

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

**May 30, 2008**

**10:00-3:00**

**NC Hospital Association**

**Meeting Summary**

**Attendees:**

*Task Force/Steering Committee:* Martha Alexander, Sherry Bradsher, Bert Bennett, Sonya Brown, April Conner, Anne Doolen, Tony Foriest, Robert Gwyther, Paula Harrington, Carol Hoffman, Larry Johnson, Lisa Mares, Sara McEwen, Kevin McDonald, Paul Nagy, Marguerite Peebles, James Ragan, Thomas Savidge, Jane Schairer, DeDe Severino, Greg Stahl, Starleen Scott Robbins, Flo Stein, Anne Thomas, David Turpin, Leza Wainwright, Michael Watson

*Interested Persons:* Melissa Godwin, Sherry Green, Denise Harb, Jessica Herrmann, Jeanette Huffam, Nidu Menon, Virginia Price, Wrenn Rivenbark, Kathleen Thomas, Dale Wileets

*Staff:* Mark Holmes, David Jones, Christine Nielsen, Pam Silberman, Daniel Shive, Berkeley Yorkery

**ALCOHOL AND OTHER DRUG ABUSE AND THEIR IMPACT ON NORTH CAROLINA'S COURT SYSTEM**

*Gregg Stahl, Deputy Director, Administrative Office of the Courts*

The North Carolina criminal justice system is comprised of local law enforcement and a state-funded and unified judicial system and correction system. This is somewhat unique in that most states have county-managed judicial systems which make system-wide congruence difficult. North Carolina, on the other hand, is better able to manage and disseminate statewide system changes like the introduction of structured sentencing in the 1990's.

*Structured Sentencing*

North Carolina's structured sentencing guideline is an award winning, grid-based sentencing structure. Structured sentencing grew out of a need to better understand and project prison populations by allowing judicial discretion within predefined sentencing limits. Better management of the prison population is integral given the increased demand for prison beds. Structured sentencing prioritizes prison beds based on the degree of harm and level of persistent criminal behavior. In other words, more serious crimes and perpetual offenders would receive mandatory prison sentences while sentences for lesser and first time offenders would be left to the judge's discretion. The policy is not rehabilitative-minded, rather it adheres to a "do the crime, do the time" motto. Structured sentencing guidelines have been developed for felonies and misdemeanors.

### *Drug Treatment Courts*

Drug Treatment Courts (DTC) were designed to offer intensive drug treatment services to convicted criminals whose crimes were drug-related. These services are targeted to community-based and intermediate sanctioned offenders under structured sentencing guidelines. As such, many DTC offenders come from the misdemeanor sentencing grid with very limited sentences or on probation. The need for these services is high as 44% of felonies and non-traffic misdemeanors were directly related to drug and alcohol use.

North Carolina utilizes several types of DTCs:

- Adult DTC (24)
- County-funded DWI courts (2)
- Youth DTC (5)
- Family DTC (11)
- Mental Health Courts (until a law enforcement diversion model is developed, AOC does not endorse use of court model)
- Domestic violence courts
- Child support courts

DTCs are not focused on case adjudication as they only come into play after a person is found guilty. As such, they have a therapeutic focus, addressing root causes of behavior. Judges, prosecutors, defense lawyers, probation officers and treatment providers work together to get the individual the help he/she needs.

North Carolina DTCs utilize state and local Memoranda of Understanding (MOUs) to clarify roles and responsibilities as defined by statute, funding streams and local preferences. Treatment dollars are tied to DHHS through MOUs. The AOC provides staffing for DTCs and DHHS provides treatment through local management entities (LME). It is the LME's responsibility for endorsing a provider that is providing a standard of care to meet offender needs.

NC DTCs rely on the full funding and effective operation of partner agencies such as DCC, DMHDDSAS, DJJDP and DSS (and their local entities) to ensure DTC participant receives all services and supports necessary for success. Compliance generally declines as severity of crime increases. As such, intermediate sanction offenders are the target for interventions. Deferred prosecution offenders are likely to succeed but are not currently funded. DTC treatment funding is tied to sentenced offenders.

Family Treatment Courts target parent/guardians whose child(ren) have been removed or who are at risk of removal because of the parent/guardian's drug and/or alcohol addiction. The primary goal of Family DTC is to reunify parents with their children. If the court determines that reunification is not possible, parental rights are terminated. At this point, the parent is also transitioned out of Family DTC. For this reason, retention in Family DTC is lower than in adult and youth DTC.

Youth Drug Treatment Courts are different from adult or family DTCs in that they are a more intensive version of the services and supports already provided by the juvenile court

and DJJDP court counselors. Youth DTC are also unique in that they involve the parent(s)/family in the treatment process. Parent(s) who are determined to have substance abuse/dependency during youth treatment are ordered to obtain an alcohol assessment and to comply with recommended treatment. Youth DTCs are then responsible for monitoring both the youth's and parent(s') recovery plans.

Unique to drug courts is a built in sense of accountability for both the offender and the court. Offenders have frequent court appearances in front of the same judge and management team who are familiar with the offender's history. Rewards and sanctions for program successes (alcohol and drug abstinence) and failures (drug and alcohol use or criminal activity) are immediate. Ultimately, DTC are focused on retention in treatment.

### **DIVISION OF ALCOHOLISM AND CHEMICAL DEPENDENCY PROGRAM**

*Virginia Price, Director, Division of Alcoholism and Chemical Dependency Programs, NC Department of Correction*

*Wrenn Rivenbark, Clinical Director, Division of Alcoholism and Chemical Dependency Programs, NC Department of Correction*

The North Carolina prison population (39,403) would rank as the 21st largest city by population in the state, and admissions are growing rapidly. Growing inmate populations increasingly strain the prison infrastructure. Perhaps nowhere is this excess demand manifested greater than in substance abuse treatment where only one treatment slot is available for every 3 inmates who needs it.

The current prison-based substance abuse treatment system is one of the largest such organizations in the state with over 175 full-time clinical staff. The treatment infrastructure consists of:

- 18 prison-based programs
  - Two 35-day programs
  - Eleven 90-day programs
  - Five 6-12 month programs
- Two private facility 6-12 month programs (one male and one female)
- One community-based residential facility for probationers and parolees (DART Cherry, male only)
  - One 28-day program (100 beds)
  - Two 90-day programs (100 beds each)

Substance abuse and other screenings are conducted in diagnostic centers upon prison admission. The initial screen uses the Substance Abuse Subtle Screening Inventory (SASSI). Based on initial SASSI assessments, it is estimated that 63 percent of the prison population is in need of inpatient substance abuse treatment. However, not all positive SASSI screens are eligible for services. After screening for other physical and mental health issues and considering 'protective population' constraints, only about two-thirds (9,578) of positive screens are ultimately eligible for treatment. An estimate of treatment need in the community corrections population (probationers and parolees) is not as definitive but could total as many as 75,000 individuals. Due to the tremendous excess

demand for services, those patients not matched to treatment beds do not receive any treatment. Currently the biggest need is for 90-day treatment beds.

The DADCP budget of \$16.8 million represents about one-percent of the total DOC annual budget. The overwhelming majority (91.5%) of DADCP funds are allocated to treatment services. On a cost-per-treatment day basis, the two private facilities represent the largest treatment expenditure (\$66 for men and \$88 for women) and the DART-Cherry facility is the least expensive (\$46 for men). Although the relative comparison of treatment cost per treatment type is useful, the Task Force requested that the marginal cost of treatment (e.g., treatment versus no treatment by facility type and gender) be presented at a future meeting.

DADCP identified several needs and next steps necessary to improve the treatment capacity of the prison population in North Carolina. Specifically,

- Establish a female residential treatment facility for probationers and parolees (female DART program)
- Create additional in-prison treatment capacity through staff recruitment and retention. Senate Bill 705 may impact hiring for entry level positions. The Division needs the ability to hire people that are in the registration process but not yet credentialed for entry level positions.
- Pilot a “single mission” treatment facility to target all resources to treatment and rehabilitation. This would mark a departure from current in-prison treatment where substance abuse treatment beds are scattered across facilities.
- Foster closer relationship with DHHS to facilitate continuity of care from prison to the community.

#### **ADDRESSING THE CHILD WELFARE AND SUBSTANCE ABUSE LINK – PART I**

*Sherri Green, Ph.D., LCSW, Professor, Appalachian State University, Perinatal Consultant for the Governor’s Institute for Alcohol and Substance Abuse*

There are an estimated 8.3 million children in the United States with at least one parent who abuse alcohol or illicit drugs. This is particularly alarming as a strong link has been demonstrated between a parent’s substance abuse and their children’s welfare.

Substance abuse was reported by 85% of states as one of the two major problems in families where maltreatment was suspected. Parents who were dependent or had abused alcohol in the past year were:

- More likely to have serious arguments, often yell at and insult other members of household
- Twice as likely to be hit or threatened by spouse/partner
- Three times as likely to hit or threaten spouse/partner

Child welfare agencies face a number of barriers, including inadequate treatment resources, inadequate training for child welfare workers on substance abuse issues and conflicts in time required for substance abuse recovery compared to legislative requirements regarding child permanency.

## **SUBSTANCE ABUSE IN WORK FIRST AND CHILD WELFARE IN NORTH CAROLINA**

*Sara Mims, MBA, Program Administrator for Work First/CPS Policy, NC Division of Social Services*

Work First's (WF) goal is to move families into employment and a self-sufficient lifestyle; however substance abuse (SA) and mental health (MH) issues are significant barriers to accomplishment of these goals. SA screening is mandatory for WF participants whereas MH screening is voluntary. After a positive SA screening, the individual is referred to a Qualified Professional in Substance Abuse (QPSA) based at their LME. If MH treatment is needed, MH screening then becomes mandatory for that individual. If a parent is found ineligible for cash assistance, they remain in the Work First Family Assistance Case, receive Medicaid, stay on the 2 year state time clock, stay on the 5 year federal time clock and participate in an employment program. Their children continue to receive cash assistance, but it is given to a protective payee such as clergy, a family member or a social worker. An applicant/recipient is not deemed "failing to comply with requirements" if appropriate treatment is not available. Class H or I felons are also eligible for assistance under certain criteria.

The total number of individuals receiving WF benefits for SFY 06-07 was 29,350, the vast majority of which (18,189) were single parents with a child under 6. The total caseload as of May 1, 2008 is 24,507 of whom two-thirds (16,904) are children.

The Multiple Response System (MRS) was implemented statewide January 1, 2006 to address the link between parental SA and child abuse/neglect. A WF/CPS initiative has been established in which a QPSA can work in CPS cases, though WF has legislative priority for them. (See presentation by Melissa Godwin for more information regarding the WF/CPS initiative.)

In 2004 the NC General Assembly appropriated funds for a dedicated position within the division and for statewide training for child welfare staff and community partners pertaining to methamphetamine. All 100 counties are developing multi-disciplinary, community Drug Endangered Children teams. The state also developed a Program Improvement Plan to address findings of a federal review of child and family services conducted in March 2007. This includes having more Spanish speaking providers and greater collaboration between the Department of Social Services (DSS) and other child serving agencies.

### **NORTH CAROLINA WORK FIRST/CPS SUBSTANCE ABUSE INITIATIVE**

*Melissa Godwin, MSW, LCSW, Clinical Instructor, Jordan Institute for Families Behavioral Health Resource Program, UNC School of Social Work*

Goals of the WF/CPS initiative include:

- Early identification of SA problems and referral for treatment
- Serving WF applicants, H or I controlled substance felons
- Expanding to CPS cases which are substantiated or in need of services
- Providing voluntary MH screenings

Each LME receives SA Prevention and Treatment Block Grant Funds which support 1-4 full-time QPSAs depending on the location. QPSAs conduct comprehensive clinical interviews and assessments, refer to treatment services and DSS, provide case consultation with DSS staff, track the provision of consumer services relevant to WF participation, and act as a liaison between the LME, treatment providers and the county DSS. The majority of referrals come from WF (41%) with 35% from CPS and 24% from class H & I felons.

A statewide meeting with LME liaisons was held in January 2008 to provide an update and review of the initiative. Regional meetings were held in April 2008 to bring LMEs and DSS on the same page. LMEs, provider agencies and QPSAs will meet in June.

The initiative works best when there is strong communication, onsite availability of the QPSA, a QPSA attending monthly meetings, timely access to services and cross training of substance abuse and DSS staff. The initiative faces many challenges including:

- Limited availability of QPSA to county DSS
- High turnover of QPSA positions
- Limited treatment services available locally
- Inconsistent communication and feedback at the local level between DSS, QPSA and LME

## **ADDRESSING THE CHILD WELFARE AND SUBSTANCE ABUSE LINK – PART II**

*Sherri Green, Ph.D.*

People receiving SA treatment have many additional issues to deal with, including MH, sexual abuse, pregnancy/motherhood, parenting skills and stigma. This is particularly true for women, although pregnancy has been found to be a motivating factor for women to initiate treatment.

Addiction in the family is particularly hard on children and has been linked to:

- Increased depression & intense fear of death
- aggressive behaviors & reduced social competencies
- Anxiety
- Sleep disturbances
- Cognitive delays

The Office for Children and Families within the Department of Health and Human Services developed competitive Regional Partnership Grants (RPG) to address these needs. North Carolina applied for and was awarded \$500,000 per year in grant funds. The NC RPG is currently used to fund a pilot program, Bridges for Families, in Robeson County. Its goal is to increase the capacity of substance abuse treatment providers, courts, and the child welfare system in order to improve the safety, permanency and well-being of children who are in out-of-home placement or at risk of out-of-home placement as a result of their parent's substance abuse. The program is off to a good start and generating much enthusiasm.