**2008-2009 Task Force on Substance Abuse**
**Updates to Recommendations: 2013**

Dependence on alcohol, tobacco, and other drugs is a complex and costly chronic illness that remains a serious problem for North Carolina. More than 575,000 people in North Carolina aged 12 years or older (7.3% of all individuals in this age group) report dependence or abuse of illicit drugs or alcohol in the past year.[1] Of these individuals, 232,000 (2.9%) individuals report illicit drug dependence or abuse and 388,000 (4.9%) report alcohol dependence or abuse.[2] While the prevalence of alcohol dependence and abuse has decreased in the past decade (from about 6.8%) the rate of dependence and abuse of illicit drugs has remained steady.[3] The prevalence of both alcohol and illicit drug dependence or abuse peak among young adults reaching 11.6% and 8% respectively among adults in North Carolina aged 18-25 years.[4]

Substance abuse incurs both direct and indirect costs to the individual and society—in addition to the costs of prevention, treatment, and recovery supports, substance abuse is associated with motor vehicle accidents, premature death, comorbid health conditions, disability, loss of productivity, crime, unemployment, poverty, homelessness, and unwanted pregnancies among other social problems. Alcohol and substance dependence and abuse is estimated to have cost the North Carolina economy over $12.4 billion in 2004.[5]

The prevention, diagnosis, and treatment of substance abuse is challenging for several reasons. Many individuals with substance abuse problems either do not recognize their problem, do not seek treatment, or are not able to access the services they need. Chronic diseases, including substance abuse disorders, are generally lifelong conditions. They are not "cured" in the acute care sense. Instead, the goal of treatement is to manage an individual's disorder so that the burden is minimzed as much as possible. People with substance abuse problems need ongoing recovery supports to help prevent relapse. Despite the high costs to the state, and the substantial need for ongoing preention, diagnosis, treatment and recovery services, more than 350,000 (4.5%) people in North Carolina aged 12 years or older report needing but not receiving treatment for aochol use in the past year and 215,000 (2.7%) people report needing, but not receiving treatment for illicit drug use.[6] Without a recovery-oriented system of care in place, those in need of services may continue to face a downward spiral. State efforts that ensure appropriate and evidence-based education, prevention, treatment, and recovery resources can

[1] NSDUH 2011-2012 Table 20
[2] NSDUH 2011-2012 Tables 16 & 18
[3] http://www.samhsa.gov/data/sites/default/files/NSDUHStateEst2011-2012/TrendTabs/Web/NSDUHsaeTrendTabs2012.pdf
[4] NSDUH 2011-2012 Tables 16 & 18
[5] Original Report, Exec. Summry #5 (Alcohol/Drug Council of NC)
[6] NSDUH 2011-2012 Tables 21 & 22

minimize the myriad problems associated with substance abuse and dependence and improve the quality of life for communities statewide.

In January 2009, the North Carolina Institute of Medicine (NCIOM) released a report entitled "Building a Recovery-Oriented System of Care: A Report of the NCIOM Task Force on Substance Abuse Services."[7] The report was the culmination of twelve months of work by the NCIOM Task Force on Substance Abuse. The North Carolina General Assembly asked the NCIOM to convene a Task Force to study substance abuse services in the state (SL-2007-323 §10.53A). The Task Force consisted of 54 legislators, state and local agency officials, substance abuse providers, and other health professionals, consumers, educatiors, and other knowledgable and interested inviduals. The North Carolina General Assembly charged the Task Force with nine goals, specifically:

1. Identifying the continuum of services needed for treatment of substance abuse services including, but not limited to, prevention, outpatient services, residential treatment, and recovery support.
2. Identifying evidence-based models of care or promising practices in coordination with the North Carolina Practice Improvement Collaborative for the prevention and treatemtn of substance abuse services and developing recommendations to incorporate tehse models into the current substance abuse service system of care.
3. Examining different financing options to pay for substance abuse services at the local, regional, and state levels.
4. Examining the adequacy of the current and future substance abuse workforce.
5. Devloping strategies to identify people in need of substance abuse services, including people who are dually diagnosed as having mental health and substance abuse problems.
6. Examining barriers that people with substance abuse problems have in accessing publicly-funded substance abuse services and explore possible strategies for improving access.
7. Examining current outcome measures and identifying other appropriate outcome measures to assess the effectiveness of substance abuse services.
8. Examining the economic impact of substance abuse in North Carolina.
9. Making recommendations on the implementation of a cost-effective plan for prevention, early screening, diagnosis, and treatment of North Carolinians with substance abuse problems.

The Task Force made 31 recommendations to improve substance abuse services and to reduce the incidence of substance abuse across North Carolina. This 2013 update includes information

[7] North Carolina Institute of Medicine Task Force on Substance Abuse Servces, *Building a Recovery-Oriented System of Care: A Report of the NCIOM Task Force on Substance Abuse Services*. Morrisville, NC: North Carolina Institute of Medicine; 2009. Available here: http://www.nciom.org/publications/?substanceabuseservices.

about the progress that has been made to implement the 2009 Task Force recommendations. In total, progress has been made in implementing 17 (55%) of all the Task Force recommendations. No action has been taken to implement 14 (45%) of the recommendations.

Total Recommendations: 31

- Fully Implemented: 5 (16%)
- Partially Implemented: 12 (39%)
- Not Implemented: 14 (45%)

**PREVENTION**

**Recommendation 4.1 (PRIORITY RECOMMENDATION) Partially Implemented**

**a) 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) The General Assembly should appropriate $1,945,000 in SFY 2010 and $3,722,000 in SFY 2011 in recurring funds to DMHDDSAS to develop this comprehensive substance abuse prevention.**

**c) Of the recurring funds appropriated by the 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 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: LMEs, 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 General Assembly should appropriate $250,000 of the Mental Health Trust Fund or from general funds to 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) **DMHDDSAS 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.**

DMHDDSAS applied for and was awarded a Strategic Prevention Framework State Prevention Enhancement Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). This one-year grant totaling $598,000 was awarded September 1, 2011. A portion of this grant funded the development of a statewide, five-year strategic plan for substance abuse prevention. Planning focused on substance abuse prevention; enhancing data collection, analysis, and reporting; service coordination; and the provision of technical assistance and training.

The General Assembly did not appropriate funding for strategic planning activities or for the implementation and evaluation of comprehensive local pilots.

**Recommendation 4.2:** **Not Implemented**

**a) The 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.[8]**
2) **Information from the State Board of Education on how local education agencies have implemented the substance abuse component of the Healthful**

[8] The Task Force was unable to identify any evidence-based strategies that had been tested to prevent, delay, or reduce the use of alcohol or drugs on a community-college setting, as the students are commuters and generally older than on college campuses. Therefore, the Task Force recommended that the North Carolina Community College System identify best practices for use in a community college system.

**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 LMEs 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 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.**

Currently, the General Assembly does not have a system or provisions in place to require state board of education or other university and college systems to review and report on substance abuse prevention plans, early intervention, or treatment services.

**Recommendation 4.3:** **Fully Implemented**

**DMHDDSAS; the North Carolina Division of Alcohol Law Enforcement; the Division of Public Health (DPH); 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.**

In September 2011, the Food and Drug Administration (FDA) awarded DMHDDSAS a federal grant (approximately $600,000) to implement an NC Tobacco Inspection Program to enforce Family Smoking Prevention and Tobacco Control Act (2009) requirements. This federal contract aims to meet two primary objectives: 1) to provide funding to conduct inspections in retail tobacco outlets in an effort to enforce photo/age requirements for the purchase of tobacco products as well as advertising and labeling restrictions and 2) to "protect kids from tobacco use" by significantly reducing access to and the appeal of cigarettes and smokeless tobacco products to children and adolescents. This FDA grant is a one year grant but may be renewed for two additional years.[9] DMHDDSAS has since been notified that the FDA contract has been extended (Option Period 1) for an additional year ending September 11, 2013.

[9] Information about this FDA Program can be found at www.fda.gov/TobaccoProducts/

During the FY contract period, DMHDDSAS conducted approximately 2,500 inspections of retail tobacco outlets. The Division is contracted to conduct 4,000 inspections of retail tobacco outlets in FY 2013 to enforce photo/age requirements for the purchase of tobacco products and advertising and labeling restrictions as outlined in the Family Smoking Prevention and Tobacco Control Act.

DMHDDSAS, in partnership with the Division of Alcohol Law Enforcement, hosted four regional workshops in May 2012 entitled "Partnering to Reduce Youth Access to Tobacco Products: Exploring New Opportunities!" The workshops accomplished the following tasks: 1) an environmental scan to highlight how far we have come in reducing youth tobacco access and youth tobacco use in NC; 2) a discussion involving the role of the federal FDA in protecting kids from tobacco, an overview of the Family Smoking Prevention and Tobacco Control Act, and a discussion involving future federal funding opportunities; 3) a review of available resources such as a Merchant Education Toolkit; and 4) a demonstration of two new web-based tools communities can use to enhance their current youth tobacco access programs. There were 120 participants in attendance including local substance abuse prevention staff, tobacco prevention staff, law enforcement agents, school personnel and community agencies.

Finally, the NC Preventing Underage Drinking Initiative is currently funded through the Office of Juvenile Justice and Delinquency Prevention Enforcing Underage Drinking Laws program through May 2013. There is no further funding planned for the Enforcing Underage Drinking Laws block grant program at this time beyond May 2013. The NC Preventing Underage Drinking Initiative provides funding support to 11 communities to implement environmental management strategies to prevent underage alcohol use with a particular focus on access, norms, and policies.[10]

**Recommendation 4.4 (PRIORITY RECOMMENDATION): Not Implemented**

- **a) The 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 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 evidence-based prevention and treatment efforts for alcohol, tobacco, and other drugs.**

[10] http://www.ncpud.org/about/index.php

North Carolina's cigarette tax was raised $0.10 in 2009 to $0.45 per pack. However, DPH is continuing to track the national cigarette tax average and advocates that NC's cigarette tax be raised to meet the national average. As of March 2012 (according to The Campaign for Tobacco Free Kids), the cigarette tax average for States was $1.46 per pack. Among States, North Carolina ranks 45th—taxing at the 5th lowest rate.[11] In March 2011, a bill was introduced that proposed raising the cigarette tax by $1.00 to meet the national average.[12] Since its introduction, there has been no movement on the bill.[13]

**Recommendation 4.5:** **Not Implemented**

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

During the 2011 legislative session, the General Assembly approved a budget that abolished the Health and Wellness Trust Fund, a program that has been instrumental in decreasing the youth smoking rate to the lowest rate in state history. Due to the abolishment of the Health and Wellness Trust Fund, Quitline funding will only continue through non-recurring state funds.

The General Assembly appropriated $2.4 million in non-recurring funds to DPH for SFY2012-2013 to support teen tobacco prevention. Some of these funds may be used to support the Quitline. DPH will still receive funding from the State Health Plan (for their plan members only) and HRSA(for the uninsured) to support the Quitline; however, there remains no idenitified recurring funding for QuitlineNC.

**Recommendation 4.6 (PRIORITY RECOMMENDATION):** **Fully Implemented**

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

On January 1, 2010 a law went into effect making NC restaurants and bars smoke-free.[14] North Carolina's smoke-free law prohibits smoking in enclosed areas of almost all bars and restaurants. Under the new law, smoking is also prohibited in most enclosed areas of lodging establishments including hotels, motels, and inns, if the lodging establishment prepares and serves food, or beverages. Further, lodging establishments may designate no more than 20% of its guest rooms as smoking rooms.

[11] http://www.tobaccofreekids.org/research/factsheets/pdf/0097.pdf
[12] http://www.ncleg.net/Sessions/2011/Bills/House/PDF/H341v1.pdf
[13] http://www.ncga.state.nc.us/gascripts/BillLookUp/BillLookUp.pl?Session=2011&BillID=S338
[14] http://www.ncga.state.nc.us/enactedlegislation/statutes/html/bysection/chapter_130a/gs_130a-496.html

This law has been successfully implemented in NC, improving air quality in NC restaurants and bars by an estimated 89%.[15] In the year that the new law was implemented, NC saw a 21% decline in emergency department visits from heart attacks. [16] Employees reporting exposure to secondhand smoke in the last week, declined from 14.6% in 2008 to 7.8% in 2010.[17]

**Recommendation 4.7 (PRIORITY RECOMMENDATION): Partially Implemented**

a) **In order to reduce underage drinking, the 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 evidence-based prevention and treatment efforts for alcohol, tobacco, and other drugs.**
d) **The 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.**

The 2009 General Assembly enacted Senate Bill 202 which increased alcohol excise tax rates (beginning September 1, 2009).[18] The increase on malt beverages (62 cents per gallon) equated to an increase of approximately 1-cent on a can/bottle of beer (malt beverage). The small tax increase did not include the recommendation that malt beverages should be indexed to the Consumer Price Index to keep pace with inflation or that the funds raised should be used to support evidence-based prevention and treatment efforts. Statewide grassroots efforts continue to make increasing the price of malt beverages a priority although it has yet to receive a favorable response from the General Assembly. No significant increase on the tax rate of malt beverages has occurred since 1969.

**Recommendation 4.8: Fully Implemented**

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

[15] http://www.no-smoke.org/goingsmokefree.php?id=156
[16] http://www.ncdhhs.gov/pressrel/2011/2011-11-09_heart_attack_down.htm
[17] http://publichealth.nc.gov/hnc2020/objectives.htm

The General Assembly has not made plans or taken action to lower the drinking age to less than 21 years of age.

**Recommendation 4.9 (PRIORITY RECOMMENDATION): Not Implemented**

**The General Assembly should appropriate $610,000 in recurring funds in SFY 2010 to DMHDDSAS 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 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.**

There is no progress to report on this recommendation. Limited funding to address underage and excessive drinking has been prioritized for the implementation of population-based, community strategies which include targeting college age and campus related alcohol issues when an Institute of Higher Education is part of a community.

**Recommendation 4.10: Partially Implemented**

**DMHDDSAS; DPH; 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 addiction**

**to other drugs, available treatment, and community resources for the affected children and their families.**

DMHDDSAS continues to support work and prevention efforts involving Fetal Alcohol Spectrum Disorder (FASD). An official state FASD prevention plan has not been created, however, work has begun. The Charlotte FASD committee, in collaboration with other stakeholders, held the first statewide FASD Collaborative meeting on July 9, 2012. There were 45 individuals in attendance at this meting. This issue and the development of a statewide prevention plan remains a priority for DMHDDSAS. However, additional funding is required for the development and finalization of a statewide FASD prevention plan and to maintain the quarterly meetings of the FASD Collaborative as well as to continue statewide education.

FASD prevention activities continue through a partnership with NC Centers for Prevention Resources. The FASD Prevention Coordinator works with the four Centers for Prevention Resources, to develop and distribute FASD prevention messages across the state by various means such as social media, conferences, mailings, campaigns, health fairs and other opportunities as they arise.

**Recommendation 4.11:** **Fully Implemented**

**DDMHSAS should work with the NC Medical Society, DPH, NC Academy of Family Physicians, NC Psychiatric Association, NC 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 NC Office of the Attorney General to explore options to allow for the exchange of information obtained from the CSRS between health care practitioners.**

The Medical Examiners bill was passed and signed into law on August 7, 2009 (S628). "This bill will allow medical examiners to have access to the CSRS for the purpose of investigating deaths. Additional areas covered [in SB628] include allowing prescribers to communicate with others who have access to the CSRS as well as increasing the frequency of dispenser reporting to the CSRS from bi-weekly to weekly starting January 2010."[19]

**EARLY INTERVENTION**

**Recommendation 4.12:** **Partially Implemented**

**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**

[19] http://www.ncdhhs.gov/dma/pharmacy/NarcTaskForceMtgMinutes081009.pdf

**should expand screening, brief intervention, and referral into 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.**

There have been many continuing education efforts around SBIRT in the state at annual specialty meetings for primary care doctors, Physician Assistants, Nurse Practitioners, Psychiatrists, Community Care of North Carolina (CCNC) networks, at hospital grand rounds and other educational sessions for resident physicians, and at the Annual Addiction Medicine Conference in 2010, 2011 and 2012. There have also been SBIRT presentations to the substance abuse work force and to students at UNC School of Public Health. The design and release of SBIRTNC.org in August 2011 with educational resources, referral & billing information, clinical tools, and video demonstrations. NC was awarded a 5 year $8.33 million SAMHSA grant that started September 2011 to implement SBIRT within two CCNC networks and later statewide.

**Recommendation 4.13 (PRIORITY RECOMMENDATION): Fully Implemented**

a) **North Carolina 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 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 SBIRT model.**

**b) The 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 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 SBIRT in outpatient settings with the full continuum of substance abuse services offered through DMHDDSAS.**

The General Assembly has not appropriated funds to meet this recommendation. However, there is continued demand for SBIRT training in North Carolina. More CME trainings for SBIRT are being offered to pharmacists, primary care physicians, and community coalitions. More recently, a greater effort has been made to include emergency physicians and their associations in SBIRT training opportunities.

CCNC and DMHDDSAS are working with the Governor's Institute on Substance Abuse on SBIRT. SBIRT trainings are being funded (in part) by organizations such as the Kate B. Reynolds Charitable Trust. KBR funded 17 co-locations (2010-2011). DMHDDSAS was also awarded an $8.33 million dollar grant by CSAT-SAMHSA to implement SBIRT in seven primary care practices affiliated with Northwest Community Care Network, Community Care of

the Sandhills, and one federally qualified health center. This five year grant which began October 1, 2011.[20]

**Recommendation 4.14:** **Partially Implemented**

a) **ORHCC should work in collaboration with DMHDDSAS; 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 General Assembly should provide $750,000 in recurring funds ORHCC 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 CCNC. 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.**

One of the primary goals of the CHIPRA grant is to encourage primary care practices to begin screening for social/emotional concerns among their patient population. School-aged and adolescent populations have been targeted since the rate of screening is currently 7% and 6% respectively (across the state). Some practices have decided to use the CRAFFT screen on their entire adolescent population given the pressures to engage in substance use at this stage of life. At the WHAT (Wilmington Health Access for Teens) clinic, each patient fills out the CRAFFT screen and is followed up with the integrated social worker to review results. At Triad Adult and Pediatric Medicine, the CRAFFT is also administered as a follow up to the Bright Futures screen when an adolescent indicates that they have used drugs or alcohol.

[20] http://www.sbirtnc.org/north-carolina-to-receive-5-year-8-33-million-samhsa-sbirt-funding/

All of the co-located mental health professionals in CHIPRA practices see patients for brief therapy and refer to more intensive services in the community if needed. Out of the 26 pediatric practices participating in CHIPRA Connect, there are 8 practices that have a mental health clinician co-located or integrated on site. There are 3 practices that are interested in this model and pursuing a mental health clinician currently.

The Kate B. Reynolds TA grant is working with 21 sites across the state, ranging from primary care with mental health integration, to reverse co-location in a mental health agency, FQHC sites, and school-based health centers. The level of substance abuse screening and referral to treatment varies at each site. For example, at Kinston Community Health Center, there is a large uninsured population and referral to community providers is difficult. Most substance abuse services are provided within the clinic. Rural Health Group uses the AUDIT tool to screen for substance abuse and primarily uses a brief intervention model with patients. The majority of sites are trying to figure out sustainability models to continue to provide behavioral health services on site, especially in rural areas where access to substance abuse services in the community is limited.

**Recommendation 4.15 (PRIORITY RECOMMENDATION): Partially Implemented**

- **a) The 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 General Assembly should direct the Division of Medical Assistance, NC 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 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) **DMHDDSAS, 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.**

The Patient Protection and Affordable Care Act builds on the Mental Health Parity Act and Addictions Equity Act of 2008. The Affordable Care Act requires coverage of mental health and substance use disorder benefits (part of "Essential Health Benefits" requirements) for non-grandfathered individual and small group health insurance plans beginning in 2014. These plans will also have to comply with federal parity law requirements which require the provision of mental health and substance use disorder benefit coverage comparable to existing medical/surgical benefit coverage.[21]

[21] http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.cfm

**Recommendation 4.16 (PRIORITY RECOMMENDATION): Partially Implemented**

**a) 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 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 NC IOM 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.**

DMHDDSAS has made significant progress in developing a recovery-oriented system of care. The state has funded six pilot programs for adults and two pilot programs for adolescents within existing substance use disorder treatment programs yearly since 2008 to allow for improved access to care. Programs offer housing, transportation, incentives, and a whole-person focus. Each of these programs implements components of recovery-oriented systems of care, and works toward a complete spectrum of services that involves peer support services, check-ins post treatment, check-ups post treatment, and engagement strategies.

In addition to intervention efforts, the state has expanded its focus on training. Each year there are a minimum of five training sessions on Recovery Oriented Systems of Care (ROSC), which are geared toward advocates, treatment providers, graduate students (including future Licensed Clinical Addiction Specialists), and policy makers. Training sessions emphasize culture change to create a recovery-oriented system of care, including conceptual shifts toward treatment of addiction as a chronic condition rather than as an acute condition and a shift from patient-centered responsibility for care and outcomes to a shared responsibility between the practitioner or peer support specialist and the individual seeking recovery. Using recovery language is another culture change effort, as it focuses on removing stigma that keeps individuals feeling shamed and unwelcomed in care systems. Finally, the Recovery Oriented Systems of Care trainings deliver hands-on tools for providers to use in their practice.

Recovery Communities of North Carolina is a new network that has formed, made up of individuals in long-term recovery, their family members and allies. This group has partnered with DMHDDSAS to conduct Recovery Community Messaging Training in addition to showing the documentary, "The Anonymous People" to improve knowledge and change attitudes regarding recovery and reduce the stigma around this condition throughout the state. DMHDDSAS has also partnered with the Young People in Recovery (YPR) national and state groups to educate and support adolescents in need of recovery and through the recovery process, and has collaborated with the Stacie Matthewson Foundation to assist universities in accessing grant funding for Collegiate Recovery Programs.

DMHDDSAS is contracting with the Governor's Institute on Substance Abuse to develop and implement a recovery initiative with recovery organizations statewide. This initiative works to improve peer support services for substance use disorders, and offers training and education to individuals and groups interested in Recovery Oriented Systems of Care. The Governor's Institute specifically partners with the Southeastern Addiction Technology Transfer Center and the UNC School of Social Works' Behavioral Health Resource Program to continuously improve knowledge about recovery and Recovery Oriented Systems of Care statewide.

The state has developed a robust network of peer support workers, which are a vital component of recovery-oriented systems of care. There are currently 1,259 Peer Support Specialists in North Carolina, and among those, 458 identify as individuals in recovery from substance use disorders themselves.

Performance-based incentives are written into the contracts with LMEs/Managed Care Organizations (MCOs) for improved engagement, retention, and outcomes. Lastly, the state has developed and offered various trainings to prevention and treatment providers to include electronic health records, cost-accounting, innovative technologies that support recovery, and business strategies in the field on a national and state scale. The state enthusiastically supports continuing education for practitioners in the field on an ongoing basis.

The state has identified barriers to implementing a recovery-oriented system of care and is working to enact solutions. Barriers to long-term recovery support service provision include lack of payment mechanisms and difficulties identifying the parties responsible for follow-up. There are similar payment challenges with utilizing Peer Support Specialists for individuals with substance use disorders. LMEs/MCOs currently use Medicaid funding to pay for Peer Support Specialists, but there is a large gap in Medicaid eligibility for receiving treatment for substance use disorders; currently, the only individuals that qualify for treatment under Medicaid are women that are pregnant and/or parenting and youth transitioning from the foster care system. DMHDDSAS is currently working to identify mechanisms for state funding for Peer Support Specialists and for other critical recovery strategies.

**Recommendation 4.17:** **Not Implemented**

- **a) North Carolina DMHDDSAS should select six county or multi-county regions to develop and implement a recovery-oriented system of care.**
- **b) The 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 MHDDSAS 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 General Assembly should appropriate $750,000 of the Mental Health Trust Fund or general appropriations to 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) **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.**

This recommendation has not been implemented. The General Assembly has not appropriated any funds.

**Recommendation 4.18 (PRIORITY RECOMMENDATION): Not Implemented**

**The General Assembly should appropriate:**

a) **$650,000 in recurring funds to DMHDDSAS 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 ORHCC to hire a statewide coordinator and administrative support to work directly with the regional CCNC 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.**

No funding for staff has been appropriated by the General Assembly to date.

**CHILDREN, YOUTH, AND YOUNG ADULTS**

**Recommendation 5.1: Partially Implemented**

- **a) DMHDDSAS should continue to work with the Department of Juvenile Justice and Delinquency Prevention to expand the pilot test of the DMHDDSAS-DJJDP Cross Area Service Program model in two additional DJJDP regions.**
- **b) The General Assembly should appropriate $500,000 in recurring funds to DMHDDSAS to support this pilot.**
- **c) If successful, the DMHDDSAS-DJJDP Cross Area Service Program model should be rolled out statewide.**

DMHDDSAS tested a regional model but a locally driven model has proven to be more successful. DMHDDSAS used existing funds to support Juvenile Justice Substance Abuse Mental Health Partnerships (JJSAMHPs) in 72 counties that are serving more than 3,000 youth annually. JJSAMHPs are local teams of LME and Division of Juvenile Justice staff working together with providers to deliver effective, family-centered services and supports for juvenile justice-involved youth with substance use and/or mental health problems. The Partnerships operate under System of Care principles and ensure the completion of comprehensive substance abuse and mental health assessments; ensure the provision of evidence-based treatment options; ensure the use of Child and Family Teams and the involvement of Juvenile Crime Prevention Councils in programming.

DMHDDSAS needs $500,000 to serve the remaining 28 counties.

**ADULTS**

**Recommendation 5.2: Not Implemented**

- **a) As part of the annual community assessment, LMEs should explore and report on the need for 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.**

This recommendation has not been addressed, as LME/MCOs are focused on preparing for reorganization under the 1915 b/c Medicaid Waiver.

**Recommendation 5.3:** **Not Implemented**

**The General Assembly should ensure that by 2014:**

a) **All individuals advertising and promoting themselves as providing EAP services in NC 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 NC licensed EAP staff.**

This recommendation has not yet been addressed.

**Recommendation 5.4:** **Not Implemented**

**The General Assembly should appropriate $475,000 in recurring funds to the Department of Health and Human Services, DMHDDSAS, for seven full-time Licensed Clinical Addiction Specialists to be distributed to the LMEs with the highest number of referrals for the Work First, Class H or I Controlled Substance felons, and CPS populations compared to existing Qualified Professionals in Substance Abuse.**

There has been no expansion of the Work First CPS Substance Abuse Initiative.

**Recommendation 5.5:** **Partially Implemented**

**The 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 DMHDDSAS to expand the availability of TASC services.**

The General Assembly did not appropriate funding for the TASC program. However, TASC provides services that reduce recidivism and drug use to 16,000 adult justice-involved individuals annually. Services are available in all 100 counties and include screening and assessment; treatment matching, referral and placement; care management; and reporting to the Justice System.

An additional 50,000 people under Community Corrections supervision with substance abuse problems remain unserved.

**Recommendation 5.6:** **Partially Implemented**

**The General Assembly should appropriate $500,000 in recurring funds in SFY 2010 to the Division of Community Corrections to expand the availability of CJPP-funded substance abuse services.**

CJPP was repealed and Treatment for Effective Community Supervision (TECS) was enacted. TECS legislation directs the Division of Adult Correction to enter into contractual agreements to provide evidence-based substance abuse treatment and cognitive behavioral interventions, particularly for people convicted of felonies that are high-risk and moderate to high-need. The General Assembly did not appropriate funding for these services. Funds remain at the same level as appropriated for CJPP.

**Recommendation 5.7 (PRIORITY RECOMMENDATION): Not Implemented**

a) **The 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 General Assembly should increase the appropriations to DMHDDSAS 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 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.**

S.L. 2011-145 eliminated funding to AOC which supported coordinator positions for drug treatment courts, however it did not repeal NCGS Chapter 7A, Article 62, North Carolina Drug Treatment Court Act of 1995. These courts continue to operate without state-funded coordinators. As of August 2012, there was one tribal, nine family, six DWI and twenty adult drug treatment courts. In FY10-11, those courts served 1,631 people. DMHDDSAS LMEs provide the support for the treatment the participants receive.

S.L. 2012-142 eliminated funding to DMHDDSAS that supported the treatment drug court participants received through the LMEs.

Local governments/counties as well as other LME and federal grant funding is used to operate existing adult treatment courts and to fund new adult treatment courts.

**Recommendation 5.8:** **Not Implemented**

**The 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 NC 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.**

No money has been appropriated.

**MILITARY PERSONNEL**

**Recommendation 5.9:** **Partially Implemented**

a) **The Veterans Administration should:**
    1) **Continue to work with appropriate partners to provide training for mental health and substance abuse professionals, DMHDDSAS and LME 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 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.**

In accordance with several of the recommendations made by the NCIOM Task Force on Behavioral Health Services for the Military and their Families, the General Assembly passed Senate Bill 597. A number of provisions outlined in the bill address the need for regular, coordinated opportunities for health professional (and other supportive services) training and education (pre-service and in-service) to occur around the health and behavioral health needs of service members and Veterans.

No funding was appropriated by the General Assembly to match VA transitional housing grants.

## SUPPLY OF SUBSTANCE ABUSE PROFESSIONALS

**Recommendation 6.1 (PRIORITY RECOMMENDATION): Not Implemented**

**a) The General Assembly should appropriate $750,000 in recurring funds in SFY 2010, and an additional $750,000 in recurring funds in SFY 2011 for a total of $1.5 million 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 General Assembly should appropriate $200,000 in recurring funds in FY 2010 to the AHEC 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.**

Scholarship funds were not appropriated by the General Assembly. However, scholarship funds continue to be available through the Governor's Institute on Substance Abuse through the Education for Substance Abuse Professionals (ESAP) scholarship program. "Beginning in January 2011, these funds will be made available directly to graduate programs (master's degree) approved by the North Carolina Substance Abuse Professional Practice Board. Candidates will be selected by faculty based on criteria of financial need and academic excellence."[22]

**Recommendation 6.2:** **Partially Implemented**

a) **The AHEC Program should work with DMHDDSAS, 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 ADATCs 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 General Assembly should appropriate $200,000 in recurring funds in SFY 2010 to the AHEC program to develop and support new clinical training rotations for residents in substance abuse.**

Currently, no funding has been appropriated and no new training experiences have been developed in response to this recommendation.

While no new monies have been received,UNC and Duke residents continue to have opportunities to rotate through addiction services sites. AHEC training occurs through a new rotation at Horizons (perinatal substance abuse in Chapel Hill and Siler City) and the Alcoholism Treatment Center (ATC) at Wake Human Services. Duke residents rotate to Triangle Residential Options For Substance Abusers (TROSA), a community-based site.

**Recommendation 6.3** **Not Implemented**

**The NC State Personnel Commission should:**

[22] http://www.edu2work.org/2010/12/esappact-scholarship-funds-to-be-available-through-graduate-schools/

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.**

**DATA**

**Recommendation 7.1:** **Not Implemented**

a) **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 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) **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) **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) **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 ADATCs, as is currently done for state hospitals.**
    6) **Continuity of care after discharge from detox and inpatient programs, as is currently done for ADATCs, and state hospitals.**
    7) **Provision of recovery-oriented treatment and support within communities.**

Currently, data systems have no new monies for this group of providers to join Health Information Exchange (HIE). Patients' records are not fully integrated. However, as LMEs become Medicaid managed care sites, they are adopting new IT systems that have the capability of adding EHRs for provider use.

The HIE option is currently to opt-out, not opt-in, meaning that only individuals who explicitly refuse sharing of their information are excluded from the HIE. Since substance abuse patients' information is federally protected by 42 CFR Part 2 confidentiality requirements, their providers cannot release their information to the HIE without signed consent forms from the individuals (opt-in system).

An opt-in system or module is required for medical practitioners to have a complete picture of a patient's needs and current care. Without access to information on treatments being provided for substance abuse, doctors are at risk of over-prescribing or prescribing medications that can cause potentially fatal interactions. Additional funding is required to build this nuanced consent capability into the current HIE.

**Recommendation 7.2:** **Not Implemented**

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, DPH, and county commissioners should provide data to DMHDDSDAS 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 General Assembly should choose and implement an equalization formula to ensure that 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.**

The Juvenile Justice department collects information on the treatment clients receive but do not have a unified data system with DMHDDSAS. DMHDDSAS continues to work with the Justice Department to determine ways to collect and share data.

Equalization of funding to the LMEs needs to take into account local capacity to use the funds effectively as well as local need to build capacity. Shifting funds from one LME to another to equalize funding has both clinical and political ramifications.