

**MINNESOTA SUPREME COURT
CHEMICAL DEPENDENCY TASK FORCE**

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

NOVEMBER <date>, 2006

**STATE OF MINNESOTA
IN SUPREME COURT
ADM-05-8002**

STATE COURT ADMINISTRATOR'S OFFICE
COURT SERVICES DIVISION
105 MINNESOTA JUDICIAL CENTER
25 REV. DR. MARTIN LUTHER KING JR., BLVD.
SAINT PAUL, MN 55155
(651) 297-7587

TABLE OF CONTENTS

	<i>Page</i>
PART I: INTRODUCTION.....	5
A. Task Force Members	5
B. Task Force Background and Purpose	6
C. Task Force Process and Report Format, Distribution and Discussion.....	7
PART II: EXECUTIVE SUMMARY	9
A. Summary of Major Task Force Recommendations	9
PART III: THE ADDICTION MODEL ADOPTED BY THE TASK FORCE	17
PART IV: TASK FORCE RECOMMENDATIONS	21
A. Recommendation for Development of Problem-Solving Approaches in Children in Need of Protection or Services (CHIPs) cases	21
B. Recommendations Regarding Other Case Types.....	27
C. Recommendations for the Statewide Development of Problem Solving Approaches for AOD Issues in the Minnesota Court System.....	30
D. General Recommendations	34
PART V: CONCLUSION	61
PART VI: ACKNOWLEDGEMENTS	62
PART VII: APPENDICES	
Appendix A: Order Establishing the Minnesota Supreme Court Chemical Dependency Task Force Amended Order	
Appendix B: The Ten Key Components of Drug Courts	
Appendix C: Problem Solving Courts in Minnesota	
Appendix D: Quadrants of Care for Co-Occurring Disorders	
Appendix E: Mental Health Disorders and Drug Use	
Appendix F: Requirements for a Trauma-informed System of Care	
Appendix G: Potential Sanctions for Women in Drug Court	
Appendix H: Promising Models for Female Participants in Drug Court	

Appendix I: Principles of AOD treatment for Criminal Justice Populations

Appendix J: Research Regarding AOD Treatment for Adolescents in the
Juvenile Justice System

DRAFT

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
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
Wes Kooistra, Assistant Commissioner for Chemical and Mental Health
Services¹
Fred LaFleur, Director, Hennepin County Community Corrections²
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, Director, Office of Traffic Safety, Minnesota Dept. of Public
Safety
Honorable Paul Widick, District Court Judge, Seventh Judicial District
Associate Justice Helen Meyer, Supreme Court Liaison

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

¹ Assistant Commissioner Kooistra joined the Task Force in September 2005 when Lynda Boudreau moved from the Department of Human Services to the Department of Health.

² Fred LaFleur withdrew from the Task Force in August, 2005.

B. TASK FORCE BACKGROUND AND PURPOSE

Background

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

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

It is imperative that cost-effective and productive ways of dealing with these issues be identified. Minnesota continues to face difficult economic times and 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. A number of other states have recently established task forces, judicial commissions, or legislatively mandated bodies that are also exploring this specific issue or similar

issues and initiatives (such as drug courts). On November 30, 2004, the state Conference of Chief Judges unanimously recommended that the Supreme Court establish a task force charged with exploring the problem of chemical dependency, and identifying potential approaches and resources for addressing that problem.

Purpose

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

1. Conduct background research on specific issues concerning AOD-dependent persons, and particularly AOD-related offenders, including:
 - a. The current extent of the problem of AOD-dependent persons, and particularly AOD offenders, in the Minnesota judicial branch;
 - b. The cost(s) of the problem and benefit(s) of proposed solutions;
 - c. Identification and assessment of current judicial strategies to address the problem of AOD-dependent persons, and particularly AOD offenders, both in Minnesota and other states;
 - d. Determination of the current and potential effectiveness of drug courts and other alternative approaches in Minnesota.
2. Conduct an inventory of current multi-agency, state-level AOD efforts in Minnesota as well as in other states, including:
 - a. Identification of promising practices;
 - b. Identification of gaps and redundancies.
3. Identify and recommend approaches, solutions, and opportunities for collaboration.

The Court directed the Task Force to submit two reports with the results of its research together with its recommendations for optimal development of alternative judicial approaches for dealing with AOD-dependent persons. An initial report focusing specifically on AOD-related criminal and juvenile offenders was to be submitted by January 3, 2006; this deadline was subsequently extended to February 3, 2006. A Final Report focusing on the overall impact of AOD problems across all case types is to be submitted by November 15, 2006.

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, and / or have provided written materials. The Task Force also solicited input from a variety of individuals, professionals, agencies, and groups having experience and interest in AOD problems and their impact on Minnesota courts.

Report Format, Distribution and Discussion

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

- Children in Need of Protection or Services (CHIPs) in the Juvenile Courts
- Domestic Violence
- Statewide Expansion of Problem Solving Approaches in Minnesota
- General Recommendations
 - Communities of Color
 - Co-Occurring Disorders
 - Trauma
 - Women and Girls
 - Criminal Justice Treatment
 - Fetal Alcohol Spectrum Disorders
 - The Use of Medications
 - The Process of Recovery
 - Screening and Assessment

Additionally, the Task Force heard testimony and has commented on civil commitment for chemically addicted individuals and on the impact of alcohol and other drugs on other case types.

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: Domestic Violence, Civil Commitment, and Other Case Types;
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 would support a proposed recommendation in order to avoid minority reports, even though some members might disagree with the proposed recommendation. The Summary of Major Task Force recommendations in Part II.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.

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.

PART II: EXECUTIVE SUMMARY

A. SUMMARY OF MAJOR TASK FORCE CONCLUSIONS AND RECOMMENDATIONS

- I. ***Children in Need of Protection or Services (CHIPS) – Problem-Solving Approaches***³: *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 alcohol and other drugs 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 believes that problem-solving approaches for the CHIPS population in the juvenile courts will greatly improve the outcomes for children living in families impacted by AOD, provide necessary treatment and ancillary services for parents, and save significant Out of Home placement costs for the state and the county.⁴ 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, with multifarious needs and resource capabilities, a menu of interventions to positively impact the occurrence of AOD on CHIPS cases, and ultimately 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

³ 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” as used here is a term of art used by courts across the country to define a specific type of innovative judicial intervention. (See this Task Force’s *Report on Adult and Juvenile Alcohol and Other Drug Offenders*, p. 21, #5; pp. 24-25)

⁴ At the time this report was written there were only two family dependency treatment courts in Minnesota – in Stearns County and Dakota County. Both courts began July, 2006.

families in the judicial child protection system more broadly available throughout the state.⁵ The essential elements⁶ 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 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 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 criteria and other program criteria.⁷*
- 4. Evidence based culturally appropriate treatment services.*
- 5. Services targeted toward children who come from addicted families.*
- 6. The availability of ancillary services (e.g., 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: Even though the exact relationship between AOD use and domestic violence has yet to be determined, the Task Force believes 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 and survivors. Additionally, failure to address abusers' AOD problems within the context of domestic violence treatment can jeopardize abusers' efforts to stop the violence.⁸

Civil Commitment: While the Task Force did not make specific recommendations in the area of civil commitment, it recognizes that civil commitments present, in certain cases only, opportunities to implement the problem-solving approach. One of the Task Force's hopes is that the

⁵ 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.

⁶ For a more detailed discussion of these elements, refer to Appendix B.

⁷ 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.

⁸ SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., U.S. DEP'T OF HEALTH & HUM. SERVICES, TREATMENT IMPROVEMENT PROTOCOL (TIP) 25, SUBSTANCE ABUSE TREATMENT AND DOMESTIC VIOLENCE, 5 (1997).

successful implementation of problem-solving approaches for AOD-addicted individuals across Minnesota will ultimately impact the number of people being civilly committed as system/s becomes more adept at intervening in addictive disorders.

Other Case Types: The Task Force also did not make specific recommendations concerning all other case types. However, it is clear that AOD has a significant impact across case types, and the degree to which the Judicial Branch trains its employees and judges on AOD issues will ultimately be the degree not only to which these cases reduce in number, but also to which AOD addicted individuals coming into the Minnesota courts experience the appropriate and effective administration of justice.

- III. **Statewide Expansion of Problem Solving Approaches in Minnesota's Courts:** *The Task Force supports the statewide development of problem solving approaches for AOD addicted individuals coming into the court system. This includes but is not limited to: adult criminal and juvenile delinquency cases, child protection / family dependency cases, civil commitments (when appropriate), and intimate partner violence (also known as 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 across the state. Since the release of the First Report by the Task Force, the Judicial Council has endorsed the following action item regarding problem solving approaches as part of its overall Strategic Plan for the next biennium:

Integrate a judicial problem-solving approach into court operations for dealing with alcohol and other drug (AOD) addicted offenders.

Further, 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
- 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)⁹ developed for that model of problem-solving court. However, drug court programs should be allowed flexibility in establishing criteria to meet local needs.¹⁰

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 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 there were several general conclusions and recommendations essential to the successful resolution of AOD problems and implementation of problem solving approaches for AOD-addicted offenders and other litigants.

Communities of Color: The Task Force expresses concern about Minnesota's current national standing in the incarceration ratio of blacks to whites.¹¹

⁹ The Ten Key Components are located in Appendix B of this report.

¹⁰ 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.

¹¹ At the time of the writing of this report, Minnesota had the twelfth highest ranking in the incarceration ratio of blacks to whites. Based on data from Prison and Jail Inmates at Midyear 2005, Bureau of Justice Statistics (May 2006). According to the Department of Corrections, 43% of all drug offenders are people of color. "For example, whereas minorities account for 92 percent of crack and 70 percent of cocaine

Specifically, significant racial disparities exist with regard to drug-related offenses.¹² The Task Force is greatly concerned that while Minnesota develops a more balanced treatment policy to deal with the growing problem of methamphetamine, it should also consider the current criminal justice response and treatment policy regarding crack cocaine (including the availability of appropriate and adequate resources), particularly in its impact on African American communities.¹³ Finally, the Task Force's goal is to move forward with one comprehensive plan that fairly and effectively addresses the impact of AOD problems on the judicial branch 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 (COD): Task Force members learned that when co-occurring disorders go unaddressed, the likelihood of AOD relapse as well as criminal recidivism greatly increases. Research in the last twenty years has definitively demonstrated the correlation between AOD problems and mental health disorders. Thus, individuals with co-occurring disorders present unique challenges for the court system, with a corresponding need for greater understanding and knowledge of promising practices in this area. It is estimated that as many as 25% of male offenders and 40% of female offenders in Minnesota prisons are diagnosed with co-occurring disorders.¹⁴ The success of problem solving approaches for AOD offenders is contingent on the availability and effective application of appropriate services. While resource availability varies, it is imperative that all problem solving

offenders, they comprise 13 percent of inmates incarcerated for methamphetamine and 17 percent of those for amphetamine." Minnesota Department of Corrections, DOC Backgrounds, February 2006.

¹² 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. 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% and the rate for Asian offenders was 33% (the rate for American Indian offenders was 23%). However, the average prison sentence for Caucasian drug offenders was greater than all other racial/ethnic groups with the exception of Latino offenders. DEFINING THE DISPARITY – TAKING A CLOSER LOOK: DO DRUG USE PATTERNS EXPLAIN RACIAL/ETHNIC DISPARITIES IN DRUG ARRESTS IN MINNESOTA? (Minn. Council on Crime and Justice date); Race-Related Sentencing Data: Focus on Drug Offenders, Minnesota Sentencing Guidelines Commission, at 5, 13.

¹³ 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 which also reported that 51% favored treatment for cocaine offenders, while 26% favored probation. 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 (June 2006).

¹⁴ Presentation by Department of Corrections (2005). This estimate is likely to be conservative due to the Department Of Correction's own admitted difficulty in assessing and properly diagnosing every offender that may have a co-occurring disorder.

approaches have awareness of COD to ensure their highest likelihood of success.

Trauma: While the issue of trauma¹⁵ 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 Force¹⁶, 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 underlined the importance of trauma as an underlying factor in the onset of addictive disorders and a key barrier to the long-term recovery of many people who enter treatment for addictive disorders. Due to the growing recognition of trauma informed services in the chemical dependency field, the Task Force thought it important to specifically address this issue.

Women and Girls: The Task Force wishes to emphasize the importance of gender-responsive services for all offenders, both men and women; however, while the advances for women and girls have been significant over the past three decades, there is still much needed improvement. Therefore, the Task Force wishes to be explicit and unequivocal in reinforcing the concerns that the Female Offender Task Force expressed in its testimony regarding the need for gender-responsive services.¹⁷ 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 created that respond to the unique needs of women, women do better. When women do better, for the most part, children 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 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, as stated in its first report, the Task Force believes that investing in treatment and

¹⁵ 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)."¹⁵

¹⁶ Carol Ackley, Dr. Larry Anderson, and Dr. Noel Larson

¹⁷ Testimony to the Task Force (May 26, 2006).

holding offenders accountable with the appropriate consequences will save public (and private) dollars by ending the common revolving door for many of these individuals. Finally, the impact on communities of transforming addicted individuals engaging in criminal behaviors and lifestyles into sober, productive, tax-paying citizens and family members cannot be overestimated. 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 (including drug courts), by ensuring that these interventions are utilized for those populations most appropriate for them. Ultimately, as in the first report, the Task Force’s vision is to see a continuum of interventions, with drug court being one of them, to provide the most effective intervention for the AOD-involved offender.

Fetal Alcohol Spectrum Disorders: Fetal alcohol exposure may be one of the most significant unrecognized factors in the challenge of our courts and other systems to adequately address the impact of alcohol and other drug 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”.¹⁸

Medication and AOD Treatment: Some advocates of the traditional behavioral approach to AOD treatment have not embraced the use of medications in treatment.¹⁹ Studies have shown that chemical dependency affects brain processes responsible for motivation, decision-making, pleasure, inhibition, and learning.²⁰ Based on this knowledge, researchers have been searching for medications and vaccines that alter these brain processes to assist in treatment and recovery.²¹ Much like the medical treatment for asthma

¹⁸ INSTITUTE OF MEDICINE, *FETAL ALCOHOL SYNDROME: DIAGNOSIS, EPIDEMIOLOGY, PREVENTION, AND TREATMENT* (Kathleen Straton et. al. eds., National Academy Press 1996).

¹⁹ Benoit Denizet-Lewis, *An Anti-Addiction Pill?*, N.Y. TIMES (June 25, 2006)

²⁰ 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. Alcohol and other drugs cause 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 production of dopamine and the number of dopamine receptors—called D2 receptors—created. As a result, the brain’s “reward system” is less likely to respond to everyday behaviors/experiences that produce a normal dopamine surge, e.g. 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 (whether depressants, stimulants, etc.) interact in the brain in order to design medications to interfere with negative effects to reduce or stop cravings.

²¹ Benoit Denizet-Lewis, *An Anti-Addiction Pill?*, N.Y. TIMES (June 25, 2006). There are over 200 medications in development for the treatment of addictions. While there is much promise in the future use

or diabetes, behavioral and lifestyle changes are needed in addition to the use of appropriate medications for AOD dependency. The research is clear: medication combined with behavioral treatment provides the best chance for recovery.^{22, 23}

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 alcohol and other drug 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: Unquestionably, screening and assessment are the lynchpins in determining which offender should go to which intervention and ultimately the program's overall efficacy and success. Currently, national researchers are developing assessment tools specifically for drug courts. At the same time, per the research of Marlowe et al., 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 and significantly enhance both the effectiveness and efficiency of the criminal justice, juvenile justice, and CHIPs system responses to AOD problems.

of these medications, there are only a few medications where there is sufficient medical research and data to recommend their current use.

²² *Id.*

²³ Benoit Denizet-Lewis, *An Anti-Addiction Pill?*, N.Y. TIMES (June 25, 2006); Presentation to the Task Force by Dr. Gavin Bart, Director of Division of Addiction Medicine, Hennepin County Medical Center, (April 28, 2006).

PART III: THE ADDICTION MODEL ADOPTED BY THE TASK FORCE

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

Addiction as a Brain Disease

In 1998, Alan I. Leshner, then-Director of the National Institute on Drug Abuse (NIDA) at the National Institute of Health, wrote an article entitled “Addiction is a Brain Disease.”²⁴ Doctor Leshner’s article is widely acknowledged to be one of the most definitive statements from the scientific community regarding alcohol and other drug addiction, and a seminal work in the field. In reaching agreement on an addiction model, the Task Force considered similar written material summarizing the latest research in the field, as well as an oral presentation by a local expert.²⁵

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.²⁶

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

From both clinical and policy perspectives, it actually does not matter very much what physical withdrawal symptoms occur. Physical dependence is not that important, because even the dramatic withdrawal symptoms of heroin and alcohol addiction can now be easily managed with appropriate medications. Even more important, many of the most dangerous and

²⁴ Alan I. Leshner, *Addiction is a Brain Disease*, Issues in Science and Technology Online (2001), <http://www.issues.org/17.3/leshner.htm>.

²⁵ Presentation to the Task Force on the Neurochemistry of Addiction by Carol Ackley, Director of River Ridge Treatment Center in Burnsville, Minnesota (April 22, 2005).

²⁶ National Institute on Drug Abuse, *Principles of Drug Addiction Treatment: A Research-Based Guide* (1999), <http://www.nida.nih.gov/PODAT/PODATindex.html>.

addicting drugs, including methamphetamine and crack cocaine, do not produce very severe physical 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.²⁷⁻²⁸

Under the brain-disease model, people initially try drugs for a variety of reasons, and some are more affected than others. These people move on to addiction. Once addicted, the brain has been changed. The chronic drug-seeking and using behavior is, for the most part, a function of addiction as a brain disease, like schizophrenia or depression.²⁹ 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.³⁰

Environment, Personality, and Genetics

The Task Force is also persuaded that although environment does not in and of itself appear to cause addiction, it does appear to play a critical role in disease development, progression, and the chance for relapse when someone is learning how to manage the

²⁷Leshner, *supra*, at 2.

²⁸ 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.

²⁹ Interview with Dr. Richard Rawson, Associate Director, Integrated Substance Abuse Programs, UCLA Dept. of Psychiatry & Biobehavioral Sciences (November 10, 2004).

³⁰ Leshner, *supra*, at 1-2.

illness. It also appears to be an important predisposing factor for addiction for many people. The first precipitant for addiction is the actual use of the drug. A person may be predisposed genetically to become addicted but never use substances, or may use them so rarely that it does not trigger addiction. Research clearly shows that aside from the genetic component of familial addiction, simply being exposed to a family member's drug use on a regular basis, having access to the substances, and being subjected to the stresses caused by living in an addicted family systems all greatly increase the risk of early individual use.³¹

Addiction as a Chronic Illness

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

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

Additionally, the Task Force notes that:

- There is a valid diagnosis for AOD addiction that has been proven reliable.
- Research shows that treatment for addiction is as effective, if not more effective, than treatment for heart disease and diabetes.³²

³¹ Two critical environmental factors in addiction appear to be cues and cravings. A frequent drug user generally uses in certain ways and develops rituals around their use. Those environmental cues, according to Leshner, “actually become ‘conditioned’ to that drug use and are thus critical to the development and expression of addiction.” *Id.* at 4. When a person encounters these cues, the brain responds and creates intense drug cravings that elicit anticipation of use of the drug. For example, passing a frequented liquor store, visiting a neighborhood where one used to buy drugs, watching people smoke cocaine in a movie, watching an advertisement for one's favorite alcoholic beverage can all elicit intense cravings. In addition, simply returning to one's home from treatment (assuming the home is associated with drug use) can cause a person to experience intense drug cravings. These cravings play a critical role in an individual's relapse. Thus learning how to identify, respond to, and manage cravings appears to be fundamental to addiction treatment and recovery.

³² A. Thomas McClellan et al., *Drug Dependence, a Chronic Medical Illness*, 284 JAMA 1689-95 (2000).

- The Minnesota Department of Human Services published an exhaustive study in 2000 monitoring treatment outcomes from 1993-1999; the number one recommendation was to provide a continuum of care consistent with the expert consensus that chemical dependency is a chronic disease.³³

The Latest Brain Research

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

The Role of Personal Responsibility

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

Does having a brain disease mean that people who are addicted no longer have any responsibility for their behavior or that they are simply victims of their own genetics and brain chemistry? Of course not. Addiction begins with the voluntary behavior of drug use, and although genetic characteristics may predispose individuals to be more or less susceptible to becoming addicted, genes do not doom one to become an addict. This is one major reason why efforts to prevent drug use are so vital to any comprehensive strategy to deal with the nation's drug problems. Initial drug use is a voluntary, and therefore preventable, behavior.

Moreover, as with any illness, behavior becomes a critical part of recovery. At a minimum, one must comply with the treatment regimen, which is harder than it sounds. Treatment compliance is the biggest cause of relapses for all chronic illnesses, including asthma, diabetes, hypertension, and addiction. Moreover, treatment compliance rates are no worse for addiction than for these other illnesses, ranging from 30 to 50 percent. Thus for drug addiction as well as for other chronic illnesses, the individual's motivation and behavior are clearly important parts of success in treatment and recovery.³⁴

³³ Patricia Harrison et al., MINNESOTA DEPARTMENT OF HUMAN SERVICES, THE CHALLENGES AND BENEFITS OF CHEMICAL DEPENDENCY TREATMENT: RESULTS FROM MINNESOTA'S TREATMENT OUTCOMES MONITORING SYSTEM 1993-1999, 3-5 (October 2000).

³⁴ Leshner, *supra*, at 6.

PART IV: TASK FORCE CONCLUSIONS AND RECOMMENDATIONS

A. RECOMMENDATIONS FOR THE DEVELOPMENT OF PROBLEM-SOLVING³⁵ 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.³⁶ Anecdotal information and reviews of sample Minnesota court files also show that approximately 75% of the child protection cases coming into the court system have AOD as an underlying factor.³⁷ 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.

There are four timelines³⁸ constantly operating as child protection cases come into the court system:

- The first is the federal permanency guidelines enacted in 1997 to 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.³⁹
- The second relates to welfare to work. This refers to the amount of time individuals have 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 treatment

³⁵ 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 this Task Force’s *Report on Adult and Juvenile Alcohol and Other Drug Offenders*, p. 21, #5; pp. 24-25).

³⁶ Navigating the Pathways: Lessons and Promising Practices in Linking Alcohol and Drug Services with Child Welfare, Technical Assistance Publication (TAP) 27, U.S. Department of Health and Human Services, pp.4-5; Responding to Alcohol and Other Drug Problems in Child Welfare: Weaving Together Practice and Policy, p.2.

³⁷ 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.

³⁸ 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. It is more fully explained in Navigating the Pathways: Lessons and Promising Practices in Linking Alcohol and Drug Services with Child Welfare, Technical Assistance Publication (TAP) 27, U.S. Department of Health and Human Services. This publication is free and can be accessed at www.samhsa.gov.

³⁹ The Adoption and Safe Families Act (ASFA), P.L. 105-89.

- is not always considered as work, though there is currently federal legislation that allows for this.⁴⁰
- 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.⁴¹
 - The fourth and perhaps the most timeline is the child development process. This is the natural psychological development of the child that is 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.⁴²

The significance of each of these four timelines is clear – all are 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 inherent tension in attempting to successfully navigate each timeline and how each one impacts the other three. A fifth timeline could also be identified – the time required for those working in the child protection system, in all three systems, to respond effectively to all of the other timelines. 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.⁴³

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.⁴⁴ 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 the parents on their path to recovery. One of the most significant decisions the courts have the power to make concerns termination of parental rights. If it becomes necessary to terminate parental rights or move to some other permanency decision in such cases, the courts and other members of the child protection system must have confidence that they 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

⁴⁰ According to the Minnesota DHS-Chemical Health Division, counties can decide whether or not individuals receiving public aid get work credit for their time in treatment.

⁴¹

⁴² The Task Force heard about all of these timelines in testimony from DHS staff and members of the CJI-AOD project.

⁴³ Minn. Stat. §260C.001, subd. 2 (2006).

⁴⁴ The Task Force heard 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.

Department of Human Services, Chief Justice Blatz developed the Children's Justice Initiative (CJI). The mission of CJI 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.

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 find safe, stable, permanent homes for abused and neglected children in as timely a manner as possible. The first permanency direction is toward 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 specifically 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).⁴⁵

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: compiling 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 (which is currently underway).

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. The idea behind this concept was simple: 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 consultant joined the core-team (the body of professional staff that developed the project, made recommendations to leadership, and implemented policies)

⁴⁵ Minnesota was one recipient among four states and an American Indian tribe to receive this second round of national technical assistance.

in order to provide a parent perspective for the work of the project. 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 that counties and CJI teams can engage parents who have been through the system and are in recovery as experts to work with their teams.⁴⁶

Discussion of Specific Services for Children of Addicted Parents

The importance of providing evidence-based and specifically targeted services to children of addicted parents cannot be overstated. Significant bodies of research show that when children from addicted family systems are given the standard regimen of services they do not do as well as children who receive services specifically geared toward the special needs of children of addicted parents.⁴⁷

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.⁴⁸ According to data from the Minnesota Department of Human Services, African American children make up 5% 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% 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, there are 82.3 for every 1,000 in out of home care.⁴⁹

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. This rate was approximated as 1 in 4.⁵⁰ In response to a congressional request to review the impact of ICWA, and more specifically, whether placement of Indian children was delayed because of it, the Government Accountability Office found no significant federal oversight of the implementation of ICWA to ensure that states were complying with the Act.⁵¹

Dr. Susan Wells from the University of Minnesota presented recent research on disproportional involvement of African American children in the child protection

⁴⁶ Parent partners are identified as persons who have personally experienced the child protection system and are in recovery from alcohol or other drugs.

⁴⁷

⁴⁸ 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. The recommendations of these two bodies can be found at:
<http://edocs.dhs.state.mn.us/lfsrver/Legacy/MS-1943-ENG> (African American) and
http://www.dhs.state.mn.us/main/groups/children/documents/pub/dhs_id_050644.pdf (American Indian)

⁴⁹ Email correspondence, Jackie CrowShoe and John Hudson, Minnesota Department of Human Services, September 20, 2006. This is an aggregate summary of data from 2000-2005.

⁵⁰ For more information on ICWA go to: <http://www.nicwa.org/policy/law/icwa/index.asp>.

⁵¹ Government Accountability Office, Existing Information on Implementation Issues Could be Used to Target Guidance and Assistance to States, 2003 accessed at:
http://www.nicwa.org/policy/law/icwa/GAO_report.pdf.

system.⁵² This is a perplexing question, because a national study of the incidence of child abuse and neglect in the United States found no difference in maltreatment between white and African American families. The study, conducted by the Minnesota African American Racial Disparities Committee, focused on three factors to determine whether a child would have a CHIPs petition filed and 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 mom with an AOD problem is more likely to be placed than a child of a Caucasian mother with an AOD 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 African American mother with "financial problems".
- A child with an African American father with legal problems more likely to go into placement than the child of a white father with legal problems.
- A higher rate of Caucasian children went into placement at a very young age, but a higher rate of African American kids went into placement at older ages (ages 6 through 9).⁵³

According to Dr. Wells, it is difficult to determine exactly why these differences exist; however, she conjectured that some of the reasons are socioeconomic, some pertain to institutional racism, and others may be associated with the type of subtle, unconscious racial bias we all experience in the United States. In the end, it appears that much of the disproportionality in out-of-home care in Minnesota does not arise from casework practice but is linked with disproportionate reporting to child protective services from neighborhoods with a high concentration of African American residents.

Based on the information detailed above and on previous testimony about the connection between involvement in the child protection system as 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.⁵⁴ The essential elements of such approaches include:

⁵² Dr. Susan Wells, Task Force testimony, 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 rates in the country, specifically for African American families/children.

⁵³ Wells, Testimony, June 30, 2006.

⁵⁴ 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. *Holding the parent accountable for his or her conduct and 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.*
9. *The use of incentives to acknowledge progress in the program and provide public support and affirmation for the parent's successes.*
10. *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.⁵⁵*
11. *Evidence based culturally appropriate treatment services.*
12. *Services targeted toward children who come from addicted families.*
13. *The availability of ancillary services (e.g., parent programs, recovery schools, tutors, vocational training, and mentors.)*
14. *A continuum of interventions.*

There are critical differences between family dependency treatment courts and adult and juvenile drug courts. First is the fact that the parents in these cases are not offenders, per se. While the parents are in juvenile court due to the relationship with their child/ren, the focus in a family dependency treatment court is primarily on the parents and their sobriety, on the assumption that parental abstinence and recovery will positively impact the parent's ability to care for and relate to the child. However, 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:

- 1) *Attention and available resources be focused on child protection cases as a means to reduce future participation 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 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.*

⁵⁵ 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.

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

Domestic Violence Cases

Problem The Task Force heard extensive testimony concerning the link between AOD problems and domestic violence. Numerous studies explore this connection. Research has consistently reported that 40 to 60 percent of married or co-habiting patients entering AOD treatment reported one or more episodes of Intimate Partner Violence (IPV) in the previous year.⁵⁶ 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.⁵⁷ 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 drinking and nearly threefold on days of cocaine use.⁵⁸ 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 (e.g. punching, use of a weapon).⁵⁹

The research community is unified that AOD problems and domestic violence are significantly correlated.⁶⁰ 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 (e.g., a mental health issues like antisocial personality disorder), or whether there is an indirect link between the two (e.g., the AOD problem leads to a breakdown in the relationship, which in turn leads to an atmosphere conducive to violence.)⁶¹ 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.⁶² 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

⁵⁶ William Fals-Stewart & Cheryl Kennedy, *Addressing Intimate Partner Violence in Substance-Abuse Treatment*, 29 J. SUBSTANCE ABUSE & TREATMENT 5 (2005).

⁵⁷ Presentation to the Task Force by Barbara Rogers, Women's Services Coordinator, Sojourner Project, Inc. Domestic Violence and Chemical Dependency: When They Co-exist in Relationships (March 24, 2006).

⁵⁸ 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).

⁵⁹ 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); 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).

⁶⁰ Kenneth E. Leonard, *Alcohol and Intimate Partner Violence: When Can We Say That Heavy Drinking Is a Contributing Cause of Violence?* 100 ADDICTION 422 (2005).

⁶¹ 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. (Forthcoming 2006)..

⁶² SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., U.S. DEP'T OF HEALTH & HUM. SERVICES, TREATMENT IMPROVEMENT PROTOCOL (TIP) 25, SUBSTANCE ABUSE TREATMENT AND DOMESTIC VIOLENCE, 5 (1997).

accountability for the violence. Or, if the survivor has an AOD problem, there is a concern that the survivor will be blamed for the violence.⁶³

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/organization that provides domestic violence services for survivors and their families.***

Civil Commitments for the Chemically Dependent Individual⁶⁴

The Task Force heard testimony⁶⁵ 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.⁶⁶

The criteria for a civil commitment are⁶⁷:

- Excessive habitual use of alcohol and/or other drugs;
- Incapable of self management;
- Failure to provide for food, clothing, shelter or medical care;
- Recent conduct because of AOD causing physical harm to self or others;
- Pregnant women have a special category.

Anyone can file a petition for civil commitment in Minnesota. While it can be voluntary, more than often it is filed by petition; doctors and hospitals are the primary petitioners in Hennepin County. In out-state 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 it 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 it must be clear and convincing, and the court must first consider any reasonable

⁶³ CRITICAL ISSUES IN DOMESTIC VIOLENCE 19 (Wilder Found. 2005), *available at* www.wilderresearch.org.

⁶⁴ Minn.Stat. § 245.50 (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.

⁶⁵ Presentation to the Task Force by Kim Bingam, Prosecutor, Ramsey County (March 24, 2006). The testimony from Kim Bingham, a Ramsey County prosecutor who has been overseeing civil commitment cases for over twenty 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.

⁶⁶ 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.

⁶⁷ Minn. Stat. § 245.50 (2004).

alternatives first; 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.⁶⁸

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. One of the challenges, according to Ms. Bingham, is that there are no longer many locked treatment facilities available for commitment.⁶⁹

The responses to the survey⁷⁰, administered with help from the State Ombudsman's Office, found that overall those working with the commitment process believe it is working well. However, listed below are some suggestions from the survey respondents to improve the process:

- Change the mandatory 72 hour hold to 96 hours to allow for more time to complete all of the necessary assessment and paperwork.
- The courts could explore the use of problem-solving approaches, when appropriate.⁷¹
- Ensure greater follow through by individuals in carrying out the court's orders.
- The court needs to better understand co-occurring disorders.
- The commitment process should not be punitive – it should be treated the same way as the mental health commitment process.
- The court, or some sort of oversight entity, should remain involved if someone is committed to a hospital/treatment center and then discharged.

⁶⁸ Minn. Stat. § 245.50 (2004), as amended by H.F. 3111.

⁶⁹ Presentation to the Task Force by Kim Bingham, Prosecutor, Ramsey County (March 24, 2006). The only current locked facilities for chemical dependency are in Anoka County and Otter Tail County (Fergus Falls).

⁷⁰ The questions asked in the survey were: 1) What about the civil commitment process is working well in your area, specifically for those who are addicted to alcohol and other drugs or suffering from co-occurring disorders? 2) What do you think needs to change in order for the civil commitment process to be more effective for the population mentioned above? 3) What specifically could the courts do to improve the civil commitment process and ensure that the court's orders are followed? 4) What other comments would you like to share about the civil commitment process specifically for those individuals addicted to alcohol and other drugs or suffering from dual disorders? A total of 15 counties responded to the survey.

⁷¹ While the Task Force agrees that problem-solving approaches could be beneficial for some of those who are civilly committed for AOD problems (primarily, chronic alcoholism), it unanimously agrees that such approaches can only be effective for those with the cognitive abilities necessary to succeed in such programs.

Based upon testimony and the responses to the survey, the Task Force offers the following specific questions for the Minnesota Judicial Branch to consider:

- How accurate is the assessment process for those being civilly committed? Are all respondents being assessed for co-occurring disorders? Is there a way of assessing who is amenable to treatment and who is not?
- How much does/should previous treatment “failures” impact the decision to civilly commit an individual?
- What is the role of the court in ensuring that those who are committed receive the services that it orders and that the committed person completes the treatment to which they have been ordered?
- Would the problem-solving court model, or specific components of the model, be effective for this population?

The Task Force found that there was not a great deal of information or research available on this issue. 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 believes that the incidence of AOD in these additional case types does merit further attention.

C. RECOMMENDATIONS FOR STATEWIDE EXPANSION OF PROBLEM-SOLVING⁷²⁷³ APPROACHES IN MINNESOTA

Problem: In order to ensure equal access to justice for all offenders in the state, the Task Force believes that the Judicial Branch and its partners must look to the experience and lessons learned from other states to develop and adopt its own multi-phased, comprehensive plan for “going-to-scale”. However, several challenges exist to

⁷² 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 MINNESOTA SUPREME COURT CHEMICAL DEPENDENCY TASK FORCE, ADM-05-8002, REPORT ON ADULT AND JUVENILE ALCOHOL AND OTHER DRUG OFFENDERS, 21, 24-25 (2006).

⁷³ For a listing of the current (11/2006) problem solving courts in Minnesota see Appendix C.

transforming a successful small-scale innovation, such as currently exists in Minnesota, 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 and enhanced 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; at the same time, it is clear that 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 broader court system?⁷⁴ Which aspects of problem-solving court success 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 defendants?⁷⁵

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:⁷⁶

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

⁷⁴ Aubrey Fox & Greg Berman, *Going to Scale: A Conversation About the Future of Drug Courts*, CRT. REVIEW, Fall 2002, at 4.

⁷⁵ John Feinblatt, Greg Berman & Aubrey Fox, *Institutionalizing Innovation*, 28 FORDHAM URB. L. J. 277, 280 (2000)..

⁷⁶ Donald J. Farole, Jr., *The Challenges of Going to Scale: Lessons from Other Disciplines for Problem-Solving Courts*, CENTER FOR CT. INNOVATION, 2006, at 4.

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.⁷⁷

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.⁷⁸ Several themes emerged from the discussion: First, achieving buy-in from key players is critical. Judges and other key personnel may need transformative personal experiences⁷⁹ 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 for 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.⁸⁰ 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.⁸¹

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.⁸²

⁷⁷ Donald J. Farole, Jr., *The Challenges of Going to Scale: Lessons from Other Disciplines for Problem-Solving Courts*, CENTER FOR CT. INNOVATION, 2006, at 5.

⁷⁸ These lessons seem to apply to all problem-solving strategies.

⁷⁹ 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.

⁸⁰ Aubrey Fox & Greg Berman, *Going to Scale: A Conversation About the Future of Drug Courts*, CRT. REVIEW, Fall 2002, at 5.

⁸¹ 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*, CENTER FOR CT. INNOVATION, June 2004, at 4-5.

⁸² Donald J. Farole, Jr., *The Challenges of Going to Scale: Lessons from Other Disciplines for Problem-Solving Courts*, CENTER FOR CT. INNOVATION, 2006, at 9-15.

- *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.⁸³

Recommendations regarding going to scale:

At the state level:

- E. The goal should be to provide equal access to comparable levels of service to all chemically dependant defendants across the state.***
- F. All programs should be based on, and adhere to, the Key Strategies (such as the Ten Key Components)⁸⁴ developed for that model of problem-solving court. However, drug court programs should be allowed flexibility in establishing criteria to meet local needs.⁸⁵***
- G. A statewide, multi-disciplinary oversight group should be formed to develop or inform statewide policy and guidelines, and provide funding direction.***
- H. All problem solving court team members should receive training endorsed by the Judicial Council before becoming operational.***
- I. The Judicial, Legislative and Executive Branches of government should collaborate and coordinate efforts to fund and support problem solving court activities.***
- J. Funding for problem solving courts should be a combination of state and local funds.***
- K. The Judicial Council should adopt statewide performance measures for problem solving courts that will support state- and local-level program evaluations.***

⁸³ 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.

⁸⁴ The Ten Key Components are located in Appendix B of this report.

⁸⁵ 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.

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

M. *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:

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

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

D. GENERAL RECOMMENDATIONS⁸⁶

1. RECOMMENDATIONS REGARDING COMMUNITIES OF COLOR⁸⁷

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 Americans⁸⁸, 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 1980s⁸⁹, which continues to affect

⁸⁶ 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.

⁸⁷ 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.

⁸⁸ 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).

⁸⁹ 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

Minnesota's communities, particularly its urban areas. While the causes of this disparity are complex, and not within the purview of the Task Force's work, the Task Force recognizes that the criminal justice response⁹⁰ 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.^{91 92}

Problem: Racial disparity has several complex and overlapping causes.^{93, 94} 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.⁹⁵ Overall population trends indicate that communities of color will continue to grow and contribute to Minnesota's identity and culture.⁹⁶ 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 leaders⁹⁷ who helped to identify the different needs, challenges, and

legislature responded by raising the legal consequences and sentencing guidelines for powder cocaine to the same level as crack cocaine.

⁹⁰ 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.

⁹¹ MINNESOTA SUPREME COURT, STATE COURT ADMINISTRATOR'S OFFICE, FORGING AHEAD: CREATING A RACIALLY FAIR FUTURE FOR THE COURTS (2003). 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."

⁹² 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 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 (August 2005).

⁹³ REDUCING RACIAL DISPARITY WHILE ENHANCING PUBLIC SAFETY: KEY FINDINGS AND RECOMMENDATIONS 2 (Council on Crime and Justice 2006), available at <http://www.crimeandjustice.org/>.

⁹⁴ 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. REDUCING RACIAL DISPARITY WHILE ENHANCING PUBLIC SAFETY: KEY FINDINGS AND RECOMMENDATIONS 2 (Council on Crime and Justice 2006), available at <http://www.crimeandjustice.org/>.

⁹⁵ S. Bilchik, C. Seymour & K. Kreisher, *Parents in Prison*, CORRECTIONS TODAY, 2001, at 63, 7, 108 - 112.

⁹⁶ MINN. ST. DEMOGRAPHIC CENTER, POPULATION NOTES SERIES, NONWHITE AND LATINO POPULATIONS IN MINNESOTA CONTINUE TO GROW RAPIDLY (August 2006).

⁹⁷ Representatives from the African-American, American-Indian, Latino, Hmong-American, and Somali/East African communities testified before the Task Force on June 24, 2006. The names of the individuals who testified can be found in the *Acknowledgments* section of this report.

promising practices in their communities. Despite diverse histories and cultures, several common themes emerged from this testimony⁹⁸:

- *The need for culturally competent staff in the criminal justice and AOD treatment systems.*⁹⁹ 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 realize when to question assumptions and step back from a situation to ask for help.¹⁰⁰
- *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.
- *The impact of racism and xenophobia*¹⁰¹. 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 self within the larger society.
- *The impact of poverty and socioeconomic level.* Among metropolitan area households the median income is lower for persons in minority households, in comparison to white households¹⁰². 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 the greatest source of strength or a significant barrier to recovery for offenders with AOD problems. The Task Force heard from several panelists that positively

⁹⁸ Task Force panel testimony, June 30, 2006.

⁹⁹ 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.

¹⁰⁰ 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

¹⁰¹ 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.

¹⁰¹ Xenophobia is a fear and/or hatred of foreigners or strangers or anything that is strange or foreign.

Merriam-Webster Online Dictionary, <http://www.m-w.com/cgi-bin/dictionary?book=Dictionary&va=xenophobia..>

¹⁰² MIND THE GAP: REDUCING DISPARITIES TO IMPROVE REGIONAL COMPETITIVENESS IN THE TWIN CITIES (Brookings Institution Metropolitan Policy Program 2005).

engaging family and community support systems can help offenders of color achieve sobriety and avoid recidivism.¹⁰³

- *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 believes it is important to provide non-religious connected services and programs as well.¹⁰⁴
- *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 believes – 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.¹⁰⁵

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. Funders and policy makers are encouraged to ensure access to appropriate and effective treatment and other criminal justice interventions be made available to all racial/ethnic populations regardless of the specific chemical that brings the offender into the system.***
- C. Funders and 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 Administrators Office should provide ongoing training to problem solving court teams, in consultation with the Racial Fairness Committee, in the following areas:***

¹⁰³ Task Force Testimony, June 30, 2006

¹⁰⁴ *Id.*

¹⁰⁵ To that effect, the Task Force applauds the current efforts of the Council on Crime and Justice at its “Call to Action”. See <http://www.racialdisparity.org/>.

- 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. 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-OCCURRING DISORDERS (COD)¹⁰⁶

¹⁰⁶ 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

Problem: Research has demonstrated that COD is a common diagnosis. Dr. Larry Anderson, a licensed psychologist and state expert on co-occurring disorders, testified to the Task Force that 53% of individuals in the general adult population with a drug disorder (other than alcohol) also have a mental health disorder.¹⁰⁷ Also, 37% of individuals with an alcohol disorder also have a mental health disorder.¹⁰⁸ Further, serious mental illness (SMI) is highly correlated with AOD problems.¹⁰⁹ 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 an AOD problem.¹¹⁰¹¹¹ 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, a worsening of psychiatric problems often leads to AOD relapse. As a result, individuals with COD may be prone to more crises, progress more slowly, and consequently require longer and more intensive treatment.¹¹²

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.¹¹³ 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.¹¹⁴ 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.¹¹⁵

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.

¹⁰⁷ See Appendix D for a chart of the most common mental health disorders as related to the drug of addiction.

¹⁰⁸ Presentation to the Task Force by Dr. Larry Anderson, Psychologist, Dual Diagnosis Issues: Understanding the Concept (April 28, 2006).

¹⁰⁹ 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.

¹¹⁰ SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., U.S. DEP’T OF HEALTH & HUM. SERVICES, TREATMENT IMPROVEMENT PROTOCOL (TIP) 42, SUBSTANCE ABUSE TREATMENT FOR PERSONS WITH CO-OCCURRING DISORDERS 4 (2005).

¹¹¹ Please see Appendix E for a visual matrix of the co-occurring service delivery systems.

¹¹² Presentation to the Task Force by Dr. Larry Anderson, Psychologist, Dual Diagnosis Issues: Understanding the Concept (April 28, 2006).

¹¹³ SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., U.S. DEP’T OF HEALTH & HUM. SERVICES, TREATMENT IMPROVEMENT PROTOCOL (TIP) 42, SUBSTANCE ABUSE TREATMENT FOR PERSONS WITH CO-OCCURRING DISORDERS, 6 (2005).

¹¹⁴ Presentation to the Task Force by Dr. Larry Anderson, Psychologist, Dual Diagnosis Issues: Understanding the Concept (April 28, 2006).

¹¹⁵ SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., U.S. DEP’T OF HEALTH & HUM. SERVICES, TREATMENT IMPROVEMENT PROTOCOL (TIP) 42, SUBSTANCE ABUSE TREATMENT FOR PERSONS WITH CO-OCCURRING DISORDERS, 9 (2005).

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 for people with COD¹¹⁶:

- **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.**

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 the expectation throughout the service system.¹¹⁷ 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 disorders are discussed)
- Individual motivational enhancement interventions that address all disorders
- Combined pharmacological interventions, in which an individual receives medication to reduce cravings as well as medication for a mental health disorder.¹¹⁸

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.¹¹⁹ In its thorough 2005 report on co-occurring disorders, SAMHSA adopted recommendations for treatment based upon the CCISC. The Task Force supports the same following recommendations:¹²⁰

- 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***

¹¹⁶ Holly A. Hills, *The Special Needs of Women with Co-occurring Disorders Diverted from the Criminal Justice System*, NAT'L GAINS TECH. ASSISTANCE & POLICY ANALYSIS CENTER FOR JAIL DIVERSION (Substance Abuse & Mental Health Services Admin.), July 2003, at 4-5.

¹¹⁷ This model is recognized as exemplary practice by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA)

¹¹⁸ SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., U.S. DEP'T OF HEALTH & HUM. SERVICES, TREATMENT IMPROVEMENT PROTOCOL (TIP) 42, SUBSTANCE ABUSE TREATMENT FOR PERSONS WITH CO-OCCURRING DISORDERS, 29 (2005).

¹¹⁹ 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.

¹²⁰ SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., U.S. DEP'T OF HEALTH & HUM. SERVICES, TREATMENT IMPROVEMENT PROTOCOL (TIP) 42, SUBSTANCE ABUSE TREATMENT FOR PERSONS WITH CO-OCCURRING DISORDERS 41-48 (2005).

- 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; e.g.: 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.*

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 COD¹²¹:

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

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: 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, etc. 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.¹²²

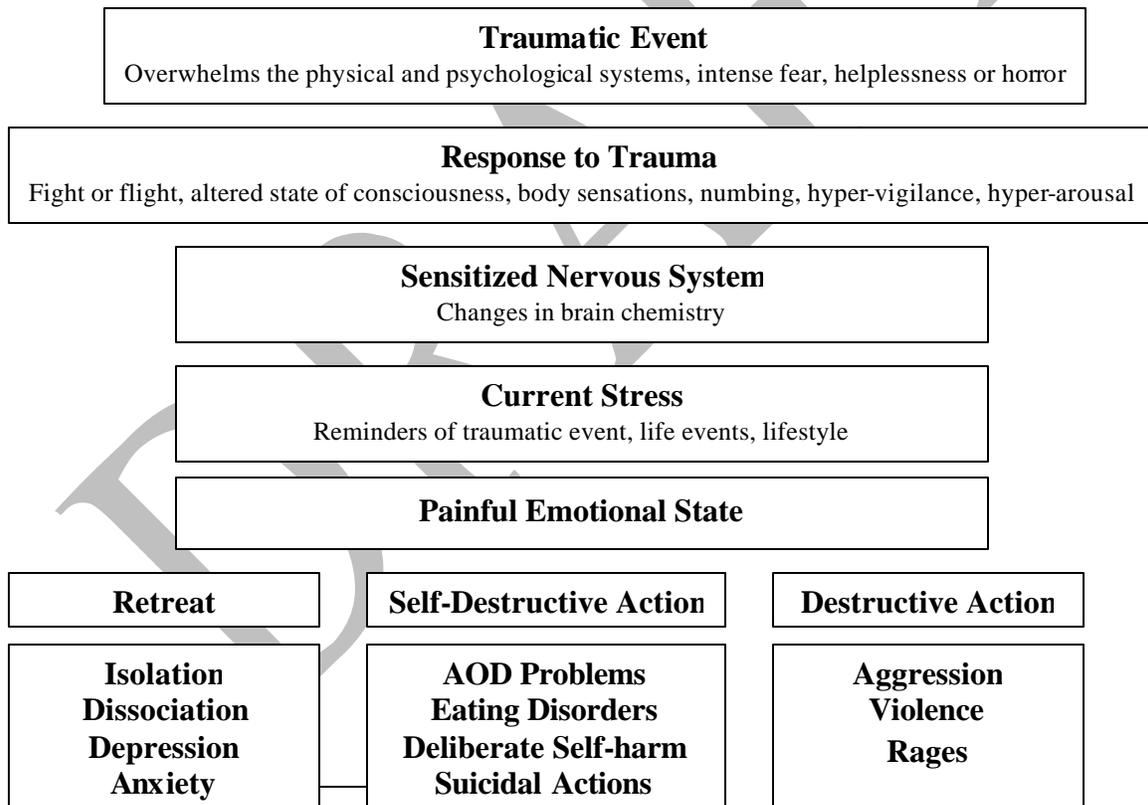
¹²¹ ROGER H. PETERS & FRED C. OSHER, CO-OCCURRING DISORDERS AND SPECIALTY COURTS 34 (The GAINS Center 2004); see generally this source as a comprehensive and useful guide for problem solving approaches for offenders with COD.

¹²² Presentation for the Task Force by Carol Ackley, Executive Director, River Ridge Treatment Center, Women's Issues in Treatment (May 26, 2006).

Experiencing trauma disrupts brain chemistry; childhood trauma can have lasting effects on brain development.¹²³ 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.¹²⁴

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.¹²⁵

THE PROCESS OF TRAUMA¹²⁶



¹²³ Presentation for the Task Force by Carol Ackley, Executive Director, River Ridge Treatment Center, Women's Issues in Treatment (May 26, 2006).

¹²⁴ 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).

¹²⁵ 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).

¹²⁶ Presentation for the Task Force by Carol Ackley, Executive Director, River Ridge Treatment Center, Women's Issues in Treatment (May 26, 2006).

Trauma-specific services are designed to directly treat 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 and reactions 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(s) itself. Rather, trauma-informed services—whether AOD treatment or criminal justice interventions (i.e., drug courts)—are designed to provide appropriate interactions tailored to the special needs of trauma survivors.¹²⁷ These services take the trauma into account by designing processes and procedures of operation that screen for trauma, and once identified, 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 victimized.¹²⁸ Often, a vicious cycle emerges as women who are using AOD are at greater risk for additional physical and sexual abuse.¹²⁹ 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.¹³⁰ 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.¹³¹

While much-needed 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

¹²⁷ 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).

¹²⁸ Maxine Harris & Roger D. Fallot, *Envisioning a Trauma-Informed Service System: A Vital Paradigm Shift*, in USING TRAUMA THEORY TO DESIGN SERVICE SYSTEMS 3, 3 (Maxine Harris & Roger D. Fallot eds., Jossey-Bass 2001).

¹²⁹ Maxine Harris & Roger D. Fallot, *Designing Trauma-Informed Addictions Services*, in USING TRAUMA THEORY TO DESIGN SERVICE SYSTEMS 57, 62 (Maxine Harris & Roger D. Fallot eds., Jossey-Bass 2001).

¹³⁰ Colleen Clark, *Addressing Histories of Trauma and Victimization through Treatment*, GAINS CENTER SERIES: JUSTICE-INVOLVED WOMEN CO-OCCURRING DISORDERS & THEIR CHILDREN (NAT'L GAINS CENTER PEOPLE CO-OCCURRING DISORDERS JUSTICE SYSTEM), Sept. 2002, at 8.

¹³¹ 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).

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.¹³² 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).^{133 134}

Men have historically been defined as the abuser – less 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.¹³⁵ 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.¹³⁶ The key challenge is not to minimize the damage done by the violence, to ensure the safety of those whom the abuser has harmed, and to not further traumatize anyone involved in the therapeutic process, including the abuser. Further, the existing research relating to men's experiences with trauma has largely been 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.¹³⁷ 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.¹³⁸

¹³² 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).

¹³³ 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).

¹³⁴ 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.

¹³⁵ Presentation to the Task Force by Dr. Larry Anderson, Psychologist, Men's Issues in Treatment: A Relational Approach to Men's Treatment and Recovery (May 21, 2006).

¹³⁶ Presentation to the Task Force by Dr. Noel R. Larson, Psychologist, Domestic Violence (April 2006).

¹³⁸ 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 he program is based on strengths rather than deficits 2) The program should build cross-over skills 3) The program should include ancillary

Recommendations:

- 1) *Each problem solving approach program team for addicted offenders in the court system should receive training on trauma disorders and trauma-informed services.*
- 2) *Drug court teams, and other problem solving interventions for AOD offenders, should design processes and procedures to prevent re-traumatizing participants with a history of trauma, and should regularly assess how well they are achieving this goal in their (bi)annual 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 GIRLS¹³⁹

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.¹⁴⁰ Gender-responsive services address the unique needs of a gender group by fostering positive gender identity development.¹⁴¹ 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 (as well as, e.g. race, sexual orientation, and class).¹⁴²

“Equal opportunity” sometimes means providing men and women with the same opportunities or treating men and women the same. However, the Task Force heard testimony, supported by research, that creating equal opportunity for recovery from AOD problems often means treating women and men differently based on their unique needs and experiences.¹⁴³ Minnesota law requires that women and girls convicted of

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). Maxine Harris & Roger D. 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).

¹³⁹ While ultimately this concept applies to both men and women, the Task Force’s current focus is on women and girls.

¹⁴⁰ PAM PATTON & MARCIA MORGAN, HOW TO IMPLEMENT OREGON’S GUIDELINES FOR EFFECTIVE GENDER-RESPONSIVE PROGRAMMING FOR GIRLS 12 (Oregon Commission on Children and Families 2002).

¹⁴¹ 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.

¹⁴² Identification as gay, lesbian, bisexual, 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.

¹⁴³ Presentation to the Task Force by the Honorable Esther Tomljanovich, Advisory Task Force to the Commissioner of Corrections on Women and Juvenile Offenders (May 26, 2006).

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.¹⁴⁴

Women

Women are 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. The female prison population grew 757 percent during this timeframe while the male prison population grew by 388 percent.¹⁴⁵ In particular, 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.¹⁴⁶ 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.¹⁴⁷

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.¹⁴⁸ 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 has shown that these children are in serious jeopardy of becoming offenders themselves.¹⁴⁹

Further, women offenders are 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

¹⁴⁴ MINN. STAT. § 241.70.

¹⁴⁵ Join Together, News Summary for May 22, 2006, <http://www.jointogether.org/news/headlines/inthenews/2006/female-prison-population> (last visited Aug. 18, 2006).

¹⁴⁶ SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., U.S. DEP’T OF HEALTH & HUM. SERVICES, TECHNICAL ASSISTANCE PUBLICATION (TAP) 23, SUBSTANCE ABUSE TREATMENT FOR WOMEN OFFENDERS: GUIDE TO PROMISING PRACTICES 4 (1999).

¹⁴⁷ 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.

¹⁴⁸ Presentation for the Task Force by Carol Ackley, Executive Director, River Ridge Treatment Center, Women’s Issues in Treatment (May 26, 2006); SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., U.S. DEP’T OF HEALTH & HUM. SERVICES, TECHNICAL ASSISTANCE PUBLICATION (TAP) 23, SUBSTANCE ABUSE TREATMENT FOR WOMEN OFFENDERS: GUIDE TO PROMISING PRACTICES 5 (1999).

¹⁴⁹ 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.

those 12.2%, nearly three-fourths have a co-occurring AOD disorder. The prevalence and impact of trauma on female offenders with AOD problems cannot be overstated. Staff at the Minnesota Shakopee women's prison estimate that 80% of the women report having been sexually or physically abused.¹⁵⁰ About one in five women offenders on probation in 2003 was a victim of intimate partner domestic violence.^{151 152}

Promising Practices for Women Offenders with AOD problems

As the population of women offenders with AOD problems began to increase 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.¹⁵³ 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.¹⁵⁴ 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.¹⁵⁵ 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.^{156 157}

¹⁵⁰ Presentation to the Task Force by the Honorable Esther Tomljanovich, Advisory Task Force to the Commissioner of Corrections on Women and Juvenile Offenders (May 26, 2006).

¹⁵¹ 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 7.

¹⁵² Further information on co-occurring disorders and trauma can be found in sections in this report devoted to those issues.

¹⁵³ SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., U.S. DEP'T OF HEALTH & HUM. SERVICES, TECHNICAL ASSISTANCE PUBLICATION (TAP) 23, SUBSTANCE ABUSE TREATMENT FOR WOMEN OFFENDERS: GUIDE TO PROMISING PRACTICES 17, 21 (1999); PAM PATTON & MARCIA MORGAN, HOW TO IMPLEMENT OREGON'S GUIDELINES FOR EFFECTIVE GENDER-RESPONSIVE PROGRAMMING FOR GIRLS 13 (Oregon Commission on Children and Families 2002).

¹⁵⁴ Presentation for the Task Force by Carol Ackley, Executive Director, River Ridge Treatment Center, Women's Issues in Treatment (May 26, 2006); Presentation to the Annual Conference of the American Society of Criminology by Ann L. Jacobs, Women's Prison Association and Home, Inc., Improving the Odds: Women in Community Corrections (November 17, 2004); 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 3.

¹⁵⁵ SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMIN., U.S. DEP'T OF HEALTH & HUM. SERVICES, TECHNICAL ASSISTANCE PUBLICATION (TAP) 23, SUBSTANCE ABUSE TREATMENT FOR WOMEN OFFENDERS: GUIDE TO PROMISING PRACTICES 8 (1999).

¹⁵⁶ *Id.* At 21; See also S.S. Covington & J.L. Surrey, *The Relational Model of Women's Psychological Development: Implications for Substance Abuse*, in Wilsnack and Wilsnack, eds. *Gender and Alcohol: Individual and Social Perspectives*, New Brunswick, NJ, Rutgers Center of Alcohol Studies (1997).

¹⁵⁷ 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.

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 the inherent collaboration of 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.¹⁵⁸

Girls

Girls are entering the juvenile justice system at a similar rate as 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, unlike boys, girls are less likely 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.¹⁵⁹

Like promising practices for adult female offenders, recommendations for gender-responsive programming for girls emphasize the need for building self-confidence and healthy relationships, which in turn 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 allow time to develop trust and healthy relationships.^{160, 161}

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 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.***

¹⁵⁸ Hills, *supra* note 13, at 8.

¹⁵⁹ Sharp, *supra* note 4 at 6.

¹⁶⁰ Patton, *supra* note 1 at 8, 31-33, 43.

¹⁶¹ 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.

- 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 not only shows that AOD treatment cannot only reduce individual AOD use, crime, and related incarceration costs, but 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.¹⁶²

Research on different types of criminal justice interventions for AOD offenders¹⁶³

¹⁶² 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?

¹⁶³ Appendix I lists 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.

Imprisonment:

As stated in the first Task Force report, prison alone has been 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.¹⁶⁴

Treatment in Prison¹⁶⁵:

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 interventions or traditional boot camp programs¹⁶⁶ on re-arrest rates or reincarceration 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.¹⁶⁷ 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.¹⁶⁸ 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.¹⁶⁹

In addition to prison, there are a large number of offenders who are incarcerated in county jails or workhouses.^{170, 171} Those in jails for a short period of time (pre-plea)

¹⁶⁴ Douglas B. Marlowe, *Effective Strategies for Intervening with Drug Abusing Offenders*, 47 Vill. L. Rev. 989, 998-998 (2002).

¹⁶⁵ 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. For the full report: <http://www.auditor.leg.state.mn.us/ped/2006/subabuse.htm>

¹⁶⁶ 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. *Substance Abuse Treatment: Evaluation Report 105* (Minnesota Office of the Legislative Auditor 2006).

¹⁶⁷ Marlowe, *supra* note 3, at 999-1001.

¹⁶⁸ Douglas B. Marlowe, *Integrating Substance Abuse Treatment and Criminal Justice Supervision*, Science and Practice Perspectives 4, 5 (Aug. 2003).

¹⁶⁹ *Id.* at 1001.

¹⁷⁰ Minn. Stat. ___ mandates those who are revoked while on felony probation to serve their time in jail, if they have less than a year to serve on probation.

¹⁷¹ 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

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 the jail. Whether the offender is incarcerated short-term or long-term, the Task Force believes that the Judicial Branch and other stakeholders need to give this issue further attention.¹⁷² Of particular importance, especially as it relates to the critical issue of public safety and because they are not appropriate for problem-solving approaches, 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.

Intermediate Community Sanctions

Programs that have been administered separate from treatment (rather, 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 of roughly four to eight percentage points.¹⁷³

Correctional Therapeutic Communities (TC’s)

TC’s 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 TC’s was evident for offenders who 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.¹⁷⁴

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

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 those 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.

¹⁷² 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 go to:

¹⁷³ *Id.* at 1004-1005.

¹⁷⁴ *Id.* at 1013.

treatment irregularly or fail to complete the treatment program.^{175, 176} 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 similarly legally mandated.¹⁷⁷ 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.^{178, 179} One of the primary reasons for drug court is to use the power of the courts to keep an offender in treatment long enough to experience the benefits.

Drug Courts and Recidivism Potential¹⁸⁰ Assessment

The concept and measuring of recidivism potential is a fundamental component in evaluating the efficacy of probation efforts.¹⁸¹ There have been many studies identifying which intervention best applies to which offender recidivism potential level. ***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,¹⁸² a leading scholar in corrections research from the University of Ohio, has studied and written extensively about the risk principle.¹⁸³ 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 program/s being evaluated.¹⁸⁴ This same research has shown that some interventions actually *increase* the recidivism of low-recidivism offenders. One of the meta-analyses reviewed found that the effectiveness of the drug court doubled when the offender had a

¹⁷⁵ *Id.* at 1006.

¹⁷⁶ 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 Criminal Justice Research, December, 2005.

¹⁷⁷ Jeanne L. Obert, Michael J. McCann, Patricia Marinelli-Casey & Richard A. Rawson, *A Clinician's Guide to Methamphetamine* 18 (Hazelden 2005).

¹⁷⁸ *Id.* at 1011.

¹⁷⁹ Not all studies have found drug courts to be cost-effective (as compared to traditional. In fact, the Government Accountability Office did not have a positive review of drug court research in its studies in 2001 and 2003; 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.

¹⁸⁰ 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.

¹⁸¹ Andrews et al., "Classification for effective rehabilitation: Rediscovering Psychology", *Criminal Justice and Behavior*, 17, 19-52; Latessa, "From Theory to Practice: What Works in Reducing Recidivism" ; Lowenkamp and Latessa, "Understanding the Risk Principle: How and Why Correctional Interventions Can Harm Low-Risk Offenders", *Topics in Community Corrections*, 2004.

¹⁸² Dr. Latessa was invited to testify before the Task Force but was unable.

¹⁸³ Again, the Task Force uses the terms "risk principle" and "recidivism potential" interchangeably.

¹⁸⁴ Lowenkamp and Latessa, "Understanding the Risk Principle: How and Why Correctional Interventions Can Harm Low-Risk Offenders", *Topics in Community Corrections*, 2004.

prior record (high recidivism potential).¹⁸⁵ Dr. Doug Marlowe¹⁸⁶, a national expert on effective treatment for the criminal justice population, has also found in his studies of drug courts that high-recidivism potential offenders seem to do better in drug court.¹⁸⁷

In the first “scientifically rigorous” study (using random assignment) evaluating the importance of the judge in drug court, Marlowe et al. 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 were not required to attend routine court hearings and instead received standard corrections case-management and treatment services, and saw the judge as traditionally indicated.¹⁸⁸ 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.¹⁸⁹

Judicial status hearings are among the most costly elements of drug court programs, and knowing how to effectively target this tool will lead to the most efficient use of drug court resources. The ability to predict which offenders will need more intense supervision will lead to greater success rates for these offenders, improved public safety for the community, and more efficient use of resources.¹⁹⁰ One of the clear caveats accompanying any conclusions from this research is that although Marlowe replicated his findings, additional research is needed to further validate the research and help drug courts determine who the best candidates are for their programs. However, as studies seek to identify the components of drug courts that work best and for which population they work best, it seems that a new concept of high recidivism potential may be developing – i.e., those diagnosed with DSM-IV antisocial personality disorder (APD) or 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.

Improving the drug court approach

Dr. Marlowe has suggested a way to determine which judicial intervention best fits which type of offender. As shown above, current research shows that offenders with high

¹⁸⁵ Lowenkamp et al., Are Drug Courts Effective: A Meta-Analytic Review, Journal of Community Corrections, Fall 2005.

¹⁸⁶ Dr. Doug Marlowe testified before the Task Force in June 2005.

¹⁸⁷ 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.

¹⁸⁸ Marlowe et al., “The Judge is a Key Component of Drug Court”, Drug Court Review, NDCI, Vol. IV, 2, pp. 1 – 34.

¹⁸⁹ In attempting to replicate his initial findings, Marlowe found that eighty percent of offenders with a prior drug treatment graduated when assigned bi-weekly judicial reviews compared to a graduation rate of only twenty 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. Marlowe et al., “The Judge is a Key Component of Drug Court”, Drug Court Review, NDCI, Vol. IV, 2, p. 18.

¹⁹⁰

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.* It also must be stated that research for drug courts is still evolving; therefore, nothing at this time is conclusive. Research analyzing the populations best served by drug courts and the critical elements that make drug courts work is even more emergent. Additionally, because few researchers have yet to publish quality research on this topic, the Task Force responds to this research tentatively.

The grid below created by Dr. Marlowe offers a way of applying the appropriate treatment to the appropriate type of offender:

	<u>High Risk for Criminality</u>	<u>Low Risk for Criminality</u>
<u>High AOD Needs</u>	<i>Accountability and Treatment</i> <i>Drug Court</i>	<i>Treatment</i> <i>Drug Court or Efforts Similar to Proposition 36¹⁹¹ (CA)</i>
<u>Low AOD Needs</u>	<i>Accountability</i> <i>Traditional Adjudication</i>	<i>Prevention</i> <i>Pre-trial Diversion</i>

Marlowe and other researchers have also noted that a significant percentage of drug court participants do not have a diagnosable or clinically significant AOD use disorder.^{192, 193} 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.¹⁹⁴ 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

¹⁹¹ Proposition 36: A statewide referendum passed in California in 2000 that mandated probation and treatment for all “non-violent” drug possession offenses. More information available at www.courtinfo.ca.gov/programs/collab/prop36.htm and www.prop36.org.

¹⁹² 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 & DELINQUENCY 114, 115 (Jan. 2006).

¹⁹³ In 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.

¹⁹⁴ *Id.* at 117.

- treated either on an individual basis or in separately stratified groups.¹⁹⁵
- 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.¹⁹⁶

Recommendations: The Task Force has believed, since its inception, 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. While the research in 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)

Problem: The Task Force heard from Joyce Holl, Executive Director of the Minnesota Organization for Fetal Alcohol Syndrome (MOFAS). 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, static encephalopathy, alcohol exposed. These effects may include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications.¹⁹⁷ Those suffering with this disability are more likely to enter the child protection system as a result of abuse and/or neglect. They often end up in the juvenile and criminal justice systems as they have trouble learning from mistakes, interacting with others, and they often exercise poor judgment.

¹⁹⁵ This recommendation relates to research, by Marlowe et al, showing that for those offenders with low recidivism potential who are put in groups with offenders with high recidivism potential the effect is often harmful for the offenders with low recidivism potential. That is, the outcomes for the offenders with low recidivism potential worsen, showing increases in AOD use and more severe crimes being committed.

¹⁹⁶ *Id.* at 131.

¹⁹⁷ Joyce Holl, Task Force Testimony, March 24, 2006

Mental health disorders and AOD addiction are among the most frequent concomitants of prenatal alcohol damage.¹⁹⁸ 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 2003.¹⁹⁹ A 2005 animal study by UW-Madison researcher, Susan M. Smith, has found that prenatal alcohol exposure to the fetus may cause changes in the brain, influencing the brain's reward circuits and making the person more susceptible to addiction later in life.²⁰⁰

FASD has largely been left out of the picture in fashioning interventions 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 and future FASD children getting into trouble with the law, dropping out of school, and mental health problems.²⁰¹ 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.²⁰²

Recommendations:

- 1) Require FASD screening of children/youth that the court has found to be in need of child protection and/or services, when there is evidence of AOD problems in the biological mother.***
- 2) Require FASD screening of biological parent(s) and/or caregivers if there is a family history of AOD problems.***

¹⁹⁸ Page, Kathryn, Ph.D., "The Invisible Havoc of Prenatal Alcohol Damage, JOURNAL OF THE CENTER FOR FAMILIES, CHILDREN & THE COURTS, 2002.

¹⁹⁹ 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. Baer, J.S., Sampson, P.D., Barr, H.M., Connor P.D., and Streissguth, A.P., "A 21-Year Longitudinal Analysis of the Effects of Prenatal Alcohol Exposure of Young Adult Drinking", ARCHIVES OF GENERAL PSYCHIATRY, Vol. 60, No. 4, April 2003.

²⁰⁰ Smith, Susan – Alcoholism; Clinical & Experimental Research

²⁰¹ Streissguth, A.P, et al., UNDERSTANDING THE OCCURRENCE OF SECONDARY DISABILITIES IN CLIENTS WITH FETAL ALCHOL 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).

²⁰² Innovative programs exist such as the Parent-Child Assistance Program (PCAP), an intervention model of intensive, long-term paraprofessional advocacy with 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 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%. Subsequent births decreased from 27% during the program to 9% during the follow-up period. For more information on this program go to:

<http://depts.washington.edu/fadu/FADU.projects.html#B23P>.

- 3) *Review all screening instruments to include questions which establish history of maternal alcoholism dating back to childbearing years.*
- 4) *Each drug court team should receive training on FAS,D and SCAO 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. (e.g. Washington State’s P-CAP – see FN. 187)*
- 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 the evidence-based practices and 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 (see below) in the treatment of opiate addiction may not meet current standards of care.²⁰³ Even so, a stigma exists that methadone is merely another form of heroin dependency. This belief, in part, has resulted in limited access to methadone maintenance clinics and 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’ offices²⁰⁴, treatment providers are hopeful that this drug will reduce the transportation and other access barriers to effective treatment for those with heroin dependency. Recent research has demonstrated that once-weekly visits to the doctor (doses of buprenorphine-naloxone still daily) in combination with twenty minutes of counseling by a primary care physician was equally effective in retaining

²⁰³ 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.

²⁰⁴ In order to prescribe buprenorphine physicians must take an eight hour course on its use.

patients in treatment and promoting abstinence as thrice-weekly doses of the drug and 45 minutes of medical management.²⁰⁵

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.²⁰⁶

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.^{207, 208} 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.²⁰⁹ 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 decrease.²¹⁰ A different study, focused on the same genetic difference, found that alcoholics treated with naltrexone and who had this genetic difference did not return to heavy drinking as soon as those treated with naltrexone without the genetic difference.²¹¹ Therefore, as is true for AOD treatment generally, there is no one-size-fits-all solution for treating alcohol dependence using medication.

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

²⁰⁵ Each combination of treatment produced this positive result in about 4 out of 10 patients.

²⁰⁶ Task Force testimony, Gavin Bart, April 28, 2006.

²⁰⁷ Testimony of Gavin Bart; *Naltrexone, Coping Skills Prevent Relapse*, Jan. 10, 2002 (Join Together e-newsletter) <http://www.jointogether.org/news/headlines/inthenews/2002/naltrexone-coping-skills.html> (accessed Aug. 17, 2006).

²⁰⁸ 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. *New Injectable Drug May Treat Alcoholism: Study Backs Effectiveness of Naltrexone at Reducing Cravings*, Reuters April 5, 2005 <http://www.msnbc.msn.com/id/7394118/> (accessed Aug 17, 2006).

²⁰⁹ Testimony of Gavin Bart.

²¹⁰ *Negative Effects of Naltrexone Reported*, July 25, 2006 (Join Together e-newsletter) <http://www.jointogether.org/news/research/summaries/2006/negative-effects-of.html> (accessed Aug. 17, 2006).

²¹¹ With an estimated 15% of the U.S. population carrying this genetic difference and there being 18 million alcoholics, almost 3 million people may benefit from this. David W Oslin, et al., A Functional Polymorphism of the m-Opioid Receptor Gene is Associated with Naltrexone Response in Alcohol-Dependent Patients, *Neuropsychopharmacology*, (2003) 28, 1546–1552.

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 and newer data indicates that it may benefit a subset of alcoholics such as those who have already achieved short-term abstinence.²¹² There is also some indication that for it to work best, patients should have the goal of abstinence.²¹³

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.***

8. RECOMMENDATIONS REGARDING THE PROCESS OF RECOVERY²¹⁴ FOR AOD ADDICTED INDIVIDUALS IN THE COURT SYSTEM

Problem: The process of achieving long-term recovery benefits individuals, families and communities. To resolve the alcohol and other drug problems of people in the court system requires greater understanding of long-term recovery and the systems that will make it possible for individuals to achieve it. The Task Force would like to emphasize that recovery is not active addiction or treatment for people who are actively using alcohol or other drugs. The Task Force believes 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 by no longer using alcohol and other drugs and by establishing themselves as productive members of the community.

Discussion of Recovery Community Organizations

²¹² Bart testimony.

²¹³ There are people who just want to reduce their use and others who want (or are forced into) treatment yet remain ambivalent about abstaining. Mason BJ, Goodman AM, Chabac S, et al., Effect of oral acamprosate on abstinence in patients with alcohol dependence in a double-blind, placebo-controlled trial: the role of patient motivation, J Psychiatr Res., 2006, 40(5), pp.382-392.

²¹⁴ Recovery can be defined as a process of change through which an individual achieves abstinence and improved health, wellness, and quality of life.

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.²¹⁵ Peer-to-peer recovery support services are not professional treatment or post-treatment after care provided by professionals. They are support services provided by people who share the experiences of addiction and long-term recovery. They help prevent relapse and promote sustained recovery and an enhanced quality of life for participants.²¹⁶ Recovery coaches and other recovery support providers know from personal experience about the stigma and discrimination that people who are participating in drug courts are experiencing. They help them know what to be looking out for and 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. Some of the most significant come when people with addictions end up in the criminal justice system and leave it having achieved recovery. That is because of the felony and other convictions that follow them after they have served their time. Public safety must always be foremost in dealing with alcohol and other drug-related crime. However, 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 of people continuing to commit crimes related to their addiction by helping them initiate and sustain their long-term recovery. The Task Force believes that public policy makers must consider the implication of policies that punish the ex-offender after a sentence has been served through the barriers that they place on an individual from being able to get a job, housing or even vote.²¹⁷ The Task Force notes that there are often collateral consequences which might, intentionally or unintentionally, place a continuing burden on convicted persons after their court-imposed sentence has

²¹⁵ 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 and directed learning, awareness and skill building experiences and 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 strengthening, sustaining, enhancing and promoting recovery.

²¹⁶ 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.

²¹⁷ Further discussion on this point can be found in the following two reports: Relief From The Collateral Consequences Of A Criminal Conviction: A State-By-State Resource Guide by Margaret Colgate Love at <http://www.sentencingproject.org/rights-restoration.cfm#tables> (Minnesota specific information for this report can be found at: <http://www.sentencingproject.org/pdfs/rights-restoration/Minnesota.pdf>) and After Prison: Roadblocks to Reentry by the Legal Action Center at <http://www.lac.org/lac/> (Minnesota specific information for this report can be found at: http://www.lac.org/lac/upload/reportcards/24_Image_Minnesota.pdf).

been fully discharged, impeding their ability to sustain their recovery from addiction to alcohol or other drugs.²¹⁸

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. Explore ways in which Minnesota can use the models developed in other states to support recovery community organizations (RCOs) and recovery support services to provide on-going support to individuals returning to their communities from treatment centers or drug courts in achieving long-term recovery.

9. RECOMMENDATIONS REGARDING SCREENING AND ASSESSMENT

Problem: One topic that the Task Force heard about in testimony from almost every subject matter expert throughout its work was 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 for individuals needing AOD treatment. The primary concern was how well issues like trauma, mental health, domestic violence, trauma and/or medication were being addressed in the drug courts and other problem solving approaches for AOD addicted persons, as well as within the larger treatment system in Minnesota. The general sentiment among the Task Force was 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 Committee²¹⁹ should research and identify, if possible, a comprehensive screening tool (to be used by all drug courts and other problem-solving approaches for AOD issues) that accurately identifies or flags the multifaceted needs and issues of the individuals in their programs.***

²¹⁸ The Legislature charged the Department of Public Safety with creating a task force to investigate the impact of collateral consequences. For more information please go to: _____.

²¹⁹ This is a proposed state level multi-branch committee to take the place of the Task Force and advise the Judicial Council in developing policies and standards for the implementation of problem-solving approaches.

PART V: CONCLUSION

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

DRAFT

PART VI: ACKNOWLEDGMENTS

The members of the Minnesota Supreme Court Chemical Dependency Task Force wish to thank everyone who has assisted in the Task Force's second phase of its 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, 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 practice/ 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, Minnesota Female Offender Task Force
 - Carol Ackley, Executive Director, River Ridge Treatment Center
 - Joel Alter, Office of the Legislative Auditor
 - 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
 - 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
 - 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 to Kathy Swanson, Office of Traffic Safety, Department of Public Safety for her commitment to the work not only of the Task Force but for all she has done to make Minnesota communities safer.

APPENDIX A

Order Establishing the Minnesota Supreme Court Chemical Dependency Task Force

Amended Order

STATE OF MINNESOTA

IN SUPREME COURT

ADM-05-8002

ORDER ESTABLISHING THE MINNESOTA SUPREME COURT CHEMICAL DEPENDENCY TASK FORCE

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

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

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

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

WHEREAS, Minnesota courts would benefit from a more deliberate and coordinated effort to investigate the current extent of the problem of AOD-dependent

persons who come in to the courts, and to assess available strategies and approaches for addressing that problem;

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

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

IT IS FURTHER ORDERED that the Task Force shall:

4. Conduct background research on specific issues concerning AOD-dependent persons, and particularly AOD-related offenders, including:
 - e. The current extent of the problem of AOD-dependent persons, and particularly AOD offenders, in the Minnesota judicial branch;
 - f. The cost(s) of the problem and benefit(s) of proposed solutions;
 - g. Identification and assessment of current judicial strategies to address the problem of AOD-dependent persons, and particularly AOD offenders, both in Minnesota and other states;
 - h. Determination of the current and potential effectiveness of drug courts and other alternative approaches in Minnesota.
5. Conduct an inventory of current multi-agency, state-level AOD efforts in Minnesota as well as in other states, including:
 - c. Identification of promising practices;
 - d. Identification of gaps and redundancies.
6. Identify and recommend approaches, solutions, and opportunities for collaboration.

IT IS FURTHER ORDERED that the Task Force shall submit two (2) reports to the Supreme Court, which will include the results of its research and its recommendations

for optimal development of alternative judicial approaches for dealing with AOD-dependent persons who come in to the Minnesota judicial branch. An initial report focusing specifically on AOD-related criminal and juvenile offenders shall be submitted by January 1, 2006; and a Final Report focusing on the overall impact of AOD dependency across all case types shall be submitted by September 30, 2006.

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

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

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

Associate Justice Helen Meyer (Supreme Court Liaison)

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

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

DATE: March 16, 2005

BY THE COURT:

/S/

Kathleen A. Blatz
Chief Justice

**STATE OF MINNESOTA
IN SUPREME COURT**

ADM-05-8002

**AMENDED ORDER ESTABLISHING THE MINNESOTA SUPREME COURT
CHEMICAL DEPENDENCY TASK FORCE**

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

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

2. Conduct an inventory of current multi-agency, state-level AOD efforts in Minnesota as well as in other states, including:
 - e. Identification of promising practices;
 - f. Identification of gaps and redundancies.
3. Identify and recommend approaches, solutions, and opportunities for collaboration.

NOW, IT IS HEREBY ORDERED that:

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

DATED: December 13, 2005

BY THE COURT:

/S/ _____
Kathleen A. Blatz

Chief Justice

APPENDIX B

*The Ten Key Components of Drug Courts*²²⁰

DEFINING DRUG COURTS: THE KEY COMPONENTS

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

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

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

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

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

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

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

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

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

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

²²⁰ Drug Court Standards Committee, National Association of Drug Court Professionals, *Defining Drug Courts: The Ten Key Components* (January 1997), <http://www.state.tn.us/finance/rds/tncomp.doc>.

APPENDIX C

Problem -Solving Courts in Minnesota

PROBLEM-SOLVING COURTS IN MINNESOTA

There are currently nineteen drug courts (eleven adult, four juvenile, two DWI, two family) operating in fourteen counties in Minnesota:

- Blue Earth (1 – Adult)
- Chisago (1 – Juvenile)
- Dakota (1 – Juvenile)
- Watonwan (1 – Adult)
- Crow Wing (1 – Adult)
- Cass County (1 – DWI)
- Aitkin (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)

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)
- Dakota (Family)
- Brown, Nicollet, Watonwan (Multi-County)
- Faribault, Martin, Jackson (Multi-County)

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)

APPENDIX D

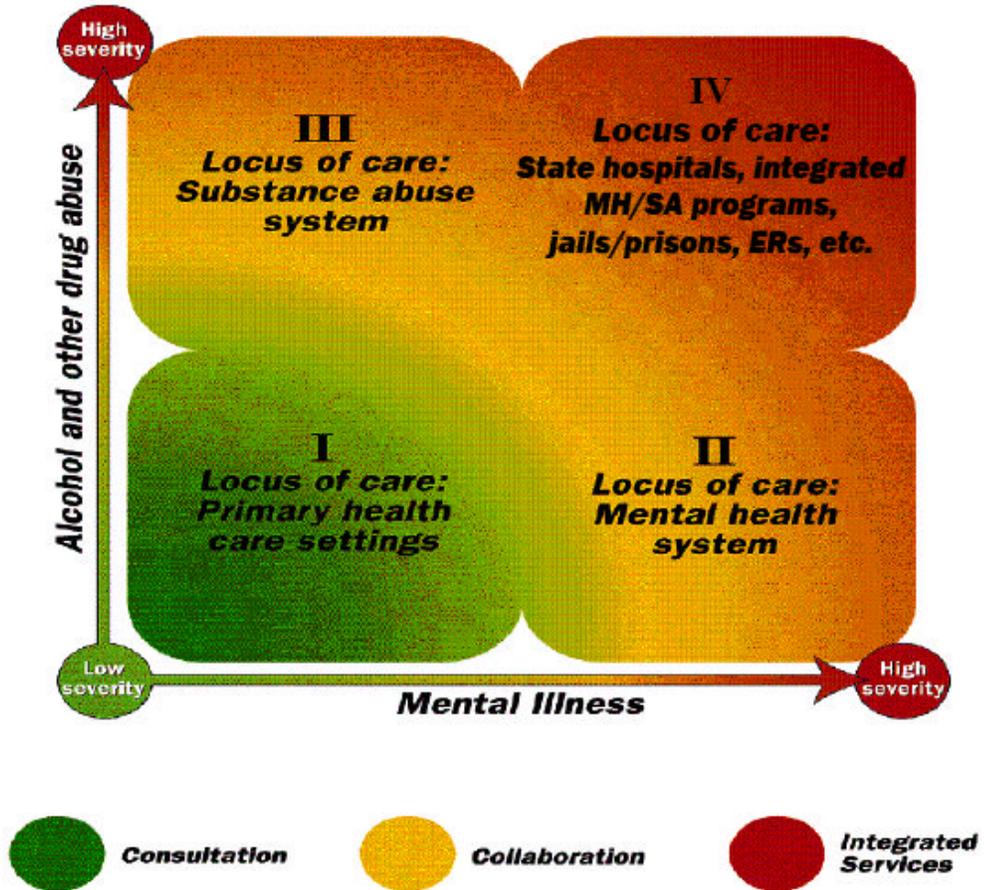
Individuals with certain mental health disorders may be more likely to use certain types of drugs. The following table summarizes the research findings in this area:²²¹

MENTAL DISORDER	TYPE OF MENTAL DISORDERS	SUBSTANCE OF USE
<i>Schizophrenia</i>	Catatonic; Disorganized; Paranoid; Undifferentiated; Residual	Poly-substance use; Alcohol and marijuana most common; rarely abuse opiates and sedative-hypnotics
<i>Delusional Disorder</i>	Erotomantic; Grandiose; Jealous; Persecutory; Somatic	Excessive use is rare
<i>Mood Disorders</i>	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.
<i>Anxiety Disorder</i>	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
<i>Adjustment Disorder</i>	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
<i>Personality Disorders</i>	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

²²¹ Task force presentation, slide 8-9

APPENDIX E

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)

APPENDIX F

Suggested requirements for a trauma-informed system of care²²²

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. The act of 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.

²²² 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 court 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.²²³

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's actually an on-site health clinic), and psychiatric evaluations. This "one-stop-shop" approach reduced 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.²²⁴²²⁵

²²³ Laura D'Angelo, Women and Addiction: Challenges for Drug Court Practitioners, 23 Just. Sys. J. 385, 386 (2002).

²²⁴ For further information see the section of this report on the child protection system.

²²⁵ *Id.* 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
- 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/narrative requirements to women 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 as a door-in to accessing services and creating a relationship for the woman.
- Chemical dependency treatment has always got to get looked at, of course, but sometimes we need to add sober housing to the treatment.

APPENDIX I

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.²²⁶

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):²²⁷

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.

²²⁶ Marlowe, *Integrating Substance Abuse Treatment and Criminal Justice Supervision*, *supra* note 7, at 8.

²²⁷ *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research Based Guide 2-5* (National Institute on Drug Abuse 2006).

APPENDIX J

RESEARCH REGARDING AOD TREATMENT FOR ADOLESCENTS IN THE JUVENILE JUSTICE SYSTEM

There has been a good amount of research looking at young people in the juvenile justice system and what treatment interventions seem to work best for them. The following are the key elements that researchers have identified as necessary for positive outcomes working with youth offenders.²²⁸

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 programs that include cognitive behavioral approaches that focus on problem-solving, anger control, communications, 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 results in matching the youth to appropriate treatment based on the assessment.
3. Developing an individualized treatment plan based on the youth's needs (not program needs), 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 ????? 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 at all levels of institutions, systems, and community.
8. Developing interagency collaboration that involves the community, creating partnerships between the juvenile justice and treatment communities, and building 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 working to ensure that programs have diverse, certified, and licensed staff.
11. Building evaluation into the program design, conducting ongoing evaluation, measuring outcomes, and disseminating information about what works.
12. Implementing a Management Information System that can be used to share information across programs and systems.

²²⁸ CENTER FOR SUBSTANCE ABUSE TREATMENT, STRATEGIES FOR INTEGRATING SUBSTANCE ABUSE TREATMENT AND THE JUVENILE JUSTICE SYSTEM: A PRACTICE GUIDE 6, 14 (U.S. Dept. Health Human Services 1999).

13. Using resources effectively, including conducting cost-benefit analyses of treatment programs, identifying resources for piloting new programs and institutionalizing proven programs.
14. Incorporating strategic planning at all points of program development and implementation.

DRAFT