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MICHIGAN DEPARTMENT OF HEALTH
AND HUMAN SERVICES

Opioid Settlement Prioritization Survey 2021–22

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CENTER FOR HEALTH
AND RESEARCH
TRANSFORMATION

2929 Plymouth Rd, Ste 245,
Ann Arbor, MI 48105
734 998-7555
chrt-info@umich.edu

CHRT.ORG

MDHHS
Michigan Department of Health & Human Services

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Opioid Settlement Prioritization Survey 2021–22

EXECUTIVE SUMMARY

In 2019, opioid overdoses killed 1,768 Michiganders, an average of almost five people every single day. In August 2019, Governor Gretchen Whitmer announced the creation of a task force to align and coordinate departmental efforts to fight the opioid epidemic in the state of Michigan.

The Michigan Opioids Task Force outlined five key values to guide the work, which included both prioritizing voices with lived experience and using data to inform strategy.

In line with these Task Force values, the Opioid Settlement Prioritization Survey 2021-22 sought to systematically gather data to understand priorities for settlement funding among respondents across Michigan, including individuals with lived experience, to inform strategies to address the opioid epidemic across the state.

Survey Results 2021–22

Between November 2021 and January 2022, over 1,000 respondents across Michigan completed a survey of priorities for opioid settlement funding dollars.

- Respondents represented at least 78 of 83 counties, though 23% of respondents did not identify a county of residence. All 10 of the prepaid inpatient health plan (PIHP) regions had survey representation.
- Most respondents (97%) identified an organization affiliation, while only 3% responded as an individual /unaffiliated.
- About one-third (32%) of respondents had lived experience with substance use, and about half of those with lived experience (i.e. 16% of all respondents), identified as being in recovery.
- Eleven percent (11%) of respondents identified as a racial minority, with an additional 9% of respondents choosing not to identify their race, and 80% identifying as Caucasian or white.

Key Priority Findings

The top three priorities overall among respondents surveyed in the Opioid Settlement Prioritization Survey 2021–22 align with the MDHHS 2021 Opioid Strategy (Figure 1), which includes long-term recovery support, prevention, and increased treatment capacity especially for medications to treat opioid use disorder (MOUDs).

Top three priorities overall among survey respondents

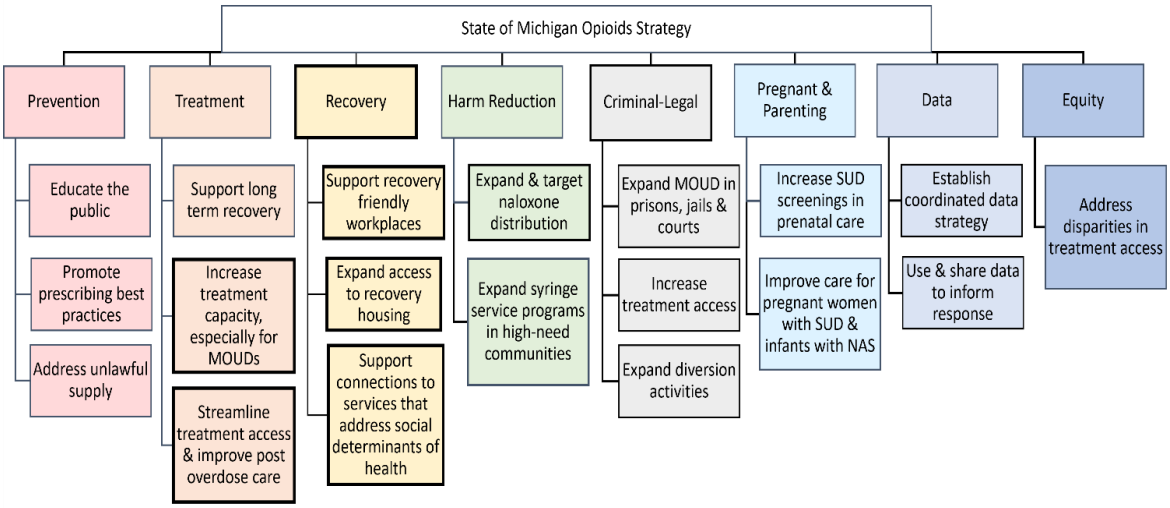
1. Recovery support services were most likely to be chosen as the overall top priority, with 36% of survey respondents identifying it as their top overall priority for settlement funding.
    - Residential treatment programming was the most commonly chosen support service with 24% of respondents including it as the top priority for treatment and recovery support services.

- Individuals with co-occurring mental health diagnoses, and/or other substance use disorders were the most frequently selected priority population/community for treatment and recovery support services, selected by 41% of respondents.

2. Prevention programming ranked second overall, selected by 19% of respondents as the overall top priority.
   - Prevention programs in K-12 schools (28%), training for first responders in programming to connect at-risk individuals with services and supports (27%), and medical provider education and outreach around opioid prescribing best practices (25%) were most commonly prioritized in the category of prevention programming.
3. Expanding access to medications to treat opioid use disorder (MOUD) and other opioid-related treatment ranked third overall, selected by 16% of respondents as the overall top priority.

Figure i

The State of Michigan Opioid Strategy strategic pillars: 1) prevention, 2) treatment, 3) recovery, 4) harm reduction, 5) criminal-legal involved populations, 6) pregnant and parenting women and new mothers, 7), data, and 8) equity.



Opioid Settlement Prioritization Survey 2021-22

Background

In 2019, Michigan and many of its municipalities filed lawsuits against numerous corporations in the opioid industry. While settlement negotiations regarding some of these lawsuits are ongoing, the State of Michigan is currently drafting legislation that would establish a fund for these resources. This opioid settlement fund would be used to support Michigan-based substance use treatment services and to address the harm created by the opioid epidemic.

In late 2021, the Michigan Department of Health and Human Services contracted with the Center for Health and Research Transformation (CHRT) to analyze results from a survey of key Michigan respondents about the best ways to use opioid settlement dollars within state and federal guidelines.

Recognizing that addressing each facet of the opioid crisis is critically important, the survey was informed by those priorities in federal settlement funding strategies Exhibit E (see appendix I) to elicit feedback as to what options respondents prioritize. The survey questions and response options were based on both the federal settlement funding strategies of Exhibit E, as well as the state's Opioid Strategy strategic pillars. Where noted, respondents were also able to write-in "other" priorities that were not included as selection options.

Methods

The Opioid Settlement Prioritization Survey 2021-22 (see appendix III for survey instrument) was fielded online between October 13, 2021, and January 17, 2022. A snowball sampling method was implemented by emailing a survey link to 45 organizations with the option to complete the survey in one of three languages (English, Spanish, or Arabic). Primary survey takers were then asked to share the survey with others. This "snowball sampling" method allowed MDHHS to access respondents that are hard to reach using conventional survey methods.

To be included in the final sample, survey respondents had to reside in the state of Michigan and must have responded to at least one of the survey's priority questions; that is, one response of substance, in order to be counted in the final sample. A total of 1,040 survey respondents were included in the final sample out of 2,009 who accessed the survey, for a response rate of fifty-two percent (52%).

Survey data were analyzed using SPSS statistical software and qualitative themes analyses. Unless otherwise noted, significant differences where the observed values differ from values expected by chance are significant at $p<.01$.

About Survey Respondents

Overall, the Opioid Settlement Prioritization Survey 2021-22 was most successful in reaching respondents affiliated with organizations (97%), and less so reaching individuals or those unaffiliated with an organization (3%). The survey was more successful reaching females (64%), which may reflect the higher proportion of women in medical and social service occupations, compared to reaching males (29%), and the survey was much more successful reaching those ages 25-64 (89%), which may also be a reflection of the high workforce/organizational representation of survey respondents. Within organizational roles, there was balance between those in leadership roles (28%) and staff roles (33%).

The survey had some success in reaching those with lived experience and in the recovery community with sixteen percent (16%) of respondents identifying as being in recovery. The survey had less success reaching Black or African American respondents[1] (7%) but did achieve input from those identifying as Native American[2] (2%) at a higher rate that the overall Michigan population. Nine percent (9%) of respondents did not disclose a race, so the actual respondent representation by race is unknown.

[1] Black or African American includes those respondents who may have also selected another race. Selections were not mutually exclusive.
[2] Native American includes those who may have selected both Native American and white.

Table 1

Respondent organizations[3]

SURVEY RESPONDENTS BY ORG TYPE	%
Substance use service provider	20%
Health care professional	17%
Mental health service provider (including PIHPs)	10%
Harm reduction and/or prevention service provider	9%
Local government (including local health department)	7%
Social service agency	7%
Judiciary/courts	6%
Academic/research institution	5%
State government or Tribal government	4%
Law enforcement/first responder	4%
Advocacy	4%
K–12 Education or early childhood	3%
Individual/self	3%
Faith-based institution	1%
OTHER (e.g. manufacturing, foundation/ philanthropic, etc)	1%

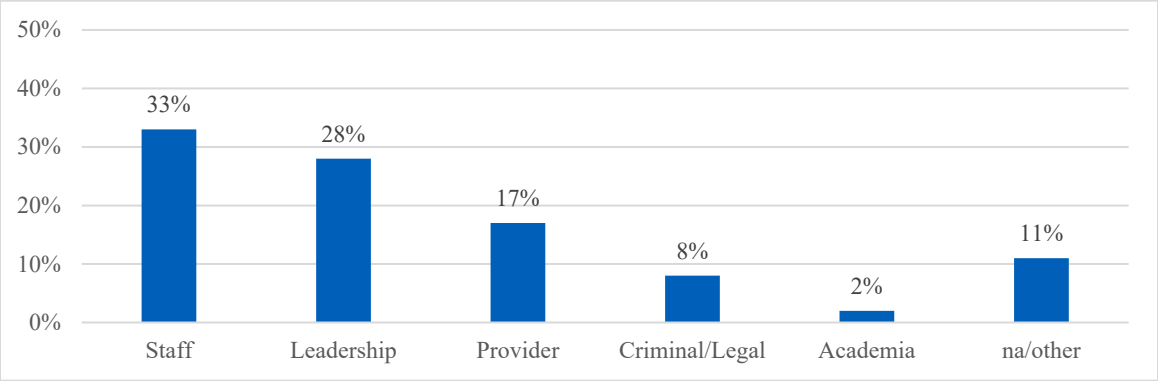
An overwhelming majority of survey respondents (97%) indicated that they were affiliated with an organization and responding in a professional capacity. Thirty percent (30%) of respondents in total indicated that they worked in either a mental health (MH) or substance use (SUD) service organization (MH/SUD organization). An additional nine percent (9%) indicated that they worked in harm reduction or prevention.

[3] Organization types were selected from a survey list. Those who selected 'other' but whose description was a clear fit for an existing category were aligned to that list category.

Roles within organizations

Figure 1

Many survey respondents were staff members, followed by leaders, then health care providers including mental health providers.

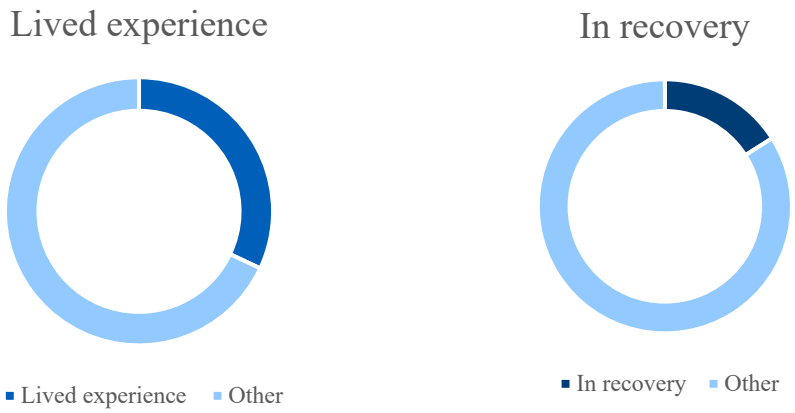


Staff roles included coordinators, specialists, managers, supervisors, administrators, etc. Leadership roles included directors, executives, etc. Provider roles included physicians, nurses, therapists, etc. Criminal/legal roles included sheriffs, first responders, jail administrators, judges, etc, Academia included professors, students, etc. N/A/other included those whose roles were indicated as 'n/a', as well as philanthropists, teachers, pastors, etc.

Experience with substance use

Figures 2 and 3

Many of the survey respondents had lived experience with substance use (32%), and about half of those with lived experience identified as being in recovery (16%).

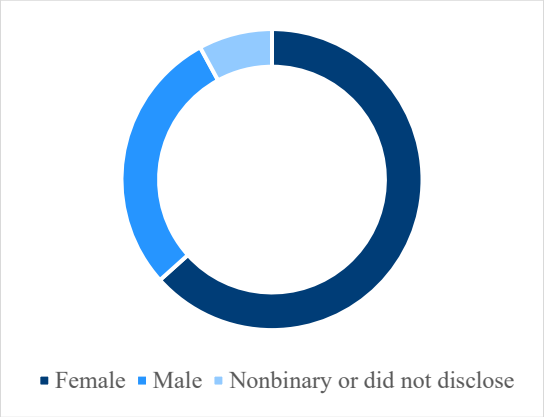


Note: Lived experience includes those who have personal experience with substance use/ in recovery, but can also include someone who counsels folks with substance use disorder, parents of those with SUD, etc. Recovery is more commonly associated with those who have had direct personal experience with substance use and/or addiction.

Gender identity

Figure 4

Two-thirds of survey respondents were female.



The proportion of females in the survey may be high because the survey was sent to many health and social service organizations, which have a higher percentage of female employees.

Race[4]

Table 2

Eighty percent of survey respondents identified as white.

Race category	%
Caucasian or white	80%
Black or African American	7%
American Indian	2%
Asian	1%
Middle Eastern or North African	1%
'Other'	1%
Prefer not to answer	9%

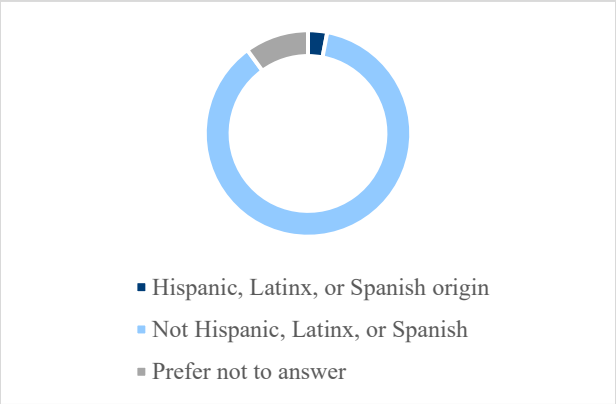
About eighty percent (80%) of the survey sample identified as white or Caucasian, which is a similar proportion to the State of Michigan; however, the survey sample also had nine percent (9%) of respondents who preferred not to answer, so the actual respondent characteristics may differ. Note that the percent total does not equal 100% due to rounding.

[4] Black or African American includes those who also indicated another race; Native American includes those who also indicated both Native American and Caucasian or white; Asian includes those who indicated Southeast Asian, East Asian, and South Asian.

Ethnicity

Figure 5

Three percent of survey respondents identified as of Latinx, Hispanic, or Spanish origin.



Three percent (3%) of survey respondents identified as of Latinx, Hispanic, or Spanish origin, including Mexican, Mexican American, or Chicano.

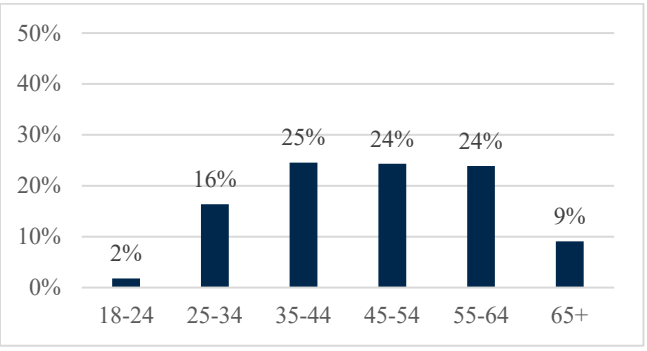
Eighty-seven percent (87%) identified as not being of Latinx, Hispanic, or Spanish origin, including Mexican, Mexican American or Chicano.

Ten percent (10%) of the sample preferred not to answer.

Age

Figure 6

Survey respondents by age.



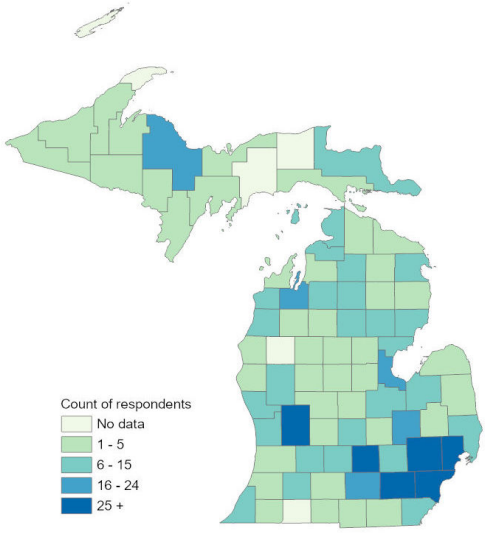
Eighty-nine percent (89%) of survey respondents reported being between the ages of 25 and 64.

This may reflect the fact that the survey was fielded predominantly among professionals.

Geography

Figure 7

Survey respondents by county

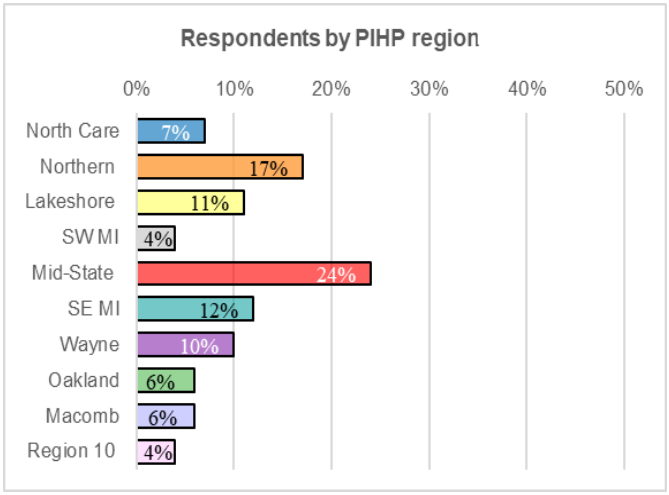


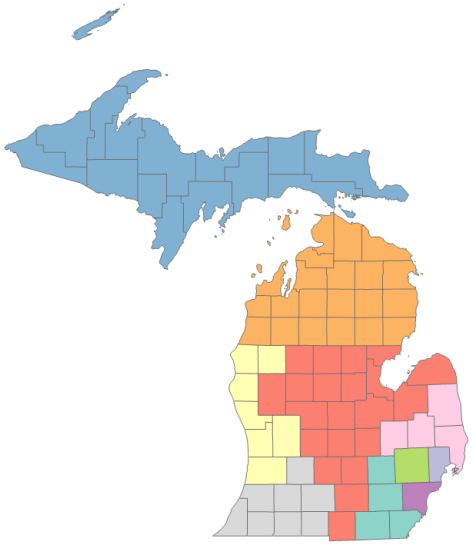
Respondents represented 78 of 83 counties across Michigan; however, about twenty-three percent (23%) of respondents did not select a county. Respondents did not indicate residence in Keweenaw, Lake, Luce, St. Joseph, or Schoolcraft counties.

Respondents who indicated a county of residence on the survey were mapped to their Michigan Prepaid Inpatient Health Plan (PIHP) Region (Figure 8)

Figure 8

Mapping respondents to PIHP regions





Survey Findings: Priority Ranking

Priority response options included in the survey were reflective of both the MDHHS Opioid Strategy (figure i), as well as options from the federal list of core strategies for opioid remediation uses (see Exhibit E in Appendix I). The order of response options appearing in the survey for each priority area was randomized to reduce order bias, i.e. the tendency to select the first or last items in a list.

Top priorities overall for opioid settlement funds

Priorities most frequently ranked as the number one priority were:

1. Recovery support services, including peer support and wrap-around services for individuals with substance use disorder and co-occurring mental health diagnoses.
2. Prevention programming.
3. Expanding access to medications used to effectively treat opioid use disorder (MOUD) and other opioid-related treatment.

Survey question 1

Which of the following priorities is most important for the investment of opioid settlement funding?

Settlement Funding (Overall)	
Priority Category	% ranked #1
Recovery support services, including peer support and wrap-around services for individuals with substance use disorder (SUD) and co-occurring mental health diagnoses	**36%**
Prevention programming	**19%**
Expanding access to medications used to treat opioid use disorder (MOUD) and other opioid-related treatment	**16%**
Support for pregnant and post-partum women affected by substance use, as well as infants with neonatal abstinence syndrome	**9%**
Naloxone distribution and training	**7%**
Treatment for incarcerated population	6%
Syringe service programs (SSP)[5]	4%
Research and evaluation of abatement strategies	3%
Total	100%

[5] People who use drugs (PWUDs) that access SSPs are 3-5 times more likely to engage in substance use disorder treatment, and to remain engaged with treatment, compared to PWUDs not accessing SSPs. This reduces the number of treatment episodes per individual, and therefore the cost burden on public and private insurance providers.

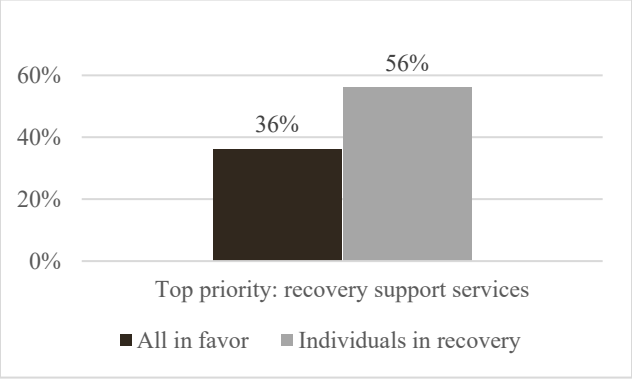
Notable differences in overall settlement funding priorities.

Respondents who identify as being in recovery were more likely to prioritize recovery support services. Interestingly, academic roles were much more likely to prioritize MOUD compared to overall. There were also differences by age, role, organization type, and PIHP region. (See Appendix II for more details).

Individuals in recovery

While 36% of all respondents were in favor of funding recovery support services, **individuals in recovery (57%)** were even more likely to favor recovery support services (Figure 9)

Figure 9

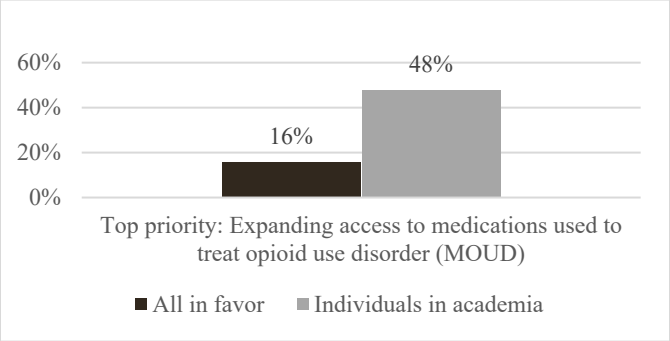


Individuals in academic roles and/or academic/research organizations

While 16% of all respondents were in favor of expanding access to MOUD, respondents in **academic roles (48%)** were more likely to be in favor (Figure 10).

Respondents who work in **academic or research organizations** were also more likely to prioritize support for pregnant and post-partum women affected by substance use, and infants with Neonatal Abstinence Syndrome (NAS) (15%) compared to respondents overall (9%).

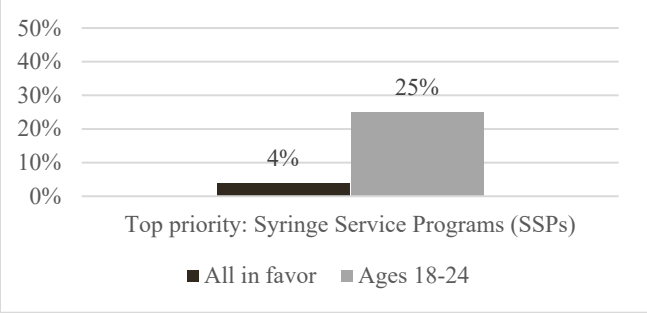
Figure 10



Respondents aged 18-24 years old

Overall, 4% of respondents ranked syringe service programs (SSPs) as their top priority, however **individuals aged 18-24 (25%)** were even more likely to support syringe service programs as a top priority (Figure 11).

Figure 11



PIHP regions

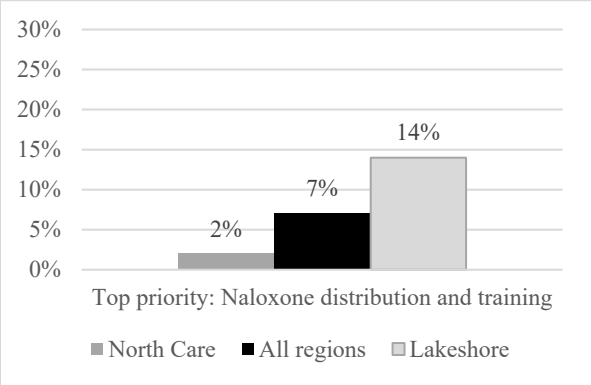
Overall, nine out of 10 PIHP regions shared the same top priority of recovery support services, with only **Oakland** ranking prevention as a higher priority. Six out of the 10 PIHPs' top three priorities included the overall top three priorities of recovery support services, prevention programing, and expanded access to MOUD.

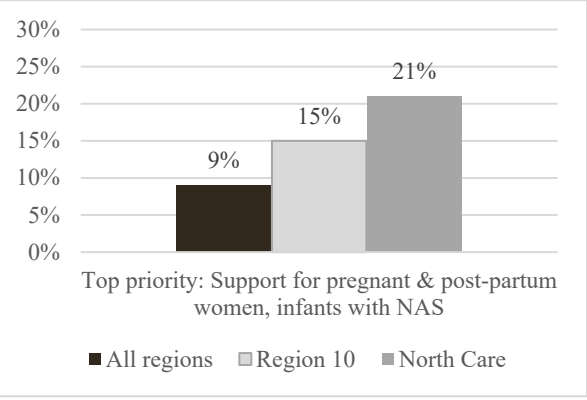
Naloxone distribution and training was the top priority for 7% of respondents, but was the top priority for 14% of those in **Lakeshore** region and only 2% of those in the **North Care** region (Figure 12). .

Syringe Service Programs (SSPs) were prioritized by 4% of respondents overall, but by 14% of those in the **Lakeshore** region.

Support for pregnant and post-partum women, infants with NAS was prioritized by 9% of respondents, but more commonly prioritized by those in the **North Care** region (21%) and the **Region 10 PIHP** (15%) (Figure 13)

Figures 12 and 13





Settlement Priorities by Priority Category

In addition to overall settlement priorities, the survey also asked about priorities within five categories: 1) prevention, 2) treatment and recovery support, 3) harm reduction, 4) population/community, and 5) data and evaluation. Notable differences in priorities are highlighted below. (See Appendix II for more details).

Prevention programming

Prevention priorities most frequently ranked as the number one priority were:

1. Evidence based prevention programs in K-12 schools.
2. Training for first responders on programming to connect at-risk individuals with services and supports.
3. Medical provider education and outreach around prescribing best practices.

Survey question 2

Which of the following prevention activities is most important to fund?

Prevention Programming Priorities	
Activity	% ranked #1
Evidence-based prevention programs in K–12 schools	**28%**
Training for first-responders on programming to connect at-risk individuals with services and supports	**27%**
Medical provider education and outreach around opioid prescribing best practices	**25%**
Media campaigns to prevent substance misuse	5%
Community drug disposal programs	2%
"Other"^	13%
Total	100%

^Many write-ins for "other" reinforced priorities already listed, other priority write-ins included family supports/'break the cycle', address source of the problem, and public health education including reducing stigma.

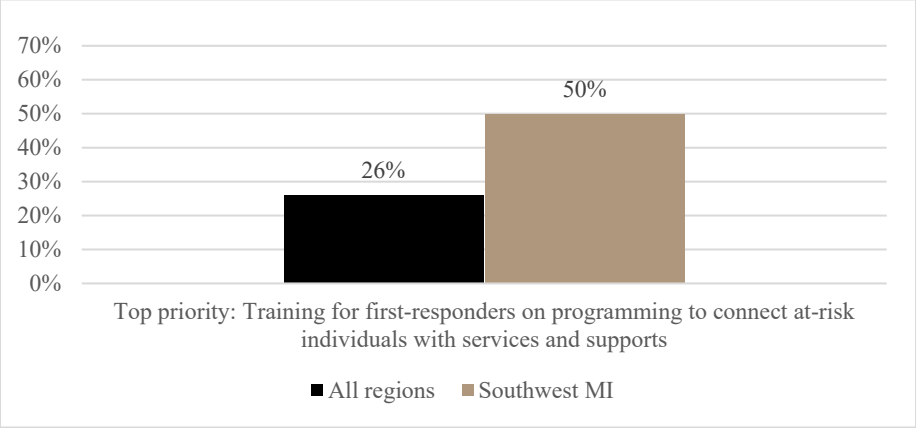
Notable differences in prevention programming priorities

Overall the top three prevention priorities were fairly consistent. The biggest differences were by PIHP regions and organization types. (See Appendix II for more details).

PIHP region

Overall, 26% of respondents ranked training for first responders on programming to connect at-risk individuals with services and supports as their top priority, however respondents in **Southwest Michigan Behavioral Health PIHP** Region were more likely to support this priority (50%) (Figure 14).

Figure 14



Treatment and recovery support services

Treatment and recovery support priorities most frequently ranked as the number one priority were:

1. Residential/inpatient programming.
2. Wrap-around service programs to address spectrum of social factors (transportation, housing, employment, etc.).
3. Access to medications used to treat opioid use disorder, including methadone, buprenorphine, and naltrexone.

Survey question 3

Which of the following treatment and recovery support services is most important to fund?

Treatment and recovery support services	
Service	% ranked #1
Residential / inpatient treatment programming	24%
Wrap-around service programs to address spectrum of social factors (transportation, housing, employment, etc.)	20%
Access to medications used to treat opioid use disorder, including methadone, buprenorphine, and naltrexone	19%
Care-coordination services to facilitate warm-handoffs into community-based services from inpatient or other institutional settings	10%
Recovery housing	8%
Outpatient treatment programming	8%
Peer support services	7%
"Other"^	5%
Total	100%

Table total varies due to rounding.
^Write-ins for 'other' included involving employers in treatment and recovery, addressing ACES, addressing social determinants of heath, and recovery community organizations (RCOs).

Notable differences in treatment and recovery support service priorities

Differences across race and ethnicity were common in treatment and recovery priorities and priorities also differed based on recovery status. Significant differences were also seen by age, role, and organization type. (See Appendix II for more details).

Individuals in recovery

Those in recovery were slightly less likely to prioritize access to MOUD (13%) compared to respondents overall (20%), and were more likely to prioritize peer supports (13%) compared to 6% of all respondents.

Native American respondents

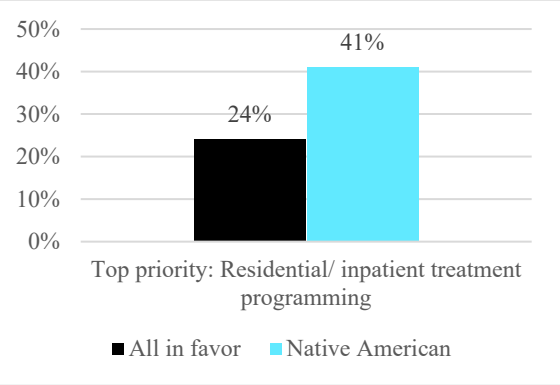
While overall support for residential / inpatient treatment programming was high at 24%, **individuals who identify as Native American** (41%) were much more likely to support residential / inpatient treatment programming. (Figure 15)

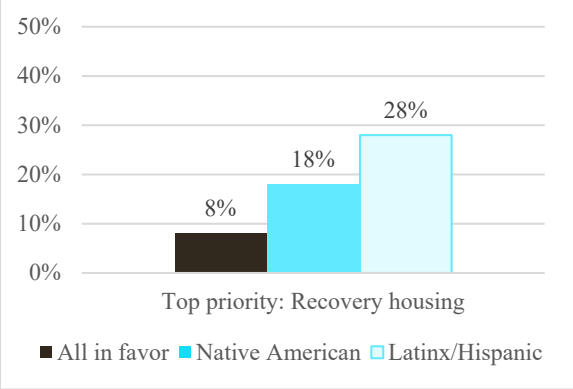
Native American respondents were also more likely to prioritize recovery housing (18%) compared to respondents overall (8%) (Figure 16)

Of Latinx, Hispanic, or Spanish origin

Overall, 8% of respondents ranked recovery housing as their top priority. Support for recovery housing was higher among and **individuals who identify as of Latinx, Hispanic, or Spanish origin** (28%) (Figure 16)

Figures 15 and 16

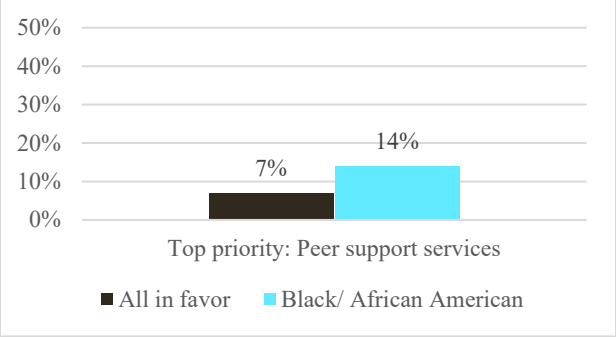




Black or African American respondents

Overall, 7% of respondents ranked support for peer support services as their top priority, however **individuals who identify as Black or African American** (14%) were more likely to favor peer support services (Figure 17).

Figure 17



Population / community priority for treatment and recovery support services

Population/ community priorities for treatment and recovery support services most frequently ranked as the number one priority were:

1. Individuals with co-occurring mental health diagnoses or other substance use disorders.
2. Pregnant and post-partum women.
3. Rural communities.

Survey question 4

Which of the following populations/communities is most important to prioritize with funding for treatment and support services?

Population/Community Priority for Treatment and Support Services	
Population/Community	% ranked #1
Individuals with co-occurring mental health diagnoses or other substance use disorders	41%
Pregnant and post-partum women	13%
Rural communities	13%
Communities where the majority of residents are racial/ethnic minorities	11%
Infants with Neonatal Abstinence Syndrome (NAS)	10%
Individuals incarcerated in jails and prisons	8%
"Other"^	5%
Total	100%

Table total varies due to rounding
^Write-in for "other" population most commonly included youth, and communities with the highest rates of SUD.

Notable differences in population /community priority for treatment and support services

Differences among PIHP regions occurred in population/community priorities. Significant differences were also apparent across role and organization type in particular around the priorities of communities where the majority of residents are racial/ethnic minorities, infants with NAS, and individuals

incarcerated in jails and prisons. There were also differences in priorities by race and ethnicity. (See Appendix II for more details).

PIHP Region

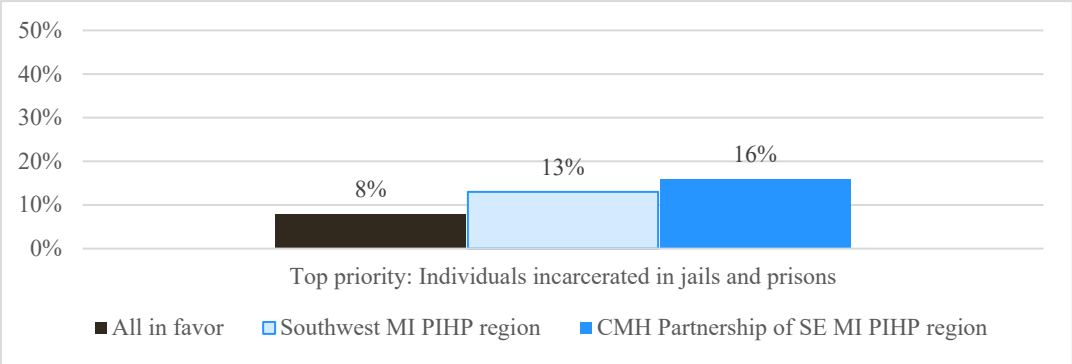
All 10 PIHPs selected individuals with co-occurring mental health diagnoses and/or other SUD most frequently as their top priority, but the frequency ranged from 53% of respondents in **Macomb**, to 29% in **Region 10**.

Respondents in the **CMH Partnership of Southeast MI PIHP region** (20%) and **Detroit-Wayne PIHP region** (21%) were more likely to prioritize communities where the majority of residents are racial/ethnic minorities compared to respondents overall (11%).

Overall, "rural communities" was a top priority for 13% of respondents, but it was a top priority for 23% of respondents from **North Care Network region**, and 26% of respondents from **Northern Michigan region**.

Overall, individuals incarcerated in jails and prisons was a top priority for 8% of respondents, but a top priority for 13% of those in **Southwest MI region** and 16% for **CMH Partnership of SE MI region** (Figure 18).

Figure 18



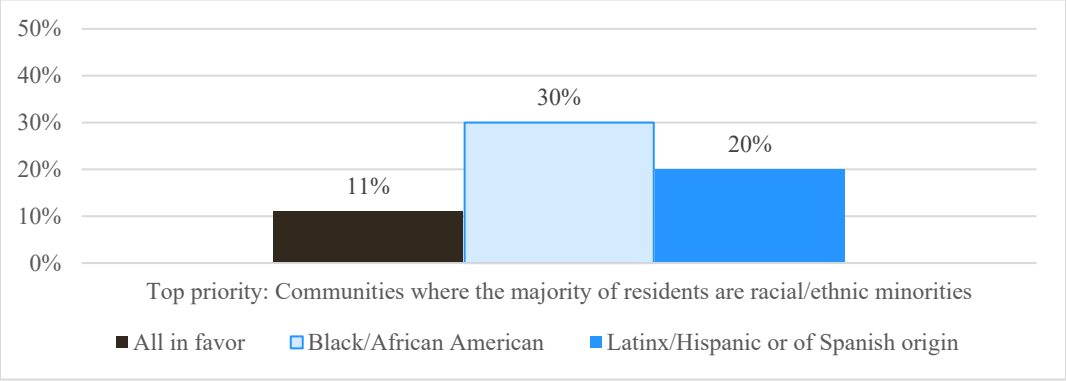
Black or African American respondents

Overall, 11% of respondents ranked communities where the majority of residents are racial/ethnic minorities as their top priority while 30% of **Black or African American respondents** supported it as a top priority (Figure 19 on next page).

Respondents who are of Latinx, Hispanic, or Spanish origin

Overall, 11% of respondents ranked communities where the majority of residents are racial/ethnic minorities as their top priority while 20% of individuals who identify as of **Latinx, Hispanic, or Spanish origin** supported it as a top priority (Figure 19 on next page).

Figure 19



Harm Reduction

Harm reduction priorities most frequently ranked as the number one priority were:

1. Expand programming to divert/deflect individuals from criminal-legal system.
2. Naloxone distribution and training.
3. Expanding capacity in existing Syringe Service Programs (SSPs) to provide more wrap-around services and linkages to treatment resources.

Survey question 5

Which of the following harm reduction activities is most important to fund?

Harm Reduction	
Activities	**% ranked #1**
Expand programming to divert/deflect individuals from criminal-legal system	40%
Naloxone distribution and training	24%
Expanding capacity in existing Syringe Service Programs (SSPs) to provide more wrap-around services and linkages to treatment resources	22%
Expanding the number of Syringe Service Programs (SSPs)	8%
"Other"^	5%
Total	100%

Table total varies due to rounding

^"Other" write-in responses most commonly included safe consumption sites, treating mental health.

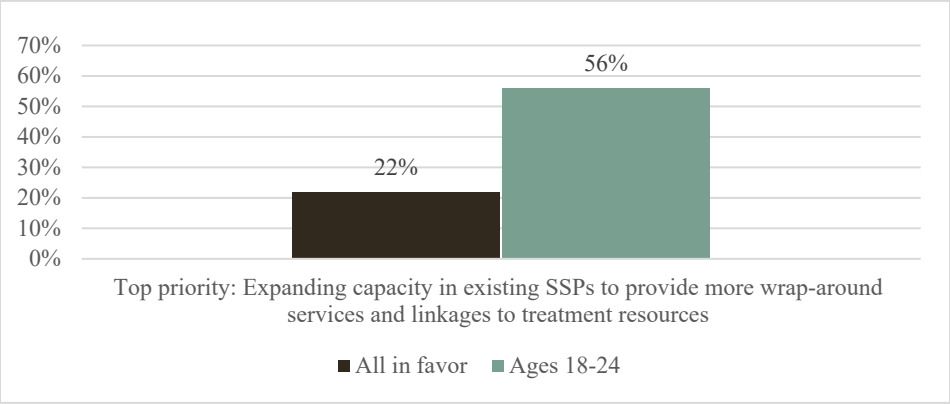
Notable differences in harm reduction priorities

There were significant differences in harm reduction priority by age group, PIHP region, race, and organization type. (See Appendix II for more details).

Ages 18-24

Respondents **ages 18–24** were much more likely to prioritize expanding capacity in existing SSPs to provide more wrap-around services and linkages to treatment resources (56%) compared to respondents overall (22%) (Figure 20).

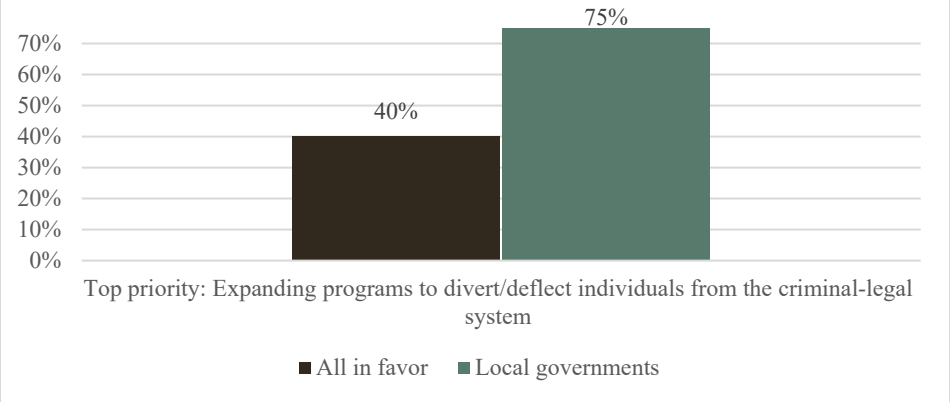
Figure 20



Local government (including local health departments)

Local government including local health departments were much more likely to prioritize expanding programs to divert/deflect individuals from the criminal-legal system (75%) compared to overall respondents (40%) (Figure 21).

Figure 21



Research and Evaluation

The research and evaluation priority most frequently ranked as the number one priority was:

1. Research on new, promising, and best practices.

Survey question 6

Which of the following data and evaluation activities is most important to fund?

Data and Evaluation Activities	% ranked #1
Research on new, promising, and best practices	**43%**
Evaluation of opioid abatement strategies	**27%**
Data collection activities	**23%**
"Other"^	**7%**

^"Other" priorities most commonly included evaluating effectiveness of current programs, and including those with lived experience.

Notable differences in research and evaluation priorities

There were no statistically significant differences across research and evaluation priorities. ($p < .01$).

Summary

The results of the Opioid Settlement Prioritization Survey 2021-22 can be used to elevate the voices of those in communities across Michigan. Although additional voices are needed to gain a more complete understanding of the priorities and needs, these results outline trends that may lead to an improved response to the issues.

Interwoven throughout these priorities were concerns about the impact of stigma on the success of amelioration efforts. Stigma was a theme that came up when respondents were asked their reason "why" they chose the priority they did.

Stigma and other themes, such as the value in treating co-occurring mental health issues along with SUD, are found in the following Qualitative Summaries of Priorities section of this report.

Note: The opinions expressed in the tables below do not necessarily reflect the views of MDHHS or of all survey respondents. Example quotes are included to add context and detail to complex survey priority topics and themes.

Qualitative Summary of Priorities

Survey respondents were asked to provide a reason why they selected the top priority they did for each of the six priority questions. Those written responses were analyzed for theme categories and frequency. The "Top 3" priorities for each question are included in the tables below, followed by a condensed table of select quotes in support of the remaining priority options for each question.

Priority most important for the investment of opioid settlement funding (overall)

Please tell us why you chose this activity as your top priority for settlement funding	
1. Recovery support services, including peer support and wrap-around services for individuals with substance use disorder (SUD) and co-occurring mental health diagnoses (n= 359)	
Common themes: • Providing care for those with a dual diagnosis/ treating mental health. • Longer term care/ services. Suggested approaches included: • Increase reimbursement from payers (for peers and other providers). • Trauma-based care/ address root causes, provide family support. • Better coordination between agencies. • Workforce development and training. Suggested target populations: • Juveniles. • Elderly. • Incarcerated individuals. • Those with a dual diagnosis. Specific Program References: CARE in Macomb County; Step Up programs; Drug Treatment Courts; Transitional Housing; Substance Use Disorder Family Support Program; Continued Connection Program.	**Select quotes (edited for clarity)**: *Access to MOUD is good, but services that build recovery capital and address social determinants of health are harder to access. Treatments of adequate quality, duration, and intensity are hard to access.* *As a provider, I see how treating the whole person and continuation of care is the most beneficial. As a small nonprofit we have attempted to start these services on our own and through the OHH program. Covid has hit us hard, and any funding would benefit the people we serve.* *Not enough people suffering from SUD are aware of how many programs are available. There are not enough programs that treat dual diagnosis for SUD and mental health disorders. Many places want to treat them separately and it results in relapse in one or both areas.*
Quotes from the recovery community: *Treatment of substance use disorder should be a multi-platform approach. More options are needed, and peer support is extremely important. It is easier to open up to a person who has been in the same position as them.* *Peer recovery coaching and other wrap-around services had proven to be effective especially with the elderly population who cannot seem to find these services within their Medicare plans.*	

Please tell us why you chose this activity as your top priority for settlement funding

2. Prevention programming (n= 187)

Common themes:

- Return on investment/cost-effectiveness of prevention.
- Education and reducing stigma.
- Addressing root causes.

Suggested approaches included:

- Education – prescriber education, age/population appropriate content in prevention education.
- Building community resilience.
- Address root causes that lead to addiction, use trauma-informed models.

Suggested target populations:

- People who have access to opioids.
- Maternal, neonatal.

Specific program references:
Communities That Care; Project ECHO; Families Against Narcotics

Select Quotes (edited for clarity):

Prevention programming is critical to prevent future addiction disorders. To clarify, it's important to think of "prevention programming" as systems work that decreases the root causes (trauma, abuse & neglect, poor academic achievement, lack of referral sources, untreated mental health issues, etc.) of youth starting to misuse substances, not just "programs." We are not going to "curriculum" our way out of addiction disorders.

Prevention education – including building resilience and strengths in communities – should be a priority because we need to stop abuse before it becomes an addiction. It's much more costly to the community after someone has become addicted. It's often easier for them to stay in drug use and abuse than to get out of it. Prevention on all levels can create open communications throughout the community and remove the stigma of needing help, putting more emphasis on strengths of being hopeful and clean.

Quotes from the recovery community:

The best time to stop a problem is before it starts.

Good prevention can stop young people from following the same destructive path.

Prevention would decrease the demand for all the other, very worthy, services.

Please tell us why you chose this activity as your top priority for settlement funding

3. Expanding access to Medications to treat Opioid Use Disorder (MOUD) and other opioid-related treatment (n= 153)

Common themes:

- Access and barriers to access.
- Eligibility, shortage of providers/staff, cost for patients, transportation, funding for implementation of programs.
- Evidence-based.
- Saves lives and allows patients to stabilize.

Suggested approaches included:

- More provider training.
- Providing access in sites where patients could benefit most.
- Primary care clinics, jails/prisons, EDs, safe consumption sites.
- Person-centered MOUD treatment.
- More choices/options for individuals, culturally competent services, equity in access.

Select Quotes (edited for clarity):

I see firsthand every single day the access barriers to MOUD treatment that our patients experience. This is my top priority for the funding because it is the first step in helping patients recover safely with evidence-based treatment and the first step that can open doors to additional treatment services.

In my clinical experience I've seen a lot of folks get better when they are first stabilized on medication because it's hard to engage in all the other services when they are actively using or in withdrawal. Folks seem to be more amenable to other forms of treatment that can help them after they are stabilized.

Quotes from the recovery community:

I put MOUD as # 1 because access is limited in our community. I work with individuals living with OUD and often assist them with trying to find treatment. I can tell you there is limited access MOUD treatment in our community.

There are not enough MOUD treatment facilities in metro areas let alone in rural areas. It is not realistic for someone to receive methadone for instance if they have to drive two hours every day to get it.

In Northern Michigan we have identified coverage and accessibility gaps. We know medications for Opiate Use Disorder can be highly effective.

"Please tell us why you chose this activity as your top priority for settlement funding" (remaining options)
4. Support for pregnant & postpartum women affected by substance use, and infants with Neonatal Abstinence Syndrome (n= 87)
There is a gap in providers who support and treat PG/PP women, or take their insurance. Many of our clients must be seen out of county creating yet another barrier. Our numbers of Sudden Unexpected Infant Deaths due to unsafe sleep primarily involve drug use in the bedroom by mom or dad. Moving upstream to treatment/assistance during the pregnancy may prevent this horrible outcome.
Changing the trajectory of a mother can impact the trajectory of the entire household/family.
I work with women with OUD and the transition from pregnancy to parenting is not being addressed. Women are seen for pregnancy and then sent to a provider that addressed their OUD but not the stress related to being a parent with an OUD.
5. Naloxone distribution and training (n= 65)
As the facilitator of a Mobile Care unit, we are witnessing the use of fentanyl in non-opioid illicit drugs, which has increased the risk of overdose and is requiring our team to be more aggressive in educating and distributing naloxone.
If people are dead none of the rest matters. I have successfully used naloxone and CPR three times. Those whom I have used it on would have died without it.
The training is VERY important, too many clinics and doctors interpret the protocols and treatment differently.
6. Treatment for incarcerated populations (n= 59)
Increased coordination for SUD Services for incarcerated individuals is vital for reducing recidivism rates.
Incarceration is an opportune time to connect with persons with SUD and provide services that help aid in stabilizing and connecting individuals to treatment, wrap around services, and programming. Community re-entry is high risk for overdose deaths and harm. If services were available, we could reduce deaths, impact recidivism, and increase the chances of recovery.
MAT treatment inside corrections settings is important for two different reasons. First, the continuation of care for those MAT involved prior to incarceration. Second, a natural reachable, teachable moment for those who are opiate involved prior to the current incarceration.
7. **Syringe Service Programs (SSP) (n=41)**
SSP programs are directly connected and interacting with the people who are most affected by the opioid epidemic. They can build relationships with people PWUD and connect them to a multitude of services. Without SSP programs we will not reach the population of PWUD.
The one thing you cannot run a syringe access program without is syringes, yet we have no sustainable funding source for this in Michigan. SSPs provide vital resources and education for individuals who use drugs, and these programs keep many people alive.
8. **Research and evaluation of abatement strategies (n= 32)**
I would like to see the money go toward public health research on best strategies. There are many clinical needs, but this is I believe is a one-time infusion and should go toward long term solutions.
Until we are able to systematically and systemically evaluate short-term and intermediate outcomes to determine the effectiveness of our programs and evaluate cost-benefit ratios to determine the efficiency of our programs, we will be wasting most of the money received from this settlement.

Priority Categories

Priority Most Important for Prevention Programming

Please tell us why you chose this activity as your top priority for prevention

1. Evidence-based prevention programs in K-12 schools (n = 268)

Common themes:

- Address root causes (i.e., focus on family, trauma) for children who have an addicted family member and at-risk youth.
- Building resilience/emotional skills development with a focus on mental health.

Suggested approaches included:

- Make prevention programming an educational requirement.
- Involve mental health professionals in the development and delivery of programming.
- Go beyond K-12 schools and start earlier (preschool).

Suggested topics included:

- Peer pressures and pitfalls of social media.
- Education on local resources and programs available to students and families.

Specific Program References:
National Harm Reduction Coalition; Drug Policy Alliance pilot program; Michigan Model for Health

Select Quotes (edited for clarity):

In the schools is where we can address the stigma and teach the impact of OUD, while also emphasizing health and wellbeing to include healthy resiliency strategies.

Finding the upstream root causes. Preventing so the other services are not needed but we need to make sure we are looking at ACES and providing support to those who have trauma.

Quotes from the recovery community:

Since most of us first start using substances in our teens, I think it's important to have effective strategies for prevention and education in K-12. Also, since many kids have parents who have substance use disorders, it's important to educate them on how it's a medical condition and how they can access support for themselves.

Drug addiction is misunderstood in society; therefore there is the need to continually educate our youth about the realities of drug addiction and alternative mental, emotional, and physical healthcare.

Please tell us why you chose this activity as your top priority for prevention

2. Training for first responders on programming to connect at-risk individuals with services and supports (n= 261)

Common themes
- Working alongside/training with other disciplines.
- Education is needed to reduce stigma around those with addiction.

Suggested approaches included:
- Ensure training is continuous/ongoing and interdisciplinary (e.g., quick response/crisis response teams, using peer supports).
- Practice diversion for calls involving substance use.

Suggested topics included:
- Harm reduction training.
- Reducing stigma, including through increased training on cultural competence.
- Mental health training.

Specific program references:
Hope Not Handcuffs (FAN); Sequential Intercept Model; ProAct Model (WSU)

Select Quotes (edited for clarity):

First responders are often the first chance for intervention. If those individuals were trained in how to easily connect individuals with services other than jail, I think it would be the most beneficial. Even though jail can be a good starting point it is not always the best starting point.

All first responders including law enforcement should be properly trained on addiction and life saving strategies including how to speak to someone suffering a mental health crisis related to SUD.

Education and training are some of the best ways to increase awareness and to allow individuals to have a safe space to exam their views, facts, beliefs about substance use and the individuals who use them.

Quotes from the recovery community:

First responders engage people in some of the worst moments of their addiction. They are also often viewed with distrust by those whom they're serving. With proper training and culture shift among first responder organizations, first responders could become a critical component of leveraging compassionate conversations with PWUD to connect them to services.

Training and education about programming to connect at-risk individuals with services is at a deficit. If law first responders were aware of the local resources at their disposal, more individuals could be connected to services.

Points of crisis can be catalysts for change. First responders are uniquely positioned to take advantage of this and connect people to appropriate services and support.

I would like to see first-responders treating OUD as an illness more than a crime. Often they are working with individuals at a critical moment where they might be willing to accept help, however they are usually sent to jail or the hospital with no follow up care, rather than getting connected with a service provider.

Please tell us why you chose this activity as your top priority for prevention

3. Medical provider education and outreach around opioid prescribing best practices (n= 244)

Common themes

- Prescription opioids are a root cause for many who develop OUD.
- Provider education is needed to reduce stigma around those with addiction.

Suggested approaches included:

- Education and prevention re: prescribing for patients naïve to opioids.
- Education and anti-stigma training for identifying and treating opioid use disorder (including with MOUD).
- Targeting those who work in jails, PCPs, dentists, and pharmacists.

Suggested topics included:

- Encourage physicians to know their own prescribing patterns, training in use of MAPS.
- Screening/training on recognizing OUD.
- MAT and harm reduction education.

Specific program references:
PreVenture Program (Canada)

Select Quotes (edited for clarity):

I believe prescribing practices contribute to opioid use disorder. Working in the field for 27 years, I have heard far too many stories where a person was prescribed opiates for an injury which was continued well beyond its intended purpose. All prescribing doctors, NPs, and PAs should be required to complete training on addictive disorders.

I still hear of medical providers not using the MAPS system and not reviewing opiate history.

Providers are afraid to prescribe buprenorphine and need better education and support. While the waiver training is substantial, there is not enough incentivization for our providers to provide this level of care to their patients.

Quotes from those with lived experience with SUD:

I believe the problem starts with medical providers. There needs to be more training before prescribing opiates to an individual. That's where the problem starts 90% of the time.

I have learned from experience that doctors have prescribed the medication without educating the patient on the potential problems/harms of taking the prescription.

We need to combat stigma in the medical field. People don't go for help when they get treated poorly.

Educating healthcare professionals on the potential dangers, as well as the proper dosing methods is essential. Especially for medicated assisted treatment. It is very misunderstood.

Please tell us why you chose this activity as your top priority for prevention
9. Media campaigns to prevent substance misuse (n = 43)
I chose this priority list because zoom/media support has helped me through first hand experience.
Social media plays an incredibly significant role in the lives of people today and holds a heavy influence. It will have the largest reach to all ages and communities to start the message that it needs to be stopped, there is help out there, and can guide those in need of how to either prevent or treat addictions.
There's still a lot of stigma around SUD. However, the media campaigns should be targeted and culturally appropriate and relevant. Peers in recovery must be involved in developing these media campaigns.
10. Community drug disposal programs (n = 22)
Often those with opioid use disorder report their first use as being from a family members medicine cabinet. Keeping drugs at home is potentially deadly and flushing them is dangerous. There should be an easy place to dispose of drugs, needles, etc. confidentially at any time.
Drug disposal programs often only run a few times a year. Better consistent access to disposal sites would be beneficial.
The training is VERY important, too many clinics and doctors interpret the protocols and treatment differently.
11. **"Other"**
Increasing mental health support: The underlying connections and causes to substance use/misuse is the most critical response. Many people will try and use drugs without addictions. Prevention begins with understanding the reasons why a person who uses drugs with end up with addictions vs someone who just uses drugs/alcohol.
Stigma education: The prevention activities listed, including media campaigns around misuse, drug disposal programs, new opioid prescribing best practices, and prevention programs in school tend to incorporate shame, stigma and harmful practices that create barriers to medication for the pain community.
Stigma training for first responders: First responders are often exposed to individuals with substance use disorder when they're at their worst. Repeated exposures to individuals when they're struggling and at their worst can cause the first responder to become desensitized. Continuing education about the disease of addiction and other mental health issues would benefit the first responder and the community.
Community-based primary prevention: We must provide concrete resources during times of need and skill-building opportunities for parents/caregivers and their children to prevent prolonged periods of stress and instability from occurring. "Primary child abuse prevention" including family/neighborhood resource centers are one important part of the solution that a portion of opioid settlement funds could support.

Priority Most Important for Treatment and Recovery Support Services

Please tell us why you chose this activity as your top priority for treatment and recovery

1. Residential/inpatient treatment programming (n = 221)

Common themes:

- Barriers to access (insurance, cost, programmatic funding, location).
- Need for immediate access for those ready to start recovery.

Suggested approaches included:

- Improve resources in existing residential/inpatient programs (in addition to funding new programs).
- Programming should promote healthy transitions to the next stage of recovery.
- Allow for longer-term care.
- Include mental health.

Suggested target populations:

- Criminal justice population.
- Juveniles.
- Low-income populations.
- Individuals on MOUD.
- Indigenous pregnant women.
- Rural communities.

Specific Program Reference:
HPRP programs; Purdue Model

Select Quotes (edited for clarity):

Access to MOUD is good, but services that build recovery capital and address social determinants of health are harder to access. Treatments of adequate quality, duration, and intensity are hard to access.

As a provider, I see how treating the whole person and continuation of care is the most beneficial. As a small nonprofit we have attempted to start these services on our own and through the OHH program. COVID has hit us hard, and any funding would benefit the people we serve.

Not enough people suffering from SUD are aware of how many programs are available. There are not enough programs that treat dual diagnosis for SUD and mental health disorders. Many places want to treat them separately and it results in relapse in one or both areas.

Quotes from the recovery community:

Every county should have an inpatient treatment facility. Some of our clients have to be transported two, three, four counties or more away from their home, their families, etc.

My order of importance is from 15 years of working with those with SUDs involved in the [criminal justice] system. Walking out of that jail door with no plan, treatment or supportive services can be deadly.

Please tell us why you chose this activity as your top priority for treatment and recovery

2. Wrap-around service programs to address spectrum of social factors (transportation, housing, employment, etc.) (n = 180)

Common themes**:**

- Providing basic needs, e.g. transportation.
- Behavioral health integration.

Suggested approaches included:

- Closed loop/ensure follow-up.
- Provide immediate access to services.
- Promote skill development/healthy transitions to the next level of care.

Specific Program References:
SOAR- certified case managers; Housing First

Select Quotes (edited for clarity):

Stability has been one of the most prominent indicators in my line of work that determines the success of a person in recovery. Their basic needs must be met for them to fully focus on recovery.

Substance abuse is not just substance abuse. Wraparound services are needed for mental health, physical health, etc.

Alpena has a large rural area where transportation is a huge problem. This becomes worse in the winter months when walking in inclement weather is common. Poor access to housing and job opportunities are very difficult for the person who is trying to be self-supporting.

Quotes from the recovery community:

Many, many people don't have their basic needs for living met. We cannot expect people to stay clean if they don't know where they will sleep at night.

Sometimes people come home and they get run through the gauntlet. The smoother the transition and more we can ease access to needed services, the more time the person has to focus on recovery and let the lessons cure.

If clients coming out of treatment had more support world wide with helping them get housing and transportation and things it would have a huge positive impact on there lives after treatment.

Transportation is the single biggest barrier to treatment right now. Many individuals with SUD do not have access to transportation to even begin to get the support they need.

Please tell us why you chose this activity as your top priority for treatment and recovery

3. Access to Medications to treat Opioid Use Disorder (MOUD), including methadone, buprenorphine, and naltrexone (n = 176)

Common themes:

- Providing MOUD alongside care coordination and wrap around services.
- Cost/affordability barriers: low cost intervention opportunity but insurance/Medicaid barrier exist.
- Lack of providers offering MOUD and need to reduce stigma around MOUD.

Suggested approaches included:

- Care coordination and wrap around services alongside MOUD including mental health and peer support.

Suggested target populations:

- ED visits.
- Patients 'barred' from MAT.

Specific Program References:
Recovery oriented system of care

Select quotes (edited for clarity):

Still not enough providers of MOUD. However, MOUD in and of itself, is not sufficient. It needs to also include support services.

MOUD + psychosocial services is the gold standard of care for individuals with OUD.

There are few providers in the Upper Peninsula and a lot of stigma around it, both in the community and among providers/professionals.

Quotes from the recovery community:

Working in the field of addiction and MH, the using community is increasing their desire to be involved in MOUD. This is the number one asked for service related to OUD that I see at this time.

Give those a chance who have OUD to stabilize their lives - not everyone needs residential treatment initially.

So many times a person cannot get into a MAT program until next week or next month. If an individual could get on a program right away, (in the ERD) then have to sign that they will be back to the hospital for follow up, could help more people.

If care coordination services are conducted properly, [support services] should be seamless.

To my knowledge MOUD often remains cost prohibitive to many OUD suffers.

If you do not have access to treatment such as MOUD, then treatment and recovery is sometimes not attainable.

Please tell us why you chose this activity as your top priority for treatment and recovery
4. Care-coordination services to facilitate warm-handoffs into community-based services from inpatient or other institutional settings (n = 90)
Integrated services (physical and medical) combined with care coordination would greatly improve care and allow for greater providers available for treatment
I was a case manager for MI REP helping those incarcerated transition back into the community successfully. I was told by those I served that they wished this service was available in the past due to helping reduce their recidivism. But now the MI REP grant ended and I believe the community will suffer due to increased use of the legal system and hospital among other resources.
We are still seeing stigma by some of our medical care facilities and first responders. Warm-handoff programs are badly needed in our ERs. They are treated for overdose and within hours released to nothing, barely being able to walk out a door. They are often treated poorly minimizing the chance of them returning if needed. I know this from personal experience.
5. Recovery housing (n = 74)
Recovery housing needs to be a Medicaid service including peer services regardless of location - it is currently not allowed in most recovery homes
One of the hardest places to be is an addict walking out of rehab. That is a very crucial and vulnerable point. We need services in place to get them out of their "old playgrounds" because they have nowhere else to go. When you take a mother and put her in a treatment, she stops using drugs and she learns a few life skills. You put her back in the same situation, the same stressors, and no support… She's going right back at it. There needs to be an in between, recovery housing and warm handoffs
6. Outpatient treatment programming (n = 71)
Quality outpatient treatment for substance use is very limited, especially for patients with Medicaid.
Many of those who need a residential level of care will not commit to it voluntarily. We need to invest in outpatient programs that utilize evidenced-based, recovery-oriented, trauma-informed service models
The level of services available on an outpatient basis in this area is minimal. I have knowledge of many adults that should be in recovery and SUD treatment, and I have never met anyone who attends IOP more than one time per week, if that. And don't get me started about the services available for juveniles. This court contracts with a private licensed substance abuse clinician because there are no services available for SUD diagnosed youth.
7. Peer support services (n = 64)
Peer support services are often difficult to bill and require staff funding grants to support the positions. Peers help agencies provide a recovery-oriented systems of care and clients often find a great deal of support through peers. Recovery Supports are often cut due to the lack of funding available through the PIHPs to fund them.
…many people who have dealt with opioid use, misuse, withdrawal, and OUD treatment are best suited to be peers, and that they have a greater credibility with those suffering acutely. Training, however, needs to be improved so that they have training on how to be great mentors, have…knowledge of all resources available to support the patients in their recovery.
8. "Other"
Employer education: 70% of the SUD population have a job-yet the employers are not educated or have policies in place to support them
Trauma informed services: The root of substance abuse is often times related to childhood trauma. If we can get to the root, help them to process the trauma and build their resiliency, they will have a better chance of sobriety.

Priority Population/ Community Most Important for Treatment and Recovery Support Services

Please tell us why you chose this population as your top priority for treatment and recovery support services

1. Individuals with co-occurring mental health diagnoses and/or other Substance Use Disorders (SUD) (n= 379)

Common themes:

- Underserved population.
- Mental health and SUD commonly co-occur.
- Untreated mental health is a barrier to SUD treatment, it is important to treat the "whole person".
- Vulnerable population with greater needs.
- Lack of coordination between MH and SUD care.
- Most difficult and complex patients to treat.

Suggested approaches included:

- Expand the capacity of treatment centers and services to provide integrated care to those with co-occurring MH & SUD.
- Expanding funding and training for dual-diagnosis providers.
- Address barriers and expand access to housing for those with co-occurring MH and SUD.

Specific Program References / Recommended Model:
Recovery Oriented Systems of Care; Recovery Cafes

Select quotes (edited for clarity):

People with co-occurring disorders are often volleyed back and forth between agencies because each org handles just 1 category of disorders. That causes many to be left without any help; or to choose 1 service over the other, but often failing to succeed in that treatment because they're weighted down by SUD or mental health issues. This a chicken & egg problem!

Co-occurring treatment centers are almost impossible to find.

There appears to be a significant lack of those trained in both mental health issues and SUD disorder co-occurring in individuals. So either one or the other is treated based on the training of the counselor.

Co-occurring treatment is the most difficult to obtain, especially for individuals that are designated severely mentally ill (SMI). There are currently very limited housing options for these individuals.

Quotes from the recovery community:

Not enough providers willing and able to treat both SUD and mental health.

This group is the least understood and have less access to comprehensive treatment and providers.

It makes it hard to treat one without options for treating the other. Many times the person using a substance is doing so to self-medicate.

Please tell us why you chose this population as your top priority for treatment and recovery support services

2. Rural communities (n=120)

Common themes:

- Underserved population.
- High concentration of individuals with SUD.
- High rates of poverty and other social needs that represent barriers to recovery.

Suggested approaches included:

- Expand treatment access and options, including access to MOUD/MAT, harm reduction, and peer coaches.
- Expand transportation supports.
- Devote resources to attract and support the SUD/OUD and mental health workforce.
- Support the development and expansion of Recovery Community Organizations (RCOs) and similar treatment centers.

Specific program references
RCOs; Hub and spoke model

Select quotes (edited for clarity):

I feel all of them are important, but being in a rural community, I know how little we have to help individuals and when they travel for residential treatment and come back, there is little in the way of support.

Rural communities were disproportionately impacted by this issue, and yet are the most under-resourced.

I chose rural communities because there are often NO options for public transportation in these areas. This creates such a hardship for people and contributes to people not accessing SUD services, and ending treatment long before they are ready.

This is a smaller, more rural community and services are not readily available. It is difficult for CMH to attract and hire and retain quality therapists and clinicians.

Quotes from the recovery community:

Rural communities only have access to NA and AA groups, which tend to be outdated and only promote abstinence-based recovery. Peer coaches can help connect them to resources and help them discover alternate pathways.

Rural communities lack the basic recovery supports needed - outside of AA meetings or Celebrate Recovery - a fully equipped RCO for rural communities will align with the current HRSA Federal proposal as well.

Please tell us why you chose this population as your top priority for treatment and recovery support services

3. Pregnant and post-partum women (n = 118)

Common themes:

- Ripple effect of positive change within the family.
- To prevent/reduce long-term negative consequences for the children.
- High-risk population.

Suggested approaches included:

- Increase access to resources specifically for pregnant and post-partum women with SUD, including beds/transitional housing.
- Expand treatment options, including options beyond methadone, Subutex, and Suboxone.
- Provide education and resources to clinicians, policymakers, and mothers on topics such as family-centered, integrated care models, and best practices for human lactation.
- Childcare assistance.

Specific program references/ recommended models:
Integrated care models that provide medical, SUD treatment, and social and peer support services to pregnant and parenting women with SUD, a PROVEN model of care for this population; family-centered SUD treatment models that prioritize family unity and keeping parents and children together, even during residential treatment

Select Quotes (edited for clarity):

There were only a few beds for pregnant women in Substance Abuse programs - we need to make it not only available, but stigma free and inviting.

This is where the family starts, with the mom and she ultimately will be making decisions for the family. If we can help support her to help support her family everyone will benefit around her. Education and communication have been key to some of our successes that we have seen.

This is the population I work with the most. I would like to see more resources for this population other than Subutex or suboxone

Quotes from the recovery community:

In that State of MI if a woman finds herself pregnant while active in Opioid use, a doctor WILL NOT allow her to detox. She will be required to start methadone. Transitional housing that take women on methadone are non-existent. If she has other children in her care there are zero options for her. Women should have the choice on how to care for her children and her addiction.

We need to protect the unborn children and look at options outside of methadone.

Due to lack of special resources for pregnant and post partum in Muskegon. Many have to go to Kent County, which is not feasible for many. Also, stigma and women and nervous to seek help with SUD for fear of losing kids and other criminal charges if they come forward.

Please tell us why you chose this population as your top priority for treatment and recovery support services
4. Infants with NAS (n= 96)
This population is the most vulnerable of the populations.
Babies should not have to suffer because of the parents choices.
5. Communities where the majority of residents are racial/ethnic minorities (n= 92)
I have witnessed first hand … the devastation that addiction has on individuals, their families, their communities and their Tribe. At any given time, run the race reports of individual's incarcerated in the Chippewa County jail for substance related offenses and you will clearly see the disparity between race populations. This is a prime opportunity to address addiction in rural Michigan locations for people of color.
Communities where the majority of residents are racial/ethnic minorities lack resources and funding. They are also the communities that have been affected most by punitive drug laws.
Nobody did a thing for the BIPOC communities back during the "crack epidemic".[…] The racial inequity in this country is staggering, and it feels like these drug scares are simply scapegoats to avoid facing this REAL issue.
6. Individuals incarcerated in jails and prisons (n= 73)
This is a perfect opportunity to provide treatment services and explain the importance of sober support meetings when released from jail or prisons.
High problem complexity leads to high service utilization. Incarcerated people tend to have high complexity, low recovery capital, and often have high problem severity. Their contact with the criminal justice system provides a valuable opportunity to reach them.
OUD/SUD is one of the most prevalent medical/behavior condition among the incarcerated population. This population is also more likely to overdose upon reentry to their community.
7. "Other"
Teenagers and young people: If you can help a young person achieve recovery it creates the most impact across time. And young people are the most easily helped group in society. It is our duty to put young people first.
Areas where the resources are most scarce: An evaluation of current resource availability should be conducted and the funding should be directed to areas in greatest need, based on that objective evaluation.
Juveniles: Services for juveniles are drastically underfunded and overlooked.

Priority Most Important for Harm Reduction

Please tell us why you chose this activity as your top priority for harm reduction

1. Expand programming to divert/deflect individuals from the criminal-legal system (n = 358)

Common themes:

- Jail is not an effective setting for rehabilitation/recovery.
- SUD is an illness, not a crime.
- There are long-term negative outcomes of incarceration.
- Diversion/deflection is cost-effective.
- Decriminalization will help combat stigma and promote seeking treatment.

Suggested approaches included:

- Expand access to drug courts.
- Couple diversion with treatment and strengthening partnerships with mental health and community-based services.
- Incorporate recovery coaches and peer recovery counselors.

Specific Program References:
Kalamazoo Defender Program; Jail Alternatives for Drug Offenders

Select Quotes (edited for clarity):

It is a known fact that criminalizing SUD does not reduce SUD. Drug/sober court programs are effective, and funding PRCs for the teams is effective. We have effective outcomes doing this in Macomb County in many courts.

Diversion programs can be very effective if the individuals are connected to the proper treatment services. Previous priorities focused on expanding the treatment infrastructure, which would only increase the success of an expanded diversion program.

Diverting people from entering the legal system may be an effective strategy to get more people actively engaged in treatment. The legal system adds stigma to treatment services (unintentional effect).

Quotes from the recovery community:

Once an individual has a criminal record, their life and opportunities are changed forever making it more difficult to get out of the cycle of substance use and criminal activity. It has been shown repeatedly that punitive measures do not solve SUD and MH disorders and an avenue towards treatment rather than incarceration will have better results.

SUD is a huge unnecessary burden on the CJ system and diversion needs to be earlier, more accessible, and streamlined.

Criminal system diversion must be the answer for those facing criminal sanctions for medical conditions, which includes an addiction. Ineffective public defenders, probation requirements that are difficult to achieve, and paying fines are all criminal justice system consequences that negatively impact those individuals who are in poverty, underemployed, unable to afford food and safe housing, and lack privilege.

Please tell us why you chose this activity as your top priority for harm reduction

2. Naloxone distribution and training (n= 215)

Common themes:

- Prevents imminent death.
- Fewer barriers to implementing this; anyone can do it.
- People afraid of stigma and criminal charges don't call for help.

Suggested approaches included:

- Reduce cost to access for consumer, make more accessible.
- Reduce dollar cost to consumer (i.e., insurance coverage).
- Make it standard practice for first responders to have training and carry naloxone.
- Community-level training; have naloxone available everywhere (e.g., libraries, pharmacies, etc.).

Select Quotes (edited for clarity):

People are dying and some places still have EMT and police services that show up with a body bag and no naloxone.

Easy to tackle, relatively cheap, and needed in community.

It immediately saves lives and can provide an opportunity for entry into recovery.

Training available for Narcan distribution as well as helping to reduce the stigma around Narcan is vital.

Quotes from the recovery community:

Naloxone provides opportunity to continue to work with the person who has had an OD reversal. I'd love to see more work being done with media to provide information that the OD reversal provides an opportunity to access other much needed services by contacting their local RCO.

Narcan is not free to everyone and not many people know where to find it. Every business, no matter what kind, should carry several kits and be properly trained.

I believe we cannot make an impact in these lives unless we keep them alive first and Narcan training is what we need. The Narcan trainings not only teach people how to use Narcan but about the stigma of addiction and stigma in the recovery community.

People are dying and some places still have EMT and police services that show up with a body bag and no naloxone.

Please tell us why you chose this activity as your top priority for harm reduction

3. Expanding capacity in existing Syringe Service Programs (SSPs) to provide more wrap-around services and linkages to treatment resources (n= 197)

Common themes
- Helping people help themselves.
- Captive audience – the population using SSPs knows they are at risk.
- Avoids the stigma of going to a local health department.
- Provide support and compassion.

Suggested approaches included:
- Ensure timeliness of services and linkages to treatment.
- Provide more funding for supplies, such as syringes.
- Use peer supports at SSPs and provide more funding to staff and training PRCs.

Specific program references:
Red Project; Comprehensive Care Model

Select Quotes (edited for clarity):

SSPs are often the first place my clients hear about treatment options and help protect them from disease.

SSP's build trust and connection to drug users, and they have the unique ability to assist in navigating the person toward available resources.

SSP can guide people to choose recovery plus it keeps them safe from reusing or sharing needles which is a public health matter.

There is a significant lack of SSPs, especially in rural areas and in the U.P. We need to expand so that everyone has access to these programs. This needs to happen before we can even begin to add wraparound services, which is also needed.

Quotes from the recovery community:

If the quality of existing SSPs is increased, then these organizations could become crucial front-line places of engagement for people with SUD. Greater coordination between peer support providers and SSPs seems essential. I'm looking at, in my organization, either staffing PRCs directly to SSP distribution sites or helping SSPs build capacity to receive PRC training and utilize aspects of peer support in their engagement with participants.

Helping individuals who are already helping themselves is essential.

SSPs provide incredible services to the community and are underfunded at this time. We are having to limit the supplies we give out to participants which pulls us farther away from what we set out to do, which is to provide enough supplies for a new syringe for every shot, therefore lowering the numbers of communicable disease. SSPs desperately need more funding, or we will begin to see the rates of communicable disease.

More SSPs with wraparound services to provide individuals with as many resources in ONE location.

Please tell us why you chose this activity as your top priority for harm reduction
4. Expanding the number of Syringe Service Programs (SSPs) (n= 67)
When they come to get their syringes they can be sure there is hope for them and find out what resources are available to them to get off the streets.
We do not have an SSP in our county.
You can use grant money to buy supplies for SSP's, which makes it difficult for a lot of regions to offer this service.
5. "Other"
Safe Supply: … there is a safe, regulated supply of alcohol, and now marijuana, but not one available for any other substances that could contain fentanyl! People are dying from essentially being poisoned, or not knowing what it is they are putting in their body. We need to be able to provide people with what it is they are seeking, in a regulated, and clean/quality fashion. This can be done through systems similar to a methadone.
Open a safe place for people to use drugs: People die of overdoses because they are relegated to using alone, often in unsafe environments. If they have access to somewhere they can safely use their product while being observed by medical personnel, many deaths will be prevented. These services are available in Canada and are shown to significantly reduce deaths as well as increase interest in seeking treatment along with reducing other complications of substance use disorder.
Expand access to psychiatric and behavioral health services for patients with OUD: I find this is and was the most helpful of interventions I offered to OUD patients. I believe that when we meet their behavioral health needs, we can reduce the triggers that cause them to reach for opioids.

Priority Most Important for Research and Evaluation (condensed)

Please tell us why you chose this activity as your top priority for research and evaluation
1. Research on new and best practices (n = 359)
Let's learn from what other communities are doing that is successful and not recreate the wheel.
What works is different in different communities and cultural groups. Learn! Learn! Learn!
Most studies indicate concurrent stimulant use – [we need] strategies to treat the multi substance use disorders.
2. Evaluation of opioid-abatement strategies (n = 223)
I believe there have been many programs funded. But we now need to examine, which programs work and why? This will require data collection from existing programs.
There is a lot of misinformation spread on how to reduce opioid use. Many people are given the spotlight and funding to say they are "reducing stigma" through education, however there is no data behind these approaches, nor is the data presented validated or considered reliable. The community would benefit from EBP guidance on data collection and abatement strategies funded by MDHHS to the provider network.
Data collection is only relevant if you can share and use the data, it has to be meaningful.
3. Data Collection Activities (n = 186)
Data collection/needs assessments with the affected populations allows for the community to share what their needs are rather than funders to assume what is needed. Nothing for us without us.
Connecting data across systems (overdose deaths to jail records; information about treatment with MOUD to jails/prisons) is important in understanding trajectories, as well as in providing continuity of care.
While all are important, currently it is difficult to analyze all services provided to an individual due to the varied systems used to collect data.
4. "Other"
Talk to SUD sufferers: I don't trust our current evaluation strategies. Our data is very rough, we ask the wrong questions and we are not open to including everything in the process and putting all solutions on the table.
Research on evidence-based treatment, prevention, and recovery services for historically excluded audiences: There is a lot of focus on the use of evidence-based strategies and programs for SUD and OUD. However, the evidence supporting these strategies and programs are often led by all-white teams of researchers and have majority white study populations. More research is needed to evaluate strategies and programs that can be effective with other audiences that have different lived experiences.
Community based participatory research: The communities impacted deserve to be a part of the research process and be compensated through focus groups. Also to have access and ownership of data.

Note: the opinions expressed in the tables above do not necessarily reflect the views of MDHHS or of all survey respondents. Example quotes are included to add context and detail to complex survey priority topics and themes.