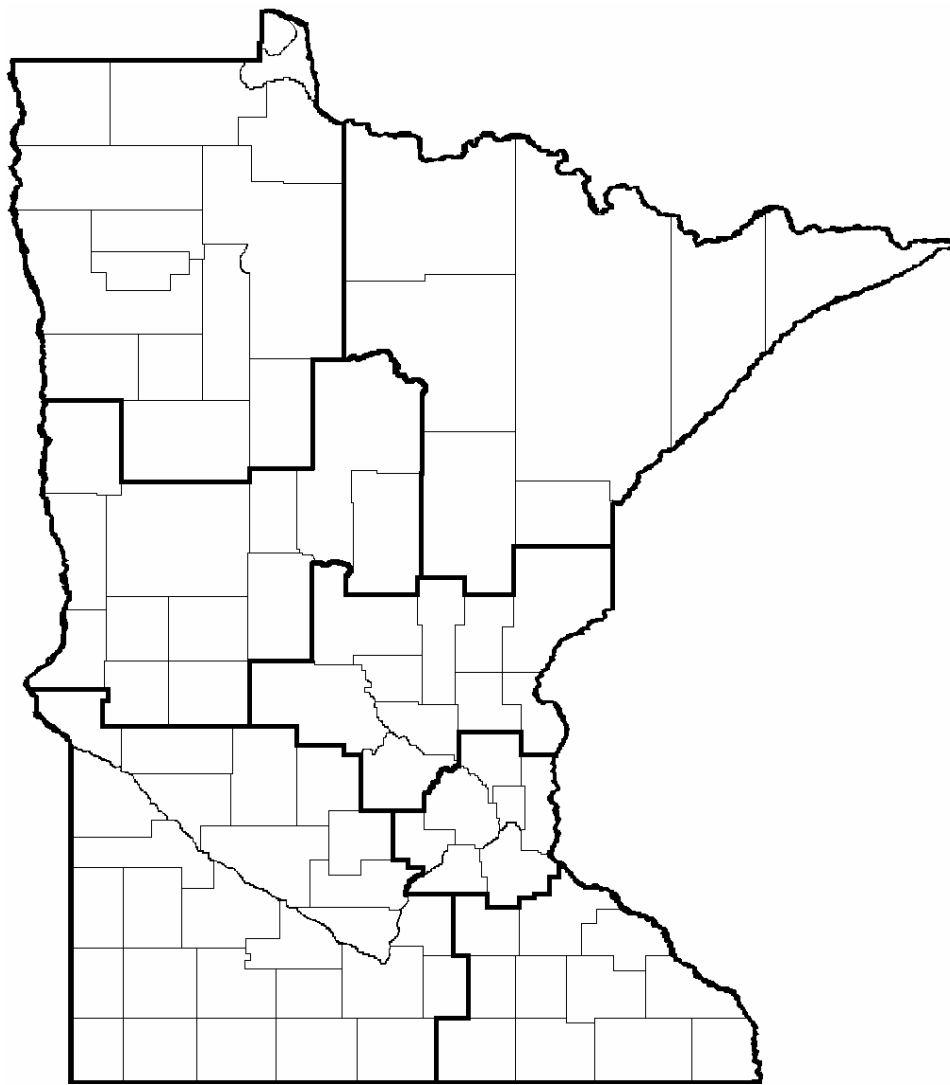


ANALYSIS REPORT

The Consolidated Chemical Dependency Treatment Fund



Chemical Health Planning Regions

**Minnesota Department of Human Services
Chemical Health Division
September, 2006**

Consolidated Chemical Dependency Treatment Fund Analysis Report

Introduction

The purpose of this report is to analyze the performance of the Chemical Dependency Consolidated Treatment Fund (CCDTF) over time, and to place the CCDTF in context with broader information about substance abuse. The report briefly describes how Minnesota compares to other states in terms of problem levels and problem response levels. Chemical dependency is described as it is now understood by researchers, along with a discussion on the etiology of chemical dependency. Data on treatment performance are discussed using information from Minnesota and from other states. The costs and benefits of treatment are discussed, primarily confined to studies of direct cost impact on government so that soft costs, such as pain and suffering, are not included. Analysis is made of who is served by the CCDTF, and how that is changing over time. CCDTF operations and financial performance are described over time in comparison to other funding systems. Then the relationships between the CCDTF and other programs are described. Finally, a summary of the elements of the CCDTF that could be improved are described, along with recommendations for further action regarding CCDTF operations, treatment and treatment support activities.

This report was prepared by staff of the Minnesota Department of Human Services Chemical Health Division, with assistance from the Performance Measurement and Quality Improvement Division, the Reports and Forecasts Division, Financial Management Division, and Dan Newman of Newman Associates. Questions or comments regarding this analysis may be directed to Wayne Raske at (651)431-2464 or wayne.raske@state.mn.us.

TABLE OF CONTENTS

BACKGROUND	2
<i>What is the CCDTF?.....</i>	<i>2</i>
<i>What is chemical dependency?.....</i>	<i>2</i>
<i>Is it behavior choices, or an illness?.....</i>	<i>5</i>
<i>The stigma of chemical dependency.....</i>	<i>7</i>
<i>What is treatment?</i>	<i>8</i>
<i>What is Minnesota's Treatment Need?</i>	<i>10</i>
THE PUBLIC BENEFITS OF TREATMENT.....	13
<i>Client Benefit</i>	<i>13</i>
<i>Completion and Relapse</i>	<i>14</i>
COST BENEFIT OF CHEMICAL DEPENDENCY TREATMENT	16
<i>Client and Cost Benefit External Studies.....</i>	<i>17</i>
CCDTF TREATMENT ACTIVITY	18
FUND STRUCTURE.....	18
CONSOLIDATED CHEMICAL DEPENDENCY FUND OPERATIONS.....	23
<i>Principles.....</i>	<i>23</i>
<i>Operations</i>	<i>23</i>
<i>CCDTF Activity Over Time</i>	<i>28</i>
<i>The Role of the CCDTF in the Overall Treatment Industry.</i>	<i>29</i>
<i>Ongoing Efforts to Improve the CCDTF and Treatment Services.....</i>	<i>30</i>
<i>Relationship to Minnesota Health Care Programs (MHCP)</i>	<i>31</i>
MAJOR ISSUES AND CHALLENGES FOR THE CCDTF	33
<i>Fund Operations</i>	<i>33</i>
<i>Recommendations for Action</i>	<i>35</i>
RECOMMENDATIONS FOR FURTHER ANALYSIS.....	38
APPENDIX FIGURE 1 – SUMMARY OF COST BENEFIT STUDIES.....	40
<i>Figure 2 – 2004 Department of Corrections Cost.....</i>	<i>40</i>
<i>Figure 3 – Percent of County Placements Paid from County Funds, 2004.....</i>	<i>41</i>
<i>Figure 4 – County Resident DWI Arrests Per 1,000.....</i>	<i>42</i>
<i>Figure 5 – CCDTF County Expense as Percentage of County Levy</i>	<i>43</i>
<i>Figure 6 – County CCDTF Admissions per 1,000.....</i>	<i>44</i>
<i>Figure 7 – Percentage of Allocation Fund Used</i>	<i>45</i>
<i>Figure 9 – Percentage Change in Primary Alcohol Problem CCDTF Admissions.....</i>	<i>47</i>

Background

What is the CCDTF?

The Chemical Dependency Consolidated Treatment Fund (CCDTF) is a State-operated, County managed system for 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. The CCDTF is the largest single treatment funding source in Minnesota, functioning as the primary payment source for 45% of all admissions.

What is chemical dependency?

Chemical dependency is a condition in which mood altering substances have caused changes in a person's body, mind, and behavior. As a result of this, dependent persons are unable to control their use of substances, despite the bad things that happen when they use them. Chemical dependency is a chronic, relapsing disorder and if the disease process progresses, recovery becomes more difficult. Chemical dependency may cause death if the person does not completely abstain from using alcohol and other mood-altering drugs. The International Classification of Diseases, 10th edition, defines Chemical Dependency as three or more of the following in a 12 month period.

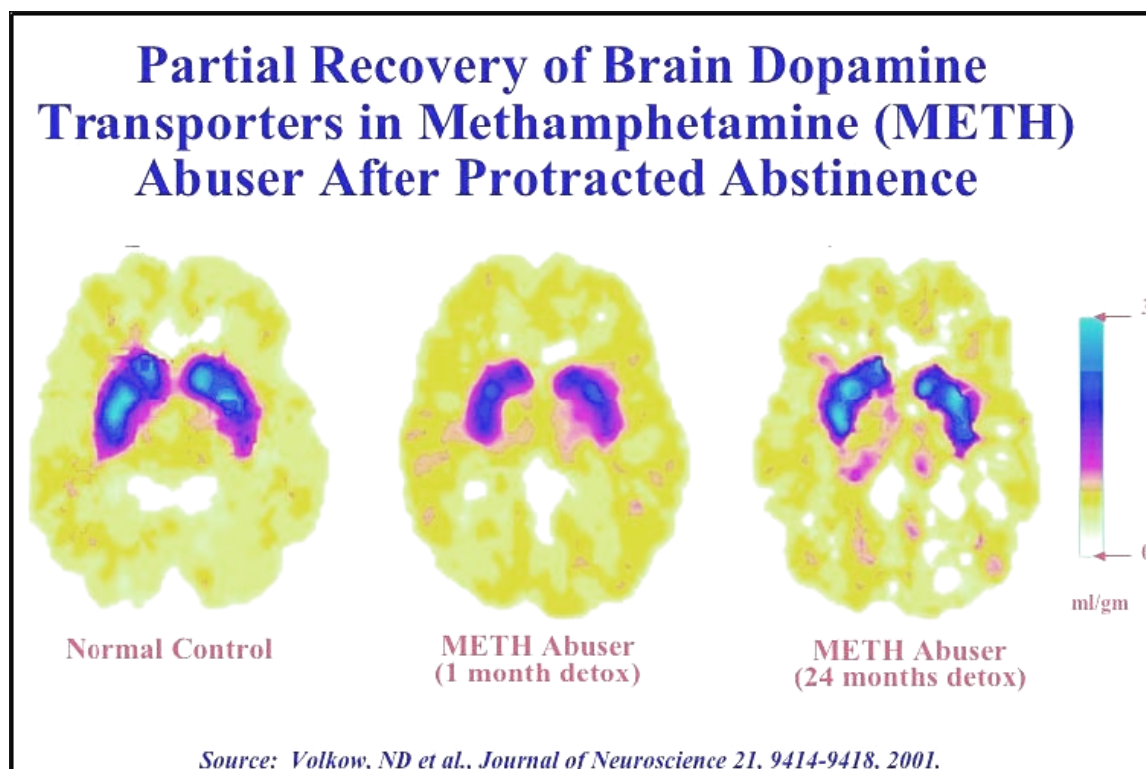
1. Difficulties in controlling substance-taking behavior in terms of its onset, termination, or levels of use
2. A strong desire or sense of compulsion to take the substance
3. Progressive neglect of alternative pleasures or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects
4. Persisting with substance use despite clear evidence of overtly harmful consequences, depressive mood states consequent to heavy use, or drug related impairment of cognitive functioning
5. Evidence of tolerance, such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses
6. A physiological withdrawal state when substance use has ceased or been reduced, as evidence by: the characteristic withdrawal syndrome for the substance; or use of the same (or a closely related) substance with the intention of relieving or avoiding withdrawal symptoms

Chemical dependency is an illness. Historically there has been a debate about whether chemical dependency was a character defect, a matter of lack of will power, or a matter of personal responsibility (more on this later). Chemical dependency has been viewed as an illness by all major medical associations, including the American Medical Association and the World Health Organization, for several decades. One of the earliest calls for this view of the condition in Minnesota was made by Dr. Charles Hewlitt of the Minnesota Board of Health in 1871. In 1913, the first State facility for care of alcoholics was opened in Willmar. In 1969, the Legislature included chemical dependency as one of the health conditions to be included in the Minnesota Hospitalization and Commitment Act.¹ That same year the Minnesota Supreme Court ruled that laws criminalizing public intoxication were not constitutional when applied to alcoholics unable to control drinking. The Court also took notice that the new commitment law indicated a legislative will to treat alcohol and other drug dependency as a disease.²

¹ Minnesota Statutes, Chapter 253A; which was repealed in 1982 as new commitment standards were placed in Chapter 253B.

² State vs. Fearon; 238 Minn. 90; 166 N.W. 2nd, 720, 1969

Chemical dependency is a brain disease. Since the policy changes of the 60's and 70's, knowledge of chemical dependency and its effects on brain and other physical functioning has been constantly improving. Increasingly, the evidence is showing and the majority of the biomedical community now believe that chemical dependency is a brain disease, whereby persistent changes occur in brain structure and function.³ However, the illness has several dimensions, including physiological and psychological harm to the individual, which in turn damage the person's ability to maintain familial, social, and economic relationships in a functional manner. These difficulties are magnified if the person has concurrent mental illness or other brain function issues such as Traumatic Brain Injury. The research is also finding that brain changes caused by chemical dependency, while usually not permanent, persist for significant periods of time after the person stops abusing chemicals. This helps us understand why chemically dependent people experience serious craving for their drug of dependency sometimes years after physical withdrawal issues have been resolved.



Chemical dependency is associated with a variety of other illnesses. This is an issue gaining increasing attention. In addition to the well known causal influence of substance abuse on other illnesses, the association is now believed to involve mutual causation, with some physical and mental illnesses functioning as risk factors for substance abuse. In studies of people in their 30's with chemical dependency, 40% were found to have another chronic physical illness.⁴ This proportion of additional serious illness increases as the severity and chronicity of chemical dependency increases. A study of late stage chemically dependent people in Hennepin County found that the number of serious diagnoses among the population was greater than the number of people studied. In other words, several people had more than one serious chronic physical

³ Addiction is a Brain Disease; Alan Leshner; Issues in Science and Technology Online; Spring, 2001.

⁴ De Alba, I., Samet, J.H. and Saitz, R. Burden of Medical Illness in Drug and Alcohol Dependent Persons without Primary Care. American Journal of Addiction, 13, pp. 33-45, 2004.

disease diagnosis in addition to chemical dependency.⁵ The association between illness and chemical dependency appears to be in both directions, with chemical abuse increasing risk for other chronic illness, while some chronic illnesses act as risk factors for chemical dependency. One recent finding is that pain-related diagnoses are more common among those addicted to narcotic medications or illicit narcotics.⁶ This implies that in some cases the drug use was initially an attempt at self-medication. Finally, there is ample research that mental health problems make a person more vulnerable to chemical dependency. We also find the reverse: that substance abuse over time can cause serious mental health problems.⁷

Age of onset matters. The majority of those who appear for chemical dependency treatment initiated their drug use prior to age 18. For all adults presenting for treatment with a primary alcohol problem, the median client first used alcohol to intoxication at age 15, and 30% first used to intoxication by age 13. For marijuana, the median client began use at age 14, and 30% first used by age 12. For our youth, the thrill-seeking impulse can lead to abuse of chemicals that damage the very areas of the brain that generate impulse control in adults. Current research shows that the brain is still under development until the 19-21 age range, and that one of the last areas of the brain to fully develop is the prefrontal cortex, where we process complex information, and where our impulse control comes from. This provides a physiological basis for the already well known fact that youth have less impulse control and are less able to make decisions based on long term consequences than adults. It has also been found that youth experience less initial physical impairment than adults when drinking, and can and do consume more alcohol per body weight than adults.⁸ But when the impulse is to abuse alcohol or drugs researchers believe there is also an effect on brain development that can permanently change the person's impulse control. Animal studies on alcohol abuse, while at a preliminary stage, show that those abusing during brain development have more damage to the prefrontal cortex and to long-term memory than those who start abusing after the brain is developed.⁹ This implies that abuse can permanently impair impulse control and other prefrontal cortex functions.

Where does chemical dependency come from?

Much research has been conducted regarding the etiology of chemical dependency. Several factors have been identified as risk factors for chemical dependency. There are family, environmental, and genetic factors that all contribute to risk of chemical dependency. Genetic studies find that identical twins are far more likely than fraternal twins to have the same likelihood of drug problems, when both groups are pairs raised together and having similar life experiences. Studies have been able to estimate the amount of risk that comes from genetic factors we all share, and compare that to specific genetic factors that are not shared by the general population. The contribution of inheritance to the likelihood of becoming chemically dependent varies by drug. For some drugs, especially opiates, analysis has found genetics to be more important than any other risk factor.¹⁰

⁵ Thornquist, L., Biros, M., Olander, R., Sterner, S.; Health Care Utilization of Chronic Inebriates; 2001.

⁶ Mertens, J.R, Lu, Yun W., Parthasarathy, S., Moore, C. and Weisner, C.M. Medical and Psychiatric Conditions of Alcohol and Drug Treatment Patients in an HMO. Archives of Internal Medicine, 163(20), pp. 2511-2517, 2003.

⁷ Sokolov, B.P., Schindler, C.W. and Cadet, J.L. Pharmacology Biochemistry and Behavior, 77, pp. 319-326, 2004.

⁸ Spear, L.P.; Alcohol's Effect on Adolescents; Alcohol and Health Research World; 26(4).

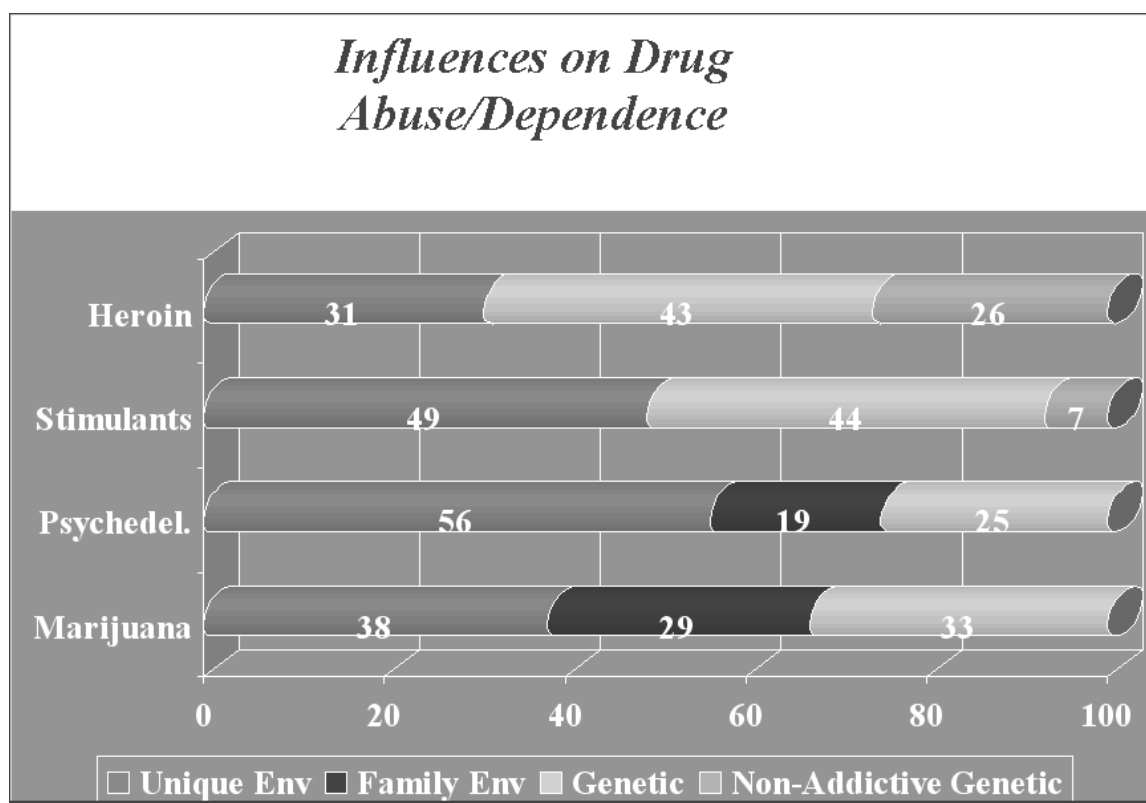
⁹ Winters, Ken C. Ph.D.; Adolescent Brain Development and Drug Abuse; Report to the Treatment Research Institute; November, 2004.

¹⁰ Using Twin Data To Identify Alternative Drug Abuse Phenotypes; Ming T. Tsuang, M.D., Ph.D.; presentation to the American Psychiatric Association, May, 2004.

But genetics is not everything. As illustrated in the figure below, each person's unique environment and family environment contribute to risk of chemical dependency. People without the genetic pre-disposition can and sometimes do abuse chemicals and have serious problems, while others with genetic risk do not have problems with drugs. As Howard Schaffer of Harvard Medical School Division on Addictions states,

*"It is interesting to recognize that as we understand more about the biology of addiction, social and cultural influences become more—not less—important. To illustrate, not everyone who is predisposed genetically to alcoholism develops the disorder. Some people who are not prone biogenetically to alcoholism or other addictions will acquire the condition. Therefore, social and psychological forces will remain very important in determining who does and who does not develop addictive behaviors"*¹¹

Elsewhere Shaffer points out that it's really not about the drug, but about the person. People get addicted to behaviors other than drug taking, and we have documentation that compulsive gamblers who do not abuse chemicals can experience symptoms similar to those for narcotic, stimulant or poly substance withdrawal after quitting gambling.¹²



Is it behavior choices, or an illness?

Opinions vary on the degree to which initial drug use is a voluntary decision for which the individual is responsible. Many people use licit and illicit drugs to feel good – to obtain the high that enhances other recreational activity, and it seems reasonable to ascribe that use to personal decisions. Most people doing this do not become dependent, though the risk of dependency varies by the drug type that is used. The responsibility issue comes more to the fore when the

¹¹ Schaffer, Howard, Ph.D., C.A.S, website of the Division on Addictions of Harvard Medical School (<http://www.hms.harvard.edu/doa/>) © The President and Fellows of Harvard College; January, 2005.

¹² Schaffer, Howard, On the Nature and Meaning of Addiction; *National Forum*, Fall 1999

substance is illegal. The issue is more clouded when the drug in question is licit, or when the person's life is fraught with risk factors for chemical use and abuse. While some initial drug use is purely recreational, for those who have a mental illness, serious physical illness, or a history of trauma from childhood abuse or other past traumatic stress even the first use may not have been about having fun.

Finally, caution should be used in ascribing personal responsibility when the initial use decision is made while the person is an adolescent. DAANES adult treatment data indicate that 30% of those admitted to treatment used alcohol to intoxication prior to age 14, and over 70% used alcohol to intoxication prior to age 17 (median age is 15). Prior to reaching age 13, a third of clients had used marijuana, 2.4% had used cocaine, and 3% had used methamphetamine. Prior to reaching age 15, the proportions are 66% for marijuana, 9% for cocaine, and 12% for methamphetamine.

Minnesota Student Survey data find that 8% of students are in need of treatment. Of those students in need of treatment, 58% have one or more of the following risk events in their life:

- 20% have been sexually abused;
- 25% have been physically abused;
- 37% have an alcohol problem in the family; and
- 31% have a drug problem in the family.

Scientists agree that for chemically dependent people drug use is no longer a voluntary activity. Despite decades of contrary research, it is still common to find large portions of the general public taking the view that chemical dependency is a behavioral issue, and that all dependent people need to do is have a sincere desire to stop using. This is accompanied by a misconception of what drug use is, from the point of view of the dependent person. While initial alcohol or drug use is pleasurable, for chemically dependent people the drug use often has changed to a search to feel normal and healthy. For certain classes of drugs, the street slang when dependent people seek drugs refers to the need to “get well” rather than to “get high.” On the other hand, many researchers agree with what has long been the premise of most self help movements regarding chemical dependency: that there is a personal responsibility element to gaining and retaining a life of recovery.

While drug use is not voluntary for dependent people, they remain responsible for many other life choices. The 1971 Minnesota law that decriminalized public intoxication included a clear provision that intoxication is not a defense when charged with a crime. There is also little controversy over society's stance that those who victimize others through criminal activity to support an expensive drug addiction should be held as accountable as anyone else for that behavior. Perhaps the clearest position on this question comes from Dr. Alan Leshner, CEO of the American Association for the Advancement of Science and former director of the National Institute on Drug Abuse.

“The clear and unambiguous message from 25 years of scientific research is that drug abuse and addiction are complex, dynamic processes. No aspect will be explained or resolved simply by choosing from a list of either/or options. There are no simple solutions. The correct answer is: “All of the above.” The assumption that addictive behavior must be either voluntary or a manifestation of brain disease is a case in point. In fact, addiction encompasses both voluntary and compulsive behaviors. A person makes a voluntary decision to use a drug, and continues to use it until the repeated drug exposures change the brain's structure and functioning. As a result of these changes, the individual's scope for voluntary acts becomes severely restricted, particularly with

respect to drug use. He or she now exhibits the essential features of addiction-compulsive, nearly irresistible drug craving, seeking, and use.

In fact, it even oversimplifies the facts to say that drug abuse is voluntary at first and subsequently becomes involuntary. There are voluntary and involuntary components to every stage of the process that leads from the initial decision to take a drug through addiction and treatment to abstinence. We know, for example, that many factors that people cannot control can either increase or decrease their likelihood of making the initial voluntary decision to use drugs. They include the quality of parenting one receives and whether or not one has undiagnosed or untreated mental illness or is exposed to a good prevention program.”¹³

Other research calls into question whether the move from first use to first abuse is, strictly speaking, as voluntary as it first appears. As the Director of the National Institute on Drug Abuse, Dr. Nora Volkow, points out:

“New imaging technologies reveal the neurochemical and functional changes that occur in the brains of drug-addicted individuals. These same techniques also demonstrate that individual differences in the numbers of certain brain receptors can predict whether a person will find a drug to be pleasant or aversive.”¹⁴

In other words, each of us has a different response to any chemical, even on first use. A drug that has a high risk for one person could pose little risk to another person. This loops the discussion back to genetics. A person who has an aversion to alcohol intoxication is having a very different experience from a person who finds intoxication enjoyable. Much of that difference is due to genetic factors. As we would expect, people who don't enjoy alcohol intoxication don't pursue the experience, and don't become alcoholic. By following normal human drives, a serious health problem is avoided. That same person, however, could be more vulnerable than the alcoholic is to dependency on another drug type such as a stimulant or nicotine. Initial use decisions are influenced in a variety of ways including peers, family, media treatment of substance abuse, availability of drugs, perceptions of risk, physical health (especially chronic pain), and social/psychological stress. But once the person reaches the stage of chemical dependency, the changes have become physiological. In the end, it's mainly about the brain, and our ability to connect the person to the supports and services that can supply the assistance necessary for the individual to overcome this condition.

The stigma of chemical dependency.

While science is clear that addiction is a brain disease, and that the majority of factors that lead to dependence are not tied to morality, strength of character, or personal responsibility, this view is not shared fully by the public, or even by the health care community. A survey sponsored by the Community Anti-Drug Coalitions of America (CADCA) set out to measure the attitudes and misperceptions of 1000 adults from the general population plus 300 physicians and 503 individuals in recovery from alcohol use disorder.

“The vast majority of those surveyed (91% of primary care physicians, 89% of people in alcohol addiction recovery, and 80% of the general public) say that there is a stigma toward alcoholics. That stigma extends to people in recovery. About three quarters (73%) of primary care physicians and individuals in recovery (71%) believe that there is a

¹³ *When the Question Is Drug Abuse and Addiction, the Answer Is 'All of the Above';* Dr. Alan I. Leshner; http://www.drugabuse.gov/NIDA_Notes/NNVol16N2/DirRepVol16N2.html; May, 2001.

¹⁴ *Measuring the Effectiveness of Drug Addiction Treatment* - Testimony before the House Committee on Government Reform Subcommittee on Criminal Justice, Drug Policy and Human Resources - United States House of Representatives; Dr. Nora Volkow; March, 2004.

stigma toward alcoholics in recovery, compared with 51% in the general public survey sample. As a side comparison, when an obese person is losing weight, it is often viewed in a positive light -- not so for recovering alcoholics. In all 3 survey populations, denial or refusal to admit severity of the problem and fear of social embarrassment were the top 2 reasons for not seeking help with alcohol addiction. In the general public, 66% believe that social embarrassment and fear of discrimination are major barriers to treatment for people with alcohol addiction. The majority of the general public (63%) believes that alcoholism is caused, at least in part, by moral weakness, compared with 43% of physicians and 11% of individuals in recovery.”¹⁵

When over 40% of physicians and two-thirds of the general public see moral weakness as a factor in chemical dependency, it is little wonder that people are reluctant to come forward for help with their alcohol or other drug problem. This means that effective public health models must include affirmative outreach to those in need, as opposed to waiting for the person to come to the system requesting help.

In research conducted just across our Northern border by the Canadian Centre for Addiction and Mental Health, it was found that people with chemical health issues experienced both the most positive and the most negative attitudes from those working most closely with the individual, including workers in the legal and health/human services systems. This Ontario study found the most stigma attaches to

- people who use illegal drugs, especially injected drugs;
- women, especially pregnant women and mothers;
- youth and the elderly; and
- Aboriginal people.¹⁶

The study recommends that people in the legal and helping professions be exposed to better information about addictions, and especially to positive stories about the changes that are possible for people who have been dealing with chemical dependency.¹⁷ With such a large difference in attitudes between those conducting scientific research on addiction and others, it is likely that spreading accurate scientific information about chemical dependency would reduce the effect of stigma. With the information we have, this effort should focus first on the helping and legal professions, and on the policy makers affecting the health and legal fields.

Stigma issues also must be recognized by following strict patient confidentiality standards regarding each person's treatment participation. Congress has passed laws and authorized rules that provide a high level of protection for all substance abuse patient information, including the identity of persons seeking or receiving services, for all federally supported treatment. Agencies that provide treatment, diagnosis, or referral for treatment must have “data walls” that prevent sharing of chemical dependency treatment information with other parts of the same agency, except as allowed by these regulations.¹⁸ These regulations are intended to maximize a person's ability to voluntarily seek treatment. However, these same regulations present challenges when attempts are made to address chemical health problems through multi-agency and multi-disciplinary approaches.

What is treatment?

¹⁵ Results of a newly completed Survey on Attitudes Toward Alcoholism; Alan Rivlin, presentation to MedScape CME project; report on a survey conducted by Peter D. Hart Research Associates, August, 2005.

¹⁶ Note that in Minnesota, by resolution of the Minnesota Inter-tribal Council, the preferred term is “American Indian.”

¹⁷ Project to Address the Stigma of Addiction; Margaret Kittle Canale and Ellie Munn; Issue 3, Newsletter of the Canadian Centre for Addiction and Mental Health; Fall/Winter, 2000.

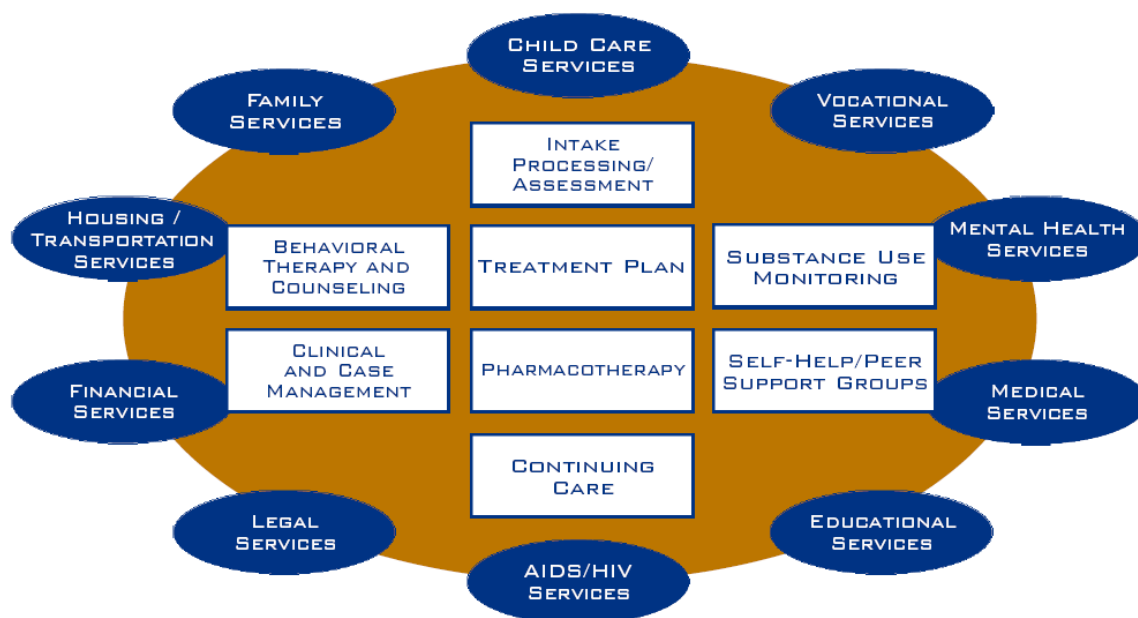
¹⁸ See Title 42, parts 2.1 to 2.67, of the Code of Federal Regulations.

Chemical dependency treatment is an array of individualized services that are intended to help the individual cope with drug craving, develop skills to avoid relapse, and orient the person to on-going participation in recovery oriented activities, services, and in some cases supportive medications. In most programs in Minnesota specific orientation to the traditions and concepts of Alcoholics Anonymous are included in the treatment process, in the context of other programmatic frameworks for provision of therapies that promote recovery.

Medical experts today generally consider alcohol and other drug dependence to be a disease that, while treatable, is chronic and relapsing. 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. Addiction and its related problems can be treated successfully, but no single treatment works for all substances, or for all substance abusers.

Substance abuse treatment may be based on one of several traditional approaches. These different approaches emphasize different elements of the disease and the recovery process. They include medical, social and behavioral models. There are also non-mainstream models of treatment such as traditional healing practices associated with specific cultural groups.

Components of Comprehensive Drug Abuse Treatment



The best treatment programs provide a combination of therapies and other services to meet the needs of the individual patient.

Treatment may use a combination of therapies, such as pharmacological therapy to treat certain dependencies (for example, the use of methadone for heroin dependence or the use of Antabuse to treat alcoholism); use of psychological therapy or counseling, education and social learning theories; and non-traditional healing methods such as acupuncture.¹⁹

Treatment may extend over the course of weeks, months, or years, depending on the severity of the alcohol and/or other drug problem and the level of burden created by clients' multiple

¹⁹ Detailed information, research summaries, and treatment manuals on various treatment therapies are made available on the world-wide web by the National Institute on Drug Abuse at <http://drugabuse.gov>.

disorders, such as HIV/AIDS, mental illness (depression being the most frequent), serious physical illnesses, and socio-economic barriers to recovery. The concepts of treatment and recovery are not one and the same. However, treatment is a very important part of the recovery process.

When the formal treatment component(s) are completed, whether outpatient, inpatient or short- or long-term residential treatment, this is not the final problem resolution for anyone with an addiction problem. Recovery is a lifelong process, with continuing risk of relapse.

Treatment Providers. Minnesota generally has adequate availability of chemical dependency treatment, but not for certain kinds of treatment. There are capacity issues for specialty programs including Methadone, services for women and children, and mental illness-chemical dependency services. Licensing rules no longer distinguish between program types, but emphasize the implementation of individual treatment plans by all providers. The following types of service are supported by the Consolidated Chemical Dependency Treatment Fund (CCDTF). In several cases a single provider is operating more than one of the following types of programs.

Outpatient chemical dependency treatment. Outpatient treatment programs are treatment programs providing primary or post-primary treatment care. There are 223 outpatient programs with an estimated static capacity of 3,560.

Primary inpatient treatment programs provide intensive, primary therapeutic services. There are 44 licensed programs with a combined static capacity of 1,257.

Extended care programs offer a long-term combination of in-house chemical dependency services and community ancillary services. There are 33 licensed programs with a combined capacity of 621.

Halfway House programs have an emphasis on aftercare, community ancillary services, and securing employment. There are 53 halfway houses with a combined capacity of 1,045.

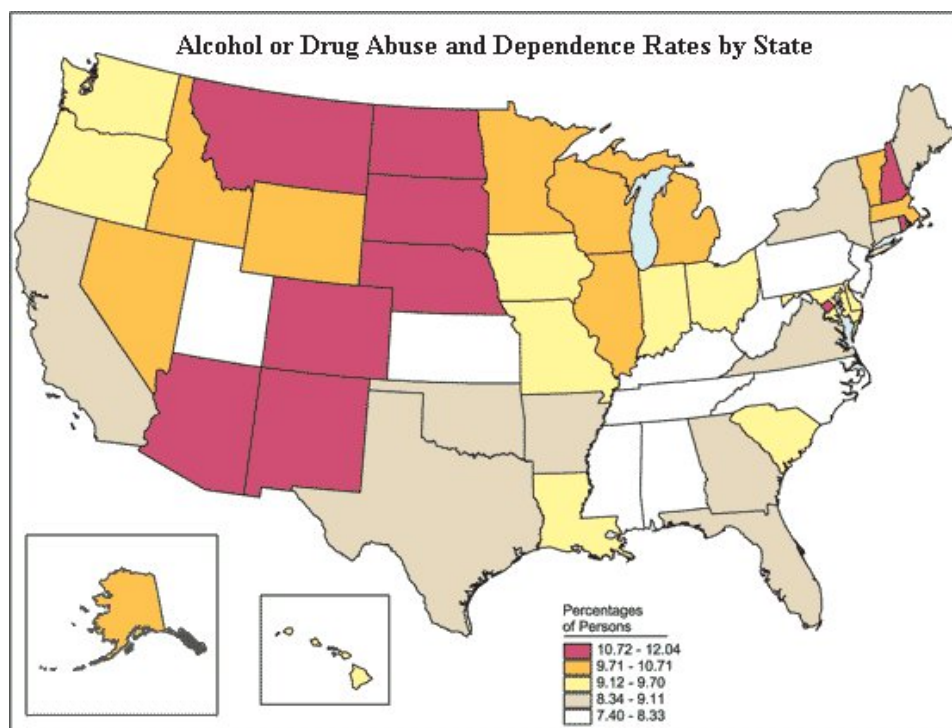
What is Minnesota's Treatment Need?

Minnesota has more people who need treatment and aren't getting it than most other states.

An estimated 387,600 adult Minnesotans were in need of chemical dependency treatment in 2005.²⁰ Of that number, approximately 12% received treatment. While Minnesota is not in the highest category on this measure, more than half of the states have less unmet treatment need per capita.²¹ As can be seen in maps supplied in the Appendix, not all areas of the State have the same treatment need, or the same treatment demand. The Northcentral, Northwestern and Eastcentral regions of the State have more treatment need than other regions of the State. Males are more likely than females to need treatment. Asians are less likely than Caucasians or African Americans to need treatment, while American Indians are more likely than other groups to need treatment.

²⁰ Estimating the need for Treatment for Substance Abuse Among Adults in Minnesota: 2004/2005 Treatment Needs Assessment Survey Final Report; Eunkung Park, Ph.D.; Minnesota Department of Human Services report, January, 2006.

²¹ National Survey on Drug Use and Health; Office of Applied Studies, Substance Abuse and Mental Health Services Administration, Department of Health and Human Services; 2003.



Factors associated with treatment need. There are several correlates to a person needing treatment, according to Minnesota needs assessment data. Males are three times more likely than females to need treatment. In terms of ethnicity, American Indians are twice as likely as Caucasians and African Americans to need treatment, while Asians are only a third as likely as Caucasians and African Americans to need treatment.²² This strong association between ethnicity and chemical dependency is consistent with research findings on the genetic factors associated with risk. However, the serious social and economic stressors that persist in American Indian communities make this finding consistent with the view that, in addition to genetic factors, environmental stress, present and historical trauma, and cultural displacement can add significantly to a person's risk for chemical dependency.

Over 9% of the adult population, or approximately 387,600 Minnesotans, are estimated to be in need of substance abuse treatment. 8% have an alcohol disorder, and 2.2% have a drug disorder (duplicated).

Problem event data show that alcohol and drug problems are not evenly distributed in Minnesota. As illustrated by maps in the appendix, there is a wide variance among counties in the prevalence of problem events associated with chemical use problems such as detoxification admissions, alcohol and drug impaired driving apprehensions, and drug arrests.

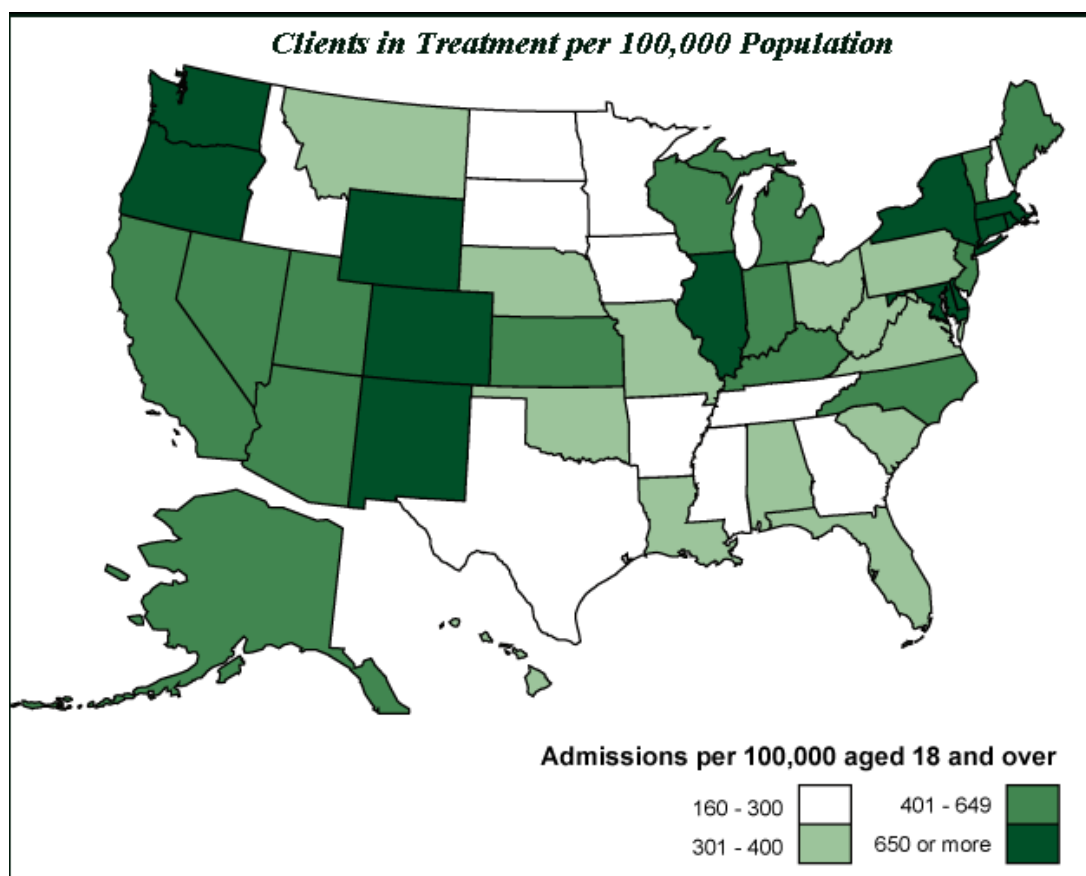
Minnesota's treatment clients are presenting more complex problems than in the past.

Compared to a decade ago, treatment clients are more likely to be addicted to drugs other than alcohol, and to be receiving other services from criminal justice and social service agencies. Household incomes, unadjusted for inflation, have declined since 1994. In general, the client funded by public programs is more likely than others to have serious problems and to be in

²² Minnesota Adult Household Survey data, 1997

poverty. Those funded by the CCDTF are slightly worse off than those in a Minnesota Health Care Plan, who in turn are not as well off as those funded by non-public sources.

Minnesota has fewer people in treatment than most other states. The annual Federal survey of all programs found Minnesota in the lowest quartile among the states for percentage of population in treatment. 45,000 treatment admissions occur annually in Minnesota. Of this number, 24,000 or just under half are funded through the CCDTF. From this, it appears that Minnesota is not doing as well as some other states at getting the treatment services to the person. It is known that the most common reason for a person to not enter treatment is that the person does not perceive the need for treatment.²³ In a great many chemical dependency admission scenarios, it is the patient who is the least convinced of the need for care, while the need is obvious to family, employer, and sometimes to local court and social service agencies.



Federal surveys find that of those who appear to need treatment, only 6% of drug abusers and 4.5% of alcohol abusers perceived that they had an unmet need for treatment.²⁴ This means that waiting for people to come to the office to request services is not a very effective approach. As will be quantified and discussed later, most public funded treatment is supplied to people involved in court or local human services processes. It is likely that services are not provided until life issues have deteriorated to the point where the person comes to the attention of

²³ National Survey of Substance Abuse Treatment Services; Substance Abuse and Mental Health Services Administration, Department of Health and Human Services; 2003 data.

²⁴ Reasons for not Receiving Substance Abuse Treatment: The National Survey on Drug Use and Health; Substance Abuse and Mental Health Services Administration, Office of Applied Studies; November, 2003.

child/adult protection or the courts because Minnesota does not have an effective outreach component to those needing treatment.

The Public Benefits of Treatment

- **Treatment benefits most clients.** Several studies and current analysis of readmission of Minnesota's clients show that most people see positive changes in their lives, including changes in chemical use, as a result of treatment.
- **Not all treatment recipients get the same results.** For example, people dependent on alcohol are more likely to experience positive treatment benefits than those dependent on other drugs, and other ethnicities obtain better improvement rates than American Indians and African Americans. There is a small sub-group that does not obtain any significant benefit from repeated exposures to treatment, for whom non-treatment alternatives such as case management and specialized permanent housing obtain better outcomes than continued attempts at more treatment.
- **Treatment pays.** Every known quality cost study has found a positive cost benefit ratio for providing treatment. Washington State documented that the cost of treatment is recouped by reduced direct State expenses within two years.

Client Benefit

All known studies agree that chemical dependency treatment significantly affects future chemical use and reduces the social and legal problems associated with abuse of alcohol and other drugs.

From 1993 to 1999, the Minnesota Department of Human Services contacted a sample of people six months after they received treatment for chemical dependency in order to learn whether they remained abstinent and how their lives had changed.²⁵ The data demonstrate that treatment increases the likelihood of abstinence and substantially improves the lives of those who receive it, reducing their burden on others. Rates of depression, anxiety, violent behavior, and family conflict decline dramatically. For example;

- Rates of arrests and involvement in illegal activities for profit declined by about 75% compared to prior to treatment among adults. Rates of decline are somewhat larger among adults than among adolescents.
- About 59% of adults and 21% of adolescents report being abstinent six months after treatment. Two factors stand out as increasing the likelihood of abstinence.
 - The first of these is completion of treatment; Harrison and Asche note that "completion is the most consistent predictor of abstinence." Completion of treatment has been found to predict good outcomes after treatment. The percentage completing treatment varies by the primary drug problem the client brings to treatment.

2004	Methamphetamine		Alcohol		Cocaine		Crack		Marijuana		Other	
Discharge Status	Count	%	Count	%	Count	%	Count	%	Count	%	Count	%
Completer	1,601	58.5	4,738	64.3	264	56.9	1,029	58.4	1,748	56.7	440	54.6
Non-completer	1,134	41.5	2,628	35.7	200	43.1	734	41.6	1,335	43.3	368	45.4

²⁵ The Challenges and Benefits of Chemical Dependency Treatment: Results from Minnesota's Treatment Outcomes Monitoring System 1993-1999; Patricia A. Harrison and Stephen E. Asche; Minnesota Department of Human Services; 2000

- The second factor is involvement in activities designed to maintain recovery, such as aftercare and peer support. Harrison and Asche note that about 80% of adults who are involved in both aftercare and peer support remain abstinent while less than half of those who do neither regularly are abstinent.

DAANES information

The Drug and Alcohol Normative Evaluation System (DAANES) has been operated by the Department of Human Services since 1982. The system was significantly revised in 1993 and is scheduled for further revision, including migration to web-based reporting, in 2006. DAANES has been designed to provide policy-makers, planners, service providers and others in Minnesota with access to current information about chemical dependency treatment activities across the continuum of care. The Department of Human Services is required by statute to collect sufficient information to evaluate the efficiency and effectiveness of treatment. In addition, Federal mandatory reporting requirements known as the Treatment Episode Data Set (TEDS) specify client information that must be provided by all programs receiving federal or state funds.

DAANES collects client intake information including level of care, conditions surrounding admission, legal status, referral sources, demographics, living arrangements, education, veteran status, occupational status, source of financial support, and treatment and detoxification admissions. This form also captures key information for linking to the Consolidated Chemical Dependency Treatment Fund (CCDTF). It also collects client history information, including substance use frequency, age of onset, and route of administration for a variety of substances. It also includes a clinical determination of primary, secondary, and tertiary substances of abuse. Legal questions address whether the client is currently under court jurisdiction, driver's license revocations, lifetime arrests, and recent arrest/conviction. This form also records whether females are pregnant at admission. Discharge information is collected, including reason for discharge (and whether funding limitations cut short the stay), diagnoses, medication and other therapies, disabilities or barriers to treatment, post-treatment environment rating and living situation, occupational status at discharge, involvement in peer support groups, discharge referrals, physical/sexual abuse history, length of stay, cost of treatment, and source of payment.

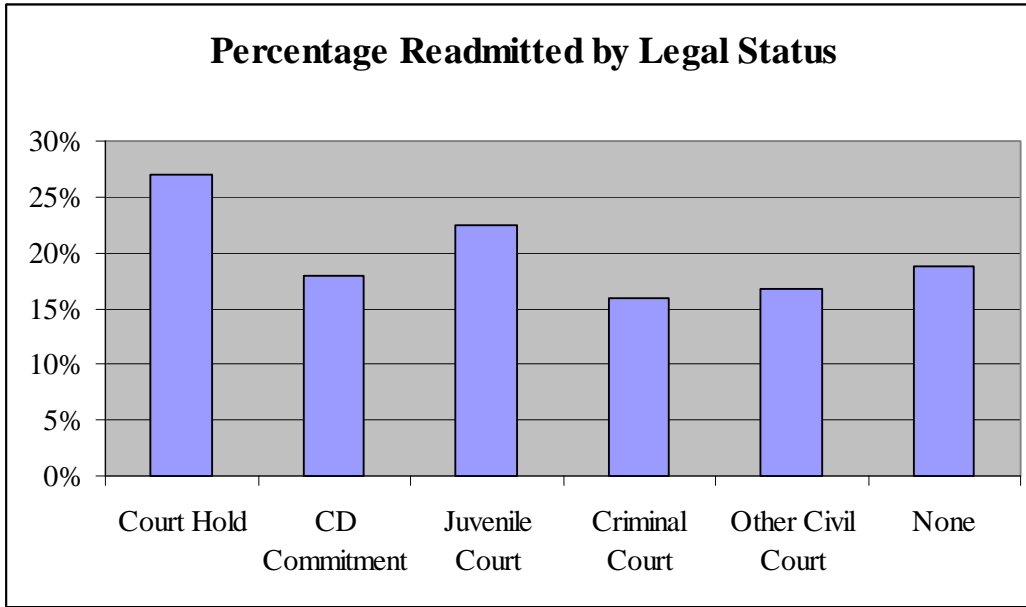
DAANES does not have a direct measure of post treatment outcomes. During the initial phase of DAANES, providers were also requested to fill out six-month follow-up forms on clients served. However, it was found that providers are not able to garner follow-up information that is useful for evaluation purposes. The client pool that is most easily contacted post-treatment is heavily biased toward successful outcome, and location of clients who have changed location was too costly for DAANES reporting programs. Because of this, the program follow-up component of DAANES was discontinued in 1992, when a Federal grant made the TAP study discussed above feasible.

However, there are indirect measures of success. The TAP follow-up study showed that treatment completion was a predictor of treatment benefit. DAANES data are now under analysis for readmission information for clients treated, which is also a useful measure.

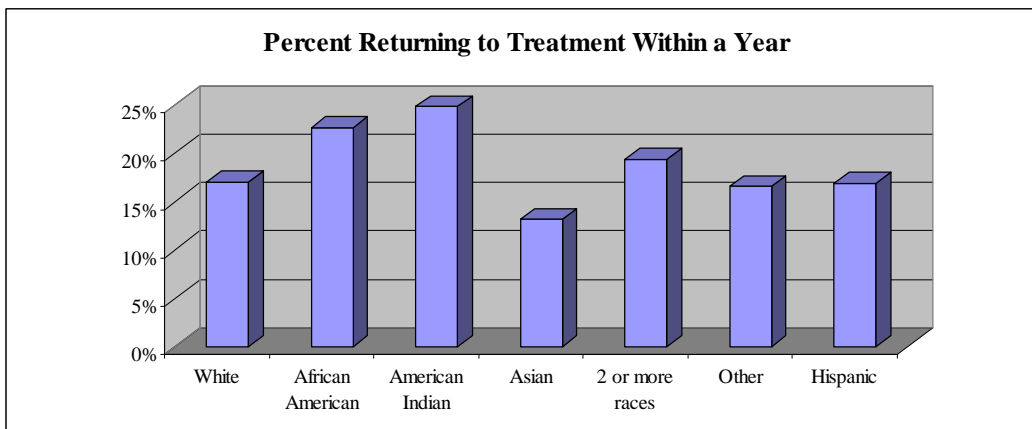
Completion and Relapse

- Analysis of Minnesota's data on program completion for methamphetamine users found that two-thirds of those who do not complete treatment are back in treatment within 30 days. In other words, not all discharges of non-completers indicate client relapse to previous chemical abuse. When a "relapse" is defined as a return to treatment more than 30 days after discharge from a previous treatment, the data become more meaningful. Further analysis of all admissions found that 82% of clients do not relapse and appear again in treatment within the year when these short spans between treatments (less than 30 days) are viewed as a single treatment episode.

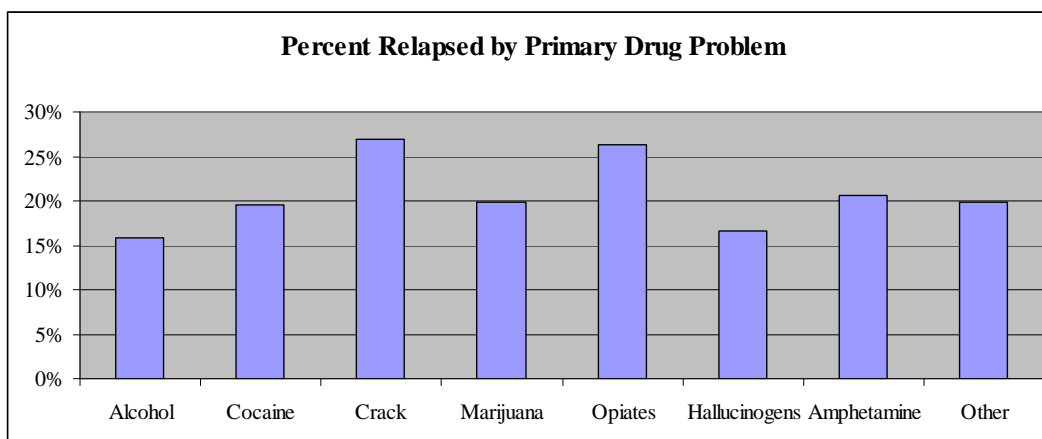
- **Legal status.** Those on court holds and those referred by Juvenile Court are more likely than others to be readmitted within a year of their treatment episode. This may be an artifact unrelated to legal status per se, since juveniles in general have lower completion rates and courts are more likely to refer cocaine and methamphetamine dependent than other case finders, also a group with somewhat lower completion rates. These data also show that the more coercive the court authority, the more likely the person is to not be readmitted. The lowest readmission rate by legal status is for clients who are under criminal court jurisdiction.



- **Ethnicity.** American Indian clients are more likely than others to return for another episode of care within a year, followed by African American and people reporting more than one race.
 - American Indians are more likely to experience problems with alcohol and other drugs, and are more likely than others to have severe forms of chemical dependency. DAANES information finds that American Indians are nine times more likely than others to enter a detoxification program the first time, but are nearly 30 times more likely to have had 20 or more detoxification admissions in their lifetime. African Americans are five times more likely than others to enter detoxification, but this proportion does not increase when looking at the group with 20 or more admissions.



- **Primary drug problem.** Relapse is associated with the person's primary drug problem.
 - Those addicted to crack cocaine or opiates are the most likely to relapse.
 - Marijuana, cocaine and amphetamine users are more likely than people with a primary alcohol problem to return to treatment, but less likely than crack or opiate users.



Cost Benefit of Chemical Dependency Treatment

Studies using a rigorous standard of direct cost savings find a cost benefit range of 1.33 to 6.32 to one. (See appendix)

Costs of Substance Abuse

- A Minnesota Department of Health study found a \$4.5 billion annual cost for alcohol abuse in Minnesota in 2001. 65% of this cost was lost productivity. The estimated cost of health care, including chemical dependency treatment, was \$650 million. Direct costs of \$290 million were found for social services and financial assistance programs. Other direct social impact costs were \$424 million for vehicle crashes, \$94 million for criminal activity, and \$155 million for property fires.²⁶
- CCDTF information, coupled with DAANES information on the percentage of treatment paid by the CCDTF yields a total treatment cost in SFY 2001 of \$107 million. Applying this method to the Department's forecast estimates, the total cost for SFY 2007 is estimated to be \$233 million, 45% of which will be CCDTF spending from all revenue sources.²⁷
- Minnesota counties spent over \$41 million in direct outlays for chemical dependency services in 2004. Of this amount, \$16 million was for CCDTF funded treatment.
- Many other human service expenses in other program areas are attributable to alcohol and other drug abuse. A low end estimate for the costs of child out-of-home placements per year attributable to substance abuse is \$28 million.

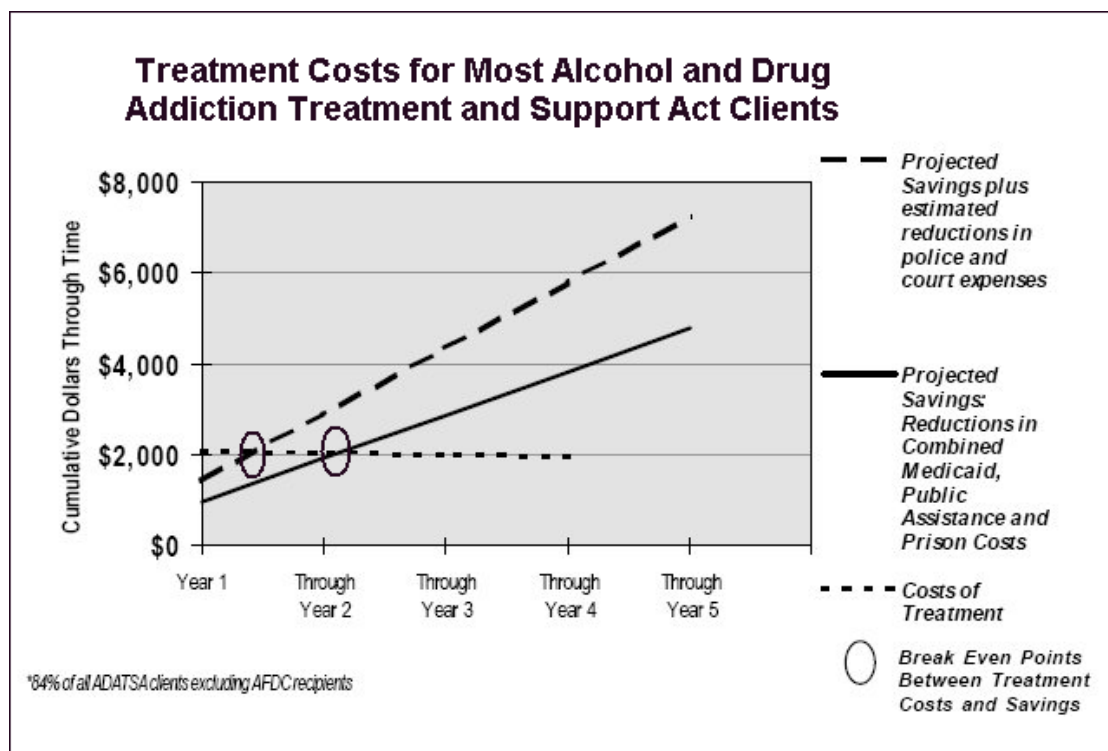
²⁶ The Human and Economic Cost of Alcohol Use in Minnesota; Minnesota Department of Health; January, 2004.

²⁷ Department of Human Services, Reports and Forecasts Division, CCDTF Forecast, November, 2005.

- A recent cost estimate coordinated by the Department of Corrections to find the direct public cost of methamphetamine abuse found \$130 million in direct outlays due to the abuse of this single drug. Of that amount, 11% was spent providing treatment. Methamphetamine accounted for 17% of CCDTF admissions in 2004.

Client and Cost Benefit External Studies

- A comprehensive Washington State cost study at one year and five years post treatment found that the break-even point for State direct expenditures from provision of treatment was two years, and the public break-even point is estimated at less than a year when police and court expenses are included.²⁸
- A recent Iowa study found that 46% of clients were abstaining from all drugs at six months post-discharge, and an additional 14% had significantly reduced use. While 31% had no arrest six months prior to admission, 89% had no arrest during the six months after discharge. Employment increased by 17%, and combined wage income by 13%.²⁹



- A meta analysis of cost benefit studies was completed by the University of Pennsylvania in 2005. The analysis looked at reliable studies that were focused on direct returns and didn't include soft cost items. The analysis found a range of benefit from 1.33 to 6.32 to one for various forms of substance abuse treatment (see Appendix Figure 1). As might be expected, the higher cost returns were for programs focused on clients involved in the

²⁸ Chemical Dependency Treatment and Cost Savings Estimates in Washington; Bill Luchansky, Ph. D. et al; Washington State Department of Social and Health Services; March, 1997.

* ADATSA is the Alcohol and Drug Addiction Treatment and Support Act, the main State program supporting chemical dependency treatment in the State of Washington.

²⁹ Outcomes Monitoring System Iowa Project: Six Year Report; Johnson, Amanda D.; Iowa Consortium for Substance Abuse Research and Evaluation; September, 2004.

criminal justice system and pregnant or parenting women, because these two groups are so costly when chemical dependency is not treated.³⁰

CCDTF Treatment Activity

Fund Structure.

The CCDTF is a State operated, county managed system for funding chemical dependency treatment. Following procedures and standards set by the State, counties set provider services and rates by contract, assess persons applying for treatment assistance, and place people in specific treatment programs. The payment system is on a fee-for-service basis, but counties, within state-wide guidelines, determine which clients need treatment, and which provider will serve the client.

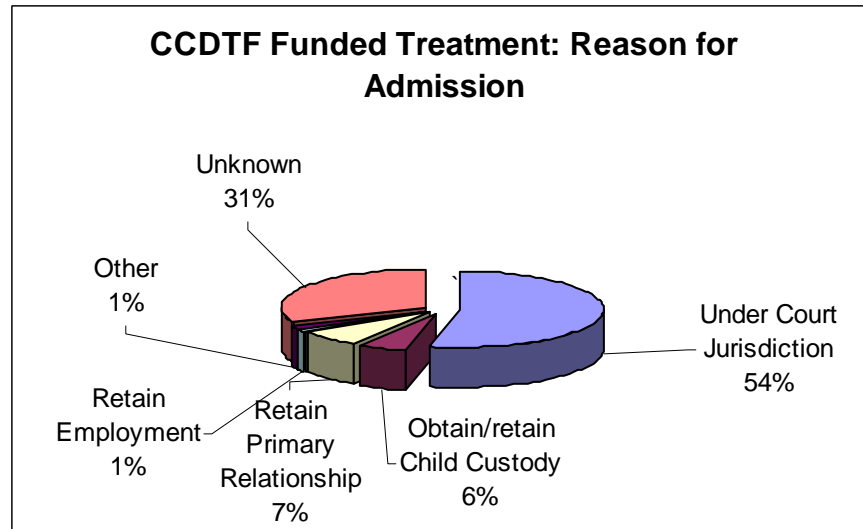
Who gets treatment? Clients accessing chemical dependency treatment through the CCDTF have a number of challenges. In several measures the client life circumstances when entering treatment are worse than they were five years or a decade ago.

- **Income.** Client household income is on the decline, more than would be predicted by the elimination of Tier 2, even without adjustment for inflation. For all households of more than one, incomes declined in unadjusted dollars when comparing 2004 to 1994. The table below shows Tier 1 annual incomes for selected years.
- **Health care program status.** In 2004, 46% of CCDTF clients were enrolled in a Minnesota health Care Program on the first day of treatment. 8% were placements of people enrolled in a PMAP. PMAPs are responsible for provision of inpatient and outpatient primary treatment, but PMAP enrollees access halfway house and extended care programs through the CCDTF. The number of CCDTF placements of PMAP enrollees has increased by 52% between 2001 and 2004, from 1,324 to 2,037. The increase partly due to increased utilization of halfway houses and extended care programs, where the number of PMAP enrolled increased from 1,263 to 1,720. During this same period of time, the proportion of all resident treatment admissions funded by an MHCP pre-paid plan doubled, from 5% to over 10%. Of those on a major program, the majority were GAMC enrolled. PMAP has had less impact on CCDTF demand than was anticipated. 38% of CCDTF admissions are clients who are enrolled in a major program on a fee for service basis. There are several possible explanations for this, but a highly likely reason is that people get enrolled in a program at about the same time that intervention regarding their chemical dependency takes place. Along with other life disorganizations caused by chemical use, drug abuse functions to prevent clients from obtaining and retaining eligibility status with medical programs.

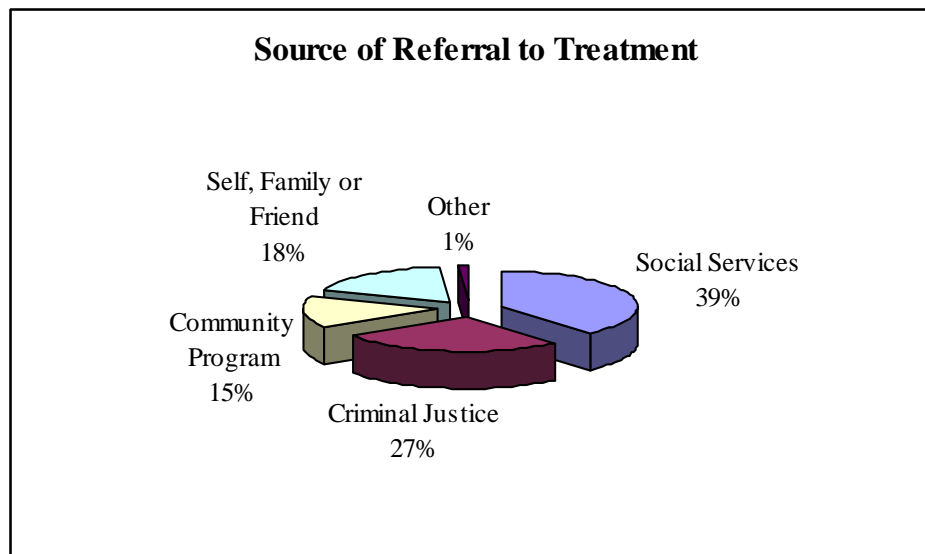
CCDTF Client Enrollment	CY 2004	Percent
Unique CCDTF Provider Admissions	24,787	
Number on public program in 2004	CY 2004	
MA	5,116	21%
GAMC	5,982	24%
MinnesotaCare	294	1%
TOTAL	11,392	46%

³⁰ Economic Benefits of Drug Treatment: A Critical Review of the Evidence for Policy Makers; Steven Belenko, et al.; Treatment Research Institute, University of Pennsylvania; February, 2005. (see appendix Figure 1)

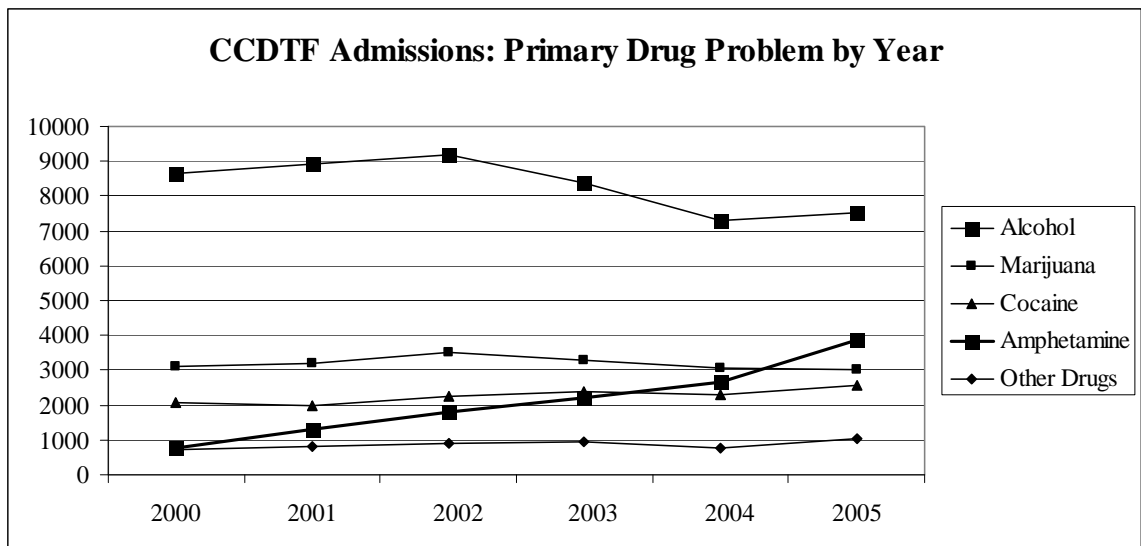
- **Circumstances of admission.** 52% of CCDTF clients are under court jurisdiction at the time of admission, up from 49% of CCDTF clients in 1994. 45% have been arrested or convicted of a crime in the last six months, compared to 33% of non-CCDTF admissions. The number of admissions that have court involvement has held steady over the last four years, but the number with civil commitments is decreasing while criminal court referrals are on the increase. The “regain drivers license” percentage is somewhat misleading, as many clients are likely reporting that their treatment is court ordered or a condition of probation instead. Responses to another DAANES question indicate that 20% of clients report that their license is revoked at the time of admission.



- **Source of Referral.** Two thirds of all CCDTF admissions were referred by government social service and criminal justice agencies. The low level of self and family referrals in the CCDTF, coupled with data showing that Minnesota has far fewer people in treatment than other states with similar problem levels, indicate that outreach and intervention activities are insufficient.



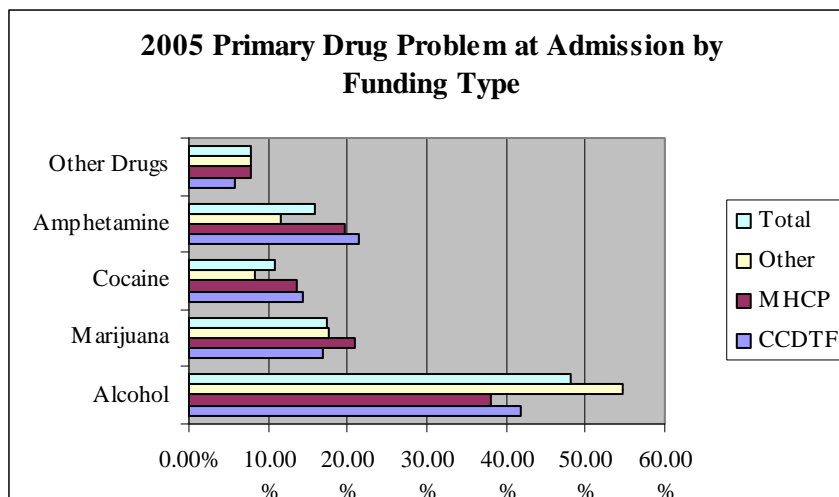
- CCDTF clients are significantly less likely to be self referrals or referred by family or friends than people entering treatment via other funding systems. While this was 18% of CCDTF admissions on average over five years, 31% of Minnesota Health Care Program (MHCP) admissions and 45% of non-public admissions were self, family, or friend referred. On the other hand, CCDTF self/family/friend referrals as a proportion of admissions are on a slow but significant increase over time, from a low of 16% of admissions in 2001 to 21% of admissions in 2004.
- The number of people who are in treatment from a criminal court order has risen by 50% over the last decade. This high proportion of court referrals speaks to the high priority courts are placing on chemical dependency issues when making sentencing decisions. However, this trend also raises questions as to whether sufficient earlier intervention activities are in place. Increasingly, treatment is not provided until the person is in serious legal or behavioral trouble that comes to the attention of social services agencies and the courts.
- Only 15% are referred by community programs, but this may be an artifact of the CCDTF system where county social services is the gatekeeper between community programs and the treatment provider. The proportion referred by community programs has been declining over time, from 2,500 referrals in 2000 to 2000 referrals in 2004. Some of this decline is due to reduction in county use of contracted Rule 25 assessors in community programs.
- 39% of admissions are from social services. More analysis is needed to determine what proportions of these referrals stem from open cases relating to other functional issues such as child or adult protection. An accountability plan that will be able to carry out this analysis is under development.
- **Primary drug problem.** While alcohol continues to be the most common reason for entry to treatment, people with alcohol problems no longer constitute the majority of CCDTF treatment clients.



The decline of alcohol admissions during this period is unexplained, as there are no indications that Minnesota's rate of alcoholism is declining. Some treatment providers believe that increasing numbers of people with an alcohol problem are also

abusing other drugs, and will state the drug other than alcohol as the primary problem when entering treatment. Over time the proportion of clients with drug problems has been increasing, while alcohol has decreased from 64% of admissions in 1994 to 42% of admissions in 2005. While marijuana and other drugs have had static demand levels in the 2000-2005 time frame; alcohol has decreased by 13%,

- cocaine has increased by 23%, and
- Methamphetamine admissions have increased by 4000%. 17% of all admissions presented with a primary methamphetamine problem in 2005, and there are no indications that the rate of increase for amphetamine admissions will slow over the next few years.
- There is a relationship between ethnicity and primary drug problem at admission. Over 60% of American Indian admissions have a primary alcohol problem, while alcohol accounts for less than half of admissions for other ethnicities. Over 20% of whites and Asians present with a methamphetamine primary problem, but less than 1% of African Americans have a methamphetamine primary problem. For African Americans, the largest proportion present with a primary cocaine problem. 37% of African Americans present with a primary crack cocaine problem, while 31% have alcohol and 21% have marijuana as the primary drug problem at admission.
- The majority of admissions from the Northern regions of the State have a primary alcohol problem. All regions have more alcohol admissions than any other drug. In terms of methamphetamine, the largest proportions are the East Central, West Central, and Southwest regions at 27%, 19% and 20% respectively.³¹ Available data predict that the proportion of methamphetamine admissions will continue to rise for the next few years, with increases seen in all regions of the State.
- CCDTF and MHCP clients are less likely to have a primary alcohol problem and more likely to have a primary cocaine or methamphetamine problem than clients funded in other ways.



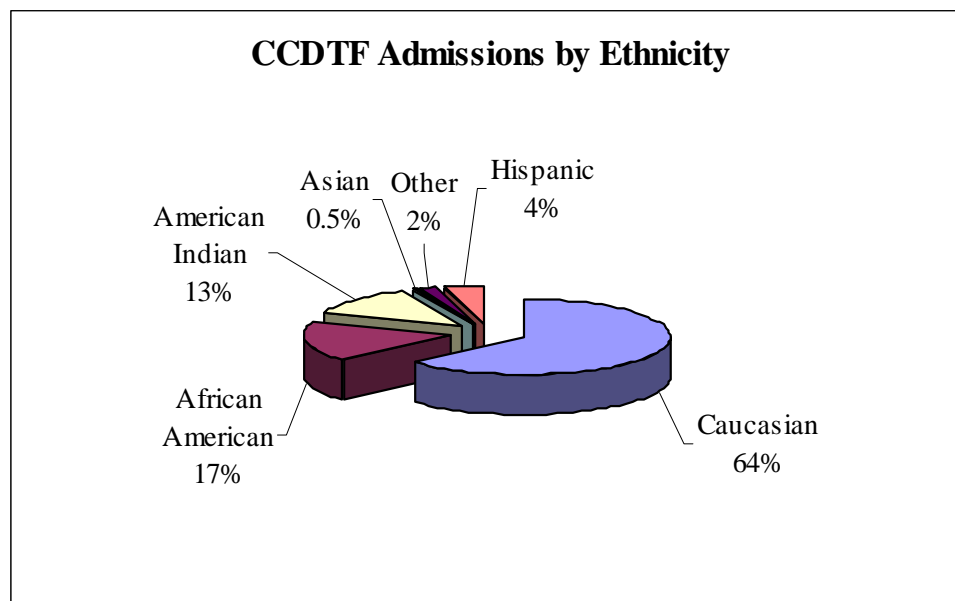
- **Employment.** Between 1999 and 2005 the proportion of CCDTF admissions with no source of income rose from 13% to 18%, while those with a job as the primary income

³¹ The map on the cover of this report shows the Chemical Health Planning Region boundaries.

source fell from 40% to 27%. There were no changes in the proportions obtaining public assistance benefits.

- **Ethnicity.** Caucasians are under-represented among those who present for treatment under public funding. 64% of admissions are Caucasians, while 89% of Minnesota's total population is Caucasian. For payment sources other than the CCDTF and MHCP's the proportion of Caucasians matches their representation in the population. American Indians are over-represented in CCDTF placements by a factor of 9, while African Americans are over-represented by a factor of 5 when compared to their proportion of total State population. Over time the sharpest increases in placements have been Hispanic and Asian clients, though these groups remain a very small proportion of the whole. These data are consistent with detoxification program information, which shows about the same distribution by ethnicity among people admitted for the first time.

- American Indians are nine times more likely than the general population to present for treatment with a chemical dependency problem, and are 29 times more likely to present with severe or chronic chemical dependency, as evidenced by the person's treatment and detoxification utilization history.³² By having a tribal allocation and placement system, Minnesota has already implemented the recommendation of the 2004 policy paper by the National Conference of State Legislatures that states pay special attention to American Indians when implementing substance abuse policies.³³
- African Americans are five times more likely than the general population to present for treatment. Treatment and detoxification utilization information show that African Americans are three times more likely than the total treatment population to present for services with chronic or severe chemical dependency.



³² Current Perspectives on Chronic Alcoholism: Implications for Social Policy; Mark Willenbring, M.D. and Wayne Raske; Minnesota Department of Human Services report, November, 1995.

³³ Treatment of Alcohol and Other Substance Use Disorders: What Legislators Need to Know; Colker, Allison C. et al; National Conference of State Legislatures; January, 2004.

Consolidated Chemical Dependency Fund Operations

Principles

When the CCDTF fund was implemented in 1988, it was both a response to the existing system of funding and program silos, and an effort to meet the issues and challenges facing the CD treatment field. These issues had been analyzed by the Minnesota Medical Association and the Citizens League in major reports on chemical dependency treatment services in the State. The principles and policy objectives of the CCDTF were explicitly defined, to drive the development process and to establish criteria for evaluating success. These principles included:

- uniform criteria for assessment and placement of all clients using public funds, through the application of Rule 25 to counties, tribes and Prepaid Medical Assistance Plans (PMAP);
- uniform client and provider eligibility, so that individual needs, not the available funding stream, could determine the placement for services;
- a market based, competitive environment in which all licensed providers are eligible for payment and can develop and deliver services that are responsive to client needs;
- flexibility to respond to changing needs and evolving best practices;
- to localize and focus decision making about placements and service needs at the county and tribal level, where the consequences of chemical dependency are felt;
- promote effective utilization of resources by having counties and tribes manage an allocation and contribute a significant portion of the cost;
- enable counties and tribes to contract for specialized services to people with co-occurring disorders, corrections involvement, and other special needs;
- neutralize the distortions created by unequal cost sharing between counties and the State in the existing funding programs;
- to be compatible with other cost control mechanisms, including PMAP programs; and
- to establish a designated allocation for services to American Indians.

Operations

Funding Sources

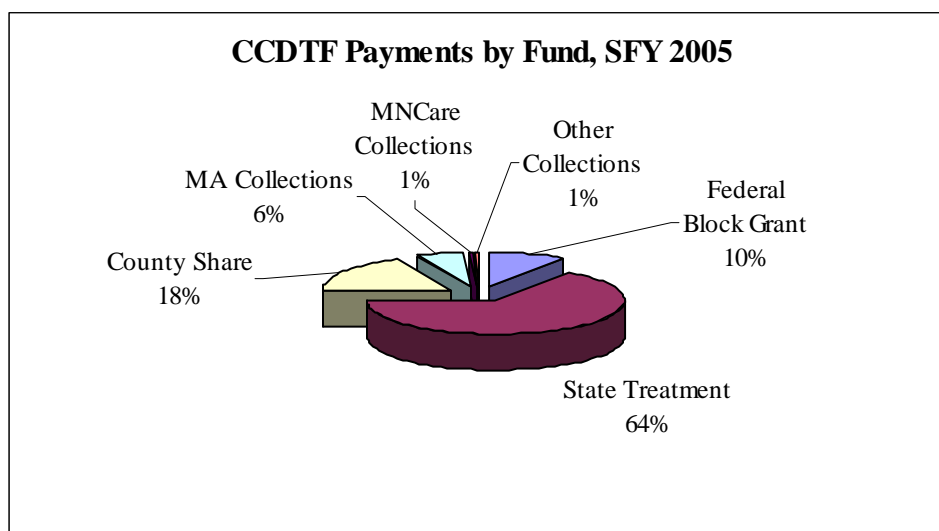
From SFY 2005 data, the State pays 65% of the cost of the CCDTF, and counties pay 18%. The percentage paid by counties has decreased during the past three years from a historical 20% share (amounting to 22% of the cost of placements made by counties) during most of the history of the CCDTF. 60% of county payments are for their 15% share of treatment under their allocations, and 37% are maintenance of effort payments, up from 30% in SFY 2003. The remaining 3% are payments made by the county for people who were not eligible for CCDTF payment. Net Federal MA participation (FFP) was only 3% of the total in SFY 2004, because substantial State repayments of improper MA billings in the 2001-2002 period were made during the year. Now that the repayment is complete, the FFP proportion has increased to 6%. 10% of the fund is from the Federal Substance Abuse Prevention and Treatment Block Grant.³⁴ A small number of clients

³⁴ On a one-time basis, the Legislature increased the Block Grant portion of the CCDTF from \$9 million to \$10 million per year for the 2002-2003 biennium. In January of 2003 an additional \$880,000 of the Block Grant was added to the CCDTF to continue partial support (household size more than one) of Tier 2.

have another third-party source of payment. Beginning January, 2006, the responsibility for collection activity for this third-party liability shifted from the State to the providers. This change will bring the CCDTF in line with other health care programs, but the effect the change will have on revenue is unknown and likely to be small.

CCDTF Payment %	SFY 03	SFY 04	SFY 05
State Treatment	54%	67%	65%
County Share	21%	19%	18%
Block Grant	14%	10%	10%
MA Collections	9%	3%	6%
Other Collections	1%	1%	1%
MNCare Collections	1%	1%	1%

Because the CCDTF pools money from a variety of sources, providers are required to meet a number of Federal requirements in addition to State requirements to be licensed and to participate in the DAANES information system. These include maintaining client waiting lists, having admission preference for pregnant women and for intravenous drug users, and provision of TB education and screening. Opioid programs and programs serving pregnant women and women with children are also required to participate in a State waiting list management system.³⁵ Spending Rules are used to assure that certain Federal requirements are met by the State, such as assuring that SAPT Block Grant funds are not used for certain inpatient hospital services or to match Federal Medical Assistance funds.

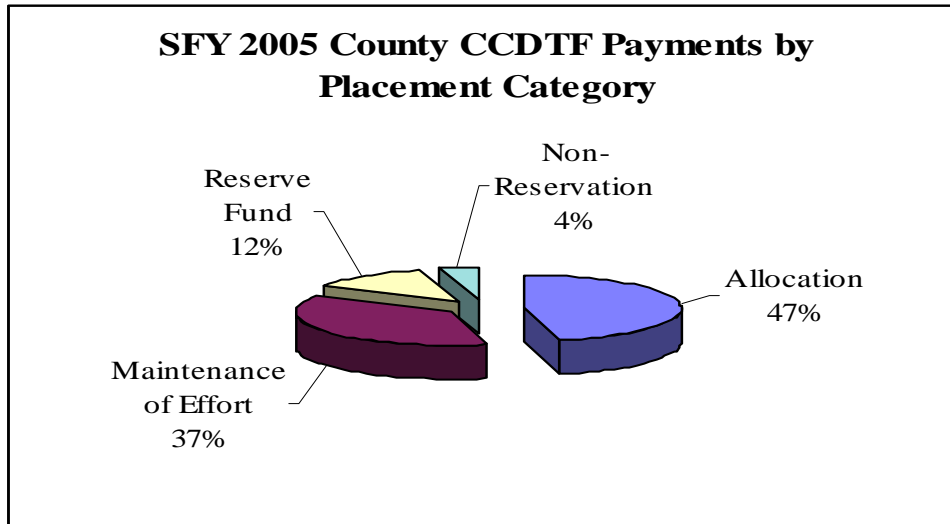


County Maintenance of Effort (MOE)

The Maintenance of Effort requirement was established to ensure that local funds being spent for CD treatment continued to be available. The MOE was initially based on county expenditures prior to establishment of the CCDTF. Each county's MOE is increased (or decreased) by the same percentage as the State appropriation to the CCDTF, if the county is not participating in

³⁵ Federal requirements specific to Substance Abuse Prevention and Treatment Block Grant funds are located at Title 45, part 96, sections 120 to 137, of the Code of Federal Regulations.

Prepaid Medical Assistance Plan (PMAP). For PMAP counties, the MOE increases or decreases with the individual county allocation. Counties can claim all county expenditures for eligible services as MOE, including services provided to CCDTF ineligible people. When the allocation has been exhausted, the county pays 100% of the cost for placements, other than non-reservation American Indian placements, until the MOE requirement is met. After the county has met its MOE requirement, the county share for any additional CCDTF services returns to 15%. There is wide county-to-county variation on the impact of the MOE requirement in terms of actual expenditures. In SFY 2005:



- 35 counties had less MOE assigned than the amount needed as county match against state allocation for treatment;
- One county (Cook) had more assigned MOE than the total amount spent for treatment, and 10 other counties had an MOE assignment in excess of 45% of the total amount spent for treatment.
- 37 counties spent a combined total of \$6.8 million in MOE payments in excess of their allocation match.
- 16 counties used less than half of their assigned MOE in excess of their allocation match, representing a total of \$3 million in unused assignment. Of that amount, \$1.6 million was accounted for by Ramsey County.
- 20 counties spent more than double their assigned MOE that was in excess of the funds needed to match the allocation. Of those, 7 spent more than triple the MOE assigned amount.

Non-Reservation American Indian Funding

The non-reservation American Indian account was established to ensure access to culturally appropriate services for all American Indians, regardless of where they live. Non-reservation American Indian placements are credited as maintenance of effort, but do not reduce the county's remaining treatment allocation. The county share is always 15%, regardless of the county's allocation and MOE status. This fund has been a very important resource for a small number of counties, and is used by most counties to some degree.

- 55 counties used at least some non-reservation funds, totaling \$4,249,000.
- 2 counties had claims totaling more than 50% of their allocation amount.
- 6 counties had claims totaling between 20% and 50% of their allocation amount.

County and Tribal Allocations. The total county allocation pool is the annual State appropriation to the CCDTF, less 6% of the total for Tribal allocations, and an additional reduction by 6% of the remainder for support of the non-reservation American Indian fund.

This allocation formula is volatile. In many cases counties see significant allocation increases and decreases from year to year, sometimes in excess of 20%. Some counties see a significant increase in one year, followed by significant decreases for the subsequent two years, and vice-versa. In 2005, 38 counties saw increases in excess of 20% over the previous year, while no county had a large decrease. For the 2006 allocation, one county had an increase in excess of 20% compared to the previous year, while nine counties had a decrease in excess of 20%. The complexity of the formula makes it difficult for counties to predict their allocation in advance with sufficient accuracy to allow for sound financial planning.

The reservation American Indian allocation is a \$10,000 base amount with the remainder assigned according to each reservation's Bureau of Indian Affairs service area population. The tribal allocation is 6% of the State appropriation, and the non-reservation account is 6% of the remainder. The BIA service area population is a stable figure over time compared to the county allocation formula elements.

The allocation is not real money. The allocation amount assigned to a county was designed to serve three functions, two of which are currently operational. First, it determines the total amount of administrative aid each county is eligible to receive. Second, it determines the expenditure point after which the county enters either the Maintenance of Effort or Reserve Fund parts of the CCDTF system. Third, when Tiers two and three were funded, the entry to reserve funding triggered elimination of CCDTF eligibility for non-entitled people. Because of the relationship between the allocation and the assignment of Maintenance of Effort potential obligations for a county, in many cases an increase in allocation causes an increase in county CCDTF expenditures. Here are three fictional examples of the ways the allocation and county expense relate to each other in light of the county's Maintenance of Effort assignment, assuming no changes in treatment demand.

Pike County is a large rural county that housed a large State Hospital treatment facility. Prior to the CCDTF, the State facility was the service provider for virtually all county residents in need of public assistance to obtain treatment. The county share for treatment in this setting was 10%. As a result of this history, the county MOE assignment has historically been less than the amount needed to match the county's allocation. This means the county will not normally pay 100% of the cost for any eligible person placed with an eligible provider. When Pike County's allocation is increased by 25%, there is no change in county expenses, except that the county may earn somewhat more administrative aid.

Perch County is a large urban county with significant alcohol and drug problems. Prior to the CCDTF county residents were served by a combination of State operated programs, County operated programs, hospital programs, and community residential and non-residential programs. The county shares ranged from 5% of MA funded hospital treatment to 100% of non-residential primary treatment. As a result of this, the county MOE assignment has historically been about 50% of the allocation amount under the CCDTF. With continuing increase in chemical dependency problems over time, Perch County uses all of the allocation, all of the assigned MOE amount, and makes a significant number of additional treatment placements. When Perch County's allocation is increased by 25%, the MOE assignment is also increased by 25%. So if Perch County had an \$850,000 MOE assignment, the allocation change increases MOE by \$212,000, all of which will be an increase in direct county costs over the year.

Bass County's residents received services from the same types of programs as was the case in Perch County prior to the CCDTF, so Bass County also has an MOE assignment that is about

50% of the allocation. However, Bass County has less treatment demand under the CCDTF than Perch County, and has never spent all of the MOE assigned. When Bass County's allocation is increased by 25%, the MOE is also increased by 25%. However, the allocation increase postpones the time of year when the county will begin paying for treatment at 100% to meet MOE, and this will save Bass County money.

So for Pike County, an allocation increase or decrease is a very minor issue. For Perch County, a significant allocation increase is very bad news, and a significant decrease is good news. For Bass County, the allocation increase is very good news, and a decrease is very bad news. It all depends on the initial MOE assignment and the amount of chemical dependency treatment demand in the county.

- **Administration.** Counties and Tribes are paid an administrative fee based on a percentage of treatment payments. The administrative aide is 5% of the first \$50,000 spent on treatment, 4% of the next \$50,000 and 3% of the remainder of the allocation. There are no administrative payments after the allocation is exhausted. DHS uses a portion of collections into the CCDTF to fund administrative costs, and the cost of operating the Drug and Alcohol Abuse Normative Evaluation System (DAANES). Operating costs totaled 17% of collections in SFY 2005.
- **Client Eligibility.** Since SFY 2004, client eligibility for the CCDTF has been limited to people who meet the MA income standard. This is the Tier 1 eligibility category. The CCDTF legislation provides for three tiers of eligibility, based on income. Tier 1 clients are entitled by State law to receive needed services. Tier 2 includes people whose incomes are up to 215% of Federal Poverty Guidelines (FPG). Tier 2 funding is dependent on State appropriations. Tier 3 includes persons up to 412% of FPG, with a sliding fee scale, and has not been funded since 1990. Tier 1 does not include any assessed client fees because of the poverty status of the recipients.

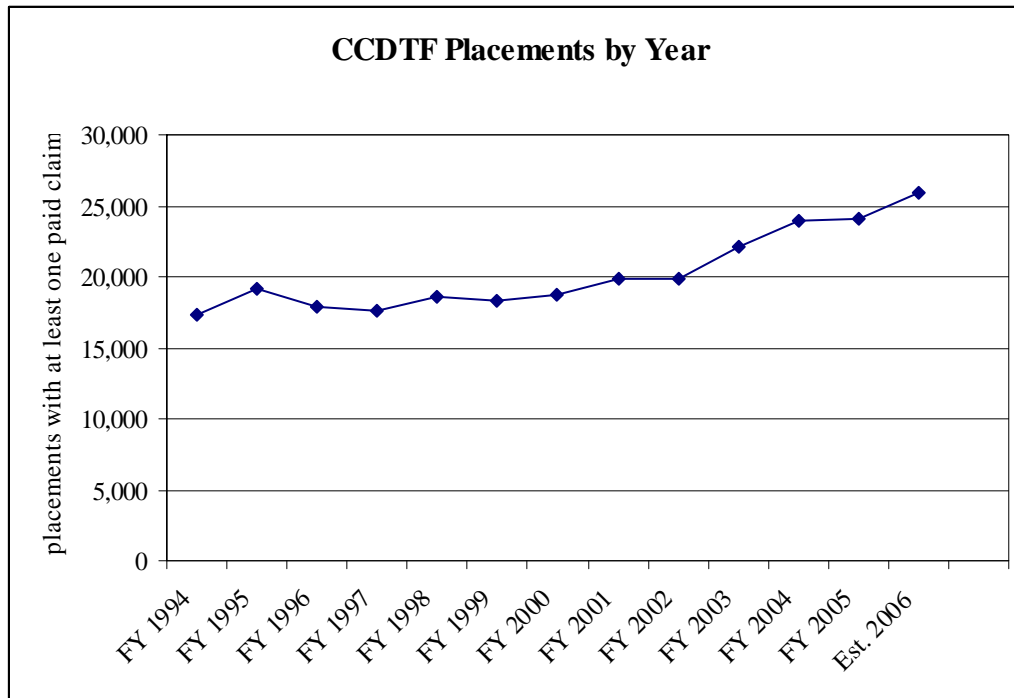
Counties can choose to provide services to people who are not eligible for the CCDTF, and pay the full cost.

- **Third Party Liability and Federal Share.** A few of the people eligible for the CCDTF have some kind of insurance coverage. All enrollees in PMAP programs receive primary inpatient and outpatient services through their managed care organization, and extended care and halfway house services from the CCDTF.

Most of the CCDTF collections are the Federal share of medical assistance. The Federal share of MA is claimed for all eligible recipients served by eligible providers. There is one group of providers that are considered institutions for mental diseases (IMD's), and are prohibited by Federal law from receiving MA funding for adults (non-hospital residential programs with more than 16 beds). All other types of programs are eligible.

- **Medicaid Waiver Provisions.** The CCDTF operates under a "Freedom of Choice" waiver. This allows the counties and the tribes to decide how services will be provided and who will provide them. The CCDTF is required to demonstrate ongoing cost effectiveness and preservation of enrollee access to treatment to retain the waiver.

CCDTF Activity Over Time



Changes in demand. In the last decade, the number of CCDTF placements has increased an average growth rate of 3% per year. The rate of increase accelerated between 2001 and 2004 despite eligibility restrictions and later elimination of Tier 2, which historically accounted for 10-15% of CCDTF demand.

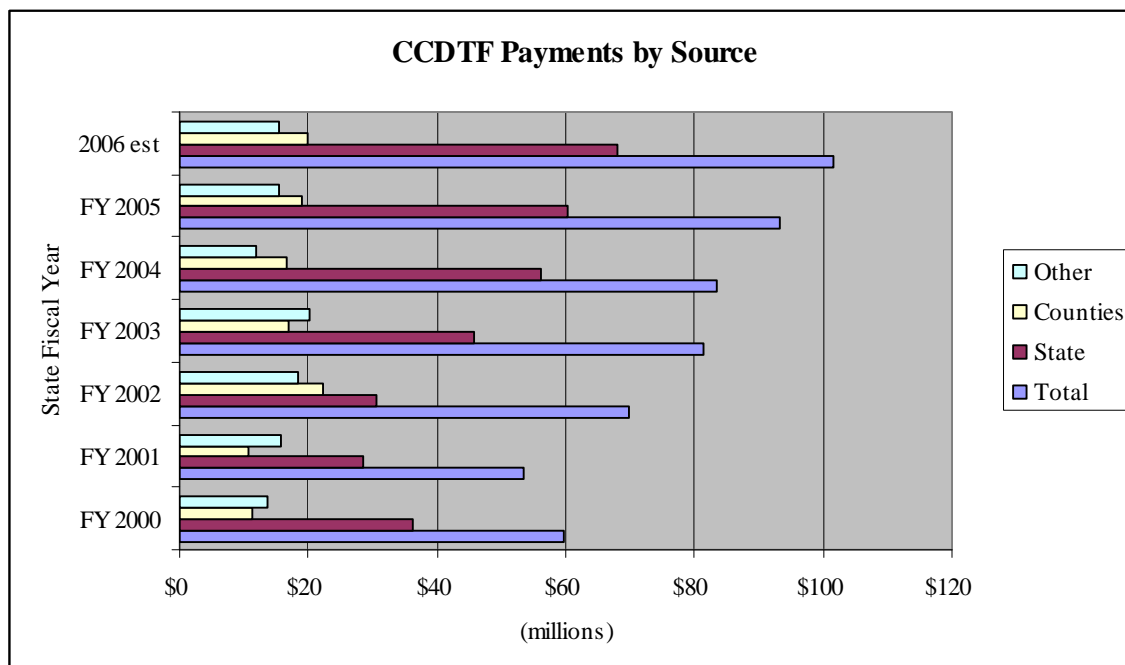
Demand is unevenly distributed. As shown in the map of CCDTF admissions per 1,000 population (appendix Figure 6) there is a large variation in treatment demand by county. This is an issue when there is no inclusion of chemical dependency prevalence information in the allocation formula. The largest demand is in the north-central and northwestern parts of the state. The lowest demand is in the southern counties of the metro area. Four counties have less than two admissions per thousand, while eight counties have more than eight admissions per thousand population. For the most part, this variation is unlikely to be due to differences in county administration of the CCDTF. Other information sources relating to alcohol and drug problems, such as DWI and drug arrests, detoxification activity, etc. show very similar patterns of variation between these areas of the state. (See appendix, figures 4 and 8 for mapping of DWI arrests and methamphetamine admissions. Other Appendix maps show the variation in CCDTF admissions and CCDTF county costs.)

Changes in cost. The cost per placement during this same time period rose by an average of two percent per year, compared to 4.3% per year for the Medical Consumer Price Index. A major factor in the cost of placement rising at a rate substantially less than inflation is legislation that limited provider rate increases for several years. From 1996-2003, CCDTF costs per placement increased 5.16%. During the same time frame GAMC Fee for Service costs per adult enrollee/month increased 12.01% and GAMC Managed Care costs per enrollee/month increased 11.01%.³⁶ Another factor affecting the cost per placement is change in the average length of stay

³⁶ Department of Human Services, Reports and Forecasts Division data.

for certain programs, especially hospital based programs. A Minnesota Department of Health hospital study found that while admissions increased by 8% between 1998 and 2002, total days of service declined by 14%.³⁷

Total cost. On average, the CCDTF total vendor payments have been rising by 6% per year over the last decade, but have accelerated to an average 8% growth rate for the last five years. As shown above, this acceleration is primarily due to increases in treatment need. These figures are somewhat misleading for the 2001-2003 period, as funds from improper FFP claims were received and later repaid.³⁸



The Role of the CCDTF in the Overall Treatment Industry.

As is the case with many other states, the public funding system is the largest single source of payment for chemical dependency treatment. Minnesota was one of the first states to have criteria for placement established on a state-wide basis that assigned the type of treatment a person was eligible to receive based on level of problem and barriers to recovery.

- **Level playing field for providers.** Prior to the CCDTF, the service and setting of the provider made a large difference when it came to participation in the public funding system. Counties paid 10% of State Operated Services programs, 5% of MA hospital programs, 100% of non-MA outpatient services, and 100% of program costs and 25% of housing costs in halfway houses. This meant that in many cases the cheapest alternative for the county could easily be the more expensive option for the tax payer. A single system with a single 15%

³⁷ Minnesota Mental Health and Chemical Dependency Treatment Utilization Trends – 1998-2002; Health Economics Program Issue Brief; November, 2004.

³⁸ Services provided in certain community residential settings to persons between ages 21 and 65 are not eligible for Federal Medical Assistance funding. During portions of fiscal years 2001 through 2003 Federal payments were improperly collected for these treatment placements due to computer programming error. These funds were repaid in fiscal years 2004 and 2005.

county share removed artificial marketing advantages and disadvantages for providers and focused attention on the actual total cost of care to the public.

- **Increased treatment options for clients.** Prior to the CCDTF, MA enrollees were referred to hospital programs, because that was where they had funding. Persons without any payment resource frequently had few or no options other than State operated programs. In other words, the clients went where the funding was, regardless of what service would be most appropriate from a clinical standpoint. Placing all licensed treatment under the same placement and payment system made the full array of treatment services available to clients, with the funding always available for the setting and type of care needed.
- **Consistent placement criteria.** All clients are assessed according to a single state-wide standard provided by rule.³⁹ Rule 25 has become the standard for placement in a number of circumstances, because it is seen as an objective standard for determining need for care. In addition to its use in DWI and drug offense courts by statute, a number of other funding sources are also accepting this placement standard.
- **Rate setting.** Rates are negotiated between the provider and the host county. Key informants in the treatment industry state that many third party payers are taking the position that they will pay only the rate that the provider has negotiated with the host county for CCDTF placements. The CCDTF system is becoming a cost containment mechanism for much of the treatment industry.
- **The county as gatekeeper.** Prior to the CCDTF, an individual had to seek treatment services from providers able to receive the particular funding for which the person was eligible. There was, within this limitation, ability for the client to choose the chemical dependency provider and interact directly with the provider to seek admission. This was changed to a system where the county makes a chemical use assessment following State criteria, and decides which specific vendor the client will use from a much larger array of providers than were available to the client prior to the CCDTF. This also placed the county between case finding agencies such as detoxification and community corrections programs and the treatment provider, changing the case finding/intervention function. The intended outcome from having the county make all placements under a State chemical use assessment rule was to shift to a system where the placing authority would be motivated to meet the needs of the individual in the most cost efficient manner. This process may not be working as intended for counties where funding pressures in the face of a steep rise in drug problems prevent attending to long term cost implications.

Ongoing Efforts to Improve the CCDTF and Treatment Services.

- **Assessing and Placing People: Rules 31 and 25.** Until January of 2005, licensure was by program type including outpatient, inpatient, extended care and halfway houses. For quite some time the treatment field has been moving in the direction of individual treatment planning and services that are flexible to meet individual needs. In order to support this, DHS has adopted a new licensing rule. Rule 31 governs community and hospital treatment services, and non-residential programs serving adolescents. If residential support is also provided it is licensed appropriately. Residential programs serving persons under the age of 16 are governed by Rule 2960, the Children's Residential Facilities rule.

Rule 25 currently assigns a level of care based on client problem level and barriers to recovery. A revision effort is currently in process. In the future, Rule 25 will implement updated client assessment and placement standards for all publicly funded clients. Rule 25

³⁹ The provisions commonly referred to as "Rule 25" are located in Minnesota Rules, parts 9530.6600 to 9530.6660.

requires individual treatment planning and delivery. The new standards will be applied by counties, tribes and PMAP programs. It is anticipated that the standards will be in place January 1, 2007.

These rules will change how clients are assessed and how services are authorized by counties and tribes, and how services are planned and delivered by providers. Training and technical assistance for counties, tribes and providers will be conducted in 2006. DHS expects that these new rules will enable continued development of individualized treatment and ongoing improvements in treatment programs.

- **Co-occurring Conditions.** When the CCDTF was designed it was intended to support the development of specialized treatment services for a variety of people, including people with mental illnesses and other disabilities. The CCDTF will pay for services that are provided by a licensed program and authorized in the individual plan of care, in accordance with the terms of the county or tribal contract. This allows counties and tribes to develop contracts that include whatever specialized services clients may need, and to combine mental health and chemical dependency services within a plan of care.

The development of specialized services continues to lag behind the need. In order to help improve the connections between mental health and chemical dependency treatment, Rule 31 now requires all licensed treatment staff to have minimum training in mental health issues.

- **Maximizing Reimbursement.** The CCDTF works to maximize Federal reimbursement for MA in several ways. All CCDTF providers are required to enroll as MA providers. Counties and tribes are reminded of their responsibility to enroll clients in the MA program whenever possible, through ongoing training and technical assistance. The Chemical Health Division made an aggressive and successful effort to work with programs that appeared to be ineligible for Federal MA because they appeared to be Institutions for Mental Disease because of the number of total beds they had, and determine whether they could be exempted on other criteria. Effective January of 2006, all CCDTF providers are required to bill and collect from possible third party payers, including Medicare, before billing the CCDTF. This is a change from the previous “pay and chase” system, and brings the program in line with other health care programs. In the last fiscal year, less than 1% of enrollees were identified as having any third party coverage other than Minnesota health care programs.
- **Training Efforts.** CHD has had several initiatives geared to transmitting best practice information to counties and providers. These included:
 - County training on how to get the most out of the CCDTF;
 - Training to counties and providers on best practice in treating methamphetamine, with more training planned for the coming year;
 - Training on evidence-based practice in treatment of stimulate dependence (e.g., cocaine, methamphetamine);
 - On-going training to chemical health practitioners on serving people with co-occurring mental and chemical health issues to bring practitioners up to new Rule 31 standards; and
 - Training on use of the six-dimensions method of treatment planning and assessment of treatment progress.

Relationship to Minnesota Health Care Programs (MHCP)

- **General PMAP/CCDTF Responsibilities.** Pre-paid Medical Assistance Plans (PMAP) are required to apply the same criteria and meet the same standards as counties and tribes for client assessment and placement. PMAP plans authorize and pay for primary treatment, in

both outpatient and inpatient programs. PMAP plans do not pay for the longer term services of extended care programs and halfway houses. This division of responsibilities is based on pre-CCDTF MA provider and service eligibility rules. Tribes have the option of placing PMAP clients through the CCDTF. In SFY2004, there were 548 placements of PMAP enrollees in extended care programs and 1172 in halfway houses. This is 7% of all placements. The cost of these placements was about \$5.4 million. The new DHS chemical dependency treatment assessment rule will change the way this delineation of authority and responsibility is structured and managed. Specific proposals are being developed.

- **Minnesota Care Interface.** Minnesota Care coverage of CD treatment services varies by benefit set. For the limited benefit set, all CD services but inpatient treatment are paid by the CCDTF. Other people are affected by the \$10,000 annual limit and co-payments.
- **CCDTF Client Eligibility for Minnesota Health Care Programs.** In calendar 2004, 11,392 (46%) CCDTF clients were enrolled in a MHCP as of the first date of CCDTF service. 1720 of them were PMAP enrollees in extended care or halfway house placements. 9672 were in the fee-for-service system, primarily because they were new enrollees at the time of assessment and placement, or were disabled. There were 265 placements of PMAP enrolled clients for whom some payment for primary treatment was made from the CCDTF. There are several reasons this can occur, including the service not being covered in the Minnesota Care benefit set, Minnesota Care limits being exceeded, or payment for room and board for clients in outpatient treatment. There are also a few occasions where a county will choose to place PMAP covered person through the CCDTF program due to special circumstances.
- **PMAP Performance.** PMAP programs are not responsible for all chemical dependency care. The CCDTF pays for all extended care and halfway house placements of PMAP enrollees. In addition, there is one MinnesotaCare option that covers only inpatient primary chemical dependency treatment, with the CCDTF paying for all other placements. The impact of PMAP on CCDTF operations has been less than was anticipated. Currently the CCDTF accounts for 45% of all treatment in the State, while PMAPs provide 11%. Over the five-year analysis period, the PMAP proportion of the total public and non-public treatment provided in Minnesota has increased by 110%, while the CCDTF proportion decreased by 5%.

The average residential stay provided by prepaid plans is slightly longer than the average hospital placement under the CCDTF, and substantially less than the average stay provided by CCDTF non-hospital primary treatment placements. The other CCDTF types of care are here for information only. MHCPs are not responsible for providing these longer term community program services.

<i>Type of residential placement</i>	<i>days</i>
Prepaid Health Plan	10.9
CCDTF Hospital	9.9
CCDTF Inpatient Primary	20.7
CCDTF Extended Care	42.4
CCDTF Halfway House	50.5
CCDTF Housing with Outpatient	28.5

- **Support for Innovative Options.** CCDTF funds are currently being used to support two innovative options. In Itasca County, all CD treatment is administered through Itasca Care, the county based purchasing entity. The county CCDTF allocation goes to Itasca Care, which provides services to all CCDTF eligible persons. In Ramsey County case management and

other supportive services are provided at county expense, but the county is allowed to claim those expenses as CCDTF maintenance of effort, offsetting the cost of these services by savings in county share payments for treatment. As new models for health care develop, we may see additional innovations in areas such as risk sharing and service integration will be proposed by counties, tribes, providers and health plans.

Major Issues and Challenges for the CCDTF

Fund Operations

The goals of CCDTF in many cases were structural goals and clearly were met. Standardized assessment, county managed placement, and uniform client and provider eligibility increased the options for treatment for all eligible clients. Virtually all licensed treatment programs have become CCDTF providers. County patterns of placement by counties and tribes appear to have been responsive to changes in the incidence and type of substance abuse. However, some features of the CCDTF are problematic.

- **County Maintenance of Effort (MOE).** The County MOE formula places an unequal burden on counties that is derived from their pre-CCDTF spending patterns. The initial MOE was set at 1986 expenditures. County MOE increases as the State appropriation increases. When PMAP began, the MOE for PMAP counties was tied to the amount of the county allocation. All but four counties are now in this position.

Some counties have an MOE that is equal to or less than their 15% cost share, but over 58 counties have an additional MOE that is as much as 55% of the cost of treatment. In SFY 2005 this “excess” MOE was over \$6 million. The overall county share of county placements is 18%. The MOE requirement creates a large variance in the percentage of treatment paid for by counties (see appendix Figure 3).

There are no cost neutral solutions to this dilemma that do not create winners and losers. CHD has identified options that would bring equity over time without causing drastic funding cuts immediately. One is to freeze any increases for counties as State appropriations increase. The second is to proportionally reduce the MOE assignment above the amount needed to match the county allocation on a fixed schedule. A third option is to expand the definition of county services that can be claimed as MOE, similar to the current Ramsey County arrangement. Any of these options would increase State CCDTF expenditures. The only cost neutral option would be to change the county share from 15% to between 18 and 20%, which would create more expenses for some counties while saving money for others.

- **County Allocation Formula.** When the CCDTF was enacted there were three tiers of client eligibility that mirrored social service eligibility standards in place at the time. There were large variations in county use of State resources for treatment. The requirement that counties assess and place clients using Rule 25 was new. The main function of tiered eligibility was to allow restrictions on placements when funds were not available to pay for all the Tier 2 demand in any year. When Tier Two eligible people were cut from the CCDTF in 2004, the allocation formula became archaic for any reason other than setting a limit on administrative payments and triggering the 100% county share until the MOE is met.
 - The allocation formula is needlessly complex, and allocation amounts are volatile over time for many counties. This makes county financial planning difficult, since for many counties the allocation amount can't be reliably predicted and has direct effect on local expenses. The allocation formula should have fewer elements, and those should be factors that change more predictably from year to year.

- By including more than one measure in the allocation relating to similar county characteristics, such as income and caseload both relating to poverty issues, a positive or negative change in a county's economic circumstances is magnified into a much larger change in allocation assignment. The formula should pick one reliable measure for each element to avoid a multiple effect on the allocation from a single county characteristic.
- When counties were moving to Pre-Paid Medical Assistance Plans, it was thought that the Plans would be providing a significant proportion of treatment services and that this should be reflected in the allocation formula. What we have learned is the vast majority of clients remain in the fee-for-service system in PMAP counties. In addition, the feature that ties MOE to the allocation for PMAP counties means that the MOE assignment can increase or decrease by large amounts from year to year, independent of the more stable and predictable State appropriation amount that determines MOE for other counties. The PMAP provisions in the formula should be removed, and county MOE assignments should all be tied to increases or decreases in the State CCDTF appropriation.
- **County Budget Impacts on Treatment Decisions.** The intended outcome from having the county make all placements under a State chemical use assessment rule was to shift to a system where the placing authority would be motivated to attend to cost efficiency while meeting the needs of the individual. This process may not be working as intended for counties where funding pressures in the face of a steep rise in drug problems prevent attending to long term cost implications. In the face of budget pressures counties have an incentive to reduce the amount of services authorized when making placements, and to look for alternatives to treatment. The passage of the Children and Community Services Act altered and reduced county duties regarding chemical use and other assessment services.
- **Supporting "Integrated Services" Efforts.** It is widely understood that chemical abuse and dependency is primary cause of, or a contributing factor to, many serious and costly conditions and social problems. Policy makers and program managers in many fields have been acting on that understanding. Treatment is provided in some prisons and jails. Drug courts have demonstrated success in diverting offenders to treatment and still holding them responsible for their actions. Mental health and CD treatment providers are working to address client needs in unified ways. The CCDTF has had the flexibility to integrate with other services and systems as these opportunities have presented themselves.

Accountability

- **Operational Accountability.** When the CCDTF was enacted, counties were given the responsibility to manage most aspects of the service delivery system, including:
 - Assessment of each applicant's chemical use according to State rules;
 - Determination of client financial eligibility;
 - Placement, including determining the amount of care authorized for payment and the specific vendor to be used; and
 - Provider contracting, rate setting and performance review.

The 15% county share and MOE requirement were considered to be a sufficient incentive for careful management. The information that would be collected through DAANES would be available for counties to use in evaluating the performance of providers.

A review by SAMHSA contracted evaluators in 2004 raised important issues about the adequacy of contract monitoring practices at the county level. County monitoring does not assure that certain Federal requirements regarding spending practices are met, and whether

performance is adequately monitored. CHD staff are addressing these concerns in county training efforts and as part of the planned implementation of revised Rule 25.

- **Outcome Accountability.** Quality outcome evaluation of chemical dependency treatment effectiveness is difficult. Direct measurement through follow-up surveys post-treatment must have a high response rate in order to have validity, and high response rates cannot be attained on an on-going basis in a cost sustainable manner. There are outcome indicators, however, that are valid and useful and don't require post-treatment client surveys. Examples include treatment completion, readmission to treatment, law enforcement and court involvement, income level, child welfare status, and health care expenses. DHS is collecting information about many of these indicators in several information systems, including DAANES, MMIS, and SSIS. Staff have been working to develop the capability to match data across these systems.

A next necessary step, currently in the planning phase, is to develop the capability to match data from other State systems, including public safety, corrections and the courts. CHD staff will need to take the lead in developing this capability and using the resulting information to improve accountability on the part of counties, tribes and providers.

While we are continuing to develop better outcome evaluation for people who have gone to treatment, we do not have any information about the people who do not get placed and what happens to them. This is a growing concern, because of the limited eligibility for the CCDTF and the increasing "deep end" status of those people getting treatment. We know that treatment of earlier stage chemical dependency is more likely to have a good outcome, and often requires less resources, but the public system has severely limited access for people whose lives are not yet severely impaired. A strong but untested hypothesis for the decline in alcohol admissions is the need for counties to conserve resources in the face of rising prevalence of drug problems, especially methamphetamine problems. The postponement of treatment increases public costs, not only for treatment but also for law enforcement, courts, corrections, child welfare, health care, education and public assistance.

- **Implementing Best Practices.** As noted above, Rules 31 and 25 will promote individual treatment planning, and services that are flexible to meet individual needs. Together they require that assessment, placement and treatment planning address six dimensions of the individual's level of chemical use problems and barriers to recovery. There has already been considerable investment in transmitting best practices to the chemical dependency field, particularly regarding mental health issues and treatment issues for methamphetamine dependence.

Recommendations for Action

- **Address the fundamental unfairness of the current county MOE and allocation processes, and the impact on placement decisions.** A process is needed to develop a proposal for transition to a more equitable system of financing. The financing system must recognize the unequal distribution of chemical health problems across the State, and ensure that counties do not deny treatment to eligible people. Ideally, the Maintenance of Effort requirement should be completely phased out of existence, and a method developed that assists counties with the highest level of treatment need.
- **Simplify and stabilize the allocation formula.** There are many formula elements, some of which have unintended consequences for certain counties. The formula contains elements that are volatile, such that counties can't forecast what their allocation and maintenance of effort will be. Now that virtually all counties are participating in PMAP, eliminating complex calculations relating to PMAP from the formula would not change the inter-county equity of the allocation. Meanwhile, the formula does not contain any direct measure of chemical

dependency problems, which adds to county inequity since the problem is not evenly distributed across counties. (See Appendix Figure 6.)

The allocation serves to trigger changes in eligibility in years when the CCDTF is funded beyond Tier 1, and to determine administrative aids. If the MOE and Tier eligibility distinctions were eliminated, there would no longer be any need for an allocation process. In that event, a simple percentage limitation on year-to-year changes in the county CCDTF allocation would provide the needed temporary allocation stability while MOE is being phased out.

- **Develop a system for county monitoring.** Currently counties do not report on a number of items that impact the quality of the CCDTF system. Numbers of assessments provided and what happens to those assessed but not placed in treatment are not collected. Little is known about the time spans between a request for an assessment and provision of the assessment, or between the assessment, placement and treatment entry. The degree to which counties may be avoiding treatment placement in order to contain costs is unknown. A thorough understanding of the CD treatment needs in Minnesota requires that there be some information about low-income people who are assessed as needing treatment, but who do not show up for services. The planned revision of the assessment rule (“Rule 25”) will also contain severity information in six life areas that could provide valuable research information. Analysis of this information can then lead to systematic targeted technical assistance and other aids to counties based on each county’s individual needs. This monitoring plan must weigh the costs of collecting and using information against the value received.
- **Provide additional technical assistance to enable better monitoring of programs by counties.** One quality promotion strategy that is not fully utilized is the contract negotiation between the provider and the county. With the CCDTF accounting for 45% of the treatment market share, the county contract can be a powerful tool for change regarding providers that have not yet linked the most modern science to their program design and operation. This becomes an even more powerful tool when counties make it clear that providers using evidence based practices will be preferred when placement decisions are made. The county training efforts that were conducted over the last two years need to be followed up with additional training so that counties can recognize and provide incentives for best practices on the part of providers. Information must also be disseminated on what is known about which client characteristics indicate a need for placement in which type of program. This must be coupled with on-going assistance so that counties make best use of the process and outcome information that is available regarding provider performance, as outcome measurement strategies continue to evolve.
- **Continue to support integrated service efforts.** The need for and opportunities to improve service delivery through integration will grow in the future. This includes more collaborative work with mental health, court services and drug courts, and continued promotion of effective treatment models where outpatient programs operate within local correctional facilities. Administrators and planners from these service areas are increasingly aware of the impact of chemical health issues on their operations, and the need for integrated services. The CHD needs to help promote, as well as respond to, these opportunities.
- **Begin stakeholder discussions regarding CCDTF access issues.** The CCDTF placement process generally works well when county social services or court services is the case finder in the same county where the client resides. However, there are many scenarios that are not that neatly tied to common county practices and policies. Sometimes inter-county situations can result in serious delays in the time frame from case identification to the onset of treatment. In turn, this can lead to a decrease in the motivation for recovery on the part of the

chemically dependent person. Methods must be analyzed, in conjunction with the other partners involved in these placements, that will make the placement process more efficient and effective.

- **Use the information already collected by State agencies to promote operational and outcomes accountability.** CHD and PMQI staff resources directed to this goal should be expanded. The plan under development to match treatment clients with other State data sources, both within and outside of DHS, should be fully implemented. Staffing should be obtained that can enable both in-depth analysis of what treatment characteristics link with better outcomes, and synthetic analysis that can effectively transmit this information in the context of other external research at the state and national level to providers, counties, and tribes. Counties, tribes, providers and other State agencies should be provided structured opportunities to participate in deciding what information is most valuable, what it means, and how it should be presented to be most useful. Data should be used to identify counties, tribes and providers where services are less efficient or effective than the norm, so that targeted technical assistance can be offered.
- **Continue the implementation of Rules 31 and 25 as the key initiative to promote effective treatment services.** There is a great deal of work to be done to implement the spirit as well as the “letter of the law” of these rules. The formal processes of treatment planning in licensing rules changed in 2005, and changes in the assessment process to conform to the treatment rules will be implemented in 2007. Some providers quickly adjusted to this approach, and a few actually anticipated the need for these changes. However, ongoing efforts will be needed to integrate this individualized approach into the daily practices of assessors and providers across the State.
- **Continue efforts to promote effective treatment strategies.** Resources have been allocated during the last two years to promotion of evidence-based practices through providing information to counties, Tribes, chemical health professionals and treatment providers. Efforts have been made regarding co-occurring disorders, and methamphetamine treatment. Additional efforts should be made to promote evidence based practice, including pharmacotherapies that have demonstrated effectiveness with certain types of alcohol and other drug dependencies. County placement authorities should have more information regarding the evidence showing the efficacy of repeated treatment episodes for certain chemically dependent sub-populations. Some counties also need more understanding of opioid dependence and the efficacy of Methadone and Buprenorphine therapies. More information should be made available on the effectiveness of non-treatment alternatives such as case management and specialized housing for the late-stage chemically dependent. Other topics will arise as the national institutes and the research projects they support arrive at new findings.
- **Promote prevention and outreach efforts.** While the focus of this paper is chemical dependency treatment, we must recognize the current implementation of a data-driven process being implemented to target prevention efforts to parts of the State with the highest need, and to evidence-based prevention strategies, as an important component of the State’s approach to chemical health issues. As shown in the background section of this paper, Minnesota does not show a good ratio between the numbers in need of treatment and the numbers getting treatment, when compared to other states. All national research efforts conducted by the Substance Abuse and Mental Health Services Administration agree that the largest cohort of those who need treatment and don’t get it believe they don’t need treatment. Admission data show that the CCDTF gets a much smaller proportion of individuals and families deciding to enter treatment prior to court or social services involvement than other funding systems, including MHCP’s. The cost findings show that in addition to reduced

health levels, this untreated chemical dependency increases public expenses in the moderate to long term. In addition to the continuing prevention work the State is doing, efforts should be promoted that reach out to engage people in treatment and recovery at every stage of the illness.

Recommendations for further analysis

This Analysis Report found a number of data items that are worthy of further investigation. In some cases, this will have to await implementation of the accountability recommendations regarding treatment outcome related data, or additional data reporting from counties. Some remaining questions would require independent base research, as no systematic data are available through current systems. In other cases, it may be possible to test various hypotheses about data related questions through currently available systems, or through the new data items that will become available after the new revision of the DAANES data system has accumulated a year of data.

- **Changes in county placement patterns.** Minnesota Department of Health data quantified an increase in admissions but a decrease in total days of service for Minnesota's hospital based chemical dependency programs. Similar changes may be happening in other types of care. Full analysis of county performance under the CCDTF awaits implementation of a better county monitoring system, with better data reporting regarding chemical dependency assessment and placement activity. However, current information could at least quantify changes in the number and type of placements and amount of services authorized by program type over time. The degree to which counties use specialized programs for special populations could also be analyzed.
- **Effectiveness of alternatives to standard intervention and treatment models.** A number of projects around the State are providing services other than licensed chemical dependency treatment for certain types of chemically dependent people. Some research is available on the impact of specialized case management services and specialized housing programs for late-stage chemically dependent, but there has not been a single, systematic research model to develop information on the cost and client benefit of these projects. Another question that could be pursued through collaboration is whether there are outcome differences between different types of client intervention, such as social services protective services, drug courts, probation interventions, and so on.
- **Development of comprehensive provider information.** Current projects will develop some information on the performance and effectiveness of CCDTF providers, and these can be used to compare programs, compensating for those client factors that indicate difficulty in attaining good treatment outcomes. However, these data are of limited use if there is no data set that provides descriptions of the operational differences between programs. We need a project that can compile detailed information on each treatment program's treatment methods, types of staffing, provision of additional non-standard therapies, and use of pharmacological adjuncts to their treatment design. This could be coupled with other useful tools for Department support of the field, including a descriptive directory of programs, a personnel needs survey, and an understanding of the strengths and challenges of the currently common treatment business models.
- **Client satisfaction brief survey.** In all health care planning, the importance of the patient's point of view is becoming increasingly recognized by planners and policy makers. The providers involved in implementation of specialized housing for late-stage chemically dependent in the mid 1990's state that important components of planning were surveys and focus groups conducted among the population the projects intended to serve. When the chemical dependency treatment and detoxification systems were in their implementation phase in Minnesota, one component of planning information was assessment of the usefulness of the various program components from the point of view of the people served.

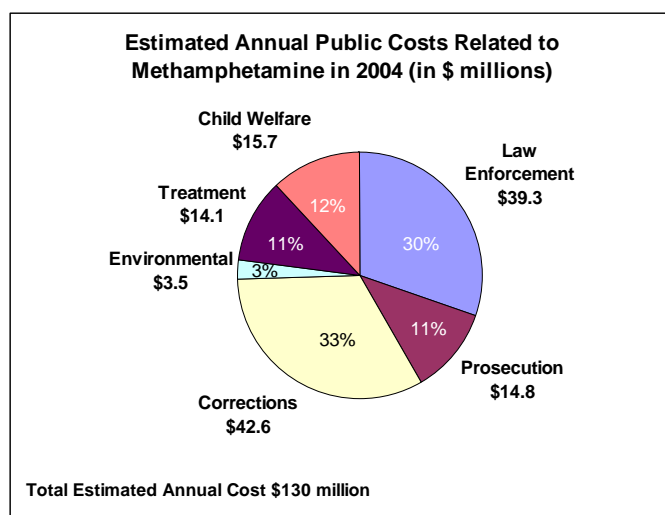
These data are now several decades old and in need of replication. In the process, a survey could gather information on the operational components of the CCDTF, including the client's views on the intervention and placement activities they experienced. Ideally (expense may prohibit this), the survey would include people who were assessed and offered no services, and people who were assessed and offered services other than chemical dependency treatment.

Appendix Figure 1 – Summary of Cost Benefit Studies.⁴⁰

Summary of Cost Benefit Analysis Findings				
Modality	Author	BCR	Net Economic Benefits ^a	Notes
Outpatient	Flynn et al. (1999)	1.33-3.26	Pre- to-post crime cost reductions 24-39%	DATOS sample
	Salomé et al. (2003)	1.49	\$881 at 6 months post treatment	Chicago Target Cities Project
	Fleming et al. (2002)	4.30	\$712 to healthcare system	Brief intervention for problem drinkers
		39.0	\$7,171 to society in reduced motor vehicle accidents	
	French, McCollister, Cacciola, et al. (2002)	3.10	\$17,143 Specialized care	Residential treatment for pregnant or parenting women
		6.50	\$8,090 Standardized care	
	Daley et al. (2004)	5.74	Not reported	3 sessions/week x 10 weeks, in prison
		3.16	Not reported	Intensive day treatment for 4 months, in prison
Residential	Daley et al. (2004)	1.79	Not reported	6 months residential TC, in prison
	French, Salomé, & Carney (2002)	4.34	\$21,329 (83% from reduced criminal activity)	5 programs in WA, short- and long-term residential
	Flynn et al. (1999)	1.68-2.73	Pre-to-post crime cost reductions of 75-79%	DATOS, long-term residential sample
	French, Roebuck, Dennis, Godley et al. (2003)	Not Reported	3 programs had net benefits at 12-month follow-up	5 structured adolescent treatments
	French, McCollister, Sacks, et al. (2002)	5.19	\$85,257 12 months post treatment	MICA patients, Modified TC
Drug Court	Carey & Finigan (2004)	Not Reported	\$4,789, including victim costs	Portland, OR
	Barnoski & Aos (2003)	1.74	\$6,779, including victim costs	Washington State, 6 courts
	Logan et al. (2004)	2.71	\$5,446	Kentucky, 3 courts
	Loman (2004)	2.80	\$2,615 per graduate, 24-month follow-up	St. Louis, MO
		6.32	\$7,707 per graduate, 48-month follow-up	

^a Per client

Figure 2 – 2004 Department of Corrections Cost



⁴⁰ Economic Benefits of Drug Treatment: A Critical Review of the Evidence for Policy Makers; Steven Belenko, et al.; Treatment Research Institute, University of Pennsylvania; February, 2005.

Figure 3 – Percent of County Placements Paid from County Funds, 2004.

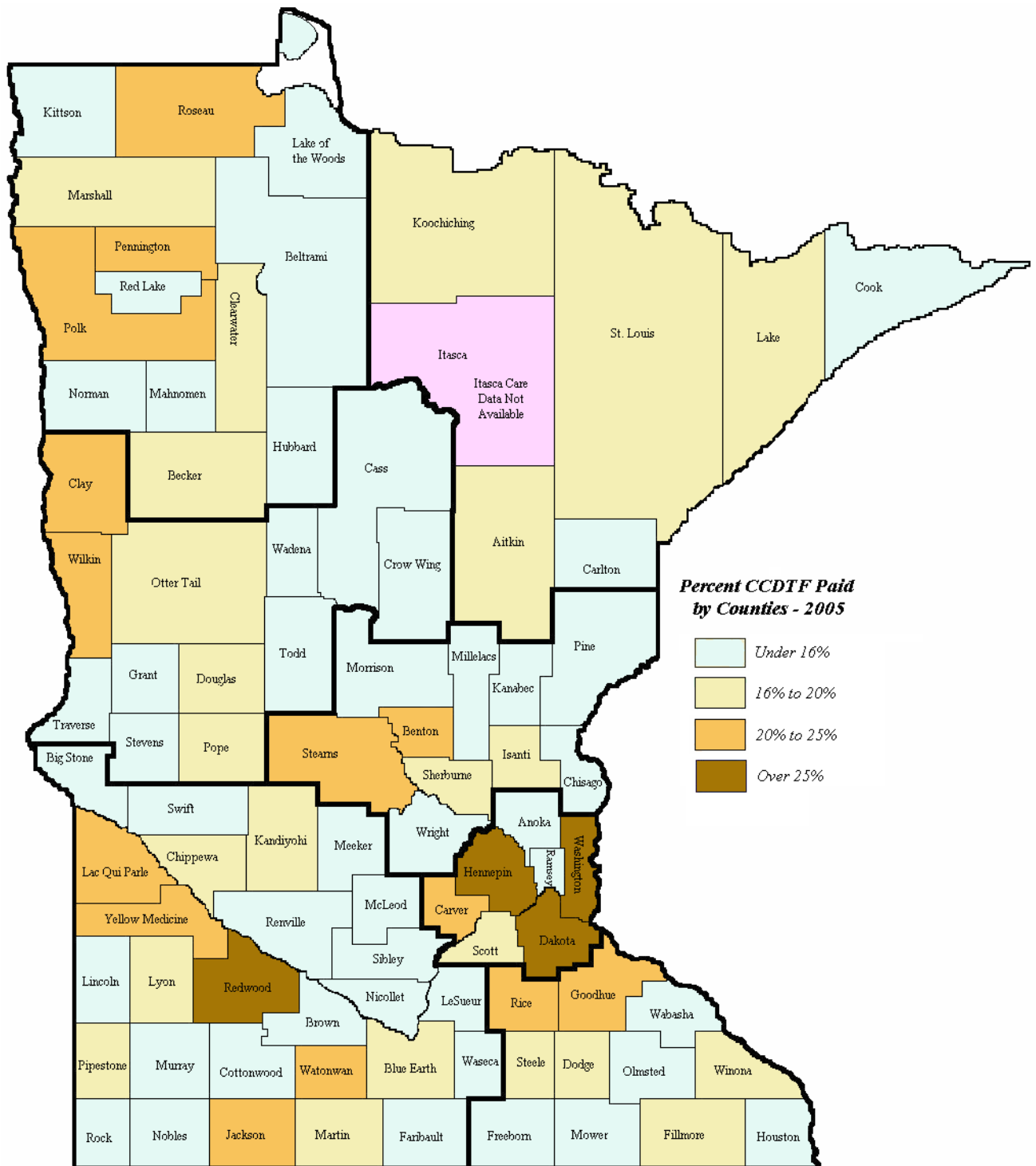


Figure 4 – County Resident DWI Arrests Per 1,000

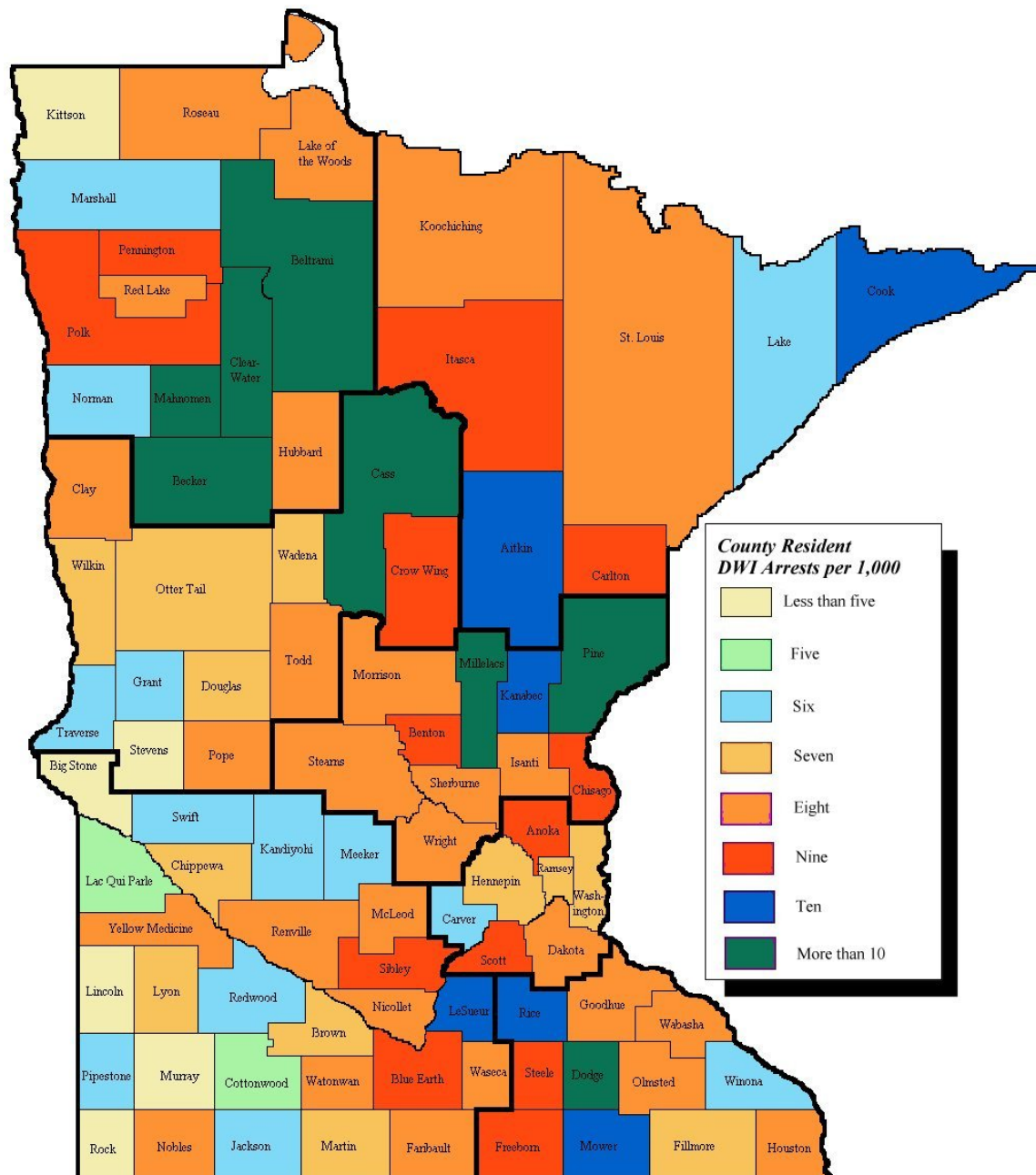
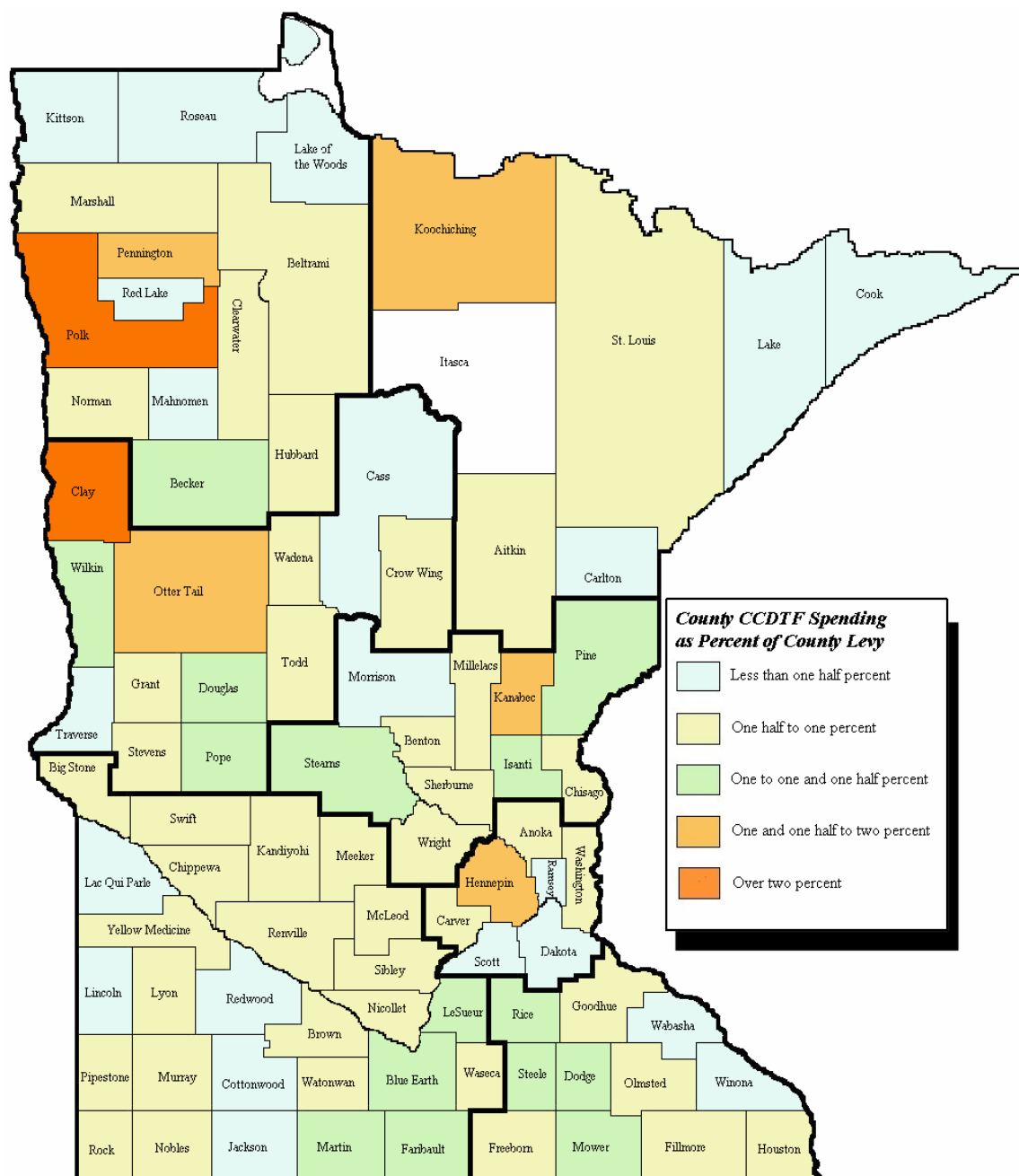


Figure 5 – CCDTF County Expense as Percentage of County Levy*



* 2004 County levy, not including special assessments. Itasca County Itasca Care costs are not included.

Figure 6 – County CCDTF Admissions per 1,000

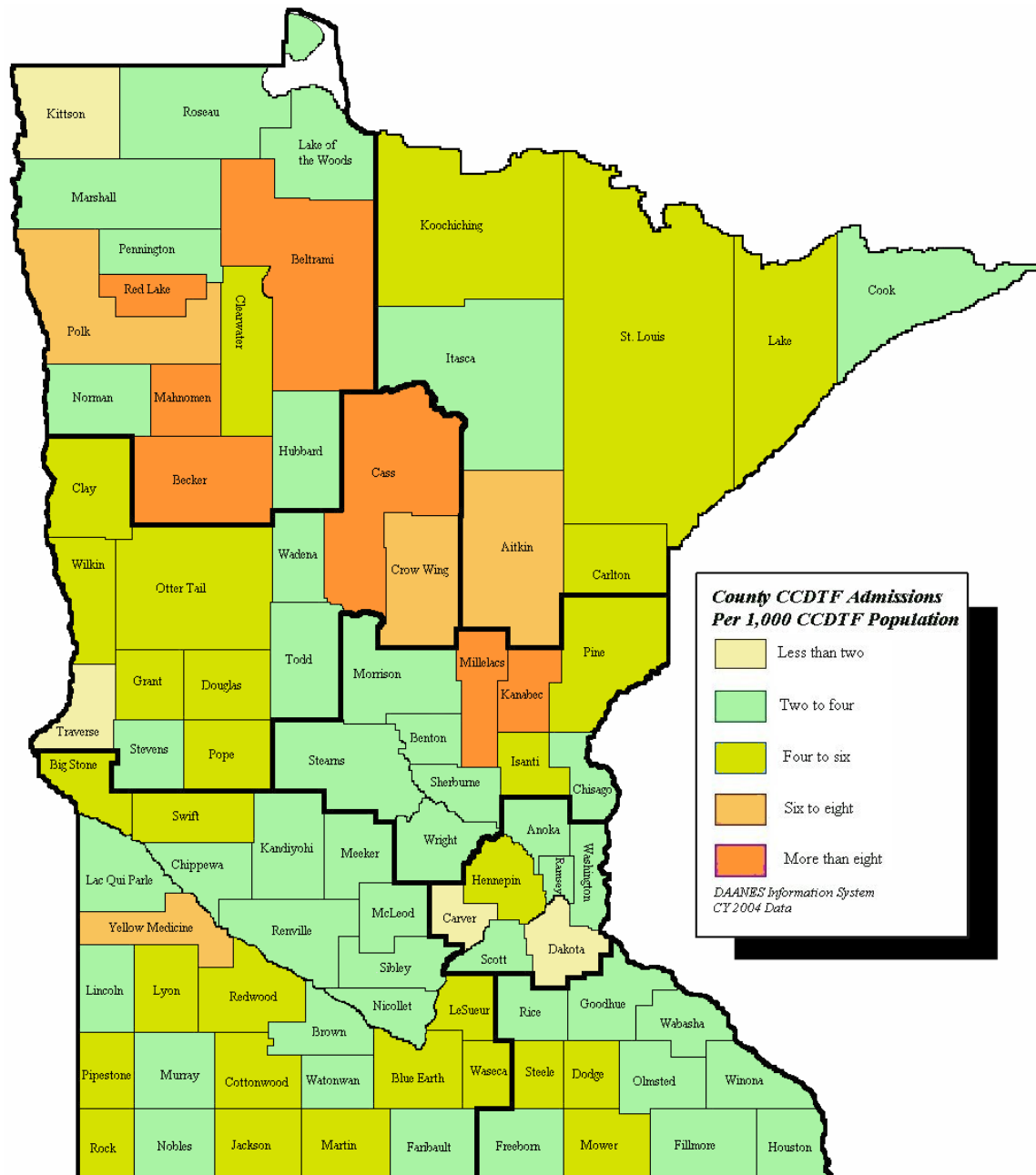


Figure 7 – Percentage of Allocation Fund Used

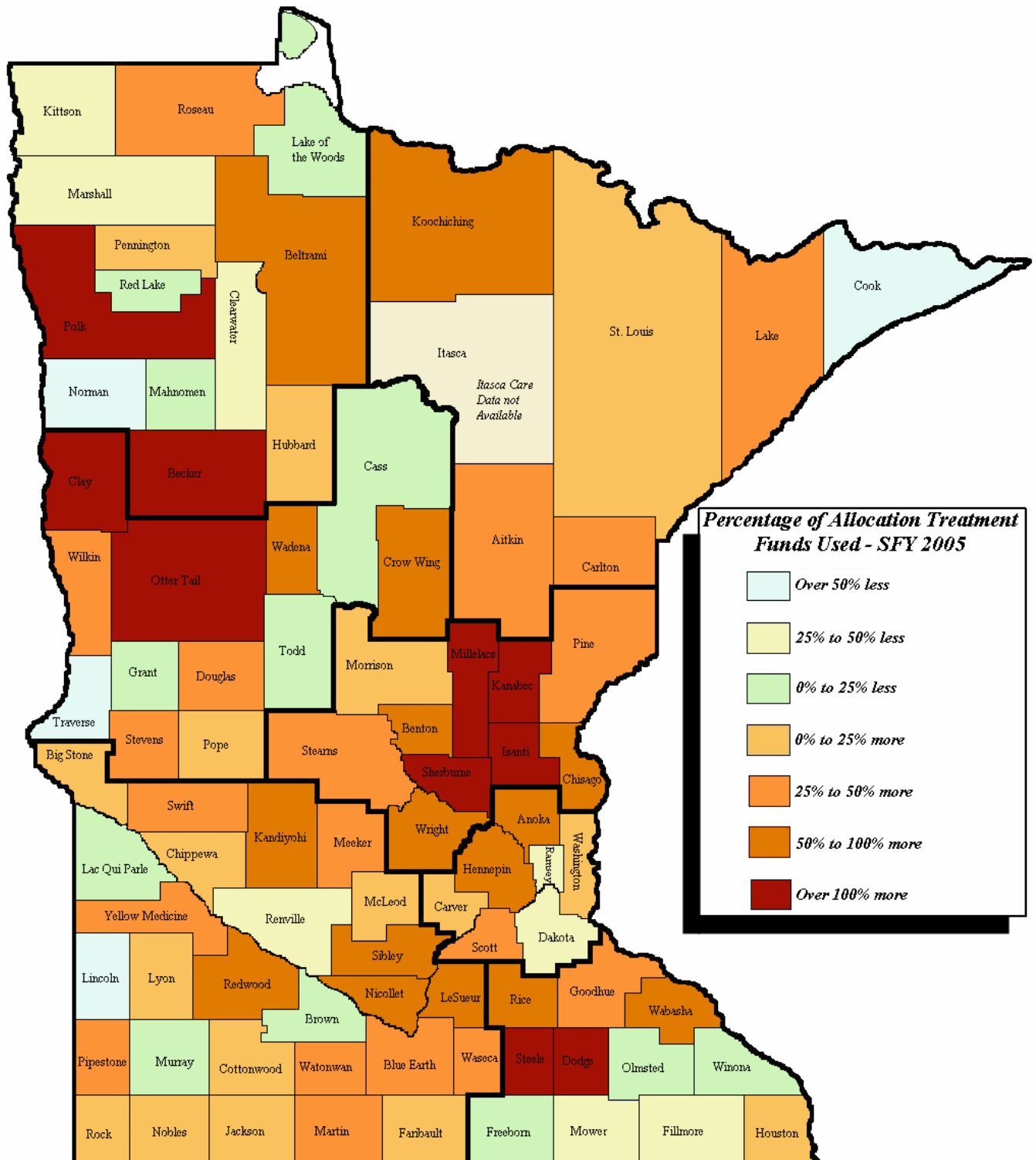


Figure 8 – Methamphetamine Admissions per 10,000

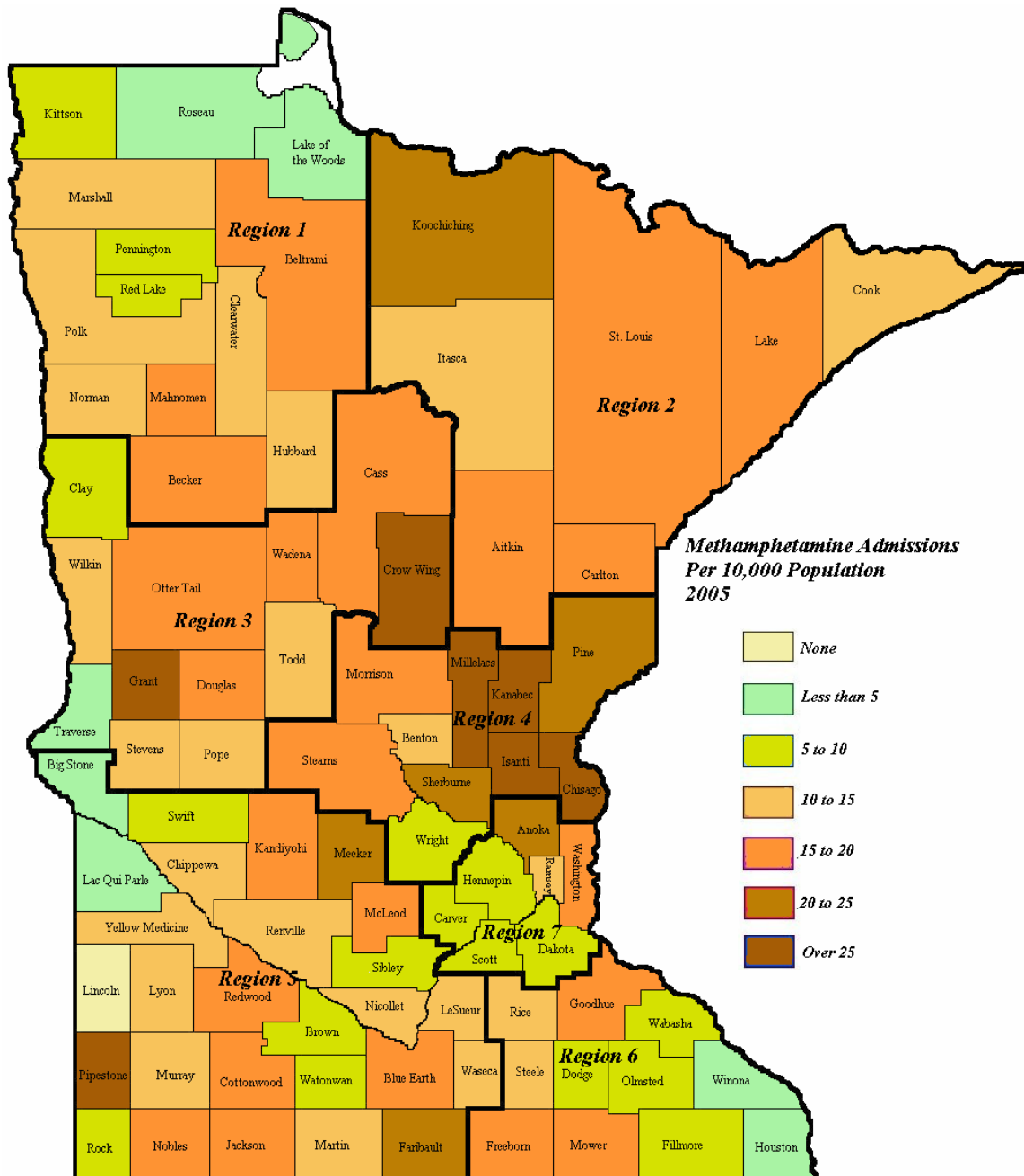


Figure 9 – Percentage Change in Primary Alcohol Problem CCDTF Admissions

