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Legislative Report

Drug and Alcohol Abuse in Minnesota a Biennial Report to the Legislature

Alcohol and Drug Abuse Division

January 2018

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I. Executive summary

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

The 2018 Biennial Report was prepared by ADAD staff. The report includes information related to: 1) The nature and consequences of substance use disorder 2) Substance use, misuse and substance use disorder trends in Minnesota 3) A description of substance use disorder reform efforts and the current continuum of care for substance use disorder in Minnesota, including recommendations to reduce barriers to services and improve the continuum by expanding the nature of services available 4) An overview of the publicly funded service delivery system in Minnesota, and 5) Identification of ongoing collaborative and cooperative efforts among state entities to increase positive outcomes.

During the last two years, ADAD has worked diligently to transform our state's substance use disorder (SUD) treatment system from an acute, episodic model of treatment to a chronic disease, longitudinal model of care. Creating a person-centered recovery-oriented system of care in Minnesota to expand and enhance the nature of services available for substance use disorder, while improving integration and coordination with the rest of health care.

Substance use disorder (SUD) reform was passed during the 2017 legislative session. Highlights of the reform package include moving the current standards for substance use disorder treatment programs to statute and changing specific standards to increase client-centered services, establishing a process for direct access to treatment via comprehensive assessment; a direction to seek federal approval to include comprehensive assessment, care coordination, peer support, and withdrawal management in the state's Medicaid benefit set, and permitting direct reimbursement for SUD services provided by appropriately credentialed professionals.

The reform legislation adds comprehensive assessment, care coordination, and peer support to the Medicaid benefit set on July 1, 2018, or upon federal approval, whichever is later. The reform legislation adds individually licensed professionals as eligible vendors for publically-funded SUD treatment services effective July 1, 2018, or upon federal approval, whichever is later and adds withdrawal management services to the Medicaid benefit set on July 1, 2019, or upon federal approval, whichever is later.

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

II. Legislation

The 2018 Biennial Report is submitted to the Governor and the Minnesota State Legislature pursuant to Minnesota Statutes, section 254A.03, subdivision 1(6).

254A.03 STATE AUTHORITY ON ALCOHOL AND DRUG ABUSE.

Subdivision 1.Alcohol and Other Drug Abuse Section.

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

III. Introduction

This report is submitted to the Minnesota Legislature pursuant to Minnesota Statutes section 254A.03, subdivision 1(6). This report was prepared by Alcohol and Drug Abuse Division staff members in the fall of 2017.

In late 2016, the U.S. Surgeon General released a landmark report titled "Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health," the report marks the first time a U.S. Surgeon General has dedicated a report to substance misuse and related disorders[2].

The report finds alcohol and drug misuse and severe substance use disorders, commonly called addiction, to be one of America's most pressing public health concerns and that nearly 21 million Americans suffer from substance use disorders.

In Minnesota, treatment admissions increased by almost 4% since 2013 with 56,406 admissions in 2016. In addition, there were 376 total opioid overdose deaths, of these, 186 overdose deaths involved prescription opioids and 142 overdose deaths involved heroin. In 2017 the opioid epidemic was declared a Nationwide Public Health Emergency.

The distribution of treatment admissions by gender remains relatively the same in 2015 and 2016 with 35.6% of admissions being women and 64.4% being men. Although Black, American Indian, and Hispanic Minnesotans represent small percentages of the entire population in the state, these individuals are over-represented in treatment admissions statistics.

The total number of alcohol admissions has decreased significantly from 45.2% in 2013 down to 38.2% in 2016. Despite the decrease, alcohol remains the primary reason for SUD treatment admissions with a nearly 16.1% difference between the second largest reason for admissions, methamphetamine use disorder. Admissions for marijuana use disorders have decreased from 16.8% in 2013 to 14.7% in 2016. Heroin use disorder admissions increased from 9.9% in 2013 to 13.2% in 2016. Admissions for other opiates, such as prescription pain medication have decreased from 8.9% in 2013 to 6.4% in 2016.

Minnesota's current response to substance misuse includes primary prevention, intervention, detoxification, treatment, continuing care and recovery support services. Substance use disorder reform efforts have been occurring over the last five years to improve the treatment system from an acute, episodic model of treatment to a chronic disease, longitudinal model of care. These efforts aim to create a person-centered recovery-oriented system of care in Minnesota that will expand and enhance the nature

[2] https://addiction.surgeongeneral.gov/

of services available for substance use disorder; while improving integration and coordination with the rest of health care. Substance use disorder reform legislation was passed in 2017, as the result of years of collaborative efforts with partners, providers and citizens of Minnesota.

The reform legislation adds comprehensive assessment, care coordination, and peer support to the Medicaid benefit set on July 1, 2018, or upon federal approval, whichever is later. The reform legislation adds individually licensed professionals as eligible vendors for publically-funded SUD treatment services effective July 1, 2018, or upon federal approval, whichever is later and adds withdrawal management services to the Medicaid benefit set on July 1, 2019, or upon federal approval, whichever is later.

To ensure timely access to services, direct access to treatment was a necessary part of the redesign. Direct access allows an individual to go directly to a provider to receive a comprehensive assessment to recommend and authorize treatment placement if indicated. This will replace the current system that utilizes placing authorities and the Rule 25 Assessment tool. The rule 25 process will be phased out during a two year period while the new process is phased in.

Services that support a person's recovery process over time, such as care coordination and peer recovery support services are included in the reform. Care coordination is a treatment service involving the deliberate, collaborative planning of SUD services with the client and other professionals involved in the client's care. Individuals with SUD often experience the need for supports in other life areas (e.g. medical, mental health, family, employment, criminal justice, housing, finances), and care coordination addresses these issues concurrently to improve treatment outcomes.

Peer support services can be provided before, during and after SUD treatment to help individuals connect with resources that support recovery. Peers are individuals who are willing to share their personal recovery experience, and often engage quickly with individuals to offer reassurance, reduce fears, answer questions, support motivation and convey hope.

The reform legislation will expand access to substance use disorder services by allowing providers to provide publically-funded assessments and other treatment services outside of a Rule 31 program, and also by adding individually licensed professionals as eligible vendors of substance use disorder treatment services. These changes will permit services to be provided at a school, government building, medical or behavioral health facility, or social service organization.

The Withdrawal Management statute (245F) was enacted in 2015 to add two new levels of service to address intoxication and withdrawal to the SUD service continuum. Withdrawal management services improve the current model of detoxification services in Minnesota by addressing medical and clinical concerns, with strategies to better engage and transition individuals to appropriate services.

IV. The nature and consequence of substance abuse

The Minnesota Department of Human Services (DHS) is responsible for the statewide response to drug and alcohol misuse and substance use disorder. In order to respond, we rely on current estimates of substance misuse and substance use disorder from the Minnesota Survey of Adult Substance Use (MNSASU). The survey also collects the information necessary to make estimates of substance use disorder for subpopulations of Minnesota adults. These subpopulations include gender, age, race and ethnicity, foreign born residents, region of residence, educational level, income level, and health insurance status. The most current data available is from a 2015 report. Please note that data from the 2015 report was collected from September 2014 through April 2015. Survey data reports represent snapshots in time. Opioids data from 2016 comes from the Minnesota Department of Health's Data-Driven Prevention Initiative (DDPI) Opioid Dashboard.

2015 Substance Use Disorders—Alcohol Use Disorders

- 5.5% of adults in Minnesota met the criteria for having an alcohol use disorder.
- One characteristic of those having an alcohol use disorder was age; 10% of those 18 to 20 years old and 13% of those 20 to 24 years old met the criteria. After age 24, the proportion of adults meeting the criteria for an alcohol use disorder decreased.
- Men are more likely than women to meet the criteria for an alcohol use disorder as are American Indians compared to other racial/ethnic groups. Those born in the United States had a higher proportion of the population meeting the criteria as well.
- Those with some college had the greatest proportion meeting the criteria for alcohol use disorder (6.3%) and those with more education had substantively lower rates. Those without health insurance were substantially more likely to have an alcohol use disorder (12.9%) than those with health insurance (5.1%).
- Regionally there was little variation; the highest proportion of the population meeting the criteria for alcohol use disorders was in the Southeast region.

2015 Substance Use Disorders-Drug Use Disorders

- About 2.0% of Minnesota adults met the criteria for a drug use disorder.
- The demographic characteristics of Minnesotan adults with drug use disorders were similar to those with alcohol use disorders: The prevalence was higher among men, young adults, American Indians and those who reported multiple/other races as well as those born in the United States compared to respective counterparts.
- The proportion of the population meeting the criteria for drug use disorder decreased as educational level increased and as income levels increased. The proportion of those without health insurance who met the criteria was much higher than for those who had health insurance.
- The region with the highest proportion of the population meeting the criteria for a drug use disorder was the Northeast (3%).

2015 Need for Treatment and Receipt of Treatment

- The need for substance abuse treatment was defined as the presence of an alcohol or drug use disorder or receipt of specialty substance abuse treatment in the past year. This specialty substance abuse treatment excludes Alcoholics Anonymous and self-help groups.
- About 5.7% of Minnesota adults needed treatment for alcohol use disorders and about 2.1% needed treatment for drug use disorders.
- Across the types of disorders, the need for treatment was greatest among those aged 18- 24, males, American Indians, those with no health insurance, and individuals who were born in the United States.
- The need for treatment for both alcohol and drug use disorders was greatest among the least educated and least financially well off.
- Overall, only 7.4% of those with substance use disorders received treatment. While about twice as many of those with drug use disorders received treatment (13.7%) than did those with alcohol use disorders (6.8%), still more than 9 out of 10 adults with a substance use disorder did not receive any treatment.

2015 Trends

- Cigarette use in 2014/2015 declined from the 2010 survey period and 2004-2005 levels, particularly in the past month timeframe.
- Alcohol use across all 3 timeframes (lifetime, past year, past month) decreased from 2004/2005 levels and shows signs of a possible decrease since 2010.
- Binge drinking and heavy drinking decreased considerably from 2004/2005 and 2010 levels.
- Past-year use of illegal drugs in 2014/2015 increased since 2004/2005 (particularly the use of marijuana).
- Use of prescription drugs in 2014/2015 was similar to 2004/2005 levels but lower than 2010 levels.
- The prevalence of alcohol use disorders has decreased considerably in recent years. Estimates show a modest decline in alcohol use, but a substantial decrease in binge drinking and heavy drinking. Slightly fewer Minnesotans are using alcohol and those who do use alcohol are less likely to engage in extreme drinking behaviors or to report major adverse effects of drinking.
- The percentage of Minnesota adults in 2014/2015 needing alcohol use disorder treatment declined from 2004/2005 and 2010 measurements, but the need for drug use disorder treatment remained similar to the needs measured in these previous years[3] .

2016 Opioids

Opioids data comes from the Minnesota Department of Health's Data-Driven Prevention Initiative (DDPI) Opioid Dashboard[4].

There were 376 total opioid overdose deaths in 2016, of these, there were 186 that involved prescription opioids and 142 that involved heroin. In 2016, there were 10,332 treatment admissions for opioid use disorder. Opioid overdose deaths increased 12% from 2015 to 2016. There has been a 25% increase in heroin-involved overdose deaths from 2015 to 2016. Native American Minnesotans are five times as likely to die from a drug overdose as White Minnesotans, with African Americans being twice as likely to die from

[3] Estimating the Need for Treatment for Substance Use Disorders Among Minnesota Adults: Results of the 2014/2015 Minnesota Survey on Adult Substance Use. MN DHS & Westat.

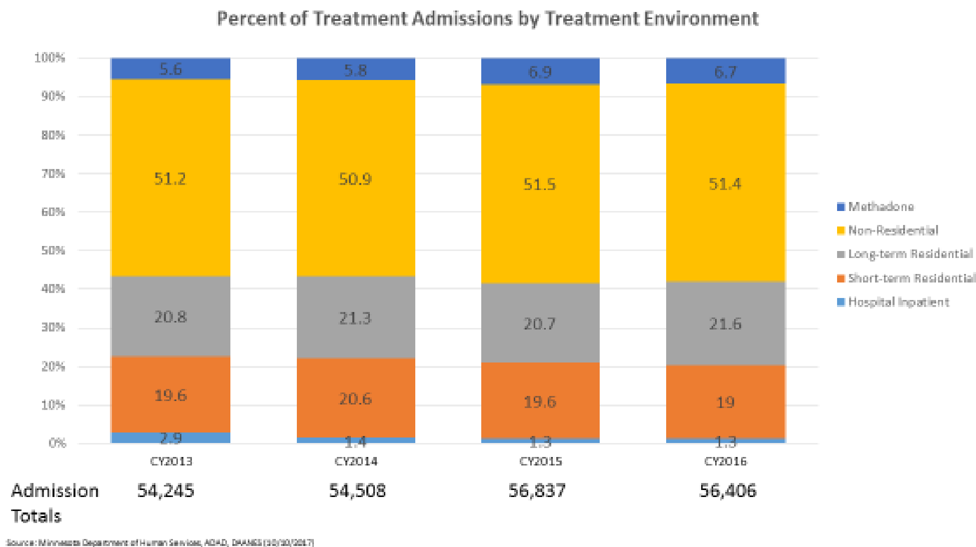
[4] http://www.health.state.mn.us/divs/healthimprovement/opioid-dashboard/index.html

drug overdose as White Minnesotans. This represents the largest disparity-rate ratio of deaths due to drug overdose in the nation[5].

Treatment Admissions

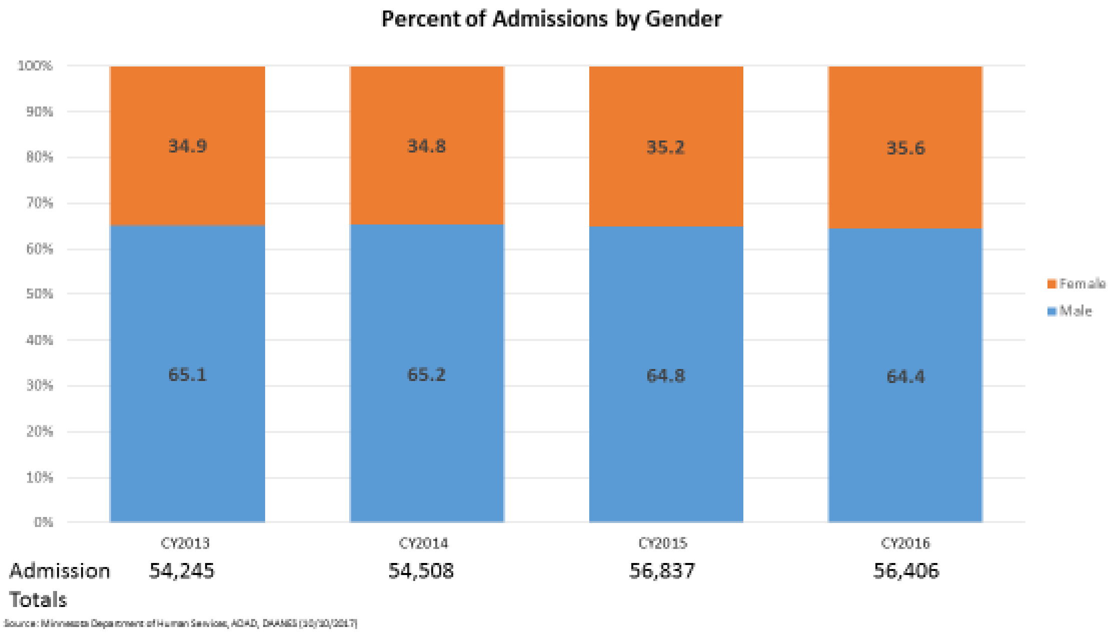
The Department of Human Services maintains the Drug and Alcohol Abuse Normative Evaluation System (DAANES). All providers of SUD treatment in the state that participate in the Consolidated Chemical Dependency Treatment Fund are required to submit data to DAANES at the time of admission and discharge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

In 2016, 56,406 treatment admissions occurred across the state of Minnesota. This is slightly less than a 4% increase since 2013, when the number of admissions was 54,245. Although treatment admission rates remained fairly steady, there were notable shifts when the nature of the treatment environment (e.g. hospital inpatient, medication-assisted treatment) are considered. In 2016, hospital inpatient admissions accounted for 1.3% of treatment admissions statewide, down from 2.9% in 2013. Since 2013, long-term residential increased from 20.8% to 21.6%, in 2016. Admissions to outpatient programs remained close to 51% since 2013. Admissions to medication-assisted treatment programs increased from 5.6% in 2013 to 6.7% in 2016.

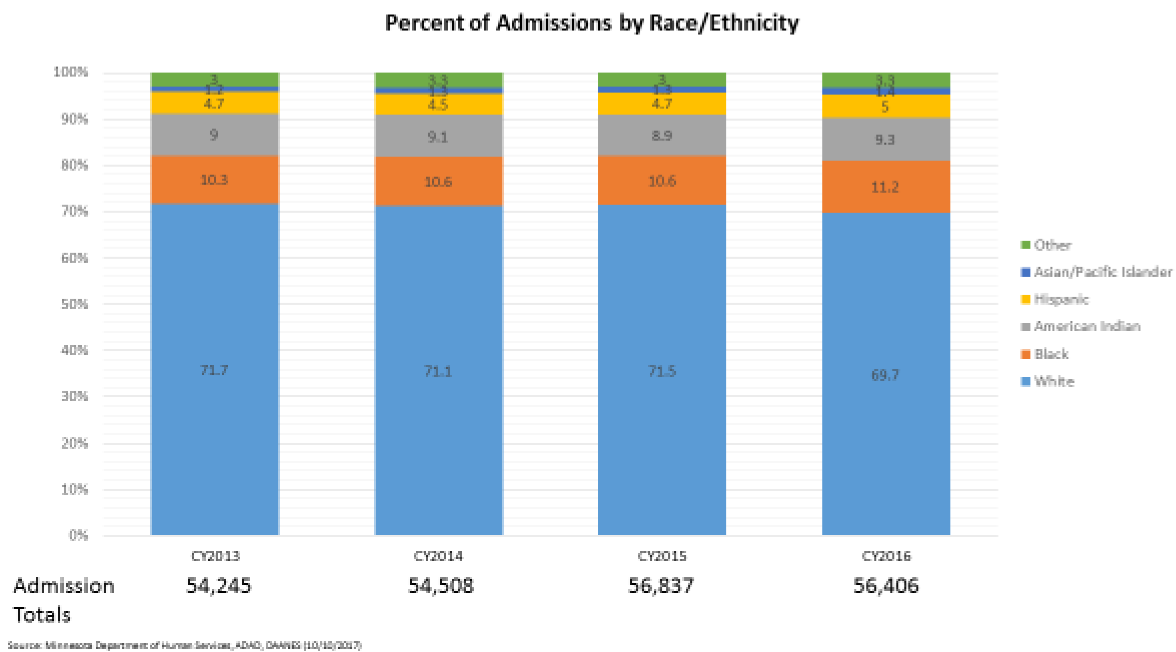


[5] http://www.health.state.mn.us/divs/healthimprovement/opioid-dashboard/index.html

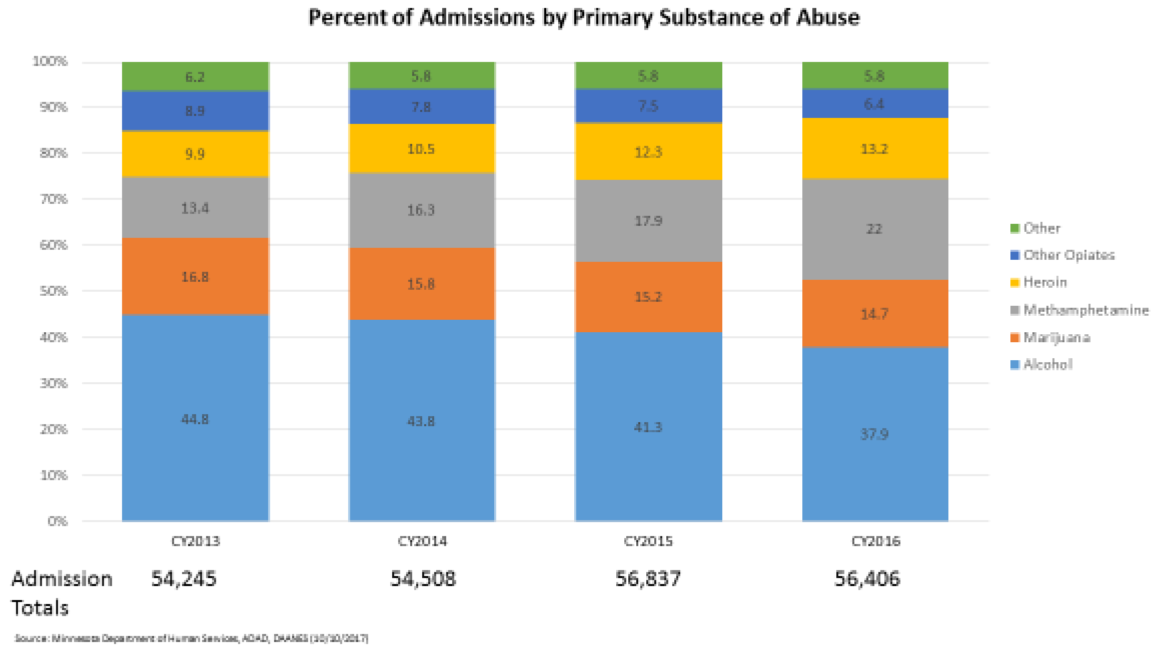
The distribution of admissions by gender remains largely the same in 2015 when compared to 2016. Between 2013 and 2016, admissions for women increased slightly from 34.9% to 35.6% while admissions for men decreased slightly from 65.1% to 64.4% in 2016.



Admission for White Minnesotans decreased from 71.7% in 2013 to 69.7% in 2016. Admissions for individuals who identify as Black increased from 10.3% in 2013 to 11.2% in 2016. Admissions for American Indians increased from 9% in 2013 to 9.3% in 2016. Admissions for Hispanic individuals have increased from 4.7% to 5% between 2013 and 2016. Improved access for all communities is significant to the mission of ADAD, but it's also important to note the disparities between ethnic groups that occur within those communities. An example being that those individuals who identify as Black, American Indian, and Hispanic represent small percentages of the entire population in Minnesota, yet these communities are significantly over-represented in treatment admission data. Census 2010 data indicates Minnesota's demographic breakdown as 85% White; 5.1% Black; 1% American Indian; 4.7% Hispanic; 4.1% Asian/Pacific Islander; and 2.1% of people who identify as "other". Given the disproportionate number of admissions in treatment from communities of color, prevention efforts should be designed to curtail the environmental factors that lead to substance abuse in these populations.



Alcohol remains the primary substance of misuse for the greatest number of admissions to treatment at 37.9% in 2016 but down significantly from 44.8% in 2013. Admissions for marijuana use disorders have decreased from 16.8% in 2013 to 14.7% in 2016. Admissions for heroin use disorders have increased from 9.9% in 2013 to 13.2% in 2016. Admissions for other opiates, such as prescription pain medication have decreased from 8.9% in 2013 to 6.4% in 2016.



V. Minnesota’s Substance Use Disorder Treatment System

Minnesota’s Current Substance Use Disorder Treatment System

Minnesota’s current substance use disorder treatment system includes services in prevention, intervention, detoxification, treatment, continuing care and recovery support. A description of the vital activities conducted in the Alcohol and Drug Abuse Division (ADAD) for each area of the continuum follows below.

Prevention

Each year, as the state authority for alcohol and drug abuse prevention and treatment, ADAD receives funding from the federal government in the form of a block grant from SAMHSA. ADAD is required to use 20 percent of the grant award for primary prevention. Primary prevention programs include activities and services provided in a variety of settings for all; in addition to focusing on sub-groups that are at high risk for substance abuse. Prevention services are provided through a combination of individual and population-based programs and strategies, though much emphasis is put on changing the local environments in which substance misuse-occurs. The Alcohol and Drug Abuse Division collaborates with other stakeholders and state agencies (Health, Education, Public Safety and Education) in data-driven planning around the delivery of prevention services throughout Minnesota.

Minnesota State Epidemiological Outcomes Workgroup

The Minnesota State Epidemiological Outcomes Workgroup (SEOW) was established in 2006 through a special grant from SAMHSA to the Department of Human Services, Alcohol and Drug Abuse Division. The SEOW is currently supported with funds from the Strategic Prevention Framework Partnerships for Success grant. The focus of this workgroup is to monitor trends in substance misuse, related consequences, and risk and protective factors for the purpose of promoting data-driven decision making. Through cross-sector collaboration with state- and community-level departments and organizations, the SEOW has identified numerous indicators of alcohol, tobacco and drug misuse and the possible consequences as a result. The information collected is useful to illustrate to key stakeholders and the general public, the substance misuse and substance use disorder concerns Minnesotans are facing every day.

SEOW workgroup activities involve analysis and interpretation of secondary data, development of data dissemination products, provision of epidemiological training and technical assistance, and serving as an advisory committee for substance abuse prevention activities and projects.

Data dissemination products include a state epidemiological profile updated annually; county, topical, and demographic fact sheets; and an online, interactive one-stop-shop website called "Substance Use in MN" (SUMN). Data on SUMN.org is available by grade, age gender, sexual orientation, race/ethnicity, county, and region.

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

Minnesota Student Survey

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

Prevention Infrastructure

Minnesota is divided into seven Alcohol, Tobacco and Other Drug Prevention Regions. The Minnesota Regional Prevention Coordinators (RPCs) support communities in their efforts to prevent alcohol, tobacco and other drug (ATOD) abuse. The RPCs help communities by building regional relationships to enhance prevention efforts, identifying and providing training opportunities, and providing technical assistance. Using federal Substance Abuse Prevention and Treatment (SAPT) Block Grant dollars, ADAD funds an RPC within each of the 7 prevention regions of the state. The RPC System covers all 87 counties. Learn more about the RPCs at http://www.rpcmn.org/.

Using federal Substance Abuse Prevention and Treatment (SAPT) Block Grant dollars, ADAD also funds five-year Community Impact grants, called Planning and Implementation (P&I) grants in ten Minnesota school districts. The focus of these grants is to provide intensive training and TA around effective prevention practices and use of the Strategic Prevention Framework. The RPC's work cohesively with key members of the community, in addition to grant staff, so that by the end of the grant lifespan the community is ready to continue effective prevention services. Each P&I grant requires a community coalition comprised of representatives from 14 community sectors. Coalition representatives conduct Responsible Beverage

Server training and alcohol compliance checks, implement evidence-based curriculum in the schools, and promote youth collaboration by forming Junior High and Senior High youth groups to combat underage alcohol use and promote healthy decision-making. Each community follows a 5-step Strategic Prevention Framework (SPF) process in developing and implementing their own strategic plan with hopes to decrease underage consumption of alcohol and other drugs. Each community effort includes a focus on Positive Community Norms and integrates the Science of the Positive framework as developed by Dr. Jeffery Linkenbach into all their activities and strategies.

Prior to receiving the P&I grant, the first cohort of school districts all had higher than state average alcohol use rates. By the end of the 5 year grant, their alcohol use rate was almost equivalent to the state average and three years after the end of the grant, their alcohol use rate was below the state average. The second cohort of P&I grantees saw the number of High School students who have ever used alcohol go down by 23% and the number of Junior High students who have ever used alcohol go down by 50%. Minnesota is currently funding the third cohort of P&I grants.

Strategic Prevention Framework Discretionary Grants

Strategic Prevention Framework Partnerships for Success Grant: The Alcohol and Drug Abuse Division is the recipient of a five-year $8.130 million dollar Strategic Prevention Framework Partnerships for Success grant which is in year four of five. This Project is designed to deliver primary prevention strategies in seven colleges and universities across the State.

Strategic Prevention Framework Prescription Drug Misuse Prevention Grant: The Alcohol and Drug Abuse Division also received a five year, 1.855 million dollar grant in 2016. This project is designed to deliver primary prevention strategies in six school districts in Cass County, MN. In addition, the grant provides funds to the MN Board of Pharmacy, Prescription Monitoring Program to deliver informational sessions to license prescribers regarding the utilization of the Prescription Monitoring Program (PMP), raise awareness regarding benefits of the PMP and adopting healthy prescribing guidelines.

State Response to the Opioid Crisis (STR) Grant: The Alcohol and Drug Abuse Division has received 10.6 million dollars in grants in 2017 to address the opioid crisis. The Opioid State Targeted Response (STR) grant is for 10.6 million dollars over two years. The primary prevention component of this grant will allow the State to partner with the Leech Lake Nation to address the high rates of opioid misuse in their communities.

Problem Gambling Program

Pursuant to Minnesota Statutes, section 245.98, the Department of Human Services, Alcohol and Drug Abuse Division administers Minnesota's Problem Gambling program. This program helps fund awareness and education campaigns, a statewide helpline, treatment for inpatient and outpatient gambling addiction services, professional training opportunities and research designated to address the needs of Minnesota

communities experiencing the effects of problem gambling. The term "problem gambling" encompasses a range of issues related to gambling that span a continuum ranging from mild to severe. The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition: (DSM-5), defines gambling disorder as a "persistent and recurrent problematic gambling behavior" leading to clinically significant impairment or distress that disrupts personal, family or vocational pursuits. Research supports that the effects on the brain and neurological reward system identified in those with substance use disorder are similar to the effects found in an individual's brain with a gambling disorder. DHS recognizes that a continuum of services is needed for problem gambling, as with other diseases of addiction, such as substance use disorder. A comprehensive continuum requires education, prevention, early intervention, treatment and recovery supports to minimize the harmful effects of problem gambling. Prevention initiatives include both individual and population-based education strategies which minimize community risk of the harmful effects of problem gambling. Early intervention and treatment services funded by Minnesota's Problem Gambling Program are intended to support a person- and family-centered care approach that is accessible, recovery-focused, and responsive to individuals, families and communities.

The Northstar Problem Gambling Alliance was formed in 2001 to serve as the Minnesota Affiliate to the National Council on Problem Gambling that provides a forum for stakeholders involved with both the gambling industry and the treatment and recovery community. Northstar is an independent non-profit organization and receives funding through private donations, organizational donations, and grants from the state legislature. Northstar is a gambling neutral entity and focused on addressing problem gambling through community awareness and education efforts, research, professional education, and advocacy. Northstar works closely with the State's Problem Gambling Program and State Advisory Committee on Problem Gambling to share information and coordinate various activities to increase awareness and access to services statewide**.** Private treatment providers, problem gambling support programs and the Minnesota Indian Gaming Association also offer services to address problem gambling in Minnesota.

Synthetic Drugs Awareness and Education Initiative

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

Tobacco Inspections

The Federal Synar Amendment requires each State to conduct annual random, unannounced inspections of retail tobacco outlets, calculate the state's retailer violation rate (RVR) and to report these findings to the HHS Secretary. In addition, the States assess local law enforcement efforts in enforcing local laws over the previous federal fiscal year. Results of these two activities are reported annually to the Substance Abuse and Mental Health Administration, through the Annual Synar Report (ASR) as part of the Annual Substance Abuse and Mental Health Block Grant report. States are required to show a State RVR of 20% or less or the state runs the risk of losing up to 40% of its federal block grant allocation.

The goal of the Congratulate & Educate/ Tobacco Merchant Education Project is to educate retailers about the important role they play in keeping Minnesota youth tobacco free. This is for educational purposes only and no penalties to the clerk or business owner are permitted. This is designed to supplement the statutorily required annual enforcement check. Police Departments, Sheriff's Departments and County Public Health Departments are all eligible to participate. Participants enter into a contract with DHS to conduct a predetermined number of educational tobacco compliance checks at a rate of $40 per check. These educational checks can be completed on any tobacco or tobacco related device (cigars, blunt wraps, e-cigarettes, e- juice) whose sales to minors is regulated by state law. If the clerk fails the inspection participants will give them a copy of the Clerk Fail Publication and read through the short publication with them, so they understand the importance of the information contained in the publication. If the clerk passes the inspection, participants will fill out the Congratulation Certificate and provide the certificate to the clerk. Whether the clerk passes or fails the compliance check participants will fill out the Owner Publication and provide the publication to the owner. In the 2017 state fiscal year DHS-ADAD has contracted with fifty-nine local law enforcement and public health departments who conducted 1,441 inspections which will cover approximately thirty-four percent of all licensed tobacco vendors in the state.

On June 22, 2009, President Barack Obama signed into law the Family Smoking Prevention and Tobacco Control Act granting the U.S. Food and Drug Administration the authority to regulate the sale and advertising of tobacco products. DHS ADAD has the contract with the FDA to conduct tobacco compliance check inspections in Minnesota to assist the FDA in determining tobacco retailer's compliance with the Federal Tobacco Control Act. We are just entering our seventh year and through September 30, 2017 Minnesota has conducted over 29,000 inspections resulting in over 1,400 warning letters, 292 civil money penalties and one no sale order.

Early Intervention

A significant prevention and early intervention strategy is the use of "SBIRT," (Screening, Brief Intervention and Referral to Treatment). SBIRT has been used in Minnesota trauma hospitals, emergency departments, and primary care and community health settings since 2007. SBIRT is an evidence-based practice that is shown to be successful in modifying the consumption patterns of at-risk substance use before more severe consequences occur, while also identifying individuals in need of more extensive, specialized treatment. The 2013 Legislature appropriated $600,000 over the biennium to ADAD to expand the utilization of SBIRT in Minnesota communities across the state by increasing the number of SBIRT trained providers. In 2014 and 2015, a hospital-based pilot was conducted to increase the number of people trained to use SBIRT techniques, increase the use of SBIRT in primary care clinics and to lower the incidence of risky drinking for clinic patients. Pilot funds were made available through the Legislature's appropriation and granted through ADAD. The pilot clinics reported that their patients experienced a reduction in the number of binge drinking sessions per weeks as a result of feedback they received after screening for risky drinking. ADAD is continuing efforts to encourage wider implementation of SBIRT throughout the state.

Detoxification

Overusing drugs and alcohol to the point of acute intoxication or overdose is one of the most dangerous symptoms experienced by individuals with the disease of addiction. Detoxification describes the biological process of ridding the body of harmful substances while withdrawal management describes the continuum of services available to people who require a safe and effective medical intervention to avoid more illness or even death. Ensuring that people who are acutely ill from chemical poisoning receive intensive medical services when clinically indicated is a critical mission.

Treatment

There are 392 programs in Minnesota that are licensed to provide SUD treatment services; 377 of which are Rule 31 programs and 16 of which are Children's Residential Facilities (CRF).

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

Treatment settings include free-standing for-profit and not-for-profit organizations, hospitals, tribal government and state-operated treatment services. Some SUD treatment programs contract with county

jails and adolescent correctional facilities to provide non-residential SUD treatment services onsite, and one rural treatment program provides outpatient addiction treatment in a nursing home facility. Currently there are a variety of population-specific programs serving females, males, Native Americans, African Americans, Hispanic, deaf and hard of hearing, lesbian/gay/bisexual/transgender, Hmong, Somali and senior populations, and there are 20 licensed adolescent-specific residential service providers in Minnesota.

Medication-assisted treatment

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines medication-assisted treatment, including opioid treatment programs (OTP) as a combination of behavioral therapies and medications to treat substance use disorders. The most common medication used today is methadone, which is used as an opioid replacement therapy. The second most common opioid replacement medication is buprenorphine. Depending on an individual's need, willingness and prescription coverage, addiction medications such as naltrexone, buprenorphine, topiramate, and methadone, may be recommended and incorporated into treatment services as an adjunct to behavioral treatment, although not all abstinence-based programs will admit clients who are prescribed some of these medications.

Integrated Dual Diagnosis Treatment (IDDT)

Integrated Dual Diagnosis Treatment seeks to ensure that persons with co-occurring substance abuse and mental illness receive the most effective and comprehensive care available. This type of service will not replace the current SUD delivery system, but it will complement and promote the expansion of effective and efficient evidence-based treatment services available in the state to meet the complex needs of persons with co-occurring disorders.

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

Culturally specific activities

The Alcohol and Drug Abuse Division supports culturally specific prevention efforts in Minnesota. From 2011 thru the end of 2016, the American Indian Section within the Alcohol and Drug Abuse Division has assisted and/or provided resources to train and educate over 600 substance abuse professionals in the following; "Native American Curriculum for Substance Abuse Programs in Minnesota" which supports SUD prevention in the tribes and urban American Indian communities in the state. The curriculum was adapted from the "Native American Curriculum for State Licensed Substance Abuse Programs in South Dakota," which was developed by Duane Mackey in 2004. This adapted curriculum contains elements specific to and reflective of the tribal makeup and historical experiences of American Indians who live in Minnesota.

The American Indian Programs section and the American Indian Advisory Council of ADAD have worked together to increase the availability of culturally-specific training and effective substance abuse treatment services for American Indians in Minnesota. In January of 2014, a joint meeting of the American Indian Advisory Council, the American Indian Mental Health Advisory Council and the American Indian Child Services Council (ICWA) met to develop common goals and advice which was given to the Commissioner of DHS for consideration. They met 3 times in 2016, and are scheduled to meet again jointly in January 2018. They will be discussing further recommendations to DHS for policy and procedures related to the services of Native American residents.

Substance Use Disorder Reform

Substance Use Disorder Reform legislation was passed in 2017, as the result of years of collaboration with partners, providers and Minnesota residents. The new SUD reform legislative standards became effective on January 1, 2018.

Background

The 2012 Legislature directed the Department of Human Services (DHS) to collaborate with counties, tribes, and other stakeholders to develop a model of care to improve the effectiveness and efficiency of Minnesota's current service continuum. The proposed model would update Minnesota's treatment system from an acute care model to a chronic care model that is comprehensive, integrated and designed to support recovery across the lifespan. A steering committee met bi-weekly from September 2012 until February 2013 to develop the recommendations, which are contained in the March 2013 legislative report *Minnesota's Model of Care for Substance Use Disorder*.

Subsequent legislation was passed during the 2013 session that directed the Department to establish pilot projects to begin implementing the measures recommended in the report. The first pilot site began operating in late 2014 and the second site began in early 2015.

To continue to evaluate the ideas put forth in the Model of Care report the Alcohol and Drug Abuse Division (ADAD) facilitated nine listening sessions in 2015. Listening sessions were conducted in the following regions and Tribal communities.

- American Indian Forum—Onamia
- Metro Region—St. Paul and Minneapolis
- Northeast Region—Duluth
- Northwest Region—Thief River Falls
- Southeast Region—Rochester
- Southwest Region—Granite Falls
- West Central Region—Fergus Falls
- Youth Listening Session—Health Occupations Students of America (HOSA) Conference-St. Paul

In 2016, community engagement initiatives continued as ADAD convened a core stakeholder workgroup, which met for five 3-hour work sessions in June 2016. Workgroup membership included representation from consumers/families, Tribal Nations, counties, providers, health plans, hospitals, prevention, problem gambling, culturally-specific providers and recovery care organizations. A fiscal stakeholder workgroup was also convened and made recommendations related to funding, including the responsibilities of the state and counties in funding substance use disorder services.

Furthermore, in order to gather input on the policy recommendations, ADAD provided a series of six community presentations statewide, starting in October 2016.

Substance Use Disorder Reform

Comprehensive Assessment/Direct Access

In order to ensure timely access to services, direct access to providers was a necessary part of the redesign. Direct access allows an individual to go directly to a provider to get a Comprehensive Assessment to authorize a level of treatment placement instead of a Rule 25 assessment. Individuals will be able to select the service provider of their choice with the level of care approved, subject to any PMAP provider network requirements. Comprehensive Assessment is added to the Medicaid benefit set July 1, 2018 or upon federal approval, whichever is later, and the language directs the Department to seek this approval. Rule 31 programs, withdrawal management programs, counties and appropriately credentialed enrolled individuals are identified as eligible vendors for Comprehensive Assessment. The process for enrolling in medical assistance is not changed by the legislation and programs will still need to confirm an individual has been approved for publically-funded services. Increased utilization of navigators to help individuals enroll in Medical Assistance will be a part of the implementation of direct access.

Direct access will need to be phased in over a period of time due to workforce and other considerations. Legislation creating the new process does not eliminate our existing placing authority process immediately but will instead run parallel for a period of up to two years to allow for the transition to the new system. During the phase-in period some individuals will still access treatment by going to a county or other placing authority to be assessed and referred to a level of care according to the current system using Rule 25 Assessment. The reform legislation contains language allowing the option to access via either route, as available.

Direct Reimbursement-Expand Delivery Sites of Treatment Services

The SUD reform allows for credentialed providers to provide publically-funded assessments and other treatment services outside of the Rule 31 program by adding individually licensed professionals as eligible vendors for publically-funded SUD treatment services effective July 1, 2018 or upon federal approval, whichever is later. Individual vendors must have licensure that provides a scope of practice to provide addiction treatment services and in addition, individuals licensed in a field other than addiction must have

a concentrated education in alcohol and drug counseling and supervised internship experience with individuals with substance use disorder

This provides an enhanced system that supports services outside of treatment centers, such as at recovery community organizations or other facilities, including schools, clinics, hospitals and jails. This will allow for increased access by decreasing geographic and transportation barriers. Expanded access points permit SUD services to be provided in the community and through direct reimbursement of appropriately credentialed professionals, who will be eligible for reimbursement of services provided independent of a licensed program.

Care Coordination and Peer Recovery Support

Services that support a person's recovery process over time, such as care coordination and peer recovery support services, were included in the state's continuum of care. By providing these services the aim is to effectively address the chronic nature of substance use disorders and make available the right level of service at the right time in the right amount.

Individuals with SUD often experience the need for support in other life areas (e.g. medical, mental health, family, employment, criminal justice, housing, finances), and care coordination addresses these issues concurrently to improve treatment outcomes. Care coordination is a treatment service involving the deliberate, collaborative planning of SUD services with the client and other professionals involved in the client's care.

Peer support services can be provided before, during and after SUD treatment to help individuals connect with resources that support recovery. Peers are considered individuals who are willing to share their personal recovery experience, and often engage quickly with individuals to offer reassurance, reduce fears, answer questions, support motivation and convey hope.

Individuals providing peer support must complete training, certification and continuing education requirements identified by the commissioner, and the training must address ethics and boundaries, mentoring, advocacy, culturally-based approaches and community resources. An individual providing peer support must have a minimum of one year of recovery from substance use disorder. An individual providing peer support must be supervised by a qualified SUD professional who understands the responsibilities and scope of work of a recovery peer.

The reform legislation identifies SUD programs, withdrawal management programs, and Recovery Community Organizations as eligible vendors of peer support services. A Recovery Community Organization must have a certification approved by the commissioner to be an eligible vendor, and the reform legislation adds a definition of Recovery Community Organization. The peers themselves would not be eligible for direct reimbursement. For the service to be reimbursable, the peer providing the peer support service must be employed and supervised by an eligible vendor of the service.

Withdrawal Management

The Withdrawal Management statute (245F) was enacted in 2015 to add two new levels of service to address intoxication and withdrawal to the SUD service continuum. Withdrawal management services improve the current model of detoxification services in Minnesota by addressing medical and clinical issues, with strategies to better engage and transition to appropriate services.

A withdrawal management program is defined at 245F.02, subdivision 26, as a licensed program that provides short-term medical services on a 24-hour basis for the purpose of stabilizing intoxicated patients, managing their withdrawal, and facilitating access to substance use disorder treatment as indicated by a comprehensive assessment.

At 245F.02, subdivision 7, "Clinically managed program" means a residential setting with staff comprised of a medical director and a licensed practical nurse. A licensed practical nurse must be on site 24 hours a day, seven days a week. A qualified medical professional must be available by telephone or in person for consultation 24 hours a day. Patients admitted to this level of service receive medical observation, evaluation, and stabilization services during the detoxification process; access to medications administered by trained, licensed staff to manage withdrawal; and a comprehensive assessment.

At 245F.02, subdivision 14, "Medically monitored program" means a residential setting with staff that includes a registered nurse and a medical director. A registered nurse must be on site 24 hours a day. A medical director must be on site seven days a week, and patients must have the ability to be seen by a medical director within 24 hours. Patients admitted to this level of service receive medical observation, evaluation, and stabilization services during the detoxification process; medications administered by trained, licensed staff to manage withdrawal; and a comprehensive assessment.

Reduced Paperwork Requirements

Reduced duplication, streamlined paperwork requirements and a sustainable rate structure are priorities identified by stakeholders and are important to sustain an effective continuum of care. In order to be truly client-driven, person-centered care will require treatment plans to evolve and be prioritized according to client need and focus. System reform efforts will be informed by these priorities and should be reflected in any modifications or additions to SUD program requirements.

Institutions of Mental Diseases (IMD)

In addition, ADAD is pursuing available avenues to address any impact of lost federal Medicaid funding due to certain residential SUD programs being newly designated as Institutions for Mental Diseases (IMD). Currently, federal Medicaid funding cannot be used for residential substance use disorder treatment programs with more than 16 beds, which are designated IMDs pursuant to federal law.

On July 27, 2015, the Centers for Medicare and Medicaid Services (CMS) announced a new opportunity for demonstration projects under Section 1115 of the Social Security Act. One component of the 1115 demonstration project is the opportunity to request authority for federal financial participation for SUD treatment provided to individuals in an IMD. ADAD has begun an ongoing analysis of the substantial changes that will be needed to the current substance use disorder treatment system to achieve the requirements for the 1115 demonstration project. These proposals, over time, will help align Minnesota's service continuum to maximize federal funding.

Opioid State Targeted Response (Opioid STR) grants

The Alcohol and Drug Abuse Division has received 10.6 million dollars in grants in 2017 to address the opioid crisis. The Opioid State Targeted Response (STR) grant is for 10.6 million dollars over two years. The Opioid STR grant was awarded to the state to implement primary prevention strategies to delay the onset and reduce prescription drug misuse, especially opioids, increase access to treatment, reduce unmet treatment needs and reduce opioid overdose related deaths. The Opioid STR grants will provide an opportunity for early implementation of reform efforts.

V. Publically funded substance use disorder services

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

The percentage of treatment paid for through the CCDTF was 43.3% in 2016. Treatment admissions covered by managed care organizations (MCO) increased from 17.1% in 2013 to 24.7% in 2016. Treatment admissions covered by All Other Sources was 31.9% in 2016.

Funding Coverage	CY2013 Count	%	CY2014 Count	%	CY2015 Count	%	CY2016 Count	%
CCDTF Client	23,073	42.5%	22,198	40.7%	22,682	39.9%	24,437	43.3%
MHCP - MCO Client	9,287	17.1%	11,829	21.7%	13,887	24.4%	13,953	24.7%
All Other Sources	21,885	40.3%	20,481	37.6%	20,269	35.7%	18,016	31.9%

VI. Collaborative and cooperative efforts with other state entities

Minnesota's State Substance Abuse Strategy is comprised of representatives from the Departments of Human Services, Corrections, Education, Health, Public Safety, Labor & Industry, the Judiciary, and the Board of Pharmacy. The State Substance Abuse Strategy is a multi-agency, multi-faceted approach with the objective to prevent and address the impacts of drug and alcohol abuse. The plan requires close coordination among state agency partners on immediate and long-term recommendations in efforts to balance public safety, prevention, intervention, treatment, recovery support services and research to decrease all substance abuse and addiction. Bringing together state entities to address substance use and abuse in Minnesota has resulted in an increase in complementary individual agency efforts, a decrease in duplicative agency efforts, and many collaborative multi-agency efforts.

In 2015, the strategy group introduced the State Opioid Oversight Project (SOOP) to provide a mechanism for the integration of state governmental efforts to reduce the impact of opioid dependence among Minnesotans while appropriately managing pain; simultaneously moving forward with more mature initiatives to reduce opioid dependence and its consequences. SOOP membership includes all the partners of the State Substance Abuse Strategy plus the Minnesota Board of Medical Practice, Dentistry, Nursing, Podiatric Medicine and the Minnesota Pollution Control Agency. The SOOP has focused its efforts around addressing opioid prescribing practices through the Opioid Prescribing Workgroup, Safe Disposal, Prevention, Neonatal Abstinence Syndrome, Medication Assisted Treatment, Prescription Monitoring Program, Increasing Access to Naloxone and just recently Justice Involved Populations. It is important to note that although state government has an important role, we cannot solve opioid misuse and abuse alone. It will require an ongoing response from multiple stakeholders including the federal government, public health, opioid prescribers, addiction experts, researchers, the medical and treatment industry, patients and local communities.

VII. Report recommendations

Stigma

1. **Stigma of SUD**. An important priority for the state is to address the stigma of SUD and its harmful impact on individuals in need of services and support. Stigma creates a barrier for people seeking treatment, can influence funding priorities, often results in prosecution and incarceration (when prevention and treatment may be a more appropriate and effective response), and at times can result in an uninviting reception from non-SUD health care providers who might be unfamiliar with the population, which is a problem that may increase as more SUD clients are moved into integrated health care. Achieving parity for SUD services can also be challenged by stigma.

Culturally Specific/Special Populations

2. **Stakeholder engagement.** Continue to conduct meaningful stakeholder engagement that is transparent and committed to honestly and persistently working through conflicts and challenges.

3. **Quality assurance for enhanced rates.** Commit to ongoing stakeholder engagement to identify quality assurance methods for the enhanced rate for culturally specific/special population services. Seek any necessary statute or rule changes to require that clients seeking treatment services be screened for culturally specific needs and ensure that those requesting culturally specific treatment services are provided access to them.

4. **Funding for culturally specific providers.** Seek non-Medicaid funding opportunities for culturally specific services to support a client's treatment goals when those services are not reimbursable from Medicaid.

5. **Decrease disparities in outcomes.** Support the development of culturally appropriate and effective treatment modalities that decrease disparities in outcomes.

6. **Workforce development.** Work with stakeholders to support workforce development that increases the number of providers competent to provide culturally specific services and encourages a workforce with increased demographic diversity.

7. **Prevention funding for underserved communities.** Seek increased prevention funding to target underserved communities experiencing disparities. Develop prevention efforts with a holistic and tailored focus for different populations.

Opioid Related Recommendations

8. **Per diem reimbursement**. Eliminate the per diem reimbursement methodology of opioid treatment programs, but retain the basic per diem for the medication and medication administration and allow opioid treatment programs to bill hourly for non-residential behavioral support services.

9. **Support persons on medication assisted treatment.** Currently clinics treating people using MAT might not offer a full range of behavioral treatment services. Meanwhile, many traditional treatment providers who focus on behavioral strategies may feel a disincentive to accepting MAT patients. Therefore, treatment providers who focus on behavioral strategies need to be supported to accept MAT clients to ensure people receive a full range of needed services.

10. **Naloxone availability**. Support the increased availability of naloxone and support providing clients with access to Naloxone, particularly upon discharge from a residential setting.

11. **Barriers to behavioral support.** Monitor barriers to behavioral support services for individuals who use medication-assisted treatment. Continue stakeholder engagement to ensure appropriate access to behavioral supports across the state for all clients, including those engaging in medication assisted treatment.

12. **Increase timely access to treatment.** Utilize early screening tools, such as "SBIRT" (substance use brief intervention and referral to treatment) to help connect people who might not otherwise have accessed treatment services to do so and to ensure people can begin receiving care as soon as they are ready, rather than wait and possibly forgoing care altogether. In addition, for individuals who do not screen positive or who only need a limited set of services, early access to initial substance use disorder services will avoid the need for a more costly comprehensive assessment.

Primary Prevention

13. **Prevention planning and implementation.** Expand the Prevention Planning and Implementation Program, which focuses on environmental strategies and has demonstrated positive outcomes and improved health.

14. **More Regional Prevention Coordinators (RPCs).** Increase the number of RPCs, which provide training and technical assistance on substance use prevention. Currently, the state is divided into seven large geographical areas covered by RPCs. Increased investment in this program would allow each RPC to have a smaller geographical area and permit more concentrated efforts.

Problem Gambling

15. **Cross-addiction education.** Support increased education regarding the risks of cross-addiction when treating gambling disorder or substance use disorder. Support increased cross-referral, integrated treatment services and continuing care when providing services to individuals with gambling and substance use disorder.

16. **Ensure best practices.** Work with stakeholders to enhance the current requirements to ensure the use of best practices and person-centered recovery-driven outcomes.

17. **Telehealth.** Support increased use of telehealth to expand access to problem gambling treatment. Increase awareness of telehealth technical assistance opportunities and the availability of teleconferencing services.

18. **Invest in Culturally Informed Prevention and Intervention Services.** Dedicate funds to support race and ethnic community informed collaborations that provide valuable information about how gambling impacts disparate communities and develop prevention and intervention services to respond to community needs in a culturally responsive manner.

19. **Research.** Establish and develop research to provide data-driven decision-making.

Tobacco Prevention

20. **Support smoking cessation**. Alcohol and Drug Abuse Division will continue to work with treatment providers to explore initiatives to support smoking cessation and to increase awareness of the nicotine cessation services available to all Minnesotans.

VIII. Appendix

Drug and Alcohol Abuse Normative Evaluation System (DAANES) Tables for Biennial Report CY2013-CY2016

Source: Minnesota Department of Human Services, ADAD, DAANES (10/10/2017)

Calendar Year	CY2013 Count	CY2013 Col %	CY2014 Count	CY2014 Col %	CY2015 Count	CY2015 Col %	CY2016 Count	CY 2016 Col %
Total Admissions	54245	100.0	54508	100.0	56837	100.0	56406	100

CD Treatment Environment	CY2013 Count	CY2013 Col %	CY2014 Count	CY2014 Col %	CY2015 Count	CY2015 Col %	CY2016 Count	CY 2016 Col %
Hospital Inpatient	1529	2.9	765	1.4	716	1.3	739	1.3
Short-term Residential	10397	19.6	11238	20.6	11118	19.6	10703	19.0
Long-term Residential	11017	20.8	11602	21.3	11784	20.7	12167	21.6
Non-Residential	27178	51.2	27723	50.9	29274	51.5	29000	51.4
Methadone	2959	5.6	3180	5.8	3945	6.9	3797	6.7

Funding Coverage	CY2013 Count	CY2013 Col %	CY2014 Count	CY2014 Col %	CY2015 Count	CY2015 Col %	CY2016 Count	CY 2016 Col %
CCDTF Client	23073	42.5	22198	40.7	22682	39.9	24437	43.3
MHCP - MCO Client	9287	17.1	11829	21.7	13887	24.4	13953	24.7
All Other Sources	21885	40.3	20481	37.6	20269	35.7	18016	31.9

Gender	CY2013 Count	CY2013 Col %	CY2014 Count	CY2014 Col %	CY2015 Count	CY2015 Col %	CY2016 Count	CY 2016 Col %
Male	35327	65.1	35527	65.2	36808	64.8	36324	64.4
Female	18918	34.9	18981	34.8	20029	35.2	20082	35.6

Race/Ethnicity	CY2013 Count	CY2013 Col %	CY2014 Count	CY2014 Col %	CY2015 Count	CY2015 Col %	CY2016 Count	CY 2016 Col %
White	38901	71.7	38780	71.1	40644	71.5	39342	69.7
Black	5602	10.3	5773	10.6	6015	10.6	6329	11.2
American Indian	4901	9.0	4987	9.1	5053	8.9	5231	9.3
Hispanic	2544	4.7	2477	4.5	2644	4.7	2848	5.0
Asian/Pacific Isander	662	1.2	704	1.3	762	1.3	785	1.4
Other	1635	3.0	1787	3.3	1719	3.0	1871	3.3

Age Groups	CY2013 Count	CY2013 Col %	CY2014 Count	CY2014 Col %	CY2015 Count	CY2015 Col %	CY2016 Count	CY 2016 Col %
Age 8 - 17	4015	7.4	3580	6.6	3379	5.9	3123	5.5
Age 18-24	12003	22.1	11291	20.7	11542	20.3	10434	18.5
Age 25-44	25994	47.9	27479	50.4	29400	51.7	30645	54.3
Age 45-64	11691	21.6	11592	21.3	11977	21.1	11657	20.7
Age 65 & Over	542	1.0	566	1.0	540	1.0	547	1.0

Primary Condition	CY2013 Count	CY2013 Col %	CY2014 Count	CY2014 Col %	CY2015 Count	CY2015 Col %	CY2016 Count	CY 2016 Col %
Avoid jail	3178	5.9	3474	6.4	3913	6.9	3925	7.0
Condition of probation-parole	15792	29.1	15839	29.1	16571	29.2	17665	31.3
Retain driver license-plates	893	1.6	758	1.4	660	1.2	595	1.1
Lose custody of children	990	1.8	946	1.7	991	1.7	1095	1.9
Regain custody of children	1409	2.6	1467	2.7	1685	3.0	2042	3.6
Avoid loss of relationship	4413	8.1	4099	7.5	4424	7.8	4248	7.5
Maintain employment-school	920	1.7	813	1.5	815	1.4	730	1.3
Retain professional license	94	0.2	103	0.2	96	0.2	97	0.2
Retain government benefits	49	0.1	39	0.1	43	0.1	25	0.0
Financial pressures	1974	3.6	1732	3.2	2037	3.6	2187	3.9
Other	15151	27.9	15149	27.8	15990	28.1	13608	24.1
None	9382	17.3	10089	18.5	9612	16.9	10189	18.1

Usual Residence	CY2013 Count	CY2013 Col %	CY2014 Count	CY2014 Col %	CY2015 Count	CY2015 Col %	CY2016 Count	CY 2016 Col %
Homeless	3,877	7.5	4,505	8.5	5,210	9.8	5,637	10.6
Dependent living	12,424	24.0	13,382	25.2	13,939	26.1	14,778	27.7
Independent living	30,785	59.5	30,458	57.5	30,066	56.4	29,199	54.7
Children with family	4,655	9.0	4,658	8.8	4,102	7.7	3,730	7.0

Prior Detox Admissions	CY2013 Count	CY2013 Col %	CY2014 Count	CY2014 Col %	CY2015 Count	CY2015 Col %	CY2016 Count	CY 2016 Col %
0	29,433	56.6	30,065	56.4	30,074	56.0	29,725	55.3
1	9,774	18.8	10,123	19.0	10,065	18.7	9,738	18.1
2	4,744	9.1	4,805	9.0	4,952	9.2	4,937	9.2
3 or more	8,020	15.4	8,294	15.6	8,592	16.0	9,363	17.4

Attend Voluntary Self Help Group	CY2013 Count	CY2013 Col %	CY2014 Count	CY2014 Col %	CY2015 Count	CY2015 Col %	CY2016 Count	CY 2016 Col %
No attendance	31072	59.3	30844	58.7	31597	57.9	32150	59.0
1-3 times past month	7517	14.4	7453	14.2	8173	15.0	7869	14.4
4-7 times past month	4748	9.1	5205	9.9	5674	10.4	5281	9.7
8-15 times past month	4058	7.7	4436	8.4	4758	8.7	4861	8.9
16-30 times past month	2382	4.5	2510	4.8	2698	4.9	2625	4.8
Some attendance	2591	4.9	2092	4.0	1683	3.1	1677	3.1

Acute Intoxication/Withdrawal Potential	CY2013 Count	CY2013 Col %	CY2014 Count	CY2014 Col %	CY2015 Count	CY2015 Col %	CY2016 Count	CY 2016 Col %
None	35721	67.2	36205	67.8	36623	65.4	37354	67.3
Minor	9623	18.1	9749	18.2	11444	20.4	11570	20.8
Moderate	4649	8.7	4542	8.5	4966	8.9	4895	8.8
Serious	2707	5.1	2536	4.7	2660	4.7	1541	2.8
Extreme	436	0.8	396	0.7	325	0.6	166	0.3

Biomedical Complications	CY2013 Count	CY2013 Col %	CY2014 Count	CY2014 Col %	CY2015 Count	CY2015 Col %	CY2016 Count	CY 2016 Col %
None	24151	45.4	24268	45.4	24456	43.7	24798	44.7
Minor	20580	38.7	21157	39.6	23360	41.7	24081	43.4

Biomedical Complications	CY2013 Count	CY2013 Col %	CY2014 Count	CY2014 Col %	CY2015 Count	CY2015 Col %	CY2016 Count	CY 2016 Col %
Moderate	5575	10.5	5141	9.6	5424	9.7	5049	9.1
Serious	2682	5.0	2674	5.0	2641	4.7	1501	2.7
Extreme	153	0.3	168	0.3	123	0.2	76	0.1

Emotional/Behavioral Complications	CY2013 Count	CY2013 Col %	CY2014 Count	CY2014 Col %	CY2015 Count	CY2015 Col %	CY2016 Count	CY 2016 Col %
None	3271	6.2	2998	5.6	2929	5.2	2598	4.7
Minor	11768	22.2	12254	23.0	12470	22.3	11327	20.4
Moderate	30864	58.1	31383	58.8	33965	60.7	36598	65.9
Serious	6970	13.1	6530	12.2	6412	11.5	4841	8.7
Extreme	224	0.4	211	0.4	205	0.4	132	0.2

Readiness for Change	CY2013 Count	CY2013 Col %	CY2014 Count	CY2014 Col %	CY2015 Count	CY2015 Col %	CY2016 Count	CY 2016 Col %
None	4852	9.1	4816	9.0	4501	8.0	4159	7.5
Minor	11782	22.2	12432	23.3	13770	24.6	13074	23.6
Moderate	19443	36.6	19359	36.3	21292	38.0	22194	40.0
Serious	14818	27.9	14673	27.5	14728	26.3	14256	25.7
Extreme	2204	4.2	2094	3.9	1668	3.0	1787	3.2

Relapse/Continued Use Potential	CY2013 Count	CY2013 Col %	CY2014 Count	CY2014 Col %	CY2015 Count	CY2015 Col %	CY2016 Count	CY 2016 Col %
None	385	0.7	299	0.6	245	0.4	187	0.3
Minor	1764	3.3	1994	3.7	2103	3.8	1308	2.4
Moderate	11351	21.4	11276	21.1	12017	21.5	11287	20.4
Serious	20932	39.4	20796	39.0	21641	38.7	20913	37.7
Extreme	18680	35.2	19009	35.6	19949	35.7	21765	39.2

Recovery Environment	CY2013 Count	CY2013 Col %	CY2014 Count	CY2014 Col %	CY2015 Count	CY2015 Col %	CY2016 Count	CY 2016 Col %
None	1259	2.4	1115	2.1	1172	2.1	1166	2.1
Minor	4417	8.3	4417	8.3	4649	8.3	3526	6.4
Moderate	12783	24.2	12617	23.7	12948	23.2	12032	21.8
Serious	18112	34.2	18171	34.1	19528	35.0	19757	35.7
Extreme	16349	30.9	16900	31.8	17481	31.3	18795	34.0

Recovery Environment	CY2013 Count	CY2013 Col %	CY2014 Count	CY2014 Col %	CY2015 Count	CY2015 Col %	CY2016 Count	CY 2016 Col %
Injection Drug Use	**CY2013 Count**	**CY2013 Col %**	**CY2014 Count**	**CY2014 Col %**	**CY2015 Count**	**CY2015 Col %**	**CY2016 Count**	**CY 2016 Col %**
Within the past 30 days	4342	8.4	4485	8.6	5139	9.5	5549	10.3
Within the past 6 months	3478	6.7	3969	7.6	4586	8.4	5162	9.6
Within the past 12 months	1138	2.2	1251	2.4	1332	2.5	1611	3.0
More than 12 months ago	3437	6.6	3446	6.6	3646	6.7	3576	6.6
Never injected	39593	76.2	38762	74.7	39609	72.9	37974	70.5

Primary Abuse Problem	CY2013 Count	CY2013 Col %	CY2014 Count	CY2014 Col %	CY2015 Count	CY2015 Col %	CY2016 Count	CY 2016 Col %
Alcohol	24290	45.2	23883	44.2	23481	41.6	21380	38.2
Cocaine	486	0.9	502	0.9	622	1.1	684	1.2
Crack	1208	2.2	1074	2.0	1038	1.8	978	1.7
Marijuana-Hashish	9102	16.9	8624	15.9	8663	15.3	8313	14.8
Heroin	5365	10.0	5724	10.6	6980	12.4	7430	13.3
Non-prescription Methadone	131	0.2	102	0.2	83	0.1	84	0.2
Other Opiates/Synthetics	4682	8.7	4134	7.6	4170	7.4	3526	6.3
PCP	29	0.1	50	0.1	39	0.1	52	0.1
Other Hallucinogens/Psychedelics	101	0.2	75	0.1	117	0.2	97	0.2
Methamphetamine	7290	13.6	8893	16.4	10148	18.0	12395	22.1
Other Amphetamines	293	0.5	273	0.5	290	0.5	218	0.4
Other Stimulants	54	0.1	48	0.1	72	0.1	77	0.1
Benzodiazepines	276	0.5	317	0.6	431	0.8	478	0.9
Other Tranquilizers	1	0.0	1	0.0	3	0.0	2	0.0
Barbiturates	13	0.0	12	0.0	3	0.0	11	0.0
Other Sedative/Hypnotic/Anxiolytic	53	0.1	39	0.1	54	0.1	46	0.1
Ketamine	5	0.0	7	0.0	8	0.0	3	0.0
Ecstasy/other club drugs	34	0.1	34	0.1	29	0.1	24	0.0
Inhalants	47	0.1	52	0.1	58	0.1	41	0.1
Over-The-Counter Medications	93	0.2	97	0.2	93	0.2	68	0.1
Other	209	0.4	130	0.2	89	0.2	77	0.1

Discharge Information	CY2013 Count	CY2014 Count	CY 2015 Count	CY2016 Count
Total Discharges	51,507	51,795	50,542	45,042

Discharge Reason	CY2013 Count	CY2013 Col %	CY2014 Count	CY2014 Col %	CY2015 Count	CY2015 Col %	CY2016 Count	CY 2016 Col %
Completed program	27775	53.9	27763	53.6	26642	52.7	23000	51.1
Patient left	11946	23.2	12620	24.4	12653	25.0	11555	25.7
Staff requested	4399	8.5	4314	8.3	4352	8.6	3868	8.6
Expiration of civil commitment	71	0.1	85	0.2	61	0.1	40	0.1
Transferred	3886	7.5	3489	6.7	3430	6.8	3359	7.5
Assessed as inappropriate	836	1.6	859	1.7	874	1.7	744	1.7
Lost financial support	295	0.6	222	0.4	227	0.4	294	0.7
Incarcerated	773	1.5	814	1.6	839	1.7	818	1.8
Death	95	0.2	75	0.1	99	0.2	54	0.1
Other	1431	2.8	1554	3.0	1365	2.7	1310	2.9