SUBSTANCE ABUSE ANNUAL REPORT FOR FISCAL YEAR 2009

(Public Health Code – Public Act 368 of 1978)

June 15, 2010

Section 6203: With the assistance of the department, the office shall:
(F) Evaluate, in cooperation with appropriate state departments and agencies, the effectiveness of substance abuse services in the state funded by federal, state, local, and private resources, and annually during the month of November, report a summary of the detailed evaluation to the governor, legislature, commission[1] and committee[2].

[1] "Commission" refers to the advisory commission on substance abuse services established by PA 368, section 6221. This commission was eliminated as a result of Executive Order 1991-3, MCL 333-26321.

[2] "Committee" refers to the interdepartmental committee on substance abuse established by PA 368, section 6201. This committee was discontinued in the late 1970s.

Michigan Department of Community Health
MDCH
Jennifer M. Granholm, Governor
Janet Olszewski, Director

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
MENTAL HEALTH & SUBSTANCE ABUSE ADMININSTRATION

BUREAU OF SUBSTANCE ABUSE & ADDICTION SERVICES

Annual Report for Fiscal Year 2009

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

The Michigan Department of Community Health, Bureau of Substance Abuse & 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."

Living the Life

D has been drinking since age 14. She started out in a troubled family that, in an effort to become stable despite the alcoholism of one parent, chose to sever relationships with certain family members. This created a huge loss in her life, and she spent the next several years trying to mend this split herself. She "got in trouble" many times, mostly as a runaway during her teens. She almost always ran to extended family. Her mental health was routinely stigmatized by her immediate family, and she was frequently chastised for, and warned away from, acting like her mother.

Age at First Use
of Primary Drug at Admission

12 and under	11.9%
13 – 16	37.1%
17 – 20	25.5%
21 – 24	9.5%
25 – 28	6.2%
29 and older	9.2%

(Median age is 17)

Her first inpatient experience was a psychiatric hospital stay at age 13. Her parents (father and step-mother) didn't believe in medication, so she wasn't allowed to have anything to help with her symptoms. She reports that this is the first place where she felt like she belonged. Even though she wasn't allowed medication to treat her symptoms, staff members at the hospital were able to help her manage her behaviors and lead a more stable life. She stayed long term in the hospital (1 year), and ended up returning home even though she didn't want to go, interrupting her mental health recovery process. By not allowing D to take medication for her mental illness, she believes her parents created an environment that caused her to use alcohol and other drugs to control symptoms that she could not manage outside of the hospital environment. She continued to run away from home, drink heavily to manage her mental illness, and make life difficult for her parents. She eventually ended up in foster care due to this behavior.

Her foster family had different views on medication, allowing her to be medicated based on her symptoms. However, her addiction had begun, and she continued to use substances, not caring whether her symptoms were managed or not. Her foster care worker finally allowed her to live with her grandmother, one of the family members she consistently ran to. While in her grandmother's care, she had little to no supervision and was able to drink and roam at will.

FY 2009 Summary of Persons Served

Treatment Programs Served:
73,334 Persons

Gender:

Male	64.7 %
Female	35.3 %

Age:

12 - 17	5.4 %
18 - 35	50.8 %
36 - 54	38.5 %
55 and older	5.2 %

(Median age is 32)

Race/Ethnicity:

White	66.0 %
African Amer./Black	27.1 %
Hispanic	2.9 %
Native American	1.3 %
Multiracial/Other	2.7 %

Primary Substance Reported at Admission:

Alcohol	42.2 %
Marijuana	20.7 %
Heroin	15.5 %
Other Opiates *	8.9 %
Cocaine	10.3 %
Methamphetamine	0.9 %
All Others	1.6 %

** includes prescription drugs*

[Additional Demographic Info]
[Primary Substance by County]

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

D was always a binge drinker. She drank to get drunk and black-out. D first became pregnant at age 17. At that time she moved out of state to be with her birth mother, who was also mentally ill. While out of state, she gave birth to an additional two children, continued to use substances, had little stable support for her mental health or addiction concerns, no access to medications, and became involved in gang activity. Her involvement with the gang was such that she began to fear for her life, and made the decision to return to Michigan.

19 years old is the average age of first use for all those entering substance abuse treatment programs in Michigan.

About one out of every six of youth ages 14 to 18 report binge drinking each month. *(NSDUH State Estimates 2005-2006)*

In FY 2009, about 3,900 youth under 18 were admitted into treatment programs for a substance use disorder. 70% of those reported marijuana as primary drug.

826,000 estimated persons in Michigan, over the age of 12, are currently dependent on or abusing alcohol or an illicit drug (about one out of every 10 residents). Many are not aware that they have a problem and many of those who do know that they have problem don't seek treatment because they feel that they can't afford it. *(NSDUH Sub-state Estimates 2004-06)*

Accompanying D on her return to Michigan was the father of her youngest child, who sold drugs out of their home to support the family of five. She finally went into treatment because of her 3 small children. She had started using cocaine while living with her boyfriend, but was not drinking during this time. Their home was raided and her boyfriend went to prison for drugs. She was very upset that the raid by police took place with the kids in the house, and this served as somewhat of a wake-up call. D still had no medication to help with her mental illness, and experienced a recent crisis when her children were removed by Children's Protective Services, as a result D returned to drinking. However, she was able to be reunified with her children, despite her drinking. Her family and non-addicted friends became frustrated and exhausted by D's needs and the needs of her children, and withdrew their support over time. As she continued to struggle with her mental illness, self-medicating and subsequent addiction, this lack of support from those closest to her led to further isolation and the inability to manage her life and children.

Relapse is common. About 6 of every 10 persons served in FY2009 had received treatment services before.

Relapse

The medical system does not regard relapse as a failure of treatment. Relapse in addiction occurs at similar rates to other chronic medical conditions such as diabetes, hypertension and asthma. Like other chronic relapsing disorders, addiction to substances may require a change in treatment until abstinence is achieved. This is similar to when people with diabetes do not take their medication or fail to exercise as outlined by their physicians; their non-compliance and relapse are not seen as a failure, rather their treatment is altered to more effectively address their problems.
(Alcohol and Other Drug Problems: A Public Health and Public Safety Priority 2008)

A friend suggested she attend Adult Children of Alcoholics meetings, both to learn about her behavior and to help build a support system in her life. She felt some benefit from the meetings, but did not feel it was really working for her or her addiction and recovery process. She tried AA, but really didn't like it. Still trying to get some help, she spoke with a worker at the health department who suggested she go to treatment. She tried outpatient treatment through the health department. She had multiple sessions during which she was not honest about her addiction and felt that she was doing a great job snowing her counselor. While D really wanted help with her problems, she was not ready to accept the realities of her mental illness and addiction. At the last session, the counselor told her she was not really an alcoholic. This was what she had been waiting to hear!

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)

As a result of this professional validation of her own beliefs, D wanted to celebrate. Throughout her night of celebrating, she had lingering doubts regarding her addiction and second guessed herself the whole night. During the time she was out drinking, she kept questioning herself, was she really an alcoholic, is this what normal people did and etc. She stayed out until the bar closed despite the fact that most of her friends had left earlier. On the way home, she stopped at the store to pick up more alcohol to take home with her. She was stopped by the police after leaving the store and cited for Driving Under the Influence. During the night in jail, she decided she really was an alcoholic. When she got out of jail the next day, she immediately went to an AA meeting and called her counselor. She wanted to return to outpatient counseling, but the program was closing due to funding cuts.

The clients, including D, stood up in support of the program. They participated in demonstrations and contacted everyone they could think of, but the program closed anyway. This was D's first experience with standing up for what she felt was right and advocating for something, and it felt good. She felt very strongly that the counselor had helped her in her recovery process and hated to see the program go away. She kept herself going and stayed sober.

Her persistence at her recovery proved beneficial. D had a better experience at AA this time, and this group became her primary support during her early recovery period. At about a year sober, someone there took her aside and talked to her about mental illness and recommended she see a psychiatrist. The psychiatrist diagnosed her with Bipolar Disorder and prescribed medication. She has had a hard time finding the best medication, but keeps trying. D's immediate family still disapproves of medications despite the obvious alleviation of symptoms she continues to experience. She persisted in AA, which continued to be a source of support for her developing recovery. In addition, she began to work in the substance use disorder treatment field, and enjoyed being able to help others, as well as the support of her co-workers.

One of every three persons who received treatment during FY2009 also had a mental health disorder (36.8%).

D went through inpatient mental health treatment again at 10 years sober. She had stopped taking her anti-depressant, because she felt like she could not meet the demands she was experiencing in her life. She wanted to experience the manic phase of her illness so she could get a lot accomplished, both at home and in her educational pursuits. During this time, she figured out that she needed to put her sobriety and her mental health together or she wasn't going to be successful. D saw a therapist at the hospital on an outpatient basis following her hospitalization.

D returned to the hospital again at 12 years sober. She was struggling to afford her medications, the high cost was prohibitive, and she didn't know where to go for help. She knew that she would not be able to cope without her medications and was afraid she would relapse without help. She was able to access the publicly funded system for treatment and medication assistance.

Her mental health and addiction recovery path has not been a pleasant or completely successful journey. D's oldest child shows symptoms of Fetal Alcohol Spectrum Disorder (FASD) and due to the behavioral and emotional problems associated with FASD was relinquished to foster care at age 8. D's youngest child also had emotional and behavioral difficulties and went to live with the father at an early age. This child has subsequently been diagnosed with Bipolar Disorder, and struggles with the symptoms of mental illness. All three children have children of their own, and one has been through treatment for substance abuse. D's relationship with the children varies, but she continues to work towards repairing what was damaged by her addiction and mental illness, while helping them get the assistance they need. It is obvious that maintaining these relationships is important to her, and by supporting her children in ways that she was not, she hopes to shorten their road to recovery and stability.

Babies & Substance Abuse

Alcohol (wine, beer, or liquor) is the leading known preventable cause of mental and physical birth defects in the United States. It is estimated that each year in the United States, 1 in every 750 infants is born with a pattern of physical, developmental, and functional problems referred to as fetal alcohol syndrome (FAS), while another 40,000 are born with fetal alcohol effects (FAE).

Is Alcoholism Inherited?

Children of alcoholics are 4 times more likely to become alcoholics when compared to other children, although the child's environment and habits are also factors.
(American Academy of Child and Adolescent Psychiatry)

Investigations have shown that there can be a certain hereditary tendency for developing alcohol problems. It is also known that certain personality characteristics, which are partly inherited, influence the risk of becoming addicted. People who are often anxious, and who seek excitement in life, and who are more antisocial, will more often become alcoholics.
(http://web4health.com)

D feels that the key to her recovery is to stay on her medication, and get help when she needs it. Her addiction is tied to her mental illness, and through her many experiences with counseling and doctors, she has a very keen understanding of this. She continues to attend AA meetings, works with the local Coordinating Agency, and helps others when she can. By staying involved in new developments in the substance use disorder system, she stays on top of her own recovery and continues to develop the skills necessary to help others on their journey. She feels she wouldn't have made it without the assistance she received through public funding. Her

prescriptions, outpatient treatment for both addiction and mental health, some brief mental health inpatient treatment, day programming (twice), and her health plan have all been publicly funded.

Then and Now

D's experiences with the substance abuse and mental health system were fairly common during the time that she was actively seeking services. Both systems now offer treatment for co-occurring disorders, so that a person who begins treatment at a substance use disorder treatment agency can also receive mental health services at that location and vice versa. Those agencies offering treatment for substance use disorders have made connections with doctors and psychiatrists to ensure that their clients can be evaluated for and have access to needed medications.

Mental Health and Substance Use Disorders

HELPGUIDE.org reports that people who self-injure have some common traits - one being that they have co-existing problems with obsessive-compulsive disorder, substance abuse, or eating disorders. The Hispanic Journal of Behavioral Sciences confirmed this in a 2007 study that shows an extensive correlation between substance abuse, self-mutilation, suicide attempts, and histories of physical and/or sexual abuse.

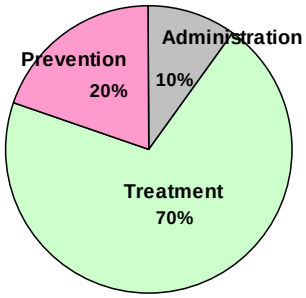
It is typical for clients to be facing two or more serious challenges in addition to their substance use disorder. These include major trauma, mental health disorder, criminal justice system involvement, and unstable/unsafe living environment. The BSAAS Strategic Plan takes this complexity into account.

Substance abuse is a chronic disease. Understanding that an individual with a chronic disease relapses has proven essential in the development of substance use disorder services. Research shows that people who engage in treatment have better success with long term sobriety if they receive additional supports to compliment formal treatment. To that end, the substance use disorder field has begun to provide services that assist clients in getting established with needed recovery supports. These connections to services can include recovery support groups, employment services, education assistance, housing assistance, connections to medical services, etc. This population often does not have the luxury of a "normal" support system. To remedy this, the substance use disorder field is moving to ensure that clients are connected with the supports that others may normally have available through family or a network of friends.

Had the recovery approach to services been available while D initially began working on her addiction and mental illness, she may have experienced a very different outcome. Services are now available to help her gain the support she was lacking, understanding and guidance to stay on her medication, and connections to the community to access other resources as she needed them. Practitioners, clients, and persons in recovery are a part of Michigan's system transformation towards a recovery oriented system of care. Michigan's recovery oriented system of care will promote individuals and families, healthy and safe communities, wellness, recovery and a fulfilling quality of life.

Primary Drug	FY2000	FY2009	Admission Trends Noted
Alcohol	34,603	28,981	Alcohol remains the most frequently reported drug at the time of admission; twice as many people identified it compared to any other substance (over 40% of all admissions during FY2000-FY2009).
Marijuana	10,099	11,707	Except for slight increases from FY2002 to FY2006, marijuana admissions have remained relatively stable.
Heroin	7,264	12,522	Admissions for both heroin and other opiates (including illicit methadone) have seen persistent and steady increases throughout the last ten years.
Other Opiates	1,494	7,779	
Cocaine/Crack	11,604	7,125	While crack and cocaine admissions increased in the middle of the decade, they have declined during each of the past two years.
Methamphetamine	101	502	Admissions for methamphetamine peaked in FY2005, and after a two year drop, have stabilized below the FY2005 high water mark of 913 admissions.

Additional information about the Bureau of Substance Abuse & Addiction Services …



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

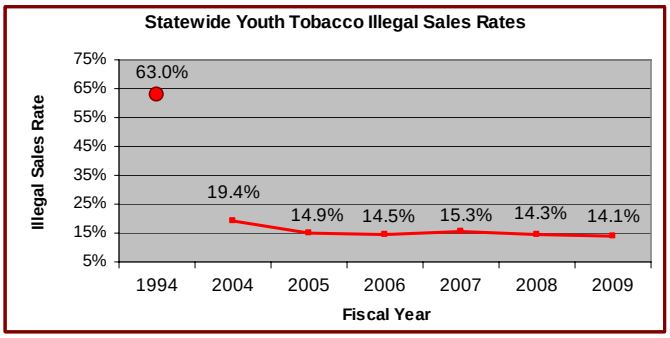
In Fiscal Year 2009, BSAAS administered over $66 million in federal funds and over $20 million in state funds to purchase services on behalf of Michigan residents. Please see our Legislative Report for spending details and information on providers (including types/quantities of services, and amounts/sources 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 FY2009, 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	189
Detroit Metro (outside Wayne Co.)	182
East Region	46
West Region	48
Upper Peninsula (UP)	7
Northern & UP - SUD & Prbl Gambling	127
Statewide During FY 2009	599

Youth Tobacco Sales Rates, Synar: A key target for prevention 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 youths under age 18.



Annual random inspections of tobacco retailers, Synar Surveys, began in 1994. Since 2001, our annual survey has shown sales to underage individuals consistently below 20%, with the 2009 rate of 14.1% being the lowest to date. Please see our Youth Access to Tobacco and Synar Info webpage for more details.

For More 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 Client Demographics (includes Correctional/Judicial involvement statistics)

Primary Substance Reported by County at Admission

Women & Pregnant Women Clients - Admissions and Discharges

Mental Health Disorder as Factor in Treatment

Treatment Services Penetration Rates

Treatment Client Activity Summary (TEDS)

Treatment Discharge Reasons

Treatment Outcomes in Abstinence, Employment, and Housing at Discharge

Prevention - - Communicable Disease

Our website also has information about other programs we oversee:

Strategic Prevention Framework / State Incentive Grant (SPF/SIG)

Prescription Drug Abuse