

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
BEHAVIOR HEALTH AND DEVELOPMENTAL DISABILITIES ADMINISTRATION
BUREAU OF SUBSTANCE ABUSE AND ADDICTION SERVICES**

Annual Report for Fiscal Year 2011

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.

This 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 2011 Summary of Admissions**Treatment Admissions/Transfers:**

64,768 Persons

Gender:

Male	61.0 %
Female	39.0 %

Age:

17 and under	4.5 %
18 - 35	52.5 %
36 - 54	36.8 %
55 and older	6.2 %

*(Median age is 32)***Race/Ethnicity:**

White	69.8 %
African Amer./Black	24.7 %
Hispanic	2.6 %
Native American	1.3 %
Multiracial/Other	1.6 %

Primary Substance Reported at Admission:

Alcohol	38.8 %
Heroin	19.1 %
Marijuana/Hashish	16.1 %
Other Opiates *	14.7 %
Cocaine/Crack	8.3 %
Methamphetamine	1.0 %
All Others	2.0 %

* includes prescription opiates

[\[Additional Demographic Info\]](#)[\[Primary Substance by County\]](#)

Recovery Oriented System of Care Transformation in Michigan

A substance use disorder (SUD) is a chronic condition, but the SUD service system in Michigan is based on an acute care model of treatment. In Michigan 54.4% of persons who received detoxification services have had at least one previous treatment admission for a SUD. Furthermore, 33% of individuals who received long-term residential services have had at least one previous admission for the same service. This means that of the 73,454 people (unduplicated clients) who received services in 2011, approximately half of those individuals have previously received treatment in the publicly funded system.

With the priority set by the Substance Abuse and Mental Health Services Administration (SAMHSA), and with several states as the forerunners, the Michigan Department of Community Health, Bureau of Substance Abuse and Addiction Services (BSAAS) began to prepare for a significant "transformation" some time ago. In the autumn of 2009, at the statewide SUD conference, the ground was struck and the first shovel of dirt turned on what would be the monumental task of reshaping the publically funded SUD service system. With research and the experiences of other states as our guide, the SUD service system began the transformation to a recovery oriented system of care (ROSC). Transformational change involves a review and revision of all aspects of the SUD service system including, but not limited to policies, processes, practices, partnerships, networks, provider orientations, goals and objectives, anticipated outcomes, data collections, expectations, and evaluations. Additionally, it will promote an integration and involvement of a broad-ranging, wide variety of services to support SUD recovery.

Within systems transformation, we need to 1) create and codify the expectation that full recovery is a life-long pursuit, supported and successful through necessary intervention and needed community support; 2) recognize that prior treatment, relapse and recovery cycles are indicative of a SUD; 3) acknowledge the fact that re-occurrence is an expected and accepted reality of the disorder; 4) embrace aftercare

as critically important to the recovery process; and 5) respect the fact that recovery requires ongoing relationships rather than brief interventions.

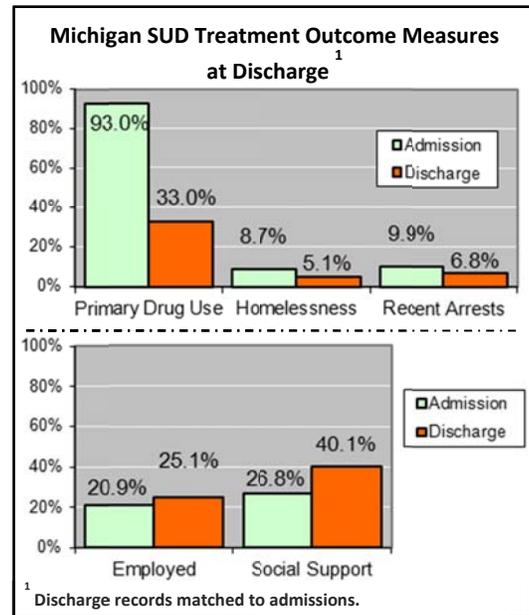
Reasons Why the System Needs to Change

- The chronic illness which encompasses substance abuse, dependence, and addiction was being treated using an acute care model. People typically enter treatment after ten years of active addiction; the longer people use the more difficult it is for them to enter and sustain recovery.
- There was limited attraction to the type of SUD treatment services being offered. Less than 10% of people who meet the current Diagnostic and Statistical

William White, one of the founders and foremost authority on ROSC, describes ROSC: "A recovery-oriented system supports person-centered and self-directed approaches to care that build on strengths and resilience. Individuals, families, and communities take responsibility for their sustained health, wellness, and recovery from alcohol and other drug related issues through the various life phases of recovery. This system refers to a macro-level organization of the larger cultural and community environment in which long-term recovery is nested and offers a complete network of formal and informal resources that support long-term recovery of individuals and families."

Manual (DSM) criteria for a SUD are currently seeking treatment.

- Although the content of the service being provided was sound, the administrative and service practices implemented led to poor engagement and retention. This resulted in less than half of those in treatment completing their treatment program. Cycling in and out of a series of disconnected treatment episodes is a product of the challenges within the current system – an inability to support sustained recovery.
- For those completing treatment there was no transitional support after treatment services were completed. There was a lack of continuing care which is needed post discharge to enhance recovery outcomes. Research shows us that only one in five individuals exiting SUD treatment received aftercare assistance. We want to broaden our system of treatment services to include ongoing support and multiple, coordinated strategies to support recovery.
- High rates of relapse were occurring. Even though addiction is a chronic and relapsing brain disease, there was no assistance in place to intervene on what we now know would be coming.



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)

The majority of people completing addiction treatment resume alcohol and other drug use within one year and most within 90 days. Fifty percent of people entering treatment services have had at least one prior episode of care. It takes four to five years of active, stabilized recovery for the risk of relapse to drop below 15%.

- The SUD service system has not paid attention to an individual's readiness for change. The system had an assessment and treatment process but services have not been well aligned with the individual's readiness for change.
- Based on the structure of the system's services and its delivery practices, most resource expenditures are utilized on a small portion of the population requesting services.
- Typically, prevention services are not incorporated into a ROSC. BSAAS has begun to integrate and enhance the coordination of prevention, follow-up or continuing care initiatives within the recovery process that will help people rebuild their life in the community.

ROSC Transformation and System Evolution

Through ROSC transformation, the system is moving toward:

- Treatment goals extending beyond abstinence or symptom management, to helping people achieve a full meaningful life in the community.
- Prior treatment not being viewed as a predictor of future treatment outcomes, and not being used as grounds for denial of treatment.
- People not being discharged from treatment for relapsing, or for confirming their diagnosis.
- Post-treatment continuing care being an integrated part of the service continuum rather than an afterthought.
- A focus on all aspects of the individual and the environment, using a strength-based perspective, and emphasizing assessment of recovery capital.
- Outreach, pre-treatment supports, and engagement getting greater emphasis.

- A more diverse menu of services and supports available for people to choose from.
- Providers making more assertive efforts to connect individuals to families and natural supports.
- Non-clinical/peer-based recovery support availability being expanded.
- Post-treatment recovery check-ups.

Age at First Use of Primary Drug at Admission	
13 and under	17.7 %
14 – 17	35.5 %
18 – 20	18.4 %
21 – 25	13.6 %
26 – 29	5.2 %
30 and older	9.6 %
<i>(Median age is 17)</i>	

ROSC Services Support Recovery and Resilience

ROSC will result in services that support recovery and resilience and will have:

- A greater emphasis on continuity of care: effective prevention, assertive outreach and engagement, treatment, and ongoing monitoring and support.
- A continuum of care whose services are holistic and integrated, culturally responsive, and whose systems are anchored in the community.
- An expanded availability and utilization of non-clinical services, such as peer supports, 12-step programs, prevention, faith-based initiatives, etc.
- An inclusion of efforts to help prevent the onset of substance use disorders.
- A public health approach by helping to create healthy communities.
- A more assertive outreach to families and communities impacted by substance use disorders.
- A more assertive post-treatment monitoring and support.
- A partnership/consultation approach rather than an expert/patient model.
- The lives and experiences of other people in recovery valued and used to help others in the journey.

Primary Drug Reported at Admission (TEDS all admissions)				
Primary Drug	FY2001	FY2006	FY2011	Trends Noted
Alcohol	29,492	30,579	21,944	Alcohol remains the most frequently reported drug at admission; twice as many identified it compared to heroin, the second most frequently reported primary drug.
Marijuana	8,528	12,368	9,307	Marijuana admissions have stabilized, and are decreasing after a measureable increase during the middle part of the last decade.
Heroin	7,857	9,958	10,924	Admissions for both heroin and other opiates (including illicit methadone) have seen persistent and steady increases throughout the last twelve years.
Other Opiates	1,882	4,918	8,222	
Cocaine/Crack	10,330	13,290	4,753	Crack and cocaine admissions continue a steady decline as admissions for all opiates (heroin, synthetic opiates, and illicit methadone) have increased.
Methamphetamine	165	707	542	Admissions for methamphetamine peaked in FY2005, and after a two year drop, have stabilized well below the FY2005 high water mark.

In the current acute care model (pre-transformation), many individuals are able to successfully initiate their recovery in treatment, but they often have difficulty maintaining their recovery following treatment. As a result, they cycle in and out of a series of disconnected treatment episodes. In a ROSC, SUDs are acknowledged as long-term or chronic illnesses that often require ongoing support and multiple coordinated strategies to promote sustained recovery. As such, people are provided with a diverse range of services and supports that assist them in not only initiating their recovery, but also sustaining it and rebuilding their life in the community.

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.

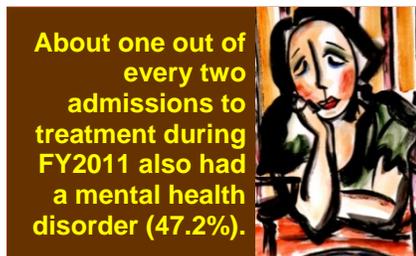
Definition Adopted by the ROSC Transformation Steering Committee, September 30, 2010

As part of the foundation that needed to be put in place for the SUD service system transformation, BSAAS established a Transformation Steering Committee (TSC). It was the goal of BSAAS to bring together representatives from the diverse components of the SUD service system, as well as critical stakeholders from other service delivery domains. The TSC seats about 40 individuals that represent state-level administration, regional coordinating bodies, and local providers within the SUD service system. Additionally, the TSC embraces representation from mental health, criminal justice, and child welfare arenas, and from the Native American and Hispanic SUD service delivery

systems. Most importantly, the TSC boasts representative from the SUD and mental health recovery community.

Strategic Planning and Structure for the ROSC Transformation Process

Once the TSC was operational and began to consider structural functioning, guidance, and priorities; the members began working to develop an implementation plan. The culmination of these efforts resulted in the development and adoption of *Michigan's Recovery-Oriented System of Care: An Implementation Plan for Substance Use Disorder Service System Transformation*. This plan identified nine goals and associated objectives to be focused on in order to establish the transformation process in Michigan. Various workgroups have been organized to address the required alignment initiatives and the goals at the core of the strategic plan.



Progress Toward the Nine Goals for ROSC Transformation

Progress has already been made toward the nine goals identified in the implementation plan:

Increase the Understanding of a System that Promotes Recovery and Resilience in Michigan.

- A Statewide Substance Use Disorder Conference, attended by over 1,000 individuals, that focused solely on recovery oriented systems of care.
- Representatives from diverse systems and organizations were invited to be part of the TSC and take information about ROSC back to their 'home' systems.
- Regional ROSC Symposiums were conducted in seven locations around the state.
- Nine fact sheets were developed addressing nine different target audiences.
- A newsletter was developed and is published quarterly to share varying ROSC information.

Develop a Shared Vision for ROSC in Michigan.

- A definition was developed for a Michigan's ROSC.

Increase Stakeholders' Understanding of Ways in which Services and Supports that Promote Recovery and Wellness may be Similar to or Different from Current Services.

- National consultants were utilized to provide presentations and trainings to the TSC, persons in recovery, regional substance abuse coordinating agency (CA) personnel and invitees, and selected key stakeholders.

Enhance our Collective Ability to Support the Health, Wellness, and Resilience of All Individuals by Developing Prevention-Prepared Communities.

- A Prevention Focus Group was conducted with selected prevention coordinators and prevention providers.
- A Prevention Workgroup was convened to work toward prevention related objectives.
- A PowerPoint was developed to explain prevention prepared communities and their role within an ROSC.

Promote Health Equity in Michigan's SUD Service System.

- A priority to work toward the establishment of integrated health (the integration of behavioral and primary health care) was established by the Michigan Department of Community Health.
- National consultants presented information on integrated health care and ROSC to the TSC.
- A Michigan Primary Care Association representative has been seated on the TSC.

Enhance the Ability of People with SUDs to Both Initiate and Sustain Their Recovery.

- A Peer Community Focus Group was held to discuss issues related to recovery needs and peer involvement in integrated health care
- A recovery support services workgroup was convened, and developed "Practice Guidelines for Peer Recovery Support Services."
- Training was held for persons from the recovery community to be 'recovery coaches', and 15 of these individuals were trained to train recovery coaches.

Ensure that Michigan Residents in Need of SUD Treatment Receive Effective Services and Supports, Regardless of the Systems They Enter.

- Presentations were provided to the TSC and select regional coordinating agencies on ROSC, the shift in the SUD culture that creates the environment for ROSC, emphasizes the important of key collaborations/partnerships within a ROSC, and the principals of a ROSC system.

- A Collaborations and Key Partnerships Workgroup was convened to address objectives related to integral associations within the implementation plan.
- Integrated health care and co-occurring service delivery were identified as integral structures within a ROSC.
- ROSC was identified, in the Action Plan Guidelines (APG) for the regional CAs, as the over-arching structure for the planning of SUD services in each region around the state.
- CAs were required, through the APG, to plan for integration with primary care.

Mobilize the Recovery Community and Increase the Hope that Recovery is a Reality in Michigan.

- A Recovery Voice Workgroup was established to formalize the role of the recovery community involvement.
- A statewide peer symposium was offered by BSAAS to share information about the ROSC transformation and the importance of peer and recovery community involvement in ROSC.
- A Recovery Community Focus Group was convened to obtain additional information on recovery experiences, recovery person's role in integrated health care, and to strengthen the voice of recovery.

Ensure that the Transformation Efforts Are Sustainable and Become Embedded in Systems and Communities Throughout Michigan.

- National consultants have presented and trained on various elements of a ROSC.
- BSAAS selected the transformation approach to establishing a ROSC, because transformation will require an evolution of services to embed ROSC deep within the roots of Michigan's publically funded SUD service system.
- BSAAS has embedded the elements of ROSC (the transformation process) within the APG and CA contractual agreements.

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)

During FY11, there were 204 drug free births to women in Michigan treatment programs.

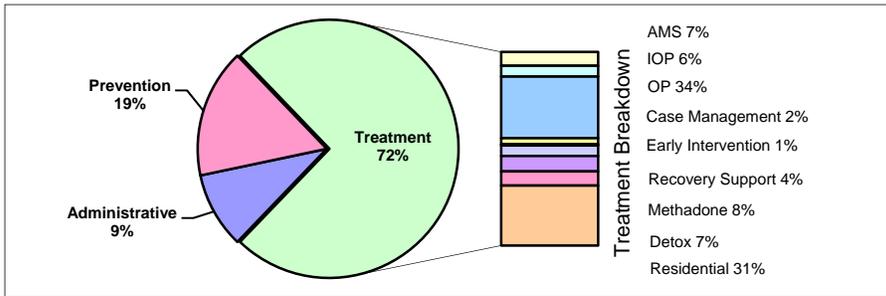
ROSC Transformation Future

The energy expended and the achievements gained have not gone unnoticed by federal administrators of SUD service funds. Through the hard work of the TSC, its members, regional CAs and their providers, Michigan has been identified as one of five states to participate in the Office of National Drug Control Policy's ROSC Learning Communities initiative. As part of this structure, Michigan will be able to share information about processes, successes, and challenges experienced as part of ROSC transformation. Through this process Michigan will be in position to mentor other states on ROSC transformation.

BSAAS is looking forward to continued transformation and the establishment of a SUD service system that is based on the recovery and resiliency of the people of Michigan.

Send comments and questions to our office by email at MDCH-BSAAS@michigan.gov.

Additional Information About BSAAS...



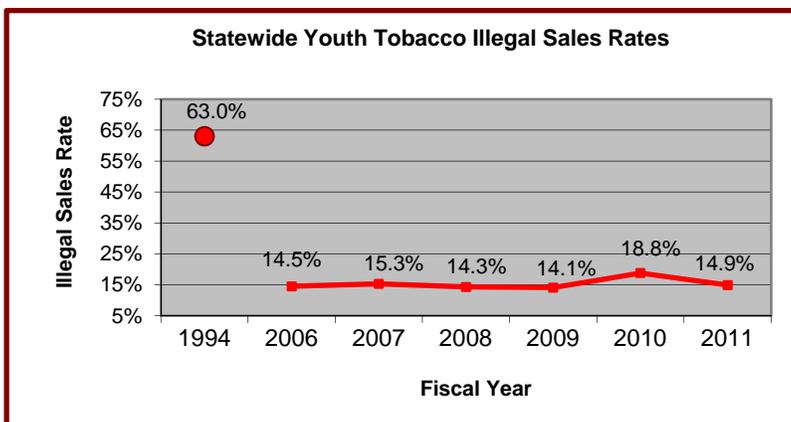
Substance Use Disorder Prevention, Treatment and Recovery Services: Regional coordinating agencies (CAs), established by Public Act 368 of 1978, locally manage services for persons with substance use disorders. Michigan has sixteen CAs (see [Coordinating Agency Map](#)) who contract with over 400 providers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

In fiscal year 2011, BSAAS administered over \$71 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. State restricted revenue, for problem gambling services, comes from several sources: casinos, lottery, and race tracks. During FY2011, Northern Michigan Substance Abuse Services participated in a pilot to provide case findings for referral and treatment in rural northern Michigan. The pilot included working with district and circuit courts, as well as substance use disorder treatment providers, to routinely screen for problem gambling; services were provided to 51 persons. In addition, in FY2011, DCH and Michigan Gaming Control Board, with assistance from the Department of Attorney General, implemented a Problem Gambling Diversion Program at the 36th District Court. This program provided first time offenders who violated the terms and conditions of Section 432.225 (Disassociated Persons Act) with a voluntary opportunity to receive treatment by enrolling in the Problem Gambling Diversion Program. Forty-nine persons on the Disassociated Persons List received problem gambling services. Please see the [BSAAS Problem Gambling webpage](#) or www.gamblersresponsibly.org for more information about problem gambling services.

Region	No. of Clients
Wayne County, including Detroit	181
Detroit Metro (outside Wayne Co.)	175
East Region	36
West Region	68
Upper Peninsula (UP)	0
Diversion Program	49
Northern Mich. - SUD & Prbm Gmbl	51
Statewide During FY 2011	560

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.



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).

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.

Since 2001, Michigan has seen a continuous decrease in RVRs. In 2011, the RVR was 14.9%, a decrease of almost four percentage points from Michigan's RVR of 18.8% reported in FY 2010,

In 2012, Michigan is taking measurable steps to address youth access to tobacco RVR increases; developing a state-level Synar Strategic Plan, 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](#)