leaa / nilecj

THE SOUTH PIEDMONT COMMUNITY-BASED
RECEPTION AND DIAGNOSTIC CENTER
SATELLITE MENTAL HEALTH CLINIC

of

HUNTERSVILLE, NORTH CAROLINA

exemplary project validation report

ursa san francisco

Huntersville (Nc) -

THE SOUTH PIEDMONT COMMUNITY-BASED RECEPTION AND DIAGNOSTIC CENTER SATELLITE MENTAL HEALTH CLINIC

of

HUNTERSVILLE, NORTH CAROLINA

EXEMPLARY PROJECT VALIDATION REPORT

Submitted to:

Mrs. Mary Ann Beck
Technology Transfer Division
National Institute of Law Enforcement and Criminal Justice
Law Enforcement Assistance Administration
U. S. Department of Justice
Washington, DC 20530

Submitted by:

Urban and Rural Systems Associates
Pier 1 1/2
San Francisco, California 94111

August 1974

CONTENTS

1.0 INTRODUCTION

1.1 Background

The Exemplary Projects Program of the National Instititue of Law Enforcement and Criminal Justice is designed to identify and document outstanding criminal justice programs across the country which are suitable for replication. The South Piedmont Community-Based Reception and Diagnostic Center - Satellite Mental Health Clinic of Huntersville, North Carolina has been nominated for designation as an Exemplary Project.

At the request of the NILECJ, Urban and Rural Systems Associates (URSA) conducted a validation study of the Huntersville unit. This report presents the findings of the visit and is intended to provide the Exemplary Projects Advisory Board with information bearing on the specific questions raised by the Board and with sufficient additional information to enable it to assess the extent to which the Huntersville Diagnostic Center and Mental Health Clinic meets the Exemplary Project Screening Criteria established by the Advisory Board. Findings are presented in Section 2.0 of this report. The specific questions posed by the Board are addressed within the context of the Screening Criteria to which they apply. The list of questions is shown in figure 1.1-A. Questions 1, 2, 3 & 4 are answered in Section 2.1 on Program Goal Achievement and Effectiveness. Questions 5 & 6 are not fully addressed in this report due to the lack of reliable, current data, both in Huntersville and in Raleigh, and the limited time and scope of this particular study. However, the issue of relative costs and the basic considerations necessary to make an effective comparison are discussed in general terms in Section 2.1 (Goal Achievement and Effectiveness) and in Section 2.2 (Measurability).

1.2 Sources of Information

The information on which this report is based was secured through a review and analysis of all available documentation on the South Piedmont Diagnostic Center and Mental Health Clinic, and through a series of interviews and observations conducted on site July 23-25, 1974. In addition, on-site interviews and observations were also conducted in Raleigh at the Central Prison Diagnostic Center and the Administrative Offices of the North Carolina Department of Corrections. The Raleigh site visits were conducted July 25 and 26, 1974.

Prior to the site visits, the URSA validation team contacted the Director of the South Piedmont Diagnostic Center and Mental Health Clinic by phone to establish the time schedule of the visit. The Director coordinated the entire effort and arranged for pertinent appointments and interviews both in Huntersville and Raleigh.

The URSA site visit team consisted of Dr. Barry Krisberg, URSA Research Director and a faculty member of the School of Criminology, University of California, Berkeley, and Mr. Pat Weinstein, URSA Senior Staff Associate.

The documents reviewed by the URSA team prior to the on-site visit included:

1. Huntersville Diagnostic Center--Satellite Mental Health Study--Evaluation of the Community-Based Diagnostic Center Satellite Mental Health Clinic (September 1973), David Wheaton.
2. Subgrant Application, Huntersville Reception--Diagnostic Center (July 1973).
3. Huntersville Community-Based Diagnostic Center--Mental Health Clinic - Final Report (December 1973).
4. Huntersville Quarterly Reports (December 1972, March 1973, June 1973, September 1973).
5. Huntersville Evaluation Status (Office of Technology Transfer, March 14, 1974).

Subsequent to the on-site visit URSA reviewed additional materials supplied by the staff of the Huntersville facility and the staff of the State Department of Corrections in Raleigh. These documents included:

1. Huntersville Quarterly Reports (April 1974 and July 1974).
2. Diagnostic Center Flow Chart Narrative.
3. Assorted Program Data and Forms.
4. Case Analysts Training Materials.
5. Prisoner Information Jacket.
6. Analysis of Admissions to Central Prison, 1973.
7. Presentence Diagnostic (PSD) Samples from Central Prison Diagnostic Center.
8. Overview and Evaluation of the Presentence Diagnostic Program (December 1972).
9. Subgrant Application (Replication of Huntersville Facility throughout North Carolina), draft July, 1974.
10. North Carolina State Correction Statistical Abstract, 1970, 1971, 1972, and 1973.
11. North Carolina Division of Corrections, Unit Evaluation Data, February 1974.

While on site in Huntersville and Raleigh the URSA field team met with the staff of the Huntersville facility and the Director of the Central Prison Diagnostic Center. In addition a series of meetings were held in Raleigh with North Carolina Division of Corrections officials who have both the administrative responsibility for replicating the Huntersville project and personal experience in operating various components of the intake, classification and mental health diagnostic process. At the present time these services are placed in the same facility only at Huntersville. At every other correctional unit in North Carolina, these services are much more fragmented, both in terms of physical location and organizational structure.

In Huntersville, URSA met with:

- Executive Director
- Consulting Psychiatrist
- Consulting Psychologists (2)
- Case Analysts (5)
- Director of Custody
- Director, Department of Corrections, South Piedmont Area
- Program Officers, South Piedmont Area (2)
- Vocational Rehabilitation Counselor

While at Huntersville, observations were made of the intake process and of the holding facilities at the Huntersville Corrections Unit approximately 2 miles away from the Diagnostic Center and Mental Health Clinic. No interviews were possible with inmates or supervisory personnel at the various units within the South Piedmont area and thus served by the Huntersville facility.

The URSA field team, while on-site in Huntersville, reviewed completed Presentence Diagnoses (PSD's) and samples of completed classification materials (those forms which, when completed, comprise the prisoner's "jacket"). All of these materials were written by the case analysts of the Huntersville staff.

While at Raleigh, interviews and discussions were held with:

- Director, Programs, State Divison of Corrections (initial Director of Huntersville facility)
- Director, Classification and Psychological Services, State Division of Corrections (Former Warden of Central Prison, Raleigh)
- Director of Presentence Diagnosis, Division of Corrections (Former Director of Mental Health Clinic, Central Prison, Raleigh)
- Director, Diagnostic Center, Central Prison, Raleigh
- Director, Diagnostic and Classification Branch, Division of Corrections

- Statistician, Divison of Corrections

The discussions were augmented by observation of the diagnostic and intake process at Central Prison and review of sample PSD's and intake materials prepared by the Diagnostic Center staff.

1.3 Project Summary

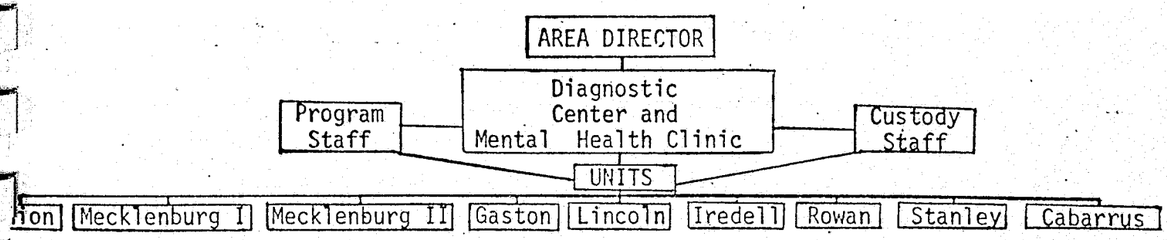
1.3.1 Structure and Concept

Organization

The South Piedmont Community-Based Reception and Diagnostic Center - Satellite Mental Health Center, is a component of the North Carolina State Division of Corrections. It provides diagnostic and mental health services to the inmates of the South Piedmont Area - a region which encompasses Iredell, Rowan, Cabarrus, Stanley, Union, Gaston, Lincoln, and Mecklenburg Counties. Within those counties are nine prison units of the North Carolina Corrections System - one for each county with the exception of Mecklenburg County (Charlotte) which has two units.

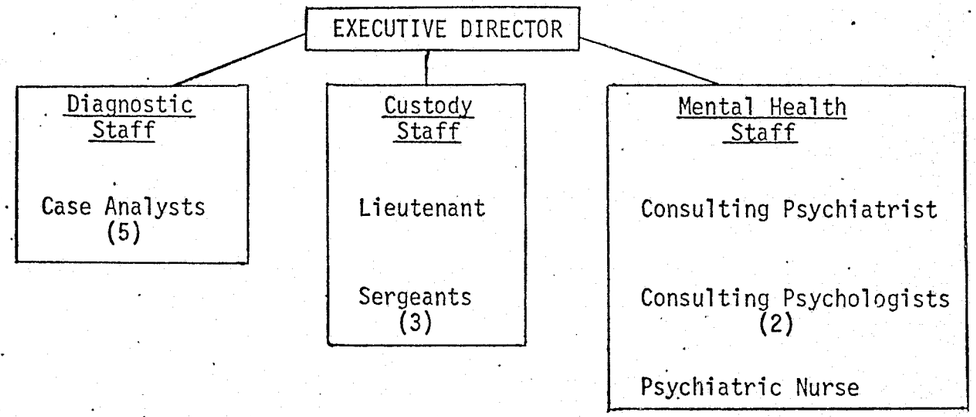
North Carolina has no county jails as a result of the state's takeover of the financially strapped county units during the Depression. Local jails serve as presentence holding facilities and provide detention services to only the most short-term misdemeanants (less than 30 days).

South Piedmont Area is organized as shown in the following chart:



Both custody staff and program staff are located in the area office and at the individual units. All diagnostic and mental health staff and consultants are located at the Diagnostic Center and Mental Health Clinic which is housed in a county owned, vacant school building situated some two miles from Mecklenburg II (Huntersville).

The Diagnostic Center - Satellite Mental Health Clinic is organized as follows:



In addition to the staff listed above the facility utilized the part-time services of a counselor from the North Carolina Department of Vocational Rehabilitation.

The program operates on an annual budget of $136,868 of which $85,007 is federal grant money (1973 data). The program has become institutionalized as part of the North Carolina Division of Corrections and is presently being replicated in the other correctional areas of the state.

The facility's function is based upon three broad objectives, relating to the level of mental health and disgnostic services available to the incarcerated. The three objectives are: (to quote from the project's 9/30/73 quarterly report)

1. More complete evaluation of inmates entering the correctional system and development of appropriate treatment programs.
2. Diagnosis and treatment of inmates with mental disorders by psychiatric and psychological consultants.
3. Development of presentence diagnostic capability for disposition of offenders convicted in local courts upon request by local judges.

The operation of the Community-Based Diagnostic Center - Satellite Mental Health Clinic is best understood in terms of the three functional areas derived from the objectives listed above.

The intake and diagnostic process and the subsequent development of inmate treatment programs involves all components of the facility. It thus places the greatest demand on staff time and also draws upon the services of the consulting psychiatrist and psychologists.

The diagnostic (intake) process is meant to serve all the male misdemeanants and felons with less than ten years sentence from the South Piedmont Corrections Area - North Carolina's most populated region. Those inmates processed by the Huntersville facility are overwhelmingly those convicted by the Area's courts. However, there are some inmates served by the facility who are sentenced elsewhere but whose residence is within the eight county South Piedmont Area. There is also some "leakage" from the Area as some felons are directly referred to Central Prison in Raleigh. Others leak out as a result of the local custody officials desire to fill their transportation vehicle with as many inmates as possible and thus collect the maximum per diem payment. Thus some convicted men who would be expected to go through the intake and diagnostic process at the Huntersville facility are in fact processed at the comparable facility in Raleigh. The number of such leaks could not be determined by any of the individuals contacted while on-site nor is it reflected in any of the published data.

The Community-Based Diagnostic Center - Satellite Mental Health Clinic

is not intended to serve felons with sentences of 10 years or more (processed at Raleigh), youthful offender felons (Harnett or Polk Youth Center) or juveniles (Western Correctional Center). Further, since the facility provides the diagnostic and intake services only to men already convicted and sentenced to the state correctional system, many individuals are diverted previously and thus do not undergo the reception process at Huntersville. Diversion of convicted men is accomplished through probation, assessment of fines and costs, or referral to other public agencies such as mental institutions or alcoholic programs. No data is available on the number of such diversions.

For those convicted men not diverted from the South Piedmont Area nor "leaked" to Central Prison the following reception process applies:

1. Transferred from local holding facilities to Mecklenburg II (Huntersville) where they are housed while undergoing initial reception process at the Diagnostic Center - Mental Health Clinic.
2. All offenders under 18 years old (juveniles), felons under 21 years old (youthful offender felons), and felons with more than 10 years sentence are immediately transferred to the appropriate reception and diagnosis center as indicated above.
3. For all others the first day's reception involves:
   a. Issuance of clothing, checking of valuables, fingerprinting and photograph taken.
   b. Basic data taken by secretary on form 134 (name, age, marital status, dependants, address).
   c. Review of basic rules and regulations of State Correction System by custody officer.
   d. Assignment to appropriate temporary housing facility:
      1) Regular misdemeanant (Mecklenburg II)
      2) Youthful offender misdemeanant (18 - 21 years old)
      3) Regular felons under 10 years sentence (Iredell)

4. With the completion of the initial reception process in day one, the second day marks the beginning of the diagnostic phase of the entire intake process. The initial part of this phase is the administration of tests to all the inmates. The texts are in most cases administered by the custody staff, although when large numbers of inmates overburden the custody staff, tests are given by the case analysts. The following tests are routinely administered:
   a. I.Q. test - the Revised Beta I.Q. is given unless otherwise requested by case analyst or psychologists.
   b. Sentence completion (read to illiterate inmates).
   c. Wide Range Achievement Test (WRAT).
   d. Minnesota Multiphasic Personality Inventory (MMPI) to (1) all misdemeanants with a sentence of 1 year or more; and (2) all misdemeanants with assaultive crime or history of assaultive behavior; and (3) all felons, regardless of crime or length of sentence; and (4) any misdemeanant upon the request of case analyst.

5. When the administration of tests is completed the next stage of the intake process begins -- Classification Referral. The steps in this phase are:
   a. Inmate "jacket" and test materials are distributed to case analysts by Case Analyst Supervisor. Most cases are randomly distributed although some cases are assigned to particular Case Analysts when deemed appropriate by the supervisor. The distribution takes into account the particular needs of the inmate and the capabilities and/or background of the Analysts -- two black males (including the supervisor), two white females, and one white male.
   b. The Analyst reviews the inmate's "jacket" and interprets test material. Analysts seek assistance from Executive Director (a psychologist) or the consulting psychologists and psychiatrist, if necessary.
   c. Case Analysts conduct private interviews with inmates; and

determine the following information:

1) Past record - arrests, probationary history, previous sentences.
2) Family background -- (home environment, marital situation, problems or concerns relating to spouse, parents, dependants, etc.).
3) Employment background -- (skills, jobs held, status of employment, employment history).
4) Crime story -- (inmate's version of crime, arrest, and conviction).
5) Identification of crime-related problems -- as determined by prisoner's narrative, test results, or personal impressions. Case Analyst may refer inmate to further testing, to consultation with psychologists or psychiatrist, or may seek guidance from professional staff for further recommendations.
6) Case Analysts answer inmate's questions, review rules and regulations of correction system, and explain some of the program options possibly available to him. Among the options are Work Release, Study Release, Alcoholics Anonymous, Training Programs, Vocational Rehabilitation referral, or counseling by the Mental Health Clinic.
7) Case Analysts discuss realistic options and determine inmates particular needs and desires as they relate to program options.

d. Analysts write classification reports which take into consideration and record:

1) Data from interview findings.
2) Diagnostic impression using test material and personal evaluation. The impressions and relevant data of these two steps are based upon observation and analytical techniques presented in the training program of Case Analysts, particularly as they apply to Presentence Diagnoses (PSD's). The PSD is in a sense a much more detailed and careful analysis

and history of the inmate, the crime, and the relevant circumstances applying to his situation.

3) Indicate which program options are of interest and value to the inmate.

4) Indicate possible custody problems and identifies areas where special handling might be necessary.

e. Case Analyst recommends housing assignment and program enrollment thereby classifying the inmate. Most often misdemeanants are housed in that misdemeanant facility nearest the man's place of residence, unless his recommended program is available only at another unit or the inmate indicates a strong interest in being assigned to another part of the Area or state. In any case, all classifications are reviewed by each unit's classification committee before final program assignment is made.

For felons and Committed Youthful Offenders the Case Analyst recommended classification is reviewed by the South Piedmont Classification Committee (SPCC). The final housing assignment is made by the SPCC which also has the authority to recommend immediate honor grade for felons. All honor grades and misdemeanants are housed in minimum security facilities whereas the felons not of honor grade must be placed in a medium security facility (Iredell, Stanley, or Union) and are thus constantly "under the gun". The SPCC has the final power within the Area to determine the inmate's corrective program and as such is the final arbitor of the Case Analyst's classifications. The committee is chaired by an Area Program Officer.

The entire reception, diagnostic and classification process at the South Piedmont Community-Based Diagnostic Center - Satellite Mental Health Clinic takes approximately one week. Upon completion of the process the inmates are transported to their assigned facility.

As a result of the interaction between themselves and the inmates, the Case Analysts see their roles as the spokesmen for the inmates within the

system. Messages are sent or phone calls made to the Case Analysts, apprising them of the status of individual inmates or of their particular requests and needs. The assumption behind such communications is that the Case Analyst will not only be able to understand the situation, but also that he or she will act, calling upon the most effective resources both inside and outside of the corrections system. There is no formal method of feeding back information to the Case Analyst about the inmate, thus this informal system of information flow is encouraged by the Analysts themselves.

Diagrammatically the system functions as follows on page 12 (a).

Final review of classification is always made by the classification committee at the local unit which is made up of the program officer and a custody officer.

Five factors presently greatly influence the functioning of this process:

1. The overcrowding in units limits the effectiveness of programs and reduces the individual inmate's access to particular programs.
2. All minimum security units (except Mecklenburg I, II, and Union) are seen as relatively similar with the same availability of programs.
3. Programs are an effective option only for long-term misdemeanants and for felons. Their length of stay makes training, counseling, etc. more practical.
4. Mecklenburg I and II and Union are differentiated from the other units in that:
   a. Mecklenburg I, located in Charlotte, is a transition unit with a very high number of inmates on work release or study release programs.
   b. Mecklenburg II, located in Huntersville, is the holding unit for the misdemeanants being processed and also serves

Local Jails

Initial Sentencing and Holding

- Felons, over 10 years
- Felons, 10 years & under
- Misdemeanants, under 30 days
- Misdemeanants, over 30 days
- Juveniles, under 18
- Youthful Offenders, felons, 13-21
- Youthful Offenders, Misdemeanants, 18-21

Reception

Western Correctional Center

Juveniles under 18

Reception

Harnett or Polk Youth Center

Youthful Offender Felons, 18-21

Reception

Central Prison

Felons Over 10 years

Reception

Huntersville Diagnostic Center

Felons 10 years & under
Misdemeanants over 30 days
Youthful Offenders, Misdemeanants, 18-21

Diagnosis

1. Testing
   - I.Q. (Beta)
   - Sentence Completion
   - Wide Range Achievement
   - MMPI (Felons, Misdemeanants with 1 or more years, assaultive crimes or behavior)
2. Case History Developed
   - History taken
   - Tests analyzed
   - Data recorded
3. Classification Recommendations Developed Based Upon:
   - Program availability
   - Type of Sentence
   - Prisoner needs and desires, and skills
   - Prisoner's home area

Misdemeanants

Assigned to minimum security nearest home

- Cabarrus
- Gaston
- Lincoln
- Mecklenburg I
- Mecklenburg II
- Rowan
- Union

Felons & Committed Youthful Offenders

Classification Review by SPCC

Honor Grade Felons

Felons
- Iredell
- Stanley
- Union

CYO
- Harnett
- Polk Youth Center
- Iredell
- Stanley
- Union

as the referral unit for misdemeanants considered management problems or in need of more long-term mental health care.

c. Union as a mixed institution houses both felons and misdemeanants.

5. Correctional programs and classifications developed at the Huntersville facility can be altered, without formal recourse, by the Unit's Classification Committee - a body heavily influenced by the policies of the Unit's Superintendent.

The second functional unit of the Huntersville facility is the mental health clinic which serves as an adjunct to the diagnostic and classification process and as an ongoing service to the inmates of the South Piedmont Corrections Area. The Clinic is open Tuesday and Thursday mornings at which time the consulting psychiatrist, the two consulting psychologists, and the Vocational Rehabilitation Counselor are on duty. On days other than Tuesday and Thursday, mental health services are provided to the Area's correction units by the Executive Director of the Huntersville facility (a psychologist by training) and by a full-time psychiatric nurse who maintains contact with the staffs at each of the units. Referral to the Mental Health Clinic is made by the inmates themselves, by unit corrections officials, or by case analysts.

All inmates are seen in individual sessions, by scheduled appointment although the schedule is always sufficiently flexible to see last-minute referrals. Long-term therapy and groups have been tried in the past, but at present are not being attempted. The rapid turn-over of inmates and the inappropriateness of longer-term techniques were given by the staff as reasons for discontinuing these methods. At present, the Clinic staff relies primarily upon short-term "reality therapy" techniques. When necessary for the inmates well-being and the smooth functioning of the corrections units, psychotropic drugs are prescribed by the consulting psychiatrist. Crisis intervention is most often performed by the Executive Director who can call upon the consulting psychiatrist for the prescription

of appropriate drugs when necessary. Crises have occurred very infrequently primarily due to the early diagnosis of mental health need and the ease of access to psychological and psychiatric services.

In addition to their ongoing treatment of the inmates of the South Piedmont Area, the consultant staff has provided in-service training to the Case Analysts and to the Unit Superintendents. The psychiatrist was primarily responsible for initiating a short seminar in the basic techniques of Transactional Analysis for both groups -- Superintendents and Case Analysts. Constant and informal supervison of the work of the Case Analysts is provided by the consulting psychiatrist and psychologists. More formal supervision is provided by the Executive Director. As a result of the close relationship between the Case Analysts and the staff of the Satellite Mental Health Clinic the techniques and analytical skills of the Case Analysts are constantly upgraded, and the Case Analysts do not hesitate to seek professional assistance when appropriate, or refer inmates to the Clinic. In addition, the consulting staff can easily turn to the Case Analysts for additional background data or personal impressions of particular inmates. The relationship between the two staffs is further fostered by their immediate proximity to each other. All offices are located off a single corridor.

The close interworkings of the two staffs is especially crucial in the performance of the Presentance Diagnosis (PSD). This is the third functional area of the Huntersville facility and calls upon the skills of both the Case Analysts and the staff of the Satellite Mental Health Clinic.

The intent of a PSD is to increase the decision-making resources of the judge thereby enabling him to sentence a convicted man to that facility and that program which is most beneficial to him and to society. The assumption is that the greater the personal data available and the more detailed the analysis of the criminal behavior, the more effective and beneficial the sentence. To that end a thorough investigation of the individual, his background, the crime, and the circumstances is

undertaken upon the request of the judge who feels that he needs the more complete analysis and the specific recommendations provided in a PSD, before he can sentence the man.

The Huntersville facility provides PSD's only for misdemeanants referred by South Piedmont Area judges. Felons who are to undergo PSD's are transferred to the State Prison at Raleigh, Youthful Offenders undergo PSD's at the Western Correctional Center.

The PSD process at Huntersville takes approximately 50 days and the man must be housed at Mecklenburg II during this period of time. The PSD is the responsibility of the Case Analyst assigned to the case. However, it is imperative that the Case Analyst call upon the resouces of the Satellite Mental Health Clinic, the local probation department school officials, other local public agencies, employers, family, and friends so as to complete a comprehensive picture of the individual. Further, the Case Analyst reviews with the inmate and the local police officials their respective descriptions of the crime or crimes for which the man was convicted.

The analytical steps in the PSD process can be divided into two segments - identification of the criminality-related pathologies (EPIC) and the identification of the areas of treatment (SCAMP). All Case Analysts follow the same two-step process which they learned while undergoing training at the Central Prison in Raleigh. The titles of the segments are acronyms for the sub-tests of investigatory criteria.

EPIC is thus an analysis of Environmental, Psychological, Integral and Corporal causal factors. Similarly, SCAMP investigates Situational, Custodial, Accultural, Medical and Psychiatric treatments.

The final product of the EPIC and SCAMP process is a "criminalysis" upon which the final recommendations are given. Recommendations need not be limited to services provided by the corrections system. In fact, utilization of outside services either while serving time or upon parole/ release is often a basic component of the final recommendation. The

final dispensation of the case is up to the judge who, after reviewing the PSD, passes final sentence.

For comparative purposes, URSA was asked to review the processes and the facilities of the Central Prison Diagnostic Center and Mental Health Clinic. Both of these separate facilities are located within the walls of the Central Prison in Raleigh, though they are in separate buildings.

Both of these facilities serve the entire state rather than any one particular region. All felons with sentences of more than three years, plus those felons immediately sentenced to Central Prison, must undergo reception, diagnosis and classification at the facility (except those felons in the South Piedmont Area, who are processed at that facility. It is presently the only facility except Central Prison certified to undertake that function.) The workload is accordingly higher than at Huntersville, as can be seen by the fact that in 1973 the Huntersville facility received, diagnosed and classified a total of 933 inmates (835 misdemeanants and 158 felons). In the same period of time Central Prison processed 2,153 inmates.

The process at Central Prison is more "assembly line" in that each step is handled by a different person with the Case Analyst only being called in after the personal history has been taken down and written up by a staff member with less training. The same battery of tests is given at Central Prison as at Huntersville, and the entire process takes approximately the same time; five to six days. Since only felons are processed at Central Prison, a Classification Board there makes the final assignment of residence and program units throughout the state. PSD's are more commonly requested of Central Prison staff, though the process there takes from 60 to 90 days as compared to Huntersville's 50 to 60 days. Central Prison processes more PSD's than Huntersville, since it must serve the entire state's needs. The Huntersville staff develops PSD's only upon the requests of the judges of the South Piedmont Area. The increased processing time needed at Central Prison is due to the inherent delays resulting from its location in Raleigh and the need to obtain information

from sources throughout the state.

The Central Prison Mental Health Clinic serves as the primary referral unit for the entire North Carolina corrections system and as such is capable of providing medium through maximum security housing for those inmates referred from other units. It thus must be prepared to accommodate the most difficult and the most long-term cases. Even though Raleigh is relatively centrally located, the distance between Central Prison and the vast majority of correctional units limits the effectiveness of the Mental Health Clinic as a resource for crisis intervention or for the treatment of short-term needs.

1.3.2 Developmental History of the South Piedmont Community-Based Diagnostic Center and Satellite Mental Health Clinic

The concept of a Huntersville type facility was initiated with the transfer of the new State Director of Programs to the South Piedmont Area in 1971. As the Area's Psychologist, he had to provide basic mental health services to all nine units. At that time, the correctional system's facilities for formal treatment of mental health problems were solely at the Mental Health Clinic at Central Prison. The distance to Raleigh, as well as the burden on the clinic's staff, limited the availability and kind of treatment for inmates. Short-term treatment and crisis intervention was handled by the Area Psychologist who was nonetheless limited by his lack of staff, lack of central facilities, and lack of the power to prescribe medication. Further, no diagnostic services were provided in the area to misdemeanants or felons with sentences of less than three years. Felons from South Piedmont with sentences of more than three years underwent reception, diagnosis and classification at the Diagnostic Center in Central Prison. Partially as the result of this lack of mental health treatment and diagnostic capability in the South Piedmont Area, 12 to 15 inmates per month were being shifted to Raleigh for treatment at that facility.

Aware of the obvious mental hygiene needs in South Piedmont, the Area Psychologist began exerting pressure for the creation of a diagnostic and treatment facility. First he worked with the Correction Unit Superintendents,

demonstrating that treatment and diagnosis of mental health problems was an effective means of diminishing management and custody problems.

Second, the Area Psychologist both determined the scope of local mental health resources and prodded them into making the appropriate services available to the area's inmate population. Among the local services contacted were the community mental health clinic, alcohol and drug abuse treatment centers, the local offices of Vocational Rehabilitation and of Social Services, and the professional psychological and psychiatric communities.

Third, the local judiciary had to be apprised of the availability of services and the means to most effectively utilize them when sentencing the convicted men.

Fourth, the State Divison of Corrections' planning staff had to be convinced of both the need for the diagnostic and treatment facility and the efficacy of providing those services to inmates.

As a result of this pragmatic approach, Pilot Cities Discretionary Funds, other LEAA funds, as well as state monies were awarded and the project was begun on October 1, 1972. In its first year of operation, the project expended $143,200.14 of which $85,007.14 was federal money and $58,193.00 was state contribution. Of the total, $136,868.65 was estimated to be annual operating costs and $6,331.49 were start-up, one-time expenditures.

The Area Psychologist served as the project's first Executive Director. In that capacity, he established its operating procedures, hired its staff and solidified its relationship to the other components of the criminal justice and social service systems in the South Piedmont Area. He was also responsible for clearly establishing the relationship of his facility to those of the Diagnostic Center and Mental Health Clinic at Central Prison.

In October of 1973, the Executive Director was promoted to the office of

Director of Programs, State Division of Corrections. He was replaced by the present Executive Director who has not altered any of the basic policies established by his predecessor.

The Huntersville facility is considered a success by the officials within the Division of Corrections. It is being utilized as a model for a statewide replication effort which is presently seeking LEAA funding. The Division of Corrections' goal is to certify a diagnostic center and mental health clinic in each of North Carolina's six Corrections Areas by June 30, 1975.

2.0 FINDINGS OF THE VALIDATION STUDY

Findings regarding the South Piedmont Community-Based Diagnostic Center and Satellite Mental Health Clinic's suitability for exemplary project status and replication are organized in this section according to the criteria established by the Exemplary Project Advisory Board. In addition, specific questions raised by the Advisory Board are addressed in this section.

2.1 Goal Achievement

2.1.1 Program Objectives and Performance

In the program's subgrant application to the North Carolina Department of Natural and Economic Resources, Division of Law and Order, dated July 23, 1973, the program's goals are listed as follows:

1. To provide complete medical, psychological and social evaluation of every misdemeanant and felon offender entering the correctional system from Region F (now entitled the South Piedmont Corrections Area);
2. To provide mental health services to include psychiatric and psychological treatment on a short-term, out-patient basis to offenders referred by correctional officials or diagnosed at this center from the nine correctional units in Region F (South Piedmont);
3. To provide to local judges a presentence diagnostic study in each case referred by the local court for assistance in determining the most appropriate sentence.

All three of these goals are operational as differentiated from impact goals. The former are used to measure the kind and level of service while the latter facilitate evaluation of the program's effectiveness as a change agent. The two types of goals are interrelated in that achievement of operational goals should logically and sequentially imply the achievement of the impact goals. However, in the case of the South Piedmont Community-Based Reception Center and Satellite Mental Health Clinic, no

impact goals have been formally articulated and presented. Nonetheless, as a result of its interviews, the URSA field team was able to establish some generalized goals. These are:

1. That improved mental health diagnostic and treatment services to inmates will result in:
   a. Fewer "management" problems for corrections staff;
   b. Reduction in recidivism;
   c. More humane conditions for the incarcerated.
2. That the provision of such services on the local level will result in:
   a. Higher quality services to the inmate population;
   b. Lower costs to the corrections system.
3. That the establishment of a model diagnostic center and mental health clinic will prompt the North Carolina state agencies to take over from the Division of Corrections the responsibility of providing health, education and social welfare services to the incarcerated population.

2.1.2 Operational Goals

All three operational goals have been met -- the facility has been providing diagnostic and reception services and has been performing PSD's. However, since the operational goals are minimal and make no statement as to quality or level of service, the evaluation effort had to go beyond the stated goals in order to make an effective assessment of the project. The issue raised by the Exemplary Project Advisory Board provided the base for this analysis of operational goals.

Responding to the first question, which simply asked for recent data on the levels of service delivery of the three components, is difficult due to the lack of comprehensive and consistent data. Since the facility's inception, a total of 1,473 misdemeanants and 249 felons have been evaluated and processed by the Diagnostic Center. The period covered by these totals is October 17, 1972 - June 30, 1974. However, even such gross figures are

not available for the Mental Health Clinic. For the period October 17, 1972 - September 30, 1973, 648 referrals were made to the clinic and 199 patients seen. After September 30, 1973, as ordered by the newly appointed Executive Director, the only data available is that of appointments kept. From September 30, 1973 - June 30, 1974, a total of 1,247 inmate appointments were made and kept. The data as presented still leaves unanswered:

1. The distribution of mental health referrals by:
   a. Type of sentence;
   b. Unit location;
   c. Type of perceived need;
   d. Method of referral;
   e. Treatment followed.
2. The average length of treatment.
3. The results of the treatment.
4. The other services or agencies utilized in treatment.
5. Means of reconciling the counting techniques before and after September 30, 1973.

The data on presentence diagnosis is available since there have been only 18 PSD's* completed during the entire period of the project's operation. However, there is no information to show whether the judges followed the recommendations of the PSD's.

The second issue raised by the Exemplary Project Advisory Board requested an approximation of the number of clients who would have gone to the Raleigh facility if the Center were not in operation. There are three groups of inmates thus affected, the first being those felons who have received a sentence of three to ten years. Before the initiation of the Huntersville facility, all would have undergone reception, diagnosis and classification at Raleigh. The second group whose service needs are treated locally rather than at Raleigh are those inmates whose mental problems were such that they could only be treated at the Mental Health Clinic at Central Prison. Presently, they are treated by the staff at the

*All data compiled from Quarterly Reports through June 30, 1974.

Clinic in Huntersville. The third group previously served only by Raleigh are PSD's.

Isolating the first two groups is very difficult, because (1) the data on the felon population has not been differentiated by length of sentence; (2) the Division of Corrections data on Huntersville (Mecklenburg II) does not differentiate between those inmates assigned to the unit and those being held there while undergoing processing at the Diagnostic Center; and (3) estimating the number of inmates who would have otherwise been transferred to the Central Prison Mental Health Clinic can only be based on the historical information for the period before October, 1972, the inception of the Huntersville facility.

To estimate the number of felons processed at Huntersville rather than at Raleigh, a ratio of those felons serving sentences of three to ten years to total felon admissions was established for the state and then applied to Huntersville Diagnostic Center felon totals. Thus,

$$\frac{1,132}{2,800} = \text{Number of Felons serving 3-10 years; statewide, 1973} \div \text{Total number Felons statewide, reported 1973}$$

which equals;

40.4%

$$\frac{40.4}{100.0} (.249) = 101 \text{ Inmates}$$

To this number would be added the average number of monthly referrals to the Central Prison Mental Health Clinic previous to the inception of the Huntersville facility. This number was estimated by the former Executive Director to be 12 to 15 per month. Thus, for the 21 months of operation, a total of approximately 283 inmates would have otherwise been transported to Raleigh for mental health services.

Thus, the 101 felons, the 18 PSD's, and the 283 potential mental health treatment cases are summed to estimate the potential savings rendered by the Huntersville facility. The total of 402 inmates served locally can only be seen as the roughest of approximations and applies to the facility's entire 21 months of operation.

The third issue raised by the Advisory Board concerns the number of inmates receiving the services of the Diagnostic Center and Mental Health Clinic who would have otherwise received no services. This group is made up of (1) all misdemeanants, (2) felons serving sentences of three years or less and (3) those inmates with mental health needs not severe or noticeable enough to previously have warranted transfer to Raleigh. The first two groups previously had not undergone a diagnostic process comparable to that presently provided at the Huntersville facility. To estimate the felon group, URSA took the converse of the ratio derived in response to the Advisory Board's second concern and applied it to the Diagnostic Center's total felon population. Thus,

1,473 misdemeanants
148 felons
1,621 inmates served by Huntersville Diagnostic facility who would otherwise have gone unserved.

The third group (those needing mental health treatment) simply could not be estimated by any source interviewed and thus no total has been shown.

The fourthissue is that of the quality of service provided at Huntersville as compared to that provided at Raleigh. The quality of output in terms of PSD's or classification reports is not substantially different. Both follow the same techniques and present the same basic data. The similarity is in part a function of the common training process for all Case Analysts and of the formal data requirements of the North Carolina Divison of Corrections.

However, in terms of the relationship between the Case Analyst or other staff and the inmate, the Huntersville facility is clearly superior. The greater responsibility of the Huntersville Case Analyst and his or her knowledge of local conditions, programs, and institutions promote a closer and more effective relationship with the convict. This is not so clearly shown in the quality or insightfulness of the reports, but is best illustrated by the regular and open communications between the inmate and his Case Analyst. Further, in working with the inmate to develop particular programs, the Case Analyst's knowledge of the strengths and weaknesses of the various programs enables him to make more practical suggestions. These in turn result in greater inmate confidence in utilizing programs such as the mental health clinic or in relying upon the Case Analyst to follow through with outside programs for family or dependents. (Hard data is not available to back this contention. Nonetheless, those interviewed in both Huntersville and Raleigh cited this confidence factor as a major benefit of the project.)

Overall, the atmosphere surrounding intake, diagnosis, and classification is much less oppressive and assembly line-like at Huntersville. One basic reason is the difference in staff in terms of organization and social characteristics. Huntersville's Case Analyst staff are racially and sexually mixed, while all of the Raleigh social history and Case Analyst staff are white males. Another factor in the difference is the facility itself at Huntersville. Raleigh is obviously the State Prison and all components within its walls are geared to medium and maximum security. In contrast, Huntersville, with an overwhelmingly misdemeanant caseload, is a primarily minimum security institution (with medium security capability) and housed in a 20-30 year old school building.

2.1.3 Impact Goals

The evaluation of impact goals can only be made on qualitative terms, utilizing the opinions of the staff at Huntersville, and the officials in Raleigh as well as the observations of the URSA field team. The lack of

data on or at Huntersville consistently hampered the evaluation effort. This problem is most acute when attempting to evaluate understood or implied goals. In the case of the Huntersville facility the impact goals were all implied and certainly not universally accepted. Consequently, no data was available which directly or indirectly focused on the impact goals.

The first set of impact goals assumes that with improved mental health and diagnostic facilities there would be a reduction in management or custody problems for the unit staffs, that the rehabilitation or correction process would more successfully result in a lower recidivism rate, and that the overall conditions for the incarcerated would be more humane. Of the three results the first and the third are very vague and subjective. Concerning the first, custody staff did indicate that the Unit Superintendents had had fewer management problems and that they attributed much of the diminution to the treatment of diagnostic services at Huntersville. In part this is borne out by the Superintendent's willingness to send inmates to Huntersville and to support the continuation of the present facility and the implementation of the replication effort state-wide.

However, these positive impressions must be balanced by the knowledge that parallel to the development of the Diagnostic Center and Mental Health Clinic, Mecklenburg II (Huntersville) became the holding facility for the Area's most severe management problems. Thus with Mecklenburg II taking on this responsibility, pressures at the other units diminished. Mecklenburg II in turn has been plagued by escapes, and recently had to place unarmed guards in the towers, a practice which had been discontinued. In response to questions concerning this problem, the most common response pointed to the abolition of road gangs in 1973 and the resultant increased inmate idleness -- not Mecklenburg II's new role. At the present time, the work and study programs available to inmates have not filled the vacuum. In fact, participation in the various programs has diminished from 1972 levels.

The goal of more humane treatment for inmates unquestionably has been met, if humane treatment is defined as the provision of previously limited or unavailable services. As has been indicated in the discussion of operational goals, the Diagnostic Center and Mental Health Clinic has substantially increased the level and professionalism of treatment and diagnostic services to the prison population.

The impact goal of lower recidivism simply cannot be evaluated. No data exists on the post-incarceration activity of inmates who have undergone either diagnosis, treatment, or both at the Huntersville facility. This lack of data is especially crucial, given the implied assumption that more humane conditions, early diagnosis, and professional treatment of mental problems will reduce the tendency to commit crimes. Without any effort to substantiate that assumption, the entire Huntersville facility could said to be based on a faulty hypothesis. (For futher disucssion of this issue, see section 3.3, General Comments, in particular the comparison to the NILECJ Corrections Standard 6.2).

The second set of impact goals emphasizes the location of the services -- following the assumption that decentralized community-based services result in services that are of a higher quality and greater efficiency than those previously provided. As has been indicated above, both in Section 1.3.3 (Developmental History) and 2.1.2 (Operational Goals), the level and kind of services provided at the Huntersville facility is substantially improved. The improvement can be most easily seen in the number of hours of professional services available and the scope and importance given to the intake, diagnostic, and classification process.

The efficiency issue is very complex and full analysis is limited by the lack of data. Nonetheless, the data in the Evaluation Report (Wheaton) and the conversations with Raleigh and Huntersville personnel do indicate that the services provided at the local facility are less costly than the comparable services rendered at Central Prison. The basic factors are the lower transportation and the daily inmate maintenance costs which result when diagnostic

and treatment facilities are provided in the South Piedmont Area. A more complete discussion of the issues and limitations of a cost benefit analysis is presented below in Section 2.3.

The final impact goal meant the shifting of the responsibility of service provision from the Division of Corrections to those state agencies mandated to supply those services to the population at large. Though in fact no wholesale shifts have occurred the Department of Education and the community college system have undertaken the development and implementation of courses to the inmates both inside and out of the South Piedmont units. However, all health related services and liaisons with local service providers is still the responsibility of the program staffs at the local units (this group includes the Case Analysts).

Overall, this goal is administrative in nature, and to be fully realized would take political and administrative changes which are only minimally promoted by the existence of a functioning model such as the Huntersville facility.

2.2 Measureability

The Huntersville facility compiles only summary data on the inmates who have utilized its services. Thus individual case records are kept on file locally, but cumulative social statistics on the inmates are collected and compiled only in Raleigh at the Division of Corrections. However, even this data is of extremely limited utility since the state does not and cannot differentiate between those inmates who enter the corrections system through the Diagnostic Center and Mental Health Clinic and those who are permanently housed at Mecklenburg II. The Division of Corrections information system lacks the necessary data bits to record the two separate flows of prisoners through Mecklenburg II (Huntersville).

As a result of this lack of basic information, URSA was not able to develop the flow data which would enable a full evaluation of the impact

of the Diagnostic Center and Mental Health Clinic. There is thus no breakdown on the distribution of the facility's inmates by unit, by program, by incidents while in prison and by post-imprisonment activities. Further, there is no data whatsoever collected on the inmates referred to the Mental Health Clinic. Even the summary data maintained at Huntersville is not consistent over the entire operational history of the facility, having been altered by the present Executive Director when he was appointed in October 1973. As has been discussed previously, the new information simply is a count of appointments kept with no information on the inmates, their illnesses, their treatment, or the results of that treatment.

No cost analysis is maintained locally, and the only attempt to determine relative costs was attempted by the outside evaluation, conducted by Dr. David Wheaton of the University of North Carolina, Charlotte, published in September, 1973. No updates or improvements have been made on that effort either at Huntersville or Raleigh. URSA has a number of questions concerning that report, however, these are more fully discussed in Section 2.3 Efficiency.

Another issue for the evaluation of Huntersville is its lack of comparability to other facilities in North Carolina and moreover the lack of comparability between North Carolina's correction system and those of the other states. Only Delaware was cited by North Carolina administrators as having a state-operated corrections system without any county units, similar to the North Carolina system. Presently there is not any comparative data on the comparable diagnostic and classification processes in the two states.

2.3 Efficiency

The cost data available from the State Department of Corrections is rather limited since there is no breakout of marginal costs. URSA was not able to ascertain whether the additional cost to the system of the care and/or processing of an inmate was equal throughout (a straight-line function)

or whether beyond certain totals the care and/or processing of one inmate resulted in greater or less costs to the system. The available data as utilized in the Wheaton evaluation has never been adjusted, thus URSA had to assume (1) that the relative costs between the Raleigh and Huntersville facilities had remained the same; (2) that Wheaton's basic data had been correct and (3) that increased inmate flow increased costs at both facilities at the constant rate applicable for all levels of service. As a result of these assumptions, URSA by default, had to assume that Huntersville was more efficient than Raleigh. This conclusion was informally corroborated in discussions with both Huntersville and Raleigh officials.

While cost data on Huntersville was limited, data on benefits was non-existent. No information whatsoever is available on the savings to the Divison of Corrections or to the individual units resulting from the implementation of the Diagnostic Center and Mental Health Clinic. The Area office staff simply had not even begun preliminary investigations into estimating the program's benefits. The staff of the Division of Corrections in Raleigh, though charged with replicating the Huntersville facility had not made an analysis of the benefits of the project.

The Exemplary Projects Advisory Board asked URSA to address the issue of fixed costs at the Raleigh facility and the issue of system-wide benefits and costs resulting from the replication of the Huntersville project and the eventual closing of the Raleigh facility. Both issues are interrelated in that they assume that the Diagnostic Center and Mental Health Clinic is intended to relieve the Raleigh facilities of their functions. As far as URSA could ascertain, the Raleigh program would always exist to serve those felons with sentences of more than 10 years, and those felons and misdemeanants who are felt to be the greatest management risks. In fact, even with the existence of the Huntersville facility, Raleigh's workload increased over 150 inmates (over 8%) between 1971 and 1973. (State Correction Statistical Abstract 1971 and 1973). Since the entire North Carolina Division of Corrections system is presently 14.3 overcrowded,

the fixed cost issue is mooted. The reductions in service demand at Raleigh, caused by the facility at Huntersville, are replaced immediately by both the increased flow of inmates from other regions and the general overall increase in the North Carolina inmate population. In 1971 the total average population was 9,958, whereas in 1973 the year end population was 11,561.

As to the issue of the closing of the Raleigh facility, the subject was not considered a viable or realistic alternative by the North Carolina Division of Corrections. Further, given the lack of data and inclination to develop such data, a cost/benefit analysis of such an alternative is beyond the scope of URSA's assignment.

2.4 Replicability

In assessing the South Piedmont Community-Based Diagnostic Center and Satellite Mental Health Clinic's potential for replication in other communities, the URSA team considered seven factors:

1. The extent to which need for similar programs exist in other communities;
2. The project's organizational structure;
3. The project's location and facility;
4. The project's staff;
5. The project's procedures, materials, and training methods;
6. The community support and cooperation;
7. The financial structure and budget of the project.

In each instance the URSA team was interested in determining whether other communities might reasonably expect to duplicate the context in which the Huntersville facility functions and draw upon similar resources or identify equally effective alternatives.

In general the URSA team concluded that the combination of services provided at the facility can be easily replicated in communities or regions

where there are sufficient psychologists and psychiatrists to provide the necessary consulting staff. However, reflecting the unique organization of the North Carolina Corrections System, replication efforts in other states should be aimed at the county level. The specifics leading to these conclusions are listed below.

2.4.1 Extent of Need

North Carolina's organization of its correction system is unlike any other state with the exception of Delaware. Thus, the need in other states most likely will be at the county level. The reasons for this conclusion are: 1) that the Huntersville facility is best equipped to handle misdemeanants and honor grade felons, a group which in other states is housed in county jails and 2) the county is the political unit which very often provides those health and social welfare services which would most effectively be linked to a Diagnostic Center and Mental Health Clinic.

The provision of such comprehensive diagnostic and treatment services for inmates is lacking, with few exceptions, throughout the country. It is certainly lacking in those facilities provided for misdemeanants. In addition to providing means for identifying potential problems and providing the necessary treatment services, the utilization of a diagnostic center - mental health clinic would provide means to divert individuals from the correction system. If the local judiciary were to be involved in the planning process and apprised of such a facility's utility, especially in terms of the presentence diagnoses (PSD's), potentially many individuals who would otherwise be sent to prison, would be diverted to those institutions or services which could most effectively treat his particular problem.

The Huntersville facility serves as a guideline for determining both the level of inmate population to be served and the population size of the general area from which services are drawn. The Huntersville staff is presently able to deliver quality and personalized services to the inmates

and to maintain a good sense of the kind and quality of community services available to the inmates and their families. Clearly, this is not true of the Raleigh facilities. Thus, URSA estimates that a combined diagnostic center - medical health clinic should serve a maximum inmate population of 1,000 to 1,500 and a general population of 400,000 to 600,000. Smaller general populations often do not have the range of community services necessary, and larger numbers tend to result in less personalized service and less personal staff knowledge of local services.

2.4.2 Organization

As has been indicated previously the North Carolina Division of Corrections is responsible for misdemeanants as well as felons. In other states, the misdemeanant population is most often handled at the county level. Reflecting this functional difference the organizational structure of the Division of Corrections is not relevant to the issue of replication. Further, the internal organization of the Huntersville facility is neither unique nor fundamental to its success.

2.4.3 Location and Facility

The Diagnostic Center and Mental Health Clinic is located in an abandoned school structure, some 20 miles from downtown Charlotte. The setting is quite rural, separated from other services, but within two miles of the misdemeanant holding facility, Mecklenburg II. The felon facility is approximately 40 miles away at Iredell. The other units served by the Huntersville unit are a comparable distance away.

The building itself obviously was constructed as a school and is not a jail. When medium security precautions are necessary, a particular room is utilized which is equipped with two fenced-in areas.

Replication of such a facility is no problem as any building would seem to be able to be converted, assuming the necessary wire screens, locks, and

fences were constructed. A rural location is certainly not necessary and in fact may be a hindrance to obtaining the necessary quality of professional services. The unit should be centralized within the coverage area so as to diminish transportation costs.

2.4.4 Staff

In evaluating the importance of the staff in replication of a project such as the Huntersville facility, URSA focused first upon the different skills necessary for implementation as opposed to those necessary for operation. Clearly the abilities and skills of the initial Executive Director were necessary to bring together the diverse elements needed to support the facility. The URSA field staff isolated the following skills basic to the initiation of such a project:

1. Professional standing and training - in this case a psychologist with proven experience is necessary to understand the skills needed for the program's operation and to evaluate the professional skills of the consultant and full-time staff he is to hire.
2. Experience in the corrections field seems to be absolutely necessary to gain the confidence of the corrections officers at the various prison units. Their initial support and continued utilization of the services is a requirement for the success of such a project.
3. Political awareness and willingness to meet issues directly -- much of the initial effort will be spent working with groups who have purposes or perceived mandates that do not dovetail with the proposed facility. Understanding the local organizations, agencies, and personalities, and working with each requires a keen awareness of political issues and ramifications. Without that awareness and the capability to constructively utilize it, the project could fail to gain local support and thus fail to be implemented.

Once the project was initiated, the skills and characteristics of the present

staff serve as a good model for continued operation:

- Executive Director: a psychologist with both administrative and clinical experience.
- Case Analysts: college graduates with academic backgrounds in sociology or psychology and some experience in corrections. Of great importance are the abilities to write well, to express oneself clearly, and to understand the concerns of the inmates.
- Consulting staff:- at least one psychiatrist is necessary to prescribe medication, but the other consulting staff could be either psychologists or psychiatrists. Psychologists are cheaper and given the kinds of disorders and treatments utilized, they may be more practical to hire. Preferably the consulting staff would have some experience with prisons and/or inmates. A full-time social worker or psychiatric nurse is also necessary to maintain continuity and to act as a liason between the mental health facility and the diagnostic center.
- Custody Staff: definitely should be aware of the aims of the facility and understand its differences from the normal correctional unit. Academic training is not necessary but a decided asset, if it is oriented towards the social and economic factors surrounding the commitment of crimes.

The staff at Huntersville is racially mixed and that reflects the policies of the initial Executive Director. It is a policy that is still followed and one that is crucial for replication. The crucial factor in the diagnostic and classification process is the relationship between the Case Analyst and the inmate. That relationship would be maximized by racial parity between the staff and the inmate population. The lack of such parity is immediately noticeable at the Central Prison Diagnostic Center.

Overall, the URSA team concluded that staff similar to that at the Huntersville facility could be assembled in most urban communities or regional centers without undue difficulty.

As a final note on staff, some unmet needs of the operation at Huntersville could be accomplished by interns from local universities. Especially relevant would be the entire area of statistical research and analysis which is presently not part of the staff responsibility.

2.4.5 Methods and Materials

All of the materials, forms and procedures utilized at Huntersville were standardized throughout the North Carolina Division of Corrections. As such they are not critical factors in replication.

The only component of interest for replication would seem to be the training method for the Case Analysts. However, when discussing training with the Case Analysts, the URSA team discovered that each of the five had undergone a different program. The only consistent aspect was the emphasis on preparing presentence diagnoses (PSD's) even though the training varied in length from one to six weeks. URSA felt that the training had components which were necessary (role-playing, working directly with the prisoner, assimilation of the goals of the correction system, working inside a prison) and which should be part of any replication effort. However, much of the training, especially the preparation of the PSD's, could more effectively be done through an on-the-job training approach, working with an experienced Case Analyst.

The interrelationship between the consultant staff and the Case Analyst is an informal and possibly unintended byproduct of the physical plant at Huntersville. Nonetheless it is an interchange that mutually benefits both parties, and should be fostered at every replication site. The encouragement can result from both physical proximity and functional interdependence.

2.4.6 Community Support and Cooperation

The success of any replication of the Huntersville project requires the full support of various segments of the local community. First, the local

psychiatrist and psychologist must not only back the project but individual professionals must commit their time to serve as consultants. Second, the local judiciary must utilize the facility for PSD's and have confidence in the recommendations of the staff and consultants. Third, the local police authorities and custody officials have to see the diagnostic and treatment services as a viable alternative to force and lock-ups as a means of control and correction. Fourth, the local service agencies must encourage linkages with the correctional system and deliver the kind and quality of services needed to maximize the efforts of the correctional and judicial systems.

The Huntersville facility has not taken full advantage of the last group, but such efforts are crucial, especially when considering the needs of the newly released inmate, the dependents of those incarcerated, and those individuals who are diverted from the corrections system to local agencies.

The physical location of the facility within a community need not be a factor in replication.

2.4.7 Financial Structure and Budget

The Huntersville facility is a component of the North Carolina Division of Corrections. As such it is supported by state funds as well as the monies from the LEAA grant. The program's continued funding is highly likely given the recent decision to replicate the project throughout the state.

The level of funding is not a unique factor in the operation of the facility and as such is not a factor in replication.

2.5 Accessibility

The operations of the Diagnostic Center - Mental Health Clinic can be easily observed. However at certain times the workload fully

utilizes the staff time, severely limiting the observer's access to the staff. Consequently visitors should make arrangements ahead of time before visiting the site.

3.0 STRENGTHS AND WEAKNESSES

In this section, the URSA team will attempt to identify the particular strengths of the South Piedmont Community-Based Diagnostic Center and Satellite and to indicate those areas which should be strengthened if replication efforts are to be undertaken. To fully understand both its strength and its weaknesses, the Huntersville facility must be placed in the context of the North Carolina corrections and judicial systems. Consideration must be given to the following facts:

1. North Carolina has no county jails, thus all misdemeanants with sentences over 30 days are housed in state facilities.
2. As recently as 1973, North Carolina utilized its inmate population for road crews.
3. Symptomatic of a state-wide policy toward a tighter law and order policy, paroles and work/study release have been made more difficult to obtain. Paroles reportedly have been granted to 1200 fewer individuals than at a comparable period last year. Similarly in the South Piedmont Area the number of inmates in work release and study release programs was significantly reduced in 1973 from the 1972 levels.
4. Partially as a result of this policy, the entire corrections system is overcrowded--as of February the system was 14.6% overcrowded.
5. Except for those inmates of the South Piedmont Corrections Area, served by the Huntersville facility, misdemeanants and felons with sentences less than three years undergo only a cursory diagnostic and classification process and are dependent upon Central Prison for long-term mental health services.

3.1 Strengths

The strengths of the Huntersville facility are:

1. It provides diagnostic services to a population which previously had not received such services.

2. It utilizes, as consultants, the professional services of individuals who have previously not provided their services to the inmate population.
3. It combines diagnostic and treatment facilities so that not only are the two components functionally interrelated, but their two staffs reinforce their respective skills.
4. It provides a more personalized intake, diagnostic, and classification process to the inmates.
5. It provides inmates with more consistent and more accessible mental health treatment facilities.
6. It provides the local judiciary with localized PSD capability.
7. It attempts to link the corrections system with local agencies and institutions which had previously not provided services to inmates.
8. It provides, at a local level, services which are otherwise provided only at Central Prison and thus at a greater cost.

3.2 Weaknesses

The weaknesses observed by the URSA team are:

1. The general lack of data which severely handicaps any assessment of present policies, which in turn limits future planning.
2. The diffuse nature of the program's goals which in turn feeds upon the failure to develop hard data.
3. The program's implied goals are not consistent with many of the policies of other components of the correction system, thereby diminishing its effectiveness. The overcrowding and the reduction in work and study release opportunities run counter to the more humane environment sought by the addition of diagnostic and treatment services for inmates.
4. The facility's services are not fully utilized by the local judiciary who have not requested many PSD's and who can still bypass it by assigning convicts directly to Central Prison.
5. Its prime function is to serve sentenced men when much of its capability could be better utilized to divert individuals

from an already overburdened corrections system. This lack of effective utilization stems primarily from its organizational location in the state system rather than as a county unit (as would be the case in other states).

6. Internal feedback is entirely lacking, thus the Case Analysts are unable to formally ascertain the impact of their analyses and recommendations.
7. Except for community colleges and the Department of Vocational Rehabilitation, other local services are not fully utilized especially as it concerns on-going assistance after the individual's release.
8. The recommendations and analyses of the project staff can be overturned by the decision of the unit classification committee and the unit superintendent, without any formal means of appeal.

3.3 General Comments

The South Piedmont Community Based Diagnostic Center - Satellite Mental Health Clinic provides an improved level of diagnostic and treatment services to the local inmate population. At present that service is unequalled anywhere in the state, though comparable services are rendered at Central Prison. However, to evaluate the project's replicability it must be compared to national standards and goals.

The national standards against which the Huntersville facility should be measured are those developed by the National Advisory Commission on Criminal Justice Standards and Goals for their publication Corrections, 1973. In particular the standards which are most relevant are:

- 6.1 Comprehensive Classification Systems
- 6.2 Classification for Inmate Management
- 6.3 Community Classification Teams
- 7.1 Development Plan for Community-Based Alternatives to Confinement
- 7.2 Marshalling and Coordinating Community Resources

Though these standards are in a sense ideals to strive for, they do indicate the areas in which the Huntersville facility could be strengthened if it were to be replicated outside North Carolina.

The discussion presented below follows the organization of the standards and principles as presented in Corrections. Thus as concerns Standard 6.1, the following principles are deficient:

2. presentation of classification standards in written form which clearly spells out the central hypothesis by which inmates are classified, details the objectives of the system for which the inmates are classified, and specifies a monitoring and evaluation mechanism to determine whether the objectives are being met.
7. The system should be sufficiently objective and quantifiable to facilitate research, demonstration, model building, intro-system comparisons, and administrative decision-making.
8. The correctional agency should participate in or be receptive to cross-classification research toward the development of a classification system that can be used commonly by all correctional agencies.

Due to the lack of data and research being done at Huntersville, URSA was not able to establish the hypotheses behind either the inmate's classification or his corrective program. URSA was therefore unable to judge the accomplishments of the program in terms of its ability to assist in the social reintegration of the offender.

In terms of Standard 6.2, the program was deficient in the following principles:

1. The use of reception-diagnostic centers should be discontinued.
6. Reclassification should be undertaken at intervals not exceeding 6 weeks

Obviously the existence of the Huntersville facility violates the first principle, but it is unrealistic to expect the Division of Corrections to immediately reject the medical model of classification which it is just now implementing statewide. Nonetheless due to the lack of data

efforts North Carolina is following the medical model of classification without any quantifiable, corroborating information. Consequently it has no clearly stated rationale for its dependence upon that particular model. Also, the failure to consistently review classification is a critical deficiency and would have to be built into any replication.

According to Standards 6.3 and 7.1 the Huntersville facility is deficient in that the concepts of Community Classification Teams or Community-Based alternatives to Confinement have not yet become stated goals of the state's future planning efforts. In fact, replication of the Huntersville model (which in itself is deficient according to the Standards) is the only long-term goal which was presented to the URSA team by the North Carolina correction officials.

As concerns Standard 7.2, the Huntersville facility is deficient in the kind and level of its relationship to community resources rather than its isolation from them. Thus Huntersville and the South Piedmont Area is most dependant upon the community college system and the Department of Vocational Rehabilitation. It has no data on the utilization of the various private and public social service agencies, though such agencies were cited continually in the various conversations while on site. Further, the community resources certainly are not involved in policy development for the facility, nor is there any joint Area planning body with a mandate to lobby for the needs of the incarcerated.

END

7 [illegible]/min