Drug and Alcohol Abuse in Minnesota:
A Biennial Report to the 2009 Minnesota Legislature

January 28, 2009

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EXECUTIVE SUMMARY

Minnesota statutes establish the alcohol and other drug abuse section within the Minnesota Department of Human Services as the state authority on alcohol and drug abuse and require a biennial report to the governor and the legislature. This is the biennial report of 2009 submitted by the Alcohol and Drug Abuse Division (ADAD) with valued input from the Minnesota Departments of Education, Military Affairs, Corrections, Health, and Public Safety, and the State Judicial Branch. It presents an overview of drug and alcohol abuse and addiction, and a thorough description of the Minnesota response in terms of primary prevention, law enforcement, courts, corrections, public treatment, ongoing collaborations, and recommendations.

The rate of current (any use in past month) alcohol use among Minnesotans is 61.7 percent, compared with 51.3 percent nationally. Likewise binge drinking is reported by 27.9 percent of Minnesotans, compared with 22.8 percent nationally. From the Minnesota Student Survey, declining alcohol use trends are reported since 1992, although the rates of binge drinking remain fairly stable among Minnesota youth.

Alcohol and drug consumption, abuse, and addiction contribute to motor-vehicle crashes, fires, falls, and drowning, and to violence such as child abuse, homicide, suicide and personal assault. Many chronic health conditions are attributable to alcohol use, including digestive diseases, certain cancers, mental disorders, and cardiovascular diseases.

The social and economic costs of substance abuse and untreated addiction are enormous and threaten the public's safety and the public's health. The National Institute on Alcohol Abuse and Alcoholism has estimated the national cost of alcohol and drug abuse at more than $270 billion per year. The Minnesota Department of Health estimates the annual economic cost of alcohol in Minnesota to be $4.5 billion or over $900 per Minnesotan (2001 estimate).

There are known effective elements of programs for alcohol and drug abuse prevention. This report summarizes those and the primary prevention efforts of the Alcohol and Drug Abuse Division and other state agencies engaged in drug and alcohol prevention activities including the Departments of Education, Public Safety, Health and Military Affairs.

This report presents an overview of the criminal justice aspects of drug and alcohol abuse and addiction in Minnesota, with information regarding the law enforcement activities of the Minnesota Department of Public Safety. The State Judicial Branch, through its 36 drug courts statewide, effectively adjudicates drug offenders while also addressing their addiction and thereby returning them to their communities as

contributing citizens. The alcohol and drug abuse-related impacts on the Minnesota Department of Corrections are presented, as are the principles of addiction treatment among correctional populations.

The number-one, long-term consequence of repeated drug and alcohol abuse is addiction. Addiction is more than simply a lot of drug abuse. It is a medical condition with both genetic and environmental factors that heighten the likelihood of its onset in any given individual. Addiction is a chronic disease with behavioral components that requires lifelong management and periodic professional services. Yet unlike people with other chronic diseases, most people who need treatment for addiction do not receive it. Of the estimated 387,600 adult Minnesotans who were in need of chemical dependency treatment in 2005, approximately 12 percent actually received treatment.

This report presents the 13 research-based principles of effective addiction treatment according to the National Institute on Drug Abuse based on decades of research on the topic. According to the most recent research, the outcomes of treatment for addiction are comparable to the outcomes of treatment for other chronic diseases with behavioral components such as asthma, hypertension and diabetes. And like other diseases, multiple treatment exposures are often required to effectively manage the disease over time.

Minnesota has a county, state and federally funded pool of dollars, the Consolidated Chemical Dependency Treatment Fund (CCDTF) that supports the provision of addiction treatment services for public clients. It is administered by counties, tribes and managed care plans. This report presents cost and trend data associated with that system.

This report also presents the most recent outcomes of addiction treatment in Minnesota, as measured by patient data and reported on: 1) the National Outcome Measures and 2) an assessment of the severity of patients' problems in each of six life functioning dimensions as gathered at admission and discharge from treatment. These measures reflect the real life outcomes for people as they attain and sustain recovery, which in turn, allows them to participate fully and productively in their communities and families. These data measure the positive changes in multiple life areas, which are attributable to addiction treatment.

Future directions of public addiction treatment in Minnesota include the following considerations:

A. Reduce the range of costs of similar addiction treatment services and increase provider accountability by linking payment to program performance;
B. Continue efforts to integrate substance abuse treatment with mental health services and primary healthcare systems;
C. Develop alternate approaches for chronic inebriates that reduce repeat treatment placements, ER episodes, and detox admissions while improving their quality of life, health and safety; and
D. Continue to make the outcomes of addiction treatment transparent by generating program specific outcome measures.

This biennial report describes current collaborative efforts across state agencies and branches of government and outlines future collaborations regarding drug and alcohol prevention, treatment and recovery.

Finally, this report suggests areas for future improvements to Minnesota's response to drug and alcohol problems. In spite of ongoing, multidisciplinary efforts, there are gaps in services and unmet needs for critical populations. These recommendations are made in response to those gaps and unmet needs:

A. Streamline access to treatment services for public patients.
B. Develop strategies to make addiction treatment services available in more settings.
C. Reduce recidivism by developing and providing shorter term treatment interventions for release violators.
D. Advance proven strategies and local efforts that reduce underage drinking on college campuses.
E. Explore opportunities/strategies for making Drug Courts economically sustainable in Minnesota as the most effective way to treat drug offenders, reduce crime, and conserve financial resources.
F. Integrate alcohol and drug screening into primary healthcare systems through Screening, Brief Intervention, Referral, and Treatment (SBIRT).
G. Maximize opportunities to educate physicians about addiction (etiology, symptoms and treatment).
H. Update sanctions and processes for DWI offenses.
I. Continue the commitment to promising practices within culturally specific services.
J. Promote expanded collaborations with recovery organizations.
K. Educate addiction treatment professionals about emerging addiction medications and psychotropic medications used in the treatment of co-occurring mental disorders.

I. Introduction/Purpose of this Report

Minnesota statutes establish the alcohol and other drug abuse section within the Minnesota Department of Human Services as the State authority on alcohol and drug abuse, and require that the State authority submit "a biennial report to the governor and the legislature containing a description of public services delivery and recommendations concerning increase of coordination and quality of services, and decrease of service duplication and cost." This is the biennial report of 2009 submitted by the Alcohol and Drug Abuse Division of the Minnesota Department of Human Services.

Minnesota Statutes, Chapter 3.197

II. Dispelling Common Myths about Alcohol and Drug Abuse

MYTH: Addiction is a choice.
REALITY: Addiction is a chronic disease with behavioral components that requires lifelong management and periodic professional services. If untreated, it can be fatal. It affects the functions of the brain in fundamental, sometimes long-lasting ways that can persist after discontinuation of drug use.

Although the initial use of drugs and alcohol is a volitional act, addiction, by definition is loss of control over drug and alcohol use. Once addiction takes over the sole focus of a life revolves around acquiring and using alcohol/drugs. Addiction is continued use of mood-altering substances in spite of repeated known and negative consequences due to their use.

Addiction is considered a disease of the brain because repeated exposure to alcohol/drugs disrupts the interaction of critical brain structures that control behavior. Continued substance use leads to abuse and possibly tolerance or the need for higher drug dosages to produce the same effect. Substance abuse, in turn, can lead to addiction, which drives a person to seek out and take alcohol/drugs compulsively in spite of negative consequences.

Addiction is a medical condition and, as such, is a primary public health concern. Yet because addiction influences the brain, especially the pre-frontal cortex, the decision-making and impulse control center, it affects a person's judgment, which in turn results in sometimes dangerous and dramatic behaviors. These behaviors threaten public safety and therefore interventions with addictions must also take in to considerations the effects on public safety.

Why one person becomes addicted and another person does not is due to a combination of factors that involve both genetic predisposition and environment. Scientists estimate that genetic factors account for roughly 55 percent of the variance in a person's vulnerability to addiction. Adolescents and individuals with mental disorders are at greater risk of drug abuse and addiction than the general population

Substance Abuse Criteria
" . . . maladaptive patterns of substance use leading to clinically significant impairment or distress, in conjunction with one or more of the following occurring within a twelve-month period:

- Recurrent use results in failure to meet obligations at school, work, or home
- Recurrent use in physically dangerous situations
- Recurrent legal problems due to use
- Continued use despite recurrent social and interpersonal problems due to use"

SOURCE*: Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., (DSM-IV), American Psychiatric Association (Washington, D.C.: APA, 1994) 182.

Substance Dependence Criteria
A group of cognitive, behavioral, and physiological symptoms that result in continued self-administered use of a substance despite major substance-related problems, characterized by tolerance, withdrawal, and compulsive alcohol/drug-taking behaviors. Three or more of the following occurring in the same twelve-month period:

- Tolerance
- Withdrawal
- Use in larger amounts than intended
- Desire or unsuccessful attempts to restrict use or cut down
- Spending a lot of time obtaining the substance
- Decline or elimination of significant social, occupational, and recreational activities due to use
- Continued use in spite of known physical or psychological problems due to use

SOURCE: *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed., (DSM-IV), American Psychiatric Association (Washington, D.C.: APA, 1994) 181.

MYTH: Treatment doesn't work.
REALITY: There is no industry-wide standard for measuring treatment outcomes for addiction. Most studies look at continuous abstinence one year post-treatment. Treatment outcome studies indicate that 40 to 60 percent of addicts are continuously abstinent one year following treatment. Compared with other chronic disorders, this compares with 30 to 50 percent for diabetics who fail to fully adhere to medication schedule one year post-diagnosis and 50 to 70 percent of hypertensives and asthmatics who fail to fully adhere to medication regimen.

And while addiction treatment outcomes compare favorably to these other chronic relapsing diseases, addiction treatment is frequently held to a higher standard than other medical treatments. This is because addiction is a complex disorder that involves nearly every aspect of an individual's functioning: at home, at work, and within the community. Therefore, due to this complexity and pervasive consequences, addiction treatment typically must involve many components, not simply the use of alcohol and drugs.

Cost-effectiveness of addiction treatment compares favorably to interdiction and other law enforcement efforts. Effective addiction treatment also reduces drug use, reduces crime, reduces long-term health care costs, reduces HIV transmission, and averts future costs. Addiction treatment has a positive effect on physical and mental health, employment, families and communities.

MYTH: Most people who need treatment for addiction receive it.
REALITY: Many more people need addiction treatment than receive it, in Minnesota and nationally. An estimated 387,600 adult Minnesotans were in need of chemical dependency treatment in 2005. Of that number, approximately 12 percent received treatment.

SOURCE*: Estimating the need for Treatment for Substance Abuse Among Adults in Minnesota: 2004/2005 Treatment Needs Assessment Survey Final Report*; Eunkung Park, Ph.D.; Performance Measurement and Quality Improvement Division, Minnesota Department of Human Services, January, 2006.

MYTH: Underage drinking is a harmless rite of passage.
REALITY: Underage alcohol use is more likely to kill young people than all illegal drugs combined. According to the 2007 Surgeon General's Call to Action to Reduce and Prevent Underage Drinking, injury is the leading cause of death among young people in the U.S. and alcohol is the leading contributor to injury deaths. An estimated 5,000 individuals under age 21 die each year from injuries caused by underage drinking. These include: about 1,900 deaths from motor vehicle crashes, 1,600 deaths by homicide, and 300 suicides.

Nationwide roughly three-fourths of 12th graders will drink alcohol before leaving high school. Alcohol use is reported by more than two-thirds of 10th graders, and about two in five 8th graders. From age 13 to age 21, the percentage of young people who report past month binge drinking increases from about 1 percent to 50 percent.

Among high school students in the U.S., those who binge drink frequently are at higher risk for the following compared with students who abstain from drinking:
- Risky Sexual Behavior

- Assaults
- Sexual Assaults
- Injuries
- Academic Problems
- Legal Problems

SOURCE: U.S. Department of Health and Human Services. (2007) The Surgeon General's Call to Action To Prevent and Reduce Underage Drinking. Office of the Surgeon General online at: www.surgeongeneral.gov/topics/underagedrinking/calltoaction.pdf

Alcohol and drug use also interact with conditions such as depression and stress to contribute to suicide, the third leading cause of death among people between the ages of 14 and 25. In one study, 37 percent of 8th grade females who drank heavily reported attempting suicide, compared with 11 percent who did not drink.

Sexual assault, including rape, occurs most commonly among women in late adolescence and early adulthood. Research suggests that alcohol use by the offender, the victim, or both, increases the likelihood of sexual assault by a male acquaintance.

Exposing the developing brain to alcohol during the adolescence period may interrupt key processes of brain development, and possibly lead to both mild, long-lasting cognitive impairment and further escalation of drinking.

Finally, longitudinal research has demonstrated that the earlier the age of onset of drug and alcohol use, the more likely the development of addiction in the course of one's lifetime. The National Longitudinal Epidemiological Alcohol Study of 43,000 individuals found that of those who started drinking alcohol at age 15 or younger, 40 percent developed alcoholism in the course of their lifetime, compared with 10 percent of those who started drinking at ages 21 and 22. This is why delaying the onset of use is a primary goal of prevention.

III. Overview of Drug and Alcohol Use in Minnesota

Addiction is a chronic disease with behavioral components that requires lifelong management and periodic professional services. Science has shown that addiction treatment is as effective as treatment of other chronic diseases with behavioral components. Unlike people with other chronic diseases, most people who need treatment for addiction do not receive it. And unlike the treatment of other chronic diseases, addiction treatment is not well-integrated into primary healthcare.

The social and economic costs of untreated addiction are enormous and threaten the public's safety and the public's health. The National Institute on Alcohol Abuse and Alcoholism has estimated the national cost of alcohol and drug abuse at more than $270 billion per year. The Minnesota Department of Health estimates the annual economic cost of alcohol in Minnesota to be $4.5 billion (2001 estimate) which translates into over $900 per Minnesotan.

Alcohol and drug consumption, abuse, and addiction contribute to motor-vehicle crashes, fires, falls, and drowning, and to violence such as child abuse, homicide, suicide and personal assault. Many chronic health conditions are attributable to alcohol use, including digestive diseases, certain cancers, mental disorders, and cardiovascular diseases.

People in Minnesota with a blood alcohol concentration (BAC) level of 0.08 or higher (0.04 in a commercial vehicle) who are in control of a moving or parked vehicle, can be arrested for driving while impaired (DWI). If a law enforcement officer can prove that alcohol use caused driving errors, a person can be convicted of DWI at lower alcohol concentrations.

Each year, more than 35,000 people are arrested in Minnesota for DWI. Each person may experience unique criminal penalties in addition to administrative license sanctions, depending on the arrest situation and previous driving violations and criminal record. Of those arrested for DWI in 2007, 39 percent were

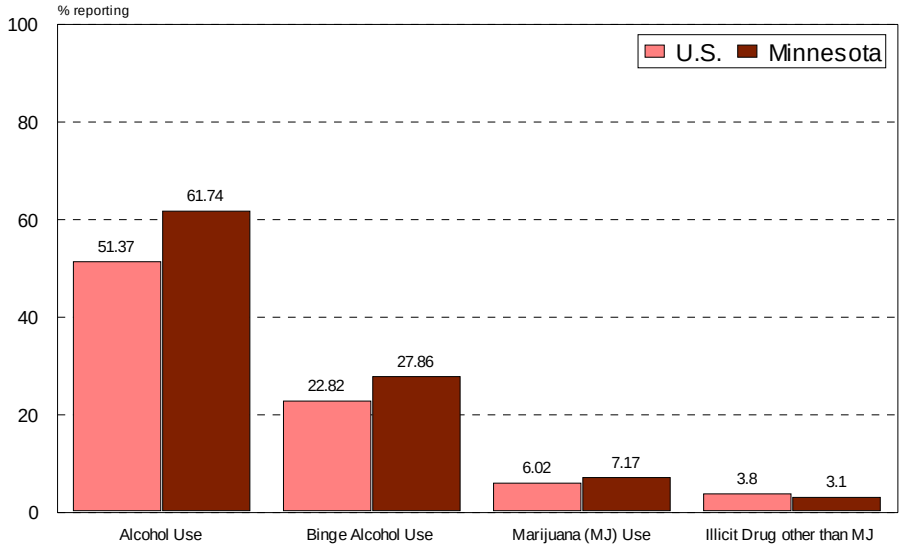
repeat offenders. Roughly one-half of the arrests (52 percent) occurred outside the Twin Cities metro area, 53 percent were committed by 21- to 34-year-olds, and 9 percent committed by people under the age of 21.

In 2007 in Minnesota, alcohol-related crashes killed 190 people at an estimated economic impact of nearly $315 million. According to the U.S. Department of Transportation, alcohol-related fatalities declined in 2007 from the previous year in the U.S. In Minnesota, however, the rate jumped 3.6 percent.

What is the extent of substance abuse in Minnesota and how does Minnesota compare with other states?

A. General Population

Past Month Use of Selected Substances by Persons Age 12 and Older
United States and Minnesota

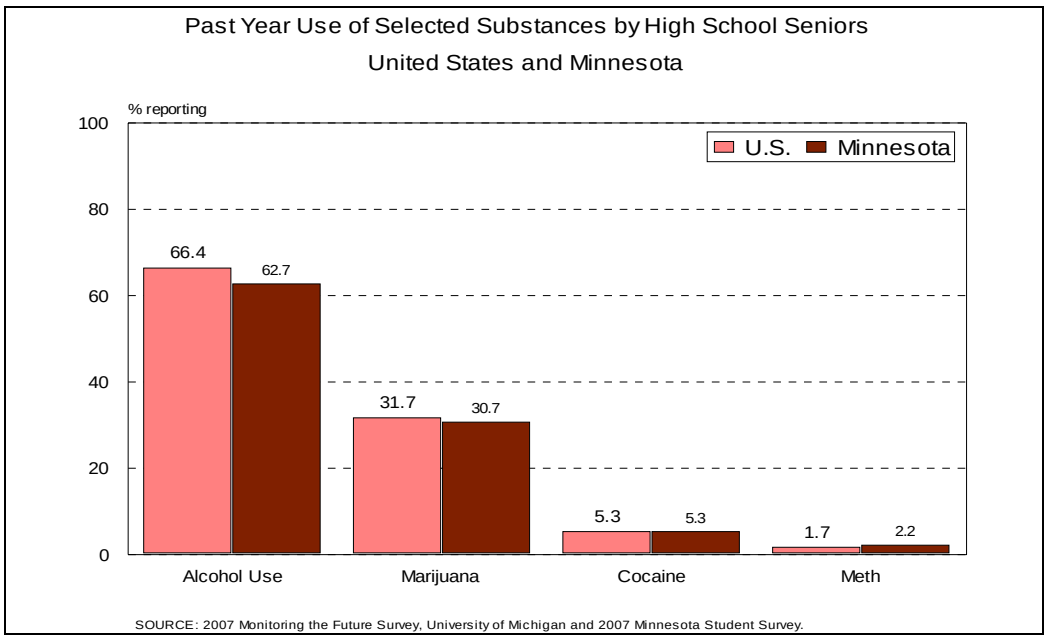


SOURCE: National Survey on Drug Use and Health , 2005 and 2006, Substance Abuse and Mental Health Services Administration, Office of Applied Studies, 2008. Binge alcohol use = 5 or more drinks on one occasion or within a couple of hours of each other at least one day in past month.

Comparing use of selected substances by person age 12 and older during the month prior to the survey for Minnesotans vs. a national sample; the most notable differences are in regard to alcohol, where rates of use in Minnesota far exceed national rates. This is true of both any drinking in the past month and binge drinking. Binge alcohol use is defined as 5 or more drinks on one occasion or within a couple of hours of each other on at least one day in past month.

B. Adolescents

Because early onset of drug and alcohol use creates numerous problems for adolescents, threatens the public safety, and is a major predictor of future addiction, a great deal of attention is directed toward delaying the onset of drug and alcohol abuse through population-based primary prevention programs. Likewise measurement efforts of drug and alcohol problems among adolescents are conducted annually by the Federal government and every three years in Minnesota.



Comparing Minnesota and the U.S., the most notable differences between high school seniors in Minnesota and nationally are the slightly lower rates of alcohol and marijuana use among Minnesota students, and their slightly higher rate of methamphetamine use.

The Minnesota Student Survey (MSS) is considered the most reliable source of data regarding adolescent drug and alcohol use in Minnesota. The Monitoring the Future Study is considered the most reliable national survey of adolescent drug and alcohol patterns.

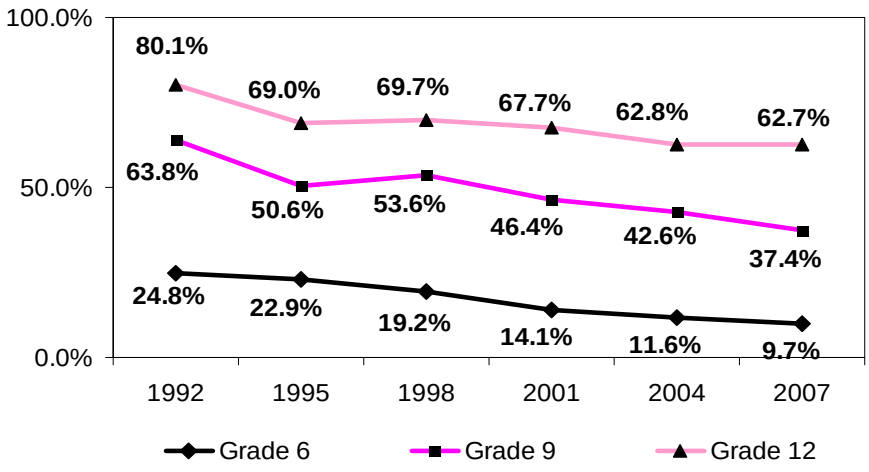
C. Minnesota Adolescents Trends Over Time

The Minnesota Student Survey has been conducted every three years since 1992. It is a paper and pencil survey of Minnesota public school students in grades 6, 9, and 12. The 2007 sample was 136,549 students, with 91 percent of school districts participating.

From 1992 to 2007, alcohol use by Minnesota students has declined at all grade levels.

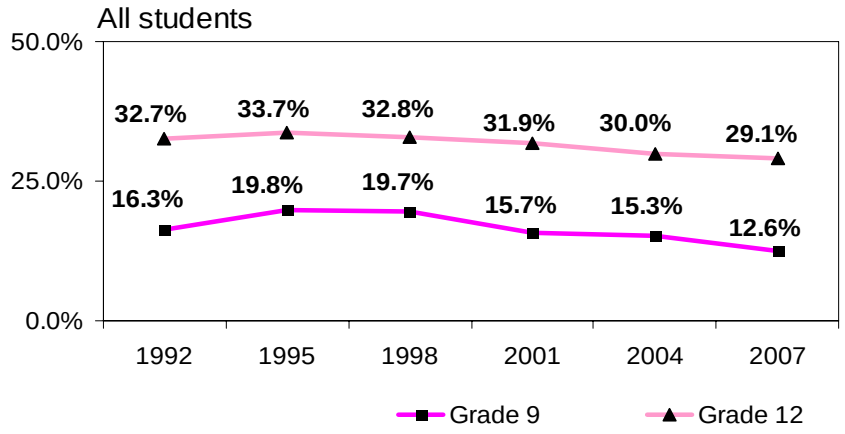
Used alcohol one or more times in past year

All students



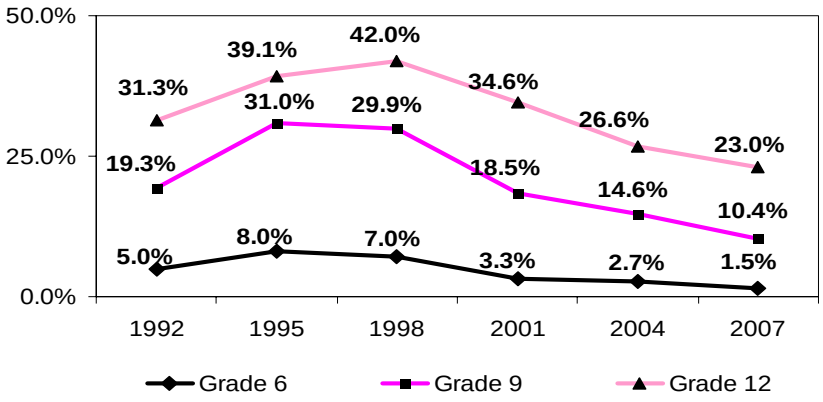
Unlike overall alcohol consumption, however, binge drinking did not decrease as significantly among Minnesota students from 1992 to 1997.

Binge drinking (five or more times in a row) in the past two weeks



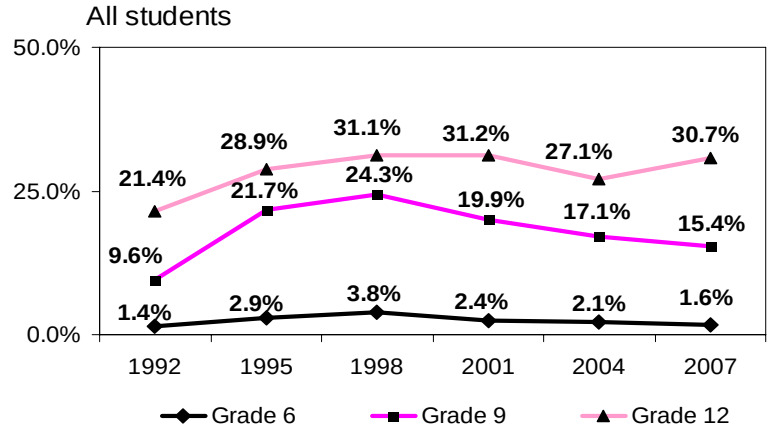
Cigarette smoking declined among Minnesota students since 1998. Students who smoke cigarettes are also more likely than those who do not to report use of alcohol and illegal drugs.

Smoked cigarettes during previous 30 days



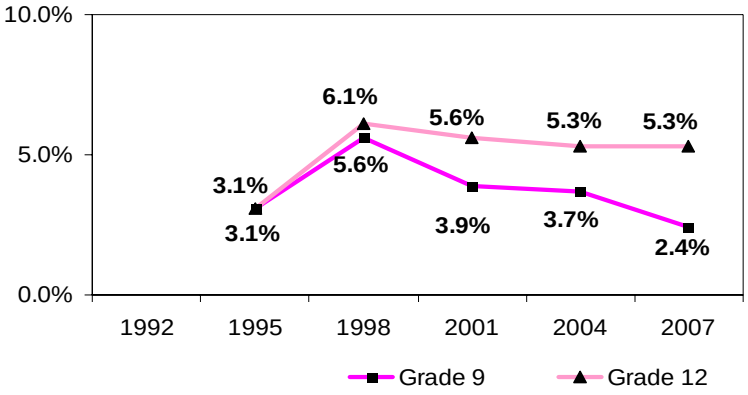
Marijuana use increased for students in all grade levels from 1992 through 2007. Although it declined from 2004 to 2007 from 6th and 9th graders, it increased for high school seniors, with 30.7 percent reporting use in the past year.

Used marijuana one or more times in the past year

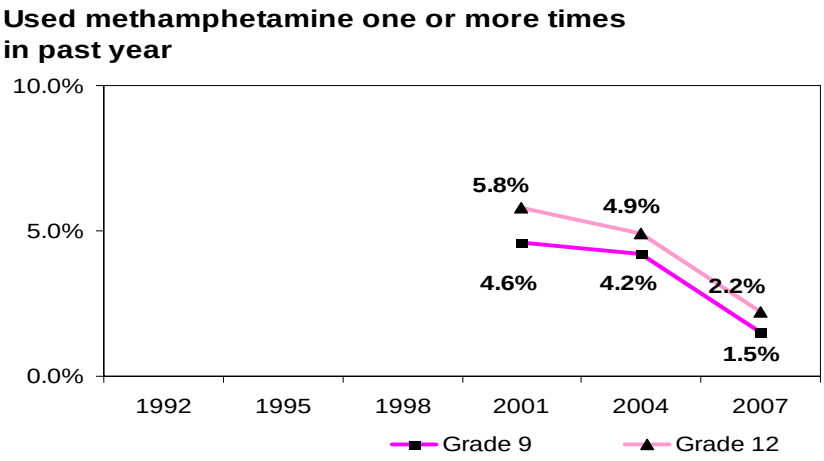


The use of crack cocaine among high school students peaked in 1998 with 6.1 percent of seniors and 5.6 percent of 9th graders reporting cocaine or crack use at least once in the past year. From 2004 to 2007, it remained constant at 5.3 percent for seniors and dropped among 9th graders from 3.7 to 2.4 percent.

Used crack or cocaine one or more times in the past year



Past year methamphetamine (meth) use declined among seniors and students in 9th grade from 2001 to 2007. In 2007, past year meth use was reported by 2.2 percent of seniors and 1.5 percent of students in 9th grade.



D. College Drinking

Underage drinking by college students is an issue of enormous public concern in Minnesota as well as nationally. Consider these basic statistics:

- 1,700 college students between the ages of 18 and 24 die each year from alcohol-related unintentional injuries, including motor vehicle crashes.
- 599,000 students between the ages of 18 and 24 are unintentionally injured under the influence of alcohol.
- More than 696,000 students between the ages of 18 and 24 are assaulted by another student who has been drinking.
- More than 97,000 students between the ages of 18 and 24 are victims of alcohol-related sexual assault or date rape.

SOURCE: Hingson, R. et al. Magnitude of Alcohol-Related Mortality and Morbidity Among U.S. College Students Ages 18-24: Changes from 1998 to 2001. *Annual Review of Public Health*, vol. 26, 259-79; 2005.

- 2.1 million students between the ages of 18 and 24 drove under the influence of alcohol annually.

SOURCE: Hingson RW, Heeren T, Zakocs RC, Kopstein A, Wechsler H. Magnitude of alcohol-related mortality and morbidity among U.S. college students ages 18-24. *Journal of Studies on Alcohol* 63 (2):136-144, 2002.

- 31 percent of college students met criteria for a diagnosis of alcohol abuse and 6 percent for a diagnosis of alcohol dependence in the past 12 months, according to questionnaire-based self-reports about their drinking.

SOURCE: Knight JR, Wechsler H, Kuo M, Seibring M, Weitzman ER, Schuckit M. Alcohol abuse and dependence among U.S. college students. *Journal of Studies on Alcohol*, 2002.

IV. The Prevention of Alcohol and Drug Abuse

Given the breadth of problems associated with the use, abuse and addiction to drugs and alcohol in Minnesota, what are State agencies doing to address these issues?

A. Alcohol and Drug Abuse Prevention Defined

1. What is Evidence-Based Prevention?

How do we prevent alcohol and drug abuse problems in our youth? Research indicates we need to have the same messages delivered by different messengers: family, schools and communities. Only when the same "no use" message comes

from multiple messengers do community norms around substance abuse start to change.

In more than 20 years of drug abuse research, the National Institute on Drug Abuse has identified important principles for prevention programs in the family, school, and community. Prevention programs often are designed to enhance "protective factors", (those associated with reduced potential for drug use), and to reduce "risk factors," (those that make drug use more likely).

Research has shown that many of the same factors apply to other behaviors such as youth violence, delinquency, school dropout, risky sexual behaviors, and teen pregnancy. When science-validated substance abuse prevention programs are properly implemented by schools and communities, the prevalence of alcohol, tobacco, and illicit substance abuse declines.

Protective factors:

- Strong and positive family bonds;
- Parental monitoring of children's activities and peers;
- Clear rules of conduct that are consistently enforced within the family;
- Involvement of parents in the lives of their children;
- Success in school performance; strong bonds with institutions, such as school and religious organizations; and
- Adoption of conventional norms about drug use.

Risk factors:

- Chaotic home environments, particularly in which parents abuse substances or suffer from mental illnesses;
- Ineffective parenting, especially with children with difficult temperaments or conduct disorders;
- Lack of parent-child attachments and nurturing;
- Inappropriately shy or aggressive behavior in the classroom;
- Failure in school performance;
- Poor social coping skills;
- Affiliations with peers displaying deviant behaviors; and
- Perceptions of approval of drug-using behaviors in family, work, school, peer, and community environments.

SOURCE: National Institute on Drug Abuse, *NIDA Notes*, Vol 16, No 6, NIH Publication No. 02-3478, February 2002.

2. Principles of Effective Alcohol and Drug Abuse Prevention

Research-based prevention programs can be cost-effective. Similar to earlier research, recent research shows that for each dollar invested in prevention, a savings of up to $10 in treatment for alcohol or other substance abuse can be seen.

The following research-based principles of prevention were developed by the National Institute on Drug Abuse and are intended to help parents, educators, and community leaders think about, plan for, and deliver research-based drug abuse prevention programs at the community level.

- Prevention programs should enhance protective factors and reverse or reduce risk factors.
- Prevention programs should address all forms of drug abuse, alone or in combination, including the underage use of legal drugs (e.g., tobacco or

alcohol); the use of illegal drugs (e.g., marijuana or heroin); and the inappropriate use of legally obtained substances (e.g., inhalants), prescription medications, or over-the-counter drugs.

- Prevention programs should address the type of drug abuse problem in the local community: tailored to address risks specific to population or audience characteristics, such as age, gender, and ethnicity, to improve program effectiveness.
- Family-based prevention programs should enhance family bonding and relationships and include parenting skills; practice in developing, discussing, and enforcing family policies on substance abuse; and training in drug education and information.
- Prevention programs can be designed to intervene as early as preschool to address risk factors for drug abuse, such as aggressive behavior, poor social skills, academic difficulties, and school dropout.
- Prevention programs for middle or junior high and high school students should increase academic and social competence with the following skills: study habits and academic support; communication; peer relationships; self-efficacy and assertiveness; drug resistance skills; reinforcement of anti-drug attitudes; and strengthening of personal commitments against drug abuse.
- Prevention programs aimed at general populations at key transition points, such as the transition to middle school, can produce beneficial effects even among high-risk families and children.
- Community prevention programs that combine two or more effective programs, such as family-based and school-based programs, can be more effective than a single program alone.
- Community prevention programs reaching populations in multiple settings such as schools, clubs, faith-based organizations, and the media, are most effective when they present consistent, community-wide messages in each setting.
- Prevention programs should be long-term with repeated interventions (i.e., booster programs) to reinforce the original prevention goals. Research shows that the benefits from middle school prevention programs diminish without follow-up programs in high school.
- Prevention programs should include teacher training on good classroom management practices.
- Prevention programs are most effective when they employ interactive techniques, such as peer discussion groups and parent role-playing, that allow for active involvement in learning about drug abuse and reinforcing skills.

SOURCE: National Institute on Drug Abuse, *Brief-Preventing Drug Use among Children and Adolescents: A Research-Based Guide for Parents, Educators, and Community Leaders,* Second Edition NIH Publication No. 04-4212(B), Printed 1997, Reprinted 1997, 1999, 2001, Second Edition October 2003.

In short, today's alcohol/drug abuse prevention programs are not simply educational programs in schools. Instead effective prevention consists of programs and policies that affect everyone, and that influence and inform knowledge, beliefs and behaviors by changing the social, cultural and political environments.

B. Statewide Alcohol and Drug Abuse Prevention Activities

The Minnesota Alcohol Tobacco and Other Drug Prevention Coordinating Council (MAPCC) is comprised of line staff from the Minnesota Departments of Human Services, Education, Health, Public Safety, and the Minnesota Prevention Resource Center. MAPCC contributes support to two annual prevention conferences: Program Sharing and Shutting OFF the Tap to Teens. It also facilitates regional prevention forums around the State twice a year.

In addition to this collaborative ongoing workgroup, various State entities contribute to alcohol and drug abuse prevention efforts as described below.

1. Minnesota Department of Human Services

As the Minnesota Single State Authority for alcohol and drug abuse prevention and treatment, the Alcohol and Drug Abuse Division (ADAD) is required to expend 20 percent of its Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant award on primary prevention.

Currently in SFY 2009, the Alcohol and Drug Abuse Division funds 40 prevention programs, including 12 prevention programs in 5 American Indian communities, and tobacco sales to minors compliance activity (Synar), at a combined amount of $5.3 million.

Prevention services are provided to over 3.1 million individuals through a combination of individual and population based programs and strategies.

ADAD of the Minnesota Department of Human Services also supports through Federal Block Grant dollars and State allocation the Minnesota Prevention Resource Center (MPRC), a longstanding, statewide clearinghouse for prevention information located in Moundsview, Minnesota. It is found online at: www.emprc.org and its accomplishments include the development and dissemination of approximately 550,000 pieces of prevention material; 3,000 calls to prevention phone lines; 187,000 Web hits on alcohol, tobacco, and other drug abuse prevention; 6,000 requests for information; and 200 prevention public service announcements to over 600 media outlets.

The Center for Substance Abuse Prevention, the prevention arm of the Federal Substance Abuse and Mental Health Administration requires that Minnesota's prevention programming implements evidence-based programs. These certified model programs may be selected by accessing the CSAP website and searching the National Registry of Evidence-based Programs & Practices (NREPP), a searchable database of interventions for prevention and treatment of mental and substance use disorders.

The ADAD also supports statewide regional prevention networks, with various prevention planning regions, each staffed by a community-based prevention specialist. See Appendix. In addition, the Division supports planning and implementation grants that transfer evidence-based prevention practices into communities through local coalitions.

In State fiscal year 2009, ADAD of DHS used Federal block grant funds for the following activities:

- Minnesota established the **Partnership for a Drug-Free Minnesota**, an affiliate membership with the Partnership for a Drug- Free America, including establishment of an advisory group. The PDFA is a nonprofit organization uniting communications professionals, renowned scientists and parents. Best known for its national drug-education campaign, the Partnership's mission is to reduce illicit drug use in America. Now in its 20th year, the Partnership helps parents and caregivers effectively address drug and alcohol abuse with their children. In 2008 Minnesota established the Partnership for a Drug-Free Minnesota, an affiliate program, and launched the broadcast media campaign throughout the State.

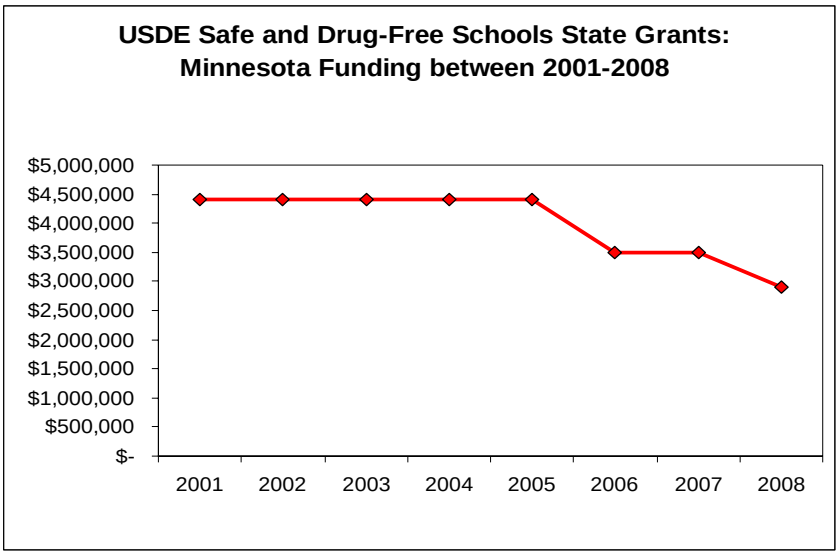
- Membership in the **Community Anti-Drug Coalitions of America** (CADCA). CADCA has forged a partnership with SAMHSA (the Substance Abuse and Mental Health Services Administration) and CSAP (the Center for Substance Abuse Prevention) to provide training and technical assistance to communities interested in establishing local community coalitions against alcohol and drug abuse.
- Sponsorship of a **Positive Community Norms Regional Training Institute** - The Montana Institute. The "Most of Us" Social Norms Marketing campaign is the most recent, statewide prevention campaign. The Montana Institute has developed an evidence-based model that centers on the science of the "positive" approach to prevention, by emphasizing that most students do not use drugs and alcohol. Minnesota has incorporated this approach to its prevention activity and launched its Minnesota Positive Community Norms Project through its funded prevention coalitions to explore and dispel myths about the actual vs. perceived extent of alcohol and drug use among youth.
- The **Cultural Diverse Community Initiative** in partnership with the Twin Cities Public Television attempts to reduce disparities across culturally diverse communities relative to alcohol and drug abuse through high-quality, educational programming. The ADAD of DHS produced a 27-minute documentary, entitled *Alcohol and Drugs: Immigrant Perspectives*, that explores how new immigrants encounter the U.S. drug-using society and their challenges to negotiate issues related to alcohol and drug abuse in the family. In addition, by filming its lunchtime lecture series ADAD produced three additional educational programs about substance abuse in various cultures: *How Alcohol Came to the American Indian, Khat in the Somali Community,* and *Opium Use: A Hmong Perspective.* All of these programs were broadcast on the Minnesota Channel of TPT in 2008 and will continue to be broadcast statewide throughout 2009.
- The **Minnesota State Epidemiological Profile** was created under the supervision of the State Epidemiological Outcomes Work group (SEOW) with financial support from the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention (CSAP). The Profile has been created to summarize and characterize consumption patterns and consequences related to the use of alcohol, tobacco and other drugs (ATOD) in Minnesota on a web-based, county-by-county, searchable basis. Online with live charting and mapping features at: www.sumn.org

2. Minnesota Department of Education

Safe and Drug Free Schools and Community (SDFSC) Act

The Federal No Child Left Behind Act (NCLB) of 2001, Title IV, Part A: Safe and Drug Free Schools and Community (SDFSC) Act State Grants program authorizes a variety of activities designed to prevent school violence and youth drug use, and to help schools and communities create safe, disciplined, and drug-free environments that support student academic achievement.

Minnesota school districts are given a per pupil allocation to develop and implement a comprehensive program. In the 2007-2008 school year, $2.9 million was distributed to 380 school districts and charter schools. The average amount distributed to Minnesota schools was $8,000 with allocations ranging from approximately $100 for small charter schools to over $500,000 for school districts with the highest concentrations of students-at-risk. Ninety percent of Minnesota public schools receive SDFSC funding and services. The majority of those schools are elementary schools followed by middle/junior high schools. Unfortunately, SDFSC funding continues to decline as shown by the following graph.



SOURCE: Minnesota Department of Education, 2008.

In Minnesota public schools, approximately 59.4 percent of all students received services from the SDFSC program. Of those students, 41.1 percent were in elementary schools, 32.6 percent in senior high schools, 25.2 percent in middle/junior high schools, and 1.1 percent of the students were in area learning centers.

The majority of SDFSC funding during the 2005-2006 school year was used in districts for Drug Prevention Instruction (71 percent) followed by Tobacco Prevention Instruction (64 percent), Violence Prevention Instruction (63 percent), Alcohol Prevention Instruction (61 percent) and Student Support Services (59 percent).

Uses of SDFSC Funding by Minnesota School Districts

Federal Defined Categories	Count of Districts	Percentage of Districts
Drug Prevention Instruction	249	71%
Tobacco Prevention Instruction	223	64%
Violence Prevention Instruction	219	63%
Alcohol Prevention Instruction	214	61%
Student Support Services	207	59%
Teacher/Staff Training	163	47%
Conflict Resolution/Peer Mediation	151	43%
Parent Education/Involvement	142	41%
Curriculum Acquisition or Development	132	38%
Special One-Time Events (Stand-Alone Types)	126	36%
Other (see below)	99	28%
Policy and Procedures Review & Improvement	63	18%
Community Service Projects	61	17%
Drop-out and/or Truancy Prevention	55	16%
Before or After-School Programs	53	15%
Alternative Education Programs	34	10%
Safety/Security Planning	36	10%
Security Personnel	34	10%
Security Equipment	21	6%

Minnesota Student Survey

Collectively the Minnesota Departments of Education, Human Services, Public Safety, and Health fund the administration, analysis and dissemination of the Minnesota Student Survey. This longstanding survey of Minnesota youth provides a basis upon which drug and alcohol prevention progress is measured in the State.

3. Minnesota Department of Health

The Minnesota Department of Health's (MDH) **Tobacco-Free Communities in Minnesota (TFC) grant program,** which began in 2003, is dedicated to creating an environment in which tobacco use is undesirable, unacceptable, and inaccessible to youth. The program is structured to:

- Reduce influences that encourage youth to use tobacco;
- Support locally-driven efforts to create tobacco-free environments;
- Build the capacity of populations at risk to reduce tobacco-related health disparities.

When the Legislature made funding available for local tobacco prevention grants, it challenged Minnesotans to reduce youth tobacco use by 30 percent. That goal has been met and exceeded. However, the work is far from done. The tobacco industry continues to spend billions of dollars annually to promote its products and bring new ones to market.

Research shows that people exposed to smoking-regardless of where (home, work, sporting event, car) or how (in movies, on Websites, through advertisements)-are more likely to smoke. Consequently, TFC grantees have tackled the problem of exposure on multiple fronts. They have used education; policy, systems and environmental change; counter-marketing; and social networking to help Minnesota communities protect their residents, youth in particular, from the harm caused by tobacco. MDH awarded approximately $3.29 million in 2007 and $3.3 million in 2008 to 21 grantees to continue this work.

The State's investment in creating Tobacco-Free Communities is reaping results. Statewide evaluation data show that between 2000 and 2008, tobacco use dropped by 45 percent for middle school students and 30 percent for high school students. Cigarette smoking declined even more dramatically, falling by 63 percent for middle school students and 41 percent for high school students.

Trend data for many other measurable outcomes tracked by MDH – including youth exposure to secondhand smoke, proportion of retailers selling tobacco to minors, and youth perceptions of smoking prevalence – also moved in a positive direction between 2000 and 2008.

These declines in tobacco use mean that an estimated 39,700 fewer students used tobacco in 2008 than in 2000. Preventing these youth from starting to smoke will ultimately lead to significant savings in direct health care costs in the future.

The Minnesota Department of Health periodically generates a report on the cost of alcohol in Minnesota. MDH also administers the **Behavioral Risk Factor Surveillance System** annually. This phone survey is the only source of annual data on adult alcohol use, binge drinking and heavy drinking in Minnesota.

The **Minnesota Department of Health Meth Lab Program** developed detailed meth lab cleanup guidelines that formed the basis for the current law requiring

notice and cleanup of meth lab properties. The program also helped develop a multi-agency meth task force to help address the challenges presented by meth. The program continues to provide information and advice to realtors, homeowners, local officials and others on proper meth lab clean-up procedures. The Methamphetamine and Meth Lab Web site maintained by the Department of Health has provided information about meth and the dangers of meth labs to thousands of Internet visitors since its inception in 2004. The site contains information about methamphetamine, meth labs, the dangers to children and others exposed to meth and meth manufacturing, clean-up techniques, and the meth lab clean-up guidelines that must be followed by companies that sell their services to clean up meth properties.

The **Chemical Health Program** distributes e-mail communications about alcohol and drug-related news stories, research, funding and training opportunities.

State grant funds support **FAS activities** are contracted as a sole source grant to the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS). It strives to eliminate birth defects caused by alcohol consumption during pregnancy and to improve the quality of life for those individuals and families affected. MOFAS works collaboratively within communities to provide resources and support for families living with Fetal Alcohol Spectrum Disorders (FASD).

Additional MDH activities related to FASD or Alcohol Exposed Pregnancy Prevention (AEPP) include:

- Adolescent Health Gateway and Adolescent Health Program – Provides information regarding resources available to adolescents, parents and the general public regarding reducing alcohol and other drug use.
- Family Home Visiting – Targets at-risk families, including those with a history of alcohol or substance abuse, screens for substance abuse, and provides education, resource and referral information to families regarding alcohol and other drug use.
- Women's, Infants and Children (WIC) – Conducts a health history and refers to appropriate community resources.
- Part C – Provides early intervention services to children exposed to alcohol during pregnancy when it is likely the exposure will result in a delay.
- Minnesota Children with Special Health Needs (MSCHN) – Provides education regarding FAS and links families to needed services.
- Birth Defects Information System (BDIS) – Conducts FAS surveillance.
- Child and Teen Check-ups (C&TC) – Conducts trainings on newborn assessment enhancing the capacity of C&TC providers in identifying conditions such as FAS and referring families to appropriate services.
- Hearing Screening – Identifies children who may have conductive or neurosensory hearing loss related to fetal alcohol exposure and supports those children and their families in receiving needed services.

4. Minnesota Department of Public Safety

The Department of Public Safety, while primarily a law enforcement agency, also contributes planning, data collection, and prevention efforts targeted at reducing the criminal consequences of alcohol and other drug abuse.

The Office of Justice Programs (OJP) houses Minnesota's Statistical Analysis Center (MNSAC) which supports Minnesota's policy-makers and leaders by providing thorough and accurate data analysis and research on all aspects of the criminal justice system. This information assists policy makers at all levels to

identify emerging critical issues and to improve the effectiveness of Minnesota's justice system.

OJP provided over $60 million in grant funds in SFY 2007; 58 percent General Fund appropriation, 38 percent Federal Funds and 4 percent Special Revenue. A significant amount of those grant funds responded to offenders or victims impacted by the use of legal and illegal substances and programs address prevention, intervention, enforcement/prosecution and victim services.

The Office of Traffic Safety (OTS) produces the *Minnesota Impaired Driving Facts Report*. This report is an ongoing source of reliable statistics that help to quantify the size and nature of the impaired driving problem. Additionally, there is information about the impaired driving law and practice in Minnesota. The OTS uses this information to develop a statewide strategic plan to reduce the number of alcohol-related fatalities and severe injuries on the roadway. Federal funding is received from the National Highway Traffic Safety Administration to support the strategic plan. Since impaired driving deals with a broad-range of issues, funding is provided for programs aimed at reducing impaired driving by a diverse population of individuals that range from the young inexperienced to the hard core drunk driver. Pro-active programs include public education, media, and high visibility enforcement intended to send a clear message of the consequences for driving impaired. Other programs, such as ignition interlock and DWI courts (intensive supervision courts) are designed to help reduce the likelihood of a repeat DWI offender driving impaired. Funding is also being used to develop a system to streamline the DWI arrest and criminal complaint process.

The Office of Traffic Safety was awarded two *Enforcing Underage Drinking Laws* Grants during the past two years from the Federal Office of Juvenile Justice and Delinquency Prevention. These funds were provided to the Minnesota Institute of Public Health, Minnesota Department of Public Safety Alcohol and Gambling Enforcement Division, and Mothers Against Drunk Driving – Minnesota to enhance a variety of underage alcohol consumption prevention, awareness, and enforcement programs throughout the State. While underage alcohol use continues to be a concern, the combined efforts of many entities and individuals working toward reducing the incidents and consequences of underage alcohol consumption have led to gradual changes in attitude being reported in many areas according to the OTS.

The Bureau of Criminal Apprehension (BCA) Law Enforcement Training Division provides over 80 courses to more than 4,000 law enforcement and criminal justice professionals throughout Minnesota on an annual basis. This training includes Drug Abuse Resistance Education (DARE), narcotic enforcement and crime prevention courses.

The BCA Breath Alcohol Testing Laboratory trains and certifies law enforcement personnel in breath alcohol testing procedures. The BCA lab owns and provides testing instruments to law enforcement throughout the State. This program is a key element in the timely detection of DWI offenders.

5. Minnesota National Guard (Department of Military Affairs)

The Counterdrug Team uses trained personnel, specialized equipment and National Guard facilities to assist law enforcement agencies, schools, and community-based organizations in response to the changing drug threat. The Minnesota National Guard Counter-Drug Program is an interdiction and education effort that receives

approximately $1.9 million in Federal funding to support about 20 full-time Guard members (FFY 08). Specific missions include support to community-based organizations and educational institutions, youth leadership development, coalition development and support, information dissemination, investigative case support, criminal analysis, aviation support, equipment procurement, and training.

In FY 2008, 21,081 Minnesota school children received substance abuse prevention-related education from the Minnesota National Guard Drug Demand Reduction Programs. In addition, 28 chemical health assessments were conducted for soldiers with chemical health issues, and 10,258 soldiers and airmen were drug tested.

V. Law Enforcement

Local law enforcement and the Minnesota Department of Public Safety are frequently involved in the consequences resulting from the inappropriate use of alcohol and the use, sale, and distribution of illegal drugs.

In 2007, police agencies in Minnesota reported:

- 17,586 narcotics offenses
- 38,669 DWI offenses and
- 15,032 liquor law violations.

More important, it is known that consumption of alcohol and the use and distribution of illegal substances may cause or contribute to a wide variety of other criminal activity from disorderly conduct to homicide. Criminal activity related to substance abuse results in significant societal and economic costs for the citizens of the State.

The mission statement of the agency reads as follows, “Minnesota Department of Public Safety is committed to protecting citizens and communities through activities that promote and support prevention, preparedness, response, recovery, education, and enforcement. These objectives are achieved through a focus on saving lives, providing efficient and effective services, maintaining public trust, and developing strong partnerships.” The Department of Public Safety understands that it is not possible to arrest your way out of these types of societal problems and therefore a comprehensive approach is needed.

The department addresses substance abuse through: planning, data collection and analysis; regulation; prevention and training; and enforcement. In addition, the department partners with Minnesota communities through the provision of grants to local jurisdictions and non-profit agencies. These community partners address substance abuse through the provision of law enforcement and prosecution programs, specialty court programs, community crime prevention, youth programming, reentry services and other evidence-based or promising pilot programs.

The following describes some of the services provided to the public by the **Department of Public Safety (DPS)** that are related to substance abuse.

The Minnesota State Patrol is Minnesota's leading police agency in DWI arrests and traffic law enforcement. Additionally, the State Patrol coordinates and oversees training in Standardized Field Sobriety Testing (SFST), Drugs That Impair Driving (DTID), and the application of Minnesota's DWI laws for all licensed police officers in Minnesota. Further, the State Patrol also coordinates the NHTSA and IACP sponsored Drug Evaluation and Classification Program (DECP), training officers in the detection of drug-impaired drivers. Minnesota currently has 170 DREs (trained Drug Recognition Experts) from 80 police agencies. They also aggressively enforce, through the use of directed patrol and saturation efforts, DWI violations that often directly contribute to fatal and injury crashes.

The Office of Justice Programs (OJP) provides support to the Gang and Drug Oversight Council which was established in 2005 to provide guidance related to the investigation and prosecution of gang and drug crime. (MN Statute 299A.641)

The **BCA Special Investigative Unit (SIU)** conducts investigations of mid- and upper-level drug trafficking organizations. Investigations are conducted in cooperation with local and county law enforcement, multi-jurisdictional drug task forces and various Federal law enforcement agencies. These collaborations, both within the State and outside Minnesota, encourage the full development of the investigations, causing maximum disruption to these criminal organizations by arrests, asset seizures and incarceration.

The **Office of Traffic Safety (OTS)** receives funding from the National Highway Traffic Safety Administration to provide grants to State, county and city law enforcement agencies to conduct high visibility enforcement and community outreach. Two programs that focus enforcement effort on impaired driving are Safe & Sober and NightCAP (nighttime concentrated alcohol patrols). Safe & Sober is a statewide enforcement program and NightCAP provides additional funding to the 13 counties with the highest number of alcohol-related deaths and severe injuries.

BCA laboratory scientists analyze blood, urine biological samples for alcohol and other drugs. They also analyze and identify suspected controlled substances. These functions are critical in proving criminal offenses.

Alcohol and Gambling Enforcement (AGE) has an Alcohol Enforcement Section that has the following mission, "protects and serves the public through the uniform interpretation and enforcement of the State Liquor Act. It protects the health and safety of the State's youth by enforcing the prohibition against sales to underage people. It operates as a central source of alcohol licenses and violation records, ensuring availability of records to related agencies and the public. It acts to maintain balance and stability in the alcoholic beverage industry through management of liquor licensing, education, enforcement and regulatory programs."

Driver and Vehicle Services (DVS) regulates who can receive a commercial or individual driver's license in the State of Minnesota according to the provisions of State law. They enforce penalties and driver's license sanctions for impaired driving.

DWI offenders that have been canceled as inimical to public safety may request to have an ignition interlock driver's license. An ignition interlock device is a system installed on a vehicle that is designed to prevent an impaired driver from operating a motor vehicle. To obtain an ignition interlock license a person must meet the qualification indicated in program standards developed by the Commissioner of Public Safety. An ignition interlock program for all repeat DWI offenders is being piloted in Hennepin and Beltrami Counties. Reports on the pilot program can be found at: www.dps.state.mn.us/ots.

VI. Judiciary

A. Background and Scope

The majority of cases coming to our courts involve alcohol/drug dependent persons. Alcohol/drug abuse and addiction is a factor in 80 to 90 percent of Minnesota's criminal cases and a pervasive problem in juvenile delinquency, child protection, and family and mental health cases as well.

Estimates suggest that up to 80 percent of the child protection cases that end up in the courts have alcohol/drug issues as a contributing factor, if not the primary factor. Individuals appearing in court with co-occurring mental health and AOD issues are on the

rise, many of these individuals come from and often return to the expensive intervention of crisis medical care in hospitals.

The financial costs to the State for all of the aforementioned cases in adjudication, incarceration and treatment are substantial and rising. Felony drug cases rose from 5,035 in 1999 to 8,268 in 2007. Methamphetamine cases accounted for 36 percent of the total drug cases. Approximately one out of every nine Minnesotans has a DWI on their record. Every year there are almost 35,000 DWI offenses in Minnesota; 39 percent of which involve repeat offenders.

In 1989 there were only 173 drug offenders, which constituted 6 percent of the overall prison population. Last year, drug offenders accounted for 21 percent of Minnesota's inmates. During the five years since the enactment of the felony DWI law on August 1, 2002, the prison population has grown by 2,157 offenders. Felony DWI offenders have accounted for 29 percent of this growth. Combined, DWI and drug offenders were responsible for 53 percent of the prison population increase from July 2002-July 2007. Eighty percent of those who receive a second DWI are chemically dependent.

The following represent the efforts that the Judicial Branch has undertaken to address the impact of alcohol and other drugs on Minnesota courts.

B. What are Drug Courts?

According to the National Drug Court Institute:

Drug courts represent the coordinated efforts of the judiciary, prosecution, defense bar, probation, law enforcement, mental health, social service, and treatment communities to actively and forcefully intervene and break the cycle of substance abuse, addiction, and crime. As an alternative to less effective interventions, drug courts quickly identify substance abusing offenders and place them under strict court monitoring and community supervision, coupled with effective, long-term treatment services.

In this blending of systems, the drug court participant undergoes an intense regimen of substance abuse and mental health treatment, case management, drug testing, and probation supervision while reporting to regularly scheduled status hearings before a judge with specialized expertise in the drug court model (Fox & Huddleston, 2003). In addition, drug courts may provide job skill training, family/group counseling, and many other life-skill enhancement services.

No other justice intervention brings to bear such an intensive response with such dramatic results; results that have been well-documented through the rigors of scientific analysis. From the earliest evaluations, researchers have determined that drug courts provide "closer, more comprehensive supervision and much more frequent drug testing and monitoring during the program than other forms of community supervision. More importantly drug use and criminal behavior are substantially reduced while offenders are participating in drug court" (Belenko, 1998; 2001). To put it bluntly, "we know that drug courts outperform virtually all other strategies that have been attempted for drug-involved offenders" (Marlowe, DeMatteo, & Festinger, 2003).

In a February 2005 report, the Government Accountability Office (GAO) concluded that adult drug court programs substantially reduce crime by lowering re-arrest and conviction rates among drug court graduates well after program completion, providing overall greater cost/benefits for drug court participants and graduates than comparison group members (GAO-05-219).

SOURCE: National Drug Court Institute at: http://www.ndci.org/courtfacts.htm

C. Minnesota Judicial Branch

The strategic priorities of the Minnesota Judicial Branch are:

- To sustain operational drug courts in Minnesota,
- To provide infrastructure of oversight and State level support, and
- To provide technical assistance to new courts.

Drug Court Initiative Advisory Committee is an advisory body to the Judicial Council (the judicial branch's top leadership body in charge of setting statewide policy). This multidisciplinary committee is responsible for advising the Judicial Council on all funding matters and specific policy issues, and for discussing collaborative efforts at the State level. As of December 5, 2008: 36 operational drug courts – 35 operational State drug courts and 1 tribal family dependency treatment court (on White Earth reservation).

- 8 Adult Drug Courts
- 3 Multi-County (neighboring counties share resources)
- 6 Family Dependency Treatment Court (child protection cases)
- 9 DWI Courts
- 5 Hybrid Courts (taking felony controlled substance, DWI, and other AOD-related cases)
- 4 Juvenile Drug Courts
- 1 Tribal Court on White Earth reservation
- Two full-time staff serve as subject matter experts; one staff has extensive background and expertise in the area of chemical health
- Unprecedented partnership with Office of Traffic Safety and Office of Justice Programs and Department of Human Services (the other funders of drug courts)
- Training and technical assistance for drug courts statewide
- Annual training on various alcohol/drug issues for over four years

Children's Justice Initiative (CJI) – Alcohol and Other Drugs (AOD)
This is a statewide collaborative effort between the Judicial Branch and the Department of Human Services for all counties to ensure the timely resolution of child protection cases.

- 2004-2007: Pilot project focused on how alcohol/drug issues impact the child protection system with significant technical assistance from national experts and unprecedented collaboration with State partners (DHS Child Welfare and Alcohol and Drug Abuse Division).
- Policy: CJI developed three priority areas with one of them being alcohol and drug abuse and mental health issues.
- Training: Staff provided training on alcohol/drug issues for over four years.

Guardian Ad Litem
Training: Standard statewide training includes core component on alcohol/drug issues.

Education and Organization Development
New judge training: identified faculty to train all new judges on alcohol/drug issues during new judge orientation (one to two times annually) Judges Annual Conference.

Staggered Sentencing
This is a nationally recognized low-intensity model for dealing with DWI offenses requiring minimal resources. Judges throughout the State, as well as many other states, use this model. This is a post-adjudication model where the judge executes one-third of the sentence and stays the other two-thirds to allow the offender to demonstrate a commitment to sobriety and remaining crime-free. The offender petitions the court at a later date to have each one-third of the remaining sentence revoked based upon progress. If there is a re-offense, a full remainder of sentence is executed.

Restorative Justice (Circles)
This is an internationally recognized model for dealing with DWI offenses. Judges throughout the State, as well as many other states, use this model whereby the judge sentences or diverts offenders into a community-based programs and offenders are held accountable by community members, focus on their sobriety, and are given the support necessary to remain crime-free.

Underage Drinking
Some courts around the State have focused on underage drinking as a way to catch early signs of alcohol dependence (and continued court involvement) with grants from the Minnesota Institute on Public Health. Chisago County has connected its efforts in this area to its juvenile drug court.

Teen Court
While not specifically a judicial intervention, a teen court is where a judge refers misdemeanor cases to a teen peer group for review and decision. Many of these cases involve underage drinking.

VII. Corrections

Several factors contribute to a very high incidence of drug and alcohol problems among Minnesota's offender populations. On a consistent basis, 90 percent of offenders are diagnosed with substance abuse or dependency. One factor is the high correlation between drug and alcohol abuse and increased risk for crime involvement. There has also been a tightening of drug and alcohol related laws and law enforcement.

Because 95 percent of offenders are eventually released back to their communities, Minnesota has invested in prison-based chemical dependency treatment programs as a means to contribute to community safety. Prison-based treatment takes advantage of incarceration to provide long-term, comprehensive programming prior to release back to the community and during a period of controlled sobriety. Department of Corrections studies show a 15 percent reduction in recidivism in three-year follow-up studies with treatment participants as well as a notable lengthening in time to reoffense with those offenders who are eventually returned to prison.

A. Principles of Addiction Treatment Among Correctional Populations

The National Institute on Drug Abuse developed the following principles of addiction treatment among correctional populations:

- Drug addiction is a brain disease that affects behavior.
- Recovery from drug addiction requires effective treatment, followed by management of the problem over time.
- Treatment must last long enough to produce stable behavioral changes.
- Assessment is the first step in treatment
- Tailoring services to fit the needs of the individual is an important part of effective drug abuse treatment for criminal justice populations.
- Drug use during treatment should be carefully monitored.
- Treatment should target factors that are associated with criminal behavior.
- Criminal justice supervision should incorporate treatment planning for drug abusing offenders, and treatment providers should be aware of correctional supervision requirements.
- Continuity of care is essential for drug abusers re-entering the community.
- A balance of rewards and sanctions encourages prosocial behavior and treatment participation.
- Offenders with co-occurring drug abuse and mental health problems often require an integrated treatment approach.
- Medications are an important part of treatment for many drug abusing offenders.

- Treatment planning for drug abusing offenders who are living in or re-entering the community should include strategies to prevent and treat serious, chronic medical conditions, such as HIV/AIDS, hepatitis B and C, and tuberculosis.

SOURCE: Principles of Drug Abuse Treatment for Criminal Justice Populations**,** NIH Publication No. 06-5316, printed September 2006.

B. Minnesota Trends

Over the past two decades, the proportion of offenders whose incarcerations are directly related to a drug crime has grown from 6 percent of the prison population to over 20 percent. Methamphetamine is the governing offense for 51 percent of drug offenders, followed by crack (21 percent) and cocaine (20 percent). Since FY 05, however, the proportion of drug offenders in Minnesota prisons has stabilized and shown a reduction in both proportion and population. The number of felony DWI offenders is growing in Minnesota prisons, currently constituting an additional seven percent of the overall population.

C. Minnesota Department of Corrections (DOC)

The Minnesota Department of Corrections provides a continuum of substance abuse services, including pretreatment, primary long-term treatment, aftercare and limited release planning. Treatment is available to offenders at every State prison custody level except maximum. Services are provided to adult and juvenile male and female offenders. The Department maintains approximately 900 treatment beds and its programs are routinely reviewed for compliance with State certification and licensure standards.

Currently, the DOC is conducting a pilot project for reentering offenders through the Minnesota Comprehensive Offender Reentry Plan. The DOC is initiating evidence-based best practices that include assessments for risks and needs through use of the LSI-R and developing case plans with offenders focusing on their incarceration programming and reentry plans for their release. The pilot project is being conducted in Hennepin, Ramsey and Dodge-Fillmore-Olmsted Community Corrections Act Counties. Grants have been awarded to these agencies to provide additional services and resources to aid in successful reentry for members of the pilot project target population.

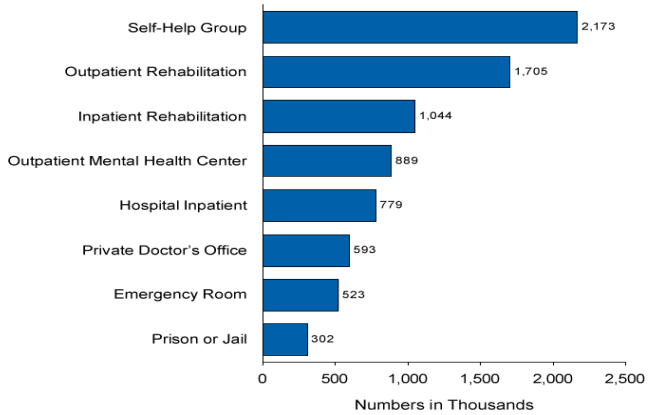
The DOC is participating with the DHS Integrated Dual Disorder project, working to integrate mental health and chemical dependency treatment services for offenders with both disorders as a means to increase the effectiveness of these services. The DOC also has been participating in a multi-year grant to develop specialized services for offenders with traumatic brain injuries.

The DOC FY 09 budget for substance abuse treatment is $5.9 million. In addition, the DOC has allocated $1.9 million to expand reentry in DOC facilities and grants to pilot counties to provide services and resources for target population offenders.

VIII. Recovery from Addiction

Not all people with addiction get well through formal addiction treatment. Self-help groups play a key role for many individuals by helping them achieve and maintain sobriety. National surveys help inform the extent of self help groups. Similar data are not available for Minnesota, although there is a longstanding self-help community in the State.

Locations Where Past Year Substance Use Treatment was Received among Persons Aged 12 or Older: United States 2007



SOURCE: Substance Abuse and Mental Health Services Administration, Office of Applied Studies (2008) *Results from the 2007 National Survey on Drug Use and Health: National Findings* (NSDUH Series H-34, DHHS Publication No. SMA 08-4343). Rockville, MD.

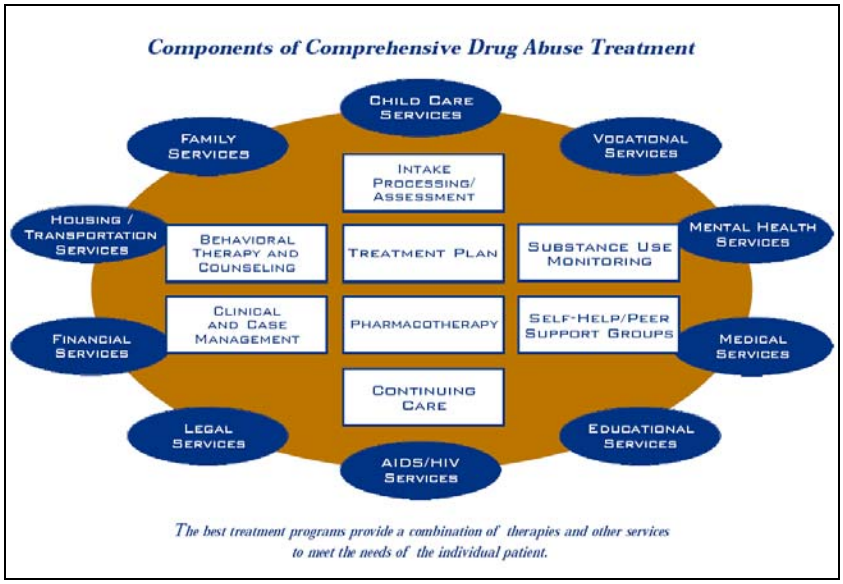
Research has also shown that participation in self-help groups during and after treatment is an effective adjunct to treatment and helps support long-term, drug-free recovery.

A. What is Addiction Treatment

Like other chronic diseases, addiction can be managed successfully. Treatment and ongoing support for a drug-free lifestyle help patients learn to counteract addiction's disruptive effects on brain and behavior and regain control of their lives. Participation in self-help support programs during and following treatment often helps maintain abstinence.

Addiction to drugs and alcohol can be effectively treated but never goes away, much like diabetes or high blood pressure, or asthma. To effectively manage chronic illnesses like these, patients need to change their behavior. Because dependency on alcohol and other drugs creates difficulties in one's physical, psychological, social, and economic functioning, treatment must be designed to address all of these areas. Case management and referral to other medical, psychological, and social services are crucial components of treatment for many patients.

Components of Comprehensive Drug Abuse Treatment



SOURCE: National Institute on Drug Abuse, 2008.

B. Principles of Addiction Treatment

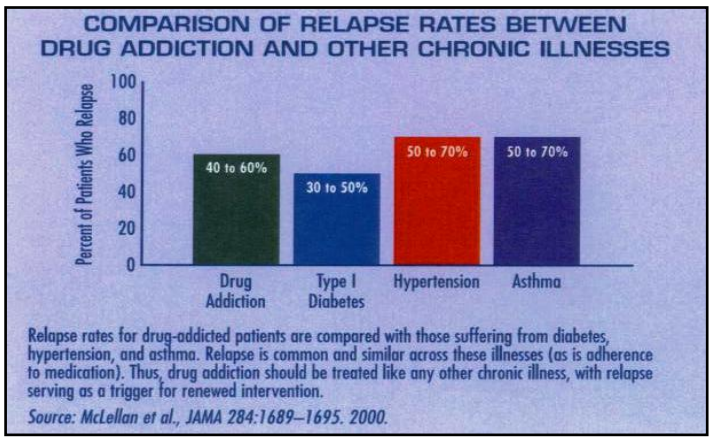
More than two decades of scientific research have yielded a set of fundamental principles that characterize effective drug abuse treatment. These principles are detailed in the research-based guide developed by the National Institute on Drug Abuse and are summarized below.

- No single treatment is appropriate for all individuals. Matching treatment settings, interventions, and services to each patient's problems and needs is critical.
- Treatment needs to be readily available. Treatment applicants can be lost if treatment is not immediately available or readily accessible.
- Effective treatment attends to multiple needs of the individual, not just his or her drug use. Treatment must address the individual's drug use and associated medical, psychological, social, vocational, and legal problems.
- Treatment needs to be flexible and to provide ongoing assessments of patient needs, which may change during the course of treatment.
- Remaining in treatment for an adequate period of time is critical for treatment effectiveness. The time depends on an individual's needs. For most patients, the threshold of significant improvement is reached at about 3 months in treatment. Additional treatment can produce further progress. Programs should include strategies to prevent patients from leaving treatment prematurely.
- Individual and/or group counseling and other behavioral therapies are critical components of effective treatment for addiction. In therapy, patients address motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships.
- Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
- Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way. Because these disorders often occur in the same individual, patients presenting for one condition should be assessed and treated for the other.
- Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use. Medical detoxification manages the acute physical symptoms of withdrawal.
- Treatment does not need to be voluntary to be effective. Sanctions or enticements in the family, employment setting, or criminal justice system can significantly increase treatment entry, retention, and success.
- Possible drug use during treatment must be monitored continuously. Monitoring a patient's drug and alcohol use during treatment, such as through urinalysis, can help the patient withstand urges to use drugs.
- Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place them or others at risk of infection.
- Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Participation in self-help support programs during and following treatment often helps maintain abstinence.

SOURCE: Principles of Drug Addiction Treatment: A Research-based Guide (NCADI publication BKD347). Available online at www.drugabuse.gov/PODAT/PODATindex.html.

C. Effectiveness of Addiction Treatment

There no single agreed upon, industry standard for measuring treatment effectiveness. Drug abuse treatment outcomes compare favorably to other chronic relapsing diseases such as hypertension and diabetes, but drug abuse treatment frequently is held to a higher standard than other medical treatments.



Treatment outcome studies generally indicate that 40 to 60 percent of addicts are continuously abstinent one year following treatment. Compared with other chronic disorders, this compares with 30 to 50 percent for diabetics who fail to fully adhere to medication schedule one year post-diagnosis and 50 to 70 percent of hypertensives and asthmatics who fail to fully adhere to medication regimen.

D. Addiction Treatment Services in Minnesota

1. Overview

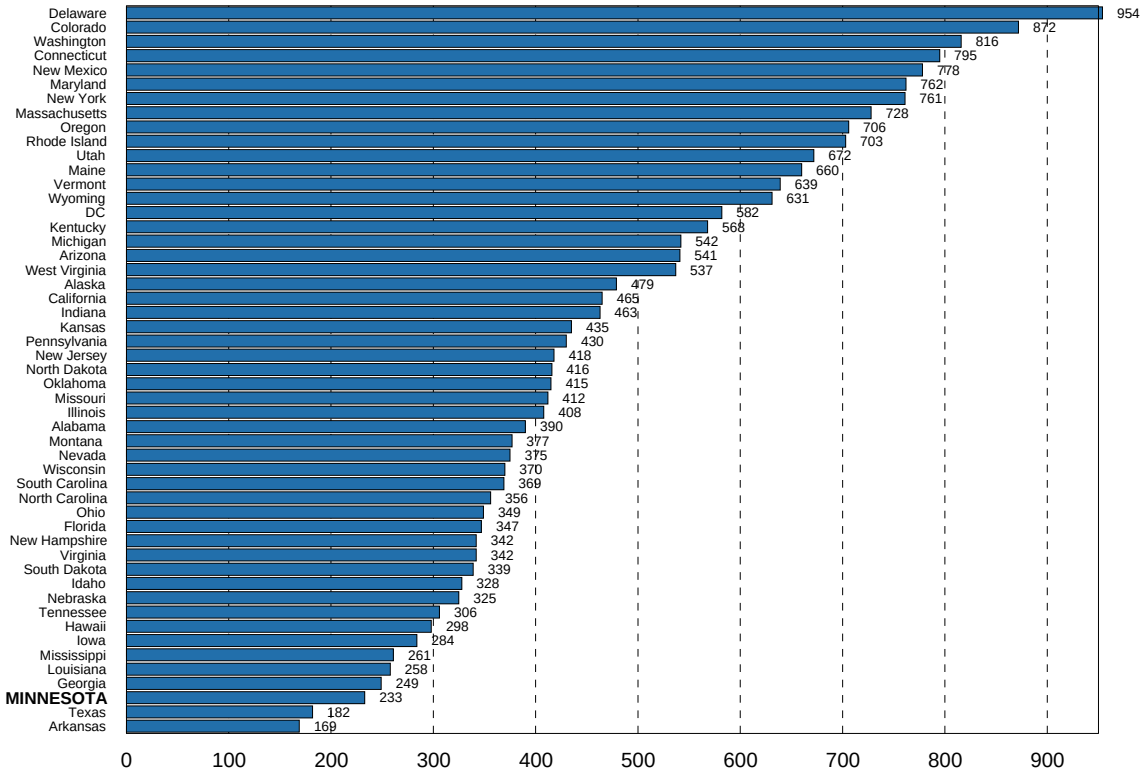
Slightly more than 300 addiction treatment services programs are licensed by the Licensing Division of the Minnesota Department of Human Services via administrative Rule 31. The Board of Behavioral Health and Therapy, created during the 2003 Legislative Session, is responsible for setting initial and continuing licensure requirements for individuals who are Licensed Alcohol and Drug Counselors.

For the past 20 years Minnesota has maintained a system of public treatment funding through the State-operated, county-administered Consolidated Chemical Dependency Treatment Fund (CCDTF). Counties contribute at least 15 percent of the cost and the SAMHSA Substance Abuse Prevention and Treatment Block Grant and State appropriations make up the balance of the CCDTF. Initially the CCDTF served a broad range of patients, including the “working poor,” but now only those at or below the Federal poverty level, for whom the disease is well-advanced, are eligible.

Chemical dependency treatment is an array of individualized services intended to help the patient understand the nature of addiction, cope with drug craving, develop skills to avoid relapse, and get introduced to ongoing recovery-oriented activities and services. In addition to cognitive behavioral and/or other types of therapy delivered in individual and group settings, lectures, family involvement, assessment and integrated treatment of co-occurring mental health disorders, many treatment programs in Minnesota and nationally also introduce patients to the concepts and traditions of Alcoholics Anonymous.

Substance abuse treatment may be based on one of several traditional approaches that emphasize different elements of the disease and the recovery process and include medical, social and behavioral models. It is a requirement of all programs that receive CCDTF that they employ evidence-based practices. There are also models, such as traditional healing practices utilized by specific cultural groups.

Clients in treatment per 100,000 population by state:
Age 18 and older - 2006



SOURCE: 2006 National Survey of Substance Abuse Treatment Services, Office of Applied Studies, Substance Abuse and Mental Health Services Administration, 2007.

The above national survey, upon which the graph is based, has been conducted every few years since the early 1990s. Minnesota has always ranked near the bottom. Given the consistent ranking, it is probable that Minnesota allocates fewer per capita treatment resources than other states. Yet this survey is only of those treatment programs licensed by DHS, and excludes self-help groups and other treatment programs not licensed by DHS, such as those operated by the Minnesota Department of Corrections that are certified under a separate system. Should these types of services be included in the survey, Minnesota's actual relative ranking would likely be higher than is indicated on this survey.

2. Treatment Funding and Trends

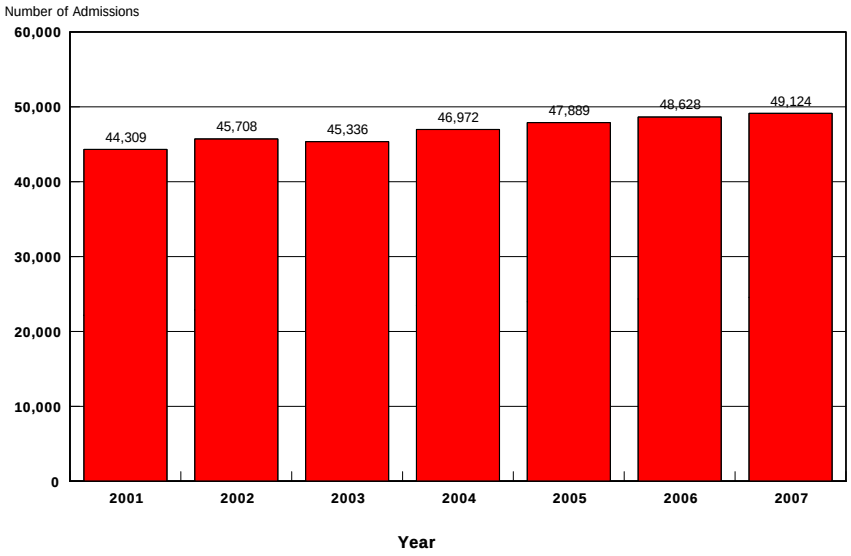
Nationwide it is estimated that 77 percent of the cost of addiction treatment is borne by public dollars. The nature of addiction is such that alcoholics and addicts typically seek help only in response to a major, negative health-related episode, or major pressure from their employer, their loved ones, or the criminal justice system. Many addicts and alcoholics have exhausted themselves financially, have lost employment, homes and families by the time this happens, and hence the reliance on the public system for the delivery of treatment services.

The Chemical Dependency Consolidated Treatment Fund (CCDTF) is a State-operated, county managed system for the provision of chemical dependency treatment to public assistance eligible persons. Counties, following State guidelines and procedures, enter into provider contracts that establish services and rates, assess clients applying for treatment services, and determine which provider will provide what amount of services to meet the determined needs of the person. Access to publicly funded treatment begins with a "Rule 25 assessment" by the county human services agency or its agent, a tribe, or a managed care

organization serving low-income patients.

July 1, 2008, marked the first-ever uniform chemical dependency assessment tool in Minnesota. Developed based on principles of the American Society of Addiction Medicine, it became a required element of all CD assessment and uses the Minnesota Matrix (patient life functioning along six dimensions) to match the severity of the patient's problem with the intensity of services. (See Appendix)

Number of Admissions to Addiction Treatment Programs by Year: Minnesota 2001 - 2007



Source: Drug and Alcohol Abuse Normative Evaluation System, Performance Measurement and Quality Improvement Division, Minnesota Department of Human Services, 2008.

Treatment episodes funded by the CCDTF have been steadily increasing in Minnesota since 2000 as have treatment admissions overall. In 2007, 60 percent of treatment admissions were paid by the CCDTF. Those admissions that are not publicly funded are covered by commercial insurance or private pay.

The tables that follow present trends in public treatment admissions paid by the Consolidated Chemical Dependency Treatment Fund (CCDTF).

Paid CCDTF Treatment Admissions 2003 - 2007

	2003		2004		2005		2006		2007	
All	24233		26420		26754		30126		29942	
Hospital	854	3.52%	772	2.92%	861	3.22%	830	2.76%	798	2.67%
Inpatient	4570	18.86%	4639	17.56%	4822	18.02%	5044	16.74%	5183	17.31%
Extended	2628	10.84%	2549	9.65%	2657	9.93%	2778	9.22%	2542	8.49%
HWH	5178	21.37%	4735	17.92%	5093	19.04%	5686	18.87%	5531	18.47%
OP TX	10017	41.34%	12398	46.93%	12157	45.44%	14194	47.12%	14288	47.72%
Methadone	986	4.07%	1327	5.02%	1163	4.35%	1594	5.29%	1600	5.34%
Residential	13230	54.59%	12695	48.05%	13433	50.21%	14338	47.59%	14054	46.94%
Outpatient	11003	45.41%	13725	51.95%	13320	49.79%	15788	52.41%	15888	53.06%
	24233		26420		26753		30126		29942	

SOURCE: Minnesota Department of Human Services, 2008.

Chemical Dependency Treatment Fund (CCDTF)
Placement Summary Report
SFY2007 (07/01/2006 – 06/30/2007)

Revenue Code	# of Total Placements	#w/at least 1 Claim	# Days or Hours	Amount Paid	Average Cost	Average Cost Per Unit
Hospital	976	784	9733	$2,616,040.95	$3,337	$269
Room & Board	755	722	26803	$2,230,490.31	$3,089	$83
Inpatient	5327	4977	120558	$30,151,723.75	$6,058	$250
Halfway	5470	5040	286790	$23,599,504.16	$4,682	$82
Extended	2673	2427	110089	$17,488,479.00	$7,206	$159
Methadone	1480	1376	159583	$1,848,528.24	$1,343	$12
OP Treatment	15369	13509	803837	$26,918,627.99	$1,993	$33
Total	32050	28835	1517393	$104,853,395		

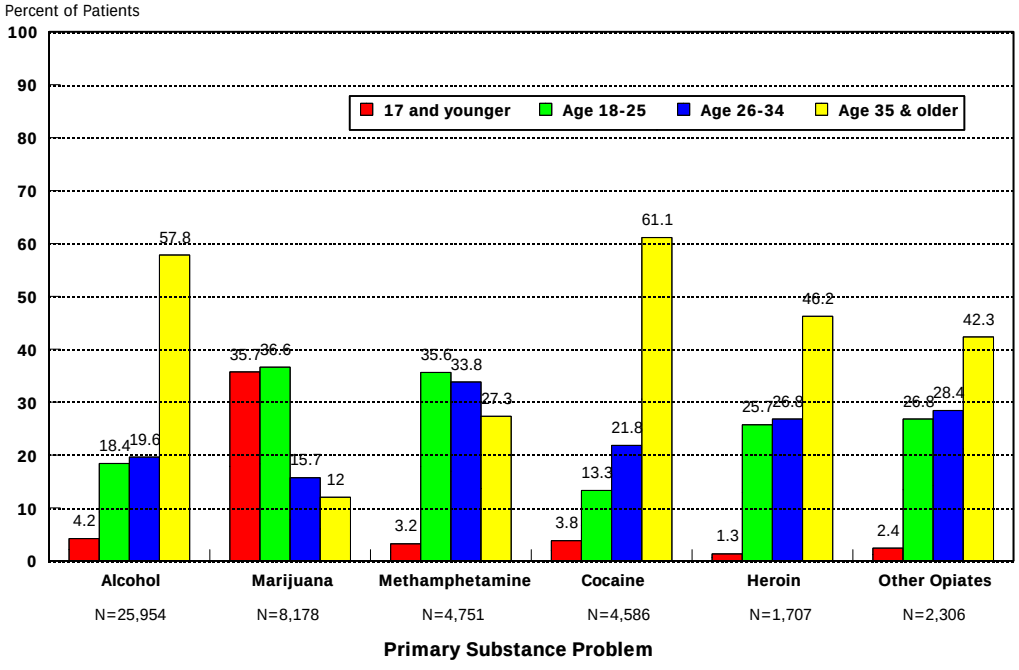
SOURCE: Minnesota Department of Human Services, 2008.

Because untreated addiction contributes to criminal justice involvement, threatens public safety, endangers children and communities, all at enormous public expense that far outweighs costs associated with the delivery of treatment services, increased placements in treatment are generally considered a positive trend.

It has been estimated that every dollar spend on addiction treatment saves seven dollars in averted future social costs related to the consequences of untreated addiction, and if you add in the averted healthcare costs, it rises to a 12:1 ratio.

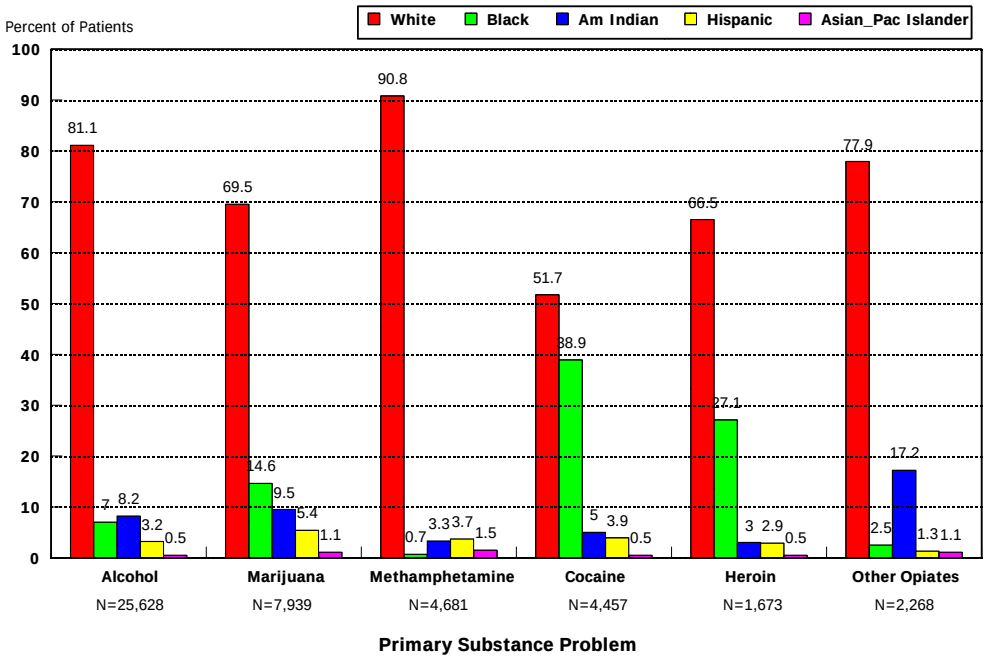
SOURCE: *California Department of Alcohol and Drug Programs*. California Drug and Alcohol Treatment Assessment (CALDATA), 1991-1993.

Addiction Treatment Admissions by Age and Primary Substance Problem - Minnesota 2007



Source: Drug and Alcohol Abuse Normative Evaluation System, Performance Measurement and Quality Improvement Division, Minnesota Department of Human Services, 2008.

Addiction Treatment Admissions by Race/Ethnicity and Primary Substance Problem - Minnesota 2007



Source: Drug and Alcohol Abuse Normative Evaluation System, Performance Measurement and Quality Improvement Division, Minnesota Department of Human Services, 2008.

Characteristics of patients admitted to Minnesota addiction treatment programs by primary substance -- 2007

Total	**Alcohol**	**Marijuana**	**Methamphetamine**	**Cocaine**	**Heroin**	**Other Opiates**
Admissions	N = 25,954	N = 8,178	N = 4,751	N = 4,586	N = 1,707	N = 2,395
(N = 49,124)	52.8%	16.6%	9.7%	9.3%	3.5%	4.9%
Gender						
Male	69.2	75.4	57.7	59.9	67.3	48.7
Female	30.8	24.6	42.3	40.1	32.7	51.3
Race/Ethnicity						
White	80.1	67.4	89.5	50.2	65.2	76.6
Black	6.9	14.1	0.7	37.9	26.6	2.5
Am Ind	8.1	9.2	3.3	4.9	2.9	17.0
Hispanic	3.1	5.2	3.6	3.8	2.8	1.3
Asian-Pac Is	0.5	1.0	1.5	0.5	0.5	1.1
Other	1.3	2.9	1.5	2.8	2.0	1.6
Age						
17 and younger	4.2	35.7	3.2	3.8	1.3	2.4
Age 18-25	18.4	36.6	35.6	13.3	25.7	26.8
Age 26-34	19.6	15.7	33.8	21.8	26.8	28.4
Age 35 & older	57.8	12.0	27.3	61.1	46.2	42.3
Route of Administration						
Oral	100.0	1.1	5.2	0.0	0.0	67.1
Smoking	0.0	98.0	67.9	65.9	5.9	2.7
Snorting/Inhalation	0.0	0.0	10.3	27.2	27.1	15.8
Injection	0.0	0.0	15.0	2.5	65.5	12.8
Unknown	0.0	0.9	1.6	4.3	1.5	1.6
Average Age of First Use (in years)	16.2	14.0	21.3	23.9	23.1	25.9
	None	Alcohol	Marijuana	Alcohol	Cocaine	Alcohol
Secondary Drug	37.8	55.0	35.3	38.6	36.7	19.2

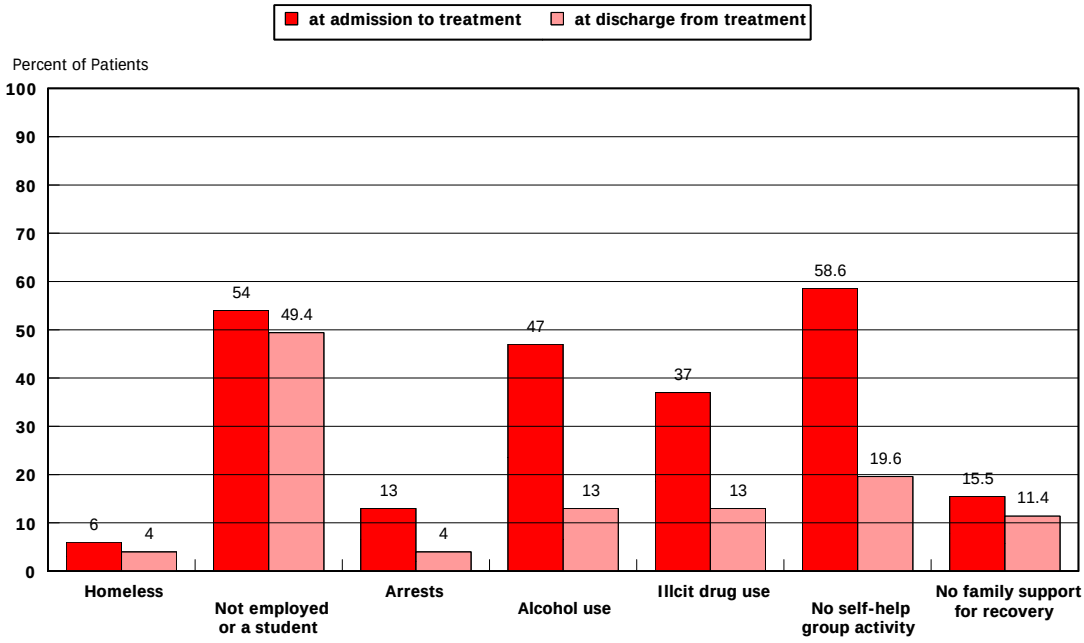
SOURCE: Performance Measurement and Quality Improvement Division, Minnesota Department of Human Services, 2008.
Percentages do not all add to 100 due to rounding and missing data.

3. Minnesota Treatment Outcome Measures

In conjunction with national efforts that require treatment outcome measures from all states, the Alcohol and Drug Abuse Division data collection and management programs support the efficient creation and dissemination of addiction treatment program performance outcome measures.

These measures attempt to capture meaningful, real-life outcomes for people who are striving to attain and sustain recovery and participate fully in their communities in the wake of receiving treatment for an active addiction to drugs or alcohol. These and other measures are captured by the Drug and Alcohol Abuse Normative Evaluation System (DAANES), the primary data collection system of the Department of Human Services used in monitoring the nature, extent, and effectiveness of substance abuse treatment services in Minnesota.

Performance Outcome Measures



Source: Drug and Alcohol Abuse Normative Evaluation System, Performance Measurement and Quality Improvement Division, Minnesota Department of Human Services, 2008. Based on over 45,000 statewide treatment admissions during calendar year 2007 with discharges as of September 1, 2008. All categories are in reference to the past 30 days. Employed includes employed or student. Self-help group refers to participation in AA or similar self-help groups that supports recovery.

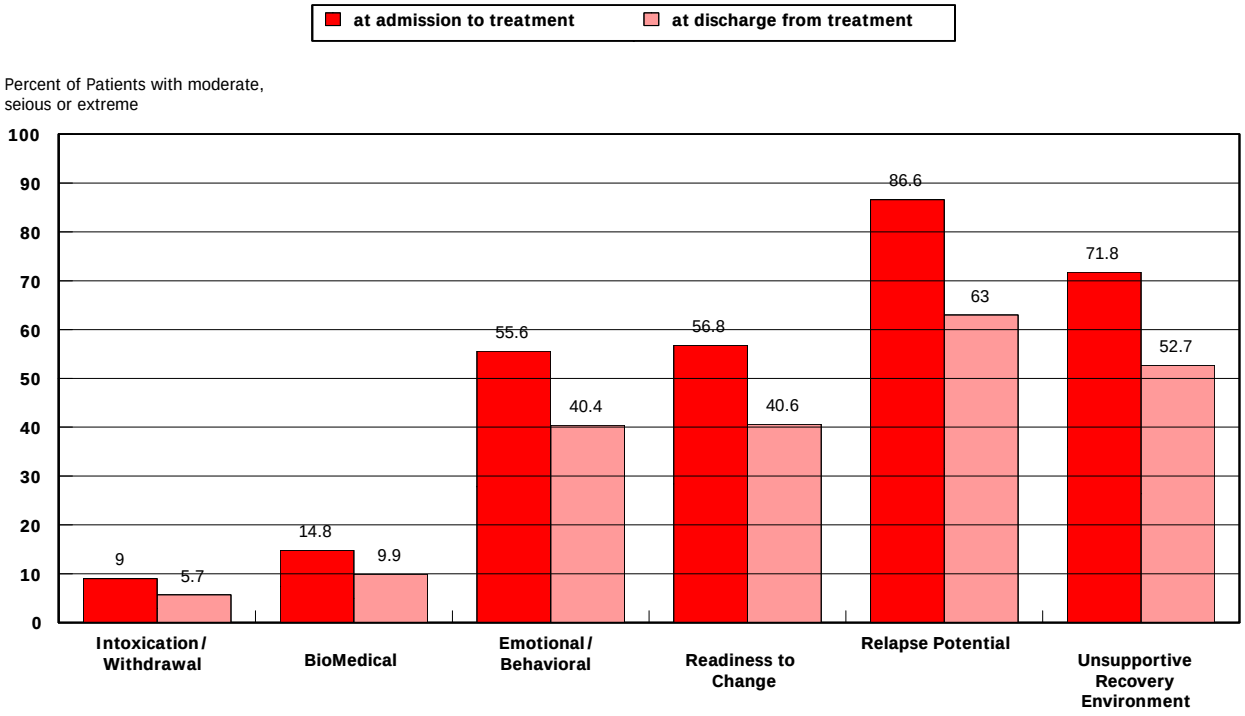
In addition to the measures above, Minnesota treatment providers licensed under State Rule 31 must report severity scores in each of six patient functioning dimensions. These scores are based on an assessment of the severity of patients' problems in each dimension upon admission and discharge from treatment services. The dimensions are:

- **Intoxication/withdrawal:** This dimension ranges from patients who exhibit no intoxication or withdrawal symptoms, to those with symptoms so severe that the patient is a threat to self or others.
- **Biomedical:** Ranges from patients who are fully functional to those with severe physical problems or conditions that require immediate medical intervention.
- **Emotional, behavioral, cognitive:** Ranges from patients with good coping skills and impulse control to such severe emotional or behavioral symptoms that the patients is unable to participate in treatment.

- **Readiness for change:** Ranges from patients who admit problems, are cooperative, motivated and committed to change, to patients who are unwilling to explore changes, are in total denial of illness, and dangerously oppositional to the extent that they are an imminent threat of harm to self and others.
- **Relapse, continued use:** Ranges from patients who recognize risk and are able to manage potential problems, to those who have no understanding of relapse issues and display high vulnerability for further substance use disorders.
- **Recovery environment:** Ranges from patients engaged in structured, meaningful activity with significant others and family, and a living environment that is supportive to recovery to patients who have a chronically or actively antagonistic significant others, family or peer group and dangerous living environments that are harmful to long-term, drug-free recovery.

The severity levels within each dimension range from 0 (no problem) to 4 (severe problem).

Chemical Health Severity Rating by Dimension



Source: Drug and Alcohol Abuse Normative Evaluation System, Performance Measurement and Quality Improvement Division, Minnesota Department of Human Services, 2008. Based on over 45,000 statewide treatment admissions during calendar year 2007 with discharges as of September 1, 2008.

As shown above, the life functioning dimensions of patients' lives improve after addiction treatment.

4. Future Directions of Public Treatment Services

The future direction of treatment of addiction for public patients in Minnesota includes the following considerations that may become reality, in part or whole, over the next several years. These approaches are best practices, consistent with national efforts, and with recommendations contained in Blueprint for the States: Policies to Improve the Ways States Organize and Deliver Alcohol and Drug Prevention and Treatment, Findings and Recommendations of a Nation Policy

Panel, (2006) Join Together, and Boston University School of Public Health. Some require a stronger financial climate, and therefore may take longer to initiate and realize.

a. Reduce the range of costs of similar addiction treatment services and increase provider accountability by linking payment to performance

Minnesota currently has a public system for addiction treatment that provides funding through the CCDTF for qualifying patients who are at or below Federal poverty level. Counties, tribes, and MCOs are the designated placing authorities. Counties negotiate the rates for addiction specialty treatment programs, and the State through the CCDTF pays for roughly 70 percent of the cost. Other than rate freezes, there has been very little State oversight or control over the county/tribal rate negotiation process. In addition, there is no system of graduated CCDTF payments that encourages programs to improve their performance.

The CCDTF could incent addiction specialty treatment providers to produce better outcomes, and thus reduce costs by reducing the number of repeat treatment episodes. Under consideration is a system of payment that incorporates quality incentives coupled with designated level of acuity and complexity scales (LACS) of patients. Quality incentive payments would consider a combination of factors such as program completion rates, national outcomes measures (NOMS), program innovations, lack of licensing violations, use of evidence-based practices, and high proportion of highest acuity patients.

Any such "pay for performance" plan would be developed with broad-based input of addiction treatment providers.

b. Continue to support efforts to integrate substance abuse treatment with mental health services and primary healthcare systems

Research supports the fact that when mental health and addiction are treated in an integrated fashion, outcomes improve. In 2006, Minnesota DHS, Mental Health Division received a $3.35 million, five-year Co-Occurring State Incentive Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). Through the grant, the State will introduce changes to encourage the use of Integrated Dual Diagnosis Treatment (IDDT) for individuals who have co-occurring mental illness and substance use disorders. Treating both disorders at the same time, preferably with the same treatment team, is called integrated treatment. Integrated treatment uses the best techniques from mental health and addiction treatment, and combines them into a unique approach specifically designed for co-occurring disorders. The ADAD continues to collaborate and work closely on these efforts and activities.

Additional efforts must be made to integrate the prevention, identification, and treatment of drug/alcohol abuse and addiction into primary healthcare. This can be accomplished through the promotion and implementation of proven screening and intervention efforts such as SBIRT, and inclusion of addiction into healthcare reform efforts in Minnesota.

The Screening, Brief Intervention and Referral to Treatment (SBIRT) initiative has made significant inroads into changing the interface between primary and emergency medical care and specialty addiction treatment. SBIRT has shown to reduce subsequent alcohol use and related problems.

To date, federally funded SBIRT programs have been established in 17 states. Four new SBIRT grants to States (Missouri, West Virginia, Georgia, and Alabama) and 11 new grants to medical schools were recently announced. These programs are in general medical settings, physician offices, trauma centers/emergency departments, mental health centers, community clinics, federally qualified centers, school-based health clinics, and campus-based health centers.

c. Develop and implement alternative approaches for chronic inebriates

The idea here is to develop alternative and less costly approaches for chronic inebriates with repeated treatment failures, and thereby reduce ER episodes, and detox admissions and improve their quality of life, health and safety.

Approximately 400 individuals have received publicly funded treatment for addiction 15 or more times in the last seven years. They also appear in the detox centers, jails and emergency rooms at great public expense. According to 2006 data by Wilder Research Center the population of homeless persons who consider themselves chemically dependent statewide is 34 percent. Over 50 percent of homeless persons surveyed had been treated in an alcohol or drug treatment program within the two years prior to the 2006 survey and 47.9 percent had been admitted to detoxification centers.

Proven methods must be utilized statewide to reduce the drain on public institutions while improving the health and safety of this group. The ADAD will continue to explore opportunities to develop a supportive housing model with services for this population based on the Duluth San Marco experience, an innovative and proven model with the chronic inebriate population. During its first year of operation the 20 residents of the San Marco in Duluth had no detox admissions versus 1,000 collectively in the four years prior.

Current housing options are limited by availability and adequacy in terms of meeting the needs of individuals who are chronic inebriates and often living on the streets. Supports that could be funded through this infrastructure investment include but are not limited to front desk coverage, meals preparation, building conversion, building maintenance and other relevant supports that cannot be funded through other funding sources.

The provision of services in conjunction with housing will promote less high-risk behavior and greater stability within this population resulting in decreased utilization of detox services, jail stays and inappropriate costly hospital emergency department services.

This activity would also contribute to the goal of ending long-term homelessness by 2010 that was established in March 2004 by the Legislature at the request of Governor Pawlenty.

d. Continue to make the outcomes of addiction treatment transparent

Using the data reported on the Drug and Alcohol Abuse Normative Evaluation System (DAANES), the primary data collection system of the Department of Human Services, ADAD will continue to capture and report meaningful, real life outcomes for people trying to attain and sustain recovery, and participate fully in their communities. In the wake of receiving treatment for an active addiction to drugs or alcohol, the quality of life improves as measured by ongoing data collected in monitoring the nature, extent, and effectiveness of substance abuse

treatment services in Minnesota. Minnesota is one of the few states that make these outcomes available on a program-by-program basis.

e. Recovery Services – Special Populations

According to the most recent census, the diversity of Minnesota's population is growing. These diverse communities experience their share of alcohol and drug abuse issues and in many cases we find disparities in the rate of substance abuse within these communities. The challenge then becomes ensuring these communities access existing services.

The Department of Human Service's priorities include the goal of addressing the substance abuse needs of the culturally diverse communities of the State through our recovery services activity, and by reducing health disparities.

The DHS **Alcohol and Drug Abuse Division** currently funds 15 programs totaling $2.8 million (SFY 2009). The focus audiences of these programs include the criminal justice populations, chronic chemically dependent and homeless, elderly, Hispanic, African American and American Indian communities. Through these efforts recovery services are provided to 7,500 individuals per year.

ADAD also funds projects to improve access, treatment, supplemental services and community support services to pregnant women and women with dependent children totaling $4 million.

The **Minnesota Department of Veteran Affairs** also administers the Minnesota Service C.O.R.E., serving Veterans, military members and their families through Case Management, Outreach, Referral and Education. It is a new, nation-leading program designed to bring essential, community-based services directly to veterans, military members and families across Minnesota at no cost to them. Because of its unique structure, this program will also provide resources to previously underserved rural areas around the State.

Under this program, there is currently no limit on the number of counseling sessions or assistance clients can receive. However, because there is a limited funding of $500,000, upon final expenditure the program will close until the fund is replenished. In an effort to offset the costs associated with the program and to maximize the limited resources, it will use third-party billing to recoup any costs possible from private insurance companies. However, there will never be a direct cost to the individual.

Finally, as Minnesota attempts to more deliberately include the large recovering community in providing recovery services to others in need, 2008 marked the formation of the **Minnesota Recovery Connection** by Rev. Dr. Jo Campe. He is the founding pastor of the Recovery Church of the Twin Cities, providing twin campus ministry to people in recovery in both St Paul and Minneapolis. Currently this ministry reaches over 2,000 people who either attend worship and/or special activities or are members of the many recovery groups that frequent Recovery Church buildings. This groups sponsors events and one training session cosponsored by the ADAD.

IX. Opportunities for Increased Collaboration

A. Recent Collaborative Efforts

The Minnesota Collaborative on Alcohol and Drug Abuse (MCADA) was recently

established by the Alcohol and Drug Abuse Division of DHS in October 2008. It includes representatives from the State Judicial Branch, the State Departments of Education, Public Safety, Health, Corrections and Military Affairs. It also includes the Governor's Meth and Drug Policy Coordinator.

The future role of this group of policy-level representatives from State agencies and branches of government is to better coordinate, on an ongoing basis, statewide efforts that address and reduce the consequences related to alcohol and drug abuse. This will be accomplished by ongoing communication and information sharing, and continued implementation of research-informed practices for all State-funded grant programs.

This multi-agency coordinating group will also develop a statewide plan that utilizes the input from all affected State entities and promote its implementation across areas, and assure that it is updated on a regular basis by the Alcohol and Drug Abuse Division of the Minnesota Department of Human Services.

These combined efforts will, in turn, increase effectiveness, reduce unnecessary duplication, and lead to better outcomes at reduced costs.

Office of the State Drug Policy and Meth Coordinator

The Office of Meth Coordinator was established in 2007 in response to Minnesota's growing problems with methamphetamine manufacture and abuse. It has since expanded to include the State Drug Policy as well, and is filled by Chuck Noerenberg and currently supported with funds from Minnesota Departments of Human Services, Public Safety and Health. This office:

- Helps provide statewide coordination of methamphetamine, alcohol, and other substance abuse policies and programs across agencies and jurisdictions,
- Reviews current substance abuse education, prevention, enforcement, and treatment programs; identifies gaps; and recommends changes to help ensure that efforts to reduce substance abuse are as effective as possible,
- Facilitates collaboration on substance abuse issues among state agencies, various levels of government, and non-government entities through information and planning meetings, written analysis, reports, and networking.
- Identifies best practices and assists in the development of statewide and community strategies to fight substance abuse,
- Promotes public awareness and provides accurate information about substance abuse through outreach to interested entities and organizations and to the media, and
- Identifies emerging issues and gaps and makes recommendations to policy makers to improve substance abuse efforts statewide.

B. Current Collaborative Efforts

Various branches of government and State agencies currently collaborate to increase the efficiency of the responses to various drug and alcohol-related problems and consequences across multiple levels of government and population groups in Minnesota.

- **The Alcohol and Other Drug Abuse Citizen's Advisory Council** of the Alcohol and Drug Abuse Division of DHS is an ongoing vehicle for public input into the processes of the State alcohol and drug abuse authority.
- **The American Indian Advisory Council** – Comprised of 11 representatives of each tribe and six representatives from four urban areas to advise the American Indian Section of the Alcohol and Drug Abuse Division of DHS.
- **At-Risk Charter Committee** – A priority group comprised of staff in multiple divisions within DHS that examines adults at risk – often due to addiction and mental

health co-occurring problems – and the multiple systems they impact such as child protection, child support, healthcare, etc.

- **Children's Justice Initiative** – A collaboration of Minnesota Judicial Branch and DHS to improve the responses in Child protection and substance that involve alcohol and drug abuse.
- **Drug Endangered Children's Initiative** – Governor Pawlenty directed the creation of a statewide Drug Endangered Children (DEC) Alliance in Minnesota to enhance efforts to rescue and protect children endangered by substance abuse. A statewide DEC Alliance is designed to provide a comprehensive approach to the needs of children exposed to drug and alcohol abuse by coordinating the policies and efforts of law enforcement, child protective services, courts, prosecutors, schools and teachers, health professionals, and prevention experts
- **Drug Court Initiative Advisory Committee** – Committee convened by Minnesota Judicial Branch that provides oversight and standards for Minnesota drug courts.
- **Ending Long-term Homelessness Initiative** – Convened by Minnesota Housing and Finance Agency
- **Enforcing Underage Drinking Laws (EUDL) Program** – Convened by the Department of Public Safety has a 19-member advisory committee.
- **Gang and Drug Oversight Council** – Convened by the Office of Justice Programs, Department of Public Safety, to provide oversight of the gang strike force and narcotics task forces throughout the State.
- **Minnesota Alcohol Tobacco and Other Drug Coordinating Council (MAPCC)** – A group of line staff from various State agencies and convened by the Minnesota Institute of Public Health.
- **Minnesota Comprehensive Offender Re-Entry Plan (MCORP)** – Convened by DOC to help make reentry after imprisonment more service-supported and therefore successful.

X. Recommendations

The following recommendations are made in response to unmet needs and existing gaps in current services that prevent drug and alcohol abuse, treat addiction, and support recovery from addiction in Minnesota. Some require financial investment, and therefore may take longer to initiate, while others may occur with enhanced coordination with other levels of government or other entities.

A. Streamline access to treatment services for public patients.

Examine alternate and improved methods of administering the CCDTF, such as having counties briefly screen patients for financial eligibility and level of care and then providing them with a list of nearby treatment providers that includes program outcome data. Examine the wide range of county-negotiated rates for treatment services and move toward increased uniformity based on the complexity and acuity of the patients served, and program performance measures. Expand patient choice of addiction treatment programs. Examine new options for patient entry into the public treatment system including detox centers and primary healthcare clinics.

B. Develop strategies to make addiction treatment services available in more settings.

While the Minnesota Department of Corrections provides a significant number of treatment opportunities for offenders each year, over half who are recommended for substance abuse treatment do not have an opportunity for treatment prior to release. Further, there are approximately 2,500 offenders returning to prison as Release Violators. This group of offenders is not currently assessed for substance abuse problems or referred to treatment. Lack of sufficient resources is part of the problem but

this subgroup also tends to have short sentence lengths, making long-term treatment impractical. Nevertheless, there are high rates of substance abuse and dependence among this group. It is likely that drugs and alcohol abuse play a significant role in the failure of these releases to maintain their conditions of release in their communities.

C. Reduce recidivism by developing and providing shorter term treatment interventions for Release Violators.

This has the potential to further reduce recidivism along with the economic and social costs associated with re-offending for this portion of the prison population. For offenders who do not receive treatment during incarceration, the DOC can provide Rule 25 evaluations to facilitate funding and expedite the process of referral to community-based substance abuse treatment on release. In addition, the goal of continued abstinence after release is enhanced for offenders completing treatment with release planning that arranges for aftercare and other community supports. The Department of Corrections currently maintains three substance abuse release planner positions. Additional release planner positions would allow a higher percentage of offenders to receive treatment planning and Rule 25 assessment services.

D. Advance proven strategies and local efforts that reduce underage drinking among school age youth and on college campuses.

Underage drinking is a matter of enormous public concern in Minnesota as well as nationally. In response, broad-based collaborations should be formed and expanded to better address the problems associated with underage college drinking in Minnesota by examining statewide legislation and promoting local policies that make alcohol less accessible to the youth market and thereby reduce the negative consequences. In addition, the formation of campus and community coalitions involving all major stakeholders can be critical to implementing these strategies effectively at the campus level.

1. Underage drinking among school age youth

Strategies to reduce alcohol consumption among school age youth fall into four categories and briefly described below:

School strategies:
Based on behavioral theory and knowledge of risk and protective factors; developmentally appropriate information about alcohol and other drugs; development of personal, social, and resistance skills; emphasis on normative education; structured, broader-based skills training; interactive teaching techniques; multiple sessions over multiple years; teacher training and support; active family and community involvement; and cultural sensitivity.

Extracurricular Strategies:
Supervision by positive adult role models; youth leadership; I intensive programs; incorporation of skills building; and part of a comprehensive prevention plan.

Family Strategies:
Improvement of parent-child relations using positive reinforcement, listening and communication skills, and problem solving; provision of consistent discipline and rulemaking; monitoring of children's activities during adolescence; strengthening of family bonding; development of skills; and involvement of child and parents.

Community/Policy Strategies:
Increase excise taxes on alcohol; enforce minimum legal drinking age of 21; and citizen action to reduce commercial and social availability of alcohol.

SOURCE: Kelli A. Komro, M.P.H., Ph.D., and Traci L. Toomey, M.P.H., Ph.D., *Strategies to Prevent Underage Drinking*, Online at: http://pubs.niaaa.nih.gov/publications/arh26-1/5-14.htm.

2. College Age Drinking

There are numerous proven strategies and policies that can be advanced with proper visibility and support from multiple partners that address college age drinking and are briefly summarized below:

The research on reducing underage drinking at colleges strongly supports the use of comprehensive, integrated programs with multiple complementary components that target: 1) individuals, including at-risk or alcohol-dependent drinkers, 2) the student population as a whole, and 3) the college and the surrounding community.

The three strategies that follow target individual, at-risk, or alcohol-dependent drinkers include: cognitive-behavioral skills, norms/values clarification, and motivational enhancement interventions.

The community-based strategies listed below have been successful with similar populations and can help change those aspects of both the campus and community culture that support excessive and underage alcohol use although they have not yet been comprehensively evaluated with college students:

- Increased enforcement of minimum drinking age laws.
- Restrictions on alcohol retail outlet density.
- Increased excise taxes and prices on alcoholic beverages.
- Responsible beverage service policies in social and commercial settings.
- Implementation, increased publicity, and enforcement of other laws to reduce alcohol-impaired driving.

SOURCE: National Institute on Alcohol Abuse and Alcoholism online at: www.collegedrinkingprevention.gov/StatsSummaries/4tier.aspx

E. Explore opportunities/strategies for making Drug Courts economically sustainable in Minnesota as the most effective way to treat drug offenders, reduce crime, and conserve financial resources.

The preponderance of evidence – over 57 research studies – demonstrates the effectiveness of drug courts throughout the country. We have no reason to believe that the drug court experience in Minnesota is any different, although a specific evaluation of Minnesota drug courts will not be available until 2011.

Nationwide 75 percent of drug court graduates remain arrest-free two years after completing the program. Drug courts also save money by offsetting the costs of law enforcement, court case processing, and future victimization, according to a 2005 report of the Government Accountability Office.

SOURCES: Roman, et al. (2003) Recidivism rates for drug court graduates: Nationally based estimate - Final report. Washington D.C., *The Urban Institute and Caliber and GAO* (2005) Adult drug courts: Evidence indicates recidivism reductions and mixed results fro other outcomes [No. GAO-05-219] Washington D.C.)

F. Integrate alcohol and drug screening into primary healthcare systems through Screening, Brief Intervention, Referral, and Treatment (SBIRT.).

SBIRT is a comprehensive, integrated, public health approach to the delivery of early screening, intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for screening and early intervention with at-risk substance users before more severe consequences occur.

- *Screening* quickly assesses the severity of substance use and identifies the appropriate level of treatment.
- *Brief intervention* focuses on increasing insight and awareness regarding substance use and motivation toward behavioral change.
- *Referral to treatment* provides those identified as needing more extensive treatment with access to speciality care.

SBIRT research has shown that large numbers of individuals at risk of developing serious alcohol or other drug problems may be identified through primary care screening. Interventions such as SBIRT have been found to: 1) Decrease the frequency and severity of drug and alcohol use, 2) Reduce the risk of trauma, and 3) Increase the percentage of patients who enter specialized substance abuse treatment.

In addition to decreases in substance abuse, screening and brief interventions have also been associated with fewer hospital days and fewer emergency department visits. Cost-benefit analyses and cost-effectiveness analyses have demonstrated net-cost savings from these interventions. Key research on SBIRT indicates:

- **Screening and brief intervention for alcohol problems in trauma patients is cost-effective and should be routinely implemented**.

An estimated 27 percent of all injured adult patients are candidates for a brief alcohol intervention. The net cost savings of the intervention was $89 per patient screened, or $330 for each patient offered an intervention. The benefit in reduced health expenditures resulted in savings of $3.81 for every $1.00 spent on screening and intervention. If interventions were routinely offered to eligible injured adult patients nationwide, the potential net savings could approach $1.82 billion annually.

SOURCE: Larry M. Gentilello, MD,* Beth E. Ebel, MD, MPH,†_ Thomas M. Wickizer, MPH, PhD,‡David S. Salkever, PhD,§ and Frederick P. Rivara, MD, MPH, Alcohol Interventions for Trauma Patients Treated in Emergency Departments and Hospitals:A Cost Benefit Analysis, *Annals of Surgery*, Volume 241, Number 4, April 2005.

- **Brief physician advice is associated with sustained reductions in alcohol use, health care utilization, motor vehicle events, and associated costs, based on the 48-month efficacy and benefit-cost analysis of Project TrEAT (Trial for Early Alcohol Treatment), a randomized controlled trial of brief physician advice for the treatment of problem drinking**.

- **Alcohol screening and brief intervention in primary health care settings is cost effective and should be implemented in the US health care system.**

SOURCE: Michael F. Fleming, Marlon P. Mundt, Michael T. French, Linda Baier Manwell, Ellyn A. Stauffacher, and Kristen Lawton Barry, Brief Physician Advice for Problem Drinkers: Long-Term Efficacy and Benefit-Cost Analysis, *Alcohol Clin Exp Res*, Vol 26, No 1, 2002: pp 36-43.

- **Alcohol screening and (brief) counseling is one of the highest-ranking preventive services among the 25 effective services evaluated using standardized methods.**

SOURCE: Leif I. Solberg, MD, Michael V. Maciosek, PhD, Nichol M. Edwards, MS, Primary Care Intervention to Reduce Alcohol Misuse - Ranking Its Health Impact and Cost Effectiveness *Am J Prev Med* 2008;34(2):143-152.

G. Maximize opportunities to educate physicians about addiction (etiology, symptoms and treatment.).

It is still the case that physicians receive little formal medical school education about addictive diseases, and as a result the symptoms are often overlooked or attributed to other conditions. Primary care physicians are rarely the source of referral into addiction specialty treatment services or programs. And because the addiction specialty treatment system developed outside of the primary healthcare system, few physicians are well-versed in the existing and emerging methods used to treat addiction, or the community-based addiction treatment resources available. Like others in society, some doctors are biased against people with addiction and may regard the fundamental nature of addiction as being moral, not medical. Other physicians may find the evidence supporting the disease concept of addiction unconvincing and subsequently believe that addiction is simply not treatable. To bridge this gap we propose to work with various credentialing, licensing, and certification boards to encourage adoption of mandatory continuing education credits and seminars for physicians on addiction and its treatment.

H. Update sanctions and processes for DWI offenses.

The Office of Traffic Safety is currently convening multidisciplinary task forces to address issues related to DWI sanctions in Minnesota.

I. Continue the commitment to promising practices within culturally specific services.

The promising practices that best inform culturally sensitive addiction prevention and treatment services include, but are not limited to, those which allow for expression of:

- Cultural beliefs
- Cultural values
- Cultural traditions (including those surrounding alcohol and drug use)
- Cultural practices
- Celebrations
- Spiritual activities (i.e. sweat lodges; ceremonies etc.)
- Community leaders and decision makers (i.e. tribes, clans)
- Language and stigma surrounding addiction and other related issues to the ability of an individual to seek and benefit from help

J. Promote expanded collaborations with recovery organizations.

Because there is persistent discrimination against people who are in recovery from addiction, the State authority should continue collaborations with groups representing people in recovery from addictive disorders to alcohol and drugs. As Minnesota moves toward "recovery-oriented systems of care," alliances and partnerships with recovery organizations need to be developed. "Recovery-oriented systems of care" are the places where the public can receive added benefits by private sector initiatives and peer group connections that support recovery from addiction within and across communities. Such groups can also help sustain public support for recovery efforts and help educate the public about the success stories about recovery from addiction.

K. Educate addiction treatment professionals about emerging addiction medications and psychotropic medications used in the treatment of co-occurring mental disorders.

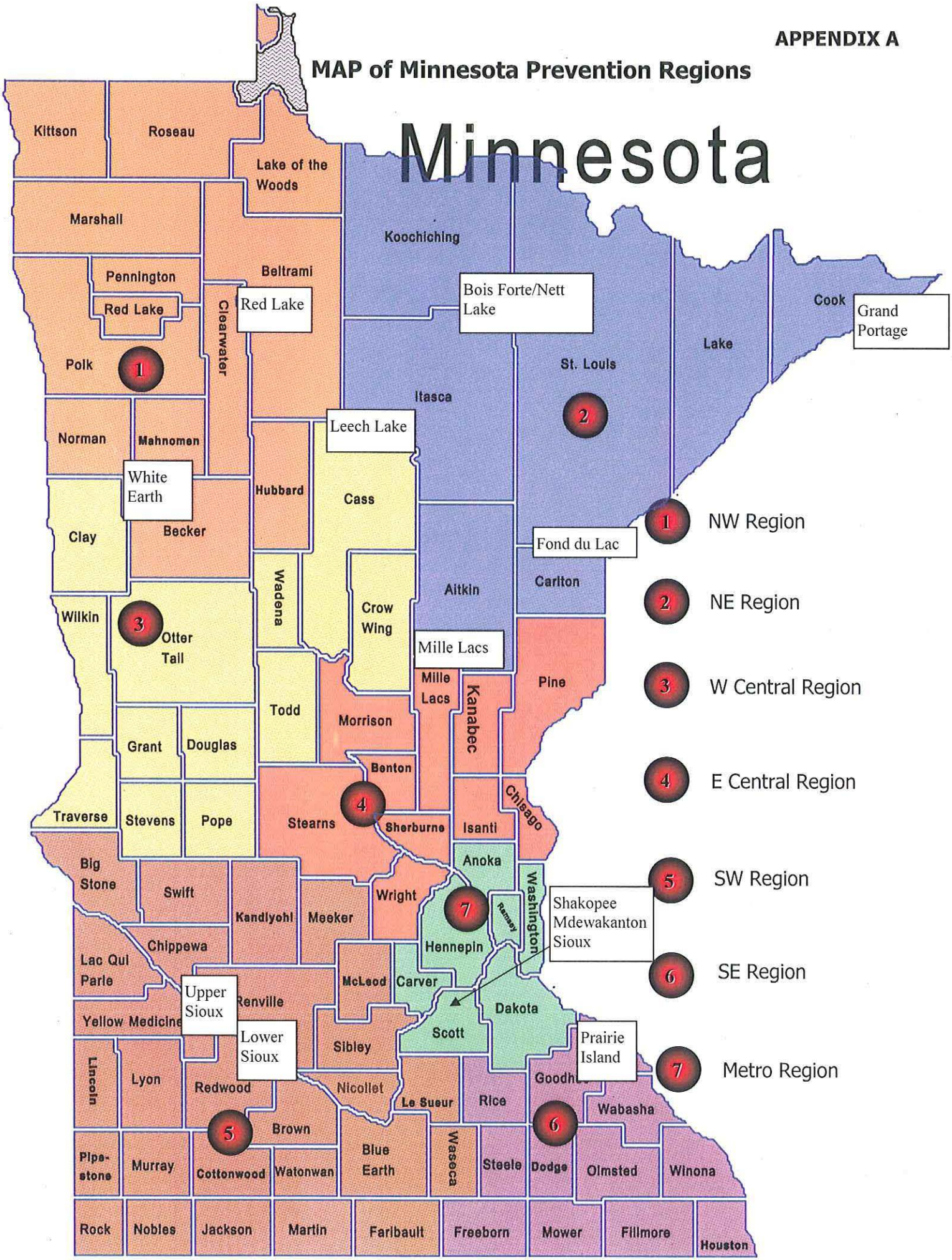
Research shows that specific medications can reduce craving and improve treatment outcomes for some individuals suffering from addiction. Yet, because many addiction specialty treatment programs developed outside of the primary health care system, most providers lack knowledge of emerging addiction medications and therefore do not include them as adjuncts to therapy. Others regard medications of any sort as contraindicated for addicted patients.

And while at least half of patients in treatment for addiction also have a diagnosed mental disorder, and again, because addiction specialty treatment developed outside of the primary healthcare system, many treatment providers lack knowledge of mental disorders and the medications used to treat them. In many cases they may require patients being treated for addiction to discontinue the use all psychotropic medications during the course of addiction treatment. To bridge this gap, we propose to work with the Board of Behavioral Health to assure the adoption of mandatory continuing education credits for addiction counselors on addiction and psychiatric medication. We also will work with the Minnesota Chapter of Addiction Medicine and others to promote regional trainings on these topics.

APPENDICES

APPENDIX A

MAP of Minnesota Prevention Regions



Minnesota Department of Human Services

Chemical Health Division

Minnesota Matrix

RULE 25 RISK DESCRIPTIONS GUIDE

SEVERITY RATING	DIMENSION I Intox/Withdrawal	DIMENSION II Biomedical	DIMENSION III Emotion/Behav/Cogn	DIMENSION IV Readiness for Change	DIMENSION V Relapse/Cont'd. Use	DIMENSION VI Recovery Environ.
0	Displays full functioning with good ability to tolerate and cope with withdrawal discomfort. No signs or symptoms of intoxication or withdrawal or resolving signs or symptoms.	Displays full functioning with good ability to cope with physical discomfort.	Good impulse control and coping skills and presents no risk of harm to self or others. Functions in all life areas and displays no emotional, behavioral, or cognitive problems or the problems are stable.	Cooperative, motivated, ready to change, admits problems, committed to change, and engaged in treatment as a responsible participant.	Recognizes risk well and is able to manage potential problems.	Engaged in structured, meaningful activity and has a supportive significant other, family, and living environment.
1	Can tolerate and cope with withdrawal discomfort. Displays mild to moderate intoxication or signs and symptoms interfering with daily functioning but does not immediately endanger self or others. Poses minimal risk of severe withdrawal.	Tolerates and copes with physical discomfort and is able to get the services that s/he needs.	Has impulse control and coping skills. Presents a mild to moderate risk of harm to self or others without means or displays symptoms of emotional, behavioral, or cognitive problems. Has a mental health diagnosis and is stable. Functions adequately in significant life areas.	Motivated with active reinforcement, to explore Tx and strategies for change, but ambivalent about illness or need for change.	Recognizes relapse issues and prevention strategies, but displays some vulnerability for further substance use or mental health problems.	Passive social network support or family and significant other are not interested in the client's recovery. The client is engaged in structured meaningful activity.
2	Some difficulty tolerating and coping with withdrawal discomfort. Intoxication may be severe, but responds to support and treatment such that the client does not immediately endanger self or others. Displays moderate signs and symptoms with moderate risk of severe withdrawal.	Difficulty tolerating and coping with physical problems or has other biomedical problems that interfere with recovery and mental health treatment. Neglects or does not seek care for serious biomedical problems.	Difficulty with impulse control and lacks coping skills. Thoughts of suicide or harm to others without plan or means; however, the thoughts may interfere with participation in some Tx activities. Difficulty functioning in significant life areas. Moderate symptoms of emotional, behavioral, or cognitive problems. Able to participate in most Tx activities.	Displays verbal compliance, but lacks consistent behaviors; has low motivation for change; is passively involved in Tx.	A) Minimal recognition and understanding of relapse and recidivism issues and displays moderate vulnerability for further substance use or mental health problems. B) Some coping skills inconsistently applied.	Engaged in structured, meaningful activity, but peers, family, significant other, and living environment are unsupportive, or there is criminal justice involvement by the client or among the client's peers, significant others, or in the client's living environment.
3	Tolerates and copes with withdrawal discomfort poorly. Severe intoxication, such that the client endangers self or others, or intoxication has not abated with support and treatment at less intensive levels of services. Displays severe signs and symptoms; or risk of severe, but manageable withdrawal; or withdrawal worsening despite detox at less intensive level.	Tolerates and copes poorly with physical problems or has poor general health. Neglects medical problems without active assistance.	Severe lack of impulse control and coping skills. Frequent thoughts of suicide or harm to others including a plan and the means to carry out the plan. Severely impaired in significant life areas and has severe symptoms of emotional, behavioral, or cognitive problems that interfere with the client's participation in Tx activities.	Displays inconsistent compliance, minimal awareness of either the client's addiction or mental disorder, and is minimally cooperative.	Poor recognition and understanding of relapse and recidivism issues and displays moderately high vulnerability for further substance use or mental health problems. Has few coping skills, rarely applied.	Not engaged in structured, meaningful activity and the client's peers, family, significant other, and living environment are unsupportive, or there is significant criminal justice system involvement.
4	Incapacitated with severe signs and symptoms. Displays severe withdrawal and is a danger to self or others.	Unable to participate in Tx and has severe medical problems, a condition that requires immediate intervention, or is incapacitated.	Severe emotional or behavioral symptoms that place the client or others at acute risk of harm. Intrusive thoughts of harming self or others. Unable to participate in Tx activities.	(A) Non compliant with Tx and has no awareness of addiction or mental disorder and does not want or is unwilling to explore change or is in total denial of the illness and its implications, or (B) Dangerously oppositional to the extent s/he is a threat of imminent harm to self and others.	No recognition or understanding of relapse and recidivism issues and displays high vulnerability for further substance use disorder of mental health problems. No coping skills to arrest mental health or addiction illnesses, or prevent relapse.	(A) Chronically antagonistic significant other, living environment, family, peer group or long-term criminal justice involvement that is harmful to recovery or Tx progress, or (B) Actively antagonistic significant other, family, work or living environment, with immediate threat to the client's safety.

KEY

☐ If it is determined that the client is in severe withdrawal/is likely to be a danger to self or others; has severe medical problems that require immediate attention; or has severe emotional or behavioral symptoms that place the client or others at risk of harm, the interview is ended and appropriate services are provided.

☐ Clients are entitled to receive any treatment services that respond to the need/scores in each of the six dimensions when they:

- Meet CCDTF eligibility guidelines, AND
- Meet DSM-IV-TR criteria for substance use disorder, AND
- Receive a Severity Rating of 2, 3, or 4 in Dimension IV, V, or IV.

Service Coordination means helping the client obtain the services and support the client needs to establish a lifestyle free from the harmful effects of substance abuse disorder. Subpart 24a. Of the changes to Rule 25

Room, board, and supervision according to 9530.6530, Subpart 1H and Minnesota Statutes, section 254B.03 and 254B.05

The CCDTF will pay for treatment services that are included in a host county contract.

EXCEPTIONS TO PLACEMENT REQUIREMENTS

Subpart 9. Client Choice: The placing authority must authorize chemical dependency treatment services that are appropriate to the client's age, gender, culture, race, ethnicity, sexual orientation, or disability, according the client's preference. The placing authority maintains responsibility and right to choose the specific provider. The provider must meet the criteria in Minnesota Statutes section 245B.05 and apply under part 9505.0195 to participate in the medical assistance program. The placing authority may deviate from the treatment planning decisions in part 9530.6622 if necessary to authorize appropriate services according to this subpart.

Subpart 10. Distance exceptions. The placing authority may authorize residential service although residential service is not indicated according to part 9530.6622, if the placing authority determines that a non-residential service is not available within 30 miles of the client's home and the client accepts residential service.

Subpart 11. Faith-based provider referral. When the placing authority recommends services from a faith-based provider, the client must be allowed to object to the placement on the basis of the client's religious choice. If client objects, the client must be given an alternate referral.

Subpart 12. Adolescent exceptions. An adolescent client assessed as having a substance use disorder may be placed in a program offering room and board when one of the criteria in item A or B can be documented.

a. The adolescent client has participated in a non-residential treatment program in the past year, and the non-residential treatment proved to be insufficient to meet the client's needs.

b. The adolescent client has a mental disorder documented by a mental health professional, as defined in MN Statutes, section 245.462, subd. 18, and 245.4871, subd. 27, that in combination with a substance use disorder present a serious health risk to a client.

RULE 25 TREATMENT PLANNING DECISION GUIDE

SEVERITY RATING	DIMENSION I Intox/Withdrawal	DIMENSION II Biomedical	DIMENSION III Emotion/Behav/Cogn	DIMENSION IV Readiness for Change	DIMENSION V Relapse/Cont'd. Use	DIMENSION VI Recovery Environ.
0	Tx planning decision isn't impacted.	Tx planning decision isn't impacted.	MAY use the attributes in the risk description to support efforts in other dimensions.	MAY use the attributes in the risk description to support efforts in other dimensions.	MAY facilitate peer support.	MAY use strengths in this dimension to address issues in other dimensions.
1	SHOULD arrange for or provide needed withdrawal monitoring that includes scheduled check-ins as determined by a health care professional.	MAY refer for medical services.	MAY monitoring and observation of behavior to determine whether stability has improved or declined in conjunction with other Tx.	MUST active reinforcement and awareness-raising strategies in conjunction with other Tx services for the client.	MAY promote peer support and authorize counseling services to reduce risk.	MAY promote peer support and awareness raising for the significant other and family.
2	MUST arrange for withdrawal monitoring services or pharmacological interventions with on-site monitoring by specially trained staff for less than 24 hours. MAY authorize withdrawal monitoring as a part of or preceding Tx.	MUST arrange for appropriate health care services and monitoring progress and Tx compliance in conjunction with other Tx services.	MUST Tx services that include referral to and consultation with mental health professionals as indicated, monitoring mental health problems and treatment compliance as part of other CD treatment and adjustment of client's services as appropriate.	MUST recommend Tx services that include client engagement strategies.	A) MUST recommend Tx services that include counseling services to reduce relapse risk and facilitate participation in peer support groups. B) Must promote peer support, counseling services or service coordination to programs complying with 9530.6500 or 42 CFR Part 8. (Methadone)	MUST recommend Tx services that help participation in a peer support group, engage the significant other or family to support Tx, and help client develop coping skills or change the recovery environment.
3	MUST arrange for detox with 24-hour structure. Unless a monitored pharmacological intervention is authorized, the detox must be provided in a facility that meets the client requirements in 9530.6510 to 9530.6590 or in a hospital as a part of or preceding Tx. (Room & Board)	MUST authorize immediate medical assessment services in conjunction with other Tx services. MUST Tx services in a medical setting based on the client's history and presenting problems.	MUST integrated chemical and mental health Tx services provided by provider licensed under part 9530.6495 and provides 24-hour supervision. (Service Coordination) (Room & Board)	MUST recommend Tx services that have specific engagement or motivational capability. (Service Coordination)	MUST recommend Tx services that include counseling services to help the client develop insight and build recovery skills. (Service Coordination) (Possible Room & Board)	MUST recommend Tx services in severity 2 above, service coordination, and assistance with finding an appropriate living arrangement. (Service Coordination) (Possible Room & Board)
4	MUST arrange detox services with 24-hour medical care and nursing supervision preceding Tx.	MUST refer for immediate medical intervention to secure safety. MUST delay Tx services until able to participate in most Tx activities.	MUST refer for acute psychiatric care with 24-hour supervision. MUST delay Tx services until risk description reduced to severity 3 in this dimension or must refer to a mental health crisis response.	MUST recommend Tx services that include (A) service coordination and specific engagement or motivational capability; (Service Coordination) or (B) 24-hour supervision and care that meets the requirements of 9530.6505. (Service Coordination) (Room & Board)	MUST recommend Tx services that include counseling services to help develop insight, service coordination, and may include room and board with 24 hour structure. (Service Coordination) (Room & Board)	MUST recommend Tx services that include room and board with 24-hour structure if appropriate living environment is not readily available. Must also include either (A) the Tx in severity 3 above and appropriate ancillary services or (B) Tx services that include service coordination and immediate intervention to secure safety. (Service Coordination) (Room & Board)

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MEMBERSHIP ROSTER

APPENDIX D

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APPENDIX D

MEMBERSHIP ROSTER

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