Drug and Alcohol Abuse in Minnesota

A Biennial Report to the Legislature

Alcohol and Drug Abuse Division

January 2016

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Legislative Report

Minnesota Department of **Human Services**

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Legislative Report

Minnesota Department of **Human Services**

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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: the American Indian Advisory Council, which primarily advises the American Indian Programs section; and the Citizens Advisory Council.[1]

The 2016 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, including recommendations to reduce barriers to services and improve the continuum by expanding the nature of services available 4) An overview of the publicly funded service delivery system in Minnesota, and 5) Identification of ongoing collaborative and cooperative efforts among state entities to increase positive outcomes.

During the last two years, ADAD moved swiftly towards advancing multiple system improvements. Through community listening sessions conducted across the state, ADAD has collected the best wisdom available for building a better treatment system. The Minnesota State Substance Abuse Strategy reached a higher level of media and stakeholder attention through the Pain. Pill. Problem symposium held in August of 2015. This event brought a US senator to speak on the problem of prescription pain medication abuse, as well as the governor of Minnesota and several experts on the topic of preventing and treating opioid addiction. In response to the legislative directive to develop a new model of care, ADAD has successfully launched a pilot program that is testing a new service design in the northern region of the state.

As ADAD gains momentum and has gained early stakeholder engagement with system-wide reform, the division recognizes that we need to respond quickly and intelligently to the morbidity and mortality associated with addiction. The division will recommend legislative proposals for advancement that are designed to transform substance use disorder (SUD) treatment in the state, while monitoring and responding to current drug trends that have the potential to hinder and destroy the lives of our citizens.

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

II. Legislation

The 2016 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. Introduction

This report is submitted to the Minnesota Legislature pursuant to Minnesota Statutes section 254A.03, subdivision 1(6). This report was prepared by Alcohol and Drug Abuse Division staff members in the fall of 2015.

Substance use disorders, ranging from mild to severe, respond well to effective treatment. Part of the work of the Alcohol and Drug Abuse Division is to ensure that everyone who needs treatment can access the right service, at the right time, and in the in the right amount. In order to increase the probability that consumers receive effective and timely treatment, we acknowledge that now is the time for SUD treatment reform.

In the Substance Abuse and Mental Health Services Administration (SAMHSA) draft report, *Description of a Modern Addictions and Mental Health Service System,* the framework and components of a well-designed health care system for consumers with substance use disorder are described: ". . . a modern mental health and addiction service system provides a continuum of effective treatment and support services that span healthcare, employment, housing and educational sectors. Integration of primary care and behavioral health are essential. As a core component of public health service provision, a modern addictions and mental health service system is accountable, organized, controls costs and improves quality, is accessible, equitable, and effective." Although the current SUD treatment service system in Minnesota is comprised of a large number of programs reaching from the metro into remote areas of the state and is nationally recognized for its pioneering treatment model, the system doesn't provide the type of care coordination and long-term care required to recover from addiction.

The areas of Minnesota's current care system that require reform include providing direct access to treatment, shifting focus from episodic care to longitudinal care, adding services which necessitate changes to the current Medical Assistance benefit set, permitting third-party reimbursement for appropriately credentialed addiction services providers, expanding the use of screening, brief intervention and referral to treatment services (SBIRT), building a telemedicine service infrastructure, ensuring the availability of a robust menu of services for consumers with opiate use disorders and adding withdrawal management services to the state's care continuum.

As we continue to transform our current treatment system, we are aware of the high numbers of people who are addicted to opioid medications and heroin and associated overdose deaths. It's imperative that we increase the availability of effective treatment for people with opioid use disorders. ADAD is committed to developing strategies that expand specialized treatment opportunities to opioid addicted consumers.

IV. The nature and consequence of substance abuse

The Minnesota Department of Human Services (DHS) is responsible for the statewide response to drug and alcohol problems. In order to respond, we rely on current estimates of substance use problems from the Minnesota Survey of Adult Substance Use (MNSASU). The survey also collects the information necessary to make estimates of substance use disorder for subpopulations of Minnesota adults. These subpopulations include gender, age, race and ethnicity, foreign born residents, region of residence, educational level, income level, and health insurance status. The most current data is now available from a 2015 report. Please note that data for the 2015 report was collected from September 2014 through April 2015. Survey data reports represent snapshots in time.

Findings from the report include:

Past Year Substance Use Disorders—Alcohol Use Disorders:

- During the past year, 5.5% of adults in Minnesota met the criteria for having an alcohol use disorder.

- One characteristic of those having an alcohol use disorder was age; 10% of those 18 to 20 years old met the criteria and 13% of those 20 to 24 years old. After age 24, the proportion of adults meeting the criteria for an alcohol use disorder decreased.

- Men are more likely than women to meet the criteria for an alcohol use disorder as are American Indians compared to other racial/ethnic groups. Those born in the United States had a higher proportion of the population meeting the criteria as well.

- Those with some college had the greatest proportion meeting the criteria for alcohol use disorder (6.3%) and those with more education had substantively lower rates. Those without health insurance were substantially more likely to have an alcohol use disorder (12.9%) than those with health insurance (5.1%).

- Regionally there was little variation; the highest proportion of the population meeting the criteria for alcohol use disorders was in the Southeast region.

Past Year Substance Use Disorders—Drug Use Disorders:

- About 2.0% of Minnesota adults met the criteria for a drug use disorder.

- The demographic characteristics of Minnesotan adults with drug use disorders were similar to those with alcohol use disorders: The prevalence was higher among men, young adults, American Indians and those who reported multiple/other races as well as those born in the United States compared to respective counterparts.

- The proportion of the population meeting the criteria for drug use disorder decreased as educational level increased and as income levels increased. The proportion of those

without health insurance who met the criteria was much higher than for those who had health insurance.

- The region with the highest proportion of the population meeting the criteria for a drug use disorder was the Northeast (3%).

Need for Treatment and Receipt of Treatment:

- The need for substance abuse treatment was defined as the presence of an alcohol or drug use disorder or receipt of specialty substance abuse treatment in the past year. This specialty substance abuse treatment excludes Alcoholics Anonymous and self-help groups.

- About 6.9% of the adult population was in need of some type of substance use disorder treatment. About 5.7% of Minnesota adults needed treatment for alcohol use disorders and about 2.1% needed treatment for drug use disorders.

- Across the types of disorders, the need for treatment was greatest among those aged 18-24, males, American Indians, those with no health insurance, and individuals who were born in the United States.

- The need for treatment for both alcohol and drug use disorders was greatest among the least educated and least financially well off.

- Overall, only 7.4% of those with substance use disorders received treatment during the past year. While about twice as many of those with drug use disorders received treatment (13.7%) than did those with alcohol use disorders (6.8%), still more than 9 out of 10 adults with a substance use disorder did not receive any treatment in the past year.

Trends:

- Cigarette use in 2014/2015 declined from the 2010 survey period and 2004-2005 levels, particularly in the past month timeframe.

- Alcohol use across all 3 timeframes (lifetime, past year, past month) decreased from 2004/2005 levels and shows signs of a possible decrease since 2010.

- Binge drinking and heavy drinking decreased considerably from 2004/2005 and 2010 levels.

- Past-year use of illegal drugs in 2014/2015 increased since 2004/2005 (particularly the use of marijuana).

- Use of prescription drugs in 2014/2015 was similar to 2004/2005 levels but lower than 2010 levels.

- The prevalence of alcohol use disorders has decreased considerably in recent years. Current estimates show a modest decline in alcohol use, but a substantial decrease in binge drinking and heavy drinking. Slightly fewer Minnesotans are using alcohol and those who do use alcohol are less likely to engage in extreme drinking behaviors or to report major adverse effects of drinking.

- The percentage of Minnesota adults in 2014/2015 needing alcohol use disorder treatment declined from 2004/2005 and 2010 measurements, but the need for drug use disorder treatment remained similar to the needs measured in these previous years.[2]

Prescription pain medication related deaths: The Injury and Violence Prevention Unit of the Minnesota Department of Health (MDH) released new data in November of 2015 which establish that the unintentional drug overdose rate is much higher than the overdose rate for suicidal intent. Among the people who have died from drug overdoses in Minnesota, the statewide rate for unintentional drug overdose death, from 2012 to 2014, is 7.5%, while death by suicide drug overdose is 1.6%. The finding that most drug overdoses are unintentional and caused by opioid medications points to the inherent danger of using prescribed pain medication.

Other findings from the MDH report:

- The statewide overdose death rate for people aged 45-54 is higher than all other age groups, closely followed by people aged 35-44.

- In greater Minnesota, people aged 35-44 are more likely to die of a drug overdose than in any other age group.

- In all parts of the state, men are more likely to die of a drug overdose than women.

- MDH reports that in 2013, 2014, and 2015 there were 527, 516, and 418 drug overdose deaths in Minnesota, respectively. The data also shows that opioid pain relievers were increasingly deadly between 2000 and 2014, compared to heroin, cocaine, benzodiazepines, and psychostimulants. [3]

Other Opioid Drug Related Findings Involving Minnesota Residents:

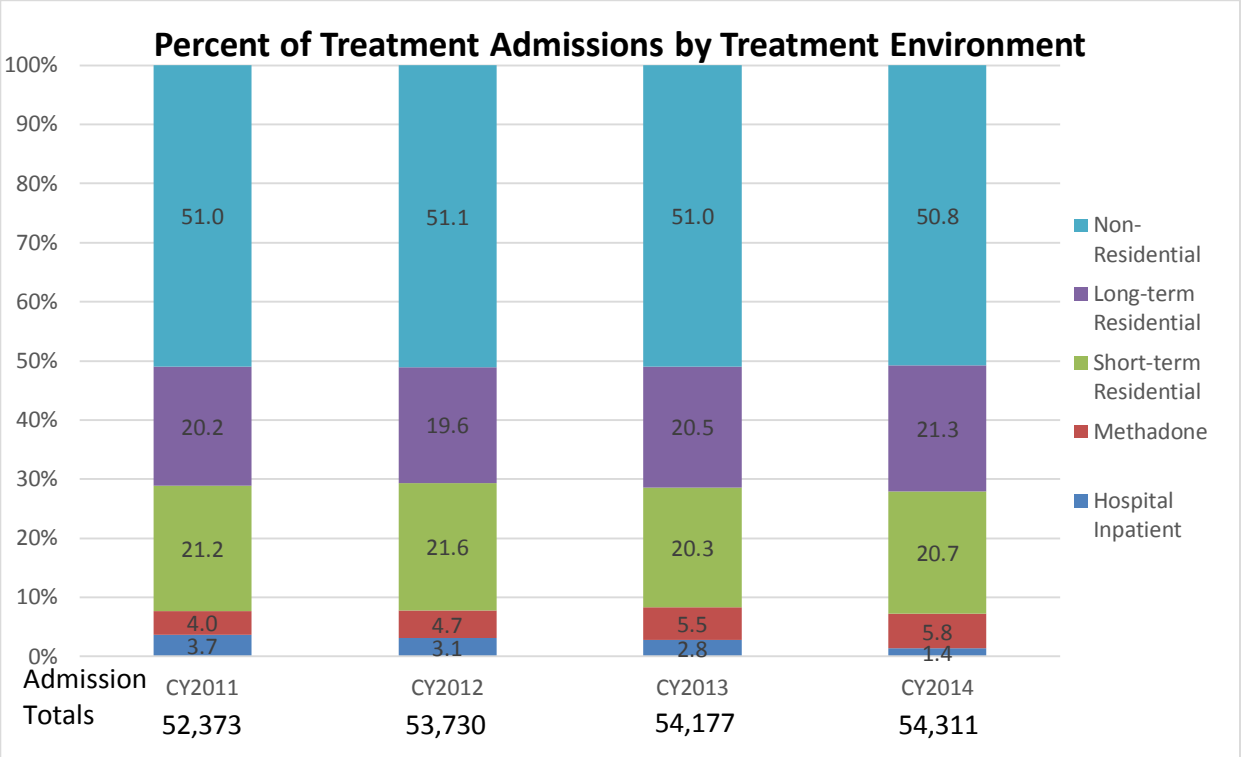
- Minnesota had the 10th lowest rate of youth drug overdose death rates according to the 2015 Trust For America's Health, which might sound reassuring, but overdose rates for youth in the state have more than tripled since 1999.[4]

[2] Estimating the Need for Treatment for Substance Use Disorders Among Minnesota Adults: Results of the 2014/2015 Minnesota Survey on Adult Substance Use. MN DHS & Westat.
[3] Data request: Drug overdose deaths among Minnesota residents, 2000-2014, Injury and Violence Prevention Unit Minnesota Department of Health, Run date: Friday, October 20, 2015; Modified: Wednesday, November 25, 2015, Contact: Nate Wright (Nate.Wright@state.mn.us); Jon Roesler (jon.roesler@state.mn.us).
[4] http://healthyamericans.org/reports/youthsubstancemisuse2015/release.php?stateid=MN, retrieved on November 20, 2015.

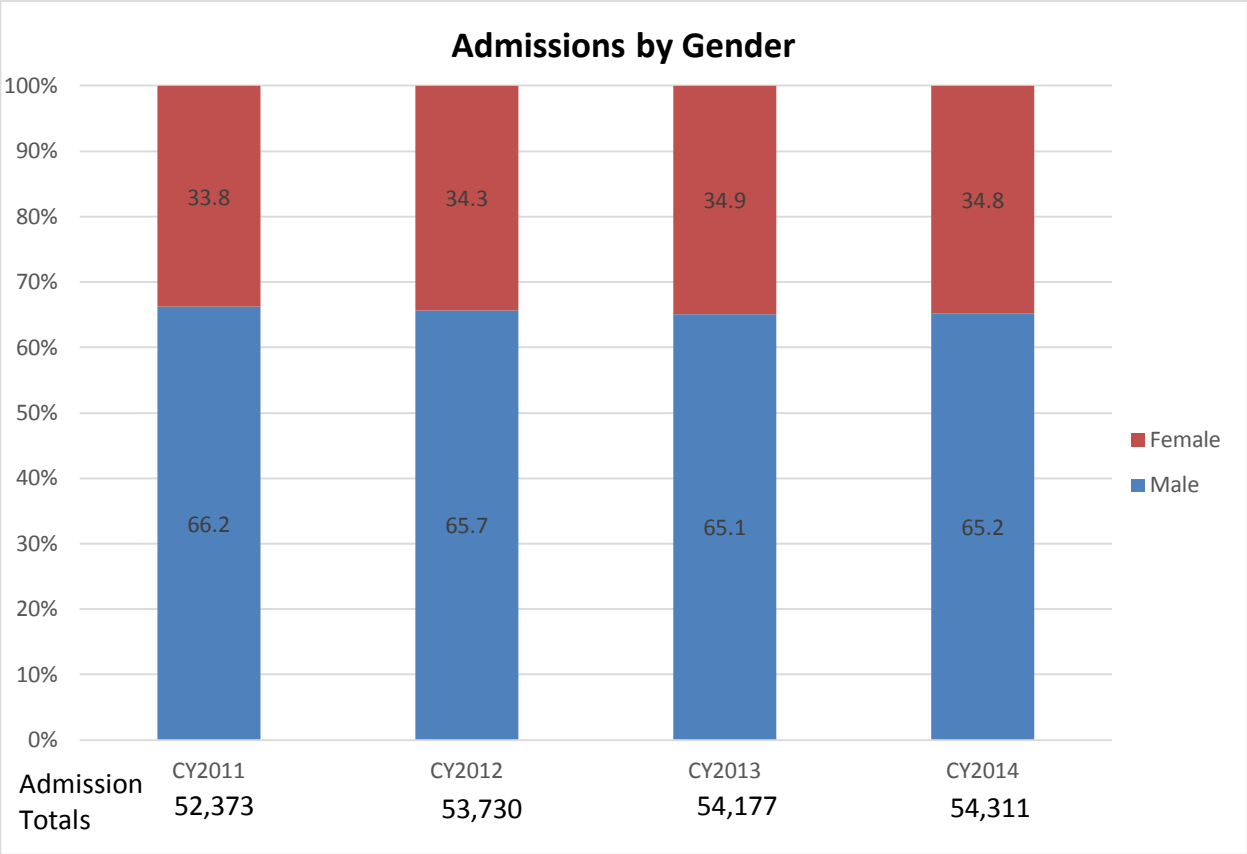
- There remains a disparate impact on the American Indian community and limited treatment access for those who live in remote parts of the state. In 2011, the Red lake, White Earth and Leech Lake reservations each declared a public health emergency with respect to prescription opioid medications and illegal drug use.

Drug and Alcohol Abuse Normative Evaluation System: 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. The tables in Appendix A reflect DAANES data utilized for the following narrative findings.

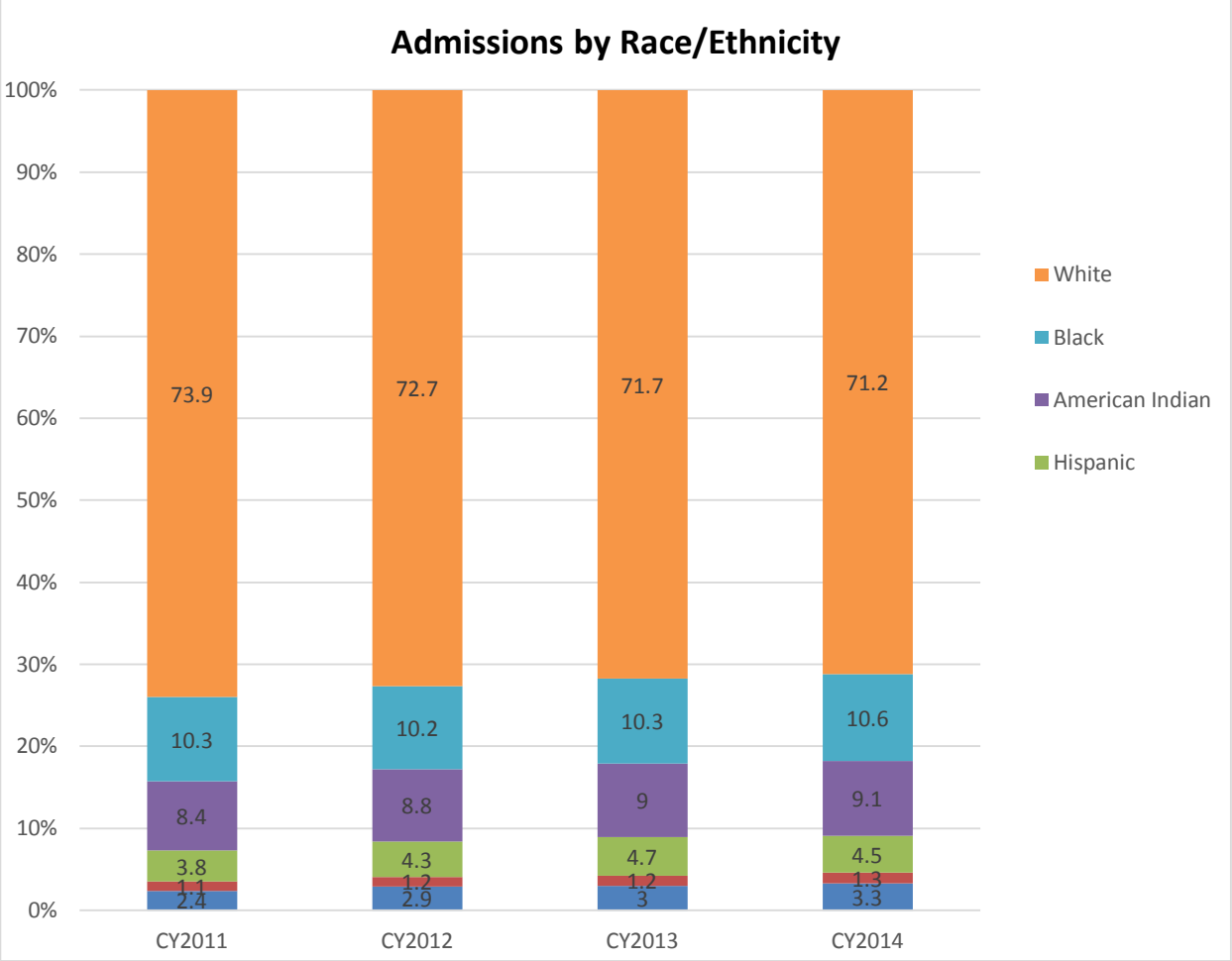
Percentage of treatment admissions by treatment environment: In 2014, 54,311 treatment admissions occurred across the state. This is slightly less than a 2% increase since 2011, when the number of admissions was 52,373. Although treatment admission rates remained fairly steady, there were notable shifts when the nature of the treatment environment is considered. In 2014, hospital inpatient admissions accounted for 1.4% of treatment admissions statewide, down from 3.7% in 2011. Since 2012, long-term residential increased from 19.6% to 21.3%, in 2014. Admissions to outpatient program remained close to 51% since 2011. Admissions to medication-assisted treatment programs increased significantly from 4% in 2011 to 5.8% in 2014. 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.



The distribution of admissions by gender remains largely the same in 2014 as in 2013. Between 2011 and 2014, admissions for women increased slightly from 33.8% to 34.8%. Since 2011, admissions for men have decreased slightly from 66.2% to 65.2% in 2014. If treatment admissions for women are beginning to trend upward, this may be a sign that outreach efforts for women are helping them more readily access treatment.

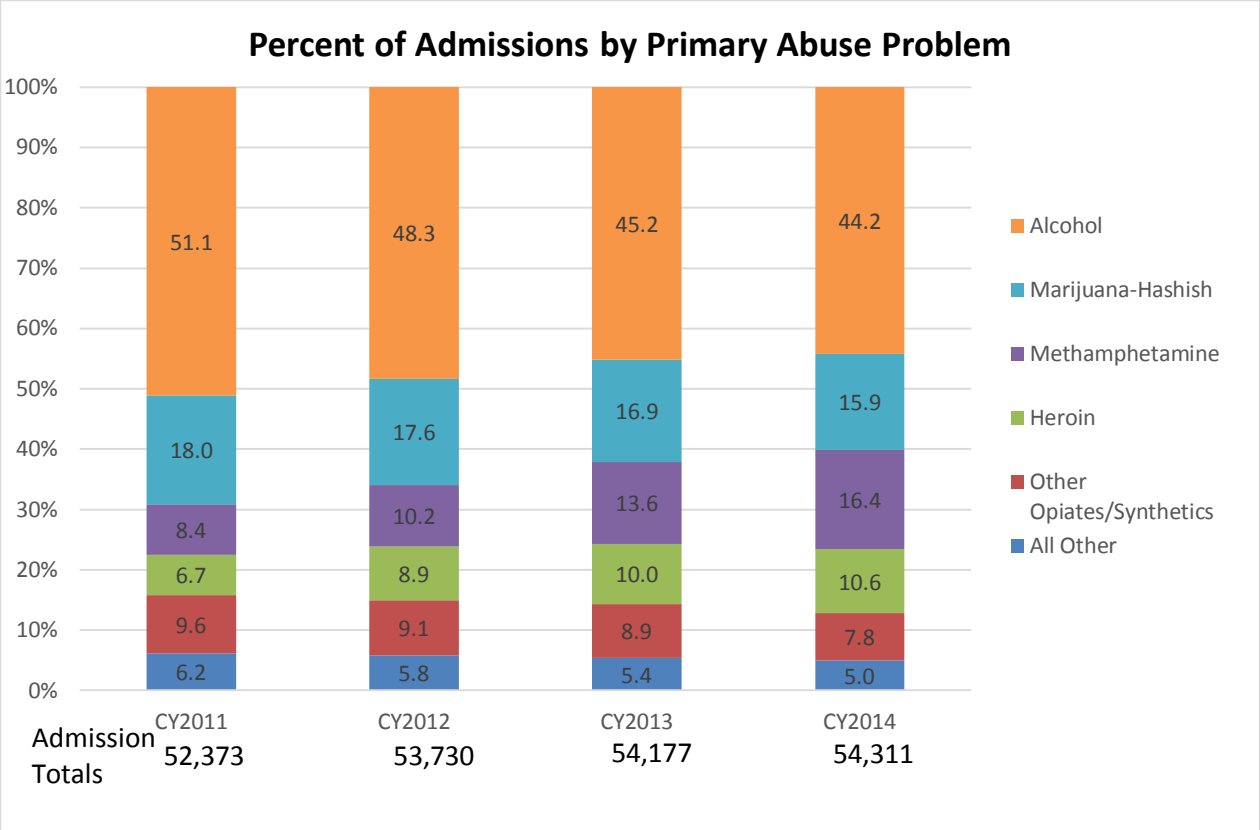


Admission trends by race/ethnicity may indicate promising signs of better access for race/ethnicities other than White recipients. Admission for White people decreased from 73.9% in 2011 to 71.2% in 2014. Admissions for Black people remained steady at close to 10% of all admissions. Admissions for American Indians increased from 8.4% in 2011 to 9.1% in 2014. Of note, ADAD has been working with American Indian communities and tribal leadership to increase treatment access for American Indian consumers. Admissions for Hispanic consumers have increased from 8.4% to 9.1% between 2011 and 2014. Improved access for all communities is significant to the mission of ADAD, but it's also important to note that Black, American Indian, and Hispanic consumers represent small percentages of the entire population in Minnesota, and therefore are over-represented in treatment admissions. 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. Given the disproportionate number of admissions in treatment from communities of color, prevention efforts should be designed to curtail the environmental factors that lead to substance abuse in these populations.



Admission Totals	52,373	53,730	54,177	54,311

Alcohol remains the primary substance problem for the greatest number of admissions to treatment at 44.2% in 2014 but down significantly from 51.1% in 2011. Admissions for marijuana use disorders have decreased from 18% in 2011 to 15.9% in 2014. Admissions for heroin use disorders have increased significantly from 6.7% in 2011 to 10.6% in 2014. Admissions for other opiates, such as prescription pain medication have decreased from 9.6% in 2011 to 7.8% in 2014. The decrease in need for treatment is encouraging, but the number of people who are substituting heroin for prescription pain medication is concerning. Also of concern is the intensity of withdrawal symptoms for people addicted to any type of opioid, indicating a need to provide outreach for consumers with opioid addiction to avoid the trend of switching from one opioid to another. Another alarming trend to note, is the increased percentage of admissions for methamphetamine use disorders, which has nearly doubled from 8.4% in 2011 to 16.4% in 2014.



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

As stated in the 2013 DHS report to the Minnesota Legislature, Minnesota's Model of Care for Substance Use Disorder, "Historically, addiction treatment has been provided as an acute episode of care. The conceptual model has been that an addicted person seeks treatment, completes an assessment, receives treatment and is discharged." The most significant change DHS is building, now and over time, is a longitudinal care system. This change impacts not only traditional residential and outpatient episodic care events but areas of care often set aside from the focal point of SUD treatment. These areas include withdrawal management, opioid treatment programs, medication-assisted treatment, care coordination and peer recovery supports. It is useful to consider all of the changes proposed as transformational rather than incremental. SUD treatment providers, counties, managed care organizations, federal relations, primary care providers, and consumers will all need to be considered as redesigned services are developed.

The Model of Care report proposed a pilot project to test a new service design, and the 2013 Legislature enacted legislation establishing the pilot. (Minnesota Statutes 2013, 254B.14). A pilot project has been implemented in the northern part of the state in two Tribal areas, White Earth Nation (in late 2014), and in Red Lake Nation (in early 2105). Services currently being tested include direct access through a comprehensive assessment by a provider, rather than a placing authority; care coordination; and recovery support services, with the potential for the provision of these services via telehealth.

Minnesota's current continuum of care: Minnesota's current continuum of care for people with chemical dependency includes services in prevention, intervention, detoxification, treatment, continuing care and recovery support services. A description of the vital activities conducted in ADAD for each area of the continuum follows below.

Prevention:
Each year, as the state authority for alcohol and drug abuse prevention and treatment, ADAD receives funds from the federal government in the form of a block grant from SAMHSA. ADAD is required to use 20 percent of its SAMHSA block grant award for primary prevention. Primary prevention programs include activities and services provided in a variety of settings for all, as well as targeted to 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.

Minnesota State Epidemiological Outcomes Workgroup - The Minnesota State Epidemiological Outcomes Workgroup (SEOW) was established in 2006 through a special grant from SAMHSA to the Department of Human Services, Alcohol and Drug Abuse Division, to monitor trends in substance use, related consequences, and risk and protective factors for the purpose of promoting data-driven decision making. Through cross-sector collaboration with state- and community-level departments and organizations, the SEOW has identified numerous indicators of alcohol, tobacco and drug use and consequences that can be used to describe

substance abuse problems facing Minnesotans for both key stakeholders and the general public alike. These indicators can also be tracked over time, serving as outcome measures to evaluate the success of prevention efforts.

SEOW Workgroup activities involve analysis and interpretation of secondary data, development of data dissemination products, provision of epidemiological training and technical assistance, and serving as an advisory committee for substance abuse prevention activities and projects. Data dissemination products include a state epidemiological profile updated annually; county, topical, and demographic fact sheets; and an online, interactive one-stop-shop website called Substance Use in MN (SUMN). Data on SUMN.org is available by grade, age gender, sexual orientation, race/ethnicity, county, and region.

The SUMN website, located at www.sumn.org, houses state, regional, and county data that can be searched by topic, location, and demographic. Users can create custom tables, maps, graphs, and charts. The website is maintained by the Alcohol and Drug Abuse Division and updated annually. The site also includes links to community resources, relevant articles, reports, and websites, and tools/tips regarding data collection, analysis, reporting, and use.

Minnesota Student Survey - Minnesota relies on the Minnesota Student Survey (MSS) to estimate prevention needs for adolescents and the Minnesota Survey of Adult Substance Abuse (MNSASU) to estimate needs for adults. The MSS is a statewide, school-based survey conducted among students in grades 5, 8, 9 and 11 in public schools. The MSS, which is especially useful for planning prevention activities for adolescents, includes a wide array of questions on risk and protective factors and is broken down into both county level data and independent School District data.

Prevention Infrastructure - The state is divided into seven regions, with a Regional Prevention Coordinator (RPC) to provide training and technical assistance to those working in the area of Alcohol, Tobacco, and Other Drug prevention within that region. They bring in speakers/trainers annually for a training held within that region. They also provide training and technical assistance to community coalitions and others within their region seeking assistance for engaging in prevention initiatives. Using federal Substance Abuse Prevention and Treatment (SAPT) Block Grant dollars, ADAD funds an RPC within each of the 7 prevention regions of the state. The RPC System covers all 87 counties.

Tobacco Inspections - DHS ADAD oversees two programs and teams of inspectors that work with youth to conduct inspections or compliance checks on licensed tobacco sellers across Minnesota. The Synar Program is funded by the federal SAPT Block Grant and an Annual Synar Report is a required deliverable under the terms and conditions of the Block Grant Award. DHS ADAD also has a separate contract with the Food and Drug Administration to conduct underage tobacco compliance checks and inspections of cigarette labeling and placement in establishments that sell tobacco.

The Congratulate & Educate Tobacco Merchant Education/ Compliance Check Project awards retailers with a certificate of congratulations for not selling tobacco products to a minor during compliance checks. Retailers who do sell tobacco products to minors receive education on the

importance of keeping tobacco away from youth and the consequences of futures violations. DHS also provides information and materials to the managers of retail businesses to educate their employees on best practices to avoid selling tobacco to minors. In 2015, agencies from 44 of 87 Minnesota counties participated in this initiative conducting 807 checks. Police departments made up the majority of partner agencies, followed by sheriff's offices and public health staff. The project is open to local law enforcement and public health departments contingent on funding.

Problem Gambling Program - The Department of Human Services, ADAD Problem Gambling Program administers a program which funds awareness and education campaigns, a statewide helpline, treatment for inpatient and outpatient services, professional training opportunities and research projects through state funds designated to address problem gambling in Minnesota.

The DHS, ADAD Problem Gambling Program also administers state funds appropriated for Northstar Problem Gambling Alliance, a non-profit, gambling-neutral organization dedicated to improving the lives of Minnesotans affected by problem gambling.

Synthetic Drugs Awareness and Education Initiative - ADAD utilizes state funds to support a synthetic drugs awareness campaign, "Know the Dangers," which has media presence through the website knowthedangers.com. Developed and launched in 2014, the campaign was initially designed to educate the general public about the dangers of synthetic drugs and specifically, adults, professionals and parents. In 2015 the campaign expanded its focus to reach out to a younger audience (potentially middle and high school aged teens). The web site is built on a platform which allowed the State to expand the site to incorporate social media, such as twitter, Facebook, and Instagram to reach a younger audience.

Intervention:

A significant prevention and early intervention strategy is the use of "SBIRT," (Screening, Brief Intervention and Referral to Treatment). SBIRT has been used 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 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 2014 and 2015, a hospital-based pilot was conducted to increase the number of people trained to use SBIRT techniques, increase the use of SBIRT in primary care clinics and to lower the incidence of risky drinking for clinic patients. Pilot funds were made available through the Legislature's appropriation and granted through ADAD. The pilot clinics reported that their patients experienced a reduction in the number of binge drinking sessions per weeks as a result of feedback they received after screening for risky drinking. ADAD would like to see a wider implementation of SBIRT throughout the state.

Detoxification (Withdrawal Management):

Overusing drugs and alcohol to the point of acute intoxication and overdose is one of the most dangerous symptoms experienced by citizens with the disease of addiction. In order to ensure that people who are acutely ill from chemical poisoning receive intensive medical services when clinically indicated, ADAD has develop a plan to modernize detoxification services. Division staff have worked with stakeholders to design a new service delivery system referred to, for the first time in Minnesota, as "withdrawal management." ADAD drafted standards for the new services, which were enacted during the 2015 legislative session with broad based stakeholder support. Although not yet funded, the enacted standards lay the groundwork for future inclusion of withdrawal management services in the state's Medicaid benefit set. Additional information about this is provided in the ADAD's 2015 Legislative Report - *A Plan to Include Detoxification Services as a Covered Medical Assistance Benefit.* [5]

Detoxification describes the biological process of ridding the body of harmful substances while withdrawal management describes the continuum of services available to people who require a safe and effective medical intervention to avoid more illness or even death.

Adding levels of service will allow providers to offer increased medical services when necessary or offer a less intensive, therefore less expensive level of care when indicated. Individuals with complex medical needs will receive medical care without admission into hospital services. Patients will receive the right amount of care based on the severity of their intoxication, the type of substance used, the severity of their substance use disorder and related health conditions.

In addition to two new levels of service, as part of the modernization of services for substance use disorder, DHS proposes that comprehensive assessment, care coordination, and peer recovery support services are added to the new service standards. It should be noted here that in order to add more services and subsequently more staff to each withdrawal management program, the service requires more robust financing than the current unfunded statutory mandate borne by county governments.

Treatment:

There are 398 programs in Minnesota that are licensed to provide SUD treatment services; 377 of which are Rule 31 programs and 18 of which are Children's Residential Facilities (CRF). Chemical dependency treatment facilities, both Rule 31 and CRF, are licensed and monitored by the Licensing Division of DHS. The Board of Behavioral Health and Therapy licenses and regulates 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.

[5] http://mn.gov/dhs/images/Withdrawal_management_report.pdf

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 and hard of hearing, lesbian/gay/bisexual/transgender, Hmong, Somali and senior populations, and there are 20 licensed adolescent-specific residential service providers in Minnesota.

Medication-assisted treatment - The Substance Abuse and Mental Health Services Administration (SAMHSA) defines medication-assisted treatment, including opioid treatment programs (OTP) as a combination of behavioral therapies and medications to treat substance use disorders. The most common medication used today is methadone, which is used as an opioid replacement therapy. The second most common opioid replacement medication is buprenorphine. 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, although not all abstinence-based programs will admit clients who are prescribed some of these medications.

Culturally specific activities - The Alcohol and Drug Abuse Division supports culturally specific prevention efforts in Minnesota. From 2011 thru 2015, the American Indian Section within the Alcohol and Drug Abuse Division has aided in the training and education of 495 substance abuse professionals and related fields on the "Native American Curriculum for Substance Abuse Programs in Minnesota" which supports 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. This adapted curriculum contains elements specific to and reflective of the tribal makeup and historical experiences of American Indians who live in Minnesota.

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 January of 2014, a joint meeting of the American Indian Advisory Council, the American Indian Mental Health Advisory Council and the American Indian Child Services Council (ICWA) met to develop common goals and advice which was given to the Commissioner of DHS for consideration. In January 2016, these same three councils will have met again to review progress and potentially develop additional recommendations for DHS's consideration.

Integrated Dual Diagnosis Treatment (IDDT) - Integrated Dual Diagnosis Treatment ensures that persons with substance abuse and mental illness receive the most effective and comprehensive care available. This type of service does 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. In 2015, the Mental Health and the Alcohol and Drug Abuse Divisions continued to

develop a process for programs/agencies to apply for the new certification. The certification application(s) and process are expected to be finalized around January 2016.

Applicants for IDDT certification will need to follow all of the integrated treatment for co-occurring disorders rule requirements, found in Minnesota Rules, parts 9533.0010 to 9533.0180, including having an integrated treatment team leader who is individually certified through one of the DHS Commissioner approved individual certification recommendations. Currently the program certification is an add-on, voluntary license. During the 2017 legislative session, additional work with regard to rates for integrated treatment for co-occurring disorders is expected.

Continuing care and peer recovery support:

Continuing care services have been sparse within our current continuum of care model. As with all chronic illnesses, substance use disorders require the right services are always available no matter how many times a person experiences a relapse of their illness. Although Minnesota has an abundance of treatment services available, our current system emphasizes services for those who are acutely ill rather than providing services for every stage of the disease of addiction. We would like to see treatment services that follow clients all the way to the remission of their illness and that respond quickly if symptoms reemerge.

Peer recovery support services include the following elements: mentoring and education, advocacy, and recovery support. Peers provide support to clients in their referrals to support groups, providing advocacy, and general discussions that focus on where to go for support groups, maintaining sobriety, how to get further services if needed. This outreach is especially directed to individuals leaving the initial intensive phase of treatment, including those transitioning from a withdrawal management program. Peers also act as role models for those newer in recovery. They may provide transportation to appointments and assist with finding resources such as housing, job search leads, training/educational applications, and support groups.

VI. Publically 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.

The percentage of treatment paid for through the CCDTF is decreasing, shown in the 2011-2014 table below representing funding coverage. Whereas in our 2014 report, which reported nearly 50% use of CCDTF funds between the four year span of 2009 – 2012, the current table shows 40.4% use of CCDTF. As would be expected, more treatment admissions were covered by managed care organizations (MCO) in the form of the prepaid medical assistance program, Minnesota Care or Medical Assistance as more consumers apply for Medicaid benefits. In 2014, 21.8% of admissions were covered by MCOs, compared to 12.3% in 2011.

Funding Coverage, CY2011 – CY2014	CY2011		CY2012		CY2013		CY2014	
CCDTF Client	24,392	46.6	22,639	42.1	22,988	42.4	21,921	40.4
MHCP - MCO Client	6,448	12.3	8,375	15.6	9,272	17.1	11,861	21.8
All Other Sources	21,533	41.1	22,716	42.3	21,917	40.5	20,529	37.8

VII. Collaborative and cooperative efforts with other state entities

Minnesota's State Substance Abuse Strategy is comprised of representatives from the Departments of Human Services, Corrections, Education, Health, Public Safety, Labor & Industry, the Judiciary, and the Board of Pharmacy. The State Substance Abuse Strategy 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.

In 2015, the strategy group introduced the State Opioid Oversight Project (SOOP) to provide a mechanism for the integration of state governmental efforts to reduce the impact of opioid dependence among Minnesotans while appropriately managing pain; simultaneously moving forward with more mature initiatives to reduce opioid dependence and its consequences. Future efforts will include work with stakeholders outside of state government. SOOP is a first step toward creating a coordinated state government response to the epidemic consequences of nonmedicinal prescription drug use. It is important to note that although state government has an important role, we cannot solve opioid misuse and abuse alone. It will require an ongoing response from multiple stakeholders including the federal government, public health, opioid prescribers, addiction experts, researchers, the medical and treatment industry, patients and local communities.

VIII. Report recommendations

1. Innovate prevention strategies that focus on populations at risk for substance abuse disorders.

2. Develop strategies to prevent the over-prescribing and misuse of opioid medications and the use of illicit opioid drugs in our populations. These strategies should operate cooperatively among state agencies through the work of the State Substance Abuse Strategy, with an emphasis on adolescent and other affected populations.

3. Propose legislation related to treatment for opioid use disorder, which may develop through a stakeholder engagement process. Changes that will likely be discussed for feasibility and desirability include modifying Rule 31 standards to prevent programs from declining to admit an individual who is prescribed any sort of medication as part of a medication assisted treatment service and creating a framework that encourages increased access to appropriate treatment opportunities for individuals with opioid use disorder.

4. Introduce legislation to permit direct access to treatment services via a substance use disorder treatment provider and discontinue the use of placement authorities. This access process is currently being tested in the Continuum of Care Pilots.

5. Establish and add additional substance use disorder treatment services to the Medical Assistance benefit set, including comprehensive assessments, peer recovery support services and care coordination. These services are being tested in the continuum of care pilots. The quantity, quality and efficacy of the services will be measured by multiple tools, some of which were designed specifically for the pilot. If statewide implementation of the pilot services occurs in the future, the data tools will provide significant support to the state's efforts to collect informative outcome measures.

6. Expand the intensity levels and geographic availability of withdrawal management services available in the state and add withdrawal management services to the Medical Assistance benefit set.

IX. Appendix

DAANES Tables for Biennial Report CY2011-CY2014
Source: Minnesota Department of Human Services, ADAD, DAANES (11/17/2015)

	CY2011		CY2012		CY2013		CY2014	
Total Admissions	Count	Col %	Count	Col %	Count	Col %	Count	Col %
	52,373		53,730		54,177		54,311	
CD Treatment Environment								
Hospital Inpatient	1,914	3.7	1,669	3.1	1,529	2.8	765	1.4
Short-term Residential	11,108	21.2	11,593	21.6	11,002	20.3	11,231	20.7
Long-term Residential	10,556	20.2	10,505	19.6	11,082	20.5	11,560	21.3
Non-Residential	26,715	51.0	27,435	51.1	27,604	51.0	27,589	50.8
Methadone	2,080	4.0	2,528	4.7	2,960	5.5	3,166	5.8
Funding Coverage								
CCDTF Client	24,392	46.6	22,639	42.1	22,988	42.4	21,921	40.4
MHCP - MCO Client	6,448	12.3	8,375	15.6	9,272	17.1	11,861	21.8
All Other Sources	21,533	41.1	22,716	42.3	21,917	40.5	20,529	37.8
Gender								
Male	34,648	66.2	35,291	65.7	35,294	65.1	35,409	65.2
Female	17,725	33.8	18,439	34.3	18,883	34.9	18,902	34.8
Race/Ethnicity								
White	38,682	73.9	39,050	72.7	38,857	71.7	38,665	71.2
Black	5,417	10.3	5,500	10.2	5,602	10.3	5,754	10.6
American Indian	4,402	8.4	4,716	8.8	4,878	9.0	4,945	9.1
Hispanic	1,993	3.8	2,301	4.3	2,543	4.7	2,470	4.5
Asian/Pacific Islander	598	1.1	622	1.2	663	1.2	702	1.3
Other	1,281	2.4	1,541	2.9	1,634	3.0	1,775	3.3
Age Groups								
Age 8 - 17	4,200	8.0	4,381	8.2	4,010	7.4	3,566	6.6
Age 18-24	11,516	22.0	12,147	22.6	11,990	22.1	11,247	20.7
Age 25-44	24,290	46.4	25,034	46.6	25,965	47.9	27,379	50.4
Age 45-64	11,841	22.6	11,616	21.6	11,670	21.5	11,556	21.3
Age 65 & Over	526	1.0	552	1.0	542	1.0	563	1.0

	CY2011		CY2012		CY2013		CY2014	
Primary Condition	Count	Col %	Count	Col %	Count	Col %	Count	Col %
Avoid jail	3,055	5.8	3,188	5.9	3,177	5.9	3,460	6.4
Condition of probation-parole	15,606	29.8	15,901	29.6	15,771	29.1	15,767	29.0
Retain driver license-plates	989	1.9	1,059	2.0	892	1.6	759	1.4
Lose custody of children	769	1.5	821	1.5	987	1.8	937	1.7
Regain custody of children	1,049	2.0	1,155	2.1	1,407	2.6	1,460	2.7
Avoid loss of relationship	4,408	8.4	4,534	8.4	4,408	8.1	4,091	7.5
Maintain employment-school	978	1.9	879	1.6	919	1.7	810	1.5
Retain professional license	101	0.2	108	0.2	94	0.2	103	0.2
Retain government benefits	54	0.1	32	0.1	49	0.1	39	0.1
Financial pressures	1,912	3.7	2,003	3.7	1,971	3.6	1,721	3.2
Other	14,734	28.1	15,798	29.4	15,130	27.9	15,123	27.8
None	8,718	16.6	8,252	15.4	9,372	17.3	10,041	18.5
Usual Residence								
Homeless	3,877	7.5	4,505	8.5	5,210	9.8	5,637	10.6
Dependent living	12,424	24.0	13,382	25.2	13,939	26.1	14,778	27.7
Independent living	30,785	59.5	30,458	57.5	30,066	56.4	29,199	54.7
Children with family	4,655	9.0	4,658	8.8	4,102	7.7	3,730	7.0
Prior Detox Admissions								
0	29,433	56.6	30,065	56.4	30,074	56.0	29,725	55.3
1	9,774	18.8	10,123	19.0	10,065	18.7	9,738	18.1
2	4,744	9.1	4,805	9.0	4,952	9.2	4,937	9.2
3 or more	8,020	15.4	8,294	15.6	8,592	16.0	9,363	17.4
Attend Voluntary Self Help Group								
No attendance	30,435	60.5	30,512	58.9	31,044	59.3	30,724	58.6
1-3 times past month	7,263	14.4	7,606	14.7	7,509	14.4	7,446	14.2
4-7 times past month	4,160	8.3	4,451	8.6	4,743	9.1	5,183	9.9
8-15 times past month	3,624	7.2	3,962	7.7	4,052	7.7	4,432	8.5
16-30 times past month	1,804	3.6	2,173	4.2	2,382	4.6	2,508	4.8
Some attendance	2,999	6.0	3,083	6.0	2,587	4.9	2,093	4.0
Acute Intoxication/Withdrawal Potential								
None	35,967	69.5	36,386	68.4	35,676	67.2	36,070	67.7
Minor	8,329	16.1	8,841	16.6	9,601	18.1	9,727	18.3
Moderate	4,535	8.8	4,615	8.7	4,650	8.8	4,524	8.5
Serious	2,511	4.9	2,885	5.4	2,707	5.1	2,536	4.8
Extreme	425	0.8	437	0.8	437	0.8	395	0.7

	CY2011		CY2012		CY2013		CY2014	
Biomedical Complications	Count	Col %	Count	Col %	Count	Col %	Count	Col %
None	24,489	47.3	24,723	46.5	24,130	45.5	24,193	45.4
Minor	18,306	35.4	19,494	36.7	20,545	38.7	21,071	39.6
Moderate	6,234	12.0	5,881	11.1	5,566	10.5	5,127	9.6
Serious	2,544	4.9	2,902	5.5	2,682	5.1	2,674	5.0
Extreme	208	0.4	169	0.3	153	0.3	168	0.3
Emotional/Behavioral Complications								
None	4,093	7.9	3,652	6.9	3,274	6.2	2,989	5.6
Minor	12,322	23.8	11,555	21.8	11,753	22.2	12,194	22.9
Moderate	27,285	52.7	29,373	55.3	30,817	58.1	31,283	58.8
Serious	7,694	14.9	8,193	15.4	6,964	13.1	6,527	12.3
Extreme	338	0.7	321	0.6	224	0.4	209	0.4
Readiness for Change								
None	5,468	10.6	5,184	9.8	4,850	9.1	4,805	9.0
Minor	11,465	22.2	11,307	21.3	11,769	22.2	12,393	23.3
Moderate	19,383	37.5	19,188	36.1	19,405	36.6	19,280	36.2
Serious	13,914	26.9	15,156	28.5	14,808	27.9	14,632	27.5
Extreme	1,514	2.9	2,271	4.3	2,202	4.2	2,090	3.9
Relapse/Continued Use Potential								
None	361	0.7	382	0.7	384	0.7	299	0.6
Minor	1,851	3.6	1,744	3.3	1,760	3.3	1,995	3.8
Moderate	14,440	27.9	11,830	22.3	11,331	21.4	11,202	21.1
Serious	26,668	51.5	21,855	41.2	20,906	39.4	20,741	39.0
Extreme	8,421	16.3	17,288	32.6	18,666	35.2	18,963	35.6
Recovery Environment								
None	1,313	2.5	1,375	2.6	1,257	2.4	1,116	2.1
Minor	5,071	9.8	4,381	8.3	4,398	8.3	4,386	8.3
Moderate	15,066	29.2	13,296	25.1	12,768	24.2	12,573	23.7
Serious	22,952	44.4	19,308	36.5	18,096	34.2	18,116	34.2
Extreme	7,280	14.1	14,550	27.5	16,336	30.9	16,854	31.8
Injection Drug Use								
Within the past 30 days	3,174	6.3	3,723	7.2	4,340	8.4	4,469	8.6
Within the past 6 months	2,300	4.6	2,881	5.6	3,478	6.7	3,951	7.6
Within the past 12 months	904	1.8	1,065	2.1	1,141	2.2	1,243	2.4
More than 12 months ago	3,207	6.4	3,266	6.3	3,437	6.6	3,442	6.6
Never injected	40,578	80.9	40,666	78.8	39,544	76.1	38,655	74.7

	CY2011		CY2012		CY2013		CY2014	
Primary Abuse Problem	Count	Col %	Count	Col %	Count	Col %	Count	Col %
Alcohol	26,622	51.1	25,788	48.3	24,251	45.2	23,822	44.2
Cocaine	657	1.3	541	1.0	487	0.9	503	0.9
Crack	1,515	2.9	1,408	2.6	1,208	2.2	1,069	2.0
Marijuana-Hashish	9,374	18.0	9,414	17.6	9,092	16.9	8,592	15.9
Heroin	3,486	6.7	4,729	8.9	5,360	10.0	5,704	10.6
Non-prescription Methadone	114	0.2	131	0.2	131	0.2	100	0.2
Other Opiates/Synthetics	4,898	9.4	4,759	8.9	4,677	8.7	4,117	7.6
PCP	15	0.0	20	0.0	30	0.1	49	0.1
Other Hallucinogens/Psychedelics	69	0.1	72	0.1	101	0.2	74	0.1
Methamphetamine	4,356	8.4	5,443	10.2	7,286	13.6	8,861	16.4
Other Amphetamines	221	0.4	275	0.5	292	0.5	273	0.5
Other Stimulants	47	0.1	43	0.1	54	0.1	48	0.1
Benzodiazepines	305	0.6	298	0.6	276	0.5	316	0.6
Other Tranquilizers	4	0.0	5	0.0	1	0.0	1	0.0
Barbiturates	20	0.0	12	0.0	13	0.0	12	0.0
Other Sedative/Hypnotic/Anxiolytic	54	0.1	61	0.1	52	0.1	39	0.1
Ketamine	4	0.0	7	0.0	5	0.0	7	0.0
Ecstasy/other club drugs	46	0.1	34	0.1	34	0.1	34	0.1
Inhalants	46	0.1	47	0.1	47	0.1	51	0.1
Over-The-Counter Medications	83	0.2	87	0.2	92	0.2	96	0.2
Other	141	0.3	227	0.4	209	0.4	131	0.2

Discharge Information

Total Discharges	50,769		51,432		50,117		47,034	

Discharge Reason

Completed program	29,057	57.2	28,512	55.4	27,187	54.2	25,450	54.1
Patient left	10,888	21.4	11,325	22.0	11,543	23.0	11,370	24.2
Staff requested	3,884	7.7	4,347	8.5	4,311	8.6	3,984	8.5
Expiration of civil commitment	63	0.1	55	0.1	68	0.1	74	0.2
Transferred	3,431	6.8	3,876	7.5	3,738	7.5	3,097	6.6
Assessed as inappropriate	734	1.4	737	1.4	813	1.6	767	1.6
Lost financial support	327	0.6	329	0.6	283	0.6	199	0.4
Incarcerated	689	1.4	707	1.4	735	1.5	707	1.5
Death	78	0.2	72	0.1	80	0.2	52	0.1
Other	1,618	3.2	1,472	2.9	1,359	2.7	1,334	2.8