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Healing Michigan: An Examination of State-Level Responses to the Opioid Epidemic in Michigan

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HEALING MICHIGAN

An Examination of State-Level Responses to the Opioid Epidemic in Michigan

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PUBPOL475

An epidemic has silently swept across America with no regard for race, location, or socioeconomic status. The recent opiate epidemic, characterized by the sudden surge in usage among Americans, is considered the most fatal drug crisis recorded in United States history[1]. With over 1.9 million Americans addicted to prescription drugs and opiates, the state of Michigan lies directly in the path of destruction: the number of drug overdose deaths in the state— a majority of which are from prescription drugs — has tripled since 1999[2]. This staggering number of Americans addicted to prescription opioids is particularly disturbing because prescription opioids serve as gateway drugs to heroin, an illegal drug which is cheaper, gives a more intense high, and has a higher fatality rate. In fact, 4 out of 5 heroin users started on prescription opioids[2].

The current opioid epidemic is unlike any in American history. Although the crack cocaine epidemic impacted primarily African-Americans, the opioid epidemic is most common among non-Hispanic white males, ages 18-24 or 45-55, who are insured by Medicaid[3]. However, no demographic has gone unaffected; heroin use has increased by 63% overall with increases observed in both genders, most age groups, and all income levels between 2002 and 2013[3]. Our country's response to the crack cocaine epidemic resulted in an equally complex problem — mass incarceration. The criminalizing approach of the "war on drugs" was ineffective in treating substance use disorder as the mental illness that it is. We cannot afford to repeat our mistakes. Upon analyzing responses to the heroin and prescription drugs epidemic, I seek to understand whether Michigan will ignore history and continue to criminalize drug use, or if it will lead the

[1] Nolan, Dan, and Chris Amico. "How Bad Is the Opiate Epidemic?" PBS. PBS, n.d. Web. 11 Dec. 2016.
[2] United States of America. National Safety Council. Prescription Nation 2016: Addressing America's Drug Epidemic. National Safety Council, 19 July 2016. Web. 11 Dec. 2016.
[3] Jones, Christopher M., Joseph Logan, Matthew Gladden, and Michelle Bohm. "Vital Signs: Demographic and Substance Use Trends Among Heroin Users — United States, 2002–2013." Morbidity and Mortality Weekly Report (2015): n. pag. CDC. Web. 11 Dec. 2016.

country toward addressing substance abuse as a challenge to its mental health system rather than its corrections system.

In this paper, I will first situate the heroin epidemic in Michigan within the context of the United States, framing the State of Michigan's current efforts to combat the epidemic both in comparison to other states as well as Michigan-specific historical policies. I will make comparisons to other states and analyze the extent to which recent state budget reflects recommendations made by the Michigan Prescription Drug and Opioid Abuse Task Force. Next, I will present data on how Michigan's local officials perceive the drug problem in their area, as well as review the effectiveness of various institutions in responding to an epidemic. Finally, based on findings described earlier in the paper, I will make three policy recommendations; one to focus on prevention, one to focus on controlling prescriptions, and one to focus on treatment. I will conclude by identifying the policy that must be implemented first, as well as provide suggestions of how these new programs can be funded.

I. Michigan: A History of Drug Abuse and Failed Responses

In mid-June 2015, Governor Rick Snyder formed a bipartisan task force to examine trends of prescription drug and opioid abuse, evaluate the various possible responses, and develop a statewide action plan by that Fall[4]. The Michigan Prescription Drug and Opioid Abuse Task Force was formed after he admitted that the "increased attention paid by law enforcement to combatting this problem" was blatantly insufficient, as opioid overdose deaths increased by 265% among men and 400% among women in the state between 1999 and 2010[5].

[4] State of Michigan. Lieutenant Governor. Prescription Drug and Opioid Task Force. Michigan.gov. Lt. Gov. Calley, 26 Oct. 2015. Web. 11 Dec. 2016.
[5] Michigan Prescription Drug & Opioid Abuse Task Force Report. Rep. State of Michgan Executive Office, 26 Oct. 2015. Web. 11 Dec. 2016.

In addition to Snyder's examination of the epidemic, the National Safety Council (NSC) recently published a report addressing America's drug epidemic where it gave every state a rating of "making progress", "lagging behind", or "failing" based on evaluation of efforts in six key indicators: 1) Mandatory Prescriber Education, 2) Opioid Prescribing Guidelines, 3) Eliminating Pill Mills, 4) Prescription Drug Monitoring Programs (PDMPs like Michigan's MAPS), 5) Increased Access to Naloxone, and 6) Availability of Opioid Use Disorder (OUD) Treatment[2]. Michigan was one of only three states which not only *failed*, but met *zero* indicators[2]. Prior to the task force or report from the NSC, Michigan made early attempts to implement a PDMP and increase access to Naloxone (a drug which blocks or reverses the effects of opioid medication).

A. PDMP Implementation

Partly because opioid addicts attain their drugs by "shopping" for physicians willing to prescribe them opioids, healthcare costs for those suffering from substance use disorders are almost ten times higher than those for those without the disorder[6]. In response to this doctor-shopping, in 2003 Michigan implemented the Michigan Automated Prescription System (MAPS), a prescription monitoring system used to identify and prevent drug diversion at all levels (patient, physician, and pharmacy) by collecting Schedule II (drugs with a high potential for abuse/dependence) drug prescriptions dispensed by pharmacies and practitioners[7]. According to MAPS, more than 11 million prescriptions were written for Schedule II drugs in 2014 — an

[6] Alan G. White et al., Direct Costs of Opioid Abuse in an Insured Population in the United States 11 J. MANAGED CARE PHARMACY 469, 479 (2005), http://www.amcp.org/data/jmcp/3.pdf.
[7] "MI Automated Prescription System (MAPS)." LARA - Statistics. N.p., n.d. Web. 11 Dec. 2016.

increase of 8 million from the 3 million prescriptions written in 2007[8]. MAPS was not as effective in slowing the rate of opioid prescriptions as compared to other states' PDMPs.

There are several reasons why MAPS may not have been effective. Use of MAPS in Michigan, unlike 29 other states' required use of PDMPs, is completely voluntary for doctors who write prescriptions[9]. This lack of regulations means that doctors are permitted to prescribe Schedule II drugs without checking if their patient is shopping for doctors. Furthermore, because Michigan's MAPS system hasn't been upgraded since 2003, the existing system is slow, prone to crashes and lacks the capacity to handle all the individuals authorized to use it[10].

Legislators have noticed this deficiency and taken action. Most recently a Senate Bill, introduced by state Senator Tonya Schuitmaker, was referred to the committee on health policy which requires physicians to run a MAPS report on all new patients when prescribing schedule II-V drugs[11]. Additionally, the recently passed state budget provides $2.4 million to upgrade the system as a result of recommendations from the Task Force[11].

There is reason to believe that increasing the effectiveness of MAPS will have a significant effect on limiting the number of prescriptions and doctor shopping. Ohio's system, OARRS, which requires prescribers to look up each patient's profile before prescribing, is credited with the State's decrease in doctor-shopping in the past three years[12]. Additionally, in 2010, Florida regulated pain clinics and stopped healthcare providers from dispensing prescription opioid pain relievers from the offices, *in combination* with establishing a PDMP. As

[8] MICH. DEP'T OF CMTY. HEALTH, A PROFILE OF DRUG OVERDOSE DEATHS USING THE MICHIGAN AUTOMATED PRESCRIPTION SYSTEM (MAPS) 5 (2014), https://www.michigan.gov/documents/mdch/MAPS_Report_2014_- _FINAL_464112_7.pdf. 39 MICH. DEP'T OF LICENS
[9] United States of America. Office of National Drug Control Policy. 2015 Annual Review of Prescription Monitoring Programs. THE NATIONAL ALLIANCE FOR MODEL STATE DRUG LAWS, Sept. 2015. Web. 11 Dec. 2016.
[10] Derringer, Nancy. "Amid Opioid Crisis, Few Doctors Use Michigan's Outdated Drug Monitoring Tool." Bridge Michigan. Bridge Michigan, 18 Aug. 2016. Web. 11 Dec. 2016.
[11] Schuitmaker, Tonya, and Mike Nofs. "Senate Bill 0769 (2016)." Michigan Legislature. Michigan Legislature, 9 Feb. 2016. Web. 11 Dec. 2016.
[12] United States of America. Ohio State Board of Pharmacy. Ohio Automated RX Reporting System. By Steven Schierholt. 2013-2014 Biennial Report, Oct. 2013. Web. 11 Dec. 2016.

a result, Florida saw a more than 50% decrease in overdose deaths related to oxycodone, a schedule II drug[13]. New York and Tennessee both required prescribers to check the state's PDMP before prescribing opioids. New York saw a 75% drop in doctor-shopping, while Tennessee saw a 36% drop in doctor-shopping[15]. From these case studies in combination with understanding the broken PDMP, Michigan must not only improve MAPS (which is already taking place), but also require physicians to use it.

However, a mere increase in use of MAPS or any PDMP will only result in a decrease of prescriptions. When given no access to prescription drugs, substance users may turn to a more dangerous, but cheaper, opioid — heroin — meaning that additional policies must address this potential consequence.

B. Access to Opioid Antagonists

While the MAPS system works to *prevent* people from using prescription to excess, opioid antagonists are prescribed *in case* of excess use: overdose. In 2014, State Senator Tonya Schuitmaker, State Representative Hugh Crawford, and State Representative Anthony G. Forlini passed a bill which mandates that all medical authorities and emergency services personnel are trained to administer opioid antagonists like Naloxone and gives more protection to these responders from criminal prosecution or sanction if they acted in good faith and reasonable care while administering the opioid antagonist[14]. Most importantly, this bill allows for prescribers and pharmacists to dispense opioid antagonists to any at-risk patient, or their family members[16]. This legislation mostly affects counties which provide emergency medical services, who must now equip each life support vehicle with opioid antagonists and trained personnel.

[13] "State Successes." Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, 2016. Web. 11 Dec. 2016.
[14] United States of America. House Fiscal Agency. Allow And Regulate Use Of Opioid Antagonists. N.p., 14 May 2014. Web. 11 Dec. 2016.

Although this increased access to Naloxone is progress, Michigan failed this indicator from the NSC because it is still weaker than 29 states' bills which give increased access to Naloxone[15]. In response to our weak legislation, Senator Schuitmaker, supporter of the 2014 bill, proposed another bill which enables Michigan pharmacies to offer Naloxone without prescription[16].While her bill has not been passed by the Michigan Senate yet, 39 other states will be allowing their pharmacies to sell Naloxone without prescriptions --- a program which Walgreens announced they would be providing[17]. After the formation of the Task Force, our State government has demonstrated that they understand what it will take to sufficiently address the opiate epidemic — understanding is one thing, investing in solutions is another. After analyzing the state budget for Fiscal Year 2017, it is not definitive that the state is fully investing in treating, rather than locking up, citizens with substance use disorder.

C. Michigan's Fiscal Year 2017 Budget

Substance use disorder is widely recognized by experts as a mental health challenge. At the state level, Governor Snyder has historically supported Medicaid, which benefits a majority of people addicted to opiates[5]. However, between a decrease of funding of 1.4% to the Department of Health and Human Services (DHHS), the department responsible for addressing mental health challenges, and an increase of 3.4% toward the Department of Corrections in light of a declining prison population, those looking to address the opiate epidemic must understand how the state is approaching people with substance use disorder — as criminals or as patients[18].

[15] "Expanding Access to Naloxone: Role of the Pharmacist." Lesson: Expanding Access to Naloxone: Role of the Pharmacist. US Pharmacist, n.d. Web. 11 Dec. 2016.
[16] Schuitmaker, Tonya. "Senate Bill 0778 (2016)." Michigan Legislature. Michigan Legislature, 10 Feb. 2016. Web. 11 Dec. 2016.
[17] Chicklas, Dana. "Michigan Pending Legislation to Offer Naloxone without Prescription to Fight Opiate Overdoses." FOX 17 West Michigan. FOX 17 West Michigan, 12 Feb. 2016. Web. 11 Dec. 2016.
[18] United States of America. State of Michigan. State Budget Office. EXECUTIVE BUDGET Fiscal Years 2017 and 2018. State of Michgan Executive Office, 10 Feb. 2016. Web. 11 Dec. 2016.

One aspect of the budget particularly seems to suggest a divestment from quality mental health services. The controversial, revised section 298 includes a $2.4 billion shift in Medicaid mental health funding; a shift that mental health advocates fear would constitute a take-over of the mental health system by for-profit Health Maintenance Organizations (HMOs)[19]. This "take-over" could also be described as a consolidation of mental, behavioral, and physical health services, which will save overlapping administrative costs. What is perhaps most troublesome is that, after a review of arguments made on either side of the shift toward HMOs, few analyses accounted for how quality of care would be affected.

One voice, Bob Sheehan, CEO of the mental health board association, fears that health plans underestimate the difficulty in caring for a complex population with poverty, housing, employment, disease, and environmental concerns, all-the-while seeking to earn high profit margins in behavioral health[20]. Others who support Snyder's move point to research which shows that the opioid epidemic has a disproportionate impact on Medicaid enrollees; Medicaid beneficiaries are prescribed painkillers at twice the rate of non-Medicaid patients and are at three-to-six times the risk of prescription painkillers overdose[21]. By coordinating health providers, there is less risk for miscommunication between physicians on providing a patient with a more comprehensive treatment plan.

Additionally, Governor Snyder's efforts to pump more funding into the Medicaid system, along with findings from the Task Force, suggest that this increased funding and likely regulations to follow, could mean taking up several more of the Task Force's recommendations.

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[19] Greene, Jay. "Michigan Would Privatize Mental Health Funding, Services under Snyder's Proposed Budget." Crain's Detroit Business. N.p., 12 Feb. 2016. Web. 11 Dec. 2016.
[20] Greene, Jay. "HMOs Seek Mental Health Bids." Crain's Detroit Business. N.p., 21 Jan. 2016. Web. 11 Dec. 2016.
[21] United States of America. Department of Health and Human Services. Centers for Medicare & Medicaid Services. Best Practices for Addressing Prescription Opioid Overdoses, Misuse and Addiction. By Vicki Wachino. Center for Medicaid & CHIP Services, 28 Jan. 2016. Web. 11 Dec. 2016.

The budget, for example, specifically provides $500,000 general fund one-time support to pilot a Medication Assisted Treatment program within existing drug treatment courts targeting new admissions with opiate disorders[20]. A promising outlook for those working to slow the opioid epidemic.

In other sections of the budget, however, there are strong implications that the state government intends to criminalize the opiate epidemic rather than treat it as the mental health challenge that it is. For example, the executive recommendation includes $700,000 in one-time funding to provide investigator and prosecution assistance to supplement the efforts of local authorities in *prosecuting* drug cases[22]. Without additional regulation, this could mean anything from creating more mental health courts or drug courts, to increasing prosecuting power and keeping up with the "war on drugs".

Furthermore, in the recent budget, the governor maintains, but does not increase support, for mental health courts and diversion services with $5.3 million[22]**.** The budget also recommends $750,000 from the general fund to expand substance abuse programs specifically designed for probationers with a history of relapse. Governor Snyder also removed the requirement of training for custody staff who handle incarcerated individuals with mental illness; the last two provisions indicate that Michigan is shifting toward pre- and post- incarceration mental health services and away from in-prison mental health services. Are these adjustments the most effective one? How can this corrections funding be utilized (or twisted) to most effectively assist those with a substance use disorder?

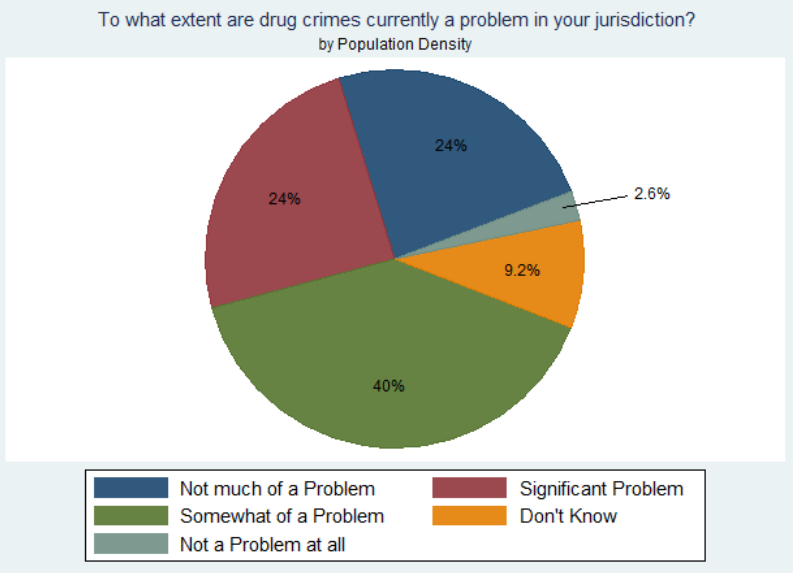
[22] Executive Budget FY17 Overview. Publication. Michigan Council on Crime and Delinquency. Lansing: Michigan Council on Crime and Delinquency, 2016. Print.

II. Effectiveness of Funding Distribution

In the following section, I will explore various possibilities that may be driving the State to increase funding for corrections and reduce funding for the Department of Health and Human Services.

A. Local Officials' Influence

To understand the effectiveness, we must first understand how local governments are perceiving the drug problem in their respective jurisdictions. Between drug courts, mental health courts, various attempted reentry programs, training of corrections officers, equipping police officers with Naloxone, and many other corrections-based solutions, a solution cannot be implemented without understanding whether or not local officials are ready to address the epidemic's effects in their jurisdiction. In 2015, the Center for Local and Urban Policy (CLOSUP) asked local officials to rate the extent to which drug crimes are a problem in their given jurisdiction. Nearly 25% of all officials responded that drug crimes are a problem in their jurisdiction, while an additional



Graph 1: Perception of Drug Crimes as a Problem for Law Enforcement

40% believe that drug crimes are somewhat of a problem[23]. As seen in Graph 1, this opinion is not dependent on population density, which reflects the general trend of the opioid epidemic.

Furthermore, because the wording is "drug crimes" rather than merely "a drug problem", it is unclear whether or not local officials are considering overdose deaths when estimating the severity of the drug crime problem. In fact, the wording "drug crimes" reflects a systemic, criminalized perception of substance use disorder. In the MPPS, although there has been a question asked about drug crimes, there has yet to be a question directly asking about the prevalence of substance use disorder. Whether it be that CLOSUP believed that "drug crimes" was the language most accessible to local officials, or that CLOSUP has an implicit bias, this wording suggests a perception of drug use as a crime rather than a disorder. Due to this wording, and the response that a majority of public officials perceive drug *crimes* as a problem, it stands to reason that local officials may be driving the increased corrections funding to combat these drug "crimes".

To substantiate this hypothesis that local officials are pushing the state for more support, we would need to understand whether or not local officials believe that their corrections departments are being sufficiently funded by the state. Although there is not data to gauge their opinion on the entire corrections department, CLOSUP asked local officials to evaluate the extent to which their jurisdiction has enough funding to meet its law enforcement needs generally[24]. If local officials feel underfunded, they could plausibly be encouraging the state to boost corrections funding.

[23] Center for Local, State, and Urban Policy. (2010). "Drug crimes as a problem in jurisdiction." Michigan Public Policy Survey, Fall 2015 data tables. Ann Arbor, MI: Center for Local, State, and Urban Policy. Retrieved from: http://closup.umich.edu/michigan-public- policy-survey/fall-2015-data/q22c.php
[24] Center for Local, State, and Urban Policy. (2010). "Enough funding to meet current law enforcement needs." Michigan Public Policy Survey, Fall 2015 data tables. Ann Arbor, MI: Center for Local, State, and Urban Policy. Retrieved from: http://closup.umich.edu/michigan-public-policy-survey/fall-2015-data/q13b.php

Upon analyzing Table 1, because the opiate epidemic has particularly challenged low density, rural areas in historically unique ways, it is not surprising to see in Table 1 that half of all officials in low population density areas either don't know or are neutral on whether or not their jurisdiction has enough law enforcement funding — this is a recent and unforeseen problem. Do they have sufficient funding and just using it ineffectively? Or do they understand the impact of the opiate epidemic, but don't believe that law enforcement is responsible for addressing it? Given recent increases in media coverage and federally funded prescription drug education programs, the latter seems equally, if not more, plausible as the first.

Key
frequency *column percentage*

Your jurisdiction has enough funding to meet its: Law enforcement needs	Population Density			
	Low <100	Mid	High >800	Total
Strongly Agree	91 15.32	76 19.69	75 24.04	242 18.73
Somewhat Agree	105 17.68	96 24.87	96 30.77	297 22.99
Neither Agree nor Dis	152 25.59	70 18.13	26 8.33	248 19.20
Somewhat Disagree	54 9.09	62 16.06	68 21.79	184 14.24
Strongly Disagree	39 6.57	34 8.81	38 12.18	111 8.59
Don't Know	153 25.76	48 12.44	9 2.88	210 16.25
Total	594 100.00	386 100.00	312 100.00	1,292 100.00

Table 1: To what extent does your jurisdiction have enough funding to meet its law enforcement needs?

Additionally, this ambivalence contrasts from high-density areas, presumably more experienced with handling substance abuse, wherein only 10% of respondents are unsure, but a majority of respondents agree that they have enough funding[26]. Nevertheless, these two results weakly suggest that local officials understand the effect of the opiate epidemic but do not believe that increased law enforcement is the solution. Thus, it is unlikely that increased corrections

funding is being driven by local officials. There are two other ways in which Governor Snyder could increase corrections funding, decrease DHHS funding, yet remain genuinely invested in addressing the opiate epidemic The first way is through focusing funds into prison-related mental health and substance abuse support programs.

B. Prison-related Mental Illness Programs

The Department of Corrections (MDOC) is responsible, by law, for providing a continuum of mental health services including: Inpatient Services, Residential Treatment Programs, Outpatient Mental Health Program, Counseling Services and Intervention, and Institutional Services[25]. In 2010, approximately 20% of Michigan's prison population was enrolled in a mental health program operated by MHS, with services ranging from brief counseling to inpatient residential placements[26]. At first glance, this 20% number may seem reasonable until we consider that the national average percentage of inmates with mental illness in a local jail is a staggering 64% and in state prisons, the national average is 56.2%[27]. After analyzing mental health programs in prisons, the University of Michigan found that the percentage of inmates with mental illness has risen by 10%. But, perhaps more important is that "roughly 65 percent of Michigan prisoners diagnosed with a severe psychiatric illness did not receive treatment while incarcerated"[28]. The system is ineffective in treating those in need. Thus, the same study recommended that the MDOC implement a better screening system to target those with the greatest need.

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[25] "Frequently Asked Questions." CORRECTIONS - Health Care - The Rights of Prisoners to Physical and Mental Health Care. Michigan Department of Corrections, n.d. Web. 11 Dec. 2016.
[26] "Prisons and Prison Services Mental Health Services." CORRECTIONS - Mental Health Services. Michigan Department of Corrections, n.d. Web. 11 Dec. 2016.
[27] James, Doris J., and Lauren E. Glaze. Mental Health Problems of Prison and Jail Inmates. Washington, DC: U.S. Dept. of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2006. Print.
[28] "Majority of Mentally Ill Inmates Don't Get Treatment | University of Michigan News." Michigan News. University of Michigan, 12 Apr. 2010. Web. 11 Dec. 2016.

In 2014, Governor Snyder signaled his position on criminalizing mental health when he signed an executive order to address five main goals including boosting pre- and post-booking jail diversions for those with mental illness[29]. These pilot programs were funded in Barry, Berrien, Kalamazoo, Kent, Marquette, Monroe, Oakland, and Wayne counties. A common thread linking successful pilots was a strong coordination between the county's Community Mental Health and Corrections departments[30]. Pilots found that those with co-occurring substance use disorders are more likely to go to jail and return to jail multiple times, rather than be diverted to mental health resources. To summarize, Although Governor Snyder made efforts to coordinate mental and physical health care, he should have made a greater effort to coordinate health care and corrections and he failed to completely decriminalize substance use disorders. Despite inefficient spending, I submit that there are ways in which corrections funding can be shifted to better serve those with substance use disorder.

III. Policy Proposals

In the following section I will make policy or program recommendations aimed toward prevention, patient identification, and treatments. However, there is one overarching recommendation that applies to all policies I will suggest below: data collection and analysis. In many cases with regard to prison-related mental illness programs, there is sufficient data collected on the effect that a certain policy has with relation to recidivism rates, but almost no data on prisoners with substance use disorder and their relapse rate; a reminder of our country's antiquated perspective on substance use. Moreover, there is insufficient data measuring the direct

[29] "Executive Order to Strengthen Mental Health Services in Michigan." Michigan Governor Rick Snyder. State of Michigan, 20 Mar. 2014. Web. 11 Dec. 2016.
[30] "Mental Health Commission Diversion." Mental Health Commission - Diversion. State of Michigan Mental Health Commission, 25 Aug. 2014. Web. 11 Dec. 2016.

mental health improvements of prisoners. Without more data, it is nearly impossible to assess the impact of prison-related programs.

There is similarly insufficient data for MAPS use and mental health courts, while all programs could benefit from better data collection. Specifically, data must be collected that measures the *quality* of each treatment, rather than just the number of patients who are affected by it, as is the case with in-prison mental health services. The federal government has just invested $2.4 million dollars into Michigan to fight the opioid epidemic[31]; this is the time to invest in data collection, Prescriber Education, Mental Health and Drug Courts, and patient identification.

A. Prevention: Prescriber Education

To slow the spread of prescription drugs and doctor-shopping, the improvements on the MAPS system are imperative. As MAPS is being updated, Physicians must be actively being informed on how the system works. Michigan should follow the lead of Washington and require all licensing boards to establish rules and adopt one evidence-based prescribing guideline[2]. In addition to MAPS, I recommend that prescribers be required to go through a checklist of prescribing guidelines before prescribing prescription drugs. This will encourage prescribers to carefully consider whether or not a schedule II narcotic is absolutely necessary. Finally, I suggest that Michigan join the other 29 states who will allow for over-the-counter prescription of naloxone, provided that pharmacists receive thorough training, especially those who work primarily with Medicaid patients. Although these trainings and processes should be relatively

[31] Wells, Kate. "Michigan Gets $3.4 Million to Battle Opioid Abuse." Michigan Radio. N.p., 13 Mar. 2016. Web. 11 Dec. 2016.

inexpensive, any expenses should be covered by regulations on HMOs to train and have certain procedures in for all prescribers.

B. Treatment: Drug and Mental Health Courts

The state of Michigan currently leads the nation in innovative courts. Drug courts are supervised treatment programs for individuals who abuse or are dependent upon any controlled substance or alcohol, providing an alternative for non-violent offenders[32]. The most frequent drug of choice for participants in drug courts was heroin/opiates[34]. As for Mental Health Courts, 61% of all participants also suffered from substance abuse disorder. Of that 61%, a majority of those who committed felonies were dependent on heroin/opiates[34]. Furthermore, not only are drug and mental health court participants two times less likely to commit another offense in the subsequent two years, but also much more likely to be employed. Overall, these "problem-solving" courts have been a huge success in treating patients. They are also extremely cost effective. As one Harvard study noted:

> *"If not for the program, the participants would have been incarcerated 3,010 days more than they were actually incarcerated over the past two years. This equates to 8.25 years of incarceration saved, the cost of which is about $235,000. The cost to operate the mental health court program is about $92,000 annually."*[33]

However, these courts can still be improved. In addition to increasing funding for these already existing programs, I suggest that they become more efficient by learning from other states. For example, Florida is able to admit and process offenders in a few hours because the

[32] Rapa, Anna R., and Lindsey F. Brewer. "Operating a Successful Mental Health Court: Where Is Michigan in the Process?" Thomas M. Cooley Journal of Practical and Clinical Law 15.2 (2014): 1-201. ArticlesPlus. Web. 11 Dec. 2016.
[33] Desmond, Brenda C., and Paul J. Lenz. "Mental Health Courts: An Effective Way for Treating Offenders with Serious Mental Illness." Mental and Physical Disability Law Reporter, vol. 34, no. 4, 2010, pp. 525–530. www.jstor.org/stable/23245065.

court heard cases every day rather than once every week[34]. Additionally, currently there is a perception that defendants are coerced into participation because they have to plead guilty before enrolling in the program. To counteract this perception, courts should offer the option of participation, explain the process, and/or not require a defendant to plead guilty to participate[34].

In order to cover the expansion of mental health courts, counties must increase cooperation between the Department of Health and Human Services and the Department of Corrections. Additionally, these problem-solving courts must seek funding from national private foundations committed treating substance use disorders and mental health such as the John D. and Catherine T. MacArthur Foundation and Bristol-Myers Squibb Foundation.

C. Patient Identification: Effective Policing

There are two primary ways of measuring the impact of the opiate epidemic: unintentional mortalities and drug crimes prosecuted. I suggest that given the state's continuous efforts to increase corrections funding, we use that funding to train and equip police officers with tools necessary to identify and handle people with substance use disorder. That is, we must equip all first responders with Naloxone. As suggested by the Task Force, we must also provide all officers with broader, 24/7 access to the MAPS system[5]. This will allow officials to both track information on drug crime suspects bolster enforcement of regulations on physicians.

IV. Concluding Remarks

All of these proposed policies, some which merely strengthen current policies, will benefit from more rigorous data collection. Given the unique nature of the opiate epidemic, we

[34] Almquist, Lauren, and Elizabeth Dodd. Mental Health Courts: A Guide to Research Informed Policy and Practice. Publication. The Council of State Governments, 1 Jan. 2009. Web. 11 Dec. 2016.

must continue a data-driven effort toward narrowing in on effective programs, working within the current system which fights to de-criminalize substance use disorders. Michigan is late to innovate in the substance abuse treatment arena, which means that it will take a united effort from all departments and all levels of government. It must start with us, citizens, talking about substance use disorder as a mental illness rather than a crime. Starting with education and ending with treatment, there is great hope that Michigan can and will defeat the opiate epidemic.