Substance Abuse Treatment Task Force
Final Report

As required by Legislative Bill 865, the Task Force met regularly to address the tasks listed in the bill. This report contains overall guiding statements, key policy statements, summary of findings for each task, and short-term, intermediate, and long-term recommendations.

GUIDING STATEMENTS:

Vision:

Nebraska communities are safe, healthy, and free of substance abuse.

Mission:

Enhance public safety and reduce criminal behavior by ensuring all governmental entities responsible for supervising individuals in the adult and juvenile justice systems have knowledge of and equal access to a full continuum of effective substance abuse services.

Guiding Recommendation:

We recommend that Health and Human Services, the Crime Commission, the Department of Probation, the Department of Corrections, the Board of Parole and all other criminal and juvenile justice entities adopt this vision and mission. Further, we recommend that the Task Force act as a coordinating body, annually reporting to the Governor and Legislature on the implementation and evaluation of the recommendations contained in this report.

SUMMARY OF WORK:

Task 1: Examine the extent of substance abuse within the criminal justice system.

<u>Key Statement for Adult Offenders</u>: Twenty-five to 40 percent of adult arrestees and 65 to 85 percent of incarcerated adult offenders need substance abuse treatment compared to only seven percent of the general adult population. Based on estimates of need among adult offenders, an estimated 13,900 to 22,241 adult arrestees needed some level of substance abuse treatment in 1997 (see Appendix A for the *Needs Assessment Report*).

Summary of Findings for Adults:[1]

- Based on data collected across system stages (i.e., from arrest to corrections), approximately 25 to 40 percent of all offenders, regardless of offense, needed substance abuse treatment for alcohol, marijuana, cocaine/crack, and/or methamphetamine.

- **The need for treatment among adult arrestees was three to six times higher than in the Nebraska population, and the need for treatment among incarcerated offenders was ten to twelve times higher than in the Nebraska population. Need increases substantially among offenders at later stages of the process.**

Need for Substance Abuse Treatment among Adults in Nebraska

Population:	Estimated Need for Treatment
Adult Nebraska Arrestees (1995-1998 Data)	*25-40%*
Adult Nebraska Incarcerated Offenders (1997 Data)	*65-85%*
Nebraska Population (1990 Data)	7.3%
U.S. Adult Population(1996 Data)	
18-25	8.5
26-34	4.8
35+	1.7

Sources:

Herz, D. and Vincent, M. 1999. *Needs Assessment Report* (See Appendix A).

Justice Research and Statistics Association. 1998. *Impact Statements and Research and Evaluation Reports*. Washington, D.C.: U.S. Department of Justice.

Health and Human Services, Division of Mental Health, Substance Abuse and Addiction Services. 1997. *Nebraska State Demand and Needs Assessment Studies.* Lincoln, NE: Department of Health and Human Services.

Epstein, J.F. and Gfroerer, J.C. 1999. *Analyses of Substance Abuse and Treatment Need Issues*.

[1] These findings were taken from the Substance Abuse Treatment Task Force's Needs Assessment Report for Adults and Juveniles (see Appendix A). All criminal justice agencies were asked to provide data on the (1) demographics of offenders; (2) prevalence of drug use among offenders; (3) need for treatment among offenders. These data were requested for the years 1995 to 1998. The amount and quality of data varied across agencies. However, several data sources were identified including: the Arrestee Drug Abuse Monitoring Program (ADAM), Rural ADAM Outreach Study, Uniform Crime Reports for drug arrests, the Douglas County Drug Treatment Court, the Department of Probation, the Department of Corrections, Health and Human Services, the Federal Pre-Trial Office, and the Federal Probation Office. These findings are limited to the data provided by these agencies.

- **In 1997, an estimated 13,900 to 22,241 adult arrestees needed some level of substance abuse treatment.** (Estimates were calculated using estimates of need in combination with the total number of Uniform Crime Report Part I offenses committed by adults in 1997 (Keelan and Wahl, 1998)).

- Estimates of treatment need were reinforced by data collected from a sample of judges. Specifically, most judges believed that up to 80 to 85 percent of offenders were involved in substance use and 60 percent of judges believed that 20 to 45 percent of offenders needed treatment.

Judges Perceptions of the Prevalence of Alcohol/Drug Use and Need for Treatment among Offenders

	Percent of Offenders…			
	Involved in Alcohol or Drugs	**Cumulative Frequency**	**Who Need Treatment**	**Cumulative Frequency**
20-25%	0 (0%)	0%	8 (27%)	27%
30-35%	2 (7%)	7%	7 (23%)	50%
40-45%	2 (7%)	14%	3 (10%)	60%
50-55%	6 (19%)	27%	2 (7%)	67%
60-65%	4 (13%)	40%	6 (20%)	87%
70-75%	8 (25%)	65%	3 (10%)	97%
80-85%	8 (25%)	94%	0 (0%)	---
90-95%	2 (7%)	100%	0 (0%)	---
100%	0 (0%)	---	1 (3%)	100%
Number of Respondents	32	---	30	---

Thirty-two judges (28%) responded to a mailed survey on offender substance use. Thirteen of the respondents were county court judges, eighteen were district court judges, one was a juvenile court judge, and one was a drug treatment court judge.

- Omaha Arrestee Drug Abuse Monitoring (ADAM) and Rural ADAM data indicated that treatment need was similar across rural and urban locations. However, the type of drug driving this need differed by location. For example, methamphetamine was the second highest drug found in rural arrestee urine specimens, whereas cocaine was the second highest drug found in Omaha arrestee urine specimens.

- Omaha ADAM female offenders reported similar rates of treatment need as male offenders except for crack cocaine. In this case, female offenders reported a higher need for treatment.

- Need for treatment was also similar across Omaha ADAM arrestees by race/ethnicity. Two exceptions to this pattern were for Native Americans who reported a higher need for alcohol treatment services compared to any other group and African-Americans who reported a higher need for crack treatment services compared to any other group.

- **Less than <u>five</u> percent of Omaha or Rural ADAM arrestees were in treatment at the time of their arrest.**

- Approximately 40 percent of offenders on probation were required to enter some type of treatment program. These offenders were most likely to access self-help groups, education, and outpatient programs.

- Probation increased the amount of drug testing dramatically between 1995 and 1998 but the percentage of offenders receiving treatment has remained the same. Twenty percent of the urine tests given to probationers were positive for marijuana.

- **Of the incarcerated offenders who successfully completed treatment at Nebraska Correctional Treatment Center between October 1996 and June 1999 (N=449), only four percent had subsequent felony convictions, nine percent received sanctions for positive urinalysis, and ten percent had their parole revoked.**

- Between 35 and 57 percent of Omaha and Rural ADAM arrestees (varied by location) reported that they were under the influence of a drug at the time of their arrest regardless of offense. The majority of these offenders reported using alcohol.

- Between 30 to 50 percent of substance abuse program clients were referred by criminal justice agencies (i.e., court) between 1996 and 1999.

- In FY 1999/2000, the Division of Mental Health, Substance Abuse, and Addiction services funded 107 substance abuse programs for adults. These programs have the capacity for 55,517 units of treatment and to house 332 people. **Persons served would include only a fraction of criminal justice offenders.**

Substance Abuse Treatment Programs for Adults in Nebraska:
Fiscal Year 1999/2000

Type of Treatment Program	Percent of Total Programming	Units of Treatment	Beds Available
Intensive Outpatient	13%	33,035	-
Outpatient Therapy/Assessment	19%	13,299	-
Community Support – SA	12%	242	-
Flex Wraparound	11%	-	-
Short-term Residential	8%	-	53
Halfway House	7%	-	133
Emergency Social Detox	6%	575	40
Crisis Assessment	5%	-	-
Civil Protective Custody	4%	-	13
Therapeutic Community	4%	-	49
Intermediate Residential	3%	-	34
Crisis 24-hour Clinician On-Call	2%	-	-
Outpatient Therapy/Assessment-Dual	1%	1130	-
Emergency Residential	1%	-	4
Therapeutic Community – Dual	1%	-	6
S/A Assessment	1%	1000	-
Partial Care	1%	620	-
Methadone Services	1%	5616	-
Totals	**107**	**55,517**	**332**

<u>Key Statement for Juvenile Offenders:</u> Thirty to 40 percent of juvenile arrestees and 65 to 80 percent of juvenile offenders in the youth rehabilitation and treatment centers at Geneva and Kearney need substance abuse treatment compared to only five percent of the general juvenile population. Based on estimates of need among juvenile offenders, an estimated 6,147 to 8,196 juvenile arrestees needed some level of substance abuse treatment in 1997 (see Appendix A for the *Needs Assessment Report*).

***Summary of Findings for Juveniles:*[2]**

- Offenders reported varying levels of use, but between 30 and 40 percent of all juvenile offenders, regardless of offense, needed some type of substance abuse treatment, usually for marijuana and/or alcohol. The need for treatment was much higher at the youth rehabilitation treatment centers. Sixty-five percent of female offenders and 85 percent of male offenders were in need of treatment.

- **The need for treatment among juvenile arrestees was six to eight times higher than in the general population and the need for treatment among juvenile offenders in Geneva and Kearney was thirteen to sixteen times higher than in the Nebraska population. Need increases substantially among offenders at later stages of the process.**

Need for Substance Abuse Treatment among Children in Nebraska

Population:	Estimated Need for Treatment
Juvenile Nebraska Arrestees (1995-1998 Data)	*30-40%*
Juvenile Offenders Held in Youth Rehabilitation Treatment Centers (Geneva and Kearney--1998 Data)	*65-80%*
Nebraska Population (1990 Data)	Not available
U.S. Juveniles 12-17 (1996 Data)	4.8%

Sources:
Herz, D. and Vincent, M. 1999. *Needs Assessment Report* (See Appendix A).
Epstein, J.F. and Gfroerer, J.C. 1997. Analyses of Substance Abuse and Treatment Need Issues.

[2] These findings were taken from the Substance Abuse Treatment Task Force's Needs Assessment Report for Adults and Juveniles (see Appendix A). All juvenile justice agencies were asked to provide data on the (1) demographics of offenders; (2) prevalence of drug use among offenders; (2) need for treatment among offenders. These data were requested for the years 1995 to 1998. The amount and quality of data varied across agencies. However, several data sources were identified including: Uniform Crime Reports for drug arrests, the *Sarpy County Drug Treatment Court Needs Assessment*, Lancaster Attention Center, the *Family Services Annual Report of Community-Based Evaluations*, the Department of Probation, a study completed by the American Probation and Parole Association, and the Office of Juvenile Services.

- **In 1997, an estimated 6,147 to 8,196 juvenile arrestees needed some level of substance abuse treatment.** (Estimates were calculated using estimates of need in combination with the total number of Uniform Crime Report Part I offenses committed by juveniles in 1997 (Keelan and Wahl, 1998)).

- **Twenty-five to 30 percent of offenders assessed by probation in 1998 using the Adolescent Chemical Dependency Inventory were high risk for a substance abuse problem.**

- **Only eight percent of juvenile offenders on probation received treatment between 1995 and 1998.** Slightly less than one half of the offenders who received treatment attended substance abuse education classes, 40 percent attended outpatient programs and ten percent attended self-help groups. One percent or less of offenders were placed into inpatient programs.

- Probation has increased the amount of drug testing dramatically since 1995 (+500 percent). Based on a study completed in 1992, substance abuse evaluations and/or treatment was rarely used for an probationer whose urine tested positive for a drug or drugs.

- The need for treatment may vary by race/ethnicity and gender, but the data collected for this report did not provide that type of information.

- In FY 1999/2000, the Division of Mental Health, Substance Abuse, and Addiction services funded 25 substance abuse programs for children. These programs have the capacity for 7,180 units of treatment and to house 13 children. **Children served would include only a fraction of juvenile justice offenders.**

Substance Abuse Treatment Programs for Juveniles in Nebraska: Fiscal Year 1999

Type of Treatment Program	Percent of Total Programming	Units of Treatment	Beds Available
Outpatient Therapy/Assessment	56%	3552	-
Youth Assessment	12%	1293	-
Intensive Outpatient	16%	2214	-
Therapeutic Community	8%	-	13
Community Support	4%	25	-
Partial Care	4%	96	-
Totals	**25**	**7180**	**13**

Task 2: Examine funding allocations for substance abuse treatment.

<u>Key Statement</u>: In Fiscal Year 1999/2000, the total amount of substance abuse treatment dollars in Nebraska was $19,702,702. Of these dollars, only four percent was specifically allocated to the adult criminal justice system (via the Department of Corrections) and one percent was specifically allocated to the juvenile justice system (via the Office of Juvenile Services). No substance abuse dollars were allocated to the courts or to probation. Thus, the need for substance abuse treatment among offenders does not match the funding available to provide treatment to offenders (see Appendix B for a detailed list of substance abuse dollars).

Summary of Funding Information:[3]

- In FY 1999/2000, the total amount of substance abuse treatment dollars (state and federal) in Nebraska was $19,702,702. This amount represents a 2% increase in treatment dollars since 1992. However, when the amount of substance abuse dollars in 1992 is adjusted for inflation, the total expenditures for substance abuse treatment is $22,955,130. **Using this adjusted figure, substance abuse treatment dollars have actually decreased 16.5% since 1992.**[4]

- Of the total amount of substance abuse treatment funding in FY 1999/2000, 81 percent was allocated for adults and 19 percent was allocated for children.

- The overall per capita rate decreased slightly between 1992 and 1999; however, the per capita rate increased slightly for adults and decreased noticeably for children. Note: These figures are not adjusted for inflation.

Comparison of Per Capita Rates between 1992 and 1999/00

	1992	1999/00
Per Capita Treatment Dollars for Nebraska Population	12.19	11.89
Per Capita Dollars for Adults, 18-54	17.78	20.48
Per Capita Dollars for Children, 12-18	35.61	23.75

- In FY 1999/2000, one percent of the Department of Corrections budget was spent on substance abuse treatment. The majority of substance abuse dollars in the Department of Corrections budget was grant money from federal sources. The Department of Corrections anticipates this funding will end within the next two to three years. If this federal funding disappears, additional state funding will be required to maintain current levels of substance abuse treatment within corrections.

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[3] The total amount of funding for substance abuse treatment was determined by identifying all state agencies that had treatment money available in Fiscal Year 1999/2000 (see Appendix B).

[4] 1992 is used for comparison because the Nebraska Legislative Division produced a report summarizing all substance abuse treatment dollars for this year in *An Overview of Substance Abuse Funding in Nebraska* (1992).

- In FY 1999/2000, the Office of Juvenile Services was the only juvenile justice agency that had a budget for juvenile substance abuse treatment. Two percent of the Office of Juvenile Services budget for youth rehabilitation facilities was spent on substance abuse treatment. Almost half of these funds were from federal sources (i.e., grant money) that will potentially disappear in the near future. In addition to the money in the Office of Juvenile Services for substance abuse treatment, juvenile offenders can access other state funds for treatment and offenders who are Medicaid eligible may also receive services through Medicaid.

- In FY 1999/2000, 45 percent of substance abuse treatment dollars in Nebraska was from federal sources. In 1992, the percentage of federal dollars was 36 percent.

- In FY 1999/2000, Health and Human Services distributed 95 percent of substance abuse treatment dollars in Nebraska. Seventy-five percent of this money was allocated through regions under the direction of the Division of Mental Health, Substance Abuse, and Addiction Services. The remaining portion of these funds was distributed through Medicaid and/or other State Aid.

- In FY 1999/2000, Native American Reservations received two percent ($438,836) of all substance abuse dollars in Nebraska from the Division of Mental Health, Substance Abuse, and Addiction Services.

Gaps in Funding

- Criminal justice entities can only access substance abuse treatment for an <u>adult offender</u> if the offender:
  (1) is determined Medicaid eligible and fulfills medical necessity criteria by receiving a diagnosis for substance abuse in combination with a primary mental health diagnosis (Note: The diagnosis for substance abuse MUST be secondary to a mental health diagnosis);
  (2) participates in criminal justice program that provides substance abuse treatment (e.g., drug treatment court);
  (3) has private insurance;
  (4) chooses a subsidized program in which he/she pays for services on a sliding scale (Note: Current sliding scale fees vary widely across Region and may differ for criminal justice clients);
  (5) is incarcerated and placed in a treatment program.

- Juvenile justice entities can only access substance abuse treatment for a <u>juvenile offender</u> if the offender:
  (1) is placed in the custody of Health and Human Services or the Office of Juvenile Services, in which case, Medicaid or state funds are used to pay for services;
  (2) is processed in a county where the juvenile court judge orders the county to pay for treatment services (this situation is extremely rare and predominately occurs in Douglas, Lancaster, and Sarpy Counties);
  (3) participates in a juvenile justice program that provides substance abuse treatment (e.g., drug treatment court);

(4) is Medicaid eligible, meets the medical necessity criteria, and accesses services from a Medicaid approved provider;
(5) is covered by private insurance;
(6) chooses a subsidized program in which he/she pays for services on a sliding scale.

Adult and juvenile offenders may not receive the appropriate level of care because:

- Medicaid uses medical necessity as criteria for service provision. Medical necessity, however, requires a physician, psychologist and/or a psychiatrist to determine eligibility for substance abuse treatment. Furthermore, Nebraska currently defines medical necessity using medical terminology and is primarily focused on mental health factors. **Consequently, medical necessity does not account for criminogenic need (i.e., factors related to criminal behavior)**.

- Differing interpretations of medical necessity and limited funding prevents private insurance and Medicaid from paying for recommended levels of care (i.e., recommendation may be for inpatient but insurance or Medicaid may only approve payment for outpatient).

- Insurance companies are increasingly unwilling to cover substance abuse treatment.

- Nebraska's knowledge of and application for discretionary federal dollars for providing treatment to adult and juvenile offenders is limited. This is partially due to an absence of leadership and coordination at a systemic level to recognize and address the overall need in the state for substance abuse treatment.

Task 3: Identify any gaps in the criminal justice system that apply to chemical dependency.

Key Statement: Limited system accountability, inconsistent communication and collaboration, inadequate resources, a limited number of certified counselors, minimal provision of any level of treatment services, and inconsistent assessment and treatment exist as primary barriers to effectively addressing chemical dependency in Nebraska's criminal and juvenile justice systems.

Summary of Gaps:

- Lack of coordination: Criminal justice entities and treatment providers have historically worked together at a distance. For instance, there is currently little, if any, partnering between Health and Human Services and the criminal and juvenile justice entities. Unfortunately, these entities have not collaborated in their efforts to identify the need for services and provide services to offenders; yet, these entities often share some of the same clients. There is a need to integrate these worlds to effectively address substance abuse among adult and juvenile offenders.

- Lack of information sharing: Information is not consistently shared across criminal and juvenile justice entities in a timely manner. Consequently, important offender information is not incorporated into the chemical dependency evaluation and multiple evaluations are completed unnecessarily.

- Lack of a standardized process and criteria for selecting offenders for chemical dependency evaluations and for evaluating offenders accurately and consistently: Consequently, offenders with a need for treatment are "missed" in the criminal justice system and the quality of evaluations varies across providers. Also, providers do not consistently incorporate important factors related to recidivism of criminal behavior.

- Lack of substance abuse treatment programming throughout the criminal justice system:
  1. A lack of diversion and alternative sanctioning programs that incorporate substance abuse as part of the program.
  2. Limited program availability at the youth rehabilitation treatment centers.
  3. Limited program availability within corrections.
  4. Limited program availability for female offenders.
  5. Limited program availability in western Nebraska for offenders supervised in the community.
  6. Ineffective aftercare for adult and juvenile offenders because there is little, if any, communication between criminal and juvenile justice personnel and treatment providers and a lack of programming, particularly for juveniles.

- Need to reexamine and update treatment approaches: Limited evaluation results render an assessment of Nebraska "best practices" almost impossible. Consequently, it is unclear which programming works best for which offenders. Furthermore, treatment programs need to expand current programming by incorporating treatment for mental health issues and other addictions (i.e., gambling).

- Treatment services are often driven by an offender's ability to pay, which may exclude him/her from appropriate treatment or treatment services entirely: The inequity in funding coverage applies to both juvenile and adult offenders. Additionally, sliding scale fees at providers vary across regions and in some cases, are not extended to criminal justice clients.

- Lack of training for criminal and juvenile justice personnel on substance abuse issues: Consequently, criminal and juvenile justice responses to substance abuse and substance abuse treatment varies, resulting in a wide disparity of outcomes for offenders with substance abuse issues.

- Lack of training for Certified Alcohol/Drug Counselors on (1) criminogenic need; (2) issues related to offending populations (e.g., gambling, domestic violence, abuse); and (3) using standardized instruments to consistently diagnose and evaluate need for treatment: These items need to be incorporated consistently within chemical dependency evaluations on adult and juvenile offenders. Without incorporating these items, an appropriate and valid recommendation for a level of care is unlikely. This

applies to all individuals currently certified to conduct chemical dependency evaluations (e.g., certified counselors, physicians, psychologists, psychiatrists, and licensed mental health practitioners).

- Lack of Certified Alcohol/Drug Counselors, particularly in western Nebraska and in the Department of Corrections, due to current certification requirements: Currently, there are 315 certified counselors and 73 provisional counselors in Nebraska. Nebraska ranks 17th in the nation for counselor to population ratio, which is 1 counselor for every 3,068 Nebraska residents (see Appendix C for a full listing). If this calculation is limited to Western Nebraska, however, the ratio quadruples to 1 counselor for every 12,500 Western Nebraska residents.

- It is difficult to identify substance abuse treatment funding streams and the specific amount of dollars spent on treatment for adult and juvenile offenders.

Task 4: Identify criminogenic needs.

<u>Key Statement</u>: Research points to several factors that help predict recidivism of criminal behavior. These factors need to be formally (1) adopted by criminal and juvenile justice personnel as well as treatment providers and (2) incorporated into the assessments and evaluations completed by the justice systems and treatment providers.

Criminogenic Needs:

- Prediction of recidivism is defined as the ability to make decisions about an offender's future behavior based on past and present factors related to the offender's environment, family, peers, and individual characteristics.

- Factors that are static or fixed in time represent "risks" related to recidivism. These "risks" cannot be changed but should be considered when determining intervention for an offender.

- Factors that are dynamic or amenable to change represent "criminogenic needs" related to recidivism. "Needs" can be changed and should be primary targets of intervention within the criminal justice system.

- Several risks and needs have been identified from research on recidivism. The following list highlights the risks and needs that have been proven to be moderate to strong predictors of recidivism.

- Criminogenic risks:
  1. Behavioral history, such as prior offenses
  2. Family history, such as family conflict and abuse/neglect
  3. Biological factors
  4. Cognitive functioning

- Criminogenic needs:
  1. Criminal or substance using peers
  2. Anti-social personality traits
  3. Substance abuse
  4. Achievement levels

- If the criminal justice system can properly address these factors, the likelihood of recidivism can be reduced substantially.

- Historically, the criminal justice system and treatment providers have not worked together to match predictors of recidivism with treatment programming (i.e., need for treatment and the proper level of care).

Task 5: Eliminate fragmentation in services through the development of a criminal justice continuum of care.

Key Statement: The process to address the fragmentation in services has started within the Standardized Assessment Subcommittee of the Task Force and should continue beyond the completion of this report. This subcommittee is comprised of criminal justice personnel and treatment providers who have rarely had a chance to share ideas. The subcommittee meetings have provided an opportunity to substantially increase understanding and information sharing across these disciplines.

Issues Related to Fragmentation of Service:

- Need to identify a standardized level of care and entry and exit criteria.

- Need to pool funding for substance abuse treatment across entities.

- Need to provide incentives to providers to become Medicaid approved providers.

- Lack of a coordinating body to coordinate services.

Task 6: Identify treatment modalities to target populations for the most effective outcome.

Key Statement: Treatment of addiction is as successful as the treatment of other chronic diseases such as diabetes, hypertension, and asthma as long as treatment "best practices" are implemented. In fact, it is estimated that for every $1 spent on treatment, there is a $4 to $7 reduction in drug-related crime and criminal justice costs. Furthermore, individuals who enter treatment under legal pressure have outcomes as favorable as those who enter treatment voluntarily.

Taken directly from: *Principles of Drug Addiction Treatment: A Research Guide*. 1999. Washington, D.C.: National Institute on Drug Abuse.

A. Effectiveness of Treatment

Summary of Research:

- Results from the California Drug and Alcohol Treatment Assessment (Gerstein, Johnson, Harwood, Fountain, Suter, Malloy, 1994) indicated that:

  Overall, there was a $7 return in savings for every $1 invested in treatment. This savings was due to the following outcomes:

  1. The level of criminal activity declined by 67 percent from before treatment to after treatment. The greater the length of time spent in treatment, the greater the percent of reduction in criminal activity.

  2. The use of alcohol and other drugs declined 40 percent from before treatment to after treatment.

  3. Hospitalizations declined about 33 percent from before treatment to after treatment.

  Additionally,

  4. Treatment effectiveness did not vary by drug.

  5. Treatment effectiveness did not vary across gender, age, or race/ethnic groups.

B. Best Practices to Ensure Effective Treatment (Taken directly from the *Principles of Drug Addiction Treatment: A Research Guide,* 1999--see Appendix D):

Summary of Research:

- Matching treatment settings, interventions, and services to each individual's needs is critical to successful outcomes. No single treatment is appropriate for all individuals.

- Treatment needs to be readily available. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.

- Effective treatment attends to multiple needs (e.g., associated medical, psychological, social, vocational, and legal problems) of the individual, not just his or her drug use.

- An individual's treatment and service plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.

- Remaining in treatment for an adequate period of time is critical for treatment effectiveness. The appropriate duration for an individual depends on his or her problems and needs.

- Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.

- Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.

- Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.

- Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use. Medical detoxification safely manages the acute physical symptoms of withdrawal associated with stopping drug use.

- **Treatment does not need to be voluntary to be effective. Sanctions or enticements from the criminal justice system can increase treatment entry, retention rates and the success of drug treatment interventions significantly.**

- Possible drug use during treatment must be monitored continuously. Feedback to patients who test positive for illicit drug use is an important element of monitoring.

- 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 themselves or others at risk of infection.

- Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning.

Task 7: Develop a model for future development of substance abuse services serving the criminal justice system and monitor and evaluate the implementation of the model.

See the *Standardized Assessment Subcommittee Final Report* (page 22).

Task 8: Examine the need for the creation of a management information services system to track substance abusing offenders.

<u>Key Statement</u>: The Task Force recognizes the significant role that a management information system will play in facilitating information sharing across criminal justice entities and between criminal justice entities and treatment providers. Given this critical role, however, this task was too large for the Task Force to adequately address within current time constraints. It is recommended that more time and resources be allocated to this task once model systems have been adopted.

Task 9: Identify any need for formal initiatives or agreements between the substance abuse system and the criminal justice system.

<u>Key Statement</u>: In light of all the information gathered by the Task Force, the Task Force recommends adopting several formal initiatives that are necessary to adequately address the barriers to providing effective substance abuse treatment to adult and juvenile offenders. These initiatives are listed in Overall Recommendations section of this report.

Task 10: Develop and recommend standardized substance abuse evaluations and assessment instruments.

See the *Standardized Assessment Subcommittee's Final Report (page 22).*

OVERALL RECOMMENDATIONS:

Despite the gaps in and problems associated with providing substance abuse treatment to offenders in the criminal and juvenile justice systems, several signs of progress were identified. These developments are important to highlight as Nebraska moves toward a seamless process of offender tracking and case management. There is still progress to be made, however. In an attempt to acknowledge what the state has already accomplished as well as what it needs to accomplish, this section identifies signs of progress as well as short-term (one year), intermediate (two years), and long-term (three years) recommendations.

A. Signs of Progress

- New relationships between treatment providers and criminal/juvenile justice personnel have developed as a result of this Task Force's activity.

- Private and public treatment providers are eager to build working relationships with criminal/juvenile justice entities.

- Community linkages to facilitate working relationships with justice entities are already in place.

- ❑ the number of quality treatment programs available to adult and juvenile offenders.

- ❑ Center and the Nebraska Correctional Center for Women.

- ❑ cognitive-behavioral treatment approaches in addition to 12-step programs.

- ❑ available throughout the state.

- ❑ size, the state can successfully tackle the problems associated with substance abuse.

- ❑ Regional Center to serve male juvenile offenders.

- ❑ Geneva.

- ❑ facilitated access to treatment for juveniles who are committed to OJS or who are wards of the state. While the access to services is good, using wardship as a means to

  happening in Nebraska.

A.

1. Specific Recommendations for _____

Within one year:

- ❑ inefficiencies and reallocate substance abuse dollars in a manner consistent with the Task Force's mission and vision.

  Recommend strategies for providing discretionary treatment funds to probation, parole, and community corrections to purchase substance abuse treatment services.

  Examine how to access more federal substance abuse treatment dollars, especially through money allocated to the Substance Abuse and Child Protection Partnership

- ❑ Support the continuation of the efforts directed at identifying and recommending a

1. Develop and utilize a continuum of care between the correctional institutions and community-based treatment providers, especially for offenders released on parole.

2. Design and develop a seamless process of offender tracking and case management through a model of continuum of care.

3. Improve continuity of care by "bundling" treatment and non-treatment service arrays and coordinate through structured case management process.

4. Standardize entrance and exit level-of-care criteria for offenders accessing treatment services.

- Develop a statewide strategy for treatment that can be used to (1) design a future coordinated allocation of federal and state resources; and (2) establish a prescribed set of formal, standardized, and uniform directives, flow charts, and timetables for coordinating offender substance abuse treatment supervision, and case management in the state.

- Oversee several pilot projects to test some of the ideas presented and then base legislative suggestions on the results of those projects.

- Design a method to monitor and document state's progress toward implementing Task Force recommendations.

- Hire a consultant to help the coordinating body implement the recommendations. Denise Herz, Ph.D., has been invaluable in the collection of information for this report. We encourage the coordinating body to continue the relationship with Dr. Herz. If the current consultant cannot continue then a formal tie with UNO is suggested.

- Begin reporting annually to the Governor and Legislature on the state's progress and obstacles to ensuring quality, affordable, accessible, and effective substance abuse services for offenders.

Within two years:

- Explore the development of legislative and administrative package to implement alternative sentencing practices, intermediate criminal sanctions, and other alternatives to incarceration that stress substance abuse treatment and offender accountability.

- Monitor the implementation of "best practices" across the state.

2. Specific Recommendations for <u>Criminal and Juvenile Justice Entities</u>

Within one year:

- Ensure that adult and juvenile offenders are properly evaluated for chemical dependency when they enter the Department of Corrections and the Office of Juvenile Services.

- Adopt the statewide strategy for treatment produced by the Task Force.

- Encourage the adoption of standardized evaluation criteria for drug treatment courts

  treatment. This will help avoid unwarranted disparities due to gender and/or race and ethnicity.

  Criminal and juvenile justice entities will match appropriate treatment to adult and juvenile offender need.

  Expand the availability of appropriate treatment for all security levels in the Department of Corrections so that treatment matches need.

  Specific Recommendations for <u>Health and Human Services</u>

- Modify the process for training and certification of substance abuse counselors to

- Evaluate use of statewide fee schedule for treatment services.

  Expand Medicaid coverage of substance abuse treatment for adults and juveniles:

  1. broadest coverage possible within Federal law and regulations for criminal and juvenile justice populations.

     Removing unnecessary barriers to accessing treatment services.

  3. not exclude juveniles from care because of behavioral issues.

  4. for substance abuse treatment (e.g., adopt the Family Services Model).

Within two years:

  Enhance substance abuse treatment at youth rehabilitation and treatment centers by:

  1. treatment comprehensive and universal at the facilities.

  2.

  3. Ensure gender-appropriate treatment is available at YRTC-Geneva.

4. Upon discharge, require aftercare programming for all youth participating in treatment programs at the YRTCs (i.e., placement in community-based treatment program).

- Provide incentives (eliminate disincentives) for substance abuse programs to become Medicaid, managed care, and regional (via the Division of Mental Health, Substance Abuse, and Addiction Services) providers.

4. Specific Recommendations for Criminal Justice and Health and Human Services Collaboratively

Within one year:

- Develop and provide formal training that includes the following priorities:

1. Require training on substance abuse issues for all criminal justice and juvenile justice personnel. Make this training a standard part of new hire training and continuing education for all employees.

2. Require Health and Human Services to provide training to juvenile justice personnel on how to determine eligibility for Medicaid or Kids Connection, how to get offenders approved for Medicaid or Kids Connection coverage, and how to access treatment services under Medicaid and/or Medicaid managed care.

3. Require training on incorporating criminogenic need and standardized instruments into chemical dependency evaluations for all state certified counselors. Make this training a standard part of the certification process and continuing education for all counselors.

4. Encourage mental health counseling Master's degree programs to offer courses on criminogenic need and standardized instruments as part of students' degree requirements. Encourage these programs to also offer substantial courses in substance abuse issues.

5. Shared training between criminal and juvenile justice personnel and state certified counselors to promote mutual understanding and to identify ways to efficiently share information between the two professions.

Within two years:

- Examine barriers to information sharing within criminal and juvenile justice entities between criminal and juvenile justice entities and treatment providers and recommend strategies to overcome barriers.

- Build a working partnership between criminal and juvenile justice and the Division of Mental Health, Substance Abuse, and Addiction Services by creating position or assigning duties to an existing position within the Division to liaison with and advocate for substance abuse services within justice.

- ❑ Adopt and implement standardized continuum of care recommended by the

5. Specific Recommendation for _____

Within two years:

- ❑ treatment and recommendations for care.

- ❑ juvenile offenders.

6. <u>Additional Research</u>

Within one year:

Identify why so few juvenile treatment programs exist and provide recommendations for expanding the availability of a treatment continuum of care for juvenile substance

adults have access to treatment services.

Within two years:

Begin evaluation of the standardized model process.

- ❑

- ❑ Identify how a statewide management information system should work.

Specific Recommendations for <u>Funding</u>

- ❑ Consider additional funding to evaluate the implementation of the standardized

- ❑ Consider additional funding to design a statewide management information system.

- ❑ Provide state support and funding for the expansion of drug treatment courts.

through the Nebraska Crime Commission.

1. completed.

2. Funds could be used for administrative costs for coordination of treatment and the payment of treatment costs.

3. Funds would be renewable on an annual basis.

4. Evaluations would be required to receive additional funding.

5. A 25% match would be required, which would include in-kind, "soft" match funds.

- Access more federal funding for treatment services within criminal and juvenile justice by establishing a federal grant coordination position under the Division of Mental Health, Substance Abuse and Addiction Services for the exclusive purpose of obtaining and managing grant dollars earmarked for substance abusing juvenile and adult offenders.

- Fund a study on how current substance abuse treatment dollars are being expended and make recommendations on the reallocation of dollars, the new dollars needed and possible funding sources.

Within three years:

- Implement the development of a statewide management information system that facilitates the exchange of information between entities for case management and evaluation purposes.

- Build the cost of comprehensive program evaluation into all drug treatment programs. These evaluations should be used to identify what programs work best with offenders. Utilization of treatment approaches within the criminal/juvenile justice substance abuse continuum that examine "best practice" with populations in the Nebraska criminal and juvenile justice systems.

Note: Recommendations specific to Task 10 on the assessment and evaluation follow the subcommittee report and start on page 33.

Substance Abuse Treatment Subcommittee
Final Report

Task 10 of Legislative Bill 865 required the Task Force on Substance Abuse Treatment to develop and recommend standardized substance abuse evaluation instruments for adults and juveniles processed in the criminal and juvenile justice systems. A subcommittee comprised of criminal and juvenile justice personnel and treatment providers was formed to accomplish this task. This subcommittee approached the task in three phases. First, subcommittee members defined three stages of assessment that should occur within the criminal justice, juvenile justice, and treatment systems. Next, members identified how the systems currently identify substance abuse among adult and juvenile offenders. By building on system strengths and addressing the system shortcomings, subcommittee members incorporated the three stages of assessment into model systems for justice and treatment evaluation. Finally, the subcommittee examined several standardized instruments to use for each of these stages. This report summarizes the results of the subcommittee's work and identifies recommendations for implementing these models.

The work of this subcommittee represents what can be produced when justice personnel and treatment providers collaborate to build bridges between the two systems. Such collaboration is critical to addressing substance abuse among adult and juvenile offenders and enhancing public safety for all Nebraska citizens.

I. Stages of Assessment

Three stages of assessment were identified and defined by the subcommittee. These stages represent the "best practices" for identifying substance abuse issues early in the criminal and juvenile justice processes and providing appropriate treatment as part of justice intervention. Both early identification of substance abuse issues and appropriate treatment ultimately enhance public safety by potentially eliminating offender drug use and future criminal behavior. Based on "best practices," all offenders processed by the adult and juvenile justice systems should be <u>screened</u> for substance abuse issues as early as possible, <u>assessed</u> for the stable and dynamic risk factors that may effect appropriate level of care, and <u>evaluated</u> for the proper level of care when necessary. These assessment stages play a critical role in accurately and effectively identifying need and the proper level of care to reduce future substance use and criminal behavior.

A. Screening: Screening involves a standardized short interview (10-15 minutes) with the offender to identify (1) immediate safety issues and (2) the need for further substance abuse evaluation.

<u>Important Points Related to Screening:</u>

- The same screening instrument will be used statewide.
- Criminal/juvenile justice personnel will administer the screening instrument.
- The screening will be completed as early in processing as possible.
- Screening information will stay with the offender throughout processing.
- Screening information will be shared with providers if an evaluation is completed.

B. Risk Assessment: This assessment is a standardized process to measure static and dynamic risk factors that assist in determining (1) the offender's probability to recidivate and (2) the proper level of justice intervention and treatment.

Important Points Related to Risk Assessment:

- Risk assessments may need to be agency specific; however, some information will be standardized across criminal and juvenile justice agencies.
- Criminal/juvenile justice personnel will administer the risk assessment as soon as possible in processing.
- Hopefully, the risk assessments will be completed before the evaluation is completed and shared with providers prior to the evaluation.
- Risk assessments completed after the evaluation will also be shared with the provider who completed the evaluation to ensure that the original recommendations are consistent with the risk assessment.
- Information from the risk assessment will stay with the offender throughout processing.

C. Evaluation: The evaluation is a standardized process completed to identify evidence of substance abuse needs and issues to determine the appropriate level of intervention required.

Important Points Related to Evaluation:

- All offenders who were screened as needing further evaluation will be evaluated.
- A Certified Alcohol and Drug Abuse Counselor or a Division of Mental Health, Substance Abuse and Addictions Services approved evaluator will complete evaluations on adult and juvenile offenders.
- A Division approved counselor must have a "justice" certification.[1]
- Criminal and juvenile justice personnel and agencies will only accept evaluations from Division certified or approved evaluators who adopt and follow the standardized evaluation model.

[1] This requirement is consistent with and dependent upon current certification changes under consideration by the Division of Mental Health, Substance Abuse and Addiction Services.

II. Model Systems

The subcommittee identified model systems for screening, assessing, and evaluating offenders in the criminal and juvenile justice systems. Although the models differ slightly across the criminal and juvenile justice systems, the model evaluation process applies to evaluations completed for both adults and juveniles. Additionally, the subcommittee identified when offenders will be screened, assessed, and evaluated (if necessary). Specifically, the following models were developed and presented in this report:

Table 1: Description of the CRIMINAL JUSTICE Model

ARREST	PRE-TRIAL HEARING	PRE-SENTENCE HEARING	SENTENCING
1. Screening and risk needs assessment completed on all offenders held in jail.	1. Offenders who plead not guilty may voluntarily submit to the screening and risk needs assessment. 2. Offenders who change their plea to guilty must submit to the screening and risk needs assessment. 3. Offenders who take a diversionary option must submit to the screening and risk needs assessment to be eligible for the diversion program.	1. All offenders who are ordered to receive a pre-sentence investigation must submit to the screening and risk needs assessment. 2. Court orders an evaluation for (1) alcohol and drug offenders and (2) offenders whose initial screening indicated a potential drug or alcohol problem. 3. Offenders placed in post-adjudicatory alternative programming must submit to screening, risk needs assessment and an evaluation (if necessary) to be eligible for the program.	1. Court orders offenders screened with a need who have not taken voluntary option to submit to CD evaluation. When applicable, appropriate treatment becomes mandatory part of sentence. 2. Applies to all offenders regardless of outcome (e.g., fines, county jail, probation, intensive supervision) 3. All offenders entering DOC reassessed. Those assessed as high risk receive a CD evaluation. The results of the CD evaluation are used to identify appropriate treatment.
NOTE: Any offender may voluntarily submit to the screening, risk needs assessment and evaluation (if necessary) at any point before they reach trial and/or sentencing. They may also voluntarily enter a treatment program based on recommendations made in the evaluation.			

Table 2: Description of the JUVENILE JUSTICE Model

ARREST	PRE-ADJUDICATION	PRE-DISPOSITION HEARING	DISPOSITION
1. Screening and risk needs assessment completed on all offenders pre-detained.	1. Offenders who plead not guilty may voluntarily submit to the screening and risk needs assessment. 2. Offenders who change their plea to guilty must submit to the screening and risk needs assessment. 3. Offenders who take a diversionary option must submit to the screening and risk needs assessment to be eligible for the diversion program.	1. All offenders who are ordered to receive a pre-disposition investigation must submit to the screening and risk needs assessment. 2. Court orders an evaluation for (1) alcohol and drug offenders and (2) offenders whose initial screening indicated the presence of a potential drug or alcohol problem. 3. Offenders placed in post-adjudicatory alternative programming must submit to screening, risk needs assessment and an evaluation (if necessary) to be eligible for the program.	1. Court orders offenders screened with a need who have not taken voluntary option to submit to CD evaluation. When applicable, appropriate treatment becomes mandatory part of disposition. 2. Applies to all offenders regardless of outcome (e.g., fines, probation, intensive supervision) 3. All offenders entering OJS are reassessed. Those assessed as high risk receive a CD evaluation. The results of the CD evaluation are used to identify appropriate referral for treatment and required as part of parole.
NOTE: Any offender may voluntarily submit to the screening, risk needs assessment and evaluation (if necessary) at any point before they reach trial and/or sentencing. They may also voluntarily enter a treatment program based on recommendations made in the evaluation.			

Table 3: When and by Whom Adult Offenders are Screened, Assessed, and Evaluated

	ARREST	PRE-TRIAL	PRE-SENTENCE	SENTENCING
SUBSTANCE ABUSE SCREENING AND RISK ASSESSMENT	Mandatory for all jail detainees.	Mandatory for all offenders pleading "guilty" or entering a diversion program.	Mandatory for offenders receiving a pre-sentence investigation or entering a post-adjudication alternative program.	Mandatory re-assessment of all offenders committed to county jails, Probation, or the Department of Corrections.
Who administers screening & assessment	*Jail Staff (screening only)*	*Diversion Program Staff or Probation*	*Probation*	*Probation or Department of Corrections Intake Staff*
EVALUATION *(Always completed by an approved provider.)*	Voluntary	Voluntary	Mandatory for offenders convicted of an alcohol or drug-related offense and any other offenders whose previous screening indicated a need for further evaluation.	Mandatory for offenders whose initial screening indicated the presence of a potential drug or alcohol problem, and all D.O.C. offenders screened and classified as "high-risk." Treatment may become a mandatory component of an offender's sentence depending on evaluation outcome.

Table 4: When and by Whom are Juvenile Offenders Screened, Assessed, and Evaluated

	ARREST	PRE-ADJUDICATION	PRE-DISPOSITION	DISPOSITION
SUBSTANCE ABUSE SCREENING AND RISK ASSESSMENT	Mandatory for all pre-detained juveniles.	Mandatory for all offenders admitting to the charges, entering Health and Human Services, or entering a diversion program.	Mandatory for offenders receiving a pre-disposition investigation or entering a post-adjudication alternative program.	Mandatory re-assessment of all offenders committed to the Office of Juvenile Services.
Who administers screening & assessment	*Intake Officer or Detention Staff*	*Diversion Program Staff, Probation, or HHS for status offenders*	*Probation*	*Probation or Office of Juvenile Services Intake Staff*
EVALUATION (Always completed by an approved provider.)	Voluntary	Voluntary	Mandatory for offenders convicted of an alcohol or drug-related offense and any other offenders whose previous screening indicated a need for further evaluation.	Mandatory for all offenders whose initial screening indicated a need for further evaluation, and all OJS. offenders screened and classified as "high-risk." Treatment may become a mandatory component of an offender's disposition and parole depending on evaluation outcome.

Table 5: Description of the Evaluation Model for Adults and Juveniles

Evaluation Description	Factors Considered in Structured Interview	Recommendation for Level of Care
Offender (or parent) selects a provider from a list of approved providers and makes an appointment for a face-to-face evaluation, which includes: A. Presenting problem B. Explain problem and implications of the evaluation to the offender C. Client history collected from interview with client (overlaps to some extent with the Addiction Severity of Index) D. Information collected from family and friends E. Information collected from the criminal/juvenile justice system a. Criminal history b. Drug testing results c. Screening and Risk Needs Assessment results d. Other relevant information F. Administer standardized assessment tools G. Derive clinical impression a. Summary of evaluation information b. Acceptance v. resistance, including awareness of the problem c. Relapse/continued use potential d. Rationale for recommendation (i.e., diagnostic summary)	Factors used to assess the need for treatment and appropriate level of care: A. Demographics B. Drug use C. Behavior patterns D. Health status E. Mental health screen F. Social competency G. Development issues H. Family description I. School history J. Work history K. Peer relationships L. Leisure/recreation M. Prior treatment history N. Individualized needs O. Motivation to change	Recommendation should be consistent with risk need and should include: A. Ideal level of care B. Barriers to placement C. Realistic level of care D. Client and family response to recommendation E. Recommendation for further assessment F. Confidentiality release

Table 6: Detailed List of Factors Juvenile & Adult Substance Abuse Evaluations

A. Demographics
- a. Age, race/ethnicity, gender
- b. Socio-economic status
- c. Living situation
- d. Military history (adults only)

B. Drug use
- a. Frequency and amount
- b. Drug and alcohol of choice
- c. History of use
- d. Use patterns
- e. Consequences of use (physiological, legal, interpersonal, vocational, etc.)
- f. Periods of abstinence
- g. Tolerance level
- h. Withdrawal history and potential
- i. Influence of living situation on use

C. Behavior patterns
- a. Legal issues
- b. Violence
- c. Impulsivity
- d. High risk behaviors

D. Health status
- a. Eating disorders
- b. Infectious diseases
- c. Head trauma
- d. Organ disease (liver, heart, other)
- e. Pregnancy
- f. Medication status and history
- g. Other medical problems

E. Mental health screen
- a. Screen to determine need for mental health evaluation
- b. Danger to self or others

F. Social competency
- a. Relationship to authority
- b. Assertiveness/submissiveness
- c. Social support network

G. Development issues

H. **H. Family description**
- a. History of use/treatment
- b. Family communication
- c. Family conflict
- d. Family constellation/relationships

I. School history
- a. Attendance
- b. Performance/goal setting
- c. Learning disabilities
- d. Cognitive functioning

J. Work history
- a. Employment history
- b. Financial responsibility
- c. Work ethic/goal setting

K. Peer relationships
- a. Substance using peers
- b. Isolation

L. Leisure/recreation
- a. Use of free time/hobbies
- b. Group v. individual activities

M. Prior treatment history
- a. Prior assessments/evaluation findings
- b. Mental health diagnosis
- c. Counseling
- d. Prior mental health or substance abuse treatment

N. Individualized needs
- a. Spirituality
- b. Culture
- c. Other addictive behaviors (e.g., gambling)
- d. Sexual abuse/trauma
- e. Gang membership
- f. Anti-social values/beliefs
- g. Nutritional
- h. Strengths
- i. Preferences
- j. Wants and needs

O. Motivation to change
- a. Level of denial or defensiveness
- b. Personal agenda

III. Selection of Instruments for the Criminal Justice Model

In order to select strong instruments to use for screening, assessment, and evaluation, the subcommittee met with two consultants in this area and was able to achieve consensus on promising instruments. This consensus, however, is contingent on continued development and discussion in this area. Specifically, the subcommittee identified at least two issues that must be resolved before the recommended instruments should be adopted statewide. First, the strength and appropriateness of these instruments must be validated for adult and juvenile offenders in Nebraska specifically. Secondly, the subcommittee recognized the need to modify these instruments slightly (e.g., adding a few questions) to ensure that all relevant information is captured.

Standardizing screening, assessment, and evaluation across the state has many advantages, which include (but are not limited to):

- Placing Nebraska on the cutting edge of justice intervention. Several states have formally recognized the connection between substance abuse and public safety and have moved forward in bridging justice and treatment systems by legislating standardized screening and evaluation as well as new funding streams for substance abuse treatment within the adult and juvenile justice systems. Some of these states include: Colorado, Florida, Minnesota, Oklahoma, and Virginia.

- Addressing substance abuse among adult and juvenile offenders consistently across the state.

- Accurately identifying offenders' level of need for intervention thereby ensuring effective outcomes.

- Collecting statewide data to (1) assess the level of need across offenders in Nebraska and (2) measure the effectiveness of substance abuse treatment on the recidivism of criminal behavior.

- Accessing federal and private dollars to fund substance abuse treatment for offenders in Nebraska.

- Making treatment as easy to get as it is to get drugs.

A. Screening

The purpose of the screening tool is to determine the presence of a current substance abuse problem and identify the need for further evaluation. The following criteria were used to select a screening instrument: minimal length of time to administer, minimal level of training needed to administer, evidence of reliability and validity, ease of scoring, and cost.

Recommendation: Simple Screening Instrument for adults (Appendix F) and Indiana Version of Simple Screening Instrument for juveniles (Appendix G)

Instrument Description:

- 15-16 items
- 10-15 minutes to administer
- Little training required
- Anyone in the system can administer
- Research supports ability to accurately predict individuals with substance abuse problems
- Public domain—no cost to use

Proposed Modifications:

- Add item related to current offense
- Add item related to suicide
- Add the following items regarding gambling:

Have you ever felt the need to bet more and more money?

Have you ever had to lie to people important to you about how much you gambled?

Source: Johnson, E.E., Harner, R., Nora, R.M., Tan, B., Einstein, N., & Engelhart, C. (1997). The Lie/Bet Questionnaire for screening pathological gamblers. Psychological Reports, 80, 83-88.

B. Risk Needs Assessment

Currently, the Office of Probation, Department of Corrections, and the Office of Juvenile Services use some type of risk assessment instrument. These instruments and the information collected by them, however, is neither standardized nor shared across agencies. Furthermore, the risk assessments are not completed on all offenders. Consequently, a recommendation for more development in this area was made in place of a recommendation for an instrument.

Recommendation: Rather than select a new instrument for all criminal and juvenile justice agencies to use, the subcommittee recommends that these instruments be reviewed to determine what information is being collected by each agency and the psychometric properties (i.e., reliability and validity) of these instruments. Once this information is gathered, the subcommittee further recommends that these agencies work together to:

- Standardize the collection of information related to static and dynamic risk factors.
- Develop policies to ensure that all offenders are being assessed.

- Ensure that risk assessment information is used in determining a appropriate level of care and treatment.
- Formalize an efficient method to share this information across agencies.

C. Evaluation

Standardizing the process to ensure consistent and accurate results and to strengthen the interaction between justice personnel and treatment providers was the priority of this subcommittee. Standardizing evaluation instruments for adult and juvenile offenders should be viewed as one of the critical steps in standardizing the entire evaluation process. Ultimately, evaluation instruments are useful tools in determining whether an offender has a substance abuse problem and if so, what level of care is appropriate.

Recommendation: Substance abuse evaluators must use the Addiction Severity Index for adult offenders (ASI—see Appendix H) and the Child Addiction Severity Index for juvenile offenders (CASI—see Appendix I). A second instrument must also be selected from a list of instruments that meet the following criteria:[2]

- Primary functions of the instruments include the comprehensive assessment of problems associated with adolescent substance abuse, and to provide information relevant to level of treatment care and clinical issues that may need to be addressed during treatment.

- Detailed coverage of several content domains, including but not limited to, substance use pattern, consequences of substance abuse, signs and symptoms of depth of abuse and dependence, and psychosocial risk/protective factors that may underlie the substance involvement.

- User-friendly administration, scoring and interpretation materials. This may include a written manual and computerized administration and scoring materials.

- Appropriate for use with juvenile offenders in settings comparable to the intended use of the instrument.

- Favorable psychometrics as provided by a detailed manual or other accompanying material that contains a detailed presentation of the instrument's reliability and validity evidence, and of the tool's standardization sample(s) (for norm-based instruments).

[2] The Coordinating Body will develop an approved list of instruments. Providers who wish to add to this list will be able to petition for an instrument by providing evidence that the instrument meets the listed criteria.

Instrument Description (applies to both the ASI and CASI):

- Takes 45-60 minutes to administer in current form (NOTE: The entire evaluation process will take approximately two hours)
- Must be administered by Division approved evaluator
- Requires training
- Available in paper and automated versions
- Paper version is public domain—no cost to use
- Automated version is copyrighted and is attached to a fee for use
- Sound scientific evidence of reliability and validity
- Measures a variety of domains, some of which may not be necessary to administer

Proposed Modifications to ASI and CASI:

- Add additional drug use history questions
- Add items to measure truthfulness
- Cut unnecessary sections from instruments without affecting psychometric properties

Issues for Further Development

- A law that requires the assessment process for all alcohol and drug offenders.

- Ensuring that status offenders are subject to the standardized assessment process.

- Ensuring that minor in possession offenders are subject to the standardized assessment process.

- Addressing any remaining groups of offenders that may currently "fall through the cracks" of the standardized assessment process.

Recommendations

Recommendations Related to Standardized Instruments and Process:

- Maintain a Coordinating Body to monitor the implementation of these recommendations and to continue the process of information exchange and collaboration between treatment providers and justice personnel.

- Continue the efforts of this subcommittee, at least temporarily, to make appropriate modifications to recommended instruments and to identify a system to formally share information across providers and justice personnel.

Recommendations Related to Training:

Within one year, the Coordinating Body in cooperation with the Division of Mental Health, Substance Abuse, and Addiction Services will require and provide training to:

- All current and newly hired criminal and juvenile justice personnel on the nature of addiction adults and juveniles, the operation of the Nebraska substance abuse delivery system, and the processes and tools utilized in standardized evaluation.

- All current and newly hired substance abuse treatment providers on the operation of the criminal and juvenile justice systems, interpreting and incorporating risk assessment information into treatment planning, and the processes and tools utilized in standardized evaluation.

- All non-CADAC approved counselors on the nature of addiction as it relates to the criminal and juvenile justice systems.

- Develop and require a certification emphasis in "substance abuse and justice" for all Division approved evaluators.

Current resources for training:

- The Nebraska Statewide Substance Abuse Conference would be an appropriate forum for the delivery of such information.

- Partner training across systems to maximize use of resources. For instance, current training held for justice personnel can be opened to providers and vice versa.

- Access current such as the Center for Substance Abuse Treatment, the Center for Substance Abuse Prevention, and the Addiction Technology Transfer Center.

Recommendations Related to the Implementation of the Model:

Within one year, the Coordinating Body, justice agencies, and the Division of Mental Health, Substance Abuse, and Addiction Services will collaborate to:

- Require and provide training to all departmental supervisors within the criminal and juvenile justice systems and the Division approved providers.

- Pilot test the implementation of substance abuse screening across the state.

- Pilot test the standardized evaluation process across the state.

- Develop protocol for processing and evaluating non-English speaking clients (i.e.,

- Examine the use of instruments currently being used to assess risk among

- Develop standardized levels of care for criminal and juvenile justice offenders.

  Publish and disseminate (through training, bar associations, etc.) results from the pilot tests of the model process and make recommendations for statewide

Within <u>two years</u>
Health, Substance Abuse, and Addiction Services will collaborate to:

-
  pilot test.

-
  administer the Simple Screening Instrument.

-

- Incorporate model into statewide management information system design.

  Create a web page and/or start a joint newsletter to facilitate the dissemination of information between the two systems.

  Identify how justice agencies can become the payor for substance abuse treatment services. This will provide an incentive for providers to adopt the standardized

Recommendations Related to Additional Funding:

- Fund a study on how current substance abuse treatment dollars are being expended and make recommendations on the reallocation of dollars, the new dollars needed and possible funding sources.

- Devise reimbursement scheme for evaluations and related costs (i.e., interpreters).

- Increase funds to provide cross-training opportunities.

- Recognize Certified Alcohol and Drug Abuse Counselors as approved for payment by third party insurance and managed care.

REFERENCES

of Justice Assistance. (1997). Impact Statements and Research and Evaluation , Washington D.C.: U.S. Department of Justice.

Epstein,
national household survey. Analyses of Substance Abuse and Treatment Need Issues.
gton D.C.: Department of Health and Human Services and Mental Health Services Administration, Office of Applied Studies.

Issues on the Nebraska Criminal Justice System.
Crime Commission on Law Enforcement and Criminal Justice.

Gernstein, Evaluating Recovery Services: California Drug and Treatment Assessment (CALDATA).
Alcohol and Drug Programs Resource Center.

Governor's Toward the of Alcohol Abuse: Strategies for Change in Nebraska.
Advisory Council on the Prevention of Alcohol Abuse.

Harwood, H. et al. Economic Costs of Alcohol and Drug Abuse in the U.S. 1992
Rockville, MD: U.S. Department of Health and Human Services.

Johnson, Nebraska Division of Alcoholism and Drug Abuse: . Lincoln, NE: Division for State Assistance Center for Substance

Keelan, M., & Walz, C. (1998). in Nebraska 1997.
Commission on Law Enforcement and Criminal Justice.

Legislative An Overview of Substance Abuse Funding in with an Assessment of the Capacity of Offender Treatment Programs.
Nebraska Legislative Council.

Mark, National Expenditures for Mental Health and Alcohol and Other . Rockville, MD: U.S. Department of Health and Human

National Institute on Drug Abuse. (1998). of Drug Addiction Treatment.

National Study Finds Federal Drug Treatment Programs Have Dramatic Impact on Drug Use, {on-line}. (1997). **http://www.samhsa.gov/97/970917t.htm**

Nebraska Department of Health and Human Services. (1997). Nebraska State Demand and Needs Assessment. Lincoln, NE: Department of Health and Human Services.

O'Leary-Morgan, K., & Morgan, S. (Eds.). (1999). Crime State Rankings 1999. Lawrence, KS: Morgan Quitno Press.

University of Nebraska-Lincoln Bureau of Sociological Research (with Alcohol and Drug Addiction Services). (1999*)*. Nebraska State Demand and Needs Assessment Studies: Alcohol and Drugs, Adult Household Survey Results. Lincoln, NE: Department of Health and Human Services.

Appendix A: Needs Assessment Report

Appendix B: Substance Abuse Dollars in Nebraska

Appendix C: Total Number of Certified Alcohol and Drug Abuse Counselors by State

Appendix D: *Principles of Drug Addiction Treatment*

Appendix E: “Blending Perspectives and Building Common Ground”

Appendix F: Simple Screening Instrument (Adults)

Appendix G: Simple Screening Instrument (Juveniles)

Appendix H: Addiction Severity Index (Adults)

Appendix I: Comprehensive Addiction Severity Index for Children (CASI)