Minnesota's Chemical Health System

A Report to the Minnesota Legislature

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Minnesota Department of Human Services
Continuing Care for Persons with Disabilities

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EXECUTIVE SUMMARY

This report is an overview of the state of the chemical health system in Minnesota, focusing on the activities of the Chemical Health Division of the Minnesota Department of Human Services and outlining future directions for the Chemical Health Division and the State of Minnesota. This report covers several significant issues related to substance abuse in Minnesota:

Substance abuse remains a pervasive and costly social problem in Minnesota

- In 1998, over $1.39 billion in state spending was related to substance abuse. This represented 10.8% of the state's budget in that year.
- Of this spending, only 4 cents out of every dollar went to treatment, prevention, and regulation/compliance.
- Minnesota ranked 10th highest for past-month illicit drug use among young people age 12 through 17 (11.6% compared with 9.9% nationally), and among those age 18 through 25 (19.2% compared with 16.1% nationally).
- Minnesotans with alcohol use problems represent 75% of all those with any kind of substance use disorder.

Treatment is effective

- Across treatment settings, individuals who are admitted to treatment show improvement in major life areas, including:
  - Alcohol and drug use, medical problems, psychological problems, family problems, unemployment/school problems, arrests/antisocial behavior, and financial problems
- About 65% of individuals admitted to treatment in Minnesota completed treatment. Including transfers and other discharges, this number rises to 76%.
- Treatment completers are more likely to be abstinent six months after treatment, but even non-completers show significant abstinence.

There is a need for more treatment than is currently provided

- Only 21.8% of those who needed chemical dependency treatment statewide received treatment at a substance abuse treatment facility.

Prevention is effective

- For every dollar spent on drug abuse prevention, communities can save four to five dollars in costs for drug abuse treatment and counseling
- The incidence of alcohol, tobacco and other drug use among youth in the State of Minnesota has decreased. From 1998 to 2001:
  - The number of 9th graders who identified themselves as nondrinkers increased 7%.
  - The number of 12th graders who reported drinking and driving decreased 8%.
  - The average frequency of cigarette smoking decreased among students in all grades surveyed. Among 9th graders, the average rate dropped 39%.
  - Fewer students reported using marijuana. For example, 80% of 9th graders reported no use of the drug, up from 76% in the 1998 survey

NATURE OF SUBSTANCE ABUSE

Why is substance abuse an important issue?

States spent $81.3 billion in 1998 to deal with this substance abuse –13.1% of their budgets – and of every dollar states spent on substance abuse, 96 cents went to address the consequences of substance abuse, while only four cents went to prevent and treat the problem. (National Center on Addiction and Substance Abuse, 2001)

Substance abuse is costly to society and individuals. The social cost of drug and alcohol addiction treatment in the U.S. is estimated at $294 billion per year in lost productivity and costs associated with law enforcement, health care, justice, welfare, and other programs and services (Coffey et al, 2001). Public health and safety problems associated with the use of alcohol and other drugs include increased risk of specific diseases, use of medical and social services, injuries, traffic accidents, and crime (McLellan et al, 1996; National Institute on Alcohol Abuse and Alcoholism, 2000). The health care costs associated with alcohol and drug abuse exceed $190 billion per year (Rice, 1999) and account for over 13% of all personal health care expenditures (Levit et al, 1997).

The costs identified above are an attempt to quantify a problem that is essentially unquantifiable. There is no way to set a price for the childhood of a girl or boy with an actively chemically dependent parent. No amount of money heals the family of DWI offender. What is the value of lost potential, or the cost of not feeling safe in your home because there are drug dealers on the corner? As the dollar costs of substance abuse are considered, it is important to remember the dollars are only a part of the picture.

What is addiction and what does recovery look like?

Addiction (to alcohol or other drugs) is a primary, chronic neurobiological illness. Genetic, psychosocial, and environmental factors influence how it develops and manifests itself. The disease is often progressive and fatal. It is characterized by continuous or periodic:

- Impaired control over one's chemical use
- Preoccupation with alcohol or other drugs
- Use despite adverse consequences
- Distortions in thinking, most notably denial

Addiction is a chronic medical illness, like other chronic illnesses such as Type 2 diabetes mellitus and hypertension, which can be treated successfully (National Institute on Alcohol Abuse and Alcoholism, 2000).

Drug or alcohol addiction may begin with a personal choice to use these substances, but research shows that, for many, a physiological dependence soon takes hold; drug dependence produces significant and lasting changes in brain chemistry and function. These drug-induced changes in brain function have behavioral consequences, including the defining characteristic of addiction: compulsion to use alcohol or other drugs despite adverse consequences (McLellan et al, 2000).

> "Successful outcomes may require more than one treatment experience. Many addicted individuals have multiple episodes of treatment, often with a cumulative impact." (National Institute for Drug Abuse, 2000*)*

Recovery is the ongoing process of overcoming active alcoholism or other drug addiction. The goal of recovery is the resolution of severe and persistent alcohol and other drug problems, with a commitment to sobriety. People in recovery work to improve or maintain their physical, mental, emotional and spiritual well being. For most people, recovery is not a cure, but the management of a chronic condition.

What is the scope of the problem?

There are three important primary indicators commonly used to assess the nature of the substance abuse problem nationally and in Minnesota: prevalence of abuse, rate of treatment, and number of people who need treatment but don't receive it. The primary method for collecting information on these indicators is the National Household Survey on Drug Abuse (Substance Abuse and Mental Health Services Administration, 2001). Information in this section comes from the 1999 and 2000 editions of this survey.

Prevalence nationally

- An estimated 14.5 million Americans aged 12 or older in 2000 were classified with dependence on or abuse of either alcohol or illicit drugs (6.5% of the total population).
- Of these, 1.9 million were classified with dependence on or abuse of both alcohol and illicit drugs (0.9% of the population).
- An estimated 2.4 million Americans were dependent on or abused illicit drugs but not alcohol (1.1% of the total population).
- An estimated 10.2 million Americans were dependent on or abused alcohol but not illicit drugs (4.6% of the population).

Prevalence nationally by race/ethnicity

- Rates of current illicit drug use among the major racial/ethnic groups in 2001 were 7.2% for whites, 6.4% for Hispanics/Latinos, and 7.4% for African Americans . The rate was highest among American Indians/Alaska Natives (9.9%) and persons reporting more than one race (12.6%). Asians had the lowest rate (2.8%).
- Whites were more likely than any other racial/ethnic group to report current use of alcohol in 2001. An estimated 52.7% of whites reported past month use. The next

highest rates were for persons reporting more than one race (43.2%). The lowest current drinking rate was observed for Asians (31.9%). The rate was 35.1% for African Americans and 35.0% for American Indians/Alaska Natives.

- Binge alcohol use was least likely to be reported by Asians (10.1%) and most likely to be reported by American Indians/Alaska Natives (21.8%) and whites (21.5%).
- Among youths aged 12 to 17 in 2001, African American and Asians were least likely to report past month alcohol use. Only 11.5% of Asian youths and 10.6% of African American youths were current drinkers, while rates were above 15% for other racial/ethnic groups. However, the rates for Asian and African American youths were significantly higher than the rates reported in 2000 (7.1 and 8.8%, for Asians and African American, respectively).

Treatment need nationally

- An estimated 4.7 million people aged 12 or older (2.1% of the total U.S. population) needed treatment for illicit drug abuse, including 4.3 million people classified with illicit drug dependence or abuse and another 0.3 million people who received specialty treatment but were not dependent or abusing.
- Of those who needed treatment, 0.8 million people (16.6% of the people who needed treatment) received treatment at a substance abuse treatment facility. The treatment gap was estimated to be 3.9 million people (1.7% of the total population).

Treatment utilization nationally

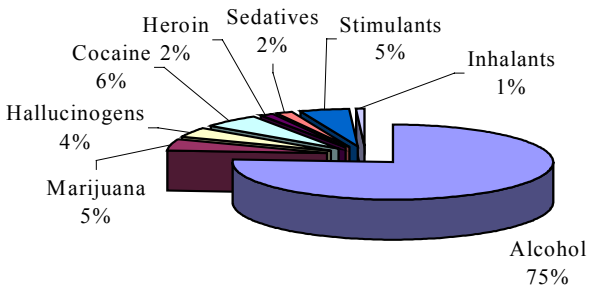
- An estimated 2.8 million people aged 12 or older (1.3% of the population) received some kind of treatment for a problem related to the use of alcohol or other drugs in the 12 months prior to being interviewed in 2000.
- Of these, 0.9 million received treatment for both alcohol and other drugs (0.4% of the total population).
- An estimated 0.4 million persons received treatment for illicit drugs but not alcohol (0.2% of the total population); an estimated 1.2 million people received treatment for alcohol but not illicit drugs (0.5% of the total population).

Prevalence in Minnesota

- 6.1% of Minnesotans, age 12 and older, reported illicit drug use in the month (preceding the survey,) compared with 6.4% nationally.
- However, Minnesota ranked 10th highest for past-month illicit drug use among young people age 12 through 17 (11.6% compared with 9.9% nationally), and among those age 18 through 25 (19.2% compared with 16.1% nationally).

- The Minnesota Survey on Adult Substance Use (Minnesota Department of Human Services, 1998) showed that Minnesotans with alcohol use problems represent 75% of all those with any kind of substance use disorder (see Figure 1)

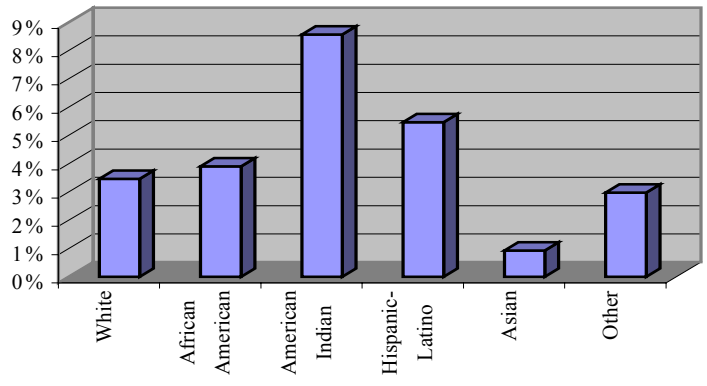
Figure 1: Chemical Use Problems by Type of Drug



Treatment need in Minnesota

- In 2001 an estimated 177,243 Minnesotans needed substance abuse treatment. Of that number, 93,164 live in the metropolitan area, and 81,893 live in greater Minnesota.
- Of those who needed treatment, 38,622 people (21.8% of the people who needed treatment) received treatment at a substance abuse treatment facility.
- When treatment need is estimated by age, it appears that 16,917 Minnesota minors need treatment, and 152,488 Minnesota adults do.
- When race and ethnicity are used to estimate numbers of people needing treatment, it appears that 152,268 are whites, 6,705 are African Americans, 1,306 are Asians, 2,072 are American Indians, 5,252 Hispanics/Latinos, and 3,137 others.
- When estimates of substance use disorders within racial/ethnic populations are compared with the ethnic population as a whole, varying frequency of need becomes apparent (see Figure 2).

Figure 2: Percent of Ethnicity in Need of Chemical Dependency Treatment



- Figure 3 illustrates the variability in detoxification facility admissions across Minnesota. This measure is a good indicator of treatment need (some counties do not participate in the detox portion of the Drug and Alcohol Abuse Normative Evaluation System – DAANES).

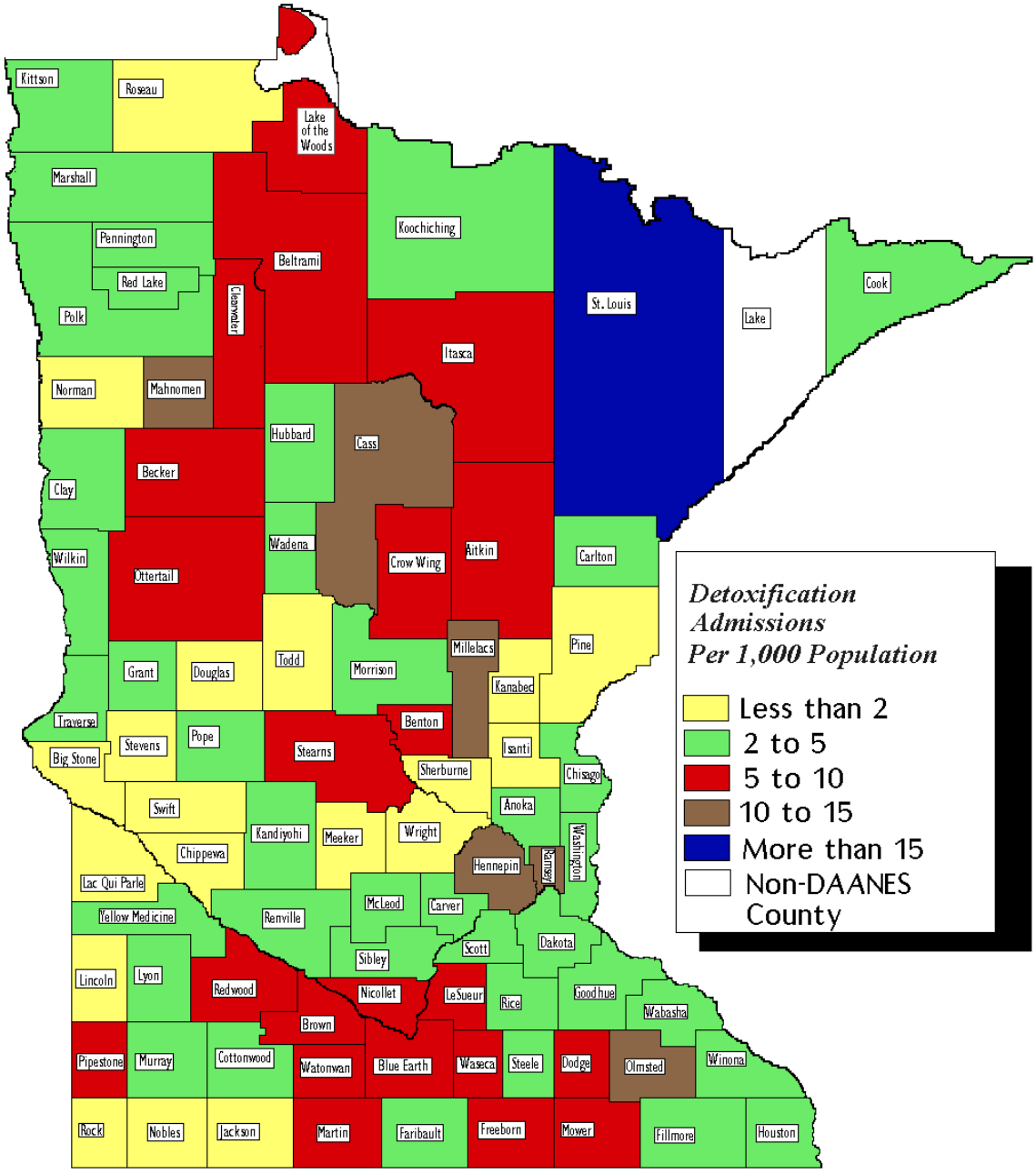


Figure 3: Detox admissions per 1,000

Treatment utilization in Minnesota

- In state fiscal year 2001 there were a total of 38,622 treatment admissions in Minnesota.

- There is considerable variation in rate of treatment admissions from county to county (see Figure 4)
- For all treatment admissions, 70% of the people receiving treatment are males, and the average age of people admitted to treatment is 33 years. Thirty percent of the admissions were for people under the age of 24.

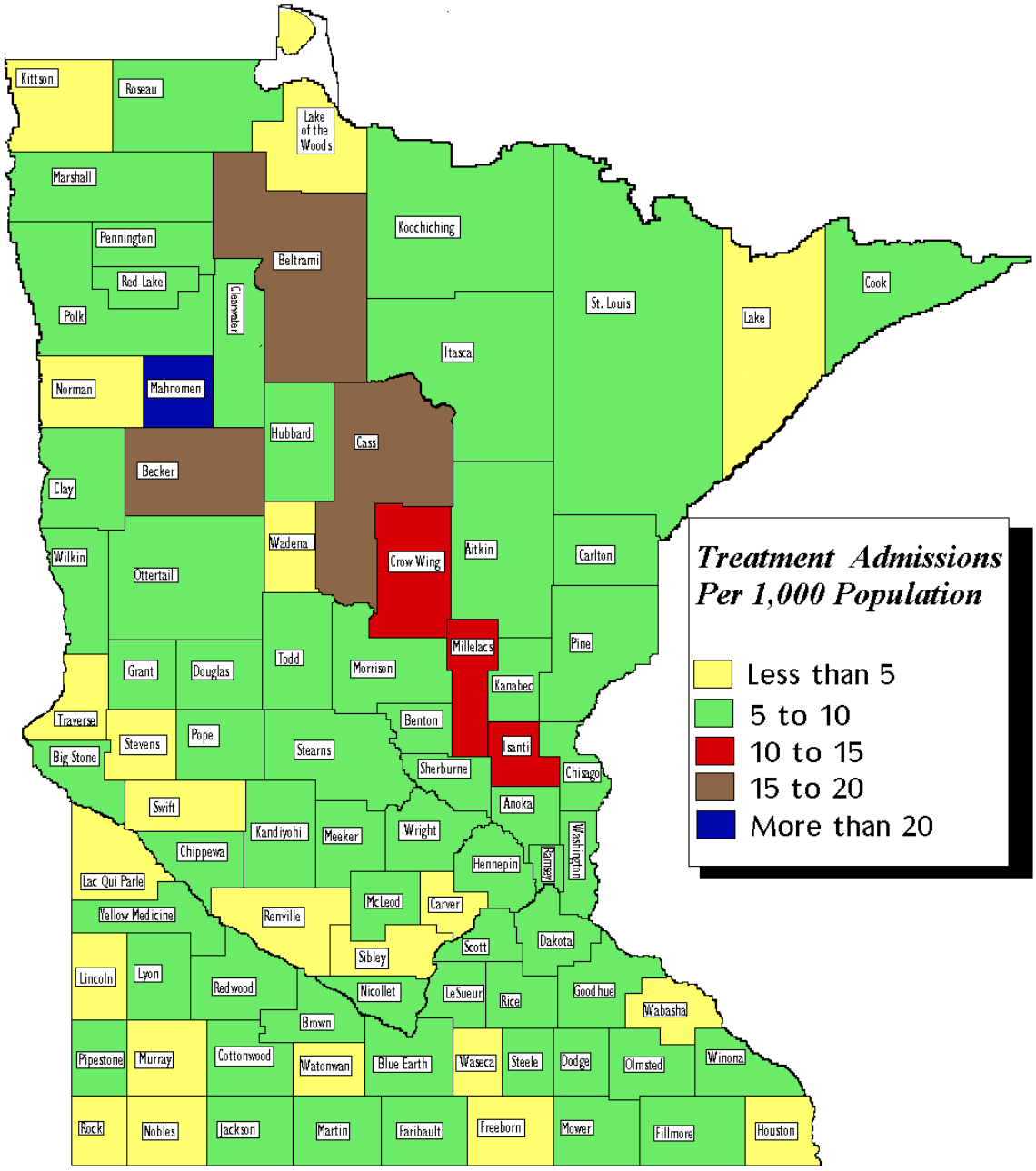


Figure 4: Treatment admissions per 1,000

- The racial and ethnic background of these admissions is 59% white, 20% African American, 12% American Indian, 2% Hispanic/Latino, 1% Asian, and 5% other.

- For all treatment admissions in Minnesota, 29% of the individuals were in treatment the first time; while 45% had only 1 or 2 prior treatments.
- When asked about their primary substance of abuse, 61% said alcohol, 19% said marijuana, 12% said cocaine, and 8% said other.

What is the cost of substance abuse?

The introduction to this report described the cost of substance abuse nationally as reported by the National Center on Addiction and Substance Abuse. For Minnesota, this report study determined that:

- Over $1.39 billion in 1998 spending was related to substance abuse.
- This represented 10.8% of the state's budget in that year.
- Of this spending, only 4 cents out of every dollar went to treatment, prevention, and regulation/compliance. The rest went towards substance abuse related costs to the justice system, education, health, child/family assistance, mental health and developmental disabilities, public safety, and state workforce health care cost.
- Over 80% of Minnesota's adult corrections spending and 66% of the juvenile justice spending was related to substance abuse.
- Other areas in which substance abuse related spending was high were health (23% of the state's budget in that area was related to substance abuse), child welfare (70%), mental health (50%), and public safety (22%).

Alcohol-related problems cost every person in the United States $633 per year, whether he or she drinks or not. (National Institute on Drug Abuse, 1998)

Funding the chemical health system

State and federal expenditures

Funding for the Chemical Health Division comes from two primary sources: state appropriations and the federal Substance Abuse Prevention and Treatment Block Grant.

State appropriation. In state fiscal year 2002, the Minnesota Legislature appropriated $41,200,000 for treatment through Tier I of the Consolidated Chemical Dependency Treatment Fund (CCDTF) and $2,515,000 for Tier II recipients. An additional $2,270,000 was appropriated for women's ancillary treatment supports, $1,055,000 for American Indian programs for prevention and treatment support, $225,000 for detox transportation grants, and $43,000 for juvenile assessment.

In addition, in calendar year 2002 $21.2 million in state and federal money was spent on the chemical dependency treatment component of capitations for the publicly-funded managed care programs: Prepaid Medical Assistance Program (PMAP), Prepaid General Assistance Medical

Care (PGAMC), and MinnesotaCare. This does not reflect the actual spending by health plans during this period.

Minnesota spent $83,197,000 in state fiscal year 2002 on treatment for low-income individuals through CCDTF.

Federal Substance Abuse Prevention and Treatment (SAPT) block grant. In state fiscal year 2002, the Chemical Health Division was awarded $21,137,596 through the federal Substance Abuse and Mental Health Services Administration (SAMHSA). Use of this money is governed by the annual spending plan, which is developed for submission to the SAMHSA as a component of the SAPT application. This block grant has a number of requirements, including the requirement that 20% of the grant be spent on prevention services. In state fiscal year 2002, the SAPT spending plan contained the following guidelines for expenditure of block grant money:

- Up to $ 5.1 million was to be spent on prevention activities. This represents representing 25% of the federal block grant total.
- Up to $13.9 million was be spent on treatment, including an anticipated $10 million designated for the CCDTF. This represents 66% of the federal block grant total.
- Up to $985,000 was to be spent on evaluation, including evaluation and coordination, health care research, and Synar research. This represents 5% of the federal block grant total.
- Up to $923,000 was to be spent on administration of substance abuse and chemical dependency programs and efforts, including staff, systems, and activities related to assuring statewide implementation of chemical dependency prevention and treatment efforts. This represents 4% of the federal block grant total.

County expenditures

Minnesota counties spent $51,078,000 on chemical health services in state fiscal year 2001 (see Figure 5).

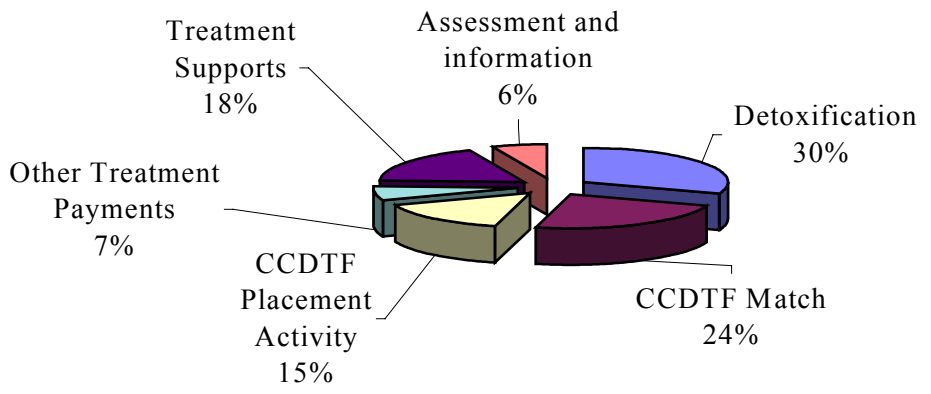
The largest cost area for counties is in provision of chemical dependency treatment services (46% of the total). Of this, CCDTF Rule 25 placement assessments and Rule 24 eligibility determinations were 15% of county chemical health expenditures, 24% was used to make county share payments for placements made in treatment programs, and an additional 7% paid for treatment services provided outside of the CCDTF.

The next largest payment area was detoxification (30% of the total).

Counties provide a number of other services in support of treatment, ranging from transportation to case management and aftercare services (18% the total).

Providing education and intervention information and referral is primarily a county activity, but doesn't cost very much (6% of the total).

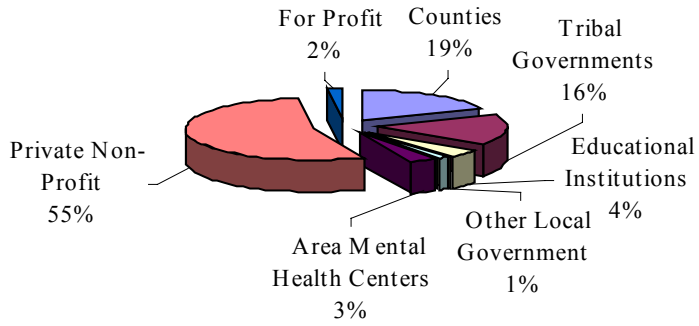
Figure 5: County Chemical Health Expenses
State Fiscal Year 2001



Collaborative nature of the chemical health system

Treatment and prevention of substance abuse involves a variety of organizations (see Figure 6).

Figure 6: Grant Funding Distribution
State Fiscal Year 2002



Prevention services are performed and arranged by prevention professionals in conjunction with schools, municipalities, public health professionals, law enforcement and civic organizations. Crisis services are offered in detoxification centers that could be a non profit organization, a hospital, a county or a regional treatment center. The funding comes from the Community Social Services Block Grant (CSSA) and from local property taxes.

The counties and tribes are responsible for determining whether an individual is in need of treatment (if the CCDTF will be used) and which treatment program will best serve the individual. Treatment is offered by a wide variety of private and public agencies.

Specific populations require additional coordination. For instance, treatment for adolescents relies heavily on families and schools. Services for women rely on child care, coordinate with employment services and child protection, work with communities to arrange safe and appropriate housing and someone (usually in a community non profit agency) to make it all come together for the good of the family. Serving individuals with criminal justice issues requires the concerted effort of community corrections agents, jail and prison staff, law enforcement, the tribe or county and a chemical dependency treatment provider.

TREATING SUBSTANCE ABUSE

What's treatment?

> "Treatment" means a process of assessment of a client's needs, development of planned interventions or services to address those needs, provision of the services, facilitation of services provided by other service providers, and reassessment.

National efforts have demonstrated that successful treatment programs and services must account for individual differences in race, ethnicity, socioeconomic status, education, religion, geographic location, age, sexual orientation, disability, and gender (Center for Substance Abuse Treatment, 2002). We also know that treatment should be timely, affordable, and of sufficient intensity and duration to be effective. The system of care must provide a comprehensive array of treatment alternatives and support practitioner and provider efforts to deliver quality care (Center for Substance Abuse Treatment, 2002). Finally, the treatment delivery system must promote the development and application of new knowledge and treatment approaches as well as innovations that improve efficiency and responsiveness care (Center for Substance Abuse Treatment, 2002).

Under DHS proposed chemical dependency treatment licensing standards, designed to replace the two existing rules, treatment programs are to provide:

- individual and group counseling to help the client identify and address problems related to chemical use and develop strategies to avoid inappropriate chemical use after termination of services;
- client education on strategies to avoid inappropriate chemical use and health problems related to chemical use and the necessary changes in life style to regain and maintain health;
- transition services to help the client integrate gains made during treatment into daily living and to reduce reliance on the treatment program's staff for support; and
- services to address issues related to co-occurring mental illness, including education for clients on basic symptoms of mental illness, the possibility of co-morbidity, and the need for continued medication compliance while working on recovery from chemical abuse or dependency.

Current treatment licensing

Under the current system separate rules are in place for residential and outpatient services. The existing treatment rules license on the basis of levels of care, which includes outpatient, inpatient, extended care, and halfway house treatment. The current model of treatment emphasizes short-term intensive treatment, which creates an expectation that a brief treatment episode should be sufficient to result in a "cure." When a client is discharged from a treatment program, they are considered to have completed treatment, even though they have significant challenges yet to be confronted. The housing which is included in treatment package is also terminated once the treatment program is complete and may leave the client homeless and at risk for relapse given the instability of their housing.

Programs located on American Indian reservations are licensed by their respective tribes.

Licensed treatment providers in Minnesota

- There are 223 **outpatient** programs in Minnesota, with an estimated capacity of 3,560.
- There are 28 **detoxification** facilities, with a combined capacity of 444. An additional 3 hospital based programs operate another 16 beds, for a total of 460.
- There are 44 **primary inpatient** programs, with a combined capacity of 1,257.
- There are 33 **extended care** programs, with a combined capacity of 621.
- There are 53 **halfway houses**, with a combined capacity of 1,045.

The new treatment services rule

An important component of the new treatment services rule is client assessment. In the new rule, assessment includes not only the client's past history but also the their current level of functioning, focusing on both their problems and strengths. It organizes assessment, planning, progress, and discharge information in six assessment dimensions to assure a comprehensive and individualized approach to treatment.

The new rule has no distinctions between levels of care and does not require a specific array of services with minimum or maximum amounts of services. It is designed to allow maximum flexibility and innovation on the part of treatment providers. The amount and type of services are based entirely on client need, so that the intensity of treatment should change as clients resolve problems or gain new skills. The new regulations will only govern the treatment services portion of programs. If room and board is provided, these functions will continue to be licensed by the Department of Health. This change reduces duplication of regulation and inspection. Historically, both Human Services and Health have regulated the residential aspect of the program.

Research on treatment outcomes states that there is a high percentage of clients in chemical dependency treatment with mental health problems and that they are repeat users of treatment services. Based on this information and the concern that these clients needs are not being met in our current system of treatment, standards were incorporated in the treatment services rule to address these concerns. These standards begin to give equal consideration to both disorders by

providers of chemical dependency treatment. The basic standards require a written policy and procedures for screening for mental health concerns and treatment objectives that directly address those issues. There are requirements for staff training and qualifications related to screening, assessment, treatment planning, and continuing education to support and enhance those competencies. The standards also require consultation with mental health providers and appropriate referrals to mental health providers when a chemical dependency treatment provider is unable to address the client needs.

Treatment support

Outcome studies indicate that there are a variety of issues outside of the treatment setting that effect treatment completion. The Chemical Health Division supports programs that improve accessibility and treatment services for pregnant women and women with dependent children by establishing capability of programs simultaneously to treat dependent women and to provide day care and therapeutic services to their children. Other grants provide ancillary services such as primary medical care for women, including prenatal care, primary pediatric care, gender specific treatment and therapeutic interventions for children, case management, transportation, and child care. Other treatment support areas assist individuals leaving the criminal justice system and individuals with chronic chemical dependency. In state fiscal year, these programs provided the following services:

- 2,050 pregnant women and women with dependent children received treatment support/recovery maintenance or case management services.
- 3,397 individuals received chemical dependency recovery maintenance services after their treatment.

Outcomes of treatment

> Compared with treatment for other common chronic diseases such as diabetes, hypertension, and asthma, chemical dependency treatment yields strikingly similar compliance and relapse rates. (Marwick, 1998)

Scientific evidence accumulated over the past 30 years substantiates the benefits of treatment for the individual patient, family members, and society. 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. In addition, improvements in patients' health and in their ability to function productively in the family, the workplace, and the broader community translate into significant cost benefits for society. Conservative estimates note that for every $1 invested in addiction treatment, there is a return of between $4 and $7 in reduced drug-related crime, criminal justice costs, and theft. When savings related to health care are included, total savings can exceed costs by a ratio of 12 to 1 (National Institute on Drug Abuse, 1998).

Results from a study of Minnesota's treatment outcomes monitoring system (Harrison and Asche, 2000), for data from 1993 to 1999, reveals some important findings about chemical dependency treatment.

Life area improvements

The treatment outcomes monitoring study showed that, across treatment settings, individuals who are admitted to treatment show improvement in major life areas, including:

- Alcohol and drug use
- Medical problems
- Psychological problems
- Family problems
- Unemployment/school problems
- Arrests/antisocial behavior
- Financial problems for adults

Treatment completion

In terms of treatment completion, which is one of the best predictors of successful outcomes, about 65% of individuals admitted to treatment in Minnesota completed treatment. When you include transfers and other discharges, this number rises to 76%. Completion was highest for outpatient programs, followed by inpatient, extended care, and halfway house.

There were individual differences in completion rates. Individuals with more severe life problems pre-treatment have lower completion rates, especially in halfway houses. People who are more likely to complete treatment are those with:

- Full-time employment
- Higher income
- Higher education
- DWI arrest or license revocation

People who are more likely to **not** complete treatment are those with any of the following characteristics:

- More arrests or convictions
- Younger
- Members of racial/ethnic minorities
- Mental health problems (as measured by taking psychotropic medications)
- Lower education
- Social isolation

It is likely that most treatment programs are not designed to meet the needs of individuals with the characteristics listed immediately above. These characteristics require "generic" programs to adjust to meet the clients' needs, which can be difficult due to program philosophy, staffing, and funding.

Post-treatment abstinence

- Abstinence rates six months post-treatment vary by age, from 21% for adolescents to greater than 65% for individuals older than 26.
- Treatment completers are more likely to be abstinent six months after treatment, but even non-completers show significant abstinence.

- Many of the factors associated with treatment completion are also associated with post-treatment abstinence. Individuals with more life area problems pre-treatment are less likely to be abstinent post-treatment.

Opportunities for improvement

The results of this outcome study also outlined some challenges faced by the chemical dependency treatment system. Despite the success rates demonstrated for chemical dependency treatment, in 1999 just over 40% of the clients in chemical dependency treatment had been in treatment three or more times (including the current admission,). This shows that a segment of the treatment population is not getting what they need to maintain recovery.

Previous Treatment Admissions for Minnesota's Treatment Clients

Calendar Year 2001		Calendar Year 2002	
None	27.7 %	None	28.3 %
One	25.3 %	One	25.3 %
Two	15.4 %	Two	16.1 %
Three or more	24.0 %	Three or more	24.2 %

Each year totals less than 100% due to incomplete data

The length of stay in inpatient programs is a prime example of how the type and extent of treatment is often determined by factors other than individual client need. The most frequently occurring length of stay for inpatient completers was 28 days (1,300 placements), the second was 21 days (1,200 placements) and third was 27 days (800 placements) with smaller spikes at 14 and 30 days. Since there is no empirical evidence to suggest that those lengths of stay are particularly effective, this data seems to indicate that length of treatment stay is primarily determined by funding patterns or the way providers have constructed their programs, not by client need.

Another example is in services associated with treatment, many of which may make the difference between treatment completion and failure. For example, only 59% of female inpatients who said that they were extremely bothered by psychological problems within the previous 30 days saw a mental health professional. Male clients and outpatient clients who were extremely bothered by mental health problems were even less likely to get a mental health service. At the same time, the 46% of the clients who were <u>not</u> bothered by psychological problems also saw a mental health professional.

The pattern repeats for medical services, family/relationship counseling, financial, legal, and employment services. Clients who are extremely bothered by problems in a specific life area are more likely to get specific services in that area than those who are not bothered or only somewhat bothered, but in some categories as low as 25% of the extremely bothered clients get the associated service. Meanwhile, from 8% to 64% of people who say that they are not bothered at all get the

associated services anyway. Taken all together, these findings indicate that treatment providers and service funders are not targeting these ancillary services based on client needs.

Our primary surrogates for treatment success, treatment completion and post-treatment abstinence, show variability across individuals and settings. Results across treatment settings show great variation in both measures:

Level of care	Completion rate	Negative discharge	Abstinence rate at six months
Outpatient	68%	25%	64%
Inpatient	65%	17%	60%
Extended Care	58%	33%	42%
Halfway House	45%	50%	47%

Abstinence rates across individuals also show great variability. When we compare post-treatment abstinence rates as a function of the number of severe life area problems people had at the beginning of treatment, we get the following results

Level of care	0 severe problems	4 or 5 severe problems
Outpatient	78%	41%
Inpatient	73%	58%

If we look at the inter-relationship between treatment completion, abstinence, and life area problems, we find that for treatment completers:

- Abstinence rates were about the same between inpatient and outpatient if the client had zero to two severe life area problems, in fact the outpatient abstinence rates were a little better.
- At three severe life area problems, inpatient rates are a little better and at four or five severe life area problems, inpatient abstinence rates are significantly better.
- Those who do better in inpatient treatment are people who have severe problems in four or five life areas OR report suicidal ideation or attempts in the past 30 days.

These findings lead to some important conclusions about treatment authorization and delivery:

- 61% of inpatients would do just as well in outpatient treatment
- 16% of outpatients would do better in inpatient treatment
- 39% of the people now going to inpatient treatment and 16% of the people now going to outpatient treatment should be receiving inpatient treatment. The balance would do just as well in outpatient.

In summary, we would see a 36% reduction in inpatient and a 19% increase in outpatient treatment placements by authorizing services with closer attention to client assessment on the life areas. This should result in better client outcomes and better use of resources.

Population-specific services

When we examine the impact of population-specific treatment programs we find some interesting results. For example, women in specialized women's programs have more severe problems than

women in general population programs, but are as likely to complete. Also, for African Americans and American Indians, 71% are likely to be abstinent in culturally specific programs and 54% in general population programs.

Research on Minnesota's treatment system advocates the need for more services designed for people of color, adolescents, and women with special needs. American Indian and African American clients in some settings were more likely to complete treatment and remain abstinent after treatment if treated in a culturally specific program. Adolescents also had higher treatment completion rates and higher post-treatment abstinence rates if treated in programs restricted to young people compared with programs designed to serve clients of all ages and should be referred to these programs.

Recovery support

Participation in post-treatment activities (i.e., peer support groups and professionally led aftercare) is an important factor for treatment success.

- The abstinence rate for treatment completers is 52% if the individual didn't engage in post-treatment activities, 72% if they participated in either aftercare or peer support, and 82% if they participated in both.
- 32% of adult treatment completers were in aftercare for four to six months after discharge from treatment.
- 56% of adult treatment completers were in weekly peer support in the six months after discharge from treatment.
- Treatment completers who stayed in aftercare or peer support programs for four to six months after discharge from treatment were more likely to be abstinent than those who stayed in aftercare or peer support programs for one to three months (82% abstinent as compared to 72%). Both groups were more likely to be abstinent than those treatment completers who participated in neither activity (52% abstinent).
- Nationally, family members and friends of individuals with addiction problems who attend 12-step support programs report strong improvements in their mental health/well-being, ability to function each day at home/work/school, and overall health status (Al-Anon Family Group, Inc., 2000).

Recognizing recovery support as part of the treatment process, rather than an add-on, is a cost-effective way to improve treatment outcomes.

How is treatment provided in Minnesota?

> 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. Further, it is declared that treatment under these services shall be voluntary when possible: treatment shall not be denied on the basis of prior treatment; treatment shall be based on an individual treatment plan for each person undergoing treatment; treatment shall include a continuum of services available for a person leaving a program of treatment; treatment shall include all family members at the earliest possible phase of the treatment process. (Minnesota Statutes, section 254A.01)

How is treatment accessed?

Minnesota residents access chemical health treatment services a variety of ways. Counties, tribal agencies, and state contracted managed care entities provide mandated assessment services resulting in half of all treatment placements in the state. The remaining placements are made through private insurance, Health Maintenance Organizations (HMOs), as well as client self-admits. In all cases, the funding source controls the access, placement, and duration of service.

Individuals seeking assistance in determining their need for treatment usually access services through their local social service agency. The Community Social Service Act (CSSA) and Minnesota State Rules require county social service agencies to be responsible for the provision of chemical use assessments to every county resident who requests one, or for whom one is requested. Chemical use assessments, often referred to as Rule 25 assessments, use a uniform statewide assessment and placement criteria to determine the level of chemical involvement in an individual's life, if treatment is appropriate, and if so, what type of treatment is appropriate (length, intensity, etc.).

CCDTF. County social service agencies also determine whether the resident is financially eligible to have his/her treatment paid for using the CCDTF. If the individual needs treatment, and is financially eligible for the CCDTF, then the county social service agency refers the individual to an appropriate program and authorizes treatment for a specific period of time.

Through agreements between the Department of Human Services and each tribal government, local tribal entities are responsible for fulfilling the same functions (the provision of chemical use assessments and treatment referrals) as county social service agencies for their tribal members who reside on reservation property.

Publicly funded health plans. For individuals who have health care coverage through the PMAP, PGAMC, or MinnesotaCare, the point of access is the health plan, or HMO, which provides their coverage. Chemical use assessments and inpatient and outpatient chemical dependency treatment are included in the benefit package contract between the State of Minnesota and the HMOs. Therefore, HMOs arrange for chemical use assessments for their enrollees and, if treatment is needed, make referrals to the appropriate placement, if it's an inpatient or outpatient setting. If

the appropriate placement is an extended care or halfway house setting, the HMO will refer the enrollee to their local social service agency to determine if s/he is financially eligible for the CCDTF, and if so, for placement in a extended care or a halfway house.

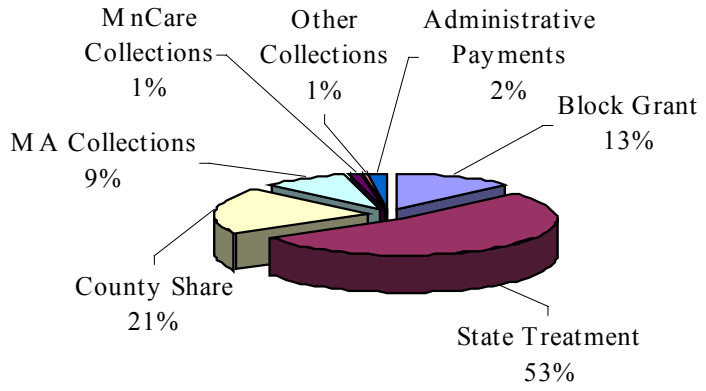
Other health insurance. Most individuals in the state would access chemical dependency treatment, if needed, through either their health insurance (health plan or other types of insurance) or through private pay. Regulation of health plans occurs through the Minnesota Department of Health and regulation of insurance occurs through the Minnesota Department of Commerce.

How is treatment funded?

CCDTF. The CCDTF was created in 1988 to fund cost effective chemical dependency treatment services for Minnesotans who meet clinical and financial eligibility criteria. The CCDTF combines previously independent funding sources, such as Medical Assistance (MA), General Assistance Medical Care (GAMC), General Assistance (GA), state appropriations, county match dollars, and federal block grant dollars into a single fund with a common set of eligibility criteria (see Figure 7 for a funding breakdown).

The CCDTF pays the provider of service and in turn is replenished with collections from first and third party payment sources such as MA and private insurance. The financially responsible county pays at least 15% of each placement.

Figure 7: CCDTF Funding Sources, SFY 2002



The CCDTF has two tiers of eligibility. Tier I is the entitlement portion, eligible individuals are persons who are enrolled in MA, GAMC, receive Minnesota Supplement Aid (MSA), or meet the MA, GAMC or MSA income limits. Tier II includes those individuals not eligible for MA whose income does not exceed 215% of the federal poverty guidelines.

In fiscal year 2002, 25,311 treatment admissions were authorized at an average cost of $3,287 per admission. Total expenditures for chemical health services were $83.2 million, of which $42.5 million were state funds. All but 5% of the licensed treatment providers in the state accept CCDTF

clients. Appendix A shows the distribution of CCDTF placements and funding by county and tribe for calendar years 2001 and 2002.

Publicly funded health plans. As described above, many lower-income Minnesotans receive their health care through PMAP, PGAMC, or MinnesotaCare. In these program, individuals receive their health care through a managed care plan. These plans are under contract with the State of Minnesota and receive a monthly capitation payment to provide health care services to enrollees. Covered services include chemical use assessment, referral, primary inpatient, and outpatient services.

Other health insurance. Since the DAANES system collects information on all treatment admissions to licensed providers, we have information on the client histories and discharge status of individuals who access treatment through these avenues, but we don't have a lot of information on expenditures for treatment for these individuals.

Grant funded. The Chemical Health Division also distributes state and federal grant funds for activities that support treatment. For example, there are grant funds used to improve accessibility and treatment services for pregnant women and women with dependent children by establishing capability of programs simultaneously to treat chemically dependent women and to provide day care and therapeutic services to their children. Other grants provide ancillary services such as primary medical care for women, including prenatal care, primary pediatric care, gender specific treatment and therapeutic interventions for children, case management, transportation, and child care. Other treatment support areas assist individuals leaving the criminal justice system and individuals with chronic chemical dependency.

PREVENTING SUBSTANCE ABUSE

What is prevention?

> Prevention is a proactive process that empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors and lifestyles (from the Center on Substance Abuse Prevention)

Substance abuse is one of the Nation's most pervasive, costly, and challenging health and social problems. The use of tobacco, alcohol, marijuana, and illicit drugs, particularly during the early years of life, is intricately entwined with the most serious personal and social problems, including school failure, crime, family violence, sexual abuse and a host of additional problems that constitute a continuing national tragedy.

In response to this problem, the Substance Abuse and Mental Health Services Administration (SAMHSA) created the Center for Substance Abuse Prevention (CSAP), which is responsible for identifying and disseminating scientifically defensible models and principles to the substance abuse

prevention field. Over the past 10 years CSAP demonstration programs have laid the foundation for a new empirically based approach to prevention programming.

CSAP has made great progress in generating new knowledge about the design, implementation and effectiveness of prevention strategies and activities. Recent studies (CSAP, January 2002) show that:

- Youth already using cigarettes, alcohol, and marijuana significantly reduced their use of substances after joining a prevention program. Substance use by program participants was 10% lower at exit than comparison youth, and use levels were 22% below comparison youth 18 months later.

- Family, peers, school, community and society can protect against substance abuse. In programs where high-risk youth were connected to positive social environments such as school, family, peers, and community, used substances less than those who lacked such connections. For youth at risk, positive connections within these five overlapping domains plays a critical role in effectively preventing substance use and abuse.

- Communities with more opportunities for participation in prevention positively impact substance use by youth. Communities that gave young people opportunities to take part in prevention activities had greater positive impact on substance abuse among these youth than communities with fewer prevention opportunities.

Characteristics of successful prevention programs

Science-based programs produce consistent and lasting reductions in substance use. Six program characteristics were scientifically verified as significantly strengthening program impacts. They are as follows:

1. **Life Skills Focus:** Programs that emphasized the promotion of attitudinal and behavioral life skills were more effective in reducing substance use than programs that only emphasized knowledge-only or affective objectives such as self-esteem.

2. **Emphasis on Building Connectedness:** Prevention programs that emphasized the use of program delivery methods designed to strengthen connectedness to positive peers and adults through team and interpersonal activities were more effective than programs that emphasized other delivery methods.

3. **Coherent Program Design & Implementation:** Prevention programs that selected strategies, implemented activities, and trained staff within a clearly articulated and coherent prevention theory were more effective than those that were designed with less clarity and consistency.

4. **Introspective Orientation:** Prevention programs that emphasized introspective learning approaches were more effective than programs that did not utilize this perspective. These learning methods encourage youth to examine their own attitudes and behaviors and determine how they impact others in social contexts that are relevant to them.

5. **Intensive Contact:** Programs with more intense contact (i.e., approximately 4 or more hours per week) achieved more positive outcomes than those with less intense contact.

6. **After-School Setting:** CSAP-funded prevention programs that offered after-school hours—when youth are most at risk for substance use—were more effective in reducing substance use for high-risk youth than those delivered exclusively within school hours.

Programs characterized by five or more of these science-based practices consistently produced stronger and longer lasting positive effects than other programs.

Theoretical frameworks in the substance use prevention field have been evolving over time. Among the most important developments in substance abuse prevention theory and programming in recent years has been a focus on risk/protective factors as a unifying descriptive and predictive framework. Research now confirms that interventions aimed at reducing the risk factors and increasing the protective factors linked to substance abuse and related problem behavior can produce immediate and long-term positive results (CSAP, 2001)

Risk factors

The more risk factors a child or youth experiences, the more likely it is that s/he will experience substance use and related problems in adolescence or youth adulthood. (Bry & Krinsley, 1990; Newcomb & Felix-Ortiz, 1992). Risk factors include characteristics such as family history of substance use, depression or antisocial personality disorder, or residence in neighborhoods where substance use is tolerated. Researchers have also found that the more the risks in a child's life are reduced, (e.g., by treating mental health disorders, improving parents' family-management skills, or stepping up enforcement of laws related to the sales of illicit drugs to minors or to drinking and driving), the less vulnerable the child will be to subsequent health and social problems (Hawkins, Catalano, & Miller, 1992).

Protective factors

Protective factors (such as solid family bonds and success in school) help safeguard youth from substance use. Research has also demonstrated that exposure to a substantial number of risk factors in a child's life does not necessarily mean that substance use or other problem behaviors will inevitably follow. Many children and youth growing up in presumably high-risk families and environments emerge relatively problem-free. The reason for this, according to many researchers, is the presence of protective factors that reduce the likelihood that a substance use disorder will develop (Hawkins et al., 1992; Mrazek & Haggerty, 1994).

The research on protective factors explores the positive characteristics and circumstances in a person's life and seeks opportunities to strengthen and sustain them as a preventive device. Among these resilient children, protective factors appear to balance and buffer the negative impact of existing risk factors (Anthony & Cohler, 1987; Hawkins et al., 1992; Mrazek & Haggerty, 1994; Wolin & Wolin, 1995). From a substance abuse prevention perspective, protective factors function as mediating variable that can be targeted to prevent, postpone, or reduce the impact of use.

Taken together, the concepts of risk and protective factors enhance understanding of how and why youth initiate or refrain from substance use. Although not all risk and protective factors are

amenable to change (e.g., genetic susceptibility to substance use), research shows that positive influence can be exerted.

Prevention outcomes – nationally

> "We are seeing encouraging signs that national prevention efforts are working. Youth drug use is now at its lowest level in years."
> — John P. Walters, Director of National Drug Control Policy (ONDCP)

For every dollar spent on drug abuse prevention, communities can save four to five dollars in costs for drug abuse treatment and counseling (National Institute on Drug Abuse, 1997).

A 2002 National Research Council report, "Community Programs to Promote Youth Development," found "consistent and compelling evidence" that youth prevention programs are effective in addressing such risks as substance abuse, adolescent pregnancy, school failure, and involvement in the juvenile justice system. (CSAP, 2002)

Brief family intervention programs designed to discourage teen drinking are both beneficial and cost effective. The Iowa "Strengthening Families Program" intervention saved $9.60 in future costs for each dollar invested (Spoth, Guyll, & Day, 2002), and the "Preparing for the Drug-Free Years" program yielded a benefit-cost ratio of $5.85 for each dollar invested (National Institute on Drug Abuse, 2002).

The 2002 Monitoring the Future study (Johnston, L.D., O'Malley, P.M., & Bachman, J.G., 2003) tracks how many teenagers have used illicit drugs in the past year or ever in their lifetime. This study has been tracking high school seniors for 28 years and following 8th and 10th graders for the past 12 years, and included nearly 44,000 students from 400 schools across the county.

Findings from the study indicate that use of alcohol, tobacco, and most drugs decreased from 2001 to 2002. There were significant declines in alcohol consumption as well as decreases in the proportions of 8th and 10th graders saying they got drunk in their lifetimes. Significant declines of cigarette use occurred in all grades and among all subgroups. The proportion of students use of any illicit drug in the last year declined among all three grade levels, and significantly so among 8th and 10th graders. For the first time, ecstasy use was down among American teens. The only significant increases in drug use were crack use by 10th graders in the past year and use of sedatives by 12th graders in the past year.

Of note for prevention efforts, marked changes in teen attitudes and perceptions contributed to the drop in ecstasy use. The number of 12th graders who said there was a great risk of harm associated with trying ecstasy reached 52%—significantly higher than 38% in 2000 and 46% in 2001. Disapproval of ecstasy rose among students in all three grades.

Prevention in Minnesota

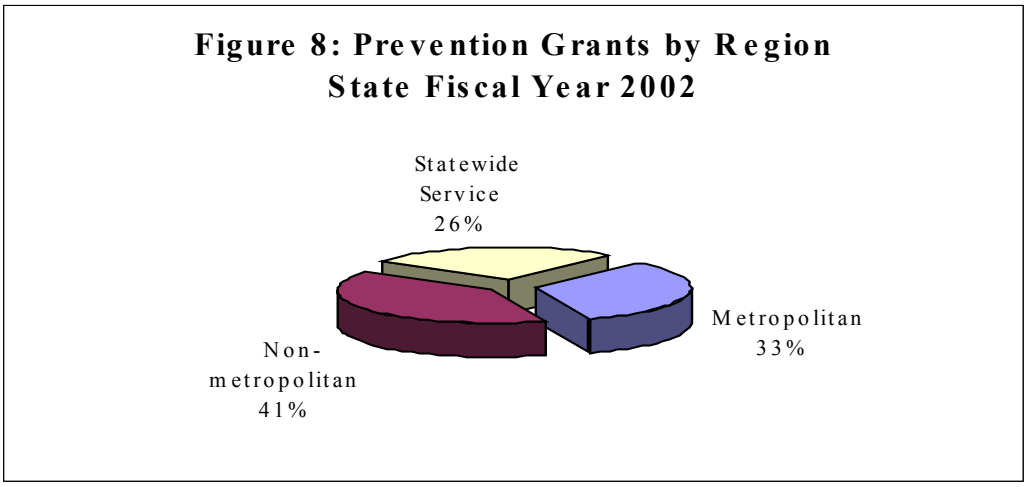
The State of Minnesota is committed to the prevention of substance abuse and the problems of addiction that result. There are a variety of state agencies that fund prevention programming in Minnesota, including the Department of Human Services, the Department of Public Safety, the Department of Children, Family and Learning, and the Department of Health. These agencies use a similar process for disseminating prevention funds. As of 2001, each state agency continued to manage its own RFP process, determine how needs are established, and what evaluation requirements and outcome measures should be use. In 2002, these agencies created the Minnesota ATOD Prevention Coordinating Council (MAPCC) to enhance collaboration and partnership in the area of prevention.

The Chemical Health Division has used CSAP's list of effective factors, prevention strategies and program practices to guide its efforts to fund effective, outcome-based prevention substance abuse programs. Prevention funds are disseminated through the issuance of Requests for Proposals (RFPs). Proposals received as the result of the RFPs go through a review process by experts recruited by the Chemical Health Division. Proposals selected for funding are forwarded to the State Alcohol and Other Drug Abuse Citizens Advisory Council, who review the funding recommendations then forward their recommendations to the Director of the Chemical Health Division for final approval. Grants are awarded to county and tribal governments, local units of government, and non-profit organizations.

Through two recent RFPs in 2001 and 2002, the Chemical Health Division has moved to soliciting proposals and funding alcohol, tobacco, and other drug (ATOD) prevention programs using either CSAP evidence-based Model Programs (which have been rigorously evaluated in multiple sites and have continuously shown positive results) or CSAP evidence-based ATOD prevention principles. Prevention is delivered at the local level based on work plans and models proposed by the applicants. Each funded program is based on the risk and protective factor framework. This focus on scientifically defensible interventions helps prevention practitioners maintain accountability and improve their capacity to provide effective services.

Prevention funding in Minnesota

In 2001, the state spent approximately $43 million on prevention programming. The Chemical Health Division's portion of this total amounted to approximately $6.7 million. Figure 8 illustrates how the Chemical Health Division's grants were distributed by region in Minnesota in 2002.



Prevention activities in Minnesota

Prevention strategies. CSAP categorizes prevention activities or strategies into six areas. Because the federal block grant application requires states to use these strategies, they are used as guidelines for projects funded by the Chemical Health Division. CSAP allows states to fund other prevention activities/strategies, provided they provide a description of the additional area.

Minnesota has added a new primary prevention strategy, Traditional/Cultural Activities. There is research that traditional/cultural activities are effective in reducing alcohol and drug use among minority population youth, such as African Americans, Hispanics/Latinos, Southeast Asians, and other immigrant groups. This research shows that adolescents with a strong cultural identification are less vulnerable to risk factors for drug use and able to benefit more from protective factors than adolescents without this identification. Initial support for this strategy came from a paper on "Cultural Practices in American Indian/Alaska Native Prevention Programs" by Ruth Sanchez-Way and Sandie Johnson.

The seven primary prevention strategies are as follows:

1. **Information dissemination** provides awareness and knowledge of the nature and extent of substance abuse and addiction and its effects on individuals, families, and communities. Types of services conducted and methods used for implementing this strategy include: *Clearinghouse/information resource centers, health fairs, health promotion, materials development, materials dissemination, media campaigns, speaking engagements, and telephone information. services.*

2. **Education** builds skills through structured learning processes. Services under this strategy aim to improve critical life and social skills, including decision making, refusal skills, critical analysis, and systematic judgment abilities. Types of services conducted and methods used for implementing this strategy include: *Children of substance abusers groups, classroom educational services, education services for youth groups, parenting/family management services, peer leader/helper programs, and small group sessions***.**

3. **Alternatives** provide for the participation of target populations in activities that exclude substance abuse. Types of services conducted and methods used for implementing this strategy include: *Alcohol-, tobacco-, and other drug-free social/recreational events, community drop-in centers, community drop-in center activities, community services, and youth/adult leadership functions.*

4. **Problem identification and referral** aims to classify those who have indulged in illegal or age-inappropriate use of tobacco or alcohol and those who have indulged in the first use of illicit drugs and to assess whether their behavior can be reversed through education. Types of services conducted and methods used for implementing this strategy include: *Employee assistance programs, student assistance programs, and Driving Under Influence, Driving while Intoxicated, and Minor In Possession programs.*

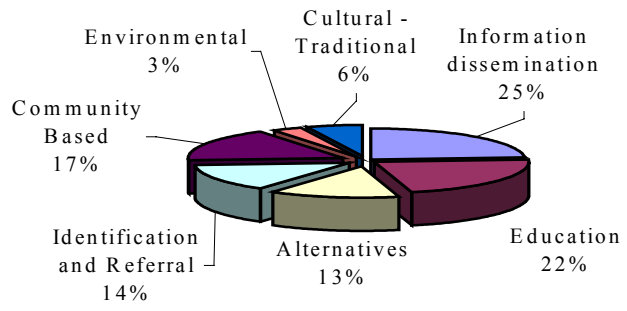
5. **Community and professional mobilization** strategies aim to enhance the ability of the community to more effectively provide substance abuse prevention and treatment. Services in this strategy include organizing, planning, and enhancing the efficiency and effectiveness of service implementation, interagency collaboration, coalition building, and networking. Types of services conducted and methods used for implementing this strategy include: *Accessing services and funding, assessing community needs, community/volunteer services, community teams, community team activities, training services, and technical assistance.*

6. **Social policy and environmental change** establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing the incidence and prevalence of the abuse of alcohol, tobacco, and other drugs by the general populations. Types of services conducted and methods used for implementing this strategy include: *Environmental consultation to communities: preventing underage sale of tobacco and tobacco products–Synar amendment; preventing underage alcoholic beverage sales; establishing ATOD-free policies; changing environmental codes, ordinances, regulations, and legislation; and public policy efforts*

7. **Traditional/Cultural** activities provide for the participation of target populations in activities that establishes or strengthens cultural identification. All of these activities assume the participation of elders and include the transmission of tribal history, values, and beliefs. Types of services conducted and methods used for implementing this strategy include*: healing ceremonies and practices such as sweat lodges and talking circles, making crafts and pow wow regalia, drumming and singing, cultural youth camps, learning the language, and story telling.*

The Chemical Health Division requires grantees to use a mixture of these strategies. Figure 9 illustrates the division of expenses across these strategies for state fiscal year 2002.

Figure 9: Prevention Expense State Fiscal Year 2002



Prevention Resource Centers. The science of ATOD use/abuse prevention has made great strides in recent years. With new knowledge about the design, implementation and effectiveness of various prevention strategies and programs comes the responsibility of prevention practitioners to implement this new knowledge through their activities. New information on specific drugs, use rates, use patterns and the roles we, as individuals, play in prevention is being developed by agencies of the government and higher education institutions at a rapid rate. In order to implement the best prevention strategies and programs, prevention providers need to have access to the best, new information. Recognizing this need, the Chemical Health Division supports ATOD use/abuse Prevention Resource Centers to achieve this objective The resource centers funded by the Chemical Health Division are:

- Minnesota Prevention Resource Center (general population);
- African American Family Services Resource Center (African American population);
- South East Asian Prevention and Intervention Network (Southeast Asian population);
- RS Eden Resource Center and Chicanos Latinos Unidos En Servicio Resource Center (Hispanic/Latino population); and
- MN Indian Women's Resource Center (American Indian population)

In addition to print and video information and resources, these Resource Centers provide training, technical assistance and statewide conferences to further ATOD prevention efforts.

Prevention in American Indian communities. Alcoholism and substance abuse are the most severe health and social problems facing American Indians today. The Chemical Health Division partners with tribes and urban Indian communities by entering into contract agreements to deliver prevention programming throughout the state.

Currently, the Chemical Health Division has 17 prevention grants with tribal and urban Indian communities that provide prevention services using several methods that will foster skills necessary to avoid the use of ATOD and other "at-risk behaviors." The most successful approaches build on

tribal values and traditions. Services provided include access to medicine men and women, healing ceremonies and practices such as vision quests, sweat lodges, talking circles, making crafts and pow wow regalia, drumming and singing. Other activities include cultural youth camps, walks for "wellbriety," learning the language, and story telling and listening. These strategies develop inner strength and a strong sense of identity, which reduces vulnerability to risk factors for drug and alcohol use and abuse.

Synar. As a federal response to the use of tobacco products by youth, Congress in 1992 enacted the Synar Amendment as a provision of the Alcohol and Mental Health Administration Reorganization Act, Title 45, Part 96.130. of the Code of Federal Regulations and 42 U.S.C. 300x-26. The Synar Amendment required states to:

1) Adopt laws prohibiting the sale and distribution of tobacco products to minors under the age of 18, which Minnesota has done;
2) Conduct annual random unannounced inspections of tobacco retailers to measure the degree of compliance with its state laws;
3) Conduct an annual assessment of law enforcement agencies' enforcement of the state laws, and
4) Meet an agreed upon compliance rate agreed to with the federal Department of Health and Human Services (DHHS).

States are required to reach the goal of 80% tobacco retailer compliance over the course of several years. The state's SAPT Block Grant can be reduced substantially (by 40% of the State=s award) for failure to meet the state's targeted compliance rate.

In 2002, Minnesota had a tobacco retailer compliance rate of 85%, substantially exceeding the federal requirement of 80%.

Enforcement agency survey. Law enforcement surveys were conducted between July and August, 2002. All 87 Minnesota counties were included in the survey, covering enforcement activities involving non-incorporated area vendors and vendors in cities of less than 2,000 population. To capture municipal enforcement activity, 103 cities with a population over 2,000 located within the geo-political units (GPUs) of the Minnesota Adolescent Community Cohort study (MACC) were sampled. The largest 5 cities in Minnesota are included in the sample (Minneapolis, St. Paul, Rochester, Duluth, St. Cloud). Minnesota was divided into 129 GPUs and 60 of them were selected based on a stratified random sampling design. The stratifying variables included geographic region and race/ethnicity. GPUs are distinct and defined as a single county, multiple-county, school district, city, or combination of planning districts or neighborhoods. Enforcement activities were constructed for a given GPU based on the teen (ages 12-16) population proportion in a city or county. A statewide estimate was derived from a weighted total of GPUs. The overall state estimates on citations and penalties were derived from the police enforcement agencies whose jurisdiction covers the sampling units (GPUs) in the MACC study.

Results of the Minnesota Department of Human Services Statewide Tobacco Enforcement Survey demonstrates that law enforcement agencies in the state are actively enforcing state laws prohibiting the sale of tobacco products to minors. The table below illustrates the type of activity and results for

the federal fiscal year 2002 assessment.

Type of activity	Counties	City Sample	State-wide Estimates
Communities where vending machine inspections were completed	442	40	
Vending Machine Citations	90	5	117
Communities where compliance checks were completed	785	90	
Clerk Citations	489	324	980
Clerk Fines	426	425	978
Business Citations	386	392	887
Business Fines	477	465	1043
Business Suspensions	13	29	54
Minor Warnings	252	1077	2547
Minor Citations	1077	4022	7600
Minor Fines	591	2395	4583

Prevention outcomes in Minnesota

As a result of grants awarded for state fiscal year 2002:

- Six substance abuse prevention resource centers responded to over 500,000 requests for assistance.
- 17,291 youth participated in prevention activities offered by 25 programs in the Twin Cities Metro Area.
- 7,125 youth participated in prevention activities offered by 16 programs throughout Greater Minnesota.
- 2,429 health and social service professionals participated in substance abuse prevention training and continuing education.

Based on analysis of the 2001 Minnesota Student Survey (Minnesota Department of Children, Families & Learning and Minnesota Department of Human Services, 2001) data for over 133,000 middle and high school students, the incidence of alcohol, tobacco and other drug use among youth in the State of Minnesota has decreased. From 1998 to 2001:

- More students identified themselves as nondrinkers. In 2001, 53% of 9th graders reported that they did not drink alcohol compared with 46% in 1998.
- The number of 12th graders who reported drinking and driving decreased 8%.
- The average frequency of cigarette smoking decreased among students in all grades surveyed. Among 9th graders, the average rate dropped 39%.
- Fewer students reported using marijuana. For example, 80% of 9th graders reported no use of the drug, up from 76% in the 1998 survey. Previous student surveys showed use of marijuana on the increase among this grade level since 1992.

Outcome measurement: Minnesota is a federal pilot state for the Minimum Data Set Version 3 (MDS-3), which is a web-based data collection and report system that enables providers, substate entities, and state agencies to uniformly collect and analyze prevention services data.

Minnesota is one of a handful of states piloting the use of this system. Chemical Health Division funded prevention programs began using the MDS-3 July 1, 2002. The MDS-3 collects information on:

- 33 service populations (i.e., youth, parents, prevention professionals) that define those individuals, organizations, and entities to whom prevention services are most often directed;
- Age, gender, and race/ethnicity of all populations receiving prevention services;
- Primary prevention strategy;
- 80 individual program activities conducted under each of the seven primary prevention strategies as supported by the SAPT Block grant;
- Number of sessions provided in recurring prevention programs;
- Number who complete a prevention program;
- Location of the prevention activity; and
- The unduplicated number of prevention services delivered.

Information from the MDS-3 system will be used in:

- Managing and accounting for SAPT Block Grant prevention activities
- Program planning and resource allocation
- Comparing people serviced with risk populations identified in needs assessments
- Comparing types of services provided with different populations/communities
- Determining how well services are distributed across the seven primary prevention strategies
- Assessing the intensity and duration of prevention services
- Determining number and types of prevention strategies utilized by substate region, by provider
- Determining the number and types of activities provided by strategy, by substate region, by provider
- Analyzing number and geographic locations of primary prevention services

While the MDS-3 collects only process level data, bringing the MDS-3 system to Minnesota laid the foundation for Minnesota to become a pilot site for the Outcome Database Builder, a web-based outcome collection and analysis system being developed for SAMHSA/CSAP. The Chemical Health Division is on schedule to begin using the Outcome Database system later this year.

FUTURE DIRECTIONS: TREATMENT

Future directions in chemical dependency treatment will focus on improving the entire delivery structure to increase flexibility and individualization and to more carefully match resources to needs.

The Chemical Health Division's efforts to improve the outcomes of chemical dependency treatment center on the findings of the Treatment Outcomes Study. Chemical dependency, a continuing chronic condition, is currently treated as an acute illness. The treatment delivery system is being reconfigured to take into account this chronicity. Additionally, the system needs to change to better identify and address each individual's impediments to recovery.

To accomplish these changes, new licensing regulations will be adopted removing distinctions between levels of care to encourage a continuous, rather than segmented, approach to treatment provision. Implementation of these regulations will require many changes on the part of some treatment providers. The Chemical Health Division will offer training to assist them in adjusting to a more client-centered way of approaching their work and in meeting the specifics of the new regulations.

Many chemical dependency clients have symptoms of mental health problems. These symptoms can be barriers to recovery. A major thrust of the new treatment rules is the expectation that all chemical dependency treatment providers will have a minimum level of mental health expertise. While chemical dependency professionals are not and should not be mental health experts, they should recognize symptoms of mental health problems, know when to make referrals, and how to adjust treatment plans to accommodate common, stable mental health issues. This is an area where the Chemical Health Division expects to focus training resources.

To garner the greatest impact of the new licensing regulations, the Chemical Health Division must address how treatment placement decisions get made. Current placement criteria are based on the segmented, acute illness approach. The Chemical Health Divsion will be developing placement criteria that allow greater flexibility and individualization in placement decisions and mesh with the new treatment rules to form a more cohesive delivery system.

Through grants to counties, tribes and nonprofits, the Chemical Health Division has provided service coordination to chemically dependent individuals with special needs. Service coordination finds and orchestrates resources to address individual needs that cannot be addressed in the treatment program. By resolving these additional problems, some individuals have as good a chance at recovery as individuals without these additional challenges. For other individuals, whose chemical dependency is late-stage and chronic, service coordination reduces their use of expensive resources such as emergency rooms, detox centers and repeat treatment placements while improving their health stability and quality of life. The Chemical Health Division is looking for ways to provide this service coordination to those who can benefit all across the state rather than in special projects.

FUTURE DIRECTIONS: PREVENTION

The Chemical Health Division's efforts to improve the outcomes of prevention programming center on making proven effective prevention opportunities available statewide. The federal Center for Substance Abuse Prevention has invested in testing the effectiveness of various prevention strategies, and the Chemical Health Division is capitalizing on that knowledge.

The first element in this effort is to complete a state prevention plan to make clear the responsibilities of each state agency and to assure that the available resources are used to complement and enhance each other. Building on the state plan, the Chemical Health Division will be in a better position to focus its efforts. The state plan will also allow a more even distribution of resources across Minnesota.

The next element is the continued promotion of evidence based strategies through implementation of the state prevention plan, prevention conferences and workshops, technical assistance, and increasing the Chemical Health Division's expectations of its grant recipients.

Another element is holding grant recipients to higher standards of accountability. In the next two years, grant recipients will be evaluated for compliance with the expectations in their grant agreements and the state prevention plan. Already, the Chemical Health Division collects standardized information on all prevention activity provided through the grants. An important factor in this heightened accountability will be the implementation of the Outcomes Database Builder, a CSAP initiated information system which builds on the system already in place.

In the area of tobacco prevention the Chemical Health Division also has responsibility for compliance with the Synar requirements to prevent sale of tobacco products to underage youth. Our efforts to reduce sales and to monitor compliance have been very successful. The Chemical Health Division will continue its efforts to improve and streamline the monitoring process while using it to increase compliance with the laws that prohibit sales to underage youth.

And last, but not least, the practice of prevention is the practice of coalition building. In communities, effective prevention requires that the same positive messages come from all possible sources. What a child hears in school must be reinforced at home, in extracurricular activities, at church, from law enforcement, from the parents of his or her friends, from health care providers. That kind of cooperation is what the Chemical Health Division expects of its grant recipients working in local communities. That same kind of cooperation is necessary at the state level, between departments and state agencies, with the tribes, and with counties and local governments. The Chemical Health Division has an ongoing responsibility to improve these relationships.

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APPENDIX A

CCDTF Placements and Paid Claims for Calendar Years 2001 and 2002

County	Calendar Year 2001						Calendar Year 2002					
	Placements			Paid Claims ($)			Placements			Paid Claims ($)		
	Tier I	Tier II		Tier I	Tier II		Tier I	Tier II		Tier I	Tier II	
		Single Adults	Other		Single Adults	Other		Single Adults	Other		Single Adults	Other
AITKIN	54	2	4	148,727	853	10,887	76	1	0	408,312	5,451	3,184
ANOKA	625	87	47	2,346,557	222,038	174,642	694	86	53	2,657,231	208,131	229,101
BECKER	174	65	55	742,834	179,687	135,848	202	35	32	819,486	97,061	120,570
BELTRAMI	195	35	19	516,986	42,363	44,631	281	36	21	840,956	80,247	44,506
BENTON	124	12	7	389,806	26,191	11,445	129	12	4	495,595	23,435	24,222
BIG STONE	15	11	0	67,140	48,048	0	15	1	1	89,387	2,577	2,005
BLUE EARTH	247	61	15	848,256	90,695	32,382	217	48	6	924,923	119,280	21,639
BROWN	36	15	11	158,470	38,978	33,002	67	14	3	299,551	54,592	34,342
CARLTON	67	18	9	198,742	42,966	21,646	66	14	12	303,017	55,077	48,067
CARVER	119	9	24	567,104	32,962	66,226	166	13	9	673,978	44,124	55,926
CASS	67	28	36	200,844	56,049	88,860	95	20	11	381,947	109,953	74,753
CHIPPEWA	25	11	9	144,107	42,306	17,016	35	4	8	242,901	60,859	65,597
CHISAGO	95	0	11	467,167	0	55,023	149	1	2	681,218	2,296	15,934
CLAY	397	13	12	1,311,829	27,854	26,082	389	17	8	1,542,256	45,561	24,723
CLEARWATER	31	2	7	99,390	8,745	10,411	31	2	5	154,858	3,588	19,876
COOK	6	6	8	17,814	11,602	11,051	8	4	0	37,262	9,859	824
COTTONWOOD	45	9	9	176,471	6,401	25,796	58	14	14	202,444	50,771	27,402
CROW WING	322	34	32	953,100	75,789	96,457	316	19	27	1,487,846	56,094	68,097
DAKOTA	541	88	48	1,690,869	275,467	133,701	519	46	35	1,932,111	136,196	94,898
DODGE	27	4	10	197,351	20,284	44,259	35	3	15	256,374	10,191	63,891
DOUGLAS	128	4	2	504,410	14,319	6,031	167	4	1	858,988	9,187	7,052
FARIBAULT	62	0	1	282,597	893	5,414	66	2	7	333,488	7,787	16,291
FILLMORE	37	14	7	108,543	27,578	14,569	46	11	8	179,453	36,468	21,552
FREEBORN	54	13	12	140,008	45,632	45,449	76	9	11	312,137	27,731	55,246
GOODHUE	152	48	25	376,809	134,839	67,862	142	26	27	613,369	72,152	123,175
GRANT	15	0	0	28,962	0	80	23	0	0	106,974	0	0
HENNEPIN	7,123	799	417	14,325,562	1,237,337	777,147	7,937	604	280	18,525,710	1,115,246	772,040
HOUSTON	44	22	8	114,288	23,559	5,956	52	17	6	172,152	44,130	18,716
HUBBARD	69	17	14	201,229	50,766	45,682	104	9	2	428,051	68,674	21,303
ISANTI	132	7	16	528,921	32,716	52,309	140	12	10	696,770	25,594	51,063
JACKSON	34	12	5	122,261	25,002	22,294	43	12	6	169,160	31,881	11,294
KANABEC	59	22	36	171,753	91,214	130,570	65	17	9	305,586	112,867	81,133
KANDIYOHI	278	10	14	1,044,752	24,698	101,150	287	10	10	1,384,140	25,535	27,111
KITTSON	15	1	0	56,915	6,440	0	5	0	0	35,630	1,861	0
KOOCHICHING	56	17	7	213,238	48,310	18,413	47	25	2	214,832	57,734	3,001
LAC QUI PARLE	12	2	0	76,116	13,668	0	22	5	2	169,790	28,619	11,076
LAKE	18	4	7	72,257	6,449	16,156	13	8	8	64,131	29,006	32,873
LAKE OF THE WOODS	15	2	2	73,397	8,357	10,768	13	7	0	91,821	41,454	0
LE SUEUR	62	15	3	315,736	37,438	8,530	85	6	2	505,210	5,189	7,929
LINCOLN	12	4	0	64,840	17,885	0	13	0	0	88,880	0	0
LYON	21	51	41	153,593	210,085	138,664	53	26	23	185,615	101,417	136,067
MCLEOD	108	9	10	308,847	24,977	22,853	133	7	0	640,328	27,242	196
MAHNOMEN	17	7	15	46,965	29,292	26,557	32	4	3	215,259	16,793	40,978
MARSHALL	13	19	18	67,742	89,614	88,071	23	7	3	112,797	39,995	28,035
MARTIN	106	7	11	443,366	14,226	23,057	124	26	4	504,183	95,666	28,694
MEEKER	100	2	2	376,446	19,185	29,098	76	6	4	364,740	8,513	10,704
MILLE LACS	84	11	11	314,675	28,968	39,830	116	5	7	533,059	19,817	16,519
MORRISON	95	30	18	207,976	45,158	19,478	136	15	22	306,562	37,526	53,104
MOWER	141	33	34	421,937	109,027	78,759	226	39	46	653,735	90,388	98,591
MURRAY	7	16	8	25,612	60,012	45,476	22	9	13	115,445	24,321	54,732
NICOLLET	47	9	13	149,592	3,192	16,236	72	10	7	424,656	22,987	33,929
NOBLES	20	30	19	69,104	65,757	61,985	44	9	13	154,867	27,443	75,869
NORMAN	13	2	6	64,794	0	16,503	25	5	6	72,304	14,351	16,192
OLMSTED	405	69	31	1,186,349	161,185	62,308	467	54	19	1,678,209	140,351	69,251
OTTER TAIL	356	58	44	1,293,291	167,367	100,366	374	49	32	1,689,198	166,965	108,089

County	Calendar Year 2001						Calendar Year 2002					
	Placements			Paid Claims ($)			Placements			Paid Claims ($)		
	Tier I	Tier II		Tier I	Tier II		Tier I	Tier II		Tier I	Tier II	
		Single Adults	Other		Single Adults	Other		Single Adults	Other		Single Adults	Other
PENNINGTON	42	18	10	183,300	40,318	21,072	38	8	9	220,504	91,152	33,597
PINE	93	4	5	352,213	7,507	14,332	90	6	4	369,267	13,935	27,659
PIPESTONE	63	0	0	293,317	13,800	375	52	7	1	262,458	21,721	7,906
POLK	130	18	12	459,869	66,600	48,240	253	16	14	1,129,614	65,425	56,951
POPE	27	18	10	79,687	61,370	8,277	39	9	5	170,033	17,068	30,622
RAMSEY	2,229	94	106	3,843,649	136,413	177,850	2,344	124	95	4,351,141	153,545	215,110
RED LAKE	8	2	1	31,790	1,050	7,181	11	3	3	35,505	20,661	13,830
REDWOOD	39	15	6	152,744	54,082	16,167	46	3	6	247,848	17,831	19,706
RENVILLE	33	10	9	151,690	27,142	33,282	57	14	8	267,629	44,544	18,148
RICE	111	21	19	419,456	61,385	83,111	104	17	15	396,762	51,564	67,148
ROCK	14	4	6	54,123	8,500	9,026	24	1	2	136,744	1,699	1,603
ROSEAU	34	9	3	120,151	28,933	18,948	34	4	0	88,617	7,137	338
ST. LOUIS	601	159	66	1,925,445	429,106	255,759	807	105	39	3,261,612	446,410	195,480
SCOTT	192	17	10	530,543	36,831	34,644	231	10	7	845,109	13,042	14,458
SHERBURNE	190	5	6	517,368	13,348	16,388	211	8	16	983,326	28,733	54,980
SIBLEY	20	15	15	149,876	61,259	74,365	45	9	13	182,315	51,858	84,012
STEARNS	289	61	20	1,119,082	157,451	42,865	270	55	16	1,184,433	265,523	83,761
STEELE	98	11	18	362,398	21,938	47,121	105	14	19	576,936	32,278	85,954
STEVENS	13	5	5	50,112	19,924	13,794	23	7	5	57,668	5,965	23,113
SWIFT	25	9	8	100,824	24,699	43,969	33	4	9	141,625	10,582	43,790
TODD	63	14	7	366,527	49,296	51,558	58	8	3	362,701	32,091	18,052
TRAVERSE	15	0	2	63,318	0	2,977	12	3	1	90,866	8,550	12,532
WABASHA	41	8	2	185,600	15,371	4,344	52	1	2	237,156	1,566	3,884
WADENA	45	0	0	113,711	12,173	13,223	34	13	2	201,955	29,265	240
WASECA	66	0	0	241,138	948	3,683	80	0	0	330,214	0	0
WASHINGTON	485	60	40	1,692,270	141,868	118,530	431	38	34	1,292,237	84,724	91,924
WATONWAN	26	1	2	140,372	8,524	671	36	2	2	170,369	0	13,854
WILKIN	21	0	0	93,792	0	0	40	1	1	171,486	0	12,892
WINONA	155	13	5	489,987	39,395	9,522	131	19	9	503,627	52,451	16,599
WRIGHT	167	30	23	562,433	88,278	66,383	272	22	23	1,185,717	60,464	125,640
YELLOW MEDICINE	35	10	8	143,029	33,413	33,541	46	1	9	308,895	5,736	42,416
MILLE-LACS TRIBE	119	0	0	502,186	0	0	107	0	5	539,745	0	22,343
BOIS-FORTE TRIBE	52	3	1	142,078	1,493	0	55	0	4	356,742	3,983	19,534
FOND-DU-LAC TRIBE	82	5	20	314,373	24,029	54,389	92	4	11	354,305	3,885	30,079
GRAND-PORTAGE TRIBE	9	0	1	40,846	0	4,736	18	2	2	70,411	0	-1,598
LEECH-LAKE TRIBE	383	14	48	1,328,915	54,048	130,617	338	21	35	2,088,101	87,699	225,305
LOWER-SIOUX TRIBE	15	0	1	72,430	0	0	19	0	1	82,866	0	0
PRAIRIE-ISLAND TRIBE	8	0	0	10,381	0	0	1	0	1	33,648	0	8,399
RED-LAKE TRIBE	384	8	28	1,179,512	16,480	81,923	396	11	17	1,458,085	19,607	58,911
SHAKOPEE TRIBE	1	0	0	1,516	0	0	2	0	0	16,250	0	0
UPPER-SIOUX TRIBE	8	0	6	40,595	0	21,614	7	2	3	37,337	5,571	18,300
WHITE-EARTH TRIBE	301	7	25	853,823	14,111	43,949	253	10	13	1,177,989	59,578	23,461
TOTALS	19854	2544	1784	54,672,919	5,895,510	4,745,412	22114	2027	1323	73,318,726	5,566,077	4,892,295