Substance Abuse–Challenges and Strategic Solutions

Final Report

Fargo, North Dakota
September 27–29, 2004

Welfare Peer Technical Assistance Network

SUBSTANCE ABUSE—CHALLENGES AND STRATEGIC SOLUTIONS

Final Report of Peer TA Activity

Conducted for the North Dakota Department of Human Services
Fargo, North Dakota
September 27–29, 2004

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This report describes the Administration for Children and Families Office of Family Assistance Welfare Peer Technical Assistance Network event that took place in Fargo, ND on September 27–29, 2004. The Agenda from the event is provided in Appendix A. Appendix B lists the event participants, and the Cass County Case Study is provided in Appendix C. The Action Planning Worksheet is presented in Appendix D, and Appendix E is the Evaluation Summary of the event.

The report is available for download at: http://peerta.acf.hhs.gov/taevents/chron.htm

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The Welfare Peer Technical Assistance (TA) Network is a federally funded initiative sponsored by the Administration for Children and Families Office of Family Assistance within the U.S. Department of Health and Human Services. The purpose of Welfare Peer TA is to provide peer-to-peer technical assistance to States, counties, and community-based organizations operating the Temporary Assistance to Needy Families (TANF) program. Welfare Peer TA facilitates the sharing of information between and among States and localities to establish linkages between organizations serving the needs of welfare recipients.

In response to a request for technical assistance from the State of North Dakota, Welfare Peer TA sponsored a statewide Roundtable event in Fargo, ND on September 27–29, 2004. Welfare Peer TA Roundtables are designed to bring together a cross-disciplinary group of professionals working in similar or complimentary disciplines in a workshop setting to foster peer-to-peer learning through interactive sessions. This particular event brought together teams of local representatives from the 8 service regions in North Dakota to address issues of substance abuse screening and identification and service integration. In addition to State staff, local regional representatives in attendance included TANF case managers, employment workers from the Jobs Services program, child welfare professionals, substance abuse staff, and mental health clinicians. The event included discussions on topics such as the impact of methamphetamine usage in rural North Dakota, substance abuse treatment and recovery, redefining treatment as a work experience, innovative ways to meet countable work requirements, the treatment/self-sufficiency continuum, and new approaches to client-focused services.

Outcomes observed by Roundtable participants included:

An improved ability of TANF workers to understand the impact of substance abuse

A clearer understanding of the impact of methamphetamine usage in rural areas

Creative strategies for operationalizing substance abuse treatment as a countable work activity

A renewed sense of the importance of customer-oriented service design and delivery

A comprehensive appreciation of the treatment/self-sufficiency continuum and the importance of system collaboration in serving customers involved with multiple service streams.

II. ROUNDTABLE BACKGROUND

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Since welfare reform passed in 1996, welfare offices nationwide have focused specific efforts on working with families that are difficult to move to self-sufficient employment, such as those presenting the multiple barriers of substance abuse, mental health issues, and/or disabilities.[1] Identification, assessment, and screening for these barriers at the time of intake as well as service integration among systems have helped TANF offices foster effective service delivery for their hard-to-serve caseloads. However, many factors hinder both identification and screening processes as well as service integration and collaboration. For example, clients with substance abuse issues may actively hide, or be unwilling to admit, their drug use for fear of the stigma associated with substance abuse, or involvement with the child welfare system. Further, systems change and service integration efforts are commonly stalled by differing mandates between agencies, conflicting philosophies, fixed habits, and attitudinal biases.

Substance abuse is recognized as one of the most prevalent barriers to employment among hard-to-serve TANF recipients. Research has indicated that substance abuse problems are more prevalent among welfare recipients as compared to the general population. For example, national estimates of TANF recipients with substance abuse issues range from 5 to 27 percent (and State and local estimates from 9 to 60 percent), compared to only 4 to 12 percent of the general non-welfare population.[2] Long-term TANF recipients are also found to be more likely to have substance abuse problems than short-term recipients.[3] In addition, substance abuse issues often exacerbate other sets of barriers to self-sufficiency for TANF customers such as low educational attainment, difficulty securing child care and transportation, poor work skills, and health issues.[4]

Both TANF and substance abuse treatment program administrators recognize that treatment in the absence of supplementary work activities does not fully meet the needs and work requirements of TANF clients facing substance abuse challenges.[5] In light of this recognition, many States are presently attempting to more effectively address the intricate processes of treatment, recovery, work, and self-sufficiency through innovative collaborations between agencies and a variety of integrated work/treatment models.[6]

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1 Hercik, J. & Jenkins, S. (2001). "Issue Brief: Co-Occurring Disorders." Fairfax, VA: Caliber Associates.

2 National Household Survey on Drug Abuse. (2000). Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

3 Physician Leadership on National Drug Policy. (2001). Best Practice Initiative: State-Level Issues for Medicaid/Welfare and Substance Abuse Treatment.

4 Capitani, J., Hercik, J, & Kakuska, C. (2001). Pathways to Self-Sufficiency: Findings of the National Needs Assessment. Washington, DC: U.S. Department of Health and Human Services, Office of Family Assistance.

5 Kakuska, C. & Hercik, J. (2003). Addressing Treatment: Where We've Been. Fairfax, VA: Caliber Associates.

6 Ibid.

Specifically in North Dakota, methamphetamine (meth) use is making an increasingly prevalent emergence in the TANF caseload. According to the current State Attorney General, methamphetamines are the number one issue facing North Dakota law enforcement over the next four years. Meth use and production in North Dakota has exponentially grown in recent years from a total of 3 meth lab raids in 1995 to 297 lab raids in 2003. These statistics, combined with the reality that serious drug dependence is more common among TANF recipients than nonrecipients, underscores the concerns of meth use in rural North Dakota and its impacts on the TANF, JOBS, and child welfare systems.

The Welfare Peer TA Network has collaborated with TANF professionals in North Dakota to complete two different technical assistance interventions. First, in late 2003, TANF professionals from Cass County, North Dakota requested technical assistance from the Welfare Peer Technical Assistance Network regarding identification, screening, and assessment tools to assist local TANF caseworkers in devising strategies to assist substance-abusing customers find and maintain employment. Although the original TA request broadly addressed substance abuse screening in general, it also included specific concerns about methamphetamine use and identification among TANF clients in Cass County, North Dakota as well as concerns about systems change. This original TA request resulted from numerous factors, such as the need for better screening tools in rural areas, clients' unwillingness to divulge substance abuse for a variety of reasons, and the impact on children when there is methamphetamine and other substance abuse in the home.

To fulfill the scope of this TA Request from North Dakota, the Welfare Peer TA Network sponsored a site visit to Cass County, which was conducted from October 13-15, 2003. The site visit included a needs assessment, an analysis of current protocols, and recommendations for improvement. The full report from this site visit is made available on the Welfare Peer TA Web Site at: http://peerta.acf.hhs.gov/pdf/north_dakota_full.pdf

Building on the first technical assistance intervention, the State of North Dakota then made a follow-up request to the Welfare Peer Technical Assistance Network for a statewide technical assistance event. Specifically, this event addressed the topics of: service integration, substance abuse diagnosis and treatment, defining work activities for TANF clients with substance abuse issues, the effects of addiction (e.g., addiction to methamphetamines) on children, how to work with clients with co-occurring mental health and substance abuse concerns, and how to incorporate a family-focus into treatment.

III. ROUNDTABLE SESSIONS

III. ROUNDTABLE SESSIONS

The Welfare Peer TA Roundtable event entitled "Substance Abuse – Challenges and Strategic Solutions" took place in Fargo, North Dakota and was comprised of two intensive full days of workshop sessions, interactive discussions, breakout groups, and presentations. The North Dakota Department of Human Resources hosted the event. The following sections of this report summarize the content of the various event sessions.

1. WELCOME AND INTRODUCTIONS

During this brief introductory session, speakers welcomed the Roundtable participants and offered their initial thoughts on the purpose, goals, and anticipated outcomes of the event. Thomas Sullivan, the Regional Administrator for ACF Region VIII, discussed the unique service needs and challenges of rural States such as North Dakota and the critical importance of finding solutions to address substance abuse in our society.

Mr. Sullivan emphasized that despite the barriers of providing services to a widely dispersed population living in rural areas, Region VIII has a strong history of providing high-quality services. John Hougen, the TANF Administrator of the North Dakota Department of Human Services, gave credit to the individuals operating a successful pilot program in Cass County, ND for providing the impetus for this statewide event. He also reiterated that because resources in North Dakota are relatively scarce, TANF, JOBS, Human Services Centers, and child welfare staff need to devise strategies for service integration to maximize what resources are available. Kathy Hogan, the Director of Cass County Social Services, spoke briefly and warned against the dangers of falling into "service silos." She pledged to continue to work to break the silos to truly make a difference in how clients are treated. Finally, John Horejsi, the Federal Project Officer for the Welfare Peer TA Network provided a summary of the role and function of Welfare Peer TA and introduced the Roundtable's overall facilitator and Project Director Dr. Rivera.

During the introductions, the following themes emerged with respect to anticipated outcomes:

Recognizing symptoms of substance abuse in TANF clients during intake

Designing/accessing more effective tools and strategies for working with substance abusing clients

Determining how to address the confidentiality issues inherent in working with this population

Identifying more available resources in the community

Creating treatment plans, safety plans, and employment plans

Understanding the physical and psychological consequences of addiction

Helping substance abusing TANF clients find and maintain employment

Working with the children of addicted parents

Learning better ways to collaborate with other service agencies

Learning more about the "meth" epidemic and the unique impacts of this drug

Handling security issues for staff working with substance abusing clients.

2. SETTING THE CONTEXT

Dr. José Rivera, Project Director for the Welfare Peer TA Network and a national expert in welfare reform, opened the program by helping the audience to see the "big picture" related to substance abuse, TANF, child welfare and workforce development. The session outlined a broad framework of ideas and concepts relating to substance abuse, such as general notions of addiction, treatment, recovery, and the systems serving substance abusers. Three expert speakers offered their own big picture issues, which were designed to provide overarching considerations related to service delivery, systems change, collaboration, and policy.

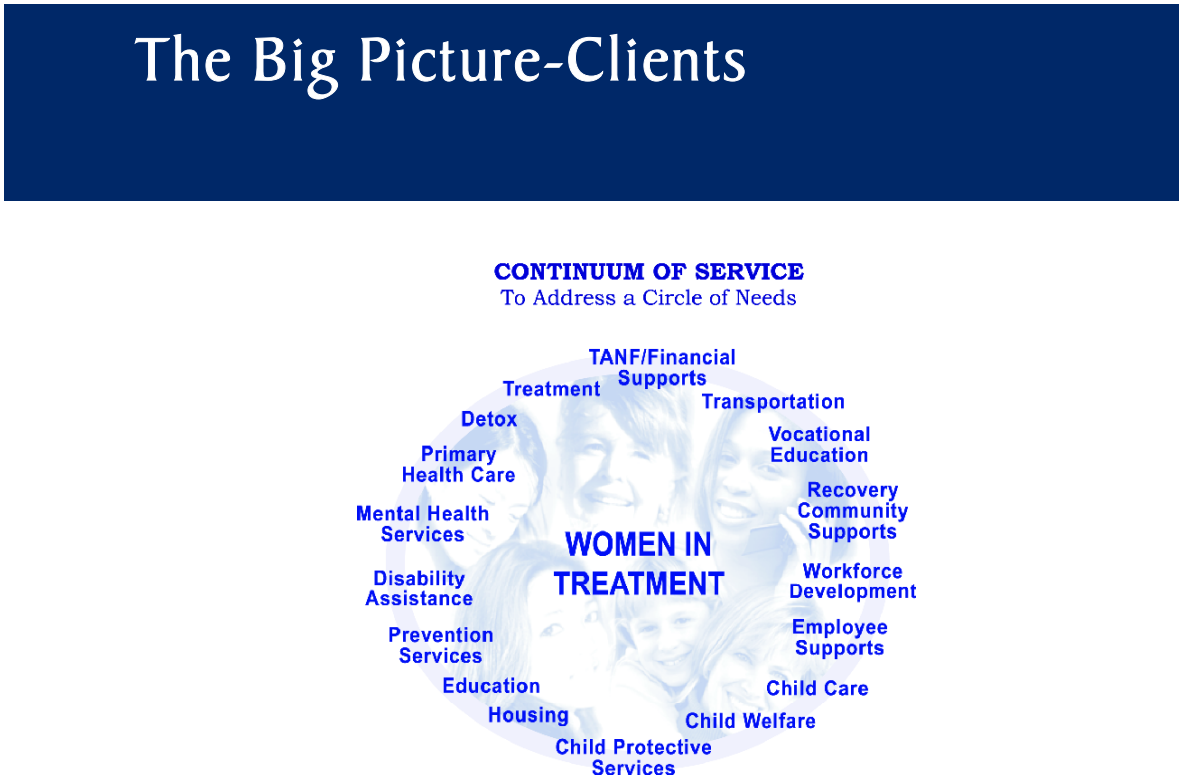
Dr. Jeanette Hercik, Deputy Project Director for Welfare Peer TA and a national expert in understanding public assistance services, opened the session by emphasizing the importance of cross-disciplinary collaboration. Collaborations, partnerships, and conversations across disciplines are all needed to move the field forward. Dr. Hercik underscored the value of the peer-to-peer learning that occurs at events like this one when States and counties can all sit in the same room and share ideas together. She highlighted the benefits of bringing together heterogeneous audiences. Dr. Hercik also offered a brief account of how the systems of social services, employment services, substance abuse services, and child welfare have all come together in recent years. Prior to welfare reform, the predominant focus of public assistance was income maintenance and providing monetary relief for those in poverty. After welfare reform in 1996, the focus of our national welfare program shifted to finding jobs and fostering self-sufficiency for those on welfare. Clients presenting with multiple barriers, such as of substance abuse addiction, mental health issues, or disabilities are often the hardest to serve and employ.[7]

[7] Morgenstern, J. R. A., McCrady, B., McVeigh, K., Blanchard, K., & Irwin, T. "Intensive Case Management Improves Welfare Clients' Rates of Entry and Retention in Substance Abuse Treatment." http://aspe.os.dhhs.gov/hsp/njsard00/retention-rn.htm. January 2001.

Dr. Hercik stated that one study[8] found 84 percent of women on TANF and in substance abuse treatment services also had an open child welfare case.

Dr. Hercik stressed the importance of shifting approaches from a systems perspective to a client-focused perspective. She also discussed the "circle of needs" of a TANF client with substance abuse issues and how the various systems can come together to wraparound these clients and work to meet all of their needs. Substance abuse rarely occurs in the absence of some preceding or subsequent problem or issue. Because of the interrelatedness of substance abuse and other issues, the systems that address substance abuse are related to and dependent upon the systems that address TANF, child welfare, and workforce development. See Exhibit III-1.

EXHIBIT III-1
CIRCLE OF NEEDS



Ms. Mary Nakashian, an expert in welfare systems and identifying substance abuse among TANF eligible clients, presented after Dr. Hercik. She framed her comments by relating the metaphor of "thinking outside the box" to the process of systems change. In this respect,

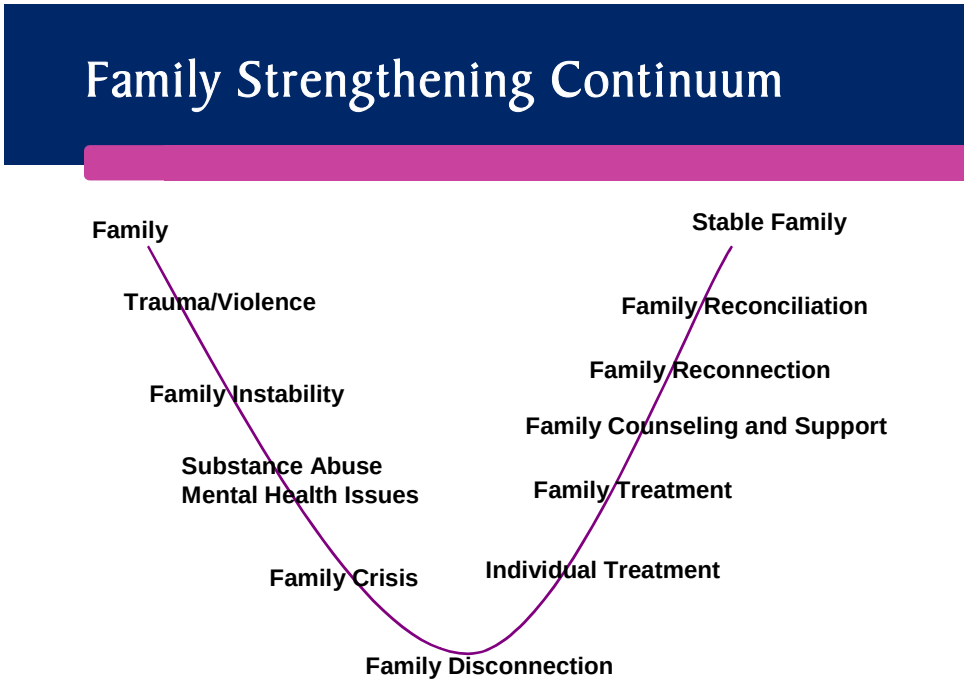
[8] Ibid.

"the box" represents any given established system, and "outside the box" would be the thought or action required to change or improve that system through new initiatives.

Reflecting on her years as an intake worker, the Deputy Executive Administrator of the New York City Human Resources Administration, and a Vice-President implementing CASAWorks, she recalled how many times people have mentioned the platitude to "think outside the box." For Ms. Nakashian, the challenge of thinking outside the box while working in and managing systems is that you need to keep one foot still in the box, metaphorically speaking, to continue to run the machine that you're responsible for. Workers and managers may not have the luxury of thinking outside the box if they're swamped with the responsibilities of maintaining the status quo and serving families. Ms. Nakashian then described some examples by applying this metaphor to the different systems represented in the audience. Regarding welfare, the box must ensure that eligibility systems are timely, accurate, and welfare checks must go out on time. Regarding child welfare, the box relates to protecting children, preserving safety, and placing children who've been removed from their homes. Ms. Nakashian reiterated that sometimes, the responsibilities of running and managing the current box do not allow the time to think about progress or grand improvements. Instead, individuals are simply too busy trying to meet the requirements of each day. Overall, Ms. Nakashian encouraged participants to embrace what she felt to be the ultimate challenge and also the greatest reward of public service: learning to balance keeping one foot in the box and one foot outside the box at the same time; that is, the balancing act of forming new initiatives while not allowing the current level of services to drop in quality.

Dr. José Rivera was the third to speak during this session and offer his big picture comments to outline the framework for the discussions over the next two days. Dr. Rivera first spoke about what he referred to as the "family-strengthening continuum." This concept refers to the reality that whenever we speak about substance abuse issues or an individual in substance abuse treatment, we are often speaking about family issues as well. See Exhibit III-2.

EXHIBIT III-2
FAMILY STRENGTHENING CONTINUUM

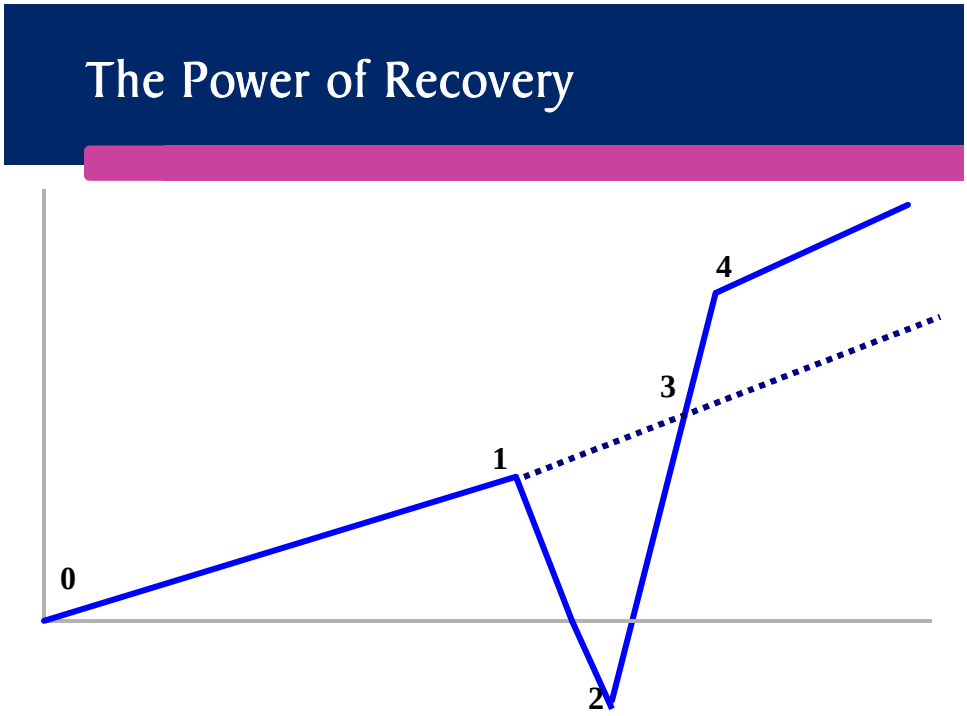


The notion also reflects an evolution of the system of substance abuse treatment. At first, professionals operated under the assumption that you could merely treat the individual for the individual disease. However, in recent years, it has increasingly become evident that substance abuse occurs within a broader context that includes a myriad of issues such as family stability, trauma, domestic violence, stress, or flux in relationships. The correlations are there. Dr. Rivera encouraged the audience to recognize that whether we work in TANF, child welfare, workforce development, or substance abuse and mental health services, we are all in the family-strengthening business together. Ultimately, the work of all providers is to create or advance the creation of a self-sufficient and stable family.

Dr. Rivera also discussed the process of recovery through a graphical depiction of an individual's life as a continuum. This continuum, pictured in Exhibit III-3, represents one person's life who has experienced issues of drug abuse. In this graph, Point 0 represents the starting point of this individual's life. This individual reaches a critical moment or event at Point 1, where circumstances lead to the initiation of drug use. Point 2 represents the "rock bottom" for this individual who has spiraled down from Point 1 and is now addicted to drugs. Point 3 represents the intersection of the person addicted to drugs after "spiraling up" and receiving treatment and the point at which they would have been had they never been addicted. Dr. Rivera referred to Point 3 as "the point of past expectations." However, the power and

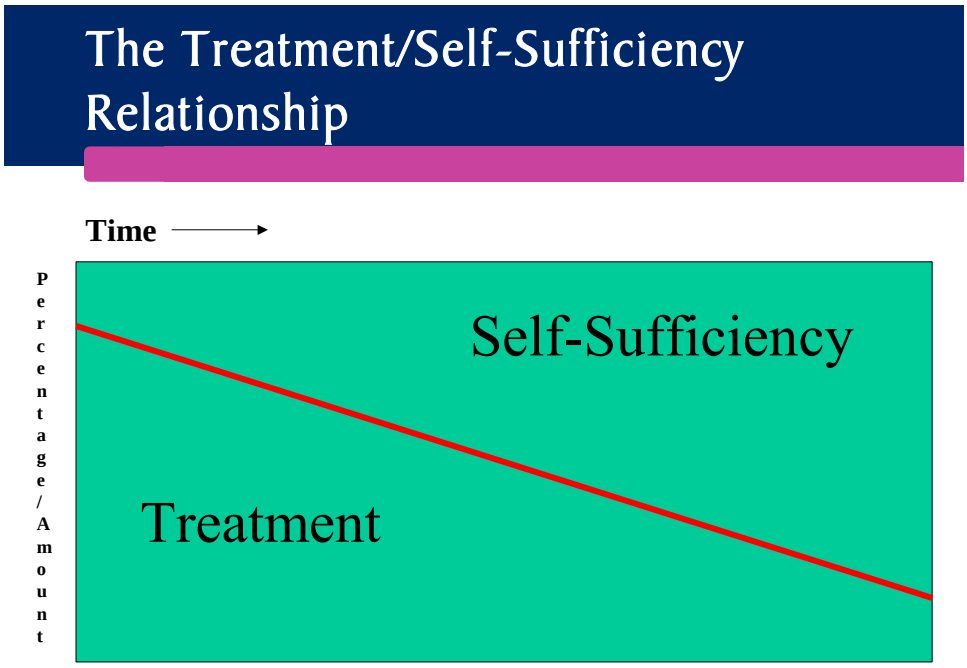
energy of the process of recovery brings this individual past Point 3 to Point 4. Dr. Rivera's primary point was to encourage participants to appreciate that the process of recovery has the power to bring an individual past Point 3. He also stated that it is good to keep in mind that TANF, child welfare, workforce development, and substance abuse professionals will see all different types of people at different points along their continuum.

EXHIBIT III-3
THE POWER OF RECOVERY



In closing, Dr. Rivera discussed the treatment/self-sufficiency continuum, pictured below in Exhibit III-4. This illustration demonstrates that treatment has a direct correlation to self-sufficiency. It also shows that treatment does not occur in a vacuum. When a person enters treatment, they may need 90 percent treatment and only 10 percent self-sufficiency services. As time moves forward and the treatment need decreases, the need for self-sufficiency services increases proportionately. The graph contradicts the commonly held notion that a person goes to treatment, disappears for a period of time, and then reemerges into society as "cured." Instead, the graph emphasizes that good treatment should be designed to prepare an individual for self-sufficiency from Day One. Dr. Rivera ended his presentation by highlighting that "good treatment, without a connection to self-sufficiency, is bad treatment."

EXHIBIT III-4
THE TREATMENT/SELF-SUFFICIENCY RELATIONSHIP



3. INVENTORY OF SUBSTANCE ABUSE CHALLENGES AND COMMUNITY AREAS

In this session, Dr. Rivera led the participants in an exercise designed to help them assess the current substance abuse challenges in their area. The local representatives from each region were asked to complete an environmental scan of their specific agencies and regions, looking particularly at strengths and weaknesses in combating substance abuse and serving substance abusers. Challenges were those that impacted the ability of local offices to help TANF customers find and maintain employment. After receiving introductory words and instructions from Dr. Rivera, the teams from the eight regions then worked on this exercise independently for approximately 20 minutes. Subsequently, a designated "reporter" from each region was asked to report their answers to the full group. The following sub-sections summarize the answers from each of the eight regions.

Region 1

Strengths:

We have a good treatment facility.

We have a pilot project in Williams County, similar to the mentoring program in Grand Forks, in which a para-professional conducts home visits. She carries a caseload of about 10.

Good communication between the systems of child welfare and TANF.

Some team case management is occurring.

Low-income housing is available and easy to access.

Our community nursing home has a child care facility.

Challenges:

We can't offer enough longer-term treatment.

Lack of understanding of the nuances of confidentiality requirements.

Still having trouble knowing what to do with indications of suspicions of drug usage among certain clients.

Medicaid doesn't pay the substance abuse evaluation fee.

We do not have an individual on the Human Services Center side who understands TANF; collaboration is impeded because they don't understand us and we don't understand them.

Transportation and far distances; lack of public transportation in Williston.

Available low-income housing.

Available child care.

Region 2

Strengths:

We have a good mentoring program.

We have para-professionals who conduct home visits.

New Hope program in Minot is intended to be long-term.

Agencies have a strong desire to collaborate and do not have turf issues; we now want to transform that desire into concrete strategies.

Challenges:

New Hope program only covers two children.

Still struggling with how to engage clients on a longer term and how to link systems.

Medicaid will not cover a substance abuse evaluation after a Driving Under the Influence (DUI) violation.

Region 3

Strengths:

Both in-patient and out-patient treatment centers.

Good collaboration between TANF, JOBS, and Safe House.

Good pilot projects underway.

Some team case management is occurring.

The SHARE Network is a great resource for finding other agencies in the area.

Challenges:

Client loads are high.

Transportation and far distances.

Clients not having driver's licenses or vehicles.

Shortage of addiction counselors and treatment centers; demand exceeds supply.

Confidentiality.

Physical and security issues for workers.

Region 4

Strengths:

We have a good mentoring program.

We have para-professionals who conduct home visits.

New Hope program in Minot is intended to be long-term.

Agencies have a strong desire to collaborate and do not have turf issues; we now want to transform that desire into concrete strategies.

Challenges:

New Hope program only covers two children.

Still struggling with how to engage clients on a longer term and how to link systems.

Medicaid will not cover a substance abuse evaluation after a Driving Under the Influence (DUI) violation.

Region 5

Strengths:

The collaborative pilot unit

Resource rich when compared to other places in North Dakota

Multiple providers of private and public treatment

Treatment providers are able to enact consequences for failure to engage in a plan

One solid residential treatment center, modeled after Grand Forks and Minot

Good public transportation.

Challenges:

Need for more residential treatment centers

Constant communication and exchanging information effectively

Maintaining the mechanism to allow funding (e.g., Medicaid) to continue after children leave a setting

No State Opt-Out Waiver: mandatory discontinuation of all TANF benefits for a person with a past drug felony.

Region 6

Strengths:

Current collaboration occurring between agencies

Good case management services in Fargo using the team case management approach between TANF, JOBS, and the Southeast Human Service Center

Good communication between TANF and HSC in terms of counseling

Cross-education, cross-training, and peer-to-peer site visits occurring between agencies.

Challenges:

Lack of residential treatment facilities

Lack of places for people to go and get care

Difficulty of collaboration with Child Protective Services due to confidentiality barriers

Need for gender-specific treatment

Staff shortages and resource constraints.

Region 7

Strengths:

There's a variety of treatment centers in Bismarck, including a number of private facilities connected with hospitals.

The faith-based community is a strength due to the number of churches.

Collaboration is growing between agencies who are learning to talk more and work together more frequently.

Strong sense of commitment among all service staff.

Challenges:

Due to a lack of transportation, people in Ft. Yates do not have access to the services in Bismarck; many people lack driver's licenses

Because towns are so small and tight-knit, everyone may know each other's business. This small size poses confidentiality concerns. Clients may be less willing to disclose substance abuse because they're afraid everyone in the town will learn.

Small town attitudes and biases of "that doesn't happen here."

Region 8

Strengths:

We have an interagency group where service agencies meet on a quarterly basis and share what's going on in our programs.

We're on the cusp of doing a TANF education program.

We have very self-sufficient communities. For example, if there's a family in need of support, someone in that community tries to help.

We have open case management between agencies.

We're always one phone call away from another source of support.

Challenges:

Distance—the time it takes for clients to get to services or for staff to get to clients

Biases, stigma, and public awareness issues about poor families

Very few private agencies in the area

Only one residential facility.

Between report-outs, Dr. Rivera, the discussion facilitator, offered his reflections and highlighted noteworthy points that were brought up. First, he stressed the importance of taking the time to visit each other's office in order to examine how other systems work and how those systems impact or interact with one's own. It is a no-cost item, but enables staff to learn so much and engage in cross-education and cross-training. Dr. Rivera also noted that "the treatment plan is very similar to the employment plan created under JOBS North Dakota." He emphasized the reality that these plans often overlap and can be collapsed and condensed into a more

comprehensive single plan. In response to transportation concerns, he suggested the creation of a regional transportation network that can be operated and subcontracted to TANF participants as a work activity. Dr. Rivera described how this is being done in Georgia. Encouraging participants in community- and faith-based organizations to become mentors for TANF participants is another option to serve TANF customers. In addition, Dr. Rivera also stressed the need to do, what he referred to as, "zero-based rethinking." In this sense, zero-based rethinking is a brainstorming session that cleans the slate and does not rely on established processes or commonly-held assumptions. Zero-based rethinking assumes nothing and starts from scratch. To end the session, Dr. Rivera closed with a final thought. He encouraged participants to consider Maslow's hierarchy of needs and how substance abusers have a similar hierarchy. All of us seek to self-actualize; however, some may not know how as well as others. For Dr. Rivera, if we remember that we all have the same needs and exist on the same hierarchy, we'll recognize that different circumstances are one of the only differentiators of a service provider from one seeking services.

4. CAUSES, SYMPTOMS, AND TREATMENT OF ADDICTION

In this session, Dr. Sushma Taylor, the CEO of Center Point, Inc. in San Rafael, CA, gave a thorough presentation on various aspects of drug addiction and the structure and philosophy of her treatment program. Her presentation can be broadly divided into two main parts, and the following sections of the report summarize her comments.

4.1 The Causes, Symptoms, and Physiology of Drug Addiction

Dr. Taylor began her presentation with the definition of addiction. Addiction is defined as "a progressive, chronic, primary disease that is characterized by compulsion, loss of control, continued use despite adverse consequences, and distortions in normal thinking." In short, addiction is a disease of the brain with significant impacts on the individual. Dr. Taylor also clarified the distinction between a "drug of abuse" and "drug use." She then delved into a detailed description of the reward pathway of addiction and outlined the physiology behind drug addiction. Dr. Taylor described how different parts of the brain govern different functions. For example, some of the functions of the prefrontal cortex include focusing attention, prioritization, suppressing primitive urges, and reducing impulsivity. Through a detailed summary of the functioning of nerve cells, synapses, and neurotransmitters, Dr. Taylor integrated the physiological effects of different drugs with her description of how the brain functions, making the basic point that addictive drugs activate a reward pathway in the brain. Consequently, drug addicts and non-addicts display clear differences of behavior as a result of frontal cortical functioning. For example, whereas many non-addicts are able to make healthy choices that abstain from immediate gratification, addicts tend to make choices without regard for

punishment, consequences, or harm. In the non-addict response, there is no pattern of repetitive use, whereas for an addict, habit and compulsion override the recognition of the harm associated with a repeated error. The addict response pattern becomes "got to have more" as they become psychologically and physically dependent on chronic use.

During her presentation, Dr. Taylor offered detailed lists of types of drugs, common methods of drug administration, and the risk factors associated with addiction. She also broke down the effects of addiction on physical, cognitive, psychological, emotional, social, and spiritual health. These effects are as follows:

Physical health – Physical health is the last aspect of health to deteriorate, but the first to return to normal after cessation of use. Some examples of physical health effects include increased tolerance for higher quantities of drugs, liver problems, headaches, fatigue, cravings, depression, agitation, intense hunger, and insomnia.

Cognitive health – Reasoning, judgment, intuition, memory, and perception are all affected by drug use.

Psychological health – Distortion of information, misinterpretation of cues, persistent suspiciousness, irritability, impatience, paranoia, restlessness, and delusion may result from drug use.

Emotional health – Emotions may be characterized by extremes, and the negative emotions of anger, hate, and resentment are frequent. Positive emotions such as love, joy, warmth, intimacy, and hope deteriorate.

Social health – Social interactions weaken as old friends are replaced by drug using acquaintances, legal and financial problems emerge, and problems at work or with family and friends may progressively worsen.

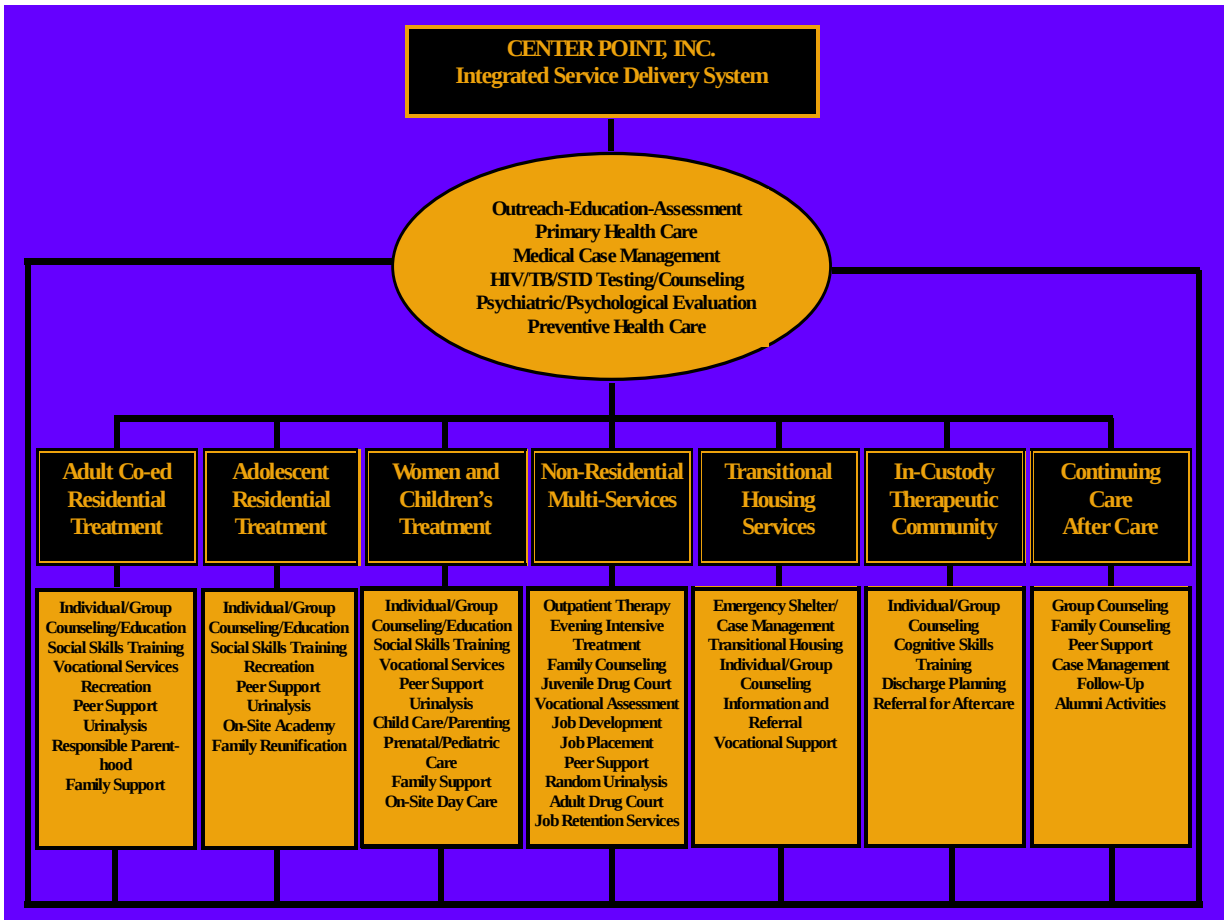
Spiritual health – Lives lack a higher meaning or spiritual purpose, users feel disconnected from life, and life begins to revolve around obtaining and using more and more drugs.

4.2 Gender-specific Substance Abuse Treatment – Center Point, Inc.

Center Point, Inc. began as an adult co-educational substance abuse treatment program in 1971. In 1981, Dr. Taylor assumed leadership over the program, and in 1989, the program added a gender-specific women and children's treatment program. Subsequently, Center Point was one of the original congressionally mandated demonstration projects for residential services for women and children. It is also one of only a few substance abuse programs to receive a competitive Welfare-to-Work grant. The program strives to offer an integrated and comprehensive set of services that include seven main components: adult co-ed residential

treatment, adolescent residential treatment, women and children's treatment, non-residential multi-services, transitional housing services, an in-custody therapeutic community, and continuing care/after care. Center Point uses a therapeutic community model. See Exhibit III-5.

EXHIBIT III-5
THERAPEUTIC COMMUNITY MODEL



Center Point's underlying service mentality focuses on the four phases of substance abuse treatment. Phase I requires crisis or medical emergency-oriented services. Most detoxification programs end at phase I. Phase II involves the addict's withdrawal from the drugs of dependence. During phase III, the previous user goes through psychological and physiological stabilization. Phase IV involves lifestyle restructuring. Dr. Taylor stated that most short-term substance abuse treatment programs span through phase III.

When Dr. Taylor became the Executive Director of Center Point in 1971, their initial treatment program length was 13 months. One of the first undertakings for Dr. Taylor was to cut the treatment program length down to six months. She restructured the treatment intervention so

that at least fifty percent of the client's time could be focused on vocational issues and aspects of community reentry. Currently, Center Point operates in three phases of service. Phase I lasts for 60-90 days and is treatment intensive. Phase II lasts for 30-60 days and is focused on re-entry and vocational issues. Phase III lasts for 30-60 days and focuses on the transition back into the community. Then, these three phases are followed by after-care and follow-up services.

To provide a snapshot of characteristics of drug users upon admittance into a substance abuse treatment program, Dr. Taylor outlined a profile of the women in her program. The profile of her program participants is as follows:

PROFILE OF CENTER POINT FEMALE CLIENTS	
Characteristic	**Percent**
Criminal justice involvement	67%
Childhood physical abuse/sexual abuse	36%
Adult physical abuse	48%
Domestic violence	53%
Parental substance abuse: Father	53%
Parental substance abuse: Mother	35%
Family substance abuse: Siblings	58%
Supporting children who are minors	35%
Loss of parental custody	65%

In addition, Dr. Taylor discussed in detail the vocational/employment services offered to Center Point residents. These services include:

Job readiness training

Addressing work stress issues

Job stability groups

Learning to respond to supervision and be held accountable

Punctuality and other vocational skills

Budgeting and money management

Tutoring for high school equivalence

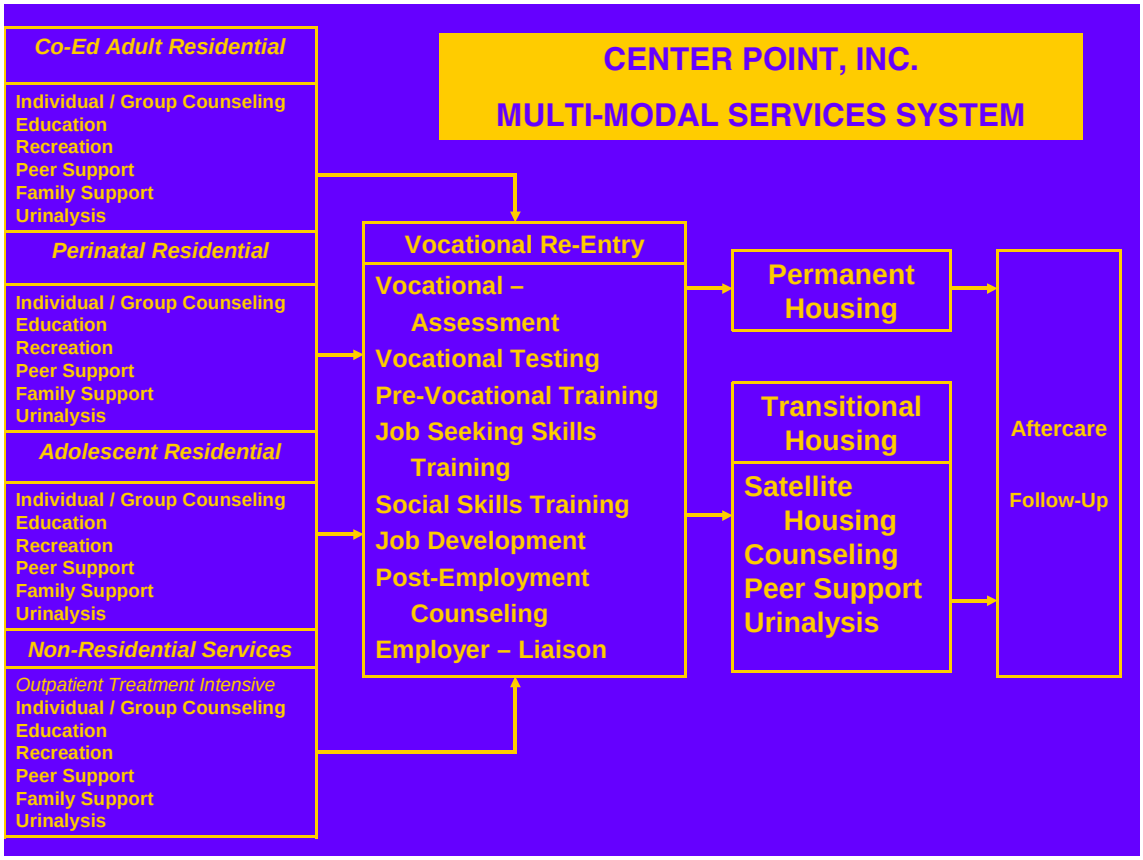
Job seeking skills

Vocational training

Job retention strategies.

Center Point also maintains a Job Databank for residents to use to search for jobs. Plus, Dr. Taylor stated that Center Point has relationships and partnerships with over 250 employers who work exclusively with her and the program. In 1982, she started the process of building relationships with local employers, and she "knocked on doors for over 20 years." Now, her program offers its residents a wide array of employment options after graduation. Center Point's employment/vocational services flow chart is displayed as Exhibit III-6.

EXHIBIT III-6
CENTER POINT, INC.
MULTI-MODAL SERVICES SYSTEM



4.3 Reflections on Presentation

One innovative strategy offered to participants during this Welfare Peer TA Roundtable was the presenter's reflections on each other's material. Following Dr. Taylor's presentation, Dr. Rivera asked Ms. Nakashian to provide her initial thoughts and reactions to spark an interactive discussion with the audience and a question and answer session. Ms. Nakashian's reflections are listed below, followed by a summary of the question-and-answer dialogue that resulted.

Most people who are substance abusers are employed – Based on data from the National Household Drug Survey, 80 percent of heavy drinkers reported being employed, and 7.2 percent of the overall workforce reported heavy drinking. In addition, 76 percent of those who reported using an illicit drug in the past month were employed either full or part time.

The definition of addiction reads quite differently than the definition of TANF – When most of us think of TANF, we think of concepts like "temporary" or "end in sight." However, when we read the definition of addiction, we hear concepts such as "progressive," "long-term," and "chronic." If you juxtapose these two definitions, you realize that many struggles may result because of how differently we define our two fields.

Children are both a motivator to get into treatment but also a trigger for relapse – In this sense, children can be a two-edged sword. Many parents are motivated to go into treatment for the sake of their children, but once out of treatment and reunified with family members, it can be very stressful when children start coming home.

It's interesting to note that there currently is no medical treatment specifically for "meth" – When we think about methadone clinics for heroine addicts, we realize that in addition to the behavioral therapy side of treatment, there are specific medical treatments for some drugs. The medical treatment for "meth" still hasn't been discovered.

It's very scary to change what you rely on every day – All of us have little habits and rituals that we rely on each day, such as a cup of coffee in the morning, or a daily run. Think, for a moment, about these safe little habits. It would be an interesting exercise to try to abstain from something you enjoy every day for the three days we're here in Fargo. An exercise like this might help you to empathize with an addict who relies on the ritual of drug use each day.

"Meth" use overlaps with issues of weight and body image – Some women smoke to stay thin. Other women also use meth to lose weight because meth suppresses appetite.

The current trend of incorporating work into substance abuse treatment is similar to the previous theme of incorporating education into work – The dynamic that is playing out now in the substance abuse and TANF communities has already played out before in the education and training communities.

Substance abuse is a disease with behavioral implications – Many other diseases don't have behavioral implications like substance abuse does. For example, if a diabetic lapses off taking insulin, we let them try again. However, if an addict relapses out of substance abuse treatment, we often blame them more harshly than those facing other medical conditions.

Long-term drug addiction causes brain damage and truly alters the way the brain functions – It changes the structure of the way people hear, think, see, and learn information. These brain changes have implications for the way we communicate with clients. It is valuable to think about the dosage and the medium through which we are communicating with our clients.

Intake interviewing is not the only way to learn about substance use from a client – It is a common assumption that improving intake interviewing is the only remedy to improve substance abuse screening and identification for TANF clients. However, there are other ways, such as health educators in waiting rooms.

Convey messages in as many ways as you can – Convey your requirements, your services, and the consequences of noncompliance in as many ways, in as small doses, and through as many different sources as you can.

Think about how current employment norms and protocols may affect drug users – It would be quite interesting to study how paychecks being given on Fridays may impact drug use. If paychecks were given on a day in the middle of the week, would it have an affect?

Screening questions as related to genetic predisposition for addiction – Due to the element of genetic predisposition for addiction, one safe question to include in an intake screening procedure might be, "Has anybody in your family history had substance abuse or alcohol addiction problems?"

4.4 Questions and Answers

Following Dr. Taylor's and Ms. Nakashian's presentations, the moderator opened up the floor of the event to transition into a dialogue of interactive questions and answers. The following section of the report recounts the question and answer session, which includes questions directed to Dr. Taylor as well as questions relating to previous presentations of the day. In addition to a few brief closing remarks and reflections on the day, this final discussion ended the first day of activities of the Roundtable event.

Q: Are there some people who will have a greater chance of becoming addicted to drugs because of the way that their brain works?

Dr. Taylor: The question is hard to answer given the current literature and research at the time. Currently, the only research we have suggests that there may be genetic risk factors for addiction. For example, the sons and daughters of alcoholic individuals are three to four times more likely to develop alcoholism.

Q: What might be the genetic cause of the risk factor?

Dr. Taylor: We still have a long way to go in learning about the genetic underpinnings of addiction. It's safe to say that something in the DNA that one inherits from their parents has an effect. But, a predisposition is not a certainty. The notion of a predisposition is that just because you're predisposed doesn't mean you'll necessarily become an addict. It means more that if in a certain behavioral context, one is exposed to certain cues, the predisposition puts you at a higher risk to become addicted than others.

Q: I read somewhere that many gamblers are also recovering addicts. Is there a correlation there?

Dr. Taylor: One similarity may be that gambling, like drug addiction, has elements of compulsion, impulsivity, a reward pathway, and lack of regard for consequences. It also provides a thrill of adrenaline that may fill some void in an addict's life, who missed the rush of getting high.

Q: Are there certain personality types that are more susceptible to addiction, like an obsessive personality?

Dr. Taylor: The research is still unclear on this question. But, we do know that it's not entirely causal. For example, every person who has obsessive compulsive disorder is not necessarily a drug addict. However, the patterns of use sometimes mirror certain personality traits. There may be other behavioral patterns as well, such as if depression, addiction, and risk-taking all go hand-in-hand. It is clear, though, that there is no cookie-cutter personality type to become an addict. It's a combination of factors that are very complex.

Q: Where is the line drawn between drug use and drug abuse?

Dr. Taylor: The use/abuse line is razor thin. The abuse/disorder line is also razor thin. There are many grey areas and many differentiating factors. What may be a tolerable level of use for one person may be addiction for another. When you think about it, dopamine can be produced naturally by something as simple as closing your eyes, thinking of a fond memory, and getting a rush from it. On the other end of the spectrum, the release of dopamine can be artificially induced from external drugs.

Q: What are some specific and unique differences about "meth" as compared to other drugs?

Dr. Taylor: Meth has a few unique features. One is its specific impact on women. During the heroine and cocaine epidemic, women were often recruited to carry drugs for dealers. In the meth world, women are now manufacturing the drug and often at the core of the distribution rings. We've even seen an increase in women admissions to prison for meth. Another unique feature of meth is how easy it is to manufacture. Up until recently, you could even find recipes for meth on the internet. Plus, it's not difficult to obtain the required ingredients. Third, meth can be produced with great flexibility and mobility. It can be produced in a suitcase. However, there are many waste products from meth distillation. In California, the area from Fresno to Sacramento has been referred to as the "interior corridor." Eighty percent of the country's meth production occurs in that corridor, but due to waste products leaking into the soil, the fruit orchards are being affected. Fifth, meth impacts the brain in very powerful and unique ways. The impact of meth on the brain is so strong and so severe the psychotic and paranoid behavior is routine. With women on meth, they'll even deny their children and lose that motherly restraint, which is unique. Lastly, the frequency of suicidal fantasies in users is also unique to meth.

Q: What is tweaking?

Dr. Taylor: The high on cocaine usually lasts about 20 minutes. The high on meth usually lasts 6-8 hours. There is a short period of time just at the end of a high which represents the few minutes or moments before the high is about to end and the user is about to crash. Over time, users learn to identify the precipice just before the crash. Tweaking refers to the process when users purposefully take a hit at the very moment before the crash to continue the high. The body can stand tweaking for up to about two weeks. After two weeks of extreme dehydration and deprivation of electrolytes, your body crashes and the user collapses.

Q: Do people use meth in conjunction with other drugs?

Dr. Taylor: Yes. Meth is known as a poly-drug, because users often use other drugs in addition to meth. You'll find meth users who are also alcoholics. Alcohol is one of the only drugs that isn't a poly-drug. Alcoholics may only drink alcohol.

Q: When does the physical withdrawal from meth start?

Dr. Taylor: We see both acute withdrawal and subacute withdrawal with meth. If a user stops using meth but you allow them to sleep heavily and frequently, occasionally the user can

sleep through the acute withdrawal. Then, the kindling effect takes place around the 55-60 day mark. If a user can get past the 90 day mark, you won't see much attrition after that.

Q: Dr. Taylor talked about the importance of creating a safe environment for healing and growth at her organization. How can we, as agencies, create that safe haven?

Dr. Rivera: A women who is a victim of domestic violence develops very resilient instincts of survival and self-protection. They can walk into a room, immediately assess how safe they feel in the room, and walk out if they feel at all unsafe or anything amiss. Some people may say, "I don't feel safe vibrations here." What we must do is learn to create the type of environments that people will walk in and choose to stay.

Dr. Taylor: I work to create that feeling of a safe haven by first working to engender a strong sense of empathy in my staff. When a new staff member gets hired, they live the life of a client for the first entire week. They have to follow the program as if they were a recipient of services for one week. Not only does this process give me feedback as to how to improve the program, it also breaks the new staff of preconceived notions they may have and develops empathy in them. I think what is in the heart of your staff really helps to create that safe environment.

Dr. Rivera: Another thing that erodes the safety and warmth of an agency is what I call "othering." Othering occurs when you look at another person and treat them as the "other." You think of them in terms of "they," "them," and "those" instead of "we" and "us." Our clients respond to othering very negatively. It's a vibration. People who've felt it before have a very acute sense of perception for it. We should all work to make our agencies a place where our clients do not feel like "others" or "they."

Q: Can you give an example of the treatment/self-sufficiency continuum and how activities that help a person to become self-sufficient can be incorporated into treatment?

Dr. Rivera: For example, anger management and time management can both be considered part of substance abuse treatment, but they can also both be considered job preparation. These are skills needed to function in the workforce.

Q: Do you think that an increase in transparency on the part of agencies would also work to create a safe environment for clients? I feel like we could be more explanatory about our protocols and decision-making criteria.

Dr. Taylor: At Center Point, we don't sugarcoat anything for our clients. We also don't cover up for our clients. We tell them exactly how decisions are made, and we explain all of our procedures to them, so they know what they're getting into.

Ms. Nakashian: It seems to me that many of the questions here today have focused this notion of creating a safe environment for clients in a public agency. To me, that question, at its essence, asks: how do public systems operationalize trust? Trust can be developed across four dimensions: 1) making workers more trustworthy for clients; 2) making agencies more trustworthy for clients; 3) making workers more trustworthy for themselves; and 4) making agencies more trustworthy for workers.

5. REFLECTIONS ON DAY 1

The second day of the Roundtable event began with a short discussion between the moderator and the participants covering reflections and reactions to the information from day one. Dr. Rivera offered each of the eight regions a chance to speak about any noteworthy or pressing comments they'd like to address with the group. The following sub-sections of the report summarize the topics that were discussed during the morning's reflections.

Worker Safety

Various regions in North Dakota are operating programs within which mentors or paraprofessionals make home visits to conduct outreach activities. However, worker safety becomes a concern due to some of the impacts of meth use on behavior and cognition. Meth can make people dangerous, paranoid, and potentially belligerent after a prolonged period of tweaking. The issue of danger for workers and home visitors is a very important one and something we should address when safety protocols are designed for these outreach programs.

Relapses, Slipping, and Setbacks During the Process of Treatment

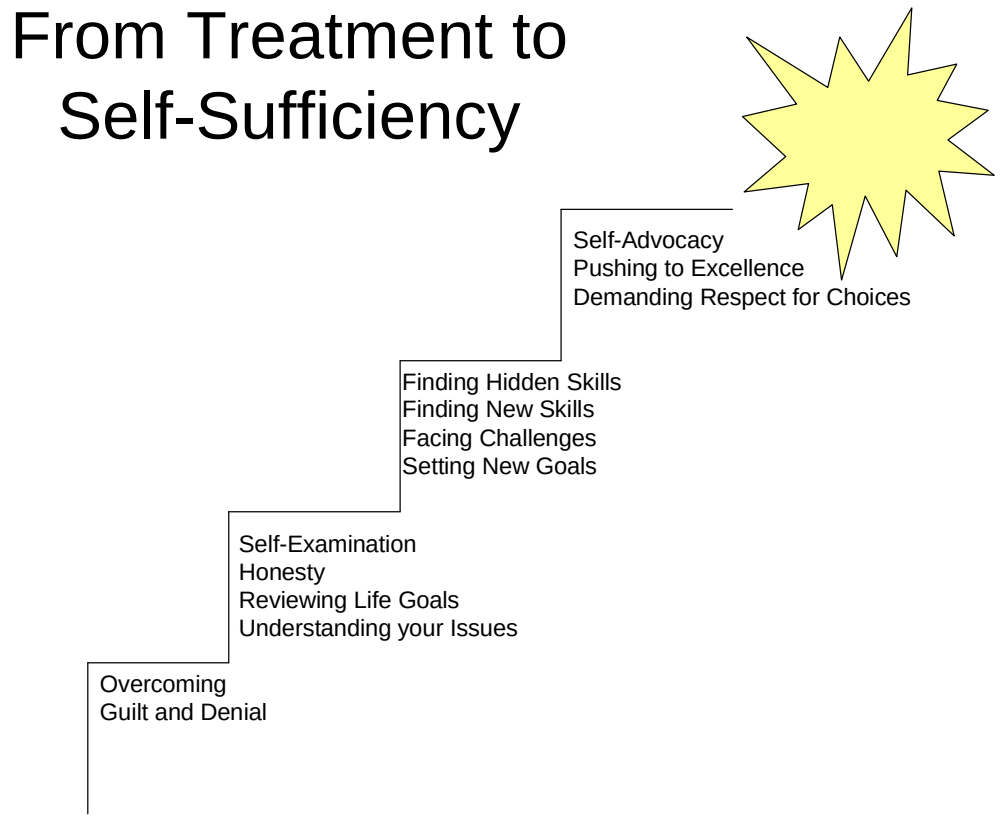
As part of TANF, there are consequences for noncompliance, and as part of Jobs Services, there are proof of performance requirements. Sanctions result when participants slip. However, it is important to brainstorm positive and persuasive strategies to keep participants engaged after a setback or relapse. As an addict tries to participate in treatment and find and maintain employment at the same time, if punitive measures for noncompliance are too strict, such measures may deter future engagement and push participants away. It is critical to ask the question: how do we help our people to perform at their best level, without allowing slipping or relapses to derail the entire pathway to self-sufficiency and process of recovery? The issue is further complicated when slippages and setbacks also have implications on family reunification, permanency, and child safety from a child welfare perspective. As relapses may be a part of the

treatment process, those relapses have implications on the ways that the TANF, workforce development, and child welfare systems will react.[9] Exhibit III-7 depicts the Staircase to Self-Sufficiency.

Tapping Community Resources

Many regions in North Dakota are facing resource constraints. These constraints require more imaginative thinking and new strategies to harness and maximize the use of other existing resources in the community. Public institutions may need to engage in proactive strategies to utilize more community resources. For example, a group of churches could band together and form a family crisis center. As an action step from this Roundtable, each region should assess all the resources available in their community and brainstorm new ways to tap those resources to serve families.

EXHIBIT III-7
STAIRCASE TO SELF-SUFFICIENCY



[9] Rivera, J. (2003). Defining and Operationalizing Work in the Substance Abuse Treatment Setting. Rockville, MD: Rivera, Sierra & Company, Inc.

The Welfare Peer TA Network is a service of the Office of Family Assistance, Administration for Children and Families, U.S. Department of Health and Human Services. The contractors supporting the Network are Rivera, Sierra & Company, Inc. and Caliber Associates, Inc. under Contract No. HHSP23320042907YC. For further information, please contact José A. Rivera, Project Director at 301-881-4700 or jrivera@riverasierra.com.