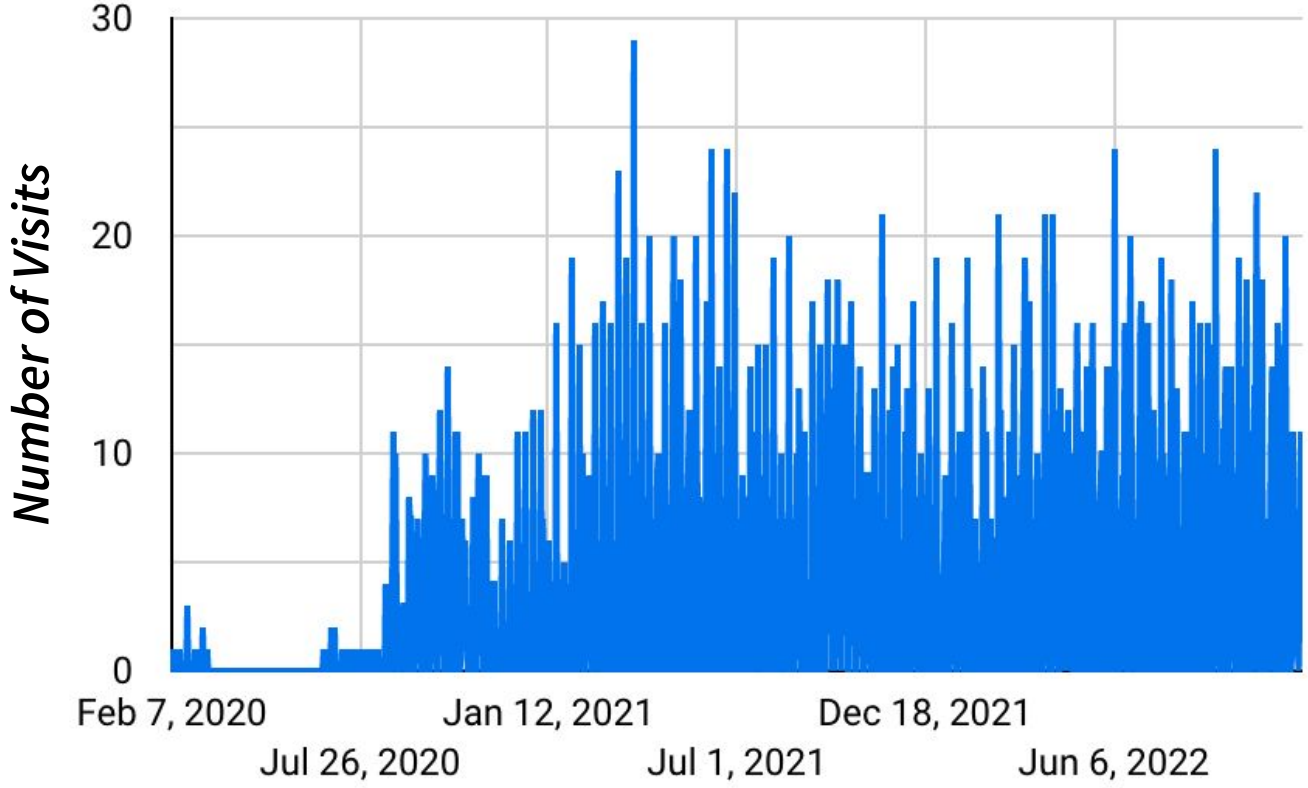
HARM:LESS
Harm Reduction Support Team





COMEBACK
POST OVERDOSE WELLNESS CHECK
AN INITIATIVE OF FAMILIES AGAINST NARCOTICS

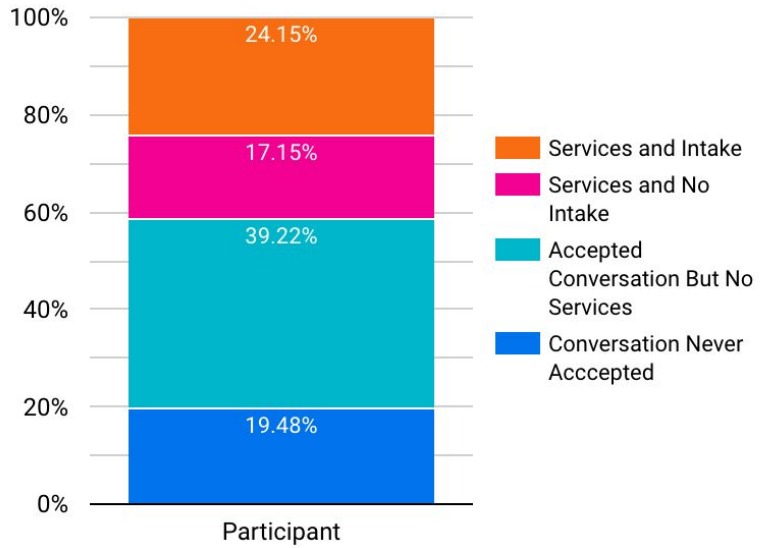
STARTED: **February 2020**
TOTAL VISITS: **3,882**
UNIQUE HOUSEHOLDS: **2,347**



COMEBACK
POST OVERDOSE WELLNESS CHECK
AN INITIATIVE OF FAMILIES AGAINST NARCOTICS

IMPACT:

Summary of participant outcomes
(for each participant when door is answered)



Services Signed Up For:

PRC	472	29.76%
FRC	327	20.62%
Detox Facility	60	3.78%
Residential Facility	78	4.92%
Outpatient Facility	47	2.96%
Intensive Outpatient	14	0.88%
Medication-assisted treat.	14	0.88%
Support Group	14	0.88%
REDIRECT	4	0.17%

COMEBACK
POST OVERDOSE WELLNESS CHECK
AN INITIATIVE OF FAMILIES AGAINST NARCOTICS

STUDIES ON FAN'S COMEBACK DATA:

WESTERN MICHIGAN UNIVERSITY

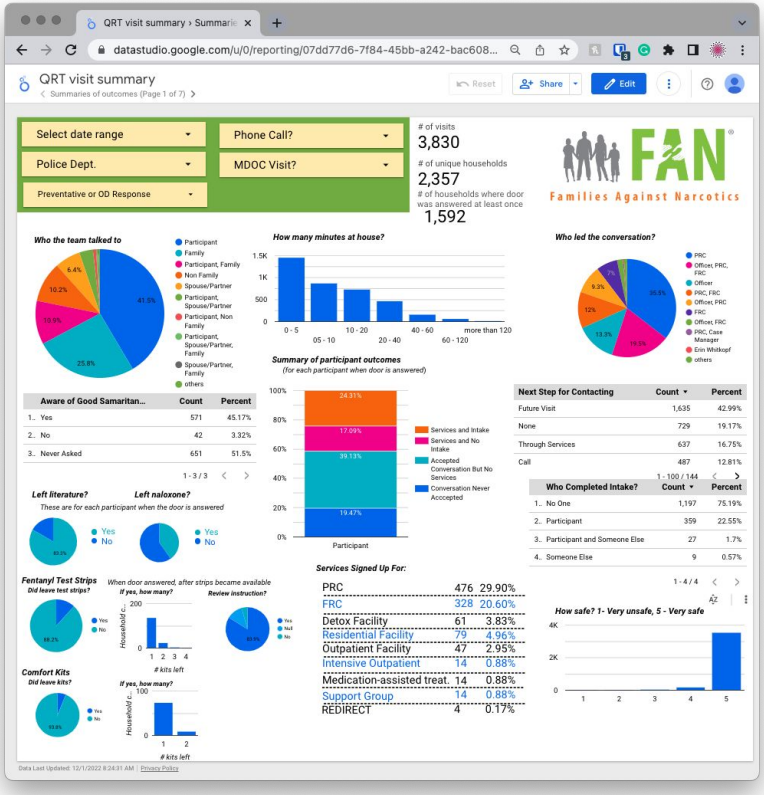
data bloom

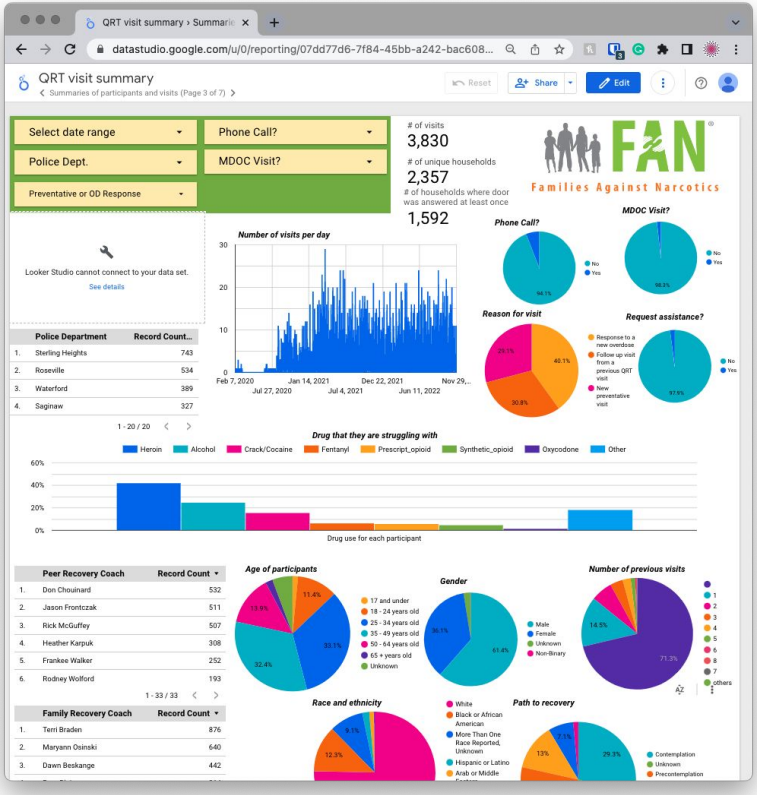
ADDITIONAL STUDIES ON OTHER PROGRAMS:

MICHIGAN

WAYNE STATE UNIVERSITY

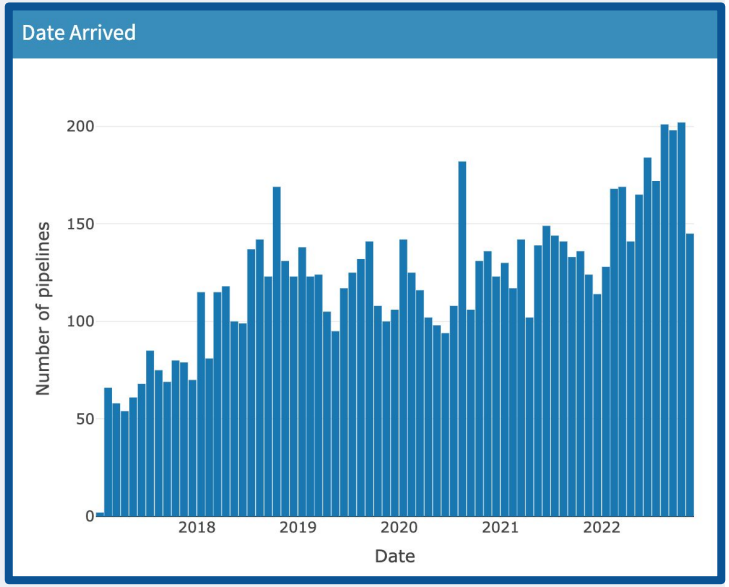
COMEBACK
POST OVERDOSE WELLNESS CHECK
AN INITIATIVE OF FAMILIES AGAINST NARCOTICS

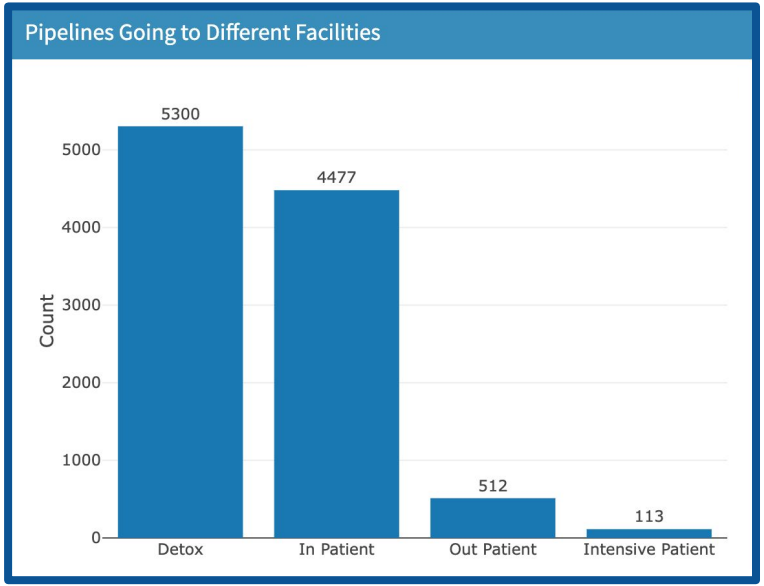




HOPE not HANDCUFFS

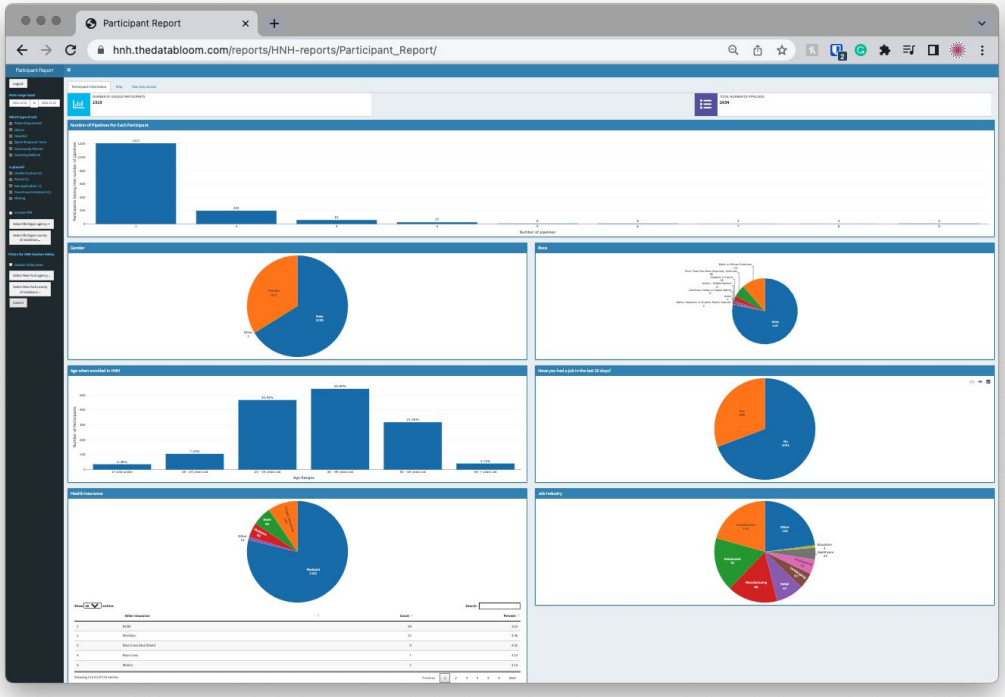
STARTED: **January 2017**
TOTAL PIPELINES: **8,564**
TOTAL PARTICIPANTS: **5,153**

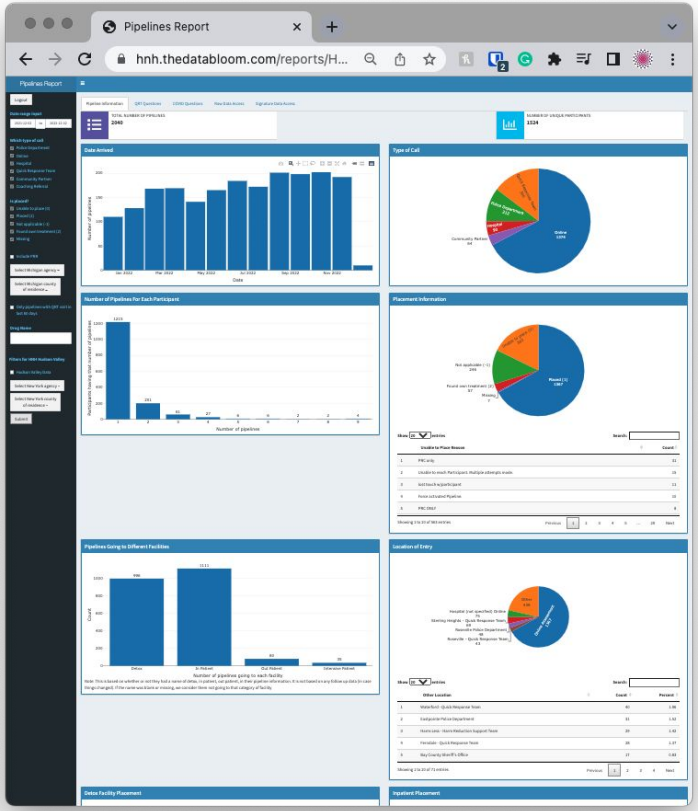




OAC Final Meeting Minutes
December 8, 2022

HOPE not HANDCUFFS





NAVIGATE
peer & family recovery coaching services

PRC

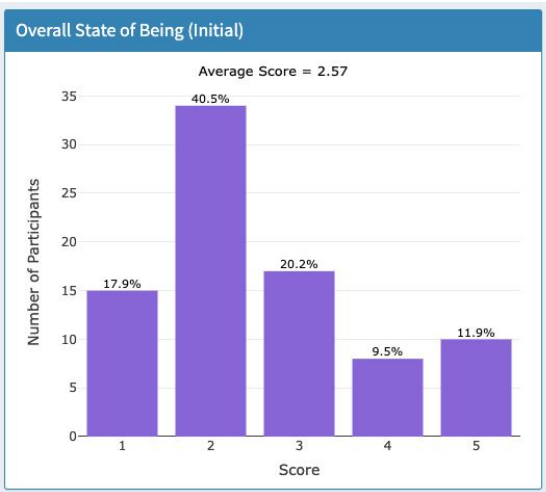
STARTED: **MARCH 2019**
TOTAL CASES: **8,292**

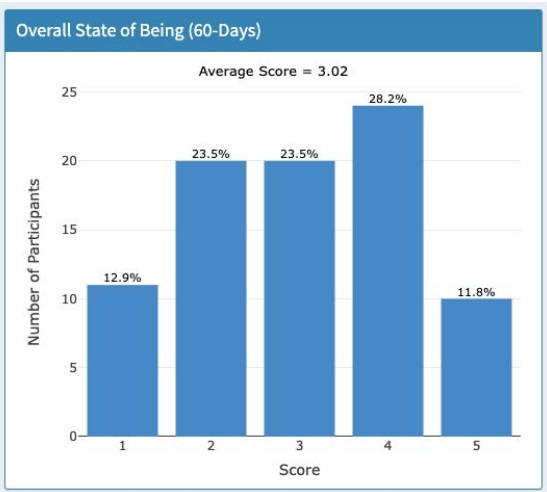
AVERAGE MONTHLY CASES: **800**
AVERAGE NUMBER OF COACH INTERACTIONS: **34**

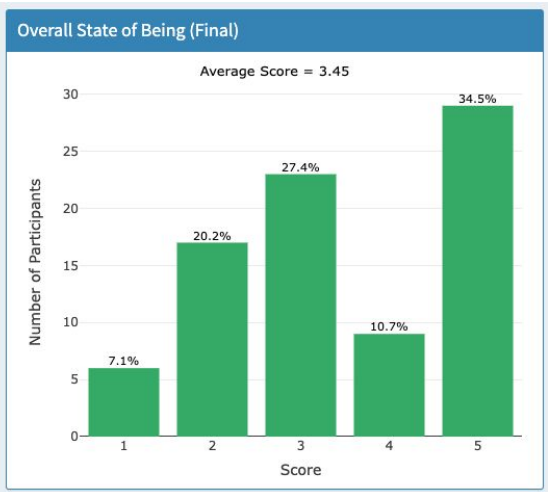
The University of Michigan did an analysis and concluded:
“Peer Recovery Coaches are highly valuable and effective in the recovery process, as witnessed by the analyses.”

NAVIGATE
peer & family recovery coaching services

PRC





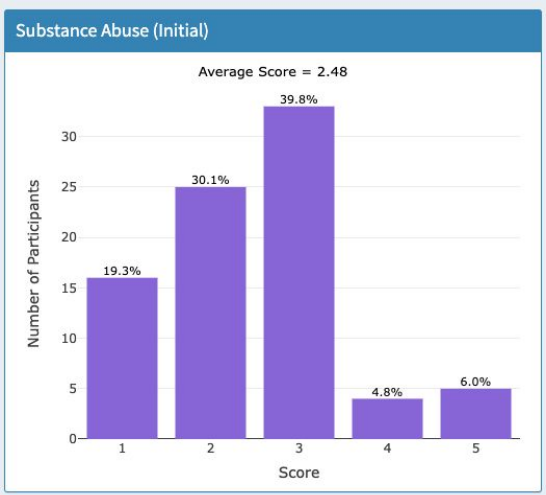


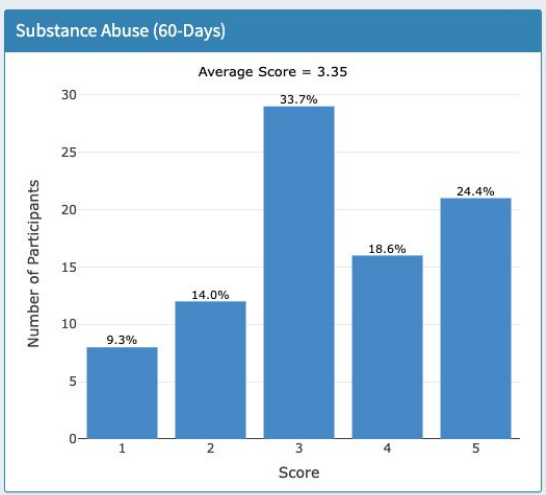
1- Low
5- High

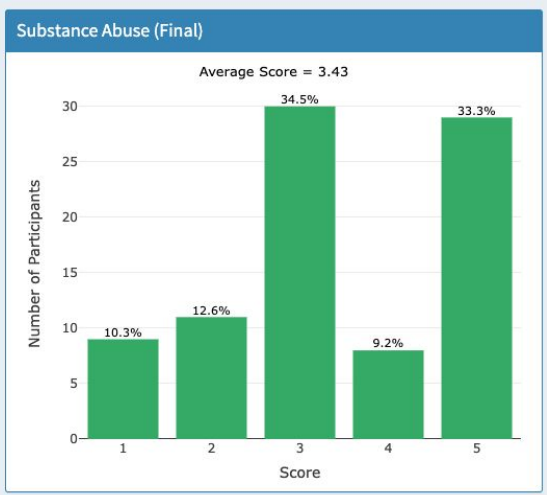
SELF SUFFICIENCY MATRIX

NAVIGATE
peer & family recovery coaching services

PRC





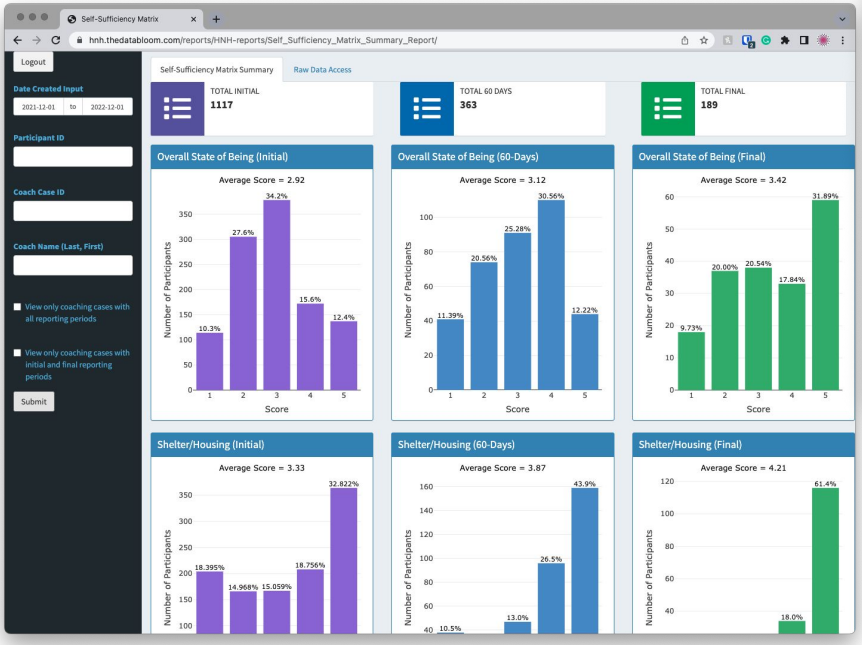


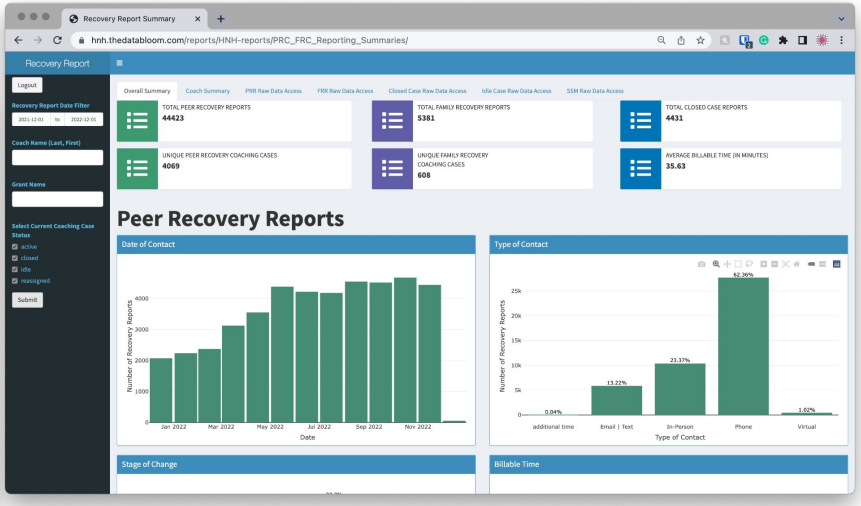
1- Meets Criteria For Severe Abuse/Dependence
2- Meets Criteria For Dependence
3- Drug Use Within 6 Months; Evidence Of Persistent Use
4- Drug Use Within 6 Months, But No Evidence Of Persistent Use
5- No Drug Use/Alcohol Abuse In Last 6 Months

SELF SUFFICIENCY MATRIX

NAVIGATE
peer & family recovery coaching services

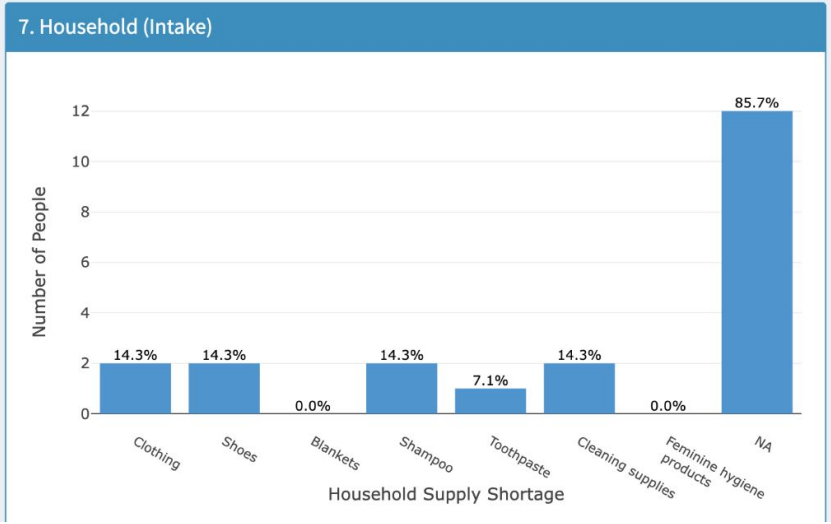
PRC

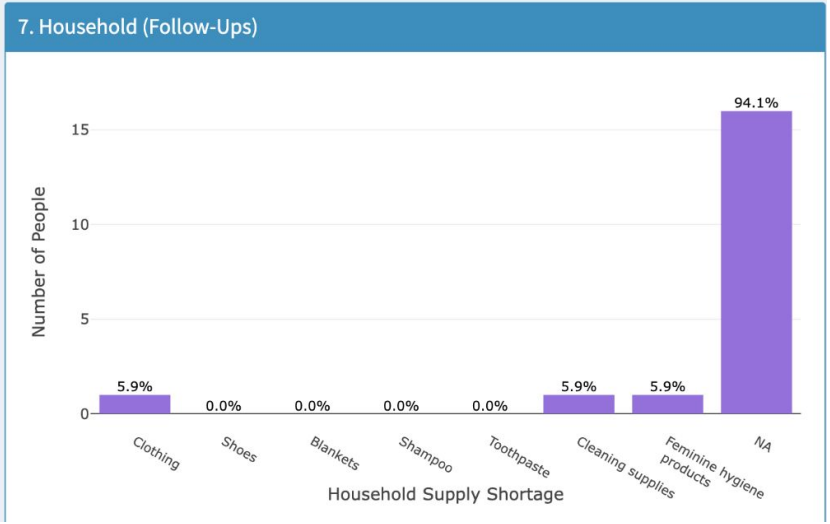




NAVIGATE
peer & family recovery coaching services

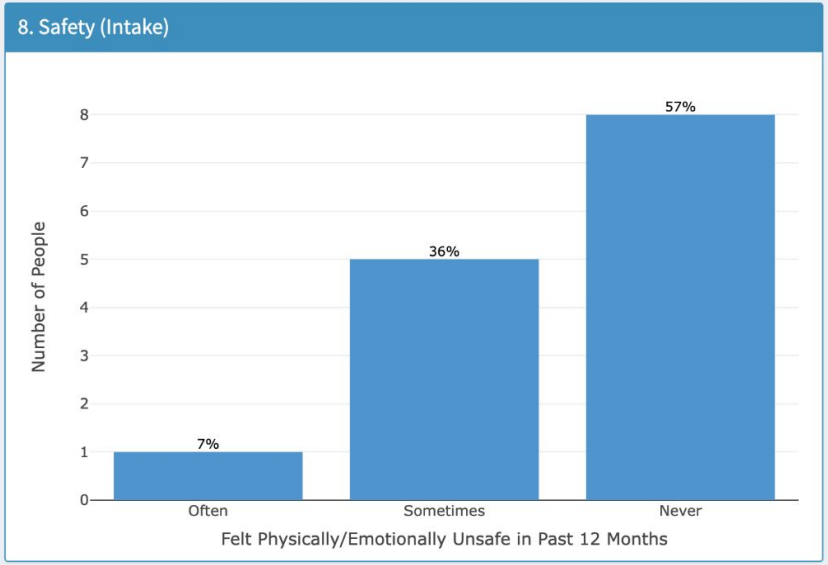
Needs Inventory

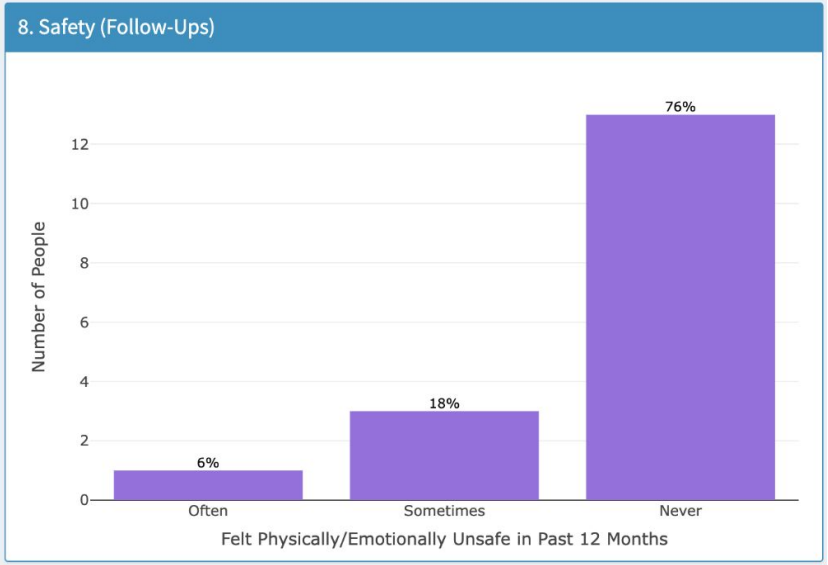




NAVIGATE
peer & family recovery coaching services

Needs Inventory

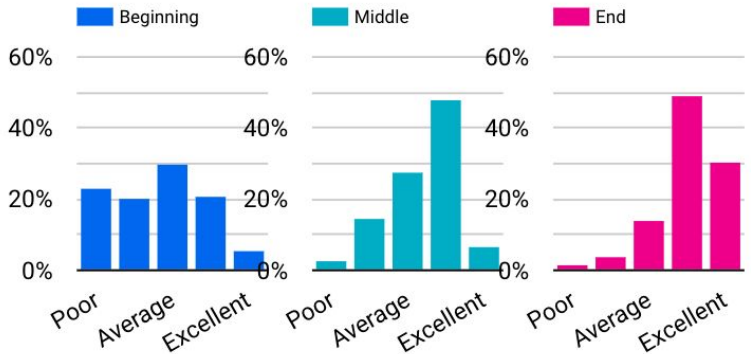




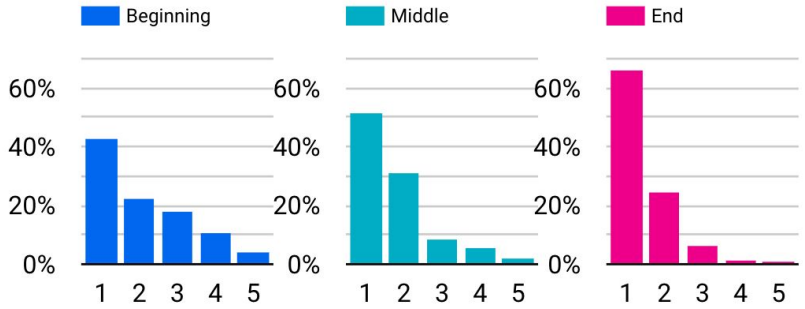
NAVIGATE
peer & family recovery coaching services

FRC

STARTED: **NOVEMBER 2019**
TOTAL CASES: **1,577**
COACHES ON STAFF (ON AVERAGE): **30**



Rate your ability to set and maintain healthy boundaries between yourself and your loved one
Poor, Fair, Average, Good, Excellent



I feel responsible for my loved one's addiction
1 - Strongly disagree, 5 - Strongly agree

NAVIGATE
peer & family recovery coaching services

FRC

STARTED: **NOVEMBER 2019**
TOTAL CASES: **1,577**
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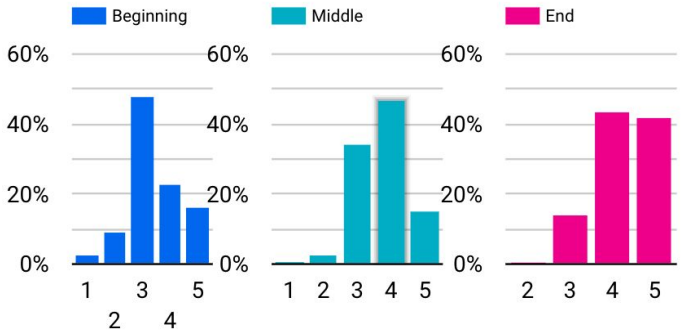
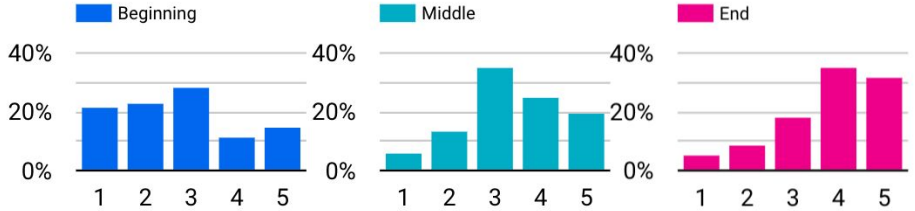


How harmful or helpful are you to your loved one's recovery from addiction?
1 - Very Harmful, 5 - Very Helpful

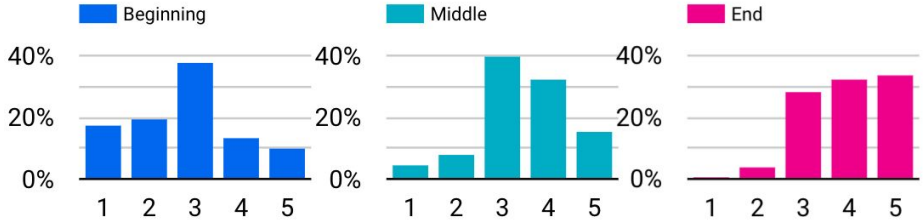
Social Interaction

1. I have little interest in social interaction outside my own family.
3. I have increased interest in social activities and events.
5. I am maintaining or enlarging my social network.



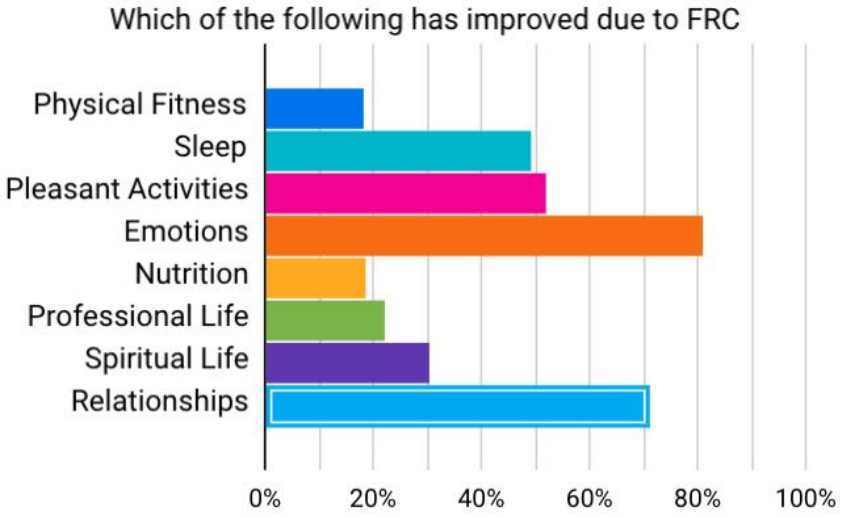
Self-care

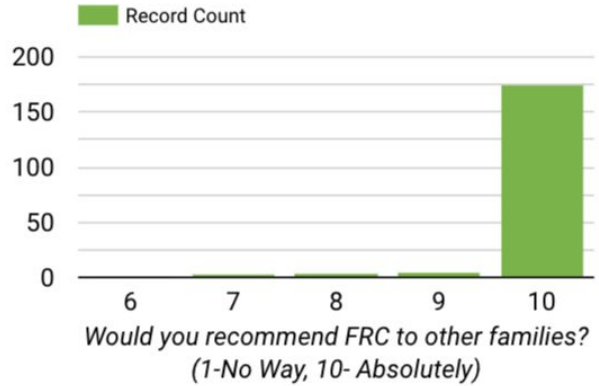
1. I am neglecting self-care. I have poor habits.
3. My self- care is improving but is not consistent.
5. My self-care habits are now part of daily routine



NAVIGATE
peer & family recovery coaching services

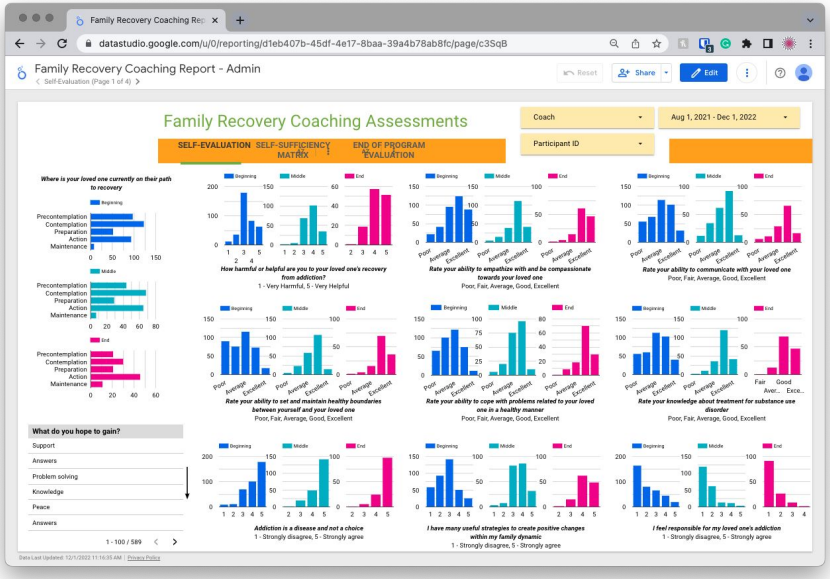
FRC

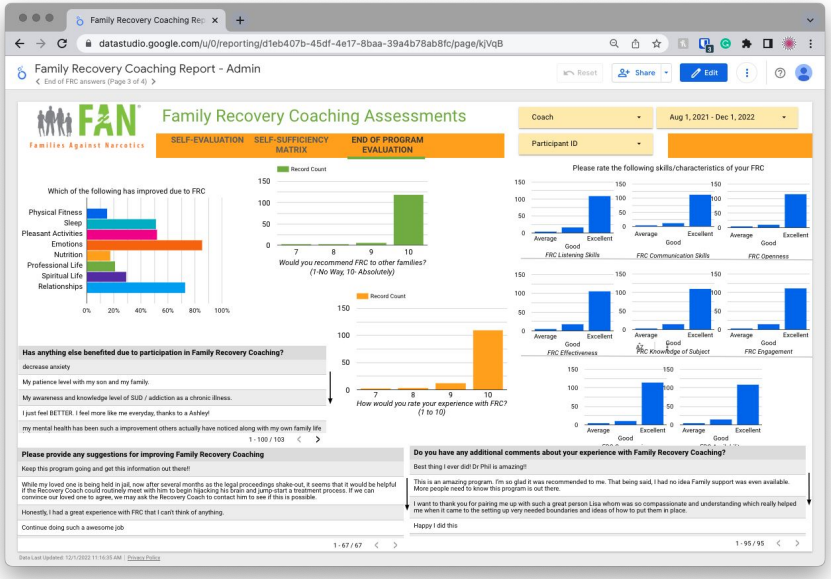




NAVIGATE
peer & family recovery coaching services

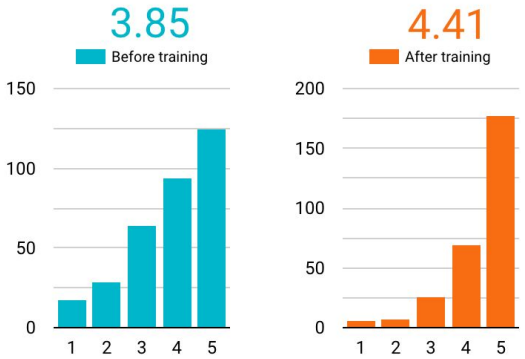
FRC



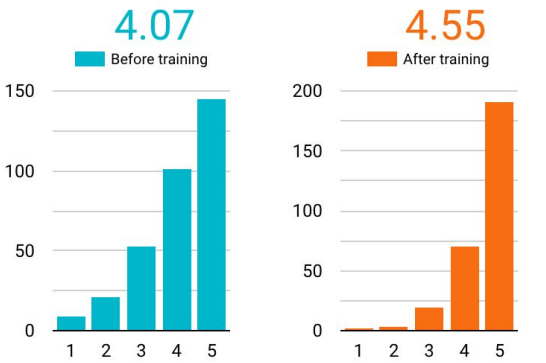


Families Against Narcotics
Your connection for information, resources, and support.

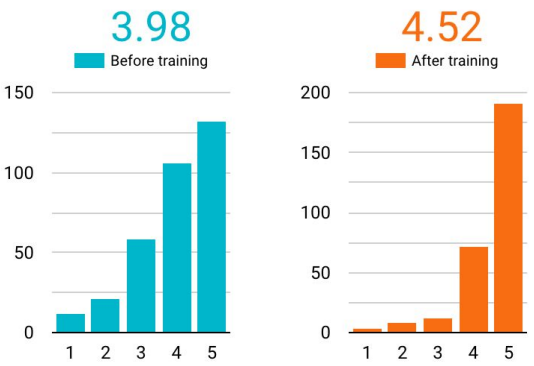
POLICE TRAININGS



Addiction is a disease and not a choice.



I feel sympathy and compassion towards individuals struggling with addiction.



It is important to accept that drug use is part of our world and to work to minimize the harmful effects rather than ignore or condemn them.

1- Strongly Disagree
5- Strongly Agree

SOBER LIVING SCHOLARSHIPS

STARTED: **MARCH 2020**
TOTAL NUMBER OF SCHOLARSHIPS: **2,385**
TOTAL DOLLAR AMOUNT GIVEN: **$518,913**

TOTAL AMOUNT OF TIME LIVING IN FACILITY: **4,686 WEEKS**
Equivalent to **90 years**

naloxone TRAINING
opioid overdose reversal

STARTED: **SEPTEMBER 2019**

Number of Trainings:

731

Number of Kits Distributed:

11,883

RE DIRECT
ADDICTION RELATED DIVERSION PROGRAM
An Initiative of Families Against Narcotics

STARTED: **OCTOBER 2022**

Number of Referrals:

65

Number of Face-to-Face Meetings:

142

STRONGER TOGETHER
Family & Friends: An Addiction Support Group

STARTED: **JANUARY 2018**

Number of People Served:

1,761

Number of Meetings:

210

CRAIN'S DETROIT BUSINESS

November 02, 2022 08:00 AM

Adolescent addiction recovery site will serve those without insurance

SHERRI WELCH

The Adolescent Addiction Recovery Center opened in late October at Children's Hospital of Michigan-Troy.

Children's Foundation and Children's Hospital of Michigan physicians group University Pediatricians have teamed up to open an outpatient substance abuse treatment site for adolescents.

The Adolescent Addiction Recovery Center opened in late October at Children's Hospital of Michigan-Troy in donated space on the second floor to provide counseling for youth 13-18 years old who are suffering from addiction to alcohol or drugs.

The center has more than $1.5 million in commitments from Children's Foundation and Delta Dental of Michigan.

The center is already seeing referrals and a lot of calls from as far away as Hurley Medical Center in Flint as news of its opening spreads word-of-mouth, said Mark Harrison, chief administrative officer and chief operations officer of University Pediatricians, which is operating the center. He expects the center to get referrals from parents, pediatricians, school systems and emergency departments in the region.

Substance use disorders continue to plague our society and the kids of the region, he said.

"We're taking a different approach in that we're providing treatment to anyone, regardless of their ability to pay," with backing from local funders, Harrison said.

Children's Foundation covered the $150,000 in costs to convert the space from a clinical area to counseling and office space and rounded up about $500,000 in annual funding for the next three years. That support includes a one-year grant from Delta Dental of Michigan

and three-year commitments from its own endowment and two funds under its umbrella: the Jamie Daniels Foundation and Georgie Ginopolis Endowed fund.

"The need is so great. Kids are dying every day because of this problem. We're helping solve it or at least save lives," said Larry Burns, president and CEO of Children's Foundation.

Operations

Dr. Matt LaCasse, a child and adolescent psychiatrist specializing in addiction and the lead psychiatrist at Children's Hospital of Michigan, will serve as director of the new center.

Local interest in launching a clinic dedicated to adolescent substance use brought LaCasse back to Michigan from Colorado last year.

"Like most areas in the country, there is an enormous need for adolescent substance use services here in Metro Detroit and Michigan," he said.

However, few places in Michigan treat adolescent addiction, and many that do are off-shoots of adult programs. They might provide psychotherapy but struggle with more severe cases when an adolescent psychiatrist or addiction psychiatrist is needed, he said.

The new Troy clinic is modeled after other adolescent recovery centers around the country, taking some of the best things from each, he said.

An old saying in the addiction world is, "'The opposite of addiction is connection," said LaCasse, who is also an assistant professor in the Central Michigan University College of Medicine. "Addiction is often a very isolating disease. Even when using with other people, as adolescents and young adults often do, the result is isolation."

Matthew LaCasse

The clinic's psychotherapy will focus on empowering youth to make actions that bring them closer to their values and the things they care about and building connectedness with themselves, their families and those around them, LaCasse said. The clinic will also provide treatment for psychiatric issues that often accompany substance use, including anxiety and depression.

The clinic is not set up for in-patient detox treatment, but patients (especially those struggling with fentanyl and other opioid addictions) will have access to life-saving medications, and the center will work closely with clients and families to support detox and make referrals to in-patient treatment sites when needed, he said.

"In the future, we plan to continue to expand our reach by getting involved in schools and elsewhere; along with building our programming and building higher levels of care such as a residential program here in Michigan."

Funding from the foundations will help cover the costs of staff, including two therapists and an office manager, and provide a pot of money for uncompensated care. If further operating support is needed beyond year three, the foundation will find it, Burns said.

"I'm very confident that we can raise additional funds from additional resources — families, individuals, foundations — because the problem is so broad, and something needs to be done," he said.

In 2020, 281,000 people aged 12 and older needed treatment for illicit drug use but did not receive it, and 508,000 individuals aged 12 and older needed treatment for alcohol use but did not receive it, according to the governor's office.

"Given what we've seen locally in Southeast Michigan and across the state, there is room for many more providers, and with the impact of COVID — growing alcohol sales, trauma, lack of coping skills, the need is only going to increase," said Kelli Dobner, chief advancement officer at Detroit-based Samaritas, which provides research- and evidence-based substance use disorder and vaping treatment for adolescents, among other programs.

Inline Play
