MINNESOTA SUPREME COURT
CHEMICAL DEPENDENCY TASK FORCE

INITIAL REPORT

February 3, 2006

STATE OF MINNESOTA
IN SUPREME COURT
ADM-05-8002

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Initial Report

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A. TASK FORCE MEMBERS

Task Force Chairs: **Honorable Joanne Smith**, District Court Judge, Second Judicial District, Chair
Honorable Gary Schurrer, District Court Judge, Tenth Judicial District, Vice-Chair

Task Force Members:
Jim Backstrom, Dakota County Attorney
Lynda Boudreau, Deputy Commissioner, Minnesota Department of Health
Chris Bray, Assistant Commissioner, Minnesota Department of Corrections
Mary Ellison, Deputy Commissioner, Minnesota Department of Public Safety
Jim Frank, Sheriff, Washington County
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Pat Hass, Director, Pine County Health and Human Services
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Wes Kooistra, Assistant Commissioner for Chemical and Mental Health Services[1]
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Bob Olander, Human Services Area Manager, Hennepin County
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Commissioner Terry Sluss, Crow Wing County
Representative Steve Smith, Minnesota House of Representatives
John Stuart, State Public Defender
Kathy Swanson, Director, Office of Traffic Safety, Minnesota Dept. of Public Safety
Honorable Paul Widick, District Court Judge, Seventh Judicial District

Associate Justice Helen Meyer, Supreme Court Liaison

Staff:
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Dan Griffin, Court Operations Analyst – Chemical Health, Court Services Division, State Court Administration

[1] Assistant Commissioner Kooistra joined the Task Force in September 2005 when Lynda Boudreau moved from the Department of Human Services to the Department of Health.
[2] Fred LaFleur withdrew from the Task Force in September, 2005.

B. TASK FORCE BACKGROUND AND PURPOSE

Background

Persons who suffer from alcohol and other drug (AOD) problems represent a pervasive and growing challenge for Minnesota's judicial branch, and, in particular, its criminal courts. The impact of AOD problems is not confined to any one case type; they are common throughout the judicial branch. In recent years, however, alternative and demonstrably more effective judicial approaches for dealing with AOD-dependent persons, and particularly criminal offenders, have evolved both in Minnesota and other states. Further, increased resources exist at both the state and national level to support the development of such alternative approaches. There has been growing recognition that Minnesota courts would benefit from a more deliberate and coordinated effort to investigate the extent to which AOD-dependent persons come into the courts, and to assess available strategies and approaches for addressing that problem.

In late 2000, courts statewide were asked to "vote" on strategic priorities for the courts over the next several years. The top four priorities selected were Access to Justice, Children's Justice, Public Trust and Confidence, and Technology. Alcohol and other drug issues ended up a very close fifth in the vote – demonstrating the clear concern about this topic among those who work in the judiciary. Since that time, methamphetamine production and use has grown at an alarming rate across the country as well as in Minnesota. As with previous such problems, courts are struggling to plan for an effective response to the inevitable resource drain this new problem will cause for the state. At the same time, courts are increasingly recognizing that few, if any, of these offenders are using only meth, and that there is a need to address "poly-drug" use in all of its manifestations. Defendants addicted to methamphetamine, crack cocaine and marijuana (which remain significant problems in urban areas of Minnesota), DWI defendants, and other chemically dependent recidivists are currently taking up significant amounts of the courts' limited resources.

It is imperative that cost-effective and productive ways of dealing with these issues be identified. Minnesota continues to face difficult economic times and a state budget deficit, so it seems particularly necessary and urgent to address AOD issues in a proactive and cohesive way with criminal justice "partners" who are facing many of the same challenges.

While there is some historical precedent in Minnesota for a task force or state-level committee focused on related issues (e.g., criminal justice effectiveness, mental health, juvenile justice), there has never been a judicial task force focused specifically on addressing the impact of AOD issues on the courts. A number of other states have recently established task forces, judicial commissions, or legislatively mandated bodies that are also exploring this specific issue or similar issues and initiatives (such as drug courts). On November 30, 2004, the state Conference of Chief Judges unanimously recommended that the Supreme Court establish a task force charged with exploring the problem of chemical dependency and identifying potential approaches and resources for addressing that problem.

Purpose

The Task Force was established by the Minnesota Supreme Court on March 16, 2005, to make recommendations as to how the Minnesota Judicial Branch can deal more effectively with persons with AOD problems who come in to the Minnesota courts. (See Appendix A for the Order creating the Task Force.) In particular, the Court directed the Task Force to:

1. Conduct background research on specific issues concerning AOD-dependent persons, and particularly AOD-related offenders, including:
   a. The current extent of the problem of AOD-dependent persons, and particularly AOD offenders, in the Minnesota judicial branch;
   b. The cost(s) of the problem and benefit(s) of proposed solutions;
   c. Identification and assessment of current judicial strategies to address the problem of AOD-dependent persons, and particularly AOD offenders, both in Minnesota and other states;
   d. Determination of the current and potential effectiveness of drug courts and other alternative approaches in Minnesota.

2. Conduct an inventory of current multi-agency, state-level AOD efforts in Minnesota as well as in other states, including:
   a. Identification of promising practices;
   b. Identification of gaps and redundancies.

3. Identify and recommend approaches, solutions, and opportunities for collaboration.

The Court directed the Task Force to submit two reports with the results of its research together with its recommendations for optimal development of alternative judicial approaches for dealing with AOD-dependent persons. An initial report focusing specifically on AOD-related criminal and juvenile offenders was to be submitted by January 3, 2006; this deadline was subsequently extended to February 3, 2006. A Final Report focusing on the overall impact of AOD problems across all case types is to be submitted by September 30, 2006.

C. TASK FORCE PROCESS AND REPORT FORMAT, DISTRIBUTION AND DISCUSSION

Process

The full Task Force met monthly beginning in April 2005[3]. In addition to the monthly meetings, groups of Task Force members also visited three sites relevant to its work:

- Turning Point (treatment facility for African American men in Minneapolis)
- Teen Challenge (faith-based treatment facility in Minneapolis)
- Stearns County Drug Court, St. Cloud, Minnesota

[3] The Task Force held two meetings in April, on April 1 and April 22.

Finally, the Task Force has considered comments made by citizens, lawyers, subject matter experts, judges and other professionals who have attended Task Force meetings and a public hearing on January 27, 2006, and / or have provided written materials. The Task Force also solicited input from a variety of individuals, professionals, agencies, and groups having experience and interest in AOD problems and their impact on Minnesota courts.

Report Format, Distribution and Discussion

The Task Force has made findings and recommendations in the following areas:

- Addiction Model
- Problem Solving Approaches for Adult and Juvenile AOD Offenders
- Methamphetamine
- DWI
- Restorative Justice and Other Interventions
- Funding of Problem Solving Approaches

Therefore this report will present the considerations and recommendations of the Task Force in eight main sections:

1. Addiction Model
2. Definitions of Key Terms and Concepts
3. Recommendations concerning Problem Solving Approaches for Adult AOD Offenders;
4. Recommendations concerning Problem Solving Approaches for Juvenile AOD Offenders;
5. Recommendations concerning Methamphetamine cases;
6. Recommendations concerning DWI offenders;
7. Recommendations concerning Restorative Justice and Other Interventions; and
8. Recommendations concerning Funding of Problem Solving Approaches in Minnesota's Courts.

The Task Force decided to make decisions by consensus, meaning that all members would agree to a proposed recommendation in order to avoid minority reports, even though some members might disagree with the proposed recommendation. The Summary of Major Task Force recommendations in Part II.B explains the areas of significant change and highlights the issues that generated the most debate by the Task Force and/or significant comment from the public.

A draft of this report and its recommendations was circulated electronically to a wide spectrum of individuals and groups who either have expressed interest or may be interested in the Task Force's work. Further, it was the subject of a public hearing on January 27, 2006. X citizens testified at the public hearing, and the Task Force received written comments from judges, lawyers and citizens. The Task Force also received comments from X, Y and Z groups during the course of its deliberations.

PART II: EXECUTIVE SUMMARY

A. MAJOR PRINCIPLES AND THEMES

Before summarizing the Task Force's major recommendations, it is important to set out a number of recurring principles and themes that have infused the Task Force's discussions of the many challenges posed by AOD addicted offenders who come into Minnesota's courts. These principles and themes underlie all Task Force recommendations.

1. AOD addiction is a treatable chronic disease. People who suffer from AOD addiction can and do recover, at the same success rates as for other chronic illnesses (e.g. asthma, diabetes, hypertension, etc.); and the process of recovery from addiction often involves relapse.

2. When attempting to address AOD problems, it is important to recognize that AOD addiction most often impacts the whole family. Therefore, the traditional fragmented approach to these issues in the courts (and the criminal and juvenile justice systems generally) – where adult cases are processed separately from juvenile cases, and both are processed separately from child protection cases, etc. – is not the most effective way to address the AOD (and mental health) problems which constitute the underlying causes of a high percentage of all cases coming into the courts.

3. Effective implementation of a judicial problem solving approach often requires a "paradigm shift" among the various participants who are needed in order to implement the approach – e.g., judge, prosecutor, defense counsel, probation / corrections, social services, law enforcement, etc. However, although the traditional roles of participants are substantially modified, they are not relinquished. It is important to maintain the distinct roles of each problem solving approach team member – in order, for example, to preserve the constitutional rights of problem solving program clients. Adequate training is essential for effective implementation of any judicial problem solving approach.

4. A distinction can and should be made between high risk and low risk AOD addicted offenders ("high risk" and "low risk" referring to their relative risk of re-offending). This distinction is important because different types and degrees of interventions are more effective for high risk as opposed to low risk offenders.

5. In order to effectively deal with the range of AOD addicted offenders, it is best to utilize a continuum of interventions which enables the court to identify and implement the most appropriate type and degree of intervention for each offender.

6. Appropriate, culturally sensitive, gender-responsive, and court-supervised treatment can be effective in fostering recovery and reducing recidivism among AOD offenders.

7. All problem-solving approaches need to be subject to rigorous and standardized evaluation. Any problem-solving court program must incorporate an evaluation component, and one that integrates with the broader statewide evaluation methodology/-ies currently being developed.

8. All treatment and other judicial interventions with AOD addicted offenders must take into consideration the specific needs of the individual who is the subject of the intervention. Special attention must be paid to gender- and culturally-specific treatment needs.

9. Adequate, consistent, and evidence-based chemical dependency and mental health assessment tools and practices are critical for success in dealing with AOD addicted offenders.

10. Co-occurring disorders (i.e., the co-occurrence of both addiction and mental health issues) are very common among AOD offenders. They need to be taken into account in identifying appropriate judicial interventions.

11. Effective collaboration among participants is essential to the success of any problem solving approach.

12. Alcohol is a drug. The magnitude of the problems caused by alcohol-related offenses dwarfs that of all other drugs, including methamphetamine.

13. Poly-drug use (including alcohol) is the norm and not the exception among AOD addicted offenders, and must be taken into account in any effort to identify and implement more effective judicial interventions.

14. Effective judicial intervention for juvenile AOD offenders is critical, in light of the connection between juvenile AOD use and later adult addiction and criminality, and as a consequence of the destructive impact of juvenile AOD use and addiction on the developing adolescent brain.

15. Broader implementation of problem solving approaches for AOD offenders in Minnesota's courts will result in greater emphasis on a restorative approach focused on intensive supervision and treatment for AOD offenders, with retribution in the form of incarceration being reserved for non-compliance, termination from the program, or those persons for whom problem solving approaches are simply not appropriate.

B. SUMMARY OF MAJOR TASK FORCE RECOMMENDATIONS

I. ***<u>Problem Solving Approaches:</u> The Task Force calls for a broad and fundamental shift in how Minnesota's courts deal with AOD addicted offenders, including greater collaboration among criminal and juvenile justice system participants (while not relinquishing their core roles and responsibilities) and creation of a comprehensive multi-phased plan to institute these changes.***

The Task Force recommends a broad and fundamental shift – a paradigm shift – in the way that Minnesota's courts currently deal with AOD addicted offenders for whom imprisonment is not initially appropriate or warranted. It involves recognition of the nature of addiction – how it affects the brain, and how it can be most effectively treated – which in turn calls for a change in the way that courts deal with AOD addicted offenders. The Task Force also recommends the creation of a comprehensive plan for broader development of problem solving approaches for dealing with AOD addicted offenders in Minnesota's courts. This recommendation is based upon research which demonstrates and experience that indicates that problem solving approaches (for example, drug courts) most effectively address the underlying causes of addiction-related criminal and juvenile behavior, and thus offer the best prospect for fostering recovery and reducing recidivism among AOD addicted offenders.

The Task Force also recommends that the Judicial Branch begin exploring the most effective way to integrate problem-solving approaches into current court operations. This systemic shift will take time and require significant commitment from all parties; however, the Task Force is convinced that the price of not changing has been high, and should not be acceptable to policymakers or the citizens of Minnesota. Other states including Missouri, California, and New York are successfully moving in this same direction.

A vital component of the paradigm shift which the Task Force advocates is the need to institutionalize collaborative relationships at all levels. However, movement toward a collaborative model does not mean relinquishing the core roles and responsibilities of each participant or entity. Prosecutors can never lose sight of their commitment to public safety, and defense counsel must always maintain their commitment to protecting the due process and other constitutional rights of each person coming through the court system. The judge must ultimately maintain his or her constitutional charge as a neutral arbiter of justice. What is essential is that the response of the entire system be coordinated so that when an offender relapses or commits another crime the response can be swift, the sanction can match the behavior, and the following intervention provides greater support and accountability.

II. ***Juveniles:*** ***As with adults, the Task Force strongly recommends the development and implementation of a plan for making problem solving approaches for juvenile AOD offenders more broadly available throughout the state.***

While the traditional juvenile justice system already functions in a manner resembling the problem-solving model when compared to the adult criminal justice system, critical additions or improvements must be made to increase success rates for juveniles with AOD problems. Specific recommendations include:

1. Explore giving Juvenile Drug Courts authority to require chemical dependency assessments for parents and to require AOD addicted parents to enter treatment, in order to better support the progress and recovery of the young person.
2. Provide treatment that is specifically tailored to juveniles based upon promising practices.
3. Utilize recovery schools as a resource for juveniles in problem solving courts, probation (when AOD problems have been identified), and the juvenile justice system generally.
4. Focus available resources on developing pilot family drug courts, including early assessment utilizing the one judge, one family model, and treating underlying family issues.

III. ***Methamphetamine:*** ***The most effective long-term judicial response to the current methamphetamine crisis is the same overall strategy being recommended by the Task Force for all AOD offenders: broader development of judicial problem solving approaches.***

Strategies for a broad judicial response to the problems caused by methamphetamine offenders should not be developed in isolation. They are a part of the recommended comprehensive response to the problems caused by all AOD addicted offenders. Focusing undue attention on methamphetamine (or any other single drug) hinders the development of an effective, rational long-term strategy which addresses the impact of all AOD addicted offenders on the criminal justice system.

IV. ***DWI Offenders:*** ***The most effective long-term judicial response to DWI offenders is the same overall strategy being recommended by the Task Force for all AOD offenders: broader development of judicial problem solving approaches.***

The Task Force believes that problem solving approaches, similar to those recommended in the National Highway and Traffic Safety Administration's "10 Promising Practices" compendium, are necessary to significantly address this seemingly intractable problem. In order for any DWI interventions to be effective, they must be collaborative, they must hold the offender accountable with swift and certain intervention, and they should minimize risks to public safety to the greatest degree possible. Like other AOD offenders, DWI offenders must be processed as quickly as possible.

V. ***Restorative Justice / Other Interventions:*** ***The Task Force recognizes that no one approach (such as drug courts, or any other single type of intervention) is appropriate for every AOD offender and every courthouse.***

Thus, the Task Force recommends that courts explore utilizing a continuum of interventions – including restorative justice, intensive supervision programs and staggered sentencing – that are proving to be effective with different groups of offenders.

VI. ***Funding and Resources:*** ***The Task Force recommends a multi-phased approach for funding widespread development of problem solving approaches for AOD addicted offenders.***

A. *Phase I: Initial Legislative Support to Lay the Critical Foundation for Broader Change:* *The Task Force recommends that the judiciary seek 2006 legislative funding for the following three items: training, a study of funding streams, and to pilot a multi-county problem solving court model.*

This phase would involve a relatively modest funding request – possibly in the range of $750,000 – for:

- Training for local and regional multidisciplinary teams on the problem solving approach for AOD offenders; and,
- A study of existing funding streams in order to recommend a more uniform and cost-effective structure for broader implementation of problem solving approaches for AOD offenders; and,
- Filling critical gaps in available treatment and other services for current problem solving courts, including services necessary to allow those courts to expand into pilot multi-county collaborative efforts.

B. *Phase II: Development of Key Elements of a Comprehensive Plan to Present to the Legislature in 2007, Based upon the Results of Phase I and Further Developments.*

This phase would build on the efforts of Phase I in order to take the development of problem solving approaches to the next level. It involves taking the findings and recommendations of the Phase I study and creating a comprehensive plan for funding more broad-based development of problem solving approaches. It would also involve integrating the findings from the Phase I multi-county pilot(s) to refine the multi-county model. Finally, the local and regional training of multidisciplinary teams will lay the groundwork for further expansion of problem solving approaches. The ultimate goal of Phase II will be to present a comprehensive, collaborative plan to the 2007 legislature for funding and broad-based development of problem solving approaches in Minnesota's courts.

Some specific options that might be considered for inclusion in the Phase II plan could be:

1. An expanded analysis of gaps in treatment and other services around the state that would inhibit broader development of problem solving approaches, especially multi-county efforts.
2. As in Phase I, seek funding to fill the identified gaps. Also as in Phase I, tie eligibility for these funds to implementation of multi-county efforts in order to develop the best and most cost-effective model(s).
3. Use funding sources to encourage other best practices, such as partnering with managed care entities to ensure adequate and consistent training and exploring potential requirements for AOD education for managed care personnel.
4. Explore the possibility of funding post-release treatment services, intensive supervision and drug testing as a follow-up to in-prison treatment.
5. Commission a state-level study to analyze the costs of renovating or building new jails in comparison to the potential reductions in need for jail space that could be realized through implementation of problem solving approaches. The goal of such a study would be to make alternative recommendations to counties that are currently looking into building a new jail or adding to an existing one.
6. Seek funding in the Judicial Branch budget to augment support at the State Court Administrator's Office for problem solving approaches, including the development of a statewide management information system (MIS) and evaluation, both outcome and cost benefit.
7. Additional local and multidisciplinary training, including advanced training in problem solving approaches, as well as training on effective marketing of problem solving approaches at the state and local level in order to support long term sustainability of local and regional efforts.
8. Create a comprehensive strategy for sustainability and funding of problem solving approaches, including multi-year funding plans at the state and local (county / district) court level.
9. Create a state level funding oversight / coordination committee.

C. *Phase III: Broad Implementation:* Implement the comprehensive plan developed in Phase II.

PART III: THE ADDICTION MODEL ADOPTED BY THE TASK FORCE

The Task Force determined that in order to carry out its charge effectively, it was necessary to identify an addiction model that would form the basis for its recommendations. Significant developments in understanding the biochemical nature of addiction have taken place in recent years. The consensus of the Task Force was that its recommendations regarding optimal judicial approaches for AOD addicted persons should align with the best current understanding of the nature of addiction and recovery.

Addiction as a Brain Disease

In 1998, Alan I. Leshner, then-Director of the National Institute on Drug Abuse (NIDA) at the National Institute of Health, wrote an article entitled "Addiction is a Brain Disease".[4] Dr. Leshner's article is widely acknowledged to be one of the most definitive statements from the scientific community regarding alcohol and other drug addiction, and a seminal work in the field. In reaching agreement on an addiction model, the Task Force considered similar written material summarizing the latest research in the field, as well as an oral presentation by a local expert.[5]

The Task Force concurs with the assessment of the National Institute on Drug Abuse that addiction is:

> [C]haracterized by compulsive, at times uncontrollable drug craving, seeking, and use that persist even in the face of extremely negative consequences. For many people, drug addiction becomes chronic, with relapses possible even after long periods of abstinence.[6]

The Task Force also concurs with Dr. Leshner's and NIDA's view on the issue of physical dependence as opposed to addiction, that the presence of withdrawal or tolerance are not critical factors to consider when assessing whether a person is addicted. According to Leshner, the distinction between physical and psychological addiction is misleading:

> From both clinical and policy perspectives, it actually does not matter very much what physical withdrawal symptoms occur. Physical dependence is not that important, because even the dramatic withdrawal symptoms of heroin and alcohol addiction can now be easily managed with appropriate medications. Even more important, many of the most dangerous and addicting drugs, including methamphetamine and crack cocaine, do not produce very severe physical dependence symptoms upon withdrawal. . . .What really matters most is whether or

[4] Alan I. Leshner, *Addiction is a Brain Disease*, Issues in Science and Technology Online, (2001), http//www.issues.org/17.3/leshner.htm.
[5] Carol Ackley, Director of River Ridge Treatment Center in Burnsville, Minnesota, presented to the Task Force on the Neurochemistry of Addiction on April 22, 2005.
[6] National Institute of Drug Abuse, Principles of Drug Addiction Treatment: A Research-Based Guide (1999) **available at** http://www.nida.nih.gov/PODAT/PODATindex.html

> not a drug causes what we now know to be the essence of addiction: uncontrollable, compulsive drug craving, seeking, and use, even in the face of negative health and social consequences.[7]-[8]

Under the brain disease model, people initially try drugs for a variety of reasons, and some are more affected than others. These people move on to addiction. Once addicted, the brain has been changed. The chronic drug seeking and using behavior is, for the most part, a function of addiction as a brain disease, like schizophrenia or depression.[9] According to Leshner and others:

> We now know in great detail the brain mechanisms through which drugs acutely modify mood, memory, perception, and emotional states. Using drugs repeatedly over time changes brain structure and function in fundamental and long-lasting ways that can persist long after the individual stops using them. Addiction comes about through an array of neuroadaptive changes and the laying down and strengthening of new memory connections in various circuits in the brain. We do not yet know all the relevant mechanisms, but the evidence suggests that those long lasting brain changes are responsible for the distortions of cognitive and emotional functioning that characterize addicts, particularly including the compulsion to use drugs that is the essence of addiction….Thus, the majority of the biomedical community now considers addiction, in its essence, to be a brain disease: a condition caused by persistent changes in brain structure and function.[10]

Environment, Personality, and Genetics

The Task Force is also persuaded that although environment does not in and of itself appear to cause addiction, it does appear to play a critical role in disease development, progression, and the chance for relapse when someone is learning how to manage the illness. It also appears to be an important predisposing factor for addiction for many people. The first precipitant for addiction is the actual use of the drug. A person may be predisposed genetically to become addicted but never use substances, or may use them so rarely that it does not trigger addiction. Research clearly shows that aside from the genetic component of familial addiction, simply being exposed to a family member's drug use on a regular basis, having access to the substances, and being subjected to the stresses caused by living in an addicted family systems all greatly increase the risk of early individual use.[11]

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[7] Leshner, *supra*, at 2.

[8] It is important, however, especially when dealing with narcotics, to distinguish between addiction and dependence, or between dependence and physiological dependence. (For example, a person who suffers from chronic pain can be physiologically dependent on a painkiller and experience withdrawal, but not be addicted.) A person can also show tolerance for the substance – needing increased amounts of the drug in order to get an effect. Additionally, although a drug may be highly addictive for one person, another may use it with little effect or compulsion to use it again. This can be due to a number of factors, including genetic vulnerability or predisposition to addiction.

[9] Interview with Dr. Richard Rawson, Associate Director, Integrated Substance Abuse Programs, UCLA Dept. of Psychiatry & Biobehavioral Sciences (November 10, 2004).

[10] Leshner, *supra* at 1-2.

[11] Two critical environmental factors in addiction appear to be cues and cravings. A frequent drug user generally uses in certain ways and develops rituals around their use. Those environmental cues, according to Leshner, "actually become 'conditioned' to that drug use and are thus critical to the development and expression of addiction." *Id.* at 4. When a person encounters these cues the brain responds and creates intense drug cravings that elicit anticipation of use of the

Addiction as a Chronic Illness

The Task Force also notes that addiction is a chronic illness. As such, it is generally characterized by the following:

- Symptoms tend to vary over time.
- Recovery requires ongoing health maintenance strategies in order to keep the disease in remission.
- Like other chronic illnesses (for example, hypertension, diabetes, and some forms of cancer), AOD addiction generally results from a combination of voluntary and involuntary factors. In other words, while addiction cannot develop without the first use of the substance, there are a number of factors, voluntary and involuntary, that determine whether a person will become addicted.
- Again like many other chronic illnesses, addiction is a relapsing illness. Due to its complicated nature and the significant behavioral aspects involved in its successful treatment, not every person stops using after their first treatment.
- Heritability – A multitude of studies have shown the genetic factor (heritability) in addiction.
- There can be considerable variance in how the disease manifests from one person to another.

Additionally, the Task Force notes that:

- There is a valid diagnosis for AOD addiction that has been proven reliable.
- Research shows that treatment for addiction is as effective, if not more effective, than treatment for heart disease and diabetes.[12]
- The Minnesota Department of Human Services published an exhaustive study in 2000 monitoring treatment outcomes from 1993-1999; the number one recommendation was to provide a continuum of care consistent with the expert consensus that chemical dependency is a chronic disease.[13]

The Latest Brain Research

In the past twenty years, research concerning the impact of alcohol and other drugs on the brain has grown exponentially. Scientists can now track changes in the brain thanks to Positron Emission Tomography (PET) scans. Since 1987, PET scans have opened up a new world to scientists

drug. For example, passing a frequented liquor store, visiting a neighborhood where one used to buy drugs, watching people smoke cocaine in a movie, watching an advertisement for one's favorite alcoholic beverage can all elicit intense cravings. In addition, simply returning to one's home from treatment (assuming the home is associated with drug use) can cause a person to experience intense drug cravings. These cravings play a critical role in an individual's relapse. Thus learning how to identify, respond to, and manage cravings appears to be fundamental to addiction treatment and recovery.

[12] A. Thomas McClellan . Drug dependence. A chronic medical illness. JAMA, 284, 1689-1695. (2000)

[13] Patricia Harrison ET AL. Minnesota Department of Human Services. The challenges and benefits of chemical dependency treatment: Results from Minnesota's treatment outcomes monitoring system, 1993-1999, 3-5, (2000).

examining the neurochemical dynamics of drug addiction. For a list of the most significant breakthroughs over the past two decades, see Appendix B.

The Role of Personal Responsibility

In adopting the brain disease model, the Task Force must also stress that this in no way diminishes the role of personal responsibility in addiction and recovery. As noted by Leshner:

> Does having a brain disease mean that people who are addicted no longer have any responsibility for their behavior or that they are simply victims of their own genetics and brain chemistry? Of course not. Addiction begins with the voluntary behavior of drug use, and although genetic characteristics may predispose individuals to be more or less susceptible to becoming addicted, genes do not doom one to become an addict. This is one major reason why efforts to prevent drug use are so vital to any comprehensive strategy to deal with the nation's drug problems. Initial drug use is a voluntary, and therefore preventable, behavior.
>
> Moreover, as with any illness, behavior becomes a critical part of recovery. At a minimum, one must comply with the treatment regimen, which is harder than it sounds. Treatment compliance is the biggest cause of relapses for all chronic illnesses, including asthma, diabetes, hypertension, and addiction. Moreover, treatment compliance rates are no worse for addiction than for these other illnesses, ranging from 30 to 50 percent. Thus for drug addiction as well as for other chronic illnesses, the individual's motivation and behavior are clearly important parts of success in treatment and recovery.[14]

Alcohol and Other Drugs and the Juvenile Brain

The Task Force also considered recent research on the impact of alcohol and other drugs on the juvenile brain.[15] That research appears to yield two major conclusions about the juvenile brain and the use of alcohol and other drugs. First, the human brain does not completely develop until a person's early twenties. Moreover, research indicates that the maturing brain is more vulnerable to the effects of alcohol compared to adults. This recent discovery makes clear that the earlier an individual uses, the more likely he or she is to develop AOD problems and cause irreparable damage to the brain.[16] Second, for various reasons, the line between addiction and misuse for a juvenile is not always clear. In other words, addiction is a much more difficult diagnosis for juveniles.[17] See Part IV.C for a fuller discussion of this issue and its implications for Minnesota's judicial approaches to juvenile AOD offenders.

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[14] Leshner, *supra* at 5.
[15] April 22, 2005 presentation of Carol Ackley, *supra*; August 26, 2005 presentation of Suzette Brann.
[16] L. Spear, The adolescent brain and college drinker: Biological basis of propensity to use and misuse alcohol, J*ournal of Studies on Alcohol*, *14*, 71-81.
[17] C. Martin and K.C. Winters, Diagnostic criteria for adolescent alcohol use disorders, Alcohol Health and Research World, 22, 95-106, 1998.

PART IV: TASK FORCE CONSIDERATIONS AND RECOMMENDATIONS

A. DEFINITIONS OF KEY TERMS AND CONCEPTS

1. ***Co-Morbidity/Co-occurring Disorders:*** Many who suffer from alcohol and other drug problems also have accompanying (co-occurring) mental health disorders that impact their ability to recover, for example, anxiety, depression, or bi-polar disorders. Treating coexisting AOD and mental health issues simultaneously is essential to long-term recovery.

2. ***Drug Courts:*** A problem-solving approach that uses the power of the court in collaboration with other participants (prosecutors, defense counsel, treatment providers, probation officers, law enforcement, educational and vocational experts, community leaders and others) to closely monitor the defendant's progress toward sobriety and recovery through ongoing treatment, frequent drug testing, regular mandatory check-in court appearances, and the use of a range of immediate sanctions and incentives to foster behavior change. It should be stressed that although in a drug court the traditional roles of participants are substantially modified, they are not relinquished. It is important to maintain the distinct roles of each drug court team member (in order, for example, to preserve the constitutional rights of problem solving program clients).

3. ***Family Drug Court:*** Many variations of the drug court model currently exist – adult, juvenile, DWI, family dependency, etc. However, the concept of a family drug court – in which all cases are consolidated for a family experiencing AOD problems – appears to be unique, does not currently exist in Minnesota, and is of great interest to the Task Force. In this model, the same judge is assigned all cases pertaining to the individual/family, and the problem solving model is used to address all of the cases and intervene in the AOD issues impacting each individual and the family as a whole.[18] A "family drug court" as described here is distinct from a "family dependency drug court". The latter is a specific type of drug court that is utilized in Child(ren) in Need of Protective Services (CHIPs) cases.

4. ***High vs. Low Risk Offenders:*** "Risk" in this context refers to the offender's risk of re-offending based on certain criteria, including age of onset of AOD use, involvement in previous drug treatment, presence of antisocial personality disorder, age of criminal onset, familial criminal involvement, and criminal associations. The level or seriousness of the criminal charge or offense does not determine whether an offender is high or low risk; for example, a felony-level offender can be low risk and a misdemeanant high risk.

[18] Development of the Family Drug Court model will be addressed more fully in the Task Force Final Report.

5. ***Problem Solving Approaches (a/k/a/ Collaborative Justice):*** Judicial approaches in which the offender is held accountable for his or her conduct and recovery with swift and certain interventions; intensive supervision is provided for high-risk offenders, including supervision by a concerned judicial officer who monitors and cares about the progress of each individual offender; essential treatment services are utilized, both chemical and mental health; effective collaboration exists between the essential participants – judge, prosecutor, defense counsel and probation / corrections, treatment providers, and others; other ancillary services are provided; and good, consistent assessment tools are used to identify the most appropriate strategies for each offender. As with Drug Courts (see 2 above), it is important to maintain the distinct roles of each problem solving approach team member.

6. ***Recovery Schools:*** High schools and college programs which, as components of the recovery continuum of care, enroll students who are committed to remaining abstinent from alcohol and other drugs and maintaining a program of recovery.

7. ***Re-entry Drug Courts:*** Post-release programs that use the drug court philosophy and approach; these courts provide a mechanism for the successful reintegration of the serious drug-using offender back into society.

8. ***Restorative Justice:*** A systemic response to wrongdoing that emphasizes healing the wounds of victims, offenders and communities that are caused or revealed by the criminal behavior. It is in contrast to retributive justice, which focuses primarily on punishing the offender.

9. ***Rule 25:*** A Minnesota administrative rule (promulgated by the Department of Human Services and found at Minn. Rules 9530.6600 - .6655) that sets forth the placement criteria for people with alcohol and other drug problems. Its goal and purpose is to align a comprehensive assessment of the individual's needs with an individualized package of services (as well as access to public funding for treatment, the Consolidated Chemical Dependency Treatment Fund, which is governed by a rule known as Rule 24 found at Minn. Rules 9530.6800 - .7031).

10. ***Staggered Sentencing:*** An innovative form of sentencing used for DWI offenders that includes a staggered incarceration period - often executing one-third of the sentence initially with the other two-thirds of the sentence left contingent upon the offender's progress, active participation in programming, home electronic alcohol monitoring (HEM) – and clearly articulated consequences for specific violations.

B. RECOMMENDATION FOR DEVELOPMENT OF PROBLEM SOLVING APPROACHES IN MINNESOTA'S COURTS

1. ***Problem:*** From 1999-2004, the number of felony drug cases filed in Minnesota courts increased from 5,035 to 8,474.[19] Methamphetamine cases accounted for 7% of all drug cases in 1999; by 2004 that figure rose to 39%.[20] The total number of methamphetamine cases in the state rose from 472 in 1999 to 3,948 in 2004.[21]

   Drug offenders present significant public safety issues for law enforcement officials. According to a United States Department of Justice report, officers attempting to take into custody a person under the influence of alcohol or other drugs may encounter some of the following problems: drug users are less likely to feel pain from pain compliance techniques; drug users are more likely to resist an officer and use violence to do so; and drug users are *twice* as likely to use a gun to resist the police.[22] The use of alcohol or other drugs is a major contributing factor in the occurrence of Sudden Custody Death Syndrome (SCDS), where the offender dies suddenly after a violent struggle with an officer.

   In 1990, drug offenders represented about 12% of new prison admissions in Minnesota; by 2003, they represented over 30%. Drug offenders occupied 9% of the state's prison space in 1990. By 2003, that figure rose to 25%.[23] Almost one-third of new drug offenders admitted to prison in Minnesota in 2003 were for fifth degree offenses (the lowest level of offense), many as a consequence of probation revocations.[24] In 2002, for the first time, drug offenders outnumbered other offenders going to prison. That trend continued in 2003. The biggest growth in offenders coming into prison, of all case types, has been methamphetamine offenders.[25]

   According to the Minnesota Department of Corrections, of the 8300 offenders currently in Minnesota prisons, 90% were diagnosed as chemically dependent or chemically abusive and were directed to complete chemical dependency treatment. Sixty percent of all offenders need primary treatment based on a chemical dependency diagnosis. Sixty-five percent of those referred for services never receive them.[26]

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[19] Minnesota State Court Administrator's Office (SCAO), Research and Evaluation Unit, 2005
[20] SCAO, *supra*
[21] SCAO, *supra*
[22] Geoffrey P. Alpert and Roger G. Dunham , Analysis of Police Use-of-Force Data, July 25, 2000, available at www.ncjrs.gov/pdffiles1/nij/grants/183648.pdf
[23] Anne Wall, Minnesota Sentencing Guidelines, presented to the Task Force on the Minnesota Sentencing Guidelines Report (2004) with updated data, July 22, 2005.
[24] According to Sentencing Guidelines (per Anne Wall's July 22 Testimony), for a fifth degree drug felon to go to prison requires a gun charge or a long criminal history. It is not necessary to have a long criminal history on a probation revocation.
[25] Anne Wall, Task Force Testimony, *supra*
[26] The Minnesota Department of Corrections reports that 1700 offenders receive treatment each year. Although it estimates a yearly need of 2170 treatment beds, it currently has only 800.

In general, relapse and recidivism rates are high for AOD offenders who are simply sent to prison. National data indicate that 30% of AOD offenders released from prison in 1998 were rearrested within six months, and 68% were rearrested within three years.[27] According to the Treatment Research Institute, 85% of people released from prison returned to AOD use within one year, and 95% returned to AOD use within three years.[28] Available Minnesota data on AOD offender recidivism generally appears to align with national trends.[29]

Research regarding treatment practice indicates that a treatment regime of ongoing judicial supervision, clinical care, and ongoing aftercare and supervision should last for a minimum of 90 days and optimally extend for 12 to 18 months. However, without such supervision (judicial and otherwise), approximately 70% of probationers and parolees drop out of treatment within 3 months; that number rises to 90% within 12 months.[30] Minnesota studies of treatment outcomes for offenders both incarcerated and on probation indicate treatment completion rates (defined as successful resolution of illness-related issues) that vary from 30 to 55%.[31]-[32] Additionally, current research shows that prisoners who receive treatment in prison but no follow-up transitional services in the community upon release are as likely to relapse and recidivate as prisoners who received no treatment at all.[33]-[34]

Data also indicate high rates of co-occurring mental health problems among Minnesota's prisoners. Twenty-five percent of the adult male Minnesota offender population and 40% of the adult female offender population are on psychiatric medications.[35] Therefore, services must take into consideration the needs of people with co-occurring mental health and alcohol and other drug problems. Lastly, service providers face the daunting challenge of meeting the specific needs of offenders in treatment while addressing the criminogenic factors, particularly gang involvement, that impact the individual's chances of establishing long-term sobriety.

In addition to recognizing the prevalence of co-occurring mental health issues with AOD addictions, the Task Force recognizes the importance of addressing the treatment needs specific to particular groups, such as different communities of color who are disproportionately over-represented in the criminal justice system but often under-

[27] West Huddleston, Director of National Drug Court Institute, presented to the Task Force on The Promise of Drug Courts, June 24, 2005.
[28] Dr. Doug Marlowe, Treatment Research Institute, presented to the Task Force on June 24, 2005 on Research Regarding Problem Solving Courts.
[29] It is difficult to say exactly how Minnesota data compares to national data, as Task Force staff was unable to identify comprehensive and reliable Minnesota recidivism data on drug offenders.
[30] Dr. Doug Marlowe, Task Force Testimony, *supra*
[31] The Task Force believes that use of problem solving approaches could increase these completion rates significantly.
[32] Robert Bakken and Martin Remus, Hennepin County Human Service and Public Health Department, Unpublished Monogrpahs 1995-2000
[33] Dr. Doug Marlowe, Task Force Testimony, *supra*
[34] Similarly, a 1997 report by the Minnesota Office of the Legislative Auditor (OLA) on recidivism reported that: "The recidivism rates of inmates who participated in programs usually were similar to the rates of inmates who did not."
[35] Minnesota Department of Corrections, DOC Facts Related to Substance Abuse, April 2005

represented in service provider organizations. The Task Force also notes current research demonstrating that female offenders achieve better outcomes when given evidence-based women-specific treatment that allows them to address gender-specific issues in a safe environment.[36] Current discussion in the field also questions whether the traditional model, commonly referred to as the male model, is actually the best approach for all men. The development of treatment protocols that more effectively take into account men's specific issues will help improve outcomes for men as well.

2. ***Recommendation:*** ***The Task Force strongly recommends the development and implementation of a plan for making problem solving approaches to AOD offenders more broadly available throughout the state.***[37]

   The first phase of the Task Force's work has yielded a clear consensus that traditional judicial approaches to AOD-addicted offenders have become increasingly unworkable, necessitating a fundamental shift in the judicial approach to such persons. At the same time, the Task Force has become convinced of the merits of problem-solving approaches. The essential elements of such approaches include:

   - Holding the offender accountable for his or her conduct and recovery with swift and certain interventions (including a continuum of sanctions while the offender is involved in the problem solving approach, and full criminal consequences for failing in the problem solving approach).
   - Intensive supervision for high-risk offenders. This includes supervision by a concerned judicial officer who monitors the progress of each individual offender.
   - Treatment services, both chemical and mental health, that adequately meet the individualized needs of the offender.
   - Effective collaboration between the essential participants in the problem solving approach – judge, prosecutor, defense counsel, probation / corrections, and treatment.[38]
   - Other ancillary services (for example, vocational education / training, parenting classes, housing).
   - Good, consistent assessment tools that identify the most appropriate strategies for each offender.
   - A continuum of interventions.

[36] The Task Force received written testimony from the Female Offender Task Force delineating the specific needs of women involved in the criminal or juvenile justice systems who have alcohol and other drug problems. Representatives from the Female Offender Task Force will be presenting to the Task Force in early 2006, and the Task Force Final Report will more fully address these issues.

[37] The Task Force understands that the state Judicial Council has indicated interest in identifying Chemical Dependency / Chemical Health as a strategic focus for the judiciary, and thus will likely be looking to the Task Force for ideas in this area, especially ideas for broad-based development. This recommendation is intended as a first step in that direction.

[38] At the local level, it is important for judges, prosecutors and defense counsel (along with other members of the problem solving team such as probation / corrections, law enforcement, and social services) to determine the eligibility criteria for participation in the problem solving approach – i.e., which specific offenses will be accepted and which will not. This is also a potential area where general guidelines could be developed at the state level.

Problem solving approaches have been demonstrated, locally and nationally, to have increased public safety by increasing the number of offenders achieving long-term recovery, significantly reduced costs to the criminal justice system as a whole, saved taxpayer dollars, and reduced recidivism among AOD addicted offenders. (See Part IV.G regarding Funding for Problem Solving Approaches.)

Recommending broad development of problem solving approaches for AOD offenders does not mean creating a drug or problem solving court in every jurisdiction. Rather, the Task Force recommends a broad shift in the way that courts deal with AOD offenders. Problem solving principles can be implemented without creating formal "drug courts". An essential element of any development plan would be training for judges and other participant groups (prosecutors, public and private defense counsel, treatment providers, probation officers, law enforcement and correctional personnel, educational and vocational experts, community leaders and others) in problem solving court principles. They must be equally committed to supporting the fundamental shift in approach entailed in the problem-solving model. Educating local policymakers, business leaders, and the general public is also vital to the success of problem-solving approaches. (See Part IV.G regarding Funding for Problem Solving Approaches.)

To support an effort of this scope, the Task Force also recommends the following:

A. Creation of a collaborative, state-level team made up of representatives from each of the major participant / stakeholder groups.
B. Creation of a multi-year plan, including:
- ***1) A Comprehensive Implementation Plan;***
- ***2) A Comprehensive Strategy for Sustainability and Funding.***

C. Collaboration among all affected groups, including:
- ***1) Regular meetings of local participant groups;***
- ***2) Regular trainings of local participant groups;***
- ***3) Development of Uniform Best Practices.***[39]

D. Designation of district and local level judicial leadership.

C. RECOMMENDATION FOR DEVELOPMENT OF PROBLEM SOLVING APPROACHES REGARDING JUVENILE AOD OFFENDERS

1. ***Problem:*** The Task Force is particularly concerned about juvenile use of and addiction to alcohol and other drugs, in light of the connection between AOD problems, juvenile justice system involvement and ongoing involvement in the adult criminal justice system, as well as the destructive impact of AOD use and addiction on the developing brain. A national expert, Suzette Brann, testified that the latest research shows a human brain does not fully develop until an individual's early twenties. The last, and most advanced, part of the brain to develop is the pre-frontal cortex, which is responsible for reasoning and

[39] Such best practices include: (1) Adoption of a consistent chemical dependency / drug court assessment tool and process to be used by all courts; (2) Adoption of a statewide evaluation methodology for AOD problem solving approaches; and (3) Creation of a statewide management information system (MIS) for such approaches.

planning.[40] When juveniles use drugs, especially alcohol, they run the risk of impeding this critical final stage of brain development.

The 2004 Minnesota Student Survey found that:

- 42.9% of ninth graders and 62.7% of twelfth graders had used alcohol at least once in the past year;
- 7% of ninth grade males and 5% of females and 28% of twelfth grade males and 15% of females admitted to binge drinking (defined as five or more drinks in a row on 10 occasions or more)[41];
- 17% of ninth graders and 26.9% of twelfth graders admitted to using marijuana at least once in the past year[42];
- 4% of ninth graders and 5% of twelfth graders admitted to using methamphetamine at least once in the past year[43];

Juvenile underage drinking is a concern for several reasons. First, it is an illegal drug for minors and a legal drug for adults. This leads to a much greater exposure to alcohol through media, public events, and in the home. Second, there is evidence that the younger a person starts drinking the greater their chance of developing an addiction to alcohol and/or other drugs. The National Institute of Alcoholism and Alcohol Abuse (NIAAA) states:

> People who begin drinking before age 15 are four times more likely to develop alcohol dependence at some time in their lives compared with those who have their first drink at age 20 or older. It is not clear whether starting to drink at an early age actually causes alcoholism or whether it simply indicates an existing vulnerability to alcohol use disorders.[44]

Third, children who come from alcoholic (or other drug addicted) homes have a much greater chance of developing an addiction problem and being involved in the juvenile justice system, *and* have much greater access to the substance(s) due to the familial addiction.[45]

Of the adolescents who undergo treatment nationwide, 50% drop out within six weeks and only 15% are still in recovery after a year.[46] Additionally, between 25% and 60% of those in treatment have mood disorders which require special clinical expertise and

[40] Suzette Brann, National Faculty for the National Council of Juvenile and Family Court Judges, presented to the Task Force on various topics related to juveniles on August 26, 2005.
[41] Minnesota Department of Education, Minnesota Student Survey, Fall 2004.
[42] Minnesota Department of Education, *supra*
[43] Minnesota Department of Education, *supra*
[44] National Institute of Alcoholism and Alcohol Abuse, Alcohol Alert, No. 59, p.2, April 2003.
[45] National Association for Children of Alcoholics, Children of Addicted Parents: Important Facts, November/December 2000.
[46] Suzette Brann, Task Force Testimony, *supra*

attention.[47] The period immediately following treatment is the time of greatest risk for relapse.[48] Those young people who leave treatment while still in school face the challenge of returning to the same environment and peers with whom they used and even the people from whom they bought drugs.[49] An added challenge faces young people who re-enter homes where an addicted parent continues to use alcohol and/or other drugs, further compromising the young person's recovery.

The Task Force is especially concerned about juveniles who become involved with the juvenile justice system at a young age and become further involved in the criminal justice system as adults. The results of the 2004 Minnesota Student Survey administered to young people in juvenile detention centers and correctional facilities are quite telling, especially as compared to the general student population. The statistics for binge drinking for this group were substantially higher than those of the general twelfth grade population – 32% of males and 37% of females (see above for general population data). The use of all other drugs was higher as well.[50] Perhaps most significant was that 48% of males and 53% of females in juvenile detention centers and correctional facilities admit having been treated for an alcohol and other drug problem, as opposed to 5% of all ninth-grade males, 3% of ninth grade females, 6% of twelfth grade males and 3% of twelfth grade females. [51]

In a survey of Minnesota prison inmates, a high percentage reported one or more out of home placements during childhood or adolescence. The highest percentage of out of home placements was reported by Native American prisoners (75%). Among other racial groups, the percentage reporting one or more placements ranged from 36% to 45%.[52] There also appears to be a link between family involvement in a child welfare case and one or more of the children later being charged as delinquent. The University of Minnesota published a recent study in which "preliminary data reveals that approximately 30% of youth ages 10-17 who were involved in a child welfare case that reached a permanency decision in 2002 became dual-system youth between 2002-2003."[53]

The percentage of delinquency cases in which the most serious charge is an alcohol or other drug offense is relatively low. In 2003, 3% of all delinquency petitions involved

[47] Suzette Brann, Task Force Testimony, *supra*

[48] Monique Bouregois, Association of Recovery Schools, presented to the Task Force on Recovery Schools on August 26, 2005.

[49] Putting a young person addicted to alcohol and other drugs back into the same school (or any other school that is not systematically set up to support the recovery of young people who have AOD problems) has been analogized to dropping an adult addicted to alcohol off at their favorite bar as soon as they are out of treatment.

[50] Minnesota Department of Education, *supra*

[51] Minnesota Department of Education, *supra*

[52] Council on Crime and Justice, A Survey of Minnesota Prison Inmates, *Risk and Protective Factors in Adolescence,* October 1994.

[53] Esther Wattenberg, Center for Advanced Studies in Child Welfare, Practice Notes #17: Double Jeopardy: Youth Involved in Dual Systems of Child Welfare and Juvenile Justice Mental Health Screening, September 2005. Note: The term "dual-system" in this context refers to children/adolescents who are involved in both the child protection and juvenile delinquency systems.

drug offenses and 21% were categorized as "other" – the most common of which were alcohol offenses.[54] However, as previously noted for adult criminal cases, because so many crimes are committed under the influence of alcohol and / or other drugs, the relatively small number of actual offenses charged as drug-related does not appear to accurately represent the degree to which offenses involve alcohol and other drug problems.

In a meta-analysis of sixty-six different studies of serious and violent juveniles, an Office of Juvenile Justice and Delinquency Prevention study group found that mental health issues, alcohol and other drug problems, and a past history of being a victim of violence were all common traits among these individuals.[55] A 2000 Minnesota study found that:

> Based on the patterns of use reported previously in this report, estimated need for treatment is likely to be even higher for juvenile offenders. Evidence suggests, however, that few juvenile justice jurisdictions provide appropriate treatment services. Nationally, it has been determined that less than 40 percent of public and private juvenile detention, correctional, and shelter facilities provide treatment. When treatment is provided, it is often limited to support groups, with gaps in the provision of comprehensive assessment and individualized treatment. Additionally, it is difficult to obtain treatment services for adolescents with co-occurring addictive and mental disorders. The importance of this barrier is underscored by evidence that adolescents with emotional problems are four times more likely to be dependent on alcohol or illicit drugs than other adolescents.[56]

These same findings were corroborated by expert testimony to the Task Force.[57] It is also not clear to what extent treatment for juveniles in Minnesota currently follows evidence-based practices.[58] Therefore, the Task Force sees a common thread of alcohol and other drug problems running from a child's first involvement in the child welfare system (to be further addressed in the Task Force's final report) to his or her eventual involvement in the adult criminal system.

2. ***Recommendation:*** ***As with adult offenders, the Task Force strongly recommends the development and implementation of a plan for making problem solving approaches for juvenile AOD offenders more broadly available throughout the state.*** While the traditional juvenile justice system already functions in a manner resembling the problem-

[54] Minnesota Supreme Court, Research and Evaluation Unit, Summary Information on Juvenile Delinquency Petitions in Minnesota Courts, March 2005.
[55] Rolf Loeber and David P. Farrington, Serious and Violent Juvenile Offenders, 1998.
[56] Council on Crime and Justice, "Responding to Juvenile Substance Abuse – Findings and Recommendations", September 2000.
[57] Suzette Brann, Task Force Testimony, *supra*
[58] Suzette Brann, Task Force Testimony, *supra*. The Task Force also heard from three Minnesota juvenile drug court judges who were unfamiliar with aspects of the best practices for juvenile treatment and questioned whether their participants were receiving those services.

solving model when compared to the adult criminal justice system, critical additions or improvements must be made to increase success rates for juveniles with AOD problems. The essential elements of juvenile problem solving approaches include:

A. Holding the offender accountable for his or her conduct and recovery with swift and certain interventions (including a continuum of sanctions while the offender is involved in the problem solving approach, and full juvenile consequences for failing in the problem solving approach).
B. Intensive supervision for high-risk offenders. This includes supervision by a concerned judicial officer who monitors the progress of each individual offender.
C. Effective collaboration between the essential participants in the problem solving approach – judge, prosecutor, defense counsel and probation/ corrections.[59]
D. Evidence based treatment services specifically for juveniles, both chemical and mental health, including:
    1. developmentally appropriate assessment tools;
    2. engagement strategies (ways of engaging not only the young person in the services and in their recovery but their family as well);
    3. consideration of the needs of the entire family;
    4. in addition to cognitive therapies and education, utilization of expressive and experiential therapies (therapies focused on music, art, drama, etc.).[60]
E. Other ancillary services (e.g. parent programs, recovery schools, tutors, vocational training, and mentors).
F. A continuum of interventions.

There are critical differences between adult and juvenile drug courts. Current drug court research shows that adult drug court participants under the age of 24 are significantly more likely to be re-arrested and charged with a new offense than those who are older – suggesting a need for different structures and services for juvenile offenders.[61] One of the distinctive needs of juveniles concerns the type of chemical dependency services they receive (as discussed above). National research shows that juveniles do not respond as well to traditional, adult-oriented treatment services, possibly due to the still-developing brain.[62] Another difference between a juvenile and adult drug court concerns the degree of leverage that a court has to keep the young person engaged. The potential punishment many adults in drug court are facing is quite severe – up to a year in jail or a year or more in prison. For many juveniles the consequences are not as severe. Sanctions and incentives (key components of a drug court) are also extremely limited for juvenile petty

[59] At the local level, it is important for judges, prosecutors and defense counsel (along with other members of the problem solving team such as probation / corrections, law enforcement, and social services) to determine the eligibility criteria for participation in the problem solving approach – i.e., which specific offenses will be accepted and which will not. This is also a potential area where general guidelines could be developed at the state level.
[60] Suzette Brann, Task Force Testimony, *supra*
[61] Suzette Brann, Task Force Testimony, *supra*
[62] Current research on brain development is much more extensive and reliable than research on the impact of AOD on the brain, which is still quite new.

alcohol offenses.[63] A final concern expressed in the testimony of several juvenile drug court judges relates to the lack of control that the courts and the juvenile justice system have over parents who are addicted to alcohol and other drugs who continue to use while their child is in recovery. While some juvenile drug courts have implemented parent programs to support the parents in dealing with their young person's addiction, it is unclear whether they have any authority to force parents into treatment even when their continued use of alcohol and other drugs is clearly impacting the young person's success in the program.[64]

In light of the above, the Task Force makes the following additional recommendations:

A. Focus attention and available resources on juvenile intervention as a means to reduce future adult participation in the criminal justice system.

B. Explore ways to give juvenile drug courts authority to require chemical dependency assessments for parents and to require AOD addicted parents to enter treatment in order to better support the progress and recovery of the young person. Also explore development of family drug courts to be utilized when any family member is addicted. (See Part IV.A.3 for a definition of Family Drug Court.)[65] See Recommendation F below.

C. Provide treatment that is specifically tailored to juveniles based upon promising practices, which may include parental or guardian participation.

D. Treatment should include services to address co-occurring disorders (the co-occurrence of AOD and mental health problems).

E. Utilize recovery schools[66] as a resource for juveniles in problem solving courts, probation (when AOD problems have been identified), and the juvenile justice system generally.

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[63] The court can impose outpatient treatment for the first or second offense. See Minn. Stat. § 260.235, subds. 4(d) and 5 (2004). Inpatient treatment does not become an option until the third offense. See id., subd. 6. But treatment can be difficult to impose because at that point, the juvenile becomes entitled to counsel, and if the juvenile entered uncounseled guilty pleas on the first two offenses, he or she has the right to withdraw those pleas. See Minn. R. Juv. Del. P. 3.02, subd. 3.

[64] It is worth noting that as an alternative, Minn. Stat. § 260B.335 allows the county attorney to file a petition with the court to establish civil jurisdiction over an individual who contributes to the delinquency of a minor. Once the petition is filed, there must be a hearing to determine whether jurisdiction is appropriate. If so, the court can order any number of things listed in subdivision 3 of the statute, including requiring the person to "participate in evaluation or services determined necessary by the court to correct the conditions that contributed to the child's delinquency." In addition, Minn. Stat. § 260B.425 allows the county attorney to file criminal charges for contributing to the delinquency of a minor, and all of the usual punishments and treatment requirements could follow from a conviction for that offense. Finally, it is possible that a court could acquire jurisdiction over a parent through a Child(ren) in Need of Protective Services (CHIPs) petition under Minn. Stat. Chap. 260C.

[65] Development of the Family Drug Court model will be more fully addressed in the Task Force Final Report.

[66] High schools and college programs which, as components of the recovery continuum of care, enroll students who are committed to remaining abstinent from alcohol and other drugs and to maintaining a program of recovery. For more

F. Focus available resources on developing pilot family drug courts (not to be confused with a family dependency drug court – see the definition of Family Drug Court in Part IV.A.3), including early assessment utilizing the one judge, one family model and treating underlying family issues. Explore moving beyond the model of separate adult, juvenile, and family dependency problem solving courts.[67]

G. Explore removing non-diverted underage drinking from the fine payables list and instead requiring a chemical health screening/assessment and a court appearance and/or a fine for underage drinking offenses.[68]

D. RECOMMENDATIONS REGARDING METHAMPHETAMINE CASES

1. ***Problem:*** Due to the growing concern about methamphetamine offenses in Minnesota, the Task Force felt it important to specifically address this growing problem, while emphasizing that this drug is more like than unlike the other drugs of addiction. Like many other drugs, methamphetamine is a neurotoxin. According to Carol Falkowski of the Hazelden Institute, "it not only affects the release and reuptake of certain brain chemicals (mostly dopamine), but also damages the neural tissue within the brain, the effects of which can be long lasting".[69]-[70]-[71]

   Recent expert testimony before the Task Force on the impact of chronic methamphetamine use indicates that some signs of adult brain healing are being shown within two years of abstinence.[72] However, the neuroscience regarding methamphetamine (and other drugs) continues to evolve; definitive conclusions are not yet available.

   The estimated annual public cost to Minnesota from methamphetamine was $140 million in 2004.[73] To put that in perspective: the estimated annual public cost of alcohol use in

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information please see: http://www.recoveryschools.org/. Minnesota is a leader in this area, with the first recovery high schools in the country. Currently there are thirteen recovery high schools across the state and one college-based recovery school (at Augsburg College).

[67] This issue and recommendation will be addressed more fully in the Task Force Final Report.

[68] This recommendation is not intended to restrict or eliminate, for example, a prosecutor's ability to divert underage drinking cases where appropriate.

[69] Carol Falkowski, Methamphetamine Across America: Misconceptions, Realities, and Solutions Spectrum, The Journal of State Government, November 2004, p. 30.

[70] P.M. Thompson et al., Structural Abnormalities in the Brains of Human Subjects Who Use Methamphetamine, The Journal of Neuroscience, 24, 26, June 2004, pp. 6028-6036.

[71] It is important with methamphetamine, as with all other drugs, to distinguish between its impact on juveniles and its impact on adults. The science for both populations regarding methamphetamine is new; however, it is imperative to identify when one is talking about the science referring to one population and not assume that the same is true for the other. This is also true for men and women, people of color, etc.

[72] Dr. Timothy Condon, Deputy Director of the National Institute on Drug Abuse (NIDA), presented to the Task Force on Methamphetamine Addiction, Treatment, and Recovery on October 28, 2005.

[73] More specifically, the itemized fiscal impacts are as follows: Corrections- $42.6m, Prosecution - $14.8m, Public Defense – $10 m, Law Enforcement - $39.3m, Environment - $3.5m, Treatment - $14.1m, Child Welfare - $15.7m. Figures provided by the Minnesota Department of Public Safety.

Minnesota alone is $4.5 billion.[74] Following are statewide numbers of methamphetamine criminal case filings over the last five years.

FILINGS – METHAMPHETAMINE STATEWIDE – 1999-2004

Category (Level) of Offense						
	1999	2000	2001	2002	2003	2004
Manufacture	104	179	281	484	662	513
First Degree	43	163	267	387	315	339
2nd Degree	30	120	204	275	299	279
3rd Degree	22	65	104	188	153	207
4th Degree	17	41	90	109	116	116
5th Degree	256	585	870	1,464	1,985	2,492
Unknown	0	1	2	4	5	2
Total	472	1,154	1,818	2,911	3,535	3,948

Female methamphetamine use demands special attention. Methamphetamine is the only drug whose use by women equals or exceeds that of men.[75] Many young women, and older women as well, are finding themselves attracted to methamphetamine not only because it brings about rapid weight loss, but also because it enables them to get more done. For example, single mothers who feel the burden of having to work and raise children by themselves get a temporary support from meth. Many more women are also finding their way into court due to their meth addiction, their affiliation with men who manufacture the drug, or their own manufacturing. Many of these women are also becoming involved in the child welfare system.[76] Criminal filings against women for methamphetamine in every category below have at least doubled and often nearly tripled since 2000[77]:

METHAMPHETAMINE FILINGS (WOMEN)

	Manufacture	First Degree	Second Degree	Third Degree	Fourth Degree	Fifth Degree
2000	32	32	24	12	8	156
2003	79	96	51	25	22	428

Research supports women-specific methamphetamine treatment in general as having better results than mixed-gender treatment.[78]

[74] Minnesota Department of Health, The Human and Economic Cost of Alcohol Use in Minnesota, January 2004.
[75] Dr. Timothy Condon, Task Force Testimony, *supra*
[76] M. Hohman at al., Methamphetamine Abuse and Manufacture: "The Child Welfare Response", Social Work. 2004 July: 49(3):373-81.
[77] Data provided by the Minnesota State Court Administrator's Officet, Research and Evaluation Unit
[78] Patricia A Harrison et al., Minnesota Department of Human Services, "The Challenges and Benefits of Chemical Dependency Treatment: Results from Minnesota's Treatment Outcomes Monitoring System 1993-1999", October 2000, p. 53.

Methamphetamine use also uniquely impacts public safety. It adversely impacts the communities where it is manufactured or used. Serious health dangers exist for those who live in residences where meth is made, both adults and children (who are found in a significant percentage of labs that are busted and are seriously endangered due to their still developing immune and other systems). The toxicity of the chemicals being dumped into the ground, lakes and rivers, or into sewers is an added environmental risk. Homes, motel rooms, and trailer homes used to make meth have to be properly cleaned or they can cause serious health problems to the unsuspecting future residents long after the manufacturing residents have vacated the property. Often the damage done to the property is so severe the building must be destroyed. Cleanup costs are covered by the offender or the property owner, irrespective of their knowledge of the illegal activities.

Those working on the front lines in the fight against this drug, especially law enforcement officials, face great dangers in dealing with methamphetamine offenders. They face individuals who can be very violent while in a state of psychosis and very difficult to subdue. According to a U.S. Department of Justice research report:

> Individuals addicted to methamphetamine often are unpredictable, frightened, and confused; they will commit violent crimes to obtain the drug; particularly during the "tweaking" stage of abuse. Methamphetamine abusers often are paranoid and delusional and frequently arm themselves against perceived threats, particularly from law enforcement officers. The effects of methamphetamine have caused many abusers to assault or kill others, including family members and friends.[79]

A particularly vulnerable time for methamphetamine users is the stage of use known as "tweaking". Tweaking is the time after the euphoric effects of the drug diminish for the user and they are more prone to violence, delusions, paranoia, and feelings of emptiness and dysphoria. During this time many individuals are not sleeping, which further exacerbates the aforementioned side effects. Additionally, these individuals (again due to increased tendencies for violence, especially for those in a meth-induced psychosis) are disproportionately involved in domestic violence, assaults, and other offenses.

A final area of concern, especially for law enforcement and public health officials, is the possibility of exposure to a methamphetamine lab. The chemicals used to make meth are dangerous and volatile. Their toxicity can endanger law enforcement personnel when "busting" a meth lab if they do not take proper precautions. According to a recent report, over 50% of officers encountering a meth lab reported experiencing symptoms of skin and lung irritation, burning eyes and throat, and other symptoms.[80] Labs that explode are often due to the inexperience of meth manufacturers working with these highly volatile chemicals. Sometimes, due to their paranoia, meth users may also "booby trap" their labs. The majority

[79] Department of Justice, Methamphetamine: Colorado Drug Threat Assessment, May 2003 can be found at www.usdoj.gov/ndic/pubs4/4300/meth.htm

[80] John W. Martyny and Shawn L. Arbuckle, Chemical Exposures Associated with Clandestine Methamphetamine Laboratories, 2001 can be found at www.nationaljewish.org/pdf/chemical_exposures.pdf

of meth labs are probably not discovered due to the lack of resources available to drug task forces and law enforcement for investigating possible and even probable sites.

METH LAB SEIZURES IN MINNESOTA [81]-[82]

	1998	1999	2000	2001	2002	2003	2004
MDH		18	43	53	216	497	320
DEA	35	102	123	154	242	301	96

Minnesota's initial response to meth has been swift and effective, as exemplified by the numerous public health ordinances and county meth task forces throughout the state. Since recent legislation was enacted to restrict access to precursor chemicals, there has already been a dramatic decrease in the number of meth labs being seized.[83] However, law enforcement officials estimate that up to 80% of the methamphetamine in Minnesota is not made in the state. Much of the meth coming into Minnesota originates in Mexico and is distributed here by various gangs. Therefore, as in other states that have passed similar legislation, while the number of labs may decrease the actual amount of methamphetamine in the state will very likely increase.[84]

2. ***Recommendation:*** ***The most effective long-term judicial response to the current methamphetamine crisis is the same overall strategy being recommended by the Task Force for all AOD offenders – i.e., broader development of judicial problem solving approaches.***

   The Task Force takes very seriously the growing concern in the state regarding methamphetamine. Nevertheless, it unanimously agrees that the judiciary's response to this crisis must be grounded in the best available evidence and research. The Task Force felt it imperative that accurate and evidence-based information regarding methamphetamine drive its response. Therefore, it will initially address several myths regarding methamphetamine as determined by recent Task Force testimony and the latest scientific research.

   Myth 1: Methamphetamine addiction is not treatable.

   Fact: The chemical dependency field has been treating methamphetamine addiction successfully for over thirty years. Although certain modalities are being empirically shown to be more effective than others, the research is clear: traditional treatment is effective for methamphetamine addiction.

[81] This information was provided by the Department of Health (MDH) and taken from the Drug Enforcement Agency (DEA) website: http://www.usdoj.gov/dea/pubs/states/minnesota.html

[82] Please note: These numbers reflect the labs reported to the MN Dept. of Health (MDH) and the Drug Enforcement Agency (DEA) by each of the counties. The reports are not required, so these figures could be low. Discrepancies in the numbers between the two groups can be attributed to DOH's increased effort to get accurate data in the past two years.

[83] Agent Terri VandeGriff, testimony presented to the Task Force on October 28th 2005.

[84] Agent Terri VandeGriff, Task Force Testimony, *supra*.

Myth 2: Methamphetamine addiction requires a specific treatment.

Fact: While there is evidence that certain treatment regimens work best for methamphetamine, they do not seem to differ greatly from those evidence-based practices that work best for the treatment of all addictive drugs. The fundamental principles of addiction and its treatment are the same. The components of the scientifically valid and rigorously tested treatment model for methamphetamine, the Matrix Model developed in California, are all part of evidence-based practices for standard chemical dependency treatment.[85]

Myth 3: Methamphetamine addicts only use meth.

Fact: While many people in treatment in Minnesota may list methamphetamine as their primary drug of choice, few, if any, use only methamphetamine.

Myth 4: Methamphetamine is instantly addicting

Fact: While methamphetamine is highly addictive, its purity, and therefore addictive potential, differs depending on many variables. There is no scientific evidence to show that methamphetamine is "instantly addicting". However, the onset of addiction for this drug can be quite rapid.

Myth 5: Methamphetamine addiction requires four to six months of detoxification.

Fact: People addicted to methamphetamine, especially chronic users, can go on extended binges where they do not sleep for days or even weeks. People addicted to methamphetamine can also suffer from meth-induced psychosis. While these people must first be attended to in the most basic of ways – sleep, diet, exercise – this period of detoxification lasts, on average, anywhere from *two days to two weeks*. While certain cases may take longer, they appear to be the exception rather than the rule.

Myth 6: All methamphetamine treatment must be residential.

Fact: There is one simple rule for determining the treatment needs of a methamphetamine addict (or a person addicted to any other drug): ongoing assessment must drive the clinical diagnosis and ongoing clinical services. There is no "one size fits all" rule for the treatment needs of people with alcohol and other drug problems. For

[85] However, it is important to remember that models developed for adult males do not work for pregnant women and mothers. These programs need to be adapted for the special needs of pregnant women, mothers, and even fathers. They need to address issues such as transportation, child care, women's health, and reproductive health. Treatment for this population needs to work towards keeping women and men connected to, rather than avoiding, the health care system (e.g., getting prenatal care).

example, the Matrix Model[86], the treatment modality currently hailed as the best practice for treating meth addiction, is based upon an outpatient model.

Myth 7: All people addicted to methamphetamine need longer treatment.

Fact: Not necessarily: assessment must drive decisions regarding treatment duration. For any drug, the longer the treatment, the greater the chance of successful remission. The length of necessary treatment is contingent on clinical assessment.

Myth 8: People rarely recover from methamphetamine addiction.

Fact: The recovery rate from methamphetamine addiction, 40% to 60%, is comparable to the recovery rates for other drug addictions. People have been recovering from methamphetamine addiction for over 30 years, and there are many in long-term recovery in Minnesota.

Myth 9: The majority of methamphetamine used in Minnesota is being manufactured here.

Fact: As indicated previously, only about 20% of the methamphetamine in Minnesota is manufactured here, largely by people who are making the drug to support their own addiction. The balance is being manufactured in "superlabs" in Mexico (and some in California, Colorado, and other southwestern states).

Myth 10: The impact of methamphetamine on the brain is irreparable.

Fact: As previously stated, the brain has significant capacity to protect itself. There is scientific evidence indicating that "relearning" in the brain after chronic methamphetamine use is possible through brain synapse connections rerouting prior learned functions to other areas of the brain. Some, if not all, of the meth effects on the brain appear to reverse with abstinence over time (again, the science is very new). However, brain recovery and the resulting cognitive and emotional recovery generally take months, not days. In addition, research is beginning to show that dopamine production will also regenerate after approximately one year of abstinence.

Myth 11: Pregnant women who use methamphetamine are causing irreparable harm to their unborn child(ren).

Fact: Scientific results are not clear regarding this issue. The best answer is that not enough is known at this time to make any definitive statements about the impact of prenatal exposure to methamphetamine.

[86] The Matrix Model is an evidence-based treatment program for methamphetamine (and other stimulant) users endorsed by the National Institute of Drug Abuse (NIDA). It is the most studied and empirically validated treatment program for methamphetamine that currently exists. While the Matrix Model is recognized as an outpatient model, there are those individuals who need additional services (such as a halfway house) to augment their treatment.

Myth 12: Babies can be born addicted to methamphetamine.

Fact: There is no scientific evidence to support the term "meth baby" or "ice baby" or to imply that a baby can be born addicted. Based on the definition of addiction, it is impossible for a baby to be born addicted.[87]

Based upon the above information and its intention that its recommendations regarding AOD offenders be comprehensive in scope, the Task Force offers the following additional recommendations:

A. Strategies for a broad judicial response to the problems caused by methamphetamine offenders should not be developed in isolation but rather as part of a comprehensive response to the problems caused by all AOD offenders. Focusing undue attention on methamphetamine (or any other single drug) hinders the development of an effective, rational, long-term strategy to address the impact of all AOD offenders on the criminal justice system.

B. The methamphetamine epidemic is serious and should not be taken lightly, but fear, overreaction, or unscientific-based information should not drive the judicial response.

C. The eligibility criteria for public treatment should be expanded. Access to treatment is critical, particularly for addiction to methamphetamine.

D. Interventions for people with AOD problems, including methamphetamine, should begin while the person is in jail or prison and continue through transition back into the community.

E. RECOMMENDATIONS REGARDING DWI OFFENDERS

The Task Force is particularly concerned about DWI offenders for several reasons: (1) DWIs represent the greatest number of AOD-related criminal offenses in the state; (2) there is a high rate of recidivism for this crime; and (3) this offense raises significant public safety concerns.

1. ***Problem:*** A 1999 report by the Minnesota Department of Public Safety showed Minnesota's overall alcohol use to be considerably higher than the national average.[88] In 2004, there were 6,789 liquor establishments (and an additional 5,000 establishments allowed to sell 3.2% alcohol) in Minnesota that brought in a total of over $2 billion of revenue. By comparison, the estimated annual public costs of alcohol use in Minnesota

[87] David C. Lewis, Physicians, Scientists to Media: Stop Using the Term "Crack Baby", Press Release, February 27 2004

[88] Minnesota Department of Public Safety, Creating a Safer Minnesota Byrne Advisory Committee Report, December 1999

are $4.5 billion.[89] The current alcohol tax in Minnesota brings in about $200 million annually.[90]

Without question, the AOD offenders who are the most frequent, most lethal, and most difficult of the chronic recidivists to change are driving while intoxicated (DWI) offenders. Over 33,000 DWI arrests occur every year in Minnesota[91], and approximately 40% of those are repeat offenders.[92] Statistically, about 60% of first time offenders do not re-offend. In turn, 50% of second time offenders do not re-offend. This pattern appears to continue at least through fourth- or fifth-time offenders. DWIs are as common in rural areas as they are in urban areas; most of the DWI fatalities occur in rural areas. There are approximately 225 alcohol-related[93] fatalities per year in Minnesota, and 73% of those occur on rural roads.[94] The Department of Public Safety estimated the 2002 economic impact of deaths, injuries, and property damage from DWIs in Minnesota to be $344,237,400.[95] There are over 427,849 Minnesota residents with DWIs on their record – about one in every nine licensed drivers.[96] In 2003, there were 32,266 DWI incidents and 26,210 convictions – 6,000 convictions were second time violators; 2,737 were third time violators; and 2,562 were fourth time violators.[97]

Not everyone who commits a DWI offense is chemically dependent; however, people who are chemically dependent commit the majority of DWI offenses. Sixty-five percent of alcohol-related fatalities involve first time offenders.[98] Research suggests that a person arrested a second time for DWI has a 70% probability of being chemically dependent.[99] In a recent study, based on initial court-ordered screening, 16.8% of offenders were diagnosed with alcohol abuse and 20.1% with alcohol dependence. At a 5-year follow-up interview, 19.9% and 60.1%, respectively, received a retrospective diagnosis of alcohol abuse or dependence at the age at which they were initially screened.[100] These "false negative" initial assessments occur because the assessment process is primarily based on self-reporting with some collateral input (i.e., input from a source other than the person being screened). Another factor contributing to false negative assessments is that an offender's blood alcohol concentration test and driving record are not available to

[89] Minnesota Department of Health, The Human and Economic Cost of Alcohol Use in Minnesota, January 2004.
[90] A complete report on the liquor tax collected in Minnesota can be found at: http://www.taxes.state.mn.us/taxes/special/alcoholic/publications/alcohol_report.pdf
[91] According to the Minnesota Department of Public Safety's Office of Traffic Safety, the average over the five years from 2000-2004 was 33,639 per year.
[92] Steve Simon, Task Force Testimony, *supra*
[93] The term "alcohol-related" is used because not all of those deaths where it is believed alcohol played a role were attributable to 'DWI'. For example, sometimes it is a pedestrian who was drunk, and not the driver. There are several such cases each year. Also, if any driver, pedestrian, or bicyclist had any alcohol in his or her system, the crash is defined as alcohol-related.
[94] Steve Simon, Task Force Testimony, *supra*
[95] Minnesota Department of Public Safety, Minnesota Motor Vehicle Impaired Driving Facts 2003, December 2004
[96] Minnesota Department of Public Safety, *supra*
[97] Minnesota Department of Public Safety, *supra*
[98] Steve Simon, Task Force Testimony, *supra*
[99] Small, J., DWI Intervention: Reaching the Problem Drinker, Alcohol Health and Research World, 7(1), 21-23, 1982.
[100] Sandra C. Lapham et al., Accuracy of alcohol diagnosis among DWI offenders referred for screening, Drug and Alcohol Dependence, 76, 2, November 2004.

independent assessors who are not part of the court system. Such assessors therefore do not have access to the offender's court records and police files. Recent DWI legislation, passed in the 2005 session, has begun to address this significant issue.

The Task Force also spent considerable time discussing the unintended consequences of driver license suspension and reinstatement fees. The primary concern is the high cost ($680) that a DWI offender must pay in order to have his or her license reinstated. The Task Force heard anecdotal testimony that this fee creates great difficulty for those who seek to follow the law, pay the penalty, and have their license reinstated. The fee also appears to have little impact, by itself, on the recidivism of offenders. This sanction also appears to particularly impact offenders from lower socioeconomic strata. (For example, having a driver's license, especially in a rural area, can determine whether or not a person is able to get and keep a job.) The Task Force also heard anecdotal testimony that many local entities (e.g. courts, prosecutors) are creating a variety of idiosyncratic solutions in an attempt to circumvent this obstacle.[101] The current license reinstatement fee appears to represent a significant, or even insuperable, obstacle for many of the working poor, who make up a significant percentage of DWI offenders.

The challenge, then, is to identify effective interventions that prevent recidivism, accurately assess AOD dependency, and are cost-effective. Two recent studies of repeat DWI offenders came to similar conclusions: (1) Jail alone is not an effective deterrent (although repeat offenders recognized that their drinking was a problem, at the time they decided to drive they believed they could drink and drive safely); and (2) Drivers license suspension did not influence whether or not they drove.[102] After examining common traditional sanctions throughout the country (licensing sanctions, vehicle sanctions, and mandatory sentencing), the National Highway Traffic and Safety Administration (NHTSA) concluded:

> Due to the ever-increasing cost of incarceration, the alcoholic tendencies exhibited by most repeat DWI offenders, and the high recidivism rates for these offenders who have received traditional legal sanctions only, some courts have begun to use alternative sanctions….[T]he studies done to date indicate these alternative sanctions appear to be promising in reducing the recidivism rates for repeat DWI offenders.[103]

Therefore, the Task Force believes that problem solving approaches, similar to those recommended in NHTSA's "10 Promising Practices" compendium, are necessary to significantly address this seemingly intractable problem.

[101]The Task Force also understands that license reinstatement fees have become a revenue source to pay for, e.g., traumatic brain injury caused by DWI-related automobile accidents, and intoxilizer tests. Thus this appears to be an area ripe for reconsideration and reassessment at a policy level in order to determine whether the current fee best balances the competing policy interests at stake.

[102] National Highway Traffic and Safety Administration, Strategies for Addressing the DWI Offender: 10 Promising Sentencing Practices, pp. 5-6, March 2005

[103] National Highway Traffic and Safety Administration, Strategies for Addressing the DWI Offender: 10 Promising Sentencing Practices, p. 8, March 2005.

2. ***<u>Recommendations:</u>*** ***The Task Force believes that in order for any interventions with DWI offenders to be effective, they must be collaborative and hold the offender accountable with swift and certain intervention, minimizing the risk to public safety to the greatest degree possible.***

   A. Like other AOD offenders, DWI offenders must be processed as quickly as possible.

   B. Courts should increase focus, resources, sentencing and monitoring on 2nd time offenders because of the high probability of their being chemically dependent.

   C. All DWI offenders should be required to pay for their chemical use assessment unless they qualify for public assistance.

   D. If an offender is not following his or her sentencing requirements, sanctions must be imposed swiftly.

   E. Prosecution practices for DWI cases should be more uniform and centralized.

   F. All Pre Sentence Investigations should include a thorough records check and determine the offender's compliance with previous sentences.

   G. DWI offenders need to be assessed immediately after arrest and, if warranted, begin treatment as quickly as possible, but no more than 30 days post-evaluation.

   H. All assessments should involve collateral information such as police reports, blood alcohol concentration, and, if available, input from family members, employers, etc. Assessments that do not include this information should not be considered valid.

   I. Training should be provided for all criminal justice system stakeholders on staggered sentencing, DWI sentencing circles, and DWI drug courts. (See parts IV.B, IV.F and IV.G regarding problem solving approaches, restorative justice, and funding of problem solving approaches.)

F. RECOMMENDATIONS REGARDING RESTORATIVE JUSTICE AND OTHER INTERVENTIONS FOR AOD OFFENDERS

1. ***Problem:*** The Task Force recognizes the tendency for policymakers and the general public to look for a single solution to a problem, even one as complex as that of AOD offenders. In the 1970s and early 1980's, an unprecedented amount of resources went to provide treatment for people with alcohol and other drug problems. The late 1980s and 1990s then saw unprecedented levels of prosecution and imprisonment of people with AOD problems. As is often the case in public policy, the pendulum seemed to swing between extremes. One solution was primarily a public health response; the other implicated the criminal justice system. It now seems safe to say, based upon volumes of research, that

neither of those solutions – when put into operation without consideration of other possible solutions – have adequately solved the problem. Some offenders simply must be imprisoned. Others are suitable for alternative interventions.

Because public safety is a primary goal of the criminal justice system, a question the Task Force has asked throughout its work is: To what extent are current approaches to AOD offenders providing exemplary, or even acceptable, public safety protections? The Task Force is convinced that incarcerating AOD addicted offenders fails to preserve public safety if the addiction that landed offenders in jail or prison is not effectively addressed. Eventually, the addicted offender is released; often they commit another crime. Sometimes they have become more adept criminals. The risk to public safety from recidivism is perhaps of greatest concern when it comes to the DWI offender, but it is true of all addicted offenders.

The Task Force's work has yielded a recognition that AOD offenders as a group present the courts with a wide range of challenges and needs. No one approach, such as drug courts, is appropriate for every offender. Thus the Task Force explored a number of other innovative judicial interventions currently employed around the state.

2. ***Recommendation:*** The Task Force envisions multiple interventions on a theoretical continuum (see Appendix H):

- AOD treatment and recovery support services;
- AOD treatment and recovery support services with community support/supervision (restorative justice interventions – sentencing circles, panels, etc.);
- AOD treatment and ancillary services with probationary services (monitoring);
- Intensive-supervised probation with AOD treatment and ancillary services;
- Drug court;
- Jail with treatment and post-release services for a definite period of time; and
- Prison with treatment and post-release services for a definite period of time.

Although all of the aforementioned interventions are currently being utilized across the state in various ways, they are not being employed in a consistent, systematic or *systemic* way that intentionally takes into consideration collaborative, offender-based interventions within the context of the theoretical continuum.

The Task Force explored three types of approaches in particular – restorative justice, intensive supervision programs and staggered sentencing – that are proving to be effective with different groups of offenders.

Restorative Justice[104]

The Task Force is interested in how restorative practices might be used to work with AOD addicted offenders either as stand alone projects or as an adjunct to current problem-solving efforts such as drug courts.

See Appendix F for a specific description of the philosophy and practice of Restorative Justice.

Strong similarities exist between the recovery process for AOD problems and restorative justice practices. In both, there is a strong emphasis on recognizing harms to others and taking responsibility; understanding the impact of one's behavior on others; breaking through the defense of denial; and the need to make amends for harms caused.[105] Many offenders who come into restorative programs are AOD offenders. The challenges for restorative programs are to provide training for working effectively with these individuals and supporting them in their recovery, and to insure that programs include the necessary entities, such as treatment providers, an AA sponsor, church member, etc.

Drug court professionals, staff at the State Court Administrator's Office, and restorative justice professionals have created a statewide steering committee to explore integrating restorative philosophies into the drug court process. Restorative Justice philosophy can be easily woven into drug courts and other problem solving approaches. That integration makes possible several things: 1) emphasis and attention on the victims of crimes committed by the drug court participant; 2) greater participation by the community; and 3) better ways for the participant to transition back into the community. Additionally, as this model evolves it could make possible significant resource savings as the community becomes a more active participant in the drug court process. The flow chart in Appendix I shows the common progression through drug court for a program participant, together with examples which indicate where restorative justice practices could be incorporated at each point in the process.

Intensive Supervision Programs and Staggered Sentencing

Intensive supervision programs (ISP's), although they vary from county to county, have some elements in common: electronic home monitoring, intensive treatment services, ongoing attendance at mutual support groups (like Alcoholics Anonymous), immediate consequences for violating terms of the sentence, and intensive field supervision. To date in Minnesota, such programs have been created primarily for alcohol-related offenders.[106]

[104] Minnesota has long been a leader in restorative justice practices. While anecdotal evidence and smaller local evaluations show restorative justice practices to be effective and a promising practice, currently no extensive or systematic evaluation data are available.

[105] Kay Pranis, National Trainer/Facilitator for Peacemaking Circles and Restorative Justice Philosophy, presented to the Task Force on the Philosophy of Restorative Justice and an Overview of Restorative Justice Programs in Minnesota, on July 22, 2005.

[106] Examples of current ISP's in Minnesota for alcohol-related offenders are programs in Anoka and Dakota counties.

Staggered Sentencing is another proven, low-cost, judge-driven program devised by Minnesota District Judge James Dehn (a rural judge who sits in several counties in the Tenth Judicial District) to reduce recidivism by repeat DWI offenders. This program has been used by judges in Minnesota for several years, has received critical review from many nationally recognized entities, and was codified in statute in Minnesota in 2003 (see Appendix G).

Based on the above, the Task Force makes the following specific recommendations:

1. ***Especially for appropriate low risk AOD offenders, courts should consider Restorative Justice practices, combined with AOD treatment, as an alternative to traditional sentencing.***
2. ***Support training for Restorative Justice professionals on AOD issues and problem-solving courts.***
3. ***Provide training on Restorative Justice for judicial problem-solving teams.***
4. ***For courts that do not have the resources to create a DWI court, staggered sentencing or other intensive supervision programs should be considered as an effective way to deal with DWI offenders.***
5. ***Encourage operational drug courts to explore how they might incorporate Restorative Justice practices and / or staggered sentencing into their programs.***

G. RECOMMENDATIONS FOR FUNDING OF PROBLEM SOLVING APPROACHES IN MINNESOTA'S COURTS

The Task Force has recommended the creation of a comprehensive plan for broader availability of judicial problem solving approaches in AOD cases. See Parts IV.B and IV.C. The development of a workable funding structure is essential to the success of any such effort. The following funding recommendations attempt to:

- Take into account the resources required both to effectively address the spectrum of needs presented by different groups of AOD offenders and to protect public safety; and
- Identify the best ways to integrate the various existing and potential sources of funding; and
- Encourage all affected entities, at both local and state levels, to consider whether latent or actual conflicts exist and, if so, the extent to which they impair optimal collective stewardship of public resources.

1. ***Problem:*** Judicial problem solving approaches for AOD addicted offenders must involve multidisciplinary approaches. Success hinges upon the ability of the different participant groups to effectively collaborate as a problem solving team. The primary participant groups in a problem solving approach include the judges and other court personnel such as problem-solving program coordinators; prosecutors; defense counsel; probation; treatment and social services; and law enforcement. A second circle of affected entities, although not often directly represented on a problem solving team, is critically important to the long-term success of any problem solving approach at the local level. It includes county board members, city council members, local business leaders,

community leaders, and the general public. While a program can achieve short-term success without the support of these policymakers and community members, its chances of long-term institutionalization and sustainability are at risk without it. Those groups most affected by AOD offenses and offenders must be integrally involved in the planning and ongoing operations of any problem solving approach if it is to achieve long-term success in the community. For many courts, this will also require a significant change in relationships with their local communities.

The success of any problem solving approach also hinges on each participant group having sufficient resources to implement the essential elements of the program:

A. The offender is held accountable for his or her conduct and recovery with swift and certain interventions (including a continuum of sanctions while involved in the problem solving approach, and full criminal consequences for failing in the problem solving approach).
B. High-risk offenders receive intensive supervision. This includes ongoing supervision by probation / corrections and by a concerned judicial officer who monitors the progress of each individual offender.
C. Effective collaboration exists between the essential participants in the problem solving approach – judge, prosecutor, defense counsel, probation and treatment.
D. Treatment services, both chemical and mental health, are provided that adequately meet the individualized needs of the offender.
E. Other ancillary services are provided (e.g., vocational education, parenting classes, and housing).
F. Good, consistent assessment tools are used that identify the most appropriate strategies for each offender.
G. A continuum of interventions is available and employed.

If any participant group lacks sufficient resources to sustain its share of the burden, the effectiveness and success of the problem solving approach will be compromised.

Following are specific problem areas identified by the Task Force:

A. Overlapping Funding. One of the current obstacles to broader development of judicial problem solving approaches is overlapping funding. One result of the multidisciplinary nature of this approach is that different funding streams and systems support the different stakeholder groups. This is not surprising given that problem solving approaches are a relatively recent innovation, and most of the funding systems in place were not created with a view to supporting this type of multidisciplinary intervention.

The existence of such overlap tends to result in a funding structure that is overly complex, fragmented, and inefficient; this situation is further compounded by poor coordination and communication between the different systems.

B. Continued Funding of Ineffective Interventions. Traditionally, AOD addicted offenders have either been given some form of treatment or have been incarcerated, which may include some form of prison-based treatment. Numerous studies support the conclusion that alcohol and other drug problems can be effectively treated. Also, incarceration is appropriate and effective for a certain segment of this population. However, the emerging body of research indicates that these alternatives by themselves are largely ineffective in reducing recidivism and supporting addiction recovery among the majority of AOD offenders.

Nevertheless, the vast majority of public funding currently being spent on AOD offenders in Minnesota is being channeled into one of those two interventions. Significant public funding is being spent to incarcerate AOD addicted offenders, at a cost of approximately $30,000 per person annually. The cost of incarcerating drug offenders in prison, not counting local jail costs, was projected to be nearly $45 million in 2004 and over $463 million between 2004 and 2012.[107] Also, substantial public dollars are being spent on various forms of in-prison treatment for such offenders.

Between these two alternatives lies a spectrum of problem solving approaches. They promise to integrate treatment with accountability and ongoing supervision, avoid the expense of incarceration for AOD offenders, and reduce recidivism. Many other states have invested in these problem solving approaches as an alternative to providing more treatment or to incarcerating addicted offenders. However, Minnesota presently spends limited state funds on problem solving approaches.

C. Funding and Cooperation. Although collaboration is becoming more common in Minnesota, the framework of different funding streams and systems has yet to harmonize with the model of problem-solving approaches. While there is encouraging precedent for agencies to work with other agencies or branches of government to coordinate use of resources (financial or otherwise), much more could be done, particularly between the judiciary and agencies in other branches. This challenge is not unique to Minnesota; its origins can be partially traced to restrictions on federal funding.[108] Other origins for this problem are systemic – each branch of government and each agency has traditionally been funded and managed separately, and this is necessary and appropriate for most of their work. However, problems occur when agencies are addressing overlapping issues and working with the same populations.

Another obstacle to an effective funding system for judicial problem solving approaches is a tendency to guard closely all allocated resources. Currently, every involved entity in a problem solving team has its own budget, and generally receives

[107] These figures are taken from the 2004 report to the Legislature by the Minnesota Sentencing Guidelines Commission concerning sentencing of drug offenders.
[108] On the flip side, several states – e.g., Louisiana, Ohio, Missouri and North Carolina – have used federal funding in creative ways to support innovative problem solving approaches.

its own allotment of federal, state and local dollars. Each entity has also invested its planning and resources in funding its own mission, without regard to the goals of other agencies. Unfortunately, agencies eventually become entrenched, and become indifferent as to whether they are cost-effective from a broader perspective.

D. Resources for Chemical Dependency Assessment, Treatment and Ancillary Services. See Appendix E for a more detailed discussion and information on treatment funding in Minnesota.

AOD offenders can have difficulty obtaining chemical use assessments for several reasons. In most cases, they must travel to an off-site appointment, which requires initiative on their part. People with AOD addictions who are not in recovery sometimes have, as part of their disorder, difficulty recognizing and responding to the seriousness of their addiction. This "denial" makes delays and waiting periods especially problematic for those who require chemical dependency treatment. Prompt access to AOD treatment is imperative for AOD addicted offenders involved in a problem-solving program. Thus the success of judicial problem solving approaches hinges on prompt access to chemical use assessments and treatment services.[109]

The wide variation from county to county in the provision of treatment services raises a related concern. Specifically, the Task Force observes that counties cannot or will not engage in reciprocal agreements to honor assessments and provide treatment for offenders who are arrested outside of their county of residence.[110] The absence of such reciprocity can create a costly delay in receiving assessment and referral to treatment during the critical window of opportunity immediately following the offender's arrest and initial court appearance.

E. Resistance to "Front-Loading". "Front-loading" refers to the investment of significant criminal justice resources early in the offender's involvement with the system. Problem solving approaches provide a greater initial investment of resources in order to achieve a substantial savings at a later time. Such savings have now been reliably demonstrated in a number of other states. In simplest terms, if a significant percentage of AOD offenders cycle repeatedly through the system with multiple treatment episodes, multiple court cases, and multiple incarcerations, an enormous amount of public resources are being spent on these offenders over time.

By contrast, problem solving approaches, such as drug courts, have demonstrated that by investing in more intensive supervision, treatment and ancillary services from the beginning, it is possible to interrupt that cycle and thereby save substantial public

[109]The same statements would appear to apply to any post-release "re-entry" programs that adopt a problem-solving type model (e.g., re-entry drug courts).

[110] The Task Force intends to make more definitive recommendations on these issues after the Office of the Legislative Auditor (OLA) issues its report on Substance Abuse Treatment in Minnesota in early 2006.

dollars over time.[111] This can also reduce AOD-related crime in general and thus result in fewer crime victims.

Current decision making about funding of criminal justice system efforts tends to discourage such early commitment of resources.

2. ***Recommendation:*** ***The Task Force recommends a multi-phased approach to funding of problem solving approaches in Minnesota (see below).***

All involved participant groups must have adequate resources to be able to insure the successful implementation of a problem-solving approach. If any participant group is inadequately staffed to be able to participate effectively, the success of the whole problem solving court effort is compromised.

The recommended problem solving approaches for the Judicial Branch and its criminal and juvenile justice partners will initially require additional resources at the local and state level if they are to be successfully developed and implemented. However, the systemic paradigm shift being proposed for dealing with AOD addicted offenders[112] does not require significant new funding. Instead, there must be a willingness to reallocate and redistribute resources at both the local and state levels in the short term in order to realize a significant cost savings in the long term. The overarching philosophy behind this proposed shift is that we need to take a longer view, and spend smarter, not more.[113]-[114]

In order to successfully implement judicial problem solving approaches on a broader scale, decision-making entities will need to do so with an understanding of how their partner entities are also funding these efforts. To facilitate this process, regular discussions will be needed among criminal justice partners about how best to use available funding and how various funding streams might work together when possible.

[111] Compare, for example, the cost of one year of treatment to one year of prison. For the cost of every person incarcerated for a year, the criminal justice system could provide substantial services for five to six people in the community and successfully intervene in the AOD addiction that is the underlying cause of the criminal behavior.

[112] This is a shift that many other states have already made or at least begun. See, e.g., "California's Collaborative Justice Courts: Building a Problem-Solving Judiciary", Judicial Council of California (2005) (a study reflecting "the commitment by courts in California and across the country to institutionalize problem-solving, or collaborative justice, courts" (from Foreword)).

[113] Numerous studies have shown the cost-effectiveness of problem solving approaches. To cite two examples: (1) A 2003 study of New York drug courts by the Center for Court Innovation determined that the reconviction rate for 2,135 defendants who participated in six of the state's drug courts was, on average, 29 percent lower over three years than the rate for the same types of offenders who did not enter the drug court. Also, based on this study, the New York State Court System estimates that $254 million in incarceration costs were saved by diverting 18,000 non-violent drug offenders into drug courts. (2) A 2002 joint study by the Judicial Council of California & California Department of Alcohol & Drug Programs determined that California's investment of $14 million in drug courts created a total cost avoidance of $43.3 million over a two-year period. This included a total of 425,014 jail days avoided, with an averted cost of approximately $26 million.

[114] Additionally, many courts across the country have developed more effective relationships with their local communities and have come up with creative strategies (e.g., creating non-profit 501(c)3 organizations) to support the financial stability of their problem solving efforts.

The following specific recommendations derive from a recognition that the particular challenges posed by AOD addicted offenders are most effectively addressed through integrated funding of the various systems that impact these individuals' lives.

A Multi-Phased Approach

The Task Force recommends a multi-phased approach to funding of problem solving approaches in Minnesota.

Phase I will involve:

1. training for local and regional multidisciplinary teams on the problem solving approach to AOD offenders; and
2. a study of existing funding streams in order to recommend a more uniform and cost-effective funding structure for broader implementation of problem solving approaches for AOD offenders;[115] and
3. filling critical gaps in available treatment and other services for current problem solving courts, including services necessary to allow those courts to expand into pilot multi-county collaborative efforts.

This phase would involve a relatively modest funding request, possibly in the range of $750,000. The Task Force recommends that the judiciary seek 2006 legislative funding for this Phase I request.

This Phase I plan will need to take into account the resource and funding needs of the other participant entities, including but not limited to county attorneys, public defenders, probation, law enforcement, human/social services, whose participation is essential to the success of any judicial problem solving program.

Development of multi-county collaborative problem solving courts is critical in order to demonstrate a more cost-effective model for broader implementation of problem solving approaches. The Phase I funding would be used in part to develop the multi-county model by tying eligibility for the available funds to a commitment to implement a multi-county pilot, as well as engage in the training identified in (1) above. A first step in

[115] A related aim of this study would be to identify (a) current funding obstacles to broader implementation of problem solving approaches; and (b) strategies to remove those obstacles. An example of such an obstacle might be the problems and delays created when a drug court in one county attempts to get assessment and treatment for a drug court participant who resides in another county (the latter county being the entity responsible for providing the assessment and treatment), especially where no reciprocity agreement exists between the two counties to provide for such situations.

Given the critical importance of getting AOD offenders into treatment as quickly as possible, one logical best practice would be to insure that any problem solving court client, in any county, be presumptively eligible for an assessment by the county handling the case. Further, any funding source -- host county, Health Maintenance Organization or other 3rd party payor - will honor the assessment within 48 hours provided that the assessment is done by a county registered and designated assessor and that the clinical recommendations meet the test for treatment eligibility.

implementing this recommendation would be to determine the extent to which treatment and other service gaps exist among current problem solving courts.

Phase II would build on the efforts of Phase I in order to take the development of problem solving approaches to the next stage. This would involve examination of the findings and recommendations of the Phase I funding study, and the consequent creation of a comprehensive plan for funding more broad-based development of problem solving approaches. It would also involve gleaning what is learned from the multi-county pilot(s) in Phase I to refine the multi-county model. Finally, the local and regional training of multidisciplinary teams in (1) above will help to lay the groundwork for further expansion of problem solving approaches. The ultimate goal of Phase II will be to present a comprehensive plan to the legislature in 2007 for funding and broad-based development of problem solving approaches in Minnesota's courts.

This comprehensive Phase II plan will need to take into account the resource and funding needs of the other participant entities involved in problem solving approaches. Participation of those entities will be critical in developing the plan. Some specific options that might be considered for inclusion in the Phase II plan could be:

1. An expanded analysis of gaps in treatment and other problem-solving program services around the state that would inhibit broader development of problem solving approaches.
2. Seek funding to fill the gaps identified by the analysis in (1). Also as in Phase I, tie eligibility for these funds to implementation of multi-county efforts in order to encourage development of the best and most cost-effective model(s).
3. Use funding sources to provide incentives for other best practices, such as partnering with managed care entities to ensure adequate and consistent training of treatment providers and exploring potential requirements for AOD education for managed care personnel.
4. Explore the possibility of funding post-release treatment services, intensive supervision and drug testing as a follow-up to in-prison treatment.
5. Commission a state-level study to analyze the costs of renovating or building new jails as opposed to the potential reductions in need for jail space that could be realized through broader implementation of problem solving approaches. The goal of such a study would be to make recommendations to counties that are currently looking into building a new jail or adding on to an existing one concerning the possible cost benefits of pursuing problem solving approaches as an alternative.[116]
6. Seek funding in the Judicial Branch budget to augment support at the State Court Administrator's Office for problem solving approaches, including the development of a statewide management information system (MIS) and evaluation, both outcome and cost benefit.

[116] On March 7, 2005, Minnesota Public Radio reported that close to 36 Minnesota counties are planning to either renovate existing jails or build new ones. Blue Earth was one such county that hired an independent consultant who advised the county to explore building an addition to its county jail and start a drug court rather than simply build a new jail.

7. Provide additional local and multidisciplinary training, including, for example, advanced training in problem solving approaches, and training on effective marketing of problem solving approaches.
8. Create a comprehensive strategy for sustainability and funding of problem solving approaches, including multi-year funding plans at the state and local court level.[117]
9. Create a state level funding oversight and coordination committee.

Phase III would involve implementation of the comprehensive plan developed in Phase II.

RATIONALE

The Task Force is recommending a multi-year plan which transforms Minnesota's courts. A unique window of opportunity now exists to lay the foundation for that process. Task Force discussions indicate that there is broad support across all three branches of state government to take significant initiative in this area, and without delay. As one member put it, "the stars are aligned" to take decisive action which addresses this pervasive and growing problem in Minnesota. The requested Phase I funding will be used to lay the essential groundwork for subsequent broad-based development. By delaying another year, the current window of opportunity for a concerted and collaborative multi-branch effort may pass.

There appears to be bipartisan legislative support for judicial innovations in this area, and particularly for development of problem solving approaches to address the problem of AOD offenders. The 2005 legislature appropriated $500,000 to the judiciary to develop or expand problem solving courts such as drug courts and mental health courts. In October, district courts in the state were invited to apply for use of those funds; in response, the State Court Administrator's Office received fifteen requests totaling over $1.9 million.

Any broad change initially meets with some resistance among affected stakeholders; this effort will likely be no different. Thus, the Task Force advocates a broad, multidisciplinary training effort as a critical first step in this new direction. Implementation will also involve tension between the need to adhere to the evidence-based model and principles of effective problem solving courts, and the need to creatively and flexibly adapt to the varying circumstances of local courts around the state. Nevertheless, the Task Force is convinced that implementation of these recommendations will increase public safety, significantly reduce costs to the criminal justice system as a whole, save taxpayer dollars, and improve life outcomes and thereby reduce recidivism among AOD-addicted offenders.

[117]Other states have been creative in planning for funding of problem solving approaches. For example, Louisiana has created a formula that establishes an adequate per capita rate for treatment services for drug court participants that is utilized consistently for drug courts throughout the state.

PART V: CONCLUSION

For the past eight months, the Task Force has intensively explored one of the most challenging issues facing the Minnesota criminal and juvenile justice system. Its work has yielded a recognition that alcohol and other drug (AOD) addicted offenders present Minnesota's courts with a significant and growing challenge, but also an extraordinary opportunity. Minnesota's courts are in a unique position to draw upon the existing resources in the state (including Minnesota's legacy as a national leader in the field of chemical dependency), together with the lessons learned from development of problem solving courts in other states, to take the lead in creating a more effective judicial response to that challenge. To be effective, however, Minnesota's judicial response will require successful, ongoing collaboration and cooperation between the courts and all other participant groups at both the state and local level.

PART VI: ACKNOWLEDGMENTS

The members of the Minnesota Supreme Court Chemical Dependency Task Force wish to thank everyone who has assisted in the Task Force's work to date. The Task Force wishes to express special gratitude to:

- Those individuals who made presentations to the Task Force, including:
  - Carol Ackley, Director, River Ridge Treatment Center;
  - Don Eubanks, Director, Chemical Health Division, Minnesota Department of Human Services
  - Jeffrey Hunsberger, Principal Planner, Chemical Health Division, Minnesota Department of Human Services
  - Gary Olson, Director, Center for Alcohol and Drug Treatment
  - C. West Huddleston, Director, National Drug Court Institute
  - Dr. Doug Marlowe, Senior Researcher and Director, Law and Ethics Division, Treatment Research Institute
  - Julius Lang, Center for Court Innovation
  - Barb Klein, Drug Court Graduate, Stearns County Drug Court
  - Jennifer Rinde, Drug Court Graduate, Stearns County Drug Court
  - Anne Wall, Minnesota Sentencing Guidelines Commission
  - Kristin Lail, Office of Justice Programs, Minnesota Department of Public Safety
  - Dr. Cheryl Hosley, Wilder Foundation Research
  - Kay Pranis, National Trainer/Facilitator for Peacemaking Circles and Restorative Justice Philosophy
  - Suzette Brann, National Faculty, President, Unlimited Horizons
  - The Honorable Edward Lynch, District Court Judge, First Judicial District
  - The Honorable Robert Rancourt, District Court Judge, Tenth Judicial District
  - The Honorable John Van de North, District Court Judge, Second Judicial District
  - Monique Bourgeois, Vice Chair, Minnesota Association of Recovery Schools
  - The Honorable James Dehn, District Court Judge, Tenth Judicial District
  - Terry Anfinson, Director, Anishinabe OIC
  - Pat Kittridge, Assistant Public Defender, Ramsey County
  - Steve Simon, University of Minnesota Law School, Chair, DWI Task Force
  - Sheila Nesbitt**,** Prevention Specialist, Minnesota Institute of Public Health
  - Dr. Timothy Condon, Deputy Director, National Institute on Drug Abuse
  - Dr. Barry Lester, Director, Center for the Study of Children at Risk and Infant Development Center, Brown University

- Those Non-Task Force members who attended meetings and contributed greatly to the work of the Task Force, including:
  - Andy Gildea, Committee Administrator, House Judiciary Finance Committee;
  - Andrea Sternberg, Legislative Assistant to Sen. Jane Ranum;

- Jeff Hunsberger, Chemical Health Division, Minnesota Department of Human Services
- Joel Alter, Office of the Legislative Auditor
- Terry VanDeGriff, Minnesota Bureau of Criminal Apprehension;
- Jean Ryan, Office of Traffic Safety, Department of Public Safety
- Carol Falkowski, Hazelden Foundation
- Valerie Bombach, Office of the Legislative Auditor

- The many professionals from a variety of disciplines who currently participate in judicial problem solving approaches in Minnesota such as adult, juvenile, family dependency and DWI drug courts, mental health courts, restorative justice, staggered sentencing, and DWI Intensive Supervision Programs. Their work in pioneering these innovative approaches in the state over the past ten years has laid the groundwork for transforming how Minnesota's courts deal with AOD addicted offenders.

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PART VIII: APPENDICES

APPENDIX A

Order Establishing the Minnesota Supreme Court Chemical Dependency Task Force

Amended Order

STATE OF MINNESOTA

IN SUPREME COURT

ADM-05-8002

ORDER ESTABLISHING THE MINNESOTA SUPREME COURT CHEMICAL DEPENDENCY TASK FORCE

WHEREAS, persons who suffer from alcohol and other drug (AOD) addiction and dependency represent a pervasive and growing challenge for Minnesota's judicial branch, and in particular its criminal justice system;

WHEREAS, the problem and impact of AOD dependency is not confined to any one case type or group of case types, but pervades all case types in the judicial branch;

WHEREAS, in recent years alternative and demonstrably more effective judicial approaches for dealing with AOD-dependent persons, and particularly criminal offenders, have evolved both in Minnesota and other states;

WHEREAS, increasing resources exist at both the state and national level to support the development of such alternative approaches;

WHEREAS, Minnesota courts would benefit from a more deliberate and coordinated effort to investigate the current extent of the problem of AOD-dependent persons who come in to the courts, and to assess available strategies and approaches for addressing that problem;

WHEREAS, on November 30, 2004, the Conference of Chief Judges unanimously voted to recommend that this Court establish a task force charged with exploring the problem of chemical dependency and identifying potential approaches and resources for addressing that problem.

NOW, THEREFORE, IT IS HEREBY ORDERED that the Minnesota Supreme Court Chemical Dependency Task Force is established.

IT IS FURTHER ORDERED that the Task Force shall**:**

4. Conduct background research on specific issues concerning AOD-dependent persons, and particularly AOD-related offenders, including:

    e. The current extent of the problem of AOD-dependent persons, and particularly AOD offenders, in the Minnesota judicial branch;
    f. The cost(s) of the problem and benefit(s) of proposed solutions;
    g. Identification and assessment of current judicial strategies to address the problem of AOD-dependent persons, and particularly AOD offenders, both in Minnesota and other states;
    h. Determination of the current and potential effectiveness of drug courts and other alternative approaches in Minnesota.

5. Conduct an inventory of current multi-agency, state-level AOD efforts in Minnesota as well as in other states, including:

    c. Identification of promising practices;
    d. Identification of gaps and redundancies.

6. Identify and recommend approaches, solutions, and opportunities for collaboration.

IT IS FURTHER ORDERED that the Task Force shall submit two (2) reports to the Supreme Court, which will include the results of its research and its recommendations for optimal development of alternative judicial approaches for dealing with AOD-dependent persons who come in to the Minnesota judicial branch. An initial report focusing specifically on AOD-related criminal and juvenile offenders shall be submitted by January 1, 2006; and a Final Report focusing on the overall impact of AOD dependency across all case types shall be submitted by September 30, 2006.

IT IS FURTHER ORDERED that the Honorable Joanne Smith is appointed Task Force Chair; and the Honorable Gary Schurrer is appointed Task Force Vice Chair.

IT IS FURTHER ORDERED that the following persons are appointed as members of the Task Force:

Honorable Joanne Smith, Ramsey County, Chair
Honorable Gary Schurrer, Washington County, Vice-Chair
Jim Backstrom, Dakota County Attorney
Lynda Boudreau, Deputy Commissioner, Minnesota Department of Human Services
Chris Bray, Assistant Commissioner, Minnesota Department of Corrections
Mary Ellison, Deputy Commissioner, Minnesota Department of Public Safety
Jim Frank, Sheriff, Washington County
John Harrington, Chief, St. Paul Police
Pat Hass, Director, Pine County Health and Human Services
Brian Jones, Assistant District Administrator, First Judicial District
Fred LaFleur, Director, Hennepin County Community Corrections
Honorable Gary Larson, Hennepin County
Bob Olander, Human Services Area Manager, Hennepin County
Shane Price, Director, African American Men's Project
Honorable Robert Rancourt, Chisago County
Senator Jane Ranum, Minnesota Senate
Commissioner Terry Sluss, Crow Wing County
Representative Steve Smith, Minnesota House of Representatives
John Stuart, State Public Defender
Kathy Swanson, Director, Office of Traffic Safety, Minnesota Dept. of Public Safety
Honorable Paul Widick, Stearns County

Associate Justice Helen Meyer (Supreme Court Liaison)

IT IS FURTHER ORDERED that Task Force vacancies shall be filled by Order of this Court.

IT IS FURTHER ORDERED that staff for the Task Force shall be provided by the Court Services Division of the State Court Administrator's Office.

DATE: March 16, 2005

BY THE COURT:

/S/
Kathleen A. Blatz
Chief Justice

STATE OF MINNESOTA

IN SUPREME COURT

ADM-05-8002

AMENDED ORDER ESTABLISHING THE MINNESOTA SUPREME COURT CHEMICAL DEPENDENCY TASK FORCE

On March 16, 2005 this Court issued an Order establishing the Minnesota Supreme Court Chemical Dependency Task Force to:

1. Conduct background research on specific issues concerning Alcohol and Other Drug (AOD)-dependent persons, and particularly AOD-related offenders, including:

   i. The current extent of the problem of AOD-dependent persons, and particularly AOD offenders, in the Minnesota judicial branch;
   j. The cost(s) of the problem and benefit(s) of proposed solutions;
   k. Identification and assessment of current judicial strategies to address the problem of AOD-dependent persons, and particularly AOD offenders, both in Minnesota and other states;
   l. Determination of the current and potential effectiveness of drug courts and other alternative approaches in Minnesota.

2. Conduct an inventory of current multi-agency, state-level AOD efforts in Minnesota as well as in other states, including:

   e. Identification of promising practices;
   f. Identification of gaps and redundancies.

3. Identify and recommend approaches, solutions, and opportunities for collaboration.

NOW, IT IS HEREBY ORDERED that:

1. The membership of the Chemical Dependency Task Force is amended to include Wes Kooistra, Assistant Commissioner for Chemical and Mental Health Services, Minnesota Department of Human Services.
2. The membership of the Chemical Dependency Task Force is amended to provide that Lynda Boudreau continue on the Task Force in her new capacity as Deputy Commissioner of the Minnesota Department of Health.
3. The membership of the Chemical Dependency Task Force is amended to remove Fred LaFleur, Director of Hennepin County Community Corrections, pursuant to his request to withdraw from the Task Force.
4. The Task Force reporting schedule and reporting structure are amended to provide that the Task Force shall submit two (2) reports to both the Supreme Court and the Judicial Council, which will include the results of its research and its recommendations for optimal development of alternative judicial approaches for dealing with AOD-dependent persons who come in to the Minnesota judicial branch. An initial report focusing specifically on AOD-related criminal and juvenile offenders shall be submitted by February 3, 2006; and a Final Report focusing on the overall impact of AOD dependency across all case types shall be submitted by September 30, 2006.

DATED: December 13, 2005

BY THE COURT:

/S/_____
Kathleen A. Blatz

Chief Justice

APPENDIX B

The Latest Brain Research on Addiction

In the past twenty years, research concerning the impact of alcohol and other drugs on the brain has grown tremendously. Scientists can now track changes in the brain thanks to Positron Emission Tomography (PET) scans. Since 1987, PET scans have opened up a new world to scientists examining the neurochemical dynamics of drug addiction. Following is a list of the most significant breakthroughs over the past two decades:

1987: Brookhaven National Laboratory (BNL) becomes "the first research institution to use positron emission tomography (PET) and other medical technologies to investigate the brain mechanisms underlying drug addiction".[118]

1990: The first link between dopamine (a neurotransmitter linked to motivation, pleasure and elation) and drug addiction is discovered.[119] The first experiments were related to cocaine; additional research has shown dopamine to be a key chemical in all drug addictions, including alcohol and nicotine.[120] For the addicted person, the drug(s) become the agents to produce good feelings and pleasure; without them, people experience anhedonia, or the inability to feel pleasure.

1993: Using PET, scientists are able to show how addicts' brains change during craving (an intense compulsion for the drug of choice). By showing videos of drug buys or an individual using drugs to a person who is addicted to cocaine and tracking changes in the brain via PET technology, scientists located central areas of the brain that activate during cravings (the same areas that activate in anticipation of sex or food).

1996: Researchers at Johns Hopkins and NIDA discover the first direct evidence that the brain's own natural opiate system is deeply involved in cocaine addiction and craving.[121]

1998: NIDA Director Alan Leshner's landmark article: Addiction is a Brain Disease.[122]

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[118] Brookhaven National Laboratory, Addiction Research at Brookhaven, at http://www.bnl.gov/bnlweb/addiction.html: BNL scientists made the first images of cocaine in the brain and the first studies linking cocaine's effects on brain function to the compulsive use of the drug. These efforts led to the first documentation of stroke-like changes in the brains of cocaine abusers and the beginning of a series of studies to map the biochemical and anatomical changes responsible for drug-addictive behaviors.

[119] ND Volkow ET AL *Effects of Chronic Cocaine Abuse on Postsynaptic Dopamine Receptors* American Journal of Psychiatry 147, 719-724, (1990)

[120] Eve Bender, American Psychiatric Association*, New NIDA Director Unravels Neurochemistry of Addiction.* Psychiatric News April 18, 2003 Volume 38 Number 8 p. 31 (2003) at http://pn.psychiatryonline.org/cgi/content/full/38/8/31.

[121] JK Zubieta ,ET AL , *Increased mu opioid receptor binding detected by PET in cocaine-dependent men is associated with cocaine craving*, Nature Medicine, 2, 11 p1225. (1996).

[122] Alan I. Leshner, *Addiction is a Brain Disease*, Issues in Science and Technology Online, (2001), http//www.issues.org/17.3/leshner.htm.

2002: Buprenorphine becomes the first prescription medication to be delivered by general practitioners for people addicted to heroin or painkillers. This breakthrough prescription marks a significant step in allowing addiction to be viewed - and treated - like any other chronic, relapsing disease.[123]

2004: Due to new brain research, Naltrexone (on the market for several years) and acamprosate (newly approved by FDA but used effectively in Europe for the previous fifteen years) are supported as new pharmacotherapies in the treatment of alcoholism.

2004: Results of a new study indicate that people who have recently stopped abusing methamphetamine may have brain abnormalities similar to those seen in people with mood disorders. The findings suggest practitioners could improve treatment success rates for methamphetamine users by also providing therapy for depression and anxiety for appropriate individuals.[124]

[123] Bob Curley *FDA Approves Two Forms of Buprenorphine for Opiate Treatment*, Join Together Online, (10/9/2002) at http://www.jointogether.org/sa/news/features/reader/0,1854,554695,00.html

[124] London, E.D, ET *AL Mood disturbances and regional cerebral metabolic abnormalities in recently abstinent methamphetamine abusers*, Archives of General Psychiatry, 61, 1, 73-84 (2004).

APPENDIX C

The Ten Key Components of Drug Courts[125]

DEFINING DRUG COURTS: THE KEY COMPONENTS

Key Component #1: Drug courts integrate alcohol and other drug treatment services with justice system case processing.

Key Component #2: Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.

Key Component #3: Eligible participants are identified early and promptly placed in the drug court program.

Key Component #4: Drug courts provide access to a continuum of alcohol and other drug and related treatment and rehabilitation services.

Key Component #5: Abstinence is monitored by frequent alcohol and other drug testing.

Key Component #6: A coordinated strategy governs drug court responses to participants' compliance.

Key Component #7: Ongoing judicial interaction with each drug court participant is essential.

Key Component #8: Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.

Key Component #9: Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.

Key Component #10: Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court effectiveness.

[125] National Association of Drug Court Professionals, Drug Court Standards Committee, Defining Drug Courts: The Ten Key Components, January 1997.

APPENDIX D

Following are the Massachusetts Standards on Substance Abuse. The Supreme Judicial Court of Massachusetts adopted the Standards on April 28, 1998. The policy statement at the beginning of the document explains the genesis and purpose of the Standards. They are included here as an example of one state's effort to develop branchwide guidelines for responding to the problem of AOD addicted offenders who come in to the courts. An expanded version with commentary can be found at http://www.mass.gov/courts/formsandguidelines/substance1.html.[126]

Massachusetts Standards on Substance Abuse

In March, 1995, the Massachusetts Supreme Court adopted the following systemwide policy to enhance the judiciary's response to the impact of substance abuse on the courts of that state:

> *Every judge in the Commonwealth should attempt to identify and appropriately respond to the indication of substance abuse by any party appearing before him or her in a court of the Commonwealth, where substance abuse is a factor in behavior related to the case. At every stage of the adjudicatory process, courts should provide access to substance abuse information and to referrals for screening, assessment and treatment for substance abuse.*

Standards were developed to provide guidance for implementation of this policy. (Extensive commentary was included with the standards. That information is not included here.) These statewide standards were approved in April, 1998.

1. ***Judge as Leader in Court's Response to Substance Abuse***. Every judge should become well informed about the problem of substance abuse and the process of recovery, and should serve as a leader in the court's efforts to address substance abuse. Judges should be aware of substance abuse, alert to its occurrence, and prepared to use their authority to take action when it is present.

2. ***Courthouse as Information and Referral Center***. Since substance abuse is a factor in a large percentage of criminal and family cases, the courthouse should serve as a substance abuse information and referral resource center. Substance abuse information and referral services should be available to every party at every stage of every case.

3. ***Access to Continuing Education***. The courts should provide all court personnel with access to continuing education about substance abuse and should encourage court personnel to avail themselves of educational opportunities inside and outside the court system.

4. ***Probation Department Responsibilities***. The probation department in every court should be responsible for identifying substance abuse, conducting substance abuse screening,

[126] The Ramsey County Bench adopted a modified version of these same standards in 2000.

performing or arranging and overseeing substance abuse assessments, ensuring that judges are informed about substance abuse assessment results, arranging for appropriate treatment placements, and monitoring compliance with treatment orders. The probation department should be available to perform these functions at any stage of a case.

5. ***Ordering Treatment***. Judges should be familiar with the options available at each stage of every case to provide access and make referrals to treatment for substance abuse, as defined in the Introduction, and to order treatment for substance abuse. Every court in every Trial Court department should make use of existing options for providing access and making referrals to treatment, if appropriate, and ordering treatment in appropriate circumstances. A list of options is provided in the Commentary.

6. ***Indications of Substance Abuse***. All judges and court personnel should look for indications of substance abuse that may be a factor related to a case before the court.

7. ***Screening.*** If there is an indication that substance abuse is a factor in a case, at the earliest stage and at any stage, the court is encouraged to use tools for prompt screening. Screening is a mechanism for rapid initial determination whether it is appropriate for a person to undergo a substance abuse assessment (as provided in Standard 8) or to participate in a treatment program. In performing screening, courts should observe applicable constitutional and statutory safeguards, including the right to counsel and the privilege against self-incrimination.

8. ***Assessments.*** When the court has determined as a result of a screening that substance abuse is a factor in the case and has issues or is considering a court order of substance abuse treatment, a substance abuse assessment should be conducted under the direction of the probation department, in order to determine which form of treatment will be most appropriate.

9. ***Treatment Matching***. Court-ordered treatment should match the party's treatment needs, and should be selected on the basis of expert information about what type of treatment will work best for the party, with full consideration of public safety.

10. ***Recommendations to Correctional Authorities***. Criminal courts should indicate to correctional authorities on the *mittimus* [i.e., commitment order] when a defendant has a substance abuse problem, to assist in classifying the inmate and addressing treatment needs. Judges are encouraged to recommend a particular treatment program or a particular institution on the *mittimus*. Courts should also provide correctional authorities with the results of court-ordered assessments and any other relevant information that will assist in the classification of the inmate.

11. ***Mandatory Abstinence***. Every court order which sets substance abuse conditions should prohibit all use of alcohol and illicit drugs for the duration of the order.

12. ***Monitoring Compliance***. Every court should intensively monitor compliance with court-imposed treatment conditions. Tools available should include drug testing, verification of attendance at counseling sessions and self help recovery meetings, and communication with treatment providers. Tools for monitoring compliance, such as drug testing and breathalyzers, should be available in every courthouse and drug testing results should be

made available as quickly as possible. The court should inform every person who is subject to court ordered treatment conditions that non-compliance with the conditions will have consequences and the court should directly and expeditiously address any non-compliance.

13. ***Relapse***. Every court should implement strategies to prevent relapse of a substance abuser who is in recovery and be prepared to address relapse. The strategies should include a plan for imposing graduated sanctions or consequences. The court should inform every party that relapse will have consequences.

14. ***Standards for Treatment Providers***. Courts should order substance abuse treatment through providers licensed by the Department of Public Health (DPH) to treat substance abuse, licensed by the Department of Mental Health (DMH) to treat mental illness, jointly licensed by DPH and DMH to treat both substance abuse and mental illness, or approved by the Probation Department or the Office of Community Corrections as qualified to provide substance abuse treatment. Subject to established rules of confidentiality, the Probation Department should require providers to communicate regularly and candidly with the court regarding a party's compliance with court-ordered behavior and treatment.

15. ***Treatment Directory***. To assist in the identification of treatment resources, the Commissioner of Probation, in consultation with the Department of Public Health, should maintain an updated directory of treatment providers. The directory should include each treatment provider's phone number, address, contact person and title, eligibility requirements, accepted payment methods, hours of operation, process of referral, treatment method, and procedures with respect to relapse. The directory should include services for a diverse population.

16. ***Community Resources***. Every court should identify the specific resources available in the community for the treatment of substance abuse, and establish and maintain relationships with local treatment providers. If services for a diverse population are not available in the community, the court should determine where such services are available and develop and maintain relationships with the providers of those services.

17. ***Communication and Collaboration within Court and With Community***. All court staff, treatment providers, prosecutors, police, defense counsel, correctional authorities, and the media should communicate clearly with one another on substance abuse issues. The first, regional administrative, or chief justice, as applicable, of each court should promote communication and collaboration on substance abuse issues within the court, as well as between the court and the community.

18. ***Use of Courthouse for Recovery and Education Sessions***. The justices who have administrative responsibility for courthouses are encouraged to seek permission from the Chief Justice for Administration and Management of the Trial Court to authorize access to court buildings for court-referred recovery meetings, counseling sessions, and substance abuse education group meetings, in order to ensure that security and other issues are addressed. All courts are encouraged to refer defendants to such meetings and sessions in the court building.

19. ***Substance Abuse within Courts***. The court system should respond to substance abuse among judges, clerks, court personnel, and lawyers. The response should include the

creation of opportunities to receive referrals for treatment and the recognition by disciplinary authorities that required participation in treatment can be an appropriate condition of discipline.

20. ***Substance Abuse among Attorneys***. Any judge or clerk-magistrate who believes that substance abuse is a factor in the professional performance of an attorney appearing before him or her should refer the attorney to a lawyer's assistance program, or, if the performance amounts to professional misconduct, report the misconduct to the Board of Bar Overseers. If the issue of professional performance arises in connection with an imminent proceeding in an active matter, the judge or clerk should make inquiries and, if necessary, postpone the proceeding.

APPENDIX E

Chemical Dependency Services in Minnesota

SUMMARY

This summary briefly describes the data which make up the rest of Appendix E. A more complete understanding of chemical dependency (CD) treatment in Minnesota can be obtained by reading this entire appendix.

- Since 1988, Minnesotans who needed CD treatment and whose incomes met certain guidelines received treatment via the Consolidated Chemical Dependency Treatment fund, or CCDTF. Of the three tiered system, only Tier I, the entitlement portion, is currently funded. Tier I pays for CD treatment for Minnesotans who earn at or below the federal poverty guidelines level.

- Despite changes that have effectively reduced CCDTF eligibility, public expenditures for CD treatment continue to grow, as do the number of placements into treatment. Counties are required to pay a percentage of the non-county government payments for CD treatment, based on historical county spending practices. The equity and effectiveness of this payment formula is currently under review.

- Alcohol is the primary substance of abuse for Minnesotans in treatment. The specific use patterns of sub-populations of Minnesota differ from one another. A higher percentage of men than women in treatment name alcohol as primary, and a woman in CD treatment is more likely than a man to name methamphetamine or crack cocaine as their primary substance of abuse.

- Nearly half of the Hispanic clients name alcohol as primary, just as white clients do, as compared to 31% of African-American clients. Twenty percent of Asian and white Minnesotans reported methamphetamine to be primary, as opposed to less than 1% of African-American clients.

- Just as gender and racial/ethnic groups have different use patterns, so do different regions of Minnesota. For example, CD treatment clients from northwestern Minnesota are the least likely of any regional subgroup to have methamphetamine ranked first, and they are most likely to have alcohol ranked first.

- Nearly all CD treatment is regulated by the Minnesota Administrative Rule commonly called Rule 31 (Minnesota Rules 9530.6405 - .6505). In effect for approximately one year, this rule emphasizes comprehensive assessment and individualized service planning and treatment.

- Access to treatment by the very poor is addressed in what are commonly called Rules 24 (Minn. Rules 9530.6800 - .7031) and 25 (Minn. Rules 9530.6600 - .6655). The subject of Rule 24 is the payment structure, while Rule 25 regulates the assessment component. Public payments for

treatment are authorized by a Rule 25 assessor after they have determined that a person qualifies under symptomatic and financial eligibility standards. On January 1, 2007 a new version of Rule 25 that complements the changes to the treatment rule will take effect.

FULL TEXT

The Task Force heard testimony describing the current fiscal and service delivery systems for Chemical Dependency services in Minnesota. The primary body overseeing the functioning of these systems is the Chemical Health Division of the Minnesota Department of Human Services.

Minnesota's Consolidated Chemical Dependency Treatment Fund[127]

The Consolidated Chemical Dependency Treatment Fund (CCDTF) was created in 1988. It combined previously independent state and federal funding sources and county match dollars into a single fund with a common set of eligibility criteria. The CCDTF once had three tiers of eligibility. Now, only Tier I, the payment system for entitlement services, is funded. Below is a brief history of changes to the CCDTF:

TIER III

Tier III is a "non-entitlement" eligibility category of the CCDTF. Tier III originally covered people earning 61%-115% of the state median income, with required co-pays on a sliding fee scale. Tier III has received no funding since 1991. Statutory changes in 2002 increased the eligibility range to include people earning between 215% and 412% of the Federal Poverty Guidelines (FPG), but absent funding, this eligibility change had no practical effect on service access.

TIER II

Like Tier III, Tier II is also a "non-entitlement" eligibility category of the CCDTF. Originally Tier II covered Minnesotans earning more than the entitlement level to those earning 60% of statewide median income. From 1993 to 1997 Tier II eligibility was limited to minors, pregnant women, and adults with minor dependents. In 2000, Tier II was expanded and made available to all other income-eligible people. In 2004, Tier II changed so that it included those who were earning between the "Entitlement Cap" of 100% FPG and 215% FPG. But, beginning in 2004 Tier II received no funding, so services have not been available to this eligibility category.

TIER I

Tier I represents the "entitlement" eligibility category for CCDTF. Tier I was originally funded with an entitlement level of 115% of state median income. In 2002 entitlement level was redefined as 100% federal poverty guidelines, as determined by household size and income guidelines, effectively reducing the earning levels eligible for CCDTF payments for treatment.

[127] All of the following information came from the Department of Human Services Chemical Health Division and the DHS Performance, Measurement and Quality Improvement Division. Special thanks to Don Eubanks, Lee Gartner, Jeff Hunsberger, Diane Hulzebos, and Carl Haerle.

Immediately below are some recent figures showing how the CCDTF has been funded (the difference between the total and the aggregate of State, Federal, and Local funding reflects funds from insurance, medical assistance and Minnesota Care collections):

Year	Local	State	Federal	Total	Total Placements
1992	$ 9,777,961	$21,539,958	Not available	$44,672,717	15,623
1995	$11,879,932	$34,342,061	$10,265,167	$59,310,970	19,141
2000	$11,263,707	$36,315,555	$9,000,000	$59,636,735	18,705
2003	$16,627,562	$45,616,152	$10,880,000	$81,255,534	24,176
2004	$16,807,636	$56,141,515	$9,000,000	$83,350,114	25,075

Despite eligibility reductions in Tier I and funding reductions for Tier II and Tier III, the amount of money being spent on treatment in Minnesota has increased each year over the past decade, as have the total number of treatment admissions. Individuals who are unemployed or are earning at or below federal poverty guidelines qualify for any needed AOD treatment under the CCDTF. Because of their unemployed status, recently released offenders will qualify for CCDTF funding in most cases. However, an offender who is above the federal poverty guidelines does not qualify for public treatment dollars. It is not clear how many people fit this category. It is also possible that some portion of this group has private insurance.

Getting an Assessment for AOD Problems

The current regulatory framework provides that people may receive a CD assessment provided by assessors in the county social services system. It also provides that individuals who qualify financially for the CCDTF and who have an assessed need for AOD services will be given AOD treatment services at no cost, unless they have private insurance that completely pays for those services.

The Task Force acknowledges that treatment for chemical dependency in Minnesota is as successful as treatment for other chronic illnesses (e.g., asthma, diabetes, hypertension) where behavior change is a critical component; and it is improving. As noted in the main text of the report, however, a critical element of a successful problem solving approach such as drug court is the ability of the court to order a timely CD assessment and engage an offender in treatment quickly. Thus, the Task Force has concerns about delays that can occur in getting offenders assessed and into treatment, especially in situations where the offender's county of residence is other than the county in which he or she is appearing in court.

What we know about Minnesotans in treatment

Following are some specific data from DHS Chemical Health Division that break down treatment episodes by gender, race/ethnicity and region for the years 2003-04.

Percentage Distribution of Primary Substance of Abuse by Gender for Public Clients CY 2003-2004			
Primary Substance	**Male**	**Female**	**Total**
Methamphetamine	12.1	18.6	14.2
Alcohol	48.8	41.3	46.4
Cocaine	2.7	3.3	2.9
Crack	10.0	12.9	10.9
Marijuana	21.6	16.1	19.8
Heroin	2.6	2.7	2.7
Other	2.3	5.1	3.2
Total	100.0	100.0	100.0

Source: MN Dept of Human Services, PMQI, DAANES

Percentage Distribution of Primary Substance of Abuse by Race/Ethnicity for Public Clients CY 2003-2004							
Primary Substance	**White**	**Black**	**Hispanic**	**Asian**	**Biracial**	**Other**	**Total**
Methamphetamine	20.3	0.7	8.4	20.7	11.7	9.8	14.4
Alcohol	47.9	30.9	49.2	31.7	35.2	44.1	46.6
Cocaine	2.7	3.7	5.4	5.3	3.8	3.4	2.9
Crack	5.1	36.5	8.3	9.3	12.1	18.1	10.6
Marijuana	18.4	21.3	24.6	24.7	30.2	19.6	19.8
Heroin	2.2	6.1	2.2	0.9	1.8	2.9	2.6
Other	3.5	0.8	2.1	7.5	5.3	2.0	3.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: MN Dept of Human Services, PMQI, DAANES

Percentage Distribution of Primary Substance of Abuse by Public Clients in Minnesota Chemical Health Regions CY 2003-2004								
Primary Substance	**No. East**	**E. Central**	**Metro**	**So. East**	**So. West**	**W. Central**	**No. West**	**Total**
Methamphetamine	13.0	27.0	11.3	14.8	20.4	19.2	7.1	14.2
Alcohol	54.3	43.2	43.4	46.8	44.6	49.6	61.1	46.4
Cocain	2.5	1.8	3.3	6.1	2.4	1.0	1.5	2.9
Crack	3.0	3.1	18.8	5.5	1.9	2.0	1.6	10.9
Marijuana	21.5	20.0	16.3	21.9	28.0	21.8	24.8	19.8
Heroin	0.7	1.0	4.5	1.6	0.5	0.6	0.4	2.7

Source: MN Dept of Human Services, PMQI, DAANES

Rule 31[128]

The DHS Chemical Health Division is making major changes to its rules and regulations to improve treatment outcomes. These changes are being made to support a delivery system that:

- is as easy as possible for an individual to access and navigate;
- begins with an assessment that is comprehensive;
- builds on that assessment as a basis to authorize treatment services;
- tailors treatment to the needs of the individual;
- treats chemical dependency as a chronic illness; and
- coordinates the need for chemical dependency services with the need for services from other disciplines.

On January 1, 2005, new program licensing rules (Minn. Rules 9530.3100-3195, collectively referred to as Rule 31) went into effect that place the emphasis on the needs of the individual client rather than any preset or "canned" structure of the program. On January 1, 2007, new placement criteria (currently Minn. Rules 9530.6600-6655, collectively referred to as Rule 25) will go into effect. The new rule will emphasize use of a comprehensive assessment of the individual's needs to better individualize a plan of care and choice of services..

Juveniles

An adolescent can access the Consolidated Chemical Dependency Treatment Fund if he or she is:

1. Assessed as in need of treatment services; and
2. Has parents whose household income is less than or equal to federal poverty guidelines; or
3. If financial eligibility determination is based on his or her own income. In order for the adolescent's income to be considered, the adolescent must give "effective consent," which in this case is based on Minn. Stat. §§ 144.347 and 144.343, subd. 1. When the adolescent signs the Client Placement Authorization form, he or she is considered to have given effective consent.

Effective July 1, 2005, Minnesota Rule 2960 (or the "Children's Residential Facility Rule"), a single rule affecting programs of both the Corrections and Human Services departments, began regulating group residential services for children. This rule is often referred to as "The Umbrella Rule". Under this rule, group homes and treatment facilities obtain a license and are then certified to provide specific treatment services. The concept behind separating licensing of residential settings and certifying specific treatment services or programs is to allow for the monitoring of whether or not children were being placed in facility programs that addressed their primary needs. For example, a child whose primary need was alcohol addiction should not be placed in a program that is not certified to do CD treatment. The goal is to prevent the court from placing a child in a facility program that does not have the services to meet the primary need/s of the child. The court could still legally place the child in such a facility, but the provider must go on record (written

[128] All information in this section was provided by the Department of Human Services, Chemical Health Division.

documentation) to notify the referring agency that it does not have the services to meet the primary needs of the child.

Current Trends in CD Treatment

Many innovations and breakthroughs are occurring in the field of chemical dependency treatment. In testimony before the Task Force, Gary Olson[129] indicated that few things have impacted the AOD field more than the changes wrought by managed care. However, these changes have challenged the field to reassess current practice and reexamine the underlying assumptions about chemical dependency treatment. Some of the new directions for the field are:

1. Recovery Management Model – while traditional treatment has involved acute episodes of care, such a model does not match the model of addiction as a chronic illness. The recovery management model allows for ongoing treatment of AOD problems (similar to treatment for other chronic illnesses such as diabetes, heart disease, and asthma). Many of the examples below fit into the overall recovery management paradigm.

2. Use of primary physicians as engagement agents in treatment and intervention – currently primary physicians play a minimal part in the treatment of addictive disorders. Physicians generally receive minimal training on addiction in medical school. However, a person's primary physician is a critical entry point for treatment. As the field continues to embrace more pharmacological supports for treatment, a doctor's role in getting an individual into treatment as well as providing ongoing checkups could increase.

3. Drug courts – one of the tougher populations to treat for AOD problems are the addicted offenders. For the most part these individuals have cycled through the courts, jails, and prison, wasting an immense amount of public resources and human capital. These courts, along with other problem-solving courts, are making a dramatic impact on this population. These models are also forcing the courts to examine the way they have handled the majority of social and public health issues that have come before them and identify more effective ways of dealing with them while maintaining the integrity and constitutional charge of the Judicial Branch.

4. Building of a consumer-based constituency to advocate for adequate services – chronic diseases, due to their high relapse rates and their strong link to behavior, are especially prone to stigma. Similar to those with mental illness, people with severe and persistent AOD problems are the object of a significant amount of discrimination and stigma. However, until only recently there have not been organized consumer groups who publicly identify as people in recovery from AOD problems. A significant obstacle is the tradition of anonymity among twelve step groups (AA, NA, etc), one of the many forms of mutual-aid recovery. That obstacle is being overcome as members of these groups are finding ways of identifying themselves publicly as being in recovery without explicitly expressing membership in the groups. A national campaign called Faces and Voices of Recovery (FAVOR) was launched in St. Paul, Minnesota in 2001 though Minnesota itself stills lacks a viable consumer-based advocacy group.

[129] Gary Olson, Director of the Center for Alcohol and Drug Treatment in Duluth, testified before the Task Force on May 27, 2005.

5. Co-occurring disorders – Until the past decade or so, people who had AOD problems and mental health issues were treated in separate systems of care, very often getting lost in the shuffle between the two fields. There is growing recognition of the significant overlap between mental health disorders and AOD problems. Addressing both issues simultaneously, and/or in better coordination with each other, is a highly effective way to ensure long-term stabilization of both health issues.

6. Stages of Change – The concept of stages of change helps explain how people make changes in their lives. While the concept applies to change in any life area, it is particularly useful in understanding changes related to AOD addiction. Using this concept, treatment strategies can be targeted to helping individuals move through the stages - pre-contemplation, contemplation, preparation, action, maintenance, and relapse. Rather than simply viewing persons with AOD problems as defiant or in denial, this model takes a more objective approach and matches treatment services to the individual's particular stage of change. Counseling techniques aimed at helping individuals to change are known as Motivational Interviewing.

APPENDIX F

Restorative Justice

Restorative Justice (RJ) is a practical and philosophical framework that offers a systemic response to wrongdoing and emphasizes healing the wounds of victims, offenders and communities that are caused or revealed by criminal behavior.[130] RJ focuses on how the entire "system" impacted by a harm can respond when the harm occurs. From the standpoint of RJ, when a harm or offense occurs, the response should focus on healing all parties involved in it – the victim, the community, and even the offender. The question becomes: How can the criminal and juvenile justice systems respond in a way that promotes healing? RJ focuses on three elements: (1) identifying the harm that has been done; (2) creating an inclusive process to address that harm; and (3) making sure to involve all stakeholders in the healing process.[131] One of the underlying beliefs of RJ is that when a person harms others he or she does harm to himself or herself. In order to heal (and often, to prevent further harm from being caused – which for offenders often means recidivism), the individual must take responsibility for his or her actions and for changing his or her behavior.

If a harm or offense has occurred, a set of questions needs to be asked:

- Who has been hurt?
- What are their needs?
- Whose obligation is it to meet those needs?
- What is the appropriate process to involve all of the stakeholders to make things right?[132]

These questions guide the restorative process, and by their nature focus much greater attention on those harmed by the crime than in the traditional system. Such emphasis has proven to be beneficial, not only for the victim, but also for the offender.[133] This approach to criminal and juvenile behavior represents a significant shift from the traditional way that justice systems have operated: It says that those who are hurt, those who cause the hurt, and the community in which the offense takes place are all essential participants in how the harm is addressed.

There are over twenty restorative justice programs in Minnesota. These programs utilize a number of different restorative practices: circle processes, victim impact panels, community service work, family group conferencing, victim offender mediated dialogue, victim impact statements, and others.[134] While it is not within the purview of this report to detail each of these practices,

[130] Kay Pranis, National Trainer/Facilitator for Peacemaking Circles and Restorative Justice Philosophy, presented to the Task Force on the Philosophy of Restorative Justice and an Overview of Restorative Justice Programs in Minnesota, on July 22, 2005.
[131] Kay Pranis, Task Force Testimony, *supra*
[132] Kay Pranis, Task Force Testimony, *supra*
[133] Kay Pranis, Task Force Testimony, *supra*
[134] All of these practices are discussed in greater detail at the following link:
http://www.doc.state.mn.us/rj/facilityconference/2003/PG%207%20App%20-%201-03.doc

sentencing circles will be described in order to provide a clearer picture of what these programs look like.

Sentencing circles[135], also known as peacemaking circles, trace their roots to indigenous forms of justice in the Americas. Sentencing circles involve the victim, victim supporters, the offender, offender supporters, judge and court personnel, prosecutor, defense counsel, police, and all interested community members. The various stakeholders come together and work to create a safe environment where they problem-solve through the active participation of the victim, the offender, and community members, as well as representatives from the criminal justice system. Sentencing circles' collaborative structure is similar to drug courts or other problem solving approaches; however, there is a greater emphasis on the role and voice of the community and the victim. In sentencing circles, family members and community members help keep the offender accountable through support, honest feedback, and by helping the offender see how his or her actions have impacted others. Responses to inappropriate and/or harmful behavior are immediate. Sentencing circles typically involve a multi-step procedure that includes: (1) application by the offender to participate in the circle process: (2) a healing circle for the victim; (3) a healing circle for the offender; (4) a sentencing circle to develop consensus on the elements of a sentencing plan; and (5) follow-up circles to monitor the progress of the offender.[136]

[135] The National Highway and Traffic Safety Administration (NHTSA) recently listed sentencing circles (with a description written by the Honorable Gary Schurrer, a judge in Minnesota's 10th Judicial District) as one of ten promising practices for effectively dealing with repeat DWI offenders.

[136] Minnesota Department of Corrections, Facilitating Restorative Group Conferences: Training Manual (Appendix), January 2003.

APPENDIX G

Staggered Sentencing

Following are the Key Components of the Staggered Sentencing Model:

1. **A Staggered Incarceration Period.** The offender is placed on probation for a specified period of time *and* the court orders a period of incarceration. The court takes the ordered period of incarceration and divides it into thirds – e.g., a 90-day sentence = 30 days served immediately, 30 days a year from sentencing, 30 days two years from sentencing.

2. **Active Participation by the Offender.** The offender is given unprecedented responsibility for "achieving the conditions of probation, scheduling court motion hearings, and convincing the court that they have adopted lifestyle changes that significantly lessen their chances of further recidivism."[137] Each 30-day period requires a court appearance (often once a year), and defendants are told that if they miss the court date they will go to jail. If the offender has been actively sober in that time they can ask forgiveness for the 30 days in jail. The offender always sees the same judge, which creates the opportunity to build rapport and offers consistency in response. The offender's sobriety is verified based upon information from their probation officer, family members, AA sponsor, and employer. Defendants are responsible for bringing all motions to the court. If the offender does not have the correct paperwork when they arrive at their court appearance, the motion is denied.

3. **Home Electronic Alcohol Monitoring (HEM).** HEM is a "non-house arrest program that allows the offender to carry on normal day activities. However, three times a day (generally, early morning, an hour after work, and late at night), the offender must be at home to provide a breath sample into a video monitoring unit, connected to the phone line."[138] For staggered sentencing, HEM is often ordered in segments of 30 days per year and based upon the individual circumstances of the offender – for instance, for some the winter holidays present a particular difficulty so their monitoring would be ordered at that time. Based upon continued sobriety, positive input from probation and others close to the offender, and good previous monitoring results, an offender can request a waiver for the next 30 days of monitoring by filing a motion with the court.

4. **Clearly Articulated Consequences for Specific Violations.** Offenders learn from the court that any arrests for a new DWI violation will result in immediate execution of the stayed sentence (i.e. the remaining period of incarceration). Other violations will result in the immediate execution of the *next segment* of the stayed sentence.

[137] Judge James E. Dehn, Strategies for Addressing the DWI Offender: 10 Promising Sentencing Practices, p.20, March 2005

[138] Judge James E. Dehn, Strategies for Addressing the DWI Offender: 10 Promising Sentencing Practices, *supra.*

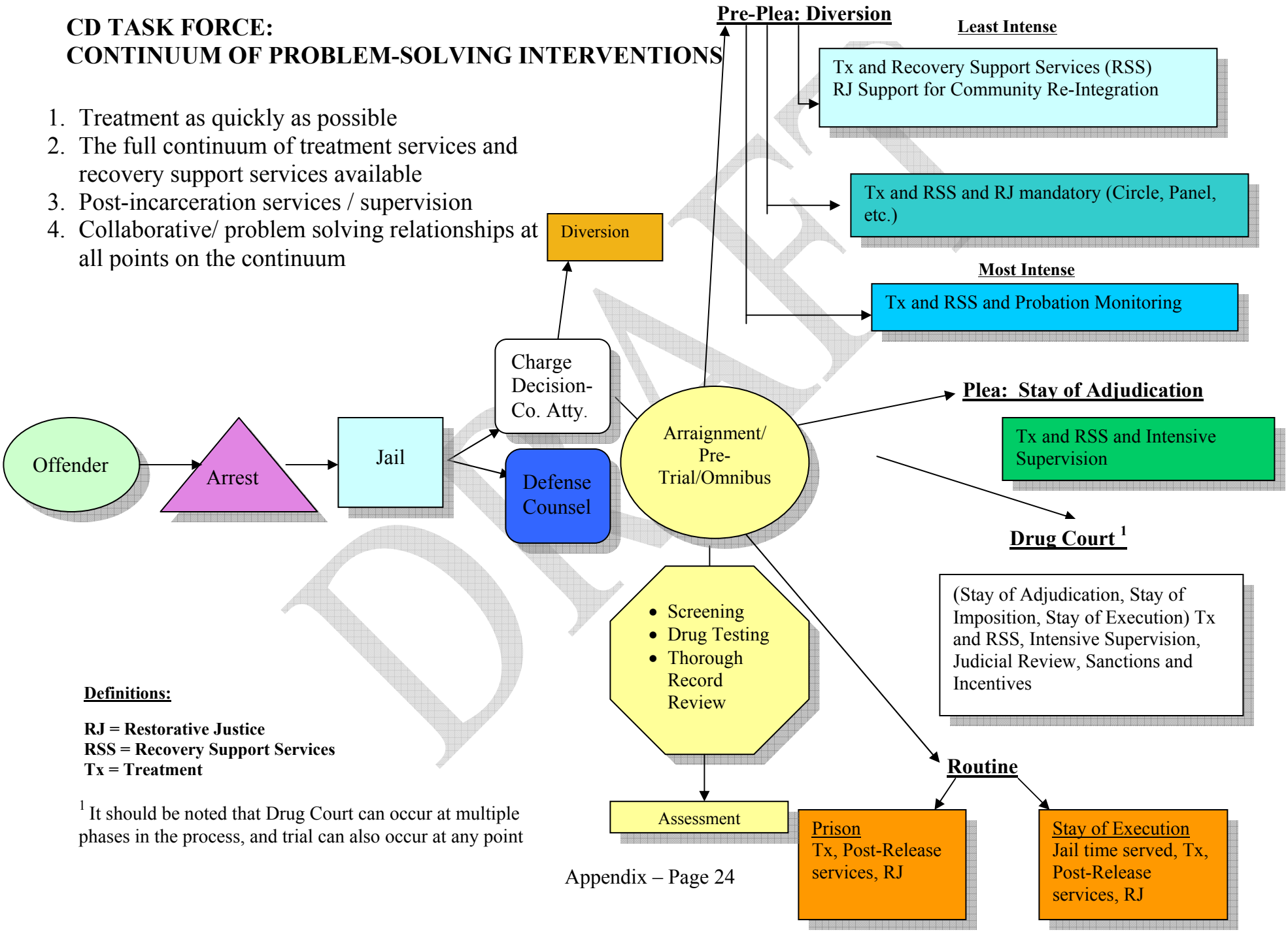
Research conducted by the Minnesota House Research office shows that offenders given staggered sentences are re-arrested for DWI at only 50% (one-half) the rate that would be expected based on the recidivism rates of comparable DWI offenders sentenced by all other Minnesota courts. The program results in 66% less incarceration time for the great majority of offenders who successfully comply with the program's conditions of release, thereby resulting in considerable jail cost savings.[139]

The Staggered Sentencing model is effective for those courts lacking the resources to develop DWI drug courts, those that have difficulty achieving meaningful system collaboration, and even for courts that have implemented the drug court model.[140] In addition to DWI offenders, this model could be used for property crime offenders and drug offenders. Staggered Sentencing is recognized as a premier program nationally by the National Association of State Judicial Educators (NASJE), The National Century Council, and The National Judicial College in Reno. Staggered Sentencing has also been highlighted by the American Bar Association, the National Highway and Traffic Safety Administration[141], and the National Governors Highway Safety Association.

[139] Jim Cleary, Staggered sentencing for repeat DWI offenders: An innovative approach to reducing recidivism, September 2002. According to the research, staggered sentencing saves $3500 per defendant.
[140] Several Minnesota drug courts have used staggered sentencing on individual offenders to increase the consequences for initial entry into the program.
[141] NHTSA recently listed staggered sentencing as one of ten promising practices for effectively dealing with repeat DWI offenders.

CD TASK FORCE:
CONTINUUM OF PROBLEM-SOLVING INTERVENTIONS

1. Treatment as quickly as possible
2. The full continuum of treatment services and recovery support services available
3. Post-incarceration services / supervision
4. Collaborative/ problem solving relationships at all points on the continuum

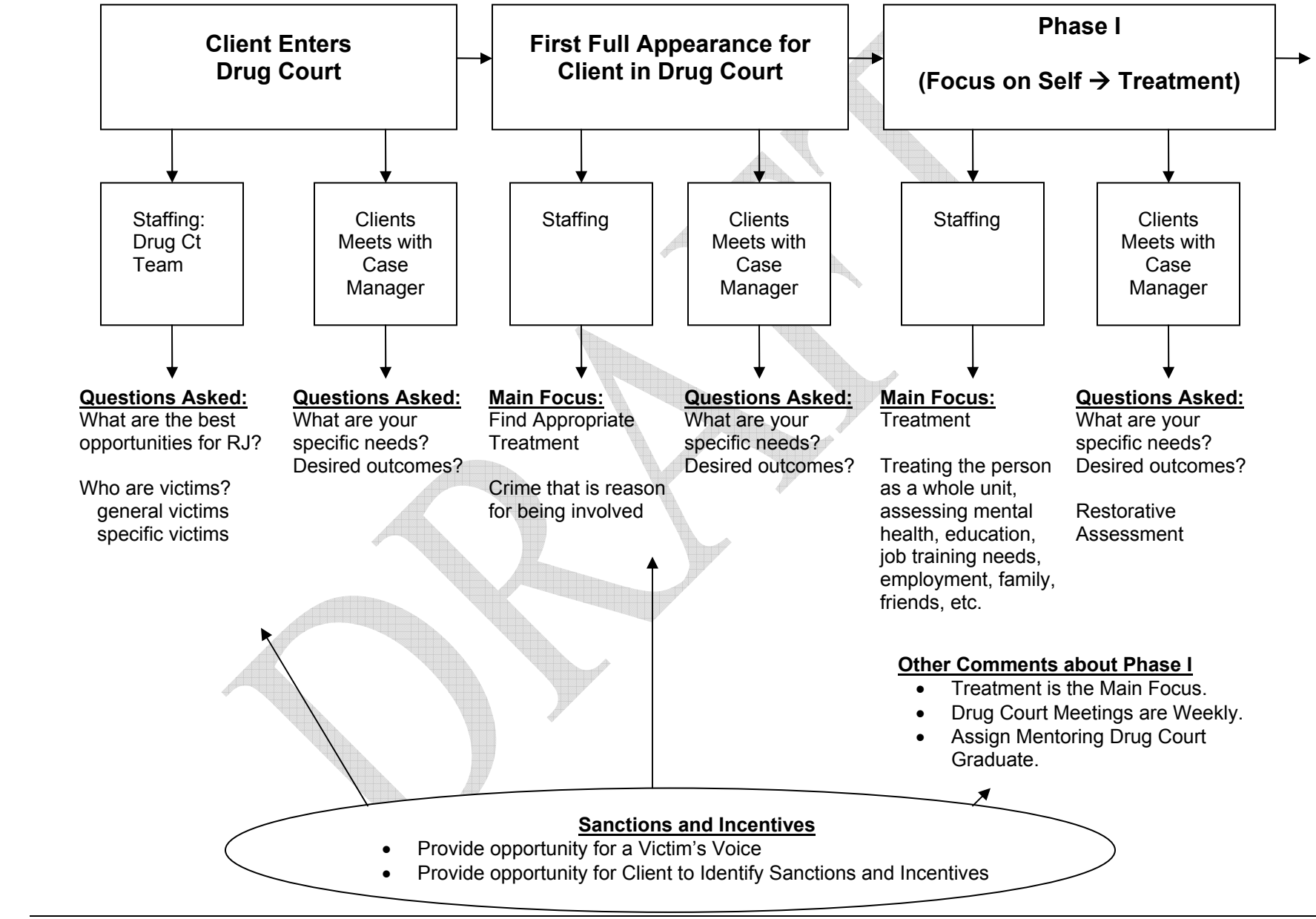


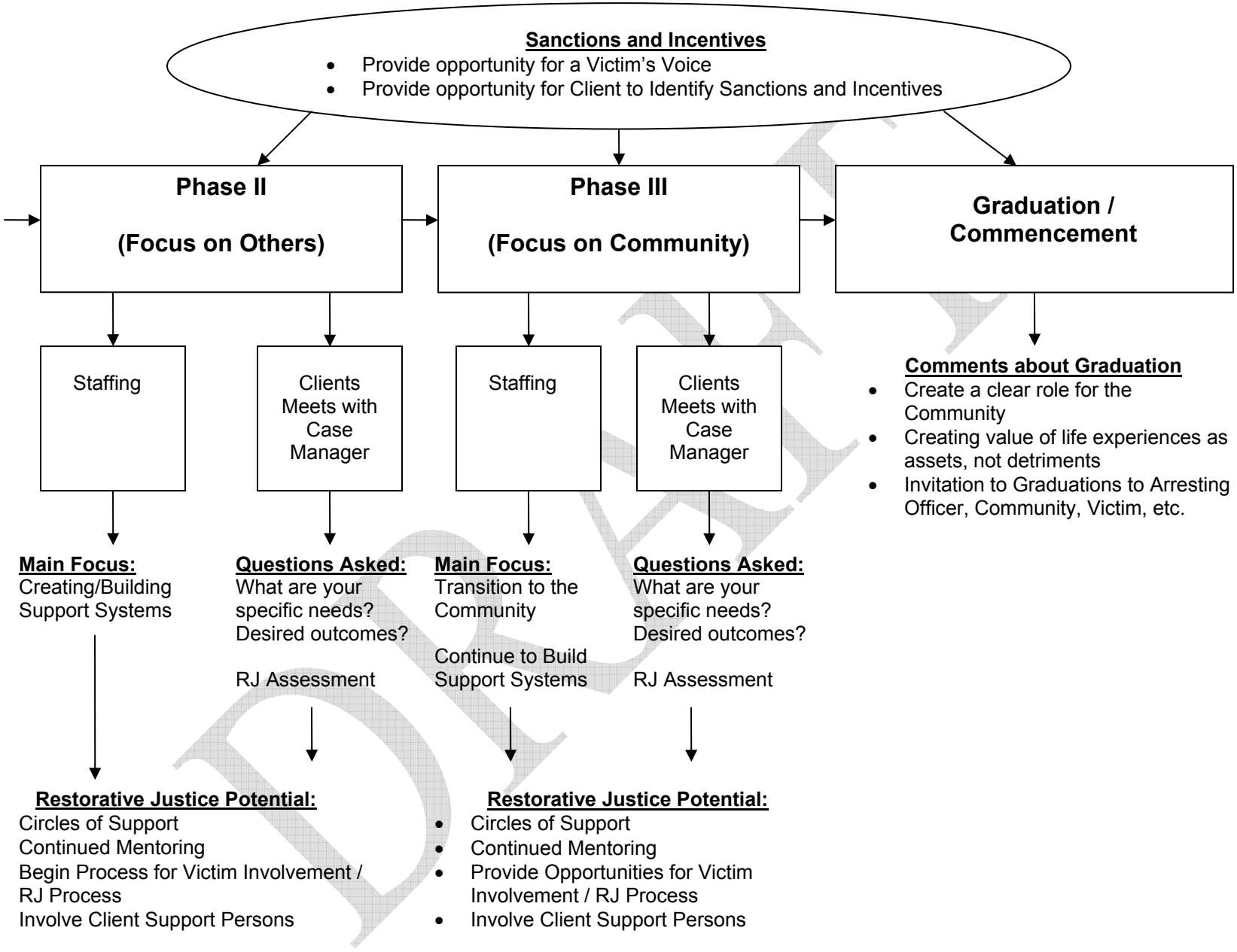
Definitions:

RJ = Restorative Justice
RSS = Recovery Support Services
Tx = Treatment

[1] It should be noted that Drug Court can occur at multiple phases in the process, and trial can also occur at any point

APPENDIX I




Sanctions and Incentives
Provide opportunity for a Victim's Voice
Provide opportunity for Client to Identify Sanctions and Incentives
Phase II
(Focus on Others)
Phase III
(Focus on Community)
Graduation / Commencement
Staffing
Clients Meets with Case Manager
Staffing
Clients Meets with Case Manager
Comments about Graduation
Create a clear role for the Community
Creating value of life experiences as assets, not detriments
Invitation to Graduations to Arresting Officer, Community, Victim, etc.
Main Focus:
Creating/Building Support Systems
Questions Asked:
What are your specific needs?
Desired outcomes?
RJ Assessment
Main Focus:
Transition to the Community
Continue to Build Support Systems
Questions Asked:
What are your specific needs?
Desired outcomes?
RJ Assessment
Restorative Justice Potential:
Circles of Support
Continued Mentoring
Begin Process for Victim Involvement / RJ Process
Involve Client Support Persons
Restorative Justice Potential:
Circles of Support
Continued Mentoring
Provide Opportunities for Victim Involvement / RJ Process
Involve Client Support Persons

APPENDIX J

Problem Solving Courts in Minnesota

PROBLEM SOLVING COURTS IN MINNESOTA

There are currently eighteen drug courts[142] (eleven adult, four juvenile, two DWI, one family) operating in fourteen counties in Minnesota:

- Blue Earth (1 – Adult)
- Chisago (1 – Juvenile)
- Dakota (1 – Juvenile)
- Watonwan (1 – Adult)
- Crow Wing (1 – Adult)
- Cass County (1 – Adult)
- Aitkin (1 – Adult)
- Dodge (2 – Adult and Juvenile)
- Hennepin (1 – Adult)
- Koochiching (1-Adult)
- Ramsey (3 – Juvenile, Adult and DWI)
- St. Louis (1 – Adult)
- Stearns (2 – Adult and Family)
- Wabasha (1 – Adult)

Many additional courts in Minnesota have expressed interest in drug courts as a result of the leadership of the Office of Justice Programs (OJP) in the Department of Public Safety, the State Court Administrator's Office (SCAO), and drug court team members across the state. The following counties are planning drug courts:

- Brown (Adult)
- Carlton (Family)
- Itasca (Adult)
- Kandiyohi (Adult)
- Hennepin (Adult DWI)
- Lake of the Woods (Adult DWI)
- Koochiching (Family)
- Nicollet (Adult)
- Martin (Adult)
- Dakota (Planning)

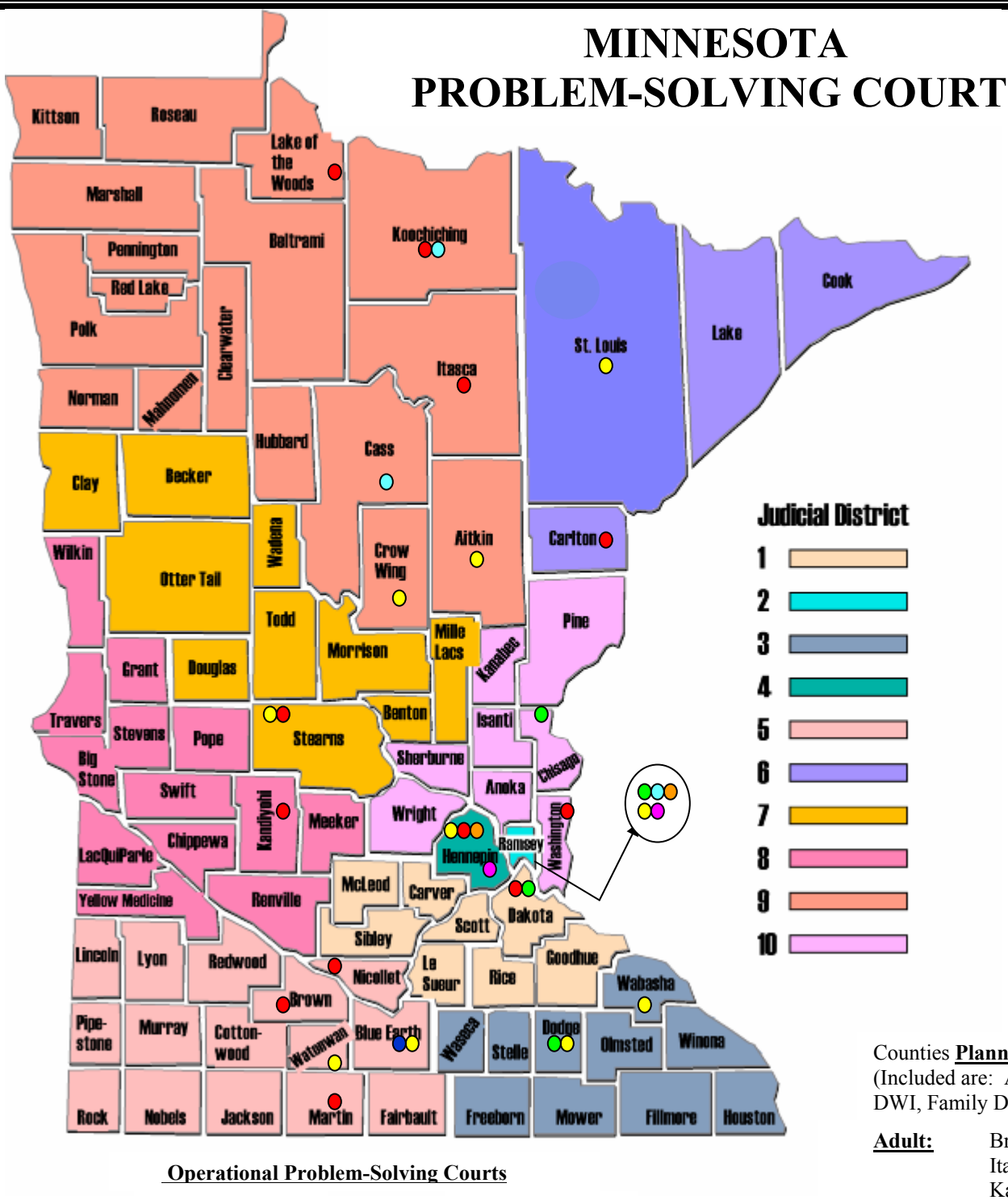
In addition to drug courts there are also truancy courts, mental health courts, and community courts in Minnesota that embrace the problem solving approach. These counties are:

- Ramsey (mental health court, community court)
- Hennepin (mental health court, community court)
- Blue Earth (truancy court)

[142] Five of the drug courts will become operational in early 2006; however, their funding has been awarded through a specialty court appropriation from the Legislature to the Judiciary. The courts and estimated start dates are: Stearns Family (July 2006), Crow Wing Adult (July 2006), Watonwan Adult (January 2006), Aitkin Adult (January 2006), Cass Adult (January 2006).

APPENDIX K

MINNESOTA PROBLEM-SOLVING COURTS



Operational Problem-Solving Courts

- Adult Drug Court
- Juvenile Drug Court
- Adult DWI Drug Court
- Family Drug Court
- Mental Health
- Community
- Truancy

Counties **Planning** Drug Cts:
(Included are: Adult, Juvenile, DWI, Family Dependency)

Adult: Brown, Itasca, Kandiyohi, Martin, Nicollet, Washington

Family: Carlton, Koochiching

Adult DWI: Hennepin, Lake / Woods