DEPARTMENT OF HUMAN SERVICES

Legislative Report

Drug and Alcohol Abuse in Minnesota: A Biennial Report to the Legislature

Behavioral Health Division

January 2020

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Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is approximately $2,000.

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Contents

I. Executive summary

The Department of Human Services (DHS) works to integrate substance use, mental health care and physical health care to promote successful prevention, intervention, treatment and recovery, while serving people close to their communities, families and other supports. The current report includes a summary of notable findings since the last report, an overview of current estimates and trends for alcohol, drug and tobacco use and need for treatment. Treatment admission data from 2015-2018 is presented for adult and adolescents, demographic information and type of treatment being utilized. An overview of Minnesota's substance use treatment system, substance use disorder reform update, snapshot of publically funded SUD services and recommendations moving forward round out the report.

This report is submitted to the Minnesota Legislature pursuant to Minnesota Statutes section 254A.03, subdivision 1(6). Below are the notable findings of this report.

Opioid Deaths have continued to increase and disparities remain.
There were 422 opioid deaths, an 11% increase from 2016 to 2017 in Minnesota. A small decline from the 12% increase in 2015-2016. Heroin use disorder admissions remained level with 12.3% in 2015 and 12.3% in 2018. Admissions for other opiates, such as prescription pain medication, have decreased significantly from 7.2% in 2015 to 4.5% in 2018. Disparities persists with Native Americans five times as likely and African Americans twice as likely to die from a drug overdose than their white counterparts.

Treatment admission for Methamphetamine use continues to rise.
From 2007 to 2018, over 80% of counties saw a marked increase in the related number of methamphetamine admissions.

Treatment admissions increased in Minnesota while demographics of those seeking treatment remain the same. Treatment admissions increased by 11.4% since 2015 with 60,398 admissions in 2018. The distribution of treatment admissions by gender remains relatively the same from 2015 to 2018 with 35.4% of admissions being women and 64.6% being men in 2018. Although Black (11.7%), American Indian (10.2%), and Hispanic (6.1%) Minnesotans represent small percentages of the entire population in the state, these individuals are over-represented in treatment admissions statistics.

The total number of admissions for alcohol, marijuana and other opiates has decreased while heroin admissions remain steady. Alcohol remains the primary reason for SUD treatment admissions. Total alcohol admissions has decreased from 40.9% of admissions in 2015 to 37% in 2018. Alcohol remains the primary reason for SUD treatment admissions with a nearly 10.2% difference between the second largest reason for admissions, methamphetamine use disorder. Admissions for marijuana use disorders have decreased from 15.6% of admissions in 2015 to 13.2% in 2018.

Risk of relapse for people leaving treatment remains high. For CY2018, over 80% of those leaving treatment have a significant chance of relapse, this is up from 78% in CY2017.

II. Legislation

The 2020 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.

…..The section shall: … (6) serve as the state authority concerning alcohol and other drug dependency and abuse by monitoring the conduct of diagnosis and referral services, research and comprehensive programs. The state authority shall submit a biennial report to the governor and the legislature containing a description of public services delivery and recommendations concerning increase of coordination and quality of services, and decrease of service duplication and cost.

III. The nature and 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 represents snapshots in time and collects the information necessary to make estimates of substance use disorder for subpopulations of Minnesota adults. The most current data available is from the 2015 report, however the leading information contained in the report is still valid. Nine out of 10 Minnesotan's who assess as needing treatment, do not receive it. The next MNSASU report process will begin in 2020.

An interactive map[1] uses more current data to calculate treatment need in the adult population by county.

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 decreases.
- 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.

[1] https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/alcohol-drug-other-addictions/adad-dashboard/

Substance Use Disorders-Drug Use Disorders

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

Need for Treatment and Receipt of Treatment

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

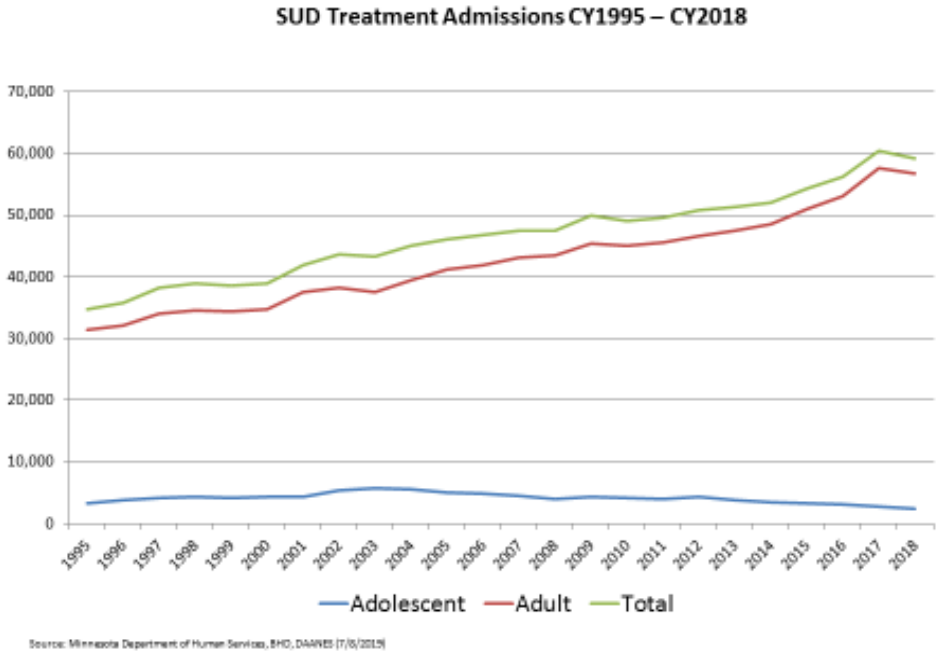
Trends

- 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[2] .

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

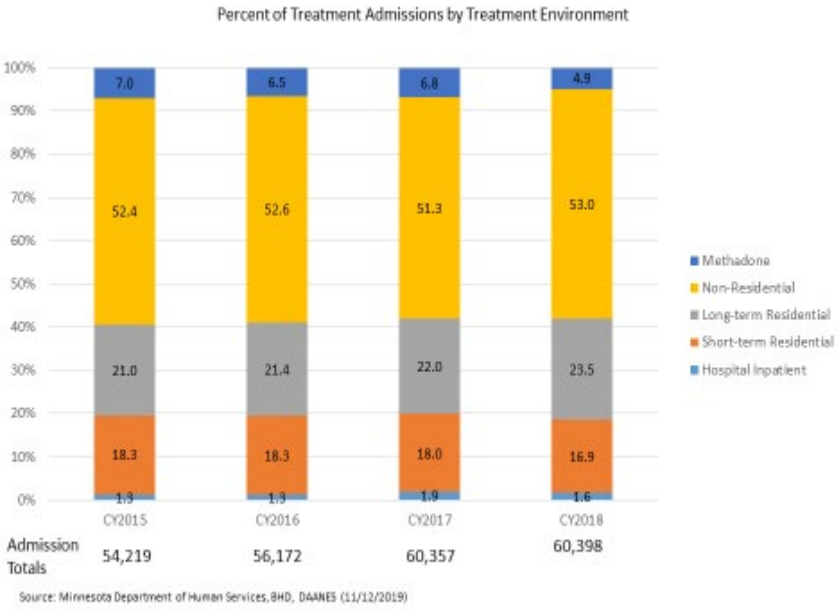
Treatment Admissions

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. While treatment admissions for adults have largely risen over time, adolescent admissions have remained largely the same.

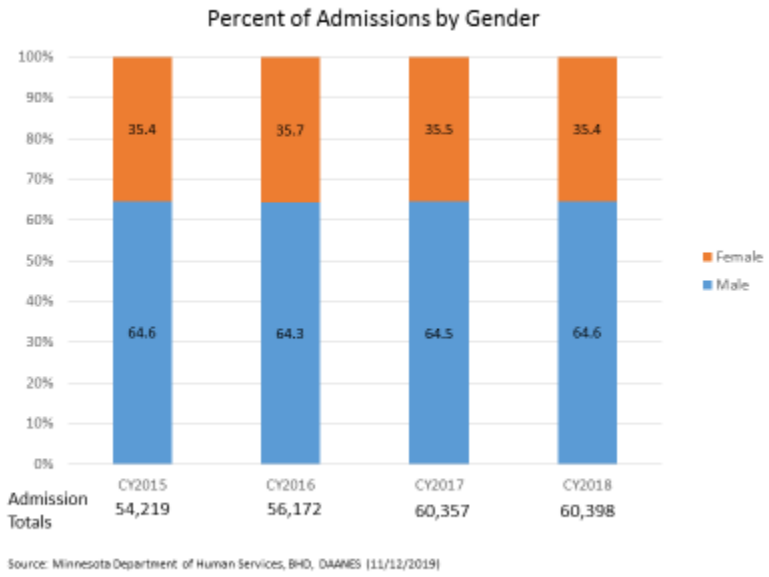


In 2018, 60,398 treatment admissions occurred across the state of Minnesota. This is an 11.4% increase since 2015, when the number of admissions was 54,219. Although treatment admission rates remained fairly steady, there were notable shifts when the nature of the treatment environment (e.g. hospital inpatient, medication-assisted treatment) are considered. In 2018, hospital inpatient admissions accounted for 1.6% of treatment admissions statewide, up from 1.3% in 2015. Since 2015, long-term residential increased from 21% to 23.5%, in 2018. Admissions to outpatient programs remained constant at around 52% from 2015 to 2018. Admissions to medication-assisted treatment programs decreased from 7.0% in 2015 to 4.9% in 2018. However, client retention in medication-assisted treatment programs has improved

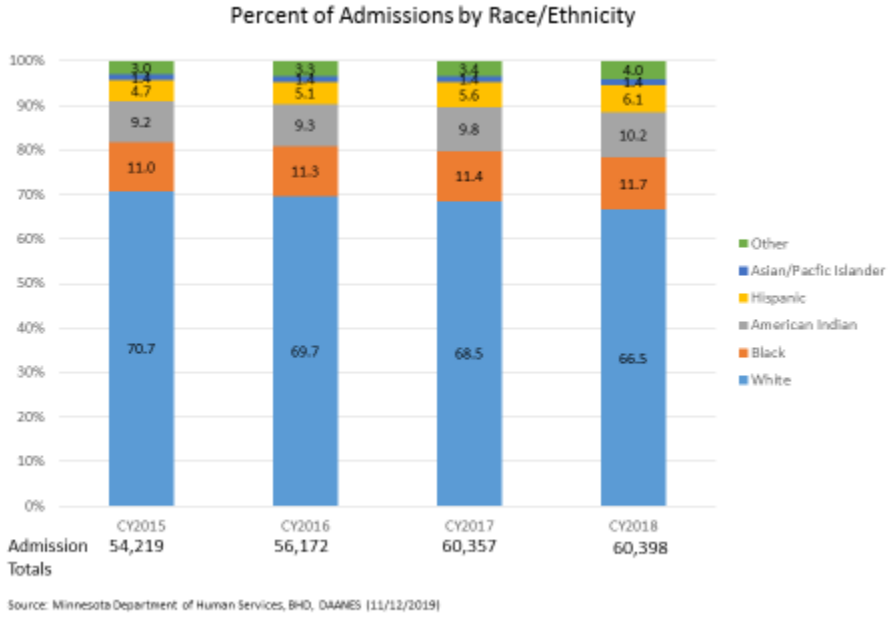
with over 6,700 clients receiving services on a daily basis in 2018 compared to 6,440 clients in 2015.



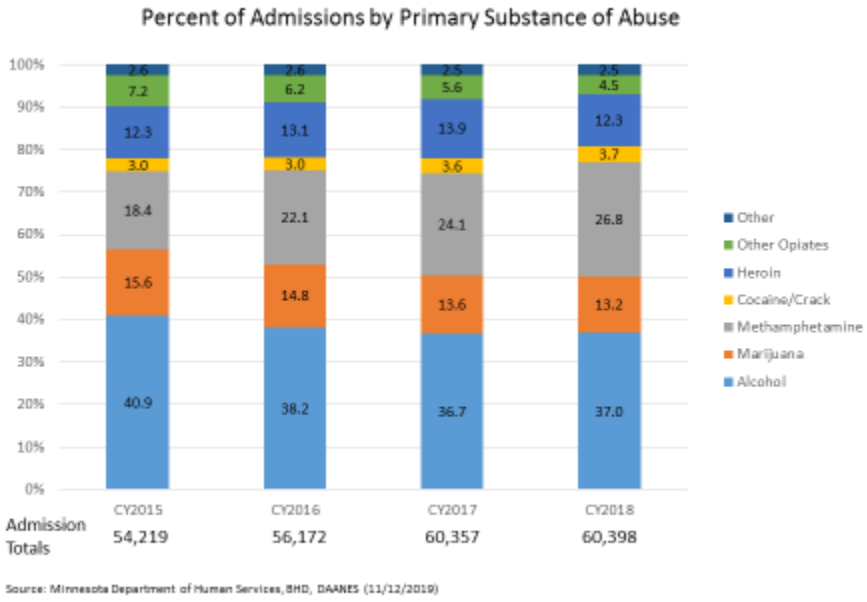
The distribution of admissions by gender remains largely the same in 2018 when compared to 2015. Between 2015 and 2018, admissions for women remained at 35% with admissions for men at 65%.

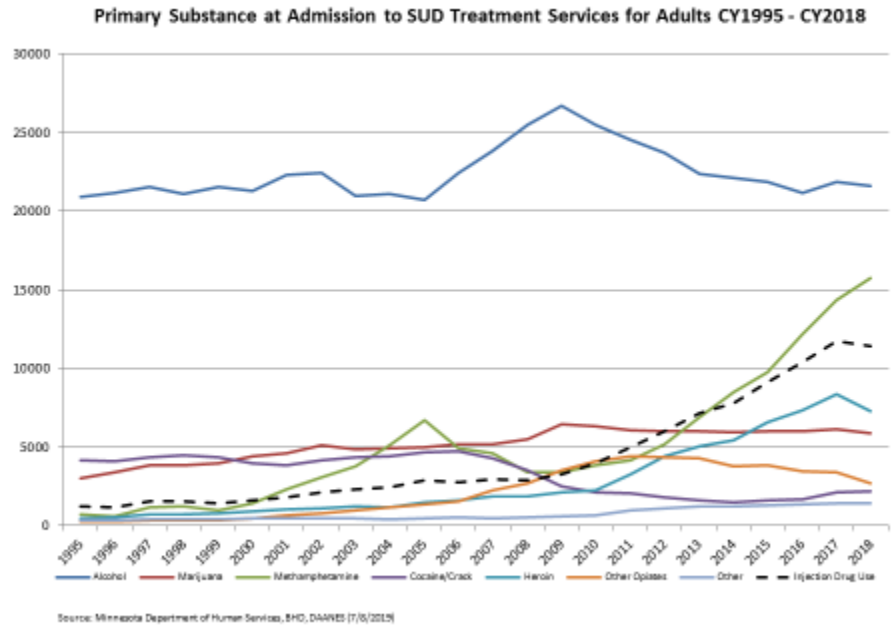


Admission for White Minnesotans decreased from 70.7% of admissions in 2015 to 66.5% in 2018. Admissions for individuals who identify as Black increased from 11% of admissions in 2015 to 11.7% in 2018. Admissions for American Indians increased from 9.2% of admissions in 2015 to 10.2% in 2018. Admissions for Hispanic individuals have increased from 4.7% of admissions to 6.1% between 2015 and 2018. Improved access for all communities is significant to the mission of the department, 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% of admissions in 2013. Admissions for marijuana use disorders have decreased from 16.8% in 2013 to 14.7% of admissions in 2016. Admissions for heroin use disorders have increased from 9.9% in 2013 to 13.2% of admissions in 2016. Admissions for other opiates, such as prescription pain medication have decreased from 8.9% in 2013 to 6.4% of admissions in 2016.

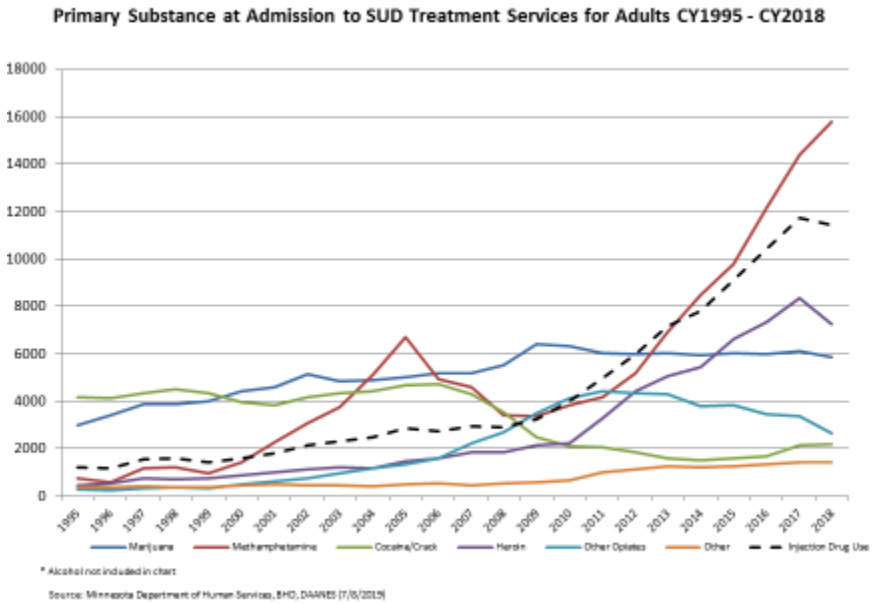


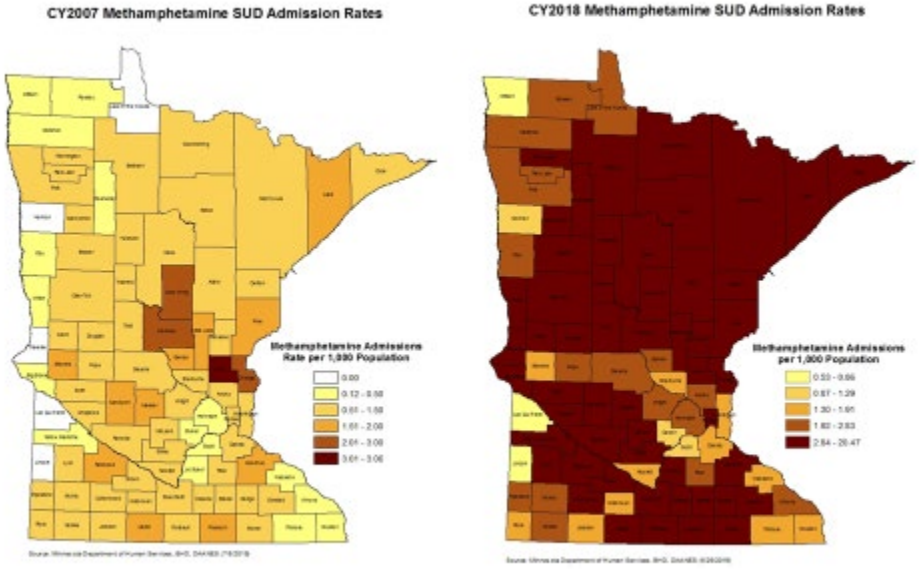


While alcohol has been the Primary Substance at Admission over time, from 1995 to 2018, Marijuana, Methamphetamine, Cocaine/Crack, Heroin and other Opiates, and other drugs have shifted in prevalence over that same time. This becomes even more apparent when the Alcohol statistics are removed and focus is on the other remaining drug categories. From 1995 to 2005, admissions due to Methamphetamine misuse rose markedly, then steadily declined until 2009. From 2010 to the present there was a resurgent marked increase in the related number of admissions. This may be due to the effective legislation to quell community manufacture of the drug, which was then offset and overcome by trafficking from outside the state. Side by side comparison of Methamphetamine SUD Admission Rates by County in 2007 and in 2018 show the total statewide effect.

There were 422 total opioid overdose deaths in 2017, of these, there were 195 that involved prescription opioids and 111 that involved heroin. In 2017, there were 11,770 treatment admissions for opioid use disorder. Opioid overdose deaths increased 11% from 2016 to 2017. 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 drug overdose as White Minnesotans. This represents the largest disparity-rate ratio of deaths due to drug overdose in the nation[3].

[3] https://www.health.state.mn.us/communities/opioids/opioid-dashboard/index.html





The maps above show the statewide impact of the rise in treatment admissions due to Methamphetamine misuse from 2007 to 2018.

Drug and Alcohol Abuse Normative Evaluation System (DAANES) Tables for Biennial Report CY2015-CY2018

Source: Minnesota Department of Human Services, DAANES (11/8/2019)

Calendar Year	CY2015	CY2016	CY2017	CY2018
Total Admissions	54,219	56,172	60,357	60,398

CD Treatment Environment	CY2015	CY2015	CY2016	CY2016	CY2017	CY2017	CY2018	CY2018
	Count	Col %	Count	Col %	Count	Col %	Count	Col %
Hospital Inpatient	680	1.3	711	1.3	1,158	1.9	992	1.6
Short-term Residential	9,918	18.3	10,307	18.3	10,888	18.0	10,214	16.9
Long-term Residential	11,400	21.0	11,996	21.4	13,253	22.0	14,195	23.5
Non-Residential	28,430	52.4	29,531	52.6	30,979	51.3	32,014	53.0
Methadone	3,791	7.0	3,627	6.5	4,079	6.8	2,983	4.9

Funding Coverage	CY2015	CY2015	CY2016	CY2016	CY2017	CY2017	CY2018	CY2018
	Count	Col %	Count	Col %	Count	Col %	Count	Col %
CCDTF Client	22,633	41.7	24,573	43.7	24,400	40.4	22,018	36.5
MHCP - MCO Client	13,607	25.1	13,771	24.5	16,347	27.1	20,275	33.6
All Other Sources	17,979	33.2	17,828	31.7	19,610	32.5	18,105	30.0

Gender	CY2015	CY2015	CY2016	CY2016	CY2017	CY2017	CY2018	CY2018
	Count	Col %	Count	Col %	Count	Col %	Count	Col %
Male	35,038	64.6	36,146	64.3	38,922	64.5	39,040	64.6
Female	19,181	35.4	20,026	35.7	21,435	35.5	21,358	35.4

Race/Ethnicity	CY2015	CY2015	CY2016	CY2016	CY2017	CY2017	CY2018	CY2018
	Count	Col %	Count	Col %	Count	Col %	Count	Col %
White	38,312	70.7	39,143	69.7	41,327	68.5	40,169	66.5
Black	5,959	11.0	6,321	11.3	6,855	11.4	7,056	11.7
American Indian	4,992	9.2	5,214	9.3	5,914	9.8	6,183	10.2
Hispanic	2,566	4.7	2,862	5.1	3,402	5.6	3,711	6.1
Asian/Pacfic Islander	739	1.4	782	1.4	823	1.4	858	1.4
Other	1,651	3.0	1,850	3.3	2,036	3.4	2,421	4.0

Age Groups	CY2015	CY2015	CY2016	CY2016	CY2017	CY2017	CY2018	CY2018
	Count	Col %	Count	Col %	Count	Col %	Count	Col %
Age 8 – 17	3,292	6.1	3,121	5.6	2,709	4.5	2,487	4.1
Age 18-24	10,760	19.8	10,334	18.4	10,664	17.7	9,628	15.9
Age 25-44	28,324	52.2	30,532	54.4	33,723	55.9	34,986	57.9
Age 45-64	11,358	20.9	11,669	20.8	12,682	21.0	12,707	21.0
Age 65 & Over	485	0.9	516	0.9	579	1.0	590	1.0

Primary Condition	CY2015	CY2015	CY2016	CY2016	CY2017	CY2017	CY2018	CY2018
	Count	Col %	Count	Col %	Count	Col %	Count	Col %
Avoid jail	3,802	7.0	3,891	6.9	4,289	7.1	4,544	7.5
Condition of probation-parole	16,411	30.3	17,755	31.6	18,476	30.6	19,024	31.5
Retain driver license-plates	639	1.2	583	1.0	489	0.8	508	0.8
Lose custody of children	974	1.8	1,099	2.0	1,110	1.8	1,173	1.9
Regain custody of children	1,673	3.1	2,047	3.6	2,216	3.7	2,195	3.6
Avoid loss of relationship	4,095	7.6	4,226	7.5	4,134	6.8	3,833	6.3
Maintain employment-school	770	1.4	691	1.2	628	1.0	656	1.1
Retain professional license	84	0.2	90	0.2	74	0.1	70	0.1
Retain government benefits	43	0.1	25	0.0	24	0.0	21	0.0
Financial pressures	1,970	3.6	2,107	3.8	2,230	3.7	2,099	3.5
Other	14,465	26.7	13,575	24.2	15,819	26.2	15,508	25.7
None	9,293	17.1	10,083	17.9	10,868	18.0	10,767	17.8

Usual Residence	CY2015	CY2015	CY2016	CY2016	CY2017	CY2017	CY2018	CY2018
	Count	Col %	Count	Col %	Count	Col %	Count	Col %
Homeless	5,900	11.1	6,506	11.8	7,295	12.3	8,052	13.6
Dependent living	15,123	28.3	16,347	29.6	17,985	30.3	18,111	30.5
Independent living	28,927	54.2	29,319	53.0	31,045	52.3	30,699	51.7
Children with family	3,418	6.4	3,128	5.7	3,059	5.2	2,492	4.2

Detox Admissions	CY2015	CY2015	CY2016	CY2016	CY2017	CY2017	CY2018	CY2018
	Count	Col %	Count	Col %	Count	Col %	Count	Col %
0	29,551	55.3	30,683	55.3	32,995	55.2	32,768	54.8
1	9,749	18.2	10,115	18.2	11,000	18.4	10,877	18.2
2	4,973	9.3	4,966	8.9	5,396	9.0	5,220	8.7
3 or more	9,181	17.2	9,738	17.5	10,352	17.4	10,887	18.2

Co-occuring substance use and mental health	CY2015	CY2015	CY2016	CY2016	CY2017	CY2017	CY2018	CY2018
	Count	Col %	Count	Col %	Count	Col %	Count	Col %
None	2,855	5.3	2,591	4.7	2,408	4.1	2,116	3.6
Minor	12,086	22.6	11,304	20.5	11,216	19.1	10,487	17.9
Moderate	33,194	62.1	36,694	66.6	41,114	69.8	42,477	72.5
Serious	5,176	9.7	4,405	8.0	4,029	6.8	3,434	5.9
Extreme	156	0.3	128	0.2	100	0.2	105	0.2

Risk of Relapse	CY2015	CY2015	CY2016	CY2016	CY2017	CY2017	CY2018	CY2018
	Count	Col %	Count	Col %	Count	Col %	Count	Col %
None	234	0.4	176	0.3	98	0.2	95	0.2
Minor	1,922	3.6	1,237	2.2	832	1.4	812	1.4
Moderate	11,666	21.8	11,331	20.6	11,821	20.1	10,751	18.3
Serious	20,048	37.5	20,575	37.4	22,252	37.8	23,110	39.4
Extreme	19,571	36.6	21,759	39.5	23,886	40.6	23,855	40.7

Recovery Environment	CY2015	CY2015	CY2016	CY2016	CY2017	CY2017	CY2018	CY2018
	Count	Col %	Count	Col %	Count	Col %	Count	Col %
None	1,140	2.1	1,149	2.1	939	1.6	805	1.4
Minor	4,378	8.2	3,434	6.3	3,010	5.1	2,697	4.6
Moderate	12,578	23.6	12,149	22.1	13,114	22.3	12,745	21.8
Serious	18,002	33.8	19,311	35.2	19,927	33.9	20,546	35.1
Extreme	17,174	32.2	18,859	34.4	21,724	37.0	21,761	37.2

Injection Drug Use	CY2015	CY2015	CY2016	CY2016	CY2017	CY2017	CY2018	CY2018
	Count	Col %	Count	Col %	Count	Col %	Count	Col %
Within the past 30 days	4,842	9.3	5,453	10.3	6,020	11.0	5,723	10.4
Within the past 6 months	4,397	8.5	5,096	9.7	5,817	10.6	5,893	10.7
Within the past 12 months	1,291	2.5	1,585	3.0	1,765	3.2	1,738	3.2
More than 12 months ago	3,527	6.8	3,530	6.7	3,761	6.9	3,739	6.8
Never injected	37,811	72.9	37,072	70.3	37,327	68.3	37,868	68.9

Primary Abuse Problem	CY2015	CY2015	CY2016	CY2016	CY2017	CY2017	CY2018	CY2018
	Count	Col %	Count	Col %	Count	Col %	Count	Col %
Alcohol	22,191	41.1	21,431	38.4	22,121	36.8	22,343	37.3
Cocaine	584	1.1	718	1.3	1,026	1.7	1,076	1.8
Crack	1,021	1.9	973	1.7	1,135	1.9	1,173	2.0
Marijuana-Hashish	8,439	15.6	8,321	14.9	8,222	13.7	7,963	13.3
Heroin	6,663	12.4	7,374	13.2	8,391	14.0	7,399	12.3
Non-prescription Methadone	78	0.1	85	0.2	78	0.1	51	0.1
Other Opiates/Synthetics	3,829	7.1	3,399	6.1	3,325	5.5	2,682	4.5
PCP	37	0.1	54	0.1	55	0.1	61	0.1
Other Hallucinogens/Psychedelics	111	0.2	95	0.2	104	0.2	111	0.2
Methamphetamine	9,972	18.5	12,386	22.2	14,532	24.2	16,164	27.0
Other Amphetamines	257	0.5	220	0.4	176	0.3	149	0.2
Other Stimulants	64	0.1	78	0.1	63	0.1	68	0.1
Benzodiazepines	377	0.7	470	0.8	544	0.9	430	0.7
Other Tranquilizers	1	0.0	2	0.0	3	0.0	6	0.0
Barbiturates	3	0.0	12	0.0	8	0.0	8	0.0
Other Sedative/Hypnotic/Anxiolytic	46	0.1	41	0.1	57	0.1	41	0.1
Ketamine	5	0.0	2	0.0	1	0.0	5	0.0
Ecstasy/other club drugs	28	0.1	23	0.0	22	0.0	26	0.0
Inhalants	54	0.1	40	0.1	48	0.1	38	0.1
Over-The-Counter Medications	91	0.2	67	0.1	61	0.1	64	0.1
Other	79	0.1	83	0.1	92	0.2	73	0.1

Discharge Information	CY2015	CY2016	CY2017	CY2018
Total Discharges	49,663	51,606	53,909	50,943

Discharge Reason	CY2015	CY2015	CY2016	CY2016	CY2017	CY2017	CY2018	CY2018
	Count	Col %	Count	Col %	Count	Col %	Count	Col %
Completed program	25,509	51.4	26,182	50.7	27,495	51.0	26,103	51.2
Patient left	12,695	25.6	13,410	26.0	13,923	25.8	13,459	26.4
Staff requested	4,389	8.8	4,430	8.6	4,500	8.3	3,719	7.3
Expiration of civil commitment	61	0.1	44	0.1	47	0.1	34	0.1
Transferred	3,519	7.1	3,780	7.3	4,068	7.5	3,753	7.4
Assessed as inappropriate	885	1.8	870	1.7	1,002	1.9	896	1.8
Lost financial support	226	0.5	313	0.6	279	0.5	234	0.5
Incarcerated	867	1.7	917	1.8	898	1.7	877	1.7
Death	111	0.2	81	0.2	82	0.2	72	0.1
Other	1,401	2.8	1,579	3.1	1,615	3.0	1,796	3.5

IV. Minnesota's Substance Use Disorder Treatment System

Minnesota's Current Substance Use Disorder Treatment System

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 ongoing 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 of services available for substance use disorder; while improving integration and coordination with the rest of health care.

Prevention

Each year, the department receives funding from the federal government in the form of a block grant from SAMHSA. The department 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 department collaborates with other stakeholders and state agencies (Health, Public Safety and Education) in data-driven planning around the delivery of prevention services throughout Minnesota.

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, the department 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/.

Minnesota State Epidemiological Outcomes Workgroup

The Minnesota State Epidemiological Outcomes Workgroup (SEOW) is 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. Data dissemination 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.

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.

Problem Gambling Program

Pursuant to Minnesota Statutes, section 245.98, the department 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. 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 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

The department utilizes state funds to support a synthetic drugs awareness campaign, "Know the Dangers," which has media presence through social media and a website. The campaign is designed to

educate the general public about the dangers of synthetic drugs to youth, adults, professionals and parents.

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. In 2019, 71 agencies participated completing 1,680 educational compliance checks, which were the highest totals in the six years of this project.

The Family Smoking Prevention and Tobacco Control Act grants the U.S. Food and Drug Administration (FDA) the authority to regulate the sale and advertising of tobacco products. The department contracts 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. The state's ninth year of this project began September 30, 2019. As of October 31, 2019 Minnesota BHD Tobacco Inspectors have conducted 38,236 inspections resulting in 2,043 warning letters, 411 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. 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. The department 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 416 programs in Minnesota that are licensed to provide SUD treatment services; 14 of which are Children's Residential Facilities (CRF) and three of which are Withdrawal Management licensed facilities.

Chemical dependency treatment facilities 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.

Culturally specific activities

The department supports culturally specific prevention efforts in Minnesota by assisting and/or providing resources to train and educate substance abuse professionals with the tribes and urban American Indian communities. The prevention efforts contain elements specific to and reflective of the tribal makeup and historical experiences of American Indians who live in Minnesota. The department and the American Indian Advisory Council have worked together to increase the availability of culturally-specific training and effective substance abuse treatment services for American Indians in Minnesota.

The 2019 legislature appropriated $4 million to tribal communities to improve access, coordination and referral processes for traditional healing in Native communities across Minnesota. Traditional healing is a multi-generational, multi-disciplinary approach to reduce the chronic mental health and substance use disparities experienced by American Indians. Traditional healing is a holistic approach that looks at all aspects of living: emotional, physical, and spiritual to promote health/healing for American Indians. Conventional behavioral health interventions have not yielded the same outcomes within the American Indian population as they have for other populations. However, traditional healing for American Indians has outcomes that are equivalent to the outcomes for conventional interventions in other populations.

The Cultural and Ethnic Minority Infrastructure grants exist to create a continuum of care for those impacted by mental health and/or substance use/misuse. A central priority is to ensure that these communities have equitable access to health care that addresses mental health and substance use/misuse disparities for cultural and ethnic minority communities.

These grants focus on funding the provision of mental health and/or substance use/misuse supports and services in the following ways:

- Workforce Development – Capacity Building for Licensure/Certification: Recruiting, Supporting, Training and Supervision Activities for Mental Health and Substance Use/Misuse Practitioners and Professionals
- Culturally Specific Supports and Services: Trauma-Informed Clinical and Ancillary Services (for individuals that are uninsured or underinsured), Early Intervention, Recovery Support and Outreach

The populations of focus include members from the following communities: African, African American, American Indian Hispanic, Latino, Asian, Immigrants, Refugees, or Lesbian Gay Bi-sexual Transgender Queer (LGBTQ) affected by substance use/misuse and/or mental health issues.

Response to the Opioid Epidemic

The State of Minnesota is a both a leader and a partner in addressing the opioid epidemic. On July 1st 2019 a law establishing the Opiate Epidemic Response went into effect that established the Opioid Epidemic Response Advisory Council (OERAC) to develop and implement a comprehensive and effective statewide effort to address the opioid addiction and overdose epidemic in Minnesota. The council's inaugural meeting was held on September 27th 2019 and they are currently meeting monthly. OERAC will need to make opioid funding recommendations to the legislature no later than by March 1st 2020.

The Department of Human Services has been able to be the lead agency on the following initiatives:

- **State Targeted Response to the Opioid Crisis**: These grants provide increases in prevention, emergency response, and treatment and recovery programs. This has allowed the state to invest in increasing access to naloxone, improvements to the withdrawal management services, recently released from incarceration, early adoption of enacting new substance use disorder reforms, increasing primary prevention efforts, creation of a opioid focused media campaign and the creation of a hub and spoke model for medication assisted treatment prescribers. Grants have been extended until April 2020 to continue these efforts.
- **Medication-Assisted Treatment expansion grants**: Allows health care providers to purchase direct injectable drugs to treat opioid addiction. These grants have expanded treatment for the African American community and the American Indian community over three years, working in partnership with tribal governments and healthcare providers.
- **State Opioid Response grant:** These federal grants are used to reach those struggling with opioids with life-saving treatment quickly, reduce deaths from opioid overdose and to prevent opioid use disorder in Minnesota's most vulnerable communities. The grants fund Naloxone training and distribution, expanding the availability of medically assisted therapy, efforts to increase the treatment workforce, and Innovative response to Minnesota's opioid epidemic. Supplemental funding for an additional two years were added in 2019. The majority of the contracts were put out for request for proposal and the remainder were awarded in sole source contracts. The request for proposal contracts are currently being negotiated.
- **Opioid Prescribing Workgroup:** The Department of Human Services convenes an advisory group of experts through the Opioid Prescribing Improvement Program that have recommended a statewide opioid prescribing protocol, measures for providers, and quality improvement processes for acute, post-acute, and chronic pain. The workgroup consists of medical professionals, consumers, health care and mental health professionals, law enforcement, and representatives of managed care organizations.

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.

Update

The goal of Substance Use Disorder Reform is to decrease barriers for people seeking substance use disorder (SUD) treatment services. The Department of Human Services is working to make sure that people get timely access to SUD treatment services and that people have a choice in a continuum of substance use disorder services. Over the past several years, DHS has worked to initiate new ways of accessing treatment services including building the groundwork for direct access, so that people can get the level of care they need at the time they need it. Direct access will allow for the person to go directly to the treatment of their choice and initiate services when they are motivated to make changes in their substance use.

In addition, specific treatment services that support a continuum of care approach are now reimbursable. Treatment coordination and peer recovery support services work to help a person navigate different options for treatment and recovery. Treatment coordination helps the person navigate between SUD treatment services and set up referrals to needed resources that have been impacted by their use, such as housing and medical needs. Peer recovery support services help navigate opportunities and remove barriers related to recovery from an individual with lived experience. Both services play an important role in supporting the continuum of care approach for people seeking SUD services and meeting the person where they are in their journey to recovery.

Recent changes in SUD treatment

SUD reform has been a multi-year process involving extensive input from counties, tribes, providers and interested community members on how to improve public-pay treatment.
As a result, in the past two years, Minnesota has made several improvements to SUD services including expanding services and offering more choice across the state:

- **Treatment coordination** is now a reimbursable service. “Treatment coordination” is a service used to assist a person in getting access to SUD treatment, coordinate services related to their substance use disorder, and make referrals that support the recovery of the individual.
- **Peer Recovery Support** is reimbursable by a Recovery Community Organization or a non-residential substance use disorder treatment facility. Peers support the individual by providing education, advocacy, mentoring through self-disclosure of personal recovery experiences, attending recovery and other support groups with the person, and much more.
- **Non-substance use disorder treatment program options** have been expanded. Licensed alcohol and drug counselors and other licensed professionals who are qualified can enroll with Minnesota Health Care Programs to be a licensed professional in private practice and can

provide substance use disorder comprehensive assessment, individual, and group treatment services independently without a substance use disorder treatment program license.
- **Substance use disorder treatment programs can now offer more options outside of their facility.** Licensed programs are able to provide some services offsite to better meet the needs of the clients.

The current process for accessing treatment is for a person to get a Rule 25 assessment from a placing authority (county, tribe or managed care organization), who then authorizes treatment. This process takes time and can be detrimental when services are not provided when someone is motivated to access them. By allowing direct access to treatment, more people will get the services they need, faster.

Moving to Direct Access

Moving forward, the State is working to ensure that people seeking SUD treatment using public-pay benefits, will be able to access treatment services immediately after the completion of a comprehensive assessment.

- No prior approval or authorization is required when the individual meets the criteria for the level of care they are seeking.
- A comprehensive assessment will be completed by a qualified licensed professional. The person doing the assessment will determine the right level of care and the client can choose to participate at that level of care or any services with a less intensive level of care.
- The licensed program or individual providing services will be able to review and update the already completed assessment.

However, due to the complex systems that need to be in place for direct access to run smoothly, the implementation of direct access is taking longer than anticipated. This effort requires significant engagement with counties, tribes and and providers. DHS is working to move forward as quickly as possible and will work closely with the legislature on any needed changes.

Care Coordination and Peer Recovery Support

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. The goal 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.

Withdrawal Management

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. 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.

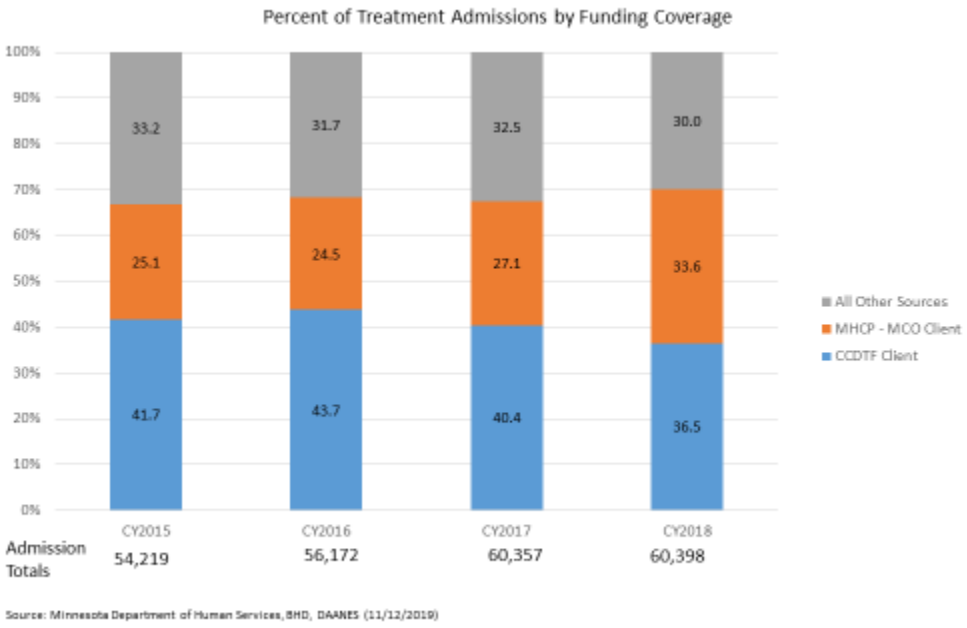
1115 Demonstration Project

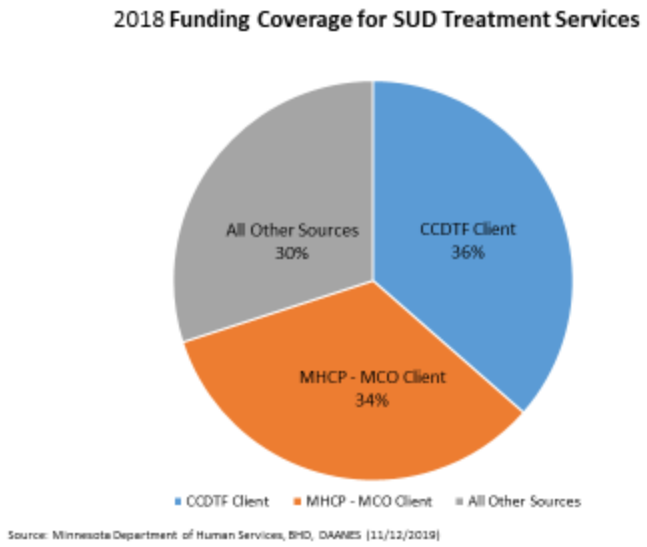
Many of Minnesota's residential provider locations have more than 16 beds, and as such, are not allowed to bill Federal Medicaid for treatment services. State and county governments share these treatment costs. Centers for Medicare and Medicaid Services (CMS) approved Minnesota's 1115 waiver application in June 2019. The state submitted the implementation plan in October 2019. Residential providers who participate in this waiver will be able to bill Medicaid for a portion of services, saving both state and county dollars.

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 to provide immediate access to treatment for those meeting standardized assessment criteria, and to consolidate a variety of funding streams into a single initial payer.

The percentage of treatment paid through the CCDTF declined from 41.4% in 2015 to 36.5% in 2018. Treatment admissions covered by state contracted managed care organizations (MCO) increased from 25.1% in 2015 to 33.6% % in 2018.





The total percentage of publicly paid admissions in 2018 was 70%. Treatment admissions covered by All Other Sources (non-public) was 30.0%.

Source: Minnesota Department of Human Services, BHD, DAANES (11/12/2019)

VI. Report recommendations

1. **Address social determinants of health risk factors to prevent substance use/misuse and promote recovery in the community.**
    - Develop and implement outreach plans to support providers, partners and communities in promoting health, well-being and stability.
    - Engage and empower staff to address social determinants of health, well-being and stability.
    - Develop and pursue opportunities for collaboration with other DHS groups and partners to address social determinants of health, well-being and stability.
    - Seek and provide funding opportunities to address social determinants of health, well-being and stability.

2. **Support people in their individual, family and community environments to make informed choices in order to lead the lives they want.**
    - Use a broad range of information and resource sharing avenues to improve outreach to support people, families and communities.
    - Provide hands-on support to enable people, families and communities to access information, resources and services as needed.

3. **Engage SUD providers, partners and stakeholders and enhance their capacity to support people, families and communities.**
    - Provide training and technical assistance for providers, partners and stakeholders that support multiple approaches which best meet the needs of people, families and communities.
    - Use engagement activities to inform capacity-building efforts.
    - Work with partners to identify and address workforce issues as appropriate.