STATE OF MINNESOTA
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MINNESOTA SUPREME COURT

CHEMICAL DEPENDENCY TASK FORCE

REPORT ON THE OVERALL IMPACT OF ALCOHOL AND OTHER DRUGS ACROSS ALL CASE TYPES

NOVEMBER 17, 2006

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Chemical Dependency Task Force
Report on the Impact of Alcohol and Other Drugs Across All Case Types

PART I: INTRODUCTION

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[1]
Mary Ellison, Deputy Commissioner, Minnesota Department of Public Safety
Jim Frank, Sheriff, Washington County[2]
John Harrington, Chief, St. Paul Police
Pat Hass, Director, Pine County Health and Human Services
Brian Jones, Assistant District Administrator, First Judicial District
Wes Kooistra, Assistant Commissioner for Chemical and Mental Health Services, Minnesota Department of Human Services[3]
Fred LaFleur, Director, Hennepin County Community Corrections[4]
Honorable Gary Larson, District Court Judge, Fourth Judicial District
Bob Olander, Human Services Area Manager, Hennepin County
Shane Price, Director, African American Men's Project
Honorable Robert Rancourt, District Court Judge, Tenth Judicial District
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 (retired), Director, Office of Traffic Safety, Minnesota Department of Public Safety
Honorable Paul Widick, District Court Judge, Seventh Judicial District
Associate Justice Helen Meyer, Supreme Court Liaison

Staff:
Dan Griffin, Court Operations Analyst – Chemical Health, Court Services Division, State Court Administration
Pam Marentette (Intern), Hamline University School of Law

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[1] Chris Bray became Deputy Director of Washington County Community Corrections in 2006.
[2] Jim Frank retired from Washington County in 2006.
[3] 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.
[4] Fred LaFleur withdrew from the Task Force in August, 2005.

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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, 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. But 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 in 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 for addressing that problem.

In 2000, courts statewide were asked to vote on strategic priorities for the judiciary over the next several years. The top four priorities selected were Access to Justice, Children's Justice, Public Trust and Confidence, and Technology. AOD 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. 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 has faced difficult economic times and state budget deficits in the past several years, 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. 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

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addressing that problem. A number of other states have also recently established task forces, judicial commissions, or legislatively mandated bodies that are exploring this specific issue or similar issues and initiatives (such as drug courts).

Purpose

The Minnesota Supreme Court established the Task Force 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 10, 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 December 8, 2006.

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

Process

The full Task Force met monthly beginning in April 2005. Following submission of its initial report in February 2006, the Task Force continued to meet monthly.

The Task Force has considered comments made by citizens, lawyers, subject matter experts, judges and other professionals who have attended Task Force meetings and public hearings on October 9, 16 and 17, 2006. Some 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

This report will present the considerations and recommendations of the Task Force in five main sections:

1. Addiction Model;
2. Recommendations concerning Problem-Solving Approaches for Children in Need of Protection or Services Cases;
3. Recommendations concerning Other Case Types including Domestic Violence and Civil Commitment;
4. Recommendations concerning the Statewide Expansion of Problem-Solving Approaches in Minnesota;
5. General Recommendations:
    a. Communities of Color
    b. Co-Occurring Disorders
    c. Trauma
    d. Women and Girls
    e. Criminal Justice Treatment
    f. Fetal Alcohol Spectrum Disorders
    g. The Use of Medications
    h. The Process of Recovery
    i. Screening and Assessment

The Task Force decided to make decisions by consensus, meaning that all members supported the recommendations in order to avoid minority reports, even though some members might have disagreed with individual recommendations. The Summary of Major Task Force recommendations in Part II.A 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.

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A draft of this report 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.

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PART II: EXECUTIVE SUMMARY

A. INTRODUCTION

The Supreme Court Chemical Dependency Task Force is committed that its reports not merely "sit on a shelf gathering dust." The Task Force is keenly aware that it is not the first body to make recommendations to address the impact of alcohol and other drugs (AOD). However, its work has been infused by a sense that the "stars are in alignment"; and that certain forces have converged to make this the optimal time to address the impact of AOD on the court system and Minnesota communities. In fact, the Judicial Branch *has* taken the initial report and recommendations of this Task Force seriously, as have many other policy and decision makers. Having now completed its work, and after receiving public comment from communities around Minnesota, the Task Force has identified seven critical factors underlying the recommendations in both its first report (February 3, 2006) and its final report (November 17, 2006):

Leadership – The Task Force supports the leadership of the Judicial Branch in implementing problem-solving approaches throughout the state of Minnesota. Implicit in this endorsement is the supposition that all stakeholders will be involved in the planning and implementation of the recommendations. Leadership is not about control or unilateral decision making. It is about bringing others to the table, creating space for all necessary voices to be heard, taking into consideration all points of view, and making effective decisions. While this type of leadership may be more challenging to implement, the Task Force is adamant that a comprehensive effort to develop problem-solving approaches for AOD-related court cases, and systemic change in how the judiciary and its partners deal with AOD (and mental health) issues, cannot succeed without this type of leadership.

Collaboration –The Task Force's research and testimony of the past nineteen months has made clear that government cannot successfully implement, operate, or execute interventions and programs without collaboration. However, true collaboration is not easy to accomplish; it is even more difficult to maintain. It requires individual team members to be open to new perspectives and approaches. It requires open and honest communication. Most importantly, it requires the ability to acknowledge and address conflict openly and respectfully when it arises. Cross-disciplinary collaboration is still relatively new to the judiciary. With the advent of problem-solving approaches across the country, courts are increasingly becoming part of collaborative efforts, without compromising the constitutional mandate of the independence and impartiality of the judicial branch. Courts, judges, and other court system stakeholders are finding that participation in collaborative efforts allows them to improve their relationships with their respective communities, have greater access to information that allows them to make more effective decisions, and administer justice more effectively. To summarize, as one Task Force member stated: "You do not need money to collaborate."

Evaluation and Management Information Systems (MIS) – The Task Force discussed the need for evaluation and MIS in its first report and reiterates the need for both

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components in the implementation of problem-solving approaches for AOD cases in the court system. If evaluation and MIS are not adequately funded, and if the plans for implementing, maintaining, and sustaining them are not clearly articulated from the beginning, these efforts will be inherently limited. Program managers and administrators too often treat evaluation and MIS as secondary to implementation—but it has become clear that this does not work. The State Court Administrator's Office should develop and properly fund a comprehensive evaluation and MIS strategy for the implementation of problem-solving approaches.

Funding/Sustainability – Considerable concern has been expressed that the Task Force's recommendations will be "unfunded mandates" that begin with money from the state or federal government in the form of "grants," but ultimately shift the costs onto local entities. Clearly, few of the Task Force's recommended changes can be implemented without substantial state funding to support them. All policy makers, including legislators, must understand that these recommended changes are an investment that will not have an immediate payoff. Additionally, their success is contingent on effective collaboration among the various stakeholders; if funding to support these efforts were to be taken from the base budgets of any of the partners – in essence, "robbing Peter to pay Paul" and thereby creating unnecessary competition or tension between the partners – this would unnecessarily compromise the effort.

The Task Force challenges all interested parties to think about funding differently – not only how programs are funded, but also how funding is viewed by *all* entities that oversee its distribution. It is common for agencies to see funding as "*their*" money. The Task Force would like to challenge this perception and encourage policymakers and agency directors to think of their stewardship of public funding as a privilege – one that requires a willingness to think about how to share funds and work collaboratively to fund the most effective programs, thus allowing innovation to flourish. The Task Force encourages this "collaborative" approach to funding at all levels—local and state. Additionally, the Task Force is convinced, based upon testimony and significant research, that the issue is not always one of finding *new money,* but rather spending current resources more effectively in order to implement new programs. Following the Task Force's first report, the legislature approved funding for a comprehensive study of the funding streams that support drug courts and other problem-solving approaches. This study will provide a snapshot of the current configuration of that funding, the efficiencies and inefficiencies, and will make recommendations on how to better configure the funding. The Task Force hopes this study will provide guidance to county and state government bodies committed to implementing problem-solving approaches and institutionalizing these practices. Ultimately, the burden of funding and supporting problem-solving programs should be borne by both state and local government, as both will benefit from them. Finally, the Task Force is aware that the Department of Human Services, Chemical Health Division has convened a task force of its own to make recommendations for changes to the consolidated chemical dependency treatment fund (CCDTF), and looks forward to the promulgation and implementation of those recommendations.

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County and Local Government Issues – Many of the Task Force's recommendations require access to necessary resources and assume the availability of such resources. The Task Force wishes to make clear that it understands that budgets are strained everywhere throughout Minnesota; and with additional cuts coming to federal funding, particularly in the area of child welfare, the fiscal concerns are even greater. However, in such times collaboration is even more crucial (see above). There is clearly an imbalance of wealth between different counties. Many of the Task Force's recommendations could strain beleaguered budgets both in the metropolitan areas and greater Minnesota. Problem-solving approaches are effective when properly implemented; therefore, every community deserves the opportunity to implement these programs. Particularly from the standpoint of the judiciary, the disproportionate distribution and availability of funding and services presents a serious concern regarding equal access to justice. Therefore, due to the obvious cost-benefits of implementing problem-solving approaches, the necessary resources should be made available to all communities, particularly those in greater Minnesota. Further, regarding needed state-level action on the Task Force's recommendations, the Task Force respectfully asks that policymakers always consider the unique needs of greater Minnesota.

Chemical Dependency and Ancillary Services – While all of the Task Force's recommendations are important, none are more critical than those that emphasize the importance of the treatment and supervision services that enable AOD addicted persons to achieve quality, long-term recovery. Implicit in all of the Task Force's recommendations is that treatment providers, as well as mental health providers, must be included in all collaborative efforts. The Task Force also understands the disproportionate impact of the implementation of problem-solving approaches on corrections professionals, and advocates strongly that probation and corrections be given adequate resources to fulfill their essential role, and that all local problem-solving initiatives work closely with their corrections stakeholders. All problem-solving approaches, teams, and appropriate services must be available in *all* communities. Agency heads and policymakers must prioritize the funding of these services while holding providers accountable for providing services that utilize evidence-based practices.

Poverty – One issue that the Task Force feels merits much more attention is that of poverty. Often the people most in need of problem-solving services are poor. When the system effectively handles the problems of poor offenders and other community members the first time, two things tend to happen: (1) their poverty does not increase; and (2) they often do not return to the system. The Task Force's work suggests that the majority of persons participating in drug courts and other problem-solving approaches are from lower socio-economic areas of society. While the Task Force does not wish to imply that only people living in poverty experience AOD problems——that is clearly not the case—it stresses that understanding the role poverty plays in the criminal justice and other court systems is essential to successfully working with and supporting changes in these individuals' lives. Further, understanding the role that addiction plays in perpetuating problems associated with poverty is essential in allowing teams to respond effectively to the needs of the individuals in their programs.

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Technology - The Task Force learned that advances in technology have done more than improve efficiency; they have also increased the accessibility of services for populations that have difficulty accessing or affording those resources. The Task Force is convinced that the innovative use of this technology will save money and produce efficiencies in service delivery not previously possible. Technological advances such as ITV (Interactive Television) and Tele-medicine allow people – especially those in widely dispersed greater Minnesota communities – convenient and cost-effective access to services. Rather than a judge and problem-solving team traveling a significant number of miles to a court, particularly in greater Minnesota, technology allows the team to remain in the same location and stay connected to those they are serving. Thus, the Task Force is convinced that new technologies should be made readily available to the communities in greater Minnesota.

B. SUMMARY OF MAJOR TASK FORCE CONCLUSIONS AND RECOMMENDATIONS

I. ***Children in Need of Protection or Services (CHIPS) – Problem-Solving Approaches:***[5] ***The Task Force calls for a broad and fundamental shift in how Minnesota's courts deal with Child in Need of Protection or Services (CHIPs) cases, in coordination with the Judicial Branch's Strategic Plan for both the Children's Justice Initiative and the commitment to problem-solving approaches in general.***

The problematic use of and addiction to AOD by parents who find themselves in juvenile court is of particular concern to the Task Force. The connection between AOD problems and ongoing involvement in the criminal justice system is clear, especially for those young children found to be in need of protection or services. There is a direct link between the Judicial Branch's commitment to the Children's Justice Initiative and the need to focus on AOD concerns within the child protection system. This need is further underlined by the increase in methamphetamine-related cases in the child protection system. It is critical that these cases be given focused attention.

The Task Force suggests that problem-solving approaches for the CHIPs population in the juvenile courts will greatly improve the outcomes for children living in AOD impacted families. They will provide necessary treatment and ancillary services for parents, as well as save significant out of

[5] The Task Force recognizes that all of those who work in the court system are actively involved in problem solving, and it neither wishes nor intends to disparage those efforts. The term "problem-solving" as used here is used by courts across the country to define a specific type of innovative judicial intervention. *See* MINNESOTA SUPREME COURT CHEMICAL DEPENDENCY TASK FORCE, REPORT ON ADULT AND JUVENILE ALCOHOL AND OTHER DRUG OFFENDERS 21, 24-25 (2006), *available at* http://www.mncourts.gov/?page=631.

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home placement costs for state and county governments.[6] The Task Force would also like to call special attention to the successes of the Children's Justice Initiative, particularly the Children's Justice Initiative – Alcohol and Other Drug Project (CJI-AOD), for embracing the concept of the "toolkit" and offering counties across the state a menu of interventions that positively impact the occurrence of AOD on CHIPs cases. They ultimately enhance the ability of the courts to safeguard the best interests of children coming from addicted family systems.

Recommendations: The Task Force strongly recommends the development and implementation of a plan for making problem-solving approaches for families in the judicial child protection system more broadly available throughout the state.[7] The essential elements[8] of such approaches include:

1. Holding the parent accountable for his or her conduct and recovery with swift and certain interventions, including a continuum of sanctions together with full consequences for failure while the parent is involved in the problem-solving approach. The immediacy of consequences is fundamental.
2. The use of incentives to acknowledge progress in the program and to provide public support and affirmation for the parent's successes.
3. Agreement between the vital parties—prosecutor, public defender, child protection, guardian ad litem, the tribe (when an American Indian family is involved) and judge—as to eligibility and other program criteria.[9]
4. Evidence-based and culturally-appropriate treatment services.
5. Services targeted toward children who come from addicted families.
6. The availability of ancillary services, such as parent programs, recovery schools, tutors, vocational training, and mentors.
7. A continuum of interventions.

II. ***Domestic Violence, Civil Commitment, and Other Case Types:***

Domestic Violence: Although the precise relationship between AOD use and domestic violence has yet to be determined, the Task Force suggests that finding effective ways to address both problems may reduce family violence and lead to better AOD treatment outcomes. Failure to address issues of violence during AOD treatment can undermine the recovery of both abusers

[6] At the time this report was written there were only two family dependency treatment courts in Minnesota—in Stearns County and Dakota County. Both court programs became operational July, 2006.
[7] The state Judicial Council has identified a comprehensive effort to expand drug courts in Minnesota in its current strategic plan. While the current strategic plan focuses on adult and juvenile offenders (per the first Task Force report), it also fully supports CJI.
[8] For a more detailed discussion of these elements, refer to Appendix B.
[9] At the local level, it is important for county attorneys, public defenders, and judges (along with other members of the problem-solving team) to determine the eligibility criteria for their problem-solving court.

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and survivors. Additionally, failure to address abusers' AOD problems within the context of domestic violence treatment can jeopardize abusers' efforts to stop the violence.[10]

Civil Commitment: While the Task Force did not make specific recommendations regarding civil commitment, it recognizes that some civil commitments present opportunities to implement the problem-solving approach. The Task Force hopes that the successful implementation of problem-solving approaches for AOD-addicted individuals across Minnesota will impact the number of people being civilly committed as the state becomes more adept at intervening in addictive disorders.

Other Case Types: The Task Force did not make specific recommendations concerning all other case types. Still, it is clear that AOD has a significant impact across case types. The degree to which the Judicial Branch trains its employees and judges on AOD issues may cause reduction in the number of such cases.

III. ***Statewide Expansion of Problem-Solving Approaches:* The Task Force supports the statewide development of problem-solving approaches for cases involving AOD addicted individuals. This includes but is not limited to: adult criminal and juvenile delinquency cases, child protection and family dependency cases, appropriate civil commitments, and domestic violence cases.**

The Minnesota Judicial Branch has reached a crossroads in addressing the impact of AOD problems on its courts. After experiencing initial success with problem-solving approaches and learning from the successes of other states, Minnesota stands poised to expand the problem-solving model. Since the release of the Task Force's first report, the Judicial Council has endorsed an action item regarding problem-solving approaches as part of its overall strategic plan for the next biennium. This strategic plan seeks to integrate a judicial problem-solving approach into court operations for dealing with AOD addicted offenders.

This strategic priority is supported by the following objectives:

- Develop a statewide education program on the philosophy of problem-solving courts
- Establish and implement statewide best practices
- Establish criteria for state court budget support
- Adopt district plans to integrate the goals of the Task Force

[10] CENTER FOR SUBSTANCE ABUSE TREATMENT, U.S. DEP'T OF HEALTH & HUMAN SERVICES, TREATMENT IMPROVEMENT PROTOCOL (TIP) 25, SUBSTANCE ABUSE TREATMENT AND DOMESTIC VIOLENCE, 5 (1997).

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- Sustain existing drug courts with potential for targeted expansion to adjoining counties.
- Develop drug court MIS
- Evaluate program outcomes.

The Task Force has made significant recommendations encouraging the statewide expansion of problem-solving courts in Minnesota. These recommendations are discussed in detail later in the report; however, several of the recommendations are highlighted below:

Recommendations regarding going to scale:

A. ***All programs should be based on, and adhere to, the key strategies (such as the Ten Key Components)[11] developed for problem-solving courts. However, drug court programs should be allowed flexibility in establishing criteria to meet local needs.***[12]

B. ***A statewide, multi-disciplinary oversight group should be formed to develop or inform statewide policy and guidelines, and provide funding direction.***

C. ***The Judicial, Legislative and Executive Branches of government should collaborate, and then coordinate efforts to fund and support problem-solving court activities.***

D. ***Funding for problem-solving courts should be a combination of state and local funds.***

At the Judicial District level:

A. ***Multi-county approaches are encouraged for the implementation of problem-solving approaches in greater Minnesota.***

B. ***Form a multi-disciplinary district level team to advise on problem-solving court development throughout the district and to support resource commitment.***

IV. ***General Recommendations:*** ***In the course of its work, the Task Force found that there were several recommendations essential to the successful resolution of AOD problems and implementation of problem-solving approaches for AOD-addicted offenders.***

[11] See Appendix B for the Ten Key Components.
[12] At the time of this writing, draft Minnesota standards for drug courts were in the process of being adopted. These standards, once endorsed by the Judicial Council, will guide the implementation of drug courts in Minnesota.

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Communities of Color: The Task Force is concerned about Minnesota's current national standing in the rate of incarceration of blacks to whites.[13] Specifically, significant racial disparities exist with regard to drug-related offenses.[14] The Task Force is greatly concerned that while Minnesota develops a more balanced, better financed treatment policy to deal with the growing problem of methamphetamine, it must also reconsider the current criminal justice response to crack cocaine, particularly its impact on African American communities.[15] The Task Force's goal is to move forward with a comprehensive plan that fairly and effectively addresses the impact of AOD problems for all drug types, regardless of the race and ethnicity of the offender. Action to address racial disparities in the criminal justice, juvenile justice, and child protection systems as a whole is warranted, and should be addressed by those in the appropriate executive, legislative, and judicial branch forum(s), such as the Minnesota Judicial Branch's Racial Fairness Committee.

Co-Occurring Disorders: Task Force members learned that when co-occurring disorders go unaddressed, the likelihood of AOD addiction relapse as well as criminal recidivism greatly increase. Research during the last twenty years has definitively demonstrated the correlation between AOD

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[13] Presently, Minnesota has the twelfth highest ranking in the incarceration ratio of blacks to whites. BUREAU OF JUSTICE STATISTICS, BULLETIN: PRISON AND JAIL INMATES AT MIDYEAR 2005 (May 2006), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/pjim05.pdf (ranking extrapolated from data within source by SCAO Research staff). According to the Department of Corrections, 43 percent of all drug offenders are people of color. "For example, whereas minorities account for 92 percent of crack and 70 percent of cocaine offenders, they comprise 13 percent of inmates incarcerated for methamphetamine and 17 percent of those for amphetamine." MINNESOTA DEPARTMENT OF CORRECTIONS, DOC BACKGROUNDER: DRUG OFFENDERS IN PRISON 1 (Feb. 2006), *available at* http://www.doc.state.mn.us/publications/backgrounders/documents/drugbackgrounder.pdf.

[14] For drug-related offenses, the arrest rate ratio of African Americans to Caucasians was 10 to 1, 4 to 1 for Latinos and Caucasians, and 3 to 1 for American Indians and Caucasians. DEFINING THE DISPARITY – TAKING A CLOSER LOOK: DO DRUG USE PATTERNS EXPLAIN RACIAL/ETHNIC DISPARITIES IN DRUG ARRESTS IN MINNESOTA?1-2 (Minn. Council on Crime & Justice 2002), *available at* http://www.racialdisparity.org/files/Defining%20the%20Disparity%20Taking%20Closer%20Look.pdf In 2004, the imprisonment rate for Caucasian drug offenders was 23.5%, while the rate for African American offenders was 28%, the rate for Latino offenders was 37%, the rate for Asian offenders was 33%, and the rate for American Indian offenders was 23%. *Id.* However, the average prison sentence for Caucasian drug offenders was greater than all other racial/ethnic groups with the exception of Latino offenders. Minnesota Sentencing Guidelines Commission, Race-Related Sentencing Data: Focus on Drug Offenders 13 (2004) (PowerPoint presentation, on file with the Minnesota State Law Library).

[15] According to a recent national survey, support among Caucasian Americans for incarceration rather than treatment for cocaine offenses has declined. Three out of four Caucasian Americans believe that first-time cocaine offenders caught with five grams or less of the drug should go to drug treatment or get probation, not go to prison. These opinions were expressed in a survey of 783 Caucasian Americans. The survey also reported that 51% favored treatment for cocaine offenders, while 26% favored probation. *White Americans Favor Treatment for Cocaine Users*, JOIN TOGETHER, http://www.jointogether.org/news/research/summaries/2006/white-americans-favor.html (for full report, *see* Rosalyn D. Lee & Kenneth A. Rasinski, *Five Grams of Coke: Racism, Moralism, and White Public Opinion on Sanctions for First Time Possession,* 17 INT'L J. DRUG POLICY 183 (2006)).

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problems and mental health disorders. Thus, individuals with co-occurring disorders present unique challenges for the court system, with a corresponding need for greater knowledge of evidence-based practices. The Department of Corrections estimates that as many as 25% of male offenders and 40% of female offenders in Minnesota prisons are diagnosed with co-occurring disorders.[16] The success of problem-solving approaches for AOD offenders is contingent on the availability and effective application of appropriate services for the mentally ill.

Trauma: While trauma[17] was not originally in the purview of the Task Force's efforts, it became clear early in the second phase of its work that trauma-informed treatment services are critical to the populations that the courts serve. According to several experts who testified before the Task Force,[18] there is a clear correlation between the onset of problematic use of AOD and trauma. Trauma also plays a clear role in the relapse of many persons in recovery. Experts who spoke in the areas of domestic violence, co-occurring disorders, and gender responsive treatment services all identified trauma as an underlying factor in the onset of addictive disorders and a barrier to the long-term recovery of many people who enter treatment for addictive disorders.

Women and Girls: The Task Force emphasizes the importance of gender-responsive services for all offenders, both men and women. We note that advances for women and girls have been significant over the past three decades, but there is still need for improvement. Therefore, the Task Force unequivocally reinforces the concerns that the Female Offender Task Force expressed in its testimony regarding the need for gender-responsive services.[19] That is, equal treatment does not and should not always mean the same services or the same treatment. The research is clear: when services are

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[16] Email from Chris Bray, Assistant Commissioner of Corrections (Mar. 16, 2005) on file with Minnesota State Law Library..

[17] DSM-IV-TR defines trauma as

> involving direct personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or a threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate. The person's response to the event must involve intense fear, helplessness or horror (or in children, the response must involve disorganized or agitated behavior).

DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS DSM-IV-TR 463 (4th ed., Am. Psychiatric Assoc. 2000).

[18] Carol Ackley, Executive Director, River Ridge Treatment Center, Testimony to the Task Force, Women's Issues in Treatment (May 26, 2006); Dr. Larry Anderson, private practitioner/ consultant, Testimony to the Task Force, Introduction to Dual Diagnosis: Understanding the concepts of co-occurring mental health and substance use disorders (April 28, 2006); Dr. Noel Larson, Counselor, Meta Resources, Testimony to the Task Force, Domestic Violence (March 24, 2006).

[19] Justice Esther Tomljanovich, Chair, Female Offender Task Force, Testimony to the Task Force (May 26, 2006).

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created that respond to the unique needs of women, women do better. When women do better, children often do better as well.

Criminal Justice Treatment: Based upon significant research and testimony over the past eighteen months, the Task Force is convinced that the Minnesota criminal and juvenile justice systems must do a better job of intervening in the addictions of the offenders coming into Minnesota's courts. The reasons for this are simple: first and foremost is the issue of public safety. When AOD addicted offenders receive the appropriate intervention, including jail or prison, in concert with the appropriate treatment services, all research points to significant decreases in recidivism. For the AOD-addicted offender the likelihood of avoiding recidivism is predicated on their sobriety. Second, the Task Force finds that investing in treatment and holding offenders accountable with the appropriate consequences will save public (and private) dollars by ending the revolving door common to many of these individuals. Finally, the benefit to communities after transforming addicted individuals engaging in criminal behaviors and lifestyles into sober, productive, tax-paying citizens and family members cannot be overstated. The Task Force also believes that application of the concept of recidivism potential (also known as the "risk principle" in corrections research) is essential to the success of problem-solving approaches; it ensures that interventions are utilized for those populations most appropriate for them. Ultimately, the Task Force's vision is to see a continuum of interventions, which provide the most effective programming for individual AOD-involved offenders.

Fetal Alcohol Spectrum Disorders: Fetal alcohol exposure is likely one of the most significant unrecognized factors that face our courts as they address the impact of AOD problems. While the impact of the prenatal exposure of all other drugs, including methamphetamine and cocaine, is still not clear, the research regarding prenatal alcohol exposure is conclusive. During the past 30 years over 20,000 scientific animal and human research studies have found that prenatal alcohol exposure is "the most serious problem by far, whether it is judged by its frequency or by its capacity to injure the fetus."[20]

Medication and AOD Treatment: Some advocates of the traditional behavioral approach to AOD treatment have not embraced the use of medications in treatment.[21] Studies have shown that chemical dependency affects brain processes responsible for motivation, decision making, pleasure, inhibition, and learning.[22] Based on this knowledge, researchers have been

[20] INSTITUTE OF MEDICINE, FETAL ALCOHOL SYNDROME: DIAGNOSIS, EPIDEMIOLOGY, PREVENTION, AND TREATMENT, FREE EXECUTIVE SUMMARY 22 (1996), http://newton.nap.edu/execsumm_pdf/4991.pdf.
[21] Benoit Denizet-Lewis, *An Anti-Addiction Pill*, N.Y. TIMES, June 25, 2006, at 48.
[22] For the past two decades, neuroscientists and others exploring the physiological basis of dependency have focused on the brain chemical dopamine. Dopamine sends signals between cells in the brain affecting a variety of critical functions, including memory, movement, emotional response, and feelings of pleasure or pain. AOD use causes an increase in the amount of dopamine secreted, leading to feelings of pleasure or euphoria. With repeated and increased AOD use, the brain responds by reducing, or down-regulating, the

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searching for medications and vaccines that alter these brain processes to assist in treatment and recovery.[23] Much like the medical treatment for asthma or diabetes, treatment of AOD dependency requires behavioral and lifestyle changes in addition to the use of appropriate medications. The research is clear: medication, when clinically indicated, combined with behavioral treatment provides the best chance for recovery.[24]

The Process of Recovery: The Task Force recognizes that our attitudes and public policies are shaped by the way in which we think about, research and describe critical issues. When it comes to addiction, the ability of people to achieve and sustain long-term recovery has been overlooked because of the emphasis on the experiences and costs of untreated addiction. The reality of long-term recovery and the many pathways to achieve it suggest that recovery-oriented systems of care need to look beyond AOD treatment to incorporate the processes that make it possible for people to improve their health, get jobs and housing, and restore their lives.

Screening and Assessment: Screening and assessment are the lynchpins in determining appropriate offender interventions. Currently, national researchers are developing assessment tools specifically for drug courts.[25] At the same time, the criminal justice system has the opportunity to create screening and assessment tools that will properly assess and place offenders within a continuum of interventions. These will significantly enhance the effectiveness of the criminal justice, juvenile justice, and CHIPs system responses to AOD problems.

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production of dopamine and the number of dopamine receptors. As a result, the brain's "reward system" is less likely to respond to everyday experiences that produce a normal dopamine surge, such as romance, music, or a good meal. Over time, the brain becomes dependent on increased doses of alcohol or other drugs to feel rewarded. The brain also responds by associating alcohol or other drug use with this reward, leading to overwhelming cravings. Pharmacology researchers study how different types of chemicals interact in the brain in order to design medications to interfere with negative effects to reduce or stop cravings. *Id.*

[23] There are over 200 medications in development for the treatment of addictions. While there is much promise in the future use of these medications, there are only a few medications where there is sufficient medical research and data to recommend their current use. *Id.*

[24] *Id.*; Dr. Gavin Bart, Director of Division of Addiction Medicine, Hennepin County Medical Center, Testimony to the Task Force, Pharmacotherapy for Addictions: Following the Evidence (April 28, 2006).

[25] *See, e.g.,* Doug Marlowe, *Integrating Substance Abuse and Criminal Justice Supervision,* SCIENCE & PRACTICE PERSP., Aug. 2003, at 11.

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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 "Addiction is a Brain Disease."[26] Doctor Leshner's seminal article is widely acknowledged to be one of the most definitive statements from the scientific community regarding alcohol and other drug addiction. 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.[27]

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

> characterized 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.[28]

The Task Force also concurs with Dr. Leshner's and NIDA's positions respecting physical dependence as opposed to addiction; the presence of withdrawal or tolerance is not a critical factor 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

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[26] Alan I. Leshner, *Addiction is a Brain Disease*, Issues in Sci. & Tech. Online (2001), http//www.issues.org/17.3/leshner.htm (last visited Nov. 22, 2006).

[27] Carol Ackley, Executive Director, River Ridge Treatment Center, Testimony to the Task Force, The Neurochemistry of Addiction (April 22, 2005).

[28] NAT'L INST. ON DRUG ABUSE, PRINCIPLES OF DRUG ADDICTION TREATMENT: A RESEARCH-BASED GUIDE 9 (Nat'l Inst. Health 1999), http://www.nida.nih.gov/PDF/PODAT/PODAT.pdf.

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dependence symptoms upon withdrawal. . . . What really matters most is whether or 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.[29,30]

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 changes. The chronic drug-seeking and using behavior is, for the most part, a function of addiction as a brain disease, like schizophrenia or depression.[31] According to Leshner:

> 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.[32]

Environment, Personality, and Genetics

The Task Force is also persuaded that while 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. 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

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[29] Leshner, *supra* note 26, at 2.

[30] 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.

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

[32] Leshner, *supra* note 26, at 1-2.

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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 system all greatly increase the risk of early individual use.[33]

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 a genetic factor 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, as treatment for heart disease and diabetes.[34]
- The Minnesota Department of Human Services published an exhaustive study in 2000, which monitored treatment outcomes from 1993-1999. The primary

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

[34] A. Thomas McClellan et al., *Drug Dependence, a Chronic Medical Illness*, 284 J. Am. Medical Assoc. 1615, 1689-95 (2000).

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recommendation was the provision of a continuum of care consistent with expert consensus that chemical dependency is a chronic disease.[35]

The Latest Brain Research

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. 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 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 [non]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 diseases, the individual's motivation and behavior are clearly important parts of success in treatment and recovery.[36]

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[35] PATRICIA HARRISON ET AL., THE CHALLENGES AND BENEFITS OF CHEMICAL DEPENDENCY TREATMENT: RESULTS FROM MINNESOTA'S TREATMENT OUTCOMES MONITORING SYSTEM 1993-1999, 3-5 (Minn. Dep't of Human Serv., 2000).
[36] Leshner, *supra* note 26, at 6.

PART IV: TASK FORCE CONCLUSIONS AND RECOMMENDATIONS

A. RECOMMENDATIONS FOR THE DEVELOPMENT OF PROBLEM-SOLVING[37] APPROACHES REGARDING THE IMPACT OF AOD ON CHILDREN IN NEED OF PROTECTION OR SERVICES

Problem: Various national studies have estimated that AOD is an underlying factor in 40-80% of the child protection cases that come into the court system.[38] Anecdotal information and reviews of sample Minnesota court files also show that approximately 75% of child protection cases have AOD as an underlying factor.[39] Many counties have also reported increases in the number of children coming into their child protection systems because of parental use and/or manufacture of methamphetamine.

Minnesota statutes provide that the paramount consideration in all child protection cases is the child's best interests and the child's need for a safe, stable, and permanent home.[40] There are four timelines[41] constantly operating as child protection cases come into the court system:

- First, the federal permanency guidelines enacted in 1997 which address the large number of children "languishing in foster-care". Under that timeline, a permanency hearing must take place no later than 12 months after a child has been ordered into foster care upon a court order finding abuse or neglect. This timeline is based upon the child development process and the child's need for a safe, stable, permanent home.[42]
- The second relates to welfare to work. It refers to the amount of time individuals are allocated to achieve gainful employment before their public aid (temporary aid to needy families--TANF) expires. One of the specific challenges related to this timeline is that

[37] The Task Force recognizes that all of those who work in the court system are actively involved in solving problems and it neither wishes nor intends to disparage those efforts. The term "problem-solving" is a term of art used by courts across the country to define a specific type of innovative judicial intervention. *See* REPORT ON ADULT AND JUVENILE ALCOHOL AND OTHER DRUG OFFENDERS, *supra* note 5, at 21, 24-25.
[38] CENTER FOR SUBSTANCE ABUSE TREATMENT, PUBLICATION NO. SMA 02-3752, NAVIGATING THE PATHWAYS: LESSONS AND PROMISING PRACTICES IN LINKING ALCOHOL AND DRUG SERVICES WITH CHILD WELFARE 4-5 (2002) (publication available for order free of charge at http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=16193); NANCY K. YOUNG, SIDNEY L. GARDNER, KIMBERLY GARDNER, RESPONDING TO ALCOHOL AND OTHER DRUG PROBLEMS IN CHILD WELFARE: WEAVING TOGETHER PRACTICE AND POLICY ,ix (CWLA Press 1998).
[39] While no definitive Minnesota data currently exists, when the Children's Justice Initiative reviewed files in many counties, AOD issues were commonly cited. Most recently, the Department of Human Services' primary child protection data system, SSIS, was amended to allow workers to identify the drug of choice of a parent. Telephone interview with Judith Nord, CJI staff attorney, Court Services Division, State Court Administrator's Office (September 13, 2006).
[40] Minn. Stat. § 260C.001, subd. 2, subd. 3 (2004).
[41] This concept, originally defined by Nancy Young, Executive Director of the National Center for Substance Abuse and Child Welfare, is the theoretical crux of the Minnesota CJI-AOD project. *See* NAVIGATING THE PATHWAYS, *supra* note 38, at 6.
[42] 42 U.S.C. § 675(5) (2000).

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treatment is not always considered as work, though there is currently federal legislation that allows for this.[43]

- The third relates to the recovery process. Recovery from the chronic illness of AOD addiction takes time, and is often delayed by relapse. The speed and effectiveness of intervention with people in the child protection system who have AOD problems significantly impact whether or not a person's AOD issues can be sufficiently stabilized to prevent termination of parental rights or another permanency decision other than reunification.[44]
- The fourth and perhaps the most important timeline is the child development process. It describes the natural psychological development of the child when significantly impacted by both AOD problems in the family and the separation from family that takes place when a child is identified as being in need of protective services.[45]

The significance of each of these four timelines is clear – all relate to critical factors impacting the court's decisions. However, when all of these temporal realities are considered as intersecting needs, what soon becomes apparent is the difficulty in attempting to successfully navigating each timeline separately, while also meeting the requirements of the other three. A fifth timeline, and perhaps the most important one of all, could also be identified – the time required for those working in the child protection system to respond effectively to all of the other timelines.[46]

There is a commonly held assumption that the recovery process is too long (especially due to AOD relapses) to allow the courts to make effective decisions within the established timelines. The Task Force heard testimony from several experts that directly contradicts that assumption.[47] To enable the courts to make the most effective decisions, parents who have AOD problems need to be identified as quickly as possible, given services immediately (even if there is some degree of court-ordered involvement to assure participation), and given coordinated support from the members of the child protection system to assist them on their path to recovery. One of the most significant decisions facing courts involves judicial termination of parental rights. If it becomes necessary to terminate parental rights, or to move to another permanency decision, the courts and other members of the child protection system must have confidence that they have served the family as effectively as possible.

The Children's Justice Initiative

Upon becoming Chief Justice, Kathleen Blatz made the needs of abused and neglected children in the court system her primary focus for reform. In partnership with the Department of Human Services, Chief Justice Blatz developed the Children's Justice

[43] According to the Minnesota DHS-Chemical Health Division, counties in Minnesota can decide whether or not individuals receiving public aid get work credit for their time in AOD treatment.
[44] *See* NAVIGATING THE PATHWAYS, *supra* note 38, at 6, 22.
[45] The Task Force learned of these timelines in testimony from DHS staff and members of the CJI-AOD project.
[46] *See* NAVIGATING THE PATHWAYS, *supra* note 38, at 7.
[47] The Task Force learned that the primary purpose of the CJI-AOD Project is to educate all three systems – courts, child protection, and chemical health – regarding this fact and to support counties in developing effective policies and practices that allow for it to happen.

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Initiative (CJI). The mission of CJI is to ensure that abused and neglected children involved in the juvenile protection court system have safe, stable, permanent families.

The Minnesota Judicial Branch and the Minnesota Department of Human Services have worked closely with the juvenile courts, social services departments, county attorneys, public defenders, court administrators, guardians ad litem, and other key stakeholders in each of Minnesota's 87 counties to improve the processing and outcomes of child protection cases. The overall objective is to ensure safe, stable, permanent homes for abused and neglected children in as timely a manner as possible. The first permanency objective is reunification with parents. However, if that is not appropriate or possible, other permanent placement options must be secured.

The Task Force heard testimony regarding a project within CJI focusing on alcohol and other drugs. In January of 2005, the Children's Justice Initiative – Alcohol and Other Drug (CJI-AOD) Pilot Project began to develop promising practices in working with families who are in the child protection system and have AOD problems. This work was bolstered by technical assistance from the National Center for Substance Abuse and Child Welfare (NCSACW).[48]

The mission of the CJI-AOD project is to ensure that, in a fair and timely manner, abused and neglected children involved in the juvenile protection court system have safe, stable, permanent families by improving parental and family recovery from AOD problems. Highlights of this effort include: compilation of results from nine diverse parent focus groups; development of a parent partner handbook that assists counties in engaging parents as experts to advise and work with the CJI teams; development of a best practice tool kit that provides an interactive resource for implementing best practices in an AOD child welfare population; and development of a statewide training plan.

Description of Best Practices Tool Kit

The CJI-AOD Project created a "Tool Kit" to provide counties throughout the state with examples of national and state recommended best practices and additional effective practices that the project, in its research, found to be compelling and of significant merit. The Tool Kit can be found at the following link: http://www.mncourts.gov/?page=1769.

Overview of Parent Partner Project

One unique factor that the CJI-AOD project incorporated was that of the parent partner. Given the critical role that parents play in the lives of their children, parents need to be actively involved in the overall development of policies and products designed to improve the child protection system. To that end, a parent partner joined the core-team (the body of professional staff that developed the project, made recommendations to leadership, and implemented policies) in order to provide a parent perspective. Parent focus groups were conducted across the state and several products were developed for counties and tribes, including a parent-partner handbook which identifies ways in which

[48] Minnesota was one recipient among four states and an American Indian tribe to receive this second round of national technical assistance.

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counties and CJI teams can engage parents who have been through the system and are in recovery as resources for their teams.[49]

Discussion of Specific Services for Children of Addicted Parents

It is impossible to overstate the importance of providing evidence-based, specifically targeted and age-appropriate services to children of addicted parents. Significant research on preventive interventions, such as educational support group programs, demonstrates the effectiveness of these services in providing children the skills needed to develop pro-social skills, even when their parents do not recover. Resilience research indicates that growing up with a significant number of caring adults can help children gain competence and cope more effectively with the trauma of parental alcoholism.[50] Conversely, without intervention and support, children experiencing the multiple losses, confusion, neglect and abuse and other forms of family violence that often accompany the existence of addiction in the family are at greatly increased risk for adolescent and adult mental health and AOD problems, as well as life time physical health problems.[51]

Over-Representation of Children of Color in the Child Protection System

The Task Force heard from several experts about the over-representation of children of color in the child protection system. Statistically, the two populations that are most significantly over-represented are American Indian and African American children.[52] According to data from the Minnesota Department of Human Services, African American children make up 5 percent of the total child population but are four times as likely as white children to be placed outside of the home. American Indian children make up 1.6 percent of the total child population and are seven times as likely as white children to experience out of home care. Further, for every 1,000 African American children under age 18, there are 45.8 in out of home care; for American Indian children under age 18, 82.3.of 1,000 are in out of home care.[53]

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[49] Parent partners are identified as persons who have personally experienced the child protection system and are in recovery from alcohol or other drugs.

[50] E. E. Werner & J.L. Johnson, *Role of Caring Adults in the Lives of Children of Alcoholics*, 39, 5, SUBSTANCE USE & MISUSE , 699–720 (2004); M. Mylant, RN, CS, PhD et al., *Adolescent Children of Alcoholics: Vulnerable or Resilient?,* 8, J. Am. Psych. Nurses Ass'n, 57-64, (2002).

[51] *see generally* Vincent J. Felitti, MD, FACP et al., Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study, 14, 4, Am. J. of Prev. Med., 245-258, (1998).

[52] In 2003, DHS convened two advisory committees – one looking at American Indian disparities in the child protection system and the other looking at African American disparities in the child protection system. *See* CHILDREN'S SERVICES, MINN. DEP'T OF HUMAN SERVICES, REPORT TO THE LEGISLATURE ON THE STUDY OF OUTCOMES FOR AFRICAN AMERICAN CHILDREN IN MINNESOTA'S CHILD PROTECTION SYSTEM (2002), *available at* http://edocs.dhs.state.mn.us/lfserver/Legacy/MS-1943-ENG; AMERICAN INDIAN DISPARITIES INITIATIVE ADVISORY COMMITTEE, SUMMARY OF RECOMMENDATIONS (2003), http://www.dhs.state.mn.us/main/groups/children/documents/pub/dhs_id_050644.pdf (last visited Nov. 22 2006).

[53] Email from Jackie CrowShoe and John Hudson, Minn. Dep't of Hum. Serv. (Sept. 20, 2006) (on file with Minn. St. Law Library). This is an aggregate summary of data from 2000-2005.

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The Indian Child Welfare Act (ICWA) was enacted in 1978 to address the high rate of American Indian children removed from their homes and tribes.[54] In response to a congressional request to review the impact of ICWA, and more specifically, whether ICWA delayed placement of Indian children the Government Accountability Office found no significant federal oversight of the implementation of ICWA to ensure that states were complying with the Act.[55]

Dr. Susan Wells from the University of Minnesota presented recent research on the disproportionate involvement of African American children in the child protection system.[56] This is a perplexing finding, because a national study of child abuse and neglect in the United States found no difference in maltreatment incidence between white and African American families.[57] The study, conducted by the Minnesota African American Racial Disparities Committee, focused on three factors to determine whether a CHIPs petition would be filed and whether a child would be sent to out of home placement: (1) issues concerning the report; (2) the family's history with the child protection system; and (3) the mother's issues. Dr. Wells explained that the causes of disproportionality are very complex and there are no easy answers; nonetheless, there were some significant findings from the study:

- A child of an African American mother with an illicit drug problem is more likely to be placed than a child of a Caucasian mother with an illicit drug problem.
- A child of a Caucasian mother with "financial problems" (whether or not she is on public assistance) is more likely to go into placement than a child of an African American mother with "financial problems".
- A child with an African American father with legal problems is more likely to go into placement than a child of a white father with legal problems.
- Caucasian children went into placement at a higher rate at very young ages, whereas African American children went into placement at a higher rate at older ages (ages 6 through 9).[58]

According to Dr. Wells, it is difficult to determine exactly why these differences exist; however, she conjectured that the reasons relate to socioeconomics, institutional racism, and a more subtle, unconscious racial bias. The study found that it appears much of the disproportionality in out-of-home care in Minnesota does not arise from casework practice but is associated with disproportionate reporting to child protective services from neighborhoods with a high concentration of African American residents. [59]

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[54] For more information on ICWA, *see* http://www.nicwa.org/policy/law/icwa/index.asp.
[55] GOVERNMENT ACCOUNTABILITY OFFICE, INDIAN CHILD WELFARE ACT: EXISTING INFORMATION ON IMPLEMENTATION ISSUES COULD BE USED TO TARGET GUIDANCE AND ASSISTANCE TO STATES (2003), *available at* http://www.nicwa.org/policy/law/icwa/GAO report.pdf.
[56] Dr. Susan Wells, Univ. of Minn., Testimony to the Task Force (June 30, 2006). African Americans are significantly over-represented in the child protection system across the country. According to Wells, Minnesota has one of the highest African American rates in the country.
[57] A.J. Sedlak & D.D. Broadhurst, *Executive Summary of the Third National Incidence Study of Child Abuse and Neglect (NIS-3)* (U.S. Dep't of Health & Human Services, 1996), *available at* http://www.childwelfare.gov/pubs/statsinfo/nis3.cfm.
[58] Wells, *supra* note 56.
[59] *Id.*

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Based on the information detailed above and on previous testimony that involvement in the child protection system is one predictor of further involvement in the juvenile delinquency and criminal justice systems, the Task Force expresses serious concern about the disproportionate involvement of children of color, particularly African American and American Indian children, in the child protection system.

2. Recommendations: The Task Force strongly recommends the development and implementation of a plan for making problem-solving approaches for families in the judicial child protection system more broadly available throughout the state.[60] ***The essential elements of such an approach include:***

1. ***Supporting parents and holding them accountable for their conduct in recovery with swift and certain interventions (including a continuum of sanctions while the parent is involved in the problem-solving approach, and full consequences for failing in the problem-solving approach, including ultimate termination of parental rights for total failure in the problem-solving approach). The immediacy of consequences is fundamental.***
2. ***The use of incentives to acknowledge progress in the program and to provide public support and affirmation for the parents' successes.***
3. ***Agreement between the vital parties – prosecutor, public defender, child protection, guardian ad litem, the tribe (when an American Indian family is involved) and judge – as to eligibility criteria and other program criteria.***[61]
4. ***Evidence-based and culturally appropriate treatment services.***
5. ***Services targeted toward children who come from addicted families.***
6. ***The availability of ancillary services, such as parent programs, recovery schools, tutors, vocational training, and mentors.***
7. ***A continuum of interventions.***

It should be noted that, particularly in reference to the Task Force's first report, critical differences exist between family dependency treatment courts and adult and juvenile drug courts. First, the parents in these cases are not offenders. While the parents are in juvenile court due to their relationship with their children, the focus in a family dependency treatment court is primarily on the parents and their sobriety; the underlying assumption is that parental abstinence and recovery will positively impact the parent's ability to care for and relate to the child. The federal guidelines and timelines set the parameters for these cases, all with the best interests of the child as the primary and paramount goal, even within the family dependency treatment court.

Additionally, the Task Force recommends that:

[60] The state Judicial Council has identified a comprehensive effort to expand drug courts in Minnesota in its current strategic plan. While the current strategic plan focuses on adult and juvenile offenders (per the first Task Force report), it also fully supports CJI.

[61] At the local level, it is important for county attorneys, public defenders, and judges (along with other members of the problem-solving team) to determine the eligibility criteria for their problem-solving court.

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1) ***Attention and available resources be focused on child protection cases as a means to reduce future involvement in the juvenile delinquency and adult criminal justice systems;***
2) ***Each CJI team have at least one representative from the chemical health field as a regular participant, or at the very least, as an identified consultant to the team;***
3) ***CJI teams receive cross-training on effective interventions regarding the overlapping of the three systems – courts, child protection, and chemical health – as part of the ongoing annual CJI trainings;***
4) ***An in-state training program be developed based on the methods that CJI-AOD pilot counties are using to address the incidence of AOD in child protection cases;***
5) ***CJI support the parent-partner model, and encourage teams to invite at least one parent to be on their team.***

B. RECOMMENDATIONS FOR DOMESTIC VIOLENCE, CIVIL COMMITMENT, AND OTHER CASE TYPES:

Domestic Violence Cases

Problem: The Task Force heard extensive testimony concerning the link between AOD problems and domestic violence. Research has consistently reported that 40 to 60 percent of married or cohabitating patients entering AOD treatment reported one or more episodes of Intimate Partner Violence (IPV) in the previous year.[62] In a recent study of 62 episodes of domestic assault in which police were summoned, 92% of the offenders reported using alcohol or other drugs on the day of the assault, and 72% had a prior arrest for an AOD-related offense.[63] Even after controlling for antisocial personality disorder and relationship distress, researchers found that the odds of male violence against a female partner increased more than fourfold on days of alcohol consumption and nearly threefold on days of cocaine use.[64] This study and others have also concluded that AOD problems may increase the chances that an episode of male-to-female violence will be severe.[65]

The research community unanimously agrees that AOD problems and domestic violence are significantly correlated.[66] However, there is controversy regarding the nature of the relationship between the two. Researchers have tried to determine whether AOD use is one cause of domestic violence, whether it is related to another factor that is the real cause (for example mental health issues such as antisocial personality disorder), or

[62] William Fals-Stewart & Cheryl Kennedy, *Addressing Intimate Partner Violence in Substance-Abuse Treatment,* 29 J. SUBSTANCE ABUSE & TREATMENT 5 (2005).
[63] Barbara Rogers, Women's Services Coordinator, Sojourner Project, Inc., Testimony to the Task Force, Domestic Violence and Chemical Dependency: When They Co-exist in Relationships (March 24, 2006).
[64] William Fals-Stewart, James Golden & Julie A. Schumacher, *Intimate Partner Violence and Substance Use: A Longitudinal Day-to-Day Examination*, 28 ADDICTIVE BEHAVIORS 1555, 1566 (2003).
[65] *Id.*; Kenneth E. Leonard, *Alcohol and Intimate Partner Violence: When Can We Say That Heavy Drinking Is a Contributing Cause of Violence?* 100 ADDICTION 422, 424 (2005).
[66] Leonard, *supra* note 65.

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whether there is an indirect link between the two where the AOD problem leads to a breakdown in the relationship, which in turn leads to an atmosphere conducive to violence.[67]

There are many reasons why this issue is controversial. Domestic violence has many complex and often interrelated causes and many abusers are not AOD dependent.[68] Too narrow a focus on abusers' AOD problems could lead to a false sense of safety for survivors. Further, many experts are concerned that abusers will use their AOD problem to deflect accountability for the violence or, if the survivor has an AOD problem, there is concern that the survivor will be blamed for the violence.[69]

Recommendations:

A. ***All problem-solving court participants, especially women, should be screened for domestic violence.***

B. ***Once a drug court participant has been identified as a survivor, the safety of the participant and any children in the home should be the first priority. A referral should be made to an appropriate agency which provides domestic violence services for survivors and their families.***

Civil Commitments for the Chemically Dependent Individual[70]

The Task Force heard testimony[71] on the civil commitment process for AOD addicted individuals. In addition, some professionals working with civil commitments of the chronically AOD dependent in Minnesota were surveyed regarding the civil commitment process.[72] It appears that civil commitment could be a tool for drug court, and further investigation regarding the interaction between civil court and criminal court would be useful.

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[67] Keith C. Klostermann & William Fals-Stewart, *Intimate Partner Violence and Alcohol Use: Exploring the Role of Drinking in Partner Violence and its Implications for Intervention*, AGGRESSION & VIOLENT BEHAV. 587 (2006).

[68] CENTER FOR SUBSTANCE ABUSE TREATMENT., U.S. DEP'T OF HEALTH & HUM. SERVICES, SUBSTANCE ABUSE TREATMENT AND DOMESTIC VIOLENCE: TREATMENT IMPROVEMENT PROTOCOL (TIP) 25, 5 (1997).

[69] CRITICAL ISSUES IN DOMESTIC VIOLENCE 19 (Wilder Found. 2005), *available at* www.wilderresearch.org.

[70] Minn. Stat. § 253B (2004). The Task Force found that there is a continuum of functionality for people who are civilly committed—from those with severe addictions that need legal intervention to those suffering the late stage effects of chronic alcoholism, e.g. organic brain disease.

[71] Kim Bingham, Prosecutor, Ramsey County, Testimony to the Task Force (March 24, 2006). The testimony from Kim Bingham, a Ramsey County prosecutor who has been overseeing civil commitment cases for over 20 years, expressed great concern about the "criminalization" of addiction over the past two decades, the shortening of approved treatment length by health plans, and the current trend to place more people in outpatient treatment, when the severity of their disease appears to indicate otherwise.

[72] This survey was meant to be informative only and was not scientific. The Task Force also recognizes that only one group was surveyed and therefore any results present a limited perspective. A copy of the survey and results is on file at the Minnesota State Law Library.

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Minnesota law defines a "chemically dependant person" as a person who, due to excessive AOD use, is:

- Incapable of self management, and
- Likely to cause physical harm to self or others.

"Chemically dependant person" also includes a pregnant woman who has engaged in excessive AOD use of certain controlled substances.

When a court finds that there is no suitable alternative to civil commitment for a chemically dependant person, the court will commit the patient to the least restrictive placement that will meet the patient's treatment needs.[73]

Anyone can file a petition for civil commitment in Minnesota. While civil commitment can be voluntary, more than often a person is committed by petition; doctors and hospitals are the primary petitioners in Hennepin County. In greater Minnesota, the social service supervisor is usually the petitioner. A doctor's support statement must be filed with the petition as well. If a statement in support of the petition cannot be secured, there must be a statement that a reasonable effort was made to obtain one, and the statement must be presented at least by the time of the commitment hearing. In order for the court to commit an individual, the evidence to support commitment must be clear and convincing, and the court must first consider any reasonable alternatives; or there must be evidence that these alternatives have been considered in the past:

- The court can appoint a guardian; however, many counties will not pursue guardianship.
- The court can accept or dismiss the petition.
- The court can commit the individual in question to residential or non-residential treatment.

According to recent law, a proposed patient may also be committed to a treatment program in a bordering state that is under contract with the state or a county.[74]

If the person has private insurance and does not qualify for public treatment funding, the health plan is asked to make its own assessment of the need for commitment. The County Attorney may override a health plan's assessment provided there is sufficient factual evidence to support that decision.

A large challenge in meeting the needs of committed individuals is the capacity of our state-wide treatment system to address multiple co-occurring disorders. This includes those persons presenting with chemical dependency, criminality, mental illness, chronic health, pregnancy, and other acute complex medical needs. In addition, harm reduction strategies need to be integrated into the continuum of care to increase both patient and public safety in lieu of complete abstinence from AOD.

[73] Minn. Stat. § 253B.02, 253B.09 (2004).
[74] Minn. Stat. § 245.50 (2004), as amended by H.F. 3111.

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Therefore, the Task Force defers further comment and is reluctant to make any significant recommendations at this time. The Task Force does recommend that the Minnesota Judicial Branch give further attention to this matter.

Other Case Types

The Supreme Court charged the Task Force to review the impact of AOD on all case types. In the course of its work, the Task Force found that there is not a great deal of research showing the impact of AOD on several case types: marital dissolution, civil, and landlord/tenant. This set of case types includes livability crimes and all other misdemeanors and gross misdemeanors. While there was some general research showing the incidence of AOD in property crimes, livability crimes, and several misdemeanor and gross misdemeanors, the Task Force was unable to find enough reliable data and research to sufficiently address these cases. The Task Force strongly suspects that AOD is a significant issue in all of these case types, even though there is currently not sufficient research or data to verify this assertion. Therefore, based upon anecdotal information and the professional experience of many of its members, the Task Force suggests that the incidence of AOD in these additional case types does merit further attention.

C. RECOMMENDATIONS FOR STATEWIDE EXPANSION OF PROBLEM-SOLVING[75,76] APPROACHES IN MINNESOTA

Problem: In order to ensure equal access to justice for all offenders in the state, the Task Force suggests that the Judicial Branch and its partners must look to the experience of other states. Several challenges exist in transforming Minnesota's successful ad hoc problem-solving courts into a comprehensive statewide system. The Task Force recognizes that going to scale in Minnesota will require careful planning to ensure that the benefits of problem-solving innovations achieved thus far will be sustained as the model is applied across the state. The Task Force is also aware that one size does not and cannot fit all local jurisdictions. Therefore, the challenge will also be to support local communities in developing problem-solving solutions that fit their needs while at the same time ensuring the integrity of the model. The Task Force seeks to promulgate a "toolbox" that offers a variety of solutions for communities; while acknowledging the most comprehensively researched model is that of problem-solving courts, specifically drug courts.

Institutionalizing the problem-solving court model requires addressing fundamental questions: Which elements of the problem-solving model should be incorporated into the

[75] The Task Force recognizes that all of those who work in the court system are actively involved in the solving of problems and it neither wishes nor intends to disparage those efforts. The term "problem-solving" is a term of art used by courts across the country to define a specific type of innovative judicial intervention. *See* REPORT ON ADULT AND JUVENILE ALCOHOL AND OTHER DRUG OFFENDERS, *supra* note 5, at 21, 24-25.

[76] For a listing of the current (11/2006) problem-solving courts in Minnesota, *see* Appendix C.

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broader court system?[77] Which aspects of problem-solving court successes are the result of small size or local control? Can any judge be a problem-solving judge – is it simply a matter of adequate training, or does it require a certain disposition on the part of the jurist? How willing are key players – judges, prosecutors, public defenders, corrections agents, and social service providers – to become actively engaged in problem-solving models? Are specialized courtrooms necessary, or can the tools developed in problem-solving courts become part of the standard approach in conventional courtrooms? Is it desirable – and politically feasible – to extend the problem-solving approach to offenders who have traditionally been ineligible, such as certain violent offenders? What are the most effective ways to address the policy and fiscal challenges at the state level that inhibit, or at their worst prohibit, the collaboration necessary to effectively institutionalize problem-solving approaches? Finally, do the financial and treatment resources exist across the state to accommodate thousands of new participants?[78]

Going to scale is often thought of in terms of increasing numbers – for example, opening more problem-solving courts and serving more individuals. However, a broader conceptualization of "going to scale" has been offered by Cynthia Coburn, an education researcher at the University of California-Berkeley. Scaling up successfully, according to Coburn, hinges on normative changes that address the following four elements:[79]

1. *Spread*: the implementation of reforms at a larger number of sites or applying such reforms to more groups.
2. *Depth*: improved quality in the conceptualization and application of the problem-solving model.
3. *Sustainability*: putting the infrastructure and systems in place to support continued improvement in practice over time. Examples of strategies that are critical to achieving sustainability are ongoing training opportunities and reliable funding streams.
4. *Shift in Ownership*: a transfer of knowledge and authority from the state to the local level to allow for continued sustainability and improvement over time. Reformers and court administrators must consider strategies that will enhance the chances that problem-solving will be adopted and cultivated at the local level.

Coburn also highlights the tensions that may arise between the four elements. For example, spreading the problem-solving model may conflict with a desire to provide depth, as funding and technical assistance are stretched to reach more jurisdictions. Also, allowing for local flexibility to cultivate a shift in ownership may conflict with a need to ensure fidelity to the original problem-solving model.[80]

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[77] Aubrey Fox & Greg Berman, *Going to Scale: A Conversation About the Future of Drug Courts*, CT. REVIEW, Fall 2002, at 4.
[78] John Feinblatt, Greg Berman & Aubrey Fox, *Institutionalizing Innovation*, 28 FORDHAM URB. L.J. 277, 280 (2000).
[79] Donald J. Farole, Jr., *The Challenges of Going to Scale*: *Lessons from Other Disciplines for Problem-Solving Courts,* CTR. FOR CT. INNOVATION, 2006, at 4.
[80] *Id.*, at 5.

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In 2002, the United States Department of Justice convened an expert group of judges, practitioners, and scholars from around the country to address the challenges inherent in bringing drug courts into the mainstream of court operations.[81] Several themes emerged from the discussion: First, achieving buy-in from key players is critical. Judges and other key personnel may need transformative personal experiences[82] in addition to an ongoing training program to fully embrace the problem-solving model. Second, local flexibility should be preserved when possible. Experts argued that an intermediary entity created to provide technical assistance and support can provide necessary quality assurance without sacrificing local control. Third, collaborations are essential to the going-to-scale effort, signaling the need for strong and productive partnerships with executive branch agencies, the legislature, service providers, and community groups.[83] Fourth, addressing resource needs at the local, state, and federal levels is vital, including funding, staffing, technology, and treatment availability. Finally, ongoing evaluation of problem-solving initiatives is needed to track successes and identify areas in need of improvement. An effective management information system (MIS) serves as the anchor for this strategy.[84]

While the most common going-to-scale strategy involves spreading problem-solving courts to new jurisdictions, there are other paths that lead to institutionalization of the problem-solving philosophy.[85]

- *Intensifying efforts within a jurisdiction*. Scaling up can take the form of handling more cases, or a wider array of cases, within a jurisdiction.
- *Integrating elements of problem-solving in quasi-specialized courts*. This approach involves taking pieces of the problem-solving court model and integrating them into quasi-specialized courts on a system-wide scale.
- *Problem-solving in conventional courts*. Rather than scaling up a specific program, this approach involves the scaling up of information, practices, or a general philosophy.[86]

Recommendations regarding going to scale:

At the state level:

[81] These lessons seem to apply to all problem-solving strategies.
[82] Examples of such transformative experiences are: a member of a judge's family or a close friend goes to treatment for chemical dependency; a judge goes to treatment for an addictive disorder or has already achieved recovery; or experiential education – such as the Professionals in Residence program at Hazelden Institute that a pilot group of Minnesota judges completed.
[83] Fox & Berman, *supra* note 77, at 5.
[84] Other scholars have stressed the need for forward-thinking and innovative strategies to address the sustainability and success of the problem-solving model (e.g., incorporating the problem-solving philosophy into the curricula of local law schools). *See* Greg Berman, *The Hardest Sell? Problem Solving Justice and the Challenges of Statewide Implementation*, CTR. FOR CT. INNOVATION, June 2004, at 4-5.
[85] Farole, *supra* note 79, at 9-15.
[86] Regarding problem-solving in conventional courts, researchers have identified several principles and practices that are most appropriate to transfer to the general courtroom docket: a proactive, problem-solving orientation of the judge; interaction with the defendant/litigant; ongoing judicial supervision; integration of social services; and a team-based, non-adversarial approach.

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A. ***The goal should be to provide equal access to comparable levels of service to all chemically dependant defendants across the state.***

B. ***All programs should be based on, and adhere to, the Key Strategies (such as the Ten Key Components)[87] developed for that model of problem-solving court. However, drug court programs should be allowed flexibility in establishing criteria to meet local needs.[88]***

C. ***A statewide, multi-disciplinary oversight group should be formed to develop or inform statewide policy and guidelines, and provide funding direction.***

D. ***All problem-solving court team members should receive training endorsed by the Judicial Council before becoming operational.***

E. ***The Judicial, Legislative and Executive Branches of government should collaborate and coordinate efforts to fund and support problem-solving court activities.***

F. ***Funding for problem-solving courts should be a combination of state and local funds.***

G. ***The Judicial Council should adopt statewide performance measures for problem-solving courts that will support state- and local-level program evaluations.***

H. ***The State Court Administrator's Office should develop a common data collection system/criteria for drug courts to facilitate program efficiency, consistency, and evaluation.***

I. ***The State Court Administrator should provide central support to the Judicial Districts in the following areas: 1) Education for judges and program staff; 2) Technical support for program software; 3) Evaluation support; 4) Resource coordination; and 5) Sharing of national and local "Best Practices."***

At the Judicial District level:

A. ***Multi-county approaches are encouraged for the implementation of problem-solving approaches in greater Minnesota.***

B. ***Form a multi-disciplinary district level team to advise on problem-solving court development throughout the district and to support resource commitment.***

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[87] *See* Appendix B for the Ten Key Components.

[88] At the time of writing this report, draft Minnesota standards for drug courts are in the process of being adopted. These standards, once endorsed by the Judicial Council, will guide the implementation of drug courts in Minnesota in the effort of going-to-scale.

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D. GENERAL RECOMMENDATIONS[89]

1. RECOMMENDATIONS REGARDING COMMUNITIES OF COLOR[90]

The Task Force supports efforts to reduce racial disparities in the court system and believes that problem-solving approaches are a vital tool in this critical endeavor. Minnesota-based research by the Council on Crime and Justice shows that there is a disproportionate number of people of color, particularly African Americans,[91] in our criminal justice and prison systems. Representatives of the African-American community have expressed concern to the Task Force regarding the one-dimensional "get tough" approach to the crack cocaine epidemic of the 1980's,[92] which continues to affect Minnesota's communities, particularly its urban areas. While the causes of this disparity in the criminal justice and carceral systems are complex, and not within the purview of the Task Force's work, the Task Force recognizes that the criminal justice response[93] to illegal drugs is an important driver of these disparities. According to a 2002 study by the Council on Crime and Justice, racial disparities are the greatest for American Indians and African Americans.[94,95]

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[89] In the course of its work, the Task Force found there were several recommendations essential to the successful resolution of AOD problems and implementation of problem-solving approaches for AOD-addicted offenders.

[90] The term "communities of color" has been used with the understanding that there is not one ideal term to cover all racial groups and ethnicities. The Task Force does not mean to disparage any group in the use of this designation. The Task Force understands that American Indian tribes are also identified as a legal/political group and that Latino/Hispanic is an ethnicity that can apply to multiple races and groups.

[91] The Task Force recognizes that many communities of color have been impacted by racial disparities in the criminal justice system. While the disparities are the greatest for the African American community, the Task Force acknowledges that further attention to this issue must focus on all of the predominant communities of color in Minnesota: African American, Latino, American Indian, Southeast Asian, and Somali/East African. In fact, in many areas in out state Minnesota, the disparities for American Indians are equal to or exceed those of African-Americans (statewide).

[92] The Supreme Court of Minnesota, in *State v. Russell*, 477 N.W.2d 886 (Minn.1991) upheld a District Court's finding that legislation providing more severe sentences for defendants convicted of possessing or distributing crack cocaine versus those defendants convicted of possessing or distributing powder cocaine had a discriminatory effect on African American defendants. The Supreme Court also upheld the District Court's finding that the legislation violated the equal protection clauses of the Minnesota Constitution, as the legislative distinction between crack cocaine and powder cocaine had "no rational basis". The legislature responded by raising the legal consequences and sentencing guidelines for powder cocaine to the same level as crack cocaine.

[93] The Task Force recognizes that much of the criminal justice response to the drug epidemic has been initiated in adherence to federal and state legislation that attempted to deal with the impact that drugs, especially crack cocaine and more recently methamphetamine, have on our communities.

[94] Judicial Council Policy states: "It is the policy of the Minnesota Judicial Branch to identify and eliminate barriers to racial and ethnic fairness within the judicial system, in support of the fundamental principle of fair and equitable treatment under law." Minn. State. Court Administrator's Office, *Forging Ahead: Creating a Racially Fair Future for the Courts* (2003).

[95] Racial disparities in the population of persons imprisoned are the greatest for African Americans, who represented 4% of Minnesota's total population in 2005, but nearly one-third (32%) of the adult prison population. American Indians represented about 1% of the population in Minnesota, but are 7% of the prison population. Nearly 4% of Minnesotans identify as Hispanic, but 7% of adult inmates are of Hispanic ethnicity. There does not appear to be a racial disparity in incarceration for Asian Minnesotans, who make

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Problem: Racial disparity in the criminal justice system has several complex and overlapping causes.[96,97] This disparity, no matter what its cause, results in significant consequences for the families and communities that are affected. In particular, the existence of a criminal record may create long-term barriers to stable employment and housing. Children of incarcerated parents are six times more likely to engage in criminal behavior.[98] Overall population trends indicate that communities of color will continue to grow and contribute to Minnesota's identity and culture.[99] Given this predicted population growth, the future of Minnesota for all citizens depends on implementing effective solutions to the problem of racial disparity in the criminal justice system.

The Task Force heard expert testimony from service providers, researchers, and community leaders[100] who helped to identify the different needs, challenges, and promising practices in their communities. Despite diverse histories and cultures, several common themes emerged from this testimony:[101]

- *The need for culturally competent staff in the criminal justice and AOD treatment systems.*[102] Cultural competence can be interpreted in a variety of ways. The Task Force specifically asked each panelist to talk about what cultural competency means in his or her community. They spoke of the need to understand the realities of peoples' lives, to understand a person's culture and country of origin, the need for language fluency, the importance of learning from reputable research, and the importance of understanding and respecting another's identity. Cultural competence means knowing enough about oneself and one's client to know when to question assumptions and step back from a situation to ask for help.[103]

- *The importance of history.* Whether it be the history of Minnesota's first peoples, the legacy of slavery, the impact of the so called "war on drugs," or the stories of refugee camps, history informs the present and leads to more effective solutions for Minnesotans of color with AOD problems.

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up about 3.5% of the population but only 2% of the adult inmate population. U.S. Census Bureau, 2004 American Community Survey (2005); Minn. Dep't. Corrections, Adult Inmate Profile as of July 1, 2005 (Aug. 2005).

[96] *See* Council on Crime & Justice, *Reducing Racial Disparity While Enhancing Public Safety: Key Findings and Recommendations* 2 (2006), *available at* http://www.racialdisparity.org/reports_final_report.php. .

[97] Racial disparity exists whenever the proportion of a racial/ethnic group in a given circumstance or socio-historical location exceeds the proportion of that group within the general population. *See id.*

[98] S. Bilchik, C. Seymour & K. Kreisher, *Parents in Prison*, Corrections Today, 2001, at 108 -112.

[99] Minn. State Demographic Ctr., Nonwhite and Latino Populations in Minnesota Continue to Grow Rapidly, Population Notes Series, Aug. 2006, at .

[100] A panel of representatives from the African-American, American-Indian, Latino, Hmong-American, and Somali/East African communities testified before the Task Force on June 30, 2006. The names of the individuals who testified can be found in the *Acknowledgments* section of this report.

[101] Panel Testimony to the Task Force (June 30, 2006).

[102] The Substance Abuse and Mental Health Services Administration (SAMHSA) defines cultural competence as the skills, knowledge, experience, and attitudes that allow individuals, organizations, and systems to work effectively with diverse racial, ethnic, and social groups.

[103] It is also important to note that culture is not limited to racial/ethnic background, but also includes socioeconomic status, religious/spiritual beliefs, historical circumstances, and many other factors

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- *The impact of racism and xenophobia.*[104] Racism is sometimes thought of as limited to individual, direct interactions, such as racial slurs or racially motivated crime. However, racism and xenophobia also take place in the millions of indirect, subtle, daily interactions that people experience throughout their lives. These encounters between individuals, systems, and media sources shape one's beliefs, sense of self, and sense of identity within the larger society.

- *The impact of poverty and socioeconomic level*. In the metropolitan area, the median income is lower for persons in minority households, in comparison to white households.[105] The income gap is most extreme in the Twin Cities. Further, re-entry from the criminal justice system into low-income neighborhoods, predominantly populated by people of color, with inadequate community resources can jeopardize offenders' recovery efforts.

- *The importance of family and community.* Family relationships are vital in every culture, and can be a source of strength or a significant barrier to recovery for offenders with AOD problems. The Task Force heard from several panelists that positively engaging family and community support systems can help offenders of color achieve sobriety and avoid recidivism.[106]

- *The importance of spirituality or religion* as a source of strength in treatment, recovery, and healing for the individual and for the community. Several panelists testified to the Task Force that the faith community is a critical resource that is under-utilized by the criminal justice system as a source of support for AOD offenders, although the Task Force suggests it is important to provide non-religious connected services and programs as well. [107]

- *A holistic, systemic approach* that addresses inequities in public education, community services, transportation, housing, employment, and health care, in addition to a strategic response by criminal justice entities, is the optimal and ideal solution. While the court system cannot directly address many of these challenges, experience shows that attempts to draw in these resources are critical to the success of problem-solving approaches.

- *The need for action.* The issue of racial disparity in the criminal justice system has been studied and reported on many times in the past. An accurate understanding of the problem is important. However, the panel clearly communicated – and the Task Force suggests – that it is time for the judicial branch, as well as those in the executive and legislative branches, to implement solutions to this difficult issue, especially in the criminal justice and child protection areas.[108]

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[104] Xenophobia is "fear and hatred of strangers or foreigners or of anything that is strange or foreign." *Merriam-Webster's Collegiate Dictionary* 1364 (10th ed. 2001).
[105] Brookings Inst. Metro. Policy Program, *Mind the Gap: Reducing Disparities to Improve Regional Competitiveness in the Twin Cities* 12 (2005), *available at* http://www.brookings.edu/metro/pubs/20051027_mindthegap.htm.
[106] Panel Testimony to the Task Force (June 30, 2006).
[107] *Id.*
[108] To that effect, the Task Force applauds the current efforts of the Council on Crime and Justice at its "Call to Action". *See* Racial Disparity Initiative, *Get Involved*, http://www.racialdisparity.org/get_involved_main.php (last visited Nov. 20, 2006).

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Recommendations:

State Level

A. ***The proposed Drug Court Initiative Advisory Committee should work with the Judicial Branch Racial Fairness Committee as it designs and implements problem-solving approaches statewide, per the Judicial Branch Strategic Plan, as they relate to the experiences of and impact on people of color.***

B. ***Policy makers are encouraged to ensure that access to appropriate and effective treatment be made available to all racial/ethnic populations regardless of the specific chemical that brings the offender into the system.***

C. ***Policy makers are encouraged to develop appropriate treatment strategies for AOD offenders in Minnesota's diverse communities to address their specific chemical problems.***

D. ***The State Court Administrator's Office should provide ongoing training to problem-solving court teams, in consultation with the Racial Fairness Committee, in the following areas:***

- ***a. Cultural competence Educational opportunities should be tailored to meet local needs. Training programs should be designed and implemented by community leaders/experts whenever possible.***
- ***b. Racial disparities in the criminal justice system.***
- ***c. Updates on promising practices for people of color regarding AOD treatment and criminal justice interventions.***

Local Level

E. ***Local problem-solving courts, whenever possible, should create an ongoing advisory committee to provide guidance regarding the problem-solving approach as it relates to the experiences of and impact on people of color in the local community.***

F. ***Local courts implementing problem-solving approaches should consult with local experts from communities of color at the beginning of planning through implementation of the program.***

G. ***Local problem-solving court teams should recruit and hire people of color to insure as much diversity as possible, particularly based upon local demographics.***

H. ***The provision of interpreter services to insure equality of access in problem-solving courts must be provided according to Minn. Stat. § 611.32, subd. 1.***

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Treatment and other services for participants should be language-appropriate whenever possible.

I. ***Problem-solving courts should collaborate with community partners to create racially/ethnically appropriate mentorship opportunities for participants of color.***

J. ***Problem-solving approaches should be flexible to allow for cultural differences concerning family/social structure and religious/spiritual practices.***

K. ***Restorative justice interventions should be utilized whenever appropriate and possible as a tool to better engage the community in the decision-making process.***

2. RECOMMENDATIONS FOR AOD OFFENDERS WITH CO-OCCURING DISORDERS (COD)[109]

Problem: Research has demonstrated that COD is a common diagnosis. Dr. Larry Anderson, a licensed psychologist and state expert on co-occurring disorders, testified that 53% of individuals in the general adult population with a drug disorder (other than alcohol) also have a mental health disorder.[110] Also, 37% of individuals with an alcohol disorder also have a mental health disorder.[111] Further, serious mental illness (SMI) is highly correlated with AOD problems.[112] Twenty-three percent of individuals with SMI also had an AOD disorder, as compared to only 8% of adults without an SMI. Among adults with AOD problems, 20% had SMI versus 7% of adults who did not have AOD problems.[113,114] Individuals who have COD often experience more severe and chronic medical, social, and emotional problems that may complicate treatment. Further, AOD relapse often leads to a worsening of the co-occurring mental health disorder; conversely, worsening psychiatric problems often leads to AOD relapse. As a result, individuals with

[109] Many terms have been used to describe individuals who have been diagnosed with both AOD dependency and a mental health disorder: 1) *Co-occurring disorders (COD)* refers to a diagnosis in which at least one substance use disorder and one mental health disorder can be established independent of the other; 2) *Dual-diagnosis* is a broad term that refers to the simultaneous presence of two independent medical disorders; 3) *Mentally ill and chemically dependent (MICD);* 4) *Mentally ill chemical abuser (MICA);* and 5) *Chemically abusing mentally ill (CAMI).* The latter three terms may correlate to the severity of one disorder in comparison to another. For example, a MICD or MICA client may be assessed as having a more severe mental health issue with a less severe AOD problem. Thus, the Task Force has adopted the term co-occurring disorders or COD.

[110] *See* Appendix D for a chart of the most common mental health disorders as related to the drug of addiction.

[111] Dr. Larry Anderson, Psychologist, Testimony to the Task Force, Dual Diagnosis Issues: Understanding the Concept (April 28, 2006).

[112] SMI refers to mental disorders that meet the *Diagnostic and Statistical Manual of Mental Disorders,* 4th edition (DSM-IV) criteria and that cause a substantial interference with one or more major life activities.

[113] Substance Abuse & Mental Health Services Admin., U.S. Dep't of Health & Hum. Services, *Substance Abuse Treatment for Persons with Co-Occurring Disorders,* Treatment Improvement Protocol (TIP) 42, 2005, at 4.

[114] *See* Appendix E for a visual matrix of the co-occurring service delivery systems.

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COD may be prone to more crises, progress more slowly, and require longer and more intensive treatment than people without COD.[115]

Despite increased awareness and research on COD, individuals with AOD and mental health disorders commonly appear at facilities that are not prepared to treat them, resulting in a "bouncing" from one type of treatment to another.[116] Misdiagnoses or automatically transferring patients with COD can result in patients falling between the cracks of two separate treatment systems. Patients themselves express the need for a single provider who can understand and address both the AOD and mental health disorders in a comprehensive way.[117] COD clients who are identified through the criminal justice system similarly require integration of AOD treatment and mental health services, with the addition of programs that address criminal thinking and behavior.[118]

Studies have shown that the lack of integrated and comprehensive care in the treatment of co-occurring disorders is associated with the following negative outcomes, inter alia, for people with COD**:**

- **Increased vulnerability to relapse and hospitalization;**
- **More psychotic symptoms, greater depression and suicidal tendencies;**
- **Episodic violence;**
- **Recidivism;**
- **Inability to manage finances and daily needs, resulting in housing instability and homelessness; and,**
- **Increased risk behavior and vulnerability to HIV infection.** [119]

In testimony from Dr. Anderson, the Task Force learned of the Comprehensive Continuous Integrated System of Care (CCISC), developed as a model to address the need for integrated treatment of COD clients. The CCISC is based on the understanding that COD are expected throughout the service system.[120] CCISC advocates that individuals with COD benefit from continuous, integrated treatment relationships. This can involve a wide range of techniques:

- Integrated screening and assessment
- Dual recovery mutual-help meetings
- Dual recovery groups (in which recovery skills for both AOD addictions and COD are discussed)
- Individual motivational enhancement interventions that address all disorders

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[115] Anderson, *supra* note 111.
[116] Substance Abuse & Mental Health Services Admin., *supra* note 113, at 6.
[117] Anderson, *supra* note 111.
[118] Substance Abuse & Mental Health Services Admin., *supra* note 113, at 9.
[119] Holly A. Hills, *The Special Needs of Women with Co-occurring Disorders Diverted from the Criminal Justice System,* 4-5 (Nat'l GAINS Ctr. TAPA Ctr. For Jail Diversion 2003), available at http://www.nhtfwa.org/publications/WomenAndSpects.pdf.
[120] This model is recognized as exemplary practice by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA).

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- Combined pharmacological interventions, in which an individual receives medication to reduce cravings as well as medication for a mental health disorder.[121]

Recommendations: While the Task Force recognizes that the availability of resources is limited, particularly in greater Minnesota, it stresses the necessity of COD resources to ensure the success of AOD offenders.[122] In its thorough 2005 report on co-occurring disorders, Substance Abuse and Mental Health Services Administration (SAMHSA) adopted recommendations for treatment based upon the CCISC. The Task Force supports the same following recommendations:

1. ***Provide access. This refers to the process by which COD clients make initial contact with the service system. A "no wrong door" policy ensures that an individual with COD has access to appropriate services no matter where he or she enters the system.***
2. ***Complete a full assessment. The challenge of assessment for individuals with COD involves initially recognizing the presence of more than one disorder and adapting an assessment as the client's needs change over time.***
3. ***Provide an appropriate level of care. Ideally, clients should be placed in a level of care appropriate to the severity of both their AOD and mental health disorders.***
4. ***Achieve integrated treatment. This is the preferred model of treatment, and it can occur through different mechanisms, such as: one clinician delivers most or all necessary services or serves as a coordinator of services; multiple clinicians collaborate to provide necessary services; one program or program model provides integrated care; or multiple agencies join together to create services that will serve the COD population.***
5. ***Provide comprehensive services. Treatment programs should be prepared to help clients access a broad array of services and support systems, including assistance with housing, employment, and other life skills.***
6. ***Ensure continuity of care. This implies coordination of care for clients who move across different service systems. Research supports the critical role of continuing care in reducing recidivism in the criminal justice population.*** [123]

Some problem-solving courts have developed separate "tracks" for participants with COD to deliver these unique modifications. Since this approach may not be feasible for all problem-solving courts, at a minimum courts should adopt the following core services to better serve participants with COD:

- ***Comprehensive screening and assessment that encompass both mental health and AOD use/dependency;***
- ***Medication monitoring in addition to AOD testing, when appropriate and possible; and***

[121] Substance Abuse & Mental Health Services Admin., *supra* note 113, at 29.
[122] The Task Force understands that one result of the proliferation of drug courts in Minnesota has been the increased availability of chemical dependency services across the state. The Task Force hopes that the same result will occur with the availability of quality COD treatment services throughout the state.
[123] Substance Abuse & Mental Health Services. Admin., *supra* note 113, at 41-48.

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- ***When possible, use of individual counseling, intensive case management and outreach, and a reduced caseload for staff serving this population.*** [124]

3. RECOMMENDATIONS REGARDING AOD OFFENDERS AND TRAUMA

Problem: Research has shown a strong correlation between trauma, AOD problems, and criminal justice involvement. Trauma can take many forms, such as: emotional, physical, or sexual abuse; participation in combat or other violent catastrophic or episodic occurrences; extremely painful or frightening medical procedures; catastrophic injuries and illnesses; assault or other crime; school bullying or taunting. Trauma can also occur over time as a result of stigmatization, e.g., the effects of racism and homophobia, or the shaming of those with mental health or AOD problems.[125]

Experiencing trauma disrupts brain chemistry; childhood trauma can have lasting effects on brain development.[126] Childhood abuse (especially sexual abuse) is related to a number of later difficulties, including AOD problems and mental and physical health problems. In general, traumatic experiences can lead a survivor to seek out alcohol and other drugs as a means to cope with the underlying pain and anxiety caused by the trauma. Therefore, trauma-related experiences, particularly if unrecognized and unaddressed, may complicate AOD treatment and recovery and potentially lead to relapse.[127]

While many who experience trauma do not require treatment to recover, trauma can lead to serious mental health issues, including Post Traumatic Stress Disorder (PTSD). For people who develop PTSD, memories of the traumatic event or events reoccur unexpectedly, intruding into their current lives.[128]

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[124] *See generally* Roger H. Peters & Fred C. Osher, *Co-Occurring Disorders and Specialty Courts* 34 (Nat'l GAINS Ctr. 2004) (providing comprehensive and useful guidance for problem-solving approaches for offenders with COD).

[125] Carol Ackley, Executive Director, River Ridge Treatment Center, Testimony to the Task Force: Women's Issues in Treatment (May 26, 2006).

[126] Id.

[127] SAMHSA's National Mental Health Information Center, The Center on Women Violence and Trauma: Men and Trauma, http://www.mentalhealth.samhsa.gov/cmhs/womenandtrauma/men_trauma.asp (last visited Aug. 14, 2006).

[128] American Psychiatric Association, APA Let's Talk Facts About...Posttraumatic Stress Disorder, http://www.psych.org/disasterpsych/fs/ptsd.cfm (last visited Aug. 14, 2006).

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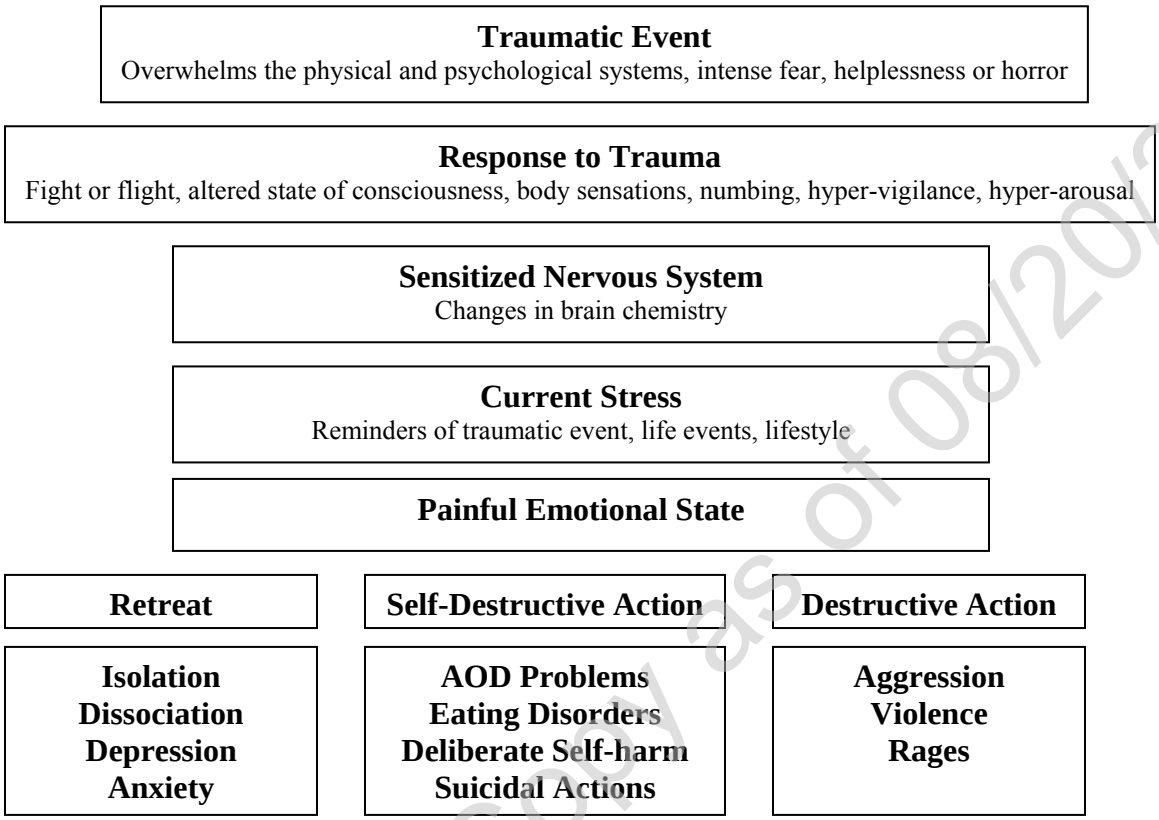
THE PROCESS OF TRAUMA[129]



Trauma-specific services are designed to treat directly the symptoms or resulting disorders of the traumatic experience(s), like PTSD. The intent of these services is to build skills and strategies that allow survivors to manage their symptoms with minimal disruption to their daily obligations and quality of life, and to eventually eliminate debilitating symptoms. *Trauma-informed (or trauma-sensitive) services* do not address the trauma disorder itself. Rather, trauma-informed services—whether AOD treatment or criminal justice interventions, such as drug courts—are designed to provide appropriate interactions tailored to the special needs of trauma survivors.[130] These services take the trauma into account by designing and procedures that screen for trauma, and greatly reduce or eliminate the triggers of trauma for the survivor. Suggested requirements for a trauma-informed system of care can be found in Appendix F.

Trauma and gender

There is a very high likelihood that women with AOD problems have experienced trauma at some point in their lives; 55 to 99 percent of women with AOD problems have been

[129] Ackley, *supra* note 125.

[130] Maxine Harris & Roger D. Fallot, *Envisioning a Trauma-Informed Service System: A Vital Paradigm Shift, in* USING TRAUMA THEORY TO DESIGN SERVICE SYSTEMS 3, 4-5 (Maxine Harris & Roger D. Fallot eds., Jossey-Bass 2001).

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victimized.[131] Often, a vicious cycle emerges as women who are using AOD are at greater risk for additional physical and sexual abuse.[132] There is a similar correlation between trauma and criminality for women in the criminal justice system. In a recent jail survey, 48% of the women reported a history of physical or sexual abuse and 28% had been raped. The incidence of trauma rises in women who have co-occurring AOD and mental health disorders.[133] For many of the women affected, their first abuse occurred when they were children or adolescents. Women victimized as children frequently lose custody of their own children due to allegations of abuse or neglect, and over 50% of child abuse and neglect cases involve parental AOD use.[134]

While considerable research has been devoted to the prevalence and effect of trauma on women, more recent research has also documented these issues for men. In community-based surveys, men report pervasive trauma exposure: 61% of men report a history of at least one traumatic event; men report an average of 5.3 traumatic events in their lifetimes. Both of these figures are slightly higher than those for women.[135] The types of experiences and resulting coping mechanisms, however, often differ between men and women. Male survivors tend to manifest trauma by externalizing it (Destructive Action in the chart above), while it is more common for female survivors to cope through internalizing (Retreating or Self-Destructive Action in the chart above).[136,137]

Historically, men have been defined as the abuser, and less frequently as those who also suffer abuse. The cycle of abuse is such that the victim very often becomes the perpetrator, especially with men who are raised to funnel many of their emotions into the expression of anger.[138] It is critical that those perpetrators of violence who suffer from PTSD or other trauma-specific injury or disorders be held accountable for their violent behavior, and at the same time be supported in addressing any underlying trauma that lies at the root of their behavior. Experts made clear to the Task Force that this is the only way to stop the cycle of violence.[139] The key challenges are not to minimize the damage done by the violence, to ensure the safety of those whom the abuser has harmed, and to avoid further traumatization of anyone, including the abuser, involved in the therapeutic process. The existing research relating to men's experiences with trauma has largely been

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[131] *Id.* at 3.
[132] Maxine Harris & Roger D. Fallot, *Designing Trauma-Informed Addictions Services, in* USING TRAUMA THEORY TO DESIGN SERVICE SYSTEMS, *supra* 128, at 57, 62..
[133] Colleen Clark, *Addressing Histories of Trauma and Victimization through Treatment,* GAINS CENTER SERIES: JUSTICE-INVOLVED WOMEN WITH CO-OCCURRING DISORDERS & THEIR CHILD. (NAT'L GAINS CENTER), Sept. 2002, at 8.
[134] SAMHSA's National Mental Health Information Center, The Center on Women, Violence and Trauma: Women, Co-occurring Disorders and Violence Study, Addressing the Impact of Violence and Trauma on Women & Adolescent Girls, http://www.mentalhealth.samhsa.gov/cmhs/womenandtrauma/wcdvs.asp (last visited Aug. 14, 2006).
[135] *Id.*
[136] *Id.*
[137] These generalities do not apply to all men nor do they apply to all women, which is again why it is imperative that informed assessment guide the process for supporting survivors of trauma.
[138] Dr. Larry Anderson, Psychologist, Testimony to the Task Force: Men's Issues in Treatment: A Relational Approach to Men's Treatment and Recovery (May 21, 2006).
[139] Dr. Noel R. Larson, Psychologist, Testimony to the Task Force: Domestic Violence (April 2006).

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limited to combat-related PTSD, rather than the more common occurrence of childhood sexual/physical abuse or community and institutional violence (particularly for inner-city men, men from families with AOD problems, and boys of color). Men and boys have, for the most part, not been encouraged to come forward as victims of sexual abuse or physical abuse. For many men who define themselves through a sense of power (often over others), to acknowledge abuse is often seen as tantamount to admitting helplessness and weakness—two traits seen as anathema to masculinity. There is a shortage of gender-responsive and culturally relevant trauma-related services for men.[140] Research on the high rate of trauma in women seeking AOD treatment has led to the recommendation of an integrated, trauma-informed approach for AOD treatment that addresses both issues simultaneously. While this approach was designed with women in mind, such an integrated approach may also be desirable for male survivors of trauma with AOD disorders.[141]

Recommendations:

1) ***Each problem-solving approach program team should receive training on trauma disorders and trauma-informed services.***
2) ***Drug court teams, and other problem-solving interventions for AOD offenders, should design procedures to prevent re-traumatizing participants with a history of trauma, and should regularly assess how well they are achieving this goal in their process evaluations.***
3) ***State-funded treatment services should incorporate evidenced-based practices regarding trauma disorders, with ongoing education and training available.***

4. RECOMMENDATIONS REGARDING GENDER-RESPONSIVE STRATEGIES FOR WOMEN AND GIRLS[142]

Problem: While the term "sex" refers to the biological differences between males and females, "gender" encompasses the socially and culturally ascribed differences between the sexes. The pathway to AOD problems and criminal behavior is often different for males and females.[143] Gender-responsive services address the unique needs of a gender

[140] Anderson, *supra* note 138.

[141] These are some of the critical elements for an integrated trauma-informed system of care: (1) The program teaches explanations that integrate trauma and AOD use and is based on strengths rather than deficits; (2) The program should build cross-over skills; (3) The program should include ancillary services; (4) The program should avoid contraindicated approaches—techniques that encourage an already demoralized survivor to feel ashamed are counterproductive. Similarly, approaches that stress confrontation and surrender may make it difficult for women in particular to find inner strength. Harris &. Fallot, *Designing Trauma-Informed Addictions Services, in* USING TRAUMA THEORY TO DESIGN SERVICE SYSTEMS 64-71 (Maxine Harris & Roger D. Fallot eds., Jossey-Bass 2001).

[142] While ultimately this concept applies to both men and women, the Task Force's current focus is on women and girls.

[143] PAM PATTON & MARCIA MORGAN, OREGON CRIMINAL JUSTICE COMMISSION, HOW TO IMPLEMENT OREGON'S GUIDELINES FOR EFFECTIVE GENDER-RESPONSIVE PROGRAMMING FOR GIRLS 10-12 (2002), available at http://159.121.112.123/JCP/JCPGenderSpecific.htm

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group by fostering positive gender identity development.[144] Gender responsive strategies for women and girls create an environment that responds to the realities of their lives. The strategies are based on research that acknowledges that pathways into addiction and the criminal justice system will often differ based on gender, together with other factors such as race, sexual orientation, and class.[145]

"Equal opportunity" sometimes means providing men and women with identical opportunities. However, the Task Force heard testimony, supported by research, that creating equal opportunity for recovery from AOD problems often requires treating women and men differently based on their unique needs and experiences.[146] Minnesota law requires that women and girls convicted of crimes be provided with "a range and quality of programming substantially equivalent to programming" offered to men and boys. Additionally, the statute requires that Minnesota provide model programs for female offenders, within the limits of financial resources appropriated by the legislature, that are designed to address the problems most often experienced by female offenders.[147]

Women

Women comprise a small percentage of the criminal justice population, but they are the fastest growing segment. The Associated Press reported on May 21, 2006 that the number of women in state prisons has grown at more than twice the rate of men between 1977 and 2004, 757 percent as opposed to 388 percent.[148] Women with AOD problems are entering jails and prisons at unprecedented rates. The increasing incarceration of women offenders has particularly impacted women of color living in poverty, who are disproportionately represented among women convicted of drug-related offenses.[149] The vast majority of women in the criminal justice system are charged with non-violent offenses. While these crimes clearly cause harm to the community and should not be minimized, women offenders often present a low risk to public safety.[150]

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[144] The terms "gender-responsive" or "gender-specific" services or programs are not synonymous with services and policies for females. It is therefore important to specify whether males or females are being discussed when using this term.

[145] Identification as gay, lesbian, bisexual, or transgender (GLBT) also has a profound effect on an individual's sense of self and pathway to AOD abuse and criminal behavior. Studies have shown that 20 to 40 percent of the runaway and street youth population is gay or lesbian. CHRISTY SHARP & JESSICA SIMON, GIRLS IN THE JUVENILE SYSTEM: THE NEED FOR MORE GENDER RESPONSIVE SERVICES 10 (Child Welfare League of Am. 2004).

[146] Tomljanovich, *supra* note 19.

[147] MINN. STAT. § 241.70 (2004).

[148] *Female Prison Population Grew 757 Percent Since 1977, Report Says,* Join Together, Mayy 22, 2006 http://www.jointogether.org/news/headlines/inthenews/2006/female-prison-population-grew.html.

[149] SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., U.S. DEP'T OF HEALTH & HUM. SERVICES, TECHNICAL ASSISTANCE PUBL'N (TAP) No. 23, SUBSTANCE ABUSE TREATMENT FOR WOMEN OFFENDERS: GUIDE TO PROMISING PRACTICES 4 (1999).

[150] Linda Sydney, *Supervision of Women Defendants and Offenders in the Community,* GENDER-RESPONSIVE STRATEGIES FOR WOMEN OFFENDERS (Nat'l Institute of Corrections, U.S. Dep't. of Justice), Oct. 2005, at 4-5.

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For many women offenders, an AOD problem is accompanied by poverty, mental health issues, a history of trauma, and involvement in abusive relationships. Eight out of every ten women entering the criminal justice system are parents.[151] While almost 90% of children whose fathers are incarcerated live with their mothers, only 25% of children of incarcerated mothers live with their fathers. As a result, criminal justice interventions have a profound ripple effect on female offenders' children. Research shows that these children are in serious jeopardy of becoming offenders themselves.[152]

Women offenders are also more likely than their male counterparts to be diagnosed with a mental health disorder. In a 2001 study, 12.2% of women entering jails were diagnosed with a serious mental illness, more than twice the rate for men at intake. Of those 12.2%, nearly three-fourths have a co-occurring AOD disorder. Further, staff at the Minnesota Shakopee women's prison estimate that 80% of the women report having been sexually or physically abused.[153] About one in five women offenders on probation in 2003 was a victim of intimate partner domestic violence.[154,155]

Promising Practices for Women Offenders with AOD problems

As the population of women offenders with AOD problems increased over the last thirty years, states either placed women in traditional AOD treatment programs developed by men for men, or worked to modify these programs for women. However, modifying services designed for men or adding special services to the male model has generally been unsuccessful for women.[156] What works for female offenders are approaches that address the interrelated complexities of women's lives. To be successful, these services must address poverty, AOD dependency, homelessness, parenting responsibilities, relationship dysfunction and trauma, and physical and mental health issues.[157] Successful women-specific programs are designed to help women build healthy relationships, learn coping and life skills, build self-esteem and feelings of empowerment, and strengthen relationships with children and family.[158] This approach is a response to modern research about women's development that has demonstrated the importance of relationships in women's lives, also known as the relational model.[159,160]

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[151] SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., *supra* note 149, at 5; Ackley, *supra* note 125.
[152] Rose Alvorado, *Strengthening America's Families: Programs That Work for Justice-Involved Women with Co-occurring Disorders,* THE GAINS CENTER SERIES: JUSTICE-INVOLVED WOMEN WITH CO-OCCURRING DISORDERS AND THEIR CHILDREN (Nat'l GAINS Center), Sept. 2002, at 1.
[153] Tomljanovich, *supra* note 19.
[154] Sydney, *supra* note 150, at 7.
[155] Further information on co-occurring disorders and trauma can be found in sections in this report devoted to those issues.
[156] SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., *supra* note 149, at 17, 21 (1999); PATTON & MORGAN, *supra* note 143*, at 9*.
[157] Sydney, *supra* note 150, at 3; Ackley, *supra* note 125; Ann L. Jacobs, Women's Prison Association and Home, Inc., Presentation to the Annual Conference of the American Society of Criminology: Improving the Odds: Women in Community Corrections (November 17, 2004).
[158] SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., *supra* note 149, at 8.
[159] *SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., supra* note 149, at 21; *see also* S.S. Covington & J.L. Surrey, *The Relational Model of Women's Psychological Development: Implications for Substance*

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The Substance Abuse and Mental Health Services Administration (SAMHSA) recommends establishing formal state networks for the facilitation of coordinated services for women offenders, much like those networks that result from team formation in problem-solving courts. Collaboration with child protection agencies is particularly important for women with children who are not in their custody. A mother who successfully achieves recovery and regains custody of her children is the best possible outcome for the criminal justice system and the community.[161]

Girls

Girls are entering the juvenile justice system at a rate similar to female adult offenders. In 2000, girls accounted for 28 percent of all juvenile arrests, compared with 19 percent in 1990. Girls, like adult females, are predominantly arrested for nonviolent crimes, including larceny-theft, shoplifting, prostitution, running away, and truancy. However, girls are less likely than boys to become chronic offenders. Rather than commit new offenses, girls commonly remain in the system through a violation of a court order, probation violation, or contempt charge.[162]

Recommendations for gender-responsive programming for girls emphasize the need for building self-confidence and healthy relationships, which can lead to resilience from delinquency and AOD problems. Girls in recovery need an environment in which they are physically safe from violence and abuse, as well as emotionally safe from teasing and harassment. Girls often do best in girls-only groups in which they are encouraged to express themselves, share feelings, and which allow time to develop trust and healthy relationships.[163,164]

Recommendations

WOMEN

A. ***The Task Force recommends that problem-solving courts design programs and processes that are gender-responsive. (Please see Appendix G for examples.)***

B. ***Women should be included in women-only groups whenever possible. If this is not feasible, any co-ed group should be modified to give women frequent***

Abuse, in GENDER AND ALCOHOL: INDIVIDUAL AND SOCIAL PERSPECTIVES (Wilsnack & Wilsnack, eds., 1997).

[160] For example, traditional Twelve Step models that emphasize an individual's powerlessness in the face of her addiction may not be as effective with women, particularly those who have experienced trauma and victimization. For many women, a modified version or women-only Twelve Step group that taps into women's need to build healthy relationships may result in better outcomes.

[161] Hills, *supra* note 119, at 8.

[162] SHARP & SIMON, *supra* note 145, at 6.

[163] PATTON & MORGAN, *supra* note 143, at 8, 31-33, 43.

[164] If there are too few girls to form a girls-only group, a co-ed group should be modified to give girls frequent opportunities to interact with staff and other girls outside the presence of boys.

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opportunities to interact with staff and other women outside of the presence of men.

C. ***Same-sex supervision of females is beneficial to women and should be provided whenever possible.***

D. ***Each problem-solving court team should receive training on gender-specific issues and gender-responsive strategies.***

E. ***The Task Force supports evidence-based treatment services that are integrated or coordinated to address women's mental health, physical health, parenting, vocational, housing, transportation, and other needs.***

F. ***Problem-solving strategies should include sanctions and incentives that are reflective of the challenges faced by custodial single mothers (suggested sanctions and incentives are listed in Appendix H) and coordinated, when possible, with the concomitant requirements of child protection in juvenile court.***

GIRLS

A. ***Girls should be included in girls-only groups when possible. If this is not feasible, a co-ed group should be modified to give girls frequent opportunities to interact with staff and other girls outside the presence of boys.***

5. RECOMMENDATIONS REGARDING CRIMINAL JUSTICE TREATMENT

Problem: Research shows that AOD treatment can reduce individual AOD use, crime, and related incarceration costs, and also suggests that treating certain AOD-dependent dealers (primarily those dealing to support their addiction) can reduce the drug supply. Three-quarters (76%) of poll respondents from the Twin Cities area and nearly two-thirds (63%) of respondents in Greater Minnesota supported treatment rather than incarceration for offenders convicted of drug possession. Seventy-two percent of Minnesotans believe that funding mandatory treatment programs for drug users is a more effective way to spend public funds to deal with drug users. Regionally, 77% of poll respondents in the Twin Cities and 67% in Greater Minnesota believed the treatment approach was more effective than building more prisons.[165]

[165] This poll was conducted by Mason-Dixon Polling & Research, Inc., of Washington D.C. between Feb. 11 and Feb. 14, 2005. A total of 625 registered Minnesota voters were interviewed statewide by telephone. All stated that they vote regularly. Those interviewed were selected at random. The margin of error is +/- 4 percentage points. The questions asked in the poll were: 1) Do you support or oppose giving those convicted of drug possession community punishment that includes treatment for their addiction rather than incarcerating them? 2) Which do you feel is the more effective way to spend public funds to deal with drug users: [a] - build more prisons to incarcerate more drug users, OR [b] - fund mandatory treatment programs for drug users?

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Research on different types of criminal justice interventions for AOD offenders[166]

Imprisonment:

Prison alone has proven to be an ineffective strategy in reducing recidivism for offenders with AOD problems. Approximately one-half of offenders with AOD problems recidivate within eighteen months of release from prison, and approximately 70% recidivate within three years of release. Prison alone also does not deter future drug use; roughly 85% of offenders with AOD problems return to drug use within one year after release from prison, and 95% return to drug use within three years.[167]

Treatment in Prison:[168]

Extensive review of over 1,600 program evaluations of in-prison programs targeted toward offenders with AOD problems found no appreciable effect of drug-focused group counseling inventions or traditional boot camp programs[169] on re-arrest rates or re-incarceration rates. While there are too few scientifically sound studies to draw definitive conclusions, results were promising for in-prison methadone maintenance, 12-step programs, and cognitive-behavioral programs.[170] There are some significant short-term benefits to in-prison treatment, even without participation in continuing care. Studies indicate that in-prison treatment is associated with fewer disciplinary infractions and increases the likelihood that the offender will enter treatment after release from prison.[171] Still, in one long-term study, offenders who attended in-prison AOD treatment but were not provided continuing care in the community relapsed at the same rate as offenders who received no in-prison treatment at all.[172]

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[166] *See* Appendix I for the most recent principles for effective criminal justice treatment, published by the National Institute of Drug Abuse (NIDA). Appendix J lists some of the key principles for effective juvenile justice treatment.

[167] Douglas B. Marlowe, *Effective Strategies for Intervening with Drug Abusing Offenders,* 47 Vill. L. Rev. 989, 998 (2002).

[168] A 2006 report by the Office of the Legislative Auditor found that, though a significant proportion of prison inmates have AOD problems, most of these inmates do not participate in treatment prior to release from prison. In addition, few AOD dependent offenders enroll in community-based treatment programs in the months following release from prison. Offender "release plans" are typically too vague regarding AOD services in the community. MINN. OFFICE OF THE LEGIS. AUDITOR, Evaluation Report: Substance Abuse Treatment 90-95 (2006), *available at* http://www.auditor.leg.state.mn.us/ped/2006/subabuse.htm.

[169] This general finding does not apply to Minnesota's Challenge Incarceration Program (CIP), a type of "boot camp" program, which has been very successful in reducing recidivism for incarcerated offenders with AOD problems as compared to other interventions. Twenty-six percent of offenders completing CIP were arrested for a new offense in the subsequent three years compared with 51% of offenders who completed medium- or long-term treatment while in prison. Id., at 105.

[170] Marlowe, *supra* note 167, at 999-1001.

[171] Douglas B. Marlowe, *Integrating Substance Abuse Treatment and Criminal Justice Supervision,* SCI. & PRAC. PERSP., Aug. 2003, at 4, 5.

[172] Marlowe, *supra* note 167, at 1001.

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In addition to prison, there are a large number of offenders who are incarcerated in county jails or workhouses.[173,174] Those in jails for a short period of time (pre-plea) should receive chemical health assessments. Those in jail for longer periods of time (sentenced to serve time) should be given AOD treatment that is connected to additional services once they leave jail. Whether the offender is incarcerated short-term or long-term, the Task Force suggests that the Judicial Branch and other stakeholders need to give this issue further attention.[175] Of particular importance, especially as it relates to public safety, violent offenders who are chemically dependent should receive all of the necessary treatment services, both while incarcerated and upon re-entering the community, to prepare them for optimal success. While these persons are not appropriate for problem-solving courts, their treatment needs must be addressed.

Intermediate Community Sanctions

Programs that have been separately administered from treatment, including those with an emphasis on probation monitoring and sanctions for noncompliance, have failed to demonstrate significant effects in reducing recidivism or AOD use. In fact, several reviews of intensive monitoring programs like "shock incarceration programs," electronic monitoring, and "Scared Straight" programs actually show increased recidivism, perhaps due to the increased detection of infractions. House arrest as an intervention is associated with no appreciable change in recidivism. Restitution programs that have been evaluated produced only a small decrease in recidivism, roughly four to eight percent.[176]

Correctional Therapeutic Communities (TCs)

TCs are residential treatment programs that segregate participants from negative drug-related influences. Participants take leadership roles in all aspects of the program's administrative and clinical functions. Clinical interventions generally include confrontational encounter groups, process groups, community meetings, and volunteer activities. The highest success rate associated with TCs was evident for offenders who

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[173] Minn. Stat. § 609.105, subd. 1.

> In a felony sentence to imprisonment, when the remaining term of imprisonment is for 180 days or less, the defendant shall be committed to the custody of the commissioner of corrections and must serve the remaining term of imprisonment at a workhouse, work farm, county jail, or other place authorized by law.

Id.

[174] The Task Force would like to call attention to the significant number of counties (approximately 36) currently planning new jails or some additional funding for refurbishing or adding onto current jails. Each of these counties is encouraged to examine how the availability of AOD and MH services are incorporated into the overall budget for the jail. Additionally, every one of these counties is encouraged to explore developing problem-solving programs to deal with the significant number of offenders entering their jails who have AOD or co-occurring disorders.

[175] The Task Force heard testimony from the Minnesota Committee on Offender Re-Entry Programs (MCORP) led by the Minnesota Department of Corrections. This multidisciplinary committee is investigating how to most effectively provide services to offenders leaving prison to allow for the greatest opportunity for successful transition into the community. For more information see: http://forums.doc.state.mn.us/mcorp/default.aspx.

[176] Marlowe, *supra* note 167, at 1004-05.

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participated in prison and continued in a work release TC. This intervention was associated with a reduction in recidivism of 30 to 50 percentage points.[177]

The Drug Court Approach

Research has demonstrated that referral to community-based treatment alone for AOD offenders is mostly ineffective because the vast majority of offenders (70%) either attend treatment irregularly or fail to complete the treatment program.[178,179] The drug court approach addresses this challenge by incorporating intensive supervision as well as positive rewards or negative sanctions for treatment compliance. As a result, drug court participants remain in treatment substantially longer than offenders in pre-trial supervision or on probation. For example, in a study comparing treatments for arrestees who were dependant on methamphetamine, those who received treatment in the context of drug court were retained in treatment at a higher level than participants who were not so mandated.[180] Participation in long-term treatment programs is one ingredient that has led to an approximately 20 percentage-point reduction in drug use for court participants, and between a ten to 30 point reduction in recidivism.[181,182] Drug courts use the power of the courts to keep an offender in treatment long enough to experience benefits.

Drug Courts and Recidivism Potential[183] Assessment

The measurement of recidivism potential is a fundamental component in evaluating the efficacy of probation efforts.[184] There have been many studies identifying these interventions which best apply to an offender's recidivism potential. ***First, it must be stated that recidivism potential refers to the likelihood of reoffending and not to the seriousness of the crime.*** Dr. Ed Latessa,[185] a leading scholar in corrections research

[177] *Id.* at 1013.
[178] *Id.* at 1006-07.
[179] There is recent research showing that community-based probation with AOD services is as effective, if not more effective, than drug court from a cost-benefit standpoint. *See* Latessa et al., *Evaluation of Ohio's Drug Courts: A Cost Benefit Analysis*, (CENTER FOR CRIM. JUSTICE RESEARCH 2005) at 18-21, 26-27.
[180] JEANNE L. OBERT ET AL., A CLINICIAN'S GUIDE TO METHAMPHETAMINE 18 (Hazelden Found. 2005).
[181] Marlowe, *supra* note 167, at 1011.
[182] Not all studies have found drug courts to be cost-effective as compared to traditional probation. In fact, the Government Accountability Office did not have a positive review of drug court research in its study in 2002; however, in 2005, more than likely due to improved methodology and more rigorous evaluation, GAO did find that drug courts reduce recidivism and were shown to be cost-effective. U.S. GOV'T. ACCT. OFF., DRUG COURTS: BETTER DOJ DATA COLLECTION AND EVALUATION EFFORTS NEEDED TO MEASURE IMPACT OF DRUG COURT PROGRAMS, REPORT TO CONGRESSIONAL REQUESTERS, (2002); U.S. GOV'T. ACCT. OFF., ADULT DRUG COURTS: EVIDENCE INDICATES RECIDIVISM REDUCTIONS AND MIXED RESULTS FOR OTHER OUTCOMES, REPORT TO CONGRESSIONAL COMMITTEES, (2005).
[183] The Task Force, to avoid any confusion, particularly as the general public is concerned, has substituted the term "recidivism potential" for the concept of "risk" common in corrections research.
[184] D. A. Andrews., James Bonta & R.D. Hoge, *Classification for Effective Rehabilitation: Rediscovering Psychology*, 17 CRIM. JUST. & BEHAV. 19 (1990); *see generally* Edward J. Latessa, *From Theory to Practice: What Works in Reducing Recidivism*, ST. OF CRIME & JUST. IN OHIO, at 170; Edward J. Latessa, *Understanding the Risk Principle: How and Why Correctional Interventions Can Harm Low-Risk Offenders*, TOPICS IN COMMUNITY CORRECTIONS (Nat'l Inst. of Corrections), 2004.
[185] Dr. Latessa was invited to testify before the Task Force but was unable to attend.

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from the University of Ohio, has studied and written extensively about the risk principle.[186] In one article, he and a colleague reviewed seven different meta-analyses, and every analysis found that adhering to the risk principle increased the effectiveness of the evaluated program.[187] This same research has shown that some interventions actually *increase* the recidivism of low-risk offenders. One of the meta-analyses reviewed found that the effectiveness of the drug court doubled when the offender had a prior record (high recidivism potential).[188] Dr. Doug Marlowe,[189] a national expert on effective treatment for the criminal justice population, has also found that offenders with high-recidivism potential seem to do better in drug court.[190]

In the first "scientifically rigorous" study (using random assignment) evaluating the importance of the judge in drug court, Marlowe found that individuals assessed as having high recidivism potential did much better when they had frequent judicial supervision. This same study found that individuals assessed as having low recidivism potential did better when they received standard corrections case-management and treatment services, and saw the judge as traditionally indicated.[191] When defining high recidivism potential for this study, Marlowe found that individuals who were diagnosed with Anti-Social Personality Disorder (APD) or who had at least one previous drug treatment had the best results in drug court. The results were so scientifically significant that the study needed to be ended.[192]

Judicial status hearings are among the most costly elements of drug court programs. The ability to predict which offenders will need more intense supervision via increased judicial status hearings will lead to greater success rates for these offenders, improved public safety for the community, and more efficient use of drug court resources.[193] Additional research is needed to further validate Marlowe's research and help drug courts identify the best candidates for their programs. As studies seek to describe the most effective components of drug courts and determine their clients, it seems as if a new concept of recidivism potential may be developing, including those diagnosed with DSM-IV antisocial personality disorder (APD) or those who had a prior history in AOD treatment in addition to the more commonly identified presence of a prior record or other "high risk" factors.

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[186] Again, the Task Force uses the terms "risk principle" and "recidivism potential" interchangeably.
[187] Christopher T. Lowenkamp, A.M. Holsinger & Edward J. Latessa, *Are Drug Courts Effective: A Meta-Analytic Review*, J. OF COMMUNITY CORRECTIONS, Fall 2005
[188] Lowenkamp, *supra* note 187, at 10.
[189] Dr. Doug Marlowe testified before the Task Force in June 2005.
[190] The specific identifiers for high risk for Marlowe's research were prior drug treatment or being assessed as having anti-social personality disorder. The identification of high risk for Lowenkamp's meta-analysis was prior record. Douglas B. Marlowe, David S. Festinger & Patricia A. Lee, *The Judge is a Key Component of Drug Court*, 4 DRUG CT. REV. 1,1 (2004); Lowenkamp, *supra* note 187, at 10.
[191] Marlowe, *supra* note 190
[192] In attempting to replicate his initial findings, Marlowe found that 80 percent of offenders with a prior drug treatment graduated when assigned bi-weekly judicial reviews compared to a graduation rate of only 20 percent for those with a prior drug treatment and assigned to as-needed hearings. Due to the significant difference, all concluded it would not be ethical to continue the study. Id. at 18.
[193] *Id*. at 25-28.

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Improving the drug court approach

Dr. Marlowe suggests a procedure for determining which judicial intervention best fits certain offender types. Current research shows that offenders with high recidivism potential seem to be best suited for drug courts. ***Again, it must be stressed that the concept of "recidivism potential" has nothing to do with the seriousness of the crime.*** The Task Force observes that research for drug courts is still evolving; nothing is presently conclusive. Research analyzing the populations best served by drug courts and the critical elements that make drug courts work is even more emergent. Since few social scientists have yet to publish quality research on this topic, the Task Force responds to this research with some hesitance.

Dr. Marlowe's grid offers a way of applying the appropriate treatment to an individual offender[194]**:**

	High Risk for Criminality	**Low Risk for Criminality**
High AOD Needs	*Accountability and Treatment* ✓ ***Status hearings*** ✓ ***Intensive treatment*** ✓ ***Compliance is primary focus in the short-term*** ✓ ***Restrictive sanctions*** ✓ ***Positive reinforcement*** *Drug Court*	*Treatment* ✓ ***Intensive treatment*** ✓ ***Attendance is primary focus in the short term*** ✓ ***Positive reinforcement*** *Drug Court or Efforts Similar to Proposition 36[195] (CA)*
Low AOD Needs	*Accountability* ✓ ***Status hearings*** ✓ ***Abstinence is primary focus in the short-term*** ✓ ***Restrictive sanctions*** *Traditional Adjudication*	*Prevention* ✓ ***Prevention*** ✓ ***Abstinence is primary focus in the short-term*** *Pre-trial Diversion*

Marlowe and other social scientists have also noted that a significant percentage of drug court participants do not have a diagnosable or clinically significant AOD use disorder.[196]

[194] Douglas B. Marlowe, *The Risk in Balancing Safety and Treatment*, slides 11-15, National Association of Drug Court Professionals Conference, Seattle, Washington, June 23, 2006

[195] Proposition 36 is a California law passed by voters in 2000 that mandates probation and treatment for all "non-violent" drug possession offenses. *See* California Proposition 36, http://www.prop36.org (last visited Nov. 5, 2005); California Courts, Proposition 36, http://www.courtinfo.ca.gov/programs/collab/prop36.htm (last visited Nov. 20, 2006).

[196] Davis S. DeMatteo, Douglas B. Marlowe & David S. Festinger, *Secondary Prevention Services for Clients Who Are Low Risk in Drug Court: A Conceptual Model,* 52 CRIME & DELINQ. 114, 115 (2006). In

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These researchers have suggested that many of the commonly used intensive drug court interventions may be ineffective or even contraindicated for participants who do not have a diagnosable AOD disorder. Rather, a secondary prevention approach that is designed to interrupt and forestall AOD dependency may be more appropriate.[197] While research on these specific prevention strategies is limited, these experts suggest the following regarding drug court participants who are **not** diagnosed as having an AOD use disorder:

- They should not have time-consuming requirements for on-site attendance (with the exception of on-site delivery of urine specimens).
- They should not be treated in heterogeneous groups and, instead, should be treated either on an individual basis or in separately stratified groups. [198]
- They should not be required to attend traditional 12-step groups that follow the disease model of addiction.
- They should not be required to admit or verbalize the negative effects of drugs on their lives but rather should receive psycho-education about the potential impacts from drugs they might experience in the future.
- They should not be exposed to classical conditioning exercises aimed at desensitizing craving responses.
- They should attend status hearings on a reduced or as-needed schedule.
- They should engage in a carefully crafted regimen of daily or weekly activity scheduling combined with self-monitoring of compliance with the schedules, which is overseen at a distance by clinical counselors through such means as phone-based or Internet-based counseling.[199]

Recommendations: Since its inception, the Task Force has believed that neither drug courts, nor any other intervention, should be construed as the only or best approach for all offenders or addicted individuals in the court system. The Task Force's resulting conclusion, based upon testimony and its review of most recent research, is that the drug court model seems to be best suited to the offender with high recidivism potential.

A. Drug courts, as one of many problem-solving court strategies, should focus on those individuals who are assessed as having high recidivism potential.
B. Scientific inquiry into the area of drug courts is still emerging; the Task Force recommends that problem-solving strategies be based upon the latest research.

6. RECOMMENDATIONS REGARDING FETAL ALCOHOL SPECTRUM DISORDERS (FASD)

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their studies, nearly one-half of misdemeanor drug court participants and one-third of felony participants scored below the threshold on the Addiction Severity Index.

[197] *Id.* at 117.

[198] This recommendation relates to research, by DeMatteo et al., showing that for those offenders with low recidivism potential who are put in groups with high recidivism potential offenders, the effect is often harmful for the offenders with low recidivism potential. That is, the outcomes for offenders with low recidivism potential worsen, showing increases in AOD use and more severe crimes committed. *Id.* at 119.

[199] DeMatteo, Marlowe & Festiner, *supra* note 196, at 131.

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Problem: Joyce Holl, Executive Director of the Minnesota Organization for Fetal Alcohol Syndrome (MOFAS) testified before the Task Force. According to Holl, Fetal Alcohol Spectrum Disorders (FASD) is the umbrella term that describes a range of effects that can occur in an individual whose mother drank alcohol during pregnancy. Diagnoses within the spectrum include Fetal Alcohol Syndrome (FAS), Partial FAS, Alcohol Related Neurodevelopmental Disorder (ARND); and alcohol exposed static encephalopathy. These effects may include physical, mental, behavioral, and learning disabilities with possible lifelong implications.[200] Children suffering with these disabilities are more likely to enter the child protection system as a result of abuse or neglect. They often end up in the juvenile and criminal justice systems as they have trouble learning from mistakes and interacting with others they often exercise poor judgment.

Mental health disorders and AOD addiction are among the most frequent results of prenatal alcohol damage.[201] Ann Streissguth, Ph.D. of the University of Washington's Fetal Alcohol Drug Unit, first reported a link between prenatal exposure and later drinking problems in 2003.[202] Susan M. Smith from the University of Wisconsin has found that prenatal alcohol exposure may cause changes in the brain, influencing the brain's reward circuits and making the person more susceptible to addiction later in life.[203]

FASD has largely been ignored as the courts and other systems have attempted to address AOD issues. Research has shown that identifying those with FASD will reduce secondary disabilities, including AOD problems. It may also prevent FASD children from getting into trouble with the law, dropping out of school, and from developing mental health problems.[204] FASD focuses on central nervous system damage and understanding what that means to the individual. For parents who have FASD and are actively using alcohol or other drugs, addiction treatment needs to be nontraditional with more support, a sober living environment with close supervision, and frequent AOD testing.[205]

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[200] Joyce Holl, Executive Director, Minnesota Organization for Fetal Alcohol Syndrome, Testimony to the Task Force (March 24, 2006).

[201] Kathryn Page, *The Invisible Havoc of Prenatal Alcohol Damage*, J. OF THE CENTER FOR FAMILIES, CHILD. & THE CTS., 2003, at 67, *available at* http://www.courtinfo.ca.gov/programs/cfcc/pdffiles/CFCCJournal03.pdf.

[202] The link held true even after researchers controlled for factors such as demographics, family history of alcoholism, growing up around alcohol and exposure to nicotine. J.S. Baer, et al., , *A 21-Year Longitudinal Analysis of the Effects of Prenatal Alcohol Exposure of Young Adult Drinking*, 60 ARCHIVES OF GEN. PSYCHIATRY 332 (2003).

[203] Susan M. Smith, Ethanol Triggers Neural Crest Apoptosis through the Selective Activation of a Pertussis Toxin–Sensitive G Protein and a Phospholipase C_–Dependent Ca2_ Transient ALCOHOLISM; CLINICAL & EXPERIMENTAL RESEARCH, VOL.29, NO. 7, JULY 2005.

[204] A. P. STREISSGUTH, ET AL., UNDERSTANDING THE OCCURRENCE OF SECONDARY DISABILITIES IN CLIENTS WITH FETAL ALCOHOL SYNDROME (FAS) AND FETAL ALCOHOL EFFECTS (FAE) (Univ. of Wash. 1996) (final report to the Ctrs. For Disease Control & Prevention, Techn Report No. 96-06).

[205] Innovative programs such as the Parent-Child Assistance Program (PCAP), an intervention model of intensive, long-term paraprofessional advocacy exist for high-risk mothers who have AOD problems during pregnancy and are estranged from community service providers. The PCAP model has been commended by Drug Strategies, a Washington D.C.-based policy research institute, as one of a few federally funded

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Recommendations:

1) Require FASD screening for children whom the court has found to be in need of child protection or services, when there is evidence of AOD problems in the biological mother.
2) Require FASD screening of biological parent(s) and other caregivers if there is a family history of AOD problems.
3) Review all screening instruments to include questions which explore any history of maternal alcoholism dating back to childbearing years.
4) Require each drug court team to receive training on FASD. The State Court Administrator's Office should work with the drug courts to incorporate these practices into their policies and procedures.
5) Incorporate evidence-based models for successful intervention with AOD-dependent women who are at-risk for having FASD babies.
6) Research and develop a pilot diversionary program for first-time offenders who are identified as having FASD.

7. RECOMMENDATIONS REGARDING MEDICATION AND AOD TREATMENT

Problem: The Task Force heard expert testimony from Dr. S.W. Kim from the University of Minnesota and Dr. Gavin Bart from the Hennepin County Medical Center on recent promising developments in medication-assisted treatment. The use of pharmacology for AOD dependency has four goals: to prevent withdrawal symptoms, reduce drug craving, normalize any disrupted physiological functions, and target treatment agents to the specific site of action, brain receptor, or physiological system affected by AOD use.

Methadone, Buprenorphine-Naloxone

Methadone has been used for several decades as a treatment for heroin addiction. Methadone works by binding to the receptors in the brain that are activated by heroin without producing similar feelings of euphoria. Thus, methadone alleviates the feelings of withdrawal and craving in persons with heroin dependency. Its use has been so effective in retaining patients that failure to provide methadone or buprenorphine in the treatment of opiate addiction may not meet current standards of care.[206] Even so, some believe that methadone is merely another form of heroin dependency. This belief has

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interventions that are succeeding nationwide. A unique feature of the model is that women are never asked to leave the program because of relapse or setbacks. A study of 45 original PCAP clients followed-up an average of 2.5 years after graduation indicated that benefits of the program were sustained. The proportion of clients abstinent from alcohol and drugs for at least 6 months at the time of interview increased significantly from 31% at graduation to 51% at follow-up. Those abstinent for at least one year increased from 38% to 48%. *See* Univ. of Wash., Current FADU Projects, http://depts.washington.edu/fadu/FADU.projects.html (last visited Dec. 12, 2006).

[206] Methadone maintenance resulted in a 50-80% one-year retention rate in treatment with significant reduction or elimination of illicit use of opiates, compared with 5-30% for non-pharmacotherapeutic treatment.

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resulted in limited access to methadone maintenance clinics as well as community stigma for those using methadone in the recovery community and the larger community, in general.

Buprenorphine-naloxone is a combination medication that is an effective and potentially safer alternative to methadone. Because buprenorphine-naloxone has been approved for prescription through primary care doctors' offices,[207] treatment providers are hopeful that this drug will reduce transportation and other access barriers to effective treatment for those with heroin dependency. Recent research has demonstrated that once-weekly visits to the doctor with daily doses of buprenorphine-naloxone in combination with twenty minutes of counseling by a primary care physician is as effective in retaining patients in treatment and promoting abstinence as thrice-weekly doses of the drug and 45 minutes of medical management.[208]

Naltrexone

Naltrexone, sometimes called the "anti-craving drug," has been proven effective for treatment of alcohol dependency. Individuals with heroin dependency who were given monthly sustained-release injections of naltrexone plus relapse prevention therapy over a two-month period stayed in therapy longer and produced more negative urine samples than those who received the therapy and a placebo injection. At this time, however, naltrexone is not shown to be more effective than methadone or buprenorphine in heroin-dependent clients.[209]

Naltrexone is also a promising medication for individuals with alcohol dependence. In a study of 80 alcoholics, naltrexone reduced heavy drinking days to 25% compared to 60% for placebo. Further, patients who received coping-skills therapy had even fewer relapses than those who did not receive this therapy, reinforcing the concept of combined pharmacological treatment with psychosocial programming.[210,211] While naltrexone may be useful for many patients with alcohol dependence, it cannot be used for individuals who are also prescribed opiates for pain, as it directly inhibits the effect of these medications.[212] Further, a new study suggests that individuals with a specific difference in their opiate receptor genes may actually experience an increase in craving rather than a

[207] In order to prescribe buprenorphine physicians must take an eight hour course on its use.
[208] Each combination of treatment produced this positive result in about 4 out of 10 patients.
[209] Bart, *supra* note 24.
[210] *Id.* ; Join Together, News Summary for Jan. 10, 2002 , Naltrexone, Coping Skills Prevent Relapse, http://www.jointogether.org/news/headlines/inthenews/2002/naltrexone-coping-skills.html (last visited Nov. 16, 2006).
[211] The sustained-release injectable form of naltrexone is a newly proven alternative to the drug in pill form. While the pill was also proven effective, the use of a monthly injection reduces the chance that a patient will miss a daily dose of the drug in pill form. MSNBC.com, New Injectable Drug May Treat Alcoholism: Study Backs Effectiveness of Naltrexone at Reducing Cravings, http://www.msnbc.msn.com/id/7394118/ (last visited Nov. 16, 2006).
[212] Bart, *supra* note 24.

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decrease.[213] A different study, focused on the same genetic difference, found that alcoholics treated with naltrexone who had this genetic difference did not return to heavy drinking as soon as those treated with naltrexone without the genetic difference.[214]

Acamprosate

Acamprosate is another drug that has been found to reduce heavy drinking as compared to placebo. Unlike naltrexone, this drug can be used with other opiates prescribed for pain control. While approximately 20 European studies have found acamprosate effective, three American studies (including the JAMA referenced above) have come to the opposite conclusion (no better than placebo). Dr. Gavin Bart, a specialist in addiction medicine at Hennepin County Medical Center, testified that more research should clarify the role of acamprosate in treating alcohol dependency. Newer data indicates that it may benefit a subset of alcoholics such as those who have already achieved short-term abstinence.[215] There is also some indication that patients should have the goal of abstinence.[216]

Recommendations: ***Research has firmly established that AOD dependency is a chronic relapsing disease of the brain, and that pharmacotherapy is an important tool in treatment planning for AOD dependency.***

> ***1. Drug courts and the treatment staff they work with should receive training on the most effective medications for each drug of addiction.***
> ***2. Methadone and buprenorphine (naloxone) should be considered for the intervention in heroin (or other opiate) dependencies. Whenever possible, these treatments should be made available.***
> ***3. Medications, such as naltrexone, should be considered for the intervention in alcohol dependency. Whenever possible and appropriate, these treatments should be made available.***
> ***4. While there may be legal and ethical precedence for mandated treatment, the choice of specific therapeutic agent (i.e., medication) should be made by a physician qualified to make an individualized evidence-based treatment plan.***

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[213] Join Together, News Summary for July 25, 2006, Negative Effects of Naltrexone Reported, http://www.jointogether.org/news/research/summaries/2006/negative-effects-of.html (last visited Nov. 16, 2006).

[214] With an estimated 15 percent of the U.S. population carrying this genetic difference, and with 18 million alcoholics, almost 3 million people may benefit. David W. Oslin, et al., *A Functional Polymorphism of the m-Opioid Receptor Gene is Associated with Naltrexone Response in Alcohol-Dependent Patients*, 28 NEUROPSYCHOPHARMACOLOGY, 1546 (2003).

[215] Bart, *supra* note 24.

[216] There are people who just want to reduce their use and others who want (or are forced into) treatment yet remain ambivalent about abstaining. B.J. Mason et al., Effect of Oral Acamprosate on Abstinence in Patients with Alcohol Dependence in a Double-Blind, Placebo-Controlled Trial, 40 J. PSYCHIATRIC RESEARCH 382 (2006).

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8. RECOMMENDATIONS REGARDING THE PROCESS OF RECOVERY[217] FOR AOD ADDICTED INDIVIDUALS IN THE COURT SYSTEM

Problem: The process of achieving long-term recovery benefits individuals, families and communities. It requires greater understanding of the process of long-term recovery and the concomitant systems to effectively resolve the AOD problems of people in the court system. The Task Force would like to emphasize that recovery is not active addiction; nor is it treatment for people who are actively using AOD. The Task Force suggests that the goal of its recommendations is to make it possible for addicted people in the court system to have optimal opportunities to achieve long-term recovery through abstaining (from the use of AOD) and by establishing themselves as productive members of the community.

Discussion of Recovery Community Organizations

Patricia Taylor, Executive Director of Faces & Voices of Recovery, discussed recovery community organizations with the Task Force. Recovery community organizations (RCOs) offer peer-to-peer recovery support services that help individuals in their communities initiate and sustain recovery as they leave treatment centers or incarceration, gain overall wellness, and connect with jobs, housing and their families.[218] Peer-to-peer recovery support services are not professional treatment or post-treatment after care; they are support services provided by people who share the experiences of addiction and long-term recovery. RCOs help prevent relapse and promote sustained recovery. [219] Recovery coaches and other recovery support providers know from personal experience about the stigma and discrimination people experience when they participate in drug courts. They work with participants to break down the barriers that could prevent them from turning their lives around.

The Task Force heard testimony from Ms. Taylor regarding the barriers that people with addictions face in achieving and maintaining recovery. The most significant come when recovered addicts leave the criminal justice system; felony and other convictions follow them after they have served their time. While public safety is a primary concern, it has become evident to the Task Force that one of the best ways to improve public safety would be to stop the revolving door where addicted people continue to commit crimes related to their addiction by helping them initiate and sustain their long-term recovery.

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[217] Recovery can be defined as a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life.

[218] An example of an RCO: In New Jersey, Friends of Addiction Recovery-New Jersey is working with drug court officials to provide recovery support learning circles. These circles are peer-led directed learning, awareness and skill building experiences that are being held at halfway homes and correctional facilities in the state. Friends of Addiction Recovery-New Jersey is also working in Mercer and Morris County with drug court participants, their family members, friends and other supporters on these volunteer efforts aimed at promoting recovery.

[219] Among the many types of peer services are: Peer-led recovery support groups and meetings; Recovery coaching or mentoring; Peer case management, information, and referral, including concrete assistance with housing, jobs and parenting; Recovery learning circles; and other forms of recovery-related adult education.

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The Task Force suggests that public policy makers must consider the consequences of policies that punish a post-sentence offender through barriers that they place on jobs, housing and equal rights.[220] The Task Force notes that there are often collateral consequences which might place a continuing burden on convicted persons after their court-imposed sentence has been fully discharged, impeding their ability to sustain their recovery from addiction to alcohol or other drugs.[221]

Recommendations:

> ***A. Drug court team members and others working with people with AOD problems in the court system should receive training on long-term recovery, including the recovery process, the many pathways to recovery, the recovery community, and the culture of recovery.***
>
> ***B. Minnesota should explore the models developed in other states to support RCOs and other recovery services to provide on-going support for individuals returning to their communities from treatment centers or drug courts in Minnesota.***

9. RECOMMENDATIONS REGARDING SCREENING AND ASSESSMENT

Problem: The Task Force heard testimony from almost every subject matter expert throughout its work regarding the importance of accurate screening and assessment. Repeatedly, the need for quality and comprehensive assessment services was identified as one of the most critical factors in being able to provide the most appropriate treatment services. The primary concern was the degree to which issues like trauma, mental health, domestic violence, and medication were being addressed in the drug courts and other problem-solving approaches. The general sentiment among Task Force members is that a global assessment tool used by the drug courts and other problem-solving interventions would be ideal.

Recommendations

1. ***The Drug Court Initiative Advisory Committee[222] should research and identify a comprehensive screening tool to be used by all drug courts and other***

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[220] *See* Margaret Colgate Love, *Relief From The Collateral Consequences Of A Criminal Conviction: A State-By-State Resource Guide,* http://www.sentencingproject.org/rights-restoration.cfm#tables (last visited Nov. 16, 2006) (Minnesota specific information for this report can be found at http://www.sentencingproject.org/pdfs/rights-restoration/Minnesota.pdf); *After Prison: Roadblocks to Reentry,* http://www.lac.org/lac/ (last visited Dec. 12, 2006) (Minnesota specific information for this report can be found at http://www.lac.org/lac/upload/reportcards/24_Image_Minnesota.pdf).

[221] The Legislature charged the Department of Public Safety with creating a task force to investigate the impact of collateral consequences. Act of May 22. 2006, Ch. 260, art. 1,§45 2006 Minn. Laws 731-32.

[222] This is a proposed state level multi-branch committee that would take the place of the Task Force and advise the Judicial Council in developing policies and standards for the implementation of problem-solving approaches.

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problem-solving approaches for AOD issues. It should accurately identify the needs of the individuals in problem-solving programs.

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PART V: CONCLUSION

For the past nineteen months, the Task Force has intensively explored one of the most challenging issues facing the Minnesota Judicial Branch. Its work has yielded recognition that AOD addicted individuals present Minnesota courts with a significant and growing challenge, but also with an extraordinary opportunity. Minnesota 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 chemical dependency field, together with the lessons learned from development of problem-solving courts in other states, in order to take the lead in creating a more effective judicial response. To be effective, Minnesota's response will require successful, ongoing collaboration and cooperation between the courts and all other participant groups at both the state and local level.

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PART VI: ACKNOWLEDGMENTS

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

Those individuals who made presentations to the Task Force, including:

- Joyce Holl, Executive Director, Minnesota Organization of Fetal Alcohol Syndrome
- Erin Sullivan-Sutton, Director, Child Safety and Permanency, Department of Human Services
- Ann Ahlstrom, Staff Attorney/ CJI Project Manager, State Court Administrator's Office
- Brigid Murphy, Problem-Solving Court Coordinator, Stearns County
- Honorable Jon Maturi, Itasca County District Judge/ CJI Lead Judge
- Dr. Noel Larson, Counselor, Meta Resources
- Barbara Rogers, Women's Resource Coordinator, Sojourner House
- Kim Bingham, Ramsey County Prosecutor
- Deb Dailey, Manager, Research and Evaluation, State Court Administrator's Office
- Sarah Welter, Research Analyst, State Court Administrator's Office
- Dr. Larry Anderson, private practitioner/ consultant
- Debra Davis-Moody, Chemical Health Division, Department of Human Services
- Dr. S. W. Kim, Professor of Psychiatry, University of Minnesota Medical School
- Dr. Gavin Bart, Hennepin County Medical Center/ University of Minnesota
- Justice Esther Tomljanovich, Chair, Minnesota Female Offender Task Force
- Carol Ackley, Executive Director, River Ridge Treatment Center
- Joel Alter, Office of the Legislative Auditor
- Chris Bray, Assistant Commissioner of Corrections, Minnesota Department of Corrections
- Gary Johnson, Housing Specialist, Minnesota Department of Corrections
- Patricia Orud, Director of Mental Health, Minnesota Department of Corrections
- The Honorable Arthur L. Burnett, Sr., National Executive Director, National African-American Drug Policy Coalition, Inc.
- Dr. Susan Wells, Gamble-Skogmo Professor of Child Welfare and Youth Policy, University of Minnesota
- Deb Moses, Operations Manager, Chemical Health Division, Department of Human Services

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- Freddie Davis-English, Division Director, Hennepin County Corrections
- John Poupart, Director, American Indian Policy Center
- Judge Korey Wahwassuck, Chief Judge, Leech Lake Tribal Court
- Jerry Guevara, Director, Hispanos en Minnesota
- Mustafa Ali, Counselor, My Home, Inc.
- Farris Glover, Director, My Home, Inc.
- Sam Simmons, Licensed Alcohol and Drug Counselor, My Home, Inc.
- Mao Xiong, Licensed Alcohol and Drug Counselor, Hennepin Faculty Associates
- Pat Taylor, Executive Director, Faces and Voices of Recovery
- Rodney Dewberry, person in recovery
- Joel H., person in recovery
- John N., person in recovery

Those Non-Task Force members who attended meetings and contributed greatly to the work of the Task Force, including:

- Jeff Hunsberger, Chemical Health Division, Minnesota Department of Human Services
- Jean Ryan, Office of Traffic Safety, Department of Public Safety
- Kristin Lail, Office of Justice Programs, Department of Public Safety

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.

The Task Force would like to give special thanks and recognition to Kathy Swanson, Office of Traffic Safety, Department of Public Safety for her commitment to the work not only of the Task Force but also for all she has done to make Minnesota communities safer.

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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, 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

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persons who come into 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**:**

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.

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

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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)

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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

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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:
   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.

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.

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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

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STATE OF MINNESOTA
IN SUPREME COURT

ADM-05-8002

AMENDED ORDER

In Re The Minnesota Supreme Court
Chemical Dependency Task Force

IT IS HEREBY ORDERED THAT:

1. The membership of the Chemical Dependency Task Force is amended to identify Jim Frank as retired Sheriff of Washington County and Chris Bray as Deputy Director of Washington County Community Corrections; and

2. The Task Force reporting schedule and reporting structure are amended to provide that a Final Report focusing on the overall impact of AOD dependency across all case types shall be submitted by November 17, 2006.

DATED: November 15, 2006

BY THE COURT:

_____

Russell A. Anderson
Chief Justice

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APPENDIX B

The Ten Key Components of Drug Courts[223]

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, 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.

[223] DRUG CT. PROGRAM OFFICE, U.S. DEP'T OF JUSTICE, DEFINING DRUG COURTS: THE KEY COMPONENTS (Jan. 1997), *available at* http://www.nadcp.org/docs/dkeypdf.pdf.

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APPENDIX C

Problem-Solving Courts in Minnesota

PROBLEM-SOLVING COURTS IN MINNESOTA

There are currently twenty-one drug courts (twelve adult, four juvenile, two DWI, two family dependency, and one multi-county) operating in seventeen counties in Minnesota:

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

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:

- Itasca (Adult)
- Kandiyohi (Adult)
- Hennepin (Adult DWI)
- Beltrami (DWI)
- Morrison (Adult)
- Clay County (Adult)
- Lake of the Woods (Adult DWI)
- Koochiching (Family)
- Brown, Nicollet, Watonwan (Multi-County)
- Becker County (Adult)
- Otter Tail County (Adult)

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)

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APPENDIX D

Mental Health Disorders and Drug Use

Individuals with certain mental health disorders may be more likely to use certain types of drugs. The following table summarizes the research findings in this area:[224]

MENTAL DISORDER	TYPE OF MENTAL DISORDERS	SUBSTANCE OF USE
Schizophrenia	Catatonic; Disorganized; Paranoid; Undifferentiated; Residual	Poly-substance use; Alcohol and marijuana most common; rarely abuse opiates and sedative-hypnotics
Delusional Disorder	Erotomanic; Grandiose; Jealous; Persecutory; Somatic	Excessive use is rare
Mood Disorders	Bipolar (Mixed, Manic, Depressed); Cyclothymia; Major Depression (single and recurrent); Dysthymia	Poly-substance use; Alcohol and stimulants for Mania; Heavy use of alcohol and depressant drugs for Depressed.
Anxiety Disorder	Panic disorder; Social phobia; Obsessive Compulsive disorder; Generalized Anxiety disorder; Post-Traumatic Stress Disorder	Some preference for alcohol and other sedative-hypnotics; may use cocaine
Adjustment Disorder	With anxious mood; with depressed mood; with disturbance of conduct; mixed; with physical complaints; with withdrawal; with work (academic) inhibition	Preference for alcohol and prescriptive drugs
Personality Disorders	Antisocial; Borderline: Passive Aggressive; Paranoid; Schizoid; Schizotypal; Histrionic; Narcissistic; Obsessive Compulsive; Avoidant; Dependent	Antisocial: all and any type of drugs; Borderline: variety of drugs and prescriptive medications, sedatives and antidepressants; Passive Aggressive: alcohol and sedative/hypnotics

[224] Dr. Larry Anderson, Psychologist, Testimony to the Task Force, Dual Diagnosis Issues: Understanding the Concept (April 28, 2006).

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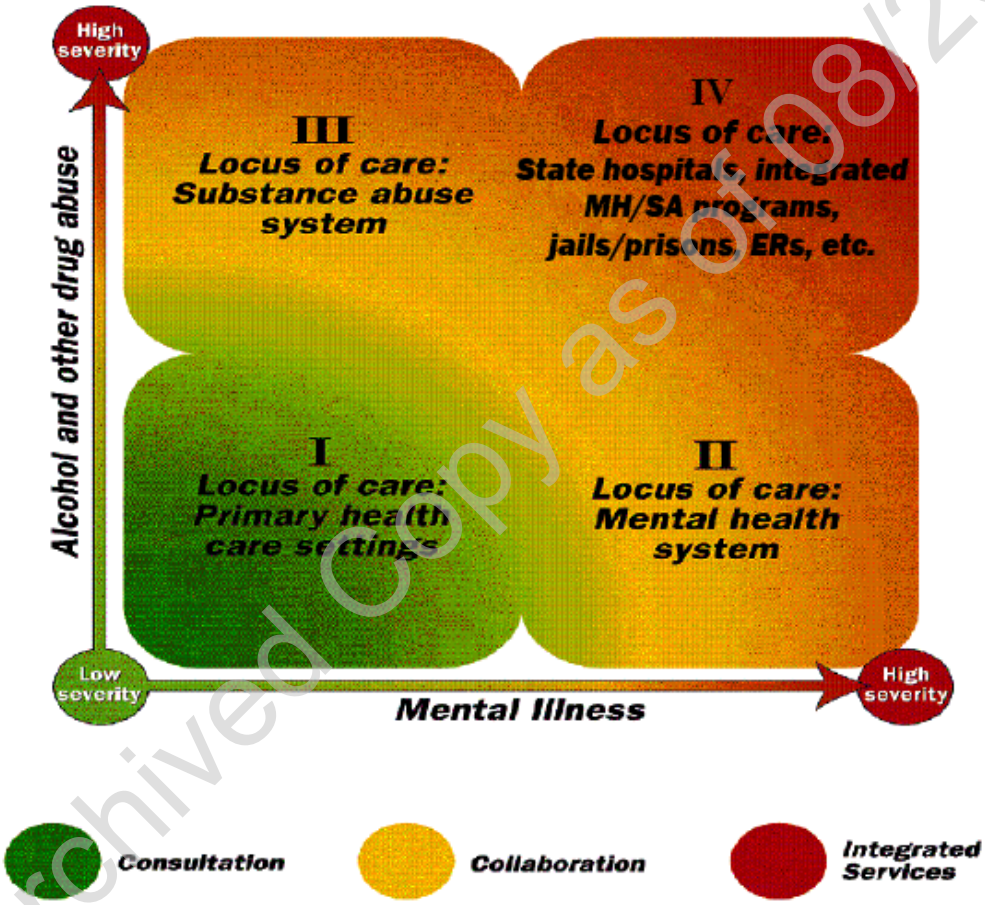
APPENDIX E

Quadrants of Care for Co-Occurring Disorders

The Quadrants of Care, below, was developed by AOD treatment experts to help conceptualize COD treatment and encourage more integration in delivery of services.



(National Association of State Mental Health Program Directors [NASMHPD] and National Association of State Alcohol and Drug Abuse Directors [NASADAD] 1999)

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APPENDIX F

Suggested requirements for a trauma-informed system of care[225]

1. Administrative commitment to change. Leaders must make a commitment to integrate knowledge about violence and abuse into the service delivery practices of the organization(s).
2. Universal screening. Asking about violence in an initial interaction with a participant/client begins the process of institutionalizing trauma awareness within an organization.
3. Training and education. A trauma survivor may interact with dozens of staff members before sitting down with a clinician who is trained to provide trauma-specific services. Therefore, even a brief general training for all staff is a first step toward providing a less frightening atmosphere for participants/clients who have been traumatized.
4. Hiring practices. When hiring new staff, organizations should ideally focus on candidates that already have an understanding of trauma and the trauma-informed approach.
5. Review of policies and procedures. Some traditional policies or sanctions may be hurtful to trauma survivors.

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[225] Maxine Harris & Roger D. Fallot, *Envisioning a Trauma-Informed Service System: A Vital Paradigm Shift, in* USING TRAUMA THEORY TO DESIGN SERVICE SYSTEMS 3, 5-9 (Maxine Harris & Roger D. Fallot eds., Jossey-Bass 2001).

APPENDIX G

Promising models for female participants in drug court

The drug courts in Kalamazoo, Michigan and Santa Clara County, California responded to the unique needs of female participants by creating separate courts for men and women. The courts have observed that its female participants are more comfortable in an all-female setting. For example, they are more inclined to offer personal thoughts and feelings in the courtroom, allowing the judge to use this information to help the women succeed. Further, the separate courts have fostered positive relationships between the female participants.[226]

The Brooklyn Treatment Court modified its intake process by hiring a psychiatric nurse to better identify women with mental health problems. Brooklyn also placed as many services as possible at the courthouse, including employment services, legal services, medical treatment (there is actually an on-site health clinic), and psychiatric evaluations. This "one-stop-shop" approach reduces delays for participants in accessing needed services, which has been shown to facilitate recovery. Because the chance at reunification with participants' children can play a crucial role in the later stages of the recovery process, case managers help to coordinate the requirements of drug court and child welfare. This service has aided mothers who would otherwise face conflicts between child visitation schedules and mandatory court appearances in two separate systems.[227, 228]

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[226] Laura D'Angelo, *Women and Addiction: Challenges for Drug Court Practitioners*, 23 JUST. SYS. J. 385, 386 (2002).
[227] For further information see the section of this report on the child protection system.
[228] D'Angelo, *supra* note 226, at 392-397.

APPENDIX H

Practical Ideas of Sanctions for Women in Drug Courts

- Depending on criminal record, they could volunteer in their child(ren)'s school, otherwise volunteer somewhere that relates to their lives.
- Attend family therapy.
- Attend parenting classes.
- Volunteer with Habitat for Humanity.
- Work with an adult mentoring program - connect with agencies that can provide mentorship.
- Work with GED or other education/job program.
- Short, constructive community service jobs like 16 hours working at the library where they can bring their children.
- Verbal warnings and admonishments by the court.
- Reassessment for level of treatment care.
- Written papers targeting specific violations.
- Relapse workbook assignments.
- Increased community support group attendance.
- Housing change.
- Increased supervision.
- Increase number of required court appearances.
- Specific service projects – knitting/crocheting for women's advocates.
- Return to earlier program phase requirements.
- Geographic restrictions.
- Restorative (or Social) Justice Projects.
- Electronic monitoring.
- Correctional halfway house placement.
- Small monetary sanctions.
- Incremental jail sentences (1, 3, 5 days).
- Community service at local churches – these places usually have childcare options.
- Try lecture/speaking requirements in other local programs, teen groups.
- Use writing – having a woman put her perspective of the violation down and present her plan for resolution helps make both concrete.
- Use psychological assignments and reports to the court (e.g., Act "As If…" a woman addresses a problem in her life by acting as if she were the opposite. Instead of being told to be sober, she could be encouraged to act as if she didn't have a drug problem for a short period of time and then report to the court what that experience was like).
- Use community service vehicle for accessing services and creating a relationship for the woman.
- Chemical dependency treatment must always be considered, but sober housing should also be considered along with treatment.

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APPENDIX I

Principles of AOD treatment for Criminal Justice Populations

Effective treatment interventions for offenders with AOD problems include the following elements in common:

- Treatment in the community.
- Opportunity to avoid a criminal record or incarceration.
- Close supervision.
- Certain and immediate consequences.[229]

Principles of AOD treatment for Criminal Justice Populations, based on a review of the scientific literature on AOD treatment and criminal behavior by the National Institute on Drug Abuse (NIDA):[230]

1. AOD dependence is a brain disease that affects behavior.
2. Recovery from AOD problems requires effective treatment, followed by management of the problem over time.
3. Treatment must last long enough to produce stable behavioral changes.
4. Assessment is the first step in treatment.
5. Tailoring services to fit the needs of the individual is an important part of effective AOD treatment for criminal justice populations.
6. Alcohol or other drug use during treatment should be closely monitored.
7. Treatment should target factors that are associated with criminal behavior.
8. Criminal justice supervision should incorporate treatment planning for offenders with AOD problems, and treatment providers should be aware of correctional supervision requirements.
9. Continuity of care is essential for offenders with AOD problems who are re-entering the community.
10. A balance of rewards and sanctions encourages prosocial behavior and treatment participation.
11. Offenders with co-occurring AOD and mental health problems often require an integrated treatment approach.
12. Medications are an important part of treatment for many offenders with AOD dependency.
13. Treatment planning for offenders with AOD problems who are re-entering the community should include strategies to prevent and treat serious, chronic medical conditions, such as HIV/AIDS, hepatitis B and C, and tuberculosis.

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[229] Marlowe, *supra* note 171, at 8.
[230] NAT'L INST. ON DRUG ABUSE, U.S. DEP'T OF HEALTH & HUMAN SERVICES, PRINCIPLES OF DRUG ABUSE TREATMENT FOR CRIMINAL JUSTICE POPULATIONS: A RESEARCH BASED GUIDE 2-5 (2006).

APPENDIX J

RESEARCH REGARDING AOD TREATMENT FOR ADOLESCENTS IN THE JUVENILE JUSTICE SYSTEM

There has been substantial research examining young people in the juvenile justice system and exploring appropriate treatment interventions. The following are the key elements that researchers have identified as necessary for positive outcomes working with youth offenders.[231]

1. Using treatment models that have been found to be effective for juvenile offenders based on research and evaluation. Review of extensive research has shown the effectiveness of cognitive behavioral approaches which focus on problem-solving, anger control, communication, moral reasoning, restructuring criminal thinking, developing conflict resolution strategies, and coping with drug cravings. Further, programming should provide comprehensive services that address all related factors that influence an adolescent's AOD use and criminal activity.
2. Screening via a comprehensive assessment that evaluates the youth's risks, needs, strengths, and motivation, and which matches the youth to appropriate treatment.
3. Developing an individualized treatment plan based on the youth's needs, including age, culture, and gender.
4. Providing overarching case management across systems and over time.
5. Involving family in all aspects of the youth's treatment.
6. Structuring a system of care that encompasses a youth's transformation from institutions to community, and that offers a range of AOD services from prevention to intervention to treatment to continuing care.
7. Building support for treatment efforts in institutions, and in communities.
8. Developing interagency collaboration that involves the community, creates partnerships between the juvenile justice and treatment providers, and builds coalitions with diverse constituencies.
9. Providing interdisciplinary cross-training to staff.
10. Taking special care with the recruitment, selection, evaluation, and retention of staff, and ensuring that programs have diverse, certified, and licensed staff.
11. Building evaluation into the program design, conducting ongoing evaluation, measuring outcomes, and disseminating information.
12. Implementing a Management Information System that can be used to share information.
13. Using resources effectively, including conducting cost-benefit analyses of treatment programs, identifying resources for piloting new programs, and institutionalizing proven programs.

[231] CENTER FOR SUBSTANCE ABUSE TREATMENT, U.S. DEP'T OF HEALTH & HUMAN SERVICES, STRATEGIES FOR INTEGRATING SUBSTANCE ABUSE TREATMENT AND THE JUVENILE JUSTICE SYSTEM: A PRACTICE GUIDE 6, 14 (1999).

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14. Incorporating strategic planning at all points of program development and implementation.

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