

**NC INSTITUTE OF MEDICINE
TASK FORCE ON SUBSTANCE ABUSE SERVICES**

June 23, 2008

10:00-3:00

NC Hospital Association

Meeting Summary

Attendees:

Task Force/Steering Committee: Patrice Alexander, Robert Bilbro, Sonya Brown, Anthony Burnett, Chris Collins, Anne Doolen, Robert Guy, Robert Gwyther, Paula Harrington, Carol Hoffman, Larry Johnson, Jinnie Lowery, Kevin McDonald, Phillip Mooring, Paul Nagy, Marguerite Peebles, Janice Petersen, Martin Pharr, Jane Schairer, Flo Stein, Anne Thomas, David Turpin

Interested Persons: Anthony Cathcart, Karen Chapple, Kelly Crowley, Patti Forest, Kathleen Gibson, Phillip Graham, Jessica Herrmann, Lynn Jones, Jeanette Jordan-Huffam, Lisa Mares, Anisa Mohanty, Robert Newman, Paul Savery, Wes Stewart, Kathleen Thomas, Margaret Weller-Stargell, Kathryn Wellman

Staff: Thalia Fuller, Mark Holmes, David Jones, Daniel Shive, Alex Tilley, Berkeley Yorkery

NORTH CAROLINA DIVISION OF COMMUNITY CORRECTIONS

Robert Guy, Director, Division of Community Corrections

The mission of the Division of Community Corrections (DCC) is ‘to protect the safety of citizens [through] providing viable alternatives and meaningful supervision of offenders.’ Part of this mission relies on an equal balance of control and treatment for offenders.

In FY 2006, the DCC budget was \$134 million which was used to manage an offender population of 126,381. The vast majority (90%) of these offenders are on probation with the next largest group (7%) consisting of unsupervised community service offenders. Most offenders are on probation due to structured sentencing guidelines. There are almost 70,000 new DCC admissions every year, three-quarters of which are intermediate or community sanctions. During any given day, there are about 19,000 DWI offenders under DCC supervision.

DCC admissions have been growing since the introduction of structured sentencing in the mid 1990s. Prior to 1994, judges only had prison and probation as punishments. Now, judges have intermediate sanctions. Intermediate sanctioned offenders represent those offenders that, under old sentencing guidelines, would have gone to prison. In the mid 1990s DCC received a large increase in resources; however, as the DCC population continued to rise through the late 1990s and early 2000s, resources failed to keep pace. Ultimately sentencing policy does not match current resource allocation.

Community correction is far less costly than incarceration. It costs, on average, \$2-\$17 per day to manage a community correction offender whereas an incarcerated offender costs over \$73 per day. As such, prison beds are reserved for more violent, non-conforming offenders while non-violent and high need offenders are redirected to intermediate sanctions. DCC offenders must meet several requirements to remain in compliance. They must:

- Work (or mandated community service)
- Pay taxes
- Pay restitution
- Support families
- Perform community service
- Participate in treatment

In addition to costing less to manage, the community correction population generates funds for the NC general fund through fees and court costs (over \$22 million in FY06-07).

The Criminal Justice Partnership program (CJP) was established in 1993 to support the Structured Sentencing Act. CJP was intended to expand sentencing options for courts while promoting better state-county coordination of DCC programs thereby improving public confidence in community based punishments. The primary goals of CJP are to reduce recidivism, probation revocations, and incarceration costs as well as to reduce alcohol and other drug dependencies among offenders. CJP consists of three different programs:

- Day reporting centers (20)
- Resource centers (18)
- Satellite substance abuse treatment centers (44)

Currently 95 counties participate in the CJP program. CJP resources represent the sole source of substance abuse treatment for some small counties, particularly counties in the eastern and western parts of the state. CJP offers a wide array of services including intensive, regular and aftercare substance abuse/drug education, TASC assessment and care management, and cognitive behavioral intervention. CJP also provide educational (GED and adult basic education) and technical (job seeking and retention skills, job placement and work programs) resources.

Intermediate sanction strategies utilize control/treatment plans specific to offender needs. There are specialized intermediate probation and intensive case officers that manage offender cases. Intermediate sanctions utilize mandatory drug screens and enforced treatment participation as well as mandatory work/school requirements. Violations of program requirement require action by the probation officer (PO). POs base decisions on the risk to the community and needs of the offender. Judges, not POs, revoke probation. It is the role of the PO to ‘selectively and proactively intervene with offenders to reduce the likelihood of future criminal activity...’ Successful probation management does not necessarily depend on the quantity of visits but rather the quality of the visits with offenders.

To facilitate better case management, DCC and DHHS developed the Offender Management Model (OMM). The OMM adheres to a focused, team-based approach to offender management using DHHS and CJP treatment resources alongside DCC officer

supervision. I-sanctioned offenders, C-sanctioned offenders at-risk of revocation, and prison treatment *releasees* are eligible for OMM services. OMM participants receive screening and assessment at a TASC. A collaborative, individualized treatment plan is developed based on this TASC assessment. The treatment plan is holistic in that it addresses multiple offender needs (e.g., employment, SA treatment, medical services, transportation, housing, food/clothing, education and mental health services). Control, care and service management are shared across the team. However, the full OMM service array is not available in most counties. In these counties is difficult to build the model around an offender in the community. A successful OMM requires community effort.

Discussion

- One of the biggest challenges of DCC is identifying the treatment and resources gaps for offenders. Counties participating in CJP are required to have county-level boards that are responsible for reporting treatment/service gaps to the state. Local boards are comprised of judges, district attorneys, school administrators, and probation officers. The local boards are ultimately accountable for how CJP funds are spent in the county.
- TASC has served as a good partner but has not been able to keep up with DCC demand. DCC is missing a big group of offenders due to a lack of TASC/treatment resources. For instance, female treatment beds are non-existent (subject of current litigation). DCC does not need more probation officers, rather it needs more resources.
- Eligibility for DCC CJP services depends on the seriousness of the crime committed and the history of the offender (I-sanctioned offenders). However, there may be some I-sanctioned offenders who do not need services and some C-sanctioned offenders who do need services but are not eligible until they violate their probation. Part of the problem is that we assess offenders after adjudication. Many states have prior sentencing investigations that help guide sentencing decisions. This issue will be re-raised during the task force meeting on access. Another issue with non-eligibility of C-sanctioned offenders arises with juvenile offenders *failing* into the adult system. Some of these individuals may have violent histories but are categorized as C-sanctioned offenders when entering the adult system and are thus not eligible for treatment services.
- There was discussion on diverting funds generated by DCC offenders to DCC operations. This approach was not seen as viable. A more viable approach would be to increase fees and divert the increase to CJP or a new treatment fund.
- Probation officers are some of the lowest paid college graduates in state government. Staff retention is difficult due to high-risk, low-reward nature of PO position.
- Conflict in funding streams for juvenile offenders because the substance abuse system sees them as children (as long as under the age of 18) whereas DCC sees them as adults (regardless of their age).

Potential Recommendation

- Increase TASC funding

- Increase CJP funding and conduct demonstrations
- Conduct structured sentencing risk assessment related to I- and C-sanctioned offenders and juvenile failures.
- Allow DWI eligibility for CJP services
- Increase fees and redirect fee increase to a new treatment fund
- Conduct evaluation of community corrections at the program and judicial district levels
- Perform diversion/pre-sentencing investigations to educate judges about community resources/alternatives
- Improve local infrastructure through education of local boards.

DEPARTMENT OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION

Martin Pharr, Clinical Director and Legislative Liaison, Department of Juvenile Justice and Delinquency Prevention

The Juvenile Justice Reform Act of 1998 condensed the juvenile and delinquency services provided by DHHS, the UNC system, and the Administrative Office of the Courts (AOC) into one cabinet level agency, the Department of Juvenile Justice and Delinquency Prevention. NC DJJDP is a bifurcated system in that it combines both judicial and executive powers.

Youths exhibit a continuum of behaviors from problem behavior to serious, violent behavior. Juveniles do not start out as serious offenders; instead more serious behavioral problems develop over time. To meet the needs of juveniles at any point in the continuum there needs to be a ‘Comprehensive Strategy’ of supports (prevention and intervention) and sanctions. Unlike adult sanctions, juvenile sanctions are rehabilitative in nature. Sanctions or controls without treatment are not effective and may actually harm juvenile offenders. DJJDP’s goal is to guarantee programming that simultaneously meets the needs of children, protects the public, and most efficiently uses the department’s limited resources.

Core principles of a comprehensive strategy for juveniles must:

- Strengthen families
- Support core social institutions
- Promote delinquency prevention
- Intervene immediately and effectively when delinquent behavior occurs
- Identify and control small group of serious, violent and chronic juvenile offenders

The majority of youth enter the JJ system have committed minor offenses. Only a small proportion of offenders require total control (e.g., youth development center).

The NC DJJDP uses graduated sanctions that allow for steps up and down in intensity of control as warranted by the behavior of the youth. Early sanctions include diversion programs and youth courts. Sanctions increase in intensity as youth behavior becomes more serious. The most intense sanction is residential placement in a Youth Development

Center. As behavior improves, youths can be stepped down into counseling and mentoring programs.

Juveniles with minor offenses may be appropriately served as the front end of the system and, when successful, prevent them from penetrating further into the system. Almost half of all juvenile complaints are diverted in this way. However, those not diverted face three levels of disposition: community, intermediate and commitment. Dispositions are based on level of control deemed necessary for each juvenile. For instance, committed youth do not necessarily have to be treated at Youth Development Centers as *commitment* refers to the level of supervision and not the location of services. Family involvement, particularly with parents, is crucial to successful rehabilitation; however, meaningful family participation in juvenile rehabilitation continues to be a challenge.

Each juvenile in the system receives a risk and needs assessment. Community risk and resources assessments are also undertaken to evaluate community needs.

Funded by DJJDP grants, each NC County maintains a Juvenile Crime Prevention Council (JCPC) which is responsible for local program planning and decision-making. JCPC are ultimately responsible for ensuring that the continuum of services is available at the local level. Local service gaps are reported to the DJJDP by JCPC. JCPCs can fund a variety of programs as long as program funds are used for the direct provision of services to youth and families. JCPC membership is set by statute and covers a wide range of community leaders from law enforcement and court representatives to county commissioners and mental health and substance abuse treatment professionals.

DJJDP funds a variety of substance abuse treatment services and programs.

- *Juvenile Detention Centers* are state-operated facilities that serve as temporary facilities where juveniles stay while waiting to be placed or go to court. With funding from MHDDSAS, detention centers contract with SA professionals (up to 25 hours per week) to provide assessments and individual and group counseling. There are currently 9 county-based JDCs.
- *Youth Development Centers* are state-operated residential treatment facilities funded through DJJDP. While youth in YDC, they may receive screenings, assessments, individual and group counseling, psychoeducation groups, and aftercare/referrals. Services are provided by SA professional employed by local mental health centers. There are currently 5 YDCs across the state. There have been several substance abuse prevention and treatment programs implemented at YDCs including the BRIDGE, SARGE and BEST programs.
 - The Holistic Enrichment of At Risk Teens (HEART) program is an ongoing program delivered in therapeutic communities that provides comprehensive treatment to substance abusing, incarcerated girls with a high probability of co-occurring mental health issues. HEART adheres to a model of blended treatment and education and utilizes the Cognitive Behavior Therapy (CBT) treatment model.
 - *YDCSAS Enhancement Initiative* was created to standardize and improve the quality of substance abuse services at YDCs. The Initiative created a

treatment manual-- *Another Choice, Another Chance*-- that provides step-by-step instructions on how to lead group therapy sessions with substance abusing, incarcerated youth. The manual is based on SAMHSA's Cannabis Youth Treatment (CYT) Series 12-session manual with supplemental information on drug education, relationship management, conflict resolution and other life skills.

- *Community Based Services* are provided by JCPCs. There are only 4 JCPC funded programs providing SA prevention services, 10 providing SA assessment and treatment services, and 2 that provide SA assessments only. There are few of these programs in the eastern part of the state mainly due to staff recruitment and retentions problems in these rural areas.
- *Managing Access to Offender Resources and Service (MAJORS)* is a federally funded program managed jointly by MHDDSAS and DJJPD. MAJORS was developed to fill a gap in substance abuse treatment services for adjudicated youth by blending court sanctions and supervision with substance abuse intervention strategies for adolescents. The MAJORS program targets adjudicated delinquent and undisciplined juveniles and juveniles with court ordered diversion contracts who have a DSM-IV substance abuse or dependence diagnosis.

Discussion

The biggest gap in services is for community-based prevention services. Per legislation, JCPCs must use program funds for treatment services.

Family involvement is crucial to treatment. YDC-based programs tend to have the best family involvement whereas probation-based programs tend to have the least family involvement. Should we give courts greater power over families of offenders to mandate participation or concentrate on ways to empower families to want to participate?

The vast majority of kids are eligible for third party reimbursement, however, JCPC services do not bill Medicaid. MAJORS, on the other hand, does draw down Medicaid and NC Health Choice funds before using state MAJORS funding.

DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES JUVENILE JUSTICE INITIATIVE

Kelly Crowley, System of Care Coordinator, Community Policy Management, Prevention and Early Intervention Team, MHDDSAS

Paul Savery, CSAT Adolescent Substance Abuse Treatment Coordination Grant Project Coordinator, Community Policy Management, Best Practices, MHDDSAS

Mental health and substance abuse disorders are prevalent in the juvenile justice population. Of the 9,220 youth adjudicated in 2007 in NC, 75% were screened to have mental health needs and 46% screened to be in need of substance abuse assessment or treatment. Youth with mental health, substance abuse or co-occurring disorders are more resource intensive and require increased collaboration, a continuity of care, and access to a qualified provider community. An adequate system of care for this population should be

community based; child and family team oriented; culturally, linguistically and gender competent; individualized; outcomes based; and data driven.

The current system of care for the JJ population lacks a single point of contact, over utilizes community supports, underutilizes evidence-based practices and fails to reflect how DJJP is organized. The MAJORS program is not widespread and is inconsistent where it does exist. MHDDSAS is proposing a remodeled MAJORS concept. The JJ initiative will use Cross-area Service Program (CASP) infrastructure. The initiative is currently in the planning stages but is expected to be piloted in 1-4 sites based on DJJDP regions.

The JJ initiative will be overseen by a DJJDP-MHDDSAS Advisory Partnership that will meet quarterly. System Coordination Teams (SCT) will be developed for each DJJDP region and will troubleshoot system issues and perform operational reviews. Each SCT will meet quarterly and report to the Advisory Partnership. Operations Teams, meeting monthly, will provide training and facilitate communication between stakeholders. Each CASP will identify a Lead Provider Agency that will be responsible for coordinating or providing the service array and serve as the single point of contact. The service array includes:

- Community services
- Family therapy
- Parent education
- Multi-family groups
- Community support
- Intensive In-Home/MST
- Therapeutic Foster Care
- Residential substance abuse services

All services defined in the service array are billable.

The JJ initiative will use the Global Appraisal of Individual Needs (GAIN) for assessments. There is a small licensing fee for use of the GAIN (currently for 6 sites); however, cost should not be impediment to adoption. The GAIN looks at both substance abuse and mental health issues. The GAIN-I is a comprehensive screen taking about 60-90 minutes to complete. Results use DSM-IV for diagnoses and ASAM for treatment placement. There is also a short screen (~5 minutes) available. The JJ initiative requires the use of evidence based practices but does not mandate the use of a specific model.

Instead, there is a menu of evidence based practices from which communities can choose.

Identified EBPs include:

- Motivational Enhancement Therapy
- Cognitive Behavioral Therapy
- Multi-dimensional Family Therapy
- Seven Challenges Program