

The Minnesota Substance Abuse Strategy was developed in 2012 under the leadership of the Minnesota Department of Human Services in partnership with the Department of Education, Department of Health, Department of Public Safety, State Judicial Branch, Department of Corrections, Department of Military Affairs/ Minnesota National Guard and Minnesota Board of Pharmacy.

Minnesota State Substance Abuse Strategy

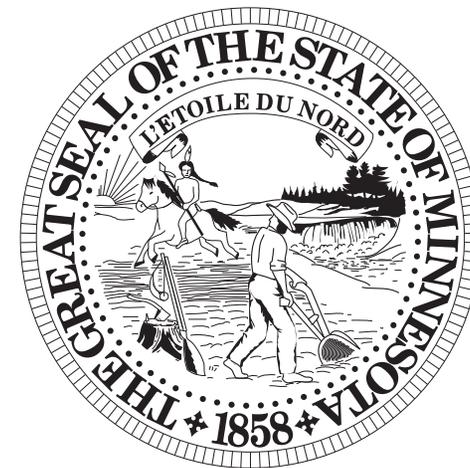


Table of Contents

Executive Summary	1
I Background and Purpose	2
A. Overview	2
B. Magnitude of the Problem: Economic Costs	3
C. Purpose of This Report	5
II Understanding Substance Abuse and Addiction	7
A. The Nature and Extent of Substance Abuse	7
B. Emerging Trends in Substance Abuse	9
C. Prevention Defined	13
D. Addiction Defined	16
E. The Treatment of Addiction	18
F. The Outcomes of Addiction Treatment	21
G. The Related Health Care Consequences of Substance Abuse and Addiction	23
III Current Minnesota State Agency Responses to Substance Abuse and Addiction.....	25
A. Department of Human Services	25
B. Department of Education	33
C. Department of Health	33
D. Department of Public Safety	35
E. State Judicial Branch	37
F. Department of Corrections	39
G. Department of Military Affairs/Minnesota National Guard	43
H. Minnesota Board of Pharmacy	43
I. Minnesota Health Professionals Services Program.....	43
J. Ongoing Multi-Agency Efforts	44
IV Guiding Principles.....	46
A. Collaboration.....	46
B. Prevention and Early Intervention Work Best	46
C. Reduce Health Disparities and Promote Cultural Competence.....	46
D. Sustain a Continuum of Services.....	47
E. An Integrated Approach to Service Delivery in Health Care	47
F. Substance Use Disorders are Treatable	47
G. Recovery is Possible	47
V Immediate Policy Priorities: Prescription Opiate and Heroin Abuse and Addiction	48
VI Strategies: A Blueprint for the Future.....	48
A. Strengthen prevention efforts within and across communities	48
B. Create more opportunities for early intervention in health care and other settings.....	49
C. Integrate the identification and treatment of substance use disorders into health care reform efforts.....	49
D. Expand support for recovery	49
E. Interrupt the cycle of substance abuse, crime and incarceration	49
F. Reduce trafficking, production, and sale of illegal drugs in Minnesota	49
G. Measure with accurate and timely data the emerging nature and extent of substance abuse and scientifically evaluate the results of various interventions	49
APPENDIX	51

Executive Summary

Substance abuse, untreated addiction, underage drinking and tobacco use have a significant and costly impact on the health, well-being and public safety of our state and nation. Substance abuse and underage drinking negatively affect adolescent development, academic performance, gainful employment and social relationships. They are linked to increased crime, illnesses, child abuse and neglect, unwanted pregnancies, birth defects, accidental injuries, motor vehicle crashes and fatalities and accidental overdose deaths. Substance abuse, untreated addiction, underage drinking and tobacco use all significantly contribute to increased health care costs that are borne largely at public expense.

Because responding to the multi-faceted, far reach of substance abuse extends beyond the purview of any single state agency, it is critical that Minnesota develop a collaborative and comprehensive multi-agency approach. Thus, in order to effectively and efficiently address the issue, the development of this statewide substance abuse strategy involved the input of multiple state agencies over the course of many months.

This Minnesota Substance Abuse Strategy is designed to help make Minnesota a healthier, safer and stronger state. It is based on the knowledge that addiction is a treatable disease, that a continuum of care is needed to effectively address the needs of individuals, families and communities affected by substance abuse and addiction; and that the nature of addiction specialty services will change as they become more integrated into the broader health care system. It is guided by the shared principles of collaboration and community/cultural responsiveness and competence, and informed by the proven effectiveness of prevention, treatment and recovery services.

This document describes the current substance abuse situation in Minnesota and the associated activities of various Minnesota state agencies. In response to the escalating public health and safety threat that stems from the unprecedented

abuse of prescription drugs and heroin in Minnesota, it outlines an immediate, priority policy plan of action. To guide future efforts to address substance abuse in Minnesota, it sets forth a long-term strategy - a blueprint for the future. Below are the defining elements of the Minnesota Substance Abuse Strategy:

- Strengthen prevention efforts within and across communities. Preventing substance abuse before it happens saves lives and cuts long-term costs.
- Create more opportunities for early intervention in health care and other settings. Medical professionals, school-based counselors, and others must be able to identify the early signs of substance abuse and intervene early.
- Integrate the identification and treatment of substance use disorders into health care reform efforts. With health care reform, treatment providers will need to adopt new business practices. The need for substance use-related services within primary care will increase.
- Expand support for recovery. For many people treatment is the first step in recovery. Community-based recovery organizations can play an important role in helping people maintain recovery throughout their lifespan.
- Interrupt the cycle of substance abuse, crime and incarceration. At all levels of government, fair and effective criminal justice interventions must be combined with evidence-based treatment, prevention and recovery efforts to stop the revolving door in and out of the criminal justice system.
- Reduce trafficking, production and sale of illegal drugs in Minnesota. Law enforcement agencies must continue to work together in order to effectively identify, disrupt, and dismantle the increasingly sophisticated criminal organizations that traffic in illegal drugs.
- Measure the emerging nature and extent of substance abuse and scientifically evaluate the results of various interventions. Policy must be grounded in sound scientific evidence and ongoing, quality surveillance systems.

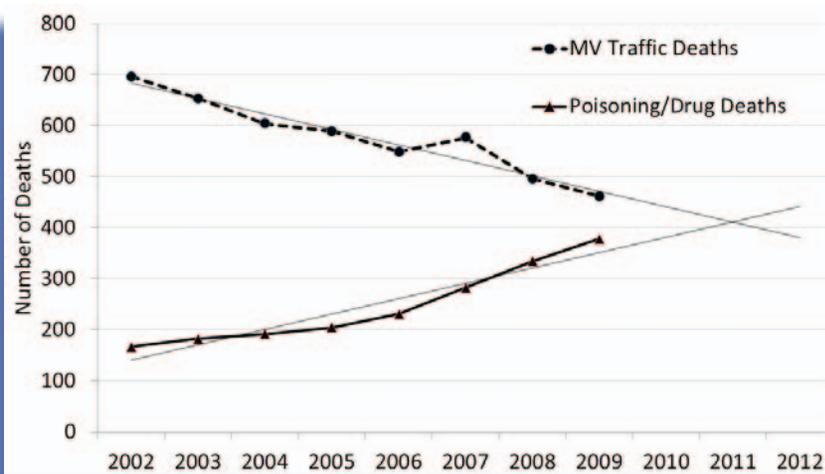
I. Background and Purpose

A. Overview

The abuse of and addiction to alcohol, tobacco and other drugs diminish the quality of life for all Americans, and compromise the safety of our roads, the security of our families, and the well-being of our communities. Substance abuse and untreated substance use disorders create a heightened threat to public safety and public health and exact enormous costs for law enforcement, courts, corrections, human services and public health systems.

The leading cause of death from injuries in the United States is poisoning. Nearly 9 out of 10 poisoning deaths are caused by drugs. Opioid analgesics were involved in more than 40 percent of drug poisoning deaths in 2008. Opioid analgesics include hydrocodone, oxycodone, morphine and methadone. In Minnesota, it is expected that unintentional poisoning/drug deaths will soon exceed motor vehicle traffic deaths.

Minnesota's unintentional poisoning/drug deaths are expected to exceed motor vehicle traffic deaths



SOURCE: Centers for Disease Control and Prevention (CDC), National Center for Health Statistics. Underlying Cause of Death 1999-2009 on CDC WONDER Online Database, released 2012. Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on Apr 24, 2012 1:09:45 PM

Moreover, deaths attributable to the abuse of legal drugs, alcohol and tobacco, far exceed the number of deaths attributable to illicit drugs.

The findings in the following table indicate that deaths from tobacco and alcohol consumption vastly exceed those from illicit drug use.

Actual Causes of Death in the United States 1990 and 2000

Actual cause	Number (%) in 1990	Number (%) in 2000
Tobacco	400,000 (19)	435,000 (18.1)
Poor diet & physical inactivity	300,000 (14)	365,000 (15.25)
Alcohol consumption	100,000 (5)	85,000 (3.5)
Microbial agents	90,000 (4)	75,000 (3.1)
Toxic agents	60,000 (3)	55,000 (2.3)
Motor vehicles	25,000 (1)	43,000 (1.8)
Firearms	35,000 (2)	29,000 (1.2)
Sexual behavior	30,000 (1)	20,000 (0.8)
Illicit drug use	20,000 (<1)	17,000 (0.7)
Total	1,060,000 (50)	1,124,000 (46.6)

SOURCE: Warner M, Chen LH, Makuc DM, Anderson RN, Miniño AM: Drug Poisoning Deaths in the United States, 1980–2008. NCHS Data Brief, No. 81, December 2011 and Mokdad AH, Marks JS, Stroup DF, Gerberding JL: Actual causes of death in the United States, 2000. JAMA. 2004 Mar 10;291(10):1238-45. Erratum in: JAMA. 2005 Jan 19;293(3):293-4. JAMA. 2005 Jan 19;293(3):298.

Most diseases and injuries have multiple potential causes and several factors and conditions may contribute to a single death. Therefore, to estimate the contribution of each factor to mortality is challenging. Investigators from the federal Centers for Disease Control and Prevention (CDC) used published causes of death, relative risks, and prevalence estimates from published literature and governmental reports to describe the actual causes of death in the United States as presented above.

B. Magnitude of the Problem: Economic Costs

Substance abuse and addiction are costly social phenomenon. The collateral consequences of substance

abuse and addiction are borne mostly at public expense, and include detoxification services, healthcare services including emergency room and addiction treatment services, child protective services, law enforcement, courts, and correctional services. These costs rarely appear as a single line item in a budget, because services and responses to substance abuse-related issues are delivered by multiple agencies that do not necessarily have substance abuse or addiction in their title.

Nationwide research studies have determined the annual cost of substance abuse to the country is \$510.8 billion in 1999.

(SOURCE: Miller, T. and Hendrie, D. Substance Abuse Prevention Dollars and Cents: A Cost Benefit Analysis, DHHS Publication No. (SAM) 07-4298, Rockville, MD., Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2008.)

Estimated economic cost of substance abuse to society in billions - 1999

Resource costs	Alcohol	Tobacco	Drugs	Total
Specialty treatment and prevention services	7.8	n/a	7.6	15.4
Treatment of medical consequences	20.0	75.9	5.4	101.3
Goods, services related to crashes, fires, crime, criminal justice	24.4	n/a	31.1	55.5
TOTAL RESOURCE COSTS				172.2
Productivity costs				
Work loss due to premature death	37.4	81.9	20.9	140.2
Work loss related to substance abuse –related illness	91.1	10.0	26.7	127.8
Work loss by crime victims	1.0	n/a	2	3
Work loss due to incarceration and criminal careers	9.9	n/a	57.7	67.6
TOTAL PRODUCTIVITY COSTS				338.6
Total resource and productivity costs	191.6	167.8	151.5	510.8

SOURCE: Miller, T. and Hendrie, D. Substance Abuse Prevention Dollars and Cents: A Cost Benefit Analysis, DHHS Publication No. (SAM) 07-4298, Rockville, MD., Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2008.

Looking at national estimates of the cost of illness for 33 specific diseases and conditions, alcohol ranked second, tobacco sixth, and drug disorders seventh. (SOURCE: National Institutes of Health (2000) Disease-specific estimates of direct and indirect costs of illness and NIH support: Fiscal year 200 update. Bethesda, MD: Office of the Director, Office of Science, Policy and Planning as cited in Miller, T. and Hendrie, D. Substance Abuse Prevention Dollars and Cents: A Cost Benefit Analysis, DHHS Publication No. (SAM) 07-4298, Rockville, MD., Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2008.)

A recent (2009) report from The Center on Addiction and Substance Abuse (CASA) at Columbia University identified the total amount spent by federal, state and local governments on substance abuse and addiction. It is estimated that collectively state governments spend

15.7 percent of their budgets (\$135.8 billion) dealing with substance abuse and addiction (up from 13.3 percent in 1998) and that federal and state governments collectively spend more than 60 times as much to clean up the devastation substance abuse and addiction inflicts on children as they do on prevention and treatment for them. (SOURCE: Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets, National Center on Addiction and Substance Abuse (CASA), Columbia University, New York, New York, May 2009.)

A National Policy Panel convened by Join Together with support from the Robert Wood Johnson Foundation, estimated the percentage of state agency budgets spent on alcohol and drug related problems and summarized the positive impact of prevention and treatment in the following table.

State agency	% of agency budgets spent on drug/alcohol problems	Positive impact of Prevention and treatment
Health	25	Families receiving addiction treatment spent \$363 less per month on regular medical care than untreated families.
Criminal Justice	77	Re-arrest rates dropped from 75 to 27 percent when inmates received addiction treatment.
Child Welfare	70	Children whose parents receive addiction treatment are less likely to remain in foster care.
Juvenile Justice	66	Adolescent re-arrest rates decrease from 64.5 percent to 35.5 percent after one year of residential treatment.
Welfare	16 - 17	After completing treatment there is a 19 percent increase in employment and an 11 percent decrease in clients receiving welfare.
Mental Health	51	Treating mental health and substance abuse disorders collaboratively produces better outcomes.
Developmental Disabilities	9	Fetal Alcohol Syndrome affects 40,000 infants annually.

SOURCE: Blueprint for the States: Policies to improve the ways states organize and deliver alcohol and drug prevention and treatment, Join Together, Boston University School of Public Health, 2006.

In Minnesota, the estimated annual cost of alcohol use in 2007 was over \$5 billion, specifically \$5,062,000,000. This translates into a cost of \$975 per person in Minnesota.

These costs were 17 times greater than the \$296 million in tax revenues collected from the sale of alcohol. (SOURCE: The Human and Economic Cost of Alcohol Use in Minnesota, Minnesota Department of Health, March 2011)

Numerous scientific studies document the economic and societal benefits of prevention and treatment.

A recent study of prevention conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that every dollar spent on effective school-based prevention programs can save an estimated \$18 in subsequent problems later in life. In addition, if effective prevention programs were implemented nationwide, substance abuse initiation would decline by 1.5 million youth, and be delayed by two years on average. (SOURCE: Miller, T. and Hendrie, D. Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis, DHHS-Pub. No. (SMA) 07-4298. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention, 2009.)

The National Institute on Drug Abuse estimates that every dollar invested in substance abuse treatment yields a return of up to \$12 in reduced drug-related crime, criminal justice and health care costs. Societal savings are also realized in terms of reduced interpersonal conflicts, increased workplace productivity and a decline in accidents. (SOURCE: Principles of Addiction Treatment, NIH Publication No. 00-4180, National Institute on Drug Abuse, 2000)

C. The Purpose of this Report

The direct and collateral consequences of substance abuse and addiction are far-reaching, serious, and costly. Responding to them requires the efforts of multiple state government agencies. Therefore, it is critical that Minnesota develop a comprehensive statewide substance abuse and addiction strategy that stems from the collective efforts of multiple state agencies, and seeks to maximize the use of state dollars, while eliminating duplication of effort and ineffective approaches.

The overarching purpose of this multi-agency initiative, the efforts of which culminate in this document, is to better align resources with long-term goals and proven strategies that effectively reduce illicit drug abuse and its consequences in the state of Minnesota.

The authority of the Minnesota Department of Human Services (DHS) to develop this broad-based, statewide strategy lies in Minnesota Statutes Chapter 254A which creates an Alcohol and Other Drug Abuse Section in the Department of Human Services that shall, among other things, 1) coordinate and review all activities and programs of all the various state departments as they relate to alcohol and other drug dependency and abuse problems, and 2) establish a state plan which shall set forth goals and priorities for a comprehensive alcohol and other drug dependency and abuse program for Minnesota.

Addressing substance abuse and addiction includes a balance of prevention, intervention, treatment and recovery support services, as well as involvement of the health care, public health, American Indian tribes and law enforcement, judicial and correctional systems.

This document encompasses all forms of illicit drug abuse and addiction, tobacco use, and alcohol abuse and addiction, including underage drinking by minors and drinking by adults in a manner that violates current laws, such as driving while intoxicated.

To help ensure a safer future for all Minnesotans with reduced levels of substance abuse and addiction, as well as ensure more



effective prevention, intervention, treatment and recovery services, this initiative advances the following vision: 1) That more Minnesota communities are free from alcohol, tobacco, and illegal drug abuse, and addiction and 2) That more Minnesota communities realize reduced collateral and direct consequences, heightened public safety and improved public health as the result of reduced alcohol, tobacco and drug abuse and addiction.

II. Understanding Substance Abuse and Addiction

A. The Nature and Extent of Substance Abuse

How widespread is substance use in Minnesota and how do we compare with other states?

The most recent state estimates are derived from the National Survey on Drug Use and Health (NSDUH), administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2006 and 2007. “Current use” is defined as any use in the past month. See Appendix Tables 1 through 6.

The Minnesota rate of current alcohol use is among the highest of any state in the nation. An estimated 60.7 percent of Minnesotans age 12 and above consumed alcohol in the past month. The highest rate was 63.1 percent in Rhode Island and the lowest was 30.9 percent in Utah. This compares with a rate of 51.4 percent nationally. See Appendix Exhibit 1.

Minnesota also has a high rate of binge alcohol use, defined as consuming five or more alcoholic drinks on one occasion for males and four or more for females. An estimated 28.7 percent of Minnesotans age 12 and above report binge drinking in the past month. North Dakota was highest with 32 percent and Utah the lowest with 15.6 percent. Nationally an estimated 23.1 percent of people age 12 and above report binge alcohol use in the past month. See Appendix Exhibit 2.

Tobacco is the second most commonly used substance in the United States. Nationally, an estimated 29.1 percent of people age 12 and above, report tobacco use in the past month. In Minnesota, an estimated 30.8 percent of people age 12 and above report the use of tobacco in the past month. Kentucky has the highest rate with 37.1 percent and Utah the lowest with 29.9 percent. See Appendix Exhibit 3.

When it comes to illegal drug abuse, Minnesota generally ranks in the middle range, relative to other states. An estimated 8.3 percent of Minnesotans age 12 and above

report the use of illegal drugs in the past month. This compares with a high of 12.5 percent in Rhode Island and a low of 5.2 percent in Iowa. Nationally, an estimated 8.1 percent of people age 12 and above, report the use of illegal drugs in the past month. See Appendix Exhibit 4.

Marijuana is the most commonly used illegal substance in Minnesota. Relative to rates of marijuana use in other states, Minnesota is somewhat at the higher end. An estimated 7.3 percent of Minnesotans age 12 and above report the use of marijuana in the past month. This compares with 5.9 percent nationally and the highest rate of 10.3 percent in Rhode Island, the lowest rate of 3.8 percent in Iowa. See Appendix Exhibit 5.

Over the past decade the increased nonmedical use of prescription drugs, in particular prescription narcotic pain relievers, has resulted in increased numbers of drug induced deaths, hospital emergency room episodes, and admissions to addiction treatment centers. The rate of nonmedical use of pain relievers in Minnesota in the past year by people age 12 and above is 4.4 percent, compared with 5 percent nationally. This compares with a high of 6.2 percent in Tennessee and a low of 3.8 percent in Hawaii. See Appendix Exhibit 6.

Within Minnesota there are regional variations in the extent of use of various substances. These differences are derived from sub-state estimates of the National Survey of Drug Use and Health from SAMHSA, which combine 2006, 2007 and 2008 NSDUH data and are presented in Appendix Exhibits 7, 8, 9 and 10.

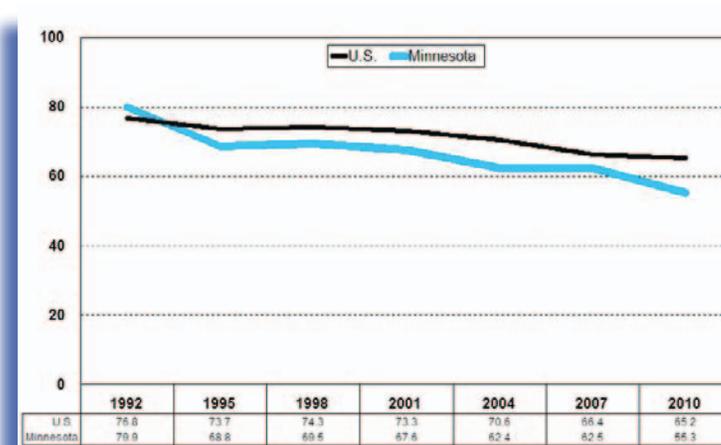
In general terms, current alcohol use is highest in the Twin Cities metro area. Binge alcohol use is more prevalent in the northern and southern outstate regions of Minnesota. Illicit drug use is most common in the northern part of the state and in Ramsey and Hennepin Counties. Marijuana use is equally and most prevalent in the Twin Cities and northern part of the state.

While the preceding findings refer to the population age 12 and above, drug and alcohol use among high school students is of heightened concern. Epidemiological and longitudinal studies have established that those who start alcohol use at age 15 or younger are many times more likely to develop addiction in the course of their lifetime than those who initiate use at the age of 21 or 22. (SOURCE: Grant, B.F., and Dawson, D.A. Age at onset of drug use and its association with DSM-IV drug abuse and dependence: Results from the National Longitudinal Alcohol Epidemiologic Survey, *Journal of Substance Abuse* 10:163–173, 1998. PMID: 9854701).

The following tables present trends in alcohol and drug abuse by Minnesota high school seniors as measured by responses to the Minnesota Student Survey, compared with a national sample of high school seniors surveyed in the National Monitoring the Future Survey, conducted by the University of Michigan. As shown below there have been significant declines in the use of alcohol, tobacco, and methamphetamine by 12th graders, both in Minnesota and nationally.

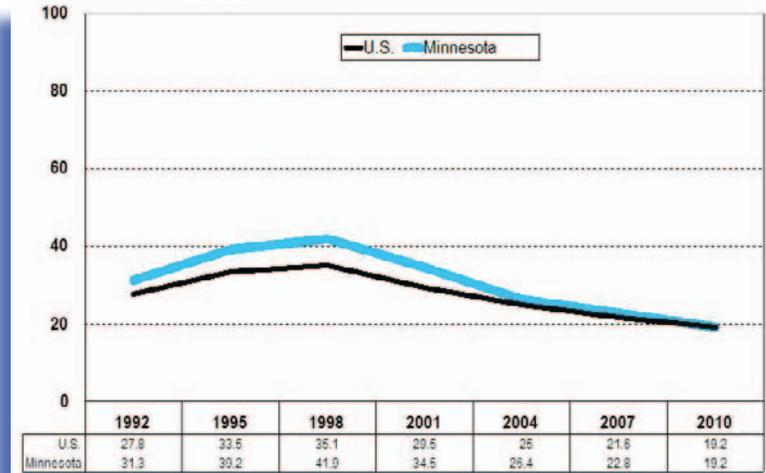
Alcohol use in the past year by 12th graders nationally and in Minnesota: 1992 - 2010*

% of 12th graders reporting



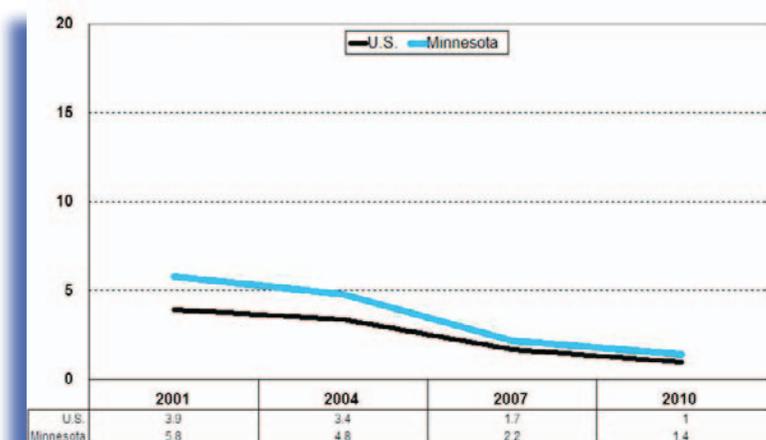
Cigarette smoking in the past 30 days by 12th graders nationally and in Minnesota: 1992 - 2010*

% of 12th graders reporting



Methamphetamine use in the past year by 12th graders nationally and in Minnesota: 1992 - 2010*

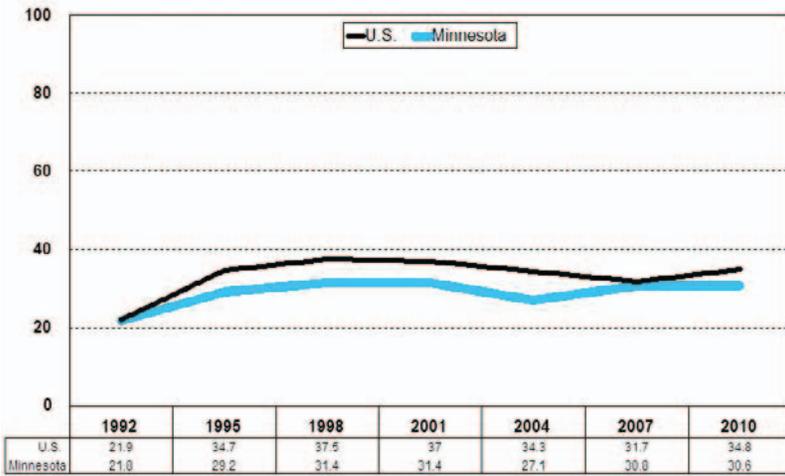
% of 12th graders reporting



While significant progress has been made in reducing the extent of alcohol, tobacco and methamphetamine use among high school seniors, both in Minnesota and nationally, that is not the case with marijuana use. In Minnesota, marijuana use among high school seniors was virtually unchanged from 2007 to 2010, with 30 percent reporting use in the past year. See graph below.

Marijuana use in the past year by 12th graders nationally and in Minnesota: 1992 - 2010*

% of 12th graders reporting



* SOURCE: Monitoring the Future Study, University of Michigan News Services retrieved on 12/14/2010 from www.monitoringthefuture.org and the Minnesota Student Survey.

In addition to the immediate heightened risks due to their impaired judgment while under the influence of drugs and alcohol, research finds strong associations between lower academic grades and the use of alcohol and marijuana in high school.

(SOURCE: CDC Youth Risk Behavior Survey Fact Sheet on Alcohol and Other Drug Use and Academic Achievement, 2010).

B. Emerging Trends in Substance Abuse

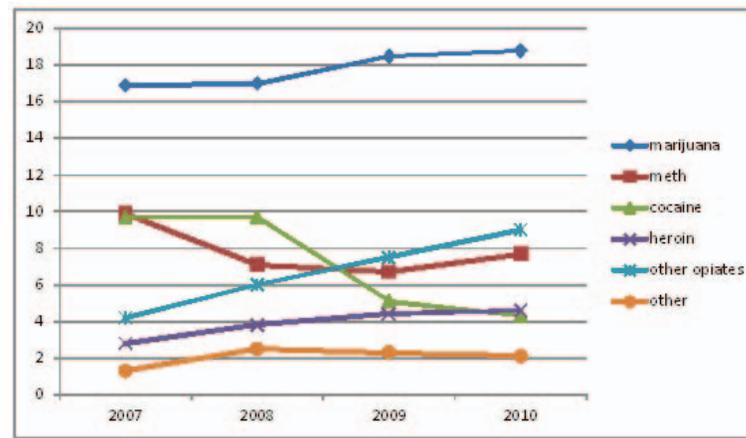
1. Opiate Abuse

Gradually over the past decade the abuse of heroin and prescription opiates, specifically narcotic analgesics also known as painkillers, has escalated throughout the state. Opiates have high abuse potential, high addictive potential and high overdose potential.

The rise in heroin and opiate addiction in Minnesota is reflected in the statewide treatment data presented below.

Minnesota statewide addiction treatment admissions by primary substance of abuse (excluding alcohol): 2007 - 2011

Percent of total admissions

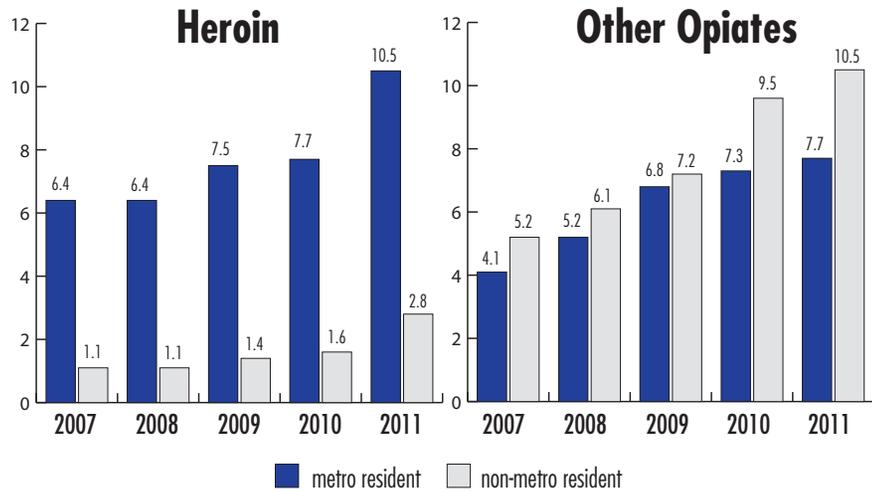


SOURCE: Drug and Alcohol Abuse Normative Evaluation System (DAANES), Minnesota Department of Human Services, Performance Measurement and Quality Improvement Division, 2012.

This recent increase in the percentage of treatment admissions that report heroin or other opiates as the primary substance problem is apparent for both metro and non-metro residents. As shown below, in 2011, 10.5 percent of metro

residents entering treatment reported heroin as the primary substance problem and 10.5 percent of non-metro residents reported other opiates as the primary problem.

Percentage of total Minnesota treatment admissions for heroin and other opiates by county of residence: 2007 - 2011



SOURCE: Drug and Alcohol Abuse Normative Evaluation System (DAANES), Minnesota Department of Human Services, Performance Measurement and Quality Improvement Division, 7/12/2012. Metro refers to the 7-county metropolitan area of Minneapolis/St. Paul, Minnesota. Non-metro refers to all other Minnesota counties.

Minnesota has white powdered heroin, brown powdered heroin, and black tar heroin, all from Mexico, and all of which produce similar effects. According to the Drug Enforcement Administration's (DEA's) Heroin Domestic Monitoring Program, the purity of Mexican heroin in Minneapolis is among the highest in the country, and the cost of heroin per pure milligram is among the lowest.

Mexican heroin price and purity: Minneapolis 2007 – 2009

	2007	2008	2009
Purity	59.9%	54.75%	53.35%
\$/pure milligram	\$0.29	\$0.26	\$0.25
# qualified samples	16	13	4

SOURCE: US Drug Enforcement Administration, US Department of Justice, 2009 Heroin Domestic Monitor Program, DEA-NCW-RPT-013-10, November, 2010.

At the same time heroin abuse has risen, so has the nonmedical use of prescription drugs, particularly prescription opiates. Because prescription opiates produce a strong euphoric effect that is similar to heroin intoxication, some opiate addicts will switch to heroin use if the circumstances are right. While a person may initially become addicted to prescription narcotics, they will often switch to using heroin: 1) If heroin is easily accessible 2) If heroin is more affordable than pills and 3) If heroin is of comparable quality. Therefore, the fact that the Twin Cities has the highest purity heroin at the lowest is of added significance.

Minnesota law enforcement narcotics agents increasingly encounter heroin and prescription narcotics as well. This is clearly reflected in the summary data from multijurisdictional narcotics task forces.

Opiate Summary Minnesota Drug Task Forces 2010 - 2011:

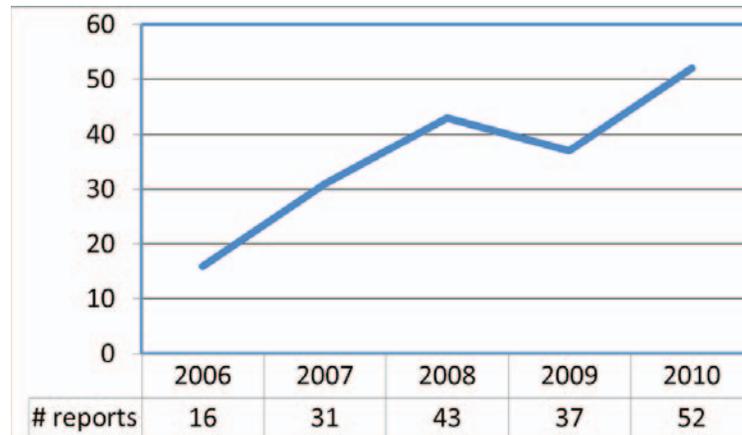
	2010	2011	Percent change 2010 to 2011
Heroin seized (grams)	228	406	78.1
Heroin arrests	108	206	90.7
Oxycodone seized (dosage units)	944	2,586	173.9
Pill arrests	483	502	3.9
% of total arrests that involve pills	14.3	14.0	--

SOURCE: Minnesota Office of Justice Programs, Minnesota Department of Public Safety, 2012 (audited). As of January 2012, there are 23 multijurisdictional law enforcement drug and violent crime task forces operating throughout Minnesota, staffed by over 200 investigators from over 120 agencies.

Law enforcement sources also report various criminal networks that sometimes exchange heroin for prescription opiates. In 2011, the Red Lake Nation, Leech Lake, and the White Earth Band of Chippewa declared public health emergencies with respect to prescription and illegal drug abuse on their reservations that are located in northern Minnesota. Addiction to prescription narcotics is at record-high levels according to numerous sources, and the collateral consequences of widespread prescription narcotic abuse, trafficking and addiction have continued to erode the quality of life and public safety in the communities.

Another indicator of rising prescription drug abuse can be found by examining the reports of loss or theft of controlled substances from a Minnesota hospital pharmacy, clinic pharmacy, retail pharmacy physically co-located in a clinic or hospital or from practitioners who were licensed to store controlled substances for use by patients (e.g., outpatient surgery center). These are reported to the U.S. Drug Enforcement Administration on "Form DEA-106, Theft or Loss of Controlled Substances." The table below presents the annual number of those reports filed from 2006 through 2010.

Theft or loss of controlled substances in Minnesota reported to the DEA: 2006 - 2010



SOURCE: Minnesota Department of Health from the U.S. Drug Enforcement Administration. Compiled from "Form DEA-106, Theft or Loss of Controlled Substances." This form is filed to report a theft or loss of controlled substances due to "employee pilferage" or "other" that occurred at a Minnesota hospital pharmacy, clinic pharmacy, retail pharmacy physically co-located in a clinic or hospital, or practitioners who were licensed to store controlled substances for use by patients (e.g., outpatient surgery center).

2. Synthetic Drugs of Abuse

In Minnesota and nationwide a growing number of online and retail sales outlets began selling synthetic, chemical substances that are designed to be consumed for their intoxicating, illegal drug-like effects (such as stimulation, hallucinations, and euphoria), but are intentionally marketed and effectively disguised as something else, such as bath salts, herbal incense or so-called research chemicals.

The use of synthetic cannabinoids, also known as cannabimimetics, continued throughout Minnesota in 2011 and 2012. Known also as "fake pot," "K2," "Spice," and other brand names, these herbal mixtures are sold as herbal incense, but when smoked, mimic the effects of plant marijuana. Sold online and in "head-shops," these mixtures of herbs are allegedly sprayed with synthetically-produced

cannabinoids. Cannabinoids are the psychoactive ingredients in plant marijuana. The Hennepin Regional Poison Center documented 28 exposures to THC homologs in 2010, 149 in 2011, and 54 in 2012 (through April).

Chemical mixtures that are sold online as so-called “research drugs” that are “not intended for human consumption,” were intentionally consumed by a group of young people in suburban Blaine, Minnesota in March 2011. The chemical compound known as 2C-E (2,5-dimethoxy-4-ethylphenylethylamine) was snorted by eleven young people who were seeking effects similar to the stimulant drug, MDMA or “ecstasy.” All experienced profound hallucinations, became distressed and were eventually hospitalized. A 19-year-old male was pronounced dead at the hospital. Exposures to 2C-E and related analogues reported to the Hennepin Regional Poison Center numbered 10 in 2010, 23 in 2011, and six in 2012 (through April).

The consumption of so-called “bath salts” by adolescents and young adults to get high, escalated in the Twin Cities in 2011, with 144 reported exposures reported to Hennepin Regional Poison Center in 2011, compared with five in 2010. These substances are not intended to be used in the bathtub, but are rather snorted, smoked or injected to produce effects similar to cocaine, methamphetamines and MDMA. They are sold online or in “head shops” under names such as Cloud 9, Ivory Wave, Pure Ivory, Ocean Burst, Purple Rain and Vanilla Sky. Some include methylenedioxypropylvalerone (MPDV), a compound that produces effects similar to stimulants or MDMA.

Minnesota exposures to selected drugs reported to Hennepin Regional Poison Center: 2009 - 2011

	2009	2010	2011
THC homologs		28	149
Bath salts		6	144
2CE and analogues	6	10	23
LSD	9	7	15
MDMA	42	26	24

SOURCE: Hennepin Regional Poison Center, Hennepin County Medical Center, January 2012.

In March 2011 the U.S. DEA used its emergency scheduling authority to temporarily designate as Schedule I substances, the chemicals used to make “fake pot” products -- JWH-018, JWH-073, JWH-200, CP-47,497, and cannabicyclohexanol. That scheduling was extended in February, 2012 for an additional 6 months. The DEA also took emergency action in October 2011 to temporarily ban the possession and sale of three synthetic stimulants, methylenedioxypropylvalerone (MDPV,) mephedrone, and methylone, that are often present in products marketed as “bath salts.”

Minnesota law, effective July 2011, banned the sale and possession of synthetic THC, bath salts, and of phenylethylamines of the 2C-E category. This law was enhanced in 2012. New federal law was also enacted in July 2012 to ban these substances nationwide. While these laws help make these substances less available in stores, they are still accessible online. The Hennepin Regional Poison Center continues to see patients with serious, adverse clinical effects due to the abuse of these agents.

C. Prevention Defined

What is prevention? What do we know about how to prevent substance abuse?

1. Risk and Protective Factors

Simply put, prevention programs are designed to enhance “protective factors,” those associated with reduced potential for drug use, and to reduce “risk factors,” those that make drug use more likely. Research has shown that many of the same risk and protective factors apply to other behaviors such as youth violence, delinquency, school dropout, risky sexual behaviors and teen pregnancy.

Protective factors:

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

Risk factors:

- Adverse childhood experiences
- Chaotic home environments, particularly in which parents abuse substances or suffer from mental illnesses;
- Ineffective parenting, especially with children with difficult temperaments or conduct disorders;
- Lack of parent-child attachments and nurturing;
- Inappropriately shy or aggressive behavior in the classroom;
- Failure in school performance;

- Poor social coping skills;
- Affiliations with peers displaying deviant behaviors; and
- Perceptions of approval of drug-using behaviors in family, work, school, peer, and community environments.

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

2. Adverse Childhood Experiences (ACEs)

Adverse Childhood Experiences include verbal, physical or sexual abuse as well as family dysfunction, such as a substance-abusing family member. ACEs have been linked to a wide range of health outcomes in adulthood including substance abuse, cardiovascular disease, diabetes, cancer and premature mortality. One of the strongest associative links is seen between the ACEs and alcohol use/abuse. Given the research indicating the negative impact of alcohol use on the neurodevelopment of adolescents, the relationship of ACEs to early initiation of alcohol use is particularly worrisome.

The negative health and social consequences of alcohol abuse and alcoholism constitute a major public health problem. ACEs have a particularly strong association with alcohol abuse. In addition, it is notable that the perpetuation of the cycle of alcohol abuse appears to be tightly interwoven with the number of ACEs, including marriage to an alcoholic.

As with initiation of alcohol use, ACEs also increase the likelihood of early smoking initiation and lead to continued smoking. Since cigarette smoking is the leading cause of preventable morbidity and mortality in the United States, one can see how growing up with ACEs contributes to many of the leading chronic health and social problems, both nationally and in Minnesota. (SOURCE: Anda RF, Brown DW: Adverse Childhood Experiences and Population Health in Washington: The Face of a Chronic Public Health Disaster. Results from the 2009 Behavioral Risk Factor Surveillance System, Washington State Family Policy Council, July 2, 2010)

Data collected in 2009 by the Centers for Disease Control and Prevention (CDC) from five states found that more than 59

percent of adults experienced one or more ACEs. Minnesota worked with the CDC to collect data on ACEs among Minnesota residents in 2011. Results are currently being tabulated and analyzed. (SOURCE: Centers for Disease Control and Prevention: Adverse childhood experiences reported by adults -- Five states, 2009. MMWR Morb Mortal Wkly Rep. 2010 Dec 17;59(49):1609-13)

Evidence-based programs exist that have demonstrated reductions in child maltreatment, such as home visits by nurses to mothers at high risk and parenting programs that teach new skills and behaviors to parents. Because most child maltreatment goes undetected, secondary and tertiary efforts are important complementary approaches to primary prevention efforts to improve the health and well-being of affected adults and families. Psychological treatments that can mitigate the progression of ACE-related health problems, such as trauma-focused cognitive-behavioral therapy, are also effective.

3. Principles of Substance Abuse Prevention

There are three types of substance abuse prevention:

- **Primary Prevention** seeks to decrease the number of new cases of a disease/event by eliminating the cause and increasing resistance (reducing risk factors and increasing protective factors in substance abuse prevention).
- **Secondary Prevention** seeks to lower the rate of established cases (screens and treatment services for substance abuse).
- **Tertiary Prevention** seeks to ameliorate consequences of existing disease/adverse events (relapse prevention for substance abuse).

Prevention programs funded by the Alcohol Drug Abuse Division (ADAD) of the Minnesota Department of Human Services are funded by the Substance Abuse & Mental Health Services Administration (SAMHSA) Block Grant. It is required that 20 percent of the block grant award be used

for primary prevention. Thus, requirements placed on the funding at the federal level dictate that prevention services are to target those who have never received, nor have ever been assessed as needing, substance abuse treatment.

Primary prevention services are further defined by Institute of Medicine which categorizes services according to the target group recipients.

- **Universal Prevention** services target everyone in the eligible population. The general population is targeted without regard to individual risk factors.
- **Selective Prevention** services target subgroups of the general population that are determined to be at higher risk for substance abuse.
- **Indicated Prevention** services target individuals identified as experiencing early signs of substance abuse and/or other related problem behavior, but have not reached the point where a clinical diagnosis of substance abuse can be made.

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

PRINCIPLE 1 - Prevention programs should enhance protective factors and reverse or reduce risk factors.

- The risk of becoming a drug abuser involves the relationship among the number and type of risk factors (e.g., deviant attitudes and behaviors) and protective factors (e.g., parental support).
- The potential impact of specific risk and protective factors changes with age. For example, risk factors within the family have greater impact on a younger child, while association with drug-abusing peers may be a more significant risk factor for an adolescent.

- Early intervention with risk factors (e.g., aggressive behavior and poor self-control) often has a greater impact than later intervention by changing a child's life path or trajectory away from problems and toward positive behaviors.
- While risk and protective factors can affect people of all groups, these factors can have a different effect depending on a person's age, gender, ethnicity, culture, and environment.

PRINCIPLE 2 - Prevention programs should address all forms of drug abuse, alone or in combination, including the underage use of legal drugs (e.g., tobacco or alcohol), the use of illegal drugs (e.g., marijuana or heroin), and the inappropriate use of legally obtained substances (e.g., inhalants), prescription medications, or over-the-counter drugs.

PRINCIPLE 3 - Prevention programs should address the type of drug abuse problem in the local community, target modifiable risk factors, and strengthen identified protective factors

PRINCIPLE 4 - Prevention programs should be tailored to address risks specific to population or audience characteristics, such as age, gender, and ethnicity, to improve program effectiveness.

PRINCIPLE 5 - Family-based prevention programs should enhance family bonding and relationships and include parenting skills, such as practice in developing, discussing, and enforcing family policies on substance abuse, and training in drug education and information.

PRINCIPLE 6 - Prevention programs can be designed to intervene as early as preschool to address risk factors for drug abuse, such as aggressive behavior, poor social skills and academic difficulties.

PRINCIPLE 7 - Prevention programs for elementary school children should target improving academic and social-emotional learning to address risk factors for drug abuse, such as early aggression, academic failure, and school dropout. Education should focus on the following skills: self-control, emotional awareness, communication, social problem-solving and academic support, especially in reading.

PRINCIPLE 8 - Prevention programs for middle or junior high and high school students should increase academic and social competence with the following skills: study habits and academic support, communication, peer relationships, self-efficacy and assertiveness, drug resistance skills, reinforcement of anti-drug attitudes and strengthening of personal commitments against drug abuse.

PRINCIPLE 9 - Prevention programs aimed at general populations at key transition points, such as the transition to middle school, can produce beneficial effects even among high-risk families and children. Such interventions do not single out risk populations and, therefore, reduce labeling and promote bonding to school and community.

PRINCIPLE 10 - Community prevention programs that combine two or more effective programs, such as family-based and school-based programs, can be more effective than a single program alone.

PRINCIPLE 11 - Community prevention programs reaching populations in multiple settings (e.g., schools, clubs, faith-based organizations, and the media) are most effective when they present consistent, community-wide messages in each setting.

PRINCIPLE 12 - When communities adapt programs to match their needs, community norms, or differing cultural requirements, they should retain core elements of the original research-based intervention which include: structure, content and delivery (how the program is adapted, implemented, and evaluated).

PRINCIPLE 13 - Prevention programs should be long-term with repeated interventions (e.g., booster programs) to reinforce the original prevention goals. Research shows that the benefits from middle school prevention programs diminish without follow-up programs in high school.

PRINCIPLE 14 - Prevention programs should include teacher training on good classroom management practices, such as rewarding appropriate student behavior. Such techniques help to foster students' positive behavior, achievement, academic motivation, and school bonding.

PRINCIPLE 15 - Prevention programs are most effective when they employ interactive techniques, such as peer discussion groups and parent role-playing, that allow for active involvement in learning about drug abuse and reinforcing skills.

PRINCIPLE 16 - Research-based prevention programs can be cost-effective. Similar to earlier research, recent research shows that for each dollar invested in prevention, a savings of up to \$10 in treatment for alcohol or other substance abuse is realized.

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

D. Addiction Defined

What is addiction? Addiction is more than simply a lot of substance use.

Addiction is a chronic disease with behavioral components that requires lifelong management and possible periodic professional services. Addiction affects the brain and behavior, sometimes in fundamental ways that last long after the effects of the drug have worn off. Scientific research has identified genetic and environmental factors that heighten the risk of any individual developing addiction.

According to the National Institute on Drug Abuse, "Addiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain; they change its structure and how it works. These brain changes can be long-lasting and can lead to many harmful, often self-destructive, behaviors."

DSM-IV Substance Dependence Criteria

The American Psychiatric Association defines substance dependence as follows:

Substance dependence is a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring any time in the same 12-month period:

1. Tolerance, as defined by either of the following: (a) A need for markedly increased amounts of the substance to achieve intoxication or the desired effect or (b) Markedly diminished effect with continued use of the same amount of the substance.
2. Withdrawal, as manifested by either of the following: (a) The characteristic withdrawal syndrome for the substance or (b) The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.
3. The substance is often taken in larger amounts or over a longer period than intended.

4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
5. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

SOURCE: American Psychiatric Association. 1994. *Diagnostic and Statistical Manual of Mental Disorders: DSM-IV*. Washington D.C.: American Psychiatric Association. (pp. 181-183)

Simply put, once addicted, the focus of the person's life centers around acquisition and compulsive use of the drug, in spite of negative consequences, and at the expense of everything else. For an active alcoholic or addict, personal relationships, hobbies, school, employment and family all take a back seat to acquiring and using the substance.

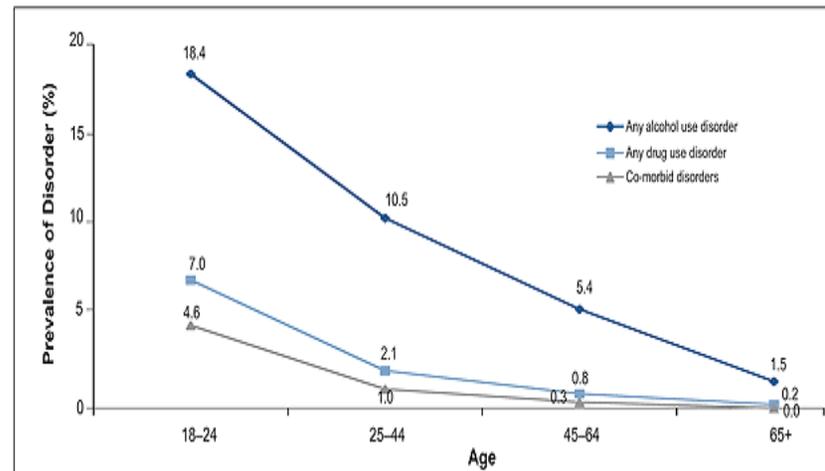
People who suffer from addiction often have one or more accompanying medical issues. These can include lung and cardiovascular disease, stroke, cancer, and mental disorders. Drug addiction and mental illness often coexist.

How widespread is addiction? Below is a discussion of two different studies that address this question.

The National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), one of the largest surveys of its kind ever performed, found that 8.5 percent of adults in the United States met the criteria for an alcohol use disorder, two percent met the criteria for a drug use disorder, and 1.1 percent met the criteria for both.

People dependent on drugs were more likely to have an alcohol use disorder than people with alcoholism were to have a drug use disorder. Young people ages 18–24 had

Prevalence of alcohol and drug use disorders in the US population



SOURCE: The National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), *Alcohol Alert No. 76, July 2008*, National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism (NIAAA).

the highest rates of co-occurring alcohol and other drug use disorders, and men were more likely than women to have problems with alcohol, drugs, or the two substances combined (SOURCE: Falk, D.; Yi, H.-y.; and Hiller-Sturmhöfel, S. An Epidemiologic Analysis of Co-Occurring Alcohol and Drug Use and Disorders: Findings From the National Epidemiologic Survey of Alcohol and Related Conditions (NESARC). *Alcohol Research & Health* 31(2):100–110, 2008)

In any given year, based on survey data from the National Survey on Drug Use and Health, it is estimated that 3.4 percent of the population age 12 and above is dependent on alcohol and 1.9 percent is dependent on illicit drugs. In Minnesota, the estimates are 3.6 and 1.7 percent respectively

(SOURCE: 2006 and 2007 National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration).

E. The Treatment of Addiction

1. Overview

Like other chronic diseases with behavioral components, addiction can be managed successfully. Treatment for addiction to alcohol and other drugs is effective and enables patients to resume normal life functioning without turning to the use of alcohol or illicit drugs. Some people recover from drug and alcohol addiction without receiving formal treatment, often through participation in self-help groups such as Alcoholics Anonymous.

Unlike the case with most other chronic diseases that affect large segments of the population, many people in need of treatment for drug and alcohol addiction do not receive it – an estimated 20 million people in the US. While most do not seek treatment because they do not think they need it, others face financial barriers that prevent them from receiving it. Indeed, our public treatment response typically reaches only those in the greatest financial need and ignores the “working poor” and uninsured whose incomes are above the federal poverty level. For many of these people, as evidenced by their impaired capacity to generate income, the disease is already quite advanced.

In Minnesota, nine percent of adults met the criteria for substance abuse or dependence, but less than one in 10 actually received treatment. This is based on 2000/2005 data. Indeed, a recent DHS reported noted, “The need for additional treatment is undeniable.” (SOURCE: The Benefits of Treatment for Substance Use Disorders, James McRae, Performance Measurement and Quality Improvement Division, Minnesota Department of Human Services, 2011)

2. Principles of Addiction Treatment

Decades of scientific research by the National Institute on Drug Abuse have yielded a set of fundamental principles that characterize effective drug abuse treatment as follows.

1. **No single treatment is appropriate for all individuals.** Matching treatment settings, interventions and services to each patient’s problems and needs is critical.
2. **Treatment needs to be readily available.** Treatment applicants can be lost if treatment is not immediately available or readily accessible.
3. **Effective treatment attends to multiple needs** of the individual, not just his or her drug use. Treatment must address the individual’s drug use and associated medical, psychological, social, vocational, and legal problems.
4. **Treatment needs to be flexible** and provide an ongoing assessments of patient needs, which may change during the course of treatment.
5. **Remaining in treatment for an adequate period of time is critical for treatment effectiveness.** The duration of treatment depends on an individual’s needs. For most patients, the threshold of significant improvement is reached at about three months of treatment. Additional treatment can produce further progress. Programs should include strategies to prevent patients from leaving treatment prematurely.
6. **Individual and/or group counseling and other behavioral therapies are critical components of effective treatment for addiction.** In therapy, patients address motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships.
7. **Medications are an important element of treatment for many patients,** especially when combined with counseling and other behavioral therapies. Methadone and levo-alpha-acetylmethadol (LAAM) help persons addicted to opiates stabilize their lives and reduce their drug use. Naltrexone is effective for some opiate addicts and some patients with co-occurring alcohol

dependence. Nicotine patches or gum, or an oral medication, such as bupropion, can help persons addicted to nicotine.

8. **Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.** Because these disorders often occur in the same individual, patients presenting for one condition should be assessed and treated for the other.
9. **Medical detoxification is only the first stage of addiction treatment** and by itself does little to change long-term drug use. Medical detoxification manages the acute physical symptoms of withdrawal. For some individuals it is a precursor to effective drug addiction treatment.
10. **Treatment does not need to be voluntary to be effective.** Sanctions or enticements in the family, employment setting, or criminal justice system can significantly increase treatment entry, retention, and success.
11. **Possible drug use during treatment must be monitored continuously.** Monitoring a patient's drug and alcohol use during treatment, such as through urinalysis, can help the patient withstand urges to use drugs. Such monitoring can also provide early evidence of drug use so that treatment can be adjusted.
12. **Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases,** and counseling to help patients modify or change behaviors that place them or others at risk of infection. Counseling can help patients avoid high-risk behavior and help people who are already infected manage their illness.
13. **Recovery from drug addiction can be a long-term process** and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug use can occur during or after successful treatment

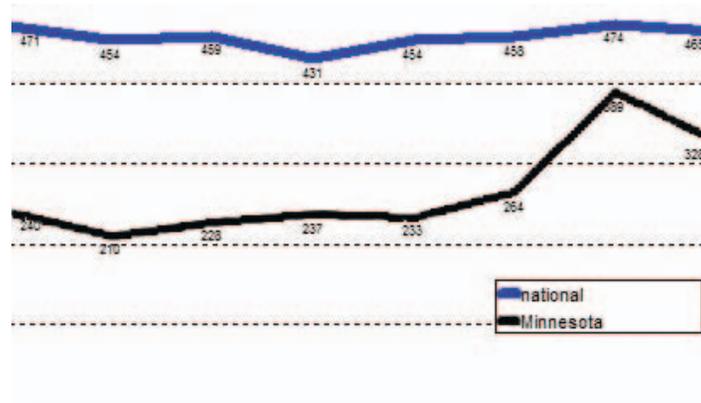
episodes. Participation in self-help support programs during and following treatment often helps maintain abstinence.

SOURCE: Principles of Drug Addiction Treatment: A Research-based Guide (NCADI publication BKD347). National Institutes of Health, National Institute on Drug Abuse. Bethesda, MD.

Each year, about 50,000 Minnesotans receive addiction treatment services. This includes those patients whose treatment is funded by public sources, as well those whose treatment services are delivered as part of their private health care insurance coverage. (SOURCE: Performance Measurement and Quality Improvement Division, Minnesota DHS.)

How does this compare with nationally? The following table presents the population-based rates of adults in addiction treatment nationally and in Minnesota from 2002 through 2009. Appendix Exhibit 11 presents a state by state comparison of population-based rates of persons in treatment.

Clients age 18 and over in addiction treatment programs per 100,000 population: nationally and in Minnesota 2002 - 2009



SOURCE: National Survey of Substance Abuse Treatment Services (N-SSATS). Substance Abuse and Mental Health Services Administration, 2003-2010. Includes patients with both alcohol and drug abuse disorders.

Addiction treatment is delivered in a variety of settings in Minnesota and nationally. The majority of addiction treatment in Minnesota (80 percent), and nationally (81 percent) is delivered in outpatient settings. Minnesota is noted for its non-hospital-based residential treatment, which is more prevalent here than nationally. There is also less opioid treatment available here in Minnesota than nationally. See Appendix Exhibits 12 and 13. SOURCE: The 2009 National Survey of Substance Abuse Treatment Services (N-SSATS), Substance Abuse and Mental Health Services Administration, 2010.

Addiction treatment consists of individualized services that are intended to help the patient understand the nature of addiction, cope with drug craving, develop skills to avoid relapse, and be introduced to ongoing recovery-oriented activities and services. In addition to cognitive behavioral and/or other types of therapy delivered in individual and group settings, treatment involves lectures, family involvement, assessment and integrated treatment of co-occurring mental health disorders.

Comparing clinical approaches that are often or sometimes used in Minnesota to national results, the largest difference is in the greater use of 12-step facilitation in Minnesota: 89.3 percent in Minnesota compared with 78.8 percent nationally. Twelve-step facilitation refers to a treatment approach that introduces patients to the concepts and traditions of Alcoholics Anonymous.

Opiate addiction can be successfully treated with the use of medications. These medications are effective in helping individuals addicts stabilize their lives and reduce their illicit drug use. An overview of the major medications that are proven effective in treating opioid addiction is below.

Naltrexone

Antagonist medication that prevents opioids from activating their receptors. Used to treat overdose and addiction, although its use for addiction is limited due to poor adherence and tolerability by patients.

An injectable, long-acting form of naltrexone (Vivitrol) originally approved for treating alcoholism, has also received FDA approval to treat opioid addiction). Because its effects last for weeks, Vivitrol is ideal for patients who do not have ready access to healthcare or who struggle with taking their medications regularly.

Methadone

A synthetic opioid agonist medication that eliminates withdrawal symptoms and relieves drug cravings by acting on the same brain targets as other opioids like heroin, morphine, and opioid pain medications. It has been used successfully for more than 40 years to treat heroin addiction, and must be dispensed through opioid treatment programs

Buprenorphine

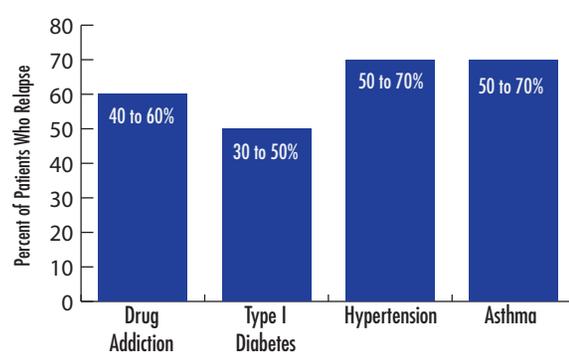
A partial opioid agonist medication (i.e., it has both agonist and antagonist properties), which can be prescribed by certified physicians in an office setting. Like methadone, it can reduce cravings and is well tolerated by patients.

F. The Outcomes of Addiction Treatment

How effective is the treatment of addiction? Since it is a chronic disease with behavioral components it can be managed but never completely cured. As stated above, “Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes.” Relapse rates refer to how often symptoms recur. These rates for drug addiction are similar to those for other well-characterized chronic medical illnesses which also have both physiological and behavioral components. Simply put, the outcomes of addiction treatment have also been shown to be as robust as the outcomes of other chronic diseases with behavioral components such as diabetes, hypertension and asthma.

In the graph below, relapse rates for drug-addicted patients are compared with those of patients with diabetes, hypertension, and asthma. Relapse is common and similar across these illnesses, as is adherence to medication. Thus, relapse serves as a trigger for renewed intervention, not as a statement of treatment failure. (SOURCE: McLellan AT, Lewis DC, O’Brien CP, Kleber HD. Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. JAMA 284(13):1689-1695, 2000.)

Comparison of relapse rates between drug addiction and other chronic illnesses



SOURCE: Journal of the American Medical Association 284(13):1689-1695, 2000.

In conjunction with national efforts that require treatment outcome measures from all states, the Alcohol and Drug Abuse Division of the Minnesota Department of Human Services, has a data collection and management program that supports the analysis and dissemination of addiction treatment program performance outcome measures. The data are from the Drug and Alcohol Abuse Normative Evaluation System (DAANES), the primary data collection system used in monitoring the nature, extent and effectiveness of substance abuse treatment services in Minnesota

These measures attempt to capture meaningful, real-life outcomes for people who are striving to attain and sustain recovery and participate fully in their communities in the wake of receiving treatment for an active addiction to drugs or alcohol.

National Outcome Measures (NOMs): Patients in treatment in Minnesota

Measures	At Admission	At Discharge
Homeless (N=47,617)	6.9 %	4.1%
Not employed (N=45,679)	59%	56.3%
Arrests in past 30 days (N=48,174)	11.7%	4.7%
Alcohol use in past 30 days (N=47,848)	48.2%	15.2%
Drug Use in Past 30 Days (N=47,846)	38.0%	14.7%
No self-help groups in past 30 days (N=44,097)	58.1%	20.7%
No family support for recovery in past 30 days (N=42,631)	12.9%	8.3%

SOURCE: Drug and Alcohol Abuse Normative Evaluation System (DAANES), Performance Measurement and Quality Improvement Division, MN Department of Human Services, 2010 using 2009 data.

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

- **Intoxication/withdrawal:** This dimension ranges from patients who exhibit no intoxication or withdrawal symptoms to those with symptoms so severe that the patient is a threat to self or others.
- **Biomedical:** Ranges from patients who are fully functional to those with severe physical problems or conditions that require immediate medical intervention.

- **Emotional, behavioral, cognitive:** Ranges from patients with good coping skills and impulse control to such severe emotional or behavioral symptoms that the patients is unable to participate in treatment.
- **Readiness for change:** Ranges from patients who admit problems, are cooperative, motivated and committed to change to patients who are unwilling to explore changes, are in total denial of illness and are dangerously oppositional to the extent that they pose an imminent threat of harm to self and others.
- **Relapse, continued use:** Ranges from patients who recognize risk and are able to manage potential problems to those who have no understanding of relapse issues and display high vulnerability for further substance use disorders.
- **Recovery environment:** Ranges from patients engaged in structured, meaningful activity with significant others and family, and who have a living environment that is supportive to recovery to patients who have chronically or actively antagonistic significant others, family or peer groups and dangerous living environments that are harmful to long-term, drug-free recovery.
- The severity levels within each dimension range from 0 (no problem) to 4 (severe problem).

The following table presents the aggregate percentage of patients with severity scores of moderate, serious, or extreme upon admission to treatment and at discharge for calendar year 2009.

**Minnesota patient severity scores:
Pre- and post- treatment for addiction**

Severity ratings of moderate, serious or extreme	At Admission	At Discharge
Acute intoxication or withdrawal (N=47,527)	10.1%	5.1%
Biomedical conditions/ complications (N=47,864)	16.2%	12.1%
Emotional/cognitive/ behavioral problems (N=47,878)	62.5%	47.7%
Resistance to change (N=47,985)	67.7%	47.7%
Relapse potential (N=47,941)	95.5%	73.2%
Unsupportive recovery environment (N=47,456)	86.6%	68.1%

SOURCE: Drug and Alcohol Abuse Normative Evaluation System (DAANES), Performance Measurement and Quality Improvement Division, MN Department of Human Services, 2010 using 2009 data.

G. Related Health Care Consequences of Abuse and Addiction

1. Emergency Department Episodes

From 2004 to 2009, the total number of drug-related hospital emergency department (ED) visits increased 81 percent from 2.5 million to 4.6 million nationwide. These visits included reports of drug abuse, adverse reactions to drugs, or other drug-related consequences. Almost 50 percent were attributed to adverse reactions to pharmaceuticals taken as prescribed, and 45 percent involved drug abuse.

The Drug Abuse Warning Network estimates that of the 2.1 million drug-related visits:

- 27.1 percent involved nonmedical use of pharmaceuticals (prescription or OTC medications, dietary supplements)
- 21.2 percent involved illicit drugs
- 32 percent (658,263) of all drug abuse ED visits in 2009 involved the use of alcohol, either alone or in combination with another drug.

Emergency department (ED) visits involving nonmedical use of pharmaceuticals (either alone or in combination with another drug) increased 98.4 percent between 2004 and 2009, from 627,291 visits to 1,244,679, respectively. Emergency department visits involving adverse reactions to pharmaceuticals increased 82.9 percent between 2005 and 2009, from 1,250,377 to 2,287,273 visits, respectively.

(SOURCE: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality (formerly the Office of Applied Studies, DAWN Report: Highlights of the 2009 Drug Abuse Warning Network (DAWN) Findings on Drug-Related Emergency Department Visits. Rockville, MD, December 28, 2010. Available at: <http://www.oas.samhsa.gov/2k10/DAWN034/EDHighlights.htm>.)

The majority of drug-related ED visits were made by patients 21 or older (80.9 percent, or 3,717,030 visits). Of these, slightly less than half involved drug abuse. Patients aged 20 or younger accounted for 19.1 percent (877,802 visits) of all drug-related visits in 2009. About half of these visits involved drug abuse.

(SOURCE: www.NIDA.NIH.gov/Infofacts/hospitalvisits accessed on 11/21/2011)

Additional research has found that mental health and substance abuse-related hospital emergency department visits were two and a half times more likely to result in a hospital admission than ED visits not related to mental health or substance abuse. Nearly 41 percent of mental health and substance abuse-related hospital emergency department visits resulted in hospitalization.

Medicare was billed most frequently for mental health and substance abuse-related hospital ED visits (30.1 percent), followed by private insurance (25.7 percent), uninsured (20.1 percent), and Medicaid (19.8 percent).

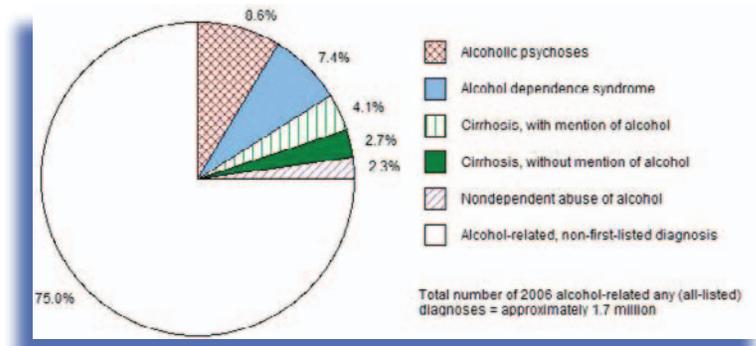
(SOURCE: HealthCare Cost and Utilization Project, Agency for Health Care Research and Quality, Mental Health and Substance Abuse-Related Hospital Emergency Department Visits Among Adults, 2007. Online at: www.hcup-us.ahrq.gov/reports/statbriefs/sb92.pdf)

Comparable state-level Minnesota data are not available yet there is no reason to assume that Minnesota trends are significantly different than national ones.

2. Hospitalization Episodes with Alcohol-Related Diagnosis

In 2006, roughly 1.7 million hospital discharge episodes had any (all-listed) alcohol-related diagnosis. These figures represent 18.1 principal (first-listed) and 72.4 any (all-listed) alcohol-related discharges per 10,000 population. This compares with the 2005 rates of 18.8 and 69.7, respectively. This NIAAA-sponsored study examines alcohol-related morbidity among patients discharged from short-stay community hospitals in the United States.

Percent distribution of principal (first-listed) diagnoses among discharges with any (all-listed) mention of an alcohol-related diagnosis



SOURCE: Chung M. Chen, M.A. Hsiao-ye Yi, Ph.D., National Institute on Alcohol Abuse and Alcoholism, Division of Epidemiology and Prevention Research, Alcohol Epidemiologic Data System, SURVEILLANCE REPORT #84, TRENDS IN ALCOHOL-RELATED MORBIDITY AMONG SHORT-STAY COMMUNITY HOSPITAL DISCHARGES, UNITED STATES, 1979–2006, August 2008. Accessed online at: <http://pubs.niaaa.nih.gov/publications/surveillance84/HDS06.htm>

III. Current Minnesota State Agency Responses to Substance Abuse and Addiction

A. Department of Human Services

1. Overview

The Minnesota Department of Human Services (DHS), Alcohol and Drug Abuse Division (ADAD) is the designated state authority for alcohol and drug abuse. It administers substance abuse prevention, treatment, and recovery services in Minnesota using various federal and state funds. See Appendix for the full citation of its statutory authority.

2. The SAMHSA Block Grants to States: Federal Expectations

The Alcohol and Drug Abuse Division (ADAD) is the recipient of the Substance Abuse Prevention and Treatment Block Grant to states, awarded by the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services. The Block Grants are awarded to states to allow them to address their unique behavioral health issues.

Specifically, the Block Grant funds are directed toward four purposes:

- Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time.
- Fund those priority treatment and support services not covered by Medicaid, Medicare or private insurance for low income individuals and that demonstrate success in improving outcomes and/or supporting recovery.
- Fund primary prevention - universal, selective and indicated prevention activities and services for persons not identified as needing treatment.

- Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services and plan the implementation of new services on a nationwide basis.

States also receive a State Mental Health Block Grant from SAMHSA. In Minnesota this has been administered by the Adult Mental Health Division and the Children's Mental Health Division of the Minnesota Department of Human Services.

In 2011 SAMHSA changed the way it administers these two block grants to states. In an effort to streamline the application and reporting procedures for these block grant programs, SAMHSA developed a single uniform application and reporting process to promote consistent planning, application, assurance and reporting dates across both block grants. The new uniform block grant application was undertaken in the expectation that states will:

- Take a broader approach in reaching beyond the populations they have historically served through block grants.
- Conduct a needs assessment and develop a plan that will identify and analyze the strengths, needs and priorities of the state's behavioral health system.
- Design and develop collaborative plans for health information systems grants and other funding.
- Form strategic partnerships to provide individuals better access to good and modern health services.
- Focus more on services in support of recovery from mental health and substance use problems.
- Focus their block programs on improving accountability for quality and performance of services they provide.
- Description of tribal consultation activities.

3. Prevention Services

The Alcohol and Drug Abuse Division supports many components of Minnesota's prevention infrastructure through a variety of efforts that are primarily funded by the federal government.

As the recipient of the federal SAPT Block Grant to states, ADAD is required to spend 20 percent of its SAPT funds supporting primary prevention.

Through the SAPT Block Grant, ADAD currently funds \$6 million annually on primary prevention community projects, a statewide prevention resource center, and Synar compliance. (Synar compliance refers to efforts that ensure tobacco retailers do not sell to minors, another SAPT requirement.). This represents 21 percent of the federal block grant total. In addition, approximately \$1.5 million of the SAPT Block Grant funds are spent on American Indian prevention services.

In order to reduce the prevalence of alcohol and another drug use/abuse among the state's population and increase the age of first use of alcohol and other drugs, DHS promotes the use of evidence-based prevention strategies and promising programs. Minnesota's goal is to provide effective and efficient prevention programming throughout the state. Work occurs in the following areas:

- **Prevention Planning and Implementation Projects.** ADAD funds planning and implementation projects through local coalitions to support communities in planning, developing, and implementing prevention projects specific to their needs. Community projects include programming focused on, but not limited to, the African American, Native American, Chicano/Latino, and Asian American communities.
- **The Minnesota Prevention Resource Center.** ADAD funds this a statewide prevention resource center to: 1) Disseminate culturally specific prevention information and 2) Implement community organizing to involve community and family members in the Hmong &

Latino communities, and 3) Provide current and accurate prevention information, strategies, and statewide programs by maintaining clearinghouses, and provide consultation to communities and schools for planning and implementation of prevention strategies at the local level. The Minnesota Prevention Resource Center (MPRC) is online at www.emprc.org. Its accomplishments include the dissemination of approximately 550,000 pieces of prevention material, 3,000 calls to prevention phone lines, 187,000 web hits on alcohol, tobacco, and other drug abuse prevention, 6000 requests for information, and 200 prevention public service announcements were developed and disseminated to over 600 media outlets.

- **Regional Prevention Coordinators.** ADAD funds seven regional prevention centers/coordinators to support its regional prevention infrastructure. These Regional Prevention Centers house regional prevention coordinators whose function is to: increase local control of prevention activity, promote local collaboration/coordination in the implementation of prevention strategies, identify current prevention efforts and needs, provide training and technical assistance to agencies and prevention professionals, and to assist in the promotion of the State Prevention Framework and goals.
- **Synar Compliance Activity.** ADAD expends federal block grant funds to contract with outside contractors to conduct random unannounced checks at the retailer level to assess compliance with state laws that prohibit sale of tobacco to minors. In addition, DHS will contract with a research entity to conduct a scientific survey of the state to determine enforcement activity in the state relating to tobacco sales to minors, and the numbers and types of penalties assessed to offenders at the local level.
- **State Systems Development.** ADAD uses block grant funds to enhance the development of its prevention system and infrastructure where feasible and appropriate.

Substance abuse and addiction prevention, within and across communities in Minnesota, is the ultimate statewide goal. ADAD estimates that prevention services are provided to over three million individuals in Minnesota through a combination of these individual and population-based programs and efforts.

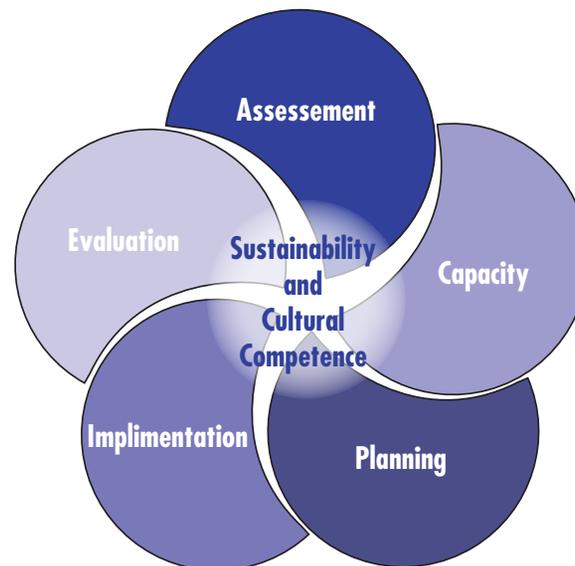
Yet the challenge of prevention is that it is not a one-shot occurrence, but an ongoing process. There are always people hearing the messages for the first time. Therefore, in order to establish a statewide prevention infrastructure, ADAD sought and received a recent infusion of additional federal dollars.

In addition to prevention initiatives funded by the SAPT Block Grant, ADAD also administers, through the Office of the Governor, a \$10.5 million Strategic Prevention Framework State Incentive Grant (SPF-SIG) from the Federal Substance Abuse and Mental Health Services Administration (SAMHSA) as of July 2009. The purpose of this grant is to build the prevention capacity of the state and sub-recipient communities to implement the SPF model.

The Strategic Prevention Framework (SPF) is a five-step, public health model that supports data-driven decision-making and outcome-based prevention planning. Cultural competence and sustainability are the two core components woven throughout the model, which also promotes the use of environmental or population level change and the use of evidence-based strategies.

The five steps are: 1) Assess local prevention needs based on epidemiological data, 2) Build prevention capacity, 3) Develop a strategic plan, 4) Implement effective community prevention programs, policies and practices, and 5) Evaluate the outcomes of the efforts. Again, throughout all five steps, the model address issues of sustainability and cultural competence as shown below.

Strategic prevention framework components



The idea behind SPF is to use the findings from public health research and local data collection, along with evidence-based prevention programs, to build prevention capacity within states, tribes, and territories. This in turn promotes resilience and reduces risk factors in individuals, families, and communities.

After conducting a needs assessment and examining statewide data on substance abuse, Minnesota's SPF-SIG Advisory Council voted on the following three priorities for Minnesota's project in May of 2010:

- To reduce past 30-day alcohol use among 6th-12th graders
- To reduce binge drinking among 9th-12th graders
- To reduce binge drinking among 18-25 year olds

SAMHSA envisions the SPF -SIGs being implemented through working partnerships between states and communities. Eighty-five percent of the state's award must be passed through to local communities. For this reason, ADAD awarded eight sub-recipient grants to communities across Minnesota in January 2012.

ADAD is using a two-phase funding model. Phase One focuses on the first three steps of the SPF. Communities take a thorough look at these alcohol problems and identify their root causes. Then sub-recipients will use the data they have collected in developing a strategic plan for the implementation phase.

At the end of Phase One in June of 2013, SPF -SIG sub-recipients will submit their strategic plans to ADAD. Once approved by ADAD and the Minnesota Evidence-Based Practices Workgroup, sub-recipients will get a contract amendment for Phase Two. This will come with a separate set of deliverables and funding to carry out the strategies proposed in the strategic plan. Phase Two is scheduled to end June 30, 2014, although an additional year of funding is possible if ADAD receives an extension from SAMHSA.

In addition to collaborating with numerous stakeholders from other agencies and organizations through the SPF-SIG Advisory Council, the State Epidemiological Outcomes Workgroup and the Minnesota Evidence-Based Practices Workgroup, ADAD also formed a team of ten SPF-SIG Master Trainers and contractors to assist sub-recipients in building their capacity, seven of whom are Block Grant-funded Regional Prevention Coordinators. This is one way that the SPF is being infused into the Block Grant and the model is reaching beyond funded sub-recipients.

In late 2011, ADAD was also awarded a Strategic Prevention Enhancement grant from SAMHSA, a one-year planning grant scheduled to expire the fall of 2012. The goal is to develop a five-year prevention plan that addresses mental health promotion, mental illness prevention, substance abuse prevention and the integration of both with primary care.

4. Addiction Treatment Services

More than 350 addiction treatment programs are licensed by the Minnesota Department of Human Services via administrative Rule 31. Individual counselors are also

licensed by the Board of Behavioral Health and Therapy, which sets initial and continuing licensure requirements for those who are Licensed Alcohol and Drug Counselors (LADCs).

For the past 25 years, Minnesota has maintained a system of public treatment funding through the state-operated, county-administered Consolidated Chemical Dependency Treatment Fund (CCDTF). Counties contribute 22.95 percent of the cost. The SAPT Block Grant and state appropriations make up the balance of the CCDTF. ADAD designates \$9 million of its SAPT Block Grant award to the CCDTF. Individuals who are at or below the federal poverty level are eligible for CCDTF funding.

Substance abuse treatment is typically based on one of several traditional approaches that emphasize different elements of the disease and the recovery process and include medical, social and behavioral models. Treatment support and recovery maintenance are supported via the SAPT Block Grant dollars as well as grants for women's treatment support and recovery maintenance. There are also models, such as traditional healing practices utilized by specific cultural groups.

ADAD utilizes public input received from two advisory councils: the Citizens Advisory Council and American Indian Advisory Council, and receives public input by posting its SAPT Block Grant spending plan online.

5. Recovery Services

Recovery support services are non-clinical services that assist individuals and families working towards recovery from substance use disorders. They incorporate a full range of social, legal and other resources that facilitate recovery and wellness by reducing or eliminating environmental or individual barriers to recovery.

The Alcohol and Drug Abuse Division supports community-based recovery organizations through its grants program.

There are currently two community-based programs that support the lives of people in recovery from addiction: the St. Paul-based Minnesota Recovery Connection and the Mankato-based Southern Minnesota Recovery Connection.

Over the past few years SAMHSA has been promoting “recovery-oriented systems of care,” known as ROSC. This concept is explained below by SAMHSA and accompanied by a more detailed diagram in the Appendix of this document.

“A ROSC is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.

The central focus of a ROSC is to create an infrastructure or “system of care” with the resources to effectively address the full range of substance use problems within communities. The specialty substance use disorder field provides the full continuum of care (prevention, early intervention, treatment, continuing care and recovery) in partnership with other disciplines, such as mental health and primary care, in a ROSC.

A ROSC encompasses a menu of individualized, person-centered, and strength-based services within a self-defined network. By design, a ROSC provides individuals and families with more options with which to make informed decisions regarding their care. Services are designed to be accessible, welcoming, and easy to navigate. A fundamental value of a ROSC is the involvement of people in recovery, their families, and the community to continually improve access to and quality of services.”

(SOURCE: Substance Abuse and Mental Health Services Administration, Recovery-Oriented Systems of Care Resource Guide, Working Draft, Sept. 2010. Accessed online at: http://partnersforrecovery.samhsa.gov/docs/ROSC_Resource_Guide_Book.pdf)

6. Recent Developments

The Chemical Dependency Consolidated Treatment Fund (CCDTF) is a state-operated, county managed system for the provision of chemical dependency treatment services to public assistance eligible persons. County human service agencies perform assessments to determine the proper level of patient severity and match it to the proper level of care. Access to publicly funded treatment begins with this “Rule 25 assessment” by the county human services agency or its agent, a tribe, or a managed care organization serving low-income patients. July 1, 2008, marked the first-ever uniform chemical dependency assessment tool in Minnesota, making it a required element of all chemical dependency assessments. It uses the Minnesota Matrix, a scale of patient life functioning along six dimensions, to help systematically match the severity of the patient’s problem with the intensity of services.

Comparing a patient’s score on the severity dimensions at the beginning of treatment and at the termination of treatment is the performance measure used to evaluate treatment outcomes. Starting in 2008, these performance outcome measures are published annually online for each licensed program.

Effective July 2011 the state, instead of 87 counties and 11 tribes, began negotiating rates for treatment services according to a newly-developed statewide rate methodology. Prior to this each county negotiated its own rates, which resulted in a great deal of variation in costs paid for like services.

The 2012 legislature directed the Human Services commissioner to review the full system of care for individuals with substance use issues and produce a report with a pilot for implementation. This report will take into account the full continuum of care including detoxification, early intervention, treatment and recovery systems of care. The report is due to the legislative committee chairs with jurisdiction over human services by March 2013.

An additional legislative initiative from the 2011 session directed ADAD to devise an Integrated Dual Disorder Treatment standard along with a screening process for persons whom have both substance use and mental health disorders. These will be reported to the legislature in 2013, followed by administrative rule-making the following year.

a. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

In 2008, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act was signed into law. This federal law requires group health insurance plans (those with more than 50 insured employees) that offer coverage for mental illness and substance use disorders to provide those benefits in ways that are no more restrictive than all other medical and surgical procedures covered by the plan. The Mental Health Parity and Addiction Equity Act does not require group health plans to cover mental health and substance use disorder benefits but, when plans do cover these benefits, the mental health and substance use disorder benefits must be covered at levels that are no lower and with treatment limitations that are no more restrictive than would be the case for the other medical and surgical benefits offered by the plan.

In the past, millions of Americans with mental health and/or substance use disorders failed to receive the treatment they need in order to get well and stay well. This historic lack of adequate health insurance coverage for mental health and substance abuse disorders has contributed to a large gap in treatment services.

The Mental Health Parity and Addiction Equity Act is important because it eliminated the practice of unequal health treatment for patients with addiction and mental illnesses, which has heretofore prevented individuals with untreated substance use and mental health disorders from receiving critically important treatment.

b. Screening, Brief Intervention and Referral to Treatment (SBIRT) in Emergency Care Settings

Alcohol and other substance abuse and addiction also contribute to health care costs in trauma settings primarily due to accidental injuries. Moreover, people who abuse alcohol and drugs have more illnesses than those who do not, and also tend to use more expensive forms of acute care such as emergency rooms.

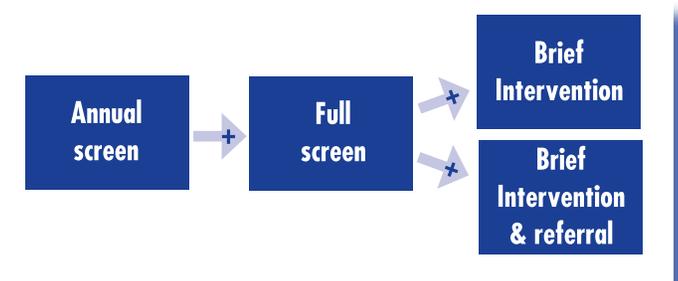
(SOURCE: Robin E. Clark, Ph.D., Elizabeth O'Connell, M.S., and Mihail Samnaliev, Ph.D.; Substance Abuse and Healthcare Costs Knowledge Asset, web site created by the Robert Wood Johnson Foundation's Substance Abuse Policy Research Program; March 2010. Online at: http://sapr.org/knowledgeassets/knowledge_detail.cfm?KAID=21)

Research shows that at critical moments, such as during the receipt of treatment at a trauma center, a brief screening and intervention can help someone reduce or stop risky substance use, in some cases before misuse crosses into addiction. To that end, Screening, Brief Intervention, and Referral to Treatment (SBIRT), is an evidence-based tool available as a preventative strategy and a treatment approach that focuses on identifying and helping people who use drugs or drink alcohol at a risky level – before addiction develops. It is being integrated into medical practice in emergency rooms and primary care clinics throughout the state and country.

The basics of SBIRT include: a quick pre-screen (often just 2-4 questions) that begins the process followed by a more in-depth screening if warranted, a brief intervention, sometimes brief treatment, and/or referral to treatment.

The general flow of an SBIRT program is illustrated below.

Screening, Brief Intervention and Referral to Treatment (SBIRT)



(SOURCE: Addiction Technology Transfer Center, Substance Abuse and Mental Health Services Administration, Addiction Messenger, online at :www.attcnetwor.org/find/news/attcnews/epubs/addmsg/references_July2010.asp).

Screening - A validated instrument quickly assesses the “risk level” of substance use and identifies individuals who might benefit from intervention. A brief questionnaire or interview is often sufficient to identify patients with substance use problems.

Brief Intervention – A patient whose initial screening indicates a risk level as moderate to high receives education about substance use, possible consequences, and other personalized feedback and counseling based on the individual’s risk level. This education and encouragement often serves to reduce their alcohol intake. Brief intervention can be a single session lasting a few minutes, with no follow-up required, or from one to four short counseling sessions with a trained interventionist. Goals are focused upon reducing consumption or negative outcomes (such as injuries, domestic violence, auto accidents, or damage to a developing fetus) and instilling motivation for change.

Referral to Treatment - Provides those at highest risk a referral to specialty care.

Key research on SBIRT indicates:

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

An estimated 27 percent of all injured adult patients are candidates for a brief alcohol intervention. The net cost savings of the intervention was \$89 per patient screened, or \$330 for each patient offered an intervention. The benefit in reduced health expenditures resulted in savings of \$3.81 for every \$1 spent on screening and intervention. If interventions were routinely offered to eligible injured adult patients nationwide, the potential net savings could approach \$1.82 billion annually.

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

■ Alcohol screening and brief intervention in primary health care settings is cost effective and should be implemented in the U.S. health care system.

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

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

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

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

c. Minnesota's SBIRT Plus: Integrating SBIRT into Primary Care Settings

SBIRT in primary healthcare settings is both a proven and a cost effective approach. From 2003 to 2008, over 600,000 patients were served by state and tribal SBIRT programs nationwide. Almost a quarter of those screened (23 percent) had substance use problems.

After a brief educational intervention delivered in a health care setting by health care professionals, at the six-month follow-up almost half of the participants who were initially consuming alcohol at inappropriate levels reported that they hadn't had a drink in the past 30 days and more than half of the participants who were using illicit drugs or misusing prescription medications had stopped that behavior.

(SOURCE: SAMHSA News, Vol 16., No.2, March/April 2008.)

Starting in 2010, ADAD has been working with the Dr. Mark Willenbring, former director of treatment research at the National Institute on Alcohol Abuse and Alcoholism (NIAAA), to introduce alcohol screening into primary care practice in Minnesota. The target group is primary care practices in managed care organizations that provide health care to Minnesota lowest income residents. Selected clinics are receiving training in SBIRT and the treatment of substance abuse problems. Treatment is the "plus" in SBIRT Plus.

SBIRT-Plus in Minnesota takes the SBIRT model one step beyond screening and referral, to give primary care doctors the tools they need to treat addiction, should the circumstance not warrant a referral to specialty care. Under this model everyone will be screened, and based on the results receive brief intervention, referral to specialty program treatment or treatment itself, depending on the circumstance. This will be a true integration of addiction services into primary health care.

Using the easily accessible, online and written training tools developed at NIAAA, primary care physicians will be trained in the screening, identification, referral to treatment and treatment of substance abuse problems. For additional information see: www.niaaa.nih.gov/guide.

Minimally, clinicians can now consider NIAAA's single-question alcohol screening question that asks patients, "How many times in the past year have you had (for men) 5 or more drinks or (for women) 4 or more drinks in a single day?" An affirmative answer to this question identifies patients who meet either NIAAA's criteria for at-risk drinking or the criteria for alcohol abuse or dependence specified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).

B. Department of Education

At present there is no source of state or federal dollars available to Minnesota school districts designated specifically for alcohol and drug abuse prevention programming.

The federal No Child Left Behind Act of 2001, Title IV, Part A: Safe and Drug Free Schools and Community Act State Grants program authorized the funding of a variety of activities designed to prevent school violence and youth drug use, and to help schools and communities create safe, disciplined, and drug-free environments that support student academic achievement. While these funds were passed on to Minnesota school districts for many years, this source of designated federal funding expired in 2011.

School districts can, however, access local funding for substance abuse prevention and intervention programming. The Safe Schools Levy (Minn. Stat. 126C.44) provides districts a way to supplement funding for safety and prevention programming, including alcohol and drug abuse, crime, gang and suicide prevention education, among others safety topics. School districts can determine the types of programming that are most appropriate for their community and most in need of funding. The amount available to each district is based on enrollment counts. According to statute language, “the maximum amount which may be levied for all costs under this section shall be equal to \$30 multiplied by the district’s adjusted marginal cost pupil units for the school year.”

C. Department of Health

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

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

Research shows that people exposed to smoking, regardless of where (home, work, sporting event, car) or how (in movies, on line, through advertisements), are more likely to smoke. Consequently, TFC grantees tackle the problem of exposure on multiple fronts. They have used education, policy, systems and environmental change, counter-marketing and social networking to help Minnesota communities protect their residents, youth in particular, from the harm caused by tobacco. MDH awarded approximately \$3.22 million in 2010 and \$3.22 million in 2011 to 19 grantees for continuing tobacco prevention work.

The state’s investment in tobacco prevention through this and other initiatives is reaping results. Evaluation data show that between 2000 and 2011, tobacco use dropped among Minnesota youth by 56 percent for middle school students and by 33 percent for high school students. Cigarette smoking declined even more dramatically, falling by 59 percent for middle school students and 44 percent for high school students. Trend data for other outcomes, such as youth exposure to secondhand smoke, also moved in a positive direction between 2000 and 2011.

These significant and marked declines in tobacco use mean that an estimated 47,600 fewer students used tobacco in 2011 than in 2000. Preventing these youth from starting to smoke will ultimately lead to significant savings in future direct health care costs.

Though its main emphasis is tobacco prevention among youth, MDH also joins with Clearway Minnesota to conduct the Minnesota Adult Tobacco Survey every three or four years. This survey presents a detailed picture of tobacco use among adults in Minnesota and is used by many organizations to guide efforts to reduce the harm caused by tobacco.

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

The MDH Alcohol and Other Drug Abuse Program electronically sends information about alcohol and drug-related news stories, research, funding and training to over 400 people around the state, and provides technical assistance, training and materials as appropriate, such as a logic model for prevention of underage and high-risk alcohol use, and a community assessment tool.

State grant funds support Fetal Alcohol Syndrome (FAS) activities as a sole source grant to the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS). It strives to eliminate birth defects caused by alcohol consumption during pregnancy and to improve the quality of life for those individuals and families affected. MOFAS

works collaboratively within communities to provide resources and support for families living with Fetal Alcohol Spectrum Disorders (FASD).

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

- Adolescent Health Gateway and Adolescent Health Program – Provides information regarding resources available to adolescents, parents and the general public regarding reducing alcohol and other drug use.
- Family Home Visiting – Targets at-risk families including those with a history of alcohol or substance abuse, screens for substance abuse, and provides education, resource and referral information to families regarding alcohol and other drug use.
- Women’s, Infants and Children (WIC) – Conducts a health history that includes screening for alcohol use, and refers to appropriate community resources.
- Part C – Provides early intervention services to children exposed to alcohol during pregnancy when there is a high probability that the exposure will result in a developmental delay.
- Birth Defects Monitoring and Analysis Program (BDMAP) - Conducts FAS surveillance and supports grants to reduce the risk of birth defects due alcohol, tobacco, and drug-affected pregnancies.
- Child and Teen Check-ups (C&TC) – Conducts training on newborn assessment that enhance the capacity of C&TC providers to identify conditions such as FAS and refer families to appropriate services.
- Hearing Screening – Identifies children who may have conductive or neurosensory hearing loss related to fetal alcohol exposure and supports those children and their families in receiving needed services.

MDH maintains the Minnesota Center for Health Statistics, the core functions of which include: 1) Collection and analysis of health-related data, 2) Design and implementation of public health surveys, 3) Coordination of health data collection efforts at the state and local levels, and 4) Provision of technical assistance and consultation. It is also responsible for the ongoing administration of the Minnesota Behavioral Risk Factor Surveillance System (BRFSS), a large-scale telephone survey conducted on a monthly basis throughout the year. The BRFSS survey is supported by the Centers for Disease Control and Prevention (CDC) and is conducted in all 50 states, the District of Columbia, and three U.S. territories of Guam, Puerto Rico and the Virgin Islands. MDH provides data to CDC monthly. Topics covered by the BRFSS include alcohol use, smoking, obesity, physical activity, chronic disease prevalence, and access to healthcare. This phone survey is the only source of annual data on adult alcohol use, binge drinking and heavy drinking in Minnesota.

The Minnesota Department of Health also periodically generates a report on the cost of alcohol in Minnesota.

D. Department of Public Safety

The Minnesota Department of Public Safety (DPS) is most frequently involved in the consequences resulting from the inappropriate use of alcohol and the use and distribution of illegal drugs.

In 2011 police agencies in Minnesota reported:

- 16,511 narcotics offenses
- 28,573 driving while intoxicated (DWI) offenses, and,
- 11,847 liquor law violations.

Criminal activity related to substance abuse results in significant societal and economic costs for the citizens of the state. Consumption of alcohol alone and the use and distribution of illegal substances contribute to a wide range of criminal behavior ranging from disorderly conduct to homicide.

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

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

The Bureau of Criminal Apprehension Special Investigative Unit (SIU) conducts investigations of mid- and upper-level drug trafficking organizations. Investigations are conducted in cooperation with local and county law enforcement, multi-jurisdictional drug task forces and various federal law enforcement agencies. These collaborations, both within the state and outside Minnesota, encourage the full development of the investigations, causing maximum disruption to these

criminal organizations by arrests, asset seizures and incarceration.

The State Patrol aggressively enforces, through the use of directed patrol and saturation efforts, DWI violations that often directly contribute to fatal and injury crashes.

The Office of Traffic Safety, through funding received from the National Highway Traffic Safety Administration, sponsors a Toward Zero Deaths (TZD) Enforcement Program. Funding is provided to law enforcement agencies to conduct highly visible enforcement and community outreach. The focus of enforcement efforts are primarily seat belt compliance, impaired driving and speed reduction. Campaigns that include paid media are conducted throughout the year and are often at the same time period as national campaigns. Over half of the state's law enforcement agencies participate in the TZD Enforcement Program along with the Minnesota State Patrol.

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

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

The Office of Justice Programs has funded multi-jurisdictional narcotics and violent crime task forces since 1988. These 23 task forces (as of January 2012) are staffed by over 200 investigators from over 120 agencies. The

2010 Minnesota legislature established a Violent Crimes Coordinating Council to provide direction and oversight.

Driver and Vehicle Services (DVS) regulate commercial and individual driver's licenses in the state of Minnesota according to the provisions of state law. They enforce penalties and driver's license sanctions for impaired driving.

Alcohol and drug impaired driving remains a significant threat to public safety in Minnesota. Consider that one of every seven current Minnesota drivers has at least one DWI.

In 2011, 28,573 DWIs were issued to drivers on Minnesota roads (78 per day on average). Of these, 11,967 (41 percent) violators had at least one prior DWI. A small percentage (six percent or 1,839) of DWIs was issued to drivers less than 21 years of age. Crash data from 2010 indicates that 2,485 people suffered injuries in alcohol-related crashes, and 32 percent (131) of the 411 fatal traffic crashes in Minnesota were alcohol-related. (SOURCE: Office of Traffic Safety, Minnesota Department of Public Safety, 2012.)

As of July 2011, first-time alcohol offenders with an alcohol concentration of 0.16 or above and all second-time alcohol offenders have the option of regaining their driving privileges by participating in the Minnesota Ignition Interlock Device Program. Drivers whose licenses are canceled and whose privileges are denied as "inimical to public safety" are required to enroll in the Ignition Interlock Device Program for a period of three to six years in order to regain full driving privileges.

Ignition interlocks are a proven tool in the fight against impaired driving. The interlocks stop DWI offenders from driving after drinking, prevent re-arrests and result in safer roads. Ignition Interlock is a breath-testing system installed on a motor vehicle and connected to the starter. To start the vehicle, a driver is required to blow into a tube that measures the alcohol concentration level in the driver's blood. If the device detects alcohol at or above a set level, 0.02 in Minnesota, the vehicle will not start. The device also allows for random "running retests" in which a driver

blows into the ignition interlock device so that their alcohol concentration can be measured periodically while driving to their destination. There are numerous protections in place to help assure that the device is not tampered with and that only the driver of the vehicle is providing breath samples into the device.

E. State Judicial Branch

Minnesota's judicial system is filled daily with people experiencing the legal consequences of alcohol and other substance abuse and addiction. A promising and effective approach for various subsets of this population of accused offenders is drug and other specialty courts.

1. Drug Courts

A drug court is a non-adversarial, treatment-based court program that utilizes justice system partners to closely monitor a non-violent, addicted defendant's progress toward recovery from addiction through ongoing treatment, drug testing, court appearances, supervision and the use of immediate sanctions and incentives to help promote behavior changes. Nationwide there are approximately 2,500 operational drug courts that serve 120,000 defendants.

Drug courts shift the traditional manner in which courts handle offenders by working on an ongoing basis with the defendant and multiple, key stakeholders in the justice system. In this approach, the court works closely with prosecutors, public defenders, probation officers, social workers, and other justice system partners to develop a strategy that will pressure an offender into completing a treatment program and abstaining from repeating the behaviors that brought them to court.

Drug courts are an effective problem-solving approach for dealing with alcohol and other drug addicted offenders in the judicial system. Drug courts closely monitor the defendant's progress toward sobriety and recovery through ongoing treatment, frequent drug testing, regular mandatory check-in court appearances, and the use of a range of immediate sanctions and incentives to foster behavior change.

In drug court, judges collaborate with other traditional court participants (prosecutors, defense counsel, treatment providers, probation officers, law enforcement, educational and vocational experts, community leaders and others) whose roles have been substantially modified but not relinquished in the interest of helping defendants deal with addiction.

How effective are drug courts? What does the research show?

2. Drug Court Research Findings

- Upon their release from prison, roughly 66 percent of drug users commit a new crime (typically a drug-related crime) and 95 percent relapse.
- The typical re-arrest rates on standard probation are 46 percent for a new offense and over 60 percent for probation violations.
- Nationwide, 75 percent of drug court graduates remain arrest-free at least two years after leaving the program.
- Rigorous studies examining long-term outcomes of individual drug courts find that reductions in crime last at least three years and can endure for over 14 years.
- Scientific meta-analyses have concluded that drug courts significantly reduce crime by as much as 35 percent more than other sentencing options.
- Nationwide, for every \$1 invested in drug court, taxpayers save as much as \$3.36 in avoided criminal justice costs alone.
- When considering other cost offsets such as savings from reduced victimization and healthcare service utilization, studies have shown benefits range up to \$12 for every \$1 invested.
- Drug courts produce cost savings ranging from \$4,000 to \$12,000 per client. These cost savings reflect reduced prison costs, reduced revolving-door arrests and trials, and reduced victimization.

SOURCE: National Association of Drug Court Professionals (NADCP). Online at: <http://www.nadcp.org/learn/nadcp-news-events>

As of April 2012, there were 38 operational drug courts in Minnesota covering 31 counties. This compares with only two in January 2002. These include:

- 10 adult drug courts
- 8 DWI courts
- 9 hybrid courts: (6) Drug/DWI; (2) Drug/DWI/FDTC; (1) Drug/FDTC
- 4 family dependency treatment courts (FDTC)
- 2 juvenile drug courts
- 2 mental health courts
- 1 veterans treatment court
- 2 tribal wellness courts(White Earth)

Between July 1, 2008 and June 30, 2010, 1,795 people participated in Minnesota's drug courts.

The Drug Court Initiative Advisory Committee (DCI) is an advisory committee regularly convened to examine the long-term and systemic challenges facing the Judicial Branch as it seeks to more effectively deal with alcohol and other drug cases in the court system. The DCI oversees and advises policy formulation and implementation and funding distribution for drug courts in Minnesota. The DCI works to establish effective cross-branch and cross-agency collaboration to reflect, at the state level, those strategies proven to be effective in the establishment of drug courts at the local level.

3. Key Components of Minnesota Drug Courts

- Drug courts integrate alcohol and other drug treatment services with justice system case processing.
- Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.
- Eligible participants are identified early and are promptly placed in the drug court program.
- Drug courts provide access to a continuum of alcohol and other drug and related treatment and rehabilitation services.
- Abstinence is monitored by frequent alcohol and other drug testing.
- A coordinated strategy governs drug court responses to participants' compliance.
- Ongoing judicial interaction with each drug court participant is essential.
- Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.
- Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.
- Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court effectiveness.

F. Department of Corrections

1. Overview

Research shows that those who have previously been convicted of a crime are much more likely to commit new crimes or violate their parole conditions if they use substances. Minnesota offenders who end up in prison have very high rates of drug and alcohol problems. Ninety percent of offenders entering prison have a diagnosable substance abuse or dependence disorder. In most cases, offenders who end up in prison have been through multiple prior addiction treatment programs and yet have relapsed. Offender populations are challenging to treat effectively and often present with multi-occurring problems such as mental illness, personality disorders and traumatic brain injury along with their substance use disorders.

As of January 2012, there were 1,560 offenders incarcerated on drug crimes with another 715 felony DWI offenders representing a combined 24.4 percent of the prison population who are directly incarcerated because of drug and alcohol offenses. A much higher proportion of incarcerated offenders were using drugs and/or alcohol at the time of their offense.

The percentage of drug offenders in Minnesota prisons has varied over time with a peak 2,187 drug offenders in 2005 associated with the rapid growth of methamphetamine abuse during that period. The number of offenders incarcerated on drug offenses has decreased by 19 percent since that time. Methamphetamines offenses are the highest in Minnesota prisons, representing 43 percent of all drug offenses, followed by crack (23 percent) and cocaine (21 percent).

Race is closely tied to drug offense type, with minorities representing 91 percent of offenders incarcerated on crack cocaine offenses. Seventy-three percent of offenders convicted of cocaine offenses are also persons of color.

The number of DWI offenders has grown progressively, more than doubling (from 312 to 715) since 2005. Most drug offenders have prior felony convictions. A 2010 review

found that the 1,763 drug offenders then incarcerated in Minnesota prisons had a combined total of 5,289 prior felony convictions at the time they were entered prison for their current drug offense. Felony level DWI offenders typically have two or more prior DWI offenses.

2. Investing in Treatment

Because recidivating among prison offenders is closely tied to drug and alcohol use and because 95 percent of offenders are eventually released back to their communities, Minnesota has invested in prison-based chemical dependency treatment programs as a means of contributing to community safety. Prison-based substance abuse treatment takes advantage of incarceration by providing long-term, comprehensive, programming during a period of controlled sobriety prior to release back into the community. Studies conducted by the Minnesota Department of Corrections (DOC) show a significant reduction in recidivism in three-year follow-up studies with treatment participants.

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

Chemical dependency treatment programs in the Minnesota prison system rely on research-based practices that are effective with the chemically dependent offender. Primary long-term (six to nine months) residential treatment is delivered in modified therapeutic communities which are separated from general population. Treatment services are individualized and based on the assessed needs of the clients. Enhanced services are available for offenders with co-

occurring mental health and substance use disorders, with an expansion of services made possible under a federal Second Chance Act Grant.

Additional innovations in chemical dependency treatment services include a short-term relapse prevention intervention for release violators. These are offenders who completed treatment in a past incarceration, but then relapsed to substance use which resulted in a violation of the terms of their supervision while in the community. The goal of this program is to stabilize these addicted offenders in their recovery. Enhanced release planning services provide more adequate community support for their recovery upon their re-release. This program serves offenders who would previously have no opportunity for effective treatment due to the short duration of their sentences, and provides an efficient and effective intervention that is more appropriate to their recovery needs than long-term primary treatment.

Chemical dependency treatment is also provided to incarcerated juvenile offenders under a DHS-licensed addiction treatment program within the DOC. It is also provided to offenders in correctional military boot camps for both men and women, with addiction treatment integrated into the structure of military training.

The added complication of working with the criminogenic needs and criminal risk in this population is effectively addressed in the DOC treatment programs. “A New Direction,” a curriculum authored by Department of Corrections treatment staff and published by Hazelden, is considered to be a best practice in the treatment of the substance-abusing criminal offender population and is sold all over the world for treatment programs in correctional settings. Minnesota DOC treatment professionals have the knowledge base and expertise that could be helpful to community-based treatment providers who will work with this unique client population upon release to the community.

3. Principles of Addiction Treatment Among Correctional Populations

The chemical dependency treatment services delivered in Minnesota's correctional settings are consistent with the research-based principles set forth by the National Institute on Drug Abuse as follows:

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

are living in or re-entering the community should include strategies to prevent and treat serious, chronic medical conditions, such as HIV/AIDS, hepatitis B and C, and tuberculosis

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

4. Focus on Re-entry

Since 2006, the DOC has invested in multiple offender reentry projects such as the Prisoner Reentry Initiative, the Minnesota Comprehensive Reentry Plan and the Second Chance Act Demonstration Project. Each of these projects has included strong chemical dependency program elements. These projects have been based on evidence-based practice and, as such, have included research measurement components. Some results are currently available by request or at the DOC website, and some data (Second Chance Project) are still being collected. Additionally, these projects have been designed to foster greater collaboration with community partners, including chemical dependency service providers.

5. Outcomes

Prison-based Chemical Dependency Treatment in Minnesota: Outcome Evaluation Results are highlighted below. Completing prison-based chemical dependency treatment, or successfully participating until release, significantly reduced the risk of recidivism by:

- 22 percent for rearrest.
- 20 percent for reconviction.
- 27 percent for reincarceration for a new offense.

SOURCE: Minnesota Department of Corrections, Prison-Based Chemical Dependency Treatment in Minnesota: An Outcome Evaluation – March 2010. Online at: www.doc.state.mn.us/publications/documents/03-10CDTXEvaluationReport_Revised.pdf

G. Department of Military Affairs/ Minnesota National Guard

The Department of Military Affairs (DMA) is responsible in providing personnel and units that are trained, equipped and supported by facilities to meet all federal and state missions. The Adjutant General is the administrative head of the Minnesota Department of Military Affairs and oversees the day-to-day operation and management of the fiscal, personnel, equipment and real property resources of the Minnesota National Guard (MNNG) and the Minnesota Department of Military Affairs.

The Minnesota National Guard is the largest military entity in the state, with nearly 14,000 citizen soldiers and airmen. Its enduring goal is to provide agile and resilient service members to fulfill any federal, state and community demand. The Minnesota National Guard focuses on two key areas: 1) Providing ready military units whenever and wherever needed and 2) Simultaneously integrating their relationships with the mutual needs and requirements of their stakeholders.

It is the policy of the Minnesota National Guard to maintain a workplace free from substance abuse. Substance abuse, which includes inappropriate use of alcohol and drugs, is inconsistent with military values and the standards of performance, discipline, and readiness necessary to accomplish the mission.

The MNNG Joint Substance Abuse Program (JSAP) mission is to strengthen the overall effectiveness of the National Guard's total workforce and to enhance the combat readiness of its service members. To achieve this goal and maintain a substance free workplace the following urinalysis testing requirements are in place:

- 100 percent of the Minnesota Army National Guard (MARNG) assigned end strength per year (at least 50 percent must come from random testing) at a testing rate of 10 percent per month or 25 percent per quarter.

- 50 percent of the Minnesota Air National Guard (MNANG) assigned end strength (at least 50 percent must come from random testing) at a rate of 5 percent per month or 13 percent per quarter.

- There are annual requirements to test 100 percent of the personnel assigned to designated career fields, such as Active Guard and Reserve (AGR), Aviation, Counterdrug, Military/Security Police, medical and other personnel.

The Minnesota National Guard's Prevention, Treatment and Outreach (PTO) program does not provide direct treatment services, but provides the following support:

- The PTO program provides two hours of substance abuse prevention education annually to all Minnesota National Guard members.
- A substance abuse climate survey is supposed to be conducted annually at each unit to assist commanders with identifying problem areas that need to be addressed that include substance abuse, mental health, domestic violence, financial and suicide issues. Based on the results of the survey, commanders can then provide appropriate training and interventions in the necessary areas.
- Soldiers, Airmen and family members found to have substance abuse issues, either through self-identification, legal identification or command identification, are referred to the state Prevention Coordinator (PC) for an assessment and referral to the appropriate level of care in their community. The state PC coordinates with the treating facility for continuity of care when guards' members complete treatment and return home.
- The state PC provides continuing follow-up with guards' members that have completed treatment for up to 12 months. The state PC provides a comprehensive 16-hour substance abuse education program for all guards' members and/or family members that have been identified as needing an education program as a result of an assessment, court order, command requirement or other means.

- The state PC collaborates with state and local providers, prevention coordinators, organizations (DHS, drug courts, probation, VA medical) and treating facilities to ensure that proper referrals are made, that prevention efforts are in line with local efforts and to assist with policy change efforts.

The Minnesota National Guard Counterdrug Task Force (MNCDTF) provides counterdrug/narco-terrorism support to federal, state, and local law enforcement, community based organizations, and schools annually throughout the state of Minnesota in support of the Governor's State Plan in order to reduce the supply and demand for illicit drugs while enhancing the skill sets and readiness of MNCDTF members. This support is in the areas of drug interdiction and civil operations. The amount of support is dependent on annual funding.

- Drug interdiction includes criminal analyst and drug detection support to federal, state and local law enforcement agencies. This support focuses on four core competencies: link analysis, document exploitation, commodity-financial analysis and case construction.
- Civil operations include coalition building and support along with drug education in collaboration with law enforcement, community-based organizations, and schools. This effort consists of fostering an effective community-based response by using unique military skill-sets and culture to assist local coalitions in supporting their implementation of evidence-based strategies.
- The MNCDTF partners with the Midwest Counterdrug Training Center (MCTC), the Bureau of Criminal Apprehension (BCA) and others to provide free or low cost training to Minnesota law enforcement and others involved in drug interdiction and prevention.

H. Minnesota Board of Pharmacy

The Minnesota Board of Pharmacy exists to protect the public from adulterated, misbranded, and illicit drugs, and from unethical or unprofessional conduct on the part of pharmacists or other licensees, and to provide a reasonable assurance of professional competency in the practice of pharmacy by enforcing the Pharmacy Practice Act M.S. 151, State Controlled Substances Act M.S. 152 and various other statutes. The Board strives to fulfill its mission through a combination of regulatory activity and technical consultation and support for pharmacy practices through the issuance of advisories on pharmacy practice issues and through education of pharmacy practitioners.

In response to the growing non-medical abuse of prescription drugs, many states including Minnesota established prescription monitoring programs. The Minnesota Board of Pharmacy was given authority under M.S. 152.126, to establish and maintain a program to help identify individuals who inappropriately obtain excessive amounts of controlled substances from multiple prescribers and pharmacies. The purpose of the Minnesota Prescription Monitoring Program (PMP), in operation since 2010, is to promote public health and welfare by detecting diversion, abuse and misuse for the prescription medications classified as controlled substances under the Minnesota statutes.

I. Minnesota Health Professionals Services Program

Health professionals, like anyone else, are susceptible to substance, psychiatric and medical disorders. Left untreated, these problems can put patients at risk. Many health care practitioners don't get the help they need, especially when suffering from substance use disorders, because they fear losing their jobs and the negative social stigma attached to addiction in general. This program facilitates early intervention and treatment before patient safety is compromised.

The State of Minnesota Health Professionals Services Program (HPSP) was created in 1994 as an alternative to board discipline.

The HPSP offers a proactive way to fulfill reporting requirements and get confidential help for illnesses. By law, health practitioners and employers can report a potential impairment to a licensing board or to HPSP. “Most choose HPSP,” according to Monica Feider, program manager, “because HPSP is supportive and non-disciplinary.”

HPSP monitors health professionals who have an illness that may impair their ability to do their job. Illnesses may include chemical dependence, physical problems or mental health issues.

All eligible health care professionals licensed in Minnesota can receive HPSP monitoring services as long as they comply with program expectations. Participants are responsible for the cost of their own evaluation, treatment, and toxicology screens.

Many people are unclear about their reporting obligations and feel uneasy about reporting themselves, a colleague or an employee to HPSP. Getting involved in the personal issues of another professional is a difficult decision. Yet, there is the ethical duty to protect patients from potential harm. All referrals made to HPSP are regarded as privileged data and kept confidential.

HPSP has received over 5,000 referrals to monitor health professionals and is currently serving nearly 600 of them. Of these, the majority either self-referred to HPSP, or were referred by a third party (employee health, colleague, supervisor, provider, health licensing board).

The program monitors treatment progress, work quality and medications, along with attendance at support groups and random urine screens, if alcohol or drug use is part of the illness. HPSP might also require counseling, work limitations or other individualized conditions that address a person’s needs and public safety. Typically, agreements are for 36 months.

J. Ongoing Multi-Agency Efforts

1. Minnesota Student Survey

The Minnesota Departments of Human Services, Public Safety, Health and Education collectively fund the administration of the Minnesota Student Survey, a primary and vital ongoing source of information about Minnesota students. The Minnesota Student Survey is conducted every three years among three populations of students in Minnesota public schools:

- Students in regular public schools, including charter schools and tribal schools (grades 6, 9, and 12 only)
- Students in alternative schools and Area Learning Centers (all grades)
- Students in juvenile correctional facilities (all grades)

The survey asks questions about activities, experiences, and behaviors. Topics covered include tobacco, alcohol and drug use, school climate, physical activity, violence and safety, connections with school and family, health and other topics. Reports are available from the Minnesota Center for Health Statistics, found online at: <http://www.health.state.mn.us/divs/chs/mss/>

2. Minnesota Collaborative on Substance Abuse

Minnesota Collaborative on Substance Abuse is comprised of individuals who represent state agencies that are directly involved in substance abuse-related activities, including law enforcement, prevention, corrections, specialty courts, addiction treatment services, and epidemiological surveillance. This group is convened at least quarterly to provide updates on the activities of each agency and to disseminate current original data and information regarding the activities of the respective agencies. The contributions of this group were central to the creation of this statewide substance abuse strategy.

Member agencies at present include the Departments of Human Services, Health, Education, Public Safety, Corrections, Veteran Affairs/Minnesota National Guard, Minnesota State Judicial Branch, State Board of Pharmacy, and the Hennepin County Regional Poison Center.

3. Minnesota State Epidemiological Profile

The Minnesota State Epidemiological Profile was created with guidance from the State Epidemiological Outcomes Workgroup and funding from the Minnesota Department of Human Services Alcohol and Drug Abuse Division. The Profile is a collection of data sets that help characterize and quantify patterns of use and consequences related to alcohol, tobacco and other drugs in Minnesota.

The interactive online website www.sumn.org provides data on 70 indicators relating to the consumption and consequences of alcohol, tobacco, and other drugs in Minnesota. The most recent available data from multiple government sources are provided at the county level, and by race/ethnicity at the state and regional levels whenever possible. The website is maintained by the Minnesota Institute of Public Health.

The purpose is: 1) To provide a one-stop-shop of useful data, reading material, and community resources related to substance use and consequences in Minnesota 2) To help varied community and professional audiences make decisions about substance abuse prevention efforts based on existing evidence and demonstration of need and 3) To provide easily accessible online data that can be used to prepare applications for funding, monitor prevention-related trends, plan programs or initiatives or to help define community-level prevention priorities.

www.sumn.org

4. Minnesota State Epidemiological Outcomes Workgroup

The Minnesota State Epidemiological Outcomes Workgroup is a collaborative effort of researchers from the Minnesota Departments of Human Services, Health, the Education, Public Safety, Corrections, and the Minnesota Institute of Public Health. The purpose of the group is to compile and disseminate the most recent available data about substance abuse and addiction across Minnesota to better inform local, county, and state prevention activities and other efforts related to assessment, planning, priority-setting and evaluation.

5. Minnesota Strategic Prevention Framework State Incentive Grant (SPF-SIG) Advisory Council

This group was formed in January of 2010 to assist the Department of Human Services ADAD in administering the Strategic Prevention Framework State Incentive Grant. The council maintains a membership of up to 40 people from across the state representing various government agencies, non-profit organizations, community-based prevention programs, and other sectors involved in substance abuse prevention.

The role of the advisory council is to guide the work of the SPF-SIG. Members were also involved in the development and selection of the three Minnesota SPF-SIG priorities, the development of the SPF-SIG Strategic Plan, and the sub-recipient request for proposals. The group meets every other month and is chaired by Tom Griffin, Ph.D., who was appointed by Governor Dayton in March 2012.

6. Minnesota Evidence-Based Practices Workgroup

The Minnesota Evidence-Based Practices Workgroup is another collaborative effort formed as a part of the Strategic Prevention Framework State Incentive Grant (SPF-SIG). Established in November 2010, it consists of researchers, prevention practitioners, technical assistance providers and community-level implementers. It provides guidance on the selection and use of evidence-based prevention interventions and the review and approval of SPF-SIG grantees' strategic plans, to help ensure that strategies selected are appropriate for their communities and will obtain the desired outcomes.

7. Minnesota Strategic Prevention Enhancement Consortium

Convened by the Alcohol and Drug Abuse Division of the Minnesota Department of Human Services, this group worked on defining commonalities among substance prevention, mental health promotion, mental illness prevention and primary care, and was specifically tasked with creating a Minnesota five-year prevention plan by the fall of 2012.

IV. Guiding Principles: Addressing Substance Abuse in Minnesota

A. Collaboration

“If everyone is moving forward together, then success takes care of itself.” - Henry Ford

Advances in public health and public safety rarely happen in the absence of collaboration. Dialogue and coordination between multiple government, community, and tribal entities is vital to successful efforts. By working together, coordinating efforts, and collectively drawing on the combined strengths of professionals and stakeholders, communities can effect changes. Preventing and responding to substance abuse-related problems, in these days of limited resources, requires ongoing and expanding collaborations and by so doing, more effectively leveraging resources.

B. Prevention and early intervention work best

One of the most effective ways of addressing a social or medical problem is to prevent it from happening in the first place. Effective prevention reduces risk factors and promotes protective factors. If educated, parents can play an important role in preventing drug and alcohol abuse among their children. If trained, health professionals learn to identify and address high-risk drinking and drugging behaviors long before addiction develops.

C. Reduce health disparities and promote cultural competence

Cultural competence is the process of communicating with audiences from diverse geographic, ethnic, racial, cultural, economic, social and linguistic backgrounds. Becoming culturally competent is a dynamic process that requires cultural knowledge and skill development at all service levels, including policymaking, administration and practice. Because substance abuse issues are local in character, the solutions must likewise be locally derived and implemented as well as culturally appropriate and meaningful.

D. Sustain a continuum of services

From Minnesota Statute section 254A.01: “It is hereby declared to be the public policy of this state that the interests of society are best served by providing persons who are dependent upon alcohol or other drugs with a comprehensive range of rehabilitative and social services. . . . [T]reatment shall include a continuum of services available for a person leaving a program of treatment; [and] treatment shall include all family members at the earliest possible phase of the treatment process.”

Because substance abuse and addiction affect individuals, families, workplaces, and entire communities, a broad continuum of care is needed to adequately address the changing needs of both individuals and others who are significantly affected by addiction and substance abuse. In particular, children raised in addictive environments, children in transition, and those with adverse childhood experiences are at heightened risk for substance use and mental health disorders, and require specialized services delivered in a coordinated manner.

E. An integrated approach to service delivery in health care

One of the most important elements of health care reform is the expansion of coverage for those with substance use and mental health disorders. Another new law requires parity, meaning that group health insurance plans must provide coverage for mental health and substance use disorders that is on par with coverage provided for other medical and surgical benefits. These sweeping changes create the foundation for the new health care environment.

Ingrained in health care reform is the public health model that supports prevention, screening and early intervention, treatment and recovery, integrated with primary health care. Complex developments that include new benefit packages and financing strategies, greater use of technology, promotion of

evidence-based practices and the very important linkage with primary care all present opportunities and challenges that will be addressed in the months and years to come.

In this evolving context, the goal of effective health care service delivery is to attain positive physical and behavioral health outcomes. To that end, physical and behavioral health care services must be integrated in a way that addresses the needs of each person, also referred to as “the right care at the right time.” Behavioral health needs to be integrated in to primary health care. The treatment of patients with co-occurring substance use and mental health disorders must be also delivered in a coordinated, integrated manner that address an individual’s physical and behavioral health needs.

F. Substance use disorders are treatable

The outcomes of addiction treatment are comparable to the outcomes of treatment for other chronic diseases with behavioral components. Treatment is effective and when people get the help they need they can turn their lives around.

G. Recovery is possible

Substance use disorders and substance abuse affect the quality of life for individuals, families and entire communities. Every Minnesotan has an important role to play in advancing drug-free, quality families, schools and communities. Recovery often requires support and is sustained when there is continued focus on maximizing collaborative relationships within the recovery community statewide.

V. Immediate Policy Priorities: Prescription Opiate and Heroin Abuse and Addiction

Because the abuse of prescription opiates and heroin is a serious and rapidly escalating problem of significant proportion in Minnesota, these are the immediate recommendations:

- Train physicians in the basics of addiction, opiate prescribing, and alternative approaches to pain management, and require that they have a certain number of Continuing Medical Education units (CMEs) on these topics as a condition of recertification of their specialty licenses.
- Train a broad range of front-line professionals about prescription drug abuse, treatment options for opiate addicts, and how to reverse an opiate overdose including: licensed addiction treatment providers, detox staff, law enforcement and first responders.
- Accelerate efforts to increase participation by prescribers and pharmacists in the Prescription Monitoring Program and examine alternate methods for law enforcement access.

VI. Strategies: A Blueprint for the Future

A. Strengthen prevention efforts within and across Minnesota communities. This will be accomplished by:

- Establishing and convening a broad-based coalition to develop and help implement consistent messaging about illegal drug abuse prevention messages. This will be comprised of health plans, prevention organizations, and key state agency prevention staff in order to develop consistent messaging so that it can be adopted by all state-funded prevention grant programs and by other entities that engage in prevention efforts around illegal drug and prescription drug abuse.
- Increasing efforts and enacting statewide polices to reduce underage drinking and alcohol abuse by:
 1. Evaluating the appropriate level of alcohol excise tax in Minnesota,
 2. Limiting drink specials in retail liquor establishments,
 3. Strengthening compliance checks to ensure that retailers do not sell tobacco and alcohol to minors,
 4. Requiring beverage server training at all liquor establishments to reduce alcohol sales to minors and intoxicated patrons,
 5. Maintaining limitations on alcohol availability including: alcohol sales restricted to 6 days a week statewide and to current locations (designated liquor outlets not grocery or convenience stores), and
 6. Ensuring adequate law enforcement resources for the enforcement of existing underage drinking, drinking and drugging laws.

B. Create more opportunities for early intervention in health care and other settings. This will be accomplished by:

- Integrating routine substance abuse screening including the use of the Prescription Monitoring Program into all health care settings and improving the skills of health care providers so they can identify high risk substance use and intervene at the earliest point possible
- Requiring Screening, Intervention, and Referral to Treatment (SBIRT) at all emergency care settings, and
- Incorporating SBIRT Plus into all primary care practices in the state.

C. Integrate the identification and treatment of substance use disorders into health care reform efforts. This will be accomplished by:

- Ensuring adequate access to and coverage for addiction treatment services and that health care reform in Minnesota creates benefits for addiction treatment that are on par with treatment benefits for other chronic diseases thereby enforcing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
- Ensuring that the Health Care Home and Health Home models in Minnesota encompass the medical management of behavioral health care needs, including addiction treatment and recovery support services.

D. Expand support for recovery. This will be accomplished by:

- Fostering and expanding the development of recovery schools, community-based recovery organizations, and other creative private and public partnerships for the provision of recovery support services and networks throughout the state.

- Ensuring adequate access to recovery support services for people in recovery, especially those transitioning into communities from institutional settings such as prisons, jails, mental health centers, and residential treatment facilities.

E. Interrupt the cycle of substance abuse, crime and incarceration. This will be accomplished by:

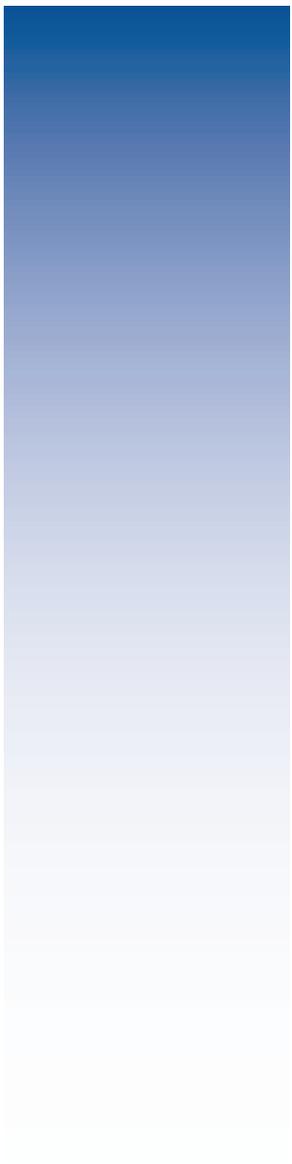
- Expanding effective prison-based treatment and access to treatment services at additional correctional settings, including local jails and county workhouses for juvenile and adult populations.
- Expanding and continuing the support of drug courts and other specialty courts in Minnesota.

F. Reduce trafficking, production and sale of illegal drugs in Minnesota. This will be accomplished by:

- Maximizing federal and state support for multi-jurisdictional drug task forces.
- Enhancing and expanding training for law enforcement about emerging drug threats so that they can most effectively adapt their investigative tools.

G. Measure with accurate and timely data the emerging nature and extent of substance abuse and scientifically evaluate the results of various interventions. This will be accomplished by:

- Producing and widely disseminating an annual “State of the State” substance abuse report card, a quantitative, analytical assessment of substance abuse-related activities and spending in Minnesota using various public data sources.
- Continuing the administration of ongoing population-based and other relevant data efforts including but not limited to the Minnesota Student Survey, the Behavioral Risk Factor Surveillance System, the Hennepin Regional Poison Center, and the Drug and Alcohol Abuse Normative Evaluation System.



APPENDIX

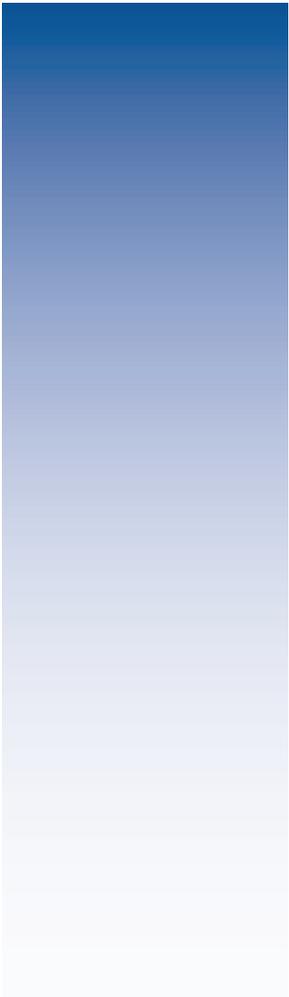
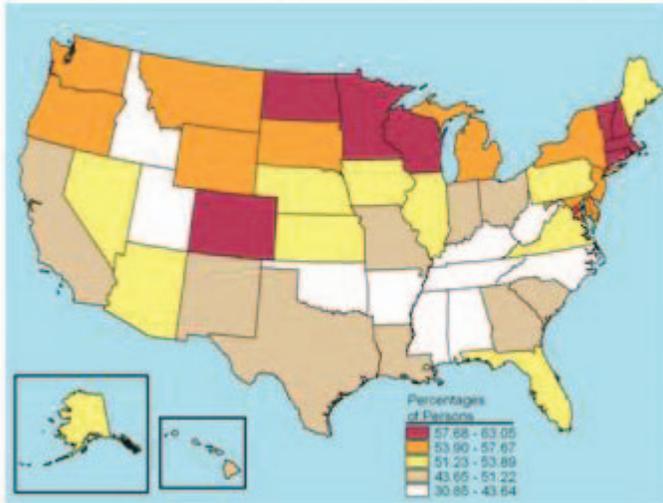


EXHIBIT 1

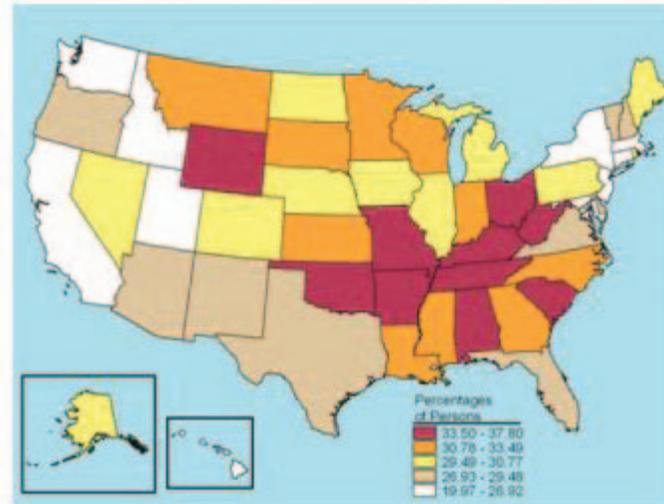
Alcohol Use in Past Month among Persons Aged 12 or Older, by State



SOURCE: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2006 and 2007.

EXHIBIT 3

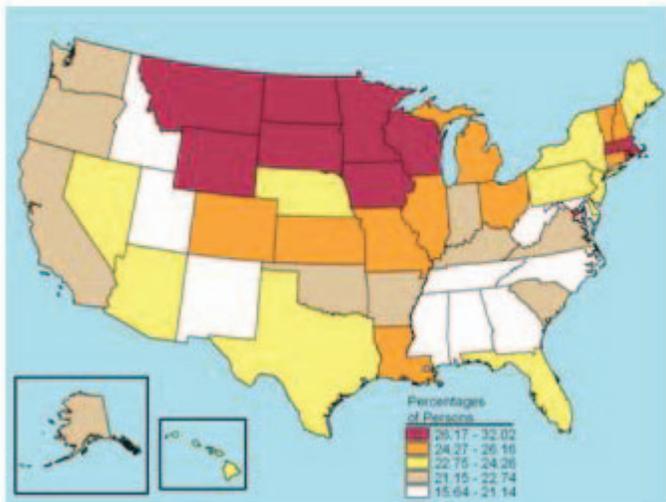
Cigarette Use in Past Month among Persons Aged 12 or Older, by State



SOURCE: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2006 and 2007.

EXHIBIT 2

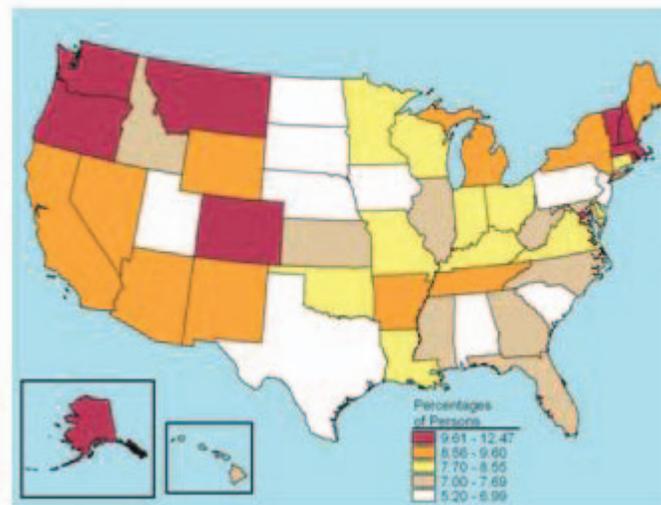
Binge Alcohol Use in Past Month among Persons Aged 12 or Older by State



SOURCE: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2006 and 2007.

EXHIBIT 4

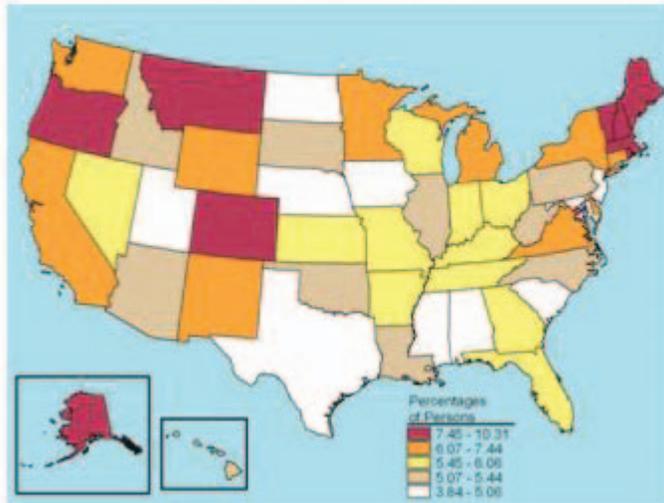
Illicit Drug Use in Past Month among Persons Aged 12 or Older by State



SOURCE: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2006 and 2007.

EXHIBIT 5

Marijuana Use in Past Month among Persons Aged 12 or Older by State



SOURCE: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2006 and 2007.

EXHIBIT 7

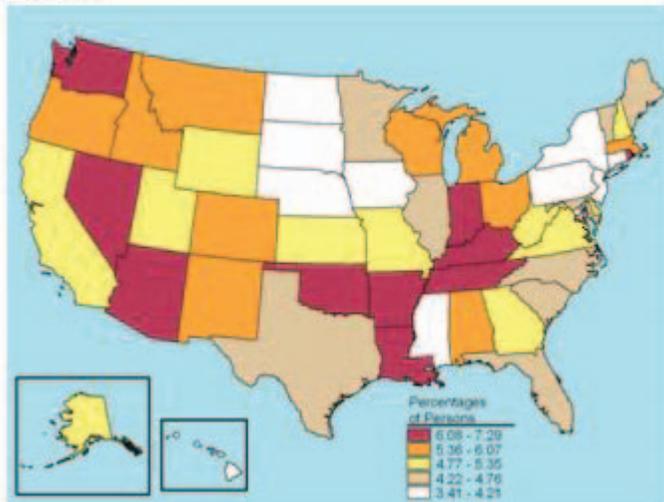
Alcohol Use in Past Month among Persons Aged 12 or Older in Minnesota, by Substate Region



SOURCE: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2006, 2007, and 2008.

EXHIBIT 6

Nonmedical Use of Pain Relievers in Past Year among Persons Aged 12 or Older by State



SOURCE: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2006 and 2007.

EXHIBIT 8

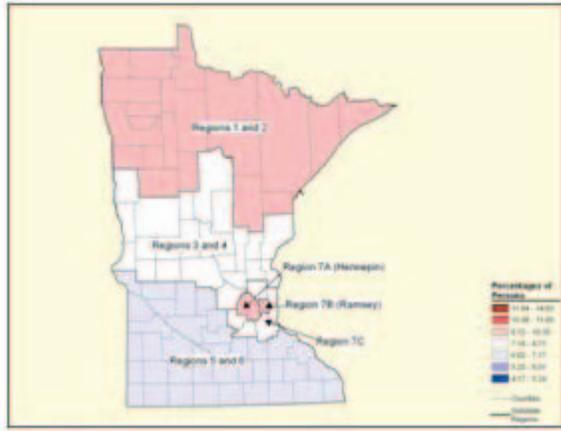
Binge Alcohol Use in Past Month among Persons Aged 12 or Older in Minnesota, by Substate Region



SOURCE: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2006, 2007, and 2008.

EXHIBIT 9

Illicit Drug Use in Past Month among Persons Aged 12 or Older in Minnesota, by Substate Region



SOURCE: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2006, 2007 and 2008.

EXHIBIT 10

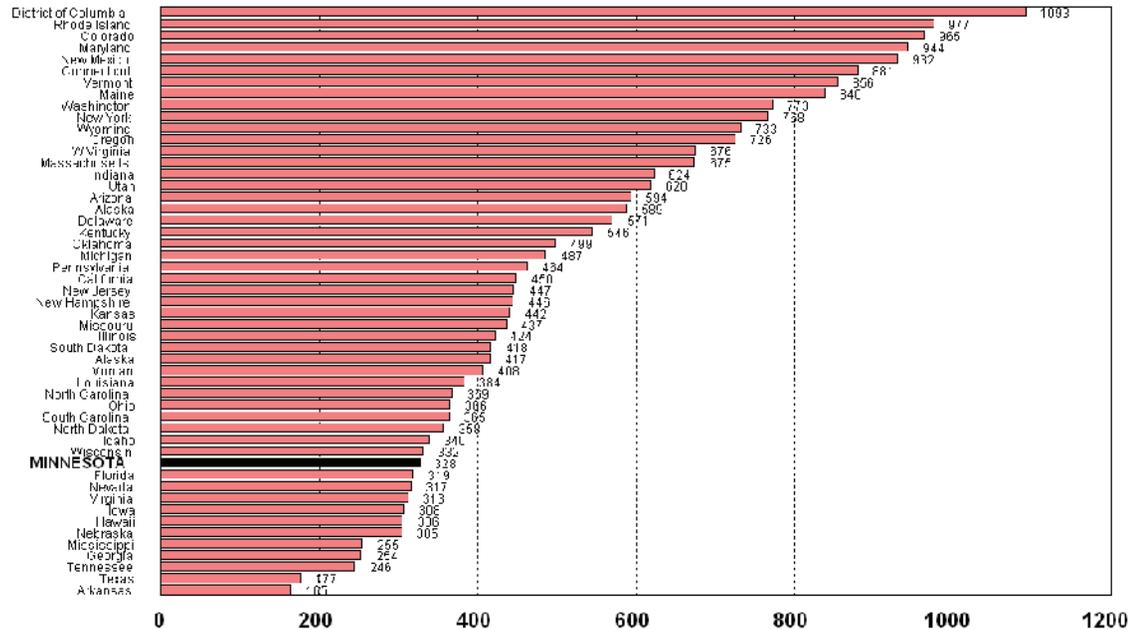
Marijuana Use in Past Month among Persons Aged 12 or Older in Minnesota, by Substate Region



SOURCE: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2006, 2007 and 2008.

EXHIBIT 11

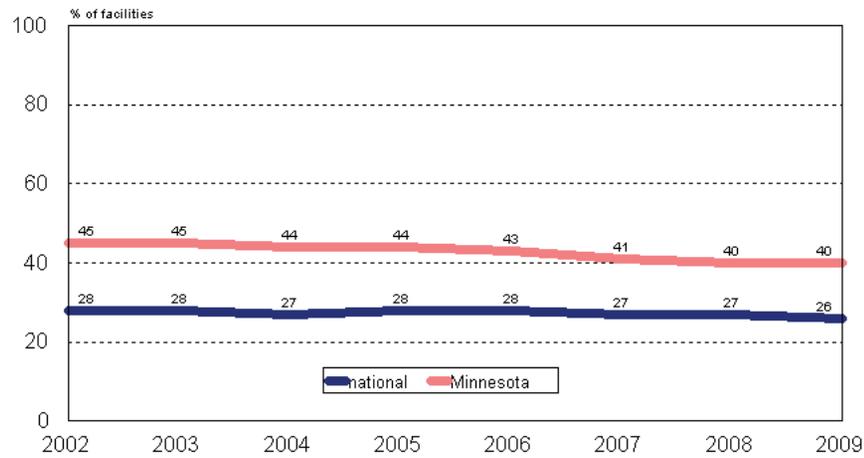
Clients age 18 and over in addiction treatment programs per 100,000 population by state: 2009



SOURCE: 2009 National Survey of Substance Abuse Treatment Services (N-SSATS), Substance Abuse and Mental Health Services Administration, 2011.

EXHIBIT 12

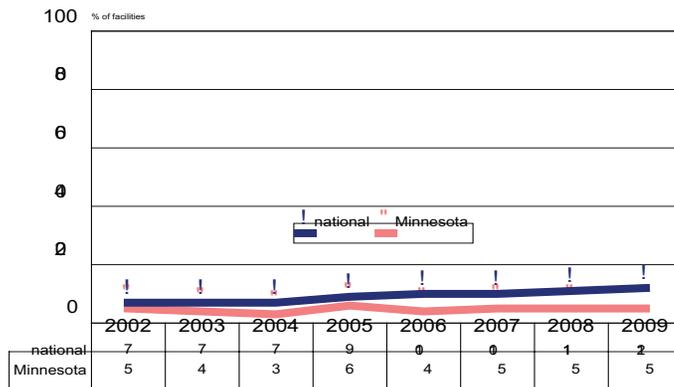
RESIDENTIAL = Type of care setting for addiction treatment facilities:
Nationally and in Minnesota 2002 - 2009 (excludes hospital-based residential)



SOURCE: National Survey of Substance Abuse Treatment Services (N-SSATS), Substance Abuse and Mental Health Services Administration (SAMHSA), 2003 – 2010.

EXHIBIT 13

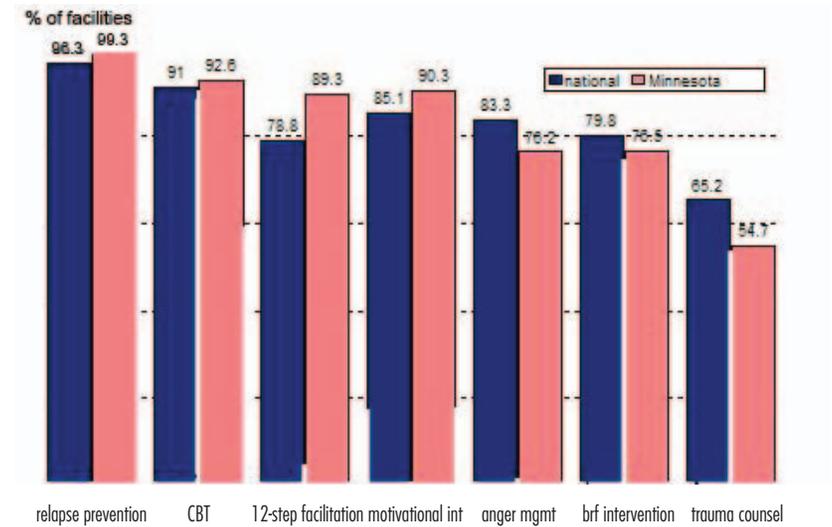
OPIOID TREATMENT PROGRAMS = Type of care setting for addiction treatment facilities: National and in Minnesota 2002 - 2009



SOURCE: National Survey of Substance Abuse Treatment Services (N-SSATS), Substance Abuse and Mental Health Services Administration (SAMHSA), 2003 – 2010.

EXHIBIT 14

Clinical approaches used sometimes/often by addiction treatment facilities:
Nationally and in Minnesota 2009



SOURCE: National Survey of Substance Abuse Treatment Services (N-SSATS), Substance Abuse and Mental Health Services Administration, 2009. CBT = cognitive behavior therapy

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. This section shall be headed by a director. The commissioner may place the director's position in the unclassified service if the position meets the criteria established in section 43A.08, subdivision 1a. The section shall:

- (1) conduct and foster basic research relating to the cause, prevention and methods of diagnosis, treatment and rehabilitation of alcoholic and other drug dependent persons;
- (2) coordinate and review all activities and programs of all the various state departments as they relate to alcohol and other drug dependency and abuse problems;
- (3) develop, demonstrate, and disseminate new methods and techniques for the prevention, treatment and rehabilitation of alcohol and other drug abuse and dependency problems;
- (4) gather facts and information about alcoholism and other drug dependency and abuse, and about the efficiency and effectiveness of prevention, treatment, and rehabilitation from all comprehensive programs, including programs approved or licensed by the commissioner of human services or the commissioner of health or accredited by the Joint Commission on Accreditation of Hospitals. The state authority is authorized to require information from comprehensive programs which is reasonable and necessary to fulfill these duties. When required information has been previously furnished to a state or local governmental agency, the state authority shall collect the information from the governmental agency. The state authority shall disseminate facts and summary information about alcohol and other drug abuse dependency problems to public and private agencies, local governments, local and regional planning agencies, and the courts for guidance to and assistance in prevention, treatment and rehabilitation;
- (5) inform and educate the general public on alcohol and other drug dependency and abuse problems;
- (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;

- (7) establish a state plan which shall set forth goals and priorities for a comprehensive alcohol and other drug dependency and abuse program for Minnesota. All state agencies operating alcohol and other drug abuse or dependency programs or administering state or federal funds for such programs shall annually set their program goals and priorities in accordance with the state plan. Each state agency shall annually submit its plans and budgets to the state authority for review. The state authority shall certify whether proposed services comply with the comprehensive state plan and advise each state agency of review findings;
- (8) make contracts with and grants to public and private agencies and organizations, both profit and nonprofit, and individuals, using federal funds, and state funds as authorized to pay for costs of state administration, including evaluation, statewide programs and services, research and demonstration projects, and American Indian programs;
- (9) receive and administer monies available for alcohol and drug abuse programs under the alcohol, drug abuse, and mental health services block grant, United States Code, title 42, sections 300X to 300X-9;
- (10) solicit and accept any gift of money or property for purposes of Laws 1973, chapter 572, and any grant of money, services, or property from the federal government, the state, any political subdivision thereof, or any private source;
- (11) with respect to alcohol and other drug abuse programs serving the American Indian community, establish guidelines for the employment of personnel with considerable practical experience in alcohol and other drug abuse problems, and understanding of social and cultural problems related to alcohol and other drug abuse, in the American Indian community.

Recovery-Oriented Systems of Care



SOURCE: SAMHSA



Minnesota Department of **Human Services**

For additional information, contact:
Kevin Evenson, Director, Alcohol and Drug Abuse Division,
Minnesota Department of Human Services.

[ADA4 \(3-12\)](#)

This information is available in alternative formats to individuals with disabilities by calling 651-431-2460. TTY users can call through Minnesota Relay at 800-627-3529. For Speech-to-Speech, call 877-627-3848. For additional assistance with legal rights and protections for equal access to human services programs, contact your agency's ADA coordinator.