Minnesota Drug Courts Funding Study – Chemical Dependency and Mental Health Services

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EXECUTIVE SUMMARY

In November 2006, the Minnesota State Court Administrator's Office (SCAO) contracted with NPC Research for a study of the funding and service provision structures of Minnesota's D.W.I. and adult drug courts. The study examined chemical dependency and mental health services and funding, and was guided by eight key policy questions of interest:

1. What are the funding sources for chemical dependency and mental health services for drug courts?
2. What funding sources are used to support which services?
3. Where are there gaps and inequities in services and in funding?
4. Where is there vulnerability in services or in funding?
5. What are the differences in service availability and funding streams between urban and rural counties?
6. How and to what degree is the Consolidated Chemical Dependency Treatment Fund (CCDTF) or private insurance used to support drug court services?
7. Are drug courts a more efficient way of utilizing public resources for treatment services?
8. Are there service structures or funding mechanisms used by other states to support their drug courts that would be useful models for Minnesota?

The study included 13 D.W.I. and adult drug courts. NPC Research collected data from the drug court sites to create a profile of chemical dependency and mental health services and funding for drug court clients, including individual-level data on drug court clients' treatment utilization. NPC Research also analyzed data on the statewide offender population to examine differences in publicly

funded treatment utilization between drug court clients and the statewide offender population. Finally, NPC Research conducted a study of 11 other states to identify promising drug court service and funding practices of possible interest to Minnesota.

Overall Findings

While many of Minnesota's drug courts are new, Minnesota is in some ways at the forefront of treatment service delivery and has already taken steps that will ensure its place among drug court systems nationally. Minnesota has established a Drug Court Initiative (DCI) Advisory Committee that is charged with establishing statewide standards of practice, policies and procedures for administering state drug court funds, and strategic planning for future drug court expansion. The state is also in the planning phase for a statewide drug court management information system, and has already conducted several statewide training, education, and public relations efforts aimed at legislators, treatment providers, and others.

Furthermore, Minnesota's Consolidated Chemical Dependency Treatment Fund (CCDTF) is a unique method and a leading model for funding chemical dependency treatment services. The CCDTF, developed in 1986 by the state legislature, pools federal, state, and local treatment resources and covers the cost of treatment for income-eligible

clients. Approximately 50% of entries into treatment in Minnesota are funded through the CCDTF.

The majority of funding for treatment services for Minnesota's drug courts comes from the CCDTF. Data from this study suggest that Minnesota's drug courts are an efficient way to use CCDTF funds. Drug court clients stay in treatment longer (for example, 1 in 10 drug court clients receiving inpatient treatment stay in that treatment for more than 90 days, compared to 1 in 100 offenders overall). Research has shown that a continuum of care, consisting of longer lengths of stay, results in a greater likelihood of treatment completion and longer-term benefits. Thus, using drug courts as a conduit for CCDTF funds may be more cost-beneficial than using the CCDTF to support offenders processed through the traditional criminal justice system. A cost-benefit study of Minnesota's drug courts could provide more definitive information about the efficiency of drug courts as a conduit for CCDTF funds.

Other sources of funding for chemical dependency services for drug courts in Minnesota are used to augment the traditional treatment services reimbursed by the CCDTF and private insurance. Some sites have established formalized relationships with treatment providers, and these agreements or contracts, in turn, can guarantee treatment availability for drug court clients, can give the drug court team some oversight of the treatment quality, can encourage the treatment provider to become part of the drug court team, and can create a more coordinated and holistic treatment experience for the drug court clients.

The drug court model calls for coordinated, comprehensive treatment services for clients. To implement this model, courts must rely upon more than CCDTF-funded treatment services. While CCDTF covers the cost of outpatient treatment, inpatient treatment, extended care, and halfway houses, other funding is necessary to implement the integrated, coordinated service model (including ensuring priority access to services, monitoring treatment quality, including the provider in drug court staffings and hearings, and providing ancillary services) that is central to drug court. Many of Minnesota's drug courts have been established within the past two years, and as such, the state should focus resources to help existing courts implement quality, full-scale drug court programs, and should then focus resources on creating additional courts.

The most noticeable gap in services identified by the current study is in the area of mental health. Minnesota is no different from other states in this regard; none of the 11 comparison states in the study have integrated mental health services into the drug court model in any systemic way. This is in spite of clear research evidence that co-occurring disorders (chemical dependency combined with mental health issues) are a massive problem for the criminal justice population and one that significantly limits the ability of chemical dependency treatment to be successful. Some examples do exist within Minnesota of drug courts that are using innovative approaches to this issue. Minnesota, by investing resources and support for local courts, can be at the national forefront on this issue. The state can provide technical assistance to local courts in designing program models that incorporate mental health services and can target state drug court funding to support such models.

Answers to the Policy Questions and Policy Recommendations

Below is a summary of the findings for each study question along with policy recommendations.

WHAT ARE THE FUNDING SOURCES FOR TREATMENT SERVICES FOR DRUG COURTS AND WHAT FUNDING SOURCES ARE USED TO SUPPORT WHICH SERVICES?

The primary funding source for chemical dependency treatment is the Consolidated Chemical Dependency Treatment Fund (CCDTF), comprising 67% of the expended funds and covering 52% of the drug court clients. A small number of drug court clients have treatment funded through private insurance or Pre-Paid Medical Assistance Plans (PMAP, a state-purchased managed care program for income-eligible individuals). Eight courts have some other source of funding for chemical dependency services, including Federal Bureau of Justice Assistance (BJA) grants, and Minnesota State Court Administrator's Office (SCAO) funds. These other sources of funds combined comprise 18% of the total funds expended on chemical dependency services for drug court clients.

WHERE ARE THERE GAPS, INEQUITIES, OR VULNERABILITIES IN SERVICES OR FUNDING?

Service Inequities

This study identified two primary service inequities: the enhanced services available to clients at courts with treatment provider contracts, and differences in per-client spending across the sites.

First, some courts have created direct contracting arrangements with treatment providers. These contracts ensure treatment availability for drug court clients, allow the court to monitor the quality of treatment services, and encourage the treatment providers to become integral members of the drug court team. While a few sites without contracts or other formalized arrangements with providers do have treatment providers who are engaged as part of the drug court team, for the most part, at these sites there is less oversight of treatment services and quality by the drug court, and less engagement by the providers in the drug court model. Further, data from this study suggest that some courts with treatment contracts tend to have clients with longer lengths of stay in treatment.

One of the 10 Key Components of drug court is the integration of treatment services with justice system case processing, including regular communication between providers and the court, and team planning and decision-making. Another of the 10 Key Components of drug court is creating a continuum of treatment, including treatment accessibility and quality control and accountability for the providers. Establishing formalized relationships with treatment providers allows drug courts to meet these key components.

Recommendation #1: Create contracting relationships with providers that can:

- **Prioritize treatment access for drug court clients;**
- **Ensure that treatment providers are supportive of the drug court model;**
- **Monitor treatment quality;**
- **Support additional treatment activities; and**
- **Allow the treatment providers to be part of the drug court team.**

The second inequity is a difference in per-client spending across courts. While most sites' per-client spending on chemical dependency treatment is close to the statewide drug court per-client average of approximately $4,219.92, some sites dedicate far more resources per client. This inequity is due to differential treatment utilization; that is, these sites rely more heavily on inpatient treatment or have clients with longer lengths of stay than other sites. Without standardized assessment practices across sites it is impossible to definitively determine whether cli-

ents at other sites need this more intensive level of service, but it is likely that many clients could benefit from this increased level of service.

Recommendation #2: NPC Research agrees with the recommendation put forth by the Minnesota Office of the Legislative Auditor that Minnesota should have a standardized chemical dependency assessment tool and process across counties.

Recommendation #3: Increase clients' lengths of stay in treatment, as longer lengths of stay are more likely to lead to treatment completion and longer-term positive outcomes.

Service Gap

The primary service gap identified by this study is the lack of emphasis on mental health assessments and treatment. Despite the well-documented link between chemical dependency and mental health disorders, mental health services are not an integral component of most courts' drug court models, and as a result, data on mental health services is limited.

The high rate of comorbid chemical dependency and mental health disorders has been detailed in the research literature (Brady & Sinha, 2005; Kessler et al., 1996; Regier et al., 1990). Individuals with chemical dependency are seven times more likely than the general population to have a comorbid mental health issue (Regier et al., 1990). Research shows that over one-third (37%) of individuals with an alcohol dependency problem and more than half of individuals with a drug problem other than alcohol dependency have co-occurring mental health problems (Regier et al., 1990). Further, drug court evaluation research illustrates a high incidence of co-occurring mental health problems among drug court clients and suggests courts prioritize inclusion of mental health treatment services (Belenko, 2001).

These findings have significant implications for treatment of comorbid disorders, especially within the drug court population. The literature highlights the importance of addressing chemical dependency and mental health disorders in concert with one another. Traditionally, treatment for individuals with co-occurring chemical dependency and mental health problems has taken place concurrently with counselors addressing each disorder separately; however, treatment for comorbid chemical dependency and mental health disorders can also be tackled collaboratively. Research evaluating the relative effectiveness of each of these approaches demonstrates that when treatment for chemical dependency and mental health problems are integrated, clients are more likely to participate in treatment and have more successful outcomes, including longer-term social adjustment (see for example, Lineham et al., 1999). Further research is necessary in this area, though to date a collaborative approach appears to be ideal.

Because research indicates that dual-diagnosis is the norm for individuals involved in the criminal justice system rather than the exception (Drug Court and Mental Health Court Institute, 2007), treatment that does not address co-occurring mental health issues presents problems for successful chemical dependency treatment.

Several drug courts have incorporated mental health services into their drug court models. The Ramsey Adult Substance Abuse Court and the Ramsey D.W.I. Court share the Psychiatric Court Clinic. The Clinic psychiatric nurse is considered a member of the drug court teams, the Clinic is co-located with the court, and at a per-client cost of approximately $2,000, this is a relatively inexpensive mental health intervention. Two other

courts have contracts with a treatment provider that is responsible for both chemical dependency and mental health services. Several sites use SCAO funds to cover the cost of mental health assessments. However, with the exception of the two Ramsey courts, even at sites with some arrangements for mental health services, most clients do not receive mental health services.

Recommendation #4: Assess clients for mental health issues as part of the drug court assessment process.

Recommendation #5: Create and fund a statewide model that incorporates mental health services into drug court services. Minnesota can take a lead nationally in integrating mental health services into the drug court model.

Recommendation #6: Give priority for state drug court funding to courts that integrate mental health services into their drug court models.

WHAT ARE THE DIFFERENCES IN SERVICE AVAILABILITY AND FUNDING STREAMS BETWEEN URBAN AND RURAL COUNTIES?

No clear urban-rural patterns emerge from the current study. Some newer, more rural sites do have fewer funding sources and lower per-client averages, but other rural sites are comparable, or ahead, of the state averages. Despite the lack of clear patterns of difference between urban and rural sites, it is worth noting that there are real differences in the number and type of treatment providers across the state, and there are obvious disadvantages for counties with few, or no, providers. Using funding to establish enticing contracting arrangements with providers can be particularly beneficial in rural communities; these contracts can provide incentives to providers to offer care in a community they otherwise would not serve, and thus can bring treatment services to communities that previously had none. For example, courts can secure contracts with providers in neighboring communities that require the providers to offer services in rural communities.

Recommendation #7: Devote resources to develop contractual relationships that provide incentives for providers to serve clients in rural areas.

HOW AND TO WHAT DEGREE IS THE CCDTF OR PRIVATE INSURANCE USED TO SUPPORT DRUG COURT SERVICES?

All 13 study sites rely on the CCDTF. The CCDTF accounts for 67% of the funds used for chemical dependency treatment at the study sites and is used by 52% of the drug court clients. Eight study sites have clients who utilize private insurance for chemical dependency services. Private insurance comprises 7% of the total funds expended and is used by 6% of the drug court clients.

Representatives from the study courts state that they have not had to turn clients away from drug court because they have not qualified for the CCDTF; courts report that either all clients have qualified, or that for those who have not qualified (and who have no alternate sources of insurance), the courts have worked to identify other funds (such as grants) that could be used to cover treatment services.

ARE DRUG COURTS A MORE EFFICIENT WAY OF UTILIZING PUBLIC RESOURCES FOR TREATMENT SERVICES?

Drug courts appear to be an efficient conduit for the CCDTF. Drug court clients remain in treatment longer than the overall Minnesota offender population, and research has established a link between time spent in treatment,

treatment completion, and longer-term positive outcomes. Chemically dependent individuals oftentimes require a heightened engagement in services, or continuum of care, consisting of a series of treatment episodes (for example, inpatient treatment followed by outpatient treatment followed by continuing care) in order to achieve sobriety; data from this study indicate that drug court clients are receiving this continuum of care while offenders overall are not. Furthermore, 1 in 10 drug court clients who enter some form of residential treatment stay in that treatment for more than 90 days, compared to approximately 1 in 100 Minnesota offenders, and drug court clients also have longer stays in outpatient treatment; research has shown that individuals who stay in treatment for longer than 90 days are more likely to have successful outcomes (National Institute of Drug Abuse, 2000).

These findings mirror recent findings regarding the relative effectiveness of drug courts as compared to a statewide treatment program for drug offenders in California. In that study, drug court clients were more likely to complete treatment and had lower criminal recidivism rates than offenders who took part in a statewide treatment diversion program (Carey, Pukstas, Waller, Mackin, & Finigan, 2007).

Furthermore, while this study did not investigate the proportion of drug court clients who enter treatment as compared to the proportion of chemically dependent offenders overall who enter treatment, other studies have shown that drug court clients are more likely to enter treatment than comparable individuals (see, for example, Worcel, Green, Furrer, Burrus, & Finigan, 2007).

Recommendation #8: Increase the number of offenders served by drug courts as a means to use the CCDTF more efficiently and effectively.

A full cost-benefit analysis of Minnesota's drug courts would allow for a more definitive investigation of the efficiency and effectiveness of drug courts. Results from cost-benefit studies have been used to inform state legislatures, have been used in successful grant applications for Federal or private foundation funds, and have been used to build support from local government agencies crucial for drug court success, such as the public defender, district attorney, or sheriff.

Recommendation #9: Conduct a cost-benefit analysis of Minnesota's drug courts.

ARE THERE SERVICE STRUCTURES OR FUNDING MECHANISMS USED BY OTHER STATES TO SUPPORT THEIR DRUG COURTS THAT WOULD BE USEFUL MODELS FOR MINNESOTA?

The primary sources of chemical dependency treatment funding for drug court clients are the same across the study's comparison states they are in Minnesota: i.e., the public treatment system, Medicaid, private health insurance, self pay, and a variety of other specialty programs. None of the states provide targeted chemical dependency funding for drug court participants; like Minnesota, drug courts in other states cobble together funding from myriad of sources.

Similar to Minnesota, none of the 11 comparison states have integrated mental health services into drug courts statewide.

In some comparison states, drug courts or judicial branches contract directly with treatment providers in relationships formalized by memorandums of understanding or actual fee for service contracts. Contracts may include agreement to provide treatment to all drug court clients, including those in rural areas, and standards for reporting treatment progress to court staff.

Representatives from the comparison states note the need for a standardized drug court management information system to streamline statewide reporting, document local outcomes, track expenditures, support program oversight and provide evidence for seeking additional funding. Where feasible, duplication can be avoided by enhancing existing data systems or integrating disparate data systems.

Recommendation #10: Develop a drug court MIS for use by all the state's drug courts. Researchers as well as practitioners should continue to be included in the planning and design process to ensure that the MIS will be of practical use for case management and other practitioner needs as well as for research and evaluation purposes.

Comparison states identified several optimal aspects of service delivery, including standardized chemical dependency and mental health assessments, offering a variety of treatment modalities, and providing a continuum of care, including continuing care.

Representatives from the comparison states also affirm that courts interested in securing funding from local government agencies or other community partners need to build relationships and increase education of the public and key partners about the advantages and benefits of drug court programs versus traditional criminal justice case processing. Courts, advocates, providers and other stakeholders in Minnesota and the comparison states have prepared and distributed educational policy briefs, evaluations and performance reviews, sponsored public opinion polling to assess the level of support for drug treatment programs, held legislative forums on drug courts and other alternatives to incarceration programs (including inviting a drug court judge from Ramsey County to speak), and holding judicial workshops on how criminal justice and chemical dependency treatment systems can work more effectively together.

Recommendation #11: Continue to build relationships and increase education of the public and key partners about the advantages and benefits of drug court programs versus traditional criminal justice processing.

In addition, states that have taken drug courts to scale statewide stress the importance of state-level drug court coordination, including the creation of standards of practice and the implementation of state-level advisory boards that are responsible for strategic planning and allocating state drug court funds.

Recommendation #12: Continue with plans to create standards of practice for all drug courts, and link funding to these standards.

Recommendation #13: Continue to expand the role of the Drug Court Initiative Advisory Committee; this group should play a key role in strategic planning to guide the expansion of drug courts across the state.

Many of Minnesota's drug courts were founded within the past 2 years, and as such, could use assistance in building partnerships in their communities, creating and solidifying

their program models and policies, and increasing their capacity and case flow. The success of the drug court model relies upon coordinated, comprehensive services for participants. Therefore, the state should focus efforts and resources on first strengthening these existing courts to be sure that these courts are operating quality, full-scale drug court programs prior to establishing additional courts. Increasing the number of drug courts, without providing the courts with adequate support and technical assistance, will result in courts with limited effectiveness.

Recommendation #14: Strengthen existing drug courts to ensure they are implementing quality programs before, or in combination with, adding new drug courts.

Finally, drug courts should be part of a larger Alternative to Incarceration Plan to treat nonviolent drug offenders that starts with bringing drug courts to scale statewide in a planned fashion. Treatment alternatives in lieu of prison should be incorporated into state laws, and the state should increase the capacity and infrastructure for a statewide diversion-from-incarceration program. Indeed, Minnesota has begun this work already; in the recent legislative session the legislature has authorized the Sentencing Guidelines Commission to develop modifications to the sentencing guidelines for drug offenders.

Recommendation #15: NPC Research agrees with the recommendation set forth by the Minnesota Chemical Dependency Task Force (Minnesota State Court Administrator's Office, 2006) that the state should create a comprehensive plan to address the needs of individuals who are chemically dependent, of which drug courts are one important component.

Conclusion

Minnesota's drug court initiative is relatively young in comparison to other states. Despite this fact, the state is making a concerted effort to foster and expand its drug court programs through the establishment of the DCI and the availability of state funds for drug courts, among other things. The state can strengthen its drug courts and move to the forefront of the national drug court movement by building a state-level drug court infrastructure to strengthen existing courts, establish additional courts, and integrate mental health services into the drug court model.

SECTION I: INTRODUCTION

Project Background and Goals

In November 2006, the Minnesota State Court Administrator's Office (SCAO) contracted with NPC Research for a study of the funding and service provision structures of Minnesota's D.W.I. and adult drug courts. The project included five objectives:

- Identify service and funding structures for drug courts;
- Identify obstacles to optimal service delivery for drug courts;
- Determine reasons for funding inequities;
- Recommend alternatives for funding and service structures; and
- Develop a methodology for a cost-benefit analysis of Minnesota's drug courts.

The economic consequences to society of drug and alcohol dependency have long been detailed. Untreated chemical dependency is costly to the individual and to taxpayers who must fund the consequences of the negative social behaviors that result from addiction. There is a well-researched link between chemical dependency and criminal behavior that results in a profound fiscal impact on the criminal justice system (Finigan, 1996).

Drug court programs are one approach to addressing this problem. Drug courts have been shown to be effective in reducing recidivism (United States Government Accountability Office, 2005) and in reducing taxpayer costs due to positive outcomes for drug court participants (Carey & Finigan, 2003; Carey et al., 2005). Some drug courts have even been shown to cost less to operate than processing offenders through business-as-usual (Carey & Finigan, 2003). Research indicates that retention and completion of treatment programs have a positive effect in reducing drug

use and criminal behavior (Belenko, 1998 and 2001).

While many studies have shown drug courts to be effective in reducing crime, relatively few have looked at the funding and service structures or the economic impact of these programs on either a local or statewide level (these few include Carey & Finigan, 2003; Piper & Spohn, 2004; Logan et al., 2001). In the typical drug court program, participants are closely supervised by a judge who is supported by a team of agency representatives including addiction treatment providers, district attorneys, public defenders, law enforcement officers and parole and probation officers who operate outside of their traditional adversarial roles and work together to provide needed services to drug court participants. Since the first drug court began operation in Miami in 1989, several hundred thousand men, women and juveniles have participated in drug court programs that have involved federal, state and local taxpayer investments of billions of dollars. There are currently well over 1,000 adult drug courts operating in all 50 states. The rapid expansion of drug courts, coupled with an uncertain fiscal climate, highlights the need to understand how these programs are structured and funded, along with whether these programs are cost-beneficial.

There has been growing recognition of the potential benefits of the drug court model for chemically dependent offenders. For example, The Minnesota Supreme Court Chemical Dependency Task Force recommended in 2006 that the state adopt problem-solving models—primarily drug courts—throughout the criminal justice system (Minnesota State Court Administrator's Office, 2006). At the same time, there has been growing acknowledgement of the challenges and barriers to providing effective treatment. Indeed, a National Treatment Accountability for Safer Communities reported on the 1999 National Drug Court Treatment Survey that the relationship between drug courts and treatment services does not appear to be well structured (Peyton & Gossweiler, 2001). Furthermore, the Minnesota Office of the Legislative Auditor conducted a study in 2006 of chemical dependency treatment in Minnesota and found significant variability in program availability and practices (Office of the Legislative Auditor, 2006). For example, the OLA report detailed differences in assessment practices and variability in the quantity and type of treatment available across regions of the state. The current study seeks to document the service and funding structures utilized by Minnesota's drug courts.

NPC Research's project for the SCAO is *not* a cost-benefit analysis of drug courts; rather, the purpose of this project is to compile and document the funding structures of Minnesota's drug courts and to provide a series of recommendations for the State to consider regarding how to provide drug court services in the most efficient and equitable manner. Below we describe the project's focus, policy questions, and tasks.

Project Description

Drug courts are complex, multidisciplinary systems involving a variety of organizational players and services. However, the SCAO and study advisory group determined that the current study should limit its focus to two areas: chemical dependency services and mental health services. Thus, the project examines the service and funding structures for **chemical dependency** and **mental health** services for drug court clients. Other services that may be included in the drug court "package," including case management, drug testing, court and attorney time, and ancillary services (e.g., housing, employment, and education services) are not included in this study.

Thirteen drug courts participated in the study, including 11 adult drug courts and 2 D.W.I. courts. These courts were all of the adult and D.W.I. courts in Minnesota that had been operational for at least 6 months prior to the start of the study in November 2006 (several other counties began drug courts at some point during the study period; these courts were not included in the study).

The study was guided by the overarching question of how Minnesota can provide the most efficient and equitable funding for drug court services. NPC Research, in collaboration with the SCAO and the study's advisory board, created nine key policy questions of interest:

1. What are the funding sources for drug courts?
2. What funding sources are used to support which services?
3. Where are there gaps and inequities in services and in funding?
4. Where is there vulnerability (e.g., services that rely on one, or very few, funding sources or where funding sources may be vulnerable to budget cuts)?
5. Where is there overlap in services and in funding?
6. What are the differences in service availability and funding streams between urban and rural counties?

7. How and to what degree is the Consolidated Chemical Dependency Treatment Fund (CCDTF) or private insurance used to support drug court services?
8. Are drug courts a more efficient way of utilizing public resources for treatment services?
9. Are there service structures or funding mechanisms used by other states to support their drug courts that would be useful models for Minnesota?

Using these policy questions as a base, NPC Research designed a study comprised of four Project Tasks.

Project Task 1—Documenting the services and funding for chemical dependency and mental health services: This was the primary task for the project, and addressed Policy Questions 1-7. The task included (1) collecting information necessary to create a profile of chemical dependency and mental health services and funding for drug court clients; (2) analyzing this data to identify inequities, overlaps, gaps, and vulnerabilities, and (3) creating recommendations for improving the service provision and funding structures.

Project Task 2—Comparing the efficiency of the use of public funds for treatment among drug court clients as compared to the larger offender population in Minnesota: This task, which addresses Policy Question 8, involved gathering and analyzing data on the utilization of public resources for treatment services for the overall offender population in Minnesota as compared to the utilization of such resources by drug court clients.

Project Task 3—Researching other states: This task, created to answer Policy Question 9, involved gathering information about the service provision and funding structures for chemical dependency and mental health services used by 11 other states in support of their drug court services. The states included in the study were California, Florida, Illinois, Indiana, Maryland, Michigan, Missouri, New York, Oregon, Pennsylvania, and Wisconsin. These states were chosen based on the interests of the SCAO, geographical or structural similarities to Minnesota, or NPC Research familiarity from previous studies.

Project Task 4—Creating a cost-benefit study design. This task involved providing the SCAO with a recommended design and methodology for a future cost-benefit study of Minnesota's drug courts.

What This Project Is Not

While this study provides a wealth of information about Minnesota's drug courts, it is important to recognize that given the focus of the project, some topics, worthy of study in their own right, fell outside the scope of the current project.

First, as discussed above, the current project focuses exclusively on chemical dependency and mental health services. There are other vital components to drug court programs that therefore are not represented in this study, including case management, drug testing, court and attorney services, and a wide variety of ancillary services. We recognize that numerous organizations provide resources, staff, and other support to drug courts in the provision of these services.

Second, the current study focused exclusively on Minnesota's adult drug courts and D.W.I. courts. Juvenile drug courts and family treatment drug courts were not included in this study, and it is likely that the service provision and funding structures for services for clients served by these courts may vary from the structures of adult and D.W.I. courts.

Third, the current study is not a cost-benefit analysis. The study does not attempt to catalogue all costs associated with drug courts (indeed, by focusing solely on chemical dependency and mental health services, this study is explicitly not focusing on all costs involved with drug courts), nor does the study provide information on the outcomes

(and related cost-savings) associated with drug courts.

Report Description

The remainder of this report covers the findings of Project Tasks 1-3, listed above. (Project Task 4, the creation of a design and methodology for a future cost-benefit study, is presented as a separate document.) Section II of this report presents a description of the study methodology. Section III summarizes the findings from Project Task 1, including individual and cross-site descriptions of service provision and funding structures; an analysis of inequities, overlaps, and gaps in funding; and recommendations for improvement. Section IV, the result of Project Task 2, provides an analysis of the relative efficiency of drug courts' utilization of public resources for treatment as compared to the larger offender population. Section V, the result of Project Task 3, presents information about the drug court service provision and funding structures used by 11 different states and offers recommendations for Minnesota. Finally, Section VI summarizes the findings for each study policy question and provides recommendations for local drug courts and state-level policymakers.

SECTION II: METHODOLOGY

The methodology used to respond to the nine policy questions involved data collection within Minnesota and from 11 other states. Below we first describe the methodology used within Minnesota, including the data collection activities (surveys, interviews, document review, individual-level drug court data collection, and statewide treatment data collection) and analysis strategies. This is followed by a discussion of the methodology used with the 11 other states, including site selection, web searches, document and literature review, and telephone interviews.

Minnesota Data Collection and Analysis

DATA COLLECTION STRATEGIES

We employed several data collection strategies to collect information about the structure of drug court services and funding including electronic surveys, telephone interviews, document review, and individual-level data collection.

Electronic Surveys

To gather some basic information about the services offered by the courts and how those services were funded, we employed a two-phase electronic survey methodology. First, we surveyed the drug court coordinators to learn what services were offered to drug court clients and which agencies oversaw those services. The surveys were administered in Survey Monkey, an online survey administration service. Then, based on the information provided by the coordinators, we conducted a second round of electronic surveys to the oversight agencies identified by the drug court coordinators. These surveys, also administered through Survey Monkey, included questions about the type of services provided, the number of clients receiving the

services, the number of agencies providing the services, and the funding sources utilized for the services. We collected survey responses from 91 agencies across the study sites.

Telephone Interviews

After the electronic surveys, we conducted a series of telephone interviews with coordinators and service providers to obtain more detailed information about how the drug court services were funded. These interviews, tailored for each respondent, included questions about the amount of money obtained from each funding source, how those funds were used, and whether there were any restrictions on the use of funds. We conducted telephone interviews with 46 respondents across the study sites.

Document Review

In addition to gathering data through surveys and interviews, we asked the sites to provide us with any written documentation available, including policy and procedure manuals, evaluation reports, and budgets. We reviewed these documents to gain a more complete understanding of each court's history, structure, and services.

Individual-level Drug Court Data Collection

In order to identify the amount of funds utilized by drug court clients for services, it was

necessary to collect individual-level data on drug court clients. The electronic surveys, telephone interviews, and document review allowed us to gain a detailed understanding of each court's service delivery structure and a general sense of the funding sources utilized, but in order to attach dollar figures to services it was necessary to collect individual-level data about drug court clients. Each site was asked to provide us with information regarding each (de-identified) client's treatment experience, including the payment source for that client (e.g., CCDTF, PMAP, private insurance, self-pay), the number of chemical dependency and mental health treatment episodes while in drug court, the entry and exit date for each episode, the treatment provider and treatment modality, and the treatment completion status. We used this data to calculate the cost associated with each funding stream, as described below.

In most cases[1], the drug court coordinator at each of the participating sites received a detailed Excel spreadsheet outlining the individual level data needed and NPC Research staff provided technical assistance to assist the coordinators with completing the spreadsheet. The coordinators reviewed drug court case files and, in some cases, treatment files, and documented each client's demographic and drug court participation information and treatment experiences for both chemical dependency and mental health services. The treatment experience data includes start and end dates, treatment type, discharge status, facility and method of payment. As these files and accompanying information are not specifically kept by the drug courts for this data collection purpose, we expect that the coordinators had to employ some estimation in order to complete the spreadsheet.

Because the Hennepin County Drug Court Program serves such a large volume of participants, NPC Research staff collected the data on a sample of drug court participants (rather than collecting data on all participants) on site in Minneapolis. The sample included those starting the Hennepin County Drug Court program between January 15-31 and March 15-31, 2006. We selected two different time points to avoid any potential seasonality effects (e.g., people who enroll in drug court at a particular time of year could be different or could have different drug court experiences than people who enroll at a different time of year). Data were assembled from probation and court records. Printed data queried from two data systems within the Hennepin County Probation department included the chronological narrative or case notes of supervision events by probation officers and the entry date, completion status and facility for chemical dependency treatment for available matched clients. In addition, court records were reviewed for drug court case progress and merged with publicly funded medical insurance claims data (treatment billing information) for individuals identified as part of the sample. Data on the Hennepin sample's health insurance claims paid for by Minnesota Health Care programs for chemical dependency and mental health service utilization came from the Hennepin County Human Services & Public Health Department. The claims data included use of chemical dependency and mental health treatment services from January 2006 to March 2007 (61 clients). The MMIS contained most (137 of 157) of the clients in the sample. About half (76 clients) did not have public insurance claims for chemical dependency or mental health services during that time period.

[1] For two sites, electronic administrative data were collected from local databases that included much of the required data elements.

Statewide Episodic Chemical Dependency Treatment Data

To analyze public funding for treatment services for drug court clients and offenders statewide the evaluation team compiled an episodic database outlining treatment experiences for both groups.

The Minnesota statewide chemical dependency treatment utilization data were drawn from the Drug and Alcohol Abuse Normative Evaluation System (DAANES) database. This database was created to meet federal requirements for treatment providers receiving federal funding. Reporting includes all episodes of chemical dependency treatment provided in each facility that use federal funding. In the state of Minnesota, nearly all treatment providers use some federal funding, indicating that the DAANES database includes nearly all treatment episodes in the state (McRae, 2006). The current analysis includes a portion of the total treatment episodes in 2005[2]. We selected these data in order to create a comparable offender sample to the drug court sample. All episodes for individuals under the age of 18 (n=3,935) and those not related to criminal justice involvement (n=17,532) were excluded from the sample. Criminal justice involvement refers to individuals who are in treatment because of a criminal court order, are under court jurisdiction, are on probation or parole, or have been arrested or convicted within the last 6 months.

The final sample includes 22,498 episodes of chemical health treatment in Minnesota in 2005. These data include, for each episode: treatment type, length of stay, discharge status, insurance type and demographic information.

[2] There were a total of 43,966 treatment episodes in 2005 that were reported to the DAANES database.

DATA ANALYSIS PROCEDURES

Below we describe the data analysis procedures used to address the policy questions about Minnesota's drug court service delivery and funding structures (Policy Questions 1-8).

Drug Court Chemical Dependency Service Cost Calculations

In order to analyze the funding structures (necessary for answering Policy Questions 1-7) of Minnesota's drug courts, it was necessary to create estimates of the amount of funding utilized by each funding source. Therefore, once we completed the data collection described above, we turned to calculating the total cost of services provided by each funding source utilized by each drug court. For all sites except Hennepin, calculating the funding costs for the study sites involved several general procedures along with some site-specific variations. Below we first describe the general procedures used for all sites except Hennepin, followed by a description of site-specific variations.

General Procedures. The study courts varied in age, with several courts barely one year old at the time of our data collection, while other courts had been operational for years. In order to report funding cost figures that were comparable across all courts, we selected a 12-month period of time for analysis; this was most often the most recent 12-month period (April 2006 through April 2007). For some courts this coincided with the age of the drug court and therefore included all clients from that court; for other courts, this was a subset of the courts' total client population.

Claims data (whether for public payment sources like the CCDTF or for private insurance) does not identify drug court clients, and therefore, in order to determine the amount of funds used by drug court clients we needed to create estimates of treatment costs. To calculate the cost of a treatment

episode we first calculated the length of stay for each client for each treatment episode. For inpatient care, we then used the state-approved billing rate per session (outpatient) or per day (inpatient)[3,4] for that provider for that type of care and multiplied this by the length of stay. For outpatient care, we estimated the number of treatment sessions obtained during the length of stay (see below) and multiplied this by the state-approved billing rate. The cost of each episode was then added into the total costs for CCDTF, PMAP, private insurance, self-pay, or some other payment type (e.g., VA, Community Corrections), depending upon the payment source listed for that client. For those sites that were unable to provide individual-level payment information, we obtained estimates of the percentage of clients who had private insurance, relied on CCDTF or PMAP, or self-paid for services; we then calculated the total treatment costs for that site and assigned those costs proportionally based on the percentage of clients estimated to use CCDTF, PMAP, private insurance, or self-pay.

To estimate the cost of outpatient treatment episodes, we needed to estimate the number of treatment sessions obtained during an episode. We did this by using the courts' written policies as well as data from other NPC Research drug court studies that involved data on the actual number of treatment sessions obtained by clients:

- Some of the current study sites' written policies included information on the number of treatment sessions clients were expected to attend each week. However, NPC Research has found in our research on adult drug courts that clients typically receive far fewer sessions than what is recorded in written policy. We therefore adjusted down by 50% the number set by policy to obtain an estimate of the number of treatment sessions actually obtained.
- Other study sites did not have written policies regarding the number of treatment sessions per week required of clients. For these sites, we used an average number of weekly sessions based on the study sites that did have written requirements (2.8 sessions per week) and adjusted this average down by 50% (for an estimate of 1.4 sessions per week).

We also needed to estimate the cost of continuing care, which typically involves fewer treatment sessions than outpatient care. Some sites provided data on continuing care separate from outpatient episodes. For these sites, given a typical policy of one session per week of continuing care, we adjusted down by 50% (based on data from other NPC Research studies that suggest that the number of sessions obtained is typically about 50% of stated policy). For those sites that did not separate out continuing care from outpatient episodes (and therefore the episode contained both the outpatient care and the continuing care), we treated the entire episode as an outpatient episode. For these sites, therefore, the outpatient cost estimates may be inflated.

Finally, we also needed to assign costs for assessments. Most assessments were conducted by local human services departments as part of their routine Rule 25 assessment responsibilities. Several sites were able to provide us with a cost figure for assessments (conducted either by external contractors or the local human services department); these sites stated assessments cost $100. We therefore used this figure across all sites.

[3] 2006 CCDTF Host County/Tribal Contract Summary Sheets for MHCP enrolled CCDTF Providers, Chemical Health Division, MN Department of Human Services.

[4] For those providers not included on the CCDTF rate list, we used the statewide median rate for that type of care. For those instances where the courts knew that clients attended treatment but did not have the provider name, we used the median rate for that type of care for the providers utilized by that site.

We followed several rules when calculating episode costs:

- First, we excluded any treatment episode that started and ended *prior* to drug court entry (some sites provided us with clients' complete treatment history).
- Second, for those episodes that began prior to the drug court entry date but continued after entry, we included in our cost estimates only those days that happened after drug court entry.
- There were several instances of missing start or end dates. In these instances, we substituted the average length of stay for that type of care for that site.
- For treatment episodes that were ongoing at the time of data collection, we substituted an end date for our cost calculations (4/15/2007, as most data were given to NPC Research around this date).

Once we calculated the costs of treatment using the individual-level data, as described above, the final step to calculating the total costs for each site was to include any additional funds utilized for treatment services, such as federal grants or SCAO funds. These types of funds were not represented in the individual-level data (which focused on treatment episodes paid by public or private insurance sources), but rather, these types of funds (which the evaluation team learned about through the survey, telephone interview, and document review data collection process) were used to augment the services reimbursed by public or private insurance.

Site-specific Procedures. The procedures above were used for all study sites except Hennepin (see the Hennepin description in Appendix A). However, within these procedures there were several site variations based on the following:

1. Whether the site could provide individual-level payment information;
2. Whether the site had a written policy regarding the number of required treatment sessions per week;
3. Whether continuing care was separated out from outpatient treatment; and
4. Any other site-specific variations in methodology.

Please see Appendix B for variations in the analysis for each site.

Analysis of Treatment Utilization

Below we describe the analysis strategy used to answer Policy Question 8, which focuses on the utilization of public funds for treatment services. Policy Question 8, investigating the relative efficiency of using public dollars to fund treatment for drug court clients as opposed to non-drug court clients, relies upon an examination of length of stay for drug court clients and the overall Minnesota offender population.

We selected a cohort of drug court clients at each site on which we based our analysis of length of stay and treatment completion status to guarantee that the individuals in the analysis across sites are at relatively the same stage in the drug court process and have had the same possible exposure time to treatment. For all sites, the cohort consists of all clients entering drug court during 2006.

We report data by region instead of by site due to small sample sizes for some courts and in order to match the statewide data, which was classified by region rather than by county.

Many clients in the drug court sample were in ongoing treatment episodes at the time of data collection; for these episodes we substituted the data collection date as the treatment episode end-date in order to calculate a length of stay. Therefore, our length of stay estimates likely underestimate the total length of stay for these drug court clients.

The comparison between the drug court clients' episodes and the statewide offenders'

episodes of treatment includes comparisons of inpatient, outpatient, and halfway house entries. While some drug court sites also reported on clients' episodes in continuing care this is not included in the statewide data, and therefore we do not include comparative analysis of continuing care. Similarly, while the statewide data includes episodes of extended care, most drug court sites did not report any extended care episodes, and therefore we provide no comparative analysis of this type of care.

Treatment completion, determined by the episode discharge status, is defined as either complete or incomplete. Successful treatment completion indicates that the episode of chemical dependency treatment was successful. For the current study, we have defined incomplete episodes as episodes in which a client's exit status was marked as incomplete, but also includes entries into treatment that had a variety of other exit statuses, including transfers to other facilities, lost financial support for their treatment, death, and other unspecified reasons for why the treatment episode ended before completion. Thus, the treatment completion rates reported here are more conservative estimates than some used by other researchers who exclude episodes with these miscellaneous exit statuses from their calculations[5]. The data are presented this way in order to match the drug court data described below.

In addition to comparing individual-level drug court episodic data with the statewide episodic treatment data, the research team examined the overall continuum of care received by drug court clients. Data collected on treatment episodes for each drug court client are combined to create the overall continuum of care received. Continuum of care is defined by the entire treatment experience or course of treatment, for each client while in drug court. To create this analysis, lengths of stay are summed for each, to include all episodes received while participating in drug court. In addition to merging lengths of stay for each episode, a combination of types of treatment and completion status (successfully completed, ongoing or not complete) is also examined.

Due to rounding some percentages do not total 100% for demographic and treatment utilization data.

Other States Data Methodology

To address the final policy question (whether there are useful funding or service delivery models in other states), NPC Research conducted research on 11 other states.

SELECTING THE STATES

We chose 11 states for the analysis of promising practices for drug court funding. These states were chosen to reflect 3 interests: 1) Minnesota's Liaison Committee requests, 2) demographic and regional similarity to Minnesota, and 3) states in which NPC Research has a breadth of knowledge.

The final list of states includes California, Florida, Illinois, Indiana, Maryland, Michigan, Missouri, New York, Oregon, Pennsylvania, and Wisconsin.

Following state selection the research process involved 4 steps:

1. Web searches,
2. Cross-state data analysis,
3. Document/literature review, and
4. Interviews with key stakeholders in each of the states.

WEB SEARCHES

The research team first conducted web searches for existing literature on states' drug

[5] For example, the 2006 OLA Substance Abuse Treatment Evaluation Report chose not to include these episodes in their analysis of treatment completion, and therefore reported higher treatment completion rates.

courts, funding practices, and treatment systems. This included accessing SAMHSA's website to compile a summary of federal grant and discretionary funds, accessing American University's Justice Programs Office website for drug courts funding, status, and related literature, and also reviewing each state's court and alcohol and other drug use single state agency websites.

CROSS-STATE DATA

Cross-state chemical dependency data were used to profile treatment use in each of the eleven states chosen for the analysis. The cross-state chemical dependency utilization data were drawn from the Treatment Episodes Data Set (TEDS, 2005). The dataset documents admissions to chemical dependency treatment, including the source of referral to treatment (e.g., criminal justice system) primary demographic information, health insurance, type of treatment, and length of stay in treatment (among other things). The unit of analysis for this data is admissions into treatment. The data includes all admissions, regardless of source of payment, into treatment for providers receiving State agency funding, including money deriving from federal block grants.

We used this data to illustrate the number of individuals involved in the criminal justice system accessing treatment, their primary insurance source, and the demographic make-up of the population, including racial and ethnic background and gender.

DOCUMENT AND LITERATURE REVIEW

The research team reviewed a number of reports to develop an understanding of the funding and service structures for drug courts across the states.

The first of these is the National Association of State Alcohol and Drug Abuse Directors survey of alcohol and other drug treatment systems conducted in 2001 under a technical assistance contract with the U.S. Center for Substance Abuse Treatment (NASADAD, 2002). The report outlines multiple alcohol and other drug (AOD) public treatment systems in 42 states, including all eleven of the other states selected for this comparison. Minnesota did not participate in the survey. The NASADAD survey asked state AOD members to identify whether agencies at two levels (i.e., state and local government) either operated chemical dependency treatment services directly, or purchased treatment services via contract. These are detailed in Section 5.

The second report that informed our analyses was the Roosevelt study on drug policy. In early 2007, the Illinois Consortium on Drug Policy (ICDP; Kane-Willis, 2007) at Roosevelt University's Institute for Metropolitan Affairs published a report examining efforts historically in 8 states to promote large-scale, statewide access to chemical dependency treatment for drug-involved offenders. Included in the study were 4 of the states selected for the current analysis.

The National Survey of Substance Abuse Treatment Services (N-SSATS) conducted by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA; N-SSATS, 2005) included information on chemical dependency service providers. This data was collected throughout the nation and is available by state. A summary of the number of facilities and their characteristics—including ownership/operating body, focus, issues treated, types of care, payment sources, funding and specialties—can be found in Appendix D.

Another report informing the recommendations and analyses was the 1999 National Drug Court Treatment Survey (Peyton & Gossweiler, 2001). The National Treatment Accountability for Safer Communities (TASC) in cooperation with the U.S. Department of Justice, Office of Justice Programs and U.S. Department of Health and Human Services, Center for Substance Abuse

Treatment compiled survey data and published a report examining chemical dependency treatment services provided to drug court clients across the country. According to this study, treatment services for drug court clients are in line with established principles of treatment effectiveness for offenders dealing with chemical dependency issues.

Reports written to local entities were also included in the document review for the other states data collection.

INTERVIEWS WITH STATE-LEVEL DRUG COURT COORDINATORS

After assembling a profile of each state's drug court services and funding structure from the available literature, the evaluation team contacted state-level drug court coordinators to obtain details about drug court funding in each state. These interviews had two purposes:

1. To identify and describe in general terms the public funding and service delivery structures for chemical dependency and mental health treatment services that are available to individuals involved in the criminal justice system (in particular, to drug court program participants) in each state, and to learn about the interrelationships among the chemical dependency, mental health, and criminal justice systems with respect to treatment resources, and;
2. To find out about any innovative models, methods, or practices in each state that might provide useful lessons for improving treatment funding and service delivery to drug court participants in Minnesota (including, if relevant, any challenges that exist or have been overcome, or lessons learned about unsuccessful or ineffective approaches).

Interview Instrument

The evaluation team developed an interview instrument that covered a range of issues. Topic areas covered include: alcohol and other drug treatment and assessment systems, funding for treatment and drug court programs, treatment within the drug court system, and a general opinion section detailing innovative practices and an open ended discussion of the structure of alcohol and other drug treatment systems available to drug court clients. Interviews typically lasted one hour. Data from the interviews was compiled by state and then by topic area and is presented in summary form without reference to the interviewee to protect confidentiality.

SECTION III: ANALYSIS OF MINNESOTA DRUG COURTS' FUNDING STRUCTURES

To address Policy Questions 1-6, we detail the service delivery and funding structures for Minnesota's drug courts. First, information is presented on each court's chemical dependency services, including the service delivery structure and funding sources. Then follows an overview of mental health services for drug court clients. The section concludes with a cross-site analysis to address the policy questions:

1. What are the funding sources for drug courts?
2. What funding sources are used to support which services?
3. Where are there gaps and inequities in services and in funding?
4. Where is there vulnerability (e.g., services that rely on one, or very few, funding sources or where funding sources may be vulnerable to budget cuts)?
5. What are the differences in service availability and funding streams between urban and rural counties?
6. How and to what degree is the CCDTF or private insurance used to support drug court services?

Site Profiles: Chemical Dependency Service Provision and Funding

The study sites vary in regard to who is responsible for overseeing chemical dependency services for clients, the nature of the relationship between the drug courts and the service providers, how the services are funded, and the amount of funding used. Provided here is a brief description of some of the primary funding sources utilized by

the drug courts for chemical dependency treatment services:

- The Consolidated Chemical Dependency Treatment Fund (CCDTF) is the primary mechanism for providing chemical dependency treatment to low income residents of Minnesota. Developed in 1986 by the state legislature, this fund is a compilation of federal, state, and local resources. Counties' maintenance of effort (MOE) requirements differ, and as a result some counties are responsible for a considerably higher share of treatment costs than others. For a detailed explanation of the CCDTF, please see the Office of the Legislative Auditor's Evaluation Report (2006).
- The Pre-Paid Medical Assistance Program (PMAP) is designed to assist low-income residents. PMAP is a managed care program; the state purchases health care from health maintenance organizations on a per-client as opposed to a per-service basis for eligible individuals.
- Rule 25 Assessments are chemical dependency assessments administered by local human services departments.
- The Federal Department of Justice Bureau of Justice Assistance (BJA) adminis-

ters competitive implementation and enhancement grants to drug courts.

The State Court Administrator's Office (SCAO) has provided funds to selected Minnesota drug courts using a request for proposal process.

The following is a synopsis of each site's chemical dependency service provision and funding.

AITKIN COUNTY SOBRIETY COURT

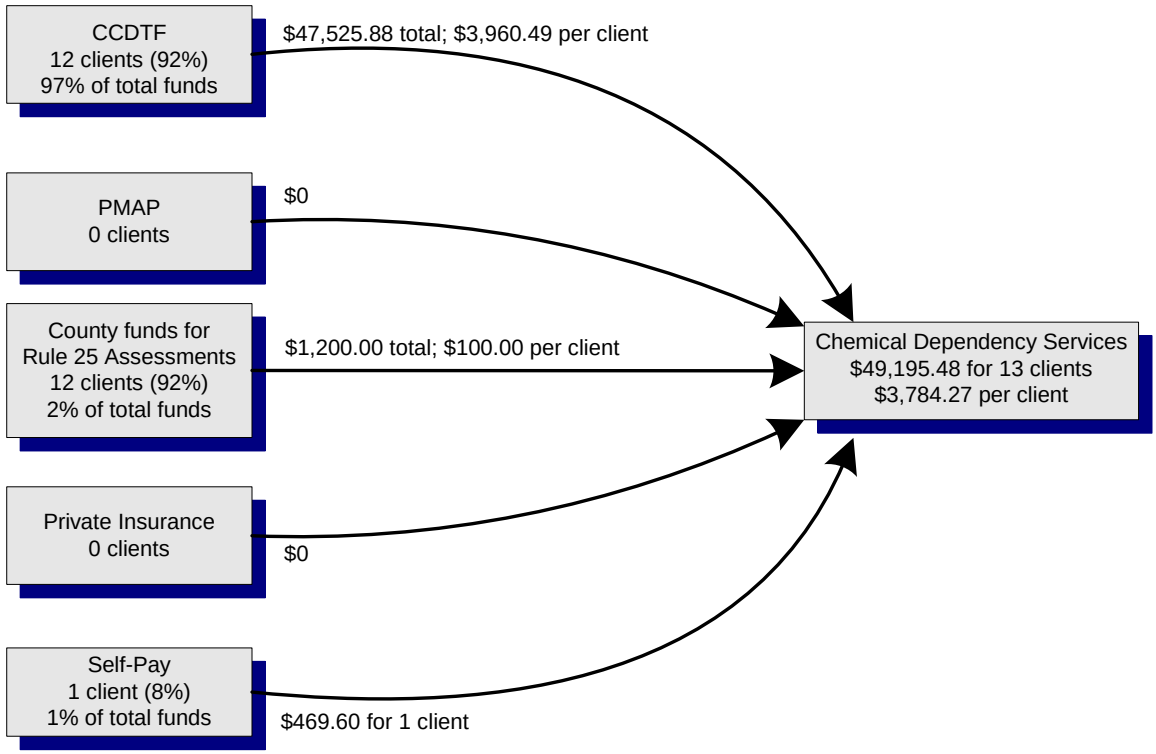
Aitkin County Department of Health and Human Services conducts chemical dependency assessments for drug court clients and oversees the provision of chemical dependency treatment. The department contracts with private treatment agencies to provide treatment services; the agencies most often utilized by drug court clients include Aurora, Northland, and Meadow Creek for inpatient care and ADAPT of Minnesota, Haven, Aurora, Northland, and Focus for outpatient care. At the time of this study, Aitkin County Sobriety Court does not have any direct contracting or oversight relationship with the treatment providers.[6]

Aitkin County Sobriety Court had 13 clients engaged in chemical dependency services between June 2006 and April 2007; approximately half of the clients' treatment episodes were inpatient stays (just over half of the inpatient episodes were 30 days or less, one-fifth were between 30 and 60 days, and two were more than 60 days) and half were outpatient treatment (three-quarters of the outpatient episodes were between 1 and 3 months, and one-quarter were more than 3 months long).

[6] Aitkin County Sobriety Court more recently has created a contract with a service provider.

As illustrated in Figure 1, Aitkin County Sobriety Court's 13 clients used $49,195.48 for chemical dependency services between June 2006 and April 2007, for a per-client average of $3,784.27. The court's clients utilized 3 different sources of funding for chemical dependency services. All but one client had treatment services covered by the CCDTF (at an average of $3,960.49 per client for those using the CCDTF), and had Rule 25 assessments. The remaining client self-paid for his/her treatment services ($469.60). No clients utilized PMAP or private insurance, and there were no other sources of funding for chemical dependency services.

Figure 1. Aitkin County Sobriety Court Chemical Dependency Costs (June 2006-April 2007)



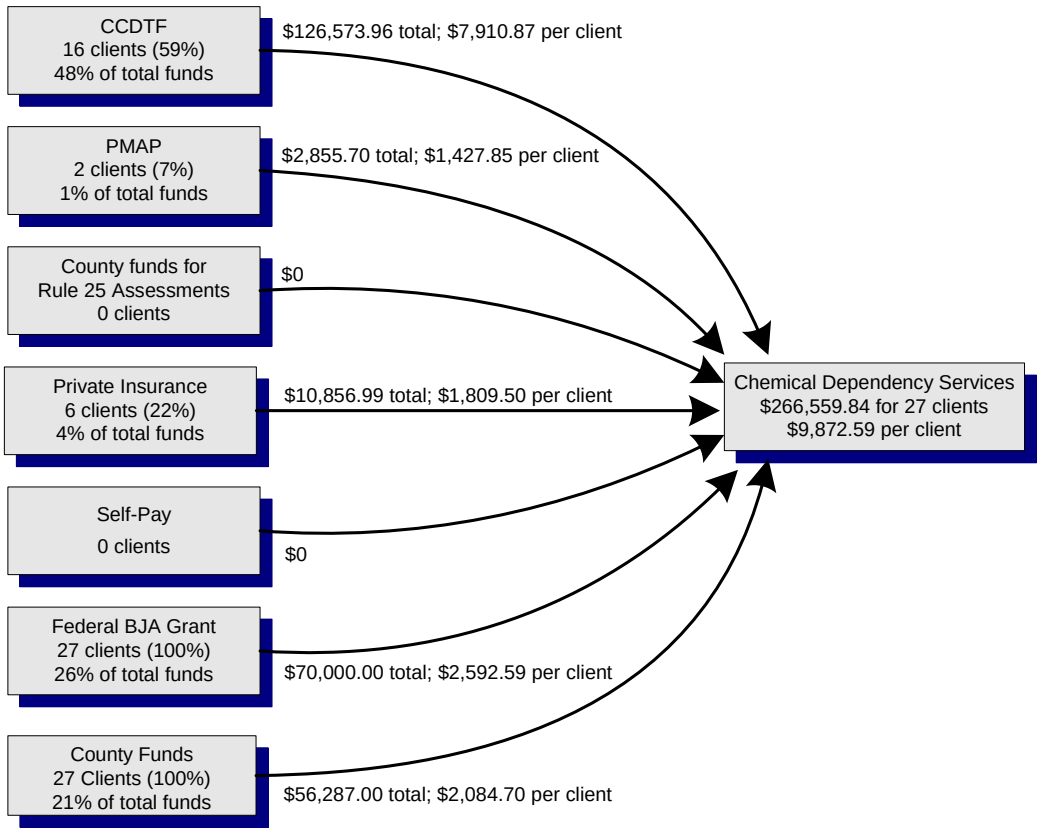
BLUE EARTH COUNTY DRUG COURT

The Blue Earth County Drug Court contracts with New Ulm Medical Center to conduct assessments and treatment with drug court clients, and New Ulm Medical Center has two counselors dedicated to serving drug court clients. These counselors are part of the drug court team and attend drug court staffings and hearings. New Ulm provides all assessments and outpatient treatment; clients in need of inpatient care receive residential treatment either with New Ulm Medical Center or with New Beginnings.

The Blue Earth County Drug Court had 27 clients engaged in chemical dependency services between April 2006 and April 2007; one quarter of these clients' treatment episodes were inpatient stays (just over half the inpatient stays were between 30 and 60 days, and the remaining inpatient stays were less than 30 days), and three-quarters of the clients received outpatient treatment (90% of the outpatient episodes lasted for over 3 months).

As displayed in Figure 2, the court's clients used $266,559.84 for chemical dependency services, for a per-client average of $9,872.59. The court's clients utilized 5 different funding sources for chemical dependency services. Sixteen clients used the CCDTF (59% of clients, for a per-client cost of $7910.87), 2 clients used PMAP (at a per-client average of $1,427.85), and 6 clients used private insurance (at a per-client average of $1,809.50). Blue Earth County Drug Court also uses a federal BJA Grant and local county match for the contract with New Ulm Medical Center to cover the salary of the two full-time chemical dependency counselors.

Figure 2. Blue Earth County Drug Court Chemical Dependency Costs (April '06-April '07)



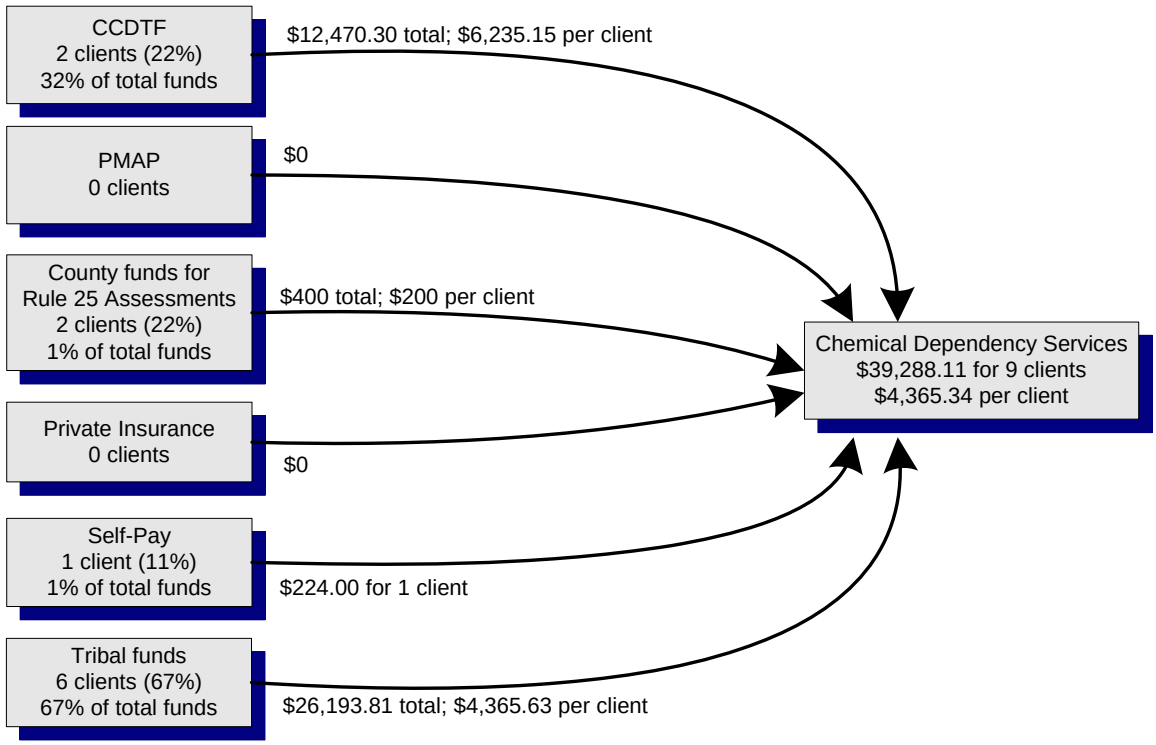
CASS COUNTY WELLNESS COURT

The Cass County Wellness Court is operated in collaboration with the Leech Lake Band of Ojibwe. Cass County Department of Human Services conducts assessments of drug court clients and refers clients to two primary providers: Leech Lake Outpatient Program and Pine Manors. The drug court does not have a formalized contracting arrangement with the providers; however, the providers are considered drug court team members. While Leech Lake is a tribal agency, the agency has agreed to serve non-tribal drug court clients as well.

The Cass County Wellness Court had 9 clients engaged in chemical dependency services between April 2006 and April 2007; one-third of these clients' treatment episodes were inpatient stays of 30 days or less, one client spent several months in a halfway house, and the remaining clients received 1-2 months of outpatient treatment followed by several months of continuing care.

As illustrated in Figure 3, the court's clients used $39,288.11 for chemical dependency services, for a per-client average of $4,365.34. The court's clients utilized four different funding sources for chemical dependency services. Two clients received Rule 25 assessments, 2 utilized the CCDTF for treatment services (for a per-client average of $6,235.15), six clients utilized tribal funds for assessment and treatment (for a per-client average of $4,365.63), and one client self-paid for treatment services at a cost of $224.00. No clients had private insurance, and there were no other funding sources supporting chemical dependency services.

Figure 3. Cass County Wellness Court Chemical Dependency Costs (April 06-April 07)



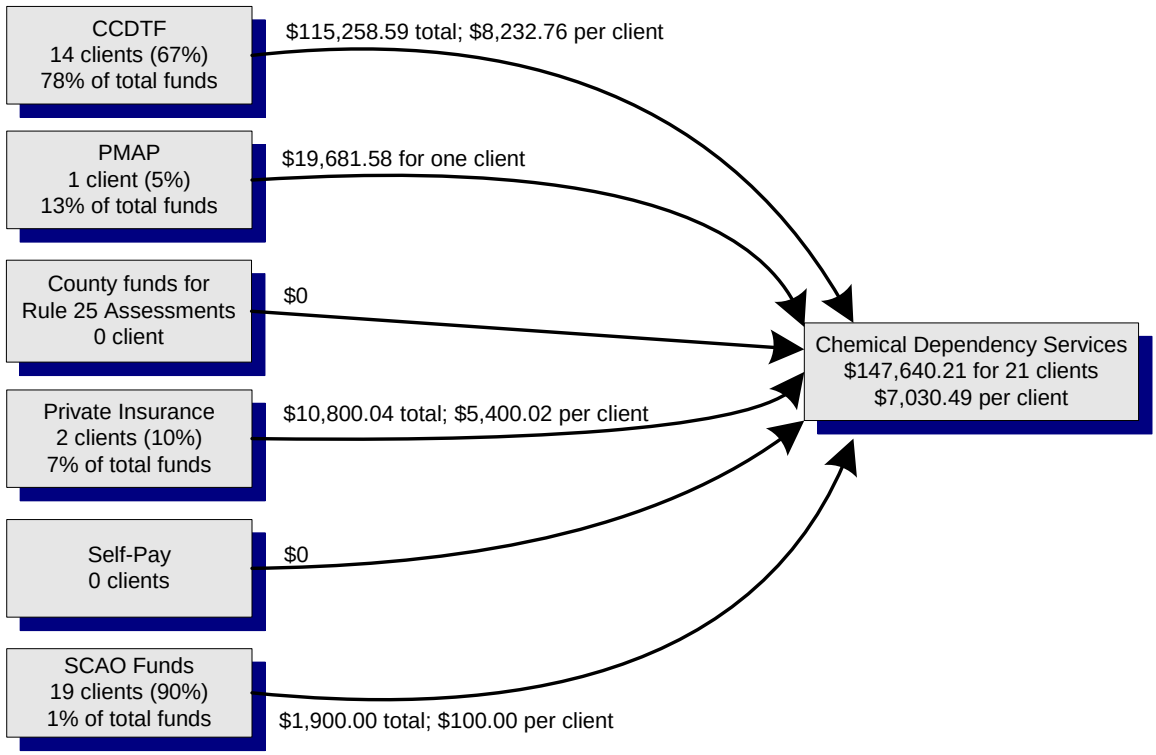
CROW WING COUNTY ADULT DRUG COURT

The Crow Wing County Department of Social Services conducts assessments of drug court clients and oversees referrals to treatment agencies. The court uses five treatment agencies for inpatient and outpatient care: Focus Unit, Four Winds, CARE, ADAPT and Avalon. The drug court does not have any direct contracting or oversight relationship with the treatment providers.

The Crow Wing County Adult Drug Court had 21 clients engaged in chemical dependency services between June 2006 and May 2007; just under half of these clients' treatment episodes were inpatient stays (all but one of which were for less than 60 days), 3 clients had episodes at halfway houses, and the remainder had outpatient treatment ranging in length from less than 30 days to more than 3 months.

As displayed in Figure 4, the court's clients used $147,640.21 for chemical dependency services, for a per-client average of $7,030.49. The court's clients utilized 4 different funding sources for chemical dependency services. Ninety percent (19 clients) of clients received assessments paid for with SCAO funds (for a per-client average of $100), 67% (14 clients) received CCDTF funded treatment (at a per-client average of $8,232.76), 5% (1 client) received PMAP funded treatment (totaling $19,681.58) and 10% (2 clients) had private insurance that covered their assessments and treatment (at a per-client average of $5,400.02). No clients self-paid for services, and there were no other funding sources supporting chemical dependency services.

Figure 4. Crow Wing County Adult Drug Court Chemical Dependency Costs (June '06-May '07)



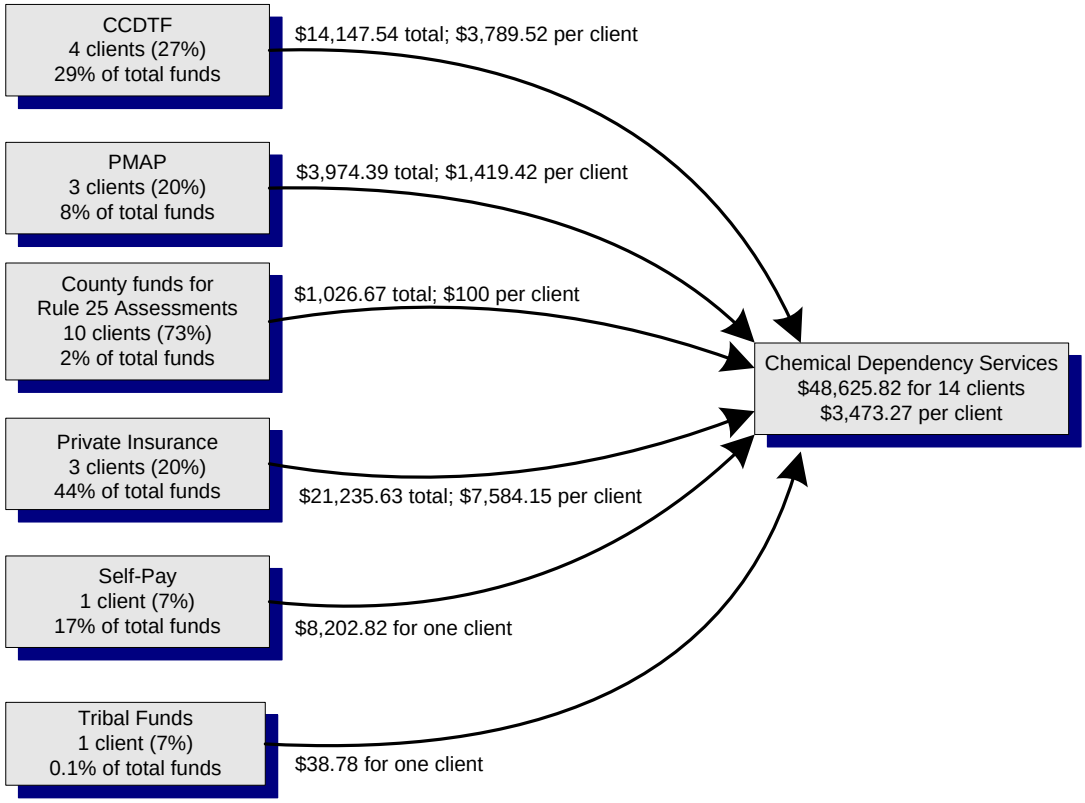
DODGE COUNTY ADULT DRUG COURT PROGRAM: DODGE'S ALTERNATIVE TO ADDICTION (D.A.T.A.)

Dodge County Department of Human Services conducts assessments for drug court clients and refers clients to five providers for inpatient and outpatient care: Rochester Behavioral Health Center, Nehemiah Family Services, Pathways, Fountain Center, and Recovery House. The drug court does not have any direct contracting or oversight relationship with the treatment providers.

As described in Appendix B, the Dodge County Adult Drug Court coordinator provided data on a sample of their clients, and therefore the evaluation team extrapolated from the experiences of the sample to create a profile for the court. Based on this sample, the Dodge County Adult Drug Court Program has an average of 14 clients engaged in chemical dependency services annually, all receiving outpatient treatment.

As displayed in Figure 5, the court's clients use $48,625.82 for a per-client average of $3,473.27. The court's clients utilized 6 different funding sources for chemical dependency services. Nearly three-quarters (73%) of the clients receive Rule 25 assessments, 27% (4 clients) have treatment services funded by the CCDTF (at a per-client average of $3,789.52), 20% (3 clients) have treatment services funded by PMAP (at a per-client average of $1,419.42), and 20% (3 clients) have treatment services funded by private insurance (at a per-client average of $7,584.15). Of the remaining two clients, one client self-pays (at a cost of $8,202.82), and one client has treatment funded by tribal funds ($38.78).

Figure 5. Dodge County Adult Drug Court: D.A.T.A. Chemical Dependency Costs (Annual Average)



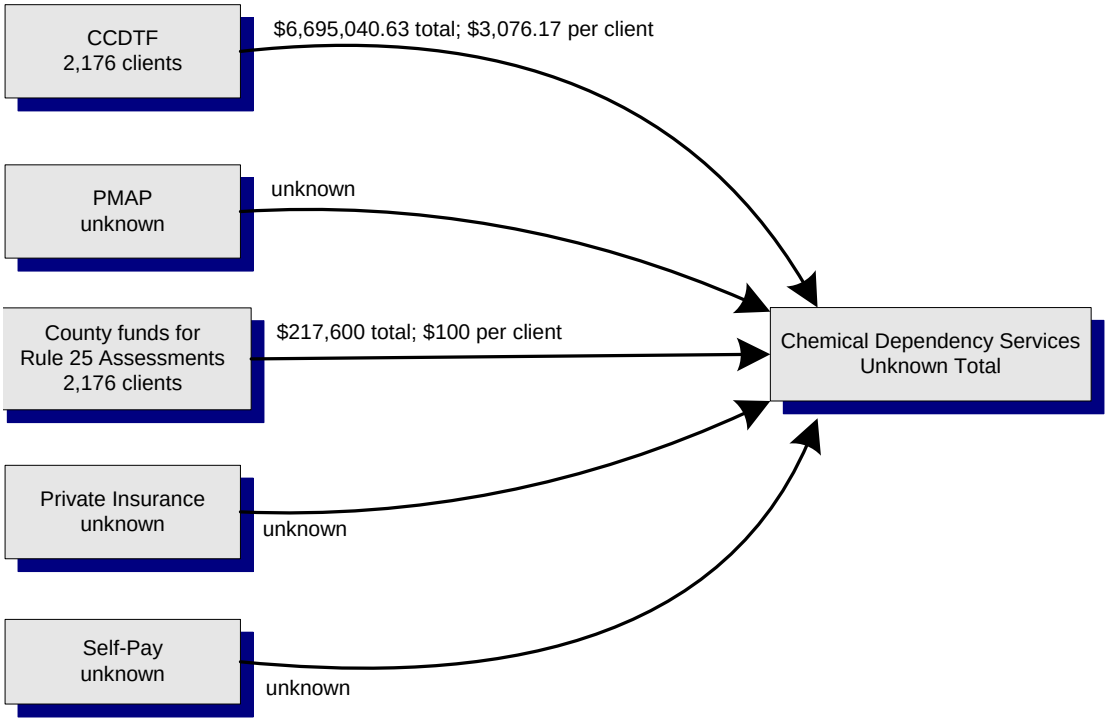
HENNEPIN COUNTY DRUG COURT PROGRAM

Hennepin County restructured its drug court program in February 2007 in order to offer targeted intensive services to a smaller number of clients. Before this restructuring, the drug court served thousands of clients per year, but many of these clients received minimal services, and often clients did not enter chemical dependency treatment at all. Under both the "old" model and the "new" model the local human services department conducts assessments for drug court clients. Where there has been a change, however, is in the provision of treatment services. Prior to 2007, drug court clients were referred by assessors to numerous treatment providers. Under Hennepin's new model the drug court team selected seven providers to serve clients: African American Family Services, CLUES, Recovery Resource Center, Salvation Army Harbor Light Beacon, RS Eden Chemical Health Programs, Chrysalis, and Park Avenue Center. These providers were selected through a competitive request for proposal process.

As described in Section II of this report, due to the large number of clients processed through the drug court, we selected a sample of clients from 2006 for analysis. (Hennepin's redesign was too recent to collect study data on clients processed through the new model.) Approximately two-thirds of the clients in the sample received no treatment services, and therefore the data reported here are based on the remaining one-third of clients who engaged in treatment services. One-fifth of the treatment episodes for clients in the Hennepin study were inpatient stays (half of these treatment episodes were less than 30 days), two-thirds of the episodes were outpatient care (two-thirds of the outpatient episodes were less than 60 days), and the remaining 12% were halfway house episodes (three-quarters of the halfway house episodes were less than 30 days).

For Hennepin County we can report funding costs only on clients who had claims filed for CCDTF reimbursement, as described in Appendix A. Using data from the sample to create an estimate for the court as a whole, Hennepin County Drug Court Program had approximately 2,176 clients receive CCDTF-funded treatment in 2006, for a total cost of $6,912,682.52 (and a per-client cost of $3,176.17), as illustrated in Figure 6. These clients also likely received Rule 25 assessments at an estimated cost of $217,600.

Figure 6. Hennepin County Drug Court Chemical Dependency Costs (January '06-January '07)



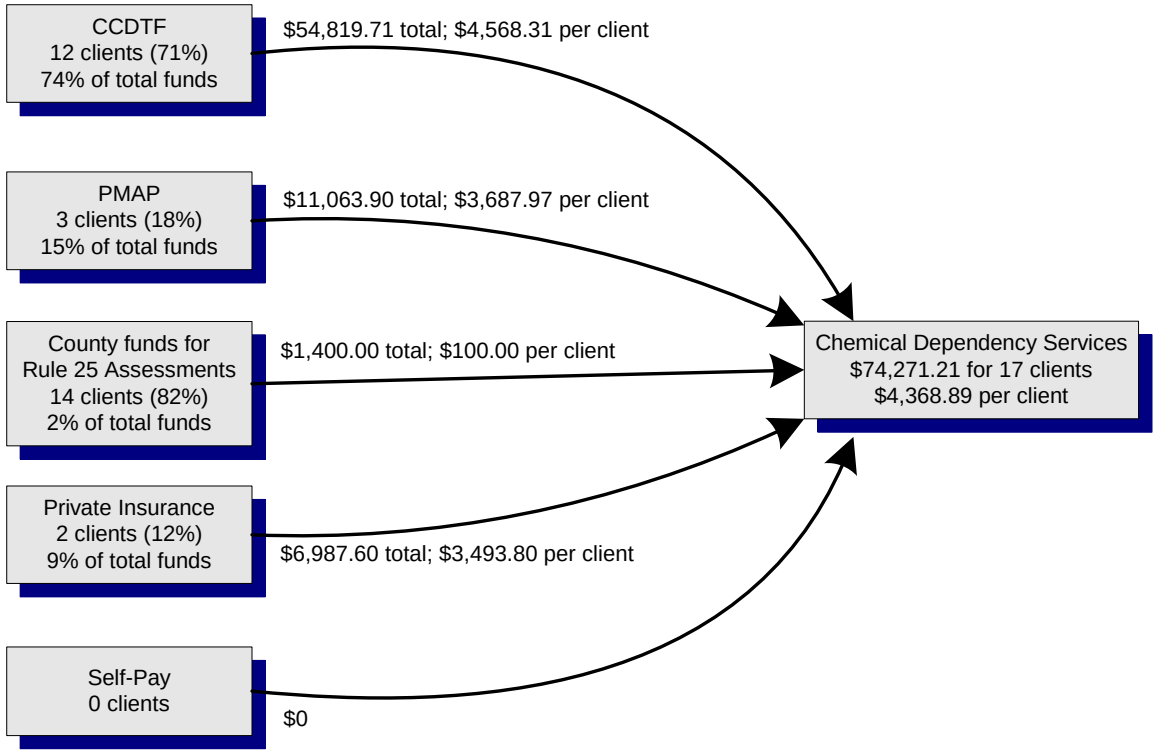
KOOCHICHING COUNTY DUI/SUBSTANCE ABUSE COURT

Koochiching County Department of Community Services conducts assessments for drug court clients and refers clients to appropriate treatment providers. Outpatient treatment is provided by Rational Alternatives, and inpatient treatment is provided by several agencies, including Pineview Recovery Center, Liberalis, and Aurora. The drug court does not have any direct contracting or oversight relationship with the treatment providers.

The Koochiching court had 17 clients engaged in chemical dependency services between April 2006 and April 2007; one-fifth of the clients' treatment episodes were inpatient stays (one-third of which were less than 30 days and the remainder were 30 to 60 days in length), and the remainder of the clients' treatment episodes were outpatient stays ranging in length from less than 30 days to more than 3 months.

As illustrated in Figure 7, the court's clients used $74,271.21, for a per-client average of $4,368.89. The court's clients utilized 4 different funding sources for chemical dependency services. Eighty-two percent (14 clients) received Rule 25 assessments, 71% (12 clients) received CCDTF funded treatment (at a per-client average of $4,568.31), 18% (3 clients) received PMAP funded treatment (at a per-client average of $3,687.97), and 12% (2 clients) used private insurance to fund both their assessments and treatment (at a per-client average of $3,493.80). No clients self-paid for services, and there were no other funding sources to support chemical dependency services.

Figure 7. Koochiching County DUI/Substance Abuse Court Chemical Dependency Costs (April '06-April '07)



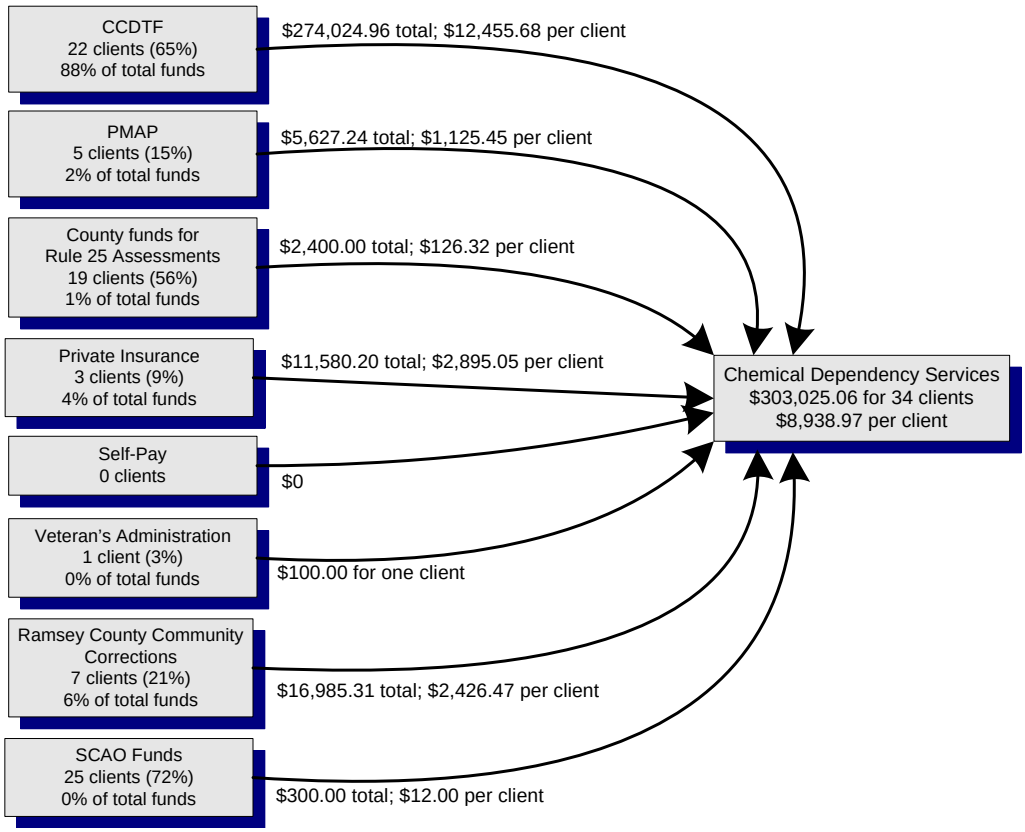
RAMSEY COUNTY ADULT SUBSTANCE ABUSE COURT (A.S.A.C.)

Project Remand, a private agency, oversees assessments (reimbursed by Ramsey County Human Services) and referrals to treatment for drug court clients. Clients are referred to a number of treatment agencies; in the past year alone, clients received treatment from almost 20 different providers. The drug court does not have any direct contracting or oversight relationship with the treatment providers.

The Ramsey County A.S.A.C. had 34 clients engaged in chemical dependency services between April 2006 and April 2007; a majority (69%) of the clients' treatment episodes were inpatient stays and residential care (70% of these episodes were less than 60 days), and the remainder of the clients received outpatient care (most of which were several months in length).

As displayed in Figure 8, the court's clients used $303,025.06 for a per-client average of $8,938.97. The court's clients utilized six different funding sources for chemical dependency services. Fifty-six percent (19 clients) received Rule 25 assessments and one client received an assessment funded by the Veteran's Administration. Sixty-five percent (22 clients) received treatment funded by the CCDTF (at a per-client average of $12,455.68), 15% (5 clients) received treatment funded by PMAP (at a per-client average of $1,125.45), 9% (3 clients) received treatment funded by private insurance (at a per-client average of $2,895.05), and 21% (7 clients) participated in Ramsey County Community Correction's Re-Entry Program (at a per-client average cost of $2,426.47). In addition, the court used approximately $300 from the SCAO to purchase curriculum and supplies for cognitive therapy groups. No clients self-paid for services.

Figure 8. Ramsey County A.S.A.C. Chemical Dependency Costs (April '06-April '07)



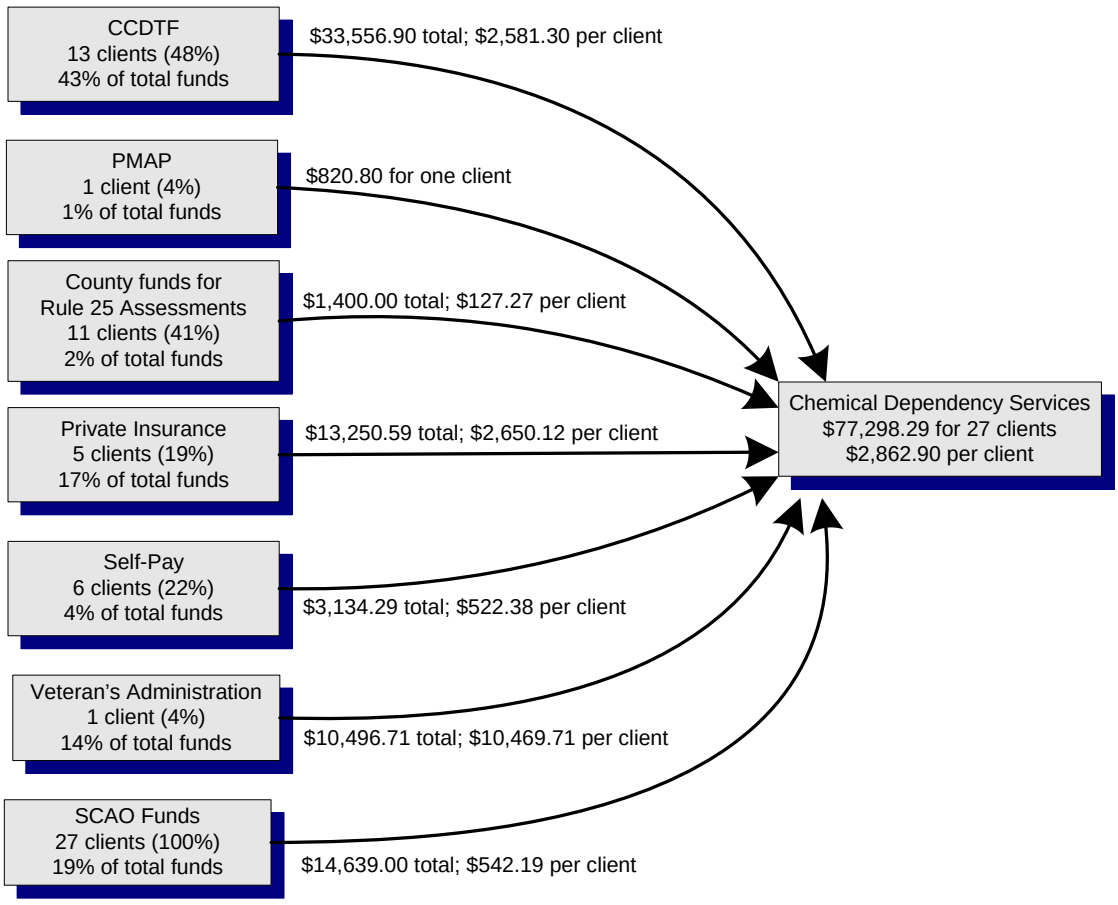
RAMSEY COUNTY D.W.I. PROGRAM

As with Ramsey County A.S.A.C., Project Remand conducts all assessments for the Ramsey County D.W.I. Court Program, and refers participants to appropriate treatment. Many clients receive Twin Town Treatment Center's "Driving with Care" curriculum, but clients are also referred to multiple other providers. In the past year, clients received services at 15 different providers. The drug court does not have any direct contracting or oversight relationship with the treatment providers.

The Ramsey County D.W.I. court had 27 clients engaged in chemical dependency services between April 2006 and April 2007; most (88%) of the clients' received outpatient treatment several months in length.

The court's clients used $77,298.29, for a per-client average of $2,862.90. As displayed in Figure 9, the court's clients utilized 6 different funding sources for chemical dependency services: 41% (11 clients) received Rule 25 assessments, 48% (13 clients) received treatment funded by the CCDTF (at a per-client average of $2,581.30), 19% (5 clients) received assessments and treatment funded by private insurance (at a per-client average of $2,650.12), 22% (6 clients) self-paid for assessments and treatment (at a per-client average of $522.38), one client had treatment funded by PMAP ($820.80), and one client had their assessment and treatment funded by the Veteran's Administration ($10,469.71). In addition, the court used a $14,639 grant from the SCAO for the "Driving With Care" curriculum.

Figure 9. Ramsey D.W.I. Program Chemical Dependency Costs (April '06-April '07)



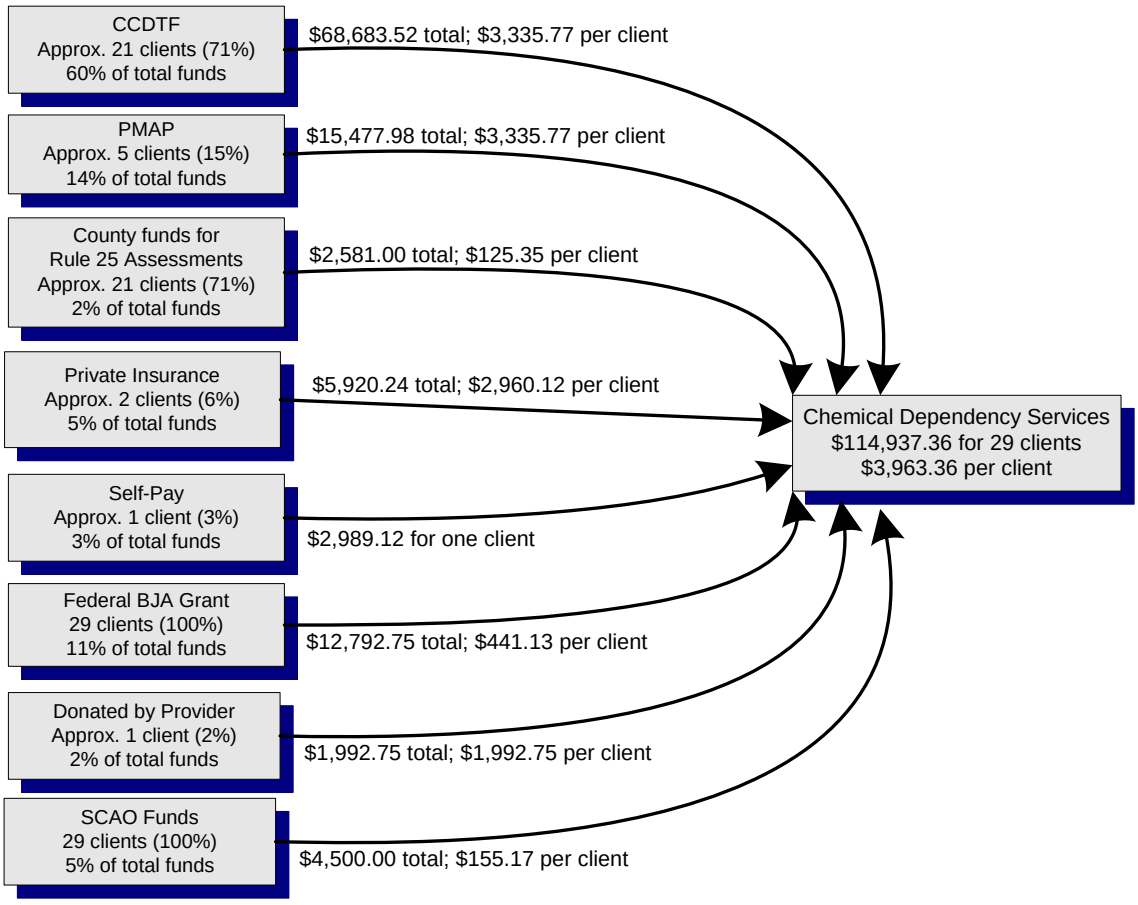
SOUTH ST. LOUIS COUNTY DRUG COURT

St. Louis County Department of Public Health and Human Services conducts assessments for drug court clients, and the Probation Department is responsible for overseeing treatment services. Duluth Bethel is the primary provider utilized by drug court clients, but clients can also be referred to inpatient treatment facilities around the state. In addition, Duluth Bethel provides cognitive skills workshops for drug court clients under a contract with the drug court and bills the drug court monthly for these services.

The South St. Louis Drug Court had 29 clients engaged in chemical dependency services between March 2006 and March 2007; 39% of the clients' treatment episodes were inpatient stays (three-quarters of which were under 60 days in length), and the remainder were outpatient treatment ranging in length from less than 30 days to over 3 months.

As illustrated in Figure 10, the court's clients used $114,937.36, for a per-client average of $3,963.36. The court could not provide individual-level payment information and instead provided NPC Research with estimates of the proportion of clients funded by each source. As described in Appendix B, we therefore calculated the total chemical dependency services cost for the court, and then allocated those costs proportionally based on the estimate of the percentage of clients covered by each insurance source. Almost three-quarters (71%, 21 clients) received Rule 25 assessments, 71% (21 clients) received treatment funded by the CCDTF (at a per-client average of $3,335.77), 15% (5 clients) received treatment funded by PMAP (at a per-client average of $3,335.77), 6% (2 clients) received assessments and treatment funded by private insurance (at a per-client average of $2,960.12), one client self-paid ($2,989.12), and one client had treatment donated by the provider ($1,992.75). In addition, the St. Louis court had a federal BJA grant, part of which funded treatment services: $900 per month covered the cost of cognitive therapy classes, and $1,989.12 covered the cost of treatment for an uninsured client. The court also used approximately $4,500 from the SCAO to cover the cost of co-pays for drug court clients.

Figure 10. South St. Louis County Drug Court Program Chemical Dependency Costs (March '06-March '07)



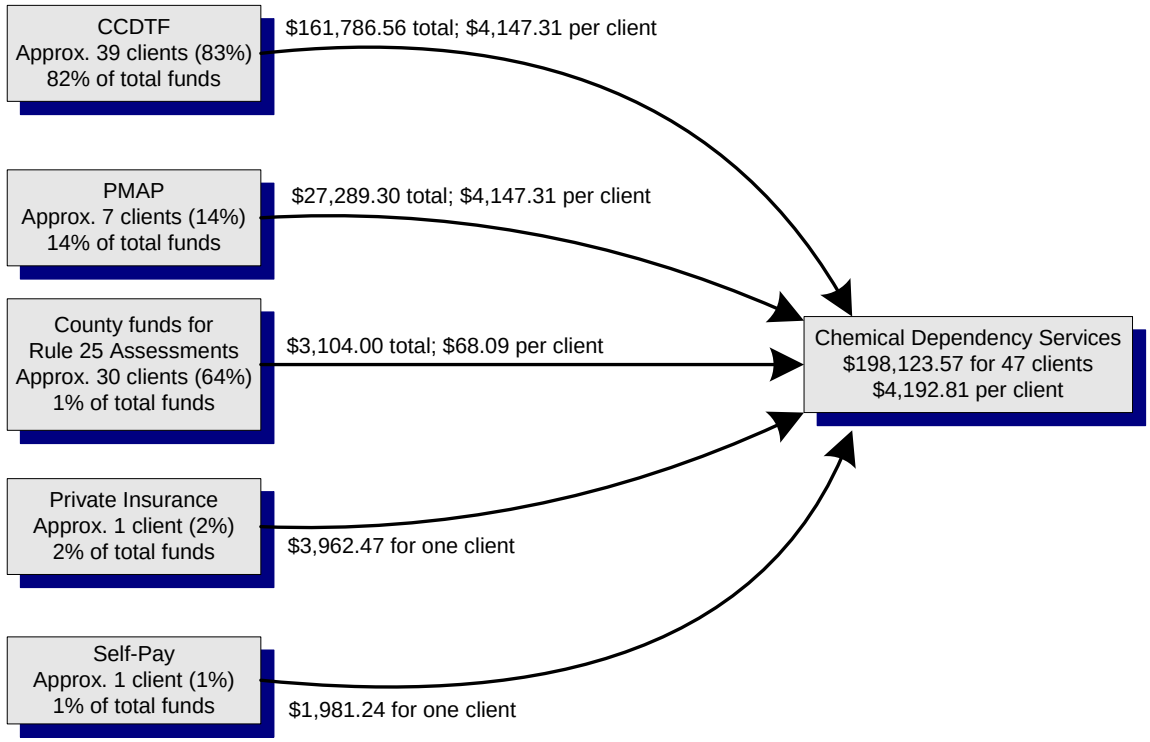
STEARNS COUNTY SUBSTANCE ABUSE COURT

Stearns County Department of Human Services conducts assessments for drug court clients and refers clients to numerous treatment providers. In the past year, drug court clients received services from approximately 15 different providers. The drug court has a Memorandum of Understanding with the County Department of Human Services that states that the Department will have sufficient staffing to assure assessment and referral for drug court clients. The drug court does not have any direct contracting or oversight relationship with the treatment providers.

The Stearns County Substance Abuse Court had 47 clients engaged in chemical dependency services between April 2006 and April 2007; 41% of these clients' treatment episodes were inpatient stays (most less than 30 days in length), and the remaining episodes consisted of outpatient treatment and continuing care.

As displayed in Figure 11, the court's clients used $198,123.57 for a per-client average of $4,192.81. The Stearns court utilized 5 funding sources: 64% (30 clients) received Rule 25 assessments, 83% (39 clients) received treatment funded by the CCDTF (at a per-client rate of $4,147.31), 14% (7 clients) received treatment funded by PMAP (at a per-client rate of $4,147.31), one client received assessment and treatment funded by private insurance ($3,962.47), and one client self-paid for services ($1,981.24).

Figure 11. Stearns County Substance Abuse Court Chemical Dependency Costs (April '06-April '07)



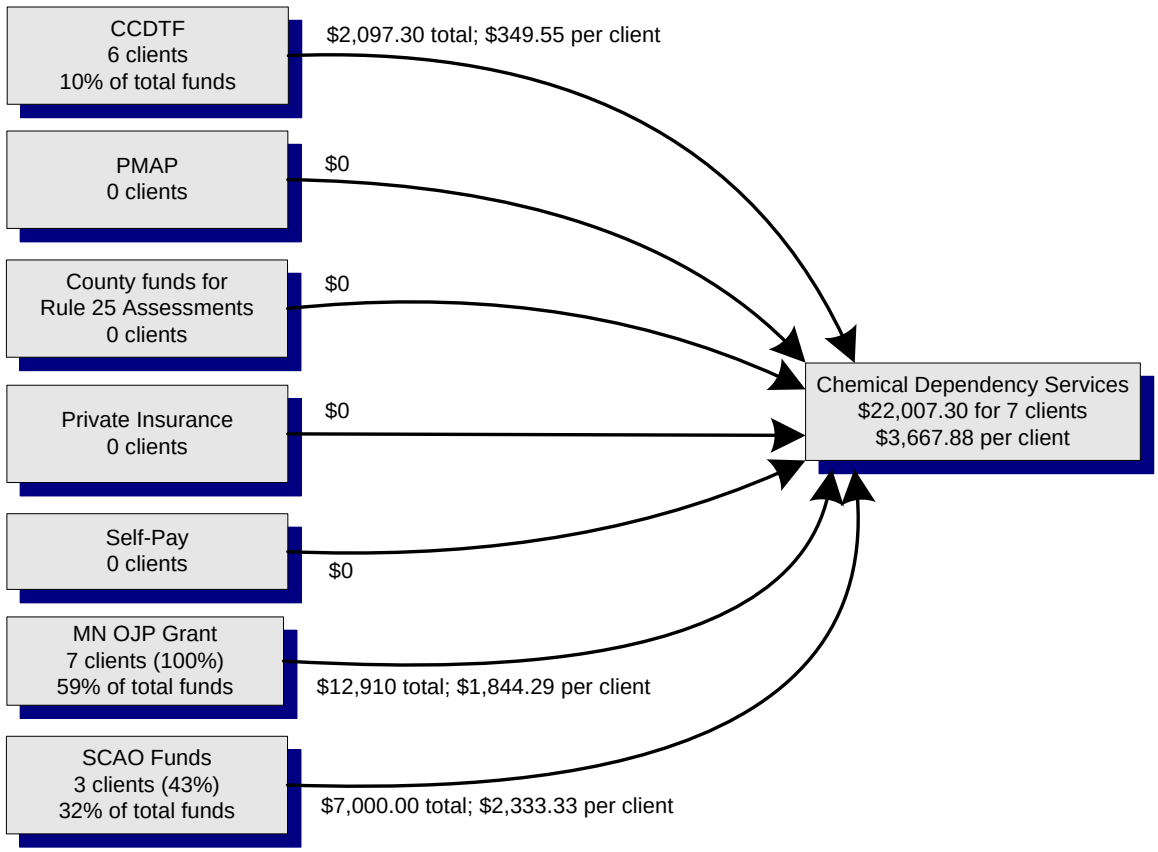
WABASHA COUNTY SUBSTANCE ABUSE COURT

Wabasha County Substance Abuse Court contracts with Wendon Recovery Center to conduct assessments and treatment with drug court clients, although clients also are referred to up to a dozen other inpatient and outpatient providers.

The Wabasha County Substance Abuse court had six clients engaged in chemical dependency services between April 2006 and April 2007; these clients received outpatient treatment (with stays ranging from less than a month to more than 3 months) and continuing care.

As illustrated in Figure 12, the court's clients used $22,007.30, for a per-client average of $3,667.88. All clients had treatment funded by the CCDTF (at a per-client average of $323.77). No clients utilized PMAP or private insurance, and no clients self-paid for services. The court budgeted $12,910 of their Minnesota Office of Justice Program (Federal Byrne funds) grant for a contract with Wendon Recovery Center that covered assessment and treatment services for drug court clients. In addition, the court used $7,000 from the SCAO to augment treatment services for clients.

Figure 12. Wabasha County Substance Abuse Court Chemical Dependency Costs (April '06-April '07)



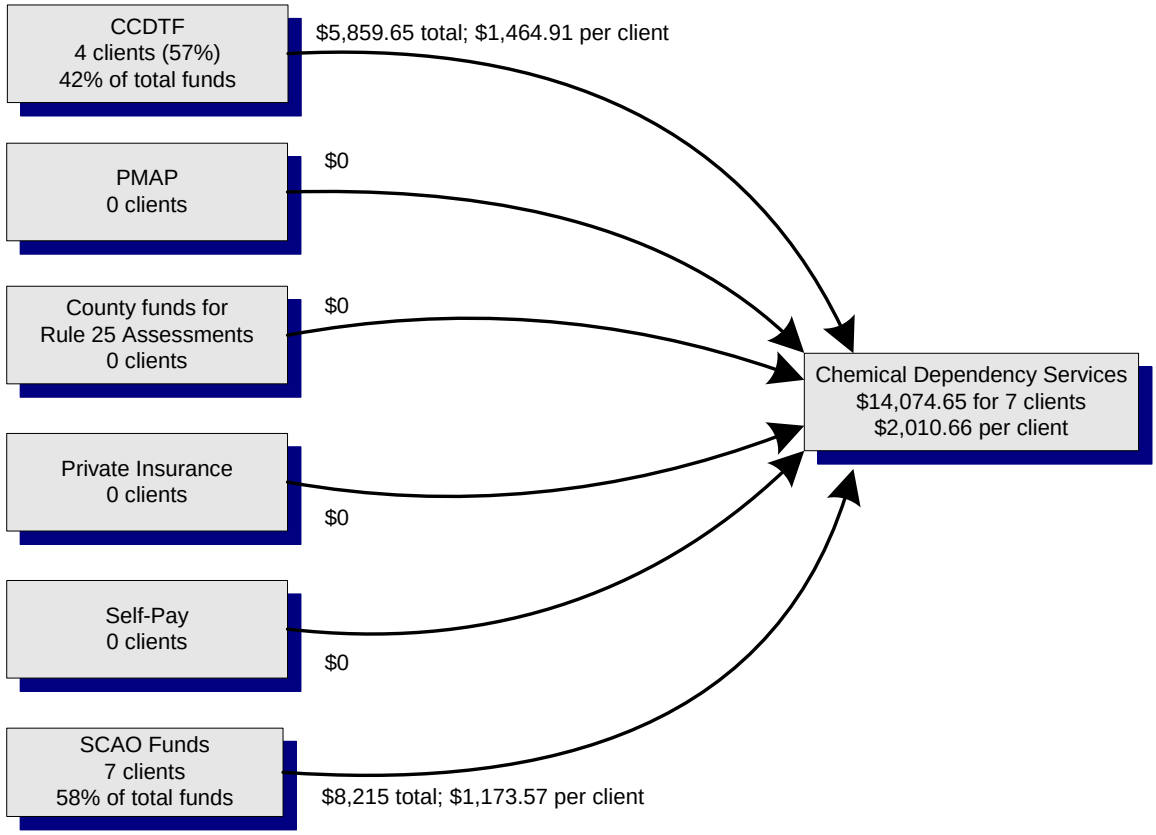
WATONWAN COUNTY ADULT DRUG COURT

Watonwan County Adult Drug Court contracts with New Ulm Medical Center to conduct assessments and treatment with drug court clients.

The Watonwan court had 7 clients engaged in chemical dependency services between March 2006 and March 2007; these clients all received outpatient care with stays of less than 30 days.

As displayed in Figure 13, the court's clients used $14,074.65 for a per-client average of $2,010.66. Four clients received treatment services and all were funded by the CCDTF (at a per-client average of $1,464.91). In addition, the court had $8,215 from their SCAO funds designated for treatment services (for a per-client average of $1,173.57); these funds were used for a contract with the treatment provider that covered assessment and treatment for drug court clients. No clients utilized PMAP or private insurance.

Figure 13. Watonwan County Adult Drug Court Chemical Dependency Costs (March '06-March '07)



Site Profiles: Mental Health Service Provision and Funding

Mental health treatment, unlike chemical dependency treatment, is not an integral component of many drug courts' programs. Below we provide a brief summary of each site's approach to mental health services. The following analyses include all data provided by the coordinators on mental health episodes.

AITKIN COUNTY SOBRIETY COURT

Aitkin County Department of Human Services oversees mental health assessments and services. The county contracts with one provider and can also refer clients to multiple other providers. Mental health services have not been an integral component of the drug court program thus far; out of 13 clients, 3 received intermittent individual counseling (not provided in conjunction with the drug court program), though data is unavailable for how clients funded these services.

BLUE EARTH COUNTY DRUG COURT

The Blue Earth County Drug Court team members can recommend a psychiatric evaluation for their drug court clients. New Ulm Medical Center, the contracted chemical dependency provider for the court, also provides mental health assessments and services. At least 17 clients (40% of all Blue Earth County Drug Court clients) received a mental health assessment, and at least 5 received outpatient mental health treatment. Mental health treatment services for Blue Earths drug court clients were funded through both public and private forms of insurance (mental health data was not available for more than half of the drug court clients).

CASS COUNTY WELLNESS COURT

The Cass County Probation Department oversees mental health assessments for drug court clients. The Wellness Court monitors assessment recommendations to ensure compliance, but the court does not fund anything aside from assessments. The court is permitted to pay Leech Lake Outpatient Program $100 per mental health assessment from the court's SCAO funds and Leech Lake also can provide some treatment; there are no other mental health providers in the area. One of the court's 9 clients received an assessment and intermittent counseling.

CROW WING COUNTY ADULT DRUG COURT

Screening for entrance into Crow Wing County Adult Drug Court includes basic mental health questions. Clients in need of an assessment and treatment services are referred to the Crow Wing County Department of Human Services, which in turn refers individuals to a variety of mental health treatment providers. Mental health services have not been an integral component of the drug court program thus far; four drug court clients (19% of Crow Wing County Adult Drug Court clients) received mental health assessments and no data was available on mental health treatment.

DODGE COUNTY ADULT DRUG COURT: D.A.T.A.

Screening for entrance into Dodge County Adult Drug Court: D.A.T.A. includes basic mental health questions. Clients in need of an assessment and services are referred to South Central Human Relations, a private agency. Most (13) clients in the study sample (15 clients) received a mental health assessment, and 5 received mental health services (primarily medicine checks and some individual counseling). All clients funded their mental health treatment services with either public or private insurance.

HENNEPIN COUNTY DRUG COURT PROGRAM

Mental health services are not provided directly by the drug court program; probation is responsible for case management of drug court clients, and in that capacity identifies clients in need of mental health assessment and services. Data from our study sample indicate that 12% of the sample (18 clients) received mental health services (a combination of outpatient and inpatient treatment). All clients funded their mental health treatment services with public insurance.

KOOCHICHING COUNTY DUI / SUBSTANCE ABUSE COURT

Koochiching County DUI/Substance Abuse Court is currently considering requiring psychiatric evaluations of all drug court participants, but until now the Koochiching County Department of Human Services was responsible for conducting basic mental health assessments as recommended by the drug court team. If treatment was necessary, the Department referred clients to Northland Counseling Center (a private provider) for a more thorough evaluation and treatment services. The court also has standing priority with the only psychiatrist in the area so that drug court clients were able to easily access this service. Drug court clients were given priority by being moved to the top of the waiting list for this doctor. Study data indicate that 6 (19%) clients received assessments and four (13%) received psychiatric evaluations and/or individual counseling (out of 32 clients). Most services were funded through public and private insurance, although the drug court did provide funds for one client's psychiatric evaluation.

RAMSEY COUNTY ADULT SUBSTANCE ABUSE COURT AND RAMSEY COUNTY D.W.I. COURT

The two Ramsey County courts share a $40,000 grant from the SCAO that supports the Psychiatric Court Clinic. The clinic, located on site at the court, includes a contracted psychiatric nurse who is part of the drug court team for both courts, and who is responsible for assessments and medicine management of drug court clients. The Psychiatric Court Clinic also has a contracted psychiatrist who prescribes medications and some individual therapy for the drug court clients.

Approximately one-third of Ramsey A.S.A.C. (15 out of 44) and Ramsey D.W.I. (6 out of 20) clients received assessments through the Psychiatric Court Clinic. Fourteen of Ramsey A.S.A.C's clients and 4 Ramsey D.W.I. clients received treatment services through the clinic (one client was referred to an inpatient program, and several clients also received dual-diagnosis services through their chemical dependency treatment provider). Given the number of clients who received assessments and services through the clinic, the per-client cost of running the clinic was just under $2,000.

SOUTH ST. LOUIS COUNTY DRUG COURT

South St. Louis County Drug Court is not involved in the oversight or provision of mental health services. Probation officers are charged with referring probationers to assessments (conducted by 3 private agencies) as needed, and if the assessor concludes that treatment is necessary, it is up to the probationers to follow through with treatment. The drug court has a small SCAO grant ($5,000) to cover the cost of mental health assessments. The drug court does not keep data on mental health services received by clients.

STEARNS COUNTY SUBSTANCE ABUSE COURT

Screening for entrance into Stearns County Substance Abuse Court includes basic mental health questions; based on this initial screening, social workers can ask the court to order a psychiatric evaluation or other mental

health services for clients, however, the Substance Abuse Court does not keep data on mental health services received by clients.

WABASHA COUNTY

Screening for entrance into Wabasha County Substance Abuse Court includes basic mental health questions; based on this initial screening, the drug court team is responsible for connecting clients with necessary services, and clients' mental health needs and treatment are discussed regularly at drug court staffing meetings. All but one client (18 out of 19) received a mental health assessment, and 5 of these clients received counseling services paid by public and private insurance. Wabasha received a $6,000 SCAO award for use with dual-diagnosis clients.

WATONWAN COUNTY ADULT DRUG COURT

Watonwan County Adult Drug Court contracts with New Ulm Medical Center, the court's contracted chemical dependency treatment provider, for mental health services. Two (out of seven) clients received assessments and counseling services.

Analysis of Minnesota Drug Courts' Chemical Dependency and Mental Health Funding Structures

POLICY QUESTIONS 1 & 2: WHAT ARE THE FUNDING SOURCES AND WHAT SOURCES ARE USED TO SUPPORT WHICH SERVICES?

Chemical Dependency Services

While there are differences between the 13 study sites in terms of service provision and funding structures, aggregating the data across sites[7] to create a statewide profile of chemical dependency funding reveals that over a 12-month period, drug court clients utilized chemical dependency treatment services costing $1,363,035.05, for a per-client average of $4,219.92. Most funding for chemical dependency treatment services is provided by the CCDTF (67% of the funds that supports 52% of the clients). Just over one-third of clients (38%) also receive assessments funded by local human services departments under Rule 25, although the assessment costs are relatively low in comparison to treatment costs, and as a result this represents only 1% of the total funds utilized by drug court clients. A handful of clients are enrolled in PMAP, have private insurance, or self-pay for services. Eight courts have some other identifiable source of funding for chemical dependency services, including federal BJA grants, SCAO funds, tribal funds, Veteran's Administration funds, and local Community Corrections funds;, these other sources combined comprise 18% of the total funds expended on chemical dependency services for drug court clients (see Figure 14). Several individual courts, such as Blue Earth County Drug Court, Wabasha County Adult Drug Court, and Watonwan County Adult Drug Court, do rely far more heavily on these other sources, however, as described earlier.

[7] Hennepin County is excluded from this aggregation because data on PMAP, Private Insurance, and Self-Pay funds were not available.

Figure 14. Funding Sources for Minnesota's Drug Courts

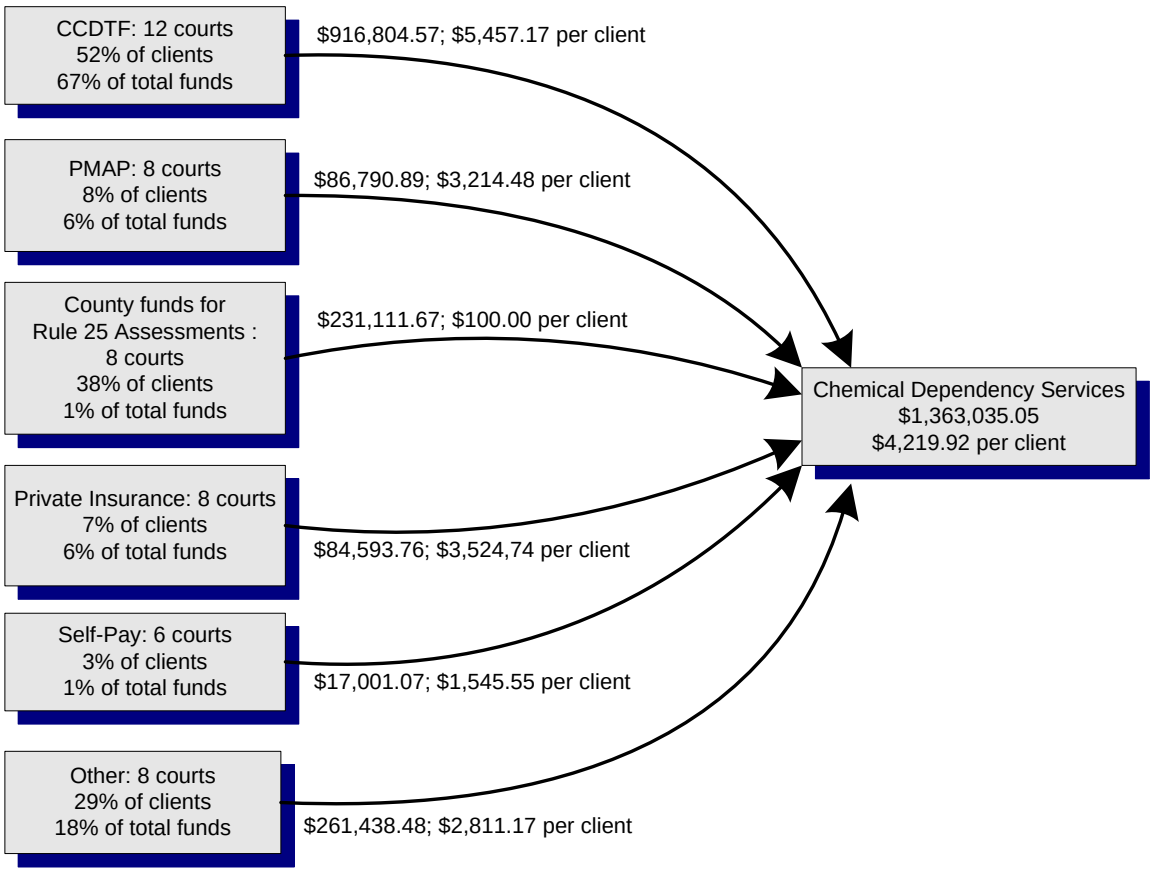
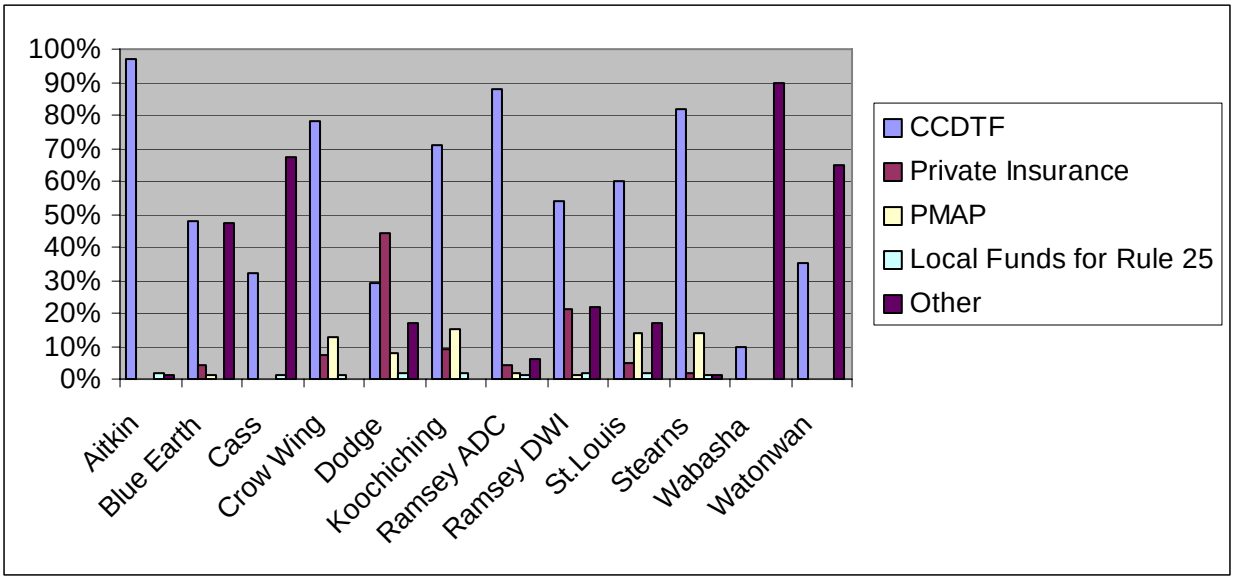


Figure 15 displays the funding sources for each of the study sites[8]. As illustrated in the figure, the CCDTF is the primary funding source for most study sites, with some exceptions. Blue Earth County Drug Court, Cass County Wellness Court, Wabasha County Drug Court, and Watonwan County Adult Drug Court have significant contributions from other funding sources (indeed, in Cass, Wabasha Watonwan, other funding sources make up the majority of funding and in Blue Earth other sources make up almost as much of the funding as did the CCDTF). In Blue Earth the "other funding" source is the court's federal BJA grant, in Cass the "other funding" is tribal funds for Native American clients, in Wabasha the "other" source is a grant from the state Office of Justice Programs, and in Watonwan the "other" source is the court's SCAO funds. Because the Wabasha County Drug Court and Watonwan County Adult Drug Court are new, they have served relatively few clients and have drawn down a relatively small amount of CCDTF dollars, and therefore the other grant funds are responsible for a majority of the overall chemical dependency service funding.

[8] Hennepin County is not included in Figures 15-17 because we were only able to obtain reliable data on CCDTF usage and therefore cannot report on other types of funding, including private insurance.

Figure 15. Funding Sources for Chemical Dependency Treatment Services for Drug Court Clients



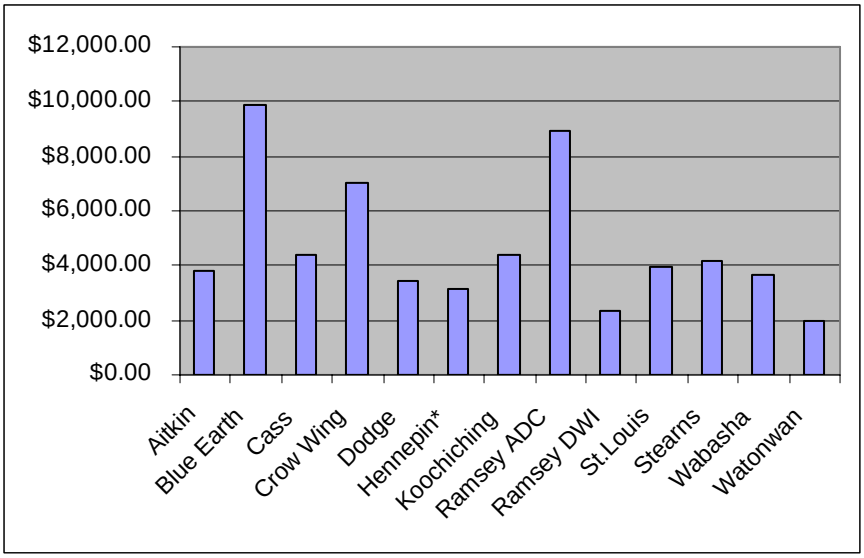
Many of the sites' average per-client spending for chemical dependency treatment services mirror the per-client average across the 13 courts of approximately $3,200. However, as illustrated in Table 1 and Figure 16, three sites' per-client averages are significantly higher: Crow Wing County's Adult Drug Court per-client average is approximately $7,000, Ramsey County A.S.A.C.'s per-client average is just under $9,000, and Blue Earth County's Drug Court per-client average is close to $10,000. These high overall per-client averages are due to CCDTF spending: the average CCDTF spending for most sites is approximately $3,000 to $4,000, whereas these three sites have per-client CCDTF spending of over $8,000. (Cass County Wellness Court also has a high per-client CCDTF average of over $7,500, but an overall per-client average similar to the cross-site average.) These high per-client averages are due to different treatment utilization patterns across sites: a majority of the Ramsey A.S.A.C's clients receive some sort of inpatient or residential (including halfway houses) treatment, and Crow Wing County Drug Court clients have roughly equivalent numbers of inpatient and outpatient treatment episodes. In contrast, at most other sites, a majority of clients receive outpatient treatment as opposed to inpatient treatment. A majority of Blue Earth and Cass County Wellness Court clients also receive outpatient treatment, but the relative length of stay for these episodes is longer than length of stays at most other sites, thus resulting in higher costs. A future cost benefit study may indicate that certain types of treatment (e.g., inpatient or outpatient) or certain lengths of stay result in more positive outcomes and long term cost savings; if so, Minnesota now knows the approximate cost of providing such services.

Table 1. Average Per Client Spending for Chemical Dependency Services for Drug Court Clients

Court	Average Per Client Spending
Aitkin	$3,784.27
Blue Earth	$9,872.59
Cass	$4,365.34
Crow Wing	$7,030.49
Dodge	$3,473.27
Hennepin*	$3,176.17
Koochiching	$4,368.89
Ramsey ASAC	$8,938.97
Ramsey DWI	$2,320.71
St. Louis	$3,963.36
Stearns	$4,192.81
Wabasha	$3,667.88
Watonwan	$2,010.66

*This is Hennepin's average per client CCDTF spending; data on other funding sources were unavailable.

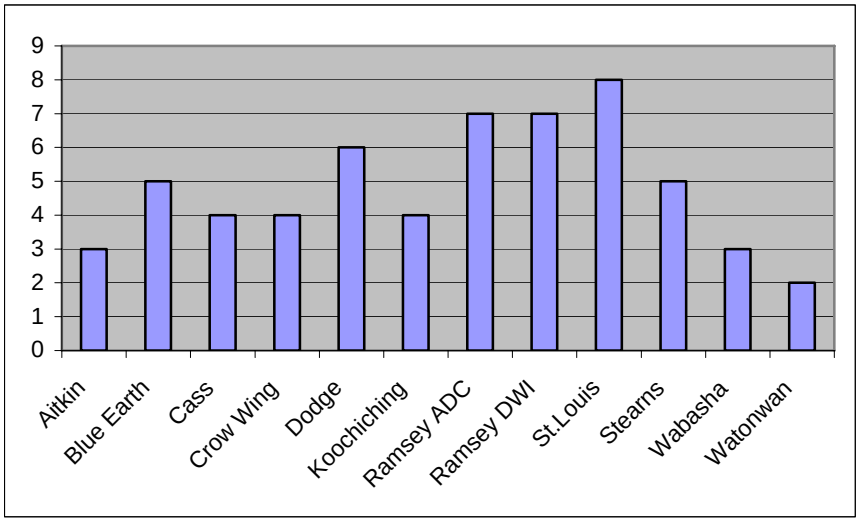
Figure 16. Average Per Client Spending for Chemical Dependency Services for Drug Court Clients



*This is Hennepin's average per client CCDTF spending; data on other funding sources were unavailable.

The number of funding sources utilized for chemical dependency services across the sites ranged from a minimum of 2 (Watonwan) to a maximum of 8 (St. Louis), as displayed in Figure 17. A future cost-benefit study could address whether courts with more or fewer funding sources produce better client outcomes.

Figure 17. Average Number of Chemical Dependency Services Funding Sources



Mental Health Services

At most sites, mental health services are not part of the drug court per-se; clients may receive such services, but they are not tracked or funded by the drug court (and instead are funded just as mental health services are funded for any other Minnesotan, through various public and private sources of insurance or through state or locally subsidized facilities). However, six drug courts do have funds dedicated to mental health services, most notably, the Psychiatric Court Clinic funded by the SCAO and shared by the two Ramsey courts; Blue Earth's and Watonwan's contracts with New Ulm Medical Center for both chemical dependency and mental health services (for Blue Earth, funded by their federal BJA grant and for Watonwan, funded by the SCAO), and Cass County Wellness Court and South St. Louis County Drug Court's use of SCAO funds for mental health assessments.

POLICY QUESTIONS 3 & 4: WHERE ARE THERE GAPS, INEQUITIES, AND VULNERABILITIES IN SERVICES AND FUNDING?

Implementing and Funding Optimal Treatment Services

While across sites most chemical dependency treatment was funded through the CCDTF, several sites did have federal BJA grants (Blue Earth, St. Louis, and Wabasha) or SCAO funds (Crow Wing, Watonwan) for chemical dependency treatment services. These sites still relied upon primary payment sources (e.g., the CCDTF or private insurance) for the bulk of clients' treatment services, but these funds were used to supplement these services. In some sites, these grant funds were used to cover the cost of assessments, in some sites the funds were used to provide additional services, such as cognitive therapy groups, to supplement costs for participants that had no other source of payment, and in some sites the funds were

used to secure contracts with a primary treatment provider to guarantee treatment slots with a provider committed to, and a team-member of, the drug court. These providers are integral members of drug court teams, and the contracting arrangement gives the provider the resources necessary to dedicate time for drug court duties such as attending staffings and hearings.

It could be argued, therefore, that sites with these arrangements may have improved or enhanced treatment services available for their clients compared to sites without these arrangements. Clients at these sites may be receiving more services (e.g., cognitive therapy groups at St. Louis) than clients at other sites. Or they may be receiving more integrated, higher quality services than clients at other sites (e.g., Blue Earth, through its contract with New Ulm Medical Center, has two treatment counselors dedicated to serving drug court clients; these counselors are members of the drug court team, support its mission, and provide comprehensive treatment and case management services to the drug court clients). Or they may have guaranteed access to treatment services not available to clients at other sites (e.g., Blue Earth, Wabasha, and Watonwan all have contracts with providers, thus guaranteeing treatment services for drug court clients). The presence of grant funds can be especially valuable for rural communities with limited treatment resources. By having funds available for contracts with dedicated treatment providers, courts can create formal agreements with providers that guarantee treatment availability for drug court clients.

A few sites do not have extra funds or formalized contracting arrangements with providers, but still consider the treatment providers to be an integral component of the drug court team. However, for the most part, those sites without formalized agreements with providers have less oversight of treatment services and quality, and the providers are less engaged in the drug court.

Of course, without an outcome evaluation to investigate the short and long-term outcomes for drug court clients across the sites, it is impossible to conclude with certainty that the presence of these funds results in higher quality care and therefore better outcomes for clients. However, NPC Research has recently completed a cross-site analysis of drug courts around the country, and data from this analysis suggests that courts that include treatment providers who are members of the drug court team have clients with more positive outcomes (Carey Finigan & Pukstas, 2007, under review). The National Drug Court Treatment Survey also supports the importance of drug court involvement in contracting or establishing direct ties with dedicated treatment services (Peyton, 2001).

One of the 10 Key Components of drug court is the integration of treatment services with justice system case processing, including regular communication between providers and the court, and team planning and decision-making. Another of the 10 Key Components of drug court is the continuum of treatment, including treatment accessibility and quality control and accountability for the providers. Establishing formalized relationships with treatment providers allows drug courts to meet these key components.

While there are advantages to using grant funds to create specialized treatment services for drug court clients, one obvious concern is the issue of sustainability. Without identifying alternate funding sources, courts run the danger of losing the enhanced services. Therefore, the state should develop funding so that courts do not need to rely upon outside, additional, grant funds to support the drug court treatment model.

Furthermore, in some cases, these contracting arrangements with providers may be possible without the use of additional funding. For example, Hennepin County has recently selected 7 providers to serve drug court clients through a competitive request for proposal

process. Through this process, the court has selected providers who will provide the type and quality of care the court deems desirable for its clients. Because the court has a high volume of clients, securing a contract with the court is advantageous for providers without the added incentive of additional funds.

It should be noted that while most drug court clients have treatment services funded through CCDTF, some clients do rely upon private insurance, in some cases managed health organizations (HMOs). Drug courts may need to work with HMOs to determine whether the courts' preferred treatment providers are within network providers for the HMOs.

Recommendation #1: Create contracting relationships with providers that can:

- **Prioritize treatment access for drug court clients;**
- **Ensure that treatment providers are supportive of the drug court model;**
- **Monitor treatment quality;**
- **Support additional treatment activities; and**
- **Allow the treatment providers to be part of the drug court team.**

Differential Chemical Dependency Treatment Utilization

As described above, some courts had higher per-client funding levels than other clients. The discrepancies were due to differential treatment utilization; that is, some sites relied more heavily on inpatient treatment than other sites, and some sites had clients with longer lengths of stay than other sites. Interestingly, three of the four sites with higher treatment utilization have written policies outlining the treatment requirements of drug court participants (for example, the number of individual and/or group sessions required per week, or the total number of hours required). Most other sites do not have written policies with explicit treatment requirements. This finding is consistent with findings from the NPC Research recently completed cross-site analysis of adult drug court: courts with clearly defined treatment requirements had clients with greater treatment utilization and ultimately more positive outcomes (Carey, Finigan, & Pukstas, 2007, under review).

It is difficult to know whether the differential treatment utilization is due to differing client needs (e.g., some sites may have clients with more severe chemical dependency problems than other sites), or whether clients at sites with lower utilization levels would benefit from the more intensive services received at other sites. It is true that some sites' participants are likely to be lower-needs clients (e.g., by definition, D.W.I. courts are more likely to work with alcohol users, while other sites may have a higher proportion of methamphetamine or cocaine users), but many of the study sites reported high proportions of seemingly high-needs clients. As noted by the Minnesota Office of the Legislative Auditor (2006), Minnesota's counties do not use a standardized assessment tool, and therefore it is impossible to draw conclusions across sites about the level of care needed by drug court clients. Indeed, the Minnesota Department of Human Services currently is developing a universal assessment tool and process for use across the state.

Recommendation #2: NPC Research agrees with the recommendation put forth by the Minnesota Office of the Legislative Auditor that Minnesota should have a standardized chemical dependency assessment tool and process across counties.

While it is not possible to determine whether clients at sites that have lower inpatient utilization rates may benefit from this treatment, it is likely that clients at sites with shorter average lengths of stay could benefit from longer treatment; the research literature abounds with studies documenting the benefits of longer treatment stays (see, for example, the National Institute on Drug Abuse, Principles of Drug Addiction Treatment). Only eight of the 13 study sites kept at least 50% of their clients in treatment for 90 days or more (see Section 4 for a more detailed analysis of the treatment utilization data).

Recommendation #3: Increase clients' lengths of stays in treatment, as longer lengths of stay are more likely to lead to treatment completion and longer-term positive outcomes.

Mental Health Services

As the site descriptions above demonstrate, mental health services are not a central component to many court's programs, and, therefore not surprisingly, sites have kept limited data on the mental health services received by drug court clients.

The high rate of comorbid chemical dependency and mental health disorders has been detailed in the research literature (Brady & Sinha 2005; Kessler et al., 1996; Regier et al., 1990). Individuals with chemical dependency are seven times more likely than the general population to have a comorbid mental health issue (Regier et al., 1990). Research shows that over one-third (37%) of individuals with an alcohol dependency problem and more than half of individuals with a drug problem other than alcohol dependency have co-occurring mental health problems (Regier et al., 1990). Further, drug court evaluation research illustrates a high incidence of co-occurring mental health problems among drug court clients and suggests courts prioritize inclusion of mental health treatment services (Belenko, 2001).

These findings have significant implications for treatment of comorbid disorders, especially within the drug court population. The literature highlights the importance of addressing chemical dependency and mental health disorders in concert with one another. Traditionally, treatment for individuals with co-occurring chemical dependency and mental health problems has taken place concurrently with counselors addressing each disorder separately; however, treatment for comorbid chemical dependency and mental health disorders can also be tackled collaboratively. Research evaluating the relative effectiveness of each of these approaches demonstrates that when treatment for chemical dependency and mental health problems are integrated, clients are more likely to participate in treatment and have more successful outcomes, including longer-term client social adjustment (see for example, Lineham et al., 1999). Further research is necessary in this area, though to date a collaborative approach appears to be ideal.

Because research indicates that dual-diagnosis is the norm for individuals involved in the criminal justice system rather than the exception (Drug Court and Mental Health Court Institute, 2007), treatment that does not address co-occurring mental health issues presents problems for successful chemical dependency treatment.

While most study sites do not place an emphasis on mental health services, some promising practices have emerged at the sites.

First, the Psychiatric Court Clinic model utilized by the two Ramsey County courts is a promising approach to integrating mental health services into the drug court model. The Clinic's psychiatric nurse is considered a member of the drug court teams, the Clinic is co-located with the court, and, at a per-client cost of approximately $2,000, it is a relatively inexpensive mental health intervention.

Second, Blue Earth County Drug Court and Watonwan both have contracts with New Ulm Medical Center, which provides both chemical dependency and mental health services. This contracting arrangement guarantees access to treatment for clients, and because New Ulm provides mental health services in addition to chemical dependency services, it guarantees that mental health services are part of the mix of services available to clients.

Third, Koochiching has built a relationship with the lone psychiatrist in the county, and this psychiatrist has agreed to move drug court clients to the top of the waiting list for services. This has resulted in drug court clients having faster access to mental health services than would otherwise be available in such a rural community.

Mental health issues may be a factor for many drug court clients, but most courts have not incorporated mental health services into their drug court models.

Recommendation #4: Assess clients for mental health issues as part of the drug court assessment process.

Recommendation #5: Create and fund a statewide model that incorporates mental health services into drug court services. Minnesota can take a lead nationally in integrating mental health services into the drug court model.

Recommendation #6: Give priority for state drug court funding to courts that integrate mental health services into their drug court models.

POLICY QUESTION 5: WHAT ARE THE DIFFERENCES IN SERVICE AVAILABILITY AND FUNDING STREAMS BETWEEN URBAN AND RURAL COUNTIES?

When looking across the sites' treatment utilization and funding structures, no clear urban-rural patterns emerged. Some newer, more rural sites did have fewer funding sources and lower per-client average costs (Wabasha and Watonwan), but other rural sites are comparable, or ahead, of the state average in terms of per-client spending or number of funding sources. Furthermore, contrary to what is expected of drug court, the study sample from Hennepin County actually had significantly lower treatment utilization rates than the other counties: approximately two-thirds of the clients in the Hennepin sample never received treatment services, whereas most clients at the other sites, even at rural sites with few treatment resources, received treatment.[9] Despite the lack of clear patterns of difference between urban and rural sites, it is worth noting that there

[9] Indeed, the redesign of the Hennepin drug court was due, in part, to the fact that the court was processing thousands of cases per year but was not able to provide the needed treatment services for all of their clients. Under the new drug court model, the court expects to enroll 300-400 clients annually and will provide all clients with the necessary services. However, because the new model was adopted in February 2007, we had to use data on clients processed through the old model.

are real differences in the number and type of treatment providers across the state. While there are obvious disadvantages for counties with few, or just one, provider (for example, individuals may have to travel long distances to receive the most appropriate care), there are also real advantages for those courts that have established relationships with one (or several) primary treatment providers, as described above.

Recommendation #7: Devote resources to develop contractual relationships that provide incentives for providers to serve clients in rural areas.

POLICY QUESTION 6: HOW AND TO WHAT DEGREE IS THE CCDTF OR PRIVATE INSURANCE USED TO SUPPORT DRUG COURT SERVICES?

The vast majority of drug court clients' chemical dependency treatment services are paid through CCDTF (52% of clients accounting for 67% of the total funds expended). Only 7% of clients have private insurance, accounting for 6% of the total funds expended. While most sites relied heavily upon the CCDTF with few, if any, clients on private insurance, Dodge County was the one exception: at that court, private insurance contributed more funds than the CCDTF to the chemical dependency services received by clients.

Representatives from the study courts state that they have not had to turn clients away from drug court because they have not qualified for the CCDTF; courts report that either all clients have qualified, or that for those who have not qualified (and who have no alternate sources of insurance), the courts have worked to identify other funds (such as grants) that could be used to cover treatment services.

Furthermore, while representatives at some courts state that they have not run into problems with counties running out of CCDTF funds (for the required county maintenance of effort), other courts report that this can sometimes be an issue. As a result, clients sometimes have shorter lengths of stay than is optimal, or take part in alternate activities (such as self-help programs) while they await treatment. In-depth process evaluations of the courts should explore this issue in more depth.

It is worth noting that Minnesota is one of the few states that require parity of chemical dependency and mental health coverage with medical coverage in private insurance, although most drug court clients tend not to have private insurance.

SECTION IV: ANALYSIS OF PUBLIC RESOURCE UTILIZATION FOR CHEMICAL DEPENDENCY TREATMENT

To address Policy Question 7, "Is the drug court an efficient method of utilizing public resources for chemical dependency and mental health treatment?" NPC Research examined a statewide profile of chemical dependency treatment episodes for individuals involved with the criminal justice system[10] from the Drug and Alcohol Abuse Normative Evaluation System (DAANES) compared with Minnesota's drug court clients. DAANES was created to meet federal requirements for treatment providers receiving federal funding; in the state of Minnesota, nearly all treatment providers use some federal funding, indicating that the DAANES database includes nearly all treatment episodes in the state (McRae, 2006).

For these analyses, the data are first organized by episodes of chemical dependency treatment rather than by the individual. An analysis of client level information to illustrate the continuum of care for drug court clients is presented at the end of this section.

This section includes the following:

1. A demographic profile of statewide offenders using chemical dependency treatment and a profile of drug court clients, specifically; and
2. A comparative analysis between drug court clients and the statewide offender population; specifically:
   - An analysis of length of stay for drug court clients as compared to the statewide sample; and
   - An analysis of types of treatment for drug court clients as compared to the statewide sample.
3. A discussion of the continuum of care received by drug court clients.

Treatment Utilization Profile

The discussion below includes an overall description of the demographic characteristics of statewide offenders and drug court clients as well as a demographic profile of offenders utilizing particular payment sources, including CCDTF, PMAP, and private insurance. For regional breakdowns, please see Appendix C.

DEMOGRAPHIC PROFILE

Overall, in the 2005 statewide episodes of chemical dependency treatment for individuals with criminal justice involvement (N=22,498), most episodes were for men (73%), with one-quarter provided to women (27%). In addition, these episodes were for individuals who were 74% White, 12% African American, 8% Native American/American Indian, 4% Hispanic, 1% Asian/Pacific Islander, 1% Other, and 1% unknown. (Overall, in the state of Minnesota, 89% of residents are White, 4% are African-

[10] Criminal justice involvement refers to individuals who are in treatment because of a criminal court order, are under court jurisdiction, are on probation or parole, or have been arrested or convicted within the last 6 months.

American, 1% are Native American/American Indian, 4% are Hispanic, and 3% are Asian.)

The gender and racial breakdown of the drug court treatment episodes for 2006 (N=526) is somewhat different: 64% male; 36% female; 67% White, 29% African American, 3% Native American/American Indian, 2% Hispanic and less than 1% are Asian/Pacific Islander.

Table 2. A Demographic Profile of Treatment Episodes

All clients	Statewide offender episodes	Drug Court episodes
Number of episodes	N=22498	N=526
% Male	N=22498	N=522
	73%	64%
Race categories	N=22,498	N=519
White	74%	67%
African American	12%	29%
Native American	8%	3%
Hispanic	4%	2%
Asian/Pacific Islander	1%	<1%
Other/unknown	2%	0

A PROFILE OF CCDTF UTILIZATION

Statewide Offender CCDTF Utilization Profile

The Consolidated Chemical Dependency Treatment Fund (CCDTF) is the primary mechanism for providing chemical dependency treatment to low income residents of Minnesota. Developed in the 1986 state legislature, this fund is a compilation of federal, state and county resources. In 2005, 17,483 of the statewide treatment episodes were funded through the CCDTF, accounting for 50% of all episodes of chemical dependency treatment. Of these episodes, 62% were for individuals involved in some way with the criminal justice system.

As displayed in Table 3, the population using the fund is racially and ethnically diverse. For people involved with the criminal justice system, those who utilize CCDTF funds are predominantly male (74%) and White (67%); however, African Americans (15%), Native Americans (11%) and Hispanics (5%) are overrepresented relative to numbers in the general Minnesota population and in the overall Minnesota treatment population.

Table 3. CCDTF Only: A Demographic Profile of Treatment Episodes

All clients	Statewide offender episodes CCDTF	Drug Court episodes CCDTF
Number of episodes	N=12,010	N=339
% Male	N=12,010	N=335
	74%	73%
Race categories	N=12,010	N=335
White	67%	60%
African American	15%	34%
Native American	11%	4%
Hispanic	5%	2%
Asian/Pacific Islander	1%	0
Other/unknown	2%	0

Drug Court CCDTF Utilization Profile

Treatment episodes for the drug court clients in our sample were primarily funded through the CCDTF (64% of the treatment episodes experienced by drug court clients, accounting for 52% of the drug court clients). Statewide, episodes funded by the CCDTF accounted for 53% of all chemical dependency treatment episodes in 2005. The demographics for the drug court episodic data indicate that drug court is serving racially and ethnically diverse populations. African Americans (34%), Native Americans (4%) and Hispanics (2%) are over-represented within the CCDTF funded episodes for drug court clients.

PMAP/Other Publicly Funded Utilization Profile

Statewide Offender PMAP/Other Publicly Funded Utilization Profile

Minnesota's Pre-Paid Medical Assistance Program (PMAP) is designed to assist low-income residents. PMAP is a managed care program; the state purchases health care from health maintenance organizations on a per-client as opposed to per-service basis for eligible individuals. Of the chemical dependency treatment episodes in 2005, 3,769 were insured through PMAP, 2,495 of which were for individuals involved in the criminal justice system.

As illustrated in Table 4, almost two-fifths (39%) of statewide offenders using PMAP to support their chemical dependency treatment are female. This payment source accounts for the largest portion of funding for episodes involving women seeking chemical dependency treatment in Minnesota. Similar to the CCDTF, African Americans (17%), Native Americans (6%) and people identifying as Hispanic (3%) are overrepresented. The remaining 70% identify as White.

Table 4. PMAP Only: A Demographic Profile of Treatment Episodes

All clients	Statewide offender episodes PMAP	Drug Court episodes PMAP
Number of episodes	N=2,495	N=23
% Male	N=2,495	N=23
	61%	35%
Race categories	N=2,495	N=23
White	70%	74%
Black	17%	9%
Native American	6%	17%
Hispanic	3%	0
Asian / Pacific Islander	1%	0
Other / unknown	2%	0

Drug Court PMAP / Other Publicly Funded Utilization Profile

The drug court sample includes only 23 chemical dependency treatment episodes supported through PMAP and other similar public funding sources. Nearly three-quarters identify as White (74%) and one-fifth (17%) as Native American. While Native Americans are overrepresented, given the small sample size (the drug court sample consisted of a total of four Native Americans), it is not possible to draw conclusions from this finding.

A PROFILE OF PRIVATE HEALTH INSURANCE UTILIZATION

Statewide Offender Private Health Insurance Utilization

Private health insurance accounts for 14,050 episodes in the statewide database for 2005. Over half of these episodes were referred to treatment through the criminal justice system (7,993). The population using private health insurance referred by the criminal justice system is three-quarters (76%) male and one-quarter female. The racial and ethnic background of those utilizing private health insurance for chemical dependency treatment is not as diverse as the population utilizing the public sources of funding. This group of episodes is comprised predominantly of individuals describing themselves as White (86%) with a small number of African American (6%), Native American (3%) and Hispanic (4%) individuals. (See Table 5.)

Table 5. A Profile of Treatment Episodes by Private Insurance

All clients	Statewide offender episodes private insurance	Drug Court episodes private insurance
Number of episodes	N=7,993	N=32
% Male	N=7,993	N=32
	76%	69%
Race categories	N=7,993	N=32
White	86%	100%
Black	6%	0
Native American	3%	0
Hispanic	4%	0
Asian / Pacific Islander	1%	0
Other / unknown	2%	0

Drug Court Private Health Insurance Utilization

Similar to the statewide comparison group, drug court clients with treatment episodes supported with private insurance are not diverse: 100% of the episodes funded in this way are by clients identifying as White.

A Comparison of Statewide Offender and Drug Court Clients' Treatment Experiences

In an effort to understand whether drug court is a more efficient use of publicly funded services than the traditional mechanisms used to treat criminal justice involved individuals, this section highlights a comparison between the treatment experience of drug court clients with the treatment experience of offenders statewide.

In this section we focus on the length of stay in treatment, and the type of treatment received. We also address regional variations on these two dimensions. As discussed in the methods section, this portion of the analysis does not address treatment completion status across groups. This is because, at the time of data collection, many clients remained in treatment and would therefore be excluded (14%). This research cannot conclusively demonstrate the efficiency of utilizing publicly funded sources to fund chemical dependency treatment; however, it does lay the groundwork for understanding the differences among funding sources within these two groups.

TREATMENT LENGTH OF STAY

The evaluation team analyzed overall length of stay in treatment between drug court client treatment episodes and statewide episodes as the first step in evaluating the efficiency of funding for chemical dependency treatment. A longer length of stay is typically associated

with successful treatment completion and future cost savings (National Institute on Drug Abuse, 2000). Figure 18 presents a graph of length of stay for the overall statewide offender episodes compared to drug court client episodes. The length of stay is averaged across all treatment types and for all sources of treatment funding and is represented in 4 categories, 0-30 days, 31-60 days, 61-90 days, and more than 90 days in treatment.

Drug court client treatment episodes are more often in the longest length of stay category than episodes for the statewide group of offenders. As illustrated in Figure 18, while both statewide offender episodes and drug court clients' episodes are most commonly 0-30 days in length, drug court client episodes have much greater representation in the 91+ days category (27%) than do the statewide offender episodes (15%). Forty percent of drug court clients' episodes are longer than 60 days as opposed to only 31% statewide.

Figure 18. Overall Length of Stay for Drug Court Clients and Statewide Offenders

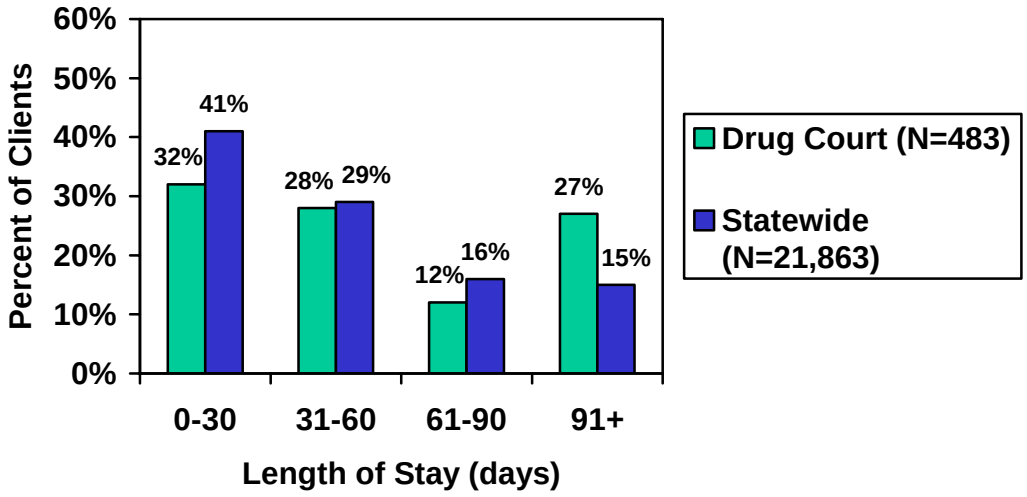


Figure 19 depicts the length of stay comparison for episodes supported by the CCDTF. Here a similar pattern emerges; drug court clients have a higher percentage of episodes lasting longer than 90 days (25%) than do the statewide offender episodes (13%). More than one-third (36%) of drug court client episodes are longer than 60 days while less than one-third of offenders' episodes are more than 60 days in length.

Figure 19. Episodes Funded by CCDTF Only: Length of Stay for Drug Court Clients and Statewide Offenders

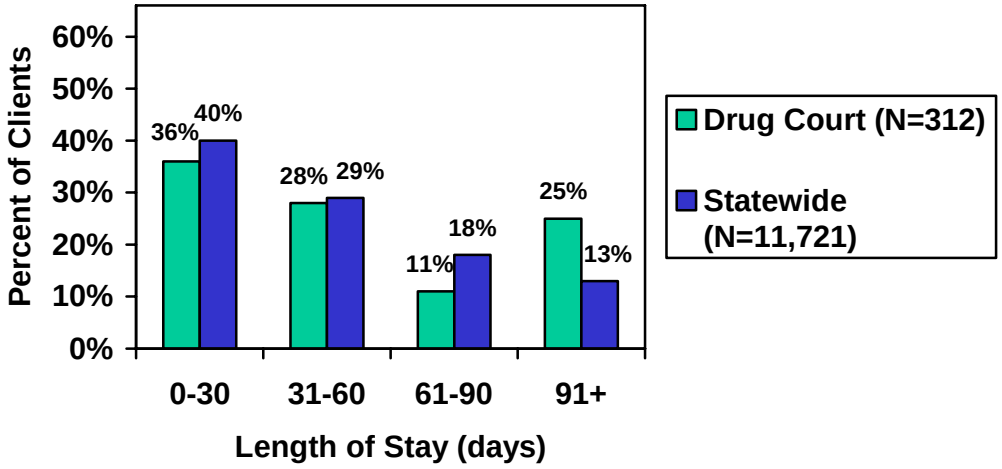


Figure 20 illustrates the length of stay comparison for PMAP funded episodes. Over half of the statewide offender episodes (52%) are 0-30 days in length. One-quarter (26%) of the remaining episodes are 31-60 days, 10% are 61-90 days and 13% are more than 90 days in length. In contrast, approximately one-fifth of episodes completed by drug court clients are 0-30 days, one-fifth are 31-60 days, 4% are 61-90 days and over half are more than 90 days in length.

Figure 20. Episodes Funded by PMAP Only: Length of Stay for Drug Court Clients and Statewide Offenders

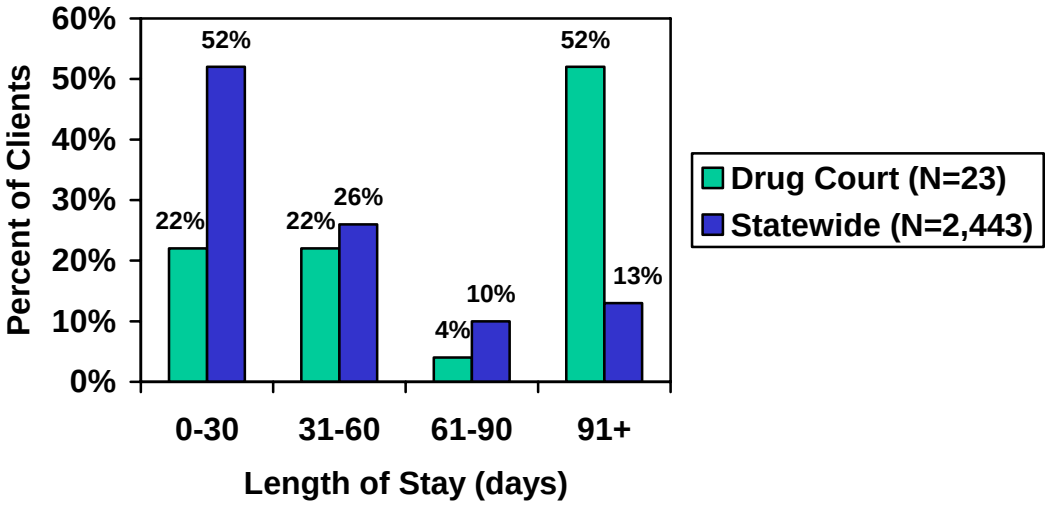
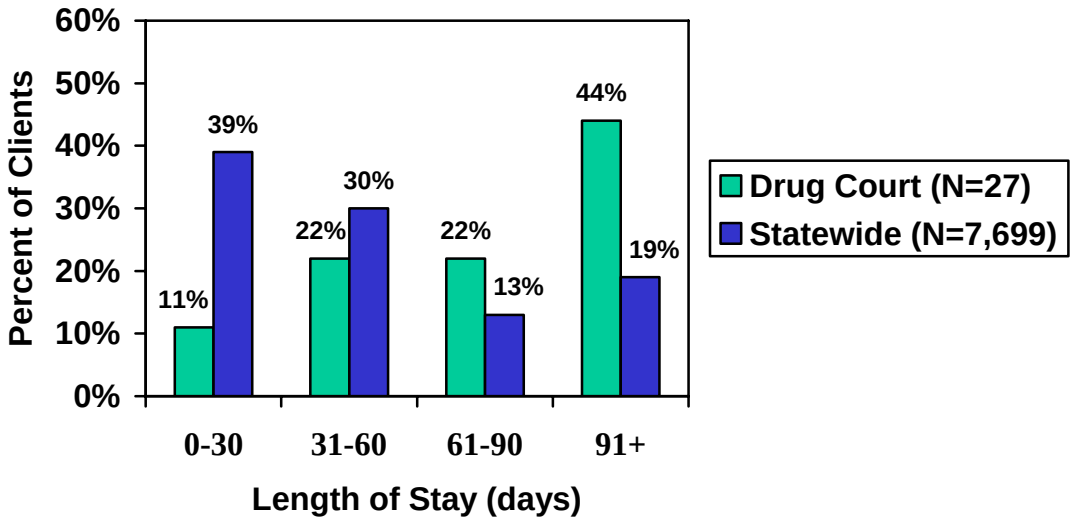


Figure 21 displays the comparison in length of stay in treatment for episodes supported with private insurance. Over 40% of drug court episodes are over 90 days in length as opposed to not quite 20% of the episodes in the statewide offender comparison group. Furthermore, 39% of the statewide episodes are 0-30 days in length as opposed to 11% of the drug court clients' episodes.

Figure 21. Episodes Funded by Private Insurance Only: Length of Stay for Drug Court Clients and Statewide Offenders



Regional Differences in Length of Stay

Regional distinctions were available in the statewide data for comparison with the drug court clients' episodes. The differences between the drug court clients' and statewide offenders' length of stay in treatment by region are described below.

Figure 22 represents the length of stay in treatment episodes in the Northeast region of Minnesota and drug court episodes from Aitkin County Sobriety Court and Koochiching County DUI/Substance Abuse Court. Similar to the statewide offender population, the drug court clients' episodes are primarily 0-60 days in length. Relatively few clients in either group remain in treatment for more than 90 days, though the percentage of drug court clients' episodes in this category is double the statewide representation (19% for the drug court clients' episodes, 10% for the statewide offenders' episodes).

Aitkin County Sobriety Court recently developed a contract with a treatment provider; however this relationship was not in place at the time of data collection. It is possible that longer periods of treatment are associated with holding these contracts (see Southeast and Southwest region drug courts). It is also possible that initial treatment episodes may be shorter as fighting addiction is a difficult process and one hard to begin (NIDA, 2000). Indeed, that National Institute on Drug Abuse argues that the early stages of treatment are the most difficult.

Figure 22. Episodes Funded by CCDTF Only: Length of Stay for Drug Court Clients and Statewide Offenders in the Northeast Region (Aitkin and Koochiching)

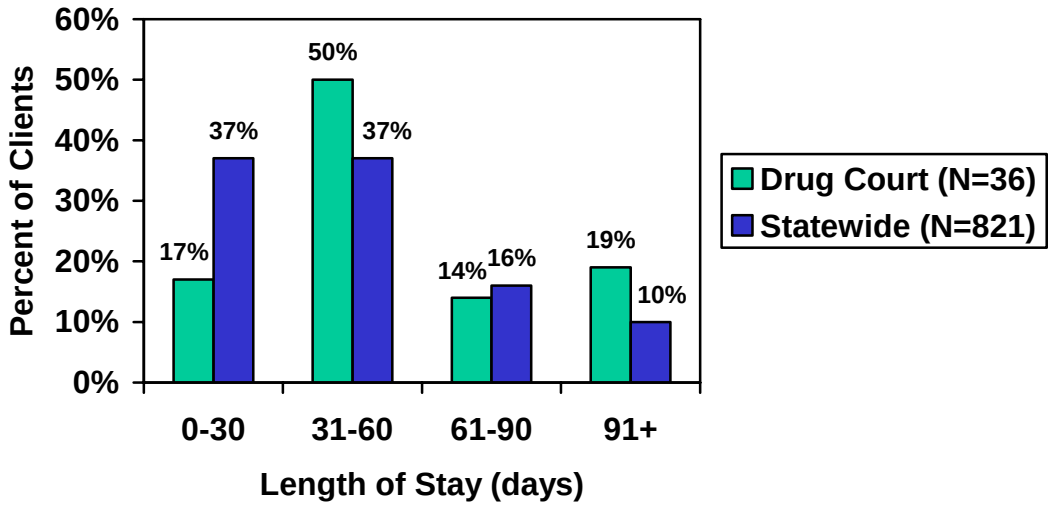
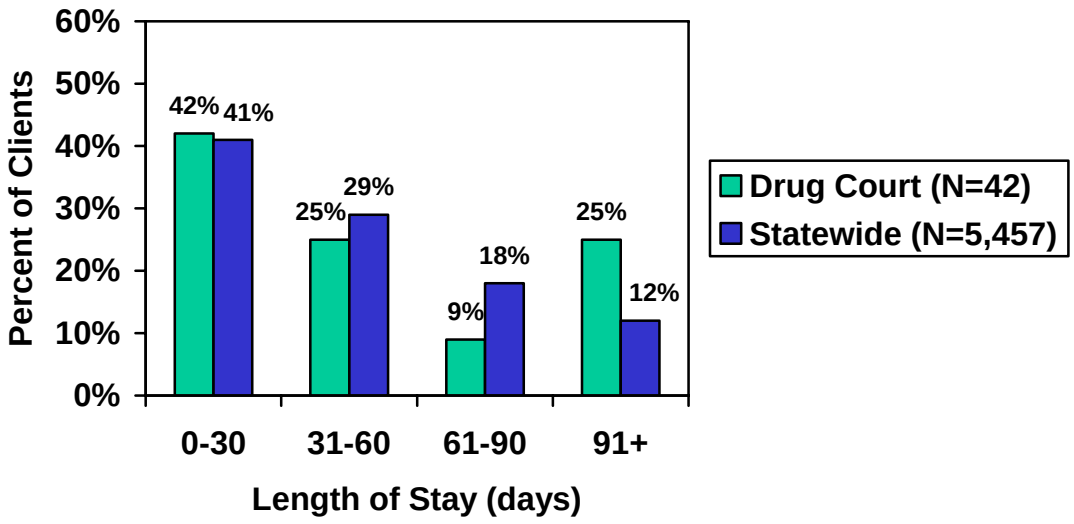


Figure 23 illustrates the length of stay for offenders and drug court clients within the Metropolitan region of Minnesota. This region includes drug court client episodes from Hennepin County Adult Drug Court, Ramsey County Adult Substance Abuse Court, and Ramsey DWI Court. For both groups, a high percentage of clients remain in treatment for 0-30 days (42% for drug court clients' episodes, 41% for statewide offenders' episodes). Of the remaining drug court client episodes, one-quarter (25%) are 31-60 days, less than one-tenth (9%) are 61-90 days, and one-quarter (25%) are more than 90 days in length. Of the remaining statewide offender episodes, 29% are 31-60 days, nearly one-fifth (18%) are 61-90 days, and 12% are more than 90 days in length.

The higher percentage of drug court treatment episodes lasting only 0-30 days may be a function of the data from Hennepin County Adult Drug Court. This court has recently restructured its program so that it can provide more intensive services for fewer clients. Prior to 2007, the court served many clients, but only a subset received treatment services. Indeed, if Hennepin were to be removed from this graph, the length of say for the two remaining courts increases: 16% of episodes are 0-30 days, 24% are for 31-60 days, 12% are for 61-90 days and nearly half of the episodes (48%) are more than 90 days.

Figure 23. Episodes Funded by CCDTF Only: Length of Stay for Drug Court Clients and Statewide Offenders in the Metro Region (Hennepin, Ramsey A.S.A.C, Ramsey DWI)



Dodge's Alternative to Addiction and Wabasha County Adult Drug Court are the study courts in the Southeast regional of the state. About half (46%) of drug court clients' episodes are more than 90 days, 18%, are 0-30 days, 18% are 31-60 days, and 18% are 61-90 days in length. Approximately one-third of drug court episodes were ongoing and excluded from this analysis, and therefore the actual drug court length of stay is underrepresented here. Alternatively, for statewide offenders' episodes, one-tenth (10%) are more than 90 days, with episodes in this region primarily 0-30 days in length, accounting for 44% of the episodes. Of the remaining episodes for the statewide offenders, 28% are 31-60 days and 19% are 61-90 days in length.

The Wabasha County Adult Drug Court has a contract with a chemical dependency service provider. As mentioned earlier in this report, in other research, these contracts have been shown to increase positive treatment outcomes and may be linked with longer lengths of stay (Carey, Finigan, & Pukstas 2007, under review).

Figure 24. Episodes Funded by CCDTF Only: Length of Stay for Drug Court Clients and Statewide Offenders Using in the Southeast Region (Dodge and Wabasha)

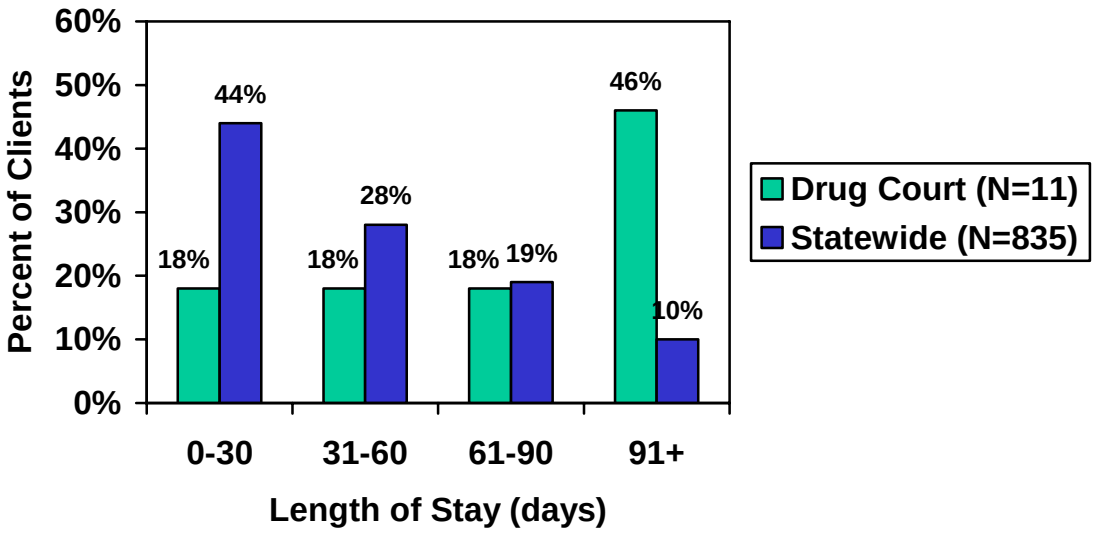


Figure 25 compares the Southwest region of Minnesota to Blue Earth County Adult Drug Court and Watonwan County Adult Drug Court clients' treatment episodes. Drug court clients' episodes are more likely to be longer than 90 days (37%) than are the statewide offender episodes (16%); however approximately one-third of episodes in both groups are 0-30 days in length. Half of drug court episodes are ongoing at the time of data collection, and therefore the length of stay reported here is likely an under representation of the actual drug court length of stay.

It is possible that the longer length of stay for drug court clients is a result of the contract Blue Earth County Drug Court and Watonwan County Adult Drug Court have with treatment providers. These contracts dictate that service providers are available specifically for serving clients of the drug court.

Figure 25. Episodes Funded by CCDTF Only: Length of Stay for Drug Court Clients and Statewide Offenders in the Southwest Region (Blue Earth and Watonwan)

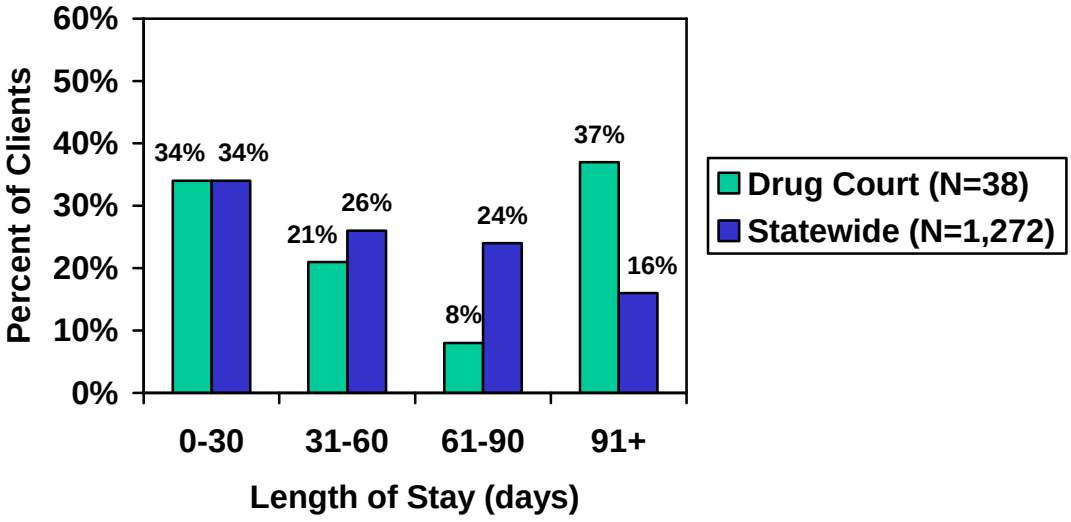
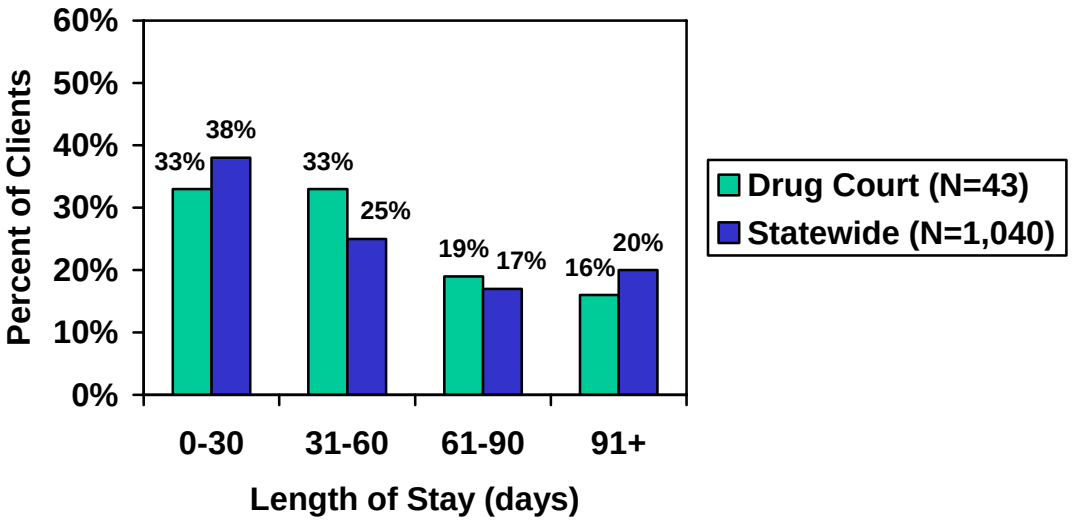


Figure 26 displays a comparison of Cass County Wellness Court and Crow Wing County Adult Drug Court client episodes with the West Central region of Minnesota. Over one-third of statewide episodes (38%) and one-third (33%) of drug court episodes are 0-30 days in length. Statewide offenders' episodes are somewhat more likely than drug court clients' episodes to be longer than 90 days (20% and 16% respectively).

Treatment episodes at these two sites were not ongoing (with the exception of one client) at the time of data collection, so the results presented here are not an underestimate of actual length of stay. However, the difference in lengths of stay in treatment programs may be attributable to the fact that both programs are in the early stages of development. Cass County began screening clients for the Wellness Court in April 2006 and Crow Wing County first admitted clients in May 2006. Often, during the first year of implementation, programs are developing systems and protocols and therefore are not yet fully functional.

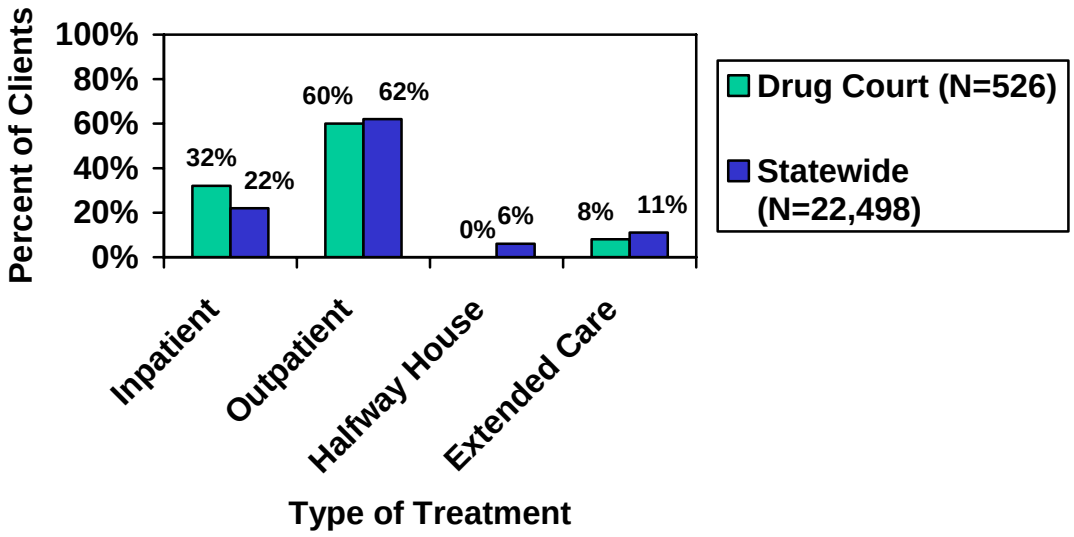
Figure 26. Episodes Funded by CCDTF Only: Length of Stay for Drug Court Clients and Statewide Offenders in the West Central Region (Cass and Crow Wing)



TYPE OF TREATMENT

Figure 27 illustrates the types of treatment utilized by the drug court clients and statewide offenders. Overall, a consistent pattern emerges. Outpatient treatment is most often utilized (60% drug court clients compared to 62% statewide), followed by inpatient (32% drug court clients compared with 22% statewide). Across payment sources the pattern remains, with few exceptions. Those funded by PMAP or private insurance in the statewide offender population are more likely to receive inpatient treatment than drug court clients, while drug court clients funded by the CCDTF are more likely to receive inpatient treatment than CCDTF-funded clients in the overall Minnesota offender sample.

Figure 27. Type of Treatment for Drug Court Clients and Statewide Offenders



Length of Stay by Treatment Type for CCDTF Episodes

To further examine CCDTF usage for chemical dependency treatment, the research team conducted an analysis of inpatient and outpatient length of stay for CCDTF funded episodes. As illustrated in Figure 28, most statewide offender inpatient treatment episodes are 0-30 days in length, accounting for more than three-quarters (84%) of all episodes in inpatient treatment. In contrast, less than half (46%) of drug court client episodes fall in this range. Few statewide offenders episodes last more than 90 days for this form of treatment (less than 1%) as compared to 9% of drug court clients' episodes. In other words, while about 1 in 100 clients in the statewide comparison sample have inpatient stays lasting more than 90 days, 1 in 10 drug court clients remain in treatment for more than 90 days.

Figure 28. Episodes Funded by CCDTF Only: Length of Stay for Drug Court Clients and Statewide Offenders for Inpatient Treatment

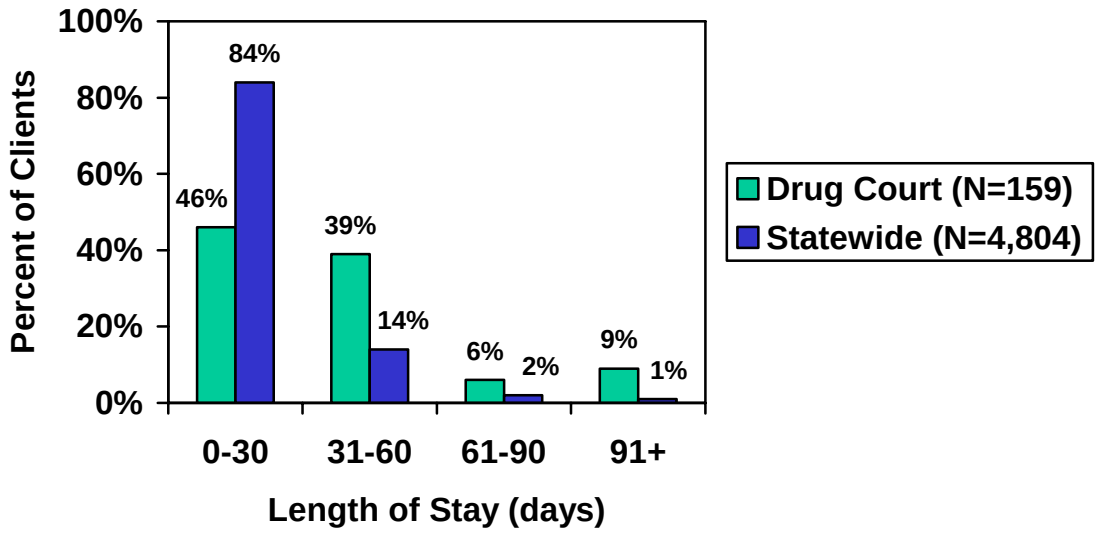
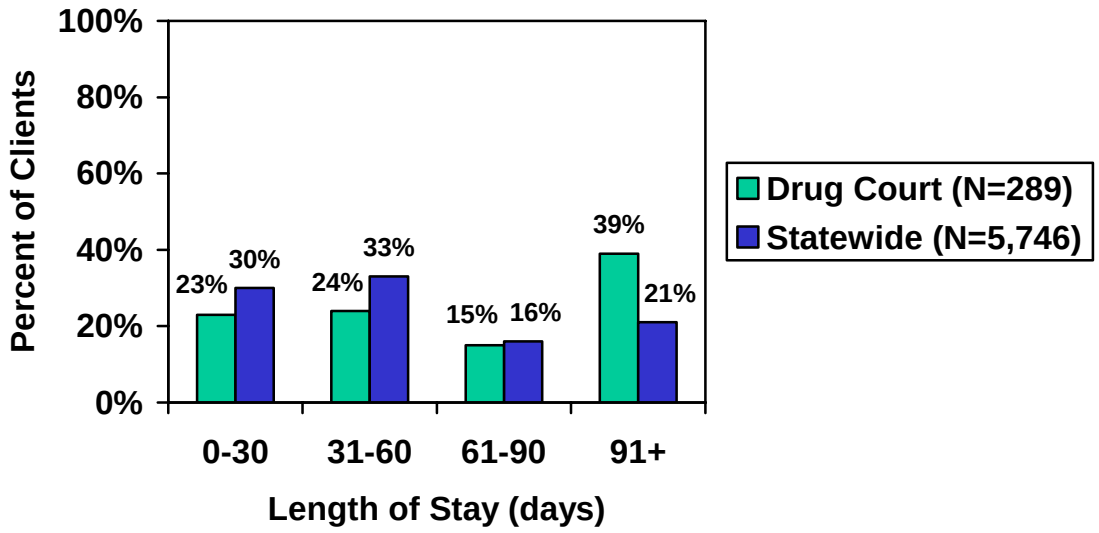


Figure 29 illustrates the length of stay between groups for CCDTF funded episodes in outpatient treatment. Almost 40% of drug court clients' episodes in outpatient treatment are more than 90 days, while only one-fifth (21%) of the statewide offenders' episodes are more 90 days in length. The statewide episodes are most commonly 0-30 days in length (30%) and 31-60 days (33%). In contrast, less than half (47%) of drug court clients' episodes are less than 60 days.

Figure 29. Episodes Funded by CCDTF Only: Length of Stay for Drug Court Clients and Statewide Offenders in Outpatient Treatment



A Closer Look at the Drug Court Treatment Experience

Above, we contrasted the length of stay and types of treatment for drug court clients' treatment episodes as compared to the statewide offender population. Below, we take a closer look at Minnesota's drug court clients by providing a profile of the continuum of care received while participating in drug court. Continuum of care is defined as the entire course of treatment while in drug court. The drug court process involves a team approach to helping the drug court client attain sobriety (NADCP, 1997) with clients motivated by criminal justice accountability to complete treatment. "Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning," (NIDA, 2000, page 5).

Clients in the general public tend to have fewer episodes of treatment than drug court clients. For example, McRae (2006), in evaluating Minnesota treatment "spans," found that over the course of 5 years, individuals entering treatment had on average 1.8 treatment entries (with a median of 1 entry into treatment). McRae defines a span as a continuum of treatment episodes that take

place within 30 days of one episode ending and another beginning. For example, an individual may enter inpatient treatment and complete, then outpatient treatment, and then move into a halfway house or continuing care. Similarly, a person may enter into outpatient treatment, then relapse and begin an episode of inpatient treatment. Each of these examples presents a continuum of care; the individual is continuing their treatment process to recovery. This continuation of episodes could be considered a course of treatment.

THE DRUG COURT EXPERIENCE

Three hundred and twenty-seven drug court clients make up the 2006 drug court cohort under analysis: 32% are African Americans. Table 6 summarizes clients' overall drug court experience, including time spent in drug court and drug court completion status.

Minnesota drug court participants in the 2006 cohort are typically in the program for more than 90 days with an average length of stay to date of 282 days.[11] Almost three-quarters are still enrolled in drug court, but of the individuals who have finished drug court, more than half (60%, or 76 clients) have graduated. Most (78%) drug court clients are utilizing the CCDTF for treatment with about one-tenth (11%) on private insurance, 6% with PMAP or another public source of funding and 5% using some other method of payment (for example: Veteran's Benefits, self-pay) to support their treatment.

[11] Almost three-quarters of the drug court clients in the cohort were still enrolled in drug court at the time of data collection, and therefore the drug court lengths of stay reported here are likely an under representation of actual lengths of stay.

Table 6. A Profile of Drug Court Clients' Experiences in Drug Court (Client-level Data)

	Drug Court Clients
Number of clients	327
% Male	67%
Race categories	N=321
White	63%
African American	32%
Native American	3%
Hispanic	2%
Asian/Pacific Islander	<1%
Drug Court length of stay	N=315
0-30	2%
31-60 days	2%
61-90 days	2%
More than 90 days	94%
Average # of days	282
Drug Court completion status	N=269
Graduated	15%
Ongoing	72%
Terminated	14%
Treatment Payment Source	N=176
CCDTF	78%
PMAP	6%
Private insurance	11%
Other	5%

DRUG COURT CLIENTS' CONTINUUM OF CARE

Table 7 presents a profile of drug court clients' continuum of care in chemical dependency treatment. The average number of treatment episodes in the continuum of care is 1.7 for the cohort of clients. Half (51%) have one treatment entry, almost half (48%) have 2-4 entries and the remaining 1% had five episodes. Drug court clients in the 2006 cohort are receiving more episodes in treatment than Minnesota's overall population. That is, while drug court clients receive on average 1.7 treatment episodes in one year alone, the statewide treatment population receives 1.8 over the course of 5 years (McRae, 2006), meaning that, on average, drug court clients have 5 times as many treatment episodes than the statewide treatment population.

The average length of stay for drug court clients (summing across all episodes) is 143 days, with over one-third of clients remaining in treatment for more than 90 days (38%); however, 46% of drug court clients have received less than 30 days of treatment.

Table 7. A Profile of the Continuum of Care (Client-level Data)

	Drug Court Clients
Average # of assessments	1.2
Number of episodes in the continuum	N=213
1	51%
2-4	48%
5+	1%
Average # of episodes	1.7*
Number of types of treatment	N=211
1	60%
2	32%
3	8%
Average # of types	1.5
Continuum of care length of stay	N=123
0-30 days	46%
31-60 days	9%
61-90 days	7%
91+ days	38%
Average # of days	143

*** This is 4.7 times greater than the average number of episodes for the statewide population.**

Table 8 illustrates a profile of the continuum of care outlining the various combinations of care that drug court clients receive. Almost half (44%) of clients receive outpatient treatment only with an additional 11% receiving outpatient and continuing care and 19% receiving outpatient and some other combination of services (Table 8). Some (14%) receive inpatient care only and 8% received inpatient and outpatient treatment. An additional 16% receive some combination of inpatient with other types of treatment. A small number of receive continuing care only (1%) or halfway house only (2%) during their participation in drug court.

Two-thirds (66%) successfully completed each of their episodes in treatment or were still in treatment at the time of data collection. One third (35%) have had an unsuccessful episode but within those clients, almost half have also had a successful episode or are in ongoing treatment.

Table 8. A Profile of the Continuum of Care (Client-level Data)

	Drug Court Clients
Types of treatment	N=211
Inpatient only	14%
Outpatient only	44%
Halfway House only	2%
Continuing care only	1%
Inpatient+Outpatient	8%
Inpatient+Continuing care	7%
Outpatient+Continuing care	11%
Inpatient, Outpatient+Continuing care	1%
Halfway House+Inpatient	3%
Halfway House+Outpatient	3%
Halfway House, Inpatient+Outpatient	6%
Continuing care, Halfway House+ Outpatient	1%
Treatment episode completion status	N=200
All Successful	46%
Successful and Ongoing	9%
Ongoing	11%
All Unsuccessful	17%
Unsuccessful+Successful	12%
Ongoing+Unsuccessful	2%
Successful, Unsuccessful+Ongoing	4%

Continuum of Care by Payment Source

Table 9 displays the length of stay in the continuum by payment source. Within the group of participants funded by the CCDTF, half (53%) have lengths of stay longer than 90 days, with approximately one-quarter of clients remaining in treatment for 0-30 days. For PMAP or other public sources of health care coverage, almost three-quarters (70%) are in the 91+ days category. About half (47%) of private insurance clients and one-third (33%) of those paying for their treatment with "other" sources have longer lengths of stay. It appears that more PMAP clients have longer continuums of care, but this may be due to very small sample sizes of those reporting this source of payment for their treatment.

Table 9. Total Length of Stay in Treatment for Drug Court Clients by Payment Source (Client-level Data)

	0-30	31-60	61-90	91+
CCDTF (N=138)	27%	12%	8%	53%
PMAP (N=10)	10%	10%	10%	70%
Private insurance (N=19)	32%	11%	11%	47%
Other (N=19)	33%	22%	11%	33%

Table 10 outlines the average continuum of care length of stay, number of episodes and number of treatment types for drug court clients by payment source. PMAP and other public health care clients along with privately insured clients have a longer length of stay than CCDTF. However, CCDTF clients have a higher average number of episodes and subsequently a higher average number of types of treatment.

Table 10. Average Length of Stay, Number of Episodes and Number of Treatment Types for Drug Court Clients' by Payment Source (Client-level Data)

	LOS (in days; N=176)	Episodes (#; N=157)	Types (#; N=155)
CCDTF	116	1.9	1.5
PMAP	132	1.3	1.2
Private insurance	129	1.4	1.3
Other	102	1.2	1.0

*** This is 5.3 times greater than the average number of episodes for the statewide population.**

Conclusions

The analysis of chemical dependency treatment utilization presented above informs Policy Question 7, whether drug courts are a more efficient use of public resources for treatment as compared to the overall offender treatment experience.

POLICY QUESTION 7: ARE DRUG COURTS A MORE EFFICIENT WAY OF UTILIZING PUBLIC RESOURCES FOR TREATMENT?

The analyses illustrate that drug court client treatment episodes last longer than the treatment episodes for the offender population in Minnesota statewide. Also, the analyses of episodic treatment data along with drug court clients' continuum of care described above illustrate that drug court clients have a greater number of treatment episodes (representing a more complete continuum of care) than the statewide treatment population and stay in those treatment episodes longer. For example, the data indicate that drug court clients have five times more treatment episodes on average than the statewide treatment population. The continuum of care for drug court clients may represent a more complete treatment process as it follows clients through the course of treatment and follow up after clients complete treatment. While the investment cost associated with extended treatment episodes is great, research indicates that prolonged treatment stays lead to future cost savings (Carey, Finigan, & Pukstas, 2007).

These analyses demonstrate that drug court appears to be an efficient conduit for the CCDTF. Given the increase in their time spent in treatment, the likelihood that these individuals will have better outcomes and future cost savings for the state dramatically increases. Indeed, research indicates that longer lengths of stay are linked to successful treatment completion (National Institute on Drug Abuse, 2000) and successful treatment completion to positive life outcomes such as reducing recidivism, (United States Govern-

ment Accountability Office, 2005) drug use, and criminal behavior (Belenko, 1998 and 2001).

These findings mirror recent findings regarding the relative effectiveness of drug courts as compared to a statewide mandatory treatment program for drug offenders in California. In that study, drug court clients were more likely to complete treatment and had lower criminal recidivism rates than offenders who took part in a statewide treatment diversion program (Carey, Pukstas, Waller, Mackin, & Fingan, 2007).

Furthermore, while this study did not investigate the proportion of drug court clients who entered treatment as compared to the proportion of chemically dependent offenders overall who enter treatment, other studies have shown that drug court clients are more likely to enter treatment than comparable individuals (see, for example, Worcel, Green, Furrer, Burrus, & Finigan, 2007).

Recommendation #8: Increase the number of offenders served by drug courts as a means to use the CCDTF more efficiently and effectively.

This analysis highlights the importance of the research question, "Do Minnesota Drug Courts lead to future cost savings?" In order to fully evaluate whether drug court is an efficient and effective use of public dollars in Minnesota, this question must be addressed through a separate formal cost-benefit analysis.

Recommendation #9: Conduct a cost-benefit analysis of Minnesota's drug courts.

LIMITATIONS

As discussed in the methods section, the data used for the above analyses have limitations. In order for the coordinator at each site to compile records of each treatment episode, they reviewed drug court case files and treatment files. Client files are not kept specifically for these purposes and therefore the treatment experience data (client start and end dates in treatment, type and method of payment) are subject to error. For example, in some cases, drug court coordinators were able to distinguish between outpatient and continuing care, while in other cases they could not. Therefore, the outpatient lengths of stay reported here may be an inflation of actual outpatient lengths of stay.

It is important to remember that while these analyses do address time spent in treatment and treatment type, they do not say anything about treatment quality and effectiveness. As indicated in the Office of the Legislative Auditor's evaluation of chemical dependency treatment, "[b]road claims that treatment is effective or ineffective are misleading. There are many forms of chemical dependency treatment, of various lengths and intensities, provided to persons with different needs, and implemented with various degrees of skill" (OLA, 2006: page X of the Executive Summary). Research to evaluate the efficiency of funding must more closely evaluate the effectiveness of treatment, taking into consideration intensity, length, and need, among many other components.

SECTION V: ANALYSIS OF OTHER STATES' DRUG COURT AND CHEMICAL DEPENDENCY SERVICES FUNDING STRUCTURES

State legislatures, federal grantors, and local governments have all directed their attention to the issue of maintaining consistent funding for drug courts and the treatment necessary for the courts to succeed. In an effort to answer Policy Question 8, "Are there service structures or funding mechanisms used by other states to support their drug courts that would be useful models for Minnesota?" the evaluation team collected information from 11 other states: California, Florida, Illinois, Indiana, Maryland, Michigan, Missouri, New York, Oregon, Pennsylvania and Wisconsin. These states were chosen to reflect 3 interests: 1) requests from the study's liaison committee, 2) demographic and regional similarity to Minnesota, and 3) states in which NPC Research has a breadth of knowledge. Below we present an overview of trends from the other states, followed by a description of funding for chemical dependency and drug court services. We conclude with a description of unique programs, promising practices, and challenges faced by the other states.

Overview

Our review of the 11 selected identified some trends across the states, described below.

The criminal justice and chemical dependency treatment systems in all states are largely independent of each other and follow traditional federal-state-local funding and administrative structures. We found no examples of fully consolidated drug court programs in which funding for the entire range of treatment and support services is fully integrated with funding for drug court operations. With limited exceptions, drug courts are not funded or administered at the state level. As in Minnesota, drug courts in most

of the selected states are initiated and operated at the circuit court (county), or in rare cases, the district court level.

The responsibility for financing, managing, and allocating public chemical dependency treatment programs rests with the executive agencies in each state. The publicly supported chemical dependency treatment system is funded through the Substance Abuse Prevention and Treatment (SAPT) Block Grant, which is administered by the single state Alcohol and Other Drug (AOD) Agency. States supplement the federal block grant dollars with state general fund revenues. The state either delivers services under its own auspices, or delegates and passes through federal and state dollars to designated county agencies. The counties may also supplement the pass-through dollars with local revenues.

Minnesota remains in the forefront of chemical dependency treatment funding structures with its unique CCDTF. While at least one other profiled state offers a state-funded program that provides a continuum of chemical dependency treatment services on a sliding fee scale for low-income addicts, it does not

include federal SAPT dollars and is not as extensive or comprehensive as Minnesota's Fund.

The primary sources of chemical dependency treatment funding for drug court participants are the same across all the selected states as they are in Minnesota: i.e., the public treatment system, Medicaid, private health insurance, self pay, and a variety of other specialty programs such as the Veteran's Administration or Indian Health Service. None of the states provide targeted chemical dependency funding for drug court participants.

Like Minnesota, drug courts in other states cobble together funding from a myriad of sources. Some states do appropriate dollars for drug court operations. These monies are distributed through the judicial branch to drug courts, or are made available to drug courts (and possibly to other alternative justice programs) as grants on a competitive basis. In most cases, drug courts may use some or all of those dollars for treatment services. Funding sources are described in more detail later in this section of the report.

The National Survey of Substance Abuse Treatment Services (N-SSATS), conducted by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA; N-SSATS, 2005), includes information on chemical dependency services providers. A summary of the number of facilities and their characteristics such as ownership/operating body, focus, issues treated, types of care, payment sources, funding and specialties can be found in Appendix D. Highlights from these data include:

- Minnesota providers receive federal, State, county or local government funds for chemical dependency programs more often than, or on par with, all other states profiled (70% of providers in Minnesota compared with a high of 78% in California and a low of 56% in Illinois);
- Minnesota providers report the same degree of, or less, specialization for co-occurring disorders than the 11 comparison states (30% of providers for Minnesota, compared to a range of 27% in Indiana to 49% in Oregon); and
- With the exception of Wisconsin, Minnesota providers report serving the fewest criminal justice clients of the states profiled (17% of Minnesota providers compared to a low of 16% in Wisconsin and a high of 34% in Oregon).

None of the 11 comparison states report including mental health treatment as a function of drug court beyond some linkages to mental health assessments. Later in this section of the report we provide some information and suggestions regarding services for drug court clients with co-occurring disorders.

American University's Drug Court Clearinghouse (BJA, 2006) lists the number of drug courts in each state and the number and types of federal grants each state has received for drug courts as of November 2006. Table 11 includes a summary of the profiled states. In addition, the evaluation team analyzed data from the national Treatment Episodes Data Set (TEDS, 2005) for each profiled state. Please see Table 12 for numbers of treatment episodes experienced by offenders and a demographic breakdown for each state.

Table 11. Numbers of Adult Drug and DWI Courts in Each State and Number of Federal Grants Received by Each State Over Time

	MN	CA	FL	IL	IN	MD	MI	MO	NY	OR	PA	WI
Number of active courts	14	92	44	19	18	13	43	62	89	24	23	13
Number of developing courts	17	2	4	4	7	4	12	15	16	3	4	3
Number of planning grants received	17	25	18	13	14	8	42	42	64	15	12	16
Number of implementation grants received	6	39	16	8	12	0	10	11	33	8	8	5
Number of enhancement grants received	2	54	13	7	3	4	1	11	21	9	4	0

Table 12. Treatment Recipients and Their Demographics in Each State

	MN	CA	FL	IL	IN	MD	MI	MO	NY	OR	PA	WI
# of treatment episodes overall	45,334	157,851	28,121	69,058	35,929	61,083	54,538	40,206	287,020	43,307	70,493	24,965
# of treatment episodes for offenders	11,144	70,685	12,075	30,651	18,194	24,070	16,282	19,134	67,660	24,237	21,304	13,170
Payment source												
Medicaid	--	--	--	14.2%	12.5%	4.6%	--	5.0%	--	0.2%	13.9%	--
Medicare / Other	--	--	--	1.3%	8.2%	5.4%	--	0.9%	--	14.8%	21.9%	--
Private Insurance	--	--	--	5.6%	10.2%	20.5%	--	2.2%	--	20.0%	9.8%	--
None	--	--	--	78.9%	69.1%	69.5%	--	91.8%	--	65.0%	54.5%	--
Demographics												
Alaskan Native / American Indian	9.3%	3.5%	0.5%	0.5%	0.7%	0.3%	1.3%	0.4%	0.8%	3.9%	0.4%	3.5%
Black	14.3%	15.4%	20.3%	35.8%	15.5%	44.4%	16.9%	25.6%	34.5%	4.0%	21.0%	6.9%
White	68.7%	49.9%	74.9%	49.9%	80.7%	50.4%	76.1%	72.5%	45.6%	88.6%	75.0%	89.0%
Other (A-PI, Mixed Race, Unknown)	7.8%	31.1%	4.3%	13.7%	3.1%	4.9%	5.7%	1.5%	19.1%	3.5%	3.6%	0.6%
% Hispanic	5.9%	36.2%	12.5%	11.5%	4.3%	5.3%	4.7%	2.0%	20.2%	13.2%	9.7%	5.3%
% Male	77.2%	71.3%	70.5%	76.4%	73.3%	78.7%	77.0%	74.2%	80.5%	74.4%	78.6%	76.0%

Chemical Dependency Treatment and Drug Court-Specific Funding

Funding for drug court programs comes from a montage of systems and resources. As with Minnesota's drug courts, much of the funding for treatment services for drug court clients in the 11 comparison states comes from federal and state sources, but courts also rely on funding from Medicaid, Medicare and other public health programs; client fees; private insurance; federal grants; foundations and other private money; and some local funds. These funding sources are described below.

STATE FUNDING FOR DRUG COURTS

While many states report that treatment for drug court clients is funded through the public and private sources of treatment funding available to other individuals seeking treatment (e.g., there are not drug court-specific funding mechanisms to support chemical dependency treatment), some states do provide funds to support treatment for drug court clients, or drug court operations more generally. Some states have created funds for drug courts through specific fees or taxes or have appropriated state general revenue funds for drug courts. In one state, drug courts have become institutionalized within the court system, and court budgets include funds for drug court operations; drug courts are not simply separate line items, but rather, are an integrated part of the overall court system.

In many states, an oversight body, similar to Minnesota's Drug Court Initiative Advisory Committee, consisting of representatives from the judicial branch, executive branch, and non-governmental entities, has been created, often by statute. The mandated parties collaborate to provide guidance and some funding for the drug courts. Representatives, often the directors, of both the state judicial branch and the state health agency related to chemical dependency are mandated to work together to create the structure and support for drug courts.

In one profiled state, drug court commissions disburse appropriations and general revenue funds. The commission is charged with securing grants and other funds in addition to property and services necessary to facilitate drug courts. The director of the Alcohol and Other Drugs (AOD) division is mandated to participate by statute along with five judicial appointees: the state court administrator, the deputy director of social services, the director of corrections, the mental health director, and a representative from public safety.

Another state's statutes mandates that the drug courts be co-administered by the judicial council and the director of the Department of Alcohol and Other Drugs (AOD). The two agencies are expected to collaborate on the design and implementation of the statewide drug court program including determining how funds are allocated, funding levels, monitoring, and research and data collection. Courts are required to provide a match for the funding they receive. There is also an executive steering committee for drug court funding which includes representatives from the appointed judicial branch, AOD programs, partner agencies, probation, and law enforcement. The commission has staff to carryout policy decisions, review grant applications, and set up regulations.

STATE FUNDING FOR CHEMICAL DEPENDENCY SERVICES

Drug courts in the profiled states utilize the existing public alcohol and other drug treatment system administered by the single state AOD agency to cover eligible participants' chemical dependency and mental health care needs, and chemical dependency treatment

services are funded through varying combinations of sources. Although much of the discussion of publicly-supported chemical dependency treatment services focuses on systems funded through the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant administered by the single state Alcohol and Other Drug (AOD) Agency in each state, publicly-supported treatment services are increasingly being provided through a number of other channels. The development of chemical dependency treatment delivery systems and accompanying financing options that are designed to meet a variety of specific needs have combined to create parallel treatment systems administered by agencies other than the state AOD Agency (NASADAD, 2002). Forty-two states responded to a National Association of State Alcohol and Drug Abuse Directors (NASADAD) survey of alcohol and other drug treatment systems in 2001, including all 11 of the other states selected for this comparison. State respondents identified a wide range of agencies and programs that provide chemical dependency treatment services to their service populations, including:

State Level Agencies

- Correctional authority
- Probation authority
- Parole authority
- Mental health agency
- Public welfare agency
- Child welfare agency
- Drug and other specialty courts

Local Level Agencies

- County jails/correctional authorities/corrections boards
- County probation agencies
- County mental health agencies/boards
- County/municipal public health agencies/boards
- County drug and other specialty courts
- County child welfare agencies
- County public welfare agencies
- Vocational rehabilitation programs
- Tribal authorities

The specific treatment systems identified by each of the comparison states in the NASADAD survey are summarized in Appendix E. Not surprisingly, the parallel treatment systems identified by 6 or more of the 11 comparison states were state and local correctional or parole authorities. Treatment settings in these systems included community-based and residential settings in addition to treatment occurring within correctional facilities. The next most frequently identified sources of chemical dependency treatment supports—cited by 4 to 5 states—were state and/or county drug courts, child welfare agencies, and public welfare programs. State justice agencies in two states reportedly purchased treatment services for drug court programs, and county drug courts purchased treatment services in 5 other states.

The NASADAD survey also found that many of the comparison states maximized treatment services or cross-system coordination with the Medicaid program. Eight of the comparison states indicated that their states provide expanded AOD treatment services under state Medicaid options or waivers. Six of those states coordinate or supplement Medicaid services with treatment services provided by the State AOD Agency. Eight states have other publicly-funded managed health care plans that provide AOD treatment services outside of the State AOD system, and six of those states routinely refer

clients in need of services beyond those provided by the public managed care plans to treatment services supported by the AOD Agency.

CLIENT FEES

Representatives from several states mentioned that clients pay for treatment themselves, or explained that client court fees (often determined using a sliding scale) are used to support the cost of drug court treatment and operations. These funds are used to pay for treatment for clients who are not eligible for any public or private health care programs. While participant fees provide only a small fraction of the funding for services, state representatives interviewed stressed that these fees are vital components of the drug court funding structure.

PRIVATE INSURANCE

Private insurance is not a significant source of funding for drug court services in the 11 comparison states, and at times runs out before drug court treatment is complete. However, two states report that about one-fifth of chemical dependency treatment episodes for offenders are covered by private health insurance.

FEDERAL GRANTS

Local and state governments may be able to apply for federal discretionary funding for drug court treatment. Some examples (SAMHSA, 2007) of these grants include:

State Incentive Grants for Treatment of Persons with Co-Occurring Substance Related and Mental Health Disorders (COSIG)

In addition to some of the other states profiled, Minnesota is a current recipient of a COSIG grant from Substance Abuse and Mental Health Services Administration (SAMHSA). The COSIG program provides funding for states to develop or enhance infrastructure to increase capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment services to persons with co-occurring chemical dependency and mental disorders. The grant funds will be used to build a network of dual disorder treatment services, including 14 outpatient mental health centers, 14 outpatient chemical dependency programs, 4 behavioral health tribal clinics, and two chemical dependency programs run by the Department of Corrections. While drug courts are not the target of the grant, with partnerships in place, these services can be available for drug court clients.

Access to Recovery Grants

Several of the 11 comparison states have an Access to Recovery grant. These 3-year competitive grants may be used for drug court treatment. Texas is currently the only state using the funds for drug court treatment, in combination with other populations. The funding provides vouchers to assessed clients to purchase treatment and recovery support services, with the goals of expanding treatment provider capacity, supporting client choice, and increasing the array of faith-based and community providers. Local providers can apply to receive the vouchers. Across the nation, fourteen states and one tribal organization currently are awarded the grants.

The program involves a voucher system for treatment and recovery support services that includes assessment, clinical treatment, and recovery support (transportation and child care, as well as life skills, family counseling, drug free housing, education and employment support). In Texas, specific providers (bound by the agreements set forth in a Memoranda of Agreement) are enrolled in the voucher program, clients are given a choice of providers, and treatment service plans are developed by a care coordinator who is independent of the court or the treatment provider. Drug court clients access

treatment through the care coordinator using the vouchers in selected Texas communities.

LOCAL MONEY

Some local governments provide funding for their drug court programs and chemical dependency treatment. Drug courts may subsist on a combination of federal, state and local funds including revenue from state and local taxes and levies, law enforcement block grants, case filing fees, court-imposed fines, and contributions of staff time and other resources from local government agency budgets.

FOUNDATIONS AND OTHER PRIVATE MONEY

Some drug courts have received federal nonprofit status (501(c) 3) making it possible for them to obtain private foundation grants and other funding targeted to nonprofit organizations. In one state, 7 courts developed community foundations that have raised an average of $30,000 per court; courts with nonprofit status in two states have participated in the local United Way funding structure. State representatives noted that local, grassroots fundraising have brought important revenue to some courts.

Policy Question 8: Are There Service Structures or Funding Mechanisms Used by Other States to Support Their Drug Courts That Would Be Useful Models for Minnesota?

Minnesota has already adopted or is actively pursuing a number of innovative approaches to drug court treatment funding and service delivery structures (e.g., the CCDTF, the Drug Court Initiative; DCI) that places it squarely alongside other leading states that are making advances in treatment alternatives for addicted offenders. Nonetheless, in our review of other states' models, we learned about a number of other unique programs, promising practices and challenges faced by state-level drug court coordinators or individual drug court programs that are worthy of note and consideration by Minnesota's drug court stakeholders.

Below we group examples of successes and lessons learned into several categories, including: contracting with a primary provider, creating a centralized data system and using it for program evaluation and cost benefit analysis, advocating for drug court funding, improving access to chemical dependency treatment and services for individuals with co-occurring disorders, and enhancing drug court coordination.

PRIMARY PROVIDER CONTRACTS OR AGREEMENTS

As suggested in the 10 Key Components of Drug Courts (NADCP, 1997) and the 1999 National Drug Court Treatment Survey (Peyton & Gossweiler, 2007), formal or informal relationships between judicial agencies at the state level or individual drug courts and chemical dependency treatment providers are recommended and may lead to better outcomes for participants (Carey, Finigan, & Pukstas, 2007, under review). In Minnesota as in most of the other states selected for this review, such relationships should be possible—at a minimum—with chemical dependency treatment services operated directly by the single state AOD agency or locally-designated sub-state agency (usually the county health or human services departments), or with community-based providers that contract with either of those agencies.

In some cases, drug courts or judicial branches contract directly with treatment providers in relationships formalized by

memorandums of understanding or actual fee for services contracts. These include contracts with providers or formal relationships with an administrative agent that contracts with local providers. Contracts may include agreement to provide treatment to all drug court clients, including those in rural areas, and standards for reporting treatment progress to court staff.

One state's strategy for dealing with drug-involved offenders is the use of a "designated program" model in which the state health department employs a single independent entity to provide assessment, referral, and case management services to offenders in all courts statewide. Treatment Alternatives for Safe Communities (TASC) is a statewide nonprofit organization in this state that provides behavioral health recovery management services for individuals with chemical dependency and mental health disorders (Braude, 2007). Although drug courts in this state are not required to use TASC for service coordination, many do. This model offers the benefits of standard assessments, clinical referral and placement with appropriate treatment providers, and statewide coordination and oversight of drug court and treatment system relationships.

Beneficial informal relationships with community providers can include the options of drug court clients receiving preferential treatment, priority placement, and/or reduced time from referral to entry into treatment. In addition, agreements to sit on the drug court team and make treatment progress information available to the drug court are part of best practices.

While there are many benefits to a drug court contracting with a single provider, the drawbacks include possible limitations on client needs matching the services offered, especially around cultural competency and mental health. Multiple providers theoretically make it possible to match clients with the provider that best fits their needs, but with a larger pool of treatment providers it becomes more difficult to monitor treatment quality and ensure treatment provider integration into the drug court team.

The experiences of these other states bolster the recommendation set forth in Section III of this report stating that Minnesota's drug courts should utilize provider contracts to guarantee treatment access, oversee treatment quality, and engage providers as part of the drug court team.

CENTRALIZED DATA SYSTEM / EVALUATION OF DRUG COURT PROGRAMS / COST BENEFIT ANALYSIS

With one notable exception (Michigan), most of the states profiled are not collecting comprehensive drug court data statewide. The need for a standardized system was echoed throughout the interviews with representatives from other states as necessary to streamline statewide reporting, document local outcomes, track expenditures (especially those not directly part of the drug court program such as treatment costs), support program oversight and provide evidence for seeking additional funding. State legislatures and court agencies that establish performance measures ideally should be able to evaluate the programs and demonstrate the cost effectiveness of local drug courts. In addition, local data is needed to determine drug court success with an eye towards how a program functions and to identify for which populations it is most successful. Local data will assist with identifying promising practices for local populations and areas for program improvements. Measures such as graduation rates, recidivism rates, services provided, demographics and criminal histories of participants and the costs of services provided, especially chemi-

cal dependency treatment, could be documented and summarized.

Michigan's statewide automated drug court case management information system allows drug courts in that state to manage their caseloads and provide individual-level data on drug court applicants and participants as required by legislation. The web-based system is organized around a series of screens associated with a client's case. Technical assistance in using the system is provided by the state justice agency to providers and drug court staff. Required use of the system helps drug courts meet reporting requirements for receipt of state-appropriated monies. Use of the system is available to all courts throughout the state without cost. State level and local program administrators and policy makers have a practical and reliable tool for managing caseloads and collecting individual level data invaluable at the state level.

Additional MIS-related suggestions made by other states include:

- Create a simplified system for counties to report data to and provide on-going technical assistance;
- Adopt a single participant tracking number, ideally throughout multiple systems (state health insurance claims, mental health and chemical dependency agencies, criminal justice agencies, etc.);
- Include the ability to track all expenditures related to drug court especially where funds are reimbursed directly to treatment providers and thus are not part of drug court records; and
- Explore the availability of federal Department of Justice funding for a statewide cost-benefit analysis and subsequent development of a statewide data system, as one of the profiled states was able to do.

Most young drug courts have an on-going evaluation mandated with federal funding from initial start-up grants. Statewide evaluations can provide a basis for larger policy changes and funding allocations. A data system will increase the efficiency of evaluating the effectiveness of the statewide program as a whole, even where programs differ locally. Where feasible, duplication can be avoided by enhancing existing data systems or integrating disparate data systems.

Recommendation #10: Develop a drug court MIS for use by all the state's drug courts. Researchers as well as practitioners should continue to be included in the planning and design process to ensure that the MIS will be of practical use for case management and other practitioner needs as well as for research and evaluation purposes.

ADVOCATING FOR DRUG COURT FUNDING

Representatives from other states described several methods of advocating for drug court funding at the state and local level. Representatives from other states repeated the need for local cost-benefit analysis results in requesting continued or new funding for drug court programs at the state level. In addition, demonstrating public support through polling or voting records on drug policy options has been part of comprehensive public education strategies. Documenting that drug court and treatment staff have received appropriate education and training provides evidence to policymakers that a state has qualified professionals available to implement a drug court program effectively. States have also found it helpful to provide

forums for state legislators to educate them on drug court programs as effective legislative strategies. Finally, using the most powerful voices possible is a recommended practice; in one state, the judge went to the governor's office to request drug court funding. Indeed, Minnesota has engaged in much of these activities already; drug court professionals and partners, including treatment providers, have had opportunities to participate in state and national trainings, drug court judges have participated in public speaking and other outreach activities, and state and local drug court professionals have provided education to the legislature.

At the local level, communities take responsibility for maintaining drug courts through activities such as:

- Treatment and recovery advocates, drug court alumni groups and judges presenting human interest stories and personal experiences of participants to local business associations, foundations and legislators;
- Utilizing the media to publicize success stories, and inviting the press to graduations;
- Collecting local data on effective practices for the local population served;
- Inviting local legislators to observe drug court hearings or graduations; and
- Offering educational symposia, discussions or forums on issues primary to serving the population, for example: how the court system and mental health system can work together more effectively.

Recommendation #11: Continue to build relationships and increase education of the public and key partners about the advantages and benefits of drug court programs versus traditional criminal justice processing.

CHEMICAL DEPENDENCY TREATMENT AND SERVICES FOR INDIVIDUALS WITH CO-OCCURRING DISORDERS

Below we discuss the importance of a statewide standardized assessment process and maintaining a trained staff of local providers in addition to identifying and addressing mental health needs in drug court participants and other ideas for increasing treatment success for drug court clients with limited funds.

A standardized chemical dependency assessment (including mental health assessment tools) with eligibility determination for publicly funded programs was cited as desirable but few had implemented this practice in their states. One interviewee called for statewide standardization of definitions of indigence and treatment program clinical eligibility to avoid inequities and differential access to treatment services across counties. It was suggested that assessments be conducted early, ideally at pre-arraignment with allocated staff for this purpose co-located at the courthouse.

Representatives in several profiled states cited ensuring there are enough qualified providers in any given area to serve drug court clients as a challenge. One interviewee suggested that additional workforce development strategies are needed in their state to improve the skills, training and compensation of chemical dependency and mental health providers. Assuring that evidence-based practices are being used and retaining qualified staff in rural areas appears to be difficult in most states. Only one solution was offered: state employees working in chemical dependency services were provided with an additional salary increase over

other state employees. Increasing the cultural competency of providers was also cited as a goal for many states.

Most key stakeholders interviewed mentioned the importance of meeting drug court clients' mental health needs and providing services that simultaneously address both chemical dependency and psychological issues. Funding through one state's drug court commission pays for mental health assessments/psychological evaluations and 3 months of medications. Most of the profiled states reported that providing services to individuals with co-occurring disorders was a challenge and this is an expected growth area within their drug court programs. Within the states profiled, interviewees highlighted two courts where these issues were beginning to be addressed: one court has chemical dependency assessments for drug court participants that include a mental health screening tool and another court has a co-occurring docket for people moving back and forth from mental health and chemical dependency services within the criminal justice system.

One state not profiled for this study used a 2004 SAMHSA discretionary grant to fund an initiative within the state health department. The goals is to implement integrated services throughout the mental health and chemical dependency service systems inviting the agencies to work together to serve the population with co-occurring disorders with integrated treatment services. A task force of community and agency leaders is working to create a system of cross-trained clinicians to deliver services. Funds are used to develop a statewide written plan, and expand relationships between mental health and chemical dependency professionals and with external entities, such as the justice system and law enforcement.

Other innovations around providing treatment include:

- Using a lab for drug testing within another state agency to lower expenses; for example, in one county, there is a lab at the department of corrections;
- One key stakeholder suggested strengthening existing drug courts and supporting the expansion of chemical dependency treatment systems in new counties before implementing new courts: ensure adequate treatment support is available in an area before implementing a drug court;
- Making case management and/or treatment resources available at the courthouse; and
- Choosing providers who are able to offer wraparound services that are flexible, consumer directed, recovery oriented and strengths and outcomes based. One state uses providers following the C-STAR model: comprehensive chemical dependency treatment and rehabilitation with clients placed in the most appropriate settings by an interdisciplinary team with multiple types of treatment available to clients through one agency.

The experiences of these comparison states further bolster the recommendations set forth in Section III regarding mental health services, namely, that Minnesota provide mental health assessments to all drug court clients, develop a model for integrating mental health services into drug court programs, and give priority for state funding to drug courts that implement such a model.

DRUG COURT COORDINATION

Based on other states' structures, successful drug court coordination at the state level includes several practices:

1. A drug court commission with a designated budget to distribute to the drug courts. The commission includes the directors of the chemical dependency agency (or the state health department) and judicial branches as well as probation, law enforcement, representatives from the governor's office, mental health agency, consumer representatives and others;
2. A certification program for drug courts, with minimum standards and requirements for drug court planning, implementation and operation. Funding should be prioritized based on compliance with these standards;
3. A state-level coordination office with staff to the commission as well as professionals available to provide technical assistance for local drug court and treatment staff on drug court implementation, grant writing, data collection and announcements of local and national funding opportunities and trainings;
4. A coordinated plan for expanding drug courts state-wide, including a focus on strengthening existing courts before adding new courts;
5. A statewide drug court management information system implemented with adequate technical assistance to local staff;
6. A standardized assessment process for both chemical dependency and mental health that includes determining eligibility for publicly funded health care programs, conducted as early as possible;
7. The state court administration providing on-going training, technical assistance and support to local drug court staff. In addition, modeling collaboration between all areas of the criminal justice system and health departments and providing support for these collaborations locally; and
8. Annual statewide conferences providing an opportunity for drug court practitioners to learn new practices in the field and create an opportunity for networking with other local professionals.

Recommendation #12: Continue with plans to create standards of practice for all drug courts, and link funding to these standards.

Recommendation #13: Continue to expand the role of the Drug Court Initiative (DCI) Advisory Committee; this group should play a key role in strategic planning to guide the expansion of drug courts across the state.

Recommendation #14: Strengthen existing drug courts to ensure they are implementing quality programs before, or in combination with, adding new drug courts.

INCORPORATING DRUG COURTS INTO STATEWIDE DIVERSION PLANS

In light of the growing movement nationwide for broad-based, statewide approaches to diverting drug-involved offenders into an appropriate array of evidence-based treatment programs—including drug courts—in lieu of traditional criminal justice approaches, Minnesota might also want to expand its current drug policy discussions and build on its own past efforts (e.g., community corrections act programs from the 1970s; Battiato, 2007). Minnesota policymakers, program managers, and advocates might benefit from thinking more broadly about how alternative treatment structures might be designed and used in their state to

maximum advantage, and how criminal justice, chemical dependency treatment, and mental health treatment systems might work better together to meet the needs of the addicted criminal population. Minnesota has already begun this work; the legislature recently authorized the Sentencing Guidelines Commission to propose modifications to the sentencing guidelines for drug offenders.

Recommendation #15: NPC Research agrees with the recommendation set forth by the Minnesota Chemical Dependency Task Force (SCAO, 2006) that the state should create a comprehensive plan to address the needs of individuals who are chemically dependent, of which drug courts are one important component.

Based on the ICDP review of initiatives in Illinois and seven other states to provide large-scale, statewide alternatives to incarceration, states should create a statewide Alternative to Incarceration Plan to treat nonviolent drug offenders that starts with bringing drug courts to scale statewide in a planned, phased, prudent fashion. Whenever possible, ensure that treatment alternatives in lieu of prison are incorporated into state laws, and increase the capacity and infrastructure for a statewide diversion-from-incarceration program (Kane-Willis et al., 2007).

SECTION VI: CONCLUSIONS AND RECOMMENDATIONS

Previous sections of this report have discussed the service provision and funding structures of Minnesota's drug courts, drug court clients' treatment utilization as compared to statewide treatment utilization, and drug court and other treatment alternatives to incarceration practices used by other states. In this final section of the report we summarize the findings and recommendations for each of the study's policy questions.

The recommendations in this report are based on the results of the surveys, interviews, administrative data analysis, Minnesota drug court client treatment data, and review of other states' programs and structures conducted for this study. To provide context for, and comparison with, national findings on this topic, the recommendations reference relevant results and policy considerations from a report on the 1999 National Drug Court Treatment Survey (Peyton & Gossweiler, 2001). The purpose of the survey was to describe chemical dependency treatment services and other treatment services in use at that time by adult drug courts across the country. The survey, commissioned by the National Treatment Accountability for Safer Communities (TASC) in cooperation with the U.S. Department of Justice, Office of Justice Programs and U.S. Department of Health and Human Services, Center for Substance Abuse Treatment, received responses from 212 (81%) of 263 operating adult drug courts contacted nationwide (Peyton & Gossweiler, 2001).

What Are the Funding Sources for Chemical Dependency and Mental Health Services for Drug Courts and What Funding Sources Are Used to Support Which Services?

The primary funding source for chemical dependency treatment is the CCDTF, comprising 67% of the expended funds and covering 52% of the drug court clients. A small number of drug court clients have treatment services funded through private insurance or PMAP. Eight courts have some other source of funding for chemical dependency services, including federal BJA grants, SCAO funds, tribal funds, Veteran's Administration funds, and local Community Corrections funds. These other sources of funds combined comprise 18% of the total funds expended on chemical dependency services for drug court clients. In some sites, these grant funds are used to cover the cost of assessments, in some sites the funds are used to provide additional services such as cognitive therapy groups, in some sites the funds are used to supplement payments that do not fully cover the costs from other sources, and in some sites the funds are used to secure contracts with a primary treatment provider to guaran-

tee treatment slots with a provider who is committed to, and a team-member of, the drug court.

Mental health services are not an integral component of most courts' program models, and as a result, data on mental health services is limited. From the data available, most clients who receive mental health services utilize either public (e.g., Medical Assistance) or private insurance sources to cover the cost of treatment. Several courts do utilize other sources of funding for mental health services, however. The Ramsey Adult Substance Abuse Court and Ramsey County DWI Court share a grant from the SCAO that funds the Psychiatric Court Clinic; the Clinic psychiatric nurse is an integral part of the drug court team, the Clinic is located on-site, and clients can receive mental health assessments, medicine checks, case management, and individual therapy. Blue Earth County Drug Court and Watonwan County Adult Drug Court have contracted with New Ulm Medical Center for the provision of both chemical dependency and mental health treatment; funds for Blue Earth County Drug Court's contract come from the court's federal BJA grant, and funds for the Watonwan County Adult Drug Court contract come from the court's SCAO grant. Cass County Wellness Court and South St. Louis Drug Court use SCAO funds for mental health assessments of drug court clients.

Where Are There Gaps, Inequities or Vulnerabilities in Services or Funding?

SERVICE INEQUITIES

There are two primary inequities in chemical dependency services and funding: the added services available to those clients at courts with treatment provider contracts and the differences in per-client spending across the courts.

First, some sites have contracts with dedicated treatment providers. These sites rely upon primary payment sources (e.g., the CCDTF or private insurance) for the bulk of clients' treatment services, but use contracting arrangements to supplement these services. In some sites, these funds are used to cover the cost of assessments or to provide additional services, such as cognitive therapy groups. Some sites use contracts to guarantee treatment slots with a provider who is committed to, and a team-member of, the drug court. These providers are integral members of drug court teams, and the contracting arrangement gives the provider the resources necessary to dedicate time for drug court duties such as attending staffings and hearings. Sites with these arrangements may have improved or enhanced treatment services available for their clients compared to sites without these arrangements. Clients at these sites may be receiving more services than clients at other sites, or they may be receiving more integrated, higher quality services than clients at other sites, or they may have guaranteed access to treatment services not available to clients at other sites.

Recommendation #1: Create contracting relationships with providers that can:

- **Prioritize treatment access for drug court clients;**
- **Ensure that treatment providers are supportive of the drug court model;**
- **Monitor treatment quality;**
- **Support additional treatment activities; and**
- **Allow the treatment providers to be part of the drug court team.**

Second, while most sites' average per-client spending for chemical dependency treatment services mirrors the per-client average across the 13 courts of approximately $4,200, some sites spend far more resources per client: Crow Wing County Adult Drug Court's per-client average is approximately $7,000, Ramsey Adult Substance Abuse Court's per-client average is just under $9,000 and Blue Earth County Drug Court's per-client average is close to $10,000. The discrepancies are due to differential treatment utilization; that is, these sites rely more heavily on inpatient treatment or have clients with longer lengths of stay than other sites. While those sites with high per-client treatment costs work with clients who have serious chemical dependency addictions (including methamphetamine and cocaine addictions), other sites do as well. It is likely, therefore, that clients at sites with lower utilization levels would benefit from the more intensive services received at these sites.

Recommendation #2: NPC Research agrees with the recommendation put forth by the Minnesota Office of the Legislative Auditor that Minnesota should have a standardized chemical dependency assessment tool and process across counties.

This recommendation is consistent with one of the policy considerations identified in the 1999 National Drug Court Treatment Survey—that drug courts should improve the methods and protocols for screening, assessing, and placing participants in treatment. National survey results indicated that, as is true currently in Minnesota, drug courts around the country "routinely conduct screening and clinical assessments to identify the treatment and other service needs of participants and to determine eligibility [for drug court programs]." However, not all drug courts used uniform, objective, professionally validated and accepted criteria and tools to make placement decisions (Peyton & Gossweiler, 2001).

"Screening and assessment in drug courts should be structured to more closely adhere to methods and instruments that have been supported by research…Developing standard definitions and using standardized assessments and rational protocols for addressing chemical dependency in drug courts will enable policymakers and evaluators to better assess the effectiveness of drug courts and suggest and provide support for program improvement" (Peyton & Gossweiler, 2001).

The differing per-client costs are due in part to differing lengths of stay across the sites. Research has demonstrated that length of stay is a key factor in treatment success, with treatment stays of greater than 90 days offering the highest probability of sobriety (NIDA, 2000). Drug courts should work to increase clients' lengths of stay in treatment, as longer lengths of stay are more likely to lead to treatment completion and longer-term positive outcomes.

Recommendation #3: Increase clients' lengths of stays in treatment, as longer lengths of stay are more likely to lead to treatment completion and longer-term positive outcomes.

Service Gap

The primary service gap identified by this study is the lack of attention to mental health assessments and treatment for drug court clients.

The high rate of comorbid chemical dependency and mental health disorders has been detailed (Brady & Sinha 2005; Kessler et al., 1996; Regier et al., 1990). Individuals evi-

dencing a chemical dependency disorder are significantly more likely than the general population to have a comorbid mental health issue (Regier et al., 1990). These findings are echoed in the National Institute of Mental Health Epidemiological Catchment Area study (Regier et al., 1990), the National Comorbidity Study (Kessler et al., 1996), and the Australian National Survey of Mental Health and Well-being (Hall et al., 1999) and have significant implications for treatment of co-occurring mental health and chemical dependency disorders. Drug court evaluation research illustrates a high incidence of co-occurring mental health problems among drug court clients and suggests courts prioritize inclusion of mental health treatment services (Belenko, 2001).

Despite the growing recognition, both among Minnesota's courts as well as nationally, of the importance of addressing mental health issues and of the prevalence of dual-diagnosis individuals within the criminal justice system, mental health services are not a central component of most courts' models, and as a result, few drug court clients receive mental health services.[12] However, some promising practices have emerged at the sites, including the Psychiatric Court Clinic shared by the two Ramsey Courts, Blue Earth County Drug Court and Watonwan County Adult Drug Court's use of a single contracted provider for mental health (and chemical dependency) services, and Koochiching DUI/Substance Abuse Court's arrangement with the lone psychiatrist in the community. In addition, some drug courts indicating that mental health issues are increasingly emerging after participants enroll in the program. As a result, they are either instituting or considering incorporating basic mental health screening as a routine part of the drug court assessment process.

The Psychiatric Court Clinic model utilized by the Ramsey Adult Substance Abuse Court and Ramsey County DWI Court is a promising approach to integrating mental health services into the drug court model. The Clinic's psychiatric nurse is considered a member of the drug court teams, the Clinic is co-located with the court, and, at a per-client cost of approximately $2,000, this is a relatively inexpensive mental health intervention.

Second, Blue Earth County Drug Court and Watonwan County Adult Drug Court both have contracts with New Ulm Medical Center, which provides both chemical dependency and mental health services. This contracting arrangement guarantees access to treatment for clients, and because New Ulm Medical Center provides mental health services in addition to chemical dependency services, it guarantees that mental health services are part of the mix of services available to clients.

Finally, Koochiching DUI/Substance Abuse Court has built a relationship with the psychiatrist in the county who has agreed to move drug court clients to the top of the waiting list for services. This has resulted in drug court clients having faster access to mental health services than would otherwise be available in such a rural community.

However, most other sites do not have any formalized structure for providing mental health services for their drug court clients, and across all sites, a majority of drug court clients receive no mental health services.

[12] Of course, without standardized mental health assessments of all of Minnesota's drug court clients, it is not possible to know the extent of the need for mental health services for drug court clients. However, it is likely many drug court clients could benefit from mental health services.

Recommendation #4: Assess clients for mental health issues as part of the drug court assessment process.

Recommendation #5: Create and fund a statewide model that incorporates mental health services into drug court services. Minnesota can take a lead nationally in integrating mental health services into the drug court model.

Recommendation #6: Give priority for state drug court funding to courts that integrate mental health services into their drug court models.

Minnesota's drug courts could use assistance from the state in creating programmatic models that incorporate mental health services into drug court services and in securing funding for such models. The state should consider the needs of drug court clients when creating the Integrated Dual Disorder Treatment (IDDT) policy as part of the COSIG program funded by SAMHSA. The COSIG program provides funding for states to develop or enhance infrastructure to increase capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment services to persons with co-occurring chemical dependency and mental disorders. The grant funds will be used to build a network of dual disorder treatment services, including 14 outpatient mental health centers, 14 outpatient chemical dependency programs, 4 behavioral health tribal clinics, and two chemical dependency programs run by the Department of Corrections. While drug courts are not the target of the grant, with partnerships in place, these services can be available for drug court clients.

In addition, 10 Minnesota counties currently are participating in a regional mental health initiative (the South Central Community Based Initiative, or SCCBI) that is geared toward improving availability and access to a comprehensive array of community-based services for individuals with severe mental illness by consolidating funding streams and service delivery. While the SCCBI is focused on severely mentally ill individuals (a population different from the population served by most drug courts), there could be models and lessons learned from the SCCBI that could inform the creation of integrated mental health services for drug courts. Minnesota is no farther behind most other states in terms of integrating mental health services into the drug court model; with some focused attention in this area, Minnesota could emerge at the forefront.

What Are the Differences in Service Availability and Funding Streams Between Urban and Rural Counties?

No clear urban-rural patterns emerge from the current study. Some newer, more rural sites do have fewer funding sources and lower per-client averages, but other rural sites are comparable, or ahead, of the state average in terms of per-client spending or number of funding sources. Furthermore, clients at one of the urban sites (Hennepin County Drug Court Program) actually have significantly lower treatment utilization rates than the other counties. Despite the lack of clear patterns of difference between urban and rural sites, it is worth noting that there are real differences in the number and type of treatment providers across the state. There are obvious disadvantages for counties with few, or no, providers (for example, individuals may have to travel long distances to receive the most appropriate care). However, counties can alleviate these disadvantages by

creating contracting arrangements that are beneficial to the contracted provider and to drug court.

Recommendation #7: Devote resources to develop contractual relationships that provide incentives for providers to serve clients in rural areas.

Priorities for state funding should include assisting rural communities with increasing the availability of treatment options.

How and to What Degree is the CCDTF or Private Insurance Used to Support Drug Court Services?

Most funding for chemical dependency treatment services is provided by the CCDTF (67% of the funds that support 52% of the clients across the 13 sites). Eight courts have clients on PMAP, but PMAP accounts for just 8% of the total funds expended and is used by 7% of the clients. Similarly, 8 courts have clients who use private insurance to cover the cost of their treatment, but private insurance accounts for just 7% of the total funds expended and is used by just 6% of the clients. While the vast majority of clients across the sites utilize the CCDTF, interestingly, in Dodge County, more clients utilize PMAP and private health insurance (3 clients each) than CCDTF (4 clients).

Representatives from the study courts state that they have not had to turn clients away from drug court because they have not qualified for the CCDTF; courts report that either all clients have qualified, or that for those who have not qualified (and who have no alternate sources of insurance), the courts have worked to identify other funds (such as grants) that could be used to cover treatment services. Furthermore, while some courts have not experienced problems with counties running out of CCDTF funds (for the required county match), other courts report that this can sometimes be an issue. As a result, clients sometimes have shorter lengths of stay than is optimal, or take part in alternate activities (such as self-help programs) while they await treatment. In-depth process evaluations of the courts should explore this issue in more depth.

Are Drug Courts a More Efficient Way of Utilizing Public Resources for Chemical Dependency and Mental Health Services?

The data from the study sites as compared to the statewide Minnesota offender population demonstrate that using the CCDTF to support drug court clients throughout their treatment program is an efficient use of publicly funded dollars. The analyses of episodic treatment data along with drug court clients' continuum of care described above illustrate that drug court clients have a greater number of treatment episodes than the statewide treatment population and stay in those treatment episodes longer, and that the majority of episodes completed by drug court clients are successful. This continuum of care therefore may represent a more complete treatment process. Given the increase in their time spent in treatment, the likelihood that these individuals will have better outcomes and future cost savings for the state dramatically increases. Indeed, research indicates that longer lengths of stay are linked to successful treatment completion (National Institute on Drug Abuse, 2000) and successful treatment completion to positive life outcomes such as reducing recidivism, (United States Government Accountability Office, 2005) drug use,

and criminal behavior (Belenko, 1998 and 2001).

Recommendation #8: Increase the number of offenders served by drug courts as a means to use the CCDTF more efficiently and effectively.

Drug courts are successful at providing for more treatment episodes and longer lengths of stay, which ultimately can lead to more positive treatment outcomes for offenders, and therefore, drug courts are a more efficient use of CCDTF funds than traditional treatment services for offenders.

This study, however, did not investigate the short or longer-term outcomes of drug court participation in Minnesota. In order to highlight the accomplishments of Minnesota's drug courts, and in order to make the case for increased funding for the courts, it is necessary to establish that the courts are effective and cost-beneficial.

Recommendation #9: Conduct a cost-benefit analysis of Minnesota's drug courts.

Are There Service Structures or Funding Mechanisms Used by Other States to Support Their Drug Courts That Would Be Useful Models for Minnesota?

The primary sources of chemical dependency treatment funding for drug court participants are the same across all the selected states as they are in Minnesota: i.e., the public treatment system, Medicaid, private health insurance, self pay, and a variety of other specialty programs such as the Veteran's Administration or Indian Health Service. None of the states provide targeted chemical dependency funding for drug court participants.

Like Minnesota, drug courts in other states cobble together funding from a myriad of sources. Some states do appropriate dollars for drug court operations. These monies are distributed through the judicial branch to drug courts, or are made available to drug courts (and possibly to other alternative justice programs) as grants on a competitive basis. In most cases, drug courts may use some or all of those dollars for treatment services.

Representatives from the 11 comparison states identify several promising practices for drug court service delivery.

First, in some cases, drug courts or judicial branches contract directly with treatment providers in relationships formalized by memorandums of understanding or actual fee for services contracts. These include contracts with providers or formal relationships with an administrative agent that contracts with local providers. Contracts may include agreement to provide treatment to all drug court clients, including those in rural areas, and standards for reporting treatment progress to court staff.

The 1999 National Drug Court Treatment Survey Report also recommends that drug courts across the country consider establishing and formalizing more effective linkages with local service delivery systems and state and local alcohol and other drug agencies. Most drug courts surveyed nationally indicated that they have established *dedicated* treatment services—generally outpatient—meaning that the services are tied directly (either formally or informally through a contract or memorandum of agreement) to the drug court program. However, as we learned in some Minnesota drug courts, the national survey found that the relationship of drug courts to local treatment providers is not always well structured (Peyton & Gossweiler, 2001).

The Treatment Accountability for Safer Communities (TASC) report suggests that increased collaboration with agencies that have primary responsibility for funding and managing treatment services could help drug courts clarify their needs and goals, as well as augment existing services. Such collaboration could also help demonstrate to local public programs and providers why drug court participants should receive a high priority for receiving services. Top administrators at state and county chemical dependency agencies may be able to help drug courts design service systems and provide support to drug courts in monitoring and managing treatment services. Treatment administrators may also be able to help identify or partner with drug courts to obtain additional funding sources for treatment, help drug court participants access medical and behavioral health benefits, and provide needed education and training for drug court professionals (Peyton & Gossweiler, 2001).

Second, representatives from the comparison states note the need for a standardized drug court management information system to streamline statewide reporting, document local outcomes, track expenditures (especially those not directly part of the drug court program such as treatment costs), support program oversight and provide evidence for seeking additional funding.

Recommendation #10: Develop a drug court MIS for use by all the state's drug courts. Researchers as well as practitioners should continue to be included in the planning and design process to ensure that the MIS will be of practical use for case management and other practitioner needs as well as for research and evaluation purposes.

This recommendation is consistent with one of the policy considerations identified in the 1999 National Drug Court Treatment Survey—that drug courts should implement effective management information systems to monitor program activity and improve operations. The National survey indicated "that most drug courts do not have management information systems that are capable of tracking participants through all drug court processes or that are adequate to support outcome evaluations…Drug courts need to have good management information systems in place to demonstrate program effectiveness, make ongoing operational improvements, and secure scarce resources." Examples from local court systems such as Oregon, Wisconsin, and New York demonstrate that it is possible to develop integrated data systems that can be used to support decision-making in drug courts, and to support the needs of policymakers and treatment systems (Peyton & Gossweiler, 2001).

Third, state representatives suggest several methods of advocating for drug court funding at the state and local level. Representatives from other states stress the need for local cost benefit analysis results in requesting continued or new funding for drug court programs at the state level. In addition, demonstrating public support through polling or voting records on drug policy options has been part of comprehensive public education strategies. States have also found it helpful to provide forums for state legislators to educate them on drug court programs as effective legislative strategies. At the local level, communities take responsibility for maintaining drug courts through activities such as presentations to local business associations and foundations, utilizing the media to publicize success stories, inviting local legislators to observe drug court, and offering educational symposia.

Recommendation #11: Continue to build relationships and increase education of the public and key partners about the advantages and benefits of drug court programs versus traditional criminal justice processing.

Representatives from the comparison states also stress the importance of state level drug court coordination. Successful states have implemented a state-level advisory board that is responsible for strategic planning, setting standards of practice, and allocating state drug court funds. These states also have a state-level office dedicated to providing technical assistance and support to drug courts.

Minnesota should continue with plans to create standards of practice for its drug courts, and drug courts should be held accountable to meeting these standards in order to receive state funding. In addition to work already completed on this effort, involved parties might want to review and incorporate relevant aspects of Indiana's drug court certification program.

Recommendation #12: Continue with plans to create standards of practice for all drug courts, and link funding to these standards.

This recommendation is consistent with one of the policy considerations identified in the 1999 National Drug Court Treatment Survey—that states and localities should explore the development of drug court treatment standards. Although most drug court participants are referred to and use appropriately licensed chemical dependency treatment counselors and providers, those licensing standards may be inappropriate or insufficient to ensure the provision of the best evidence-based services and practices for the drug court population. Drug court professionals, providers, and chemical dependency program administrators should work together to develop criteria and standards that delineate the components of effective treatment for drug court participants. Those treatment standards should also recognize that other standard drug court program features—i.e., frequent drug testing, reporting to case managers and/or probation officers, attending court status hearings, and participating in other services designed to improve skills and promote social competency and productivity—are essential therapeutic components to achieve positive outcomes for drug court participants (Peyton & Gossweiler, 2001).

The DCI will play an important role in creating and enforcing statewide standards of practice, and in years to come, should play a key role in strategic planning to guide the expansion of drug courts across the state.

Recommendation #13: Continue to expand the role of the Drug Court Initiative (DCI) Advisory Committee; this group should play a key role in strategic planning to guide the expansion of drug courts across the state.

Many of Minnesota's drug courts were founded within the past 2 years, and as such, could use assistance in building partnerships in their communities, creating and solidifying their program models and policies, and increasing their capacity and case flow. The success of the drug court model relies upon coordinated, comprehensive services for participants. Therefore, the state should focus efforts and resources on first strengthening these existing courts to be sure that these courts are operating quality, full-scale drug

court programs prior to establishing additional courts. Increasing the number of drug courts, without providing the courts with adequate support and technical assistance, will result in courts with limited effectiveness.

Recommendation #14: Strengthen existing drug courts to ensure they are implementing quality programs before, or in combination with, adding new drug courts.

Finally, drug court initiatives should be viewed within a larger context of statewide planning for alternatives to incarceration for drug offenders. Drug courts are one important part of a statewide system of alternatives to traditional criminal justice case processing.

Recommendation #15: NPC Research agrees with the recommendation set forth by the Minnesota Chemical Dependency Task Force (SCAO, 2006) that the state should create a comprehensive plan to address the needs of individuals who are chemically dependent, of which drug courts are one important component.

NPC Research agrees with the recommendation set forth by the Minnesota Chemical Dependency Task Force (2006) that the state should create a comprehensive plan to address chemically dependent offenders. Drug courts should be part of a larger Alternative to Incarceration Plan to treat non-violent drug offenders that starts with bringing drug courts to scale statewide in a planned fashion. Treatment alternatives in lieu of prison should be incorporated into state laws, and the state should increase the capacity and infrastructure for a statewide diversion-from-incarceration program. Indeed, Minnesota has begun this work already; in the recent legislative session the legislature has authorized the Sentencing Guidelines Commission to propose modifications to the sentencing guidelines for drug offenders.

Conclusion

Minnesota's drug court initiative is relatively young in comparison to other states. Despite this fact, the state is making a concerted effort to foster and expand its drug court programs through the establishment of the DCI and the availability of state funds for drug courts, among other things. The state can strengthen its drug courts and move to the forefront of the national drug court movement by building a state-level drug court infrastructure and by supporting and enhancing the chemical dependency and mental health services provided by the individual drug courts.

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APPENDIX A: HENNEPIN COUNTY DATA COLLECTION METHODS

Hennepin Methodology

Our Hennepin cost calculation methodology differed from the other sites in several ways. First, because the Hennepin court serves far more clients than the other courts in the study, we collected data on a sample of clients rather than all clients. To select a sample of Hennepin clients, we selected all clients who entered the drug court during two two-week periods in early 2006 (n=149). We then collected data from court and probation records for these clients. Second, for this site, we were able to gather treatment claims data and therefore did not need to estimate treatment costs for this site. The court submitted the names of the clients in the selected sample to Hennepin County Human Services & Public Health Department who then matched these clients to public treatment claims data. NPC Research was then given the de-identified dataset. This dataset included all treatment claims made to CCDTF/other public health care programs during 2006 for the sampled clients. The advantage of receiving this data is that we did not need to do the cost estimation procedures used at the other sites—we had the actual dollars claimed. However, the disadvantage was that this dataset included only CCDTF/other public health care programs expenditures; the Hennepin probation and court records were not complete enough to be able to gather information on self-pay and private pay clients. We therefore can only report on CCDTF/other public health care programs expenditures for Hennepin County drug court clients.

We extrapolated from the Hennepin sample to create an estimate of the total CCDTF funds expended on treatment services for the entire population of individuals served by Hennepin's drug court in 2006 (an estimate of 2,176 clients received CCDTF-funded treatment services out of 5,965 clients processed through the court that year).

APPENDIX B: SITE SPECIFIC COST CALCULATION METHODS

Aitkin

1. Aitkin provided individual-level payment information.
2. Aitkin's written policies do not specify a required number of sessions per week, so we used the 1.4 session per week estimate described above.
3. Aitkin's data did not separate out continuing care, so the outpatient cost estimates may be inflated if those episodes included a period of continuing care.

Blue Earth

1. Blue Earth provided individual-level payment information.
2. Blue Earth's written policy includes required numbers of sessions per week for each phase; we took an average across the phases and adjusted down by 50% for an estimate of 1.5 sessions per week.
3. Blue Earth's data did not separate out continuing care, so the outpatient cost estimates may be inflated if those episodes included a period of continuing care.

Cass

1. Cass provided individual-level payment information.
2. Cass's written policy includes required numbers of sessions per week for each phase; we took an average across the phases and adjusted down by 50% for an estimate of 1.3 sessions per week.
3. Cass's data did separate outpatient episodes from continuing care; we therefore used the 1.3 session per week estimate for outpatient and the 0.5 session per week estimate described above for continuing care.

Crow Wing

1. Crow Wing provided individual-level payment information.
2. Crow Wing's written policies do not specify a required number of sessions per week, so we used the 1.4 session per week estimate described above.
3. Crow Wing's data did separate outpatient episodes from continuing care; we therefore used the 1.4 session per week estimate for outpatient and the 0.5 session per week estimate described above for continuing care.

Dodge

1. Dodge provided individual-level payment information.
2. Dodge's written policy includes required numbers of session per week for each phase; we took an average across the phases and adjusted down by 50% for an estimate of 2.4 sessions per week.
3. Dodge's data did separate outpatient episodes from continuing care; we therefore used the 2.4 session per week estimate for outpatient episodes and the 0.5 session per week estimate described above for continuing care.
4. There was an additional unique feature to the Dodge cost calculations: Dodge was able to provide us with data on only a sample of their clients (15 out of the 56 clients the court has served over 4 years), and therefore we calculated costs based on these

clients, increased those estimates proportionally to arrive at court-wide cost estimates, and then divided by 4 to get an annualized (12-month) estimate of costs.

Koochiching

1. Koochiching provided individual-level payment information.
2. Koochiching's written policies do not specify a required number of sessions per week, so we used the 1.4 session per week estimate described above.
3. Koochiching's data did not separate out continuing care, so the outpatient cost estimates may be inflated if those episodes included a period of continuing care.

Ramsey Adult

1. Ramsey Adult provided individual-level payment information.
2. Ramsey Adult's written policies do not specify a required number of sessions per week, so we used the 1.4 session per week estimate described above.
3. Ramsey Adult's data did not separate out continuing care, so the outpatient cost estimates may be inflated if those episodes included a period of continuing care.

Ramsey DWI

1. Ramsey DWI provided individual-level payment information.
2. Ramsey DWI's written policies do not specify a required number of sessions per week, so we used the 1.4 session per week estimate described above.
3. Ramsey DWI's data did not separate out continuing care, so the outpatient cost estimates may be inflated if those episodes included a period of continuing care.

Stearns

1. Stearns did not provide individual-level payment information, but could provide estimates of the percentage of clients covered by each payment source: 83% CCDTF, 14% PMAP, 1% self, and 2% private insurance. We therefore computed the total treatment cost for Stearns and divided it proportionally among these payment sources.
2. Stearns' written policies do not specify a required number of sessions per week, so we used the 1.4 session per week estimate described above.
3. Stearns' data did separate outpatient episodes from continuing care; we therefore used the 1.4 session per week estimate for outpatient and the 0.5 session per week estimate described above for continuing care.

St. Louis [h5]

1. St. Louis did not provide individual-level payment information, but could provide estimates of the percentage of clients covered by each payment source: 71% CCDTF, 16% PMAP, 3% self, 6% private insurance, 2% grants, and 2% donated by the provider). We therefore computed the total treatment cost for Stearns and divided it proportionally among these payment sources.
2. St. Louis' written policies do not specify a required number of sessions per week, so we used the 1.4 session per week estimate described above.

3. St. Louis' data did not separate out continuing care, so the outpatient cost estimates may be inflated if those episodes included a period of continuing care.
4. St. Louis had one additional site-specific variation: the individual-level data did not identify individual episode lengths and providers, and instead provided simply a total number of inpatient and outpatient days for each client. We therefore calculated the average inpatient and outpatient rate for those providers most commonly used by this site and used those average rates for all clients.

Wabasha

1. Wabasha provided individual-level payment information.
2. Wabasha's written policies do not specify a required number of sessions per week, so we used the 1.4 session per week estimate described above.
3. Wabasha's data did separate outpatient episodes from continuing care; we therefore used the 1.4 session per week estimate for outpatient and the 0.5 session per week estimate described above for continuing care.

Watonwan

1. Watonwan provided individual-level payment information.
2. Watonwan's written policy includes required numbers of sessions per week for each phase; we took an average across the phases and adjusted down by 50% for an estimate of 2 sessions per week.
3. Watonwan's data did not separate out continuing care, so the outpatient cost estimates may be inflated if those episodes included a period of continuing care.

APPENDIX C: SUMMARY OF REGIONAL DATA ON STATEWIDE AND DRUG COURT OFFENDER TREATMENT EPISODES

Table C1: Treatment Episodes by Region

Northeast	***Statewide offender episodes***	***Drug court episodes***
Number of Episodes	N=1711	N=83
% Male	N=1711	N=83
	71%	55%
Race categories	N=1711	N=83
White	76%	88%
African American	3%	7%
Native American	17%	5%
Hispanic	2%	0%
Asian/Pacific Islander	<1%	0%
Other/Unknown	2%	0%
Length of stay	N=1648	N=81
0-30	40%	19%
31-60 days	34%	40%
61-90 days	14%	16%
More than 90 days	13%	26%
Average : range: 0-3 (s.d.)	1.00(1.02)	1.49(1.07)
Type of treatment	N=1711	N=83
Inpatient	27%	37%
Outpatient	52%	63%
Extended care	10%	0%
Halfway house	11%	0%
Treatment completion	N=1711	N=75
Percent completing treatment	67%	92%

East Central	***Statewide Offender Episodes***	***Drug Court Episodes***
Number of Episodes	N=2382	N=60
% Male	N=2382	N=60
	71%	35%
Race Categories	N=2382	N=60
White	90%	78%
African American	2%	18%
Native American	4%	0%
Hispanic	1%	0%
Asian/Pacific Islander	1%	3%
Other/Unknown	1%	0%
Length of Stay	N=2326	N=58
0-30	42%	43%
31-60 days	29%	36%
61-90 days	14%	10%
More than 90 days	15%	10%
Average: range: 0-3 (s.d.)	1.01(1.07)	.88(.98)
Type of Treatment	N=2382	N=60
Inpatient	18%	57%
Outpatient	65%	43%
Extended Care	6%	0%
Halfway House	11%	0%
Treatment Completion	N=2382	N=54
Percent Completing Treatment	68%	74%

Metro	***Statewide Offender Episodes***	***Drug Court Episodes***
Number of Episodes	N=11080	N=262
% Male	N=11080	N=258
	74%	66%
Race Categories	N=11080	N=255
White	67%	46%
African American	20%	49%
Native American	4%	3%
Hispanic	5%	2%
Asian/Pacific Islander	1%	0%
Other/Unknown	2%	0%
Length of Stay	N=10785	N=232
0-30	43%	37%
31-60 days	29%	25%
61-90 days	15%	11%
More than 90 days	14%	28%
Average: range: 0-3 (s.d.)	.99(1.06)	1.30(1.23)
Type of Treatment	N=11080	N=262
Inpatient	18%	27%
Outpatient	68%	63%
Extended Care	5%	0%
Halfway House	9%	10%
Treatment Completion	N=11080	N=216
Percent Completing Treatment	62%	55%

Southeast	***Statewide Offender Episodes***	***Drug Court Episodes***
Number of Episodes	N=1803	N=16
% Male	N=1803	N=16
	73%	75%
Race Categories	N=1803	N=16
White	85%	100%
African American	5%	0%
Native American	3%	0%
Hispanic	5%	0%
Asian/Pacific Islander	1%	0%
Other/Unknown	1%	0%
Length of Stay	N=1751	N=16
0-30	40%	25%
31-60 days	28%	13%
61-90 days	18%	19%
More than 90 days	14%	44%
Average: range: 0-3 (s.d.)	1.07(1.07)	1.81(1.28)
Type of Treatment	N=1803	N=16
Inpatient	24%	0%
Outpatient	60%	100%
Extended Care	3%	0%
Halfway House	14%	0%
Treatment Completion	N=1803	N=10
Percent Completing Treatment	68%	60%

Southwest	***Statewide Offender Episodes***	***Drug Court Episodes***
Number of Episodes	N=2216	N=59
% Male	N=2216	N=59
	75%	97%
Race Categories	N=2216	N=59
White	87%	86%
African American	2%	10%
Native American	3%	0%
Hispanic	7%	3%
Asian/Pacific Islander	<1%	0%
Other/Unknown	1%	0%
Length of Stay	N=2182	N=50
0-30	35%	26%
31-60 days	30%	16%
61-90 days	19%	6%
More than 90 days	16%	52%
Average: range: 0-3 (s.d.)	1.17(1.08)	1.84(1.32)
Type of Treatment	N=2216	N=59
Inpatient	25%	24%
Outpatient	54%	61%
Extended Care	5%	0%
Halfway House	16%	15%
Treatment Completion	N=2216	N=28
Percent Completing Treatment	68%	75%

West Central	***Statewide Offender Episodes***	***Drug Court Episodes***
Number of Episodes	N=1475	N=46
% Male	N=1475	N=46
	71%	61%
Race Categories	N=1475	N=46
White	74%	91%
African American	2%	0%
Native American	19%	9%
Hispanic	3%	0%
Asian/Pacific Islander	<1%	0%
Other/Unknown	1%	0%
Length of Stay	N=1419	N=46
0-30	36%	30%
31-60 days	24%	35%
61-90 days	17%	20%
More than 90 days	24%	15%
Average : range: 0-3 (s.d.)	1.28(1.18)	1.20(1.05)
Type of Treatment	N=1475	N=46
Inpatient	29%	46%
Outpatient	43%	39%
Extended Care	11%	0%
Halfway House	17%	15%
Treatment Completion	N=1475	N=46
Percent Completing Treatment	60%	67%

Table C2: Treatment Episodes by Payment Source by Region

Northeast[13]	***Statewide Offender Episodes CCDTF***	***Drug Court Episodes CCDTF***
Number of Episodes	N=845	N=38
% Male	N=845	N=38
	70%	71%
Race Categories	N=845	N=38
White	68%	90%
African American	4%	5%
Native American	25%	5%
Hispanic	2%	0%
Asian/Pacific Islander	<1%	0%
Other/Unknown	2%	0%
Length of Stay	N=821	N=36
0-30	37%	17%
31-60 days	37%	50%
61-90 days	16%	14%
More than 90 days	10%	19%
Average: range: 0-3 (s.d.)	.98(.96)	1.36(.99)
Type of Treatment	N=845	N=38
Inpatient	30%	42%
Outpatient	34%	58%
Extended Care	18%	0%
Halfway House	18%	0%
Treatment Completion	N=845	N=38
Percent Completing Treatment	64%	95%

[13] Northeast regional breakdowns by payment source include only Aitkin County Sobriety Court and Koochiching County DUI/Substance Abuse Court. They do not include South St. Louis County Drug Court because the coordinator was unable to provide us with client payment source for substance abuse treatment.

East Central[14]	*Statewide Offender Episodes CCDTF*	*Drug Court Episodes CCDTF*
Number of Episodes	N=1228	NA
% Male	N=1228	NA
	71%	
Race Categories	N=1228	NA
White	88%	
African American	2%	
Native American	7%	
Hispanic	1%	
Asian/Pacific Islander	1%	
Other/Unknown	1%	
Length of Stay	N=1203	NA
0-30	42%	
31-60 days	31%	
61-90 days	16%	
More than 90 days	11%	
Average: range: 0-3 (s.d.)	.96(1.01)	
Type of Treatment	N=1228	NA
Inpatient	17%	
Outpatient	52%	
Extended Care	10%	
Halfway House	21%	
Treatment Completion	N=1228	NA
Percent Completing Treatment	64%	

[14] There is no data in the drug court sample in the East Central regions for the regional breakdowns by payment source. This is because Stearns County, which makes up the entirety of the East Central region for our drug court sample was unable to provide information on client payment source for treatment.

Metro	***Statewide Offender Episodes CCDTF***	***Drug Court Episodes CCDTF***
Number of Episodes	N=5610	N=200
% Male	N=5610	N=196
	76%	69%
Race Categories	N=5610	N=196
White	58%	40%
African American	27%	55%
Native American	5%	3%
Hispanic	6%	2%
Asian/Pacific Islander	1%	0%
Other/Unknown	3	0%
Length of Stay	N=5457	N=184
0-30	41%	42%
31-60 days	29%	25%
61-90 days	18%	9%
More than 90 days	12%	25%
Average: range: 0-3 (s.d.)	1.02(1.04)	1.16(1.21)
Type of Treatment	N=5610	N=200
Inpatient	15%	31%
Outpatient	61%	58%
Extended Care	9%	0%
Halfway House	16%	12%
Treatment Completion	N=5610	N=165
Percent Completing Treatment	60%	50%

Southeast	***Statewide Offender Episodes CCDTF***	***Drug Court Episodes CCDTF***
Number of Episodes	N=852	N=11
% Male	N=852	N=11
	73%	64%
Race Categories	N=852	N=11
White	85%	100%
African American	6%	0%
Native American	3%	0%
Hispanic	5%	0%
Asian/Pacific Islander	1%	0%
Other/Unknown	1%	0%
Length of Stay	N=835	N=11
0-30	44%	18%
31-60 days	28%	18%
61-90 days	19%	18%
More than 90 days	10%	46
Average: range: 0-3 (s.d.)	.95(1.01)	1.91(1.22)
Type of Treatment	N=852	N=11
Inpatient	30%	0%
Outpatient	37%	100%
Extended Care	5%	0%
Halfway House	28%	0%
Treatment Completion	N=852	N=7
Percent Completing Treatment	65%	71%

Southwest	***Statewide Offender Episodes CCDTF***	***Drug Court Episodes CCDTF***
Number of Episodes	N=1292	N=47
% Male	N=1292	N=47
	74%	100%
Race Categories	N=1292	N=47
White	85%	83%
African American	3%	13%
Native American	4%	0%
Hispanic	8%	4%
Asian/Pacific Islander	<1%	0%
Other/Unknown	1%	0%
Length of Stay	N=1272	N=38
0-30	34%	34%
31-60 days	26%	21%
61-90 days	24%	8%
More than 90 days	16%	37%
Average: range: 0-3 (s.d.)	1.23(1.09)	1.47(1.31)
Type of Treatment	N=1292	N=47
Inpatient	27%	30%
Outpatient	39%	51%
Extended Care	8%	0%
Halfway House	26%	19%
Treatment Completion	N=1292	N=28
Percent Completing Treatment	63%	75%

West Central	*Statewide Offender Episodes CCDTF*	*Drug Court Episodes CCDTF*
Number of Episodes	N=1040	N=43
% Male	N=1040	N=43
	71%	65%
Race Categories	N=1040	N=43
White	70%	91%
African American	3%	0
Native American	24%	9%
Hispanic	2%	0
Asian/Pacific Islander	0	0
Other/Unknown	1%	0
Length of Stay	N=1016	N=43
0-30	38%	33%
31-60 days	25%	33%
61-90 days	17%	19%
More than 90 days	20%	16%
Average: range: 0-3 (s.d.)	1.19(1.14)	1.19(1.08)
Type of Treatment	N=1040	N=43
Inpatient	31%	44%
Outpatient	30%	42%
Extended Care	15%	0
Halfway House	24%	14%
Treatment Completion	N=1040	N=43
Percent Completing Treatment	59%	65%

Northeast	***Statewide Offender Episodes PMAP***	***Drug Court Episodes PMAP***
Number of Episodes	N=360	N=4
% Male	N=360	N=4
	63%	50%
Race Categories	N=360	N=4
White	79%	50%
African American	4%	0%
Native American	13%	50%
Hispanic	1%	0%
Asian/Pacific Islander	1%	0%
Other/Unknown	3%	0%
Length of Stay	N=344	N=4
0-30	42%	0%
31-60 days	34%	50%
61-90 days	12%	0%
More than 90 days	13%	50%
Average: range: 0-3 (s.d.)	.95(1.02)	2(1.16)
Type of Treatment	N=360	N=4
Inpatient	31%	0%
Outpatient	60%	100%
Extended Care	1%	0%
Halfway House	8%	0%
Treatment Completion	N=360	N=4
Percent Completing Treatment	62%	100%

East Central	***Statewide Offender Episodes PMAP***	***Drug Court Episodes PMAP***
Number of Episodes	N=239	NA
% Male	N=239	NA
	52%	
Race Categories	N=239	NA
White	88%	
African American	5%	
Native American	2%	
Hispanic	1%	
Asian/Pacific Islander	2%	
Other/Unknown	2%	
Length of Stay	N=237	NA
0-30	52%	
31-60 days	31%	
61-90 days	8%	
More than 90 days	9%	
Average: range: 0-3 (s.d.)	.74(.95)	
Type of Treatment	N=239	NA
Inpatient	17%	
Outpatient	81%	
Extended Care	1%	
Halfway House	2%	
Treatment Completion	N=239	NA
Percent Completing Treatment	62%	

Metro	***Statewide Offender Episodes PMAP***	***Drug Court Episodes PMAP***
Number of Episodes	N=1259	N=10
% Male	N=1259	N=10
	63%	20%
Race Categories	N=1259	N=10
White	59%	60%
African American	30%	20%
Native American	5%	20%
Hispanic	3%	0%
Asian/Pacific Islander	1%	0%
Other/Unknown	2%	0%
Length of Stay	N=1232	N=10
0-30	55%	50%
31-60 days	23%	10%
61-90 days	9%	0%
More than 90 days	13%	40%
Average: range: 0-3 (s.d.)	.80(1.06)	1.3(1.49)
Type of Treatment	N=1259	N=10
Inpatient	26%	30%
Outpatient	72%	70%
Extended Care	2%	0%
Halfway House	1%	0%
Treatment Completion	N=1259	N=10
Percent Completing Treatment	55%	70%

Southeast	***Statewide Offender Episodes PMAP***	***Drug Court Episodes PMAP***
Number of Episodes	N=146	N=2
% Male	N=146	N=2
	56%	100%
Race Categories	N=146	N=2
White	85%	100%
African American	8%	0%
Native American	3%	0%
Hispanic	4%	0%
Asian/Pacific Islander	0%	0%
Other/Unknown	1%	0%
Length of Stay	N=143	N=2
0-30	55%	0%
31-60 days	15%	0%
61-90 days	15%	0%
More than 90 days	15%	100%
Average: range: 0-3 (s.d.)	.92(1.15)	3.0(0.0)
Type of Treatment	N=146	N=2
Inpatient	49%	0%
Outpatient	49%	100%
Extended Care	1%	0%
Halfway House	1%	0%
Treatment Completion	N=146	NA
Percent Completing Treatment	64%	

Southwest	***Statewide Offender Episodes PMAP***	***Drug Court Episodes PMAP***
Number of Episodes	N=229	N=4
% Male	N=229	N=4
	60%	50
Race Categories	N=229	N=4
White	84%	100%
African American	2	0%
Native American	3	0%
Hispanic	11	0%
Asian/Pacific Islander	<1%	0%
Other/Unknown	0%	0%
Length of Stay	N=228	N=4
0-30	48%	0%
31-60 days	33%	0%
61-90 days	8%	0%
More than 90 days	11%	100%
Average: range: 0-3 (s.d.)	.82(.99)	3.0(0.0)
Type of Treatment	N=229	N=4
Inpatient	45%	0%
Outpatient	55%	100%
Extended Care	<1%	0%
Halfway House	0%	0%
Treatment Completion	N=229	NA
Percent Completing Treatment	59%	

West Central	*Statewide Offender Episodes PMAP*	*Drug Court Episodes PMAP*
Number of Episodes	N=119	N=3
% Male	N=119	N=3
	54%	0%
Race Categories	N=119	N=3
White	77%	100%
African American	3%	0%
Native American	15%	0%
Hispanic	2%	0%
Asian/Pacific Islander	1%	0%
Other/Unknown	3%	0%
Length of Stay	N=116	N=3
0-30	50%	0%
31-60 days	17%	67%
61-90 days	14%	33%
More than 90 days	19%	0%
Average: range: 0-3 (s.d.)	1.02(1.19)	1.33(.58)
Type of Treatment	N=119	N=3
Inpatient	39%	67%
Outpatient	58%	0%
Extended Care	0%	0%
Halfway House	3%	33%
Treatment Completion	N=119	N=3
Percent Completing Treatment	64%	100%

Northeast	***Statewide Offender Episodes Private Insurance***	***Drug Court Episodes Private Insurance***
Number of Episodes	N=506	N=3
% Male	N=506	100%
	79%	
Race Categories	N=506	N=3
White	89%	100%
African American	1%	0%
Native American	7%	0%
Hispanic	2%	0%
Asian/Pacific Islander	<1%	0%
Other/Unknown	1%	0%
Length of Stay	N=483	N=3
0-30	42%	33%
31-60 days	29%	0%
61-90 days	11%	67%
More than 90 days	18%	0%
Average: range: 0-3 (s.d.)	1.05(1.11)	1.33(1.16)
Type of Treatment	N=506	N=3
Inpatient	20%	33%
Outpatient	77%	67%
Extended Care	2%	0%
Halfway House	<1%	0%
Treatment Completion	N=506	N=3
Percent Completing Treatment	74%	100%

East Central[15]	*Statewide Offender Episodes Private Insurance*	*Drug Court Episodes Private Insurance*
Number of Episodes	N=915	NA
% Male	N=915	NA
	77%	
Race Categories	N=915	NA
White	94%	
African American	2%	
Native American	2%	
Hispanic	2%	
Asian/Pacific Islander	<1%	
Other/Unknown	1.0%	
Length of Stay	N=886	NA
0-30	40%	
31-60 days	26%	
61-90 days	13%	
More than 90 days	21%	
Average: range: 0-3 (s.d.)	1.15(1.16)	
Type of Treatment	N=915	NA
Inpatient	19%	
Outpatient	78%	
Extended Care	2%	
Halfway House	<1%	
Treatment Completion	N=915	NA
Percent Completing Treatment	75%	

Metro	***Statewide Offender Episodes Private Insurance***	***Drug Court Episodes Private Insurance***
Number of Episodes	N=4211	N=18
% Male	N=4211	44%
	74%	
Race Categories	N=4211	N=18
White	82%	100%
African American	9%	0%
Native American	2%	0%
Hispanic	4%	0%
Asian/Pacific Islander	1%	0%
Other/Unknown	2%	0%
Length of Stay	N=4096	N=13
0-30	42%	0%
31-60 days	31%	46%
61-90 days	11%	23%
More than 90 days	16%	31%
Average : range: 0-3 (s.d.)	1.01(1.08)	1.85(.90)
Type of Treatment	N=4211	N=18
Inpatient	22%	17%
Outpatient	76%	72%
Extended Care	2%	0%
Halfway House	1%	11%
Treatment Completion	N=4211	N=15
Percent Completing Treatment	68%	87%

Southeast	***Statewide Offender Episodes Private Insurance***	***Drug Court Episodes Private Insurance***
Number of Episodes	N=805	N=3
% Male	N=805	100%
	76%	
Race Categories	N=805	N=3
White	87%	100%
African American	5%	0%
Native American	3%	0%
Hispanic	4%	0%
Asian/Pacific Islander	1%	0%
Other/Unknown	1%	0%
Length of Stay	N=773	N=3
0-30	33%	67%
31-60 days	31%	0%
61-90 days	18%	33%
More than 90 days	19%	0%
Average : range: 0-3 (s.d.)	1.23(1.10)	.67(1.16)
Type of Treatment	N=805	N=3
Inpatient	13%	0%
Outpatient	85%	100%
Extended Care	1%	0%
Halfway House	1%	0%
Treatment Completion	N=805	N=3
Percent Completing Treatment	71%	33%

Southwest	***Statewide Offender Episodes Private Insurance***	***Drug Court Episodes Private Insurance***
Number of Episodes	N=695	N=8
% Male	N=695	100%
	81%	
Race Categories	N=695	N=8
White	91%	100%
African American	1%	0%
Native American	3%	0%
Hispanic	4%	0%
Asian/Pacific Islander	<1%	0%
Other/Unknown	1%	0%
Length of Stay	N=682	N=8
0-30	32%	0%
31-60 days	36%	0%
61-90 days	15%	0%
More than 90 days	18%	100%
Average: range: 0-3 (s.d.)	1.18(1.07)	3.0(0.0)
Type of Treatment	N=695	N=8
Inpatient	15%	0%
Outpatient	82%	100%
Extended Care	2%	0%
Halfway House	2%	0%
Treatment Completion	N=695	NA
Percent Completing Treatment	79%	

West Central	*Statewide Offender Episodes Private Insurance*	*Drug Court Episodes Private Insurance*
Number of Episodes	N=316	NA
% Male	N=316	NA
	78%	
Race Categories	N=316	NA
White	87%	
African American	1%	
Native American	5%	
Hispanic	5%	
Asian/Pacific Islander	1%	
Other/Unknown	1%	
Length of Stay	N=287	NA
0-30	24%	
31-60 days	20%	
61-90 days	17%	
More than 90 days	39%	
Average: range: 0-3 (s.d.)	1.71(1.21)	
Type of Treatment	N=316	NA
Inpatient	17%	
Outpatient	81%	
Extended Care	2%	
Halfway House	1%	
Treatment Completion	N=316	NA
Percent Completing Treatment	62%	

APPENDIX D: SUMMARY OF CHARACTERISTICS OF CHEMICAL DEPENDENCY TREATMENT FACILITIES FOR SELECTED STATES

Excerpted from the National Survey of Substance Abuse Treatment Services (N-SSATS) conducted by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA): March 2004 or 2005 (http://www.oas.samhsa.gov/dasis.htm#Reports)

	MN		CA		IL(1)		IN		MD		MI	
FACILITIES CHARACTERISTICS	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Chemical dependency treatment facilities responding to the 2005 N-SSATS	253	--	1739	--	572	--	335	--	356	--	546	--
Facility response rate	--	98%	--	95%	--	97%	--	96%	--	96%	--	97%
Adult clients in chemical dependency treatment on March 31, 2005	9,362	--	124,477	--	38,184	--	25,162	--	32,972	--	40,572	--
FACILITY OWNERSHIP/OPERATION												
Private non-profit	139	54%	1,140	66%	343	60%	212	63%	148	42%	301	55%
Private for-profit	90	36%	363	21%	201	35%	97	29%	135	38%	183	34%
Local government	7	3%	197	11%	14	2%	20	6%	22	6%	42	8%
State government	7	3%	5	<1%	7	1%	3	1%	45	13%	5	1%
Federal government	3	1%	25	1%	7	1%	3	1%	6	2%	5	1%
Dept. of Veterans Affairs	2	<1%	11	1%	5	1%	3	1%	2	1%	5	1%
Dept. of Defense	--	--	9	1%	2	<1%	--	--	3	1%		
Indian Health Service	1	<1%	5	<1%	--	--	--	--	--	--		
Other	--	--	--	--	--	--	--	--	1	<1%		
Tribal government	7	3%	9	1%	--	--	--	--	--	--		
PRIMARY FOCUS OF FACILITY												
Chemical dependency treatment services	210	83%	1,268	73%	343	60%	127	38%	286	80%	236	43%
Mental health services	1	<1%	61	4%	37	7%	54	16%	14	4%	92	17%
Mix of SA & MH treatment services	38	15%	356	21%	165	29%	145	43%	47	13%	197	36%
General health care	3	1%	28	2%	15	3%	4	1%	4	1%	13	2%
Other/unknown	1	<1%	26	2%	12	2%	5	2%	5	1%	8	2%
CHEMICAL DEPENDENCY PROBLEMS TREATED							(3)				(4)	
Alcohol & drug dependency	238	96%	1,476	93%	487(2)	94%	242	96%	307	95%	468	94%
Drug dependency only	177	71%	1,234	78%	430	83%	212	84%	265	82%	422	85%
Alcohol dependency only	200	80%	1,122	71%	448	87%	220	87%	246	76%	428	86%
TYPE OF CARE												
Outpatient	193	76%	1,236	71%	501	88%	310	93%	296	93%	505	93%
Residential	111	44%	703	40%	112	20%	47	14%	85	24%	82	15%
Hospital Inpatient	15	6%	69	4%	35	6%	38	11%	12	3%	16	3%
TYPE OF PAYMENT ACCEPTED												
Cash or self payment	249	98%	1,507	87%	544	95%	333	99%	329	92%	525	96%
Private health insurance	223	88%	699	40%	411	72%	264	79%	215	60%	439	80%
Medicare	66	26%	297	17%	156	27%	188	56%	100	28%	279	51%
Medicaid	97	38%	466	27%	277	48%	195	58%	172	48%	352	65%

Other state-financed insurance	158	63%	239	14%	124	22%	177	53%	103	29%	210	39%
Federal military insurance	96	38%	221	13%	154	27%	165	49%	92	26%	199	36%
No payment accepted	--	--	89	5%	6	1%	2	1%	14	4%	9	2%
Other type of payment	4	2%	36	2%	31	5%	24	7%	8	2%	14	3%
Sliding fee scale	74	29%	1,155	66%	405	71%	250	75%	237	67%	356	65%
Treatment at no charge for clients who cannot pay	68	26%	1,019	59%	287	50%	107	32%	182	51%	265	49%
FACILITY ADMINISTRATRIVE & FUNDING CHARACTERISTICS												
Has agreements or contracts with managed care organizations for provision of chemical dependency treatment services	196	78%	459	26%	270	47%	183	55%	165	46%	367	67%
Receives federal, State, county, or local government funds for chemical dependency treatment programs	178	70%	1,177	78%	318	56%	213	64%	203	57%	328	60%
PROGRAMS BY SPECIAL GROUPS												
Co-occurring disorders	75	30%	666	38%	188	33%	91	27%	124	35%	169	31%
Women	73	29%	599	34%	141	25%	87	26%	137	39%	160	29%
DUI/DWI offenders	73	29%	155	9%	296	52%	118	35%	156	44%	188	34%
Criminal justice clients	43	17%	581	33%	125	22%	103	31%	92	26%	153	28%
Men	62	25%	482	28%	106	19%	63	19%	107	30%	134	25%
Pregnant or postpartum women	27	11%	343	20%	61	11%	30	9%	46	13%	70	13%
TYPES OF SERVICES OFFERED												
Assessment services	237	94%	1,587	91%	553	97%	327	98%	347	97%	534	98%
Chemical dependency therapy & counseling	248	98%	1,709	98%	567	99%	329	98%	354	99%	543	99%
Testing	227	90%	1,587	91%	491	86%	291	87%	343	96%	393	72%
Other services: case management	174	69%	1,340	77%	402	70%	238	71%	238	67%	265	49%

(1) Illinois data represent responses as of March 31, 2004.
(2) Excludes 55 facilities that were not asked or did not respond to this question.
(3) Excludes 8 facilities that were not asked or did not respond to this question.
(4) Excludes 48 facilities that were not asked or did not respond to this question.

	MN		MO		NY		OR		PA		WI	
FACILITIES CHARACTERISTICS	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Chemical dependency treatment facilities responding to the 2005 N-SSATS	253	--	221	--	1044	--	223	--	443	--	298	--
Facility response rate	--	98	--	91%	--	98%	--	93%	--	97%	--	96%
Adult clients in chemical dependency treatment on March 31, 2005	9,362	--	15,681	--	112,545	--	18,508	--	36,607	--	16,196	--
FACILITY OWNERSHIP/OPERATION												
Private non-profit	139	54%	167	76%	728	69%	118	53%	314	71%	136	46%
Private for-profit	90	36%	42	19%	158	15%	59	27%	110	25%	106	36%
Local government	7	3%	2	1%	92	9%	35	16%	6	1%	48	13%
State government	7	3%	3	3%	49	5%	1	<1%	5	1%	2	1%
Federal government	3	1%	7	2%	12	1%	2	1%	8	2%	2	1%
Dept. of Veterans Affairs	2	<1%	5	1%	11	1%	1	<1%	8	1%	2	1%
Dept. of Defense	--	--	1	<1%	1	<1%	--	--	--	--		
Indian Health Service	1	<1%	1	<1%	--	--	1	<1%	--	--		
Other	--	--	--	--	--	--	--	--	--	--		
Tribal government	7	3%	--	--	5	1%	8	4%	--	--	14	5%
PRIMARY FOCUS OF FACILITY												
Chemical dependency treatment services	210	83%	127	58%	893	85%	148	66%	308	70%	102	34%
Mental health services	1	<1%	22	10%	24	2%	11	5%	22	5%	33	11%
Mix of SA & MH treatment services	38	15%	64	29%	102	10%	60	27%	105	24%	146	49%
General health care	3	1%	4	2%	16	2%	3	1%	4	1%	12	4%
Other/unknown	1	<1%	4	2%	9	1%	1	<1%	4	1%	5	2%
CHEMICAL DEPENDENCY PROBLEMS TREATED											(5)	
Alcohol & drug dependency	238	96%	156	93%	929	94%	196	98%	373	91%	251	93%
Drug dependency only	177	71%	132	79%	859	87%	75	87%	354	87%	217	81%
Alcohol dependency only	200	80%	135	81%	731	74%	168	84%	332	81%	244	91%
TYPE OF CARE												
Outpatient	193	76%	206	93%	728	70%	199	90%	344	78%	240	81%
Residential	111	44%	62	28%	272	26%	53	24%	131	30%	65	22%
Hospital Inpatient	15	6%	13	6%	112	11%	3	1%	29	7%	46	15%
TYPE OF PAYMENT ACCEPTED												
Cash or self payment	249	98%	212	96%	951	91%	216	97%	415	94%	279	94%
Private health insurance	223	88%	170	77%	763	73%	189	85%	317	72%	261	88%
Medicare	66	26%	86	39%	457	44%	73	33%	158	36%	178	60%
Medicaid	97	38%	137	62%	873	84%	140	63%	322	73%	220	74%
Other state-financed insurance	158	63%	78	35%	476	46%	142	64%	192	43%	170	57%
Federal military insurance	96	38%	111	50%	312	30%	92	41%	108	24%	165	55%
No payment accepted	--	--	3	1%	23	2%	1	<1%	3	7%	11	4%
Other type of payment	4	2%	5	2%	17	2%	4	2%	16	4%	13	4%

Sliding fee scale	74	29%	168	76%	807	77%	177	79%	224	51%	156	52%
Treatment at no charge for clients who cannot pay	68	26%	101	46%	568	64%	123	55%	201	45%	121	41%
FACILITY ADMINISTRATRIVE & FUNDING CHARACTERISTICS												
Has agreements or contracts with managed care organizations for provision of chemical dependency treatment services	196	78%	118	53%	584	56%	148	66%	364	82%	203	68%
Receives federal, State, county, or local government funds for chemical dependency treatment programs	178	70%	170	77%	637	61%	149	67%	333	75%	183	61%
PROGRAMS BY SPECIAL GROUPS												
Co-occurring disorders	75	30%	82	37%	469	45%	110	49%	178	40%	106	36%
Adult women	73	29%	55	25%	572	55%	104	47%	163	37%	75	25%
DUI/DWI offenders	73	29%	81	37%	203	19%	139	62%	116	26%	118	40%
Criminal justice clients	43	17%	76	34%	284	27%	75	34%	146	33%	49	16%
Adult men	62	25%	35	16%	450	43%	75	34%	117	26%	45	15%
Pregnant or postpartum women	27	11%	25	11%	120	12%	40	18%	60	14%	24	8%
TYPES OF SERVICES OFFERED												
Assessment services	237	94%	212	96%	990	95%	218	98%	414	93%	285	96%
Chemical dependency therapy & counseling	248	98%	218	99%	1,035	99%	222	100%	441	100%	284	95%
Testing	227	90%	209	95%	1,026	98%	221	99%	370	84%	233	78%
Other services: case management	174	69%	169	76%	631	60%	182	91%	242	55%	162	54%

(5) Excludes 29 facilities that were not asked or did not respond to this question.

APPENDIX E: SUMMARY OF PUBLICLY FUNDED ADULT CHEMICAL DEPENDENCY TREATMENT SYSTEMS OTHER THAN STATE AOD AGENCIES AND MEDICAID PROGRAMS FOR SELECTED STATES

Minnesota Drug Courts Funding Study—Chemical and Mental Health Services

Source: National Association of State Alcohol and Drug Abuse Directors, Inc. (August 2002). Identification and Description of Multiple Alcohol and Other Drug Treatment Systems: Final Report. Health Systems Research, Inc.: Washington, D.C. Data collected September 2001. Compiled 5/07

	CA	FL	IL	IN	MD	MI	MO	NY	OR	PA	WI
State Agency OPERATED treatment services											
Department of Corrections	X		X	X	X	X	X	X		X	X
Department of Child and Family Services		X	X					X			X
Department of Mental Health			X								
Division of Parole and Probation					X						
Office of Mental Health								X			
Department of Public Welfare										X	
Local Government Agency OPERATED treatment services											
County Jails		X	X		X		X	X			
County Mental Health Authorities	X(2)					X		X			
County Departments of Public Health			X		X	X					
Municipal Health Agencies			X								
Community Corrections Boards					X						
County Juvenile/Family Courts							X				
County Drug Courts										X(7)	
Unidentified County Agency											X
State Agency PURCHASED treatment services											
Probation Authority					X		X	X			
Parole Authority	X				X	X	X	X	X		
Correctional Authority	X	X	X					X	X	X	
Child Welfare	X		X			X					
Drug Courts					X			X			
Other Courts					X						
TANF/Welfare to Work		X	X		X	X		X			
Unidentified Other State Authority								X			
Local Agency PURCHASED treatment services											
Vocational Rehabilitation								X			
Probation Authority									X		
Correctional Authority	X	X	X					X	X	X	
Child Welfare						X		X	X	X	
	CA	**FL**	**IL**	**IN**	**MD**	**MI**	**MO**	**NY**	**OR**	**PA**	**WI**
Drug Courts	X	X			X	X	X			X	
Other Courts							X				
TANF/Welfare to Work	X							X	X		
Tribal Authorities						X					
Other Authorities IL: Public Health and Mental Health Boards (Taxing Authorities) NY: unidentified other authorities			X					X			
Percentage of clients treated under PURCHASE arrangements that are reported to the state AOD agency (8 selected states reported)											

0-19%		X		X			X		X	X	
20-39%	X										
40-59%											
60-79%					X						
80-100%			X								
Medicaid AOD Treatment Services											
Coverage limited to required inpatient hospital services				X						X	X
Services are coordinated or supplemented with services provided by the State AOD Agency										X	
Expanded AOD treatment services are provided under state Medicaid options or waivers	X	X	X		X	X	X	X	X		
Services are coordinated or supplemented with services provided by the State AOD Agency	X	X	X			X		X	X		
AOD treatment services are provided under managed care plans in which the State AOD Agency does not participate financially	X	X	X		X	X	X	X		X	
Extent of coverage compared to State AOD agency?											
About the same					X					X	
Varies with the plan	X		X								
Less extensive		X					X	X			
A public client in managed care in need of services beyond those provided by a plan rare routinely referred to services supported through the AOD Agency	N/R	X	X			X	X	X		X	