EVALUATION REPORT

ON

STATE SPONSORED

CHEMICAL DEPENDENCY PROGRAMS

PROGRAM EVALUATION DIVISION

OFFICE OF THE LEGISLATIVE AUDITOR

February 15, 1979

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STATE OF MINNESOTA

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PREFACE

In June 1978, the Legislative Audit Commission (LAC) directed the Program Evaluation Division to review state sponsored chemical dependency (CD) programs and evaluate the performance of the Department of Public Welfare (DPW) in chemical dependency program planning, research, evaluation, and contract monitoring. This report presents our findings.

In several respects the findings of this report are critical of DPW's performance. However, we wish to note that the Department's top management was supportive of the evaluation effort and the Chemical Dependency Program Division staff cooperated fully.

In the course of this study, we met many dedicated service providers and administrators who are striving to provide effective programs. We hope that our findings will achieve for them and their clients a stronger state chemical dependency system.

The evaluation was conducted by Elliot Long (Project Manager), Tom Sims, Jo Vos, and Jerry Cathcart.

James Nobles, Deputy Legislative Auditor
for Program Evaluation

CHEMICAL DEPENDENCY PROGRAM EVALUATION

SUMMARY OF FINDINGS

As directed by the Legislative Audit Commission, the Program Evaluation Division carried out a study focussing on three major objectives. These are:

- to review the existing evidence on chemical dependency program effectiveness;
- to review the performance of DPW, particularly its Chemical Dependency Program Division, in CD planning research, and evaluation; and
- to review DPW's performance of its contract monitoring responsibilities.

A few points about the current chemical dependency service system in Minnesota suggest why this review is timely.

- In 1978, approximately $67 million was spent in Minnesota for chemical dependency programs. This includes about $15 million by the federal government, $23 million by state government, $7 million by local government, and $22 million in patient fees and third party payments.
- Minnesota appropriates more state money, per capita, on chemical dependency programs than most states.
- Minnesota has more residential treatment beds per capita than any other state, and more than four times the national average.
- In the early and mid-1970's legislation was passed decriminalizing public intoxification, extending health insurance coverage to include CD treatment, and providing new support for prevention, education, and early intervention programs. These initiatives resulted in growth in the CD service system and created a variety of new administrative challenges.

GOVERNOR'S BILL PROGRAMS

Employee Assistance Programs

- A comparison of data on expenditures and services delivered leads us to conclude that Governor's Bill employee assistance programs have been excessively costly to operate.

Discussion. During fiscal 1977 and 1978, about $1.7 million was spent by area mental health boards to set up and operate employee assistance programs (EAPs). These programs are designed to identify employees with job performance problems, and to refer them for appropriate treatment. Typically, a referral requires a one or one and a half hour interview between a troubled employee and a trained D&R worker.

In 1977, a total of 265 employees were interviewed and referred for treatment, 100 of these for a chemical dependency problem. In 1978, 1,503 people were referred, 550 for a CD problem. Our best estimates of the cost per referral for employee assistance programs are $860 for 1977 and $345 for 1978.

We believe that it should cost less, if not much less, to deliver diagnostic and referral (D&R) services. As a basis for comparison, the employee assistance program for state employees administered by the Chemical Dependency Program Division (CDPD) has contracted with service providers willing to deliver diagnostic and referral (D&R) services at $35 per referral. Indeed, several days of residential care in a detox center or state hospital CD unit can be provided for less than what it costs on the average

to make one referral through Governor's Bill employee assistance programs.

Programs Aimed at Youth and Other Underserved Populations

- We conclude that group sessions and diagnostic and referral services aimed at youth and other underserved groups (Y&O) have been excessively costly.
- Although diagnosis and referral was conceived as a major component of Y&O programs, almost no D&R services were delivered to youth and other underserved groups outside of the Twin Cities area.

Discussion. The Governor's Bill provides funds to area boards for the purchase of diagnosis and referral, education, outreach and, in certain circumstances, treatment services for youth and other underserved populations (Y&O). DPW Rule 24 implementing the Governor's Bill defines the targeted groups as youth, women, the elderly, Blacks, Chicanos, and gays/lesbians.

Expenditures for these programs totaled about $1.2 million in fiscal 1977 and $1.6 million in 1978. In 1978, 6,289 referrals were made and 6,513 group sessions were conducted in which 22,014 people participated.

There is no record of how this money is divided between diagnosis and referral and other services, or among the target groups listed above; thus it is difficult to compute costs per referral, per educational session, etc. However, we have compared information on total services delivered and total costs. As a result we conclude that either D&R services, or group sessions, or, more likely, both have been excessively expensive.

If cost per referral is arbitrarily assumed to be $100, in 1978 cost per group session was $136, and cost per participant was about $47.

There is a distinct difference between how Y&O programs worked in the Twin Cities area and in the balance of the state. Although support of diagnosis and referral was conceived as the primary purpose of Y&O programs, almost no D&R services were delivered to youth and other underserved groups outside the Twin Cities area. Instead group education, outreach, and counseling activities were the primary focus outstate, and fewer of these services were delivered per dollar outstate than in the Twin Cities area.

American Indian Chemical Dependency Programs

- American Indian CD programs are administered separately from other CD programs within CDPD. This reflects legal recognition of the special status of American Indians, but the extent of separate control seems to go beyond statutory requirements, and creates management problems in the Division.
- The focus of non-residential Indian CD programs supported by the Governor's Bill and federal formula funds is broad, and program activities are diverse and often related only indirectly to CD prevention or treatment.

Discussion. DPW management needs to clarify the authority structure within CDPD. In our opinion, nothing in Chapter 254A supports the present degree of autonomy of the special assistant for Native American programs. Also, Indian programs supported by federal funds receive no real scrutiny by the Citizens Advisory Council (CAC) which is responsible for

approving applications for these funds. We believe that the Citizens Advisory Council, CDPD, and DPW should be responsible for the administration of Indian programs to the same degree as they are for other programs.

Chemical dependency funds have been used to sponsor trips, spiritual ceremonies, sports events, and other activities not closely related to CD treatment. DPW asserts that it is appropriate to use state funds for these purposes, based on its interpretation of M.S. 254A.031. We believe the intent of the statute needs clarification.

PROGRAMS SUPPORTED BY STATE GRANTS-IN-AID

- Detoxification is a major source of concern around the state among area board staff responsible for securing detox services.
- Basic descriptive information on detox, halfway house, and counseling and coordinating activites is inadequate in light of the approximate $7.5 million DPW annually sends to area boards via grants-in-aid.
- The Chemical Dependency Program Division has recognized the need to compile data on detox and halfway house service activity, but its efforts to collect and periodically report data on service activity are not yet successful. Useful data would permit computation of expenditures, admissions/discharges, and average cost per day, for the state as a whole and area board service regions separately.
- Available data on detox costs and service activity show the statewide average cost to be approximately $61 per day, with a three day stay typical. However, detox costs vary considerably around the state indicating that areas are either providing rather different styles of care or comparable care at different costs.
- DPW is not enforcing the provisions of Rule 32 governing detox centers. The length of time it has taken to develop an operational detox rule is symptomatic of DPW's failure to set chemical dependency policy in this area.

- The rise of halfway houses has been rapid during the 1970s, partly as a consequence of deliberate state policy. Data necessary to perform even a cursory analysis of the cost, capacity, or effectiveness of halfway houses in Minnesota are absent.

- While nearly two million dollars is provided annually to area boards for CD counseling and coordinating activities, very little is known about the number and kinds of services being delivered.

Discussion. Grants-in-aid (GIA) to area boards are used to support detoxification, halfway house, and certain non-residential CD counseling services as well as local CD planning. In 1978, state expenditures totaled approximately $4.4 million for detox, $1.1 million for halfway house services, and $2.0 million for counseling and coordinating. For detox, state funds are matched with local funds in a 75-25 ratio. For halfway houses the state provides up to 30 percent of expenditures, and up to 50 percent for counseling and coordinating.

Administrative control of CD grants-in-aid at DPW is split between the Chemical Dependency Program Division and the Community Programs Division. CDPD approves the program content of grant-in-aid applications. The Community Programs Division is responsible for administering the mental health, mental retardation and chemical dependency grant-in-aid program as a whole. The division of labor between these divisions needs to be more effectively coordinated.

STATE HOSPITAL PROGRAMS

- Approximately $9.5 million was spent in 1978 on state hospital CD programs. We estimate the state share of this to be about eight million dollars.

- In 1977, the last year for which data are available, 5,600 CD patients were discharged and the average daily client population totaled 571 in the seven state hospital CD units.

Discussion. Our examination of state hospital programs is based on a limited search for information on costs and service activity. According to DPW, no studies of program effectiveness have been undertaken. Since the annual cost of state hospital CD units is approximately ten million dollars, we believe that this area should receive greater attention by DPW and CDPD.

PLANNING, RESEARCH, AND EVALUATION RESPONSIBILITIES

- There are many gaps and inconsistencies in the basic descriptive data compiled by the Chemical Dependency Program Division. We conclude that CDPD has failed to perform up to a reasonable standard in collecting and reporting basic information on publicly supported CD programs.

- In our judgment, issues of high state and local priority have not received the attention they deserve.

- The planning, research, and evaluation projects of CDPD are not as useful as they should be. Either they fail to accomplish their intended objectives, or they are not designed to yield products which will help decide questions about program effectiveness, assist in resource allocation decisions, answer questions raised by the legislature, or help in other management decisions.

- CDPD is expected to provide staff support to the Chemical Dependency Citizens Advisory Council (CAC) responsible for approving federal formula fund allocations. CDPD has not proposed a clear set of funding priorities and criteria to the CAC. Staff support of the CAC is inconsistent and poorly organized.

- CDPD presently commands the financial resources to conduct a significant planning, research, and evaluation program, but needs to strengthen its staff capabilities in these areas.

Discussion. The Chemical Dependency Program Division is responsible for CD planning, research, and evaluation. We reviewed the performance of the Division by reviewing all significant planning, research, and evaluation projects conducted by Division staff and contractors over a two year period.

CDPD should arrange for basic data on program costs, service activity, and program effectiveness in this order of priority. CDPD will continue to be asked regularly for such information by DPW management and the legislature. An ambitious program of planning, research, and evaluation studies does not make sense if basic descriptive information is unavailable.

CDPD is torn, in part, by its responsibility as CD program advocate on one hand, and program evaluator on the other. So far, advocacy has outweighed evaluation and program monitoring. These functions are at least partially incompatable and perhaps should not be merged in one organizational unit.

CONTRACT MONITORING

- The monitoring of projects supported by federal formula funds is disorganized. We experienced difficulty in even identifying a complete list of funded projects, and we found project files to be in a state of disorder.
- Contract language was frequently vague, making it difficult for the Division to monitor the work of contractors or even decide if agreements were satisfactorily carried out.
- Clear assignment of contract monitoring responsibility has not been made in the CDPD. Staff also lack a uniform understanding of what is required in site visits and other techniques of program monitoring.
- DPW does not have a financial auditing program covering recipients of chemical dependency funds.

Discussion. In 1978, the Chemical Dependency Program Division directly administered about two million dollars in federal formula funds, and an additional $1.2 million in Governor's Bill American Indian funds. Both are used to sponsor a variety of chemical dependency research, education, prevention, and treatment programs. CDPD also approves the allocation of Governor's Bill funds to area mental health boards and monitors their performance.

The Division has made progress in clarifying contract language, assigning program monitoring responsibilities within the Division, and maintaining project files.

Historically, contract monitoring has had less appeal at CDPD than advocacy and program development. The importance of monitoring and evaluation after a period of rapid innovation is now recognized in the Division. We believe that it is appropriate for these activities to be carried out more aggressively and with a greater sense of urgency than they have been in the past.

I. OVERVIEW OF THE CHEMICAL DEPENDENCY SERVICE SYSTEM

This chapter describes the chemical dependency (CD) service system in Minnesota. We discuss chemical dependency funding, key events in the historical development of the CD system, and the organization of CD services.*

A. CHEMICAL DEPENDENCY FUNDING

We estimate that, in fiscal 1978, $67 million was spent in public and private funds in Minnesota for chemical dependency projects and services. Table 1 presents a breakdown of this total by funding source. The total of $67 million includes private as well as public funds. The Department of Public Welfare (DPW) estimates that approximately $22 million was spent in

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* Study findings and methods are presented in greater detail in five staff papers available from the Program Evaluation Division. For more information on this chapter, see staff paper entitled "The Chemical Dependency Service System".

TABLE 1

FUNDING OF CHEMICAL DEPENDENCY PROGRAMS IN MINNESOTA
- FISCAL 1978 -

	FUNDING SOURCE	GENERAL COVERAGE	ESTIMATED EXPENDITURES ($1,000,000)
FEDERAL	National Institute on Alcohol Abuse and Alcoholism	Training, Prevention, Research, Direct Services and Other Special Projects	1.3
	National Institute on Drug Abuse		1.7
	U.S. Department of Health, Education, and Welfare	Title XX Social Services: Primary Treatment, Halfway House, Information & Referral, Counseling	8.9
	Other Federal*		3.5
	Total Federal		15.4
STATE	Governor's Bill	Employee Assistance Programs	1.6
		Underserved Populations	1.2
		American Indian programs	1.0
	Grant-in-aid	Detoxification	4.4
		Halfway Houses	1.1
		Counseling and Coordination	2.0
	State Hospitals	Primary Treatment	8.0
	Other State **		3.6
	Total State		22.9
LOCAL	Local Government (General Revenue)		6.9
	Private (Client Fees and 3rd-party Payments)		22.1
	Total Local		29.0
	GRAND TOTAL		67.3

* Examples: Title XIX, Veterans Administration, and Law Enforcement Assistance Administration.

** Examples: Minnesota Departments of Vocational Rehabilitation, Corrections, and Public Safety.

Source: Chemical Dependency Program Division, Minnesota DPW.

fiscal 1978 in client fees and third party payments. The size of this amount reflects the fact that Minnesota has greater CD residential treatment capacity per capita than any other state. While state hospital programs are predominantly supported by direct state appropriations, most other residential treatment facilities are predominantly supported by client fees and third party payments.

Table 2 presents a comparison between Minnesota and other states in per capita funding of chemical dependency programs. Because it is impossible to match precisely comparable figures in different states, these figures should be taken as approximate. Also, they exclude client fees and third party payments and reflect only certain comparable federal, state, and local government expenditures. The per capita figure of $5.71 for Minnesota is based on statewide expenditures of $22.6 million (rather than $67 million) and the per capita figures for other states are also based on comparable expenditures.

The point of this comparison is not to estimate an accurate per capita figure for Minnesota but to calculate a figure which could be compared with expenditures in other states. Such a comparison shows that, even without county, private, and third party payments, more money is spent on CD programs in Minnesota than in most other states, and significantly more than the national average of $3.85 per person.

TABLE 2

AN INTERSTATE COMPARISON OF PER CAPITA FUNDING FOR CHEMICAL DEPENDENCY PROGRAMS - FISCAL 1977

STATE	FEDERAL FUNDS	STATE FUNDS	LOCAL FUNDS	TOTAL
California	$1.30	$3.57	$ .14	$5.00
Illinois	.84	2.48	.45	3.78
Indiana	.55	.35	.01	.92
Iowa	.84	.89	.07	1.81
Louisiana	1.37	1.27	*	2.64
Michigan	1.18	1.79	.68	3.64
Minnesota	.75	3.37	1.59	5.71
New York	1.89	6.46	.30	8.65
Ohio	.78	.82	.45	2.05
Texas	1.04	2.09	.06	3.19
Vermont	2.83	2.38	.00	5.22
Virginia	.84	1.06	.03	1.94
Wisconsin	.90	3.71	.06	4.67
National Average	$ 1.25	$ 2.32	$ .28	$ 3.85

* Not Reported

NOTES:

1. Calculations are based on 1976 population estimates from U.S. Bureau of the Census.
2. Federal Funds include only money awarded directly from the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse to state alcohol and drug authorities.
3. State Funds include primarily state revenue obligated specifically for chemical dependency programs.
4. Local Funds includes only local matching dollars used to obtain state funds for alcohol programs.

SOURCE:

National Institute on Alcohol Abuse and Alcoholism
National Institute on Drug Abuse
National Association of State Drug Abuse Program Coordinators

B. RECENT HISTORY

There are a number of benchmarks which denote the development of CD programs in Minnesota. In 1957, the state legislature established community mental health service programs and a state grant-in-aid subsidy to local units to defray the costs of these programs. The units which administer these direct services, commonly referred to as "area boards", were given the additional responsibility to coordinate, plan, and evaluate all mental retardation, mental health, and chemical dependency programs on an area-wide basis.*

In 1967, the Minnesota governor established the Commission on Alcohol Problems and, in 1971, the legislature established the Drug Abuse Section of the State Planning Agency. These two offices were eventually reorganized to become the current Chemical Dependency Program Division (CDPD) of DPW.

In 1971, Minnesota decriminalized public drunkenness, and required all area boards to arrange for detoxification services. State money was made available to help establish and maintain these centers. In the same year, the U.S. Congress established the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and one year later established the National Institute on Drug Abuse (NIDA). For 1978, these two agencies allocated over three million dollars to Minnesota for CD programs.

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* "Area board" is a contraction of "area mental health board", also known as community mental health board.

In 1972, halfway houses in Minnesota for chemically dependent people became eligible for grants of $20,000 each (totaling $640,000 statewide) from distribution of a judgement received in a class-action suit brought against the Pfizer Pharmaceutical Company in New York. These funds helped to initiate numerous halfway house programs in the state.

In 1973, Minnesota passed legislation requiring health insurance plans to include coverage of residential treatment of chemical dependency. Subsequent amendments expanded coverage to include non-residential treatment as well.

Residential treatment in general, and residential primary treatment in particular, have been extensively developed in Minnesota, in voluntary hospitals, free-standing facilities, and state hospitals. Minnesota has more alcoholism and CD beds per capita than any other state and approximately four times as many beds per capita as, for example, New York, Illinois, Wisconsin, Massachusetts, and Missouri.* Minnesota's extensive residential treatment capacity may be due, in part, to the passage of mandatory insurance coverage for CD treatment, as well as the efforts of residential health care providers to offer new services to counteract declining bed utilization.

In 1976, the so-called "Governor's Bill" (Laws of 1976, Chapter 125) authorized new support for several kinds of programs:

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* Data published from the American Hospital Association's 1976 annual survey reveal that Minnesota had 1,590 hospital beds in alcoholism and CD units; this amounts to four beds per 10,000 population compared to the national average of 0.9 beds per 10,000 population.

- employee assistance programs aimed at identifying and referring workers with chemical dependency and other problems affecting job performance;

- education, outreach, referral, and, in some cases, counseling programs aimed at certain target groups thought to be underserved by the established treatment system; (these were defined by DPW Rule 24 to be youth, women, the elderly, Blacks, Chicanos, and gays/lesbians);

- prevention, education, and outreach programs, and residential treatment for American Indians.

A summary of the legislative and administrative authority for chemical dependency programs is presented in Table 3.

C. ORGANIZATION AND ADMINISTRATION OF CHEMICAL DEPENDENCY SERVICES

While most chemical dependency services are supported by at least some public funds, most services are provided by private vendors under contract with local area boards or the state. Area boards funded by state grants-in-aid also provide certain CD services themselves.

Chemical dependency service providers generally function within broad programs which are administered, funded, monitored, and regulated by the state Department of Public Welfare (DPW). DPW is the state agency with the predominant responsibility for administering CD programs.* It receives nearly all the federal

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* The State Planning Agency has some CD-related responsibilities because it functions as the State Health Planning and Development Agency (SHPDA) and is thereby responsible for the development of all hospital programs in the state. Under the Federal A-95 review process, the State Planning Agency also reviews all program applications for direct federal funding. The Minnesota Department of Health (MDH) is responsible for certifying most residential facilities in the state from a public health perspective. The programs which are operated within the facilities are normally licensed by that agency whose orientation is most relevant.

TABLE 3

LEGISLATION RELATED TO CHEMICAL DEPENDENCY PROGRAMS

COMMON NAME	SESSION LAW	STATUTE	DPW RULE NUMBER
Governor's Bill	1976c125	254A.031 254A.12 254A.14 to .17	24
State Authority on Alcohol and Drug Abuse	1971c892 1973c572 1976c125	254A.01 to .03 254A.04 to .10	None
State Grant-in-Aid; Community Mental Health Services	1957c392 1969c1043 1973c123 1976c163	245.61 to 245.69	28 (under revision)
Detox, Receiving Centers	1971c892 1973c572 1976c125	254A.08 and 245.78 to 245.82	32 (under revision)
Residential Treatment: primary treatment extended care halfway house hospital-based	*	245.78 to 245.82	35
Outpatient Treatment	*	254A.02 254A.03 254A.10 245.791 to .813	43 (in draft)
Accident and Health Insurance Coverage	1973c585 1976c262 1978c793	62A.149	None
Commitment Procedures	*	253A	None

* No session laws or statutes directly address these specific services. The statutes referred to here are cited in the rule and relate either to general provisions regarding CD services or to the authority of the Commissioner of DPW to promulgate rules and regulations.

money that is targeted for alcohol and drug programs and for social services in general.

The Department of Public Welfare relies upon three main governmental and private units to arrange services for clients: state hospitals, county welfare departments, and area mental health boards. DPW contains organizational units which are responsible for the administration of the programs provided by each of these service units. Figure 1 shows a model of the basic components of the CD service and administration system.

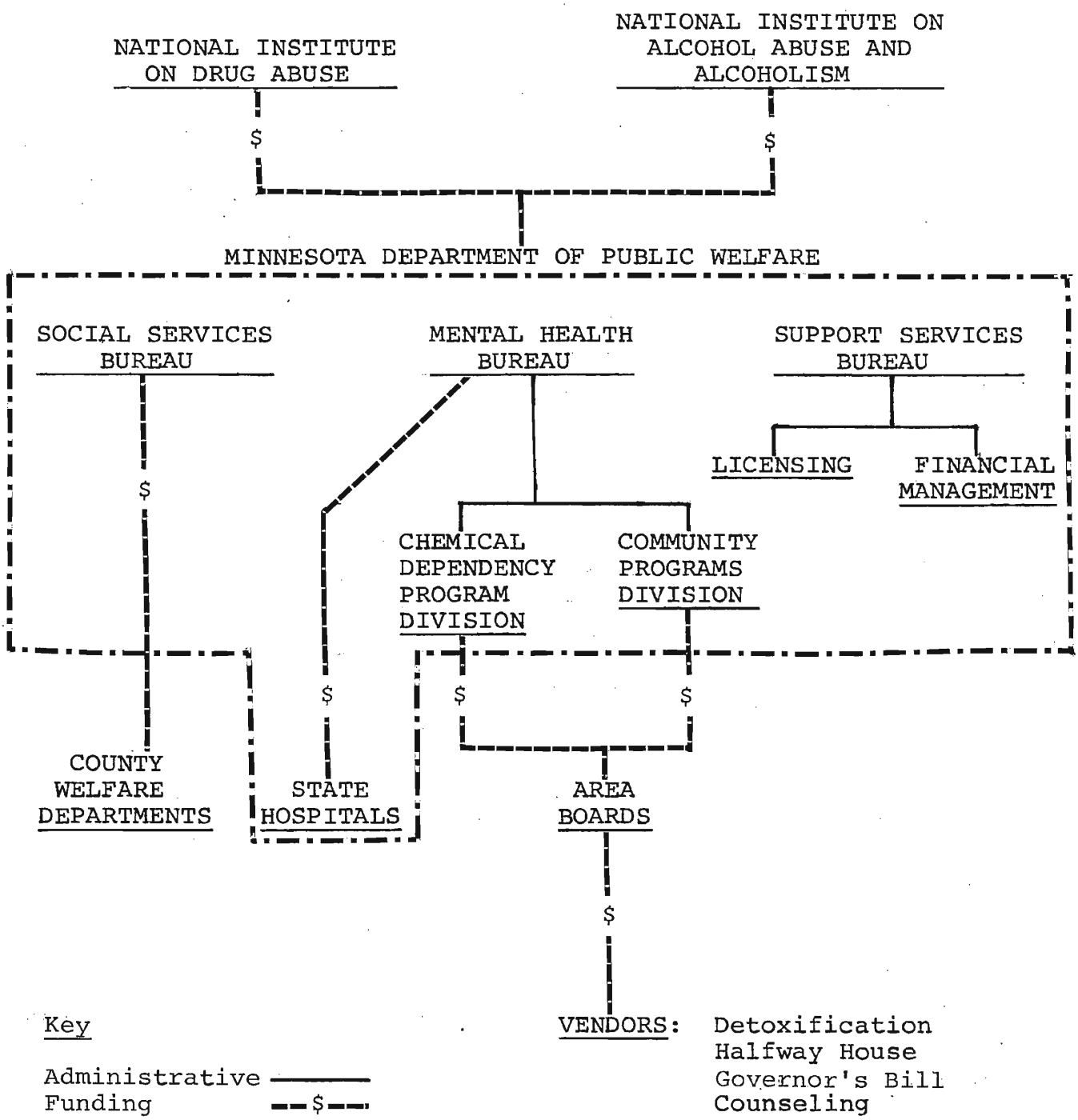
In the most general terms, the administration of CD programs is as follows: the Chemical Dependency Program Division (CDPD) of DPW is responsible for administering federal CD funds and the state's Governor's Bill program; the Community Programs Division (CPD) administers the state's mental health grant-in-aid program (which includes CD services); and the Social Service Bureau manages the federal/state social service program (which provides money for CD services for welfare clients). Relevant to our research on CD program activities, DPW also houses the Financial Management Office which monitors expenditures of state and federal funds, and the Licensing Division which regulates programs that are subject to DPW authority.

1. CHEMICAL DEPENDENCY PROGRAM DIVISION

The Chemical Dependency Program Division of DPW was established in April, 1974. It is responsible for planning, research, evaluation, technical assistance, grants and contracts management, public information, and coordinating CD activities and programs for the state. The Chemical Dependency Program

FIGURE 1

SCHEMATIC OF MINNESOTA CHEMICAL DEPENDENCY SYSTEM



Division also functions as Minnesota's CD "single state agency" making it the recipient and disburser of major federal chemical dependency funds from NIAAA and NIDA.* CDPD also distributes federal and state money primarily through grant awards and purchase-of-service contracts with both area boards and private vendors. As a result, CDPD is responsible for overseeing approximately seven million dollars in state and federal CD funds.

The CDPD has two permanent advisory bodies. The first is the Citizens Advisory Council (CAC) appointed by the governor, which assists in the formulation of policies. It is also formally expected to advise the commissioner of DPW and director of CDPD on policies, goals, and the operation of the state chemical dependency plan, and to make recommendations to the commissioner regarding grants to community mental health boards. The second advisory body of the CDPD is the American Indian Advisory Board. It reviews all proposals and grant applications for American Indian programs.

In the last eight years , the state's alcohol and drug unit has undergone considerable change. The CDPD has had four different directors and turnover of the other staff has been extensive. Although CDPD was once an independent unit reporting directly to the governor, it is now a division within a large state bureaucracy. There have been problems and policy disputes between CDPD and central DPW offices. Authority and related responsibilities have been divided and recombined. Low morale

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* It is estimated that, in fiscal 1978, $840,000 was awarded by the federal government directly to CD programs in Minnesota which was not channeled through DPW.

continues to be a problem. Responsibility and communication are fragmented both within DPW and between state and local CD administrators.

2. COMMUNITY PROGRAMS DIVISION

The Community Programs Division (CPD) administers the state grant-in-aid program which, in fiscal 1978, allocated $7.5 million in state funds to area mental health boards for local planning and coordination, counseling, detoxification, and halfway house services. Non-residential CD services are usually provided by a chemical dependency coordinator and CD counselors who are regular employees of the community mental health center run by each area board. Detoxification and halfway house services, on the other hand, are normally secured by the area board through a "purchase of service" agreement with a private vendor.

The Community Programs Division is responsible for the administration of DPW Rule 28 which regulates the activities of community mental health centers. The director of the Community Programs Division conducts site visits to the local mental health centers and is accompanied by staff from the Mental Retardation, Mental Illness, and Chemical Dependency Program Divisions.

For fiscal 1979, the Community Programs Division used a formula to allocate non-residential grant-in-aid dollars based on: an area's share of the state's total population, the number of families below poverty level, and the geographic area. In the future, detoxification and halfway house grant-in-aid allocations will be based upon rates of utilization. In general, the budget

amounts covered by state grant-in-aid are limited as follows: 50 percent for non-residential (counselors/coordinator), 75 percent for detoxification, and up to 30 percent for halfway houses.

3. FINANCIAL MANAGEMENT OFFICE

The Financial Management Office (FMO) contains the accounting, budgeting, and fiscal reporting units of DPW. It carries out the procedures prerequisite to distribution of authorized funds to grantees or service providers.

The Financial Management Office does not conduct financial post audits of DPW grant recipients on a routine basis. The FMO conducts such audits only when they are specifically requested by one of the program divisions. There is no routine or substantial communication between the FMO and program division staff to combine program and expenditure information.

4. LICENSING DIVISION

The Licensing Division is responsible for Rules 32, 35, and 43 which relate to CD programs. DPW Rule 32 regulates the licensing of detoxification centers, but the Licensing Division is not enforcing the rule. At present, none of the receiving centers in Minnesota are licensed by DPW.

DPW Rule 35 regulates the licensing of residential treatment centers for chemically dependent people. This rule covers halfway houses, residential primary treatment centers, and board and lodging facilities. Although programs based at licensed hospitals are excluded, it is, nonetheless, DPW's policy that

state hospital CD programs be licensed under Rule 35.

DPW Rule 43 is currently being drafted to cover non-residential treatment programs. The Chemical Dependency Program Division has been active in reviewing and approving programs according to its standards. Once Rule 43 is promulgated, the responsibility for its administration will be transferred from the CDPD to the Licensing Division.

5. COMMUNITY MENTAL HEALTH CENTERS

Minnesota Laws of 1957, Chapter 392, established community mental health service programs and provided state grants-in-aid to assist local communities to establish and operate such programs. In Minnesota, all but two community mental health centers are private, non-profit corporations.

Area boards (community mental health boards) are responsible for the planning, development, coordination, and evaluation of all programs for the chemically dependent populations in the geographic area they serve. Community mental health "centers" or "clinics" actually provide services.

Area boards must establish three advisory bodies, one each for mental health, mental retardation, and chemical dependency. These advisory bodies are active in soliciting, reviewing, and recommending local program proposals, monitoring the development of the local service delivery network, and providing input into the local area's annual grant-in-aid plan which is submitted to the state for approval.

6. COUNTY WELFARE DEPARTMENTS

Each of the 87 counties in Minnesota has a welfare program. Welfare clients receive not only money but services which may include detoxification, CD primary treatment, extended rehabilitation, and halfway house services. County welfare departments provide these services by direct provision using their own staff or by purchasing services from another public or private vendor. The county welfare department, in turn, requests reimbursement from the state. During each of the past seven years, Minnesota has received approximately $46 million in reimbursable Title XX funds under the U.S. Social Security Act. Of this amount, nearly nine million dollars is spent each year for CD services.

D. SUMMARY

This chapter has provided the reader with background information on the Minnesota sponsored chemical dependency service system. The chapter has described the funding structure for CD services and reviewed the historical development of the system. The types of currently available CD services have been delineated. This chapter also describes the structure of the state Department of Public Welfare which is primarily responsible for CD programs in Minnesota.

The remaining chapters of this report summarize our findings on program efficiency and effectiveness; the performance of DPW in conducting planning, research, and evaluation; and DPW's activities in contract monitoring.

II. SERVICE ASSESSMENTS

This chapter reports what we have been able to learn about CD program effectiveness and efficiency from a systematic review of available data.* In each area of service activity we have asked the following questions:

- What are the program costs?
- What services have been delivered?
- What is the unit cost of services?
- What are the results or benefits?

The following chapter examines data on CD programs receiving direct state support. These are:

- Governor's Bill programs, mainly education, outreach, diagnosis and referral, and case-finding activities;
- programs supported by state grants-in-aid to area mental health boards: detoxification centers, halfway houses, and out-patient counseling services;
- American Indian programs, funded by state and federal money; and
- state hospital CD programs.

The scope of the study was necessarily limited by the availability of descriptive and evaluative data on CD programs. No effort was made to collect extensive new data either from service providers or from program clients, although this study did mount

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* For greater detail, see staff paper entitled "Service Assessments".

an extensive review of existing sources of information on program costs and operations.

Chapter 125, Laws of 1976, known as the Governor's Bill, provided funds for new chemical dependency programs aimed at education, outreach, and case-finding. It also mandated close monitoring of service activity. As a result, there is some useful information available on the number and kinds of Governor's Bill services which have been delivered, although nothing is available on client follow-up. For this reason, and because of high interest in the operation of these programs, more space is devoted to Governor's Bill programs in the following pages than other CD services.

While DPW and its Chemical Dependency Program Division and Community Programs Division recognize the need to monitor detoxification services, halfway house services, state hospital programs, and other state-supported CD services, the information available on these programs is sketchy. Our report comments on the absence of reliable information where this problem exists and interprets the data which are available.

A. CHEMICAL DEPENDENCY PROGRAMS SUPPORTED BY GOVERNOR'S BILL APPROPRIATIONS

This section discusses Governor's Bill employee assistance programs, the state run employee assistance program for state employees, and programs for youth and other underserved populations. Programs aimed at American Indians funded by the Governor's Bill

and federal formula monies (both administered directly by CDPD) are discussed later in this chapter.

1. EMPLOYEE ASSISTANCE PROGRAMS

Employee assistance programs (EAPs) consist of two components: occupational program consultant (OPC) services and diagnostic and referral (D&R) services. OPC services consist of policy writing, staff training, and public relations efforts which are necessary in setting up an EAP for a given employer. Diagnostic and referral services refer to the interviews between employees with problems affecting job performance and trained D&R workers.

a. Description of Costs and Services

The Governor's Bill provides funds to area mental health boards to purchase OPC and D&R services from private vendors. Under the terms of the Governor's Bill, area boards are prohibited from providing these (or other Governor's Bill services) directly through the community mental health centers they control.

Fiscal 1977 was the first year of operation for EAPs funded by the Governor's Bill. As Table 4 shows, 190 EAPs were established and 265 employees received diagnostic and referral services in 1977. Of this total, 100 people were referred because of a CD problem affecting them or a family member. The cost of setting up the EAPs and making these referrals was $734,620 in fiscal 1977. In fiscal 1978, $1,029,299 was spent on setting up 429 programs and making 1,503 referrals of which 550 were for a chemical dependency problem.

TABLE 4

EMPLOYEE ASSISTANCE PROGRAMS:
PRESENTATION OF COSTS AND SERVICE ACTIVITY

Expenditures*		EAPs Established	Employees Covered	Total Referrals	CD Referrals
1977					
OPC	$633,242	190	42,323	265	100
D&R	101,378				
TOTAL	$734,620				
1978					
OPC	$639,195	429	54,493	1,503	550
D&R	390,104				
TOTAL	$1,029,299				

* The distribution of total expenditures between OPC and D&R is estimated.

Source: Chemical Dependency Program Division, Governor's Bill Reporting System.

In fiscal 1977 and 1978, a total of approximately $1.7 million was spent on Governor's Bill employee assistance programs. For reasons fully explained elsewhere,* data limitations make it impossible to precisely compute unit costs for OPC and D&R services. Basically, DPW does not know how much money is spent on each, only the combined total. We used Hennepin County's more complete data on how costs were distributed between OPC and D&R services as a standard** and computed three estimates of the cost per referral and the cost per CD referral for 1977 and 1978 for the state as a whole. These are presented in Table 5. Method 1 simply divides total expenditures by total referrals, equivalent to allocating all start-up costs to a single year. Method 2 assumes that program start-up costs should be spread over five years; and Method 3 omits all start-up costs in order to show how much operating costs alone amount to on a per referral basis.

A unit of D&R is usually one interview, lasting one to one and a half hours, between a trained D&R worker and an employee whose work performance has caused some concern.*** As Table 5 shows,

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* For more detailed information, see staff paper entitled "Service Assessments".

** In reviewing this point, CDPD argues that Hennepin County's distribution between OPC and D&R should not be considered typical of the state as a whole, and that proportionately less is spent on D&R outstate than in metropolitan areas. No data exist to settle this point, however.

*** In some cases more than one interview is required. Twenty-eight percent of the time two interviews are necessary and, in eighteen percent of the cases reviewed here, three or more meetings were required. These can take varying amounts of time, but D&R interviews are not supposed to involve treatment or counseling.

for 1977, per referral cost estimates range between $383 and $2,772, and between $1,014 and $7,346 per CD referral. Unit costs are lower for 1978, ranging between $260 and $685 per referral and between $709 and $1,871 per CD referral. The best unit cost estimates we can compute are the Method 2 estimates of $860 per referral in 1977 and $345 per referral in 1978. In essence these numbers allocate one-fifth of the OPC costs to a year of program operations and divide D&R expenditures plus one-fifth of OPC expenditures by total referrals.

b. Analysis

Although our per referral cost estimates are based on incomplete data, we believe they support the conclusion that Governor's Bill employee assistance programs have been excessively costly. In part, this conclusion is based on a cost comparison between Governor's Bill EAPs and the state-operated EAP. We discuss this comparison below, and consider a number of factors which may have contributed to high program costs.

(1) Comparison Between Governor's Bill and State EAPs

The State of Minnesota, as an employer, operates an employee assistance program. Executive Order #133 signed December 29, 1976, authorized the establishment of an EAP for state employees and designated the Chemical Dependency Program Division (CDPD) of DPW as responsible for the design, implementation, and coordination of the program.

TABLE 5

EMPLOYEE ASSISTANCE PROGRAM UNIT COSTS

1977	Method 1	Method 2	Method 3
Cost Per Referral	$2,772.15	$ 860.48	$ 382.56
Cost Per CD Referral	$7,346.20	$2,280.26	$1,013.78

1978	Method 1	Method 2	Method 3
Cost per Referral	$ 684.83	$ 344.62	$ 259.55
Cost per CD Referral	$1,871.45	$ 941.75	$ 709.28

Source: Computations based on Governor's Bill Reporting System data.

CDPD has contracted with vendors to deliver D&R services at a cost per referral of $35. The best comparison between the statewide estimates presented in Table 5 and this figure uses the Method 3 estimates of $383 and $260 which look at D&R costs alone. Thus the amount spent on EAPs by area boards purchasing services from private vendors is many times the amount the CDPD was able to negotiate with a statewide network of providers.

There are a couple of important points to note in connection with this comparison. The state is not prevented by law, as are area boards, from purchasing D&R services from community mental health centers, and the state as a single large purchaser is possibly in a position to negotiate a better deal than individual area boards. The state negotiated a $35 unit price with private vendors as well as with CMHCs, however, in setting up an EAP network for state employees. The state EAP also does not have to meet certain reporting, follow-up, and outreach requirements that other programs are required to meet.

When the state offered to purchase D&R at $35 per referral, willing providers were found to cover all areas of the state. We conclude that $35 must be sufficient to cover the unit cost of D&R. Since the Governor's Bill EAPs are costing many times this amount, it is reasonable to conclude that they are too costly.

(2) Discussion of Factors Contributing to Excessive Expenditures. Several factors may contribute to the high cost of employee assistance services. These include: area boards' inexperience in recruiting and selecting vendors, CDPD's failure to

accurately project EAP costs, and CDPD's inability to provide needed assistance to area boards in recruiting and selecting vendors.

Not all area mental health boards were experienced in recruiting vendors and negotiating contracts. Most non-metropolitan boards reported problems in recruiting qualified vendors in response to our survey of area board staff.*

The Chemical Dependency Program Division (CDPD) is responsible for providing assistance to area boards in recruiting vendors and CDPD itself is responsible for the EAP for state employees. The CDPD made cost assumptions that led to its budget request for the state EAP which virtually guarantees per referral expenses of over $200.

Because the CDPD did not accurately forcast EAP costs for its own program, it is perhaps understandable that area boards which depend on CDPD for guidance were similarly unable to project costs and negotiate reasonable contracts with private vendors.

Most area board chemical dependency coordinators and program directors call for a change in law which would permit area boards to directly provide EAP services instead of purchasing these from private vendors. Some area board staff say that they can provide these services more cheaply than private vendors.

The provision prohibiting area boards from directly providing Governor's Bill services was designed to prevent Governor's Bill funds from being used to permanently expand the capacity of

* For a report of survey methods and findings, see staff paper entitled "Area Board Survey".

CMHCs in a way which would be hard to subsequently cut back. Governor's Bill programs were conceived as an initiative of limited duration rather than a permanent addition to state funded chemical dependency treatment capacity.

If the predominant view of CMHC program directors and CD coordinators is correct, CMHCs are one of the few sources of D&R expertise in many parts of non-metropolitan Minnesota. However, area board staff opinion on this question could be motivated by self-interest.

CDPD staff feel that CMHCs should be permitted to receive reimbursement for D&R services under certain conditions and it is possible that CDPD could propose alternative safeguards which would prevent temporary programs from becoming institutionalized, while allowing certain CMHCs to deliver D&R services.

2. PROGRAMS AIMED AT YOUTH AND OTHER UNDERSERVED GROUPS

The Governor's Bill provides funds to area boards for the purchase of services aimed at identification, outreach, and, in certain circumstances, treatment services for youth and other underserved populations (Y&O). DPW Rule 24 implementing the Governor's Bill defines the targeted groups as youth, women, the elderly, Blacks, Chicanos, and gays/lesbian.

a. Description of Costs and Services

Y&O programs consist of service activities aimed directly at target groups often through programs run by target group members. Y&O programs are also aimed at people who work with target group members; therefore, Y&O programs also include services

to teachers, social workers, or other professionals in a position to identify and refer clients for treatment.

In reviewing Y&O programs, we examined all available information on costs, services delivered, and program results. There are no client follow-up data which can be used to evaluate the effectiveness of Y&O programs. The absence of such data is understandable since it is difficult to quantify the outcome of education or outreach efforts. Data are available for the volume of service activity and the number of referrals made.

A severe impediment to understanding Y&O program results, however, is the fact that DPW does not collect information on how expenditures are distributed across service categories or among programs aimed at specific target groups. That is, area boards are not required to report to DPW how much money is being spent separately on youth, women, the elderly, etc., or how much is being spent on D&R, education, counseling, etc. This lack of data makes it difficult to compare costs and service activity in order to reach conclusions about program efficiency.

Table 6 summarizes Y&O expenditures and service activity for fiscal 1977 and 1978. In fiscal 1977, $1.2 million was spent on D&R, education, outreach, and other programs targeted at youth and other underserved groups. As a result, 3,882 referrals were made and 4,932 group sessions were held. A total of 97,927 people attended group sessions, although this is a duplicated count of "people at group meetings" rather than an unduplicated count of how many participants were reached by Y&O programs during the year.

TABLE 6

YOUTH AND OTHER UNDERSERVED PROGRAM ACTIVITIES

	Governor's Bill Y&O Expenditures	Total Referrals	Number of Group Sessions Conducted	Number of People in Groups
1977	$1,199,217	3,882	4,932	97,927*
1978	$1,569,914	6,289	6,513	22,014*

* 1977 data are a duplicated count of participants at group sessions; 1978 data are an unduplicated count.

Source: Chemical Dependency Program Division, Governor's Bill Reporting System.

In fiscal 1978, $1,569,914 was spent, 6,289 referrals were made, 6,513 group sessions were held, and an unduplicated count of 22,014 participants were involved in these groups.

The main concept behind the Governor's Bill was to provide support for diagnostic and referral services. If total expenditures are divided by the number of D&R services, D&R unit costs equaled about $309 in 1977 and $250 in 1978. As Table 6 shows, however, other services were also delivered and boards were allowed to use five percent of their grants to cover administrative costs. DPW does not collect data from area boards which show how monies were divided between group sessions and D&R, but it is illuminating to make some assumptions about what D&R services might cost and, under these assumptions, compute the cost of delivery, education, outreach, or other services to groups.

Table 7 presents unit cost estimates for the state as a whole, and is based on certain assumptions about how the money was spent. If D&R is assumed to cost $35 per unit on the average, then group sessions cost $198 in 1978. If D&R is assumed to cost $100 per unit, then group sessions cost $136 in 1978. The implications of other D&R cost assumptions are also presented in Table 7.

It is impossible to determine, from available information, the average size of group presentations or the cost of running different kinds of groups. The predominant purpose of group sessions is education. The best information on group size is from 1977; the average group contained just under 20 participants. In 1978, a total count of participants was not recorded, but an

TABLE 7

UNIT COST ESTIMATES FOR YOUTH AND OTHER UNDERSERVED PROGRAMS

Assuming D&R Unit Costs Equal	Total D&R Costs Equal	Group Session Costs Equal	Per Session Costs Equal	Per Participant * Costs Equal
		1977		
$ 35	$135,870	$1,003,386	$203.44	$10.25
100	388,200	751,056	152.28	7.67
150	582,300	556,956	112.93	5.69
200	776,400	362,856	73.57	3.71
250	970,500	168.756	34.22	1.72
		1978		
$ 35	$ 220,115	$1,291,953	$198.37	$68.31
100	628,900	883,168	135.60	46.69
150	943,350	568,718	87.32	30.07
200	1,257,800	254,268	39.04	13.44

All computations assume that five percent (the allowable maximum) of all allocations went to area boards for administrative costs.

* 1977 figures are based on a duplicated count of participants; 1978 figures are based on an unduplicated count. In 1977, participants were counted as often as they attended group sessions; in 1978, participants were counted only once, even if they attended a series of sessions.

Source: Computations based on Governor's Bill Reporting System data.

unduplicated count was; each group session reached an average of 3.6 new participants (persons who had not participated previously). Thus, group sessions were typically conducted in series involving many of the same participants in more than one meeting.

b. Analysis

Even though precise data are not available, the information which does exist leads us to conclude that the cost of Y&O programs is excessively high.

As we pointed out in discussing employee assistance programs, it has proved possible to purchase D&R services for $35 per referral from private vendors as well as from community mental health centers. Even if $100 per D&R unit is chosen as a generous estimate of what D&R should cost for Y&O groups around the state, the cost of conducting groups seems excessive. This has been estimated at $136 per session for 1978, involving an average of 20 people, most of whom were attending a series of sessions.

Assuming that D&R costs are $100 per session, it cost $47, on the average, to reach an individual via a group meeting devoted to education, outreach, or counseling. D&R costs may have been higher and group session costs lower. Table 7 provides a series of computations based on different assumptions. We conclude that if D&R costs are assumed to be reasonable, then group session costs must have been excessive in 1978. Only if D&R costs are assumed to be excessive, do unit costs for group sessions become reasonable.

A geographical comparison reveals obvious differences in Y&O service between Hennepin and Ramsey Counties and the remainder of Minnesota. Data in Table 8 reveal that, in 1977 and 1978, almost all D&R services aimed at youth and other underserved groups in all of Minnesota were delivered in Hennepin and Ramsey Counties: 3,683 out of 3,882 D&R sessions in 1977 and 5,293 out of 6,273 in 1978.

Group sessions, however, were fairly evenly split between Hennepin and Ramsey Counties and the remainder of the state. In 1978, for example, the number of group sessions conducted were almost evenly split between these regions as were the number of participants, as Table 8 shows. Expenditures were $861,676 for Hennepin and Ramsey and $701,762 for the rest of the state in 1978. Thus, roughly equal expenditures purchased significantly more units of service in Hennepin and Ramsey Counties than elsewhere in Minnesota. In connection with these findings, it is interesting to note that, in our survey of chemical dependency coordinators and program directors, more metropolitan area board staff describe their Y&O programs as very successful than do non-metropolitan staff.

B. CHEMICAL DEPENDENCY PROGRAMS SUPPORTED BY STATE GRANTS-IN-AID

State grants-in-aid to area mental health boards for chemical dependency programs totaled $7,498,460 for fiscal 1978. These funds supported detoxification centers, halfway houses, and

TABLE 8

YOUTH AND OTHER UNDERSERVED PROGRAMS:

Metropolitan and Outstate Comparison

	Gov.'s Bill Y & O Expenditures	Total Referrals	CD Referrals	Number of Group Sessions Conducted	Number of People In Groups*
FY 77					
Metro	$ 663,500	3,683	3,464	NA	41,529
Outstate	535,717	199	140	NA	56,398
Total	1,199,217	3,882	3,424	4,932	97,927
FY 78					
Metro	$ 861,676	5,293	4,781	3,229	11,067
Outstate	701,762	980	767	2,921	10,947
Total	1,569,914	6,273	5,548	6,150	22,014

Metro = Ramsey and Hennepin Counties

NA = Data Not Available

Source: Chemical Dependency Program Division, Governor's Bill Reporting System.

the counseling and coordination activities of community mental health centers. Table 9 presents a breakdown of expenditures in these areas for fiscal 1977 and 1978.

For grant-in-aid (GIA) programs as for other components of the state's CD program, we have made an effort to assemble data on costs, service activity, unit costs, and program effectiveness. This effort has not yielded much insight into the efficiency or effectiveness of grant-in-aid supported programs because only sketchy and unreliable information is available. We expected this to be the case for information on program effectiveness because it is difficult to collect and analyze such information. However, we also found an absence of information on service activity and information which allows a comparison of costs and service activity.

We believe that it is essential for DPW to assemble basic descriptive information on the operation of GIA programs so that agency and legislative decision-making can be supported in an improved fashion. The necessary mechanisms for collecting this information already exist, since area boards apply to DPW annually for financial support. DPW clearly has a legitimate need for basic descriptive information on programs for which it is allocating nearly eight million dollars a year.

1. DETOXIFICATION CENTERS

a. Description of Costs and Services

Receiving centers (detox centers) were established as an alternative to the incarceration of publicly intoxicated

TABLE 9

CHEMICAL DEPENDENCY EXPENDITURES

Grant-in-Aid Components	Fiscal Year 77	Fiscal Year 78	Total
Detox	$3,675,349	$4,412,320	$8,087,669
Halfway House	1,057,243	1,105,194	2,162,437
Non-Residential (Counseling and Coordination)	1,627,407	1,980,946	3,608,353
Total	$6,359,999	$7,498,460	$13,858,459

Sources: FY 77 GIA "Chemical Dependency Fiscal Reconciliation Reports"

FY 78 GIA "Chemical Dependency Fiscal Reconciliation Reports"

people, in order to provide a medically safe environment for detoxification and an appropriate referral for treatment. On the average, the statewide length of stay for an individual in a receiving center is roughly three days. There is no limit to the length of stay in a center, except for individuals arrested while inebriated who must appear in court for formal charges within 72 hours of arrest.

Grant-in-aid funds for detox services are distributed to area boards according to a formula based on population size, income, and population density. Funds are allocated to area boards on a quarterly basis and, in the case of detox, state funds are matched with local funds in a 75-25 ratio. As Table 9 shows, the state share totaled approximately $4.4 million in 1978. State grant-in-aid combined with local matchable funds totaled $6.2 million in 1978.

Since the decriminalization of public intoxification, the state and local jurisdictions have been struggling with a variety of problems connected with providing a safe environment for detoxification and a proper referral for subsequent treatment. Our survey of area board program directors and CD coordinators confirms that problems associated with detox services are a priority concern across the state. Area board staff report problems arranging for detox services, and a substantial number call for more aggressive development of alternatives to detox centers for the chronic recidivist. Therefore, concern with collecting and analyzing basic descriptive data on detox centers should be a priority for the Chemical Dependency Program Division, which is responsible for evaluating the effectiveness of CD

services and assisting, if not leading, in the development of state CD treatment policies.

The Chemical Dependency Program Division has, in fact, recognized the need to compile information on detox services on an ongoing basis and has been working for several years to develop a management information system. As we discuss in the next chapter, the development of this system has been unsuccessful and, as a result, data on detox services are sketchy and unreliable.

Table 10 presents some descriptive information on detox centers and service activity that we have been able to put together from various sources. Although CDPD is currently sponsoring a client follow-up study of detox clients, results are not yet available.

Table 10 presents expenditure data for fiscal 1978 for each area board and the state as a whole. The first column of this table represents the combined state and local matchable share for detox services. As the final line of the first column shows, detox expenditures totaled approximately $6.2 million in fiscal 1978. The comparable figure was $4.7 million for fiscal 1977.

In 1977, the number of detox discharges was 28,451. In 1978, it was 32,515. Dividing total costs by number of discharges, the cost per discharge was $165 in 1977 and $189 in 1978 for the state as a whole.

Costs for detox services vary considerably around the state, both because the average length of stay varies considerably among centers, and because average cost per day of service varies from approximately $50 to over $100. The statewide average is

TABLE 10

DETOX COST PER DAY OF SERVICE ESTIMATES

Area Mental Health Board	GIA and Local Match Expenditures FY 78[1]	Number of Discharges FY 78[2]	Average Length of Stay FY 78[2]	Estimated Days of Service	Average Cost Per Day of Service[4]
Anoka	$ 78,262.78	466*	3.0	1,414	$ 55.35
Blue Earth-LeSueur-Waseca	187,732.00	749*	2.5	1,872.5	100.25
Carver	29.261.81	185*	3.1	577	50.72
Central	173,490.74	970	2.8	2,716	63.88
Dakota	168,430.01	755	2.8	2,170	77.62
Faribault-Martin-Watonwan/ Brown-Nicollet	126,060.24	485	2.7	1,309.5	96.26
Five County	88,045.00	606	2.8	1,696.8	51.89
Freeborn-Mower	90,209.94	424	3.2	1,356.8	66.49
Hennepin County	2,410,899.00	14,204*	3.2	45,452.8	53.04
Lakeland	217,147.12	930	2.8	2,604	83.39
Northeast	401,117.27	2,428	2.8	6,798.4	59.00
Northwestern	173,747.01	650	3.4	2,210	78.62
Ramsey/Washington County	712,842.68	3,601*	3.4	12,243.4	58.22
Range/Northland	232,629.03	1,061	3.2	3,395.2	68.52
Scott	51,186.47	307*	2.9	890	57.51
Sibley	5,109.90	21*	3.1	87	58.72
Southwestern	98,767.09	432*	2.3	1,021	96.74
Upper Mississippi/ Northern Pines	290,562.88	1,513	2.7	4,085.1	71.13
West Central	222,150.48	1,035	2.8	2,898	76.65
Western	74,256.97	210*	3.1	657	113.02
Luther Youngdahl/Zumbro Valley/Hiawatha	319,649.92	1,463	2.5	3,657.5	87.39
Total	$6,151,658.34	32,515	3.1	100,796.5	$61.03

[1]FY 78 GIA "Chemical Dependency Fiscal Reconciliation Reports".

[2]FY 78 Data obtained from Chemical Dependency Program Division management information system.

[3]Estimated Days of Service - Avg. Length of Stay X Number of Discharges.

[4]Average Cost Per Day of Service = Expenditures ÷ Estimated Days of Service.

*These data were obtained from individual area boards.

approximately $61 per day of care.

b. Analysis

The data presented in Table 10 illustrate the kinds of information which we feel CDPD should collect and analyze. Prior to this study, CDPD had some rough statewide estimates of service activities and costs but no data for separate areas. In addition, a computer programming quirk caused computation of average stays to be erroneous. The data in Table 10 are only the beginning of the monitoring and evaluation approaches which can be pursued, and they alone raise more questions than they settle. The following questions (among others) can be addressed as a next step.

- Why are some boards apparently more successful than others in securing inexpensive detox services?
- How can the successful experiences of individual boards be used by DPW to help solve problems around the state?
- How can the state improve its policy concerning the cost and kind of detox services to be provided?
- What are the characteristics of expensive compared to inexpensive detox services?

Data in Table 10 show that detox costs vary considerably. Some areas appear to spend nearly twice as much as others per day of care. DPW is in a unique position to examine the experiences of numerous individual providers and promote the adoption of successful techniques and innovations as well as to offer technical assistance where needed.

There is sufficient variation in the costs of detox services to safely conclude (even if there are some accuracy problems in the data) that areas are providing either widely different styles of detox care or are purchasing comparable detox services at rather different prices. Both explanations of the variation in costs are probably true. Since it is direct state money which largely finances detox care, it may be appropriate for the state to establish detox program guidelines so that the citizens of Minnesota are provided with basically comparable detox services wherever they live.

It should be mentioned here that DPW Rule 32, which was promulgated some years ago to license detox centers, has been administratively shelved at DPW. A rule covering detox centers offers one mechanism for establishing program guidelines. The absence of an active rule governing detox services is symptomatic of the lack of DPW policy governing detoxification.

As a concept, the purpose and nature of detox services are straightforward when compared to the variety of services offered under the Governor's Bill, federal formula monies, and halfway house and non-residential appropriations. But Minnesota's detox policy and DPW's information on service activity are both poorly developed.

2. HALFWAY HOUSES

a. Description of Costs and Services

The state CD grant-in-aid program provides a little over one million dollars annually to area boards to be used to

provide halfway house (HWH) services. The state share provides up to 30 percent of an area board's expenditures on halfway house care. Thus, about two million dollars is spent in local matchable funds, in addition to the more than one million dollars in state grant-in-aid funds. Halfway house fees are typically not covered by insurance, yet HWH care is, in principal, a cheaper alternative to extending primary residential care, and is designed to provide certain clients with a transition from relying on a structured environment.

As discussed above, CDPD has attempted to set up a management information system to provide some basic descriptive information on service activity supported by state appropriations. This includes an effort to track basic information on halfway house clients and service providers. However, CDPD has experienced problems setting up reporting relationships with halfway houses as they have with detox centers. Consequently, CDPD is able to report only fragmentary and unreliable information.

CDPD is currently sponsoring a limited follow-up study on halfway house clients but data are not yet available. CDPD sponsored a descriptive study of the halfway house industry and this report was delivered in early 1978. It provides some general information on the kinds of HWH services offered and the type of clients served by them.

Publicly funded halfway houses number approximately 44 out of a total of possibly 61 "residential transitional facilities" operated in Minnesota.

CDPD reports limited information on halfway houses and halfway house clients in the 1979 state plan. Combining data

from Hennepin County's management information system with comparable data on halfway houses in the remainder of the state indicates that the 44 publicly supported programs admitted approximately 2,400 clients in 1977. Approximately three-fourths of halfway house clients were male; about three-fourths were white.

CDPD does not have reliable estimates of utilization rates or program effectiveness. The figures which are available are contradictory and unreliable. The analysis and presentation of data pertaining to halfway houses in the 1979 state plan (pp. 227-231) are so contradictory and confusing that they signal a real problem at CDPD in analyzing and presenting basic information on the state's entire CD program.

b. Analysis

The data necessary to perform even a cursory analysis of the cost, capacity, or effectiveness of halfway houses in Minnesota are absent. The rise of halfway houses has been rapid during the 1970's partly as a consequence of deliberate state policy. CDPD's own priorities suggest that a serious look at halfway house policy and programs is necessary.

3. COUNSELING AND COORDINATION

a. Description of Costs and Services

Part of state grant-in-aid to area boards supports outpatient counseling services, either provided by community mental health centers or purchased by area boards. It also supports the local planning and coordination activities of the chemical

dependency coordinators in each area. In fiscal 1978, as Table 9 at the beginning of this section shows, these activities cost $1,980,946.

DPW knows very little about the volume of service activity financed by these funds or their effectiveness. The Community Programs Division of DPW conducts an annual survey of area boards which collects some information on service activity. Their report covering fiscal 1977 activities presents some statistics on the clientele of mental health center programs. For fiscal 1977, the unduplicated active client caseload was reported as 90,869, of which 32 percent (29,337) were clients of CD programs. This, however, includes clients of detox centers and halfway houses as well as out-patient programs; it is impossible to relate CD program expenditures to service activity more precisely.

A small amount of additional data on the kinds of non-residential CD services provided are available through hand tabulations made by the Community Programs Division for 20 programs reporting for 1977, but the available information does not provide a helpful view of service activity nor does it provide any basis for examining the cost effectiveness of CD counseling services offered through mental health centers.

The fiscal 1978 survey is structured along the same lines as the 1977 survey. Although it has been refined somewhat and should yield better information, it holds no real promise of providing decision makers within DPW or elsewhere with the kind of information which would allow an assessment of program effectiveness or efficiency.

b. Analysis

The potential users within DPW of information on program operations, including top management, should collaborate with the Community Programs Division in order to settle questions about the kind of information needed to support planning and resource allocation decisions of the department and the legislature.

Area board staff have been quite vocal concerning the onerous nature of the reporting requirements they must meet. We are not recommending any increase in their reporting burden. The mechanisms for collecting essential information on costs and program activity are already in place. DPW needs a clear sense of exactly what information is necessary to support agency decision-making. Also, DPW needs to solve the problems of collecting and reporting such data. As matters stand, almost no hard data are available on the out-patient CD services purchased or provided by area mental health centers. Yet, about two million dollars is allocated annually for these services and the local planning and coordination of CD services through state grants-in-aid.

C. AMERICAN INDIAN CHEMICAL DEPENDENCY PROGRAMS

Chemical dependency programs designed to serve Minnesota's American Indians are supported by funds from the same general sources which fund other CD programs, but are controlled somewhat differently.

The Chemical Dependency Program Division includes the position of special assistant for Native American programs and an assistant to this position. By law (M.S. 254A.03 Subd. 2), the

special assistant reports to the Chemical Dependency Program Division director. In practice, the person has functioned with a large amount of autonomy, and American Indian programs have been treated differently than other programs under perview of CDPD. For example, all federal formula funding decisions must be approved by the Citizen's Advisory Council, but in practice, this body has given perfunctory approval to Indian programs recommended by the special assistant and the Native American Advisory Board set up to advise him.

CDPD management has been concerned about the autonomy of the American Indian office, and claims that American Indian staff have resisted CDPD efforts to bring Indian programs into the same planning, research, evaluation, and program monitoring systems which control other CD programs.

1. DESCRIPTION OF COSTS AND SERVICES

Several sources fund chemical dependency programs aimed at serving Minnesota's American Indian population. Table 11 presents information on the approximate level of this support by funding source.

TABLE 11

APPROXIMATE FISCAL YEAR ALLOCATIONS TO AMERICAN INDIAN PROGRAMS BY FUNDING SOURCE

	1977	1978	1979
Federal Formula	$270,000	$ 370,000	$350,000
Governor's Bill	195,000	1,182,000	900,000
Grant-in-aid	*	650,000	650,000
Direct Federal Grants	*	561,000	*
Total	*	$ 2,763,000	*

* Data not available

The following are brief descriptions of activities that were funded by the above sources in 1978.

- Federal formula monies, totaling approximately $370,000, supported counseling, information and referral, client follow-up, community awareness, and public information programs.
- Governor's Bill funds, amounting to $1.2 million, went to build and operate a twenty-eight bed residential treatment center, and approximately $33,000 went to each of six reservations and urban Indian groups to fund education, outreach, community awareness, and prevention programs.
- Across the state, approximately $650,000 of the grants-in-aid went to Indian programs for detox, halfway house, and counseling services.
- According to the CDPD Indian desk, Indian programs received $561,000 through direct federal grants which were neither administered by DPW nor necessarily known to DPW.

Federal and state dollars to American Indian chemical dependency programs in Minnesota totaled $2.8 million in fiscal 1978. Assuming that Minnesota's American Indian population was

44,000 in 1978,* Indian programs were funded at roughly $61 per person (exclusive of local government and private contributions). However, CDPD only controls American Indian funds equivalent to $29 per capita.

The focus of Indian CD programs supported by the Governor's Bill and federal formula dollars is broad, and the activities are diverse and have often related only indirectly to chemical dependency treatment. For example, CD funds have been used to sponsor trips, spiritual ceremonies, sports events, and other activities not closely related to chemical dependency treatment although qualifying, in a sense, as prevention or as an alternative to alcohol or drug abuse.

2. ANALYSIS

A 1978 report of the Senate Counsel was critical of the use of state money for trips, athletic events, and spiritual ceremonies.** DPW responded that it is appropriate for state funded programs to offer such opportunities,*** and cited the following Governor's Bill provision (M.S. 254A.031):

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* Special Assistant for Native American Programs, CDPD, DPW.

** "Report on Selected Chemical Dependency Programs", Senate Counsel, January 10, 1978.

*** "Questions and Answers Arising from the Chemical Dependency Study", memorandum to Terry Montgomery, Governor's Office, from Edward Dirkswager, Jr., Commissioner of DPW, March 23, 1978.

> All programs shall be designed to meet the needs identified by the native American community, and appropriate recognition shall be given to the cultural and social needs of native Americans.

We believe there is a significant difference of opinion among DPW and certain legislators and legislative staff concerning the meaning of this provision.

DPW management needs to clarify the nature of the authority structure within CDPD and the status of the Indian desk. There is nothing in Chapter 254A which supports the degree of autonomy presently characterizing the relationship of the special assistant for Native American programs to the remainder of the Division. We believe the CDPD and DPW should be held responsible for the successes and failures of Indian programs to the same extent they are responsible for other programs.

Data on program activities supported by federal formula and Governor's Bill Indian funds are too fragmentary to permit analysis. Data on program effectiveness (data bearing on the question of whether desirable client outcomes can be attributed to program activity) are absent, although effectiveness studies are not particularly feasible when the intended impact of programs is supposed to be general and long term.

D. STATE HOSPITAL CHEMICAL DEPENDENCY PROGRAMS

The Department of Public Welfare operates nine state hospitals which provide services for the chemically dependent, the mentally ill (MI), and the mentally retarded (MR). State hospital services are normally limited to treatment of MI, MR, and

CD disability related problems. Seven of the nine state hospitals offer chemical dependency programs. While the Mental Health Bureau of DPW is responsible for overall administration of these facilities, each hospital is managed independently by its own chief executive officer.

1. DESCRIPTION OF COSTS AND SERVICES*

In fiscal 1978, approximately $9.6 million was spent on state hospital chemical dependency programs. We estimate the state share of this to be eight million dollars. Current financial reporting does not allow precise computation of the actual costs of operating state hospital CD programs. In fiscal 1978, $3.9 million was budgeted for CD programs, but this amount covered only CD unit staff salaries. All other direct and indirect costs were included in the hospital budget for general operation and maintenance.

Using two methods, we reached similar estimates of the total cost of operating the CD programs. The first estimate is based on the fact that, in fiscal 1977, CD programs accounted for 11 percent of total hospital patient days, accounting for 10 percent of the costs of running state hospitals.** This method yields an estimate of $9.4 million as the cost of CD programs.

The second estimate was based upon cost per diem for operating CD programs. The gross per diem for CD services in

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* For greater detail, see staff paper entitled "Service Assessments". Our review yielded no information on service effectiveness.

** The cost for operating nursing homes was not included in the computation.

fiscal 1977 was estimated by DPW to be $39.50.* DPW also estimated that the gross per diem increased 16 percent between fiscal 1977 and fiscal 1978. Assuming that CD patient days remained constant at 213,000, CD programs would have cost $9.8 million in fiscal 1978.

DPW can predict approximately how much reimbursement it will receive from private payments, federal programs, and county government, and how much of the cost of CD programs it will have to absorb itself. Using DPW data, we estimate that state hospital CD programs require $9.4 million in revenue annually, and that 85 percent of this or $8.0 million will come from state revenue. Table 12 shows our revenue estimates by source.

TABLE 12

SOURCE OF REVENUE FOR STATE HOSPITAL CD PROGRAMS - FY 1978

SOURCE	AMOUNT	
Federal:		$ 102,200
State:		
Primary state subsidy	4,058,000	
Secondary state subsidy	2,060,200	
Debts absorbed by state	1,865,700	
		$ 7,983,900
Private:		1,351,000
	TOTAL:	$ 9,437,100

Data Source: Office of the Commissioner, DPW.

* DPW estimated $41.01 for MI and $46.05 for MR program per diems. DPW also computed disaggregated per diems for CD services for fiscal 1977 as follows:

program and treatment related costs at $21.72;
life support and maintenance costs at $5.65;
general support at $10.10; and
other miscellaneous at $2.04.

Table 13 lists the seven state hospitals which have CD programs and provides a set of descriptive data compiled by DPW. Projections of DPW show a slight increase in CD unit population for the future. The seven state hospitals with CD units provide a variety of services, such as:

emergency detoxification,
outpatient treatment,
primary treatment,
extended care,
family programs,
after care,
adolescent programs,
women's programs, and
American Indian programs.

State hospitals also provide or arrange for a variety of supplemental services for CD patients.

At any given time, 75 percent of the hospital CD population are patients of primary treatment programs. Based on a review of year-end residents of CD units at all state hospitals, 80 percent or more were diagnosed primarily for alcoholism.*

Of the 5,600 CD patients discharged in fiscal 1977, approximately 50 percent returned to their own home, 8 percent went into halfway house programs, 12 percent went to a variety of other arrangements, and the disposition of 31 percent was unknown.

2. ANALYSIS

The amount of money spent on state CD programs as well

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* Patient Oriented Information System, DPW.

TABLE 13

STATE HOSPITAL CD PROGRAM DATA

	ANOKA	BRAINERD	FERGUS FALLS	MOOSE LAKE	ROCH-ESTER	ST. PETER	WILLMAR	TOTAL
Licensed Beds 1978	100	55	179	158	40	58	150	740
Average Client Population 1977	74	41	103	135	30	39	96	571
Utilization Rates 1977	74%	75	58	85	75	67	64	77%
Projected Client Population 1980	70	45	120	160	48	48	100	591
Average Length of Stay (Days) 1977	43	30	46	44	35	43	44	42
Gross Per Diem 1977	$56	44	36	36	39	32	38	$40
Treatment Per Diem as % of Gross Per Diem 1977	59%	58	48	54	47	53	60	55%

Data Sources: Minnesota Department of Public Welfare, Licensing Division.
Minnesota Department of Public Welfare, Commissioner's Office.

as the high degree of concern about use of residential treatment in general would appear to make state hospital programs a good candidate for attention by CDPD as part of its research planning, and evaluation activities.

III. PLANNING, RESEARCH AND EVALUATION RESPONSIBILITIES

Our evaluation of the Chemical Dependency Program Division's performance in planning, research, and evaluation* is based on a review of two general areas of responsibility:

- arranging for essential management information, and
- conducting a program of CD planning, research, and evaluation.

The first part of this chapter examines the management information resources developed by CDPD. Our conclusions are based on the review of data relating to CD programs discussed in the preceding chapter as well as an examination of two specific management information projects carried out by the Division.

The second part of this chapter reviews the planning, research, and evaluation process in the Chemical Dependency Program Division. Based on a review of work carried out by Division staff and contractors, we discuss: topic selection, policy development, selection and performance of contractors, utilization of project results, and other issues on which our conclusions about Division performance are based.

A. MANAGEMENT INFORMATION

Among other things, the Chemical Dependency Program Division is responsible for collecting, maintaining, and reporting

*For greater detail, see staff paper entitled "Planning, Research, and Evaluation Responsibilities".

descriptive, analytical, and evaluative information on chemical dependency programs in Minnesota. The CDPD should be an expert source of information on CD programs around the state if it is to respond to predictable calls for information from DPW management, the legislature, and federal funding authorities.

Part of our evaluation was to examine existing information collected and compiled either by CDPD or by contractors and consultants working for CDPD. Chapter II of this report summarizes the results of this review. Below we present some general conclusions.

There are many gaps and inconsistencies in the basic descriptive data compiled by CDPD. We conclude that CDPD has failed to perform up to a reasonable standard in compiling basic descriptive information on publicly supported CD programs.

The commissioner of DPW is authorized by law to request needed information from publicly supported programs.* Providing certain information is currently a formal requirement for obtaining state money and publicly supported programs must meet a variety of reporting requirements. The only way to assure that essential financial and programmatic information is supplied to CDPD without placing an onerous or unnecessary burden on service providers is to develop a clear sense of what descriptive and analytic information is essential to the administrative and policy decisions of DPW, and then to use existing authority to obtain it.

In the case of detox centers, halfway houses, and non-residential services, we found that reliable descriptive information

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* References to the commissioner's authority appear in DPW Rule 28, M.S. 245.68, and M.S. 245.69.

on costs, service activity, and client characteristics is generally absent. Certain information is available, and, to some extent, our study has made some progress in collecting and organizing information and relating it to policy issues. In the case of Governor's Bill programs, basic data on service activity are available, possibly because a provision of the law setting up the programs specifically call for evaluating Governor's Bill program results.

In the following sections, we review two key efforts of CDPD which have failed: the management information system designed to provide information on detox and halfway house clients, and a treatment program survey carried out by CDPD in order to meet federal planning requirements.

1. MANAGEMENT INFORMATION SYSTEM

Since June of 1974, CDPD has been working to develop a management information system which would meet certain federal reporting requirements and also provide essential information on halfway house and detox service activity. Basically, the task was to set up a system reporting client service at 32 detox centers, 45 halfway houses, and 11 federally funded drug programs, and to collect data from 50 other federal programs for a resource directory.

This project encountered numerous delays, false starts, and failures. There are still no reliable data on halfway houses and detox services. Relatively minor technical problems have not been addressed with any proficiency. The inability of CDPD and DPW to meet the reasonably modest objectives of the management

information system in a straightforward fashion (although some were ultimately met to a limited degree) is, in our view, a significant failure, and symptomatic of managerial and technical weaknesses in the Division.

2. TREATMENT PROGRAM SURVEY

In order to respond to federal reporting requirements and to provide data supporting state-level decision making, CDPD decided to survey all CD programs in early 1978. CDPD received a poor response to its questionnaire. The data produced by this effort are incomplete and unreliable.

According to CDPD, private programs had little incentive to respond to the survey; however, even programs receiving state money failed to respond. Other factors mentioned as contributing to the poor response were inadequate record keeping by individual programs and a lack of commitment to the survey by DPW management.

CDPD's problems in obtaining a good response to its data collection efforts, especially from state supported programs, are difficult to understand. We conclude that the 1978 program survey was not well designed or executed.

B. REVIEW OF CDPD'S PLANNING, RESEARCH, AND EVALUATION PROJECTS

We systematically reviewed the planning, research, and evaluation studies sponsored by CDPD during fiscal years 1977 and 1978. CDPD's planning, research, and evaluation program is carried out directly by Division staff and also by contract with

consultants and research firms.

Through interviews with CDPD staff and an examination of project materials, we investigated the following issues:

- topic selection;
- policy development;
- selection and performance of contractors;
- utilization of project results;
- needs assessment; and
- staffing requirements.

1. TOPIC SELECTION

Selection of planning, research, and evaluation projects has been motivated by several considerations, including:

- federal requirements;
- professional interests; and
- state priorities.

Federal Requirements. Each year CDPD has written a plan acceptable to the federal authorities which approve the allocation of federal formula money. Unfortunately, writing the state plan has been an annual upheaval rather than a well integrated activity of the Division.

CDPD receives nearly two million dollars annually in federal formula funds. Although CDPD has reasonably wide latitude in choosing how to spend these, the CDPD has taken the view that

federal formula funds should not, except with great reluctance, be used to sponsor state mandated research or evaluation efforts. We believe that mandated or not, if planning, research, evaluation, or service delivery projects are matters of high priority, federal monies should be used to accomplish them. Minnesota makes one of the nation's largest commitments to CD programming and ought not to be reluctant to exercise a high degree of control over federal funds for which it qualifies.

Professional Interests. Staff of CDPD are legitimately concerned that Minnesota's effort be respectable in the judgement of professional peers. Several of the Division's projects are either described as experimental or are justified in terms of their significance to a national audience. In our judgement, the Problem Monitoring System (discussed later in this chapter) is an example of a major effort which seems to have more appeal to remote audiences than practical utility for administrative or policy decisions at DPW.

State Priorities. Because of repeated requests by legislators and DPW management, efforts have been made over the last several years to assemble and report basic descriptive information on costs, service activity, and program effectiveness. As this report points out, these efforts have not yet succeeded, although some progress has been made. An evaluation of Governor's Bill programs was mandated by Laws of 1976, Chapter 125, and, as a result, more is known about service activity in this area than in any other.

2. POLICY DEVELOPMENT

Certain topics of high interest which could yield useful research or evaluative information have been ignored. Yet, some topics which have been selected are not clearly related to forseeable policy and program decisions. For example, in 1973 and 1976, legislation was passed which mandated private insurance coverage of first residential and then outpatient CD treatment as a part of the health insurance coverage offered to workers in Minnesota. No research has been undertaken or sponsored by CDPD to assess the consequences. Even though prevention, case-finding, and early intervention have received considerable attention, the CD services uppermost on the minds of local planners and policy makers are residential care in state and private hospitals, free standing programs, and detoxification centers.

We believe that CDPD should focus on studies which illuminate decisions on issues such as: state hospital CD programs, residential treatment in general, detoxification services, and the impact of mandated insurance coverage on residential programs. Although CDPD is active in some of these areas, we base our judgement on consideration of emphasis and degree, and conclude that the primary effort should be:

- to remedy the serious gaps in information on costs and service activity for major state sponsored programs; and
- to relate CDPD's program of research to high priority issues as determined by the legislature and DPW.

3. SELECTION AND PERFORMANCE OF CONTRACTORS

Although it has only been a couple of years since CDPD first let a contract via a totally open competitive process where a request for proposals (RFP) is issued, bidders solicited, proposals evaluated, and price negotiation conducted, the Division now prefers this mechanism and has demonstrated capability in using it. There continue to be instances, however, where RFPs are not used, nor are competitive bids sought by other means.

Our review of the planning, research, and evaluation projects sponsored by CDPD did not reveal a single case of poor performance by contractors in terms of effort. Some reports were late, however, and some products were not as useful as anticipated.

4. UTILIZATION OF PROJECT RESULTS

The most important indication of success in planning, research, and evaluation, in our opinion, is the usefulness of project products. We believe that, for the most part, CDPD has not sponsored useful work, and this is its most serious failure in planning, research, and evaluation.*

The usefulness of projects and their chances for success are often related to their scope. The research, evaluation, and planning program of CDPD is at once ambitious and unsuccessful. We recommend postponing ambitious, difficult projects, whose success is never predictable, until basic descriptive information

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* The staff paper "Planning, Research, and Evaluation Responsibilities" presents a review of each Division project conducted during fiscal 1977 and 1978, along with our judgment concerning the usefulness of these projects.

is available on state CD programs and until policy questions of pressing concern are addressed.

5. NEEDS ASSESSMENT

To qualify for federal formula funds, CDPD is required to assess the extent of alcohol and drug abuse problems as a basis for setting priorities and making resource allocation decisions. Federal requirements aside, sound planning requires that the CDPD examine the location and extent of chemical dependency problems as well as make an assessment of treatment resources to ensure that new or continuing program efforts are appropriate to actual demands and service needs. CDPD has made an effort to accomplish these goals, but the results are unsatisfactory in our opinion. The discussion of treatment resources and needs in the state plan is awkward if not incoherent.

Estimating the incidence or prevalence of alcohol and drug abuse problems in Minnesota is a complex task. If there were a clear methodology of choice, CDPD would undoubtedly use it. CDPD has chosen to sponsor the development of a "Problem Monitoring System" which compiles data on drug and alcohol related phenomena and combines the information into a "Substance Abuse Problem Index". We believe that this index is theoretically and methodologically unsound, and that it diverts attention from more productive kinds of analysis of the very data on which it is based.

The Problem Monitoring System was funded for $63,000 in 1978 and has been funded for an additional $45,000 for 1979, and would annually require additional funds if it were to be implemented in the fashion planned. Since federal formula monies

are intended to support start-up efforts, state funds would probably be required in the future.

6. PLANNING, RESEARCH, AND EVALUATION STAFFING NEEDS

The CDPD needs a staff complement which includes expertise in data collection, management, and analysis. In our judgment, many of the problems described in this chapter result from a shortage of staff skilled in these areas.

Much of CDPD's planning, research, and evaluation program is performed by consultants and contractors; this arrangement requires a staff able to effectively negotiate contracts and monitor the performance of consultants.

CDPD is expected to staff the CD Citizen's Advisory Council which was set up to provide guidance in developing CD policy and approve the allocation of federal formula funds. The Division should provide leadership in its work with the council. For example, it should propose a set of funding priorities for council discussion and approval. At present, the council is approving the allocation of federal formula monies in the absence of priorities and sometimes without sufficient staff work on individual applications.

IV. CONTRACT MONITORING

This chapter presents a summary of findings from our review of the Chemical Dependency Program Division's contract monitoring activities.* CDPD is directly responsible for monitoring programs receiving federal formula and Governor's Bill American Indian funds. CDPD also monitors Governor's Bill grants made to area boards. We reviewed DPW and CDPD contract monitoring policies and procedures, interviewed staff, and conducted a systematic review of contract files. We focused on contracts for fiscal 1976 through 1979.

In fiscal 1978, CDPD awarded 81 federal grants totaling $2.0 million, 7 Governor's Bill American Indian grants totaling $1.1 million, and 24 Governor's Bill grants made to area boards totaling $2.8 million.

We found CDPD's monitoring system to be inadequate in the following areas:

- file maintenance;
- contract language;
- reporting requirements;
- on-site monitoring; and
- financial auditing.

A. CONTRACT FILES

We found the filing system for the contracts administered directly by CDPD to be poorly organized and maintained. CDPD did

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* For more detailed information, see staff paper entitled "Contract Monitoring".

not have accurate lists of all contracts. Furthermore, some individual files could not be located. Files should contain on-site reviews, funding proposals, contracts, program correspondence, and all required reports. However, they frequently did not.

Area board files were in better order. Individual files were easy to locate; we found numerous documents in them, including staff notes and checklists. There was evidence of frequent communication between CDPD and area board staff.

In our opinion, CDPD contract and area board files should include the following:

- contracts,
- required reports,
- on-site monitoring reviews,
- funding and expenditure reports,
- evaluation reports,
- program correspondence, and
- notes from informal visits, telephone conversations, etc.

All documents should be dated as they arrive at CDPD, and each file should be prefaced with a log showing the grant duration, the date reports were received, the date on-site visits were made, and lists of other CDPD grants going to the service provider.

B. CONTRACT LANGUAGE

Clear and specific contract language helps to insure that all parties understand what products are to be delivered and makes it easier for Division staff to monitor projects. The language of the CDPD contracts which we reviewed was often vague.

However, contract language has improved; only 10 percent of the fiscal 1976 contracts had measureable performance objectives, compared to nearly 90 percent in fiscal 1978. Less than 50 percent of all CDPD contracts contained timetables for completing performance objectives. Area board contracts did not show similar improvement over time; less than 25 percent of the contracts in any fiscal year contained measureable objectives. Also, area board contracts did not contain timetables.

CDPD should continue to write measureable performance objectives into all contracts. In our opinion, DPW should develop guidelines for writing performance objectives. When writing requests for proposals, contracts, and plans, CDPD staff, area board staff, and service providers should use DPW guidelines which focus on objectives which are measureable, but allow flexibility in methods.

C. REPORTING REQUIREMENTS

CDPD requires contractors and area boards to furnish various documents. These typically include program plans, contracts, and periodic reports on finances and program activities. The required documents are stipulated in the contract or as a Division policy.

In the past, compliance with these requirements has been poor. During our review of contract files, we found many documents missing. Only 13 percent of CDPD contract files for fiscal 1976 contained all required reports. This improved to 50

percent for fiscal 1978.*

Area boards have also failed to submit some required documents. CDPD requires copies of Governor's Bill contracts between area boards and service providers, but our review turned up only 40 percent of the contracts for any given year. Area boards were somewhat better in submitting program plans; we found that three-fourths of the area boards had program plans on file in CDPD for each fiscal year. CDPD files, though, contained few requests for proposals.

CDPD should enforce its reporting requirements or eliminate them. Current contracts specify the required documentation and reports, and DPW policy now states that continued funding is contingent upon meeting these requirements. Guidelines explaining enforcement have been distributed to area boards. Consideration for future funding should include a program's past compliance with these requirements.

D. ON-SITE MONITORING

CDPD did not have a formal system for on-site monitoring of service providers. During fiscal 1978, on-site activities varied considerably. When visits were made, no standardized forms were used nor did staff receive instructions on how to proceed. There were no records of visits in the central files.

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* It should be noted that just prior to our review of its files, CDPD sent a letter to all vendors whose files were missing reports and requested the submission of such reports.

In the past, CDPD staff have been assigned to monitor contracts but did not receive explanations of their actual responsibilities. There was no staff training in contract management and monitoring.

A formal on-site monitoring program that is linked to contract objectives should be developed. In addition, CDPD staff should receive training on how to conduct on-site monitoring visits. And because area boards are expected to monitor the contract performance of their service providers, CDPD should provide technical assistance to them in this area.

E. FINANCIAL AUDITING

Although DPW has several units with financial auditing responsibilities, none are currently conducting routine financial audits of chemical dependency programs.* In 1978, the Legislative Auditor's Office** examined DPW's financial auditing of grantees and recommended that:

- DPW should develop guidelines defining requirements for documenting and reporting expenditures from grant funds;
- DPW should develop audit guidelines specifying necessary information to determine allowable expenditures and compliance with grant requirements. Grantees who have regular audits by private firms should request that the auditor prepare this supplemental information and report it to DPW;

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* Three audits were done by the Financial Management Office in the past year; two of these resulted from Senate Counsel inquiries while one was at CDPD's request.

** "Audit Report: Department of Public Welfare, years ended June 30, 1975, 1976 and 1977.", Financial Audits Division, Office of the Legislative Auditor, August 29, 1978.

- DPW audit staff should assist grant recipients in establishing adequate financial records and controls and should verify grant compliance for agencies which do not have independent audits; and

- DPW should increase fiscal monitoring of grant programs to verify that all reporting requirements are met before grantees are paid.

F. SUMMARY

The Minnesota Department of Public Welfare and its Chemical Dependency Program Division have not performed well in maintaining a system which monitors the activities of those who receive funds from DPW. Various measures have been taken which should help eliminate some of the deficiencies and CDPD appears to be moving in the right direction. DPW should develop monitoring guidelines and a related training program for both its own staff and those of the area boards. DPW does not have the internal audit staff to perform financial audits on every recipient of state funds, and CD programs have been almost totally ignored. We recommend increased attention to CD programs.

LIST OF STAFF PAPERS

Staff Paper 1: The Chemical Dependency Service System

Staff Paper 2: Service Assessments

Staff Paper 3: Planning, Research, and Evaluation Responsibilities

Staff Paper 4: Contract Monitoring

Staff Paper 5: Area Board Survey