Spring Issue 2015

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES ADMINISTRATION
OFFICE OF RESCOVERY ORIENTED SYSTEMS OF CARE

The Transformational News:

Michigan's Transition to a Recovery Oriented System of Care for Behavioral Health

From the Office Director's Desk

On April 10, 2015, the Michigan Department of Community Health merged with the Department of Human Services to form the Michigan Department of Health and Human Services. Under Director Nick Lyon's leadership, the new department's goal is to "better serve our residents as people, rather than focusing on our programs".

Lynda Zeller will continue as the Deputy Director of Behavioral Health and Developmental Disabilities Administration (BHDDA). BHDDA has lead responsibility for four areas – Bureau of State Hospitals and Behavioral Health Administrative Service, Bureau of Community Based Services, Children and Adults with Autism Spectrum Disorder and Developmental Disabilities Council. The Office of Recovery Oriented Systems of Care (OROSC) remains in the Bureau of Community Based Services. OROSC will continue to promote and strengthen the delivery of behavioral health services including behavioral health promotion, prevention, treatment and recovery across the lifespan of individuals and families. The Recovery Oriented System of Care Transformation Steering Committee (ROSC TSC) will be a key vehicle in addressing service delivery challenges.

The TSC is poised to move ahead with a ROSC agenda. One of our first new tasks is to work on SUD policies that are no longer applicable. Other workgroups include Medication Assisted Treatment Guidelines, Prevention, State Epidemiological Outcomes, and Peer Recovery Coach credentialing and curriculum. Our membership includes representatives from the SUD oversight policy board, providers, PIHP directors, Michigan Department of Corrections, Michigan Department of Education, Michigan Department of State Police, SAPT directors, Primary Care Association, Inter-Tribal Council of Michigan, persons with lived experience and BHDDA staff. Summary meeting minutes will be posted on our website at www.michigan.gov/bhrecovery.

We have new department name, a new goal, and we are continuing to advance recovery oriented systems of care in Michigan.

> "THE SECRET OF CHANGE IS TO FOCUS ALL OF YOUR ENERGY, NOT ON FIGHTING THE OLD, BUT ON BUILDING THE NEW."
> – SOCRATES

A Closer Look at E-Cigarettes

Electronic cigarettes, e-hookah, vape pens… no matter what you call them, they are items whose popularity only seems to grow each day. In Michigan, that growth comes with rising concerns. National studies indicate that e-cigarettes are not only popular among adults, but are increasingly popular with young people. Indeed, a University of Michigan study released in December 2014 indicated that for the first time, e-cigarettes are more popular than conventional cigarettes among middle and high school students. Poison control center reports across the nation have highlighted the need to treat e-cigarettes and their refills as you would any other household hazardous product. In December 2014, a toddler in New York died from ingesting

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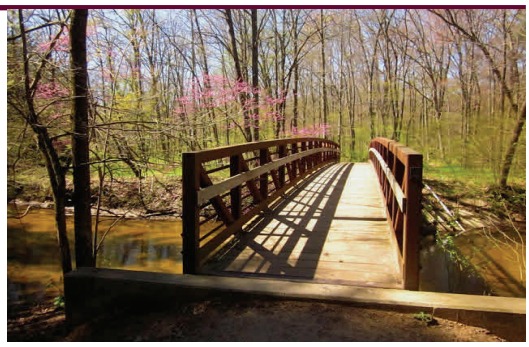

A Closer Look at E-Cigarettes (Continued)

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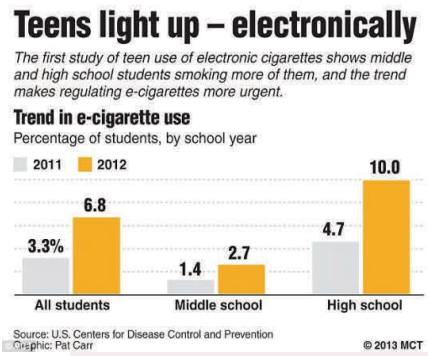
the contents of an e-cigarette cartridge raising concerns among health officials that if steps aren't taken to protect children, they could see more fatal accidents similar to this one.



According to the Centers for Disease Control and Prevention, in 2013 **more than a quarter million** middle and high school students, who never smoked regular cigarettes, had used e-cigarettes. Retailers, Governor Snyder, and the Michigan Legislature have shown interest in keeping e-cigarettes and refills out of the hands of youth. Though Michigan does not yet have a law prohibiting e-cigarette sales to youth, recognizing that e-cigarettes and their refills are tobacco products, most distributors are not selling e-cigarettes and their refills to minors. Some facts about e-cigarettes include:

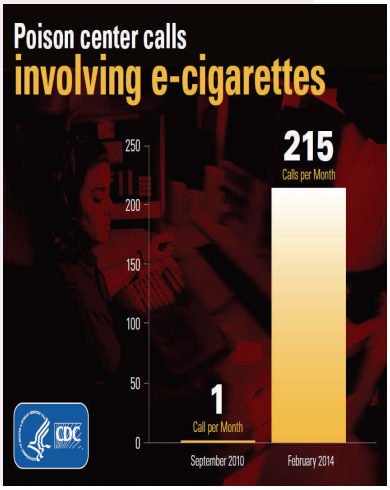
- An atomizer heats liquid in the cartridge which can thermally breakdown into carcinogenic compounds such as formaldehyde and acetaldehyde.
- Nicotine content in e-cigarettes is highly variable, regardless of the advertised content, because of the market's lack of standard manufacturing processes.
- The liquid stimulant used, known as e-liquid, can cause vomiting, seizures, or death when ingested or absorbed through the skin.
- After only 5 minutes of use, e-cigarette smokers show signs of airway constriction and inflammation.
- Higher voltage batteries in e-cigarettes deliver high levels of nanoparticles, which can trigger inflammation and are linked to asthma, stroke, heart disease, and diabetes.
- Infections may be harder to kill among e-cigarette users.
- E-cig vapors help protect the antibiotic-resistant bacteria linked to pneumonia.
- Propylene glycol and glycerin are the main ingredients of e-liquid.
- E-liquid compounds are known to be eye and respiratory irritants when heated and vaporized, and may also create carcinogenic compounds.
- If the e-liquid is substituted with unregulated synthetic drugs the potential for harm is amplified.

Figure 1. **Public Support for Electronic Cigarette Laws**

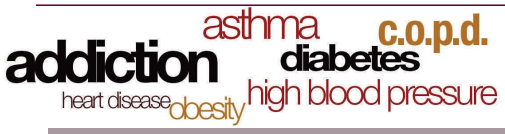
	2010	2013
Require manufacturers to test for safety	91%	88%
Prohibit the sale to people younger than 18	85%	86%
FDA regulation like other nicotine products	82%	77%
Restrict marketing on social networking sites	79%	71%
Prohibit use in indoor places and workplaces	69%	64%

Source: C.S. Mott Children's Hospital National Poll on Children's Health, 2013.

No long-term studies exist on the risks of e-cigarette smoking, nor does the industry currently possess a regulated manufacturing process—addictive nicotine and an unregulated mix of chemicals plague e-cigarettes just as they do traditional cigarettes. While touted as the healthier" cousin of the traditional cigarette, e-cigarettes still pose great risk to users.



Spotlight on ROSC Action in Michigan: Managing Addiction as a Chronic Disease



Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological and social manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. The basis of this lies in the part of the brain called the Limbic system. This is the system responsible for motivation, happiness and a feeling of contentedness. In the disease of addiction this area is altered by a significant decrease in the neurochemical dopamine. To the human species the lack of dopamine causes more stress and anxiety than the lack of even food or water. Thus, as in times of severe dehydration or starvation, the brain will go to extreme and many times illogical lengths to obtain dopamine. This may be a search for heroin, alcohol, cocaine or the next jackpot at the casino. This cycle becomes repetitive and even more potent each time it repeats.

Thus, addiction is characterized by an inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

A variety of effective treatments are available for Opioid Use Disorders (OUDs). Treatment tends to be more effective when opioid use is identified early. The treatments that follow vary depending on the individual, but methadone, buprenorphine and naltrexone have a proven record of success for people addicted to heroin or prescription opioids. Other non-pharmaceutical approaches, such as behavioral therapies also are used for treating OUDs. When these therapies are used in conjunction patient outcomes are superior, stability is maintained and a patient's life function can be restored.

Methadone treatment has been used for more than 30 years to effectively and safely

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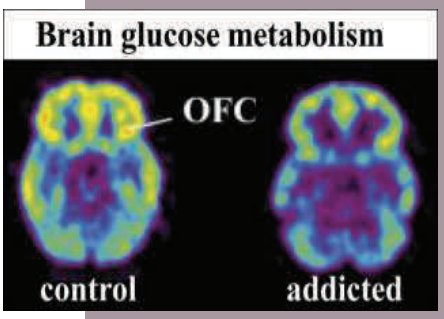
CHRONIC DISEASE MANAGEMENT

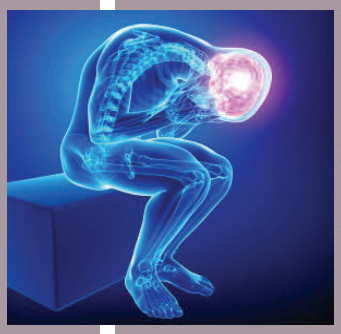
(Continued from page 2)

treat opioid addiction. Properly prescribed, methadone is not intoxicating or sedating, and its effects do not interfere with ordinary activities such as driving a car. The medication is taken orally and it suppresses opioid withdrawal for 24 to 36 hours. Patients are able to perceive pain and have emotional reactions. Most important, methadone relieves the craving, a major reason for relapse, associated with Opioid Use Disorders. It has also been shown that the quality of life in patients on methadone maintenance treatment is significantly improved. Among methadone patients, it has been found that normal street doses of heroin are ineffective at producing euphoria, thus making the use of heroin more easily extinguishable.

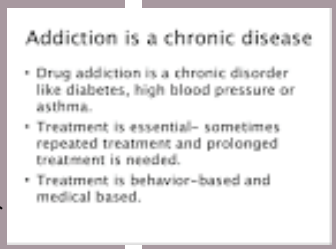
Buprenorphine is a particularly attractive treatment for Opioid Use Disorders because, compared with other medications, such as methadone, it causes weaker opiate effects and is less likely to cause overdose problems. It is a partial agonist at the mu opioid receptor which allows for a decreased overall increase in dopamine release thus creating a ceiling effect of the addictive potential of the medication. Buprenorphine also produces a lower level of physical dependence, so patients who discontinue the medication generally have fewer withdrawal symptoms than do those who stop taking methadone. Because of these advantages, buprenorphine is appropriate for use in a wider variety of treatment settings than other currently available medications. Several other medications with potential for treating heroin overdose or addiction are currently under investigation by NIDA.[6, 7]



Naloxone and naltrexone are medications that also block the effects of morphine, heroin, and other opioids. As antagonists, they are especially useful as antidotes. Naltrexone has long-lasting effects, ranging from 1 to 3 days, depending on the dose. The injectable version of naltrexone (Vivitrol*) lasts for 30 days. Naltrexone blocks the pleasurable effects of heroin and is useful in treating some highly motivated individuals. Naltrexone has also been found to be successful in preventing relapse by former opioid addicts released from prison on probation.



Although behavioral and pharmacologic treatments can be extremely useful when employed alone, science has taught us that integrating both types of treatments will ultimately be the most effective approach. There are many effective behavioral treatments available for Opioid Use Disorders. These can include residential and outpatient approaches. An important task is to match the best treatment approach to meet the particular needs of the patient. Moreover, several new behavioral therapies, such as contingency management therapy and cognitive-behavioral interventions, show particular promise as treatments for patients with Opioid Use Disorders, especially when applied in concert with pharmacotherapies.



The MAT guidelines for the treatment of Opioid Use Disorders are intended to be read by those involved in providing psychosocially assisted pharmacological treatments at any level. The targeted readership falls into three broad groups:

- Policy makers and administrators who make decisions on the availability of medicines and the structure and funding of services in countries or in subnational health administrative regions
- Managers and clinical leaders responsible for the organization of specific health-care services, and for the clinical care those services provide
- Health-care workers treating patients within the health-care system.

Prescription-opioid users often have pain problems and obtain their opioids legally from a prescriber indicating that they were still under medical supervision for their pain; these patients are more likely to have psychiatric treatment and take sedatives/anxiolytics or antidepressants. This presents an especially refractory group of patients as there are no guidelines for the treatment of pain in the patient who also has an opioid use disorder. The MAT guidelines did not attempt to make recommendations related to these patients but touches on appropriate screening methodology to determine who would be a good versus a bad candidate for an opioid pain medication.

Opioid Replacement Therapy (ORT) is based on a harm reduction philosophy and represents one component of a continuum of treatment approaches for opioid-dependent individuals. Opioid replacement therapy is a substitution therapy that allows a return-to-normal physiological, psychological and societal functioning. It is one possible treatment for opioid dependence. For some people, opioid replacement therapy may continue for life, while others may be able to eventually discontinue opioid replacement therapy and remain abstinent while preserving the normal level of function they attained while on opioid replacement therapy. Each patient must be assessed, treated, and monitored on an individual basis. Successful outcomes through ORT require knowledge, experience, vigilance, and diligence on the part of the clinical provider, the patient, and all of those involved in treatment. Medication alone does not constitute effective treatment of opioid dependency. Effective opioid replacement therapy services should comprise all of the components enabling a clinician to live up to the standards of care as presented by the American Society of Addiction Medicine (ASAM) and backed by the National Institute of Drug Addiction and Substance Abuse and Mental Health Services Administration (SAMHSA).

Contributed by Dr. Corey Waller

Regional Substance Abuse Prevention and Treatment Directors

As part of the behavioral health system integration that combined the mental health and the substance use disorder systems, the mandating legislation required each region of the state to have a Substance Abuse Prevention and Treatment (SAPT) Director. One of the advantages of this requirement is that you have an identified source to go to with specific substance use disorder questions and concerns, within Michigan's now combined behavioral health system. For your convenience, the SAPT Directors for each of the 10 Prepaid Individual Health Plans (PIHP) Regions area listed in the next two columns.

- **Region 1** – Judi Brugman
jbrugman@up-pathways.org
(906) 225-7286
- **Region 2** – Sara Sircely
ssircely@nmre.org
(231) 439-1277
- **Region 3** – Mark Witte
markw@lsre.org
(231) 332-3838
- **Region 4** – Mindie Smith
mindie.smith@swmbh.org
(269) 202-8398
- **Region 5** – Dani Meier
dani.meier@midstatehealthnetwork.org
(517) 253-7525
- **Region 6** – Marci Scalera
scaleram@cmhpsm.org
(734) 222-3816
- **Region 7** – Darlene Owens
dowens@dwmha.com
(313) 833-2410
- **Region 8** - Christina Nicholas
nicholasc@occmha.org
(248) 858-0949
- **Region 9** - Randy O'Brien
randy.obrien@mccmh.net
(586) 469-5676
- **Region 10** – Kimberly Prowse
prowse@region10pihp
(810) 966-3517

Peer Viewpoint

Peer Viewpoint is a designated space in the *Transitional News* to provide an opportunity where the voices of those in recovery can share important messages about the recovery journey. These messages share wisdom, hope, compassion, and knowledge to all who experience the disease of addiction, but more importantly the messages share the promise of wholeness, health and re-unification with life, family, and community. The individuals who submit articles give a great gift

My name is Kristy, and I am a recovering addict. I had a wonderful childhood and my family and I were very close. My Dad worked and my Mom stayed home and took care of my brother and I. I grew up having hopes and dreams like everyone else and I never planned for my life to go the way it did.

When I was 16 I smoked marijuana for the first time. I was the "sheltered", over protected child, so when my parents finally let me out, I went crazy.

When I turned 17, I tried Vicodin for the first time and I fell in love. I continued to smoke and take pills and when the Vicodin weren't enough anymore, a friend introduced me to Oxycontin. Everything went downhill from there. I started stealing from my family and friends and I was constantly in trouble. I was in and out of jail, staying two weeks to six months at a time. I was on probation for years because I never complied. No one trusted me and my family didn't want me around. I was taking every kind of opiate I could get to get high and it still was not working, so I started shooting up. I had to use just to feel normal and not be sick at that point. When that was not enough, I started doing heroin also.

In 2009 I got in trouble and went to jail. In lieu of jail they told me I could do 90 days in treatment. So I went to Clearview in Port Huron and I ended up doing 60 of the 90 days because I finished the program early. After I got back from treatment I did fine for about a month and then relapsed. Then about three months after being home I got pregnant with my son. I knew I had to quit and I couldn't do it alone. I had learned about methadone in treatment, so looked up clinics and found Victory Clinical Services. I started the following day on December 31, 2009. The first 5 months I was at Victory, while pregnant, I continued to smoke marijuana. After I had my son in May, I relapsed yet again. I was sure I could never live life sober and I was destined to keep failing. I didn't think I could quit and now I thought I was going to lose my kids too. I had my counselor at Victory, a CPS worker, and my probation officer telling me to get it together or there would be consequences. It was either jail or death, so I decided it was time I grow up and get it together.

On July 16, 2010 I stopped using and have been clean since. I got off probation, found employment, and got a job working at Victory Clinical Services as a Peer Recovery Coach. I wanted to be a Recovery Coach because I want to help people who were in and had been in my position and show them that they can live a drug-free life. I wish I would've had someone to help, support, and give me that extra push to work harder on myself and my recovery. I will now have 5 years clean on July 16 and I have never been happier!

Contributed by Kristy Kopec

MDHHS
Michigan Department of Health & Human Services
RICK SNYDER, GOVERNOR | NICK LYON, DIRECTOR

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Substance Abuse Treatment Assistance
www.michigan.gov/bhrecovery

Problem Gambling Help-line
800-270-7117 (24/7)

We're on the Web
www.michigan.gov/bhrecovery

Excerpts from the Bureau of Substance Abuse and Addiction Services 2009-2012 Strategic Plan

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.

One of our priorities:
Establish a Recovery Oriented System of Care (ROSC)

The Bureau of Substance Abuse & Addiction Services (BSAAS) is working to transform the public substance use disorder service system into one that is focused on supporting individuals seeking recovery from chronic illness. A ROSC requires a transformation of the entire service system to one more responsive to the needs of individuals and families that are impacted by addiction. To be effective, a recovery-oriented system must infuse the language, culture, and spirit of recovery throughout the entire system of care. The values and principles that are developed must be shaped by individuals, families, and community stakeholders.

Michigan's ROSC Definition

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.

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

Key Dates and Upcoming Events

Mark Your Calendars

Upcoming Events

May 4, 5, 11 & 12 - SAPST: 4 days

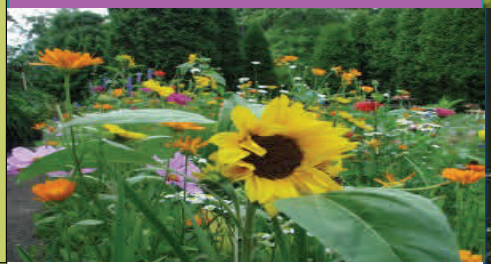
May 14 , 15, 21to 22 - SAPST: 4 days

May 26—28—MI Annual Peer Conference

July 9 - Women's Treatment

June 15 - Improving Outcomes...Fetal Alcohol Spectrum Disorders (FASD)…

July 20, 21, 22, 31 - SAPST: 4 days

August 17, 18, 24, 15 - SAPST: 4 days

More Training Opportunities
Information on workshops, conferences and other educational/training events can be viewed at
https://www.macmhb.org/