MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
BEHAVIOR HEALTH AND DEVELOPMENTAL DISABILITIES ADMININSTRATION

BUREAU OF SUBSTANCE ABUSE AND ADDICTION SERVICES

Annual Report for Fiscal Year 2010

Required by Public Act 368 of 1978, Section 6203(f)

The Michigan Department of Community Health, Bureau of Substance Abuse and Addiction Services (BSAAS), is the lead agency for the administration of federal and state funds for substance use disorder treatment, prevention, and recovery services. BSAAS also administers Michigan's publicly-funded problem gambling services.

The following report was prepared to give the reader information about BSAAS administered services, the people we help, and the effectiveness of our programs in serving the people of Michigan.

Hyperlinks [in blue] are found throughout this document, click on these to view related information and reports on our website.

BSAAS VISION

A future for the citizens of the state of Michigan in which individuals and families live in healthy and safe communities that promote wellness, recovery and a fulfilling quality of life.

BSAAS MISSION

Promote wellness, strengthen communities, and facilitate recovery.

Visit our website, www.michigan.gov/mdch-bsaas, for more information about our office.

For additional copies of this report or for a copy of our *Legislative Report*, visit our website and along the left choose "Reports and Statistics," then under "Data" choose "S.A. Annual & Legislative Reports."

FY 2010 Summary of Admissions

Treatment Admissions/Transfers:
63,622 Persons

Gender:

Male	61.6 %
Female	38.4 %

Age:

12 - 17	4.9 %
18 - 35	52.5 %
36 - 54	37.25 %
55 and older	5.5 %

(Median age is 32)

Race/Ethnicity:

White	68.6 %
African Amer./Black	25.7 %
Hispanic	2.8 %
Native American	1.3 %
Multiracial/Other	1.6 %

Primary Substance Reported at Admission:

Alcohol	40.1 %
Heroin	17.7 %
Marijuana/Hashish	17.1 %
Other Opiates *	13.0 %
Cocaine/Crack	9.4 %
Methamphetamine	0.9 %
All Others	1.8 %

** includes prescription opiates*

[Additional Demographic Info]
[Primary Substance by County]

A Recovery Oriented System of Care

Historically, the service delivery system has addressed the treatment of substance use disorders with an acute illness perspective. Once the treatment phase ended, the individual was discharged with the advice to attend 12-step meetings to replace the support no longer available from the treatment program. Evidence and results revealed that the acute treatment model presented challenges in keeping the individual engaged in treatment and sustaining their recovery. It is now known that utilizing an acute treatment model for a chronic illness, such as alcoholism and addiction, does not provide an individual with the assistance needed to work toward wellness and sustained recovery. It was also evident that the acute treatment model presented challenges in engaging and retaining clients in treatment programs. There was not adequate community support to allow individuals to gain stability in their recovery process, nor help to build the capacity for long-term social functioning or the skills to attain a better way of life. This resulted in high rates of relapse.

A recovery oriented system of care (ROSC) is a long-term sustainable process that helps individuals, families and communities recover from addiction, sustain improved health and achieve an improved quality of life. This is accomplished through establishing continuity of care that includes prevention, treatment, recovery supports, and the development of necessary life skills, which lead to the capacity to shape a full and meaningful life in the community. A ROSC promotes and supports recovery and resiliency by providing services that focus on proven methods, such as:

Michigan's recovery oriented system of care supports an individual's journey toward recovery and wellness by creating and sustaining networks of formal and informal services and supports. The opportunities established through collaboration, partnership and a broad array of services promote life-enhancing recovery and wellness for individuals, families and communities.

Definition Adopted by the ROSC Transformation Steering Committee, September 30, 2010

- Place a greater emphasis on continuity of care: effective prevention, assertive outreach and engagement, quality treatment, and ongoing monitoring and support.
- Establish continuum of care in which services are holistic and integrated, culturally responsive, and include systems anchored in the community.
- Expand the availability of non-clinical services such as peer supports, prevention, and faith-based initiatives, etc.
- Help to prevent the onset of substance use disorders.
- Employ a public health approach by helping to create healthy communities.
- Reach out more assertively to families and communities impacted by substance use disorders.
- Provide more assertive post-treatment monitoring and support.
- Focus on a partnership consultation approach rather than an expert patient model.
- Value the lives and experiences of people in recovery and use them to help others on the journey.

The National Conference of State Legislatures indicates that states well into the ROSC transformation process report an adjustment in the blended provision of clinical and recovery support services resulting in 87% abstinence from alcohol and other drugs at discharge, 40% increase in employment, and a decrease in arrests and jail time by over 8,000 days (www.ncls.org). Through the implementation of a ROSC, the quality of life is significantly improved for individuals, families and communities.

Through the implementation of a ROSC, individuals will be provided with the services and supports they need to achieve and sustain recovery and create an improved quality of life. Additional benefits associated with a ROSC include better use of resources, and shifts in spending patterns that lead to savings in high-cost service areas. These savings will be applied to lower-cost services and supports necessary to sustain recovery, and provide improved care and better resource management through the reduction of costly acute care claims.

The Cycle of Addiction

Alcoholism and addiction are chronic diseases that require services to address acute episodes of illness, as well as supports and resources for sustained periods of good health. It is a rare occurrence that a person wakes up one day and decides they want to become addicted to drugs or alcohol. In many cases, the use and abuse of substances begins as a way to cover up a trauma or mistreatment that has happened in the person's past. It becomes a way for the person to survive a day, week, month and year.

The longer a substance is used, the more significant the negative impact on families and communities. Therefore, prevention, early intervention, treatment and post-treatment recovery supports must be included in a substance use disorder (SUD) service network in order to minimize those harmful impacts and keep communities healthy.

Primary Drug Reported at Admission (TEDS all admissions)				
Primary Drug	**FY2000**	**FY2005**	**FY2010**	**Trends Noted**
Alcohol	34,603	30,185	26,052	Alcohol remains the most frequently reported drug at admission; twice as many identified it compared to any other substance (over 40% of all admissions during FY2000-FY2010).
Marijuana	10,099	11,816	11,275	Except for slight increases through FY2005, marijuana admissions have remained relatively stable.
Heroin	7,264	9,601	11,358	Admissions for both heroin and other opiates (including illicit methadone) have seen persistent and steady increases throughout the last eleven years.
Other Opiates	1,494	4,002	8,448	
Cocaine/Crack	11,604	12,382	6,064	While crack and cocaine admissions increased in the middle of the decade, they have declined during each of the past four years.
Methamphetamine	101	913	611	Admissions for methamphetamine peaked in FY2005, and after a two year drop, have stabilized below the FY2005 high water mark.

Jane's Recovery Story

The following is the recovery story of one blended family that came together at the beginning of their recovery journey. As you read about the life path traveled by Jane, you may note numerous missed opportunities for intervention by systems working parallel to one another, beginning in childhood and moving through to adulthood. A ROSC not only enhances the system's knowledge and recognition of substance use disorders, it also develops patterns and weaves together system collaborations and partnerships that can provide interventions, treatment and supports to individuals, as they seek recovery and work toward wellness.

The Path. *Jane came from a large family with one full- and two half-sisters, as well as numerous step-siblings and grandparents. The primary female role models in her life were verbally abusive and used love and affection as a reward for "good" behavior. Her mother used marijuana regularly when she was growing up, and allowed Jane and her sisters to do the same as teens. Jane's maternal grandfather was loving and supportive, but her maternal grandmother abused prescription drugs and was very negative and abusive at times.*

At age five, her father moved out of state with his new wife and took Jane and her sister with him. This was a significant source of trauma for the five-year-old-girl, who was not able to see her mother for a year, nor was she allowed the things that made her feel safe, like her blanket. During their time out of state, a male relative began to sexually abuse both girls, and the abuse continued for several years, even after their return to Michigan. Neither girl reported this abuse while it was occurring.

Upon their return to Michigan, Jane was allowed to spend time with her maternal grandparents. Her mother was still absent from her life, but did reappear with a new husband, three step-children and a younger sister for Jane. She was allowed to return to her mother's house full time when her father and step-mother divorced, shortly before she entered third grade. Jane soon learned that her new step-father was a harsh disciplinarian who regularly abused his children and wife. While she and her sister were never physically punished by their step-father, they experienced hours of standing in the corner or holding their noses against the wall. After this return to her mother's home full time, it was years before she saw her own father again.

Age at First Use
of Primary Drug at Admission

13 and under	19.1 %
14 – 17	36.9 %
18 – 20	17.3 %
21 – 25	13.6 %
26 – 29	4.6 %
30 and older	8.5 %

(Median age is 17)

Jane's family alternately lived on their own and with her maternal grandparents, depending on their financial situation. When staying with her grandparents, she was the "go-to-girl" for getting grandma's "medication" from the stash she maintained. Jane thought that this made her "special" and a favorite of her grandmother, and she was pleased with this responsibility. As she became a teenager, her episodes of rage increased and became more frequent. These episodes were mainly directed at her mother. She could not control herself when she was angry; she felt humiliated, embarrassed and weak after an outburst. She also developed migraine headaches around this time, and had her first experience with illicit prescription medication, courtesy of her grandmother. She recalls the euphoria from the medication, that she slept for hours, and that her mother was very angry with her grandmother for giving her the pills.

There were many opportunities for intervention as Jane was growing up. In a ROSC, the family would have been able to access counseling services to address her mother's and grandmother's substance abuse, as well as the frequent verbal abuse in the family. By having a system that works together on the multiple challenges a family can face, there would have been collaboration with child welfare services, mental health services for both the children and adults, the opportunity for parenting education, resources for housing and employment, and cross training for primary care physicians regarding the abuse of medications.

The Cycle. *Jane began experimenting with drugs at age 21, after years of exposure to marijuana use and the diversion and abuse of prescription drugs on the maternal side of her family. Despite the feelings of paranoia she experienced, she continued to use marijuana when offered and eventually was using regularly with her family. Her sister began supplying her with prescription medications, and these were her first choice for getting high. She felt they made her happy.*

Approximately eight years ago, Jane's mother was not feeling well and asked Jane to transport her to the hospital. It was a regular occurrence for her mom to claim that she did not feel well to get out of work, and her daughters would frequently challenge her claims. This day was no different, and Jane was furious that her mother would ask her to take time from her day to go to the emergency room for what would amount to nothing, so she ultimately refused. Her mother made it to the hospital that day, and Jane discovered later that evening that her mom was given a prescription

for an anti-anxiety medication and sent home. She felt vindicated that, once again, her mother's complaints amounted to nothing, and stayed overnight at her sister's apartment. Her mother had a heart attack that night and died in her sleep. Jane's guilt over this incident and the horrible things she said to her mother in anger, have played a large role in her continuing to abuse substances.

Babies & Substance Abuse

The latest studies estimate that 40,000 infants are born each year with Fetal Alcohol Spectrum Disorders (FASD) – 1 out of every 100 births in the U.S.

Direct costs associated with Fetal Alcohol Syndrome, estimated at $3.9 billion annually, include not only healthcare costs, but also costs associated with social services and incarceration.

- Of individuals with FASD, 60% will end up in an institution (mental health facility or prison).
- It is estimated that almost 70% of children in foster care are affected by prenatal alcohol exposure in varying degrees.

(National Organization on Fetal Alcohol Syndrome)

Money from life insurance and a wrongful death settlement with the hospital sent her life spiraling out of control. Not only did she spend all of her portion of her mother's life insurance, she spent her niece's portion as well. During this time she became pregnant. While she did not use alcohol during her pregnancy, she did not stop or change her drug use in any way. Her child was born early and small, but did not test positive for drugs, so she was able to leave the hospital with the infant.

In the past year, over 700 admissions to treatment services were pregnant women, for their alcohol and/or drug use disorders, through Michigan's publicly funded agencies.

About one out of every two admissions to treatment during FY2010 also had a mental health disorder (47.2%).

She began to feel so depressed that she checked herself into the psychiatric unit of a local hospital. It was there that she first discovered a substance abuse treatment program she could go to that also allowed her son to accompany her. While she had experienced minimal success in a previous treatment program, she stayed in the next treatment program, with her son, for 18 months.

It often takes a threat like losing one's children, significant other, home, or job to motivate a person into treatment. While it is good to get in the door of the treatment center, motivation to change at that point varies greatly from person to person, and this affects their treatment outcomes. It is important that all treatment facilities meet the person where they are in their addiction and recovery journey. For that reason, a ROSC stresses individualized treatment, based on each person's needs, strengths and challenges.

While in treatment, challenges can arise. Sometimes there are problems at home with significant others, children, or even housing, that cause a person to leave treatment. Sometimes, unearthing all the emotions that have been buried in addiction is simply too painful, and the person leaves treatment to return to active addiction. Even worse, sometimes there is a problem with insurance coverage and the person is unable to remain in treatment as long as they should. In all of these examples, if the individual can remain connected to services or the recovery community in some way, whether through a recovery coach, a recovery support drop-in center, or even case management, the opportunity remains for them to become engaged in services again.

Readiness to Change

There are six stages that a person with a substance use disorder may experience while using substances and seeking treatment; they are:

1. Pre-contemplation: a person who is not currently considering change.
2. Contemplation: ambivalent about change.
3. Preparation: some experience with change and are trying to change.
4. Action: practicing new behavior for 3-6 months.
5. Maintenance: continued commitment to sustaining new behavior.
6. Relapse: resumption of old behaviors.

(Prochaska and DiClemente)

Under a ROSC model, Jane's mental health and substance abuse needs would have been addressed by a single treatment provider specializing in co-occurring disorders. If separate providers were necessary, collaboration and coordination between systems would have ensured that treatment for both disorders followed a similar service plan

and did not conflict. Services would have been available for Jane's child and niece, both to keep them safe, and to help them understand the challenges within their family.

Even something as benign as budgeting, nutrition and life skills could have helped this family become more self sufficient, and created a better environment for the children to grow up in. It also would have been another opportunity for someone on the outside to view how this family was functioning and encourage intervention before they were in crisis.

Navigating a New Path. *While in treatment, Jane met Tom, also in treatment, and they began to develop a bond. Jane and Tom shared a similar background. They both suffered traumatic events during childhood, and both were single parents. Eventually, they began to date, and have been together since, marrying in 2008. To support their recovery, they both participated in outpatient substance abuse treatment for over two years. In addition, Jane participated in a dual recovery group that helped address her depression, as well as her substance abuse. She also reported that the groups most helpful to her during her treatment were the groups that addressed grief, shame and guilt.*

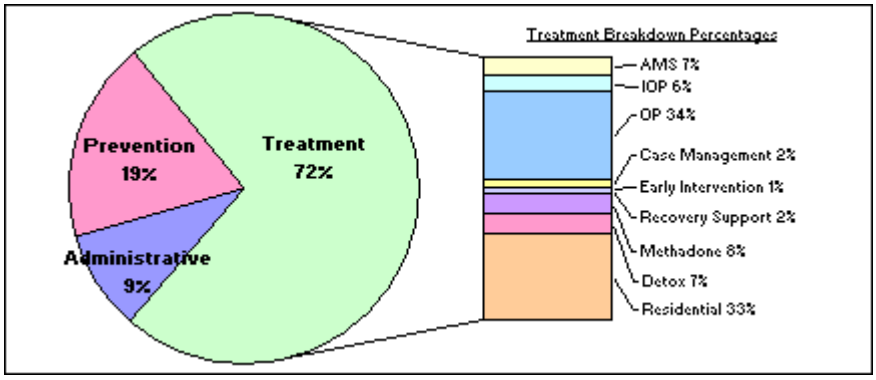
Being together has been a challenge for Jane and Tom: managing the recovery needs of two people in addition to managing the recovery needs of their family as a whole, blending a family that has experienced the trauma of addiction and loss of a parent at one time or another, and learning how to not only be a person who does not use or abuse substances, but to be a couple who does not do this is a daily struggle. Along with these challenges, there are rewards as well: there is always someone who understands and is available for support, and the children can relate to one another due to their similar experiences.

Jane and Tom were fortunate that they were able to access a treatment program that had the ability to meet the majority of their needs, whether it was intensive treatment for the parents, therapy and prevention for the children, or continued support and treatment through outpatient therapy services. However, because these services were contained within the same program, this has isolated the family, and especially the parents. Their outside support network is related to individuals and supports established through their treatment program and select family members. This has resulted in the family having little support or established relationships within their community.

A ROSC encourages individuals to learn to interact with their total community: faith-based entities, recreation-based organizations, prevention services, employment and educational services, and organizations that offer life skills training. Individuals are also encouraged to establish a supportive environment based on services available within their community.

Individuals typically enter treatment after ten years of active addiction. The longer a person uses, the more difficult it is for them to enter and sustain recovery. After formal treatment, it takes four to five years for the risk of relapse to drop below 15%. Michigan's current system focuses on acute treatment, but does not provide the sustained support necessary to stabilize recovery. With recovery as a focus, all systems can work together to intervene on the path of a chronic illness such as alcoholism or addiction, with intervention, treatment, ongoing healthcare, support services for daily survival, monitoring of wellness and sustained recovery.

Additional Information About BSAAS...



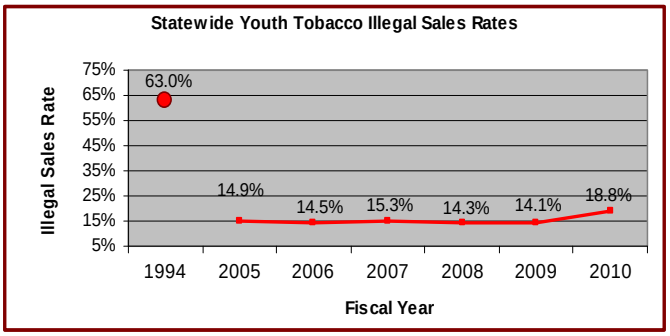
Substance Use Disorder Prevention, Treatment and Recovery Services: Regional coordinating agencies (CAs), established by Pubic Act 368 of 1978, locally manage services for persons with substance use disorders. Michigan has sixteen CAs (see Coordinating Agency Map) who contract with over 400 providers to make services available statewide.

In fiscal year 2010, BSAAS administered over $67 million in federal funds and over $18 million in state funds to purchase services on behalf of Michigan residents. Please see our Legislative Report for spending details and information on providers (including types/quantities of services, and amounts/sources of funds).

Problem Gambling: Services available to Michigan residents include: 24-hour help-line, treatment and prevention programs. State restricted revenue, for problem gambling services, comes from several sources: casinos, lottery, and race tracks. During FY2010, four CAs participated in pilots to provide problem gambling treatment services to persons through the substance use disorder (SUD) service network. Please see the BSAAS Problem Gambling webpage or www.gambleresponsibly.org for more information about problem gambling services.

Admissions to Problem Gambling Treatment in Michigan	
Region	**No. of Clients**
Wayne County, including Detroit	203
Detroit Metro (outside Wayne Co.)	175
East Region	46
West Region	64
Upper Peninsula (UP)	6
Northern & UP - SUD & Prbl Gambling	104
Statewide During FY 2010	598

Youth Tobacco Sales Rates, Synar: A key target for prevention services is reducing youth access to tobacco. Statewide, prevention agencies, anti-tobacco groups, selected tobacco retailers, and law enforcement agencies continue to work at reducing the frequency of illegal tobacco sales to youth under the age of 18.
5
Studies show that strict compliance enforcement of youth access to tobacco laws is a strong deterrent for youth who are contemplating initiation of tobacco or experimenting with tobacco use.[1, 2] Michigan began conducting annual random inspections of tobacco retail outlets in 1994 to determine the extent of youth access to tobacco. In accordance with the Synar regulation issued by the Substance Abuse and Mental Health Services Administration, beginning in 1997, Michigan was required to survey tobacco retailers and achieve a federally prescribed retailer violation rate (RVR).



Since 2001, Michigan has seen a continuous decrease in RVRs. However, in 2010, the RVR increased by 4.7 percentage points bringing Michigan's RVR to 18.8%, the highest since 2004. Likewise, RVRs across the nation have increased.[3] Attributable factors include budgetary constraints, which have limited enforcement efforts, and the overall economic downturn reported by states.[4]

---

1 Doubeni, C.A., Wenjun, L., Fouayzi, H., and DiFranza, J.R. (2008). Perceived accessibility as a predictor of youth smoking. *Annals of Family Medicine*, 6(4): 323–330.

2 Forester, J.L., Murray, D.M., Wolfson, M., Blaine, T.M., Wagenaar, A.C., and Hennrikus, D.J. (1998). The effects of community policies to reduce youth access to tobacco. *American Journal of Public Health*, 88(8): 1193–1198.

3 Substance Abuse and Mental Health Services Administration (2009). FFY 2009 annual Synar reports youth tobacco sales. [serial online], 3- 4. Retrieved March 23, 2011, from http://store.samhsa.gov/shin/content//SYNAR-10/SYNAR-10.pdf.

4 Centers for Disease Control and Prevention. (2008). Cigarette Use Among High School Students— United States, 1991–2007. *Morbidity and Mortality Weekly Report,* 57(25): 689–691. Retrieved March 23, 2011, from http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5725a3.htm.

In 2011, Michigan is taking measurable steps to address youth access to tobacco RVR increases; reconvening the state's Youth Access to Tobacco (YATT) workgroup, pooling additional funding streams to increase enforcement efforts, and aligning services to reflect a holistic approach to develop prevention prepared communities. Please see our Youth Access to Tobacco and Synar Info webpage, on our website under Prevention, for more details.

For More Statistical Information: Reports with statistical information by regional areas are also available as listed below. They are on our website at www.michigan.gov/mdch-bsaas, along the left side choose "Reports and Statistics."

- Treatment Demographics (includes Correctional/Judicial involvement statistics)
- Primary Substance Reported at Admission by County
- Women & Pregnant Women - Admissions and Discharges
- Reported Mental Health Disorder as Factor in Treatment
- Treatment Activity Summary (TEDS)
- Treatment Discharge Reasons
- Treatment Outcomes Measured at Discharge
- Treatment Services Penetration Rates
- Prevention - - Youth Tobacco Sales Rates, Synar
- Prevention - - Communicable Disease
- Problem Gambling Services

Other Programs We Oversee: Our website also has information about other programs we oversee:

- Prescription and Over-The-Counter Drug Abuse