

Criminal Justice Perspective:
Challenges We Face When The Mentally Ill &/or Substance
[Ab]user Intersects With the Criminal Justice System.

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NC Federal/State Criminal Law Specialist
&
Walter Lee Christian Cox, IV
Investigator and Legal Assistant

VIDEO PRESENTATIONS

Summary: Whatever systems are in place and funded to support provision of effective assessment and treatment of those with mental health and substance abuse issues who come through the criminal justice system to divert from jail/prisons is not getting to the end user nor effective in thwarting recidivism.

<u>Witness</u>	<u>Occupation</u>	<u>Length</u>
Abraham P. Jones, Esq. 434 Fayetteville Street, STE. 2300 Raleigh, NC 27601 919-817-2714 legalaffairs@abejoneslaw.com	Former Superior Court Judge - 17 years Attorney	33 min.

Talking Points: *From Attorney and 17 year Superior Court Judge's Perspective*

- * Divert Mentally Ill/Addicts to Specialty Court funded to ensure effective treatment
resulting in expungement at Court's discretion (not prosecuting authority)
- * Use available resources more efficiently
- * Over 40% of crime is related to drug use
- * There is inappropriate over reliance on probation officers to ensure treatment success
- * We need centralized resource in NC for evaluation and processing to ensure services on

demand and to place defendants appropriately, safely and dependably

Donya M. Strong, Esq. **Durham County Assistant District Attorney** **6 min.**
510 South Dillard Street, 8th **Prosecuting Attorney**
Durham, NC 27701
919-808-3310
Donya.M.Strong@nccourts.org

Talking Points: *From a Prosecutor's Perspective*

- * To affect recidivism, we need to bridge the gap between what is ordered by the Court
("Follow recommended treatment"), and what is achieved
- * Pretrial and after sentencing, there is no reliable oversight for medicine management
and therapy, transport and housing essential to compliance when individual is not
in jail or in-patient leading to re-offend.
- * What we are missing is a "Community Support Service" person dedicated to treatment
(not to reporting violation as is the function of probation)

Charles Caldwell, Esq.

Wake County Public Defender

35 min.

300 South Salisbury Street, STE 500 **Defense Attorney**

Raleigh, NC 27601

919-792-5469

Charles.F.Caldwell@nccourts.org

Talking Points: *From a Defense Attorney's Perspective*

- * Wake County has a task force looking at this for over a year
- * Our clients are indigent, and community treatment options are limited by access to transportation and housing, as well as oversight of medication consumption
- * After the judgment, there is ineffective follow-up

Advice:

- * Provide education to district attorneys about what mental illness is and how it affects behaviors
- * Provide the same education to Probation Officers and Law Enforcement, and ensure they have all available resources at their disposal
- * There needs to be local "CIT"s (Crisis Intervention Teams) available to the defendant at the point of arrest at the jail for the purpose of diverting to appropriate processing and treatment out of the justice system at the first intersection
- * Drug court works. It needs to be statewide.
- * Mental Health courts are expensive; Wake is trying to set up diversion alternatives.

The Milwaukee Trustee program serves as one model.

The Honorable Vince Rozier

300 South Salisbury Street, STE 1000
Raleigh, NC 27601
vrozierjr@aol.com

District Court Judge
Wake County

24 min.

Talking Points: From a District Court Judge's Perspective

* Discussion of how Mental Health & Substance Use issues come before District Court,

and resolve: Pre-trial & Post-conviction

* Considerations to allowing release from custody: lack of options available

* Cycle of ineffective treatment:

Order treatment => Probation => Violation => Back in court

* Resources:

Have - Drug Court

Central Regional

Wakebrook

Need - At sentencing assessment tools & options

Non-probation supervised treatment options to count for active time

* Over reliance on probation to implement treatment plans ordered by the Court

Advice: How do we create results based alternative to incarceration sufficient to satisfy

the needs of protection of the public and of impaired defendants?

* We need an alternative to jail/prison treatment center

* Now, limited resources are available as options. *"I am uninformed on the bench."*

* This [failure of effective treatment options] results inevitably in recidivism, and

potential danger to the public.

Ms. Vann Eure

Angus Barn
9401 Glenwood Avenue
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Jill@angusbarn.com

Restaurateur

Owner, *The Angus Barn*
“Walk For Hope” Charity

10 min.

Talking Points: *From a Citizen family and Charity organizer Perspective*

#1

* “Foundation of Hope” - founded because her brother was bi-polar in 1980s/

Research funds were needed for treatment of mental illness

* \$3 billion in research funds have been raised by them

Support locally Wake Pediatric Behavioral Clinic

#2

* “Walk for Hope” 11 October 2015 - 4 to 5,000 people participate

As result, people in crisis call on the Eures, but no place after Dix closed

* Resources:

Holly Hill, Butner, UNC => Limited beds, transportation issues, homeless population

* Dorothea Dix closing was a great loss to the community.

Mr. David Mountcastle
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Recovering

Alcoholic/Addict/ADHD/Depressive
33 months in NCDOC
Mandatory, trafficking weight cocaine
(SA denied)

25 min.

Talking Points: *From Perspective of a recovering addict forced to suspend 2 year pre-sentencing treatment program to serve a mandatory active prison sentence, released 30 days prior to this interview (filed 10-10-2015)...he could be your neighbor, uncle, brother or son.*

- * At arrest was in a 14 month spiral depression, alcoholism and cocaine addiction, having been in recovery for over a decade
- * After full debriefing of cocaine distribution in Five Points neighborhood, Raleigh, NC by law enforcement, chose to go immediately into in-patient treatment in Asheville, NC until sentencing, facilitated by release conditions
- * At sentencing was 2 years sober, with supportive family and good job with health insurance. Superior Court judge denied substantial assistance, and imposed mandatory 33 months active in prison, despite showing of mental health and addiction issues, employment, family and community support. Lost job.
- * NC has a \$1.8 billion dollar budget; DOP is \$1.1 billion of that.
- * Treatment in DOP is incompetent and money spent on housing mentally ill wasteful as there is severe decomposition, resulting in release in worse condition and circumstances, and ultimately recidivism
- * There must be a change in the law related to mandatory prison terms for addicts

Dr. Richard H. Weisler, MD Adjunct Associate Professor of Psychiatry & 25 min.

700 Spring Forest Road, #125 Behavioral Sciences, Duke University School

Raleigh, NC 27609 Of Medicine

(919) 616-4704 Adjunct Professor of Psychiatry, UNC School of

rweisler@aol.com Medicine, Chapel Hill, NC

Private Practice, Richard H. Weisler, MD, PA &

Associates,

Raleigh, NC. **Other references available

* All sources referenced available to handout.

Talking Points: *From Perspective of a treatment psychiatric care provider and consultant*

(Disclosure Note: Dr. Weisler provided invaluable insight and assistance to undersigned in a federal criminal prosecution (PFF) from this past summer of a combat PTSD victim, a Desert Shield/Storm Marine; federal judge declined to pay for his services when initial report to court was found clearly incompetent, used consult of the same BOP doctor, and imprisoned the offender, despite his condition unchallenged and documented to the Court, finding he was a career offender with a one day long incident in PTSD trauma. Clearly, education of the judiciary, both State and Federal, is crucial to success and implementation of any program, in this attorney's experience and opinion. I point this out with continued gratitude for the integrity and brilliant work of Dr. Weisler. Deb Newton)

* Shortage of Psychiatrists is severe.

* Figures related to available beds versus patients reveals there is 24.6 beds for every

100k patients. NC population is now almost 10 million. We have 2.3 - 2.4

million kids ... there are only 371 beds. 10.9% girls attempt suicide in high

school; in 2013 41k died by suicide, in NC 1200 died by suicide. ***Suicides result***

in an estimated \$51 billion in combined medical and work loss costs.

* Substance Use: Alcohol, cocaine, marijuana, tranquilizers.

Dr. Ashwin Patkar & Weisler collaborated on unintentional opiate deaths >1000

last year died from unintentional substance use. [Exhibit: Mental Health Courts

Show Promise]

* Veterans: We have 124 beds for Vets

DOD has invested in RTP million dollars for ganglion interceptor treatment.

Problem is getting vets to a place where they can accept talk therapy; this treatment shows promise. 31% Marines, 38% Army, 49% Reservists ==> VA wait times even if willing to seek treatment. Therefore Vets:

1. Self-medicate
2. Use drugs/alcohol

Resulting in family members who wind up with PTSD symptoms as consequence of Vet with PTSD who has problems or dies.

* Court Perspective: Mental Health sufferers in jail/courts

In jail: <u>% Problems</u>		<u>% Receiving Treatment</u>
35 -54% => Mania		1 - 3% State
15...% => Depression	vs	1 - 4% Federal
10 -24% => Psychosis		<u>1 - 6% Jail</u>

* Life expectancy of individuals with mental illnesses: Death 25 years too early

* People need proper diagnosis and treatment; problem is lone waits for evaluation

ER waits are \$1500.00 per day.

So they get discharged, get in trouble again, decline treatment and die by accidents, get arrested, etc.

* State Hospitals/Veterans Administration:

With Fort Bragg and Camp Lejeune we have 800k vets living here

We need to work in that area.

* Suicides:

Diagnosable psychiatric disorder complicated by substance abuse.

If a Vet came back with injuries, needs pain treatments, gets addicted/depressed

==> overdoses intentionally or accidentally

- * More people can benefit from pharmacological therapy, but also cognitive therapy
- * A strong Vocational Rehabilitation is needed. If a person does not graduate high school, they die earlier. We have a shortage of resources in community and for veterans. We need to intervene with high school dropouts. ** We must also work with the school system to solve this because of the high risk.

- * ADD, ADHD, etc. in youth, young adult to 30s:

School Nurses: They are telling us at conferences they are in charge of increasing numbers of children; these children need to be identified by a trained medical professional for ADD/ADHD, etc. IF additional services are provided and training vocationally they will be more functioning and more likely a productive person. *CROSS REFERENCE HERE: Dr. Poole, AAP urges medically trained professional perform assessments and oversee intervention for effectiveness, coupling medical and psychiatric services but removing lay person execution.

- * “It is short sighted not to treat effectively. We spend a great deal of money only partially treating in jail as compared to other costs to society. This is what it is all about as a State. We will all be better off to do that.”

In 1815 the United States population was 7-8 million.

Men - lived to around 38 years

Women - lived to around 37 years

They had 8 children, 6 lived

Now, 14% of the US population lives to over 65 years

We need to make sure people are productive.

=> We need good resources: Medical/Legal/Education to work together.

SUPPLEMENTAL VIDEO:

* \$51 billion cost of suicide

* Dix Hospital:

In 2004 study, 1439 beds for psychiatry available; population 300 million

=> 1 bed per 300k people.

In 1995, 1 bed for 300 people (10x more likely to find bed than in 2004)

Now? It has gotten worse. Therefore, people are more likely to be treated in jail.

These numbers are similar to the 1840s.

Dr. James Poole, MD

Growing Child Pediatrics
11130 Capital Boulevard
Wake Forest, NC 27587
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Pediatrician

FastBraiin, ADD/ADHD Expert

13 min.

Talking Points: *From Perspective of Treatment Provider of Adult ADD/ADHD, and medical professional intersecting with un-credentialed providers purporting to assess and serve patients with diagnosable ADD/ADHD without exit measures or performance assessments, resulting in zero sum intervention effectiveness and resources wasted by the State.*

* Fast-Braiin - ADD/ADHD

These kids are assets. *“God didn’t say whoops when he made us.”*

* Problems:

1. - Access to care
 - Inadequately trained teachers
 - Self esteem support not available

==> School suspensions out of control!
2. Babysitting in NC:
 - \$500million wasted spent on 2-18yo non-physician diagnosis of ADD/ADHD
 - & untrained “in-home care.”

Advice:

Teach medical providers to care for mental health issues
Intercede with kids and effectively treat ADD/ADHD

FOLLOW-UP VIDEO - ON ISSUE OF FUNDING ACCOUNTABILITY

* Issues with intensive home therapy for mental health:

There are no outcome measures for each patient over the last five years.

- * Physician measures: 82% of professionally medically treated 4000 Medicaid ADHD & other comorbidities as bipolar/depression achieve A/B honor roll. It is possible to measure success with effective treatment. That is not at present occurring.
- * Mental Health disease needs a medical plan by trained professional. This plan needs to be working and partnering with patient's medical doctor, at present not occurring.
- * We need to look at training of "qualified professional" going to home visit - not presently close to sufficient for disease care for \$100/hour rate the State presently pays.
- * We need to compare the mental health plan to the actual results.
- * We need to account for money into the program and costs of all administration and care, following the amount getting to the patient for education by trained educators/computers/tutors.
- * What separates physical health providers from mental health providers when primary health providers are the ones making in office diagnosis yet others reimbursed to care for their mental health.
- * We need to know why the number of mental health visits by untrained as compared to MD count against the MD being able to see patient.
- * Why are non-medical personnel making a diagnosis, resulting in one patient having

three agencies receiving money for the same care.

* We need to track amount of money to “home visit person” versus amount agency receives.

* Why are primary care MDs not CAHBA agency approved by State to do this.

* American Academy of Pediatrics wants Pediatricians assessing mental health . . .¹

¹Policy Statement—The Future of Pediatrics: Mental Health Competencies for Pediatric Primary Care

abstract

Pediatric primary care clinicians have unique opportunities and a growing sense of responsibility to prevent and address mental health and substance abuse problems in the medical home. In this report, the American Academy of Pediatrics proposes competencies requisite for providing mental health and substance abuse services in pediatric primary care settings and recommends steps toward achieving them. Achievement of the competencies proposed in this statement is a goal, not a current expectation. It will require innovations in residency training and continuing medical education, as well as a commitment by the individual clinician to pursue, over time, educational strategies suited to his or her learning style and skill level. System enhancements, such as collaborative relationships with mental health specialists and changes in the financing of mental health care, must precede enhancements in clinical practice. For this reason, the proposed competencies begin with knowledge and skills for systems-based practice. The proposed competencies overlap those of mental health specialists in some areas; for example, they include the knowledge and skills to care for children with attention-deficit/hyperactivity disorder, anxiety, depression, and substance abuse and to recognize psychiatric and social emergencies. In other areas, the competencies reflect the uniqueness of the primary care clinician’s role: building resilience in all children; promoting healthy lifestyles; preventing or mitigating mental health and substance abuse problems; identifying risk factors and emerging mental health problems in children and their families; and partnering with families, schools, agencies, and mental health specialists to plan assessment and care. Proposed interpersonal and communication skills reflect the primary care clinician’s critical role in overcoming barriers (perceived and/or experienced by children and families) to seeking help for mental health and substance abuse concerns.

Pediatrics 2009;124:410–421

* This against US Gov't mandate each patient must have a medical home to direct care.

NOTE: All speakers have executed waivers so that their remarks may be available for use by the Commission. Each have agreed to be invited to an in-person presentation available for questions if the Commission Members would like to have them.

**ADDENDUM TO VIDEO PRESENTATION:
RESOURCES AVAILABLE TO INSTRUCT OUR PROGRESS**

We need not reinvent the wheel. Other States have addressed this precise problem, under the same model, and have issued reports publicly. To follow are links to helpful reports concluding the same type of study we are asked to perform, with recommendations published, to guide our work.

I. Other State Mental Health & Substance Use Task Force Reports (Preceding Models)

New York: 2014 Task Force Recommendations: **

<http://www1.nyc.gov/assets/criminaljustice/downloads/pdf/annual-report-complete.pdf>

Virginia: 2015 Task Force Recommendations

<http://www.dbhds.virginia.gov/library/document-library/omh-mhtaskforce-final-report-oct2014.pdf>

Wisconsin: Milwaukee Task Force, 2004

<http://www.milwaukeeemhtf.org/>

II. Other Country Mental Health & Substance Use Task Forces/Reports:

UK - NHS England

<http://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2015/09/fyfv-mental-hlth-taskforce.pdf>

INTRODUCTION

The purposes of this policy statement are to articulate competencies—skills, knowledge, and attitudes—needed by primary care clinicians (PCCs) to address the mental health problems prevalent among children and adolescents in the United States and to promote use of the competencies in guiding residency education and continuing education of PCCs

III. **Others Addressing/Resourcing MH & SU Issues:**

The Carter Center (National)

http://www.cartercenter.org/health/mental_health/taskforce.html

American Health Lawyers Association

<https://www.healthlawyers.org/members/practicegroups/taskforces/BH/Pages/default.aspx>

American Academy of Pediatrics

<http://pediatrics.aappublications.org/content/124/1/410.full.pdf+html>

* See Dr. James Poole, *fn.1*.

CONCLUSORY OBSERVATIONS

I want to thank the fine Attorneys, Judges, Citizens, and Medical Professionals who agreed to provide their input through a video interview to the Commission on Mental Health and Substance Use through my seat on the issues we are assembled to address. I inquired of them: *What are the problems with assessing and properly treating effectively individuals who come to the attention of the criminal justice system with diagnosable mental illnesses and/or addiction issues, what resources are available, and what is your recommendation for solving those problems?* It is my belief that we cannot possibly find effective solutions until we hear from the stakeholders who must grapple with these human problems day to day on what they find problematic. I am very proud of each of these truly wonderful individuals for their professionalism and leadership, displayed by selflessly offering their insight and perspectives to help guide us. You should listen to them. They each meet the problem at the crucial intersection between intervention and prison.

As Criminal Attorneys, we are by disposition and training well suited to solving the complex legal problems presented by the mentally ill and addicted with compassion. However, in every courtroom, federal or state, on any given day in North Carolina you can drop in to see a well-prepared lawyer unsuccessfully begging a Judge to divert an individual from jail - whether pretrial or for sentencing upon conviction - and to offer hope by virtue of effective treatment alternatives to prison. *Our frustration is this:* Even if we have done our job and convinced an enlightened judge to grant our proposal, we are all left with ... Where? How? And always, when?

The wisdom you have heard from different video perspectives, Judges, Prosecutor,

Defense Attorney, Medical Doctors, Defendant, Compassionate Citizen, at the very least requires you accept that we need an accountable and accessible, brick-and-mortar, centrally located processing center for unrestricted intake, evaluation and diversion to proper treatment from a comprehensive master list of service providers wherever found in North Carolina to facilitate diversion with safe alternatives. We must provide a facility equally accessible around the State, with one number that everyone comes to know (1-800-HELPME!, for example), where a master list of all resources in the State is available, that can serve as an intake and assignment point, where community resources (voluntary and otherwise) can provide medical, legal, physical, support, and safe options to complement what Abe Jones described as a diversion upon arrest. We need a safe home facility in the State where the parent with a teenager with defiant disorder self medicating yet violent can deliver the teen, knowing he/she will be safe, and assured that it will not be a revolving door unless the kid is overdosing or suicidal, like we have now. We need accountability in treatment measures to ensure effectiveness, as Dr. Poole states. We need resources for Judges and prosecutors to rely on for public safety and to ensure compliance with ordered treatment, as Judge Rozier, ADA Strong and PD Caldwell advise. Certainly, we need to direct funding where it is most needed and effectively utilized, as Dr. Weisler and Mr. Mountcastle demonstrate. No longer should North Carolina citizens and families be forced to drive out of state to seek compassionate care, nor worry that a criminal conviction will forever thwart their future plans because of illness and addiction. Nor should any child suffering from ADD/ADHD drop out and grow up to become a killer in a gang for failure to intervene. We can do better. We have the resources to make this a reality, certainly by accounting for waste and reassigning funds for effective options, among others. We simply need the courage to say it will

change, and then do it. This is an issue for our entire community, across all demographics. It is a moral and a public safety issue at a crisis point.

On behalf of the criminally accused suffering from mental illnesses and addictions in North Carolina federal and state courts, and their families, I thank you for your work, your compassion, and your time.

Deb