Community Mental Health Partnership of Southeast Michigan
Substance Use Disorder Prevention, Treatment, and Recovery Strategic Plan
2021 - 2023

COMMUNITY MENTAL HEALTH PARTNERSHIP
of Southeast Michigan

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COMMUNITY MENTAL HEALTH PARTNERSHIP OF SOUTHEAST MICHIGAN
SUD STRATEGIC PLAN
FY 2021 -2023

1.0 Submission transmittal letter from the CMHPSM Regional Board

See Attachment I - Transmittal Letter

2.1 A narrative identifying and prioritizing substance use disorder problems impacting the community:

Region 6 consists of the four-county entity known as the Community Mental Health Partnership of Southeast Michigan (CMHPSM) and includes Lenawee, Livingston, Monroe and Washtenaw counties. The partnership serves as the Prepaid Inpatient Health Plan for Community Mental Health and the integrated substance use prevention, treatment and recovery services for the four-county region beginning October 1, 2014. The geographic area covers a total of 2,570.97 square miles. Livingston County sits in the northernmost area of the region; Washtenaw follows south of the Livingston border and Lenawee and Monroe counties lie south of Washtenaw with their southernmost borders on the Ohio-Michigan state line. The 2019 population across the four counties is estimated at **808,547**.

The population in the region was assessed through the review of data collected from the following sources: 2019 Census estimates; 2019 Livingston County Health Dashboard; Washtenaw County Public Health Opioid surveillance data reports; Michigan Behavioral Risk Factor Survey of 2018; Michigan Profile for Healthy Youth (MiPHY) 2019-2020; Health Improvement Plan (HIP) of Washtenaw County 2015; National Center for Educational Statistics (2003 data); Robert Wood Johnson (RWJ) Health Rankings and Roadmaps 2020 report and Lenawee Health Department Health Assessment Report of 2017. Additionally, the National Survey on Drug Use and Health (NSDUH) data for 2016, 2017 and 2018 was included in the reference. The targeted population includes individuals within Washtenaw, Livingston, Lenawee and Monroe counties. This information is focused on individuals who have a high-risk for substance use, as well as those who suffer from mental illness, by identifying specific community-based areas, contributing factors and disadvantaged populations.

The population estimate for Lenawee County is 98,451; 93.7% of the population is White, 3.0% African American, 8.2% Hispanic or Latino and 0.5% Asian. Ten-point four percent fall below the federal poverty level. The median income is $53,972, with 90.8% high school graduation rate for adults over 25, and 20.9% having a bachelor's degree or higher. Eight percent of the adult population lack basic literacy skills (2003). Twenty-one-point one percent of the population is below the age of 18 and 19% is over 65. Healthy Michigan enrollment as of April 2020 was 4,167. Also, the April 2020 unemployment rate for Lenawee county is at 28.2%. Census data indicates (2019) 5.9% of Lenawee County individuals under the age of 65 are uninsured. Lenawee Health Assessment (2017) reported 1% of individuals over the age of 65 lacked health insurance coverage. Sixty percent of adults had at least one alcoholic drink in the past month. Nearly one-fifth (17%) of all Lenawee County adults were binge drinkers. Three percent reported using marijuana in the past 6 months, although that was collected before the recreational use law was enacted. Six percent indicated misuse of prescription drugs and 5% reported using other recreational drugs in the past 6 months. Twenty three percent reported having their life impacted because of a physical, mental or emotional problem. In the 2020 RWJ report, 20% report excessive drinking and 46% of driving deaths are alcohol related. Seventeen percent of adults report

smoking. The Lenawee County Office of Medical Examiner (ME) annual report of 2018 indicated there were 9% drug related deaths; 15% of reported deaths were caused by accident, a progressive rise over the years. This was primarily a result of a doubling of drug-related deaths to 25 (caused exclusively or in part by an injected or an ingested substance). During the past 5 years, fentanyl (a synthetic opioid many times more powerful than morphine) was included in two thirds of drug related deaths and was often combined with heroin or other abuse substances. The 2019 HUD Point in Time report for Lenawee County indicated there were 123 individuals experiencing homelessness with 7% reporting chronic SUD. MiPHY data shows that 12.6% of high school and 10.2% of middle school students identify as gay, lesbian or bisexual.

The population estimate for Livingston County is approximately 191,995 citizens; 94.2% of the population is White, 0.6% is African American, 2.5% is Hispanic or Latino and 1.0% is Asian. Five percent fall below the federal poverty level. The median income is $80,897, with 95.4% high school graduation rate for adults over 25 and 34.8% having a bachelor's degree or higher. Four percent of adults lack basic literacy skills. Twenty-one-point two percent of the population is under 18- and 17.2% is over 65. Healthy Michigan enrollment as of April 2020 was 4,833. As of April 2020, the unemployment rate for Livingston County is 21.9%. According to the 2019 Livingston County Health Dashboard, 6.3% of residents indicated they had no insurance coverage. Seven-point four percent of residents reported that they have poor mental health. Sixteen percent of adults are smokers, and 4.5% of high school students admit to smoking in the last 30 days. Nineteen-point one percent of adults binge drink, while 10.6% of high school students are binge drinking. Prescription drug class 2-3 rate per 1,000 is 934, almost one for everyone living in Livingston County. In the 2020 RWJ report, 20% report excessive drinking and 29% of driving deaths are alcohol related. Livingston County Human Services Collaborative Body Health and Human Services Needs Fact Sheet in 2015 reported that they have consistently ranked above the national average for opioid deaths in the last decade in statistics from the CDC. The county finds itself listed as one of the 24 counties in Michigan at high risk in the national epidemic. Law enforcement indicated the primary drug of choice in overdoses is heroin. The 2019 HUD Point in Time report for Livingston County indicated there were 89 individuals experiencing homelessness with 6% reporting chronic SUD. MiPHY data shows that 8.7% of high school and 5.7% of middle school students identify as gay, lesbian or bisexual.

The population estimate for Monroe County is 150,500. Ninety-four-point three percent of the population is White; 2.7 % is African American; 3.7% is Hispanic or Latino; and 0.7% are Asian. Ten percent fall below the federal poverty level. The median income is $61,514 with 92.1% of adults over 25 having a high school diploma and 19.1% having a bachelor's degree or higher. Seven percent of adults lack basic literacy skills. Twenty-one-point one percent of the population is under 18- and 18.8% is over 65. Healthy Michigan enrollment as of April 2020 is 6,370. Monroe's April 2020 unemployment rate is 5.8%. According to the 2020 RWJ report, 5% of Monroe County residents are uninsured, 20% of adults engage in excessive drinking, 17% of adults smoke, 46% of driving deaths are alcohol related and 4% report poor mental health days. Additionally, RWJ reports 14% are in poor or fair health. The 2019 Monroe County ME Annual Heroin and Fentanyl Overdose Data Report indicates the number of overdose deaths were 220 in 2017 and 195 in 2018. Interestingly, there have been several "pill mills" raided by law enforcement in Monroe County resulting in convictions of the prescribers. This sparked the epidemic early in the county, which resulted in the community coming together to address the issue in a similar way to the Project Lazarus Model across the country. The 2019 HUD Point in Time report for Monroe indicated there were 167 individuals experiencing homelessness with 11% reporting chronic

SUD. MiPHY data shows that 12.7% of high school and 2.7% of middle school students identify as gay, lesbian or bisexual.

The population estimate for Washtenaw County is approximately 367,601. The population consists of 74.2% White, 12.3% African American, 4.9% Hispanic or Latino and 9.4% Asian. Fifteen percent of the population falls below the federal poverty level (2018). The median income is $69,434 with 95.2% of adults over 25 having graduated high school and 55.2% having a bachelor's degree or higher. Six percent of adults lack basic literacy skills. Eighteen-point four percent of the population is under 18- and 14.5% is over 65. Healthy Michigan enrollment as of April 2020 was 13,740. As of April 2020, the Washtenaw County unemployment rate was 14.9%. It is important to note that Washtenaw County is the largest in region 6, with significant disparities. Zip Codes 48197-48198 on the eastern side of the county are economically and socially disadvantaged and experience a higher concentration of overdose events, with disproportionate numbers of fatal overdoses. In 2015, the county had the fifth highest income inequality rate in Michigan compared to other counties. Unfortunately, as of 2019, the county income inequality had worsened to the third highest in the state. The 2020 RWJ report indicates that 5% of Washtenaw County residents are uninsured, 21% engage in excessive drinking, and 12% of adults smoke. Also, 30% of driving deaths are alcohol related, 12% of residents report poor or fair health and 4% report having poor mental health days. Based on the WCPH opioid report, there were a total of 408 opioid related deaths between January and September 2019, which was 20% fewer than 2018. One percent of all Washtenaw County opioid related poisoning emergency department visits during November 2015 - May of 2019 were discharged to SUD treatment facilities; 44% went home, 23% to inpatient; 7% to skilled nursing facilities; 4% left against medical advice 3% to psychiatric hospital care and 18% to other facilities. The 2019 HUD Point In Time count found 273 individuals experiencing homelessness, with 35% reporting chronic SUD. MiPHY data shows that 9.9% of high school and 8.8% of middle school students identify as gay, lesbian or bisexual.

The region has capacity to support recovery for the individuals served. There are over 500 AA meetings and 60 NA meetings in the four-county region each week, with at least one Alano Club within each county. There are also a few dual diagnosis anonymous meetings available for this special population, as well as youth focused meetings in each county. There are Medication Assisted Recovery Anonymous (MARA) meetings held in Monroe County, which have been expanded as recently as June 2020. Because the CMHPSM supports the concept of "multiple pathways to recovery", clients are informed of other self-help groups, such as SMART RECOVERY (Self-Management and Recovery Training), Refuge Recovery, and others. Additionally, the CMHPSM has supported the development of Recovery Community Organizations (RCO) in each of the four counties. Currently, two RCO's have achieved certification by the Association for Recovery Community Organizations (ARCO) through Faces and Voices of Recovery, a national organization dedicated to persons in recovery, family, friends and allies.

The sub-populations needing focus in the near future include adolescents and older adults with Substance Use Disorders; Persons with Opioid Use Disorders; and African-Americans and Hispanics/Latinx because the penetration rates for services are significantly lower than the statewide rates and there are many health and social disparities in these populations that lead to disproportionate substance use, particularly opioids.

The current system of care in the four-county region for prevention and treatment has achieved transformational change since reported in the previous SUD strategic plan (2015-2017). Treatment services continue to be provided through a "core provider" model in which access and

other administrative responsibilities are delegated. This enables the core provider to ensure the individual seeking services receives a coordinated, recovery focused local approach that addresses their readiness for change, provides for recovery supports and addresses their resource needs through provision of case management and recovery focused services. Given the core provider is also the Community Mental Health Service Provider (CMHSP) or Co-Occurring Enhanced provider, the opportunity for integrated behavioral healthcare is a high priority. The CMHPSM requires all treatment providers to be co-occurring capable at a minimum.

Over the last several years, there have been some changes to the core provider structure, in that Monroe County CMHA expanded their Access department to integrate the SUD screening, assessment and referral services. The PIHP continues to provide utilization management and authorization for continuing care for Monroe and Washtenaw counties, but delegates that function to Livingston and Lenawee CMH core providers. Out of region specialty services include residential, opioid replacement treatment (ORT)/methadone, withdrawal management and other services that are coordinated through the core provider to ensure continuity of care is maintained. Services have expanded to primary care sites, that not only provide medication for Opioid Use Disorders (MOUD), but also SBIRT and other Recovery Coach services as well. Prior to COVID-19, the CMHPSM contracted for virtual web-based OUD treatment services through the SOR and SOR Supplemental grants. Tele-health became a necessity this year as Michigan issued an order for citizens to stay safe and stay-at-home. All providers have paid recovery coaches and/or certified peer specialists. Many providers have volunteer peers that coordinate and link individuals with activities in the community. Each county has community-based coalitions that address behavioral health needs, prevention needs and health needs of their respective communities. This is where our treatment, prevention and recovery focused issues are discussed, planned and initiatives are born. Continuing efforts in each of our counties involves addressing the heroin and opioid overdose/deaths crisis from a multi-disciplinary stratified collaborative approach. This brings treatment and prevention providers together with other community members to develop multi-level strategies to address the issues. This approach is aligned with ROSC elements, as systems of care are anchored in the community and the community can come together to solve problems.

Since the prior strategic plan, the outcome of community collaboration has launched numerous programs, including expanding enhanced women's services, e-cigarette prevention programming strategies, development of engagement centers, RCO's, jail supports, and opioid epidemic workgroups.

The region currently has four core treatment providers: Lenawee County Community Mental Health, who in turn sub-contracts with Parkside Family Counseling for adult and adolescent outpatient services, Catholic Charities of Lenawee County for adult outpatient services, McCullough-Vargas for outpatient treatment, recovery services, case management, women's specialty, women's residential and adolescent outpatient services; Salvation Army Harbor Light and Dawn Farm for withdrawal management and residential services; and Victory Clinic in Jackson County for MOUD treatment. Livingston County Community Mental Health sub-contracts with Complete Counseling Center for adult outpatient services, Key Development and Livingston County Catholic Charities for outpatient, case management, recovery and adolescent services; Dawn Farm and Home of New Vision in Washtenaw County are core providers directly contracted by the CMHPSM for all levels of care and are available to other core providers for these services. Also, in Washtenaw County are two MOUD treatment providers; Ann Arbor Comprehensive Treatment Center and Therapeutics, Inc.; and Catholic Social Services of Washtenaw County provides outpatient services. Additionally, the CMHPSM contracts with Community Medical Services (formerly Premier Services) for MOUD for the

region. In Monroe County, the CMHPSM contracts with Salvation Army Harbor Light for withdrawal management, residential, IOP, outpatient services, and recovery services; and Catholic Charities of Southeast Michigan for outpatient, adolescent, Intensive Wraparound, women's specialty and recovery services and Passion of Mind Healing Center in Monroe County for MOUD services. The CMHPSM has integrated SUD access services with Monroe County Community Mental Health for Monroe County residents. Other specialty services are available for the entire region: Hegira Oakdale Recovery Services for withdrawal management, residential and IOP; Sacred Heart Recovery Center for withdrawal management, residential and women's specialty services; Greenbrook Recovery Center for outpatient, IOP and MAT; Personalized Nursing Light House for IOP with domicile, men's and women's residential/withdrawal management; Holy Cross for men's, women's and adolescent residential, as well as women's specialty services; Kalamazoo Probation Enhancement Program (KPEP) for residential services; Bear River for withdrawal management and residential Services; Marie's House of Serenity for recovery in Washtenaw County; Paula's House, Salvation Army Harbor Light and Touchstone Recovery for recovery housing in Monroe County.

CMHPSM SUD Prevention Services for FY 2020-21 are provided by Avalon Housing, Catholic Social Services of Washtenaw County, Catholic Charities of Southeast Michigan, Eastern Michigan University, Karen Bergbower & Associates, Key Development Center, Livingston County Catholic Charities, Monroe County Intermediate School District, St. Joseph Mercy Health, and United Way of Lenawee and Monroe counties.

As the gap in available trained peers was identified in the last strategic plan, the CMHPSM has addressed the issue of expansion of persons in recovery who are trained peers and recovery coaches. Through the development of RCO's and having regional trainers certified through the state and/or Connecticut Community for Addiction Recovery (CCAR), we have developed a network of individuals who are either employed or volunteer to assist those clients entering early recovery. This addresses some of the gaps identified in the prior plan, such as transportation to meetings, court and medical appointments. We have piloted the virtual MOUD program with the intent of serving folks who are in "treatment deserts" in far rural areas of the region.

Additionally, partnering with the FQHC's, we have been able to reach far more individuals closer to their homes through local SBIRT and peer services. However, transportation continues to remain an ongoing issue. In certain circumstances, ride sharing programs through UBER and LYFT are another resource for persons getting to needed services. However, in some counties, these services do not exist. Helping people navigate their individual circumstances is a priority for our providers, especially while we incorporate the review of social determinants of health for each client. There continues to be a gap in capacity for higher levels of care since facing the opioid epidemic. We have expanded residential, but also recovery housing supports individuals in early recovery. We have specialized recovery that focus on persons with OUD, because stigma within the recovery community and even some treatment providers still exists for this population. Other innovations that have been developed in the community, either through direct programming with the CMHPSM grant funds or discussions at opioid workgroups, are implementation of Project ASSERT in the emergency departments; prescribing suboxone in the emergency departments, distribution of Naloxone prior to discharge in the jails; and law enforcement and community wide training on overdose reversal. Jail Based Medication Assisted Treatment (MAT) programs (from 2018 CMHPSM SOR Jail-Based MAT Expansion proposal) funded through SOR: The project goal is to ensure eligible inmates are identified and receive appropriate MOUD services before release and continue with programming at the FQHC or other MOUD providers. There are two objectives: 1. MOUD Treatment will be provided in regional county jails: and 2. Jail-based MAT recipients will receive linkages to community

treatment upon release. The program staff will monitor engagement in community and track progress via GPRA data.

Based on 2019 Census estimates, there are approximately 646,489 persons over the age of 18 living in our region. Additionally, there are approximately 46,000 persons between ages 10-17 in the region. NSDUH prevalence estimates 7.35% of persons over 18 (48,000) to have a SUD diagnosis. For children 12-17, the estimate is 2.8%, or approximately 1,288 regionally. While that seems low it is because of the difficulty with mismatched population estimates. Of the 18+ population, approximately 2.41% (1,200) needed treatment for illicit drug use and 5.26% (2,525) needed treatment for alcohol that did not receive it. Alcohol use in the past 30 days is at 57.22% regionally, with binge drinking rates at 27.62%. Youth (ages 12-20) alcohol use is at 26.38% for the region and binge drinking for this population is at nearly 18%. In 2019, publicly funded services within our region have been provided to approximately 5% of the population in need, or 2,797 unique individuals. Of the population served, 55% had a co-occurring mental health disorder which contributed to their need for treatment. Many of these individuals did not meet the serious mental illness requirement for CMH services, which represents a significant capacity and resource issue for the SUD and CMH provider network in our region. However, there are providers in the network that meet the Co-occurring Disorders (COD) enhanced designation, with psychiatry on hand to assist those clients in need. For example, in 2019, Home of New Vision, a long-time provider of mental health services to their SUD population, had 74 new clients receive psychiatric evaluations, with 353 services provided over the year. Catholic Charities of Southeast Michigan in Monroe was able to bring on psychiatric coverage by contracting with a psychiatric physician's assistant in April 2020 and has served 23 clients to date.

While these services are available, the capacity to meet the needs of persons with COD within the SUD services array could benefit from additional expansion. The CMHPSM's regional COD workgroup is responsible for review of the COD services across the region. The workgroup is made up of representatives from the Core providers and key CMH Clinical staff. Data indicates that about 60% of all regional mental health consumers have a COD. One of the objectives of the workgroup is to address the COD service needs across the system, including the frequency and prevalence of psychiatric hospitalizations where COD is identified. Presently, the average number of days spent in the hospital for consumers with COD is higher than for non-COD consumers. The workgroup-initiated strategies for addressing the COD clients' needs to avoid admission and to reduce the length of stay. The highest days occurred in Q4, 2018 at almost 7 days, but then dropped and remained consistently at 5 days on average during 2019 and 2020. Approximately 25% of inpatient admissions were for persons who had a prior or active SUD treatment admission. About 60% of the regional psychiatric hospital admissions were for persons at CMH with a COD diagnosis. Work continues to be done around reducing the need for inpatient services by persons enrolled at CMH with a COD. As the CMHSP's become more integrated, services for persons with COD are more accessible, especially where the CMHSP is the core provider. Another innovation is the pilot for a CCBHC in Washtenaw County, where basic outpatient SUD services are being provided and coordination for higher levels of care occurs.

Regionally, the opioid epidemic has had a significant impact on service needs and response in the past several years. As reported in the last plan, we noticed and addressed the increasing prevalence of OUD in our clients and the community at large. The response ranged from increased local, state and federal funding for innovative programming, community collaboration, outreach, new partnerships and supports for individuals with OUD and their families. NSDUH 2018 estimates the regional illicit drug use rate other than marijuana is 3.3% (27,000 persons). Data shows that primary drug of choice at admission to treatment remained higher for heroin and opioids until Quarter 2 of FY2018, where alcohol

began to climb again. Currently we are seeing an overall downward trend for opioids as primary, and slight downward trend for alcohol as well. We believe that this is a direct result of prevention efforts, community education, community based MOUD and other initiatives. However, 50% of persons aged 25-34 and 33% of persons aged 35-44 cite heroin or other opioids as primary drug of choice upon admission. It is important to note that continuing these programs is crucial to maintaining the downward trends in order to build upon previous successes. Additionally, we are seeing 78% of persons 17 and under have cited marijuana as their primary drug of choice. Regionally, an estimated 18.22% of the population used marijuana in the past year and 11.8% in the past 30 days. Monitoring marijuana use in various populations will be key as the rate may change due to legalization of marijuana in Michigan. This will need to be addressed in prevention and treatment services especially for adolescents in the region.

The CMHPSM uses multiple factors/resources in determining the prioritized consequences and intervening variables regarding reducing underage drinking and reducing prescription and over the counter drug abuse. This includes data collection and analysis from several sources, local input through the coalitions and prevention collaboratives, human services collaboratives, community forums, summits and regional surveys.

Continuing to support service integration across the behavioral health continuum is a critical factor embedded within the CMHPSM ROSC paradigm. Additionally, continuing the tradition of collaborative relationships from the SUD prevention and treatment providers, mental health, public health, primary care, community resource providers; recovery community, law enforcement, education and faith-based representatives joining together to address service delivery and gaps in service, the broader community benefits from the coordinated approach that engages the community as a whole. Over the last six years, these initiatives, unique to each county, have relied on the organized group that serves as leadership on initiatives related to SUD and mental health. In Livingston County, the Livingston Human Services Collaborative Body has maintained substance use as a priority area and a community wide workgroup that involves staff from the CMHPSM in a collaborative role. Focus areas include prescription drug/heroin abuse, supporting youth prevention efforts and improving the health of the community. In Washtenaw County, the Washtenaw Health Initiative (WHI) is a community wide initiative through the Center for Healthcare and Research Transformation (CHRT) that supports the mental health and substance use disorder work group. Over the last several years, the partnerships between CMHPSM, Washtenaw County Public Health and others ensured the Opioid Project has been active within the community to foster community education on the opioid epidemic through annual summits; partnered with the emergency departments and healthcare systems in the county to address the needs of persons experiencing overdose rescue, distributed naloxone to law enforcement and the community; provided a monthly forum for multidisciplinary discussions on opioid related topics & trends; created and advised on policy issues locally and statewide and used media to further the information.

The Lenawee and Monroe County prevention coalitions and Human Service Networks have taken the lead on opioid and other SUD issues community wide. The Lenawee County ROSC workgroup has been working on relationships with various community members to build upon the opportunities for persons entering recovery from mental health and Substance Use Disorders. All of the above groups have a stake in assessing their respective community needs and taking action to address those identified gaps collectively. The CMHPSM SUD team is involved with each county's efforts.

YOUTH ACCESS TO TOBACCO (YATT)

In order to address youth access to tobacco and nicotine products which can lead to addiction and health problems, the following processes are used in the CMHPSM region, in addition to mandated Synar Compliance Checks, to reduce youth access to tobacco and nicotine products:

Vendor Education: Regional Designated Youth Tobacco Use Representatives (DYTURs) are required to provide vendor education to at least 50% of the tobacco/Electronic Nicotine Device (ENDs) retailers within each county of the region. DYTURs prioritize visiting new retailers, retailers that failed a Non-Synar or Synar compliance check in the previous two years, and retailers that did not receive a visit in the previous year. DYTURs consult the FDA website to review retailers within our region that have failed their FDA compliance check and provide them with an education visit. During education visits, DYTURs discuss the Michigan Youth Tobacco Act and any changes in federal and/or state legislation, provide and post birthdate signs and other educational materials, and emphasize retailers' role in youth tobacco/nicotine access prevention.

Non-Synar Compliance Checks: Regional DYTURs are required to partner with local law enforcement to conduct Non-Synar Compliance Checks with at least 25% of the tobacco/ENDs retailers within each county of the region. Law enforcement issue citations to retailers that have violated the law. After compliance checks have been completed, each retailer that was checked receives a letter from the DYTUR; retailers that were compliant receive a letter congratulating them, while the retailers that failed receive a letter reminding them of the importance of checking all IDs to verify age and comply with the law. DYTURs personally follow-up with each of the retailers that failed their check to provide additional education and to address retailer questions.

Community Engagement: Regional DYTURs participate in numerous community events and speaking engagements, and consistently seek opportunities to keep communities up to date on tobacco and ENDs-related trends with our region's youth. As an example, DYTURs provide press releases, individual classroom presentations within regional school districts, and attend and/or participate in community fairs, open houses, and health events. In an effort to remain up to date in tobacco/ENDs-related data, evidence-based and promising practices, and changes to federal and state legislation, DYTURs partner with local coalitions and state-wide coalitions and workgroups, including the Tobacco Free Michigan Coalition and the MDHHS E-Cigarette Workgroup.

Over the course of FY21 – FY23, the CMHPSM would like to further develop and improve our region's ENDs prevention efforts to address the prevalence of vaping amongst our region's youth, including staying up to date with emerging trends and products. Additionally, we would like to cultivate a working partnership with the FDA Inspector(s) assigned to conduct federal compliance checks within our region to share data and strategies. We will continue to support the following efforts to decrease sales to minors at the federal, state, and local levels:

- Support amending the Michigan Youth Tobacco Act to prohibit the sale of tobacco to youth under 21
- Support restrictions in the sale of flavored ENDs products
- Increase cost of tobacco
- Support state tax increase on tobacco, especially loose tobacco and non-traditional tobacco products
- State mandate the use of computerized identification methods which cannot be bypassed
- Increase penalties for first time and repeat offenders
- Increase communication between retailers and law enforcement

- Empower retailers to know and understand their rights
- Encourage retailers to call local law enforcement at every underage purchase attempt
- Explain to businesses the higher cost of taxes when they sell to minors i.e. long-term health care costs, loss of employee work time, higher premiums on insurance etc.

The CMHPSM has continued to build upon the current communicable disease framework. Contracting with Unified – HIV Health and Beyond (UHHB), we continue to provide communicable disease education services to clients at the provider programs and community, and to provide harm reduction outreach services in the region. This includes mobile syringe support program (SSP) services, with the ability of expansion through an additional mobile unit. Additional funding is necessary to meet the demand for outreach regionally and to build capacity for support services. As part of our monitoring process, providers use risk assessments and referral to local resources when necessary. Communicable disease training is a policy requirement for staff and providers. Bringing this expertise to the community is the role of UHHB, and they do provide some health education/HIV/AIDS information to the community on behalf of the CMHPSM using local funds. UHHB is offering Hepatitis C testing on the mobile unit as well as part of their overall HIV/STI testing services. The trainings are different from the old communicable disease training. They currently conduct HIV 101 information sessions at Substance Use Disorder treatment centers and offering Hepatitis C, HIV/STI testing afterwards. They are in the process of getting estimates for a new mobile unit as well as getting the current one repaired and refurbished. UHHB has been trying to conduct SSP in Monroe and are currently conducting testing there. The leadership in Monroe County is hesitant to start SSP and embrace true harm reduction strategies. UHHB is in the process of relationship building to conduct SSP in the Out Wayne area as well. It has been difficult to get SSP up and running in other counties as well as internal to the region, mostly due to stigma and reluctance that continues to influence decision making in communities. UHHB is still conducting Naloxone and rescue training and overdose prevention trainings in the field and for various community groups.

UHHB has also been involved in youth outreach, peer driven services by providing SMART recovery at the Corner Health (young adult health center in Washtenaw County) and Whittaker Library for 14B drug court participants. They are collaborating with Ozone House (youth shelter and drop-in center), and other youth-based organizations and libraries to bring opioid education to this population. The impact of COVID-19 has made it difficult to maintain some staff, but UHHB plans on being creative in their implementation of these initiatives. Plans to expand SMART recovery groups; producing podcasts and using media resources to reach youth are ways to provide additional support. In person events, when possible, will also be implemented.

Gambling Disorders present additional addiction issues impacting our communities. Gambling Disorder is a significant impediment to recovery with financial, legal, social, vocational, familial, physical, and emotional impact. Recent data indicates individuals experiencing Gambling Disorder have been found to also present with a broad range of co-occurring behavioral health disorders. According to the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), 73.2% of pathological gamblers had an alcohol use disorder; 38.1% had a drug use disorder; 49.6% had a mood disorder; 60.8% had a personality disorder and 15-20% attempted suicide. To further address the gambling crisis in our state, the OROSC issued a Request for Application (RFA) to establish Michigan Gambling Disorder Prevention Projects (MGDPP) at the regional and community levels. The purpose of MGDPPs is to increase Gambling Disorder awareness, promote treatment and reduce Gambling Disorder among youth, young adult and adult populations. Region 6 utilized the Strategic Prevention Framework to organize a regional gambling disorder workgroup charged with engaging in problem identification, conducting a region wide

needs assessment; determine capacity and high-risk areas of need utilizing data driven decisions and strategies; and identify evidence-based practices to address local needs.

The Gambling Disorder Prevention RFA included a mandate from MDHHS for anyone assessing SUD clients to utilize the National Opinion Research Center DSM-IV Screen (NODS) assessment. The NODS assessment is based on DSM criteria for Pathological Gambling. A positive NODS assessment would result in a possible treatment plan goal and referral to the MDHHS Gambling Disorder Helpline. CMHPSM has a goal for 85% of SUD client assessments to include a completed NODS CLiP and has consistently surpassed that goal since its implementation in November 2019.

Veterans navigation services: Launched in 2017, the CMHPSM began the Veteran's Navigation program. This program reaches within the region to assist veterans and military families in seeking support and resources for services within the behavioral health and VA systems. Navigation is needed in this population, especially where families struggle to help veterans or for issues, they are experiencing themselves. The navigator has been able to cut through red tape in assisting these families and works directly with the CMHSPs; hospital EDs; SUD treatment providers; VA affairs; VA hospitals/healthcare; law enforcement; primary care and other local resources. The navigator has served over 182 unduplicated veterans and their families since 2018.

2.2 A narrative, based on an epidemiological profile, identifying and explaining data driven goals, and objectives that can be quantified, monitored, and evaluated for progress:

SUBSTANCE ABUSE TREATMENT

The CMHPSM recognizes the importance of targeting needs and strategies to promote healthy communities and individual well-being. We continue to use a data-driven approach to drive substance abuse prevention and treatment efforts throughout the region. Using data from our electronic health record (EHR), *Comprehensive Record for Consumer Treatment* (*CRCT*) which was updated in 2018, we monitor treatment wait times; total units of service over time, by provider, by level of care; number of clients served; timeliness by level of care and by provider; and service diversity by provider. We look at the National Outcome Measures in reviewing the impact of services on clients and utilize surveys, such as the Recovery Self-Assessment (RSA), to ensure service providers, including our mental health partners, are embedding the recovery principles and practices and that our clients experience recovery focused care. ***Attachment A*** demonstrates a review of data elements such as NOMS, data trends, the RSA over time, and the community survey.

The CMHPSM will continue to review trends in treatment such as primary drug of choice, co-occurring services, psychiatric hospital admissions, timeliness data and other program specific outcome measures. The BHTEDS data currently shows primary drug of choice overall for all counties is alcohol which, as mentioned above, has surpassed heroin and opioids for persons who are seeking treatment. One possible factor for the drop in opioid primary drug of choice has to do with many clients receiving services outside of the traditional SUD treatment system and in primary care settings, as the admission data is not tracked in the CMHPSM EHR. With the young adolescent population, data shows that marijuana is a primary problem, yet treatment utilization for this young population is low at best. While treatment strategies are individually client driven; availability of programming to manage the need will change as more innovative programming is developed to target the growing problems, such as heightened focus on Alcohol Use Disorders (AUD) in programs and outreach to the community. As with the opioid epidemic, the implementation of new and innovative services; prevention efforts and bringing the community together, appear to have made an impact. The challenge is

how to continue these services at the appropriate levels and ensure other focused services target new and developing needs without diminishing progress. The CMHPSM is committed to continual monitoring and evaluation of the impact of our efforts by using both internal and external data sources, such as county specific indicators through epidemiological means and in partnership with others. Again, this speaks to the importance of a recovery-oriented system of care, as the voice and indicators from within the community are key to informing the pathway for services.

The Self Sufficiency Matrix, which has been utilized by the CMHSPs and SUD providers regionally, is being reviewed for continuation. We have experienced issues with validity and fidelity, as there have been modifications that are not consistent across the region. We are exploring a tool that will better meet the needs of our entire region for both CMHSPs and SUD providers. The CMHPSM will continue to monitor contractor compliance with submission of the required data, as well as conduct annual reviews of services, documentation and operational policies.

SUBSTANCE ABUSE PREVENTION

The CMHPSM funds substance use disorder prevention programs, initiatives, and coalitions within the four-county region (Lenawee, Livingston, Monroe, and Washtenaw). Identifying and understanding substance abuse related issues in our region is vital to making recommendations for potential improvements. Thus, prevention implementers utilize data to guide local decisions and create a comprehensive plan for programming based on the Strategic Prevention Framework (SPF). The SPF is an outcome-based, data driven, population-level approach to substance abuse prevention planning. SPF includes five steps: assessment, capacity, planning, implementation, and evaluation. All five steps in the SPF process must be conducted in a culturally competent manner and with a goal of sustainability. Substance abuse continues to be associated with various individual, familial, and community issues. The CMHPSM understands the importance of targeting needs and strategies to promote healthy communities and individual well-being. Critical to the chances for success in substance abuse prevention is the implementation of evidence-based interventions targeted to multiple sectors within a community. The CMHPSM uses the MDHHS Guidelines for Prevention Services Planning to direct outcome-based initiatives. Applicants were required to note local, regional, or state data that has been identified, compiled, and used to support the consequence/primary problem for their selected community. The data drives the entire prevention effort and includes the identification of the primary problem, supportive data, associated intervening variables/risk and protective factors, evidence-based strategies, geographic area, population type and activity related short term outcomes.

CMHPSM PRIORITY AREAS

Prevention implementers focus on one or more of the following priority areas: (1) reducing childhood and underage drinking; (2) reducing prescription and over the counter drug abuse/misuse; (3) reducing youth access to tobacco and nicotine; and (4) reducing illicit drug use. Epidemiological evidence is required by the prevention provider/entity to support the selection of a priority area in a specific community. Due to current service gaps in various locations within the four-county region, the CMHPSM encouraged prevention providers to explore geographic areas within the region that have not recently been recipients of prevention programming or have been previously underserved.

PREVENTION SERVICES & COVID-19

The CMHPSM recognizes the impact of the coronavirus (COVID-19) on prevention services and the unique challenges and needs this health crisis creates in our communities. This is a vital time for SUD prevention services as the associated concerns are varied and complex and include: frequency and amount of substance use; physical and behavioral health issues; and the impact on multiple service domains (individual, familial, and societal). In turn, the methodology for prevention service delivery has been greatly impacted.

Providers were encouraged to consider the current crisis surrounding COVID-19 and identify the risk and protective factors associated with substance use/abuse in their respective communities. While several variables such as the timeline for face-to-face contact with program participants were unknown at the time of application for funds, providers were required to demonstrate how their proposed efforts could be applied with fidelity to the model program in a virtual format. Providers were informed that these adjusted methodologies should ultimately be addressed with the program developer and integrated into the program. Applicants for funds were required to complete a Virtual Services Planning Form which included questions to consider if physical distancing measures due to COVID-19 continue into FY21.

MONITORING & EVALUATION

Prevention providers utilize an Evidence-based Intervention Implementation & Evaluation Plan designed to elicit a logical sequence of information that includes the identification of consequences/supportive data and the associated underlying causes in a specific community; the selection and implementation of evidence-based interventions and prevention strategies based on the data; and the verification of results/outcomes. The plan provides information that demonstrates the relationship between the elements of the intervention and the expected outcome. In turn, the short-term outcome must specifically address the intervening variables/risk and protective factors which initially drove the selection of the evidence-based intervention.

Coalitions were required to develop and utilize a Coalition Strategic Plan for Community-Level Change based on the Community Anti-Drug Coalitions of America's Seven Strategies for Community Level Change:

- Provide information
- Enhance Skills
- Provide Support
- Enhance Access/Reduce Barriers
- Change Consequences
- Change Physical Design
- Modify/Change Policies

Funded programs are required to use SMART (Centers for Disease Control and Prevention) criteria: specific, measurable, achievable, realistic, and time-phased and report on each outcome (mid-year & year-end). An evaluation method for each outcome is required. This provides both the funded agencies and CMHPSM the opportunity to quantify, monitor, and evaluate progress toward achieving targeted outcomes. Given the timing of this strategic plan, data driven objectives/outcomes are under development and not yet finalized.

FY 2020-2021 SUD PREVENTION SERVICES – The data below includes selected epidemiological evidence provided by agencies to support the basis for substance use disorder prevention programs/initiatives in Lenawee, Livingston, Monroe, and Washtenaw counties.

LENAWEE COUNTY PREVENTION

Priority Area: Reduce Youth Access to Tobacco & Nicotine

The FY2019 Lenawee Synar Retailer Violation Rate (RVR) was 33% and 41.7% of Lenawee high school students reported that it is sort of easy or very easy to get cigarettes (MiPHY, 2019-20). Additionally, 21.9% of Lenawee high school students used an electronic vapor product during the past 30 days (MiPHY, 2019-20).

LIVINGSTON COUNTY PREVENTION

Priority Area: Reducing Childhood and Underage Drinking

According to the 2017-2018 Michigan Profile for Healthy Youth (MiPHY), over half (58%) of Livingston County youth have reported that alcohol is "sort of easy" or "very easy to get" and 38% of high school students and 36% of middle school students do not perceive regular alcohol use to be a moderate or great risk (MiPHY, 2017-18). This is an increase from 2013-2014 MiPHY.

Priority Area: Reducing Prescription and Over the Counter Drug Abuse/Misuse

Livingston County has seen a 61.5% increase in the number of prescriptions written for Schedule 2 substances from 2010-2014. Given that approximately 87.4% of Livingston County residents have health insurance coverage, there is easy access to prescription drugs. According to the results of MiPHY (2017-18), 93.8% of middle school students and 85.3% of high school students reported their friends felt using prescription drugs not prescribed to them to be wrong or very wrong.

Priority Area: Reducing Illicit Drug Use

Contributing to youth substance use is the legalization of recreational marijuana in the State of Michigan. With discrepancies in State and Federal law, the perceived risk of marijuana use by youth has dramatically fallen, while past 30-day use has skyrocketed. Additionally, there is at least one out-of-county dispensary that will deliver to Livingston County. There have been multiple attempts by medical and recreational marijuana groups to change cities' and townships' zoning laws to allow for additional dispensaries. If successful, this will contribute to youth accessibility. According to the MiPHY, Livingston County has seen perception of harm of regular marijuana use decrease among 7th and 9th grade students in Livingston County.

Priority Area: Reduce Youth Access to Tobacco

The FY2019 Livingston Synar RVR was 0% as they were able to achieve full compliance. According to the 2017-18 MiPHY, 46% of Livingston high school students reported it is sort of easy or very easy to get cigarettes. Twenty-eight percent of Livingston high school students used an electronic vapor product during the past 30 days (MiPHY, 2017-18).

MONROE COUNTY PREVENTION

Priority Area: Reducing Childhood and Underage Drinking

The MiPHY data released in 2018 indicated the average age of students reporting their first drink at 9.2 years which shows that the Monroe County youth are experimenting with alcohol at a much younger age (MiPHY, 2017-18). Additionally, 29% of middle school students reported sort of easy or very easy to get alcohol. In the 2019-2020 school year, the Monroe County Student Assistant Program Coordinator received 10 middle school student referrals for alcohol use.

Priority Area: Reducing Prescription and Over the Counter Drug Abuse/Misuse

The 2015-2016 MiPHY data shows 18.7% of Monroe County high school students have reported using a prescription drug not prescribed to them, however, new MIPHY data, released in 2018 shows a decline and a new statistic of 11.4% of Monroe County high school students reporting using a prescription drug not prescribed to them. According to MiPHY data in 2015 – 2016, there were 12.6% of Monroe County middle school students who reported using a prescription drug not prescribed to them. The MiPHY data in 2018 indicated 11.6% of Monroe County middle school students who reported using a prescription drug not prescribed to them. Monroe County Student Assistance Program Coordinator received 0 middle school student referrals for prescription pill use during 2019-2020 school year.

Priority Area: Reducing Illicit Drug Use
According the MiPHY survey results for 2017-2018, 14.8% of Monroe County high school students have reported using marijuana in past 30 days of survey and 11.5 was identified as the average age that Monroe County middle school students report using marijuana for the first time (MiPHY, 2017-18). The Monroe County Student Assistance Program Coordinator received 43 high school student referrals for marijuana use during the 2019-2020 school year and 16 middle school student referrals for marijuana use during the 2019 - 2020 school year. In 2018 there were 254 births to mothers who smoked during pregnancy in Monroe County. In 2019, the Monroe County Intermediate School District received 73 referrals for children who tested positive for prenatal exposure to alcohol, tobacco, and illicit drugs such as heroin, cocaine and marijuana, and/or prescription drugs.

Priority Area: Reduce Youth Access to Tobacco
The FY2019 Monroe Synar RVR was 20%. The 2017-2018 MiPHY data shows that 26.5% of Monroe County high school students used an electronic vapor product during the past 30 days. The Monroe County Student Assistance Program Coordinator received 23 high school student referrals for electronic vape use during the 2019-2020 school year. MiPHY data from 2015-2016 indicated that 11.1% of Monroe County middle school students have reported using some form of tobacco and/or nicotine in the past 30 days of survey. The 2018 MiPHY reports a decrease in tobacco use, however 7.1% of students reported use of an electronic vape in the past 30 days. The Monroe County Student Assistance Program Coordinator received 13 middle school student referrals for electronic vape use during the 2019 -2020 school year.

WASHTENAW COUNTY PREVENTION
Priority Area: Reducing Childhood and Underage Drinking
In Washtenaw County, approximately 11.9% of high school students reported having had at least one drink in the past 30 days and 6.4% reported having had 5 or more drinks, within a couple of hours, within the past 30 days, meeting the criteria for binge drinking (MiPHY, 2017-18). Almost 45% of 11th graders, according to the 2019 MIPHY data, have drank alcohol compared to 22% of 9th graders, with a 22% of both 9th and 11th having been drunk. Most students surveyed who drank alcohol, drank it at home (40%) with 20% of it being provided by a family. Of the Washtenaw County high school students surveyed (MiPHY, 2019-20), almost 23% of 11th graders have taken a drink in the last 30 days, with one third of those students stating they drank at home.

Priority Area: Reducing Prescription and Over the Counter Drug Abuse/Misuse
According to the 2019-20 MiPHY, 78% of those surveyed (Ann Arbor Public Schools, primarily), perceived drugs not prescribed to them demonstrate a moderate or great risk, but this percentage drops significantly with African American students, Latino students and those academically challenged. Additionally, misuse of prescription drugs can often be peer driven, and thus addressing the context of use as well as its impact is the best preventive strategy. According to the most recent National Survey on Drug Use and Health (2018), prescription drugs that are misused are mainly obtained from friends or close family, which include peers and cousins. More than half (51.3%) of people who misused pain relievers in the past year obtained the pain relievers the last time from a friend or relative.

Priority Area: Reducing Illicit Drug Use
A third (32%) of 12th graders who responded to the MiPHY survey (2019-20) tried marijuana with only 51% of them thinking smoking is ‘wrong or very wrong’ compared to 78% of them thinking using prescription drugs not prescribed to them as ‘very wrong’. In 2018, according to MiPHY, 13% of those surveyed used marijuana in the past 30 days. However, studies in states which legalized marijuana noted an increase in youth use, with Colorado noting a 65% increase (of first-time users) since legalization (National Survey on Drug Use and Health [NSDUH] 2006-2017).

Priority Area: Reduce Youth Access to Tobacco
Most concerning for public health officials was the significant increase in vaping among high school students. “More than 18% of Washtenaw County high school students have used electronic vapor products in the last 30 days, according to a survey conducted by the Michigan Departments of Education and Health and Human Services, (MLIVE
- https://www.mlive.com/news/annarbor/2018/09/vaping_increasing_among_washte.html**).** Whereas there has been a steady drop in cigarette smoking that has been replaced by vaping use among high schools. As a result, efforts to educate youth on the health impact of vaping are critical.

2.3 Narrative illustrating goals, objectives, and strategies for coordinating services with public and private service delivery systems:

Since the implementation of the PIHP programs in early 2000, the CMHPSM, like its predecessor, has a rich history of public/private partnerships in order to enhance services for the population served. For example, the impetus to develop the original engagement center sobering facility in Washtenaw County was supported by the two hospital systems emergency departments; emergency medical services; mental health, private foundations; law enforcement and other key groups back in 2009. The concept of coming together to address a need regardless of public funding eligibility was a way to address a solution to an overarching problem that individuals were experiencing when in crisis. This scenario has been repeated in the development of all three engagement centers in the remaining counties of the region. This is especially relevant as the opioid epidemic left many individuals in need of a safe, welcoming place to assist with crisis and connection to necessary services. Each engagement center received support from sources other than the CMHPSM for acquisition of space, startup funding, materials and other ongoing supports. The CMHPSM is involved in various collaboratives in each county within the region. They represent both public and private entities, including education, faith communities, youth-based services, housing, older adult services, community foundations, health systems, foster-care and adoption services, recovery communities and advocacy groups. Because these relationships have been built between public and private sectors, opportunities for addressing community issues are able to cross systems for solutions and strategies.

In Washtenaw County, the Opioid Project continues to involve both public and private members in influencing policy change, services and community education. Health plan representatives participate in monthly discussion both on the project and the WHI mental health substance abuse workgroups. The CMHPSM and providers were participants when the University of Michigan hosted a discussion with the Bloomberg Foundation as they were seeking input on strategies to fund opioid related initiatives. Policy changes for prescribing medication for OUD in emergency departments and jails have been vetted through community workgroups and collaboratives. Early training and distribution of naloxone was able to occur because of collaborative discussions and sharing ideas and supports. Additionally, in implementing the opioid focused federal grants (STR and SOR), there was a need to expand medication for Opioid Use Disorder services to private providers and FQHC’s. Women’s enhanced programs provide peer recovery coaching and case management services to pregnant women who may be receiving OB/GYN care from a private, community provider as this specialty may be limited in many communities. The veteran's navigator coordinates with each county veterans service offices and with the VA hospitals in the state. There are hosted events for veterans and their families for outreach. We have oversight policy board members from education and faith communities and other private sectors. Our funded prevention providers implement primary prevention strategies that require them to implement and report on efforts that they conduct in partnership with private businesses in their community. Examples include: Project Sticker Shock, which is

conducted as part of Communities Mobilizing for Change Against Alcohol, and necessitates a partnership between local coalitions and alcohol retailers; coalition partnerships with local pharmacies to provide information on safe medication disposal and the Big Red Barrel; and, during the COVID-19 pandemic, a sticker campaign with primary prevention educational messaging that was conducted in partnership with local restaurants to label to-go meal containers for curbside pick-up.

Goal #1: The CMHPSM will participate in coordinated and collaborative efforts within the region that support building healthy, recovery friendly communities through public and private partnerships to identify and address the comprehensive needs of the community at large.

Objective 1: Ensure CMHPSM is represented on key collaborative bodies and coalitions to champion public/private sector initiatives with a recovery focused perspective. Advocate for the voice of recovery to be incorporated across systems and supports.

Objective 2: Continue ROSC focused workgroups in each county that engage the recovery community, professionals and other key community members (courts, healthcare, human services, mental health, SUD prevention and treatment providers, veterans, education, housing, faith-based, etc.) charged with building recovery supports for persons served across the continuum. Utilize community wide data elements to support the knowledge base and inform the process. Utilize data to determine community priorities relative to SUD trends.

Objective 3: Coordinate information on access to services, capacity, barriers and gaps to the community. Coordinate needs assessments, outcome evaluations and surveys with the public to assure transparency and willingness to address issues collaboratively. Participate in strategic planning with updates periodically in order to understand current trends and status of services.

Objective 4: Continue to assess provider capabilities to implement recovery focused services and ensure that any needed modifications are identified, and strategies are developed. Publish results of annual monitoring (report card) and provider status on CMHPSM website.

Objective 5: Participate in planning discussions within CMHPSM systems to promote integration of SUD prevention, treatment and recovery focused services as service delivery changes are considered. Ensure the Oversight Policy Board has adequate representation in these discussions at the regional board level.

The CMHPSM has received federal funding for the opioid epidemic which presented other opportunities for public/private opportunities. SOR Prevention Providers: Eastern Michigan University implements Prime for Life; St. Joseph Mercy, Chelsea implements Guiding Good Choices and Livingston Community Mental Health implements OEND. SOR funded Treatment Providers: Workit Health- OUD Treatment; Home of New Vision- Recovery Housing, Outpatient Peer Support, OUD Recovery Services; Livingston Community Mental Health- Recovery Housing, OUD Recovery Services; Family Medical Center- Outpatient Peer Support; Catholic Charities of Southeast Michigan- OUD Recovery Services; Lenawee Community Mental Health Authority- OUD Recovery Services; Monroe Community Mental Health Authority- Jail Based

MAT/MI REP; and finally, SOR Supplemental Providers: Workit Health- OUD Treatment; Touchstone- Recovery Housing; and Paula's House- Recovery Housing.

Goal #2: The CMHPSM will implement jail-based MAT services to increase access to treatment for criminal justice involved population returning to communities. This is planned through SOR/SOR 2. The project goals and objectives are to ensure eligible inmates are identified and receive appropriate MOUD services before release and continue with programming at the FQHC or other MOUD providers.

Objective 1: MOUD will be provided in regional county jails:

- Secure agreements with county jails and other partners for program implementation
- Identify inmates with OUD at high risk of relapse and overdose via existing jail medical prescriber services.
- Coordinate with jail staff, medical services, and case managers to arrange for MOUD induction
- Utilize SOR funds to purchase medication and/or labs where needed.
- Coordinate peer recovery coach supports where necessary from existing community programs or new SOR funded peers.

Objective 2: Jail-based MAT recipients will receive linkages to community treatment upon release.

- Ensure coordination with post release treatment provider and counseling services
- Monitor engagement in community and track progress via GPRA data

2.4 Summary of key decision-making processes and findings undertaken by the SUD policy oversight board or other regional advisory or oversight board if the SUD policy oversight board is not established during the development of the strategic plan:

In 2014, the Region 6 Substance Use Disorder Oversight Policy Board (OPB) was established. The Oversight Policy Board is made up of sixteen members from our four-county region. Membership is comprised of two representatives from each county appointed by the county Board of Commissioners and two members from each county appointed by the CMHPSM Regional Board with recommendations from each respective Community Mental Health Board. In addition, each county has at least one member representing the recovery community, or person with lived experience. Once appointed, all representatives serve a three-year term. The OPB's mission is to support the CMHPSM Regional Board's ability to make an informed decision of maximum benefit by representing voices of the community, discussing trends and concerns; in order to make recommendations on comprehensive recovery-based substance abuse prevention and treatment services.

Due to increasing opioid overdose deaths in our region, the OPB was called upon to support initiatives in each county to address this issue. Having significant overdoses and deaths in Monroe County, the OPB supported the Heroin Summits with mini grant funds. Livingston County introduced the region to Project Lazarus and held a community meeting to begin addressing the Opioid epidemic, which was also supported by the OPB. The Washtenaw Health Initiative (WHI) Opioid Project was created in 2014 and later funded by CMHPSM OPB. The WHI Opioid Project brings together community members from law enforcement, public health, hospitals, community mental health, treatment facilities, and other providers to reduce opioid overdose deaths. Using the Project Lazarus model, the WHI Opioid Project uses experience, data, and compassion to prevent drug overdose and works to meet the needs of those living with chronic pain (Information from: https://www.whiopioidproject.org/our-story-1). The OPB also assisted Lenawee County initiatives with Project Lazarus funding and subsequent community events and

summits. Recovery Coach training was another priority supported by the OPB. In 2015, the RFP for regional prevention programing including DYTUR was released. Contracts were awarded to Lenawee CMH; Livingston County Catholic Charities; Monroe Substance Abuse Coalition, Washtenaw County Catholic Social Services Bi-County Senior Connections and SOS WASSUP. The CMHPSM released the Substance Use Disorder Prevention and Treatment PA2 Funded Special Initiatives RFP in March of 2015 along with an RFI to examine the overall network of treatment and core providers, as well as a specific prevention RFP for Monroe County Prevention. The RFP requested programs and initiatives that fit into programming priorities, including:

- Collaboration with School Systems/Justice Systems
- Recovery Housing
- Integrated Care Models
- Reduction of Opioid/Heroin Use, Overdose and Related Deaths
- Engagement Centers

Identifying and understanding current and projected, substance use disorder related issues and trends in the CMHPSM region was vital for applicants and the development of potential improvements and effecting change. From this RFP several initiatives were funded including creating a pool of funds to purchase naloxone; funds for training initiatives; continuation of fee for services provider panel; and continuation of existing and two new prevention providers.

In 2016 the Oversight Policy Board completed a SWOT analysis of the Substance Use Disorder services and supports in our region in order to guide the Strategic Plan. The analysis helped identify strengths, weaknesses, opportunities, and threats to Substance Use Disorder programs and providers in our region. In 2017, the Oversight Policy Board created a Strategic Plan and determined twelve priority areas the Oversight Policy Board would work to address. These priority areas are:

- Address lack of capacity for the demand of services
- Address limited adolescent treatment capacity
- Address limited integration with CMH and Primary Care
- Address fragmented and inconsistent access to care across the region (i.e. eligibility, diagnosis, medical necessity, etc.)
- Address poor communication between providers
- Need regional quarterly and annual reports that demonstrate spending by county per person, funds per capita per county, and spending per treatment service per county
- Cultivate opportunity to develop partnerships/collaborations and education for primary care, dental services, hospital systems, CMHs and safety net providers
- Simplify Access process and create procedures for provider communication
- Look for new best practice models
- Strategize for possible state policy changes and political systems that may impact system of care
- Plan for working with Department of Corrections, including how to address requirements by state and conflicts of treatment philosophy and service mandates for providers
- Address denial of SUD needs by communities, parents and schools

Despite successful initiatives and programming in our region, Substance Use Disorders continued to be correlated with various individual, familial, and community issues. In order to further impact change and implement evidence-based interventions targeted to multiple sectors within our community, in March of 2017, CMHPSM released the Substance Use Disorder Prevention and Treatment PA2 Funded Special Initiatives RFP for FY17-FY20. The RFP built upon the previous RFP priority areas and was expanded to include the following:

- Collaboration with School Systems/Justice Systems
- PEER Recovery Services
- Recovery Housing
- Integrated Care Models
- Reduction of Opioid/Heroin Use, Overdose and Related Deaths
- Engagement Centers
- Recovery Community Organizations (RCO)

From this RFP, CMHPSM funded the following initiatives to address the above priorities: Core providers; DYTUR; evidence-based prevention initiatives and fee for service panel. Special initiatives were engagement centers in Washtenaw, Livingston and Lenawee counties; Recovery Housing; harm reduction and outreach; peer training; youth initiatives; collaboration with health centers for integration and SBIRT; case management outreach teams; youth focused wrap-around services; grass roots community initiatives; peers in court; and case management in high risk housing programs.

With a goal of targeting needs and strategies to promote healthy communities and individual wellbeing, the CMHPSM released the Substance Use Disorder Prevention and Treatment PA2 Funded Strategic Initiatives in May of 2020. This RFP continues to expand previous RFP's and included the following programming priorities:

- Collaboration with Justice Systems
- Services for Youth
- Peer Recovery Services
- Recovery Housing
- Integrated Care Models
- Addressing Emerging Substance Trends
- Engagement Centers
- Recovery Community Organizations (RCO)
- Harm Reduction Services

In addition to funding PA2 funded Strategic Initiatives, the Oversight Policy Board annually sets aside a specific amount of funds per county for Mini-Grants. Mini-Grants are designated for small initiatives that arise during the fiscal year in an amount not to exceed $1,000. Mini-Grants are only awarded for special activities or initiatives related to Substance Use Disorders education, awareness, community activities and events.

The CMHPSM Oversight Policy Board has been dedicated to sustaining initiatives in our region. Understanding the value of community collaboration and recognizing the importance of continuing previously grant funded projects, the CMHPSM Oversight Policy Board has recently continued funding through PA2 funds for Project ASSERT, Michigan Association of Recovery Residences (MARR) certification for recovery housing, medication for MAT programs, prevention programs, provider and community trainings, and more. Throughout its six-year history, the CMHPSM Oversight Policy Board has supported Substance Use Disorder programming and prevention in our region. They have provided guidance, sustainability and ensured that services are available to those in our communities. In the time since the last strategic plan, the CMHPSM Oversight Policy Board has been vital in the progress and completion of previous goals, such as expansion of capacity; engagement centers; pilot projects; integration with primary care; coordination with coalitions; and financial analysis of system, to name a few. CMHPSM and the Oversight Policy Board are dedicated to continuing the work needed to envision that our communities have both an awareness of the impact of substance abuse and use, and the ability to embrace wellness, recovery and strive for a greater quality of life.

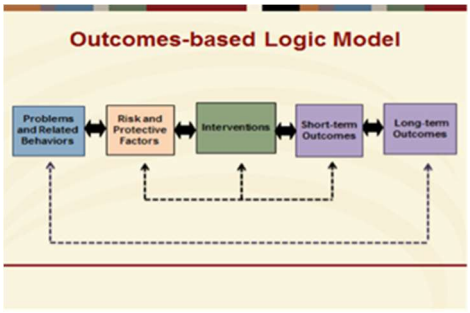
2.5 A narrative complete with a detailed logic model for selecting and implementing evidence-based programs, policies, and practices for implementing a recovery-oriented system of care that includes prevention and treatment, as well as all other services in your array necessary to support recovery:

For prevention, treatment and recovery services in the CMHPSM region, the selection and implementation of evidence-based programs, policies and practices for implementing a recovery-oriented system of care is driven by the identification of priority areas, consequences, and intervening variables (logic models).

PREVENTION LOGIC MODEL (Attachment II .1)

As noted in Section 2.2 of this Strategic Plan, data drives the entire prevention effort and includes the identification of the primary problem(s), supportive data, associated intervening variables/risk and protective factors, evidence-based strategies, geographic area, population type and activity related short term outcomes. Thus, CMHPSM prevention providers were required to provide a logical sequence of information in planning for the next fiscal year. As shown in the Graphic 1 below, an Outcomes-based Logic Model (SAMHSA) depicts the connection between the problem, risk/protective factors, intervention/strategies, short-term outcomes and long-term outcomes. When applying for prevention funds, applicants in Lenawee, Livingston, Monroe, and Washtenaw counties were provided examples of consequences and intervening variables by focus area. These included factors that have been identified as being strongly related to and influence the occurrence and magnitude of substance use and associated consequences as seen in Attachment I. Depending, of course, on data to support the consequences and intervening variables in the provider's selected county and/or community.

Graphic 1



SAMHSA

As demonstrated in the Prevention Logic Model (Attachment II.1), the CMHPSM plans to address the following overall goals: (1) to reduce childhood and underage drinking, (2) to reduce prescription and over-the-counter drug abuse/misuse, including opioids, (3) to reduce youth access to tobacco and nicotine, and (4) reduce illicit drug use.

In addition to Section 2.2 of this document, the following narratives identify selected highlights addressed in the CMHPSM Prevention Logic Model, Attachment II.1. Given the timing of this strategic plan, data driven outcomes are under development and not yet finalized.

LOGIC MODEL Priority Area #1: Reduce Childhood and Underage Drinking

Livingston County:
There are various consequences/primary problems to be addressed in Livingston County (i.e., delinquent/problem behavior, traffic crash deaths/injuries and early addiction). Associated intervening variables include: low perceived risk; perceived peer pressure; norms that support use; and easy access. The evidence-based programs to target these issues are Communities Mobilizing for Change on Alcohol (CMCA), Curriculum Based Support Group (CBSG), MOST Social Norming Campaign, Project SUCCESS and Youth Led Prevention. Efforts include multiple CSAP strategies and will target numerous outcomes, such as: access to alcohol; increase knowledge on risks and consequences; shift in attitudes; and increase in protective factors.

Monroe County:
Underage drinking will be targeted in Monroe County via Student Prevention Leadership Teams and the Monroe County Substance Abuse Prevention Coalition. Multiple CSAP strategies will be utilized along with the CADCA Community-Level Change Strategies. Targeted outcomes include increased knowledge of risks and consequences of underage alcohol use.

Washtenaw County:
The Prime for Life Program, Prevention Theatre Collective, Botvins Transitions, and Project SUCCESS will be implemented in Washtenaw County. Some of the targeted problem areas include education and social connectedness, early addiction, high-risk behaviors leading to harm and family conflict. Numerous intervening variables will be addressed, such as: low perception of risk of use on health; lack of knowledge; lack of social supports/social isolation; low perceived risk of negative consequences; peer rejection/perceived peer pressure; truancy, refusal skills lacking; peer influence; and social norms. Targeted outcomes include: increased knowledge and perception of risks and consequences of underage alcohol use; increased knowledge of opportunities for social engagement; increased refusal skills; increased communication; prosocial, relationship building and coping skills; increased referrals made for behavioral health disorders; and increased ability to handle peer pressure and decreased 30-day use.

LOGIC MODEL Priority Area #2: Reduce Prescription and Over-the-Counter Drug Abuse.

Livingston County:
Data demonstrates the need to address delinquent/criminal/problem behavior and Opioid related overdoses and deaths in Livingston County. There is a low perceived risk, peer pressure, easy access and norms that support use which will be addressed via CMCA, CBSG, MOST Campaign, Project SUCCESS and Youth Led Prevention efforts. Examples of targeted outcomes are: increase knowledge on risks and consequences associated with substance use/abuse; maintain or improve non-use attitudes towards substances; shift attitudes and community norms regarding how many teens use substances; decrease perceived peer pressure to use substances; increase protective factors; increase willingness to discuss substance abuse amongst parents and children; increase knowledge of safe disposal; and increase knowledge on drug misuse.

Monroe County:
Intervening variables in Monroe County regarding reducing prescription drug abuse/misuse are varied (i.e., students and families lack information about safe medication disposal and students lack knowledge of the risks associated with prescription pill use). The Student Prevention Leadership Teams and the Monroe County Substance Abuse Prevention Coalition will provide strategies to address these areas. Include in the

targeted outcomes are an increase in knowledge of risks and consequences of prescription and over-the-counter drug abuse and misuse.

Washtenaw County:
Health issues, addiction escalation, social isolation, interference with education and community alienation are problem areas in Washtenaw County. Numerous intervening variables are associated with reducing prescription drug abuse (i.e., low perception of risk, refusal skills lacking, social norms and attitudes, peer influence, truancy, lack of knowledge of prescriptions, lack of knowledge of drug interactions, lack of family supervision of medication and storage and easy access through family). The Get Connected Program for older adults will be implemented as well as Botvins Transitions and Prevention Theatre Collective (peer to peer approach). Programming efforts plan to increase knowledge and perception of risks and consequences of prescription and over-the-counter drug abuse and misuse, increase refusal skills, increase communication, prosocial, relationship building and coping skills, increase knowledge of community resources, and increase knowledge of proper disposal.

LOGIC MODEL Priority Area #3: Reduce Youth Access to Tobacco & Nicotine

On December 18, 2018, U.S. Surgeon General Jerome Adams issued an advisory about the dangers of electronic cigarette use among U.S. teenagers after he officially declared e-cigarette use among youth an epidemic in the United States. The surgeon general's advisory was a call to action. KBA answered that call to action by partnering with CMHPSM and prevention implementers across our region to create the Regional Vaping Prevention Initiative (RVPI). This initiative provides an array of evidence-based prevention strategies across the region to impact vaping, including both population-based strategies and individual strategies. The strategies address the identified contributing factors of easy access, norms that support use, perceived peer pressure, and low perception of harm.

Lenawee County:
Retail access, easy access to tobacco, norms that support electronic nicotine product use, perceived peer pressure, low perception of harm will be targeted in Lenawee County via Tobacco/Electronic Nicotine Product Retailer Education, Non-Synar Compliance Checks and the Regional Vaping Prevention Initiative (environmental and community-based strategies). Targeted results are varied (i.e., decrease youth access to tobacco and nicotine products, increase knowledge regarding Michigan Youth Tobacco Act, increase knowledge on risks and consequences of youth tobacco and nicotine product use and decrease the likelihood of youth e-cigarette use).

Livingston County:
Similar to efforts in Lenawee County, programming in Livingston County will include Tobacco/Electronic Nicotine Product Retailer Education, Non-Synar Compliance Checks and the Regional Vaping Prevention Initiative (environmental and community-based strategies) to ultimately reduce youth access to tobacco and electronic nicotine products.

Monroe County:
In addition to the above efforts in other counties in the southeast region, Monroe County will target reducing youth access to tobacco and nicotine products by addressing the associated factors of addiction, poor health, and struggles with managing stress in a healthy way. Utilizing multiple prevention and CADCA strategies via the Student Prevention Leadership Teams in the schools and the Monroe County Substance Abuse Prevention Coalition providers will increase the knowledge of risks and consequences of tobacco and nicotine product use and increase refusal and healthy coping skills

Washtenaw County:
Along with the region-wide tobacco and nicotine reduction efforts, the Project SUCCESS Program in Washtenaw County will address various problem areas and intervening variables (i.e., low perceived risk of future/school consequences, lack of coping skills, anti-social behavior/delinquency and perceived peer pressure). Anticipated results are: an increase in coping skills; improved relationships and ability to handle peer pressure; an increase in knowledge or risks and consequences of tobacco and electronic nicotine product use; a decrease in 30-day use; and a decrease in anti-social behavior.

LOGIC MODEL Priority Area #4: Reduce Illicit Drug Use

Livingston County:
Delinquent/criminal/problem behaviors and early addiction are areas to be addressed by programming efforts in Livingston County (i.e. CMCA, CBSG, MOST Campaign, Project SUCCESS and Youth Led Prevention). Low perceived risk, norms that support use and easy access will be targeted utilizing multiple CSAP strategies. Targeted results consist of: increase in knowledge on risks and consequences associated with substance use/abuse; maintain or improve non-use attitudes towards substances; shift attitudes and community norms regarding how many teens use substances; decrease perceived peer pressure to use substances; increase protective factors; and increase willingness to discuss substance abuse amongst parents and children.

Monroe County:
Fetal effects of prenatal exposure to illicit drugs and an associated interference with education will be addressed in Monroe County via the ISD (i.e., parent education, developmental screening and evaluation, service coordination, and on-going support/community referrals for families with young children identified as being at-risk). Additionally, the health and legal issues, and poor coping skills by youth will be the focus of the Student Prevention Leadership Teams.

Washtenaw County:
There are a multitude of variables to consider when addressing the issue of reducing illicit drug use in Washtenaw County (i.e., low perception of risk of use on health, lack of knowledge, lack of social supports/social isolation, lack of coping skills, peer rejection/perceived peer pressure, low academic achievement, and truancy). Prevention efforts will include the implementation of Prime for Life, Botvins Transitions, Project SUCCESS, and the Prevention Theatre Collective.

TREATMENT AND RECOVERY LOGIC MODEL (Attachment II.2)
Treatment and recovery issues to be addressed in by the CMHPSM are indicated in the logic model. In brief, these are: 1) low utilization of clinical and recovery services for adolescents in the region; 2) the need to expand capacity for treatment and recovery support services, especially in areas where certain services are limited and improve access and support services to ensure waitlists are minimized; and 3) continue addressing the high rates of opioid/heroin use and overdose/death events in each county. Specific strategies are identified within the logic model format.

2.6 Provision of an allocation plan, derived from input of the SUD Policy Oversight Board or other regional advisory or oversight board for funding a recovery oriented system of care that includes prevention and treatment, as well as all other services in your array, necessary to support recovery in identified communities of greatest need consistent with a data-driven, needs based approach and evidence based practices:

For FY21, the CMHPSM released a Request for Proposals (RFP) under the authorization of the OPB, for prevention services in our region that highlighted four priorities which include: 1) reducing childhood/underage drinking, 2) reducing prescription and over the counter drug misuse/abuse, 3) reducing youth access to tobacco and 4) reducing illicit drug use. Additionally, an RFQ for DYTUR was released, along with the specialty treatment and prevention services RFP primarily funded through local dollars. These included other priorities for locally funded treatment and recovery services such as: collaboration with justice systems; services for youth; peer recovery services; recovery housing; integrated care models; addressing emerging substance trends; engagement centers; recovery community organizations; and harm reduction services. Providers were not limited to these areas and could propose to provide other programming by providing epidemiological evidence of the issue in the specific region.

Under the block grant, the funding set aside for Prevention Services mandates 20% of the Community Grant allocation. The CMHPSM uses PA2 dollars to supplement prevention initiatives. While the prevention budget includes the required portion of the block grant, the percentage has been at 25% due to the programming needs of the region which has been adjusted each year by allocation amendments. All prevention service providers are required to utilize evidence-based practices and demonstrate implementation of the strategic prevention framework along with ensuring a Recovery Oriented System of Care (ROSC) focus.

SUD Treatment services in our region are recovery focused and include a range of recovery supports. ROSC core providers are required by contract to provide a full continuum of care that includes a recovery plan that addresses goals and objectives and is based on medical necessity. The intent is to maintain treatment funding levels subject to the availability of funds and based on population and need. Evidence based practices are utilized by the provider network in their treatment practices, and include, but are not limited to motivational enhanced treatment, Cognitive Behavioral Therapy; Dialectal Behavioral Therapy; Contingency Management; and others. Recovery supports in the form of coaching; recovery housing and case management are also provided as part of the available services which are coordinated across the system. Telehealth services have been introduced to the panel of providers as part of the COVID-19 response. Medication for Opioid Use Disorder is provided through primary care and specialty ORT providers.

The CMHPSM periodically reviews the active provider panel in order to ensure there is adequate capacity to meet the needs of the population served. This is done by having an open panel for fee for service providers and an RFP for special services or core providers. Based upon data, the CMHPSM includes communication with providers and the community to determine specific needs. Where capacity is limited in a particular area of the region, the CMHPSM will attempt to seek providers able to fill that gap or increase capacity with existing providers. While there are no tribal entities in our region, services are open to any Native Americans who may require culturally competent services from our providers. There is limited service availability for persons with hearing impairments and vision impairments, although, the service providers will make all attempts for accommodations in order to assist the client. Older adults are another population to expand services as the population ages, and persons with SUD may need different approaches or clinical strategies. In many communities the population is aging. In 2018,

Washtenaw County's residents 60 years and older accounted for 18.3% of the county's population. Regionally, the number of residents aged 60 years and older is expected to double over the next twenty years. Prevention services will also expand to include those caring for elders both in professional and non-professional capacities. This may include but is not limited to caregivers, family members and community professionals.

A recent community needs survey indicated that improvement is needed in the following areas: Ease of access to services that includes improved screening processes; extending length of stay in treatment; improved waitlist management for certain service levels of care; increased access to medication for Opioid Use Disorders; adolescent treatment and recovery services; expanded recovery housing opportunities; and prevention services in areas where they are limited. In order to address this, CMHPSM issues RFPs to address the needs. Additionally, the OPB has maintained a spending strategy for PA2 funds that initially looks at the available revenue and savings by county, then issues the specialty services funding that is county specific. The OPB maintains a specific reserve to ensure PA2 funds are available to cover potential gaps in block grant funded services or supports Medicaid treatment services where funding is limited.

Providers are contractually obligated to provide services to the priority populations within the required timeframes, while managing their priority population waitlists, as well as submitting their reports to the CMHPSM treatment coordinator on a monthly basis for state submission. Contract language also requires adherence to all CMHPSM SUD policies, including the Access Policy which specifies the urgency of admission for priority populations. The CMHPSM will also maintain multiple fee-for service contracts that will provide additional capacity as needed. Opioid replacement therapy services have been expanded in the region, as has MOUD/MAT in primary care settings and an innovative telehealth pilot program for MOUD is being evaluated.

The CMHPSM Trauma-Informed Practice Policy requires all providers to maintain a safe, calm and secure environment with supportive care, a system-wide understanding of trauma prevalence and impact, recovery and trauma specific services and recovery-focused, consumer driven services by policy. Trauma informed services are required to be evidenced based. In the last several years, there has been interest by providers to receive training in Adverse Childhood Experiences (ACES) and some have begun to incorporate this as part of their assessment processes where indicated. Use of this assessment process has assisted the provider in determining treatment approaches for their clients to better meet their needs.

2.7 Implementation plan that describes how key prevention, treatment, and recovery services, as well as all other services necessary to support recovery, will be implemented and a three year timeline:

ROSC transformation became fully incorporated into the CMHPSM SUD system of care following measures that started in 2010 and culminated fully by 2016. As recovery focused practices and strategies were embedded into all provider work, including expanding recovery based services, increasing capacity for coaches and peers within organizations, non-traditional community centered programs, such as engagement centers, Recovery Community Organizations (RCO) and recovery housing expansion, the CMHPSM believes the broader system of care reaped the ROSC benefits. Central to this process was the voice of the individual in service and the broader community. The value in partnerships that are relationship based, collegial, multidisciplinary and multicultural, has driven the system of care to meet the needs of the individuals who we serve.

Using the Strategic Prevention Framework and assessing needs are the bedrock of the work done over the years by the CMHPSM, in concert with the Oversight Policy Board. Our partners continue to be providers, CMHSPs; primary care; law enforcement and first responders; public health, healthcare systems, in particular the emergency departments, schools, youth-based agencies, coalitions and task forces, university resources, faith-based partners and local community leaders. While this has been an incredible opportunity for transformational change, there still is much work to be done. We have recognized that stigma has impeded the movement toward fully becoming recovery focused communities. Persons with SUD continue to experience some form of stigma that impacts their life. For example, those individuals with OUD have had difficulty accessing some services such as recovery housing and even some 12 step meetings to assist with their ongoing recovery paths. Because of this, specialty recovery housing was made available to persons on MOUD to give them the same opportunities as others. Accepting the principle that there is no wrong path to recovery has been hard for some providers. Ensuring that all providers accept persons treated with MOUD supporting the alternatives has been difficult.

Bringing key staff from mental health and SUD providers together in each county to build relationships, discuss misconceptions and myths is an activity that has helped to bridge the stigma gap between systems and fosters relationships that can be called upon when providing joint, coordinated services. Funding joint programming between mental health and SUD, has broken down barriers and forged long-lasting collaboration as successes are realized.

However, as much great work has been completed, there is always room for improvement. It has been ten years since we first implemented transformational change; we have weathered many storms. The opioid epidemic; implementation of the affordable care act; marijuana legislation; and now COVID-19; we must re-examine our entire approach to funding and operations to ensure we still are achieving the outcomes in a way that demonstrates fiscally sound, clinically responsive and culturally and recovery supportive practices. Goals for the next three years must focus on financial stability; capacity building; sound workforce development; culturally specific services that support vulnerable populations within our region. It is important that we continue to apply the principles of ROSC in all community relationships because we believe the community that embraces health and recovery enables individuals to achieve success. We do recognize that the community work requires continued commitment and refining. Each community presents different challenges and has a set of different constituents that change over time. The CMHPSM will continue to assess and redevelop priorities.

***SEE ATTACHMENT** B*: *IMPLEMENTATION PLAN AND TIMELINE documents the process for the upcoming three years:*

2.8 An evaluation plan that identifies baseline and outcome data for implementing a recovery oriented system of care that includes prevention and treatment, as well as all other services necessary to support recovery:

In order to promote the success of ROSC and continue to make improvements in implementing this model, the CMHSPM recognizes the importance of evaluating the progress on various substance abuse prevention, treatment, and other health indicators in the region. Thus, specific outcome data will be utilized and monitored in service areas necessary to support recovery, and adjustments made where necessary, to enhance the opportunity for success.

PREVENTION/OUTCOMES TABLE – Evaluation Process and Procedures:

In order to promote the success of ROSC and continue to make improvements in implementing this model, the CMHSPM recognizes the importance of evaluating the progress on various substance abuse prevention, treatment, and other health indicators in the region. Thus, specific outcome data will be utilized and monitored in service areas necessary to support recovery, and adjustments made where necessary, to enhance the opportunity for success.

Consistent with MDHHS, all prevention programming in the CMHSPM region must be conducted utilizing a data guided approach. The logic model was utilized to elicit a logical sequence of information from associated consequences, through planned strategies and outcomes. As identified in Section 2.2 of this strategic plan, monitoring, and evaluating programs relies on SMART (Centers for Disease Control and Prevention) criteria: specific, measurable, achievable, realistic, and time phased. Given the timing of this strategic plan, data driven outcomes are under development and not yet finalized. Providers will be expected to report on the progress toward achieving their respective outcomes, utilize reliable tools such as survey instruments for verifying results, assess fidelity to evidence-based models and report any deviations. CMHSPM staff will monitor and review the progress toward achieving program outcomes and provide direction/consultation to agencies as needed.

PREVENTING YOUTH ACCESS TO TOBACCO – Evaluation Process and Procedures:
The CMHPSM will continue to use a comprehensive approach to ultimately decrease youth access to tobacco and nicotine products. Vendor Education and Non-Synar Compliance Checks will target those stores that sold tobacco during the prior year's compliance checks, as well as new retailers from the updated Master Retailer List, and stores that did not receive a visit within the previous year. Additionally, DYTURs consult the FDA website to review the list of retailers within our region that have failed their FDA compliance check and provide them with an education visit and/or Non-Synar Compliance Check. Focused attention will be put on retailers that sell both tobacco products and ENDs. Targeted vendor education to at least 50% of the retailers within each county of the region has helped reduce our Regional Retailer Violation Rate (RVR) over the last five years; in fact, our regional RVR has remained below 15% between FY 2016 and FY 2019. In FY 2015, the RVR was 33.3% and in FY 2019, the RVR was 13.3%. We plan to maintain our region's 80% compliance rate, and DYTURs have been working to ensure that retailers are versed in the differences between the Federal Tobacco 21 legislation and the Michigan Youth Tobacco Act, including the restriction of selling ENDs to minors. Through Vendor Education, DYTURs will continue to be empower retailers to know and understand their right to deny sales if they determine tobacco will be given to a minor or calling in attempted sales to law enforcement.
DYTURs will continue to be involved with community coalitions, such as the Lenawee Substance Abuse Prevention Coalition, the Monroe Substance Abuse Prevention Coalition, and the Livingston County Community Alliance, in order to educate potential partners about the negative consequences of tobacco and ENDs use, as well as engaging youth and community partners in compliance efforts. Classroom and community education will also continue to serve in increasing awareness about tobacco and ENDs. Our goal is to reduce youth access to tobacco using the multi-level strategies identified above which include education, compliance checks, and enforcement of the Michigan Youth Tobacco Act.

TREATMENT AND OTHER RECOVERY SERVICES – Evaluation Process and Procedures:
Overall, the experience with adopting the principles and elements of recovery oriented systems of care has resulted in improved services, sustained engagement, reduction of waitlists, involvement of persons in recovery at all levels, and redistribution of resources that sustain services across the year. This has been

confirmed through consumer and community feedback surveys to verify their experience of the services provided. Additionally, review of specific utilization data; state data indicators and evaluation elements in turn informs the process for modification and change when necessary. In 2017, we saw an 8% increase in admissions. That number jumped to 17% in 2018 and dropped to 13% in 2019. Because the demand increased for more intensive services, the CMHPSM increased the number of residential and withdrawal management beds within Washtenaw County. This enabled the region to have somewhat more capacity for individuals within our borders. However, this still remains a priority for two specific counties within the region, Livingston and Lenawee where these services are either very limited or not available, thus requiring out of county services. Additionally, the ability to provide recovery housing for persons who are in early recovery and attending treatment services enabled individuals without stable housing to benefit from treatment while they seek employment or obtain benefits to cover the cost of their housing. This is especially critical for new moms or those who have small children to be able to live in a supported environment while in early recovery and unable to return to work. Beginning in FY 17, the CMHPSM was able to provide recovery housing for 372 unique individuals who are supported through the block grant and an additional 400 + individuals through local funds. However, this is limited to sixty to ninety days, with some minor individual exceptions. Measuring the impact of programs such as this is important. Since the implementation of the ROSC core provider system in the region in 2010, the system has evolved to address new challenges, such as the Opioid epidemic with the need to expand services into non-traditional settings, such as primary care. New ways to reach individuals who are isolated in "service deserts" where there is limited transportation and other resources has been paramount in the last few years. COVID-19 has highlighted the need to be responsive with non-face to face interventions such as implementing tele-health and other outreach capacity. Integrating treatment into non-traditional settings, such as primary care, corrections, emergency departments and housing sites have made it necessary to review system implementation overall and ensure the original goals and objectives for transformation are current and relevant. In order to determine if the system still meets the needs of those we serve, several questions must be explored. Using the evaluation process to ensure we are maximizing efficiencies, clinical impact and return on investment highlights the priority for modernization and adjustment of practices. An example of this is the review of specific outcome measures as part of the ROSC Core Provider contracts. This provides clarification of expectations leading to achieving further ROSC integration and meeting performance standards necessary for funding requirements.
Funds spent on services are monitored on a monthly basis by comparing general ledger and financial status report data with the service level data submitted via the electronic health record. The service level data is reported by CPT code and by funding source. It can be detailed by provider level and also summarized across the PIHP. The CPT codes are cross walked to level of care and includes any modifiers being reported, including integrated health services and recovery supports. This level of detail allows the CMHPSM to keep apprised of any significant changes in service level and to monitor individual providers operating within the ROSC system to ensure the full array of services are being provided.

The CMHPSM will utilize a quarterly dashboard of indicators to measure specific outcomes on a regular basis and will incorporate performance levels to ensure compliance and accountability. The following table indicates the evaluation mechanisms to be utilized to track performance in specific domains.

ATTACHMENT C *contains the baseline and outcomes data measures and evaluation mechanisms for each domain required.*

WOMEN'S SPECIALITY SERVICES – Evaluation Process and Procedures:
The CMHPSM has ensured that service availability to the Women Specialty Services (WSS) population has now been implemented in all four counties within our region.
Eligible women have been defined as, "those who are either pregnant or parenting, or those involved with the child welfare system that are at risk of losing or attempting to regain custody of their children." These populations have also been identified as a federal or state priority for admission to treatment. Eligible men will have access to ancillary services.

Women's Specialty Services are treatment services available for eligible women or single men that are raising their own minor children. Women's specific funding is restricted to assuring access for chemically dependent, pregnant, post-partum women, as well as single men who are raising their children and are in treatment. These services assist with the provision of transportation, childcare, and medical care for those who are eligible and their children.

Michigan law extends priority population status to men whose children have been removed from the home or are at danger of being removed under the child protection laws. To support their entrance into and success in treatment, men who are shown to be the primary caregivers for their children are also eligible to access ancillary services such as child care, transportation, case management, therapeutic, interventions for children, and primary medical and pediatric care, as defined by 45 CFR Part 96.

Women Specialty Services will be sustained by:

- Utilizing cross-systems collaboration and the involvement of informal supports to promote a person's recovery.
- Utilizing a client-centered, goal-oriented approach to accessing and coordinating services across multiple systems by:
  - assessing needs, resources and priorities
  - planning for how the needs can be met
  - establishing linkages to enhance a person's access to services to meet those identified needs
  - coordinating and monitoring service provision through active cross-system communication and coordinated treatment/service plans
  - removing barriers to treatment and advocating for services

A woman's needs determine the connections with agencies and systems that impact her life or family's life, despite the number of agencies or systems involved. Ideally, each woman will have a single, collaboration treatment plan or service plan used across systems. Care/case coordination and peer recovery services is the key to an individual's progress in recovery. The CMHPSM ensures that peer recovery support services are also incorporated into the women's specific programming, especially for enhanced services to pregnant women with OUD. Treatment revolves around the role women have in society, therefore treatment services must be gender specific.

- Gender-responsive programs are not simply "female only" programs that were designed for males.
- A woman's sense of self develops differently in women-specific groups as opposed to co-ed groups.
- Because women place so much value on their role in society and relationships, to not take this into consideration in the recovery process is to miss a large component of a woman's identity.
- Equality does not mean sameness; in other words, equality of service delivery is not simply about allowing women access to services traditionally reserved for men. Equality must be

defined in terms of providing opportunities that are relevant to each gender so that treatment services may appear very different depending on to whom the service is being delivered.
- The unique needs and issues (e.g., physical/sexual/emotional victimization, trauma, pregnancy and parenting) of women should be addressed in a safe, trusting and supportive environment.
- Treatment and services should build on women's strengths/competencies and promote independence and self-reliance.
- A model that emphasizes the importance of relationships in a woman's life and attempts to address the strengths as well as the problems arising for women from a relational orientation.

Outpatient services, case management, transportation and childcare are available in each county in the region and residential treatment is coordinated with the women's specialty program through Sacred Heart Clearview in Memphis, MI, and Holy Cross in Saginaw, MI.

CMHSPM monitors each of the WSS programs expenditures and reviews its WSS programs during site visits. Site visits include reviewing the providers WSS policy and procedures, referrals logs, WSS curriculums, progress notes and treatment plans. WSS Coordinator monitors each of the WSS programs, attends WSS trainings, meetings and workshops, as required. The designated Regional Treatment Coordinator oversees all SUD treatment services for the CMHSPM and works in conjunction with treatment providers on ensuring women's specific services are provided. The Women's Specialty Treatment Services Policy guides services for all providers in the region. There is one certified women's specialty service provider for women and parenting men in each county. Home of New Vision serves Washtenaw County; Key Development serves Livingston County; McCullough Vargas serves Lenawee County, and Catholic Charities of Southeast Michigan serves Monroe County. In 2016, the CMHPSM was able to utilize funds to provide enhanced services for pregnant women with Opioid Use Disorders and provided more intensive services in conjunction with OB/GYN high risk pregnancy programs in their counties to primarily address the opioid epidemic and increasing incidents of Neonatal Abstinence Syndrome. Coordination with parenting programs, prevention efforts and other key stakeholders enabled women to have special services along with their regular neonatal regimen and post-partum opportunities. Paula's House in Monroe County is a recovery home in the region that accepts women and their children. The introduction of recovery peers working alongside the case managers adds more support to women in early recovery. Access to women's specific recovery housing and MOUD friendly living situations has added more benefit to women struggling with OUD.

PERSONS WITH OPIOID USE DISORDERS – Evaluation Process and Procedures:

The CMHSPM response to the increase in opioid and heroin addiction and dependencies, overdoses and related deaths, has been comprehensive and innovative. Each County in the region now has a focused workgroup or coalition which has been the point of community coordination for information on the epidemic through community opioid and heroin summits; participation on community collaboratives and CMHPSM partner in activities in the communities. The CMHPSM has been the point of contact for naloxone rescue kits; law enforcement training and support; prevention efforts and community change efforts, as well as expansion of treatment opportunities in primary care and other office-based services. Expansion of the engagement centers also offers a safe space for persons with OUD who are in crisis and needing to access treatment and recovery services. Building the recovery coach workforce to expand peer services through treatment programs and RCO's for more active recovery communities have afforded opportunities for persons with OUD. There has been coordination with the jails to increase access to naloxone for persons prior to release and even attempts at providing medication while in Jail, but most importantly, transfer to MOUD treatment post release. Providing outreach to the using population

with syringe support services, education and referral opportunities is important to reach persons who may be reluctant to seek services. Partnering with law enforcement in some parts of our region enables peers to reach out to persons experiencing overdoses quickly and providing follow up post event. The opioid workgroups have supported discussions on prescribing suboxone at the ED's, with follow up in the community. Also, we are evaluating a SOR funded pilot program where MOUD and treatment services are mostly virtual, being able to reach individuals with OUD who do not have or want access to local ORT clinics or do not have transportation. Over the past several years, the CMHPSM has been able to expand services to the OUD population. This included adding providers to the panel who provide ORT; working with primary care to expand providers who are prescribers of MOUD; provide access to services at the FQHC's where there are prescribers and other ancillary services available. Since the implementation of the collective efforts in the region, there has been a reduction in overdose deaths and events.

The CMHPSM recognizes the importance of evaluating all these efforts on the population served. We continue to require individuals requesting ORT services, to complete an initial assessment through access at their core provider, or CMH Access services, which includes an orientation to the recovery supports and services available to them. Consumers that are a priority population are assessed within 24 hours and referred to provider for services within 24 hours. Support services and case management are immediately available through the core provider. Individuals who are requesting office based MOUD services either being referred from jail release; hospital discharge or ED referrals can schedule directly or with peer coach assistance at the primary care site. ORT's also are able to treat individuals with medication other than methadone. While we have not had a waitlist for MOUD services, in the event that a client is unable to be admitted to the ORT program, interim services would be available through their core provider or another outpatient provider. Clients are encouraged to participate in recovery support groups available on a regular basis regardless of admission to the ORT or primary care clinics.

Pregnant women with opioid use disorder are typically seen through the local high risk OBGYN clinics and referred to the ORT programs for the term of the pregnancy. They are followed by the Women and Families case manager for any additional service needs and provided enhanced services. Providers coordinate with OB/GYN physicians, who may receive consultation from an addictionologist as needed.

The State Opioid Response (SOR) grant offers additional programs for persons with OUD. Utilizing this funding, Workit Health provides web-based treatment for individuals with OUD which includes funding for medication. Outpatient peer support programs through Home of New Vision and Family Medical Center enhance peer-based outreach to people who are using opioids, have opioid use disorder and who will benefit from peer services to engage in or stay engaged in Medicated Assisted Treatment services. Recovery Housing is enhanced through Home of New Vision, Touchstone, and Paula's House, as well as Livingston CMHA assisting with increasing access to SUD recovery housing for individuals with OUD with a priority for those on Medication Assisted Treatment in Livingston County. SOR supports OUD Recovery Programs in each county: Home of New Vision increases available recovery resources and supports for individuals with OUD in Washtenaw County by linking and leveraging a wide range of resources and efforts already underway through WRAP; Catholic Charities of Southeast Michigan implements Recovery Advocacy Warriors (RAW), a Recovery Community Organization (RCO) which will work within the Monroe community to provide advocacy and reduce stigma commonly associated with substance use; Livingston CMHA conducts programming to increase involvement for consumers in early recovery interested in utilizing ongoing support in their recovery path through their engagement center; and Lenawee CMH conducts programming to increase involvement for consumers in early recovery interested in utilizing an ongoing support in their recovery path, also through their engagement center. SOR Prevention EBIs include Prime for Life through Eastern Michigan University and

Guiding Good Choices through St. Joseph Mercy Chelsea. Overdose Education and Naloxone Distribution is funded for CMHPSM as well as Livingston CMHA. MI-REP at the Monroe County Jail is also supported through this grant. Pending award of funding, SOR II is planned to continue and grow much of the above programming and add new providers and programs to the region, including an Opioid Health Home and continued efforts in jail-based MAT services, further supporting individuals with OUD. SOR II would also expand coverage to include individuals with Stimulant Use Disorder.

All SOR funded programs are evaluated through monthly, quarterly and year end reports submitted to and evaluated by the State and Wayne State University. Additionally, OUD Treatment, Outpatient Peer Support, Recovery Housing, and MI-REP programs are evaluated by GPRA assessments at intake, 6-month follow-up, and discharge of service. SOR funded prevention programs are also evaluated by pre- and post-tests completed by program participants.

2.9 Evidence of a process and procedure for ensuring that policies, programs, and practices will be conducted in a culturally competent manner:

The CMHPSM places high value on cultural competence for the services provided to its consumers. The CMHPSM sets the expectations for cultural competency within the region with its Culturally and Linguistically Relevant Services policy updated in 2017. The purpose of the policy, which applies to all staff, students, volunteers and contractual organizations within the provider network of the CMHPSM, is to ensure that consumers and families with culturally diverse backgrounds and/or linguistically different needs have access to needed translation services so that planning and service delivery can be conducted in a way that facilitates the consumer's desired outcomes.

The CMHPSM requires that all staff and contractual network service providers effectively and efficiently address the treatment and psychological needs of consumers and families with diverse values, beliefs, and sexual orientations, in addition to backgrounds that vary by race, ethnicity, religion, abilities, and language. Every effort is made to ensure that services and staff are participating in the ongoing process of achieving cultural competence.

To further ensure that services are culturally competent and relevant, Community Mental Health Service Providers (CMHSPs) and SUD contract service providers:

- Promote awareness of cultural differences and concerns, develop knowledge of cultural issues, develop skills to work well with differences, and embed cultural experiences within all levels of the organization.
- Make every effort to implement strategies to recruit, retain, and promote, at all levels of the organization, a diverse staff and leadership team that are representative of the demographic characteristics of the service area.
- Incorporate a management strategy that addresses culturally and linguistically relevant services and incorporates community and consumer involvement in the design, execution, and service delivery.
- Conduct annual organizational self-assessments of culturally and linguistically relevant services to identify further opportunities to integrate cultural and linguistic competence-related measures into internal audits, performance improvement programs, satisfaction assessments and outcomes-based evaluations.
- Ensure that service for all consumers shall be relevant to their culture and life experiences.
- Ensure that individual plans of service/treatment plans have documented evidence of cultural/LEP issues and values.

- Ensure that culturally and linguistically competent literature is made available on prevalent psychiatric disorders, medical treatment options, and pharmacological interventions.
- Develop participatory, collaborative partnerships and outreach activities with communities to facilitate community and consumer involvement to improve cultural and linguistic related activities. Make available to the public information about progress and successful innovations of cultural and linguistically relevant activities.
- Ensure that the physical environment uses visual images that reflect the diversity of the community. Artwork, photographs, colors, and decorations will be utilized that reflect this cultural diversity.
- Ensure training of all employees during orientation and as required by the Regional Training Grid regarding core Cultural Competency and LEP policies and procedures. Components of the training shall include:
- Overall awareness of cultural competency/LEP and issues involved, including ethnic/ racial backgrounds, gender culture, socioeconomic/education status, sexual orientation, physical capacity, age/generation, personality type, spiritual/ religious beliefs, regional perspectives, multi-cultural influences, and LEP.
- Completion of the cultural competency and LEP training will be required as part of the initial and on-going credentialing process. Documentation of the training will be maintained that includes the employees' names and dates of training.
- Ensure that any person receiving services within the CMHPSM who believes that he or she has been excluded from the participation in, denied the benefits of, or subjected to discrimination under any program or activity within the CMHPSM, understands that they may file a Recipient Rights Complaint with the CMHPSM designated Recipient Rights Officer or Customer Services.
- Ensure that conflict resolution, grievance, and appeals processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by consumers.