Substance Abuse Prevention and Treatment Programs Targeted to Specific Subpopulations

Chapter 5

In addition to the services provided to the general public through the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) system described in Chapter 3, other state agencies fund and/or provide prevention, treatment, and recovery supports. Most of these services are targeted to specific subpopulations, such as youth involved in the juvenile justice system, adults in workforce settings, welfare recipients or those involved with Child Protective Services, adults in the prison system or community corrections, or active or returning military. Sometimes, the services are provided through Local Management Entities (LMEs) or DMHDDSAS under a Memorandum of Agreement (MOA) with another agency. Other times, the services are provided jointly by DMHDDSAS and another state or local agency. In other cases, another state agency or organization provides the services directly.

This chapter is organized around subpopulations. The chapter begins with programs aimed at youth involved in the juvenile justice system and follows with a discussion of services available to adults whether as employees, families involved in Work First and/or Child Protective Services, adults in the criminal justice system, or active or retired military personnel. This report describes the programs and services available to these populations and highlights barriers, if any, which hamper effective prevention, early intervention, treatment, and recovery supports for these targeted populations.

CHILDREN, YOUTH AND YOUNG ADULTS

Youth Involved in the Juvenile Justice System

The Department of Juvenile Justice and Delinquency Prevention (DJJDP) is responsible for providing prevention and intervention services to reduce delinquency, as well as providing treatment services and sanctions for juvenile offenders. Unlike the adult criminal justice system, the juvenile justice system is more rehabilitative in nature. By statute, the juvenile court can use a continuum of graduated sanctions to step up or down the intensity of control based on the risks and needs of the juvenile and his or her family. Juveniles are assessed at disposition to determine their risks and needs. This assessment includes questions about substance use. In 2007, 43% of juveniles were found to need further assessment or treatment for substance use.[1] The assessments are used by court counselors to determine the level and type of supervision a juvenile needs as well as the individual's plan of care. Adjudicated juveniles may be placed into community programs with varying levels of supervision. High-risk offenders may be placed into a Youth Detention Center or Youth Development Center.

Prevention and Intervention Services to Reduce Delinquency

Each county has a Juvenile Crime Prevention Council (JCPC) charged with assessing the need for juvenile delinquency prevention and treatment programs for at-risk

youth and their families.[a] JCPCs are required to assess the risks of youth delinquency in the county and determine the availability of services to meet the needs of youth, including juveniles at risk of delinquency or those involved in juvenile justice system. The JCPCs are also charged with developing recommendations for the County Commissioners for services needed to meet the needs of at-risk youth. However, the array of services offered in particular counties is ultimately contingent on county funding or other funding sources.

Most JCPC funds are used to support broad prevention efforts. Thus, there are only a handful of JCPC-funded programs that focus primarily on providing substance abuse services. These include four programs providing substance abuse prevention services, two providing substance abuse assessments, and ten providing assessments and treatment services. JCPC-funded substance abuse services are geographically maldistributed, with few substance abuse programs available in the eastern parts of the state.[1] Although the majority of JCPCs do not fund programs whose primary purpose is to provide targeted substance abuse services, some do fund programs that provide general psychological assessment services and counseling services.

There are only a handful of programs funded by the Juvenile Crime Prevention Council that focus primarily on providing substance abuse services.

Community-Based Services for Juveniles Involved in the Juvenile Justice System

There are several programs that provide community-based services to youth with substance abuse problems involved in the juvenile justice system. The largest is the Managing Access for Juvenile Offender Resources and Services (MAJORS) program. It is available in a majority of counties throughout the state. The state also has juvenile drug treatment courts that supervise the treatment services for youth involved in the juvenile justice system. In addition, the state is piloting a DMHDDSAS-DJJDP Cross Area Service Program and partnering with Reclaiming Futures.

MAJORS: The MAJORS program provides the majority of substance abuse services for youth involved in the juvenile justice system. MAJORS is funded by DMHDDSAS and administered by DMHDDSAS in collaboration with DJJDP. MAJORS provides specialized community-based substance abuse treatment services to children and adolescents under 18 years of age who are involved in the DJJDP system and have substance abuse problems. Youth are referred to MAJORS by juvenile court counselors or judges.[b] MAJORS provides substance abuse screening and assessment, therapy, life skills training, and ongoing monitoring. MAJORS staff also provide services to youth transitioning from youth development centers and residential programs back to their home communities. MAJORS is currently offered in 31 judicial districts spanning 61 counties.

Juvenile Drug Treatment Courts (JDTCs): JDTCs work with non-violent juvenile offenders whose drug and/or alcohol use is negatively impacting their lives at home, in school, and in the community. JDTCs may require that the child and family participate in treatment, submit to drug testing, appear at court hearings,

a County commissioners in each county appoint members of a JCPC as mandated by General Statute. DJJDP provides funds to the JCPC that are matched by local funding sources.
b Judges in JDTCs often refer youth to MAJORS as part of their court ordered treatment.

and other conditions with the goal of rehabilitation and cessation of delinquent activity. JDTCs include a treatment court judge and court-based team who provide on-going, active involvement and oversight of the youth. The goals are to support youth to help them perform well in school, develop healthy family relationships, and connect to their communities. JDTCs are available in five counties.[c]

In addition to these ongoing initiatives, DMHDDSAS, in collaboration with DJJDP and other agencies, are involved in testing two new models:

DMHDDSAS/DJJDP Cross Area Program: DMHDDSAS and DJJDP are currently developing a new system of providing substance abuse services to juveniles. This new model is a Cross Area Service Program that will provide a single point of contact for juvenile courts and court counselors, reduce over utilization of Community Support, be based on evidence-based practices and address substance use, mental health, and co-occurring disorders. MAJORS programs will function as a substance abuse services provider within the new model. Initially DMHDDSAS intended to pilot this program in each of the four DJJDP regions, but funding was only available to test the model in two regions. The first pilot program begins in January 2009. The University of North Carolina at Greensboro has received a contract to provide project management and to evaluate this model.

To ensure that the DMHDDSAS-DJJDP Cross Area Service Program model is adequately tested to determine its effectiveness before statewide implementation, the Task Force recommended:

Recommendation 5.1

a) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) should continue to work with the Department of Juvenile Justice and Delinquency Prevention (DJJDP) to expand the pilot test of the DMHDDSAS-DJJDP Cross Area Service Program model in two additional DJJDP regions.

b) The North Carolina General Assembly should appropriate $500,000 in recurring funds to the DMHDDSAS to support this pilot.

c) If successful, the DMHDDSAS-DJJDP Cross Area Service Program model should be rolled out statewide.

Reclaiming Futures: Six Reclaiming Futures sites in North Carolina were officially launched in September 2008 by the Kate B. Reynolds Charitable Trust and the Robert Wood Johnson Foundation.[d] The Robert Wood Johnson Foundation originally provided resources to 10 founding communities to create and test a 6-step model that helps young people in trouble with drugs, alcohol, and crime by reinventing

c JDTCs are located in: Durham (Dist. 14), Forsyth (Dist. 21), Mecklenburg (Dist. 26), Rowan (Dist. 19C) and Wake (Dist. 10).
d More information about reclaiming futures is available at: www.reclaimingfutures.org.

the way police, courts, detention facilities, treatment providers, and the community work together to meet this urgent need. While communities need to hold teens accountable for their actions, they must provide drug and alcohol treatment and support in the community. To be effective, treatment programs must work in a coordinated fashion and use evidence-based practices. They also must involve families, address cultural, age, and gender issues, and coordinate with judges, probation programs, and schools. The Reclaiming Futures framework and the goals of the DMHDDSAS-DJJDP Cross Area Service Program model are in alignment. DMHDDSAS and DJJDP will be working closely with these sites over the next two years.

Institutional Services

To be effective, treatment programs must work in a coordinated fashion and use evidence-based practices.

At the institutional level, juveniles in juvenile detention centers or youth detention centers are assessed for substance abuse problems and can receive substance abuse services.

Juvenile Detention Centers (JDCs): JDCs are short-term, secure facilities for youth who are waiting to go to court, being detained as part of a dispositional sanction, awaiting placement in a Youth Development Center (YDC), or needing secure custody until placement in an appropriate community setting can be found. Using DMHDDSAS funding, DHHS, through Memoranda of Agreement with DJJDP and the local county-operated detention centers, contracts with substance abuse professionals to provide assessments and counseling (group and individual) to youth detained in the detention facilities. There are nine state-operated and four county-operated detention centers in the state.[e]

Youth Development Centers (YDCs): YDCs are state-operated residential facilities for juvenile offenders. YDCs provide screening and assessment services, medical and psychiatric services, individual and group counseling, psycho-educational groups, and intensive therapeutic interventions. There are five long-existing YDCs and four new YDCs that have opened as replacement beds.[f] The MAJORS program provides referral and aftercare services for participating youth as they are released from YDCs.

ADULTS

Employees

Behavioral health problems often affect individuals' ability to be productive employees. Individuals with substance abuse problems may have performance or conduct problems—including attendance problems or diminished productivity—that adversely impact their job performance. Additionally, employees with substance abuse problems may be at increased risks for work related accidents and health care

e State JDCs are located in the following counties: Alexander, Buncombe, Cumberland, Gaston, New Hanover, Perquimans, Pitt, Richmond and Wake. County-operated JDCs are located in Durham, Forsythe, Mecklenburg, and Guilford counties.

f Current YDCs include: C.A. Dillon, Samarkand, Swannanoa, Dobbs, and Stonewall Jackson youth detention centers. These facilities will be replaced by a 96-bed facility in Cabarrus County and three 36-bed facilities in Chatham, Lenoir and Edgecombe counties.

costs which impact employer costs. Loss of productivity, depression, and alcohol and drug addiction cost businesses $287 billion each year.[2] Many companies turn to employee assistance programs (EAPs) to help them identify and resolve employee productivity problems because of the large impact that employees' personal concerns, including substance abuse, can have on a business's bottom line.

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Employee Assistance Programs (EAP) are worksite-based programs that help identify and resolve productivity problems with employees. Employees identified with problems affecting their job performance are offered EAP assistance. EAPs use a combination of problem identification, assessment, constructive confrontation, and referral for diagnosis and treatment. For example, if an assessment reveals that an employee has a problem, such as substance abuse, the EAP then provides a referral for diagnosis, treatment, and assistance and may provide case monitoring and follow-up services. Ensuring the people with substance abuse problems obtain treatment helps the work environment. Studies show that reported job problems such as incomplete work, absenteeism, tardiness, work-related injuries, mistakes, and disagreements among employees are cut by an average of 75% among employees who have received treatment.[3]

Two EAP models exist: the Medical/Network Model, typically offered by some type of insurance company, and the Human Resources/Worksite Model, offered by an EAP service organization working closely with the company. Worksite Models are more visible in the workplace, have greater utilization, received more supervisory referrals, and identified more employee substance abuse cases than the Medical Model.[4] However the Medical Model may cost less. A company's choice of EAP (if any) depends on many factors including the size and location of the firm, availability and fit of a network or worksite model, and cost.

Finding an affordable Worksite Model EAP can be quite challenging, especially for small rural firms. Many of these companies would benefit from using a local EAP service organization which has strong relationships with local services providers and can quickly respond in person to worksite concerns.

Recommendation 5.2:

a) As part of the annual community assessment, Local Management Entities (LME) should explore and report on the need for Employee Assistance Program (EAP) services by employers in their catchment area and the availability of organizations providing EAP services to meet this need.

b) If the LME determines that there are insufficient EAP providers to address the needs of employers, then the LMEs should work with the local Chambers of Commerce, other business organizations, and others to develop a strategy to promote the availability of EAP services in the community.

North Carolina has a "title" licensure law that requires professionals who hold themselves out as Licensed Employee Assistance Professionals to be licensed by the North Carolina Board of Employee Assistance Professionals (NCBEAP). However, other non-licensed individuals also offer EAP services. As long as these individuals do not hold themselves out to be EAP professionals, North Carolina law does not require these individuals to have specific EAP training. Additionally, companies that profess to offer EAP services do not always provide the six core services, defined in the statute. These include: 1) Expert consultation and training of appropriate persons in the identification and resolution of job performance issues related to the employees' personal concerns; 2) The confidential, appropriate, and timely assessment of problems; 3) Short-term problem resolution for issues that do not require clinical counseling or treatment; 4) Referrals for appropriate diagnosis, treatment, and assistance to certified or licensed professionals when clinical counseling or treatment is required; 5) Establishment of linkages between workplace and community resources that provide such services; and 6) Follow-up services for employees and dependents who use such services.[g]

To ensure that professionals providing EAP services have actual training to provide the services and that EAP providers have the capability of providing all of the statutorily defined services, the Task Force recommends:

Recommendation 5.3:

The North Carolina General Assembly should ensure that by 2014:

a) All individuals advertising and promoting themselves as providing Employee Assistance Program (EAP) services in North Carolina must be licensed or have EAP specific training and work under the supervision of professionals licensed to provide EAP services by the North Carolina Board of Employee Assistance Professionals.

b) All programs or organizations located in North Carolina that advertise, or promote themselves, as providers of EAP services should be able to document that they have the capability of providing the core services as defined in statute and that the services are provided under the supervision of North Carolina licensed EAP staff.

Work First Recipients or Those Involved in the Child Protective Services System

The North Carolina Division of Social Services (DSS), within the North Carolina Department of Health and Human Services, is responsible for administering the Work First and Child Protective Services (CPS) system. The goal of the Work First program is to move families with dependent children into employment and self-sufficiency. However, substance abuse and mental health issues are significant barriers to self-sufficiency. All Work First applicants and recipients are screened

g NCGS § 90-500(3).

for possible substance abuse problems. If the outcome of the screening is positive, the individual is referred to a Qualified Professional in Substance Abuse (QPSA)[h] for additional assessment and treatment if deemed appropriate by the QPSA. If an individual refuses to be screened or is non-compliant once referred to the QPSA, the individual is ineligible to receive Work First benefits.[i]

Substance abuse problems also contribute to cases of child abuse and neglect. In SFY 2006-2007, more than one-fourth (27.6%) of adults in the North Carolina CPS system with a finding of substantiated child abuse or neglect or services needed, had alcohol or substance abuse problems. More than one-third (37%) of the adults who had their children removed and placed in foster care also had alcohol or substance abuse problems.[5] This is a very low estimate as the current state data system only lists the primary factor contributing to abuse, neglect, or removal from the home. Substance use or abuse is often listed as the second or third factor leading the substantiated cases of child abuse or neglect. According to studies by the Child Welfare League of America, alcohol and/or drug abuse are factors in the placement of at least 75% of children entering foster care.[6]

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There are a number of different programs or services available to identify and treat adults with substance abuse problems who are receiving Work First or involved in the CPS system. The Work First/CPS Substance Abuse Initiative helps provide assessments, link adults into community treatment, provide care coordination, and provide case consultation with the Department of Social Services. District courts also supervise treatment for some adults who have lost, or are at risk of losing their children due to abuse, neglect or dependence. In these instances, substance abuse treatment may be required as a condition of reunification. In addition, North Carolina is piloting a new, more coordinated system to provide services to families with children at risk of out of home placements or who have been placed out-of-home due to their parents' substance use. This initiative is called Bridges for Families. The state also offers more intensive residential services to some women and children.

Community Based Services

The Work First/CPS Substance Abuse Initiative was designed to provide early identification of Work First recipients who have substance abuse problems severe enough to impact their ability to become self-sufficient. This initiative was also designed to help parents involved with CPS who have substance abuse problems engage in appropriate treatment. This program is funded by DMHDDSAS, administered by the LMEs, and operates in accordance with a memorandum of

h A Qualified Professional in Substance Abuse includes: an individual who holds a license, provisional license or certification from the NC Substance Abuse Professional Practice Board; is a graduate of a college or university with a Masters degree in a human service field and who has one year of full-time, post-graduate degree accumulated supervised experience in alcoholism and drug abuse counseling; is a graduate of a college or university with a bachelor's degree in a human service field and who has two years of full-time, post-bachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling; or is a graduate of a college or university with a bachelor's degree in a field other than human services and who has four years of full-time, postbachelor's degree accumulated supervised experience in alcoholism and drug abuse counseling.

i North Carolina General Statutes. § 108A-29.1. substance abuse treatment required; drug testing for work first program recipients.

agreement between DMHDDSAS and DSS at the state and local levels. Each LME receives funding to support this initiative. Qualified Professionals in Substance Abuse (QPSAs) are outstationed, when possible, in the local departments of social services to provide screening, assessment, care coordination, and referral to treatment. Ideally, QPSAs, LMEs, and the Work First case manager or CPS worker jointly develop a substance abuse treatment plan for the family to ensure success.

Substance abuse services are typically provided by local substance abuse professionals under contract with the LMEs. However, in many communities, there is a lack of coordination between the QPSAs, LMEs, and DSS workers which hampers the most effective provision of services to these families. Further, there are insufficient substance abuse resources to meet the needs of all families who need services. There is high turnover of QPSA staff and a limited availability of QPSA staff for county DSS offices. Further, limited treatment services are available locally.[7] The federal government conducted a review of the North Carolina Child and Family Services system in March 2007 and identified the lack of substance abuse services—both in terms of accessibility and the array of services offered—as a primary concern.[5]

To address the shortage of QPSAs in the Work First/CPS program, the Task Force recommended:

Recommendation 5.4

The North Carolina General Assembly should appropriate $475,000 in recurring funds to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for seven full-time Licensed Clinical Addiction Specialists to be distributed to the Local Management Entities with the highest number of referrals for the Work First, Class H or I Controlled Substance felons, and Child Protective Services populations compared to existing Qualified Professionals in Substance Abuse.

District Court: District courts judges preside over civil abuse, neglect, and dependency hearings. Parents whose children have been removed from their care in abuse, neglect or dependency cases cannot regain custody of their children until they complete a recommended course of treatment and/or other services and stipulations. The Administrative Office of the Courts (AOC) has entered into a Memorandum of Agreement with the Division of Social Services regarding coordination of efforts and responsibilities related to those children and families served in district court in abuse, neglect, or dependency cases.

While District Courts typically serve families with cases of abuse, neglect, or dependency, Family Drug Treatment Courts (FDTCs) are also available in some judicial districts. FDTCs work with parents who have been determined to be addicted or have a high likelihood of addiction to drugs and/or alcohol and who have lost custody or are in danger of losing custody of their children due to abuse and/or neglect. FDTC participants are also assessed for domestic violence, trauma, and other mental health concerns and are referred to treatment. Although the FDTC cannot promise that the children will be returned to the parents if they

successfully complete treatment, a parent who is successful in the FDTC is much more likely to be determined by DSS and the Abuse, Neglect, and Dependency Court to be fit to have their child(ren) returned. Parents who do not comply with the requirements of the FDTC will be sanctioned by the court and may be ordered to serve jail time.[j,k]

Bridges for Families: In addition to the ongoing services available through the Work First/CPS Substance Abuse Initiative or offered in conjunction with abuse, neglect and dependency cases, North Carolina obtained a five-year, $2.5 million grant from the US Department of Health and Human Services for Children and Families to provide more coordinated substance abuse treatment and services to families with children at risk of out-of-home placement due to their caretaker's substance abuse problems. The initiative, Bridges for Families, is being piloted in Robeson County. It is an attempt to create a broad-based community collaborative that implements evidence-based programs and practices involving the family drug treatment courts, LME, and child welfare programs.[8] This initiative is in the early stages of implementation and will be evaluated. If successful, the state will determine whether it should be implemented statewide.

Residential Services

While offering a comprehensive array of outpatient services will help meet the needs of many people with addiction disorders, some individuals need more intensive services than can be offered on an outpatient basis. DMHDDSAS offers a limited number of residential placements for certain women with more intensive needs through CASAWORKS for Families and the Maternal and Perinatal Substance Abuse Initiative.

While offering a comprehensive array of outpatient services will help meet the needs of many people with addiction disorders, some individuals need more intensive services than can be offered on an outpatient basis.

CASAWORKS for Families Residential Initiative: The NC CASAWORKS for Families Residential Initiative is a collaborative project between DMHDDSAS and DSS. This Initiative supports nine comprehensive residential substance abuse programs for Work First women and their children. To help Work First families become economically self-sufficient, this program integrates gender-specific substance abuse treatment and job readiness supports, vocational training, and employment.[9]

Maternal and Perinatal Substance Abuse Initiative: There are currently 21 perinatal and maternal substance abuse residential programs, 12 residential, and 9 comprehensive outpatient. On average, about half of the women in the program are mandated into treatment, and of these, 75% were mandated into treatment by DSS.[8] These programs provide comprehensive family-focused, gender-specific substance abuse services that include, but are not limited to, screening, assessment, case management, outpatient services, parenting skills, residential care, referrals for preventive and primary care, and referrals for appropriate interventions for

j FDTCs are located in: Buncombe (Dist. 28), Chatham (Dist. 15B), Cumberland (Dist. 12), Durham (Dist. 14), Gaston (Dist. 27A), Halifax (Dist. 6A), Lenoir (Dist. 8), Mecklenburg (Dist. 26), Orange (Dist. 15B), Robeson (Dist. 16B), Union (Dist. 20), and Wayne (Dist.8).

k FDTC team members include: Juvenile Court Judge, DSS/County Attorney, Parent Attorney, Guardian ad Litem, County Department of Social Services staff, FDTC Coordinator and Treatment professional(s). The court team may also include professionals from the Health Department, Housing or others.

the children. The goal of this initiative is to help the women achieve abstinence, improve birth outcomes, develop and strengthen parenting skills, establish a stable living environment free of domestic or family violence, and develop a safety net of recovery and emotional support.

Adults Involved the Criminal Justice System

Use and abuse of alcohol and other drugs can contribute to disorderly and illegal behaviors. Many of the people arrested for criminal activities have underlying addiction disorders. Driving while impaired is a criminal offense; more than one-quarter of motor vehicle fatalities involved the use of alcohol. Approximately 90% of the criminals who enter the prison system have a substance abuse problem, and 63% required residential treatment.[10] In response to these problems, North Carolina agencies have developed special substance abuse assessment, treatment and monitoring programs for people convicted of driving while impaired, including those who have been convicted and are serving their sentences or probation in the community (community services) as well as for those serving active prison sentences (institutional services).

Approximately 90% of the criminals who enter the prison system have a substance abuse problem, and 63% require residential treatment.

There are two major considerations which significantly impact on the success of substance abuse treatment for adult offenders. First, sufficient resources must be available to pay for the necessary treatment services and supervision. Second, individuals must be offered and stay in treatment for long enough periods of time for the treatment to be effective.

Four national studies, which began as early as 1968 and ended as recently as 1995, assessed approximately 70,000 patients, 40% to 50% of whom were court ordered or otherwise mandated into residential and outpatient treatment programs. Two major findings emerged. First, the length of time a patient spent in treatment was a reliable predictor of his or her post-treatment performance. Beyond a 90-day threshold, treatment outcomes improved in direct relation to the length of time spent in treatment, with one year generally found to be the minimum effective duration of treatment. Second, coerced patients tended to stay in treatment longer than their non-coerced counterparts. In short, the longer a patient stays in drug treatment, the better the outcome.[11-14]

Community-Based Services for People Convicted of Driving While Impaired

In 1983, the North Carolina General Assembly enacted the Safe Roads Act, which repealed all previous laws on drunk driving in North Carolina and replaced them with a single offense of Driving While Impaired (DWI). As a result of this change, North Carolina developed a substance abuse intervention system for individuals with DWI offenses. The system requires individuals undergo a clinical substance abuse assessment and then complete an educational program or treatment as determined by the assessment. While DWI offenders use the court system like others involved in the criminal system, the treatment system for DWI offenders has evolved as its own system, largely because the vast majority of DWI offenders receive treatment through the private sector, unlike other adult criminal offenders receiving publicly financed services.

In North Carolina, 5.4% of motor vehicle crashes are committed by people who are under the influence or alcohol or drugs.[15] However, 29% of motor vehicle fatalities were alcohol-related in 2007—an increase of 66 alcohol-impaired driving fatalities from the previous year—representing the largest increase in number of fatalities among all the states.[16] Individuals who have either been convicted of driving while impaired, or are under 21 and have been found to be under the under the influence of alcohol or drugs while driving, have their drivers licenses revoked.

In order to have their licenses restored by the Division of Motor Vehicles (DMV), individuals must have a substance abuse assessment and complete any required education or treatment services. Individuals who do not have significant risk factors or clinical symptoms of a substance use disorder must complete an educational intervention called Alcohol and Drug Education Traffic School (ADETS). Individuals with a substance use disorder must complete substance abuse treatment which may include short-term outpatient, longer-term outpatient, day treatment/intensive outpatient, or residential/inpatient treatment. In SFY 2007, of the 28,097 assessments reported, 84% were referred to some form of substance abuse treatment.[17] The majority of these services are provided through private agencies and paid for by the individual. Slightly over 2% of individuals received publicly-funded substance abuse services. DMHDDSAS authorizes and monitors agencies that provide DWI-related services and verifies the completion of services prior to the DMV considering restoration of an individual's driver's license.

Twenty-nine percent of motor vehicle fatalities were alcohol-related in 2007—an increase of 66 alcohol-impaired driving fatalities from the previous year—representing the largest increase in number of fatalities among all the states.

Community Services for other Adult Offenders

Most adult offenders remain in the community where they are supervised and referred to services and supports that are provided by a variety of state, local, and non-profit agencies. There are multiple agencies involved in the provision of services, oversight, or care coordination for adult offenders with substance abuse disorders. For example, Treatment Accountability for Safer Communities program (TASC) provides screening, assessment, and care management services. This program is administered by DMHDDSAS. The Criminal Justice Partnership Program (CJPP) provides grants to support community-based programs, including some programs that address the needs of people with substance abuse problems. This is funded through the Division of Community Corrections (DCC). In addition, some counties operate adult drug treatment courts. These courts are operated through the Administrative Office of the Courts (AOC).

These three agencies, DCC, AOC, and DMHDDSAS, developed an interagency Memorandum of Agreement to improve communication and coordination of the adult offenders with substance abuse disorders. This interagency coordination occurs through the Offender Management Model (OMM), a team-based approach to manage the treatment and ongoing monitoring of offenders sentenced to

intermediate punishments or community punishments or people who have been released from prison who are completing a treatment program.[l]

Under the OMM model, the Courts (primarily through existing Drug Treatment Courts) provide judicial oversight and intervention. The DCC serves as the lead agency for adult criminal offenders who remain in the community. They provide supervision to offenders on probation or who were sentenced to the community service work program. To remain in the community, probationers must work, pay taxes and restitution, support their families, perform community services, and participate in treatment or other order support services. DMHDDSAS provides care management through TASC (Treatment Accountability for Safer Communities), overseeing all treatment support services including screening, assessment, and treatment services. DCC, through the Criminal Justice Partnership Program, provides and/or funds treatment services in local communities.[m] These programs are described in more detail below.

In SFY 2008, Treatment Accountability for Safer Communities provided screening, assessment, and case management services for individuals involved in the criminal justice system who needed substance abuse and/or mental health services…however, more than 75,000 people may need these services.

Treatment Accountability for Safer Communities (TASC): TASC is administered by DMHDDSAS and provides screening, assessment, and care management services for individuals involved in the criminal justice system who needed substance abuse and/or mental health services.[18] TASC care managers work in conjunction with partner agency staff to link clients to appropriate levels of treatment and support, using the authority of the criminal justice system to engage and retain people in treatment with the goal of reducing drug use and corresponding criminal behavior. An NC Sentencing and Policy Advisory Commission recidivism study found that adult offenders who received TASC services and completed their treatment were less likely to be rearrested over the next 2 years.[19]

TASC services are available in all 100 counties throughout the state. In SFY 2008, TASC served more than 18,000 people but did not have the resources to serve all in need. In SFY 2008, the Division of Community Corrections supervised 24,773 offenders convicted of non-trafficking drug offenses; however, as many as 75,710

l Intermediate and community levels of punishment are outlined in North Carolina's structured sentencing guidelines. An intermediate punishment requires that the offender be placed on supervised probation with one or more of the following special conditions: split sentence, electronic house arrest, intensive supervision, day reporting center and drug treatment court. Generally, offenders must follow strict rules, work, pay restitution, and participate in drug or other types of treatment. A community punishment is generally thought of basic probation (does not involve prison, jail time or an intermediate punishment). A community punishment may also include fines, restitution, community service and/or substance abuse treatment.

m Case management for adult offenders, provided by probation officers, includes general supervision, monitoring to ensure compliance with Court orders, providing feedback to the Court, and connecting offenders with services in the community. Care management for adult offenders, provided by TASC, includes securing and coordinating mental health and substance abuse services.

people may need substance abuse services.[n] To adequately begin serving this population, TASC needs an additional 258 care managers with a caseload of 60 offenders and 18 additional clinical supervisors to provide supervision to care managers. This will cost approximately $14 million. The North Carolina General Assembly should incrementally increase appropriations to the TASC program by $2.8 million over five years to provide drug treatment to offenders who have been placed on probation or released back into the community.

To further expand the availability of TASC services, the Task Force recommends:

Recommendation 5.5

The North Carolina General Assembly should appropriate $2.8 million in recurring funds in SFY 2010 and an additional $2.8 million in recurring funds in SFY 2011 to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to expand the availability of Treatment Accountability for Safer Communities (TASC) program services.

Criminal Justice Partnership Program (CJPP): CJPP provides grants to support community-based programs aimed at reducing recidivism, probation revocations, alcoholism and other drug dependencies, with the goal of decreasing the costs of incarceration to the state and counties. DCC administers the CJPP program. TASC care managers may link offenders to programs funded by CJPP in their community. The eligible offender population includes adult sentenced offenders who receive an intermediate punishment, post-release offenders, and parole offenders.

The Criminal Justice Partnership Program provides grants to support community-based programs aimed at reducing recidivism, probation revocations, alcoholism, and other drug dependencies, with the goal of increasing the costs of incarceration to the state and counties.

There are 83 CJPP funded programs operating in 93 counties. CJPP operates three types of programs: Day Reporting Centers, Resource Centers, and Satellite Substance Abuse Programs.[o] Services offered through CJPP programs include combinations of substance abuse treatment, drug testing, cognitive behavioral interventions, employment assistance, and academic/vocational education assistance.[20] In some small, rural counties, particularly in the eastern and western parts of the state, CJPP resources represent the sole source of substance abuse treatment services for offenders.

n The US Department of Justice estimated that about 67% of people on probation "can be characterized as alcohol- or drug- involved offenders." (Bureau of Justice Statistics, Special Report. Substance Abuse and Treatment of Adults on Probation, 1995. March 1998. NCJ 166611). There are currently approximately 113,000 people on probation in North Carolina, which suggests that as many as 75,710 people on probation may need substance abuse services. TASC is currently serving only 18,045 people.

o *Day Reporting Centers* (DRCs) offer a variety of treatment and support services, including drug screening, regular and intensive outpatient treatment services, cognitive behavioral interventions, education and employment assistance, and supportive and aftercare services. DRCs are open both day and night to facilitate compliance and to work within the schedules of offenders. DCC officers are housed within each center, providing a measure of control alongside treatment. There are currently 20 DRCs located throughout the state.
Resource Centers are similar to DRCs except that they are not required to offer a set of core services. Services are based on community need and funding constraints. There are currently 18 resources centers operating in the state.
Satellite Substance Abuse (SSA) Programs provide a central point of contact for substance abuse assessment, treatment, and aftercare services. Services are provided through contractual agreements with substance abuse treatment providers in the community. DCC officers provide oversight and program compliance. There are 44 SSA programs throughout the state.

To further expand the availability of CJPP-funded substance abuse services, the Task Force recommends:

Recommendation 5.6

The North Carolina General Assembly should appropriate $500,000 in recurring funds in SFY 2010 to the Division of Community Corrections to expand the availability of Criminal Justice Partnership Program (CJPP)-funded substance abuse services.

Adult Drug Treatment Courts (DTCs): Adult drug treatment courts operate in 21 counties and receive referrals from public defenders, judges, prosecutors, probation officers, and/or private defense attorneys.[p] Each referral is screened for legal eligibility based on local court policies and likelihood of chemical dependency based upon the Substance Abuse Subtle Screening Inventory II (SASSI). All Adult DTCs limit eligibility to individuals addicted to alcohol and/or other drugs. DTCs use a court-based legal supervision and treatment team to provide intensive case management and judicial supervision to ensure that the individuals remain active in treatment and other support services. Individuals who are involved in the DTCs are subject to frequent alcohol and drug testing and receive sanctions and incentives based upon their compliance with the court expectations.

Individuals who are involved in the drug treatment courts are subject to frequent alcohol and drug testing and receive sanctions and incentives based upon their compliance with the court expectations.

To better match DTC eligibility to the public treatment available for offenders, Adult DTCs, funded by the AOC, target sentenced, intermediate punishment offenders or community punishment offenders at risk of revocation. Those adult DTCs that admit DWI offenders target sentenced Level 1 and 2 DWI offenders (highest risk) who have an accompanying charge of Driving While License Revoked.

Typically, North Carolina's drug treatment courts begin through federal grants. This is done to provide the community an opportunity to launch the court and work through any systemic challenges. However, once implemented the courts require on-going funding from the state. Providing funding solely to the AOC to sustain the work of the drug treatment courts is not sufficient; for drug treatment courts to be successful, the services that support such courts (treatment services, oversight, and monitoring) must also receive additional funding.

To ensure that sufficient resources are available to fund additional drug treatment courts, the Task Force recommended:

p Adult DTCs are located in: Avery (Dist. 24), Buncombe (Dist. 28), Brunswick (Dist. 13B), Burke (Dist. 25), Carteret (Dist. 3B), Caswell (Dist 9A), Catawba (Dist. 25),Craven (Dist. 3B), Cumberland (Dist. 12), Durham (Dist. 14), Forsyth (Dist. 21), Guilford--one in Greensboro and one in High Point (Dist. 18), McDowell (Dist. 29A), Mecklenburg--five criminal DTCs (Dist. 26), New Hanover (Dist. 5), Person (Dist 9A), Pitt (Dist. 3A), Orange (Dist. 15B), Randolph (Dist 19B), Rutherford (Dist. 29A), and Wake (Dist. 10). Adult DTC team members include: District or Superior Court Judge, Assistant District Attorney, Defense Attorney, Specialized Probation Officer, TASC provider, DTC Coordinator and Treatment professional. The courts may also include professionals from the Health Department, Housing, Vocational/Rehabilitation, or others.

Recommendation 5.7 (PRIORITY RECOMMENDATION)

a) The North Carolina General Assembly should increase the annual appropriations to the Administrative Office of the Courts to fund eight new adult drug treatment courts. The amount of the increased appropriations should be as follows:

1) $500,000 in recurring funds in SFY 2010 for four new adult drug treatment court coordinators

2) $500,000 in recurring funds in SFY 2011 for four new adult drug treatment court coordinators

b) The North Carolina General Assembly should increase the appropriations to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services by $570,000 in recurring funds in SFY 2010 and an additional $570,000 in recurring funds in SFY 2011 to support treatment services for adult drug treatment court participants.

c) The North Carolina General Assembly should increase the annual appropriations to the Department of Correction, Division of Community Corrections, by $269,940 in recurring funds in SFY 2010 to fund four new probation officers and an additional $269,940 in recurring funds in SFY 2011 to fund an additional four probation officers to support the new drug treatment courts.

Institutional Services

At the institutional level, most prisoners receive an assessment upon entering prison in North Carolina.[q] Prison officials are trained through the Substance Abuse Screening and Intervention Program to provide substance abuse screening and assessments in order to identify appropriate treatment services.[r,21] Of the 23,111 offenders screened in SFY 2007, 63% needed residential substance abuse treatment, and another 23% needed some other substance abuse intervention.[10] In total, almost 90% of the offenders who were screened had an underlying substance abuse problem. The Division of Alcoholism and Chemical Dependency (DACDP) provides different levels of substance abuse services, depending on the needs of the prisoners: DACDP intervention-48 programs, intermediate DACDP programs, long-term treatment programs, and DART-Cherry therapeutic community.

q In SFY 2007, 86% of all offenders who entered prison were screened, using the Substance Abuse Subtle Screening Inventory (SASSI), a validated screening instrument. Some prisoners are not screened when they enter prison due to serious health conditions, language barriers, or other issues.

r The Substance Abuse Screening and Intervention Program (SASIP) is a statewide program that provides drug testing lab services, training for DCC officers and outside agencies on drug testing procedures, education of DCC officers on drugs and other substance abuse issues, and trend monitoring.[33] (Division of Community Corrections, North Carolina Department of Correction. Coming together: annual report of program services, FY2005-2006. http://www.doc.state.nc.us/dcc/annualreport/2005-06Annual%20Rpt%20Programs.pdf. Accessed March 28, 2008.)

DACDP Intervention-48: The DACDP Intervention-48 program is designed to provide 48 hours of content over a period of six to eight weeks for male and female prison inmates determined to be substance abusers, but not dependent. This program is under implementation across the prison system in late summer and fall of 2008.

Intermediate DACDP programs: Intermediate programs range from 35-180 days and are available in 13 residential settings located in prisons across the state for male and female prison inmates.

Long-term treatment programs: There are 2 types of long-term treatment programs: those offered directly in the prison system (5 programs) and those provided under contract with private treatment facilities (2 facilities). Each is designed to treat seriously addicted male and female prison inmates. Participants remain in long-term treatment programs for 180-365 days.[22]

Because of limited resources, only about one-third of the prisoners who need services receive them.

DART-Cherry Therapeutic Community: DART-Cherry is a community-based residential treatment program for male probationers/parolees. DART offers one 28-day program (100 beds), and two 90-day programs (100 beds each). The North Carolina General Assembly funded a female version of this program in Black Mountain for 50 beds in 2008.

Altogether there were 1,490 treatment beds in SFY 2007. Between SFY 2001-2007, the prison population grew by 20% (from 31,899 to 38,423), but the treatment beds declined by 21% (from 1,898 to 1,490).[21] Because of limited resources, only about one-third of the prisoners who need services receive them.

Other states have had success developing single mission treatment prisons for inmates with substance abuse addiction disorders. The Sheridan drug prison and reentry program in Illinois has been shown to be successful in reducing recidivism among offenders (either re-arrest or re-incarcerations). The Sheridan prison offers a therapeutic community that provides drug treatment and cognitive skills development, as well as mental health services. Inmates are also required to participate in job preparedness programs prior to release to give them the skills needed find work. TASC works with offenders while still in prison to develop reentry plans including ongoing treatment and recovery supports. After the first year of operation, an evaluation found that those released from the Sheridan drug prison and reentry program had a 21% lower risk of re-arrest for a new crime, with those who had been in the program for longer periods of time experiencing an even lower re-arrest rate. Offenders who had nine or more months of the Sheridan program also had a much lower risk (49%) of re-incarceration than a comparison group.[23]

In order to more adequately address the needs of prisoners with substance abuse problems, the Task Force recommended:

Recommendation 5.8:

The North Carolina General Assembly should:

a) **Appropriate $1,500,000 in recurring funds in FY 2010 to the North Carolina Department of Correction, Division of Alcoholism and Chemical Dependency Programs, to expand the availability of state substance abuse services to adults within the prison system.**

b) **Appropriate $2,000,000 in recurring funds in FY 2010 to the Department of Correction, Division of Alcoholism and Chemical Dependency Programs, to build one additional residential treatment facility for female adult offenders with substance abuse and addiction problems who are on probation or parole.**

c) **Appropriate $1,000,000 in recurring funds in FY 2010 to the North Carolina Department of Correction, Division of Alcoholism and Chemical Dependency Programs, to expand the existing residential treatment facility at DART Cherry in Goldsboro for adult male offenders with substance abuse and addiction problems who are on probation and parole.**

d) **Appropriate $12,500 in non-recurring funds to the Department of Correction, Division of Alcoholism and Chemical Dependency Programs, to study the feasibility of establishing a single mission drug treatment and re-entry prison for offenders with substance abuse and addiction problems.**

MILITARY PERSONNEL

North Carolina has the fourth largest number of military personnel in the country. In North Carolina, there are currently 107,000 active duty personnel based at one of seven military bases or deployed overseas.[24] Because of base closings and consolidations across the nation, North Carolina is likely to receive another 45,000 active duty members by 2011. There are another 11,500 soldiers, marines, and airmen who live in North Carolina and serve in the National Guard or reserves. Most of the active duty military, reserves, and National Guard have served in Operation Iraqi Freedom (OIF) or Operation Enduring Freedom (OEF) in Afghanistan. In addition to these men and women actively serving in our armed forces, we have another 773,630 veterans who live in North Carolina.

Alcohol and other drug use is a serious problem for many in the military.

Alcohol and other drug use is a serious problem for many in the military. Almost one-fourth (24%) of active duty military personnel reported alcohol dependence symptoms in a recent Department of Defense anonymous survey of health-related behaviors among active duty personnel.[25] Similarly, 24% of the returning National Guard reported alcohol abuse.[26] The rate of all psychological problems, including substance abuse, increases with repeated deployments. As of March 2007, of the 1.4 million United States' military troops that have served in Iraq or Afghanistan, approximately 30% have been deployed more than once.[27] Nearly 25% of National Guard and Reservists have been deployed more than once.[27] Further, many of the returning veterans report post-traumatic stress disorder, depression and substance abuse disorders. A study of more than 88,000 soldiers who returned from active duty in Iraq showed that 20.3% of active duty soldiers and 42.4% of the National

Guard and reserve component were identified as needing mental health or substance abuse treatment post-deployment.[28]

TRICARE provides health care services to active duty service members, retirees, their families, survivors and certain other individuals connected to the military as well as National Guard and Reserve members while they are active. TRICARE, through its contract with the Department of Defense, provides treatment at military treatment facilities or through a broader civilian provider network. In addition to TRICARE, the Veterans Administration (VA) provides health services to certain veterans. Returning OEF/OIF veterans are entitled to five years of free care after returning from active duty for health problems related to their military service.[29] Veterans who have a combat-related disability may continue to receive health care services after the initial five-year period, but may have to pay income-related copayments. There are four VA medical centers, three outpatient clinics, six community-based outpatient clinics, and five vet centers in North Carolina.[s] Both the VA and the active military have moved to integrating mental health and substance abuse services into the primary care setting. In North Carolina, three VA centers have collocated mental health and substance abuse professionals in the primary care setting, making these services more accessible to a broader array of veterans.[30]

While some mental health and substance abuse services are available to active and returning military personnel and their families, these services are not sufficient to address all of the needs of the returning veterans.

While some services are available to active and returning military personnel and their families, these services are not sufficient to address all of the needs of the returning veterans. The state and federal governments, community agencies, and other partners have been working together since 2006 as part of the North Carolina Focus on Returning Combat Veterans and their Families. The goal of this initiative is to develop broader systems of care for returning veterans and their families, including mental health and substance abuse services. As part of this initiative, the Alcohol and Drug Counsel of North Carolina is developing a statewide registry of trained Licensed Clinical Addiction Specialists who can respond to requests for assistance from the Guard and Reservists for substance abuse problems. In addition, the Governor's Institute on Alcohol and Substance Abuse, AHEC, Behavioral Healthcare Resource Program at the School of Social Work at The University of North Carolina at Chapel Hill, and the Durham VA Medical Center developed a statewide training initiative to increase the skills and awareness of community mental health, substance abuse, and medical practitioners on the medical and behavioral health needs of returning veterans and their families.[t,31] While the training can be made available and tailored to different health professionals across the state, more work is needed to ensure that this information is disseminated more broadly. For example, health professionals may be unaware of the need to

s The VA Medical Centers are located in Asheville, Durham, Fayetteville, and Salisbury. The outpatient clinics are located in Charlotte, Hickory and Winston-Salem. There are six community based outpatient clinics located in Durham, Greenville, Jacksonville, Morehead City, Raleigh and Wilmington. In addition, there are five Vet centers located in Charlotte, Fayetteville, Greenville, Greensboro, Greenville, and Raleigh. United States Department of Veterans Affairs. http://www1.va.gov/directory/guide/state.asp?STATE=NC.

t AHEC provides 6-hour trainings for different health professionals, and one-hour webinars are available to primary care providers through I-CARE.

check returning veterans or their families for post traumatic stress disorder, depression, or substance abuse disorders. School personnel outside of military communities may not know about a parent's connection to the National Guard or reserves, and thus may not know when a child's discipline problem is due to the deployment or return of a parent from OEF/OIF.

Returning veterans and their families often need other non-health related services. North Carolina has a 24-hour, 7-day a week, 365-day a year information and referral hotline, NC Care Link, which can help link veterans and their families to services at www.nccarelink.gov.[u] In addition, the VA offers other services, such as housing vouchers, for returning veterans. However, returning veterans do not always know about the availability of these services. The VA also offers the annual Homeless Providers Grant and Per Diem Program to fund community agencies providing supportive housing, such as transitional housing, and service centers to homeless veterans. The grants provide 65% of funding for construction, renovation, or acquisition of buildings for supportive housing or service centers. Recipients must provide the remaining 35% in matching funds.[32]

Because North Carolina has such a large number of returning veterans who are living throughout the state, the Task Force recommended:

Recommendation 5.9

a) The Veterans Administration should:

1) Continue to work with appropriate partners to provide training for mental health and substance abuse professionals, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and Local Management Entities agency staff, primary care providers, psychiatrists, school personnel, and other appropriate organizations about the medical and behavioral health needs of returning veterans and their families.

2) Provide consultation services for veterans being treated by community-based primary care providers, mental health, or substance abuse professionals.

3) Work with the North Carolina Division of Social Services, Department of Housing and Urban Development, and other community agencies to ensure that veterans learn of other support services, such as housing vouchers, employment opportunities, and family services.

b) The North Carolina General Assembly should appropriate $200,000 to pay the 35% match for the Veterans Administration Homeless Providers Grant and Per Diem Program for transitional housing for homeless veterans with substance abuse or mental health disorders.

u North Carolina operates a statewide information and referral system, NC Care Line, that is available to anyone throughout the state. NC Care Line also has specific referral information for veterans and their families. Information can be accessed through the internet at: http://www.nccarelink.gov/ or at: 1-800-662-7030.

References

1 Center for the Prevention of School Violence, Department of Juvenile Justice and Delinquency Prevention. Annual school resource officer census, 2007-2008. http://www.ncdjjdp.org/cpsv/pdf_files/SRO_Census_07_08.pdf. Accessed January 16, 2009.

2 *The Dollars and Sense of Employee Assistance.* Arlington, VA: EAPA Publications; 2003.

3 Comprehensive Assessment Treatment Outcomes Registry (CATOR)/New Standards, Inc. *Cost Effectiveness System to Measure Drug and Alcohol Treatment Outcomes.* Columbus, OH; Ohio Dept of Health and Human Services; 1995.

4 Alexander P, Horton F. Employee assistance programs. Presented to: The North Carolina Institute of Medicine Task Force on Substance Abuse Services; September 26, 2008; Cary, NC.

5 Mims SA. Substance abuse in Work First and child welfare in NC. Presented to: The North Carolina Institute Medicine Task Force on Substance Abuse Services; May 30, 2008; Cary, NC.

6 The Schneider Institute for Health Policy. *Substance abuse: the nation's number one health problem.* Princeton, NJ: The Robert Wood Johnson Foundation; 2001.

7 Godwin M. NC Work First/CPS Substance Abuse Initiative. Presented to: The North Carolina Institute Medicine Task Force on Substance Abuse Services; May 30, 2008; Cary, NC.

8 Green SL. Addressing the child welfare and substance abuse link. Presented to: North Carolina Institute Medicine Task Force on Substance Abuse Services; May 30, 2008; Cary, NC.

9 The National Center on Addiction and Substance Abuse at Columbia University. *CASAWORKS for Families a Promising Approach to Welfare Reform and Substance-Abusing Women.* New York, NY: Columbia University; 2001. http://www.casacolumbia.org/Absolutenm/articlefiles/CASAWORKS_for_Families_6_4_01.pdf. Accessed April 10, 2008.

10 Division of Alcoholism and Chemical Dependency Programs, North Carolina Department of Correction. Annual legislative report, 2006-2007. http://www.doc.state.nc.us/Legislative/2008/2006-07_Annual_Legislative_Report.pdf. Published March 2008. Accessed October 14, 2008.

11 Simpson DD, Sells SB. Effectiveness of treatment for drug abuse: an overview of the DARP research program. *Adv Alcohol Subst Abuse.* 1983;2:7-29.

12 Hubbard RL; RTI International. *Drug Abuse Treatment: A National Study of Effectiveness.* Chapel Hill, NC: University of North Carolina Press; 1989.

13 Simpson DD, Curry SJ. Special issue: Drug Abuse Treatment Outcome Study (DATOS). *Psychol Addict Behav.* 1997;11(4):211-335.

14 Center for Substance Abuse Treatment, Substance Abuse, and Mental Health Services Administration. *The National Treatment Improvement Evaluation Study, NTIES.* Rockville, MD: US Dept of Health and Human Services; 1997.

15 All NC crash data, 2007. The University of North Carolina Highway Safety Research Center website. http://www.hsrc.unc.edu/ncaf/crashes.cfm. Accessed October 14, 2008.

16 National Center for Statistics and Analysis, National Highway Traffic Safety Administration. 2007 traffic safety annual assessment – alcohol-impaired driving fatalities. http://www-nrd.nhtsa.dot.gov/Pubs/811016.PDF. Accessed October 23, 2008.

17 Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, North Carolina Department of Health and Human Services. Driving while impaired (DWI) substance abuse services report. GS 122C-142.1. http://www.ncdhhs.gov/mhddsas/statspublications/reports/dwi-leg06-07rpt.pdf. Published February 2008. Accessed March 28, 2008.

18 Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. *TASC in North Carolina.* Raleigh, NC: North Carolina Dept of Health and Human Services; 2007. http://northcarolinatasc.org/TASCfactsheet07.pdf. Accessed March 28, 2008.

19 North Carolina Sentencing and Policy Advisory Commission, North Carolina Court System. Correctional program evaluation: offenders placed on probation or released from prison in fiscal year 1996/97. April 2000.

20 Division of Community Corrections, North Carolina Department of Correction. Annual legislative report on the Criminal Justice Partnership Act. http://www.doc.state.nc.us/Legislative/2008/Criminal_Justice_Partnership_Act_Annual_Report.pdf. Published March 1, 2008. Accessed March 28, 2008.

21 Price V, Rivenbark W. NC Department of Correction, Division of Alcoholism and Chemical Dependency Programs. Presented to: The North Carolina Institute Medicine Task Force on Substance Abuse Services; May 30, 2008; Cary, NC.

22 Division of Alcoholism and Chemical Dependency Programs, North Carolina Department of Correction. Annual legislative report FY 2006-2007. Published March 2008. Accessed March 28, 2008.

23 Olson DE, Rapp J, Powers M, Karr SP; Illinois Criminal Justice Information Authority. Program evaluation summary: Sheridan Correctional Center Therapeutic Community: Year 2. http://www.icjia.state.il.us/public/pdf/ProgEvalSummary/Sheridan.pdf. Published May 2008. Accessed November 19, 2008.

24 Williams JW Jr. Serving the health needs of our military and veterans. *NC Med J*. 2008;69(1):23-26.

25 RTI International. 2005 Department of Defense survey of health related behaviors among active duty military personnel. http://www.ha.osd.mil/special_reports/2005_Health_Behaviors_Survey_1-07.pdf. Published December 2006. Accessed October 30, 2008.

26 Wheeler E. Self-reported mental health status and needs of Iraq veterans in the Maine Army National Guard. http://www.ptsd.ne.gov/publications/MENG-veterans-study-full-report.pdf. Accessed January 16, 2009.

27 Korb L, Rundlet P, Bergmann M, Duggan S, Juul P. *Beyond the Call of Duty: A Comprehensive Review of the Overuse of the Army in the Administration's War of Choice in Iraq*. Washington, DC: Center for American Progress; 2007. http://www.americanprogress.org/issues/2007/03/pdf/readiness_report.pdf. Accessed December 18, 2008.

28 Milliken CS, Auchterlonie JL, Hoge CW. Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq war. *JAMA*. 2007;298(18):2141-2148.

29 VA health care eligibility and enrollment: combat veterans. United States Department of Veterans Affairs website. http://www.va.gov/healtheligibility/eligibility/CombatVets.asp. Accessed October 30, 2008.

30 Post EP, Van Stone WW. Veterans health administration primary care-mental health integration initiative. *NC Med J*. 2008;69(1):49-52.

31 Stein F. Coming home: the NC focus on returning combat veterans and their families. Presented to: The North Carolina Institute Medicine Task Force on Substance Abuse Services; October 24, 2008; Cary, NC.

32 Grant and per diem program homepage. United States Department of Veterans Affairs website.http://www1.va.gov/HOMELESS/page.cfm?pg=3. Updated October 29, 2008. Accessed December 19, 2008.