

REPRESENTATIVE ERIK SIMONSON, 07B
Representative Kathy Lohmer, 39B
Representative Jim Newberger, 15B
Representative Dan Schoen, 54A
Representative John Ward, 10A



88TH LEGISLATIVE SESSION

**THE SELECT COMMITTEE ON
CONTROLLED SUBSTANCES
& SYNTHETIC DRUGS**

REPORT & RECOMMENDATIONS

ADOPTED ON
JANUARY 29, 2014

CHAIR: REPRESENTATIVE ERIK SIMONSON

**MEMBERS: REPRESENTATIVES KATHY LOHMER, JIM NEWBERGER,
DAN SCHOEN, AND JOHN WARD**

EXECUTIVE SUMMARY

In recent years, synthetic drugs have emerged as a new threat to Minnesota's drug abuse prevention efforts. Both synthetic cathinones (a.k.a. Bath Salts) and synthetic cannabinoids (a.k.a. Synthetic "Marijuana") have grown increasingly popular in many communities across our state, having a serious and often devastating impact on not only individual users and their families, but the economic prosperity of particular areas as well.

The Minnesota Legislature recently enacted strong legislation to address this issue. In 2011, Rep. John Kriesel authored a bill that created penalties for the sale and possession of synthetic cannabinoids, as well as adding several other prominent synthetic drugs to Schedule I of the controlled substance schedules, to include bath salts, plant food, 2C-E and 2C-1. Rep. Kriesel's bill also made the drug schedules more flexible so that the law did not need to be changed each time a new synthetic drug was detected. For the first time, a definition of analog was added to statute to extend the controlled substances offenses to their respective analogs.

In 2012, Rep. Bob Barrett authored an act that changed the offense level for the sale of synthetic cannabinoids from a gross misdemeanor to a felony. Rep. Barrett's bill also added many of the recently detected synthetic substances to Schedule I of the controlled substance schedules. The bill also granted the Minnesota Board of Pharmacy expedited rule making authority to allow additions of newly identified substances, with subsequent approval by the Legislature. It was believed this would minimize delays, as new compounds were identified.

As you will read later in this report, despite the Legislature's good intentions, manufacturers and distributors of harmful synthetic drugs continued to skirt the law, finding loopholes and preying on delays in our legal system. Sales of these drugs continued, sometimes in blatantly obvious defiance of the law. While we believe in and support wholly our current analog laws, this Committee believes more can be done to protect Minnesotans from both the direct and indirect effects of synthetic drug sales and use.

As we travelled across the state and received incredibly compelling testimony from law enforcement, health care professionals, victims, family members, community members and so many others, it became evident that our approach needed to be multi-faceted. In addition to the criminal side of our recommendations, there also needed to be significant emphasis on a strong educational campaign designed to target at-risk populations, namely middle school through high school children and their families. It is a very common and sad misperception that synthetic "marijuana" is no more harmful than "regular" marijuana. Nothing can be further from the truth. In fact, the Committee early on stopped referring to it as "synthetic marijuana" for the simple reason that it is nothing like marijuana—it is many times more harmful and devastating.

According to the Minnesota Department of Public Safety, synthetic cannabinoids are up to 100 times more powerful than typical marijuana. It is a plant material sprayed with extremely potent psychotropic drugs containing ever changing chemical strains. These products are most often sold in head shops, smoke shops, or over the internet. They are often labeled as incense and marked 'Not for Human Consumption' in a weak attempt to skirt the federal laws. They have a

hallucinogenic effect similar to PCP (angel dust). Long term effects of using these products is still unknown.

Synthetic cathinones (aka bath salts) are certainly not your traditional aromatic bath salts. It is a drug designed to target the central nervous system, with effects similar to those seen with cocaine, methamphetamines and LSD use. They come in a powder or crystal form, and users high on these drugs are often resilient to Tasers and/or pepper spray. Again, the long term effects remain unknown.

The Select Committee on Controlled Substances and Synthetic Drugs has completed its task and has compiled this report for presentation to the House of Representatives during its 2014 regular session. The report consists of the following:

- Driving forces behind a need for further change,
- Review of previous legislative changes in Minnesota,
- Identification of an emerging statewide impact,
- Role of the Minnesota Bureau of Criminal Apprehension Lab,
- Recommended legislative actions,
- Recommended agency actions, and
- A summary of documents collected through various hearings and discussions over the interim.

The Committee stands behind the recommendations in this Report unanimously. We strived to perform our work in a non-partisan fashion, focusing solely on the health, safety and wellbeing of all Minnesotans. We believe the recommendations included here can be embraced by the full Legislature, and look forward to a bill moving forward that can be signed into law.

IMPETUS BEHIND THE INITIATIVE

The City of Duluth has been the epicenter of Minnesota's synthetic drug problem. The reason is due in part to a local retailer who sold an incredible amount of illegal product from a very public retail setting in the heart of downtown Duluth. The Last Place on Earth store was a multi-million dollar operation that resulted in an overburden of local law enforcement and the emergency response system. Local trauma centers were inundated with people who over overdosed on synthetic drugs which often contained unknown chemicals. Area retailers felt the impact to their businesses as people were frankly afraid to be in the area due to the tremendous amount of disruptive traffic generated by this illegal business. Duluth's downtown was under attack. In 2013, the owner of Last Place on Earth was convicted of criminal charges, and the business has closed.

Make no mistake, synthetic drugs are being sold and used within all of our communities. Perhaps not as visible as Duluth's problem was, nonetheless the Committee has learned it is prevalent statewide, especially with teens and young adults. As one college student said, "If you're not doing synthetics, you're in the minority." Something needs to be done to provide law enforcement and prosecutors the tools necessary to stop retail sales of illegal drugs, and to do so as quickly as possible, thereby minimizing the impact to individuals and our communities.

We know our analog laws are some of the best in the country. We also know the federal laws are sound. We wanted to take further steps to ensure that:

- As many tools as possible are available to law enforcement,
- Additional resources are made available to prosecutors to ensure successful prosecutions, and
- Education is provided to our children and to their families regarding the extreme risk associated with synthetic drugs.

Something needs to be done. The Committee recommends a continued and aggressive approach to the analog laws in addition to a comprehensive approach that includes an aggressive education and prevention effort. We hope these recommendations make significant headway in reducing the sale and use of synthetic drugs in Minnesota.

PROCESS

Speaker Paul Thissen announced the formation of the Select Committee on Controlled Substances and Synthetic Drugs on May 29, 2013, appointing Representative Erik Simonson as Chair, with Representatives Kathy Lohmer, Jim Newberger, Dan Schoen and John Ward serving as members. The Committee was directed to hold interim hearings to examine drug abuse issues and recommend legislation to combat the spread of the sale of synthetic drugs across Minnesota. The Committee was charged with issuing a report with its recommendations by February 25, 2014.

Shortly after formation, the Committee began its work both convening hearings and attending meetings held by others. These included the following:

- Duluth public hearing convened by Attorney General Lori Swanson on June 7, 2013, to hear hours of testimony, primarily centered around the Last Place on Earth,
- Saint Paul hearing on July 9, 2013, to learn some of the chemistry and history behind the issue,
- Brainerd hearing on August 22, 2013, to hear about the impact on individuals and communities, especially the spread to other areas after the closing of Last Place on Earth,
- Virginia Community Forum at the Range Rehab Auditorium on September 25, 2013, attended by Representative Kathy Lohmer,
- Joint hearing with the Health and Human Services Policy Committee and the Public Safety Finance and Policy Committee on October 9, 2013, and
- Bureau of Criminal Apprehension Laboratory tour on October 9, 2013, to observe and learn about the process involved in testing synthetic drugs.

At these hearings, the Committee received testimony from medical professionals, scientists, law enforcement, treatment providers, users, family members, and community members about the impact of synthetic drugs on themselves personally and professionally as well as the impact on the community. Scientists explained the complex chemistry and history behind synthetic drugs.

Following this information gathering, the Chair met with Commissioners and Assistant Commissioners from the Departments of Health, Public Safety, and Human Services about an interdisciplinary approach with a public education campaign as a key component. The Chair then met with Attorney General Lori Swanson regarding potential legal avenues and legislation. After gathering information and consulting experts and stakeholders, this Report was drafted to be presented to members of the Committee at its final hearing on January 29, 2014.

PREVIOUS SYNTHETIC DRUG LEGISLATION

In recent years, the Minnesota Legislature enacted laws to combat the sale and possession of synthetic drugs. In 2011, the Legislature added synthetic cannabinoids and synthetic cathinones (“bath salts”) to schedule I of the controlled substance schedules. Schedule I drugs are defined as those drugs that have a high potential for abuse and have no currently accepted medical use. The Legislature took a two-pronged approach to address synthetic cannabinoids and synthetic cathinones separately. A person who sells synthetic cathinones is subject to a 15-year felony. A person who possesses synthetic cathinones is subject to a 5-year felony. The Legislature established separate penalties for synthetic cannabinoids, which the Legislature subsequently amended in 2012. Under the law as enacted in 2011, a person who sold synthetic cannabinoids was subject to a gross misdemeanor and a person who possessed synthetic cannabinoids faced a misdemeanor penalty. The Legislature also adopted an analog statute in 2011. Under the analog law, substances that are substantially similar to schedule I and II drugs are treated as the equivalent for drug crimes. The analog law is based on federal law.

In 2012, the Legislature passed additional legislation targeting synthetic drugs. The legislation increased the penalty for the sale of synthetic cannabinoids to a five-year felony. The law also synced the controlled substance schedules maintained in statute with the controlled substance schedules maintained by the Board of Pharmacy. The Board’s schedules had steadily expanded over the years without the Legislature keeping the statutory schedules up to date. Many of the substances on the Board’s schedules that were missing from the statutory schedules were synthetic drugs. Discrepancies between the two sets of schedules led to confusion among law enforcement and other criminal justice practitioners. Finally, the Legislature granted the Board of Pharmacy emergency rule-making authority to schedule newly discovered street drugs expeditiously.

STATEWIDE IMPACT

As stated above, the Committee held hearings and attended meetings convened by others. At these gatherings, the Committee heard testimony from people from all over the state who had a wide range of experience with synthetic drugs. Professionals in the medical and law enforcement fields testified as well as those who encountered synthetic drugs in their personal lives through their own use, the use of a friend or family member, or as a member of a community with significant synthetic-drug-related activity. The Committee learned about users, some of them first-time users, permanently disabled both physically (*e.g.*, gouging out their own eyeball) and psychologically (*e.g.*, civilly committed). Small business owners testified about losing employees due to safety concerns (*e.g.*, being intimidated by the large gatherings outside head shops selling synthetic drugs). Elected officials testified regarding the decline in visitors and the overall condition of their communities (*e.g.*, avoiding stepping on pink vomit). What is

difficult to convey in a written report is the emotion evident as people told of their experiences—what they saw, what they felt, and how their lives had been changed. With every hearing, it became more and more clear that the impact of synthetic drugs is widespread and deeply felt.

MINNESOTA BUREAU OF CRIMINAL APPREHENSION LAB

The Committee received testimony from the Bureau of Criminal Apprehension (BCA) on July 9, 2013. Violet Stephens, a forensic scientist with the BCA, walked through the origins of synthetic drugs and how they continue to be modified to skirt federal and state laws. The BCA also presented slides showing a significant decrease in the frequency of cases involving the synthetic drug compounds included in recent synthetic drug legislation. However, the BCA Scientists indicated that when certain specific compounds were banned, they would then see an increase in other synthetic drug compounds that had not (yet) been banned.

On October 9, 2013, the Committee toured the BCA to learn more about the successes and challenges presented by the influx of synthetic drugs in Minnesota. The Select Committee toured the BCA Lab where samples are tested and saw a small selection of the hundreds of samples that the Lab has had to purchase over the past couple of years to use for comparison. The scientists noted that limited resources are a barrier to this work because when they receive synthetic drug evidence, they typically do not have a sample in Lab to compare it to because manufacturers are constantly altering the formulas to skirt laws. Scientists use what they have to try and narrow the scope of what the drug compound might be and then rely on their international network to see if any other labs have come across the same compound. Once BCA Scientists find a potential match, the BCA Lab then has to purchase a sample compound to run against the submitted compound. This process is both time-intensive and expensive. In addition to the cost of acquiring samples and the amount of staff time needed to figure out these ever changing compounds, the BCA Scientists must spend time trying to figure out if the identified drug was banned by state legislation at the time it was seized. These responsibilities are in addition to the other evidence processing that the BCA completes for criminal cases throughout Minnesota.

RECOMMENDATIONS

The Committee recommends that the State of Minnesota take a comprehensive approach to further combating synthetic drugs. The Committee recommends the following specific initiatives:

A. Legislative initiatives.

1. The Legislature should expand the definition of “drug” in statute to include any compound, substance, or derivative which is not approved for human consumption by the United States Food and Drug Administration or specifically permitted by Minnesota law, and when introduced into the body, induces an effect substantially similar to that of a Schedule I or Schedule II controlled substance regardless of whether the substance is marketed for the purpose of human consumption.

2. The Legislature should empower the Board of Pharmacy to issue cease and desist orders to businesses that sell synthetic drugs. The Board should have the authority to order a business to cease selling synthetic drugs that, in the Board's opinion, are a banned substance or analog of schedule I or schedule II drugs. An affected business would be entitled to an administrative hearing to challenge the Board's order.
3. The Legislature should remove the sunset on the Board of Pharmacy's emergency drug scheduling authority. In 2012, the Legislature authorized the Board to schedule newly discovered synthetic drugs using emergency rule-making authority. The Board's authority is set to expire on August 1, 2014.
4. The Legislature should strike the statutory requirement that the Board of Pharmacy's emergency drug scheduling decisions must be ratified by the Legislature to make the Board's actions final. As a check on the Board's emergency rule-making authority, the Legislature established a legislative ratification requirement. Removing the ratification process will make the emergency rule-making process less burdensome for the Board. The Legislature would retain the authority to overturn a scheduling decision by the Board of Pharmacy with regard to a specific compound.
5. The Legislature should create and fund a pilot project that trains prosecutors in the best practices of prosecuting synthetic drug cases and funds expert witnesses in synthetic drug investigations and trials. Specifically, the pilot project should train prosecutors in the application of the state's drug analog statute.
6. To assist in the criminal prosecution of synthetic drug cases, the Legislature should appropriate funds to the Bureau of Criminal Apprehension for analyzing and testing synthetic drugs. Anecdotal evidence suggests that some synthetic drug prosecutions are hampered by a shortage of resources at the BCA to analyze and test unconventional drugs.
7. The Legislature should direct the Commissioner of Education, Commissioner of Health, and Commissioner of Human Services to formulate and implement an educational awareness campaign on the dangers of synthetic drug use. The education campaign should be designed to reach a broad audience but contain targeted messages for students and youth.
8. Efforts to reduce and prevent all forms of drug abuse should be reviewed regularly by pertinent Legislative Committees.
9. The Minnesota Legislature and state agencies should work together with Minnesota's federal Congressional delegation and federal agencies to pursue further efforts to control internet sales of illegal drugs.

B. Local initiatives.

1. Local units of government should consider adopting comprehensive drug paraphernalia ordinances similar to Moorhead's ordinance (see Appendix 16). Experts believe that gaps in many drug paraphernalia laws allow headshops to skirt the law on the prohibition of drug paraphernalia which in turn makes it easier for persons to consume illicit drugs. The open sale of drug paraphernalia also creates the perception that illicit drug use is acceptable because the tools needed to use the drugs are available for sale in storefronts.
2. Local county attorneys should use resources across the state when considering charges and/or prosecution strategy in synthetic drug cases.

INDEX OF APPENDICES

1. LIST OF AGENCIES, ORGANIZATIONS, ENTITIES, AND INDIVIDUALS CONSULTED BY THE COMMITTEE
2. JULY 9, 2013 AGENDA
3. HOUSE RESEARCH ACT SUMMARY, CHAPTER 53, 2011 REGULAR SESSION, ANALYST: JEFF DIEBEL
4. HOUSE RESEARCH ACT SUMMARY, CHAPTER 240, 2012 REGULAR SESSION, ANALYST: JEFF DIEBEL
5. DESIGNER DRUG TRENDS, VIOLET STEPHENS, FORENSIC SCIENTIST, BUREAU OF CRIMINAL APPREHENSION, MINNESOTA DEPARTMENT OF PUBLIC SAFETY
6. SYNTHETIC DRUG CRIME ENFORCEMENT IN MINNESOTA, BRIAN MARQUART, STATEWIDE GANG AND DRUG COORDINATOR, OFFICE OF JUSTICE PROGRAMS, MINNESOTA DEPARTMENT OF PUBLIC SAFETY
7. WRITTEN TESTIMONY, KARIN L. SONNEMAN, WINONA COUNTY ATTORNEY, AND CHRISTINA DAVENPORT, ASSISTANT WINONA COUNTY ATTORNEY
8. WRITTEN TESTIMONY, MARK S. RUBIN, SAINT LOUIS COUNTY ATTORNEY
9. AUGUST 22, 2013 AGENDA
10. SYNTHETICS: THE BATTLE FOR DULUTH, NATHAN N. LACOURSIERE, ASSISTANT CITY ATTORNEY, CITY OF DULUTH
11. OCTOBER 9, 2013 AGENDA
12. STATEWIDE SUBSTANCE ABUSE STRATEGY, RECOMMENDATIONS TO THE SELECT COMMITTEE ON CONTROLLED SUBSTANCES & SYNTHETIC DRUGS, OCTOBER 9, 2013, DAVE HARTFORD, ASSISTANT COMMISSIONER, CHEMICAL & MENTAL HEALTH SERVICES
13. DRUG ABUSE TRENDS IN MINNEAPOLIS/ST. PAUL, MINNESOTA: JUNE 2013, CAROL FALKOWSKI, DRUG ABUSE DIALOGUES
14. MINNESOTA STATE SUBSTANCE ABUSE STRATEGY
15. MINNESOTA VIOLENT CRIME COORDINATING COUNCIL, KEY ELEMENTS OF A STATEWIDE STRATEGIC FRAMEWORK, C/O MINNESOTA DEPARTMENT OF PUBLIC SAFETY, OFFICE OF JUSTICE PROGRAMS, ADOPTED JUNE 13, 2012
16. CITY OF MOORHEAD DRUG PARAPHERNALIA ORDINANCE

AGENCIES, ORGANIZATIONS, ENTITIES, AND INDIVIDUALS CONSULTED BY THE COMMITTEE

Office of Minnesota Attorney General Lori Swanson

Department of Public Safety

Mark A. Dunaski, Assistant Commissioner

Wade Setter, Superintendent, Bureau of Criminal Apprehension

Drew Evans, Assistant Superintendent, Bureau of Criminal Apprehension

Violet Stephens, Forensic Scientist, Bureau of Criminal Apprehension Laboratory

Brian Marquardt, Statewide Coordinator, Law Enforcement Task Forces, Office of Justice Programs

Department of Human Services

Lucinda Jesson, Commissioner

Dave Hartford, Assistant Commissioner, Chemical & Mental Health Services

Department of Health

Edward P. Ehlinger, M.D., MS.P.H., Commissioner

Jon Roesler, M.S., Epidemiologist Supervisor, Center for Health Promotion

Board of Pharmacy

Cody Wiberg, Pharm.D., M.S., R.Ph., Executive Director

Minnesota State Substance Abuse Strategy Working Group

Dave Hartford, Assistant Commissioner, Chemical & Mental Health Services, Department of Human Services

Mayor Mary Hess, City of Aurora

Winona County Attorney Karin Sonneman

Christina Davenport, Assistant County Attorney

Crow Wing County Attorney Don Ryan

David Hermerding, Assistant County Attorney

St. Louis County Attorney Mark S. Rubin

Jon Holets, Assistant County Attorney

Duluth City Attorney's Office

Nathan N. LaCoursiere, Assistant City Attorney

Baxter Police Department

Jim Ersted, Chief

Brainerd Police Department

Corky McQuiston, Chief

Duluth Police Department
Lt. Steve Stracek

Moorhead Police Department
Lt. Brad Penas

MN Adult and Teen Challenge
Sam Anderson, Center Director, Central Minnesota
Adam Pederson, Prevention Specialist, Minneapolis
Caleb Burch
Eddie Loyd
Charles Boehodie
Jake McSpadden

Carol Falkowski, Drug Abuse Dialogues, Saint Paul

Kristin Engebretsen, Pharm.D., DABAT, FAACT, Clinical Toxicologist, Regions Hospital,
Emergency Medicine Department

Marc Conterato, M.S., North Memorial Medical Center

Randall Seifert, Pharm. D, Associate Dean, University of Minnesota, Duluth, Pharmacology
Program

Megan Gistodeau, NPMH, LADC

Loren Beilke, USA Mobile Drug Testing

Lynn Habegger

Peggy Kates

Cindy Moore, The Shop

Select Committee on Controlled Substances and Synthetic Drugs

Chair: Rep. Erik Simonson

July 9, 2013

10:30 a.m.

5 State Office Building

AGENDA

- I. Call to Order
- II. Jeff Diebel, House Research Analyst
- III. Cody Wiberg, Minnesota Board of Pharmacy
- IV. Violet Stephens, Forensic Scientist, Bureau of Criminal Apprehension Laboratory,
Minnesota Department of Public Safety

Break for lunch

- V. Brian Marquart, Statewide Coordinator, Law Enforcement Task Forces
- VI. Karin Sonneman, Winona County Attorney
Christina Davenport, Assistant Winona County Attorney
- VII. Jon Holets, Assistant St. Louis County Attorney
- VIII. Public Testimony
- IX. Discussion regarding committee plans
- X. Adjournment

House Research Act Summary

CHAPTER: 53

SESSION: 2011 Regular Session

TOPIC: Controlled Substances

Analyst: Jeff Diebel

Date: July 8, 2013

This publication can be made available in alternative formats upon request. Please call 651-296-6753 (voice); or the Minnesota State Relay Service at 1-800-627-3529 (TTY) for assistance. Summaries are also available on our website at: www.house.mn/hrd/.

Overview

This act contains a variety of policy changes related to controlled substances including creating criminal penalties for the sale and possession of synthetic marijuana and other synthetic substances. This act also amends first- through third-degree controlled substance *possession* offenses and the offense of possession of a small amount of marijuana so that law enforcement/prosecutors may not charge an offense based on the weight of water used in a bong or water pipe.

Section

- 1** **Mixture.** Amends the definition of “mixture” in the controlled substances chapter of law (Minn. Stat. ch. 152) to reflect the changes made below in sections 2, 6, 7, and 8. Under current law, prosecutors may make charging decisions based on the entire weight of a mixture that contains a controlled substance even if the drug is only a small fraction of the mixture. Sections 2, 6, 7, and 8 would change this policy as it relates to first- through third-degree controlled substance *possession* offenses and the offense of possession of a small amount of marijuana. (Of note, these sections (sections 1, 2, 6, 7, and 8) have immediate effective dates.)
- 2** **Small amount.** Amends the definition of “small amount,” which relates to the offense of possession of a small amount of marijuana so that the weight of bong water may not be used to determine what constitutes a “small amount” when the bong water measures less than four fluid ounces.
- 3** **Analog.** Adds a definition of “analog” to the controlled substances chapter of law. The definition is patterned after Federal law.

Section

- 4** **Schedule I.** Adds the substances known as 2C-E and 2C-I, plant food, bath salts, and synthetic cannabinoids to the list of Schedule I drugs in the controlled substances chapter of law. Provides that an analog of a Schedule I or II controlled substance is considered a Schedule I controlled substance.
- 5** **Modifying the controlled substance schedules.** Eliminates the Board of Pharmacy's obligation to undertake an annual review of the controlled substance schedules. Prohibits the board from deleting or rescheduling a drug that is in Schedule I except as otherwise provided in law.
- 6** **1st Degree Possession.** Amends the offense of first-degree controlled substance possession so that the weight of bong water may not be used to determine the level of offense in cases where a person is accused of possessing a "mixture" that contains less than four fluid ounces of bong water.
- 7** **2nd Degree Possession.** Amends the offense of second-degree controlled substance possession so that the weight of bong water may not be used to determine the level of offense in cases where a person is accused of possessing a "mixture" that contains less than four fluid ounces of bong water.
- 8** **3rd Degree Possession.** Amends the offense of third-degree controlled substance possession so that the weight of bong water may not be used to determine the level of offense in cases where a person is accused of possessing a "mixture" that contains less than four fluid ounces of bong water.
- 9** **Sale or possession of synthetic cannabinoids.** Provides that anyone who unlawfully sells any amount of a synthetic cannabinoid is guilty of a gross misdemeanor and that anyone who unlawfully possesses any amount of a synthetic cannabinoid is guilty of a misdemeanor. Defines "synthetic cannabinoid." Clarifies that the penalties provided in the first- to fifth-degree controlled substances crimes do not apply for these substances.

House Research Act Summary

CHAPTER: 240

SESSION: 2012 Regular Session

TOPIC: Controlled Substances

Date: May 23, 2012

Analyst: Jeff Diebel

This publication can be made available in alternative formats upon request. Please call 651-296-6753 (voice); or the Minnesota State Relay Service at 1-800-627-3529 (TTY) for assistance. Summaries are also available on our website at: www.house.mn/hrd.

Overview

This bill updates the statutory controlled substance schedules so that they match the controlled substance schedules maintained by the Board of Pharmacy in rules. The bill grants the board expedited drug scheduling authority. The bill also modifies the definition of synthetic cannabinoids and enhances the penalties for selling such substances.

- 1** **Controlled substance schedules.** Amends the statutory controlled substance schedules to bring them up-to-date with the controlled substance schedules maintained by the Board of Pharmacy in rules. Modifies the definition of synthetic cannabinoids and adds recently detected synthetic stimulants and hallucinogens to Schedule I. The amendments contained in this section are also intended to increase the flexibility of the schedules for use by prosecutors.

Authorizes the Board of Pharmacy to use the expedited rule-making process to add a substance to schedule I. Eliminates the board's obligation to complete an annual study of implementation of chapter 152 in relation to drug abuse in Minnesota. Strikes obsolete language.
- 2** **Sale or possession of synthetic cannabinoids.** Bifurcates the current gross misdemeanor penalty for selling synthetic cannabinoids into a gross misdemeanor and a felony. A person who "sells" a synthetic cannabinoid for no remuneration is guilty of a gross misdemeanor. All other sales of a synthetic cannabinoid carry a five-year felony penalty.
- 3** **Deferring prosecution for certain first time drug offenders.** Authorizes judges to defer prosecution for certain offenders charged with misdemeanor possession of synthetic cannabinoids.

DESIGNER DRUG TRENDS



Violet Stephens

Forensic Scientist 3/Technical Leader

Drug Chemistry

violet.stephens@state.mn.us



Synthetic Cannabinoids

Commonly sold as “Spice” or “K2”



Synthetic Cannabinoids

- ▣ Herbal plant material onto which the active compounds have been sprayed



- ▣ Also occurs in powder form

Synthetic Cannabinoids

- ▣ What is in these products?
 - Abusers do not know.....
 - Distributors and sellers do not know...
- ▣ High variability between products, even the same label:
 - Constituents and components change within product label and batch to batch
 - Different effects may be experienced from products with the same label due to different drugs.

Hundred's of Herbal Incense Products



History of SynCanns

- ▣ John W. Huffman (JWH)
 - Professor at Clemson University
 - Developed cannabinoid compounds to aid in medical research
 - Headed research team which further characterized receptors through comparing “potency” of various synthesized compounds to THC and other known syncanns.
 - Individual compounds sequentially numbered named with his initials (JWH)

History of SynCanns

- ▣ AM- Alexandros Makriyannis
- ▣ CP- Pzifer
- ▣ HU- Hebrew University
- ▣ BAY- Bayer

Timeline

1967- Synthesis of synthetic THC

1960s

1964 – Isolation of THC from Cannabis

1970s

1980s

Pfizer starts developing CP cannabinoids for analgesic effects

1988- HU-210 investigated at Hebrew University

1988- Isolation of CB1 Receptor

1990s

1993- CB1 Receptor discovered

1995- John W. Huffman research

2000s

2008- U.S. encounters Spice products at POE

2004- K2 sold on the Internet

2009- Military bans spice

2009- European countries begin controlling

2010s

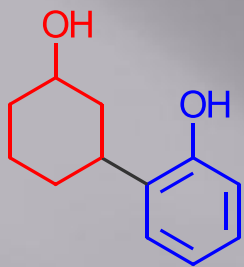
2011- Temporarily Scheduled

2010- States pass legislation

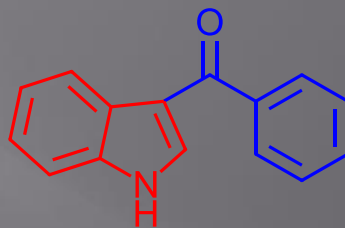
Affinity Constant (K_i) for CB1 Receptor

- ▣ High affinity is defined as $K_i < 100$ nM
- ▣ Low affinity is defined as $K_i > 100$ nM

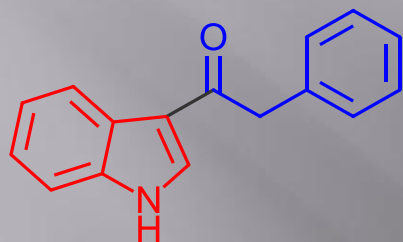
Substance	K_i (nM)
Δ^8 THC	16.5
Δ^9 THC	10.2
JWH-018	2.9 (3.5X)
HU-210	0.06 (170X)
AM-2201	1.0 (10X)



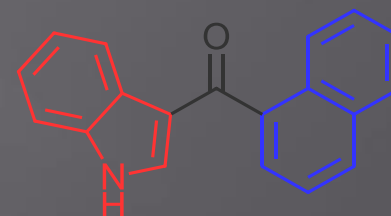
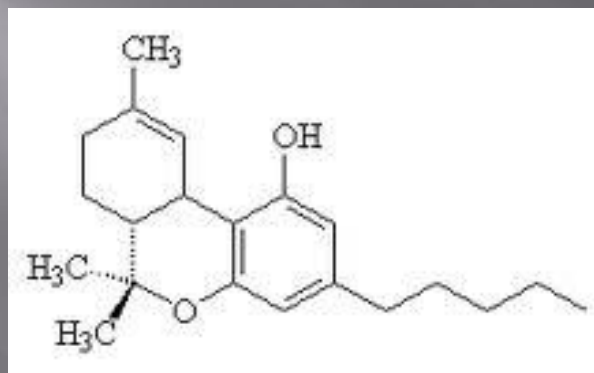
Cyclohexylphenol



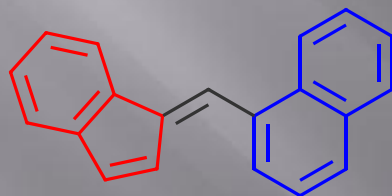
Benzoylindoles



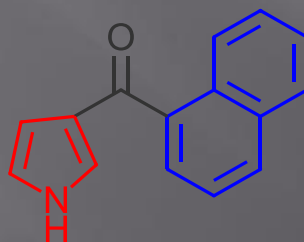
Phenylacetylindoles



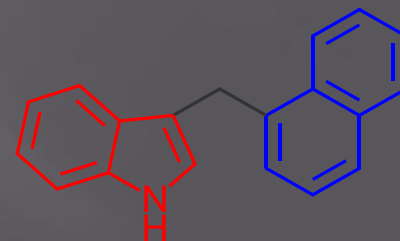
Naphthoylindole



Naphthylmethylenes

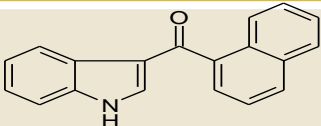
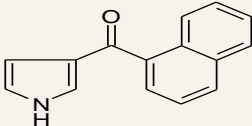
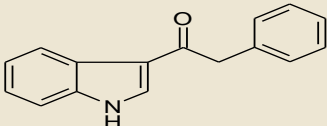
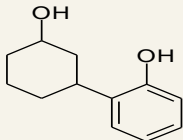
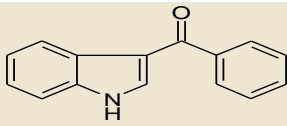
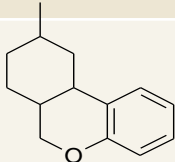


Naphthylpyrroles



Naphthylmethylindeoles

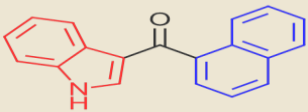
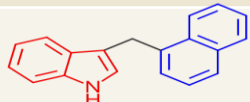
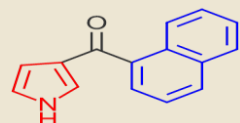
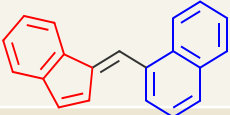
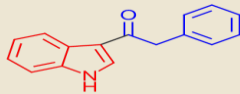
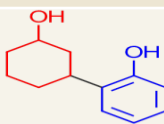
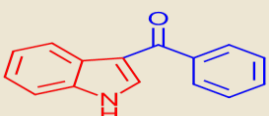
Controlled Cannabinoids in MN-2011

General Class Chemical	Chemical Structure	Compounds currently marketed or identified in case submissions
Naphthoylindoles		JWH-007, JWH-015, JWH-018, JWH-019, JWH-073, JWH-081, JWH-098, JWH-200, JWH-164, JWH-210, JWH-398, WIN 55,212-2
Naphthoylpyrroles		
Phenylacetylindoles		JWH-203, JWH-250
Cyclohexylphenols		CP 47,497
Benzoylindoles		
Tricyclic benzopyrans		HU-201, Tetrahydrocannabinols

Response to 2011 Legislation

- ▣ Clandestine manufacturers quickly adapted and expanded to include numerous compounds
- ▣ Statements by distributors indicated control measures had no effect on their business or their intent to continue
- ▣ AM-2201

Controlled Cannabinoids in MN-2012

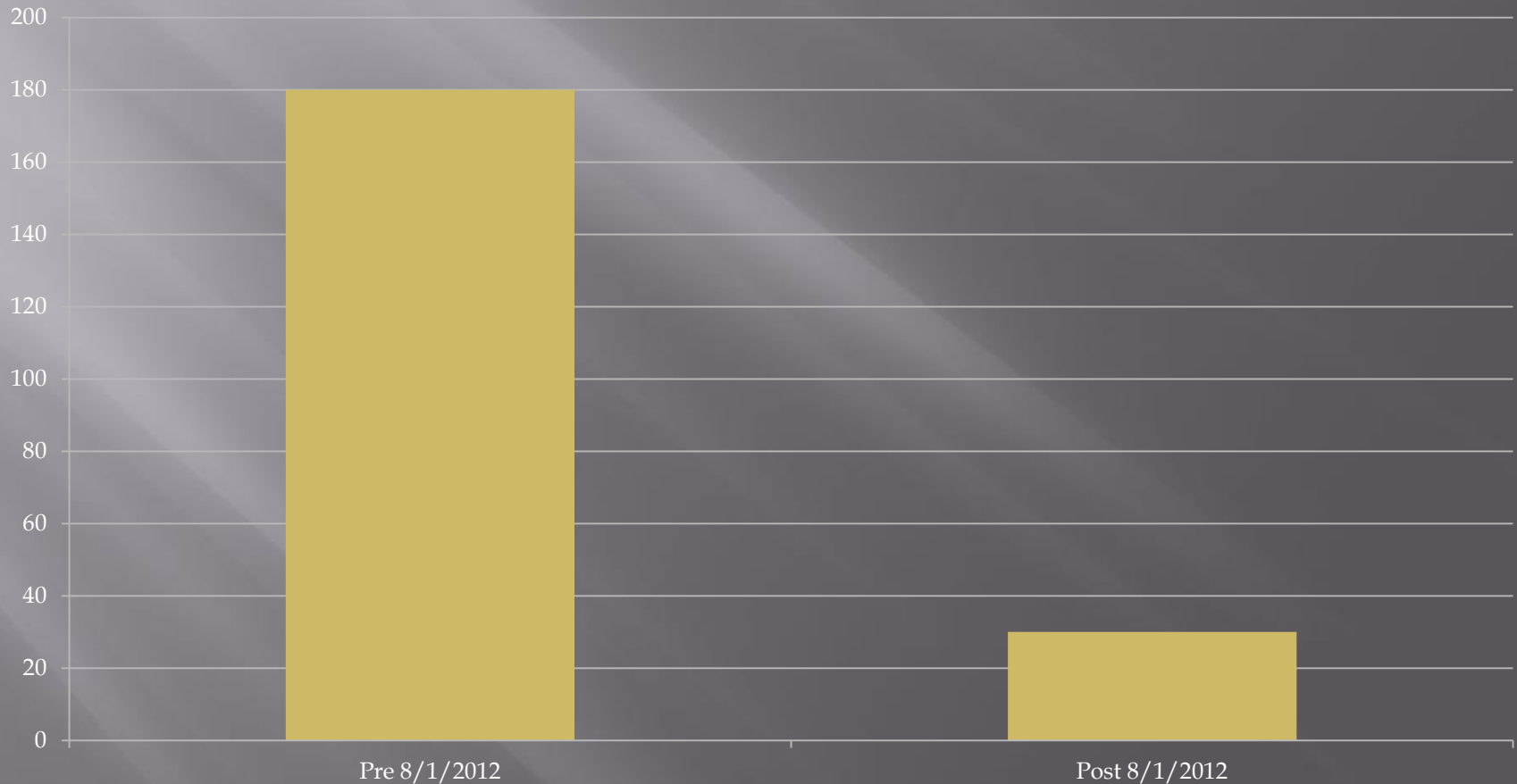
General Class Chemical	Chemical Structure	Compounds currently marketed or identified in case submissions
Naphthoylindoles		Examples include but are not limited to JWH-007, JWH-015, JWH-018, JWH-019, JWH-073, JWH-081, JWH-122, JWH-200, JWH-210, JWH-398, AM-2201, JWH-175, JWH-184, AM-2201, AM-1220
Naphthylmethylindoles		Examples include but are not limited to JWH-175, JWH-184
Naphthoylpyrroles		Examples include but are not limited to JWH-307, JWH-370, JWH-030
Naphthylmethylindenes		Examples include but are not limited to JWH-176
Phenylacetylindoles		Examples include but are not limited to RCS-8, JWH-250, JWH-251, JWH-203
Cyclohexylphenols		Examples include but are not limited to CP 47,497, CP 47,497 C8 homologue, CP 55, 940
Benzoylindoles		Examples include but are not limited to RCS-4, AM-694, WIN 48,098 or Pravadoline

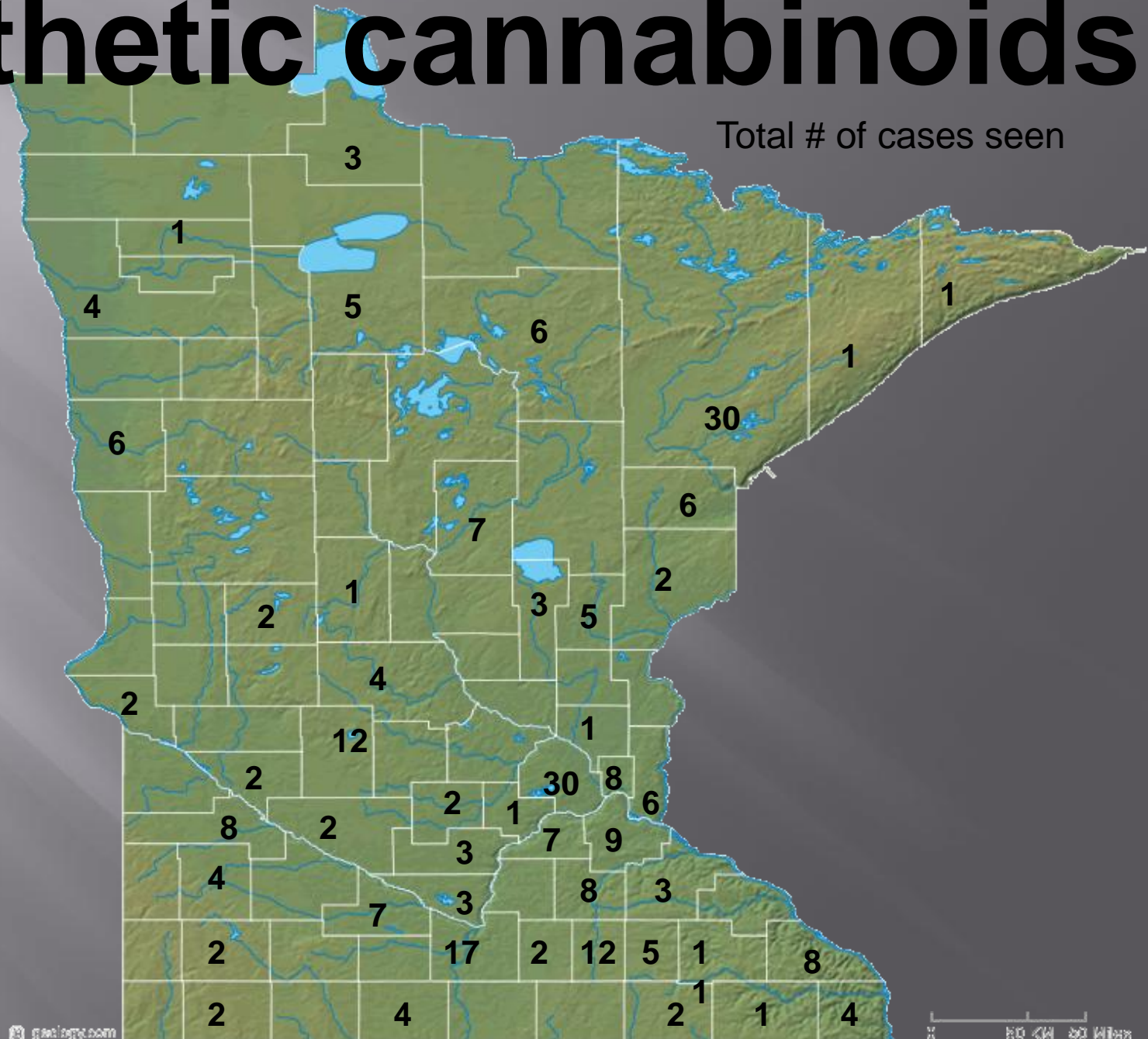
Controlled Cannabinoids in MN-2012

- ▣ Others Specifically Named
 - HU-210
 - HU-211
 - WIN 55,212-2

Controlled Cannabinoids in MN – 8/1/12-Items Analyzed

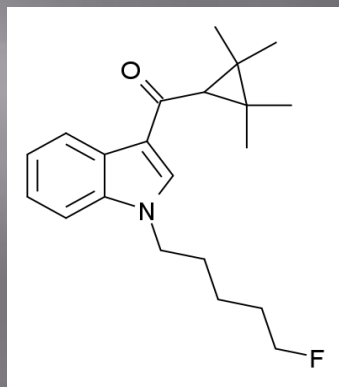
AM-2201



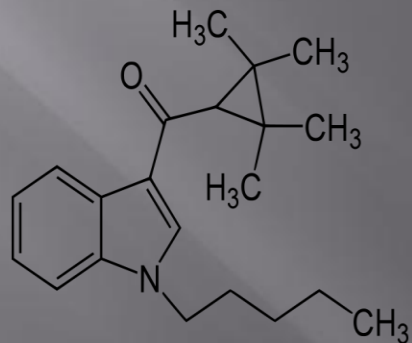
[illegible][illegible]

Clandestine Manufacturers Response to 2012 Legislation

▣ XLR-11

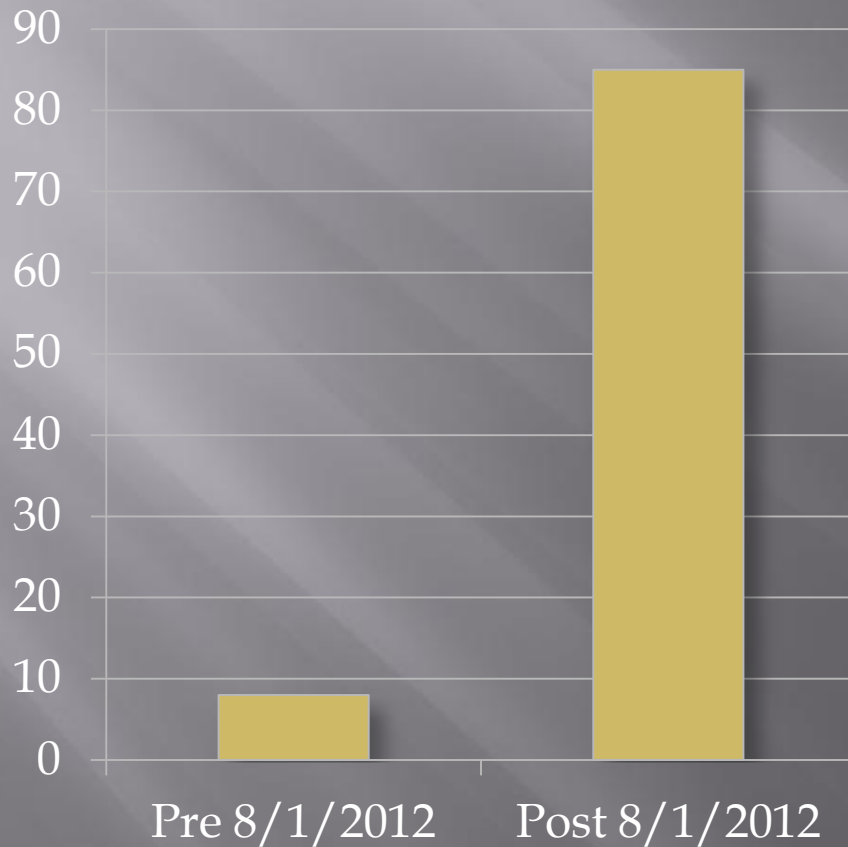


▣ UR-144

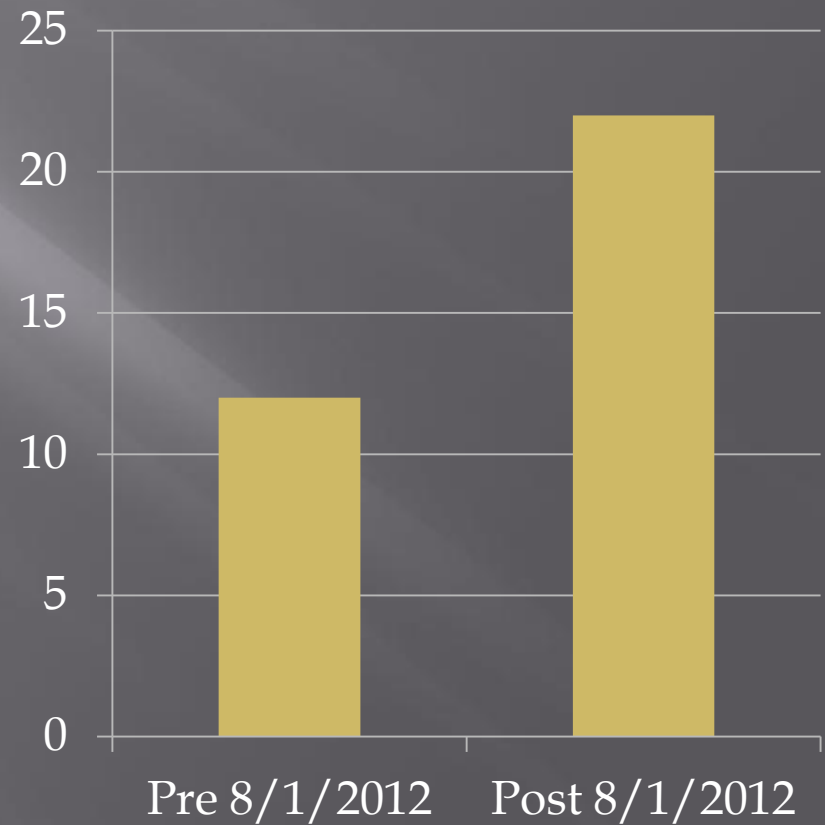


XLR-11 and UR-144-Items Analyzed

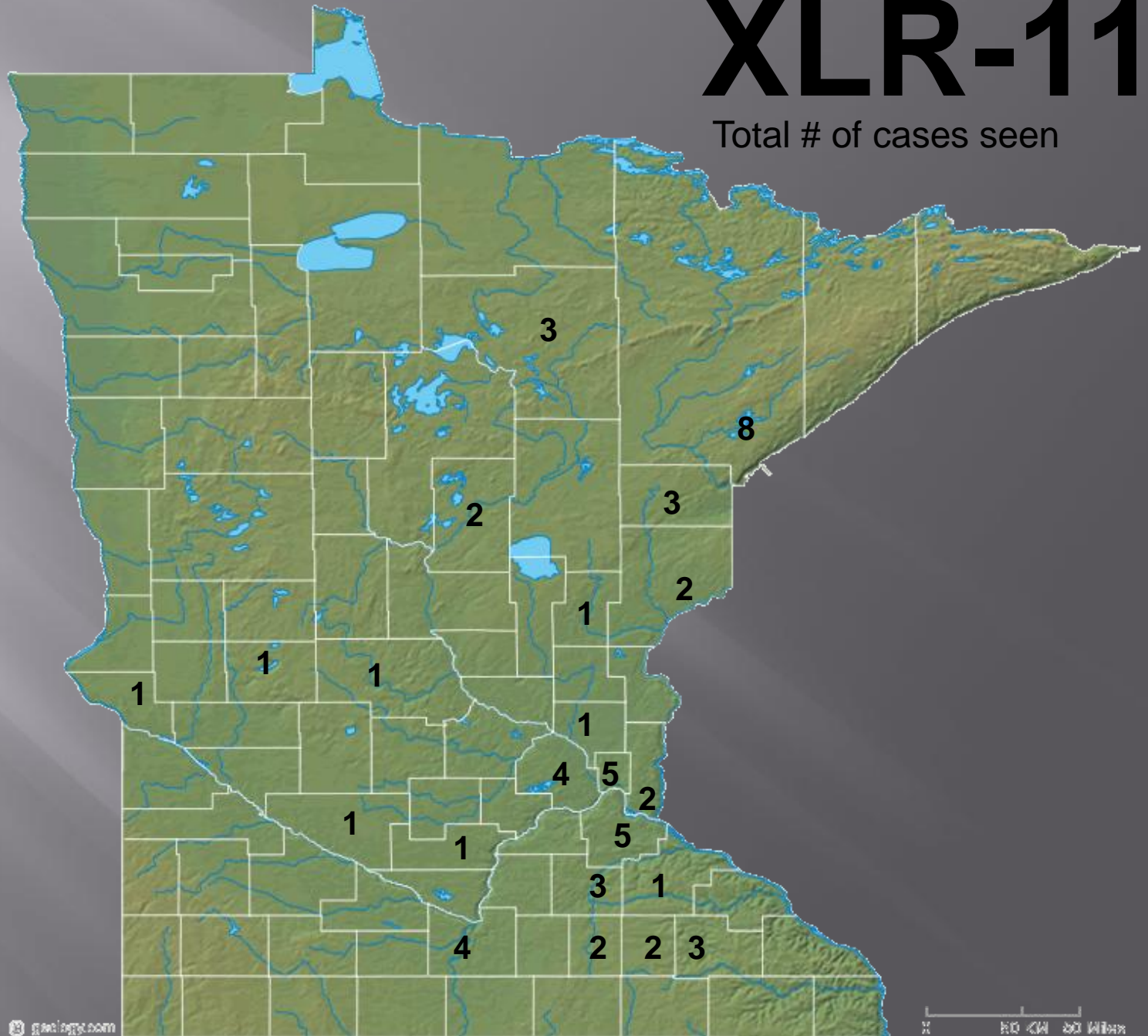
XLR-11

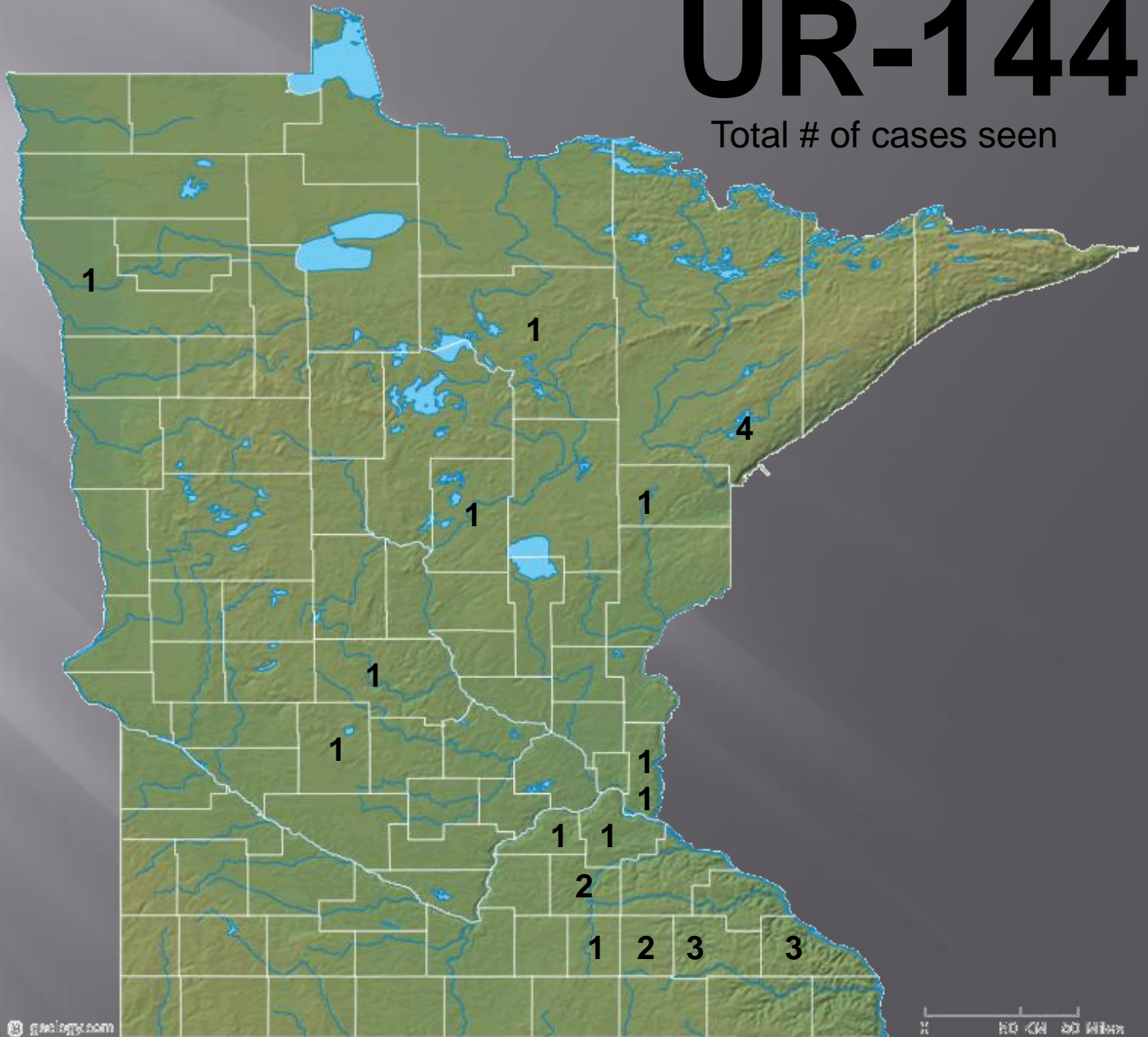


UR-144



Total # of cases seen



[illegible][illegible]

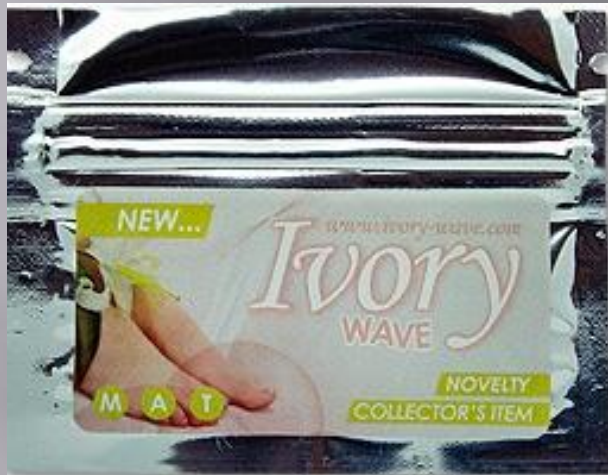
HF1117-3

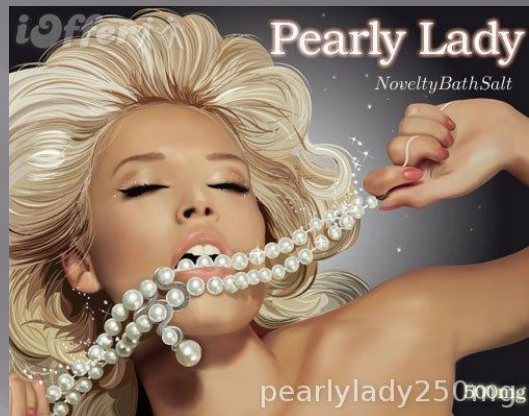
Effective 8-1-2013

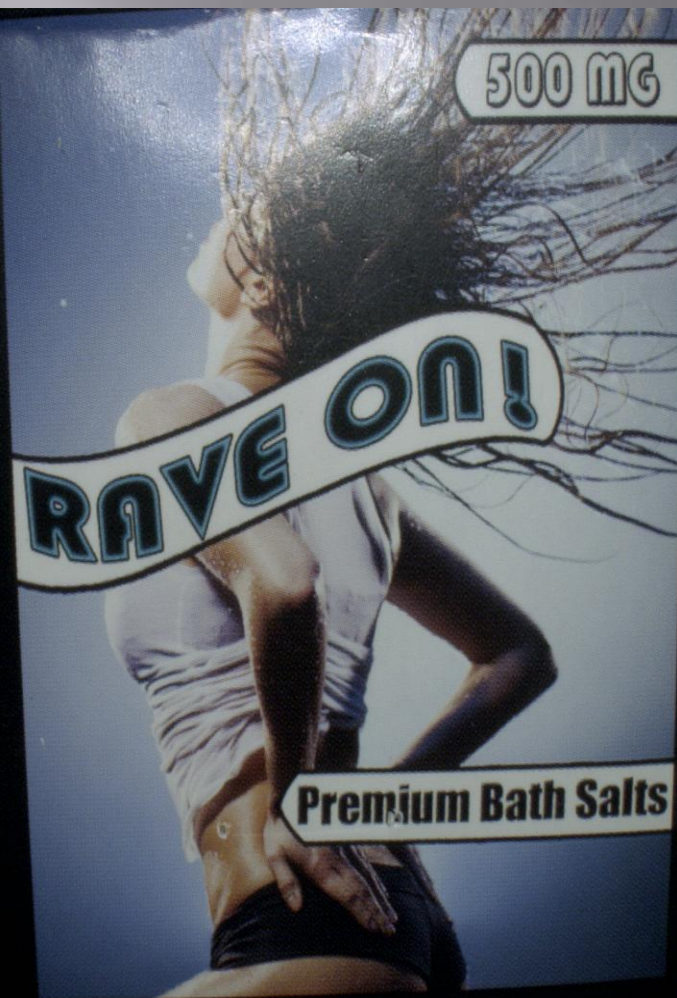
- ▣ **UR-144** and **XLR-11** will be added to the list of Schedule 1 controlled substances.

“Bath Salts”

- ▣ Commonly sold as but is not limited to “Ivory Wave” or “Vanilla Sky”
- ▣ No legitimate bath, beauty or plant food purposes
- ▣ No accepted medical uses







Lens Z00:X5

2011/08/16

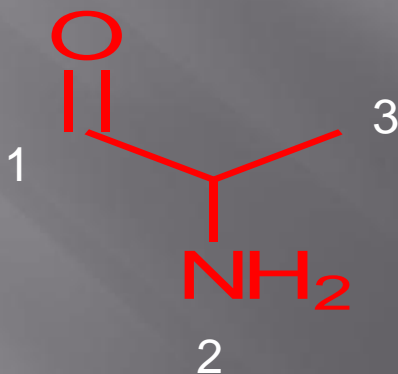
1000.00µm

“Bath Salts”

- ▣ Usually contain Methylmethcathinone (**Mephedrone**), Methylenedioxymethcathinone (**Methylone**), Methylenedioxypyrovalerone (**MDPV**), or one of nearly 30 other substances.
- ▣ These are mood altering stimulants, not unlike cocaine or methamphetamine
- ▣ Currently controlled at the state

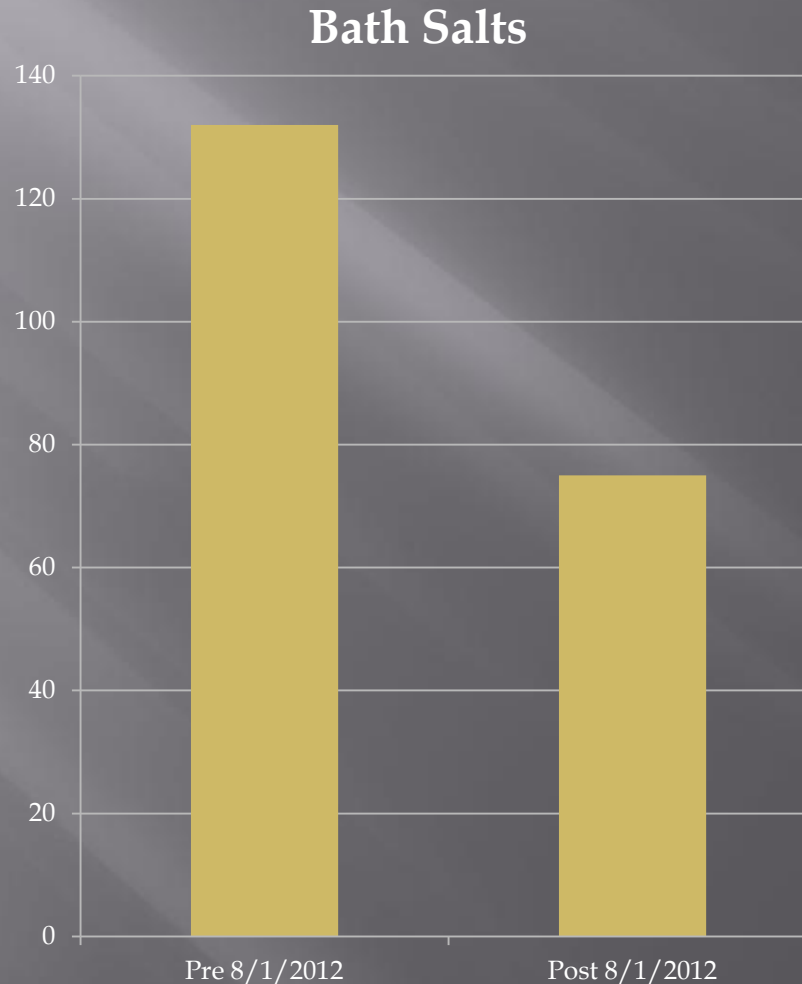
MN Statute 152.02

- ▣Substance, except bupropion, that is structurally derived from 2-aminopropan-1-one with substitution at the 1,2, or 3 position:



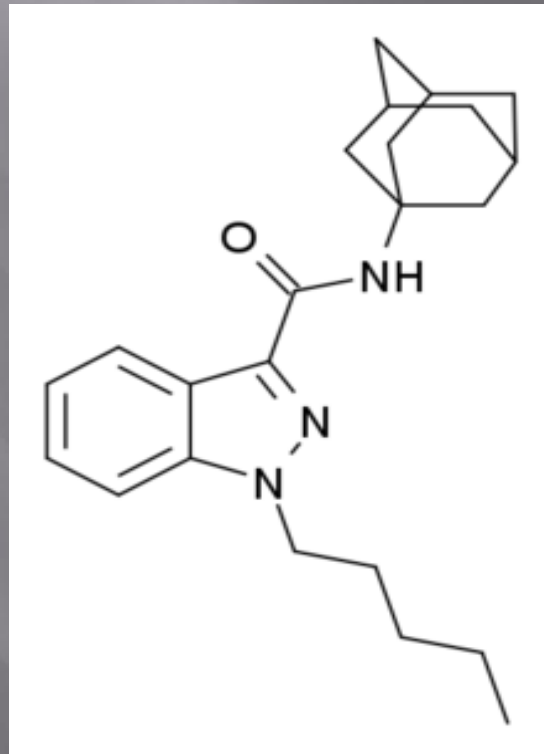
Bath Salts (eg. α -PVP, methytlone, MDPV)

Items Analyzed



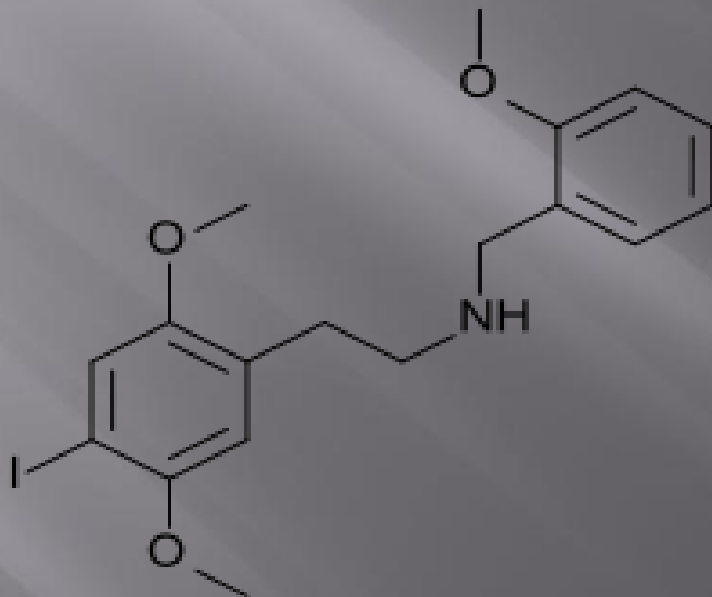
Other Designer Drug Encountered at the BCA Lab

- ▣ AKB-48 (APINACA)



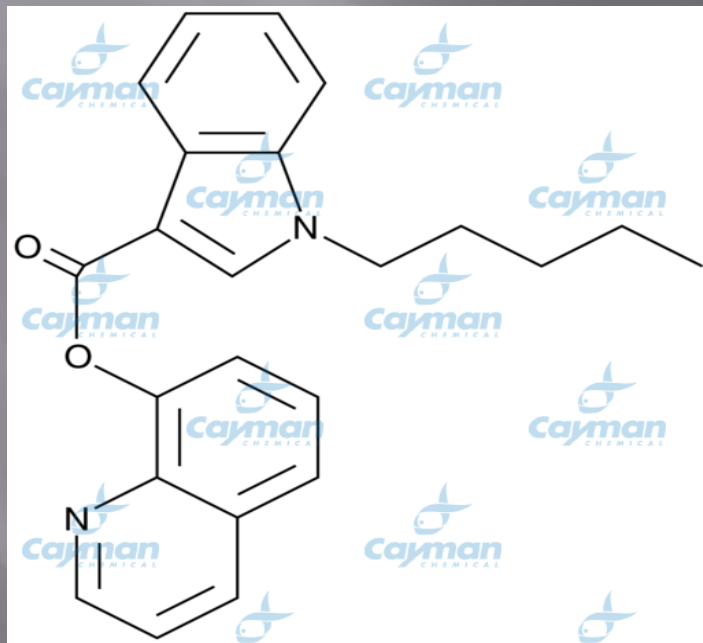
Other Designer Drug Encounters at the BCA Lab

▣ 25I-NBOMe



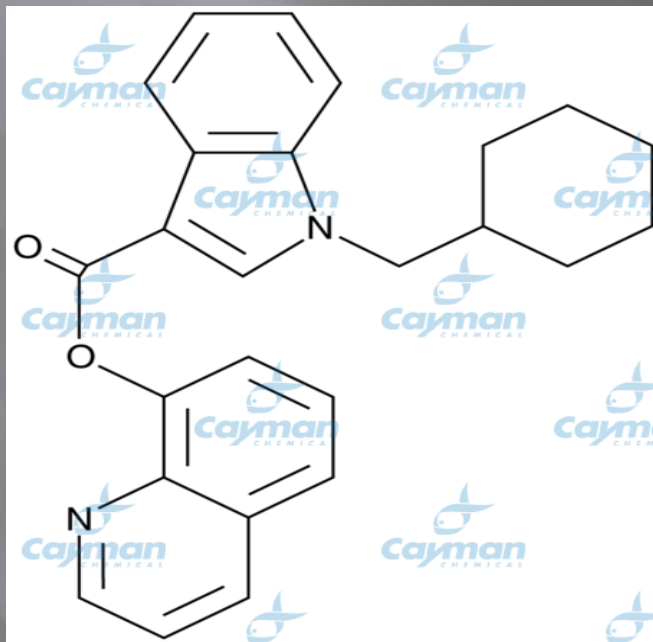
Emerging Trends

▣ PB-22



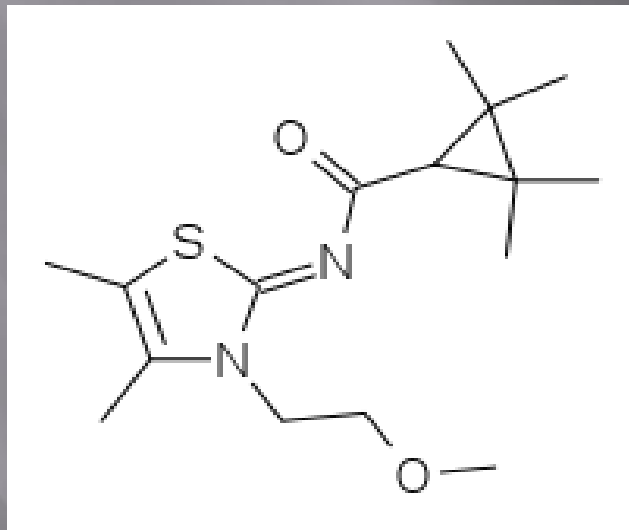
Emerging Trends

BB-22



Emerging Trends

▣ A-836,339



HF1117-3

Effective 8-1-2013

- ▣ The following drugs will be added to the list of Schedule 1 controlled substances:
 - 25I-NBOMe
 - AKB-48(APINACA)
 - 5-Fluoro-AKB-48
 - PB-22
 - 5-Fluoro PB-22

Challenges to the BCA Lab

- ▣ Compounds are not easily identified
- ▣ Difficulty of obtaining standards
- ▣ Cost: 2 – 3X more than routine standards

Example:

5 mg of 25I-NBOMe is \$285

10 mg of Methamphetamine is \$58

References

- ▣ Terrence Boos, Chemist/ Acting Section Chief
 - DEA Office of Diversion Control
- ▣ Jeremiah Morris
 - Johnson County (KS) Sheriff's Office
- ▣ Clemson University Dept. of Chemistry
- ▣ Cayman Chemicals

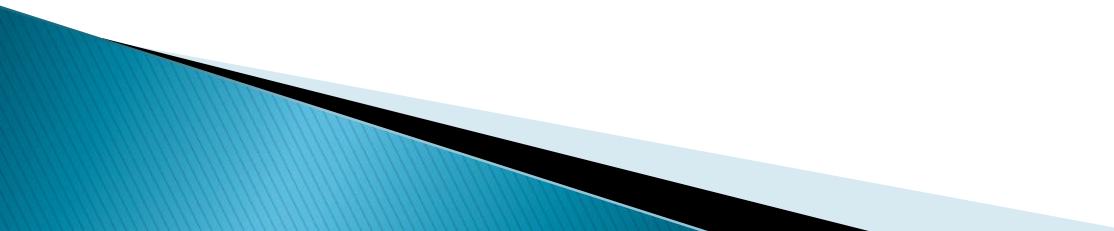
Synthetic Drug Crime Enforcement in Minnesota



Minnesota Department of Public Safety
Office of Justice Programs
Brian Marquart, Statewide Gang and Drug
Coordinator

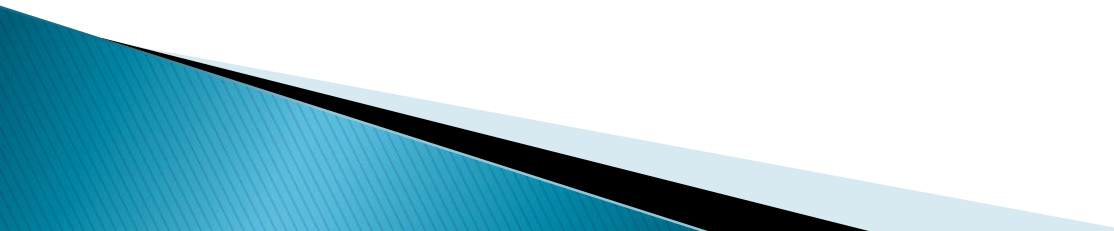
Background

▶ Enforcement Structure

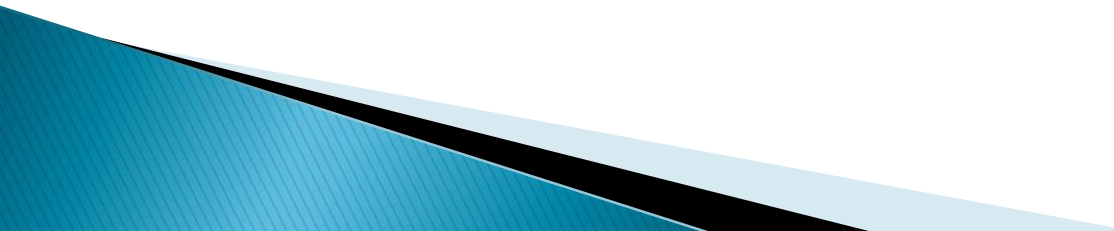
- 23 state funded gang and drug task forces that cover 63 counties and a large number of city municipalities throughout MN
 - Federal and State monies used by task forces to form Violent Crime Enforcement Teams (VCETs)
 - VCETs focus on drug enforcement, gang enforcement, other violent crimes
- 

Background

▶ 2012 Task Force Activity

- Conducted over 7,000 active investigations
 - Over 3,900 arrests
 - 84% of arrests for felony-level crimes
 - Task Forces collectively seized thousands of grams of heroin, methamphetamines, cocaine and marijuana, along with other drugs
 - Over ½ of the VCETs have reported a dramatic increase in Synthetic Cathinones (bath salts) and Synthetic Cannabanioids investigations and seizures over the past year
- 

WHAT ARE SYNTHETIC CATHINONES (BATH SALTS)?

- ▶ Not the traditional bath salts used legitimately for water-softening or aroma therapeutic purposes
 - ▶ A central nervous stimulant used as a recreational drug
 - ▶ Marketed as “bath salts” or sometimes “plant food” to avoid regulation
 - ▶ Age range of users varies but most popular among teens and young adults
- 

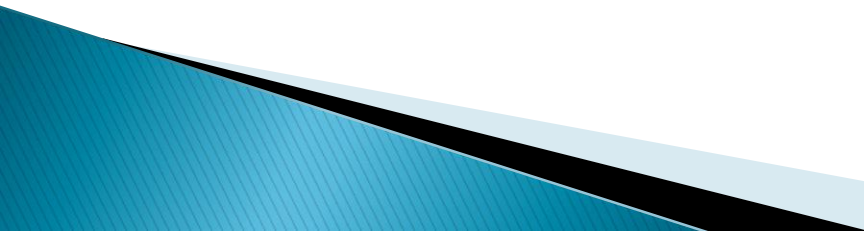
WHAT ARE BATH SALTS?

(continued)

- ▶ Powder and crystal form that crumbles easily
- ▶ White to light brown in color
- ▶ Sold in 50 mg to 500 mg packets or containers
- ▶ Labeled “Not for human consumption”
- ▶ Sold for \$25 to \$75 per packet
- ▶ Easily available through the Internet, “head shops” or tobacco shops



EFFECTS


- ▶ Highly similar to cocaine, methamphetamines, MDMA (Ecstasy) or LSD
 - ▶ Initial euphoria lasts 3–4 hours
 - ▶ Psychosis
 - ▶ Suicidal
 - ▶ Long term effects remain unknown
 - ▶ Users often cannot be subdued with pepper spray or Tasers
 - ▶ Cited as an **“imminent threat to public safety”** by the DEA
- 

INGESTION METHODS

- ▶ Snorted (most common)
- ▶ Injected
- ▶ Smoked (similar to crack)
- ▶ Mixed with food
- ▶ Mixed with drink
- ▶ Airborne mist



SIGNS/SYMPTOMS

- ▶ Agitation/extreme anxiety
 - ▶ Extreme paranoia/hallucinations
 - ▶ Psychotic features (reporting seeing demons, monsters, foreign soldiers, or aliens)
 - ▶ Violent behavior
 - ▶ Chest pain/rapid heartbeat
 - ▶ Confusion
 - ▶ High blood pressure
 - ▶ Sweating
 - ▶ Hyper-alertness
 - ▶ Tremors/seizures
- 

EXAMPLES of Bath Salts

- ▶ – Blue Silk
- ▶ – Vanilla Sky
- ▶ – Ivory Soft
- ▶ – Cosmic Blast
- ▶ – Cloud 9
- ▶ – Zeus 2
- ▶ – Bliss
- ▶ – Purple Wave
- ▶ – Plus many others

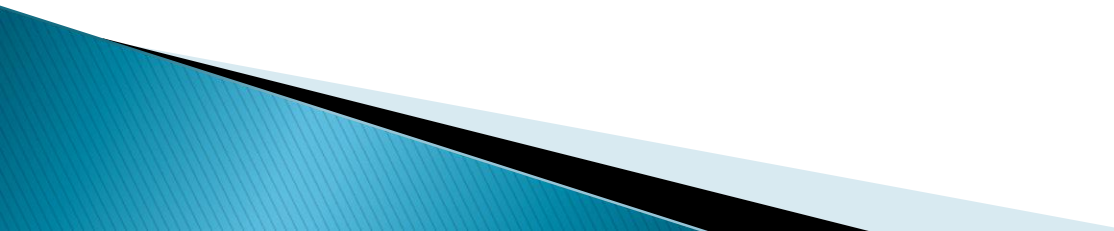


SYNTHETIC CANNABANOIDS

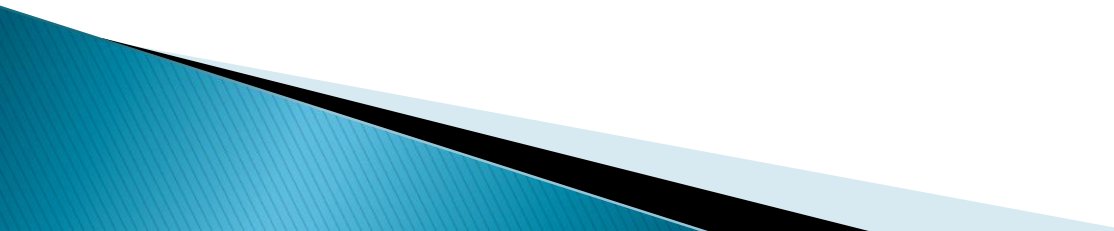
- ▶ Synthetic Cannabanoids are a mixture of plant material sprayed with potent psychotropic drugs.
- ▶ Often contaminated with unidentified toxic substances.
- ▶ Sold in “head shops”, smoke shops and on the internet
- ▶ Labeled as “incense” marked “not for human consumption”



SYNTHETIC CANNABANOIDS (continued)

- ▶ Sold in 3-15 gram bags for \$15-\$45
 - ▶ Most commonly smoked but can be mixed with food or drink
 - ▶ Can cause hallucinogenic effects similar to PCP
 - ▶ Can be 4-100 times more potent than marijuana
- 

Effects

- ▶ Numbness/tingling
 - ▶ Elevated blood pressure/heart rate
 - ▶ Increased anxiety/agitation
 - ▶ Seizures/tremors
 - ▶ Coma/unconsciousness
 - ▶ Hallucinations
 - ▶ Suicidal
 - ▶ Long term effects are unknown
- 

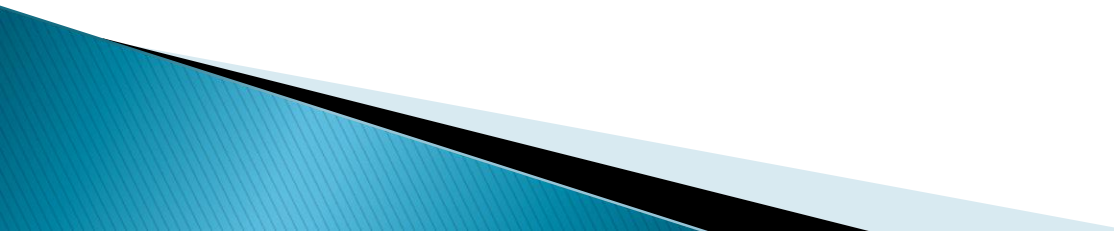
Product Names

- ▶ K2
- ▶ Scooby Snack
- ▶ King Kong
- ▶ Spice
- ▶ Diamond
- ▶ Smoke
- ▶ Yukatan Fire
- ▶ Sense
- ▶ Spice Gold

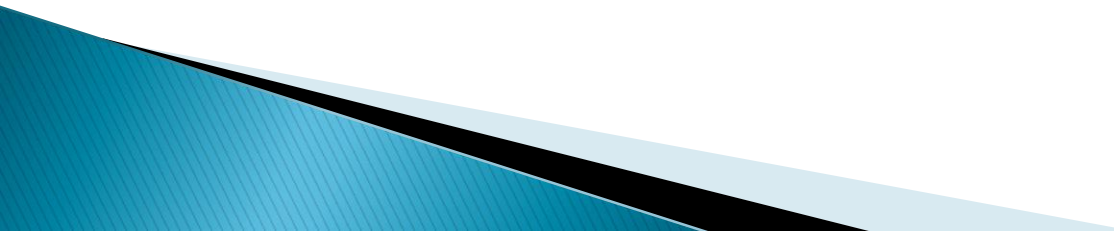


Background

▶ Synthetic Drugs in Minnesota

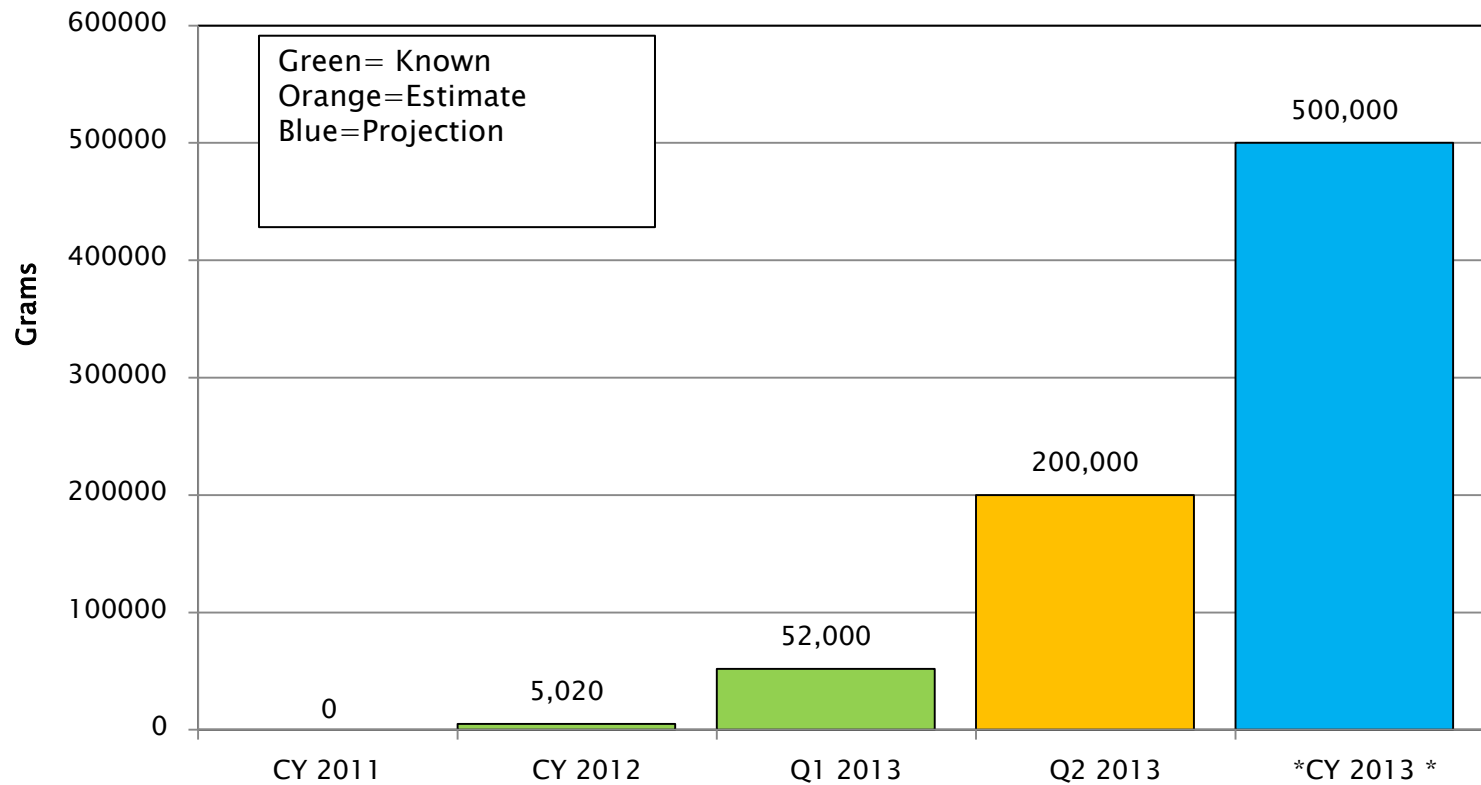
- In 2010–2011, task forces see synthetic drugs becoming increasingly popular in MN
 - Usage particularly high among teens, young adults
 - Products became available in retail outlets, head shops and via the internet
 - Increasing number of reports from poison control centers, hospitals, and law enforcement regarding synthetics
- 

Research and Statistics

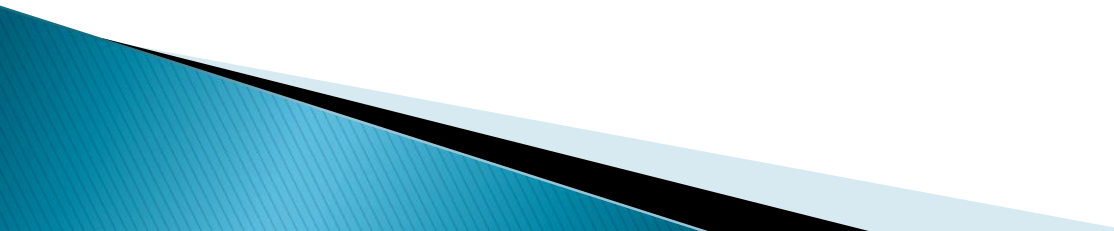
- 2012 University of Maryland study reports that synthetic cannabinoids were the third most used substance by US students in grades 9–12
 - Minnesota Student Survey has added a question on youth synthetic drug use for the 2013 administration
 - OJP began collecting data on synthetic substances encountered by task forces in 2012
- 

Task Force Seizure Data

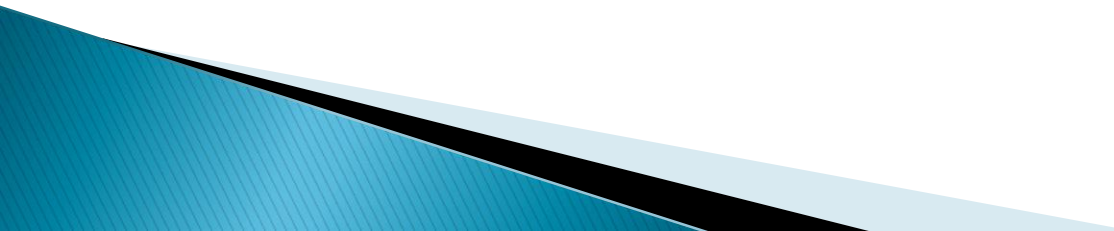
MN TASK FORCE SYNTHETIC DATA



Challenges for Law Enforcement

- Seller's portrayal of synthetic substances as legal and/or not harmful
 - Bizarre and unpredictable behavior exhibited by users
 - Increase in police calls
 - Increased lab analysis necessary to determine if substances are controlled by state or federal law
 - Difficulty for state and federal legislation to keep up with changing chemical compositions
 - County Attorneys difficulty in determining charges under analog statute
 - Prohibitive costs of expert testimony
- 

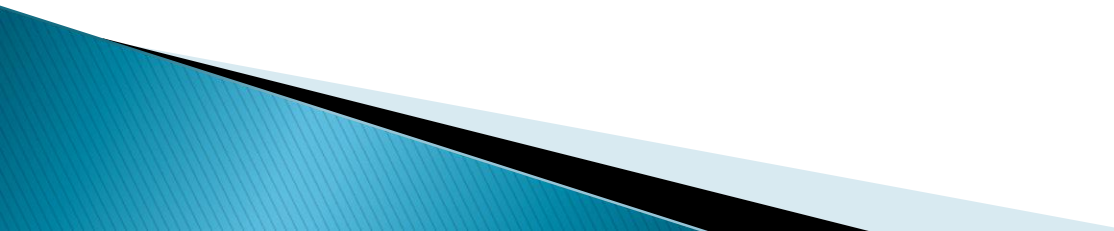
Response and Training

- Task forces continue to coordinate with state, local and federal agencies to address synthetics and other controlled substances crimes
 - OJP has provided synthetics trainings at the last two Minnesota State Association of Narcotics Investigators (MSANI) conferences
 - Task force personnel regularly conduct narcotics presentations to community groups, law enforcement and government entities
 - Cities enacting local ordinances
 - Violent Crime Coordinating Council (VCCC) ad hoc committee on synthetics
 - Statewide Substance Abuse Strategy (SSAS) has identified synthetic drug abuse as an emerging issue
- 

Thank You

► Contacts:

- Statewide Gang and Drug Coordinator
 - Brian Marquart
 - 651-201-7338

 - State Program Administrator
Kristin Lail
 - 651-201-7322
- 

**Written Statement on Winona County Historical Experience Up Until March 2013 to
Supplement Testimony Before the
Minnesota House Select Committee on Controlled Substances and Synthetic Drugs
July 9, 2013, Room 5, State Office Building, St. Paul, Minnesota**

**“Synthetic Drugs/An Overview of the Winona County Experience:
Designer Werewolves, Shadows, and Demons – What a High!”**

Based on Our March 29, 2013 Webinar and August 2012 Minnesota Criminal Justice Institute
Presentation with Accompanying Powerpoint (attached).

Winona County Attorney Karin L. Sonneman
Assistant Winona County Attorney Christina Davenport

Our story starts in fall of 2010:

September 2010 – Probationer is picked up on warrants with a hallowed out pen in his pocket and a tear off containing a white substance that is labeled, “White Gold Plant Food” and “Not for Human Consumption.” Charges dismissed in December 2010 because the powder was not a controlled substance.

November 2010 - Winona City Police break up downtown fight. White powder in plastic bags is seized, but they are not a controlled substance.

Ring in the New Year-2011 with Werewolves, Shadows, Demons

- People under the influence of some unknown substance appear with greater frequency, causing great concern and stressing the system.
- More people than usual are showing up with paranoia, hallucinations, and bizarre behaviors.
- Police respond to more calls.
- Emergency Rooms see more admissions with symptoms that medical personnel cannot treat.
- Rule 20's, civil commitments, and child protection cases jump.

What's Going On?

- Winona County law enforcement, prosecutors, and probation agents reach out to colleagues in nearby counties and across Minnesota asking if they have seen the same things that are happening in Winona County.
- No one has heard of it ...

I. Designer Synthetic Drug Background

A. Synthetic Drugs

- Synthetic drugs are not naturally occurring.
- They are made through a chemical process.
- The October 2004 National Synthetic Drugs Action Plan focused on MDMA and methamphetamine.

Compare:

- Natural drugs - composed of plant or other living system in itself or isolating part of it through extraction (i.e. marijuana, morphine).

- Semi-synthetic drugs - produced from natural sources, but have to undergo a chemical process (i.e. heroin, LSD).
- Synthetic drugs – artificially produced almost exclusively through chemical compounds for illicit market (i.e. amphetamine, benzodiazepines).

B. Designer Synthetic Drugs

- The term “designer synthetic drugs” most accurately reflects the issue because the drugs are specifically designed to evade the law.
- Minor chemical changes are used to get around substances that are specifically articulated within statutes.
- Commonly labeled with “Not For Human Consumption.”

C. Most common designer synthetic drugs in Winona

<i>name</i>	<i>chemical composition</i>	<i>street name</i>
synthetic cannabinoids	JWH-018, etc.	Spice, K-2, K-3, herbal incense
MDPV	3,4-methylenedioxypyrovalerone	Turbo, bath salts, (plant food)
mephedrone	4-methylmethcathinone	Plant food
Alpha-PVP	<u>alpha-Pyrrolidinopentiophenone</u> a substituted 2-aminopropan-1-one	Plant food, the new Turbo

II. Winona County Case Examples and the Strain on the Criminal Justice System, Social Services, and Health Systems

A. Calls to Law Enforcement

- Frequent calls to law enforcement reporting werewolves, shadows, and demons chasing users.
- People shooting at hallucinations and stabbing animals/punching walls and televisions to get the demons out.
- Dealers sell mephedrone and MDPV under the guise of cocaine and methamphetamine.
- Hardcore methamphetamine users contact law enforcement to find out what they actually bought because they say it was the worst high they ever had.
- Marketed to youth as a “safe” high alternative. Sometimes dyed fun colors.

B. Healthcare

- ER admissions increase with people suffering from hallucinations, paranoia, stammering, inability to speak, bizarre behavior, and violent actions toward self and others.
- Medical professionals have difficulties diagnosing and treating unknown conditions and substances.
- A woman had her “plant food” and cellular telephone hidden in her vagina. While a doctor was helping her, she bit him, leaving a mark. Resulted in fourth degree assault conviction.

C. Juvenile Delinquency

- Juveniles increasingly appear in court exhibiting symptoms of mood-altering substance use, but test negative for controlled substances.
- Concerns arise regarding the unknown cognitive and physical effects.
- Unprecedented Rule 20 requests.

D. Child Protection

- In 2011, about 75% of the non-truancy CHIPS cases involved allegations of one or both parents using “plant food.”
- Parents essentially abandoned their children, neglecting their basic needs.

- Abandonment and lack of care during critical developmental years have lasting impact on children.
- E. 2011 CHIPS examples**
- Children under ten removed from home due to neglect caused by both parents using “plant food” and other drugs. At one point after the children were removed, the mother was found running around in a wooded area looking for the graves of her dead children. Fortunately, the children were alive and well, but the mother was obviously psychotic while under the influence.
 - Law enforcement called to apartment on report that a giant marshmallow-type man was trying to get into the second floor apartment. Both parents are obviously high, the mother looks like a concentration camp survivor, and the apartment is in shambles. An officer sees a mound of clothing on the couch start to move. There is a two-year old child sleeping under the mound. The parents did nothing toward reunification with three children under the age of seven and eventually transferred physical and legal custody to maternal grandparents.
 - Hearing on mother of six-month old infant using “plant food” and other drugs.
- F. Civil Commitment**
- The “plant food” commitments were as psychotic as our office has seen for some time. Some had no prior history of any mental illness.
 - One individual was making “jailhouse burritos” out of food scraps and feces.
 - A female was using “plant food” and other drugs early in her pregnancy. She was placed until after her baby’s delivery.

III. Law Enforcement, Prosecutorial, and Legislative Responses – Seeking a Legal Silver Bullet

A. Law enforcement

- Initial response was to take hallucinating and psychotic users to the hospital and detox. This would temporarily put them in a safe environment where they could be monitored.

B. Prosecutorial

- Started requesting as condition of release and probation not to use/possess “mood-altering substances.”
- Used developing patterns to try to screen controlled substances from non-controlled substances when charging cases.

C. Legislative

- Initially considered local ordinance to at least get some grasp on the problem.
- Minnesota Senator Jeremy Miller spoke with local authorities and initiated swift legislative action criminalizing synthetic cannabinoids, mephedrone, and MDPV on July 1, 2011.

a) 2011 State Legislation

- Synthetic cannabinoids, mephedrone, and MDPV are made schedule I controlled substances. (Minn. Stat. 152.02, subd. 2(6); Minn. Stat. 152.02, subd. 2(7))
- As schedule I controlled substances, can be used in DWIs when there is any amount in a driver’s body. (Minn. Stat. 169A.20, subd. 1(7))
- Essentially the same severity regardless of amount of substance involved.
- MDPV & mephedrone
 - Sale → Fourth Degree Controlled Substance Crime (Minn. Stat. 152.024, subd. 1(1))
 - Possession → Fifth Degree Controlled Substance Crime (Minn. Stat. 152.025 subd. 2(a)(1))

- synthetic cannabinoids
 - Sale → gross misdemeanor (Minn. Stat. 152.027, subd. 6(b))
 - Possession → misdemeanor (Minn. Stat. 152.027, subd. 6(c))

i) Update: 2011 Law is Effective on Many Fronts

- As of July 2012, there have been no new CHIPS cases involving “plant food.” Some of the 2011 cases are still active in the system, but two mothers are close to getting their children back.
- There has been a drop in the number of Rule 20’s and civil commitments related to designer synthetic drug use.
- There are fewer calls to law enforcement for help and a decrease in hospital ER admissions related to designer synthetic drugs use.
- While it appears the law has had some deterrent effect and has helped users get treatment, it has also resulted in users and dealers being more secretive because their conduct is now illegal.

b) 2012 State Legislation

- July 26, 2012, Governor Dayton signs new legislation.
- Effective August 1, 2012.
- Statutory language now covers controlled substance analogs in addition to salts and isomers. (In 2011 update, analog was only included in the synthetic cannabinoid section.)
- The statute uses broader isomer language instead of specific positions to help eliminate questions over what is actually covered.
 - Mephedrone removed the 4- from methylmethcathinone
 - MDPV removed 3,4- from methylenedioxypyrovalerone
- Modifications to synthetic cannabinoids given that shops continued to sell these substances and appear willing to pay a fine as a cost of doing business. (Public Safety – New Laws 2012: Fighting Synthetic Drug Sale, Use)
 - Synthetic cannabinoid sales → felony (Minn. Stat. 152.027, subd. 6(c))
 - Synthetic cannabinoid sales for no remuneration → gross misdemeanor (Minn. Stat. 152.027, subd. 6(b))
 - Synthetic cannabinoid possession → misdemeanor (Minn. Stat. 152.027, subd. 6(d))
- Synthetic cannabinoid possession also eligible for 152.18 (Minn. Stat. 152.18, subd. 1)
- Board of Pharmacy granted expedited rulemaking authority, with sunset provision if not later adopted by the legislature. This expedited authority is granted until August 1, 2014. (Minn. Stat. 152.02, subd. 8b)
 - The expedited authority makes it possible to control a substance in about 44 days. (Minn. Stat. 14.389)
 - Board of Pharmacy previously only granted authority to control substances under specific rules in Minn. Stat. ch. 14. While that process requires no further legislative action, it is a much longer process with multiple variables affecting timeframes. It could take roughly 52 days if the process were

extremely efficient (although likely not possible) to 320 days, and there is the possibility of extensions.

c) 2012 Federal Legislation

- In July 2012, President Obama signed "Food and Drug Administration Safety and Innovation Act."
- Title XI – Other Provisions – Subtitle D – Synthetic Drugs.
- Section 1152 adds designer synthetic drugs to schedule I controlled substances.

IV. Ongoing Issues and Future Concerns: Taming the Wilde Beasties

- Given the ongoing drug problem, we need to ask ourselves what is causing people to feel the need to escape through substance abuse?
- It is an important question for our society as a whole, but especially for criminal justice system participants. The criminal justice system is an effective and imperative tool in intervening in these cases to protect the community generally and the user specifically, but wilde beasties will continue evolving if we do not do more.
- Information sharing is invaluable in responding to designer synthetic drugs, both within agencies and educating citizens.
- We cannot keep up with simply changing the laws, however. We also need to look into what communities can do for themselves to change lives.

Contact Information:

Please feel free to contact us with any questions or to discuss these issues further:

ksonneman@co.winona.mn.us
cdavenport@co.winona.mn.us
Winona County Attorney's Office: 507.457.6310

WINONA COUNTY ATTORNEY'S OFFICE RECOMMENDATION

July 9, 2013

In order to more accurately reflect the serious nature of the conduct, the harm to the community, and the dangerousness of the substances, the Winona County Attorney's Office recommends:


- 1) Scheduling 4-methylmethcathinone, 3,4-methylenedioxypyrovalerone, and a substituted 2-aminopropan-1-one as narcotic drugs.
- 2) Specifically listing 4-methylmethcathinone, 3,4-methylenedioxypyrovalerone, and a substituted 2-aminopropan-1-one in Minnesota statutes 152.021-152.023 in the same places methamphetamine is listed.


In effect, this would then make "plant food" offenses (mephedrone, MDPV, and Alpha-PVP) as serious as cocaine, heroin, and methamphetamine crimes. "Plant food" offenses could then move beyond always being a 4th Degree Sale and a 5th Degree Possession, regardless of amount, and instead be sentenced in correlation to the seriousness of the offense as provided in the Minnesota Sentencing Guidelines (see attached grid).

4.A. Sentencing Guidelines Grid

Presumptive sentence lengths are in months. Italicized numbers within the grid denote the discretionary range within which a court may sentence without the sentence being deemed a departure. Offenders with stayed felony sentences may be subject to local confinement.

SEVERITY LEVEL OF CONVICTION OFFENSE (Example offenses listed in italics)		CRIMINAL HISTORY SCORE						
		0	1	2	3	4	5	6 or more
<i>Murder, 2nd Degree</i> (intentional murder; drive-by-shootings)	11	306 261-367	326 278-391	346 295-415	366 312-439	386 329-463	406 346-480 ²	426 363-480 ²
<i>Murder, 3rd Degree</i> <i>Murder, 2nd Degree</i> (unintentional murder)	10	150 128-180	165 141-198	180 153-216	195 166-234	210 179-252	225 192-270	240 204-288
<i>Assault, 1st Degree</i> <i>Controlled Substance Crime, 1st Degree</i>	9	86 74-103	98 84-117	110 94-132	122 104-146	134 114-160	146 125-175	158 135-189
<i>Aggravated Robbery, 1st Degree</i> <i>Controlled Substance Crime, 2nd Degree</i>	8	48 41-57	58 50-69	68 58-81	78 67-93	88 75-105	98 84-117	108 92-129
<i>Felony DWI</i>	7	30 26-34	42 37-47	54 46-64	60 51-72	66 57-79	72 62-84 ²	72 62-84 ²
<i>Controlled Substance Crime, 3rd Degree</i>	6	21 18-24	27 23-31	33 29-39	39 34-46	45 39-54	51 44-61	57 49-68
<i>Residential Burglary</i> <i>Simple Robbery</i>	5	14 12-16	18 15-21	24 20-28	33 29-39	38 33-45	43 37-51	48 41-57
<i>Nonresidential Burglary</i>	4	12 ¹ 10-14	15 12-18	18 15-21	21 17-25	24 21-28	27 23-32	30 26-36
<i>Theft Crimes (Over \$5,000)</i>	3	12 ¹ 10-14	15 12-18	18 15-21	21 17-25	19 17-22	21 18-25	23 20-27
<i>Theft Crimes (\$5,000 or less)</i> <i>Check Forgery (\$251-\$2,500)</i>	2	12 ¹ 10-14	12 ¹ 10-14	15 12-18	18 15-21	17 14-20	19 16-22	21 18-25
<i>Sale of Simulated Controlled Substance</i>	1	12 ¹ 10-14	12 ¹ 10-14	14 ¹ 11-17	16 13-19	15 12-18	17 14-20	19 17-22

 Presumptive commitment to state imprisonment. First-degree murder has a mandatory life sentence and is excluded from the Guidelines under Minn. Stat. § 609.185. See Guidelines section 2.E. Mandatory Sentences, for policies regarding those sentences controlled by law.

 Presumptive stayed sentence; at the discretion of the court, up to one year of confinement and other non-jail sanctions can be imposed as conditions of probation. However, certain offenses in the shaded area of the Grid always carry a presumptive commitment to state prison. Guidelines sections 2.C. Presumptive Sentence and 2.E. Mandatory Sentences.

¹ 12¹ = One year and one day

² Minn. Stat. § 244.09 requires that the Guidelines provide a range for sentences that are presumptive commitment to state imprisonment of 15% lower and 20% higher than the fixed duration displayed, provided that the minimum sentence is not less than one year and one day and the maximum sentence is not more than the statutory maximum. Guidelines section 2.C.1.-2. Presumptive Sentence.

Effective August 1, 2012



OFFICE OF THE SAINT LOUIS COUNTY ATTORNEY

MARK S. RUBIN COUNTY ATTORNEY

Statement Select Committee on Controlled Substances and Synthetic Drugs

Chair Erik Simonson and Distinguished Members of the Select Committee:

I am sorry that I am not able to be with you and participate in this hearing today. However, you will find we are well-represented by Jon Holets, our lead prosecutor in matters involving synthetic drugs.

You will learn that our office has assumed a great deal of leadership on this issue and we are grateful for the work by the Legislature trying to keep up with the ever-changing nature of the substances that are being disseminated into our communities. Through the Minnesota County Attorneys Association, we will be putting together a Crime Prevention/Education Alert for the month of February 2014 that helps bring this issue even more to the forefront for the safety of our communities.

I want to point out that earlier this year I was proud to bring Representative Simonson's bill from the last session before the Board of Directors at the Minnesota County Attorneys Association. At the session, my fellow Board members unanimously supported the concept of the legislation. Unfortunately, it was too late in the session to have received any special attention through a hearing.

Thank you for the work you are doing in this area.

Respectfully,

MARK S. RUBIN
St. Louis County Attorney

☐ DULUTH COURTHOUSE
100 N. FIFTH AVE. W., #501
DULUTH, MINNESOTA 55802
218-726-2323

☐ GOVERNMENT SERVICES CENTER
320 W. SECOND ST., #403
DULUTH, MINNESOTA 55802
218-726-2034

☐ VIRGINIA COURTHOUSE
300 S. FIFTH AVE., #222
VIRGINIA, MINNESOTA 55792
218-749-7101

☐ HIBBING COURTHOUSE
1810 TWELFTH AVE. E., #107
HIBBING, MINNESOTA 55746
218-262-0158

Select Committee on Controlled Substances and Synthetic Drugs

Chair: Rep. Erik Simonson

August 22, 2013

5:00 p.m.

Chalberg Theatre

Central Lakes College

Brainerd, Minnesota

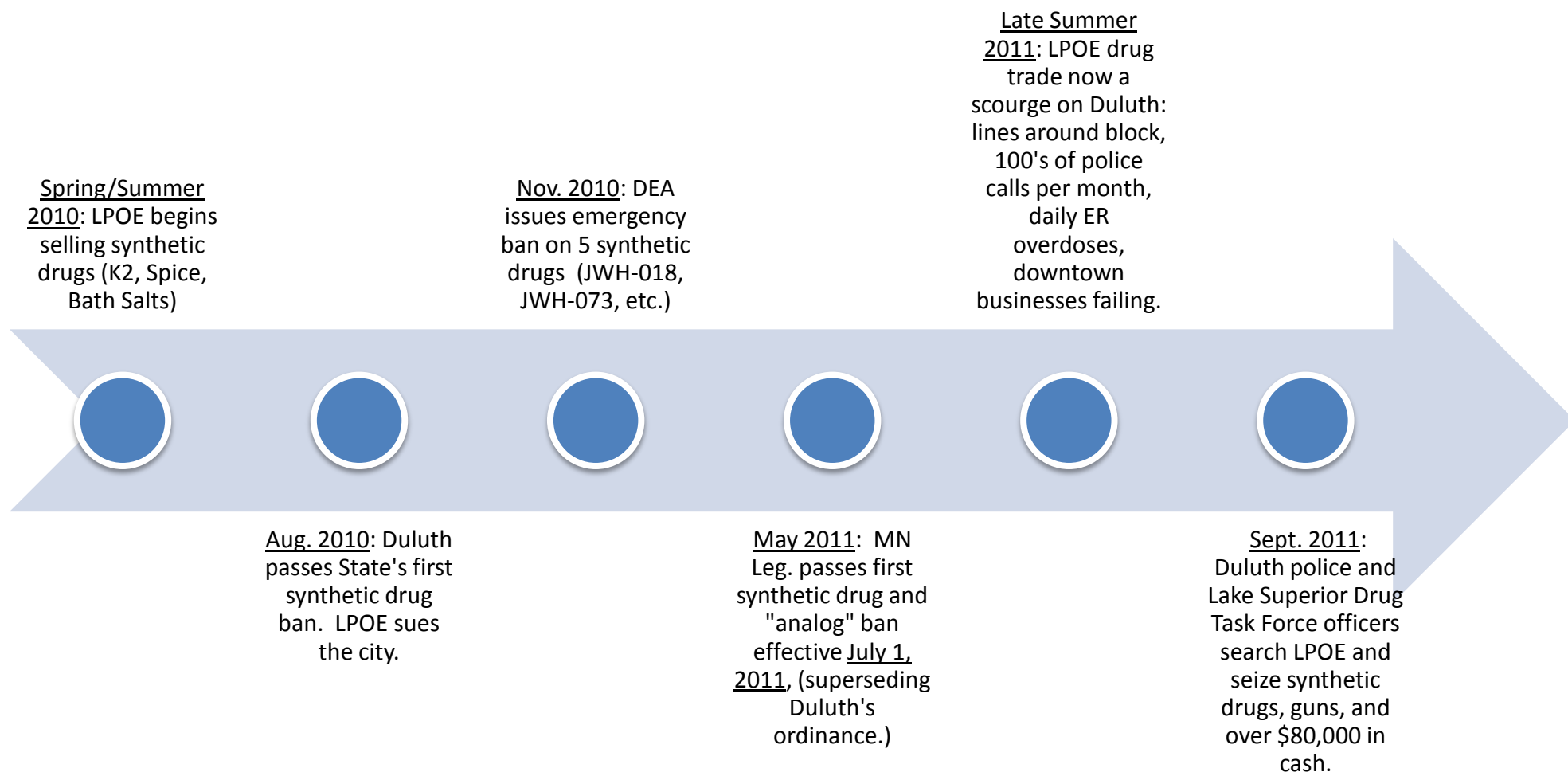
AGENDA

- I. Call to Order
- II. Introduction of members of the committee
- III. Short film presentation: *Ground Zero: Duluth's Battle Against Synthetic Drugs*
- IV. Public Testimony
- V. Adjournment

Synthetics: The Battle for Duluth

(Timeline of Events Related to the Sale of Synthetic Drugs at the Last Place on Earth)

Nathan N. LaCoursiere, Assistant City Attorney, City of Duluth



Oct. 2011: LPOE
sues City of Duluth
over September
2011 search
(Duluth later
obtains dismissal in
both State district
and appellate
courts).

July 26, 2012:
Federal agents
(DEA/FDA), working
with DPD, Lake
Superior Drug Task
Force, and County
law enforcement
officers search
LPOE, seize drugs,
and freeze over \$3
million in assets.

August 10, 2012:
LPOE continues
selling synthetics -
City of Duluth
serves first Notice
of Public Nuisance
on the business,
and proceeds with
the nuisance suit
on October 12,
2012

July 9, 2012:
President Obama
makes the previous
DEA ban
permanent by
signing the
Synthetic Drug
Abuse Prevention
Act of 2012.

Effective August 1,
2012: MN Leg.
beefs up original
synthetic drug ban
by adding several
new compounds,
including AM-2201
(the heir to JWH-
018 found in many
of LPOE's
products).

Nov. 9, 2012: Hon. Shaun R. Floerke hears Duluth's first motion for an injunction ending the sale of synthetic drugs at LPOE.

Jan. 2, 2013: Citing thousands of police calls and nuisances surrounding LPOE, Judge Floerke issues injunction requiring LPOE to pay DPD costs for additional security detail (\$250,000 from Jan.-July 19, 2013).

Late March 2013: Undercover buys by DPD/Drug Task Force following the rectum incident result in the the St. Louis County Attorney filing felony charges against Carlson for additional State controlled substance violations.

Ded. 2012 (Federal Indictment): USAO charges Carlson, his son (Gellerman), and girlfriend (Haugen) with over 50 counts of violating federal FDA and Controlled Substance Acts.

March 2013 (the "rectum incident"): LPOE keeps selling, switching to new bath-salt-like stimulants causing horrific events, such as the man found by DPD and DFD running naked and screaming in the middle of the street, covered in feces with packages of Everest up his rectum.

May 2013: City commences second Public Nuisance suit against LPOE based on 2012 and 2013 controlled substance violations.

July 11, 2013: New Duluth ordinances go into effect. Carlson sues the city in federal court seeking an injunction against enforcement of the new laws. He loses.

July 19, 2013: The city files its third public nuisance suit against LPOE. Judge Hylden issues a TRO shuttering the business. It has never reopened.

June 10, 2013: Duluth passes two new ordinances regulating "synthetic drug establishments" within the city, requiring specific packaging, labeling and product information.

July 18, 2013: Within hours of the federal court rejecting his challenge to the new Duluth ordinance, Carlson opens LPOE and starts selling synthetic drugs without a license.

Aug. 19-20, 2013: Trial on city's 2nd and 3rd public nuisance actions. City presents evidence of controlled substance violations and the burden on local law enforcement, emergency medical facilities, and nonprofits.

Sept. 17, 2013: MN Court of Appeals rules in favor of the City of Duluth on LPOE's challenges to the September 2011 search and the city's first public nuisance suit

Oct. 7, 2013: Carlson found guilty by federal jury on 51 of 55 counts and is immediately taken into custody. Carlson's subsequent requests for release and a new trial are denied.

Jan. 5, 2014: Carlson appeals the City's permanent injunction. Carlson is also in the process of appealing his convictions to the Eighth Circuit Court of Appeals.

Sept. 17, 2013: Federal jury trial commences on the indictment against Carlson, Gellerman and Haugen. The trial lasts three weeks.

Nov. 5, 2013: Judge Floerke rules in favor of Duluth in 2nd and 3rd public nuisance actions, issuing permanent injunction against LPOE, closing the business for one full year, and enjoining future sales of synthetic drugs.

Conclusion: Since LPOE was shuttered on July 19, 2013, police calls and ER visits related to synthetics have dropped off the map, and downtown businesses report a resurgence in activity. Broad State and federal legislative efforts remain imperative to stay ahead of the industry and ensure the Duluth experience is never repeated.

Select Committee on Controlled Substances and Synthetic Drugs, Chair: Rep. Erik Simonson
Public Safety Finance and Policy Committee, Chair: Rep. Michael Paymar
Health and Human Services Policy Committee, Chair: Rep. Tina Liebling

October 9, 2013
12:30 p.m.
10 State Office Building

AGENDA

- I. Call to Order
- II. Testimony from professionals on experiences in the field, trends, and research regarding controlled substances and synthetic drugs
- III. Minnesota State Substance Abuse Strategy Work Group
- IV. Public testimony
- V. Discussion regarding committee plans
- VI. Adjournment



Minnesota Department of **Human Services**

Statewide Substance Abuse Strategy

Recommendations to the Select Committee on Controlled Substances & Synthetic Drugs

October 9, 2013

Dave Hartford, Assistant Commissioner
Chemical & Mental Health Services

1

Statewide Substance Abuse Strategy

- Statewide collaboration using a multi-agency, multi-faceted approach for recommendations to achieve a healthier, safer and stronger Minnesota.
- Established in 2012
- Convenes monthly as a group and with executive sponsorship quarterly

Minnesota State Substance Abuse Strategy

Minnesota Departments/agencies:

- -- Human Services
- -- Education
- -- Health
- -- Public Safety
- -- Labor & Industry
- Corrections
- State Judicial Branch
- MN Board of Pharmacy

Work groups

- -- Data and Measurements
- -- Opiate
- -- Prevention Messaging
- SBIRT
- Specialty Courts
- Drug Task Forces

Opiate work group

- -- Human Services
- -- Public Health
- -- Safety
- -- MN Board of Pharmacy

Synthetic Drug Problem

Problem: Synthetic drugs are creating a public health and safety issue in Minnesota communities.

How do we solve the problem?

Legal and educational approaches

Utilize best practice and evidence based prevention strategies

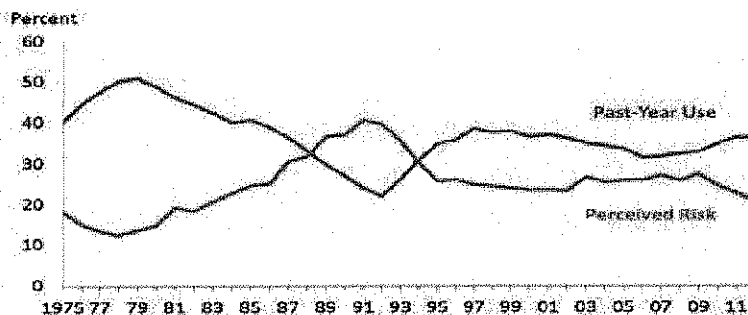
Work with communities and design prevention efforts to meet their needs.

Substance Abuse Problem

- ❖ 95.6 cents of every dollar spent by federal, state and local governments on risky substance use and addiction go to pay for the consequences; only 1.9 cents go to prevention and treatment.
- ❖ In 2009 more than 1/3 of teens (8.7 million) said they can get prescription drugs to get high within one day. Nearly 1 in 5 teens (4.7 million) could access drugs within one hour.
- ❖ Addiction and risky use are causal and contributing factors in more than 70 other conditions requiring medical care and drive a wide range of costly social consequences.
- ❖ A child who reaches age 21 without smoking, drinking, or using other drugs is virtually certain never to do so.

Perception and Attitude

**Marijuana Past-Year Use vs.
Perceived Risk among 12th Graders**



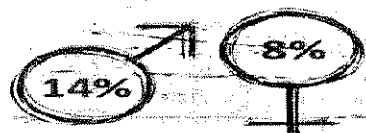
Source: University of Michigan, 2012 Monitoring the Future Study

Synthetic Marijuana Lands Thousands of Young People in the ER, Especially Young Males

Since bursting on the scene a few years ago, synthetic marijuana (MJ)—often called “Spice” or “K2”—has become the second most popular illegal drug among American teenagers, after MJ. It is especially popular among teenage boys. Sometimes touted as a “natural,” “safe,” and (until recently) legal alternative to pot, this very *un-natural* class of designer chemicals has shown itself to be a dangerous threat. Thousands of teens and young adults, mostly young males, are ending up in emergency rooms with severe symptoms that may include vomiting, racing heartbeat, elevated blood pressure, seizures, or hallucinations.

How Many Teens Are Using Synthetic MJ?

In 2012, 11% of American high school seniors used synthetic marijuana in the past year.¹



11,406 ER Visits In 2010 Were Associated With Synthetic MJ.²

75% were among adolescents and young adults ages 12-29.

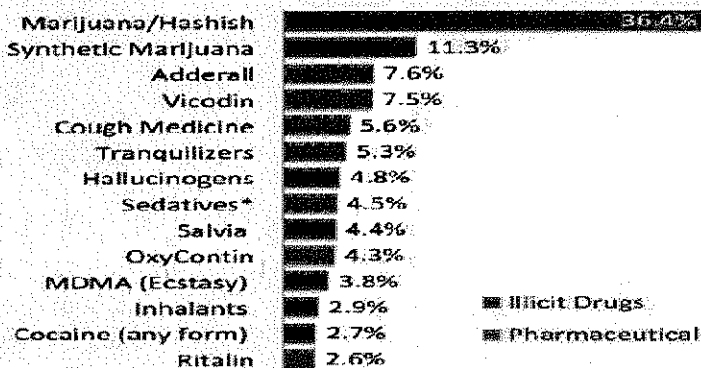
22.5% of these visits involved females, and 77.5% involved males.



1. Monitoring the Future Survey, 2012/13. Drug Abuse Warning Network, 2013

Marijuana and Synthetic Marijuana Use

Past-Year Use of Illicit Drugs and Pharmaceuticals among 12th Graders

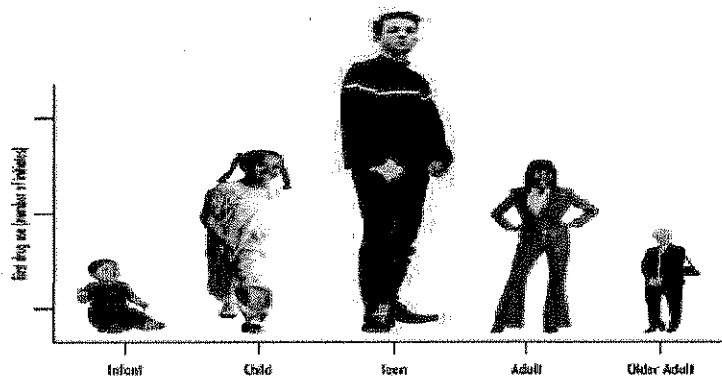


SOURCE: University of Michigan, 2012 Monitoring the Future Study

Preventing Drug Abuse

- ❖ If we can prevent drug abuse, we can prevent drug addiction.
- ❖ National drug use surveys indicate some children are already abusing drugs by age 12 or 13.

Drug abuse starts early and peaks in teen years

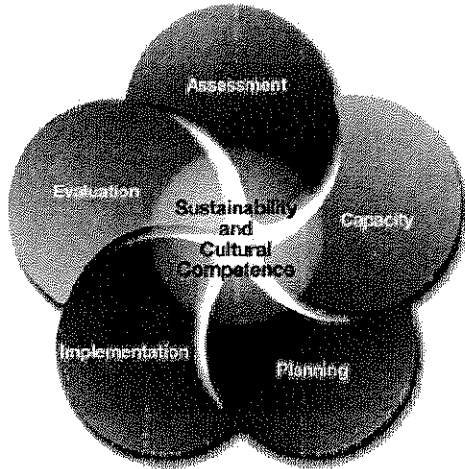


Federal Prevention Funding Requirements

Evidence-based models focus on:

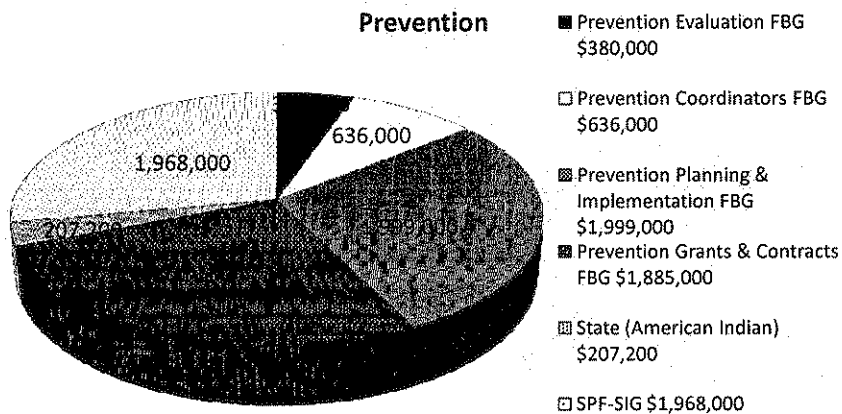
- Community not programs
- Includes many partners; youth, family, community
- Support the same prevention messages
- Strives to support positive community norms around alcohol and drug use

Strategic Prevention Framework for Sustainability & Cultural Competence



- Step 1: Assess Needs
- Step 2: Build Capacity
- Step 3: Plan
- Step 4: Implement
- Step 5: Evaluation

Alcohol and Drug Abuse Division Grants



Excludes Federal Tobacco Money

Current State Synthetic Drug Prevention Plan

- 20,000 synthetic brochures distributed through MN prevention agencies; completed in 2013
- Utilize regional prevention agencies and statewide strategy partners to communicate comprehensive synthetic drug messaging by October of 2014
- Creation and maintenance of an audience specific website by December of 2014
- Complete an assessment of current drug education and intervention efforts in MN schools by December of 2014

Minnesota Substance Abuse Prevention Initiatives

Prevention Planning & Implementation Grants
(10)

Regional Prevention Coordinators (7)

Minnesota Prevention Resource Center

Strategic Prevention Framework (6)

American Indian Tribal Prevention

\$1,056,537.00 (FY14)

Recommended Investments

- ❖ Recommend investment into evidence-based interventions and diversion programs for students identified at risk.
- ❖ Recommend the identification of culturally appropriate intervention and prevention efforts for diverse populations and resources.
- ❖ Recommend replacement funding for (ongoing) Federal Strategic Prevention Framework/State Incentive Grant (current funding ends 6/14; 9.8M/5 yr)

❖ Target five to six communities over five years with defined criteria for prevention and maintenance

Lessons Learned/Closing Thoughts

- Collaborative work of many partners on local, state & federal levels to coordinate a response to a public health hazard
- Efforts will take innovative constructive balance of prevention, public safety and healthcare.
- Priority on a policy plan for action

Drug Abuse Trends in Minneapolis/St. Paul, Minnesota: June 2013

Carol Falkowski
Drug Abuse Dialogues

ABSTRACT

Heroin and prescription opiates dominated the drug abuse situation in the Minneapolis/St. Paul metropolitan area in 2012. From 2011 to 2012 opiate-related deaths increased in Ramsey County (from 36 to 45) but remained stable in Hennepin County (84). Heroin-involved visits at hospital emergency departments nearly tripled from 2004 to 2011 (from 1,189 to 3,493), and rose 54.8 percent from 2010 to 2011 alone. Emergency department visits involving prescription narcotic analgesics more than doubled from 2004 to 2011 (from 1,940 to 4,836), a 149.3 percent increase. Admissions to addiction treatment programs for heroin accounted for 12.9 percent of all admissions to treatment in 2012, compared with 10.7 percent in 2011. Among these, 41.6 percent were patients age 18 - 25. Treatment admissions for other opiates accounted for 9.5 percent of total admissions in 2011 and 9.0 percent in 2012. Still, combining these, one in five treatment admissions (21.9 percent) were for heroin or other opiates in 2012.

From 2011 to 2012 methamphetamine-related deaths went from 7 to 14 in Hennepin County and from 3 to 7 in Ramsey County. Methamphetamine-related hospital emergency department visits increased 58.8 percent from 2009 to 2011, and treatment admissions increased 18.9 percent from 2011 to 2012. Cocaine-related deaths and treatment admissions continued to decline. The use of synthetic THC products (cannabimimetics) and "bath salts" (substituted cathinones) continued. From 2011 to 2012, reported exposures to the Hennepin Regional Poison Center involving THC homologs increased from 149 to 157, while substituted cathinone exposures decreased from 144 to 87.

INTRODUCTION

This report analyzes current and emerging trends in substance abuse in the metropolitan area of Minneapolis/St. Paul, Minnesota (the Twin Cities), utilizing the most recent data obtained from multiple sources. It is produced twice annually for participation in the Community Epidemiology Work Group of the National Institute on Drug Abuse, an epidemiological surveillance network of selected researchers from 20 U.S. metropolitan areas.

Area Description

The Minneapolis/St. Paul metropolitan area includes Minnesota's largest city, Minneapolis (Hennepin County), the capital city of St. Paul (Ramsey County), and the surrounding counties of Anoka, Dakota, and Washington, unless otherwise noted. According to the 2010 Census, the population of each county is as follows: Anoka, 330,844; Dakota, 398,552; Hennepin, 1,152,425; Ramsey, 508,640; and Washington, 238,136, for a total of 2,588,907, roughly one-half of Minnesota's 5.3 million population.

Regarding race/ethnicity, 80.1 percent of the Minneapolis/St. Paul metropolitan area population is White. African-Americans constitute the largest minority group (9.1 percent), with Asians accounting for 6.1 percent, American Indians 0.7 percent, and Hispanics of all races 6.0 percent. The estimated size of the Twin Cities Somali immigrant population ranges from 30,000 to 60,000. The Hmong population in Minnesota is estimated at 60,000 to 70,000, making it one of the largest Hmong communities in the country.

Minnesota shares a northern, international border with Canada. To the west Minnesota borders North Dakota and South Dakota, two of the country's most sparsely populated States, with less than one million residents each.

Illicit drugs are distributed and sold by Mexican drug trafficking organizations, street gangs, independent entrepreneurs, and other criminal organizations. Drugs concealed in private or commercial vehicles are typically shipped or transported into the Twin Cities area for further distribution throughout the State. Interstate Highway 35 starts in Minnesota at the United States-Canadian border, and runs south all the way to the United States-Mexican border.

According to the most recent data from the Behavioral Risk Factor Surveillance System, 63.6 percent of Minnesotans used alcohol in the past month, compared with 57.1 percent nationally, and 22.1 percent reported binge drinking, compared with 18.3 percent nationally. (Binge drinking is defined as 4 or more drinks on one occasion for females, and 5 for or more for males). According to the most recent National Survey on Drug Use and Health, 6.97 percent of Minnesota residents reported using illicit drugs in the past month compared with 8.82 percent nationally.

Data Sources

Survey data are from: 1) Behavioral Risk Factor Surveillance System Survey Data 2011, U.S. Centers for Disease Control and Prevention; and 2) National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration, State Estimates from the National Survey on Drug Use and Health: 2009 - 2010.

Mortality data on drug-related deaths are from the Ramsey County Medical Examiner and the Hennepin County Medical Examiner (through December 2012). Hennepin County cases include accidental overdose deaths in which drug toxicity or mixed drug toxicity was the cause of death and those in which the recent use of a drug was listed as a significant condition contributing to the death. Ramsey County cases include accidental overdose deaths in which drug toxicity or mixed drug toxicity was the cause of death.

Hospital emergency department (ED) data are from the Drug Abuse Warning Network, Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, accessed 9/12/2012. These weighted estimates of ED visits are based on a representative sample of non-Federal, general, short-stay hospitals with 24-hour EDs in the 11-county Minneapolis/St. Paul/Bloomington, MN-WI Metropolitan Statistical Area (through December 2011).

Addiction treatment data are from the Drug and Alcohol Abuse Normative Evaluation System (DAANES) of the Performance Measurement and Quality Improvement Division, Minnesota Department of Human Services (through December 2012).

Data on human exposures to various substances are reported to the Hennepin Regional Poison Center (through April 2013).

Crime laboratory data are from the National Forensic Laboratory Information System (NFLIS), U.S. Drug Enforcement Administration (DEA) queried on May 7, 2013 according to location of seizure. All federal, state and local laboratory data are included in the total number of drug items seized as primary, secondary or tertiary drugs in the 7-county metropolitan area including the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and Washington in calendar 2012. St. Paul crime lab data were not reported after May 2012.

Arrestee drug use data are from the Arrestee Drug Abuse Monitoring Program conducted by the Office of National Drug Control Policy of the Executive Office of the President. Hennepin County participated in this program through 2011. Arrestees were sampled to represent all adult male arrestees booked in each 24-hour period over one consecutive 21-day data collection period. Data were statistically annualized to represent the entire year.

Drug seizure and arrest data are from the multijurisdictional drug and violent crime task forces that operate throughout the State, compiled by the Office of Justice Programs, Minnesota Department of Public Safety (through 2012). As of January 2012, there were 23 drug and violent crime task forces operating throughout Minnesota, staffed by more than 200 investigators from more than 120 agencies.

Prescription drug data are from the Minnesota Prescription Monitoring Program, Minnesota Board of Pharmacy. In April 2013, 566,453 prescriptions were dispensed and reported to the Minnesota Prescription Monitoring Program. As of March 2013, roughly 30 percent of Minnesota prescribers were enrolled in this system.

Data on hepatitis C virus (HCV) and human immunodeficiency virus (HIV) infection are from the Minnesota Department of Health (through 2012).

Additional information is from interviews with addiction treatment providers, narcotics agents, and school-based drug specialists (ongoing).

DRUG ABUSE TRENDS

Cocaine

Most indicators related to cocaine have fallen continuously in the Twin Cities area over the past several years. Cocaine-related deaths declined in both major metropolitan counties in 2012. See exhibit 1. In Ramsey County, there were three cocaine-related deaths in 2012, compared with six in 2011. All were White males and the average age was 42.3 years. In Hennepin County, there were 18 cocaine-related deaths in 2012, compared with 28 in 2011, and 59 in 2007. Three listed cocaine toxicity as the cause of death, and 15 listed recent cocaine use as a significant condition contributing to the death. Nine decedents were African-American; seven were White (including one stillborn); and two were Hispanic. The age ranged from 20 to 60 with an average age of 41.6 years.

Cocaine-involved visits at Twin Cities hospital emergency departments declined 36.7 percent from 2006 to 2011, although rose slightly from 4,121 to 4,279 from 2010 to 2011. See exhibit 2.

The number of cocaine-related treatment admissions declined 52.5 percent from 2007 to 2012. See exhibit 3. Cocaine was the primary substance problem for 5.2 percent of total treatment admissions in both 2012 and 2011 (exhibit 4), compared with 14.1 percent of admissions in

2006. Most cocaine-related treatment admissions in 2012 (74 percent) were for crack cocaine (exhibit 5). Half (50.6 percent) were African-American, and 34.1 percent were White. Females accounted for 41.8 percent, and almost three-quarters (72.4 percent) were age 35 and older.

Cocaine was present in 17.9 percent of the drug items analyzed by NFLIS laboratories in 2012 (exhibit 6). Gangs remain involved in the street-level, retail distribution of crack cocaine. A rock of crack ranged in price from \$15 to \$20; a gram of cocaine powder cost \$80 to \$120; an ounce ranged from \$1,200 to \$1,700; and a kilogram from \$35,000 to \$45,000. As was the case in some other U.S. cities, the age of arrestees who tested positive for cocaine in Hennepin County increased from 2000 to 2011 (exhibit 7), suggesting an aging cohort of cocaine users.

Heroin and Other Opiates

Measurable, adverse consequences related to heroin and other opiate addiction in the Twin Cities increased over the past decade. Most indicators remained at heightened levels in 2012.

From 2011 to 2012 opiate-related deaths remained the same in Hennepin County and increased in Ramsey County. Of the 84 opiate-related decedents in Hennepin County in 2012, 67.8 percent were White; 17.8 percent were African-American; 13 percent were American Indian; and 1.1 percent was Hispanic. The decedents ranged in age from 18 to 73, with an average of 42.5 years. At least 28 cases involved heroin (33.3 percent), 15 involved cocaine used in combination with an opiate (17.8 percent), 13 involved methadone (15.5 percent), four involved oxycodone, six fentanyl and two the use of methamphetamine in combination with an opiate.

From 2011 to 2012 opiate-related deaths in Ramsey County went from 36 to a record-high 45, a 25 percent increase. Of these 45 decedents, 77.8 percent were White; 15.5 percent were African-American; and 6.6 percent were Hispanic. They ranged in age from 14 to 76, with an average of 42.9 years. One quarter of the cases (26.7 percent) involved methadone, 24 percent involved cocaine used in combination with opiates, 22.5 percent involved oxycodone, 15.5 percent involved heroin, and one case involved fentanyl.

Heroin-involved hospital emergency department (ED) visits nearly tripled from 2004 to 2011 (from 1,189 to 3,493) growing 54.8 percent from 2010 to 2011 alone. Emergency department visits for prescription opioids grew as well, most notably "unspecified opioids/opiates" increased ten-fold from 2004 to 2011; and "total narcotic analgesics" more than doubled from 1,940 in 2004 to 4,836 in 2011 (a 149.3 percent increase). From 2010 to 2011, ED visits involving "unspecified opioids/opiates" increased 40.8 percent, and "total narcotic analgesics" increased by 2.9 percent.

Methadone-involved hospital ED visits doubled from 2004 to 2010 (104.3 percent increase), yet declined slightly from 2010 to 2011, from 893 to 828. Similarly hydrocodone/combinations increased 94.3 percent from 2004 to 2010, but fell slightly from 2010 to 2011, from 1,092 to 1,044. Hospital ED visits involving oxycodone/combinations grew 258.8 percent from 2004 to 2010, with 2,397 visits annually in both 2010 and 2011. See exhibit 2.

From 2011 to 2012 heroin treatment admissions increased 20.9 percent, while treatment admissions for other opiates (prescription pain medications and opium) fell 6.5 percent. Addiction treatment admissions for heroin and other opiates combined accounted for 20.3 percent of all treatment admissions in the Twin Cities in 2012, second only to alcohol admissions.

Heroin accounted for 12.9 percent of admissions to addiction treatment programs in 2012, compared with 10.7 percent in 2011, 7.8 percent in 2010, and 3.3 percent in 2000. Anecdotally, many of these young patients entering treatment reported initially using prescription opiates and eventually progressing to heroin addiction. Of the 2,724 heroin admissions in 2012, 41.6 percent were age 18-25. Very few (1.5 percent) were younger than 18. Whites accounted for 66.1 percent; African-Americans 20.7 percent; and American Indians 6.1 percent. Injection was the most common route of administration (60.6 percent).

"Other opiates" include prescription narcotic analgesics, opium and all opiates other than heroin. Other opiates were the primary substance problem reported by 1,879 admissions in 2012, representing 9.0 percent of total treatment admissions. This compares with 9.5 percent in 2011, 8.4 percent in 2010, and 1.4 percent in 2000. Of these admissions, almost one-half were female (47.8 percent). More than one-quarter (26.2 percent) were age 18-25, and 2.7 percent were younger than 18. Whites accounted for 77.9 percent, followed by American Indians (8.3 percent), and African-Americans and Hispanics (both 4.1 percent). Oral was the most common route of administration (65.4 percent), followed by snorting (15.4 percent) and injection (11.1 percent).

From 2011 to 2012, heroin exposures reported to the Hennepin Regional Poison Center went from 78 to 127, a 62.8 percent increase. Hydrocodone exposures increased 8.8 percent and oxycodone 10.6 percent from 2011 to 2012. See exhibit 8.

All levels of law enforcement in the metropolitan area and statewide reported increased activities focused on heroin in 2012. Minnesota multijurisdictional drug and violent crime task forces seized 588.1 percent more heroin and 51.6 percent less oxycodone in 2012 than in 2011. From 2011 to 2012, heroin arrests by these task forces rose from 1,206 to 482, a 133.9 percent increase (exhibit 9). Heroin was present 10.2 percent of the drug items analyzed by NFLIS in 2012, and oxycodone in 2.0 percent.

The percentage of arrestees age 18 - 24 who tested positive for opiates grew from 13 percent in 2000 - 2003, to 34 percent in 2010 and 2011 (exhibit 7).

Hydrocodone with acetaminophen was the most frequently prescribed drug reported on the Minnesota Prescription Monitoring Program in April 2013. See exhibit 10. It accounted for 22 percent of all prescriptions; oxycodone with acetaminophen 8.9 percent; and oxycodone hydrochloride 7.1 percent.

Mexico, and to a lesser extent South America, were the primary sources of heroin in the Twin Cities and Minnesota. This includes both black tar heroin and the brownish-colored heroin powder. Mexican heroin typically costs \$20 per dosage unit and \$100 per gram. An "eight-ball" (1/8 of an ounce) costs roughly \$400. The DEA's Heroin Domestic Monitoring Program in 2009 found that the purity of Mexican heroin in Minneapolis was among the highest in the country (53 percent), and sold at the lowest cost (\$0.25 per pure milligram).

Opium smoking within the Twin Cities' Hmong community remained an ongoing concern. The opium is typically concealed in various packages, some of which are intercepted by U.S. Customs and Border Protection as they arrive in the Twin Cities having been shipped from Asia.

Methamphetamine and Other Stimulants

In both metro counties, methamphetamine-related deaths doubled from 2011 to 2012. In Ramsey County there were seven methamphetamine-related deaths in 2012, compared with three in 2011. This included five White males, one White female and one African-American male. The age ranged from 36 to 53 with an average of 46.7 years. In Hennepin County there were 14 methamphetamine-related deaths in 2012, compared with seven in 2011. Nine listed methamphetamine toxicity as the cause of death and five involved recent methamphetamine use as a significant condition contributing to the death. These decedents included a stillborn, nine Whites, two African Americans, and two American Indians. The age ranged from 23 to 60, with an average of 41.1 years.

Methamphetamine-involved hospital ED visits declined from 2004 to 2009, increased sharply in 2010 (71.1 percent), and fell slightly in 2011 (from 1,660 to 1,541). Amphetamine-related hospital ED visits grew from 255 in 2004 to 644 in 2011, more than doubling.

Methamphetamine-related treatment admissions accounted for 6.4 percent of total admissions in both 2010 and 2011. In 2012 this rose to 7.4 percent. Of these 1,562 admissions in 2012, 37.1 percent were female; 80.9 percent were White; 5.3 percent were Hispanic; and 4.5 percent were Asian. Smoking was the most common route of administration (66.2 percent). Only 1.2 percent were younger than 18, and 23.2 percent were between the ages of 18 and 25.

Methamphetamine was present in 22.6 percent of drug items analyzed by NFLIS laboratories in 2012. Methamphetamine cost \$20 per dosage unit and ranged in price from \$80 to \$150 per gram, \$1,000 to \$1,400 per ounce, and \$13,000 to \$15,000 per pound. Statewide, Minnesota drug and violent crime task forces seized 27 methamphetamine labs in 2012.

Other stimulants of abuse include:

- Khat (pronounced "cot") is a plant that is indigenous to East Africa and the Arabian Peninsula. Users chew the leaves, smoke it, or brew it in tea for its stimulant effects. It is used within the Somali community in the Twin Cities.
- Methylphenidate (Ritalin®), a prescription medication used in the treatment of attention deficit hyperactive disorder, is also abused nonmedically to increase alertness and suppress appetite, often by adolescents and young adults. Crushed and snorted, or ingested orally, each pill sells for up to \$5 or is simply shared with others at no cost. It is sometimes known as a "hyper pill" or "the study drug." In April 2013, 5.9 percent of prescriptions reported to the Minnesota Prescription Monitoring Program were for methylphenidate, and 9 percent were for amphetamines. See exhibit 10.
- MDMA (3,4-methylenedioxymethamphetamine), also known as ecstasy, "X," or "e," sold for \$20 per pill. MDMA has stimulant and hallucinogenic properties. It produces feelings of energy and euphoria in users, but can adversely heighten body temperature and precipitate feelings of confusion and agitation. There were 19 exposures involving MDMA reported to Hennepin Regional Poison Center in 2012 and 8 through April 2013 (exhibit 8).
- "Molly" (slang for "molecular"), refers to the pure crystalline powder form of the drug MDMA. The Hennepin Regional Poison Center received 6 reports of Molly exposures from January through April 2013, and none in 2012.

Marijuana

Marijuana-involved visits at hospital emergency departments grew 52.5 percent from 2004 to 2010, and slightly declined from 2010 to 2011 (from 6,794 to 6,627).

In 2012, marijuana was the primary substance problem for 16.3 percent of total treatment admissions, compared with 16.6 percent in 2011. Of these, 32.3 percent were younger than 18; 36.8 percent were age 18–25; and only 12.8 percent were 35 and older. More than one-half (54.2 percent) were White; 28.4 percent were African-American; 6.7 percent were Hispanic; and 2.9 percent were American Indian. Females accounted for 22.4 percent; the lowest percentage of females in any drug category.

Marijuana/cannabis was present in 17.8 percent of items analyzed by NFLIS laboratories in 2012. Marijuana sold for \$5 per joint, and up to \$225 per ounce. The cost of standard grade Mexican marijuana ranged from \$600 to \$1,000. per pound and "BC Bud" from \$3,400 to \$4,200 per pound. The drug and violent crime task forces operating throughout the State reported a significant increase in the number of wild marijuana plants seized in 2012 (exhibit 11). Arrests for marijuana cultivation fell from 57 in 2011 to 49 in 2012.

Synthetic cannabinoids (cannabimimetics) refer to dried herbal mixtures that have been sprayed with synthetically produced chemicals that when smoked mimic the effects of THC, the active ingredient in plant marijuana. They are sold as "herbal incense" with a warning "not for human consumption." Although many such products are illegal to sell or possess under State and Federal laws, they continue to be sold online and at retail outlets under many names, such as "K2," "Spice," "Smoke XXXX," "Stairway to Heaven," or "California Dreams." The Hennepin Regional Poison Center reported 149 THC homolog exposures in 2011, 157 in 2012, and 30 in 2013 through April. From 2010 to 2011 hospital ED visits for synthetic cannabinoids rose from 170 to 418.

Hallucinogens and Emerging Synthetic Drugs

LSD (lysergic acid diethylamide) or "acid", a strong, synthetically produced hallucinogen, typically sold as saturated, tiny pieces of paper, known as "blotter acid," for \$5 to \$10 per dosage unit. The Hennepin Regional Poison Center reported 37 LSD exposures in 2012 and 10 in 2013 through April. Other emerging synthetic drugs include:

- Substituted cathinones are sold as so-called "bath salts" online and in "head shops," and consumed to produce effects similar to those of illegal drugs, such as cocaine or MDMA. The Hennepin Regional Poison Center reported 144 bath salt exposures in 2011, 87 in 2012 and 16 in 2013 through April. Substituted cathinones may contain mephedrone or many other chemicals alone or in combination, such as MDPV (3,4-methylenedioxypyrovalerone), methylone (3,4-methylenedioxymethcathinone or MDMC), naphyrone (naphthylpyrovalerone or NRG-1), 4-Fluoromethcathinone or 3-FMC0, methedrone (4-methoxymethcathinone or bk-PMMA or PMMC), or butylone (beta-keto-N-methylbenzodioxolylpropylamine or bk-MBDB). These are sold under names such as "Vanilla Sky," "Bliss," and "Ivory Wave." Mephedrone by itself is also known as "Meow Meow," "M-CAT," "Bubbles," or "Mad Cow." Because the actual ingredients are unknown, the effects are unpredictable and can include agitation, paranoid delusions, and extreme psychosis.

- Exposures to the 2C-E phenethylamine and related analogs reported to the Hennepin Regional Poison Center numbered 23 in 2011, 24 in 2012 and 9 in 2013 through April. Sold online as a "research drug" that is "not intended for human consumption," this chemical compound known as 2C-E (2,5-dimethoxy-4-ethylphenylethylamine) was intentionally consumed by a group of young people at a party in suburban Blaine, Minnesota, in March 2011 who were seeking effects similar to the stimulant drug MDMA or "ecstasy." All eleven users experienced profound hallucinations, became distressed, and sought hospital emergency department services. One 19-year-old male was pronounced dead at the hospital. The person who provided the substance was eventually convicted of third degree murder and sentenced to 10 years in prison.
- The chemical compound 1-benzylpiperazine (BZP) was present in 1.6 percent of drug items analyzed by the National Forensic Laboratory Information System in 2012. It is abused for its amphetamine-like effects.

Alcohol

Roughly one-half (46.5 percent) of total admissions to addiction treatment programs reported alcohol as the primary substance problem in 2012 (exhibit 5). Of these 9,798 patients, over one-half (57.3 percent) were 35 and older; 73.2 percent were White; 14.6 percent were African-American; and 4.1 percent were of Hispanic origin.

DRUG ABUSE-RELATED INFECTIOUS DISEASES

Hepatitis C, the contagious liver disease that results from infection with HCV, can range from a mild illness lasting a few weeks to a serious, lifelong chronic disease. Most people contract HCV by sharing needles or other equipment used to inject drugs. It is transmitted when blood from a person infected with HCV enters the body of someone who is not infected. As of December 31, 2012, there were 39,303 people living in Minnesota with past or present HCV infection, of which 62 percent resided in the seven-county Twin Cities metropolitan area (exhibit 12). The median age was 55 years. The population-based rate in Minnesota is highest for American Indians, with 2,929 cases per 100,000 population, followed by 2,136 for African-Americans, 425 for Hispanic-origin persons, 383 for Whites, and 362 per 100,00 population for Asian/Pacific Islanders. See exhibit 13.

As of December 31, 2012, 7,516 persons residing in Minnesota were known to be living with HIV/AIDS (acquired immunodeficiency syndrome), an increase of 5.3 percent from 2011. Most individuals resided in the seven-county Twin Cities metropolitan area. Regarding the mode of exposure among these cases, male-to-male sex (MSM) accounted for 67 percent of cases among males; injection drug use accounted for 5 percent; and MSM and injection drug use accounted for 7 percent. Among females, heterosexual contact accounted for 73 percent, and injection drug use 9 percent. See exhibit 14.

*With inquiries concerning this report, contact Carol Falkowski, Drug Abuse Dialogues,
Phone: 651-485-3187, E-mail carol.falkowski@gmail.com*

Exhibit 1

Drug-related deaths by county: 2006 - 2012

	2006	2007	2008	2009	2010	2011	2012
HENNEPIN COUNTY							
Meth	8	6	9	6	9	7	14
Cocaine	48	59	21	10	25	28	18
Opiates	69	67	84	77	65	84	84
RAMSEY COUNTY							
Meth	6	7	5	7	4	3	7
Cocaine	13	11	10	11	7	6	3
Opiates	27	39	31	36	27	36	45

SOURCE: Hennepin County Medical Examiner and Ramsey County Medical Examiner, 2013.

Exhibit 2

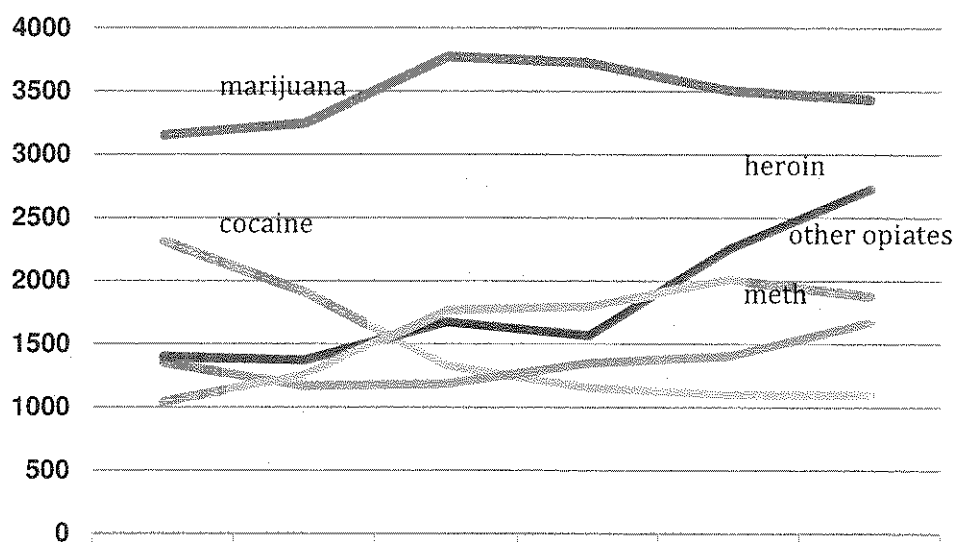
Estimates of drug-related emergency department visits
in Minneapolis/St. Paul/Bloomington, MN-WI
Metropolitan Statistical Area: 2004 - 2011

Drug	2004	2005	2006	2007	2008	2009	2010	2011
Cocaine	6,228	6,076	6,764	5,189	5,390	3,843	4,141	4,279
Heroin	1,189	1,023	1,312	1,691	1,651	1,855	2,256	3,493
Marijuana	4,455	4,468	4,302	5,757	5,617	5,596	6,794	6,627
Synthetic cannabinoids	*	*	*	*	*	*	170	418
Amphetamines	255	388	278	335	361	230	361	644
Methamphetamine	1,741	2,209	1,120	1,103	1,001	970	1,660	1,541
MDMA (Ecstasy)	204	254	252	433	485	475	362	397
PCP	*	69	132	*	*	80	*	*
Miscellaneous hallucinogens	123	68	*	142	134	115	138	153
Inhalants	183	128	*	80	100	92	126	*
Opiates/opioids, unspecified	162	282	495	559	1,052	826	1,150	1,619
Total Narcotic analgesics	1,940	1,872	2,491	3,391	3,905	3,890	4,697	4,836
Hydrocodone/combinations	562	506	625	985	1,016	1,019	1,092	1,044
Hydromorphone/combinations	*	87	115	142	252	256	297	284
Methadone	437	430	547	643	794	757	893	828
Morphine/combinations	108	120	193	272	265	288	334	413
Oxycodone/combinations	668	742	954	1,484	1,657	1,810	2,397	2,397

SOURCE: Drug Abuse Warning Network, Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, accessed 9/12/2012. These weighted estimates of ED visits are based on a representative sample of non-Federal, general, short-stay hospitals with 24-hour EDs in the Minneapolis/St. Paul/Bloomington, MN-WI Metropolitan Statistical Area.

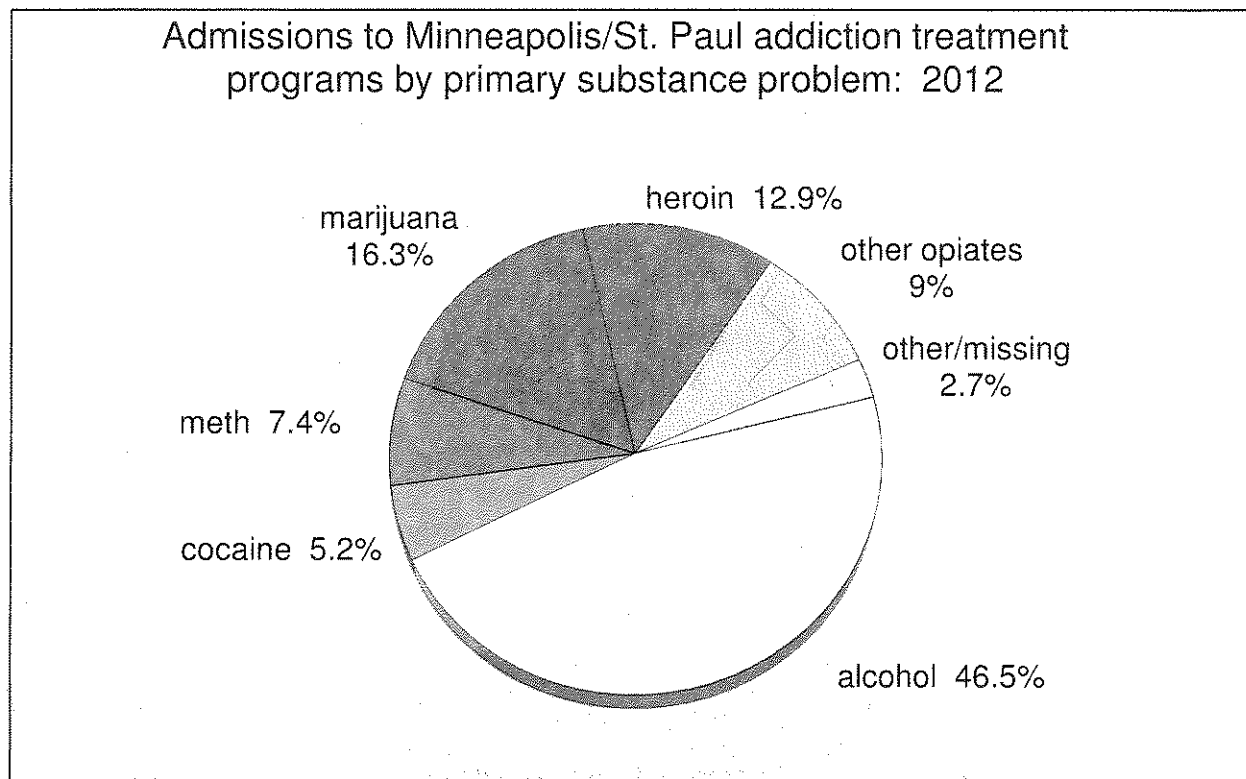
Exhibit 3

Number of admissions to Minneapolis/St. Paul addiction treatment programs by primary substance problem (excluding alcohol): 2007 - 2012



SOURCE: Drug and Alcohol Abuse Normative Evaluation System, Minnesota Department of Human Services, Performance Measurement and Quality Improvement Division, 2013.

Exhibit 4



SOURCE: Drug and Alcohol Abuse Normative Evaluation System, Minnesota Department of Human Services, Performance Measurement and Quality Improvement Division, 2013.

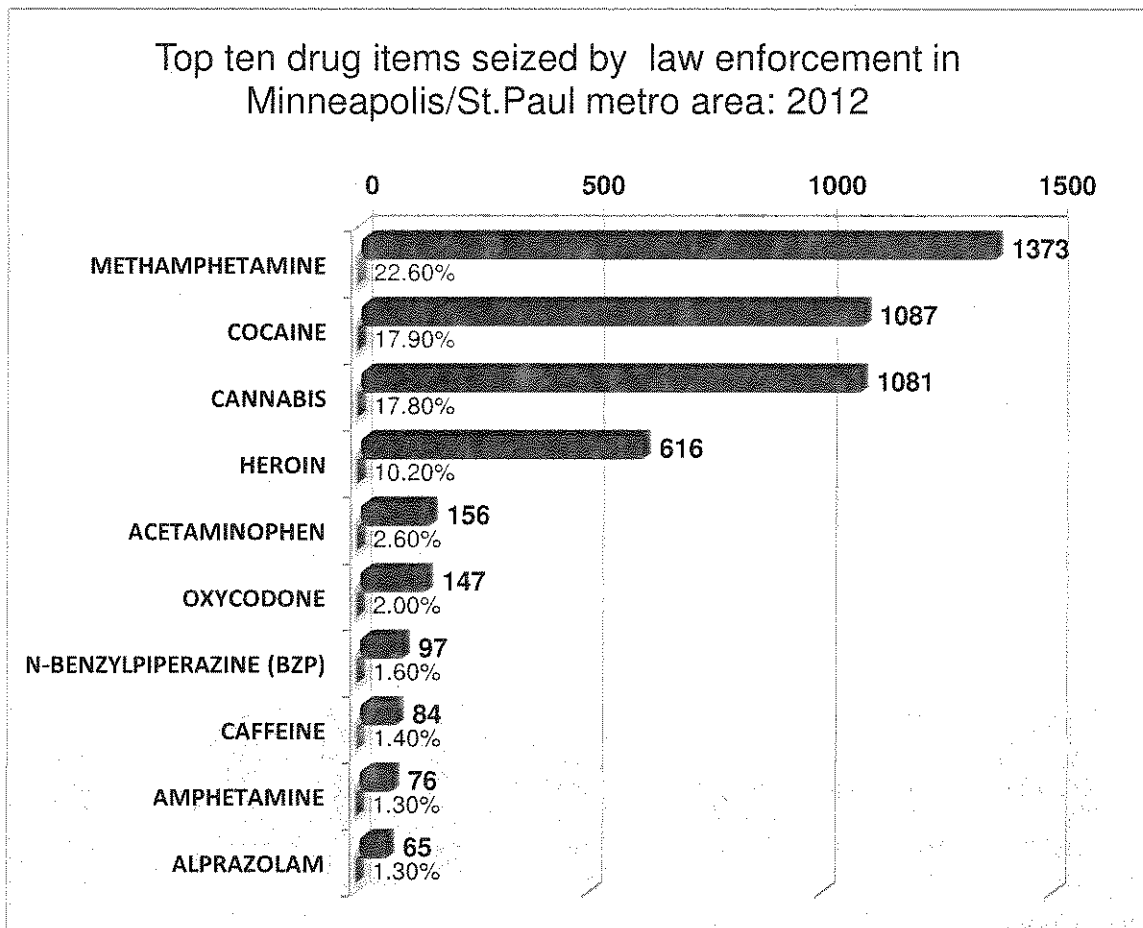
Exhibit 5

Characteristics of patients admitted to Minneapolis/St. Paul addiction treatment programs by primary substance problem: 2012

TOTAL ADMISSIONS 21,051	ALCOHOL 9,798 46.5%	MARIJUANA 3,435 16.3%	COCAINE 1,097 5.2%	METH 1,562 7.4%	HEROIN 2,724 12.9%	OTHER OPIATES 1,879 9.0%
GENDER						
% male	67.3	77.6	58.2	62.9	64.6	52.2
% female	32.7	22.4	41.8	37.1	35.4	47.8
RACE/ETHNICITY						
% White	73.2	54.2	34.1	80.9	66.1	77.9
% African Am	14.6	28.4	50.6	2.6	20.7	4.1
% Am Indian	3.5	2.9	4.5	3.5	6.1	8.3
% Hispanic	4.1	6.7	6.4	5.3	3.7	4.1
% Asian/Pacific Isl	1.6	1.5	1.3	4.5	1.0	3.1
% Other	3.0	6.2	3.2	3.2	2.4	2.4
AGE						
% 17 and under	1.8	32.3	0.9	1.2	1.5	2.7
% 18 - 25	16.8	36.8	10.1	23.2	41.6	26.2
% 26 - 34	24.1	18.2	16.6	38.7	24.2	32.5
% 35 +	57.3	12.8	72.4	36.8	32.5	38.7
ROUTE OF ADMINISTRATION						
% oral/multiple	100	2.5	-	3.7	1.0	65.4
% smoking		97.1	74.0	66.2	10.3	6.0
% snorting		-	22.4	6.9	26.3	15.4
% injection		-	1.4	20.6	60.6	11.1
% unknown		0.4	2.2	2.7	1.9	2.1

SOURCE: Drug and Alcohol Abuse Normative Evaluation System, Minnesota Department of Human Services, Performance Measurement and Quality Improvement Division, 2013. Unknown primary drug = 134 (0.6%). All other primary drugs = 422 (2%).

Exhibit 6



SOURCE: National Forensic Laboratory Information System (NFLIS), U.S. Drug Enforcement Administration (DEA) queried on May 7, 2013 according to location of seizure. All federal, state and local laboratory data are included in the total number of drug items seized as primary, secondary or tertiary drugs in the 7-county metro area including the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott and Washington in calendar 2012. St. Paul crime lab data were not reported after May 2012. All other = 1,285.

Exhibit 7

Changes in cocaine- and opiate- positive arrestees

Average Age of Arrestees Testing Positive for Cocaine Metabolites

ADAM Site	2000-2003	2007-2009	2010-2012
Atlanta*	35.1	40.8	41.2
Charlotte*	33.4	38.3	37.5
Chicago	36.0	37.2	37.2
Denver*	33.6	36.7	38.0
Indianapolis*	34.3	37.3	37.8
Minneapolis*	34.5	37.5	38.7
New York*	37.5	39.4	42.7
Portland*	35.3	37.7	37.6
Sacramento	37.0	37.4	35.4
Washington, DC*	37.4	44.9	43.7

Percentage of Arrestees 18-24 Testing Positive for Opiates

ADAM Site	2000-2003	2007-2009	2010-2012
Atlanta	25%	14%	23%
Charlotte	26%	17%	35%
Chicago	7%	13%	12%
Denver	26%	19%	16%
Indianapolis*	13%	33%	30%
Minneapolis*	13%	16%	34%
New York	11%	11%	11%
Portland*	18%	22%	27%
Sacramento	20%	19%	30%
Washington, DC	5%	3%	3%

SOURCE: Arrestee Drug Abuse Monitoring Program, 2012 Highlights, Office of National Drug Control Policy, presented by of M. Fe Caces, Statistician/Demographer, June 13, 2013, St Louis, Missouri. Used with permission. *Significant difference over time at $p < .05$

Exhibit 8

Exposures to selected drugs reported to Hennepin Regional
Poison Center: 2010 through April 2013

	2010	2011	2012	2013 thru April
THC Homologs	28	149	157	30
Bath Salts	5	144	87	16
2CE and Analogues	10	23	24	9
MDMA	26	24	19	8
Hydrocodone	621	655	713	207
Oxycodone	580	575	636	193
Heroin	52	78	127	41

SOURCE: Hennepin Regional Poison Center, Hennepin County Medical Center, 2013.

Exhibit 9

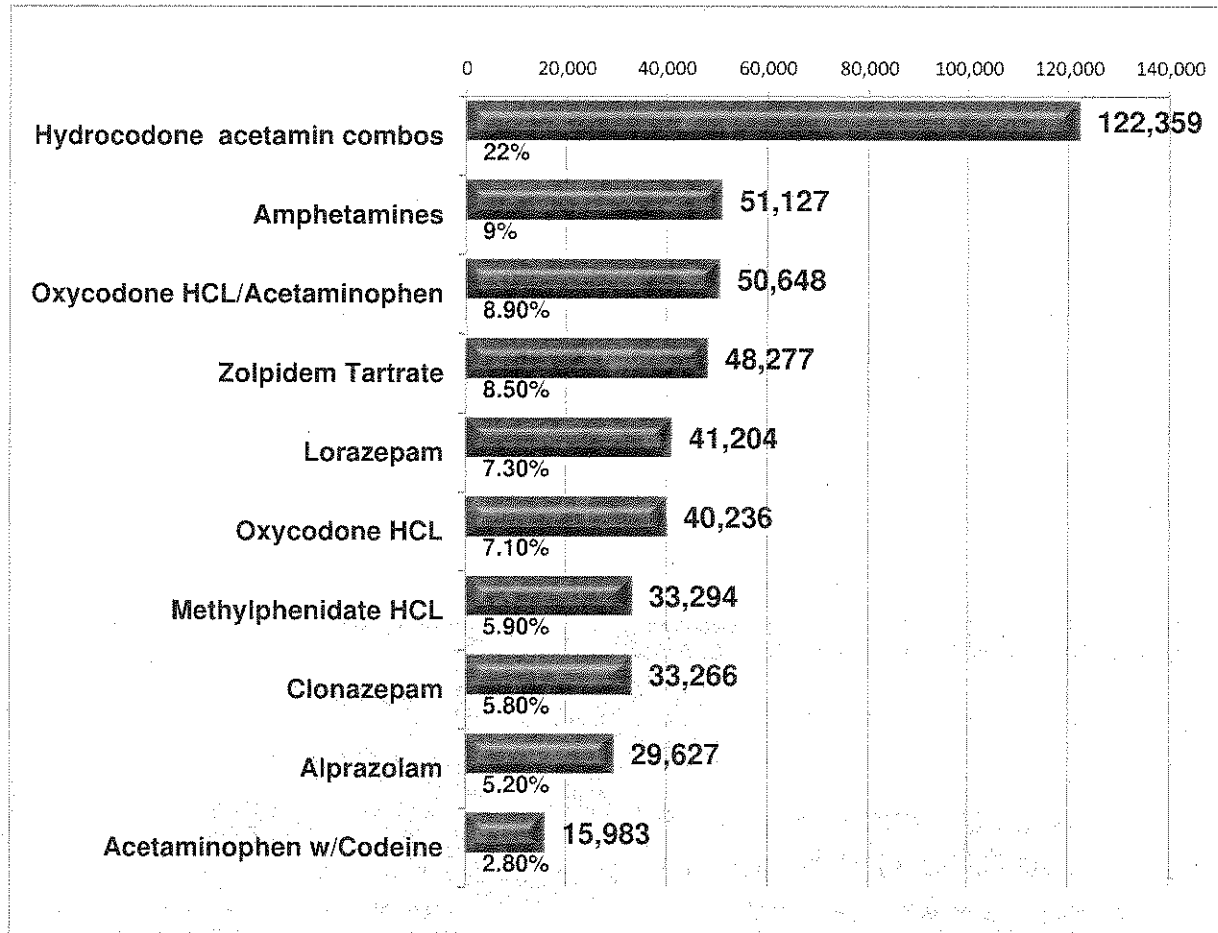
Opiate enforcement summary:
Minnesota Drug and Violent Crime Task Forces

	2010	2011	2012	% change 2011 to 2012
Heroin seized (grams)	228	406	2,794	588.1
Heroin arrests	108	206	482	133.9
Oxycodone seized (dosage units)	944	3,409	1,649	(51.6)
Rx drugs seized (dosage units)	16,414	10,711	14,254	33.1
Pill arrests	483	531	577	8.7

SOURCE: Office of Justice Programs, Minnesota Department of Public Safety, 2013 (unaudited). In 2012 there were 23 multijurisdictional law enforcement drug and violent crime task forces operating throughout the state and staffed by over 200 investigators from over 120 agencies.

Exhibit 10

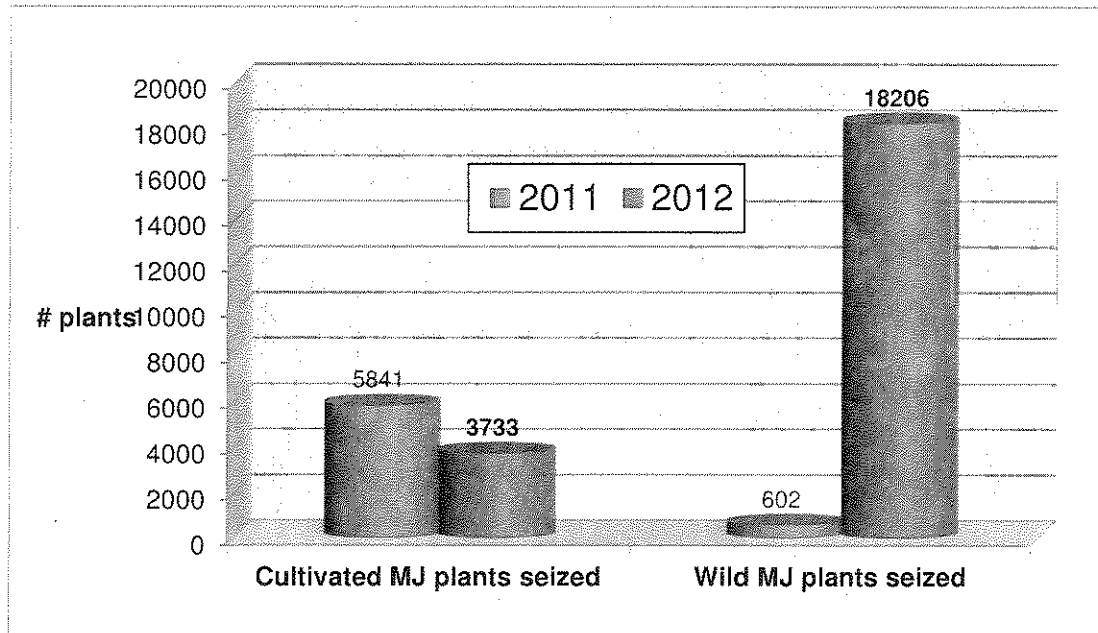
Top ten prescriptions dispensed in Minnesota: April 2013



SOURCE: Minnesota Prescription Monitoring Program, Minnesota Board of Pharmacy, May 2013. 566,453 prescriptions were dispensed and reported to the Minnesota Prescription Monitoring Program in April 2013.

Exhibit 11

Marijuana enforcement summary:
Minnesota Drug and Violent Crime Task Forces



SOURCE: Office of Justice Programs, Minnesota Department of Public Safety, 2013 (unaudited). In 2012 there were 23 multijurisdictional law enforcement drug and violent crime task forces operating throughout the state and staffed by over 200 investigators from over 120 agencies.

Exhibit 12

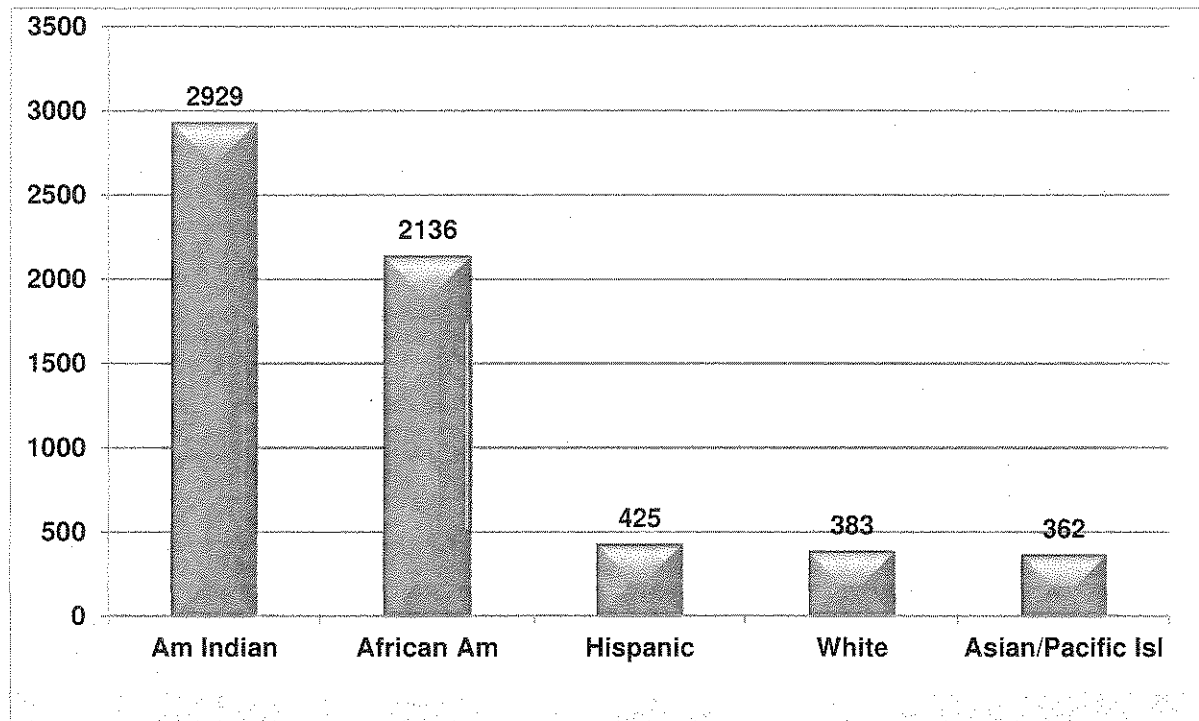
Persons living with Hepatitis C (HCV), HIV (non-AIDS)
and AIDS by in Minnesota by area of residence: 2012

	HCV	HIV	AIDS
St. Paul	11%	13%	14%
Minneapolis	23%	40%	39%
Suburban metro	28%	32%	32%
Rest of state	38%	14%	15%

SOURCE: Minnesota Department of Health. As of 12/31/2012 there were 37,819 individuals of known residence living with HCV; 3,949 living with HIV and 3,523 individuals living with AIDS. Residence information was missing for 1,484 individuals living with HCV, 5 individuals living with HIV, and 19 individuals living with AIDS. Percentages may not add to 100% due to rounding. Suburban counties include Anoka, Carver, Dakota, Hennepin (except Minneapolis), Ramsey (except St. Paul), and Washington.

Exhibit 13

Rates of past or present HCV in Minnesota by race
(per 100,000 population): 2012



SOURCE: Minnesota Department of Health. As of 12/31/2012 there were 39,303 individuals reported to MDH, assumed alive and living in Minnesota with past or present Hepatitis C (HCV) infection. Rates calculated using US Census data and excludes cases with multiple and unknown races. This includes persons who have been previously infected but do not have evidence of current infection.

Exhibit 14

Persons living in Minnesota with HIV (non-AIDS) and AIDS
by gender and mode of exposure: 2012

	Males				Females			
	HIV (non-AIDS)	AIDS	Total		HIV (non-AIDS)	AIDS	Total	
			Cases	%			Cases	%
Mode of Exposure								
MSM	2,112	1,745	3,857	67%	--	--	--	--
IDU	105	156	261	5%	69	89	158	9%
MSM/IDU	176	206	382	7%	--	--	--	--
Heterosexual (Total)	(91)	(135)	(226)	4%	(711)	(559)	(1270)	73%
with IDU	23	47	70	--	71	85	156	--
with Bisexual Male	-	-	-	--	50	43	93	--
with Hemophiliac/other	2	2	4	--	7	1	8	--
with HIV+	66	86	152	--	262	165	427	--
Hetero, unknown risk ^{IV}	0	0	0	--	321	265	586	
Perinatal	25	17	42	1%	41	10	51	3%
Other	9	20	29	1%	3	2	5	0%
Unspecified	292	329	621	11%	81	55	136	8%
No Interview, Unspecified	180	173	353	6%	79	46	125	7%
Total	2,990	2,781	5,771	100%	984	761	1,745	100%

SOURCE: Minnesota Department of Health. Cases reported as of 12/31/2012 assumed to be alive and currently residing in Minnesota. MSM = Men who have sex with men. IDU = Injecting drug use. Heterosexual = for males: heterosexual contact with a female known to be HIV+, an injecting drug user, or a hemophiliac/blood product or organ transplant recipient. For females: heterosexual contact with a male known to be HIV+, bisexual, an injecting drug user, or a hemophiliac/blood product or organ transplant recipient. Perinatal = Mother to child HIV transmission. Other = Hemophilia patient/blood product or organ transplant recipient. Unspecified = Cases who did not acknowledge any of the risks listed above. No Interview, Unspecified = Cases who refused to be, could not be or have not yet been interviewed.

The Minnesota Substance Abuse Strategy was developed in 2012 under the leadership of the Minnesota Department of Human Services in partnership with the Department of Education, Department of Health, Department of Public Safety, State Judicial Branch, Department of Corrections, Department of Military Affairs/ Minnesota National Guard and Minnesota Board of Pharmacy.

Minnesota State Substance Abuse Strategy

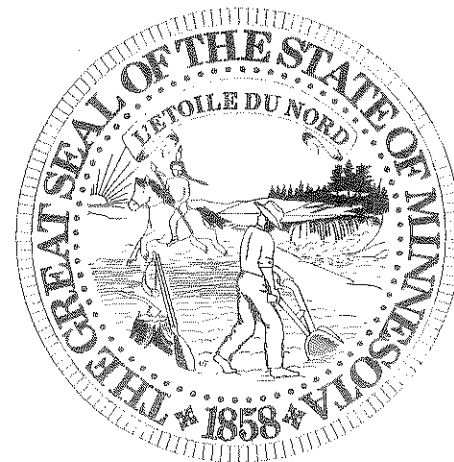


Table of Contents

Executive Summary	1	IV Guiding Principles	46
I Background and Purpose	2	A. Collaboration.....	46
A. Overview	2	B. Prevention and Early Intervention Work Best	46
B. Magnitude of the Problem: Economic Costs	3	C. Reduce Health Disparities and Promote Cultural Competence.....	46
C. Purpose of This Report	5	D. Sustain a Continuum of Services	47
II Understanding Substance Abuse and Addiction	7	E. An Integrated Approach to Service Delivery in Health Care	47
A. The Nature and Extent of Substance Abuse	7	F. Substance Use Disorders are Treatable	47
B. Emerging Trends in Substance Abuse	9	G. Recovery is Possible	47
C. Prevention Defined	13	V Immediate Policy Priorities: Prescription Opiate and	
D. Addiction Defined	16	Heroin Abuse and Addiction	48
E. The Treatment of Addiction	18	VI Strategies: A Blueprint for the Future.....	48
F. The Outcomes of Addiction Treatment	21	A. Strengthen prevention efforts within and across communities	48
G. The Related Health Care Consequences of Substance Abuse and Addiction	23	B. Create more opportunities for early intervention in health care and other settings.....	49
III Current Minnesota State Agency Responses to Substance Abuse and Addiction.....	25	C. Integrate the identification and treatment of substance use disorders into health care reform efforts.....	49
A. Department of Human Services	25	D. Expand support for recovery	49
B. Department of Education	33	E. Interrupt the cycle of substance abuse, crime and incarceration	49
C. Department of Health	33	F. Reduce trafficking, production, and sale of illegal drugs in Minnesota	49
D. Department of Public Safety	35	G. Measure with accurate and timely data the emerging nature and extent of substance abuse and scientifically evaluate the results of various interventions	49
E. State Judicial Branch.....	37	APPENDIX	51
F. Department of Corrections	39		
G. Department of Military Affairs/Minnesota National Guard	43		
H. Minnesota Board of Pharmacy	43		
I. Minnesota Health Professionals Services Program.....	43		
J. Ongoing Multi-Agency Efforts	44		

Executive Summary

Substance abuse, untreated addiction, underage drinking and tobacco use have a significant and costly impact on the health, well-being and public safety of our state and nation. Substance abuse and underage drinking negatively affect adolescent development, academic performance, gainful employment and social relationships. They are linked to increased crime, illnesses, child abuse and neglect, unwanted pregnancies, birth defects, accidental injuries, motor vehicle crashes and fatalities and accidental overdose deaths. Substance abuse, untreated addiction, underage drinking and tobacco use all significantly contribute to increased health care costs that are borne largely at public expense.

Because responding to the multi-faceted, far reach of substance abuse extends beyond the purview of any single state agency, it is critical that Minnesota develop a collaborative and comprehensive multi-agency approach. Thus, in order to effectively and efficiently address the issue, the development of this statewide substance abuse strategy involved the input of multiple state agencies over the course of many months.

This Minnesota Substance Abuse Strategy is designed to help make Minnesota a healthier, safer and stronger state. It is based on the knowledge that addiction is a treatable disease, that a continuum of care is needed to effectively address the needs of individuals, families and communities affected by substance abuse and addiction; and that the nature of addiction specialty services will change as they become more integrated into the broader health care system. It is guided by the shared principles of collaboration and community/cultural responsiveness and competence, and informed by the proven effectiveness of prevention, treatment and recovery services.

This document describes the current substance abuse situation in Minnesota and the associated activities of various Minnesota state agencies. In response to the escalating public health and safety threat that stems from the unprecedented

abuse of prescription drugs and heroin in Minnesota, it outlines an immediate, priority policy plan of action. To guide future efforts to address substance abuse in Minnesota, it sets forth a long-term strategy - a blueprint for the future. Below are the defining elements of the Minnesota Substance Abuse Strategy:

- Strengthen prevention efforts within and across communities. Preventing substance abuse before it happens saves lives and cuts long-term costs.
- Create more opportunities for early intervention in health care and other settings. Medical professionals, school-based counselors, and others must be able to identify the early signs of substance abuse and intervene early.
- Integrate the identification and treatment of substance use disorders into health care reform efforts. With health care reform, treatment providers will need to adopt new business practices. The need for substance use-related services within primary care will increase.
- Expand support for recovery. For many people treatment is the first step in recovery. Community-based recovery organizations can play an important role in helping people maintain recovery throughout their lifespan.
- Interrupt the cycle of substance abuse, crime and incarceration. At all levels of government, fair and effective criminal justice interventions must be combined with evidence-based treatment, prevention and recovery efforts to stop the revolving door in and out of the criminal justice system.
- Reduce trafficking, production and sale of illegal drugs in Minnesota. Law enforcement agencies must continue to work together in order to effectively identify, disrupt, and dismantle the increasingly sophisticated criminal organizations that traffic in illegal drugs.
- Measure the emerging nature and extent of substance abuse and scientifically evaluate the results of various interventions. Policy must be grounded in sound scientific evidence and ongoing, quality surveillance systems.

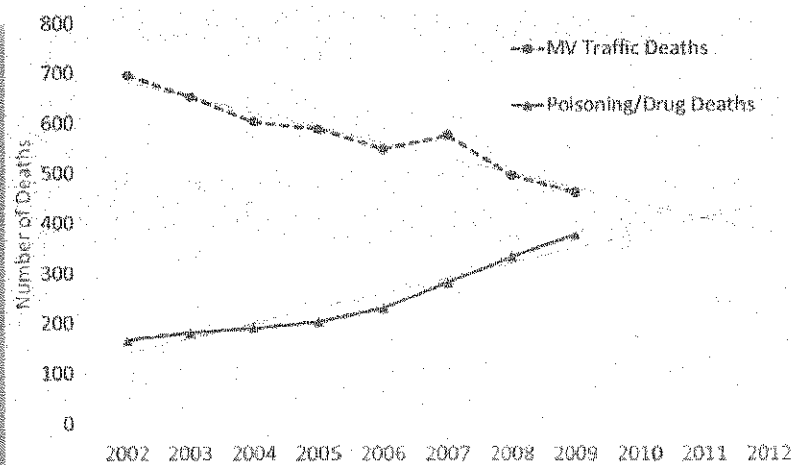
I. Background and Purpose

A. Overview

The abuse of and addiction to alcohol, tobacco and other drugs diminish the quality of life for all Americans, and compromise the safety of our roads, the security of our families, and the well-being of our communities. Substance abuse and untreated substance use disorders create a heightened threat to public safety and public health and exact enormous costs for law enforcement, courts, corrections, human services and public health systems.

The leading cause of death from injuries in the United States is poisoning. Nearly 9 out of 10 poisoning deaths are caused by drugs. Opioid analgesics were involved in more than 40 percent of drug poisoning deaths in 2008. Opioid analgesics include hydrocodone, oxycodone, morphine and methadone. In Minnesota, it is expected that unintentional poisoning/drug deaths will soon exceed motor vehicle traffic deaths.

Minnesota's unintentional poisoning/drug deaths are expected to exceed motor vehicle traffic deaths



SOURCE: Centers for Disease Control and Prevention (CDC), National Center for Health Statistics. Underlying Cause of Death 1999-2009 on CDC WONDER Online Database, released 2012. Accessed at <http://wonder.cdc.gov/ucd-icd10.html> on Apr 24, 2012 1:09:45 PM

Moreover, deaths attributable to the abuse of legal drugs, alcohol and tobacco, far exceed the number of deaths attributable to illicit drugs.

The findings in the following table indicate that deaths from tobacco and alcohol consumption vastly exceed those from illicit drug use.

Actual Causes of Death in the United States 1990 and 2000

Actual cause	Number (%) in 1990	Number (%) in 2000
Tobacco	400,000 (19)	435,000 (18.1)
Poor diet & physical inactivity	300,000 (14)	365,000 (15.25)
Alcohol consumption	100,000 (5)	85,000 (3.5)
Microbial agents	90,000 (4)	75,000 (3.1)
Toxic agents	60,000 (3)	55,000 (2.3)
Motor vehicles	25,000 (1)	43,000 (1.8)
Firearms	35,000 (2)	29,000 (1.2)
Sexual behavior	30,000 (1)	20,000 (0.8)
Illicit drug use	20,000 (<1)	17,000 (0.7)
Total	1,060,000 (50)	1,124,000 (46.6)

SOURCE: Warner M, Chen LH, Makuc DM, Anderson RN, Miniño AM: Drug Poisoning Deaths in the United States, 1980-2008. NCHS Data Brief, No. 81, December 2011 and Mokdad AH, Marks JS, Stroup DF, Gerberding JL: Actual causes of death in the United States, 2000. JAMA. 2004 Mar 10;291(10):1238-45. Erratum in: JAMA. 2005 Jan 19;293(3):293-4. JAMA. 2005 Jan 19;293(3):298.

Most diseases and injuries have multiple potential causes and several factors and conditions may contribute to a single death. Therefore, to estimate the contribution of each factor to mortality is challenging. Investigators from the federal Centers for Disease Control and Prevention (CDC) used published causes of death, relative risks, and prevalence estimates from published literature and governmental reports to describe the actual causes of death in the United States as presented above.

B. Magnitude of the Problem: Economic Costs

Substance abuse and addiction are costly social phenomenon. The collateral consequences of substance

abuse and addiction are borne mostly at public expense, and include detoxification services, healthcare services including emergency room and addiction treatment services, child protective services, law enforcement, courts, and correctional services. These costs rarely appear as a single line item in a budget, because services and responses to substance abuse-related issues are delivered by multiple agencies that do not necessarily have substance abuse or addiction in their title.

Nationwide research studies have determined the annual cost of substance abuse to the country is \$510.8 billion in 1999.

(SOURCE: Miller, T. and Hendrie, D. Substance Abuse Prevention Dollars and Cents: A Cost Benefit Analysis, DHHS Publication No. (SAM) 07-4298, Rockville, MD., Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2008.)

Estimated economic cost of substance abuse to society in billions - 1999

Resource costs	Alcohol	Tobacco	Drugs	Total
Specialty treatment and prevention services	7.8	n/a	7.6	15.4
Treatment of medical consequences	20.0	75.9	5.4	101.3
Goods, services related to crashes, fires, crime, criminal justice	24.4	n/a	31.1	55.5
TOTAL RESOURCE COSTS				172.2
Productivity costs				
Work loss due to premature death	37.4	81.9	20.9	140.2
Work loss related to substance abuse --related illness	91.1	10.0	26.7	127.8
Work loss by crime victims	1.0	n/a	2	3
Work loss due to incarceration and criminal careers	9.9	n/a	57.7	67.6
TOTAL PRODUCTIVITY COSTS				338.6
Total resource and productivity costs	191.6	167.8	151.5	510.8

SOURCE: Miller, T. and Hendrie, D. Substance Abuse Prevention Dollars and Cents: A Cost Benefit Analysis, DHHS Publication No. (SAM) 07-4298, Rockville, MD., Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2008.

Looking at national estimates of the cost of illness for 33 specific diseases and conditions, alcohol ranked second, tobacco sixth, and drug disorders seventh. (SOURCE: National Institutes of Health (2000) Disease-specific estimates of direct and indirect costs of illness and NIH support: Fiscal year 200 update. Bethesda, MD: Office of the Director, Office of Science, Policy and Planning as cited in Miller, T. and Hendrie, D. Substance Abuse Prevention Dollars and Cents: A Cost Benefit Analysis, DHHS Publication No. (SAM) 07-4298, Rockville, MD., Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration, 2008.)

A recent (2009) report from The Center on Addiction and Substance Abuse (CASA) at Columbia University identified the total amount spent by federal, state and local governments on substance abuse and addiction. It is estimated that collectively state governments spend

15.7 percent of their budgets (\$135.8 billion) dealing with substance abuse and addiction (up from 13.3 percent in 1998) and that federal and state governments collectively spend more than 60 times as much to clean up the devastation substance abuse and addiction inflicts on children as they do on prevention and treatment for them. (SOURCE: Shovel Up II: The Impact of Substance Abuse on Federal, State and Local Budgets, National Center on Addiction and Substance Abuse (CASA), Columbia University, New York, New York, May 2009.)

A National Policy Panel convened by Join Together with support from the Robert Wood Johnson Foundation, estimated the percentage of state agency budgets spent on alcohol and drug related problems and summarized the positive impact of prevention and treatment in the following table.

State agency	% of agency budgets spent on drug/alcohol problems	Positive impact of Prevention and treatment
Health	25	Families receiving addiction treatment spent \$363 less per month on regular medical care than untreated families.
Criminal Justice	77	Re-arrest rates dropped from 75 to 27 percent when inmates received addiction treatment.
Child Welfare	70	Children whose parents receive addiction treatment are less likely to remain in foster care.
Juvenile Justice	66	Adolescent re-arrest rates decrease from 64.5 percent to 35.5 percent after one year of residential treatment.
Welfare	16 - 17	After completing treatment there is a 19 percent increase in employment and an 11 percent decrease in clients receiving welfare.
Mental Health	51	Treating mental health and substance abuse disorders collaboratively produces better outcomes.
Developmental Disabilities	9	Fetal Alcohol Syndrome affects 40,000 infants annually.

SOURCE: Blueprint for the States: Policies to improve the ways states organize and deliver alcohol and drug prevention and treatment, Join Together, Boston University School of Public Health, 2006.

In Minnesota, the estimated annual cost of alcohol use in 2007 was over \$5 billion, specifically \$5,062,000,000. This translates into a cost of \$975 per person in Minnesota.

These costs were 17 times greater than the \$296 million in tax revenues collected from the sale of alcohol. (SOURCE: The Human and Economic Cost of Alcohol Use in Minnesota, Minnesota Department of Health, March 2011)

Numerous scientific studies document the economic and societal benefits of prevention and treatment.

A recent study of prevention conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that every dollar spent on effective school-based prevention programs can save an estimated \$18 in subsequent problems later in life. In addition, if effective prevention programs were implemented nationwide, substance abuse initiation would decline by 1.5 million youth, and be delayed by two years on average. (SOURCE: Miller, T. and Hendrie, D. Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis, DHHS-Pub. No. (SMA) 07-4298. Rockville, MD: Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention, 2009.)

The National Institute on Drug Abuse estimates that every dollar invested in substance abuse treatment yields a return of up to \$12 in reduced drug-related crime, criminal justice and health care costs. Societal savings are also realized in terms of reduced interpersonal conflicts, increased workplace productivity and a decline in accidents. (SOURCE: Principles of Addiction Treatment, NIH Publication No. 00-4180, National Institute on Drug Abuse, 2000)

C. The Purpose of this Report

The direct and collateral consequences of substance abuse and addiction are far-reaching, serious, and costly. Responding to them requires the efforts of multiple state government agencies. Therefore, it is critical that Minnesota develop a comprehensive statewide substance abuse and addiction strategy that stems from the collective efforts of multiple state agencies, and seeks to maximize the use of state dollars, while eliminating duplication of effort and ineffective approaches.

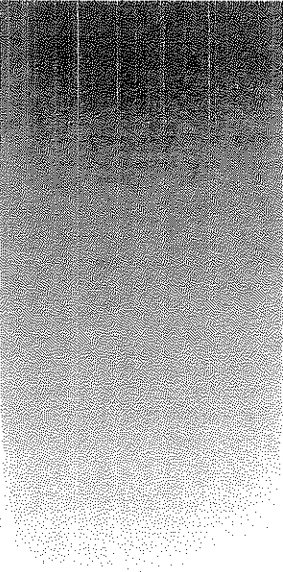
The overarching purpose of this multi-agency initiative, the efforts of which culminate in this document, is to better align resources with long-term goals and proven strategies that effectively reduce illicit drug abuse and its consequences in the state of Minnesota.

The authority of the Minnesota Department of Human Services (DHS) to develop this broad-based, statewide strategy lies in Minnesota Statutes Chapter 254A which creates an Alcohol and Other Drug Abuse Section in the Department of Human Services that shall, among other things, 1) coordinate and review all activities and programs of all the various state departments as they relate to alcohol and other drug dependency and abuse problems, and 2) establish a state plan which shall set forth goals and priorities for a comprehensive alcohol and other drug dependency and abuse program for Minnesota.

Addressing substance abuse and addiction includes a balance of prevention, intervention, treatment and recovery support services, as well as involvement of the health care, public health, American Indian tribes and law enforcement, judicial and correctional systems.

This document encompasses all forms of illicit drug abuse and addiction, tobacco use, and alcohol abuse and addiction, including underage drinking by minors and drinking by adults in a manner that violates current laws, such as driving while intoxicated.

To help ensure a safer future for all Minnesotans with reduced levels of substance abuse and addiction, as well as ensure more



effective prevention, intervention, treatment and recovery services, this initiative advances the following vision: 1) That more Minnesota communities are free from alcohol, tobacco, and illegal drug abuse, and addiction and 2) That more Minnesota communities realize reduced collateral and direct consequences, heightened public safety and improved public health as the result of reduced alcohol, tobacco and drug abuse and addiction.

II. Understanding Substance Abuse and Addiction

A. The Nature and Extent of Substance Abuse

How widespread is substance use in Minnesota and how do we compare with other states?

The most recent state estimates are derived from the National Survey on Drug Use and Health (NSDUH), administered by the Substance Abuse and Mental Health Services Administration (SAMHSA) in 2006 and 2007. "Current use" is defined as any use in the past month. See Appendix Tables 1 through 6.

The Minnesota rate of current alcohol use is among the highest of any state in the nation. An estimated 60.7 percent of Minnesotans age 12 and above consumed alcohol in the past month. The highest rate was 63.1 percent in Rhode Island and the lowest was 30.9 percent in Utah. This compares with a rate of 51.4 percent nationally. See Appendix Exhibit 1.

Minnesota also has a high rate of binge alcohol use, defined as consuming five or more alcoholic drinks on one occasion for males and four or more for females. An estimated 28.7 percent of Minnesotans age 12 and above report binge drinking in the past month. North Dakota was highest with 32 percent and Utah the lowest with 15.6 percent. Nationally an estimated 23.1 percent of people age 12 and above report binge alcohol use in the past month. See Appendix Exhibit 2.

Tobacco is the second most commonly used substance in the United States. Nationally, an estimated 29.1 percent of people age 12 and above, report tobacco use in the past month. In Minnesota, an estimated 30.8 percent of people age 12 and above report the use of tobacco in the past month. Kentucky has the highest rate with 37.1 percent and Utah the lowest with 29.9 percent. See Appendix Exhibit 3.

When it comes to illegal drug abuse, Minnesota generally ranks in the middle range, relative to other states. An estimated 8.3 percent of Minnesotans age 12 and above

report the use of illegal drugs in the past month. This compares with a high of 12.5 percent in Rhode Island and a low of 5.2 percent in Iowa. Nationally, an estimated 8.1 percent of people age 12 and above, report the use of illegal drugs in the past month. See Appendix Exhibit 4.

Marijuana is the most commonly used illegal substance in Minnesota. Relative to rates of marijuana use in other states, Minnesota is somewhat at the higher end. An estimated 7.3 percent of Minnesotans age 12 and above report the use of marijuana in the past month. This compares with 5.9 percent nationally and the highest rate of 10.3 percent in Rhode Island, the lowest rate of 3.8 percent in Iowa. See Appendix Exhibit 5.

Over the past decade the increased nonmedical use of prescription drugs, in particular prescription narcotic pain relievers, has resulted in increased numbers of drug induced deaths, hospital emergency room episodes, and admissions to addiction treatment centers. The rate of nonmedical use of pain relievers in Minnesota in the past year by people age 12 and above is 4.4 percent, compared with 5 percent nationally. This compares with a high of 6.2 percent in Tennessee and a low of 3.8 percent in Hawaii. See Appendix Exhibit 6.

Within Minnesota there are regional variations in the extent of use of various substances. These differences are derived from sub-state estimates of the National Survey of Drug Use and Health from SAMHSA, which combine 2006, 2007 and 2008 NSDUH data and are presented in Appendix Exhibits 7, 8, 9 and 10.

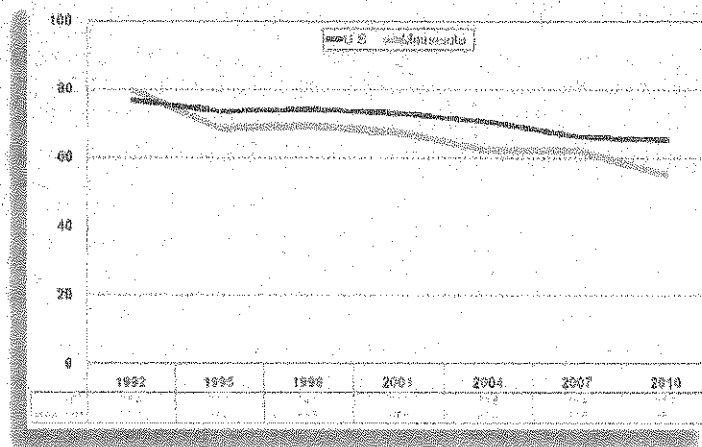
In general terms, current alcohol use is highest in the Twin Cities metro area. Binge alcohol use is more prevalent in the northern and southern outstate regions of Minnesota. Illicit drug use is most common in the northern part of the state and in Ramsey and Hennepin Counties. Marijuana use is equally and most prevalent in the Twin Cities and northern part of the state.

While the preceding findings refer to the population age 12 and above, drug and alcohol use among high school students is of heightened concern. Epidemiological and longitudinal studies have established that those who start alcohol use at age 15 or younger are many times more likely to develop addiction in the course of their lifetime than those who initiate use at the age of 21 or 22. (SOURCE: Grant, B.F., and Dawson, D.A. Age at onset of drug use and its association with DSM-IV drug abuse and dependence: Results from the National Longitudinal Alcohol Epidemiologic Survey, *Journal of Substance Abuse* 10:163-173, 1998. PMID: 9854701).

The following tables present trends in alcohol and drug abuse by Minnesota high school seniors as measured by responses to the Minnesota Student Survey, compared with a national sample of high school seniors surveyed in the National Monitoring the Future Survey, conducted by the University of Michigan. As shown below there have been significant declines in the use of alcohol, tobacco, and methamphetamine by 12th graders, both in Minnesota and nationally.

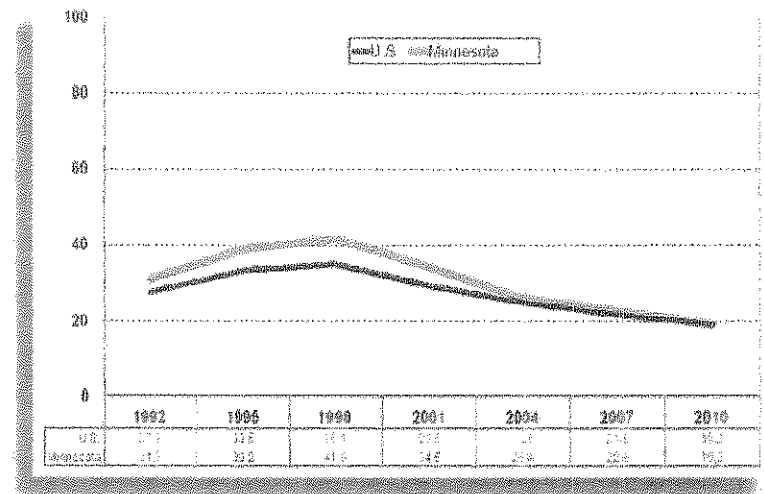
Alcohol use in the past year by 12th graders nationally and in Minnesota: 1992 - 2010*

% of 12th graders reporting



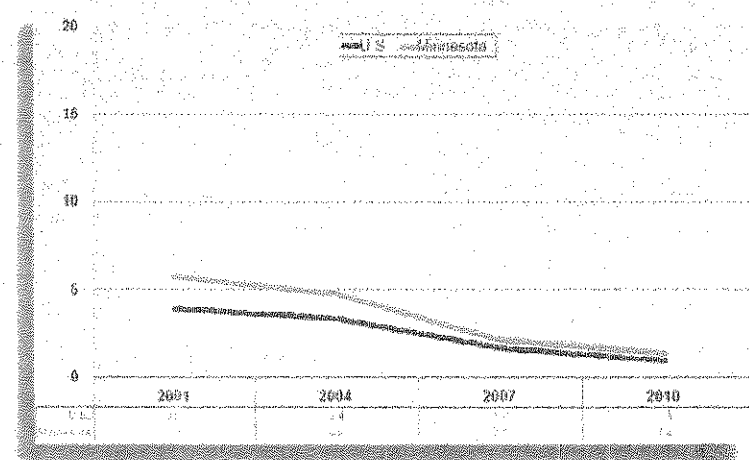
Cigarette smoking in the past 30 days by 12th graders nationally and in Minnesota: 1992 - 2010*

% of 12th graders reporting



Methamphetamine use in the past year by 12th graders nationally and in Minnesota: 1992 - 2010*

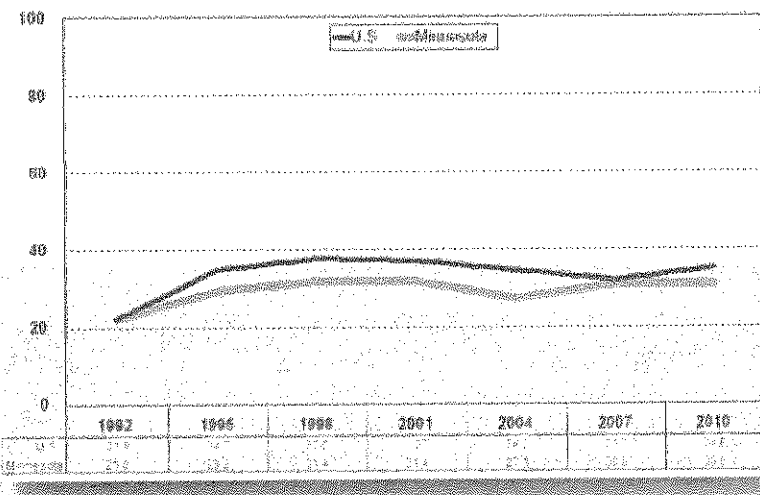
% of 12th graders reporting



While significant progress has been made in reducing the extent of alcohol, tobacco and methamphetamine use among high school seniors, both in Minnesota and nationally, that is not the case with marijuana use. In Minnesota, marijuana use among high school seniors was virtually unchanged from 2007 to 2010, with 30 percent reporting use in the past year. See graph below.

Marijuana use in the past year by 12th graders nationally and in Minnesota: 1992 - 2010*

% of 12th graders reporting



* SOURCE: Monitoring the Future Study, University of Michigan News Services retrieved on 12/14/2010 from www.monitoringthefuture.org and the Minnesota Student Survey.

In addition to the immediate heightened risks due to their impaired judgment while under the influence of drugs and alcohol, research finds strong associations between lower academic grades and the use of alcohol and marijuana in high school.

(SOURCE: CDC Youth Risk Behavior Survey Fact Sheet on Alcohol and Other Drug Use and Academic Achievement, 2010).

B. Emerging Trends in Substance Abuse

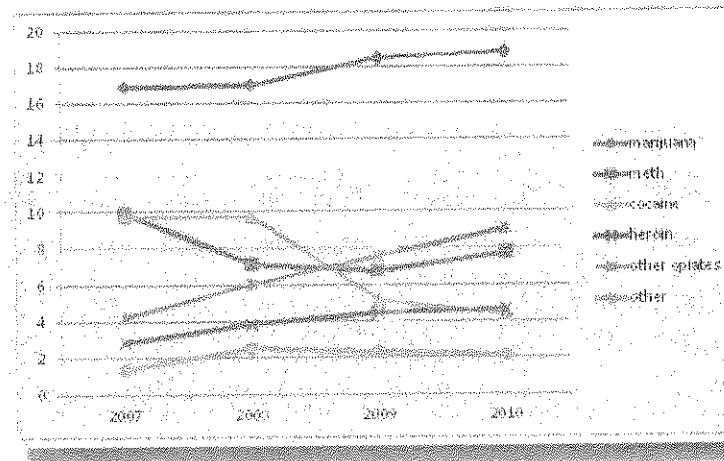
1. Opiate Abuse

Gradually over the past decade the abuse of heroin and prescription opiates, specifically narcotic analgesics also known as painkillers, has escalated throughout the state. Opiates have high abuse potential, high addictive potential and high overdose potential.

The rise in heroin and opiate addiction in Minnesota is reflected in the statewide treatment data presented below.

Minnesota statewide addiction treatment admissions by primary substance of abuse (excluding alcohol): 2007 - 2011

Percent of total admissions

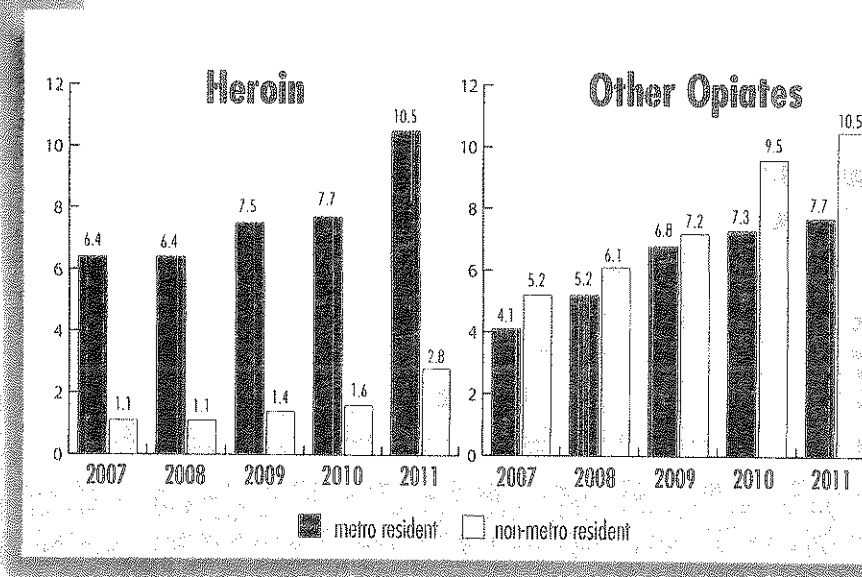


SOURCE: Drug and Alcohol Abuse Normative Evaluation System (DAANES), Minnesota Department of Human Services, Performance Measurement and Quality Improvement Division, 2012.

This recent increase in the percentage of treatment admissions that report heroin or other opiates as the primary substance problem is apparent for both metro and non-metro residents. As shown below, in 2011, 10.5 percent of metro

residents entering treatment reported heroin as the primary substance problem and 10.5 percent of non-metro residents reported other opiates as the primary problem.

Percentage of total Minnesota treatment admissions for heroin and other opiates by county of residence: 2007 - 2011



SOURCE: Drug and Alcohol Abuse Normative Evaluation System (DAANES), Minnesota Department of Human Services, Performance Measurement and Quality Improvement Division, 7/12/2012. Metro refers to the 7-county metropolitan area of Minneapolis/St. Paul, Minnesota. Non-metro refers to all other Minnesota counties.

Minnesota has white powdered heroin, brown powdered heroin, and black tar heroin, all from Mexico, and all of which produce similar effects. According to the Drug Enforcement Administration's (DEA's) Heroin Domestic Monitoring Program, the purity of Mexican heroin in Minneapolis is among the highest in the country, and the cost of heroin per pure milligram is among the lowest.

Mexican heroin price and purity: Minneapolis 2007 - 2009

	2007	2008	2009
Purity	59.9%	54.75%	53.35%
\$/pure milligram	\$0.29	\$0.26	\$0.25
# qualified samples	16	13	4

SOURCE: US Drug Enforcement Administration, US Department of Justice, 2009 Heroin Domestic Monitor Program, DEA-NCW-RPT-013-10, November, 2010.

At the same time heroin abuse has risen, so has the nonmedical use of prescription drugs, particularly prescription opiates. Because prescription opiates produce a strong euphoric effect that is similar to heroin intoxication, some opiate addicts will switch to heroin use if the circumstances are right. While a person may initially become addicted to prescription narcotics, they will often switch to using heroin: 1) If heroin is easily accessible 2) If heroin is more affordable than pills and 3) If heroin is of comparable quality. Therefore, the fact that the Twin Cities has the highest purity heroin at the lowest is of added significance.

Minnesota law enforcement narcotics agents increasingly encounter heroin and prescription narcotics as well. This is clearly reflected in the summary data from multijurisdictional narcotics task forces.

Opiate Summary Minnesota Drug Task Forces 2010 - 2011:

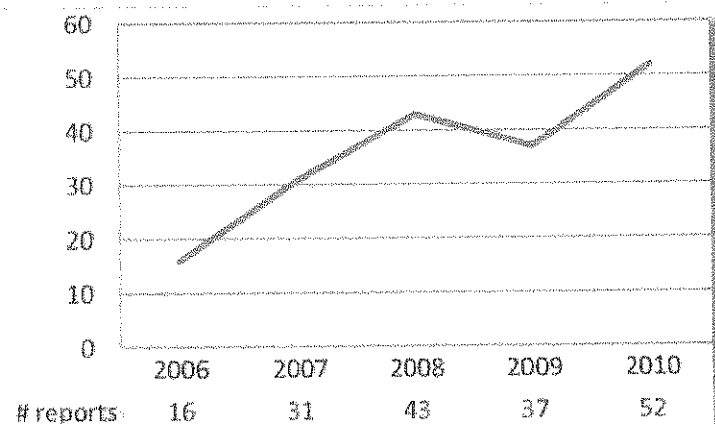
	2010	2011	Percent change 2010 to 2011
Heroin seized (grams)	228	406	78.1
Heroin arrests	108	206	90.7
Oxycodone seized (dosage units)	944	2,586	173.9
Pill arrests	483	502	3.9
% of total arrests that involve pills	14.3	14.0	--

SOURCE: Minnesota Office of Justice Programs, Minnesota Department of Public Safety, 2012 (audited). As of January 2012, there are 23 multijurisdictional law enforcement drug and violent crime task forces operating throughout Minnesota, staffed by over 200 investigators from over 120 agencies.

Law enforcement sources also report various criminal networks that sometimes exchange heroin for prescription opiates. In 2011, the Red Lake Nation, Leech Lake, and the White Earth Band of Chippewa declared public health emergencies with respect to prescription and illegal drug abuse on their reservations that are located in northern Minnesota. Addiction to prescription narcotics is at record-high levels according to numerous sources, and the collateral consequences of widespread prescription narcotic abuse, trafficking and addiction have continued to erode the quality of life and public safety in the communities.

Another indicator of rising prescription drug abuse can be found by examining the reports of loss or theft of controlled substances from a Minnesota hospital pharmacy, clinic pharmacy, retail pharmacy physically co-located in a clinic or hospital or from practitioners who were licensed to store controlled substances for use by patients (e.g., outpatient surgery center). These are reported to the U.S. Drug Enforcement Administration on "Form DEA-106, Theft or Loss of Controlled Substances." The table below presents the annual number of those reports filed from 2006 through 2010.

Theft or loss of controlled substances in Minnesota reported to the DEA: 2006 - 2010



SOURCE: Minnesota Department of Health from the U.S. Drug Enforcement Administration. Compiled from "Form DEA-106, Theft or Loss of Controlled Substances." This form is filed to report a theft or loss of controlled substances due to "employee pilferage" or "other" that occurred at a Minnesota hospital pharmacy, clinic pharmacy, retail pharmacy physically co-located in a clinic or hospital, or practitioners who were licensed to store controlled substances for use by patients (e.g., outpatient surgery center).

2. Synthetic Drugs of Abuse

In Minnesota and nationwide a growing number of online and retail sales outlets began selling synthetic, chemical substances that are designed to be consumed for their intoxicating, illegal drug-like effects (such as stimulation, hallucinations, and euphoria), but are intentionally marketed and effectively disguised as something else, such as bath salts, herbal incense or so-called research chemicals.

The use of synthetic cannabinoids, also known as cannabimimetics, continued throughout Minnesota in 2011 and 2012. Known also as "fake pot," "K2," "Spice," and other brand names, these herbal mixtures are sold as herbal incense, but when smoked, mimic the effects of plant marijuana. Sold online and in "head-shops," these mixtures of herbs are allegedly sprayed with synthetically-produced

cannabinoids. Cannabinoids are the psychoactive ingredients in plant marijuana. The Hennepin Regional Poison Center documented 28 exposures to THC homologs in 2010, 149 in 2011, and 54 in 2012 (through April).

Chemical mixtures that are sold online as so-called “research drugs” that are “not intended for human consumption,” were intentionally consumed by a group of young people in suburban Blaine, Minnesota in March 2011. The chemical compound known as 2C-E (2,5-dimethoxy-4-ethylphenylethylamine) was snorted by eleven young people who were seeking effects similar to the stimulant drug, MDMA or “ecstasy.” All experienced profound hallucinations, became distressed and were eventually hospitalized. A 19-year-old male was pronounced dead at the hospital. Exposures to 2C-E and related analogues reported to the Hennepin Regional Poison Center numbered 10 in 2010, 23 in 2011, and six in 2012 (through April).

The consumption of so-called “bath salts” by adolescents and young adults to get high, escalated in the Twin Cities in 2011, with 144 reported exposures reported to Hennepin Regional Poison Center in 2011, compared with five in 2010. These substances are not intended to be used in the bathtub, but are rather snorted, smoked or injected to produce effects similar to cocaine, methamphetamines and MDMA. They are sold online or in “head shops” under names such as Cloud 9, Ivory Wave, Pure Ivory, Ocean Burst, Purple Rain and Vanilla Sky. Some include methylenedioxypyrovalerone (MDPV), a compound that produces effects similar to stimulants or MDMA.

Minnesota exposures to selected drugs reported to Hennepin Regional Poison Center: 2009 - 2011

	2009	2010	2011
THC homologs		28	149
Bath salts		6	144
2CE and analogues	6	10	23
LSD	9	7	15
MDMA	42	26	24

SOURCE: Hennepin Regional Poison Center, Hennepin County Medical Center, January 2012.

In March 2011 the U.S. DEA used its emergency scheduling authority to temporarily designate as Schedule I substances, the chemicals used to make “fake pot” products -- JWH-018, JWH-073, JWH-200, CP-47,497, and cannabicyclohexanol. That scheduling was extended in February, 2012 for an additional 6 months. The DEA also took emergency action in October 2011 to temporarily ban the possession and sale of three synthetic stimulants, methylenedioxypyrovalerone (MDPV,) mephedrone, and methylone, that are often present in products marketed as “bath salts.”

Minnesota law, effective July 2011, banned the sale and possession of synthetic THC, bath salts, and of phenylethylamines of the 2C-E category. This law was enhanced in 2012. New federal law was also enacted in July 2012 to ban these substances nationwide. While these laws help make these substances less available in stores, they are still accessible online. The Hennepin Regional Poison Center continues to see patients with serious, adverse clinical effects due to the abuse of these agents.

C. Prevention Defined

What is prevention? What do we know about how to prevent substance abuse?

1. Risk and Protective Factors

Simply put, prevention programs are designed to enhance “protective factors,” those associated with reduced potential for drug use, and to reduce “risk factors,” those that make drug use more likely. Research has shown that many of the same risk and protective factors apply to other behaviors such as youth violence, delinquency, school dropout, risky sexual behaviors and teen pregnancy.

Protective factors:

- Strong and positive family bonds;
- Parental monitoring of children's activities and peers;
- Clear rules of conduct that are consistently enforced within the family;
- Involvement of parents in the lives of their children;
- Success in school performance;
- Strong bonds with institutions, such as schools and religious organizations; and
- Adoption of conventional norms about drug use.

Risk factors:

- Adverse childhood experiences
- Chaotic home environments, particularly in which parents abuse substances or suffer from mental illnesses;
- Ineffective parenting, especially with children with difficult temperaments or conduct disorders;
- Lack of parent-child attachments and nurturing;
- Inappropriately shy or aggressive behavior in the classroom;
- Failure in school performance;

- Poor social coping skills;
- Affiliations with peers displaying deviant behaviors; and
- Perceptions of approval of drug-using behaviors in family, work, school, peer, and community environments.

SOURCE: National Institute on Drug Abuse, NIDA Notes, Vol 16, No 6, NIH Publication No. 02-3478, February 2002.

2. Adverse Childhood Experiences (ACEs)

Adverse Childhood Experiences include verbal, physical or sexual abuse as well as family dysfunction, such as a substance-abusing family member. ACEs have been linked to a wide range of health outcomes in adulthood including substance abuse, cardiovascular disease, diabetes, cancer and premature mortality. One of the strongest associative links is seen between the ACEs and alcohol use/abuse. Given the research indicating the negative impact of alcohol use on the neurodevelopment of adolescents, the relationship of ACEs to early initiation of alcohol use is particularly worrisome.

The negative health and social consequences of alcohol abuse and alcoholism constitute a major public health problem. ACEs have a particularly strong association with alcohol abuse. In addition, it is notable that the perpetuation of the cycle of alcohol abuse appears to be tightly interwoven with the number of ACEs, including marriage to an alcoholic.

As with initiation of alcohol use, ACEs also increase the likelihood of early smoking initiation and lead to continued smoking. Since cigarette smoking is the leading cause of preventable morbidity and mortality in the United States, one can see how growing up with ACEs contributes to many of the leading chronic health and social problems, both nationally and in Minnesota. (SOURCE: Anda RF, Brown DW: Adverse Childhood Experiences and Population Health in Washington: The Face of a Chronic Public Health Disaster. Results from the 2009 Behavioral Risk Factor Surveillance System, Washington State Family Policy Council, July 2, 2010)

Data collected in 2009 by the Centers for Disease Control and Prevention (CDC) from five states found that more than 59

percent of adults experienced one or more ACEs. Minnesota worked with the CDC to collect data on ACEs among Minnesota residents in 2011. Results are currently being tabulated and analyzed. (SOURCE: Centers for Disease Control and Prevention: Adverse childhood experiences reported by adults -- Five states, 2009. MMWR Morb Mortal Wkly Rep. 2010 Dec 17;59(49):1609-13)

Evidence-based programs exist that have demonstrated reductions in child maltreatment, such as home visits by nurses to mothers at high risk and parenting programs that teach new skills and behaviors to parents. Because most child maltreatment goes undetected, secondary and tertiary efforts are important complementary approaches to primary prevention efforts to improve the health and well-being of affected adults and families. Psychological treatments that can mitigate the progression of ACE-related health problems, such as trauma-focused cognitive-behavioral therapy, are also effective.

3. Principles of Substance Abuse Prevention

There are three types of substance abuse prevention:

- **Primary Prevention** seeks to decrease the number of new cases of a disease/event by eliminating the cause and increasing resistance (reducing risk factors and increasing protective factors in substance abuse prevention).
- **Secondary Prevention** seeks to lower the rate of established cases (screens and treatment services for substance abuse).
- **Tertiary Prevention** seeks to ameliorate consequences of existing disease/adverse events (relapse prevention for substance abuse).

Prevention programs funded by the Alcohol Drug Abuse Division (ADAD) of the Minnesota Department of Human Services are funded by the Substance Abuse & Mental Health Services Administration (SAMHSA) Block Grant. It is required that 20 percent of the block grant award be used

for primary prevention. Thus, requirements placed on the funding at the federal level dictate that prevention services are to target those who have never received, nor have ever been assessed as needing, substance abuse treatment.

Primary prevention services are further defined by Institute of Medicine which categorizes services according to the target group recipients.

- **Universal Prevention** services target everyone in the eligible population. The general population is targeted without regard to individual risk factors.
- **Selective Prevention** services target subgroups of the general population that are determined to be at higher risk for substance abuse.
- **Indicated Prevention** services target individuals identified as experiencing early signs of substance abuse and/or other related problem behavior, but have not reached the point where a clinical diagnosis of substance abuse can be made.

The following principles of prevention were derived from decades of research, and developed by the National Institute on Drug Abuse. These principles are intended to help parents, educators, and community leaders think about, plan for, and deliver research-based drug abuse prevention programs at the community level.

PRINCIPLE 1 - Prevention programs should enhance protective factors and reverse or reduce risk factors.

- The risk of becoming a drug abuser involves the relationship among the number and type of risk factors (e.g., deviant attitudes and behaviors) and protective factors (e.g., parental support).
- The potential impact of specific risk and protective factors changes with age. For example, risk factors within the family have greater impact on a younger child, while association with drug-abusing peers may be a more significant risk factor for an adolescent.

- Early intervention with risk factors (e.g., aggressive behavior and poor self-control) often has a greater impact than later intervention by changing a child's life path or trajectory away from problems and toward positive behaviors.
- While risk and protective factors can affect people of all groups, these factors can have a different effect depending on a person's age, gender, ethnicity, culture, and environment.

PRINCIPLE 2 - Prevention programs should address all forms of drug abuse, alone or in combination, including the underage use of legal drugs (e.g., tobacco or alcohol), the use of illegal drugs (e.g., marijuana or heroin), and the inappropriate use of legally obtained substances (e.g., inhalants), prescription medications, or over-the-counter drugs.

PRINCIPLE 3 - Prevention programs should address the type of drug abuse problem in the local community, target modifiable risk factors, and strengthen identified protective factors

PRINCIPLE 4 - Prevention programs should be tailored to address risks specific to population or audience characteristics, such as age, gender, and ethnicity, to improve program effectiveness.

PRINCIPLE 5 - Family-based prevention programs should enhance family bonding and relationships and include parenting skills, such as practice in developing, discussing, and enforcing family policies on substance abuse, and training in drug education and information.

PRINCIPLE 6 - Prevention programs can be designed to intervene as early as preschool to address risk factors for drug abuse, such as aggressive behavior, poor social skills and academic difficulties.

PRINCIPLE 7 - Prevention programs for elementary school children should target improving academic and social-emotional learning to address risk factors for drug abuse, such as early aggression, academic failure, and school dropout. Education should focus on the following skills: self-control, emotional awareness, communication, social problem-solving and academic support, especially in reading.

PRINCIPLE 8 - Prevention programs for middle or junior high and high school students should increase academic and social competence with the following skills: study habits and academic support, communication, peer relationships, self-efficacy and assertiveness, drug resistance skills, reinforcement of anti-drug attitudes and strengthening of personal commitments against drug abuse.

PRINCIPLE 9 - Prevention programs aimed at general populations at key transition points, such as the transition to middle school, can produce beneficial effects even among high-risk families and children. Such interventions do not single out risk populations and, therefore, reduce labeling and promote bonding to school and community.

PRINCIPLE 10 - Community prevention programs that combine two or more effective programs, such as family-based and school-based programs, can be more effective than a single program alone.

PRINCIPLE 11 - Community prevention programs reaching populations in multiple settings (e.g., schools, clubs, faith-based organizations, and the media) are most effective when they present consistent, community-wide messages in each setting.

PRINCIPLE 12 - When communities adapt programs to match their needs, community norms, or differing cultural requirements, they should retain core elements of the original research-based intervention which include: structure, content and delivery (how the program is adapted, implemented, and evaluated).

PRINCIPLE 13 - Prevention programs should be long-term with repeated interventions (e.g., booster programs) to reinforce the original prevention goals. Research shows that the benefits from middle school prevention programs diminish without follow-up programs in high school.

PRINCIPLE 14 - Prevention programs should include teacher training on good classroom management practices, such as rewarding appropriate student behavior. Such techniques help to foster students' positive behavior, achievement, academic motivation, and school bonding.

PRINCIPLE 15 - Prevention programs are most effective when they employ interactive techniques, such as peer discussion groups and parent role-playing, that allow for active involvement in learning about drug abuse and reinforcing skills.

PRINCIPLE 16 - Research-based prevention programs can be cost-effective. Similar to earlier research, recent research shows that for each dollar invested in prevention, a savings of up to \$10 in treatment for alcohol or other substance abuse is realized.

SOURCE: National Institute on Drug Abuse and appear in their Publication In Brief- Preventing Drug Use among Children and Adolescents: A Research-Based Guide for Parents, Educators, and Community Leaders, Second Edition NIH Publication No. 04-4212(B), Printed 1997, Reprinted 1997, 1999, 2001, Second Edition October 2003.

D. Addiction Defined

What is addiction? Addiction is more than simply a lot of substance use.

Addiction is a chronic disease with behavioral components that requires lifelong management and possible periodic professional services. Addiction affects the brain and behavior, sometimes in fundamental ways that last long after the effects of the drug have worn off. Scientific research has identified genetic and environmental factors that heighten the risk of any individual developing addiction.

According to the National Institute on Drug Abuse, "Addiction is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain; they change its structure and how it works. These brain changes can be long-lasting and can lead to many harmful, often self-destructive, behaviors."

DSM-IV Substance Dependence Criteria

The American Psychiatric Association defines substance dependence as follows:

Substance dependence is a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring any time in the same 12-month period:

1. Tolerance, as defined by either of the following: (a) A need for markedly increased amounts of the substance to achieve intoxication or the desired effect or (b) Markedly diminished effect with continued use of the same amount of the substance.
2. Withdrawal, as manifested by either of the following: (a) The characteristic withdrawal syndrome for the substance or (b) The same (or closely related) substance is taken to relieve or avoid withdrawal symptoms.
3. The substance is often taken in larger amounts or over a longer period than intended.

4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.
5. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
6. Important social, occupational, or recreational activities are given up or reduced because of substance use.
7. The substance use is continued despite knowledge of having a persistent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

SOURCE: American Psychiatric Association. 1994. Diagnostic and Statistical Manual of Mental Disorders: DSM-IV. Washington D.C.: American Psychiatric Association. (pp. 181-183)

Simply put, once addicted, the focus of the person's life centers around acquisition and compulsive use of the drug, in spite of negative consequences, and at the expense of everything else. For an active alcoholic or addict, personal relationships, hobbies, school, employment and family all take a back seat to acquiring and using the substance.

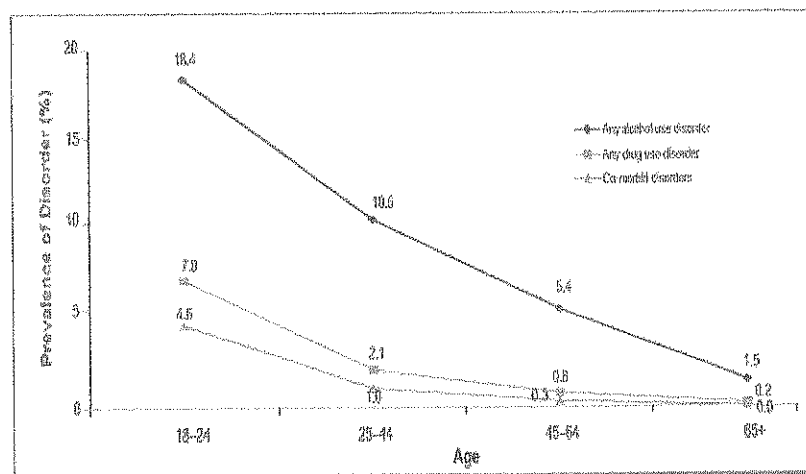
People who suffer from addiction often have one or more accompanying medical issues. These can include lung and cardiovascular disease, stroke, cancer, and mental disorders. Drug addiction and mental illness often coexist.

How widespread is addiction? Below is a discussion of two different studies that address this question.

The National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), one of the largest surveys of its kind ever performed, found that 8.5 percent of adults in the United States met the criteria for an alcohol use disorder, two percent met the criteria for a drug use disorder, and 1.1 percent met the criteria for both.

People dependent on drugs were more likely to have an alcohol use disorder than people with alcoholism were to have a drug use disorder. Young people ages 18-24 had

Prevalence of alcohol and drug use disorders in the US population



SOURCE: The National Epidemiologic Survey on Alcohol and Related Conditions (NESARC). *Alcohol Alert* No. 76, July 2008. National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism (NIAAA).

the highest rates of co-occurring alcohol and other drug use disorders, and men were more likely than women to have problems with alcohol, drugs, or the two substances combined (SOURCE: Falk, D.; Yi, H.-y.; and Hiller-Sturmhöfel, S. An Epidemiologic Analysis of Co-Occurring Alcohol and Drug Use and Disorders: Findings From the National Epidemiologic Survey of Alcohol and Related Conditions (NESARC). *Alcohol Research & Health* 31(2):100-110, 2008)

In any given year, based on survey data from the National Survey on Drug Use and Health, it is estimated that 3.4 percent of the population age 12 and above is dependent on alcohol and 1.9 percent is dependent on illicit drugs. In Minnesota, the estimates are 3.6 and 1.7 percent respectively

(SOURCE: 2006 and 2007 National Survey on Drug Use and Health, Substance Abuse and Mental Health Services Administration).

E. The Treatment of Addiction

1. Overview

Like other chronic diseases with behavioral components, addiction can be managed successfully. Treatment for addiction to alcohol and other drugs is effective and enables patients to resume normal life functioning without turning to the use of alcohol or illicit drugs. Some people recover from drug and alcohol addiction without receiving formal treatment, often through participation in self-help groups such as Alcoholics Anonymous.

Unlike the case with most other chronic diseases that affect large segments of the population, many people in need of treatment for drug and alcohol addiction do not receive it -- an estimated 20 million people in the US. While most do not seek treatment because they do not think they need it, others face financial barriers that prevent them from receiving it. Indeed, our public treatment response typically reaches only those in the greatest financial need and ignores the "working poor" and uninsured whose incomes are above the federal poverty level. For many of these people, as evidenced by their impaired capacity to generate income, the disease is already quite advanced.

In Minnesota, nine percent of adults met the criteria for substance abuse or dependence, but less than one in 10 actually received treatment. This is based on 2000/2005 data. Indeed, a recent DHS reported noted, "The need for additional treatment is undeniable." (SOURCE: The Benefits of Treatment for Substance Use Disorders, James McRae, Performance Measurement and Quality Improvement Division, Minnesota Department of Human Services, 2011)

2. Principles of Addiction Treatment

Decades of scientific research by the National Institute on Drug Abuse have yielded a set of fundamental principles that characterize effective drug abuse treatment as follows.

1. **No single treatment is appropriate for all individuals.** Matching treatment settings, interventions and services to each patient's problems and needs is critical.
2. **Treatment needs to be readily available.** Treatment applicants can be lost if treatment is not immediately available or readily accessible.
3. **Effective treatment attends to multiple needs** of the individual, not just his or her drug use. Treatment must address the individual's drug use and associated medical, psychological, social, vocational, and legal problems.
4. **Treatment needs to be flexible** and provide an ongoing assessments of patient needs, which may change during the course of treatment.
5. **Remaining in treatment for an adequate period of time is critical for treatment effectiveness.** The duration of treatment depends on an individual's needs. For most patients, the threshold of significant improvement is reached at about three months of treatment. Additional treatment can produce further progress. Programs should include strategies to prevent patients from leaving treatment prematurely.
6. **Individual and/or group counseling and other behavioral therapies are critical components of effective treatment for addiction.** In therapy, patients address motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships.
7. **Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.** Methadone and levo-alpha-acetylmethadol (LAAM) help persons addicted to opiates stabilize their lives and reduce their drug use. Naltrexone is effective for some opiate addicts and some patients with co-occurring alcohol

dependence. Nicotine patches or gum, or an oral medication, such as bupropion, can help persons addicted to nicotine.

8. **Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.** Because these disorders often occur in the same individual, patients presenting for one condition should be assessed and treated for the other.
9. **Medical detoxification is only the first stage of addiction treatment** and by itself does little to change long-term drug use. Medical detoxification manages the acute physical symptoms of withdrawal. For some individuals it is a precursor to effective drug addiction treatment.
10. **Treatment does not need to be voluntary to be effective.** Sanctions or enticements in the family, employment setting, or criminal justice system can significantly increase treatment entry, retention, and success.
11. **Possible drug use during treatment must be monitored continuously.** Monitoring a patient's drug and alcohol use during treatment, such as through urinalysis, can help the patient withstand urges to use drugs. Such monitoring can also provide early evidence of drug use so that treatment can be adjusted.
12. **Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counseling to help patients modify or change behaviors that place them or others at risk of infection.** Counseling can help patients avoid high-risk behavior and help people who are already infected manage their illness.
13. **Recovery from drug addiction can be a long-term process** and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug use can occur during or after successful treatment

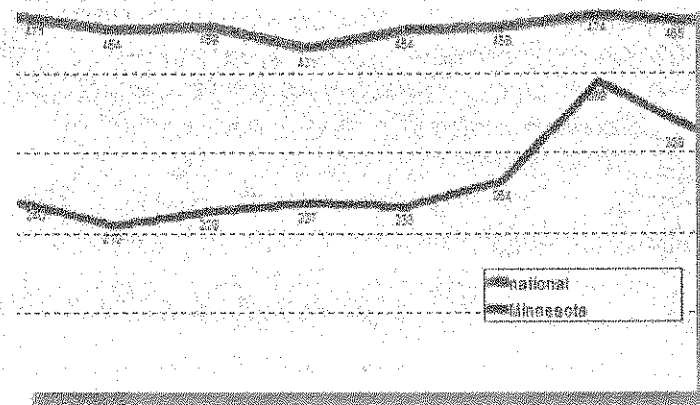
episodes. Participation in self-help support programs during and following treatment often helps maintain abstinence.

SOURCE: Principles of Drug Addiction Treatment: A Research-based Guide (NCADI publication BKD347). National Institutes of Health, National Institute on Drug Abuse. Bethesda, MD.

Each year, about 50,000 Minnesotans receive addiction treatment services. This includes those patients whose treatment is funded by public sources, as well those whose treatment services are delivered as part of their private health care insurance coverage. (SOURCE: Performance Measurement and Quality Improvement Division, Minnesota DHS.)

How does this compare with nationally? The following table presents the population-based rates of adults in addiction treatment nationally and in Minnesota from 2002 through 2009. Appendix Exhibit 11 presents a state by state comparison of population-based rates of persons in treatment.

**Clients age 18 and over in addiction treatment programs
per 100,000 population:
nationally and in Minnesota 2002 - 2009**



SOURCE: National Survey of Substance Abuse Treatment Services (N-SSATS). Substance Abuse and Mental Health Services Administration, 2003-2010. Includes patients with both alcohol and drug abuse disorders.

Addiction treatment is delivered in a variety of settings in Minnesota and nationally. The majority of addiction treatment in Minnesota (80 percent), and nationally (81 percent) is delivered in outpatient settings. Minnesota is noted for its non-hospital-based residential treatment, which is more prevalent here than nationally. There is also less opioid treatment available here in Minnesota than nationally. See Appendix Exhibits 12 and 13. SOURCE: The 2009 National Survey of Substance Abuse Treatment Services (N-SSATS), Substance Abuse and Mental Health Services Administration, 2010.

Addiction treatment consists of individualized services that are intended to help the patient understand the nature of addiction, cope with drug craving, develop skills to avoid relapse, and be introduced to ongoing recovery-oriented activities and services. In addition to cognitive behavioral and/or other types of therapy delivered in individual and group settings, treatment involves lectures, family involvement, assessment and integrated treatment of co-occurring mental health disorders.

Comparing clinical approaches that are often or sometimes used in Minnesota to national results, the largest difference is in the greater use of 12-step facilitation in Minnesota: 89.3 percent in Minnesota compared with 78.8 percent nationally. Twelve-step facilitation refers to a treatment approach that introduces patients to the concepts and traditions of Alcoholics Anonymous.

Opiate addiction can be successfully treated with the use of medications. These medications are effective in helping individuals addicts stabilize their lives and reduce their illicit drug use. An overview of the major medications that are proven effective in treating opioid addiction is below.

Naltrexone

Antagonist medication that prevents opioids from activating their receptors. Used to treat overdose and addiction, although its use for addiction is limited due to poor adherence and tolerability by patients.

An injectable, long-acting form of naltrexone (Vivitrol) originally approved for treating alcoholism, has also received FDA approval to treat opioid addiction). Because its effects last for weeks, Vivitrol is ideal for patients who do not have ready access to healthcare or who struggle with taking their medications regularly.

Methadone

A synthetic opioid agonist medication that eliminates withdrawal symptoms and relieves drug cravings by acting on the same brain targets as other opioids like heroin, morphine, and opioid pain medications. It has been used successfully for more than 40 years to treat heroin addiction, and must be dispensed through opioid treatment programs

Buprenorphine

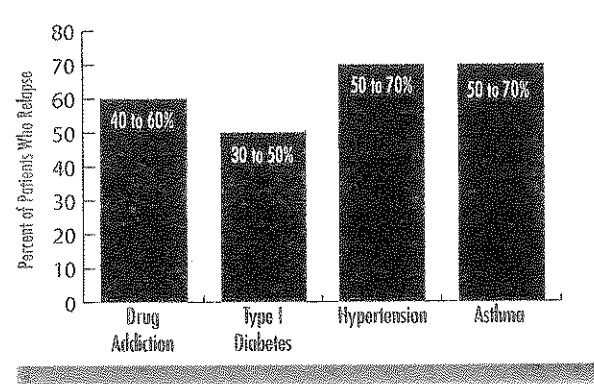
A partial opioid agonist medication (i.e., it has both agonist and antagonist properties), which can be prescribed by certified physicians in an office setting. Like methadone, it can reduce cravings and is well tolerated by patients.

F. The Outcomes of Addiction Treatment

How effective is the treatment of addiction? Since it is a chronic disease with behavioral components it can be managed but never completely cured. As stated above, "Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes." Relapse rates refer to how often symptoms recur. These rates for drug addiction are similar to those for other well-characterized chronic medical illnesses which also have both physiological and behavioral components. Simply put, the outcomes of addiction treatment have also been shown to be as robust as the outcomes of other chronic diseases with behavioral components such as diabetes, hypertension and asthma.

In the graph below, relapse rates for drug-addicted patients are compared with those of patients with diabetes, hypertension, and asthma. Relapse is common and similar across these illnesses, as is adherence to medication. Thus, relapse serves as a trigger for renewed intervention, not as a statement of treatment failure. (SOURCE: McLellan AT, Lewis DC, O'Brien CP, Kleber HD. Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. JAMA 284(13):1689-1695, 2000.)

Comparison of relapse rates between drug addiction and other chronic illnesses



SOURCE: Journal of the American Medical Association 284(13):1689-1695, 2000.

In conjunction with national efforts that require treatment outcome measures from all states, the Alcohol and Drug Abuse Division of the Minnesota Department of Human Services, has a data collection and management program that supports the analysis and dissemination of addiction treatment program performance outcome measures. The data are from the Drug and Alcohol Abuse Normative Evaluation System (DAANES), the primary data collection system used in monitoring the nature, extent and effectiveness of substance abuse treatment services in Minnesota.

These measures attempt to capture meaningful, real-life outcomes for people who are striving to attain and sustain recovery and participate fully in their communities in the wake of receiving treatment for an active addiction to drugs or alcohol.

National Outcome Measures (NOMs): Patients in treatment in Minnesota

Measures	At Admission	At Discharge
Homeless (N=47,617)	6.9 %	4.1%
Not employed (N=45,679)	59%	56.3%
Arrests in past 30 days (N=48,174)	11.7%	4.7%
Alcohol use in past 30 days (N=47,848)	48.2%	15.2%
Drug Use in Past 30 Days (N=47,846)	38.0%	14.7%
No self-help groups in past 30 days (N=44,097)	58.1%	20.7%
No family support for recovery in past 30 days (N=42,631)	12.9%	8.3%

SOURCE: Drug and Alcohol Abuse Normative Evaluation System (DAANES), Performance Measurement and Quality Improvement Division, MN Department of Human Services, 2010 using 2009 data.

In addition to the measures above, licensed Minnesota treatment providers report severity scores in each of six patient functioning dimensions. These scores are based on an assessment of the severity of patients' problems in each dimension upon admission and discharge from treatment services. The dimensions are:

- **Intoxication/withdrawal:** This dimension ranges from patients who exhibit no intoxication or withdrawal symptoms to those with symptoms so severe that the patient is a threat to self or others.
- **Biomedical:** Ranges from patients who are fully functional to those with severe physical problems or conditions that require immediate medical intervention.

- **Emotional, behavioral, cognitive:** Ranges from patients with good coping skills and impulse control to such severe emotional or behavioral symptoms that the patients is unable to participate in treatment.
- **Readiness for change:** Ranges from patients who admit problems, are cooperative, motivated and committed to change to patients who are unwilling to explore changes, are in total denial of illness and are dangerously oppositional to the extent that they pose an imminent threat of harm to self and others.
- **Relapse, continued use:** Ranges from patients who recognize risk and are able to manage potential problems to those who have no understanding of relapse issues and display high vulnerability for further substance use disorders.
- **Recovery environment:** Ranges from patients engaged in structured, meaningful activity with significant others and family, and who have a living environment that is supportive to recovery to patients who have chronically or actively antagonistic significant others, family or peer groups and dangerous living environments that are harmful to long-term, drug-free recovery.
- The severity levels within each dimension range from 0 (no problem) to 4 (severe problem).

The following table presents the aggregate percentage of patients with severity scores of moderate, serious, or extreme upon admission to treatment and at discharge for calendar year 2009.

**Minnesota patient severity scores:
Pre- and post- treatment for addiction**

Severity ratings of moderate, serious or extreme	At Admission	At Discharge
Acute intoxication or withdrawal (N=47,527)	10.1%	5.1%
Biomedical conditions/ complications (N=47,864)	16.2%	12.1%
Emotional/cognitive/ behavioral problems (N=47,878)	62.5%	47.7%
Resistance to change (N=47,985)	67.7%	47.7%
Relapse potential (N=47,941)	95.5%	73.2%
Unsupportive recovery environment (N=47,456)	86.6%	68.1%

SOURCE: Drug and Alcohol Abuse Normative Evaluation System (DAANES), Performance Measurement and Quality Improvement Division, MN Department of Human Services, 2010 using 2009 data.

G. Related Health Care Consequences of Abuse and Addiction

1. Emergency Department Episodes

From 2004 to 2009, the total number of drug-related hospital emergency department (ED) visits increased 81 percent from 2.5 million to 4.6 million nationwide. These visits included reports of drug abuse, adverse reactions to drugs, or other drug-related consequences. Almost 50 percent were attributed to adverse reactions to pharmaceuticals taken as prescribed, and 45 percent involved drug abuse.

The Drug Abuse Warning Network estimates that of the 2.1 million drug-related visits:

- 27.1 percent involved nonmedical use of pharmaceuticals (prescription or OTC medications, dietary supplements)
- 21.2 percent involved illicit drugs
- 32 percent (658,263) of all drug abuse ED visits in 2009 involved the use of alcohol, either alone or in combination with another drug.

Emergency department (ED) visits involving nonmedical use of pharmaceuticals (either alone or in combination with another drug) increased 98.4 percent between 2004 and 2009, from 627,291 visits to 1,244,679, respectively. Emergency department visits involving adverse reactions to pharmaceuticals increased 82.9 percent between 2005 and 2009, from 1,250,377 to 2,287,273 visits, respectively.

(SOURCE: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality (formerly the Office of Applied Studies, DAWN Report: Highlights of the 2009 Drug Abuse Warning Network (DAWN) Findings on Drug-Related Emergency Department Visits. Rockville, MD, December 28, 2010. Available at: <http://www.oas.samhsa.gov/2k10/DAWN034/EDHighlights.htm>.)

The majority of drug-related ED visits were made by patients 21 or older (80.9 percent, or 3,717,030 visits). Of these, slightly less than half involved drug abuse. Patients aged 20 or younger accounted for 19.1 percent (877,802 visits) of all drug-related visits in 2009. About half of these visits involved drug abuse.

(SOURCE: www.NIDA.NIH.gov/Infofacts/hospitalvisits accessed on 11/21/2011)

Additional research has found that mental health and substance abuse-related hospital emergency department visits were two and a half times more likely to result in a hospital admission than ED visits not related to mental health or substance abuse. Nearly 41 percent of mental health and substance abuse-related hospital emergency department visits resulted in hospitalization.

Medicare was billed most frequently for mental health and substance abuse-related hospital ED visits (30.1 percent), followed by private insurance (25.7 percent), uninsured (20.1 percent), and Medicaid (19.8 percent).

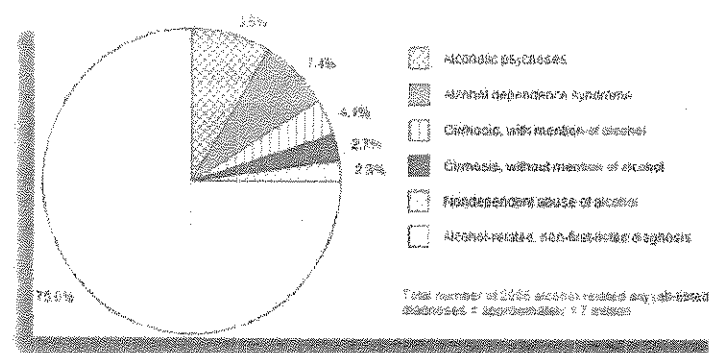
(SOURCE: HealthCare Cost and Utilization Project, Agency for Health Care Research and Quality, Mental Health and Substance Abuse-Related Hospital Emergency Department Visits Among Adults, 2007. Online at: www.hcup-us.ahrq.gov/reports/statbriefs/sb92.pdf)

Comparable state-level Minnesota data are not available yet there is no reason to assume that Minnesota trends are significantly different than national ones.

2. Hospitalization Episodes with Alcohol-Related Diagnosis

In 2006, roughly 1.7 million hospital discharge episodes had any (all-listed) alcohol-related diagnosis. These figures represent 18.1 principal (first-listed) and 72.4 any (all-listed) alcohol-related discharges per 10,000 population. This compares with the 2005 rates of 18.8 and 69.7, respectively. This NIAAA-sponsored study examines alcohol-related morbidity among patients discharged from short-stay community hospitals in the United States.

Percent distribution of principal (first-listed) diagnoses among discharges with any (all-listed) mention of an alcohol-related diagnosis



SOURCE: Chiung M. Chen, M.A. Hsiao-ye Yi, Ph.D., National Institute on Alcohol Abuse and Alcoholism, Division of Epidemiology and Prevention Research, Alcohol Epidemiologic Data System, SURVEILLANCE REPORT #84, TRENDS IN ALCOHOL-RELATED MORBIDITY AMONG SHORT-STAY COMMUNITY HOSPITAL DISCHARGES, UNITED STATES, 1979-2006, August 2008. Accessed online at: <http://pubs.niaaa.nih.gov/publications/surveillance/84/HDS06.htm>.

III. Current Minnesota State Agency Responses to Substance Abuse and Addiction

A. Department of Human Services

1. Overview

The Minnesota Department of Human Services (DHS), Alcohol and Drug Abuse Division (ADAD) is the designated state authority for alcohol and drug abuse. It administers substance abuse prevention, treatment, and recovery services in Minnesota using various federal and state funds. See Appendix for the full citation of its statutory authority.

2. The SAMHSA Block Grants to States: Federal Expectations

The Alcohol and Drug Abuse Division (ADAD) is the recipient of the Substance Abuse Prevention and Treatment Block Grant to states, awarded by the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services. The Block Grants are awarded to states to allow them to address their unique behavioral health issues.

Specifically, the Block Grant funds are directed toward four purposes:

- Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time.
- Fund those priority treatment and support services not covered by Medicaid, Medicare or private insurance for low income individuals and that demonstrate success in improving outcomes and/or supporting recovery.
- Fund primary prevention - universal, selective and indicated prevention activities and services for persons not identified as needing treatment.

- Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services and plan the implementation of new services on a nationwide basis.

States also receive a State Mental Health Block Grant from SAMHSA. In Minnesota this has been administered by the Adult Mental Health Division and the Children's Mental Health Division of the Minnesota Department of Human Services.

In 2011 SAMHSA changed the way it administers these two block grants to states. In an effort to streamline the application and reporting procedures for these block grant programs, SAMHSA developed a single uniform application and reporting process to promote consistent planning, application, assurance and reporting dates across both block grants. The new uniform block grant application was undertaken in the expectation that states will:

- Take a broader approach in reaching beyond the populations they have historically served through block grants.
- Conduct a needs assessment and develop a plan that will identify and analyze the strengths, needs and priorities of the state's behavioral health system.
- Design and develop collaborative plans for health information systems grants and other funding.
- Form strategic partnerships to provide individuals better access to good and modern health services.
- Focus more on services in support of recovery from mental health and substance use problems.
- Focus their block programs on improving accountability for quality and performance of services they provide.
- Description of tribal consultation activities.

3. Prevention Services

The Alcohol and Drug Abuse Division supports many components of Minnesota's prevention infrastructure through a variety of efforts that are primarily funded by the federal government.

As the recipient of the federal SAPT Block Grant to states, ADAD is required to spend 20 percent of its SAPT funds supporting primary prevention.

Through the SAPT Block Grant, ADAD currently funds \$6 million annually on primary prevention community projects, a statewide prevention resource center, and Synar compliance. (Synar compliance refers to efforts that ensure tobacco retailers do not sell to minors, another SAPT requirement.). This represents 21 percent of the federal block grant total. In addition, approximately \$1.5 million of the SAPT Block Grant funds are spent on American Indian prevention services.

In order to reduce the prevalence of alcohol and another drug use/abuse among the state's population and increase the age of first use of alcohol and other drugs, DHS promotes the use of evidence-based prevention strategies and promising programs. Minnesota's goal is to provide effective and efficient prevention programming throughout the state. Work occurs in the following areas:

■ Prevention Planning and Implementation Projects.

ADAD funds planning and implementation projects through local coalitions to support communities in planning, developing, and implementing prevention projects specific to their needs. Community projects include programming focused on, but not limited to, the African American, Native American, Chicano/Latino, and Asian American communities.

■ The Minnesota Prevention Resource Center. ADAD funds this a statewide prevention resource center to:

- 1) Disseminate culturally specific prevention information
- 2) Implement community organizing to involve community and family members in the Hmong &

- Latino communities, and 3) Provide current and accurate prevention information, strategies, and statewide programs by maintaining clearinghouses, and provide consultation to communities and schools for planning and implementation of prevention strategies at the local level. The Minnesota Prevention Resource Center (MPRC) is online at www.emprc.org. Its accomplishments include the dissemination of approximately 550,000 pieces of prevention material, 3,000 calls to prevention phone lines, 187,000 web hits on alcohol, tobacco, and other drug abuse prevention, 6000 requests for information, and 200 prevention public service announcements were developed and disseminated to over 600 media outlets.

■ Regional Prevention Coordinators. ADAD funds seven regional prevention centers/coordinators to support its regional prevention infrastructure. These Regional Prevention Centers house regional prevention coordinators whose function is to: increase local control of prevention activity, promote local collaboration/coordination in the implementation of prevention strategies, identify current prevention efforts and needs, provide training and technical assistance to agencies and prevention professionals, and to assist in the promotion of the State Prevention Framework and goals.

■ Synar Compliance Activity. ADAD expends federal block grant funds to contract with outside contractors to conduct random unannounced checks at the retailer level to assess compliance with state laws that prohibit sale of tobacco to minors. In addition, DHS will contract with a research entity to conduct a scientific survey of the state to determine enforcement activity in the state relating to tobacco sales to minors, and the numbers and types of penalties assessed to offenders at the local level.

■ State Systems Development. ADAD uses block grant funds to enhance the development of its prevention system and infrastructure where feasible and appropriate.

Substance abuse and addiction prevention, within and across communities in Minnesota, is the ultimate statewide goal. ADAD estimates that prevention services are provided to over three million individuals in Minnesota through a combination of these individual and population-based programs and efforts.

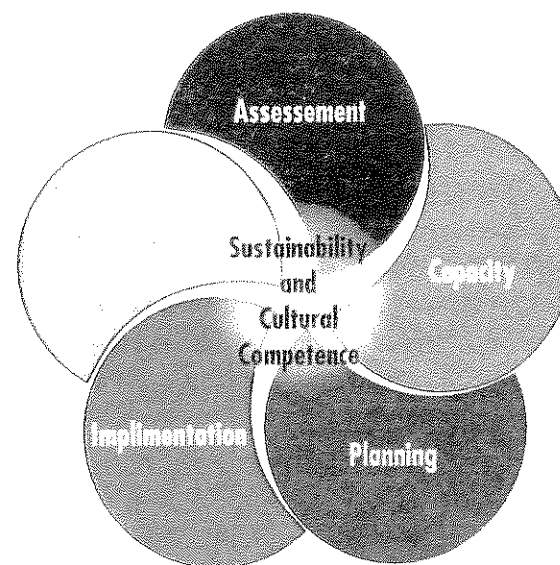
Yet the challenge of prevention is that it is not a one-shot occurrence, but an ongoing process. There are always people hearing the messages for the first time. Therefore, in order to establish a statewide prevention infrastructure, ADAD sought and received a recent infusion of additional federal dollars.

In addition to prevention initiatives funded by the SAPT Block Grant, ADAD also administers, through the Office of the Governor, a \$10.5 million Strategic Prevention Framework State Incentive Grant (SPF-SIG) from the Federal Substance Abuse and Mental Health Services Administration (SAMHSA) as of July 2009. The purpose of this grant is to build the prevention capacity of the state and sub-recipient communities to implement the SPF model.

The Strategic Prevention Framework (SPF) is a five-step, public health model that supports data-driven decision-making and outcome-based prevention planning. Cultural competence and sustainability are the two core components woven throughout the model, which also promotes the use of environmental or population level change and the use of evidence-based strategies.

The five steps are: 1) Assess local prevention needs based on epidemiological data, 2) Build prevention capacity, 3) Develop a strategic plan, 4) Implement effective community prevention programs, policies and practices, and 5) Evaluate the outcomes of the efforts. Again, throughout all five steps, the model address issues of sustainability and cultural competence as shown below.

Strategic prevention framework components

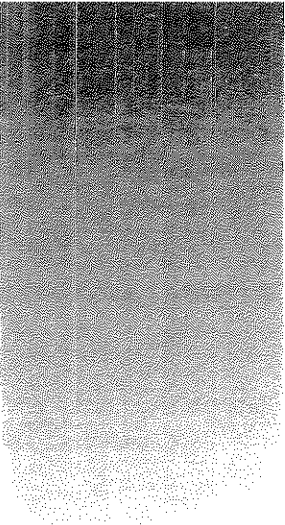


The idea behind SPF is to use the findings from public health research and local data collection, along with evidence-based prevention programs, to build prevention capacity within states, tribes, and territories. This in turn promotes resilience and reduces risk factors in individuals, families, and communities.

After conducting a needs assessment and examining statewide data on substance abuse, Minnesota's SPF-SIG Advisory Council voted on the following three priorities for Minnesota's project in May of 2010:

- To reduce past 30-day alcohol use among 6th-12th graders
- To reduce binge drinking among 9th-12th graders
- To reduce binge drinking among 18-25 year olds

SAMHSA envisions the SPF -SIGs being implemented through working partnerships between states and communities. Eighty-five percent of the state's award must be passed through to local communities. For this reason, ADAD awarded eight sub-recipient grants to communities across Minnesota in January 2012.



ADAD is using a two-phase funding model. Phase One focuses on the first three steps of the SPF. Communities take a thorough look at these alcohol problems and identify their root causes. Then sub-recipients will use the data they have collected in developing a strategic plan for the implementation phase.

At the end of Phase One in June of 2013, SPF -SIG sub-recipients will submit their strategic plans to ADAD. Once approved by ADAD and the Minnesota Evidence-Based Practices Workgroup, sub-recipients will get a contract amendment for Phase Two. This will come with a separate set of deliverables and funding to carry out the strategies proposed in the strategic plan. Phase Two is scheduled to end June 30, 2014, although an additional year of funding is possible if ADAD receives an extension from SAMHSA.

In addition to collaborating with numerous stakeholders from other agencies and organizations through the SPF-SIG Advisory Council, the State Epidemiological Outcomes Workgroup and the Minnesota Evidence-Based Practices Workgroup, ADAD also formed a team of ten SPF-SIG Master Trainers and contractors to assist sub-recipients in building their capacity, seven of whom are Block Grant-funded Regional Prevention Coordinators. This is one way that the SPF is being infused into the Block Grant and the model is reaching beyond funded sub-recipients.

In late 2011, ADAD was also awarded a Strategic Prevention Enhancement grant from SAMHSA, a one-year planning grant scheduled to expire the fall of 2012. The goal is to develop a five-year prevention plan that addresses mental health promotion, mental illness prevention, substance abuse prevention and the integration of both with primary care.

4. Addiction Treatment Services

More than 350 addiction treatment programs are licensed by the Minnesota Department of Human Services via administrative Rule 31. Individual counselors are also

licensed by the Board of Behavioral Health and Therapy, which sets initial and continuing licensure requirements for those who are Licensed Alcohol and Drug Counselors (LADCs).

For the past 25 years, Minnesota has maintained a system of public treatment funding through the state-operated, county-administered Consolidated Chemical Dependency Treatment Fund (CCDTF). Counties contribute 22.95 percent of the cost. The SAPT Block Grant and state appropriations make up the balance of the CCDTF. ADAD designates \$9 million of its SAPT Block Grant award to the CCDTF. Individuals who are at or below the federal poverty level are eligible for CCDTF funding.

Substance abuse treatment is typically based on one of several traditional approaches that emphasize different elements of the disease and the recovery process and include medical, social and behavioral models. Treatment support and recovery maintenance are supported via the SAPT Block Grant dollars as well as grants for women's treatment support and recovery maintenance. There are also models, such as traditional healing practices utilized by specific cultural groups.

ADAD utilizes public input received from two advisory councils: the Citizens Advisory Council and American Indian Advisory Council, and receives public input by posting its SAPT Block Grant spending plan online.

5. Recovery Services

Recovery support services are non-clinical services that assist individuals and families working towards recovery from substance use disorders. They incorporate a full range of social, legal and other resources that facilitate recovery and wellness by reducing or eliminating environmental or individual barriers to recovery.

The Alcohol and Drug Abuse Division supports community-based recovery organizations through its grants program.

There are currently two community-based programs that support the lives of people in recovery from addiction: the St. Paul-based Minnesota Recovery Connection and the Mankato-based Southern Minnesota Recovery Connection.

Over the past few years SAMHSA has been promoting “recovery-oriented systems of care,” known as ROSC. This concept is explained below by SAMHSA and accompanied by a more detailed diagram in the Appendix of this document.

“A ROSC is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resiliencies of individuals, families, and communities to achieve abstinence and improved health, wellness, and quality of life for those with or at risk of alcohol and drug problems.

The central focus of a ROSC is to create an infrastructure or “system of care” with the resources to effectively address the full range of substance use problems within communities. The specialty substance use disorder field provides the full continuum of care (prevention, early intervention, treatment, continuing care and recovery) in partnership with other disciplines, such as mental health and primary care, in a ROSC.

A ROSC encompasses a menu of individualized, person-centered, and strength-based services within a self-defined network. By design, a ROSC provides individuals and families with more options with which to make informed decisions regarding their care. Services are designed to be accessible, welcoming, and easy to navigate. A fundamental value of a ROSC is the involvement of people in recovery, their families, and the community to continually improve access to and quality of services.”

(SOURCE: Substance Abuse and Mental Health Services Administration. Recovery-Oriented Systems of Care Resource Guide, Working Draft, Sept. 2010. Accessed online at: http://partnersforrecovery.samhsa.gov/docs/ROSC_Resource_Guide_Book.pdf)

6. Recent Developments

The Chemical Dependency Consolidated Treatment Fund (CCDTF) is a state-operated, county managed system for the provision of chemical dependency treatment services to public assistance eligible persons. County human service agencies perform assessments to determine the proper level of patient severity and match it to the proper level of care. Access to publicly funded treatment begins with this “Rule 25 assessment” by the county human services agency or its agent, a tribe, or a managed care organization serving low-income patients. July 1, 2008, marked the first-ever uniform chemical dependency assessment tool in Minnesota, making it a required element of all chemical dependency assessments. It uses the Minnesota Matrix, a scale of patient life functioning along six dimensions, to help systematically match the severity of the patient’s problem with the intensity of services.

Comparing a patient’s score on the severity dimensions at the beginning of treatment and at the termination of treatment is the performance measure used to evaluate treatment outcomes. Starting in 2008, these performance outcome measures are published annually online for each licensed program.

Effective July 2011 the state, instead of 87 counties and 11 tribes, began negotiating rates for treatment services according to a newly-developed statewide rate methodology. Prior to this each county negotiated its own rates, which resulted in a great deal of variation in costs paid for like services.

The 2012 legislature directed the Human Services commissioner to review the full system of care for individuals with substance use issues and produce a report with a pilot for implementation. This report will take into account the full continuum of care including detoxification, early intervention, treatment and recovery systems of care. The report is due to the legislative committee chairs with jurisdiction over human services by March 2013.

An additional legislative initiative from the 2011 session directed ADAD to devise an Integrated Dual Disorder Treatment standard along with a screening process for persons whom have both substance use and mental health disorders. These will be reported to the legislature in 2013, followed by administrative rule-making the following year.

a. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

In 2008, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act was signed into law. This federal law requires group health insurance plans (those with more than 50 insured employees) that offer coverage for mental illness and substance use disorders to provide those benefits in ways that are no more restrictive than all other medical and surgical procedures covered by the plan. The Mental Health Parity and Addiction Equity Act does not require group health plans to cover mental health and substance use disorder benefits but, when plans do cover these benefits, the mental health and substance use disorder benefits must be covered at levels that are no lower and with treatment limitations that are no more restrictive than would be the case for the other medical and surgical benefits offered by the plan.

In the past, millions of Americans with mental health and/or substance use disorders failed to receive the treatment they need in order to get well and stay well. This historic lack of adequate health insurance coverage for mental health and substance abuse disorders has contributed to a large gap in treatment services.

The Mental Health Parity and Addiction Equity Act is important because it eliminated the practice of unequal health treatment for patients with addiction and mental illnesses, which has heretofore prevented individuals with untreated substance use and mental health disorders from receiving critically important treatment.

b. Screening, Brief Intervention and Referral to Treatment (SBIRT) in Emergency Care Settings

Alcohol and other substance abuse and addiction also contribute to health care costs in trauma settings primarily due to accidental injuries. Moreover, people who abuse alcohol and drugs have more illnesses than those who do not, and also tend to use more expensive forms of acute care such as emergency rooms.

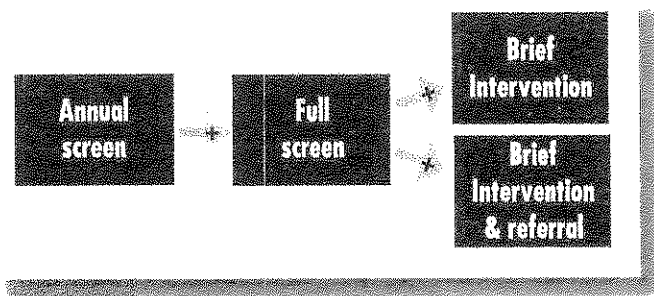
(SOURCE: Robin E. Clark, Ph.D., Elizabeth O'Connell, M.S., and Mihail Samnaliev, Ph.D.; Substance Abuse and Healthcare Costs Knowledge Asset, web site created by the Robert Wood Johnson Foundation's Substance Abuse Policy Research Program; March 2010. Online at: http://sapr.org/knowledgeassets/knowledge_detail.cfm?KAID=21)

Research shows that at critical moments, such as during the receipt of treatment at a trauma center, a brief screening and intervention can help someone reduce or stop risky substance use, in some cases before misuse crosses into addiction. To that end, Screening, Brief Intervention, and Referral to Treatment (SBIRT), is an evidence-based tool available as a preventative strategy and a treatment approach that focuses on identifying and helping people who use drugs or drink alcohol at a risky level – before addiction develops. It is being integrated into medical practice in emergency rooms and primary care clinics throughout the state and country.

The basics of SBIRT include: a quick pre-screen (often just 2-4 questions) that begins the process followed by a more in-depth screening if warranted, a brief intervention, sometimes brief treatment, and/or referral to treatment.

The general flow of an SBIRT program is illustrated below.

Screening, Brief Intervention and Referral to Treatment (SBIRT)



(SOURCE: Addiction Technology Transfer Center, Substance Abuse and Mental Health Services Administration, Addiction Messenger, online at www.attcnetwork.org/find/news/attcnnews/epubs/addmsg/references_july2010.asp).

Screening - A validated instrument quickly assesses the “risk level” of substance use and identifies individuals who might benefit from intervention. A brief questionnaire or interview is often sufficient to identify patients with substance use problems.

Brief Intervention - A patient whose initial screening indicates a risk level as moderate to high receives education about substance use, possible consequences, and other personalized feedback and counseling based on the individual's risk level. This education and encouragement often serves to reduce their alcohol intake. Brief intervention can be a single session lasting a few minutes, with no follow-up required, or from one to four short counseling sessions with a trained interventionist. Goals are focused upon reducing consumption or negative outcomes (such as injuries, domestic violence, auto accidents, or damage to a developing fetus) and instilling motivation for change.

Referral to Treatment - Provides those at highest risk a referral to specialty care.

Key research on SBIRT indicates:

- **Screening and brief intervention for alcohol problems in trauma patients is cost-effective and should be routinely implemented.**

An estimated 27 percent of all injured adult patients are candidates for a brief alcohol intervention. The net cost savings of the intervention was \$89 per patient screened, or \$330 for each patient offered an intervention. The benefit in reduced health expenditures resulted in savings of \$3.81 for every \$1 spent on screening and intervention. If interventions were routinely offered to eligible injured adult patients nationwide, the potential net savings could approach \$1.82 billion annually.

(SOURCE: Larry M. Gentilello, MD, Beth E. Ebel, MD, MPH, Thomas M. Wickizer, MPH, PhD, David S. Salkever, PhD, and Frederick P. Rivara, MD, MPH, Alcohol Interventions for Trauma Patients Treated in Emergency Departments and Hospitals: A Cost Benefit Analysis, *Annals of Surgery*, Volume 241, Number 4, April 2005.)

- **Alcohol screening and brief intervention in primary health care settings is cost effective and should be implemented in the U.S. health care system.**

Brief physician advice is associated with sustained reductions in alcohol use, health care utilization, motor vehicle events, and associated costs, based on the 48-month efficacy and benefit-cost analysis of Project TrEAT (Trial for Early Alcohol Treatment), a randomized controlled trial of brief physician advice for the treatment of problem drinking.

(SOURCE: Michael F. Fleming, Marlon P. Mundt, Michael T. French, Linda Baier Manwell, Ellyn A. Stauffacher, and Kristen Lawton Barry, Brief Physician Advice for Problem Drinkers: Long-Term Efficacy and Benefit-Cost Analysis, *Alcohol Clin Exp Res*, Vol 26, No 1, 2002: pp 36-43.)

- **Alcohol screening and (brief) counseling is one of the highest-ranking preventive services among the 25 effective services evaluated using standardized methods.**

(SOURCE: Leif I. Solberg, MD, Michael V. Maciosek, PhD, Nichol M. Edwards, MS, Primary Care Intervention to Reduce Alcohol Misuse - Ranking Its Health Impact and Cost Effectiveness *Am J Prev Med* 2008;34(2):143-152.)

c. Minnesota's SBIRT Plus: Integrating SBIRT into Primary Care Settings

SBIRT in primary healthcare settings is both a proven and a cost effective approach. From 2003 to 2008, over 600,000 patients were served by state and tribal SBIRT programs nationwide. Almost a quarter of those screened (23 percent) had substance use problems.

After a brief educational intervention delivered in a health care setting by health care professionals, at the six-month follow-up almost half of the participants who were initially consuming alcohol at inappropriate levels reported that they hadn't had a drink in the past 30 days and more than half of the participants who were using illicit drugs or misusing prescription medications had stopped that behavior.

(SOURCE: SAMHSA News, Vol 16., No.2, March/April 2008.)

Starting in 2010, ADAD has been working with the Dr. Mark Willenbring, former director of treatment research at the National Institute on Alcohol Abuse and Alcoholism (NIAAA), to introduce alcohol screening into primary care practice in Minnesota. The target group is primary care practices in managed care organizations that provide health care to Minnesota lowest income residents. Selected clinics are receiving training in SBIRT and the treatment of substance abuse problems. Treatment is the "plus" in SBIRT Plus.

SBIRT-Plus in Minnesota takes the SBIRT model one step beyond screening and referral, to give primary care doctors the tools they need to treat addiction, should the circumstance not warrant a referral to specialty care. Under this model everyone will be screened, and based on the results receive brief intervention, referral to specialty program treatment or treatment itself, depending on the circumstance. This will be a true integration of addiction services into primary health care.

Using the easily accessible, online and written training tools developed at NIAAA, primary care physicians will be trained in the screening, identification, referral to treatment and treatment of substance abuse problems. For additional information see: www.niaaa.nih.gov/guide.

Minimally, clinicians can now consider NIAAA's single-question alcohol screening question that asks patients, "How many times in the past year have you had (for men) 5 or more drinks or (for women) 4 or more drinks in a single day?" An affirmative answer to this question identifies patients who meet either NIAAA's criteria for at-risk drinking or the criteria for alcohol abuse or dependence specified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV).

B. Department of Education

At present there is no source of state or federal dollars available to Minnesota school districts designated specifically for alcohol and drug abuse prevention programming.

The federal No Child Left Behind Act of 2001, Title IV, Part A: Safe and Drug Free Schools and Community Act State Grants program authorized the funding of a variety of activities designed to prevent school violence and youth drug use, and to help schools and communities create safe, disciplined, and drug-free environments that support student academic achievement. While these funds were passed on to Minnesota school districts for many years, this source of designated federal funding expired in 2011.

School districts can, however, access local funding for substance abuse prevention and intervention programming. The Safe Schools Levy (Minn. Stat. 126C.44) provides districts a way to supplement funding for safety and prevention programming, including alcohol and drug abuse, crime, gang and suicide prevention education, among others safety topics. School districts can determine the types of programming that are most appropriate for their community and most in need of funding. The amount available to each district is based on enrollment counts. According to statute language, "the maximum amount which may be levied for all costs under this section shall be equal to \$30 multiplied by the district's adjusted marginal cost pupil units for the school year."

C. Department of Health

The Minnesota Department of Health (MDH) administers the Tobacco-Free Communities in Minnesota (TFC) grant program, which began in 2003 and is dedicated to creating an environment in which tobacco use is undesirable, unacceptable, and inaccessible to youth. The program is structured to:

- 1) Reduce influences that encourage youth to use tobacco
- 2) Support locally-driven efforts to create tobacco-free environments and
- 3) Build the capacity of populations at risk to reduce tobacco-related health disparities.

Research shows that people exposed to smoking, regardless of where (home, work, sporting event, car) or how (in movies, on line, through advertisements), are more likely to smoke. Consequently, TFC grantees tackle the problem of exposure on multiple fronts. They have used education, policy, systems and environmental change, counter-marketing and social networking to help Minnesota communities protect their residents, youth in particular, from the harm caused by tobacco. MDH awarded approximately \$3.22 million in 2010 and \$3.22 million in 2011 to 19 grantees for continuing tobacco prevention work.

The state's investment in tobacco prevention through this and other initiatives is reaping results. Evaluation data show that between 2000 and 2011, tobacco use dropped among Minnesota youth by 56 percent for middle school students and by 33 percent for high school students. Cigarette smoking declined even more dramatically, falling by 59 percent for middle school students and 44 percent for high school students. Trend data for other outcomes, such as youth exposure to secondhand smoke, also moved in a positive direction between 2000 and 2011.

These significant and marked declines in tobacco use mean that an estimated 47,600 fewer students used tobacco in 2011 than in 2000. Preventing these youth from starting to smoke will ultimately lead to significant savings in future direct health care costs.

Though its main emphasis is tobacco prevention among youth, MDH also joins with Clearway Minnesota to conduct the Minnesota Adult Tobacco Survey every three or four years. This survey presents a detailed picture of tobacco use among adults in Minnesota and is used by many organizations to guide efforts to reduce the harm caused by tobacco.

The Minnesota Department of Health Meth Lab Program developed detailed meth lab cleanup guidelines that formed the basis for the current law requiring notice and cleanup of meth lab properties. They also helped develop a multi-agency meth task force to help address the challenges presented by meth. The program continues to provide information and advice to realtors, homeowners, local officials and others on proper meth lab clean-up procedures. The Methamphetamine and Meth Lab website maintained by MDH has provided information about meth and the dangers of meth labs to thousands of Internet visitors since its inception in 2004. The site contains information about methamphetamine, labs, the dangers to children and others exposed to meth and meth manufacturing, cleanup techniques. The meth lab cleanup guidelines that must be followed by companies that clean up meth-exposed properties.

The MDH Alcohol and Other Drug Abuse Program electronically sends information about alcohol and drug-related news stories, research, funding and training to over 400 people around the state, and provides technical assistance, training and materials as appropriate, such as a logic model for prevention of underage and high-risk alcohol use, and a community assessment tool.

State grant funds support Fetal Alcohol Syndrome (FAS) activities as a sole source grant to the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS). It strives to eliminate birth defects caused by alcohol consumption during pregnancy and to improve the quality of life for those individuals and families affected. MOFAS

works collaboratively within communities to provide resources and support for families living with Fetal Alcohol Spectrum Disorders (FASD).

Additional MDH activities related to FASD or Alcohol Exposed Pregnancy Prevention (AEPP) include:

- **Adolescent Health Gateway and Adolescent Health Program** – Provides information regarding resources available to adolescents, parents and the general public regarding reducing alcohol and other drug use.
- **Family Home Visiting** – Targets at-risk families including those with a history of alcohol or substance abuse, screens for substance abuse, and provides education, resource and referral information to families regarding alcohol and other drug use.
- **Women's, Infants and Children (WIC)** – Conducts a health history that includes screening for alcohol use, and refers to appropriate community resources.
- **Part C** – Provides early intervention services to children exposed to alcohol during pregnancy when there is a high probability that the exposure will result in a developmental delay.
- **Birth Defects Monitoring and Analysis Program (BDMAP)** – Conducts FAS surveillance and supports grants to reduce the risk of birth defects due alcohol, tobacco, and drug-affected pregnancies.
- **Child and Teen Check-ups (C&TC)** – Conducts training on newborn assessment that enhance the capacity of C&TC providers to identify conditions such as FAS and refer families to appropriate services.
- **Hearing Screening** – Identifies children who may have conductive or neurosensory hearing loss related to fetal alcohol exposure and supports those children and their families in receiving needed services.

MDH maintains the Minnesota Center for Health Statistics, the core functions of which include: 1) Collection and analysis of health-related data, 2) Design and implementation of public health surveys, 3) Coordination of health data collection efforts at the state and local levels, and 4) Provision of technical assistance and consultation. It is also responsible for the ongoing administration of the Minnesota Behavioral Risk Factor Surveillance System (BRFSS), a large-scale telephone survey conducted on a monthly basis throughout the year. The BRFSS survey is supported by the Centers for Disease Control and Prevention (CDC) and is conducted in all 50 states, the District of Columbia, and three U.S. territories of Guam, Puerto Rico and the Virgin Islands. MDH provides data to CDC monthly. Topics covered by the BRFSS include alcohol use, smoking, obesity, physical activity, chronic disease prevalence, and access to healthcare. This phone survey is the only source of annual data on adult alcohol use, binge drinking and heavy drinking in Minnesota.

The Minnesota Department of Health also periodically generates a report on the cost of alcohol in Minnesota.

D. Department of Public Safety

The Minnesota Department of Public Safety (DPS) is most frequently involved in the consequences resulting from the inappropriate use of alcohol and the use and distribution of illegal drugs.

In 2011 police agencies in Minnesota reported:

- 16,511 narcotics offenses
- 28,573 driving while intoxicated (DWI) offenses, and,
- 11,847 liquor law violations.

Criminal activity related to substance abuse results in significant societal and economic costs for the citizens of the state. Consumption of alcohol alone and the use and distribution of illegal substances contribute to a wide range of criminal behavior ranging from disorderly conduct to homicide.

The Department addresses substance abuse through planning, data collection and analysis, regulation, prevention and training and enforcement. The department partners with Minnesota communities through the provision of grants to local jurisdictions and non-profit agencies. These community partners address substance abuse through the provision of law enforcement and prosecution programs, specialty court programs, community crime prevention, youth programming, reentry services and other evidence-based or promising pilot programs.

The following describes some of the services provided to the public by the Department of Public Safety that are related to substance abuse.

The Bureau of Criminal Apprehension Special Investigative Unit (SIU) conducts investigations of mid- and upper-level drug trafficking organizations. Investigations are conducted in cooperation with local and county law enforcement, multi-jurisdictional drug task forces and various federal law enforcement agencies. These collaborations, both within the state and outside Minnesota, encourage the full development of the investigations, causing maximum disruption to these

criminal organizations by arrests, asset seizures and incarceration.

The State Patrol aggressively enforces, through the use of directed patrol and saturation efforts, DWI violations that often directly contribute to fatal and injury crashes.

The Office of Traffic Safety, through funding received from the National Highway Traffic Safety Administration, sponsors a Toward Zero Deaths (TZD) Enforcement Program. Funding is provided to law enforcement agencies to conduct highly visible enforcement and community outreach. The focus of enforcement efforts are primarily seat belt compliance, impaired driving and speed reduction. Campaigns that include paid media are conducted throughout the year and are often at the same time period as national campaigns. Over half of the state's law enforcement agencies participate in the TZD Enforcement Program along with the Minnesota State Patrol.

The BCA Laboratory scientists analyze blood and urine biological samples for alcohol and other drugs. They also analyze and identify suspected controlled substances. These functions are critical in proving criminal offenses.

Alcohol and Gambling Enforcement (AGE) has an Alcohol Enforcement Section that has the following mission, "Protects and serves the public through the uniform interpretation and enforcement of the State Liquor Act. It protects the health and safety of the state's youth by enforcing the prohibition against sales to underage people. It operates as a central source of alcohol licenses and violation records, ensuring availability of records to related agencies and the public. It acts to maintain balance and stability in the alcoholic beverage industry through management of liquor licensing, education, enforcement and regulatory programs."

The Office of Justice Programs has funded multi-jurisdictional narcotics and violent crime task forces since 1988. These 23 task forces (as of January 2012) are staffed by over 200 investigators from over 120 agencies. The

2010 Minnesota legislature established a Violent Crimes Coordinating Council to provide direction and oversight.

Driver and Vehicle Services (DVS) regulate commercial and individual driver's licenses in the state of Minnesota according to the provisions of state law. They enforce penalties and driver's license sanctions for impaired driving.

Alcohol and drug impaired driving remains a significant threat to public safety in Minnesota. Consider that one of every seven current Minnesota drivers has at least one DWI.

In 2011, 28,573 DWIs were issued to drivers on Minnesota roads (78 per day on average). Of these, 11,967 (41 percent) violators had at least one prior DWI. A small percentage (six percent or 1,839) of DWIs was issued to drivers less than 21 years of age. Crash data from 2010 indicates that 2,485 people suffered injuries in alcohol-related crashes, and 32 percent (131) of the 411 fatal traffic crashes in Minnesota were alcohol-related. (SOURCE: Office of Traffic Safety, Minnesota Department of Public Safety, 2012.)

As of July 2011, first-time alcohol offenders with an alcohol concentration of 0.16 or above and all second-time alcohol offenders have the option of regaining their driving privileges by participating in the Minnesota Ignition Interlock Device Program. Drivers whose licenses are canceled and whose privileges are denied as "inimical to public safety" are required to enroll in the Ignition Interlock Device Program for a period of three to six years in order to regain full driving privileges.

Ignition interlocks are a proven tool in the fight against impaired driving. The interlocks stop DWI offenders from driving after drinking, prevent re-arrests and result in safer roads. Ignition Interlock is a breath-testing system installed on a motor vehicle and connected to the starter. To start the vehicle, a driver is required to blow into a tube that measures the alcohol concentration level in the driver's blood. If the device detects alcohol at or above a set level, 0.02 in Minnesota, the vehicle will not start. The device also allows for random "running retests" in which a driver

blows into the ignition interlock device so that their alcohol concentration can be measured periodically while driving to their destination. There are numerous protections in place to help assure that the device is not tampered with and that only the driver of the vehicle is providing breath samples into the device.

E. State Judicial Branch

Minnesota's judicial system is filled daily with people experiencing the legal consequences of alcohol and other substance abuse and addiction. A promising and effective approach for various subsets of this population of accused offenders is drug and other specialty courts.

1. Drug Courts

A drug court is a non-adversarial, treatment-based court program that utilizes justice system partners to closely monitor a non-violent, addicted defendant's progress toward recovery from addiction through ongoing treatment, drug testing, court appearances, supervision and the use of immediate sanctions and incentives to help promote behavior changes. Nationwide there are approximately 2,500 operational drug courts that serve 120,000 defendants.

Drug courts shift the traditional manner in which courts handle offenders by working on an ongoing basis with the defendant and multiple, key stakeholders in the justice system. In this approach, the court works closely with prosecutors, public defenders, probation officers, social workers, and other justice system partners to develop a strategy that will pressure an offender into completing a treatment program and abstaining from repeating the behaviors that brought them to court.

Drug courts are an effective problem-solving approach for dealing with alcohol and other drug addicted offenders in the judicial system. Drug courts closely monitor the defendant's progress toward sobriety and recovery through ongoing treatment, frequent drug testing, regular mandatory check-in court appearances, and the use of a range of immediate sanctions and incentives to foster behavior change.

In drug court, judges collaborate with other traditional court participants (prosecutors, defense counsel, treatment providers, probation officers, law enforcement, educational and vocational experts, community leaders and others) whose roles have been substantially modified but not relinquished in the interest of helping defendants deal with addiction.

How effective are drug courts? What does the research show?

2. Drug Court Research Findings

- Upon their release from prison, roughly 66 percent of drug users commit a new crime (typically a drug-related crime) and 95 percent relapse.
- The typical re-arrest rates on standard probation are 46 percent for a new offense and over 60 percent for probation violations.
- Nationwide, 75 percent of drug court graduates remain arrest-free at least two years after leaving the program.
- Rigorous studies examining long-term outcomes of individual drug courts find that reductions in crime last at least three years and can endure for over 14 years.
- Scientific meta-analyses have concluded that drug courts significantly reduce crime by as much as 35 percent more than other sentencing options.
- Nationwide, for every \$1 invested in drug court, taxpayers save as much as \$3.36 in avoided criminal justice costs alone.
- When considering other cost offsets such as savings from reduced victimization and healthcare service utilization, studies have shown benefits range up to \$12 for every \$1 invested.
- Drug courts produce cost savings ranging from \$4,000 to \$12,000 per client. These cost savings reflect reduced prison costs, reduced revolving-door arrests and trials, and reduced victimization.

SOURCE: National Association of Drug Court Professionals (NADCP). Online at <http://www.nadcp.org/learn/nadcp-news-events>

As of April 2012, there were 38 operational drug courts in Minnesota covering 31 counties. This compares with only two in January 2002. These include:

- 10 adult drug courts
- 8 DWI courts
- 9 hybrid courts: (6) Drug/DWI; (2) Drug/DWI/FDTC; (1) Drug/FDTC
- 4 family dependency treatment courts (FDTC)
- 2 juvenile drug courts
- 2 mental health courts
- 1 veterans treatment court
- 2 tribal wellness courts(White Earth)

Between July 1, 2008 and June 30, 2010, 1,795 people participated in Minnesota's drug courts.

The Drug Court Initiative Advisory Committee (DCI) is an advisory committee regularly convened to examine the long-term and systemic challenges facing the Judicial Branch as it seeks to more effectively deal with alcohol and other drug cases in the court system. The DCI oversees and advises policy formulation and implementation and funding distribution for drug courts in Minnesota. The DCI works to establish effective cross-branch and cross-agency collaboration to reflect, at the state level, those strategies proven to be effective in the establishment of drug courts at the local level.

3. Key Components of Minnesota Drug Courts

- Drug courts integrate alcohol and other drug treatment services with justice system case processing.
- Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.
- Eligible participants are identified early and are promptly placed in the drug court program.
- Drug courts provide access to a continuum of alcohol and other drug and related treatment and rehabilitation services.
- Abstinence is monitored by frequent alcohol and other drug testing.
- A coordinated strategy governs drug court responses to participants' compliance.
- Ongoing judicial interaction with each drug court participant is essential.
- Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.
- Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.
- Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court effectiveness.

F. Department of Corrections

1. Overview

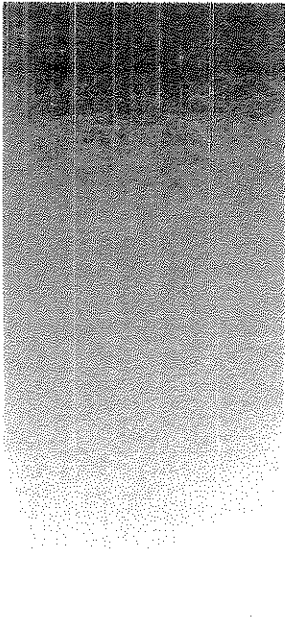
Research shows that those who have previously been convicted of a crime are much more likely to commit new crimes or violate their parole conditions if they use substances. Minnesota offenders who end up in prison have very high rates of drug and alcohol problems. Ninety percent of offenders entering prison have a diagnosable substance abuse or dependence disorder. In most cases, offenders who end up in prison have been through multiple prior addiction treatment programs and yet have relapsed. Offender populations are challenging to treat effectively and often present with multi-occurring problems such as mental illness, personality disorders and traumatic brain injury along with their substance use disorders.

As of January 2012, there were 1,560 offenders incarcerated on drug crimes with another 715 felony DWI offenders representing a combined 24.4 percent of the prison population who are directly incarcerated because of drug and alcohol offenses. A much higher proportion of incarcerated offenders were using drugs and/or alcohol at the time of their offense.

The percentage of drug offenders in Minnesota prisons has varied over time with a peak 2,187 drug offenders in 2005 associated with the rapid growth of methamphetamine abuse during that period. The number of offenders incarcerated on drug offenses has decreased by 19 percent since that time. Methamphetamines offenses are the highest in Minnesota prisons, representing 43 percent of all drug offenses, followed by crack (23 percent) and cocaine (21 percent).

Race is closely tied to drug offense type, with minorities representing 91 percent of offenders incarcerated on crack cocaine offenses. Seventy-three percent of offenders convicted of cocaine offenses are also persons of color.

The number of DWI offenders has grown progressively, more than doubling (from 312 to 715) since 2005. Most drug offenders have prior felony convictions. A 2010 review



found that the 1,763 drug offenders then incarcerated in Minnesota prisons had a combined total of 5,289 prior felony convictions at the time they were entered prison for their current drug offense. Felony level DWI offenders typically have two or more prior DWI offenses.

2. Investing in Treatment

Because recidivating among prison offenders is closely tied to drug and alcohol use and because 95 percent of offenders are eventually released back to their communities, Minnesota has invested in prison-based chemical dependency treatment programs as a means of contributing to community safety. Prison-based substance abuse treatment takes advantage of incarceration by providing long-term, comprehensive, programming during a period of controlled sobriety prior to release back into the community. Studies conducted by the Minnesota Department of Corrections (DOC) show a significant reduction in recidivism in three-year follow-up studies with treatment participants.

The Minnesota Department of Corrections provides a continuum of substance abuse services, including pretreatment, primary long-term treatment, aftercare and limited release planning. Addiction treatment is available to offenders at every state prison custody level except maximum. Services are provided to adult and juvenile male and female offenders. The DOC maintains approximately 900 treatment beds and its programs are routinely reviewed for compliance with state certification and licensure standards.

Chemical dependency treatment programs in the Minnesota prison system rely on research-based practices that are effective with the chemically dependent offender. Primary long-term (six to nine months) residential treatment is delivered in modified therapeutic communities which are separated from general population. Treatment services are individualized and based on the assessed needs of the clients. Enhanced services are available for offenders with co-

occurring mental health and substance use disorders, with an expansion of services made possible under a federal Second Chance Act Grant.

Additional innovations in chemical dependency treatment services include a short-term relapse prevention intervention for release violators. These are offenders who completed treatment in a past incarceration, but then relapsed to substance use which resulted in a violation of the terms of their supervision while in the community. The goal of this program is to stabilize these addicted offenders in their recovery. Enhanced release planning services provide more adequate community support for their recovery upon their re-release. This program serves offenders who would previously have no opportunity for effective treatment due to the short duration of their sentences, and provides an efficient and effective intervention that is more appropriate to their recovery needs than long-term primary treatment.

Chemical dependency treatment is also provided to incarcerated juvenile offenders under a DHS-licensed addiction treatment program within the DOC. It is also provided to offenders in correctional military boot camps for both men and women, with addiction treatment integrated into the structure of military training.

The added complication of working with the criminogenic needs and criminal risk in this population is effectively addressed in the DOC treatment programs. "A New Direction," a curriculum authored by Department of Corrections treatment staff and published by Hazelden, is considered to be a best practice in the treatment of the substance-abusing criminal offender population and is sold all over the world for treatment programs in correctional settings. Minnesota DOC treatment professionals have the knowledge base and expertise that could be helpful to community-based treatment providers who will work with this unique client population upon release to the community.

3. Principles of Addiction Treatment Among Correctional Populations

The chemical dependency treatment services delivered in Minnesota's correctional settings are consistent with the research-based principles set forth by the National Institute on Drug Abuse as follows:

- Drug addiction is a brain disease that affects behavior.
- Recovery from drug addiction requires effective treatment, followed by management of the problem over time.
- Treatment must last long enough to produce stable behavioral changes.
- Assessment is the first step in treatment.
- Tailoring services to fit the needs of the individual is an important part of effective drug abuse treatment for criminal justice populations.
- Drug use during treatment should be carefully monitored.
- Treatment should target factors that are associated with criminal behavior.
- Criminal justice supervision should incorporate treatment planning for drug abusing offenders, and treatment providers should be aware of correctional supervision requirements.
- Continuity of care is essential for drug abusers re-entering the community.
- A balance of rewards and sanctions encourages pro-social behavior and treatment participation.
- Offenders with co-occurring drug abuse and mental health problems often require an integrated treatment approach.
- Medications are an important part of treatment for many drug abusing offenders.
- Treatment planning for drug abusing offenders who

are living in or 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

SOURCE: Principles of Drug Abuse Treatment for Criminal Justice Populations, NIH Publication No. 06-5316, printed September 2006.

4. Focus on Re-entry

Since 2006, the DOC has invested in multiple offender reentry projects such as the Prisoner Reentry Initiative, the Minnesota Comprehensive Reentry Plan and the Second Chance Act Demonstration Project. Each of these projects has included strong chemical dependency program elements. These projects have been based on evidence-based practice and, as such, have included research measurement components. Some results are currently available by request or at the DOC website, and some data (Second Chance Project) are still being collected. Additionally, these projects have been designed to foster greater collaboration with community partners, including chemical dependency service providers.

5. Outcomes

Prison-based Chemical Dependency Treatment in Minnesota: Outcome Evaluation Results are highlighted below. Completing prison-based chemical dependency treatment, or successfully participating until release, significantly reduced the risk of recidivism by:

- 22 percent for rearrest.
- 20 percent for reconviction.
- 27 percent for reincarceration for a new offense.

SOURCE: Minnesota Department of Corrections, Prison-Based Chemical Dependency Treatment in Minnesota: An Outcome Evaluation – March 2010. Online at: www.doc.state.mn.us/publications/documents/03-10CDTXEvaluationReport_Revised.pdf

G. Department of Military Affairs/ Minnesota National Guard

The Department of Military Affairs (DMA) is responsible in providing personnel and units that are trained, equipped and supported by facilities to meet all federal and state missions. The Adjutant General is the administrative head of the Minnesota Department of Military Affairs and oversees the day-to-day operation and management of the fiscal, personnel, equipment and real property resources of the Minnesota National Guard (MNNG) and the Minnesota Department of Military Affairs.

The Minnesota National Guard is the largest military entity in the state, with nearly 14,000 citizen soldiers and airmen. Its enduring goal is to provide agile and resilient service members to fulfill any federal, state and community demand. The Minnesota National Guard focuses on two key areas: 1) Providing ready military units whenever and wherever needed and 2) Simultaneously integrating their relationships with the mutual needs and requirements of their stakeholders.

It is the policy of the Minnesota National Guard to maintain a workplace free from substance abuse. Substance abuse, which includes inappropriate use of alcohol and drugs, is inconsistent with military values and the standards of performance, discipline, and readiness necessary to accomplish the mission.

The MNNG Joint Substance Abuse Program (JSAP) mission is to strengthen the overall effectiveness of the National Guard's total workforce and to enhance the combat readiness of its service members. To achieve this goal and maintain a substance free workplace the following urinalysis testing requirements are in place:

- 100 percent of the Minnesota Army National Guard (MARNG) assigned end strength per year (at least 50 percent must come from random testing) at a testing rate of 10 percent per month or 25 percent per quarter.

- 50 percent of the Minnesota Air National Guard (MNANG) assigned end strength (at least 50 percent must come from random testing) at a rate of 5 percent per month or 13 percent per quarter.
- There are annual requirements to test 100 percent of the personnel assigned to designated career fields, such as Active Guard and Reserve (AGR), Aviation, Counterdrug, Military/Security Police, medical and other personnel.

The Minnesota National Guard's Prevention, Treatment and Outreach (PTO) program does not provide direct treatment services, but provides the following support:

- The PTO program provides two hours of substance abuse prevention education annually to all Minnesota National Guard members.
- A substance abuse climate survey is supposed to be conducted annually at each unit to assist commanders with identifying problem areas that need to be addressed that include substance abuse, mental health, domestic violence, financial and suicide issues. Based on the results of the survey, commanders can then provide appropriate training and interventions in the necessary areas.
- Soldiers, Airmen and family members found to have substance abuse issues, either through self-identification, legal identification or command identification, are referred to the state Prevention Coordinator (PC) for an assessment and referral to the appropriate level of care in their community. The state PC coordinates with the treating facility for continuity of care when guards' members complete treatment and return home.
- The state PC provides continuing follow-up with guards' members that have completed treatment for up to 12 months. The state PC provides a comprehensive 16-hour substance abuse education program for all guards' members and/or family members that have been identified as needing an education program as a result of an assessment, court order, command requirement or other means.

- The state PC collaborates with state and local providers, prevention coordinators, organizations (DHS, drug courts, probation, VA medical) and treating facilities to ensure that proper referrals are made, that prevention efforts are in line with local efforts and to assist with policy change efforts.

The Minnesota National Guard Counterdrug Task Force (MNCDTF) provides counterdrug/narco-terrorism support to federal, state, and local law enforcement, community based organizations, and schools annually throughout the state of Minnesota in support of the Governor's State Plan in order to reduce the supply and demand for illicit drugs while enhancing the skill sets and readiness of MNCDTF members. This support is in the areas of drug interdiction and civil operations. The amount of support is dependent on annual funding.

- Drug interdiction includes criminal analyst and drug detection support to federal, state and local law enforcement agencies. This support focuses on four core competencies: link analysis, document exploitation, commodity-financial analysis and case construction.
- Civil operations include coalition building and support along with drug education in collaboration with law enforcement, community-based organizations, and schools. This effort consists of fostering an effective community-based response by using unique military skill-sets and culture to assist local coalitions in supporting their implementation of evidence-based strategies.
- The MNCDTF partners with the Midwest Counterdrug Training Center (MCTC), the Bureau of Criminal Apprehension (BCA) and others to provide free or low cost training to Minnesota law enforcement and others involved in drug interdiction and prevention.

H. Minnesota Board of Pharmacy

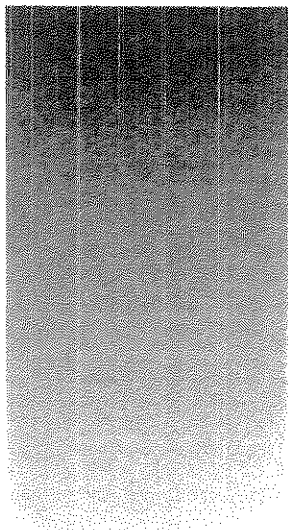
The Minnesota Board of Pharmacy exists to protect the public from adulterated, misbranded, and illicit drugs, and from unethical or unprofessional conduct on the part of pharmacists or other licensees, and to provide a reasonable assurance of professional competency in the practice of pharmacy by enforcing the Pharmacy Practice Act M.S. 151, State Controlled Substances Act M.S. 152 and various other statutes. The Board strives to fulfill its mission through a combination of regulatory activity and technical consultation and support for pharmacy practices through the issuance of advisories on pharmacy practice issues and through education of pharmacy practitioners.

In response to the growing non-medical abuse of prescription drugs, many states including Minnesota established prescription monitoring programs. The Minnesota Board of Pharmacy was given authority under M.S. 152.126, to establish and maintain a program to help identify individuals who inappropriately obtain excessive amounts of controlled substances from multiple prescribers and pharmacies. The purpose of the Minnesota Prescription Monitoring Program (PMP), in operation since 2010, is to promote public health and welfare by detecting diversion, abuse and misuse for the prescription medications classified as controlled substances under the Minnesota statutes.

I. Minnesota Health Professionals Services Program

Health professionals, like anyone else, are susceptible to substance, psychiatric and medical disorders. Left untreated, these problems can put patients at risk. Many health care practitioners don't get the help they need, especially when suffering from substance use disorders, because they fear losing their jobs and the negative social stigma attached to addiction in general. This program facilitates early intervention and treatment before patient safety is compromised.

The State of Minnesota Health Professionals Services Program (HPSP) was created in 1994 as an alternative to board discipline.



The HPSP offers a proactive way to fulfill reporting requirements and get confidential help for illnesses. By law, health practitioners and employers can report a potential impairment to a licensing board or to HPSP. "Most choose HPSP," according to Monica Feider, program manager, "because HPSP is supportive and non-disciplinary."

HPSP monitors health professionals who have an illness that may impair their ability to do their job. Illnesses may include chemical dependence, physical problems or mental health issues.

All eligible health care professionals licensed in Minnesota can receive HPSP monitoring services as long as they comply with program expectations. Participants are responsible for the cost of their own evaluation, treatment, and toxicology screens.

Many people are unclear about their reporting obligations and feel uneasy about reporting themselves, a colleague or an employee to HPSP. Getting involved in the personal issues of another professional is a difficult decision. Yet, there is the ethical duty to protect patients from potential harm. All referrals made to HPSP are regarded as privileged data and kept confidential.

HPSP has received over 5,000 referrals to monitor health professionals and is currently serving nearly 600 of them. Of these, the majority either self-referred to HPSP, or were referred by a third party (employee health, colleague, supervisor, provider, health licensing board).

The program monitors treatment progress, work quality and medications, along with attendance at support groups and random urine screens, if alcohol or drug use is part of the illness. HPSP might also require counseling, work limitations or other individualized conditions that address a person's needs and public safety. Typically, agreements are for 36 months.

J. Ongoing Multi-Agency Efforts

1. Minnesota Student Survey

The Minnesota Departments of Human Services, Public Safety, Health and Education collectively fund the administration of the Minnesota Student Survey, a primary and vital ongoing source of information about Minnesota students. The Minnesota Student Survey is conducted every three years among three populations of students in Minnesota public schools:

- Students in regular public schools, including charter schools and tribal schools (grades 6, 9, and 12 only)
- Students in alternative schools and Area Learning Centers (all grades)
- Students in juvenile correctional facilities (all grades)

The survey asks questions about activities, experiences, and behaviors. Topics covered include tobacco, alcohol and drug use, school climate, physical activity, violence and safety, connections with school and family, health and other topics. Reports are available from the Minnesota Center for Health Statistics, found online at: <http://www.health.state.mn.us/divs/chs/mss/>

2. Minnesota Collaborative on Substance Abuse

Minnesota Collaborative on Substance Abuse is comprised of individuals who represent state agencies that are directly involved in substance abuse-related activities, including law enforcement, prevention, corrections, specialty courts, addiction treatment services, and epidemiological surveillance. This group is convened at least quarterly to provide updates on the activities of each agency and to disseminate current original data and information regarding the activities of the respective agencies. The contributions of this group were central to the creation of this statewide substance abuse strategy.

Member agencies at present include the Departments of Human Services, Health, Education, Public Safety, Corrections, Veteran Affairs/Minnesota National Guard, Minnesota State Judicial Branch, State Board of Pharmacy, and the Hennepin County Regional Poison Center.

3. Minnesota State Epidemiological Profile

The Minnesota State Epidemiological Profile was created with guidance from the State Epidemiological Outcomes Workgroup and funding from the Minnesota Department of Human Services Alcohol and Drug Abuse Division. The Profile is a collection of data sets that help characterize and quantify patterns of use and consequences related to alcohol, tobacco and other drugs in Minnesota.

The interactive online website www.sumn.org provides data on 70 indicators relating to the consumption and consequences of alcohol, tobacco, and other drugs in Minnesota. The most recent available data from multiple government sources are provided at the county level, and by race/ethnicity at the state and regional levels whenever possible. The website is maintained by the Minnesota Institute of Public Health.

The purpose is: 1) To provide a one-stop-shop of useful data, reading material, and community resources related to substance use and consequences in Minnesota 2) To help varied community and professional audiences make decisions about substance abuse prevention efforts based on existing evidence and demonstration of need and 3) To provide easily accessible online data that can be used to prepare applications for funding, monitor prevention-related trends, plan programs or initiatives or to help define community-level prevention priorities.

www.sumn.org

4. Minnesota State Epidemiological Outcomes Workgroup

The Minnesota State Epidemiological Outcomes Workgroup is a collaborative effort of researchers from the Minnesota Departments of Human Services, Health, the Education, Public Safety, Corrections, and the Minnesota Institute of Public Health. The purpose of the group is to compile and disseminate the most recent available data about substance abuse and addiction across Minnesota to better inform local, county, and state prevention activities and other efforts related to assessment, planning, priority-setting and evaluation.

5. Minnesota Strategic Prevention Framework State Incentive Grant (SPF-SIG) Advisory Council

This group was formed in January of 2010 to assist the Department of Human Services ADAD in administering the Strategic Prevention Framework State Incentive Grant. The council maintains a membership of up to 40 people from across the state representing various government agencies, non-profit organizations, community-based prevention programs, and other sectors involved in substance abuse prevention.

The role of the advisory council is to guide the work of the SPF-SIG. Members were also involved in the development and selection of the three Minnesota SPF-SIG priorities, the development of the SPF-SIG Strategic Plan, and the sub-recipient request for proposals. The group meets every other month and is chaired by Tom Griffin, Ph.D., who was appointed by Governor Dayton in March 2012.

6. Minnesota Evidence-Based Practices Workgroup

The Minnesota Evidence-Based Practices Workgroup is another collaborative effort formed as a part of the Strategic Prevention Framework State Incentive Grant (SPF-SIG). Established in November 2010, it consists of researchers, prevention practitioners, technical assistance providers and community-level implementers. It provides guidance on the selection and use of evidence-based prevention interventions and the review and approval of SPF-SIG grantees' strategic plans, to help ensure that strategies selected are appropriate for their communities and will obtain the desired outcomes.

7. Minnesota Strategic Prevention Enhancement Consortium

Convened by the Alcohol and Drug Abuse Division of the Minnesota Department of Human Services, this group worked on defining commonalities among substance prevention, mental health promotion, mental illness prevention and primary care, and was specifically tasked with creating a Minnesota five-year prevention plan by the fall of 2012.

IV. Guiding Principles: Addressing Substance Abuse in Minnesota

A. Collaboration

"If everyone is moving forward together, then success takes care of itself." - Henry Ford

Advances in public health and public safety rarely happen in the absence of collaboration. Dialogue and coordination between multiple government, community, and tribal entities is vital to successful efforts. By working together, coordinating efforts, and collectively drawing on the combined strengths of professionals and stakeholders, communities can effect changes. Preventing and responding to substance abuse-related problems, in these days of limited resources, requires ongoing and expanding collaborations and by so doing, more effectively leveraging resources.

B. Prevention and early intervention work best

One of the most effective ways of addressing a social or medical problem is to prevent it from happening in the first place. Effective prevention reduces risk factors and promotes protective factors. If educated, parents can play an important role in preventing drug and alcohol abuse among their children. If trained, health professionals can learn to identify and address high-risk drinking and drugging behaviors long before addiction develops.

C. Reduce health disparities and promote cultural competence

Cultural competence is the process of communicating with audiences from diverse geographic, ethnic, racial, cultural, economic, social and linguistic backgrounds. Becoming culturally competent is a dynamic process that requires cultural knowledge and skill development at all service levels, including policymaking, administration and practice. Because substance abuse issues are local in character, the solutions must likewise be locally derived and implemented as well as culturally appropriate and meaningful.

D. Sustain a continuum of services

From Minnesota Statute section 254A.01: "It is hereby declared to be the public policy of this state that the interests of society are best served by providing persons who are dependent upon alcohol or other drugs with a comprehensive range of rehabilitative and social services. . . . [T]reatment shall include a continuum of services available for a person leaving a program of treatment; [and] treatment shall include all family members at the earliest possible phase of the treatment process."

Because substance abuse and addiction affect individuals, families, workplaces, and entire communities, a broad continuum of care is needed to adequately address the changing needs of both individuals and others who are significantly affected by addiction and substance abuse. In particular, children raised in addictive environments, children in transition, and those with adverse childhood experiences are at heightened risk for substance use and mental health disorders, and require specialized services delivered in a coordinated manner.

E. An integrated approach to service delivery in health care

One of the most important elements of health care reform is the expansion of coverage for those with substance use and mental health disorders. Another new law requires parity, meaning that group health insurance plans must provide coverage for mental health and substance use disorders that is on par with coverage provided for other medical and surgical benefits. These sweeping changes create the foundation for the new health care environment.

Ingrained in health care reform is the public health model that supports prevention, screening and early intervention, treatment and recovery, integrated with primary health care. Complex developments that include new benefit packages and financing strategies, greater use of technology, promotion of

evidence-based practices and the very important linkage with primary care all present opportunities and challenges that will be addressed in the months and years to come.

In this evolving context, the goal of effective health care service delivery is to attain positive physical and behavioral health outcomes. To that end, physical and behavioral health care services must be integrated in a way that addresses the needs of each person, also referred to as "the right care at the right time." Behavioral health needs to be integrated in to primary health care. The treatment of patients with co-occurring substance use and mental health disorders must be also delivered in a coordinated, integrated manner that address an individual's physical and behavioral health needs.

F. Substance use disorders are treatable

The outcomes of addiction treatment are comparable to the outcomes of treatment for other chronic diseases with behavioral components. Treatment is effective and when people get the help they need they can turn their lives around.

G. Recovery is possible

Substance use disorders and substance abuse affect the quality of life for individuals, families and entire communities. Every Minnesotan has an important role to play in advancing drug-free, quality families, schools and communities. Recovery often requires support and is sustained when there is continued focus on maximizing collaborative relationships within the recovery community statewide.



V. Immediate Policy Priorities: Prescription Opiate and Heroin Abuse and Addiction

Because the abuse of prescription opiates and heroin is a serious and rapidly escalating problem of significant proportion in Minnesota, these are the immediate recommendations:

- Train physicians in the basics of addiction, opiate prescribing, and alternative approaches to pain management, and require that they have a certain number of Continuing Medical Education units (CMEs) on these topics as a condition of recertification of their specialty licenses.
- Train a broad range of front-line professionals about prescription drug abuse, treatment options for opiate addicts, and how to reverse an opiate overdose including: licensed addiction treatment providers, detox staff, law enforcement and first responders.
- Accelerate efforts to increase participation by prescribers and pharmacists in the Prescription Monitoring Program and examine alternate methods for law enforcement access.

VI. Strategies: A Blueprint for the Future

A. Strengthen prevention efforts within and across Minnesota communities. This will be accomplished by:

- Establishing and convening a broad-based coalition to develop and help implement consistent messaging about illegal drug abuse prevention messages. This will be comprised of health plans, prevention organizations, and key state agency prevention staff in order to develop consistent messaging so that it can be adopted by all state-funded prevention grant programs and by other entities that engage in prevention efforts around illegal drug and prescription drug abuse.
- Increasing efforts and enacting statewide policies to reduce underage drinking and alcohol abuse by:
 1. Evaluating the appropriate level of alcohol excise tax in Minnesota,
 2. Limiting drink specials in retail liquor establishments,
 3. Strengthening compliance checks to ensure that retailers do not sell tobacco and alcohol to minors,
 4. Requiring beverage server training at all liquor establishments to reduce alcohol sales to minors and intoxicated patrons,
 5. Maintaining limitations on alcohol availability including: alcohol sales restricted to 6 days a week statewide and to current locations (designated liquor outlets not grocery or convenience stores), and
 6. Ensuring adequate law enforcement resources for the enforcement of existing underage drinking, drinking and drugging laws.

B. Create more opportunities for early intervention in health care and other settings. This will be accomplished by:

- Integrating routine substance abuse screening including the use of the Prescription Monitoring Program into all health care settings and improving the skills of health care providers so they can identify high risk substance use and intervene at the earliest point possible
- Requiring Screening, Intervention, and Referral to Treatment (SBIRT) at all emergency care settings, and
- Incorporating SBIRT Plus into all primary care practices in the state.

C. Integrate the identification and treatment of substance use disorders into health care reform efforts. This will be accomplished by:

- Ensuring adequate access to and coverage for addiction treatment services and that health care reform in Minnesota creates benefits for addiction treatment that are on par with treatment benefits for other chronic diseases thereby enforcing the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
- Ensuring that the Health Care Home and Health Home models in Minnesota encompass the medical management of behavioral health care needs, including addiction treatment and recovery support services.

D. Expand support for recovery. This will be accomplished by:

- Fostering and expanding the development of recovery schools, community-based recovery organizations, and other creative private and public partnerships for the provision of recovery support services and networks throughout the state.

- Ensuring adequate access to recovery support services for people in recovery, especially those transitioning into communities from institutional settings such as prisons, jails, mental health centers, and residential treatment facilities.

E. Interrupt the cycle of substance abuse, crime and incarceration. This will be accomplished by:

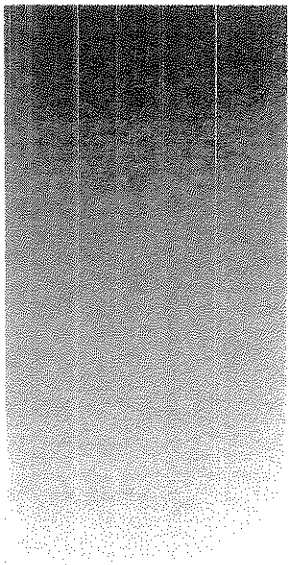
- Expanding effective prison-based treatment and access to treatment services at additional correctional settings, including local jails and county workhouses for juvenile and adult populations.
- Expanding and continuing the support of drug courts and other specialty courts in Minnesota.

F. Reduce trafficking, production and sale of illegal drugs in Minnesota. This will be accomplished by:

- Maximizing federal and state support for multi-jurisdictional drug task forces.
- Enhancing and expanding training for law enforcement about emerging drug threats so that they can most effectively adapt their investigative tools.

G. Measure with accurate and timely data the emerging nature and extent of substance abuse and scientifically evaluate the results of various interventions. This will be accomplished by:

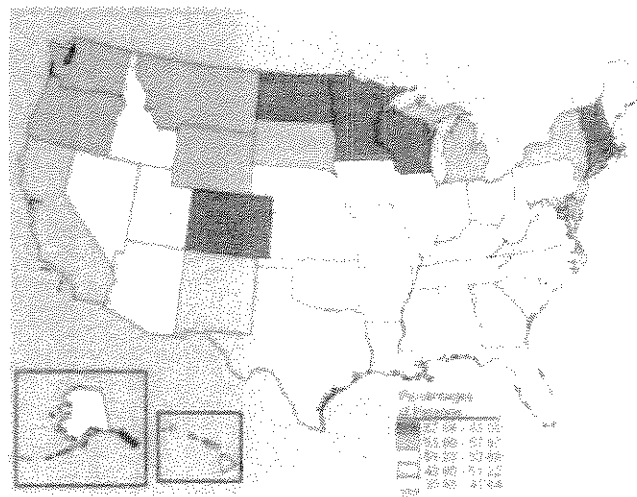
- Producing and widely disseminating an annual "State of the State" substance abuse report card, a quantitative, analytical assessment of substance abuse-related activities and spending in Minnesota using various public data sources.
- Continuing the administration of ongoing population-based and other relevant data efforts including but not limited to the Minnesota Student Survey, the Behavioral Risk Factor Surveillance System, the Hennepin Regional Poison Center, and the Drug and Alcohol Abuse Normative Evaluation System.



APPENDIX

EXHIBIT 1

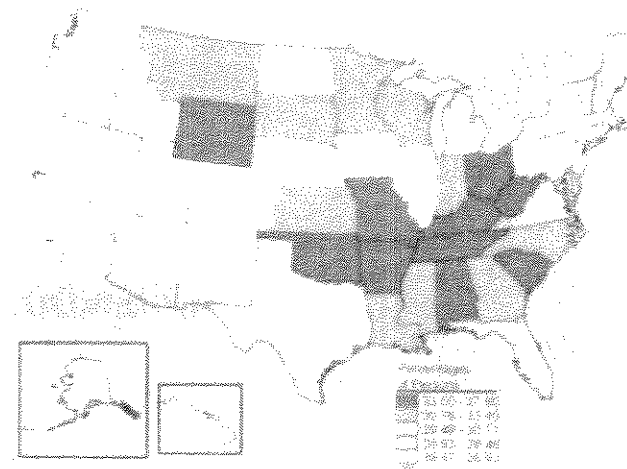
Alcohol Use in Past Month among Persons Aged 12 or Older, by State



SOURCE: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2006 and 2007.

EXHIBIT 3

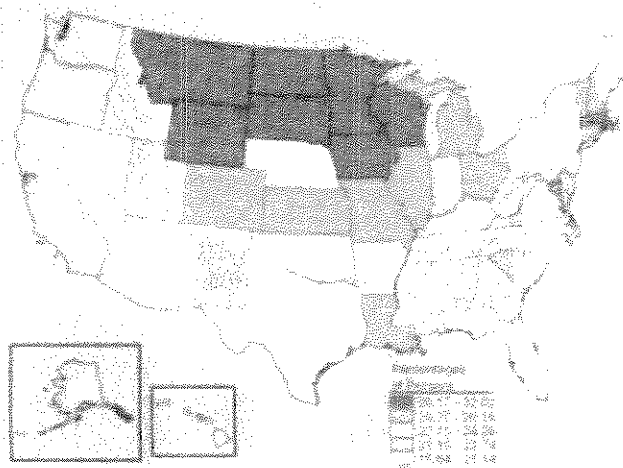
Cigarette Use in Past Month among Persons Aged 12 or Older, by State



SOURCE: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2006 and 2007.

EXHIBIT 2

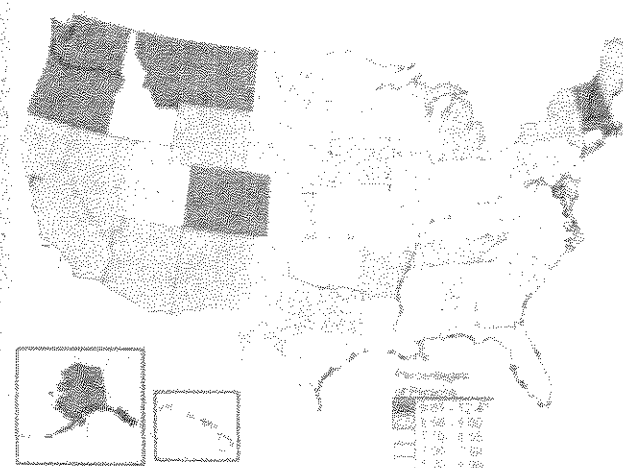
Binge Alcohol Use in Past Month among Persons Aged 12 or Older by State



SOURCE: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2006 and 2007.

EXHIBIT 4

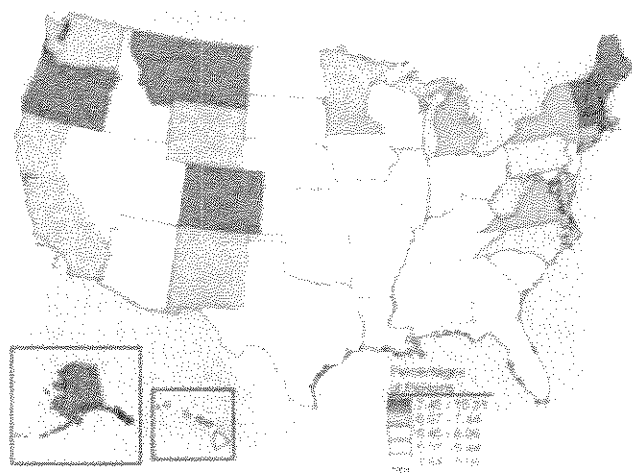
Illicit Drug Use in Past Month among Persons Aged 12 or Older by State



SOURCE: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2006 and 2007.

EXHIBIT 5

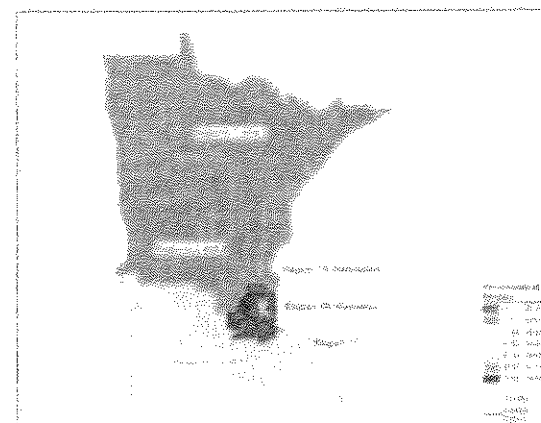
Marijuana Use in Past Month among Persons Aged 12 or Older by State



SOURCE: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2006 and 2007.

EXHIBIT 7

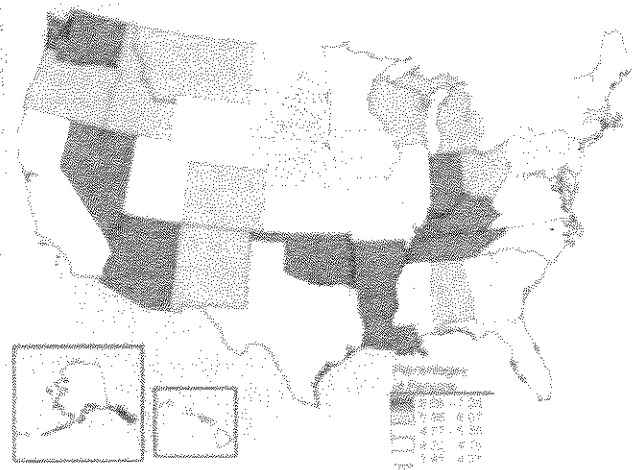
Alcohol Use in Past Month among Persons Aged 12 or Older in Minnesota, by Substate Region



SOURCE: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2006, 2007, and 2008.

EXHIBIT 6

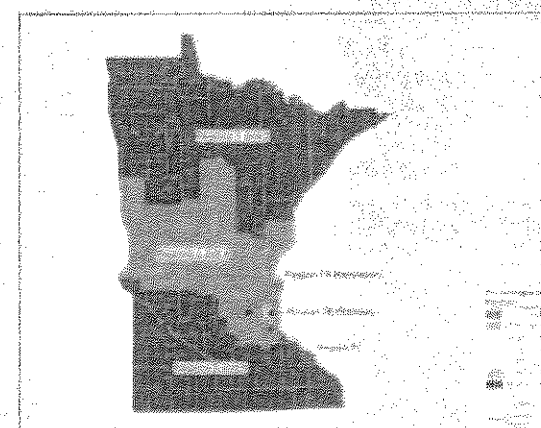
Nonmedical Use of Pain Relievers in Past Year among Persons Aged 12 or Older by State



SOURCE: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2006 and 2007.

EXHIBIT 8

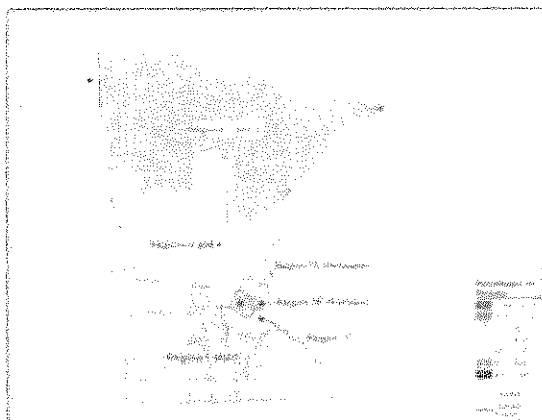
Binge Alcohol Use in Past Month among Persons Aged 12 or Older in Minnesota, by Substate Region



SOURCE: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2006, 2007, and 2008.

EXHIBIT 9

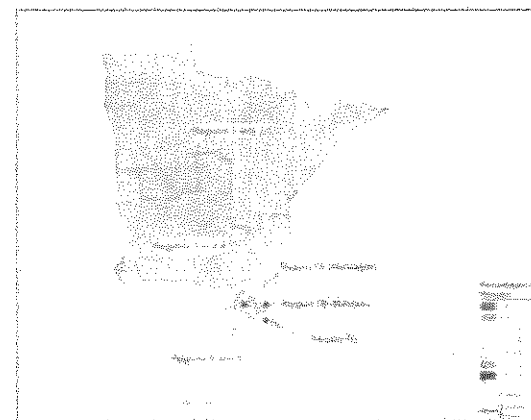
Illicit Drug Use in Past Month among Persons Aged 12 or Older in Minnesota, by Substate Region



SOURCE: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2006, 2007 and 2008.

EXHIBIT 10

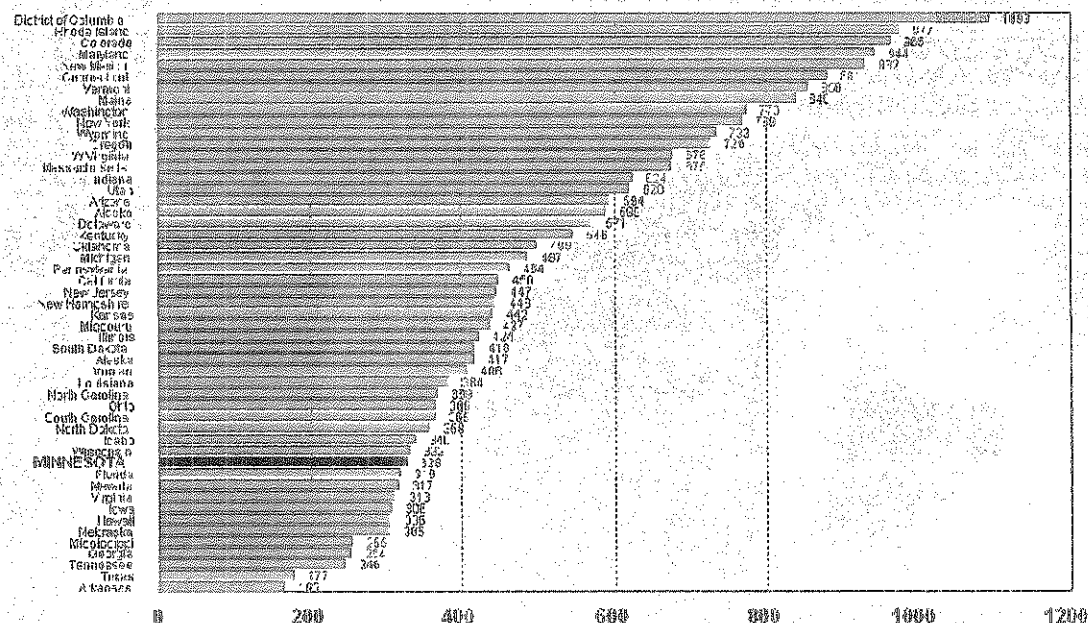
Marijuana Use in Past Month among Persons Aged 12 or Older in Minnesota, by Substate Region



SOURCE: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2006, 2007 and 2008.

EXHIBIT 11

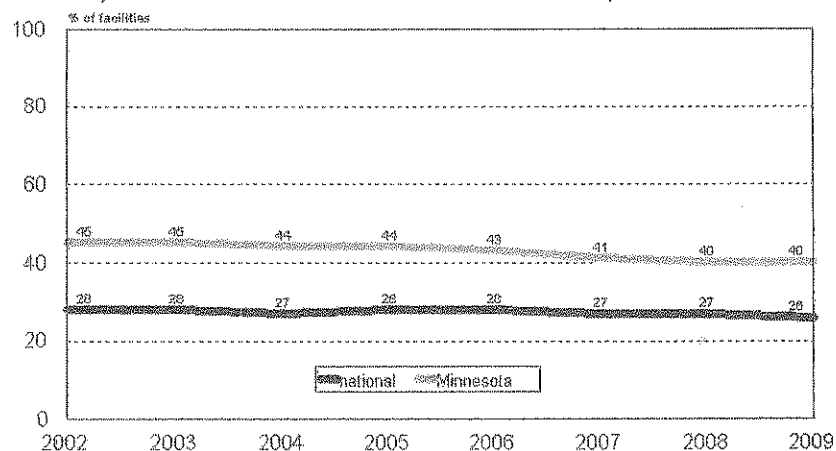
Clients age 18 and over in addiction treatment programs per 100,000 population by state: 2009



SOURCE: 2008 National Survey of Substance Abuse Treatment Services (SSATS), Substance Abuse and Mental Health Services Administration, 2011.

EXHIBIT 12

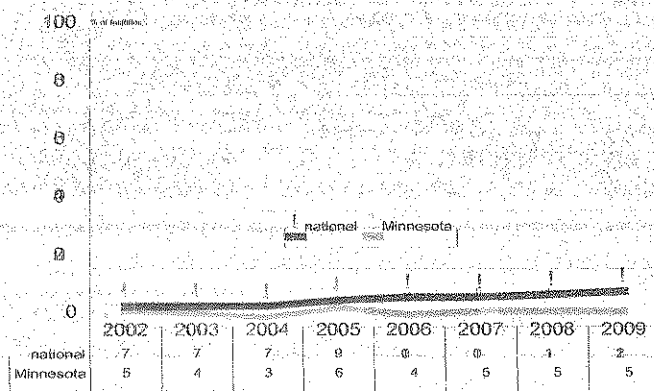
RESIDENTIAL = Type of care setting for addiction treatment facilities:
Nationally and in Minnesota 2002 - 2009 (excludes hospital-based residential)



SOURCE: National Survey of Substance Abuse Treatment Services (N-SSATS), Substance Abuse and Mental Health Services Administration (SAMHSA), 2003 - 2010.

EXHIBIT 13

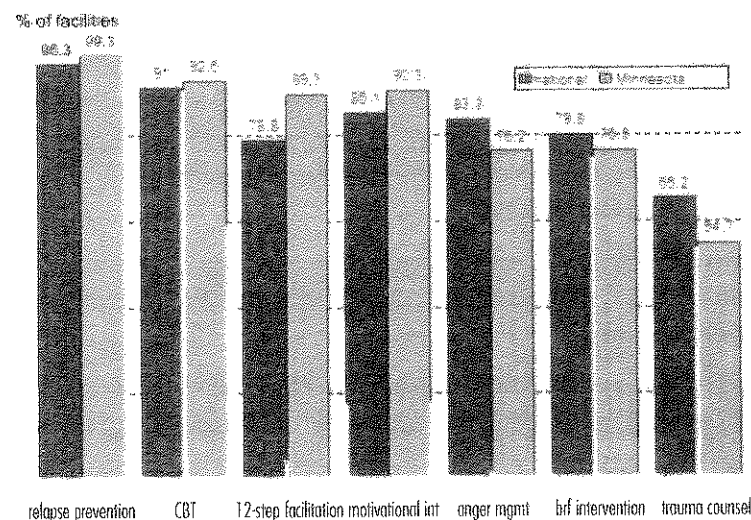
OPIOID TREATMENT PROGRAMS = Type of care setting for addiction treatment facilities: National and in Minnesota 2002 - 2009



SOURCE: National Survey of Substance Abuse Treatment Services (N-SSATS), Substance Abuse and Mental Health Services Administration (SAMHSA), 2003 - 2010.

EXHIBIT 14

Clinical approaches used sometimes/often by addiction treatment facilities:
Nationally and in Minnesota 2009



SOURCE: National Survey of Substance Abuse Treatment Services (N-SSATS), Substance Abuse and Mental Health Services Administration, 2009. CBT = cognitive behavior therapy

STATE AUTHORITY ON ALCOHOL AND DRUG ABUSE.

Subdivision 1. Alcohol and Other Drug Abuse Section:

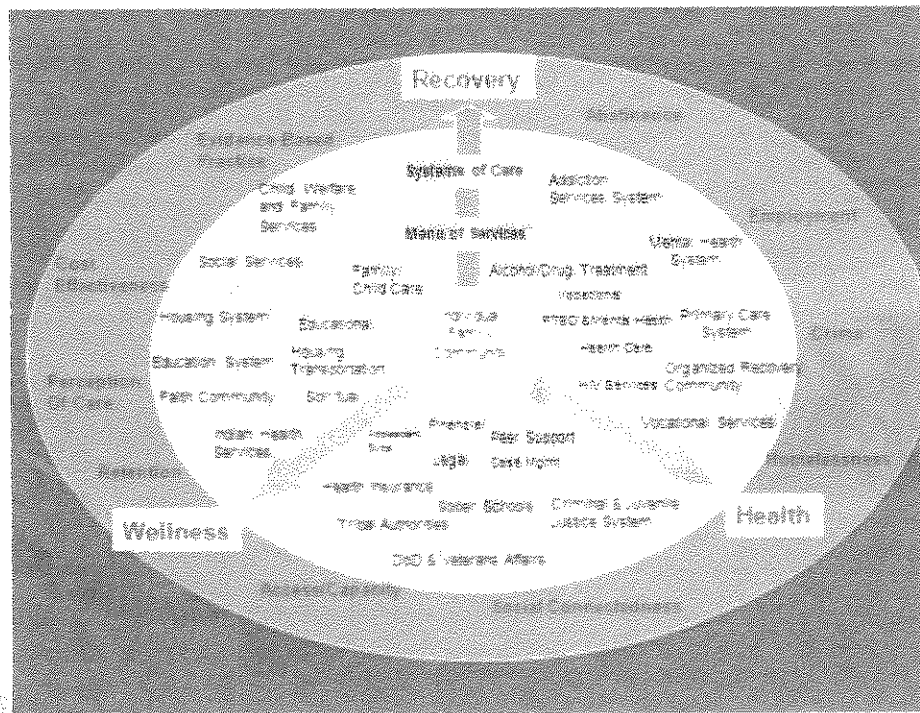
There is hereby created an Alcohol and Other Drug Abuse Section in the Department of Human Services. This section shall be headed by a director. The commissioner may place the director's position in the unclassified service if the position meets the criteria established in section 43A.08, subdivision 1a. The section shall:

- (1) conduct and foster basic research relating to the cause, prevention and methods of diagnosis, treatment and rehabilitation of alcoholic and other drug dependent persons;
- (2) coordinate and review all activities and programs of all the various state departments as they relate to alcohol and other drug dependency and abuse problems;
- (3) develop, demonstrate, and disseminate new methods and techniques for the prevention, treatment and rehabilitation of alcohol and other drug abuse and dependency problems;
- (4) gather facts and information about alcoholism and other drug dependency and abuse, and about the efficiency and effectiveness of prevention, treatment, and rehabilitation from all comprehensive programs, including programs approved or licensed by the commissioner of human services or the commissioner of health or accredited by the Joint Commission on Accreditation of Hospitals. The state authority is authorized to require information from comprehensive programs which is reasonable and necessary to fulfill these duties. When required information has been previously furnished to a state or local governmental agency, the state authority shall collect the information from the governmental agency. The state authority shall disseminate facts and summary information about alcohol and other drug abuse dependency problems to public and private agencies, local governments, local and regional planning agencies, and the courts for guidance to and assistance in prevention, treatment and rehabilitation;
- (5) inform and educate the general public on alcohol and other drug dependency and abuse problems;
- (6) serve as the state authority concerning alcohol and other drug dependency and abuse by monitoring the conduct of diagnosis and referral

services, research and comprehensive programs. The state authority shall submit a biennial report to the governor and the legislature containing a description of public services delivery and recommendations concerning increase of coordination and quality of services, and decrease of service duplication and cost;

- (7) establish a state plan which shall set forth goals and priorities for a comprehensive alcohol and other drug dependency and abuse program for Minnesota. All state agencies operating alcohol and other drug abuse or dependency programs or administering state or federal funds for such programs shall annually set their program goals and priorities in accordance with the state plan. Each state agency shall annually submit its plans and budgets to the state authority for review. The state authority shall certify whether proposed services comply with the comprehensive state plan and advise each state agency of review findings;
- (8) make contracts with and grants to public and private agencies and organizations, both profit and nonprofit, and individuals, using federal funds, and state funds as authorized to pay for costs of state administration, including evaluation, statewide programs and services, research and demonstration projects, and American Indian programs;
- (9) receive and administer monies available for alcohol and drug abuse programs under the alcohol, drug abuse, and mental health services block grant, United States Code, title 42, sections 300X to 300X-9;
- (10) solicit and accept any gift of money or property for purposes of Laws 1973, chapter 572, and any grant of money, services, or property from the federal government, the state, any political subdivision thereof, or any private source;
- (11) with respect to alcohol and other drug abuse programs serving the American Indian community, establish guidelines for the employment of personnel with considerable practical experience in alcohol and other drug abuse problems, and understanding of social and cultural problems related to alcohol and other drug abuse, in the American Indian community.

Recovery-Oriented Systems of Care



SOURCE: SAMHSA



For additional information, contact:
Kevin Evenson, Director, Alcohol and Drug Abuse Division,
Minnesota Department of Human Services.

ADA4 (3-12)

This information is available in alternative formats to individuals with disabilities by calling 651-431-2460. TTY users can call through Minnesota Relay at 800-627-3529. For Speech-to-Speech, call 877-627-3848. For additional assistance with legal rights and protections for equal access to human services programs, contact your agency's ADA coordinator.

Minnesota Violent Crime Coordinating Council

Key Elements of a Statewide Strategic Framework

C/o Minnesota Department of Public Safety,
Office of Justice Programs
Adopted June 13, 2012

The Minnesota Violent Crime Coordinating Council 2012 Statewide Strategy

A Move Toward Coordination and Strategic Thinking

A RICH HISTORY OF PROTECTING THE PUBLIC

Multijurisdictional Task Forces - Since 1988, the Minnesota Department of Public Safety Office of Justice Programs has funded multijurisdictional narcotics and gang task forces with funding provided by the State of Minnesota and the U.S. Department of Justice, Bureau of Justice Assistance. This funding supports programs that integrate law enforcement agencies and prosecutors to conduct effective, multijurisdictional drug and violent crime investigations and prosecutions. Federal and state resources provide \$9 million in funding to support the operations of 23 multijurisdictional task forces in the SFY 12-13 biennium. This is in addition to significant local contributions of cash and personnel, as well as in-kind contributions.

From 1988 to 2004, the Narcotics Enforcement Coordinating Committee (NECC), an informal advisory body, provided guidance to the Commissioner of Public Safety on matters relating to the multijurisdictional drug task forces. The 2005 Minnesota Legislature passed legislation to formalize the coordination of gang and drug enforcement efforts throughout the state. The Gang and Drug Oversight Council was established to provide leadership for those efforts.

The 2010 Minnesota Legislature subsequently established the Violent Crime Coordinating Council ("Council") to provide guidance related to the investigation and prosecution of gang and drug crime. The council provides direction and oversight to the multijurisdictional task forces and enforcement teams located throughout the state. This new council replaced the Gang and Drug Oversight Council.

The Council is composed of 19 voting members, including four citizen members and 15 members representing federal, state and local law enforcement and prosecution agencies. The council's primary duty is to "develop an overall strategy to ameliorate the harm caused to the public by gang and drug crime within the state of Minnesota." In addition, the council works closely with the Commissioner of Public Safety and is charged with additional responsibilities that include:

- Development of an operating procedures and policies manual to guide gang and drug investigations;
- Development of processes to collect and share investigative data;

- Identification and recommendation of an individual to serve as the statewide gang and drug coordinator;
- Development of grant eligibility criteria and application review process;
- Adoption of objective criteria and identifying characteristics for use in determining whether individuals are or may be members of gangs involved in criminal activity.
- Development of policies to prohibit the improper use of personal characteristics to target individuals for law enforcement, prosecution or forfeiture actions; and
- Recommendation for multijurisdictional task force funding termination for those not operating in a manner consistent with the best interest of the state or the public;

Statewide Strategy

FIRST YEAR ACCOMPLISHMENTS

The Council first convened in December 2010 and took initial steps towards a comprehensive approach to gang and drug enforcement in the state. To date, the Council has:

- Adopted By-laws to govern the work of the council.
- Established a subcommittee structure to address the duties and issues facing the council.
- Recruited citizen members and devised communication strategies to inform community members and solicit input.
- Reviewed and approved the "Request for Proposal" and review process for 2012 task force funding.
- Amended the current Operating Procedures and Guidelines Manual to ensure that proper investigative protocols and record-keeping are used by all funded task forces. This included revisions to the impartial policing section that prohibits the improper use of personal characteristics to target individuals.
- Reviewed performance data and monitoring reports for all of the multijurisdictional task forces.
- Convened three community forums to hear subject matter experts, law enforcement, and community members' comments on the current criteria and the changes that they believe are necessary for determining whether individuals are or may be members of gangs involved in criminal activity.
- Assessed potential information sharing systems for use by task forces.

NOTE: Additional information on the work of the Council can be found at:
<https://dps.mn.gov/divisions/ojp/Pages/violent-crimes-coordinating-council.aspx>

CHARTING THE COURSE FOR THE FUTURE

On November 2–3, 2011, the Council and invited professional and community experts gathered for a planning session to determine the strategic elements necessary to address the harm caused to the public by gang and drug crime within the State of Minnesota. Thirty individuals worked with a facilitator in both large group activities and small discussion groups. Participants represented statewide, rural, metro, and suburban constituencies and represented subject matter expertise in law enforcement, prosecution, community involvement, gang intervention and corrections.

The objectives for the session were to:

- Understand current and emerging trends in gang and drug crimes,
- Identify stakeholder perspectives on key trends,
- Determine elements of vision, priorities, recommendations, and roles, and
- Develop a tactical plan for the coming year.

The result has informed the Council's development and implementation of the following statewide strategic framework:

1. There is a need for a community-led paradigm shift and broader collaboration between criminal justice agencies and community organizations.

- There needs to be a realization that the harm caused to the public by gang and drug crime is not just a law enforcement problem.
- It is critical for law enforcement and other criminal justice agencies to earn public trust and participation through proactive engagement and an effort to create a shared understanding of the issues and goals.
- Community ownership and representation will help to establish and promote healthy community norms and reduce the demand for drugs and the tolerance of gangs and criminal activity.
- An opportunity exists for partnerships between public and private organizations with similar goals, particularly for prevention and intervention activities or services.
- Success will require a focused effort to reduce language and other barriers with cultural and ethnic groups.

TACTICAL PLAN FOR 2012: Clarify mutual expectations between citizens, council members and task forces. Develop a community engagement strategy.

2. A centralized information and intelligence sharing system is a key component for efficient and effective investigation and prosecution of drug, gang and related violent crime.

- Because individuals and organized groups do not confine their criminal activity to limited geographic areas, timely sharing of information and resources across jurisdictional borders is essential to public safety.
- Coordinated investigative efforts will also provide deconfliction information for enhanced officer safety.
- To address valid privacy concerns, information access should be controlled, oversight must be in place, and regular audits should be conducted to ensure appropriate use. Accountability will be based upon concrete standards for performance and consequences when warranted.
- The Council supports the selective, appropriate, and secure sharing of information among law enforcement and any legislative changes necessary to accomplish that goal.

TACTICAL PLAN FOR 2012: Determine the commitment of key stakeholders and link with those working to modify Minnesota Statutes Chapter 13 to include a classification for criminal intelligence data.

3. An effective strategy requires continual adaptation to increasing complexity and change in drug and gang crime.

- The Council believes that drug crime will continue to evolve in terms of access and self-manufacturing and that hybridization of gangs will continue.
- Law enforcement must move from traditional gang and drug investigative protocols to non-traditional techniques. Proactive, intelligence-driven strategies will replace reactive enforcement, and advancements in technology will change the way that investigations are conducted.
- The focus and priority must be on the most violent and/or habitual offenders.

- Training is a critical component and must be funded.

TACTICAL PLAN FOR 2012: Monitor trends identified by task forces, raise awareness and identify resources and evidence-based best practices for response.

4. Gang and drug education, prevention, intervention and treatment efforts are an important component of an overall statewide strategy.

- The development and implementation of an overall statewide strategy to address substance abuse and drug and gang prevention cannot be the sole responsibility of the Council, but criminal justice stakeholders are key and they must provide leadership while partnering with others in the planning process.
- The Council will encourage the efforts of task forces to use existing resources and personnel wherever possible to perform public outreach and prevention education in the community.
- The Council will support law enforcement and community partnerships in a coordinated effort to prevent gang and drug involvement.
- The Council supports increased access to treatment options to help break the cycle of addiction, crime, and violence.

TACTICAL PLAN FOR 2012: The Council will disseminate educational materials to task forces statewide in support of local gang and drug prevention efforts and will establish performance measures to monitor success.

5. The existing task force model must be examined and a determination made as to whether changes are appropriate.

- The nature of criminal activity may require fewer task forces that are more strategically placed, with additional participation by analysts, law enforcement specialists, prosecutors, and community corrections personnel.
- There should be a role for community organizations to work with the task force to mobilize community members in response to community violence.

- While there is a need for all task forces to comply with best practice procedures, there will always need to be flexibility to address regional and local needs in combating of violent crime.

TACTICAL PLAN FOR 2012: The Council determined it would table this issue for future examination.

6. The continuation of successful multijurisdictional task force efforts in combating violent crime requires sustainable external funding that adds to the resources that local jurisdictions currently provide.

- Local agencies currently bear most of the costs of sworn personnel assigned to task forces. Multijurisdictional investigations often require supplemental funding given the specialized nature of the work and expanded enforcement areas.
- A long-term funding commitment must be established at the state and federal levels to ensure that task forces receive the resources necessary to maintain operations.
- The viability of establishing dedicated funds to create a stable, long-term funding stream for multijurisdictional task force operations must be examined.
- Resources for technology and equipment infrastructure investments must be identified and made available.
- There is a need to create a wide variety of outreach and marketing documents that promote the impact of task forces. These can be utilized at the local level to support efforts to increase local resources dedicated to the program.
- Grant funding should be awarded through a fair, equitable, and objective process that rewards performance that is consistent with statewide goals.

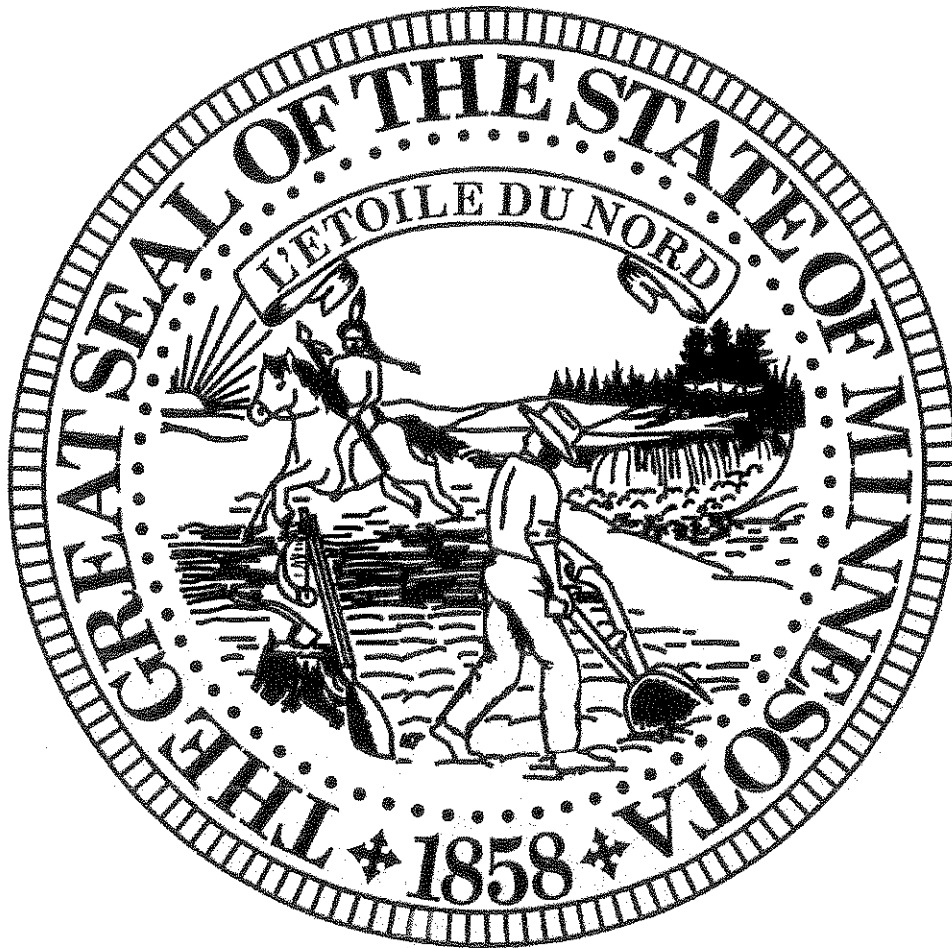
TACTICAL PLAN FOR 2012: The Council will determine how much funding is needed for annual grants and necessary infrastructure investments. The Council will research options for the funding of task forces at the local, state, federal and private levels and develop a strategy to execute a comprehensive plan.

Conclusion

Gang activity, drug abuse, drug trafficking and related violent crime continue to pose significant threats to the safety and well-being of the citizens of Minnesota. Multijurisdictional task forces have proven to be a very effective law enforcement strategy.

The continuation of multijurisdictional efforts and the implementation of the key components outlined in this strategy will not happen without funding beyond what local jurisdictions can provide. Without outside support, many task forces report they will not be able to continue operations. Thus, given shifting federal priorities, reliable and sufficient funding remains a critical, yet uncertain, strategic component. A long-term commitment must be established at the state and local levels to ensure that task forces receive the necessary funding to maintain operations.

Guided by this statewide strategy and supported by a reliable funding stream, multijurisdictional task forces working cooperatively with the Violent Crime Coordinating Council can achieve even greater results.



DRUG & VIOLENT CRIME TASK FORCES
2012 Annual Report

July 2012

Prepared by the Office of Justice Programs – Minnesota Department of Public Safety

BACKGROUND

Narcotics Task Forces – Since 1988, the Minnesota Department of Public Safety-Office of Justice Programs has funded multijurisdictional narcotics and gang task forces with funding provided by the State of Minnesota and the U.S. Department of Justice, Bureau of Justice Assistance. This funding supports programs that integrate law enforcement agencies and prosecutors to conduct effective, multijurisdictional drug and violent crime investigations and prosecutions. Federal and state resources provide \$9 million in funding to support the operations of multijurisdictional task forces in the SFY 12-13 biennium. This is in addition to significant local contributions of cash and personnel, as well as in-kind contributions.

There are currently twenty-three funded task forces that span sixty-five counties. The task forces are staffed by over 200 investigators from over 115 police agencies. An additional 53 police agencies provide non-personnel support to the task forces. Annual grant amounts range from \$33,775 to \$480,750. The work of the task force teams is supported by an appointed Statewide Gang and Drug Coordinator; an experienced sworn officer who provides training, monitoring and technical assistance services to all funded task forces. Task force officers also sought to develop their own professional skills, completing 9,020 hours of POST certified training in 2011.

From 1988 to 2004, the Narcotics Enforcement Coordinating Committee (NECC), an informal advisory body, provided guidance to the Commissioner of Public Safety on matters relating to the multijurisdictional drug task forces. The 2005 Minnesota Legislature passed legislation to formalize the coordination of gang and drug enforcement efforts throughout the state. The Gang and Drug Oversight Council was established to provide leadership for those efforts.

Subsequently, the 2010 Minnesota Legislature established the **VIOLENT CRIMES COORDINATING COUNCIL (“VCCC”)** to provide guidance related to the investigation and prosecution of gang crime, drug crime and related violent crime. The Council is comprised of 19 voting members that represent federal, state and local law enforcement and prosecution agencies and includes four citizen members. The council provides direction and oversight to the multijurisdictional task forces and enforcement teams located throughout the state. This new council replaced the Gang and Drug Oversight Council that had been in existence since 2005.

The council’s primary duty is to “develop an overall strategy to ameliorate the harm caused to the public by gang and drug crime within the State of Minnesota”. In addition, the council works closely with the Commissioner of Public Safety and is charged with additional responsibilities:

- The development of an operating procedures and policies manual to guide gang and drug investigation;
- The identification and recommendation of an individual to serve as the statewide gang and drug coordinator;
- The development of grant eligibility criteria and application review process;
- The recommendation for multijurisdictional task force funding termination for those not operating in a manner consistent with the best interest of the state or the public;
- The development of processes to collect and share investigative data;

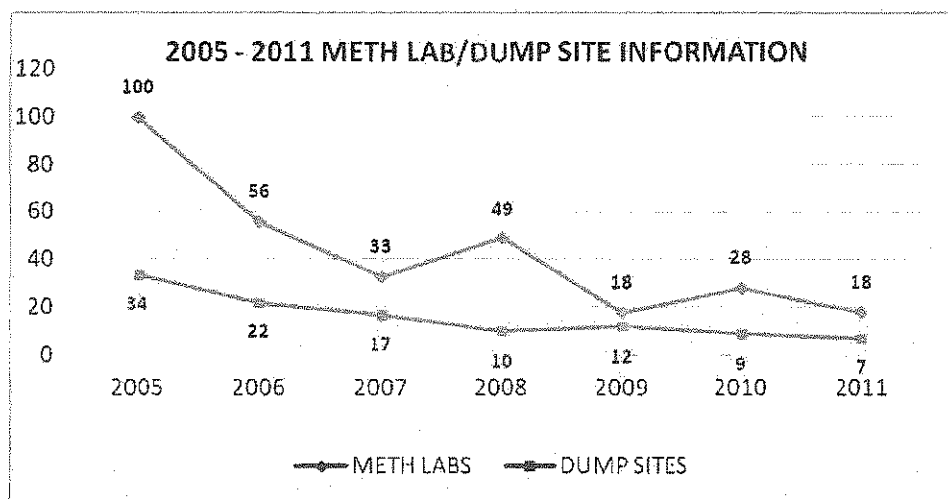
- The development of policies to prohibit the improper use of personal characteristics to target individuals for law enforcement, prosecution or forfeiture actions; and ,
- The adoption of objective criteria and identifying characteristics for use in determining whether individuals are or may be members of gangs involved in criminal activity.

STATEWIDE THREAT ASSESSMENT

As a part of their application for funding that was completed in the Fall of 2011, each task force was asked to comment on the current threats and emerging trends they were facing within their service area. They also report on emerging trends when they prepare extensive quarterly narrative reports submitted to the office of Justice Programs. A summary follows.

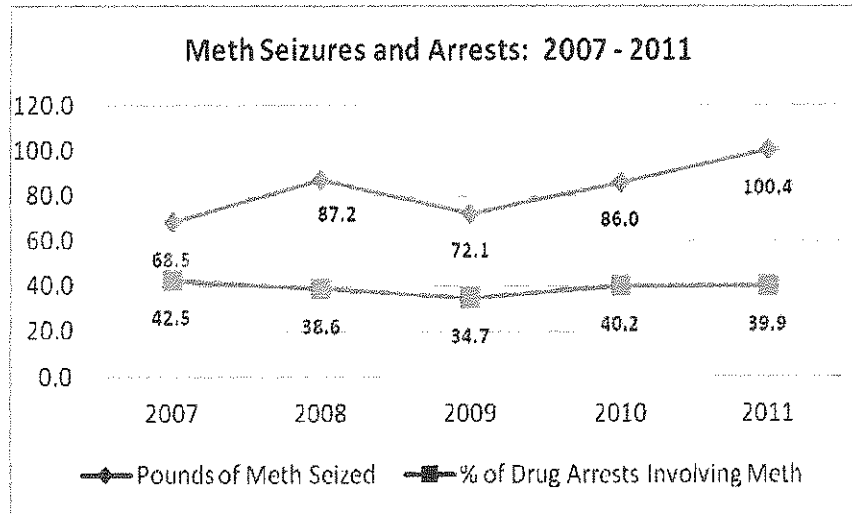
DRUG ASSESSMENT

The wide spread production of methamphetamine has continued to taper off, with most regions reporting significant drops in lab seizures since 2004. After a brief uptick in 2010, the year 2011 indicated a downward trend. The reduction over time is largely attributed to legislation restricting access to precursor ingredients needed in the production of methamphetamine. However, some regions are now reporting smaller scale (and "one pot") production of methamphetamine. Task force reports in 2011 indicated anhydrous thefts and the identification of individuals buying significant amounts of precursor drugs. It is assumed that most individuals involved are producing quantities for personal use.

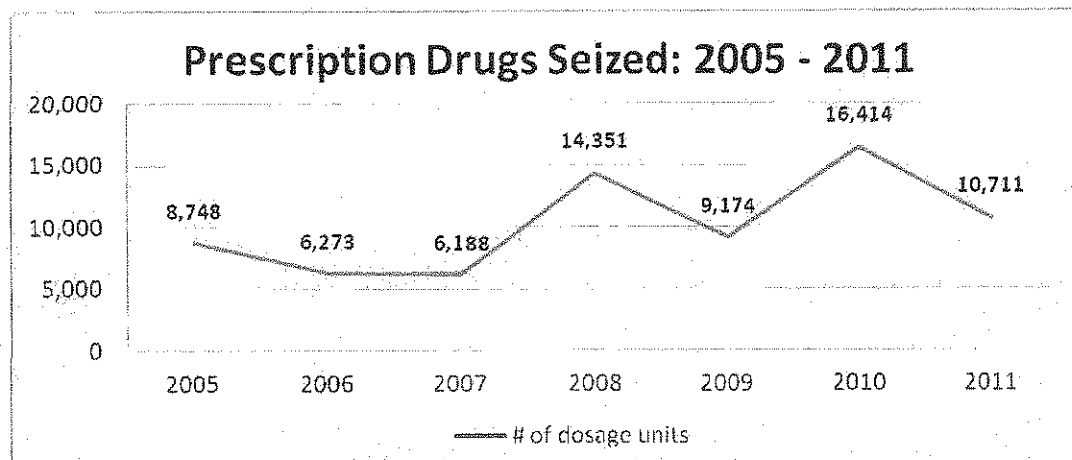


Despite the statewide reduction in the manufacture of methamphetamine, it continues to be the greatest concern for many of the task force regions in the state. Increasingly, large quantities of high grade methamphetamine are being trafficked into the area from the southwest U.S. and Mexico. Evidence of intravenous use of methamphetamine has increased in some task force areas. This all comes along with high rates of property crimes, child abuse and neglect, and the drain on social services agencies that are seeing families affected by addiction to

methamphetamine. Fortunately, use by minors has decreased due to the success of anti-methamphetamine advertising campaigns.

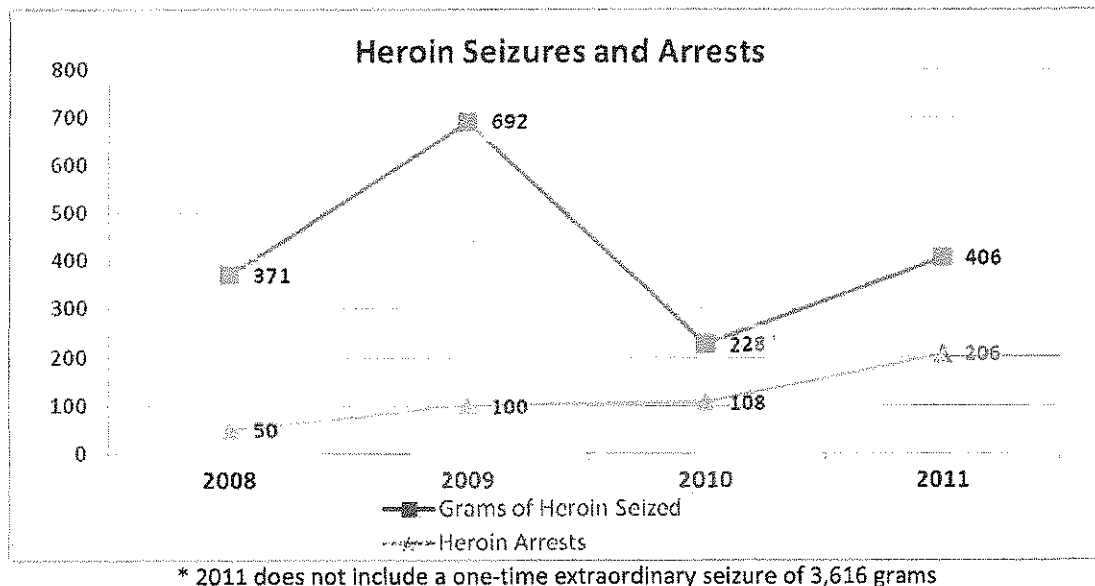


The abuse and illegal sale of pharmaceutical drugs, such as OxyContin, has also significantly increased. Seizures and arrests involve both pills and fentanyl patches. This has been a particular problem on Indian reservations in the northern part of the state. In fact, both the White Earth and Red Lake nations declared public health emergencies related to prescription drug abuse. In 2005, prescription drugs were involved in 4.5% of drug arrests and that number increased to 14.4% in 2011. Task forces have reported some significant sale cases where large quantities of OxyContin have been sold. At an average cost of \$1.00/milligram, there is a high profit margin on the sale of the drug. Illicit sellers are getting their product from forged prescriptions, “doctor shopping”, paid procurers of the drug and pharmacy burglaries. There have been an alarming number of minors and young adults abusing prescription medications. Individuals often take it from household medicine cabinets or receive it or buy it from friends.



Historically, increases in the abuse of prescription pain killers including OxyContin; morphine; codeine; and fentanyl patches, reduced the demand for heroin. This is no longer true as

investigators have seen an increase in the trafficking and use of heroin. In fact, the abuse of pharmaceuticals appears to be a gateway to heroin. Many users have transitioned to heroin due to the high price of pharmaceuticals. Minnesota has been identified as the state that has the lowest price and highest purity of heroin available. Heroin related overdose deaths and hospital emergency room visits increased significantly in 2011. Past use of heroin by 12th graders in Minnesota is above the national average. Heroin arrests increased 412% from 2008 to 2011. While the majority of arrests have been in the metro area, Duluth and Greater Minnesota task force jurisdictions including Indian reservations; other areas throughout the state are beginning to see the emergence of heroin use and trafficking. Most troubling is that the user profile is predominantly young people ages 16 – 28.



Marijuana is undoubtedly the most commonly abused and readily available drug throughout the state. The potency of marijuana has risen with higher concentrations of THC found in seized samples. It is cultivated locally and imported from Canada and source states along the border with Mexico. Task forces have also noted importation from the medicinal marijuana states of California and Colorado. In terms of local production, indoor marijuana grow operations continue, but at a lower rate this past year. Grow operations are often more sophisticated than seen in the past. Nationwide, the environmental and health hazards of such operations are becoming apparent.

The importation and local cultivation of marijuana continues to be a significant target for task forces primarily with high volume trafficking and the dismantling of grow operations. In 2011, task forces seized over 6,000 pounds of marijuana and marijuana was associated with 38% of all drug arrests. The sale of marijuana is very profitable and is often associated with violence. According to the local Drug Enforcement Administration office, an ounce of fairly low quality Mexican marijuana retails for \$150 - \$175. The lack of serious criminal consequences for cultivators and sellers of marijuana makes it difficult to disrupt the supply of this very available drug.

While cocaine and crack cocaine continues to be a fairly common drug of abuse it is declining in popularity for distribution and use throughout the state. The amounts encountered by task forces are lower, but the cost has increased significantly. Cocaine and crack cocaine are more prevalent in the Mankato, Rochester, southwestern metro and Duluth areas. In these areas, the importation and distribution of the drug is often gang related. In Greater Minnesota, the principal wholesale distribution centers for cocaine and crack cocaine are Minneapolis, Chicago and Detroit.

Other substances have also presented challenges for law enforcement in 2011.

- Synthetic marijuana products (K2, Spice, Blade, Red X Dawn, etc.) have been found in many parts of the state and have become increasingly popular, particularly among teens and young adults. These products consist of plant material that has been coated with chemicals that claim to mimic THC, the active ingredient in marijuana, and are sold at a variety of retail outlets, in head shops, and over the Internet. These products that can cause serious side effects for users. There have been an increasing number of reports from poison control centers, hospitals and law enforcement regarding these products.
- Mephedrone is also being sold in both the metro and greater Minnesota areas. This is a synthetic stimulant. It is reportedly manufactured in China and is chemically similar to the compounds found in khat. It comes in the form of tablets or a powder, which users can swallow, snort or inject, producing similar effects to MDMA, amphetamines and cocaine. In the USA it can be sold legally if labeled as 'plant food' or 'bath salts'.

In several areas of the state, synthetic drug use has escalated rapidly with calls for service for both medical and law enforcement personnel on the rise. A well-known case in Blaine, Minnesota led to the death of a 19 year old male. Long term effects of these drugs are still unknown, but use of these substances often leads to suicide threats or other erratic actions that sometimes includes assaultive behavior.

GANG AND VIOLENT CRIME ASSESSMENT

According to many task force reports, gang activity related to the sale and distribution of narcotics continues. In addition to narcotics violations, weapons violations appear to be the criminal activity of choice. Prostitution and other forms of human trafficking and victimization of women are also criminal ventures for some street gangs. Investigators continue to see evidence that some gang members have moved away from collective activity to a more individualized criminal enterprise. Members from once rival gangs are reported to be working together, on an individual basis, in narcotics sales and stolen goods. These gang members appear to prioritize monetary gain over turf and membership issues.

Many regions are reporting intensified recruiting efforts by gangs, and many gang members from major metropolitan areas such as Chicago, Minneapolis and Detroit are moving into rural regions for criminal purposes. The Surenos 13 is the fastest growing gang in Minnesota. This is a gang that has a history of violence and connections to drug cartels in South America. Another growing gang threat in Minnesota, particularly within the Twin Cities and Rochester areas, is from the evolution of Somali gangs. Somali gangs are believed to be responsible for crimes ranging from drive by

shootings to drug activity. It has been difficult for law enforcement to penetrate these gangs due to language and cultural barriers as well as the "closed network" in which they operate.

Both metro and rural task forces are experiencing an increase in the size and violence of hybrid gangs as they attempt to gain power. Individuals may join one or more of these loosely affiliated "gangs" that have no organized leadership or code of conduct. In the case of hybrid gangs, rival gang members are more apt to work together in criminal endeavors. The metro area reports that currently, gangs tend to be smaller and more factionalized with violence becoming less about drug territory and more about on-going feuds.

The primary distributors of the three most common drugs (cocaine, meth and marijuana) are Mexican drug trafficking organizations (DTOs). As a result, illegal drugs are becoming available in increasing amounts. The use of extreme violence by DTO's is well documented as they advance their interests in Mexico as well as the United States. Some of these organizations have connections to the La Familia gang and there are multiple cells operating within the northern portion of Dakota County. It is only logical that their presence will continue to grow in the twin cities area.

Outlaw motorcycle gangs operate throughout the state and prison based gang members reside in many parts of the state. Gangs operating in Minnesota include the Sons of Silence, Hells Angels, Hells Outcasts, Las Valientes and Outlaws. Task forces see an increase in the recruiting of new members by all the motorcycle gangs and clubs. The Supreme White Power "SWP" prison gang members are active in the Iron Range area after recently being paroled. Members of the local task force (with assistance from the MN BCA) are continuing to monitor and attempting to build a case against a number of Supreme White Power "SWP" members that are suspected in methamphetamine sales throughout the Iron Range area. Several members of this group have lengthy and violent criminal histories and pose a serious safety threat.

Native gangs pose significant threats on tribal lands and in parts of the Twin Cities. There has been a significant increase in gang violence in the state and local areas involving the Native Mob and associates. During the past 12-18 months Native Mob members and associates have been the victim of drive-by shootings, assaults and other violence. It has been reported that as older members of the Native Mob are being released from prison the gang is becoming more structured and organized throughout the state. This is substantiated by Department of Corrections investigations and informant information. There has also been an increase in 'council' meetings for the Native Mob across the state.

Violence in the community has increased and in many cases is violence for the sake of violence. Task forces report increases in armed robberies and burglaries. The frequency of weapons seized during investigations continues to increase. High capacity guns are not unique. The firearm issue has resulted in task forces using a variety of tactics to promote officer and community safety. Whenever possible, suspects that have potential to be violent or have access to weapons are arrested in tightly controlled situations. It is not unusual for some gang members, particularly members of outlaw motorcycle gangs, to have a permit to carry a firearm. Removal of guns and gun permits through felony criminal charges is a strategy used to disrupt structures within gangs.

In discussing the escalating violence being encountered, one task force reported that "We continue to seize many handguns during our operations and search warrants. The suspects we are arresting are more willing to flee, fight and use any means possible to evade arrest or injure officers. During one of our operations in the first quarter of 2012 an officer had to shoot a suspect who pointed a gun at him during an arrest. Two guns were recovered from two suspects along with a large amount of meth."

Task forces have also noted that they are experiencing more shoplifting, check forgery, burglaries, auto thefts and thefts from autos over the last two years. They speculate that these crimes are often related to repeat offenders who commit these crimes to obtain drugs by trading or selling the stolen property. Home invasions are also becoming more common and drug "rips" can be lucrative and low risk due to infrequent reporting by the victims.

OPERATIONAL TRENDS

Task force methods have become more analytical and technology driven over the last several years. Many task forces have added or increased the number of analysts assigned to their units. Analyst work involves detailed research and analysis of criminal information in order to develop links between criminals and crime groups or patterns of criminal activity.

Criminals are using social media to promote their criminal activities and recruit gang members and lure victims. In turn, investigators and analysts often use social media to identify suspects and build criminal cases. Traditional media and social media are also being used by law enforcement for crime alerts, solicitation of anonymous tips and public awareness and education.

Increasing internet sales of synthetic drugs and shipments of marijuana and other illegal substances to local distributors have led to cooperative working relationships between task forces and postal/parcel delivery personnel. Drug detection dogs are often used with suspicious packages and controlled deliveries then lead to search warrants and arrests.

BENEFITS OF THE TASK FORCE MODEL

In their regular reporting, task forces provide testimony and examples of the benefits of the task force approach and examples of how collaboration has fostered success. In the words of one task force commander, "We also have had some luck in identifying out-of-the-area sources and pass that information on to other task forces and agencies or collaborate with them on continuing the investigation. Collaborating with other law enforcement fosters information and resource sharing and creates relationships that are mutually beneficial." The situation in the past where there was competition for good cases has been replaced by cooperation. Data from 2010 indicate the highest degree of cooperation ever experienced with over 1,500 cases worked collaboratively with another law enforcement entity.

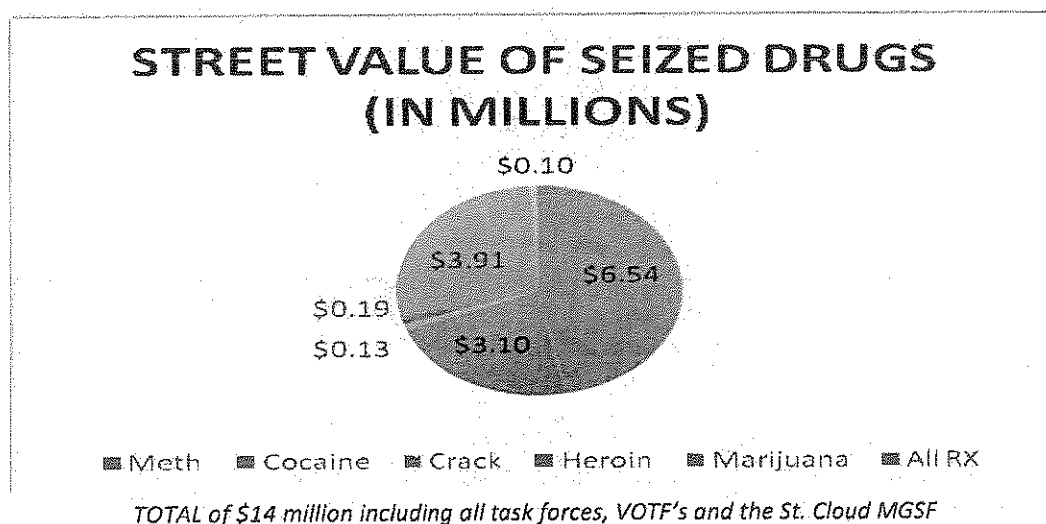
In previous examinations of the task force model as employed in Minnesota, the following were identified as benefits: (1) The level of expertise and knowledge increases when you combine a

variety of experience and training in one location; (2) Task force officers have access to training not readily available to officers on other assignments; (3) When officers return to their home agencies, they take that experience, training and their resources back to their departments; (4) Co-location provides for constant communication between task force members and helps to build rapport, trust and solid relationships. It also provides an atmosphere where a wide variety of techniques and experiences can be consulted while discussing and planning investigative activities; (5) Task forces frequently provide assistance and resources to other law enforcement agencies during other non-drug investigations. That assistance is usually welcomed by other agencies, and helps task forces produce positive results and create a favorable image within the law enforcement community.

RESULTS OF 2011 TASK FORCE OPERATIONS

The following is a summary of task force results throughout the state.

Drug Enforcement - In calendar year 2011, task forces made 3,522 arrests for narcotics violations with 92% of the arrests at a felony-level. Individuals prosecuted at the federal level numbered 196. Of the arrests, 39.9% involved methamphetamine, 37.7% involved marijuana, 14.4% involved prescription drugs, 15.2% involved cocaine/crack cocaine and 5.9% involved heroin. In the course of their investigations, task forces seized 18 methamphetamine labs, 50 pounds of cocaine/crack cocaine, 100 pounds of methamphetamine, 8.5 pounds of heroin, 2092 dosage units of ecstasy, over 10,000 dosage units of prescription drugs, 6,038 pounds of marijuana and 5,320 cultivated marijuana plants. Firearm seizures totaled 687. In addition to drug arrests, task force officers made 417 arrests for other criminal activity.



Results over the last five years indicate that task forces are improving and addressing what the program intends: major cases that have the potential to significantly affect drug trafficking and related crimes within their regions. The year 2007 saw the highest results ever in terms of: percentage of felony arrests and the percentage of cases prosecuted federally. In 2009, the highest percentage of drug arrests for "sales" was attained. Working these complex cases requires

collaboration with other task forces, as well as other local, state and federal agencies. Data from 2011 indicates that approximately 40% of all the cases worked by task forces were done in cooperation with another local, state or federal law enforcement entity.

Gang Specialists Assigned to Task Forces - In 2011, there were 9 task forces outside the metro area that had a total of 17 assigned gang officers. In addition, 3 suburban task forces added gang and violent crime specialists in 2010 to ensure that specialized gang knowledge was not lost with the demise of the Metro Gang Strike Force. Other metro agencies also incorporated gang specialists to their task forces. These officers worked hand in hand with the drug agents and their specialized knowledge of gangs, gang crimes and gang members enhanced the work of the task forces. Specifically, of the arrests noted above under "drug enforcement," 103 of the arrests were of suspected or confirmed gang members. Of the non-drug arrests noted, there were 17 violent Part I crimes, 7 non-violent Part I crimes and 16 Part II crimes committed by suspected or confirmed gang members. In addition, 29 individuals were arrested for outstanding warrants or probation violation. Eighteen of those arrested were charged federally. Twenty-five handguns were seized from gang members. In addition to enforcement activities, gang officers made 105 presentations to over 3300 individuals.

In assessing the value of having knowledgeable gang specialists serving as investigators in task forces one task force indicated: "Investigators were successful in working a heroin sales case and charging a long time heroin dealer in the Twin Ports. A previously documented Gangster Disciple was charged with 1st degree possession with intent to distribute heroin, multiple counts of 3rd degree sale of heroin and possession of a firearm by a prohibited person.

St. Cloud Metro Gang Strike Force - This multijurisdictional effort between the City of St. Cloud and Sherburne County began in 2007. For 2011 the unit reported 80 felony-level drug arrests. Thirty-five of the individuals arrested were confirmed gang members. Sixteen additional arrests were made for felony-level violent offenses and eleven of those arrested were confirmed gang members. Thirty-one additional arrests were made for non-felony drug arrests, non-violent Part I offenses and other Part II offenses. Probation violation or outstanding warrants accounted for nineteen arrests. In the course of their work they executed 27 search warrants, seized 15 firearms, and took quantities of crack, marijuana and meth off the streets; most notably over 90 pounds of marijuana. They responded to 72 requests for assistance from other units/agencies and expended over 560 person hours in doing so. In addition to their enforcement duties they made 14 presentations to 705 individuals.

In early 2011, the strike force noted that three gangsters broke into a residence carrying weapons and firing shots. They were arrested for 1st degree burglary, 2nd degree assault, and felon in possession of a firearm. They pled guilty and were sentenced to 150 months. These gang members were also suspects in other burglaries and controlled substance crimes.

In reporting trends, the SCMGSF notes that gang members affiliated with different gangs often work together to distribute controlled substances. The pursuit of profit often trumps gang rivalries.

Effective January 1, 2012, the St. Cloud Gang Strike Force merged with the Central Minnesota Gang and Drug Task Force to form the Central Minnesota Violent Offender Task Force (CMVOTF). The creation of the CMVOTF will make investigations in the St. Cloud and surrounding areas much more efficient. All investigators will work together as a unified team that is able to be more productive with increased manpower and resources. Communication between the investigators will be greatly improved as there are no longer two task forces in the area with similar objectives and targets. The residents of the task force area will also benefit from this merger by having a cohesive group focused on violent and persistent criminal activity in the area.

Violent Offender Task Forces - Newly funded in 2008 were two task forces in Hennepin County that target violent offenders. The Violent Offender Task Forces (VOTFs) were started as a new strategy in combating violent crimes that was increasing in some neighborhoods in Minneapolis and the surrounding suburbs.

Analyses of the problem showed clearly that the vast majority of the violence was due to guns and drugs but, more importantly, that the same individuals were at the core of the problem time and time again. An overloaded system was ineffectively dealing with the same repeat violent offenders continually engaged in narcotics trafficking, gang activity and related violence.

To deal with these challenges, task forces were formed that consist of local and federal investigators and prosecutors. The rationale behind the VOTFs is: rather than target a specific crime (i.e. narcotics, robbery, etc.), target the individuals who are repeatedly causing the violent crimes. The methods of investigation in these cases are lengthy, complex and resource intensive. In 2010, the Minneapolis VOTF was reconfigured as a FBI "Safe Streets" task force and the Bureau of Criminal Apprehension and the St. Paul Police Department joined the effort.

In 2011, the two Violent Offender Task Forces demonstrated meaningful results. In some instances they work cases jointly. The VOTFs executed 264 search warrants and seized 150 firearms, including 53 handguns and 65 semi-automatic weapons. Substantial amounts of narcotics were also seized including: 19.5 pounds of cocaine and crack cocaine, 49 pounds of marijuana, and, 11.8 pounds of methamphetamine. Over 100 individuals were arrested for probation violations or outstanding warrants. They charged 190 individuals for narcotics and violent crime violations, and 36 of those individuals were charged in federal court. Many of the arrested individuals were gang-affiliated. Of those who were federally indicted, almost all dependents pled guilty to crimes that will result in sentences averaging ten years. In addition to their own arrests, the two VOTFs participated in the arrests of other individuals while responding to requests for assistance from other law enforcement entities. In addition to their enforcement work, the VOTF's made presentations to over 800 people. The Safe Streets Task Force had multiple long-term gang-related investigations underway in 2011. The investigations were designed to disrupt and dismantle organized criminal activity by targeting the organization instead of individuals. These investigations have been worked collaboratively with a number of state and local agencies and task forces.

There are several excellent examples of the impact that the VOTFs are having on the quality of life and crime within neighborhoods in the metro area. The Safe Streets initiative developed information

about gang shootings that were planned to occur during a major event in St. Paul. Suspects were identified and the violence prevented. In December 2011, Hennepin County VOTF personnel were on a surveillance operation in North Minneapolis. During this detail, VOTF personnel observed the suspect and two other male parties conduct a robbery of a person at gun point. Investigators effected an arrest of the suspect and the two other male parties fled on foot. A perimeter was set up and a second suspect was arrested a short time later. A K-9 officer conducted a search and recovered two handguns. A follow up search warrant was executed and a third firearm and gang photos were recovered. The primary suspect was charged with Prohibited Person in Possession of a Firearm and two counts of Aggravated Robbery. His accomplice was charged with two counts of 1st Degree Aggravated Robbery. The two arrested individuals are documented gang members and identified "Top 20 Violent Offenders."

Partnership with the National Guard Counterdrug Program - The National Guard Counterdrug Program has been a welcome partner and is very interactive with task forces statewide. The Counterdrug Program has embedded National Guard crime analysts in several federal agencies and multijurisdictional task forces around the state. This has greatly improved the ability of law enforcement agencies to analyze and share case-related information. The Guard's Counterdrug Program also provides materials and assistance for counterdrug training courses and they provided financial assistance to the Midwest Counterdrug Training Center (MCTC) to sponsor thirty training classes available free of charge to law enforcement officers in Minnesota and adjoining states.

Prevention and Education - It is important to note that beyond their objective of combating drug trafficking through law enforcement, task force officers spent a significant amount of time educating other criminal justice personnel, health professionals, teachers, parents and members of the public about drugs and gangs. In the words of one task force, "officers gave five presentations to community groups, schools, and law enforcement and news agencies. These presentations are an opportunity to inform the public of our presence and give rudimentary training on drug and gang activity in the task force area. We also work with local law enforcement to keep them abreast of gang activity, drug trends, and legal updates pertaining to narcotics and search and seizure". In 2011, task force officers made 372 presentations with a total attendance of 14,577 people.

Many task forces are sponsoring or participating in drug "take-back" events which have been very successful. For example, the **Washington County Drug Task Force** reported in October 2011 that "our third Drug Take-Back event in the County was a success, with several hundred pounds of prescription drugs gathered from the public. We plan on participating in drug take-back event(s) in 2012. We are currently working with the County to set up a permanent site at the Sheriff's Office for prescription drug drop off. This program is set to launch in the 1st quarter of 2012."

The Kandiyohi County Board received a briefing from the **CEE-VI Drug & Gang Task Force** about their current operations and local trends. The meeting was televised over local cable TV. The task force commander noted, "it is important for them to know not only the numbers of arrests but also the stories that go with it and the unique situation our county is facing."

Task force personnel also participate in many local initiatives aimed at reducing the demand for drugs and sharing enforcement strategies to address emerging issues. For example the **Southeast Minnesota Task Force** Commander, Olmsted County Sheriff, and chief of the Rochester Police Department continue to work with the United Way with the "Community Gang Initiative". Also participating is the Olmsted County Attorney, Mayor of Rochester, and the Director of Olmsted County of Public Health, Dodge/Fillmore/Olmsted Community Corrections, Rochester Schools, Boys and Girls Club, Editor of the Post Bulletin and other local agencies.

Another example is that in response to an emerging trend, the Southwest Metro Task Force produced a PowerPoint slide show educating people about synthetic marijuana and the problems and dangers associated with its use. It has been presented to the emergency room staff at one of the local hospitals and was shared with local school liaison officers. It was subsequently presented to the counselors at a local high school who then showed it to the all of the 9th grade health classes. At their request, it was presented to one of the local city councils who are acting on banning the substances.

Last, but not least, task force officers engage in prevention in specific and sometimes a very personal way. The following are just a few examples:

- Ramsey County VCET officers participated in the fishing event sponsored by the Neighborhood House. It was a daylong event where the officers brought their own boats and fished with youth to provide a positive experience to youth attending the event. A good time was had by all.
- Agents of the CEE-VI Task Force overheard radio traffic from a local ambulance service related to a critical situation involving an elderly female. Agents responded to the unresponsive female in order to assist the lone paramedic. Due to the quick response, the individual walked out of the hospital a short time later. Because of their help and their family being present when agents arrived, they received a handwritten note from the family thanking them for their hard work.
- The BLLRR Task Force commander continued to do his radio talk show "Twenty Minutes with the Task Force." Most recently he discussed the widespread abuse of prescription drugs.

ATTACHMENTS

- Gang and Drug Case Summaries
- Map of 2012 Drug and Violent Crime Enforcement Teams
 - List of 2012 Task Force Grants
- List of Violent Crime Coordinating Council Members

GANG and DRUG CASE SUMMARIES

The following are selected summaries of completed or active investigations. These are examples as to the types of investigations and types of illegal activities being committed by different criminal elements throughout the state.

The **Dakota County Task Force**, along with the Ramsey County Violent Crime Enforcement Team, conducted a joint operation with search warrants executed in St. Paul and South St. Paul. The searches resulted in the seizure of over a pound of methamphetamine, illegal firearms, and more than \$60,000 in cash. Three illegal aliens from Mexico were charged in federal court and deported.

During the month of August 2011, agents of the **Dakota County Task Force** assisted the Eagan Police Department with a home invasion and shooting over a drug deal gone wrong. The task force was a crucial component in this investigation by developing the needed information to execute a search warrant and bring the case to a successful resolution.

In February 2011, the **Southeast Minnesota Task Force** arrested 3 people in Fillmore County for various charges related to methamphetamine. The suspects were charged with sales, possession, and manufacturing of meth. The suspects were also charged with child endangerment. The suspect admitted to manufacturing meth 22 times in 30 days. One of the suspects was taken into custody by the United States Marshals Service and will face federal charges for failing to register as a sex offender.

In October 2011, the **Buffalo Ridge Task Force** agents acted on anonymous tips and executed a rural Nobles County search warrant that resulted in the seizure of 35 cultivated marijuana plants and ten firearms. The suspect provided a statement and claimed that he had been growing marijuana in Minnesota and Wisconsin for the past 20 years. The suspect sold marijuana throughout the area and was a source of supply to high-school students. December 2011 activities included surveillance in Pipestone County that led to the execution of a search warrant. Meth was located throughout the residence, children were placed in protective custody, and six adults were arrested.

A pharmacy in Blackduck was burglarized and approximately 10,000 pills were taken. A **Paul Bunyan Task Force** agent worked with the Minnesota Bureau of Criminal Apprehension and the Superior Wisconsin Police Department to identify the suspects and build a case against them. Following a controlled buy, an additional person was arrested and over 1400 pills were recovered and both suspects confessed to their roles in the burglary. Two task force officers were instrumental in obtaining those confessions. The primary offender admitted to having committed dozens of these burglaries throughout the Midwest.

Agents of the **North Central Task Force** assisted Mille Lacs County investigators with a string of burglaries of residences on the north end of Mille Lacs County and surrounding counties. Taken in these burglaries were guns and electronics. The investigations resulted in numerous arrests and

many stolen guns and other items were recovered. Some of the suspects in these burglaries were members of various gangs in and around the Mille Lacs lake area including the Native Mob.

Pine to Prairie Task Force officers worked a lengthy joint investigation with the Polk County Sheriff's Office. It ended in a consent search of a rural Fosston, Minnesota, residence occupied by a husband and wife. The couple had been involved in multiple sales of marijuana. During the search, the following items were seized: individually wrapped bags of marijuana, hallucinogenic mushrooms, \$1375 in cash, a 9mm semi-automatic handgun and a notebook appearing to document more than \$30,000 in drug sales.

Paul Bunyan Task Force investigated a gang-related drive-by shooting took place on the Leech Lake Reservation. Five people were arrested as a result of this collaboration with the Leech Lake Police Department and Cass County Sheriff's Office. The task force is involved in an ongoing gang investigation addressing violent crime, as well as drug dealing, in the task force area.

An **Anoka-Hennepin Task Force** assisted the U.S. Marshals Office on an arrest warrant in Fridley. Information was developed that methamphetamine might be hidden in the suspects' vehicle. A K-9 sniff alerted on the car and, during the search of the car, 1.5 pounds of meth were located.

The **Boundary Waters Task Force** reports working in conjunction with the BCA and the Anoka-Hennepin Narcotics Task Force investigating a methamphetamine sales ring. A male from the Ely, area was routinely picking up meth from the metro area and transporting it back to the Ely area. A number of targets were identified during this investigation and a number of search warrants were executed in Ely, East Bethel, and Blaine. The male from Ely, MN has been charged with 1st Degree Sales and other charges including felon in possession of firearms. This arrest has disrupted a large supply of methamphetamine being supplied to the Ely area.

In support of their goal to stay on top of new threats and trends, the **Lake Superior Drug & Gang Task Force** undertook a major investigation beginning in August 2011. Calls for service in the downtown Duluth area, specifically in the 100 block of East Superior Street, had skyrocketed as a result of the new synthetic craze. While evidence of bath salts use is still prevalent in the Twin Ports, synthetic marijuana, sold as "incense," was the source for the increased police activity. The business "Last Place on Earth" became the target of this investigation. Undercover purchases of synthetic marijuana were made and probable cause developed to support a search warrant. On 09/21/2011, a search warrant was executed at the "Last Place on Earth" at which time over \$80,000, 31 guns and thousands of dosage units of suspected synthetic marijuana were seized. The evidence in this investigation is still being analyzed and charges are pending.

Central Minnesota Task Force investigators executed a search warrant at a residence in a small town in western Stearns County where law enforcement has received numerous complaints about a family involved with controlled substances, late night thefts and burglaries. The subject was a felon due to previous controlled substance convictions. Investigators located 55 grams of methamphetamine, a stolen firearm, a handgun, blasting caps, hazardous chemicals and \$8287 in US Currency that was admitted drug money. The Bloomington Bomb Squad and Stearns County

Environmental Services assisted with the incident. The subjects were charged with first degree controlled substance crimes and felon in possession.

The **Red River Valley Task Force** gang officer coordinated with Fargo Police Department and North Dakota Bureau of Criminal Investigation to purchase several ounces of cocaine from two Latin King Members. The two suspects are associated with several other Latin King members from our area and are working with them to distribute larger quantities of cocaine. Ultimately a buy/bust for two ounces of cocaine was set up and one of the targets was arrested. The investigation is ongoing in both Moorhead and Fargo on other Latin King members that are associates of these subjects and are also distributing cocaine.

During the 3rd quarter of 2011, the **Lake Superior Task Force** successfully concluded over a year's worth of intense investigation by task force investigators and the ATF. Our case "High Life" and the sub-investigation "Pills in a Box" addressed Opana (oxymorphone), Oxycontin and heroin trafficking in the Twin Ports. Twenty-seven Federal indictments for conspiring to distribute these controlled substances were issued as well as charges ranging from continuing a criminal enterprise, possession with intent to distribute, and using a firearm during/in relation to drug trafficking. On 09-27-2011, nine federal search warrants were executed along with all of the accompanying arrest warrants in this case. This was a large scale "round-up" participated in by numerous federal, state and local agencies.

Members of the **South Central Task Force** teamed with agents from Rice County and the MN BCA, on a large and time consuming case. Several southern Minnesota businesses have been targeted in recent weeks by an organized group of counterfeiters, who coincidentally were also involved in the use and sale of methamphetamine. The case required countless hours conducting surveillance, gathering information, recovering counterfeit currency, and making undercover purchases of counterfeit currency. The case was presented to agents of the US Treasury/Secret Service and they agreed to participate in the case and undercover operations continued for several more weeks. Eventually the case was presented to the US Attorney's Office and it was accepted for federal prosecution. The final day of the investigation went smoothly and several arrests were made with the hope that at least five of the individuals will be indicted federally. Close to \$40,000 in counterfeit currency was either purchased or recovered during the course of this investigation and victim businesses stretching from Iowa to Mankato to the Twin Cities and over to Rochester, have been saved from further damage by this group.

The **Minnesota River Valley Task Force** agents initiated several investigations involving the distribution of prescription medication; the majority of which by college-aged individuals. Agents utilized a female agent from an adjoining task force to complete a purchase of an amount of Morphine tablets from a subject in the area. Another agent of the was able to successfully complete a purchase of an amount of Adderall from one male, an amount of Valium and Xanax from another college student and then more Adderall from a male who had recently been kicked out of college. The task force believes that these types of investigations are only going to increase as the year progresses.

The **Lakes Area Drug Investigation Division (LADID)** completed an investigation into the sale and distribution of meth in Crow Wing County. The suspect was an individual whom LADID had arrested in 2009 for sale of meth. The suspect had just gotten out of prison and was on Intensive Supervised Release with the DOC. LADID was able to make an arrest when the suspect was coming back from the metro area with approx. 12 oz of meth. The investigation continues and could possibly result in the federal prosecution of this and other suspects involved in the case. Despite this arrest, LADID continues to receive constant information about the availability of meth in Brainerd/Crow Wing County. There seems to be several individuals involved bringing large amounts of meth to the area. The task force has been working with agents from North Central MN Drug Task Force attempting to identify suppliers.

The **Northwest Metro Task Force (NWMDTF)** worked on a heroin case using informants to do controlled buys of white heroin. Search warrants were executed and the task force was able to seize a good amount of heroin and charge a person in the case. The timing was important due to the fact the suspect was already going to be sentenced for a separate heroin case. With this new case the suspect was held without bail and is now looking at a more significant sentence.

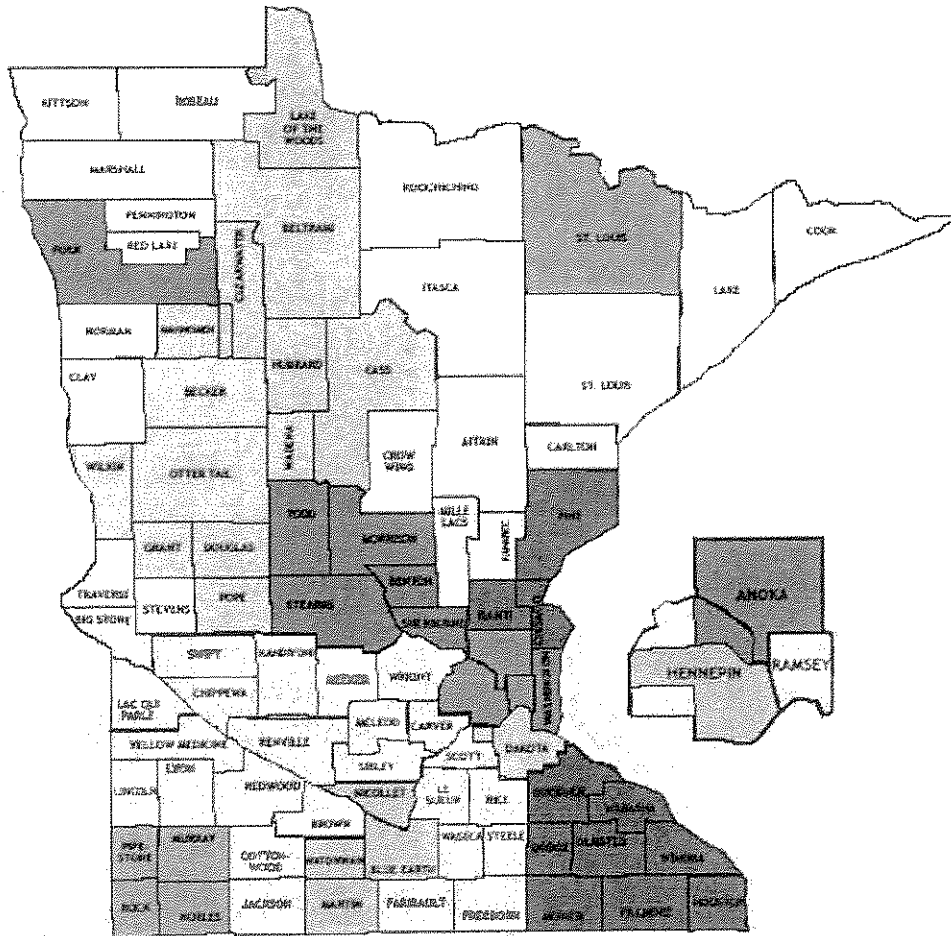
Another case that the NWMDTF worked on alongside Hennepin County Narcotics Unit personnel and Drug and DEA involved a Mexican Drug Trafficking organization that was distributing methamphetamine in the Twin Cities area. In this case suspects were identified and officers executed a search warrant on a vehicle destined for California that was believed to have money in it. During the search \$90,000.00 US currency was recovered that was hidden in the vehicle. Although no drugs were recovered, the loss of the money will negatively impact the traffickers.

Ramsey County Violent Crime Enforcement Team (RCVCET) investigators were working the Hmong New Year event and a gang saturation patrol in St. Paul when a kidnapping from the Maplewood Mall was aired. RCVCET investigations went to the kidnapping location and quickly determined it was an actual forced abduction from the former boyfriend. Investigators gathered suspect information and used technology to locate the suspect vehicle in Oakdale. We were not able to make contact with residents in the home so entry was forced. The suspect, victim and homeowner were all inside. The homeowner stated the suspect would not let her answer the door for police. The suspect was arrested for kidnapping.

CEE-VI Task Force agents were working with what they thought was a low level confidential informant and found out that there were ties to larger narcotics suppliers in the area. The task force found out that significant quantities of drugs, including numerous ounces, and sometimes pounds of methamphetamine, were being transported into and through the area on a weekly basis. The investigation helped to put an end to it. Two defendants are now faced with 1st degree controlled substance charges for drug trafficking in and around the Willmar area.

2012 Drug and Violent Crime Enforcement Teams

Department of Public Safety
OFFICE OF JUSTICE PROGRAMS



TASK FORCES (listed north to south and west to east):

- | | | |
|--|---|----------------------------------|
| Paul Bunyan Narcotics Task Force | East Central Task Force | Brown/Lyon/Redwood Task Force |
| Boundary Waters Drug Task Force | C.E.E. VI Narcotics Task Force | Buffalo Ridge Drug Task Force |
| Lake Superior Drug Task Force | Southwest Metro Drug Task Force | MN River Valley Drug Task Force |
| Pine to Prairie Drug Task Force | Anoka-Hennepin Narcotics Task Force | South Central MN Drug Task Force |
| County shared by: Red River Valley, ND and West Central MN Drug Task Force | Washington County Drug Task Force | Southeast MN Drug Task Force |
| West Central MN Drug Task Force | Northwest Metro Drug Task Force | Areas not in a Task Force |
| Lakes Area Drug Task Force | Hennepin County VCET | |
| Central Minnesota MACU | Ramsey County VCET | |
| North Central Task Force | Dakota County Drug Task Force (includes portion of Scott Co.) | |

2012 MULTI JURISDICTIONAL TASK FORCE GRANTS

Task Force	Fiscal Agent	2012 Grant	COMMANDER
Anoka-Hennepin TF	Anoka County Sheriff's Office	\$240,000	Lieutenant Bryon Fuerst
❖ B-L-L-R Task Force	New Ulm Police Department	\$164,125	Commander Jody Gladis
Boundary Waters TF	St. Louis County Sheriff's Office	\$96,043	Sergeant Jason Akerson
Buffalo Ridge TF	Worthington Police Department	\$190,675	Commander Troy Appel
❖ CEE-VI TF	Kandiyohi County Sheriff's Office	\$177,375	Detective Sgt. Tony Cruze
Central MN VOTF	Central Minnesota Major Crimes Investigation Unit	\$310,000	Lieutenant Jerry Edblad
❖ Dakota County TF	City of Eagan	\$285,546	Sergeant Dan Bianconi
East Central Drug TF	Pine County Sheriff's Office	\$100,000	Investigator Justice Wood
Hennepin County VOTF	Hennepin County Sheriff's Office	\$408,086	Lieutenant Steve Labatt
Lake Superior TF	Duluth Police Department	\$310,813	Lieutenant Steve Stracek
Lakes Area TF	Crow Wing Co Sheriff's Office	\$33,775	Sergeant Joe Meyer
MN River Valley TF	No. Mankato Police Department	\$147,368	Lieutenant Dan Davidson
North Central TF	Mille Lacs County Sheriff's Office	\$60,000	Captain Jason LaSart
Northwest Metro VCET	St. Louis Park Police Dept.	\$66,432	Sergeant Jon Hunt
Paul Bunyan TF	Beltrami County Sheriff's Office	\$296,386	Commander Gary Pederson
Pine To Prairie TF	Crookston Police Department	\$115,088	Sergeant Travis Halvorson
Ramsey County VOTF	Ramsey County Sheriff's Office	\$480,755	Commander Rich Clark
Red River Valley TF	Moorhead Police Department	\$119,375	Lieutenant Brad Penas
South Central TF	Owatonna Police Department	\$153,320	Sergeant Tim Hassing
Southeast MN TF	Olmsted County Sheriff's Office	\$162,373	Captain Mark Erickson
Southwest Metro TF	Shakopee Police Department	\$81,630	Sergeant Mark Williams
Washington County TF	Washington Co Sheriff's Office	\$85,000	Sergeant Andy Ellickson
West Central TF	Douglas County Sheriff's Office	\$153,656	Deputy Scot Umlauf
TOTAL		\$4,259,806	

❖ Funded in whole or part by federal funds from grant award # 2010-DJ-BX-0438

MINNESOTA VIOLENT CRIME COORDINATING COUNCIL (January 2012)

TITLE	NAME	AGENCY
Superintendent	Wade Setter	Bureau of Criminal Apprehension
U.S. Attorney	B. Todd Jones	District of Minnesota
Deputy Attorney General	David Voigt	Office of the Attorney General
Exec. Commander (CHAIR)	Ken Reed	St. Paul Police Department
Chief	Tim Dolan	Minneapolis Police Department
Chief	Mike Goldstein	Plymouth Police Department
Chief (Vice-CHAIR)	Gordon Ramsay	Virginia Police Department
Sheriff	Rich Stanek	Hennepin County Sheriff's Office
Sheriff	Matt Bostrom	Ramsey County Sheriff's Office
Sheriff	Bill Hutton	Washington County Sheriff's Office
Sheriff	Jim Jensen	Dodge County Sheriff's Office
Director	Cari Gerlicher	MN Department of Corrections - Office of Special Investigations
Sr. Assistant County Attorney	Hilary Caligiuri	Hennepin County Attorney's Office
Assistant County Attorney	Benjamin Bejar	Rice County Attorney's Office
Investigator	Chris Benson	White Earth Tribal Police Department
Mr.	Hector Garcia	Chicano Latino Affairs Council
Mr.	Bill Ziegler	Little Earth of United Tribes
Mr.	Melvin Carter	Save Our Sons
LEGAL COUNSEL		
Asst. Attorney General	John Gross	Office of the Attorney General



STATE OF MINNESOTA

Violent Crime Coordinating Council

c/o Department of Public Safety, Office of Justice Programs
445 Minnesota Street, Suite 2300
St. Paul, Minnesota 55101-1515
Voice: 651-201-7350 – Fax: 651-284-3317

St. Paul Police Ex. Commander, Ken Reed, Chair; Duluth Chief Gordon Ramsay, Vice-Chair

MEETING MINUTES FOR 8/8/2012 OF THE VIOLENT CRIME COORDINATING COUNCIL (VCCC)

Council members in attendance: David Voigt, Deputy Attorneys General; Cari Gerlicher, DOC; Dave Bjerga, BCA (for Wade Setter); Chris Benson, White Earth Police Department; Sheriffs Representatives: Jim Jensen, Matt Bostrom, Bill Hutton and Pete Dietzman (for Rich Stanek); Chiefs of Police Representatives: Gordon Ramsay, Scott Gerlicher (for Tim Dolan), and Ken Reed; County Attorney Representative: Benjamin Bejar; Citizen Representatives: Hector Garcia and Melvin Carter

Staff: OJP Staff: Sue Perkins, State Program Administrator; Jeri Boisvert, Executive Director; and Bob Bushman, Statewide Gang and Drug Coordinator. John Gross, Assistant Attorney General (legal counsel)

Excused: Carol Keyser (for B. Todd Jones), U.S. Attorney's Office; Chief Michael Goldstein, Senior Assistant County Attorney Hilary Caligiuri and Bill Ziegler.

Guests: Dan Rothstein, DOC, John Kirkwood (RCSO) and Mark Dunaski (DPS Asst. Commissioner)

WELCOME AND INTRODUCTIONS

The meeting was called to order at 10:07 a.m. by Chair Ken Reed.

Meeting materials included: agenda, 6/13/2012 meeting minutes, statewide coordinator's report, Forfeiture training announcement and heroin data and narrative materials.

Action on 6/13/12 meeting minutes: Motion by Hutton and second by Ramsay to approve. Motion passed.

Action on 8/8/12 agenda: Chair Reed announced that John Gross would be handling the Community Engagement Committee Report and Chief Ramsay would handle the Synthetic Drug report. Motion by Ramsay and second by Benson to approve agenda. Motion passed.

MNJAC UPDATE

DPS Assistant Commissioner Mark Dunaski provided a verbal update on the current status and plans for MNJAC and the Integrated Search System (ISS) project. AC Dunaski spoke about:

- ✓ The history, mission statement, operating model and Memorandum of Understanding (MOU) related to MNJAC. He expressed that the mission had sound ideals but after implementation there were concerns that it did not fulfill its mission in quickly gathering and disseminating information.

- ✓ He noted that there is not currently any state funding for MNJAC and it is not authorized nor acknowledged in statute. It has been operating with locally donated personnel and federal grant funding.
- ✓ The MNJAC advisory group recently met to discuss the past, present and future of the initiative.
- ✓ Chapter 13 statutes have been a barrier to MNJAC meeting its mission. DPS supports VCCC and other association efforts to make changes to Chapter 13.
- ✓ For the foreseeable future, MNJAC will operate with two sections; a federal section to address federal priorities and a state section to provide assistance to state agencies. As local agencies are unable to deploy staff to MNJAC, positions will be filled with state employees.
- ✓ As a starting point to better share information; BCA is working on an Integrated Search System (ISS) which may be of significant value to local agencies. It will be web based with access to incident based information from multiple systems. It will also include an analytical tool. It compares to the federal NCIC system.
- ✓ The ISS has already created portals from 15 different RMS systems. The BCA budget can incorporate some of the development costs, but not the analytics tool.
- ✓ Gerlicher pointed out that privacy advocates may also have issues with incident based data, particularly as it contains information about victims and witnesses. Gross pointed out that "ownership" of the information and retention will need to be addressed.

AC Dunaski stated that he and Commissioner Dohman will look forward to further discussion on this topic at the October retreat as both intend to come.

UPDATE ON STATEWIDE COORDINATOR POSITION

Bob Bushman reported that he will be retiring before year's end and probably in October, 2012. Melvin Carter wanted the record to reflect that "Bob is irreplaceable". Chair Reed reported that the Governance Committee has begun the process to update the position description.

Jeri Boisvert described the process for the state to approve a job description, establish the proper classification and post the position for applications. It was explained that the VCCC is responsible for recommending a candidate or candidates to the Commissioner of Public Safety to serve in the unclassified position. She noted that the Governance Committee met to develop a succession plan for the replacement of the coordinator position. The Governance Committee is reviewing and updating the position description. Jeri will put it into a state format and it will be sent to Public Safety Human Resources and assigned a state classification which will dictate the salary. Mobility transfers would be allowable but given the pay structure of state government it would be unlikely that the amount available would cover the entire local salary and benefit package.

Perkins described the process that was used by VCCC in 2005 to establish the job duties for the position; screen, interview and check references for applicants and make a selection recommendation to then commissioner, Michael Campion.

DATA COMMITTEE REPORT

Chair Reed announced that he had talked to Commissioner Dohman about the gang criteria recommendations recently submitted to her. She advised Reed that she will respond soon. If members have any questions or concerns in the interim they should be directed to him.

GOVERNANCE COMMITTEE REPORT

Gordon Ramsay provided a draft agenda for the VCCC retreat to be held in October. Focus will be on intelligence data and heroin and other opiate abuse. The agenda will include presentations and discussions and will include invited presenters and guests from partner organizations that may take the lead on any needed legislative changes.

Sue Perkins reminded everyone that the retreat will be held on October 9-10 at the Canal Park Lodge in Duluth. OJP will handle room reservations for council members and invited guests. Plan to begin at noon with brief business meeting then focus on afternoon retreat topic and concluding by noon on the second day.

PROFESSIONAL STANDARDS & ACCOUNTABILITY COMMITTEE REPORT

Gerlicher stated that no new business. Sue reported the auditor's office will be completing the remaining audits by the end of year. The status of the Crow Wing county task force was questioned and Bushman reported that they met their certification condition at the end of June.

COMMUNITY ENGAGEMENT COMMITTEE REPORT (written report distributed) John Gross submitted the meeting notes from the July 23rd meeting which reports discussion points and activity on the 2012 Tactical Action Plan. They have sent out emails to task force commanders to get information about the minority communities with whom they interact and asked to have community leaders identified. Post survey, they hope to begin developing the round tables to have honest, problem solving conversations around the state.

UPDATE ON LEGISLATION EFFECTIVE 8/1/12

John Gross reported on the problem of staying on top of synthetic compounds. There was hope that language created last year would suffice but it is clear that this will be an ongoing challenge as similar chemical structures and similar pharmacological effects are difficult to attest to with even a minor change in formula. Creative chemists are constantly creating new compounds.

He reported that the changes to forfeiture law will be the subject of an ongoing webinar conducted by the Minnesota County Attorney's Association. There are 400 registrants thus far. Information is contained in the meeting packet.

11:50 Break for lunch—VCCC reconvened at 12:15

STATEWIDE COORDINATOR REPORT and OJP Update

Bob Bushman provided a written report and discussed the highlights. Sue Perkins noted the information in the packet about local data for the first six months of 2012 related to heroin and other opiates and also pointed out national data on emergency room visits prompted by overdoses.

NEW BUSINESS

There was no new business proposed. A motion to adjourn the meeting was made, seconded and passed. The meeting was adjourned at 12:55 p.m.

Respectfully submitted by: Jeri Boisvert, OJP



STATE OF MINNESOTA

Violent Crime Coordinating Council

c/o Department of Public Safety, Office of Justice Programs
445 Minnesota Street, Suite 2300
St. Paul, Minnesota 55101-1515
Voice: 651-201-7350 – Fax: 651-284-3317

St. Paul Police Ex. Commander, Ken Reed, Chair; Duluth Chief Gordon Ramsay, Vice-Chair

MEETING MINUTES FOR 6/13/2012 OF THE VIOLENT CRIME COORDINATING COUNCIL (VCCC)

Council members in attendance: David Voigt, Deputy Attorneys General; Cari Gerlicher, DOC; Dave Bjerga, BCA (for Wade Setter); Chris Benson, White Earth Police Department; Sheriffs Representatives: Matt Bostrom, Bill Hutton and Pete Dietzman (for Rich Stanek); Chiefs of Police Representatives: Gordon Ramsay, Michael Goldstein, Scott Gerlicher (for Tim Dolan), and Ken Reed; County Attorney Representatives: Hilary Caligiuri and Benjamin Bejar; Citizen Representatives: Hector Garcia, Melvin Carter, and Bill Ziegler.

Staff: Sue Perkins, State Program Administrator and Kristin Lail, Grants Manager, OJP. John Gross, Assistant Attorney General (legal counsel)

Excused: Carol Keyser (for B. Todd Jones), U.S. Attorney's Office; Sheriff Jim Jensen; and Bob Bushman, OJP.

Guests: Dan Rothstein, DOC, Manuel Guerrero, and Mara Gottfried, Pioneer Press

WELCOME AND INTRODUCTIONS

There were brief introductions and the meeting was called to order at 10:00 a.m. by Chair Ken Reed.

Meeting materials included: agenda, 4/11/2012 meeting minutes, statewide coordinator's report, DEA narcotics training announcement and Heroin in Minnesota Fact Sheet.

Action on 4/11/12 meeting minutes: Motion by Caligiuri and second by Guerrero to approve. Motion passed.

Action on 6/13/12 agenda: Motion by C. Gerlicher and second by Ramsay to approve agenda. Motion passed.

Action on amendment to the VCCC bylaws: Chair Reed summarized the changes to the bylaws discussed at the previous meeting and e-mailed to members. Hilary Caligiuri clarified that the Professional Standards & Accountability Committee would review audit reports and present findings to the VCCC which would then make recommendations to the Commissioner of Public Safety. Ramsay moved to accept the proposed committee structure clarification, Benson seconded and the motion carried. Reed then asked for a motion

to accept changes to the VCCC bylaws. Caligiuri made the motion, C. Gerlicher seconded, and the Bylaw changes were approved.

GOVERNANCE COMMITTEE

Gordon Ramsay summarized the VCCC Strategic Framework noting that it was the work product of the retreat last fall and provides a road map for the next year. A draft was distributed at the previous meeting for review. There were only a few edits with no substantive changes. There were no additional comments or changes. **Action on VCCC strategic Framework:** Motion by Caligiuri and second by C. Gerlicher to approve. Motion passed.

Sue Perkins announced that the retreat will be held on October 9-10 in Canal Park in Duluth. The executive committee will meet to determine agenda items and location. Plan to begin at noon with brief business meeting then focus on afternoon retreat topic and concluding by noon on the second day. She noted that the April meeting minutes included list of proposed retreat topics, but it may be too close to election to invite legislators.

COMMUNITY ENGAGEMENT COMMITTEE

Pete Dietzman reported on behalf of Kip Carver about plans for this new subcommittee that will hold its first meeting later this summer to develop action steps in support of key elements from the strategic framework. The six action items, established in February, include reporting to citizens on task force activities, establishing minimum requirements for task force community meetings and presentations, and developing a method for ongoing community input. Gross serves as Attorney General's liaison to Councils of Color and forwards VCCC information to those who do not attend. C. Gerlicher noted that this subcommittee will have a report at the next VCCC meeting.

DATA COMMITTEE UPDATE

Mike Goldstein reported that the Data Committee have met several times with law enforcement and community input, followed by a word-by-word review of all gang criteria recommendations. He directed members to the June 2012 draft of the Gang Criteria Recommendations to the Commissioner of Public Safety. Caligiuri asked if the cover letter was included and Reed read aloud the brief transmittal letter. Caligiuri also clarified that the report cover, page 1 and transmittal letter should all refer to subdivision 3(8) rather than 12(8). Goldstein further explained that the committee was very deliberate in taking time to review input to develop a balanced report representative of many interests. The focus is on the 9 point criteria with recognition of prevention and intervention for consideration in the future. He noted that there were concerns about database references that were not addressed in this report, but will also require future consideration.

C. Gerlicher asked about the change from "felony" to "crime of violence" at the top of page 5, noting that female offenders are often involved in significant property crimes. She also recommended changing "prisoners" in the 5th bullet on page 8 to either "incarcerated individuals" or "inmates." Caligiuri asked about the written documentation such as drawings, lists, prayers and the Chair clarified it was addressed in Criteria #6 on rosters and #9 on graffiti. Ziegler thanked the committee for their work in capturing the voice of community concerns about both prevention and enforcement.

Hutton readdressed the crime of violence concerns and Bjerga noted that it is very broadly defined in subdivision 5 of the Minnesota Statute. Reed questioned the change from "felony and gross misdemeanors" in the previous definition and Goldstein noted it was a deliberate change by the committee to crimes of violence. Caligiuri confirmed that the focus of the decision was on officer safety. Bejar pointed out that the definition of gang affiliation is based on a minimum of 3 of the 9 criteria, but that a conviction for a crime of violence is required for confirmation.

Action on gang criteria: Reed asked for a motion to approve the gang criteria with the correction of the noted subdivision and change from the wording of "prisoner" to "incarcerated individual". Caligiuri made the motion, Bejar seconded and Perkins requested a roll call vote. The vote was unanimous to accept the gang criteria and forward the recommendation to the Commissioner of Public Safety. Carter thanked the committee for their work.

PROFESSIONAL STANDARDS & ACCOUNTABILITY COMMITTEE UPDATE

Cari Gerlicher noted that the State Auditor has completed several task force reports that have been reviewed by the committee. Bjerga suggested that the committee summarize common issues identified, allowing time to discuss any significant findings.

- * impound lots should send a copy of signed owner release back to task force
- * supervisors should sign forms when there is a disbursement of confidential funds
- * supervisors should not sign out funds to themselves
- * record of confidential funds disbursement should be in both the case file and a central file

Guerrero asked if audit reports are available online and Reed requested a link on the VCCC website. Perkins noted that the statewide coordinator prepares a corrective action plan and monitors it on subsequent site visits. She also noted that anything egregious would be brought to the committee immediately.

Perkins also noted that the Lakes Area Task Force (in Baxter, Brainerd and Crow Wing County) had been sent a conditional termination letter because they had an old MOU in place and had not taken steps to develop a new joint powers agreement. Voigt clarified that this action was taken by the grant manager rather than the VCCC. Perkins agreed and noted that if terminated, she would inform the VCCC. There has been no response to the letter from the Sheriff but the County Attorney had contacted Bushman for sample JPAs. Bjerga believed that Sheriff Dahl was aware of the issue and that they would meet the deadline.

11:00 Break for lunch—VCCC reconvened at 11:30

Perkins verified that the state auditor reports will be posted on the DPS website.

Gross noted several questions as follow-up to legal update provided at the Can-Am conference, particularly on changes to forfeiture law. Perkins noted that the County Attorney's Association was developing a Webinar on forfeiture law changes.

OJP UPDATE

Sue Perkins provided a summary of Bushman's state commander update including Task Force Commanders Training, Can-Am Conference, PCA Hearing, upcoming DEA narcotics training, Heroin Facts, and Marijuana anti-legalization resources on CD and Minnesota Gang Trends handout. Gross noted that if it was intended for "law enforcement purposes only" it should not be distributed at a public meeting. It was agreed that such reports could be forwarded directly to law enforcement members.

Perkins explained that the funding plan for 2013 would support all current task forces at the same level amending all grants in good standing. They would plan for 1-year grant extensions, which would change only if state legislature makes cuts in the next session, which is not expected. However, she noted that there have been significant cuts in Federal JAG funding which will affect grants in 2014.

Perkins noted that heroin is an emerging issue citing task force arrest and seizure data, a survey and meeting of commanders and meeting of task force analysts. As a result, each task force has designated a heroin liaison to work with DEA and other task forces using an informal pointer system. Perkins is also preparing a disk of heroin prevention resources. Garcia suggested that DPS could connect with youth through his organization and Ziegler agreed that training frontline staff would be most helpful. Reed also noted that Chiefs and Sheriffs have connections with community organizations beyond the task forces. Training for patrol officers, kid, parents and service provides will be helpful.

Bejar requested similar resources for bath salts and other synthetic drugs noting that prosecutors are struggling to make cases. Bjerga agreed citing a backlog in testing since the chemical formulas are constantly changing. Ramsay noted that in August the new law raises it to a felony with the Board of Pharmacy reviewing analogs. Gross cited continued concerns about weights and repeat offenders. Dietzman noted that there have been some recent deaths on synthetic drugs, but difficult to prove. Bejar reiterated that synthetics also seem to be a significant issue for prevention and training. Perkins agreed.

NEW BUSINESS

There was no new business proposed. A motion to adjourn the meeting was made by C. Gerlicher, seconded by Hutton and passed. The meeting was adjourned at 11:30 p.m. The next meeting will be on Wednesday, August 8th at the DOC.

Respectfully submitted by: Kristin Lail, OJP

MOORHEAD, MINNESOTA CITY CODE

4-4-21: OFFENSES RELATING TO DRUG PARAPHERNALIA:

A. Use Or Possession Prohibited: It is unlawful for any person knowingly or intentionally to use or to possess drug paraphernalia. Any violation of this subsection is a petty misdemeanor.

B. Delivery Or Manufacturing Prohibited: A person may not deliver, possess with intent to deliver, or manufacture with intent to deliver, drug paraphernalia, if that person knows or should reasonably know that the drug paraphernalia will be used to plant, propagate, cultivate, grow, harvest, manufacture, compound, enhance, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, conceal, inject, ingest, inhale, or otherwise introduce into the human body a controlled substance in violation of Minnesota statutes chapter 152. Any violation of this subsection is a misdemeanor.

C. Definitions:

DRUG PARAPHERNALIA: 1. Except as otherwise provided in subsection 2 of this definition, "drug paraphernalia" means all equipment, products, and materials of any kind, which are used, intended for use, or designed for use in planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, enhancing, converting, producing, processing, preparing, testing, analyzing, packaging, repackaging, storing, containing, concealing, injecting, ingesting, inhaling, or otherwise introducing into the human body a controlled substance in violation of Minnesota statutes chapter 152.

2. "Drug paraphernalia" does not include the possession, manufacture, delivery, or sale of hypodermic needles or syringes.

3. The term paraphernalia includes, without limitation:

- a. Kits used, intended for use, or designed for use in planting, propagating, cultivating, growing, or harvesting of any species of plant which is a controlled substance or from which a controlled substance can be derived.
- b. Kits used, intended for use, or designed for use in manufacturing, compounding, converting, producing, processing, or preparing controlled substances.
- c. Isomerization devices used, intended for use, or designed for use in increasing the potency of any species of plant, which is a controlled substance.
- d. Testing equipment used, intended for use, or designed for use in identifying or in analyzing the strength, effectiveness, or purity of controlled substances.
- e. Scales and balances used, intended for use, or designed for use in weighing or measuring controlled substances.
- f. Diluents and adulterants, including quinine hydrochloride, mannitol, dextrose, and lactose, used, intended for use, or designed for use in cutting controlled substances.
- g. Separation gins and sifters used, intended for use, or designed for use in removing twigs and seeds from, or in otherwise cleaning or refining, marijuana.
- h. Blenders, bowls, containers, spoons, grinders, and mixing devices used, intended for use, or designed for use in compounding, manufacturing, producing, processing, or preparing controlled substances.
- i. Capsules, balloons, envelopes, and other containers used, intended for use, or designed for use in packaging small quantities of controlled substances.

j. Containers and other objects used, intended for use, or designed for use in storing or concealing controlled substances or products or materials used or intended for use in manufacturing, producing, processing, or preparing controlled substances.

k. Objects used, intended for use, or designed for use in ingesting, inhaling, or otherwise introducing controlled substances to include, but not limited to, marijuana, cocaine, hashish, or hashish oil into the human body, including:

(1) Metal, wooden, acrylic, glass, stone, plastic, or ceramic pipes with or without screens, permanent screens, hashish heads, or punctured metal bowls.

(2) Water pipes.

(3) Carburetion tubes and devices.

(4) Smoking and carburetion masks.

(5) Objects, sometimes commonly referred to as roach clips, used to hold burning material, for example, a marijuana cigarette, that has become too small or too short to be held in the hand.

(6) Miniature cocaine spoons and cocaine vials.

(7) Chamber pipes.

(8) Carburetor pipes.

(9) Electric pipes.

(10) Air driven pipes.

(11) Chillums.

(12) Bongs.

(13) Ice pipes or chillers.

l. Ingredients or components to be used or intended or designed to be used in manufacturing, producing, processing, preparing, testing, or analyzing a controlled substance, whether or not otherwise lawfully obtained, including anhydrous ammonia, nonprescription medications, methamphetamine precursor drugs, or lawfully dispensed controlled substances.

D. Drug Paraphernalia Guidelines: In determining whether an object is drug paraphernalia, a court or other authority shall consider, in addition to all other logically relevant factors:

1. Statements by an owner or by anyone in control of the object concerning its use.

2. Prior convictions, if any, of an owner, or of anyone in control of the object, under any state or federal law relating to any controlled substance.

3. The proximity of the object, in time and space, to a direct violation of this section.

4. The proximity of the object to controlled substances.

5. The existence of any residue of controlled substances on the object.

6. Direct or circumstantial evidence of the intent of an owner, or of any person in control of the object, to deliver the object to another person whom the owner or person in control of the object knows, or should reasonably know, intends to use the object to facilitate a violation of this section. The innocence of an owner, or of any person in control of the object, as to a direct violation of this section may not prevent a finding that the object is intended or designed for use as drug paraphernalia.
7. Instructions, oral or written, provided with the object concerning the object's use.
8. Descriptive materials accompanying the object, which explain or depict the object's use.
9. National and local advertising concerning the object's use.
10. The manner in which the object is displayed for sale.
11. Whether the owner, or anyone in control of the object, is a legitimate supplier of like or related items to the community, for example, a licensed distributor or dealer of tobacco products.
12. Direct or circumstantial evidence of the ratio of sales of the object or objects to the total sales of the business enterprise.
13. The existence and scope of legitimate uses for the object in the community.
14. Expert testimony concerning the object's use.
15. The actual or constructive possession by the owner or by a person in control of the object or the presence in a vehicle or structure where the object is located of written instructions, directions, or recipes to be used, or intended or designed to be used, in manufacturing, producing, processing, preparing, testing, or analyzing a controlled substance. (Ord. 2011-11, 11-28-2011)