Drug and Alcohol Abuse in Minnesota

A Biennial Report to the Legislature

January 2014

Alcohol and Drug Abuse Division
Chemical and Mental Health Services Administration
Department of Human Services

Minnesota Department of **Human Services**

Legislative Report

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I. Executive Summary

Minnesota Statutes, section 254A.03 establishes the *Alcohol and Other Drug Abuse Division* (ADAD) within the Minnesota Department of Human Services as the State Authority on alcohol and drug abuse. The Alcohol and Drug Abuse Division is advised in its ongoing efforts by two advisory councils, both of which are established and required by state statute:[1] the American Indian Advisory Council, which primarily advises the American Indian Programs section; and the Citizens Advisory Council. The Alcohol and Drug Abuse Division conducts its activities informed by the knowledge that:

- Behavioral health is essential to overall health
- Prevention works
- Treatment is effective
- Recovery from addiction is possible

The *2014 Biennial Report* was prepared by ADAD staff. The report includes information related to: 1) The nature and consequences of substance abuse; 2) Substance use and abuse trends in Minnesota; 3) A description of the current continuum of care for substance use disorder in Minnesota, includingrecommendations to reduce barriers to services and improve the continuum by expanding the nature of services available; 4) An overview of the publiclyfunded service delivery system in Minnesota, including a description of recent rate reform activities and an identification of additional funding opportunities presented by the implementation of the Affordable Care Act; and 4) An identification of ongoing collaborative and cooperative efforts among state entities to increase positive outcomes, while reducing duplicative efforts and state expenditures.

Key Facts and Findings**:**

- Treatment is cost effective
- Updating Minnesota's treatment system from an acute, episodic model of treatment to a chronic, longitudinal model of health care would expand the continuum of care to include the essential services of continuing care and recovery support and will improve integration and coordination with primary care and the rest of behavioral health
- Telehealth and telemedicine services will improve access to treatment services for those in need.
- The Affordable Care Act creates new opportunities for substance use disorder treatment

[1]The American Indian Advisory Council at Minnesota Statutes, section 254A.035; the Citizens Advisory Council at section 254A.04.

II. Legislation

The 2014 Biennial Report is submitted to the Governor and the Minnesota State Legislature pursuant to Minnesota Statutes,section 254A.03, subdivision 1(6).

254A.03 STATE AUTHORITY ON ALCOHOL AND DRUG ABUSE.
Subdivision 1.Alcohol and Other Drug Abuse Section.
There is hereby created an Alcohol and Other Drug Abuse Section in the Department of Human Services. … The section shall: … (6) serve as the state authority concerning alcohol and other drug dependency and abuse by monitoring the conduct of diagnosis and referral services, research and comprehensive programs. The state authority shall submit a biennial report to the governor and the legislature containing a description of public services delivery and recommendations concerning increase of coordination and quality of services, and decrease of service duplication and cost.

III. The nature and consequences of substance abuse

Every year substance abuse causes destruction to thousands of lives and families, and its consequences account for billions in costs to the medical, social, and criminal justice systems. In 2011, the Minnesota Department of Health completed a study[1] utilizing data from 2007. Key findings from that study include:

- Alcoholism costs the state's economy $5.06 billion annually. This amounts to over $975 annually for every person in the state.[2]
- Seventy-three percent of the costs associated with alcohol use are attributed to lost productivity ($3.7 billion), mainly due to alcohol-related illnesses and premature death. In 2007, there were 1,150 alcohol-attributable deaths in Minnesota.
- Healthcare expenditures for medical consequences of alcohol use and the treatment, prevention, and support for alcohol use disorders amounted to $938 million.
- Eight percent of the costs of alcohol use are attributed to other impacts on society, such as property and administrative costs of alcohol-related motor vehicle crashes, social welfare administration, fire destruction, and various criminal justice system costs of alcohol-related crime.

A 2004/2005 study[3] measured the extent of substance use, treatment need and receipt of treatment in Minnesota and concluded that about one in 10 Minnesotans meet the criteria for substance use disorders but only about one in ten of those who need treatment receive it in a given year. Data from Minnesota show that most of those who enter treatment complete it and show considerable improvement in housing, employment, use of substances, criminal behavior, and participation in self-help groups. Studies in Minnesota which follow people after treatment show that abstinence and other benefits tend to persist and that most people remain out of

[1] Minnesota Department of Health, March 2011. *The Human and Economic Cost of Alcohol Use in Minnesota*.
[2] On April 24, 2013, *PoliGraph*, a fact-checking feature Minnesota Public Radio reviewed the study and deemed the findings accurate.
[3] Park, Eunkyung., 2006. *Substance Use, Treatment Need and Receipt of Treatment in Minnesota: Results from Minnesota Student Survey, Minnesota Survey on Adult Substance Use, and Drug and Alcohol Abuse Normative Evaluation System*. St. Paul: Department of Human services.

treatment in the year following discharge. Studies from other states confirm that treatment is an effective use of resources and returns are garnered more in financial benefits than it costs. Treatment reduces medical costs, reduces criminal justice costs, increases earnings, and even reduces mortality.

The American Society of Addiction Medicine defines addiction as a primary, chronic disease of brain reward, motivation, memory and related circuitry. The resulting repeated physical, emotional, psychological and social suffering is not a choice. Active addiction is characterized by an inability to consistently abstain, impairment in behavioral control, experience of craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic conditions, addiction may involve cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction progresses and can result in disability or premature death for the individual, in addition to negative impacts on families and society.

Minnesota's current continuum of care provides treatment services for individuals who meet diagnostic criteria for substance use disorder as outlined in the current edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM). In May 2013, the newest edition (DSM-V) was released. The DSM-V combines the previously separated categories of substance abuse and substance dependence into one group of substance use disorder (SUD). Criteria determine SUD as mild, moderate or severe. Addiction treatment services address all levels of SUD. NOTE: The terms SUD and addiction are used interchangeably throughout this report.

People with SUD may not seek treatment for a variety of reasons, including denial of a problem, a belief they should be able to solve the problem without help, shame or fear about entering treatment, physical withdrawal from drug use, and fear of failure to recover. In addition, the stigma of addiction and shame about what one's family, friends, and employers might think prevents many individuals from being open to seeking help for SUD.

Individuals with addiction who do access treatment have usually experienced significant family, legal, employment and health problems prior to entering treatment. Many individuals have previously made multiple unsuccessful attempts to moderate, decrease or stop consumption of alcohol or illicit drug use.

Despite periods of abstinence, resuming substance use with the intended goal of moderate substance use is often unsuccessful for individuals with SUD. Addiction eventually escalates to previous levels of severity or further progression of illness and consequence. Some believe their time in treatment (away from active addiction) equates a "cure" or absence of illness.

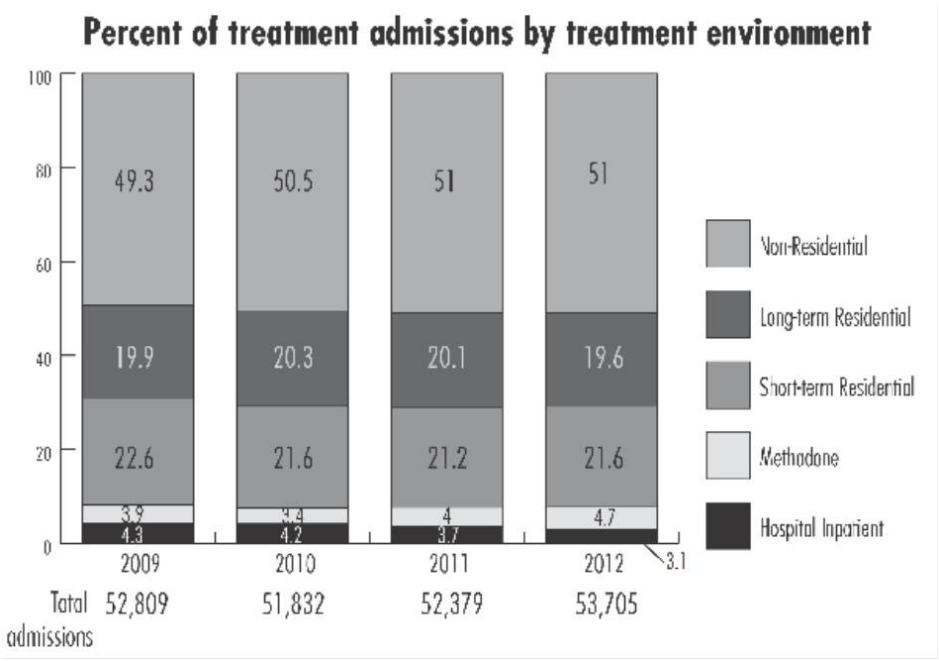
Individuals with SUD often promise themselves and others they will quit, and at times can abstain. However, the underlying causes to addiction are not as simple as ending the cycle of using, it is also maintaining a substance free lifestyle. Substance use disorder treatment addresses the physical, emotional, cognitive, behavioral, and spiritual components necessary to 'stay quit,' which enhances the likelihood of long-term recovery.

Across varioussettings, individuals who complete treatment show improvement in major life areas, with fewer social, emotional, medical, financial and psychological problems. Due to the physical, cognitive, and emotional effects of addiction, abstinence from alcohol and other illicit drug use marks potential for optimal recovery in individuals diagnosed with SUD. Like other chronic illnesses (diabetes, asthma, hypertension), addiction recovery requires mindful maintenance and periodic professional care.

IV. Statewide substance use and abuse trends

The Department of Human Services maintains the Drug and Alcohol Abuse Normative Evaluation System (DAANES). All providers of SUD treatment in the state that participate in the Consolidated Chemical Dependency Treatment Fund are required to submit data to DAANES at admission and discharge for all episodes of treatment.[1] The tables in Appendix A reflect DAANES data utilized for the following narrative findings.

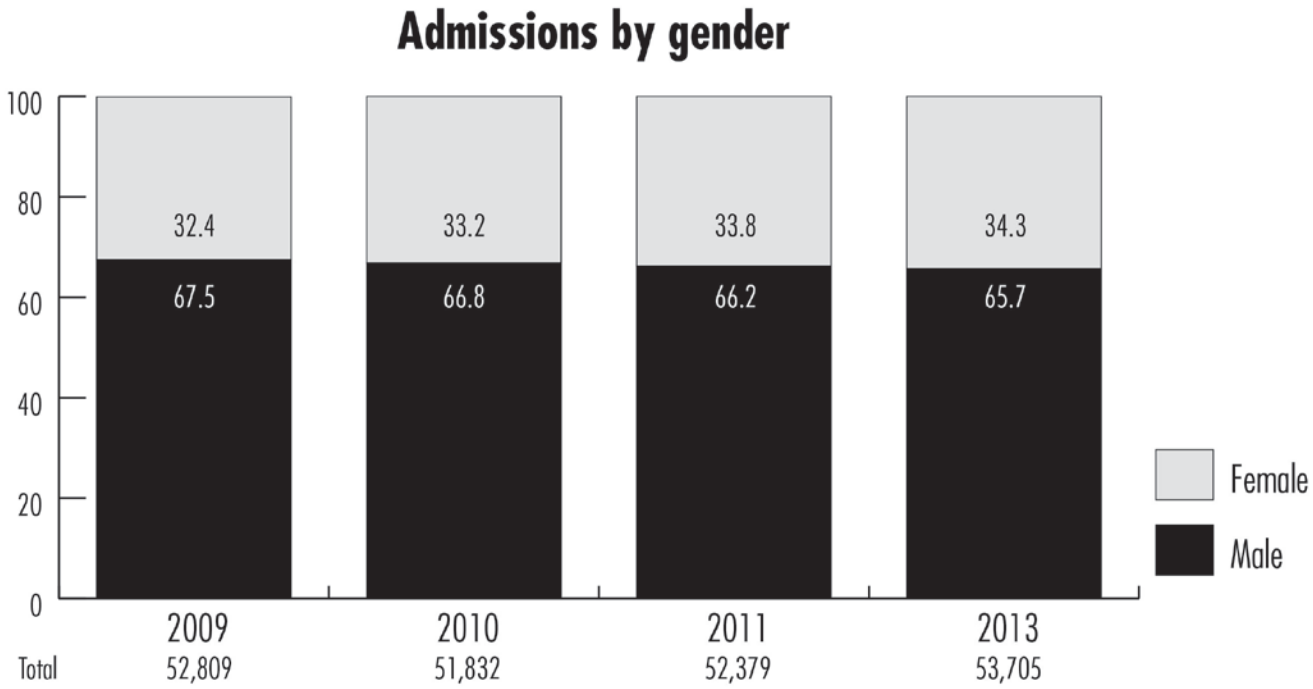
In 2012, 53,705 treatment admissions occurred across the state. This is slightly less than a 2% increase since 2009, when the number of admissions was 52,809. Although treatment admission rates remained fairly steady, there were notable shifts when the nature of the treatment environment is considered. In 2012, hospital inpatient admissions accounted for 3.1% of treatment admissions statewide, down from 4.3% in 2009.There was a simultaneous slight reduction in admissions to residential programs, which in 2009was42.6% and in 2012 was 41.2.Settings with increased proportions of admissions wereoutpatient (1.7% increase) and medication-assisted treatment[2] (1.8% increase).The increased placements in medication-assisted settings correspond with an increased availability and abuse of opioid pain medications as well as the rise in heroin use across the state.



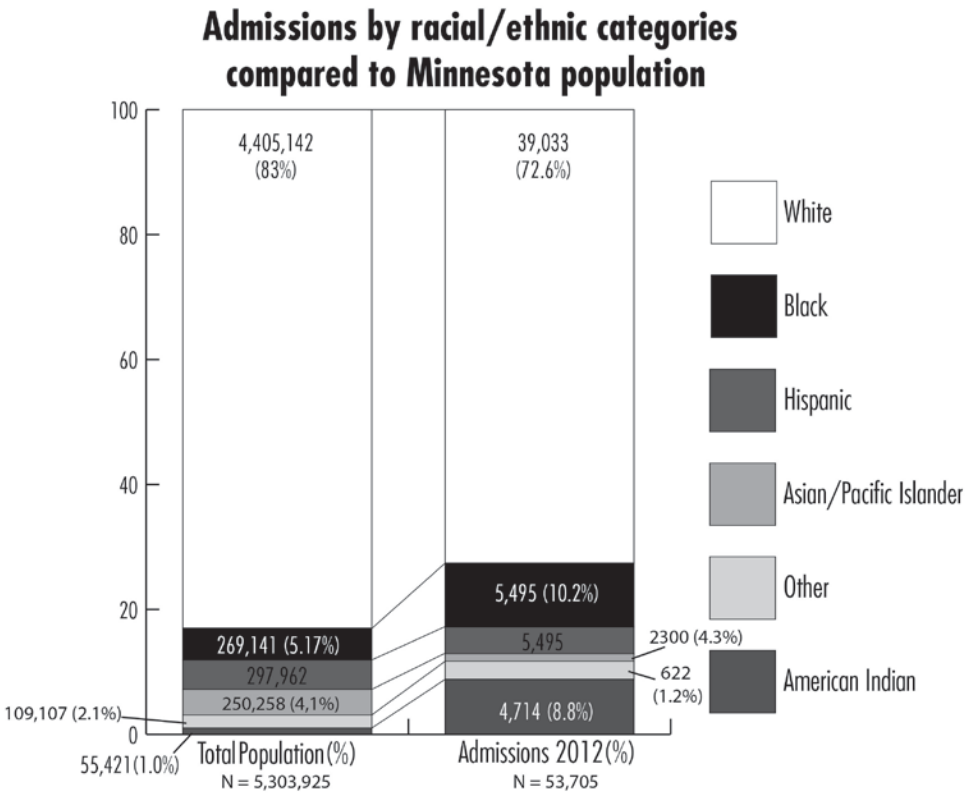
[1] A few providers, such as the U.S. Department of Veteran Affairs and the Minnesota Department of Corrections, are exempt from this requirement.

[2] Medication Assisted Treatment is utilized for opioid addiction, e.g. methadone programs.

Gender breakdown in admissions changed somewhat since 2009. Males represented 67.5% of treatment admissions in 2009, but this decreased in 2012 to 65.7%. Female admissions in 2009 were 32.5% and this increased to 34.3% in 2012.



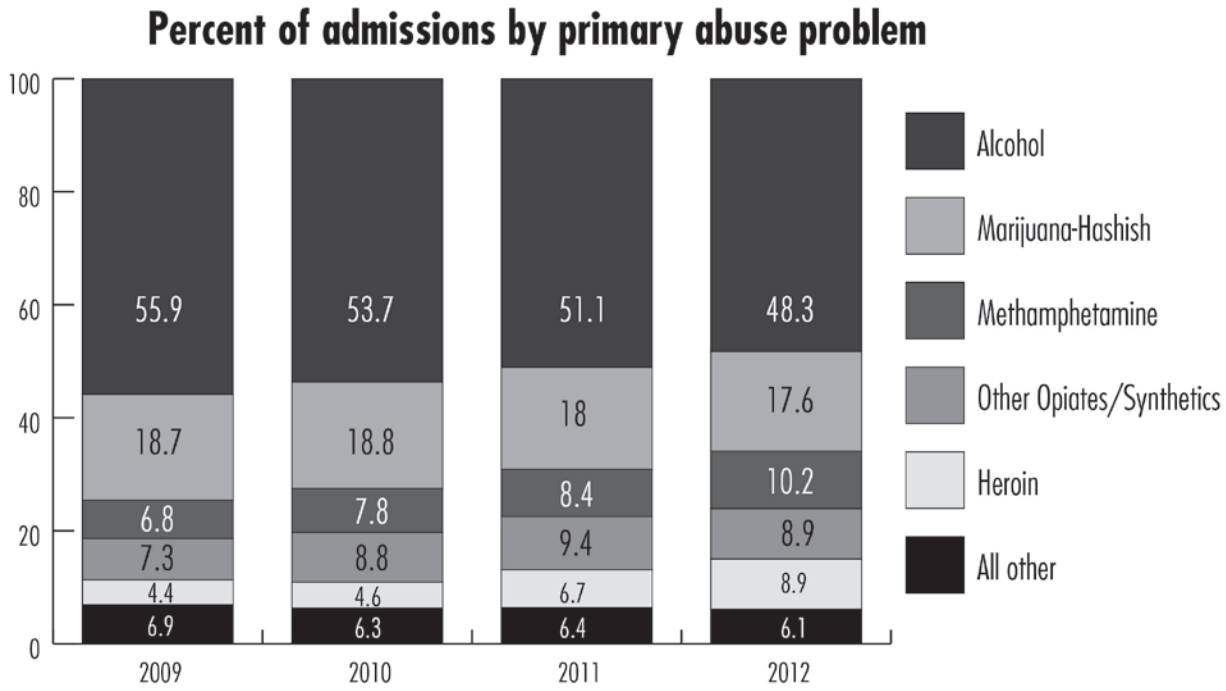
In 2012, 72.7% of individuals admitted were white; 10.2% Black; 8.8% American Indian; 4.3% Hispanic; 1.2% Asian/Pacific Islander; and 2.9% other. Despite the lack of notable trends over the past four years, the ratio of admissions for identified populations indicates a disparity in the number of admissions when compared to racial demographics in the state. Census 2010 data indicate Minnesota's demographic breakdown as 85% White; 5.1% Black; 1% American Indian; 4.7% Hispanic; 4.1% Asian/Pacific Islander; and 2.1 other.



In 2011, the Red Lake, White Earth and Leech Lake reservations each declared a public health emergency with respect to prescription controlled-substance medication and illegal drug abuse. Relevant data supports this as trends noted in admission datareveal increases in admissions with opiates and methamphetamines as the primary abuse problem.

Admissions data identifying methadone as the primary problem increased from 6.8% in 2009 to 10.2% in 2012. All opiates (when considered as a group) as the primary problem has increased from 11.9% in 2009 to 18% in 2012.

Alcohol remains the primary substance problem for the greatest number of admissions to treatment, identified so in 48.3% of cases. Opiates follow alcohol for the most often cited abuse problem in 2012, passing marijuana for the first time in the previous four years. Prescription drug abuse is a national problem, but according to a 2009 federal study from the Substance Abuse and Mental Health Services Administration,it appears to be a larger problem for American Indians, for whom the rate of prescription drug abuse is twice the rate of whites.



V. Minnesota's continuum of care for substance use disorders

Chemical dependency services have historically been offered as an acute model of care. More recently,consistent with the chronicity of the disease of addiction, the Substance Abuse and Mental Health Services Administration (SAMHSA) and other leading entities have promoted a transformation of chemical health services to a chronic disease model of care with longitudinal availability of SUD services and recovery-oriented systems of care.

Increased opportunities to expand the essential health benefit and overall availability of SUD services is anticipated as the Affordable Care Act is implemented nationwide. The current reactive model with a "one size fits all" approach will transform into a flexible, recovery supported model; possessing the ability to tailor to individuals needs and meet their point of access earlier than if referred through a traditional Rule 25.

Minnesota's current continuum of care for people with chemical dependency includes services in prevention, intervention, detoxification, treatment,continuing care and recovery support services.In 2012, the Minnesota Legislature enacted a law directing the Commissioner of DHS to collaborate with counties, tribes, and other stakeholders to develop a community-based integrated model of care to improve the effectiveness and efficiency of the service continuum for chemically dependent individuals in Minnesota.[1] The Alcohol and Drug Abuse Division completed the directive and in March 2013, presented the Legislative Report "Minnesota's Model of Care for Substance Use Disorder." The model proposed in the report accomplishes the shift to a chronic model of care in a manner integrated with physical health and the rest of behavioral health, and results in a "no wrong door" to ensure appropriate services for any individual, regardless of circumstance. The report proposed a pilot project to test the new

[1] Laws of Minnesota 2012, Chapter 247, Article 5, Section 8.

services, and the 2013 Legislature enacted legislation establishing the pilot.(Minnesota Statutes 2013, 254B.13). Efforts are underway to operationalize the pilot project in the northern, metro and southern areas of the state. Additional services for future implementation that are identified in the model include comprehensive care coordination,recovery support services and the provision telehealth and telemedicine services. Minnesota's current continuum is described below, including a discussion of the new services anticipated to be available in the future.

Prevention:
The reduction in the prevalence of alcohol and other drug use/abuse and the delay in age of the "first use," are two strategies employed in primary prevention methods. ADAD promotes evidence-based primary prevention strategies to "identify and address high-risk" substance use,before addiction develops.

Utilizing more than 20 years of drug abuse research, the National Institute on Drug Abuse identified important principles for primary prevention programs in the family, school and community. In accordance with this research, prevention programs are often designed to enhance "protective factors," (those associated with reduced potential for substance use), and to reduce "risk factors," (those that make substance use more likely). Research-based primary prevention programs can be cost-effective; recent research shows that for each dollar invested in primary prevention, a savings of up to ten dollars in SUD treatment costs can be seen.

As the state authority for alcohol and drug abuse prevention and treatment, ADAD is required to use 20 percent of its SAMSHA Block Grant award on primary prevention. Primary prevention programs include activities and services provided in a variety of settings for all, as well as targeted sub-groups at high risk for substance abuse.Prevention services are provided through a combination of individual and population-based programs and strategies, though much emphasis is put on changing the local environments in which substance use occurs. The Alcohol and Drug Abuse Division collaborates with other stakeholders and state agencies (Health, Education, Public Safety and Education)in data-driven planning around the delivery of prevention services throughout Minnesota.

Activities funded through the Block Grant and the SAMHSA-funded Strategic Prevention Framework State Incentive Grant (SPF-SIG)include:

- Eighteen community-based prevention grants that utilize a public health approach topreventing alcohol problems among young people.
- Seven regional prevention coordinators who deliver capacity-building prevention services to local communities.
- Development (or maintenance) of a statewide prevention resource center.
- Annual undercover inspections of licensed tobacco retailers (conducted by ADAD.)

In addition to SPF-SIG funding, between 2006 and 2011, ADAD provided grants for community-based planning andimplementationprograms. Prior to receipt of the grants, the communities had a reported rate of past 30 day use of alcoholthat was nearly nine percentage points higher than the rest of Minnesota, and the community rates were increasing while rates for the rest of state were decreasing. Six years later, with ADAD oversight and management, the communities closed the gap between them and the rest of the state,and reversed their trendsfrom

increasing to decreasing. The communities cumulatively reduced youth past-thirty-day alcohol use by thirty percent from 2004-2010 compared to a 21% reduction in the rest of the state.

The Alcohol and Drug Abuse Division supports culturallyspecific prevention efforts in Minnesota. In 2010, the Alcohol and Drug Abuse Division contracted with a consultant to develop the "Native American Curriculum for Substance Abuse Programs in Minnesota" to support SUD prevention in the tribes and urban American Indian communities in the state. The curriculum was adapted from the "Native American Curriculum for State Licensed Substance Abuse Programs in South Dakota," which was developed by Duane Mackey in 2004. The primary purpose of the Minnesota curriculum is to provide education to prevention specialists and staff of licensed SUD programs in Minnesota. The adapted curriculum contains elements specific to and reflective of the tribal makeup and historical experiences of American Indians who live in Minnesota.

Outreach in prevention has been directed to raise the public's awareness to the dangers of synthetic drugs. The sales, use and accessibility of synthetic drugs heightened in 2013 with the Federal prosecution of a Duluth business owner selling substances out of his downtown storefront. The high profile story generated media attention and exposed the public to the consequences resulting from dangerous drugs, commonly disguised to look like a video game or baseball card. This community effort prompted the Department to educate on the risk synthetic drug usage. This effort consisted of the development and printing of 20,000 synthetic drug "ALERT" brochures for distribution through primary prevention outlets. Outlets include seven regional prevention coordinators, 10 prevention, planning, and implementation communities, seven strategic prevention framework/state incentive grant awardees, and other partners in prevention. The first outlet to receive the brochures was located in the St. Louis County Public Health agency. The Department requested the agency's assistance to disseminate the ALERT in St. Louis County, and specifically in Duluth.

Secondly, the Department has partnered with the Minnesota Bureau of Criminal Apprehension to join their efforts in preventing the accessibility of synthetic drugs across the state. This partnership will continue to work together and explore solutions to address these challenges.

In addition, the Chemical & Mental Health Services Administration has been an engaged voice at the table regarding the rising use of synthetic drugs primarily in adolescent and college aged users. Assistant Commissioner Dave Hartford testified to the Legislature's Select Committee on Controlled Substances and Synthetic Drugs on October 9, 2013 to the overall prevention efforts taken thus far in Minnesota and those proven nationally to have the greatest impact. A plan outlining recommended investments by which the Department of Human Services will deliver was presented and accepted by the committee. These investments include ongoing efforts through the Statewide Substance Abuse Strategy Committee to strengthen educational and policy driven support, an audience specific, prevention based website, and a school constructed survey.

Intervention:
A significant prevention and early intervention strategy is the utilization of "SBIRT," (Screening, Brief Intervention and Referral to Treatment). SBIRT has been utilized in Minnesota trauma hospitals, emergency departments, primary care and community health settings since 2007. SBIRT is an evidence-based practice that is shown to be successful in modifying the consumption/use patterns of at-risk substance use before more severe consequences occur, while also identifying individuals in need of more extensive, specialized treatment. The 2013 Legislature appropriated $600,000 over the biennium to ADAD to expand the utilization of SBIRT in Minnesota communities across the state by increasing the number of SBIRT trained providers.In December 2013, ADAD issued a Request for Proposals for a qualified grantee(s) to implement the training and the selection of one or more grantees will be completed, and the project implemented during 2014.

Detoxification:
Detoxification is a medical intervention that manages an individual safely through the process of acute withdrawal. Detoxification services[1] are an integral component of the SUD continuum of care, and the longitudinal availability of detoxification services is essential for responding to SUD as a chronic disease. There are currently 21 detoxification programs in the state of Minnesota, two of which do not provide services for publiclyfunded clients. In 2011, the number of admissions to detoxification programs was 30,662.

Each county in Minnesota is required by statute 254A.08, Subdivision 1 to provide detoxification services for drug dependent persons,[2] (the mandate permits utilization of existing services to meet this responsibility). However, an individual who receives detoxification services at a hospital-based detoxification program may be eligible for Medicaid-reimbursed services.

Detoxification costs are county costs. County stakeholders have informed the Department that satisfying this statutory requirement means growing costs resulting from placements in detox centers, emergency department/hospital services, law enforcement, and transportation. These expenditures have put counties in a financial hardship. In 2001, Minnesota had 30 detox programs whereas today it is 21. While costs have increased, detoxification program admission data show a decline from 38,344 admissions in 2000 to 30,662 in 2011. (PMQI ,DAANES)
In addition to the county stakeholders, the Department has established a workgroup representing tribes, health plans, law enforcement, and detoxification service providers. The stakeholder workgroup has identified problems such as:

- A lack of lower-intensity services for individuals who are in need of detoxification services, but for whom the existing levels are unnecessarily intense
- Geographic obstacles exist in rural areas when an individual is identified as in need of detoxification services but is a great distance from the nearest detoxification facility

[1]The standards for the operation of detoxification programs are prescribed in Minnesota Rules 9530.6510-9530.6590 (Rule 32).
[2] Minnesota Statutes 254A.08, subdivision 1

- Limited service capacity in more densely populated areas. In some areas, individuals are regularly diverted to emergency departments, at a significantly greater cost than that of a lower intensity detoxification program
- Programs providing detoxification services to individuals eligible for publically-funded services report challenges obtaining reimbursement for services provided. .

The statutory provision assigning the county of financial responsibility has resulted in an uneven distribution of financial expenditures for detoxification services among counties across the state. The American Society of Addiction Medication identifies five levels of care for detoxification services and sets universal standards for each. The intensity of the levels varies from minimally intensive services to hospital-based medically-managed intensive inpatient programs. Minnesota Rules permit the top two intensity levels of detoxification programs to be operated in Minnesota; both are inpatient, though only the highest intensity level is hospital based. Work has begun to identify and implement other levels of detoxification services needed improve access and provide efficient services.

Treatment:
350 programs in Minnesota are licensed to provide SUD treatment services. Chemical dependency treatment facilities (Rule 31)[1] are licensed and monitored by the Licensing Division of DHS. The Board of Behavioral Health and Therapy licenses and regulates alcohol and drug counselors, known as Licensed Alcohol and Drug Counselors, or LADCs. The SUD programs in Minnesota provide a continuum of effective research-based treatment services for individuals in need of SUD services. Treatment programs include individual and group therapy in outpatient or residential settings. Outpatient treatment may include integrated or parallel co-occurring mental health services in the community, and/or medical services, medication-assisted therapies with/without adjunct behavioral services, and service coordination/case management.

Depending on client motivation, preference and likelihood of effectiveness, treatment providers utilize various evidence-based approaches, including 12-step facilitation, cognitive behavioral therapies, dialectical behavioral therapy, motivational interviewing and motivational enhancement therapy in their approach. Depending on an individual's need, willingness and prescription coverage, addiction medications such as naltrexone, buprenorphine, topiramate, and methadone, may be recommended and incorporated into treatment services as an adjunct to behavioral treatment.

Individual clinical needs may indicate that room and board services be provided in tandem with outpatient services. Low, medium and high intensity residential treatment services are provided for individuals with advanced illness severity. Residential SUD treatment services may include integrated or parallel co-occurring services in the community, medical services, adjunct medication therapy, and service coordination/case management. Some outpatient and residential programs serving women also provide childcare or children's services.

Approximately half of the licensed SUD programs in the state are licensed to provide integrated co-occurring services for persons who are diagnosed with both a SUD and a low, moderate, or

[1]Minnesota Rules 9530.6405 - 9530.6505.

managed severe co-occurring mental disorder. The majority of the remaining providers address client mental health needs via coordinated collaborative partnerships with mental health providers in their communities. The Alcohol and Drug Abuse Division and the Adult Mental Health and Children's Mental Health Divisions of DHS have recently completed the rule-making process for creating a certification for integrated dual disorders treatment (IDDT). This rule will help ensure that persons with substance abuse and mental illness receive the most effective and comprehensive care available. This will not replace the current SUD delivery system, but it will enhance and promote the expansion of effective and efficient evidence-based treatment services available in the state to meet the complex needs of persons with co-occurring disorders.

Treatment settings include free-standing for-profit and not-for-profit organizations, hospitals, tribal governments and state-operated treatment services. Some SUD treatment programs contract with county jails and adolescent correctional facilities to provide non-residential SUD treatment services onsite, and one rural treatment program provides outpatient addiction treatment in a nursing home facility. Currently there are a variety of population-specific programs serving females, males, Native Americans, African Americans, Hispanic, deaf andhard of hearing, lesbian/gay/bisexual/transgender, Hmong, Somali and senior populations, and there are 20 licensed adolescent-specific residential service providers in Minnesota.

In October 2013, DHS convened a stakeholder group to establish a revised definition of "culturally specific programs" when applicable to culturally specific services and to recommend legislative language based on the proposed definition. The stakeholder group met over the course of four months to identify community priorities and essential characteristics of culturally specific programs and critical elements to include in the proposed definition. This group will have concluded its work and offer recommendations during the 2014 Legislative session.

The American Indian Programs section and the American Indian Advisory Council of ADAD have worked together to increase the availability of culturally-specific training and effective substance abuse treatment services for American Indians in Minnesota. In addition to the culturally specific program developed for prevention in the American Indian community described earlier in this report, a culturally-specific treatment model for providing effective chemical dependency treatment services to American Indians has also been developed and is in use in Minnesota, and a culturally specific training module on motivational interviewing has been adapted to the American Indian population.

Continuing care and peer recovery support:
Modification of the state's funding frameworkwill be required to provide better case coordination and connect clients to peers in recovery.

Continuing care and recovery support are important interventions for individuals with substance use disorder. Individuals with SUD are commonly experiencing problems in other areas of their lives concurrent with a treatment experience, and if their other problems are addressed alongsidewith treatment, better outcomes are likely.[1]Many individuals would benefit from continuing care/case management services and recovery support in the following areas:

[1]http://www.ncbi.nlm.nih.gov/books/NBK64863/

- Medical health/mental health
- Employment
- Accessing connection and support in the recovery community
- Criminal justice matters
- Educational needs
- Housing concerns or homelessness
- Spiritual needs
- Financial issues
- Child care issues and other concerns related to children.
- Relationship challenges
- Transportation needs

Ongoing recovery support services can help an individual avoid a lapse, which can in turn prevent the need for detoxification or intensive treatment services. Individuals leaving a detoxification program commonly return to the community for a short period of time while awaiting entry into a treatment program. These individuals would benefit from peer support while waiting for treatment admission. Under the present continuum of care, continuing care and peer recovery services may not be available to this individual.

Recovery supports may include a wide range of practices that fall under the umbrella of harm reduction. Policies and practice regarding harm reduction are strongest when rooted in evidence based practice and thorough clinical assessment. Motivational interviewing, a specific counseling technique that may be used for harm reduction, supports change in small increments over time. Others may need to secure basic needs like safe housing and food before changes in substance use can be sustained. Evidence suggests treatment is most successful when individualized to the person,grounded to their unique life circumstances.

VI. Publicly funded substance use disorder services

Since 1988, Minnesota has maintained as a system of public funding for treatment through the state-funded, county-administered Consolidated Chemical Dependency Treatment Fund (CCDTF). The CCDTF was created in 1988 to consolidate a variety of funding sources for chemical dependency treatment services for low-income, chemically-dependent Minnesota residents.

Nearly 50% of treatment admissions over the four year span of 2009 – 2012 were paid for through the CCDTF and anadditional 16% of admissions were provided through a prepaid medical assistance program, Minnesota Care or Medical Assistance, which includes at least partial public subsidization. The ratio of admissions that included some level of public subsidization has remained fairly constant over the four-year span. Most treatment providers in the state accept CCDTF clients.

Institutions of Mental Disease (IMD) are defined in Public Law 100-360 as “a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases...” This definition applies to those residential facilities which provide substance use disorder treatment.

There is an "IMD Exclusion" from federal financial participation (FFP) by Medicaid. The significance of this is that FFP is not available for any medical assistance services under title XIX for services provided to any individual who is under age 65 and over age 21 and who is a patient in an IMD. This exclusion assures that States, rather than the Federal government, have principal responsibility for funding inpatient psychiatric (and substance use disorder) services.

The Department of Human Services will continue to monitor this segment of the treatment service system, as growth in this area, borne entirely by state funds, will be more burdensome to Minnesota than are services provided in non-IMD facilities.

Related, the Substance Abuse and Mental Health Services Administration (SAMHSA) has signaled approaching changes in the way states expend the Federal Block Grant. With the Affordable Care Act's broadening of Medicaid eligibility, those eligible for treatment of substance use disorders will increase, lessening the financial impact on the Federal Block Grant for this service.

VII.Collaborative and cooperative efforts with other state entities

In September 2012, the State Substance Abuse Strategy Group issued a document developed by a multi-agency partnership initiated by the Department of Human Services. The Strategy Group was led by the Department of Human Services and joined by the Departments of Corrections, Education, Health, Public Safety, Military Affairs/Minnesota National Guard, The State Judicial Branch, The Minnesota Board of Pharmacy, and the Minnesota Health Professional Services Program. The State Substance Abuse Strategy document was the first broad, state agency collaboration to address the problems caused by substance abuse. It contained 23 recommendations and three immediate policy priorities. Five additional departmental priority strategies were added by the group's executive sponsors, to increase substance abuse screenings in health care contacts, improve outcome-focused data collection, expand prevention efforts, grow drug/specialty courts, and strengthen support for drug task forces. The work during the year since the report's release has included additional agencies: the Department of Labor and Industry, the Minnesota Prevention Resource Center, and the University of Minnesota/Boynton Health Service. At the time of this report, planning for 2014 is underway.

A sample of results from the Strategy Group's first year include:

- More than 16,000 physicians were informed of how to obtain the ability to prescribe opioid-replacement therapy medication Buprenorphine, and of best practices.
- An agreement was reached between the American Association of Addiction Psychiatry and the University of Minnesota Medical School faculty to provide Buprenorphine training for all medical school residents.

- More than 1,600 front-line professionals were trained on prescription drug abuse, treatment options for persons addicted to opioids, and on how to reverse an opiate overdose.
- Offering additional training for primary care clinicians to provide substance abuse brief intervention and referral to treatment (SBIRT) services supported by $600,000 from the Governor and Legislature in 2014 that will include creating a SBIRT curriculum, managing the identification, treatment and flow of people with electronic medical records and evaluating the individual and program outcomes.
- Tightening of regulation of opioid treatment, requiring programs to provide education concerning other treatment options, allowing state licensors to monitor for program compliance to federal regulations, and granting discretion to county and tribal placing authorities when placing persons who have an opioid addiction.

The state'sstrategy is a multi-agency, multi-faceted approach with the objective to prevent and address the impacts of drug and alcohol abuse. The plan requires close coordination among state agency partners on immediate and long-term recommendations in efforts to balance public safety, prevention, intervention, treatment, recovery support services and research to decrease all substance abuse and addiction.Bringing together state entities to address substance use and abuse in Minnesota has resulted in an increase in complementary individual agency efforts, a decrease in duplicative agency efforts, and many collaborative multi-agency efforts.

APPENDIX A

Minnesota Substance Abuse Treatment Admission and Discharge Information
Source: MN Department of Human Services, PMQI, DAANES (12/5/2013)

Total Admissions	CY2009	CY2010	CY2011	CY2012
	52809	51832	52379	53705

CD Treatment Environment	CY2009	CY2010	CY2011	CY2012
Hospital Inpatient	2252 (4.3%)	2164 (4.2)	1913 (3.7)	1669 (3.1)
Short-term Residential	11955 (22.6)	11206 (21.6)	11107 (21.2)	11590 (21.6)
Long-term Residential	10517 (19.9)	10522 (20.03)	10553 (20.01)	10503 (19.6)
Non-Residential	26029 (49.3)	26168 (50.5)	29716 (51)	27414 (51)
Methadone	2056 (3.9)	1772 (3.4)	2090 (4)	2529 (4.7)

Funding Source	CY2009	CY2010	CY2011	CY2012	
CCDTF	25561 (48.4%)	27753 (53.5%)	25216 (48.1%)	23398	43.6%
MHCP- MCO Client	8878 (16.8)	6423 (12.4)	8062 (15.4)	10437	19.4
Other sources	18370 (34.8)	17656 (34.1)	19101 (36.5)	19870	37

Gender	CY2009	CY2010	CY2011	CY2012
Male	35668 (67.5%)	34610 (66.8)	34652 (66.2)	35271 (65.7)
Female	17141 (32.5)	17222 (33.2)	17727 (33.8)	18434 (34.3)

Race Ethnicity	CY2009	CY2010	CY2011	CY2012
White	38721 (73.3%)	38097 (73.5)	38691 (73.9)	39033 (72.7)
Black	5797 (11)	5393 (10.4)	5416 (10.3)	5495 (10.2)
American Indian	4649 (8.8)	4556 (8.8)	4399 (8.4)	4714 (8.8)
Hispanic	2015 (3.8)	2026 (3.9)	1994 (3.8)	2300 (4.3)
Asian/Pacific Islander	497 (0.9)	572 (1.1)	598 (1.1)	622 (1.2)
Other	1130 (2.1)	1188 (2.3)	1281 (2.4)	1541 (2.9)

Admission Totals

Primary Conditions	CY2009	CY2010	CY2011	CY2012
Avoid jail	3488 (6.6%)	2974 (5.7)	3055 (5.8)	3186 (5.9)
Condition of probation-parole	16273 (30.8)	15902 (30.7)	15604 (29.8)	15891 (29.6)
Retain driver license-plates	1093 (2.1)	1032 (2)	990 (1.9)	1058 (2)
Lose custody of children	763 (1.4)	712 (1.4)	768 (1.5)	821 (1.5)
Regain custody of children	865 (1.6)	918 (1.8)	1048 (2)	1154 (2.1)

Avoid loss of relationship	3928 (7.4)	4020 (7.8)	4413 (8.4)	4533 (8.4)
Maintain employment-school	1011 (1.9)	928 (1.8)	979 (1.9)	879 (1.6)
Retain professional license	112 (0.2)	119 (0.2)	101 (0.2)	108 (0.2)
Retain government benefits	31 (0.1)	29 (0.1)	54 (0.1)	33 (0.1)
Financial pressures	1899 (3.6)	1754 (3.4)	1912 (3.7)	2002 (3.7)
Other	13174 (24.9)	13968 (26.9)	14737 (28.1)	15791 (29.4)
None	10172 (19.3)	9476 (18.3)	8718 (16.6)	8249 (15.4)

Admission Data:

Usual Residence	**CY2009**	**CY2010**	**CY2011**	**CY2012**
Homeless	3568 (6.8)	3492 (6.8)	3876 (7.5)	4503 (8.5)
Dependent living	11865 (22.7)	11966 (23.3)	12420 (24)	13375 (25.2)
Independent living	32222 (61.7)	31173 (60.7)	30795 (59.5)	30443 (57.5)
Children with family	4558 (8.7)	4700 (9.2)	4656 (9)	4657 (8.8)

Detox Admissions	**CY2009**	**CY2010**	**CY2011**	**CY2012**
0	30372 (58)	29211 (56.8)	29434 (56.6)	30051 (56.4)
1	9360 (17.9)	9805 (19.1)	9778 (18.8)	10121 (19)
2	4644 (8.9)	4437 (8.6)	4745 (9.1)	4805 (9)
3 or more	7975 (15.2)	7941 (15.5)	8020 (15.4)	8285 (15.6)

Attend Voluntary Self Help Group	**CY2009**	**CY2010**	**CY2011**	**CY2012**
No attendance	29789 (58.7)	29299 (58.9)	30439 (60.5)	30500 (58.9)
1-3 times past month	48 (0.1)	4556 (9.2)	7264 (14.4)	7601 (14.7)
4-7 times past month	9 (0)	2558 (5.1)	4160 (8.3)	4447 (8.6)
8-15 times past month	7 (0)	1804 (3.6)	3625 (7.2)	3962 (7.7)
16-30 times past month	* (0)	1015 (2)	1804 (3.6)	2172 (4.2)
Some attendance	20867 (41.1)	10474 (21.1)	2999 (6)	3082 (6)

Chemical Health Severity Ratings at Admission

Acute Intoxication-Withdrawal	**CY2009**	**CY2010**	**CY2011**	**CY2012**
None	37483 (71.9)	36422 (71)	35964 (69.5)	36366 (68.4)
Minor	8709 (16.7)	8863 (17.3)	8329 (16.1)	8837 (16.6)
Moderate	4700 (9)	4367 (8.5)	4544 (8.8)	4614 (8.7)
Serious	1194 (2.3)	1462 (2.8)	2511 (4.9)	2885 (5.4)
Extreme	66 (0.1)	204 (0.4)	425 (0.8)	437 (0.8)

Biomedical Conditions	**CY2009**	**CY2010**	**CY2011**	**CY2012**
None	25960 (49.8)	25088 (48.9)	24491 (47.3)	24708 (46.5)
Minor	17455 (33.5)	17928 (35)	18306 (35.3)	19483 (36.7)

Moderate	7107 (13.6)	6468 (12.6)	623712)	5882 (11.1)
Serious	1521 (2.9)	1675 (3.3)	2545 (4.9)	2902 (5.5)
Extreme	82 (0.2)	121 (0.2)	208 (0.4)	169 (0.3)

Emotional-Behavioral Conditions	**CY2009**	**CY2010**	**CY2011**	**CY2012**
None	5322 (10.2)	4386 (8.6)	4095 (7.9)	3646 (6.9)
Minor	14354 (27.5)	13777 (26.9)	12326 (23.8)	11550 (21.8)
Moderate	24631 (47.3)	25642 (50)	27286 (52.7)	29356 (55.3)
Serious	7527 (14.4)	7225 (14.1)	7693 (14.9)	8196 (15.4)
Extreme	279 (0.5)	223 (0.4)	338 (0.7)	321 (0.6)

Readiness for Change	**CY2009**	**CY2010**	**CY2011**	**CY2012**
None	6230 (12)	6132 (12)	5471 (10.6)	5179 (9.8)
Minor	10910 (20.9)	10899 (21.3)	11468 (22.2)	11301 (21.3)
Moderate	20084 (38.5)	19786 (38.6)	19387 (37.5)	19181 (36.1)
Serious	13470 (25.9)	13234 (25.8)	13910 (26.9)	15149 (28.5)
Extreme	1414 (2.7)	1211 (2.4)	1514 (2.9)	2271 (4.3)

Relapse-Continued Use Potential	**CY2009**	**CY2010**	**CY2011**	**CY2012**
None	307 (0.6)	239 (0.5)	361 (0.7)	383 (0.7)
Minor	2106 (4)	1638 (3.2)	1851 (3.6)	1741 (3.3)
Moderate	16364 (31.4)	15342 (29.9)	14452 (27.9)	11822 (22.3)
Serious	28321 (54.4)	29781 (58.1)	26666 (51.5)	21845 (41.2)
Extreme	5002 (9.6)	4259 (8.3)	8417 (16.3)	17283 (32.6)

Recovery Environment	**CY2009**	**CY2010**	**CY2011**	**CY2012**
None	1533 (2.9)	1236 (2.4)	1315 (2.5)	1376 (2.6)
Minor	5863 (11.3)	5031 (9.8)	5074 (9.8)	4374 (8.3)
Moderate	16594 (31.9)	15987 (31.2)	15073 (29.2)	13294 (25.1)
Serious	23674 (45.5)	25117 (49.1)	22949 (44.4)	19298 (36.5)
Extreme	4336 (8.3)	3833 (7.5)	7277 (14.1)	14543 (27.5)

Injection Drug Use	**CY2009**	**CY2010**	**CY2011**	**CY2012**
Within the past 30 days	2051 (4)	2526 (5.1)	3176 (6.3)	3724 (7.2)
Within the past 6 months	1597 (3.1)	1884 (3.8)	2300 (4.6)	2878 (5.6)
Within the past 12 months	647 (1.3)	676 (1.4)	903 (1.8)	1062 (2.1)
More than 12 months ago	3681 (7.2)	3308 (6.6)	3211 (6.4)	3266 (6.3)
Never injected	43005 (84.4)	41532 (83.2)	40581 (80.9)	40649 (78.8)

Primary Abuse Problem	CY2009	CY2010	CY2011	CY2012
Alcohol	29314 (55.9)	27719 (53.7)	26625 (51.1)	25772 (48.3)
Cocaine	693 (1.3)	600 (1.2)	655 (1.3)	541 (1)
Crack	1968 (3.8)	1636 (3.2)	1514 (2.9)	1407 (2.6)
Marijuana-Hashish	9802 (18.7)	9688 (18.8)	9374 (18)	9409 (17.6)
Heroin	2325 (4.4)	2360 (4.6)	3490 (6.7)	4726 (8.9)
Non-prescription Methadone	108 (0.2)	104 (0.2)	114 (0.2)	131 (0.2)
Other Opiates/Synthetics	3853 (7.3)	4563 (8.8)	4901 (9.4)	4758 (8.9)
PCP	12 (0)	14 (0)	15 (0)	20 (0)
Other Hallucinogens/Psychedelics	57 (0.1)	48 (0.1)	69 (0.1)	72 (0.1)
Methamphetamine	3545 (6.8)	4016 (7.8)	4355 (8.4)	5443 (10.2)
Other Amphetamines	132 (0.3)	213 (0.4)	221 (0.4)	275 (0.5)
Other Stimulants	24 (0)	15 (0)	47 (0.1)	43 (0.1)
Benzodiazepines	254 (0.5)	290 (0.6)	305 (0.6)	298 (0.6)
Other Tranquilizers	* (0)	* (0)	* (0)	5 (0)
Barbiturates	18 (0)	13 (0)	20 (0)	12 (0)
Other Sedative/Hypnotic/Anxiolytic	70 (0.1)	54 (0.1)	54 (0.1)	61 (0.1)
Ketamine	* (0)	* (0)	* (0)	7 (0)
Ecstasy/other club drugs	79 (0.2)	70 (0.1)	46 (0.1)	34 (0.1)
Inhalants	69 (0.1)	50 (0.1)	46 (0.1)	47 (0.1)
Over-The-Counter Medications	71 (0.1)	91 (0.2)	83 (0.2)	87 (0.2)
Other	47 (0.1)	62 (0.1)	141 (0.3)	228 (0.4)

Discharge Totals

	CY2009	CY2010	CY2011	CY2012
Total Discharges	51440	50065	50174	50124

Discharge Reason	CY2009	CY2010	CY2011	CY2012
Completed program	31091 (60.4)	29913 (59.7)	28953 (57.7	28087 (56)
Patient left	9946 (19.3)	10173 (20.3)	10766 (21.5)	11004 (22)
Staff requested	3693 (7.2)	3641 (7.3)	3866 (7.7)	4292 (8.6)
Expiration of civil commitment	42 (0.1)	48 (0.1)	63 (0.1)	55 (0.1)
Transferred	3555 (6.9)	3155 (6.3)	3328 (6.6)	3648 (7.3)
Assessed as inappropriate	664 (1.3)	683 (1.4)	725 (1.4)	722 (1.4)
Lost financial support	313 (0.6)	278 (0.6)	321 (0.6)	323 (0.6)
Incarcerated	611 (1.2)	669 (1.3)	679 (1.4)	673 (1.3)
Death	65 (0.1)	74 (0.1)	68 (0.1)	52 (0.1)

Other	1460 (2.8)	1431 (2.9)	1405 (2.8)	1268 (2.5)

Chemical Health Severity Ratings at Discharge

Acute Intoxication - Withdrawal	CY2009	CY2010	CY2011	CY2012
None	41979 (84.8)	40681 (84.2)	39217 (81.5)	38738 (80.4)
Minor	4576 (9.2)	4855 (10.1)	5314 (11)	5709 (11.8)
Moderate	2262 (4.6)	1913 (4)	2287 (4.8)	2366 (4.9)
Serious	571 (1.2)	726 (1.5)	1155 (2.4)	1227 (2.5)
Extreme	142 (0.3)	126 (0.3)	165 (0.3)	162 (0.3)

Biomedical Conditions	CY2009	CY2010	CY2011	CY2012
None	29385 (58.9)	27907 (57.2)	26865 (55.3)	26945 (55.5)
Minor	14362 (28.8)	15054 (30.9)	15755 (32.5)	16071 (33.1)
Moderate	4927 (9.9)	4519 (9.3)	4431 (9.1)	4125 (8.5)
Serious	1059 (2.1)	1125 (2.3)	1279 (2.6)	1262 (2.6)
Extreme	154 (0.3)	151 (0.3)	207 (0.4)	187 (0.4)

Emotional Behavioral Conditions	CY2009	CY2010	CY2011	CY2012
None	8221 (16.5)	7410 (15.2)	7172 (14.8)	6491 (13.4)
Minor	17906 (35.9)	17727 (36.4)	16863 (34.8)	16077 (33.1)
Moderate	17442 (35)	17967 (36.9)	18395 (37.9)	19844 (40.8)
Serious	5834 (11.7)	5239 (10.7)	5566 (11.5)	5684 (11.7)
Extreme	490 (1)	405 (0.8)	528 (1.1)	515 (1.1)

Readiness for Change	**CY2009**	**CY2010**	**CY2011**	**CY2012**
None	12458 (24.9)	11941 (24.4)	11516 (23.7)	10466 (21.5)
Minor	13728 (27.4)	13314 (27.3)	13168 (27.1)	13139 (27)
Moderate	12014 (24)	12004 (24.6)	11461 (23.6)	11070 (22.7)
Serious	8945 (17.9)	9055 (18.5)	9360 (19.2)	9984 (20.5)
Extreme	2873 (5.7)	2541 (5.2)	3157 (6.5)	4085 (8.4)

Relapse-Continued Use Potential	**CY2009**	**CY2010**	**CY2011**	**CY2012**
None	2014 (4)	1857 (3.8)	2308 (4.7)	2094 (4.3)
Minor	11389 (22.8)	10700 (21.9)	10389 (21.4)	9675 (19.9)
Moderate	15012 (30)	14161 (29)	12253 (25.2)	9874 (20.3)
Serious	17100 (34.2)	18044 (37)	16552 (34.1)	14787 (30.4)
Extreme	4466 (8.9)	4043 (8.3)	7100 (14.6)	12269 (25.2)

Recovery Environment	CY2009	CY2010	CY2011	CY2012
None	4498 (9.1%)	4065 (8.4)	4197 (8.7)	3885 (8)
Minor	11517 (23.3)	10789 (22.2)	10218 (21.1)	9183 (19)
Moderate	14967 (30.2)	14429 (29.7)	13166 (27.2)	11255 (23.2)
Serious	15203 (30.7)	16063 (33.1)	14882 (30.8)	13933 (28.8)
Extreme	3344 (6.8)	3165 (6.5)	5924 (12.2)	10190 (21)

Medications Used in Treatment	CY2009	CY2010	CY2011	CY2012
Methadone	2196 (4.3%)	2009 (4)	2129 (4.2)	2098 (4.2)
OtherOpioid	1104 (2.1)	1143 (2.3)	1322 (2.6)	1581 (3.2)
Antabuse	222 (0.4)	192 (0.4)	176 (0.4)	179 (0.4)
Naltrexone	601 (1.2)	708 (1.4)	803 (1.6)	1002 (2)
OtherAnti-Craving	1951 (3.8)	1666 (3.3)	1399 (2.8)	1280 (2.6)
Anti-Depressant	13225 (25.7)	13700 (27.4)	13906 (27.7)	13817 (27.6)
Anti-Anxiety	8416 (16.4)	9425 (18.8)	9525 (19)	9978 (19.9)
OtherPrescribed	3382 (6.6)	3693 (7.4)	3901 (7.8)	3964 (7.9)
Acupuncture	701 (1.4)	605 (1.2)	741 (1.5)	717 (1.4)

Primary Diagnosis	CY2009	CY2010	CY2011	CY2012
Alcohol Dependence	27437 (53.3)	25483 (50.9)	24101 (48)	22756 (45.4)
Heroin, methadone, other opiate/synthetic dependence	5393 (10.5)	6095 (12.2)	7134 (14.2)	7850 (15.7)
Benzodiazepine, other tranquilizer, barbiturate, other sedative/hypnotic dependence	344 (0.7)	343 (0.7)	370 (0.7)	375 (0.7)
Cocaine or crack dependence	2382 (4.6)	1971 (3.9)	1943 (3.9)	1707 (3.4)
Cannabis (marijuana) dependence	7369 (14.3)	7451 (14.9)	7106 (14.2)	6766 (13.5)
Methamphetamine, other amphetamine dependence	3318 (6.5)	3800 (7.6)	4152 (8.3)	5070 (10.1)
Phencyclidine (PCP) dependence	12 (0)	20 (0)	15 (0)	25 (0)
Inhalant dependence	49 (0.1)	45 (0.1)	45 (0.1)	58 (0.1)
Phencyclidine (PCP) abuse	* (0)	* (0)	10 (0)	9 (0)
Hallucinogen dependence	306 (0.6)	280 (0.6)	350 (0.7)	383 (0.8)
Psychoactive substance dependence not otherwise specified (other stimulant)	90 (0.2)	97 (0.2)	142 (0.3)	220 (0.4)
Alcohol Abuse	2076 (4)	2001 (4)	2038 (4.1)	2044 (4.1)
Nicotine dependence	0 (0)	0 (0)	0 (0)	0 (0)
Cannabis (marijuana) abuse	935 (1.8)	920 (1.8)	1074 (2.1)	1129 (2.3)
Hallucinogen abuse	16 (0)	11 (0)	24 (0)	22 (0)

Benzodiazepine, other tranquilizer, barbiturate, other sedative/hypnotic abuse	41 (0.1)	36 (0.1)	30 (0.1)	33 (0.1)
Heroin, methadone, other opiate/synthetic abuse	131 (0.3)	110 (0.2)	166 (0.3)	141 (0.3)
Cocaine or crack abuse	83 (0.2)	74 (0.1)	93 (0.2)	69 (0.1)
Methamphetamine, other amphetamine abuse	138 (0.3)	134 (0.3)	141 (0.3)	138 (0.3)
Inhalant abuse	18 (0)	13 (0)	14 (0)	14 (0)
Psychoactive substance abuse not otherwise specified (other stimulant)	28 (0.1)	26 (0.1)	34 (0.1)	53 (0.1)
Poly-substance dependence	1272 (2.5)	1151 (2.3)	1191 (2.4)	1262 (2.5)

AttendVoluntarySelfHelpGroup	**CY2009**	**CY2010**	**CY2011**	**CY2012**
No attendance	10017 (21.4%)	10144 (22.2)	10734 (23.5)	10753 (23.5)
1-3 times past month	589 (1.3)	7855 (17.2)	9967 (21.8)	9957 (21.7)
4-7 times past month	536 (1.1)	6932 (15.2)	8548 (18.7)	8321 (18.2)
8-15 times past month	321 (0.7)	6943 (15.2)	8981 (19.7)	9047 (19.7)
16-30 times past month	72 (0.2)	3308 (7.2)	4368 (9.6)	4873 (10.6)
Some attendance	35172 (75.3)	10516 (23)	3100 (6.8)	2890 (6.3)