OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

EVALUATION REPORT

Substance Abuse Treatment

FEBRUARY 2006

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OFFICE OF THE LEGISLATIVE AUDITOR

State of Minnesota • James Nobles, Legislative Auditor

February 2006

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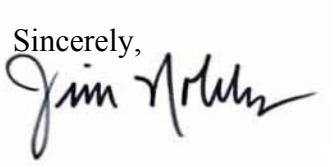
Substance abuse does great harm to individuals, families, and society. While some types of treatment may mitigate the harm, research shows that not all treatment is effective.

Our evaluation found that Minnesota needs stronger leadership to help ensure that effective treatments are more widely available. The Department of Human Services should foster the development of effective treatment options, particularly in parts of the state that are underserved. In addition, the department should more closely monitor local decisions that place people in publicly-funded treatment to better ensure that appropriate services are being used.

We found that many chemically dependent prisoners have not received any treatment during or after their time in prison. Thus, we recommend that the Department of Corrections work with the Legislature to develop more treatment opportunities for prisoners. We also recommend that the department work with local corrections agencies to more effectively plan for inmates' post-prison treatment needs.

This report was researched and written by Joel Alter (project manager), Valerie Bombach, and Kelly Lehr. During our evaluation, we received full cooperation from the Department of Human Services, Department of Corrections, Department of Public Safety, Sentencing Guidelines Commission, and county human services and corrections agencies.

Sincerely,



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Summary

Stronger state leadership and oversight are needed to improve the availability and effectiveness of substance abuse treatment in Minnesota.

Major Findings:

- Broad claims—positive or negative—about the effectiveness of substance abuse treatment are misleading. Research has produced mixed evidence, with some studies showing that certain types of treatment can achieve positive client outcomes, while others have little evidence of effectiveness. (pp. 18-21)
- The Department of Human Services has not provided enough oversight of county practices to ensure that clients are placed in appropriate treatment, nor has it done enough to foster the development of sufficient treatment options to effectively meet clients' needs statewide. (pp. 36, 46, 55-62)
- Despite uniform placement criteria, there is wide variation in counties' use of publicly-funded substance abuse treatment for low income persons, and the treatment clients receive depends partly on where they live. (pp. 37-41)
- Inmates who complete substance abuse treatment programs in prison have lower overall arrest and conviction rates following release than (1) inmates who complete short education programs, and (2) untreated inmates. However, Minnesota prisons do not have enough capacity in their substance abuse treatment programs to serve all of the inmates who need treatment. (pp. 92, 103-105)
- Few inmates deemed chemically dependent by prison staff enroll in treatment upon release from prison, which partly reflects inadequate planning by state and local corrections officials to address inmates' post-prison treatment needs. (pp. 93-94)

Key Recommendations:

- The Department of Human Services should (1) strengthen its oversight of local assessment and referral practices; (2) develop strategies to increase the availability of effective treatment options; (3) improve placement decisions by providing counties with more information on treatment program outcomes and quality; and (4) assess options for improving the equity of state laws governing county obligations to pay for treatment costs. (pp. 50, 68, 69, 82)
- The Department of Corrections should (1) develop a strategy for improving the post-release outcomes of chemically dependent inmates who do not complete treatment in prison; (2) present the Legislature with a plan for ensuring that more offenders receive the treatment they need during and after prison, and (3) work with local agencies to improve post-release substance abuse plans for individual inmates. (pp. 95, 96, 108)

State policy supports the use of substance abuse treatment, although evidence about treatment outcomes is limited.

Report Summary

State policy supports the use of treatment for individuals with substance abuse problems. For example, state law says that "the interests of society are best served by providing persons who are dependent upon alcohol or drugs with a comprehensive range of rehabilitative and social services."[1]

There were nearly 42,000 admissions of Minnesota residents to substance abuse treatment in 2004, and 55 percent were publicly-funded. The main source of public funding was the Consolidated Chemical Dependency Treatment Fund. State appropriations for this fund have increased in recent years (reaching $63 million in fiscal year 2006), but the 2003 Legislature discontinued funding for persons with household incomes above the federal poverty line.

Effectiveness Studies Show Mixed Results, And Information On Minnesota's Community Programs Is Limited

Broad claims that treatment is effective or ineffective are misleading. There are many forms of substance abuse treatment, of various lengths and intensities, provided to persons with different needs, and implemented with various degrees of skill. National research has produced a mix of positive and negative findings regarding the effectiveness of substance abuse treatment. A limited number of studies have isolated the impact of treatment on clients, apart from other variables.

Studies have demonstrated the potential for certain counseling-based programs to reduce clients' chemical use and improve their social functioning, based on comparisons to persons who did not undergo treatment or persons in other types of programs. Also, there have been favorable outcomes for some other approaches, such as maintaining heroin addicts on methadone for a period of time and having primary care professionals conduct brief interventions with problem drinkers. But there is still much to learn about which treatments work best in various circumstances. There are also certain subgroups of clients, such as adolescents and methamphetamine users, for whom there has been a limited amount of rigorous research. The Department of Human Services should develop an inventory of the approaches used in Minnesota's treatment programs so that it can ensure that there are appropriate, effective placement options for clients throughout the state.

In general, research has shown that persons who complete their treatment programs or remain in programs for longer periods tend to have better outcomes. In Minnesota, 60 percent of persons who entered publicly-funded treatment in 2004 "completed" their programs, while 31 percent left "without staff approval." The National Institute on Drug Abuse has suggested that treatment should generally last for at least 90 days, and there is a growing consensus that many chemically dependent persons need extended periods of services, even if some are provided at low levels of intensity. However, the duration of many treatment episodes in Minnesota is shorter than 90 days, and the average length of treatment has been declining.

State regulations have various provisions that are intended to ensure that clients receive individualized treatment, but many local corrections and human services officials told us that programs need to be more effectively tailored to meet individual clients' needs. For example, 96 percent of the directors of community-based corrections agencies favored stronger emphasis by substance abuse treatment programs on addressing clients' mental health needs.

[1] *Minnesota Statutes* 2005, 254A.01.

Counties are the "gatekeepers" of Minnesota's publicly-funded chemical health program, and the Department of Human Services should more closely monitor their assessment and referral practices.

Legislators have expressed some concern about repeated placements of clients into community-based treatment. We found that, among persons over age 30 who were discharged from publicly-funded treatment in 2004, 37 percent had no prior episodes of treatment in Minnesota since 1995 and 22 percent had only one episode, while 20 percent had at least four prior episodes. Thus, some clients experience frequent readmissions, but this is not the norm.

Existing data do not conclusively show whether Minnesota's treatment programs are effective. However, the Department of Human Services should provide counties and tribes with better information to help them judge program outcomes and quality, including information on programs' client completion rates, client readmission rates, compliance with state regulations, and peer reviews.

Use Of Community-Based Treatment Reflects Significant Variation In Program Availability And Local Referral Practices

Public funding pays for the substance abuse treatment of persons who meet state-prescribed financial and clinical eligibility criteria. Despite uniform criteria, there are wide variations in the counties' use of publicly-funded treatment for low income persons, and the treatment clients receive depends partly on where they live. For example, the average number of adult admissions in 2003-04 to publicly-funded treatment per 1,000 adult residents in poverty ranged from 22 in Kittson County to 168 in Mahnomen County. The range among counties in the Twin Cities area was from 53 in Dakota County to 129 in Anoka County. In addition, some counties made most of their placements to outpatient treatment, while other counties relied much more on other types of care.

To some extent, these differences reflect variations in assessment practices. Counties and American Indian tribes are "gatekeepers" in Minnesota's chemical health system, assessing residents and making referrals to publicly-funded treatment. Some counties are much more likely than others to find the clients they assess to be chemically "dependent" (rather than the less serious diagnosis of chemically "abusive"), and the types of programs to which clients can be referred depends partly on this determination. Also, local agencies use a variety of assessment instruments, which differ in how thoroughly they document clients' underlying problems.

The Minnesota Department of Human Services is required by law to monitor "the conduct of [substance abuse] diagnosis and referral services," but it has not done in-depth reviews of local practices for several years. The department should (1) provide local agencies with information on "best practices" in substance abuse assessment, including model protocols for assessment of adults and adolescents, and (2) initiate ongoing compliance monitoring of local assessment and referral practices.

Variations in treatment referrals also reflect the uneven availability of treatment programs around the state, and the department should develop a strategy for addressing gaps in treatment services. About 51 percent of publicly-funded admissions to treatment in 2004 were at programs outside of the client's home county. Local corrections and human services officials expressed concerns about the availability of treatment in halfway house and "extended care" settings, as well as treatment and related services for adolescents, persons with dual diagnoses of mental illness and chemical dependency, persons with cognitive limitations, and methamphetamine users.

In addition, local corrections officials told us that criminal offenders'

financial eligibility for publicly-funded, community-based treatment has affected whether these offenders enroll in treatment. Ineligibility for public funding could be one reason why nearly half of the offenders sentenced to probation in 2003 for felony-level substance use or possession did not enter community-based treatment prior to sentencing or during the period immediately following their sentencing date or release from jail.

Prisons Need More Treatment Beds And Better Planning For Services Following Release

Most chemically dependent inmates do not complete treatment in prison or when they are released.

Persons imprisoned for drug-related offenses now comprise 25 percent of Minnesota's prison population, up from 9 percent in 1990. In addition, a high percentage of other types of offenders in Minnesota's prisons have histories of substance abuse. All but two of Minnesota's prisons have programs for inmates with substance-related problems. Some are treatment programs, lasting 6 to 12 months and providing a variety of group and individual counseling, while others are substance abuse education programs, lasting three months or less and offering no individual counseling.

Among chemically dependent inmates released from prison in early 2004, only 25 percent participated in substance abuse treatment prior to release (17 percent completed a program and another 9 percent started a program but did not complete it). Another 30 percent participated only in short-term education programs prior to release. Many inmates do not serve enough time in prison to complete a treatment program, but there is also a shortage of treatment beds to meet the needs of inmates with substance use problems.

Among chemically dependent inmates released from prison in 2002, a majority had arrests or convictions for new offenses within three years (including 36 percent with arrests or convictions for drug or alcohol crimes). Prisoners who completed the Challenge Incarceration Program (a boot camp with a chemical dependency treatment component) and other prison-based treatment programs generally had lower post-release recidivism rates than those who failed treatment or completed short-term education programs. It is unclear whether the lower recidivism rates for treatment completers were attributable to treatment rather than other factors, such as the offenders' motivation to change.

When inmates near their dates of release from prison to correctional supervision in the community, the Department of Corrections and supervising agency develop plans for helping the offenders succeed in the community. But prison "release plans" have contained little direction regarding post-release chemical use assessments and programming. In addition, less than 10 percent of chemically dependent inmates released from prison to community supervision in 2004 entered community-based treatment in the six months following their release. The Department of Corrections should develop a strategy for improving the availability of treatment in prisons and ensuring that chemically dependent offenders receive the treatment they need following release.

Introduction

Abuse of alcohol and other drugs has widespread impacts. It often leads to reduced personal productivity, harmful health effects, and damaged personal relationships. In addition, substance abuse can have broader social impacts, contributing to child abuse, welfare dependence, and criminal activity. Thus, interventions that reduce substance abuse may serve important public purposes. Accordingly, Minnesota law declares that it is the state's policy to provide chemically dependent people with rehabilitative services.[1]

But policy makers have asked many questions about substance abuse treatment in recent years. In April 2005, the Legislative Audit Commission directed our office to evaluate substance abuse treatment in Minnesota communities and state prisons. Our evaluation addressed the following questions:

- **Are substance abuse treatment programs effective?**
- **Is there adequate treatment for chemically dependent criminal offenders sentenced to prison and probation?**
- **To what extent do counties vary in how they assess and refer individuals to community-based substance abuse treatment, and should policy makers be concerned about these variations?**
- **Do public agencies use reasonable methods to determine individuals' needs for substance abuse treatment?**

We used existing data from the departments of Human Services, Corrections, and Public Safety to assess outcomes for persons who entered treatment programs. For example, we examined the extent to which chemically dependent inmates who participated in prison-based treatment programs were arrested and convicted of new crimes following release from prison. For community-based treatment, we examined measures such as program completion rates and rates of readmission to treatment following treatment discharge. We recognize that factors other than treatment may have contributed to the outcomes we observed, so we also examined findings from previous studies of substance abuse treatment.[2]

We looked at treatment use and availability in Minnesota, including variation among counties. Local human services agencies play a key role in treatment

[1] *Minnesota Statutes* 2004, 254A.01.

[2] We did not conduct "experimental" research, in which persons are randomly assigned to various programs or to no treatment at all. Such studies provide more definitive evidence of treatment's impacts.

placement decisions, and we conducted site visits to eight counties and contacted some others by phone.[3] Publicly-funded treatment for low-income persons accounts for more than half of Minnesota's substance abuse treatment admissions, so we gave particular attention to its use. We looked at variation among counties in the share of treatment costs they bear, but we did not conduct an in-depth evaluation of the formula used to allocate state treatment funds to counties.

Because of the close association between substance use and crime, we also looked at treatment availability and use among Minnesota's criminal offenders. Specifically, we examined the extent to which chemically dependent offenders enrolled in treatment programs in prison, after prison, and during probation. Community-based corrections agencies supervise many offenders with substance abuse problems, so we conducted a statewide survey of the directors of these agencies to better understand their perceptions about treatment availability and adequacy.[4]

Chapter 1 provides background information on substance abuse treatment services in Minnesota communities and prisons. Chapter 2 reviews previous research on treatment effectiveness. The next two chapters examine community-based treatment in Minnesota, including client placements (Chapter 3) and certain treatment outcomes (Chapter 4). The final two chapters examine prison-based treatment, including availability (Chapter 5) and rates of post-prison recidivism and relapse (Chapter 6).

Finally, we often use the terms "substance abuse" and "chemical dependency" interchangeably in this report. Chapter 1 notes the diagnostic distinctions between "abuse" and "dependency," and Chapter 3 examines differences among counties in their diagnoses, but elsewhere in the report we do not differentiate between "substances" and "chemicals" or between "abuse" and "dependency."

[3] We did not review individual clients' case files during our site visits, such as assessment reports or treatment plans.

[4] To provide probation services, each Minnesota county (1) participates in the state's Community Corrections Act (CCA) and receives state funds for this purpose, (2) receives "county probation officer" (CPO) funding from the state, or (3) obtains services from the Minnesota Department of Corrections (DOC). We surveyed and received responses from all of the 54 directors of CCA agencies, CPO agencies, and DOC's district offices and supervised release offices.

1 Background

SUMMARY

Minnesota law supports treatment and other rehabilitative services for people with substance abuse problems. The state has provided significant funding for community-based treatment for low income persons, as well as funding for substance abuse programs in most of the state-operated prisons. Current state rules that define chemical "dependency" do not reflect diagnostic criteria commonly used by mental health professionals, although changes to the outdated definition are scheduled for implementation in 2007. Alcohol remains the predominant substance abused by people entering treatment in Minnesota, but the number of people entering treatment for methamphetamine use grew dramatically during the past decade.

A variety of factors contribute to chemical dependency, including social influences, genetic predispositions, the nature and availability of the substances abused, and underlying psychological disorders.[1] Substance abuse involves voluntary behaviors, at least initially, but it may also evolve into compulsions and loss of control. Substance abuse treatment takes many forms, and relapses are common. This chapter provides background information on substance abuse treatment, and it addresses the following questions:

- **How are substance "abuse" and "dependency" defined?**
- **What types of treatment programs are offered in community-based and prison-based settings?**
- **What roles do Minnesota's state and local governments play in overseeing substance abuse treatment programs, paying for treatment, and helping individuals access treatment services?**
- **What are the primary substances abused by persons entering treatment, and how has this changed in recent years?**

KEY TERMS

Substance "Abuse" and "Dependency"

Definitions of chemical "abuse" and "dependency" are important because Minnesota's administrative rules prescribe the types of publicly-funded treatment for which persons are eligible, based partly on whether the person is determined

[1] George E. Vaillant, "Natural History of Addiction and Pathways to Recovery," in *Principles of Addiction Medicine,* 2nd ed., ed. Allan W. Graham and Terry K. Schultz (Chevy Chase, MD: American Society of Addiction Medicine, 1998), 295-308.

to be chemically dependent rather than chemically abusive.[2] As shown in Table 1.1, the rules define chemical abuse as less severe than chemical dependency.[3] We found that:

- **Minnesota's criteria for determining who is "chemically dependent" are not consistent with current professional criteria for diagnosing mental health disorders.**

The Minnesota rules that define "abuse" and "dependency" are based on the 1980 edition of the American Psychiatric Association's *Diagnostic Statistical Manual.*[4] The rules require that dependency be based, in part, on evidence of

State administrative rules define substance "abuse" and "dependency."

Table 1.1: Definitions of Chemical Abuse and Dependency in Minnesota Rules

Chemical abuse is a pattern of inappropriate and harmful chemical use which exceeds social or legal standards of acceptability, the outcome of which is characterized by *three* or more of the following indicators:

- Weekly use to intoxication.
- Inability to function in a social setting without becoming intoxicated.
- Driving after consuming sufficient chemicals to be considered legally impaired, whether or not an arrest takes place.
- Excessive spending on chemicals that result in an inability to meet financial obligations.
- Loss of friends due to behavior while intoxicated.
- Chemical use that prohibits one from meeting work, school, family, or social obligations.
- Continued use of chemicals by a woman after she has been informed that she is pregnant and that continued use may harm her unborn child.

Chemical dependency is a pattern of pathological use accompanied by the physical manifestations of increased tolerance to the chemical or chemicals being used or withdrawal syndrome following cessation of chemical use. "Pathological use" means the compulsive use of a chemical characterized by *three* or more of the following indicators:

- Daily use required for adequate functioning.
- An inability to abstain from use.
- Repeated efforts to control or reduce excessive use.
- Binge use, such as remaining intoxicated throughout the day for at least two days at a time.
- Amnesic periods for events occurring while intoxicated.
- Continuing use despite a serious physical disorder that the individual knows is exacerbated by continued use.
- Continued use of chemicals by a woman after she has been informed that she is pregnant and that continued use may harm her unborn child.

SOURCE: *Minnesota Rules* 2005, 9530.6605, subp. 6, 7, 18, and 20.

[2] For example, the rules specify that inpatient (or "primary rehabilitation") treatment may be used only for persons assessed to be chemically dependent. In contrast, outpatient treatment may be used for persons who are either chemically dependent or chemically abusive.

[3] In Minnesota rules, chemical "dependency" is defined as involving a "pattern of pathological use," while chemical "abuse" has no such pattern.

[4] The *Diagnostic Statistical Manual* has the most widely used criteria in the United States for determining psychiatric disorders.

physical tolerance of a chemical or physical withdrawal symptoms following cessation of chemical use. But, since 1987, the *Diagnostic Statistical Manual* has treated physical tolerance and withdrawal as no different from other symptoms that can characterize "dependence." As shown in Table 1.2, the manual now regards physical, psychological, and behavioral symptoms of dependency in a balanced way, rather than emphasizing physical symptoms.[5] Unlike current mental health criteria, Minnesota rules still require evidence of physical dependency to make a diagnosis of chemical dependency. Thus, Minnesota's criteria to determine eligibility for particular types of publicly-funded treatment are not consistent with the most widely recognized diagnostic standards in the substance abuse profession.

In recent years, Minnesota's criteria for identifying chemical dependency differed from accepted professional standards.

The Minnesota Department of Human Services (DHS) has been drafting revisions to the rules that govern chemical use assessments, with the intention of implementing new rules on January 1, 2007. The most recent draft states that, to qualify for treatment, individuals must meet the criteria for "substance use

Table 1.2: American Psychiatric Association Criteria for Substance Dependence

Substance dependence is a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by *three* or more of the following indicators, occurring at any time in the same 12-month period:

1. Tolerance, as defined by either of the following:
   - ✓ A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
   - ✓ Markedly diminished effect with continued use of the same amount of the substance.
2. Withdrawal, as manifested by either of the following:
   - ✓ The characteristic withdrawal syndrome for the substance.
   - ✓ The same (or a closely related) substance is taken to relieve or avoid symptoms.
3. The substance is often taken in larger amounts or over a longer period than was intended.
4. The person experiences a persistent desire (or unsuccessful efforts) to reduce or control substance use.
5. A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance, or recover from its effects.
6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

SOURCE: American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., Text Revision (Washington, D.C.: American Psychiatric Publishing, 2000).

[5] Samuel A. Ball and Therese A. Kosten, "Diagnostic Classification Systems," in *Principles of Addiction Medicine*, 2nd ed., 280.

disorder" in the current version of the *Diagnostic Statistical Manual*.[6] The draft rules, if adopted, would eliminate the outdated definitions of "dependency" and "abuse" that are still being used.

Substance-Related "Treatment"

State administrative rules define "treatment" as:

> [A] process of assessment of a client's needs, development of planned interventions or services to address those needs, provision of services, facilitation of services provided by other service providers, and reassessment. The goal of treatment is to assist or support the client's efforts to alter the client's harmful pattern of chemical use.[7]

Minnesota has about 300 state-licensed treatment programs.

There are about 300 substance abuse treatment programs licensed by the Department of Human Services. Table 1.3 shows services that licensed treatment programs must provide, as well as several "optional" services. Treatment programs also employ a variety of treatment approaches and philosophies. For example, the widely-referenced "Minnesota model" of treatment incorporates the "12 steps" of Alcoholics Anonymous (AA) and views substance abuse as resulting from underlying biological or psychological vulnerabilities.[8] In contrast, some treatment approaches start with the assumption that substance abuse is a learned, maladaptive behavior and aim to change clients' distorted thinking about substance use.[9] In addition, treatment programs have varying goals. Some programs view total abstinence from alcohol and drugs as an essential part of recovery, while other programs emphasize reduced consumption.[10]

Unfortunately, there is no systematic, statewide inventory of the types of treatment approaches used by various programs, or the extent to which the programs offer the optional services listed in Table 1.3. Thus, it is hard to characterize which approaches and services are the most common. DHS staff told us that they used to produce a statewide program directory but stopped because the information was self-reported by treatment providers and considered to be of limited value.[11] However, some county officials told us that a statewide

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[6] Department of Human Services, "Proposed Permanent Rules Relating to Chemical Dependency Treatment," July 31, 2004.

[7] *Minnesota Rules* 2005, 9530.6405, subp. 19.

[8] Unlike Alcoholics Anonymous self-help groups, "Minnesota Model" treatment programs are professionally directed.

[9] Paige Crosby Ouimette, John W. Finney, and Rudolf H. Moos, "Twelve-Step and Cognitive-Behavioral Treatment for Substance Abuse: A Comparison of Treatment Effectiveness," *Journal of Consulting and Clinical Psychology* 65, no. 2 (1997): 230-240.

[10] Medications may also be an important part of a client's substance abuse treatment. For example, there are medications that reduce cravings, discourage alcohol use, or address psychiatric disorders. But, while treatment programs may administer medications that have been prescribed by a physician (if properly staffed to do so), program staff are not permitted to prescribe medications.

[11] In response to our request for information about the nature of Minnesota's treatment programs, DHS provided us with the brief descriptions of chemical dependency programs from MinnesotaHelp, an online database intended to help consumers locate social services agencies near their homes. The database is sponsored by DHS and several other agencies. The program descriptions in MinnesotaHelp varied considerably in their scope and level of detail.

Table 1.3: Services in Community-Based Treatment Programs

Mandatory Services	Optional Services
• Individual and group counseling	• Case management services
• Client education (e.g., regarding health impacts of chemical use and ways to avoid inappropriate chemical use)	• Relationship counseling
• "Transition services" (e.g., to help clients integrate lessons learned in treatment into daily living)	• Therapeutic recreation
• Services to address issues related to co-occurring mental illness	• Stress management
	• Living skills development
	• Employment or educational services
	• Socialization skills development
	• Room, board, and supervision provided at the treatment site

SOURCE: *Minnesota Rules* 2005, 9530.6430, subp. 1 and 2.

inventory would be a helpful tool for their staff to consult when making treatment placements. In Chapter 3, we recommend the development of a statewide program inventory, partly to provide local agencies and the general public with more consistent information as they choose from among the various programs. Also, an inventory could help state and county agencies exercise program oversight, by helping to identify gaps in services or differentiating programs when analyzing client outcomes.

COMMUNITY-BASED TREATMENT IN MINNESOTA

In this report, we use the term "community-based treatment" to refer to all substance abuse treatment programs that are licensed by DHS. State law requires DHS to license programs that provide services such as care, supervision, and rehabilitation outside of a person's home.[12] Minnesota's licensed programs serve a mix of privately- and publicly-funded clients in residential and non-residential settings.

State law supports treatment for persons who are chemically dependent.

State Policy

Minnesota law establishes a policy that supports treatment and other services for persons who are chemically dependent. Specifically, the law says:

[12] *Minnesota Statutes* 2004, 245A.02, subd. 10 and 14. DHS licenses the treatment programs offered in some of Minnesota's local jails, but it does not license programs in Minnesota's state prisons (discussed later in this chapter). Programs in the community that provide exclusively detoxification services are licensed by DHS separately from treatment programs and were not a part of our review.

> It is hereby declared to be the public policy of this state that the interests of society are best served by providing persons who are dependent upon alcohol or other drugs with a comprehensive range of rehabilitative and social services.[13]

Furthermore, the law states that: (1) treatment should be voluntary when possible; (2) treatment may not be denied on the basis of prior treatment; (3) treatment must be based on individualized treatment plans; (4) there must be a continuum of services available for persons leaving treatment programs; and (5) treatment must include all family members at the earliest possible phase of the treatment process.[14]

The emphasis of these policies on treating and providing services to substance abusers is balanced in the law by criminal penalties for the sale, possession, and manufacture of "controlled substances," as well as driving under the influence of alcohol or "controlled substances."[15] However, Minnesota's criminal statutes also address treatment, by requiring probation agencies to give judges information about certain offenders' treatment needs before the offenders are sentenced.[16]

State Oversight

The Department of Human Services oversees community-based substance abuse treatment services.

Minnesota law assigns the Department of Human Services primary administrative responsibility for the state's community-based substance abuse services.[17] For example, the law requires DHS to coordinate and review state agencies' activities related to substance abuse problems. DHS must prepare a state plan that sets goals and priorities for chemical dependency treatment, and it must prepare biennial reports for the Governor and Legislature that address service coordination, quality, duplication, and cost.[18]

DHS also has statutory responsibility to monitor the delivery of chemical dependency services. The law requires DHS to collect information regarding treatment programs' efficiency and effectiveness, and DHS must monitor the services that lead to client diagnosis and referral. DHS licenses treatment programs and develops the administrative rules that govern client placement and treatment.

In addition, DHS is required by law to monitor, conduct, and foster research related to chemical dependency services. The department must inform the general public about chemical use problems, and it must develop and disseminate new methods of treating chemical dependency.

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[13] *Minnesota Statutes* 2004, 254A.01.

[14] *Ibid.*

[15] *Minnesota Statutes* 2004, 152.021-152.027 and chapter 169A.

[16] *Minnesota Statutes* 2004, 609.115, subd. 8.

[17] In particular, see *Minnesota Statutes* 2004, 254A.03, subd. 1.

[18] DHS has periodically prepared statewide chemical dependency strategic plans. However, DHS has not reviewed the consistency of other state agencies' plans and budgets with its own goals and priorities, contrary to the law's requirements.

Finally, state law assigns fiscal responsibilities to DHS. For example, the department administers state and federal funding for chemical use programs, and it trains local agencies on procedures for handling payments.

Funding

More than half of Minnesota's treatment admissions are publicly funded, mostly with state funds.

Minnesota's main mechanism for providing publicly-funded substance abuse treatment to low income persons is the Consolidated Chemical Dependency Treatment Fund (CCDTF), created by the 1986 Legislature.[19] This fund combines state and federal resources to pay for treatment of persons who meet financial and clinical eligibility criteria. A complex statutory formula specifies how CCDTF funds are allocated among county and American Indian tribal agencies. Also, state law requires counties to pay for a portion of the cost of CCDTF-funded treatment, as we describe in more detail in Chapter 3.[20] Treatment programs are eligible to receive payment from CCDTF if they have a contract with a "host county" that includes a negotiated rate of payment for publicly-funded clients.[21]

We analyzed records on Minnesota treatment admissions[22] submitted to DHS by treatment providers and found that:

- **About 44 percent of admissions of Minnesota residents to substance abuse treatment programs in 2004 were funded by the state's Consolidated Chemical Dependency Treatment Fund.**

In addition, 11 percent of admissions were funded by prepaid health care plans that contract with the Minnesota Department of Human Services to serve persons enrolled in Medical Assistance, General Assistance Medical Care, and MinnesotaCare. The remaining 45 percent of admissions were paid by clients themselves or by their private health insurance.[23]

The Department of Human Services estimates that CCDTF payments to substance abuse treatment providers in fiscal year 2005 totaled $93.2 million, and payments to counties for related administrative costs totaled another $1.7 million. The state's share of these costs was $62.0 million (65 percent), and the counties' share was $17.3 million (18 percent).[24]

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[19] *Laws of Minnesota* 1986, chapter 394.

[20] *Minnesota Statutes* 2004, 254B.02.

[21] *Minnesota Statutes* 2004, 254B.03, subd. 1(b), requires that county boards, with the approval of the DHS commissioner, "select eligible vendors of chemical dependency services who can provide economical and appropriate treatment."

[22] Individuals sometimes have more than one admission during an "episode" of treatment, perhaps as part of a planned sequence of care. In addition, an individual may have multiple admissions to treatment over longer periods of time. Generally, an admission occurs when a client starts a new program, even if this occurs immediately after transferring from another one.

[23] The percentages presented here are based solely on Minnesota residents who entered treatment.

[24] Federal funds, MinnesotaCare reimbursements, and other sources paid for the remaining $15.5 million of CCDTF expenditures.

Block grants authorized by the state's Children and Community Services Act provide another source of state funding that counties can use for a variety of social services, such as chemical use assessments. Counties must submit biennial service plans to DHS to receive these funds.[25]

Client Assessment and Referral

County agencies assess and refer most publicly-funded clients.

State law requires county human services agencies to "provide chemical dependency services to persons residing within [their] jurisdiction who meet criteria established by the [Department of Human Services]."[26] Also, state rules require chemical use assessments of persons seeking publicly-funded treatment for chemical abuse or dependency (or for whom such treatment is sought).[27] County agencies conduct most of these assessments. In addition, organizations that contract with DHS to provide prepaid health care funded by Medical Assistance or General Assistance are required to assess their own enrollees, and tribal governments have contracts with DHS that require them to offer chemical use assessments to tribal members.[28]

Assessments conducted by counties, tribes, or prepaid public health plans must (1) rate a client's level of chemical involvement, and (2) use criteria in state rules to refer the client to the appropriate type of program. Clients may be referred to the types of programs shown in Table 1.4.

Treatment Trends

Data on all publicly- or privately-funded admissions to chemical dependency treatment programs show that:

- **In recent years, there has been growth in Minnesota's number of chemical dependency treatment admissions, more reliance on outpatient care, and some decline in alcohol's longstanding prevalence as the most common substance abused.**

The number of admissions of Minnesota residents to the state's chemical dependency treatment programs increased from 32,292 in 1995 to 41,519 in 2004, a 29 percent increase. In addition, the number of Minnesota residents who entered at least one treatment program during a given year grew from 26,080 in 1995 to 33,383 in 2004, a 28 percent increase.[29] During the 1995-2004 period, the state's population increased 11 percent.

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[25] *Minnesota Statutes* 2004, 256M.30.

[26] *Minnesota Statutes* 2004, 254B.03, subd. 1.

[27] *Minnesota Rules* 2005, 9530.6610, subp. 1. This is part of what is often referred to as "Rule 25." *Minnesota Statutes* 2004, 169A.70 has separate provisions that require chemical use assessments of persons convicted of impaired driving. The law requires these assessments to use the Rule 25 placement criteria, but the assessment forms are developed by and reported to the Department of Public Safety. Also, *Minnesota Statutes* 2004, 169A.284 requires persons convicted of impaired driving to pay a surcharge to help offset county assessment costs.

[28] Some prepaid health plans contract with county agencies to conduct their assessments.

[29] This is based on the unduplicated number of individuals entering treatment in a given year. The other analyses in this section are based on all admissions to treatment during the time period.

Table 1.4: "Levels of Care" in Community-Based Substance Abuse Treatment

Inpatient treatment (or "primary rehabilitation"): A residential program that provides intensive therapeutic services following detoxification. Provides at least 30 hours a week of services for each individual.

Outpatient treatment: A non-residential program that provides primary (or post-primary) health care with a defined regimen for five or more individuals at a time who have chemical use problems. Provides at least ten hours of total service time and must provide time-limited therapeutic services.

Halfway house: A residential program that offers treatment, aftercare, community ancillary services, and help in securing employment. Provides at least five hours a week of rehabilitative services.

Extended care: A residential, long-term program that combines in-house chemical dependency treatment and community-based ancillary resources. Provides at least 15 hours a week of chemical dependency services, which may include counseling, education, and other rehabilitative services.

NOTE: The rules also specify a category called "combination inpatient/outpatient treatment" meaning inpatient primary rehabilitation of 7 to 14 days, followed by outpatient treatment of three weeks or more. However, this category is rarely used by treatment providers to categorize their admissions in the data they report to DHS. Detoxification facilities are not considered to be treatment programs.

SOURCE: *Minnesota Rules* 2005, 9530.6605.

Outpatient treatment accounted for 53 percent of admissions to community-based treatment in 2004.

Table 1.5 shows how the characteristics of admissions to treatment among Minnesota residents in 1995 compared with those in 2004. Outpatient treatment accounted for 53 percent of the state's admissions in 2004, up from 48 percent in 1995. Meanwhile, the percentage of admissions to inpatient treatment and halfway houses declined during this period.

Alcohol has been, and remains, the predominant substance abused by persons admitted to treatment. However, cases in which alcohol was the primary substance abused have comprised a declining percentage of admissions. The percentage of admissions that were primarily due to methamphetamine use increased dramatically during this ten-year period, from 2.4 percent of admissions to 13.5 percent of admissions.

PRISON-BASED TREATMENT IN MINNESOTA

Offenses related to substance abuse are a large and growing part of Minnesota's criminal justice system. Between 2001 and 2004, the number of offenders sentenced in Minnesota for felony-level drug offenses grew by 56 percent.[30] For methamphetamine offenses alone, the number of persons sentenced for felonies

[30] Minnesota Sentencing Guidelines Commission, *Sentencing Practices, Controlled Substance Offenses: Offenders Sentenced in 2004* (St. Paul, October 2005), 3. The number sentenced was 2,596 in 2001, 3,424 in 2002, 3,896 in 2003, and 4,038 in 2004.

Table 1.5: Characteristics of Persons Admitted to Community-Based Treatment, 1995 and 2004

Client or Treatment Characteristic	Percentage of Admissions to Substance Abuse Treatment in:	
	1995	2004
Level of Care		
Inpatient treatment	33.9%	30.7%
Outpatient treatment	47.5	52.9
Halfway house	11.1	9.9
Extended care	5.5	5.3
Gender		
Male	70.3	67.7
Female	29.7	32.3
Age		
Under 18	9.5	10.6
18-65	88.9	88.5
Over 65	1.6	0.9
Education Level		
Did not complete high school	32.4	32.2
High school graduate or GED	49.3	50.2
Some college, but not a four-year degree	11.1	10.6
College graduate	5.5	5.5
Graduate or professional degree	1.7	1.5
Primary Substance Abuse Problem		
Alcohol	64.9	50.5
Marijuana/hashish	16.6	19.9
Methamphetamine	2.4	13.5
Crack cocaine	10.2	7.3
Powder cocaine	2.4	2.7
Heroin	1.3	2.3

SOURCE: Office of the Legislative Auditor's analysis of Department of Human Services' Drug and Alcohol Normative Evaluation System data. The analysis shown here includes only persons who were Minnesota residents. Some totals do not add to 100 percent because certain categories were excluded from the table.

Alcohol is the predominant substance abused by persons admitted to community-based treatment.

during this period increased by 132 percent.[31] Many of Minnesota's criminal offenders with substance abuse problems are sentenced to probation in the community and could be referred to treatment in the community-based programs discussed in the previous section. But offenders convicted of more serious offenses or with longer criminal histories can be sentenced to prison, and we found that:

[31] *Ibid.*, 4.

- **The number of offenders in Minnesota prisons for substance-related offenses has increased significantly.**

There was a 689 percent increase between 1990 and 2004 in the number of persons in prison for drug offenses (from 276 to 2,178).[32] Drug offenders now comprise 25 percent of Minnesota's prison population, up from 9 percent in 1990. The increase in drug offenders in prison partly reflects stricter sentences. For example, the percentage of persons convicted of drug-related felonies who were sentenced to prison was 25 percent in 2004, up from 12 percent in 1990.[33]

State law directs the Department of Corrections to provide "rehabilitative programs" for prison inmates.

State law requires the Commissioner of Corrections to provide "rehabilitative programs" for prison inmates "within the limitations imposed by the funds appropriated for such programs."[34] The Department of Corrections' fiscal year 2006 budget for chemical dependency services is $3.6 million, including $3.3 million from state funding. In previous years, the department did not track spending for chemical dependency services separately from other types of prison-based treatment, so we were unable to measure spending trends.

Minnesota has eight state prisons for adults, and all but the Oak Park Heights and Rush City prisons presently have a treatment or educational program related to substance abuse.[35] In addition, the two state-run correctional institutions for juveniles each have substance abuse programs. Table 1.6 lists the programs in Minnesota's correctional facilities, as of January 2006. The prison-based treatment programs generally take 6 to 12 months to complete, while the substance abuse education programs (which are not considered to be "treatment") cover less material and last 3 months or less. The substance abuse treatment and education programs both have group counseling sessions, but only the treatment programs offer individual counseling. The Lino Lakes prison offers "aftercare" programs for inmates who have completed a prison-based substance abuse program.

There are more similarities than differences among the prison-based treatment programs in Minnesota. All of the programs use a curriculum specifically targeted to a population of chemically dependent criminal offenders. The programs aim to get offenders to understand the progression of behaviors and

[32] Minnesota Department of Corrections, based on July 1 prison populations each year. The number of drug offenders in prison more than doubled between July 2000 and July 2005 (1,006 to 2,178).

[33] Minnesota Sentencing Guidelines Commission, *Sentencing Practices, Controlled Substance Offenses: Offenders Sentenced in 2004*, 8. The imprisonment rate for drug cases reached a high of 28 percent in 2003 before dropping to 25 percent in 2004. By comparison, the imprisonment rate for *non-drug* felonies was 23 percent in both 2003 and 2004.

[34] *Minnesota Statutes* 2004, 244.03.

[35] Prison-based treatment programs are subject to slightly different standards than community-based treatment programs. *Minnesota Statutes* 2004, 241.021, subd. 4a., says that if the commissioners of Corrections and Human Services agree that the human services licensing rules cannot "reasonably apply" to prison-based programs, then "alternative equivalent standards" shall be developed by these agencies through interagency agreement.

Table 1.6: Chemical Dependency Programs in Department of Corrections Institutions, January 2006

Correctional Institution	Program Name/Description	Number of Beds or Slots
Treatment Programs		
Lino Lakes—Adult men	Treatment intake/orientation	10-20
Lino Lakes—Adult men	"TRIAD" long-term treatment	75
Lino Lakes—Adult men	"TRIAD" medium-term treatment	77
Lino Lakes—Adult men	"TRIAD" mental illness/chemical dependency dual diagnosis treatment	20
Lino Lakes—Adult men	"TRIAD" treatment for prisoners with special needs	10
Lino Lakes—Adult men	Sex Offender Treatment Program (medium- and long-term treatment)	48
Stillwater—Adult men	"Atlantis" medium-term treatment	36
St. Cloud—Adult men	"Reshape" medium-term treatment	28
Shakopee—Adult women	"Changing Paths" medium-term treatment	40
Willow River—Adult men	"Challenge Incarceration Program" medium-term treatment	90
Thistledew—Adult women	"Challenge Incarceration Program" medium-term treatment	24
Red Wing—Juvenile boys	"New Freedom" medium-term treatment	60
		518-528
Psycho-Educational Programs		
Lino Lakes—Adult men	Short-term psycho-educational program	75
Faribault—Adult men	Short-term psycho-educational program	106
Thistledew—Juvenile boys	Short-term psycho-educational program focused on methamphetamine addiction	12
		193
In-Prison Aftercare Programs		
Lino Lakes—Adult men	Various aftercare programs	175

SOURCE: Minnesota Department of Corrections.

Most of Minnesota's state-run correctional facilities have substance abuse treatment or education programs.

thinking patterns that lead to criminality and addiction. In each of Minnesota's prison-based treatment programs, the program participants live together in separate residential units of their prisons, known as "therapeutic communities."

The most distinctive of Minnesota's prison-based treatment programs is the Challenge Incarceration Program (CIP) at the Willow River and Thistledew facilities. While inmates in the other correctional facilities are "directed" by prison staff to participate in treatment (and can be sanctioned if they do not), inmates apply to participate in the CIP program. The program's first six months occur in a boot camp environment, and participants who successfully complete

this first program phase may be eligible for early release from prison. In subsequent phases of CIP, participants remain under correctional supervision in the community following their release from prison.[36]

Several of the other prison-based programs have unique elements. A chemical dependency treatment program at the Lino Lakes prison is specifically designed for sex offenders. Participants in this program complete a chemical dependency treatment curriculum before starting a sex offender treatment curriculum. A second Lino Lakes program focuses on inmates with "special needs," such as persons with brain injuries or developmental disabilities, and another Lino Lakes program focuses on inmates who have dual diagnoses of chemical dependency and mental illness.

Several prisons will add chemical dependency treatment beds in 2006 or 2007.

The Department of Corrections intends to add treatment beds at several prisons during 2006 and 2007. The largest addition will be 90 new beds at the Challenge Incarceration Program in Willow River. Also, the department plans to add 12 beds to its Stillwater program and start a 24-bed program for adults at the Moose Lake portion of the Moose Lake/Willow River institution. The department also plans to start a 50-bed sex offender treatment program at the Rush City prison that will include a chemical dependency treatment component.[37]

[36] According to *Minnesota Statutes* 2004, 244.172, the second phase of CIP (following release from prison) consists of at least six months of intensive supervision, and the third phase lasts until the Commissioner of Corrections determines that the offender has successfully completed the program or the offender's sentence expires (whichever comes first).

[37] In addition, the department uses a private correctional facility in Minnesota for some of its inmates, and this facility plans to add a 25-bed chemical dependency treatment program during 2006.

2 Previous Research on Treatment Effectiveness

SUMMARY

Research examining the effectiveness of substance abuse treatment has yielded mixed results. Careful studies have shown that certain types of treatment have better client outcomes, on average, compared with other types of treatment or no treatment at all. For example, studies have yielded positive findings, on average, for "brief interventions" with problem drinkers, methadone maintenance programs, and certain "psychosocial" treatment programs. Also, there is an emerging consensus that many chemically dependent clients need extended periods of services, even if this includes some low-intensity treatment or monitoring. But there is still much to learn about what types of treatment work best in particular circumstances. Even the more effective treatments do not succeed with all clients, and there is limited evidence on the effectiveness of some common programs.

Studies that rigorously examine the impact of treatment often require extended periods of time to complete, including time to track participants' outcomes following treatment. Also, some of the better studies involve random assignment of individuals to programs. We could not complete such a study, so this chapter addresses the following questions:

- **What has research indicated about the overall effectiveness of substance abuse treatment? Does research show that certain types of treatment are more effective than others?**

- **What have researchers concluded about the appropriate length of treatment, the appropriate setting for treatment (such as inpatient or outpatient), and the impact of treatment on drug court participants?**

The research findings discussed in this chapter are based primarily on the results of studies from academic, professional, and government publications. Most of these studies did not evaluate Minnesota programs, but we think their findings are pertinent to Minnesota's policy makers and treatment administrators.

GENERAL OBSERVATIONS

Persons working in the substance abuse treatment field often make the general assertion that "treatment works." In 2003, the Minnesota Department of Human Services (DHS) summarized previous research by stating in a report to the

Legislature that "treatment is effective."[1] According to DHS, "Studies have consistently found that treatment reduces substance use frequency by at least 40 to 60 percent, and markedly reduces the criminal activity associated with addictions."[2] But, in our view,

- **Broad claims—positive or negative—about the effectiveness of substance abuse treatment are misleading, given variation in past research findings and a need for more definitive evidence about the circumstances in which treatment is effective.**

There are many types of substance abuse treatment, implemented in different settings with various degrees of skill.

First, the term "treatment" is too ill-defined for such generalizations. There are dozens of treatment approaches, of various lengths and intensities, provided to persons with different needs, and implemented in many different settings with various degrees of skill. Some studies provide limited descriptions of treatment programs' features and the characteristics of the clients served, making it difficult to draw general conclusions about what worked with whom. As one summary of treatment research concluded,

> [R]esearch to date has conclusively established that treatment can be effective, but there are only preliminary indications at this time as to why treatment is effective or what it is within treatment that makes it effective.[3]

Second, previous research on the effectiveness of substance abuse treatment has produced a mix of positive and negative findings, so a generalization that "treatment works" is one-sided. One recent research summary said that the outcomes for some of the more common types of substance abuse treatment "are rather consistently negative," but it also said that positive findings for certain other types of treatment provide "reason for optimism."[4]

Third, even when the evidence suggests that, on average, treatment has a positive impact on a particular population, there will always be individual cases in which treatment does not lead to favorable outcomes. The assertion that "treatment works" may imply that treatment *always* works for *all* participants, which is unrealistic. As a recent commentary in a substance abuse journal stated:

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[1] Minnesota Department of Human Services, *Minnesota's Chemical Health System: A Report to the Minnesota Legislature* (St. Paul, February 21, 2003), i.

[2] *Ibid*, 12. The department's comment is similar to one in National Institute on Drug Abuse, *Principles of Drug Addiction Treatment: A Research-Based Guide* (Washington, D.C., October 1999): "According to several studies, drug treatment reduces drug use by 40 to 60 percent and significantly decreases criminal activity during and after treatment" (p. 13).

[3] A. Thomas McLellan and James R. McKay, "Components of Successful Treatment Programs: Lessons from the Research Literature," in *Principles of Addiction Medicine*, 2nd ed., ed. Allan W. Graham and Terry K. Schultz (Chevy Chase, MD: American Society of Addiction Medicine, 1998), 338.

[4] William R. Miller, Paula L. Wilbourne, and Jennifer E. Hettema, "What Works? A Summary of Alcohol Treatment Outcome Research," in *Handbook of Alcoholism Treatment Approaches: Effective Alternatives*, 3rd ed., ed. Reid K. Hester and William R. Miller (Boston: Allyn and Bacon, 2003), 34, 40.

> The effusive optimism of the [treatment field's] "Treatment Works" slogan masks a brutal reality: there are legions of families whose loved ones are dying addiction-related deaths, languishing in prisons, or living addiction-deformed lives—all after one or more episodes of addiction treatment. The slogan "Treatment Works" is painfully contradicted by the experiences of these families.[5]

Many studies have not isolated the impact of treatment, apart from other factors that can affect client recovery.

Fourth, the methods used in many studies have not allowed researchers to determine which client improvements were attributable to treatment rather than to other factors. Numerous studies have documented reductions in substance use and criminal behavior by persons during and after treatment, compared with the period before entering treatment. But people often enter treatment following a crisis or prolonged problems, so a reduction in substance use or criminal behavior *could* be part of a natural course of events, even without treatment. The most definitive studies of treatment's impacts are those in which researchers randomly assign persons either to treatment or no program at all, thus allowing the researchers to focus on the impact of the treatment experience. Unfortunately, most studies of substance abuse programs have not compared outcomes for "treated" clients to "untreated" clients, reflecting the understandable reluctance of program administrators and researchers to deny potentially beneficial treatment to persons.[6]

While it would be misleading to make a sweeping claim that "treatment works," it would also be wrong to generalize that "treatment does not work." As discussed in the next sections,

- **Studies have demonstrated the potential for certain treatment programs to reduce clients' chemical use and improve their social functioning, based on comparisons to (1) clients who did not receive treatment, or (2) clients who were in other programs.**

In the following sections, we discuss key findings from previous research, highlighting types of treatment that appear to have stronger evidence of effectiveness.

RESEARCH ON COMMUNITY-BASED TREATMENT

Over the past several decades, researchers have conducted hundreds of studies of community-based substance abuse treatment, examining various treatment approaches. This section begins by discussing the mixed research findings regarding "psychosocial" treatments, which typically involve counseling,

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[5] William L. White, "Treatment Works: Is it Time for a New Slogan?" *Addiction Professional* (January 2005): 23.

[6] A recent report by the National Research Council observed that "the almost complete lack of no-treatment control groups in drug treatment research is striking," and it recommended greater use of randomized trials that assign some persons to "no treatment." See National Research Council, *Informing America's Policy on Illegal Drugs: What We Don't Know Keeps Hurting Us* (Washington, D.C.: National Academy Press, 2001), 252, 258.

therapy, or instruction.[7] Later, we provide brief discussions on a series of specific topics related to community-based treatment that, in our view, may be of particular interest to legislators.

Overall Effectiveness of Psychosocial Treatments

Minnesota's licensed substance abuse programs employ "psychosocial" treatment approaches.

In Minnesota, most persons who are assessed by counties as chemically dependent are referred to "psychosocial" types of treatment. State administrative rules require licensed substance abuse treatment programs to provide individual and group counseling, client education strategies, services to help clients make the transition from treatment to independent daily living, and services to address co-occurring mental illness.[8]

In the past 40 years, the federal government has initiated several national studies of substance abuse treatment outcomes, mostly based on clients who were in psychosocial treatment.[9] These studies looked at data on about 66,000 clients and provided extensive information on factors associated with positive client changes following treatment. But the clients in these studies were not randomly assigned to "comparison groups," so the National Research Council concluded that these studies "could not provide rigorous evidence on the relative effectiveness or efficacy of particular drug-by-treatment combinations, or for estimating the absolute effect size, cost-effectiveness, or benefit-cost ratio of treatment."[10]

One recent analysis focused on previous studies that included "comparison groups." Specifically, it examined 78 studies that compared drug treatment participants with similar clients who received minimal or no treatment.[11] It concluded that, on average, clients who participated in drug treatment had somewhat better outcomes than those who received little or no treatment. The authors reported that treatment had larger impacts on participants' drug use than

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[7] In Chapter 1, we noted that there is no statewide inventory of Minnesota's substance abuse programs' treatment approaches. Thus, it is hard to determine the extent to which Minnesota's programs have incorporated the approaches that are most strongly supported by research.

[8] *Minnesota Rules* 2005, 9530.6430. Department of Human Services officials told us that they have used the state rule-making process to help ensure that treatment is tailored to client needs. As we discuss in Chapter 3, the department implemented new treatment rules in 2005 and intends to implement new assessment rules in 2007.

[9] The Drug Abuse Reporting Program (DARP) examined 44,000 clients who entered treatment programs between 1969 and 1973. The Treatment Outcome Prospective Study (TOPS) collected data on 12,000 clients who entered treatment programs between 1979 and 1981. The Drug Abuse Treatment Outcome Study (DATOS) reviewed data on 10,000 clients who entered treatment between 1991 and 1993.

[10] National Research Council, *Informing America's Policy on Illegal Drugs*, 249.

[11] Michael Prendergast, Deborah Podus, Eunice Chang, and Darren Urada, "The Effectiveness of Drug Abuse Treatment: A Meta-Analysis of Comparison Group Studies," *Drug and Alcohol Dependence* 67 (2002): 53-72. Of the studies reviewed, 59 percent involved "random or quasi-random" assignment of clients to programs. The authors acknowledged that clients' levels of motivation could explain some of the results.

on their levels of criminal activity, concluding that, "overall, people with drug abuse problems are better off being in treatment than not."[12] However,

- **Research has not conclusively shown which specific types of psychosocial substance abuse treatment are more effective than others.**

Studies of treatment effectiveness have produced mixed results.

The question of which types of psychosocial treatment are "best" for particular clients is a matter of ongoing research. A 2003 review of 381 clinical trials concluded that several treatment methods have shown evidence of success with persons having varying levels of alcohol problems.[13] Among the psychosocial approaches, those with the strongest evidence of effectiveness included: (1) **behavior management strategies** (for example, teaching clients ways to exercise self-control, change their thinking patterns, or achieve specific goals); (2) the **"community reinforcement" approach** (for example, creating incentives for clients to reduce their drinking, or working with friends or relatives on ways to support the clients' sobriety); (3) **strategies to help improve clients' personal relationships**, such as social skills training and certain types of marital therapy. On the other hand, the authors concluded that many of the more commonly-used psychosocial treatment approaches—such as psychotherapy, educational lectures and films, confrontational interventions, and general substance abuse counseling—had much weaker track records.[14]

Some direct comparisons of different treatment approaches have not found clear differences in outcomes. The largest clinical study of substance abuse treatments (known as Project MATCH) examined the performance of various clients with three types of outpatient psychosocial treatment: (1) **cognitive-behavioral therapy** (helping clients "unlearn" certain habits and cope with situations that might lead to relapse), (2) **12-step facilitation therapy** (based on the "12 steps" of Alcoholics Anonymous, but involving professionally directed treatment rather than just self-help groups), and (3) **motivational enhancement therapy** (stimulating clients' self-motivation to make changes, rather than guiding clients systematically through recovery). The results of Project MATCH indicated that "the three treatments were not substantially different in their effectiveness."[15]

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[12] *Ibid*., 66. Even this research summary did not provide definitive evidence of treatment's effectiveness. The authors noted that "traditional" types of community-based treatment modalities were underrepresented in the studies, and that programs rated as being "well implemented" had better outcomes than other programs (pp. 59, 63).

[13] Miller, Wilbourne, and Hettema, "What Works? A Summary of Alcohol Treatment Outcome Research," 13-63. The analysis gave greater weight to studies that used stronger research methods. It identified 18 treatment methods (out of 47 methods with three or more outcome studies) for which the authors' ratings of the research evidence was positive, on balance.

[14] Discussing the limitations of their research summary, the authors note that (1) some treatments have been the subject of much more study than others, and (2) the aggregate ratings of various treatments do not fully account for the strength of the treatments against which they were compared in individual studies.

[15] William R. Miller and Richard Longabaugh, "Summary and Conclusions," in *Treatment Matching in Alcoholism*, ed. Thomas F. Babor and Frances K. Del Boca (Cambridge: Cambridge University Press, 2003), 211. When this experiment began in the mid-1990s, cognitive-behavioral therapy was the only one of these approaches that had clear evidence of its general effectiveness. The authors noted that the 12-step approach and the closely related Minnesota Model "had not been subjected to rigorous randomized clinical trials," and motivational enhancement had strong evidence for clients with less severe alcohol problems but not for clients with severe problems.

The study was designed to determine which treatments worked best with particular clients, but it found limited evidence of differing effects.[16]

In practice, individual treatment programs often use multiple approaches.

Researchers have often studied the effectiveness of individual treatment approaches (such as those discussed above), but, in practice, treatment programs often combine multiple approaches. For example, a program that emphasizes 12-step therapy might also incorporate elements of motivational enhancement therapy or community reinforcement, for some or all of its clients. Thus, it can be challenging to categorize a treatment program as having predominantly one type of approach or another.

The National Institute on Drug Abuse (NIDA)—one of the federal government's lead agencies for substance abuse research—has observed that "not all drug abuse treatment is equally effective."[17] Thus, NIDA developed a set of "principles of effective treatment" based on reviews of prior research, shown in Table 2.1. For example, NIDA suggests the need for a variety of treatment options, due to the fact that no one type of treatment is appropriate for all persons with substance abuse problems. Also, NIDA suggests that issues other than substance use—such as mental health, legal, social, and vocational problems—should be addressed during treatment.

Research Findings on Several Specific Issues Regarding Community-Based Treatment

The discussion above focused on the overall effectiveness of treatment, including the effectiveness of various psychosocial treatment approaches. Below, we briefly summarize research on several other issues. First, psychosocial treatment is not the only way to treat substance abuse, so we discuss two alternative approaches that have had particularly strong research findings: methadone maintenance programs for heroin addicts, and "brief interventions" for problem drinkers.[18] Second, legislators have asked questions about the effectiveness of treatment for methamphetamine users and adolescents, so we present information from the limited body of research on these two subpopulations of chemical users. Third, legislators specifically asked us to address program characteristics that might influence treatment outcomes. Thus, we discuss previous research on the

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[16] *Ibid.*, 211-214. The study found that (1) motivational enhancement was more effective for clients with "high anger" and less effective for clients with "low anger," (2) 12-step therapy was more effective than motivational enhancement for clients with social networks that supported their drinking, (3) 12-step therapy was more effective than cognitive-behavioral therapy for outpatient clients without psychiatric impairments, and (4) in aftercare settings, cognitive-behavioral therapy was more effective than 12-step therapy for clients with "low dependence," while 12-step therapy was more effective than cognitive-behavioral for clients with "high dependence." This study was designed to compare the effectiveness of these three treatments, not to determine whether treatment resulted in better outcomes than "no treatment."

[17] National Institute on Drug Abuse, *Principles of Drug Addiction Treatment*, 8.

[18] This section discusses methadone maintenance as a treatment for opiate addiction, but some other medications have been shown to be effective for other addictions. For example, a comprehensive review of research concluded that two medications (acamprosate and naltrexone) have been shown to be among the more successful treatments for alcohol-dependent persons. See Miller, Wilbourne, and Hettema, "What Works? A Summary of Alcohol Treatment Outcome Research," 23-26.

Table 2.1: National Institute on Drug Abuse's "Principles of Effective Treatment"

1. No single treatment is appropriate for all individuals.
2. Treatment needs to be readily available.
3. Effective treatment attends to multiple needs of the individual, not just his or her drug use.
4. An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.
5. Remaining in treatment for an adequate period of time is critical for treatment effectiveness.
6. Counseling and other behavioral therapies are critical components of effective treatment for addiction.
7. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
8. Addicted or drug-abusing individuals with co-existing mental disorders should have both disorders treated in an integrated way.
9. Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.
10. Treatment does not need to be voluntary to be effective.
11. Possible drug use during treatment must be monitored continuously.
12. Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases, and counseling to help patients change behaviors that place themselves or others at risk of infection.
13. Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.

SOURCE: National Institute on Drug Abuse, *Principles of Drug Addiction Treatment: A Research-Based Guide* (Washington, D.C., October 1999), 1-3.

The federal government has suggested several key principles for substance abuse treatment.

length of treatment, whether treatment occurs in an inpatient or outpatient setting, and the impact of individual counselors. Fourth, there is considerable interest nationally and in Minnesota in the use of specialized courts for drug offenders, typically with referral of the offenders to treatment. We discuss research on the outcomes of these courts. Finally, we discuss self-help groups for chemically dependent persons, which often supplement professionally-directed treatment (or are sometimes used in place of treatment).

Methadone Maintenance for Heroin Addiction

Heroin is a highly addictive opiate. In a methadone maintenance program, the heroin addict takes an oral dose of a legally prescribed drug (methadone) to reduce or eliminate use of an illegal one (heroin). Methadone is intended to prevent symptoms of opiate withdrawal and eliminate the intense "highs" and "lows" associated with heroin use. In Chapter 3, we note that there are only two programs in Minnesota that have methadone maintenance programs for publicly-funded clients. Heroin was the primary substance of abuse in about 2 percent of Minnesota's 2004 admissions to substance abuse treatment.

Extensive research has shown that:

- **When properly administered, methadone maintenance therapies for heroin addicts result in better outcomes, on average, compared with treatments not involving medications or no treatment at all.**

Research has supported the use of methadone for heroin addicts.

In 1990, the National Academy of Sciences' Institute of Medicine concluded that the benefits of methadone maintenance exceeded the cost of treatment. While acknowledging that some clients "do not respond well to [methadone] programs," depending in part on whether the programs set appropriate dosages for clients, the Institute concluded:

> The evidence from experimental and quasi-experimental studies clearly points toward the existence of a substantial number of heroin-dependent individuals who perform at least moderately well in response to methadone maintenance and who would do poorly without it, even when other kinds of treatment are available.[19]

According to the federal government's National Institute on Drug Abuse, methadone maintenance treatment should last for a minimum of 12 months.[20]

Studies indicate that some other medications also show promise for heroin addicts. A recent review of clinical trials found that buprenorphine was an effective medication for heroin dependence, but not more effective than methadone administered at appropriate doses.[21] Another study found that buprenorphine, levo-alpha acetylmethadol, and "high-dose" methadone treatment were all more effective than "low-dose" methadone treatment.[22]

"Brief Interventions" for Alcohol Abuse

"Brief interventions" for alcohol abuse, as they are usually implemented, are not considered "treatment" under Minnesota's substance abuse treatment licensing rules. Unlike licensed treatment, brief interventions are usually provided by

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[19] Institute of Medicine, ed. Dean R. Gerstein and Henrick J. Harwood, *Treating Drug Problems: A Study of the Evolution, Effectiveness, and Financing of Public and Private Drug Treatment Systems*, v. 1 (Washington, D.C.: National Academy Press, 1990), 136-154. The analysis concluded that treatment participants had reduced illicit drug use and criminal behavior compared with (1) untreated persons, (2) persons who were simply detoxified and released, and (3) persons terminated arbitrarily from methadone. Also, studies have generally shown that higher doses of methadone are more successful in controlling illicit drug use while clients are in treatment, and studies have suggested that administration of medication treatments may be enhanced by counseling.

[20] National Institute on Drug Abuse, *Principles of Drug Addiction Treatment*, 14.

[21] R.P. Mattick, J. Kimber, C. Breen, and M. Davoli, "Buprenorphine Maintenance Versus Placebo or Methadone Maintenance for Opioid Dependence (Cochrane Review)," in *The Cochrane Library*, Issue 1 (2005).

[22] Rolley E. Johnson, Mary Ann Chutuape, Eric C. Strain, Sharon L. Walsh, Maxine L. Stitzer, and George E. Bigelow, "A Comparison of Levomethadyl Acetate, Buprenorphine, and Methadone for Opioid Dependence," *New England Journal of Medicine* 343, no. 18 (2000): 1290-1297. In the three more effective treatments, the percentage of clients with 12 or more consecutive opium-free urine tests ranged from 26 to 36 percent, suggesting that complete abstinence is a difficult goal to achieve.

"Brief interventions" by health care professionals can help address problem drinking before treatment is required.

primary care physicians or other health care professionals. Following chemical use screening, these professionals give clients feedback on their drinking patterns and provide advice on behavior management techniques. Brief interventions often have several sessions, each ranging in length from a few minutes to an hour. They offer little opportunity to teach clients new skills or ways of thinking, but researchers theorize that these "wake-up calls" enhance some clients' motivation to change their drinking behaviors.[23]

One summary of nearly 400 clinical trials of various types of treatments and interventions concluded that:

- **Among the various types of interventions for alcohol abuse, "brief interventions" by health care professionals have shown strong evidence of effectiveness.**

Specifically, the authors said that "brief intervention has one of the largest literature bases and is the most positive by far."[24] Other research summaries have also concluded that there is strong favorable evidence for brief interventions.[25] Despite such findings, this approach has had limited implementation in practice across the nation.[26] The extent to which Minnesota's health care providers use brief interventions is unknown, and staff with the Minnesota Department of Human Services told us they did not think that the department has made efforts to promote the use of brief interventions for adults.[27]

Treatment for Methamphetamine Abuse

In Minnesota, methamphetamine was the primary substance abused in 13.5 percent of admissions to substance abuse treatment in 2004. The growing abuse of this stimulant has led placement agencies and policy makers to ask which

[23] Paula Wilbourne and William R. Miller, "Treatment for Alcoholism: Older and Wiser?" *Alcoholism Treatment Quarterly* 20, no. 3/4 (2002): 44.

[24] Miller, Wilbourne, and Hettema, "What Works? A Summary of Alcoholism Treatment Outcome Research," 21. The brief approaches with positive results on balance included brief interventions, motivational enhancement, case management, and self-administered forms of behavioral self-control training.

[25] For example, see Javier Ballesteros, John C. Duffy, Imanol Querejeta, Julen Arino, and Asuncion Gonzalez-Pinto, "Efficacy of Brief Interventions for Hazardous Drinkers in Primary Care: Systematic Review and Meta-Analyses," *Alcoholism: Clinical and Experimental Research* 28, no. 4 (April 2004): 608-618, and Robert J. Tait and Gary K. Hulse, "A Systematic Review of the Effectiveness of Brief Interventions with Substance Using Adolescents by Type of Drug," *Drug and Alcohol Review* 22, no. 3 (September 2003): 337-346.

[26] Ann M. Roche and Toby Freeman, "Brief Interventions: Good in Theory But Weak in Practice," *Drug and Alcohol Review* 23 (March 2004): 11-18.

[27] For adolescents, DHS has developed the Adolescent Health Review, a screening instrument to help primary care providers identify behavioral health issues.

types of treatment can best address this problem. So far, the amount of rigorous research on methamphetamine treatment has been very limited.[28] In addition,

- **Research has provided little indication that specialized treatments for methamphetamine users work better than other treatments.**

For example, a large-scale study of methamphetamine users compared the outcomes of a 16-week outpatient treatment for treating stimulant abuse (the "Matrix Model") with outcomes for various types of outpatient "treatment as usual." The Matrix Model produced better outcomes during treatment (fewer failed drug tests and higher program completion rates), but Matrix and the other approaches had similar post-treatment outcomes on measures of drug use and client functioning.[29] A review of research by University of Iowa researchers concluded that "special treatment" for methamphetamine abuse was not supported by previous studies, although longer treatment or client monitoring might be needed to address the drug's longer impacts on brain functioning.[30] Although research has not identified specialized treatment approaches that are uniquely effective with methamphetamine addicts, treatments for these clients may need to be supplemented with other services "to address methamphetamine patients' more severe medical and psychiatric problems."[31]

There has been a limited amount of rigorous research on treatment targeted at methamphetamine users and adolescents.

Treatment for Adolescents

In Minnesota, about 11 percent of admissions to substance abuse treatment in 2004 were for persons under 18 years old. However,

- **There has been much less research on substance abuse treatment for adolescents than for adults, and conclusions about "what works" are still emerging.**

One recent research summary identified a total of 15 "controlled evaluations" of adolescent treatment between 1989 and 2002, compared with more than 300 such

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[28] Richard A. Rawson, Alice Huber, Paul Brethen, Jean Obert, Vikas Gulati, Steven Shoptaw, and Walter Ling, "Status of Methamphetamine Users Two to Five Years After Outpatient Treatment," *Journal of Addictive Diseases* 21, no. 1 (2002): 107-119; Yih-Ing Hser, David Huang, Chih-Ping Chou, Cheryl Teruya, and M. Douglas Anglin, "Longitudinal Patterns of Treatment Utilization and Outcomes Among Methamphetamine Abusers: A Growth Curve Modeling Approach," *Journal of Drug Issues* (Fall 2003): 921-938.

[29] Richard A. Rawson, 14 others, and the Methamphetamine Treatment Project Corporate Authors, "A Multi-Site Comparison of Psychosocial Approaches for the Treatment of Methamphetamine Dependence," *Addiction* 99 (2004): 708-717.

[30] Margaret Cretzmeyer, Mary Vaughan Sarrazin, Diane L. Huber, Robert I. Block, and James A. Hall, "Treatment of Methamphetamine Abuse: Research Findings and Clinical Directions," *Journal of Substance Abuse Treatment* 24 (2003): 267-277. According to Richard A. Rawson, M. Douglas Anglin, and Walter Ling, "Will the Methamphetamine Problem Go Away?" *Journal of Addictive Diseases* 21, no. 1 (2002): 5-19, many of methamphetamine's brain impacts appear to be reversible, but this can take 6 to 12 months of abstinence.

[31] Amy L. Copeland and James L. Sorenson, "Differences Between Methamphetamine Users and Cocaine Users in Treatment," *Drug and Alcohol Dependence* 62 (2001): 94.

evaluations of alcohol abuse treatment for adults.[32] As with studies of adult treatment, most studies have compared one type of adolescent treatment to another, rather than to comparison groups that received no treatment.[33]

A 2004 summary of adolescent treatment studies concluded that two types of psychosocial treatment for adolescents had the strongest support in past research: (1) **"multidimensional family therapy"** (individual and family counseling sessions that address interpersonal relationships), and (2) **cognitive-behavioral treatment groups** (helping clients to "unlearn" certain ways of thinking and improving their ability to cope with difficult situations). It also noted that: "Although there exists a range of effective and promising treatments, many interventions were found to be either ineffective or of uncertain efficacy."[34]

Two earlier reviews of adolescent treatment research (in 2000 and 2001) were inconclusive about the relative effectiveness of different types of treatment, due to the limited number of studies that had been conducted at the time of the reviews.[35] Other researchers have noted that adolescents have usually shown less favorable outcomes than adults in large-scale treatment evaluations.[36]

Treatment Duration and Retention

Earlier, we noted that there has been strong research evidence favoring the use of "brief interventions" among persons with alcohol problems. These interventions often involve no extended counseling and are often intended to address problems before there is a need for more intensive services. But, for persons who enroll in counseling-based programs, researchers have observed that:

- **On average, persons who complete substance abuse treatment programs or remain in the programs for longer periods are more likely to experience positive outcomes than persons with shorter or uncompleted treatments.**

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[32] Michael G. Vaughn and Matthew O. Howard, "Adolescent Substance Abuse Treatment: A Synthesis of Controlled Evaluations," *Research on Social Work Practice* 14, no. 5 (2004): 325-335.

[33] Robert J. Williams, Samuel Y. Chang, and Addiction Centre Adolescent Research Group, "A Comprehensive and Comparative Review of Adolescent Substance Abuse Treatment Outcome," *Clinical Psychology* 7, no. 2 (2000): 138-166, reported finding only two studies that used untreated control groups.

[34] Vaughn and Howard, "Adolescent Substance Abuse Treatment," 329. The review rated 24 treatment approaches. For the "Minnesota Model" 12-step approach, the review said there were insufficient data to draw conclusions.

[35] Deborah Deas and Suzanne E. Thomas, "An Overview of Controlled Studies of Adolescent Substance Abuse Treatment," *American Journal on Addictions* 10, no. 2 (2001): 178-188, said that family-based therapies "may be effective" but few studies have used validated measures of substance use outcomes. It also said that more studies were needed before conclusions could be drawn about cognitive-behavioral therapy. Williams, Chang, and Addiction Centre Adolescent Research Group, "A Comprehensive and Comparative Review," said that outcome studies of adolescent programs tend to be weak. However, it said that family therapy "appears superior to other forms of outpatient treatment" (p. 159).

[36] Yih-Ing Hser, Christine E. Grella, Robert L. Hubbard, Shih-Chao Hsieh, Bennett W. Fletcher, Barry S. Brown, and M. Douglas Anglin, "An Evaluation of Drug Treatments For Adolescents in Four U.S. Cities," *Archives of General Psychiatry* 58, no. 7 (2001): 689-695.

A summary of several national studies said that beneficial effects from treatment often materialized after 90 days in treatment.[37] Based on general patterns in the research evidence, the National Institute on Drug Abuse suggested minimum thresholds of 90 days for residential and outpatient treatment and one year for methadone treatment. This does not mean that all clients require treatment of at least these durations, but the Institute said that "research has shown unequivocally that good outcomes are contingent on adequate lengths of treatment."[38]

Of course, there can be important differences in the intensity and nature of treatment, even within similar durations. For example, over the course of 90 days, a client might receive 28 hours of treatment in an outpatient program that has weekly, two-hour meetings, compared with more than 80 hours of treatment in a 90-day outpatient program that has two-hour meetings three times a week. The emerging consensus in the substance abuse treatment field seems to be that there is often a need for sustained periods of contact with clients, even if it includes periods of low-intensity treatment or monitoring. Two leading researchers summarize previous research in the following way:

There is often a need for sustained contact with clients, even if it includes periods of low-intensity treatment or monitoring.

> [R]eviews of treatment intensity, length of stay, and aftercare suggest that an effective strategy may be to provide lower intensity addiction treatment for a longer duration—that is, treatment spread out at a lower rate over a longer period…. More extended treatment may improve patient outcomes because it provides patients with ongoing support and the potential to discuss and resolve problems prior to the occurrence of a full-blown relapse.[39]

In addition, research has shown that it is reasonable to expect better outcomes among clients who complete the treatment programs they begin. In 2000, the Minnesota Department of Human Services found that this was true in all types of substance abuse programs. In fact, for both adults and adolescents, program completion was the most consistent predictor of clients' abstinence in the six-month period after leaving a program.[40] This is consistent with findings from national research literature. For example, a review of adolescent substance abuse

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[37] D. Dwayne Simpson, "A Conceptual Framework for Drug Treatment Process and Outcomes," *Journal of Substance Abuse Treatment* 27, no. 2 (2004): 99-121. This summary said that outcomes improved "in a generally linear fashion as retention increases from 3 months up to 12 to 24 months or more." Another study found relationships between treatment duration and outcomes in methadone maintenance, outpatient, and long-term residential programs, but not in short-term residential programs—see Zhiwei Zhang, Peter D. Friedmann, and Dean R. Gerstein, "Does Retention Matter? Treatment Duration and Improvement in Drug Use," *Addiction* 98 (2003): 673-684.

[38] National Institute on Drug Abuse, *Principles of Drug Addiction Treatment*, 14.

[39] John W. Finney and Rudolf H. Moos, "What Works in Treatment: Effect of Setting, Duration and Amount," in *Principles of Addiction Medicine*, 2nd ed., ed Allan W. Graham and Terry K. Schultz (Chevy Chase, MD: American Society of Addiction Medicine, 1998): 349.

[40] Minnesota Department of Human Services, *The Challenges and Benefits of Chemical Dependency Treatment: Results from Minnesota's Treatment Outcomes Monitoring System*, 1993-1999 (St. Paul, 2000), 3, 32-53.

treatment found that treatment completion was the variable "with the most consistent relationship to positive outcome."[41]

Inpatient vs. Outpatient Treatment

There are a variety of settings in which chemically dependent persons may be treated. One key distinction is between "inpatient" treatment, which is provided in a location where the client resides, and "outpatient" treatment, which is provided outside the client's residence. We found that:

- **Research has not clearly indicated the superiority of either inpatient or outpatient care. Either setting may be appropriate for clients, depending on their circumstances.**

Either inpatient or outpatient care may be appropriate for clients, depending on their circumstances.

One often-cited review of previous research concluded that factors such as therapist characteristics and the amount of treatment provided had more impact on clients' post-treatment functioning than the setting in which treatment occurred. This review reported that, in 14 studies that specifically examined the treatment setting, 7 found no differences between inpatient and outpatient treatment, 5 favored inpatient treatment, and 2 favored outpatient treatment. The authors suggested using outpatient treatment "for most individuals with sufficient social resources and no serious medical/psychiatric impairment," and it also recommended the development of more *intensive* outpatient care for certain clients.[42]

A 2000 study by the Minnesota Department of Human Services said that, based on rates of post-treatment abstinence, inpatient treatment was superior for (1) clients with recent "suicidal behavior," or (2) "severe" problems in at least four of the following areas: alcohol use, drug use, psychological distress, social isolation, and unemployment. But, overall, the study concluded that there were too few persons placed in outpatient care in Minnesota. It said that 60 percent of adults treated in inpatient care in Minnesota "would do just as well in outpatient settings," while 84 percent of adults in outpatient settings were appropriately placed.[43]

In cases where the agencies that make client placements perceive no clear therapeutic advantage for inpatient treatment, outpatient treatment may be the more cost-effective option. For example, the Department of Human Services study estimated in 2000 that the average cost of publicly-funded outpatient treatment was $1,400, compared with $4,200 for short-term inpatient treatment.[44]

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[41] Williams, Chang, and Addiction Centre Adolescent Research Group, "A Comprehensive and Comparative Review," 157.

[42] John W. Finney, Annette C. Hahn, and Rudolf H. Moos, "The Effectiveness of Inpatient and Outpatient Treatment for Alcohol Abuse: The Need to Focus on Mediators and Moderators of Setting Effects," *Addiction* 91, no. 12 (1996): 1773-1796. Generally, this review concluded, the more "intensive" treatment (whether inpatient or outpatient) had better results.

[43] Minnesota Department of Human Services, *The Challenges and Benefits of Chemical Dependency Treatment*, 60.

[44] *Ibid*., 17. The report said the median length of outpatient treatment was 6.5 weeks, while the median length of short-term inpatient treatment was 3 weeks.

Impact of Individual Counselors

The content of treatment programs matters, but so does the skill of individual treatment staff.

The effectiveness of substance abuse treatment depends not only on the content of the treatment program but also on the way services are provided. In one large-scale study, outcomes for the three types of treatment tested were significantly influenced by the therapist to whom clients were assigned.[45] However, as a leading researcher has commented, "it is less clear what distinguishes more effective from less effective therapists."[46]

Some studies indicate that individual therapists' ability to listen to their clients and accurately understand the clients' perspectives may be an important determinant of treatment effectiveness. Likewise, the therapists' manner, tone of voice, and expectations for the client may affect program outcomes.[47]

Drug Courts

As of late 2005, Minnesota had nine adult drug courts and four juvenile drug courts.[48] A drug court is a specialized type of court that aims to stop drug offenders' substance use and related criminal activity. Drug courts rely on active judicial involvement in individual cases, close monitoring and drug testing by probation staff, and offender participation in community-based drug treatment. The courts may dismiss charges or reduce criminal penalties for persons who comply with drug court requirements, or they may impose sanctions on non-compliant participants. When offender relapse occurs, the courts often respond with additional sanctions or enhanced treatment, rather than immediate termination from the drug court.[49] So far,

- **National research suggests that drug courts contribute to reductions in criminal recidivism, but it has not indicated the extent to which individual components of drug courts—including substance abuse treatment—affect program results.**

Recently, the U.S. Government Accountability Office (GAO) examined the results of 27 drug court evaluations from across the nation. It found that participants in drug court programs usually had rearrest and reconviction rates that were lower than those of comparison groups in the year following program

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[45] Miller and Longabaugh, "Summary and Conclusions," 214.

[46] A. Thomas McLellan, "Is Addiction an Illness—Can It Be Treated?" in *Strategic Plan for Interdisciplinary Faculty Development: Arming the Nation's Health Professional Workforce for a New Approach to Substance Use Disorders*, ed. Mary R. Haack and Hoover Adger, Jr. (Providence, RI: Association for Medical Education and Research in Substance Abuse, September 2002), 84.

[47] Miller and others, "What Works? A Summary of Alcohol Treatment Outcome Research," 38-39.

[48] The first drug court started in Miami in 1989, and there were 1,621 drug courts nationwide in 2004, according to C. West Huddleston, III, Karen Freeman-Wilson, Douglas B. Marlowe, and Aaron Roussell, *Painting the Current Picture: A National Report Card on Drug Courts and Other Problem Solving Court Programs in the United States* (Washington, D.C.: Bureau of Justice Assistance, May 2005), 1.

[49] U.S. Government Accountability Office, *Adult Drug Courts: Evidence Indicates Recidivism Reductions and Mixed Results for Other Outcomes* (Washington, D.C, February 2005), 38-39.

completion. Meanwhile, GAO found "mixed results" regarding the substance use of drug court participants who had completed treatment.[50]

The role of treatment in the success of drug courts is unclear.

But, in cases where drug courts have shown positive effects, it is unclear whether they are due to the amount or type of treatment received, the actions of the judge, the supervision provided by correctional staff, or other factors.[51] Researchers who have observed that drug courts "outperform virtually all other strategies that have been attempted for drug-involved offenders" have also said that drug courts are best thought of as "experimental" until more is learned about how they work and the circumstances in which they are most likely to succeed.[52]

Self-Help Groups

Finally, it is worthwhile to consider previous research on "self-help" or "mutual aid" groups, such as Alcoholics Anonymous (AA). These groups do not involve professionally-directed "treatment," but they are popular and are often used in combination with psychosocial treatment. A recent summary of the effectiveness of these groups concluded the following:

> The data about the effectiveness of self-help groups are limited and mixed. No controlled evaluations of self-help groups other than AA have been reported, and controlled trials of AA alone have not yielded positive findings. However, evaluation studies provide suggestive hints of the positive benefits of AA—large numbers of persons attend and those who maintain their involvement are likely to abstain from the use of alcohol. Evidence suggests strongly that combining AA and professional treatment may enhance the probability of a positive treatment outcome.[53]

RESEARCH ON PRISON-BASED TREATMENT

The community-based programs discussed in the previous sections serve a variety of clients, including many criminal offenders directed to treatment by the courts or their probation officers. However, some chemically dependent offenders are sentenced to prison, due to the severity of their offenses or the length of their criminal histories. Thus, in addition to reviewing past studies of

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[50] *Ibid.,* 5-6, 44-61. The studies with statistically significant differences in rearrest rates had differences ranging from 8 to 35 percentage points. The studies with statistically significant differences in reconviction rates had differences ranging from 8 to 21 percentage points.

[51] *Ibid.,* 5-6; Douglas B. Marlowe, David S. DeMatteo, and David S. Festinger, "A Sober Assessment of Drug Courts," *Federal Sentencing Reporter* 16, no. 2 (December 2003): 156.

[52] Marlowe and others, "A Sober Assessment of Drug Courts," 153, 156. The authors said: "The not-so-simple fact is that drug courts are neither successful nor unsuccessful. They "work" for some clients under some circumstances but are ineffective or contraindicated for others. They can be administered poorly and inefficiently and, unfortunately, we do not know enough to identify specific errors in implementation" (p. 156).

[53] Barbara S. McCrady, A. Thomas Horvath, and Sadi Irvine Delaney, "Self-Help Groups," in *Handbook of Alcoholism Treatment Approaches: Effective Alternatives*, 184.

community-based substance abuse treatment, we also examined research on treatment provided to prisoners. Many studies have examined the extent to which persons released from prison commit new offenses, but relatively few have rigorously examined the role that treatment plays in offender behaviors after prison. It is challenging for researchers to isolate the impact of treatment programs from other variables, such as offenders' willingness to change their behaviors. In recent years, however, several studies have used careful research methods to examine the effects of substance abuse treatment in federal and state prisons.

In general, the more rigorous studies of substance abuse programs have shown that:

- **On average, prisoners who have participated in treatment have had more favorable outcomes than prisoners who did not.**

Several studies have shown favorable outcomes for prison-based treatment programs, at least in the short term.

In prison-based settings, the strongest evidence of favorable outcomes is from several studies of "therapeutic communities," in which the program participants live together in units separate from the general prison population.[54] For example, one study found that federal prison inmates who completed drug treatment programs in therapeutic communities were 44 percent less likely to use drugs in the six months following release than untreated inmates. Also, treated inmates were 73 percent less likely to be rearrested in the six months following release than untreated inmates.[55]

Studies of a California therapeutic community program showed that inmates who participated in prison-based treatment were significantly less likely to return to prison than untreated inmates during the first two years following prison release. Differences between treated and untreated offenders were no longer apparent three years after release from prison.[56]

Multi-year studies of prison treatment in Delaware have consistently shown better outcomes for treated inmates than for comparable groups of untreated ones. Inmates who completed treatment in prison *and* participated in post-prison aftercare had lower levels of drug use and arrests than (1) inmates who completed prison treatment but did not enter aftercare following prison, (2)

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[54] Ojmarrh Mitchell, Doris Layton MacKenzie, and David B. Wilson, "The Effectiveness of Incarceration-Based Drug Treatment on Offending and Drug Use: An Empirical Synthesis of the Research," Paper presented at Annual Meeting of the American Society of Criminology, Chicago, 2002, said that therapeutic communities have been the most effective type of prison-based treatment.

[55] Bernadette Pelissier, Susan Wallace, Joyce Ann O'Neill, Gerald G. Gaes, Scott Camp, William Rhodes, and William Saylor, "Federal Prison Residential Drug Treatment Reduces Substance Use and Arrests After Release," *American Journal of Drug and Alcohol Abuse* 27, no. 2 (2001): 315-337. This study did not involve random assignment of inmates to treatment, but it used methods that controlled for the characteristics of inmates entering (or not entering) treatment.

[56] Michael L. Prendergast, Elizabeth A. Hall, Harry K. Wexler, Gerald Melnick, and Yan Cao, "Amity Prison-Based Therapeutic Community: Five-Year Outcomes," *The Prison Journal* 84, no. 1 (March 2004): 36-60. Treated offenders had significantly lower return-to-prison rates after five years, but the study said that this may have been explained by variables other than in-prison treatment.

inmates who dropped out of prison treatment, and (3) inmates who received no treatment in prison.[57]

Likewise, researchers found that Texas offenders who completed both prison-based treatment and community-based aftercare were less likely to return to prison than comparable offenders who did not. Positive treatment outcomes in the three years following release from prison were especially strong for offenders assessed as having more severe crime and drug-related problems than other offenders.[58]

Aftercare may enhance the effects of prison-based treatment, although further research is needed.

Each of the studies discussed above reported that inmate participation in community-based aftercare programs (following prison-based treatment) is associated with improved outcomes. While some researchers have concluded that in-prison treatment *without* community-based aftercare has little impact,[59] others think that additional research is needed to determine whether the apparent impacts of aftercare programs are due to enrollment of the more motivated offenders in these programs.[60]

[57] James A. Inciardi, Steven S. Martin, and Clifford A. Butzin, "Five-Year Outcomes of Therapeutic Community Treatment of Drug-Involved Offenders After Release from Prison," *Crime and Delinquency* 50, no. 1 (January 2004): 88-107. Even among inmates who completed Delaware's prison-based treatment and community-based aftercare, 52 percent were rearrested and 71 percent used chemicals in the five years after release from prison. The authors tried to control for differences in the treated and untreated inmates, but they acknowledged that they may have been unable to account for some variables.

[58] Kevin Knight, D. Dwayne Simpson, and Matthew L. Hiller, "Three-Year Reincarceration Outcomes for In-Prison Therapeutic Community Treatment in Texas," *The Prison Journal* 79, no. 3 (September 1999): 337-351. Offenders were not randomly assigned to treatment, but the researchers considered differences in offender demographics and motivation during the analysis.

[59] Clifford A. Butzin, Steven S. Martin, and James A. Inciardi, "Evaluating Component Effects of a Prison-Based Treatment Continuum," *Journal of Substance Abuse Treatment* 22 (2002): 63-69, noted that the California and Delaware studies found little difference in outcomes for offenders who only received treatment in prison and those who received no treatment.

[60] Prendergast and others, "Amity Prison-Based Therapeutic Community," 55.

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Community-Based Treatment: Use and Availability

SUMMARY

There is uneven access to publicly-funded substance abuse treatment across the state, despite the existence of uniform placement criteria. Local assessment and referral practices vary, and they have been subject to insufficient oversight by the Minnesota Department of Human Services. Treatment availability also varies, and the department should foster the development of appropriate amounts and types of treatment to effectively meet clients' service needs. Local officials have particular concerns about the lack of adequate treatment options for adolescents, persons with dual diagnoses of substance abuse and mental illness, and methamphetamine users.

State law establishes a policy advocating rehabilitative services for persons with substance abuse problems. But treatment cannot have positive effects if the people who need it do not have access to it. This chapter addresses the following questions:

- **To what extent do Minnesota counties vary in how they assess and refer clients to community-based chemical dependency treatment? Should policy makers be concerned about these variations?**

- **Do local human services agencies have consistent, appropriate methods for assessing the needs of individuals for community-based substance abuse treatment? Has the Department of Human Services adequately overseen local assessment and referral practices?**

- **How has state policy affected eligibility for and use of publicly-funded substance abuse treatment? To what extent do counties vary in their financial responsibility for the costs of publicly-funded treatment?**

- **Is there adequate community-based treatment to meet the needs of local agencies in Minnesota? Has the Department of Human Services taken sufficient steps to ensure the availability of appropriate treatment throughout Minnesota?**

DEPARTMENT OF HUMAN SERVICES' ROLE

State law assigns the Minnesota Department of Human Services (DHS) important regulatory and oversight responsibilities that affect Minnesotans' access to publicly-funded treatment. First, the law requires DHS to establish statewide criteria to determine which persons shall be placed in various types of publicly-funded treatment.[1] Second, since 1984, state law has required DHS to monitor "the conduct of [substance abuse] diagnosis and referral services," which are performed by counties and tribal agencies.[2] Third, the law assigns DHS lead responsibility among state agencies for helping to ensure that Minnesota has a coherent, coordinated system of treatment. For example, the department must prepare a statewide plan for chemical dependency services, and it is supposed to develop new approaches for addressing chemical dependency problems.[3]

Consistent with these responsibilities, DHS has adopted statewide placement criteria, which we discuss later in this chapter. In addition, DHS is in the process of developing new assessment rules that are intended to promote more individualized services. DHS has also provided statewide training on various substance abuse prevention and treatment services. While these efforts have been important and valuable,

- **The Department of Human Services has not (1) provided enough oversight of county practices for placing clients in treatment, or (2) fostered the development of sufficient amounts and types of treatment to effectively meet clients' service needs.**

Stronger DHS leadership, oversight, and guidance could help address inconsistencies in substance abuse treatment.

As we discuss in this chapter, Minnesota has not yet achieved equitable access to publicly-funded treatment. Some clients appear to have better access to services than others, depending on where they live and their service needs. This problem results partly from local variation in (1) assessment and referral practices, and (2) the availability of appropriate treatment services. Local agencies determine who should be treated, where they should be treated, and how state treatment funds should be spent. However, DHS does not systematically examine local agencies' compliance with state regulations on client assessment and referral, nor has the department identified model instruments for assessing clients.[4] And, despite some efforts by the department to foster new treatment programs and approaches, important gaps in services remain around the state.

We recognize that it is not possible to have entirely uniform access to treatment throughout the state. There will always be some geographic regions or types of

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[1] *Minnesota Statutes* 2004, 254A.03, subd. 3, and 254B.03, subd. 1.

[2] *Minnesota Statutes* 2004, 254A.03, subd. 1.

[3] *Ibid*.

[4] Prior to 2003, state law required the department to conduct "quality control audits" of county social services, but DHS officials told us that the agency has not conducted these reviews of local chemical health services since before 2000. In late 2005, DHS assigned chemical health staff to various regions of the state to improve its communications with local officials on treatment-related issues.

clients that are more difficult to serve than others. Also, some differences in the use of treatment reflect differences in counties' spending preferences or their residents' service needs. But, in our view, important inconsistencies could be addressed with stronger DHS leadership, oversight, and guidance. We offer specific recommendations later in the chapter.

COUNTIES' USE OF SUBSTANCE ABUSE TREATMENT

Publicly-funded treatment is targeted toward people with low incomes.

In 2003, the Department of Human Services reported "considerable variation" in counties' admission rates to treatment, including both publicly- and privately-funded treatment.[5] For our report, we focused on the use of publicly-funded treatment, which is targeted in Minnesota toward persons with household incomes at or below the poverty level. To help us account for variations among counties in their levels of poverty, we compared each county's number of adults using publicly-funded treatment to the county's number of adults in poverty.[6] As shown in Table 3.1, we used two measures of treatment utilization, obtained from independent sources.[7] From our analysis, we concluded that:

- **Counties' widely varying rates of treatment use suggest that there is uneven access to publicly-funded substance abuse treatment around the state.**

Statewide, during 2003 and 2004, there were 80 admissions of adults to publicly-funded treatment per 1,000 adults living in poverty. The rates for individual counties ranged considerably, from 168 in Mahnomen County to 22 in Kittson County. Thus, low income persons from Mahnomen County were about eight times more likely to be admitted to publicly-funded treatment than low income persons from Kittson County. In the seven-county Twin Cities area, the number of adult admissions to publicly-funded treatment per 1,000 adults living in poverty ranged from 129 in Anoka County to 53 in Dakota County. Analyses based on local agencies' client authorizations for publicly-funded treatment showed similar patterns (see Table 3.1). Some variation in the use of publicly-funded treatment may reflect differences in the incidence of substance abuse

[5] Minnesota Department of Human Services, *Minnesota's Chemical Health System: A Report to the Minnesota Legislature* (St. Paul, February 2003), 6.

[6] Estimates of individual counties' poverty-level populations are not very accurate in the years between the decennial census. For our analysis, we used each county's 1999 poverty-level population, as reported in the 2000 U.S. Census.

[7] First, we determined the number of clients authorized for treatment paid for by the Consolidated Chemical Dependency Treatment Fund (CCDTF), according to the clients' county of residence. This information is reported by counties and tribes to DHS. Second, we determined the number of admissions to treatment funded by either the CCDTF or the Prepaid Medical Assistance Program, as reported by treatment providers to DHS.

among subgroups of low income persons, but the extent of such differences is unclear.[8]

Table 3.1: Utilization of Publicly-Funded Treatment, 2003-04

Region/County	Average Number of Adult Residents Authorized for Treatment Annually per 1,000 Adults in Poverty	Average Number of Adult Admissions into Publicly-Funded Treatment per 1,000 Adults in Poverty
Statewide	**63**	**80**
Twin Cities Metro Area	**81**	**92**
Washington	109	118
Hennepin	95	109
Anoka	78	129
Scott	72	100
Carver	70	92
Ramsey	65	55
Dakota	56	53
Outstate Counties	**48**	**71**
Select Outstate Counties With Highest Rates		
Mahnomen	155	168
Beltrami	136	156
Becker	102	120
Select Outstate Counties With Lowest Rates		
Stevens	17	34
Winona	16	24
Lincoln	14	28
Kittson	12	22

NOTE: We calculated the average number of annual treatment authorizations and admissions by using data for a two-year period (2003-2004). Treatment authorization rates are based on approved client placement authorizations reported from both counties and tribes to the Department of Human Services, by clients' county of residence. We calculated admissions into treatment using data on treatment services reported by treatment providers to the department. Some counties' low admission rate relative to their treatment authorization rate may be partly due to underreporting by providers to the department or clients' failure to appear for treatment. The number of admissions is typically higher than the number of authorizations because (1) the admissions data include treatment funded by either the Consolidated Chemical Dependency Treatment Fund (CCDTF) or the Prepaid Medical Assistance program, while the authorizations data include only CCDTF-funded cases, and (2) clients may be admitted to more than one treatment program following a county assessment, such as inpatient care followed by outpatient care.

SOURCE: Office of the Legislative Auditor's analysis of data from the Department of Human Services and 2000 U.S. Census.

[8] Demographic factors such as racial or cultural differences *may* contribute to some of the differences in counties' overall rates of treatment utilization. For example, the three outstate counties shown in Table 3.1 with high treatment utilization (Mahnomen, Becker, and Beltrami) each have sizable American Indian populations and, in each of these counties, American Indians accounted for a larger share of 2003-04 publicly-funded adult chemical dependency treatment admissions than their share of the adults in poverty. However, *within* individual racial categories, we also found sizable differences among counties' rates of treatment utilization by low income persons.

Wide variation in referrals to publicly-funded treatment suggests uneven access to services.

We also found that the use of publicly-funded treatment for adolescents varied widely around Minnesota, suggesting uneven access to services. Among the counties with at least 200 adolescents in poverty-level households, five had fewer than 20 treatment admissions in 2003-04 per 1,000 adolescents in poverty-level households, while six counties had more than 100 admissions per 1,000 adolescents in poverty-level households. Among individual counties, the number of admissions per 1,000 adolescents in poverty ranged from 183 in Cass County to 10 in Fillmore County.[9]

We also looked at counties' use of various *types* of care for clients. As we noted earlier, Minnesota law requires the Commissioner of Human Services to establish uniform statewide placement criteria that counties and tribes must use to determine the appropriate "level of care" for public assistance recipients who seek chemical dependency treatment.[10] However,

- **The type of care that individuals receive depends considerably on which county makes the placement.**

Currently, state assessment rules identify the following "levels of care": outpatient, primary rehabilitation (sometimes called "inpatient care"), extended care, and halfway houses (see Table 1.4). Each type of care has state-specified placement criteria. Statewide, counties rely mostly on outpatient services for clients who are authorized for treatment paid for by the Consolidated Chemical Dependency Treatment Fund, as shown in Table 3.2. During the 2003-04 period, 61 percent of these publicly-funded clients were referred to outpatient care *at least once* (in combination with or exclusive of other care). Meanwhile, 31 percent of clients had a referral to inpatient treatment, 25 percent had a referral to a halfway house, and 12 percent had a referral to extended care.

But Table 3.2 shows that individual counties differed considerably in their use of the various levels of care for clients authorized for publicly-funded treatment. For example, Dakota used outpatient care for 83 percent of its clients, while another Twin Cities county (Anoka) used outpatient care for just 52 percent of its clients. Some counties used inpatient care for less than 20 percent of their publicly-funded clients, while LeSueur County placed 63 percent of its clients in inpatient care. Overall, counties in the Twin Cities area tended to rely more on

[9] The rates cited here are from the 40 counties that had at least 200 persons ages 12 to 17 living in poverty-level households, according to 2000 census data. We examined the number of adolescents admitted to publicly-funded treatment in 2003 and 2004 and compared the average annual number of admissions of residents from each county to the county's total number of adolescents who, according to census data, lived in households with poverty-level incomes. An analysis of counties' treatment *authorizations* during this period showed similarly wide variation to what we found in the *admissions* data.

[10] *Minnesota Statutes* 2004, 254A.03, subd. 3. According to the law, "the criteria shall address, at least, the family relationship, past treatment history, medical or physical problems, arrest record, and employment situation."

Table 3.2: Select Counties' Treatment Referral Practices for Consolidated Chemical Dependency Fund Clients, 2003-04

Region/County	Average Number of Care Levels per Client	Percentage of Clients With at Least One Inpatient Referral	Percentage of Clients With at Least One Outpatient Referral	Percentage of Clients With at Least One Extended Care Referral	Percentage of Clients With at Least One Halfway House Referral	Median Age of Clients Assessed[a]
Statewide	**1.3**	**30.7%**	**61.4%**	**12.5%**	**24.6%**	**32**
Twin Cities Metro Area	**1.3**	**25.2**	**68.7**	**11.9**	**23.9**	**34**
Scott	1.4	34.2	62.1	14.0	33.9	28
Anoka	1.4	39.0	52.4	14.3	35.5	30
Hennepin	1.3	26.5	64.4	13.0	30.7	36
Washington	1.3	23.1	73.4	9.9	24.8	29
Ramsey	1.1	18.6	79.6	9.6	3.2	35
Carver	1.1	18.3	65.2	12.1	14.7	27
Dakota	1.1	14.8	82.9	3.0	8.3	29
Outstate	**1.4**	**40.2**	**54.1**	**14.0**	**27.1**	**28**
Select Counties[b]						
Otter Tail	1.6	45.2	48.7	22.6	41.9	29
Kandiyohi	1.5	43.0	57.0	20.3	33.9	25
Mille Lacs	1.5	43.1	54.9	11.8	44.4	29
Pennington	1.1	18.9	67.0	8.5	13.2	34
LeSueur	1.1	63.0	33.8	3.2	7.1	25

NOTE: Analysis represents only those clients who were assessed and authorized for treatment paid for by the Consolidated Chemical Dependency Treatment Fund. It includes clients and referrals for each county in which a client was assessed and authorized for CCDTF-funded treatment during 2003-04; assessments and referrals by tribal agencies were excluded. All analysis of care levels and inpatient referrals includes both primary inpatient care and combination inpatient portions of referrals. Primary outpatient and combination outpatient portions of referrals are also combined.

[a] Based on clients' age at time of most recent assessment for that county or region.

[b] Counties with more than 100 residents assessed and authorized for CCDTF-funded treatment during 2003-04.

SOURCE: Office of the Legislative Auditor's analysis of Department of Human Services' Client Placement Authorization data.

outpatient treatment and less on inpatient care than counties elsewhere in the state.[11]

Also, some counties were considerably more likely than others to refer clients to multiple levels of care during this two-year period. Such referrals might be done to provide a sequence of treatment to clients (such as inpatient care followed by outpatient care), or to try different treatment approaches with clients who have been through treatment previously. Table 3.2 shows that the average client authorized for publicly-funded treatment from Otter Tail County was referred to 1.6 levels of care during 2003-2004. In contrast, clients authorized for treatment

[11] Data on total admissions in the 2003-04 period showed similar variation in county placement patterns. Among counties with more than 100 admissions into treatment by their residents in 2004, the percentage of admissions into inpatient care ranged from 11 percent in Carver County to 54 percent in Cass County. Admissions into outpatient care ranged from 17 percent of all admissions in Otter Tail County to 69 percent in Dakota County.

from counties such as LeSueur and Dakota were usually referred to just one type of care.

We offer no opinions about whether individual counties have made the "right" types of treatment referrals. For example, placing clients in multiple levels of care is not necessarily preferable to placing them in single levels of care. While it is reasonable to expect some variation in counties' referral practices and use of treatment, the large variations we note here suggest uneven access to treatment services. Interviews and surveys led us to consider two possible explanations, discussed in the next sections: (1) differences in local assessment practices, and (2) differences in the availability of treatment services around the state.

CHEMICAL USE ASSESSMENTS

Counties are "gatekeepers" for Minnesota's publicly-funded substance abuse treatment services.

County agencies play key roles as "gatekeepers" in Minnesota's chemical health system, conducting assessments and making referrals to publicly-funded services. Given the variation among counties in substance abuse treatment utilization discussed in the previous section, we explored local variation in the assessment process. We focused on assessments that are conducted by, or on behalf of, county human services agencies for the purpose of making referrals to treatment. These assessments are commonly referred to as "Rule 25" assessments.[12]

Scope of County Assessment Responsibilities

State law requires that each local human services agency "provide chemical dependency services to persons residing within its jurisdiction who meet criteria established by the [Commissioner of Human Services] for placement in a chemical dependency residential or nonresidential treatment service."[13] To be placed in publicly-funded treatment, state rules require persons to first undergo a chemical use assessment.[14] These assessments are conducted by counties and American Indian tribes, as well as prepaid health plans that contract with the Department of Human Services.[15] The assessments determine whether

[12] *Minnesota Rules* 2005, 9530.6600-6660, are commonly referred to as Department of Human Services "Rule 25." We did not examine in detail the chemical use assessments of persons convicted of impaired driving, which are conducted by court-appointed assessors. According to *Minnesota Statutes* 2004, 169A.70, the impaired driving assessments must be conducted by assessors who meet the training requirements specified in state rules for Rule 25 assessors. Like Rule 25 assessments, these assessments indicate the severity of the person's chemical involvement and recommend a level of care. The law requires assessment reports on convicted impaired drivers to be submitted to the courts and the Minnesota Department of Public Safety.

[13] *Minnesota Statutes* 2004, 254B.03, subd. 1.

[14] *Minnesota Rules* 2005, 9530.6615, subp. 1.

[15] *Minnesota Rules* 2005, 9530.6610, subp. 1 requires counties to assess "all clients who seek treatment or for whom treatment is sought." But the rules also require prepaid health plans to assess and place their enrollees, using the placement criteria in the rules. In addition, DHS contracts with each tribal government to assess persons living on reservations.

individuals have chemical use problems and, if so, the programs to which they should be referred.[16]

In addition to assessing persons before they are placed in publicly-funded treatment, county human services agencies have broader responsibilities for chemical use assessments and services. Since 1979, counties have received block grants from the state to help them provide a system of social services, including services for persons with drug or alcohol problems. The state's Community Social Services Act provided the statutory framework for this system until its repeal in 2003.[17] Since then, the Children and Community Services Act has governed the state and local system of social services.[18] However,

- **State law does not explicitly define which persons local human services agencies must assess for chemical dependency, and this contributes to variations in clients' access to services.**

Recent changes in state laws gave counties more latitude to determine whom to assess.

Until 2003, state law required counties to conduct "an assessment of the needs of each person applying for [social services] assistance."[19] Chemical health officials from the Minnesota Department of Human Services told us that they instructed counties to assess all persons seeking chemical use assessments, without regard to eligibility for publicly-funded treatment.[20]

The 2003 Legislature made significant changes to the laws governing county-administered social services. The new act gave counties more latitude to curtail services, including assessment, due to funding limitations. The law no longer required assessment of each person seeking assistance, and assessment was not among the services that were required to receive counties' "highest funding priority."[21] Department of Human Services officials said they did not know whether legislators were fully aware that the 2003 statutory changes weakened the assessment obligations of county human services agencies.

We visited eight counties and conducted phone interviews with chemical health staff in several other counties. We found that local human services agencies vary in their policies regarding which clients they will assess. For example, most county human services agencies we contacted said they would assess any person

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[16] State rules also require licensed treatment programs to conduct a "comprehensive assessment" of clients within three calendar days of service initiation, examining all of the areas listed in Table 3.3. Thus, Rule 25 assessments are not the only assessments of clients, but they are a critical first step toward directing clients to services that will address their needs.

[17] *Minnesota Statutes* 2002, 256E.01-256E.115 (repealed by *Laws of Minnesota* 2003 First Special Session, chapter 14, art. 11, sec. 12).

[18] *Minnesota Statutes* 2004, chapter 256M.

[19] *Minnesota Statutes* 2002, 256E.08, subd. 1.

[20] State chemical dependency rules do not address the obligation of counties to assess persons who are not eligible for publicly-funded treatment. *Minnesota Rules* 2005, 9530.6615, subp.1, requires counties to "provide a chemical use assessment for each client seeking treatment or for whom treatment is sought," where "client" is defined as a person who is eligible for treatment funded by certain public programs.

[21] *Laws of Minnesota* First Special Session 2003, chapter 14, art. 11, sec. 8.

who requested or was referred for a chemical use assessment.[22] However, two counties told us that they initially determine a person's eligibility for publicly-funded treatment, and they will not assess persons who are not eligible for such treatment. Persons in these two counties could be assessed by other trained substance abuse assessors, such as probation staff or private vendors, but they might have to pay for it.[23]

Many counties assess anyone who is referred for an assessment, but some counties do not.

Another county's Rule 25 assessment staff told us they will not conduct chemical use assessments of persons who do not admit to a substance abuse problem. For example, in a case where the court orders an assessment but the offender denies a substance abuse problem, the offender would be expected to pay for an assessment by a private vendor.[24]

Thus, while many human services agencies are willing to assess all persons who seek assessments or are referred for assessments, some are not. As a result, some persons have to pay for assessments that persons in other counties would receive free of charge. It is plausible that this discourages some persons from seeking assessments and, consequently, receiving treatment.[25]

Assessment Procedures

State administrative rules establish a uniform framework for Rule 25 chemical use assessments. First, staff who conduct the assessments must meet minimum education and training requirements.[26] Second, the rules set general requirements regarding the content of assessments. Assessments must include a personal interview with the client, a "review of relevant records or reports regarding the client," and contacts with other persons who are familiar with the client's circumstances.[27] Rule 25 assessors must consider the topics listed in Table 3.3

[22] Counties typically encourage persons to get assessments from their insurers, if they have insurance, because insurers may have their own criteria for making referrals to treatment. However, if insured persons prefer to have the county conduct an assessment, most staff in most counties we visited told us they would do so.

[23] In a statewide survey of directors of community-based corrections agencies, 30 percent of the directors said that their agencies had at least one probation officer who regularly conducted Rule 25 assessments. The survey asked the directors not to consider the assessments of impaired drivers required by *Minnesota Statutes* 2004, 169A.70 when responding to this question.

[24] Staff in this county told us they do not think they have authority in law or rule to make clinical judgments about service needs for clients who do not admit to problems. The Minnesota Department of Human Services disagrees with this interpretation, noting that there are no exclusions in state rules for persons who are not motivated to change their behaviors.

[25] There are no statewide data on the extent to which persons seek treatment but do not receive it, either because the assessor did not recommend placement or because no assessment was conducted.

[26] *Minnesota Rules* 2005, 9530.6615, subp. 2. There are several ways to meet the requirements, all of which require completion of 30 hours of classroom instruction on chemical dependency assessment in addition to other requirements for education or work experience. Also, assessors must annually complete at least eight hours of in-service training or continuing education.

[27] *Minnesota Rules* 2005, 9530.6615, subp. 3. The rules require "collateral contacts," which may include contacts with family members, criminal justice agencies, educational institutions, and employers. The rules do not specify how many collateral contacts must be made, and they require assessors to explain reasons in client records for any failures to make collateral contacts. Regarding the personal interviews with clients, staff in the eight counties we visited indicated that the typical length of these interviews ranges from 30 minutes in one county to two hours in another.

during the assessment process. Third, assessors must rate each client's "level of chemical involvement" as: (a) no apparent problem, (b) "at risk" of developing future problems associated with chemical use, (c) chemical "abuse," or (d) chemical "dependence" (a more severe level of substance use than the other categories). Fourth, state rules specify an appeals process for clients who disagree with the results of an assessment.

State rules establish a uniform framework for chemical use assessments.

Table 3.3: Required Topics for Consideration in Rule 25 Assessments

- **Amount and frequency of chemical use**
- **Client characteristics** (age, sex, cultural background, sexual preference, and location of home)
- **Client's behaviors under the influence of chemicals**
- **Family issues** (family status and history, level of family support, effects of client's chemical use on family members and significant others, and effect on client of chemical use by family members or significant others)
- **Client's prior assessments or attempts at treatment** (for chemical use or mental illness)
- **Client's physical or mental disorders**
- **Prior arrests or legal interventions related to chemical use**
- **Impact of chemicals on client's ability to work**
- **Impact of chemicals on client's ability to learn**

SOURCE: *Minnesota Rules* 2005, 9530.6620, subp. 1.

Local Officials' Perceptions Regarding Rule 25 Assessments

To help us evaluate the adequacy of Rule 25 assessments, we surveyed the directors of community-based corrections agencies. These agencies frequently refer criminal offenders for Rule 25 assessments. As shown in Table 3.4, most corrections agency directors said that their counties' Rule 25 assessments are generally accurate in identifying which offenders need treatment. However,

- **Many corrections directors expressed concerns about the consistency, timeliness, and thoroughness of the assessments.**

For example, 41 percent of the directors said that there is "sometimes," "rarely," or "never" consistency between counties in their application of the state's criteria for determining clients' need for placement. Also, 32 percent of the directors, including directors serving five of the state's seven largest counties, said that offenders' mental health needs are "sometimes," "rarely," or "never" adequately considered during Rule 25 assessments.

In addition, some county and judicial officials expressed concerns about the timeliness of Rule 25 assessments. State rules do not specify what constitutes a reasonable time period for completing a Rule 25 assessment following a client's referral, and local agencies do not report data to the Department of Human Services that could be used to measure how much time elapses.[28] In some cases,

[28] Lacking a benchmark for timeliness in state rules, we did not ask corrections directors in our survey to rate the timeliness of the Rule 25 assessment process. Still, several respondents commented on this issue.

local officials told us that assessments are done promptly. For example, defendants arraigned in Hennepin County's drug court typically receive their Rule 25 assessments on the same day as their first court appearance. However, we also heard concerns such as the following:

> A corrections director in western Minnesota said: *"In some of our counties, it can be three months or so before we receive the assessment back. During this time, the offender is not receiving services in the community and is most likely continuing to use, which increases the likelihood of probation violations or new offenses."*
>
> A corrections director in northern Minnesota said: *"Waiting lists [for assessment] can be as long as three months on occasion. Very concerning because this may jeopardize public safety and health of offender."*

Table 3.4: Local Corrections Directors' Perceptions of Rule 25 Assessments

	Percentage of Directors Who Said:		
	Always, Almost Always, or Usually	Sometimes, Rarely, or Never	Don't Know
There is good communication between our agency and the Rule 25 assessors of the offenders we supervise.	92%	8%	0%
Rule 25 assessments conducted in my agency's county accurately identify which offenders need treatment.	83	15	2
Probation officers provide assessment staff with information on the offense history of offenders referred for assessment.	76	24	0
Within counties with more than one Rule 25 assessor, there is consistency among assessors in their application of state criteria.	76	22	2
The mental health needs of offenders are adequately considered during the Rule 25 assessment process.	60	32	7
Rule 25 assessments rely too much on self-reported information from the subjects of the assessments.	41	57	2
Between counties, there is consistency among Rule 25 assessors in their application of state criteria.	39	41	20

SOURCE: Office of the Legislative Auditor's survey of community-based corrections directors, September 2005 (*N*=54). Persons who responded "not applicable" were excluded from the calculations.

Some local corrections officials report that chemical use assessments are not timely or rely too much on self-reported information.

In various locations around the state, judges and local human services officials told us about difficulties getting timely assessments for offenders who were in jail outside their home counties. For example, some described situations in which the offender's home county refused to allow the county in which the jail was located to conduct the assessment, but the home county also refused to send staff to the jail to conduct the assessment.[29]

Some corrections directors also expressed concerns about the thoroughness of Rule 25 assessments. As shown in Table 3.4, 41 percent of the corrections directors responding to our survey said that the assessments "usually," "almost always," or "always" rely too much on self-reported information from the offenders. Most corrections directors said that their agencies typically provide information to the Rule 25 assessors on offenders' criminal histories, but some agencies expressed frustration that they are not consulted by the assessors more regularly:

> A corrections official from a county in the Twin Cities metropolitan area said: *"It should be a requirement that, if there is an assigned probation officer, he/she be contacted as a collateral contact during the assessment and referral process."*[30]
>
> A corrections director in northern Minnesota said: *"We, many times, have a ton of information (reports, assessments, investigations) on clients that we could, if asked and with appropriate signed release, provide to [the Rule 25] assessor and treatment facility."*

Assessment Instruments

We met with human services staff in eight counties to discuss their assessment practices in more detail. In each county, we reviewed the instruments that the Rule 25 assessors used to collect information from the people they assess. Table 3.3 listed topics that must be addressed during these assessments, although state rules do not prescribe that assessors use a particular assessment instrument. In our site visits, we found that:

- **Counties use varied approaches to conduct chemical use assessments, which probably contributes to inconsistencies in assessors' conclusions regarding clients' service needs.**

All of the counties we visited use some sort of structured interview to gather information from clients during the assessment process. Most rely extensively on instruments they developed rather than commercial instruments. As a result, there are differences among the instruments, such as those shown in Table 3.5.

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[29] Also, officials in several counties told us that there have been occasional disputes about which county is the "home county" of a person needing an assessment. Financial responsibility for human services is governed by *Minnesota Statutes* 2004, chapter 256G (Minnesota Unitary Residence and Financial Responsibility Act), but counties have sometimes had differing interpretations of this law.

[30] The 2005 Legislature passed a law requiring assessors to contact probation officers during chemical use assessments of persons convicted of impaired driving, but there is no such requirement for Rule 25 assessments (see *Laws of Minnesota* 2005, chapter 136, art. 18, sec. 9).

Table 3.5: Examples of Differences in Counties' Substance Abuse Assessment Instruments

Withdrawal symptoms: One of the criteria for determining whether someone is chemically dependent is whether the person has experienced withdrawal symptoms following cessation of chemical use. Some counties' instruments had specific questions that addressed this. For example, one county listed 16 symptoms with the following question: "Have you ever felt any of the following after two days or longer of not using/drinking?" In contrast, some instruments simply asked clients whether they had experienced withdrawal (with no discussion of possible symptoms), and other instruments had no questions that specifically addressed withdrawal.

Mental health symptoms: Some counties' instruments had a series of specific questions in which assessors asked clients about current or previous mental health problems—for example, prior diagnoses, hospitalizations, medications, or other treatments for mental illness; thoughts of suicide or suicide attempts; histories of emotional, sexual, or physical abuse, eating disorders, or violent behaviors; and use of chemicals to cope with depression. In contrast, some counties' assessment instruments only had open-ended categories (such as "mental health history") with no specific questions, leaving considerable discretion to the assessors.

SOURCE: Office of the Legislative Auditor's review of assessment instruments in select counties.

There are important differences in counties' practices for conducting chemical use assessments.

There are also potential inconsistencies *within* counties. One county uses several instruments that differ considerably in detail and format, and each of its assessors uses the instrument he or she prefers. In another county, judges told us that some Rule 25 assessors are more likely to recommend treatment than others, and that judges sometimes consider this when deciding where to refer offenders for assessment.

We also examined whether individual counties have implemented specialized approaches to assess adolescents. Adolescents and adults often have similarities in their patterns and symptoms of substance use. But, as one recent research review concluded, "it appears just as likely that an adolescent could be using substances problematically, yet bear little or no resemblance to an adult with a substance-use disorder. In this respect, the need for adolescent-specific assessment is apparent."[31] Also, a young adolescent who drinks alcohol regularly might warrant some sort of intervention, even if the same consumption level in an adult would not necessarily be cause for concern.[32] The American Society for

[31] William R. Miller, Verner S. Westerberg, and Holly B. Waldron, "Evaluating Alcohol Problems in Adults and Adolescents," in *Handbook of Alcoholism Treatment Approaches: Effective Alternatives*, 3rd ed., ed. Reid K. Hester and William R. Miller (Boston: Allyn and Bacon, 2003), 83.

[32] *Ibid.*

Addiction Medicine has recommended the use of distinct placement criteria for adults and adolescents, although Minnesota rules do not specify separate criteria.[33] We found that:

- **For the most part, Rule 25 assessors in the counties we visited do not use adolescent-specific assessment instruments or placement criteria.**

Most of these counties conduct structured interviews of adolescents using instruments that are similar to (or the same as) those used for adults.[34] There are a variety of commercial instruments specifically designed for assessing adolescent substance use, although the "state of the art" in adolescent assessment is less developed than adult assessment.[35]

County Findings of "Abuse" and "Dependence"

Determinations of "abuse" and "dependency" affect the types of treatment clients are eligible to receive.

The types of care in which publicly-funded clients can be placed depend partly on whether the clients are determined by assessors to be chemically "dependent," rather than chemically "abusive." For example, according to Minnesota's administrative rules, clients cannot be placed in inpatient treatment or extended care unless they have been assessed as chemically dependent.[36] We looked at counties' 2003-04 assessment findings for clients authorized for treatment paid for by the Consolidated Chemical Dependency Treatment Fund, and we found:

- **Among counties, the percentage of clients assessed as "dependent" ranged from 45 percent to 100 percent.**

Statewide, counties assessed 84 percent of clients authorized for publicly-funded treatment as chemically dependent, with the other 16 percent assessed as chemically abusive.[37] But, among counties, there were considerable differences in the assessment findings for clients. Table 3.6 shows the variation in assessment results for select counties and regions of the state during the two-year period. While it is reasonable to expect some variation in counties' assessment findings, the differences discussed here provide further evidence of inconsistency in counties' assessment practices. Such differences may contribute to unequal access, because abuse and dependency determinations directly affect the types of treatment for which persons are eligible.

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[33] American Society of Addiction Medicine, Inc., *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders*, 2nd ed. revised, ed. David Mee-Lee (Chevy Chase, MD: ASAM, 2001).

[34] Staff in one county mentioned several adolescent-specific instruments that they often use to supplement standard interviews, and staff in another county said that they require at least one parent to be present during adolescent assessments.

[35] Miller, Westerberg, and Waldron, "Evaluating Alcohol Problems in Adults and Adolescents," 82.

[36] *Minnesota Rules* 2005, 9530.6630, subp. 1, and 9530.6640.

[37] Local agencies do not report information to the Department of Human Services on the number of clients who were *not* referred to treatment following an assessment.

Table 3.6: Assessment Results of Clients Authorized for Publicly-Funded Treatment, Select Counties, 2003-04

Region/County	Number of Clients Authorized for Treatment Paid for by the Consolidated Chemical Dependency Treatment Fund (CCDTF)	Percentage of CCDTF Clients Assessed as Chemically Dependent	Percentage of CCDTF Clients Assessed as Chemically Abusive
Statewide	**30,302**	**84%**	**16%**
Twin Cities Metro Area	**17,817**	**84**	**16**
Carver	224	95	5
Scott	301	92	8
Ramsey	3,819	90	10
Washington	757	90	10
Anoka	1,190	87	13
Hennepin	10,583	82	18
Dakota	943	69	31
Outstate	**12,485**	**83**	**17**
Counties with Highest Rate of "Dependent" Clients[a]			
Martin	182	98	2
LeSueur	154	97	3
Freeborn	164	96	4
Meeker	105	95	5
Counties with Lowest Rate of "Dependent" Clients[a]			
Mower	331	64	36
Morrison	168	63	37
Douglas	215	62	38
Beltrami	416	55	45

NOTE: Analysis represents only those clients who were assessed and authorized for treatment paid for by the Consolidated Chemical Dependency Treatment Fund. Assessment results include clients assessed by county agencies only, and exclude clients assessed by tribal agencies. Clients and assessment results were included for each county in which a client was assessed and authorized for CCDTF-funded treatment during 2003-04.

[a] Counties with more than 100 residents assessed and authorized for CCDTF-funded treatment.

SOURCE: Office of the Legislative Auditor's analysis of Department of Human Services' Client Placement Authorization data.

Assessment Recommendations

Minnesota's regulations for substance abuse treatment are changing. New state rules governing chemical dependency treatment programs took effect in January 2005, eliminating the "level of care" categories that have often been used to categorize programs (inpatient treatment, outpatient treatment, halfway houses, and extended care). DHS staff regard the new treatment rule as "client-focused" rather than "program-focused"—that is, encouraging programs to tailor services to individual needs, rather than the previous approach of trying to "fit" clients

into distinct program categories. Under the rule, treatment programs are expected to continuously monitor client progress (using the "dimensions" shown in Table 3.7) and adjust treatment accordingly.

DHS plans to implement new rules in 2007 for assessing clients prior to their referral to treatment.

Meanwhile, the department is drafting new rules for pre-referral chemical use assessments. These rules, which are scheduled to take effect in January 2007, would require counties, tribes, and prepaid health plans to assess clients' risks in each of the areas shown in Table 3.7. The rules specify services that must be provided for persons at various risk levels.[38] Local assessors would still have considerable latitude in determining what specific information to obtain from clients to make judgments about placement.

Table 3.7: Client "Dimensions" that Substance Abuse Treatment Providers Must Assess

1. Potential for acute intoxication and withdrawal
2. Biomedical conditions and complications
3. Emotional and behavioral conditions and complications
4. Treatment acceptance and resistance
5. Potential for relapse and continued substance use
6. Recovery environment

SOURCE: *Minnesota Rules* 2005, 9530.6422, subp. 2.

The department's efforts to develop new assessment rules have considerable support among local officials with whom we spoke. However, we think there are several issues that state policy makers and administrators should address to improve client assessments and referrals.

RECOMMENDATIONS

To provide more consistency in assessment practices, the Department of Human Services should:

- ***Distribute information to chemical health assessors on "best practices" in assessments, including model instruments for adults and adolescents; and***

- ***Monitor the compliance of local agencies with assessment and referral rules.***

There is considerable support within the chemical dependency and corrections fields for the use of standardized or "semi-structured" assessment instruments, to help ensure that assessments (1) identify symptoms that are relevant for purposes of diagnosis, placement, and treatment planning, (2) do not overlook important

[38] For example, for clients with low motivation for change and passive involvement in treatment (risk level 2 on the "treatment acceptance and resistance" dimension), the draft rules require that treatment include "engagement strategies" (which are undefined).

client characteristics, and (3) result in reasonably consistent findings by different assessors.[39] In several counties we visited, staff said that they would welcome guidance from the Minnesota Department of Human Services regarding "model" instruments for chemical use assessment.

DHS should provide guidance to counties on good assessment methods, and it should monitor actual assessment and referral practices.

We do not recommend that the department or Legislature mandate the statewide implementation of a single assessment instrument. But we think that the department should provide ongoing guidance to help assessors understand the strengths and weaknesses of various assessment methods. In late 2005, the Department of Human Services hired a consultant to prepare a report discussing the most promising assessment tools for substance abuse in adolescents. It is too early to know how the department will use this information, but these efforts were a good first step. We think the department should help counties identify model instruments for adult assessments, too. Similarly, the department could provide guidance on particular assessment components (such as assessment of clients' mental health status), or ways to assess clients that are sensitive to age, gender, or cultural characteristics. The department told us that it intends to incorporate guidance on assessment practices into its 2006 statewide training related to the implementation of new assessment rules.

We also think that the Department of Human Services should fulfill its statutory obligation to oversee local assessment and referral processes. Increased state oversight would promote consistency. Rule 25 assessments play a key role in local decisions regarding who will be referred to treatment services that are funded largely by the state, yet the state does not actively monitor these assessments. Just as the department now reviews treatment programs' compliance with state licensing rules, the department should monitor local compliance with state assessment rules.

RECOMMENDATION

The Department of Human Services should develop a directory that identifies key characteristics of each licensed chemical dependency treatment program.

In our view, the appropriateness of client placements could be enhanced if local agencies had more information about the state's licensed treatment programs. There are nearly 300 treatment programs in Minnesota and, as of January 2005, they are no longer distinguished by labels such as "primary treatment" (inpatient or residential care), "outpatient treatment," "extended care," and "halfway house." These labels have been a centerpiece of the state's placement criteria, but assessors will now need to rely on their knowledge of differences in programs' content. Assessors often gain a working understanding of the programs in their regions, but some county staff told us that they would welcome

[39] For example, U.S. Department of Health and Human Services, *Treatment for Alcohol and Other Drug Abuse: Opportunities for Coordination* (Washington, D.C., 1994) says that substance abuse assessment instruments should be evaluated for validity and reliability. Also, Re-Entry Policy Council, *Charting the Safe and Successful Return of Prisoners to the Community*, (New York, 2004), 133, encourages "the use of only validated screening and assessment instruments in the intake procedure."

additional information. As discussed in Chapter 1, there is no statewide directory of substance abuse treatment programs that indicates the types of treatment approaches the programs use or which optional services they provide. Such a directory could also indicate which programs have specialized staff (such as psychologists or other mental health staff), on-site housing, and "case management" services for ongoing client monitoring. This information may help local agencies ensure that clients are receiving appropriate types of services, in the proper setting, and for the right duration.

Also, an inventory of treatment programs could help state and local agencies exercise program oversight. For example, it could help these agencies identify gaps in services, or determine whether existing services are consistent with research-based treatment practices (such as those discussed in Chapter 2). Descriptions of program characteristics could also help state and local officials to differentiate programs when they analyze client outcomes.

RECOMMENDATION

To address concerns about the timeliness and thoroughness of assessments, the Legislature should amend state law:

- ***To clarify responsibility for chemical use assessments of persons jailed outside their home counties; and***
- ***To require that chemical use assessors interview the probation officers of persons on probation.***

State law should be amended to help ensure timely chemical use assessments of persons in jail.

DHS' draft assessment rules would establish timeframes in which Rule 25 assessments must be conducted.[40] However, the draft rules do not directly address what happens in cases where clients are taken into custody by law enforcement outside their home counties. Some local chemical dependency officials told us their agencies do not have sufficient resources to travel to other counties' jails to conduct assessments. Without provisions for these inter-county cases, the stipulation of assessment deadlines in the new rules might not fully address problems with assessment timeliness. In our view, a preferable approach is the one specified in law for chemical use assessments of convicted impaired drivers. For such persons, the assessment must be conducted by the home county within a statutorily-specified period, or else the county where the person will be sentenced must conduct the assessment and bill the home county.[41]

In addition, we think that assessors should be required to contact probation officers when assessing the chemical health of persons on probation. This would help to address concerns that some Rule 25 assessments rely too much on self-reported information. We think that the impaired driving statutes again provide a useful model, as they require assessors of convicted impaired drivers to make

[40] The draft rules specify that, for any client "seeking treatment or for whom treatment is sought," the client must be interviewed within 15 calendar days from the date an appointment was requested, and the assessment must be completed within 7 days of the initial interview.

[41] *Minnesota Statutes* 2004, 169A.70, subd. 4.

"collateral contacts" with probation officers (for offenders who have them).[42] There is no such requirement in statute or rule for Rule 25 assessments.[43]

RECOMMENDATION

The Legislature should consider amending state law to prohibit Rule 25 assessors from having financial conflicts of interest with treatment providers, except in circumstances that are now specified in state rules.

State laws and rules should have consistent provisions regarding conflicts of interest for people who conduct chemical use assessments.

In most counties we visited or contacted, Rule 25 assessments are usually done by county assessment staff in a social services or probation agency. In some cases, however, counties contract with private organizations to conduct assessments, and some of these organizations also provide substance abuse treatment.

Currently, state rules governing chemical use assessments prohibit counties from contracting with assessors who have a "direct shared financial interest or referral relationship resulting in shared financial gain with a treatment provider," except in certain cases specified in the rules.[44] The Department of Human Services has proposed eliminating language regarding conflict of interest from the assessment rules.[45] However, state law still prohibits such conflicts of interest in chemical use assessments that are conducted as part of offenders' pre-sentence investigations.[46] Also, state law prohibits such conflicts in chemical use assessments of impaired drivers, and these statutory provisions reference the rule language that DHS proposes to eliminate.[47] We think that it would be confusing and contradictory to have differing requirements regarding conflicts of interest for different types of chemical use assessments. Thus, before DHS proceeds with adoption of proposed rules during the coming year, we suggest that the Legislature consider amending *Minnesota Statutes* chapter 254A to include the conflict of interest provisions that are now in the existing rules. Alternatively, if the Legislature does not wish to adopt these provisions into law for Rule 25 assessments, it should consider repealing the statutory conflict of interest provisions that now apply to pre-sentence investigations and impaired driver assessments.

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[42] *Laws of Minnesota* 2005, chapter 136, art. 18, sec. 9.

[43] Also, it would be a good practice for probation officers to regularly share relevant information with assessors about offenders that the officers (or courts) have referred for assessment, rather than waiting for the assessors to initiate this contact.

[44] *Minnesota Rules* 2005, 9530.6610, subp. 3. The rules authorize exceptions to this general provision, if the county can document that (1) the assessor provides "culturally specific" services or provides services designed for individuals of a particular age, sex, or sexual preference, or (2) it does not employ enough qualified assessors, and the only available assessor in the county has financial interests with a treatment provider.

[45] DHS staff told us that such conflicts of interest are less common than they used to be, and counties have been made aware of the risks of such arrangements. Also, DHS staff noted that counties, not assessors, have the ultimate responsibility for making client placements.

[46] *Minnesota Statutes* 2004, 609.115, subd. 8(b).

[47] *Minnesota Statutes* 2004, 169A.70, subd. 4.

AVAILABILITY OF SUBSTANCE ABUSE TREATMENT

One of the National Institute on Drug Abuse's principles of effective substance abuse treatment is that treatment needs to be readily available. According to the institute,

> Because individuals who are addicted to drugs may be uncertain about entering treatment, taking advantage of opportunities when [the individuals] are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.[48]

In July 2005, there were 280 licensed substance abuse treatment programs in Minnesota. We found that:

- **The number of non-residential treatment programs in Minnesota grew in recent years, while the number of residential programs remained fairly stable.**

Table 3.8 shows that the number of licensed non-residential programs grew from 113 in 2000 to 188 in 2005, a 66 percent increase. Non-residential programs are not licensed for a specified capacity, so it is hard to determine precisely what impact the program increase had on the availability of non-residential treatment "slots." Meanwhile, the number of residential programs and their total licensed capacity did not change much from 2000 to 2005, although there were minor fluctuations during this period.[49]

Table 3.8: Licensed Substance Abuse Treatment Programs, 2000-05

		Number of Programs:		
Year	Licensed Capacity of Residential Programs	Residential	Non-Residential	Total
2000	2,882	91	113	204
2001	3,021	96	121	217
2002	3,045	99	141	240
2003	3,171	99	159	258
2004	3,228	100	177	277
2005	2,974	92	188	280

NOTE: Program counts are as of July 1 each year.

SOURCE: Office of the Legislative Auditor's analysis of data from Department of Human Services.

[48] National Institute on Drug Abuse, *Principles of Drug Addiction Treatment: A Research-Based Guide* (Washington, D.C., 1999), 1.

[49] Programs in the seven-county Twin Cities area accounted for 46 percent of the state's total number of licensed programs and 47 percent of the residential capacity in 2005. These seven counties had an estimated 54 percent of Minnesota's population in 2004.

In the sections below, we examine local perceptions regarding treatment availability, the extent to which persons are admitted to treatment outside their home counties, trends in the state's public treatment funding, and the extent to which persons sentenced to probation for felony offenses have entered community-based treatment.

Local Perceptions About Treatment Availability

Substance abuse treatment in the community is often a part of multi-pronged efforts by courts and corrections agencies to hold offenders accountable and encourage rehabilitation, so we conducted a statewide survey of community-based corrections directors.[50] Also, during site visits to eight counties, we interviewed county human services officials about the availability of substance abuse treatment for the broad range of clients served by their agencies. In many cases, the comments we heard from human services officials echoed the concerns that were documented more systematically in our corrections survey.

Local officials have particular concerns about the availability of treatment in halfway houses and extended care programs.

We asked the corrections directors to rate their satisfaction with the availability of community-based programs that are (1) of adequate quality, and (2) within a reasonable distance of the offenders their agencies supervise. Table 3.9 summarizes the survey findings for various "levels of care," as defined in state rules prior to 2005. First, we found that:

- **Corrections officials expressed more satisfaction with the availability of inpatient and outpatient treatment programs in their regions than with halfway houses and extended care programs.**

In the case of services for adults, more than 60 percent of corrections directors expressed satisfaction with the availability of inpatient and outpatient options, while only about one-third of the directors were satisfied with the availability of other levels of care.

Second, Table 3.9 indicates that:

- **Corrections officials tended to be more dissatisfied with the availability of treatment programs for adolescents than for adults.**

In each of the four levels of care shown in the table, a higher percentage of corrections directors expressed dissatisfaction with the availability of services for adolescents compared with adults. The director of a corrections agency serving offenders in several western Minnesota counties said: "Quality programming… is virtually non-existent in our area for juvenile offenders." Another county corrections director expressed similar concerns: "Adolescent outpatient services have been virtually non-existent in Southeast Minnesota…." Meanwhile, human

[50] Criminal offenders account for a significant share of Minnesota's treatment admissions, according to data reported to DHS by treatment providers. For example, in 2004, 41 percent of Minnesota admissions to publicly-funded, community-based substance abuse treatment were for persons (1) with a criminal or juvenile court order to treatment at the time of admission, or (2) for whom the primary reason for treatment was reported as a condition of probation or parole, or the client's choice instead of going to jail.

There is considerable dissatisfaction with the availability of adolescent treatment in all levels of care.

Table 3.9: Local Corrections Directors' Views Regarding Treatment Availability, by Level of Care

	Percentage of Corrections Directors Who Were:		
Level of Care	Satisfied	Dissatisfied	Neither Satisfied nor Dissatisfied
Adults			
Residential or inpatient	61%	26%	13%
Outpatient	69	13	19
Halfway houses	37	45	18
Extended care	30	45	25
Adolescents			
Residential or inpatient	46%	38%	16%
Outpatient	42	38	20
Halfway houses	33	50	17
Extended care	20	57	23

NOTE: The "satisfied" category in this table includes those who responded "satisfied" or "very satisfied" on the survey. The "dissatisfied" category in this table includes those who responded "dissatisfied" or "very dissatisfied." Persons who responded "not applicable" were excluded from the calculations.

SOURCE: Office of the Legislative Auditor's survey of directors of community-based corrections agencies, September 2005 (*N*=54).

services staff in St. Louis County noted that there has never been a substance abuse treatment program on the Iron Range (in northeastern Minnesota) that serves adolescents.

In addition, Table 3.10 shows correctional directors' satisfaction with treatment availability for particular categories of offenders. The table shows that directors were somewhat more satisfied with treatment options for male offenders than for female offenders, both for adults and adolescents. In addition, the table shows that:

- **For both adults and adolescents, local corrections and human services officials reported little satisfaction with services for persons with (1) "dual diagnoses" of mental illness and chemical dependency, and (2) persons with cognitive limitations.**

Persons with substance abuse problems often have mental health problems, too. A national study found that, among persons with a current drug use disorder who sought treatment in the previous 12 months, 60 percent had at least one mood disorder that was not substance-induced.[51] However, Table 3.10 shows that only 19 percent of Minnesota's community-based corrections directors said they were

[51]Bridget F. Grant, Frederick S. Stinson, Deborah A. Dawson, Patricia Chou, Mary C. Dufour, Wilson Compton, Roger P. Pickering, and Kenneth Kaplan, "Prevalence and Co-occurrence of Substance Use Disorders and Independent Mood and Anxiety Disorders: Results From the National Epidemiologic Survey on Alcohol and Related Conditions," *Archives of General Psychiatry* 61 (August 2004): 807-816. For persons with a current alcohol use disorder who sought treatment in the previous 12 months, the comparable figure was 41 percent.

Table 3.10: Local Corrections Directors' Views Regarding Treatment Availability for Certain Offender Groups

Type of Offender	Percentage of Corrections Directors Who Were: Satisfied	Dissatisfied	Neither Satisfied nor Dissatisfied
Adults			
• Males	77%	11%	11%
• Females	60	21	19
• With dual diagnoses of mental health and chemical dependency problems	19	58	23
• With developmental disabilities or brain injuries	8	62	31
• With alcohol abuse or dependence	81	8	11
• With amphetamine abuse or dependence	9	72	19
• With opiate abuse or dependence	14	32	54
Adolescents			
• Males	54	30	16
• Females	40	42	18
• With dual diagnoses of mental health and chemical dependency problems	10	64	26
• With developmental disabilities or brain injuries	0	69	32
• With alcohol abuse or dependence	50	28	22
• With amphetamine abuse or dependence	8	70	22
• With opiate abuse or dependence	13	41	46

NOTE: The "satisfied" category in this table includes those who responded "satisfied" and "very satisfied" on the survey. The "dissatisfied" category in this table includes those who responded "dissatisfied" and "very dissatisfied" on the survey. Persons who responded "not applicable" were excluded from the calculations.

SOURCE: Office of the Legislative Auditor's survey of directors of community-based corrections agencies, September 2005 (*N*=54).

satisfied with the availability of treatment for adults with dual diagnoses of substance abuse and mental health problems, and only 10 percent were satisfied with such treatment options for adolescents. Local human services officials told us that many counties' mental health and chemical dependency services are poorly integrated, and that some chemical dependency treatment programs are

ill-equipped to address serious mental health problems. According to one county chemical dependency director, some counties have been reluctant to spend their chemical dependency funds to address the mental health needs of chemically dependent persons.

It is too early to judge the impact of new rules intended to improve services to clients diagnosed with both chemical dependency and mental health problems.

In 2005, the Department of Human Services adopted new substance abuse treatment rules that, among other things, were intended to improve services to clients with "dual diagnoses" or "co-occurring disorders." Under the rules, all chemical dependency treatment programs are required to assess clients for co-occurring disorders and integrate services for these disorders into the clients' service plans, when applicable. Also, the rules require licensed treatment programs' chemical dependency counselors, nurses, supervisors, and directors to meet a minimum level of training in mental health disorders.[52] The department provided 12 hours of free training to about 1,200 chemical health professionals prior to implementation of the rule, and the 12-hour course is now offered for a fee by the Minnesota State Colleges and Universities system. In our view, the new rules are a step in the right direction, especially in light of the views of corrections officials cited above. It is too early, however, to judge whether the rules will significantly improve services and outcomes for clients with dual diagnoses.

Local corrections and human services officials also said that it is difficult to find substance abuse treatment for persons with developmental disabilities or brain injuries. For this population, certain treatment programs may not be appropriate, such as those that focus on thinking skills or expect participants to offer insights about their problems. For both adults and adolescents, less than 10 percent of the corrections directors we surveyed expressed satisfaction with treatment options for persons with cognitive limitations.

In addition, Table 3.10 indicates that:

- **Corrections directors reported far less satisfaction with the availability of treatment for amphetamine abuse than for alcohol abuse.**

For adults, 81 percent of corrections directors said they were satisfied with the availability of appropriate treatment options for persons with alcohol-related problems. In contrast, only 9 percent were satisfied with treatment for persons with amphetamine-related problems. As the director of one outstate Minnesota corrections agency said:

> The lack of a "continuum" of treatment for meth offenders is very problematic. Best practices [have] shown that these offenders first need a longer amount of time to simply detoxify (typically in the jail setting) followed by extended care primary treatment, then halfway house and then aftercare services. The chemical dependency assessors and treatment centers, until recently, did not seem to understand that need. If the offender is actively using meth and is not in a position to detoxify in jail before entering treatment, the first [part] of traditional "treatment"

[52] *Minnesota Rules* 2005, 9530.6422, 9530.6430, and 9530.6460.

> [is] a waste of funding. However, there is no other alternative available at this time.[53]

Some county human services staff said that it has become more difficult to find available beds in treatment programs in recent years, partly due to the influx of methamphetamine users in programs. In addition, some officials expressed a desire for more treatment programs that specialize in serving methamphetamine users, even if the programs use similar treatment approaches to other programs. For example, human services staff in Olmsted County became frustrated by the repeated failure of methamphetamine users in existing treatment programs, so they designed new programs specifically for methamphetamine users who are criminal offenders.[54]

The 2005 Legislature authorized grants to foster appropriate treatment for methamphetamine users.

The 2005 Legislature appropriated $1.5 million to the Department of Public Safety for the fiscal year 2006-07 biennium for methamphetamine treatment grants. The Legislature instructed the department to give priority to counties "that demonstrate a treatment approach that incorporates best practices as defined by the Minnesota Department of Human Services."[55] Following the issuance of a request for proposals, the Department of Public Safety selected five county organizations in December 2005 to receive grants.[56]

Finally, we asked corrections directors about their satisfaction with several other types of community-based services for chemically dependent offenders under their supervision. As shown in Table 3.11, the most significant area of dissatisfaction was the availability of housing options for chemically dependent persons, such as "sober houses" for persons who are attending outpatient treatment. In addition, many corrections directors expressed dissatisfaction with the availability of aftercare services for persons who completed treatment in prison-based or community-based programs. If the directors' perceptions about the lack of such services are correct, this is contrary to the state's policy supporting a continuum of services for persons leaving treatment programs.[57]

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[53] In many cases, persons who have used methamphetamines have impaired cognitive skills and require more sleep in the period immediately following discontinuation of use. This presents special challenges if the persons are immediately assigned to treatment programs that require active participation.

[54] Olmsted has a short-term education program (14 hours) that is provided to offenders in jail. It is a "warm-up" for a longer-term program that typically provides more than 100 hours of community-based treatment per offender over the course of a year. Staff said that the long-term program combines elements of cognitive-behavioral, 12-step, and skills-building treatment approaches.

[55] *Laws of Minnesota* 2005, chapter 136, art. 1, sec. 9, subd. 6.

[56] The proposals receiving funding were from Dodge-Fillmore-Olmsted Community Corrections and the human services agencies in Carlton, Anoka, Sherburne, and Faribault-Martin counties.

[57] *Minnesota Statutes* 2004, 254A.01.

Local officials have significant concerns about the availability of housing and aftercare options for chemically dependent persons.

Table 3.11: Local Corrections Directors' Views on the Availability of Treatment-Related Services

Type of Service or Treatment	Percentage of Corrections Directors Who Were: Satisfied	Dissatisfied	Neither Satisfied nor Dissatisfied
Housing specifically for chemically dependent persons (e.g., "sober houses")	2%	91%	8%
Aftercare following prison-based treatment	7	69	24
Aftercare following community-based treatment	30	43	26
Case management services to help offenders access social services	33	38	29
Random drug or alcohol testing	69	20	11

NOTE: The "satisfied" category in this table includes those who responded "satisfied" and "very satisfied" on the survey. The "dissatisfied" category in this table includes those who responded "dissatisfied" and "very dissatisfied" on the survey. Persons who responded "not applicable" were excluded from the calculations. For the question regarding aftercare following prison-based treatment, we excluded the responses of directors whose agencies do not supervise adult felons (thus, *N*=29).

SOURCE: Office of the Legislative Auditor's survey of directors of community-based corrections agencies, September 2005 (*N*=54).

Treatment Placements Outside Residents' Home Counties

Another measure of the availability of substance abuse treatment is the extent to which persons receive treatment outside their counties of residence. On one hand, it may be therapeutic for some treatment participants to attend programs that are far removed from their normal environments. Also, some programs attract clients from considerable distances due to their strong reputations. But, on the other hand, clients may sometimes enter distant treatment programs because there are limited or no options closer to home. In addition, placements far from home can make it more difficult for treatment staff to work with family members or foster supportive relationships for the client following treatment.[58] As a director of a county probation agency commented to us, "People need family support—shipping our people away doesn't fix what our clients will go back to."

We examined the extent to which persons whose treatment was paid for by the Consolidated Chemical Dependency Treatment Fund attended treatment programs outside their counties of residence. We found that:

[58] *Minnesota Statutes* 2004, 254A.01, establishes a state policy of including family members as soon as possible in the treatment process.

- **About 51 percent of publicly-funded admissions to substance abuse treatment in 2004 were at programs located outside of the clients' home counties.**

Persons entering outpatient substance abuse treatment were much more likely to remain in their home counties for care than were persons entering other types of treatment. Among CCDTF-funded clients from Minnesota who entered outpatient treatment in 2004, 27 percent of admissions were to programs outside the clients' home counties. In contrast, the percentages of out-of-county admissions for other levels of care were 69 percent for inpatient treatment, 63 percent for halfway houses, and 85 percent for extended care.[59]

Many counties rely entirely on programs in other counties to provide certain levels of care to their residents.

Many counties relied entirely on out-of-county treatment programs to provide certain levels of care, as shown in Table 3.12. The table shows that *all* of the persons admitted to inpatient treatment in 2004 from 60 of Minnesota's 87 counties entered programs outside their home counties. Similarly, for a large majority of counties, all residents who entered halfway houses or extended care programs did so at programs outside their home counties. The complete absence of in-county admissions in certain levels of care appears to indicate that residents did not have such treatment options within their counties. For example, as one corrections director from southwestern Minnesota commented in our survey: "[One of my counties] has outpatient services only. [The other county] has no treatment services available. We are needing to send clients for inpatient treatment to locations several hours away or to other states."

Table 3.12: Number of Counties With All Treatment Admissions Provided Outside of Clients' Counties of Residence, by Level of Care

Level of Care	Number of Counties for Which All 2004 Admissions of County Residents to This Level of Care Occurred Outside County of Residence
Inpatient	60
Outpatient	24
Halfway houses	69
Extended care	67

NOTE: This table includes all clients who entered treatment, including both publicly- and privately-funded clients.

SOURCE: Office of the Legislative Auditor's analysis of Department of Human Services' Drug and Alcohol Abuse Normative Evaluation System data.

[59] Based on Office of the Legislative Auditor analysis of the Department of Human Services' Drug and Alcohol Abuse Normative Evaluation System data.

Availability of Methadone Maintenance Programs

Methadone maintenance is a type of substance abuse treatment for opiate (mainly heroin) addicts, and Chapter 2 reported that this treatment has positive results, on balance, when properly managed. Treatment participants go to licensed clinics to receive daily oral doses of methadone, a synthetic substance that relieves symptoms of opiate addiction. We found that:

- **Only two methadone maintenance programs serve publicly-funded clients, and they operate near capacity.**

Some opiate users regularly travel long distances to obtain methadone treatment.

Minnesota has a total of seven outpatient programs that are licensed by the Department of Human Services to operate methadone programs, but the only two programs that serve CCDTF clients are located in Hennepin County.[60] Because of the limited number of methadone programs, some opiate addicts regularly travel long distances within Minnesota to obtain methadone. To reduce the amount of home-to-clinic travel by methadone users, the Department of Human Services can authorize individual clients who live far from clinics to obtain up to seven daily doses of methadone per weekly visit.[61]

As of late 2005, the two programs authorized to serve publicly-funded clients accounted for half of the 2,200 authorized treatment "slots" in Minnesota's methadone clinics.[62] Since the beginning of 2003, these two clinics have consistently operated at or above 90 percent capacity.[63] Department of Human Services staff told us that they have been unable to persuade counties to enter additional contracts with methadone clinics to serve publicly-funded clients. They said that officials in many counties object to the idea of using a drug to treat drug users.

Public Funding For Treatment

Since it started in 1988, the Consolidated Chemical Dependency Treatment Fund (CCDTF) has been Minnesota's primary source of public funding for substance abuse treatment. CCDTF combines federal and state revenue sources. In addition, state law requires counties to pay for a portion of CCDTF-funded treatment. To qualify for publicly-funded treatment, individuals must meet state-prescribed income eligibility standards. We found that:

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[60] There are four programs that only serve private-pay clients because the programs do not have a contract with a "host county" to serve CCDTF-funded clients. In addition, a small program run by the Veterans Administration only serves military veterans.

[61] As of mid-November 2005, DHS had authorized nearly 500 clients during 2005 to receive multiple doses during individual visits to their clinics.

[62] The total number of authorized slots increased from about 1,600 in 2001 to 2,200 in late 2005.

[63] Based on a review of reports filed with the Department of Human Services, we estimated that the two CCDTF clinics filled 97 percent of their authorized slots between January 2003 and August 2005. During this period, the state's other methadone clinics filled 89 percent of their slots. Programs have occasionally operated over 100 percent of capacity, probably due to staffing fluctuations.

- **The income limit for persons eligible for state chemical dependency treatment funding has declined in recent years, but the number of persons receiving publicly-funded treatment has increased.**

State law establishes three tiers of eligibility for CCDTF-funded treatment, as shown in Table 3.13. Persons in "Tier 1" are (1) eligible for Medical Assistance, General Assistance Medical Care, or Minnesota Supplemental Assistance, or (2) have household incomes at or below the federal poverty line. By law, persons who meet the "Tier 1" criteria are entitled to CCDTF-funded treatment. In contrast, state law says that persons within the "Tier 2" and "Tier 3" income ranges shall be eligible for CCDTF-funded treatment "within the limit of funds appropriated for this group for the fiscal year."[64] The Legislature discontinued Tier 3 funding in 1991, and it discontinued Tier 2 funding in 2003.

State law establishes three tiers of eligibility for publicly-funded treatment, but only one tier is presently funded.

Table 3.13: Consolidated Chemical Dependency Treatment Fund Eligibility

Funding Tier	Household Income Limit (Percentage of Federal Poverty Guidelines)	Are Eligible Clients Entitled to Funding?	Is Funding Appropriated for This Tier in the 2005-07 Biennium?
1	100%[a]	Yes	Yes
2	215	No	No
3	412	No	No

[a] Also, persons eligible for Medical Assistance, General Assistance Medical Care, or Minnesota Supplemental Assistance are CCDTF-eligible, regardless of income.

SOURCE: Minnesota Department of Human Services, *Bulletin: DHS Updates CCDTF Operations, Eligibility for State Fiscal Year 2006* (St. Paul, July 27, 2005).

The maximum income of persons eligible for CCDTF funding declined sharply when Tier 2 funding was discontinued. For example, the maximum qualifying income for a single person with no children dropped from $19,066 in fiscal year 2003 to $8,988 in fiscal year 2004. For a person in a household of three, the maximum qualifying household income dropped from $32,302 to $15,264 during this period.[65]

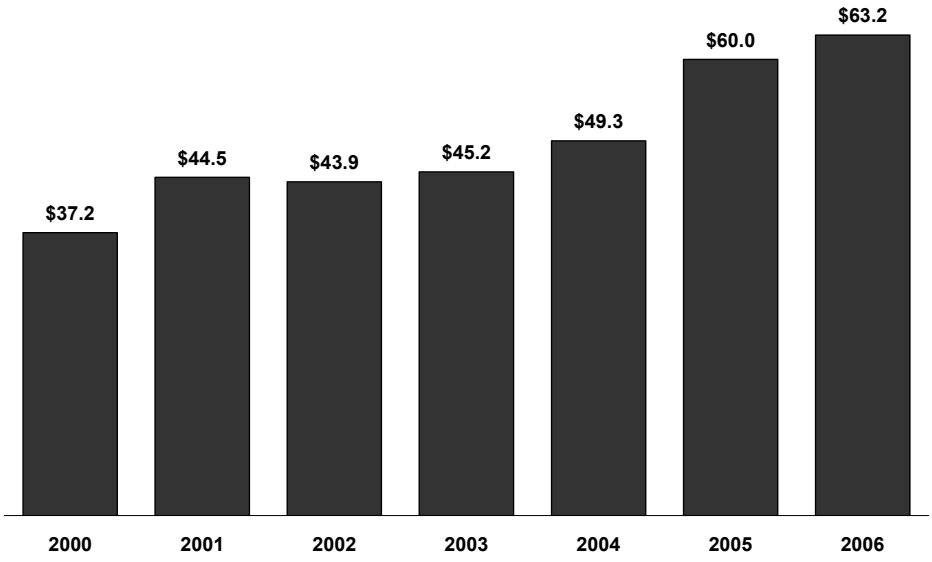
Although the elimination of Tier 2 funding significantly restricted individuals' eligibility for publicly-funded treatment, the state's total appropriation to CCDTF has grown. Figure 3.1 shows that, unadjusted for inflation, appropriations to the fund increased from $37.2 million in fiscal year 2000 to $63.2 million in fiscal

[64] *Minnesota Statutes* 2004, 254B.04, subd. 1.

[65] Minnesota Department of Human Services, *Bulletin: DHS Updates CCDTF Operations, Eligibility for State Fiscal Year 2003*, June 28, 2002, and *Bulletin: DHS Updates CCDTF Operations, Eligibility for State Fiscal Year 2004*, June 26, 2003. In January 2004, before funding for Tier 2 was eliminated, DHS tightened Tier 2 eligibility due to funding limitations.

Figure 3.1: State Appropriations (in Millions) for Consolidated Chemical Dependency Treatment Fund, FY 2000-06

Total state appropriations for chemical dependency treatment have increased.



NOTE: Dollar amounts are not adjusted for inflation.

SOURCE: Minnesota Department of Human Services.

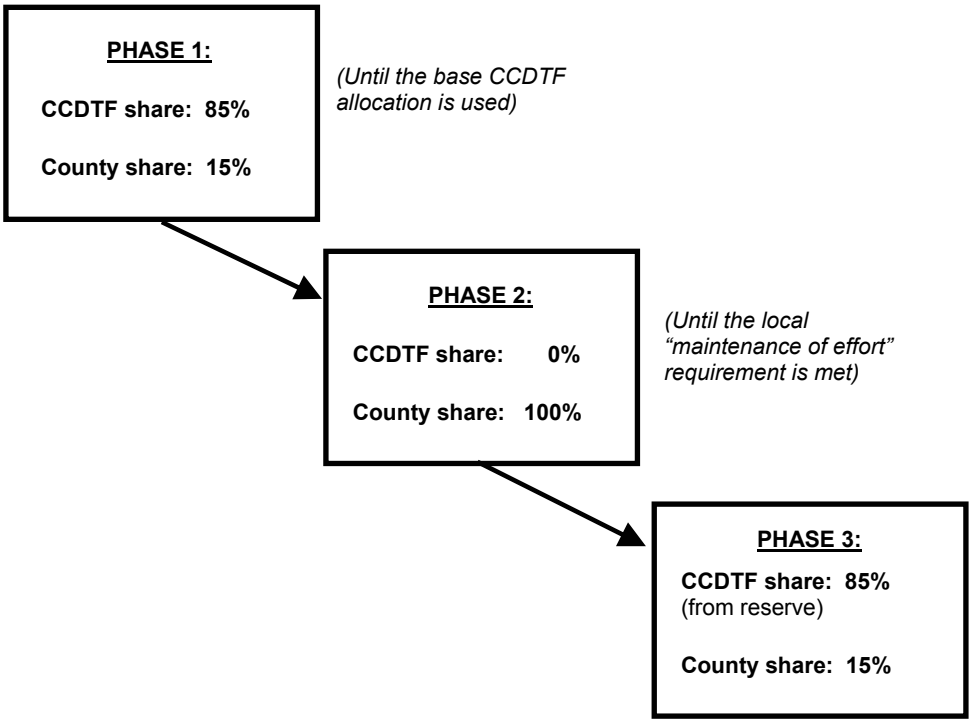
year 2006.[66] Adjusted for inflation, state appropriations grew by 17 percent between 2000 and 2004, and during this period the annual number of individuals served by CCDTF increased by 19 percent.[67]

The Minnesota Department of Human Services administers annual allocations from the CCDTF to each county, based on a complex statutory formula that takes into account the county's population, welfare eligibility, and median income for married couples. Figure 3.2 summarizes the three phases of financial responsibility for the treatment costs of individuals who meet the CCDTF criteria. During a fiscal year, a county initially pays 15 percent of individuals' treatment costs, until its annual CCDTF allocation is spent. Then, the county pays 100 percent of treatment costs, until it has met its statutorily-required

[66] Department of Human Services staff told us that the Legislature increased appropriations mainly due to projected increases in demand for services. In addition, they said, the state had to repay the federal government in the current biennium for prior cases in which federal funds paid for chemical dependency services that should have been paid by state funds.

[67] We adjusted for inflation using the federal government's implicit price deflator for state and local government expenditures. The unduplicated number of individuals authorized for CCDTF-funded treatment grew from 15,477 in 2000 to 18,281 in 2002. The number declined to 17,040 in 2003 (when eligibility restrictions took effect), and then increased to 18,414 in 2004.

Figure 3.2: Financial Responsibility for Publicly-Funded Substance Abuse Treatment



SOURCE: *Minnesota Statutes* 2004, chapter 254B.

The share of treatment costs paid by a county depends on whether it has exhausted its state funding allocation and met its "maintenance of effort" requirement.

"maintenance of effort." After this, a CCDTF "reserve account" pays 85 percent of treatment costs, and the county pays the remaining 15 percent.[68]

The "maintenance of effort" requirement is a key determinant of an individual county's financial responsibility for treatment costs. State law defines the "maintenance of effort" amount as "the amount of local money used for eligible services in calendar year 1986," adjusted in subsequent years in proportion to changes in state appropriations for the CCDTF.[69] The "maintenance of effort" requirement was originally intended to discourage counties from reducing their own spending in response to increases in state appropriations for CCDTF. However, we observed that:

[68] Also, counties may choose to pay the full cost of treatment for any clients who are deemed ineligible for CCDTF, and such spending counts toward their "maintenance of effort."

[69] *Minnesota Statutes* 2004, 254B.02, subd. 3. For counties that provide Medical Assistance or General Assistance Medical Care through managed care plans, the base year for determining the "maintenance of effort" level used in the funding allocation process was fiscal year 1995 or the subsequent year in which the county started its managed care.

- **There are significant differences among counties in their financial responsibility for the cost of publicly-funded substance abuse treatment, partly reflecting longstanding statutory provisions that have questionable relevance today.**

In 2004, the percentage of treatment costs paid by individual counties ranged from the statutory minimum of 15 percent (38 counties) to 36 percent (Washington County). There was even greater variation in the "maintenance of effort" requirements faced by individual counties, which may influence actual county spending levels. Counties' 2004 "maintenance of effort" levels, as a percentage of their CCDTF allocations, ranged from a low of 4 percent (Big Stone County) to 70 percent (Washington, Hennepin, and Mahnomen counties). The following example is illustrative of the differing provisions:

> *Anoka and Dakota counties are suburban Twin Cities area counties with similar numbers of residents and similar CCDTF base allocations.*[70] *However, Anoka's required local "maintenance of effort" ($284,000, or 15 percent of its base allocation) was much lower than Dakota's "maintenance of effort" ($858,000, or 49 percent of its base allocation), reflecting Anoka's lower county spending for chemical dependency treatment in the mid-1980s. Anoka could meet its entire "maintenance of effort" requirement with its payments of 15 percent of treatment costs during "Phase 1" of the fiscal year (see Figure 3.2). The county could then skip Phase 2 (100 percent county financial responsibility for treatment costs) and move directly to Phase 3, where most treatment costs are covered by the CCDTF reserve.*[71] *In contrast, if Dakota County were to use up its 2004 CCDTF base allocation, it would then be solely responsible for another $500,000 in treatment costs before it would be eligible to receive CCDTF reserve funding.*

Some counties can leverage more state funding than others, due to differences in their "maintenance of effort" requirements.

The differences among counties' "maintenance of effort" requirements mean that some counties' local expenditures can leverage more CCDTF dollars than other counties' local expenditures. This does not necessarily mean that counties with higher "maintenance of effort" requirements make fewer placements into treatment. In fact, we found little relationship between counties' "maintenance of effort" requirements and their utilization rates for publicly-funded treatment.[72] In other words, counties that were expected to pay for larger shares of treatment due to high "maintenance of effort" requirements did not necessarily make fewer publicly-funded placements per 1,000 low-income residents; in fact, they sometimes made more placements.

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[70] Anoka was eligible for a CCDTF base allocation of $1.90 million in 2004, and Dakota was eligible for an allocation of $1.77 million.

[71] In 2004, Anoka was 1 of 35 counties that could meet their entire annual "maintenance of effort" requirement by paying the 15 percent county match for their annual base level CCDTF allocation (Phase 1 in Figure 3.2).

[72] We examined the relationship between counties' 2004 maintenance of effort (as a percentage of the counties' base allocations) and their number of publicly-funded 2003-04 adult admissions per 1,000 adults in poverty. The correlation of these two variables was +0.30, indicating that higher maintenance of effort was modestly associated with higher placement rates.

Participation in Treatment by Offenders on Probation

Criminal offenders are more likely than other persons to rely on public funding to pay for substance abuse treatment.

In general, criminal offenders are more likely than non-offenders to rely on public funding to pay for treatment. For example, CCDTF paid for 49.5 percent of the substance abuse treatment admissions of persons with criminal court orders who entered treatment in 2004, compared with 41.5 percent of admissions of persons without court orders who entered treatment.[73] In our statewide survey of directors of community-based corrections agencies, we asked about the role of the Consolidated Chemical Dependency Treatment Fund in paying for treatment of offenders under their supervision. We found that:

- **Criminal offenders' eligibility for publicly-funded treatment often affects whether they participate in treatment, according to many probation directors.**

About 85 percent of the directors estimated that chemically dependent offenders who were deemed eligible for CCDTF-funded services "always," "almost always," or "usually" entered substance abuse treatment. In contrast, only 32 percent of the directors estimated that chemically dependent offenders who were *not eligible* for CCDTF funding "always," "almost always," or "usually" entered treatment. Thus, if the 2003 Legislature's elimination of Tier 2 CCDTF funding made some offenders ineligible for publicly-funded treatment, this may have adversely affected their likelihood to participate in treatment.

We examined the extent to which persons who were sentenced to probation for drug or alcohol offenses entered treatment in the community. We selected a representative random sample of persons sentenced by Minnesota courts in 2003 for felony-level crimes involving possession or use of drugs or alcohol.[74] Using Department of Human Services data on treatment admissions, we looked for evidence that these offenders entered a licensed treatment program in the community between (1) their offense date, and (2) a date six months after their sentencing date or their last possible date in jail.[75] We found that:

- **In 2003, 46 percent of felony-level drug or alcohol offenders sentenced to probation in the community did not enter substance abuse treatment in their pre-sentence period or in the period immediately following their sentencing.**

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[73] Office of the Legislative Auditor analysis of Department of Human Services Drug and Alcohol Normative Evaluation System data.

[74] Using data from the Minnesota Sentencing Guidelines Commission, we selected a random sample of 340 offenders who were sentenced in 2003. A sample of this size enabled us to be 95 percent sure that the statewide percentage of persons who entered treatment was within 5 percentage points of what we measured using the sample population (assuming that the treatment data were complete).

[75] Among the offenders in our sample, the average period of time for which we looked for evidence of participation in treatment was 529 days. We did not have information on the "conditions of probation" set by the sentencing judges in these cases, but we assumed that persons sentenced for felony-level drug and alcohol crimes would be more likely than lower-level offenders to be ordered to treatment.

Within our sample, persons sentenced for driving under the influence of alcohol or other drugs were the most likely group to enter treatment (66 percent), while persons sentenced for powder cocaine offenses were the least likely probationers to enter treatment (37 percent). Forty-two percent of the offenders sentenced to probation in our sample *completed* a treatment program during the time period we examined.

We did not fully explore the reasons why the drug and alcohol offenders in our sample did not enroll in treatment. Perhaps courts or probation officers did not direct some of the offenders to treatment. Maybe other offenders could not afford treatment, refused to participate in treatment, moved out of state, or were incarcerated for new crimes or probation violations. But, whatever the reasons, we think it is reasonable to expect a higher percentage of felony-level drug and alcohol offenders to enter treatment before or immediately following sentencing.

Treatment Availability Recommendations

RECOMMENDATION

DHS should present the 2007 Legislature with a plan for improving the availability of community-based substance abuse treatment in Minnesota.

DHS should increase its efforts to foster new treatment services to address clients' needs.

The availability of substance abuse treatment varies around the state. In some locations, Minnesota lacks the range of programs or services to effectively meet the needs of different types of clients. State law designates the Minnesota Department of Human Services as the lead agency for coordinating chemical dependency services in Minnesota. For example, the law requires the department to establish a state plan that sets forth goals and priorities for a "comprehensive" approach to addressing substance abuse.[76] We think that DHS should help the Legislature to consider possible strategies for improving the availability of substance abuse treatment for low income persons, hard-to-serve populations, and criminal offenders. The department has made some previous efforts to improve existing services.[77] Still, we think that treatment availability remains an important issue, and the department should increase its efforts to foster the development of new programs that can effectively address clients' needs (or to improve existing programs). This may require additional expenditures in some (but not necessarily all) cases, and DHS should seek additional funding, if necessary.

To help contain human services expenditures at a time when the state faced a large budget shortfall, the 2003 Legislature restricted eligibility for publicly-funded treatment so that only the lowest income clients ("Tier 1") qualified. We think that DHS' plan for improving service availability should discuss the merits

[76] *Minnesota Statutes* 2004, 254A.03.

[77] For example, the department has issued a request for proposals for a methadone maintenance program in outstate Minnesota. Also, the department has sponsored training in methamphetamine treatment (in 2004 and 2005), and it has provided training on several substance abuse treatment approaches identified by the U.S. Department of Health and Human Services as "model" programs.

of various options, including the possibility of Tier 2 funding, at least for certain client subgroups (such as adolescents, or criminal offenders ordered by the courts to participate in treatment).

RECOMMENDATION

The Department of Human Services, with input from local officials, should report to the 2007 Legislature on the merits of changing the statutory "maintenance of effort" provisions of the Consolidated Chemical Dependency Treatment Fund.

DHS should examine options for changing the state's chemical dependency treatment funding formula.

The CCDTF funding formula is one of several factors that may affect the access of individuals around the state to treatment. At a minimum, it affects the costs that local agencies face to provide treatment services to their residents. Although a complete review of the CCDTF formula was beyond the scope of our evaluation, we noted earlier that individual counties' level of treatment spending in the 1980s provides a starting point in the current funding formula for determining the local share of financial responsibility for treatment costs. We question whether this is still appropriate. Local spending patterns prior to the implementation of the Consolidated Chemical Dependency Treatment Fund in 1988 may have reflected a very different system of treatment placement and financing options. For example, a county in which a state hospital was located could have made many of its substance abuse placements at the hospital, mostly at state expense, while other counties' treatment options may have involved greater county expense per placement.

The Department of Human Services recently established a task force of state and local officials to examine the formula and consider the need for possible statutory changes. We support this effort and suggest that the department assess options for changes and their possible impacts.

RECOMMENDATION

The Department of Human Services should work with the Department of Health to develop guidelines and training materials for health care organizations on the use of "brief interventions" for alcohol abuse.

State officials should encourage the use of "brief interventions" by health care professionals.

In Chapter 2, we summarized selected findings from research literature on the effectiveness of substance abuse treatment. We cited a recent research summary that reported that "brief interventions" have shown strong evidence of effectiveness among various approaches for persons who abuse alcohol. Such interventions could be provided by doctors, nurses, or other health care professionals, and they do not involve the longer-term counseling and skill-building that is a part of licensed treatment programs. "Brief interventions" are perhaps best used as part of a prevention strategy, rather than as a substitute for intensive treatment.

We do not know the extent to which Minnesota health care agencies now use "brief interventions," but staff with the Minnesota Department of Human

Services told us they do not recall activities by their agency to encourage the implementation or effective use of "brief interventions" for adults.[78] We think the department should foster their use, given that (1) alcohol is the most common substance abused by persons entering treatment in Minnesota, and (2) the research evidence on "brief interventions" is relatively strong.

[78] For adolescents, DHS has developed the Adolescent Health Review, a screening instrument to help primary care providers identify behavioral health issues.

4

Community-Based Treatment: Outcomes and Program Oversight

SUMMARY

There are limited data on the outcomes of Minnesota's community-based substance abuse treatment programs. A majority of persons complete the programs they enter, but the length of treatment is often shorter than experts recommend. It is common for people to have more than one admission to treatment, although frequent readmissions have not been the norm. Many local officials think that community-based treatment services should be better tailored to clients' needs, especially clients with mental health problems. To help local agencies make appropriate decisions about client placements, the Department of Human Services should provide more information on treatment program outcomes, compliance with state regulations, and overall quality.

Policy makers regularly pose questions about the adequacy of Minnesota's substance abuse treatment programs. Chapter 2 noted that it is challenging to definitively measure the impact of treatment, but this chapter addresses the following questions:

- **Are treatment services sufficiently tailored to meet clients' individual needs?**
- **Do clients receive sufficient amounts of treatment, as measured by the length of time in treatment and the extent to which they complete their programs?**
- **To what extent do clients have repeated admissions to community-based treatment, and should policy makers be concerned about readmissions?**
- **Do agencies that place clients in treatment have sufficient information about the programs' performance and outcomes?**

ADDRESSING INDIVIDUAL NEEDS

To help ensure better client outcomes, there is general support within the substance abuse treatment profession for the principle of tailoring services to the needs of individual clients. For example, the National Institute on Drug Abuse said that this is "critical to [clients'] ultimate success in returning to productive

functioning in the family, workplace, and society."[1] Clients who receive inadequate services may be more likely to relapse.

State rules require individual assessments of persons before and after placement in publicly-funded treatment.[2] The rules also require treatment providers to develop individual treatment plans that set forth treatment goals and methods. These plans, which "must continually be updated" to reflect new priorities and needs, address the amount, frequency, and anticipated duration of treatment. Treatment methods "must be appropriate to the client's language, reading skills, cultural background, and strengths," and treatment services "must address cultural differences and special needs of all clients."[3]

Treatment programs develop plans for each client, but some local officials think programs should do more to tailor services to individual needs.

These requirements do not necessarily ensure that treatment is, in fact, modified to meet client needs. We found that:

- **Directors of community-based corrections agencies expressed mixed views about the extent to which treatment programs tailor their services to meet individual needs, and they had particular concerns about the adequacy of programs' mental health services.**

In response to our statewide survey, 47 percent of corrections directors said that substance abuse treatment programs "always," "almost always," or "usually" tailor their services to meet client needs. Meanwhile, 53 percent of corrections directors said that programs "sometimes," "rarely," or "never" do so, including six of seven directors in the Twin Cities metropolitan area (which accounts for about half of the state's admissions of offenders to treatment).

We also asked corrections directors whether the needs of offenders they supervise would be better addressed if treatment programs gave more or less emphasis to certain types of programming. Table 4.1 shows their responses. Among the services shown, the highest percentage (96 percent) of directors favored more efforts by substance abuse treatment programs to address offenders' mental health needs. In addition, a majority of directors thought that offenders' needs would be addressed more effectively with more cognitive-behavioral treatment (87 percent), more efforts to enhance client motivation (85 percent), more efforts to improve clients' suitability for employment (81 percent), and more marital or family therapy (54 percent). In contrast, a majority of corrections officials said they did not see a need for more abstinence-based treatment programs, spiritually-based treatment activities, 12-step treatment programs, or programs that allow controlled use of alcohol.

Because mental health services were a significant concern among corrections officials and some of the county human services staff with whom we spoke, it is worth reiterating (as discussed in Chapter 3) that administrative rules implemented in January 2005 require all licensed substance abuse treatment

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[1] National Institute on Drug Abuse, *Principles of Drug Addition Treatment: A Research-Based Guide* (Washington, D.C., 1999), 1.

[2] *Minnesota Rules* 2005, 9530.6615, subp. 1, and 9530.6422, subp. 1. Treatment providers must conduct comprehensive assessments within three days of initiating services for a client.

[3] *Minnesota Rules* 2005, 9530.6425 and 9530.6430, subp. 1.

Nearly all corrections directors said treatment programs should make greater efforts to address clients' mental health issues.

Table 4.1: Local Corrections Directors' Preferences for Greater or Lesser Use of Certain Treatment Approaches

Treatment Approach or Type of Service	Percentage of Corrections Directors Who Said: Need More	No Change Needed	Need Less/Fewer	Don't Know
Efforts to address clients' mental health needs	96%	2%	0%	2%
Use of cognitive-behavioral treatment	87	11	0	2
Efforts to enhance client motivation to successfully complete treatment	85	15	0	0
Efforts to help clients improve their suitability for employment	81	17	2	0
Marital or family therapy	54	37	2	6
Expectations that clients will maintain complete abstinence from alcohol	32	55	8	6
Spiritually-based activities	20	52	11	17
Expectations that clients will control, but not necessarily eliminate, their alcohol use	21	44	19	17
Use of the "12-step" treatment model	12	68	10	8

SOURCE: Office of the Legislative Auditor's survey of directors of community-based corrections agencies, September 2005 (*N*=54). Persons who responded "not applicable" were excluded from the calculations.

programs to provide "services to address issues related to co-occurring mental illness."[4] The new rules represent the Department of Human Services' attempt to ensure better integration of mental health services into substance abuse programs, with a goal of improving clients' treatment outcomes.[5]

LENGTH OF TREATMENT

Programs differ in the intensity and content of the services they provide over a given period of time, so the duration of treatment is only one factor that affects program outcomes. Still, we noted in Chapter 2 that there is an emerging consensus in the substance abuse field that persons with addictions often require services over an extended period of time, even if some of those services are provided infrequently or at low levels of intensity. The National Institute on Drug Abuse has stated that "remaining in treatment for an adequate period of time is critical for treatment effectiveness" and that: "Generally, for residential

[4] *Minnesota Rules* 2005, 9530.6430, subp. 1.

[5] Treatment providers should not bear full responsibility for ensuring that services are properly tailored to individual needs; this is also the responsibility of local agencies that make treatment referrals. One county corrections agency expressed concern to us that its county human services agency routinely alternates referrals between the county's two treatment providers—with one referral to the first provider, the next to the second provider, the next to the first provider, and so on. Corrections staff questioned whether this resulted in the best services for individual offenders.

or outpatient treatment, participation for less than 90 days is of limited or no effectiveness, and treatments lasting significantly longer often are indicated."[6] However, we found that:

- **The duration of chemical dependency treatment is typically shorter than that recommended by national experts.**

The National Institute on Drug Abuse says treatment should generally last at least 90 days to be effective.

Table 4.2 shows that, for people who *completed* publicly-funded treatment in 2004, the average duration per admission was less than 90 days, regardless of the level of care.[7] We also looked at the duration of treatment after taking into account those instances in which individuals transferred directly from one type of treatment to another. For example, sometimes persons move from inpatient to outpatient care as a planned sequence in their treatment regimen. Thus, for a sample of offenders sentenced to probation in 2003 who subsequently entered community-based treatment, we identified each person's longest continuous "episode" of treatment.[8] We found that only 29 percent of the 183 "treated" probationers were in community-based treatment for a cumulative period of at least 90 days. Also, we examined the treatment history of a sample of about 400 persons discharged from treatment in 2004, and only 22 percent of the continuous treatment "episodes" for these persons between 1995 and 2004 were for periods of 90 days or more.[9]

Table 4.2: Average Duration of Publicly-Funded Treatment for Treatment "Completers," 2004

Treatment Level of Care	Average Days in Treatment per Admission[a]	Number of Completers
Inpatient/Residential	27.3	4,280
Outpatient	58.5	5,928
Halfway House	85.6	1,833
Extended Care	60.4	1,124
Total[b]	52.7	13,289

NOTE: Based on admissions of Minnesota residents to publicly-funded treatment in 2004 who were coded by treatment providers as having completed their treatment program.

[a] Represents average total days elapsed between treatment admission and discharge.

[b] Includes 124 admissions for treatment reported in two other level-of-care categories (combined inpatient and combined outpatient).

SOURCE: Office of the Legislative Auditor's analysis of Department of Human Services' Drug and Alcohol Normative Evaluation System data.

[6] National Institute on Drug Abuse, *Principles of Drug Addiction Treatment*, 1, 14.

[7] Some people leave treatment before they have completed the treatment provider's full regimen, or before they have completed the amount of treatment recommended bv county officials. Including non-completers in the analyses in this section would reduce the average length-of-stay.

[8] We identified the longest continuous treatment episode that started between the date of the criminal offense and a date six months subsequent to sentencing. If a person left one program and entered another within 30 days, we added the total days in the first program (between admission and discharge) to the total days in the second program. Thus, we did not count days between treatment stays in our calculations of the length of treatment episodes.

[9] If a person in this sample entered a treatment program within 30 days of leaving another program, we counted the days of care from both placements as part of a single "episode" of treatment.

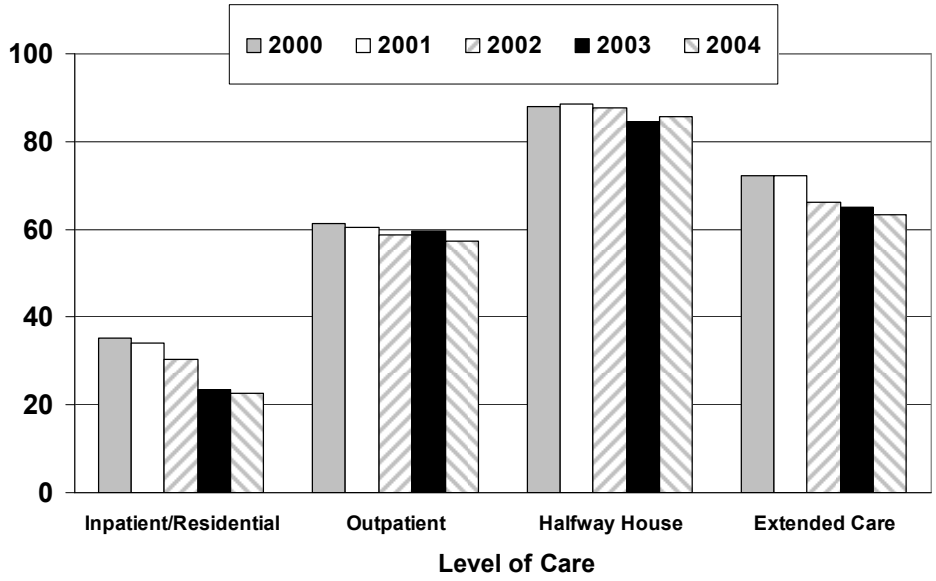
In addition, we found that:

- **The average duration of chemical dependency treatment in Minnesota has grown shorter in recent years, especially for inpatient/residential treatment and "extended care."**

Figure 4.1 shows statewide trends for various levels of care, based on all admissions to publicly- and privately-funded treatment that resulted in a completed program. Since 2000, the average length of treatment for clients in inpatient/residential care declined by 36 percent, from 35.4 days to 22.8 days.[10] During this period, the declines in average length-of-stay for other types of treatment were 6 percent for outpatient care, 12 percent for extended care, and 3 percent for halfway houses. Among program completers, the overall average length of treatment per admission declined from 55 days in 2000 to 48 days in 2004 (13 percent).

The average length of inpatient treatment declined 36 percent between 2000 and 2004.

Figure 4.1: Average Length (in Days) of Completed Treatment per Admission, 2000-04



SOURCE: Office of the Legislative Auditor's analysis of data from the Department of Human Services' Drug and Alcohol Normative Evaluation System data.

We also examined comparable trends for persons who entered treatment primarily due to amphetamine use. Some researchers and public officials contend that methamphetamine addicts need longer treatment than other persons, due to longer periods of detoxification and the longer cognitive effects of the drug. We found reductions between 2000 and 2004 in the average duration of

[10] Our analysis of the length of treatment was based on the total number of days between clients' dates of admission and discharge. This analysis did not count consecutive treatments (where an admission was within 30 days of a discharge) as part of a single "episode" of treatment.

completed treatment for amphetamine users in all categories of care: inpatient/residential care (from 56 days in 2000 to 25 days in 2004), outpatient care (from 58 to 53 days), halfway houses (from 91 to 86 days), and extended care (from 75 to 62 days).[11]

Finally, from our survey of directors of community-based corrections agencies, we found that:

- **A majority of probation directors favored longer treatment programs for persons who abused amphetamines, cocaine, opiates, and multiple substances.**

As Table 4.3 shows, 98 percent of the directors favored longer programs for adults who abused amphetamines, and 96 percent favored longer programs for adolescents who abused amphetamines. In contrast, most corrections officials did not favor longer treatment programs for persons who abused alcohol.

Many corrections directors would prefer longer treatment programs for substance abusers.

Table 4.3: Local Corrections Directors' Preferences for Changes in Treatment Program Duration

Offender Type (Age, Substance of Abuse)	Percent of Directors Who Said They Preferred: Longer Programs	No Change	Shorter Programs	Percent Who Responded "Don't Know"
Adults				
Amphetamines	98%	2%	0%	0%
Multiple substances	89	7	0	4
Cocaine	72	19	0	9
Opiates	65	20	0	16
Marijuana	37	59	0	4
Alcohol	31	65	0	4
Adolescents				
Amphetamines	96	2	0	2
Multiple substances	90	4	0	6
Cocaine	66	21	0	13
Opiates	56	24	0	20
Marijuana	52	42	2	4
Alcohol	40	54	2	4

SOURCE: Office of the Legislative Auditor's survey of directors of community-based corrections agencies, September 2005 (*N*=54). Persons who responded "not applicable" were excluded from the calculations.

[11] Among program completers, there was a 20 percent decline between 2000 and 2004 in the overall average length-of-stay for persons whose main substance of abuse was amphetamines.

PROGRAM COMPLETION RATES

In 2000, a Minnesota Department of Human Services research report concluded that "treatment completion is the most consistent predictor of abstinence [in the six months following treatment]."[12] The report said this was true for both adults and adolescents, in all levels of care.

Clearly, it is a preferable outcome for a client to complete treatment or transfer from one program to a complementary one. We found that:

- **In 2004, 61 percent of persons who entered publicly-funded treatment "completed" their programs, while 31 percent left programs "without staff approval."[13]**

Completion rates varied by level of care, partly reflecting differences in clients' average length-of-stay. For example, 67 percent of publicly-funded clients who entered inpatient treatment in 2004 completed these programs, which had the shortest average duration among Minnesota's main levels of care. In contrast, the completion rates for publicly-funded clients in other levels of care were 60 percent for outpatient treatment, 61 percent for extended care, and 50 percent for halfway houses.

Even within these level-of-care categories, there was considerable variation in clients' completion rates at individual treatment programs. For example, among the individual programs that discharged at least 50 publicly-funded clients from outpatient treatment in 2004, we found that the client completion rates ranged from 26 percent to 83 percent.[14]

Variation in completion rates is partly due to differences in the nature of the programs and the clients they serve.

Variations in completion rates may reflect the unique circumstances of individual programs and the difficulty of the clients they serve, according to treatment administrators with whom we spoke. For example, one program with a high completion rate serves offenders who are required to participate in treatment to remain eligible for work release from the county jail, so the offenders have strong incentives to comply with the program. Staff at another program attributed its high completion rate to (1) the program's nurturing atmosphere, and (2) the fact that successful completion of the program is a prerequisite for some clients to reunite with their children. In contrast, staff from a program with a low completion rate said that the program's limited resources (one counselor) and

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[12] Minnesota Department of Human Services, *The Challenges and Benefits of Chemical Dependency Treatment: Results From Minnesota's Treatment Outcomes Monitoring System, 1993-1999* (St. Paul, 2000), 3. The report also said that one reason that research has linked better outcomes to longer treatment is that short stays often occur in cases where treatment is not completed (p. 38).

[13] Most of the other discharges were due to client transfers to other programs, but there were also discharges due to clients being assessed as inappropriate for a program, expiration of civil commitments or hold orders, deaths, and loss of financial support.

[14] This was based on CCDTF-funded clients only. In a similar analysis, we also counted clients who were discharged because of "transfer to another program" as program "completers," reflecting the fact that some programs are specifically intended to provide an initial phase of treatment in preparation for a transfer to another phase. Among individual programs that discharged at least 50 clients in 2004, the combined rate of completion and transfer ranged from 32 percent to 93 percent.

low intensity (one hour of treatment per week) make it difficult to adequately address the needs of its impoverished clientele. Staff from another program with a low completion rate said that many of its clients have serious physical and mental health disabilities, which often limit their program participation and employment prospects. Overall, we think that program completion rates are a potentially valuable measure of program performance, but they should also be interpreted with care.

Local corrections officials are mostly satisfied with the efforts treatment programs have made to ensure that clients complete their programs. In our survey, 79 percent of the directors of community-based corrections agencies said that treatment programs "always," "almost always," or "usually" take reasonable steps to help ensure that offenders complete the programs they begin.[15] However, several directors cited concerns about programs that, in their view, have been too hasty to discharge clients who have relapsed or violated program rules.

READMISSIONS TO TREATMENT

The basic goal of treatment is to help clients change their behaviors.

Persons who enter substance abuse treatment have a range of drug and alcohol problems, and their patterns of recovery also vary. Some people maintain long periods of sobriety following treatment. For others, chemical dependency is a chronic health problem, characterized by frequent relapses.[16] Nevertheless, a goal of substance abuse treatment is to help clients reduce their chemical use or abstain altogether. Program counselors try to help clients change their behaviors while in treatment and equip them to maintain sobriety following treatment. For this reason, many studies have looked at clients' readmission to treatment as one indicator of treatment's success.

Readmission rates are an imperfect measure of treatment effectiveness because some persons who relapse following treatment do not re-enter treatment. Not all relapses are serious enough to warrant readmission to treatment, and some clients may have difficulty accessing appropriate treatment. In addition, readmissions could occur because of factors other than the failure of a treatment program.[17] Despite such limitations, we think that readmission rates provide useful information on post-treatment outcomes. Also, data on readmissions are more readily available to public agencies than measures of clients' ongoing sobriety and general well-being.

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[15] Office of the Legislative Auditor survey of directors of community-based corrections agencies, September 2005 (N=54). Twenty-one percent of directors said that treatment programs "sometimes," "rarely," or "never" take reasonable steps to ensure that offenders complete their programs.

[16] Researchers have noted similarities between the relapse rates of chemical dependence and chronic illnesses such as diabetes, hypertension, and asthma—see A. Thomas McLellan, David C. Lewis, Charles P. O'Brien, and Herbert D. Kleber, "Drug Dependence, A Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation," *Journal of the American Medical Association* 284, no. 13 (October 4, 2000): 1689-1695. The authors cite evidence that 40 to 60 percent of clients return to active substance use within a year following treatment discharge.

[17] Keith Humphreys and Kenneth R. Weingardt, "Assessing Readmission to Substance Abuse Treatment as an Indicator of Outcome and Program Performance," *Psychiatric Services* 51, no. 12 (December 2000): 1568-1569.

We found that:

- **Among persons over age 30 discharged who completed treatment in 2004, more than one-third had no history of treatment in the previous decade, and about one-fifth had at least four prior admissions.**

Using data reported to DHS by treatment providers, we examined the treatment history since 1995 of nearly 400 persons over age 30 who completed substance abuse treatment in Minnesota in late 2004.[18] As shown in Figure 4.2, 37 percent of our sample had no treatment episodes in Minnesota prior to the one that ended in 2004, and another 22 percent had a single prior episode.[19] In addition, 21 percent had two or three prior treatment episodes since 1995, and 20 percent had four or more. Thus, while most of the clients we tracked had some prior admissions to treatment, *frequent* readmissions were not the norm. Among individuals in our sample, the most prior episodes of treatment in the ten-year period was 14, and the most time spent in treatment cumulatively was 2.5 years.[20]

Many clients enter treatment more than once, but frequent readmissions are not typical.

Some policy makers have asked about the frequency with which individuals have been admitted to *publicly-funded* treatment. Thus, we examined the extent to which persons authorized in 2004 for publicly-funded treatment had previous authorizations for publicly-funded treatment (since 1995).[21] Again, we limited our analysis to persons who were over age 30 by the end of 2004. We found that, among persons placed in publicly-funded treatment in 2004, 39 percent had no prior placements in publicly-funded treatment in Minnesota during the previous ten years, while 17 percent had been authorized for publicly-funded treatment at least four previous times.

We found no accepted benchmarks in substance abuse literature for "normal" rates of readmission to substance abuse treatment. The fact that a majority of "treated" individuals had a history of just one or two episodes of treatment does

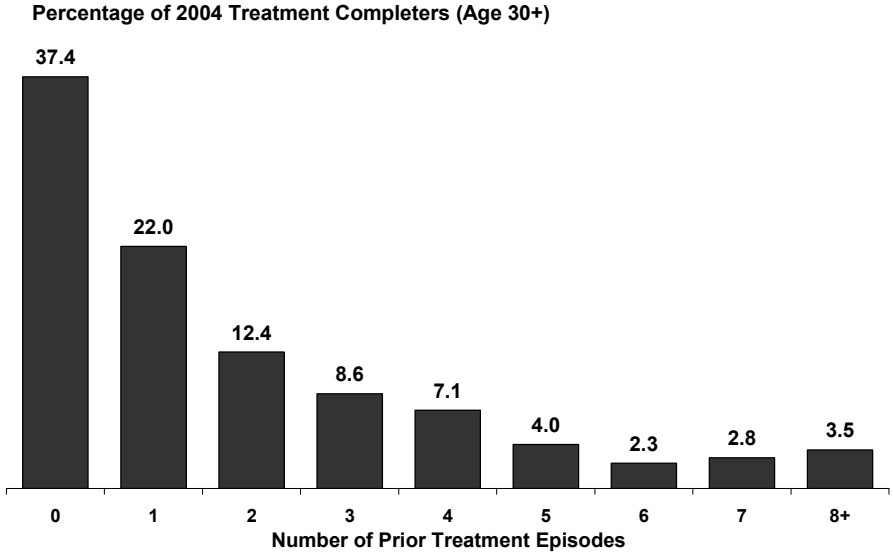
[18] We selected a representative random sample of individuals who had completed an episode of care in 2004 that was publicly-funded. Our analysis of prior treatments included all provider-reported episodes of care, whether publicly- or privately-funded, during the previous ten years. We could not determine instances in which clients' names changed over time, or instances in which treatment programs inaccurately or incompletely reported data to the Department of Human Services, so our analysis may understate the true readmission rate.

[19] If persons entered a treatment program within 30 days of leaving another program, we did not count these as separate "episodes" of treatment.

[20] In our sample of persons who completed treatment in 2004, rates of prior admissions for clients whose primary substance of dependency was alcohol were somewhat higher than rates for users of other substances. For example, 33 percent of alcohol users had no record of prior treatment episodes during the previous ten years, 22 percent had one prior episode, 24 percent had two or three prior episodes, and 22 percent had four or more. In contrast, 43 percent of other persons in our sample had no prior treatment episodes, 22 percent had one prior episode, 18 percent had two or three prior episodes, and 17 percent had four or more.

[21] This analysis was based on "client placement authorizations" by counties and tribes. These authorizations are reported to the Department of Human Services for clients whose local assessment led to an authorization for treatment paid for by the Consolidated Chemical Dependency Treatment Fund. Clients sometimes have more than one treatment admission resulting from a single authorization, but generally multiple admissions are part of a planned sequence (or "episode") of care.

Figure 4.2: Number of Prior Treatment Episodes for Persons Who Completed Community-Based Treatment in 2004



NOTE: Prior treatment episodes are those that occurred between 1995 and 2004, not including the episode of treatment that was completed in late 2004. If a person entered treatment within 30 days of discharge from another program, we counted these treatments as part of a single "episode" of care.

SOURCE: Office of the Legislative Auditor's analysis of sample data from the Department of Human Services' Drug Abuse and Alcohol Normative Evaluation System.

not prove that treatment has been effective. However, for policy makers concerned about the extent to which individuals re-enter publicly-funded treatment, the data indicate that it is not typical for individuals to have large numbers of repeat placements in publicly-funded treatment.

DHS should help local agencies identify strategies for handling cases involving repeat placements.

Counties may not refuse to place clients in treatment who have been through treatment repeatedly.[22] But counties sometimes try different approaches with clients who have had prior placements. For example, Stearns and Dakota counties have funded staff to work intensively with caseloads of chronic substance abusers. Some counties consider alternatives to intensive treatment for chronic clients, such as board-and-lodging facilities or short-term relapse prevention programs. County human services agencies sometimes consult with additional people before authorizing "repeat" placements, such as mental health and probation staff. We think that decisions regarding services to persons who have previously been through publicly-funded treatment should be made with special care, to help ensure that appropriate options have been considered.

RECOMMENDATION

The Department of Human Services should provide local agencies with examples of "best practices" for addressing the needs of persons being considered for "repeat" placements into publicly-funded treatment.

[22] *Minnesota Statutes* 2004, 254A.01, says that "treatment shall not be denied on the basis of prior treatment."

EXTERNAL REVIEWS OF TREATMENT PROGRAMS

The outcomes of chemical dependency treatment depend considerably on the performance of individual treatment programs. In this section, we discuss oversight of these programs by local and state agencies and by peer reviewers.

County Oversight of Treatment Programs

State law requires that county boards, with the approval of the DHS commissioner, "select eligible vendors of chemical dependency services who can provide economical and appropriate treatment."[23] Counties enter into "host county" contracts with treatment programs and negotiate payment rates for treatment services.

State laws and rules do not prescribe specific "quality control" activities that counties must undertake to ensure appropriate services. We interviewed human services staff in eight counties and found that:

- **Most counties we visited do not regularly conduct in-depth quality assurance reviews of the treatment providers they use, and many have limited information on program outcomes.**

Staff in the two largest counties (Hennepin and Ramsey) each review samples of client files at least once a year for each of the main treatment programs with which the counties contract. The purpose of these reviews is to monitor whether the programs are appropriately serving the clients referred to them. Staff in the other counties we visited said that they do not conduct systematic file reviews on a regular basis, or they review client records only in response to concerns raised about a particular program.[24] One county's chemical dependency staff told us they did not know whether they have legal authority to review individual clients' treatment records.

Counties have limited information on treatment outcomes.

Most counties we visited collect limited or no information regarding treatment outcomes. Three counties told us that they regularly monitor program-specific information on the extent to which clients complete the programs they start, and one of these counties has negotiated completion rate goals with each of its programs.[25] One county's contracts with treatment programs require the programs to provide biweekly progress reports to the county on each client served. Another county's contracts require treatment providers to collect self-reported information from clients regarding their post-treatment chemical use,

[23] *Minnesota Statutes* 2004, 254B.03, subd. 1(b).

[24] Some county officials told us that their chemical dependency staff see client records during ongoing contacts with treatment programs, so they have not seen a need to schedule separate "quality assurance" reviews.

[25] The goals have differed among programs, depending on their "level of care" and the types of clients they serve.

family relationships, employment status, arrests, and "quality of life."[26] In addition, DHS provides all counties with periodic reports on the characteristics of their residents entering treatment, but most counties said these reports have been of limited use for evaluating treatment services.[27]

Recent changes in state rules may present new challenges for monitoring client progress.

Recent changes to the state's rules for substance abuse treatment could present new challenges as local agencies try to monitor client progress. As we discussed in Chapter 3, the new rules are intended to promote more individualized treatment for clients. Terms previously used in state rules to categorize treatment programs (inpatient, outpatient, extended care, and halfway houses) have been eliminated, which places more responsibility on counties to understand differences in programs' content, or to explain variations in programs' outcomes. It may also be more challenging for counties to hold treatment programs accountable as some programs evolve from standardized treatment approaches toward more individualized services.

We think that DHS should identify "best practices" for county oversight of services. This should include ways to monitor individual client progress, as well as ways to monitor overall program outcomes. In addition, DHS can help foster improved oversight by providing counties with additional information on client outcomes, such as program completion rates and client readmission rates (especially for clients in publicly-funded treatment). This information could help local agencies make more informed decisions about client placements.

RECOMMENDATIONS

The Department of Human Services should identify "best practices" to help local agencies monitor the progress of the clients they place in treatment.

The department should periodically provide these agencies with statewide information on treatment outcomes.

Also, to the extent possible, DHS should insure the integrity of data distributed to local agencies. DHS staff told us they have had some concerns about the completeness of data reported by some treatment providers, especially for privately-funded clients.[28]

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[26] This county has set target performance levels regarding the percentage of clients who remain arrest-free and sober following treatment. The most ambitious targets are for clients from outpatient programs, while the least ambitious targets are for clients from halfway houses.

[27] DHS' standard reports summarize information that treatment providers are required by state rules to collect on every person entering treatment, including demographic information, chemical use history, length-of-stay, and reasons for discharge. The only program-specific information in the standard reports is total number of admissions. Also, the reports do not have separate information on publicly- and privately-funded clients.

[28] As a condition of eligibility for payment from the Consolidated Chemical Dependency Treatment Fund, state rules require providers to submit information to DHS "on all individuals who are served by the vendor" (*Minnesota Rules* 2005, 9530.7030).

Licensing Reviews and Peer Reviews

Licensing reviews examine whether treatment programs are in compliance with state laws and rules.

The Department of Human Services issues licenses to substance abuse treatment programs and monitors the compliance of these programs with state and federal regulations. During periodic site visits, the department's licensing staff fulfill a "quality control" function by examining programs' policies and practices, based partly on reviews of client records.

During each licensing review, department staff document any violations of laws or rules that they observed. In many cases, the violations are procedural in nature—for example, a program does not have the state-required descriptions of its health care services, nursing services, dietary services, and emergency physician services. In other cases, violations relate more directly to client care, such as whether a program offers both individual and group counseling (as required by state rules). Occasionally, the department cites facilities for egregious violations, such as a recent case in which the department found evidence of maltreatment by a substance abuse program, which contributed to a resident's death by overdose.

Figure 4.3 shows recent trends in the average number of violations found per program reviewed.[29] There was a sharp increase in the average number of regulatory violations by treatment programs in 2005, although this does not necessarily mean that treatment quality declined. DHS licensing staff said that treatment providers are probably still gaining familiarity with the new licensing requirements that took effect in January 2005. Some of these new rules established more demanding standards than previously existed.

Besides the department's licensing reviews, there are also periodic peer reviews of licensed programs. As a condition of receiving federal block grant funding for substance abuse services, Minnesota must ensure that peer reviews annually examine at least 5 percent of the state's licensed providers, including a representative sample of their clients' records.[30] In addition, peer reviews must examine the client intake process, assessments, treatment and discharge planning, treatment services, and indicators of treatment outcomes. DHS staff randomly select programs for review, solicit treatment staff to conduct the reviews, and draft brief reports based on the reviewers' findings.[31]

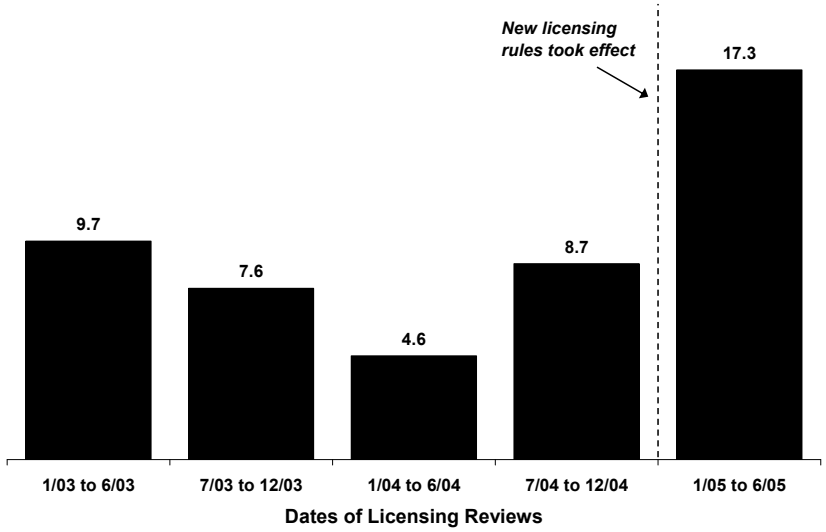
In our view, local agencies that place clients in treatment should take an interest in the department's licensing reviews and peer reviews, as two measures of program performance. This is particularly true in cases where counties have

[29] The specific programs reviewed by DHS differ from one six-month period to the next. However, department staff thought that the programs reviewed in a given six-month period are, in aggregate, similar to those reviewed in other periods, so they thought it was reasonable to look at trends in programs' average numbers of violations.

[30] 45 *Code of Federal Regulations* 2005, 96.136. The peer review process is intended "to assess the quality, appropriateness, and efficacy of treatment services."

[31] The one-page peer review reports provide limited details but are still potentially useful. For example, a recent review concluded that a program needed to increase its staffing levels, update its policies, improve documentation in client records, and improve client assessments.

Figure 4.3: Average Number of Violations per Licensed Program Reviewed, 2003-05



SOURCE: Office of the Legislative Auditor's analysis of Department of Human Services' licensing data.

entered into "host county" contracts with programs to serve publicly-funded clients. However,

- **Most counties do not receive copies of licensing reviews and peer reviews of substance abuse treatment programs.**

DHS should make external reviews of treatment programs more accessible to agencies that place clients.

DHS does not routinely provide counties with copies of its licensing reviews of substance abuse treatment programs, and only two counties (Hennepin and Ramsey) have specifically requested to get copies of all reviews for programs in their counties.[32] Also, during our visits to selected counties, we found that county staff were generally unaware that peer reviews of treatment programs were conducted, and they had not seen copies of peer review reports.

RECOMMENDATION

The Department of Human Services should post copies of state licensing reviews and treatment program peer reviews at an online location where they could be reviewed by agencies that make client placements.

Nonpublic information that is examined during the course of licensing reviews or peer reviews should be protected by DHS from public disclosure. However, we think that the final reports that summarize reviewers' findings could provide useful information to agencies that make client placements.

[32] DHS staff told us that they routinely notify the county in which a chemical dependency program is located only if the department issues a fine or conditional license, or if it revokes or suspends a program's license.

5

Treatment for Prisoners: Use and Availability

SUMMARY

A large proportion of prison inmates have substance abuse problems, but most of these inmates do not participate in treatment prior to their release from prison. Many inmates are not imprisoned long enough to complete a treatment program, but there is also a shortage of treatment beds for chemically dependent offenders. In addition, few chemically dependent offenders enroll in community-based treatment in the months following their release from prison, and offenders' "release plans" typically have vague provisions regarding substance abuse services in the community. The Department of Corrections and local corrections agencies should work together to determine which substance abuse assessments and services are needed by individual offenders upon release.

Offenders with substance abuse problems have been a large and growing part of Minnesota's population of prison inmates. The number of persons in prison for drug-related offenses increased from 276 in 1990 to 2,178 in 2005. In addition, many persons imprisoned for other types of offenses have histories of substance abuse. Regardless of the prior treatment histories of these offenders, a prison sentence provides an opportunity for corrections officials to engage offenders in rehabilitative programs before the offenders return to the community. In this chapter, we examine the following questions:

- **Does the Minnesota Department of Corrections (DOC) have appropriate processes for determining inmates' needs for substance abuse treatment in prison?**
- **Are there adequate opportunities for inmates to participate in substance abuse treatment while in prison?**
- **Is there adequate planning for services for chemically dependent prisoners following their release from prison?**

ASSESSMENT PRACTICES

Inmates who enter prison are "screened" for possible drug or alcohol problems. As part of a broader health screening process, this screening determines which offenders will be referred for a more detailed "assessment" of drug or alcohol

problems.[1] Since 2003, the department has used the Texas Christian University Drug Screen for its chemical health screenings of inmates. We found that:

- **The initial screening instrument used by the Department of Corrections is considered to be a valid, accurate tool by experts in the substance abuse field.**

In 2000, a study compared the effectiveness of eight screening instruments in detecting substance abuse disorders among prison inmates. This study identified three instruments—including the Texas Christian University Drug Screen—as providing the most accurate screening outcomes.[2] The study reported lower performance by the screening instrument that DOC used until 2003.

According to DOC policy, offenders whose screenings indicate possible chemical use problems must subsequently receive a more in-depth assessment "using a standardized assessment instrument."[3] According to DOC policy, the assessment should provide a "comprehensive review of chemical dependency issues," including the severity of the inmate's problems and the assessor's "diagnostic impression."[4] Until 2003, DOC used a commercially available assessment tool and had information regarding its reliability and validity.[5] However, the department discontinued using this instrument as a way of managing agency-wide budget reductions.

The Department of Corrections revised its methods of assessing prison inmates in 2003.

Since 2003, the department has used an assessment instrument that staff developed in-house to conduct "structured interviews" prior to decisions about treatment referrals. While developing this instrument, DOC solicited input from an outside consultant, the departments of Human Services and Public Safety, and DOC's behavioral health advisory committee. The structured interviews help assessors obtain information from inmates that is related to professionally-recognized diagnostic criteria for chemical dependency. The interviews are used in combination with information collected from other sources, such as local pre-sentence investigations and the screening conducted when the inmate entered prison.

DOC's assessment instrument for conducting structured interviews is less detailed than the one it used prior to 2003, and its validity and reliability are

[1] Minnesota Department of Corrections Policies 500.050 and 500.308.

[2] Roger H. Peters, Paul E. Greenbaum, Marc L. Steinberg, Chris R. Carter, Madeline M. Ortiz, Bruce C. Fry, and Steven K. Valle, "Effectiveness of Screening Instruments in Detecting Substance Use Disorders Among Prisoners," *Journal of Substance Abuse Treatment* 18 (2000): 349-358.

[3] Minnesota Department of Corrections Policy 500.308. In practice, all female inmates are jointly screened and assessed at intake. In 2002, more than 80 percent of DOC's male inmates were assessed, while the others were "screened out" for having low risks for substance use problems, according to Norman G. Hoffman, *Diagnosis of Substance Use Disorders: Annual Report, 2002* (Smithfield, RI: Evince Clinical Assessments, February 2003), 2.

[4] Minnesota Department of Corrections Policy 203.013.

[5] Hoffman, *Diagnosis of Substance Use Disorders: Annual Report, 2002.*

unknown.[6] DOC staff acknowledged that this pre-referral assessment does not provide enough information to develop a treatment plan, so inmates who enter treatment receive another, more in-depth assessment. Thus, it is unclear that this instrument meets DOC's requirement for a "comprehensive review" of inmates' chemical health problems prior to the issuance of a treatment directive.

The inmate assessment process should be subject to periodic independent reviews.

DOC staff told us that they believe this instrument serves its main purpose—specifically, helping assessors make reasonable judgments about: (1) whether an inmate is chemically dependent or abusive, and (2) which type of program (treatment or psycho-educational) the inmate should be referred to, if any. They think it is reasonable to conduct the more detailed chemical dependency assessment after an inmate enters treatment, rather than before. Perhaps the department is correct, but we think it would be useful to have periodic independent reviews of the content and sequence of DOC's assessment process, given its important role in treatment referrals.

RECOMMENDATION

The Department of Corrections should periodically obtain external reviews of the assessment procedures it uses to determine inmates' needs for chemical dependency services.

At a minimum, we think that DOC should have the Department of Human Services (DHS) review its assessment process, perhaps every two or three years. DHS is responsible in law for monitoring "the conduct of [substance abuse] diagnosis and referral services" in Minnesota.[7] In addition, it would be useful for DOC to have assessment experts from outside of Minnesota state government periodically examine its practices.

DOC does not have a written policy regarding how soon a chemical use assessment must be completed after intake, but the director of DOC's behavioral health services told us that her goal is to have assessments completed within 30 days.[8] She estimated that, as of 2003, DOC had not met this timeframe for about 1,000 prison inmates. To address this problem, the department temporarily assigned two central office staff to help conduct assessments. The director of behavioral health services told us that the department has eliminated its assessment backlog for persons newly committed to prison, but it is still working

[6] Many assessment experts recommend that assessments incorporate instruments with proven validity and reliability, although this depends somewhat on the purposes for which the assessment is used. A recent national report on prison practices suggested "the use of only validated screening and assessment instruments in the intake procedure" (see Re-entry Policy Council, *Charting the Safe and Successful Return of Prisoners to the Community* (New York, 2004), 133).

[7] *Minnesota Statutes* 2004, 254A.03, subd. 1.

[8] Meeting this goal is not entirely within the department's control, as assessors often seek information from county agencies to supplement inmates' self-reports.

to conduct more timely assessments of offenders returning to prison for violating their supervised release.[9]

PARTICIPATION IN TREATMENT WHILE IN PRISON

A large proportion of the offenders sentenced to prison have drug or alcohol problems. In the nearly 4,000 prison-based assessments administered by DOC in 2004, assessors concluded that 64 percent of the subjects were "chemically dependent," and another 25 percent were "chemically abusive."

While in prison, inmates assessed as having substance use problems may be referred to relatively short education programs or longer treatment programs.

DOC staff told us that inmates assessed to be "chemically dependent" are usually recommended by assessors to participate in treatment programs lasting at least six months, assuming the inmates have sufficient prison time remaining to complete a prison-based program. For inmates assessed as "chemically abusive," assessors typically recommend placement in psycho-educational substance abuse programs lasting three months or less.[10]

DOC policy does not authorize the chemical dependency assessors to direct inmates to treatment. Rather, "program review teams," appointed by wardens at each prison, issue treatment directives on behalf of the Commissioner of Corrections after the offenders have been assessed. DOC policy states that the program review team "will direct all offenders who are assessed to need chemical dependency rehabilitative treatment to participate in treatment."[11] If inmates refuse to follow these directives, they are subject to disciplinary action (typically, 30 to 45 days of additional incarceration).[12]

We examined levels of inmate participation in prison-based treatment programs for substance abuse (as distinguished from short-term substance abuse education programs). We found that:

- **Due to expanded treatment capacity, the number of inmates enrolled in prison-based substance abuse treatment in recent years grew faster than the size of the state's inmate population.**

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[9] The department has not kept track over time of the number of inmates needing assessments who have not yet received them. However, the director of behavioral health services asked prison staff to notify her of any cases in which assessments were not completed prior to the end of the prison intake process, and she said there have been no recent notifications regarding persons newly committed to prison.

[10] Minnesota Department of Corrections Policy 500.308 has more detailed guidelines regarding which inmates should be referred to treatment, psycho-educational programs, or no program. For example, inmates determined by assessors to be "chemically abusive" rather than "chemically dependent" might be referred to prison-based treatment if the offenders' chemical use directly contributed to the offenses leading to their imprisonment. Also, inmates determined by assessors to be "chemically dependent" but with insufficient prison time to complete a treatment program are referred to a psycho-educational substance abuse program.

[11] Minnesota Department of Corrections Policy 203.013.

[12] *Minnesota Statutes* 2004, 244.03 authorizes the Commissioner to impose sanctions for refusal to participate in rehabilitative programs. There are no disciplinary consequences for inmates whose non-participation is due to a lack of beds in these programs.

In recent years, admissions to prison-based treatment programs grew more slowly than admissions to education programs.

Annual admissions to Minnesota's prison-based substance abuse treatment programs grew from 519 in 2000 to 793 in 2004, according to DOC records. This mainly reflected the addition or expansion of substance abuse treatment programs at the facilities in Shakopee, Lino Lakes, Willow River, and Thistledew. During this period, the state's total prison population also grew, from 6,276 in July 2000 to 8,333 in July 2004. Overall, the growth in admissions to treatment programs (53 percent) was somewhat greater than the growth in the prison population (33 percent). Thus, the percentage of the state's inmate population that entered treatment grew from 8.3 percent in 2000 to 9.5 percent in 2004. DOC was unable to provide us with data on trends in actual expenditures for substance abuse treatment during this period, mainly because data on these expenditures were commingled with data on spending for other behavioral health services. DOC staff said that the program expansions occurred partly by increasing the number of inmates per therapist in existing treatment programs.

During the 2000-04 period, the department also increased inmates' opportunities to participate in aftercare in prison following completion of prison-based treatment. The department has two such aftercare programs at the Lino Lakes prison, and total admissions to these programs more than doubled—from 143 in 2000 to 380 in 2004.

In addition, three prisons (Lino Lakes, Faribault, and Shakopee) have had "psycho-educational" programs that address substance abuse issues. DOC does not consider these programs to be "treatment," due to their short duration and lack of individual counseling. We found that:

- **The Department of Corrections has expanded inmates' opportunities to participate in short-term substance abuse education programs in recent years.**

The number of admissions to DOC's psycho-educational substance abuse programs grew from 322 in 2000 to 898 in 2004, mainly due to the expansion of existing programs. The percentage of the state's inmate population that entered a psycho-educational program grew from 5.1 percent in 2000 to 10.8 percent in 2004. Thus, there was significant growth in admissions to education programs that addressed substance abuse, compared with the more modest growth in admissions to the prisons' substance abuse treatment programs.

Decisions about whether to refer inmates to treatment or psycho-educational programs have depended partly on the amount of time inmates are scheduled to serve in prison.[13] Prison-based treatment programs typically last from 6 to 12 months, while prison-based psycho-educational programs are three months or less. Table 5.1 shows that nearly 45 percent of all persons who entered prison in 2004 had less than six months of prison time to serve, so they would not have had time to complete even the shortest prison-based treatment program and would only have been eligible for prison-based psycho-educational programs.

[13] DOC is in the process of making psycho-educational programming the initial stage of its prison-based treatment programs, rather than a stand-alone type of program. Some offenders—such as those with short times to serve in prison—would only complete the psycho-educational component of treatment in prison, and DOC officials said they hope to help these offenders continue treatment in the community upon release.

Many offenders are not in prison long enough to complete a treatment program lasting six months or more.

Table 5.1: Projected Length of Prison Time for Persons Entering Prison, 2004

Type of Prisoner	Projected Length of Stay in Prison	Number of Persons Entering Prison	Percentage
New Court Commitments or Probation Violators	Less Than 6 Months	1,168	26.1%
	6 to 12 Months	1,107	24.7
	1 to 3 Years	1,464	32.7
	More Than 3 Years	740	16.5
		4,479	100.0%
Supervised Release Violators	Less Than 2 Months	444	22.4%
	2 to 3 Months	808	40.8
	4 to 7 Months	520	26.3
	8 to 12 Months	105	5.3
	More than 1 Year	102	5.2
		1,979	100.0%

NOTE: The length of prison stays is relevant because prison-based substance abuse treatment programs typically require at least six months to complete. In contrast, prison-based substance abuse education programs typically require three months or less to complete.

SOURCE: Minnesota Department of Corrections.

We examined the extent to which inmates actually participated in prison-based treatment prior to their release. We selected random samples of inmates released from prison in January to March 2004 whose most recent prison assessment indicated that they were "chemically dependent."[14] Our samples were large enough to be representative of all chemically dependent inmates released during this period.[15] We found that:

- **A large majority of chemically dependent inmates did not participate in prison-based substance abuse treatment prior to their release in 2004.**

Overall, 75 percent of chemically dependent male inmates did not participate in substance abuse treatment in prison. Meanwhile, 25 percent did participate, including 17 percent who completed treatment prior to release and 8 percent who started treatment but did not finish it. Besides inmates who participated in treatment, another 30 percent of the chemically dependent male inmates participated only in short-term education programs that, as noted earlier, are not considered to be "treatment." Altogether, 55 percent of chemically dependent male inmates participated in prison-based treatment or education programs, while 45 percent did not participate in any sort of substance abuse program.

[14] We did not conduct such an analysis for inmates assessed to be "chemically abusive." Earlier, we noted that chemically abusive inmates comprised about 25 percent of inmates assessed in 2004.

[15] We examined a sample of chemically dependent male inmates and all chemically dependent female inmates released during this period.

Seventeen percent of chemically dependent inmates completed treatment in prison prior to release.

Among chemically dependent female inmates, 71 percent did not participate in substance abuse treatment in prison. About 29 percent enrolled in treatment, including 17 percent who completed treatment prior to release and 12 percent who started treatment but did not complete it. In addition, 26 percent of chemically dependent female inmates participated only in short-term education programs. Altogether, 55 percent of chemically dependent female inmates participated in prison-based treatment or education programs, while 45 percent did not participate in any sort of substance abuse program.

The Department of Corrections has limited information regarding reasons for offenders' non-participation in treatment. In some cases, inmates in our sample who were assessed as chemically dependent were not recommended for treatment by DOC's assessment staff, perhaps due to the remaining length of their prison sentences. In some cases, inmates who had been recommended for treatment by assessors were not directed to treatment by the program review team. But a majority of chemically dependent inmates were directed to treatment by the program review teams and did not receive it. Currently, DOC's management information systems do not provide reliable information about reasons that individual inmates did not receive treatment, such as inmate refusal to participate, lack of space in treatment programs, or other reasons.[16]

Whatever the reasons for inmates' non-participation in treatment, we found that:

- **Officials in most agencies that supervise released prisoners are dissatisfied with the availability of prison-based treatment.**

Of the directors of community-based corrections agencies that supervise released inmates, 12 percent expressed satisfaction with the availability of substance abuse treatment in prison, 69 percent expressed dissatisfaction, and the remainder offered no opinion.[17] In our view, these directors are in a reasonable position to judge the availability of prison-based treatment, given their responsibilities to arrange for services and supervision that offenders need following prison.

The Governor's 2006-07 biennial budget request did not include a request for additional substance abuse programming.[18] But, in 2005, the Department of Corrections responded to legislative questions by stating that it would need large increases in substance abuse program capacity to "adequately" serve the state's inmates. Specifically, the department said that it needed a total of 2,170 beds in prisons for inmates in primary treatment programs, well above its existing 500 beds. The department also said that it needed 400 beds for persons in psycho-

[16] We did not examine the department's paper records for individual inmates to determine whether these files documented reasons for non-participation in treatment.

[17] Office of the Legislative Auditor survey of community-based corrections directors, September 2005. The responses shown here are for the 29 agencies (representing "Community Corrections Act" counties and counties where offender supervision is provided by the Department of Corrections) that supervise adult felons, excluding three agencies that responded "not applicable" to the question.

[18] The department requested $920,000 a year in state funding to continue 14 chemical dependency positions for which federal funding was scheduled for elimination. This request was not intended to expand substance abuse programming.

educational substance abuse programs, which is double its existing 200 beds.[19] Department staff estimated that such expansions in treatment and psycho-educational programming would entail additional staffing expenditures of about $23 million annually.[20]

In our view, the department should reconsider its estimate of the number of treatment beds needed. The estimate was based on the assumption that 60 percent of 6,500 offenders entering prison annually need chemical dependency treatment before they are released.[21] However, as noted earlier, nearly 45 percent of the persons entering prison in 2004 had less than six months of prison time to serve, which would have made them ineligible to enter a treatment program.[22] In addition, some inmates are assessed to be neither chemically dependent nor abusive, while others refuse to participate in programming, drop out of programs (or are terminated from them), or have barriers to participation (such as lack of English skills). This suggests that the department's estimate of treatment bed needs was too high. Although questions can be raised about the department's estimate, we think it is still clear that:

There is a shortage of treatment beds in Minnesota's prisons, although the number of beds needed appears to be less than DOC has estimated.

- **There are too few substance abuse treatment beds in Minnesota prisons to meet the needs of inmates with chemical use problems.**

We offer no recommendations on what level of additional investment in treatment the Legislature should make, but we think that the shortage of treatment beds represents a lost opportunity to engage offenders in the prison-based "rehabilitative programs" required by state law.[23] The 2005 Legislature increased funding somewhat for prison-based substance abuse treatment. It appropriated $1 million per year "for increased funding for [prison-based] chemical dependency treatment programs," although the department also faces the possible loss of $920,000 per year in federally-funded chemical dependency positions sometime during the current biennium. The 2005 Legislature also authorized funding to expand the Challenge Incarceration Program, which has a chemical dependency treatment component.[24] In the next section, we

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[19] Dennis Benson, Deputy Commissioner, Department of Corrections, letter to Senator Jane Ranum, March 21, 2005.

[20] Patricia Orud, Minnesota Department of Corrections, e-mail to Joel Alter, Office of the Legislative Auditor, September 8, 2005.

[21] *Ibid.*

[22] Of the 4,479 persons who entered prison on "new commitments" in 2004, the department estimated that 1,168 had less than six months to serve at the time of admission. Of the 1,979 supervised release violators who returned to prison in 2004, the department estimated that 1,772 had less than seven months to serve at the time of admission. Some of these offenders could be served by short-term education programs, but they would not have enough prison time to complete an entire treatment program.

[23] *Minnesota Statutes* 2004, 244.03.

[24] *Laws of Minnesota* 2005, chapter 20, art. 1, sec. 22, subd. 4, authorized a building to accommodate "up to 100 additional beds" at the Challenge Incarceration Program's Willow River site. In addition, the department is in the process of adding 12 beds to the Stillwater treatment program (through double-bunking), creating a 24-bed program at the Moose Lake prison, and creating a 50-bed sex offender treatment program at the Rush City prison with a chemical dependency treatment component. Also, a private Minnesota prison used for some DOC inmates intends to add a 25-bed chemical dependency unit during 2006.

recommend that the department develop a plan for improving substance abuse services for inmates, both during and after prison.

PARTICIPATION IN TREATMENT AFTER RELEASE FROM PRISON

Previous studies have questioned whether prison-based treatment programs can be effective without "aftercare" following an offender's release, as we discussed in Chapter 2. After leaving prison, offenders have more access to chemicals and less direct supervision, and they may need ongoing support to maintain sobriety.

In Minnesota, a key element in an inmate's transition from prison to the community is the "release plan." According to DOC policy, a draft release plan must be sent by DOC to the agency that will supervise the offender after release.[25] The plan sets forth conditions with which the offender must comply, perhaps including participation in chemical dependency services. The supervising agent may accept or reject the draft plan, and differences of opinion between the agent and DOC are to be resolved by DOC's Deputy Commissioner for Community and Juvenile Services.

We examined the release plans for more than 130 chemically dependent inmates who were released during the first three months of 2004. We found that:

- **Prison release plans for inmates assessed as chemically dependent have provided minimal direction regarding post-release substance abuse assessment and programming.**

Prison release plans often have vague provisions regarding post-release chemical dependency services, and this is a source of concern to local corrections officials.

Nearly all release plans contained a boilerplate condition of release such as: "Comply with chemical dependency programming as directed by the agent/designee." Typically, the plans did not specify the type or intensity of the programming—for example, whether the offender needed professionally-directed treatment, participation in a support group, or some other substance abuse services. Also, the plans did not direct supervising agents to arrange for chemical use assessments in the community following the offender's release. Rather, the plans usually left complete discretion regarding assessment and programming to the supervising agents in the community.

Although the supervising agencies have authority to reject DOC's draft release plans, many of the agencies expressed concern regarding the chemical dependency components of release plans. In a statewide survey of community-based corrections agency directors, only 31 percent said that the release plans "always," "almost always," or "usually" have adequate provisions regarding the need for chemical health services in the community, while 69 percent said that the plans "sometimes," "rarely," or "never" have adequate provisions.[26] In addition, 55 percent of directors said that their agencies "sometimes," "rarely," or

[25] Minnesota Department of Corrections Policy 203.010. The draft must be sent four months prior to the offender's supervised release date, if time permits.

[26] Office of the Legislative Auditor survey of community-based corrections directors, September 2005. The responses reported here only include responses from directors of Community Corrections Act agencies and Department of Corrections district offices (*N*=29).

"never" received adequate information from DOC on the substance abuse services that offenders on supervised release received in prison.[27]

We also examined the extent to which inmates entered licensed, community-based substance abuse treatment programs following their release from prison.[28] Our review indicated that:

- **Among chemically dependent persons placed on supervised release from prison in 2004, only 8 percent of the men and 10 percent of the women entered a licensed chemical dependency treatment program within six months of their release.**

Most chemically dependent inmates do not complete treatment in prison, yet few enter treatment when they leave prison.

Our analysis did not consider the participation by released offenders in other types of substance abuse services, such as support groups. For example, one of the prison-based treatment programs—the Challenge Incarceration Program at Willow River—encourages its "graduates" released to locations in the Twin Cities metropolitan area to participate in a six-month, state-funded aftercare program.[29] In addition, it is likely that some prison releasees participate in support groups such as Alcoholics Anonymous, for which we did not have information on participation. Also, Department of Corrections officials told us that vigorous correctional supervision is the most important aspect of post-release "aftercare" that offenders receive.

But, while aftercare can take various forms, most directors of community-based corrections agencies expressed concerns to us about the lack of aftercare options for released prisoners. Only 7 percent said they were satisfied with the availability of aftercare services in the community for offenders who completed substance abuse treatment in prison. Sixty-nine percent of the directors expressed dissatisfaction with aftercare, and the rest expressed no opinion.[30]

For some chemically dependent prisoners, it is possible that support from friends, family, or informal groups such as Alcoholics Anonymous is sufficient to maintain sobriety in the community. But most chemically dependent inmates do not receive substance abuse treatment in prison. We think it would be preferable for DOC and local corrections agencies to jointly develop specific plans for post-

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[27] *Ibid.*

[28] Specifically, we looked at the experience of a representative, random sample of 267 inmates who were assessed in prison as chemically dependent and released from prison in the first three months of 2004. As noted in the previous section, most of these inmates did not enroll in treatment during prison. To determine whether offenders enrolled in community-based treatment programs following their release, we searched for the offenders' names and birthdates in data that are regularly submitted by substance abuse treatment providers to the Department of Human Services. Our analysis may underestimate treatment participation if treatment providers have not fully reported treatment participation information to the Department of Human Services, as required.

[29] The Challenge Incarceration Program's aftercare consists of three months of weekly aftercare meetings, followed by three months of monthly meetings. The aftercare program is not a licensed treatment program. Offenders may be excused from aftercare meetings for reasons such as work or family obligations.

[30] Office of the Legislative Auditor survey of community-based corrections directors, September 2005. These responses reflect the Community Corrections Act agencies and Department of Corrections district offices, which supervise adult felons (N=29).

release chemical dependency services, rather than leaving these decisions entirely to the supervising agencies.

RECOMMENDATION

DOC should work with community-based corrections agencies to develop more specific plans for individual inmates' post-release chemical dependency services.

For an offender who has been in prison-based substance abuse treatment, the prison release plan should direct the supervising agency to provide appropriate services based on a review of DOC's treatment program discharge summary or pre-release chemical use assessment. DOC staff told us they intend to conduct chemical use assessments, just prior to release, on all offenders who have participated in prison-based treatment. They said that this could provide a basis for determining these offenders' needs for continuing services in the community.[31] If a county refuses to recognize the validity of a pre-release assessment done by DOC, the release plan should require the county to arrange for a post-release chemical use assessment, provided by the county or the offender's insurer.[32]

We also think DOC should be prepared to write release plans that address the needs of chemically dependent inmates who did *not* participate in prison-based treatment. DOC has not yet adopted a policy on pre-release assessments, but department officials told us they do not intend to conduct pre-release assessments on inmates deemed chemically dependent at prison intake who did not participate in prison-based treatment. At a minimum, however, we think that such offenders should be required in their release plans to obtain community-based chemical use assessments, as arranged by the supervising agency.

Prisoners' release plans and treatment discharge summaries should have more specific provisions about inmates' service needs following release.

We recognize that the availability of community-based substance abuse services varies around the state, as does public funding for them. Thus, local agencies should play a key role in identifying which services can best meet the needs of released offenders. But, where possible, we think that offenders' prison release plans and prison treatment discharge summaries should have more specific provisions about the need for post-release substance abuse assessments or services, thus providing a stronger basis for the supervising corrections agents to hold the offenders accountable for participation. DOC officials told us they are in the process of implementing several initiatives to help prisoners successfully return to the community, and we think that our recommendation is consistent with these efforts.[33]

[31] Most local agencies do not send staff to the prisons to conduct chemical use assessments before an inmate is released.

[32] State laws and rules do not require local "placing agencies" (counties, tribes, and prepaid health plans that contract with DHS) to abide by assessments conducted by DOC prior to a prisoner's release, and some local agencies told us they do not use DOC's assessments.

[33] For example, DOC intends to hire staff in its minimum security units to help coordinate pre-release support groups and post-release continuing care. In addition, DOC is in the process of adding chemical dependency "release and reintegration specialists" at some prisons to work with the prisons' case managers on inmate release planning.

RECOMMENDATION

The Department of Corrections should present the 2007 Legislature with a plan for (1) improving the availability of substance abuse treatment and related services in Minnesota's prisons, and (2) helping to ensure that chemically dependent offenders receive the treatment or related services they need upon release from prison.

DOC should develop a strategy for improving chemically dependent offenders' access to treatment during and after prison.

In this chapter, we noted that there has been limited participation by inmates in chemical dependency treatment during and after prison. In our view, there is a need for additional state funding for such treatment. First, we think there is a need for additional treatment capacity in Minnesota prisons, although the bed needs should be documented further by the Department of Corrections. Second, post-release treatment (if it is provided at all) is now usually paid for by the offender's private insurance or the state's Consolidated Chemical Dependency Treatment Fund, but some released offenders do not have insurance and are not eligible for the Consolidated Fund. To help ensure that there is follow-through on offenders' release plans, the Legislature may wish to appropriate some designated chemical dependency funding that could "follow the offender" into the community following release, particularly for higher risk offenders.

RECOMMENDATION

For offenders released from prison, the Legislature should amend state law to require that DOC provide the supervising corrections agency with prison records of each offender's assessments and services for chemical use.

We think that DOC and the Legislature should help to ensure that community-based corrections agencies receive sufficient information about the prison-based assessments and services received by inmates who will be released to these agencies' supervision. Earlier in this chapter, we noted that a majority of directors of community-based corrections agencies said they were dissatisfied with the information they have received from DOC on offenders' prison-based substance abuse services. DOC officials told us they have been working to increase the amount of treatment-related information shared with supervising agents, but they said they would welcome statutory clarification of the department's obligations in this area. The 2005 Legislature amended state law to require that, for sex offenders released from prison, DOC provide supervising corrections agencies with information on the prison-based services these offenders received.[34] We think that the Legislature should enact similar provisions regarding prison-based substance abuse assessments and services, for the purpose of helping community-based agencies make appropriate decisions regarding treatment and supervision.

[34] *Laws of Minnesota* 2005, chapter 136, art. 3, sec. 3.

6

Treatment for Prisoners: Outcomes

SUMMARY

A key goal of substance abuse treatment for chemically dependent offenders is to reduce criminal behavior. Inmates who completed treatment programs in Minnesota prisons had lower arrest and conviction rates following release than (1) inmates who completed short-term substance abuse education programs, and (2) inmates who started treatment but failed to complete it. Recidivism rates were particularly low for inmates who completed the Challenge Incarceration Program, a boot camp program with a substance abuse treatment component. The Department of Corrections should develop a strategy for improving the post-release outcomes of chemically dependent inmates assigned to short-term programs and those who do not complete treatment.

In Chapter 5, we said that too few offenders receive substance abuse treatment in prison, and there is insufficient release planning for inmates' post-prison substance abuse services. However, before the Department of Corrections or Legislature expand existing prison-based programs, it is important to consider whether these programs are providing effective services. In this chapter, we examine the following questions:

- **To what extent do prison inmates complete the substance abuse programs they enter in prison?**
- **What impact, if any, does completion of a prison-based substance abuse program have on chemically dependent persons' rates of subsequent arrest and conviction?**
- **To what extent do prisoners have chemical use relapses following completion of a prison-based substance abuse program?**

PROGRAM COMPLETION RATES

Completing a treatment program does not guarantee "success" when an inmate leaves prison, but studies have indicated that the duration of time spent in treatment is related to post-treatment outcomes.[1] To maximize the impact of a

[1] William M. Burdon, Nena P. Messina, and Michael L. Prendergast, "The California Treatment Expansion Initiative: Aftercare Participation, Recidivism, and Predictors of Outcomes," *The Prison Journal* 84, no. 1 (March 2004): 61-80. The authors found that time spent in prison-based treatment was a significant predictor of aftercare participation and returns to incarceration in the 12 months following release.

program, it is generally preferable for a treatment participant to complete the full regimen, rather than quitting or being discharged early by staff. Also, it is important to follow completion of a prison-based program with appropriate post-release programming in the community, as recommended in Chapter 5.

The Department of Corrections (DOC) has two general types of prison-based substance abuse programs, with differing duration and content. First, substance abuse **treatment programs** generally take 6 to 12 months to complete, and they include education, group counseling, and individual counseling components. Second, substance abuse **psycho-educational programs** generally take three months or less, are not considered "treatment," and do not include individual counseling. The impact of treatment depends on both the duration and nature of services provided, but we noted in Chapter 3 that the National Institute on Drug Abuse has suggested that programs of less than 90 days are of "limited or no effectiveness."[2]

In Chapter 5, we noted that only about 25 percent of chemically dependent inmates released in 2004 participated in prison-based substance abuse treatment programs prior to release, and another 30 percent participated only in substance abuse education programs. Table 6.1 shows completion rates for the prison-based substance abuse programs among inmates who left these programs in 2004. Completion rates indicate the percentage of inmates who completed a program they started.[3] We found that:

- **Most inmates complete the prison-based substance abuse programs they enter, although participants in treatment programs generally have lower completion rates than participants in shorter education programs.**

In 2004, 66 percent of inmates completed the prison-based treatment programs they entered.

For the treatment programs lasting 6 to 12 months, 66 percent of the inmates who left these programs in 2004 had completed them.[4] In contrast, the shorter psycho-educational programs had a completion rate of 81 percent in 2004. Higher completion rates do not necessarily translate into better outcomes, and we note later in this chapter that inmates who completed the education programs had relatively high recidivism rates compared with some other categories of chemically dependent inmates.

Variation among individual programs' completion rates partly reflects the types of inmates they serve, according to DOC staff. For example, the Lino Lakes prison has two substance abuse treatment programs that each last 9 to 12 months but have very different completion rates. One program serves only sex offenders, and 86 percent of persons leaving the program in 2004 completed it. Staff said that the participants in the substance abuse program for sex offenders tended to

[2] National Institute on Drug Abuse, *Principles of Drug Addiction Treatment: A Research-Based Guide* (Washington, D.C., 1999), 1, 14.

[3] Inmates who never entered a program (which happens often, as discussed in Chapter 5) are not counted as "non-completers" in the completion rates discussed here.

[4] The 66 percent completion rate includes the Challenge Incarceration Program, which has a chemical dependency treatment component during its six-month first phase. As we note later, this program has unique penalties for non-completion. If this program is excluded from our analysis, the overall completion rate for treatment programs was 60 percent in 2004.

Table 6.1: Client Completion Rates for Prison-Based Substance Abuse Programs, 2004

	Total Inmates Discharged	Percentage of Discharges Due to Program Completion
Treatment Programs		
Challenge Incarceration (Thistledew)	21	95%
Sex offender long-term CD treatment (Lino Lakes)	28	86
Challenge Incarceration (Willow River)	183	83
Sex offender medium-term CD treatment (Lino Lakes)	12	83
Reshape medium-term (St. Cloud)	58	72
TRIAD medium-term (Lino Lakes)	187	68
Atlantis medium-term (Stillwater)	89	58
Shakopee long-term	34	56
TRIAD program for mentally ill, chemically dependent inmates (Lino Lakes)	38	53
TRIAD long-term (Lino Lakes)	134	40
Total	784	66%
Psycho-Educational Programs		
Shakopee short-term	66	91%
Shakopee relapse	49	88
New Dimensions (Faribault)	459	81
TRIAD (Lino Lakes)	320	79
Total	894	81%

SOURCE: Office of the Legislative Auditor's analysis of Department of Corrections data.

be more compliant than the offenders served in the prison's long-term "TRIAD" treatment program, which staff described as serving the most criminal and chemically dependent inmates. The TRIAD program had a completion rate of 40 percent in 2004.

In addition, differences in programs' completion rates may reflect differences in the sanctions that inmates face for failing to complete the programs. State law authorizes the Commissioner of Corrections to impose disciplinary sanctions on inmates who refuse to participate in rehabilitative programs.[5] For most programs, the typical penalty for failing to participate is 30 to 45 days of additional incarceration, according to staff with DOC's Hearings and Release Unit.[6] But inmates in DOC's Challenge Incarceration Program have stronger incentives than inmates in other programs to complete their program, which may

[5] *Minnesota Statutes* 2004, 244.03.

[6] Minnesota Department of Corrections, *Offender Discipline Regulations* (St. Paul, 2005), Policy 510, authorizes penalties of up to 360 days of additional incarceration for refusal to participate in a program to which the inmate has been directed. Within each prison, a "program review team" designated by the warden has authority to issue treatment directives. The department does not keep summary data regarding how many offenders have received penalties for refusal to participate in programs, or the length of these penalties.

partly account for the fact that more than 80 percent of its participants in 2004 completed the prison-based phase of the program that included chemical dependency treatment. Inmates who successfully complete the first six-month phase of the Challenge Incarceration Program, unlike other inmates, can be released from prison before serving two-thirds of their sentence. In addition, inmates who fail to complete the Challenge Incarceration Program have time added to their term of imprisonment, equal to the time they spent in the program.[7]

We also analyzed changes over time in inmates' completion of treatment programs lasting six months or longer, including inmates in the Challenge Incarceration Program.[8] We found that:

- **The overall completion rates for prison-based substance abuse treatment programs have increased in recent years.**

Sixty-six percent of inmates who left prison-based treatment programs in 2004 had completed them, compared with a 48 percent completion rate among inmates who left treatment programs in 2000.[9] The improvements in completion rates are encouraging, but we think that the Department of Corrections should continue working to increase them. The department's authority to direct prisoners to treatment and sanction them for not participating provides a unique opportunity to intervene in the lives of chemically dependent offenders. But we also recognize that if the department gave longer periods of "extended incarceration" to inmates who do not comply with treatment directives, this could increase the size of the department's prison population.[10] This is an important consideration at a time when the state's prisons are operating at capacity.

DOC should aim to increase inmates' compliance with directives to treatment.

CRIMINAL RECIDIVISM FOLLOWING TREATMENT

One goal of substance abuse treatment is to reduce the likelihood that chemically dependent offenders will commit new crimes following treatment, and thus reduce the threat to public health and safety. For our study, we tracked 507 adult offenders released from a Minnesota state prison between January and March 2002 to determine the extent to which they were arrested or convicted for a new

[7] Besides these incentives to complete the Challenge Incarceration Program, inmates apply to participate in the program, so they may be more amenable to treatment than inmates who are directed by DOC to participate in treatment. In addition, *Minnesota Statutes* 2004, 244.17, subd. 3, excludes from this program persons who were imprisoned for murder, manslaughter, criminal sexual assault, kidnapping, robbery, arson, or other offenses involving death or intentional personal injuries.

[8] This analysis did not include shorter-term, psycho-educational programs, which are not considered to be "treatment."

[9] Completion rates were 53 percent in 2001, 56 percent in 2002, and 69 percent in 2003. The 2004 program completers represented 6 percent of the state's total July 2004 inmate population (not all of whom are chemically dependent), while the 2000 program completers represented 4 percent of the state's total July 2000 inmate population.

[10] It is also possible that stronger penalties for non-compliance would have the intended effect of encouraging inmates to participate in treatment, with minimal need for the use of extended incarceration.

offense during the three years following their release.[11] The Department of Corrections had assessed each of these prisoners as chemically dependent for at least one substance prior to their release. We also looked at the relationship between inmates' recidivism rates and participation in treatment, among other variables.[12]

First, we looked at overall recidivism rates for all 507 chemically dependent prisoners in our sample. We found that:

- **Among Minnesota inmates deemed chemically dependent and released from prison in early 2002, a majority were arrested for a new offense in the three years following their release.**

Fifty-nine percent of chemically dependent inmates were rearrested within three years of their release.

As shown in Figure 6.1, 59 percent of the released inmates were arrested for a new offense in Minnesota. Also, nearly 37 percent were convicted of at least one "serious" criminal offense—that is, one that is reported to the Minnesota Bureau of Criminal Apprehension.[13] (The bureau tracks felonies, gross misdemeanors, and select misdemeanors.) These offenders' new arrests and convictions were for a mix of violent crimes (such as murder or sex offenses), property crimes, drug crimes, and other types of crime (such as weapons offenses).[14]

Some of the 507 released prisoners did not have convictions for serious criminal offenses, but they had convictions for driving-related offenses, as reported to the Minnesota Department of Public Safety's Driver & Vehicle Services Division. Considering *all* driving offenses—including those deemed serious—we found that 50 percent of the released prisoners were convicted for offenses ranging

[11] Each of the 507 chemically dependent prisoners we tracked was released under one of the following conditions: supervised release, Intensive Supervised Release, work release, discharged from sentence, or released under the Challenge Incarceration Program. We looked at Department of Corrections data on bookings into a local jail facility as a proxy for arrests, noting that all offenders "booked" into a jail facility have been arrested, but there may be instances where persons are arrested but not booked. We looked at convictions using data reported to the Minnesota Department of Public Safety's Driver & Vehicle Services Division (driving offenses), and to the department's Bureau of Criminal Apprehension (felonies, gross misdemeanors, and select misdemeanors). We included only those offenses that appeared to be a new offense committed subsequent to a prisoner's release date, and we excluded cases coded only as a "violation of probation."

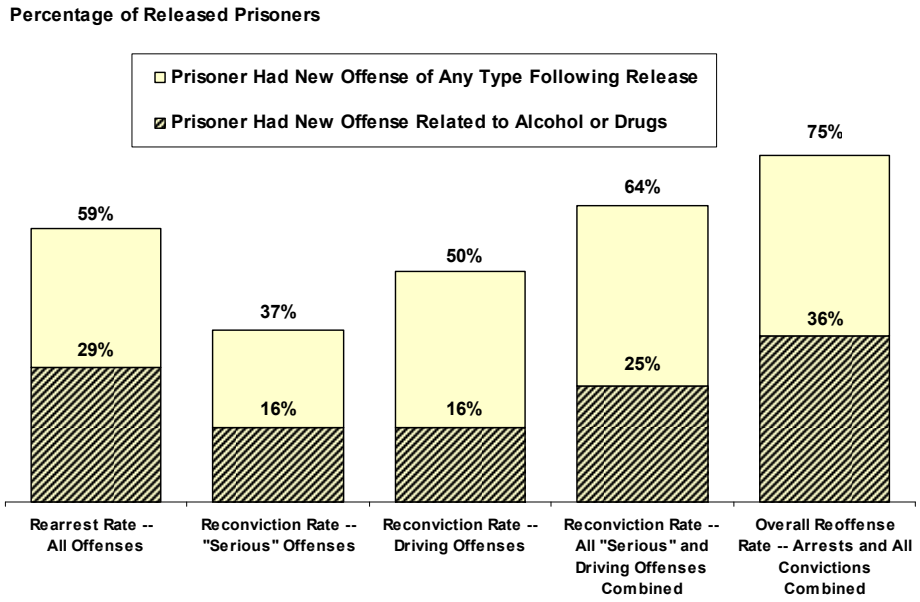
[12] Our analysis of prisoners' recidivism was a retrospective review of arrest and conviction data, not a controlled study in which prisoners were randomly assigned to specific treatment programs. Thus, we could not definitively determine treatment's impact on recidivism. Also, we did not try to evaluate whether the Department of Corrections assigned these prisoners to the "right" treatment programs in prison. Some offenders participated in more than one treatment program during their incarceration, so we could not isolate the effects of various programs on individual offender's recidivism.

[13] The lower conviction rate does not necessarily mean that a large number of the arrested offenders were innocent. Some were awaiting trial at the end of the three-year period, some were convicted of lower-level offenses that did not require reporting to the bureau's database, and others were not prosecuted.

[14] Previous research has examined overall recidivism rates of Minnesota's released prisoners. These rates provide some context for the rates presented in this study, even though not all released prisoners have chemical use problems. A 1997 study by our office found that 59 percent of all prisoners released in 1992 were rearrested and 45 percent were reconvicted of a new offense within three years, based on Minnesota offenses only—see Office of the Legislative Auditor, *Recidivism of Adult Felons* (St. Paul, January 1997), 51-52.

Figure 6.1: Recidivism Rates of Chemically Dependent Prisoners Released in 2002

Within three years of release from prison, 36 percent of chemically dependent inmates had a new arrest or conviction explicitly related to alcohol or drugs.



NOTE: Our sample included 507 offenders released between January 1, 2002, and March 31, 2002, who were diagnosed by DOC as chemically dependent for at least one substance. Arrests include all "bookings" (as a proxy for arrests) into a local jail facility. In this analysis, "serious" offenses include felonies, gross misdemeanors, and select misdemeanors reported to the Department of Public Safety's Bureau of Criminal Apprehension. Driving convictions include all driving offenses reported to the Department of Public Safety's Driver & Vehicle Services Division. We included only those offenses that appeared to be a new offense subsequent to a prisoner's release date, and we excluded cases coded only as a "violation of probation."

SOURCE: Office of the Legislative Auditor's analysis of data from the Department of Corrections and the Department of Public Safety's Bureau of Criminal Apprehension and Driver & Vehicle Services Division.

from speeding and reckless driving to felony-level offenses such as driving-while-impaired and criminal vehicular operation resulting in bodily harm.[15] Altogether, 64 percent of the inmates were *convicted* of a new offense (criminal or driving), and 75 percent were either *arrested* or *convicted* of a new offense within three years of their release from prison.

Figure 6.1 also shows that 29 percent of the offenders in our sample had post-release arrests that were explicitly related to drugs or alcohol, and 25 percent had post-release convictions for offenses (criminal or driving) that were explicitly related to these substances. Overall, 36 percent of the inmates were either *arrested or convicted* for substance-related offenses within three years of their

[15] Among prisoners with a new driving conviction, 92 percent had (1) multiple new driving convictions, (2) also been rearrested for a criminal offense, or (3) also been reconvicted of a criminal offense reported to the Bureau of Criminal Apprehension. Driving convictions for the remaining 8 percent were primarily for driving after withdrawal of license, failure to obey traffic signs, speeding, and driving without insurance. Parking offenses were not included in our calculation of recidivism rates for driving offenses.

release. Drugs or alcohol could have been a factor in other crimes that led to the arrests or convictions, but this was not always apparent from the arrest and conviction data we examined.

We then looked at the relationship between participation in prison-based treatment programs and recidivism following release from prison. We did not determine treatment's impact on recidivism apart from other factors, such as offenders' previous treatment history and motivation to participate in treatment. As shown in Table 6.2, we examined recidivism rates of three subgroups of our sample of chemically dependent prisoners: (1) those who successfully completed their assigned substance abuse program prior to release (220 prisoners), (2) those who either quit a program prior to completion or were terminated from their assigned program early by treatment staff for program violations (55 prisoners), and (3) those whose treatment status was "indeterminate" (220 prisoners).[16] For the latter group, DOC computer records had no indication that the offenders entered a prison substance abuse program, but DOC officials cautioned that these records could be incomplete.[17] The Department of Corrections determined the length and type of programming for the prisoners based on program availability and the prisoner's needs and length of prison stay.

Treatment completers had lower overall recidivism rates than other chemically dependent prisoners.

For the 220 prisoners who had *completed* their assigned program, we looked at the relationship between recidivism rates and the length and type of prison-based program they were directed to complete. First, we found that:

- **Prisoners who completed medium- or long-term treatment generally had lower rates of post-release arrest and conviction than other chemically dependent prisoners, although one-third were rearrested or reconvicted for substance-related offenses.**

As Table 6.2 shows, the chemically dependent inmates who had completed medium- or long-term treatment in prison had a lower rearrest rate (51 percent) than the inmates who had quit or failed programs in prison (65 percent), or inmates whose treatment status was "indeterminate" (60 percent). They also had a lower reconviction rate (27 percent) compared with those who quit or failed programs (49 percent) and the "indeterminate" group (36 percent). However, their rate of arrests or convictions for any *substance-related* offense (33 percent) was similar to that of the inmates who failed programs in prison (31 percent), and the indeterminate group (35 percent).[18]

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[16] We reviewed, but were unable to control for, possible differences in our subgroups of prisoners. For example, we examined differences in the groups' median offense severity and criminal history score (although the reporting in the department's information system was sometimes incomplete). Overall, prisoners who completed substance abuse programs in prison had lower median criminal history scores than non-completers (2.0 vs. 3.0), but completers and non-completers had the same median offense severity level (5.0).

[17] Because of incomplete reporting in the Department of Corrections prison management information system regarding prisoners' chemical dependency treatment, we were unable to obtain accurate information on all 507 prisoners' treatment histories. The department said that paper files contain more complete information on treatment history, but even these files have incomplete information about why prisoners did not complete their treatment directives.

[18] Program completers had a higher reconviction rate for driving offenses (55 percent) than inmates who failed programs (44 percent) and inmates with "indeterminate" treatment histories (47 percent).

Table 6.2: Reoffense Rates of Chemically Dependent Prisoners Released in 2002, by Program Participation

Program Group	N	Percent Rearrested	Percent Convicted of a New "Serious" Offense[a]	Percent Rearrested or Convicted for a New Drug or Alcohol Offense[b]
All Chemically Dependent Prisoners	**507**	**59%**	**37%**	**36%**
Prisoner Subgroups:				
(1) Completed a Substance Abuse Program	**220**	**56**	**34**	**39**
• Medium- or Long-Term Treatment[c]	67	51	27	33
• Challenge Incarceration Program	23	26	4	17
• Short-Term Psycho-Educational Program	130	64	42	46
(2) Quit Program or Were Terminated by Staff	**55**	**65**	**49**	**31**
(3) Indeterminate[d]	**220**	**60**	**36**	**35**

NOTE: Our sample included 507 offenders released between January 1, 2002, and March 31, 2002, who were diagnosed by DOC as chemically dependent for at least one substance. We included only those offenses that appeared to be a new offense committed subsequent to but within 36 months of a prisoner's release date, and we excluded offenses coded only as a "violation of probation." The subgroup data excludes 12 prisoners who were actively participating in, but did not complete, substance abuse programs prior to their release, as we were unable to precisely determine how much programming they had received.

[a] For purposes of this analysis, "serious" offenses are those reported to the Department of Public Safety's Bureau of Criminal Apprehension's Computerized Criminal History database, and they include felonies, gross misdemeanors, and select misdemeanors.

[b] Includes arrest data from the Department of Corrections and conviction data from the Department of Public Safety's Bureau of Criminal Apprehension and Driver & Vehicle Services Division.

[c] Persons who completed prison-based aftercare programs are included. Generally, aftercare participants are inmates who have completed medium- or long-term treatment.

[d] Prisoners with "Indeterminate" program status were inmates whose DOC computer records had no indication that the offenders entered a prison-based substance abuse program. DOC officials cautioned that some of the computer records might be incomplete.

SOURCE: Office of the Legislative Auditor's analyses of data from the Department of Corrections, and the Department of Public Safety's Bureau of Criminal Apprehension and Driver & Vehicle Services Division.

On the other hand, we found that:

- **Prisoners who completed short-term psycho-educational substance abuse programs had recidivism rates similar to prisoners who quit or were terminated from treatment, and they were the most likely to have new arrests or convictions for a substance-related offense.**

DOC officials do not consider the short-term educational programs to be "treatment" because they do not include individual counseling components. On all three of the recidivism measures shown in Table 6.2, prisoners who completed short-term substance abuse programs had higher reoffense rates than prisoners who completed longer programs. DOC staff suggested that the higher recidivism rates for short-term educational substance abuse programs may reflect differences in the types of inmates these programs tend to serve. For example, DOC said that, compared with other programs, short-term educational programs serve more inmates who have violated their supervised release or caused discipline problems in prison.

Third, we found that:

- **Inmates who completed the Challenge Incarceration Program (CIP) in prison had the lowest recidivism rates compared with other chemically dependent prisoners, including those who completed other prison-based substance abuse programs.**

As Table 6.2 shows, 26 percent of prisoners completing CIP were arrested for a new offense in the subsequent three years, compared with 51 percent of inmates who completed medium- or long-term treatment, 64 percent of inmates completing short-term programs, and 65 percent who quit or were terminated from programs. Only 4 percent of prisoners completing CIP were convicted of a serious offense, compared with 27 percent for completers of medium- or long-term treatment, 42 percent for completers of short-term programs, and 49 percent for those who quit or failed programs. CIP participants also had considerably lower recidivism rates for alcohol- and drug-related offenses (17 percent) than the full sample of 507 chemically dependent prisoners (36 percent).

Inmates who completed the Challenge Incarceration Program had relatively low recidivism, but it is unclear whether this was due to the program or the types of inmates it served.

As noted previously in this chapter, the Challenge Incarceration Program is different from other prison-based treatment programs. Offenders apply to participate in the program, rather than being directed to enter it. By statute, some types of serious offenders are excluded from participating in this program.[19] Compared with other programs, offenders in CIP potentially face stronger incentives for completing the program and harsher sanctions for failing it.[20] Perhaps the Challenge Incarceration Program simply attracts more motivated inmates than other programs. Alternatively, perhaps the program is more effective than other treatment programs. Our findings were based on a small group of program completers, so the program's recidivism over time should be monitored by the Department of Corrections. However, it is encouraging that graduates of this program had lower recidivism rates than other inmates on all of our measures.

[19] *Minnesota Statutes* 2004, 244.17, subd. 3.

[20] Inmates who complete the first phase of CIP may qualify for release from prison before their scheduled supervised release date, and inmates who fail to complete CIP have their prison time extended by the number of days they were in CIP.

Finally, we looked at the relationship between recidivism rates and prisoners' gender and age for our sample of 507 chemically dependent prisoners.[21] Table 6.3 presents rearrest and reconviction rates based on these characteristics. Our analysis showed that, among chemically dependent offenders released from prison in early 2002, males had somewhat higher recidivism rates than females. For example, 38 percent of chemically dependent males had a post-release arrest or conviction for offenses explicitly related to drugs or alcohol, as did 26 percent of females. But, among the males, 42 percent of those who completed a prison-based substance abuse program had a post-release arrest or conviction for a drug or alcohol offense, compared with 31 percent of the males who failed such a program.[22]

In addition, we found that chemically dependent inmates under age 41 at the time of release had higher recidivism rates than older inmates who were chemically dependent. For example, 49 percent of released prisoners under age 21 had new arrests or convictions related to drugs or alcohol, compared with 26 percent for released prisoners over age 40. This is consistent with research that has shown the declining likelihood of criminal behavior as people grow older, but it also highlights the need for programs to effectively address younger inmates' chemical dependency problems.[23]

DOC should consider how to improve outcomes for chemically dependent offenders who do not complete treatment in prison.

Overall, we do not know whether the differences in inmates' post-release recidivism rates reflect differences in the effectiveness of prison-based programs rather than other factors that we could not adequately measure, such as offenders' underlying criminality and self-motivation to change. However, the differences in post-release recidivism between the Challenge Incarceration Program and the short-term psycho-education programs are noteworthy. We offer no recommendations for specific changes in the content of Minnesota's prison-based substance abuse programs, but we think that DOC should consider ways to better address the treatment needs of the offenders now referred to short-term substance abuse programs. This is important due to the short prison stays of many of these inmates and their relatively high recidivism rates compared with other chemically dependent inmates. Perhaps some of these offenders need more intensive programs in prison. Also, Chapter 5 recommended improvements in DOC's prisoner release planning process, to help ensure that chemically dependent offenders receive appropriate services when they leave prison.

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[21] Our sample consisted of 441 males and 66 females, ranging in age from 18 to 61, with a median age of 30.

[22] In Table 6.3, the program "completers" include inmates who completed either a substance abuse treatment or substance abuse education program in prison.

[23] As shown in Table 6.3, the inmates under age 41 who completed prison-based substance abuse programs had lower overall rates of arrest and conviction than those who quit or were terminated from programs. However, the program completers under age 41 had higher rates of post-release arrest or conviction for drug or alcohol offenses than the inmates under age 41 who failed treatment.

Table 6.3: Reoffense Rates of Chemically Dependent Prisoners Released in 2002, by Gender and Age

Prisoner Group	Total	Percent Rearrested	Percent Reconvicted for a New Serious Offense[a]	Percent Rearrested or Convicted for a New Drug or Alcohol Offense
All Chemically Dependent Prisoners	**507**	**59%**	**37%**	**36%**
Gender				
All Male	**441**	**59%**	**37%**	**38%**
• Completed Substance Abuse Program	192	58	34	42
• Quit a Program or Terminated by Staff	55	65	49	31
All Female	**66**	**56%**	**33%**	**26%**
• Completed Substance Abuse Program	28	43	32	18
• Quit a Program or Terminated by Staff	0	NA	NA	NA
Age at Time of Release				
All 18-20	**35**	**66%**	**49%**	**49%**
• Completed Substance Abuse Program	11	55	46	55
• Quit a Program or Terminated by Staff	4	75	50	25
All 21-40	**375**	**62%**	**39%**	**38%**
• Completed Substance Abuse Program	166	58	35	40
• Quit a Program or Terminated by Staff	44	68	50	30
All 41 and Older	**97**	**44%**	**24%**	**26%**
• Completed Substance Abuse Program	43	49	26	30
• Quit a Program or Terminated by Staff	7	43	43	43

NOTE: Our sample included 507 offenders released between January 1, 2002, and March 31, 2002, who were diagnosed by DOC as chemically dependent for at least one substance. We included only those offenses that appeared to be a new offense committed subsequent to and within 36 months of a prisoner's release date, and we excluded offenses coded only as a "violation of probation."

[a] Includes conviction data from the Department of Public Safety's Driver & Vehicle Services Division and the Bureau of Criminal Apprehension's Computerized Criminal History database of felonies, gross misdemeanors, and select misdemeanors.

SOURCE: Office of the Legislative Auditor's analyses of data from the Department of Corrections and the Department of Public Safety's Bureau of Criminal Apprehension and Driver & Vehicle Services Division.

RECOMMENDATION

The Department of Corrections should develop a strategy for improving the post-release outcomes of (1) inmates who are directed to complete short-term programs in prison, and (2) inmates who fail the prison-based substance abuse programs they start.

DOC should ensure that it has accurate records of inmate participation in substance abuse programs.

Aside from any changes in the content of prison-based programs, DOC should consider reassessing these offenders prior to release and, where possible, provide clearer direction in prison release plans regarding substance abuse services these offenders may need in the community.

We also think that the department should regularly monitor the recidivism rates of inmates assessed as chemically dependent, including those who participate in prison-based programs and those who do not.[24] However, the department needs better data in its main information system regarding whether inmates have completed substance abuse programs. Also, in cases where inmates did not complete programs as directed, the department's information system should clearly indicate why.

RECOMMENDATION

The Department of Corrections should:

- ***Periodically determine the recidivism rates of inmates assessed as chemically dependent; and***
- ***Improve its recordkeeping of prisoners' participation in substance abuse programs while incarcerated, including the reasons why inmates do not comply with directives to participate in prison-based substance abuse programs.***

RELAPSE RATES FOLLOWING RELEASE FROM PRISON

As we discussed previously in this chapter, relapse prevention is a critical goal of substance abuse treatment. Rearrest and reconviction rates for drug and alcohol offenses are useful measures of whether offenders return to using chemicals following treatment. The extent to which individuals enter treatment following release from prison can also be a way of measuring the extent of chemical use relapses.

[24] DOC officials noted that budget constraints have limited the department's ability to conduct research in recent years. Still, DOC has periodically examined offender recidivism, and we think that DOC could occasionally focus some of its attention on key subgroups (such as chemically dependent offenders) as part of these ongoing efforts.

We tracked rates of entry into community-based treatment for 220 inmates who had completed a substance abuse program in prison prior to their release in early 2002. Using data collected by the Department of Human Services, we identified the offenders' admissions to community-based treatment within the three years following their release from prison.[25] We recognize that admission to community-based treatment or aftercare immediately following release from prison may be a good way for offenders to reinforce the lessons they gained from treatment in prison. Some offenders may have been directed into community-based treatment as part of their release plan. Thus, our analysis did not count as "relapses" any instances in which offenders entered community-based treatment within two months of leaving prison.[26] However, if offenders had been out of prison at least two months before entering treatment, we assumed that subsequent treatment admissions probably indicated some return to chemical use.

With these conditions in mind, we found that:

The relapse rates of persons who completed substance abuse programs in prison were similar to those of persons who completed treatment in the community.

- **Nearly one-fourth of all chemically dependent inmates who had completed substance abuse programs while incarcerated were readmitted to community-based treatment within three years of their release.**

About 23 percent of the prisoners were subsequently admitted for one or more episodes of care in the community, as shown in Table 6.4. Relapse rates for those prisoners who had post-release arrests or convictions (25 percent) were slightly higher than relapse rates for prisoners who did not (18 percent).

To provide a benchmark for the relapse rates of the persons who completed prison-based substance abuse programs, we also examined relapse rates for a sample of individuals from the general population who had completed treatment in the community.[27] Overall, we found that chemically dependent prisoners who completed prison-based substance abuse programs were admitted into community-based treatment at a rate that was similar to that of individuals who had completed treatment in the community.[28]

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[25] Our analysis may underreport readmissions to treatment. First, we did not determine readmissions to prison-based treatment for offenders that were reincarcerated within three years of their release. Second, offenders sometimes use aliases that would make it difficult to track subsequent treatment placements. Finally, treatment providers might not always report treatment episodes to the Department of Human Services.

[26] Also, if offenders started a community-based program within two months of leaving prison, and then entered another treatment program within 30 days of their discharge from the first program, we did not count either admission as a relapse.

[27] We randomly selected 350 individuals who had successfully completed community-based treatment between January and March 2002 and tracked their readmissions to treatment over a three-year period.

[28] We estimated that 18 percent of individuals treated in the community were readmitted for care at least once within the subsequent three years, with a margin of error (or "confidence interval") of 5 percentage points. This relapse rate was not statistically different from the 23 percent rate we found for released prisoners.

Table 6.4: Relapse Rates of Prisoners and Others Who Completed Substance Abuse Programs in 2002

Treatment Group	Percentage of Individuals With Reported New Episodes of Community-Based Treatment Within Three Years[a]				
	Number of Relapse Episodes				
	Total	0	1	2	3 or more
All Released Prisoners Who Completed Prison-Based Substance Abuse Programs	**220**	**77%**	**18%**	**4%**	**1%**
• Prisoner Was Rearrested or Reconvicted[b]	165	75	19	4	2
• Prisoner Was Not Rearrested or Reconvicted	55	82	16	2	0
Individuals Who Completed Community-Based Treatment	**350**	**82**	**12**	**5**	**<1**

NOTE: Our sample included 220 offenders released between January 1, 2002, and March 31, 2002, who were diagnosed by DOC as chemically dependent for at least one substance and had completed substance abuse programs prior to their release. We included new episodes of care that occurred within 36 months of release. We included only those offenses that appeared to be a new offense committed subsequent to a prisoner's release date, and we excluded offenses coded only as a "violation of probation." For comparison purposes, we selected a sample of 350 individuals who had completed community-based treatment between January and March 2002. This sample may have included individuals previously convicted of criminal offenses.

[a] Based on data reported by treatment providers to the Department of Human Services.

[b] Based on conviction data from the Department of Public Safety's Driver & Vehicle Services Division and the Bureau of Criminal Apprehension's Computerized Criminal History database of felonies, gross misdemeanors, and select misdemeanors.

SOURCE: Office of the Legislative Auditor's analyses of data from the departments of Public Safety, Corrections, and Human Services.

List of Recommendations

The Legislature should:

- Amend state law to clarify responsibility for chemical use assessments of persons jailed outside their home counties (p. 52);
- Amend state law to require that chemical use assessors interview the current probation officer when assessing a person on probation (p. 52);
- Consider amending state law to prohibit Rule 25 assessors from having financial conflicts of interest with treatment providers, except in circumstances that are now specified in state rules (p. 53); and
- Amend state law to require that DOC provide the supervising corrections agency with prison records of each released offender's assessments and services for chemical use (p. 96).

The Department of Human Services should:

- Distribute information to chemical health assessors on "best practices" in assessments, including model instruments for adults and adolescents (p. 50);
- Monitor the compliance of local agencies with assessment and referral rules (p. 50);
- Develop a directory that identifies key characteristics of each licensed chemical dependency treatment program (p. 51)
- Present the 2007 Legislature with a plan for improving the availability of community-based substance abuse treatment in Minnesota (p. 68);
- Report to the 2007 Legislature on the merits of changing the statutory "maintenance of effort" provisions of the Consolidated Chemical Dependency Treatment Fund (p. 69);
- Work with the Department of Health to develop guidelines and training materials for health care organizations on the use of "brief interventions" for alcohol abuse (p. 69);
- Provide local agencies with examples of "best practices" for addressing the needs of persons being considered for "repeat" placements into publicly-funded treatment (p. 80);

- Identify "best practices" to help local agencies monitor the progress of the clients they place in treatment (p. 82);

- Periodically provide these agencies with statewide information on treatment outcomes (p. 82); and

- Post copies of state licensing reviews and treatment program peer reviews at an online location where they could be reviewed by agencies that make client placements (p. 84).

The Department of Corrections should:

- Periodically obtain external reviews of the assessment procedures it uses to determine inmates' needs for chemical dependency services (p. 87);

- Work with community-based corrections agencies to develop more specific plans for individual inmates' post-release chemical dependency services (p. 95);

- Present the 2007 Legislature with a plan for (1) improving the availability of substance abuse treatment and related services in Minnesota's prisons, and (2) helping to ensure that chemically dependent offenders receive the treatment or related services they need upon release from prison (p. 96);

- Develop a strategy for improving the post-release outcomes of (1) inmates who are directed to complete short-term programs in prison, and (2) inmates who fail the prison-based substance abuse programs they start (p. 108);

- Periodically determine the recidivism rates of inmates assessed as chemically dependent (p. 108); and

- Improve its recordkeeping of prisoners' participation in substance abuse programs while incarcerated, including the reasons why inmates do not comply with directives to participate in prison-based substance abuse programs (p. 108).

Minnesota Department of **Human Services**

February 7, 2006

James R. Nobles
Legislative Auditor
Office of the Legislative Auditor
Centennial Office Building
658 Cedar Street
St. Paul, MN 55155

Dear Mr. Nobles:

Thank you for the opportunity to review and respond to your office's evaluation of substance abuse treatment and the activities and performance of State and local agencies. The Department of Human Services (DHS) supports the key recommendations of the report. These recommendations are consistent with our current goals and objectives, and the development and implementation of some of these changes is already underway.

As you are aware, DHS is in the process of implementing new requirements that will individualize treatment for each client, replacing the current program-centered approach. When the process is completed, these requirements will ensure that assessment and treatment planning follow best practice methods based on the American Society of Addiction Medicine's guidelines. These changes will strengthen statewide assessment, referral and treatment practices, and lay a foundation for other improvements to the chemical dependency treatment system.

There are two recommendations in the report on which we would like to comment:

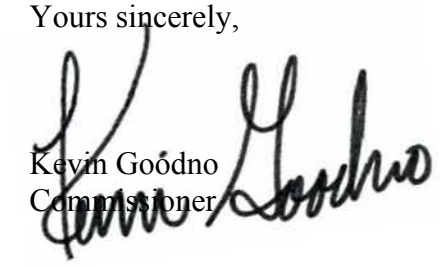
- We agree with the recommendation that DHS should strengthen its oversight of county assessment practices to address the variation in utilization of publicly-funded substance abuse treatment. However, we would like to reinforce that conclusions about access to treatment in any single county under the Consolidated Chemical Dependency Treatment Fund (CCDTF) cannot be drawn simply by measuring placement activity. Needs assessment and problem event data show that chemical use problems are not evenly distributed among counties. In addition, chemical use problems and treatment need vary from county to county based on population demographics such as ethnicity, co-occurring disorders and age. For example, the county noted in the report as having the least CCDTF placement activity per adult in poverty is also the lowest ranked county in the State for DWI arrests, drug arrests, and detoxification program admissions.

Conversely, the county with the highest placement rate also had the highest detoxification admission and DWI incident rate in the State, and the largest percentage of American Indian population (an ethnicity demonstrated to have higher treatment need). The primary reason for variance in CCDTF placement rates appears to be variation in need. Still there continues to be variances in county placement practices that cannot be explained by demographics and other factors that warrant further evaluation.

- We agree with the recommendation that the Department should provide counties with more information about treatment program outcomes including information regarding licensing citations. We have concerns with the recommendation that peer review information should be made available to the public. The purpose of peer review is quality assessment of the program by other members of the chemical health treatment community. Unlike licensing, peer review is not conducted on all programs, is voluntary on the part of the program, and has no due process component should the program believe that the reviewers are in error. The department plans to pursue other ways for providing counties with information about treatment program outcomes.

Thank you for the work of your office in conducting this evaluation and addressing important issues regarding the effectiveness and availability of substance abuse treatment.

Yours sincerely,



Kevin Goodno
Commissioner

MINNESOTA DEPARTMENT OF CORRECTIONS

OFFICE OF THE COMMISSIONER
Contributing to a Safer Minnesota

February 8, 2006

Honorable James R. Nobles
Legislative Auditor
658 Cedar Street Room 140
Saint Paul, MN 55155-1603

Dear Mr. Nobles:

Thank you for the opportunity to review the Legislative Auditor's evaluation of Substance Abuse Treatment programs in Minnesota. In our judgment, the Report represents a concise survey of our state's treatment infrastructure, a good summary of the current challenges and important recommendations for reform. The Report is a very useful document.

As a survey of the current challenges:

- The Report correctly notes that too little is known about why some offenders fail to succeed in treatment and how these failures might be linked to later recidivism. (*See,* Final Report at 98 - 110).

  So as to discover some of the missing data, DOC has initiated an evaluation project for the Chemical Dependency Treatment Program. Likewise, among the next steps in the Department's reentry initiative – known as the Minnesota Comprehensive Offender Reentry Plan, or MCORP – are assessments and case planning for each offender, and "electronic case plans" that will enable better tracking of outcomes.

- The Report confirms the importance of obtaining external reviews of the Department's assessment procedures. (*See,* Final Report at 87).

  A key part of the collaboration between DOC and the Department of Human Services is the regular reviews of DOC's Chemical Dependency services – including DOC's assessment practices. Moreover, on a quarterly basis, external stakeholders on the Behavioral Health Advisory Committee review the Department's treatment methods, policies and procedures.

As an outline for possible reform:

- The Report corroborates our view that the pace of improvements, innovation and coverage of our treatment practice is bounded only by the availability of resources. (*See,* Final Report at 96). The Department of Corrections has already undertaken a number of pioneering improvements to its substance abuse treatment practice, and will do more as additional resources are available.

- The Report rightly concludes that a stronger continuum of services would prevent relapses. (*See,* Final Report at 108). To build this broader continuum of services, DOC has implemented the MCORP project and, to the extent that resources are available, hopes to increase the number of Rule 25 chemical dependency assessments that are completed on offenders. With greater collaboration among agencies, and improved access to the Consolidated Treatment Fund, we believe that better outcomes are within reach.

- The Report correctly states that in order to strengthen the continuum of treatment services, DOC needs to fortify its collaborations with community-based agencies. (*See,* Final Report at 95). The DOC is strengthening these relationships through its advisory committees and a statewide commitment to offender reentry. These early successes point the way for future work.

In summary, the Department of Corrections shares your commitment to improving outcomes from the state's investment in substance abuse treatment, and regards this Report as a vital tool for educating everyone on these important issues.

We look forward to working with your office, the Minnesota Legislature and other stakeholders in developing a set of treatment strategies that will lead the nation in their efficacy and value.

Very truly yours,

Joan Fabian
Commissioner of Corrections

Recent Program Evaluations

Forthcoming Evaluations
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Liquor Regulation, March 2006
Public Assistance Eligibility Determination for Non-Citizens, Spring 2006

Agriculture
Animal Feedlot Regulation, January 1999

Criminal Justice
Substance Abuse Treatment, February 2006
Community Supervision of Sex Offenders, January 2005
CriMNet, March 2004
Chronic Offenders, February 2001
District Courts, January 2001

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School District Integration Revenue, November 2005
No Child Left Behind, February/March 2004
Charter School Financial Accountability, June 2003
Teacher Recruitment and Retention: Summary of Major Studies, March 2002
Early Childhood Education Programs, January 2001
School District Finances, February 2000
Minnesota State High School League, June 1998
Remedial Education, January 1998

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Compensation at the University of Minnesota, February 2004
Higher Education Tuition Reciprocity, September 2003
The MnSCU Merger, August 2000

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State-Funded Trails for Motorized Recreation, January 2003
Water Quality: Permitting and Compliance Monitoring, January 2002
Minnesota Pollution Control Agency Funding, January 2002
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Counties' Use of Administrative Penalties for Solid and Hazardous Waste Violations, February 1999
Metropolitan Mosquito Control District, January 1999
School Trust Land, March 1998

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Directory of Regulated Occupations in Minnesota, February 1999
Occupational Regulation, February 1999

Government Operations
Professional/Technical Contracting, January 2003
State Employee Health Insurance, February 2002
State Archaeologist, April 2001
State Employee Compensation, February 2000
State Mandates on Local Governments, January 2000
Fire Services: A Best Practices Review, April 1999
State Building Code, January 1999
9-1-1- Dispatching: A Best Practices Review, March 1998
State Building Maintenance, February 1998

Health
Nursing Home Inspections, February 2005
Minnesota Care, January 2003
Insurance for Behavioral Health Care, February 2001

Human Services
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Child Support Enforcement, February 2006
Child Care Reimbursement Rates, January 2005
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Economic Status of Welfare Recipients, January 2002
Juvenile Out-of-Home Placement, January 1999
Child Protective Services, January 1998

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Preserving Housing: A Best Practices Review, April 2003
Managing Local Government Computer Systems: A Best Practices Review, April 2002
Local E-Government: A Best Practices Review, April 2002
Affordable Housing, January 2001
Preventive Maintenance for Local Government Buildings: A Best Practices Review, April 2000

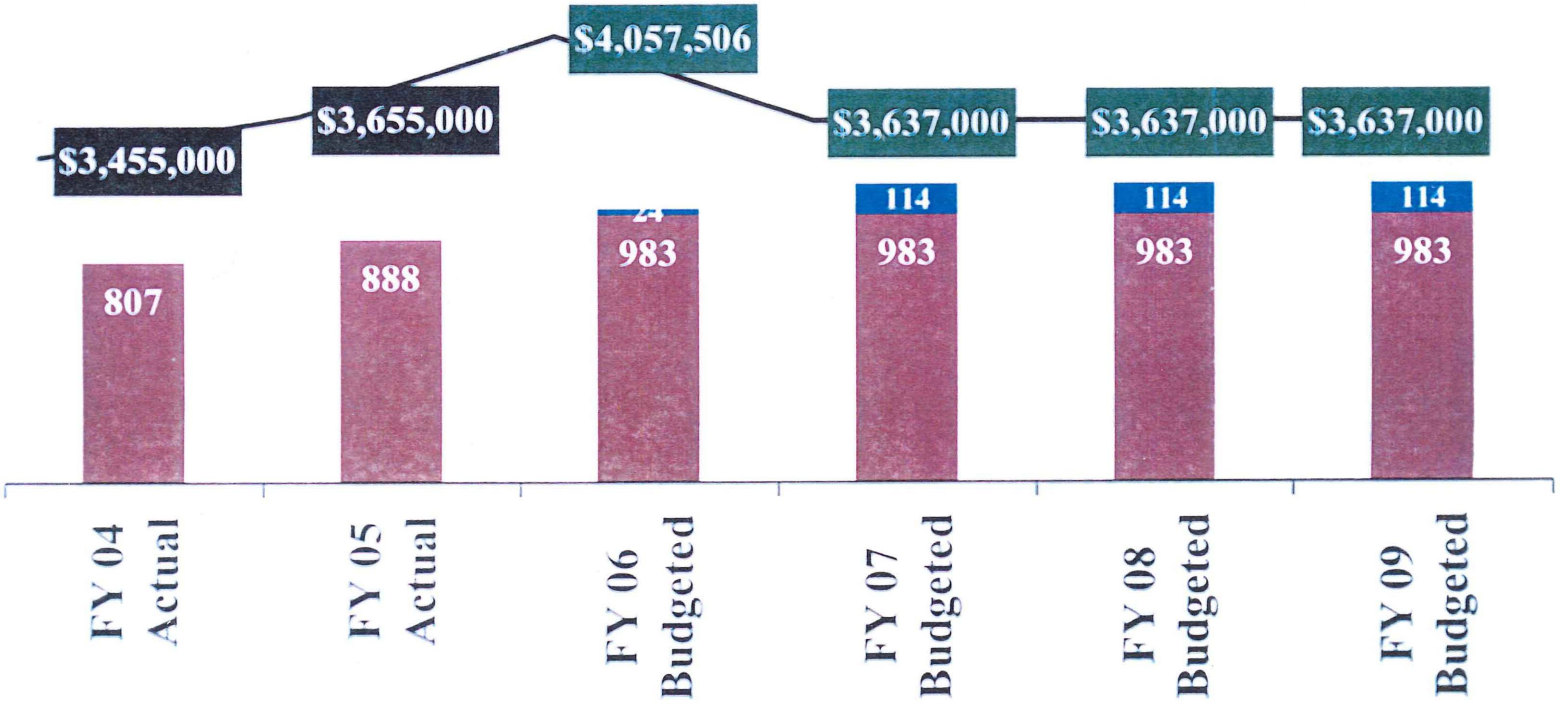
Jobs, Training, and Labor
Workforce Development Services, February 2005
Financing Unemployment Insurance, January 2002

Miscellaneous
Gambling Regulation and Oversight, January 2005
Minnesota State Lottery, February 2004

Transportation
Metropolitan Airports Commission, January 2003
Transit Services, February 1998

Evaluation reports can be obtained free of charge from the Legislative Auditor's Office, Program Evaluation Division, Room 140 Centennial Building, 658 Cedar Street, Saint Paul, Minnesota 55155, 651/296-4708. Full text versions of recent reports are also available at the OLA website: http://www.auditor.leg.state.mn.us

Minnesota Department of Corrections
Chemical Dependency Funding
(as of January 25, 2006)



Expended State and Federal Expenditures

Budgeted State and Federal Expenditures

DOC CD Treatment Beds
(as of the end of each FY)

Proposed CD Treatment Bed Expansion
(as of the end of each FY, if funding becomes available)

CONTRIBUTING TO A SAFER MINNESOTA

Minnesota Department of Corrections

Chemical Dependency Treatment Programs as of 7/2005

Facility	Program	Services	Number of Beds
MCF-LL	TRIAD	Primary treatment and institutional aftercare	452
MCF-LL	Sex Offender Treatment Program	CD treatment coordinated with sex offender treatment	48
MCF-STW	Atlantis	Primary treatment	36
MCF-FRB	New Dimensions	Psychoeducational programming	106
MCF-SCL	Reshape	Primary treatment	28
MCF-SHK		Primary treatment	32
MCF-RW		Chemical dependency intervention programming	60
MCF-WR (CIP)		Primary treatment	90
MCF-THD	Juvenile Program	Chemical dependency intervention	12
MCF-THD (CIP)	Adult Female	Primary treatment	24
Total			888

Chemical Dependency Programs added in FY06 With Base Funding

Facility	Program	Services	Number of Beds
MCF-STW	Atlantis	Primary treatment	12
MCF- SHK	CRP	Primary treatment	8
MCF-RC	SO Treatment Program	Primary treatment	50
Prairie Correctional Facility		Primary treatment	25
Total			95

Proposed Future Chemical Dependency Programs

Facility	Program	Services	Number of Beds
MCF-ML		Primary treatment	24[1]
MCF-WR	CIP	Primary treatment	90[2]
Total			114

[1] This program will be funded through Byrne funding, if received.
[2] The budget does not reflect operational increases for this expansion.