

# North Carolina

## UNIFORM APPLICATION

### FY 2016/2017 - STATE BEHAVIORIAL HEALTH ASSESSMENT AND PLAN

### SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 06/30/2018  
(generated on 01/27/2016 11.59.33 AM)

Center for Substance Abuse Prevention  
Division of State Programs

Center for Substance Abuse Treatment  
Division of State and Community Assistance

# State Information

## State Information

### Plan Year

Start Year 2016

End Year 2017

### State DUNS Number

Number 809785363

Expiration Date

### I. State Agency to be the Grantee for the Block Grant

Agency Name NC Dept of Health and Human Services

Organizational Unit Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSAS)

Mailing Address 3001 Mail Service Center

City Raleigh

Zip Code 27699-3001

### II. Contact Person for the Grantee of the Block Grant

First Name Flo

Last Name Stein

Agency Name DMHDDSAS, NC DHHS

Mailing Address 3001 Mail Service Center

City Raleigh

Zip Code 27699-3001

Telephone 919-733-4670

Fax 919-733-4556

Email Address flo.stein@dhhs.nc.gov

### III. Expenditure Period

State Expenditure Period

From

To

### IV. Date Submitted

Submission Date 10/1/2015 4:38:06 PM

Revision Date 1/27/2016 11:58:33 AM

### V. Contact Person Responsible for Application Submission

First Name DeDe

Last Name Severino

Telephone 919-715-2281

Fax 919-733-4556

Email Address dede.severino@dhhs.nc.gov

Footnotes:



# State Information

## Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority

Fiscal Year 2016

U.S. Department of Health and Human Services  
 Substance Abuse and Mental Health Services Administrations  
 Funding Agreements  
 as required by  
 Substance Abuse Prevention and Treatment Block Grant Program  
 as authorized by  
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act  
 and  
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	<a href="#">42 USC § 300x-21</a>
Section 1922	Certain Allocations	<a href="#">42 USC § 300x-22</a>
Section 1923	Intravenous Substance Abuse	<a href="#">42 USC § 300x-23</a>
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	<a href="#">42 USC § 300x-24</a>
Section 1925	Group Homes for Recovering Substance Abusers	<a href="#">42 USC § 300x-25</a>
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	<a href="#">42 USC § 300x-26</a>
Section 1927	Treatment Services for Pregnant Women	<a href="#">42 USC § 300x-27</a>
Section 1928	Additional Agreements	<a href="#">42 USC § 300x-28</a>
Section 1929	Submission to Secretary of Statewide Assessment of Needs	<a href="#">42 USC § 300x-29</a>
Section 1930	Maintenance of Effort Regarding State Expenditures	<a href="#">42 USC § 300x-30</a>
Section 1931	Restrictions on Expenditure of Grant	<a href="#">42 USC § 300x-31</a>
Section 1932	Application for Grant; Approval of State Plan	<a href="#">42 USC § 300x-32</a>
Section 1935	Core Data Set	<a href="#">42 USC § 300x-35</a>
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	<a href="#">42 USC § 300x-51</a>
Section 1942	Requirement of Reports and Audits by States	<a href="#">42 USC § 300x-52</a>
Section 1943	Additional Requirements	<a href="#">42 USC § 300x-53</a>

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

## ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

## LIST of CERTIFICATIONS

### 1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

### 2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

### 3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Richard O. Brajer

Signature of CEO or Designee<sup>1</sup>: \_\_\_\_\_

Title: Secretary, NC Department of Health and Human Services

Date Signed: \_\_\_\_\_

mm/dd/yyyy

<sup>1</sup>If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

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3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
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I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Richard O. Brajer

Signature of CEO or Designee:

  
for Secretary Richard O. Brajer

Title: Secretary, NC Department of Health and Human Services

Date Signed: 10/01/2015

mm/dd/yyyy

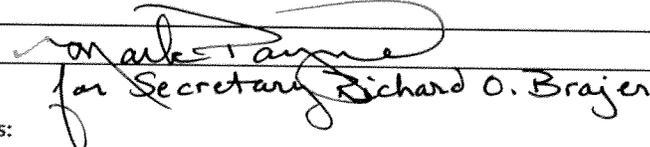
## State Information

### Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

Name	Richard O. Brajer
Title	Secretary
Organization	NC Department of Health and Human Services

Signature:  Date: 10/01/2015

**Footnotes:**

The signature of the Secretary of the NC Department of Health and Human Services is an attestation that, as an agency of state government, no lobbying activities occur.





STATE OF NORTH CAROLINA  
OFFICE OF THE GOVERNOR

PAT McCrORY  
GOVERNOR

September 29, 2015

Ms. Virginia Simmons  
Grants Management Officer  
Office of Financial Resources, Division of Grants Management  
Substance Abuse and Mental Health Services Administration  
1 Choke Cherry Road, Room 7-1109  
Rockville, Maryland 20850

Dear Ms. Simmons:

As the Governor of the State of North Carolina, for the duration of my tenure, I delegate authority to the current Secretary of the North Carolina Department of Health and Human Services, or anyone officially acting in this role in the instance of a vacancy, as the single state agency (SSA), for all transactions required to administer the Substance Abuse and Mental Health Services Administration's (SAMHSA) Substance Abuse Prevention and Treatment Block Grant (SAPTBG).

Sincerely,

A handwritten signature in black ink that reads "Pat McCrory".

Governor Pat McCrory

C: Secretary Richard O. Brajer, NC Department of Health and Human Services

## State Information

### Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

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---

Name	Richard O. Brajer
Title	Secretary
Organization	NC Department of Health and Human Services

---

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

#### Footnotes:

The signature of the Secretary of the NC Department of Health and Human Services is an attestation that, as an agency of state government, no lobbying activities occur.  
Please see the Attachments section for the signed attestation.

5  
6

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9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
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11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955. as amended (42 U.S.C. §§7401 et seq.): (a)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

## LIST of CERTIFICATIONS

### 1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

### 2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

### 3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Richard O. Brajer

Signature of CEO or Designee:

  
for Secretary Richard O. Brajer

Title: Secretary, NC Department of Health and Human Services

Date Signed:

10/01/2015

mm/dd/yyyy

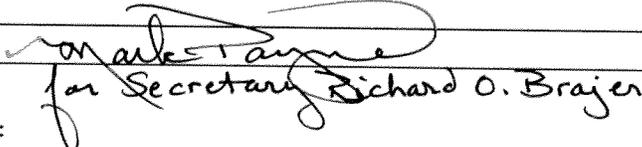
## State Information

### Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

[Standard Form LLL \(click here\)](#)

Name	Richard O. Brajer
Title	Secretary
Organization	NC Department of Health and Human Services

Signature:  Date: 10/01/2015

#### Footnotes:

The signature of the Secretary of the NC Department of Health and Human Services is an attestation that, as an agency of state government, no lobbying activities occur.



## Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

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Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

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transition services, wellness and living skills, to create a more robust continuum of care. Telehealth/telemedicine is utilized in areas that have shortages of therapists and/or psychiatrists. Community Prevention Resources (CPRs), funded through the Substance Abuse Prevention and Treatment Block Grant and the State's 2004 Strategic Prevention Framework/State Incentive Grant, provide additional resources. The Division also supports recovery supports services through its Access to Recovery grant, as well as through SABG funds for collegiate recovery programs and recovery community centers.

**A Cross Area Service Program (CASP)** is a Division designated specialty service program that is funded by the Division through federal and/or state funds to address the distinctive needs of an identified age and disability consumer and family special population. A CASP is designated by the Division as a result of a critical federal grant initiative or a priority state service initiative.

Dedicated federal and/or state one-time and continuation funding is directed by the Division and allocated to an identified sponsoring LME/MCO in a three-way partnership with a Division designated or approved provider. Funds are intended to address comprehensive statewide service needs, most commonly across multiple Local Management Entity/Managed Care Organizations (LME/MCOs). This sponsoring LME/MCO partners with the Division and a designated provider in implementing a specific age and disability based initiative, in accordance with Division established requirements, guidelines, and parameters. CASP services are planned, contracted, authorized, reimbursed, and evaluated by the LME/MCO, in consultation with the Division. Most CASPs are intended to be able to serve consumers, providers and LME/MCOs from any region of the state.

Examples of Cross Area Services Programs include opioid treatment programs (OTPs), juvenile detention centers, regional residential treatment programs for adolescents with substance use disorders, CASAWORKS programs, residential treatment programs for women who are pregnant, etc.

DMH/DD/SAS/DD/SAS receives funds from the General Assembly, and utilizes block grant funds, for crisis services (mobile crisis teams, walk-in crisis and psychiatric after-care and crisis intervention teams) geared towards the reduction of hospitalizations, use of emergency department services and jail diversion for people with substance use and mental health disorders.

The United States Department of Commerce (2015) reports that North Carolina is currently home to the third largest active military population in the country. This population is comprised of each branch of the military: Army, Marines, Navy, Air Force and Coast Guard. An additional 45,000 soldiers, marines, and airmen and women live in all 100 counties of North Carolina and serve in the National Guard or Reserves. North Carolina's veteran population is even larger, consisting of nearly 800,000 veterans, placing the state eighth in veteran population in the country. More than 100,000 children and adolescents of active members/National Guard/Reserves live in North Carolina and about 35% of the state's population is in the military, a veteran, spouse, survivor, parent or dependent of someone connected to the military. (*Honoring Their Service: A Report of the NC Institute of Medicine Task Force on Behavioral Health Services for the Military and Their Families, January 2011*).

The Division coordinates with the North Carolina National Guard, Veterans Administration, Tricare and the Citizen Soldier Support Program, as well as with the NC General Assembly, the Division of Vocational Rehabilitation Services, Department of Public Safety, Department of Public Instruction, Department of Labor, Governor's Institute, Area Health Education Programs, state universities, provider organizations

and faith-based organizations on various initiatives that address active duty military, veterans, National Guard members, the Reserve and family members of the military. In 2008, SAMHSA invited representatives of state mental health and substance abuse agencies to join with the Department of Defense (DOD) and the Department of Veterans Affairs (VA) to begin to construct a behavioral health response for combat veterans returning from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). Upon returning from this initial national summit, DMH/DD/SAS/DD/SAS, with the approval of the NC DHHS, initiated work utilizing a strategic plan that strengthens collaboration, coordination and resource sharing between the State of North Carolina, federal military partners and service members and their families.

The Governor's Working Group on Veterans, Service Members and Their Families is a collaborative intradepartmental work group focused on job creation, workforce enrichment, health and wellness, legal and financial services and benefits for veterans. Governor Pat McCrory has charged the Working Group "with facilitating collaboration and coordination among ALL federal, state and local agency partners that touch a veteran's life in the state of North Carolina." Flo Stein, Deputy Director of DMH/DD/SAS/DD/SAS is one of three current Vice Chairs of the Working Group.

The Working Group promotes evidence-based practices in the screening, assessment and treatment of active and reserve components, veterans and military family members in North Carolina, including traumatic brain injury (TBI). It successfully competed to participate in three national policy academies supported by SAMHSA where the team works with national leaders to continually refine the North Carolina Plan. The North Carolina process to support veterans has received national recognition and has provided technical assistance to many other states.

Recent activities include the following:

- September 2012: SAMHSA Policy Academy, State Plan Boot Camp, Preparing States and Communities to Support the Behavioral Health Needs of Service Members, Veterans, and their Families:
  - North Carolina Team Leader, Flo Stein participated in a panel to provide advice and lessons learned to nine new states. A new cohort of nine states participated; in addition, representatives from eight alumni states, including North Carolina, and Washington, DC, comprised the State Leadership Team. Ms. Stein was one of three state panelists that presented on Lessons Learned: Advice from States that are Still Learning. She also presented the state example in a panel on Expanding Peer-to-Peer Across Systems. Priorities addressed infrastructure and leadership; needs assessment, data, and information sharing; service system design and best practice integration; workforce capacity and capacity building; and financing and sustainability. A TA request on the development of memoranda of understanding between the Division and other agencies resulted from the Academy.
- March 2014: SAMHSA hosted a Military and Veterans' Families Implementation Academy for State teams across the country to learn about evidence-informed practices for military and veterans' families and to provide the opportunity for teams to further expand components of existing strategic plans.

- Flo Stein, Deputy Director of the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services led a five-person team that participated in an orientation call, a pre-planning call, the academy and a post-academy call. These efforts resulted in the decision to assess family strengths and challenges more fully, through focus groups and surveys, culminating in a statewide conference in March 2015.
- September 2014: SAMHSA held a conference on Meeting the Behavioral Health Needs of Service Members, Veterans, and their Families (SMVF) through Workforce Development so that State teams could learn strategies for increasing the skills of the behavioral health workforce to provide services and supports for military-connected individuals.
  - Flo Stein, Deputy Director of the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services, served as a presenter and also led a four-person team that learned not only about core competencies but also about evidence-based practices, peer supports, and technology.

The SA contract prevention providers are dedicated to the delivery of the appropriate and quality services. There are several partnerships, alliances, coalitions, and collaborative providing individual and population based strategies to communities throughout NC. The LME/MCOs contract with local prevention providers to deliver primary prevention activities throughout the 100 counties across the state. The LME/MCO receives guidance from the state office prevention staff about federal substance abuse prevention guidelines and policies. Local contract prevention providers conduct community need assessments to determine services and activities. The LME/MCO and prevention provider enter into a contract agreement that outlines specific prevention activities including target population and use of evidence based curriculum. The LME/MCO is responsible for monitoring, reporting, and participation in any evaluation of the local prevention providers. The LME/MCO is required to conduct a needs assessment and gap analysis of their service area. Each LME/MCO works with the contract substance abuse prevention provider to assist with identifying target populations and services based on the results. Local contract prevention providers infuse cultural diversity policies into all prevention activities.

In addition to contracting with the eight LME/MCOs for the delivery of prevention and treatment services, the Division also contracts with several other entities to address needs and gaps within the system. Following are some examples of those contracts:

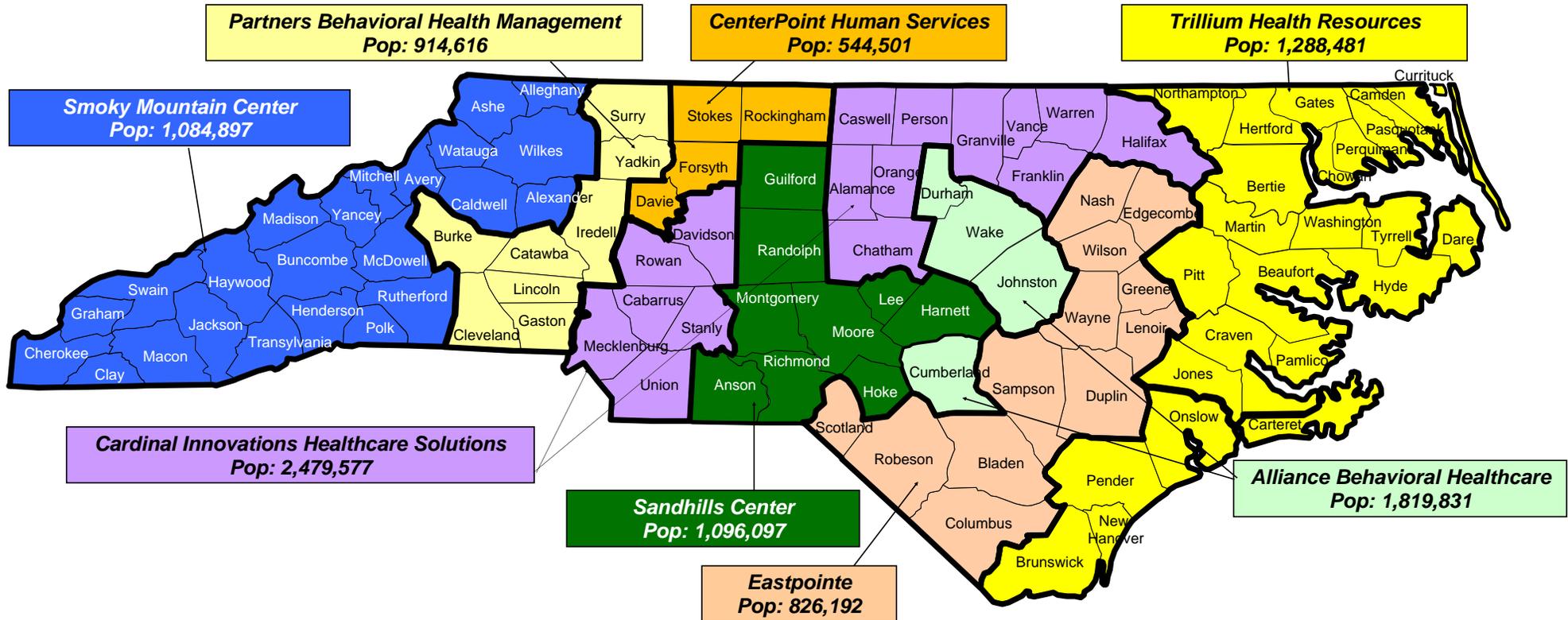
- ***Governor's Institute on Substance Abuse*** – the primary objective of this contract is to increase access to and improve the quality of services provided in the state by: (1) expanding the use of evidence-based/best practices; (2) promoting the integration of behavioral healthcare with primary healthcare in two regions of North Carolina and the rest of the state; (3) improving physician understanding of addictions; and (4) enhancing the quality of the workforce and provider agencies in the state, with a special emphasis on service members, veterans and their families.

- **Oxford House, Inc.** – this contract allows for the continuation of substance use recovery home management services by opening new houses, administering loans and serving and mentoring re-entering substance users in their transition from incarceration.
- **NC State University, Center for Urban Affairs and Community Services** – this contract provides for the management of the web-based Treatment Outcomes and Program Performance System (NC TOPPS) which allows Local Management Entities/Managed Care Organizations (LME/MCOs) and their contracted network service providers to submit initial and periodic updates, as well as episode completion interview information for all consumers within specified substance abuse and mental health populations. Data entered into the system is then used in developing accountability measures for both the Mental Health and Substance Abuse Block Grants.
- **University of North Carolina, School of Social Work, Behavioral Healthcare Resource Program** - the primary goal of this contract is to increase access to and improve the quality of prevention, treatment and recovery support services by: (1) expanding the use of prevention, treatment and recovery support services for substance abuse that demonstrate success in improving outcomes and/or supporting recovery; (2) enhancing the quality of the workforce providing prevention, treatment and recovery support services; (3) enhancing the ability of provider agencies to determine the ongoing effectiveness of substance abuse prevention, treatment and recovery support services; and (4) planning the implementation of new, expanded or enhanced services within the state.
- **NC Substance Abuse Professional Practice Board** – The NC Substance Abuse Professional Practice Board (NCSAPPB) will continue to register, certify, approve and issue associate-level licensed clinical addictions specialists and credentialed substance abuse professionals in accordance with state and federal requirements to improve substance abuse related services for consumers throughout North Carolina.
- **NC Division of Public Health** – this multi-year inter-departmental agreement augments HIV/Early Intervention Services provided through contracts with the LME/MCOs and is integral to North Carolina’s adherence to the requirements for HIV designated states. The Division of Public Health provided testing, counseling services and therapeutic interventions to nearly 5000 individuals in SFY15.
- **Alcohol/Drug Council of North Carolina** – this contract provides information and referral services, as well as public education related to substance use and addiction across the entire state. This agency is also responsible for the Perinatal Substance Use Project, which includes screening, telephone hot-line, information and appropriate referrals for women throughout North Carolina who are pregnant or parenting and using substances. The project provides information on bed availability for substance use services in the NC Perinatal/Maternal and

CASAWORKS Initiative on a weekly basis, as well as training and technical assistance to agencies working with women who are pregnant or parenting on issues related to substance use.

- ***Recovery Communities of North Carolina (RCNC)*** – this is a relatively new contract for the Division which was initiated to increase the availability of, and access to, recovery support services for individuals pursuing their recovery. RCNC will provide assistance and "mentoring" to other communities and groups that have expressed a desire to create their own recovery community center, and ultimately aid in the establishment of four or more recovery community centers across the state. Other areas of focus include recovery messaging training and refinement of a curriculum for peers with lived experience in the area of substance use.

## Local Management Entity - Managed Care Organizations (LME-MCOs) DHHS currently has -- Eight-- LME-MCOs operating under the 1915 b/c Waiver



- Reflects LME-MCOs and shows the population within their catchment area as of 7/1/15.
- Total NC population is 10,054,192. Source: NC OSBM July 2015 county single-age population estimates.
- Shows the merger of ECBH and CoastalCare forming Trillium Health Resources that occurred on 7/1/15.
- Information current as of 7/1/15.

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Dedicated federal and/or state one-time and continuation funding is directed by the Division and allocated to an identified sponsoring LME/MCO in a three-way partnership with a Division designated or approved provider. Funds are intended to address comprehensive statewide service needs, most commonly across multiple Local Management Entity/Managed Care Organizations (LME/MCOs). This sponsoring LME/MCO partners with the Division and a designated provider in implementing a specific age and disability based initiative, in accordance with Division established requirements, guidelines, and parameters. CASP services are planned, contracted, authorized, reimbursed, and evaluated by the LME/MCO, in consultation with the Division. Most CASPs are intended to be able to serve consumers, providers and LME/MCOs from any region of the state.

Examples of Cross Area Services Programs include opioid treatment programs (OTPs), juvenile detention centers, regional residential treatment programs for adolescents with substance use disorders, CASAWORKS programs, residential treatment programs for women who are pregnant, etc.

DMH/DD/SAS/DD/SAS receives funds from the General Assembly, and utilizes block grant funds, for crisis services (mobile crisis teams, walk-in crisis and psychiatric after-care and crisis intervention teams) geared towards the reduction of hospitalizations, use of emergency department services and jail diversion for people with substance use and mental health disorders.

The United States Department of Commerce (2015) reports that North Carolina is currently home to the third largest active military population in the country. This population is comprised of each branch of the military: Army, Marines, Navy, Air Force and Coast Guard. An additional 45,000 soldiers, marines, and airmen and women live in all 100 counties of North Carolina and serve in the National Guard or Reserves. North Carolina's veteran population is even larger, consisting of nearly 800,000 veterans, placing the state eighth in veteran population in the country. More than 100,000 children and adolescents of active members/National Guard/Reserves live in North Carolina and about 35% of the state's population is in the military, a veteran, spouse, survivor, parent or dependent of someone connected to the military. (*Honoring Their Service: A Report of the NC Institute of Medicine Task Force on Behavioral Health Services for the Military and Their Families, January 2011*).

The Division coordinates with the North Carolina National Guard, Veterans Administration, Tricare and the Citizen Soldier Support Program, as well as with the NC General Assembly, the Division of Vocational Rehabilitation Services, Department of Public Safety, Department of Public Instruction, Department of Labor, Governor's Institute, Area Health Education Programs, state universities, provider organizations

and faith-based organizations on various initiatives that address active duty military, veterans, National Guard members, the Reserve and family members of the military. In 2008, SAMHSA invited representatives of state mental health and substance abuse agencies to join with the Department of Defense (DOD) and the Department of Veterans Affairs (VA) to begin to construct a behavioral health response for combat veterans returning from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). Upon returning from this initial national summit, DMH/DD/SAS/DD/SAS, with the approval of the NC DHHS, initiated work utilizing a strategic plan that strengthens collaboration, coordination and resource sharing between the State of North Carolina, federal military partners and service members and their families.

The Governor's Working Group on Veterans, Service Members and Their Families is a collaborative intradepartmental work group focused on job creation, workforce enrichment, health and wellness, legal and financial services and benefits for veterans. Governor Pat McCrory has charged the Working Group "with facilitating collaboration and coordination among ALL federal, state and local agency partners that touch a veteran's life in the state of North Carolina." Flo Stein, Deputy Director of DMH/DD/SAS/DD/SAS is one of three current Vice Chairs of the Working Group.

The Working Group promotes evidence-based practices in the screening, assessment and treatment of active and reserve components, veterans and military family members in North Carolina, including traumatic brain injury (TBI). It successfully competed to participate in three national policy academies supported by SAMHSA where the team works with national leaders to continually refine the North Carolina Plan. The North Carolina process to support veterans has received national recognition and has provided technical assistance to many other states.

Recent activities include the following:

- September 2012: SAMHSA Policy Academy, State Plan Boot Camp, Preparing States and Communities to Support the Behavioral Health Needs of Service Members, Veterans, and their Families:
  - North Carolina Team Leader, Flo Stein participated in a panel to provide advice and lessons learned to nine new states. A new cohort of nine states participated; in addition, representatives from eight alumni states, including North Carolina, and Washington, DC, comprised the State Leadership Team. Ms. Stein was one of three state panelists that presented on Lessons Learned: Advice from States that are Still Learning. She also presented the state example in a panel on Expanding Peer-to-Peer Across Systems. Priorities addressed infrastructure and leadership; needs assessment, data, and information sharing; service system design and best practice integration; workforce capacity and capacity building; and financing and sustainability. A TA request on the development of memoranda of understanding between the Division and other agencies resulted from the Academy.
- March 2014: SAMHSA hosted a Military and Veterans' Families Implementation Academy for State teams across the country to learn about evidence-informed practices for military and veterans' families and to provide the opportunity for teams to further expand components of existing strategic plans.

- Flo Stein, Deputy Director of the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services led a five-person team that participated in an orientation call, a pre-planning call, the academy and a post-academy call. These efforts resulted in the decision to assess family strengths and challenges more fully, through focus groups and surveys, culminating in a statewide conference in March 2015.
- September 2014: SAMHSA held a conference on Meeting the Behavioral Health Needs of Service Members, Veterans, and their Families (SMVF) through Workforce Development so that State teams could learn strategies for increasing the skills of the behavioral health workforce to provide services and supports for military-connected individuals.
  - Flo Stein, Deputy Director of the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services, served as a presenter and also led a four-person team that learned not only about core competencies but also about evidence-based practices, peer supports, and technology.

The SA contract prevention providers are dedicated to the delivery of the appropriate and quality services. There are several partnerships, alliances, coalitions, and collaborative providing individual and population based strategies to communities throughout NC. The LME/MCOs contract with local prevention providers to deliver primary prevention activities throughout the 100 counties across the state. The LME/MCO receives guidance from the state office prevention staff about federal substance abuse prevention guidelines and policies. Local contract prevention providers conduct community need assessments to determine services and activities. The LME/MCO and prevention provider enter into a contract agreement that outlines specific prevention activities including target population and use of evidence based curriculum. The LME/MCO is responsible for monitoring, reporting, and participation in any evaluation of the local prevention providers. The LME/MCO is required to conduct a needs assessment and gap analysis of their service area. Each LME/MCO works with the contract substance abuse prevention provider to assist with identifying target populations and services based on the results. Local contract prevention providers infuse cultural diversity policies into all prevention activities.

**How the state staff is organized:** Substance abuse primary prevention services is currently housed with the Community Wellness, Prevention and Health Integration Team. This team is comprised of the Section Chief, and 10 staff that are responsible for Substance Abuse Prevention including underage drinking and the Partnership for Success 2013 grant focusing on prescription drug use/misuse, Tobacco Prevention and Cessation/FDA compliance and Mental Health Promotion/Early Intervention including Suicide Prevention. The Substance Abuse Prevention Block Grant Manager is responsible for overseeing the overall management of the Substance Abuse Prevention Block Grant including programmatic and financial compliance, monitoring and reporting, training and technical assistance, interagency relationships, coordination and planning, needs assessment and the utilization of evidenced based programs, policies and practices.

Through town hall meetings, focus groups conducted in October of 2014 and Regional Networking meetings hosted by the CPRs, the state determined the need for a more accurate, consistent and efficient reporting and monitoring system that will assist us with more accurate reporting on consumers

served and services delivered. We have requested assistance via our federal project officer for this task. We are also in the process of making sure that policies and procedures for the delivery of primary prevention services are communicated consistently and have published and implemented via training coordinated by the CPRs.

Strengths of the state's substance abuse prevention program include long and strong relationships with the NC Commission on Indian Affairs, NC Department of Public Instruction, NC Office of Juvenile Justice and Delinquency Prevention, NC Teen Pregnancy Prevention Program, NC Department of Social Services, NC Office of Youth Advocacy, NC Highway Safety Program, Wake Forest University, East Carolina University, Research Triangle Institute, Pacific Institute for Research and Evaluation Southeast CAPT, CADCA and statewide substance abuse prevention partnerships, alliances, collaboratives and coalitions who have contributed time, resources, effort, and passion to ensure the delivery of quality and effective substance abuse prevention services to youth, their families and communities.

North Carolina focuses their attention on youth ages 4-18 and their parents/caregivers using a variety of universal, selective and indicated strategies to meet the needs of the diverse population. Parents are identified as adults age 19 and older who are the parent/caregiver of a youth utilizing our services. Substance abuse prevention services for adults are mainly in the form of parenting programs. The North Carolina substance abuse prevention system uses a number of partnerships to assist with assuring the needs of diverse populations are met. The LME/MCO and their contract providers conduct an annual needs assessment of the local community to ensure the inclusion of services that are needed for diverse populations, ages, gender and ethnicities. The LME/MCO and their providers must submit a comprehensive strategic plan each year using the SPF model for their local communities. The Division and the substance abuse prevention system has a 20+ year relationship with the NC Commission on Indian Affairs. Local contracted substance abuse prevention providers also have strong committed relations with tribes in their communities such as the Lumbee Tribe where "Project Alert" and "Too Good for Drugs" are delivered to Native American Youth at the Boys and Girls Club. Several local contracted substance abuse prevention providers have attempted to reach out to LGBTQ youth in the community, although with limited success to date.

In addition to contracting with the eight LME/MCOs for the delivery of prevention and treatment services, the Division also contracts with several other entities to address needs and gaps within the system. Following are some examples of those contracts:

- **Governor's Institute on Substance Abuse** – the primary objective of this contract is to increase access to and improve the quality of services provided in the state by: (1) expanding the use of evidence-based/best practices; (2) promoting the integration of behavioral healthcare with primary healthcare in two regions of North Carolina and the rest of the state; (3) improving physician understanding of addictions; and (4) enhancing the quality of the workforce and provider agencies in the state, with a special emphasis on service members, veterans and their families.
- **Oxford House, Inc.** – this contract allows for the continuation of substance use recovery home management services by opening new houses, administering loans and serving and mentoring re-entering substance users in their transition from incarceration.

- **NC State University, Center for Urban Affairs and Community Services** – this contract provides for the management of the web-based Treatment Outcomes and Program Performance System (NC TOPPS) which allows Local Management Entities/Managed Care Organizations (LME/MCOs) and their contracted network service providers to submit initial and periodic updates, as well as episode completion interview information for all consumers within specified substance abuse and mental health populations. Data entered into the system is then used in developing accountability measures for both the Mental Health and Substance Abuse Block Grants.
- **University of North Carolina, School of Social Work, Behavioral Healthcare Resource Program** - the primary goal of this contract is to increase access to and improve the quality of prevention, treatment and recovery support services by: (1) expanding the use of prevention, treatment and recovery support services for substance abuse that demonstrate success in improving outcomes and/or supporting recovery; (2) enhancing the quality of the workforce providing prevention, treatment and recovery support services; (3) enhancing the ability of provider agencies to determine the ongoing effectiveness of substance abuse prevention, treatment and recovery support services; and (4) planning the implementation of new, expanded or enhanced services within the state.
- **NC Substance Abuse Professional Practice Board** – The NC Substance Abuse Professional Practice Board (NCSAPPB) will continue to register, certify, approve and issue associate-level licensed clinical addictions specialists and credentialed substance abuse professionals in accordance with state and federal requirements to improve substance abuse related services for consumers throughout North Carolina.
- **NC Division of Public Health** – this multi-year inter-departmental agreement augments HIV/Early Intervention Services provided through contracts with the LME/MCOs and is integral to North Carolina’s adherence to the requirements for HIV designated states. The Division of Public Health provided testing, counseling services and therapeutic interventions to nearly 5000 individuals in SFY15.
- **Alcohol/Drug Council of North Carolina** – this contract provides information and referral services, as well as public education related to substance use and addiction across the entire state. This agency is also responsible for the Perinatal Substance Use Project, which includes screening, telephone hot-line, information and appropriate referrals for women throughout North Carolina who are pregnant or parenting and using substances. The project provides information on bed availability for substance use services in the NC Perinatal/Maternal and CASAWORKS Initiative on a weekly basis, as well as training and technical assistance to agencies working with women who are pregnant or parenting on issues related to substance use.

- ***Recovery Communities of North Carolina (RCNC)*** – this is a relatively new contract for the Division which was initiated to increase the availability of, and access to, recovery support services for individuals pursuing their recovery. RCNC will provide assistance and "mentoring" to other communities and groups that have expressed a desire to create their own recovery community center, and ultimately aid in the establishment of four or more recovery community centers across the state. Other areas of focus include recovery messaging training and refinement of a curriculum for peers with lived experience in the area of substance use.

## Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

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This step should identify the unmet services needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data set including, but not limited to, the [National Survey on Drug Use and Health](#) (NSDUH), the [Treatment Episode Data Set](#) (TEDS), the [National Facilities Surveys on Drug Abuse and Mental Health Services](#), the annual [State and National Behavioral Health Barometers](#), and the [Uniform Reporting System](#) (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance abuse prevention, and substance abuse treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase behavioral health services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

[SAMHSA's Behavioral Health Barometer](#) is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the [National Survey of Substance Abuse Treatment Services](#) (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the [Behavioral Health Barometers](#). States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the [Healthy People Initiative](#)<sup>18</sup> HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

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<sup>18</sup> <http://www.healthypeople.gov/2020/default.aspx>

Footnotes:

## Step 2: Identify the unmet service needs and critical gaps within the current system

Approximately 8.43 percent of all North Carolinians aged 12 or older are expected to have Substance Use Disorders (SUDs). The current prevalence estimates, which vary by age, are slightly higher than reported in 2011 for young adults and adults: 5.9 percent for those between the ages of 12 - 17 years; 18.5 percent for young adults aged 18 to 25; and 7.1 percent for adults aged 26 and up. (*Data Source: Table 20 - Dependence or Abuse of Illicit Drugs or Alcohol in the Past Year, by Age Group and State: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, Annual Averages Based on 2012-2013 NSDUHs, published 12.17.14.*)

As of July 2015, North Carolina had an estimated total population of 10,054,192 people, making it the ninth largest state in the United States. Given the above prevalence rates, it is estimated that of the 793,650 youth between the ages of 12 – 17, 5.9 percent or about 46,825 youth will have a substance use disorder. Young adults between the ages of 18-25 have a much higher incidence of substance use; accordingly of those 1,133,305 young adults, approximately 209,661 will have a substance use disorder. Adults ages 26 and older have the lowest prevalence rate; given the population of over 6.6 million adults, 470,341 will have a substance use disorder. (*Data Source: NC Office of State Budget and Management (OSBM) website.*

[http://www.osbm.state.nc.us/demog/countytotals\\_singleage\\_2015.html](http://www.osbm.state.nc.us/demog/countytotals_singleage_2015.html). Last updated: 10/13/14.)

Since submission of the previous application and plan, North Carolina has fully transitioned to a new multi-payer Medicaid Management Information System for the NC Department of Health and Human Services, called NCTracks. NCTracks is used by the Division of Medical Assistance (DMA), the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) and the Division of Public Health (DPH). Providers enrolled in DMA, DMH/DD/SAS and DPH health plans submit claims for payment of covered health care services through the NCTracks Provider Portal. NCTracks coordinates processing among the payers to ensure the proper assignment of the payer, benefit plan and pricing methodology for each service on a claim. NCTracks processes health care claims for about 70,000 enrolled DHHS providers who serve over one million North Carolina citizens. It should be noted that providers who are contracted by Local Management Entities/Managed Care Organizations (LME/MCOs) to enroll and perform state and federal block grant funded services, through funding from DMH/DD/SAS, submit their claims to the LME/MCO.

As is often the case with transitions of this magnitude, the Division has experienced some difficulty in determining the accuracy of data through paid claims. As a result, some of the data below was gathered prior to the implementation of the multi-payer system. Additionally, some of the data below was reported from the LME/MCOs based on information within their own information and payer systems. Data from NCTracks continues to improve; therefore, we anticipate the availability of more and better data this fiscal year.

The table below illustrates data reported by the LME/MCOs for state fiscal year 2014. The measurement period was July 2013 through June 2014, and based on claims paid as of October 31, 2014. The estimates of the uninsured were based on county rates reported by the NC Institute of Medicine 2010-2011 Data Snapshot, which was released January 4, 2013 and applied to the state population at the beginning of the state fiscal year, as reported by the NC Office of State Budget and Management.

Number and Percent of Uninsured Persons Who Received State/Block Grant Funded Substance Use Services in SFY14		
Age Range	3 - 17	18 - 64
Number of uninsured population	161,479	1,280,613
Number that received at least one service	354	33,940
Percent that received at least one service	.22%	2.7%

Over the last several years, North Carolina has implemented a 1915(b)/(c) waiver that is now statewide. All 100 counties are part of a catchment area covered by one of eight local management entities/managed care organizations (LME/MCOs) that assure the delivery of services that are of the appropriate intensity and duration for consumers with intellectual/developmental disabilities or mental health/substance use issues. Each LME/MCO contracts with providers, the majority of whom are nationally accredited, for specific services for specific populations; i.e., adults with a substance use disorder, children with a serious emotional disturbance, etc. In order for LME/MCOs to be eligible to receive categorical substance abuse block grant funds, the LME/MCO must assert and assure that the federally mandated priority populations be served; i.e., pregnant women with a substance use disorder, individuals injecting drugs, etc.

The Division of MH/DD/SA Services and the Division of Medical Assistance require the LME/MCOs to annually complete a *Provider Capacity, Community Needs Assessment and Gaps Analysis*. DMH/DD/SAS and DMA each have performance agreements/contracts with LME/MCOs containing requirements for assessments of community need, provider capacity, gaps in services and strategic plans to address gaps. A statewide, in-depth analysis to aggregate results of the most current reports from each LME/MCO is still underway; therefore selected needs and gaps from the 2013 reports can be found in the Attachment section titled ***Gaps and Needs Overview SFY13***. Designated staff will work with the LME/MCOs to identify strategies to address gaps related to the provision of prevention, treatment and recovery support services for youth and adults at risk or with substance use disorders.

The Public Health Service Act requires the substance abuse block grant to address prevention and early intervention. In addition, it also specifies populations that must be served with grant funds. These are:

- pregnant women with substance use and women with substance use who also have dependent children;
- persons who use drugs intravenously (IDU);
- individuals with tuberculosis;
- persons with or at risk for HIV/AIDS who are in treatment for a substance use disorder

According to the *2014 North Carolina HIV/STD Surveillance Report*, published by the North Carolina Department of Health and Human Services, Division of Public Health:

- As of December 31, 2014, the number of people diagnosed and living with HIV infection in North Carolina was 28,526;
- In 2014, 1,351 new diagnoses of HIV infection were reported, at a rate of 13.4 per 100,000 population;
- Of the new infections, 1,341 infections occurred in the adult and adolescent population, with a rate of 16.3 per 100,000 population. This number is similar to what has been seen in previous years.

As North Carolina has been identified as a “designated state” by SAMHSA, at least five percent of substance abuse block grant funding is spent on HIV early intervention services for people who are participating in treatment for a substance use disorder. This funding is distributed to the LME/MCOs who then contract with providers. In addition, the Division also has a Memorandum of Understanding with the Division of Public Health, Communicable Disease Section, to provide testing and intervention services for persons that have substance use disorders. In 2011, injecting drug use accounted for eight percent of HIV disease cases for adult/adolescent females and six percent of adult/adolescent males.

The North Carolina Institute of Medicine (NCIOM) is an independent, quasi-state agency that was chartered by the North Carolina General Assembly in 1983 to provide balanced, nonpartisan information on issues of relevance to the health of North Carolina’s population. In 2007, the North Carolina General Assembly enacted Session Law 2007-323 that led to the creation of the Task Force on Substance Abuse Services facilitated by the NCIOM. Funded with SAPTBG funds, the Task Force on Substance Abuse Services convened a steering committee that included representation from the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services. In collaboration with the Division of Public Health and the NC Department of Health and Human Services, the NCIOM convened a Task Force on Prevention that met between 2008 and 2009 to develop the NC Prevention Plan. Both Task Forces recommended the development of a comprehensive substance abuse plan that would have prevention at its core with children, adolescents, young adults and their parents as priority targets.

The State has also identified juveniles and adults with substance use disorders who are involved with the law as a population of focus. According to the North Carolina Division of Alcoholism and Chemical Dependency Programs, approximately 90% of the criminal offenders who enter the prison system have substance abuse problems. (*North Carolina Division of Alcoholism and Chemical Dependency Programs, North Carolina Department of Correction. Annual legislative report, 2006-2007.*

[http://www.doc.state.nc.us/Legislative/2008/2006-07\\_Annual\\_Legislative\\_Report.pdf](http://www.doc.state.nc.us/Legislative/2008/2006-07_Annual_Legislative_Report.pdf). Published March 2008.) Treatment Accountability for Safer Communities (TASC) services continue to be delivered in all 100 counties for adults with SUDs by the NC TASC Network through the TASC Regional Coordinating Entities. More than two out of five youth in the state’s juvenile justice system are in need of further assessment or treatment services for substance abuse, as noted in the 2007 annual report from the North Carolina Department of Juvenile Justice and Delinquency Prevention.

([http://www.ncdjdp.org/resources/pdf\\_documents/annual\\_report\\_2007.pdf](http://www.ncdjdp.org/resources/pdf_documents/annual_report_2007.pdf). Published March 2007.)

The Division and the Department of Public Safety have been in collaboration with each other since 1997 to provide services to youth involved with juvenile justice and to develop a program of service delivery for youth who are involved in the justice system in partnership with their families.

Community integration/recovery support is another area that has been and will continue to be a focus of the state. The ability to obtain and sustain safe, affordable housing is one of the most significant challenges facing persons in the early stages of recovery. In addition, having meaningful work is integral to many individuals’ recovery. The state has an ongoing contract with Oxford House, Inc. to provide housing for people in recovery and has set aside \$100,000 for the support of statewide consumer housing

through the Cross Area Service Program (CASP) Substance Abuse Services initiative. A substantial portion of block grant funds were utilized last fiscal year to support recovery housing (in addition to Oxford Houses). In that safe, affordable housing continues to be an area of need, the Division will work with LME/MCOs and providers to identify barriers that impede an individual's access to housing and employment.

Because of the strong association between substance use and trauma, the state will emphasize trauma-informed care as well as the use of evidence-based practices in the treatment of substance use disorders. North Carolina supports a full continuum of substance abuse services including prevention, intervention and treatment for pregnant and parenting women and their families and women seeking custody of their child(ren). The Perinatal and Maternal Substance Abuse Initiative is composed of specialized programs for pregnant and parenting women with a substance related disorder and their children. These programs provide comprehensive, gender-responsive, substance abuse services that include, but are not limited to the following: screening, assessment, case management, outpatient substance abuse and mental health services, parenting skills, residential services, referrals for primary and preventative health care and referrals for appropriate interventions for their children. The children in these families benefit from various services, including those provided by the local health departments (pediatric care), early intervention programs, etc. The NC CASAWORKS for Families Residential Initiative is a collaborative project between the Division of MH/DD/SAS and the Division of Social Services. This Initiative supports eight comprehensive residential substance abuse programs for women receiving Work First cash assistance and their children. Emphasis will be placed on identifying and removing any barriers to accessing these services, increasing referrals and improving outcomes. Due to the increased use of prescription pain medications, the Division will emphasize improved access to and retention in opioid treatment programs for pregnant women.

As stated above, North Carolina, like many states, has seen an increase in the use of painkillers, creating a higher demand for opioid treatment programs or medication-assisted therapies. Related to such, in 2013, the Division of Public Health, Injury and Violence Prevention section, published *The Burden of Unintentional Poisonings in North Carolina*. Highlights from that publication include the following:

- In 2012, 1,101 people died from unintentional poisoning in North Carolina;
- North Carolina's unadjusted death rate from unintentional poisoning is slightly higher than the national death rate;
- Unintentional poisonings are the second leading cause of injury death in the state (1,101 deaths) after motor vehicle crashes (1,185 deaths);
- Men die at much higher rates of unintentional poisoning than women; whites die at higher rates than other racial groups;
- Approximately 92 percent of all unintentional poisoning deaths are drug or medication related;
- Nonfatal poisoning deaths are very common in young children, particularly those under five years of age.

There are currently 50 opioid treatment programs in the state, of which approximately 20 are eligible to provide services to publicly-funded consumers. The Division will focus efforts on improving access, retention and outcomes specific to these programs.

North Carolina is home to a large number of active military, National Guard and Reserves, veterans, and military families, ranking third in the country on this criterion. In a recent study, the NC Institute of Medicine noted that 35% of North Carolinians have some relationship to the military. The number of reserve component members in the state sum up to 22,000. A total of 116,000 are in the active military, while a total of 775,020 are veterans and 190,896 are dependents of service members. DMH/DD/SAS serves the needs of the military primarily through the Governor's Working Group on Veterans, Service Members and Their Families, a project that it supports and funds through the SABG. The Governor's Working Group promotes evidence-based and best practices in the screening, assessment, and treatment of active duty, National Guard, reservists and veterans who served in the military and their families.

The State Epidemiological Outcomes Workgroup (SEOW) for the NC Strategic Prevention Framework/State Incentive Grant (SPF/SIG) that was funded by the Center for Substance Abuse Prevention in 2005 further identified alcohol related deaths and under-age drinking as target areas for the state's SPF/SIG project. More recently, prescription drug misuse and abuse has been identified as a target area. The state epidemiological profile produced by the SEOW also identified four other high-ranked areas of focus: (1) driving while impaired (DWI) disposed cases/convictions for those under 21; (2) deaths from drug overdose; (3) possession of a controlled substance in violation of the law among students grades K-12 and under; and (4) adults aged 18 or older arrested for drug law offenses. According to the 2012 Social Indicator Study initiated by the NC SEOW, there has been an increase in:

- Suicides among NC residents (13.25%)
- Prescription drug use among youth aged 12 to 21, but especially among those aged 12 to 14

2011 YRBS data suggests that youth are starting to drink alcohol and smoke marijuana at age 10 compared to the first age of use of alcohol and marijuana at age 13, ten years ago. Underage consumption of alcohol and tobacco continues to rank high as well as prescription drug misuse and abuse. There has also been evidence of increase in marijuana and youth violence.

The Substance Abuse Block Grant will continue to provide universal, selective and indicated prevention intervention and early intervention activities in community settings. It will also continue to provide treatment to the priority groups enumerated above, emphasizing the use of trauma-informed care and evidence-based practices. Division staff will continue to work with LME/MCOs, providers, individuals in recovery and their family members and other stakeholders to further identify and prioritize areas of greatest need and strategize ways to reduce these gaps with the resources available.

## Step 2: Identify the unmet service needs and critical gaps within the current system

Approximately 8.43 percent of all North Carolinians aged 12 or older are expected to have Substance Use Disorders (SUDs). The current prevalence estimates, which vary by age, are slightly higher than reported in 2011 for young adults and adults: 5.9 percent for those between the ages of 12 - 17 years; 18.5 percent for young adults aged 18 to 25; and 7.1 percent for adults aged 26 and up. *(Data Source: Table 20 - Dependence or Abuse of Illicit Drugs or Alcohol in the Past Year, by Age Group and State: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, Annual Averages Based on 2012-2013 NSDUHs, published 12.17.14.)*

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[http://www.osbm.state.nc.us/demog/countytotals\\_singleage\\_2015.html](http://www.osbm.state.nc.us/demog/countytotals_singleage_2015.html). Last updated: 10/13/14.)

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Number and Percent of Uninsured Persons Who Received State/Block Grant Funded Substance Use Services in SFY14		
Age Range	3 - 17	18 - 64
Number of uninsured population	161,479	1,280,613
Number that received at least one service	354	33,940
Percent that received at least one service	.22%	2.7%

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The Public Health Service Act requires the substance abuse block grant to address prevention and early intervention. In addition, it also specifies populations that must be served with grant funds. These are:

- pregnant women with substance use and women with substance use who also have dependent children;
- persons who use drugs intravenously (IDU);
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- As of December 31, 2014, the number of people diagnosed and living with HIV infection in North Carolina was 28,526;
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The State has also identified juveniles and adults with substance use disorders who are involved with the law as a population of focus. According to the North Carolina Division of Alcoholism and Chemical Dependency Programs, approximately 90% of the criminal offenders who enter the prison system have substance abuse problems. (*North Carolina Division of Alcoholism and Chemical Dependency Programs, North Carolina Department of Correction. Annual legislative report, 2006-2007.*

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As stated above, North Carolina, like many states, has seen an increase in the use of painkillers, creating a higher demand for opioid treatment programs or medication-assisted therapies. Related to such, in 2013, the Division of Public Health, Injury and Violence Prevention section, published *The Burden of Unintentional Poisonings in North Carolina*. Highlights from that publication include the following:

- In 2012, 1,101 people died from unintentional poisoning in North Carolina;
- North Carolina's unadjusted death rate from unintentional poisoning is slightly higher than the national death rate;
- Unintentional poisonings are the second leading cause of injury death in the state (1,101 deaths) after motor vehicle crashes (1,185 deaths);
- Men die at much higher rates of unintentional poisoning than women; whites die at higher rates than other racial groups;
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- Nonfatal poisoning deaths are very common in young children, particularly those under five years of age.

There are currently 50 opioid treatment programs in the state, of which approximately 20 are eligible to provide services to publicly-funded consumers. The Division will focus efforts on improving access, retention and outcomes specific to these programs.

North Carolina is home to a large number of active military, National Guard and Reserves, veterans, and military families, ranking third in the country on this criterion. In a recent study, the NC Institute of Medicine noted that 35% of North Carolinians have some relationship to the military. The number of reserve component members in the state sum up to 22,000. A total of 116,000 are in the active military, while a total of 775,020 are veterans and 190,896 are dependents of service members. DMH/DD/SAS serves the needs of the military primarily through the Governor's Working Group on Veterans, Service Members and Their Families, a project that it supports and funds through the SABG. The Governor's Working Group promotes evidence-based and best practices in the screening, assessment, and treatment of active duty, National Guard, reservists and veterans who served in the military and their families.

The State Epidemiological Outcomes Workgroup (SEOW) for the NC Strategic Prevention Framework/State Incentive Grant (SPF/SIG) that was funded by the Center for Substance Abuse Prevention in 2005 further identified alcohol related deaths and under-age drinking as target areas for the state's SPF/SIG project. **The state continues to use the SEOW to assist in identifying trends and needs and gaps in services of the substance abuse prevention and mental health needs of the consumers in the state. The SEOW is comprised of representatives from the following agencies: NC Department of Public Health, Injury and Violence Prevention Branch, NC Problem Gambling section within DMHDDSAS, NC Center for Health Statistics, PIRE, NC Department of Public Instruction, University of North Carolina School of Public Health, Department of Epidemiology and NC Action For Children meet on the second Friday of each month to assist us in assuring that we are using the current and appropriate data to help us determine needs and gaps in substance abuse prevention services. The members of the SEOW have been dedicated and passionate about assisting with the task of identifying the most appropriate data to inform decision making about substance abuse prevention planning. More recently, prescription drug misuse and abuse has been identified as a target area according to data received from the North Carolina Injury and Violence Prevention Branch.** The state epidemiological profile produced by the SEOW also identified four other high-ranked areas of focus: (1) driving while impaired (DWI) disposed cases/convictions for those under 21; (2) deaths from drug overdose; (3) possession of a controlled substance in violation of the law among students grades K-12 and under; and (4) adults aged 18 or older arrested for drug law offenses. According to the 2012 Social Indicator Study initiated by the NC SEOW, there has been an increase in:

- Suicides among NC residents (13.25%)
- Prescription drug use among youth aged 12 to 21, but especially among those aged 12 to 14

**The state will coordinate and collaborate with its partners to address any identified trends, as well as needs and gaps in substance abuse prevention services.** The 2013 YRBS data suggests that youth are starting to drink alcohol and smoke marijuana at age 10 compared to the first age of use of alcohol and marijuana at age 13, ten years ago. Underage consumption of alcohol and tobacco continues to rank high as well as prescription drug misuse and abuse. There has also been evidence of increase in marijuana and youth violence. **The state also reviewed data from NSDUH, Monitoring the Future, CDC, Community Care of North Carolina, Bureau on Indian Affairs and the North Carolina Youth Tobacco**

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In accordance with SABG guidelines outlined by SAMHSA, the substance abuse prevention system will continue to provide universal, selective and indicated prevention intervention and early intervention activities in community settings. It will also continue to provide treatment to the priority groups enumerated above, emphasizing the use of trauma-informed care and evidence-based practices. Division staff will continue to work with LME/MCOs, providers, individuals in recovery and their family members and other stakeholders to further identify and prioritize areas of greatest need and strategize ways to reduce these gaps with the resources available.

## Step 2: Identify the unmet service needs and critical gaps within the current system

Approximately 8.43 percent of all North Carolinians aged 12 or older are expected to have Substance Use Disorders (SUDs). The current prevalence estimates, which vary by age, are slightly higher than reported in 2011 for young adults and adults: 5.9 percent for those between the ages of 12 - 17 years; 18.5 percent for young adults aged 18 to 25; and 7.1 percent for adults aged 26 and up. *(Data Source: Table 20 - Dependence or Abuse of Illicit Drugs or Alcohol in the Past Year, by Age Group and State: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, Annual Averages Based on 2012-2013 NSDUHs, published 12.17.14.)*

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Survey, along with local health department assessments. These data were used to help assess needs and gaps of substance abuse prevention services in the state.

In accordance with SABG guidelines outlined by SAMHSA for the 20% Primary Prevention Set-Aside, the substance abuse prevention system will continue to provide universal, selective and indicated prevention intervention and early intervention activities in community settings.

In addition, the SABG will also continue to provide treatment through activities outlined outside of the 20% Primary Prevention Activities. These will be provided to the priority groups enumerated above, emphasizing the use of trauma-informed care and evidence-based practices. Division staff will continue to work with LME/MCOs, providers, individuals in recovery and their family members and other stakeholders to further identify and prioritize areas of greatest need and strategize ways to reduce these gaps with the resources available.

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As of July 2015, North Carolina had an estimated total population of 10,054,192 people, making it the ninth largest state in the United States. Given the above prevalence rates, it is estimated that of the 793,650 youth between the ages of 12 – 17, 5.9 percent or about 46,825 youth will have a substance use disorder. Young adults between the ages of 18-25 have a much higher incidence of substance use; accordingly of those 1,133,305 young adults, approximately 209,661 will have a substance use disorder. Adults ages 26 and older have the lowest prevalence rate; given the population of over 6.6 million adults, 470,341 will have a substance use disorder. (*Data Source: NC Office of State Budget and Management (OSBM) website.*

[http://www.osbm.state.nc.us/demog/countytotals\\_singleage\\_2015.html](http://www.osbm.state.nc.us/demog/countytotals_singleage_2015.html). Last updated: 10/13/14.)

Since submission of the previous application and plan, North Carolina has fully transitioned to a new multi-payer Medicaid Management Information System for the NC Department of Health and Human Services, called NCTracks. NCTracks is used by the Division of Medical Assistance (DMA), the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) and the Division of Public Health (DPH). Providers enrolled in DMA, DMH/DD/SAS and DPH health plans submit claims for payment of covered health care services through the NCTracks Provider Portal. NCTracks coordinates processing among the payers to ensure the proper assignment of the payer, benefit plan and pricing methodology for each service on a claim. NCTracks processes health care claims for about 70,000 enrolled DHHS providers who serve over one million North Carolina citizens. It should be noted that providers who are contracted by Local Management Entities/Managed Care Organizations (LME/MCOs) to enroll and perform state and federal block grant funded services, through funding from DMH/DD/SAS, submit their claims to the LME/MCO.

As is often the case with transitions of this magnitude, the Division has experienced some difficulty in determining the accuracy of data through paid claims. As a result, some of the data below was gathered prior to the implementation of the multi-payer system. Additionally, some of the data below was reported from the LME/MCOs based on information within their own information and payer systems. Data from NCTracks continues to improve; therefore, we anticipate the availability of more and better data this fiscal year.

The table below illustrates data reported by the LME/MCOs for state fiscal year 2014. The measurement period was July 2013 through June 2014, and based on claims paid as of October 31, 2014. The estimates of the uninsured were based on county rates reported by the NC Institute of Medicine 2010-2011 Data Snapshot, which was released January 4, 2013 and applied to the state population at the beginning of the state fiscal year, as reported by the NC Office of State Budget and Management.

Number and Percent of Uninsured Persons Who Received State/Block Grant Funded Substance Use Services in SFY14		
Age Range	3 - 17	18 - 64
Number of uninsured population	161,479	1,280,613
Number that received at least one service	354	33,940
Percent that received at least one service	.22%	2.7%

Over the last several years, North Carolina has implemented a 1915(b)/(c) waiver that is now statewide. All 100 counties are part of a catchment area covered by one of eight local management entities/managed care organizations (LME/MCOs) that assure the delivery of services that are of the appropriate intensity and duration for consumers with intellectual/developmental disabilities or mental health/substance use issues. Each LME/MCO contracts with providers, the majority of whom are nationally accredited, for specific services for specific populations; i.e., adults with a substance use disorder, children with a serious emotional disturbance, etc. In order for LME/MCOs to be eligible to receive categorical substance abuse block grant funds, the LME/MCO must assert and assure that the federally mandated priority populations be served; i.e., pregnant women with a substance use disorder, individuals injecting drugs, etc.

The Division of MH/DD/SA Services and the Division of Medical Assistance require the LME/MCOs to annually complete a *Provider Capacity, Community Needs Assessment and Gaps Analysis*. DMH/DD/SAS and DMA each have performance agreements/contracts with LME/MCOs containing requirements for assessments of community need, provider capacity, gaps in services and strategic plans to address gaps. A statewide, in-depth analysis to aggregate results of the most current reports from each LME/MCO is still underway; therefore selected needs and gaps from the 2013 reports can be found in the Attachment section titled ***Gaps and Needs Overview SFY13***. Designated staff will work with the LME/MCOs to identify strategies to address gaps related to the provision of prevention, treatment and recovery support services for youth and adults at risk or with substance use disorders.

The Public Health Service Act requires the substance abuse block grant to address prevention and early intervention. In addition, it also specifies populations that must be served with grant funds. These are:

- pregnant women with substance use and women with substance use who also have dependent children;
- persons who use drugs intravenously (IDU);
- individuals with tuberculosis;
- persons with or at risk for HIV/AIDS who are in treatment for a substance use disorder

According to the *2014 North Carolina HIV/STD Surveillance Report*, published by the North Carolina Department of Health and Human Services, Division of Public Health:

- As of December 31, 2014, the number of people diagnosed and living with HIV infection in North Carolina was 28,526;
- In 2014, 1,351 new diagnoses of HIV infection were reported, at a rate of 13.4 per 100,000 population;
- Of the new infections, 1,341 infections occurred in the adult and adolescent population, with a rate of 16.3 per 100,000 population. This number is similar to what has been seen in previous years.

As North Carolina has been identified as a “designated state” by SAMHSA, at least five percent of substance abuse block grant funding is spent on HIV early intervention services for people who are participating in treatment for a substance use disorder. This funding is distributed to the LME/MCOs who then contract with providers. In addition, the Division also has a Memorandum of Understanding with the Division of Public Health, Communicable Disease Section, to provide testing and intervention services for persons that have substance use disorders. In 2011, injecting drug use accounted for eight percent of HIV disease cases for adult/adolescent females and six percent of adult/adolescent males.

The North Carolina Institute of Medicine (NCIOM) is an independent, quasi-state agency that was chartered by the North Carolina General Assembly in 1983 to provide balanced, nonpartisan information on issues of relevance to the health of North Carolina’s population. In 2007, the North Carolina General Assembly enacted Session Law 2007-323 that led to the creation of the Task Force on Substance Abuse Services facilitated by the NCIOM. Funded with SAPTBG funds, the Task Force on Substance Abuse Services convened a steering committee that included representation from the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services. In collaboration with the Division of Public Health and the NC Department of Health and Human Services, the NCIOM convened a Task Force on Prevention that met between 2008 and 2009 to develop the NC Prevention Plan. Both Task Forces recommended the development of a comprehensive substance abuse plan that would have prevention at its core with children, adolescents, young adults and their parents as priority targets.

The State has also identified juveniles and adults with substance use disorders who are involved with the law as a population of focus. According to the North Carolina Division of Alcoholism and Chemical Dependency Programs, approximately 90% of the criminal offenders who enter the prison system have substance abuse problems. (*North Carolina Division of Alcoholism and Chemical Dependency Programs, North Carolina Department of Correction. Annual legislative report, 2006-2007.* [http://www.doc.state.nc.us/Legislative/2008/2006-07\\_Annual\\_Legislative\\_Report.pdf](http://www.doc.state.nc.us/Legislative/2008/2006-07_Annual_Legislative_Report.pdf). Published March 2008.) Treatment Accountability for Safer Communities (TASC) services continue to be delivered in all 100 counties for adults with SUDs by the NC TASC Network through the TASC Regional Coordinating Entities. More than two out of five youth in the state’s juvenile justice system are in need of further assessment or treatment services for substance abuse, as noted in the 2007 annual report from the North Carolina Department of Juvenile Justice and Delinquency Prevention. ([http://www.ncdjjdp.org/resources/pdf\\_documents/annual\\_report\\_2007.pdf](http://www.ncdjjdp.org/resources/pdf_documents/annual_report_2007.pdf). Published March 2007.) The Division and the Department of Public Safety have been in collaboration with each other since 1997 to provide services to youth involved with juvenile justice and to develop a program of service delivery for youth who are involved in the justice system in partnership with their families.

Community integration/recovery support is another area that has been and will continue to be a focus of the state. The ability to obtain and sustain safe, affordable housing is one of the most significant challenges facing persons in the early stages of recovery. In addition, having meaningful work is integral to many individuals’ recovery. The state has an ongoing contract with Oxford House, Inc. to provide housing for people in recovery and has set aside \$100,000 for the support of statewide consumer housing

through the Cross Area Service Program (CASP) Substance Abuse Services initiative. A substantial portion of block grant funds were utilized last fiscal year to support recovery housing (in addition to Oxford Houses). In that safe, affordable housing continues to be an area of need, the Division will work with LME/MCOs and providers to identify barriers that impede an individual's access to housing and employment.

Because of the strong association between substance use and trauma, the state will emphasize trauma-informed care as well as the use of evidence-based practices in the treatment of substance use disorders. North Carolina supports a full continuum of substance abuse services including prevention, intervention and treatment for pregnant and parenting women and their families and women seeking custody of their child(ren). The Perinatal and Maternal Substance Abuse Initiative is composed of specialized programs for pregnant and parenting women with a substance related disorder and their children. These programs provide comprehensive, gender-responsive, substance abuse services that include, but are not limited to the following: screening, assessment, case management, outpatient substance abuse and mental health services, parenting skills, residential services, referrals for primary and preventative health care and referrals for appropriate interventions for their children. The children in these families benefit from various services, including those provided by the local health departments (pediatric care), early intervention programs, etc. The NC CASAWORKS for Families Residential Initiative is a collaborative project between the Division of MH/DD/SAS and the Division of Social Services. This Initiative supports eight comprehensive residential substance abuse programs for women receiving Work First cash assistance and their children. Emphasis will be placed on identifying and removing any barriers to accessing these services, increasing referrals and improving outcomes. Due to the increased use of prescription pain medications, the Division will emphasize improved access to and retention in opioid treatment programs for pregnant women.

As stated above, North Carolina, like many states, has seen an increase in the use of painkillers, creating a higher demand for opioid treatment programs or medication-assisted therapies. Related to such, in 2013, the Division of Public Health, Injury and Violence Prevention section, published *The Burden of Unintentional Poisonings in North Carolina*. Highlights from that publication include the following:

- In 2012, 1,101 people died from unintentional poisoning in North Carolina;
- North Carolina's unadjusted death rate from unintentional poisoning is slightly higher than the national death rate;
- Unintentional poisonings are the second leading cause of injury death in the state (1,101 deaths) after motor vehicle crashes (1,185 deaths);
- Men die at much higher rates of unintentional poisoning than women; whites die at higher rates than other racial groups;
- Approximately 92 percent of all unintentional poisoning deaths are drug or medication related;
- Nonfatal poisoning deaths are very common in young children, particularly those under five years of age.

There are currently 50 opioid treatment programs in the state, of which approximately 20 are eligible to provide services to publicly-funded consumers. The Division will focus efforts on improving access, retention and outcomes specific to these programs.

North Carolina is home to a large number of active military, National Guard and Reserves, veterans, and military families, ranking third in the country on this criterion. In a recent study, the NC Institute of Medicine noted that 35% of North Carolinians have some relationship to the military. The number of reserve component members in the state sum up to 22,000. A total of 116,000 are in the active military, while a total of 775,020 are veterans and 190,896 are dependents of service members. DMH/DD/SAS serves the needs of the military primarily through the Governor's Working Group on Veterans, Service Members and Their Families, a project that it supports and funds through the SABG. The Governor's Working Group promotes evidence-based and best practices in the screening, assessment, and treatment of active duty, National Guard, reservists and veterans who served in the military and their families.

The State Epidemiological Outcomes Workgroup (SEOW) for the NC Strategic Prevention Framework/State Incentive Grant (SPF/SIG) that was funded by the Center for Substance Abuse Prevention in 2005 further identified alcohol related deaths and under-age drinking as target areas for the state's SPF/SIG project. **The state continues to use the SEOW to assist in identifying trends and needs and gaps in services of the substance abuse prevention and mental health needs of the consumers in the state. The SEOW is comprised of representatives from the following agencies: NC Department of Public Health, Injury and Violence Prevention Branch, NC Problem Gambling section within DMHDDSAS, NC Center for Health Statistics, PIRE, NC Department of Public Instruction, University of North Carolina School of Public Health, Department of Epidemiology and NC Action For Children meet on the second Friday of each month to assist us in assuring that we are using the current and appropriate data to help us determine needs and gaps in substance abuse prevention services. The members of the SEOW have been dedicated and passionate about assisting with the task of identifying the most appropriate data to inform decision making about substance abuse prevention planning. More recently, prescription drug misuse and abuse has been identified as a target area according to data received from the North Carolina Injury and Violence Prevention Branch.** The state epidemiological profile produced by the SEOW also identified four other high-ranked areas of focus: (1) driving while impaired (DWI) disposed cases/convictions for those under 21; (2) deaths from drug overdose; (3) possession of a controlled substance in violation of the law among students grades K-12 and under; and (4) adults aged 18 or older arrested for drug law offenses. According to the 2012 Social Indicator Study initiated by the NC SEOW, there has been an increase in:

- Suicides among NC residents (13.25%)
- Prescription drug use among youth aged 12 to 21, but especially among those aged 12 to 14

**The state will coordinate and collaborate with its partners to address any identified trends, as well as needs and gaps in substance abuse prevention services.** The 2013 YRBS data suggests that youth are starting to drink alcohol and smoke marijuana at age 10 compared to the first age of use of alcohol and marijuana at age 13, ten years ago. Underage consumption of alcohol and tobacco continues to rank high as well as prescription drug misuse and abuse. There has also been evidence of increase in marijuana and youth violence. **The state also reviewed data from NSDUH, Monitoring the Future, CDC, Community Care of North Carolina, Bureau on Indian Affairs and the North Carolina Youth Tobacco**

Survey, along with local health department assessments. These data were used to help assess needs and gaps of substance abuse prevention services in the state.

In accordance with SABG guidelines outlined by SAMHSA for the 20% Primary Prevention Set-Aside, the substance abuse prevention system will continue to provide universal, selective and indicated prevention activities in community settings.

In addition, the SABG will also continue to provide treatment through activities outlined outside of the 20% Primary Prevention Activities. These will be provided to the priority groups enumerated above, emphasizing the use of trauma-informed care and evidence-based practices. Division staff will continue to work with LME/MCOs, providers, individuals in recovery and their family members and other stakeholders to further identify and prioritize areas of greatest need and strategize ways to reduce these gaps with the resources available.

# Planning Steps

## Quality and Data Collection Readiness

### Narrative Question:

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Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's [NBHQF](#). The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at <http://www.samhsa.gov/data/quality-metrics/block-grant-measures>. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?
4. If not, what changes will the state need to make to be able to collect and report on these measures?

*Please indicate areas of technical assistance needed related to this section.*

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

## Planning Steps: Quality and Data Collection Readiness

**1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).**

Please see the following attached graphic that provides an overview of North Carolina's data and reporting processes.

**2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).**

The DMH/DD/SAS current data process is a large combined data system. It includes data on the populations of individuals receiving mental health services and substance use disorder services, as well as data on individuals with a developmental disorder and those who have a traumatic brain injury.

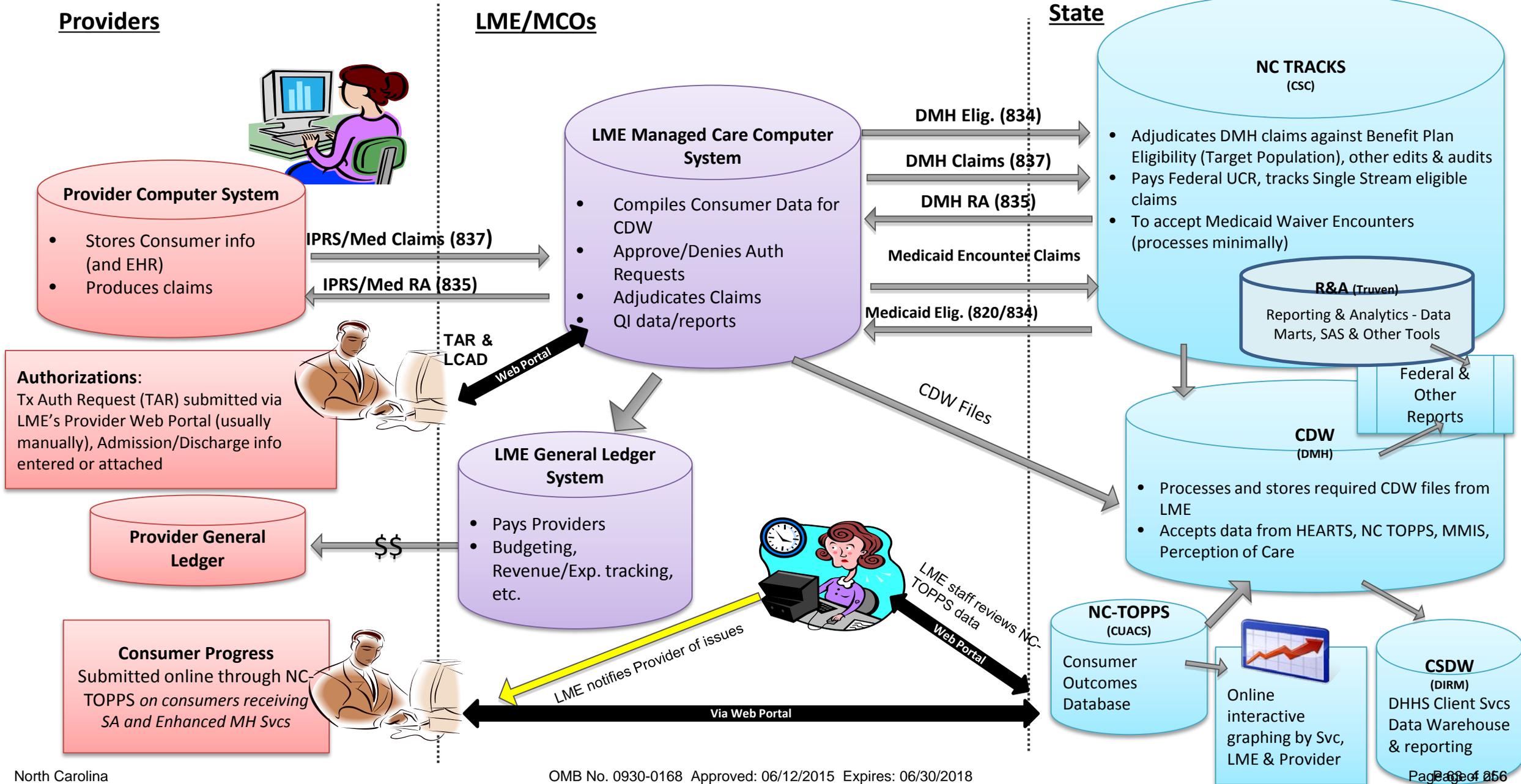
**3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?**

The state's current data system is able to collect and report measures at the individual client level, with full protection of client identifying information.

**4. If not, what changes will the state need to make to be able to collect and report on these measures?**

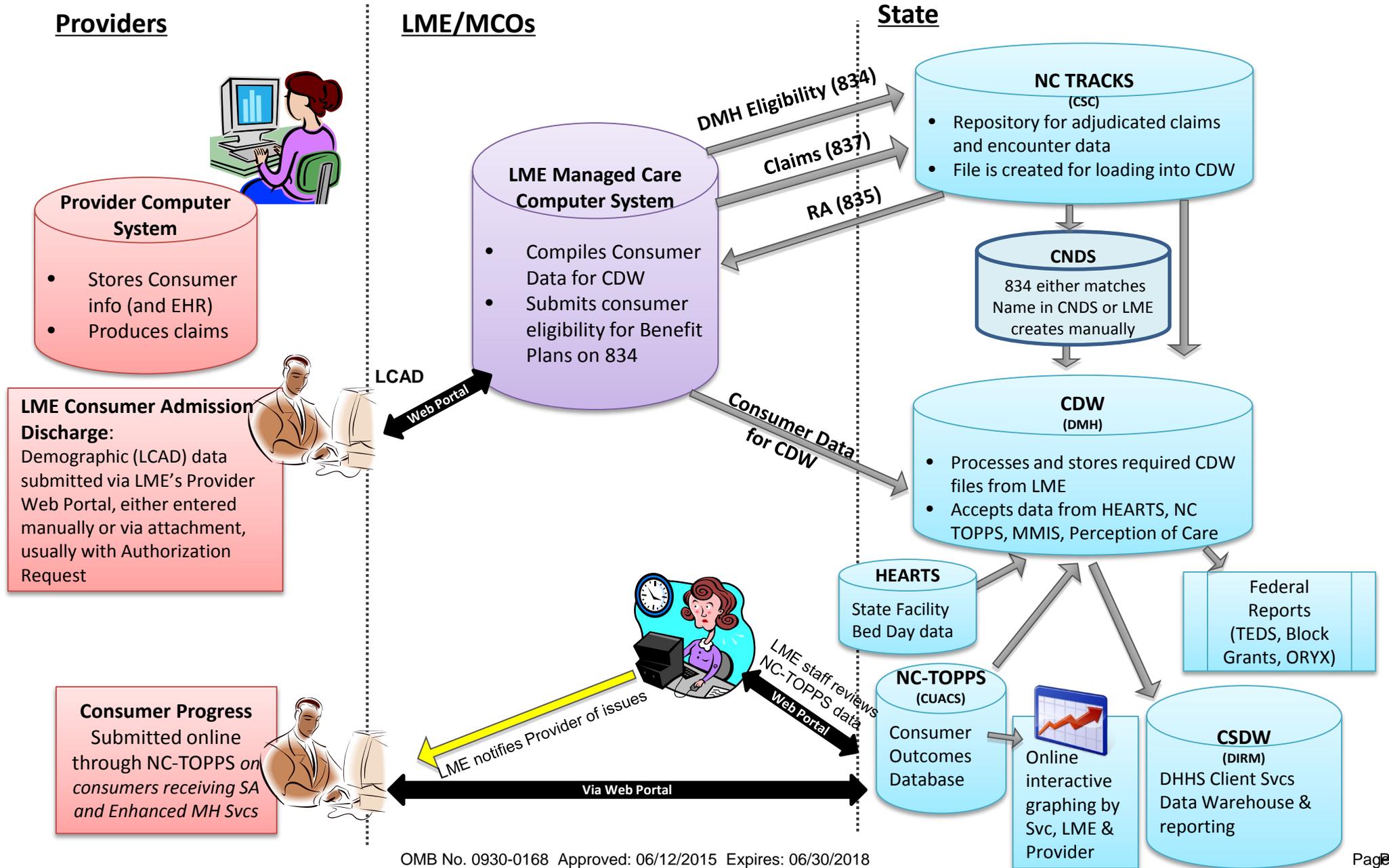
The state does not need to make any changes to the existing data system at this time to collect information at the individual client level.

# NC MHDDSAS Data Flow Overview



# NC MHDDSAS Data Flow – Client Data Warehouse (CDW)

NC DMHDDSAS QMT  
8/18/14



## Planning Steps: Quality and Data Collection Readiness

**1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).**

Please see the following attached graphic that provides an overview of North Carolina's data and reporting processes.

Currently NC POPS collects the following data related to primary prevention services:

- Gender, Ethnicity, Age and Race of consumers;
- The number of consumers served for each IOM classification of Universal, Selective and Indicated, as well as the percentage served;
- The number of consumers served in each one of the 6 strategies (information dissemination, education, alternatives, problem identification and referral, community based process and environmental strategies; and,
- The problem statement, a measurable goal and a desired outcome.

**2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).**

The DMH/DD/SAS current data process is a large combined data system. It includes data on the populations of individuals receiving mental health services and substance use disorder services, as well as data on individuals with a developmental disorder and those who have a traumatic brain injury.

**3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?**

The state's current data system is able to collect and report measures at the individual client level, with full protection of client identifying information.

**4. If not, what changes will the state need to make to be able to collect and report on these measures?**

The state does not need to make any changes to the existing data system at this time to collect information at the individual client level.

# Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1  
Priority Area: Health Disparities  
Priority Type: SAT  
Population(s): PWWDC, IVDUs, Other (All other individuals participating in treatment for a substance use disorder)

Goal of the priority area:

Improved integrated care

Objective:

Increase the number of individuals participating in treatment for a substance use disorder who receive a physical examination, detailed medical history and/or routine health risks screenings.

Strategies to attain the objective:

Promotion of integrated care and utilization of E&M codes

## Annual Performance Indicators to measure goal success

Indicator #: 1  
Indicator: Number of individuals participating in treatment for a substance use disorder who receive physical exams, health risk screenings, etc.  
Baseline Measurement: During FY15, 699 individuals received a health-related service, as evidenced by the billing of specific, identified Evaluation and Management CPT codes  
First-year target/outcome measurement: During FY16, the number of individuals who receive a health-related service, as evidenced by the billing of specific, identified Evaluation and Management CPT codes will increase by 5%  
Second-year target/outcome measurement: During FY17, the number of individuals who receive a health-related service, as evidenced by the billing of specific, identified Evaluation and Management CPT codes will increase by an additional 5%

Data Source:

NCTracks

Description of Data:

Paid claims data

Data issues/caveats that affect outcome measures::

Paid claims data continues to improve; however, some LME/MCOs have been more successful than others in successfully submitting claims and/or working denials. Also if timely filing deadlines are extended (which allows the LME/MCOs more opportunity to submit claims), data could be delayed.

Priority #: 2  
Priority Area: HIV - Early Intervention Services  
Priority Type: SAT  
Population(s): HIV EIS

Goal of the priority area:

Provide HIV early intervention services to individuals involved in substance use disorder treatment

Objective:

To increase the number of people who receive early intervention services related to HIV while they are engaged in treatment for a substance use disorder

Strategies to attain the objective:

- (1) Continue to provide HIV set-aside funding to participating LME/MCOs and the Division of Public Health in high risk and greatest need areas of the state.
- (2) Continue to support the required components of these early intervention services, including pre- and post-test counseling, testing for HIV and providing therapeutic measures as part of individuals' recovery.
- (3) Monitor the provision of these services.
- (4) Assess the need for expansion to other areas of the state.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of persons who are participating in treatment for a substance use disorder that receive an HIV test

Baseline Measurement: During SFY15, approximately 8783 individuals were tested for HIV

First-year target/outcome measurement: Number tested will increase by 2%

Second-year target/outcome measurement: Number tested will increase by an additional 2%

Data Source:

Semi-Annual SABG Compliance reports and reports from the Division of Public Health

Description of Data:

The Compliance reports are received semi-annually from all LME/MCOs and report how many individuals received testing, as well as pre- and post-test counseling. This data is also collected by the agencies with whom the Division of Public Health contracts and is provided to DMH/DD/SAS as well.

Data issues/caveats that affect outcome measures::

None anticipated

Priority #: 3

Priority Area: Intravenous Drug Use

Priority Type: SAT

Population(s): IVDUs

Goal of the priority area:

Reduced number of deaths of individuals participating in opioid treatment

Objective:

To reduce the number of deaths of individuals during the induction/stabilization phase of opioid treatment provided by a publicly funded program.

Strategies to attain the objective:

- (1) Monthly meetings with OTP Medical Directors and quarterly meetings with OTP Program Directors to review protocols and best practice approaches for the provision of medication assisted therapies;
- (2) Regional summits annually with all prescribers;
- (3) Tightening/monitoring the scope of practice for nurses working in OTPs;
- (4) Promoting/promulgating best practice guidelines specifically related to the use of benzodiazepines and methadone.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Decreased number of deaths of individuals participating in a publicly-funded opioid treatment program during the induction/stabilization phase (1st 90 days)

Baseline Measurement: 10 deaths were reported by the 19 state and federally funded OTPs during SFY 15 during the first 90 days of opioid treatment, compared with a total of 59 deaths at any stage of opioid treatment; i.e., 16.94%

First-year target/outcome measurement: The percentage of deaths that occur during the first 90 days of opioid treatment will be reduced by 20%

Second-year target/outcome measurement: The percentage of deaths that occur during the first 90 days of opioid treatment will be reduced by an additional 25%

Data Source:

IRIS (Incident Reporting and Improvement System)

Description of Data:

The IRIS database collects adverse events, including deaths.

Data issues/caveats that affect outcome measures::

There are on occasion, delays in reporting adverse events if the provider is unaware of the occurrence of such.

Priority #: 4

Priority Area: Juvenile justice

Priority Type: SAT

Population(s): Other (Criminal/Juvenile Justice)

Goal of the priority area:

To appropriately address treatment needs of juvenile justice involved youth as directed by assessment

Objective:

Increase the percentage of assessments to juvenile justice involved youth

Strategies to attain the objective:

DMH/DD/SAS will collaborate with the Department of Public Safety, Juvenile Justice, and other key stakeholders to identify and maximize resources for justice involved youth and families with substance use or co-occurring issues.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of all justice-involved youth with a complaint who were assessed

Baseline Measurement: During SFY15, assessments were conducted on 17% of youth with a complaint

First-year target/outcome measurement: Increase the number of assessments performed with youth who have had a complaint by 1%

Second-year target/outcome measurement: Increase the number of assessments performed with youth who have had a complaint by an additional 1%.

Data Source:

Juvenile Justice Substance Abuse Mental Health Partnerships (JJSAMHP) teams report monthly the number of assessments. This information is compiled into an annual report.

Description of Data:

JJSAMHP teams report the number of assessments on a monthly basis. This information is compiled into an annual report.

Data issues/caveats that affect outcome measures::

Current data and goals reflect the percentage of youth receiving an assessment at complaint. These youth have not yet gone through the intake process where they would be screened for substance use concerns; therefore there may or may not be substance use issues. DMH/DD/SAS seeks to refine this data by determining the percentage of youth receiving an assessment that were screened (during intake process) and indicative of a substance use issue.

Indicator #: 2  
Indicator: Percentage of youth receiving an assessment who have been screened and identified for substance use concerns via the intake process  
Baseline Measurement: This is the first year for collecting this data  
First-year target/outcome measurement: Increase the number of assessments performed by 1%  
Second-year target/outcome measurement: Increase the number of assessments performed by an additional 1%

Data Source:

Juvenile Justice Substance Abuse Mental Health Partnerships (JJSAMHP) teams report monthly the number of assessments. This information is compiled into an annual report.

Description of Data:

JJSAMHP teams report the number of assessments on a monthly basis. This information is compiled into an annual report.

Data issues/caveats that affect outcome measures::

Current data and goals reflect the percentage of youth receiving an assessment at complaint. These youth have not yet gone through the intake process where they would be screened for substance use concerns; therefore there may or may not be substance use issues. DMH/DD/SAS seeks to refine this data by determining the percentage of youth receiving an assessment that were screened (during intake process) and indicative of a substance use issue. This will require comparing partnership monthly reporting to Juvenile Justice data on intakes.

Priority #: 5  
Priority Area: Community Integration  
Priority Type: SAT  
Population(s): Other (Homeless, Inadequately housed)

Goal of the priority area:

Greater access to supported housing through the development of additional Oxford Houses in NC

Objective:

To increase the availability of housing through additional Oxford Houses

Strategies to attain the objective:

- (1) DMHDDSAS will continue to provide no less than the current level of funding to Oxford House, Inc. to support additional staff to increase outreach efforts and the number of Oxford House beds;
- (2) DMHDDSAS will notify LME/MCOs of newly opened Oxford Houses in their catchment areas;
- (3) The Contractor will assure that LME/MCOs are aware of newly opened Oxford Houses and the processes for referral.

Annual Performance Indicators to measure goal success

Indicator #: 1  
Indicator: Number of NC Oxford House beds available that are integrated in the community to serve men, women and women with children.  
Baseline Measurement: At the end of SFY14, there were 1333 total beds available for men, women and women with children.

First-year target/outcome measurement: No less than 1460 Oxford House beds will be available to adults with substance use disorders

Second-year target/outcome measurement: No less than 1560 Oxford House beds will be available to adults with substance use disorders

Data Source:

Monthly Oxford House Activity Reports and Attestation Reports, which are completed on newly opened Oxford Houses

Description of Data:

Monthly reports contain the location of the houses, number, type (male, female, child) and status (filled or vacant) of the beds.

Data issues/caveats that affect outcome measures::

Rarely, but on occasion, an Oxford House may be forced to close or move to a different location.

Indicator #: 2

Indicator: Number of re-entering (transitioning from incarceration) individuals recovering from substance use disorders housed in an Oxford House

Baseline Measurement: This is a new measure

First-year target/outcome measurement: Serve and mentor 20 re-entering individuals

Second-year target/outcome measurement: Serve and mentor an additional 5 re-entering individuals

Data Source:

Oxford House NC Criminal Justice Program Quarterly Total reports

Description of Data:

Quarterly reports lists correctional institutions in which programs were established to educate individuals recovering from SUD on the Oxford House model, the number individuals interviewed for housing, and the number of referred individuals placed in a NC Oxford House.

Data issues/caveats that affect outcome measures::

No additional issues anticipated

Priority #: 6

Priority Area: Access to quality opioid treatment for pregnant women and women of child-bearing age

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Increased access to opioid treatment for pregnant women and women of child-bearing age

Objective:

Increase the number of pregnant women and women of child-bearing age who have entered treatment for opioid use

Strategies to attain the objective:

- (1) Continuation of the state-wide multi-disciplinary stakeholder's work group which focuses on identifying and eliminating barriers to care;
- (2) Development and dissemination of educational materials for numerous professional disciplines regarding opioids, pregnancy, medication assisted treatment and women's gender responsive treatment;
- (3) Provision of training and technical assistance.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of pregnant women and women of child-bearing age participating in treatment for an opioid use disorder

Baseline Measurement: During SFY14, 351 pregnant women and women of child-bearing age (between the ages of 18-45) accessed to treatment for an opioid use disorder

First-year target/outcome measurement: Increase by 1% the number of pregnant women and women of child-bearing age involved in opioid treatment

Second-year target/outcome measurement: Increase by an additional 1% the number of pregnant women and women of child-bearing age involved in opioid treatment

Data Source:

Client Data Warehouse (CDW), NCTOPPS

Description of Data:

This is North Carolina's individual outcomes and program performance database

Data issues/caveats that affect outcome measures::

None anticipated

Priority #: 7

Priority Area: Access to gender-responsive, family-centered substance use disorder treatment and related services for pregnant women and women with dependent children

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Increased access to treatment for pregnant women and women with dependent children

Objective:

Increase the number of pregnant women and women with dependent children who are referred to treatment for substance use disorders through the 1-800 hotline

Strategies to attain the objective:

- (1) Maintain a dedicated Perinatal Use Specialist position to ensure pregnant and parenting women receive appropriate screening and referrals through the hotline for behavioral health and prenatal care;
- (2) Maintain and regularly update the statewide capacity management database to identify available treatment slots in the Perinatal, Maternal and CASAWORKS programs;
- (3) Increase awareness of substance use issues and available resources specific to pregnant and parenting women with substance use disorders.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of pregnant women and women with dependent children referred to gender-responsive treatment through the 1-800 hotline

Baseline Measurement: 256 pregnant women and women with dependent children received referrals during SFY15

First-year target/outcome measurement: Increase the number of treatment referrals by 1%

Second-year target/outcome measurement: Increase the number of treatment referrals by an additional 1%

Data Source:

Annual Perinatal Substance Use Project report

Description of Data:

The annual Perinatal Substance Use Project report includes the number of pregnant and parenting women who call the hotline requesting treatment resources for a substance use disorder.

Data issues/caveats that affect outcome measures::

None anticipated

Priority #: 8  
Priority Area: Increased access to substance use disorder treatment for individuals with a substantiated CPS case  
Priority Type: SAT  
Population(s): PWWDC

Goal of the priority area:

Increased identification of individuals with a substance use disorder who are CPS involved

Objective:

In partnership with the Division of Social Services, Child Protective Services, increase the number of individuals receiving assessment for treatment by the Work First-Child Protective Services Substance Use Initiative QPSA staff

Strategies to attain the objective:

Maintain the presence of QPSAs (qualified professionals in substance abuse) in North Carolina counties to conduct assessments with identified CPS referred individuals

#### Annual Performance Indicators to measure goal success

Indicator #: 1  
Indicator: Number of individuals with a substantiated CPS case or found in need of services due to substance use who were referred for an assessment  
Baseline Measurement: 2824 individuals referred by local CPS were assessed during SFY15  
First-year target/outcome measurement: Increase the number of individuals assessed by 1%  
Second-year target/outcome measurement: Increase the number of individuals assessed by an additional 1%

Data Source:

Quarterly Project Report of the Work First-Child Protective Services Substance Abuse Initiative, which is completed by the LME/MCOs

Description of Data:

The data in this Report includes the number of individuals with a substantiated CPS case or found in need of services due to substance use who were assessed.

Data issues/caveats that affect outcome measures::

None anticipated

Priority #: 9  
Priority Area: Prevention of under-age drinking  
Priority Type: SAP  
Population(s): PP, Other (Adolescents w/SA and/or MH, Students in College, Children/Youth at Risk for BH Disorder, At-risk, high risk youth and their families)

Goal of the priority area:

Increased awareness of the consequences of underage drinking

Prevent and reduce the consequences of underage drinking

Strategies to attain the objective:

- (1) Continue to provide \$360,000 of primary prevention funding for underage drinking coalitions to implement activities and strategies activities state;
- (2) Continue to provide funding for local LME/MCO contracted substance use prevention providers to provide activities and strategies for underage drinking such as Project Graduation and Prom Promise.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of youth and community members attending Prevention of Underage Drinking activities provided by the Preventing Underage Drinking Coalitions

Baseline Measurement: 110,000 youth, their families and community members received underage drinking information and education by participating in activities to prevent underage drinking consequences, such as Project Graduation, Prom Promise and youth substance abuse prevention coalitions during SFY15.

First-year target/outcome measurement: Increase the number of youth, their families and community members who receive underage drinking education and prevention activities by 2%.

Second-year target/outcome measurement: Increase the number of youth, their families and community members who receive underage drinking education and prevention activities by an additional 3%.

Data Source:

Quarterly Reports from the NC Preventing Underage Drinking Coalitions

Description of Data:

These Quarterly Reports indicate the type of activity and number of youth, families and community members reached.

Data issues/caveats that affect outcome measures::

None anticipated

Indicator #: 2

Indicator: The number of youth reporting no access to alcohol in their home, community and other environments.

Baseline Measurement: At least 50,000 youth have reported not having access to alcohol in their home, community, schools and other environments.

First-year target/outcome measurement: Increase the number of youth reporting no access to alcohol in their home, community, schools and other environments by 2%.

Second-year target/outcome measurement: Increase the number of youth reporting no access to alcohol in their home, community, schools and other environments by an additional 2%.

Data Source:

NC Youth Risk Behavior Survey and Alcohol Law Enforcement data

Description of Data:

Annual and quarterly reports from Alcohol Law Enforcement and the NC Youth Risk Behavior Survey

Data issues/caveats that affect outcome measures::

None anticipated

Priority #: 10

Priority Area: Prevention and reduction of prescription drug abuse and misuse

Priority Type: SAP

Population(s): PP, Other (At risk and high risk youth)

Goal of the priority area:

To reduce the incidence of prescription drug misuse and abuse among youth

Objective:

Reduce prescription drug misuse and abuse among youth age 12-25

Strategies to attain the objective:

- (1) Provide 13 additional information and educational opportunities for youth to learn more about the dangers and consequences associated with using and misusing prescription drugs;
- (2) Provide 26 additional educational opportunities that will provide the necessary knowledge for youth 12-25 to take medications as they are prescribed.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: The number of youth with information and education about the dangers and consequences of prescription drug misuse and abuse.

Baseline Measurement: 16,000 youth, their families and communities received information, education and prevention activities regarding prescription drug misuse and abuse during SFY15.

First-year target/outcome measurement: Increase the number of youth aged 12 to 25 receiving education regarding prescription drug misuse and abuse by 2%.

Second-year target/outcome measurement: Increase the number of youth aged 12 to 25 receiving education regarding prescription drug misuse and abuse by an additional 2%.

Data Source:

Quarterly Reports from the Substance Abuse Prevention Coalitions

Description of Data:

These reports indicate the type of activity and numbers of youth reached.

Data issues/caveats that affect outcome measures::

None anticipated

Indicator #: 2

Indicator: The number of youth reporting awareness of taking medications as prescribed

Baseline Measurement: Approximately 3,500 youth reported increased awareness of taking medications as prescribed during SFY15.

First-year target/outcome measurement: At least 4000 youth will report increased awareness of taking medications as prescribed.

Second-year target/outcome measurement: At least 5000 youth will report increased awareness of taking medications as prescribed.

Data Source:

Reports from the NC Office of State Statistics

Description of Data:

Quarterly reports from the NC Office of State Statistics

Data issues/caveats that affect outcome measures::

None anticipated

Priority #: 11
Priority Area: Veterans and their families
Priority Type: SAT
Population(s): Other (Military Families, veterans)

Goal of the priority area:

Improved access to primary and behavioral health care for veterans and their families

Objective:

Increase the number of referrals to primary and behavioral health care resources for veterans and their families

Strategies to attain the objective:

- (1) Contract with the Alcohol/Drug Council of NC (ADCNC) to provide screening and referral services for veterans and their families;
(2) Maintain a dedicated Veterans Specialist position at each LME/MCO to increase community awareness of the availability of services and better assure accessibility to those services;
(3) Provide technical assistance to the LME/MCOs, provider agencies and other organizations as needed.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of calls received from veterans and their families, screened and referred to primary and/or behavioral health care resources

Baseline Measurement: This is the first year NC will be collecting this data

First-year target/outcome measurement: Number of referrals will increase by 5%

Second-year target/outcome measurement: Number of referrals will increase by an additional 2%

Data Source:

ADCNC quarterly call data

Description of Data:

ADCNC will collect all data related to the above and provide a report on a quarterly basis

Data issues/caveats that affect outcome measures::

None anticipated

Priority #: 12
Priority Area: Intravenous Drug Use
Priority Type: SAT
Population(s): IVDUs

Goal of the priority area:

Reduced number of deaths of individuals involved in SUD treatment at private and publicly funded opioid treatment programs (OTPs) and Cross Area Services Programs (CASPs) from heroine/opiate overdoses.

Objective:

Promote the increased access, availability and utilization of naloxone in private and publicly funded opioid treatment programs (OTPs) and Cross Area Services Programs (CASPs).

Strategies to attain the objective:

1. During monthly meetings with OTP medical directors, quarterly meetings with OTP program directors and monthly conference calls with CASP providers, promote the practice and utilization of naloxone.
2. Assure the availability of naloxone through coordination strategies with various agencies including the Harm Reduction Coalition, Project Lazarus, etc.
3. Promote/promulgate guidelines and recommendations related to the utilization of naloxone.

Annual Performance Indicators to measure goal success

Indicator #: 1  
Indicator: Number of OTPs and CASPs that have naloxone available on-site.  
Baseline Measurement: North Carolina will collect this data during FY15-16.  
First-year target/outcome measurement: Increase the number of CASPs and OTPs that have naloxone available by 1%.  
Second-year target/outcome measurement: All CASPs and OTPs have naloxone available on-site.

Data Source:

DMH/DD/SAS staff will collect this data through site visits, conference calls, etc. directly to the programs, as well as in conjunction with the Harm Reduction Coalition, Project Lazarus, etc.

Description of Data:

This is just a count of the number of programs/sites that have naloxone available on-site.

Data issues/caveats that affect outcome measures::

None known

Footnotes:

# Planning Tables

Table 2 State Agency Planned Expenditures

Planning Period Start Date: 7/1/2015      Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	\$61,453,838		\$17,133,172	\$2,363,308	\$246,120,254	\$0	\$0
a. Pregnant Women and Women with Dependent Children*	\$15,196,316		\$8,768,978	\$0	\$6,523,820	\$0	\$0
b. All Other	\$46,257,522		\$8,364,194	\$2,363,308	\$239,596,434	\$0	\$0
2. Substance Abuse Primary Prevention	\$17,349,824		\$0	\$2,474,174	\$0	\$0	\$0
3. Tuberculosis Services	\$2,000,000		\$0	\$0	\$0	\$0	\$0
4. HIV Early Intervention Services	\$4,337,456		\$0	\$0	\$0	\$0	\$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention							
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	\$908,000		\$0	\$0	\$0	\$0	\$0
11. Total	\$86,049,118	\$0	\$17,133,172	\$4,837,482	\$246,120,254	\$0	\$0

\* Prevention other than primary prevention

**Footnotes:**

As per feedback from North Carolina's CSAP Project Officer, we have adjusted the amounts on this table to reflect projections for the planning periods of SFY16 and SFY17.

# Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015      Planning Period End Date: 6/30/2017

Service	Expenditures
Healthcare Home/Physical Health	\$285,000
General and specialized outpatient medical services;	
Acute Primary Care;	
General Health Screens, Tests and Immunizations;	
Comprehensive Care Management;	
Care coordination and Health Promotion;	
Comprehensive Transitional Care;	
Individual and Family Support;	
Referral to Community Services;	
Prevention Including Promotion	\$

Screening, Brief Intervention and Referral to Treatment ;	
Brief Motivational Interviews;	
Screening and Brief Intervention for Tobacco Cessation;	
Parent Training;	
Facilitated Referrals;	
Relapse Prevention/Wellness Recovery Support;	
Warm Line;	
Substance Abuse Primary Prevention	\$8,674,912
Classroom and/or small group sessions (Education);	
Media campaigns (Information Dissemination);	
Systematic Planning/Coalition and Community Team Building(Community Based Process);	
Parenting and family management (Education);	
Education programs for youth groups (Education);	
Community Service Activities (Alternatives);	
Student Assistance Programs (Problem Identification and Referral);	

Employee Assistance programs (Problem Identification and Referral);	
Community Team Building (Community Based Process);	
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);	
Engagement Services	\$525,000
Assessment;	
Specialized Evaluations (Psychological and Neurological);	
Service Planning (including crisis planning);	
Consumer/Family Education;	
Outreach;	
Outpatient Services	\$1,497,916
Individual evidenced based therapies;	
Group Therapy;	
Family Therapy ;	
Multi-family Therapy;	

Consultation to Caregivers;	
Medication Services	\$1,645,973
Medication Management;	
Pharmacotherapy (including MAT);	
Laboratory services;	
Community Support (Rehabilitative)	\$5,501,315
Parent/Caregiver Support;	
Skill Building (social, daily living, cognitive);	
Case Management;	
Behavior Management;	
Supported Employment;	
Permanent Supported Housing;	
Recovery Housing;	
Therapeutic Mentoring;	
Traditional Healing Services;	

Recovery Supports	\$10,000
Peer Support;	
Recovery Support Coaching;	
Recovery Support Center Services;	
Supports for Self-directed Care;	
Other Supports (Habilitative)	\$
Personal Care;	
Homemaker;	
Respite;	
Supported Education;	
Transportation;	
Assisted Living Services;	
Recreational Services;	
Trained Behavioral Health Interpreters;	

Interactive Communication Technology Devices;	
Intensive Support Services	\$4,060,469
Substance Abuse Intensive Outpatient (IOP);	
Partial Hospital;	
Assertive Community Treatment;	
Intensive Home-based Services;	
Multi-systemic Therapy;	
Intensive Case Management ;	
Out-of-Home Residential Services	\$2,037,609
Crisis Residential/Stabilization;	
Clinically Managed 24 Hour Care (SA);	
Clinically Managed Medium Intensity Care (SA) ;	
Adult Mental Health Residential ;	
Youth Substance Abuse Residential Services;	
Children's Residential Mental Health Services ;	

Therapeutic Foster Care;	
Acute Intensive Services	\$970,703
Mobile Crisis;	
Peer-based Crisis Services;	
Urgent Care;	
23-hour Observation Bed;	
Medically Monitored Intensive Inpatient (SA);	
24/7 Crisis Hotline Services;	
Other	\$
Total	\$25,208,897

**Footnotes:**

This table does not include the nearly \$4.7 million of SABG treatment funds that are captured in Table 6a - Resource Development Activities.

It is expected that during fiscal years 16 and 17 the bulk of recovery support services will be funded through NC's Access to Recovery grant.

# Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2015      Planning Period End Date: 9/30/2017

Expenditure Category	FY 2016 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	\$30,726,919
2 . Substance Abuse Primary Prevention	\$8,674,912
3 . Tuberculosis Services	\$1,350,000
4 . HIV Early Intervention Services**	\$2,168,728
5 . Administration (SSA Level Only)	\$454,000
6. Total	\$43,374,559

\* Prevention other than primary prevention

\*\* 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by CDC, National Center for HIV/AIDS, Hepatitis, STD and TB Prevention. The HIV Surveillance Report, Volume 24, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for HIV at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state does not meet the AIDS case rate threshold for the fiscal year involved. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

Footnotes:

The total in Line 1, Substance Abuse Prevention and Treatment, includes \$4,693,378 noted in Table 6, Resource Development, planned treatment activities. The remaining \$26,033,541 is for prevention other than primary prevention and treatment programming.

The total in Line 2, Substance Abuse Primary Prevention, includes \$1,733,229 noted in Table 6, Resource Development, planned prevention activities. The remaining \$6,941,683 is for primary prevention programming.

# Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2015    Planning Period End Date: 9/30/2017

Strategy	IOM Target	FY 2016
		SA Block Grant Award
Information Dissemination	Universal	\$467,000
	Selective	\$225,782
	Indicated	\$174,710
	Unspecified	
	Total	\$867,492
Education	Universal	\$1,005,236
	Selective	\$1,536,281
	Indicated	\$928,449
	Unspecified	
	Total	\$3,469,966
Alternatives	Universal	\$233,745
	Selective	\$100,000
	Indicated	\$100,000
	Unspecified	
	Total	\$433,745
Problem Identification and Referral	Universal	\$153,745
	Selective	\$140,000
	Indicated	\$140,000
	Unspecified	
	Total	\$433,745

Community-Based Process	Universal	\$397,937
	Selective	\$198,968
	Indicated	\$198,969
	Unspecified	
	Total	\$795,874
Environmental	Universal	\$265,292
	Selective	\$132,646
	Indicated	\$132,645
	Unspecified	
	Total	\$530,583
Section 1926 Tobacco	Universal	\$200,000
	Selective	\$110,000
	Indicated	\$100,278
	Unspecified	
	Total	\$410,278
Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	
Total Prevention Expenditures		\$6,941,683
Total SABG Award*		\$43,374,559
Planned Primary Prevention Percentage		16.00 %

\*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

This table does not include the remainder of the mandatory 20% of prevention funds, \$1,733,229, which are described in Table 6 Resource

Development Activities. This amount (\$1,733,229) plus \$6,941,683 equals the required amount of \$8,674,912 (found in Table 4, Line 2).

# Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2015      Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award	
Universal Direct	\$1,859,726	
Universal Indirect	\$2,059,491	
Selective	\$1,845,550	
Indicated	\$1,176,916	
Column Total	\$6,941,683	
Total SABG Award*	\$43,374,559	
Planned Primary Prevention Percentage	16.00 %	

\*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

**Footnotes:**

The total in this table (\$6,941,683) plus the total in Table 6, Resource Development Activities (\$1,733,229) equals the amount found in Line 2 of Table 4, which is the required set aside amount - \$8,674,912.

# Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Targeted Substances	
Alcohol	b
Tobacco	b
Marijuana	b
Prescription Drugs	b
Cocaine	b
Heroin	b
Inhalants	b
Methamphetamine	b
Synthetic Drugs (i.e. Bath salts, Spice, K2)	b
Targeted Populations	
Students in College	b
Military Families	b
LGBT	b
American Indians/Alaska Natives	b
African American	b
Hispanic	b
Homeless	b
Native Hawaiian/Other Pacific Islanders	b
Asian	b
Rural	b
Underserved Racial and Ethnic Minorities	b

Footnotes:

# Planning Tables

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period Start Date: 10/1/2015      Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award			
	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	\$80,968	\$148,162	\$0	\$229,130
2. Quality Assurance	\$0	\$0	\$0	
3. Training (Post-Employment)	\$296,593	\$244,584	\$0	\$541,177
4. Education (Pre-Employment)	\$540,842	\$481,105	\$0	\$1,021,947
5. Program Development	\$0	\$2,856,649	\$0	\$2,856,649
6. Research and Evaluation	\$814,826	\$962,878	\$0	\$1,777,704
7. Information Systems	\$0	\$0	\$0	
8. Total	\$1,733,229	\$4,693,378		\$6,426,607

Footnotes:



# Environmental Factors and Plan

## 1. The Health Care System and Integration

### Narrative Question:

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Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.<sup>26</sup> Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “[h]ealth system factors” such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.<sup>27</sup> It has been acknowledged that there is a high rate of co-occurring mental illness and substance abuse, with appropriate treatment required for both conditions.<sup>28</sup> Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The [Framingham Heart Study](#) produced the idea of “risk factors” and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence-based practices<sup>29 30</sup> that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.<sup>31</sup> Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.<sup>32</sup> In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.<sup>33</sup> Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.<sup>34</sup> Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.<sup>35</sup> In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.<sup>36</sup>

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.<sup>37</sup> Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.<sup>38</sup> Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes<sup>39</sup> and ACOs<sup>40</sup> may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.<sup>41</sup> Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.<sup>42</sup>

One key population of concern is persons who are dually eligible for Medicare and Medicaid.<sup>43</sup> Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.<sup>44</sup> SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.<sup>45</sup> Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.<sup>46</sup> SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.<sup>47</sup> It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.<sup>48</sup>

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.<sup>49</sup> Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.<sup>50</sup>

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.<sup>51</sup> However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be charged with coordinating care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?
6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

10. Indicate tools and strategies used that support efforts to address nicotine cessation.

- Regular screening with a carbon monoxide (CO) monitor
- Smoking cessation classes
- Quit Helplines/Peer supports
- Others \_\_\_\_\_

11. The behavioral health providers screen and refer for:

- Prevention and wellness education;
- Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
- Recovery supports

*Please indicate areas of technical assistance needed related to this section.*

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Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

## 1. The Health Care System and Integration

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?

North Carolina chose not to expand Medicaid coverage for adults at this time following conversations with CMS and also decided to opt for the federally operated health insurance exchange, but will offer plans through the federal exchange. Block grant and state dollars will therefore continue to be used for people who are uninsured. These funds will also be used to pay for services that are not covered by insurance and Medicaid. Screening and brief interventions for alcohol and drug misuse and depression screening are currently covered if provided by physicians and other medical practitioners in primary care clinics.

2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?

DMH/DD/SAS has a system for monitoring access to mental health and substance use services that is based on payments made by state, Medicaid and other federal sources of funding for appropriate services. DMH and DMA have performance contracts with LME-MCOs. Performance data is shared twice per month with the Secretary of DHHHS. Measures include access to care, timeliness, and transition from hospitals to the community and consumer satisfaction. The Division also plans to expand its role to monitor QHPs in the exchange, including access to care, actual benefit plans and adherence to parity requirements.

3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.

Currently, the Division of Medical Assistance and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services are jointly responsible for monitoring the Local Management Entities-Managed Care Organizations. Each LME-MCO submits data to DMH/DD/SAS on a quarterly basis that measures timely access to services, based on the urgency of the need (emergent, urgent or routine). The Intradepartmental Monitoring Team (IMT), which consists of staff from DMH/DD/SAS and DMA meets quarterly with each LME-MCO to review various performance indicators, including access to care. Any future plans that will be offered through the federal exchange will be monitored by DMH/DD/SAS.

4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations of MHPAEA?

As North Carolina will offer plans through the federal exchange, the Division will work with the federal government to ensure that we have a role in reviewing complaints. DMH/DD/SAS will collaborate with the Office of the Insurance Commissioners to review complaints. The Consumer Services Section of DMH/DD/SAS offers telephone and face to face support for consumers and families and will monitor complaints related to MHPAEA. Provider organizations have hosted training with Carol McDaid regarding final parity rules and conducted planning to monitor implementation. The NC Institute of Medicine recently hosted a presentation by NC Blue Cross Blue Shield/Magellan regarding their implementation of the new rules.

5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

The essential health benefit is a basic benefit; therefore North Carolina will continue to pay for services not covered that are believed to be essential to the overall stabilization and recovery of individuals, such as recovery support services. The service array offered by the state Medicaid plan for individuals with a substance use disorder is robust and exceeds services required in the essential benefit.

6. Is the SSA/SMHA involved in the various coordinated care initiatives in the state?

Primary care and behavioral health care integration activities in DMH/DD/SAS have revolved around collaboration between the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) and Local Management Entity-Managed Care Organizations (LME-MCOs) in cooperation with Community Care of North Carolina (CCNC). CCNC is at the center of a vibrant partnership between the NC Department of Health and Human Services (DHHS) and 14 independent medical care networks consisting of 4,500 physicians in 1,360 primary care practices. CCNC currently provides a health home for approximately 1.27 million Medicaid patients in North Carolina.

CCNC and LME-MCOs meet regularly at the local level to collaborate on care coordination for individuals with severe mental health and substance use disorders and other chronic medical conditions.

DMH/DD/SAS has been successful in being awarded a five year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) for the design and implementation of a state-level SBIRT (Screening, Brief Intervention, and Referral to Treatment) program to address alcohol and substance use concerns of patients at primary care sites affiliated with CCNC. This project is a collaboration of DMH/DD/SAS, the Governor's Institute on Substance Abuse and CCNC. Over the course of the project, NC plans to serve over 37,000 adults across 13 counties, with the subsequent intent to expand to all 14 CCNC networks. In these locations, patients who are identified with a potential alcohol or substance use disorder are administered alcohol and drug screening tools, are also assessed for depression and other mental health disorders, and as appropriate are provided education, intervention, or referral to treatment provided by licensed behavioral health clinicians on-site (at the primary care practice), or are referred for behavioral health treatment at specialty provider agencies. DMH in cooperation with DMH/DD/SAS has a CMS approved plan to offer services through primary care health homes that coordinate behavioral health care through the LME-MCOs. The Kate B. Reynolds foundation funds demonstration projects to explore models of integrated care in MH provider agencies and funds the Center for Excellence for Integrated Care to provide technical assistance for behavioral health providers seeking to improve integration. Performance contracts with LME-MCOs and providers include the requirement to monitor annual visits with a primary care providers.

Additionally, Dr. Courtney Cantrell, Director of the Division of MH/DD/SAS is the designated lead staff for integrated care initiatives across all divisions within the NC Department of Health and Human Services. She chairs various workgroups to assure coordination of integrated care strategies, as well as to establish common performance indicators and measures specific to integrated care.

7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices and the publicly funded behavioral health providers?

In 2011, DMH/DD/SAS was awarded a five-year \$8.33 million grant from SAMHSA for funding to design and implement a state-level SBIRT (screening, brief intervention, referral and treatment) program in NC. This project is a collaboration of DMH/DD/SAS, the Local Management Entities-Managed Care Organizations of CenterPoint Human Services and Sandhills, the Governor's Institute on Substance Abuse, Community Care Network of North Carolina, and several providers including Daymark Recovery Services, Insight and Robeson Health Care Corporation. Five primary care practices affiliated with CCNC and three sites of Robeson Health Care Corporation, a Federally Qualified Health Center, are currently implementing SBIRT. Each site has an onsite clinician providing brief intervention, brief treatment, and referral to treatment. At the end of its fourth year, NC SBIRT provided more than 25,000 screening on alcohol and drug use, delivered on-site interventions and referrals to about 1,000 patients with substance use and co-occurring disorders. Outcomes have been consistently positive. Rates for alcohol use and drug use have decreased, the changes being statistically significant. Psychological well-being has improved; the number of days when participants felt depressed or anxious have gone down as shown by follow-up interviews for the sixth month follow-up and discharge samples. Participants have also reported decreases in trauma-related symptoms such as nightmares, situation avoidance, numbness and detachment between baseline and follow-up interviews.

Additionally, in collaboration with the Division of Medical Assistance, DMH/DD/SAS submitted an application in response to the recent SAMHSA RFA for *Planning Grants for Certified Community Behavioral Health Clinics*. If awarded this planning grant, the two divisions will work together to enhance availability and access to integrated care through certified community behavioral health clinics.

8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?

Yes, the Division has been actively working with the Division of State Operated Health Facilities (DSOHF) and the Division of Public Health to support an increase in nicotine dependence treatment in state facilities (psychiatric hospitals, developmental centers, alcohol and drug abuse treatment centers), as well as in other public and private treatment facilities. DSOHF, in collaboration with the University of North Carolina at Chapel Hill, received a grant in 2011 from the Pfizer Medical Group to implement a Quality Improvement Project with two treatment facilities to integrate nicotine dependence treatment into their systems. With support from DPH, an online Tobacco Dependence Training Program was created that addresses tobacco use treatment integration into chemical dependence services; assessment diagnosis and pharmacotherapy; behavioral interventions; treatment planning and practical applications. The Division will work with DPH to disseminate this training to providers across the state.

Additionally, in 2011, NC became one of SAMHSA's Leadership Academies for Wellness and Smoking Cessation. Through this effort, a diverse group of stakeholders including treatment providers came together to create an action plan for reducing the prevalence of tobacco use among behavioral health consumers. The partners adopted the target to reduce smoking prevalence among the general population to 16%; adult mental health clients to 39%; and adult substance abuse clients to 39%, each

by end of year 2016. This initiative, named Breathe Easy NC, is working on the following strategies: 1) Facilities, 2) Provider Education and Quitline, 3) Consumers and Community, 4) Policy Systems Performance Measures and Outcomes and 5) Sustainability. Each strategy group is working on specific tasks to be completed over the next year. The stakeholders meet annually in September to assess progress in achieving its established targets. The Facilities and Provider Education/Quitline committees have been working to offer nicotine dependence training and 5 A's Training for providers. They also have presented on tobacco dependence treatment in conferences such as the Addiction Professionals of NC and webinars. The SSA has also been routinely promoting the use of the QuitlineNC to providers across the state not only to assist their clients with quitting their tobacco use, but for their staff as well.

Tobacco cessation programs are covered by LME-MCOs and can be billed by physicians and physician extenders. Physicians, nurse practitioners and physician assistants can use codes 99406 and 99407 for this purpose.

North Carolina Medicaid covers a variety of products for smoking cessation. Tobacco cessation products are listed on the Preferred Drug List. Most generic drugs that offer rebates and the preferred drugs are covered without a prior approval. Non-preferred drugs are covered after the beneficiary has tried and failed on two of the preferred drugs or if the provider presents clinical information why the beneficiary cannot use the preferred drugs. Coverage is as follows:

<b>Preferred</b>	<b>Non-Preferred</b>
Bupropion SR	Nicoderm CQ patch
Chantix	Nicotrol
Nicorette	Zyban
Nicotine Gum	
Nicotine Lozenge	
Nicotine Patch	

**9. What agency/system regularly screens, accesses, and addresses smoking among persons served by the behavioral health system?**

In addition to the above, NC DHHS also provides routine screening and assessment, and provides treatment options for smoking cessation and for other unhealthy behaviors for patients at state operated psychiatric and addictions treatment facilities.

**10. Indicate tools and strategies used that support efforts to address nicotine cessation.**

- Regular screening with a carbon monoxide (CO) monitor
- Smoking cessation classes
- Quit Helplines/Peer supports
- Others \_\_\_\_\_

Additional resources from Division of Public Health, Tobacco Prevention and Control Branch, include:

- QuitlineNC 24/7 assistance for all NC tobacco users who want to quit at 1-800-QuitNow or [www.QuitlineNC.com](http://www.QuitlineNC.com);
- Telephone coaching integrated with web-based coaching and texting;

- Coaching available in English or Spanish; translation for other languages;
- 10-call program for pregnant women;
- Fax referral forms available for clinicians to refer their clients for QuitlineNC services;
- Training and technical assistance on integrating tobacco dependence treatment, systems changes, billing and referrals to QuitlineNC;
- Assistance in communicating messages about tobacco cessation to tobacco users who want to quit;
- Assistance with policy planning and implementation to make behavioral health and substance use treatment facilities smoke-free/tobacco free.

11. The behavioral health providers screen and refer for:

- Prevention and wellness education
- Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
- Recovery supports

The Division of Medical Assistance requires through Clinical Coverage Policy 8-C, that all comprehensive clinical assessments include information on an individual's chronological general and medical health history and current issues, as well as current medications for physical conditions. These assessment requirements are applicable for all consumers and adherence is reviewed and monitored annually through block grant monitoring reviews.

In addition, the Division of Mental health, Developmental Disabilities and Substance Abuse Services has promoted the screening for health risks during assessments and routine office visit through the use of various Evaluation and Management CPT Codes by physicians and psychiatrists.

# Environmental Factors and Plan

## 2. Health Disparities

Narrative Question:

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In accordance with the [HHS Action Plan to Reduce Racial and Ethnic Health Disparities](#)<sup>52</sup>, [Healthy People, 2020](#)<sup>53</sup>, [National Stakeholder Strategy for Achieving Health Equity](#)<sup>54</sup>, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, and people living with HIV/AIDS or other chronic diseases/impairments) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).<sup>55</sup>

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The top Secretarial priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."<sup>56</sup>

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.<sup>57</sup> This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.<sup>58</sup> In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the population they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

*Please indicate areas of technical assistance needed related to this section.*

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<sup>52</sup>[http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS\\_Plan\\_complete.pdf](http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf)

<sup>53</sup><http://www.healthypeople.gov/2020/default.aspx>

<sup>54</sup><http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf>

<sup>55</sup><http://www.ThinkCulturalHealth.hhs.gov>

<sup>56</sup>[http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS\\_Plan\\_complete.pdf](http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf)

<sup>57</sup><http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208>

<sup>58</sup>[http://www.whitehouse.gov/omb/fedreg\\_race-ethnicity](http://www.whitehouse.gov/omb/fedreg_race-ethnicity)

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

## 2. Health Disparities

### **1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?**

Access and enrollment in services is captured via data submitted to the Client Data Warehouse (CDW), which is required of all LME/MCOs at the time an individual is screened for services. In addition to identifying up to three presenting problems, race, ethnicity, gender, age, military status and accommodations for special needs, such as a need for interpreters either for foreign languages or American Sign Language, visual impairment, mobility issues, childcare, etc., individuals are provided an appointment with a provider of their choosing.

Once connected to a provider, individuals participate in NC TOPPS, which is administered during the initial appointment as well as at regular intervals throughout the individual's course of treatment. Questions on NC TOPPS include those mentioned above, as well as a question related to "difficulty entering treatment because of problems with . . . language or communication issues, stigma or embarrassment, deaf or hard of hearing." Compilation of this data will allow us to measure access and retention in treatment by race, ethnicity, gender and age.

The state can identify language needs through data collected at the time of screening and reported via the CDW. As mentioned earlier in this document, LME/MCOs are required to conduct a community need and provider capacity assessment using a standardized process and reporting format defined by the Secretary. The assessment takes into consideration the population in the catchment area, identified gaps in the service array, including gaps for underserved populations, perceived barriers to service access, and the number and variety of age disability providers for each service. The assessment includes input from consumers, families, community stakeholders and CFAC. In evaluating the adequacy of the provider community, the LME/MCO considers issues such as the cultural and linguistic competency of existing providers. The LME/MCOs report the results of the assessment to DMH/DD/SAS, provide updates as needed and must demonstrate their engagement in development efforts to address service gaps identified in the assessment. If the gaps analysis identifies an absence of provider(s) for any MH/DD/SA service, the LME/MCOs submit a plan for developing a local provider community that offers choice for each service in their catchment areas in the next state fiscal year.

### **2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.**

The Cultural Competency Plan is a process to help further develop and oversee a culturally responsive and sensitive community behavioral health system. Its goal is to provide objectives and actions as well as provide guidance on implementation of the objectives and actions. The DMH/DD/SAS system is one where effective treatment and appropriate services are provided to those served in a culturally competent manner while maintaining the highest level of clinical competency required. We believe that increased cultural competency sensitivity will help to increase the level of clinical competency in the state behavioral health system.

The intention of the Cultural Competency Plan is to ensure the diverse cultural and linguistic needs of those we serve are met and systems policies and procedures reflect those same diverse needs. The plan will offer guidance to the Division by making a series of recommendations that will positively impact the people we serve and further supporting the overall success of the Division. It is believed that this plan will motivate the System in integrating cultural factors into clinical care and assist mental health, developmental disability and substance use disease professionals with broadening their awareness of culture and embracing and respecting diversity.

### **3. Are linguistic disparities/language barriers identified, monitored, and addressed?**

The LME/MCOs capture data specific to English language proficiency as well as primary language designation. Additionally, there is data collected that attempts to determine how well the person served was able to understand their interaction with providers. These data points can be analyzed and evaluated to further determine how well linguistic differences are being addressed. They can also be used to determine gaps and whether there are any required next steps.

### **4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.**

The LME-MOCs translate many of their documents and website materials to ensure that non-English speaking clients are able to access and understand the publicly funded behavioral health system and also make an effort to have bilingual staff available to assist with communication. Each LME/MCO operates a 24-7-365 call center and each is required to have interpreting services available for any calls that come in from individuals who do not speak English. All of the LME/MCOs contract with language interpreting service providers that offer a vast number of languages and that are available within a few seconds after the LME/MCO call center receives a call and identifies a need for an interpreter.

In addition, all LME/MCOs must offer TTY or other similar type services for individuals who are deaf or hard of hearing. LME/MCOs further have responsibility that the linguistic and cultural needs of populations within their catchment areas are met through contractual agreements with behavioral health providers who are competent in identified languages and cultures.

### **5. Is there state support for cultural and linguistic competency training for providers?**

In its contract/performance agreement with all LME/MCOs, the Division of MH/DD/SA Services requires that each LME/MCO annually complete an assessment of community need, provider capacity, gaps in services and strategic plans to identified address gaps. As per the contract, "The LME/MCO shall conduct a community need and provider capacity assessment during the first quarter of this contract, using a standardized process and reporting format defined by the Secretary. The assessment shall take into consideration the population in the catchment area, identified gaps in the service array, including gaps for underserved populations, perceived barriers to service access, and the number and variety of age-disability providers for each service. The assessment shall include input from consumers, families, community stakeholders, and CFAC. In evaluating the adequacy of the provider community the LME/MCO shall consider issues such as the cultural and linguistic competency of existing providers and provisions of evidence based practices and treatments and the availability of community services to address housing and employment issues."

Under the terms of this Contract, the DHHS delegates the authority to develop and manage a qualified provider community in accordance with community needs including enrollment, disenrollment and certification of providers including assessment of qualifications and competencies in accordance with applicable state and federal rules, standards and the provider qualifications established by the LME/MCO and deemed necessary for the effective provision of quality services. The Division of MH/DD/SA Services, in collaboration with the Division of Medical Assistance, reviews the gaps analyses completed by the LME/MCOs and provides feedback, recommendations and approval of their plans to address identified needs. Each LME/MCO receives both administrative and direct services funding. Administrative funds are often utilized by the LME/MCOs to facilitate and provide training to their contracted behavioral health providers in areas and topics necessary to assure the needs of the populations are met. This can include training in linguistic and cultural competence.

**Technical Assistance Needs:**

We do not currently have a mechanism for tracking the types of language services requested and/or provided, nor do we currently collect data specific to the LGBTQ population and will seek technical assistance regarding collecting and incorporating these and related data elements into our collection systems.

# Environmental Factors and Plan

## 3. Use of Evidence in Purchasing Decisions

### Narrative Question:

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There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including mental health and substance abuse services. Over the past several years, SAMHSA has received many requests from CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance abuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states use of the block grants for this purpose. The NQF and the Institute of Medicine (IOM) recommend that evidence play a critical role in designing health and behavioral health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP<sup>59</sup> is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with (SED). The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General<sup>60</sup>, The New Freedom Commission on Mental Health<sup>61</sup>, the IOM<sup>62</sup>, and the NQF.<sup>63</sup> The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."<sup>64</sup> SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocols (TIPs)<sup>65</sup> are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)<sup>66</sup> was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding mental health and substance abuse services.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
  - a. Leadership support, including investment of human and financial resources.
  - b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
  - c. Use of financial incentives to drive quality.

- d. Provider involvement in planning value-based purchasing.
- e. Gained consensus on the use of accurate and reliable measures of quality.
- f. Quality measures focus on consumer outcomes rather than care processes.
- g. Development of strategies to educate consumers and empower them to select quality services.
- h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.
- i. The state has an evaluation plan to assess the impact of its purchasing decisions.

*Please indicate areas of technical assistance needed related to this section.*

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<sup>59</sup> [Ibid, 47, p. 41](#)

<sup>60</sup> United States Public Health Service Office of the Surgeon General (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

<sup>61</sup> The President's New Freedom Commission on Mental Health (July 2003). *Achieving the Promise: Transforming Mental Health Care in America*. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

<sup>62</sup> Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*. Washington, DC: National Academies Press.

<sup>63</sup> National Quality Forum (2007). *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. Washington, DC: National Quality Forum.

<sup>64</sup> <http://psychiatryonline.org/>

<sup>65</sup> <http://store.samhsa.gov>

<sup>66</sup> <http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345>

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

### 3. Use of Evidence in Purchasing Decisions

#### 1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.

The Division of MH/DD/SAS established the North Carolina Practice Improvement Collaborative (NC PIC) in 2005 to review evidence-based or promising practices and assess their applicability to the system of care in North Carolina. NC PIC is composed of state agency personnel, academicians and providers specializing in the fields of mental health, developmental disabilities and substance use disorders. The Deputy Director of Community Policy Management, DMH/DD/SAS, was integral to the creation of this professional collaborative and continues to function as the Project Manager.

In 2013, the Adult Mental Health (AMH) section within the Division was expanded to include the hiring of three evidence based practice specialists. The AMH team was able to add an additional four staff in the fall of 2014. Two of these staff serve as subject matter experts on ACT, and are trained as lead TMACT (Tool for the Measurement of Assertive Community Treatment) evaluators. Two other staff are identified as subject matter experts on Individual Placement Support-Supported Employment, and are trained as lead IPS-SE fidelity reviewers. One staff is both an ACT and IPS-SE subject matter expert. The remaining two staff provide data support, technical assistance and assistance with the development of trainings and learning collaboratives for providers, LME/MCO staff and individuals/family members.

Additionally, there are subject matter experts on the Addictions and Management Operations, Justice Systems Innovations, Community Health, Prevention and Wellness teams who are also knowledgeable in other evidence based practices, including: Seeking Safety, Motivational Interviewing, Cognitive Behavioral Therapy, Wellness Recovery Action Planning, Wellness Management and Recovery, recovery support services, eCPR, etc. These teams regularly identify ways to improve the service delivery system by identifying evidence based and promising practices that can enhance and strengthen the service array for prevention, early intervention, treatment and recovery supports services.

#### 2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?

The Division of MH/DD/SAS reviews information regarding evidence-based or promising practices in purchasing or policy decisions. The Division uses information from the literature or from the NREPP and other SAMHSA websites supporting the EBP or promising practice. EBP developers or proponents and subject matter experts are invited to present to the NC PIC on the EBP or practice.

DMH/DD/SAS uses multiple sources of information to guide its recommendations. There is no singular source referenced for EBP selection due to the nature and complexity of the practice protocols and intended outcomes for targeted behavioral health populations, especially those in most serious need who live with complex behavioral health challenges. To date the NC PIC process has worked well, especially when implementation science informs both practice selection and implementation processes.

3. **Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?**

The state has used information regarding evidence-based practices to develop guidance for LME/MCOs in their choices of EBPs for people that they serve. An example is the release of the manual *Developing Effective, High-Quality Community Mental Health and Substance Abuse Services: A Guide for Local Management Entities* (<http://www.ncpic.net>).

In addition, publications from the North Carolina Institute of Medicine (NCIOM) Task Force include the Plan on Suicide Prevention for the Division of MH/DD/SAS populations served, as well as the NCIOM Task Force Report on Growing Well on early social, emotional and mental health needs of very young children provide comprehensive guide to EBPs and implementation strategies and challenges ([www.nciom.org](http://www.nciom.org)). The more recent NCIOM Task Force on Essentials for Childhood published *Safe, Stable and Nurturing Relationships and Environments to Prevent Child Maltreatment* in 2015. This group, which included staff from the Division of MH/DD/SAS, was tasked with studying and developing a collaborative, evidence-based, systems-oriented, public health-grounded strategic plan to reduce child maltreatment and secure family well-being in North Carolina. This report summarizes the findings of the Task Force and the Task Force recommendations. Taken together, the recommendations of the Task Force will ensure North Carolina has a comprehensive, coordinated system to support child and family well-being.

4. **Does the state use a rigorous evaluation process to assess emerging and promising practices?**

As stated earlier, through a contract with the Governor's Institute on Substance Abuse, in 2005 the Division developed the North Carolina Practice Improvement Collaborative (NC PIC) to provide guidance in determining which specific evidence based services and supports will be provided through the public system. The Chief of the Community Policy Management section within the Division of MH/DD/SAS was integral in the creation of this professional collaborative and continues to provide clinical guidance and leadership, as well as financial support. The mission of NC PIC is to ensure that each time any North Carolinian—whether a child or an adult, a member of a majority or minority, from an urban or rural area—comes into contact with the DMH/DD/SAS system, that individual will receive excellent care that is consistent with our scientific understanding of what works (*New Freedom Commission on Mental Health, 2003*).

The NC PIC is comprised of representatives from all three disabilities, and meets quarterly to review and discuss relevant programs. Annually the group presents a report of prioritized program recommendations to the Division Director at a public forum. This forum, defined as the North Carolina Practice Improvement Congress, features brief educational descriptions of the practices being recommended by the NC PIC in its report. The work of the NC PIC is primarily achieved during quarterly subcommittee meetings. At each meeting, the members review and discuss applications that have been submitted for evaluation. In addition, NC PIC has been instrumental in providing information, trainings and webinars on specific topics or practices such as Trauma-Focused Cognitive Behavioral Therapy, Integrated Dual Disorders Treatment, Contingency Management, *"Comparison of Treatment Foster Care Models," "From the War Zone to the Home Front"*, etc. More information can be found at the following website: <http://www.ncpic.net/>.

In June 2012, the Quality Management Team, within DMH/DD/SAS, released the results of its survey on evidence-based practices that was administered to all critical access behavioral health agencies (CABHAs – similar to comprehensive community behavioral health centers). The survey’s objectives were to identify the evidence-based practices utilized by CABHAs and obtain information on how CABHAs monitored fidelity to those evidence-based practices. Of the CABHAs that responded, Motivational Interviewing was the most common evidence-based practice utilized, followed by Relapse Prevention, Dialectical Behavior Therapy, the Matrix Model and Integrated Dual Disorders Treatment. LME/MCOs, as per their Performance Agreement with DMH/DD/SAS, are required to “endeavor to ensure consumers have a choice of evidence based practices and treatments.”

#### 5. Which value based purchasing strategies do you use in your state?

The Division of MH/DD/SA Services utilizes the following:

- a. **Leadership support, including investment of human and financial resources:** As stated above, the several DMH/DD/SAS teams are involved in various ways and levels to assure that specific services meet fidelity measures. LME/MCOs are able to and have been supported in offering enhanced rates to providers of quality, evidence-based and fidelity services.
- b. **Use of available and credible data to identify better quality and monitor the impact of quality improvement interventions:** Each LME/MCO is required, as part of its national accreditation and external quality review processes to have a quality assurance plan and identify quality improvement projects. Often these quality improvement projects are identified through a needs and gaps analysis or through regular collection and reporting on data elements required by the Division.
- c. **Use of financial incentives to drive quality:** As stated above, the Division is supportive of the LME/MCOs efforts to offer enhanced rates to providers of quality, evidence-based and fidelity services.
- d. **Provider involvement in planning value-based purchasing:**
- e. **Gained consensus on the use of accurate and reliable measures of quality:** The majority of the measures of quality utilized by the Division are based on nationally accepted models and data, primarily HEDIS. These measures have been used for a number of years and the LME/MCOs are able to provide input on parameters and methodology through several mechanisms, such as monthly conference calls and/or meetings with the Quality Management Directors (each LME/MCO must have a QM department).
- f. **Quality measures focus on consumer outcomes rather than care processes:** As stated above, most of the Division’s measures are HEDIS. Some are outcomes-focused, such as readmission rates to inpatient settings 30-days post discharge and 180-days post discharge.

# Environmental Factors and Plan

## 4. Prevention for Serious Mental Illness

### Narrative Question:

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SIMs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.<sup>67</sup> The "Prodromal Period" is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.<sup>68</sup> In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.<sup>69</sup> The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.<sup>70 71</sup> This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

\*\*\*\*It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

*Please indicate areas of technical assistance needed related to this section.*

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<sup>67</sup> Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

<sup>68</sup> Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

<sup>69</sup> Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

<sup>70</sup> van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D.H., Yung, A.R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12-month and longer-term follow-ups. Schizophr Res. Sep;149(1-3):56-62.

<sup>71</sup> McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

Footnotes:

Not applicable to the SABG.

# Environmental Factors and Plan

## 5 Evidence-Based Practices for Early Intervention (5 percent set-aside)

Narrative Question:

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P.L. 113-76 and P.L. 113-235 requires that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.<sup>72</sup> SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded [Recovery After an Initial Schizophrenia Episode \(RAISE\) initiative](#)<sup>73</sup>, a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, evidenced-based supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity.

States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented.

It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting.

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.
2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.
3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.
5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

*Please indicate areas of technical assistance needed related to this section.*

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<sup>72</sup> <http://samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf>

<sup>73</sup> [http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm\\_source=rss\\_readers&utm\\_medium=rss&utm\\_campaign=rss\\_full](http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full)

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

Not applicable to the SABG.

# Environmental Factors and Plan

## 6. Participant Directed Care

Narrative Question:

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As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them through the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

*Please indicate areas of technical assistance needed related to this section.*

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

North Carolina is not utilizing a voucher system at this time other than through its Access to Recovery discretionary grant. However, North Carolina has supported and required the use of person-centered thinking and person-centered planning for a number of years. Additionally, LME/MCOs are required to offer potential clients a choice of no less than two (2) providers for most services, unless a waiver for such has been requested and granted by the Division.

# Environmental Factors and Plan

## 7. Program Integrity

### Narrative Question:

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SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 USC § 300x- 55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance abuse programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include:(1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
  - a. Budget review;
  - b. Claims/payment adjudication;
  - c. Expenditure report analysis;
  - d. Compliance reviews;
  - e. Client level encounter/use/performance analysis data; and
  - f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

*Please indicate areas of technical assistance needed related to this section.*

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

## 7. Program Integrity

1. **Does the state have a program integrity plan regarding the SABG and MHBG funds?**

Yes, please see the attached *Service System Integrity Plan*.

2. **Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?**

Procedures for assuring that the federal program requirements are conveyed to intermediaries and providers are through contractual agreements. A performance contract held between NC DMH/DD/SAS and each LME/MCO clearly outlines the policies, procedures and practices required for all funding, including state funding, and specifically, SABG and MHBG funding received. NC DMH/DD/SAS assists providers in adopting practices that promote compliance with program requirements, including quality and safety standards through a combination of means including contractual requirements, training, monitoring and independent peer review. Technical assistance and support are provided to the LME/MCOs, the provider networks and consumers in communities by designated subject matter experts. The Compliance Reviews that are conducted by the Audit Team include plans of correction, when necessary, that address exceptions with the required program elements.

3. **Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:**

- a. **Budget review;**
- b. **Claims payment/adjudication;**
- c. **Expenditure report analysis**
- d. **Compliance reviews;**
- e. **Client level encounter/use/performance analysis data; and,**
- f. **Audits**

The program integrity activities that NC DMH/DD/SAS employs for monitoring the appropriate use of block grant funds and oversight practices include program and budget staff who are responsible for budget review, planning and allocation decisions; reviewing, monitoring and updating claims/payment adjudication; completing a thorough expenditure report analysis and encounter/utilization/performance analysis; implementing compliance reviews and audits. State and local compliance reviews and subrecipient monitoring are completed by designated administrative and programmatic staff. Compliance reviews and subrecipient monitoring are completed by designated administrative and programmatic staff. State level monitoring of the LME/MCOs is completed, documented and reported monthly. The same is true for other subrecipient relationships. The LME/MCOs are required by their performance contract and business plan with NC DMH/DD/SAS to comply with all subrecipient monitoring requirements.

4. **Describe payment methods used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.**

To ensure that payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of service delivered, NC DMH/DD/SAS convenes a State Services workgroup

comprised of staff from finance, audit and policy, program managers, quality management and clinical staff. This group reviews state and block grant funded services, proposed alternative services, determines appropriateness of the service or support and corresponding rate structures (cost, provider credentials, medical necessity, intensity, frequency and duration). These services are then implemented and paid through the NCTracks system.

**5. Does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?**

NC DMH/DD/SAS assists providers in adopting practices that promote compliance with program requirements, including quality and safety standards through a combination of means including contractual requirements, training, monitoring and independent peer review. The Compliance Reviews by the Audit Team include plans of correction that address exceptions with the required program elements. Included are elements that relate to consumer safety, such as TB testing and HIV/Early Intervention services. Each LME/MCO has staff designated as the Substance Abuse Point of Contact for their agency. Monthly conference calls are conducted by the Program Managers with the SA Points of Contact to provide technical assistance, updates and trainings on specific or requested topics. Compliance checks are also conducted by staff. For example, Prevention and Early Intervention team staff conduct site visits to review for fidelity to best practices for Project T&D and All Stars. CPM staff also provide training at conferences such as the Summer and Winter Schools for Alcohol and Drug Studies.

**6. How does the state ensure block grant funds and state dollars are used for the four purposes?**

NC DMH/DD/SAS ensures that block grant funds and state dollars are used for the four purposes by monitoring that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid through an integrated claims adjudication system. This system (NCTracks) regularly scans for claims where Medicaid eligibility applies and re-adjudicates and reverses payments made with Block Grant funds. The state monitors to ensure that LME/MCOs include State/Block Grant services in their Coordination of Benefit (COB) Policies and Procedures and are sampling State/Block Grant services when they monitor Providers. This will occur as a part of the quarterly fiscal monitoring and annual settlement. The quarterly fiscal monitoring review serves the purpose of observing and understanding the LME/MCO's operations and providing technical assistance. And the annual settlement ensures compliance of the following:

- i. Compliance with the requirements of the DMHDDSDAS contract;
- ii. G.S. 159 (Fiscal Control Act)
- iii. The LME/MCOs compliance with G.S. 122C
- iv. OMB circulars A-87, A-122, and A-133
- v. Compliance with requirements and restrictions of the SAPTBG, CMHSBG, SSBG, CASP dollars and their accompanying state MOE requirements, the PATH Program federal formula grant, SPF-SIG, SDFSCA, and other federally funded or designated projects.
- vi. Compliance with all state and federal laws and regulations.

a) NC DMH/DD/SAS funds those priority treatment and support services not covered by Medicaid, Medicare or private insurance for low-income individuals and that demonstrates success in improving outcomes and/or supporting recovery. The LME/MCOs adopt and publish the benefit plan for target population consumers that define the services that individuals in each target population may expect to receive. The benefit plan shall be flexible to maximize the services and promote the expected outcomes that consumers may receive while ensuring the LME/MCO delivers services within available funding shall ensure that non-Medicaid funds are utilized for DMHDDSAS specified priority populations. The priority population areas are as follows:

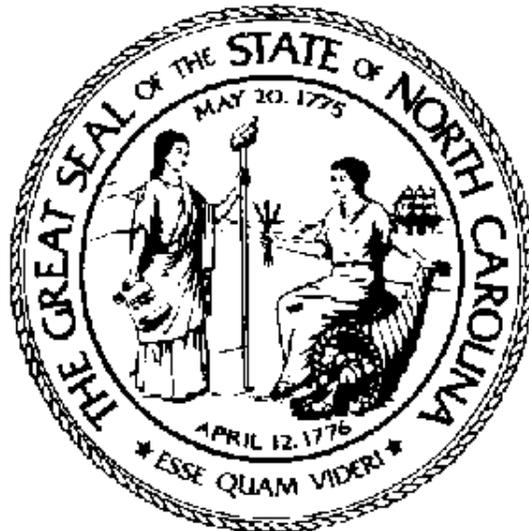
- i. Individuals who are at risk of harming self or others
- ii. High Risk individuals (for adults with over three (3) crisis and/or inpatient events in the past 12 months, or for children and adolescents with over two (2) crisis and/or inpatient events in the past 12 months)
- iii. Individuals with a Mental Illness or Substance Use Disorders who are transitioning from an inpatient, facility-based crisis, detoxification or withdrawal management service, or residential care service setting to the community
- iv. Youth and young adults (ages 16 to 25) who experience a first episode psychosis
- v. Individuals with Severe and Persistent Mental Illness, who are not stable
- vi. Individuals with Co-occurring MI/SU or MI/DD
- vii. Individuals who are Homeless or At Risk of Homelessness
- viii. Individuals with Traumatic Brain Injury (TBI)
- ix. Individuals who are Criminal or Juvenile Justice System involved
- x. Individuals who are Deaf or Hard of Hearing
- xi. Veterans, military service members and their families
- xii. Individuals with complex medical disorders
- xiii. Individuals with Department of Justice (DOJ) settlement agreement involvement
- xiv. Department of Social Services (DSS) involved adults
- xv. Individuals assessed with an American Society of Addiction Medicine (ASAM) level indicating the need for Residential or Inpatient level (Level 3.1 to 4.0) including detoxification or Withdrawal Management (Level 3.2TWM to 4.0 WM)
- xvi. Individuals who inject drugs
- xviii. Pregnant women who use alcohol and/or other drugs
- xix. Individuals with Communicable Disease Risk/HIV
- xx. Children and adolescents with a mental health disorder and who are living with an adult with a MI or SUD
- xxi. Individuals with I/DD who are at risk of abuse, neglect or exploitation
- xxii. Individuals with I/DD who are transitioning from institutions and residential placements
- xxiii. Individuals with I/DD who are transitional age youth who are moving from school to employment and/or other community involvement
- xxiv. DSS involved adults include individuals receiving Work First cash assistance, individuals who are involved with Child Protective Services or individuals who have been convicted

of a Class H or I controlled substance felony in NC and who are applicants for or recipients of Food Stamps.

LME/MCOs are responsible for both ensuring continuity of care for individuals in service, and availability of services throughout the year for priority population consumers and applicants for services. Changes to the LME/MCO Benefit Plan shall be submitted to the Division 30 days prior to publication for Division's State Services committee approval.

- b) NC DMH/DD/SAS provides SABG funds for primary prevention: universal, selective, and indicated prevention activities and services for persons not identified as needing treatment. The LME/MCOs provide leadership, technical assistance, and participation in community wide prevention and early intervention strategies, coalitions and other initiatives to discourage inappropriate access, misuse, and abuse of legal and illegal substances (alcohol, tobacco, and other drugs) by minors and adults and to improve the emotional health and well-being of individuals in their catchment area.
- c) NC DMH/DD/SAS collects performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment and recovery support services and to plan the implementation of new services. The North Carolina - Treatment Outcomes and Program Performance System (NC-TOPPS) is a web based program by which DMH/DD/SAS measures the quality of substance abuse and mental health services and the impact on individuals' lives. By capturing key information on an individual's service needs and life situation during a current episode of care, NC-TOPPS aids in developing meaningful treatment plans and evaluating the impact of services on an individual's life, as well as, the effectiveness of the service system.

North Carolina Department of Health and Human Services



**Service System Integrity Plan SFY: 2015-2016**  
for

The Division of Mental Health, Developmental Disabilities  
and Substance Abuse Services

Revised  
July 2015

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## Mission

It is the mission of the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) programs to, ***provide people with, or at risk of, mental illness, developmental disabilities, and substance use problems and their families the necessary prevention, intervention, treatment services and supports they need to live successfully in communities of their choice.***

## Plan Purpose

It is the purpose of the Service System Integrity Plan to support compliance, proper expenditure and accountability within NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) programs by ensuring that State and Block Grant dollars are utilized appropriately, in accordance with statutory and regulatory framework, and in support of programmatic goals.

## Plan Guiding Principles

This Service System Integrity Plan will promote the following principles:

1. Promote a cost efficient and effective behavioral health care system.
2. Ensure adherence to statutory and regulatory standards and practices.
3. Develop and monitor communication methods, training and technical assistance regarding service system integrity.
4. Support appropriate strategies and approaches to carrying out effective Service System Integrity efforts.
5. Proactively recognize areas of risk that may adversely affect Service System Integrity and proactively address vulnerabilities.
6. Fair and reasonable enforcement of system integrity monitoring. Failure to comply with system integrity efforts may result in technical assistance, plans of correction or other actions.

## Responsible Staff

**Audit/Policy Team** - responsible for coordination of System Integrity Plan activities; monitoring/auditing LME-MCOs for compliance with State and Federal Block Grant rules and regulations; development of the DMH/DD/SAS subrecipient monitoring plan and oversight of its implementation.

**Block Grant Coordinators** - responsible for keeping abreast of Block Grant regulations and requirements, communication with DHHS staff and LME-MCOs and coordination of planning goals and strategies relevant to the Block Grant within DMH/DD/SAS.

**Chief of Addictions and Management Operations** - responsible for programmatic leadership and policies regarding utilization of State and Block Grant funds.

**Contract Managers** - responsible for administering the performance contract with Division contractors and monitoring compliance with the terms of the contract.

**Financial Operations Section** - responsible for budget management of State and Block Grant funds and supervision of staff that conduct the State and Federal NonUCR Settlement, performing audits of financial status reports submitted by non-profits; chairing the Center of Excellence contract review committee.

**LME Performance Team** - responsible for administering the performance contract with LME-MCOs and monitoring LME-MCO compliance with the terms of the contract.

**Program Managers** - responsible for monitoring specific programs and initiatives; ensuring compliance with project objectives and funding requirements.

**Quality Management Section** - responsible for developing and monitoring performance measures and communicating areas of concern to designated teams and management.

**State Services Committee** - responsible for ensuring the Service System Integrity Plan for State and Block Grant funds is carried out; ensuring State and Block Grant funds are used in compliance with state and federal requirements and policies.

## Plan

### 1. **Budget Review**

- a) The NC DMH/DD/SAS contracts with the LME-MCOs to administer and oversee State funds and Federal Block Grant funds for the provision of prevention and treatment services for mental health and substance use disorders.
  - i) NC DMH/DD/SAS allocates State and Block Grant funds to LME-MCOs annually. The Financial Operations Section sends annual Continuation Allocation letters to the LME-MCOs and tracks all revisions to the initial continuation allocation through subsequent allocation letters.
  - ii) Federal Block grant funds are awarded by federal fiscal year and tracked by cost centers specific to the award year. The accounts are also separate for Unit Cost Reimbursement (UCR) and expenditure-based (Non-UCR) subcontracting. The Financial Operations Section ensures that Block Grant funds allocated to LME-MCOs are in accordance with the approved block grant plan), and revises LME-MCO allocations to reflect changes in Federal allocations as necessary based on utilization and changes in availability. LME-MCOs may request a realignment of Federal funds from one account to another; the LME-MCO must make a request in writing and justify the request. These realignments are reviewed by the Financial Operations Section in coordination with program staff, and when necessary, by the State Services Committee for compliance with funding regulations and Block Grant Plan goals, by the Financial Operations Section for fund availability, by the DHHS Budget and Analysis Office and approved by the Office of State Budget and Management.
  - iii) State service funds are allocated to the LME-MCOs once state General Assembly approves an annual budget, and these allocation are communicated to the LME-MCOs via the continuation allocation letter and subsequent allocation letters. The majority of these state funds are allocated into the single stream funds account, however, there are additional specific accounts for funds whose expenditures are subject to specific reporting requirements. These funds are deemed "special categorical" funds. Single stream funds are allocated as non-UCR funds, but LME-MCOs are required to submit claims for services rendered and the value of these claims will be considered in settlement of the single stream funding account. Since the single stream funds are flexible in nature, LME-MCOs do not have to request a realignment of these funds, however for special categorical funds any request to change their designation has to be requested in writing and be considered by the Division.
- b) Direct contracts that utilize State and/or Block Grant funds are managed by Program Managers in the program sections of NC DMH/DD/SAS. The Program Managers ensure that the subcontractors fulfill requirements of the Federal government and the approved application for Federal funds. These contracts are reimbursed on an expenditure basis within a contract maximum and are monitored by the Contract Managers according to Subrecipient Monitoring procedures. The Financial Operations Section tracks the subrecipient monitoring that is completed by program managers to assure compliance with the requirements and cost principles of the Federal Office of Management and Budget and the requirements set within the contracts (A-87, A-122, Omni-circular). The Financial Operations Section reports and

follows up on the findings as required to the DHHS Office of Internal Auditors, the Controller's office and the State Auditor

- c) The Financial Operations Section manages the administrative portion of State and Federal Block Grant funds through specific cost centers in the State budget for NC DMH/DD/SAS. The annual Cost Allocation Plan determines which administrative expenses are allocated to Federal grants. Financial Operations works with the responsible staff members to ensure that the correct methodology is utilized. Financial Operations staff ensures that expenditures are restricted to budgetary limits as allowable under the block grant plan throughout the fiscal year.

**2. Claims Payment and Adjudication**

- a) Claims for Block Grant and State funded UCR services are adjudicated locally by the LME-MCO. The LME-MCO then submits these claims to the State's claims vendor for secondary adjudication for reimbursement. The LME-MCOs have a choice of paying the service provider based on their local adjudication or waiting until the State level adjudication occurs. LME-MCOs have adjudication audits/edits in place to ensure at a minimum, that the provider has a valid contract, the service is not duplicated, the fields contain valid values, the service was authorized by the LME-MCO and the rate is at or below the contract maximum for that service. LME-MCOs also have systems to check that both the consumer and provider are eligible to receive funding for services.
- b) The State claims system adjudication includes similar edits that are determined by the State Services Committee. The State claims vendor also adjudicates for diagnostic match with the Benefit Plan eligibility, as well as compliance with other service definition requirements, such as same day exclusions for certain procedure codes. The LME-MCO must also designate in the State's claims adjudication system which of their subcontractors are eligible to earn Federal Block Grant funds.
- c) Budget Criteria are established annually by the State Services Committee and published on the NC DMH/DD/SAS website, which designate the criteria for payment from each Federal Block Grant account. For example, certain accounts are limited to specific clinical Benefit Plans and procedure codes. Benefit Plans are specific to Block Grant funding categories, such as "Injecting Drug User/Communicable Disease Risk" and "Adult Substance Abuse Women". Services that meet the Budget Criteria, but are adjudicated after the LME-MCO has pulled down their Federal allocation, count toward justification for the State funds allocation.

Periodically, a transfer or adjustment between accounts or grant award periods may occur after the claim was first adjudicated. LME-MCOs also have the capacity to correct errors on a paid claim.

**3. Expenditure Analysis**

- a) Non-UCR Block Grant and State funds are managed by the LME-MCOs. They subcontract with providers who carry out the Block Grant treatment and prevention goals required by the Federal government and specified in the approved NC Block Grant Assessment and Plan, along with services funded by the NC General Assembly according to policies set by NC DMH/DD/SAS. Each LME-MCO is responsible for monitoring Non-UCR Block Grant expenditures throughout the fiscal year, both fiscally and programmatically. The State

Services Committee, reviews the NonUCR Expenditure Overview report, which summarizes expenditures by LME-MCO and Account, periodically for overall and LME-MCO specific earnings year-to-date relative to budgets. Financial Operations also tracks these expenditures regularly for utilization review.

- b) UCR Block Grant expenditures are monitored periodically by the NC DMH/DD/SAS State Services Committee. The committee reviews a summary report which shows YTD expenditures by Block Grant UCR account. This report displays the earnings relative to the budget for each LME-MCO and for each account as a whole. The Committee identifies earnings issues and recommends transfers of funds as appropriate. Each LME-MCO is expected to monitor Block Grant earnings on at least a monthly basis and take remedial actions at the local level to ensure funds are drawn down appropriately throughout the fiscal year.

#### **4. Compliance Reviews**

- a) Substance Abuse Block Grant prevention and treatment services and Mental Health Block Grant services are monitored by LME-MCOs. Program and individual monitoring is conducted annually by the Financial Operations Section Audit Team. The Audit Team has the lead role in the Division for the standardization of local monitoring to be completed by the LME-MCOs. The monitoring tools are posted on the NC DMH/DD/SAS website and are specific to the Block Grant program requirements ( e.g., prevention, Women's Set-Aside, IV Drug Users, etc.). The Block Grant Steering Committee selects a sample of providers and individuals whose services were reimbursed with Federal Block Grant funds from claims reimbursed with Federal Block Grant funds. The Audit Team produces a monitoring report for each LME-MCO.
- b) In accordance with the NC DMH/DD/SAS Policy and Procedure for the Review, Approval and Follow-Up of Plan(s) of Correction, if systemic compliance issues are found, a plan of correction is required. Any contractor must submit a plan of correction within 15 days from receipt of their monitoring report to submit the plan of correction, which is reviewed by the subject matter experts within the NC DMH/DD/SAS. Additionally, within 60 days after the approval of the plan of correction, the Audit Team coordinates across the Division from issuance to point of resolution for non-compliant findings from LME-MCOs or non-profit entities which DMH/SS/SAS contracts.
- c) Semi-Annual Compliance Reports are submitted by each LME-MCO to the Block Grant Coordinator within the CPM Section. These Compliance Reports serve as a mechanism to ensure that the LME-MCOs are adhering to the broad categorical requirements of the Substance Abuse Prevention and Treatment Block Grant; i.e., assuring priority admission for specific populations, providing outreach services for certain populations, as well as reporting specific prevention activities. These reports are reviewed by the Block Grant Coordinator and program managers for accuracy and content and feedback is provided to the LME-MCOs by the Block Grant Coordinator.
- d) Independent Peer Reviews (IPR) are conducted annually by a third party under contract with the DMH/DD/SAS for the treatment component of both the Substance Abuse and Mental Health Block Grants. The purpose of IPR is to assess the quality, appropriateness and efficacy of treatment services funded with block grant monies, and to ensure that at least five percent of contracted block grant providers are reviewed. Specific services are selected each fiscal year for review, with the goal of ensuring a representative sample of providers, across

all regions of the state that work with a diversity of consumers in a variety of settings. The following criteria are considered in the selection process: (1) total amount of UCR funds paid during the fiscal year; (2) location/region; (3) treatment program modality and size/census; (4) service areas/facility licensure type; (5) availability for review; (6) accreditation status. Reviewers are volunteers, selected based on clinical experience and expertise in the service area being reviewed, appropriate certifications/licensure, cultural sensitivity, interest in the process and completion of the IPR training. Reviewers complete and submit individual reports to DMH/DD/SAS, as well as to the agencies reviewed. In addition, feedback surveys are completed by the reviewers, as well as the participating sites.

## **5. Utilization/Performance Analysis**

- a) The Quality Management Section tracks and monitors LME-MCO system performance through a set of contractual indicators and service utilization measures. Measures are selected to support priorities of the DMH/DD/SAS and, where possible, are based on nationally recognized behavioral health measures. Performance standards are set annually based on the previous year's state average to encourage incremental improvements. When an LME-MCO is found to be performing below standards on performance measures, the LME-MCO Monitoring and Technical Assistance Procedure is followed to improve the performance of the LME-MCO. The LME Performance Team also uses the monthly NC DHHS LME-MCO Performance Summary Report to review with the LME-MCOs their performance standards that do not meet the expected measures. The LME Performance Team member indicates a plan of action needed on the subrecipient monitoring tool and follow-up as needed.
- b) The Clinical Quality Committee reviews identified outliers and significant service trends, contingent on the availability of data, to determine if there is concern that service delivery might be out of compliance with the service definition, rules or statutes. Where appropriate, these outliers, trends or compliance concerns will be monitored according to the Targeted Services Monitoring Procedure by the Audit Team, once approved and implemented.
- c) In cases where the utilization of Federal Block Grant funds is determined to be out of compliance and a payback required, the Financial Operations Section ensures that those funds are utilized within the period of availability for that block grant award. If the availability period for the returned funds has ended, the DHHS Controllers Office refunds the funds to the Federal government.

## **6. Financial and Year-End Activities**

- a) Each LME-MCO's state and block grant non-UCR funds are financially monitored quarterly and settled annually by field staff from the Financial Operations Section with assistance from the LME Performance Team (see procedures Preparation of Tentative Settlement Report and LME-MCO Settlement Guidelines). These procedures review expenses related to the LME-MCO service delivery to ensure that they are allowable under state and federal guidelines and are supported with the appropriate documentation. If the LME-MCO has disallowed costs and a payback is required, funds that are received are processed by the Financial Operations Section according to State policy. Based on findings from the quarterly fiscal monitoring or annual settlement and LME-MCO may be required to enter into a Plan of Correction (POC) to remediate systemic or material findings (please see NC DMH/DD/SAS

Policy for the Review, Approval and Follow-Up of Plan(s) of Correction. LME-MCOs have 15 days from receipt of their monitoring report to submit the plan of correction, which is reviewed by the subject matter experts within the NC DMH/DD/SAS.

- b) The Office of the State Auditor audits the NC DMH/DD/SAS' monitoring procedures for the Federal Block Grants on an annual basis for compliance with federal regulations. The Audit Team and Financial Operations Section respond with a plan of correction to any findings and recommendations issued by the State Auditor.

**7. Disbursement of Funds**

- a) NC DMH/DD/SAS checks that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered. This is accomplished in two ways. For Non-UCR (expenditure based allocations) the LME-MCOs are responsible for local management of the funds. The LME-MCO designates a staff person to oversee the Federal CMHBG and SAPTBG funds, who oversees program development, budgets, contracts and reimbursement. The Non-UCR Settlement process conducted by the Financial Operations Section and LME Performance Team checks that Federal cost principles and regulations are followed. The state has established state wide default rates for most services, and rates that are substantially higher than other established rates for that service are reviewed and approved/denied by the Financial Operations Section in consultation with Program Managers.

**8. Promotion of Compliance Practices**

- a) NC DMH/DD/SAS assists providers in adopting practices that promote compliance with program requirements, including quality and safety standards through a combination of means including contractual requirements, training, monitoring and independent peer review (as noted in number 4 above). The Compliance Reviews by the Audit Team include plans of correction that address exceptions with the required program elements. Included are elements that relate to consumer safety, such as TB testing and HIV/Early Intervention services. Each LME-MCO has staff designated as the Substance Abuse Point of Contact for their agency. Monthly conference calls are conducted by the Program Managers with the SA Points of Contact to provide technical assistance, updates and trainings on specific or requested topics. Compliance checks are also conducted by staff. For example, Prevention and Early Intervention team staff conduct site visits to review for fidelity to best practices for Project T&D and All Stars. Program staff also provide training at conferences such as the Summer and Winter Schools for Alcohol and Drug Studies.

**9. Funds Utilized for SAMHSA's Four Purposes**

- a) NC DMH/DD/SAS monitors that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid through an integrated claims adjudication system. This system (NCTracks) regularly scans for claims where retro-active Medicaid eligibility applies and re-adjudicates and reverses payments made with Block Grant funds. The state monitors to ensure that LME-MCOs include State/Block Grant services in their Coordination of Benefit (COB) Policies and Procedures and are sampling State/Block Grant services when they monitor Providers. This will occur as a part of the quarterly fiscal monitoring and annual settlement. The quarterly fiscal monitoring review serves the purpose of observing and understanding

the LME-MCO's operations and providing technical assistance. And the annual settlement ensures compliance of the following:

- i. Compliance with the requirements of the DMHDDSAS contract;
  - ii. G.S. 159 (Fiscal Control Act)
  - iii. The LME-MCOs compliance with G.S. 122C
  - iv. OMB circulars A-87, A-122, and A-133
  - v. Compliance with requirements and restrictions of the SAPTBG, CMHSBG, SSBG, CASP dollars and their accompanying state MOE requirements, the PATH Program federal formula grant, SPF-SIG, SDFSCA, and other federally funded or designated projects.
  - vi. Compliance with all state and federal laws and regulations.
- b) NC DMH/DD/SAS fund those priority treatment and support services not covered by Medicaid, Medicare, or private insurance for low-income individuals and that demonstrate success in improving outcomes and/or supporting recovery. The LME-MCOs adopt and publish the benefit plan for target population consumers that define the services that individuals in each target population may expect to receive. The benefit plan shall be flexible to maximize the services and promote the expected outcomes that consumers may receive while ensuring the LME-MCO delivers services within available funding shall ensure that non-Medicaid funds are utilized for DMHDDSAS specified priority populations. The priority population areas are as follows:
- i. Individuals who are at risk of harming self or others
  - ii. High Risk individuals (for adults with over three (3) crisis and/or inpatient events in the past 12 months, or for children and adolescents with over two (2) crisis and/or inpatient events in the past 12 months)
  - iii. Individuals with a Mental Illness or Substance Use Disorders who are transitioning from an inpatient, facility-based crisis, detoxification or withdrawal management service, or residential care service setting to the community
  - iv. Youth and young adults (ages 16 to 25) who experience a first episode psychosis
  - v. Individuals with Severe and Persistent Mental Illness, who are not stable
  - vi. Individuals with Co-occurring MI/SU or MI/DD
  - vii. Individuals who are Homeless or At Risk of Homelessness
  - viii. Individuals with Traumatic Brain Injury (TBI)
  - ix. Individuals who are Criminal or Juvenile Justice System involved
  - x. Individuals who are Deaf or Hard of Hearing
  - xi. Veterans, military service members and their families
  - xii. Individuals with complex medical disorders
  - xiii. Individuals with Department of Justice (DOJ) settlement agreement involvement
  - xiv. Department of Social Services (DSS) involved adults
  - xv. Individuals assessed with an American Society of Addiction Medicine (ASAM) level indicating the need for Residential or Inpatient level (Level 3.1 to 4.0) including detoxification or Withdrawal Management (Level 3.2TWM to 4.0 WM)
  - xvi. Individuals who inject drugs
  - xviii. Pregnant women who use alcohol and/or other drugs
  - xix. Individuals with Communicable Disease Risk/HIV

- xx. Children and adolescents with a mental health disorder and who are living with an adult with a MI or SUD
- xxi. Individuals with I/DD who are at risk of abuse, neglect or exploitation
- xxii. Individuals with I/DD who are transitioning from institutions and residential placements
- xxiii. Individuals with I/DD who are transitional age youth who are moving from school to employment and/or other community involvement
- xxiv. DSS involved adults include individuals receiving Work First cash assistance, individuals who are involved with Child Protective Services or individuals who have been convicted of a Class H or I controlled substance felony in NC and who are applicants for or recipients of Food Stamps.

LME-MCOs are responsible for both ensuring continuity of care for individuals in service, and availability of services throughout the year for priority population consumers and applicants for services. Changes to the LME-MCO Benefit Plan shall be submitted to the Division 30 days prior to publication for Division's State Services committee approval.

- c) NC DMH/DD/SAS provides SABG funds for primary prevention: universal, selective, and indicated prevention activities and services for persons not identified as needing treatment. The LME-MCOs provide leadership, technical assistance, and participation in community wide prevention and early intervention strategies, coalitions and other initiatives to discourage inappropriate access, misuse, and abuse of legal and illegal substances (alcohol, tobacco, and other drugs) by minors and adults and to improve the emotional health and well-being of individuals in their catchment area.
- d) NC DMH/DD/SAS collects performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment and recovery support services and to plan the implementation of new services. The North Carolina - Treatment Outcomes and Program Performance System (NC-TOPPS) is a web based program by which DMH/DD/SAS measures the quality of substance abuse and mental health services and the impact on individuals' lives. By capturing key information on an individual's service needs and life situation during a current episode of care, NC-TOPPS aids in developing meaningful treatment plans and evaluating the impact of services on an individual's life, as well as, the effectiveness of the service system.

# Environmental Factors and Plan

## 8. Tribes

Narrative Question:

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The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the [2009 Memorandum on Tribal Consultation](#)<sup>74</sup> to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

*Please indicate areas of technical assistance needed related to this section.*

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<sup>74</sup> <http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president>

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

## 8. Tribes

1. **Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.**
2. **Describe current activities between the state, tribes and tribal populations.**

According to the 2000 census, North Carolina has one of the largest American Indian populations east of the Mississippi and the eighth largest population in the nation exceeding 120,000 for eight state recognized tribes (Coharie, Eastern Band of Cherokee (also federally recognized), Haliwa-Saponi, Lumbee, Meherrin, Ocaneechi Band of Saponi, Sappony and Waccamaw Siouan) and four urban American Indian organizations (Association for Indian People, Guilford Native American Association, Metrolina Native American Association and Triangle Native American Society). American Indian population growth exceeds that of many other ethnic groups in the state. The Lumbee, who number close to 70,000, is the largest of the state tribes.

The DMH/DD/SAS has a 25-year partnership with the NC Commission on Indian Affairs. Both agencies collaborate with each other to engage the eight tribes and four urban associations in determining needs, planning and capacity building, implementation and evaluation of mental health and substance use disorder services for Native Americans in North Carolina. The Commission on Indian Affairs has participated in the advisory board for prevention services, the Cooperative Agreement Advisory Board (CAAB) and the statewide Fetal Alcohol Syndrome Disorders Coalition.

Although gambling has been an important and multi-functional element in Cherokee culture, current issues regarding problem gambling as it impacts families and the community are of interest to tribal agencies and leaders. The North Carolina Department of Health and Human Services (NC DHHS) is funding a needs assessment that will assist and inform agencies serving tribal members and their community. Through this grant, the Center for Native Health is working closely with Analenisgi, the tribe's behavioral health program to develop programmatic strategies to benefit the Eastern Band of Cherokee Indians (EBCI). DHHS has provided training for EBCI members in the Stacked Deck curriculum, which is listed on SAMHSA's NREPP website. Stacked Deck is offered to students in grades 7-12, as well as youth being served at the substance abuse treatment center, Unity Healing Center, in Cherokee, NC.

The NC Screening, Brief Intervention, and Referral to Treatment (SBIRT) grant project is working with the Lumbee, the Coharie and the Waccamaw Siouan Tribes of North Carolina on issues related to mental health and substance use. The tribes have identified traditional practices that may be effective in addressing these issues and have held "Talking Circles" and drumming events with the support of grant funds.

In addition, during its first year, the NC Access to Recovery IV (NC ATR IV) grant project has identified two counties (Robeson and Sampson) in which to develop recovery support services with a focus on the Lumbee, Coharie and Waccamaw-Siouan tribes. Services, which are primarily provided by tribal members, include spiritual counseling, Native American Healing and other traditional practices as types of recovery services that can be reimbursed by NC ATR IV. Additionally, staff are working with tribal administrators to develop a more robust recovery-oriented system of care.

A new initiative in the Division of MH/DD/SA Services during fiscal year 2016 will be the establishment of four to six recovery community centers in various locations across the state, which will be partially funded with SABG monies. The Division has partnered with Recovery Communities of North Carolina to develop and implement this component of the state's recovery-oriented system of care. To date several listening forums have been conducted with the Lumbee and Coharie tribes in response to their expressed interest in establishing recovery community centers. Designated Division staff, Access to Recovery staff and RCNC staff will continue to collaborate with these tribes.

# Environmental Factors and Plan

## 9. Primary Prevention for Substance Abuse

### Narrative Question:

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Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- Community-based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning
- Environmental Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- Universal: The general public or a whole population group that has not been identified based on individual risk.
- Selective: Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data-driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:
  - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
  - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
  - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
  - a. A statewide licensing or certification program for the substance abuse prevention workforce;
  - b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
  - c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

*Please indicate areas of technical assistance needed related to this section.*

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

## 9. Primary Prevention for Substance Abuse

### **1. Please indicate if the state has an active SEOW. If so, please describe:**

Yes, the state does have an active SEOW. The SEOW meets the 2<sup>nd</sup> Friday of each month. The SEOW has been tasked with producing a state level epidemiological profile (NC EPI Profile) that summarizes the and characterizes behavioral health indicators of substance abuse consumption patterns and related consequences. The SEOW is also tasked with collecting data for the NC Social Indicator Study , a prevention needs assessment and planning profile of each of North Carolina's 100 counties including a display of 31 risk constructs composed of one or more social constructs derived from archival sources. County profiles reflect various dimensions of substance abuse and substance use related problems and outcomes that may exist in communities as well as sociodemographic characteristics and vital statistics believed to be associated with substance use and the risk for and protection from substance use. The profiles were designed to provide local substance abuse prevention providers and their partners with a factual, concise visual of each county's pattern of substance use related indicators, trends and needs. Data has been collected on children, youth, young adults and adults. There are plans to focus on minorities, and other underserved populations related to health disparities and substance use related consequences.

Data is collected and analyzed from several sources including the National Study of Drug Use and Health (NSDUH), Monitoring the Future, United States Department of Justice, North Carolina, State Center for Health Statistics, NC Highway Safety Research Center. US Census Bureau, archival sources, BRFSS, North Carolina Division of Social Services, State Epidemiological Outcome Workgroup (SEOW), NC IOM reports and other research.

### **2. Please describe how needs assessment data is used to make decisions about the allocation Of SABG Primary Prevention funds.**

The Community Wellness, Prevention and Health Integration Team within DMH/DD/SAS uses data from multiple sources to drive prevention funds, including the National Study of Drug Use and Health (NSDUH), Monitoring the Future, YRBSS, North Carolina State Epidemiological Report (2012) and the North Carolina Social Indicator Study Report (2011, 2012) NC IOM reports, archival and local data. The North Carolina Social Indicator Study Report contains data about alcohol, tobacco and other drugs consumption and consequences. The compilation of this assessment is used to assist the state in identifying needs, trends and gaps in prevention service delivery, and to continue to build upon successful initiatives.

According to the 2013 NC YRBSS, alcohol consumption by youth ages is on the decline. The percent of high school students that had their first drink of alcohol other than a few sips before age 13 years has **decreased** significantly from 1993 (30.4%) – 2013 (14.3%). Additionally, there was a significant **decrease** in the percentage of middle school students who reported having their first drink of alcohol other than a few sips before age 11 years.

Similar downward trends are seen with alcohol use rates. The percent of high school students who had at least one drink of alcohol on one or more of the past 30 days has **decreased** significantly from 1993 (43.7%) -2013 (32.2%). There was a significant **decrease** in the percentage of middle school students

who reported ever having a drink of alcohol, other than a few sips (decreasing from 34.9% in 2007 down to 26.2% in 2013).

Despite these downward trends in use among middle and high school students, alcohol use is an ongoing problem. There are increasingly identified disparities in current alcohol use rates. Developing statewide strategies to address these disparities, through existing underage drinking initiatives is a focus for the coming years.

The NC state office of prevention will continue to focus efforts on preventing and/or delaying the onset of and mitigate symptoms and complications from substance abuse; preventing and reducing consequences of underage drinking and preventing and reducing prescription drug misuse and abuse as well as tobacco and other drugs.

**3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?**

Building capacity is a key strategy for the promotion and sustainability of substance abuse prevention programs. Capacity building allows for the exchange of data and ideas, skills to effectively address prevention needs and physical resources to meet that need. The Division will continue to fund the Centers for Prevention Resources to assess training and technical assistance needs for communities and providers, coordinate regional networks through meetings and trainings, increase training opportunities for substance abuse prevention at regional and statewide conferences and coordinate additional local and regional trainings as needed, assist communities with the development of logic models based on their local contributing factors and assess cultural competence and sustainability and develop plans for their communities. The Community Wellness, Prevention and Health Intergradation Team will continue to utilize Partnerships, Alliances, Coalitions and Collaboratives (PACCS) as a conduit to encourage resource sharing and community mobilization. We will also continue to collect and analyze data from local substance abuse prevention providers to ensure a comprehensive service delivery system utilizing evidence based and effective programs, practices and policies.

**4. Please describe if the state has:**

- **A statewide licensing or certification program for the substance abuse prevention workforce;**

NC does have a statewide licensing/ certification program for the substance abuse prevention workforce. The North Carolina Substance Abuse Professional Practice Board certifies substance abuse prevention Consultants after they have completed all the requirements and passed the certification exam.

- **A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and**

NC does have a formal mechanism to provide training and technical assistance to the substance abuse prevention workforce. With guidance from the state office of substance abuse prevention, the Centers for Prevention Resources assess training and technical assistance needs for communities and providers, coordinate regional networks through meetings and trainings, increase training opportunities for substance abuse prevention at regional and statewide conferences and coordinate additional local and regional trainings as needed, assist communities with the development of logic models based on their local contributing factors, assess cultural competence and sustainability and develop plans for their

communities. Other partners that assist us with training include, the NC Area Health Education Centers (AHECs), NC Parent Resource Center, Research Triangle Institute (RTI) and (North Carolina Coalition Institute. (NCCI)

- ***A formal mechanism to assess community readiness to implement prevention strategies.***

NC does have a formal mechanism to assess community readiness via the Local Management Entities (LME) and their local contracted prevention providers, each funded community is to submit a comprehensive prevention plan that includes a community readiness assessment rooted in the Strategic Prevention Framework, based on a model by the Tri-Ethnic Center.

***5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?***

The Prevention and Early Intervention Team within DMH/DD/SAS has utilized data from several sources, including the North Carolina Youth Tobacco Survey, YRBSS, National Study of Drug Use and Health (NSDUH), North Carolina State Epidemiological Report (2012) and the North Carolina Social Indicator Study Report (2011, 2012) State Epidemiological Outcome Workgroup (SEOW), NC IOM reports and other research. We have used the risk and protective factor framework for over 20 years to assist us with planning for prevention services. Because risk factors are precursors of substance abuse, social indicators have been used for many years for both research and planning purposes. The risk and protective factor framework has been particularly important for developing data-driven approaches to prevention; reducing risk factors or protecting against them can prevent the occurrence of such behaviors. Technical assistance needs were identified through data received from some of the sources mentioned above. Data revealed the need for technical assistance to communities and prevention providers around the five steps of the Strategic Prevention Framework, workforce development, model fidelity, alcohol and tobacco policy, prescription drug abuse, parenting education, family programs and evaluation. These data sources assisted the state in identifying trends, needs and gaps in prevention service delivery.

Recent data from the 2013 NC YRBSS revealed that 12<sup>th</sup> grade students were significantly more likely than 9<sup>th</sup> grade students to have had 5 or more drinks of alcohol within a couple of hours during the past 30 days.

***6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.***

Yes, the state has a strategic plan that was developed, completed and approved in 2012 by SAMHSA/CSAP as part of the SPF-SPE grant that was received in 2012. However since that time, data has been reviewed from Gap Analysis from the LME's and their contracted local prevention providers and the social indicator study that has warranted review and revision of the plan to reflect current needs and trends. The purpose of the 5 year Strategic Prevention Plan is to strengthen the capacity and continue

to enhance the infrastructure plan of the NC prevention systems in order to achieve the recommendations of the 2009 NCIOM Action plan. It will also impact the Healthy NC 2020 objectives that are highlighted below:

Healthy NC 2020 Objectives
<b>Substance Abuse</b>
Reduce the percentage of high school students who had alcohol on one or more of the past 30 days
Reduce the percentage of traffic crashes that are alcohol related
Reduce the percentage of individuals aged 12 years and older reporting any illicit drug use in the past 30 days
<b>Tobacco Use</b>
Decrease the percentage of adults who are current smokers
Decrease the percentage of High School students reporting current use of any tobacco product
Decrease the percentage of people exposed to secondhand smoke in the workplace in the past seven days

We have used the strategic plan to ensure service coordination across agencies, to improve communications to the substance abuse prevention field, improve data collection, analysis and reporting, promote sustainability efforts and enhance performance and evaluation.

***7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.***

North Carolina uses the “The North Carolina Practice Improvement Collaborative (NC PIC) to function as the evidence based workgroup. The mission is to ensure that all North Carolinians will receive excellent care that is consistent with our scientific understanding of what works whenever they come into contact with the DMH/DD/SAS/DD/SAS system.

To improve the lives of clients during the current era of system transformation, North Carolina must focus on the content and quality of services and supports that are offered. Research has found that even some of the most popular and well disseminated programs are not evidence based and in fact can be counterproductive. The provision of quality services and supports involve fidelity to proven intervention models.

To facilitate guidance in determining the future evidence-based services and supports that will be provided through our public system, the Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services has developed the North Carolina Practice Improvement Collaborative (NC PIC). The NC PIC is comprised of representatives of all three disabilities and meets thrice yearly to review and discuss current and emerging best practices for adoption and implementation across the State.

We are continuously seeking out other agencies who are providing substance abuse prevention activities to collaborate and coordinate our services. Some of the state, local and federally funded agencies that we are working with include, NC ABC Commission, NC Department of Public Instruction, NC Division of Public Health and funded Drug Free Communities grantees.

***8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.***

#### Information Dissemination

- Media Campaigns
- NC Parent Resource Center
- Community Health fairs

#### Education

- Classroom and/or small group sessions
- Evidence-Based Curricula substantiated through local needs assessment
- Parenting and family management
- Education programs for youth groups

#### Alternatives

- Community Service Activities
- Prom Promise
- Project Graduation
- Project Venture

#### Problem ID and Referral

- Referral to other appropriate services
- Referral to Student Assistance Programs

#### Community Based Process

- Systematic Planning/Coalition and Community Team Building
- Community Team Building
- Assessing Services and Funding
- Multi Agency Coordination

## Environmental

- Promoting the establishment or review of alcohol, tobacco, and drug use policies
- Modifying Alcohol and Tobacco access and sale to minors policies and practices
- Modifying Alcohol and Tobacco advertising practices
- Communication Campaigns

These specific programs, practices and strategies were selected based on feedback from local prevention providers via local needs assessment, requests from partners with local providers, and data received from community level county health assessments, NC YRBSS and comprehensive prevention plans submitted as part of the LME/MCO Semi-Annual Block Grant compliance reports that identified needs, trends and gaps in substance abuse prevention services.

### ***9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?***

Providers are required to submit all other funding sources of primary prevention activities via the Semi-Annual Substance Abuse Prevention Treatment Block Grant Compliance Report (due in January and July) and within 30 days of receipt of funding if it is received after the reporting period. A comprehensive community plan utilizing all five steps of the Strategic Prevention Framework (SPF) will be submitted to the Substance Abuse Prevention Block Grant Manager for review, technical assistance and approval. Prevention providers will use the National Registry of Evidence-based Practices and Programs (NREPP) system to identify potential evidence-based curricula and the Substance Abuse Prevention Block Grant Manager will consult and provide technical assistance to select and implement the most appropriate and cost effective programs for the communities. The state will continue to fund universal, selective and indicated evidence based practices, programs and policies via information dissemination, education, alternatives, problem identification and referral, community-based processes and environmental strategies. Prevention providers will continue to use local needs assessments to drive the identification of the substance abuse prevention needs, trends and gaps in their communities and their selection of appropriate activities and strategies for their communities.

### ***10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?***

Process data is collected on, numbers served by age, race and gender and ethnicity via the semiannual block grant compliance reports that are submitted by the LME/MCOs. Numbers served are also reported by services delivered via the six strategies. The LME/MCO and their local contract providers are responsible for taking attendance of consumers who receive their services and administering consumer satisfaction surveys that provide feedback on the services that they receive. This feedback is reported to us via the LME/MCO semiannual block grant compliance reports and used to evaluate the effectiveness of the NC Prevention systems. This report also assist us in identifying training and technical assistance needs.

### ***11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded***

***prevention strategies and how will this data be used to evaluate the state's prevention system?***

***The state will collect data on*** 30-day substance use, perceived risk of use, age of first use, ATOD suspensions and expulsions, number of persons served by age, race , gender and ethnicity and the total number of evidence based programs and strategies. This data will be used to assist the state in enhancing and improving services as well as identifying additional appropriate activities, strategies and services that may be needed to prevent substance use and abuse.

***Please indicate areas of technical assistance needed related to this section.***

The state is in the process of assessing needs and capacity of its evaluation, monitoring and reporting systems as well as the delivery of training and technical assistance through a formal TA request. Modifications in the current reporting and monitoring systems are required to ensure accurate reporting along the CSAP six strategies as the prevention system is shifted to meet the prevention needs of the state. We are also participating in TA, along with other states, to address rising RVR rates for tobacco initiatives.

## 9. Primary Prevention for Substance Abuse

### **1. Please indicate if the state has an active SEOW. If so, please describe:**

Yes, the state does have an active SEOW. The SEOW meets the 2<sup>nd</sup> Friday of each month. The SEOW has been tasked with producing a state level epidemiological profile (NC EPI Profile) that summarizes the and characterizes behavioral health indicators of substance abuse consumption patterns and related consequences. The SEOW is also tasked with collecting data for the NC Social Indicator Study , a prevention needs assessment and planning profile of each of North Carolina's 100 counties including a display of 31 risk constructs composed of one or more social constructs derived from archival sources. County profiles reflect various dimensions of substance abuse and substance use related problems and outcomes that may exist in communities as well as sociodemographic characteristics and vital statistics believed to be associated with substance use and the risk for and protection from substance use. The profiles were designed to provide local substance abuse prevention providers and their partners with a factual, concise visual of each county's pattern of substance use related indicators, trends and needs. Data has been collected on children, youth, young adults and adults. There are plans to focus on minorities, and other underserved populations related to health disparities and substance use related consequences.

The SEOW is comprised of representatives from the following agencies: NC Department of Public Health, Injury and Violence Prevention Branch, NC Problem Gambling section of DMHDDSAS, NC Center for Health Statistics, PIRE, NC Department of Public Instruction, University of North Carolina School of Public Health, Department of Epidemiology and NC Action For Children meet on the second Friday of each month to assist us in assuring that we are using the current and appropriate data to help us determine needs and gaps in substance abuse prevention services. The members of the SEOW have been dedicated and passionate about assisting with the task of identifying the most appropriate data to inform decision making about substance abuse prevention planning.

Data is collected and analyzed from several sources including the National Study of Drug Use and Health (NSDUH), Monitoring the Future, United States Department of Justice, North Carolina, State Center for Health Statistics, NC Highway Safety Research Center. US Census Bureau, archival sources, BRFSS, North Carolina Division of Social Services, State Epidemiological Outcome Workgroup (SEOW), NC IOM reports and other research.

### **2. Please describe how needs assessment data is used to make decisions about the allocation Of SABG Primary Prevention funds.**

The Community Wellness, Prevention and Health Integration Team within DMH/DD/SAS uses data from multiple sources to drive prevention funds, including the National Study of Drug Use and Health (NSDUH), Monitoring the Future, YRBSS, North Carolina State Epidemiological Report (2012) and the North Carolina Social Indicator Study Report (2011, 2012) NC IOM reports, archival and local data. The North Carolina Social Indicator Study Report contains data about alcohol, tobacco and other drugs consumption and consequences. The compilation of this assessment is used to assist the state in identifying needs, trends and gaps in prevention service delivery, and to continue to build upon successful initiatives.

According to the 2013 NC YRBSS, alcohol consumption by youth ages is on the decline. The percent of high school students that had their first drink of alcohol other than a few sips before age 13 years has **decreased** significantly from 1993 (30.4%) – 2013 (14.3%). Additionally, there was a significant **decrease** in the percentage of middle school students who reported having their first drink of alcohol other than a few sips before age 11 years.

Similar downward trends are seen with alcohol use rates. The percent of high school students who had at least one drink of alcohol on one or more of the past 30 days has **decreased** significantly from 1993 (43.7%) -2013 (32.2%). There was a significant **decrease** in the percentage of middle school students who reported ever having a drink of alcohol, other than a few sips (decreasing from 34.9% in 2007 down to 26.2% in 2013).

Despite these downward trends in use among middle and high school students, alcohol use is an ongoing problem. There are increasingly identified disparities in current alcohol use rates. Developing statewide strategies to address these disparities, through existing underage drinking initiatives is a focus for the coming years.

The NC state office of prevention will continue to focus efforts on preventing and/or delaying the onset of and mitigate symptoms and complications from substance abuse; preventing and reducing consequences of underage drinking and preventing and reducing prescription drug misuse and abuse as well as tobacco and other drugs.

**3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?**

Building capacity is a key strategy for the promotion and sustainability of substance abuse prevention programs. Capacity building allows for the exchange of data and ideas, skills to effectively address prevention needs and physical resources to meet that need. The Division will continue to fund the Centers for Prevention Resources to assess training and technical assistance needs for communities and providers, coordinate regional networks through meetings and trainings, increase training opportunities for substance abuse prevention at regional and statewide conferences and coordinate additional local and regional trainings as needed, assist communities with the development of logic models based on their local contributing factors and assess cultural competence and sustainability and develop plans for their communities. The Community Wellness, Prevention and Health Intergradation Team will continue to utilize Partnerships, Alliances, Coalitions and Collaboratives (PACCS) as a conduit to encourage resource sharing and community mobilization. We will also continue to collect and analyze data from local substance abuse prevention providers to ensure a comprehensive service delivery system utilizing evidence based and effective programs, practices and policies.

**4. Please describe if the state has:**

- **A statewide licensing or certification program for the substance abuse prevention workforce;**

NC does have a statewide licensing/ certification program for the substance abuse prevention workforce. The North Carolina Substance Abuse Professional Practice Board certifies substance abuse prevention Consultants after they have completed all the requirements and passed the certification exam.

- ***A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and***

NC does have a formal mechanism to provide training and technical assistance to the substance abuse prevention workforce. With guidance from the state office of substance abuse prevention, the Centers for Prevention Resources assess training and technical assistance needs for communities and providers, coordinate regional networks through meetings and trainings, increase training opportunities for substance abuse prevention at regional and statewide conferences and coordinate additional local and regional trainings as needed, assist communities with the development of logic models based on their local contributing factors, assess cultural competence and sustainability and develop plans for their communities. Other partners that assist us with training include, the NC Area Health Education Centers (AHECs), NC Parent Resource Center, Research Triangle Institute (RTI) and (North Carolina Coalition Institute. (NCCI)

- ***A formal mechanism to assess community readiness to implement prevention strategies.***  
NC does have a formal mechanism to assess community readiness via the Local Management Entities (LME) and their local contracted prevention providers, each funded community is to submit a comprehensive prevention plan that includes a community readiness assessment rooted in the Strategic Prevention Framework, based on a model by the Tri-Ethnic Center.

***5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?***

The Prevention and Early Intervention Team within DMH/DD/SAS has utilized data from several sources, including the North Carolina Youth Tobacco Survey, YRBSS, National Study of Drug Use and Health (NSDUH), North Carolina State Epidemiological Report (2012) and the North Carolina Social Indicator Study Report (2011, 2012) State Epidemiological Outcome Workgroup (SEOW), NC IOM reports and other research. We have used the risk and protective factor framework for over 20 years to assist us with planning for prevention services. Because risk factors are precursors of substance abuse, social indicators have been used for many years for both research and planning purposes. The risk and protective factor framework has been particularly important for developing data-driven approaches to prevention; reducing risk factors or protecting against them can prevent the occurrence of such behaviors. Technical assistance needs were identified through data received from some of the sources mentioned above. Data revealed the need for technical assistance to communities and prevention providers around the five steps of the Strategic Prevention Framework, workforce development, model fidelity, alcohol and tobacco policy, prescription drug abuse, parenting education, family programs and evaluation. These data sources assisted the state in identifying trends, needs and gaps in prevention service delivery.

Recent data from the 2013 NC YRBSS revealed that 12<sup>th</sup> grade students were significantly more likely than 9<sup>th</sup> grade students to have had 5 or more drinks of alcohol within a couple of hours during the past 30 days.

**6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.**

Yes, the state has a strategic plan that was developed, completed and approved in 2012 by SAMHSA/CSAP as part of the SPF-SPE grant that was received in 2012. However since that time, data has been reviewed from Gap Analysis from the LME's and their contracted local prevention providers and the social indicator study that has warranted review and revision of the plan to reflect current needs and trends. The purpose of the 5 year Strategic Prevention Plan is to strengthen the capacity and continue to enhance the infrastructure plan of the NC prevention systems in order to achieve the recommendations of the 2009 NCIOM Action plan. It will also impact the Healthy NC 2020 objectives that are highlighted below:

Healthy NC 2020 Objectives
<b>Substance Abuse</b>
Reduce the percentage of high school students who had alcohol on one or more of the past 30 days
Reduce the percentage of traffic crashes that are alcohol related
Reduce the percentage of individuals aged 12 years and older reporting any illicit drug use in the past 30 days
<b>Tobacco Use</b>
Decrease the percentage of adults who are current smokers
Decrease the percentage of High School students reporting current use of any tobacco product
Decrease the percentage of people exposed to secondhand smoke in the workplace in the past seven days

We have used the strategic plan to ensure service coordination across agencies, to improve communications to the substance abuse prevention field, improve data collection, analysis and reporting, promote sustainability efforts and enhance performance and evaluation.

**7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.**

North Carolina uses the "The North Carolina Practice Improvement Collaborative (NC PIC) to function as the evidence based workgroup. The mission is to ensure that all North Carolinians will receive excellent

care that is consistent with our scientific understanding of what works whenever they come into contact with the DMH/DD/SAS/DD/SAS system.

To improve the lives of clients during the current era of system transformation, North Carolina must focus on the content and quality of services and supports that are offered. Research has found that even some of the most popular and well disseminated programs are not evidence based and in fact can be counterproductive. The provision of quality services and supports involve fidelity to proven intervention models.

To facilitate guidance in determining the future evidence-based services and supports that will be provided through our public system, the Director of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services has developed the North Carolina Practice Improvement Collaborative (NC PIC). The NC PIC is comprised of representatives of all three disabilities and meets thrice yearly to review and discuss current and emerging best practices for adoption and implementation across the State.

We are continuously seeking out other agencies who are providing substance abuse prevention activities to collaborate and coordinate our services. Some of the state, local and federally funded agencies that we are working with include, NC ABC Commission, NC Department of Public Instruction, NC Division of Public Health and funded Drug Free Communities grantees.

***8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.***

Information Dissemination

- Media Campaigns
- NC Parent Resource Center
- Community Health fairs

Education

- Classroom and/or small group sessions
- Evidence-Based Curricula substantiated through local needs assessment
- Parenting and family management
- Education programs for youth groups

<b>PROGRAM</b>	<b>AGES</b>	<b>IOM PREVENTION CATEGORY</b>
<b>HALO (HEALTHY ALTERNATIVES FOR LITTLE ONES)</b>	0-5	Universal
<b>GUIDING GOOD CHOICES</b>	8-14	Universal
<b>MEDIA READY</b>	11-14	Universal
<b>HIP HOP TO PREVENT HIV/SUBSTANCE ABUSE</b>	13-17	Universal, Selective

<b>ALL STARS</b>	11-14	Universal, Selective
<b>ACTIVE PARENTING OF TEENS</b>	13-17	Selective
<b>STORYTELLING FOR EMPOWERMENT</b>	6-12	Selective
<b>PROJECT TND</b>	14-19	Selective
<b>PROJECT ALERT</b>	13-17	Selective
<b>EARLY RISERS</b>	6-12	Selective
<b>RECONNECTING YOUTH</b>	13-17	Selective, Indicated
<b>PROJECT SUCCESS</b>	13-17	Indicated
<b>NOT ON TOBACCO</b>	13-17	Indicated

#### Alternatives

- Community Service Activities
- Prom Promise
- Project Graduation
- Project Venture

#### Problem ID and Referral

- Referral to other appropriate services
- Referral to Student Assistance Programs

#### Community Based Process

- Systematic Planning/Coalition and Community Team Building
- Community Team Building
- Assessing Services and Funding
- Multi Agency Coordination

#### Environmental

- Promoting the establishment or review of alcohol, tobacco, and drug use policies
- Modifying Alcohol and Tobacco access and sale to minors policies and practices
- Modifying Alcohol and Tobacco advertising practices
- Communication Campaigns

These specific programs, practices and strategies were selected based on feedback from local prevention providers via local needs assessment, requests from partners with local providers, and data received from community level county health assessments, NC YRBSS and comprehensive prevention plans submitted as part of the LME/MCO Semi-Annual Block Grant compliance reports that identified needs, trends and gaps in substance abuse prevention services.

**9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?**

Providers are required to submit all other funding sources of primary prevention activities via the Semi-Annual Substance Abuse Prevention Treatment Block Grant Compliance Report (due in January and July) and within 30 days of receipt of funding if it is received after the reporting period. A comprehensive community plan utilizing all five steps of the Strategic Prevention Framework (SPF) will be submitted to the Substance Abuse Prevention Block Grant Manager for review, technical assistance and approval. Prevention providers will use the National Registry of Evidence-based Practices and Programs (NREPP) system to identify potential evidence-based curricula and the Substance Abuse Prevention Block Grant Manager will consult and provide technical assistance to select and implement the most appropriate and cost effective programs for the communities. The state will continue to fund universal, selective and indicated evidence based practices, programs and policies via information dissemination, education, alternatives, problem identification and referral, community-based processes and environmental strategies. Prevention providers will continue to use local needs assessments to drive the identification of the substance abuse prevention needs, trends and gaps in their communities and their selection of appropriate activities and strategies for their communities.

**10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?**

Process data is collected on, numbers served by age, race and gender and ethnicity via the semiannual block grant compliance reports that are submitted by the LME/MCOs. Numbers served are also reported by services delivered via the six strategies. The LME/MCO and their local contract providers are responsible for taking attendance of consumers who receive their services and administering consumer satisfaction surveys that provide feedback on the services that they receive. This feedback is reported to us via the LME/MCO semiannual block grant compliance reports and used to evaluate the effectiveness of the NC Prevention systems. This report also assist us in identifying training and technical assistance needs.

**11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?**

**The state will collect data on** 30-day substance use, perceived risk of use, age of first use, ATOD suspensions and expulsions, number of persons served by age, race, gender and ethnicity and the total number of evidence based programs and strategies. This data will be used to assist the state in enhancing and improving services as well as identifying additional appropriate activities, strategies and services that may be needed to prevent substance use and abuse.

**Please indicate areas of technical assistance needed related to this section.**

The state is in the process of assessing needs and capacity of its evaluation, monitoring and reporting systems as well as the delivery of training and technical assistance through a formal TA request. Modifications in the current reporting and monitoring systems are required to ensure accurate reporting

along the CSAP six strategies as the prevention system is shifted to meet the prevention needs of the state. We are also participating in TA, along with other states, to address rising RVR rates for tobacco initiatives.

# Environmental Factors and Plan

## 10. Quality Improvement Plan

Narrative Question:

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In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

*In an attachment to this application, states should submit a CQI plan for FY 2016-FY 2017.*

*Please indicate areas of technical assistance needed related to this section.*

Please use the box below to indicate areas of technical assistance needed related to this section:

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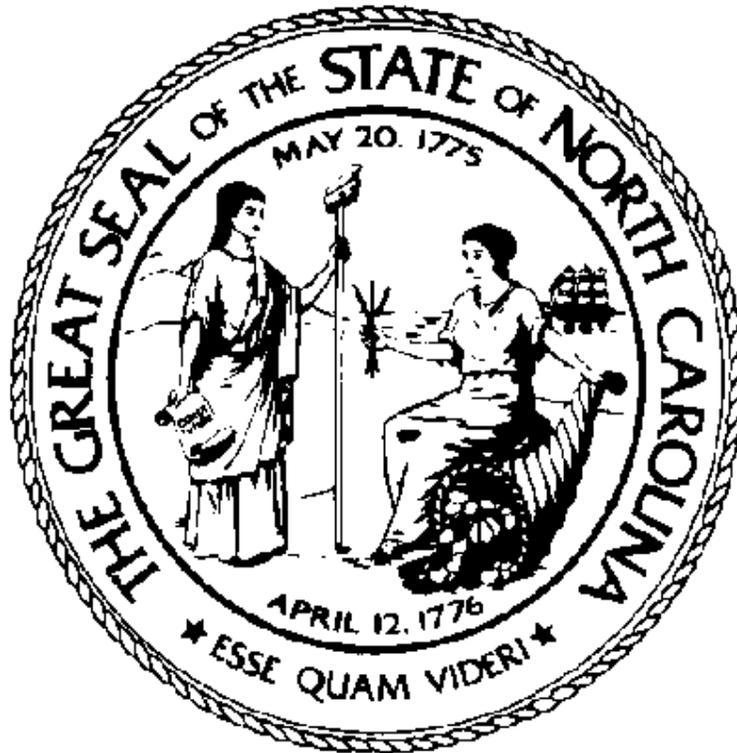
Footnotes:

## 10. Quality Improvement Plan

**In an attachment to this application, states should submit a CQI plan for FY2016-FY2017.**

Please see the attached ***Quality Management Plan for SFY15-16 for the Division of Mental Health, Developmental Disabilities and Substance Abuse Services.***

**Quality Management Plan SFY: 2015 - 2016**  
for  
The Division of Mental Health, Developmental Disabilities  
And Substance Abuse Services



Revised & Approved:  
April 28, 2015

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## Values and Guiding Principles of the Quality Management Program

The [Division of Mental Health, Developmental Disabilities and Substance Abuse Services](#) (DMH/DD/SAS or Division) Quality Management Plan weaves together the mission and vision of the NC Department of Health and Human Services and DMH/DD/SAS and with the National Behavioral Health Quality Framework(NBFQF), the Federal Centers for Medicare and Medicaid Services Quality Framework and a Total Quality Management philosophy to formulate a structure and a process to achieving a high quality MH/DD/SA service system.

The mission of the [NC Department of Health and Human Services](#) (NC DHHS) is, ***in collaboration with its partners, to protect the health and safety of all North Carolinians and to provide essential services.*** This mission is driven by a vision that all ***North Carolinians will enjoy optimal health and well-being.***

It is the mission of the Division to, ***provide people with, or at risk of, mental illness, developmental disabilities, and substance abuse problems and their families the necessary prevention, intervention, treatment services and supports they need to live successfully in communities of their choice.***

In 2009 NC DHHS launched a management and organizational vision to ensure better quality of care, customer service, efficiency and responsibility through being:

- ❖ **Customer service focused.** North Carolinians are the center of our service design and delivery, and allocation of human and fiscal resources.
- ❖ **Anticipatory.** DHHS actively monitors changes in the needs of its customers and the impact of its services and applies new and innovative approaches in a timely, targeted and effective manner.
- ❖ **Collaborative.** DHHS values internal and external partnerships.
- ❖ **Transparent.** DHHS shares information, planning and decision-making processes and communicates openly with its customers and partners.
- ❖ **Results-oriented.** DHHS emphasizes accountability and measures its work by the highest standards.

The Division's Quality Management plan outlines the Division's Quality Management Program, its values and guiding principles, approach, structure, responsibilities, and improvement initiatives.

# Customer Service

## North Carolina's Service System

The Division's organizational structure is designed to implement North Carolina's public mental health, developmental disability and substance use service system. Our programs are governed by rules created by the MH/DD/SA Commission and we are advised by the State Consumer and Family Advisory Committee. MH/DD/SAS services are managed by Local Management Entities-Managed Care Organizations (LME-MCO) that oversee comprehensive provider networks that *provide the necessary MH/DD/SA services and supports that North Carolinian's need to live successfully in communities of their choice* (See Appendix A: Local Management Entities Map).

## Quality Management Infrastructure

Keeping those we serve at the center of service design and delivery the Division's Quality Management structure provides the focus for ongoing attention to the clinical quality and effectiveness of the service system. The Division's Steering Committee brings together staff from across the Division to plan, monitor and evaluate initiatives to improve the clinical quality of the service system and the effective use of state and federal funds (See Appendix B: Division Quality Management Infrastructure).

## A Culture of Quality

Customer focused quality management is championed at the Division by Executive Operations team to promote a collaborative, accountable and results-based organization. Through this the Division created a workforce development model that includes:

- ❖ Quality Improvement as part of job descriptions, employee training and evaluation
- ❖ Standards for internal customer service
- ❖ A Code for Ethical Conduct for staff
- ❖ Guidelines designed to promote teamwork
- ❖ Focus on establishing an effective work culture in the midst of change

## Fiscal Resources

It is the Division's responsibility to provide a cost efficient publicly funded behavioral health care system while supporting quality service delivery. The Division will monitor compliance, efficiency and accountability within NC DMH/DD/SAS programs by detecting and preventing fraud, waste, program abuse, and by ensuring that State and Block Grant dollars are utilized appropriately, in accordance with laws and regulations, and in support of programmatic goals through the DMH/DD/SAS Service System Integrity Plan.

# Anticipatory

## Performance Monitoring

To ensure the needs of those we serve are being met the Division monitors key indicators to help assure that the system is working as intended, opportunities for improvement area identified and acted upon, desired improvements are recognized and efforts to sustain successful practices are implemented and monitored to maintain achievements, as priorities change.

A process for periodic monitoring of key indicators is coordinated by the Steering Committee. Monitoring of indicators will include:

- ❖ Reviewing valid and reliable performance and outcome data
- ❖ Determining significance of trends and patterns
- ❖ Implementing improvement initiatives
- ❖ Evaluating improvement initiatives
- ❖ Raising the bar on measures when appropriate
- ❖ Evaluating and revising the Quality Management plan annually

Quality Management and Performance Expectations for LME-MCOs are established per contract. Routine monitoring against performance targets or standards provides information on how the system is doing. The Division supports a statewide Incident Response Improvement System for reporting and documenting responses to emergency and critical incidents with a focus on future prevention. Contract requirements address reporting and resolution requirements related to complaints and grievances and establishes standards for resolution timeframe.

Regular and ongoing feedback within the Division and to Local Management Entities-Managed Care Organizations and system stakeholders is a key to ensuring and sustaining improvements in quality. The guidelines for critical outcomes and performance measures are described in the North Carolina LME-MCO Performance Measurement and Reporting Guide. Measurement is based on valid and reliable data, consistent with the NBHQF and describe the health and functioning of the MH/DD/SA system.

The Division evaluates the overall performance of the Local Management Entities-Managed Care Organization and their network through the review of each management function, compliance with reporting requirements, through statewide measures of service quality, input from stakeholders via surveys and outcome measurement systems, analysis of emergency and critical incidents, and review and follow-up of complaints and grievances.

In December 2013, The Department of Health and Human Services announced the Local Management Entities-Managed Care Organizations Consolidation Plan. As this transition occurs over the next several years the Division and system stakeholders will anticipate and manage the impact of the system transition on MH/DD/SA services and supports.

# Collaborative

## Involvement of Stakeholders

Success of our service system is dependent on the collaboration between the Division, Local Management Entities-Managed Care Organizations, direct service providers, consumers and families and other community stakeholders. The Executive Operations Team will ensure coordination with standing advisory and stakeholder committees with responsibilities for quality of the service system including:

- ❖ DMH/DD/SAS External Advisory Team
- ❖ State Consumer & Family Advisory Committee
- ❖ DHHS LME-MCO Director Meetings
- ❖ DHHS LME-MCO Clinical Director Meetings
- ❖ DHHS LME-MCO Medical Director Meetings
- ❖ DHHS LME-MCO Quality Management Directors Forum
- ❖ Joint Clinical Policy Collaborative
- ❖ Block Grant Planning Council
- ❖ Departmental Waiver Advisory Committee
- ❖ Service Advocacy Organizations

The Executive Operations Team continues to ensure regular communication and feedback through communication bulletins, websites, forums, trainings and conference participation.

Division Leadership will foster collaborative efforts with the [Division of Medical Assistance](#) to ensure coordinated oversight of the 1915 b/c Medicaid Waiver, Partnership for Healthy North Carolina, and the Division of Medical Assistance Quality Strategy for the North Carolina Behavioral Health Prepaid Inpatient Healthcare Plans. Division staff will be a part of the Intra-departmental monitoring teams responsible for the monitoring the operations and services related to the waivers, block grants and state funded services.

## **Transparent**

### **Communication**

Communication is critical to the success of any quality improvement effort. The Division's Leadership will communicate priorities, a directional vision and goals for the MH/DD/SA service system. The Steering Committee will monitor and communicate progress and performance related to Division initiatives and quality improvement projects in relation to the priorities and goals.

The Division's Leadership will support a culture conducive to open communication, information sharing and champion data driven decision making at the State and local levels. Report results and highlights will be communicated on the Division website, in memos and other communiqués so that together as a system we can learn from each other. Sharing information and data will encourage innovation and enable replication of successful practices.

## **Results Oriented**

### **Performance Measurement & Sustainability**

The Steering Committee is charged with the overall implementation and success of the Division's quality management plan. It oversees all quality management committees and monitors Division initiatives. The Steering Committee is responsible for promoting excellence and assisting with identifying potential issues and opportunities for improvement and ensuring that they are referred to and addressed at the appropriate level.

Reports will be based on consistent and credible data and will be examined to determine if changes have produced the desired results, or if further adjustments are needed to achieve success. On an annual basis, the Steering Committee will oversee the review of reporting requirements, data sources and reporting formats to ensure that reporting elements remain relevant and support the desired system outcomes.

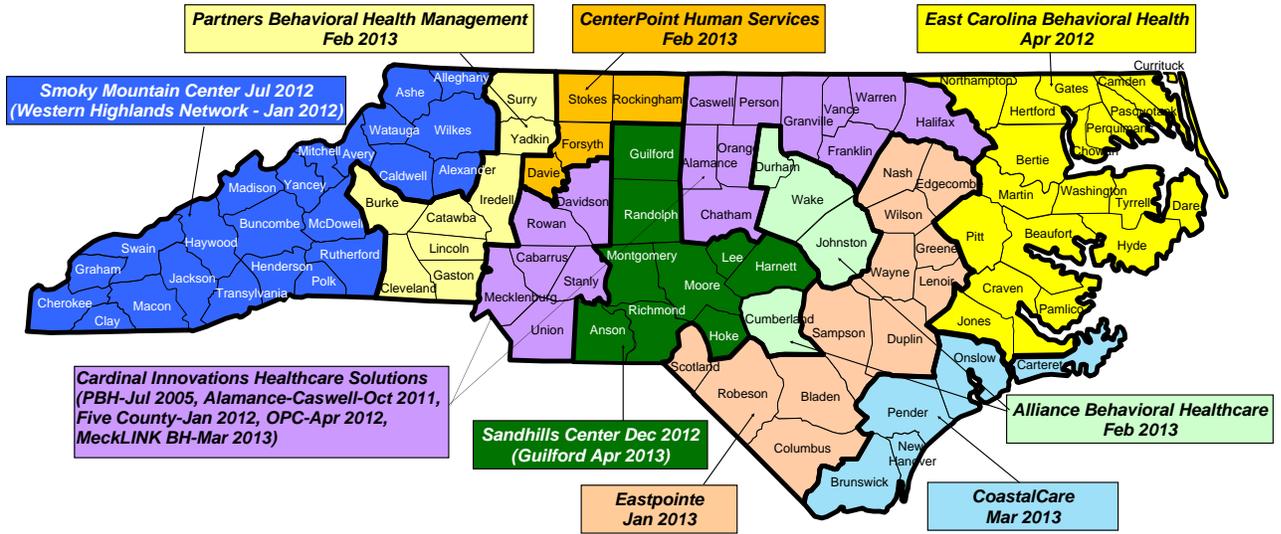
The Steering Committee ensures improvement actions and quality initiatives are followed-up for successful resolution and sustainability. The Steering Committee champion information sharing when change actions result in demonstrable improvements; those actions will be recognized and spot-lighted. Additionally, communication on system performance will occur throughout the quality improvement process using the Centers for Medicare and Medicaid Services Quality Framework to promote strategic and solution focused initiatives. (See Appendix C: Quality Framework)

# Appendix A

## Local Management Entity Map

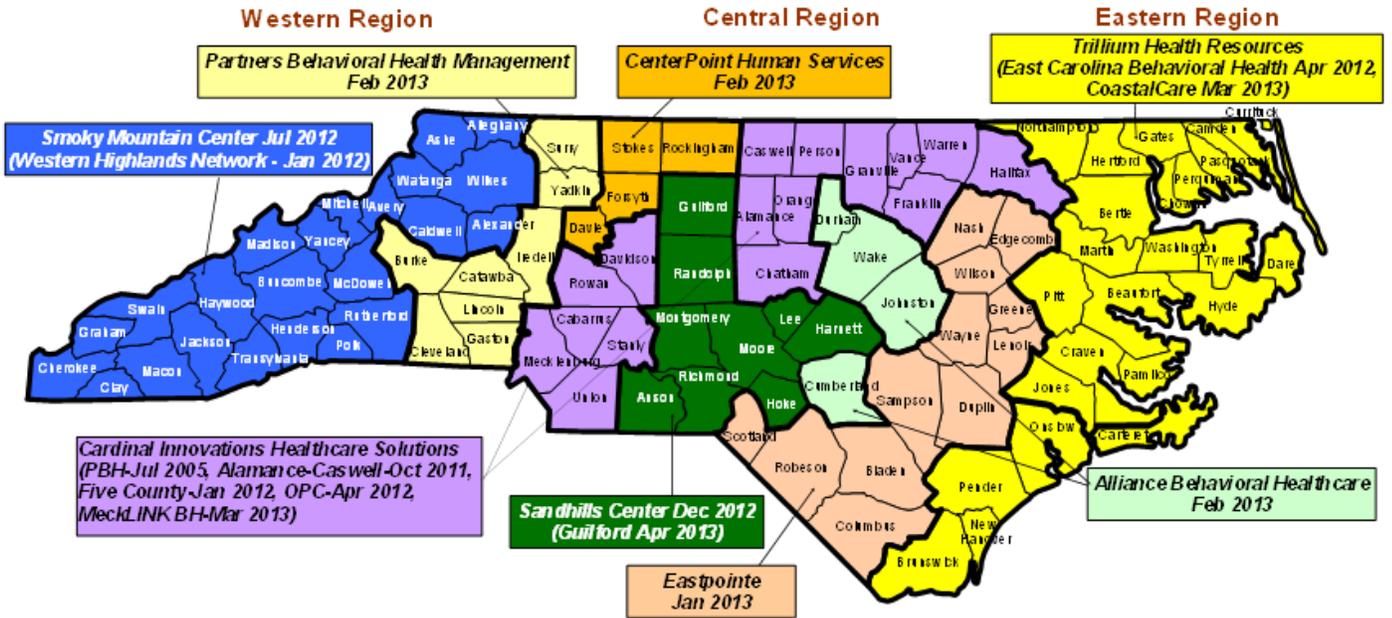
### SFY 14-15 Configuration

#### Local Management Entity - Managed Care Organizations (LME-MCOs) and 1915 b/c Medicaid Waiver Implementation Dates



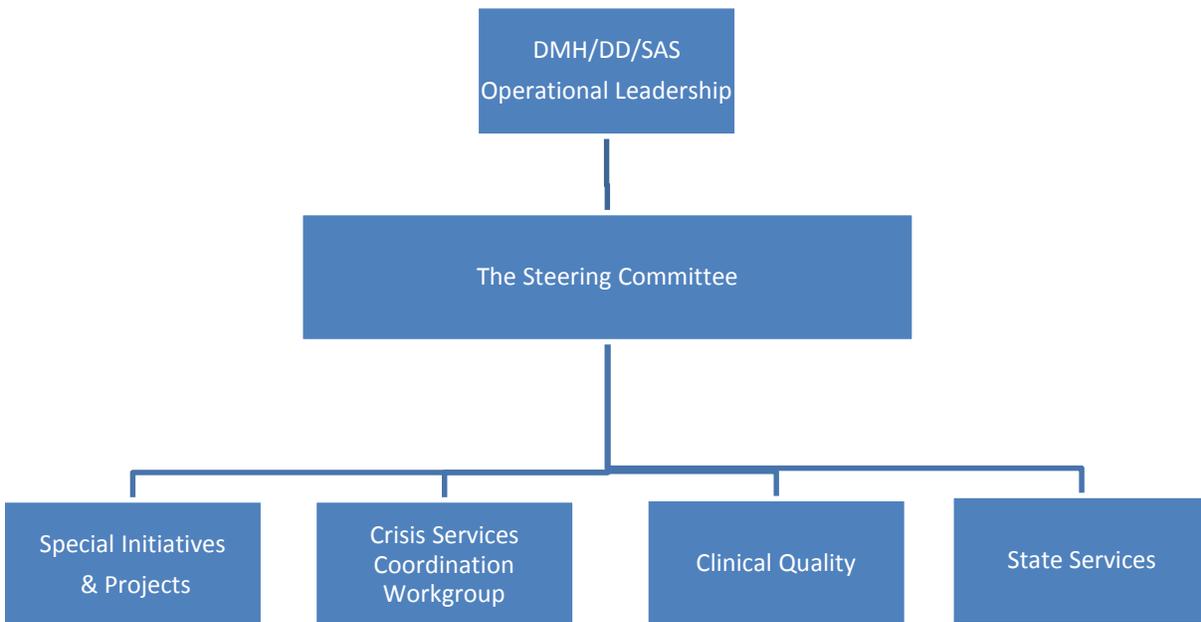
- Reflects LME-MCOs as of 4/1/14.  
 - Western Highlands Network operating under a management agreement 10/1/13, merger date 7/1/14.

### Configuration July 2015



## Appendix B

# Division Quality Management Infrastructure



### The Steering Committee

Ultimate responsibility for a comprehensive and sustainable quality management program at the Division is delegated to the Division's Steering Committee. The Steering Committee is charged with the overall success of the Division's quality management activities. It oversees all quality management responsibilities in the Division and serves as the hub receiving reports and recommendations from the Quality Cross-Functional Committees and Special Initiatives/Projects, and it serves as the link to other DHHS quality initiatives.

On an annual basis, the Steering Committee reviews and approves the QM Plan and Steering Committee membership for the upcoming year. The Steering Committee membership will comprise the Cross-Functional Committee chairs, the LME-MCO liaisons, the project management supervisor, the medical director, key quality management and finance staff, the deputy directors and chaired by the Division Director.

The Steering Committee meets at least monthly and is responsible for promoting excellence and for identifying potential problems and opportunities for improvement and ensuring that they are referred to and addressed at the appropriate level within the organization. The Steering Committee ensures that corrective action and quality initiatives are followed-up on for successful resolution and keep the Executive Operations Team informed.

### **The Steering Committee's Responsibilities Include:**

1. Development of the Division's Quality Management Plan, which will be reviewed and updated annually. The Quality Management Plan will identify performance measures and procedures for monitoring state established waivers, block grants and Division priorities.
2. Oversight of the Quality Cross-Functional Committees Analysis of reports related to LME-MCO operations to gain broader perspective of statewide service system and performance. LME-MCO Reports include:
  - Local Business Plan
  - Gap Analysis and Community Needs Assessment
  - Performance Improvement Projects
  - Intra-departmental Monitoring Reviews
  - Monthly Monitoring Reports
  - DMA & DMH Performance Measures
  - Performance Contract Reports/Data Requirements
  - Stakeholder Satisfaction Surveys
  - Reports regarding emergencies, critical incidents, complaints and grievances
3. Review reports and recommendations from the Cross Functional Committees including Clinical Quality, State Services and Crisis Services Coordination Workgroup for service system impacts.
4. Review Special Initiative/Project progress, trends and monitor for impact on other parts of the service system.
5. Identify the need for special studies, initiatives or technical assistance and refer to the appropriate committee or team for implementation and monitoring.
6. Identify methods for communicating service system performance and improvement initiatives with Division staff and external advisory and stakeholder committees who share responsibility for the quality of the service system.
7. Ensure annual review of Division required LME-MCO reporting tools and requirements, to ensure reporting requirements accurately assess service system performance and that data is used to support decision making and performance monitoring; and to ensure that required data reporting is reviewed and communicated in a timely manner with system stakeholders.

### **Quality Cross-Functional Committees**

The Steering Committee delegates priority quality improvement initiatives to specialized Quality Cross-Functional Committees with expertise in clinical quality, data analytics and state service implementation. Committees may also have workgroups that address specific topics within the purview of the Committee. Each committee regularly reports to the Steering Committee its activities, any areas of concern and success it has identified, and provides recommendations for action to improve the service system. Each

committee monitors the results of corrective action and quality initiatives within its purview to ensure successful resolution and keeps the Steering Committee and Executive Operations Team informed.

**Cross Functional Committees Responsibilities Include:**

1. Responsible for monitoring and providing oversight of specific areas within its charge and identifying potential problems or opportunities for improvement.
2. Committee determines most effective way to provide technical assistance or implement improvement actions and provides ongoing monitoring.

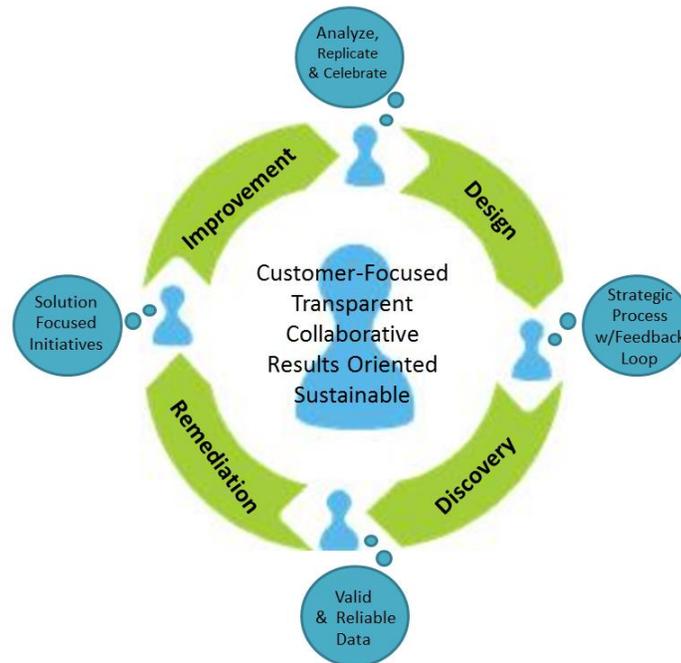
**Time Limited Workgroups & Special Initiatives/Projects**

Time-limited workgroups and special initiatives/projects will be established as needed to address a specific issue, formulate a recommendation for an appropriate course of action, or implement a particular initiative. Membership will be drawn from staff with relevant experience and skills. Each group will have a charge that specifies a facilitator, responsible staff persons, deliverables, timelines and routes of communication. Workgroups and Special Initiative/Projects will regularly report to a Cross-Functional Committee or to the Steering Committee on activities, any areas of concern and success identified, and provides recommendations for improvement actions.

## Appendix C

### Quality Framework

The Federal Centers for Medicare and Medicaid Services promote a comprehensive framework for managing waiver plans. The Division has adopted and promoted this framework since 2003; it consists of four distinct, but related, activities that form a continuous, interdependent process. The framework is applied to clinical and performance outcome measures to assist with communicating and monitoring quality improvement initiatives.



**Design:** The design function refers to strategies for building quality assurance and quality improvement into the conception and design of the system. It includes mechanisms such as effective information systems, communication channels, feedback loops.

**Discovery:** The discovery function refers to the collection, analysis and reporting of information to make certain that people, processes and products are meeting basic requirements of quality and to evaluating progress toward goals. It includes compliance monitoring and audit activities, collection and analysis of trend data on services, consumer perceptions and outcomes, recurring management reports and dashboards and targeted evaluation studies.

**Remediation:** Remediation refers to strategies used to identify, analyze and correct problems quickly and effectively. Mechanisms vary based on the situation and can include consultation and technical assistance, training, development of new initiatives, plans of correction, repayment of funds, loss of certification and redirection of resources.

**Improvement:** Improvement refers to systematic strategies to make incremental enhancements to operations and procedures that move the system toward achieving specified goals.

## Total Quality Management Framework

The Division's long-term success will be achieved through a Total Quality Management approach that promotes a customer-focused atmosphere that involves all employees in continual improvement efforts. Our customers include persons receiving services and their families, our funders, all DHHS divisions, Local Management Entities-Managed Care Organizations and their provider networks, State and local Consumer and Family Advisory Committees (CFACs) and other state and local stakeholders. A culture of quality requires DMH/DD/SAS to effectively communicate and champion service delivery and project improvement initiatives.

To be effective, quality management requires integrated structures and processes that permeate all levels of every organization within the service system and works toward the objectives of:

- ❖ **Safeguarding** the health, safety and rights of persons served
- ❖ **Improving customer services** through collaboration with or input from persons served and family involvement
- ❖ Ensuring **fair and easy access** to services
- ❖ Supporting the achievement of desired **outcomes and satisfaction** for persons served
- ❖ Ensuring the **integrity, effectiveness and continuous quality improvement** of services through review of consistent and credible data
- ❖ Ensuring **compliance** and guiding improvements of the services provided under state and federal funding and Medicaid waivers
- ❖ **Cultural competence**
- ❖ **Collaboration with other agencies**

Total Quality Management will be achieved through implementing a culture, approach and agency structure that provides a collaborative approach to enable persons served to live successfully in their communities.

# Environmental Factors and Plan

## 11. Trauma

Narrative Question:

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**Trauma**<sup>75</sup> is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems<sup>76</sup>. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed approach consistent with “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach”.<sup>77</sup> This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma<sup>78</sup> paper.

Please consider the following items as a guide when preparing the description of the state’s system:

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state’s policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

*Please indicate areas of technical assistance needed related to this section.*

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<sup>75</sup> Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.*

<sup>76</sup> <http://www.samhsa.gov/trauma-violence/types>

<sup>77</sup> <http://store.samhsa.gov/product/SMA14-4884>

<sup>78</sup> *Ibid*

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

## 11. Trauma

### **1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?**

The state's standardized screening/triage/referral process (STR) which is required for admission into the service delivery system includes questions on trauma history. In addition, the state's web-based data collection – the NC Treatment and Outcomes Program Performance System – that is completed by service providers includes questions on trauma.

### **2. Describe the state's policies that promote the provision of trauma-informed care.**

The state does not currently have any policies in place; however, the provision of trauma-informed care is highly promoted. In addition to utilization of the UCLA PTSD Screening Index, the GAIN, which has a robust section on victimization and trauma, has been implemented in all youth detention centers in North Carolina and is used by a significant number of outpatient providers. Seven Challenges, which is indicated for youth with co-occurring trauma, has been implemented with seven of the eight residential programs for youth and has significant utilization by the cadre of providers who serve adolescents with substance use disorders. Outpatient providers, as well as two adolescent residential programs, have received training in Seeking Safety.

Although the state currently does not have specific policies designed to connect individuals with trauma histories to trauma-focused therapy, there are a number of initiatives underway that support pilot efforts where results will inform future policy direction and enhance the ongoing awareness, education, delivery, and monitoring around provision of trauma-informed care. Please refer to Question/Answer #3 below for more detail.

### **3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?**

**NC Child Treatment Program:** In 2013, the North Carolina General Assembly (NCGA) granted a \$1.8 million annually-recurring appropriation to the North Carolina Child Treatment Program (NC CTP), a program of the Center for Child and Family Health (CCFH), to support program infrastructure, activities, and expansion of the child mental health service array.

Specifically, over the course of SFY 2015, the scope of training provided by NC CTP increased from one (1) to five (5) evidence-based child trauma treatment models for children from birth to 18 years of age, including:

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) -- TF-CBT is designed to help youth ages 3 to 18 experiencing posttraumatic stress in returning to a healthy state of functioning after a traumatic event.

- Parent-Child Interaction Therapy (PCIT) -- PCIT is a treatment for young children ages 2 to 7 with emotional and behavioral disorders emphasizing improvement of the quality of the parent-child relationship and changing parent-child interactions.
- Child-Parent Psychotherapy (CPP) -- CPP is an intervention for children from birth through age 5 who have experienced at least one traumatic event and who are experiencing behavioral, attachment, and/or mental health problems as a result.
- Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) -- SPARCS is a 16-session group intervention designed to address the mental health needs of chronically traumatized adolescents who may still be living with ongoing stress and may be experiencing problems in several areas of functioning.
- Attachment and Biobehavioral Catch-up (ABC) -- ABC is a 10-session intervention aimed at helping caregivers provide nurturing care to young children ages six months to two years who have experienced early maltreatments and/or disruptions in care.

In addition to the annually-recurring operation budget, the NCGA allocated \$500,000 to be used over a period of two years (2013-2015) to support development of the NC CTP data exchange tool, *NC Performance and Outcomes Platform (NC POP)*.

**Project Broadcast:** The NC Division of Social Services (NCDSS) has been awarded grant funding for *Project Broadcast: Disseminating Trauma-Informed Practices to Children in the North Carolina Child Welfare System*. NCDSS is collaborating with NC DMH/DD/SAS in the nine pilot counties. NC DMH/DD/SAS is engaging its LME-MCOs and their providers in establishing local task forces for implementation, and training providers in trauma informed EBTs to serve children and their families in the local child welfare systems. Project Broadcast:

- Provides training and professional development for resource parents (i.e., foster, adoptive, kinship) using the National Child Traumatic Stress Network's (NCTSN) Resource Parent Curriculum; child welfare professionals will also use the NCTSN's Child Welfare Toolkit
- Increases access to trauma-informed, evidence-based treatments for children and youth by training more clinicians in these interventions:
  - Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)
  - Attachment and Bio behavioral Catch-up (ABC)
  - Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)
  - Parent-Child Interaction Therapy (PCIT)
- Creates systemic changes so that the training and interventions offered to the nine demonstration counties can eventually be expanded to all 100 North Carolina counties.

**4. Does the state provide trainings to increase the capacity of providers to deliver trauma-specific interventions?**

In addition to the project noted above, affordable trainings are offered by Local Management Entities-Managed Care Organizations, the Area Health Education Centers (AHECs), hospital systems, provider organizations, and universities to increase the capacity of providers to deliver trauma-specific interventions.

# Environmental Factors and Plan

## 12. Criminal and Juvenile Justice

Narrative Question:

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More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.<sup>79</sup>

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.<sup>80 81</sup> Rottman described the therapeutic value of problem-solving courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem-solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs." Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.<sup>82</sup>

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

Please consider the following items as a guide when preparing the description of the state's system:

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?
4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

*Please indicate areas of technical assistance needed related to this section.*

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<sup>79</sup> <http://csqjusticecenter.org/mental-health/>

<sup>80</sup> The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman, 2000.

<sup>81</sup> A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs, U.S. Department of Justice, Renee L. Bender, 2001.

<sup>82</sup> Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice*. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNeil, Dale E., and Renée L. Binder. [OJJDP Model Programs Guide](#)

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

## 12. Criminal and Juvenile Justice

### **1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as part of coverage expansions?**

This is not applicable to North Carolina. The state government has decided not to expand Medicaid coverage for adults. It has also decided that it will not set up a health insurance exchange.

### **2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?**

Yes, an array of services, which include screening, triage, referral, assessment, treatment and crisis prevention and recovery planning for those who are/may become involved with the justice and court system are provided across the state prior to adjudication and/or sentencing for individuals with mental health and/or substance use disorders. Some of these services and processes for access to services and/or diversion are highlighted below:

- Throughout North Carolina, law enforcement, mental health professionals and advocates are joining in partnership to establish Crisis Intervention Teams (CIT). CIT programs provide law enforcement the knowledge and skills they need to de-escalate persons in crisis and emphasize treatment rather than jail time for persons displaying symptoms of mental illness. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (MH/DD/SAS) coordinates this statewide initiative through its Justice Systems Team.
- Persons charged with Driving While Impaired (DWI) may obtain an assessment from a network of more than 400 authorized substance abuse service provider agencies prior to their initial court appearance.
- Drug Education Schools (DES) are a diversion opportunity for first-time offenders per NC General Statute 90-96 in cooperation with District Attorneys' offices. The NC Justice Reinvestment Act of 2011 expanded eligibility criteria regarding felony charges in NC General Statute 90-96 and required that the option be made available to all first-time felony drug possession offenders. Previous law only allowed for felony possession of less than one gram of cocaine and it was at the prosecutor's discretion whether to defer prosecution on any drug offense. The Division of MH/DD/SAS coordinates this statewide initiative through its Justice Systems Team by approving programs to provide DES as well as ensuring the training and certification of DES Instructors.
- Juvenile Justice Substance Abuse Mental Health Partnerships emphasize checking eligibility for and enrolling eligible clients in programs, such as Medicaid and Health Choice (SCHIP in NC), so that SABG and MHBG funds may be used to provide services, supports and other needs that have no other funding source. Juvenile Justice Substance Abuse Mental Health Partnerships serve youth that have been adjudicated delinquent, adjudicated undisciplined or on diversion contracts and are pre-adjudication (see description in #3). The LME-MCO representative on the local team is often a member of the System of Care, Care Coordination, or Community Relations section of that LME-MCO. Operating under System of Care principles and using Child and Family Teams, the Partnerships are particularly designed to address coordination of care, including

transitioning youth from Detention and Youth Development Centers back to the community.

**3. Do the SMHA and the SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?**

The Division of MH/DD/SAS is a signatory of a Memorandum of Agreement with the Division of Adult Correction and Juvenile Justice and the Administrative Office of the Courts. This MOA, initiated in 2000 and recently re-signed, guides local operations and articulates the state's commitment to evidence based treatment and correctional practices.

- Treatment Accountability for Safer Communities (TASC) bridges justice and treatment systems by linking treatment and justice goals of reduced drug use and criminal activity. Objectively balancing public safety and public health, the TASC care management model reduces recidivism and improves justice, treatment and individual outcomes. TASC is organized into four regions which reflect the state's four judicial divisions, consistent with the unified court and statewide probation systems, and is available in all 100 North Carolina counties. Services include: screening and assessment of an offender's need for substance abuse or mental health services; treatment matching to ensure that the offender receives the correct level and type of care; referral and placement with appropriate service providers; and care management through individualized service planning, coordination and monitoring to ensure compliance with criminal justice conditions, progress in treatment and recovery supports.

While the majority of adult justice-involved offenders are not Medicaid eligible, the TASC Standard Operating Procedures outline in the Placement Activities chapter the responsibilities for considering potential funding sources. TASC assists offenders in accessing services through authorization and coordination of services with the LME-MCO and treatment provider requirements. In an effort to maximize treatment resources, all available treatment programs are considered, including those funded by the Department of Public Safety. Through the navigation of services, supports and resources, TASC assists probationers, parolees and post-releases for a healthy and safe return to their communities.

- The Division of MH/DD/SAS has a long-standing partnership with the Judicial Branch and the NC Division of Adult Correction in the development, implementation and on-going support of North Carolina's Drug Treatment Courts. DMH/DD/SAS was an original partner in the development of the program and serves as a legislatively mandated member of the State Advisory Committee and is a signatory to the State Memorandum of Agreement regarding the operation of Drug Treatment Courts. TASC provides the care management for most of the adult treatment courts.
- At the request of the Department of Public Safety, DMH/DD/SAS is participating in a task force to address issues related prison inmates with mental illness. Recommendations are being developed in the areas of: evidence-based correctional mental health treatment practices, the use of restricted housing, re-entry practices related to community-based treatment, safe transportation practices, disciplinary procedures, the use of restraints, training for custody staff

- Driving While Impaired (DWI) Services are specialized services that ensure individuals with DWI convictions complete a clinical substance use assessment, and either substance abuse intervention or treatment before their license may be considered for reinstatement. The services offered include the following levels of care: ASAM Level .05 (early intervention), ASAM Level I (outpatient), ASAM Levels II.1 and II.5 (intensive outpatient and comprehensive outpatient) and various ASAM Level III services (residential and inpatient). DMH/DD/SAS administration of these services includes: policy development; technical assistance; training; oversight of DWI-related evidence-based practices, laws and rules; and authorization and monitoring of DWI-specific service providers. The DWI Services office coordinates with the Division of Motor Vehicles (DMV), NC Department of Transportation, to ensure substance abuse services are verified and communicated to DMV as required for DWI offenses and DWI-related Driving While License Revoked offenses. An automated process for directly entering information regarding treatment compliance into the individual's motor vehicle record at DMV is used.
- DMH/DD/SAS works collaboratively with the Department of Public Safety, Division of Adult Correction and Juvenile Justice (DACJJ), to manage the Juvenile Justice Substance Abuse Mental Health Partnerships. The Partnerships are local teams lead by LME/MCO and JJ staff working together with providers to deliver effective, family-centered services and supports for juvenile justice- involved youth with substance use issues or co-occurring substance use and mental health problems. The Partnerships operate under System of Care principles and ensure the completion of comprehensive substance use and mental health screening and assessments; the provision of evidence-based treatment options; the use of Child and Family Teams; and the involvement of JJ's Juvenile Crime Prevention Councils to support a recovery-oriented system of care. Partnerships are active in 72 out of 100 counties and serve youth that have been adjudicated delinquent, adjudicated undisciplined or on diversion contracts and are pre-adjudication.

**4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?**

Yes, interagency and cross-trainings are provided for behavioral health providers and criminal/justice to support and expand our collaborative work, increase awareness and skills in working across systems and with those who live with serious mental illness and/or mental health challenges, and/or substance use disorders.

- CIT trainings are conducted in all LME/MCOs in North Carolina. Since its inception, as of January 2015:
  - 7,004 law enforcement officers are CIT certified;
  - 352 law enforcement agencies participate in CIT;
  - 755 telecommunicators (dispatchers) have received CIT training; and,
  - 399 emergency medical technicians, paramedics and fire fighter have completed CIT training.

- This past calendar year (2014), an additional 1,094 officers became CIT certified, resulting in 19% more CIT certified officers than existed in 2013. Currently, approximately 33% of all law enforcement officers in North Carolina have completed CIT training. Also, an additional 21 law enforcement agencies began participating in a CIT program in North Carolina in 2014, representing a 6% increase from the previous year in the number of law enforcement agencies participating in a CIT program. In addition, 2014 saw an additional 73 telecommunicators trained in CIT, an 11% increase from the previous year.
- Regional meetings are held one to two (1-2) times per fiscal year which address training needs for behavioral health and juvenile justice. The meetings are held with the local teams of the Juvenile Justice Substance Abuse Mental Health Partnerships. The regional meetings are held to model collaboration at the state level and encourage collaboration at the local level. Training offered through these meetings is determined by the local team's requests and needs and has included topics such as the role of Young Adult Advocates, Increasing Family Engagement, Creating an Effective System of Care for Juvenile Justice-Involved Youth, Care Coordination, Collecting and Using Data to Inform Local Decision Making, and Responsible Information Sharing. Through this juvenile justice initiative, a variety of other trainings are provided to promote the use of evidence-based practices and treatments across the systems, such as the Global Appraisal of Individual Needs, Trauma-Informed Care, Seven Challenges and Brief Challenges. Additional training can be requested by local teams via the technical assistance and training program.
- Through TASC, no-cost online trainings, webinars and face-to-face are available to treatment providers and criminal justice professionals – particularly the Department of Public Safety on topics such as Training for Community Corrections Officers on People with Cognitive Disabilities, Tools of the Trade: Incorporating Science into Practice, Treatment Planning, Trauma-Informed Improves Case Management for Criminal Justice-Involved Clients, Co-Occurring Disorders, Confidentiality and Mental Health First Aid.

DMH/DD/SAS and TASC assisted the Division of Adult Correction in the development of statewide training for probation officers on mental illness. The modules included:

- Module 1 - Using the Risk Need Assessment (RNA) flags to determine the need for a Mental Health referral: reviews Mental Health flag on the RNA, explains why certain questions are asked and explains what the questions mean. Gives suggestions for follow up questions, ways to initiate a conversation with an offender about their answers, how to interpret answers & what steps to take for referrals to TASC & other providers.
- Module 2- Severe & Persistent Mental Illness: explains the term, "Severe and Persistent Mental Illness" or SPMI. Reviews major disorders & their symptoms. Briefly discusses how substance abuse can co-occur with mental illness.
- Module 3- Helping Offenders with Mental Illness Adhere to Medications: discusses the reasons people may not take their medications as prescribed. Gives suggestions for how to talk with offenders about medications & help offenders better adhere to their

medication regimens. Provides a medication chart which lists the major psychiatric medicines and their uses and side effects.

- Module 4- Other MH Disorders: explains personality disorders & focuses more specifically on borderline & antisocial personality disorders. Discusses PTSD & traumatic brain injury.
  - Module 5- Crisis Response: explains what it means for a person to be in crisis, how to tell if someone is in crisis, & how to talk to a person in crisis. Discusses referrals that officers can make when an offender is having a MH crisis & provides web links to resources in their county.
  - Module 6- Recognizing and reducing the negative effects of job-related stress: discusses burnout & vicarious traumatization that probation officers may experience. Describes how to recognize the symptoms & gives suggestions for preventing & addressing burnout & vicarious trauma. Officers are provided with Employee Assistance Program referral information.
- For DWI Services at the ASAM .05 level of care, Prime for Life, an evidence-based curriculum was adopted for individuals who are not diagnosed with a substance use disorder but have been convicted of a single DWI offense. DMH/DD/SAS trains providers in this curriculum. DMH/DD/SAS DWI Services staff provide training through a variety of existing training venues as well.

# Environmental Factors and Plan

## 13. State Parity Efforts

Narrative Question:

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MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.<sup>83</sup>

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.<sup>84</sup>

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. SMHAs and SSAs should collaborate with their state's Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Please consider the following items as a guide when preparing the description of the state's system:

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

*Please indicate areas of technical assistance needed related to this section.*

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<sup>83</sup> <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf>

<sup>84</sup> Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. *Psychiatric Services*. 60(12) 1589-1594

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

## 13. State Parity Efforts

**1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?**

A specific financial amount has not been earmarked, but efforts have been made to host training events for providers and stakeholders to educate them about The Affordable Care Act, Parity, and the changing health care environment.

**2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?**

Yes - the Alcohol and Drug Council of North Carolina received a CMS Navigator grant targeting individuals with mental health and substance use disorders for enrollment. North Carolina had one of the highest number of enrollments of the uninsured in the nation.

**3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?**

Yes – the state has provided resources to provider and consumer organizations to assist them in understanding health insurance options and the requirements of parity.

# Environmental Factors and Plan

## 14. Medication Assisted Treatment

Narrative Question:

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There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40<sup>85</sup>, 43<sup>86</sup>, 45<sup>87</sup>, and 49<sup>88</sup>. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

*Please indicate areas of technical assistance needed related to this section.*

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<sup>85</sup> <http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939>

<sup>86</sup> <http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214>

<sup>87</sup> <http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131>

<sup>88</sup> <http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380>

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

## 14. Medication Assisted Treatment

- 1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?**
- 2. What steps and processes can be taken to ensure broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?**
- 3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately?**

There are two major types of opioid use disorder treatment programs certified by SAMHSA's Center for Substance Abuse Treatment (CSAT), Division of Pharmacologic Therapies (DPT), and registered with the US Department of Justice, Drug Enforcement Administration (DEA), in which medications are utilized for the treatment of opioid use disorder. These are:

- **Opioid Treatment Program or OTP**
  - In North Carolina, there are 50 OTPs across the state providing services to approximately 15,000 patients, of which approximately 19-20 of these programs receive public funding; i.e., Medicaid, state or federal block grant;
  - North Carolina regulations are outlined in 10A NCAC 27G .3600 and "Core Rules" (NC DHSR and DMHDDSAS-SOTA) and the North Carolina Controlled Substances Act and Regulations (DMHDDSAS Drug Control Unit);
  - OTP Medical Directors and Program Physicians (MDs and DOs) are responsible for ordering of medications;
  - RNs are responsible for overseeing the administration of these medications;
  - Physician order and administration only allowed (prescriptions for medications are not allowed);
  - Take-Home doses of methadone or buprenorphine are regulated by federal and state regulations;
  - Counseling and drug testing are required by federal and state regulations;
  - Number of patients is not limited by federal or state regulations;
  - Required counselor to patient ratios: North Carolina's regulations require a minimum of one certified counselor for every 50 patients;

- OTPs must be nationally accredited by an agency such as CARF or The Commission.
- **Drug Abuse Treatment Act of 2000 (DATA 2000) or OBOT**
  - Referred to as Office-Based Opioid Treatment or “OBOT”;
  - Referred to as Buprenorphine Physician Waiver Program;
  - In North Carolina, there are a total of 657 DATA Waiver Physicians, 401 with caseloads of up to 30 patients and 256 with caseloads of up to 100 patients;
  - North Carolina limits its oversight and jurisdiction of DATA 2000 sites to program registration with the DMH/DD/SAS Drug Control Unit;
  - Buprenorphine only;
  - Both dispensing and prescribing are allowed;
  - Take-Home doses of buprenorphine are not federally regulated in DATA 2000 sites;
  - Patient limits are up to 30 patients in the first year of certification, and up to 100 patients thereafter.

Innovations in Medication Assisted Treatment (MAT) include those initiatives and practices advanced by the NC State Opioid Treatment Authority that spearhead comprehensive planning, implementation, and evaluation of MAT practice approaches that improve patient safety, quality of care, and effectiveness of treatment services. Steps and processes that have been taken to ensure broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women, include some of the following:

1. The NC State Opioid Treatment Authority (SOTA) and the Addictions Section coordinate closely with the NC Controlled Substances Reporting System (CSRS) prescription monitoring program, with both entities under the direct administration and management of the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services. Through the direction and support of the SOTA, the CSRS is routinely used by all of the state’s 50 Opioid Treatment Programs as a key clinical tool for patient admissions and continuing care, in assessing patient needs and progress related to patterns of use of prescription medications;
2. The SOTA sponsors a series of monthly and annual initiatives directed at providing OTP Physician, Physician Assistant, and Nurse Practitioner training, coordination and expert consultation resources regarding best clinical practices in opioid treatment;
3. The SOTA sponsors quarterly meetings with OTP Program Directors and staff for the provision of training, coordination and technical assistance regarding OTP policies and practices.
4. The SOTA collaborates closely with the state Medicaid agency, the Division of Medical Assistance, in formulating progressive payment policies and clinical practices for MAT;
5. The SOTA coordinates regularly with the state licensing agency, the Division of Health Service Regulation, in the provision of regular surveyor training and clinical consultation regarding opioid treatment best practices;

6. The Addictions Section and the SOTA, in cooperation with the Quality Management Section, has sponsored the development, implementation, and continuous improvement of the North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS) for tracking the outcomes of patients and programs in the effectiveness of MAT;
7. The Addictions Section, in cooperation with the SOTA and Quality Management Section, has supported the development, implementation, and continuous improvement of the North Carolina Incident Reporting Improvement System (IRIS) for the timely reporting and follow-up of adverse incidents involving Opioid Treatment Program patients;
8. The SOTA provides daily phone consultation and on-site clinical monitoring of licensed programs, and provides technical assistance, consultation and training regarding critical clinical and administrative issues and concerns;
9. The SOTA actively supports and promotes the use of the Center for Substance Abuse Treatment (CSAT) OTP Extranet Exception Request System for daily clinical review and feedback by the SOTA to the state's 50 Opioid Treatment Programs about clinical practices in implementing the federal regulations in 42 CFR Part 8;
10. The SOTA actively supports the work of the North Carolina Harm Reduction Coalition in its efforts to distribute Naloxone Overdose Kits to persons in the community who are at risk for opioid overdose. These efforts have included outreach to OTP patients, their families, treatment professionals, first responders, law enforcement, and others who have regular contact with individuals who are using opioid drugs.

# Environmental Factors and Plan

## 15. Crisis Services

### Narrative Question:

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In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, [Practice Guidelines: Core Elements for Responding to Mental Health Crises](#)<sup>89</sup>,

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports being used to address crisis response include the following:

#### Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

#### Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

#### Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

*Please indicate areas of technical assistance needed related to this section.*

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<sup>89</sup>Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. <http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427>

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Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

## 15. Crisis Services

### **Please indicate areas of technical assistance needed related to this section.**

The state has made significant progress in understanding the need for ongoing development of a continuum of crisis intervention services, and has established the NC Crisis Solutions Initiative in order to manage the related work. Please see [www.nccrisissolutions.org](http://www.nccrisissolutions.org) for specific details. The state is also grateful for a recently approved technical assistance request for consultation around the development of peer operated hospital diversion services. It is in the area of the use of peers throughout the crisis intervention continuum where the state could most use continued outside expertise and consultation.

There are several projects in the Crisis Solutions Initiative that are supported with SABG funds. Most relevant to this section are the following two that are funded with a combination of SABG, MHBG and state funds:

1. Behavioral Health Urgent Care and Facility-Based Crisis Centers – Funding was awarded to four (4) LME/MCOs and provider agencies to establish these alternatives to emergency department utilization and inpatient hospitalization:

- Smoky Mountain Center, in conjunction with RHA Behavioral Health, is developing a 24-hour behavioral health urgent care center to serve youth and adults, and a co-located 16-bed facility-based crisis unit for adults in Asheville, NC.
- CenterPoint Human Services, in conjunction with Monarch, is developing a 24-hour behavioral health urgent care center to serve youth and adults, and a co-located 16-bed facility-based crisis unit for adults in Winston-Salem, NC.
- Eastpointe, in conjunction with Monarch, is renovating an existing 11-bed facility-based crisis unit, adding five beds, as well as developing a co-located behavioral health urgent care center in Lumberton, NC.
- Cardinal Innovations Healthcare Solutions, in conjunction with Monarch, is developing the state's first 16-bed facility-based crisis unit for children and adolescents in Charlotte, NC.

2. Community Paramedic Behavioral Health Crisis Response – Mini-grants were awarded to the LME/MCOs with 11 EMS departments interested in developing behavioral health response skills in their paramedic workforce, and partnerships with their crisis providers that will allow transport of individuals in crisis to alternative non-hospital services.

# Environmental Factors and Plan

## 16. Recovery

### Narrative Question:

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The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see [SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders](#).

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- |  |   |  |
|--|---|--|
| • Drop-in centers                          | • Family navigators/parent support partners/providers | • Mutual aid groups for individuals with MH/SA Disorders or CODs |
| • Peer-delivered motivational interviewing | • Peer health navigators                              | • Peer-run respite services                                      |
| • Peer specialist/Promotoras               | • Peer wellness coaching                              | • Person-centered planning                                       |
| • Clubhouses                               | • Recovery coaching                                   | • Self-care and wellness approaches                              |
| • Self-directed care                       | • Shared decision making                              | • Peer-run crisis diversion services                             |
| • Supportive housing models                | • Telephone recovery checkups                         | • Wellness-based community campaign                              |
| • Recovery community centers               | • Warm lines  |  |
| • WRAP                                     | • Whole Health Action Management (WHAM)               |  |
| • Evidenced-based supported                |   |  |

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Recovery is based on the involvement of consumers/peers and their family members. States should work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

Please consider the following items as a guideline when preparing the description of the state's system:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

*Please indicate areas of technical assistance needed related to this section.*

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

## 16. Recovery

- 1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?**

The state has adopted the SAMHSA definition of recovery and its ten guiding principles. The Recovery Summit held in March 2013 gathered people in recovery and other stakeholders to discuss recovery and make recommendations for recovery integration (mental health and substance use), recovery in practice (clinical services, consumer-operated services) and recovery in policy (managed care, state level). In planning this Summit, the state received technical assistance from SAMHSA's BRSS TACS initiative. The state currently has an Access to Recovery IV (ATR IV) grant project that is being implemented in partnership with Recovery Communities of North Carolina (a non-profit organization that is run wholly by people in recovery).

Additionally, the US DOJ Settlement Agreement calls for ensuring that the state develops a Recovery-Oriented System of Care. It states *"Individuals have access to the array and intensity of services and supports they need to successfully transition to and live in community settings, including supported housing. Such services and support shall: be evidence-based, recovery-focused and community-based."*

Since the inception of the Person-Centered Plan (PCP) in 2006, the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services has supported and encouraged the utilization of person-centered planning and the professional development and growth of all people engaged in the process. Through ongoing evaluation of the PCP, the Division of MH/DD/SAS has monitored the achievement of objectives using quantifiable measures, assessed the effectiveness of particular interventions and policies, as well as monitored public opinion. Subsequently, the PCP format has been redeveloped over the last five years, taking into careful consideration legislative requirements, new priorities that have emerged, innovative approaches that are available and evaluative information that has provided new direction for the planning process.

The Person-Centered planning process supports strengths and recovery and applies to everyone supported and served in the North Carolina mental health, developmental disabilities and substance use disorder system. Person-centered planning provides for the individual with, or the family of a person with, a disability, assuming an informed and in-command role for life planning, service, support and treatment options. The person with a disability, and his/her family, or the legally responsible person directs the process and shares authority and responsibility with system professionals about decisions made.

The policy of the NC Division of MH/DD/SAS is that the Person-Centered Plan (PCP) is the umbrella under which all planning for treatment, services and supports occurs. Person-centered planning begins with the identification of the reason the individual/family is requesting assistance. The plan focuses on the identification of the individual's/family's needs and desired life outcomes. This is not just a request for a specific service(s). The Qualified Professional responsible for the development of the PCP must

assure that the plan captures all goals and objectives and outlines each team member's responsibilities within the plan. This plan is based on what is most important to and for the individual/family as identified by the person/family to whom the plan belongs and the people who know and care about the person. This planning approach therefore supports good action and crisis planning. The plan captures long term and short term outcomes, goals and objectives, including detailed information regarding justification for continuation, modification or termination of a goal and it outlines each team members' responsibilities within the plan.

Person centered planning is based on a variety of approaches, values, principles or "tools" to organize and guide community change and life planning with people with disabilities, their families and friends. All approaches or "tools" have distinct practices, but share common beliefs. The NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services strongly believes that the key values and principles listed below must be evident in the planning process.

The Division of MH/DD/SA Services has recently completed a draft version of its ***Strategic Plan for SFY 15-17*** in which it identified specific priorities and key measures for progress for the next three years. The Division is committed to the following priority areas and initiatives as an effort to continue the advancement of the public system of mental health, developmental disabilities and substance use disorders services:

- Recovery is Possible
- Crisis Solutions Initiative
- Housing Options
- The Resilient Child and Family
- Integration of Behavioral Health and Physical Health Service
- Employment
- Advancing Innovative Technology

The following section, "***Recovery is Possible,***" has been excerpted from the plan, as it is still in draft form, but is illustrative of the Division's desire and efforts to move more formally towards a recovery-oriented system of care.

**WE SUPPORT THE IMPLEMENTATION OF A STATEWIDE RECOVERY-ORIENTED SYSTEM OF CARE (ROSC) FOR INDIVIDUALS WITH NEEDS RELATED TO SUBSTANCE USE TO PROMOTE SELF-DIRECTED APPROACHES TO SUPPORT SUSTAINED RECOVERY AND IMPROVED HEALTH, WELLNESS AND QUALITY OF LIFE BY:**

**Objectives:**

1. Providing access to a continuum of recovery and resiliency supports in the community.
2. Developing system capacity to support Recovery-Oriented Systems of Care including financing, policy enhancement, workforce development, technology, system partnerships and other identified resources.
3. Expanding Screening, Brief Intervention and Referral to Treatment (SBIRT) to support the integration of substance use and primary care services.
4. Monitoring the system for improved outcomes for individuals who are striving to attain and sustain recovery that include: abstinence, education, employment, reduced criminal justice involvement, stable housing, improved health and social connectedness.
5. Supporting Recovery-Oriented Systems of Care in all LME/MCO catchment areas.

6. Increasing screening, assessment, service coordination and treatment for individuals involved in the criminal justice and juvenile justice system.
7. Developing strategies to identify individuals eligible for new insurance options.
8. Developing faith based initiatives to support individuals in their communities.
9. Expanding Access to Recovery services to increase availability to recovery support services.
10. Providing Recovery Messaging training to DMH/DD/SAS staff.

The Plan also contains Strategies for attaining the Objectives listed above, as well as Key Measures to assure we are making the desired progress to fully transforming the system of care for individuals with or at risk of substance use disorders.

On May 13, 2014, Governor Pat McCrory signed Executive Order 52, the ***“Establishment of North Carolina Governor’s Substance Abuse and Underage Drinking Prevention and Treatment Task Force,”*** which is provided as an attachment. One of the initiatives of this Task Force includes utilization of SABG funds for collegiate wellness and recovery programs. The funding, which was continued again this state fiscal year, provides for the enhancement and/or establishment of wellness and recovery support services and programming on six (6) college campuses selected by Governor McCrory, which are as follows:

- East Carolina University
- NC A&T
- UNC-Chapel Hill
- UNC-Charlotte
- UNC-Greensboro
- UNC-Wilmington

Each campus submitted a proposal for development and/or enhancement of recovery activities, programming and services. At the end of the first partial year of funding, campuses had successfully implemented the following:

- Hiring of professional staff, graduate assistants and students in recovery to provide various services, including clinical assessments and treatment, marketing, outreach, education, prevention and recovery support services;
- Identifying dedicated space in order for students in recovery to have a place to socialize, study, host mutual aid meetings, etc.;
- Implementing “sober-focused” matching for roommates, as well as sober-living housing opportunities;
- Providing opportunities for designated staff to attend various trainings and conferences, such as the National Collegiate Recovery Conference;
- Hosting sober-living activities, particularly during times typically associated with increased alcohol consumption.

Designated staff from the Division will continue to work with these campuses this fiscal year on continuation strategies and planning, as well as enhancements to current services and programming.

Another initiative of Governor McCrory is the Crisis Solutions Initiative, which has been mentioned previously in the Crisis section of this application. A component of the Crisis Solutions Initiative is also the establishment of recovery community centers. Funding from the SABG has been identified to support the development of four to six recovery community centers in areas of North Carolina that have

a strong recovery movement and community support for the creation of such. The Division has contracted with Recovery Communities of North Carolina, a community organization comprised of individuals in recovery to develop methodology to solicit and select proposals from communities, and guide each community as it opens its center.

**2. How are treatment and recovery support services coordinated for any individual served by block grant funds?**

The Division received its first Access to Recovery grant last October, 2014. It provides the infrastructure to implement a new initiative that adds recovery support services to the existing treatment provider community, as well as supports the development of a more robust recovery-oriented system of care.

The ultimate goal of this initiative is to strengthen the ability of individuals with substance use disorders to sustain their recovery. The project will specifically focus on services and supports that increase the ability of individuals to lead healthy and productive lives, build up resilience and enhance the system's capacity. The program initially focused on Wake and Durham counties, with quick expansion into Robeson, Sampson and Johnston counties, but over the course of the grant, will move to a broader rollout.

Funds from this grant are focused on the provision of vouchers for recovery support services, which are often integral to an individual's sustained recovery. Formal, clinical treatment services are readily available to youth and adults with no other source of coverage in North Carolina. It is a function of the Access to Recovery Service Coordinators to assume the role of care coordinators and work with individuals who are in treatment and also receiving vouchers for recovery support services.

**3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations and families/significant others?**

A statewide Peer Support Services policy has been developed to ensure there is consistent across the state and it is recovery-focused and evidence-based. The stakeholder workgroup includes Certified Peer Support Specialists, peer support providers and other advocates.

As of 08/21/2015 there are a total of **1883** Certified Peer Support Specialists. See the attached chart following this section for specific demographics.

Peer Supports have been added to the Medicaid State Plan Amendment and are now included as a Medicaid 1915 (b)(3) service. In addition, as part of the Settlement Agreement with the U.S. Department of Justice, Peer Supports have been included in a variety of new functions. Certified Peer Support Specialists have been hired as "In Reach" specialists for assertive engagement of individuals living in adult care homes and hospitals. They are required staff for ACT teams. They will be hired in Supported Employment programs as "Employment Peer Mentors" and as "Tenancy Support Specialists" to help people gain and maintain independent living skills in order to better assure community integration.

**4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program or standards for peer-run services?**

The state provides and supports training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers through the Consumer Empowerment Team and through training contracts with consumer and family organizations, universities and Area Health Education Centers.

This is also supported through the Division's contract with the Governor's Institute on Substance Abuse and is also operationalized through trainings offered on recovery-oriented systems of care through the Behavioral Healthcare Resource Program, UNC School of Social Work.

**5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches and services within the state's behavioral health system?**

To facilitate guidance in determining the future evidence-based services and supports that will be provided through North Carolina's public system, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services developed the North Carolina Practice Improvement Collaborative (NC PIC). The NC PIC is comprised of representatives of all three disabilities and meets thrice yearly to review and discuss current and emerging best practices for adoption and implementation across the State.

The mission for the NC PIC is to ensure that all North Carolinians will receive excellent care that is consistent with scientific understanding of what works whenever they come into contact with the DMH/DD/SAS system. Research has found that even some of the most popular and well disseminated programs are not evidence based and in fact can be counterproductive. The provision of quality services and supports involve fidelity to proven intervention models.

Through its contract with the Division, NC PIC conducts literature reviews and provides critical thinking and analysis to specific questions regarding trends, best practices and implementation of services in the publicly funded system. They are tasked with building on on-going research, providing analysis and promoting information that will aid North Carolina providers in implementing high-fidelity, evidence-based and best practices. They have a specific focus on the development of a state-wide systems of care related to recovery supports and services and trauma-focused care.

PIC meetings must be conducted regularly on topics endorsed by the Division. These conferences must focus on implementation and fidelity monitoring strategies. Examples of recent trainings include: ***Addressing the Needs of Our Military Families in North Carolina, The Future of Crisis Response in North Carolina*** and ***Early Identification and Treatment of First-Episode Psychosis***.

**6. Describe how individuals in recovery and family members are involved in the planning, delivery and evaluation of behavioral health services (e.g., meetings to address concerns of**

**individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).**

DMH/DD/SAS has developed policy DO 112, *Consumer and Family Member Volunteer Appointment to DMH/DD/SAS Workgroups and Committees*. This policy was developed so that all interested individuals have an equal opportunity to participate in the policy and decision making bodies of the system. Notices of all volunteer opportunities are posted on the Division website at <http://www.ncdhhs.gov/mhddsas/services/advocacyandcustomerservice/volunteer.htm> and are also sent out to a mass mailing of all local Consumer and Family Advisory Committees (CFACs) and other grass roots organizations. This policy was developed due to the desire of DMH/DD/SAS to have consumers and family members on all internal and external workgroups related to policy development. Any time a DMH/DD/SAS committee or workgroup needs assistance locating a consumer or family member for participation in their group, this policy is followed. Also LME/MCOs are encouraged to utilize either their local consumer and family advisory committee members or other individuals in recovery to assist in planning at the local level.

**7. Does the state support, strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks and recovery-oriented services?**

In 2001, the General Assembly enacted Mental Health System Reform legislation that also required the state to develop a state plan. The first guiding principle of the 2001 State Plan reads "Treatment, services, and supports to consumers and their families shall be appropriate to needs, accessible and timely, consumer-driven, outcome-oriented, culturally- and age-appropriate, built on consumer's strengths, cost-effective, and reflective best practices."

The State provides funding and supports for existing consumer, family and youth organizations to expand self-advocacy, mutual aid programs, support networks and recovery oriented services. Peer Support is included in at least three of the State's reimbursable service definitions: Assertive Community Treatment Team, Community Support Team, and Social Detoxification. In addition, several Local Management Entities/Managed Care Organizations have promoted recovery-oriented services and are reimbursing for these services through alternative service definitions and through PATH funds.

In 2006, the State developed and implemented the NC Certified Peer Support Specialist program (NCCPSS) to train and certify peer specialists. Currently, there are over 1800 Peer Support Specialists (CPSS) in the state. Peer specialists have been hired by providers and LME/MCOs to provide peer support and assist in various projects to promote advocacy and empowerment of consumers and family members. The state has also developed a web-based course designed to assist managers and supervisors wishing to enhance their skills supervising NC Certified Peer Support Specialists. All approved courses under this program are guided by recovery principles, national research and best practice reports (e.g. Pillars of Peer Support), and the evidence-based practice delineated in SAMHSA's consumer-operated services toolkit.

In August 2012, the state signed a Settlement Agreement with the U.S. Department of Justice to develop and implement effective measures to prevent inappropriate institutionalization of individuals with

SMI/SPMI. This includes the development of (1) permanent supportive housing, (2) transition protocols that include new “Transition Coordinators” and “In-Reach” staff providing engagement and linkage, and (3) community wrap-around supports and services such as ACT, Peer Support, Supported Employment, and Tenancy Supports. The state is engaged in workgroups with stakeholders, including consumers and families, to receive input in the planning process and ensure services are recovery-focused and evidence-based. Peer Supports have been included in a variety of new functions as a result of the settlement implementation plan. Certified Peer Support Specialists will be hired as “In Reach” specialists for assertive engagement of individuals living in adult care homes and hospitals. They are required staff for ACT teams. They will be hired in Supported Employment programs as “Employment Peer Mentors” and as “Tenancy Support Specialists” to help people gain and maintain independent living skills in housing.

Peer Supports have been added to the Medicaid State Plan Amendment and are now included as a Medicaid 1915(b)(3) service. Previously, Peer Support services were being paid mainly through alternative service definitions with limited state funds. Peer Supports are paid through Medicaid funding across all LME/MCOs as they expand managed care.

Additionally, the US DOJ Settlement Agreement calls for ensuring the state develops a Recovery-Oriented System of Care. It states “Individuals have access to the array and intensity of services and supports they need to successfully transition to and live in community settings, including supported housing. Such services and support shall: be evidence-based, recovery-focused, and community-based.” becomes a shared value of individuals we serve, service providers and administrators.

It is important to note that transition age youth do not always relate to the idea of “recovery.” The system and premise North Carolina embraces for children, youth and families is that of building resilience; some youth better identify with ‘pre-recovery.’ To this end, the State has provided funding to North Carolina Families United (NCFU), the statewide family organization, to produce a training curriculum for families and service providers on how to implement system of care and how to choose service providers for families with SED and their families. With support from the block grant, NCFU has funded and trained Family Support Partners and specialists. NCFU works with NAMI in NC as well as community mental health associations and Family Support Network organizations in an effort to unify and strengthen work in this arena. Each of these entities along with other community and state organizations and agencies participate in the NC Collaborative for Children, Youth and Families, and statewide interagency forum for promoting the tenants and practices that further strengthen an effective System of Care in North Carolina. Partnerships with families and youth leaders and those in transition is vital to the success and sustainability of an SOC that promotes strengths and builds resilient children, youth and families, especially those living with or at risk for experience behavioral health challenges.

In addition, the State has legislation requiring consumer and family participation at the state and local level. NC General Statute 122C-1701 State Consumer and Family Advisory Committee (SCFAC), enacted in 2006 requires consumer and family member participation at the state and local level. The SCFAC functions as a consumer advisory board to DMH/DD/SAS. A local Consumer and Family Advisory Committee (CFAC) is similarly required at each LME/MCO to review, comment on and monitor the implementation of the local business plan; identify service gaps and underserved populations; make recommendations regarding the service array and monitor the development of additional services;

review and comment on the LME/MCO programs budget, participate in quality improvement measures and performance indicators; and submit to the State CFAC findings and recommendations regarding ways to improve the service delivery system.

The Substance Abuse Block Grant's Advisory Committee, comprised of members from the Substance Use Disorder Federation, which consists of providers, and individuals in and allies of recovery that assists in formulating the SABG plan, including determining targets for the block grant indicators. The Advisory Committee and the Federation also review State plans and provide advice and recommendations to the State on service delivery issues. Several of the Federation members also sit on the State Consumer and Family Advisory Committee (SCFAC) and the LME/MCO local Consumer and Family Advisory Committees (CFACs).

The state has supported the development and growth of Person Centered Thinking (PCT) and Person Centered Plans (PCP). All treatment plans must include a completed PCP for each individual receiving care. Consumers and family members are entitled to participate in their own individual plan of care. Advocacy and Customer Service staff has educated consumers and family members of their rights and opportunities to advocate for services.

The state has provided technical assistance to LME/MCOs so that they can conduct Crisis Intervention Training (CIT) in their local communities in order to educate law enforcement officers. In addition, local CFAC members participate on the CIT panel presenting information relevant to dealing/living with persons with disabilities.

The State sponsors meetings that identify individual and family members' issues and needs regarding the behavior health system and developed a process for addressing these concerns. DMH/DD/SAS developed policy DO 112 Consumer and Family Member Volunteer Appointment to DMH/DD/SAS workgroups and committees. This policy was developed so that all interested individuals have an equal opportunity to participate in the policy and decision making bodies of the system. Notices of all volunteer opportunities are posted on the Division website and also sent out to a mass mailing of all local CFACs, SCFAC and other grass root organizations. Members of the Consumer Empowerment Team (CET) of the Division attend all local CFAC meetings and have developed connections with individuals and local advocacy organizations in each of the catchment areas. CET members routinely inform their individual contacts about opportunities for inclusion and participation in the ongoing development and monitoring of mental health, developmental disability, and substance use service system.

Information on local support groups, advocacy organizations at the state and federal level, and various self-help options are posted on the website. DHHS and DMH staff meet monthly with advocates to discuss ongoing issues across the state. The State has provided funding for Recovery Education Centers (REC) that focus on evidence-based practice curriculums designed to build recovery skills or wellness recovery practices. The Division has funded two consumer-run organizations which teach advocacy skills and provide ongoing support to their members: The NC Mental Health Consumers Organization and the NC Association of Self Advocates. Some LME/MCOs use state dollars to provide funding and support to local NAMI Chapters and NC First in Families to provide ongoing education and support to their members. Some LME/MCOs also provide meeting space and other types of support for 12-step programs and other peer support groups. The Consumer Empowerment Team has begun to present information to local community groups on how to access services in their local communities. The Consumer Empowerment Team will further continue to expand their contact beyond LME/MCO CFACs

to grass roots organizations, faith based organizations and other community groups to develop a large network of advocates across the state.

- 8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.**
- 9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity and other co-morbid health conditions.**

The Division has promoted integrated care efforts of behavioral health providers for several years. It has also promoted the use of “Evaluation and Management” procedural codes that call for the provision of health screening and risk assessments for obesity, high blood pressure and other conditions often associated with long-term use of medications frequently prescribed for serious mental illnesses.

The Division of Medical Assistance has recently clarified the inclusion of tobacco cessation programs by LME/MCOs and can be billed by physicians and physician extenders. Physicians, nurse practitioners and physician assistants can use codes 99406 and 99407 for this purpose.

The NC DHHS screens, assesses and provides treatment options for smoking and other unhealthy behaviors at all three state psychiatric facilities. In 2011, NC became one of SAMHSA’s Leadership Academies for Wellness and Smoking Cessation. Through this effort, a diverse group of stakeholders including treatment providers came together to create an action plan for reducing the prevalence of tobacco use among behavioral health consumers. The partners adopted the target to reduce smoking prevalence among the general population to 16%; adult mental health clients to 39%; and adult substance abuse clients to 39%, each by end of year 2016. This initiative, named *Breathe Easy NC*, is working on the following strategies: 1) Facilities, 2) Provider Education and Quitline, 3) Consumers and Community, 4) Policy Systems Performance Measures and Outcomes and 5) Sustainability. Each strategy group is working on specific tasks to be completed over the next year. The stakeholders meet annually in September to assess progress in achieving its established targets. The Facilities and Provider Education/Quitline committees have been working to offer nicotine dependence training and 5 A’s Training for providers. They also have presented on tobacco dependence treatment in conferences such as the Addiction Professionals of NC and webinars. The Division has also been routinely promoting the use of the Quitline NC to providers across the state not only to assist their clients with quitting their tobacco use, but for their staff as well.

The Division has been actively working with the Division of State Operated Health Facilities (DSOHF) and the Division of Public Health to support an increase in nicotine dependence treatment in state facilities (psychiatric hospitals, developmental centers, alcohol and drug abuse treatment centers), as well as in other public and private treatment facilities. DSOHF, in collaboration with the University of North Carolina at Chapel Hill, received a grant in 2011 from the Pfizer Medical Group to implement a Quality Improvement Project with two treatment facilities to integrate nicotine dependence treatment into their systems. With support from DPH, an online Tobacco Dependence Training Program was created that addresses tobacco use treatment integration into chemical dependence services; assessment diagnosis and pharmacotherapy; behavioral interventions; treatment planning and practical applications.

**10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?**

The State Mental Health Agency has a housing plan to address the housing needs of persons with serious mental illness so that they live in the least restrictive setting possible. The Community Mental Health Team in the DMH/DD/SAS has two housing specialists on its staff, as well as an additional housing coordinator who works full-time on finding and increasing housing opportunities for people with mental health and/or substance use disorders and/or who are in need of developmental disability services.

One of these staff oversees the Division's contract with Oxford Houses, Inc. Oxford Houses help fill the gap for peer operated recovery homes and provide a level of support not found in other settings. Specifically, this model provides for community-based, integrated housing that is safe, affordable and drug-free, with the support of peers in recovery and Oxford House staff. It also encourages utilization of other services and supports in the community that promote recovery and self-sufficiency. As of June 2015, there were 176 houses in North Carolina as follows:

- Men's Houses 128 (975 beds)
- Women's Houses 45 (352 beds)
- Women's and Children Houses 3 (6 beds)

With the 176 houses, Oxford House has the capacity to assist more than 1,333 North Carolinians recovering from substance use disorders. House members split house expenses, which average \$90.00 - \$125.00 per person per week. The Division has continued to work successfully with Oxford House, Inc. and allocated \$450,000 in federal funds to finance the contract with Oxford House, Inc. The major purpose of this contract is to support Oxford House in opening new houses and to provide technical assistance and support for the establishment of these self-run, self-supported recovery homes throughout the State of North Carolina by the end of the contract period.

Oxford House, Inc. also maintains the North Carolina Recovery House Revolving Loan Fund by administering the application, administration and repayment of start-up loans made to eligible applicants of eight or more recovering individuals. This revolving loan fund provides up to \$4,000 per house to use to cover start-up costs, which is an essential resource for many recovering individuals who do not have sufficient financial means for securing safe, affordable housing on their own. One of the shared current initiatives focuses on identifying housing specifically for individuals with a substance use disorder who are re-entering the community after incarceration. Funding has also been provided to Oxford House to implement peer-led case management services for those newly entering an Oxford House to aid those individuals in continued access to care, mutual aid groups and other resources necessary for sustained recovery.

Each LME/MCO has its own full-time housing coordinator working on the same tasks. DMH/DD/SAS participates in housing programs of the state such as the State Department of Housing and Community Development, the State Housing Finance Agency, and Local Housing Authorities. The State Housing Trust Fund, funded with \$9.6 million in recurring funds by the NC General Assembly, provides support

for supportive housing, home ownership, construction, rental apartments, new construction, and rehabilitation. It also participates in a variety of federal housing programs such as those funded by the US Department of Housing and Urban Development. The state is currently engaged in a project to transition people with mental illness living in adult care homes to more appropriate settings where they will receive better services and supports.

The State of North Carolina entered into a settlement agreement with the United States Department of Justice (USDOJ) on August 23, 2012. The purpose of this agreement is to assure that persons with mental illness are allowed to reside in their communities in the least restrictive settings of their choice. This Agreement is intended to ensure the state will meet the requirements of the ADA, the Rehab Act, and the Olmstead decision, which require that services offered to individuals with disabilities shall be provided in the most integrated setting appropriate to meet their needs. While this settlement agreement was designed to address specific Olmstead issues, it is the desire of the Division that this will provide the infrastructure for a more comprehensive housing response and plan. An integral component of the agreement includes the utilization of peers as "In Reach" Specialists who provide in reach services to individuals residing in adult care homes who may desire more independent housing options. These In Reach Specialists, typically either directly employed by the LME/MCOs or under contract through a provider agency, will play a vital role in transitioning individuals to less restrictive settings.

For the past several years, each LME/MCO has had a contractual requirement to have at least one FTE designated as the Housing Specialist for their catchment area. The responsibilities of the Housing Specialist, which encompass all disability groups, include the following broad categories:

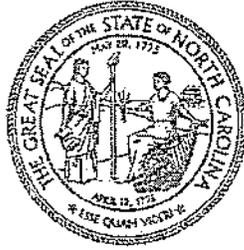
- Serve as Lead Agency for the Targeting Program and the Housing 400 Initiative to ensure DMH/DD/SAS tenants have the support services they need in addition to affordable housing;
- Actively participate in the local Continuum of Care (US Department of Housing and Urban Development housing programs that provide units for DMH/DD/SAS consumers who are homeless) by engaging in activities that support the expansion of housing opportunities to ensure DMH/DD/SAS consumers have access to Continuum of Care housing units;
- Develop and annually update a Strategic Housing Plan that includes an inventory of local, existing housing for DMH/DD/SAS consumers; the housing needs of DMH/DD/SAS consumers; strategies for filling the gap between existing housing and housing needs; barriers to implementing those strategies; and means for assessing implementation of the Strategic Housing Plan;
- Participate in the quarterly meetings for Housing Specialists that are offered by DMH/DD/SAS;
- Educate and be a resource for MH/DD/SAS professionals, advocates, consumers, families and service providers in identifying, accessing and maintaining affordable housing, regarding the NC Landlord-Tenant and Fair Housing laws and on negotiating reasonable accommodations;
- Develop a positive working relationship with local public housing authorities and HUD Section 8/Housing Choice Voucher administrating agencies to improve access and increase the supply of these resources;

- Establish partnerships with other local, affordable housing and MH/DD/SAS advocates to improve access and increase the supply of resources for MH/DD/SAS consumers;
- Develop and maintain an internal wait list for consumer referrals to housing resources that have referral relationships with the LME/MCO; and
- Work with other agencies to identify and secure housing and support services funding opportunities from private, city, county, state and federal sources.

Many of the above responsibilities speak to systemic progression. In addition, each LME/MCO has the capacity to develop alternative service definitions to better meet specific needs of their geographic areas. For example, some LME/MCOs have developed service definitions that provide a reimbursement mechanism for contracted providers to maintain contact and provide supportive services to individuals (that do not meet medical necessity criteria for higher levels of care) in independent housing settings. This helps assure that individuals have the necessary supports in place to remain in less-restrictive settings.

**11. Describe how the state is supporting the employment and educational needs of individuals served.**

North Carolina has supported the Individual Placement Support- Supported Employment (IPS-SE) Evidence Based Practice for adults with severe mental illness and co-occurring mental health and substance use disorders since 2013. There are currently 34 teams providing the service across the state, and DMH/DD/SAS continues to partner with LME/MCOs to identify gaps in services and possible solutions to ensure individuals across the state can access this service. DMH/DD/SAS staff are primarily responsible for completing fidelity reviews on all teams, developing fidelity action plans, and providing training and technical assistance to support providers in implementing this model. DMH/DD/SAS actively partners with the Division of Medical Assistance and the Division of Vocational Rehabilitation to ensure that fidelity based practice is supported by all divisions. DMH/DD/SAS also partners with stakeholder groups, including: NAMI, NC ACT TA Center and Employment First NC to increase awareness of IPS-SE across the state, and ensure that these stakeholder groups have information to advocate for this service. Finally, North Carolina is a member of the Dartmouth IPS Learning Collaborative, which provides technical assistance and support not only from other states and countries implementing this service, it provides a direct means of communication with the organization that developed and researched this model.



# State of North Carolina

**PAT McCRORY**

GOVERNOR

May 13, 2014

EXECUTIVE ORDER NO. 52

**ESTABLISHMENT OF NORTH CAROLINA GOVERNOR'S SUBSTANCE ABUSE  
AND UNDERAGE DRINKING  
PREVENTION AND TREATMENT TASK FORCE**

**WHEREAS**, alcohol and other substance abuse at an early age are critical risk factors for lifelong physical and mental health problems and the development of healthy behaviors at an early age promotes lifelong wellness; and

**WHEREAS**, substance abuse is a major public health problem that costs the citizens of North Carolina billions in medical care, work time lost, law enforcement and criminal justice response and pain and suffering; and

**WHEREAS**, underage drinkers consume nearly 10% of all alcohol sold in North Carolina and binge and underage drinking are the third leading preventable cause of death in the United States among youth; and

**WHEREAS**, the State of North Carolina has a responsibility to raise awareness and reduce the prevalence of substance abuse and to increase treatment and recovery services for individuals battling substance abuse; and

**WHEREAS**, the State of North Carolina is working to mobilize efforts with community partners and individuals statewide to implement strategies designed to reduce instances of substance abuse including underage drinking, binge drinking, illegal drug use, abuse of prescription drugs and to increase treatment and recovery services; and

**WHEREAS**, the ABC Commission is committed to developing and implementing programs to address alcohol and substance abuse among underage persons; and

**WHEREAS**, the University of North Carolina System is committed to developing collegiate wellness programs to address substance abuse issues among collegians;

**NOW THEREFORE**, pursuant to the authority vested in me as Governor by the Constitution and the laws of the State of North Carolina. **IT IS ORDERED:**

Section 1. Establishment.

The North Carolina Governor's Substance Abuse and Underage Drinking Prevention and Treatment Task Force is hereby established (hereinafter the "Task Force").

## Section 2. Task Force.

The Task Force shall consist of twenty (20) members, each appointed for a term of two years. All members shall be appointed by the Governor and shall serve at the pleasure of the Governor. The Governor's appointees shall include:

- i. The Chair of the ABC Commission who shall also serve as co-chair;
- ii. The Secretary of The Department of Public Safety who shall also serve as co-chair;
- iii. A representative from UNC General Administration;
- iv. A representative from the North Carolina Independent Colleges and Universities;
- v. A representative from the NC Community Colleges System Office;
- vi. A member of the NC State Board of Education;
- vii. A representative from one of the UNC system campuses;
- viii. A representative from a private, nonprofit college or university in North Carolina;
- ix. A representative from NC DHHS;
- x. A representative from the Office of the Governor;
- xi. A representative from ALE;
- xii. A representative from a local law enforcement agency;
- xiii. A representative from an alcohol or substance abuse treatment organization;
- xiv. A representative from an alcohol treatment organization with an emphasis on youth treatment;
- xv. A representative from the NC Department of Transportation, Division of Motor Vehicles;
- xvi. A representative from the wholesale alcohol industry;
- xvii. A representative from the Administrative Office of the Courts;
- xviii. An individual in recovery;
- xix. Two current students, at least one of whom is under age 21.

Members shall serve without compensation.

## Section 3. Meetings.

- (a) The Task Force shall meet quarterly and as often as called by the Chair to carry out the Task Force's purpose. The Chair shall set the times and locations of all meetings.
- (b) For the purpose of conducting business, a quorum of the Task Force shall consist of seven members.

## Section 4. Purpose.

- (a) The Task Force shall receive, no later than August 1, 2015:
  1. A comprehensive report from the ABC Commission regarding its efforts to combat underage drinking and substance abuse, including a detailed report of the use of State appropriations and ABC Commission funds to facilitate its effort;
  2. A comprehensive report from the six pilot campuses on the use of appropriated funds and the effectiveness of their prevention efforts; and
  3. A comprehensive report from the Center for Safer Schools regarding its efforts to combat underage drinking and substance abuse.
- (b) The Task Force shall prepare and submit to the Governor and the General Assembly by October 1, 2015 a comprehensive plan for effectively addressing (1) the underage sale and use of alcohol and drugs, (2) risky behaviors and substance abuse among collegians, (3) and the provision of treatment and recovery services for individuals struggling with substance abuse. The Task Force shall review and consider the reports outlined in Section (a) above in the development of the report to submit to the Governor and General Assembly no later than October 1, 2015.
- (c) The Task Force shall, in preparation of the comprehensive plan, adapt existing national efforts for application to North Carolina and/or create new awareness program elements designed to combat substance abuse in North Carolina. The Initiative's recommendation shall be actionable, measurable, and able to be replicated in local communities and/or public and private colleges.
- (d) The Task Force may convene workgroups to aid the Task Force in its mission.

Section 5. Staffing.

The ABC Commission shall provide administrative and staff support to the Task Force. The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse shall provide additional support as necessary and as determined by the Co-Chairs.

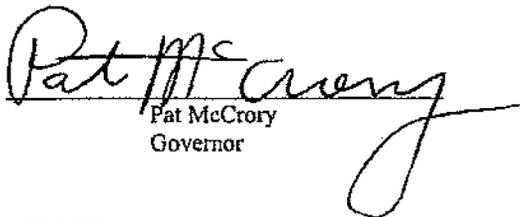
Section 6. Cooperation of State Agencies.

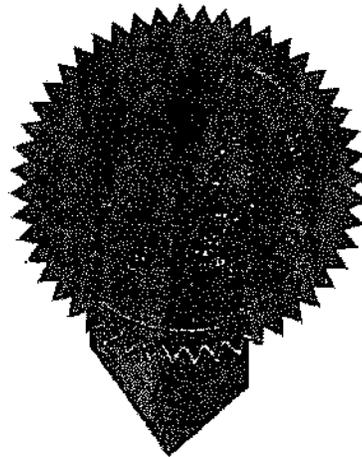
All cabinet agencies and boards, commissions, councils and offices, now existing and hereafter established, which are administratively housed in the cabinet agencies or the Office of the Governor, shall cooperate with the Task Force in the development of the plan and recommendations to the Governor for actions that are deemed necessary under Section 4 of this Order. The Board of Governors of the University of North Carolina System, the State Board of Community Colleges, local boards of education, and the Council of State agencies are encouraged and invited to participate in this Executive Order.

Section 7. Effect and Duration.

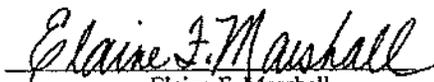
This Executive Order is effective immediately and shall remain in effect until December 31, 2015, pursuant to N.C. Gen. Stat. § 147-16.2, or until earlier rescinded.

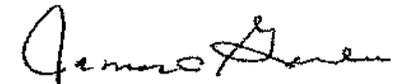
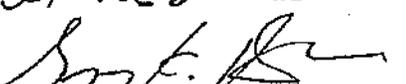
IN WITNESS WHEREOF, I have hereunto signed my name and affixed the Great Seal of the State of North Carolina at the Capitol in the City of Raleigh, this thirteenth day of May in the year of our Lord two thousand and fourteen, and of the Independence of the United States of America the two hundred and thirty-eight.

  
Pat McCrory  
Governor



ATTEST:

  
Elaine F. Marshall  
Secretary of State


# Environmental Factors and Plan

## 17. Community Living and the Implementation of Olmstead

Narrative Question:

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The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in [Olmstead v. L.C., 527 U.S. 581 \(1999\)](#), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office of Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

*Please indicate areas of technical assistance needed related to this section.*

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

## 17. Community Living and the Implementation of Olmstead

### 1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services and employment services.

North Carolina's Olmstead plan includes a comprehensive supportive community based housing initiative. Through a housing first approach, individuals that would like to live in the community with supports, can be placed in homes without the requirement to demonstrate "readiness." We have worked with our partners at the LME/MCO level and their contracted providers to meet individuals "where they are at" and assist them with skills necessary to live outside of an institutional setting.

North Carolina has a few projects identified to assist individuals with the expense of living in the community. In addition to utilizing other existing subsidized housing programs such as Housing Choice Vouchers, Shelter Plus Care, and SHP programs, North Carolina offers the Targeting Unit program. This is a tax incentive program, where in exchange for a tax adjustment, developers of new housing units dedicate at least 10% of their project to low income individuals. This is the project on which the HUD 811 project was based. Individuals can also receive rental assistance through the Keys program funded through the NC Housing Finance Agency. A new program call Transitions to Community Living assists an identified population with leaving state hospitals or adult care homes (ACH), and transitioning back into the community.

Key to the success of an individual remaining in the community is the type of supports provided. These are identified with the individual through the Personal Care Plan process. North Carolina sets up services for individuals by way of our LME/MCO system. Each LME/MCO is responsible for a specific catchment area and contracting with providers to meet the presenting need. For supportive housing some key services include ACT, Community Support Teams and Peer Supports. ACT services are currently being reviewed to make sure they meet fidelity. This is being done by reviewing them in the Team ACT standards. Peer specialists are certified through an intensive program developed by the state with its university partners. In addition to support services, individuals are assisted with community living by supported employment. These programs are also being review for fidelity on the Dartmouth model.

### 2. How are individuals transitioned from hospital to community settings?

Individuals are transitioned out of hospitals through an In Reach and Transition model. Each LME/MCO has received state funding to provide staff to first identify individuals that want to live in a more independent situation in the community. Once those individuals are identified, then the Transition Coordinator meets with the individual to begin the planning process. Everything from housing selection, to services, to furnishings, is reviewed and set up in the individual's plan. Transition Coordinators are trained in the process to assist individuals out of the institutional setting and have a full knowledge of housing options available.

**3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead decision of 1999?**

To assist with meeting the Olmstead decision, North Carolina is working on a state wide housing plan. This will encompass all aspects of supportive housing. A special focus will be on developing new and additional housing resources. In a state that is well over 60 percent rural, housing options that meet Federal level inspections can be difficult to identify. Through partnering with the Housing Finance Agency, efforts are being made to determine how to encourage more property owners to participate with stipend type programs. Efforts are being put in place to see if incentives can be identified to correct inspection issues in exchange for an agreed upon lease period. Lastly, discussions on how to assist those individuals with poor credit or criminal backgrounds move beyond those barriers are taking place.

In addition to state level plan, each LME/MCO is funded by state dollars to employ a Housing Specialist in their organization. Those housing staff will be required to build off the state plan and develop a housing plan that reflects the issues in their catchment area. It should include how the housing staff will assist in developing housing opportunities. This includes participation on and in their local CoCs, networking with local housing authorities, and being a contact person for their local Targeting Unit program.

**4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved.**

North Carolina is involved with a settlement with the Department of Justice over adults with severe mental illness (and often co-occurring substance use) residing in adult care homes. The settlement was reached in the fall of 2012. It is an eight year plan to move a total of 3000 individuals into supportive community based housing. At this time the state is entering the fourth year of the eight year settlement.

The overall plan is to assist two thousand individuals out of ACHs and an additional one thousand individuals who are residing in a state facility without appropriate housing and are at risk of entering an adult care home. In both the adult care home and hospital setting, LME/MCO staff start by providing "in reach" to individuals in these settings. Here certified peer specialists meet with individuals and explore what type of living situation they would be interested in. If an individual requests assistance with moving back to the community, In Reach then activates the individual in the Transitions to Community Living (TCL) project and the Transition Coordinator leads a team to support the move back to the community.

Through extensive planning that includes housing, services and benefits, plans are identified and individuals are moved to the community. In order to make the housing affordable, the state has implemented its own voucher program and the individual will only pay 30% of their income towards housing.

LME/MCOs are currently working with the state to make sure contracted providers of ACT and Supported Employment are operating programs that meet fidelity for that service model. Any individual

participating can refuse services, however, everyone will receive at least Tenancy Supports as a means of providing well-being checks in the community.

# Environmental Factors and Plan

## 18. Children and Adolescents Behavioral Health Services

### Narrative Question:

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MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.<sup>90</sup> Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.<sup>91</sup> For youth between the ages of 10 and 24, suicide is the third leading cause of death.<sup>92</sup>

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.<sup>93</sup> Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with more than 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.<sup>94</sup>

According to data from the [National Evaluation of the Children's Mental Health Initiative](#) (2011), systems of care<sup>95</sup>:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance

use, and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

*Please indicate areas of technical assistance needed related to this section.*

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<sup>90</sup> Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

<sup>91</sup> Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

<sup>92</sup> Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from [www.cdc.gov/injury/wisqars/index.html](http://www.cdc.gov/injury/wisqars/index.html).

<sup>93</sup> The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

<sup>94</sup> Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from <http://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings/PEP12-CMHI2010>.

<sup>95</sup> Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from <http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf>.

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

## 18. Children and Adolescents Behavioral Health Services

### 1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental health and substance use disorders?

North Carolina's response to the Willie M. lawsuit in 1979 originated the national System of Care model. The Willie M. lawsuit was a class action lawsuit on behalf of several adolescents who had been adjudicated delinquent, had a history of assaultive behaviors and demonstrated significant psychiatric problems. The class action suit stated that they were not receiving the behavioral health, educational, or community-based services they needed in order to succeed in at home, in school and in the community. The settlement stipulated that children meeting the class criteria had the right to individualized treatment in the least restrictive setting possible (NC DHHS, 1999). The resulting Willie M. program taught administrators, policymakers, researchers, practitioners a number of lessons upon which System of Care is founded:

- Importance of child-serving systems owning the children that the nobody else wanted
- Creating a new approach to treatment
- Creating seminal concepts in service delivery
- Focusing on measurable goals
- Changing the way scholars theorized about child psychopathology
- Establishing an innovative cost-accounting system
- Developing new community-based services for children
- Understanding the critical role of training.
- Demonstrating the crucial value of human relationships in mental health treatment

By 1999, the number of youth under this class action had grown to 1,650 and North Carolina was spending over \$100 M annually on this group, at an average of \$51,000 per child per year. (Willie M.: A Legacy of Legal, Social and Policy Change on Behalf of Children – Kenneth A. Dodge, Ph.D., Janis B. Kupersmidt, Ph.D., Reid Griffith Fontaine, J.D., M.S.)

When the lawsuit ended in 1999, North Carolina remained committed to the System of Care concept. Access to the Willie M. funding expanded to a broader population of children/youth with mental health needs, hoping to mitigate an increase in the numbers of young consumers with high/complex needs beyond what the existing continuum of care could meet. In addition, from 1995 to 2007, North Carolina won a series of SAMHSA Child Mental Health Initiative (CMHI) grants that initiated the development of local systems of care in 30 counties in North Carolina. Through both the Willie M. program and the CMHI grants, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) which is also the State Mental Health Authority and the Single State Agency for substance use, learned that the following SOC elements were necessary to achieve positive outcomes:

- Family/Youth co-leadership in the development of a local SOC;
- Strength-based approach to working with children and families;
- A full service array to meet the range of child/youth mental health needs;
- Necessity to partner with other child-serving systems and coordinate service supports in order to meet the mental health needs of children;

- A system of accountability at work at the individual child/family level, the local level and state level;
- Importance of growing and training a diverse workforce that can deliver effective treatment; and,
- Identification and measurement of treatment outcomes.

North Carolina adopted the System of Care approach as the framework for the organization and the delivery of all child-serving systems in 2001. Since then North Carolina has established the following SOC infrastructure components:

- State/Local Collaboratives – The NC Collaborative on Children, Youth and Families -- a state-level interagency body that includes senior staff from all the public state child-serving agencies, family representatives and child and family advocates -- was established in 2000. The purpose of the State Collaborative is to identify shared goals for an overlapping population of children/youth with complex, multi-agency- involved challenges and to find solutions for those challenges.

In addition, local collaboratives (comprised of local public agency decision-makers, family representatives and child/family advocates) were established in the catchment areas of the local mental health entities. These collaboratives are to identify and negotiate barriers through an examination of local policies and administrative processes which undergird the local service delivery system and to support effective child and family teaming.

Whether at the state or local level, Collaboratives were designed as forums for cross-systems discussions and strategy development representatives to tackle barriers to effective service delivery at either the local and/or state level to create change that would result in improved outcomes for children and families. At both the local and state level, collaborative participants are charged with coordinating services, funding, training and local reporting requirements to eliminate service duplication, improve system responsiveness to children and their families, and to increase the available array and range of services/resources.

The State Collaborative now generates its own funding through an online SOC training for providers that it developed through the collaboration of agencies and family and youth.

**Going Forward:** The next developmental phase for the State Collaborative is to become an entity that shares responsibility and accountability at the state level regarding how agencies and families work together to produce better outcomes for children and families. More specifically, the State Collaborative will move into examining opportunities to maximize incentives, analyzing the state's current financing of child and family services, and identifying opportunities to align practice with program and system goals statewide.

Lastly, the State Collaborative's leadership role will be strengthened by creating a two-way communication channel with local collaboratives for the purposes of 1) to convey clear expectations regarding outcome accountability to Community Collaboratives 2) for the State Collaborative to hear from the Community Collaboratives about local progress (or not) and the resulting impact on child and family outcomes and 3) for Community Collaboratives to provide

feedback about policies, funding constraints and other administrative barriers that impede positive outcomes at the local level

- **Family/Youth Leadership at all levels of the North Carolina System of Care:** North Carolina Families United (NCFU) is the statewide family network and the state chapter of the National Federation of Families. A statewide agency was established in 1997 as part of the first CMHI grant. NCFU became a nonprofit 501 (c)(3) organization (<http://www.ncfamiliesunited.org>) in 2000. It is a family support and advocacy organization that links families to State and community partners to improve the lives of children and youth with serious emotional disorders and their families; to educate and advise policymakers and other stakeholders on the unique strengths and needs of children with severe emotional disturbance; and to actively promote philosophy and guiding principles of SOC. It has nearly 500 family leaders/supporters/advocates across the state, including at least 40 who have received the national certification as family partners in SOC.

As the statewide chapter of Youth M.O.V.E (Motivating Others through Voices of Experience), NCFU also assists young adults and agency partners with bringing youth leadership to their area; offers individual youth membership to young adults interested in transforming systems; improves youth involvement on decision-making boards at the local and state levels; unites the voices of young adults through youth leadership development and expands local chapters of Youth M.O.V.E.; and creates opportunities for peer-to-peer mentoring. The first NCFU President co-chaired the State Collaborative with a Duke Child and Family Policy researcher for the first few years. NCFU staff and members continue to be active participants in the State Collaborative as it evolves. NCFU staff also provide technical assistance to local collaboratives and family groups to encourage family participation in local SOC planning, training, supports in local child and family teams, etc. There are 47 youth leaders around the state.

**Going Forward:** With the state family/youth leadership component well-established (if not fully stabilized), the focus now is on identifying financing opportunities that will allow the local communities to recruit and expand the family and youth voices involved in the local system of care development. North Carolina has sent a team of family members, youth and administrators to participate in the *Growing the Youth and Parent-Peer Support Movement: Working Strategically to Support Implementation (Peer Support)* in July 2015.

- One of the first decisions of the State Collaborative was to use the **Child and Family Team as the organizing principle for service delivery** for all children receiving public funding services. Through the Willie M. Program and the early CMHI demonstration grants, North Carolina learned the concept of individualized treatment planning for children/youth with mental health needs within a “wraparound” approach. In Wraparound, a team of people (including people from formal and informal agencies and natural family/community supports) help the family to coordinate existing resources, supports and services into an individualized plan for the identified child/youth. The preferences and choices of the child/youth and his/her family leads the development and implementation of the plan. Although the other child-serving systems (i.e. child welfare, juvenile justice, education, etc.) have individual histories, guiding philosophies, and

best practice models, the CFT process has become the common basis of operation in North Carolina.

**Going Forward:** The challenge today is that there are multiple child and family teams, with multiple purposes, definitions and processes. Families who are multi-agency involved find themselves subjected to many meetings with uncoordinated objectives and multiple plans for which they are held accountable. The primary objective now is to look for ways that a single CFT process can be used to accomplish key goals within each system and to coordinate across systems, so the child and family's access to services for which they are eligible is maximized (and not duplicated); and the number of meetings and paperwork is streamlined.

Various local communities have looked at the issue of ensuring that the current CFTs are operating with fidelity. DMH/DD/SAS has shared resources with LME/MCOS for monitoring CFT processes. However, through the High Fidelity Wraparound component of the SOC Expansion grant, DMH/DD/SAS intends to work with the State Collaborative to identify/develop a tool that can be used statewide to set standards for all CFT meetings (regardless of the service delivery system) and to measure the team's fidelity to those set standards.

- **Establishing a workforce of local SOC Coordinators** specifically charged to support/facilitate local system of care development across the state. Based on the success of the three CMHI SOC demonstration projects (from 1995-2007), DMH/DD/SAS obtained \$2 M per year in recurring state funds to establish SOC coordinator positions at the state and local levels. These coordinators are responsible for performing specific required SOC functions to ensure the ongoing local SOC development throughout the state. The demonstration grants initiated system of care development in 30 counties and established several essential state infrastructural components. This particular workforce segment has been critical to NC's efforts to take SOC to scale. These SOC coordinators collaborate with local child and family advocates, local child-serving public agencies, private providers and a host of community-based agencies to keep growing and spreading SOC.

**Going Forward:** One component critical to maintaining the depth of SOC development and continued expansion is a training and technical assistance system. North Carolina does not have this infrastructure component in place. As will be discussed in Question #4, DMH/DD/SAS has found a way to provide support for the evidence-based program development aspect of SOC. However, North Carolina has not been able to create a sustainable training and technical assistance system that supports ongoing child and family team practice development, collaborative development, family and agency leadership development and strategic planning necessary. The Division has been able to plant seeds of support at universities (e.g. UNC-Chapel Hill BHRP, UNC-Greensboro Child, Youth, and Family Partnership, Duke University Child and Family Policy, etc.) through contracts to support various aspects. However, this is fragmented and incomplete. The goal is to develop a comprehensive training and technical assistance that will address all of the components needed to implement SOC within each local community and across the state.

The other challenge facing the SOC implementation goals in North Carolina is the profound change that the behavioral health system has undergone in the past 15 years. In October 2001, a substantial change to the public behavioral health system in North Carolina. House Bill 381 (S.L. 2001-437) known as the Mental Health System Reform Act transformed area programs that directly employed individuals to provide services to Local management Entities (LMEs) who managed services by contracting with providers for the delivery of services in their respective catchment areas, effectively separating management from delivery functions. Between 2001 and 2010 the number of LMEs was reduced from 41 to 23.

In 2001, the state contracted with a private for-profit company to conduct utilization reviews to determine the medical necessity of mental health and substance abuse services for Medicaid recipients as a means of controlling costs. This was the state's first foray into managed care for the public behavioral system.

The change over to the LME system had a substantial impact and some unintended consequences on state agencies, providers, and the people served through the public service delivery system. One unintended consequence was the explosion of private provider agencies in the state. This changed the nature of the workforce through a dramatic volume increase as well as an extreme diversity in the range of skills, level of expertise, and philosophical commitment of the individuals in the field.

In 2005, the state designated a Local Management Entity – Piedmont Behavioral Health – to pilot Section 1915 (b) Managed Care/Freedom of Choice Waiver and (c) the Home and Community-based Services Waiver that allowed the pilot LME greater flexibility in authorizing, budgeting, managing, and delivering innovative mental health and substance use services under a Managed Care environment where it received a set amount of funding from the state based on a capitated amount for each Medicaid-eligible person served in its catchment area. Under the waivers, Piedmont Behavioral Health established the Comprehensive Community Model that established criteria for staffing and services in the selection of the mental health and substance use agencies for the closed network of providers in the catchment area. The waiver program was expanded to other sites beginning in 2011. As of July, North Carolina is composed of nine sites currently operating as Managed Care Organizations. [Note: All entities still retain their LME responsibilities as well.]

During this time DMH/DD/SAS merged branches in its organizational structure that served age or disability-specific populations into sections composed of teams formed along function and content expertise lines.

Further changes are anticipated based on current legislative debates underway. Eventually there may be 4 regional accountability entities. The NC Expansion grant participating sites were chosen based on their geographic presence in the potential regional catchment areas to ensure SOC development would be fully incorporated in NC's managed care evolution.

Wrestling to integrate the SOC development with the managed care evolution may be the biggest challenge for local system of care development throughout NC. This change is presenting an opportunity and incentive to become more creative about filling the gaps in the child behavioral health service array. Hospitalization and residential treatment are the biggest expenditures in the North Carolina child behavioral health system. MCOs are developing alternative service and in lieu of definitions based on evidence based programs and local best practices. MCOs are also paying enhanced rates for specialized evidence-based therapies (e.g. trauma-focused cognitive behavioral therapy and parent-child interaction therapy).

Another unintended side effect of the reform is that as the local Area programs morph into LME/MCOs that cover larger geographic service areas than before and struggle to absorb new high level management responsibilities, leadership can lose sight of local community efforts that are necessary in order for a system of care approach to function well. To that end, Division staff have been diligent each year in ensuring that System of Care functions and milestones are part of the Performance Agreement established between DHHS and these local LME/MCO. DMH continues to track the local SOC development work through SOC reports that are compiled by the SOC Coordinators, through each LME/MCOs progress on the Community Progress Indicator Report that is published quarterly, and the NCTOPPS (NC Treatment and Outcomes Program Performance System) reports. QM Team disseminates reports and provides Dashboard summaries through the DMH/DD/SAS website. The Division's audit process is evolving to take into account system of care objectives as well.

- **Data system:** The Willie M. Program and the CMHI demonstration grants taught state policy makers and administrators the importance of measuring treatment outcomes and identifying indicators of progress. DMH developed a web-based system (NCTOPPS) for collecting data (based on mental health indicators derived from the demonstration grants) and a system for analyzing the impact on mental health consumers. LME/MCOs are required to use this instrument as part of their Quality Management responsibilities. The performance agreement dictates that LME/MCOs require their service providers to train and collect data using this instrument. NCTOPPS data is now supplemented by another web-based substance abuse data collection tool.

**Going Forward: (See question #5 for further discussion of the State's continued development of the overall management information system.)** Local collaboratives are encouraged to gather data/information directly from families and youth who use the child service delivery systems, as well as, to use data from various grants and pilot projects. Such data combined with risk and need, utilization, cost, and outcomes data from each of the systems is helpful to each community for identifying strengths and challenges, formulating critical system concerns and for promoting policy and funding recommendations.

This year, through a joint endeavor, NC DMH/DD/SAS, the NC Division of Social Services and the Jordan Institute of UNC-Chapel Hill School of Social Work provided training to six local collaboratives on *Effective Cross-agency Continuous Quality Improvement (CQI)*. The project goals were for the collaborative members to 1) learn the 4 step CQI process for improving

outcomes; 2) understand the role of readiness in CQI and 3) prepare to address readiness issues within the collaborative. The overall purpose is to help all partners in the collaborative to learn to use a standard model to analyze data and develop goals and action steps that will lead to improved outcomes. The training project included face-to-face training for LME/MCO Quality Improvement staff who became the local facilitators for the CQI process, a two part webinars for the CQI teams, and a one hour facilitator conference call. Six collaboratives were selected through a competitive application process. Each collaborative chosen designated a CQI team of 4-6 people. Each team selected a readiness priority and/or a child outcome to address. Each team began the progress of collecting baseline data through review of local, shared data and making hypotheses and goals. After the collection of baseline data and the development of hypotheses, each team will develop an action plan that uses shared data to track progress and make improvements to their projects. The first reports are to be presented in November 2015. Based on the progress of this CQI pilot, DMH/DD/SAS will develop a plan of training and technical support for the remainder of Community Collaboratives in the use of a continuous quality improvement process in the development and tracking of priorities.

- **Enhancement of the continuum of care/service array.** The establishment of a Child Mental Health Plan in 2003 established the service array that is necessary to support children/youth with moderate and severe mental health needs. Division staff have continued to work with DMA to create both Medicaid and state funded service definitions to support the development and expansion of those services. Additionally, when DMH received a three-year grant for Adolescent Treatment and Coordination Grant in 2005, North Carolina continued to enhance the existing service array by expanding the treatment needs focus of the continuum of care to include the substance use disorder needs as well. The current strategic plan for statewide SOC development includes identification of evidence-based programs to be added to the service. More recently, DMH is now layering on the concept of developing a trauma-informed care environment in which all the public child-serving delivery systems will operate.

**Going Forward:** The NC SOC Expansion grant will work with the North Carolina Child Treatment Program (CTP or Effective Mental Health Treatment for Children, Adolescents, and Families Coping with Traumatic Stress, Loss, and Parenting Difficulties) and other experts on trauma as members of planning collaboratives to develop a plan for infusing the system with trauma-informed care. A consortium of faculty and staff from the Center for Child and Family Health-NC, Duke University Evidence-Based Practice (EBP) Implementation Center (that includes staff from SAMHSA's national Center for Child Traumatic Stress and the School of Medicine at the University of North Carolina at Chapel Hill) is responsible for the CTP. Their collaboration and that of others will lead to a plan focused on the identification of key Evidence-based Programs and other strategies (e.g., Trauma-focused Cognitive Behavioral Therapy, decreasing multiple child placements) and a plan for sustainable education and training, emphasizing cultural and linguistic competency, recovery, standardized assessment, clinical competency, clinical supervision, model fidelity, and implementation strategies. The Expansion grant will also include the development of comprehensive primary prevention plan in order to reach a broader population of children and youth to promote their healthy socio-emotional development. Furthermore, early intervention and recovery support services will be enhanced to promote stability and avert crises.

Additionally, the service array development will continue to emphasize the linkages with primary care providers.

In addition to the above mentioned services and programs, the Division also provides funding and oversight for the **Adolescent Substance Use Disorder Regional Residential Program Initiative**, described as follows:

### **Mission**

Our mission is to provide medium-term residential treatment and public education services to prepare individuals under 18 years old with substance use and other co-occurring problems for ongoing community based recovery services.

### **History**

In 1988, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services developed the Adolescent Substance Use Disorder Regional Residential Program Initiative in collaboration with the NC Department of Public Instruction and selected treatment providers and selected Local Management Entities (LMEs) and their associated Local Education Authorities (LEAs).

All the programs under this initiative admit youth and families from anywhere across the state of North Carolina, which is part of the Division's Cross Area Service Programs (CASPs) initiative. These programs provide 24-hour residential services through supervised living or similar licensure and intensive outpatient or day treatment services. The majority of the sites provide public education through local teachers assigned to the program by the LEA.

### **Location**

The eight adolescent substance use disorder Regional Residential Programs are located strategically across North Carolina and serve residents of every county.

### **Finance**

As state and block grant funded facilities, Adolescent Substance Use Disorder Regional Residential Programs accept prospective clients regardless of financial resources or insurance status. A financial interview is conducted at the time of admission.

### **Length of Stay**

Residents receive a combination of residential and outpatient treatment and educational services for an average of 90 to 120 days, followed by referral to a community treatment provider.

### **Treatment services**

- Counseling is provided to assist youth and their family in becoming actively involved in their own recovery. This is achieved through comprehensive assessment, treatment planning, group therapy individual therapy, and continuing care planning. Treatment is based on evidence based practices.

- A child and Family Team will be utilized with every youth and their family. The team will have the responsibility of updating the youths Person Centered Plan (PCP). This also includes discharge planning and care coordination for when the youth returns to their home to ensure continuing treatment through their local community outpatient treatment programs, self-help groups, and other community resources.
- Psychological services include the provision of diagnostic testing and specialized psychotherapy for youth when appropriate. Psychiatric evaluation and medication management are also available for youth.
- Family services are offered to family members and other significant people in the youth's life and include weekly individual and multi-group sessions.
- Therapeutic Recreational services are provided daily. Programs use their own recreational facilities on site and recreational facilities in the community such as the local YMCA.

**2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance use and co-occurring disorders?**

Since 2006, the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) has supported and encouraged the utilization of person-centered planning and the professional development and growth of all people engaged in the process. Through ongoing evaluation of the Person-Centered Plan (PCP), DMH/DD/SAS has monitored the achievement of objectives using quantifiable measures, assessed the effectiveness of particular interventions and policies, as well as, monitored public opinion. Subsequently, the PCP format was redeveloped in 2010, taking into careful consideration legislative requirements, new priorities that have emerged, innovative approaches, and evaluative information.

As stated previously, Child and Family team planning and the concept of the development of a unique plan for every child/youth served by the system were critical elements of the Willie M. Program. These elements were solidified in the North Carolina System of Care that emerged from the federal CMHI grants. As North Carolina began the overall reform of the mental health system, DMH/DD/SAS moved towards Person-Centered Planning as one of the key aspects of the system overhaul. The DMH/DD/SAS Child Mental Health Team, in the process of creating a vision for the child/youth and family behavioral system with the SOC approach as the foundational organizational principle of that vision, compared the SOC CFT process to Person-Centered Planning. The SOC CFT process was shown to hold the same values as the person-centered planning process. A technical assistance document created in 2004 to help local communities see the overlap between CFT and PCP stated that "primarily, the child and family team planning process is designed to achieve a set of outcomes that reflect the voice and choices of the child and family". Fidelity to the child and family team process would mean that the process must include the following elements:

- Individualized service planning driven by strengths and needs
- Needs and preferences of the child and family dictate the types and mix of services provided.
- Family participation in ALL aspects of planning, service delivery and evaluation.

- Prevention, early identification and intervention.
- Planning and service coordination or case management of comprehensive, integrated services across the child-serving systems and into the adult service system.
- Nondiscrimination in access to services. No rejection, no ejection from services.
- Services provided in the least restrictive environment
- SOC should be community-based, with the focus of the services, management and decision-making responsibility resting at the community level.
- Human rights protection and advocacy.
- Culturally competent and responsive to the cultural, racial and ethnic differences of the population served.

The SOC CFT process was formally recommended by DMH/DD/SAS as the best practice process to be used for children/youth with a mental health or substance use disorder and for children/youth with both disorders. Although the PCP process continues to be modified as new issues are identified -- for example, the PCP process was further enhanced by new guidelines for the development of the companion comprehensive crisis plan in 2014 -- the CFT planning process continues to be the recommended approach for children/youth with behavioral needs.

**3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?**

Aside from continuing to staff the North Carolina Collaborative on Children, Youth and Families (i.e. the State Collaborative), DMH/DD/SAS collaborates with other child-and-youth-serving agencies on initiatives where the population of focus is children with severe emotional disturbance who are generally involved with multiple agencies.

One interagency collaborative effort that has been instrumental in local system of care development has been an initiative under the Department of Public Safety/Division of Adult Correction and Juvenile Justice. This initiative is the *North Carolina Reclaiming Futures Initiative*. It is designed to help improve the work among juvenile courts, probation, adolescent substance abuse and mental health treatment, and the community to reclaim youth. The model embodies three major elements: improvement in treatment services for mental health and drug and alcohol use; a comprehensive system of care that coordinates services, and the involvement of the community in creating new opportunities for the youth. In 2011, a statewide office was established to support the implementation. This is a public-private partnership that includes the Kate B. Reynolds Charitable Trust and The Duke Endowment. DMDDSAS participates in oversight through an advisory group. The Initiative is underway in 29 counties.

DMH/DD/SAS also collaborates with the Department of Public Instruction on a SAMHSA-funded Bullying and Suicide Prevention Program; with the Division of Public Health on Project Launch (early intervention); with Division of Social Services on a SAMHSA-funded trauma-focused grant for children and youth in foster care; and with the Divisions of Public Health, Medical Assistance and Child Development and Early Education and the NC Interagency Coordinating Council for Children with Disabilities on early childhood mental health. (See also discussion in question #5 related to a new Department of Public Instruction Mental Health Stakeholders Group.)

**4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?**

In 2009, DMH/DD/SAS provided seed funding from the MHBG and state mental health trust fund for a project that would help to increase access to evidenced based treatment.- The seed money was able to leverage Duke Endowment and other regional funding sources. The result was the creation of a public-private partnership that established The NC Child Treatment Program through the Center for Child and Family Health. NCCTP trains clinicians in evidence-based interventions through Learning Collaboratives. NCCTP trains, supervises and coaches practitioners in a year-long learning community experience. The clinicians who successfully complete the training, maintain fidelity to the model and can demonstrate positive outcomes are included in a roster system managed by NCCTP. NCCTP facilitates access of children and families who need access to these specialized trauma therapies. NCCTP trains the following evidence-based practices: trauma focused cognitive behavioral therapy, parent-child interaction therapy, child parent psychotherapy, and structured psychotherapy for adolescents responding to chronic stress.

The NCCTP has been able to train clinicians from around the state. As of this date, there are 445 in-training or graduated practitioners affiliated with the NCCTP, including 347 TF-CBT rostered clinicians. Additionally, NCCTP has developed a secure database that tracks individual and aggregate level fidelity and outcome data with interface capability to work with existing networks within state agencies.

DMH/DD/SAS developed the North Carolina Practice Improvement (NCPIC) to facilitate the identification of current and future evidence-based services and supports that will be incorporated in North Carolina's public behavioral health system. The NCPIC is comprised of representatives of the DMH/DD/SAS disability areas and meets three times a year to review and discuss current and emerging best practices for adoptions and implementation across the State. Applications may be submitted for evaluation at these meetings. The members look to confirm the completeness of the evidence base. Annually, the group presents a report of prioritized program recommendations to the Division Director at a public forum. This forum features brief educational descriptions of the practices being recommended by the NC PIC in its report. NCPIC is hosted by the Governor's Institute on Substance Abuse.

The Division provides training through Area Health Education Centers, family advocacy and support agencies, the State Collaborative, and through universities using state or MH Block grant funds. LME/MCOs also provides practice skill development training to their provider networks. Additionally the North Carolina Council of Community Programs provides a range of training to both provider and LME/MCO staff from around the state. This is an area in the SOC infrastructure development that the Division would like to see significantly enhanced in order to ensure that there is consistent, quality, and in depth training/coaching of both policy and practice around the state to develop the broad, diverse, well-informed workforce required to achieve a comprehensive service array.

**5. How will the state monitor and track service utilization, costs, and outcomes for children and youth with mental, substance use and co-occurring disorders?**

The State collects performance indicators information through the Client Data Warehouse (CDW) from LME/MCOs and client level data through the web-based NC TOPPS.

Through data infrastructure grants, the Division developed database structure and definitions in its two client data warehouses, the DMH Client Data Warehouse (CDW), which is the Division level production database, and the Client Services Data Warehouse (CSDW) which is the enterprise level web-based decision support database. Currently, the system has the capability of web-based reporting, utilizing data from the Perception of Care surveys, Medicaid, State funded services, the client information systems of LME/MCOs, the billing and information system of the Health Enterprise Accounts Receivable and Tracking System for State Facilities (HEARTS) and archived data. Reports based on databases are produced through corporate or ad-hoc queries and are disseminated to end-users. The Division produces the LME/MCO Performance Measurement Report based on Medicaid and state and county claims data, LME/MCO reported data, access data, and state hospital data including the alcohol and addiction treatment centers from the CDW and LME/MCO reports. This report monitors the LME/MCO's performance on the critical performance measures (timely initiation and engagement in service, timely follow-up after inpatient care, etc.) against statewide averages for services to persons in need by age and disability.

North Carolina Treatment Outcome and Program Performance System (NC-TOPPS), Initial, Update, and Episode completion interview information for all consumers within specified substance abuse and mental health populations. NC-TOPPS information provides one method for the collection of the Division's consumer functional outcomes data. Consumer functional outcomes data are the DHHS source of information utilized to monitor the impact of services.

In December 2008 the North Carolina Department of Health and Human Services (DHHS) awarded a contract to Computer Sciences Corporation (CSC) to develop and implement a Replacement Medicaid Management Information System (NCMMIS+) in support of healthcare administration for multiple DHHS agencies. NCTracks, the Replacement NCMMIS+, is used by the Division of Medical Assistance (DMA), the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), the Division of Public Health (DPH), the Migrant Program for the Office of Rural Health and Community Care (ORHCC) and the Division of Health Service Regulation (DHSR). NCTracks processes health care claims for enrolled DHHS providers who serve the citizens of North Carolina.

NCTracks is a multi-payer system that facilitate provider enrollment and consolidate claims processing activities for multiple DHHS health plans. By having a multi-payer system the Divisions within DHHS have the ability to analyze and interpret data reported through NCTracks regarding State and Federally funded behavioral health and Medicaid related physical health and pharmacy claims.

The Division's data system described above will provide data for consumers six years and older. To know about the utilization and costs for the early childhood population, the Division will have to partner with other child-serving systems where children under six years of age are more likely to be identified for early intervention behavioral health services (e.g. school systems, social services, early childhood education programs). For consumers three years and younger, the Division will need to work with the Child Developmental Service Agencies (CDSAs) or through private providers who are working on fee for service basis.

DMH is starting to develop data sharing agreements with other divisions and Departments in order to track at both the child-level and systems level service utilization and cost rates for children/youth with behavioral health needs. At this point, the only analysis available to the Division is based on the paid claims for services submitted by providers.

Keeping those we serve at the center of service design and delivery the Division's Quality Management structure provides the focus for ongoing attention to the clinical quality and effectiveness of the service system. The Division's Quality Management Steering Committee brings together staff from across the Division to plan, monitor and evaluate initiatives to improve the clinical quality of the service system and the effective use of state and federal funds.

To ensure the needs of those we serve are being met the Division monitors key indicators to help assure that the system is working as intended, opportunities for improvement area identified and acted upon, desired improvements are recognized and efforts to sustain successful practices are implemented and monitored to maintain achievements, as priorities change.

A process for periodic monitoring of key indicators is coordinated by the Steering Committee. Monitoring of indicators will include:

- Reviewing valid and reliable performance and outcome data
- Determining significance of trends and patterns
- Implementing improvement initiatives
- Evaluating improvement initiatives
- Raising the bar on measures when appropriate
- Evaluating and revising the Quality Management plan annually

Quality Management and Performance Expectations for LME/MCOs are established per contract. Routine monitoring against performance targets or standards provides information on how the system is doing. The Division supports a statewide Incident Response Improvement System for reporting and documenting responses to emergency and critical incidents with a focus on future prevention. Contract requirements address reporting and resolution requirements related to complaints and grievances and establishes standards for resolution timeframe.

Regular and ongoing feedback within the Division and to Local Management Entities-Managed Care Organizations and system stakeholders is a key to ensuring and sustaining improvements in quality. The guidelines for critical outcomes and performance measures are described in the North Carolina LME/MCO Performance Measurement and Reporting Guide. Measurement is based on valid and reliable data, consistent with the NBHQF and describe the health and functioning of the MH/DD/SA system.

The Division evaluates the overall performance of the Local Management Entities/Managed Care Organization and their network through the review of each management function, compliance with reporting requirements, through statewide measures of service quality, input from stakeholders via surveys and outcome measurement systems, analysis of emergency and critical incidents, and review and follow-up of complaints and grievances.

- 6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?**

The Department of Health and Human Services has not currently identified a liaison to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services.

The closest North Carolina has come to establishing behavioral health liaisons to support school systems was through the Child and Family Support Team (CFST) initiative. The CFST initiative was originally authorized and funded in the 2005 session of the NC General Assembly. The budget provided \$11.0 M for teams of school nurses and school social workers to be placed in 100 schools, in 21 local education agencies (LEAs). These teams were assigned to work with a target population of children/youth who were at risk of drop out based on socio-economic needs, poor academic scores, suspension rates and behavioral health needs. To assist those teams, the General Assembly funded a recurring allocation of approximately \$944,000 to hire 1 LME Care Coordinator and DSS team facilitators in the LME catchment area of the CFST LEAs. These LME staff were called school care coordinators and were assigned to provide training to school staff, to participate with school staff in service planning for identified students and to assist students with accessing mental health and substance abuse services. In the 2011 Appropriations Act, the General Assembly eliminated the funding for the DSS Facilitator and LME Care Coordinator positions but continued to ask the LME to appoint specific staff members to continue serving in the same capacities. This resulted in reduced access to the behavioral health system for the CFST schools (January 2013 Legislative Report to the Office of the Governor and Legislative Committees/Subcommittees by the North Carolina Child and Family Leadership Council.)

As North Carolina moved into a behavioral health managed care environment, LME/MCOs took on care coordination responsibilities within the service area for which they are responsible. Under the 1915 (b)/(c) waivers, this form of care coordination is a risk-management and quality-management function that is designed to proactively intervene and manage care for Special Needs Populations. Children/Youth who are hospitalized, have had a certain number of crisis episodes, or are in Level III group homes or PRTFs are designated special needs populations. Some LME/MCOs have identified specific care coordinators to serve the child/youth special needs population. These care coordinators find themselves working with school systems especially when coordinating discharge planning from a residential setting back to the child's home community. Otherwise, schools may be able to find some general guidance with the local behavioral health system through the Community Relations component of an LME/MCO from either a SOC Coordinator or another staff.

However, there has been a long history (going back to the establishment of the Willie M. Program) of dialogue, joint planning and implementation between the state public mental health system and the state education system. In June 2015, the Department of Public Instruction's Exceptional Children's Director invited a representative group of stakeholders involved in mental health services to children across the state to participate in a daylong Mental Health Stakeholder meeting. The purpose of this Stakeholder group is to forge a consensus around the most relevant issues and the development of a strategic plan. The intent is use the jointly developed strategic plan to develop legislation and/or policy to create school-based mental health programming. The expectation is that the Stakeholder Group will lead to a series of smaller meetings throughout the year to address the specific concerns that are identified.

The current issues identified through the Stakeholder Group include:

- Lack of consistent availability of a comprehensive range of mental health and substance abuse services across the state;
- Non-Medicaid students (even with private insurance) having less access to specialized therapies and/or enhanced services to which Medicaid students have more access;
- As public behavioral system shifts to Managed Care orientation, the increased complexity in getting onsite services in school systems;
- Lack of coordination between school systems and behavioral health providers when students are placed in residential programs outside of their home communities;
- Meeting the behavioral health needs of students who are not identified as Exceptional Children (i.e. special education).

**7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.**

In North Carolina, the cut-off age for receiving public behavioral health services in the child/adolescent system is 18 or up to 22 years of age if the youth has Medicaid. There is not a state-designed transition process for individuals aging out of the child/youth behavioral health system into the adult system.

This area is noted by several LME/MCOs as a major community needs and gaps issue. Local communities are testing a variety of strategies to find ways to support youth through the transition. One LME/MCO received permission from the Division of Medical Assistance (DMA) in SFY 14-15 to use an Alternative Medicaid Service Definition to use Medicaid funding to support a transitional living program for consumers aged 16-25. The provider – Youth Villages – has been providing a specific transitional living program for youth aging out the foster care and juvenile justice systems --around the county for several years. This program – now called YVLifeSet – has trained specialists who work with eight youths at a time. The specialists provide assessments and partner with the youth to develop an individualized treatment plan across education, career, housing, financial, relationship and health domains. The plan takes into account the particular needs and goals of each young person. The youth meet with specialists on a weekly basis to set goals and plan how they will navigate their transition to adulthood. The program provides intensive, individualized, and clinically focused case management, support, and services. The program also provides limited financial support to help with specific objectives in the plan (e.g. apartment application fee, money to buy clothes for a job interview, materials for school). A University of Chicago study of the YVLifeSet program in Tennessee (funded by multiple foundations) has provided the following key findings after a one-year follow-up:

- The program boosted earnings by 17 percent, increased housing stability and economic well-being (including a 22 percent decrease in the likelihood of experiencing homelessness), and improved some of the primary outcomes related to health and safety (including improvements in mental health and a decrease in intimate partner violence). However, it did not significantly improve outcomes in the areas of education, social support, or criminal involvement.
- The program was found to be equally effective across different subgroups of youth, including youth with and without histories of juvenile justice custody.

Youth Villages currently has a proposal before the state legislature proposing a statewide implementation of this transitional living program. Depending on its legislative success, this could become a cornerstone of an integrated approach to supporting the transition of youth to adulthood in multiple service systems.

Alliance Behavioral Healthcare LME/MCO is midway through a SAMHSA grant that targets high-risk 16-21 year olds in Durham County who have mental health challenges and have become disconnected from services and supports that would normally assist them in transitioning to adulthood. Through partnerships within the community, BECOMING connects these youth with literacy support services, coordination of clinical care, employment services, positive recreational opportunities and leadership training, with a goal of helping make these transitions more successful.

Since 2008, NC DMH/DD/SAS has contracted with NCFU to improve the quality and outcomes of community based services for transition-aged youth in accordance with the Community Mental Health Services Block Grant. NCFU has been able to leverage MHBG funding to raise additional funding to expand the services and supports to emerging young adults. The program offered is called *Transition Mentoring Services*. NCFU provides intensive coaching and mentoring to at least 8 transitioning youth (annually) who have been identified as having the most difficulty transitioning out of high school to engage them in the process of becoming successful adult members of their communities. NCFU also reaches youth not yet identified as needing treatment to seek and find services enhancing positive mental health and behavioral health outcomes. The Rehabilitation for Empowerment, Natural Supports, Education and Work (RENEW) model will continue to be the process used.

RENEW Secondary Transition Model core activities include providing 1-3 hours (per week) of intensive mentoring with our Program Director and engaging the young adult in a youth-directed planning process called Futures Planning. Futures Planning is a person-centered planning process developed by the young adult through a supportive youth driven process which identifies priorities, goals, and strategies such that the role of the youth/young adult and those with a role in supporting achievement are clearly identified. The Program Director then partners with the youth to prepare and co-lead in developing an individualized team to assist them with reaching their goals.

In addition to the use of RENEW, Transition Mentoring also involves the youth and their families in transition-related learning opportunities and expands their peer to peer networks through involvement Youth M.O.V.E.'s Youth Leadership Series (YLS). NCFU runs the seven-session series designed to encourage adolescents and young adults with mental and behavioral health concerns to participate on relevant advisory boards at the local, state and national levels. Participants in the NC YLS are encouraged to join Youth M.O.V.E. NC, housed within NCFU, serving as the statewide youth partners for the family-run organization. The YLS creates a culture of unconditional care and serves as a pathway for adolescents and emerging young adults in transition to become advocates for self and others and engage in leadership roles. Since 2008, 62 transition age-youth have received the intensive coaching and mentoring services.

NCFU partnered with the Department of Psychology UNC-Charlotte and the Department of Maternal and Child Health at the UNC School of Public Health to identify successes of transition-related services as well as challenges and barriers that young adults continue to experience as a result of systemic

challenges and/or lack of available /responsive systems equipped to address the nature of issues encountered by this population. The data collected and analyzed were derived from qualitative techniques that included focus groups, interviews appreciative inquiry, and a photovoice project. A total of 53 past and present young adults participated. Some of the participants were in restrictive settings.

The evaluation report documented the following youth-reported successes after engagement in the program for 9 months:

Relatively high levels of confidence in their self-determination and mental health coping abilities and that they 'sometimes' or 'almost always' acted in a self-determined way;:

- Improved optimism about adult role functioning (e.g., obtaining a good job, completing school);
- Improved progress toward goals was directly linked to support from mentors and work settings;
- Improvement of certain types of support, including informed decision-making for best outcomes and support in crises;
- Improvement of certain types of support, including informed decision-making for best outcomes and support in crises;
- Improvement in perceptions of self-determined behavior, and smaller, statistically marginal improvements in feelings of self-determination and support self-determination at home;
- Improvements in perceptions of safety at home and at school.

The following barriers/challenges for transition-age youth were summarized from a series of interviews with randomly selected young adults who had participated in RENEW (n=6):

Employment:

- Finding stable employment was the most frequently identified barrier experienced in meeting plan goals because:
  - prescribed medications limited the youth's ability to perform certain tasks.
  - juvenile justice/criminal court records supposedly expunged, still showed up in background checks.
- Difficulty finding housing because:
  - meager resources with disability.
  - long delays proved discouraging and depressing.
  - lack of variety of housing options
- Lack of effective mentors:
  - Mentors not able to connect with youth's life experience
  - Short lived mentoring that ends before youth has accomplished critical goals
  - Insufficient communication with mentors.
- Behavioral Health problems creating a barrier:
  - Difficulty getting the right medication and/or appropriate services
  - Difficulty finding a strengths-based treatment environment
  - Difficulty finding a physician or psychiatrist willing to listen to their story, symptoms, challenges and who can give accurate diagnoses based on the youth's lived experience.

(Jackson-Diop, D., and Fadumo Abdi, UNC-Chapel Hill graduate student and public health intern, *NCFU Brief on Youth Transition Support Services*, 2014.)

The NC Collaborative on Children, Youth and Families has been working on a Strategic Plan for the upcoming sfy 15-16 year. Transition Age Youth issues has been designated as a top priority on which agencies need to collaborate. The current legislative session includes bills that will impact this age group including a juvenile justice bill to change the current policy of 16 and 17 year olds automatically being tried in the adult criminal court system, regardless of alleged infraction and the *Fostering Success* bill that would extend the provision of foster care services to the age of nineteen and provide for the extension of guardianship services through age 19. The North Carolina Institute of Medicine just started a Taskforce to focus on the needs of the transition age youth in June 2015. Based on the **2012 Kids Count Data Center**, there are 1,347,888 in the transition age group (15 – 24 years old). Recommendations from this group are expected in 2016.

# Environmental Factors and Plan

## 19. Pregnant Women and Women with Dependent Children

Narrative Question:

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Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant ([Title XIX, Part B, Subpart II, Sec.1922 \(c\)](#)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at <http://www.samhsa.gov/women-children-families>: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges*.

Please consider the following items as a guide when preparing the description of the state's system:

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
  - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
  - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
  - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
  - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

*Please indicate areas of technical assistance needed related to this section.*

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

## 19. Pregnant Women and Women with Dependent Children

- 1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.**
- 2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.**
- 3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.**
- 4. Discuss who within your state is responsible for monitoring the requirements in 1-3.**
- 5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)**
  - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?**
  - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?**
- 6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)**
  - a. How many of the programs offer medication assisted treatment for the pregnant women in their care?**
  - b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?**

The North Carolina Perinatal and Maternal Substance Abuse and CASAWORKS for Families Initiatives represent a nationally recognized state-wide approach to the many social and health challenges associated with family addiction. Comprised of 26 programs using evidence-based treatment models located in 13 counties across the state, women with substance use and associated co-morbidities are supported to engage with family-centered, gender-responsive treatment with their children.

Over 19 years of research shows us that women are motivated to engage with treatment and recovery by concern for their children or pregnancy but that they are often unwilling to seek treatment if it means leaving their children. The NC Initiatives address this by providing family-responsive care. All of the programs in the Initiatives are considered cross-service area, and this helps us to meet the need of pregnant and parenting women who do not have gender- or family-responsive treatment in their home communities. Through a capacity management system, health care providers, department of social services social workers and treatment providers can refer women and their children to the services they need anywhere in the state. Women in need of services and their families can also access this system to identify appropriate treatment resources statewide. Programs provide gender-responsive, family-

centered and trauma informed services that include, but are not limited to, evidence-based behavioral health screening, intervention and treatment services for pregnant and parenting women, case management, parenting support, arrangements for prevention and treatment services for children, referral for and coordination with medical care for women, pediatric and developmental care for children and transportation. Job readiness and job coaching are key provisions in our seven (7) CASAWORKS for Families residential sites which have a primary goal of self-sufficiency.

The statewide Perinatal & Maternal Substance Abuse Initiative includes 19 specialized programs for the provision of services to pregnant women and parenting women with a substance use disorder and their children. Seven of the programs are comprehensive outpatient programs (including outpatient (individual, group and family counseling) and intensive outpatient and or comprehensive outpatient services) and one transitional housing program. Additionally, eleven of the programs are residential services for women and their children. Residential length of stay is up to one year based on medical necessity. Outreach is provided to women in high risk prenatal clinics, department of social services, health departments, drug treatment courts, domestic violence programs and other community service settings. All of the programs are required to collaborate with community programs/agencies including public health, domestic violence, vocational rehabilitation, social services, mental health and other partners in the community to assist in addressing the multiple needs of this population.

The NC CASAWORKS for Families Residential Initiative continued to be a collaborative project between the Division of MH/DD/SAS and the Division of Social Services. This Initiative includes seven (7) comprehensive residential substance use disorder programs for women receiving or who are eligible for Work First cash assistance and their children. The CASAWORKS for Families model was developed by the Center for the Study of Addiction and Substance Abuse (CASA) at Columbia University in response to the impact of welfare reform on families with substance use involvement. The model proposes that the best way to help TANF families with substance use involvement become economically self-sufficient is to provide an integrated and concurrent gender-specific substance abuse treatment and job readiness, training and employment program.

All of the programs are able to access medication assisted therapy for individuals with opioid use disorders (either methadone or buprenorphine or both) with the exception of six (6) programs. Three of those programs will have access in the near future due to the availability of a recent contract provider in their area for Medicaid supported services. The other three programs are unable to take women who are receiving methadone or buprenorphine at this time. Barriers to medication assisted therapy include distance to services, cost of medication, physicians only wanting to prescribe to individuals their agencies provide SUD treatment to, DATA 2000 or OTP maximum patient limits met, physicians not wanting to prescribe to pregnant women, etc.

The three (3) state operated Alcohol and Drug Abuse Treatment Centers (ADATCs) in Butner, Greenville and Black Mountain, North Carolina, also provide inpatient level service (with state funds) for pregnant and parenting women. The Walter B. Jones ADATC has a specialty unit that allows women to bring infants up to one year old into treatment with them. Each of the ADATCs collaborates with the high risk prenatal units at the local hospital in their area. Gender-responsive, trauma informed substance use disorder services are provided to women at these Centers. Each of the ADATCs also has the ability to maintain individuals on medication assisted therapy. Additionally, Walter B. Jones ADATC located in

Greenville is a licensed opioid treatment program and has the ability to start an individual on medication assisted therapy.

Additionally, the Work First/CPS Substance Use Initiative provides early identification of Work First recipients that have substance use problems severe enough to impact their ability to become self-sufficient and provides substance use assessment and referral to treatment for parents who have been found in need of service or have a substantiated CPS case with substance use involvement. Each Local Management Entity receives funding to support this initiative. Qualified Professionals in Substance Abuse (QPSAs) were out-stationed, when possible, in the local Departments of Social Services to provide screening, assessment, care coordination and referral to treatment. The QPSAs also provide case consultation, substance use /mental health training and other supports to the DSS, as needed. The QPSA and the Work First case manager or CPS worker jointly develop a plan for the family to support success.

The NC Division of MH/DD/SAS and the NC Division Public Health jointly fund a Substance Use Specialist position housed at Alcohol and Drug Council of North Carolina. The Substance Use Specialist can be reached at 1-800-688-4232 hotline, Monday through Friday, from 8 am to 5 pm. Services are available to the public and professionals to provide support in accessing gender-responsive substance abuse treatment services statewide. Technical assistance, training, and education regarding screening and referral for pregnant women with a substance-related disorder are also available. The Substance Use Specialist also exhibits and conducts presentations at conferences statewide to publicize these services. A capacity management (bed availability) listing of residential substance abuse services for pregnant and parenting women and their children is maintained in order to assist the public and professionals to identify appropriate and available services statewide. The bed availability listing is distributed to over 500 professionals and interested stakeholders in the local communities across NC on a weekly basis.

The Substance Abuse Prevention and Treatment Block Grant Women's Set Aside funds are allocated to the eight (8) Local Management Entities/Managed Care Organizations (LME/MCOs) across the state. The Performance Contract requires each LME/MCO to abide by the SAPTBG regulations which includes the Women's Set Aside requirements. These funds are monitored on an annual basis through the following means: Semi-Annual SAPTBG Compliance Reports, onsite monitoring by the Division's Fiscal Management Section, Annual Cross Site Evaluations required for each of the programs in the Perinatal and Maternal Initiative, and other monitoring as needed. LME/MCOs complete the Semi-Annual SAPTBG Compliance Reports which includes their policies and procedures on addressing priority admissions and their effort to advertise and publicize priority admissions. Additionally, the Fiscal Management Section, in collaboration with the Addictions and Operations Management Section, provide onsite monitoring of the LME/MCOs and the contract agencies to ensure funds are meeting the SAPTBG Women's Set Aside requirements. This monitoring includes review of policies and procedures of the appropriate entity, LME/MCO and/or contract agencies, regarding treating the family as a unit, priority admissions, interim services, gender specific treatment, therapeutic interventions for children, case management, child care and transportation, outreach services, primary and preventive health care for women and their children. These elements are monitored at both the program level with a review of current policies and procedures and at the individual level with a review of a sample of individual service records to ensure compliance.

Additionally, each of the programs in the Perinatal and Maternal Substance Use Initiative completes and submits an annual cross site evaluation. This evaluation includes a narrative specific to each of the SAPTBG Women's Set Aside requirements, focus group process outcomes, aggregate admission and treatment data, budget information and outcome evaluations. The information from the cross site evaluation is submitted to the Women's Services Coordinator and reviewed by the Coordinator and her program evaluator. Any non-compliance or problem areas presented by the programs are addressed with each agency. Onsite technical assistance is provided is needed.

# Environmental Factors and Plan

## 20. Suicide Prevention

Narrative Question:

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In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised [National Strategy for Suicide Prevention \(2012\)](#).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#).<sup>96</sup>

*Please indicate areas of technical assistance needed related to this section.*

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<sup>96</sup> [http://www.samhsa.gov/sites/default/files/samhsa\\_state\\_suicide\\_prevention\\_plans\\_guide\\_final\\_508\\_compliant.pdf](http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf)

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

## 20. Suicide Prevention

**1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised NSSP 2012.**

The Executive Summary of the North Carolina State Suicide Prevention Plan (NC DHHS, 2015) can be found in the attachment section of this plan. The Plan in its entirety can be accessed at <http://www.injuryfreenc.ncdhhs.gov/preventionResources/docs/2015-NC-SuicidePreventionPlan-2015-0505-FINAL.pdf>

**2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.**

**3. Include a new plan (as attachment to the block grant app) that delineates the progress of the state suicide plan since the FY 2014-2105 Plan. Please follow the format outlined in the new SAMHSA Guidance for State Suicide Prevention Leadership and Plans.**

Below is a description of the planning process and the way in which NC's State Suicide Prevention Plan was created to mirror the format, core components and strategies as outlined in the NSSP (2012).

In addition, the planning process engaged as well as the plan explicitly includes all individuals, in particular those populations most at risk for suicide attempts or death by suicide, those living of all ages with SED, SMI and/or co-occurring disorders (including SUD, IDD/DD, chronic pain or terminal illness). These populations are the same as those supported through the MHBG funds.

The NC DHHS, Divisions of Public Health and Mental Health, Developmental Disabilities and Substance Abuse Services (MH/DD/SAS) facilitated stakeholders through a process to develop [\*Saving Tomorrow's Today, North Carolina's Plan to Prevent Youth Suicide\*](#) to align with six goals from the *2001 National Strategy for Suicide Prevention (NSSP)*.

In late 2012, the Substance Abuse and Mental Health Services Administration (SAMHSA) released its second [\*National Strategy for Suicide Prevention\*](#), outlining 13 goals and 60 objectives, organized by four strategic directions: 1) *Healthy and Empowered Individuals, Families, and Communities*; 2) *Clinical and Community Preventive Services*; 3) *Treatment and Support Services*; and 4) *Surveillance, Research, and Evaluation*. To coincide with its release, SAMHSA encouraged states to develop suicide prevention plans across the lifespan.

Concurrent with the *2012 NSSP*, the N.C. Department of Health and Human Services (DHHS) Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) worked with the North Carolina Institute of Medicine (NCIOM) to develop a mental health treatment focused [\*Suicide Prevention and Intervention Plan\*](#), which concentrates on the role of health care and community based providers to reduce suicide contemplations, attempts, and deaths in the state of North Carolina.

In late 2013, the NC DHHS, through coordinated leadership of the Divisions of Public Health and Mental Health, Developmental Disabilities and Substance Abuse Services initiated a 16-month process to develop a statewide *2015 N.C. Suicide Prevention Plan*. The development of a new plan, seen as a complement to the DMH/DD/SAS plan, provided an opportunity to bring together a group of approximately 180 diverse suicide prevention stakeholders to contribute to its creation.

The primary purpose of the *2015 N.C. Suicide Prevention Plan* is to empower all North Carolinians with knowledge and to highlight examples of the actions they can take to reduce suicide. Funds and resources available to support coordinated suicide prevention efforts are limited. As such, the plan development process focused on developing a road map for stakeholder groups in North Carolina to address the burden of suicide. The road map approach aligns with current efforts across the state that can leverage partnerships and resources to prevent suicide. Using this plan, practitioners from a variety of disciplines at the state, regional, and local level can align their efforts to plan, implement, and evaluate suicide prevention efforts. Moreover, those individuals with lived experience, survivors, attempters, and those touched by suicide are critical partners and catalysts at the community, regional and state levels. As an example, the platform Miss Statesville 2015 chose was “Mental Illness, Change the Story.” She openly discussed her lived experience in high school and college with mental illness, suicide attempts, treatment, recovery and successful outcomes as a college graduate, working in her profession. Effective strategies that span life transitions, opportunities and events through lived experience are core to community impact and drivers for change. Those with FEP are at particularly high risk and are included in this plan, as well as is safety planning in the Coordinated Specialty Care model implementation through the MHBG 5% set aside funding.

In reviewing and using the *2015 N.C. Suicide Prevention Plan* in its entirety, for ease of reference, hyperlinks are provided to allow readers to quickly advance to various sections of the plan, including lists of examples of how each of the following 10 stakeholder groups can contribute to suicide prevention in North Carolina: 1) Governmental Agencies/Departments (Federal, State, Local); 2) Tribal Governments; 3) Health Care Systems, Insurers and Clinicians; 4) Businesses, Employers and Professional Associations; 5) Primary and Secondary Schools; 6) Colleges and Universities; 7) Nonprofit, Community and Faith-based Organizations; 8) Research Organizations (including universities); 9) Individuals, Families, Consumers and Concerned Citizens; and 10) Military Entities.

Significant progress and accomplishments since the previous block grant plans include:

- The state now has a suicide prevention plan, released in January 2015.
- The plan and process followed the recommended *SAMHSA Guidance for State Suicide Prevention Leadership and Plans*. This spring focused on highlighting the plan and making connections with existing work in communities to prevent suicides.
- A combined *DHHS/DMH/DD/SAS Crisis Solutions Initiative and NC Practice Improvement Collaborative Forum* was held in January 2015 with a focus on preventing suicides and implementing effective crisis services and supports in communities and ways to better utilize the *National Suicide Prevention Lifeline* through North Carolina’s call center, REAL Crisis Intervention, Inc., and the LME/MCO 1-800 Access Screening, Triage and Referral (STR) lines.

- *Crisis Intervention Training (CIT) Conference* in February 2015, highlighted those with lived experience, those who attempted and those receiving supportive intervention from CIT trained police officers and school resource officers.
- A *Suicide Prevention Summit* was held in May 2015, to promote use of the plan among stakeholders and strategies outlined.
- A *Mental Health First Aid (MHFA) Instructors Institute* was held in May 2015, to facilitate essential connections between MHFA and suicide prevention and special populations impacted across our state, including schools, faith communities, health care and law enforcement.
- *Breaking the Silence: Telling Our Stories* was a primary track of the NC Parent Resource Center Conference, May 2015, to engage prevention providers and community stakeholders in implementing the suicide prevention plan through the courage and core leadership of those with lived experience and in recovery.
- Collaborative efforts to create and submit a *SAMHSA Cooperative Agreement for State-Sponsored Youth Suicide Prevention and Early Intervention*, June 2015; when funded, suicide prevention strategies will be implemented in the eastern most counties of our state with targeted focus on those youth 16-25 most at risk who are LGBTQ, American Indians and military/veterans.





**Injury and Violence Prevention (IVP) Branch  
N.C. Chronic Disease and Injury Section  
N.C. Division of Public Health**



**Policy Development/Prevention and Early Intervention Team  
N.C. Division of Mental Health, Developmental Disabilities,  
and Substance Abuse Services  
N.C. Department of Health and Human Services**



**The University of North Carolina Gillings School of Global Public Health  
Department of Health Behavior**

## EXECUTIVE SUMMARY

### A. Section 1 - Introduction

The North Carolina Injury and Violence Prevention (IVP) Branch is located in the Chronic Disease and Injury (CDI) Section, within the N.C. Division of Public Health (DPH), which has been designated by the N.C. General Assembly as the lead agency for injury prevention in North Carolina. The IVP Branch's programs provide funding, training, and technical assistance to public health professionals working across North Carolina. The Branch works to promote the use of research and data to ensure local communities are implementing initiatives that are effective. In 2004, the IVP Branch led stakeholders through a process to develop [Saving Tomorrow's Today, North Carolina's Plan to Prevent Youth Suicide](#) to align with six goals from the *2001 National Strategy for Suicide Prevention (NSSP)*.

In late 2012, the Substance Abuse and Mental Health Services Administration (SAMHSA) released its second [National Strategy for Suicide Prevention](#), outlining 13 goals and 60 objectives, organized by four strategic directions: 1) *Healthy and Empowered Individuals, Families, and Communities*; 2) *Clinical and Community Preventive Services*; 3) *Treatment and Support Services*; and 4) *Surveillance, Research, and Evaluation*. To coincide with its release, SAMHSA encouraged states to develop suicide prevention plans across the lifespan. Concurrent with the *2012 NSSP*, the N.C. Department of Health and Human Services (DHHS) Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) worked with the North Carolina Institute of Medicine (NCIOM) to develop a mental health treatment-focused [Suicide Prevention and Intervention Plan](#), which concentrates on the role of multiple medical care facilities to reduce suicide contemplations, attempts, and deaths in the state of North Carolina.

In late 2013, the IVP Branch initiated a 16-month process to develop a statewide *2015 N.C. Suicide Prevention Plan*. The development of a new plan, seen as a complement to the DMH/DD/SAS plan, provided an opportunity to bring together a group of approximately 180 diverse suicide prevention stakeholders to contribute to its creation.

The primary purpose of the *2015 N.C. Suicide Prevention Plan* is to empower all North Carolinians with knowledge and to highlight examples of the actions they can take to reduce suicide. Funds and resources available to support coordinated suicide prevention efforts are limited. As such, the plan development process focused on developing a road map for stakeholder groups in North Carolina to address the burden of suicide. The road map approach aligns with current efforts across the state that leverage partnerships and resources to prevent suicide. Using this plan, practitioners from a variety of disciplines at the state, regional, and local level can align their efforts to plan, implement, and evaluate suicide prevention efforts.

Those interested in preventing suicide in North Carolina are encouraged to review the *2015 N.C. Suicide Prevention Plan* in its entirety. However, hyperlinks are provided to allow readers to quickly advance to various sections of the plan, including lists of examples of how each of the following 10 stakeholder groups can contribute to suicide prevention in North Carolina: 1) Governmental Agencies/Departments (Federal, State, Local); 2) Tribal Governments; 3) Health Care Systems, Insurers, and Clinicians; 4) Businesses, Employers, and Professional Associations; 5) Primary and Secondary Schools; 6) Colleges and Universities; 7) Nonprofit, Community, and Faith-based Organizations; 8) Research Organizations (including universities); 9) Individuals, Families, and Concerned Citizens; and 10) Military Entities.

### B. Section 2 - How the 2015 N.C. Suicide Prevention Plan Was Developed

From September 2013 through December 2014, a planning team comprised of staff from the IVP Branch, the DMH/DD/SAS, Community Policy Management Section, and the University of North Carolina at Chapel Hill Gillings School of Global Public Health, Department of Health Behavior, led the plan development process. They engaged the assistance of more than 180 suicide prevention stakeholders, representing 10 stakeholder groups, from across the state. Stakeholders worked in either a Working Group or a Consulting Group. Members of both groups: a) completed an online survey to assess alignment of North Carolina activities and needs with the *2012 NSSP*; b) identified examples of what stakeholders in North Carolina are doing to address suicide; c) provided feedback on drafts of individual plan sections; and d) submitted endorsements of the plan.

Working Group members also attended two in-person meetings (April 30 and June 24, 2014). At the first in-person working group meeting participants worked in small groups to: a) determine how 2012 NSSP objectives should remain for consideration in the North Carolina plan; and b) identify examples describing what stakeholder groups could be or are already doing to prevent suicide in North Carolina. Following the meeting, Working and Consulting Group members completed an online exercise to collect over 500 additional examples of what stakeholders are doing or could be doing to address suicide in North Carolina. At the second in-person meeting, Working Group members participated in small group activities to prioritize goals and objectives by importance (e.g., reduces the burden of suicide in North Carolina, uses a comprehensive approach that targets multiple levels, uses interventions that are cost-effective) and feasibility (high, medium, low) for emphasis in the plan.

Following a formal review by the N.C. Department of Health and Human Services Office of Communications, the final version of the 2015 N.C. Suicide Prevention Plan was completed and uploaded to the [N.C. Injury and Violence Prevention Branch's website](#). Additional marketing materials were developed by IVP Branch staff as part of a separate communication and dissemination plan for the 2015 N.C. Suicide Prevention Plan.

### C. Section 3 - How Can You Use the 2015 N.C. Suicide Prevention Plan?

The plan was developed to provide stakeholders with a greater understanding of how everyone can contribute to the prevention of suicide and suicidal behaviors in our state, including the following examples:

**Identify examples of what you can do.** This plan was specifically created to allow anyone to pick it up and identify different ways that they can work to address suicide prevention in North Carolina.

*Example: A business owner, distressed over the recent suicide of one of her staff members, refers to the plan to gather ideas on how to better promote mental health wellness and offer support for her employees.*

**Identify resources.** Increase your knowledge about the local and national resources available to people who are in crisis, so that you are able to provide information about those resources to those who might benefit.

*Example: A university staff member familiarizes himself with the resources listed in Section 7 of the plan; subsequently, he posts and distributes information to students about the National Suicide Prevention Lifeline, the Trevor Project, and other resources.*

**Advocate for suicide prevention.** Contact local and state policymakers to express concern about the burden of suicide and suicidal behaviors within North Carolina, and to promote the development of strong suicide prevention practices and supportive resources for suicide loss and suicide attempt survivors statewide.

*Example: An individual writes her legislator to advocate for easier accessibility to low- or no-cost mental health treatment resources within her community, utilizing the data about suicide in North Carolina within the plan to illustrate the burden of the problem within the state.*

**Get involved/get trained.** Promote accessibility of suicide intervention skills training for all, and utilize the resources described in this plan to complete training yourself, if you have not already done so.

*Example: Upon reading about it in the plan, a health care provider enrolls in a Question, Persuade, Refer (QPR) training so that she can better understand and respond to patients who demonstrate warning signs of suicidal ideation and behavior.*

**Leverage this information for funding opportunities.** Use the data and information within this plan as supporting evidence to apply for funding for suicide prevention or mental health promotion programs, or research.

*Example: The development director of a nonprofit organization applies for grant funding to support his organization's suicide prevention activities. He references the plan in the application to showcase the significant amount of interest in and concern about the problem of suicide in N.C. and to demonstrate the need for increased funding by highlighting data about its impact.*

Readers are encouraged to consider these ideas as a springboard to action and the overall plan as a guide for their efforts, as well as to share this plan with others in their communities. Suicide prevention efforts in North Carolina will be stronger,

more sustainable, and have greater impacts if each of us develops a comprehensive understanding of the problem and is prepared to act, together.

#### D. Section 4 - What Does the Problem of Suicide Look Like in North Carolina?

Six data sources (five statewide and one national) were used to provide a broad, population-based overview of suicide and self-inflicted injury in North Carolina. Understanding the burden of suicide and self-inflicted injury in North Carolina is essential to developing and implementing effective prevention and intervention strategies:

- In 2012, suicide became the leading cause of injury death in North Carolina and remained so in 2013.
- Non-fatal self-inflicted injuries resulting in hospitalization or an Emergency Department (ED) visit are more common than suicide deaths.
- Firearms are the most common method of suicide in North Carolina.
- Males are more likely to die as a result of suicide than females. Females are more likely to be hospitalized or visit an ED for a self-inflicted injury than males.
- Youth and young adults have the highest rates of self-inflicted injury hospitalizations and ED visits of all age groups in North Carolina.
- In addition to sex and age, suicide related disparities in North Carolina have been identified by race, sexual orientation, and veteran status.

The [Burden of Suicide in North Carolina 2013](#)<sup>1</sup> and the [State of North Carolina Coordinated Chronic Disease, Injury, and Health Promotion State Plan 2013](#)<sup>2</sup> have additional information on the burden of suicide in North Carolina.

#### E. Section 5 - In What Direction Should N.C. Be Heading?

The 2015 N.C. Suicide Prevention Plan aligns closely with the [2012 National Strategy for Suicide Prevention \(NSSP\)](#)<sup>3</sup>. As a result, the goals and objectives in the 2015 N.C. Suicide Prevention Plan are organized according to the four strategic directions (SD) included in the 2012 NSSP. These strategic directions outline a comprehensive strategy for suicide prevention through the continued support of effective approaches and the identification of areas in need of greater development or resources. The 2012 NSSP included 13 Goals that describe more information about the strategic directions. Developers of the 2015 N.C. Suicide Prevention Plan adopted all 13 Goals (Table ES-1). Color-shading is used throughout the plan to indicate the four strategic directions.

Table ES-1. N.C. Goals (n=13) by Strategic Direction.

##### #1 - Healthy and Empowered Individuals, Families, and Communities

**GOAL 1.** Integrate and coordinate suicide prevention activities across multiple sectors and settings.

**GOAL 2.** Implement research-informed communication efforts designed to prevent suicide by changing knowledge, attitudes, and behaviors.

**GOAL 3.** Increase knowledge of the factors that offer protection from suicidal behaviors or promote wellness and recovery.

**GOAL 4.** Promote responsible media reporting of suicide, accurate portrayals of suicide and mental illnesses in the entertainment industry, and the safety of online content related to suicide.

##### #2 - Clinical and Community Preventive Services

**GOAL 5.** Develop, implement, monitor effective programs that promote wellness and prevent suicide and related behaviors.

**GOAL 6.** Promote efforts to reduce access to lethal means of suicide among individuals with identified suicide risk.

**GOAL 7.** Provide training to community and clinical service providers on the prevention of suicide and related behaviors.

##### #3 - Treatment and Support Services

**GOAL 8.** Promote suicide prevention as a core component of health care services.

**GOAL 9.** Promote and implement effective clinical and professional practices for assessing and treating those identified as

<sup>1</sup> North Carolina Department of Health and Human Services, Division of Public Health, Chronic Disease and Injury Section, Injury and Violence Prevention Branch (N.C. DPH), 2013a

<sup>2</sup> N.C. DPH, 2013b

<sup>3</sup> U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention (DHHS), 2012

Table ES-1. N.C. Goals (n=13) by Strategic Direction.

being at risk for suicidal behaviors. <b>GOAL 10.</b> Provide care and support to individuals affected by suicide deaths and attempts to promote healing and implement community strategies to help prevent further suicides.
#4 - Surveillance, Research, and Evaluation
<b>GOAL 11.</b> Increase the timeliness and usefulness of national surveillance systems relevant to suicide prevention and improve the ability to collect, analyze, and use this information for action. <b>GOAL 12.</b> Promote and support research on suicide prevention. <b>GOAL 13.</b> Evaluate the impact and effectiveness of suicide prevention interventions and systems and synthesize and disseminate findings.

For the 61 objectives developed for the 2015 N.C. Suicide Prevention Plan, stakeholders in North Carolina identified **32 prioritized objectives** (ordered by importance and feasibility) for emphasis in the 2015 N.C. Suicide Prevention Plan. Table ES-2 lists the 32 prioritized objectives in rank order, based on weighted scoring of importance and feasibility. For each objective, the level of feasibility (high or medium) is noted following the wording of the objective.

Table ES-2. Rank-Ordered Objectives Prioritized by Importance and High/Medium Feasibility (N=32).

Rank	Obj	Objective Wording and Feasibility Level (shown in italics)
1	5.2	Encourage community-based settings to implement effective programs and provide education that promote wellness and prevent suicide and related behaviors. <i>High</i>
2	7.1	Develop training on suicide prevention to community groups. <i>High</i>
3	11.3	Improve and expand state/territorial, tribal, and local public health capacity to routinely collect, analyze, report, and use suicide-related data to implement prevention efforts and inform policy decisions. <i>Medium</i>
4	9.1	Adopt, disseminate, and implement guidelines for the assessment of suicide risk among people receiving care in all settings. <i>High</i>
5	8.3	Promote timely access to assessment, intervention, and effective care for individuals with a heightened risk for suicide. <i>Medium</i>
6	1.1	Integrate suicide prevention into the values, culture, leadership, and work of a broad range of organizations and programs with a role to support suicide prevention activities. <i>High</i>
7	8.2	Develop and implement protocols for delivering services for individuals with suicide risk in the most collaborative, responsive, and least restrictive settings. <i>High</i>
8	6.1	Encourage providers who interact with individuals at risk for suicide to routinely assess for access to lethal means. <i>High</i>
9	11.2	Improve the usefulness and quality of suicide-related data. <i>High</i>
10	13.3	Examine how suicide prevention efforts are implemented in different communities, demographic groups to identify the types of delivery structures that may be most efficient and effective. <i>High/Medium</i>
11	4.1	Accurate data and resources readily available and accessible for pick up use by media and other. <i>Medium</i>
12	7.3	Develop and promote core education and training guidelines on the prevention of suicide and related behaviors by all health professions, including graduate and continuing education. <i>Medium</i>
13	3.1	Promote effective programs/practices that increase protection from suicide risk. <i>High</i>
14	9.2	Disseminate and implement guidelines for clinical practice and continuity of care for providers working with people with suicide risk. <i>Medium</i>
15	10.3	Engage suicide attempt survivors in suicide prevention planning, including support services, treatment, community suicide prevention education, and the development of guidelines and protocols for suicide attempt survivor support groups. <i>Medium</i>
16	13.6	Establish resources/guides to gain access to impact/effectiveness data (e.g. toolkit, resource centers). <i>High</i>
17	5.1	Strengthen the coordination, implementation, and evaluation of comprehensive state/territorial/tribal/local suicide prevention programming. <i>Medium</i>
18	5.3	Strengthen efforts to increase access to/delivery of effective programs and services for mental health/substance use disorders. <i>High</i>

Table ES-2. Rank-Ordered Objectives Prioritized by Importance and High/Medium Feasibility (N=32).

Rank	Obj	Objective Wording and Feasibility Level (shown in italics)
19	10.1	Develop guidelines for effective comprehensive support programs for individuals bereaved by suicide and promote the full implementation of these guidelines at the state/territorial, tribal, and community levels. <i>Medium</i>
20	2.4	Increase knowledge of the warning signs for suicide and of how to connect individuals in crisis with assistance and care. <i>High</i>
21	1.5	Integrate suicide prevention into all relevant health care reform efforts. <i>Medium</i>
22	10.5	Provide health care providers, first responders, others with care/support when a patient under their care dies by suicide. <i>High</i>
23	8.8	Develop collaborations between emergency departments and other health care providers to provide alternatives to emergency department care and hospitalization when appropriate, and to promote rapid follow-up after discharge. <i>Medium</i>
24	2.1	Develop, implement, and evaluate communication efforts designed to reach defined segments of the population. <i>High</i>
25	2.2	Reach policymakers with dedicated communication efforts. <i>Medium</i>
26	7.5	Develop and implement protocols and programs for clinicians and clinical supervisors, first responders, crisis staff, and others on how to implement effective strategies for communicating and collaboratively managing suicide risk. <i>High</i>
27	9.5	Adopt and implement policies and procedures to assess suicide risk and intervene to promote safety and reduce suicidal behaviors among people receiving care for mental health/substance use disorders. <i>Medium</i>
28	7.2	Provide training to mental health and substance abuse providers on the recognition, assessment, and management of at-risk behavior, and the delivery of effective clinical care for people with suicide risk. <i>High</i>
29	9.3	Promote the safe disclosure of suicidal thoughts and behaviors by all. <i>Medium</i>
30	3.2	Reduce the prejudice and discrimination associated with suicidal behaviors and mental and substance use disorders. <i>Medium</i>
31	3.3	Promote the understanding that recovery from mental and substance use disorders are real and possible for all. <i>Medium</i>
32	9.4	Adopt and implement guidelines to effectively engage families and concerned others, when appropriate, throughout entire episodes of care for people with suicide risk. <i>Medium</i>

## F. Section 6 - What Can We (Stakeholders) Do to Address Suicide in N.C.?

Planning process participants identified over 500 examples of what various stakeholder groups, collectively and individually, can do to address suicide in North Carolina.

Section 6 includes lists of stakeholder suicide prevention examples organized by strategic direction, with bolded objectives and examples representing prioritized objectives (i.e., high importance and high/medium feasibility). Examples are presented by stakeholder group in ascending order with three numerical references (i.e., #.#.#): the first number represents the goal number; the second represents the objective number; and the third represents the example number (i.e., 5.2.6 label refers to goal 5, objective 2, and example 6). Detailed information about examples identified is included in [Appendix D](#) of the plan. Some of the examples identified may be the same or similar for multiple objectives. In addition, some examples were identified as being relevant for more than one stakeholder group, and when so, are cross-listed. It is possible that some examples may also be relevant for additional stakeholder groups, but were not identified as such. The complete list of examples, presented by the stakeholder group(s) for which the example was identified, is included in Appendix E.

The examples identified through the planning process may or may not be inclusive of: a) all known evidence-based strategies; b) all types of interventions occurring in North Carolina c) examples relevant for all target audiences; or d) opportunities to address high risk-populations that available data indicate are disproportionately affected by suicide. Some examples may be more or less effective, as the plan development process did not require that all examples listed have

evidence of effectiveness. For some examples, it may be important to tailor the activity for specific target populations at increased risk of suicide (e.g., people with disabilities, LGBTQ citizens, and military or veterans).

## **G. Section 7 - Where Can I Go to Learn More about Suicide Prevention?**

The *2015 N.C. Suicide Prevention Plan* provides information and hyperlinks for additional resources about suicide prevention, at the state and national level, for the following categories: a) Suicide Prevention; b) Mental Health; c) Suicide Disparities ; d) Evidence Based-Practices; e) Advocacy and Awareness; and f) Data and Surveillance.

## **H. Section 8 - Endorsements**

A total of 46 entities and organizations have provided a formal endorsement of the *2015 N.C. Suicide Prevention Plan*.

# Environmental Factors and Plan

## 21. Support of State Partners

Narrative Question:

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The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

*Please indicate areas of technical assistance needed related to this section.*

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

## 21. Support of State Partners

### **1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.**

The NCDHHS and the NC Division of MH/DD/SAS have strong intra-agency and interagency alliances that work to achieve common goals and outcomes through shared strategies for universal and targeted populations across the state. A few of the larger current collaborations are highlighted below.

The Division relies heavily on strategic partnerships within the NC Department of Health and Human Services (DHHS), with other state government agencies and the State university system, as well as local government entities, advocacy organizations, consumer organizations, professional organizations and other stakeholder groups.

Specifically, the Division works collaboratively with other divisions and offices of the NC DHHS, including:

- The Division of State Operated Healthcare Facilities
- The Division of Vocational Rehabilitation
- The Division of Public Health
- The Division of Aging and Adult Services
- The Division of Services for the Blind
- The Division of Services for the Deaf and Hard of Hearing
- The Division of Child Development and Early Learning
- The Division of Health Services Regulation
- The Division of Medical Assistance (Medicaid and Medicare)
- The Office of Rural Health and Community Care
- The Division of Social Services (Child and Adult Welfare)
- Office of Medicaid Management Information Systems

The largest initiatives in which the Division is currently involved include the statewide implementation of the 1915 (b)/(c) Medicaid Waiver and integration of behavioral health specialty care and physical health care. These result in particularly close working relationships between every section of the Division of MH/DD/SAS and the Division of Medical Assistance and the Office of Rural Health and Community Care with its Community Care of North Carolina.

An additional critical partnership with the Division of Medical Assistance is the Department of Justice settlement agreement “Transitions to Community Living.” This initiative, which has specific deliverables over an eight year period, aims to assist individuals in transitioning from an adult care home or state institution to community living.

The Division's Justice Systems Innovations Team is a best practice team responsible for addressing policies and practices regarding adult and child substance use, mental health and intellectual/developmental disabilities needs relative to the criminal and juvenile justice systems, including Drug Control and Driving While Impaired services. The team provides leadership regarding evidence-based, best and promising practices related to services and supports for individuals, systems performance and multi-system coordination. Collaboration occurs with law enforcement (federal, state, county and local) and community and institutional corrections systems (detention centers, youth development centers, jails, prisons, adult and juvenile courts, probation, parole and post-release supervision). Activities are intended to inform and operationalize public policy, identify areas of need, test models and strategically plan with other agencies, such as:

- Department of Correction (DOC)
- Division of Community Corrections (DCC)
- Division of Alcoholism & Chemical Dependency Programs (DACDP)
- Division of Prisons (DOP)
- Administrative Office of the Courts (AOC)
- Department of Public Safety (DPS – includes Juvenile Justice, Violence Prevention, School Safety, jails, detention, prisons, law enforcement, emergency disaster response)
- Department of Public Instruction (DPI – public schools, local education agencies - LEAs)
- Governor's Crime Commission (GCC)
- Division of Motor Vehicles (DMV)
- Office of the Attorney General
- State Bureau of Investigation (SBI)
- Drug Enforcement Agency (DEA)
- Local Law Enforcement Agencies
- Sheriffs' Association

There are numerous other interagency initiatives and collaborative efforts across departments of public instruction, public safety, administrative office of the courts, higher education public academic liaisons, primary care and other providers, consumers, youth and families in which the NC Division of MH/DD/SAS is engaged in order to achieve common goals and outcomes through shared strategies for universal and targeted populations across the state. A number of these have been highlighted throughout this plan in prior sections. Areas in which there is targeted focus include early childhood and family development, school age prevention and early intervention initiatives, youth in transition, adolescent health, suicide prevention, positive parenting, homeless and housing, employment and education, military children and families, and transitions to community living among others. Each of these collaborative initiatives plays a role in building resilience and promoting recovery in North Carolina.

## Environmental Factors and Plan

### 22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

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Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created [Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration](#).<sup>97</sup>

Additionally, [Title XIX, Subpart III, section 1941 of the PHS Act \(42 U.S.C. 300x-51\)](#) applicable to the SABG and the MHBG, requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

*For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.*

*For MHBG and integrated BHPC: States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.*

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

*Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.*<sup>98</sup>

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<sup>97</sup><http://beta.samhsa.gov/grants/block-grants/resources>

<sup>98</sup>There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Please use the box below to indicate areas of technical assistance needed related to this section:

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Footnotes:

Please see the Attachments section for a list of the Advisory members to the SABG.

## 22. Public Comment

**For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.**

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services posts its Substance Abuse Prevention and Treatment Block Grant on the department's website after approval from the Secretary of the NC Department of Health and Human Services. The application and plan for 2014-2015 can be found at:

<http://www2.ncdhhs.gov/mhddsas/statspublications/Publications/blockgrants/index.htm>

The cover letter of the application instructs readers on where to send comments, questions and suggestions. In addition, the Plan is provided to and discussed with various other stakeholders, including the Substance Use Disorder Federation, the Advisory Committee for the SABG of the Substance Use Disorder Federation, the Division's Consumer Empowerment Team, members of the State Consumer and Family Advisory Committee (SCFAC), various state agency partners, etc. LME/MCOs are encouraged to share the plan with its boards and local Consumer and Family Advisory Committees.

North Carolina provides opportunities for the public to comment on the State's FY 2016-17 application during the development of the plan and after submission of the plan. DMH/DD/SAS sought feedback and input from the Substance Use Disorder Federation, the Advisory Committee for the SABG of the Substance Use Disorder Federation, the Division's Consumer Empowerment Team and members of the State Consumer and Family Advisory Committee (SCFAC) on several occasions throughout the last year. These meetings focused on reviewing services data, trends and expenditure reports and identifying plan priorities, strategies and targets.

The Advisory Committee for the SABG of the Substance Use Disorder Federation will continue to assist in the review of the 2016-2017 plan and any public comments submitted throughout the upcoming year during its regular monthly meetings. DMH/DD/SAS will publish the final plan on the Division's website to facilitate comments from any person (including federal or other public agencies) after the submission of the plan to SAMHSA in October 2015. Instructions for submitting comments will be given on the web.

## Environmental Factors and Plan

### Behavioral Health Advisory Council Members

Start Year:

End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
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No Data Available

#### Footnotes:

Please see the Attachments section for a list of the Advisory Members for the SABG.

## SUD Federation Membership List

Addiction Professional of NC	Mark Ezell
Alcohol/Drug Council of NC	Mary Powell / Keith Kimbro
Caring Services, Inc.	Ralph Rodland / Jason Yates
Carolina Outreach, LLC	Larry Clubine/Jenae Hebb
Coastal Horizons Center, Inc.	Deeanna Hale-Holland / Karen Chappell
NC Division of Vocational Rehab Services	Gina Price / Jim Swain
NC Parent Resources Center	Phil Mooring / Anna Goodwin
NC Providers Council	John Tote / Bob Hedrick
NC Psychiatric Association	Robin Huffmann / Kristin Milam
NC Stakeholder Engagement Group	Kelly Friedlander
NC Substance Abuse Prevention Providers Association	Erin Day / Deborah Hendren
NC Treatment Accountability for Safer Communities	Erin Day / Deborah Hendren
Oxford House of North Carolina	Kurtis Taylor (Chair) / Tony Sowards
Piedmont Area Substance Abuse Provider Association	Angie Banther
Recovery Communities of North Carolina	Betty Currier / Tom Edwards
R.J. Blackley & Division of State Operated Healthcare Facilities	Lisa Haire
Southlight Healthcare	Tad Clodfelter / Mary Ann Johnson
Wake County Drug Treatment Court	Nicole Singletary / Kenneth White
Youth Focus	Eric Davis

# Environmental Factors and Plan

## Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)		
Family Members of Individuals in Recovery* (to include family members of adults with SMI)		
Parents of children with SED*		
Vacancies (Individuals and Family Members)	<input type="text"/>	
Others (Not State employees or providers)		
State Employees		
Providers		
Federally Recognized Tribe Representatives		
Vacancies	<input type="text"/>	
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text"/>	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text"/>	

\* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes: