CITIZENS LEAGUE REPORT

NEXT STEPS IN THE EVOLUTION OF

CHEMICAL DEPENDENCY CARE IN MINNESOTA

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The Committee on Chemical Dependency
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Approved by
Citizens League Board of Directors
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PREFACE

Before voting to approve this report, at its meeting on June 13, the Board of Directors gave an intensive review to the findings, conclusions and recommendations brought to it by the study committee.

The Board concurs fully with the report: with the findings, conclusions and recommendations, specifically, in the area of the *Basic System*–the system of identification and referral and the unmet needs and opportunities. In the first area, in particular, the Board believes, the work of the study committee makes a major contribution to the discussion of the chemical dependency program in this community. Never until now, literally, has there been assembled the kind of comprehensive information about the size and shape of the treatment system, that is presented here in this report. It should have, and we are confident it will have, widespread discussion.

We did not have as much time as we would have liked to focus on the area of the *Payment System.* We are deeply concerned about the payment system stemming from the problem in health care. The Citizens League found this to be a serious problem, due in significant part to the sytem of the third-party reimbursement which separates the care and treatment of patients from the responsibility of payment of the costs incurred. The Citizens League concluded that, in various ways, these increases in costs should (indeed, must be) restrained. And the CL has, in some specific cases since 1977, recommended specific actions to accomplish this restraint.

There are important relationships between the cost problem and chemical dependency. The first thing to say, emphatically, is that these programs have saved money, by reducing the doctor and hospital bills formerly incurred by chemically dependent people. The questions remains, however, how much needs to be spent to achieve these savings: the study committee found much uncertainty about the relative effectiveness of the various treatment modes (inpatient and outpatient; hospital-based and non-hospital-based), and significant differences in cost among them. It concluded that, in the absence of any demonstrated differences in program effectiveness the lower cost treatment options should be favored. That leads to the question: how, precisely, would this be accomplished? Further, as this report shows, the treatment system has been expanding rapidly. How close, then, is the community to having enough capacity?

We would have liked for this study to have provided strong recommendations, to deal with these questions. The Board of Directors recognized, however, after some considerable discussion, that this is a very substantial task that will require more time, and more work, from some other committee. We would hope at this point, then, simply to make it clear to the reader that the Citizens League continues to be concerned about the unsolved problem of health care cost containment, and remains committed to making its best effort to help the community address this immensely difficult question in the years ahead.

Citizens League BOARD OF DIRECTORS

June 13, 1980

MAJOR IDEAS IN OUR REPORT

Within the metropolitan area there is a large and growing chemical dependency treatment system that is having a positive effect.

Over a relatively short period of time there has developed a chemical dependency treatment profession that is now geared up to provide initial or *primary* treatment for over 26,000 persons per year. In addition, there has developed an extensive system of *transitional* or post primary care programs, other *extended* or long-term programs, and a large and active participation in Alcoholics Anonymous.

Broad local acceptance of chemical dependency as treatable disease has led to the rapid growth of treatment.

Nearly all of the very large Twin Cities' area employers now have special programs for identifying chemically dependent employees and referring them to treatment. Similarly, school districts, criminal justice agencies, social workers, mental health professionals and others have become increasingly sensitive to alcohol and drug dependency and the value of chemical dependency treatment programs.

Local programs are having a strong, positive impact on most patients as measured by abstinence, and changes in physical, emotional and psychological health. However, there is a lack of good evidence to show how differences in treatment modes, length and expense may affect the likelihood of treatment success.

With the increased community sensitivity to chemical dependency and the expanding quantity of treatments, there has been a marked change in the condition of people coming into treatment.

Current patients receiving treatment tend to be younger, have used alcohol and other drugs harmfully for shorter periods, and are less severely impacted by their chemical use than the typical patient in treatment a few years ago.

Minnesota law requires health insurance policies covering Minnesota residents to provide rather full coverage of chemical dependency treatments. This gives people basically free choice of chemical dependency treatment options with little cost consequences for the user.

The lack of system-wide data as to the size, content, cost, utilization and effectiveness of chemical dependency treatment is a serious problem.

Public monitoring and regulation of chemical dependency treatment is split between the Minnesota Health Department and the Minnesota Department of Public Welfare (MnDPW). Even within the MnDPW the licensing and state hospital program functions are separate from the Chemical Dependency Division.

Chemical dependency treatment funding is an important factor affecting where people are referred for treatment, and what services are provided them. The total cost of providing a client with a treatment program can run anywhere from a few hundred dollars to over $10,000, depending on a variety of factors.

Numerous factors suggest the possibility of an over-supply of treatment facilities relative to need. A surplus supply could result in unnecessary expenditures, and an imbalance in the type and location of programs provided.

People need additional help in deciding when the use of mood-altering chemicals is inappropriate and harmful, and what they should do about such use. Public efforts to facilitate identification and referral have focused at the professional assistance level, rather than helping the public recognize the problem user at an early stage, and determine what can be done to correct the problem.

Treatment interests of the dependent person are best served when the financial barriers to appropriate care are eliminated, but when there is patient participation and a clear incentive to be cost conscious. Treatments should be no longer, more structured, costly or restrictive than necessary for the successful treatment of the dependent person.

While special efforts have been made to seek out chemically dependent women, youth, elderly, members of minorities, and homosexuals, the factors making these groups more difficult to serve remain in tact. Episodic chemical abuse by individuals who may not be chemically dependent represents a problem not well addressed today.

SUMMARY OF RECOMMENDATIONS

The Minnesota Legislature should strengthen the state's planning, monitoring and evaluation of chemical dependency services by consolidating responsibility in a single unit or chemical dependency agency.

The chemical dependency agency should develop projections on the demand for chemical dependency treatment services, evaluate the capacity for the system to meet the demand, and develop plans and proposals for dealing with problems stemming from imbalances in supply and demand.

The chemical dependency community in Minnesota should join together to launch an ongoing program comparable to such groups as the Heart Association or Cancer Society, but aimed at helping the general public clarify appropriate use of mood-altering chemicals, identify harmful chemical use, and secure appropriate help for the problem user.

The Minnesota Legislature should require certain professions and encourage others to receive formal instruction and continuing education on chemical dependency identification and referral.

The state's chemical dependency agency should develop specific proposals as to the form and amount of instruction to be provided such licensed or certified professionals as physicians, pharmacists, nurses, other health care professionals, teachers, counselors and law enforcement officers.

The chemical dependency agency should develop specific legislative proposals to mandate minimum training on chemical dependency identification and referral for all personnel engaged in the sale of alcoholic beverages.

The chemical dependency agency should work with private groups to encourage the provision of special education on chemical dependency identification referral for such nonlicensed groups as the clergy, supervisors, judges and social workers.

The Department of Public Safety should expand the amount of information on the effects of intoxification in the driver's examination handbook and as part of the written driver's examination in the state.

The Minnesota Legislature should charge the chemical dependency agency to develop proposals that encourage the provision of treatment that is no longer, no more or less structured, costly or restrictive than is necessary for the successful treatment of the dependent person.

Governmental agencies, HMO's and private employers should purchase chemical dependency services on a flat fee basis for the entire treatment, whenever possible.

The chemical dependency agency should broadly disseminate information on the availability of chemical dependency treatment programs, including their average cost of treatment.

Chemical dependency treatment centers should voluntarily list their average total treatment cost and make their services available on a fixed-package rate basis.

Corporations, public agencies and others employing professional chemical dependency diagnosis and referral specialists should assign these individuals broad responsibility for arranging referrals to the most appropriate setting, and monitoring the cost effectiveness of programs with clients.

Counties should give high priority to funding chemical dependency programs and program reimbursement for "under-served" populations.

The chemical dependency industry should examine treatneeds by age, sex, race and sexual preference, and then work to voluntarily refocus their attention as needed to better serve the disadvantaged groups.

The Minnesota Legislature should direct the chemical dependency agency to encourage and support the development of programs aimed at assisting individuals with chemical use problems who are not chemically dependent.

During the next decade, both private and public groups concerned with alcohol and other drug problems should give special attention to the prevention of chemical abuse, and the community attitudes that encourage and facilitate inappropriate use.

BACKGROUND

CONCERN ABOUT ALCOHOL AND DRUG ABUSE HAS LED TO THE DEVELOPMENT OF A *MINNESOTA MODEL* OF RESPONSE.

In Minnesota, as nationally, abusive use of alcohol and other mood-altering drugs is a serious problem.

For example, in 1978, 64% of all Minnesota traffic fatalities involved drivers who had been drinking, and 51.9% of the drivers had a blood alcohol content of 0.1% or above, thus exceeding the legal limit for driving. During 1978, 61.1% of the pedestrians killed in Minnesota had been drinking and 40.7% had a blood alcohol content above 0.1%.

A study done for the Minnesota Council on Health found that in 1977 Minnesotans paid, lost or never earned an estimated $1 billion ($250 per capita), due to chemical abuse.[1] The *Draft #2 of the Preliminary Minnesota Health Plan* lists the reduction of chemical abuse as a priority health status goal, noting that 6.6% of Minnesota residents can be identified as having a substance use problem. This is consistent with national figures developed for the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

Applying the national rates to the Twin Cities metropolitan area would produce a figure of approximately 120,000 afflicted people, while the 6.6% estimate would suggest approximately 130,000 people. Per capita alcohol consumption in Minnesota ranks 25th among the fifty states.

The Preliminary Minnesota Health Plan notes that the average white person can expect to die fifteen years after becoming an alcoholic, and the average nonwhite person in nine years. It also notes that alcohol-induced birth defects are estimated at one for every 100 in which mothers had consumed more than one ounce of alcohol daily during pregnancy, and that 71% of the infants born to women who drink heavily have physical and developmental disabilities.[2]

Chemical dependency essentially is a Minnesota concept.

In Minnesota the term chemical dependency is generally used in reference to alcoholism and dependence on other mood-altering chemicals. At the federal level alcoholism is generally separated from *drug abuse,* with separate agencies administering programs in each area. Outside Minnesota the term chemical dependency is not as commonly used.

Use of a single category for alcohol and other drug abuse has a long history in Minnesota with terms such as *inebriety* and *intemperance* used in defining problem behavior from territorial days forward. For example, an 1873 report to the governor and legislature was entitled, *The Duty of the State in the Care and Cure of Inebriates,* and recommended that: "The law should recognize intemperance as a disease and provide other means for its management than fines, stationhouses and jails."[3]

The actual term *chemical dependency* was developed by the Governor's Advisory Committee on Alcohol and Drug Abuse Problems and incorporated in its report to the governor in 1967. It reflected the fact that the use of other mood-altering chemicals was widespread in Minnesota, and that in Minnesota individuals using alcohol and other drugs were receiving treatment in the same program framework.

The *Minnesota Model* for treating chemical dependency evolved from experiences at Willmar State Hospital and the work of members of Alcoholics Anonymous in Minnesota. In 1907 the Minnesota Legislature voted a 2% tax on liquor licenses to build and maintain an institution for chronic alcoholics. Willmar State Hospital was then opened in 1912, and over a period of years developed a multidisciplinary approach to treating persons with alcohol and other drug abuse problems.

Alcoholics Anonymous came to Minnesota at the start of the 1940s, and expanded rapidly. For some time it was assumed that an alcoholic must *bottom out* before his/her situation would be sufficiently desperate to turn to a program of sobriety. However, through experience at Willmar State Hospital and other treatment programs that had developed, it was found that results just as good could be achieved by individuals cajoled into treatment before they had bottomed out. This is described by some AA members as *raising the bottom.*

This process was defined as early intervention, and was refined and promoted by the Johnson Institute to the point where it is now a central part of the Minnesota Model.

Representatives from the treatment industry consistently reported in testimony to our committee that "all, or nearly all," the clients they treat have been pressured into treatment by someone in a position to influence their lives . . . such as a spouse, the family, an employer, or the justice system. The treatment professionals explain that it is the nature of the disease of chemical dependency that the untreated alcoholic or addict will deny that he or she is dependent and resist the notion that treatment is necessary.

Nearly all chemical dependency treatment programs in Minnesota are designed to help the patient or client achieve abstinence from chemical use, and are based on the twelve steps of Alcoholics Anonymous. Primary, or initial, treatment tends to be about four weeks in duration, during which the individual is provided lectures, group counseling and discussion, and individual counseling. Most programs give emphasis to working with the entire family, rather than just with the chemically dependent individual.

Upon release from primary treatment, most clients are encouraged to participate in an aftercare program provided by the treatment center, and become lifetime participants in AA. For those patients who have living conditions that would undermine their recovery, there is an extensive system of facilities called *halfway houses, extended care facilities* or *transitional care facilities* in which several months of additional therapy and a chemically free environment can be provided before the treated patient returns fully to the community. Some long-term programs serve both the primary and transitional care role, and may be licensed as either primary or extended care facility.

Both private and public leadership have helped shape chemical dependency programs in Minnesota. By the late 1940s AA in Minnesota had grown significantly, and a Hennepin County group opened the Pioneer House Treatment Program in October 1948. This was followed in March 1949 by the opening of the Hazelden program at Center City by Saint Paul interests.

Private hospital involvement in the treatment of alcoholics began in the mid-1960s. St. Mary's and Northwestern Hospitals in Minneapolis and St. Luke's in Saint Paul inconspicuously began admitting some patients diagnosed as alcoholic. In 1968 St. Mary's Hospital began the first Minnesota primary treatment center located in a private hospital.

Having had favorable experiences with employees treated at Hazelden and other centers, Minnesota corporations began requesting that employee health insurance coverage include chemical dependency treatment. Such coverage expanded voluntarily during the late 1960s and early 1970s.

On the public side, the Governor established a commission on alcohol problems in 1967, and in 1971 the Legislature established a drug abuse section in the State Planning Agency. These two offices were later merged into the current Chemical Dependency Division of the Department of Public Welfare.

In 1969 the Minnesota Supreme Court ruled in the *Fearon Case* that an individual could not be arrested for public drunkenness and in 1971 the Minnesota Legislature required all area mental health boards to arrange for detoxification services.

With money from a judgment in an unrelated class action suit brought by the attorney general, extended care treatment facilities for chemically dependent persons became eligible for grants of $20,000 each. These funds helped inititate the startup of numerous halfway house programs in Minnesota.

Starting in 1973, the Minnesota Legislature passed several laws requiring health insurance plans to include coverage of chemical dependency treatment. Today, Minnesota law mandates that health insurance policies covering Minnesota residents provide rather full coverage of chemical dependency treatment on both an inpatient and outpatient basis at any licensed primary center (see page 15).

In 1976 the Minnesota Legislature passed what is generally known as the *Governor's Bill* providing for new programs aimed at improving the identification and referral to treatment of individuals with a chemical abuse problem employed by small firms and government or who belong to groups *underserved* by current programs.

Data presented in a Legislative Audit Commission report in 1979 shows that direct state and local public expenditures (excluding federal funding) in Minnesota on chemical dependency was $4.96 per capita in 1977, as compared to a national average of $2.60.

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[1]Carter/Locey and Associates, *The Economic Cost of Chemical Abuse in Minnesota,* The Minnesota Council on Health, Minneapolis, MN, January 1978.

[2]*Preliminary State Health Plan,* State Planning Agency, Saint Paul, MN, January 1980.

[3]Charles M. Hewitt, M.D., *The Duty of the State in the Care and Cure of Inebriates,* Minnesota Health Board, January 1873.

OVERVIEW

I. FINDINGS ABOUT BASIC SYSTEM.

WITHIN THE METROPOLITAN AREA THERE IS A LARGE AND GROWING TREATMENT CAPACITY THAT IS HAVING A POSITIVE IMPACT.

The absence of consistent system-wide licensure, data collection and evaluation has obscured the size, scope and impact of chemical dependency programming.

Our committee found that very little data is now collected on primary or initial chemical dependency treatment. The Department of Public Welfare does collect input data for detoxification centers, programs receiving Governor's Bill funding, and most extended care facilities. However, even in these areas there have been data processing problems and the most current data is for fiscal 1978.

Regulatory authority divided. Over half of the chemical dependency treatments in the metropolitan area are provided at hospital-based programs licensed by the Department of Health. The balance are provided by independent residential facilities, extended care facilities, and outpatient clinics licensed by the Department of Public Welfare. As part of overall hospital monitoring, the Metropolitan Health Board and the Minnesota Health Department receive regular size and utilization figures for the inpatient hospital-based chemical dependency programs. However, even this minimal data is not normally collected for the primary treatment programs licensed by the Department of Welfare.

League overview compiled from many sources. In order for our committee to gain an understanding of the chemical dependency system operating in the Twin Cities, we relied upon a review of national literature, extensive discussion with people operating local programs, and sent our own questionnaire to treatment centers. Fortunately, we received good help in reviewing the available literature. Staff from local programs were most generous in sharing their time and thoughts, and we received a 100% response to our questionnaire.

1979 legislation mandates comprehensive evaluation. The Omnibus Health, Welfare and Corrections Appropriation Act of 1979 directed the Commissioner of Public Welfare to develop and present three options for the evaluation of chemical dependency programs. The Department of Public Welfare was provided $75,000 per year for program evaluation and was directed as follows:

> The program evaluation shall provide for, but need not be limited to, an evaluation of the following factors: (1) comparative unit costs of program components including education, outreach, consultation, early detection, diagnosis and referral, training, treatment and administration; (2) comparative success in reaching goals with respect to number of clients serviced and specific program components; (3) comparative success in the design and implementation of an effective system of program evaluation; and (4) comparative success in outcomes for persons served, especially in the treatment component.

The current year's funding has not yet been spent, and the program evaluation procedures are still in the planning stage. A complicating factor is that the Social Service Block Grant to counties specifies that counties should do their own program evaluation, and the Chemical Dependency Division has not yet gotten the counties to agree to follow a common state format that can be tabulated state-wide. It is also unclear what reporting requirements, if any, the division can enforce on the independent primary treatment centers and the hospital-based programs.

Broad evidence that treatment helps.

During the committee's visits to 15 different treatment facilities, and discussions with staff from many other facilities, the committee was favorably impressed by the breadth of services provided. See Work of the Committee for a list of centers visited and resource persons heard from.

While there is no consensus as to how treatment success should be defined and measured, the results of comprehensive reviews of literature and national follow-up studies clearly indicate that treatment for alcohol and drug abuse has a substantial long-term positive affect in reducing consumption and improving the quality of life, as measured by various criteria. The special report to Congress on alcohol and health in June 1979 by NIAAA found that the

overall success rate, according to many studies, ranges from 30% to 70%, depending upon how broadly success is measured. This is consistent with a study by the Rand Corporation released in January 1980 which found that 46% of a random sample of patients treated in 1973 were in remission at the time of a four-year post treatment interview.[4]

The committee received data taken from follow-up studies of alumni of a number of Twin City area programs showing a much higher success rate than is generally found in the national follow-up studies. While the committee has not attempted to scrutinize the methodology used in these studies, it appears to us that the local programs are having a strong, positive impact on most patients as measured by abstinence, reduced consumption and changes in physical, emotional and psychological health.

Many forms of assistance.

Capacity for 26,000 primary patients per year. Currently primary treatment programs operating within the metropolitan area have a treatment capacity of about 26,000 patients per year ... 14,000 on an inpatient basis and 12,000 on an outpatient basis. Data developed from responses to a Citizens League questionnaire sent to primary centers in the metropolitan area show that during the latest 12 months for which each center has data, about 20,000 persons were actually served. Approximately 73% of these were residents of the metropolitan area, 14.2% outstate Minnesota and 12.8% came from out-of-state. See Table 1.

The current utilization rate is actually higher since the 20,000 figure understates the current rate of treatment by not reflecting that end-of-year rates were higher than the average due to the growth which occurred during the 12-month period. Moreover, inpatient utilization averaged about 90% the past year.

Chemical dependency treatment capacity, particularly for young people, has been expanding rapidly. Questionnaire responses indicate that during the last year at least 119 primary treatment slots were added for young people, producing a total annual added treatment capacity of 1,150.

In addition, there has been a substantial expansion of outpatient treatment utilization due to state action mandating insurance coverage. Depending upon the anniversary date of a given policy, group coverage was not necessarily available until after September 30, 1977, and individual policy coverage was not necessarily mandated until after April 6, 1979.

Of the 20,000 persons in the 12 months covered by our questionnaire, approximately 7,600 were treated at hospital inpatient programs, 4,900 at inpatient residential programs, 3,800 at hospital-based outpatient programs, 2,100 at outpatient programs conducted at independent residential centers, and 1,200 at outpatient clinics. See Table 2.

Service to more than 2,000 extended care patients. At least 26 residential facilities licensed or operating primarily as chemical dependency programs treat over 2,000 patients per year. Resource persons from *transitional* or post primary care programs have indicated that the amount of individual and group therapy provided per client often exceeds the amount provided during primary care, but is spread over a longer period. Other *extended* care or long-term programs function as primary centers, but work with patients requiring more time and assistance.

One thousand separate Alcoholic Anonymous groups. Perhaps the largest source of help for persons with chemical use problems are Alcoholics Anonymous groups, of which there are more than 1,000 separate chapters registered with the Minneapolis and Saint Paul intergroup offices. The director of one of the largest hospital-based treatment programs in the Twin Cities told our committee that he looks at his program as being a prep school for an ongoing lifetime participation in AA. Data from the League's survey shows that more than 85% of the patients

TABLE 1
CLIENT'S PLACE OF RESIDENCE

FACILITY TYPE	METROPOLITAN AREA	OUTSTATE MINNESOTA	OUT-OF-STATE
Overall[1]	73.0%	14.2%	12.8%
Hospital	75.5	15.4	9.1
Independent Residential	63.9	14.3	21.8
Outpatient Clinics	94.1	5.4	0.5

[1] Includes a center in a nursing home, not included in the subgroup categories.

TABLE 2
TREATMENT CAPACITY AND UTILIZATION

FACILITY TYPE	INPATIENT Beds	INPATIENT 12-Month Capacity[1]	INPATIENT Past 12 Months Utilization[1]	OUTPATIENT Slots	OUTPATIENT 12-Month Capacity[1]	OUTPATIENT Past 12 Months Utilization[1]
Overall[2]	**1,258**	**14,353**	**12,768**	**892**	**12,010**	**7,251**
Hospitals	678	8,388	7,641	351	5,719	3,819
Independent Residential	525	5,703	4,900	207	3,343	2,129
Outpatient Clinics	0	0	0	324	2,782	1,203

[1] The 12-month capacity figures reflect current program size and should not be compared to past 12 months utilization figures as many programs expanded in size and/or utilization during the year.

[2] The 33-inmate Atlantis Treatment Program at Stillwater State Prison is, of course, not available to the general public, and was not included in our survey. It does include a center in a nursing home, not included in the subgroup categories.

completing treatment in the Twin Cities are referred to AA as part of their aftercare programming.

Because of AA's anonymity, accurate information as to the number of AA participants in the region isn't available. While impressions of some people involved are that a significant portion of AA members have achieved sobriety without going through a formal treatment program, no one actually knows.

In addition to the help Alcoholics Anonymous provides directly to its recovering membership, Alanon and Alateen provide help for large numbers of persons who are related to alcoholics or other drug users.

Some counseling and instruction at detoxification centers. During fiscal year 1978, there were a total of 29,438 discharges from detoxification centers in the metropolitan area, many of which involved repeaters. The average stay at the centers was 3.2 days per admission.

The primary function of detoxification centers is the safe detoxification of the client, and assessment and referral for treatment of the client when evaluations indicate this is appropriate. Some detoxification programs are located at treatment centers, facilitating the transition from detox to primary treatment. Most of the detoxification center clients, however, are served at free-standing detoxification centers.

The larger detoxification centers provide a counseling and education program that occurs during the latter part of the time spent in the center. In addition to interviews with the counselors, lectures on chemical dependency are presented and films shown.

Treatment levels increased. Much of the growth in chemical dependency treatment is occurring in the expansion, or increased intensity, of chemical dependency service offered in existing programs. For example, several resource persons suggested to our committee that there is a trend in halfway houses to increase the amount of treatment activities programmed for their clients.

Similarly, it appears that a wide range of social service agencies have become increasingly sensitized to chemical dependency problems, and accordingly, work on chemical use problems as part of family counseling, group education, etc.

Other forms of chemical dependency programming. The Governor's Bill programs have stimulated a considerable amount of *low structure* or informal chemical dependency programming outside the primary chemical dependency treatment system. For example, interviews with a random sample of 312 clients who received diagnosis and referral services in Hennepin County under the Governor's Bill program revealed that the great majority were referred to low structure programs.[5] Only 41 or 13.1% were referred to primary inpatient or outpatient treatment and a total of 4.8% actually accepted the referral to primary inpatient treatment, as did 4.5% to primary outpatient programs.

Ninety-one individuals or 29.2% accepted a referral for brief chemical dependency counseling . . . generally by the same agency providing the diagnosis and referral service. Seventy-nine or 25.3% accepted a referral to group counseling, 17.6% accepted a referral to a drug education program, 16.7% accepted a referral to individual chemical dependency counseling, 11.5% accepted a referral to Alanon/Alateen, 10.6% accepted a referral to AA, 4.9% were taken

to a detox center, 3.8% were enrolled in a structured daycare program, 1.3% were hospitalized for acute care.

The treatment system is fed by a diverse referral system.

The Citizens League survey of primary care centers found that only 8.9% of the reported admissions lists the user as the source of referral. Even then the self referral listing does not reflect pressure applied by others to get the user to accept treatment.

The League survey found that 8.5% of the referrals are made by family and relatives, 3.2% by friends, 13.2% by recovering alcoholics, 13.2% by employer or school, 11.7% by criminal justice agencies, 10.5% by public social service agencies, 9.2% by physicians, 6.4% by health service agencies, 5.9% by detox centers, and 9.3% by others.

As can be seen in Table 3, hospitals receive relatively more clients from physicians, detoxification centers, and self referrals. Whereas independent residential programs rely more on criminal justice agencies, recovering alcoholics, and health service agencies.

Outpatient clinic programs receive relatively more of their clients from criminal justice agencies, employers and schools, and self referrals. Bridgeway Nursing Home gets approximately one-half of its patients from physicians' referrals.

State halfway house statistics for fiscal 1978 show 8.6% of their admissions were made by the user, 0.5% by family members or relatives, 0.8% by a friend, 5.8% by a hospital-based primary treatment center, 1.6% by a free-standing primary treatment center, 23.6% by an unspecified residential treatment facility, 16.4% by a detox center, 14.4% through a corrections parole, 4.5% through court probation, 4.2% by county welfare departments, 2.4% by other criminal justice agencies, and 16.2% by others.

State detox admissions records for fiscal 1978 show that 22.7% of the admissions were made by self, 7.4% by family or relative, 7.5% by a friend, 50.1% by a law enforcement agency, 2.4% by a medical service clinic, 1% by AA, NA or Alanon/Alateen, and almost 9% by a wide variety of other sources each accounting for less than one-half of one percent.

Acceptance of chemical dependency as a treatable disease has led to early interventions, special programs for the underserved, and HMO attention to chemical dependency.

The rapid growth of treatment is a result of the public's acceptance of chemical dependency as a treatable disease. Nearly all the very large Twin Cities area employers now have special programs for identifying chemically dependent employees and referring them to treatment. Similarly, school districts in the metropolitan area have become more sensitized to the problem and have developed chemical

TABLE 3
SOURCES OF REFERRAL
TO CHEMICAL DEPENDENCY TREATMENT

TYPE OF REFERRAL	OVERALL[1]	HOSPITALS	INDEPENDENT RESIDENTIAL	OUTPATIENT CLINICS
Recovering Alcoholic	13.2%	10.1%	19.4%	5.7%
Employer or School	13.2	13.9	11.9	14.8
Criminal Justice System	11.7	10.3	13.8	12.2
Public Social Service Agency	10.5	10.5	11.5	6.6
Physician	9.2	13.2	3.5	4.4
Self	8.9	10.4	6.7	10.5
Family	8.5	8.9	7.8	6.1
Health Service Agency	6.4	2.7	10.8	12.4
Detoxification Center	5.9	6.0	6.4	2.3
Friend	3.2	3.7	2.3	4.5
Private Social Service Agency	3.1	3.1	2.4	6.1
Another Treatment Program	2.8	3.7	.9	5.9
Court Commitment	2.1	2.2	1.2	6.0
Clergy	1.2	1.0	1.2	2.4

[1] Includes a center in a nursing home, not included in the subgroup categories.

dependency programs. While these programs are not uniform in intensity or scope, the trend is to upgrade the schools' abilities to deal with the problem.

Interventions occur at an earlier stage. Resource persons with a long history of involvement in the chemical dependency field in Minnesota reported to our committee that the clients they see today are in better shape than those they were working with in previous years. With earlier interventions, clients today are younger and less likely to require treatment more than once.

The Governor's Bill programs represent a concentrated state effort to secure treatment for historically hard-to-reach groups of chemical abusers. Employee assistance programs have been set up for smaller employers and government employees who historically have not had access to this service. In addition, special programs have been set up to work with specific targeted populations including: women, youth, elderly, Indians, Blacks Hispanics, and gays and lesbians.

Special attention has been given to chemical dependency treatment by Health Maintenance Organizations and others. In part this is because of the direct expense of providing chemical dependency treatment, but more importantly it is because untreated chemically dependent persons create disproportionate expenses for health care providers. A current project by the Foundation on Health Care Evaluation is aimed at detecting previously undiagnosed chemically dependent persons as a means of reducing medical problems stemming from chemical abuse.

Basic policy issues have arisen regarding amount of chemical dependency programming, the use of coercion in referrals to treatment, and program effectiveness.

Numerous factors suggest the possibility of an upcoming over-supply of treatment program capacity and facilities relative to need.

- Without any system to monitor size, the treatment industry has become larger than is generally recognized. The amount of treatment capacity disclosed by our questionnaire was, in total, much larger than anyone we talked to had estimated.

  With primary treatment centers alone having an inpatient treatment capacity of 14,000 per year and outpatient capacity of 12,000 per year–approximately 20% of the total estimated number of persons thought to be subject to developing a dependency could be treated annually.

- The system is still growing rapidly. Within the first three months after our questionnaire was sent out, we learned through the news media of three new centers: a 30-bed chemical dependency center approved as part of a hospital application, a separate 48-bed independent residential chemical dependency treatment center, and an outpatient clinic. Oddly enough, all three of these centers are being developed in the same second-ring suburban community.

- The trend toward earlier and earlier interventions has begun to meet opposition from those who maintain that some people are being pressured into treatment who are not actually chemically dependent. This was a principal theme of a major series in the Minneapolis Tribune running the week of May 20, 1979. Once the trend toward earlier intervention reaches a stable point, this source of growth in demand will end.

- The extension of state mandated insurance coverage to outpatient care, the growth of HMO enrollments, and greater experience and familiarity with shorter term inpatient and outpatient programs are reducing the amount of treatment resources needed per treatment. The trend to shorter, less structured treatment appears to be a natural response to the *less impacted* clients now being referred to treatment.

- As chemical dependency treatment becomes more readily available throughout the state and nation, there may be less demand on metropolitan area programs by outsiders. An increased recognition of the importance of family participation in treatment has been cited by some as a reason why treatments can be expected to be provided on a localized basis wherever possible. The current 12.8% proportion of patients from out-of-state, is generally thought to be down from the level of a few years ago.

- The special Minnesota initiative to identify and refer into treatment the underserved groups targeted in the Governor's Bill program will be more difficult to maintain as some counties discontinue the funding under the Social Service Block Grant program.

The use of coercion is a controversial matter. It is generally agreed that people who are chemically dependent inherently deny that they are dependent. Recovering alcoholics (alcoholics who are now abstinent) and chemical dependency professionals consistently pointed out to the committee that as long as the dependent person is still using alcohol or other drugs there is a deep-rooted *denial system* at work.

Because of the dependent person's inability to accept that he or she is dependent, outside pressure is required to

get the user into treatment. Typically, those applying the pressure will find specific instances of where there has been trouble stemming from the abuse. They will note the magnitude of their concern and then inform the user of the steps they feel they must take to protect themselves, if the user is unwilling to accept treatment. At times, this can include termination of employment, a marriage, or other personal relationships.

Because the diagnosis of dependency on alcohol or other drugs is not precise, there is a point at which disagreement sometimes arises as to whether a user is or is not dependent. Those particularly sensitive to the damage done by dependency tend to favor earlier intervention than those who may not understand or accept the denial concept or who may be relatively more sensitive to the user's freedom of choice.

Lack of demonstrated differences in treatment effectiveness raise policy issues. Different resource people noted to our committee that there is a lack of evidence indicating one form of treatment is better than another. One researcher noted that a systematic review of literature conducted by his group shows that studies which identify variables affecting the success of chemical dependency treatment consistently show that a supportive environment is important. However, "beyond that, the data developed in the various studies tended to be inconsistent and often contradictory as to the effect different variables had on the success of treatment."[6]

He suggested that "if we can find what forms of treatment, if any, work best for individuals with given characteristics, this would be a big help. On the other hand, if we establish that the form of treatment does not make a difference in certain cases, then we are in a position to select the least expensive treatment modes."

Opinions vary on how much is known or even knowable about treatment outcomes. There are those who argue that there has been a significant amount of research done on chemical dependency treatment outcomes on a national basis, and that shorter, less structured programs are not shown to be less effective than the more expensive counterparts. Accordingly, they argue that steps should be taken to encourage the provision of treatment in the least confining and least expensive mode, consistent with the special needs of the client.

Others argue that comparative evaluations generally do not reflect differences in the severity of patients' problems in different programs and that until shown differently, common sense suggests that programs utilizing greater resources and longer periods of time can be more effective.

In visiting various treatment centers in the metropolitan area, our committee did not receive any conclusive information to show any one program was more productive or successful with its patients than any other. We did find, however, that many programs make efforts to evaluate the success of their alumni following treatment, and some go to considerable lengths in the process.

The Joint Commission on the Accreditation of Hospitals (JCAH) has required that accredited hospitals develop an evaluation tool. A number of local hospitals have contracted with the Medical Education Research Foundation of St. Paul-Ramsey Hospital for the development of a common evaluation program for each of their chemical dependency units. The Hazelden Foundation has a research arm that is now evaluating the results of its own and other center programs.

The St. Louis Park Medical Center Health Services Research Center currently has underway an extensive research project to evaluate the relative effectiveness of treatment provided at different programs where the Center makes referrals.

One problem complicating the evaluation of chemical dependency treatment stems from some disagreement as to the relative value of such things as abstinence, reduced consumption, and social functioning. A second complicating factor is the lack of a systemized way of measuring the relative difficulty in achieving success among clients with different use patterns and background characteristics. There is also a lack of agreement on how to measure alumni's current status with reasonable validity.

II. CONCLUSIONS ABOUT BASIC SYSTEM.

CHEMICAL DEPENDENCY PROGRAMS IN MINNESOTA NOW DO A GOOD JOB OF PROVIDING TREATMENT FOR THOSE INDIVIDUALS THAT CAN BE READILY IDENTIFIED AND TREATED.

Broad public acceptance in Minnesota of chemical dependency as a treatable disease that is doing considerable harm has produced a high level of support for treatment. By publicly mandating broad treatment coverage for those with health insurance, and providing substantial public funding for the treatment of those without insurance coverage, the state has eliminated much of the financial hardship for individuals in securing treatment.

Efforts have been marshalled to identify dependent people and get them into treatment. Referrals to treatment have been facilitated directly by public and private employee

assistance programs; special identification and referral programs for women, youth and minorities; counseling at detoxification centers; the provision of a treatment alternative for individuals arrested for driving while intoxicated; and by criminal justice diversions and referrals to chemical dependency treatment programs.

Private hospitals and independent treatment groups have responded to the treatment demand by developing programs that are recognized throughout the nation for their quality.

The lack of system-wide data as to the size, content, cost, utilization and effectiveness of chemical dependency treatment is a serious deficiency.

Chemical dependency is too important and has grown too large and expensive not to be given careful scrutiny. Rapidly rising health insurance premiums have become a serious concern of economists, health care planners, employers, and individuals paying part or all of their own premiums.

Chemical dependency has come to be recognized as an important part of the health service costs. The annual cost of chemical dependency treatments for metropolitan area residents is about $20 per capita.

With counties having to raise 50% of the funding under the Social Service Block Grant, and having to weigh the chemical dependency expenditures against other social services, important questions of cost effectiveness will be—and should be—raised. However, better information will be required in order to properly evaluate program expenditures.

Without better information to evaluate the relative effectiveness of different programs with different clients, we will not know the extent to which dependent persons are being pushed into programs that are inappropriate as to focus, length, intensity, and restrictiveness.

Just as it is important not to subject the dependent person to programs which are unnecessarily restrictive or costly, it is also important not to deny the dependent person the form and amount of treatment required, simply because we do not have the capacity to document why a more effective form of treatment is likely to be more effective in a specific situation. However, the burden of proof in the long run, will—and should—rest with the providers having to show those paying the bill that a more expensive treatment is justified.

A continued public and private commitment to providing treatment for chemically dependent individuals is important for both social and economic reasons.

The loss or deterioration of life due to the abuse of mood-altering chemicals by chemically dependent individuals is a major problem that warrants a priority level of response. The close relationship between chemical abuse and social ills such as child beating, rape, incest, assaults, unemployment, accidents, and loss of health can not be ignored. Interventions with dependent individuals by employers, relatives and friends, etc., are appropriate and necessary in some form.

Financial savings incurred from successful chemical dependency treatments clearly exceed the expense of treatments by reducing the extra money that would otherwise be spent, lost or never earned by the dependent persons involved. From health care cost considerations alone, other studies have established that it is less expensive to treat chemical dependency then to bear the additional expenses incurred in treating related medical problems for the dependent individuals, as they abuse alcohol and other mood-altering drugs.

The continued growth of chemical dependency treatment capacity, and the uncertainty as to the size of future demand raises the possibility of a surplus total supply that could result in unnecessary expenditures, and an imbalance in the type and location of programs provided.

An excess capacity in conventional programs serving the general public may accompany an inadequate supply of programs serving the special needs of special groups. Accordingly, treatment capacity should be assessed in terms of the groups to be served.

With the pressure from the community for hospitals to cut back on the number of acute-care beds, there may be pressure from hospitals to transfer acute-care beds to chemical dependency treatment. Resource persons suggest the chemical dependency programs in some area hospitals now are used to subsidize other hospital services and help maintain the viability of entire hospitals.

The use of chemical dependency treatment as a means of adjusting to surplus hospital beds could artifically distort the balance in type and location of chemical dependency services. It also could deter more basic changes as acute hospital capacity is reduced.

A general rule of counseling therapy is that it is inappropriate to place anyone in a program which is longer, more structured, or restrictive then is necessary for the successful treatment of the client. In a situation of surplus program capacity, this principle runs counter to the institutional instinct to perpetuate programs.

It is important to the general public and the suppliers of

chemical dependency services that this issue of supply and demand be addressed early, and that appropriate policy be formulated as part of larger health policy issues.

III. RECOMMENDATIONS ABOUT BASIC SYSTEM.

A. The Minnesota Legislature should strengthen the state's planning, monitoring, and evaluation of chemical dependency services by consolidating responsibility into a single unit or chemical dependency agency.

- The chemical dependency agency should have the authority and responsibility to approve and monitor all chemical dependency treatment programs in the state.
- Data should routinely be collected, analyzed, and disseminated regarding the size, utilization, population served, recidivism and cost of chemical dependency treatment programs at hospitals and independent treatment centers.
- The chemical dependency agency should furnish chemical dependency treatment providers with assistance and funding for the joint, cooperative development of standard criteria for evaluating programs and monitoring the rate of treatment success. The same criteria and evaluation procedures should be utilized for chemical dependency treatment programs in hospitals, independent residential centers, and outpatient clinics.

B. The chemical dependency agency should develop projections on the demand for chemical dependency treatment services, evaluate the capacity of the system to meet the demand, and develop plans and proposals for dealing with problems stemming from imbalances in supply and demand.

C. Counties should proceed slowly in considering any curtailment of chemical dependency services under the Social Service Block Grant funding, until adequate assessments can be made as to the relative costs incurred and benefits derived. Moreover, the need for expanded chemical dependency services for underserved populations should be explored.

"The loss or deterioration of life due to the abuse of mood-altering chemicals by chemically dependent individuals is a major problem that warrants a priority level of response. The close relationship between chemical abuse and social ills such as child beating, rape, incest, assaults, unemployment, accidents, and loss of health can not be ignored."

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[4]The Rand Study was based on a random sample of 922 males who made contact in 1973 with any of eight alcoholism treatment centers funded by NIAAA. While 46% of the patients were classified as being in remission at the time of the four-year follow-up interview, 28% had been abstinent for the previous six months and only 7% remained abstinent for the entire four-year period. Eighteen percent were classified as "drinking without problems." J. Michael Polich, David J. Armor, Harriet B. Braiker, *The Course of Alcoholism: Four Years After Treatment,* The Rand Corporation, Santa Monica, CA, January 1980.

[5] Stephan Mayer, *Client Impact Study of Chemical Dependency Prevention and Early Intervention Programs for Special Populations (Governor's Bill),* Rainbow Research, Minneapolis, MN, March 1979.

[6]J. Paul O'Connor, Director of the Health Service Research Center, St. Louis Park Medical Center, to the Citizens League Committee on Chemical Dependency, May 23, 1979.

IDENTIFICATION AND REFERRAL

I. FINDINGS ABOUT IDENTIFICATION AND REFERRAL.

THE IDENTIFICATION OF A CHEMICAL USE PROBLEM AND THE SEARCH FOR OUTSIDE HELP NORMALLY TAKES PLACE BEFORE A DIAGNOSIS OF CHEMICAL DEPENDENCY IS MADE AND THE DEPENDENT PERSON IS REFERRED TO TREATMENT.

The initial identification of chemical use problems depends upon someone in contact with the user.

Normally, this will not be someone with professional chemical dependency training. Rather, the initial identification tends to be made by those closest to the user . . . the spouse, children, parents, siblings, friends, co-workers, etc. It can also involve individuals related to the user in a somewhat more arms-length relationship such as teachers, counselors, supervisors, police, lawyers, social workers or clergy.

Once **those directly around the user recognize the problem** *then* **the individuals with expertise in the area of chemical dependency diagnosis and referral may be drawn upon for help.** These include employee assistance officers, public and private social service agencies, medical and mental health personnel, school chemical dependency counselors, etc.

There are, of course, cases where the two overlap. For example, a physician may detect physical symptoms before the user, and those around the user, recognize there is a problem.

Public efforts to facilitate identification and referral have focused at the professional assistance level, rather than helping the public to recognize the problem user at an early stage, and determine what can be done to correct the problem.

Educational institutions and the media have given attention to chemical use problems, but the material presented and approaches taken have not been consistently helpful. In fact, there has been some confusion about what information is helpful.

Society is faced with hard decisions regarding the determination of when the use of mood-altering chemicals is inappropriate and harmful, and what people should do about such use. Conflicting messages are sent out directly by product **ads and public service announcements, and** indirectly by the way drinking and drug use are dealt with in music, humor, literature and drama.

Past community standards that defined harmful use simply in terms of the legality of the substance and the age of the user no longer seem adequate. For example, reports from the Surgeon General point out the smoking of tobacco represents the largest single preventable health problem, and others point out that alcoholism is the predominant form of chemical addiction for all age groups.

Considerable emphasis has been given to the importance of early intervention, and the role of families, employers, and others in applying the pressure necessary to cajole a dependent person into treatment. Even when this approach is understood and accepted, uncertainty over when a person is dependent, and how the family can best respond to chemical abuse before the intervention stage is reached, is a serious problem.

Current efforts by the news media to provide self help and referral information to the readers is a positive approach to the problem. This, coupled with attention given prominent people such as Betty Ford and Wilbur Mills who have undergone treatment, has helped bring the problem out in the open, reduced the stigma, and helped dispel treatment fears.

Professional diagnosis and referral programs are not uniform in their availability or content.

Some are more likely to reach problem users than others, and some are more likely to be cost-conscious in their referrals.

The field of professional diagnosis and referral for chemical dependency is relatively new. It has expanded rapidly in the last few years. Professional diagnostic and referral services are now available through public programs provided direct-

ly or indirectly by the counties, Governor's Bill agencies, employee assistance programs, private clinics, social service agencies, chemical dependency treatment centers, health care providers, educational institutions and others.

Public diagnosis and referral services vary from county to county. For example, Washington County has centralized its chemical dependency programs into one agency, Washington County Human Services, Inc, while most other counties have numerous groups involved in publicly funded diagnosis and referral services.

Hennepin County operates its own program—Alcohol Information and Diagnosis (AID)—with services available to all residents regardless of income. Additional diagnosis and referral takes place in a variety of other publicly funded programs in the county. Scott County also operates its own service with a two-person staff, while the other four metropolitan counties arrange for most public funded referral services less directly.

Criminal justice agencies tend to be sensitive to dependency and the potential of treatment to change individual lives. Representatives from law enforcement agencies, court services, and corrections indicated that criminals often view referral to chemical dependency treatment as an alternative to serving time in jail or prison. However, the committee received conflicting testimony as to the effectiveness of diverting individuals from corrections programs into chemical dependency treatment. Some people feel an offender's preoccupation with crime and the justice system gets in the way of earnest recovery when treatment becomes a way of avoiding or reducing time behind bars. Others see the threat of incarceration as an ideal motivator for treating chemical dependency. In either case, treating chemically dependent criminals presents a dual set of behavioral problems that affect treatment.

Probate court commitments represent the most coercive method of getting individuals into chemical dependency treatment. A study done for the Minnesota Supreme Court estimates that in 1977, 1713 individuals were committed for inebriety and another 349 were committed through probate court for a combination of mental illness and inebriety.

These numbers, however, understate the magnitude of treatments resulting from the state's inebriety laws. As one resource person noted, "with the threat of commitment hanging over the individual's head, most individuals can be convinced to go into treatment without actually going through the commitment process."

Under Minnesota law any interested person may file a petition in court to have someone committed. By law, the individual filing the petition must either have a statement by a physician as to the need for treatment, or an explanation why such a statement was not obtainable. In fact, the Supreme Court study found a high percentage of petitions are filed without a physician's statement.

Court commitments are more likely to be used with the socially and economically disadvantaged portions of the population. Court commitments make heavy use of the state hospitals for the referrals.

There is a variance of scope among employee assistance programs. Some focus exclusively on chemical abuse. These are designed to identify a broad range of personal employee problems that may be interfering with their work.

Resource persons appearing before our committee suggested that more employees are likely to utilize the program and then be identified with a chemical use problem, if the employee assistance program takes the multiple service approach. They explain that this is because chemical abusers are often unable to recognize or admit the causal relationship of their use to other problems. It is related problems that often bring the user to employee assistance. However, the broader programs are more expensive, and some legislators feel public funds under the employee assistance portion of the Governor's Bill program should be limited to chemical abuse counseling.

Some employee assistance programs concentrate on working with the individual employees, while others are oriented towards working with supervisors . . . so that supervisors will recognize the employees with chemical use problems.

It appears to be a common practice of companies to take advantage of the enthusiasm and dedication of recovering alcoholics in the development of their employee assistance programs. In many ways, the recovering alcoholic is able to be particularly insightful in identifying problems and defense mechanisms. However, there has been some criticism that the recovering person's own experience can interfere with his objectivity in evaluating referral alternatives.

In some cases, the employer's relationship with an employee can interfere with attempts to utilize outpatient treatment. For example, we were told that some employee assistance officers feel uncomfortable telling an employee that he has a sufficiently serious chemical use problem to warrant his dismissal if he does not receive treatment . . . but the case is not so severe as to require the expense of inpatient treatment. Also, some supervisors object to using employees while they are in outpatient treatment.

Resource persons noted that the physicians often are not

sensitive to early indications of dependency as they might be with more training in the area. Little time is now spent at most medical schools on problems of chemical dependency. However, physicians and the medical community are becoming increasingly aware of the importance of identifying chemical dependency at an early stage and arranging treatment.

The Minnesota Medical Society has been active in working with the membership on chemical dependency problems for a number of years. This has taken the form of organizing a pool of speakers on the topic, generating written materials, developing a "war kit" of materials in a packet for the use of individual physicians, urging physicians to be cautious in prescribing chemicals for patients, and by pushing for improved physician education in the area of chemical dependency at the University of Minnesota Medical School.

Leaders in the effort note that physicians, as a group, still have a long way to go in their handling of chemical dependency.

Once physicians identify chemical use problems, they are more likely to refer patients for treatment in hospitals. This probably reflects the familiarity and loyalty to specific hospitals, easier contact with the patient during treatment, and related medical problems.

Over the years, there has been a degree of disagreement between people working with mental health and chemical dependency. Resource persons indicated that mental health professionals tend to see chemical abuse as a result of underlying psychological problems, while chemical dependency professionals tend to see the chemical abuse as primary.

It appears that as the chemical dependency treatment industry has matured, mainstream psychological therapy techniques have been increasingly employed. It also appears that mental health professionals are increasingly sensitive to the chemical use side of the patient's problems, and are more likely to work on the problem directly and/or refer clients directly to chemical dependency treatment programs. The greatest areas of current controversy tend to be over the handling of juveniles with behavioral problems involving chemical abuse.

The role of the professional referral agent in managing the use of the chemical dependency treatment system raises important policy issues.

For example, what, if any, responsibility does the referral professional have to consider the relative expense of treatment options, if treatment is covered by third-party payments? One view expressed to our committee by the head of one referral program was that it would be professionally inappropriate to consider cost where there is full third-party reimbursement. This contrasts to the heavy community and governmental pressure placed upon the general medical community to become more sensitive to cost considerations.

Another policy question concerns the role of the referral professional, once the user begins treatment. There appears to be less follow-up by the referring professional in most cases than would be the case in a typical medical referral.

One administrator of a hospital-based chemical dependency program noted to our committee that a physician will be asked to move a patient to another hospital, if the physician wants to follow the patient's care on a day-to-day basis. Others feel that the referral agent has an important role in monitoring a patient's treatment progress, and making suggested changes in care. The St. Louis Park Medical Center has gone so far as to instigate an extensive five-year study to monitor the impact different treatment programs have on clients referred by the clinic.

III. CONCLUSIONS ABOUT IDENTIFICATION AND REFERRAL.

THE IDENTIFICATION OF PEOPLE DEPENDENT UPON ALCOHOL AND OTHER MOOD-ALTERING DRUGS, AND THEIR REFERRAL TO APPROPRIATE TREATMENT PROGRAMS IS THE CORNERSTONE IN BUILDING A SUCCESSFUL RESPONSE TO CHEMICAL DEPENDENCY.

A fully successful program of identification and referral will require a better informed general public, better use of special contact points, and improved professional referrals.

It is very important that the general public be better informed as to the nature of harmful chemical use, how it can best be identified, and how to secure help.

The lay public should be assisted in making better decisions as to what is appropriate and inappropriate use of mood-altering chemicals. While it may not be possible—or desirable—to establish a uniform set of standards, public programs and the media can play an important role in stimulating thought and debate over what constitutes appropriate and inappropriate use.

New programs need to be developed to help the lay public identify chemical use problems early, and where people can turn for referral or other program assistance. At minimum, a well publicized central referral source should be available for people to turn to for impartial information.

Special emphasis should be given to providing additional information and training about chemical abuse, the identification of dependency and sources of referral to those groups having a special opportunity to identify and assist people with chemical use problems.

Current programs to educate and sensitize teachers, health care professionals, employers, supervisors, clergy, social workers, attorneys, and criminal justice personnel about chemical dependency should be maintained and strengthened. Other groups with a special opportunity to help should be identified and programs should be developed to facilitate their sensitivity and assistance with the problem.

Referral professionals should be assigned a broad role in arranging referrals to the most appropriate setting and monitoring costs and effectiveness of programs with clients.

Professional referral personnel currently play a significant role in determining who gets treatment, treatment program content, cost, and potential treatment success. Without reducing the emphasis on arranging for help through intervention and diagnostic services, identification and referral professionals should assume responsibility for relating their decisions to program costs and effectiveness with clients.

III. RECOMMENDATIONS ABOUT IDENTIFICATION AND REFERRAL.

A. The chemical dependency community in Minnesota should join together to launch an ongoing program comparable to such groups as the Heart Association or Cancer Society, but aimed at helping the general public clarify appropriate use of mood-altering chemicals, identify harmful chemical use, and secure appropriate help for the problem user.

- The program should include a toll-free telephone answering service to provide information on chemical dependency and the availability of referral services.

- The program should develop and disseminate information on the identification and referral of individuals with a chemical use problem.

- The cooperation of the liquor and pharmaceutical industries should be sought in the development and distribution of appropriate information as to what can be done about chemical use problems.

- The program should encourage bars and restaurants serving alcoholic beverages to furnish customers with information relating blood alcohol content to the amount of consumption, and concerning the 0.1% limit for drivers.

- The program should promote greater public awareness and concern over what is and is not appropriate chemical use, and how non-abusers often reinforce or enable abusive use of chemicals by others.

B. The Minnesota Legislature should review the 0.1% blood alcohol content limit for drivers in the light of the state's own statistics and the experience of other states and countries with different limits. The limits set, at whatever level, should be vigorously enforced by law enforcement agencies and public prosecutors throughout the state, as a means of securing help for the abuser.

C. The Department of Public Safety should expand the amount of information on the effects of intoxification in the driver's examination handbook and as part of the written driver's examination in the state.

D. The Minnesota Legislature should require certain professions and encourage others to receive formal instruction and continuing education on chemical dependency identification and referral.

- The state's chemical dependency agency should develop specific proposals as to the form and amount of instruction to be provided such licensed or credentialed professions as physicians, pharmacists, nurses, other health care professionals, teachers, counselors, and law enforcement officers.

- The chemical dependency agency should develop specific legislative proposals to mandate minimum training on chemical dependency identification and referral for all personnel engaged in the sale of alcoholic beverages.

- The chemical dependency agency should work with private groups to encourage the provision of special education on chemical dependency identification referral for such nonlicensed groups as the clergy, supervisors, judges and social workers.

SYSTEM OF PAYMENT

I. FINDINGS ABOUT PAYMENT SYSTEM.

The funding of chemical dependency treatment is closely tied to the larger issue of health care costs and inflation in America. The recent Citizens League report, *More Care About the Cost in Hospitals,* reflected the broad community concern about rapidly increasing health care expenditures in general, and hospitals in particular.

The study noted that with the expansion of third-party payments for hospital expenditures, health care costs in recent years have been rising at a rate half again higher than the cost of living in general . . . from less than 5% gross national product in 1950 to 9% by 1978.

Local attention to health care costs have focused on the region's high utilization of hospitals and hospital beds, the effects of third-party reimbursement provisions, and the growing utilization of health maintenance organizations. It is in this broader setting of health care cost considerations that chemical dependency funding must be considered.

Chemical dependency treatment funding is an important factor affecting where people are referred to for treatment, and what services are provided them.

Chemical dependency referral professionals appearing before our committee indicated that they have found the cost of providing a client with a treatment program can run anywhere from a few hundred dollars to over $10,000, depending on a variety of factors. These include direct program variables such as length, location, intensity and resources used; and indirect factors such as the age, health and home environment of the patient served.

The wide range of cost was confirmed by treatment directors responding to a Citizens League questionnaire sent to all *primary* treatment centers licensed by the state and serving the seven-county metropolitan area. The average total estimated cost of treatment reported in the questionnaires ran from $190 at an outpatient clinic primarily serving persons arrested for driving while intoxicated to a total of $10,200 at an inpatient program for adolescents.

Questionnaire responses for programs primarily serving adults show an average total estimated treatment cost of $2,555 at hospital-based inpatient programs, $1,914 at independent residential inpatient programs, $713 at hospital-based outpatient programs, $732 at independent residential outpatient programs, and $548 for programs at outpatient clinics. Programs primarily serving juveniles tend to be longer and more expensive with the average costs running $3,875 at hospital-based inpatient programs, $10,200 at the Jamestown independent residential inpatient program, and $2,037 at outpatient clinics. See Table 4.

In addition there are other costs of inpatient treatment programs which are not reflected in the direct payment for the treatment. These costs are incurred by employers who pay sick pay and disability while employees are receiving treatment, and who also must find and train others—possibly less qualified—to perform the employees' work during inpatient treatment. It is possible that these additional costs could be equal to or greater than the actual direct cost of inpatient treatment itself.

Most private insurance coverage provides free choice of treatment for chemical dependency with little cost consequence for the user.

Chemical dependency treatment coverage is mandated under Minnesota group insurance law for individuals with private health insurance . . . including inpatient and outpatient treatment for all licensed care centers. Regardless of the level of coverage for other programs, insurers must provide a minimum of 28 days inpatient coverage at hospitals or other residential centers, and up to 130 hours of outpatient treatment for each 12-month policy year.

Additionally, chemical dependency coverage must be at least 20% of the total inpatient coverage allowed. Therefore, a policy providing more than 140 days inpatient coverage would provide more than the 28-day minimum.

An exception to this general coverage mandate are federal employees, whose coverage is not subject to Minnesota regulations. Additionally, some insurance companies are challenging in court Minnesota's power to regulate contracts covering Minnesota employees, where the contract is

TABLE 4
TOTAL TREATMENT EXPENDITURE
AT PRIMARY CENTERS

	PATIENTS TREATED	AVERAGE COST ADULT PROGRAMS	AVERAGE COST ADOLESCENT PROGRAMS	TOTAL COST
Overall[1]	**20,019**	**$1,837**	**$3,699**	**$37,346,234**
INPATIENT				
Hospitals	7,641	$2,555	$3,875	$20,791,161
Independent Residential	4,900	1,914	10,200	10,206,700
OUTPATIENT				
Hospitals	3,819	713	650	2,707,671
Independent Residential	2,129	732		1,558,428
Outpatient Clinics	1,203	548	1,989	833,679

[1] Includes a center in a nursing home, not included in the subgroup categories.

issued to companies with headquarters in other states.

Chemical dependency coverage is also limited by policy provisions relating to deductibles, limits on room rates payable, co-payment features, etc. However, referral sources for most Minnesota residents with private health insurance coverage are able to select freely among the various primary chemical dependency treatment programs available, without having any significant financial cost to the client.

Employers self-insuring their employees, or given insurance rates based on the company's own pay-out experience, are directly affected by treatment costs.

For this reason some corporations have given an element of responsibility for controlling benefit costs to the people operating their employees' assistance programs. However, this is the exception rather than the rule.

Most health care expenditure decisions are made independently by physicians and patients without an opportunity for the employer to be involved in the decision. The exception of an employee assistance program for chemical dependency indentification and referral appears, either not to be generally recognized by the employers, or not felt to be appropriate or sufficiently important to take an initiative in the area.

Health Maintenance Organizations provide an alternative in which patients trade the choice of treatment providers for increased coverage and/or lower costs. Under conventional insurance, the policyholder has the free choice as to who will provide his health care treatment services. However, with Health Maintenance Organization (HMO) coverage the patient must use the HMO to provide her or her service, or pay all or part of the service charge directly without reimbursement.

Accordingly, with the HMO the decision as to what form of treatment will be used is made by the party (HMO or consumer) making the payment. The HMO has an incentive to arrange the treatment in the least expensive form that it feels will do the job. If the insured party is unwilling to accept the treatment arranged by the HMO, he/she must then bear part or all of the treatment cost.

This is both the strength and weakness of the HMO approach. Proponents argue there is a wholesome incentive to get and keep patients well at the lowest cost. Opponents argue that there is a direct conflict of interest in which the provider's interest in holding down costs can override the provision of care in the highest quality form.

Individuals without private insurance coverage do not have a free choice of treatment programs without a cost consequence to them. Without private insurance individuals must either pay for chemical dependency treatment directly, secure care on a gratis basis by the treatment center, or avail themself to publicly funded treatment.

Public funding limits treatment choices in a variety of ways depending upon the specific program.

Groups covered by public medical assistance programs generally must receive their treatment in Joint Commission on Accreditation of Hospitals (JCAH) approved facilities. Even then, coverage will only be provided, if less than 50% of the patients at a center are there for mental health or

chemical dependency treatments. In effect, for an individual who qualifies for one of the federal government Title XIX programs for the elderly or youth, or state general assistance for medical care to have a chemical dependency treatment program paid for through the program, the treatment must be provided at hospitals or nursing homes approved by JCAH. In fact, it has only been in recent months that hospitals could get Medicare/Medicaid reimbursement for outpatient programs. Prior to that, only hospital-based inpatient programs qualified.

One argument given for restricting chemical dependency treatment to JCAH general care facilities under the public medical assistance programs is that it would cost more to open the coverage to programs at non-JCAH approved, free standing facilities. While the cost per treatment is less outside the hospital setting, the case is made that the non-hospital-based programs would attract additional patients raising the total funding costs.

Chemical dependency treatment provided at state hospitals is largely funded by the state. The state hospitals charge $58.25 per day for chemical dependency treatments, if the patient is able to pay the fee personally. However, generally patients at the state hospitals are unable to pay their own treatment charges, and the county from which the patient is referred is charged the minimal rate of $10 per month, with the balance made up from state appropriations. This arrangement gives the counties a strong incentive to utilize the state hospital system for the chemical dependency treatments they secure for their residents.

Other chemical dependency treatments are also provided with direct government funding. The federal government provides service directly at the Veterans' Administration Hospital, and through the purchase of specific slots at treatment programs by the National Institute on Drug Abuse. In addition, counties use a combination of federal, state and local funds to provide or purchase treatment services for a variety of clients without other access to treatment funding.

Relatively heavy reliance on local funding. Information gathered for the legislative auditor's report showed that in fiscal 1977 Minnesota received only 75 cents per capita in federal funds in chemical dependency as compared to the national average of $1.25. State expenditures were $3.37 as compared to a national average of $2.32. However, the biggest difference in expenditure patterns is the $1.59 expenditure of local funds in Minnesota as compared to a national average of only 28 cents. The local funding comes from general funds that are raised principally from property taxes.

Financial incentives appear to be reflected in Twin Cities treatment patterns.

As can be seen in Tables 5 and 6, HMO funding accounts for only 1.8% of the patients at hospital inpatient programs and 4.9% of inpatients at independent residential facilities. On the other hand, HMO's provide 7.8% of the hospital outpatient clients, 11.5% of the independent residential outpatient clients, and 23.2% of the clients at outpatient clinics.

Similarly, 2.8% of the patients at hospital inpatient programs pay their own bill . . . as compared to 26.4% of those at independent residential centers, 9.2% at hospital outpatient programs, 12% at independent residential outpatient programs, and 29.3% at outpatient clinics.

Using the same questionnaire data we can examine a breakdown of patient treatments by source of their treatment funding. Of all HMO funded primary treatments, 36.7% are provided on an inpatient basis as compared to 72.0% of individuals covered with conventional insurance,

TABLE 5
INPATIENT TREATMENT OF PATIENTS
BY SOURCE OF FUNDING

	HOSPITAL INPATIENT	NURSING HOME INPATIENT	INDEPENDENT RESIDENTIAL	TOTAL INPATIENT
HMO	1.8%	0%	4.9%	2.8%
Other Insurance	56.2	2.0	58.4	56.1
Medicare/Medicaid	10.6	85.0	0	8.2
Other Public	28.7	5.0	10.3	22.2
Self Payment	2.8	8.0	26.4	10.7
TOTAL	**100.1%**	**100.0%**	**100.0%**	**100.0%**

TABLE 6
OUTPATIENT TREATMENT OF PATIENTS
BY SOURCE OF FUNDING

	HOSPITAL OUTPATIENT	NURSING HOMES OUTPATIENT	INDEPENDENT RESIDENTIAL OUTPATIENT	OUTPATIENT CLINICS	TOTAL OUTPATIENT
HMO	7.8%	0%	11.5%	23.2%	12.0%
Other Insurance	56.5	0	74.1	40.1	54.9
Medicare/Medicaid	7.1	0	0	.5	4.3
Other Public	19.4	87.5	2.4	7.0	14.3
Self Payment	9.2	12.5	12.0	29.3	14.5
TOTAL	**100.0%**	**100.0%**	**100.0%**	**100.1%**	**100.0%**

82.7% of those covered by Medicare or Medicaid, and 80.1% of the treatments funded through other public programs. Sixty-five percent of the treatments involving self payment occurred on an inpatient basis. However, if the Hazelden Treatment Center, with 60% of its patients coming from out-of-state, is not included in the data, only 35.4% of the self payments went to inpatient treatment and 64.6% went to outpatient treatment.

While there are certainly other factors involved, it appears that financial incentives and requirements effect the very substantial differences in use patterns shown in Table 7.

The fiscal incentive to hold down treatment expenses when funded by property tax revenues can be seen by comparing the services provided directly by Hennepin County and other treatment centers in Appendix A, Table I. Hennepin County's inpatient program runs 21 days as compared to a regional average of 32.7 days. It also appears to be reflected in Hennepin County's provision of slightly over twice as many treatment slots on an outpatient basis as on an inpatient basis.

II. CONCLUSIONS ABOUT PAYMENT SYSTEM.

THE FUNDING OF CHEMICAL DEPENDENCY TREATMENT SHOULD SERVE THE TREATMENT GOAL OF PROVIDING CARE THAT IS NO LONGER, MORE STRUCTURED, COSTLY OR RESTRICTIVE THAN IS NECESSARY FOR THE SUCCESSFUL TREATMENT OF THE DEPENDENT PERSON.

The greatest cost to the community associated with chemical dependency is not the cost of treatment, but rather the enormous human and economic costs incurred by dependent persons as a result of their use of mood-altering chemicals. This does not, however, diminish the need to be

TABLE 7
DISTRIBUTION OF PATIENTS BY SOURCE OF FUNDING

	HMO	OTHER INSURANCE	MEDICARE/ MEDICAID	OTHER PUBLIC	SELF PAYMENT	TOTAL
INPATIENT	**36.7%**	**72.0%**	**82.7%**	**80.1%**	**65.0%**	**63.8%**
Hospitals	15.3	47.1	70.3	67.5	11.0	38.2
Nursing Homes	0	<.1	12.4	0.2	0.7	1.1
Independent Residential	21.4	24.9	0	12.4	53.3	24.5
OUTPATIENT	**63.3**	**28.0**	**17.3**	**19.9**	**35.0**	**36.2**
Hospitals	24.0	16.9	16.8	15.7	13.0	19.1
Nursing Homes	0	0	0	1.2	.3	.5
Independent Residential	9.9	6.2	0	.6	4.7	10.7
Outpatient Clinics	29.4	4.9	.5	2.4	17.0	6.0
TOTAL	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

conscious of the cost and relative cost effectiveness of chemical dependency treatment options. In the absence of any demonstrated differences in the likely program effectiveness, lower cost treatment options should be favored.

Treatment interests of the client are best served when the financial barriers to appropriate care are eliminated, but where there is a clear incentive to be cost conscious.

The provision of treatment with no financial cost or sacrifice to the patient or the patient's family may reduce the prognosis for a successful treatment. Just as treatment centers find it necessary and appropriate not to tell charity cases that their care is provided on a gratis basis, it is important for individuals covered by third-party payment mechanisms to have some degree of financial participation in their treatment.

Treatment providers should be encouraged to improve their cost effectiveness.

The current financial incentives for chemical dependency treatment centers do not necessarily favor reducing treatment length or cost. In fact, legislatively-mandated minimum insurance coverage provides a financial incentive to structure programs around the minimum third-party coverage required.

For example, family care and after care programs are heavily subsidized or fully funded through the rate structure established for the portion of the program mandated by law. While the provision of family care and after care programs is probably cost effective use of community resources, their funding points out relative lack of constraint on expenditures covered by the mandate.

Public programs which pay for chemical dependency treatment only when it is provided at JCAH accredited hospital and nursing home programs artificially raises the cost per treatment and denies users access to some independent residential and outpatient treatment options.

The committee feels that it is false economy to restrict public medical assistance programs for chemical dependency to JCAH accredited general health care facilities. To the degree that the restriction does result in fewer people receiving chemical dependency treatment, the program is particularly wasteful of public funds, due to the extra medical and social costs associated with untreated chemical dependent individuals.

III. RECOMMENDATIONS ABOUT PAYMENT SYSTEM.

A. The Minnesota Legislature should charge the chemical dependency agency to develop proposals that encourage the provision of chemical dependency treatment that is no longer, no more or less structured, costly or restrictive than is necessary for the successful treatment of the dependent person.

- A study should be commissioned to determine the appropriateness of current minimum treatment coverage required by health insurance companies under Minnesota law, and recommend possible changes to the Legislature. The study should consider such items as the effect of treatment length on treatment success, the relative cost and effectiveness of inpatient and outpatient treatments, the relative cost and effectiveness of hospital and free standing centers, and how incentives can best be developed to encourage cost effectiveness. It should specifically include consideration of how co-insurance may affect treatment choices and patient motivation.

- The chemical dependency agency should broadly disseminate information on the availability of chemical dependency treatment programs, including their average cost of a course of treatment.

B. Chemical dependency treatment centers should voluntarily list their average total treatment cost and make their services available on a fixed-package rate basis.

Governmental agencies, HMO's and private employers should purchase chemical dependency services on a flat fee basis for the entire treatment, whenever possible.

C. Third-party payers and employer groups should be encouraged to establish utilization review programs in conjunction with treatment programs. Utilization review objectives would be to determine whether the appropriate type of program and length of treatment was provided. Utilization review should establish areas of inappropriate service and focus on correcting or eliminating them.

D. Corporation, public agencies and others employing professional chemical dependency diagnosis and referral specialists should assign these individuals broad responsibility for arranging referrals to the most appropriate setting, and monitoring the cost effectiveness of programs with clients.

The responsibilities of employee assistance officers–who provide chemical dependency treatment counseling to employees and their families–should be broadened so that these officers have a clear mandate from top management to include the element of cost of treatment as a factor in making referrals. These officers should be specifically instructed to keep in mind the different costs of (a) outpatient, (b) inpatient residential, and (c) inpatient hospital treatment. Management should secure from its insurers the

statistical analyses necessary to indicate the amounts being spent for chemical dependency and other major categories of medical and hospital care.

The employee assistance officers should be instructed to recommend treatments that are no longer in time and no more restrictive or costly than is necessary for a successful result; recognizing that in some cases (especially where family and other social support systems are lacking, or where medical complications are present) inpatient treatment will be clearly indicated.

Where it is not, the patient and/or family should retain the option to select the more expensive treatment mode. At the same time, however, employers may then wish to provide less-than-full salary reimbursement for time off during treatment, reflecting the fact that the employee has chosen an inpatient treatment longer in duration or more expensive than the assistance officer felt was appropriate.

E. The Minnesota Legislature should charge the state's chemical dependency agency to study the financial and service implications of continuing to restrict GAMC reimbursements to JCAH accredited facilities. Serious consideration should be given to providing general assistance for medical care reimbursements for chemical dependency treatments provided at licensed primary and extended care facilities, and providing similar coverage for patients eligible for federal Title XIX funding through changes in federal guidelines or supplemental state grants.

HYPOTHEDICAL CHEMICAL DEPENDENCY TREATMENT CENTER
100 North Main Street
Twin Cities, MN 55199

STATEMENT

John P. Doe, Sr.
503 East Lake Road
Twin Cities, MN 55119

June 13, 1980

FOR TREATMENT May 13, 1980 to June 13, 1980

Room Charge for 31 days @ $76.00		$2,356.00
Miscellaneous Charges		221.95
	Admit Physical	$50.00
	Admit Lab	18.00
	Tine Test	2.00
	Withdrawal Observation	11.50
	Psychological Evaluation	70.00
	Doctor's Consult	9.00
	Prescription #2769	7.95
	X-ray	28.50
	Upper Respiratory Infection Medicine	25.00
TOTAL		$2,577.95

(Make Check Payable to HCDTC)

UNMET NEEDS AND OPPORTUNITIES

I. FINDINGS ABOUT UNMET NEEDS AND OPPORTUNITIES.

CURRENTLY, MANY PEOPLE WHO ARE CHEMICALLY DEPENDENT CAN NOT BE READILY IDENTIFIED, AND, OF THOSE IDENTIFIED, MANY ARE UNLIKELY TO BE PRESSURED INTO TREATMENT BY CARING FRIENDS.

As noted earlier, most chemical dependency treatments come about only after an element of cajoling or outright coercion has been applied by people with an influence on the dependent individual. The degree of effectiveness others have in encouraging treatment depends largely on the relationship of the others to the dependent person.

Employers often are more effective than family. Family may be more effective than friends. Acting collectively, the influence is magnified.

For some dependent persons there is no one who is able or willing to point out the problem, and facilitate a referral to treatment. In this situation, the difficulty in getting people into treatment stems from a lack of sufficient motivating factors to which the system is attuned.

Another obstacle to treatment centers around the expressed difficulty in locating treatment programs that are structured to the need of specific clients. Some people believe that treatment provided at most treatment centers in the area is designed for employed, white, middle class males, and does not work as effectively for other groups.

For a variety of reasons, the *under-served* populations identified in the Governor's Bill program frequently remain under served.

While special efforts have been made to seek out and assist chemically dependent women, youth, elderly, members of racial minorities, and homosexuals, the factors making these groups more difficult to serve remain intact.

It appears that maintaining special programs may be more difficult in the future, as only 34 counties have, at the writing of this report, indicated that they intend to continue services started under the Governor's Bill program, while 25 indicate their plan to drop the Governor's Bill programs, and 28 remain undecided.

Women are less likely to be identified and referred to treatment than men.

The questionnaire data from the primary centers show that only 28.0% of the clients served in the past year were females. See Table 8. It is unclear to what degree this reflects a lower rate of consumption and abuse by women, and to what degree it reflects a smaller portion of those in need receiving treatment.

Resource persons appearing before our committee suggested several reasons why women with chemical use problems are less likely to be identified and referred to treatment than men are:

"Women are more likely to hide their use, due to a greater stigma attached to a woman being inebriated.

"It is easier for an unemployed housewife to use a chemical in an unobserved manner during the day.

TABLE 8
SEX OF CLIENTS
IN CHEMICAL DEPENDENCY TREATMENT

FACILITY TYPE	MALES	FEMALES
Overall[1]	**72.0%**	**28.0%**
INPATIENT		
Hospitals	70.6	29.4
Independent Residential	71.4	28.6
OUTPATIENT		
Hospitals	81.4	18.6
Independent Residential	68.0	32.0
Outpatient Clinics	65.0	35.0

[1] Includes a center in a nursing home, not included in the subgroup categories.

"Females tend to become chronic users in a shorter period of time than males.

"Family members and employers may find it harder to admit that a female abuser has a use problem.

"Women are more likely to obtain and use prescription drugs than men.

"Women are less likely to hold jobs where chemical abuse is identified and employer pressure applied to get the individual into treatment."

Juveniles present special diagnosis and treatment problems. Chemical abuse by juveniles often is relatively easy to detect. As students, they have a regular schedule that must be maintained. As youngsters, their abuse is frequently accompanied by conspicuous behavior.

However, it is much more difficult to diagnose what is chemical dependency in a juvenile. Many of the signs of abnormal behavior that suggests chemical dependency in an adult do not, necessarily, indicate behavior that is abnormal in a juvenile. A juvenile user may experience problems of coping with adolescence that do not reflect a dependency. The history of uncontrollable and destructive use is hard to document, when use patterns are relatively short and possibly erratic.

There currently is controversy as to whether we are over-diagnosing chemical dependency in youth. Resource persons from some centers suggest that identifying a youngster as being chemically dependent or treating them in a program bearing a chemical dependency treatment label may not be helpful. The important thing is to help young people move through the problem stage in which they are abusing chemicals.

Resource persons appearing before our committee suggested the following special considerations should be given to the treatment of juveniles with chemical use problems:

"Most juvenile chemical use problems are episodic behavioral situations rather than dependency.

"Juveniles may profit from a more highly structured program than adults.

"Abstinence is particularly hard to achieve when treating juveniles.

"There is a correlation between juvenile chemical use and juvenile delinquency, physical abuse, school problems, and parent conflict."

"Kids who are taken out of school for chemical dependency treatment often have a hard time when they go back to school.

"Chemical dependency in adolescents is a problem in and of itself–not just a symptom of other problems."

Although NIAAA estimates suggest that just one-fourth of all problem users of alcohol are adolescents, our survey of primary treatment centers found that only 18.5% of their clients in the most recent 12 months for which data is available were under 18 years of age. See Table 9. The difference is even greater since the survey includes drug users, and drug abuse is relatively more common among youth than adults.

TABLE 9
AGE OF CLIENTS
IN CHEMICAL DEPENDENCY TREATMENT

FACILITY TYPE	<18 YEARS	18-65 YEARS	>65 YEARS
Overall[1]	**18.5%**	**75.6%**	**5.9%**
INPATIENT			
Hospitals	17.0	75.7	7.3
Independent Residential	20.5	72.5	7.0
OUTPATIENT			
Hospitals	17.6	80.4	2.0
Independent Residential	11.0	87.1	1.9
Outpatient Clinics	31.7	67.1	1.3

[1] Includes a center in a nursing home, not included in the subgroup categories.

The elderly are less likely to be identified and referred to treatment than younger people. This is particularly the case with elderly individuals who have neither employment nor direct family obligations to meet on a daily basis.

Additionally, the elderly are particularly susceptible to prescription drug problems, due to the increased ailments for which they are treated, and the greater effect a given dosage may have on their system.

As shown in Table 9, only 5.9% of the people receiving treatment were over 65 years of age. This compares with 8.9% of the region's population that is 65 years of age or older. For the elderly who do enter treatment, more time is required and the prognosis for success is much lower. This appears to be because of longer use patterns, greater resistance to change with age, and lower opportunities for employment and family motivation.

A particular problem for the Black community is that chemical dependency is often not recognized as being a problem. Resource persons observed that just a few years ago many people working with alcohol problems in Minnesota tended to assume that Blacks were somehow immune to alcoholism.

The director of the Minnesota Institute of Black Chemical Abuse noted that among members of the Black community chemical dependency does not have as high a priority of concern as many other problems facing Blacks. This is despite the fact that a review of literature done for NIAAA found that while Blacks as a group have a higher rate of abstainers, they also have a higher rate of heavy drinkers than whites.

This is supported by the data we received from primary treatment centers indicating that 3.5% of their clients in the most recent year for which they had data were Blacks. This compares with a 1975 Urban League study suggesting that 2.2% of the metropolitan area's population is Black.

Resource persons appearing before our committee suggested a number of special problems providing chemical dependency treatment assistance to Blacks:

"Mistrust of police and social agencies make it less likely that a Black community will report problems relating to intoxication.

"Untreated poly-drug use among Blacks is a particularly serious problem requiring attention.

"Black alcoholics tend to be younger than white alcoholics.

"There appears to be a correlation among problem drinking, health problems, and social problems in crowded Black communities.

"Blacks are less likely to view excessive drinking as a disease and slower to confront it as a problem requiring help."

Chemical dependency among American Indians is a particularly serious problem. Measurements of chronic alcoholism among American Indians show a consistently higher rate than any other racial or ethnic group. The problem is compounded by a particularly low success rate for Indians in chemical dependency treatment. A random study of chronic repeaters in Hennepin County in 1975 showed that 48% were American Indians. In fiscal 1978, 29.3% of the Hennepin County detoxification admissions were American Indians as were 10.7% of the halfway house discharges. This compares with an Urban League study that 1.4% of

TABLE 10
RACE OF CLIENTS IN CHEMICAL DEPENDENCY TREATMENT

FACILITY TYPE	BLACK	AMERICAN INDIAN	HISPANICS	CAUCASIAN
Overall[1]	**3.5%**	**4.6%**	**.9%**	**90.8%**
INPATIENT				
Hospitals	4.3	4.7	1.1	90.0
Independent Residential	3.2	4.4	1.1	91.3
OUTPATIENT				
Hospitals	2.5	3.2	.5	93.8
Independent Residential	4.7	7.7	.1	87.5
Outpatient Clinics	.7	1.1	.7	96.6

[1] Includes a center in a nursing home, not included in the subgroup categories.

Hennepin County's population is American Indian.

The problem is also reflected in Table 10 data from primary treatment centers showing that 4.6% of the primary treatment patients within the metropolitan area were American Indians. This compares with an estimated 1% of the metropolitan area population that is American Indian.

Resource persons appearing before our committee noted the following problems complicate the treatment of chemical dependency for American Indians:

"There is a far more poly-drug use among American Indians today.

"There is a growing number of chronic alcoholic Indians in the 15 to 25 age group.

"Indians do not relate well to group therapy techniques used in most chemical dependency treatment programs.

"Urban Indians are not provided access to the special treatment programs provided outstate Indians."

Providing treatment for Hispanics is complicated by their bilingual and bicultural heritage. A chemical abuse service agency for Hispanics in Saint Paul found that 30% of their clients are Spanish speaking, 40% are bilingual, and 30% are English speaking.

Resource persons indicated that because of the role the extended family plays in the Hispanic culture there is more enabling of individuals with chemical use problems to continue their abuse. Drinking is reported to be a symbol of male machismo that is often treated as a right to be protected by the family.

As shown in Table 10, 0.9% of the primary treatments were for Hispanic individuals. This compares with an estimated 1.2% of the metropolitan area's population that is Hispanic.

In addition to bilingual and bicultural apsects of the chemical dependency problem for Hispanics, resource persons noted that Hispanics often tend to be shy and hard to get involved in some aspects of a conventional treatment program.

Lesbians and gays are alleged to have a much higher percentage of chemical use than the general public. Estimates of chemical abuse among homosexuals given our committee by resource persons run from 25% to 45%. One reason cited for this high percentage is that "bar life" often plays a cultural role for homosexuals. This leads to greater consumption in the normal pattern of life, and greater difficulty with abstinence following treatment. Resource persons reported that alienation from the mainstream of society tends to encourage homosexuals to turn to bar life as a center of activity. To counter this, members of the Twin Cities' lesbian community have set up their own coffee house.

Due to the private nature of a person's sexual preference, hard data on the number of homosexuals and their rate of problem use is not available.

Social/economic conditions still make it difficult to identify and treat the chemical dependency of some people.

The unemployed, chronic user without close family ties represents the most striking case of a population group for which little progress has been made. No program identified to date appears to be particularly helpful in working with the chronic user whose environment does not support treatment. However, long term programs may improve the client's health while in care, help some achieve abstinence, and reduce the demand for more expensive public medical services. This appears to be the case with the chronics currently being sent by Hennepin County to long term treatment at the Bell Hill Center.

In general, unemployed people tend to attract less attention with their dependency, are less likely to be referred to treatment since they are free from the pressure an employer might normally exert. While no specific data is now available, the level of unemployment of chemically dependent people appears much higher than that of the general public. This undoubtedly reflects, in part, the inability of some dependent people to secure and maintain jobs. It also may reflect greater abuse of chemicals by individuals when they are not working.

Questionnaire responses indicate that 56.1% of the people receiving primary care in the metropolitan area were employed, and 43.9% were not. By comparison, an estimated 59.8% of the state and 62.7% of the metropolitan are population 16 and over are employed. See Table 11.

White collar workers with a chemical use problem are often less readily detectable than blue collar workers with a chemical use problem. Employee assistance officers noted that because workers in a sales or administrative role are less likely to be supervised, and that changes in their productivity resulting from chemical abuse are not as easily distinguished from other factors affecting output, their abuse is less likely to be identified at an early stage.

Chemical dependency is more prevalent among single individuals than married couples, and single individuals frequently lack the supporting environment necessary to identify their chemical abuse early and encourage referral

TABLE 11
EMPLOYMENT OF CLIENTS
IN CHEMICAL DEPENDENCY TREATMENT

FACILITY TYPE	EMPLOYED	UNEMPLOYED
Overall[1]	**56.1%**	**43.9%**
INPATIENT		
Hospitals	45.2	54.8
Independent Residential	53.9	46.1
OUTPATIENT		
Hospitals	75.8	24.2
Independent Residential	78.3	21.7
Outpatient Clinics	59.3	40.7

[1] Includes a center in a nursing home, not included in the subgroup categories.

into treatment. The higher prevalence of chemical dependency among single individuals probably reflect several factors including: a lower marriage rate, less ability to maintain a marriage, and greater opportunities for the single individual to get by abusing chemicals.

Data received from the primary centers show that 61.2% of the individuals they treated were single. Of those programs with more than 90% of their patients over 18 years of age, 57.4% of the patients were single. In contrast, 63.1% of the state's population over 16 years is married. See Table 12.

Episodic chemical abuse by individuals who may not be chemically dependent represents a problem not well addressed under our current coercion oriented chemical dependency intervention and referral system.

American culture accepts a lot of inappropriate behavior on the part of chemical users without registering clear signs of disapproval. In fact, intoxication appears to be sanctioned and encouraged as the public often responds to drunken behavior as being humorous or at least understandable.

Family, friends, employers and others are often slow to connect personal problems with chemical abuse, and then they tend to be reluctant to confront the user with the problem until the severity has reached the point where the user's position in the family or job is threatened. Even then, the family may be reluctant to intervene because the intervention would call attention to the problem and possibly place the dependent person's employment in jeopardy.

Currently there is a lack of clear **societal norms as** what is or is not acceptable chemical use. Experience in other cultures show that strong societal stands against such things as driving while intoxicated, boisterous or hostile behavior, etc., can greatly reduce or eliminate these manifestations of intoxication.

Very few chemical dependency counseling programs in Minnesota deal with the modification of chemical use as an alternative to abstinence. This leaves a void in helping individuals that may not be chemically dependent, but have serious chemical use problems.

Social Service Block Grant funding raises some uncertainty about the future of programs for the underserved and disadvantaged.

The 1979 session of the Minnesota Legislature passed legislation providing for a Social Service Block Grant to counties. To a significant degree this legislation shifted the decision-making on which social services will be provided from the state to the counties.

During the first two years under the new legislation counties are able to shift their expenditures, starting January 1980, in such broad areas as chemical dependency, but they will not be able to reduce the total expenditure in the area. Starting in 1983, county boards will have the liberty to shift funds from an area such as chemical dependency to daycare, or vice versa.

TABLE 12
MARITAL STATUS OF CLIENTS
IN CHEMICAL DEPENDENCY TREATMENT

FACILITY TYPE	MARRIED	SINGLE
Overall[1]	**38.9%**	**61.1%**
Adult Programs[2]	**42.6**	**57.4**
INPATIENT		
Hospitals	33.8	66.2
Independent Residential	43.9	56.1
OUTPATIENT		
Hospitals	40.0	60.0
Independent Residential	49.0	51.0
Outpatient Clinics	31.2	68.8

[1] Includes a center in a nursing home, not included in the subgroup categories.

[2] Excludes programs with over 10% of clients under 18.

Under the Block Grant program 50% of the social service funding must come from the county. This will generally mean a higher percentage of local funding in the area of chemical dependency as the state currently pays 75% of the expense of detoxification services and 100% of the Governor's Bill programs.

Some fear counties may reduce funding for chemical dependency in general, and programs for under-served and disadvantaged persons in particular. The concern is based, in part, on the apprehension that county board members may not recognize the importance or the nature of chemical dependency as a treatable disease.

Chemical dependency programs are more recent and accordingly somewhat less secure than most social programs covered by the Social Service Block Grant. The traditional social worker often is not as informed or concerned with chemical dependency as other problems. There is also concern about the lack of an effective constituency to represent the case of providing chemical dependency programs for minority groups and disadvantaged persons.

Under Block Grant funding, counties will have a strong incentive to re-evaluate their detox programs. The basic law of decriminalizing public drunkenness and requiring a provision of detoxification services remains in effect. However, with the removal of the special 75% funding provision for detoxification, detoxification programs are likely to come under increased scrutiny.

Of particular concern will be how best to handle the special situation of the chronic recidivist that recycles through detox many times during the course of a year and make a disproportional use of public resources.

II. CONCLUSIONS ABOUT UNMET NEEDS AND OPPORTUNITIES.

DESPITE THE EFFORTS AND PROGRESS MADE TO DATE. THERE IS REASON FOR CONCERN THAT THOSE LEAST WELL SERVED CURRENTLY WILL BE EVEN LESS LIKELY TO SECURE ASSISTANCE IN THE FUTURE.

The focus of attention on chemical dependency services has shifted to the counties, and the next round of discussion is less likely to be on how to broaden and improve services than on which public programs are to be curtailed or eliminated.

The continuation of special efforts to reach out and help dependent individuals from the under-served populations is very important in reducing chemical abuse and the resulting substantial cost to the community.

Greater attention will be required under the Social Service Block Grant program to secure treatment for the special populations in programs that are equipped to meet their special needs in an effective manner. In particular, extra emphasis and attention should be given as follows:

The needs of women are different. Without special efforts to sensitize people to chemical dependency among women, the dependency of many women will continue to go unattended. Once identified, special support services, such as child care arrangements, will be required for women to be able to participate in treatment. Others may not receive the treatment they need without the availability of treatment programs oriented to the special problems confronting chemically dependent women.

Chemical dependency among juveniles and the elderly is harder to treat. Special attention must be given to the poly-drug nature of chemical abuse among many juveniles, and the interrelationship between chemical abuse and other psychological problems associated with their age group. Similarly, treatment of the elderly is a longer and more difficult process, due to physical, social and mental changes associated with their age.

Racial minorities and homosexuals often do not relate well to conventional chemical dependency programs. In part, just being in a minority probably creates an additional element of psychological concern for the dependent individual. However, additionally, there are real and important differences in the problems faced by Black, American Indian, Hispanic, gay and lesbian persons in treatment that may not be adequately dealt with in a program primarily serving white majority clients.

Greater attention needs to be given to the varying needs of different detoxification center clients, and steps should be taken to seek out the most productive approach to serve each of the different client categories.

County boards are likely to be under pressure to cut back the portion of chemical dependency expenditures going for detoxification programs. To simply cut back detoxification services providing medically safe detoxification for those individuals creating a problem with their intoxification is not adequate. Detoxification centers make a valuable contribution by helping identify and refer those individuals that can best profit by chemical dependency treatment.

Assistance should be provided at an early stage to individuals creating problems for themselves and others through chemical abuse.

A new emphasis should be given to identifying and discouraging inappropriate chemical use throughout the consuming public. Individuals do not have to be chemically dependent to have a chemical use problem, and steps can and should be taken to correct abusive behavior whenever it occurs.

Broad programs of public education should be designed to help the abuser and those around the abuser identify chemical use problems and take steps to avoid them.

The prevention of chemical abuse before problems occur is the most fundamental need of our society in dealing with mood-altering drugs.

While our committee was not charged to look at education and prevention programs, we consistently were told of the need for the development of new community standards and public attitudes about the use of alcohol and other mood-altering chemicals. Special attention should be given to the development of clearer, more reasoned attitudes on the use of mood-altering chemicals, and the nature of inappropriate use and dependency.

III. RECOMMENDATIONS ABOUT UNMET NEEDS AND OPPORTUNITIES.

A. Counties should give high priority to funding chemical dependency programs and program reimbursement for "under-served populations."

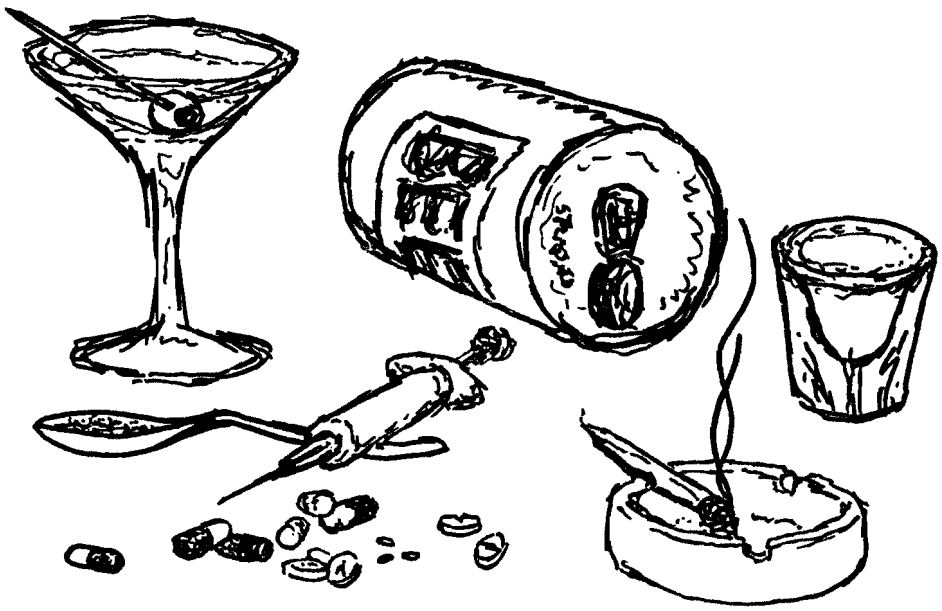
B. The chemical dependency industry should consider the current and expected needs of chemically dependent persons by age, sex, race and sexual preference, and then work to voluntarily refocus their attention as needed to better serve the disadvantaged groups.

C. The Minnesota Legislature should monitor the provision of chemical dependency services, and be prepared to intercede, if necessary, to protect current programs and stimulate additional ones to serve the "under-served groups."

D. The Minnesota Legislature should direct the chemical dependency agency to encourage and support the development of programs aimed at assisting individuals with chemical use problems who are not chemically dependent.

The private marketplace should become increasingly sensitive to the current needs of problem chemical users who are not actually chemically dependent. Programs aimed at individual problem assessment and the development of alternative use patterns should be encouraged as an extension of current community efforts to help dependent persons.

E. During the next decade, both private and public groups concerned with alcohol and other drug problems should give special attention to the prevention of chemical abuse, and the need to rethink community attitudes that encourage and facilitate inappropriate use.



ABOUT THIS REPORT

CITIZENS LEAGUE PROCEDURES

Each year the Citizens League Board of Directors adopts a research program with several topics based upon their importance to the community and the potential contribution of the League studies. An ad hoc committee of the Board of Directors then develops a specific charge or assignment for a study committee, which is made up of members of the Citizens League who have been given an opportunity to participate through an announcement in the League's biweekly newsletter.

The ad hoc committee of the Board of Directors monitors the work of the study committee, advises the study committee on procedures, and may raise questions about the report as it is considered for approval by the Board of Directors.

Under the League's constitution and by-laws, the Board of Directors approves all League reports and position papers before they become official League policy and are released to the public. However, the chairman and members of the committee are frequently asked to help explain the report to the community.

COMMITTEE ASSIGNMENT

Since its beginning in 1952, the Citizens League has been actively involved in health related issues. However, this is the first League study dealing with the question of alcohol and drug abuse. The committee received the following charge from the Board:

> " . . . the committee assignment shall focus on the system by which funding bodies, referral agencies and operators of treatment programs make decisions on who shall be provided with the treatment and on what form of treatment shall be offered.
>
> "It is important that the committee understand that its assignment does not include making subjective judgments about one form of treatment over another or about theoretical approaches to the problem. Instead the committee will be looking at the way decisions are made by individuals, organizations and courts which work with chemically dependent persons."

COMMITTEE MEMBERSHIP

The committee had the active participation of 28 members. Professional staff assistance was furnished by Calvin Clark, with Hertha Lutz providing secretarial and administrative assistance. The members are:

W. Andrew Boss, Chairman
Betty Bayless
Kenneth Beitler
James J. Bowe
Judith Crowley
Leo J. Feider
Virginia Greenman
Robert E. Hannon
Ann D. Hutchins
Carl E. Johnson
Yleen Joselyn
William A. Madden
Aaron Mark
Phyllis Mark
William G. Masuda
Richard Niemiec
Ron J. North
Albert W. Oertwig
Robert P. Provost
Steve Rood
Dennis A. Sokol
Arthur J. Stock
Joane Vail
Carol R. Watkins
Kay Welsch
Wheelock Whitney
Edwin M. Wistrand
Elizabeth J. Zerby

COMMITTEE PROCEDURES

The committee met 37 times from May 23, 1979 to April 16, 1980. The committee met 2½ hours per week except during a six-week period early in 1980 in which the committee met 3½ hours per week. During the first four months the committee met at 15 different treatment facilities.

The committee received a substantial amount of written background material from throughout the country, in addition to direct discussions with the following resource persons:

Daniel Anderson, president, Hazelden Foundation
P. K. Artz, director, Team House
Joe Bedeau, director, Indian Neighborhood Club
Peter Bell, executive director, MN Institute of Black

ical Abuse
H. Leonard Boche, administrator, New Pioneer House
Gordon Bohl, director, Family Care and Counseling
Thomas Briggs, MD, chairman, MN State Medical Association Committee on Alcohol and Drug Abuse
C. Peter Brock, director, Johnson Institute
John Brodin, sargent, Minneapolis Police Department
Jack Callies, Chemical Dependency Program, St. John's Hospital
Randy Cox, director, Chemical Dependency Program, Metropolitan Clinic on Counseling
Dick Craven, counselor, MN State Prison
Dagny Christensen, executive director, Granville House
Leo Cullen, Ramsey County Receiving Center for Inebriates
John Curran, Hennepin County Chemical Dependency Program
Judy Erickson, program director, Progress Valley II
Anice Flesh, probation officer, Hennepin County Government Center
Lee Gartner, Chemical Dependency Division, Department of Public Welfare
William Gowan, Chemical Dependency Counselor, St. Louis Park Medical Center
Anne Griffith, manager, Chemical Dependency Program, Chrysalis
Patrick Griffin, manager, Chemical Dependency Program, Washington County
Thomas Griffin, chemical dependency consultant, MN State Department of Education
Phil Hansen, executive director, Abbott/Northwestern Hospital Chemical Dependency Program
Bob Haven, director, Twin Town Treatment Center
John Jacoby, MD, director, Occupational & Environmental Health, Honeywell
Jim Jenson, director, Chemical Dependency Program, St. Joseph's Hospital
Carl E. Johnson, captian, Minneapolis Police Department
Sharron Johnson, director, Crossroads Aftercare Program
Bob Jones, executive consultant, Control Data Corporation
Dan Kelly, director, Chemical Dependency Program, Metropolitan Medical Center
Phillip Kelly, program director, Bridgeway Care Center
James Kincannon, professor, University of Minnesota and senior clinical psychologist, Hennepin County
Bud Larson, president, Metropolitan Clinic on Counseling
Orville Larson, director, Fellowship Club
Steve Lepenski, executive director, Store Front
Elliot Long, Program Evaluation Division, Legislative Auditor's Office
John Loughren, chemical dependency director, Abbott/Northwestern Hospital
Maryann Machand, program director, Jane Dickman House
George Mann, MD, director, Chemical Dependency Program, St. Mary's Hospital Rehabilitation Center
Aaron Mark, MD, private practice internist
Stephen Mayer, MD, executive director, Rainbow Research, Inc.
Mike McMonigal, director, Family Treatment Program
Doug Morgan, program coordinator, C.R.E.A.T.E.
Harry Neimeyer, board member, Citizens League
Lizbeth Nudell, principal staff, Supreme Court Probate Court Study
Paul O'Connell, director, St. Louis Park Medical Center
Robert Olander, former director, Hennepin County Methadone Program
Bruce Olson, director, Anoka State Hospital Chemical Dependency Program
Mark Olson, director, Exchange Outpatient Program
Robert P. Provost, president, MN Insurance Information Center
Jim Schaefer, director, Office of Alcohol & Other Drug Abuse Program, University of Minnesota
John Selstad, MN Behavioral Institute
Ed Sharlau, program director, 3M Employee Assistance Program
Jim Shaw, secretary, Employee Benefit Committee, Northwestern Bell Telephone
Bernie Shellum, reporter, Minneapolis Tribune
Ned Skahen, Ramsey County Receiving Center for Inebriates
Wy Spano, chairman of board, Eden House
Carl Sporer, director, Hennepin County Chemical Dependency Services
Patrick Stevens, director of treatment, New Connections
Harold Swift, administrator, Hazelden Foundation
Vincente B. Tauson, MD, director, Dual Disability Program, Mental Health Dept., St. Paul-Ramsey Hospital
Lorraine Teel, director, Eden House
John Thompson, director, Minneapolis AA Intergroup Office
Reed Vinge, probation officer, Hennepin County
Simeon Wagner, counselor, Harbor Light Center
Michael Weber, director, Hennepin County Community Services
Wheelock Whitney, president, MN Council on Health
Chuck Wiesen, administrator, Minneapolis Age and Opportunity Center
Mark Wilcox, director, Chemical Dependency Division, MN Department of Public Welfare
Carole Williams, counselor, Operation de Nova
Mark Zimmerman, administrator, CASA

Following this extensive input from background materials and resource persons, the committee developed multiple drafts of findings, conclusions and specific recommendations which in their final form make up this document.

BOARD ACTION

An ad hoc committee of the Board of Directors chaired by Harry Neimeyer met on three occasions in developing the committee charge, four times to discuss progress and procedures during the committee's deliberations, and four times following the presentation of the committee's report to the Board of Directors to explore whether the recommendations in the area of the payment system might be expanded.

The Board did expand the report slightly by developing more detailed suggestions as to how employers might encourage the arrangement of treatment that is no longer, costly or restrictive than necessary . . . while leaving the final choice to the employee and his or her family. Also added by the Board was the Preface explaining the League's concern about keeping health care costs down.

The Board also received a proposal for several changes in the report from Lois Yellowthunder. Ms. Yellowthunder's proposal did not pass, but is presented here as a minority position of a Board member.

BOARD MEMBER MINORITY REPORT

A major conclusion of the chemical Dependency Committee report (p8) and explicitly stated in the "Proposed Preface" is the following:

> . . . in the absence of any demonstrated difference in program effectiveness the lower-cost treatment options should be favored.

There are two issues involved:

1. Do we know anything about treatment effectiveness?
2. How is "cost" being defined?

TREATMENT EFFECTIVENESS

A number of factors relating to treatment effectiveness are known. For example, a number of studies have demonstrated that family treatment (as part of an overall treatment program) is positively correlated with improvement in the chemically dependent individual's status. Individual diversity is also a factor in treatment outcomes.

Employee assistance programs need to take these factors into consideration.

COST

Cost figures generated by the study committee questionnaire did not include information relating to how cost is calculated and thus it is difficult to compare costs across treatment centers. Testimony to the committee indicates that overhead and administrative costs for an outpatient program, which also includes an inpatient program at the same facility, may not be included in cost calculations.

RECOMMENDATIONS

1. Family treatment should be considered an integral part of chemical dependency treatment.

2. Change "Lack of demonstrated differences in treatment effectiveness" (p8) to *Although some of the factors related to treatment effectiveness are known, more research needs to be carried out.*

3. Change "Opinions vary on how much is known or even knowable about treatment outcomes" (p8) to *Opinions vary on criteria that are considered in relation to treatment outcomes.*

4. Omit the following sentence in the "Proposed Preface:" . . . in the absence of any demonstrated differences in program effectiveness the lower-cost treatment options should be favored.

5. Amend Recommendation on employee assistance (p19) as follows: The employee assistance process should place a high priority on positive patient outcome in addition to a concern for cost effectiveness on a case by case basis.

Such a process to include:

1. A consideration of individual differences and needs.

2. A consideration of a wide variety of options including, but not exclusively involving treatment.

3. The use of a 3-7 day "retreat" at a treatment center for observation and assessment.

4. Consultation with treatment center counselor, industrial counselor, and client to determine option.

LOIS YELLOWTHUNDER

TABLE I
CAPACITY, UTILIZATION AND TREATMENT LENGTH AT CHEMICAL DEPENDENCY TREATMENT CENTERS SERVING THE TWIN CITIES METROPOLITAN AREA[1]

CENTER	PATIENT CAPACITY	AVERAGE UTILIZATION	TREATMENT LENGTH IN DAYS Range	Average
INPATIENT–Total All Centers	**1,258**	**1,116.3**	**14-180**	**31.6**
I. HOSPITALS	**678**	**617.6**	**14-180**	**29.5**
Abbott-Northwestern	56	49.6	27-35	31.0
Anoka State	101	86.0	100	46.0
Golden Valley Health Center	44	42.0	26-30	28.0
Mercy Medical Center	43	40.0	21-28	25.7
Metropolitan Medical Center	39	34.4	14-28	20.3
Mounds Park	31	28.2	21-30	25.0
St. John's	64	63.0	25-28	24.0
St. Joseph's	50	38.4	28	28.0
St. Mary's Rehabilitation Center	112	107.5	14-35	27.6
St. Paul-Ramsey	30	27.0	25	25.0
Veteran's Administration	41	39.0	28-35	31.0
Lutheran Deaconess (Adolescent)	16	15.5	28	26.0
St. Mary's (Adolescent)	51	47.0	28-32	31.0
Bridgeway[2]	55	47.6	14-180	76.7
II. INDEPENDENT RESIDENTIAL	**525**	**451.1**	**27-180**	**33.6**
Chanhassen	55	43.0	28	28.0
Family Treatment Center	50	47.9	27-35	30.0
Hazelden	191	162.3	28-34	32.9
Hennepin County	38	33.4	21	21.0
New Pioneer House	64	50.5	40-60	39.0
Parkview	35	29.7	28	NA[3]
Twin Town	50	46.7	28-35	NA
Jamestown (Adolescent)	24	22.6	150-180	150.0
New Connections (Adolescent)	18	NA	56-84	NA
OUTPATIENT–Total All Centers	**885**	**531.3**	**5-180**	**28.8**
I. HOSPITALS	**351**	**234.4**	**19-35**	**22.4**
Abbott-Northwestern	120	78.0	22-27	25.0
Golden Valley Health Center	20	14.0	20	20.0
Mercy Medical Center	16	12.0	20	20.0
Metropolitan Medical Center	20	10.0	20	20.0
Mounds Park	15	7.5	20-25	20.0
St. John's	48	42.0	19-21	20.0
St. Mary's Rehabilitation Center	40	36.9	20-25	20.0
St. Paul-Ramsey	20	19.0	20	20.0
Veteran's Administration	12	6.0	28-35	31.0
Lutheran Deaconess (Adolescent)	20	NA	40	35.0
St. Mary's (Adolescent)	20	9.0	20-35	23.0
Bridgeway[2]	10	6.0	NA	22.0
II. INDEPENDENT RESIDENTIAL	**207**	**131.8**	**20-28**	**22.6**
Chanhassen	30	21.0	20	20.0
Hazelden	45	38.7	28	28.0
Hennepin County	80	55.5	21	21.0
Parkview[4]	40	26.6	14 IP + 28 OP	NA
Twin Town	12	5.5	20	20.0
III. OUTPATIENT CLINICS	**324**	**159.1**	**5-180**	**60.5**
Chrysalis	38	31.6	60-180	120.0
Community Family Counseling	54	42.0	180	180.0
C.R.E.A.T.E.	50	13.0	20 hrs.	20 hrs.
Exchange Program	20	NA	16	NA
Fairview Southdale	28	20.0	70	70.0
First Step Program	15	NA	12	12.0
5001 Chemical Dependency	25	10.0	112 hrs.	112 hrs.
Metropolitan Clinic of Counseling	20	NA	15-25	20.0
South Lake Center	24	15.0	36	36.0
Adolescent Drug Treatment Ltd.	30	18.0	40	40.0
Renaissance	20	9.5	5-30	30.0

[1] All data taken from treatment center responses to a Citizens League questionnaire dated October 1979.
[2] Located in a nursing home; not included in the hospital or independent residential summary.
[3] NA: Information not available.
[4] Two weeks inpatient plus four weeks outpatient.

TABLE II
COST ESTIMATES FOR TREATMENT AT PRIMARY CHEMICAL DEPENDENCY TREATMENT CENTERS SERVING THE TWIN CITIES METROPOLITAN AREA[1]

CENTER	Estimated Total Cost	Physician Fees and Other Outside Charges	Per Diem Rate	Family Care Charges	Aftercare Charges
INPATIENT–Total All Centers	**$2,504**	**$149.38**	**[illegible]**	**NA[2]**	**NA**
I. HOSPITALS	**2,721**	**168.35**	**89.57**	**NA**	**NA**
Abbott-Northwestern	3,100	100.00	96.00	0	0
Anoka State	2,038	0	58.25	0	0
Golden Valley Health Center	2,800+	NA	76.00	0	0
Mercy Medical Center	2,840	200.00	90.00	0	$750.00
Metropolitan Medical Center	2,395	320.00	83.00	0	0
Mounds Park	2,325+	NA	93.00	[illegible]	0
St. John's	2,352	0	98.00	[illegible]	12/session
St. Joseph's	2,344	20.00	83.00	[illegible]	120.00
St. Mary's Rehabilitation Center	2,754+	NA	90.00	70.00 to [illegible]/wk.	0
St. Paul-Ramsey	2,500	500.00	90.00	[illegible]	0
Veteran's Administration	NA	NA	NA	NA	NA
Lutheran Deaconess (Adolescent)	3,600	NA	145.00	0	NA
St. Mary's (Adolescent)	4,000+	0	135.00	100.00/52.50	23.00
Bridgeway[3]	4,985	90.00	65.00	0	0
II. INDEPENDENT RESIDENTIAL	**2,083**	**127.09**	**66.65**	**52.20**	**NA**
Chanhassen	2,565	0	85.00	0	0
Family Treatment Center	1,950	100.00	75.00	0	0
Hazelden	2,200	75.00	60.00	100.00	10/session
Hennepin County	1,180	0	56.22	0	0
New Pioneer House	2,250	249.00	64.50	0	0
Parkview	2,966	NA	NA	150.00	0
Twin Town	3,000	150.00	74.00	0	0
Jamestown (Adolescent)	10,200	300.00	70.00	0	0
New Connections (Adolescent)	NA	NA	NA	NA	NA
OUTPATIENT–Total All Centers	**$714**		**NA**	**NA**	**NA**
I. HOSPITALS	**709**		**[illegible]**	**NA**	**NA**
Abbott-Northwestern	875		38.50	0	0
Golden Valley Health Center	660		33.00	0	0
Mercy Medical Center	750		35.00	0	750.00
Metropolitan Medical Center	700		35.00	0	0
Mounds Park	540		27.00	0	0
St. John's	700		35.00	0	12/session
St. Mary's Rehabilitation Center	705		NA	130/wk.	0
St. Paul-Ramsey	450		22.50	0	0
Veteran's Administration	NA		NA	NA	NA
Lutheran Deaconess (Adolescent)	1,900		55.00	0	NA
St. Mary's (Adolescent)	640		32.00	100/52.50	23.00
Bridgeway[3]	1,170		13/hr.	0	0
II. INDEPENDENT RESIDENTIAL	**732**		**NA**	**52.20**	**NA**
Chanhassen	680		11/hr.	0	0
Hazelden	550		28.75	100.00	10/session
Hennepin County	750		35.80	0	0
Parkview[4]	1,050		NA	150.00	0
Twin Town	635		NA	125.00	60.00
III. OUTPATIENT CLINICS	**693**		**NA**	**NA**	**NA**
Chrysalis	42/wk.		5/wk.	0	0
Community Family Counseling	758		18.95	10/hr.	0
C.R.E.A.T.E.	190		NA	NA	NA
Exchange Program	1,108		16.00	30/hr.	0
Fairview Southdale	2,034/family		NA	0	0
First Step Program	650 or 825/family		NA	200.00	0
5001 Chemical Dependency	896/family		32.00	0	10/wk.
Metropolitan Clinic of Counseling	600		NA	50.00	50.00
South Lake Center	850		24.00	NA	10/hr.
Adolescent Drug Treatment Ltd.	2,200		51.00	0	NA
Renaissance	1,750		45.00	NA	10/hr.

[1] All data taken from treatment center responses to a Citizens League questionnaire dated October 1979.
[2] NA: Information not available.
[3] Located in a nursing home; not included in the hospital or independent residential summary.
[4] Two weeks inpatient plus four weeks outpatient.

TABLE III
FUNDING OF TREATMENT AT PRIMARY CHEMICAL DEPENDENCY TREATMENT CENTERS SERVING THE TWIN CITIES METROPOLITAN AREA[1]

CENTER	HMO Insurance	Other Insurance	Medicare and Medicaid	Other Public	Self Pay
INPATIENT–Total All Centers	**2.8%**	**56.1%**	**8.2%**	**22.2%**	**10.7%**
I. HOSPITALS	**1.8**	**56.2**	**10.6**	**28.7**	**2.8**
Abbott-Northwestern	0	**48.0**	**46.0**	**3.0**	**3.0**
Anoka State	NA[2]	NA	NA	95.0	NA
Golden Valley Health Center	5.0	75.0	2.5	15.0	2.5
Mercy Medical Center	0	76.0	3.0	17.0	1.0
Metropolitan Medical Center	4.2	54.9	6.1	33.5	4.2
Mounds Park	NA	56.4	1.5	40.0	1.5
St. John's	5.9	62.4	8.2	21.9	2.4
St. Joseph's	.6	58.4	5.5	34.2	1.2
St. Mary's Rehabilitation Center	.1	67.9	24.9	NA	7.1
St. Paul-Ramsey	1.5	59.0	5.5	32.5	1.5
Veteran's Administration	0	0	0	100.0	0
Lutheran Deaconess (Adolescent)	5.0	74.5	0	20.0	.5
St. Mary's (Adolescent)	1.0	65.0	0	29.0	5.0
Bridgeway[3]	0	2.0	85.0	5.0	8.0
II. INDEPENDENT RESIDENTIAL	**4.9**	**58.4**	**0**	**10.3**	**26.4**
Chanhassen	18.0	60.0	0	10.0	12.0
Family Treatment Center	1.0	88.0	0	3.0	8.0
Hazelden	NA	35.0	0	10.0	50.0
Hennepin County	NA	NA	NA	NA	NA
New Pioneer House	1.8	70.8	0	20.4	1.8
Parkview	3.0	90.0	0	1.0	6.0
Twin Town	14.8	NA	0	0	NA
Jamestown (Adolescent)	0	38.5	0	61.5	0
New Connections (Adolescent)	NA	NA	NA	NA	NA
OUTPATIENT–Total All Centers	**12.0%**	**54.9%**	**4.3%**	**14.3%**	**14.5%**
I. HOSPITALS	**7.8**	**56.5**	**7.1**	**19.4**	**9.2**
Abbott-Northwestern	5.0	75.0	10.0	5.0	5.0
Golden Valley Health Center	15.0	75.0	0	7.0	1.0
Mercy Medical Center	0	97.0	0	1.0	2.0
Metropolitan Medical Center	21.3	56.2	1.1	9.0	12.4
Mounds Park	NA	NA	NA	NA	NA
St. John's	26.2	42.9	11.9	7.1	11.9
St. Mary's Rehabilitation Center	1.7	66.5	10.4	NA	21.4
St. Paul-Ramsey	1.0	54.1	4.9	34.9	5.1
Veteran's Administration	0	0	0	100.0	0
Lutheran Deaconess (Adolescent)	NA	NA	NA	NA	NA
St. Mary's (Adolescent)	0	55.0	0	23.0	22.0
Bridgeway[3]	0	0	0	79.0	11.0
II. INDEPENDENT RESIDENTIAL	**11.5**	**74.1**	**0**	**2.4**	**12.0**
Chanhassen	18.0	60.0	0	0	22.0
Hazelden	NA	80.0	0	10.0	10.0
Hennepin County	NA	NA	NA	NA	NA
Parkview[4]	3.0	90.0	0	1.0	6.0
Twin Town	27.5	NA	0	0	NA
III. OUTPATIENT CLINICS	**23.2**	**40.1**	**.5**	**7.0**	**29.3**
Chrysalis	0	0	0	100.0[5]	100.0[5]
Community Family Counseling	28.7	51.0	1.1	.5	18.6
C.R.E.A.T.E.	12.0	6.0	1.0	15.0	62.0
Exchange Program	0	5.6	5.4	88.3	.7
Fairview Southdale	NA	NA	NA	NA	NA
First Step Program	28.9	63.9	0	1.2	6.0
5001 Chemical Dependency	5.0	37.5	0	0	57.5
Metropolitan Clinic of Counseling	76.0	24.0	0	0	0
South Lake Center	13.0	63.0	0	0	24.0
Adolescent Drug Treatment Ltd.	10.0	40.0	0	18.0	2.0
Renaissance (Adolescent)	0	88.6	0	2.3	9.1

[1] All data taken from treatment center responses to a Citizens League questionnaire dated October 1979.
[2] NA: Information not available.
[3] Located in a nursing home; not included in the hospital or independent residential summary.
[4] Two weeks inpatient plus four weeks outpatient.
[5] For each patient they receive 95% NIAAA funding and 5% client fees.

TABLE IV
POPULATIONS SERVED AT PRIMARY CHEMICAL DEPENDENCY TREATMENT CENTERS SERVING THE TWIN CITIES METROPOLITAN AREA[1]

CENTER	SEX		AGE			MARITAL STATUS	
	Male	Female	<18	18-65	>65	Married	Single
INPATIENT–Total All Centers	**72.0%**	**28.0%**	**18.1%**	**74.0%**	**7.9%**	**37.8%**	**62.2%**
I. HOSPITALS	**70.6**	**29.4**	**17.0**	**75.7**	**7.3**	**33.8**	**66.2**
Abbott-Northwestern	65.0	35.0	5.0	60.0	35.0	60.0	40.0
Anoka State	84.0	16.0	1.0	94.0	5.0	15.0	85.0
Golden Valley Health Center	75.0	25.0	NA[2]	NA	5.0	51.0	49.0
Mercy Medical Center	55.0	45.0	0	90.0	10.0	NA	NA
Metropolitan Medical Center	68.1	31.9	2.4	91.5	6.1	34.7	65.3
Mounds Park	62.7	37.3	8.7	88.5	2.8	34.5	65.5
St. John's	63.5	36.5	11.8	83.5	4.7	51.8	48.2
St. Joseph's	72.9	27.1	9.3	86.4	4.3	33.9	66.1
St. Mary's Rehabilitation Center	77.0	23.0	0	94.4	5.6	NA	NA
St. Paul-Ramsey	75.0	25.0	6.1	89.4	4.5	51.5	48.5
Veteran's Administration	98.0	2.0	1.0	96.0	3.0	30.0	70.0
Lutheran Deaconess (Adolescent)	60.0	40.0	99.0	1.0	0	0	100.0
St. Mary's (Adolescent)	53.0	47.0	94.0	6.0	0	0	100.0
Bridgeway[3]	72.3	27.7	0	58.8	41.2	17.4	84.6
II. INDEPENDENT RESIDENTIAL	**71.4**	**28.6**	**20.5**	**72.5**	**7.0**	**43.9**	**56.1**
Chanhassen	75.0	25.0	0	95.0	5.0	60.0	40.0
Family Treatment Center	72.0	28.0	5.0	94.5	.5	63.5	36.5
Hazelden	70.0	30.0	19.0	65.0	16.0	53.0	47.0
Hennepin County	85.0	15.0	0	100.0	0	24.0	76.0
New Pioneer House	69.0	31.0	61.0	39.0	0	10.0	90.0
Parkview	61.7	38.3	12.0	87.7	.3	60.0	40.0
Twin Town	69.7	30.3	12.2	87.2	.6	40.7	59.3
Jamestown (Adolescent)	58.0	42.0	100.0	0	0	0	100.0
New Connections (Adolescent)	NA	NA	NA	NA	NA	NA	NA
OUTPATIENTS–Total All Centers	**72.1%**	**27.9%**	**19.3%**	**78.6%**	**2.1%**	**41.0%**	**59.0%**
I. HOSPITALS	**81.4**	**18.6**	**17.6**	**80.4**	**2.0**	**40.0**	**60.0**
Abbott-Northwestern	80.0	20.0	0	98.0	2.0	25.0	75.0
Golden Valley Health Center	80.0	20.0	NA	NA	1.0	60.0	40.0
Mercy Medical Center	92.0	8.0	0	98.0	2.0	NA	NA
Metropolitan Medical Center	74.2	25.8	9.0	89.8	1.1	42.7	57.3
Mounds Park	NA	NA	NA	NA	NA	NA	NA
St. John's	78.6	11.4	28.6	71.4	0	69.0	31.0
St. Mary's Rehabilitation Center	NA	NA	NA	NA	NA	NA	NA
St. Paul-Ramsey	80.4	19.6	5.2	91.2	3.6	51.4	47.6
Veteran's Administration	100.0	0	0	100.0	0	20.0	80.0
Lutheran Deaconess (Adolescent)	60.0	40.0	99.0	1.0	0	0	100.0
St. Mary's (Adolescent)	56.0	44.0	100.0	0	0	0	100.0
Bridgeway[3]	66.0	34.0	0	53.0	47.0	13.0	87.0
II. INDEPENDENT RESIDENTIAL	**68.0**	**32.0**	**11.0**	**87.1**	**1.9**	**49.0**	**51.0**
Chanhassen	NA	NA	NA	NA	NA	63.5	36.5
Hazelden	68.0	32.0	21.5	71.5	7.0	47.6	52.4
Hennepin County	65.0	35.0	14.0	84.0	2.0	35.0	65.0
Parkview[4]	**70.5**	**29.5**	**NA**	**NA**	**NA**	**75.0**	**25.0**
Twin Town	**73.0**	**17.0**	**0**	**99.3**	**.7**	**52.6**	**47.4**
III. OUTPATIENT CLINICS	**65.0**	**35.0**	**31.7**	**67.1**	**1.3**	**31.2**	**68.8**
Chrysalis	0	100.0	0	100.0	0	24.0	76.0
Community Family Counseling	80.3	19.7	6.4	90.4	3.2	51.1	48.9
C.R.E.A.T.E.	71.0	29.0	35.0	64.0	1.0	20.0	80.0
Exchange Program	69.2	30.8	50.0	50.0	0	5.8	94.2
Fairview Southdale	62.7	37.3	0	97.0	3.0	59.0	41.0
First Step Program	52.5	47.5	7.5	91.5	1.0	50.0	50.0
5001 Chemical Dependency	76.0	24.0	2.0	92.0	6.0	48.0	52.0
Metropolitan Clinic of Counseling	64.0	36.0	23.0	77.0	0	50.0	50.0
South Lake Clinic	63.0	37.0	35.0	65.0	0	50.0	50.0
Adolescent Drug Treatment Ltd.	60.0	40.0	90.0	10.0	0	0	100.0
Renaissance (Adolescent)	70.5	29.5	100.0	0	0	0	100.0

[1] All data taken from treatment center responses to a Citizens League questionnaire dated October 1979.
[2] NA: Information not available.
[3] Located in a nursing home; not included in the hospital or independent residential summary.
[4] Two weeks inpatient plus four weeks outpatient.

TABLE IV, Continued

EMPLOYENT		RACE				
Employed	Not Employed	Black	American Indian	Hispanic	Caucasian	CENTER
47.7%	52.3%	3.9%	4.7%	1.1%	90.1%	INPATIENT–Total All Centers
45.2	54.8	4.3	4.7	1.1	90.0	I. HOSPITALS
50.0	50.0	5.0	5.0	1.0	89.0	Abbott-Northwestern
5.0	95.0	6.0	14.0	0	80.0	Anoka State
72.0	72.0	5.0	1.0	0	94.0	Golden Valley Health Center
67.0	33.0	1.0	2.0	2.0	97.0	Mercy Medical Center
66.5	33.5	7.5	6.5	1.2	84.8	Metropolitan Medical Center
42.3	57.7	3.4	6.3	6.3	83.7	Mounds Park
43.5	56.5	3.5	2.3	0	96.2	St. John's
43.6	56.4	NA	NA	NA	NA	St. Joseph's
61.0	39.0	NA	NA	NA	NA	St. Mary's Rehabilitation Center
59.4	40.6	5.2	1.2	3.0	90.6	St. Paul-Ramsey
30.0	70.0	3.0	2.0	0	94.0	Veteran's Administration
40.0	60.0	4.0	6.0	0	90.0	Lutheran Deaconess (Adolescent)
7.0	93.0	NA	NA	NA	NA	St. Mary's (Adolescent)
0	100.0	2.7	9.8	1.6	85.4	Bridgeway[3]
53.9	46.1	3.2	4.4	1.1	91.3	II. INDEPENDENT RESIDENTIAL
85.0	15.0	3.0	4.0	4.0	89.0	Chanhassen
83.5	16.5	0	.3	.2	99.5	Family Treatment Center
54.0	46.0	NA	NA	NA	NA	Hazelden
19.0	81.0	10.0	14.0	0	76.0	Hennepin County
18.0	82.0	.4	1.3	.7	97.6	New Pioneer House
90.0	10.0	1.0	1.0	0	98.0	Parkview
67.7	32.3	1.6	.2	.6	97.6	Twin Town
0	100.0	0	9.3	1.2	89.5	Jamestown (Adolescent)
NA	NA	NA	NA	NA	NA	New Connections (Adolescent)
73.9%	26.1%	2.9%	4.4%	.4%	92.1%	OUTPATIENT–Total All Centers
75.8	24.2	2.5	3.2	.5	93.8	I. HOSPITALS
95.0	5.0	2.0	7.0	0	81.0	Abbott-Northwestern
98.0	2.0	3.0	3.0	0	93.0	Golden Valley Health Center
90.0	10.0	6.0	0	0	99.0	Mercy Medical Center
91.0	9.0	6.7	7.9	1.1	84.3	Metropolitan Medical Center
NA	NA	NA	NA	NA	NA	Mounds Park
83.3	16.7	0	0	0	100.0	St. John's
86.2	13.8	5.1	1.1	3.4	90.4	St. Paul-Ramsey
NA	NA	NA	NA	NA	NA	St. Paul-Ramsey
15.0	85.0	4.0	1.0	0	95.0	Veteran's Administration
40.0	60.0	4.0	6.0	0	90.0	Lutheran Deaconess (Adolescent)
0	100.0	NA	NA	NA	NA	St. Mary's (Adolescent)
9.0	91.0	4.0	5.0	0	91.0	[redacted][3]
78.3	21.7	4.7	7.7	.1	87.5	II. [redacted]
NA	NA	NA	NA	NA	NA	[redacted]
70.0	30.0	NA	NA	NA	NA	Hazelden
71.0	29.0	8.0	14.0	0	78.0	Hennepin County
95.0	5.0	1.0	.6	0	98.4	Parkview[3]
92.7	7.3	3.6	0	1.5	94.2	Twin Town
59.3	40.7	.7	1.1	.7	96.9	III. OUTPATIENT CLINICS
47.0	53.0	0	2.0	0	98.0	Chrysalis
98.9	1.1	.5	.5	0	99.0	Community Family Counseling
70.0	30.0	1.0	1.0	1.0	95.5	C.R.E.A.T.E.
48.8	51.2	3.5	5.8	4.7	81.4	Exchange Program
63.8	36.2	.6	1.2	0	98.2	Fairview Southdale
72.5	27.5	0	0	0	100.0	First Step Program
NA	NA	1.5	4.0	0	86.0	5001 Chemical Dependency
89.0	11.0	1.0	.5	1.0	97.5	Metropolitan Clinic of Counseling
25.0	75.0	0	0	0	100.0	South Lake Clinic
40.0	60.0	1.0	1.0	2.0	95.0	Adolescent Drug Treatment Ltd.
0	100.0	0	0	2.3	97.7	Renaissance (Adolescent)

TABLE V
SOURCES OF REFERRAL FOR TREATMENT AT PRIMARY CHEMICAL DEPENDENCY TREATMENT CENTERS SERVING THE TWIN CITIES METROPOLITAN AREA[1]

CENTER	Self	Family and Relatives	Friends	Public Social Service Agencies	Private Social Service Agencies	Employer or School	Physicians
TOTAL ALL CENTERS	**8.9%**	**8.5%**	**3.2%**	**10.5%**	**3.1%**	**13.2%**	**9.2%**
I. HOSPITALS	**10.4**	**8.9**	**3.7**	**10.5**	**3.1**	**13.9**	**13.3**
Abbott-Northwestern	3.0	6.0	3.0	16.0	9.0	12.0	14.0
Anoka State	4.0	0	0	11.0	3.0	0	2.0
Golden Valley Health Center	6.0	2.0	3.0	1.0	0	39.0	18.0
Mercy Medical Center	10.0	13.2	7.3	6.5	10.2	2.9	22.3
Metropolitan Medical Center	7.4	1.2	6.3	6.3	0	14.9	22.9
Mounds Park	21.3	18.8	.6	5.3	2.5	5.3	4.4
St. John's	16.5	4.7	3.9	13.4	3.1	22.8	3.1
St. Joseph's	18.9	9.1	7.6	18.4	3.3	14.2	11.0
St. Mary's Rehabilitation Center	14.3	16.0	3.4	5.8	NA[2]	2.5	14.3
St. Paul-Ramsey	6.9	21.1	4.0	4.1	2.1	23.0	12.6
Veteran's Administration	22.0	9.0	6.0	0	0	3.0	1.0
Lutheran Deaconess (Adolescent)	1.0	8.0	1.0	24.0	2.0	23.0	2.0
St. Mary's (Adolescent)	2.0	7.0	2.0	17.0	0	19.0	27.0
Bridgeway[3]	NA	10.9	0	NA	2.1	0	49.0
II. INDEPENDENT RESIDENTIAL	**6.7**	**7.8**	**2.3**	**11.5**	**2.4**	**11.9**	**3.5**
Chanhassen	NA	15.0	NA	10.0	11.0	15.0	2.0
Family Treatment Center	2.0	6.0	5.0	2.0	2.0	11.0	3.0
Hazelden	15.0	----------	----------	10.0	----------	15.0	0
Hennepin County	5.0	15.0	5.0	15.0	0	0	11.0
New Pioneer House	3.6	3.6	2.4	27.1	1.6	3.6	.9
Parkview	5.0	30.0	5.0	10.0	10.0	36.0	1.0
Twin Town	1.3	2.2	NA	2.2	.8	19.3	NA
Jamestown (Adolescent)	1.2	6.3	0	18.3	0	0	1.2
New Connections (Adolescent)	NA	NA	NA	NA	NA	NA	NA
III. OUTPATIENT CLINICS	**10.5**	**6.1**	**4.5**	**6.6**	**6.1**	**14.8**	**4.4**
Chrysalis	NA	NA	NA	NA	NA	NA	NA
Community Family Counseling	0	3.2	7.4	17.0	0	22.9	1.1
C.R.E.A.T.E.	3.1	2.6	6.5	.6	.6	12.2	5.4
Exchange Program	5.8	5.8	5.8	NA	NA	NA	NA
Fairview Southdale	20.0	1.0	6.0	14.0	30.0	0	4.0
First Step Program	0	2.5	4.5	10.0	2.0	1.0	2.0
5001 Chemical Dependency	17.5	7.5	5.0	0	7.5	25.0	0
Metropolitan Clinic of Counseling	34.0	0	0	0	0	7.0	18.0
South Lake Center	25.0	3.8	0	0	0	0	0
Adolescent Drug Treatment Ltd.	NA	NA	NA	NA	NA	70.0	NA
Renaissance (Adolescent)	0	2.3	2.3	22.7	29.5	11.4	0

[1] All data taken from treatment center responses to a Citizens League questionnaire dated October 1979.
[2] NA: Information not available.
[3] Located in a nursing home; not included in the hospital or independent residential summary.

TABLE V, Continued

Clergy	Detox Centers	Other Treatment Programs	AA or Other Recovering	Health Service Agencies	Court Commitment	Criminal Justice	CENTER
1.2%	5.9%	2.8%	13.2%	6.4%	2.1%	11.7%	TOTAL ALL CENTERS
1.0	**6.0**	**3.7**	**10.1**	**2.7**	**2.2**	**10.3**	**I. HOSPITALS**
2.0	6.0	2.0	18.0	5.0	3.0	7.0	Abbott-Northwestern
0	48.0	0	0	2.0	15.0	15.0	Anoka State
0	7.0	3.0	16.0	0	3.0	2.0	Golden Valley Health Center
NA[2]	NA	NA	14.6	NA	NA	9.5	Mercy Medical Center
1.2	4.1	5.0	10.0	3.0	1.0	8.1	Metropolitan Medical Center
0	7.2	2.2	4.4	.9	0	9.1	Mounds Park
0	3.9	3.9	4.8	9.5	0	10.2	St. John's
.9	1.8	6.3	3.5	1.3	0	2.9	St. Joseph's
3.4	NA	5.8	NA	NA	.8	5.8	St. Mary's
0	1.8	1.0	3.1	1.1	.1	19.1	St. Paul-Ramsey
1.0	5.0	2.0	35.0	0	6.1	15.0	Veteran's Administration
1.0	2.0	10.0	2.0	1.0	23.0		Lutheran Deaconess (Adolescent)
.5	1.0	6.0	0	1.0	.5	21.5	St. Mary's (Adolescent)
0	32.0	4.0	0	0	5.9		Bridgeway[3]
1.2	**6.4**	**.9**	**19.4**	**10.8**	**1.2**	**13.8**	**II. INDEPENDENT RESIDENTIAL**
1.0	4.0	0	7.0	21.0	14.0		Chanhassen
1.0	5.0	1.0	25.0	20.0	3.0	12.0	Family Treatment Center
0	0	0	50.0	10.0	0	0	Hazelden
3.0	10.0	0	0	0	0	34.0	Hennepin County
1.8	35.5	3.8	2.9	2.6	0	8.4	New Pioneer House
1.0	1.0	2.0	6.0	1.0	1.0	0	Parkview
NA	.8	1.6	16.1	39.6	3.2	4.1	Twin Town
0	0	18.3	0	0	54.7		Jamestown (Adolescent)
NA	NA	NA	NA	NA	NA	NA	New Connections (Adolescent)
2.4	**2.3**	**5.9**	**5.7**	**12.4**	**6.0**	**12.2**	**III. [illegible]**
NA	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**Chrysalis**
4.3	3.2	0	0	0	43.1	1.1	Community Family Counseling
.6	.9	6.0	1.2	16.2	0	26.7	C.R.E.A.T.E.
NA	NA	NA	NA	NA	46.6		Exchange Program
5.0	0	9.0	4.0	7.0	0	1.0	Fairview Southdale
5.0	0	3.0	25.0	45.0	0	0	First Step Program
7.5	0	0	15.0	2.5	0	7.5	5001 Chemical Dependency
0	15.0	7.0	11.0	3.1	0	22.0	Metropolitan Clinic of Counseling
0	0	13.0	0	12.0	0	12.0	South Lake Center
NA	NA	NA	NA	NA	NA	NA	Adolescent Drug Treatment Ltd.
0	2.3	6.8	4.6	9.1	0	9.1	Renassiance (Adolescent)

TABLE VI
PLACE OF RESIDENCE OF PATIENTS AT CHEMICAL DEPENDENCY TREATMENT CENTERS SERVING THE TWIN CITIES METROPOLITAN AREA[1]

CENTER	METROPOLITAN AREA	OUTSTATE MINNESOTA	OUT-OF-STATE
TOTAL ALL CENTERS	73.0%	14.2%	12.8%
I. HOSPITALS	**75.5**	**15.4**	**9.1**
Abbott-Northwestern	73.0	22.0	5.0
Anoka State	97.0	3.0	0
Golden Valley Health Center	80.0	15.0	5.0
Mercy Medical Center	81.1	17.9	.8
Metropolitan Medical Center	93.3	5.6	1.1
Mounds Park	90.0	8.0	2.0
St. John's	62.0	26.0	12.0
St. Joseph's	74.0	13.0	13.0
St. Mary's Rehabilitation Center	59.0	12.0	29.0
St. Paul-Ramsey	88.0	10.0	2.0
Veteran's Administration	68.0	25.0	7.0
Lutheran Deaconess (Adolescent)	80.0	12.0	8.0
St. Mary's (Adolescent)	77.5	7.5	15.0
Bridgeway[2]	74.0	18.0	8.0
II. INDEPENDENT RESIDENTIAL	**63.9**	**14.3**	**21.8**
Chanhassen	60.0	30.0	10.0
Family Treatment Center	28.0	52.0	20.0
Hazelden	35.0	5.0	60.0
Hennepin County	85.0	12.0	3.0
New Pioneer House	89.0	9.0	2.0
Parkview	90.0	5.0	5.0
Twin Town	68.1	9.1	22.8
Jamestown (Adolescent)	74.0	25.0	1.0
New Connection (Adolescent)	NA[3]	NA	NA
III. OUTPATIENT CLINICS	**94.1**	**5.4**	**0.5**
Chrysalis	99.0	1.0	0
Community Family Counseling	70.0	30.0	0
C.R.E.A.T.E.	99.0	1.0	0
Exchange Program	100.0	0	0
Fairview Southdale	89.0	9.0	2.0
First Step Program	90.0	8.0	2.0
5001 Chemical Dependency	65.0	35.0	0
Metropolitan Clinic of Counseling	98.0	0	2.0
South Lake Center	NA	NA	NA
Adolescent Drug Treatment Ltd.	100.0	0	0
Renaissance (Adolescent)	100.0	0	0

[1] All data taken from treatment center responses to a Citizens League questionnaire dated October 1979.
[2] Located in a nursing home; not included in the hospital or independent residential summary.
[3] NA: Information not available.

TABLE VII

TREATMENT COMPLETIONS AND TRANSFERS AT PRIMARY CHEMICAL DEPENDENCY TREATMENT CENTERS SERVING THE TWIN CITIES METROPOLITAN AREA[1]

CENTER	Treatment Comp. as % of Admissions	Non-comp. due to Inapprop. Ref.	Inapprop. Ref. Rereferred to Other Prog.	Transfers Inpatient <–> Outpatient
INPATIENT–Total All Centers	**78.3%**	**14.3%**	**83.9%**	**NA**
I. HOSPITALS	**80.2**	**18.1**	**87.6**	**9.4**
Abbott-Northwestern	85.0	60.0	100.0	2.0
Anoka State	55.0	10.0	50.0	
Golden Valley Health Center	89.0	50.0	82.0	2.0
Mercy Medical Center	73.0	NA[2]	NA	NA
Metropolitan Medical Center	95.0	.8	100.0	15.0
Mounds Park	95.0	13.0	38.5	25.0
St. John's	61.0	5.0	100.0	Some
St. Joseph's	76.7	NA	NA	
St. Mary's Rehabilitation Center	86.6	<5.0	NA	10.0
St. Paul-Ramsey	99.0	1.0	100.0	5.0
Veteran's Administration	80.0	2.0	100.0	10.0
Lutheran Deaconess (Adolescent)	80.0	2.0	100.0	Some
St. Mary's (Adolescent)	85.0	3.0	100.0	5.0
Bridgeway[3]	61.0	5.0	NA	Some
II. INDEPENDENT RESIDENTIAL	**77.9**	**10.4**	**87.6**	**3.7**
Chanhassen	95.0	2.5	40.0	5.0
Family Treatment Center	77.0	50.0	100.0	
Hazelden	80.0	3.0	33.0	2-3.0
Hennepin County	88.0	NA	NA	5.0
New Pioneer House	31.0	5.0	100.0	
Parkview	96.0	5.0	100.0	5.0
Twin Town	75.8	NA	NA	1.3
Jamestown (Adolescent)	58.0	12.0	22.0	
New Connections (Adolescent)	NA	NA	NA	
OUTPATIENT–Total All Centers	**81.1**	**16.4**	**91.4**	
I. HOSPITALS	**81.9**	**32.1**	**92.3**	
Abbott-Northwestern	75.0	80.0	100.0	
Golden Valley Health Center	70.0	70.0	45.0	
Mercy Medical Center	90.0	10.0	100.0	
Metropolitan Medical Center	96.0	1.0	100.0	
Mounds Park	80.0	5.0	100.0	
St. John's	73.0	5.0	100.0	
St. Mary's Rehabilitation Center	90.0	<5.0	NA	
St. Paul-Ramsey	98.0	2.0	0	
Veteran's Administration	80.0	20.0	100.0	
Lutheran Deaconess (Adolescent)	55.0	NA	100.0	
St. Mary's (Adolescent)	80.0	5.0	100.0	
Bridgeway[3]	5.0	NA	NA	
II. INDEPENDENT RESIDENTIAL	**84.0**	**4.6**	**4.6**	
Chanhassen	**NA**	**NA**	**NA**	
Hazelden	**78.0**	**3.0**	**100.0**	
Hennepin County	**85.0**	**NA**	**NA**	
Parkview[4]	**94.5**	**10.0**	**100.0**	
Twin Town	73.5	NA	NA	
III. OUTPATIENT CLINICS	**73.9**	**10.4**	**98.0**	
Chrysalis	57.0	33.3	80.0	
Community Family Counseling	77.0	25.0	100.0	
C.R.E.A.T.E.	85.0	5.0	100.0	
Exchange Program	NA	NA	NA	
Fairview Southdale	**81.0**	**6.0**	**100.0**	
First Step Program	**90.0**	**3.0**	**NA**	
5001 Chemical Dependency	**75.0**	**33.0**	**100.0**	
Metropolitan Clinic of Counseling	**78.0**	**10.0**	**NA**	
South Lake Center	85.0	5.0	100.0	
Adolescent Drug Treatment Ltd.	55.0	NA	NA	
Renaissance (Adolescent)	NA	11.4	100.0	

[1] All data taken from treatment center responses to a Citizens League questionnaire dated October 1979.
[2] NA: Information not available.
[3] Located in a nursing home; not included in the hospital or independent residential summary.
[4] Two weeks inpatient plus four weeks outpatient.

TABLE VIII
POST TREATMENT REFERRALS BY PRIMARY CHEMICAL DEPENDENCY TREATMENT CENTERS SERVING THE TWIN CITIES METROPOLITAN AREA[1]

CENTER	Own Aftercare	AA or NA	Transitional Care Facility	Another Primary Care Center	Mental Health Counseling	Social Service Counseling
TOTAL ALL CENTERS	58.3%	85.0%	12.9%	2.3%	5.1%	13.3%
I. HOSPITALS	**76.0**	**95.2**	**14.6**	**1.9**	**5.9**	**15.0**
Abbott-Northwestern	50.0	100.0	10.0	2.0	0	50.0
Anoka State	20.0	100.0	35.0	0	5.0	70.0
Golden Valley Health Center	95.0	95.0	5.0	1.0	2.0	3.0
Mercy Medical Center	54.0	100.0	NA[2]	NA	8.1	NA
Metropolitan Medical Center	100.0	100.0	25.0	1.6	4.6	2.6
Mounds Park	80.0	NA	NA	NA	NA	NA
St. John's	98.0	98.0	1.0	.5	.5	1.0
St. Joseph's	51.7	100.0	30.5	0	4.6	0
St. Mary's Rehabilitation Center	90.0	90.0	20.0	7.0	2.3	10.0
St. Paul-Ramsey	100.0	100.0	10.0	.1	6.4	.1
Veteran's Administration	80.0	95.0	35.0	0	2.0	0
Lutheran Deaconess (Adolescent)	90.0	90.0	7.0	1.0	1.0	1.0
St. Mary's (Adolescent)	72.0	100.0	10.0	1.0	2.0	11.0
Bridgeway[3]	41.1	41.1	7.8	14.9	NA	NA
II. INDEPENDENT RESIDENTIAL	**31.2**	**79.0**	**12.0**	**1.8**	**2.9**	**10.7**
Chanhassen	59.0	92.0	4.0	2.0	4.0	7.0
Family Treatment Center	20.0	100.0	3.0	3.0	7.0	8.0
Hazelden	14.0	70.0	18.0	0	2.0	NA
Hennepin County	6.0	80.0	9.0	4.0	3.0	15.0
New Pioneer House	21.4	20.2	42.9	NA	NA	NA
Parkview	100.0	100.0	5.0	1.0	1.0	5.0
Twin Town	82.0	82.0	18.0	0	NA	NA
Jamestown (Adolescent)	100.0	0	9.3	0	2.4	0
New Connections (Adolescent)	NA	NA	NA	NA	NA	NA
III. OUTPATIENT CLINICS	**64.5**	**64.9**	**2.3**	**7.3**	**8.0**	**13.6**
Chrysalis	100.0	100.0	NA	NA	NA	7.0
Community Family Counseling	100.0	80.8	0	4.1	11.6	7.5
C.R.E.A.T.E.	0	2.5	0	6.0	9.5	31.3
Exchange Program	100.0	NA	NA	NA	NA	NA
Fairview Southdale	100.0	100.0	9.0	3.5	4.0	6.0
First Step Program	94.4	60.0	0	6.8	3.0	1.0
5001 Chemical Dependency	50.0	99.0	0	24.9	0	7.1
Metropolitan Clinic of Counseling	78.0	100.0	4.8	12.0	27.0	25.0
South Lake Center	NA	NA	NA	NA	NA	NA
Adolescent Drug Treatment Ltd.	80.0	100.0	5.0	15.0	0	0
Renaissance (Adolescent)	85.7	14.3	0	0	0	0

[1] All data taken from treatment center responses to a Citizens League questionnaire dated October 1979.
[2] NA: Information not available.
[3] Located in a nursing home; not included in the hospital or independent residential summary.

WHAT THE CITIZENS LEAGUE IS

Formed in 1952, The Citizens League is an independent, nonpartisan, nonprofit, educational corporation dedicated to understanding and helping to solve complex public problems of our metropolitan area.

Volunteer research committees of the Citizens League develop recommendations for solutions after months of intensive work.

Over the years, the League's research reports have been among the most helpful and reliable sources of information for governmental and civic leaders, and others concerned with the problems of our area.

The League is supported by membership dues of individual members and membership contributions from businesses, foundations and other organizations throughout the metropolitan area.

You are invited to join the League, or, if already a member, invite a friend to join. An application blank is provided for your convenience on the reverse side.

WHAT THE CITIZENS LEAGUE DOES

RESEARCH PROGRAM

- Four major studies are in progress regularly.
- Each committee works 2½ hours per week, normally for 6-10 months.
- Annually over 250 resource persons made presentations to an average of 25 members per session.
- A fulltime professional staff of seven provides direct committee assistance.
- An average in excess of 100 persons follow committee hearings with summary minutes prepared by staff.
- Full reports (normally 40-75 pages) are distributed to 1,000-2,000 persons, in addition to 3,000 summaries provided through the CL NEWS.

CL NEWS

- Four pages; published every other week; mailed to all members.
- Reports activities of the Citizens League, meetings, publications, studies in progress, pending appointments.
- Analysis, data and general background information on public affairs issues in the Twin Cities metropolitan area.

PUBLIC AFFAIRS ACTION PROGRAM

- Members of League study committees have been called on frequently to pursue the work further with governmental or nongovernmental agencies.
- The League routinely follows up on its reports to transfer, out to the larger group of persons involved in public life, an understanding of current community problems and League solutions.

COMMUNITY LEADERSHIP BREAKFASTS

- Held from September through May at 7:30 - 8:30 a.m.
- Minneapolis breakfasts are held each Tuesday at the Grain Exchange Cafeteria.
- Saint Paul Breakfasts are held every other Thursday at the Pilot House Restaurant in the First National Bank Building.
- South Suburban breakfasts are held the last Friday of each month at the Northwestern Financial Center Cafeteria, Bloomington.
- An average of 35 persons attend each of the 64 breakfasts each year.
- The breakfast programs attract news coverage in the daily press, television and radio.

QUESTION-AND-ANSWER LUNCHEONS

- Feature national or local authorities, who respond to questions from a panel on key public policy issues.
- Each year several Q & A luncheons are held throughout the metropolitan area.

PUBLIC AFFAIRS DIRECTORY

- A directory is prepared following even-year general elections and distributed to the membership.

INFORMATION ASSISTANCE

- The League responds to many requests for information and provides speakers to community groups on topics studied.

Citizens League non-partisan public affairs research and education in the St. Paul-Minneapolis metropolitan area. **84 S. 6th St., Minneapolis, Mn. 55402 (612) 338-0791**

Application for Membership (C.L. Membership Contributions are tax deductible)

Please check one: ☐ Individual ($20) ☐ Family ($30) ☐ Contributing ($35-$99) ☐ Sustaining ($100 and up) ☐ Fulltime Student ($10)

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