

**Initial Report to the
MA Treatment Study Committee
of the
Nebraska Community Corrections Council:**

**MOVING PAST THE ERA OF GOOD INTENTIONS:
METHAMPHETAMINE TREATMENT STUDY**

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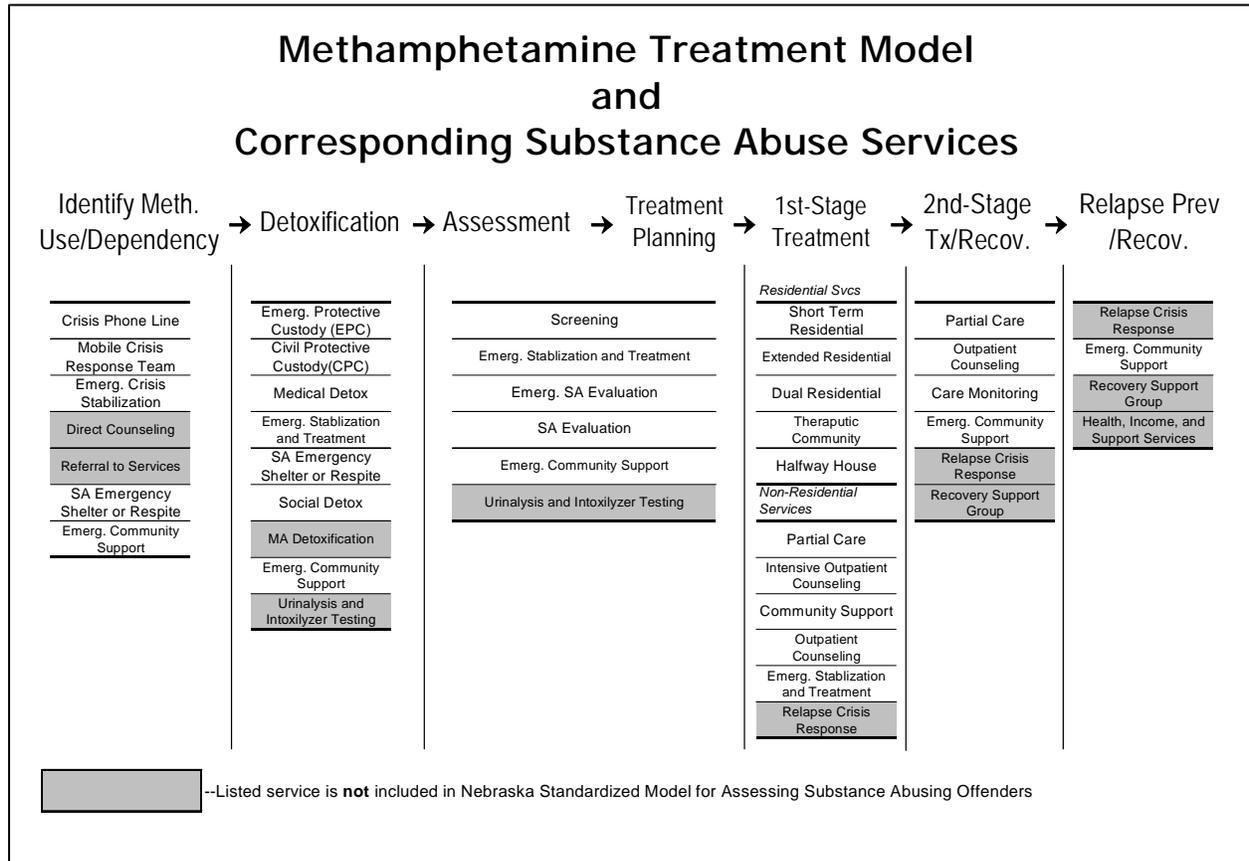
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Recommendations

With a treatment model, cost and prevalence data, site-visit data, and feedback from treatment, social service, and justice providers, a foundation has been laid for final recommendations. The Figure below, illustrates the general MA treatment response model and those substance abuse services which correspond to the different phases of treatment.



A model and service array does not make a treatment and recovery strategy, however. Both the model and services listed above are already implemented to some degree through-out Nebraska. The problem is that gaps, delays, and explicit barriers exist in Nebraska’s present substance abuse system which hinder motivated addicts’ pursuit of recovery and allow un-motivated addicts to slip between the cracks. To reduce methamphetamine abuse, an infrastructure must be laid which enforces a state-wide response to the problem and channels addicts into a fast-flowing stream of recovery to which it is easier to succumb than escape.

This infrastructure includes three core components beyond the model and service array: people, buildings, and data. The main recommendations for changing or expanding the infrastructure for Nebraska’s methamphetamine response system include:

- ***Legislative action and incentives to develop more methamphetamine treatment professionals throughout the state;***
- ***Incentives for treatment providers to expand and develop localized methamphetamine abuse treatment programs***

- *Funding and legislative action to establish and staff day/night reporting centers across Nebraska*
- *Promoting an increased utilization of the WEC as a methamphetamine treatment facility for those offenders whose crimes and risk do not warrant incarceration by DCS*
- *A centralized substance abuse treatment facility for medium and low risk offenders committed to the custody of the Department of Correctional Services*
- *Expanding the use of ASI/CASI evaluations and the standardized reporting format throughout all of justice and HHS*
- *A centralized database where substance abuse evaluation results and treatment summaries are kept and accessed by social service, justice, and treatment providers*
- *Ongoing research to drive targeted capacity expansion for treatment and recovery services*
- *Ongoing research to monitor the effectiveness of treatment programs*
- *Creating an office which can coordinate the implementation of any recommendations which may be adopted and report to the Governor, Legislature, and Supreme Court on the progress being made*

The next section discusses in detail each of these recommendations and other recommendations which will contribute to Nebraska's reform effort. To illustrate how these recommendations actively promote a best practices model for methamphetamine treatment, they are organized according to the methamphetamine treatment protocols contained in *Treatment for Stimulant Use Disorders: Treatment Improvement Protocol, Series #33* (Rawson, 1999).

Maximizing Treatment Engagement

Methamphetamine users must be able to easily initiate the treatment process. Rawson says telephone inquiries about treatment must be handled quickly and positively. Treatment locations must be within easy reach of users and accommodate a variety of schedules. The administrative burden of accessing treatment must be minimal and support services such as on-site child-care, targeted financial assistance, and food or shelter vouchers need to be in place.

To maximize treatment engagement for methamphetamine users within Nebraska, the following recommendations need to be implemented.

- 1) *Improve methamphetamine addicts' ability to link up with assessment and treatment services when they are willing to do so*
 - a) *Widely publicize a hotline service by which addicts and families can identify assessment and treatment resources (similar to the gambling addiction hotlines)*
 - b) *Educate all justice and social service providers about where to refer addicts and families for assessment and treatment services (tip cards, in-services, dispatcher trainings)*

While detoxification and treatment services exist throughout the state, there is no prominent hotline or referral resource which has been widely marketed to the general public. Compare, however, the numerous television and radio advertisements which identify similar referral services for gambling and other social issues such as pregnancy assistance. If a methamphetamine addict is actually motivated enough to reach out for help, they must know where to call to find out about recovery options. Even when local services are unavailable for

special populations, such as non-English speaking minorities, multi-lingual public service announcements could provide a starting point for addicts and their families.

One of the greatest frustrations for program directors is the inability to match their services with clients who would benefit most. Police officers, dispatchers, social workers, community support specialists, medical doctors, and, in the case of methamphetamine use, dentists can constitute a formidable network of referral sources. Ideally, they should have training on how to provide direct counseling to methamphetamine addicts and families in crisis when the factual circumstances of a situation do not permit official action to be taken. Giving these front-line professionals the means by which they can provide concrete information about available services, though, is a major step towards activating a powerful, but untapped resource in the fight against methamphetamine abuse.

- 2) *The state must address the scarcity of methamphetamine treatment providers.*
 - a) *Immediately develop and implement methamphetamine-specific training for Nebraska mental health and chemical dependency counselors which includes use of the MATRIX Model of methamphetamine treatment*
 - i) *Condition state-reimbursement for methamphetamine treatment services on the completion of the state-provided training*
 - b) *Re-examine certification and licensure qualifications of LADACs and provisional LADACs to ensure that education and clinical requirements are in accord with the minimal competencies required and are not an artificial disincentive to students and professionals who would otherwise make effective substance abuse treatment counselors*
 - c) *Create a degree track within Nebraska schools by which a pool of chemical treatment professionals can be developed; completion of degree, clinical work, and passing of an exam should suffice for licensing and certification requirements*
 - i) *Actively recruit students for these programs from the minority populations in Nebraska and establish support mechanisms beneath them as encouragement for them to adopt substance abuse counseling as a viable career*
 - d) *Improve financial incentives for people to pursue a career in substance abuse treatment and agencies to provide substance abuse treatment*
 - i) *Increase reimbursement rates for substance abuse treatment to reflect the education level and financial/time expenses of becoming a substance abuse treatment specialist*
 - ii) *Conduct a salary study to improve the state's ability to attract out-of-state providers, maintain our current base of Nebraska providers, and identify critical positions for which premium salaries are required in order to meet the State's needs*
 - iii) *Establish tuition reimbursement and student loan re-payment programs for LADACs who remain in Nebraska*

One of the more surprising findings from the research is that the Nebraska cannot buy its way past the biggest hurdle to establishing effective methamphetamine treatment, at least not very quickly. The State presently faces such a severe shortage of substance abuse clinicians and treatment professionals, support that every level of service for every type of substance abuse within the continuum of care has a waiting list. Justice and treatment professionals from across Nebraska report that regardless of an individual's personal financial resources, even the initial assessment on which so many critical legal and treatment decisions depend is often delayed for weeks. Similarly, once an assessment has been obtained, addicts face more delays waiting for

admission to the most appropriate level of treatment, if it exists at all. This delay threatens to destroy addicts' motivation. Worse, it increases the likelihood that users and offenders who wish to avoid treatment will escape it: a particularly important concern since most methamphetamine users come to treatment reluctantly. (Rawson, 1999)

The impact of this shortage on individual methamphetamine users is fairly obvious. The impact on the justice and social service process is more subtle, but equally profound. The primary mission for justice and social services is to hold substance abusing offenders accountable for their crimes and/or the family crises of child-abuse or neglect related to their methamphetamine use. When criminal rehabilitation and the restoration of parental responsibility turn on eliminating a person's substance abuse problem, these waiting lists and gaps in the continuum of assessment, treatment and recovery become part of the transactional calculus offenders and parents use to avoid the compelled surrender of addiction. Addicts play justice professionals, social service workers, and treatment providers against each other, exploiting these gaps and shortages as excuses for their lack of recovery progress.

At first blush, it seems the State could solve this dilemma by simply increasing reimbursement rates to entice substance abuse professionals to migrate from other states. As other Nebraska studies have shown, however, this strategy provides only a partial remedy. Unless all substance abuse rates are increased across the board, Nebraska treatment professionals will simply shift around to fill the more lucrative positions and those jobs which rely on state-reimbursed case-loads will remain less financially attractive to out-of-state chemical dependency counselors.

Increasing reimbursement levels would motivate more people to complete the rigorous education and training requirements to become treatment professionals and possibly improve Nebraska's ability to recruit and retain them from other states. The forgiveness of student loans and tuition reimbursement programs for students serving as interns while working on their degree would also make the pursuit of such a career more appealing.

If clinicians are in short supply generally, the scarcity of culturally and linguistically competent providers is even worse. The measures discussed above must be combined with active recruitment, mentoring networks, and the promise of quick jobs upon the completion of prerequisite training to motivate Spanish, Sudanese and members of Nebraska's other minority populations to fill the gaps in treatment services for non-English speaking addicts and offenders.

While it may take years for these types of efforts to pay off, the State must act quickly to fill the current void of methamphetamine expertise in Nebraska. At best practices meetings, participants repeatedly spoke of poor outcomes when treatment specialists tried to apply alcohol and marijuana-related treatment strategies to methamphetamine addicts. The confrontational dynamics of most alcohol recovery programs have proven to be ineffective responses to methamphetamine addicts struggling to maintain sobriety. Although it will shift some treatment capacity away from alcohol and other illicit drug programs until new providers enter the market, the State has little choice but to motivate some existing providers to acquire a specialized expertise in methamphetamine treatment.

In a similar vein, the Nebraska must seize this opportunity to establish standardized treatment requirements and documentation regarding methamphetamine. The State is moving towards the widespread adoption of a standardized assessment process with the ASI/CASI and it is not unreasonable to condition reimbursements and contracts on the use of a standardized, evidence-based treatment program for methamphetamine. The MATRIX treatment model has been the most scrutinized and successful methamphetamine addiction program of the past ten

Methamphetamine Treatment Study

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years. It is a manualized, 16 week program designed for outpatient settings, but can easily be adapted and applied within the therapeutic community program of a correctional or treatment facility. Until a more successful treatment model for methamphetamine emerges, Nebraska should aggressively push providers to utilize the MATRIX as the prevailing treatment strategy.

- 3) *The State must address the scarcity of treatment and supervision locations across Nebraska.*
 - a) *Improve financial incentives for local health agencies to provide substance abuse treatment and recovery-support services*
 - b) *Fund multiple treatment and recovery hubs across Nebraska's regional population centers*
 - i) *Create mobile reporting centers from which supervision and treatment services can be remotely delivered*

The primary obstacle to wide-spread implementation of community-based treatment services is that too few providers are scattered across the State to make this goal feasible. As the recommendations under section 1, above, gradually increase the pool of treatment professionals, hospitals, clinics, and treatment facilities must have an economic basis for recruiting these new professionals. Reimbursement rates need to be differentially structured to account for the situational difficulties of recruiting treatment staff to Greater Nebraska. Policy makers have to realize that many providers require additional work to be located for spouses before they can move to the less populated areas around the State. Financial incentives in the recruitment of treatment providers alleviate the strain on these families and compensate for the diminished income their husbands and wives face. Facility administrators have repeatedly stated these dynamics render the present profit potential from state-reimbursed contracts insufficient to operate chemical dependency programs on the scale needed to meet the State's needs.

One way Nebraska can solve several problems with one stroke is to establish at least one twenty-four hour reporting center in every Probation District or Mental Health Region across the State. Staffed by probation officers, parole officers, LADACS, psychologists/mental health providers, and social workers/community support specialists, these centers would become a hub for all the substance abuse services, supervision, and drug and alcohol testing which will sustain methamphetamine recovery over time. The supervisory powers of probation and parole officers can compensate for less than ideal levels of direct treatment. The centers' physical space will become a venue through which intensive outpatient, individualized counseling, group counseling, and relapse crisis response can be administered and ease the transportation and logistical challenges methamphetamine users face during recovery. The availability of multiple counseling group options and recovery support services will allow offenders to continue their pursuit of sobriety even after they have been discharged from drug courts, probation, or parole.

Day/night reporting centers also provide policy makers with one more way to lure treatment professionals into practice. Free or subsidized office space with telephone, photocopying, and computer networking and internet services comes at a relatively modest cost to the State, but can be a lucrative benefit to contract and private treatment providers delivering services to the offender and HHS populations. To the extent that cities and counties desire the placement of reporting centers in their locations, local government should be able to partner with the State in bearing some of the costs associated with the buildings in which the reporting centers are housed. Alternatively, private/commercial agencies may be willing to provide probation and

parole officers space and support in order to secure convenient access to offender populations for their staff counselors and psychologists who are delivering treatment services.

Obviously day/night reportings such that Jfrom strongly support the creation of . Staffed with a probation officer and a treatment specialist, these vehicles could travel between communities with significant numbers of methamphetamine users and serve many of work and residences are removed from and the loss of driving privileges make it illegal for them to drive themselves a regional center.

- 4) *Increase utilization of the WEC as a methamphetamine treatment facility for those offenders whose crimes and risk do not warrant incarceration by DCS*
 - a) *Judges need to better appreciate Probation's ability to provide offenders with intensive treatment services at the WEC*
 - b) *WEC should be allowed salary and/or reimbursement premiums to improve its ability to recruit treatment providers*
 - i) *WEC should be granted license to pilot video-conference treatment strategies*

Last year Probation supervised 1250 cases in which the offender had been convicted of methamphetamine possession or some other methamphetamine-related charge. If the full capacity of the WEC had been dedicated strictly to methamphetamine offenders, approximately 300 Probation clients could have rotated through the program. One of the main obstacles to keeping the WEC even half-full of methamphetamine users, though, is that judges do not fully appreciate WEC's ability to provide offenders with intensive, quality substance abuse treatment. It is unclear how these perceptions can be altered, but attempts must be made to do so.

During the research team's site visit, the WEC was revealed to be a bright, comfortable facility, well-equipped with the technological capacity to implement a number of innovative pilot projects. Perhaps the best example of this flexibility is the video-conference system. To compensate for treatment staff shortages, a pilot around group or individual counseling using a remote therapist should be designed and implemented. To improve the re-integration of WEC residents in their home community, a pilot project in which community-based probation officers remotely confer with the residents on re-entry case planning should be attempted and evaluated. To ensure that supportive family members remain connected with WEC residents during their stay, an experiment which allows video-conferenced visitations may prove an effective alternative to expensive, time-consuming trips. These examples and others illustrate that the WEC possesses untapped potential for providing Probation and the justice system with a wider array of options for rehabilitating methamphetamine-dependent offenders whose recovery progress requires a brief removal from their home community until abstinence can be established.

Efforts of this nature instituted and evaluated over the next twelve to fourteen months will reveal whether expanding WEC's capacity for a larger residential population is justified. Using WEC as a lab where innovative treatment strategies exploit modern communication technology holds the potential for developing discovering even more ways by which the State can attack its overall shortage of treatment professionals.

Assessments and Orientations

Rawson says assessments should be focused, orient the addict to realistic expectations about treatment, provide them with different treatment options to consider, and involve family

and friends who support the treatment and recovery process. For methamphetamine users, the person conducting the assessment should be warm, straightforward and non-judgmental. Confrontational tactics can not only diminish a methamphetamine user's motivation for treatment but may also provoke violence.

An evidence-based, standardized assessment process is important to developing effective treatment plans for individual methamphetamine users. It is critical, however, to developing accurate data about Nebraska's treatment services needs on which policy makers can rely while mapping out future capacity expansion strategies and appropriations. To reap the full benefit of assessing methamphetamine users, the State needs to adopt and implement the following recommendations.

1) Methamphetamine detoxification must be managed as part of the assessment process

Methamphetamine addicts undergo two stages of detoxification after they have stopped using. In the first stage, the intense symptoms of methamphetamine intoxication typically resolve by the user going through a long period of sleep. Complications are rare and the only medical responses reported in the literature relate to monitoring the user for hyperthermia and treating it with ice-baths if it becomes severe. This stage of detoxification does not pose any particular problem for assessment.

However, the assessment of methamphetamine users in the second stage of detoxification can be compromised by lingering effects the drug has on an addict's cognitive and psychological capacity. During the site-visit to the Norfolk Regional Center, it was learned that many of the methamphetamine users committed to NRC exhibit signs of psychosis and neurological deficits which suddenly clear 45 to 60 days following the cessation of methamphetamine use. The treatment research literature also reports that methamphetamine addicts experience physiological changes that can produce sudden episodes of psychosis, violence without any prior warning signs, and lead to relapse as many as 45 to 120 days into treatment. This phenomenon, commonly known as "The Wall" is a critical consideration when developing strategies for treatment and relapse prevention for methamphetamine addicts (Obert 2004).

These characteristics of methamphetamine detoxification must be managed in order for a reliable drug abuse assessment to be completed. Unlike most other drugs, assessment results for a methamphetamine user can be dramatically distorted during the 45 to 60 days after their last use. Failure to account for these possibilities can lead to treatment decisions which become inappropriate for the methamphetamine user's new state of mind. The manifestation of severe symptoms in a treatment setting can put staff, family, and other recovering addicts at risk of harm.

For these reasons, it is recommended that the assessment process for methamphetamine users include explicit plans for addressing these potential changes in the addict. At a minimum, methamphetamine addicts should have access to the resources required to obtain two or three assessments as needed during the initial four months after drug use has stopped. Methamphetamine users should also have access to services during this time period which can best be described as "Methamphetamine Detox". These services would help the addict manage the temporary cognitive and neurological deficits, anticipate and avoid violent behavior, and guard against relapse.

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- 2) *All justice agencies should immediately work to implement the Standardized Model for Assessing Substance Abusing Offenders*
- 3) *All social service and treatment providers should move towards adopting the ASI/CASI for their initial substance abuse assessment tool*

Thanks to the leadership of the Supreme Court, Probation Administration, and the Department of Corrections, most state-level justice officials are actively striving to implement the Standardized Model for Assessing Substance Abusing Offenders. While it is expected that local justice agencies will eventually follow suit, county attorneys and drug courts need to be particularly mindful of adopting these assessment protocols. General diversion and drug courts must work to incorporate ASI/CASI results as part of the criteria by which candidates are selected.

Similarly, it is unclear to what extent, if any at all, HHSS plans to utilize the ASI in assessing the substance abuse treatment needs of parents whose methamphetamine use has interfered with their ability to properly care for children. Adopting the Standardized Model as a key part of reunification planning and/or family counseling would convey the same benefits to juvenile court proceedings for abuse and neglect that are expected in criminal matters. If HHSS is reluctant to utilize this assessment model in all chemical dependency cases, it would greatly contribute to the State's overall methamphetamine reform effort if the ASI could at least be used with parents who are methamphetamine users. The data produced by these assessments would provide a common platform from which the relative treatment service needs of HHSS and justice agencies could be evaluated.

- 4) *Collect assessment results to a centralized data-base within State government*
 - a) *Ensure that all justice, social service and treatment providers can access and review assessment results as needed for treatment and supervision case-planning*
 - b) *Ensure that assessment results obtained on juveniles are included in the data system*
 - c) *Utilize assessment results and tx histories to identify which treatment providers and treatment models promote the best recovery outcomes*
 - i) *Ensure that researchers have access to the data for evaluation purposes*

Many of the planning questions the Legislature raised in crafting this study have proven impossible to answer more definitively than the estimates reported earlier in the report. For example, despite the Legislature's obvious interest in expanding treatment services which are underdeveloped in the State's present substance abuse response system to ensure that methamphetamine users have all the levels of treatment and recovery services which are needed to ensure success, answering these questions depends on access to standardized assessment results which have been collected throughout justice and HHSS. This data does not exist. This data will not exist even if the ASI/CASI are used for every methamphetamine addict assessed over the next five years—if those results are not collected in a centralized database.

A small group within the JSAT subcommittee of the Community Corrections Council has been working to develop a modest application in which ASI/CASI results can be amassed and accessed by justice and treatment providers. Since this effort has largely relied on the time and resources which its members can string together on an ad hoc basis, progress has been slow. Uncertainties about funding resources have also constrained design expectations and an implementation schedule. The possible purchase and implementation of similar systems from

other states has been explored, but issues related to cost and development schedules have essentially foreclosed this strategy.

That said, a good deal of discussion and planning for the database has already been completed and the group is well-acquainted with most of the design and deployment issues. Mike Overton of the Crime Commission and Dave Wegner of State Probation have provided critical leadership in the process. If funding were made available for the creation of such a database, much of this planning could be harnessed towards a final design and implementation.

For Nebraska to move towards an evidence-based system for substance abuse treatment, however, collecting assessment results is only the first step. A comprehensive data-system would also include treatment summaries which would enable the effectiveness of different services to be evaluated. Accordingly, if the recommendation for a centralized database is adopted, sufficient resources must be provided to grow the application beyond the concept on which the JSAT group has concentrated its energy.

Planning Treatment

Rawson recommends treatment for 12 to 24 weeks followed by some type of support group participation. The MATRIX model of methamphetamine treatment lasts 16 weeks.

- 1) *All points of the justice system must commit to substance abuse treatment as an effective deterrent to methamphetamine users' future offending.*
 - a) *Criminal sanctions must be structured to balance punitive considerations against the rehabilitative potential of substance abuse treatment.*
 - b) *Except when public safety and/or moral outrage demand otherwise, justice planning should be driven by an offender's substance abuse treatment needs.*

When treated offenders and neglectful parents quickly re-enter society and the lives of their families, far from being treated soft-heartedly, they are being held accountable for their acts in the most appropriate way society can design: they are being forced to daily resume responsibility for repairing the damage left in the wake of their substance abuse and offending. With sufficient recovery support and relapse prevention services in place, methamphetamine addicts can reassume their role as a contributing member of society and the web of social involvement which keeps them from succumbing to their old habits strengthens.

The first step in treatment planning depends, therefore, on those justice providers who possess the greatest discretion—prosecutors and judges—to prioritize recovery over sanctions or punishments which are unlikely to resolve the central factor contributing to recidivism, methamphetamine use. At most, prosecutors and judges can ensure that the legal constraints placed on an offender contribute to the addict's recovery; at the least, they have the power to see that legal controls do not detract from it.

- 2) *Treatment should be community based and non-residential except for addicts with significant, persistent mental health issues*

People who suffer from serious mental health problems *and* methamphetamine addiction present treatment management issues which may not be amenable to outpatient treatment models. As explained above, symptoms from methamphetamine use can mask or distort the perceived mental health of even those people who actually have no psychological or cognitive

impairments. Upon the discovery of a methamphetamine user's history for recurring mental health problems, the detoxification process demands a strict abstinence from additional use so that treatment providers can observe and document the user's true state of mental disease. In these instances, residential detoxification during the early stages of recovery may be the only way for clinicians to separate the two.

- 3) *Treatment should be community based and non-residential except for offenders at a high risk of continued criminal behavior or whose crimes require incarceration*
 - i) *A centralized treatment facility with 225 to 250 beds should be developed for the Department of Correctional Services*
 - ii) *Assuming the State closes the Norfolk Regional Center, the DCS facility should be located in Norfolk, Nebraska*
 - iii) *If the State accepts this recommendation, a Program Statement prepared by an architecture or engineering firm should be commissioned to more accurately estimate the construction, staffing, and operational expenses of the proposed facility*

One of more pressing questions for which the Legislature has sought an answer is whether Nebraska needs to develop a centralized facility for methamphetamine treatment and, if so, where, for how many, and for how much. As the literature review of the Initial Report indicates, the most effective treatment models for the majority of methamphetamine addicts actually focuses on outpatient treatment as the primary intervention strategy. This is good news given Nebraska's desire to develop alternatives to incarceration founded on community based correction and treatment options and fits perfectly with the State's efforts to grow community based mental health services.

A group of offenders will always exist, however, whose resistance to treatment and recovery will outpace even the most complete system of intervention services available at stages prior to incarceration within the Department of Corrections Services. Last year alone, more than five hundred men and women were admitted to the custody of DCS with evidence of a methamphetamine problem. Though the sentences for these offenders vary, all will be reviewed as possible parolees and all will eventually return to society. The question is whether they will have obtained the level of substance abuse treatment and recovery services that are required to keep them from falling back into old patterns of use and offending.

DCS requires a centralized, secure facility in which those offenders who have proven unamenable to the justice and social service system's alternative interventions can finally be forced to initiate aggressive, non-negotiable treatment for their methamphetamine abuse problems. The research shows that while methamphetamine users' are overwhelmingly ambivalent about seeking treatment, they also tend to do just as well in coerced treatment as those who pursue it voluntarily. (Brecht M., 2005)

The potential for a DCS treatment facility to be effective would be greatly enhanced if two more slight changes were made in the justice process points around sentencing an individual to prison. First, to the extent that other security and risk factors permit, all offenders committed to the custody of DCS should go immediately from the DEC to the centralized treatment facility. This practice would enable DCS to detoxify prisoners, identify the degree to which serious, persistent mental health problems emerge upon the remission of drug-related symptoms, deliver the complex array of treatment strategies and structure required for this resistant population, and

Methamphetamine Treatment Study

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better orient these inmates for the transfer to regular prison life, transitional incarceration such as OCC, or even parole.

Granted, some inmates may fail and be removed from this treatment facility, but DCS is no worse off for it—they were going to have to place and manage these prisoners eventually. When the strategy succeeds, however, the benefits to DCS and society are tremendous. DCS now has an inmate whose withdrawal and substance abuse-related problems have already been given the maximum response the State of Nebraska can provide. Not only will this minimize potential management problems of the inmate within prison facilities, it positions the offender to better avail him or herself of the vocational, educational, and other therapeutic services DCS provides. This practice shifts DCS focus from simply having to house and manage inmates, and makes them an active, positive force in preparing an inmate to return to society. The strides taken as part of the prisoner's DCS custody establish a solid foundation on which Parole can build re-entry case-plans which optimize the offender's likelihood of success. Similarly, with the treatment gains achieved under DCS custody, HHSS can begin the crucial process to reconnect offender-parents with their children and change the chance of re-unification from a remote possibility to a reality.

The second change required to maximize the effective reach of a centralized treatment facility within DCS is to transplant a few key drug court concepts into Nebraska's criminal courts. Wyoming pursued this strategy and passed legislation which now requires every offender convicted of a felony to receive a comprehensive substance abuse evaluation regardless of their actual crime. Given Nebraska's severe shortage of substance abuse providers, this sort of legislation may not be immediately feasible, but Courts can change the way in which an offender approaches his or her sentence.

Nebraska law allows judges to set both a minimum and maximum period in their sentencing decisions. If DCS had a comprehensive treatment facility in which the court could be confident that offenders would receive aggressive interventions against their substance abuse problem, judges could structure sentence minimums as an incentive for offenders to abide by treatment recommendations and pursue their recovery. Offenders whose primary offenses relate to drug and alcohol use, could even transition directly from the treatment facility to less secure, re-entry oriented facilities like OCC.

Last year DCS admitted 418 men and 109 women who were confirmed methamphetamine users. DCS believes commitment practices to the York Correctional Facility can be adjusted to implement the above treatment protocols for women without a separate facility. The substance abuse treatment program that DCS presently operates runs for ten months. As resources and staff permit, DCS intends to create and implement individualized, evidence-based methamphetamine treatment strategies in which treatment duration is determined by the pace of an addict's recovery progress. Under these circumstances, a male inmate's average length of stay at a centralized treatment facility is expected to be approximately six months. Assuming that methamphetamine users enter DCS custody at a fairly even rate, the treatment facility will require capacity for 225-250 beds.

In discussions with DCS about a centralized treatment facility, it was determined that methamphetamine users who were classified as requiring a maximum security institution would receive their treatment from within one of the State's maximum security facilities. Methamphetamine users who met medium or low security classification criteria would be sent to the centralized treatment facility.

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The total capital cost per bed for the maximum security, 960 bed Tecumseh Correctional Facility was approximately \$77,000 per bed. (Carter Goble Associates, 1997) The minimum security, 100 bed Work Ethic Camp cost approximately \$65,000 per bed to complete. Since the centralized treatment facility would require only medium security, its costs are expected to be somewhere between the two; factoring in inflation places its per bed estimate at \$70,000, with an estimated final expense of \$15.8 million to \$17.5 million. If the Legislature and Governor adopt this recommendation, the State will need to commission an architecture/engineering firm to complete a detailed Program Statement projecting the specific construction, staffing and operational costs.

Assuming that the State remains committed to closing the Norfolk Regional Center, the centralized treatment facility for DCS should be built in Norfolk, Nebraska. In addition to the considerable amount of land which the State already owns at the NRC, upon NRC's closure, Norfolk will become the only city in Nebraska with at least a temporary surplus of alcohol and drug counselors, LMHP's, and psychologists. Every county, including Madison county, faces an overall scarcity of treatment providers, but none of the other counties have a significant population of treatment specialists who are about to become unemployed. Though other counties, such as Adams, Douglas, and Lancaster, have a larger ratio of treatment providers than Madison County, there are no events pending which will require a large number of them to find alternative employment in the foreseeable future. Though the planned closure of the NRC is only six months away, information gathered during the site visit indicated that the overall staff remained intact.

DCS could build a centralized treatment center anywhere in the state, however, the staffing needs for such a facility would have a devastating effect on most Nebraska cities' community-based service capacity. There are already waiting lists for treatment resources throughout the State. A facility the size of the one recommended for DCS would draw heavily from the local pool of community based treatment providers and simply exacerbate treatment shortages for the surrounding, non-incarcerated substance abuse population. Opening a DCS treatment facility in Norfolk should have little more effect than simply leaving the NRC open.

Among the factors that figure in Norfolk's favor is that DCS may be able to utilize the current NRC facility as an interim treatment center pending the planning and construction of a new building. Though security, fire-code compliance and a complete re-hiring process would have to be managed, the effort would help to keep a core of treatment providers and facility support together and enable DCS to quickly implement its new front-end treatment strategy at least on a more modest scale.

Other factors which point to Norfolk being the most appropriate place in which to locate a DCS treatment facility include:

- A 50+ year success rate in recruiting and maintaining the professional clinical staff required for such a facility
- Extremely strong, vocal, community support for sustaining a treatment facility like NRC and the DCS project
- An established relationship with State educational institutions as a teaching hospital—the maintenance of which will be a crucial element in Nebraska's effort to grow its state-wide pool of treatment providers
- The population of methamphetamine users who are to receive treatment at the facility are not particularly inconvenienced by its Norfolk location because they are there for a

relatively short time and they will ordinarily transition from the center into other DCS institutions before returning to their home community

- b) Every case plan should encompass both the initial stages of substance abuse treatment and a long-term strategy for recovery and maintaining abstinence*

While this recommendation would improve treatment planning from a clinical perspective, it is really aimed at promoting the State's need to understand where gaps in the service array exist. Case-plans which encapsulate only the immediate and short-term treatment needs of the methamphetamine user lack the documentation Nebraska policy makers require to evaluate whether sufficient services are in place to maintain the progress of recovery over time. It is easy to say that support and relapse prevention services are an integral part of an addict's recovery, but debates over funding priorities turn on hard data, not theoretical concepts. The collection of full course treatment plans provides a source from which responsible analyses can be conducted to isolate the extent these late term services demand and deserve funding.

- 4) Treatment case plans and progress reports must be collected at centralized database within State government*
 - a) Ensure that all justice, social service and treatment providers can access and review treatment plan and progress notes as needed*
 - b) Ensure that treatment plans and progress notes for juveniles are included in the data system*
 - c) Utilize assessment results and tx histories to identify which treatment providers and treatment models promote the best recovery outcomes*
 - i) Ensure that researchers have access to the data for evaluation purposes*

the assessment and treatment histories of methamphetamine offenders are t

Initiating Treatment and Managing Withdrawal

There is no single point in the justice or social services process where policy makers can fix funding decisions or capacity expansion. Instead, every agency and justice provider possesses some lever which can be used to press methamphetamine addicts to seek help or maintain the recovery process.

- 1) Initiate assessment/treatment at all stages of the justice/social service process*
 - a) Capitalize on addict's contact with any stage of the justice/social service process*
 - b) Make voucher funds available at all stages of the justice/social service process*
 - c) Fund substance abuse capacity expansion within those stages of the justice/social service system with the potential to impact addiction*

Whether it is the police, HHSS case-workers investigating abuse/neglect allegations, judges making sentencing decisions, parole officers supervising offenders' re-entry programs, or any of the other justice and social service providers executing their official duties, each of these contacts with an addict is one more opportunity to steer offenders to treatment. When these

efforts are successful, additional barriers have been erected to keep the methamphetamine user from pushing on to more expensive, intensive systems of punishment.

To promote the conversion of all justice and social service system points into portals for engaging treatment, voucher funds must be available. Flexible funding for assessments and treatment services are the best way to transform these possibilities into genuine opportunities.

Policy makers may debate what priority, if any should be given to the distribution of voucher funds. For example, since the children of HHSS clients are facing the devastating loss of their parents, should these parents receive greater priority for voucher resources than Probation clients who face prison if they violate the terms of their supervision or re-offend? If carefully designed and implemented, the voucher program could eliminate the need for the Legislature to somehow anticipate which agency will require what levels of funding on an annual basis, by simply distributing funds on a first come, first served basis until the support is exhausted.

This type of funding strategy also holds offenders more accountable for their progress in recovery. Consider the example of a newly convicted methamphetamine user. As part of the PSI process, Probation requests the person to complete a substance abuse evaluation. When the offender demonstrates they lack the \$75 to \$155 for the evaluation, a voucher can issue for the assessment. If the offender continues to follow-through with the treatment paid for by the voucher program, they should remain eligible to receive voucher funds in support of their recovery progress. If the user resists treatment, then voucher funds would not be issued and the user is left to the legal consequences that may result. Similarly, parents involved with HHSS for whom methamphetamine treatment is required, would be motivated to incrementally pursue recovery one step at a time in order to capitalize on the chain of funding support as they seek reunification and the restoration of their family.

2) *Fund urinalysis at all stages of the justice/social service process and collect the results in a centralized database*

One way for the social service and justice systems to monitor the sincerity of a methamphetamine user's efforts to take advantage of these treatment opportunities is the regular use of urinalysis tests. Funding or a State-sponsored testing program need to be created so that the financial impact to state and local agencies for testing is not a disincentive for it to be used as often as necessary. If these agencies are to bear increasing responsibility for intercepting and diverting methamphetamine users from higher levels of justice involvement, they must have all the tools they need to achieve success.

Maintaining Treatment Progress and Abstinence

- 1) *Establish information exchange required to advance addict's progress through the continuum of recovery.*
 - a. *The centralized data base must provide assessment, treatment plans, urinalysis test result and progress notes to treatment, justice and social/service providers at every stage.*
- 2) *Establish the financial resources required to advance an addict's progress through the continuum of recovery.*

- a. *When addicts continue to satisfy treatment expectations, financial resources must be available to obtain any services reasonably related to long term recovery.*
- 3) *Leverage justice and social service resources in support of substance abuse treatment.*
 - a. *Use justice related supervision to monitor, promote and enforce abstinence, treatment participation and community reintegration.*
 - b. *Use prosecution, incarceration and release decisions as incentives for offenders to complete treatment and remain abstinent.*

The familiar ring of these statements demonstrates that the recommendations advanced above constitute elements in a true system of methamphetamine treatment response. Just as these recommendations secured the solid initiation and engagement of treatment earlier, they now extend the addict's journey towards eventual recovery.

Relapse Prevention

- 1) *The historical neglect of long-term recovery support and relapse crisis services must be rectified*
 - a. *Make voucher funds available for health, employment, and general support services*
 - b. *Provide methamphetamine addicts with access to recovery support groups and other substance abuse treatment services even after they have been discharged from the oversight and control of justice and social service systems.*

The State's commitment to the end of the recovery process must match its commitment to the initiation of treatment. Once the sobriety of an addict has been stabilized through initial interventions, their continued abstinence will always depend on the accessibility of recovery support and relapse prevention services. Recovery is like a long trip up a steep hill: if the support pushing a methamphetamine user falters, they risk not only stalling, but a rapid plunge back into the valley of addiction from which they had emerged. This fails the methamphetamine user, but it betrays social service, justice, and treatment providers by squandering the time, energy, and resources they already expended.

As with the earlier stages of treatment, the State's best appropriation strategy for promoting life-long abstinence is a pool of flexible voucher funds which can be accessed as the recovered methamphetamine user requires. The availability of these funds will catalyze the expansion of such services. Provided addicts have demonstrated an ability to capitalize on these investments by the state, eligibility should be maintained even though no formal link between Nebraska's social service and justice agencies remains.

Integrating the Implementation of These Recommendations

While this final recommendation does come from *TIP #33* (Rawson, 1999), it provides pivotal support to the State's efforts to implement the recommendations discussed above.

- 1) *Create an office which can coordinate the implementation of any recommendations which may be adopted and report to the Governor, Legislature, and Supreme Court on the progress being made*

The recommendations of the Initial Report fall across many points of the social service and justice systems and require the coordinated efforts of state and local agencies to keep time from being lost and money from being wasted. A Coordinator with sufficient support staff to organize meetings, promote inter-agency agreements, monitor overall progress, and serve as a liaison to the Governor, Legislature and Supreme Court will be necessary. The overall process cannot be adequately managed by the agencies charged with actually designing and deploying the variety of reforms envisioned. For these reasons, it is recommended that some point of oversight be established within State government.

Summary

As Nebraska attempts to address the MA crisis which it is currently facing, both practitioners and clients will require tools to ensure progress. Some of these tools will be MA-specific; others will be more system specific. The state must develop solutions which address the long term challenge of recovery. The practice of recycling MA addicted offenders through the justice system until they are incarcerated must stop.