Recommendations of the NCIOM Task Force on Substance Abuse Services

Appendix F

Chapter 4:
Substance Abuse Comprehensive System of Care

PREVENTION

Recommendation 4.1 (PRIORITY RECOMMENDATION)

a) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) should develop a comprehensive substance abuse prevention plan for use at the state and local levels. The plan should increase the capacity at the state level and within local communities to implement a comprehensive substance abuse prevention system, prioritizing efforts to reach children, adolescents, young adults, and their parents. The goal of the prevention plan is to prevent or delay the onset of use of alcohol, tobacco, or other drugs, reduce the use of addictive substances among users, identify those who need treatment, and help them obtain services earlier in the disease process.

    1) DMHDDSAS should work with appropriate stakeholders to develop, implement, and monitor the prevention plan at the state and local level. Stakeholders should include, but not be limited to, other public agencies that are part of the Cooperative Agreement Advisory Board, consumer groups, provider groups, and Local Management Entities (LMEs).

    2) DMHDDSAS should direct LMEs to involve similar stakeholders to develop local prevention plans that are consistent with the statewide comprehensive substance abuse prevention plan.

b) North Carolina General Assembly should appropriate $1,945,000 in SFY 2010 and $3,722,000 in SFY 2011 in recurring funds to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) to develop this comprehensive substance abuse prevention.

c) Of the recurring funds appropriated by the North Carolina General Assembly, $1,770,000 in SFY 2010 and $3,547,000 in SFY 2011 should be used to fund six pilot projects to implement county or multi-county comprehensive prevention plans consistent with the statewide comprehensive substance abuse prevention plan. DMHDDSAS should make funding available on a competitive basis, selecting one rural pilot and one urban pilot in the three DMHDDSAS regions across the state. Technical assistance should be provided to the selected communities by the regional Centers for Prevention Resources. LMEs should serve as fiscal and management agencies for these pilots. The six pilot projects should:

    1) Involve community agencies, including but not limited to the following: Local Management Entities, local substance abuse providers, primary care providers, health departments, social services departments, local education agencies, local universities and community colleges, Healthy Carolinians, local tobacco prevention and anti-drug/alcohol coalitions, juvenile justice organizations, and representatives from criminal justice, consumer, and family advisory committees.

    2) Be comprehensive, culturally appropriate, and based on evidence-based programs, policies, and practices.

3) Be based on a needs assessment of the local community that prioritizes the substance abuse prevention goals.

4) Include a mix of strategies designed for universal, selective, and indicated populations.

5) Include multiple points of contact to the target population (i.e. prevention efforts should reach children, adolescents, and young adults in schools, community colleges and universities, and community settings).

6) Be continually evaluated for effectiveness and undergo continuous quality improvement.

7) Be consistent with the systems of care principles.

8) Be integrated into the continuum of care.

d) The North Carolina General Assembly should appropriate $250,000 of the Mental Health Trust Fund or from general funds to the DMHDDSAS to arrange for an independent evaluation of these pilot projects and for implementation of the state plan. The evaluation should include, but not be limited to, quantifying the costs of the projects; identifying the populations reached by the prevention efforts; and assessing whether the community prevention efforts have been successful in delaying initiation and reducing the use of tobacco, alcohol, and other drugs among children, adolescents, and young adults. To determine effectiveness, the evaluation should include an analysis of the performance of the pilot communities with appropriate comparison groups. The evaluation should also include other community indicators that could determine whether the culture of acceptance of underage drinking or other inappropriate or illegal substance use has changed, including but not limited to arrests for driving under the influence, underage drinking, or use of illegal substances; alcohol and drug related traffic crashes; reduction in other problem indicators such as school failure; and incidence of juvenile crime and delinquency.

e) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should use the findings from the independent evaluation of prevention services to develop a plan to implement the successful strategies statewide. The plan should be presented to the Legislative Oversight Committee on Mental Health within six months of when the evaluation is completed.

Recommendation 4.2

a) The North Carolina General Assembly should direct the State Board of Education, Office of Non-Public Education, North Carolina Community College System, and University of North Carolina System to review their existing substance abuse prevention plans, programs and/or policies, and availability of substance abuse screening and treatment services, in order to ensure that these educational institutions offer comprehensive substance abuse prevention, early intervention, and treatment services to students enrolled in their schools. These institutions should submit a description of their prevention plans, programs and/or policies, procedures for early identification of students with substance abuse problems, and information on screening, treatment, and referral services to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, the Appropriations Subcommittee on Education, and Education Committees no later than the convening of the 2010 session. The description should include the following:

1) Information about what evidence-based or promising prevention programs, policies, and practices have been or will be implemented to prevent or delay children, adolescents, and young adults from initiating the use of tobacco, alcohol, or other drugs, or reducing the use among those who have used these substances in public schools, community colleges, and the public universities.
2) Information from the State Board of Education on how local education agencies have implemented the substance abuse component of the Healthful Living Curriculum, including the educational curriculum or other services provided as part of the Safe and Drug Free Schools Act.
3) A plan from the Office of Non-Public Education to incorporate similar prevention strategies into home school and private school settings.
4) Information from the State Board of Education, North Carolina Community College System, and University of North Carolina System on the schools treatment referral plans, including linkages to the Local Management Entities and other substance abuse providers, the criteria used to determine when students need to be referred, and whether follow-up services and recovery supports are available on campus or in the community.

b) The Department of Public Instruction, North Carolina Community College System, and University of North Carolina system should coordinate their prevention efforts with the other prevention activities led by the DMHDDSAS to ensure the development of consistent messages and optimization of prevention efforts. Prevention efforts should be based on evidence-based programs that focus on intervening early and at each stage of development with age appropriate strategies to reduce risk factors and strengthen protective factors before problems develop.

Recommendation 4.3

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; the North Carolina Division of Alcohol Law Enforcement; the Division of Public Health; and the Department of Public Instruction should develop a strategic plan to further reduce tobacco and alcohol sales to minors. The plan may include, but not be limited to: additional compliance checks, outlet control or server education.

Recommendation 4.4 (PRIORITY RECOMMENDATION)

a) The North Carolina General Assembly should increase the tax on a pack of cigarettes to meet the current national average. The cigarette tax should be regularly indexed to the national average whenever there is a difference of at least 10% between the national average cost of a pack of cigarettes (both product and taxes) and the North Carolina average cost of a pack of cigarettes.

b) The North Carolina General Assembly should increase the tax on all other tobacco products to be comparable to the current national cigarette tax average, which would be 50% of the product wholesale price.

c) The increased fees should be used to fund effective prevention and treatment efforts for alcohol, tobacco, and other drugs.

Recommendation 4.5

The North Carolina General Assembly should appropriate $1.5 million in recurring funds to the Division of Public Health to support Quitline NC. The Division of Public Health should use some of this funding to educate providers and the public about the availability of this service.

Recommendation 4.6 (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should enact a law which prohibits smoking in all public buildings including, but not limited to, restaurants, bars, and worksites.

Recommendation 4.7 (PRIORITY RECOMMENDATION)

a) **In order to reduce underage drinking, the North Carolina General Assembly should increase the excise tax on malt beverages (including beer). Malt beverages are the alcoholic beverages of choice among youth, and youth are sensitive to price increases.**

b) **The excise taxes on malt beverages and wine should be indexed to the consumer price index so they can keep pace with inflation. The excise tax for beer was last increased in 1969, and wine was last increased in 1979. The increased fees should be used to support prevention and treatment efforts for alcohol, tobacco, and other drugs.**

c) **The increased fees should be used to fund effective prevention and treatment efforts for alcohol, tobacco, and other drugs.**

d) **The North Carolina General Assembly should appropriate $2.0 million in recurring funds in SFY 2010 to support a comprehensive alcohol awareness education and prevention campaign aimed at changing cultural norms to prevent initiation, reduce underage alcohol consumption, reduce alcohol abuse or dependence, and support recovery among adolescents and adults.**

Recommendation 4.8

The North Carolina General Assembly should not lower the drinking age to less than age 21.

Recommendation 4.9 (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should appropriate $610,000 in recurring funds in SFY 2010 to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services over three years to support efforts to reduce high-risk drinking on college campuses.

a) **$500,000 per year should be used to be used to replicate the Study to Prevent Alcohol Related Consequences (SPARC) intervention at six additional North Carolina public universities by establishing campus/community coalitions that use a community organizing approach to implement evidence-based, environmental strategies.**

b) **$110,000 per year should be allocated to provide coordination, monitoring and oversight, training and technical assistance, and evaluation of these campus initiatives.**

Recommendation 4.10

a) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; the Division of Public Health; the Division of Social Services; and appropriate provider associations should develop a prevention plan to prevent fetal alcohol spectrum disorders and use of other drugs during pregnancy and report this plan to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services no later than July 1, 2009. The plan should include baseline data and evidence-based strategies that have been shown to be effective in reducing use of alcohol or other drugs in pregnant women and adolescents as well as strategies for early screening and identification, intervention, and treatment for children who are born with fetal alcohol spectrum disorders or addicted to other drugs in utero. The plan should:

1) Focus on women and adolescents at most risk of giving birth to children with fetal alcohol spectrum disorders.

2) Identify a standardized substance abuse screening tool that local health departments, primary care, and obstetrical providers can use for early identification and appropriate referral for services for pregnant women.

3) Include strategies to educate, train, and support caregivers of children born with fetal alcohol spectrum disorders.

4) Identify strategies to educate primary care providers about early identification of infants and young children born with fetal alcohol syndrome disorder or addicted to other drugs, available treatment, and community resources for the affected children and their families.

Recommendation 4.11

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should work with the North Carolina Medical Society, North Carolina Academy of Family Physicians, North Carolina Psychiatric Association, North Carolina Chapter of the American Society of Addiction Medicine, Governor's Institute on Alcohol & Substance Abuse, physician representation from the Controlled Substances Reporting System (CSRS) Advisory Committee, and North Carolina Office of the Attorney General to explore options to allow for the exchange of information obtained from the CSRS between health care practitioners.

EARLY INTERVENTION

Recommendation 4.12

a) North Carolina health professional schools, the Governor's Institute on Alcohol and Substance Abuse, the North Carolina Area Health Education Centers (AHEC) program, residency programs, health professional associations, and other appropriate organizations should expand Screening, Brief Intervention, and Referral to Treatment (SBIRT) training for primary care providers and other health professionals in academic and clinical settings, residency programs or other continuing education programs with the goal of expanding the health professional workforce that has demonstrated competencies in SBIRT. The curriculum should include information and skills-building training on:

1) Evidence-based screening tools to identify people who have or are at risk of tobacco, alcohol, or substance abuse or dependency.
2) Motivational interviewing.
3) Brief interventions including counseling and brief treatment.
4) Assessments to identify people with co-occurring mental illness.
5) Information about appropriate medication therapies for people with different types of addiction disorders.
6) Successful strategies to address commonly cited disincentives to care for patients in a primary care.
7) Strategies to successfully engage people with more severe substance abuse disorders and refer them to specialty addiction providers for treatment services.
8) The importance of developing and maintaining linkages between primary care providers and trained addiction specialists to ensure bi-directional flow of information and continuity of care.

Recommendation 4.13 (PRIORITY RECOMMENDATION)

a) The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) should work collaboratively with the North Carolina Office of Rural Health and Community Care (ORHCC), the Governor's Institute on Alcohol and Substance Abuse, North Carolina Area Health Education Centers (AHEC) program, and other appropriate professional associations to educate and encourage healthcare professionals to use evidence-based screening tools and offer motivational counseling, brief intervention, medication assisted therapies, and referral to treatment to help patients prevent, reduce, or eliminate the use of or dependency on alcohol, tobacco, and other drugs as outlined in the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model.

b) The North Carolina General Assembly should appropriate $1.5 million in recurring funds to DMHDDSAS to work with the aforementioned groups to develop a plan to implement SBIRT within primary care and ambulatory care settings. The plan should include:

   1) Mental health and substance abuse system specialists to work with the 14 Community Care of North Carolina (CCNC) networks and other provider groups. These staff will work directly with the CCNC practices to implement and sustain evidenced-based practices and coordination of care between primary care and specialty services. This would include but not be limited to the SBIRT model allowing for primary care providers to work toward a medical home model that has full integration of physical health, mental health, and substance abuse services. In keeping with the SBIRT model, the mental health and substance abuse system specialists would work within communities to develop systems that facilitate smooth bidirectional transition of care between primary care and specialty substance abuse care.
   2) Efficient methods to increase collaboration between providers on the shared management of complex patients with multiple chronic conditions that is inclusive of mental health, developmental disabilities, and substance abuse. An effective system would smooth transitions, reduce duplications, improve communication, and facilitate joint management while improving the quality of care.

3) A system for online and office-based training and access to regional quality improvement specialists and/or a center of excellence that would help all healthcare professionals identify and address implementation barriers in a variety of practice settings such as OB/GYN, emergency room, and urgent care.

4) Integrated systems for screening, brief intervention, and referral into treatment in outpatient settings with the full continuum of substance abuse services offered through DMHDDSAS.

Recommendation 4.14

a) The North Carolina Office of Rural Health and Community Care should work in collaboration with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; the Governors Institute on Alcohol and Substance Abuse; the ICARE partnership; and other professional associations to support and expand co-location in primary care practices of licensed health professionals trained in providing substance abuse services.

b) The North Carolina General Assembly should provide $750,000 in recurring funds to the North Carolina Office of Rural Health and Community Care to support this effort. Primary care practices eligible for state funding include private practices, federally qualified health centers, local health departments, and rural health clinics that participate in Community Care of North Carolina. Funding can be used to help support the start-up costs of co-location of licensed substance abuse professionals in primary care practices for services provided to Medicaid and uninsured patients. Alternatively, funding may be used to support continuing education of mental health professionals who are already co-located in an existing primary care practice in order to help them obtain substance abuse credentials to be qualified to provide substance abuse services to Medicaid and uninsured patients with substance use disorders. The goal is to offer evidence-based screening, counseling, brief intervention, and referral to treatment to help patients prevent, reduce, or eliminate the use of or dependency on tobacco, alcohol, and other drugs. Funding priority should be given to practices that meet one or more of the following criteria:

   1) Primary care practices with a co-located mental health professional.

   2) Primary care practices with a significant population of dually diagnosed patients with mental health and substance abuse problems who have prior experience in screening and intervention for mental health and/or substance abuse problems.

   3) Primary care practices actively involved in other chronic disease management programs.

Recommendation 4.15 (PRIORITY RECOMMENDATION)

a) The North Carolina General Assembly should mandate that insurers offer coverage for the treatment of addiction diseases with the same durational limits, deductibles, coinsurance, annual limits, and lifetime limits as provided for the coverage of physical illnesses.

b) The North Carolina General Assembly should direct the Division of Medical Assistance, North Carolina Health Choice program, State Health Plan, and other insurers to review their reimbursement policies to ensure that primary care and other providers can be reimbursed to screen for tobacco, alcohol, and drugs, provide brief intervention and counseling, and refer necessary patients for specialty services.

1) Specifically, the plans should provide reimbursement for:
    i) Screening and brief intervention in different health settings including, but not limited to, primary care practices (including OB/GYN, federally qualified health centers, rural health clinics, and hospital-owned outpatient settings), emergency departments, Ryan White Title III medical programs, and school-based health clinics.
    ii) CPT codes for health and behavior assessment (96150-96155), health risk assessment (99420), substance abuse screening and intervention (99408, 99409), and tobacco screening and intervention (99406, 99407) and should not be subject to therapy code preauthorization limits.
    iii) Therapy codes (90801-90845) for primary care providers who integrate qualified mental health professionals into their practices.
    iv) Appropriate telephone and face-to-face consultations between primary care providers and psychiatrists or other specialists. Specifically, payers should explore the appropriateness of reimbursing for CPT codes for consultation by a psychiatrist (99245).
2) Reimbursement for these codes should be allowed on the same day as a medical visit's evaluation and management (E&M) code when provided by licensed mental health and substance abuse staff.
3) Fees paid for substance abuse billing codes should be commensurate with the reimbursement provided to treat other chronic diseases.
4) Insurers should allow psychiatrists to bill using E&M codes available to other medical disciplines.
5) Providers eligible to bill should include licensed healthcare professionals including, but not limited to, primary care providers, mental health and substance abuse providers, emergency room professionals, and other healthcare professionals trained in providing evidence-based substance abuse and mental health screening and brief intervention.

c) The Division of Medical Assistance should work with the Office of Rural Health and Community Care (ORHCC) to develop an enhanced Carolina Access (CCNC) per member per month (PMPM) for co-located practices to support referral and care coordination for mental health, developmental disabilities, and substance abuse services.

d) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, in collaboration with the ORHCC, should work collaboratively with the Governor's Institute on Alcohol and Substance Abuse, Academy of Family Physicians, North Carolina Pediatric Society, North Carolina Psychiatric Association, North Carolina Primary Health Care Association, ICARE, and other appropriate groups to identify and address barriers that prevent the implementation and sustainability of co-location models and to identify other strategies to promote evidence-based screening, counseling, brief intervention, and referral to treatment in primary care and other outpatient settings.

COMPREHENSIVE SYSTEM OF SPECIALIZED SUBSTANCE ABUSE SERVICES

Recommendation 4.16 (PRIORITY RECOMMENDATION)

a) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) should develop a plan organized around a recovery-oriented system of care to ensure that an appropriate mix of substance abuse services and recovery supports for both children and adults is available and accessible throughout the state. The plan should utilize the American Society of Addiction Medicine (ASAM) levels of care. In developing this plan, DMHDDSAS should:

   1) Develop a complete continuum of locally and regionally accessible substance abuse crisis services and treatment and recovery supports.

   2) Ensure effective coordination of care between substance abuse providers within and between different ASAM levels of care as well as with other health professionals such as primary care providers, emergency departments, or recovery supports.

   3) Develop a minimum geographic-based access standard for each service. In developing its plan, DMHDDSAS should identify strategies for building an infrastructure in rural and underserved areas.

   4) Include evidence-based guidelines for the number of patients to be served, array of services, and intensity and frequency of the services.

b) DMHDDSAS should work with Local Management Entities (LMEs) and providers to develop a more comprehensive performance-based accountability plan that includes incentives and contract requirements between the Division, LMEs and providers.

   1) The plan should include meaningful substance abuse performance measures for LMEs and providers to ensure that: substance abuse services are successfully extended to a significant portion of those persons in need, substance abuse services are provided to individuals in a timely fashion, people are provided the intensity of services appropriate to their needs, people are engaged in treatment for appropriate lengths of time, individuals successfully complete treatment episodes, and that these individuals are provided appropriate recovery supports.

   2) This plan may include, but not be limited to, financial incentive payments, regulatory and/or monitoring relief, advantages in the competitive bidding process, independent peer review recognition, and broader infrastructure support.

   3) The plan should strengthen the Division's current performance benchmarking system for LMEs, including the establishment of more rigorous performance standards and targets for LMEs.

   4) The plan should develop a similar performance benchmarking system for LMEs to use with providers. The benchmarking system for providers should include, but not be limited to, measures of active engagement, consumer outcomes, fidelity with evidence-based or best practices, client perception of care, and program productivity.

   5) In developing the plan, DMHDDSAS, LMEs and providers should consider other incentive strategies developed by the National Institute on Drug Abuse Blending Initiative.

   6) The plan should include data requirements to ensure that program performance is measured consistently by LMEs and providers across the state.

c) DMHDDSAS should develop a plan to implement electronic health records for providers that use public funds.

d) DMHDDSAS should develop consistent requirements across the state that will reduce paperwork and administrative barriers including but not limited to:

   1) Uniform forms for admissions, screening, assessments, treatment plans, and discharge summaries that are to be used across the state.

   2) Standard contract requirements and a system that does not duplicate paper work for agencies that serve residents of multiple LMEs.

   3) Methods to ensure consistency in procedures and services across LMEs along with methods to enforce minimum standards across the LMEs. Enforcement methods should include, but not be limited to, remediation efforts to help ensure consistent standards.

   4) Standardized outcome measures.

e) DMHDDSAS should develop a system for timely conflict resolutions between LME and contract agencies.

f) DMHDDSAS should work with its Provider Action Agenda Committee to identify barriers and strategies to increase the quality and quantity of substance abuse services and providers in the state. These issues include, but are not limited to, administrative barriers, service definitions, and reimbursement issues.

g) DMHDDSAS, in collaboration with the Department of Juvenile Justice and Delinquency Prevention and the Department of Public Instruction, should immediately begin expanding the capacity of needed adolescent treatment services across the state including new capacity in the clinically intensive residential programs, consistent and effective screening, assessment, and referral to appropriate treatment and recovery supports for identified youth. In addition, the plan should systematically strengthen early intervention services for youth and adolescents in mainstream settings such as schools, primary care, and juvenile justice venues.

h) DMHDDSAS should report the plans specified in Recommendation 4.16.a-b, report on the progress in developing the plan for electronic health records in Recommendation 4.16.c, and report on progress made in implementing Recommendations 4.16.d-g to the NCIOM Task Force on Substance Abuse Services and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services no later than September 2008.

Recommendation 4.17

a) The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) should select six county or multi-county regions to develop and implement a recovery-oriented system of care.

b) The North Carolina General Assembly should appropriate $17.2 million in SFY 2010 and $34.4 million in SFY 2011 to DMHDDSAS in recurring funding to support these six pilot programs. DMHDDSAS should make funding available on a competitive basis, selecting one rural pilot and one urban pilot in the three DMHDDSAS regions across the state. Funding should include planning, evaluation, and technical assistance. The pilot programs should:

1) Identify those in need of treatment.
2) Ensure or provide a comprehensive continuum of services for adolescents and adults. Services should include screening, counseling, brief treatment, and the full spectrum of ASAM services for both adolescents and adults.
3) Provide recovery supports for those who return to their communities after receiving substance abuse specialty care, including Oxford Houses or other appropriate recovery supports. The goal of the project is to reduce the length and duration of relapses that require additional specialty substance abuse care. Programs should work closely with existing recovery services, programs, and individuals and build on the foundations that exist in their local communities.
4) Ensure effective coordination of care between substance abuse providers within and between different ASAM levels of care as well as with other health professionals such as primary care providers, hospitals, or recovery supports.

c) The North Carolina General Assembly should appropriate $750,000 of the Mental Health Trust Fund or general appropriations to the DMHDDSAS to arrange for an independent evaluation of these pilot programs. The evaluation should compare the performance of the pilot programs to comparison (control) counties to determine whether the comprehensive pilot programs lead to increased number of patients served, timely engagement, active participation with appropriate intensity of services, and program completion.

d) The DMHDDSAS should use the findings from the independent evaluation of the pilot programs implementing county or multi-county recovery-oriented systems of care to develop a plan to implement the successful strategies statewide. The plan should be presented to the Legislative Oversight Committee on Mental Health within six months of when the evaluation is completed.

Recommendation 4.18 (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should appropriate:

a) $650,000 in recurring funds to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Servcies to hire 13 FTE staff to assist in developing and implementing a statewide comprehensive prevention plan, a recovery-oriented system of care, a plan for performance-based incentive contracts, and consistent standards across the state to reduce paperwork and administrative barriers; oversee and provide technical assistance to the pilot programs; and otherwise help implement the Recommendations 4.1-4.3, 4.9-4.10, 4.13, 4.14-4.17, and Recommendation 5.1, supra.

b) $100,000 in recurring funds to the Department of Public Instruction to hire staff to implement Recommendations 4.1-4.3 and 4.16 above.

c) $130,000 in recurring funds to Office or Rural Health and Community Care to hire a statewide coordinator and administrative support to work directly with the regional Community Care of North Carolina quality improvement specialists funded in recommendation 4.13 and to assist in implementing recommendation 4.14.

d) $81,000 in recurring funds and $50,000 in nonrecurring funds to the Department of Health and Human Services, Division of Medical Assistance, to hire five positions to implement Recommendations 4.13-4.15 above.

Chapter 5: Substance Abuse Prevention and Treatment Programs Targeted to Specific Subpopulations

CHILDREN, YOUTH, AND YOUNG ADULTS

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.

ADULTS

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.

Recommendation 5.3:

The North Carolina General Assembly should ensure that by 2014:

a) All individuals advertising and promoting themselves as providing 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.

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.

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.

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.

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.

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

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.

Chapter 6: Substance Abuse Workforce

Recommendation 6.1 (PRIORITY RECOMMENDATION)

a) The North Carolina General Assembly should appropriate $750,000 in recurring funds in SFY 2010, $1.5 million in recurring funds in SFY 2011, increasing to $2.0 million in SFY 2013 to the Governor's Institute on Alcohol and Substance Abuse to create a scholarship program to increase the number of qualified professionals in the field of substance abuse treatment. Funding should be used to:

   1) Pay up to $3,000 per year for up to two years of community college training for 50 students enrolled in a human services program with the intention to enter the substance abuse field.

   2) Pay up to $5,000 per year for up to four years of undergraduate training for 50 qualified undergraduates who have declared a major in a human services occupation that would meet the requirements for LCAS, CSAC, CSAPC, CSARFD, or CCJP

   3) Pay up to $5,000 per year for up to two years of graduate level substance abuse training to 50 eligible individuals with a bachelor's degree who have been accepted into one of North Carolina's master's level substance abuse programs.

   4) Pay up to $2,000 per year for up to two years to purchase training or supervision hours for 50 qualified individuals with a bachelor's or master's degree in an appropriate field who are working towards CSAC, LCAS, or CCS licensure.

   5) Students who receive scholarship funds would be required to work for one year in a public or private not-for-profit substance abuse treatment program for every $4,000 received in scholarship funds and would be required to pursue substance abuse licensure or certification.

   6) Students who do not complete their substance abuse training or licensure, or who fail to meet the work requirements would be required to pay back the scholarship funds with 10% interest with appropriate time standards.

b) The North Carolina General Assembly should appropriate $200,000 in recurring funds in FY 2010 to the Area Health Education Centers program to create and incentivize five programs to serve as substance abuse clinical training sites for people seeking CSAC, LCAS, CCS, CCJP, CSARFD or CSAPC credential.

Recommendation 6.2

a) The Area Health Education Centers Program should work with the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, the North Carolina Psychiatric Association, and other relevant organizations to develop residency rotations for psychiatrists and other physicians in addiction medicine. The goal is to develop clinical training opportunities in existing residency programs in Alcohol and Drug Addiction Treatment Centers and other appropriate settings to improve the substance abuse training of psychiatrists, family physicians, emergency medicine or other physicians likely to enter into the addiction field in both inpatient and outpatient settings.

b) The North Carolina General Assembly should appropriate $200,000 in recurring funds in SFY 2010 to the Area Health Education Centers program to develop and support new clinical training rotations for residents in substance abuse.

Recommendation 6.3

The North Carolina State Personnel Commission should:

a) Reevaluate and increase the pay grades for substance abuse professionals with a LCAS, CCS, CSAC, CCJP, and CSAPC credentials.

b) Allow for a trainee progression for LCAS and CCS.

Chapter 7: Data

Recommendation 7.1

a) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) should develop a long-term consumer-centered Information Technology (IT) vision and plan to meet the state's data needs through enhanced integration of current systems, including the statewide adoption of an Electronic Health Record among community providers and LMEs.

b) The North Carolina General Assembly should appropriate $1.2 million in recurring funds to DMHDDSAS to enhance and expand current data collection systems and develop new data systems as needed to provide epidemiological information on people with substance abuse issues across the lifespan.

c) The DMHDDSAS should develop capacity to utilize data to identify patterns and trends in the prevalence, prevention, and treatment of substance abuse so as to provide an evidence-based process for the development and evaluation of prevention and treatment interventions, as well as provide a data-driven platform for the funding of prevention and treatment programs across the state.

d) The DMHDDSAS should review national research on patterns of consumer participation and client referral within the substance abuse prevention and treatment systems. Special studies should be undertaken as needed to determine if there are systemic patterns and barriers to identification, referral, and engagement of substance abuse consumers into treatment in North Carolina.

e) The DMHDDSAS should enhance their collection and analysis of data on substance abuse services to include information on:

    1) Active identification and timely screening, triage, and referral into care for substance abuse consumers separately from other disability groups.

    2) Timely and effective coordination of care between screening, triage, and referral (STR) and engagement in treatment.

    3) Length of time in treatment.

4) **Responsiveness of community systems, including utilization of inpatient programs, as is currently done for detox and outpatient programs.**
5) **Admission and readmission into Alcohol and Drug Abuse Treatment Centers, as is currently done for state hospitals.**
6) **Continuity of care after discharge from detox and inpatient programs, as is currently done for Alcohol and Drug Abuse Treatment Centers, and state hospitals.**
7) **Provision of recovery-oriented treatment and support within communities.**

Recommendation 7.2

a) **The Department of Juvenile Justice (Juvenile Crime Prevention Council), Department of Corrections (Criminal Justice Partnership program), Division of Public Instruction, Division of Social Services, Division of Public Health, and county commissioners should provide data to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services quarterly on public funds used to support substance abuse prevention and treatment services, number of people served, and types of services provided in each county.**

b) **The North Carolina General Assembly should choose and implement an equalization formula to ensure that Local Management Entities (LMEs) receive comparable funding to achieve equity in access to care and services while recognizing the inherent challenges of delivering services in low-wealth rural counties. This equalization formula should be used to distribute any new state funds provided to support substance abuse prevention and treatment activities, with low-funded LMEs obtaining a higher proportion of the funding.**