

**MICHIGAN'S  
STATE PREVENTION  
ENHANCEMENT PROJECT AND  
FIVE-YEAR STRATEGIC PLAN**

**Michigan Department of Community Health  
Bureau of Substance Abuse and Addiction Services**

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# MICHIGAN'S STATE PREVENTION ENHANCEMENT PROJECT AND FIVE-YEAR STRATEGIC PLAN

## INTRODUCTION

Michigan is a coastal state with picturesque lakes, a large, culturally diverse population, and a diversified economy. In 2010, it ranked as the nation's eighth largest state with an estimated 9,883,640 people.<sup>1</sup> Its diversity is manifested by a patchwork of racial, linguistic, geographic, gender, age, and socio-economic characteristics. Approximately, 79% of the state's population is White, 14% African American, 4.4% Hispanic, 2.5% Asian/Pacific Islander, and 0.6% Native American. English is the primary language spoken at home by 91% of the residents of Michigan, followed by languages other than English 9%, and Spanish 2.9%.<sup>2</sup>

An estimated 47% of Michigan's population resides in Southeast Michigan (Lapeer, Livingston, Macomb, Oakland, St. Clair, Washtenaw and Wayne Counties), according to the 2010 Census. Although minority populations reside throughout the state, there are concentrated sectors as follows: About 70% of all African Americans in Michigan reside in Southeastern Michigan, primarily in Wayne and Oakland counties; 43% of Michigan's total Hispanic population resides in Southeast Michigan; and higher densities of Asian-Americans tend to be in Western and Southeast Michigan. The largest Arab American and Chaldean population in the United States primarily resides in Wayne, Oakland and Macomb Counties, and combined, estimated population whose ancestry is Arab American and Chaldean totals 490,000.<sup>3</sup> In addition, many of the 12 federally acknowledged Native American tribes live in the northern part of Michigan.<sup>4</sup> Almost 14% of the state's population is over 65 years-of-age, with 24% under 18 years-of-age. An estimated 51% of the state's population is female; 49% is male.<sup>5</sup>

Michigan's population whose education level is completion of high school or higher remains above U.S. estimates. Eighty-eight percent of Michigan's residents, 25 years-of-age and older, possess a high school diploma or equivalent, and 33% have attained an Associate's Degree or higher. While Michigan tends to have a higher percentage of high school graduates than the U.S., the state trends for attainment of a Bachelor's degree remain lower than the national average.<sup>6</sup>

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<sup>1</sup> U.S. Bureau of the Census. (2010). Population of Michigan by single year of age, race, sex, and Hispanic origin. Retrieved from [http://www.michigan.gov/cgi/0,4548,7-158-54534\\_51713\\_51714-261003--,00.html](http://www.michigan.gov/cgi/0,4548,7-158-54534_51713_51714-261003--,00.html).

<sup>2</sup> U.S. Bureau of the Census. (2008-2010). American community survey. Retrieved from [http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS\\_10\\_3YR\\_DP02&prodType=table](http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_10_3YR_DP02&prodType=table)

<sup>3</sup> The Arab American Institute. (2011). Demographics. Retrieved from <http://www.aaiusa.org/pages/demographics/>.

<sup>4</sup> State of Michigan. (2010). Michigan tribal governments. Retrieved from [http://www.michigan.gov/som/0,1607,7-192-29701\\_41909--,00.html](http://www.michigan.gov/som/0,1607,7-192-29701_41909--,00.html).

<sup>5</sup> U.S. Bureau of the Census. (2008-2010). American community survey. Retrieved from [http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS\\_10\\_3YR\\_DP05&prodType=table](http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_10_3YR_DP05&prodType=table).

<sup>6</sup> U.S. Bureau of the Census. (2008-2010). Educational attainment. American community survey. Retrieved from [http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS\\_10\\_3YR\\_DP02&prodType=table](http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_10_3YR_DP02&prodType=table).

Michigan's socio-economic profile reflects a diverse set of industries, including agricultural, construction, manufacturing, wholesale trade, retail, transportation, financial, professional, scientific, education, health service, arts, entertainment, food service and public administration. However, from 2000 to 2008, Michigan has lost over 500,000 jobs in the manufacturing sector, primarily due to the downturn in the auto industry.<sup>7</sup>

Michigan's preliminary annual average unemployment rate of 10.4% in 2011 dropped by over two full percentage points from the 2010 annual rate of 12.5%. The national annual average unemployment rate in 2011 was 8.9%, seven-tenths of a percentage point below the 2010 annual rate of 9.6%. The state's 2011 preliminary annual jobless rate was nearly three full percentage points below Michigan's recent high unemployment rate of 13.3% in 2009. However, Michigan's unemployment rate remains elevated relative to historical levels.<sup>8</sup>

From 2010 to 2011, the average annual number of unemployed declined in Michigan by 110,000 or 18%, while total employment moved upward by 23,000 or 0.5%. The state's labor force dropped by 87,000 or 1.8% during 2010. This reflects the long-term trend in Michigan, with the state's workforce decreasing consistently since 2006. Although unemployment declined in 2011, the average number of weeks that individuals remained unemployed in Michigan increased from 40 weeks in 2010 to 45 weeks in 2011.<sup>9</sup>

The percentage of individuals living below the poverty line in Michigan has changed significantly over the last nine years, individual poverty rates for Michigan changed from 10.1% in 2000 to 14.4% in 2008 to 16.8% in 2010, while the U.S. individual poverty rate was 12.2% in 2000, 13.2% and 14.3% respectively. The percentage of families living below the poverty line showed a similar trend, the family poverty rate for Michigan was 7.7%, while the U.S. family poverty rate was 9.3% in 2000. In 2010, Michigan's family poverty rate was estimated as 12.1% and that of the U.S. was 10.5%.<sup>10</sup>

As of February 2012, over 158,000 residents are eligible to receive Family Independence Payments; 1.84 million are eligible for the Food Assistance Program; 8,926 are eligible to receive State Disability Assistance; 66,447 are eligible to receive Child Care and Development services; and 1.92 million are eligible to receive Medicaid benefits.<sup>11</sup>

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<sup>7</sup> American Manufacturing Trading Action Coalition. (2008). Quick fact sheet for Michigan's worsening eight-year depression: paying the price for \$1 trillion in U.S. auto-trade losses. Retrieved from <http://www.amtacdc.org/SiteCollectionDocuments/2008/09%2026%2008%20Michigan%20factsheet.pdf>.

<sup>8</sup> Michigan Department of Technology, Management, and Budget. (2012). Michigan's December unemployment rate declines: 2011 Annual rate drops. Retrieved from [http://www.michigan.gov/documents/dmb/LMI-JanuaryRelease\\_373934\\_7.pdf](http://www.michigan.gov/documents/dmb/LMI-JanuaryRelease_373934_7.pdf).

<sup>9</sup> Ibid.

<sup>10</sup> U.S. Bureau of the Census. (2009). American community survey. Retrieved from <http://factfinder.census.gov/servlet/>

<sup>11</sup> Michigan Department of Human Services. (2012). Green book report of key program statistics. Retrieved from [http://www.michigan.gov/documents/dhs/DHS-PUB-0064\\_271204\\_7.pdf](http://www.michigan.gov/documents/dhs/DHS-PUB-0064_271204_7.pdf).

## **MICHIGAN'S STATE PREVENTION ENHANCEMENT PROJECT**

The primary purpose of Michigan's State Prevention Enhancement (SPE) project was to strengthen and expand Michigan's prevention framework; thereby increasing state capacity to support effective substance abuse and mental health promotion services across systems.

Since 2009, Michigan has adopted the recovery oriented systems of care (ROSC) concept as the core philosophy for the design and delivery of SUD prevention, treatment, recovery and mental health promotion services. The ROSC will be used as a roadmap on how to align substance abuse prevention and fiscal infrastructure with other state and community-level partners. Prevention prepared communities (PPCs) are essential to the successful implementation of a ROSC.

The increased capacity developed through the SPE Project will allow Michigan to implement the Substance Abuse and Mental Health Services Administration's (SAMHSA) Strategic Initiative number one: Prevention of Substance Abuse and Mental Illness. By implementing Strategic Initiative #1, Michigan is developing five PPCs effective in achieving the following goals:

- A. Reducing underage and adult problem drinking.
- B. Preventing prescription drug abuse.
- C. Preventing suicide.
- D. Developing a workforce to accomplish goals A, B, and C.
- E. Recommending and implementing policy changes across state-level partners and stakeholders responsible for substance use disorder (SUD) prevention and mental health promotion that will facilitate success in achieving the purpose of this grant.

Based on the various need indicators including: non-medical use of pain relievers; level of past 30-day use of alcohol and binge drinking among youth 12-20 years-of-age; alcohol involved deaths and serious injuries; past year psychological distress; past year major depressive episode; and age-adjusted suicide rates, the following five high need communities were selected as sites for the development of PPCs: Riverhaven Coordinating Agency; Kalamazoo Community Mental Health and Substance Abuse Services; Mid-South Substance Abuse Commission; Pathways to Healthy Living; and Western Upper Peninsula Substance Abuse Services (CA).

These communities encompass 36 of 83 counties in Michigan and will develop and build capacity for prevention that will be effective in serving multi-racial, urban, and rural populations including: Hispanics; Arab Americans; Native Americans; lesbian/gay/bisexual/transgender/questioning/intersex (LGBTQI) youth and their families; and military families.

Based on the success of these five communities in achieving the goals outlined above, the Bureau of Substance Abuse and Addiction Services (BSAAS) will provide a template for statewide expansion of PPCs.

## **FOUR MINI-PLANS**

*Required for inclusion according to the “Directions for completing the 5-year Strategic Plan.” This is a summary of the progress and accomplishments made to date in meeting the goals and objectives outlined in the four mini-plans that comprise Michigan’s Capacity-Building/Infrastructure-Enhancement Plan submitted at the end of the 3<sup>rd</sup> month of the grant.*

### **Mini-Plan for Data Collection, Analysis and Reporting**

#### **1. State Epidemiological Outcomes Workgroup**

Michigan has maintained a functioning State Epidemiological Outcomes Workgroup (SEOW) that was implemented as part of the Strategic Prevention Framework, State Incentive Grant (SPF/SIG). The mission of the SEOW is to expand, enhance and integrate the substance use disorder needs assessment, and develop the capacity to address mental, emotional and behavioral conditions by incorporating mental health data that will allow us to create state and community profiles that share common indicators, intervening variables and consequences related to mental emotional and behavioral (MEB) disorders.

Membership on the SEOW includes representatives of various state-level departments, including the Department of Community Health (MDCH), Department of Education (DOE), and Michigan State Police (MSP), as well as regional substance abuse coordinating agencies (CAs), community coalitions, and the Michigan Primary Care Association. The SEOW also includes a Centers for Disease Control and Prevention (CDC) fellow assigned to the state to research epidemiological trends related to alcohol use. The chairperson on the SEOW is the lead epidemiologist for the Department of Community Health.

Michigan will be completing the second year of the CSAP funded SEOW project. To date, deliverables submitted to CSAP include a state charter; state-level epidemiological profile; community-level epidemiological profile; and a dissemination plan for products submitted by the SEOW.

Also, currently under development by the SEOW is a web-based central data repository linking all the federal and state data sources that can be easily accessed and updated.

Through BSAAS collaboration with MDCH, Bureau of Disease Control, Prevention, and Epidemiology, Michigan DOE and the MSP, the SEOW has direct access to state-level surveillance systems, as well as relevant primary and secondary data, on an annual basis. The SEOW also obtains, on an annual

basis, data directly from federal data sources, including the National Survey on Drug Use and Health (NSDUH) and the Drug Abuse Warning Network (DAWN).

For its initial activities, including the review of data sources, assessment of data quality and data utility, followed by its recommendations for prioritization of problems, Michigan's SEOW reviewed and utilized the State Epidemiological Data System (SEDS) indicators developed by SAMHSA for the SPF/SIG process. A listing of some of the major surveillance systems and indicators used during that process are included below. With the expansion to a SEOW model, mental health and other new domains will be examined using some of the same methodologies that were established to support the SPF/SIG process. The latter are highlighted by an asterisk (\*).

#### Nationally Recognized Data Sources Utilized:

- National Survey on Drug Use and Health (NSDUH)
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- Treatment Episode Data Set (TEDS) - Admissions & Discharges
- Drug Abuse Warning Network (DAWN)
- Fatality Analysis Reporting System (FARS)

#### State-specific data sources utilized:

- **Child Adolescent Functioning Assessment Scale (CAFAS)\*:** [MDCH, Bureau of Community Mental Health Services, Division of Mental Health Services to Children and Families (MHSCF)] The public mental health system utilizes standardized CAFAS subscales to assess a youth's functioning in the following domains: school/work, home, community (reflects on delinquent behavior), behavior toward others, moods/emotions (reflects on depression and anxiety, primarily), self-harmful behavior, substance use, and thinking (reflects major thought problems or severe communication problems). There are also two parent/caregiver subscales that assess basic needs/material and parent support. These tools provide historical data to assist the workgroup in refining priorities and action strategies.
- **Michigan Death Certificates:** (Michigan Department of Community Health, Bureau of Epidemiology, Division for Vital Records and Health Statistics) The death certificate database is a computerized dataset containing demographic and cause of death information for all Michigan residents (out-of-state deaths included) and non-Michigan residents dying in Michigan. Death certificates are one of public health's vital records for monitoring the health of citizens. Death certificates are used to determine the prevalence of acute and chronic alcohol and drug related mortalities in the state of Michigan.
- **Michigan Behavioral Risk Factor Surveillance System (BRFSS):** (Michigan Department of Community Health, Bureau of Epidemiology) The Michigan

BRFSS is the only source of estimates in the prevalence of certain health behaviors, conditions, and practices associated with the leading causes of death among adults. The BRFSS is used to determine the prevalence of alcohol, tobacco and other drug (ATOD) consumption and risky behaviors associated with ATOD for Michigan residents. The survey also annually collects health-related quality of life measures, including the number of days in the past month where a respondent's poor mental health (stress, depression, problems with emotions) interfered with daily activities. Estimates are based on annually collected data from a random-digit dial telephone survey of Michigan households. The proposed sample size for 2011 was 9,000 participants, with 600 cell phone users contributing. Statewide estimates are produced annually, and multiple years of data can be grouped to provide regional and county estimates for those with larger populations.

- **Michigan Traffic Crash Facts (MTCF):** (The Michigan State Police, Criminal Justice Information Center) The basic purpose of the MTCF is to provide data users the ability to analyze data to make Michigan roads safer and to save lives. This includes, but is not limited to, vehicle engineering, roadway engineering, occupant protection, Department of Natural Resources regulations, education, emergency medical care, along with the ability to assess if new or improved laws need to be implemented. MTCF is used to estimate the prevalence of alcohol-related automobile accidents and incidents. Information can be obtained on traffic crash summaries, reported alcohol involvement and age of drivers, by county. The database retains information for the current year, plus 10 previous years. Michigan Traffic Crash Facts consist of archives to 1992 with online data to 2004.
- **Michigan Inpatient Database (MIDB)\*:** (Michigan Health and Hospital Association) These data help support the state health planning activities, and are used by healthcare facilities for internal evaluation. At MDCH, the Vital Records and Health Data Services Section of the Division for Vital Records and Health Statistics develop annual library tables containing discharge rates and length-of-hospital stay for various ICD-9-CM groupings, by age, sex, and county. Reports cannot be published that identify individual hospitals. The MIDB data are routinely used for public health surveillance, including annual provision of estimates on preventable hospitalizations. The MIDB will be used to provide prevalence estimates of alcohol- and drug-related hospitalizations for Michigan residents at both state and local (at least regional) levels. These data can also be used to examine hospital discharges related to mental health issues, although the data quality may be compromised due to reporting constraints associated with privacy concerns.
- **Michigan Youth Risk Behavior Survey (YRBS):** (Michigan Department of Education oversees the implementation of the Michigan YRBS.) The YRBS is part of a nationwide surveying effort led by the CDC, to monitor students' health risks and behaviors identified as most likely to result in adverse outcomes. The



YRBS is administered statewide to students in grades 9-12, every other year. The YRBS includes indicators related to ATOD use, including the illegal use of prescription drugs, unintentional injury, school violence, dietary behaviors, physical activity, depression and suicide, and sexual behavior that contributes to unintended pregnancy or disease. The YRBS provides state but not local-level estimates.

- **Michigan Profile for Healthy Youth (MiPHY):** (Michigan Department of Education) The MiPHY survey is administered during the years that the YRBS is not conducted. The survey is intended to secure information from students in grades 7, 9 and 11, regarding health risk behaviors including substance abuse violence, physical activity, nutrition, sexual behavior and emotional health in individual, school, community and family domains. The MiPHY results are extrapolated at the county level, and are useful for data-driven decisions to improve prevention programming performed at schools within the county.
  - **Uniform Crime Reports:** The Michigan State Police is responsible for collecting this data from all law enforcement agencies within the state of Michigan, per Public Act 319 of 1968, and submit the data to the Federal Bureau of Investigation (FBI) Uniform Crime Program. This data is used to create the annual “Crime in Michigan” report that is published on the web every year, which is then forwarded to the FBI Uniform Crime Reporting Program. This data is also used by the governor, legislature, police agencies, and the general public to determine crime trends. MSP Uniform Crime Reports are also used to determine the prevalence of alcohol and drug-related crimes occurring in Michigan.
  - **Liquor Licenses:** (Michigan Liquor Control Commission) The Michigan Liquor Control Commission collects data to determine the quota of issued and existing licenses. Liquor licenses are used to determine the density of alcoholic beverage outlets in urban and rural parts of Michigan.
  - **Michigan Prevention Data System:** (BSAAS) Michigan has established a web-based Prevention Data System (PDS) used by all prevention providers and CAs to collect and report process and capacity data, which has been effective for both state- and community-level data collection. In addition to basic information related to core strategies and demographic information of the recipient, the number of evidence-based programs are reported to and captured in the PDS. BSAAS submits aggregate reports on prevention service capacity to SAMHSA in accordance with Substance Abuse Prevention and Treatment Block Grant reporting guidelines.
2. Michigan has developed several epidemiological planning tools for state and local communities:
- A. Michigan has a 2012 state-level epidemiological profile which may be found at [www.michigan.gov/documents/mdch/Final MI Epi Profile 2012 382198](http://www.michigan.gov/documents/mdch/Final_MI_Epi_Profile_2012_382198)

[7.pdf](#). Additionally, regional epidemiological profiles are available for each of the five SPE CA communities and, most recently, the eleven expansion CA communities.

- B. Currently under development is a web-based central data repository linking all the federal and state data sources that can be easily accessed and updated. This will be key for use by state, regional, and local groups assessing prevention needs and measuring outcomes.
- C. Remaining efforts to be accomplished in the Data Collection, Analysis and Reporting Mini-Plan by the end of the capacity development year of the SPE grant:
  - Expand representation of key stakeholders on the SEOW, including members of the recovery, Native American, Hispanic, Arab American, lesbian/gay/bisexual/transgender, and military communities.
  - Develop and administer environmental scans to physicians, pharmacists and dentists to determine knowledge level of prescription drug abuse and opportunities for education and awareness around the subject.
  - Increase state and community level data sources available to assess mental health issues in communities, and the link to risk and protective factors, life stressors, and other potential indicators.

### **Mini-Plan for Coordination of Services**

1. The Bureau of Substance Abuse and Addiction Services (BSAAS) functions as the Single State Authority within the Michigan Department of Community Health (MDCH). Responsibilities include the administration of federal and state funding for substance abuse prevention, treatment, recovery, and gambling addiction. BSAAS allocates the Substance Abuse Prevention and Treatment Block Grant (SAPT BG) funding through 16 regional coordinating agencies (CAs), whose responsibilities include planning, administering, funding, and maintaining the provision of substance abuse treatment and prevention services for 83 counties in Michigan. All CAs, including the five CAs participating in the SPE Grant Project, have prevention coordinators (PCs), who receive input from and empower local communities in their response to substance abuse prevention needs.
2. Mental health and developmental disability services in Michigan are delivered through county-based community mental health services programs (CMHSPs). MDCH, along with 46 regional CMHSPs, contracts public funds for mental health and developmental disability services. Medicaid funds, which are paid on a per Medicaid-eligible capitated basis, are contracted with CMHSPs, or affiliations of CMHSPs, as prepaid inpatient health plans (PIHPs). Each region is required to

have an extensive array of services that allows for maximizing choice and control on the part of individuals in need of service. Individual plans of service are developed using a person-centered planning process for adults, and a person-centered process and family-centered care for children. MDCH is actively promoting values of recovery and resiliency. MDCH contracts with 18 of its PIHPs to provide Medicaid specialty services. Limited outpatient mental health services are available through Medicaid health plans (MHPs).

3. A sound functioning and well-organized community prevention infrastructure exists in Michigan. CAs are contractually required to submit multiple year action plans (APs) to BSAAS, which address priority problems identified, and target specific interventions related to the appropriate intervening variables. These prevention strategies illustrate evidence of the five-step Strategic Prevention Framework/State Incentive Grant (SPF/SIG) planning process by utilizing local community coalitions, and parents and youth as part of this ongoing planning process. The CAs must complete a comprehensive strategic plan, based on this data-driven planning model process, and complete a planning chart using a logic model approach with their submission.
4. Since 2002, BSAAS has parlayed and leveraged the strength and value of our state and community level prevention infrastructure by securing four major awards specific to substance abuse prevention: 1) State Incentive Grant (SIG); 2) SPF/SIG; and the 3) Center for Substance Abuse Prevention (CSAP) State Epidemiology Outcomes Workgroup (SEOW) award; and the State Prevention Enhancement Grant.
  - A. Deliverables from these four awards have strengthened our infrastructure systemically to:
    - Foster the use of a data-driven planning process.
    - Expand the use of evidenced-based programs.
    - Develop epidemiological profiles and logic models.
    - Undertake collaborative efforts with prevention, treatment, mental health and primary care.

This has increased state and local capacity to address mental, emotional and behavioral conditions that support and improve the quality of life for citizens of Michigan.

- B. Implemented as part of the SPF/SIG grant, BSAAS convened the Evidence-Based Practices Workgroup (EBPW) and the Childhood and Underage Drinking Workgroup (CUAD).

- The EBPW provided guidance on the implementation of effective, evidence-based policies, programs and practices. Members of the EBPW included representatives from coalitions, MDE, CAs, OHSP, school health coordinators, and prevention providers. The workgroup published a guide in January 2012 for selecting evidence-based practices that will strengthen the development of sound prevention systems and strategies, and increase the ability of the system to identify and select appropriate evidenced-based interventions. This document may be found at [http://www.michigan.gov/documents/mdch/Mich\\_Guidance\\_Evidence-Based\\_Prvn\\_SUD\\_376550\\_7.pdf](http://www.michigan.gov/documents/mdch/Mich_Guidance_Evidence-Based_Prvn_SUD_376550_7.pdf). For the past decade, BSAAS has also required CAs to assure that a minimum of 90 percent of services funded are evidenced-based.
  - The CUAD provided and distributed a best practice blueprint for preventing underage drinking at the community level, employing evidence-based and environmental strategies in 2010. This document may be found at [http://www.michigan.gov/documents/mdch/Blueprint\\_for\\_Michigan\\_336742\\_7.pdf](http://www.michigan.gov/documents/mdch/Blueprint_for_Michigan_336742_7.pdf). The CUAD recently participated in the planning of an underage drinking video funded by CSAP. Members of this workgroup include representation from Michigan Beverage Association, OHSP, coalitions, prevention coordinators, and prevention providers.
- C. In response to the epidemic of prescription and over-the-counter drug abuse in Michigan, BSAAS has identified the reduction of prescription and over-the-counter drug abuse as a priority focus. An interdisciplinary workgroup was established, consisting of a physician, prevention coordinators, (including prevention coordinators from the communities selected for the SPE Project), MDE staff, OHSP staff, Department of Human Services (DHS) staff, a pharmacist, Prevention Network (PN) staff, and coalitions. This team developed the Prescription and Over-the-Counter Drug Abuse Strategic Plan, [http://www.michigan.gov/documents/mdch/RxOTC\\_Drug\\_Abuse\\_Strategic\\_Plan\\_Final\\_389362\\_7.pdf](http://www.michigan.gov/documents/mdch/RxOTC_Drug_Abuse_Strategic_Plan_Final_389362_7.pdf).
- D. Historically, the MDE and BSAAS have coordinated funding, planning and programming of prevention initiatives including administration of the Governor's Discretionary Grant, Safe and Drug Free Schools and Communities funding and development and marketing of the Michigan Profile for Healthy Youth. A representative from MDE serves on the ROSC Transformation Steering Committee, the SPE Policy Enhancement Consortium, the SEOW, and the Prescription and Over-the-Counter Drug Abuse Workgroup. In 2011, a representative from BSSAS served on MDE's Strategic Planning Team for Building State Capacity for Youth Substance Use and Violence Prevention.
5. The required inclusion of government agencies and community stakeholders in the grants referenced above has helped to facilitate the Recovery Oriented

System of Care (ROSC) in Michigan. The ROSC Transformation Steering Committee (TSC), an advisory group to the BSAAS, has established several workgroups, one of which is the Prevention Workgroup. This workgroup serves as the SPE Policy Consortium.

Membership of this group includes representatives from the Michigan Association of Substance Abuse Coordinating Agencies (MASACA), MDE, OHSP, the five CAs participating in the SPE Grant Project, substance abuse coalitions, faith-based agencies, prevention providers, and administrators.

The state SPE Policy Consortium provided invaluable input into capacity building and infrastructure enhancement in the five SPE CA communities by coordinating and providing feedback to the development, implementation, and evaluation of the four mini-plans in “The Capacity Building/Infrastructure Enhancement Plan.” In addition, the state SPE Policy Consortium will develop, implement, and provide coordination and oversight responsibilities for this comprehensive, five-year State Strategic Prevention Plan.

6. Prevention Network (PN) is another partner involved in the established organizational structure that works together to coordinate and allocate funding to high-need communities. PN provides support, training, technical assistance and mini-grants to grassroots community groups to offer a full continuum of substance abuse prevention services. As part of PN, the Michigan Coalition to Reduce Underage Drinking (MCRUD) assists local communities across the state, including the five communities participating in the SPE Grant Project, specifically with underage drinking initiatives. From 2004 to 2010, BSAAS and OHSP braided federal and state funding to support underage drinking initiatives conducted by PN.
7. The Michigan Inter-Tribal Council (ITC) has been an integral partner for SPF/SIG, SEOW and the Training Cadre, and BSAAS has supported substance abuse training to member tribes of the ITC. Two of the tribal communities – Little Traverse Bay Band and Grand Traverse Bay Band – are SPG/SIG Grant recipients and have participated in learning communities and technical assistance sessions provided by BSAAS. This relationship exemplifies an ongoing process and support system that addresses and responds to the substance abuse prevention related needs of tribes and tribal organizations in the state.
8. BSAAS has recently developed partnerships with the Michigan National Guard and the Michigan Primary Care Association (MPCA). The Michigan National Guard is an active participant on the Prescription and Over-the-Counter Drug Abuse Task Force. MPCA has become an active participant in the SEOW. Although relatively new to collaborative efforts with BSAAS, the partnership with these two organizations will continue to be strengthened through the implementation of this five-year plan.

9. Under the direction of the SPE Policy Consortium, the evaluator from Wayne State University completed a Work Force Development Scan and an Environmental Scan in the five SPE CA regional communities. These were web-based surveys distributed through the CAs to their substance abuse prevention and treatment providers and local coalitions.

There were 63 respondents to the Work Force Development Scan focused on describing: prevention services and clientele served; career/workplace attributes; and training and technical assistance needs. The report of this scan is at [http://www.michigan.gov/documents/mdch/Workforce\\_Development\\_Survey\\_Report\\_Final\\_4\\_27\\_12\\_389418\\_7.pdf](http://www.michigan.gov/documents/mdch/Workforce_Development_Survey_Report_Final_4_27_12_389418_7.pdf).

There were 67 respondents to the Environmental Scan focused on describing: organizational characteristics, readiness to become a PPC and support ROSC, barriers to integration, training needs, and data collection. This report is at [http://www.michigan.gov/documents/mdch/Environmental\\_Scan\\_Survey\\_Report\\_FINAL\\_4\\_23\\_12\\_389417\\_7.pdf](http://www.michigan.gov/documents/mdch/Environmental_Scan_Survey_Report_FINAL_4_23_12_389417_7.pdf).

10. Wayne State University will complete two more environmental scans by the end of the grant year targeting mental health and primary care service providers in the five SPE CA regional communities. This will provide data identifying strengths and challenges that may exist in collaboration and integration of services.
11. In response to information gathered through the Work Force Development and Environmental Scans of prevention and treatment and under the direction of the SPE Policy Consortium, training was provided to the five SPE CA regional communities to help their local coalitions to:
  - Assess their progress in establishing a recovery oriented system of care and identify next steps appropriate for their coalition to take in order to strengthen ROSC at the local level.
  - Learn more about how to become a prevention prepared community.
  - Identify and work with new collaborative partners.

One hundred thirty-four individuals attended the trainings: Western UP (14), Eastern UP (23), Kalamazoo (46), Bay Arenac/Riverhaven (21), and Mid-South (30).

The two trainings in the Upper Peninsula were scheduled for four hours each and the three CA regions in the Lower Peninsula held three hours sessions. The agenda included a PowerPoint presentation developed by the SPE Policy Consortium, completion of an extensive Local Community Readiness

Assessment activity, a case study on ROSC, updates on training plans, and a brief discussion on forming relationships with other agencies, groups, and organizations.

Generally, the trainings were well received though reactions were different in each of the regions. Comments about what was most helpful about the training were mixed but people definitely liked and intended to use the Local Community Readiness Assessment tools. Many people found the PowerPoint presentation to be helpful.

Wayne State University provided a compilation of the evaluations of the trainings using a four-point scale, with 1 representing Strongly Disagree and 4 representing Strongly Agree. On all objectives the mean scores for all five trainings together were 3.1 or higher. Mean scores evaluating the objectives for the individual trainings were 3.0 or higher with the exception of participants reporting learning more about ROSC. On this particular item, participants in regions in the Lower Peninsula did not “Strongly Agree” that they learned more as frequently (two of the three regions averaged 2.9) as the two regions in the Upper Peninsula who averaged 3.4 and 3.5. An explanation for this is that participants in the Lower Peninsula may have previously had access to more training and discussions on developing Recovery Oriented Systems of Care than the Upper Peninsula regions. Members of the SPE Policy Consortium had suggested this might be the case, which is why the training in the Upper Peninsula was scheduled for four hours and the Lower Peninsula for three.

12. This training will become part of a Prevention Prepared Community Tool-Kit that will be developed before the end of the grant year and made available to communities across the state as part of the expansion of SPE over the next five years.

### **Mini-Plan for Technical Assistance and Training**

BSAAS provides training and technical assistance to the prevention, treatment and recovery practitioners in the state, via a contract through the Michigan Prevention, Treatment, and Education (MI PTE) Project. Funding for the training and technical assistance is supported by the SAPT Block Grant and state general fund dollars. Historically, about one third of the training budget had been dedicated to prevention.

An assessment of training and technical assistance needs is conducted by BSAAS, based on the requests provided by CAs in their action plans for prevention, treatment and recovery. Another assessment of training is conducted by the advisory committee to the MI PTE Project. These assessments are reviewed and prioritized by BSAAS staff and are incorporated into a training plan. Content experts in the state are identified and secured for training and technical assistance sessions. For the dissemination of prevention technology statewide, BSAAS employs a training cadre consisting of state of Michigan and community professionals.

Training and technical assistance on the application of evidence-based practices, including the design and implementation of a ROSC, has also been provided by CSAP, Center for Applied Prevention Technology (CAPT), and the Center for Substance Abuse Treatment (CSAT) Great Lakes Addiction, Treatment and Recovery Center (GLATRC.)

In an effort to encourage workforce development, the cost to participants for training and technical assistance has been minimal and all workshops offer credit toward certification to encourage attendance by as many practitioners as possible. Training and technical assistance supported by CSAP and CSAT has greatly enhanced the expansion and diffusion of prevention, treatment and recovery technology in Michigan. The Central CAPT has provided financial support and experts for training and technical assistance related to the implementation of the SIG, SPF/SIG and the SEOW projects.

BSAAS also holds an annual substance abuse conference including workshops on evidence-based practices for prevention, treatment and recovery issues. The conference includes plenary sessions performed by national experts representing behavioral health administration and service delivery. In addition to the plenary session, workshops on specific topic areas are provided to conference participants. In each of the last three years, attendance at the conference averaged over 1,000 persons.

During this SPE grant year the following related trainings have been provided in the state of Michigan

- Michigan Behavioral Health & Prevention Webinar – offered twice and filled both times – for a total of over 50 participants.
- Prevention and the ROSC Framework Webinar – 25 participants.
- Suicide Prevention Prepared Communities training – 6 hour training provided by the Michigan Department of Community Health Violence Prevention Program Coordinator/Suicide Prevention Program Director. This training was offered in four of the five SPE CA regions reaching 116 participants.

SBIRT Training the Trainer Workshops are in process statewide to selected CA representatives, including the five SPE CA regions.

### **Mini-Plan for Performance Evaluation**

The performance management and evaluation process and methodology are accomplished through various mechanisms. Michigan has established the Prevention Data System (PDS) to collect and process data, which has been effective for both state and community-level data collection. In addition to basic information



related to core strategies and demographic information of the recipient, evidence-based programs are reported to the PDS. This system is being expanded to allow pre- and post-assessment of program effectiveness and to track perception of harm, 30-day use, and behavior changes tied to national outcome measures (NOMs).

In addition, site visits are conducted by coordinating agencies (CAs) and the Bureau of Substance Abuse and Addiction Services (BSAAS.) The focus of these site visits is to assure contract compliance, as well as provide technical assistance and quality assurance monitoring consistent with the fifth step of the SPF/SIG planning framework.

BSAAS also has developed closer collaboration with Wayne State University (WSU) to strengthen our evaluation processes.

## DATA DRIVEN PRIORITIES

*Required for inclusion per numbers 1 and 2 in the “Directions for completing the 5-year Strategic Plan.” Using the 2012 Epidemiology Report prepared under the direction of the SEOW, the three priority need areas of reducing underage and adult problem drinking, preventing prescription drug abuse, and preventing suicide were affirmed and long-term and short-term consequences at the state and community levels are identified. This section also identifies and explains data-driven goals related to these priority need areas that can be quantified, monitored, and evaluated for change over time.*

The following table shows data measuring consequences, consumption patterns, and intervening variables that may be used at the state, regional and local level to establish baseline measures for planning and developing data-driven goals for monitoring and evaluation.

### From the Michigan Epidemiological Profile

Area	Consequences	Consumption Patterns	Intervening Variables
<a href="#"><u>Alcohol Use</u></a>	<p><b>Youth:</b></p> <ul style="list-style-type: none"> <li>• Alcohol-Related Traffic Crash Deaths and Serious Injury (ARTCD/SI)</li> <li>• Underage Drinking (UAD) and Driving/Riding with Drinking Driver</li> <li>• Use Linked to Other Risky Behaviors and Consequences</li> <li>• Costs</li> <li>• Abuse and Addiction</li> <li>• ARTCD with Drinking Drivers Ages 16 to 25</li> </ul> <p><b>General/Adult:</b></p> <ul style="list-style-type: none"> <li>• ARTCD</li> <li>• ARTCD/SI</li> <li>• Abuse and Addiction</li> <li>• Drove Vehicle After Drinking</li> </ul>	<p><b>Youth:</b></p> <ul style="list-style-type: none"> <li>• <i>Current Use (last 30 days)</i></li> <li>• <i>Lifetime Use</i></li> <li>• <i>Early Initial Use</i></li> <li>• <i>Binge Drinking</i></li> </ul> <p><b>General/Adult:</b></p> <ul style="list-style-type: none"> <li>• <i>Current Use (last 30 days)</i></li> <li>• <i>Heavy Drinking</i></li> <li>• <i>Binge Drinking</i></li> </ul>	<p><b>Youth:</b></p> <ul style="list-style-type: none"> <li>• <i>Laws &amp; Policies</i></li> <li>• <i>Law Enforcement</i></li> <li>• <i>Social Norms</i></li> <li>• <i>Age of Onset</i></li> </ul> <p><b>General/Adult:</b></p> <ul style="list-style-type: none"> <li>• <i>Safety Belt Use</i></li> <li>• <i>Focus on ARTCD and UAD on statewide level</i></li> </ul>
<a href="#"><u>Prescription Drug Abuse</u></a>	<p><b>Youth:</b></p> <ul style="list-style-type: none"> <li>• <i>Overdoses, Poisonings, etc.</i></li> <li>• <i>Related Risky Behaviors and Consequences</i></li> <li>• <i>Death and Serious Injury from Impaired Driving/Riding</i></li> <li>• <i>Abuse and Addiction</i></li> <li>• <i>Related Crime (gap in data)</i></li> </ul> <p><b>General/Adult:</b></p> <ul style="list-style-type: none"> <li>• <i>Abuse and Addiction</i></li> <li>• <i>Traffic Deaths and Injuries</i></li> <li>• <i>Overdoses and Related Mortality</i></li> </ul>	<p><b>Youth:</b></p> <ul style="list-style-type: none"> <li>• <i>Compared to Other States</i></li> <li>• <i>Various Consumption Patterns</i></li> <li>• <i>Special Population Patterns</i></li> </ul> <p><b>General/Adult:</b></p> <ul style="list-style-type: none"> <li>• <i>National Data</i></li> <li>• <i>Ranking Compared to Other States</i></li> </ul>	<p><b>Youth/General/Adult:</b></p> <ul style="list-style-type: none"> <li>• <i>Access: Point of Access and Disposal</i></li> <li>• <i>Military Considerations</i></li> <li>• <i>Social Norms</i></li> <li>• <i>Perception of Risk</i></li> </ul> <p><b>General:</b></p> <ul style="list-style-type: none"> <li>• <i>Access: Prescriptions Written</i></li> <li>• <i>Social Norms and Perception of Risk</i></li> </ul>
Area	Suicide Prevalence and Prevention	Depression and Serious Mental Illness Prevalence and Prevention	
<a href="#"><u>Mental Health Indicators</u></a>	<p><b>Youth:</b></p> <ul style="list-style-type: none"> <li>• <i>Attempted Suicide</i></li> </ul> <p><b>General/Adult:</b></p> <ul style="list-style-type: none"> <li>• <i>Suicide</i></li> </ul>	<p><b>Youth:</b></p> <ul style="list-style-type: none"> <li>• <i>Depressive Feelings</i></li> <li>• <i>Co-Occurrence of Depressive Feelings and Alcohol Consumption/Illicit Drug Use</i></li> <li>• <i>Functioning Outcomes</i></li> </ul> <p><b>General/Adult:</b></p> <ul style="list-style-type: none"> <li>• <i>Depressive Episode and Serious Mental Illness</i></li> </ul>	

Note Priorities are shown above in italics.

## Alcohol Data

### Alcohol Use Consequences - Youth

#### *ALCOHOL-RELATED TRAFFIC CRASH DEATHS AND SERIOUS INJURIES*

Youth may be killed or seriously injured as an innocent victim or as an impaired driver, and they may kill or severely injure others. Alcohol-related traffic crashes involving at least one driver 16-20 years-of-age who had been drinking, caused an annual average of 173 deaths and serious injuries (KAs) in Michigan each year between 2004 and 2010. Between 2004 and 2010, Michigan averaged 29 fatalities annually in which at least one driver was 16-20 years-of-age and had been drinking, with a corresponding rate of 2.9 deaths per million residents. The annual average of incapacitating injuries was 144, with a corresponding rate of 14.4 serious injuries per million residents, as indicated in Table 1.

**Table 1 – Fatal Traffic Crashes Attributable to Alcohol Impaired Underage Drivers 16 to 20 Years-of-Age, 2004-2010**

<i>Alcohol Impaired Average Fatalities per Year</i>	<i>Alcohol Impaired Average Fatality Rate per 1,000,000 Population</i>	<i>Alcohol Impaired Average Incapacitating Injuries per Year</i>	<i>Alcohol Impaired Incapacitated Injury Average Rate per 1,000,000 Population</i>	<i>Alcohol Impaired Total Fatalities for 2004-2010</i>	<i>Alcohol Impaired Total Incapacitating Injuries for 2004-2010</i>
29.0	2.9	144.0	14.4	204	1,013

Source: Michigan Office of Highway Safety Planning, February 2012

#### *UNDERAGE DRINKING AND DRIVING/RIDING WITH DRINKING DRIVER*

Data from the 2009 MiYRBS indicated that 8.0% of 9<sup>th</sup> through 12<sup>th</sup> graders had driven while drinking, and 28.0% had ridden in a vehicle with someone who had been drinking, during the last 30 days.<sup>12</sup>

#### *ALCOHOL USE LINKED TO OTHER RISKY BEHAVIORS AND CONSEQUENCES*

According to the 2009 MiYRBS, 25.0% of 9<sup>th</sup> through 12<sup>th</sup> graders who had sex in the last three months reported doing so after using alcohol or drugs.<sup>13</sup> Binge drinking is most common in late teens and early twenties; however, it is reported as continuing well into the thirties and forties.<sup>14</sup> Binge drinking is defined as five

<sup>12</sup> Michigan Department of Education. (2009). Michigan youth risk behavior survey 2009. Contact Kim Kovalchick at [kovalchickk@michigan.gov](mailto:kovalchickk@michigan.gov) or (517) 241-4292. Retrieved from [http://www.michigan.gov/documents/mde/09YRBSDetail\\_327165\\_7.pdf](http://www.michigan.gov/documents/mde/09YRBSDetail_327165_7.pdf).

<sup>13</sup> Ibid.

<sup>14</sup> Michigan Department of Community Health. (2009). Binge drinking in Michigan youth and adults. Retrieved from [http://www.michigan.gov/documents/mdch/Youth\\_Adult\\_Binge\\_Drinking\\_Fact\\_Sheet\\_342124\\_7.pdf](http://www.michigan.gov/documents/mdch/Youth_Adult_Binge_Drinking_Fact_Sheet_342124_7.pdf).

or more drinks of alcohol in one occasion for youth, four or more drinks in one occasion for women, and five or more drinks in one occasion for men.<sup>15</sup>

Binge drinking leads to several adverse outcomes for men, women, and children. These adverse outcomes include intentional and non-intentional injuries, unplanned sexual intercourse, unprotected sex, sexually transmitted diseases, and unintentional pregnancy.

Women with unintended pregnancies are more likely to start prenatal care later in their pregnancy and are less likely to engage in healthy behaviors such as quitting smoking during pregnancy or consuming adequate amounts of folic acid. Thus, unintended pregnancies can also have adverse impacts on infants and children. No amount of alcohol is safe for a fetus during pregnancy. Exposure to alcohol in early phases, often before a teen realizes she is pregnant, is linked to miscarriage, mental retardation, and other preventable birth defects, such as Fetal Alcohol Syndrome.<sup>16</sup>

California researchers who compared the brains of teen drinkers to non-drinkers found that young alcohol users suffered damage to nerve tissues that could cause attention deficits among boys and faulty visual information processing among girls.<sup>17</sup> A multitude of research has documented the effects of alcohol on the developing brain, noting that brain development is not complete until about 25 years-of-age.

## COSTS

It is estimated that underage alcohol use costs Michigan taxpayers over \$2 billion per year, including the cost of youth violence, treatment, traffic crashes, property crimes, and medical costs. Underage drinking (UAD) cost Michigan \$2.1 billion in 2010, which translated to an annual cost of \$2,084 for each youth in the state; and ranked Michigan as the 28<sup>th</sup> highest among the 50 states,<sup>18</sup> as indicated in Table 2. Excluding pain and suffering, the direct costs of UAD incurred through medical care and loss of work cost Michigan \$820 million each year. Youth violence and traffic crashes by underage drinkers represent the largest UAD costs for the state. Among teen mothers, fetal alcohol syndrome (FAS) alone costs Michigan \$34 million yearly.<sup>19</sup>

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<sup>15</sup> Center for Disease Control. (2009). Behavioral Risk Factor Surveillance System (BRFSS). Retrieved from <http://www.cdc.gov/brfss/index.htm>.

<sup>16</sup> Michigan Department of Community Health, Family and Community Health. (2005). Preconceptional binge drinking and unintentional pregnancy. Michigan PRAMS Delivery, Vol.2 (4). Retrieved from [http://www.michigan.gov/documents/April\\_2005\\_MI\\_PRAMS\\_Delivery\\_124472\\_7.pdf](http://www.michigan.gov/documents/April_2005_MI_PRAMS_Delivery_124472_7.pdf).

<sup>17</sup> Join Together. (2010). Teen drinkers suffer nerve damage in brain. Newsroom. Retrieved from <http://www.jointogether.org/news/research/summaries/2010/teen-drinkers-suffer-nerve.html>.

<sup>18</sup> Pacific Institute for Research and Evaluation. (2011). Underage drinking in Michigan, the facts. Funding from the Office of Juvenile Justice and Delinquency Prevention (OJJDP). Chapel Hill, N.C.

<sup>19</sup> Ibid.

**Table 2 – Cost of Underage Drinking by Problem, Michigan 2010**

Problem	Total Cost (In millions)
<i>Youth Violence</i>	<i>\$1,405.0</i>
<i>Youth Traffic Crashes</i>	<i>\$251.1</i>
<i>High-Risk Sex, Ages 14-20</i>	<i>\$122.3</i>
<i>Youth Property Crime</i>	<i>\$158.4</i>
<i>Youth Injury</i>	<i>\$53.9</i>
<i>Poisonings and Psychoses</i>	<i>\$19.5</i>
<i>Fetal Alcohol Syndrome among Mothers, Ages 15-20</i>	<i>\$34.2</i>
<i>Youth Alcohol Treatment</i>	<i>\$72.4</i>
<i>Total</i>	<i>\$2,116.8</i>

Table 2 Source: 2010 Data from *Underage Drinking in Michigan; The Facts*, produced for the Underage Drinking Enforcement Training Center (UDET) by the Pacific Institute for Research and Evaluation (PIRE) with funding from the Office of Juvenile Justice and Delinquency Prevention (OJJDP), September 2011, available at <http://www.udetc.org/factsheets/Michigan.pdf>.

## ALCOHOL ABUSE AND ADDICTION

Young people who begin drinking before the age of 15 are four times more likely to develop alcohol dependence and are two and a half times more likely to become abusers of alcohol, than those who begin drinking at 21 years-of-age.<sup>20</sup> In 2011, 3,993 youth, 12-20 years-of-age, were admitted for alcohol-involved treatment in Michigan, accounting for 10.8% of all alcohol involved treatment admissions in the state.<sup>21</sup>

### Alcohol Consumption - Youth

The 2011 MiYRBS, for 9<sup>th</sup> through 12<sup>th</sup> graders in public schools, reported that 64% of these students had at least one alcoholic drink during their lifetime. Students initiating early alcohol use, before 13 years-of-age, trended significantly downward over the last decade, reported as 16% for all in 2011. Current use is defined as consuming one or more drinks on one or more occasion within the last 30 days. Thirty-one percent of the students reported currently drinking in 2011, which has decreased over the last ten years. Binge drinking trended downward from 1999 to 2011, 18 percent of youth reported binge drinking, which is five or more drinks in a row for youth, in the last 30 days in 2011.<sup>22</sup> Trend data shows general decreases in alcohol use from 1999 to 2011, as indicated in Table 7.

<sup>20</sup> Grant, B. & Dawson, D. (1997). Age at onset of alcohol use and its association with DSM-IV alcohol abuse and dependence: results from the national longitudinal alcohol epidemiologic survey. *Journal of Substance Abuse*, 9(103-110).  
<sup>21</sup> Michigan Department of Community Health, Bureau of Substance Abuse and Addiction Services (n.d.). Treatment Episode Data Set (TEDS). Lansing, MI  
<sup>22</sup> Michigan Department of Education. (2012). Michigan youth risk behavior survey 2011. Contact Kim Kovalchick at [kovalchickk@michigan.gov](mailto:kovalchickk@michigan.gov) or (517) 241-4292.

**Table 7 – Alcohol Trend Data from Michigan Youth Risk Behavior Survey**

CB#	Indicator Description	Behavior	MI 99	MI 01	MI 03	MI 05	MI 07	MI 09	MI 11
Q #									
39	% of students who had at least one drink of alcohol on one or more days during their life	Alcohol Ever	81.7	77.4	75.9	72.6	72.2	68.8	63.8
40			79.4-84.1	74.2-80.6	74.0-77.7	68.9-76.4	69.0-75.1	65.8-71.7	60.8-66.8
40	% of students who had their first drink of alcohol, other than a few sips, before age 13	Alcohol before age 13	32.2	26.9	26.9	22.6	21.4	18.8	15.6
41			28.9-35.5	24.6-29.2	24.7-29.1	19.2-25.9	18.7-24.4	16.7-21.1	13.6-17.8
41	% of students who had at least one drink of alcohol on one or more of the past 30 days	Recent alcohol use (30 days)	48.5	46.2	44.0	38.1	42.8	37.0	30.5
42			45.4-51.7	42.6-49.8	41.2-46.7	34.7-41.5	39.4-46.2	34.4-39.7	27.3-34.0
42	% of students who had 5 or more drinks of alcohol in a row, that is, within a couple of hours, on one or more of the past 30 day.	Alcohol binge (30 days)	29.9	29.3	27.4	22.5	24.6	23.2	17.8
43			27.0-32.8	25.6-33.1	24.1-30.7	19.4-25.6	20.8-28.9	20.9-25.6	15.0-21.1

Source: Michigan Department of Education, MiYRBS, 1999-2011

In September of 2011, the Pacific Institute for Research and Evaluation (PIRE) reported that in 2009 approximately 405,000 underage youth consumed 16.5% of all alcohol sold in Michigan, totaling \$704 million, which provided profits of \$345 million to the alcohol industry.<sup>23</sup>

The Michigan Liquor Control Commission, report of August 2011, noted 14% of 308 establishments were cited in their “controlled buy” activities for sales to minors, with 72% of sales occurring in spite of an ID check.<sup>24</sup>

## Alcohol Intervening Variables - Youth

### *LAWS/POLICIES*

Graduated licensing for first time drivers, zero tolerance, social host laws, and keg registration are in place in Michigan. In 2004, Michigan revised its underage drinking regulation to better track first time offenders who were being cited under local ordinances, provide an educational/treatment intervention for first time offenders, and use of jail time to enforce treatment requirement stipulated in probation for repeat violators. Since July 2009, Michigan drivers’ licenses and identification cards issued by the Michigan Secretary of State to those under 18 years-of-age utilize vertical formatting with red highlights, contrasting the horizontal licenses for those 21 years-of-age and over, and making underage status much easier for clerks and servers to recognize.

Reductions in motor vehicle crashes are the result, in part, of many policy and program measures including: keeping the minimum legal drinking age to 21 years-of-age,<sup>25</sup> administrative revocation of licenses for drinking and driving,<sup>26</sup> lower legal blood alcohol limits for youth<sup>27</sup> and adults,<sup>28</sup> and higher prices through increased taxation of alcoholic beverages.<sup>29, 30</sup> Higher prices for alcoholic

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<sup>23</sup> Pacific Institute for Research and Evaluation. (2011). Underage drinking in Michigan, the facts. Funding from the Office of Juvenile Justice and Delinquency Prevention (OJJDP). Chapel Hill, N.C.

<sup>24</sup> Michigan Liquor Control Commission. (2011). August report. Retrieved from [http://michigan.gov/lara/0,4601,7-154-10570\\_15011-264672--00.html](http://michigan.gov/lara/0,4601,7-154-10570_15011-264672--00.html).

<sup>25</sup> O'Malley, P. M., & Wagenaar, A. C. (1991). Effects of minimum drinking age laws on alcohol use, related behaviors and traffic crash involvement among American youth: 1976–1987. *Journal of Studies on Alcohol*, 52(5), 478-491. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/1943105?dopt=Abstract>.

<sup>26</sup> Zador, P. L., Lund, A.K., Fields, M., et al. (1989). Fatal crash involvement and laws against alcohol impaired driving. Institute for Highway Safety. Arlington, VA.

<sup>27</sup> Hingson, R. Heeren, T., and Winter, M. (1994). Lower legal blood alcohol limits for young drivers. *Public Health Reports* 109(6) 738-744. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/7800781?dopt=Abstract>.

<sup>28</sup> Hingson, R.; Hereen, T.; and Winter, M. (1996). Lowering state legal blood alcohol limits to 0.08 percent: the effect on fatal motor vehicle crashes. *American Journal of Public Health* 86(9): 1297-1299.

<sup>29</sup> Chalopuka, F. J.; Saffer, H.; and Grossman, M. (1993). Alcohol-control policies and motor-vehicle fatalities. *Journal of Legal Studies* 22:161-186.

<sup>30</sup> Ruhm, C. J. (1996). Alcohol policies and highway vehicle fatalities. *Journal of Health Economics* 15:435-454. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/10164038?dopt=Abstract>.

beverages also are associated with reduced frequency of drinking and driving.<sup>31</sup> In 2003, Michigan instituted a BAC limit of .08 (set to expire in 2013). Effective in November 2010, Michigan implemented mandatory use of ignition interlocks for first-time driving-under-the-influence offenders convicted with a BAC of .17 or higher. Training programs are in place for servers and clerks, and are often used as a consequence of sales to minors in regards to license protection or reinstatement by the Michigan Liquor Control Commission (LCC). In addition, community coalition/provider programs involving multiple city departments and private citizens have reduced both driving after drinking, and traffic deaths and injuries. Since 2005, the MDCH has focused on UAD and ARTCD with the SPF/SIG.<sup>32</sup>

## LAW ENFORCEMENT

The OHSP funds Party Patrols, Public Service Announcements, and many other initiatives to the law enforcement community. Local law enforcement division partners with communities for compliance checks and other youth access prevention initiatives. However, the recent economic struggles have forced budget cuts in law enforcement. “Making It Click” is an initiative by the OHSP to encourage high school student seat belt use.<sup>33</sup>

## ACCESS

Packaging for alcoholic energy drinks mimics that of the non-alcoholic energy drinks, confusing retail clerks, parents, and school staff, making it easier for minors to access and drink this form of alcohol. To address public health and safety risks associated with alcohol energy drinks, on November 4, 2010, the Michigan LCC issued an administrative order that banned the sale and distribution of alcohol energy drinks in Michigan.<sup>34</sup> According to the 2007 Youth Tobacco Survey, the most common source of alcohol for Michigan high school youth was ‘giving money to someone to buy it for them’ (29%). Almost as common, was ‘someone giving it to them’ (22%) which was equivalent to the percentage of those ‘getting it some other way’. Eleven percent of students reported ‘they took from a store or family member’ and nine percent said, ‘restaurant, bar or club’. Seven percent said ‘convenience store’ and 3% said ‘concert or sporting event’.<sup>35</sup>

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<sup>31</sup> Zador, P. L.; Lund, A. K.; Fields, M.; et al. (1989). Fatal crash involvement and laws against alcohol impaired driving. Institute for Highway Safety: Arlington, VA.

<sup>32</sup> MDCH BSAAS. (2005). State prevention framework state incentive grant. Retrieved from [http://www.michigan.gov/mdch/0,1607,7-132-2941\\_4871\\_29888-162850--,00.html](http://www.michigan.gov/mdch/0,1607,7-132-2941_4871_29888-162850--,00.html).

<sup>33</sup> Office of Highway Safety Planning. (2009). Making it click. Retrieved from [http://www.michigan.gov/documents/msp/high\\_school\\_seatbelt\\_program\\_06\\_296925\\_7.pdf](http://www.michigan.gov/documents/msp/high_school_seatbelt_program_06_296925_7.pdf).

<sup>34</sup> Michigan Department of Energy Labor and Economic Growth. (2010). Energy Drink Ban. Administrative Order. Retrieved from [http://www.michigan.gov/documents/dleg/Alcohol\\_Energy\\_Drink\\_Order\\_11\\_4\\_2010\\_337775\\_7.pdf](http://www.michigan.gov/documents/dleg/Alcohol_Energy_Drink_Order_11_4_2010_337775_7.pdf).

<sup>35</sup> Usual Source of Alcohol Reported by Michigan Youth, (2011). MDCH, Bureau of Epidemiology, Alcohol Epidemiology Program, based on the 2007 Youth Tobacco Survey. Retrieved from [http://www.michigan.gov/documents/mdch/Usual\\_Source\\_of\\_Alcohol\\_Among\\_MI\\_Youth\\_Fact\\_Sheet\\_345057\\_7.pdf](http://www.michigan.gov/documents/mdch/Usual_Source_of_Alcohol_Among_MI_Youth_Fact_Sheet_345057_7.pdf).



## *SOCIAL NORMING*

Social norms are people's beliefs, attitudes, and expectations about the behaviors that are considered normal or acceptable in a certain social environment. Parental acceptance of underage drinking and the provision of alcohol to minors by family and friends remains a national issue. In Michigan, various media campaigns and evidence-based programming within communities address "It's Not a MINOR issue."<sup>36</sup> Popular drinking games and portrayal in media have increased. Many communities and college campuses are using social norms marketing campaigns to reduce underage and high-risk drinking. High school and college students often have inflated views of how much their peers use alcohol and other drugs. These exaggerated views may influence students to increase their own alcohol use to fit in with what they perceive is "normal." Social norms marketing campaigns use advertising techniques to correct these misperceptions, which have been associated with decreases in the perceived pressure to use alcohol. Social norms marketing messages are different from traditional prevention messages in their use of statistics and non-judgmental messages about behaviors the majority of students are engaging in, such as not using alcohol, in order to encourage that behavior in others. Social norms marketing campaigns have also been used to target parents who believe it is acceptable to host parties and provide alcohol to minors.

## *AGE OF ONSET*

Efforts to delay age of onset are considered critical in research, noting that a need to screen and counsel adolescents about alcohol use should be coupled with policies and programs that delay alcohol consumption.<sup>37</sup>

## Alcohol Consequences – General/Adult

### *ALCOHOL-RELATED TRAFFIC CRASH DEATHS AND SERIOUS INJURIES*

Of the 9,876,187 persons living in Michigan in 2010, one out of every 10,548 was killed in a traffic crash and one out of every 140 persons was injured. The Michigan State Police (MSP) Criminal Justice Information Center (CJIC) and the Office of Highway Safety Planning (OHSP), in conjunction with the University of Michigan Transportation Research Institute (UMTRI), compiles and publishes an annual report. Overall 2001 to 2010 trend data are shown in Table 4. While alcohol and/or drug related traffic crash fatalities declined from 504 in 2001 to 357 in 2010, the relative percentage of overall traffic fatalities remained constant. In addition, the MSP also works with the Secretary of State (SOS) to produce a

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<sup>36</sup> New York State Office of Alcoholism and Substance Abuse Services. (n.d.). Underage drinking: not a minor problem. Retrieved from [http://www.oasas.state.ny.us/ud/OASAS\\_TOOLKIT/instructions.htm](http://www.oasas.state.ny.us/ud/OASAS_TOOLKIT/instructions.htm).

<sup>37</sup> Hingson, R. W., Heeren, T., and Winter, M. (2006). Age at drinking onset and alcohol dependence, age at onset, duration and severity. ARCH Pediatric Adolescent Medicine/Vol 160. Retrieved from [www.archpediatrics.com](http://www.archpediatrics.com).

drunk driving audit report annually. Of all 2010 traffic crash fatalities, 21.8% involved drinking but no drugs, 7.9% involved drugs but no drinking, and 8.4% involved both drinking and drugs. County-level data is available on Michigan OHSP's website, [www.michigantrafficcrashfacts.org](http://www.michigantrafficcrashfacts.org), and in the MSP Drunk Driving Audit.<sup>38</sup>

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<sup>38</sup> Michigan State Police (n.d.). Michigan drunk driving audit. Retrieved from [http://www.michigan.gov/msp/0,1607,7-123-1645\\_3501\\_4626-27728--,00.html](http://www.michigan.gov/msp/0,1607,7-123-1645_3501_4626-27728--,00.html).

**Table 4 – Michigan Traffic Crash Facts, 2001-2010**

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Total Crashes	400,813	395,515	391,486	373,028	350,838	315,322	324,174	316,057	290,978	282,075
Total Injuries	112,292	112,484	105,555	99,680	90,510	81,942	80,576	74,568	70,931	70,501
Total Fatalities	1,328	1,279	1,283	1,159	1,129	1,084	1,084	980	871	937
Fatal Crashes	1,206	1,175	1,172	1,055	1,030	1,002	987	915	806	868
Death Rate*	1.4	1.3	1.3	1.2	1.1	1.1	1.0	0.9	0.9	1.0
Fatal Crash Rate**	1.2	1.2	1.2	1.1	1.0	1.0	0.9	0.9	0.8	0.9
Restraint Use, Percent***	47.4%	51.4%	49.8%	51.0%	54.7%	54.9%	54.4%	49.7%	50.4%	51.6%
Percent of Alcohol/Drug-Involved Crashes to total fatal crashes	38.0%	35.8%	34.4%	36.5%	35.0%	39.6%	35.4%	39.0%	40.7%	37.9%
Alcohol/Drug Involved Fatalities	504	463	442	418	408	440	381	379	351	357
Percent of Alcohol/Drug Involved Fatalities to total fatalities	38.0%	36.2%	34.5%	36.1%	36.1%	40.6%	35.1%	38.7%	40.3%	38.1%
OUIL Arrests (all agencies)	58,562	57,782	55,728	55,056	54,036	53,297	49,867	47,251	45,893	41,883
Registered Vehicles (Millions)	8.89	9.00	9.92	9.93	9.69	8.70	8.33	8.38	8.11	8.06
MVMT (Billions)	96.5	96.5	98.2	100.2	101.8	103.2	104	104.6	100.9	95.9
Population (Millions)	9.99	10.05	10.08	10.08	10.11	10.12	10.09	10.07	10.00	9.97

2007 Footnote: Total registered vehicles will be changed from this year forward to subtract the registered trailer plates.

\*Death Rate=Persons killed per 100 million MVMT

\*\*Fatal Crash Rate=Fatal Crashes per 100 million MVMT

\*\*\*Restraint Use by deceased occupants of motor vehicles equipped with safety belts

Source: Michigan Office of Highway Safety Planning, February 2012.

## SUBSTANCE ABUSE AND ADDICTION

TEDS indicated that numbers for alcohol treatment, within Michigan’s public service delivery system, have varied slightly between 2001 and 2011, but have maintained a decline since 2001, as indicated in Table 5.

**Table 5 – Self-Reported Primary Drug of Choice Trend Data, from Treatment Episode Data, at Admission into Michigan Publicly Funded Services**

Fiscal Year	Alcohol		Cocaine		Heroin		Other Opiates		Marijuana		Meth		Other Stim		All Others		Totals
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N
2001	29,492	49.3%	10,330	17.3%	7,857	13.1%	1,882	3.1%	8,528	14.3%	165	0.3%	108	0.2%	1,459	2.4%	59,821
2002	28,091	50.1%	9,558	17.1%	6,517	11.6%	1,929	3.4%	8,834	15.8%	280	0.5%	81	0.1%	759	1.4%	56,049
2003	31,710	48.4%	11,708	17.9%	7,935	12.1%	2,618	4.0%	10,262	15.6%	506	0.8%	77	0.1%	768	1.2%	65,584
2004	29,927	45.3%	11,765	17.8%	8,726	13.2%	3,246	4.9%	10,893	16.5%	689	1.0%	97	0.1%	742	1.1%	66,085
2005	30,185	43.2%	12,382	17.7%	9,601	13.8%	4,002	5.7%	11,816	16.9%	913	1.3%	92	0.1%	817	1.2%	69,808
2006	30,579	42.1%	13,290	18.3%	9,958	13.7%	4,918	6.8%	12,368	17.0%	707	1.0%	87	0.1%	712	1.0%	72,619
2007	30,488	42.1%	12,895	17.8%	9,931	13.7%	5,603	7.7%	12,264	16.9%	444	0.6%	77	0.1%	759	1.0%	72,461
2008	28,496	42.0%	9,698	14.3%	10,365	15.3%	6,154	9.1%	11,680	17.2%	500	0.7%	93	0.1%	790	1.2%	67,776
2009	28,981	41.5%	7,125	10.2%	12,522	17.9%	7,779	11.1%	11,707	16.8%	502	0.7%	124	0.2%	1,092	1.6%	69,832
2010	26,052	40.1%	6,064	9.3%	11,358	17.5%	8,448	13.0%	11,275	17.3%	611	0.9%	120	0.2%	1,101	1.7%	65,029
2011	25,489	38.7%	5,495	8.3%	12,465	18.9%	9,621	14.6%	10,793	16.4%	712	1.1%	168	0.3%	1,137	1.7%	65,880

Note: Does not include private practice data. This table may include duplicate counts of persons if they entered treatment more than one time during the year, either for the same or other substance.  
Source: MDCH, BSSAS, February 2012

Data also indicated that during 2008 to 2010, 15.1% of Michigan adults had no health coverage, perhaps influencing a decline in access to care,<sup>39</sup> as shown in Table 6.

**Table 6 – Adult Health and Safety Patterns from Michigan Behavioral Risk Factor Survey**

<b>Michigan</b>	<b>N Sample Size</b>	<b>Percent</b>	<b>Table</b>
<b>Heavy Drinking</b>	<b>26,738</b>	<b>5.4%</b>	<b>13</b>
<b>Binge Drinking</b>	<b>26,992</b>	<b>16.6%</b>	<b>13</b>
<b>Drove a vehicle after drinking alcohol</b>	<b>14,906</b>	<b>2.7%</b>	<b>14</b>
<b>Always wears seatbelt</b>	<b>14,863</b>	<b>88.3%</b>	<b>15</b>
<b>No Health Coverage</b>	<b>27,634</b>	<b>15.1%</b>	<b>9</b>

Source: Based on 2008-2010 Michigan BRFSS, May 2011

### **DROVE VEHICLE AFTER DRINKING**

The combined 2008 to 2010 Michigan Behavioral Risk Factor Survey (MIBRFS) regional and local health department estimates indicated that 2.7% of Michigan adults drove after drinking, as shown previously in Table 6 above. Also notable is the fact that many children reside with parents and caregivers who have substance abuse issues, and are dependent upon them to provide transportation.<sup>40</sup>

### Alcohol Consumption – General/Adult

According to the 2010 NSDUH report, there were 4.7 million persons aged 12 or older who had used alcohol for the first time within the past 12 months. Most of these (82.4%) were under 21 at the time of initiation and the mean age of first use in this group was 16.1 years. The 2008 to 2010 MIBRFS regional and local health department estimates, released May 2011, indicate the following consumption patterns for individuals 18 years-of-age and older: 5.4% heavy drinking and 16.6% binge drinking, as shown previously in Table 6.

### Alcohol Intervening Variables – General/Adult

### **SAFETY BELT USE**

Michigan's seat belt law became a primary enforcement law on April 1, 2000. Seat belt use has dramatically increased (70% to 98%) from 1998 to 2009, with a

<sup>39</sup> Michigan Department of Community Health, Bureau of Epidemiology. (2011). Regional and local health departments. Michigan Behavioral Risk Factor Survey (BRFS). Contact Chris Fussman at [MiBRFSS@michigan.gov](mailto:MiBRFSS@michigan.gov) or 517-335-8144.

<sup>40</sup> University of Maryland, Center for Substance Abuse Research (2009). More than one in ten children in the U.S. live with substance-abusing or substance-dependent parent. CESAR Fax, 18(18). Retrieved from <http://www.cesar.umd.edu/cesar/cesarfax/vol18/18-18.pdf>.

rate of 95.2% in 2010.<sup>41</sup> According to Fatality Analysis Reporting System (FARS) data, during 1998 and 2009 there were decreases in total traffic fatalities (1,366 to 871, respectively), unrestrained fatalities (518 to 168), alcohol-involved fatalities with .01 BAC or higher (502 to 291), and alcohol-involved fatalities with .08 BAC or higher (427 to 246).<sup>42</sup> Increased belt use has contributed to reducing fatalities in alcohol-involved crashes and all crashes; the official National Center for Statistics and Analysis methodology estimates fewer potential “lives saved” as total fatalities decrease but still shows about 500 Michigan lives saved by safety belts every year.<sup>43</sup> Safety belt use is addressed as a health and safety issue by the Michigan OHSP.

### *STATEWIDE FOCUS OF SPF/SIG ACTIVITIES ON ARTCD*

The federal SPF/SIG has afforded dollars to build community capacity to address ARTCD during 2004 to 2010. Community-level needs assessments, capacity building, and strategic plans were completed by sub-state entities for MDCH/BSAAS. Implementation plans and evaluations are continuing. ARTCD and underage drinking remain a focus of statewide prevention planning for 2010 to 2011.

## **Prescription Drugs Data**

### Prescription Drug Abuse Consequences – Youth/General/Adult

Prescription drugs are considered misused if taken in amounts or in ways in which they were not prescribed and/or if they are taken by a person other than to whom they were prescribed. Drug overdoses and interactions, accidental poisonings and deaths are consequences of this behavior, as indicated in Table 8.

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<sup>41</sup> National Highway Safety Administration, National Center for Statistics and Analysis. (2011). Seat Belt Use in 2010 – Use rates in the States and Territories. Retrieved from <http://www-nrd.nhtsa.dot.gov/Pubs/811493.pdf>

<sup>42</sup> National Highway Safety Administration, National Center for Statistics and Analysis. (2009). Fatality analysis reporting system. Data Resource Website. Retrieved from <http://www-fars.nhtsa.dot.gov/Main/index.aspx>.

<sup>43</sup> National Highway Safety Administration, National Center for Statistics and Analysis. (2009). The increase in lives saved, injuries prevented, and cost savings if seat belt use rose to at least 90 percent in all states. Traffic safety facts, research notes. Retrieved from <http://www-nrd.nhtsa.dot.gov/Pubs/811140.PDF>.

**Table 8 – Prescription Drug Overdose Death Rates of Michigan Residents by Age and Sex**

Annual Overdose rates by age and gender, Michigan, 2007-2009						
Age Category	Males			Females		
	Number	Population	Rate	Number	Population	Rate
<20	9	1,373,851	0.7	4	1,311,664	0.3
20-29	48	673,744	7.1	22	655,089	3.4
30-39	50	637,597	7.9	27	629,216	4.3
40-49	67	741,866	9.1	64	749,960	8.5
50-59	54	692,622	7.7	53	715,789	7.5
60+	18	804,249	2.2	19	1,017,775	1.9
Total	246	4,923,929	5.0	190	5,079,493	3.7

Source: MDCH, Vital Records, and Health Statistics

This category of misuse and abuse is also known as “medication abuse.” Violence and extreme risk taking may also become by-products of misuse. According to the 2009 MiYRBS, 25.0% of 9<sup>th</sup> through 12<sup>th</sup> graders who had sex in the last three months reported doing so after using alcohol or drugs.<sup>44</sup> Healthy pregnancy outcomes are threatened by drug use. Prescription drug abuse also leads to impaired driving and traffic crashes causing severe injury or death, as shown previously in Table 4.

The most commonly abused prescription drugs:<sup>45</sup>

- **Opioids** – for pain oxycodone (OxyContin), propoxyphene (Darvon), hydrocodone (Vicodin), hydromorphone (Dilaudid), meperidine (Demerol), and diphenoxylate (Lomotil)
- **Depressants** – for anxiety and sleep disorders barbiturates: pentobarbital sodium (Nebutol); benzodiazapenes: diazepam (Valium), and alprazolam (Xanax)
- **Stimulants** – for narcolepsy, ADHD, and obesity dextroamphetamine (Dexedrine), methylphenidate (Ritalin), and steroids (anabolic/androgenic)

<sup>44</sup> Michigan Department of Education. (2009). Michigan youth risk behavior survey 2009. Contact Kim Kovalchick at [kovalchick@michigan.gov](mailto:kovalchick@michigan.gov) or 517-241-4292. Retrieved from [http://www.michigan.gov/documents/mde/09YRBSDetail\\_3271657.pdf](http://www.michigan.gov/documents/mde/09YRBSDetail_3271657.pdf).

<sup>45</sup> U. S. Department of Health and Human Services, National Institute of Drug Abuse. (n.d.). Research report series - prescription drugs: abuse and addiction. Retrieved from <http://www.nida.nih.gov/researchreports/prescription/prescription2.html>.

Many prescription drugs are addictive to varying degrees and result in the need for substance abuse and addiction treatment. The Drug Enforcement Agency (DEA) evaluates drugs and other substances for the sake of regulations and classifies these drugs into five schedules according to their abuse potential, addictive nature, and whether or not they have accepted medical use for treatment.

### ABUSE AND ADDICTION

In looking at Michigan publicly funded treatment sought in 2010 and 2011, where the initial treatment involved prescription drugs, as primary, secondary or tertiary drug of choice, for youth 20 years-of-age and under; treatment decreased from 234 in 2010, to 180 in 2011, as indicated in Table 9. National data is readily available, but state data collection is just beginning and is fragmented. State data collection is considered a gap for the SEOW to focus on, as the problem has escalated nationally and continues to make headlines within the state.

**Table 9 – Initially Prescribed Drugs Involved Treatment: Self-Reported as Primary, Secondary, or Tertiary Drug of Choice for Treatment in Michigan Publicly Funded Services, 2010-2011**

Age in Years	Client Gender								TOTAL COUNTS	
	Male				Female					
	Count		Percentage		Count		Percentage			
	2010	2011	2010	2011	2010	2011	2010	2011	2010	2011
< 14	0	0	0.0%	0.0%	0	0	0.0%	0.0%	0	0
14-17	13	18	44.8%	50.0%	16	18	55.2%	50.0%	29	36
18-20	112	82	54.6%	56.9%	93	62	45.4%	43.1%	205	144
21-25	340	298	40.2%	36.2%	506	525	59.8%	63.8%	846	823
26-29	434	468	43.4%	43.8%	566	604	56.6%	56.2%	1,000	1,069
30-35	504	571	45.9%	43.3%	594	747	54.1%	56.7%	1,098	1,318
36-44	406	487	40.8%	44.9%	589	598	59.2%	55.1%	995	1085
45-54	351	400	47.2%	46.7%	392	457	52.8%	53.3%	743	857
55-64	105	134	52.8%	54.9%	94	110	47.2%	45.1%	199	244
65+	2	4	18.2%	80.0%	9	1	81.8%	20.0%	11	5
<b>Total</b>	<b>2,267</b>	<b>2,462</b>	<b>44.2%</b>	<b>44.1%</b>	<b>2,859</b>	<b>3,119</b>	<b>55.8%</b>	<b>55.9%</b>	<b>5,126</b>	<b>5,581</b>

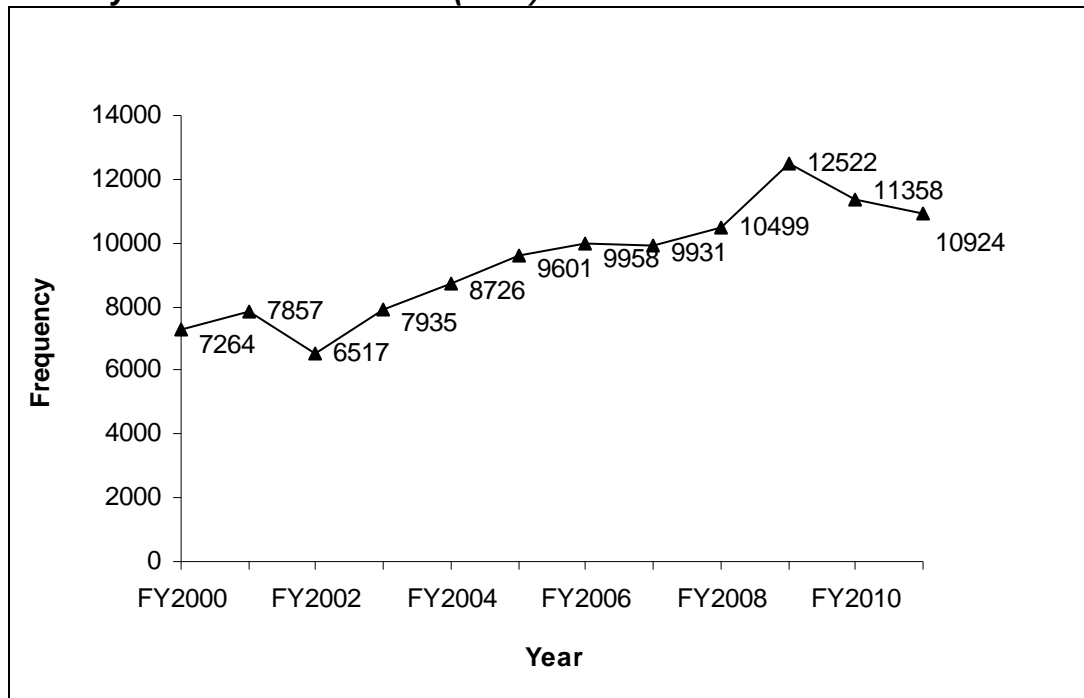
Note: Does not include private practice data. Data may include duplicate counts of persons if they entered treatment more than one time during the year, either for the same or other substance.

Source: MDCH, BSSAS, February 2012



The percentage of treatment admissions for opiate abuse and addiction has increased fourfold from 3.1% in 2001 to 14.6% in 2011, as shown in previously Table 5. Michigan publicly funded treatment involving prescription drug abuse as the primary, secondary, and tertiary drug of choice totaled 5,581 treatment entrances in 2011, with the highest rates in adults 21 to 54 years-of-age, with a sharp increase in rates from 2010 to 2011 among adults 30 to 35 years-of-age, as shown in Table 9 above. Illicit drug use has also increased as it becomes a more affordable option for a person to progress from expensive prescriptions to more affordable illicit substances,<sup>46</sup> as illustrated in Figures 1, 2, and 3.

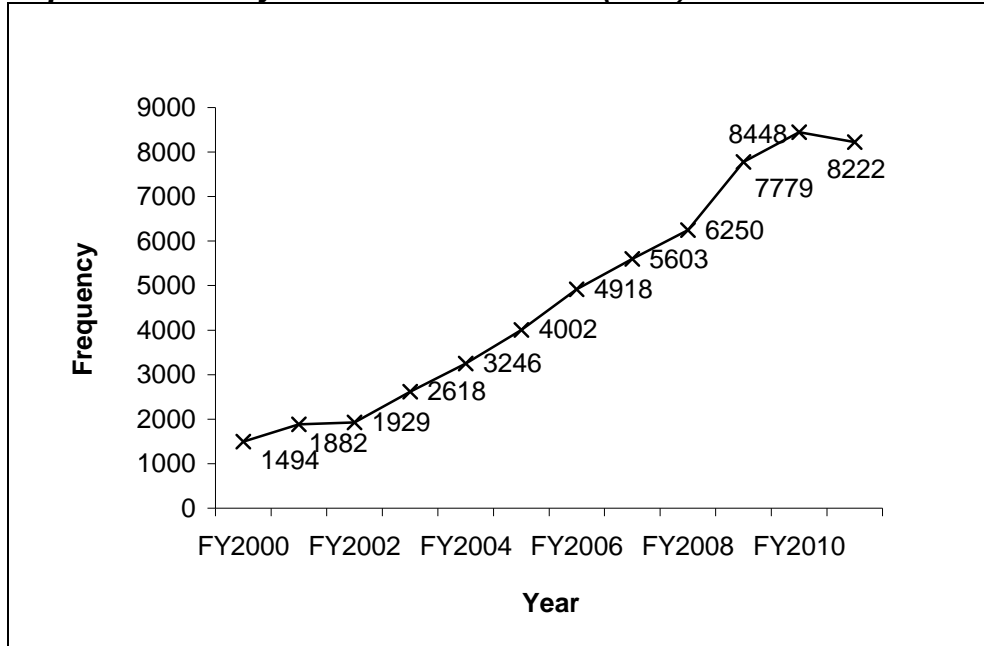
**Figure 1 – Heroin Primary Drug of Choice Trend Data, as Self-Reported Primary Substance of Abuse (PSA)**



Source: MDCH/BSAAS, Treatment Episode Data Set (TEDS), February 2012

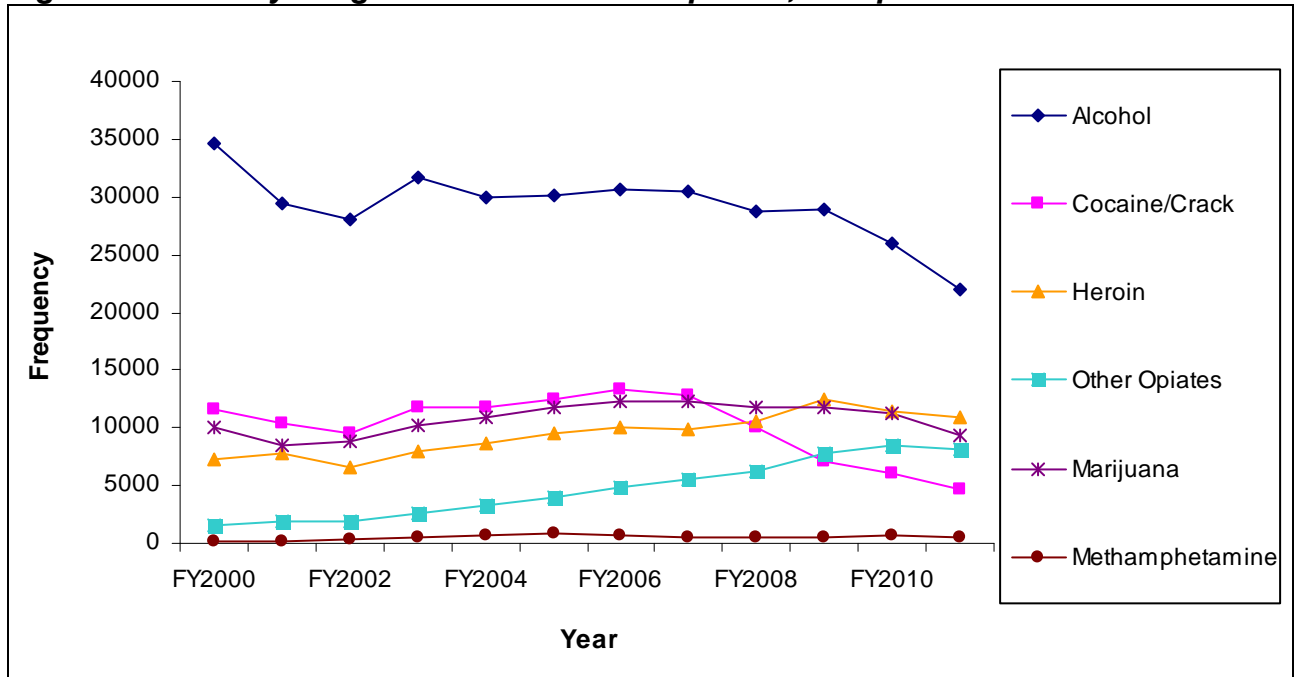
<sup>46</sup> Canfield, M., Keller, C., Frydrych, L., Ashrafioun, L., Purdy, C., & Blondell, R. (2010). Prescription opioid use among patients seeking treatment for opioid dependence. *Journal of Addiction Medicine*. 4(2), 108-113.

**Figure 2 – Other Opiates Primary Drug of Choice Trend Data, as Self-Reported Primary Substance of Abuse (PSA)**



Source: MDCH/BSAAS, Treatment Episode Data Set (TEDS), February 2012

**Figure 3 – Primary Drug of Choice as Self-Reported, Comparison**



Source: MDCH/BSAAS, Treatment Episode Data Set (TEDS), February 2012

## TRAFFIC DEATHS AND INJURIES INVOLVING DRUGS

The number of deaths involving drugs slightly increased from 119 in 2009, to 153 in 2010. The number of people injured in crashes involving alcohol and/or drugs decreased from 6,271 in 2009, to 6,175 in 2010. However, drivers injured who had both alcohol and drugs in their system increased from 463 in 2009, to 616 in 2010.<sup>47</sup> Some of the numbers involve illicit drug use, which is often an outcome of progressive addiction to prescription drugs, as noted previously.

### Prescription Drug Consumption – Youth/General/Adult

Prescription drug misuse is an emerging trend. According to NSDUH, the prevalence of past year nonmedical use of pain reliever among youth aged 12 to 17 years decreased, but not significantly, from 6.6 percent in 2009 and to 6.2 percent in 2010. Although national data is prevalent, state data is limited. Two questions regarding prescription drug use were asked on the Michigan Profile of Healthy Youth (MiPHY) last school year (2009-10) for the first time.<sup>48</sup> According to the 2009 MiYRBS, illegal drugs were offered, sold, or given on school property to 30% of students within the last year. Six percent of 9<sup>th</sup> through 12<sup>th</sup> graders have taken barbiturates without a doctor's prescription in the last 30 days. This rate is significantly higher for Hispanic/Latino students (11%) and eleventh graders (8%). Ten percent of 9<sup>th</sup> through 12<sup>th</sup> graders have used barbiturates without a prescription at least once in their life, again with higher rates for Hispanic/Latino students (16%). Nine percent of 9<sup>th</sup> through 12<sup>th</sup> graders have used club drugs one or more times during their life, with higher rates for Hispanic/Latino students (16%) and eleventh (13%) and twelfth (11%) graders. Four percent of students have taken steroid pills or shots at least once, and three percent have done so in the last 30 days. The 2009 MiYRBS data also show that 14% of students have sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paint or spray to get high one or more times during their life.<sup>49</sup> Prescription drug misuse is prevalent in the headlines and media. "Pharming" parties are common among youth.

Nationally, nonmedical use of pain relievers in the past year among persons aged 12 or older did not change between the NSDUH 2002 to 2003 and 2008 to 2009 surveys (4.8% in 2002 to 2003 and in 2008 to 2009). The prevalence in Michigan increased but not significantly over this time-period (5.2% in 2002 to 2003 and 5.7% in 2008 to 2009). Declines in nonmedical use of pain relievers

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<sup>47</sup> Michigan State Police, Criminal Justice Information Center. (2011). Michigan annual drunk driving audit. Retrieved from [http://www.michigan.gov/documents/msp/2010\\_audit\\_for\\_web\\_deployment\\_357302\\_7.pdf](http://www.michigan.gov/documents/msp/2010_audit_for_web_deployment_357302_7.pdf)

<sup>48</sup> Michigan Department of Education (2009-2010). MiPHY questions. Retrieved from <http://www.michigan.gov/miphy>.

<sup>49</sup> Michigan Department of Education. (2009). Michigan youth risk behavior survey 2009. Contact Kim Kovalchick at [kovalchick@michigan.gov](mailto:kovalchick@michigan.gov) or 517-241-4292. Retrieved from [http://www.michigan.gov/documents/mde/09YRBSDetail\\_327165\\_7.pdf](http://www.michigan.gov/documents/mde/09YRBSDetail_327165_7.pdf).

were observed among youths 12 to 17 years-of-age, while increases were noted among persons aged 18 to 25.<sup>50</sup>

### Prescription Drug Intervening Variables – Youth/General/Adult

#### ACCESS

Results from the NSDUH indicate that prescription drugs are obtained most commonly free from friends or relatives.<sup>51</sup> Therefore, the home is a point of access for prescription drug abuse. Adults are often ill informed about how accessible their prescriptions are to their family, friends, babysitters, and visitors. Prescriptions are often discontinued before completely used and kept beyond their expiration dates. The DEA has sponsored Nationwide Prescription Drug Take-Back Days to encourage proper disposal techniques of unwanted and unused prescription drugs across communities in all 50 states.<sup>52</sup> Of particular interest is Hydrocodone. During 2010, there were over 5.8 million prescriptions for this Schedule III category drug, accounting for 31.2% of all controlled substance prescriptions in Michigan. Hydrocodone is also dispensed under the names of Vicodin, Lortab, Tussionex, etc.

The number of legitimate prescriptions written has consistently increased, as indicated in Figure 4. The Michigan Automated Prescription Service (MAPS) reported over 18.8 million prescriptions were written in 2010. Prescriptions for Hydrocodone have dramatically increased since 2005, accounting for 31.2% of all controlled substance prescriptions in 2010. Suboxone prescriptions increased 957.6% from 2005 to 2010.<sup>53</sup> Suboxone's patent expired in late 2009 and has been generically available thereafter, which usually spikes prescriptions.

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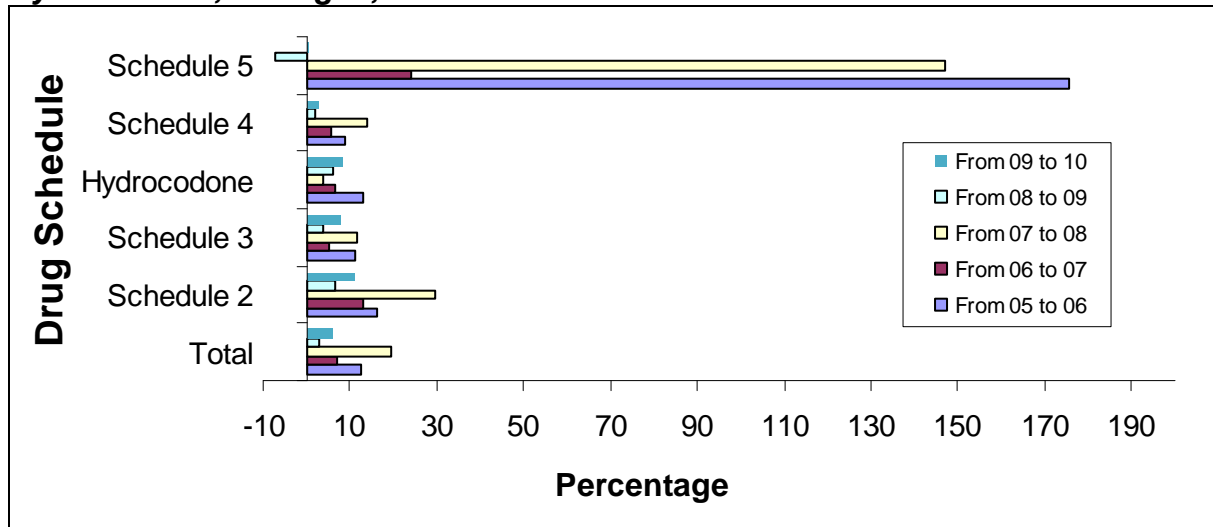
<sup>50</sup> SAMHSA (n.d.). State Estimates of Substance Use from the 2008-2009. National surveys on drug use and health. Retrieved from <http://www.oas.samhsa.gov/2k9State/TOC.htm>.

<sup>51</sup> SAMHSA (n.d.). Results from the 2010 national survey on drug use and health: summary of national findings. National surveys on drug use and health. Retrieved from <http://oas.samhsa.gov/NSDUH/2k10NSDUH/2k10Results.htm>.

<sup>52</sup> U.S. Department of Justice, Drug Enforcement Administration. (2010). American public overwhelmingly responds to DEA prescription drug take-back effort. Retrieved from <http://www.nationaltakebackday.com/toolbox/documents/TakeBackRelease%20Update.docx>.

<sup>53</sup> Michigan Department of Community Health, Bureau of Health Professions. (2006-2010). Prescription data. Michigan Automated Prescription System (MAPS).

**Figure 4 – Change in Legitimate Prescriptions Filled by Schedule and Hydrocodone, Michigan, 2005-2010**



Note: "Legitimate" refers to the prescription written as part of thorough medical care, including blood tests, regular doctor visits, health history, etc. Source: Michigan Automated Prescription System (MAPS), 2005-2010 Prescription Data, Bureau of Health Professions

Some highlights from the MAPS data for 2010 include frequency of prescribed controlled substance by NSDUH Use Category: pain relievers at 8.9 million, tranquilizers at 3.5 million, stimulants at 2.1 million, and sedatives at 1.5 million, as shown previously in Table 11. Almost every category of controlled drug has increased in number of prescriptions since 2003. From 2003 to 2010, the biggest increase noted was with Opioid antagonists (Suboxone/Subutex, Schedule III); the number of prescriptions increased rapidly (327 prescriptions in 2003 and 285,059 in 2010), as shown previously in Table 10. Increases shown in Schedule II (stimulants and pain relievers) drug prescriptions from 2003 to 2010 include: oxycodone (113%), methadone (146%), and hydromorphone (275%). Numerous prescriptions decreased from 2003 to 2010 including: methyphenidate 82.4% (Ritalin, Schedule II stimulant), fentanyl 40.8% (Schedule II pain reliever), and propoxyphene 18.1% (Darvocet/Darvon, Schedule IV pain reliever). The most commonly prescribed pain relievers in 2010 were: Hydrocodone (Vicodin, etc., Schedule III) at 5.8 million prescriptions, codeine (Tylenol #3 and #4, Schedule III) at 0.72 million, and oxycodone (OxyContin, etc., Schedule II) at 0.69 million.<sup>54</sup>

#### MILITARY CONSIDERATIONS

Wartime creates additional stress with deployments, wounds, and loss of lives, for both the veterans and their families. These stressors create a high-risk for all and often increased access. The prevalence of illicit drug use, including prescription drugs, increased from 5% in 2005, to 12% in 2008. The increased prevalence was primarily attributed to the addition of questions that asked for

<sup>54</sup> Ibid.

usage of prescription medication for non-medical reasons.<sup>55</sup> Stigma has created apprehension about utilizing treatment within the military, with veterans often returning to civilian life with unresolved substance issues.

### *SOCIAL NORMS*

Sharing prescriptions, attitudes about self-medicating for even minor complaints, advertising campaigns, and jovial acceptance in media, all contribute to misuse and abuse of prescription drugs.

### *PERCEPTION OF RISK*

Prescription drugs are often thought safer because they are initially prescribed by a doctor.

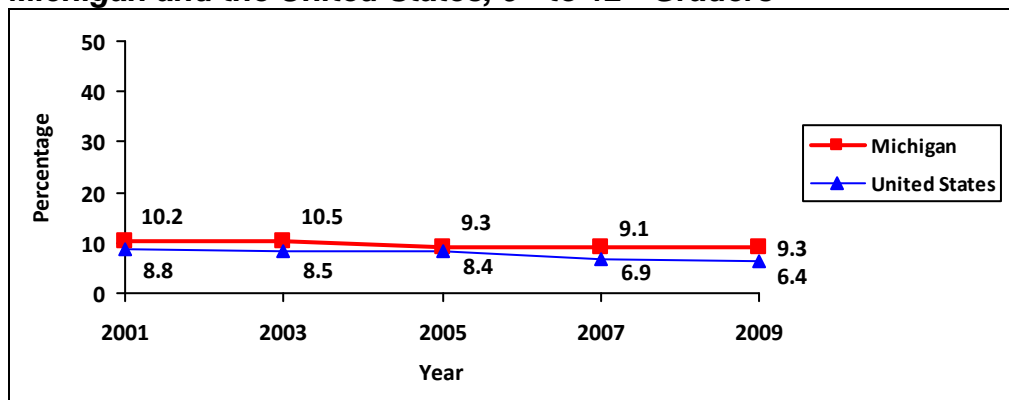
## **Mental Health Indicators**

### Suicide Prevalence

#### *ATTEMPTED SUICIDE – YOUTH*

In 2009, 16% of Michigan public high school students reported having seriously considered suicide in the past 12 months, compared to 13.8% of youth nationally. About one in every 11 Michigan public high school students (9.3%) reported having attempted suicide one or more times in the past year with three percent of respondents requiring medical attention after an attempted suicide,<sup>56</sup> as indicated in Figure 5.

**Figure 5 – Percentage of Youth Who Attempted Suicide in the Past Year in Michigan and the United States, 9<sup>th</sup> to 12<sup>th</sup> Graders**



Source: MiYRBS and YRBS

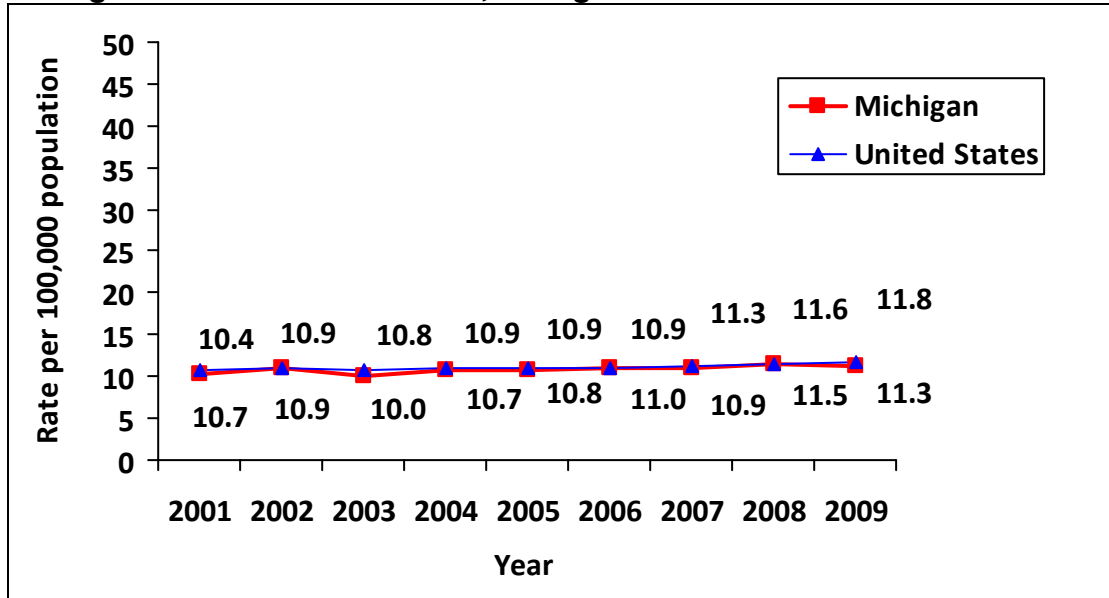
<sup>55</sup> Department of Defense. (2008). Survey of health related behaviors among active duty military personnel. Retrieved from <http://www.tricare.mil/2008HealthBehaviors.pdf>.

<sup>56</sup> Michigan Department of Education. (2009). Youth risk behavior survey. Retrieved from [http://www.emc.cmich.edu/YRBS/2009/2009\\_YRBS\\_V\\_S.pdf](http://www.emc.cmich.edu/YRBS/2009/2009_YRBS_V_S.pdf).

## SUICIDE – GENERAL/ADULT

One objective of Healthy People 2010 is to reduce the suicide rate to 5.0 suicides per 100,000 population. In 2009, Michigan's age-adjusted suicide rate was 11.3 per 100,000 population, which is two times the target and slightly lower than the national rate of 11.8 suicides per 100,000 population as illustrated in Figure 6.

**Figure 6 – Rate of Suicide Deaths per 100,000 Population, Age Adjusted in Michigan and the United States, All Ages**



Source: MDCH, Vital Records and Health Statistics, April 2011

Since 2001, the U.S. and Michigan suicide rates were virtually equivalent. The rate of death for males in Michigan was approximately four times higher than that of females (18.6 per 100,000 for males, versus 4.7 per 100,000 for females),<sup>57</sup> as illustrated in Figure 7. The leading method of suicide for males was a firearm (55%), while for females it was poisoning (45%).<sup>58</sup>

Four of the five participating SPE CA regional communities have suicide rates higher than the state's overall rate. The two CAs in the Upper Peninsula of Michigan each have one county (local community) that has a suicide rate that is in the highest category in the state. The other CAs have at least one county in the next highest category rate.

<sup>57</sup> Michigan Department of Community Health, Vital Records and Health Statistics Section. (2009). Interview.

<sup>58</sup> Michigan Department of Community Health. (2007). Michigan critical health indicator. Retrieved from [http://www.michigan.gov/documents/mdch/Critical\\_Health\\_Indicators\\_2007\\_198949\\_7.pdf](http://www.michigan.gov/documents/mdch/Critical_Health_Indicators_2007_198949_7.pdf).



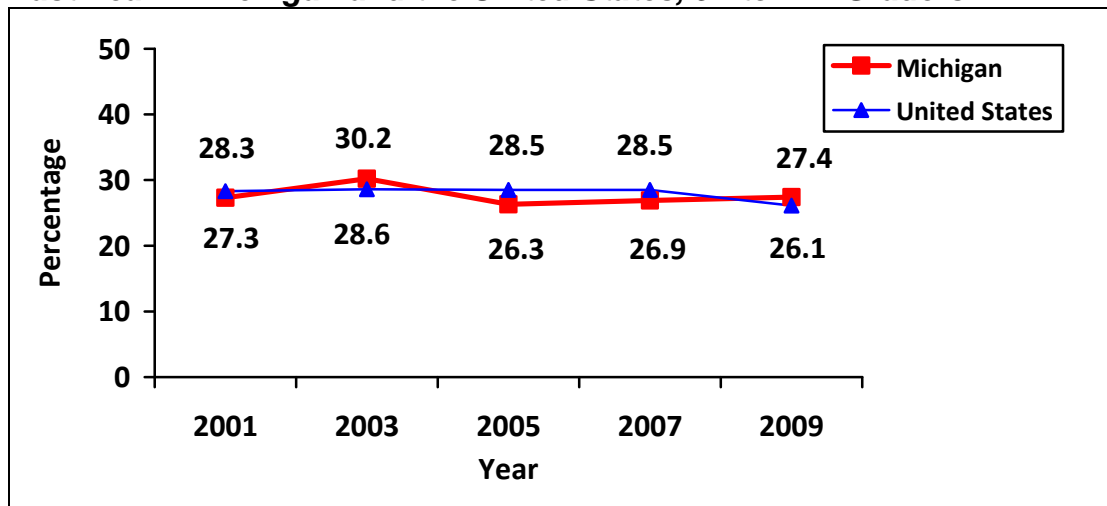


## Depression and Serious Mental Illness Prevalence

### DEPRESSIVE FEELINGS – YOUTH <sup>59</sup>

While there has been some variability, the rate of past year depressive feelings reported by 9<sup>th</sup> through 12<sup>th</sup> graders in Michigan declined from 30.2% in 2003 to 26.3% in 2005. The rate, however, as shown in Figure 8, has slightly increased from 26.9% in 2007 to 27.4% in 2009.<sup>60</sup> Depressive feelings was defined as feeling so sad or hopeless, almost every day for two weeks or more in a row, that the person stopped doing some of their usual activities.

**Figure 8 – Percentage of Youth Who Reported a Depressive Episode in the Past Year in Michigan and the United States, 9<sup>th</sup> to 12<sup>th</sup> Graders**



Source: Michigan Youth Risk Behavior Survey, [http://www.michigan.gov/mde/0,1607,7-140-28753\\_38684\\_29233\\_41316---,00.html](http://www.michigan.gov/mde/0,1607,7-140-28753_38684_29233_41316---,00.html) and Youth Risk Behavior Surveillance System, <http://www.cdc.gov/HealthyYouth/yrbs/>

### CO-OCCURENCE OF DEPRESSIVE FEELINGS AND ALCOHOL CONSUMPTION/ ILLICIT DRUG USE

Similar proportions of Michigan's male and female high school students reported current drinking (36% of males and 37% of females) and binge drinking (23.8% and 22.4% respectively). Past year depression was related to alcohol consumption in addition to increased risk of attempting suicide, as shown in Table 13.

<sup>59</sup> Given data source of YRBS, rather than using 'depression', the term 'depressive feelings' for youth is appropriate.

<sup>60</sup> Michigan Department of Education. (2009). Michigan youth risk behavior survey. Contact Kim Kovalchick at [kovalchickk@michigan.gov](mailto:kovalchickk@michigan.gov) or 517-241-4292.

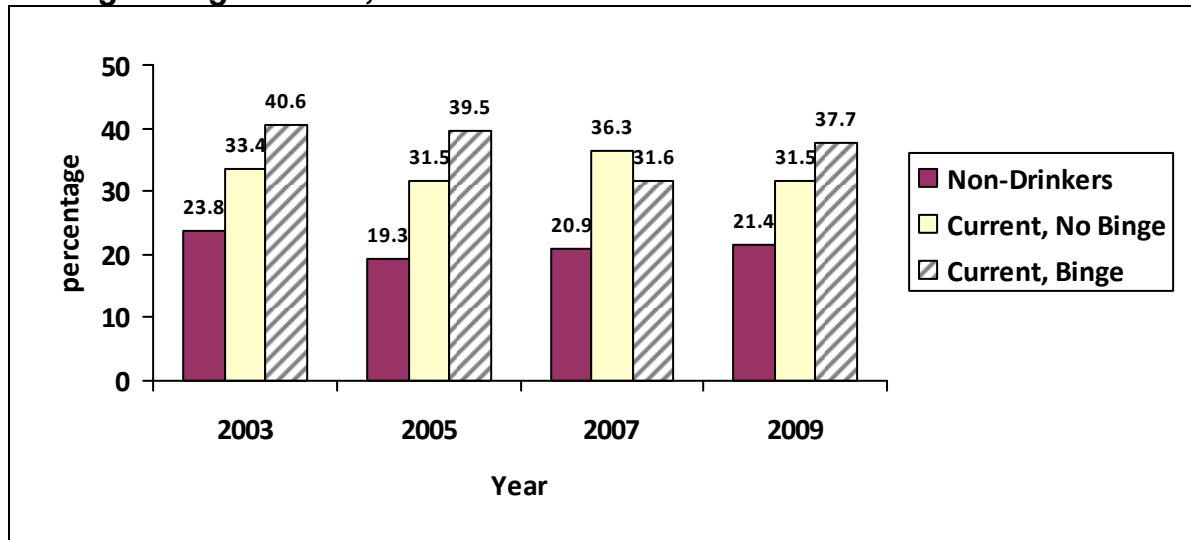
**Table 13 – Prevalence of Attempting Suicide and Alcohol Consumption in the Past 12 Months Among Michigan Youth, MiYRBS 2003-2009**

<i>Attempted suicide one or more times during the past 12 months</i>				
<i>Drinking Status</i>	2003	2005	2007	2009
Non-Drinkers	6.3 %	5.9 %	6.1 %	6.4 %
Current, Not Binge	<b>13.1%</b>	9.1 %	10.5 %	9.5 %
Current, Binge	<b>15.9%</b>	<b>16.7%</b>	<b>12.4%</b>	<b>11.7%</b>

Note: All bolded values indicate a significant difference of  $p \leq .05$  ( $\chi^2$  test) compared to non-drinkers Source: MiYRBS, 2003-2009

Compared to non-drinkers, binge and current drinkers reported a significantly higher prevalence of feeling sad or hopeless for almost every day during a two week period, which included considering suicide, and making a suicide plan during the previous 12 months,<sup>61</sup> as shown in Figures 9, 10, and 11.

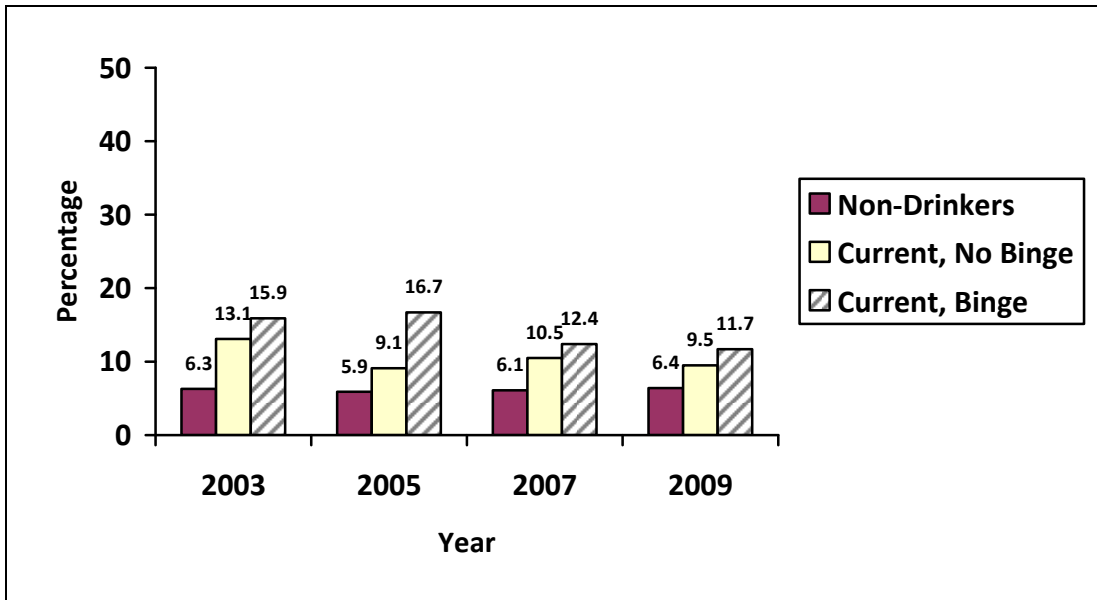
**Figure 9 – Prevalence of Depressive Feelings and Alcohol Consumption Among Michigan Youth, MiYRBS 2003-2009**



Source: MiYRBS, 2003-2009

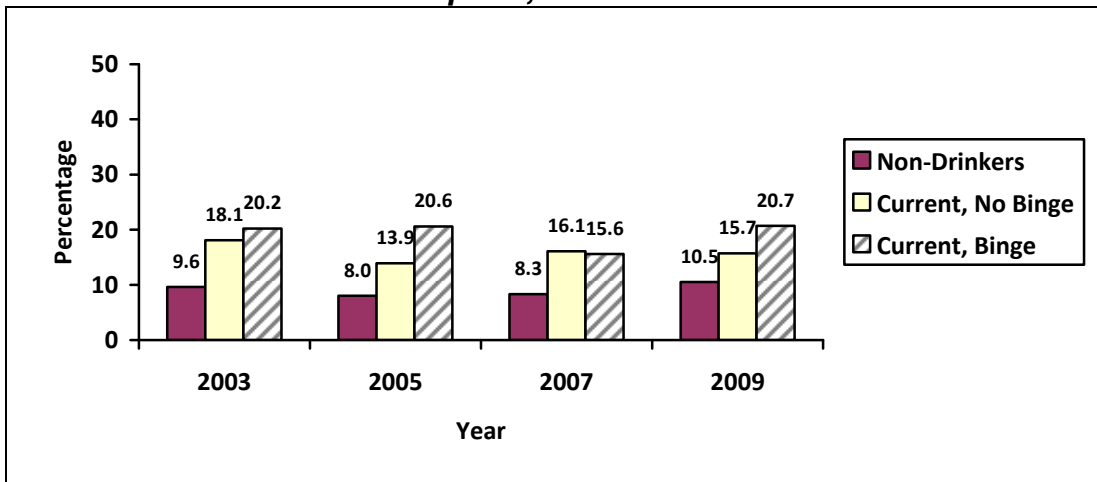
<sup>61</sup> Michigan Department of Community Health, Bureau of Epidemiology, and the Michigan Department of Education. (2010). Violence and mental distress in current and binge drinking mi youth. Michigan alcohol surveillance brief. 1(1). K. Gonzales, K. Kovalchick & L. Cameron (Eds.).

**Figure 10 – Prevalence of Students Who Seriously Considered Attempting Suicide during the Past 12 Months and Alcohol Consumption, MiYRBS 2003-2009**



Source: MiYRBS, 2003-2009

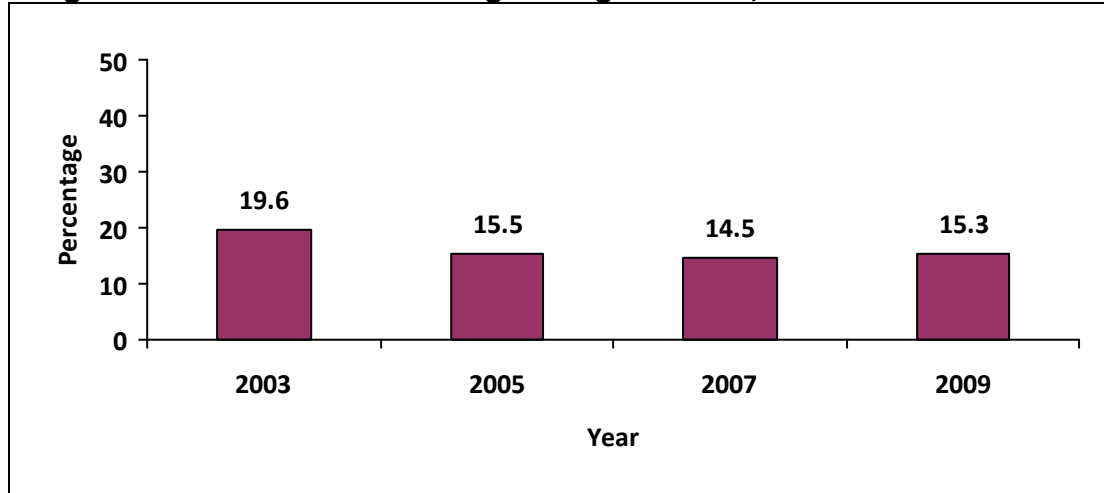
**Figure 11 – Prevalence of Students Who Made a Suicide Plan in the Past 12 Months and Alcohol Consumption, MiYRBS 2003-2009**



Source: MiYRBS, 2003-2009

The co-occurrence of reported drug use and depressive feelings among Michigan's youth declined during 2003 to 2007, however, the prevalence of reported depressive feelings and lifetime illicit drug use co-occurrence slightly increased from 14.5% in 2007 to 15.3% in 2009, as indicated in Figure 12.

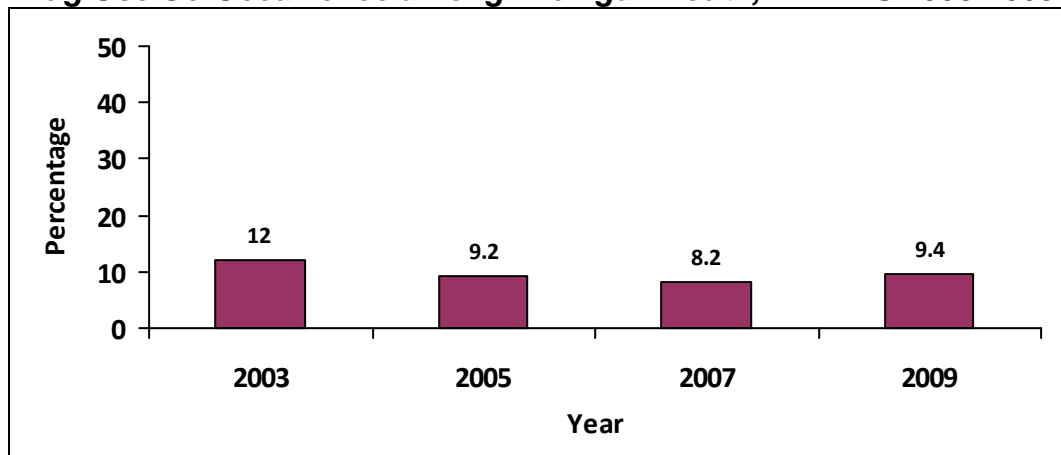
**Figure 12 – Prevalence of Past Year Depressive Feelings and Lifetime Illicit Drug Use Co-Occurrence among Michigan Youth, MiYRBS 2003-2009**



Source: MiYRBS, 2003-2009

On the other hand, the co-occurrence prevalence of reported depressive feelings and current illicit drug use declined from 12% in 2003 to 9.4% in 2009, as indicated in Figure 13. In 2009, lifetime and current illicit drug use prevalence estimates were significantly higher among Michigan youth reported depressive feelings than those who did not report depressive feelings.<sup>62</sup>

**Figure 13 – Prevalence of Past Year Depressive Feelings and Current Illicit Drug Use Co-Occurrence among Michigan Youth, MiYRBS 2003-2009**



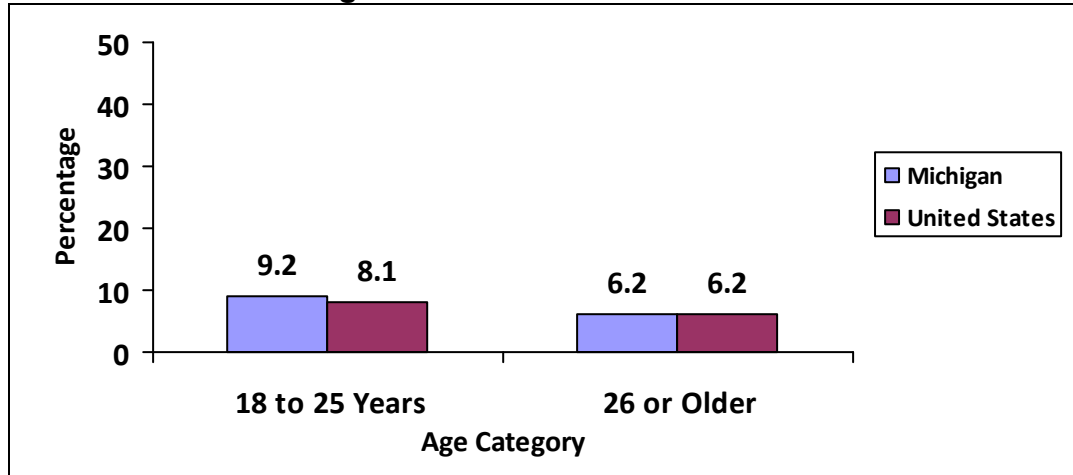
Source: MiYRBS, 2003-2009

<sup>62</sup> Michigan Department of Community Health, Bureau of Epidemiology. (2011). Evaluation of the youth risk behavior surveillance system for monitoring co-occurrence of drug use and depressive feelings among Michigan youth, 2003-2009. K. Hekman, C. Miller & L. Cameron (Eds.).

## Depressive Episode and Serious Mental Illness – General Adult

According to NSDUH, young adults between 18 to 25 years-of-age in Michigan showed higher rates of a major depressive episode in the past year, compared to adults 26 or older (9.2% for 18 to 25 years-of age versus 6.2% for 26 years-of age and older) in 2008 and 2009 estimates, as indicated in Figure 15.

**Figure 15 – Percentage of Persons Who Had a Major Depressive Episode in the Past Year in Michigan and the United States**

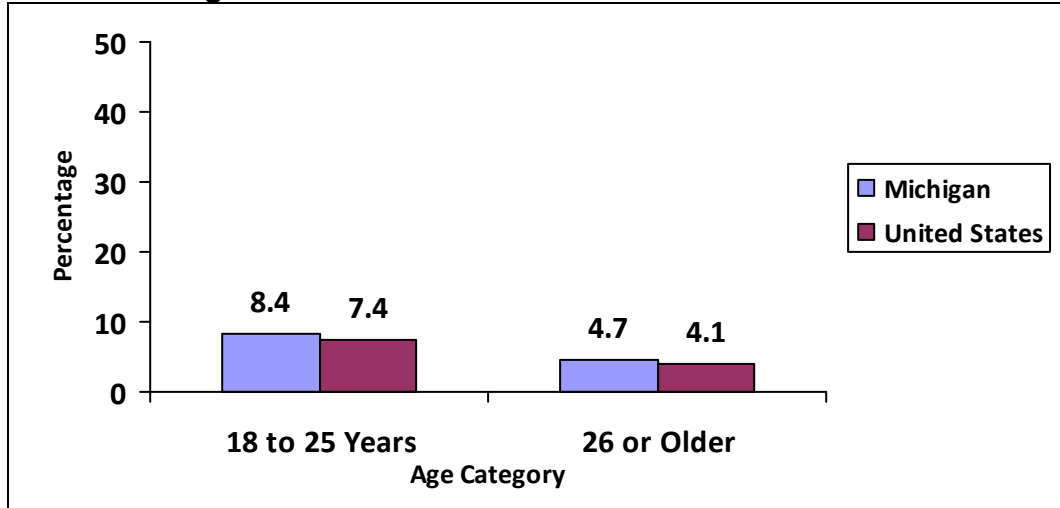


Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2008-2009

In the DSM-IV, a major depressive episode is defined as a period, of two weeks or longer, of either a depressed mood or loss of interest or pleasure, and at least four other symptoms that reflect a change in functioning, such as problems with sleep, eating, energy, concentration, and self-image. Young adults also had higher rates of serious mental illness compared to individuals 26 or older (8.4% for 18 to 25 years-of age versus 4.7% for 26 years-of age and older), as indicated in Figure 16. Serious mental illness is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a substance use disorder, that met the criteria found in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* and results in serious functional impairment.<sup>63</sup>

<sup>63</sup> SAMHSA (n.d.). State estimates from the 2008-2009 NSDUH. Retrieved from <http://www.oas.samhsa.gov/2k9State/Ch6.htm#6.1>

**Figure 16 – Percentage of Persons with Serious Mental Illness in the Past Year in Michigan and the United States**



Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2008-2009

## **REGIONAL AND LOCAL DATA**

The following table provides comparisons for the five SPE communities for the 24 ATOD and mental health indicators and 4 social and health indicators provided on pages 14-15. Only significant differences between the indicators for the regions and state are listed below, which are based on 95% confidence intervals.

<b>SPE Community</b>	<b>Region Indicator is Better than State Indicator</b>	<b>Region Indicator is Worse than State Indicator</b>
BABH/Riverhaven	Infant mortality Violent crime	Alcohol-impaired deaths and incapacitating injuries in a motor vehicle crash Perception of great risk of smoking one or more packs of cigarettes per day Suicide deaths
Kalamazoo	Violent crime	Alcohol-induced deaths Binge alcohol use among persons aged 12 to 20 (2002-2004 only) Lung cancer deaths Suicide deaths
Mid-South	Health insurance coverage Infant mortality Violent crime Incidence of lung cancer Drug-induced deaths	Alcohol-impaired deaths and incapacitating injuries in a motor vehicle crash Alcohol and binge alcohol use among persons aged 12 to 20 (2006-2008 only)
Pathways	Infant mortality Violent crime Drug-induced deaths	Alcohol-impaired deaths and incapacitating injuries in a motor vehicle crash Alcohol-induced deaths Alcohol (2002-2004 and 2006-2008) and binge alcohol use (2002-2008) among persons aged 12 to 20 Suicide deaths

SPE Community	Region Indicator is Better than State Indicator	Region Indicator is Worse than State Indicator
Western U. P.	Violent crime Drug-induced deaths Use of marijuana (2002-2004 only)	Alcohol-impaired deaths and incapacitating injuries in a motor vehicle crash Alcohol-induced deaths Alcohol and binge alcohol use among persons aged 12 to 20 (2006-2008 only) Suicide deaths

### **Data Limitations and Gaps**

As is the case in many states, information gaps exist in alcohol, tobacco, other drug (ATOD) and mental health data available within Michigan at the state and local level. These gaps in information may limit the ability to address a complete profiling of population needs, resources, and readiness. The SEOW has identified these information gaps, which are primarily the result of systems issues. Subsequently, these gaps may have impacted the formulation of statewide and local community indicators and need statements, and what has been included in this document.

When assessing data, the SEOW looked at measure, availability, analysis and frequency of data collection as a first tier consideration of whether to include specific data sets. This contributed to the level of confidence in what the data appeared to be showing. Other considerations related to data gaps and limitations included:

- Limited use of available tools in communities. One example of this was the limited number of school districts using the Michigan Profile for Healthy Youth (MiPHY). Through efforts of the SEOW, community coalitions, CAs, the Michigan Department of Education and other stakeholders, attention has been given to community readiness and responsiveness to conducting the MiPHY, and the number of school districts now participating has increased substantially.
- Limited data being collected on specific drugs (e.g. methamphetamine, prescription and over-the-counter drugs, etc.) or specific correlations (e.g. the link between child health and maternal alcohol consumption related to fetal alcohol spectrum disorders [FASD] or potential mental health indicators, the link between substance use/abuse and child abuse and neglect cases, etc.)
- The need for substance use disorder treatment data that is not limited to publicly funded programs (and a disclaimer to be added to current data on this limitation).
- Limitations in data sources available to assess mental health issues in communities, and the link to risk and protective factors, life stressors, and other potential indicators.
- Local level risk and protective factor data related to environment/access, school, community and individual domains, as well as specific populations (e.g., college students, adjudicated youth, the elderly, etc.).

The above examples of gaps in data are acknowledged, and are important for the reader to consider when reviewing this document. Although accomplishments have been achieved in developing and accessing more data in recent years, there is still work to be done. It is expected that as the SEOW work proceeds additional indicators will be added in future reports as data is identified and new linkages are made. The SEOW views this as one of its primary roles. The assistance and support of the Michigan Department of Community Health will be invaluable to this process.

## **Service Coordination and Integration**

*Required for inclusion per number 3 in the “Directions for completing the 5-year Strategic Plan.” The following section provides essential goals, objectives, and strategies for coordinating services with public and private service delivery systems, including primary health care.*

The Michigan Department of Community Health (MDCH) is responsible for health policy and management of the state’s publicly funded health service systems. The Michigan Public Health Code, Public Act 368 of 1978 (as amended), Sections 6201 and 6203, establishes the state's single state authority (SSA) and its duties. The BSAAS functions as the SSA within MDCH. Responsibilities include the administration of federal and state funding for substance abuse prevention, treatment, recovery, and gambling addiction. As explained on p.8, BSAAS allocates Substance Abuse Prevention and Treatment (SAPT) Block Grant (BG) funding through 16 coordinating agencies CAs, whose responsibilities include planning, administering, funding, and maintaining the provision of substance abuse treatment and prevention services for 83 counties in Michigan. All CAs have prevention coordinators (PCs), who receive input from and empower local communities in their response to substance abuse prevention needs.

In fiscal year 2010, \$40.4 million was invested at both the state and local level through multi-agency collaborative partnerships. These resources included federal and state funding administered by the Michigan Department of Education (MDE), Michigan State Police (MSP), Office of Highway Safety Planning (OHSP), Michigan Department of Human Services (DHS), and Prevention Network (PN).

In addition to the above multi-agency partnerships, other divisions and sections within MDCH, including Epidemiology, Injury and Violence Control, Adolescent Teen Health Centers, Maternal and Child Health, and the Drug Surveillance Team are strong partners with BSAAS in addressing mutual priorities. Examples of these collaborative efforts include development of underage drinking fact sheets, unintentional drug poisoning overdose death information and conference presentations with MDCH Epidemiology; participation on the Wayne County Drug Surveillance Team that included responding to fentanyl, other prescription drug, and synthetic cannabinoids overdose deaths in the City of Detroit; and collaboration with Maternal and Child Health in relationship to fetal alcohol spectrum disorder (FASD) planning and program implementation.



The Michigan Association of Substance Abuse Coordinating Agencies (MASACA), the Michigan Association of Local Public Health (MALPH), and the Michigan Primary Care Association (MPCA) are other statewide partner organizations and key stakeholders that are important partners in moving forward in service coordination. MASACA and MALPH are statewide organizations whose membership is comprised of the directors of the organizations they represent.

MPCA is the organization in Michigan which provides oversight to federally qualified health centers (FQHCs). These health centers are local, non-profit, community-owned providers of quality primary and preventive health care, and are located in medically underserved communities. Their clients include subpopulations comprised of racial, ethnic, and sexual/gender minority groups vulnerable to health disparities. In Michigan, 32 health centers serve nearly 600,000 patients at over 190 sites across the state and include community health centers, migrant health centers, health care for the homeless centers, and public housing health centers. Each health center's staffing model, facility, scope of service and approaches are tailored to meet the unique needs of its patients and community, and provide culturally appropriate health care that is close to where patients live, at times that are convenient, and in languages the person can understand.

BSAAS has recently established contact with Indian Health Services (IHS)-Central (Bemidji area) region. The Bemidji Area administers several service units which provide care through IHS practitioners. It also administers federally recognized tribal and urban programs which deliver services through health care providers directly hired by the tribes. Many tribal members are geographically isolated from the urban facilities and community health centers, and must rely on tribal and contract providers for their health care needs.

In addition, a strong partnership has been developed over the past two years with the Michigan Army National Guard. Members of this branch of the armed forces are members of both the SPE Policy Consortium and the SEOW, and were active participants as the state's Prescription and Over-the-Counter Drug Strategic Plan was created.

It should be evident from this description that Michigan has strong partnerships at the state level that will help facilitate coordination of services with public and private service delivery systems, including primary health care.

As Michigan moves forward over the next five years, its plan is to focus on system integration at the regional and local level. Emphasis on developing PPCs and successful ROSC will promote coordination of services.

- By the end of 2013 all CAs will have participated in the expansion of the SPE revised training on prevention prepared communities.

- In FY 2012, BSAAS issued a request for proposals (RFP) to CAs to implement projects that will initiate MI-SBIRT; modeled after the federally funded SBIRT programs. The purpose of this project is to implement MI-SBIRT services for individuals in primary care and/or community health settings, with substance misuse and substance use disorders (SUD). The projects are expected to:
  1. Expand/enhance the continuum of care for substance misuse services and promote behavioral health and primary health integration efforts.
  2. Reduce alcohol and drug consumption and their negative health impact.
  3. Increase abstinence and reduce costly health care utilization.
  4. Promote sustainability and improve treatment outcomes.

MI-SBIRT is designed to expand and enhance the continuum of care in primary care and a mix of other community health settings (e.g., health centers, university health centers, emergency departments, and office-based practices), and support the use of clinically appropriate services for persons at-risk for, or diagnosed with, a SUD. It also seeks to identify and sustain systems and policy changes to increase access to prevention and treatment services in generalist and specialist medical settings. The MI-SBIRT process supports the overall goal of the MDCH to integrate behavioral health and primary care in Michigan while promoting recovery, wellness, and a fulfilling quality of life.

Four CAs (none of these are one of the five SPE CAs) were recipients of these MI-SBIRT project grants. These projects are all in urban settings varying in size and scope. All will be carefully evaluated. It is expected that the SBIRT project grant program will be expanded beginning in 2014 incorporating what is being learned in the four pilot areas.

Michigan is in the process of completing a Training the Trainers for fifteen individuals representing the five SPE communities, the four MI-SBIRT project grants, recovery coaches/the recovery community, school health coordinators, Michigan's training cadre, and community coalitions. The individuals being trained represent every geographical area of the state. This training will be completed in August 2012 and should enable SBIRT training to be provided throughout the state in 2013.

- By 2014 all local communities will have access to webinars on accessing and using data. This is intended to strengthen the measurement of consequences, intervening variables, and the identification and measurement of outcomes.
- Over the next two years trainings on topics of mutual interest to prevention, treatment, mental health, and primary care will be offered widely throughout the state encouraging participants from different sectors to attend training events together (e.g., Trauma in early childhood, SBIRT, QPR-Question, Persuade, Refer Training for Suicide Prevention, and Peer Recovery Coach Training).
- Beginning in 2015 CA Action Plans will reflect new standards for reporting on collaborations and coordination of services. By this date, all local communities

will be collaborating with their county collaborative, local health department, and area primary care providers.

- By 2016, ninety percent of counties will have sufficient school district participation in utilizing the MiPHY (Michigan Profile of Healthy Youth) to be able to use the results to assess substance abuse prevalence and risk and protective factors at the local community level.
- Michigan has about 200 local substance abuse coalitions. By 2017, ninety percent of these groups will be part of PPCs actively supporting ROSC and coordinating prevention services with mental health and primary care providers.

## **SPE Policy Consortium Oversight**

*Required for inclusion per number 4 in the “Directions for completing the 5-year Strategic Plan.” The following section summarizes the key decision making processes and findings undertaken by the SPE Policy Consortium during the development of the Strategic Plan.*

The SPE Policy Consortium was created as a workgroup of Michigan’s TSC in December of 2011. Membership in this group includes representatives from the MASACA, MDE, OHSP, the Michigan Army National Guard, the five CA regional communities participating in the SPE grant project, local substance abuse coalitions, faith-based agencies, prevention providers. Additional participants are BSAAS administrators and the Wayne State University evaluator. The consortium has met monthly since its creation.

During the grant funded year its role has been oversight of all SPE activities. The group provided invaluable input into developing and implementing the four mini plans that comprised the capacity building and infrastructure enhancement plan. This was primarily defined by the goal of developing a workforce capable of implementing recovery oriented systems of care in the context of prevention prepared communities.

- The consortium provided guidance on the development of the workforce development scan, the prevention and treatment environmental scan, and the mental health environmental scan. They will also review the primary care scan scheduled to be administered before the end of the grant year.
- It will be the responsibility of the consortium to review, analyze, and incorporate the findings from the scans into on-going prevention enhancement planning.
- The consortium designed and field tested the PowerPoint program currently being used in the state to educate people widely on ROSC and PPCs. This program was included in the trainings of the five regional communities on ROSC and PPCs. See p. 12.

The PowerPoint will be revised prior to the end of the grant year under the direction of the consortium for use with trainings to expand SPE to the eleven other regional CAs.

- The consortium provided guidance on the development of the above mentioned training on ROSC and PPCs. This included reviewing the agenda and all of the materials used in the trainings.
- The consortium provided guidance on the development of this 5-year strategic plan deciding that expansion to the remaining eleven regional CAs should occur in year one of the plan and shall be done simultaneously with additional training being offered to the original five SPE communities.

The consortium will continue to function as a workgroup of the TSC providing guidance to the implementation of this 5-year strategic plan. It will work actively with TSC to recommend and implement policy changes across state-level partners and stakeholders responsible for SUD prevention and mental health promotion.

## Planning Guidelines

*Required for inclusion per number 5 in the “Directions for completing the 5-year Strategic Plan.” The following section describes in detail the processes, procedures and logic model criteria that are used at the state and community levels including by community coalitions for selecting and implementing evidence-based programs, policies, and practices. This logic model approach requires that communities identify the key risk and protective factors contributing to both substance abuse and its consequences.*

The Current “Action Plan Guidelines for Regional Substance Abuse Coordinating Agencies” was published in May 2011 and applies to Fiscal Years 2012-2014. This document applies to both prevention and treatment services administrations and providers.

Included in the action plan guidelines document under the section labeled “Michigan Department of Community Health Priorities” was the following statement,

### **SAMHSA Strategic Initiatives:**

*In the 2011 publication, [Leading Change: A Plan for SAMHSA’s Roles and Actions 2011-14](http://www.samhsa.gov) (<http://www.samhsa.gov>), SAMHSA lists prevention of substance abuse and mental illness as strategic initiative number one. The promotion of mental health and prevention of SUDs are essential to SAMHSA’s mission to reduce the severity of substance abuse, mental illness, and related conditions in communities across the country. Please note the following primary goals under this initiative.*

- 1.1 *Build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness.*

- 1.2 *Prevent or reduce consequences of underage drinking and adult problem drinking.*
- 1.3 *Prevent suicides and attempted suicides among populations at high risk, especially military families; LGBTQI youth; and American Indians and Alaskan Natives.*
- 1.4 *Reduce prescription drug misuse and abuse.*

The implementation of Prevention Prepared Communities (PPCs) will be the primary objective used to meet these goals. A PPC is a community equipped to use a comprehensive mix of data driven prevention strategies, interventions, and programs across multiple sectors to promote emotional health and reduce the likelihood of mental illness, substance abuse (including tobacco), and suicide among youth, tribal communities, and military families.

During the implementation of the Strategic Prevention Framework State Incentive Grant (SPF/SIG) and Drug Free Communities Support Grants, coordinating agencies (CAs) began the process of building and developing PPCs. Action plans should reflect evidence of the development of PPCs for the prevention of SUDs and mental illness, and the promotion of mental health in support of ROSC implementation. This initial planning marks an evolutionary braiding of inter-agency services that integrates the strengths and resources of each.”

Directions for community coalitions and CA prevention coordinators include a logic model approach that requires communities to identify “consequences”, “intervening variables” (defined as modifiable risk and protective factors), and “evidence-based services/interventions” specific for each targeted intervening variable.

The details of requirements in the “Action Plan Guidelines for Regional Substance Abuse Coordinating Agencies” are contained in Appendix A.

Since the publication of these guidelines CAs have developed and implemented action plans for one funding year, 2012. Five of these CA’s have been recipients of capacity and infrastructure development as part of the SPE grant. It is expected that their action plans for 2013 will begin to reflect this greater capacity for developing PPCs that are better positioned to accomplish the above goals.

Beginning with funding year 2013, Michigan will expand the capacity and infrastructure development experienced by the five SPE communities in the grant year to additional CA regions until all are fully able to work with local coalitions and other organizations to effectively establish PPCs throughout Michigan. This expanded capacity should become visible in CA action plans.

## Funding Formula Recommendations

*Required for inclusion per number 6 in the “Directions for completing the 5-year Strategic Plan.”*

As agreed upon by the SPE Policy Consortium, Michigan will use the SAMSHA federally approved funding formula for the allocation of state substance abuse prevention resources.

## Implementation Plan

*Required for inclusion per number 7 in the “Directions for completing the 5-year Strategic Plan.” The following implementation plan describes how key prevention strategies will be implemented, a timeline, those responsible for completion and expected completion dates.*

### **Prevent or Reduce Consequences of Underage and Adult Problem Drinking.**

Michigan has a long history of addressing underage drinking jointly supporting (with OHSP) the Michigan Coalition to Reduce Underage Drinking for nearly 15 years; creating a Childhood and Underage Drinking (CUAD) Workgroup as part of SPF/SIG; supporting over 200 local community coalitions through the regional CA system; and including it as a required priority in CA action plans for the last four years. It has demonstrated some success as reported earlier in this report.

In 2010 Michigan’s CUAD Workgroup completed the “Blueprint for the Delivery of Alcohol and Drug Prevention and Treatment” utilizing the six recommendations outlined in the “Blueprint for the States.”<sup>64</sup> Since that time Michigan has passed a keg tracking law and banned alcohol energy drinks. All areas of the state regularly do compliance checks for sales to minors.

BSAAS with assistance from the CUAD Workgroup recently developed a seven minute video titled “Do Your Part” highlighting individuals who share how they are doing their part to prevent underage drinking, and inviting other adults to “Do Your Part.” Five 30-second public service announcements targeting parents, coaches, retailers, educators, and law enforcement are available for free distribution as 30 second Public Service Announcements (PSAs) at [www.michigan.gov/doyourpart](http://www.michigan.gov/doyourpart). This video was produced through collaboration with the federal Center for Substance Abuse Prevention (CSAP) Underage Drinking Prevention Education Initiatives (UADPEI).

BSAAS has been collaborating with Dr. Stephen Guertin, MD, Medical Director, Sparrow Children's Center, Lansing, Michigan, around the issue of underage drinking and the link to fetal alcohol spectrum disorders (FASD).

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<sup>64</sup> Join Together (2006). *Blueprint for the States – Policies to Improve the Ways States Organize and Deliver Alcohol and Drug Prevention and Treatment*. Retrieved from [www.jointogether.org/aboutus/policy-panels/blueprint/order-form.html](http://www.jointogether.org/aboutus/policy-panels/blueprint/order-form.html).

The following goals have been established to guide Michigan in its efforts to further reduce underage and adult drinking.

1. Increase Multi-System Collaboration

The collaboration at the state level has been well documented here. At the local coalition level the collaboration is primarily with the twelve sectors called for in organizing drug free communities. In almost every case for the community to become an effective PPC these collaborations need to be expanded to include the multi-purpose collaboratives, health departments, hospitals and primary care service agencies, drug and sobriety courts, representatives from the juvenile justice system, community colleges and universities. BSAAS will expand the list that CAs are required to report to as part of the annual action plans.

2. Reduce adult abuse by engaging all segments of the community in establishing ROSC and increase the use of brief interventions.

- Over the next five years, BSAAS will increase the training for physicians in Screening, Brief Intervention, Referral, and Treatment (SBIRT). See p. 42 for details.
- In 2013 trainings on developing PPCs will be provided to all CA regions.

3. Engage parents in helping to reduce underage drinking.

During the next three years, through training and technical assistance and use of AP requirements, encourage local coalitions to

- offer evidence-based programs that will improve parenting skills such as *Strengthening Families* or *Active Parenting for Teens: Families in Action*.
- provide strong networks for parents of teens that reinforce no underage use messages.
- use the recently developed 30-second “Do Your Part” PSA to outreach to parents.

4. Over the next five years, all existing community coalitions will become PPCs and implement at least one environmental strategy.

- Leadership for strengthening community coalitions to become PPCs will be led by a revitalized CUAD or MCRUD. The *Communities that Care* model program will be widely distributed to inactive or weak coalitions.
- BSAAS will provide training on the evidenced based program *Community Trials*.

## **Prevent Suicides and Attempted Suicides Among High-Risk Populations**

As part of the SPE planning year BSAAS organized four Suicide Prevention Prepared Communities trainings (p. 14). Through the development and implementation of these trainings it became apparent that knowledge of suicide and suicide prevention varies greatly throughout the state. Participation in suicide prevention groups is more prevalent for mental health professionals than it is for substance abuse prevention professionals. In many communities there are groups working on suicide prevention who have no connection to the local substance abuse prevention coalition. This includes some suicide prevention groups organized by multi-purpose collaboratives.

Most groups are organized around preventing youth suicides often in response to a local youth who has committed suicide. Youth, however, are not the group most at risk for suicide with the exception of LGBTQI youth.

The group who is most at risk are white men between the ages of 35-54 and over 80 (with the latter being by far the most at risk).

Most groups are not systematically connecting to LGBTQI youth or military families. Only in a few instances is there good outreach to American Indians.

The state published a Suicide Prevention Plan for Michigan in 2005. It is scheduled to be reviewed and revised this year. Much of it is still relevant and provides good guidance to the state for what should be happening.

1. BSAAS has a good working relationship with the Injury and Violence Prevention Section of MDCH, participated in the writing of the 2005 Suicide Prevention Plan, and will participate in its review and revision.
2. Coordinating agencies will encourage local community coalitions to collaborate with any existing suicide prevention group in their local area. If there is not an already existing group the coalition should work with appropriate partners to establish one. Local community coalitions will be expected to report to this in their 2013 annual report.
3. By the end of 2015, every county/pairing of counties/or group of counties should have a functioning suicide prevention group that has a local plan to accomplish the following goals:
  - Reduce the incidence of suicide attempts and deaths across the lifespan
  - Develop broad based support for suicide prevention
  - Promote awareness and reduce the stigma



- Develop and implement community-based suicide prevention programs using the “Best Practices Registry” available from the Suicide Prevention Resource Center (SPRC)
- Promote Efforts to Reduce Access to Lethal Means and Methods of Suicide
- Improve the Recognition of and Response to High Risk Individuals Within Communities
- Improve use of existing surveillance systems

### **Reduce Prescription Drug Misuse and Abuse**

In February 2011, BSAAS established an Rx/OTC Drug Abuse Workgroup. The goal of the workgroup was to develop a strategic plan, including recommendations, for reducing Rx/OTC drug abuse. The strategic plan is to serve as a template for community-level agencies committed to developing local-level action plans. The workgroup membership included representatives of the state- and community-level agencies responsible for the provision of behavioral health care, substance use disorder prevention, education, law enforcement, and environmental quality.

In December 2011, the Rx/OTC Drug Abuse Workgroup distributed a *Community Scan Survey* to community coalitions, CAs, pharmacy retailers, local law enforcement, local public health departments, schools, and substance use disorder treatment and prevention providers. The purpose of the scan was to elicit feedback from community-level stakeholders on their level of capacity to conduct education, law enforcement and prescription drug storage or disposal programs in their respective communities.

Based on feedback from over 400 stakeholders at the 2009 Rx/OTC Drug Abuse Summit and the *Community Scan Survey*, the BSAAS Rx/OTC Drug Abuse Prevention Workgroup identified four goals to be addressed:

#### 1. Increase Multi-System Collaboration

BSAAS has collaborative relationships with the following key state-level stakeholders and partners, including the Michigan Department of Education, MSP, Michigan Department of Environmental Quality, Michigan National Guard, Michigan Pharmacy Association, the Michigan Primary Care Association, and the Michigan Association of Substance Abuse Coordinating Agencies.

Over the next two years BSAAS will increase collaboration with the following agencies: Michigan Department of Human Services, Michigan Department of Licensing and Regulation, Michigan Dental Association, Michigan State Medical Society, Michigan Health and Hospital Association, Michigan Broadcasters Association, and the DEA. These agencies include diverse expertise and resources that are essential in combating Rx/OTC drug abuse.

In September of 2012, primary care physicians, dentists, and pharmacists in the five SPE communities will be surveyed to determine their knowledge and attitudes about prescription drug abuse and their willingness to collaborate at the local level to address this issue.

By the third quarter of 2014, BSAAS will work with the Pharmaceutical Associations to develop recommendations for the dispensing of prescription opioids.

2. By the end of 2013, BSAAS will develop statewide media messages to be delivered to the general public, parents, and caregivers. The primary agents for delivering the media messages would be law enforcement, CAs, coalitions, educational institutions, pharmacies, and primary health care agencies.

Media messages and campaigns should be developed considering the following guidance:

- Consider existing data when developing a new theme, materials, or suggesting existing messages and materials. Does the message speak to the data?
- Pinpoint the desired goal of the message and materials. What is desired to be achieved? What is the desired behavior change for the target audience?
- Consider the audience. Who is the message targeting? Is it culturally sensitive and relevant?
- Determine the cost and benefit for a target audience behavior modification. What is the motivation for the target audience to change their behavior?
- Identify existing messages and materials before developing new ones. Are there existing campaign materials and messaging that meet identified needs?
- Use a multi-pronged strategic approach. How will the campaign educate the public about the effects and prevalence, proper disposal, and where to take unwanted or unused medications?
- Remember positive messages work better than negative messages and scare tactics.
- Consider using focus groups to help tailor messaging for specific audiences.
- Determine if the overall message should be a statewide theme or community specific. What works best?
- Simple is better. How can it be made easy for the audience to adopt the desired behavioral change?

Other means of broadening statewide media messages would include the development and dissemination of toolkits distributed statewide. The toolkits would include: educational materials that stress the dangers of using Rx/OTC drugs, a listing of existing resources that will inform the public and patients on safe usage, educational materials on proper storage and disposal of Rx drugs, promotion of existing disposal programs, and educational materials for law enforcement to aid them in identifying and stopping illegal and/or questionable

prescribing practices. Resource materials and toolkit examples can be found at the following websites:

SPONSOR	WEBSITE
Office of National Drug Control Policy	<a href="http://www.whitehouse.gov/ondcp">www.whitehouse.gov/ondcp</a>
National Institute on Drug Abuse	<a href="http://www.drugabuse.gov/">www.drugabuse.gov/</a>
U. S. Drug Enforcement Administration	<a href="http://www.justthinktwice.com/">www.justthinktwice.com/</a>
Department of Community Health	<a href="http://www.michigan.gov/mdch-bsaas">www.michigan.gov/mdch-bsaas</a> , see Prevention, RxOTC Drug Abuse
The Mayo Clinic	<a href="http://www.mayoclinic.com/health/prescription-drug-abuse/DS01079/DSECTION=prevention">www.mayoclinic.com/health/prescription-drug-abuse/DS01079/DSECTION=prevention</a>

### 3. Broaden Rx/OTC Drug Abuse Education and Use of Brief Screenings

According to the MAPS, the number of legitimate prescriptions written for pain relievers was at 6.3 million in 2003 and 8.9 million in 2010. However, between 2003 and 2010, the number of prescriptions filled for Suboxone, a partial opioid agonist used in treatment addiction, increased rapidly (327 prescriptions in 2003 and 285,059 in 2010). Prescriptions for hydrocodone (e.g., Vicodin) also accounted for 31.2% of all controlled substance prescriptions in 2010.

Over the next five years, BSAAS will increase the training for physicians in Screening, Brief Intervention, Referral, and Treatment (SBIRT). See p. 42 for details.

There was a 369% increase (1,189 to 5,581), from 2000 to 2011 in the number of persons admitted to Michigan’s publicly-funded treatment system for addiction to prescription drugs. The primary substance of abuse was opioid based synthetics. This massive increase in the number of persons needing treatment due to their addiction to prescription drugs has placed a considerable strain on the public service delivery system. Since the prescriptions for opioids to treat pain were written in primary care settings, physicians and other healthcare providers are in a position to provide appropriate SBIRT for the patient who is at-risk for developing a dependence on prescribed medications.

Support law enforcement alcohol and drug screening initiatives on the part of the MSP and OHSP to provide the Advanced Roadside Impaired Driving Enforcement (ARIDE) Program and DRE training. There are now 19 DREs in Michigan, with 15 more planned to be trained during FY 2012. In addition, there are currently 500 law enforcement officers around the state who have completed the ARIDE Standardized Field Sobriety Test (SFST) training, with one class being offered each month to train an additional twenty officers each time. OHSP has recommended SFST training to be part of basic training for all officers.

CAs, coalitions, schools, and the military must continue to provide prescription drug education programming that targets grades four through twelve. Evidence-

based programs such as the Michigan Model will prove invaluable for expanding education to this age group.

4. By 2014, increase access to and use of the Michigan Automated Prescription System (MAPS)

BSAAS will work with the Department of Licensing and Regulatory Affairs (LARA) who should update the MAPS to increase usage by the general public, including users of pain medications, pharmacists, law enforcement, Behavioral Health and Developmental Disabilities Administration (BHDDA), and the BSAAS State Epidemiological Outcomes Workgroup (SEOW).

It is also recommended that LARA expand MAPS to include a report that identifies current information, and a template for requesting the data and an analysis of that data.

Additionally, LARA should convene a training conference on the use of MAPS by the end of fiscal year 2013.

At the start of FY 2010, all 16 CAs were required to address Rx/OTC drug abuse in their Action Plan (AP) submissions for prevention. Utilizing a Strategic Planning Framework, each CA developed and implemented a plan to prioritize needs within their region.

These APs will be evaluated and strengthened each year following the four recommendations contained in this plan.

## Evaluation Plan

*Required for inclusion per number 8 in the "Directions for completing the 5-year Strategic Plan." The following section provides an evaluation plan that identifies baseline and outcomes data as well as processes and procedures for conducting an evaluation at the state and community level. The evaluation plan describes how needs assessment and evaluation data will be used for ongoing adjustments.*

There are two types of information that will be used to evaluate the progress of this implementation plan:

1. Reports about activities spelled out in this report that when accomplished should create the capacity to actually reduce underage and adult problem drinking, suicide, and prescription drug abuse.

These activities at a broad level are building a ROSC and creating a PPC. They fit under goals like "Increase multi-level collaboration." Because Michigan's implementation is happening at a regional and local level more than it is at the state level, tracking all these hundreds of actions becomes very important.

Measuring not only the number of these activities but also the quality helps to explain progress or lack thereof in meeting the outcome goals.

The multi-year action plans and progress reports completed locally and then by the CAs are key to providing the tools for assessment and process evaluation.

2. The other type of information is data that measures consequences (the effects of use, misuse and abuse of a substance on quality-of-life: health, mortality, crime, dependence, accidents, and potential life lost); consumption patterns (prevalence, use, patterns); and intervening variables (positive and negative contributing factors, such as: availability, enforcement and adjudication, promotion, social norms, laws and policies, risk/protective factors, and other mediating resources). Michigan has identified 24 of these measures, not all of which are relevant to this plan.

For the purposes of this document emphasis will be placed on the need indicators that were used to identify the five SPE communities as high-need and others that will be useful at the regional level to measure successful expansion of strategic prevention enhancement: level of past 30-day use of alcohol and binge drinking among youth 12-20 years-of-age; alcohol involved deaths and serious injuries; non-medical use of pain relievers; past year psychological distress; past year major depressive episode; and age-adjusted suicide rates.

While Michigan’s epidemiological report is updated every year, not all data is reported out every year and some indicators are best reported for a range of years rather than just a single year at a time. Within the context of these limitations, the following data will be reviewed every year of the plan at the state and regional level:

Indicator	Baseline	Milestone	2017 goals
Past 30-day use of alcohol among youth 9 <sup>th</sup> -12 <sup>th</sup> grades (M-YRBS)	(2011) 30.5%	(2013) 29.0%	(2017) 26.0%
Binge drinking in past month among youth 9 <sup>th</sup> -12 <sup>th</sup> grades (M-YRBS)	(2011) 17.8%	(2013) 17.0%	(2017) 14.5%
Percent of individuals over 18 who are heavy drinkers (NSDUH)	(2008-10) 5.4%	(2012-14) 5.3%	(2014-16) 5.2%
Alcohol involved deaths when at least one driver was 16-20 years-of-age and had been drinking	(Average of 2004-10) 29	(Avg. of 2009-14) 28.5	(Avg. of 2011-17) 28
Alcohol involved serious injuries when at least one driver was 16-20 years-of-age and had been drinking	(Average of 2004-10) 144	(Avg. of 2009-14) 143	(Avg. of 2011-17) 142
Non-medical use of pain relievers by youth aged 12 to 17 (NSDUH)	(2008-09) 7.4%	(2012-14) 7.3%	(2014-16) 7.1%
Non-medical use of pain relievers by youth aged 18 to 25 (NSDUH)	(2008-09) 13.9%	(2012-14) 13.4%	(2014-16) 12.7%
Past year major depressive episode experienced by youth in 9 <sup>th</sup> -12 <sup>th</sup> grades in 2009 (M-YRBS)	(2011) 27.4%	(2013) 29.0*	(2017) 26.4%
Age-adjusted suicide rates 2009	11.3 per 100,000	11.1 per 100,000**	10.8 per 100,000

\*This measure is expected to go up before it goes down based on community awareness and capacity to respond.

\*\*2014

Individual communities and regions may select additional indicators to monitor on an annual basis, especially those that measure intervening factors that they are targeting as part of a prevention strategy. This would be particularly true for a community implementing the Community Trials model program.

## **Action/Sustainability Plan**

*Required for inclusion per number 9 in the “Directions for completing the 5-year Strategic Plan.” The following section provides an action/sustainability plan that describes the primary strategies for sustaining the state infrastructure and outcomes, and for implementing the plans developed as a result of this grant.*

In developing this plan, BSAAS is utilizing the infrastructure it has in place including its collaborative partners, workgroups like the SEOW and the TSC-Prevention Policy Consortium, and the 16 regional coordinating agencies, so it is highly likely that the systems and expectations already in place will be able to implement and sustain this plan.

The targeted outcomes have been consistently identified and are already incorporated in the Guidelines for Action Plans 2012-2014. Community groups and CAs are well trained in the SPF planning process so they understand the development of data driven needs assessment and data driven goals.

The evidenced based strategies identified here are ones with which many in the prevention field are already familiar and already being implemented in some locations in the state.

The challenges in this plan rest in the variety and quantity of relationships that are required to implement this plan but even this challenge has been part of developing ROSC which has been Michigan’s primary focus for the last two years. The emphasis on creating PPCs helps make it more concrete at the local level.

Specific actions that will be taken to insure sustainability are:

1. Maintenance of the SPE Policy Consortium which is a sub-committee of the Transformational Steering Committee. This group will continue to supply oversight to implementation of the plan.
2. Creation of the web-based data repository for use in local and regional planning.
3. Maintenance of the SEOW and the regional epidemiology workgroups.
4. A review will be done of the Action Plan Guidelines to insure that all aspects of the plan are incorporated.

5. A tool-kit will be developed that contains resources for developing a PPC. The extension of SPE to the remaining CA regional communities may be one of the one important actions to sustain this plan because it will have everyone operating from a similar understanding.
6. Maintenance of the state training cadre providing training to the prevention workforce (especially new members) and full utilization of federal training resources including advocating use of new on-line training tools.
7. Secure federal discretionary grants.

## Directions for Prevention Coordinators

Prevention programming is intended to reduce the consequences of SUDs in communities by preventing or delaying the onset of use, and reducing the progression of SUDs in individuals. Prevention is an ordered set of steps along a continuum that promotes individual, family and community health; prevents mental and behavioral disorders; supports resilience and recovery; and reinforces treatment principles to prevent relapse. Prevention services are most effective when the services are conducted within a PPC.

ROSC Implementation Plan goal four: ‘To enhance our collective ability to support the health, wellness, and resilience of all individuals by developing prevention prepared communities.’ That goal underscores the value of PPCs as the cornerstones of a ROSC. It is evident that PPCs are designed to promote behavioral health and wellness, provide the multi-sector infrastructure necessary, and are critical to the successful implementation of a ROSC. This is consistent with SAMHSA’s primary strategic initiative of preventing substance abuse and mental illness.

In concert with implementation of the ROSC, SAMHSA’s strategic initiative related to PPCs, and MDCH priorities related to obesity and infant mortality, CAs are expected to sustain a SPF process and a service delivery system that will show evidence of working toward community-level change. A role for prevention services directed toward individual behavior change remains for specific high-risk selective and indicated populations.

CAs are expected to employ the six SAMHSA Center for Substance Abuse Prevention (CSAP) strategies to engage individuals and the community to effect population-based change. It is critical to note that, especially in the case of information dissemination and alternatives, multi-component community-based strategies are more effective than single-component strategies. The six strategies are as follows:

- Information dissemination.
- Education alternatives.
- Problem identification and referral.
- Community-based process.
- Environmental.
- Alternatives

This multi-component and strategic approach should cover all age groups including support for children, senior citizens, all socio-economic classes, diverse cultures, minority and under-served populations, service men and women, gender-specific and targeted high-risk groups.

The ultimate goal of implementing the six strategies would be the development of PPCs with community norms that reduce alcohol and other drug consumption, or modify the conditions under which they are consumed. This will, in turn, reduce SUDs.



## Prevention Services Planning Chart for Prevention Prepared Communities:

All CAs must complete a 'Prevention Services Planning Chart for Prevention Prepared Communities' for each of the prevention priorities. Each of these priorities will require a separate planning chart.

The 'Prevention Services Planning Chart' is designed to elicit a logical sequence of information from consequences, through planned outcomes, provider involvement, and training needs. Each chart is expected to represent summary information, and should be limited to two legal-sized pages, per prevention priority.

The preparation of the 'Prevention Services Planning Chart' must show evidence of a data-guided planning process indicative of the collection and analysis of baseline data to validate the selection of primary problems (consequences) for each priority. Evidence of input from a regional community epidemiological workgroup, in concert with a community collaborative (e.g. Drug Free Communities, Community Strategic Prevention Planning Collaborative, etc.), is required. The workgroup and community collaborative must be representative of diverse community sectors.

### The content on this chart is described in the instructions that follow:

#### PREVENTION SERVICES PLANNING CHART FOR PREVENTION PREPARED COMMUNITIES

CA Name: \_\_\_\_\_ Plan Fiscal Year: \_\_\_\_\_ Contact Person's Name and Email: \_\_\_\_\_

Prevention Priority: \_\_\_\_\_

NOTE: This section looks at how the CA is working toward community involvement.

1. Who are the CA's partners in this prevention priority, and what specific role(s) do the partners play?

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2. What partners are missing, and what is the CA's strategy to get additional partners involved?

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Consequence(s)/ (Primary Problem)	Consequence Support Data (Include data sources)	Associated Intervening Variable(s) to be Targeted	Primary Federal Strategies (specific and Evidence-based Services/Interventions (specific) for Each Strategy	Geographic Area Served	Population Type/ Service Population (Specify based on CSAP Priority Populations)	Activity Related - Immediate Outcomes	Performance Indicator - Intended Long-term Outcome, including link to National Outcome Measures (NOMS)	Provider Agency or Coalition Responsible for Activity	Training and TA needs of the CA to implement this plan
1.									
2.									
3.									
4.									

## **Prevention Services Planning Chart for Prevention Prepared Communities**

### **INSTRUCTIONS**

The Prevention Services Planning Chart for PPCs, is designed to elicit a logical sequence of information from associated consequences, through planned outcomes, provider involvement, and identifying training needs for the priorities.

The chart presents information in a horizontal manner. [COLUMN HEADINGS ARE BOLDED IN THESE INSTRUCTIONS.] The **consequence** is identified in the first column (one per box), with all associated information following in the same row. When a box/column is reached in which multiple items may be listed, i.e., **Associated Intervening Variables to be Targeted**, and the information in the following five boxes/columns is directly related to each item in the previous box/column, please align the associated information adjacent to one another and assign a common number to both items of information. Please provide all necessary information in a concise manner.

#### **CA (Coordinating Agency) name and plan fiscal year:**

Enter the name of the coordinating agency who is submitting the prevention plan, and indicate which fiscal year the plan is intended.

#### **Contact person's name and email:**

Enter the name and email address of the person who is responsible for the plan and responding to any questions or clarification that may arise.

#### **Prevention priority:**

Indicate the overall Prevention Priority:

- Each CA must complete separate planning charts for the following priorities that have been identified as statewide priorities:
  - 1) Childhood and Underage Drinking
  - 2) Prescription and Over-the-Counter Drug Abuse/Misuse
- A third priority may be identified at the CAs discretion, however this priority must be based on data and may be related to either an emerging trend or known problem already identified in the region.

#### **Who are the CA's partners in this prevention priority, and what specific role(s) do the partners play?**

In response to this question, please identify CA partners in addressing this prevention priority. Also indicate what role the partners play in their collaboration with the CA. When completing this section, note that BSAAS is interested in how the CA is involving the community in the prevention planning process for each priority.

**What partners are missing, and what is the CA’s strategy to get additional partners involved?**

In response to this question, please identify community partners, currently absent, who would strengthen the CA region’s response to addressing the priority problem and note strategies that have been identified to secure their involvement in the future.

**Consequence(s)/ primary problem:**

Identify the specific consequence(s)/primary problem in the CA region that relates to the overarching prevention priority. Consequences and primary problems are identified through the analysis of data, and are defined as social, economic and health problems associated with the use of alcohol, tobacco and other drugs (ATOD).

Note: Numerous consequences can be identified within a single prevention priority; however, it is not feasible or effective to address all or many consequences with limited resources. CAs are encouraged to think beyond “consumption only” problems, and look more closely at the negative impact that occurs as a result of consumption. Again, through the use of data, political will and changeability, prioritization of consequences must occur.

Example: Related to prevention priority “Reduce Childhood and Underage Drinking” the consequence/primary problem may be “Alcohol-related traffic crash deaths among young adults between the ages of 16 and 21 in the region have increased.”

Each CA may identify and select up to five consequences per identified prevention priority.

**Consequence support data:**

Enter local, regional or state data that has been identified, compiled and used to support the consequence selection for the regional prevention plan. This answers the question “How does the CA know this is a problem in the region?”

Example: Related to consequence “Alcohol-related traffic crash deaths” the support data may be “Between 2005 and 2010 there were 268 alcohol-related traffic crash deaths in the CA region.” Also site the specific data source, including author. For this example, the data source may be 2010 Michigan Traffic Facts for Counties/Communities, Office of Highway Safety Planning.

**Associated intervening variables (modifiable risk and protective factors) to be targeted:**

Enter modifiable risks or protective factors associated with a consequence. These factors contribute to the conditions, favorable (risk) or unfavorable (protective), to the existence of the consequence. They are factors that “cause” substance-related

consequences and consumption in communities. There can be numerous variables and factors linked to a consequence. This is where individualization of your region (or to specific communities within your region) should be evident. Prioritization and selection of the variables and/or factors must occur based on the interventions you chose to target.

Identify and list, in order of priority, the variables and/or factors you have selected to target, in relationship to your identified consequence.

Example: Related to consequence “Alcohol-related traffic crash deaths” the intervening variables may be: “Availability of substances; Promotion of substances; Social norms regarding use; and Enforcement of existing laws.”

**Primary federal strategies (specific) and evidence-based services/ interventions (specific) for each strategy:**

List the CSAP federal strategy and the evidence-based services/interventions that have been selected under each strategy that: 1) will impact the prioritized variable/factor and in turn the prioritized consequence; and 2) are appropriate to the target populations. Note: evidence-based services/interventions selected must be consistent with the implementation of the ROSC. For more information on the evidence-based services/intervention efforts linked to ROSC refer to Michigan’s ROSC implementation plan goals (specifically goals III, IV, V, and IX) in Appendix C.

**At least 90% of services/interventions being provided must be evidenced-based.**

If “Information Dissemination” strategies are used, they must be part of a multi-faceted regional prevention strategy/initiative. Independent or stand-alone information dissemination services are disallowed. In addition, if “Alternative” strategies are used in the region, the service must reflect evidenced-based approaches and best practices, such as multi-generational and adult-to-youth mentoring.

Example: Related to federal strategy “Environmental” the intervention may be “Increase enforcement of existing alcohol sales laws.”

Following are the Center for Substance Abuse Prevention’s (CSAP) six prevention strategies. All prevention services can be categorized under one of these six federal prevention strategies, and the link to the corresponding intervention for each must be made. The federal prevention strategies that should have priority in each region are “Community-Based Process” and “Environmental,” and to a lesser extent “Education” and “Problem Identification and Referral.”

- 1 Information Dissemination: This strategy provides information about the nature and extent of drug use, abuse, and addiction and its effects on individuals, families and communities. It also provides information on available prevention programs and services. The dissemination of information is characterized by one-way

communication from the source to the audience, with limited contact between the two.

- 2 Education: This strategy involves two-way communication, and is distinguished from merely disseminating information by the fact that it is based on an interaction between the educator and the participants. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, and critical analysis (e.g., of media messages).
- 3 Alternatives: This strategy provides for the participation of target populations in activities that exclude drug use. The assumption is that because constructive and healthy activities offset the attraction to drugs, or otherwise meet the needs usually filled by drugs, then the population would avoid using drugs.
- 4 Problem Identification and Referral: This strategy aims to identify those who have indulged in the illegal use of drugs in order to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if an individual is in need of treatment.
- 5 Community-Based Process: This strategy aims to enhance the ability of the community to more effectively provide prevention and treatment services for substance use disorders. Activities in this strategy include organizing, planning, enhancing the efficiency and effectiveness of service implementation, building coalitions, and networking.
- 6 Environmental: This strategy seeks to establish or change community standards, codes and attitudes, thereby influencing the incidence and prevalence of drug abuse in the general population.

**Geographic Area Served:**

If a portion of the CA region has been identified as a prime area related to a consequence, and will subsequently be targeted for prevention services, please identify that portion of your catchment area as a target. Alternatively, if services will be provided region-wide, please indicate that intent.

Examples: East side of the City of Detroit; City of Williamston, Ingham County; Zip Codes 11111, 99999, 55555, and 33333.

**Population Type/Service Population:**

List by Institute of Medicine (IOM) category the service population(s) for the identified intervention(s) as appropriately selected to impact the consequence (hence the prioritized variable/factor). All selected interventions and related target populations are associated to one of these three categories.

Example: Related to population type “Selective” the service population may be: “Children in homes where substance use is widely accepted.”

The IOM prevention intervention categories are Universal, Selective, and Indicated, and are defined as follows:

Universal: The general public or the whole population group that has not been identified on the basis of individual risk; also the population of a geographic area as a whole.

Selective: Individuals or a subgroup of the population whose risk of developing a substance use disorder is significantly higher than average.

Indicated: Activities targeted to individuals who are identified as being in high-risk environments, having minimal but detectible signs or symptoms foreshadowing a substance use disorder, or having biological markers indicating a predisposition for disorder but not yet meeting diagnostic levels.

### **Activity Related – Immediate Outcomes:**

Cite the intended immediate outcome(s) for each planned intervention. Immediate outcomes are directly related to the service and are immediate or short-term changes achieved by the intervention. An immediate outcome is the initial change in a sequence of changes expected to occur as a result of program implementation. The more immediate the outcome, the more influence the program has over its achievement.

There is no right number of outcomes. The number of outcomes selected depends upon the nature and purpose of the program, resources, size and number of constituencies represented.

Example: Related to intervention “Parent education/training programs” the immediate outcome may be: “Changes in participant’s family management skills.”

### **Performance indicator – intended long-term outcome, including link to NOMS:**

Cite the performance indicator(s) – long-term outcomes anticipated to be impacted and/or achieved through the implementation of interventions. Associate the indicator to the relevant intervention(s).

Over time, the change(s) that result from the program or intervention are known as long-term outcomes. A confluence of multi-factored prevention initiatives can, therefore, merge to create impact toward a final outcome. Long-term outcomes can be influenced by a variety of factors in the socio-cultural, political and economic environment. It is expected that multiple intervening variables would need to be targeted in order to lead to an impact on the long-term outcome. CAs are asked to provide direct linkage of all long-term outcomes for the region to a specific NOM, as appropriate for each indicator.

Example: Related to intervention “Parent education/training programs” the long-term outcome may be: “Decreased adolescent alcohol use.”

**Provider agency or coalition responsible for activity:**

Cite the provider agency responsible for implementing the identified activity or intervention. A provider agency is a subcontracted entity having a written agreement to provide specific activities. A coalition is a representative group of a given community consisting of members, stakeholders, or constituents of that community. This group collaborates and coalesces around common concerns, issues and actions. If a coalition is coordinating, funding or actively involved with the planned activity, they may be cited as the provider.

The aforementioned entities providing programs to impact specific consequences/intervening variables are those that would be cited here, linked to the specific strategy, intervention and population type.

Examples: “Joe’s Agency,” “Organization for Annie,” and “Eastside Coalition.”

**Training and technical assistance (TA) needs of the CA to implement this plan:**

If the CA has any training or technical assistance needs to help in the implementation of the plan in their region, identify those needs in the last column. These would be trainings provided by BSAAS, by others through the BSAAS training project, or by the CSAP-identified Central Regional Expert Team.

Plan Review Criteria: The ‘Prevention Services Planning Chart’ will be reviewed based on the following criteria:

- Demonstrating use of a consequence-based, data-guided process for the multiple year planning format, including evidence of input from community epidemiological workgroups in concert with a community collaborative (e.g. Drug Free Communities, Community Strategic Prevention Planning Collaborative, etc.), representative of diverse community sectors.
- Identifying priority problems and target populations based on local epidemiological evidence.
- Implementing evidence-based interventions for priorities consistent with the implementation of the ROSC, MDCH priorities and the SAMHSA Strategic Initiative.
- Supporting development of PPCs by strengthening the regional prevention services system, based on the implementation of the ROSC.”