North Carolina

UNIFORM APPLICATION

FY 2024/2025 SUPTRS BG Only ApplicationBehavioral Health Assessment and Plan

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 06/15/2023 - Expires 06/30/2026
(generated on 09/16/2024 1.34.25 PM)

Center for Substance Abuse Prevention
Division of Primary Prevention

Center for Substance Abuse Treatment
Division of State and Community Systems (DSCS)

State Information

State Information

Plan Year

Start Year 2024

End Year 2025

State Unique Entity Identification

Unique Entity ID DKT3LLBWFVL3

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 Use Services (DMHDDSUS)

Mailing Address 3001 Mail Service Center

City Raleigh

Zip Code 27699-3001

II. Contact Person for the Grantee of the Block Grant

First Name Kelly

Last Name Crosbie

Agency Name DMHDDSUS, NC DHHS

Mailing Address 3001 Mail Service Center

City Raleigh

Zip Code 27699-3001

Telephone 984-239-0657

Fax

Email Address kelly.crosbie@dhhs.nc.gov

III. Expenditure Period

State Expenditure Period

From

To

IV. Date Submitted

Submission Date 9/29/2023 3:04:08 PM

Revision Date 9/29/2023 3:04:32 PM

V. Contact Person Responsible for Application Submission

First Name DeDe

Last Name Severino

Telephone 984-236-5122

Fax

Email Address dede.severino@dhhs.nc.gov

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

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

Fiscal Year 2024

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
Tile 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	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
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Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
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Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**

Section 1943	Additional Requirements	**42 USC § 300x-53**
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

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 19 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, as applicable, with 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 Coastal 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 Clean 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.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
    a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
    b. Collecting a certification statement similar to paragraph (a)
    c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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 Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. 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, daycare, 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.

By signing the certification, the undersigned 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 subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health 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 PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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 other Certifications summarized above.

State: ______________________

Name of Chief Executive Officer (CEO) or Designee: Kody Kinsley

Signature of CEO or Designee[1]: ______________________

Title: Secretary, NC DHHS

Date Signed: ______________________
mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

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STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

KODY H. KINSLEY
SECRETARY

SECRETARIAL DIRECTIVE 003

DATE: 09/26/22 | 5:02 PM EDT

SUBJECT: Delegation of Authority Concerning Grants, Budget and Financial Matters

1. **SCOPE**. This Directive applies to all divisions, offices, facilities, and units within the North Carolina Department of the Health and Human Services. The provisions of this Directive shall not be construed to interfere with or impede the authorities or duties prescribed by law to specific divisions, offices, facilities or units, or individuals within those units.
2. **SIGNATURE AUTHORITY.** The provisions of Secretarial Directive 001 are incorporated herein. In addition, the following directives shall govern the authority of officers and employees of the Department in seeking grant funding from public and private entities that binds the Department or any division, office, facility or unit, or individual within those units.
   a. **Department Grant Funding**. For any grant application or proposal for funding, including competitive and non-competitive grant applications, formula and other types of mandatory grants and block grants in which the Department is the named party (as opposed to a specific Division, Office, or Facility), the appropriate Deputy Secretary, including the Chief Deputy Secretary, or their designee shall have the authority to review, approve, and sign all grant applications or proposals for funding. Regardless of the final signatory, in order to ensure strategic use of grant funds, the approval process for grant applications and other associated documents should include leaders from divisions and offices across the Department with a stake in that work. As a part of this directive, the Deputy Secretary shall further ensure that a documented delegation of authority is in place to an authorized organizational representative(s) for the purpose of submitting grant applications and proposals once the grant application or proposals has been approved.
      i. **State plans and state plan amendments and reporting for grant funding.** The appropriate Deputy Secretary or their designee shall have the authority to review, approve, and sign all state plans, state plan amendments and required reporting.
      ii. **Grant continuation, application renewals and federal cooperative agreements**. The appropriate Deputy Secretary or their designee shall have the authority to review, approve, and sign all grant continuation, renewals, and federal cooperative agreements.
      iii. **Block Grants.** The appropriate Deputy Secretary, or their designee, shall have the authority to review, approve block grant plans for each block grant under their purview, including any reporting.

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- **iv.** A Deputy Secretary shall not delegate any actions under (a)(i)-(iii) involving (1) commitment for a new program or service not authorized under the Department's purview or an explicit act of the General Assembly, and/or (2) continuing financial commitment obligating the Department as a consequence of accepting the grant funds beyond the period of the grant or action.
- **v.** The Chief Deputy Secretary may sign or, notwithstanding paragraphs (a)(i)-(iii), may specifically designate a Deputy Secretary to sign the subject grant, proposal, agreement or other document. Any grant, proposal, agreement or other document defined above, may also be signed by the Chief Deputy Secretary.
- **vi.** Any delegation by a Deputy Secretary for carrying out the above obligations shall be documented in writing and submitted to the General Counsel.

b. **Budget Formulation.** The appropriate Deputy Secretary shall review primary budget documents for the biennial planning period and recommended adjustments to that budget reflecting change budgets including expansion, block grant plans and supplemental budgets, proposed and submitted by the departmental divisions, facilities and offices, etc. These budget documents may be submitted through the division or office director and/or assistant secretaries, as applicable. After review, the Deputy Secretaries shall make appropriate recommendations to the Chief Deputy Secretary and Secretary regarding modification and approval and submission to the Office of State Budget and Management.

c. **Budget Execution and Control of Funds.** The appropriate Deputy Secretary, including the Chief Deputy Secretary, shall delegate in writing to appropriate Assistant Secretaries, Senior Directors and/or Division, Office or Facility directors the authority to:
- **i.** incur obligations and make expenditures within the budgetary resources appropriated, certified and/or authorized to the division, office or facility consistent with applicable State and federal authority;
- **ii.** request allotment of funds in accordance with State policy;
- **iii.** salary control; and
- **iv.** operationalize, adjust and/or realign requirements and revenues in the division, office of facility's base or authorized budget to maintain appropriate operational levels.

d. The Deputy Secretaries shall have oversight and delegate responsibility to the Division/Office/Facility Director to maintain a system of administrative control of funds including cash management as authorized and in accordance with State accounting and financial policies and procedures of the Division of Budget and Analysis, Office of State Budget and Management, the Office of the DHHS Controller, the Office of State Controller and state statute.

e. The Deputy Secretaries shall have authority and be responsible for the preparation, review, and the execution of responses to correspondence or inquiries regarding issues of direct relevance to departmental budgetary matters, programmatic issues of direct relevance to the Fiscal Research Division and other relevant legislative divisions of the North Carolina General Assembly, issues of direct relevance to the North Carolina Office of the Governor, Office of State Budget and Management, Office of the State Controller and Department of Administration.

1. **AUTHORITIES**.

a. N.C. Gen. Stat. § 143B-10

b. N.C. Gen. Stat. § 143B, Article 3

c. N.C. Gen. Stat. § 143C

2. **OFFICE OF PRIMARY INTEREST**. The Office of the General Counsel; Division of Budget and Analysis; Office of the Controller
3. **SECRETARY AUTHORITY**. This Directive and any delegation of authority herein shall not deprive the Secretary from performing, in lieu of the Chief Deputy Secretary, Deputy Secretary or any other named official, any of the acts set forth above. This delegation of authority may be amended or withdrawn by the Secretary at any time and without notice. This delegation of authority shall not apply to any actions which by law, regulation or Executive Order, may only be executed by the Secretary.
4. **PRIOR DIRECTIVES AND DELEGATIONS**. This Directive and any delegation of authority herein shall supersede any previously issued directive or delegation, whether by the below signed Secretary or any previous Secretary, that conflicts with the terms set forth above.

DocuSigned by:

D7816E4CBA6F4A8...

Kody H. Kinsley

Secretary

State Information

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Fiscal Year 2024

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Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**

Section 1943	Additional Requirements	**42 USC § 300x-53**
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

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 19 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, as applicable, with 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 Coastal 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 Clean 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.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at **http://sam.gov [sam.gov]**
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. 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.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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 Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. 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, daycare, 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.

By signing the certification, the undersigned 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 subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health 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 PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

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 other Certifications summarized above.

State: North Carolina

Name of Chief Executive Officer (CEO) or Designee: Kody Kinsley

Signature of CEO or Designee[1]: DocuSigned by: Mark T. Benton 65A1EF320AD6419...

Title: Secretary, NC DHHS

Date Signed: 09/28/23 | 11:09 AM EDT

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

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

Kody Kinsley

Title

Secretary

Organization

NC DHHS

Signature: DocuSigned by: Mark T. Benton 65A1EF320AD6419...

Date: 09/28/23 | 11:09 AM EDT

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

See signed document in attachments.

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

Kody Kinsley

Title

Secretary

Organization

NC DHHS

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

See signed document in attachments.

Planning Steps

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

Narrative Question:

Provide an overview of the state's M/SUD prevention (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD 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 SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

Further, in support of the **Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government**, SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

SUBG Assessment and Plan 2024 - 2025

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

Specific Instructions: *Provide an overview of the state's M/SUD prevention (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD 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 SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.*

Further, in support of the Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government, SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

The Division of Mental Health, Developmental Disabilities and Substance Use Services (DMHDDSUS) of the North Carolina Department of Health and Human Services is the Single State Agency for the Substance Use Prevention, Treatment and Recovery Services (SUPTRS/SUBG) Block Grant and the State Mental Health Agency for the Community Mental Health Services (CMHS) Block Grant. The Division consists of the Director's Office and six (6) sections, each of which contains one or more teams. The executive leadership team is comprised of the Director, Deputy Director, Assistant Director for Policy and Program Design, Assistant Director for System Performance, Assistant Director for Stakeholder Engagement, Assistant Director for Strategy and Planning, the Chief Medical Officer for Behavioral Health and IDD and the Chief Financial Officer for Behavioral Health and IDD.

The overall structure of DMHDDSUS is both functional in nature as well as disability specific. **Please see the DMHDDSUS organizational chart following the end of this document for specific detail.**

The Assistant Director for Policy and Program Design is responsible for the largest number of sections and teams within the Division. Those teams consist of the Addictions and Management

Operations team, the Community Wellness, Prevention and Health Integration team, the Community Mental Health Team, the Transitioning Populations team and the Justice Populations section, which includes the Drug Control Unit, as well as the Intellectual/Developmental Disabilities/Traumatic Brain Injuries team. The Mental Health, Addictions and Management Operations and Intellectual/Developmental Disabilities/TBI sections have staff with expertise in each of the populations of focus, who are further specialized along the developmental stages of early childhood (0-5), later childhood (6-12), youth (13-17) and adulthood. However, it should be noted that a new division was created approximately two years ago, the Division of Child and Family Wellbeing, that now primarily oversees whole child health, including mental health programs, System of Care, pediatric mental health care access, etc.

The Addictions and Management Operations team is responsible for clinical policy development, implementation and guidance specific to addictions treatment and recovery services and supports, including the 1115 Substance Use Disorder Demonstration Medicaid Waiver clinical policies and related tasks in coordination with the Division of Health Benefits (NC Medicaid). This team is responsible for the development of the biannual Substance Use Prevention, Treatment and Recovery Services (SUPTRS/SUBG) Block Grant plan and annual reports, as well as federal discretionary grants that focus on SUD treatment and recovery. This team includes the NC State Opioid Treatment Authority (SOTA) that provides oversight, monitoring and TA to 86 opioid treatment programs across the state. The Adolescent Services Coordinator provides services development, oversight and technical assistance to several adolescent CASP (cross-area services programs) for residential treatment. The Women's Services Coordinator provides management of state and federal funds that support gender responsive substance use disorder treatment services for women and their families and coordinates the statewide capacity management system for treatment services for pregnant and parenting women and their families. This team also includes the NC Problem Gambling Program funded through the NC Education Lottery which aims to mitigate the harms associated with problem gambling by providing a 24/7 helpline, education, outreach and treatment services across the state. Additional contractors and time-limited staff support women's services, the SOTA, problem gambling, as well as the State Opioid Response (SOR) 3 grant.

The Community Wellness, Prevention and Health Integration team is responsible for SUD primary prevention. This team is comprised of the Section Chief and staff who are responsible for SUD primary prevention initiatives under the block grant, including programmatic and financial compliance, contract administration, monitoring and reporting, training and technical assistance, interagency relationships, coordination and planning, needs assessment, the utilization of evidenced based programs, policies and practices, and evaluation. Other areas of focus include underage drinking, fetal alcohol spectrum disorder, Synar/FDA compliance, and the prevention components of the State Opioid Response grant. Time-limited staff oversee the SPF-Rx grant focusing on prescription drug use/misuse and the Partnership for Success grant which focuses on the prevention of underage drinking ages 9-20, marijuana and e-cigarettes; and the Preventing Drug Overdose grant that focuses on reducing prescription drug and opioid overdose related deaths and related events among individuals 18 years and older.

The Justice Populations section provides leadership and expertise in addressing policies, planning and developing behavioral health (mental health and substance use disorders) and IDD services and supports to people involved in the NC criminal and juvenile justice systems. This section has

established strong partnerships with the Departments of Adult Correction (DAC) and Public Safety (DPS), including prisons and community corrections, as well as local jurisdiction partners including county jails and law enforcement agencies throughout the state. Primary purposes of the Justice Systems Innovations section include establishing statewide strategies in collaboration with justice-related state, local, and community-based partners to address challenges and improve outcomes for individuals with behavioral health disorders and intellectual/developmental disabilities (IDD) who are, or at risk of being, justice involved and implementing a state-level approach to reduce the overall number of people with behavioral health needs in criminal and juvenile justice systems. This section is specifically responsible for the oversight of particular justice related programs including TASC, compliance reviews of prison based behavioral health and substance use disorder treatment programs, Crisis Intervention Team (CIT) and Mental Health First Aid (MHFA) training coordination at the state level, Drug Education Schools, coordination of Stepping Up Sequential Intercept Mapping (SIM) initiatives and leadership and coordination of the Juvenile Justice Behavioral Health Partnership.

The Drug Control unit, a component of the Justice Populations section, works to identify and prevent diversion of controlled substances, and improve patient care and safety in the use of prescribed controlled substances. Relevant legislation: NC Controlled Substances Act, NC Controlled Substances Reporting System Act, and the Epilepsy Alternative Treatment Act. The Unit has three teams: the Regulatory team, who oversee the state's controlled substances licensing program; the State's prescription drug monitoring program known as the Controlled Substances Reporting System (CSRS) team; and the Unit management team (manager and coordinator), who manage the epilepsy alternative treatment act in addition to general unit management.

The Assistant Director for System Performance oversees the Quality Management team, the Financial Audit and Program Integrity team, the Information Systems team, the LME/MCO Liaisons team, the DWI team and the System Advocacy team.

The Assistant Director for Stakeholder Engagement oversees the Customer Rights team, the Community Engagement and Empowerment team, Military and Veterans Services and a field-based team. The Community Empowerment section provides consumer advocacy leadership and ensures that state-operated healthcare facilities and community-based systems are in compliance with rights' protections for individuals served through the system.

The Chief Financial Officer oversees all business and financial operations of the division, including financial reporting, budget management and contracts and grants.

The Chief Medical Office oversees the PASSAR team as well as various medical and pharmacy personnel in both DMHDDSUS and the Division of State-Operated Health Facilities (DSOHF).

The Deputy Director and Chief Operating Officer oversees the Legislative and Regulatory Affairs team, the Chief Financial Officer, Human Resources and several singular positions responsible for facility management and information technology.

Transformation of System Structure

Substance use disorder treatment and prevention, and mental health services were formerly provided directly by service providers (individuals) employed by area/county programs. With the 2001 Mental Health Reform legislation passed by the NC General Assembly, the focus of area programs shifted from direct service provision to the management of the local service delivery system. These Local Management Entities (LMEs) began contracting with providers for the delivery of services in their catchment areas. Between 2001 and 2010, the number of LMEs was incrementally reduced from 48 to 23. In April 2005, the state piloted the 1915 (b) Freedom of Choice Waiver/(c) Innovations Home and Community Based Services (HCBS) Managed Care Waiver with one LME. Under these waivers, Medicaid services are funded through capitated Pre-paid Inpatient Health Plans (PIHP) that allowed the Managed Care Organizations (MCO) to have more flexibility in service delivery. Due to the success of the pilot, in December 2009, DHHS submitted a waiver amendment to CMS designed to expand the 1915 (b)/(c) waiver statewide over a period of several years.

Numerous mergers between LMEs have occurred since then, resulting to date in six (6) LME/MCOs covering all 100 counties. DMHDDSUS and the Division of Health Benefits (also called NC Medicaid) jointly administer the LME/MCOs. The Division is primarily responsible for the oversight of services delivered by Local Management Entities/Managed Care Organizations (LME/MCOs), as they are the Division's intermediaries at the local level. **Please see the map at the following link for the counties covered by each LME/MCO: https://www.ncdhhs.gov/providers/lme-mco-directory.**

In 2015, the NC General Assembly enacted legislation directing DHHS to transition Medicaid and NC Health Choice from fee-for-service to managed care. Under managed care, the state contracts with insurance companies, which are paid a predetermined set rate per enrolled person to provide all services. In July 2020, legislation authorized NC Medicaid Managed Care to begin July 1, 2021, for Standard Plans and July 1, 2022, for Behavioral Health I/DD Tailored Plans. However, the department made the decision to delay the start of Tailored Plans to allow LME/MCOs, which will operate the Tailored Plans, more time to contract with additional providers to support member choice and to validate that data systems are working appropriately. This decision better ensures beneficiaries can seamlessly receive care on day one. While Tailored Plan implementation will go forward, a specific date is still to be determined.

This plan is an integrated health plan designed for individuals with significant behavioral health needs and/or intellectual/developmental disabilities (I/DDs). The Behavioral Health I/DD Tailored Plan will also serve other special populations, including Innovations and Traumatic Brain Injury (TBI) waiver enrollees, and waitlist members, and be responsible for managing the state's non-Medicaid behavioral health, developmental disabilities and TBI services for uninsured and underinsured North Carolinians. This final policy guidance describes detailed eligibility criteria and processes to guide enrollment into Behavioral Health I/DD Tailored Plans, including transitions of these beneficiaries across health plans and delivery systems. In developing these criteria and processes, the Department relied on the following key principles:

- **Enroll Beneficiaries in the Managed Care Product that Best Meets Their Needs.** Standard Plans and Behavioral Health I/DD Tailored Plans will offer integrated physical health, behavioral health and pharmacy services but Behavioral Health I/DD Tailored Plans will offer a more robust set of behavioral health, I/DD and TBI benefits, and specialized care

management. The Department will leverage available data to enroll beneficiaries in the product best suited to meet their needs.

- **Minimize Barriers to Access.** The Department will strive to minimize barriers for beneficiaries who need to transition between plans to access a benefit only available in a Behavioral Health I/DD Tailored Plan. This includes making sure there is a clear process for beneficiaries who are not identified as meeting Behavioral Health I/DD Tailored Plan eligibility through available data.
- **Comply with Legislation.** The Department will ensure that Behavioral Health I/DD Tailored Plan eligibility criteria and benefits meet the North Carolina General Assembly's vision for Behavioral Health I/DD Tailored Plans as articulated in legislation.
- **Be Responsible Stewards of Public Funds.** The Department will ensure that only beneficiaries who will benefit from more intensive behavioral health, I/DD, and TBI services and specialized care management enroll in a Behavioral Health I/DD Tailored Plan, and other beneficiaries who do not meet the level of need do not unnecessarily enroll in the higher cost Behavioral Health I/DD Tailored Plan.

Following a competitive selection process, the Department announced the selection of six organizations to serve as Behavioral Health and Intellectual/Developmental Disability Tailored Plans (Behavioral Health I/DD Tailored Plans). The following organizations were awarded a contract to serve as regional Behavioral Health I/DD Tailored Plans:

- Alliance Health Plan
- Eastpointe
- Partners Health Management
- Sandhills Center
- Trillium Health Resources
- Vaya Health

Individuals who need certain services to address a serious mental illness, serious emotional disturbance, severe substance use disorder, intellectual/developmental disability, or traumatic brain injury, will enroll in a Behavioral Health I/DD Tailored Plan.

Although Tailored Plan implementation has been delayed, the Behavioral Health and Intellectual/Developmental Disability (I/DD) Tailored Care Management (TCM) model has successfully moved forward. TCM reflects the goal of whole-person care management in NC Medicaid Managed Care. Provider-based care management promotes integrated care and offers beneficiaries choice in how they receive care management. Through Tailored Care Management, Behavioral Health I/DD Tailored Plan beneficiaries have a single, designated care manager supported by a multidisciplinary care team to provide integrated care management that addresses all their needs, spanning physical health, behavioral health, I/DD, TBIs, pharmacy, long-term services and supports (LTSS), as well as unmet health-related resource needs.

In October 2018, the federal Centers for Medicare and Medicaid Services (CMS) approved North Carolina's 1115 Demonstration Waiver application submitted in November 2017. The approval is effective January 1, 2019 through October 31, 2024. The amended waiver is the result of collaboration

among DHHS, beneficiaries and their families, advocates, health care providers, health plans and associations, lawmakers and other stakeholders throughout North Carolina.

Additionally, as part of its commitment to expand access to treatment for substance use disorders (SUDs), North Carolina's Department of Health and Human Services has been approved for an 1115 SUD Demonstration waiver to strengthen its SUD delivery system by:

- Expanding its SUD benefits to offer the complete American Society of Addiction Medicine (ASAM) continuum of SUD services:
    - DMHDDSUS and DHB NC Medicaid are working collaboratively to develop and revise state-funded and Medicaid clinical SUD policies across the ASAM conium of care. ASAM Level .5 expanding the SBIRT Codes to increase the types of licensed professionals eligible to bill these codes in a primary care setting was implemented. Additionally, the clinical coverage policies under ASAM Level 1, comprehensive clinical assessments and diagnostic assessments, were revised to ensure any individual who is diagnosed with a substance use disorder receives an ASAM level of care determination even when it is not a primary diagnosis. All other ASAM levels of care will be implemented in July 2022 in line with the Tailored Plan implementation.
- Obtaining a waiver of the Medicaid institution for mental diseases (IMD) exclusion for SUD services:
    - As of July 2019, under North Carolina's 1115 waiver authority, Substance Use Disorder ("SUD") services for individuals in an Institution for Mental Disease ("IMD") as well as any other Medicaid State Plan services for which they may be eligible during their stay in the IMD, shall be reimbursed under Medicaid. There is not a day limit nor is there a cap on the rate that may be paid to the IMD.
- Ensuring that providers and services meet evidence-based program and licensure standards:
    - DMHDDSUS and DHB are working closely with the Division of Health Services Regulation to ensure temporary licensure rules or waivers are in place to implement all new or revised ASAM levels of care.
- Building SUD provider capacity;
- Strengthening care coordination and care management for individuals with SUDs:
    - DMHDDSUS is developing a state-funded case management clinical policy for individuals with a behavioral health condition. This will be a time limited, provider-based service incorporating evidenced based practices for individuals with high needs including but not limited to the following:
        - Are placed at an inappropriate level of care or are at risk of being discharged from their current placement due to their complex needs;
        - Have a medical co-morbidity (including pregnancy);
        - Have co-occurring mental health, SUD, I/DD, and/or TBI disorders;
        - Have complex behaviors requiring additional supervision than is typically available and/or highly specialized interventions;
        - Have a legal history affecting ability to live in congregate settings and/or in proximity to children.
- Improving North Carolina's prescription drug monitoring program (PDMP).

The SUD component of North Carolina's Medicaid Reform Section 1115 demonstration expires on

October 31, 2023, whereas the other components of the demonstration currently have an end date of October 31, 2024. NC is seeking an extension request to extend the SUD component of the demonstration for an additional five years. North Carolina is not requesting any changes to the delivery system, eligibility requirements, benefit coverage, or cost sharing, as compared to the State's current demonstration features.

Please see the document titled **NCDHHS Public Notice for Section 1115 Waiver Extension** at the following link for more details: https://medicaid.ncdhhs.gov/meetings-notices/proposed-program-design.

In March 2023, bipartisan majorities in the NC General Assembly passed Medicaid expansion, finally putting the state on a path to close the coverage gap and enable access to care for more than 600,000 North Carolinians. Since that time, NCDHHS has been completing the extensive policy and technical work necessary to launch expansion and working with partners to be ready on day one. However, the General Assembly tied authority to implement Medicaid expansion to the state budget's enactment. As of submission of this plan, budget discussions have been delayed. It appears the General Assembly will neither pass a budget nor authorize NCDHHS to launch Medicaid expansion by September 1st, and as such, Medicaid expansion will not launch on October 1, 2023, as anticipated. With the continued uncertainty around when final authority will be granted to NCDHHS, determining a new launch date is not feasible.

This delay will result in more than 600,000 North Carolinians not being able to access care when they may need it most, especially with Continuous Coverage Unwinding causing nearly 9,000 people each month lose full health care coverage that would qualify under expansion. Nearly half of the people eligible for expansion – 300,000 people – would have been automatically enrolled in full coverage under Medicaid expansion on October 1st, but now have to wait. Each month of delay costs the state hundreds of millions of dollars flowing into communities across the state to support care and treatment for people and keep providers' doors open. Unfortunately, this delay will further strain providers who were gearing up to serve those newly eligible. We hope that we receive the authority to move forward with this historic opportunity to improve the health of North Carolinians as soon as possible.

North Carolina has fully transitioned to a multi-payer Medicaid Management Information System for the NC Department of Health and Human Services, called NCTracks. NCTracks was the largest, most complex IT project in state history and was the first public multi-payer system in the United States. NCTracks is used by the Division of Health Benefits (NC Medicaid), the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMHDDSUS), the Office of Rural Health and Community Care and the Division of Public Health (DPH). Providers enrolled in NC Medicaid, DMHDDSUS 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 over 70,000 enrolled DHHS providers who serve over 1 million North Carolina citizens. Providers who are contracted by LME/MCOs to enroll and perform state funded DMHDDSUS services submit their claims to the LME/MCO.

Prevention and Wellness Services

Six LME/MCOs currently subcontract with local prevention providers in their catchment areas to deliver primary substance use prevention services across the state. There are 23 local nonprofit prevention providers across the state that serve all 100 counties. The LME/MCO is responsible for monitoring, reporting, and participation in any evaluation of the local prevention providers. The LME/MCO receives guidance from the state's Prevention and Wellness team about federal substance abuse prevention guidelines and policies to support their oversight and monitoring of local prevention providers. The LME/MCO and their designated prevention providers enter into contract agreements that outlines specific prevention activities including target population, use of evidence-based practices and programs, and reporting requirements. Local contract prevention providers conduct community need assessments to determine services and activities. Each LME/MCO works with the contract substance abuse prevention provider to assist with identifying target populations and services based on local needs assessment results. In addition to the LME/MCO-Provider network, there are several partnerships, alliances, coalitions, and collaboratives providing individual and population-based strategies to communities throughout NC.

North Carolina has transitioned our prevention system to one that requires local prevention providers to utilize the **Strategic Prevention Framework** (SPF) to assess local needs, build community capacity, plan strategically, implement evidence-based strategies for the prevention of alcohol, tobacco, and other drugs, and evaluate program reach and effectiveness. Additionally, statewide training and technical supports are framed by the SPF.

- ***Needs Assessment*** - For data collection, the state requires prevention providers to complete a needs assessment every 3 years to determine populations in need of primary prevention services including racial, ethnic, sexual and gender minorities as well as American Indian and Alaskan Native populations; and the specific intervening variables that should be targeted for each population. Providers are required to capture substance use prevention consumption, consequences, and intervening variables for every county in the state. To support local needs assessment and planning efforts, the state provided administrative data for all 100 counties for the completion of a needs assessment in FY20. They are further given guidance on identifying disparately impacted populations. The state has developed a data dashboard, providing a wide cross section of administrative data available at the county level, and conducted a youth prevention survey to support prevention providers in this effort. They have also provided training in assessment, including data collection methods and follow-up technical assistance, to provide a theoretical understanding of the process, hands on application, and then individually tailored assistance with the assessment process. To support further needs assessment efforts, the state administered the latest statewide youth prevention survey in FY23.
- ***Planning*** – Utilizing the results of the needs assessment process, providers identify evidence-based practices, programs and policies to effectively address identified needs. To support the identification and selection of evidence-based strategies, the state has thoroughly researched and provided an approved list of evidence-based strategies for providers' use. The approved list

includes evidence-based strategies across the CSAP Six strategies (education, community-based processes, environmental strategies, information dissemination, problem identification and referral and alternative activities).

- ***Capacity building*** – To support local providers, the state has formed a Statewide Prevention Consortium (SPC) that consists of training and technical assistance agencies, discretionary grant leads, prevention evaluation center, and other statewide prevention resources. The consortium ensures the effective implementation of high-quality prevention services, delivered in alignment with state business policies for the prevention system. Partners within the consortium supports the state and local providers through the provision of training in evidence-based programs, policies and practices; developing CSAP Six strategies best practice guidance; training and technical support in conducting local needs assessment and strategic planning; supporting process and outcome evaluation efforts; workforce development that supports credentialing and local capacity building efforts. Additionally, the state communicates policies and procedures for the delivery of primary prevention services at least annually during regional statewide meetings. Regional meetings and state sanctioned trainings are published online with support from the statewide training and technical assistance center to ensure ongoing access to up to date state communications as well as training and technical support resources.

- ***Implementation*** - A majority of funds, approximately 80%, are expended for universal and population-based strategies. Local prevention providers implement data-informed, individual and community-center approaches and programs framed within the CSAP Six strategies and through the SPF in each of their assigned counties. Local prevention providers infuse diversity, inclusion and equity policies into all prevention activities. Furthermore, local providers implement programs and practices according to the guidance provided by the developers of the selected evidence-based programs as well as by best practice action steps provided by the state.

- ***Evaluation*** - The state has contracted with Prospectus Group to utilize their ECCO data collection system to capture primary prevention implementation plans and reporting. ECCO is cloud-based platform for reporting data to support Substance Abuse Block Grant Reporting requirements in North Carolina. The statewide training and technical assistance center, within the SPC, provides daily oversight of ECCO and works with Prospectus to ensure that ECCO accurately captures key program/provider metrics. Metrics include but are not limited to demographics (race, ethnicity, gender, age), tracking fidelity to best practice steps for specific CSAP Six strategies, individual and population reach, capacity building efforts, development and dissemination of resources, community-based processes metrics,

and Synar efforts metrics. Furthermore, the state has contracted evaluation services with a local university and private nonprofit research company since FY18.

The NC Prevention and Wellness team operates a Behavioral Health Equity Initiative to serve as a resource to further address behavioral health disparities. This Initiative provides training and guidance, through the NC Prevention Consortium to ensure adequate planning and identification of disparities across the state including racial, ethnic, sexual and gender minorities as well as American Indian and Alaskan Native populations. This is a project that serves as a framework that is used to provide guidance statewide. Identification of and planning for behavioral health disparities is built into the SPF process that every prevention agency implements.

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 that 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.

SUD Treatment and Recovery System

The SSA supports a comprehensive system of care to enable individuals that it serves to live in communities of their choosing and avoid inpatient hospitalization and institutionalization to the greatest extent possible. The array of available services includes basic outpatient services (assessment, individual therapy, group therapy, family therapy), enhanced services (Substance Abuse Intensive Outpatient Program, Substance Abuse Comprehensive Outpatient Treatment, Community Support Team, Intensive In-Home, Adolescent Day Treatment), opioid/medication assisted treatment, halfway house and supported housing services, Work First services and Treatment Accountability for Safer Communities (TASC) for people involved in the criminal justice system. A robust array of gender-specific/gender responsive services are available for women, including women who are pregnant and/or have dependent children. In addition, mobile and walk-in crisis services, various levels of detoxification, residential and inpatient treatment services are available throughout the state. Over the last few years, the Division has focused on more fully developing and implementing its recovery-oriented system of care philosophy. Funding is provided for recovery community organizations that work with several funded and grass-roots recovery community centers, recovery supported housing and other recovery services and supports, as well as collegiate recovery programs.

Utilization of peer supports, recovery coaching and mentoring are becoming more embedded in services as integral components of treatment and recovery success, including in emergency departments, prisons and jails. DMHDDSUS and the Division of Health Benefits worked together to develop a statewide Peer Supports service definition. The state-funded service definition became effective August 1, 2019, and Clinical Coverage Policy 8G – Peer Support Services - was added to the

State Plan Amendment, and most recently amended in December 2020. Please see the section on Recovery Services for more detailed information.

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. This better assures that availability for services is adequate, as some populations, such as adolescents or pregnant women, may access any program or level of care across the state if local programs are at capacity.

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 and parenting and their children, initiatives for preventing underage drinking, etc.

NC Problem Gambling Program

The North Carolina Problem Gambling Program (NCPGP) within the Addictions Team, DMHDDSUS, recognizes that this addiction lives on a continuum, and the goal is to help people who are experiencing harm, even if they do not meet the full clinical criteria for a clinical diagnosis. We recognize that people are more than their addictions and struggles, therefore we use the terms people experiencing problems related to gambling or people living with a gambling disorder. North Carolina began providing prevention and treatment services relating to the area of problem gambling as a legislative mandate when the North Carolina Education Lottery (NCEL) was created in 2005 and is solely funded through the NCEL ($1million annually). Our program has four major components, our 24/7 helpline, treatment, recovery, prevention and education.

The mission of the North Carolina Problem Gambling Program (NCPGP) is to provide and support effective problem gambling prevention, education, outreach and treatment services throughout North Carolina. Our purpose is to provide statewide treatment services, training and technical support in-person and on-line for prevention and provide education and outreach to promote awareness through media, partnerships and integration.

1. **Helpline**

We operate a 24/7, no cost confidential helpline, in both English, Spanish and hundreds of other languages. Individuals seeking information on problem gambling can call 877-718-5543, text “more than a game” to 53342 or click the chat option on our website.

Our helpline is operated by master’s level clinicians specifically trained to provide support and assess for gambling disorder. Helpline staff can refer a person experiencing a problem with gambling or an affected other to a variety of no-cost treatment options. We have provider registry with over 70 providers across the state who offer clinical treatment services both in person and through telehealth.

2. Treatment

All treatment options are at no cost to the individual or affected other. In addition to in-person clinical treatment, a variety of other options to support someone in their recovery journey is available in NC:

- distanced-based treatments for those unable or unwilling to attend treatment in person. The ***call 2 change*** program offers two levels of help based on the severity of the problem someone may be experiencing.
- software called GamBan, which allows the user to block gambling websites, apps and purchases on up to 15 devices.
- peer support services as well as recovery coaching support services for those who do not wish to engage in formal clinical services or just wish to learn more about their recovery options.
- training for treatment providers who will specifically focus on youth and young adult treatment.
- 24-week motivational text messaging program to help people who are looking for extra support in their recovery journey.

3. Prevention and Education

Due to the risk factors associated with developing a problem with gambling, the NC Problem Gambling Program focuses its prevention efforts on youth. It is also important because youth gamble at very young ages. Studies from across the globe indicate about 60-80% of adolescents have gambled (Monaghan, 2008). In North Carolina, we are working on a multi-pronged approach in preventing problem gambling in adolescents and college-age students. The approaches are based on an understanding of the protective factors that reduce addictions, including problem gambling. The protective factors we promote in our programs not only help prevent problem gambling, but also help prevent other mental health disorders and addictions.

The first approach is offering ***Stacked Deck***, the only evidence-based program that is effective in preventing and reducing the risk of problem gambling among teens. Offered in six sessions, the program aims to change gambling-related attitudes, knowledge, beliefs, and practices. It also seeks to improve decision-making and problem-solving. The Stacked Deck curriculum is interactive, including activities such as role-playing and discussion of case scenarios involving gambling and substance misuse. Students engage in outreach by participating in a poster competition or PSA and given take-home pages to discuss with their parents and guardians.

Grants of up to $5,000 are available for middle schools, high schools, and at-risk community-based programs to implement the Stacked Deck Curriculum. Educators are provided training, technical support, and materials to implement the program.

The second approach is training educators on Adverse Childhood Experiences (ACEs) and providing them with skills to work with students in a trauma-informed and resiliency-focused skills lab. Research indicates that coupling problem-gambling education in schools with resiliency-focused programs increases the effectiveness of prevention efforts.

The third approach is providing treatment to children and adolescents with caregivers who are experiencing problem gambling or experiencing problem gambling themselves. This approach is the newest addition to the prevention model in North Carolina. The treatment program has officially launched and e-learning training modules for child and adolescent treatment providers will be open by the end of February 2021. This program is insurance blind because the treatment is provided at no cost.

4. Recovery

Recovery from problem gambling is possible, and treatment works. There are millions of Americans living their best life in recovery from problem gambling. The recovery process involves seeking the supports needed to aid in vulnerable, healthy human connection and environmental change to pursue a gambling-free lifestyle, understanding how to avoid the behaviors which led to gambling becoming a problem. Those seeking recovery from problems with gambling may make mindful decisions to live a gambling-free lifestyle, understanding that even a single bet could cause a reoccurrence of symptoms. There are many routes a person can choose when starting their recovery journey, from professional treatment, state funded peer support, to self-help books, and 12-step programs like Gamblers Anonymous. The helpline can provide referrals and resources for those seeking help with problematic gambling.

Women's and Children's SUD Services

The mission of Women's and Children's Substance Use Services is to provide comprehensive gender-specific, family-centered substance use disorder treatment and recovery services and supports to pregnant and parenting women with substance use disorders and their children. The major Initiatives address the treatment, health, and safety needs of a high-risk group of women and children, reducing the impact of maternal and parental substance use on the health and wellbeing of women and their children and families through provision of gender specific, trauma informed, and evidence based or evidence informed treatment and health care services. Evidence based, evidence informed, and best practices for this population have been found in national clinical trials to reduce symptoms of neonatal abstinence syndrome for prenatally exposed infants, improve the health and wellbeing of children and their mothers, and reduce risk of criminal justice or child welfare involvement for families, thus having a positive impact on family wellbeing and reducing societal costs. Families involved in the programs have a wide range of needs to be addressed as part of recovery, health and stability for their families. Many of the needs that are met outside the scope of the initiatives' direct services, are accomplished through linkages and active coordination with other services and programs. The following are examples of the current Initiatives:

1. **Perinatal Substance Use Project - Alcohol/Drug Council of NC (ADCNC):** The NC Division of MH/DD/SUS and the NC Division Public Health jointly fund a Substance Use Specialist position housed at ADCNC. The Substance Use Specialist can be reached at 1-800-688-4232 or through the 1-800-FOR-BABY hotline, Monday through Friday, from 8 am to 5 pm. Services are available to the public and professionals to provide support in accessing gender-specific substance abuse treatment services statewide. Technical assistance, training and education regarding screening and referral for pregnant women with a substance use disorder are also available. A capacity management (bed availability) listing of residential substance use disorder treatment services for pregnant and parenting women and their children is maintained to assist the public and professionals to identify appropriate and available services statewide.

2. **North Carolina Perinatal and Maternal Substance Use & NC CASAWORKS for Families Residential Initiative:** The Perinatal and Maternal Substance Use Initiative is composed of 19 specialized programs for pregnant and parenting women with a primary substance use disorder and their children. These programs provide comprehensive gender-responsive substance use disorder treatment services that include, but are not limited to, the following: screening, assessment, case management, out-patient substance use disorder and mental health services, parenting skills, residential services, referrals for primary and preventative health care, and referrals for appropriate interventions for the children. The children also benefit from the services provided by the local health departments (pediatric care), early intervention programs and care management for at-risk children (CMARC).

The NC CASAWORKS for Families Residential Initiative supports seven (7) comprehensive residential substance use disorder programs for women a primary substance use disorder 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 who are substance use involved. The model proposes that the best way to help families receiving TANF become economically self-sufficient is to provide an integrated and concurrent gender specific substance use disorder and co-occurring treatment and job readiness, training, and employment program.

The residential services that are a part of the NC Perinatal and Maternal Substance Use Initiative and the CASAWORKS for Families Residential Initiative are considered Cross Area Service Programs and are available to any pregnant or parenting women and her children who meet medical necessity for the services based on ASAM criteria. The outpatient only programs are offered to pregnant and parenting women who meet the ASAM criteria for this level of care in the specific LME/MCO catchment area.

Through the collaborative work between the DMHDDSUS and the Division of Health Benefits (DHB) NC Medicaid, a new state-funded and Medicaid covered residential substance use disorder service for pregnant and parenting women and their children is being developed. This residential service is in alignment with the American Society of Addiction Medicine (ASAM) 3.5 level of care. This service is currently primarily supported through SUBG funds with the treatment component reimbursed through Medicaid funding. This new proposed service provides more Medicaid funding to support the 24-hour therapeutic care and support required to effectively and efficiently provide this level of care to this population. SUBG funds will continue to provide 'room and board' associated costs and

other non-Medicaid reimbursable services and supports such as non-medical transportation and childcare.

3. Work First/CPS Substance Use Initiative: The Work First/CPS Substance Use Initiative is a joint initiative of the Division of Mental Health, Developmental Disabilities and Substance Use Services (DMHDDSUS) and the North Carolina's Division of Social Services (DSS). The two Divisions have an interagency memorandum of agreement in place delineating the roles and responsibilities of each entity. This Initiative provides appropriate assessment, treatment referral, and case coordination for eligible Work First (TANF), Class H or I Controlled Substance Felons eligible for Food and Nutrition Services (FNS) and certain categories of recipients of Child Protection Services (CPS).

The goal of the Work First/CPS Substance Use Initiative is to provide early identification and connection to treatment, of Work First recipients and eligible Food and Nutrition Services recipients who have substance use problems severe enough to affect their ability to become self-sufficient. The program also assists parents who have substance use problems and who are involved with CPS engage in appropriate treatment. Each of the county department of social services has access to a Qualified Professional in Substance Abuse (QPSA), contracted by the Local Management Entity - Managed Care Organization (LME/MCO).

The COVID pandemic impacted this Initiative in a variety of ways. The Work First and Food and Nutrition Services requirements of individuals meeting certain criteria, to participate in a substance use disorder assessment, shifted in order to account for health and safety precautions. This has meant that significantly fewer referrals were made to the QPSAs, for their services during the Public Health Emergency (PHE) under this Initiative. Specifically, the referrals from Food and Nutrition Services were suspended during the PHE, with the requirement for referrals reinstated July 1, 2023. The 3-year hiatus meant a backlog of individuals needed assessments beginning July 1. Leading up to the end of the FNS referral suspension, DMHDDSUS worked diligently and collaboratively with the Division of Social Services to develop a plan to manage the volume and disseminate information to ensure that requirements were met, with no applicants or recipients having their FNS eligibility negatively impacted.

The rate of referrals from Child Protection Services continued and maintained during the PHE. The QPSAs remained available to all 100 counties' department of social services, as contracted through the LME/MCOs. As a result of policy changes during the PHE, clinical assessment services are offered through telehealth, for Work First, FNS and CPS recipients and applicants based on access and individual choice. The LME/MCO is responsible for submitting quarterly reports to DMHDDSUS. These reports reflect the numbers of individuals who have had assessments completed, delineated by referral source or cause (Work First, CPS, H or I felon). Quarterly statewide Initiative meetings with the QPSAs and LME/MCOs occur to review the aggregate quarterly data and discuss the barriers and successes that each county is experiencing in serving these populations The LME/MCOs are responsible for local monitoring of the community providers that have been contracted for the QPSA positions. Ongoing technical assistance is provided to the LME/MCOs, DSSs, and QPSAs by DMHDDSUS.

4. Reproductive Life Planning and Substance Use Disorder Treatment Project: The North Carolina Division of Mental Health, Developmental Disabilities and Substance Use Services (DMHDDSUS) has partnered with the North Carolina Division of Public Health (NCDPH) Family Planning and Reproductive Health Unit to provide cross training to the clinicians and recovery staff of perinatal and maternal substance use and opioid treatment programs in our statewide initiatives. Participants also include staff from the Federal Title X funded Local Health Departments (LHDs) corresponding to the identified treatment programs.

The cross disciplinary training on reproductive life planning and substance use disorders promotes the local partnerships of the identified substance use disorder treatment programs and their Local Health Departments. These partnerships will impact effective support of individuals with substance use disorders, and in recovery, in their reproductive life plans. It is specifically intended to be non-coercive and non-judgmental in the provision of the information and connection to services. Training objectives Include:

- Increase knowledge about the key components of reproductive life planning.
- Increase or review knowledge about addiction and the importance of language when work with individuals with substance use disorder.
- Increase or review knowledge about reproductive biology and sexually transmitted diseases.
- Increase awareness about the importance of counseling all individuals of reproductive age with substance use disorder about reproductive life planning.
- Improve reproductive life planning counseling skills.
- Facilitate local partnerships.

The SUD treatment programs track the occurrences of individual and group reproductive life planning specific sessions and referrals, reporting on the aggregate data quarterly. Also included in the quarterly report data are the numbers of individuals who required transportation assistance to necessary appointments related to reproductive life planning.

Monthly meetings to support the implementation of the RLP-SUD practices include the state partners and the community level SUD treatment programs and the LHD professionals. These meetings include deidentified case presentations and specific topics that are covered through didactic and discussion. Technical assistance is available to the SUD treatment programs and the Title X Local Health Departments on an ongoing basis from the state partners.

5. Perinatal & Maternal Substance Use Learning Collaborative: The collaborative meets monthly with the goal of developing and supporting ongoing capacity to effectively treat pregnant and postpartum women with substance use disorders and their families. The methods to achieve these goals include:

- clinical case-based learning to master complexity;
- didactic topics to support best practices clinically and programmatically;
- All teachers/All learners with Hub & Spoke format; and
- sharing of resources and expertise from individual programs.

The objective of the collaborative is to train onboarding and continuing Perinatal and Maternal Substance Use Disorder family-centered treatment providers, to provide comprehensive gender responsive services.

6. Pregnancy and Substance Use Disorder Training and Technical Assistance: NC Pregnancy and Opioid Exposure Project (NCPOEP) is a web- based resource with information and support for professionals and the public seeking resources in caring for women who are pregnant with opioid use disorders as well as connecting them to prenatal care and SUD treatment.
Substance Use Disorder Services to Women technical assistance and training is provided throughout the fiscal year to professionals working with pregnant and parenting women. An average of 360 hours of technical assistance and training is provided to professionals in child welfare, public health, behavioral health, prenatal care, medication for opioid use disorders, pediatricians, and the criminal justice systems. Frequent training topic requests include Connecting Women to Treatment, Pregnancy and Opioid Exposure, and Perinatal Substance Use Disorders.

An online, asynchronous training, providing content on subjects related to perinatal and maternal substance use disorders and treatment is being developed for launch in October 2023. The purpose of the training is to support providers and collaborators' skills and abilities in effectively working with impacted individuals and families. Audiences will include child welfare, health care, justice, and behavioral health professionals. Professional continuing education credits will be offered.

The Reproductive Life Planning and Substance Use Disorder Treatment Project is a collaboration with the Division of Public Health, intended to support people in substance use services settings to have information and access to reproductive health care. The Reproductive Life Planning and Substance Use Disorder Treatment training is also being developed as an online, asynchronous training, scheduled to launch in October 2023. The purpose of the training is to support substance use services to have effective reproductive life planning conversations with their clients and medical professionals to work more effectively with people of reproductive age who may have substance use disorders. Professional continuing education credits will be offered. We anticipate that there will be wide participation in this training. The participants in the asynchronous training will be invited, upon completion, to participate in follow up implementation meetings, co-facilitated by DMH/DD/SUS and DPH.

Additionally, the Work First/CPS Substance Use Initiative assessment requirements are carried out, in all 100 NC counties by Qualified Professionals in Substance Abuse (QPSAs). Due to the legislation and current policy guiding this Initiative, we are moving to having all QPSAs credentialed as licensed professional in substance use disorders. We are seeking ways to support the sustainability of the Initiative in order to meet the mandates, while also promoting progression of the work force. QPSAs in these positions who are not currently licensed are required to develop a plan, with their supervisor, to work towards licensure.

Adolescent Substance Use Disorder Services

The team continues to assess and review the adolescent SUD workforce and the network of community-based SUD treatment providers. Staff are working on different ways to identify where the pressure points are in the system, to identify and address reasons why youth are housed in EDs, waiting for services, when capacity exists.

Current priority areas include:

- Identification - Under identification of adolescents engaging in substance use and those with a SUD, challenges identifying Tx providers with the experience and skills needed to treat adolescents.
- Treatment availability - Ensuring access to appropriate services when needed, including Community based services, Residential services, Services for 'High need, High acuity' individuals (Aggression, Co-occurring Disorders, Elopement, Multi-agency involvement etc.), Age-appropriate Recovery supports.
- Medications - Promoting the use of evidence-based treatments, including the use of FDA approved medications (bup, naloxone). Adolescent access to addiction medications is limited. Lack of awareness, lack of knowledge, lack of training, and stigma all contribute to the restrictions adolescents face with addiction medications.
- Stakeholder Meetings - Host sessions with State CFAC, LME/MCOs, Treatment providers and others to identify potential areas of opportunity for enhancing and supporting adolescent SUD system (Adolescents receiving a DMH/DD/SUS or DHB funded SUD service has been declining for several years).

Services available for youth, who are often diagnosed with other behavioral or mental health disorders, in addition to substance use, include:

- Outpatient Therapy
- Outpatient Therapy Plus (some LME/MCOs)
- Day Treatment
- SA Intensive Outpatient
- Intensive In-Home Services
- Multisystemic Therapy
- Facility Based Crisis (including withdrawal management)

In addition to the above, the Adolescent Substance Use Disorder Regional Residential Program Initiative was created to promote the availability of SUD residential services for adolescents in every region of the State of North Carolina. The mission is to provide medium-term residential services and public education to prepare individuals under 18 years old with substance use disorders, and other co-occurring problems, for ongoing community- based recovery services.

All programs under this initiative admit youth from anywhere in the state, serving all 100 counties, giving them the distinction of Cross Area Service Programs (CASPs). All programs use proven evidence- based SUD models at their facilities. These programs provide 24-hour residential services through supervised living or similar licensure and intensive outpatient or day treatment services. Some sites provide public education through local teachers assigned to the program by the local education authority or Department of Public Instruction.

These programs provide evidence-based SUD treatment services that include counseling to assist youth and their families in becoming actively involved in their own recovery. This is achieved through comprehensive assessment, treatment planning, group therapy, individual therapy and continued care planning. A Child and Family Team is constructed for every youth and family. The team has the responsibility of developing and updating the youth's Person Centered Plan (PCP) for recovery. This also includes discharge planning and care coordination for when youth return to their homes and community to ensure continuing treatment through their local community outpatient treatment programs, and other community resources.

The youth receive psychological services that include the provision of diagnostic testing and specialized psychotherapy for youth when appropriate. Psychiatric evaluation and medication-management are also available to 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 Recreation Services are provided daily, and programs use their own recreation facilities on site along with community facilities such as the YMCA. Each program develops internal incentives to teach and encourage the youth while in the program. Each adolescent Substance Use Disorder Regional Residential Program is unique; therefore, there are some variations in the services offered by the individual programs across the state.

Presently, North Carolina has two (2) Substance Use Disorder Regional Residential facilities operational including the following: (1) PORT Aberdeen is a 10-bed facility in south central North Carolina; (2) PORT Greenville is a 10- bed facility in the eastern part of the state. This number has decreased from five in the last two years. The team is currently working with two LME/MCOs to identify additional providers and sites to expand statewide residential services for adolescents and enhance best practices within these facilities.

The duration of services is based upon ASAM criteria for level of care and continued service and discharge criteria. The average length of stay ranges from 90 to 120 days.

Additionally, through the collaborative work between the DMHDDSUS and the Division of Health Benefits (DHB) NC Medicaid, a new state-funded and Medicaid covered residential substance use disorder service for adolescents is being developed. This residential service is in alignment with the American Society of Addiction Medicine (ASAM) 3.5 level of care. This service is currently primarily supported through SUBG funds with the treatment component reimbursed through Medicaid funding. It includes a new Licensed Recreation Therapist position not formerly covered by Medicaid to assist adolescents with how to address time management in recovery. This new proposed service provides more Medicaid funding to support the 24-hour therapeutic care and support required to effectively and efficiently provide this level of care to this population. SUBG funds will continue to provide 'room and board' associated costs.

Juvenile Justice Behavioral Health Partnerships (JJBHP)

Juvenile Justice Behavioral Health Partnerships is a network of local teams across the state working together to deliver effective, family-centered services and supports for juvenile justice-involved youths with mental health, substance use, or co-occurring challenges. Currently, 21 teams are

operational, serving 97 counties across NC with an organized person-centered system working from a System of Care perspective. Partnerships can include any interested person or agency but at minimum contain representatives from the local LME/MCO, juvenile court, and treatment providers.

JJBH Partnerships collaborate to ensure that justice-involved youth are appropriately served through the provision of comprehensive clinical assessments by licensed professionals, evidence-based treatment options for justice-involved youth with behavioral health needs, use of child and family team meetings, involvement of family members and youth advocates, and involvement of Juvenile Crime Prevention Councils in their programming. Partnerships also work to promote collaborative relationships between parties involved in the care of justice-involved youth to address problems that arise in the areas of service planning, referrals, and funding related to services for these youth.

Treatment Alternatives for Safer Communities (TASC)

Treatment Alternatives for Safer Communities (TASC) is a cross-area service program supported predominately by SUBG funds which provides specialized care management and facilitates access to services for high-risk individuals under criminal justice supervision who have substance use disorders, either alone or co-occurring with a mental illness. TASC services are currently delivered by three organizations, which between them provide services in every North Carolina county.

Since its inception in the 1970s, TASC has supported thousands of North Carolinians with substance use disorders. In 2019, prior to the onset of the COVID-19 pandemic in the United States, TASC served approximately 25,000 people. TASC services have been shown to promote decreases in subsequent re-offense rates and substance use, and increases in access to and utilization of behavioral health services and resources. Participation dropped in 2020 and 2021, but current data has shown service use is increasing, with 19,459 individuals completing TASC services in 2022-23.

State Opioid Treatment Authority/Medication Assisted Treatment

The road to recovery is unique to everyone, and treatment for an individual may consist of any combination of services at different points in time. Treatment with medications is the standard of care for an opioid use disorder and substantially reduces overdose, transmission of infectious diseases such as HIV and hepatitis C, crime and unemployment.

The NC Opioid Treatment Program (OTP) system of care strives to be accessible, evidence-based, individualized and comprehensive by offering FDA-approved medications, as well as various levels of clinical care in order to best serve those with varying degrees of necessity.

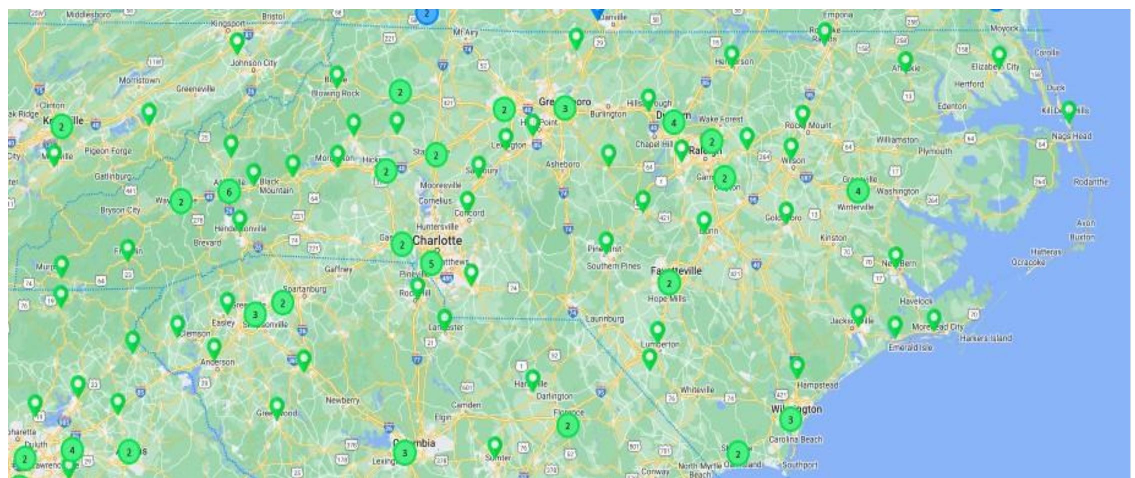
The majority of OTPs in North Carolina are involved in their communities. Critical opportunities to initiate care are taking place in the jail system, in the prison system and in hospital emergency departments.

The mission of the North Carolina State Opioid Treatment Authority (SOTA) is to reduce the impact of opioid use disorder in North Carolina communities and promote excellence in Opioid Treatment Programs. The State Opioid Treatment Authority Administrator and two field staff provide technical assistance and monitoring of the 86 opioid treatment programs in North Carolina serving an average of over 21,600 patients with an OUD daily. With a capacity of approximately 30,000 patients, capacity management, guest dosing and emergency management (in the event of natural disasters)

functions are managed through a contract with an outside central registry vendor. **Please see the map of all OTPs in NC directly below:**

SOTA – OTPs in NC

- 86 OTP Programs across the state
- 2 are North Carolina state operated inpatient Alcohol and Drug Abuse Treatment Centers (ADATC)
- 1 is operated by Eastern Band of Cherokee Indians on Tribal Land



Visit https://www.thecentralregistry.com/map/ to find contact information for the OTP in your area

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To date, the State Opioid Treatment Authority (SOTA), located within the Addictions and Management Operations section of the Division of Mental Health, Developmental Disabilities and Substance Use Services, has been primarily involved with the opioid treatment programs. As with many other states, North Carolina has seen substantial growth in the number of agencies opening programs. The certification process is lengthy and involves various other agencies, including the Division of Health Services Regulation, the Division's Drug Control Unit, the DEA and SAMHSA. Each OTP operating in NC is approved by the North Carolina State Opioid Treatment Authority, which is

responsible for program approval, for monitoring compliance with the regulations related to scope of staff, and operations, as per 10A NCAC 27G.3604.

North Carolina's OTPs are operated as either for-profit businesses or nonprofit organizations, as well as through the two of the state's three state-run facilities (Walter B. Jones Alcohol and Drug Abuse Treatment Center located in Greenville and Julian F. Keith located in Black Mountain). All but two of the current 86 OTPs accept Medicaid beneficiaries and/or uninsured individuals.

NC State Opioid Treatment Authority (SOTA) responsibilities include the following:

1. Clinical and administrative on-site review and monitoring of approximately 86 local Opioid Treatment Programs (OTPs) on a daily basis, including consultation and technical assistance, with emphasis on safety and quality of care issues related to program leadership, staffing, supervision, scope of practice, admission and discharge protocols, medication ordering and administration, specialty patient treatment such as pregnant women and justice involved patients, and incident reviews, including deaths, non-fatal overdoses and injuries, and serious medication errors, and implementation of program policies and procedures in accordance with federal and state regulations, standards of care, NC-TOPPS patient and program outcomes evaluation and capacity management using Lighthouse Central Registry.

2. Clinical and administrative review on a daily basis of Opioid Treatment Program (OTP) patient incidents and complaints, including patient deaths, non-fatal overdoses, accidents, serious medication errors, admissions concerns, patient management issues, administrative discharges, medication diversion, and other adverse incidents involving patient, family, and community health and safety, and complaints about patient respect and dignity, program performance, and quality of care issues.

3. Coordination with the Center for Substance Abuse Treatment (CSAT) - Division of Pharmacological (DPT) Therapies and the Drug Enforcement Administration (DEA) regarding local program approval, monitoring, and program practices involving implementation of federal regulations, guidelines, advisories, and national accreditation standards.

4. Coordination with the NC Division of Health Service Regulation (DHSR) and the DMHDDSUS Drug Control Unit regarding local program approval, monitoring, and program practices regarding the implementation of federal and state regulations, guidelines, advisories, and national accreditation standards.

5. Clinical review and approval of daily individual patient and program take-home medication exception requests through the SAMHSA Center for Substance Abuse Treatment (CSAT) Opioid Treatment Program (OTP) Extranet System for take-home privileges for methadone and buprenorphine in accordance with 42 CFR Part 8.

6. Coordination with the NC Division of Health Benefits (DHB) and LME/MCOs in the development and implementation of statewide policies regarding Medication-Assisted Treatment (MAT) utilizing methadone and buprenorphine, and the support of LME/MCOs in local Opioid Treatment Program credentialing, contracting, access, service authorization, monitoring, and program practices involving implementation of best

practice guidelines and standards of care, as well as federal and state regulations, guidelines, advisories, and national accreditation standards.

7. Coordination with the National Association of State Alcohol and Drug Addiction Directors (NASADAD) and other national groups regarding the development and promotion of state, regional, and national approaches to addressing current and emerging issues in practice, including the development and implementation of prescription monitoring programs (PMPs), such as the NC CSRS, responses to the continuing threat posed by prescription drug use and heroin use, and the support of harm reduction approaches such as the distribution and utilization of Narcan overdose kits among at risk populations.

8. Development and implementation of specialized provider training, consultation, and networking opportunities with emphasis on OTP physicians, PAs, NPs, and Program Directors, through such vehicles as monthly physician/PA/NP group case consultation phone calls, quarterly meetings with program directors, annual regional training seminars for physicians/PAs/NPs, and targeted specialty OTP sessions in the annual Addiction Medicine Conference.

Patients entering medication assisted treatment are required to be seen by a physician (face-to-face) prior to the provision of medication. All patients are assessed based on ASAM criteria, which determines the recommended level of care. North Carolina Administrative Code (10a NCAC 27g.0205) requires that each facility counselor, in partnership with the patient, develops a treatment plan that includes anticipated outcomes to be achieved by the services, projected achievement dates, treatment plan strategies and the manner in which the achievement of outcomes will be measured. The plan must be developed with the patient and the patient must acknowledge his/her participation and agreement by signing the document. At a minimum, each OTP clinic is required to develop and implement systems to ensure each patient receives minimally two counseling sessions a month within the first year of treatment and once monthly thereafter.

The number of opioid treatment programs (OTPs) continues to increase in NC; as of September 2023, there were 86 programs serving over 21,000 individuals daily and approximately 30,000 individuals annually. Of the total OTPs, only two do not have contracts with an LME/MCO for uninsured individuals and/or Medicaid beneficiaries. Although monthly calls have traditionally been held with the Medical Directors of all OTPs, since the onset of the COVID pandemic, weekly calls have been conducted to better assure access to care is maintained in a safe manner. NC has two state-run facilities that offer MAT.

Session Law 2023, House Bill 190, was recently enacted which allows the state to fill geographic service gaps in rural and under-served areas through implementation of medication units and mobile units. Geographically separated from its "home" opioid treatment program, a medication unit or mobile unit is often located within 30-90 miles of its "brick and mortar" main clinic. Medication and mobile units will have the authorization and capacity to administer medicine such as methadone and buprenorphine to curb withdrawal symptoms from opioid addiction, prevent relapse and quell the physical discomfort that frequently accompanies recovery from opioid use disorder. These units may provide a full range of medication-assisted treatment (MAT) services including individual and group counseling. NC is particularly interested in pursuing utilization of these mobile units for individuals who are in detention settings or prisons. House Bill 190 can be accessed here: https://www.ncleg.gov/Sessions/2023/Bills/House/PDF/H190v7.pdf

Other Opioid Initiatives/Medications for Opioid Use Disorder (MOUD)

As with many states, addressing the opioid epidemic remains a top priority for North Carolina. We intend to continue our efforts and will work in partnership with our providers and through stakeholder engagement to determine the most effective, efficient, and impactful ways to deploy funds. For example, McKinsey Settlement funds were awarded to 20 community-based providers in September 2022 to enhance and supplement existing services and/or implement new services including the following:

- Expand employment and transportation supports through innovative pilot programs;
- Support individuals with opioid use disorder who are involved in the criminal justice system;
- Expand proven evidence-based treatment supports, such as medication assisted treatment and to improve connections to care, especially for individuals hospitalized for overdose;
- Expand Developing evidence-based supportive housing services, such as Housing First, that are inclusive of individuals with substance use disorders, particularly those participating in medication assisted treatment.

SUBG ARPA funds have supported services for individuals with opioid use disorder in two ways: (1) implementation of an Emergency Medical Services Medication Assisted Treatment Bridge (EMS MAT Bridge) pilot, and (2) implementation of opioid treatment services including medication for individuals on community supervision in several Tier one and two counites in NC.

The EMS MAT Bridge program awarded funds to eight counties or county systems to induct individuals on buprenorphine after an overdose event, and then use community paramedics and peers and/or post overdose response teams to follow up and continue to provide medication and supports until the person is connected to a formal OTP or other OBOT service. Counties implementing this pilot include Cumberland, Davie, Durham, Gaston, Halifax, Lincoln, Rockingham and Surry.

The MAT Community Supervision pilot program is for individuals recently released from prison and on probation. The Department of Adult Correction (DAC), in conjunction with DMHDDSUS, was instructed by the NC General Assembly to "select at least five counties to participate in the expanded pilot program that represent tier one and tier two counties with the highest need." To that end, staff from both Divisions have analyzed county data for Tier one and Tier two counties, including substance use-related supervision violations, prevalence of opioid use, uninsured status, overdose and ED visits, as well as resources for opioid use disorder treatment. 14 counties were identified across four LME/MCOs and all counties have begun providing MOUD/MAT and other clinical services to individuals on community supervision.

NC has utilized part of its SUBG COVID supplemental award to engage with the NC Community Health Center Association, which provides oversight of the state's federally qualified health centers (FQHCs) and community health centers, for the primary purpose of expanding the availability of MOUD and other associated care, including clinical services such as individual and group therapies, peer services and supports and/or other recovery oriented services, for individuals with opioid use disorder. This initiative focuses efforts in numerous rural and under-served areas, with additional emphasis on reaching marginalized populations. Funding has been utilized to cover costs for new prescribers, additional hours for current prescribers, medication costs for buprenorphine, participant

co-pays, outreach, patient transportation, clinical treatment services, such as individual counseling, group and family therapies, care coordination, and peer or other recovery supports. Over 20 FQHCs and community health centers were selected to implement this pilot. FQHCs play a vital role in counties, and it is expected these efforts will result in an increase in the number of individuals engaged in MOUD in these settings. Primary care settings are often more accessible to individuals, both in terms of logistics (less travel time and less frequency of appointments) and because less stigma is associated with presenting for care in FQHC settings.

Much of the work specific to opioids is guided by the North Carolina Opioid and Substance Use Action Plan, which was updated in May 2021, and includes comprehensive reduce opioid addiction and overdose death. A copy of the **Opioid and Substance Use Action Plan 3.0 may be accessed here: https://www.ncdhhs.gov/about/department-initiatives/overdose-epidemic/north-carolinas-opioid-and-substance-use-action-plan.**

Persons Who Inject Drugs (PWID)

North Carolina assures priority admission preference for individuals who inject drugs through its contract with the six (6) LME/MCOs. All LME/MCOs operate a 24/7/365 crisis line that performs various services. These Access/Customer Services call centers provide information about providers and community resources, accept complaints, and perform screening, triage and referral, including telephonic crisis intervention. The LME/MCO is required to publicize priority preference for substance use disorder admission and treatment for individuals who are injecting drugs and substance using pregnant women. The function of screening, triage and referral is required to be completed by a Qualified Professional and /or by a licensed professional. A licensed clinician will be available for consultation. If the call is determined to be clinical in nature such as an individual needing a screening and triage either in routine, urgent or emergent type call, the customer call center staff will do a warm line transfer to an available qualified professional for screening, triage and referral.

Also, per the contract, each LME/MCO shall adopt and publish annually the benefit plan for non-Medicaid services that defines the available services and eligibility criteria for individuals in each DMHDDSUS benefit plan. The benefit plan shall be flexible to maximize the services that consumers may receive as an adequate service array, within available resources. LME/MCOs authorize non-Medicaid funds for medically necessary services for DMHDDSUS-specified priority populations with mental health, intellectual or developmental disabilities or substance use disorders. The contract includes a list of all priority populations for which the LME/MCO must assure adequate service selection and availability.

Additionally, each LME/MCO develops a Member Handbook which is made electronically available to persons receiving State-funded services. The Handbook is designed to assist individuals in understanding the North Carolina public MH/IDD/SA system, member rights and responsibilities, complaint processes and information about the non-Medicaid benefit plan. The LME/MCO is required to publicize this information either through its website, targeted brochures, the Member Handbook or other means, that individuals injecting drugs and substance using pregnant women have program admission priority.

The Division requires each LME/MCO to complete the *Semi-Annual SUBG Compliance Report* which contains sections for policies and practices related to PWID, both in terms of priority admission, as well as capacity management and interim services, as evidenced from the following excerpted sections of the *Compliance Report*:

Section V: Priority Admission Preference for Women Who are Pregnant and Injecting Drugs, Women Who are Pregnant and Using Substances and Other Individuals Who are Injecting Drugs

Part A. LME/MCO Policies and Practices for Assuring Priority Admission Preference

Describe your **LME/MCO program policies and practices assuring priority admission preference** for all women who are pregnant and injecting drugs, pregnant and using substances and other individuals who are injecting drugs in all LME/MCO programs and contract agencies. Describe your LME/MCO's contract management and monitoring, training, technical assistance and quality management practices that ensure that all LME/MCO and contract agency direct services staff provide Priority Admission Preference for all women who are pregnant and injecting drugs, pregnant and using substances and other individuals who are injecting drugs.

Part B. Documentation of Efforts to Publicize Priority Admission

Document and/or attach evidence of satisfactory efforts of your **LME/MCO** to advertise and publicize priority admission policies **in the current fiscal year** assuring admission to all women who are pregnant and injecting drugs, pregnant and using substances and other individuals who are injecting drugs.

Section VI: Capacity of Treatment for Individuals Who are Injecting Drugs

Part A. LME/MCO Policies and Practices for Assuring Timely Admission

Describe your **LME/MCO's policies and practices that ensure that individuals who are injecting drugs** are admitted for services within 14 days of the request for services, or if at capacity, within 120 days of the request for services, with the provision of interim services within 48 hours after the request for care if admission within 14 days is not possible. If the LME/MCO maintains a waiting list, or contracts with providers that may maintain a waiting list, please provide additional information on how the wait list is managed.

It should be noted that the Division requires that all individuals screened as having a substance use disorder be provided a referral to treatment/appointment within 48 hours of calling an LME/MCO Access line.

While North Carolina does not utilize any of its SUBG funds for syringe services programs, syringe services programs (SSPs) became legal in North Carolina on July 11, 2016, when the Legislature passed NC General Statute 90-113.27. As of July 1, 2017, local funds may be used to purchase syringes, needles and other injection supplies. Public funds may be used for other program development and operation costs (rent, salaries and stipends, testing resources, naloxone training and distribution, etc.). Included in the law is a provision that protects SSP employees, volunteers, and participants from being charged with possession of syringes or other injection supplies, including those with residual amounts of controlled substances present, if obtained or returned to a SSP. SSP employees, volunteers and participants must provide written verification (including a participant card or other documentation) to be granted limited immunity.

Syringe services programs in North Carolina are required to provide the following services:

- Syringe disposal
- Distribution of sterile syringes and new injection supplies at no cost and in sufficient quantities to prevent sharing or reusing
- Site, personnel and equipment security, including annual written plans to police and/or sheriff's departments within whose jurisdictions they operate
- Education materials including prevention of disease transmission, overdose and addiction
- Treatment options, including medication-assisted therapy (MAT) and referrals
- Naloxone distribution and training, or referrals for those resources
- Consultations/referrals to mental health or substance use disorder (SUD) treatment

The law encourages syringe return to ensure that they are disposed in a safe and secure manner, but does not require participants to return used syringes. Prior to commencing operations, NC SSPs are required to register with the NC Division of Public Health (DPH), by completing and submitting the form Starting a Syringe Exchange Program in NC and each SSP is required to submit annual reports to DPH. There are currently over 50 mobile and fixed site syringe services programs in NC.

Syringe services programs are financially practical ways to reduce costs associated with treating HIV and hepatitis A and C infections. Recently, multiple states, including North Carolina have reported upticks in outbreaks of hepatitis A associated with person-to-person transmission. Cases have occurred primarily among three risk groups: (1) persons who use injection or non-injection drugs; (2) persons who are experiencing homelessness; and (3) men who have sex with men. According to the Harm Reduction Coalition, approximately 20 percent of AIDS cases and upwards of 55 percent of hepatitis C cases can be attributed to injection drug use, which underscores the viability of SSPs as a tool in the fight against HIV/AIDS.

Syringe exchanges are important for public safety. Fear or hesitation to disclose syringe possession puts law enforcement officers and other emergency responders are at risk of needle stick injuries from used syringes. In addition to providing limited immunity for possession of drug paraphernalia (including used syringes), syringe exchange laws authorize places to dispose of used syringes safely and securely, limiting risk of harm to others. Furthermore, by investing in relationships with their communities, exchanges can alert public health agencies about observed changes in drug use, new health risks, and spread of infectious diseases.

As mentioned in the previous section, North Carolina has 86 opioid treatment programs, with capacity to serve 27,000 individuals on a daily basis. As many individuals who begin using opioids progress to injection drug use, these programs typically have availability and capacity to serve more participants.

Veterans and Military Families

According to the *Veterans Data Council,* North Carolina is home to the fourth largest active duty and reserve members of the military in the country. This population is comprised of each branch of the military: Army, Marines, Navy, Air Force and Coast Guard. Of the total, over 94,000 are active military and over 43,000 serve in the National Guard and Reserve forces. North Carolina's veteran population of 637,790 comprises about 8% of the total state population, with an unemployment rate of 3.9%.

More than 90,000 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 Governor's Working Group on Service Members, Veterans and Their Families is a collaborative intradepartmental work group focused on job creation, workforce enrichment, health and wellness, suicide prevention, legal and financial services and benefits for veterans. This monthly working group is jointly chaired by the following agencies: NC Department of Military and Veterans Affairs, NC Department of Commerce, NC DHHS DMHDDSUS, as well as the Veterans Administration Management from the Veterans Health Administration (VHA VISN-6) and the Veterans Benefits Administration (VBA). Regular participants in this collaborative forum include the Department of Public Instruction, Department of Adult Correction, other DHHS Divisions, the North Carolina Institute of Medicine (NCIOM) NC National Guard, UNC System and NC Community College System schools, Area Health Education Centers (AHECS) and members of the NC General Assembly.

The GWG has grown to become a nationally recognized forum, which hosts a monthly meeting, newsletter, and website (http://ncgwg.org), as well as a YouTube Channel and Facebook LIVESTREAM, which has greatly expanded viewership. This real-time referral and collaboration network cuts red tape by linking decision makers, service providers, and military members (current and former) and their families together in a best-practices sharing environment.

Charged with facilitating collaboration and coordination among ALL federal, State, local, and non-profit partners who work with North Carolina's nearly Veterans and their families, monthly sessions highlight:

- Health and Wellness, including Behavioral Health, especially for those in recovery
- Transitional Services
- Veterans Benefits and Claims
- Community-based Services and Supports
- Housing Resources
- Education and GI Bill
- Job Creation and Workforce Enrichment
- Legal and Financial Services

Functioning collaborations fostered at the GWG sessions include:

- NC STRIVE (Student Transition Resources Initiative for Veterans Education)
- Operation HOME: Ending Veterans Homelessness Task Force
- Women Veterans Summit and Expo NC
- Governor's Challenge to Prevent Veteran Suicide
- The "Ask the Question – Have You or a Loved One Ever Served in the Armed Service" Campaign

In North Carolina, significant gaps were identified in coordinated service delivery for Veterans and their families. NCServes provides the coordinated networks, with associated technology (UniteUS), needed to connect Veterans and their families to the resources they need, while allowing the tracking of system-wide outcomes that support system improvement.

In 2021 NCCARE360 (https://nccare360.org/) and NCServes, working with Unite US, joined forces to create the Nation's first fully synchronized statewide resources referral and care coordination network for Veterans, service members and their families in a unified platform. Participation and reporting via NCServes is required of all community partners in this section. In one year, call volumes to the network increased over 129%

NCServes has provided a strategic opportunity for North Carolina to continue to improve access across the social determinants of health that contribute to Best in Region:

- Reductions of homelessness, suicide, and unemployment
- Improved quality of life
- Improved health and well-being because of NCServes' community-level coordinated care model.

To date, NCServes has connected over 19,000 Veterans and Family members to over 46,000 individual service requests, an average of 2.4 service requests per individual, with a nearly 80% successful resolution rate.

The Veterans Life Center of North Carolina, which opened in July 2020, (https://vlcnc.org/) is located in Butner, NC, and is a 100 bed residential facility for 21st Century Veterans (male and female) who are housing insecure and considered at-risk. The Veterans Life Center was designed and executed as a public-private partnership between the NCDHHS, NC Commerce, the Town of Butner and the Veterans Life Center. This facility operates in close conjunction with the Division of State Operated Hospital Facilities (DSOHF) as well as the Durham VA Health Care System to assist veterans who are experiencing reintegration problems. This highly individualized program utilizes an Individual Recovery Plan (IRP) developed by the veteran and staff to develop a path to self-reliance. Services include physical wellness, mental fitness, life skills training, post-secondary and vocational education, case management, Moral Injury and Family Reconciliation counseling and community reintegration.

Deaf Services

NC DMHDDSUS has been providing specialized services to Deaf, Hard of Hearing and Deaf-Blind individuals since 1992. These services stem from one of the earliest ADA complaints filed in NC, alleging Deaf individuals were not receiving appropriate care in the public mental health system.

While the original complaint was resolved long ago, the state continues to show commitment to providing language accessible and culturally competent MH/SUD services to this population.

Since 2017, the state has contracted directly with RHA Behavioral Health to provide MH/SUD services to this population across the state. This direct service contract allows the Division to achieve budget efficiencies and ensure services are provided evenly across the state.

RHA employs full time licensed clinicians, Outreach Consultants (3 are certified Peer Support Specialists), a program director, business manager and a part-time administrative assistant. All staff are sign language fluent as measured by the Sign Language Proficiency Interview (SLPI). About 90% of RHA program staff are deaf. Funds from the SUBG support sign language proficient (SLP) workers to accompany deaf individuals to mutual aid support groups, as well as formal clinical treatment services if SLP staff are not available. The Addictions team continues to work with RHA to develop services, including Substance Abuse Intensive Outpatient Programs in more locations to better meet the needs of deaf individuals who are in need of this level of care.

Tuberculosis Services

Screening for tuberculosis has been incorporated into each provider's comprehensive clinical assessment tool and/or assessment process for a number of years. As the Division's intermediaries, LME/MCOs are required to assure tuberculosis screening and referral for care (if indicated) are carried out by SUBG designated providers. Division staff monitor and review sample records annually to ascertain these activities are conducted and issue plans of correction if such screenings do not occur.

In accordance with 10A NCAC 27A .0213 and 10A NCAC 27A .0216, TB screenings are required with the aim of identifying individuals who are at high risk of becoming infected with Tuberculosis. Persons with substance use issues and with limited access to medical care are at increased risk for Tuberculosis infection. North Carolina has required those involved in treatment programs as well as individuals who inject drugs to be screened for possible infection. Providers are to query service recipients about their health history as it relates to TB signs and symptoms. The Division of MH/DD/SUS has required certain elements to be included in the provider's screening documentation:

- Medical treatment in the past three months,
- Current place of residence (jail, streets, shelter, etc.),
- History of TB tests (prior positive skin tests, proximity to others diagnosed with TB in the past year),
- Physical/visible symptoms of TB, such as night sweats, prolonged cough, shortness of breath, and unexplained weight loss.

A sample screening tool and accompanying guidance is available to LME/MCOs and their contracted providers. Based upon an individual's positive responses to symptoms in the screening tool, a referral must be made to the local county health department or the individual's medical practitioner for follow-up testing and care. Those who have been found to be infected with TB must be referred to the appropriate State official for follow-up treatment.

Health Disparities and Inequities

Health inequities and disparities among historically marginalized populations (HMP) in the United States and North Carolina existed long before COVID-19, however the pandemic has spotlighted these glaring problems. While race and ethnicity have been and continue to be the basis for much of the discrimination and oppression seen throughout society, they are not the only defining characteristics of a historically marginalized population. Several other communities have also endured longstanding and well documented structural marginalization, and it is important to also acknowledge, engage and consider their unique needs as we strive for health equity. These communities include, but are not limited to, individuals with disabilities, the LGBTQ+ community, homeless populations, rural communities, and refugee and immigrant populations.

In July 2021, the Department revised and issued the *Historically Marginalized Populations Engagement Toolkit,* which can be accessed at: https://www.ncdhhs.gov/search/cse?keys=equity%20and%20inclusion#gsc.tab=0&gsc.q=equity%20and%20inclusion&gsc.sort= This toolkit is geared towards healthcare systems and providers and is intended as a guide for NC healthcare providers to help ensure historically marginalized populations are appropriately engaged in all aspects of public health and healthcare delivery – from planning to evaluation, whether emergency preparedness and response efforts or everyday programs and services. The toolkit is organized to provide a framework for embedding health equity into organizational infrastructure for long-term reduction in health disparities and improved health outcomes beyond the pandemic as well as health equity considerations and strategies specific to COVID-19 response efforts.

In September 2021, NC DHHS announced the hiring of the Department's first ever Chief Health Equity Officer. NCDHHS created the position as well as the Office of Health Equity to lead its focus to advance health equity and reduce disparities in opportunity and outcomes for historically marginalized populations. This position serves as a member of the Department's executive leadership team and leads the Department's overarching strategy and operational goals to promote health equity, diversity, and inclusion across all health and human services divisions. This position is responsible for developing, implementing, facilitating, and embedding health equity strategic initiatives into every aspect of DHHS' programs, services, actions, outcomes and internal employee culture, as well as overseeing the Office of Health Equity, Office of Rural Health, and the Office of Diversity, Equity and Inclusion.

The Health Equity Portfolio has worked to identify four strategic areas to focus efforts on in 2023 – Strategy, Operational Excellence and Daily Operations, Community and Partner Engagement, and HE and DEI Consultation and Technical Assistance, as described in the table below:

Strategy
Develop guiding principles/framework for applying DEI and HE equity lens to policy and procedure development and equity promoting programs and practices.
Serve as technical advisors in the development of a DEI workforce plan, training, and implementation.
Operational Excellence and Daily Operations
Establish alignment of HE Portfolio offices to the HE Portfolio strategy and implement DEI, HE, Rural Health-related initiatives.
Develop capacity within HE Portfolio offices to conduct data analysis and reporting.
Provide consultation, technical guidance, training, learning, and development opportunities for local health departments, community groups and organizations, and historically marginalized populations.
Community and Partner Engagement
Develop and implement a community and partner engagement plan.
HE and DEI Consultation and Technical Assistance (TA)
Serve as a technical resource on DEI/HE/Rural Health and Learning & Development to the enterprise.

In January of 2021, the DMHDDSUS officially launched its own Diversity, Equity and Inclusion (DEI) Council. The DEI Council is an advisory group composed of staff that help guide the Division's DEI process. It is a vehicle for changing the Division's culture and policies that will ideally lead to a more diverse, equitable and inclusive workplace and behavioral health system. The DEI Council is the official entity within the Division that is responsible for evaluating the Division's progress and providing information and recommendations to leadership to help guide the Division in reaching its DEI mission and goals, and manifesting its values as articulated in its charter.

The DEI Council's responsibilities include the following:

1. Research, assess and set forth the Division's DEI strategy and action plan, which focuses on improvements and leads to systemic changes in the division's current practices, procedures, and climate.
2. Develop a mission statement and create policies and initiatives that are in accordance with the mission statement.
3. Create, manage, and assess DEI action plans in consultation with staff and executive team.
   - Ensure Division infrastructure, policies, practices, procedures, resources, and metrics are sufficient and aligned to drive DEI efforts across the Division.
4. Communicate DEI action plans, efforts, and successes consistently and repeatedly to all internal stakeholders.
5. Develop links and partnerships with external DEI-related industry groups and community stakeholders.
6. Provide helpful counsel to leaders and staff regarding DEI issues.
7. Champion and model positive DEI behaviors and actions.

The standing workstreams and their respective functions as of January 2021 are as follows:

1. Data
   - The functions of the Data workstream are to: collect, analyze, and report on key data metrics that illuminate DEI trends across several human resources domains including hiring, recruitment, promotions, pay, performance evaluations, corrective actions, terminations, etc.; and identify and recommend to leadership key DEI improvement metrics and benchmarks as evidence of the Division's ongoing commitment to DEI principles.

2. Education and Communications

- The functions of the Education and Communications workstream are to: develop and implement a strategy to educate Division staff on DEI principles, practices and effects using peer-reviewed research and industry practices; provide regular education via webinars, virtual meetings, All-Staff presentations, and sharing of written documents; and identify and invite DEI industry experts to present on emerging trends in DEI within government agencies.

3. System Reform (internal)

- The functions of the System Reform (internal) workstream are to: using historical and contemporaneous data to help create a work environment wherein everyone can do their best work by establishing best practices based on internal data and diversity, equity, and inclusion research; and engaging and empowering staff through fostering a more culturally diverse and inclusive work environment by removing barriers resulting from systemic inequities and social injustices.

4. System Reform (external)

- The functions of the System Reform (external) workstream are to: examine external practices including contracts, engagement, and access; make recommendations for systemic and structural changes that better reflect DEI principles; ensure a fair and equitable distribution of system resources.

5. Policy

- The functions of the Policy workstream are to assist the DEI Council in developing a policy to define its scope of authority and operations in accordance with the mission statement and to identify policies within the Division that are best reflective of DEI practices; make recommendations on policies that need review and establish benchmarks and standards.

See the DEI informational flyer following this document.
More recently, DMHDDSUS has developed four governance committees, including a Health Equity Committee. This committee will develop the Health Equity framework for DMHDDSUS, including the following:

- Identify and promote best practices for programs, contracts, grants to reduce/eliminate inequities;
- Support the implementation of strategies that create opportunities for the more equitable provision or services and supports;
- Provide a forum for cross-matrix collaboration and discussion to decrease health disparities and promote health equity.

LME/MCOs and provider agencies often develop their own cultural competency related activities, tools and trainings, influenced by DMHDDSUS-related trainings. The Division does not develop or direct the development of cultural competency trainings; however, its work often influences LME/MCO and provider outputs in this regard.

The fundamental precepts of cultural competence include developing respect for differences; cultivating successful approaches to diversity; increasing awareness of oneself and of unstated institutional cultural norms and practices; and having a working knowledge of the history, culture, beliefs, values and needs of diverse people and communities. A culturally competent approach to services requires the system to examine and potentially transform each component of mental health, intellectual and developmental disability and substance use services.

The 26 Perinatal/Maternal and CASAWORKs programs have implemented strategies to assure participants in these programs are served competently. Annually each program completes a "cross-site evaluation" and reports on specific questions related to cultural competency, which are then reviewed and/or evaluated by Division staff. A sampling of those questions includes the following:

1. Describe the level of diversity of your agency's staffing in terms of race, gender and language.
2. Describe how your agency's environment is conducive for providing culturally competent treatment services.
3. Please describe any challenges you may have faced recruiting a culturally diverse clinical team.
4. How are issues of culture addressed in individual clinical supervision?
5. What strategies are you employing to assure all women in need of your services have access to care?

Data Collection

The North Carolina Treatment Outcomes and Program Performance System (NCTOPPS) is the program by which the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services measures the quality of substance use disorder and mental health services and their impact on consumers' lives. By capturing key information on a consumer's service needs and life situation during a current episode of care, NCTOPPS aids in developing appropriate treatment plans and evaluating the impact of services on a consumer's life. It supports LME/MCOs in their responsibility for monitoring service outcomes in each LME/MCO's catchment area. The data generated through NCTOPPS helps the DMHDDSUS, LME/MCOs and provider agencies improve the quality of services. In addition, NCTOPPS provides data for meeting federal performance and outcome measurement requirements, which allows North Carolina to evaluate its service system in comparison to other states.

NCTOPPS began as a pilot study funded through a 1997 federal Center for Substance Abuse Treatment (CSAT) grant. North Carolina was one of 14 States that received the CSAT grant. This initiative was a partnership between the federal government and grantees to prepare States for development of a system to monitor and evaluate substance use disorder treatment services. Based on information gathered during the pilot period lasting approximately two years, the Division transitioned the pilot program into an on-going data collection, feedback and planning system. NCTOPPS later became a statewide system. Assessment instruments were built on research findings and field practice. Individual assessment items were discussed and agreed upon by participating programs and State Addictions team staff.

In the spring of 2004, the Division decided to expand the NCTOPPS web-based data collection system into the mental health arena. A participatory, collaborative and consensus-building process, similar to the process used for substance abuse assessments, was established involving mental health providers, Local Management Entities, researchers and consumers to develop and improve measures for mental health. On July 1, 2005, NCTOPPS became the statewide method of collecting information necessary for accountability, quality improvement and tracking outcomes for consumers of the State's substance abuse and mental health treatment services.

As a web-based system, NCTOPPS today can be used on most laptops, tablets and cell phones. Through regular consumer-to-clinician interviews during an episode of care at intake and months three, six, 12, 18, 24, etc., NCTOPPS captures information about an individual's current situation, including such topics as symptoms, well-being, family and social relations, housing, employment, and legal system involvement. It also gathers consumers' perspectives on the system, including barriers to treatment, choice of providers, timeliness of care and involvement in treatment planning.

NCTOPPS gives providers information to develop person-centered plans and track goal attainment. It gives LME/MCOs information to evaluate consumer needs and improve local service quality. Furthermore, it gives State decision-makers, NC residents and the federal government information to help evaluate and improve the effectiveness of the service system.

Interview information provides one method for collection of the Division's consumer functional outcomes data. Consumer functional outcomes data are the Division's source of information to monitor the impact of services. These data are also used to respond to departmental, legislative, and federal reporting requirements. NCTOPPS accountability measures based on outcomes along with other performance measures are used for both the MHBG and the SUBG reporting. In addition, the system provides data to meet SAMHSA's reporting requirements for the National Outcome Measures (NOMs) and the Treatment Episode Data System (TEDS) data as requested. The Division has the ability to modify or add questions as needed; as such, questions specific to sexual orientation and transgenderedness were added in 2016. Division staff will monitor the results of this data to determine the percentage of transgendered, gay and lesbian individuals are accessing care.

The NCTOPPS system provides information on outcomes and program performance that can be used to improve service delivery and, ultimately, the quality of life for people with mental health and substance use disorder needs who are served in the public service system. The following NCTOPPS links are provided:

- NCTOPPS Login: https://nctopps.ncdmh.net/Nctopps2/Login.aspx
- Public Dashboard: https://nctopps.ncdmh.net/ProviderQuery/Index.aspx
- Website: https://www.ncdhhs.gov/providers/provider-info/mental-health/nc-treatment-outcomes-and-program-performance-system

Contracts

In addition to contracting with the six LME/MCOs for the delivery of prevention, treatment and recovery 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 objectives of this contract are to increase access to and improve the quality of prevention, treatment, and recovery support services for individual with behavioral health disorders by: (1) Expanding the use of prevention, treatment and recovery support services for behavioral health that demonstrate success in improving outcomes and/or supporting recovery; (2) Enhancing the quality of the behavioral health workforce providing prevention, treatment and/or recovery support services, with a special emphasis on service members, veterans and their families; (3) Enhancing the ability of provider agencies to determine the effectiveness of the behavioral health promotion, treatment and recovery support services they provide; (4) Enhancing the ability of physicians and other health care providers in primary care settings to provide better prevention, treatment, and recovery services to their patients particularly in regard to treating opioid use disorders, including medication assisted treatment; (5) Enhancing the ability of physicians and other health care providers to provide patient education and resources to augment self-management skills, and in so doing, improve health status and outcomes for patients with other chronic diseases; (6) Promoting systems of health and human services that offer a wide spectrum of services and supports aimed at engaging people with mental health and substance use conditions into care and promoting their resilience and long-term recovery; (7) Utilize a health equity lens when implementing the performance requirements including:

    - Ensuring the program design, implementation and evaluation efforts are promoting health equity such as specific outreach to underserved communities and engagement with historically marginalize populations
    - Using disaggregated data to identify priority populations when applicable
    - Engaging priority populations in program planning, implementation and/or evaluation
    - Providing opportunities for staff and partners to learn about health equity and social determinants of health, and apply these concepts to program design, implementation, and evaluation
    - Ensuring education and communication materials are culturally sensitive, linguistically appropriate and at an appropriate comprehension level to accommodate stakeholders with varying backgrounds
    - Partnering with organizations, agencies and/or community groups that focus on the social determinants of health or health equity.

    Highlighted projects include the following: (1) Physician and Prescriber Initiatives - These initiatives cover important practice areas relevant to both addiction medicine providers as well as psychiatrists and other primary care providers. SUDs are often overlooked in many clinical practice settings for a variety of reasons including inadequate knowledge and skills on the part of clinicians in identifying, intervening, and managing SUDs and related psychiatric comorbidities. The GI initiatives include CME and other training events on integrated care and a range of addiction medicine topics including SBIRT, pain management and safer opioid

prescribing, medication assisted treatment including office based opioid treatment, and other relevant topic areas. (2) Substance Use Disorder Higher Education Consortium / Graduate Scholarship Initiative - This program seeks to engage students and faculty at Criteria C Universities (as defined by the NC Substance Abuse Professional Practice Board) and select Criteria A schools to provide funds for scholarships to individuals who are working to complete graduate-level education. (3) Professional Addiction Workforce and Counselor Continuing Education - The goal of this program is to identify and engage emerging leaders in the Substance Use Disorders field. Those awarded scholarships must be currently working within public substance use disorder prevention, treatment and recovery services and be in good standing with their organization. Assistance includes but is not limited to standardized test reimbursement, and registration fees for various substance use disorder conferences and trainings. (4) Focus on SAMHSA-Supported Services to Military Service Members, Veterans, and Their Families - The project includes other divisions within the NC Department of Health and Human Services, the US Department of Veterans Affairs, the NC National Guard, the NC Department of Military and Veterans Affairs, the NC Department of Commerce, as well as several other state agencies, active duty and reserve components, higher education, non-profit organizations, advocates, and others who are working together to meet the needs of veterans, service members, and their families in North Carolina. (5) Support for Veteran Service Officers and the Veteran Service Specialist Program - This program will host, update and expand the Veteran Service Specialist (VSS) a program designed to encourage the use of evidence-based tools to support Veterans in North Carolina. (6) New Audience Acquisition and Community Engagement Through Targeted Communications - This pilot program will advocate and promote non-profits, organizations and campaigns across North Carolina that offer myriad services and supports aimed at engaging people with substance use disorders and mental health conditions and promoting resilience and long-term recovery. The program will also help distribute evidence-based tools to support Veterans in North Carolina and seek to expand the pool of Veterans, service members and their families who benefit from the wide array of support services available in the Tar Heel State. (7) Decreasing Youth Access to Tobacco and Advancing Statewide Tobacco Enforcement - The project objectives are to assess and reduce youth access to tobacco products by persons under the age of 21 in NC. (8) Program evaluation and technical assistance for the SUBG Women's Set Aside funded statewide Perinatal and Maternal Substance Use and CASAWORKS for Families Residential Initiatives.

- ***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. As of March 2020, there were 281 homes in North Carolina with more than 2176 beds, with a total of 17 homes that accommodate women with dependent children. In 2017, Oxford House opened its first house for men with dependent children and has long focused on the re-entry population.

- ***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 (NCTOPPS) 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 Community Mental Health and Substance Abuse Block Grants.

- ***University of North Carolina, School of Social Work, Behavioral Health Springboard*** - 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 training, with an emphasis on ASAM training; (3) enhancing the ability of provider agencies to determine the ongoing effectiveness of substance use prevention, treatment and recovery support services; and (4) planning the implementation of new, expanded or enhanced services within the state. UNC Springboard is the contracted vendor responsible for conducting Independent Peer Review for SUBG-funded agencies annually and also supports the development of North Carolina's certified peer support specialist workforce. Additionally, UNC Behavioral Health Springboard is funded for a position that works in coordination with and supervision of the DMHDDSUS Women's Services Coordinator to support the statewide Work First/CPS Substance Use Initiative, Reproductive Life Planning Project, Infant Plan of Safe Care policy work, and technical assistance and training related to women's SUD services including pregnancy and opioid use.

- ***NC Division of Public Health*** – The DMHDDSUS and DPH have an interagency memorandum of agreement in place to jointly fund a licensed Perinatal Substance Use Specialist to provide capacity management, training and technical assistance regarding pregnant and parenting women with SUD and their children. This position is contracted through the Alcohol/Drug Council of North Carolina (ADCNC). The Perinatal Substance Use position is housed at DPH, DMHDDSUS and ADCNC throughout the week and is clinically supervised by the Addictions team's Women's Services Coordinator.

- **NC Division of Social Services-** The DMHDDSUS has a Memorandum of Agreement with DSS to establish the relationship and responsibilities of each Division to carry out the policies and practices of the Work First/CPS Substance Use Initiative as required by legislative statute.

  Objectives of the MOA between the Divisions for this Initiative include:

- Interagency collaboration;
- Involvement in planning and policy discussions that impact the population served;
- The requirements of local county DSSs and LME/MCOs and their providers serving this population; and
- Referrals required from DSS to DMHDDSUS by way of LME/MCO providers and compliance with federal confidentiality requirements.

DMHDDSUS and DSS staff meet on a quarterly basis with the LME/MCOs and their contracted providers to provide policy updates, review quarterly data, discuss accomplishments and challenges.

- ***Alcohol/Drug Council of North Carolina*** – This contract provides for the operation of a 24/7/365 substance use disorder information and referral to treatment helpline to provide resources and referrals to individuals with substance misuse and disorders and their families, primarily provided by Peer Call Responders. 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 Substance Use and CASAWORKS for Families Residential Initiatives 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. It also provides advocacy and education for recovery advocates, stigma reduction training, as well as an annual conference for addition professionals. This agency also houses the National Guard Project, whose mission is to strengthen the overall fitness and effectiveness of the NCNG workforce, to conserve manpower, and enhance the combat readiness of soldiers through the provision of assessments for Guard who have been identified with a potential SUD, as well as up to four (4) brief intervention sessions conducted by Licensed Clinical addiction Specialists.

- ***UNC – General Administration*** – The purpose of this contract is to continue the collegiate wellness and recovery projects at 14 university campuses, as part of the Crisis Solutions Initiative that was established by then Governor McCrory in 2015 due to concerns over alcohol consumption by college students and the need to provide a college atmosphere that is not "recovery hostile." These collegiate wellness and recovery programs focus on the issues related to substance use on college campuses by providing enhanced and expanded prevention, intervention, treatment and particularly recovery-oriented services to address the growing needs of students on college campuses. Each of the 14 schools submit plans to develop, continue, expand or enhance services and programs; five campuses have very recently been identified and are more in the development phase. Additionally, efforts will be focused on identifying two more historically black colleges and universities (HBCUs) interested in developing or enhancing their collegiate recovery programs. Five of the 14 current schools are HBCUs. Schools currently funded through this contract include: (1) East

Carolina University, (2) NC A&T, (3) UNC-Charlotte, (4) UNC-Chapel Hill, (5) UNC-Greensboro, (6) UNC-Wilmington, (7) NC Central University, (8) Appalachian State, (9) NC State University, (10) Fayetteville State University (11) Elizabeth City State University, (12) UNC-Pembroke, (13) Winston-Salem State University and (14) UNC-Asheville. Please see the Recovery section for additional detail on collegiate recovery initiatives.

- ***Sunrise Community for Recovery and Wellness -*** The purpose of this contract is to provide funding for a recovery community organization and center in Buncombe County to support individuals seeking to sustain recovery from substance use disorders. The Recovery Community Center is a "hub" for recovery resources and offers a safe space within the community for individuals to utilize for support. Other initiatives include provision of peer support specialists as recovery coaches training, recovery messaging and stigma reduction training and development/implementation of specialized Peer Support Ambassadors who have been trained in problem gambling. Additionally, funds will also support the continuation of one (1) recovery community center located within the Qualla Boundary of the Eastern Band of the Cherokee Indians, as well as six to eight additional recovery community centers located in the western region of the state, selected through a competitive process. Please see the Recovery section for additional detail on these recovery community organization initiatives.

- ***Recovery Communities of North Carolina -*** The purpose of this contract in is to continue funding for a recovery community center in Wake County to support individuals seeking to sustain recovery from substance use disorders. The recovery community Center is a "hub" for recovery resources and offers a safe space within the community for individuals to utilize for support. Other initiatives include provision of peer support specialist trainings and recovery coach curricula, recovery messaging and stigma reduction training. Additionally, funds provided to RCNC will also support the continuation of four to six additional recovery community centers located in the central to eastern areas of the state.

- ***Addiction Professionals of North Carolina (APNC)*** – This contract was executed to advance policy, services, and professional development that reflect the highest standards of the prevention and treatment profession, strengthen its value to the community and promote the values of its members. This contract addresses the training, technical assistance and education needs of the substance use disorder prevention and treatment professionals by providing training and professional development scholarships, expanding professional development opportunities with conferences and regional trainings and expanding opportunities to learn about substance use disorder policies.
  This contract also:
  - provides a mechanism for providing support to treatment and recovery organizations who are grappling with decreased revenue, minimal staff, and required changes in

operational capacities to address COVID-19 currently, and the impacts on addiction during and after the virus subsides.

- provides supports to organizations through state system reforms, as we move through Medicaid transformation and whole person, integrated care.
- employs a Director of Scholastic Recovery who oversees several collegiate initiatives including (1) Rapid Deployment of Support Across College Campuses; (2) Bridging Prevention and Recovery Training; (3) Recovery Program Training and Assistance for Collegiate Recovery Programs; (4) NC Collegiate Leadership Academies. This position works directly with all 18 collegiate recovery programs and in collaboration with UNC which shares general oversight responsibilities.
- funds a Recovery Support Services (RSS) Outreach Coordinator for western North Carolina, which focuses on building collaborative partnerships across interdisciplinary teams with stakeholders focused on promoting community-based recovery supports and opportunities for people living with substance use disorder in the western region of North Carolina to achieve enhanced recovery.
- identifies and provides the necessary support for knowledge and implementation of the NC Strategic Prevention Framework-Partnership for Success program (SPF-PFS). APNC will support the following goals: Prevent the onset and reduce the progression of underage alcohol use, vaping, marijuana use, and their related problems; Strengthen the prevention infrastructure capacity to use the Strategic Prevention Framework to facilitate local and state-level change in substance abuse and its consequences; and utilize evaluation results of the project to make prevention efforts effective.
- NC Prevention Training and Technical Assistance Center - identifies and supports needed for the prevention workforce on an ongoing basis. They conduct a workforce study to identify areas of concern for providers and the state system. The need for increased emphasis on prevention certification and additional support around retaining and recruiting prevention workforce has been an ongoing identified need.
- Collegiate Primary Prevention Initiatives – to build the capacity of higher education institutions to plan, implement and evaluate primary prevention strategies on college campuses.
- Health Policy/Funding Technical Assistance - to provide substance use disorder treatment, prevention and recovery providers operations-level technical assistance in implementing emerging best practices in service delivery, business operations (including necessary changes related to Medicaid transformation), assurances of confidentiality and patient protections and new funding models that would assist in the long-term sustainability of their programs.

- ***UNC-Chapel Hill, School of Medicine, Addiction Medicine Fellowship -***
  The purpose of this contract is to expand capacity and access to addiction treatment for all residents in NC with an emphasis on supporting underserved and at-risk populations. The UNC Addiction Medicine Program shall direct this work through the UNC Addiction Medicine

Fellowship, the NC Substance Treatment and Recovery Network (NC STAR Network) and the UNC Mobile Services for Addiction Treatment. This contract continues the collaborative relationship between the UNC Department of Psychiatry and DMHDDSUS to obtain both parties' goals of increasing the number of medical professionals in North Carolina trained to treat addiction and prescribe appropriate medications for such. This contract also allows for the provision of direct clinical services to adolescents and adults with substance use disorders. Selected goals, strategies and deliverables of the of the Addiction Medicine Fellowship include:

- Ensuring the fellows have quality educational experiences and that the Fellowship meets the requirements set forth by UNC Graduate Medical Education (GME) office.
- The Fellowship shall ensure fellows are trained to provide comprehensive evaluations and treatment for patients with substance use disorders.
- The Fellows shall have clinical responsibilities that include outpatient addiction treatment, whereby the fellows shall provide comprehensive evaluation and treatment to 100% of the patients they are assigned.
- The fellows shall be assigned direct patient care responsibilities in a variety of settings, which may include medically supervised detox, inpatient addiction treatment, inpatient pain treatment, outpatient addiction treatment, and opioid treatment program.

Selected goals, strategies and deliverables of the of the NC STAR Network include:

- Maintain a statewide network of addiction treatment providers utilizing a hub and spoke network, such that UNC, MAHEC and ECU serve as academic hubs and community clinics, including community health centers, serve as Spokes.
- Follow an evaluation plan that shall gauge provision of services for substance use disorders, including opioid use disorder, to ensure residents of NC have an increased capacity for accessing addiction treatment.
- Utilize evidence-based outcome measures for measuring engagement in addiction treatment.
- Maintain a focus on underserved populations, including uninsured, those experiencing homelessness, underserved minority populations, pregnant/parenting, and justice-involved.
- The hubs shall provide mentorship and training to the spokes, ensuring best practices are being taught for treating substance use disorders, including opioid use disorder.
- Each hub shall ensure employment of addiction medicine specialists, including physicians board certified in addiction medicine and/or addiction psychiatry, case managers with expertise in addiction services, and peer support specialists who have lived experience with substance use disorder(s).
- Ensure all addiction specialists at the hubs are receiving national-level training in order to remain up to date on best practices.

Selected goals, strategies and deliverables of the of the Mobile Unit include:

- Provide weekly, in-person services for addiction treatment to residents of Robeson County.
- Ensure delivery of MOUD to those residents in Robeson County who are engaged with the service.
- Provide medical services, including medical exams, urine toxicology screening, blood work screening.
- Provide multidisciplinary services from Peer Support Specialists, Medical Assistant or Nurse, Physician or APP, Pharmacist, and Case Managers.
- Follow an evaluation plan that shall gauge provision of services for substance use disorders, including opioid use disorder, to ensure services for OUD/SUD treatment are expanded to residents of Robeson County.
- Maintain a focus on underserved populations, including the Lumbee tribe and underserved minority populations.

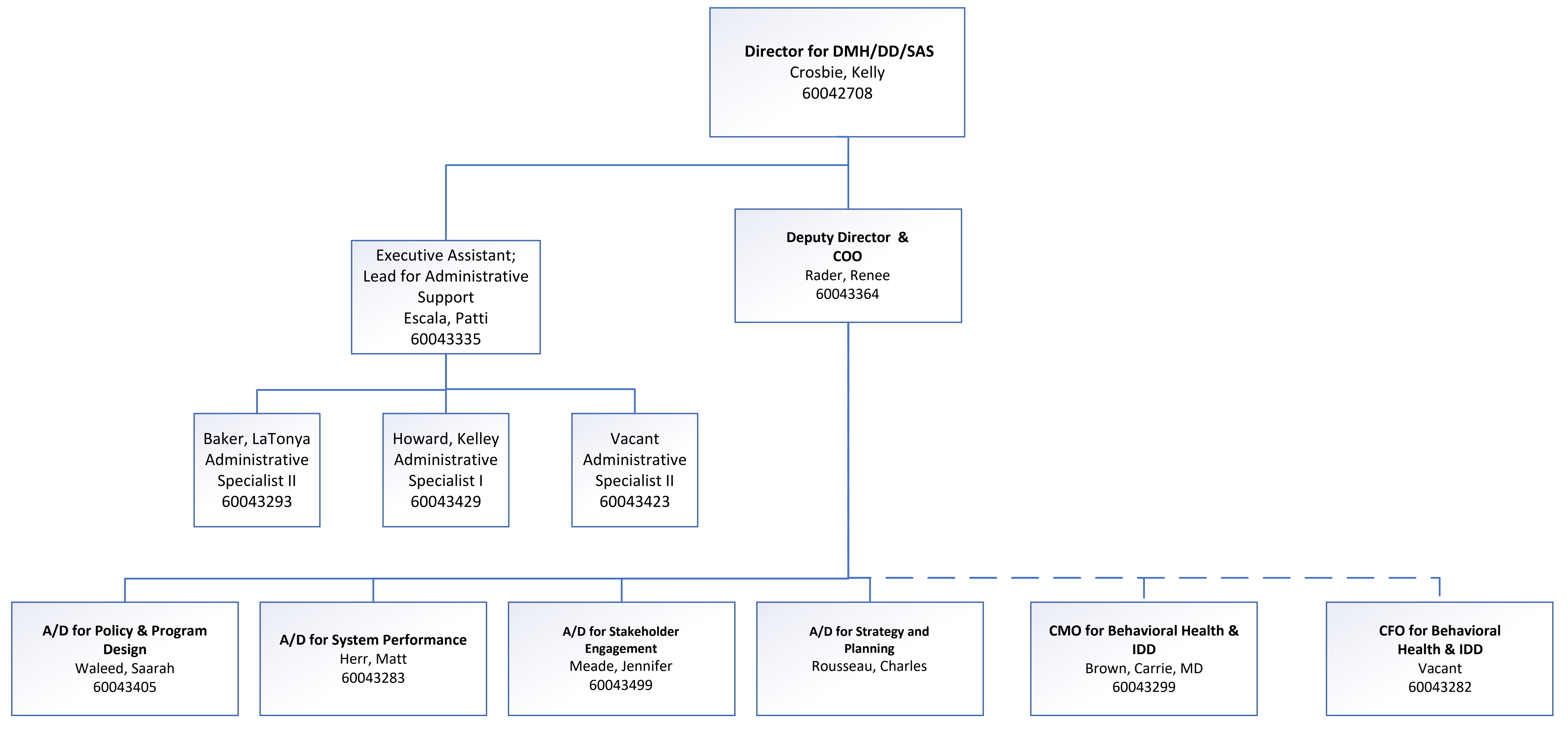
- **Community Impact NC -** This contract identifies and provides support to alcohol, tobacco and other drug prevention coalitions and connects with the existing training, technical assistance and evaluation contractors to provide support in starting and successfully maintaining coalitions with communities and block grant providers who are a part of substance misuse coalitions.

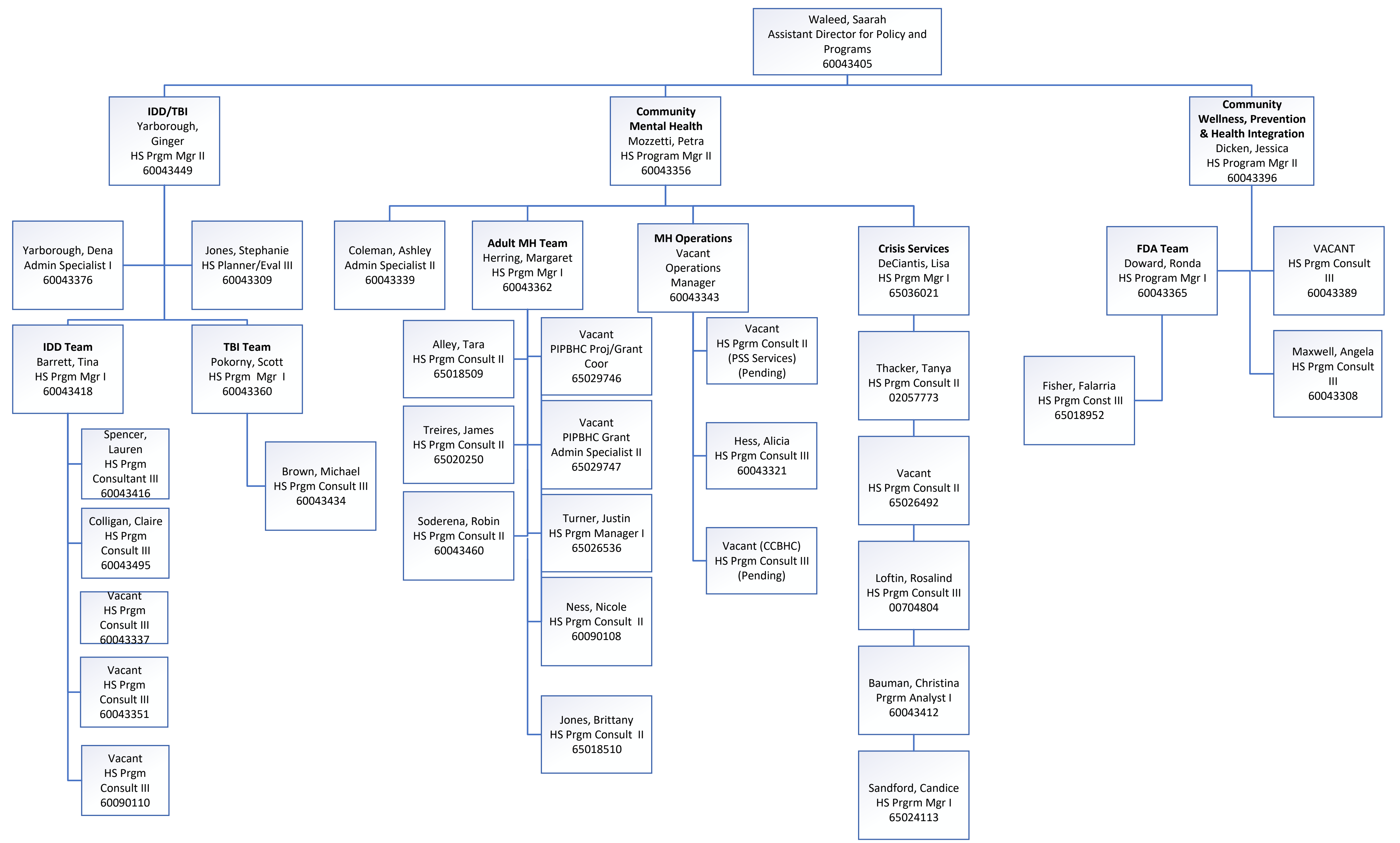
- **Wake Forest University -** This contract provides assessment support to the prevention block grant providers, supports data-driven decision making and information and makes recommendations to the state for continuation/discontinuation of evidence-based prevention programming. This contract serves as the convener of the Statewide Epidemiological Outcomes Workgroup (SEOW).

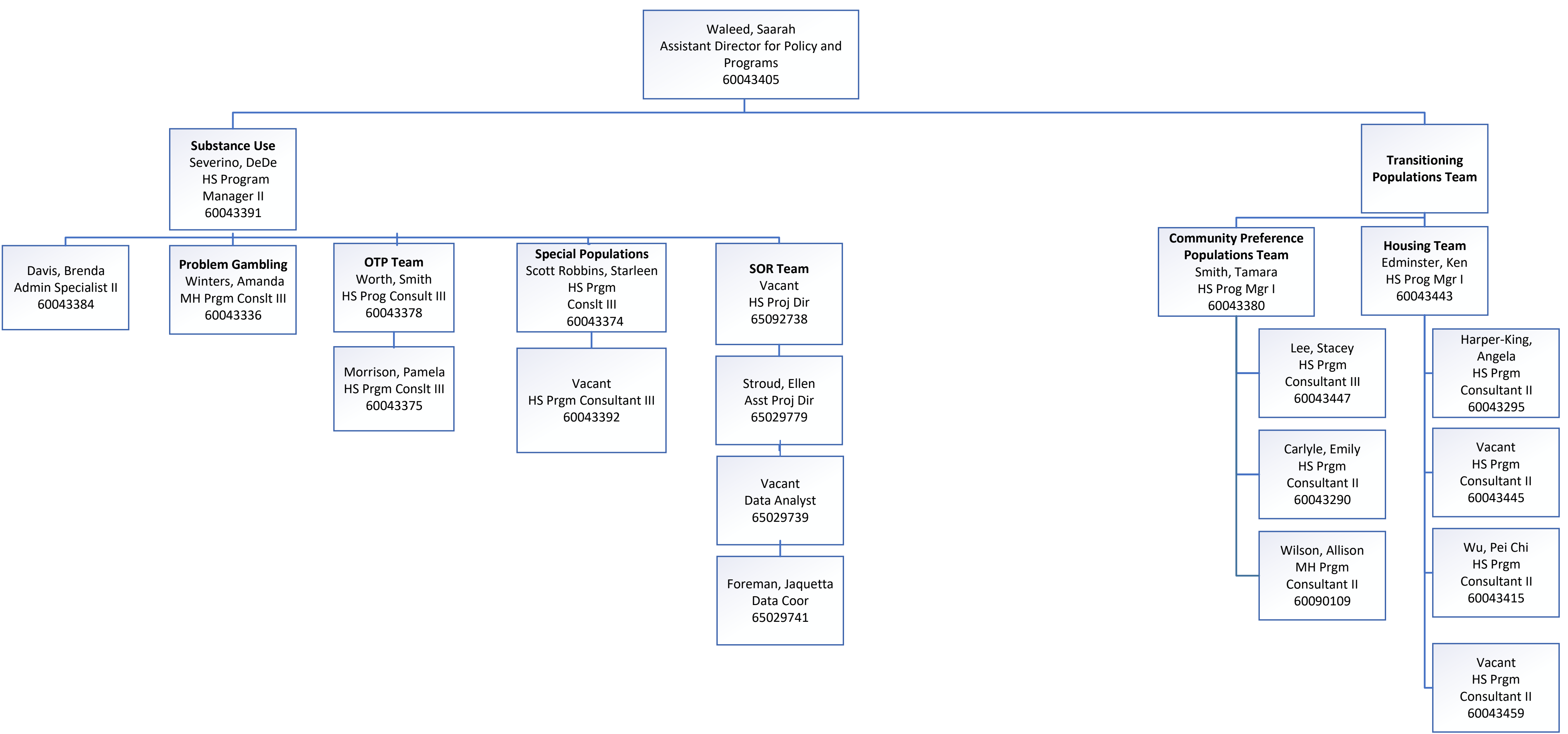
- **PIRE** - This contract provides evaluation support to the prevention block grant providers, supports data-driven decision making and information and makes recommendations to the state for continuation/discontinuation of evidence-based prevention programming.

- **Arc of NC** – this contract strives to prevent alcohol-exposed pregnancies. Arcs provide training, education, and resources to professionals who serve individuals of reproductive age, as well as professionals who provide support to families and people impacted by fetal alcohol spectrum disorders (FASD).

Division of Mental Health, Developmental Disabilities and Substance Use Services
Organizational Chart as of August 23, 2023
Executive Leadership Team




Waleed, Saarah
Assistant Director for Policy and Programs
60043405
IDD/TBI
Yarborough, Ginger
HS Prgm Mgr II
60043449
Community Mental Health
Mozzetti, Petra
HS Program Mgr II
60043356
Community Wellness, Prevention & Health Integration
Dicken, Jessica
HS Program Mgr II
60043396
Yarborough, Dena
Admin Specialist I
60043376
Jones, Stephanie
HS Planner/Eval III
60043309
IDD Team
Barrett, Tina
HS Prgm Mgr I
60043418
TBI Team
Pokorny, Scott
HS Prgm Mgr I
60043360
Spencer, Lauren
HS Prgm Consultant III
60043416
Colligan, Claire
HS Prgm Consult III
60043495
Vacant
HS Prgm Consult III
60043337
Vacant
HS Prgm Consult III
60043351
Vacant
HS Prgm Consult III
60090110
Brown, Michael
HS Prgm Consult III
60043434
Coleman, Ashley
Admin Specialist II
60043339
Adult MH Team
Herring, Margaret
HS Prgm Mgr I
60043362
Alley, Tara
HS Prgm Consult II
65018509
Treires, James
HS Prgm Consult II
65020250
Soderena, Robin
HS Prgm Consult II
60043460
Vacant
PIPBHC Proj/Grant Coor
65029746
Vacant
PIPBHC Grant Admin Specialist II
65029747
Turner, Justin
HS Prgm Manager I
65026536
Ness, Nicole
HS Prgm Consult II
60090108
Jones, Brittany
HS Prgm Consult II
65018510
MH Operations
Vacant
Operations Manager
60043343
Vacant
HS Pgrm Consult II
(PSS Services)
(Pending)
Hess, Alicia
HS Prgm Consult III
60043321
Vacant (CCBHC)
HS Prgm Consult III
(Pending)
Crisis Services
DeCiantis, Lisa
HS Prgm Mgr I
65036021
Thacker, Tanya
HS Prgm Consult II
02057773
Vacant
HS Prgm Consult II
65026492
Loftin, Rosalind
HS Prgm Consult III
00704804
Bauman, Christina
Prgrm Analyst I
60043412
Sandford, Candice
HS Prgrm Mgr I
65024113
FDA Team
Doward, Ronda
HS Program Mgr I
60043365
Fisher, Falarria
HS Prgm Const III
65018952
VACANT
HS Prgm Consult III
60043389
Maxwell, Angela
HS Prgm Consult III
60043308


Waleed, Saarah
Assistant Director for Policy and Programs
60043405
Substance Use
Severino, DeDe
HS Program Manager II
60043391
Davis, Brenda
Admin Specialist II
60043384
Problem Gambling
Winters, Amanda
MH Prgm Conslt III
60043336
OTP Team
Worth, Smith
HS Prog Consult III
60043378
Morrison, Pamela
HS Prgm Conslt III
60043375
Special Populations
Scott Robbins, Starleen
HS Prgm Conslt III
60043374
Vacant
HS Prgm Consultant III
60043392
SOR Team
Vacant
HS Proj Dir
65092738
Stroud, Ellen
Asst Proj Dir
65029779
Vacant
Data Analyst
65029739
Foreman, Jaquetta
Data Coor
65029741
Transitioning Populations Team
Community Preference Populations Team
Smith, Tamara
HS Prog Mgr I
60043380
Lee, Stacey
HS Prgm Consultant III
60043447
Carlyle, Emily
HS Prgm Consultant II
60043290
Wilson, Allison
MH Prgm Consultant II
60090109
Housing Team
Edminster, Ken
HS Prog Mgr I
60043443
Harper-King, Angela
HS Prgm Consultant II
60043295
Vacant
HS Prgm Consultant II
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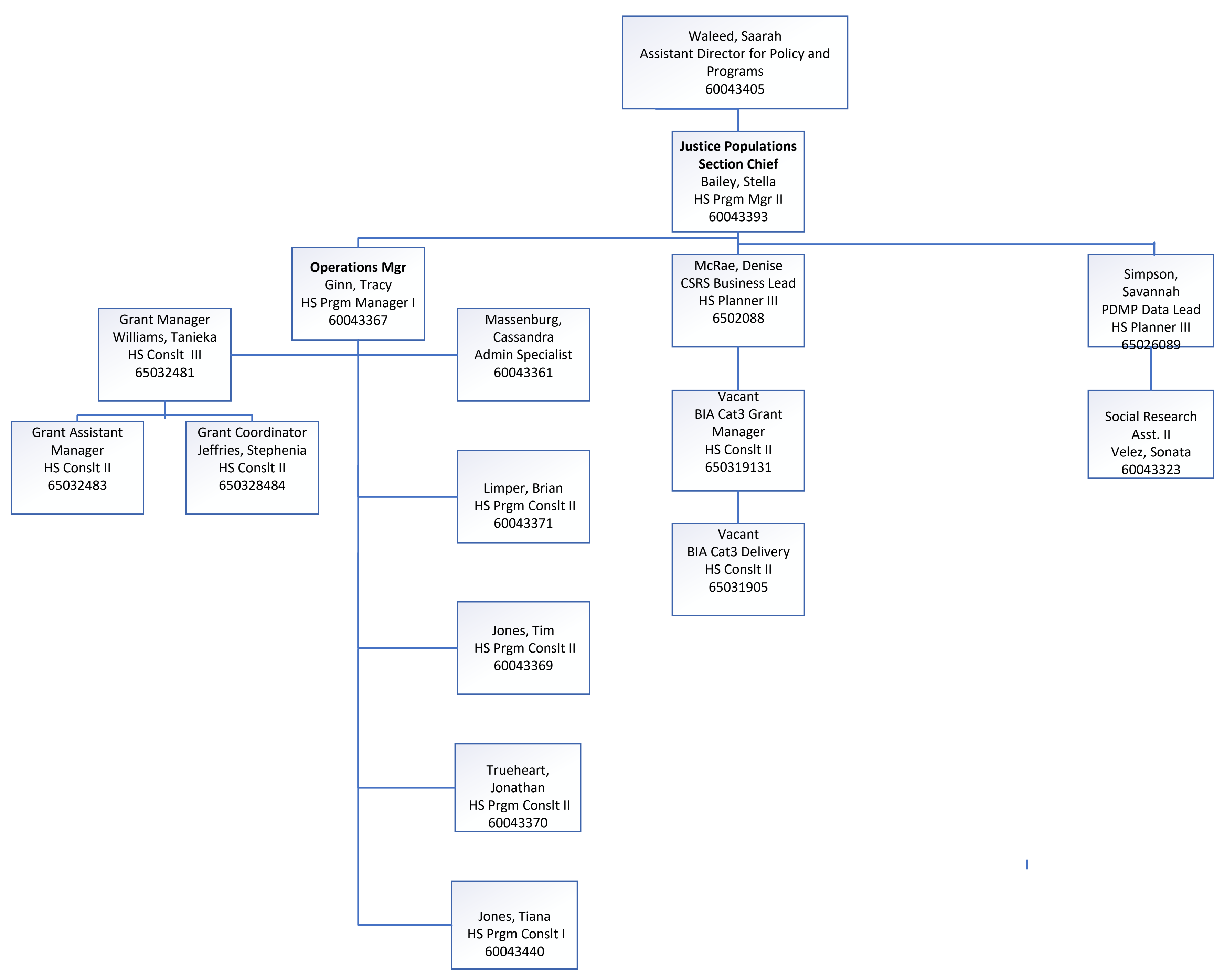
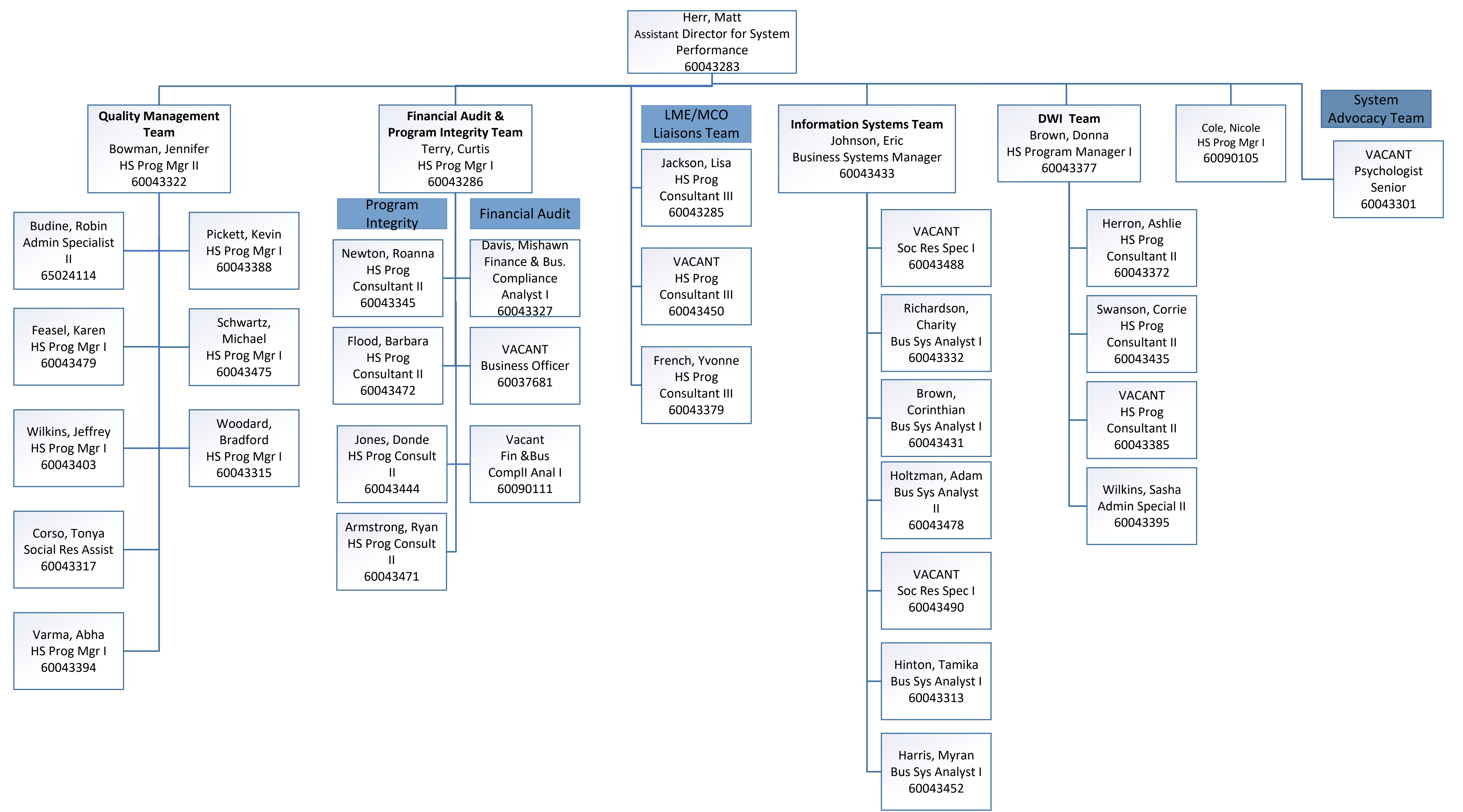
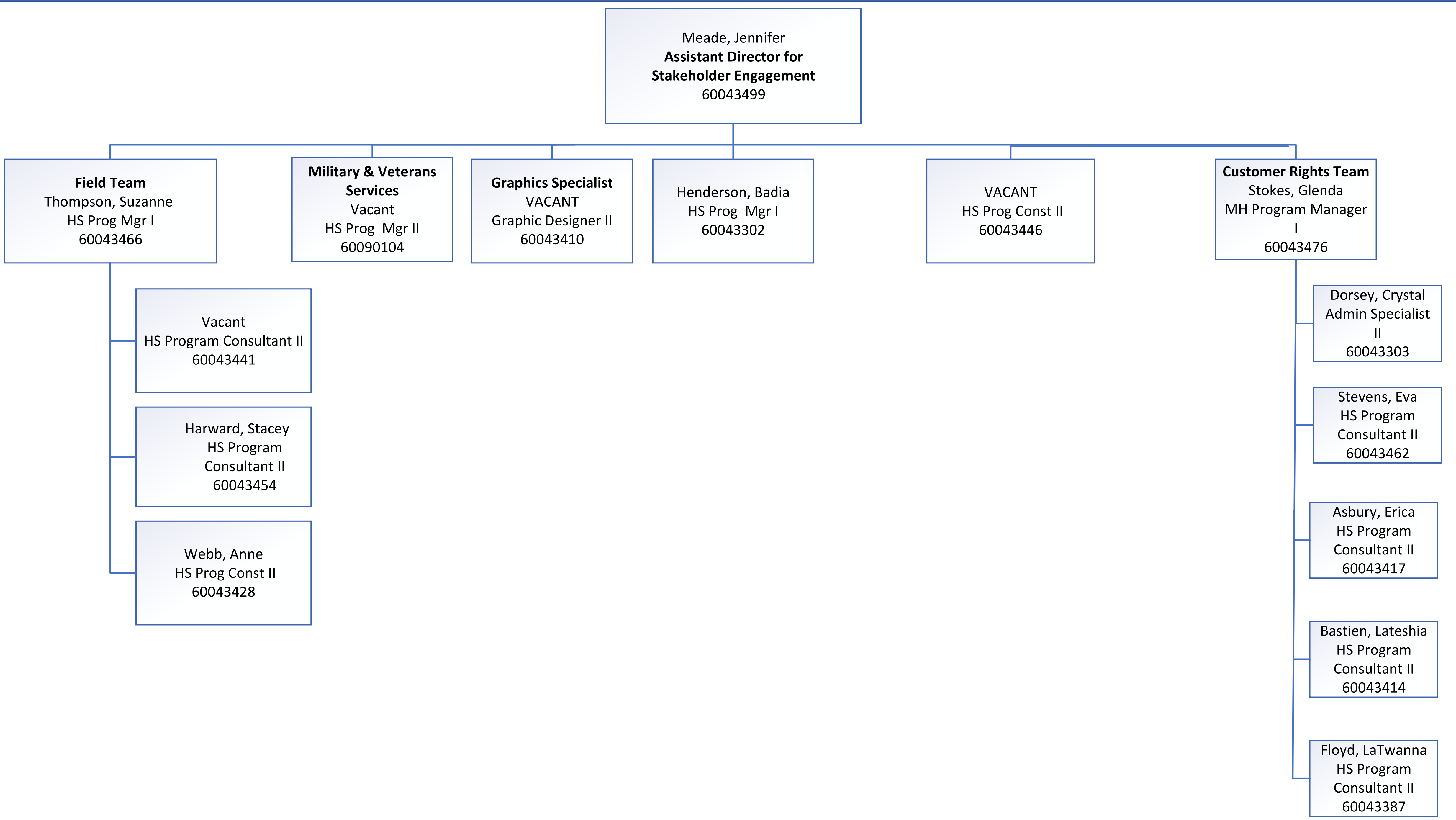
Wu, Pei Chi
HS Prgm Consultant II
60043415
Vacant
HS Prgm Consultant II
60043459

Policy and Program Design (page 3)

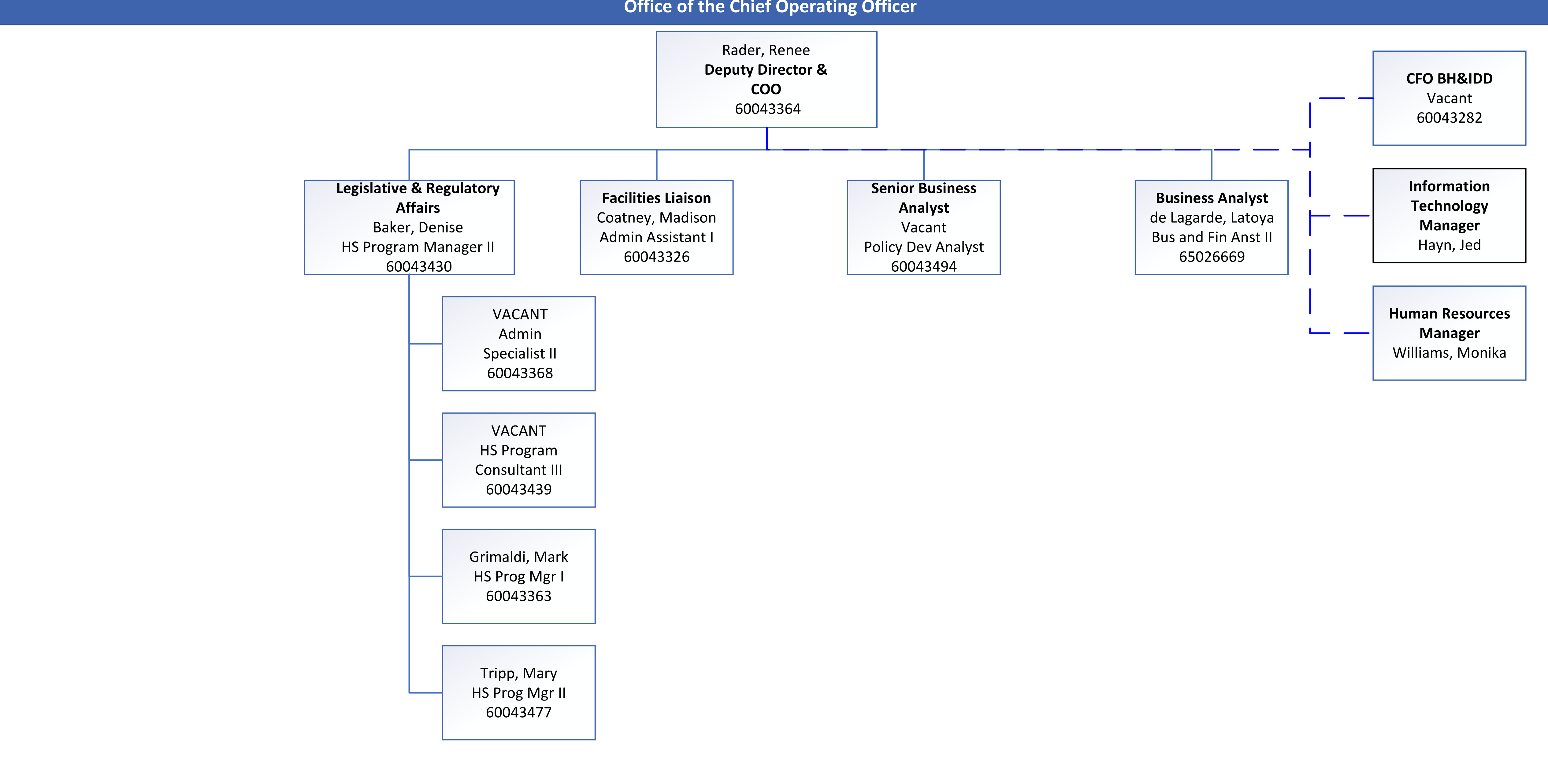


System Performance Team



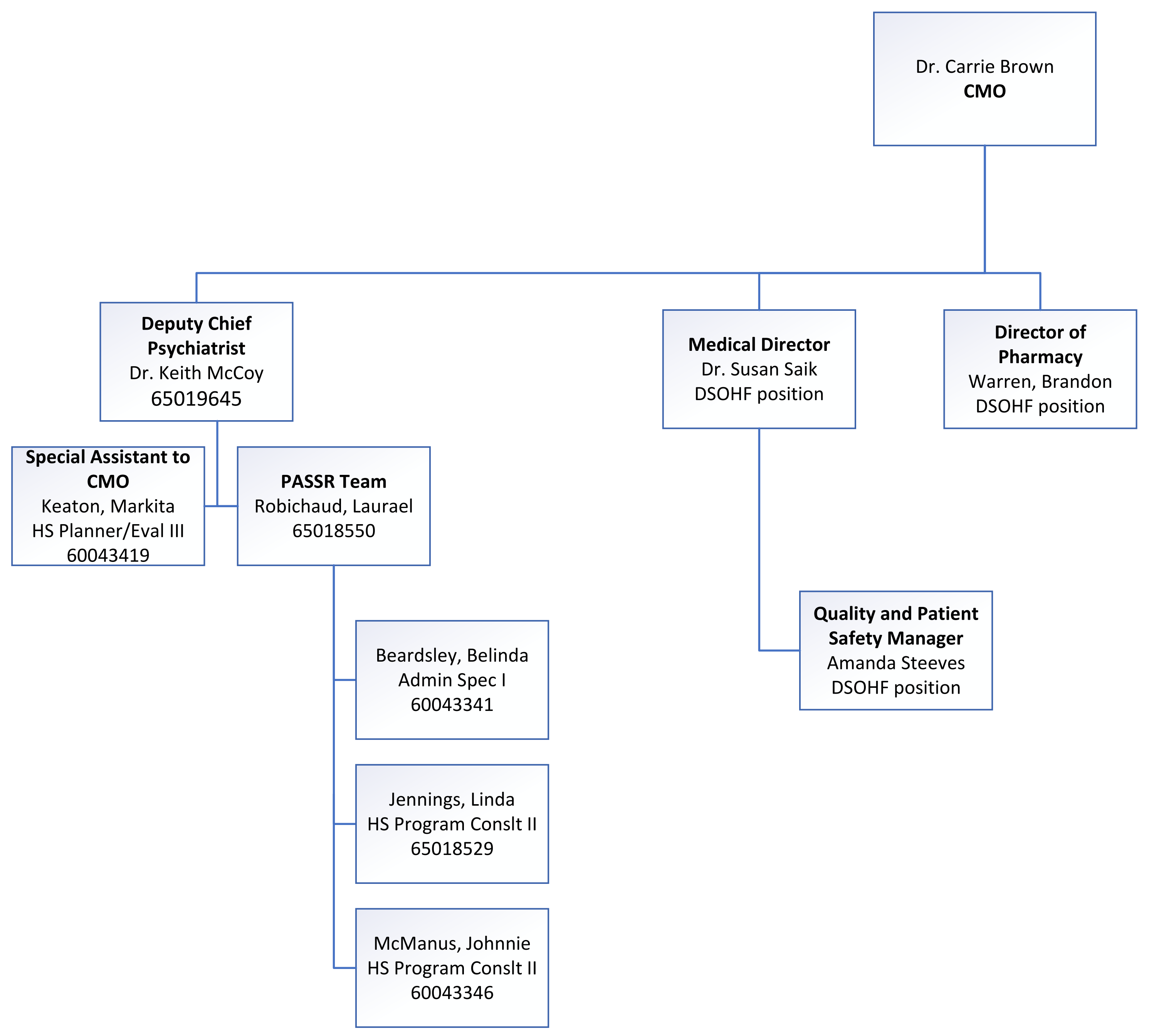


Consumer Support Services and Community Stakeholder Engagement
Meade, Jennifer
Assistant Director for Stakeholder Engagement
60043499
Field Team
Thompson, Suzanne
HS Prog Mgr I
60043466
Military & Veterans Services
Vacant
HS Prog Mgr II
60090104
Graphics Specialist
VACANT
Graphic Designer II
60043410
Henderson, Badia
HS Prog Mgr I
60043302
VACANT
HS Prog Const II
60043446
Customer Rights Team
Stokes, Glenda
MH Program Manager I
60043476
Vacant
HS Program Consultant II
60043441
Harward, Stacey
HS Program Consultant II
60043454
Webb, Anne
HS Prog Const II
60043428
Dorsey, Crystal
Admin Specialist II
60043303
Stevens, Eva
HS Program Consultant II
60043462
Asbury, Erica
HS Program Consultant II
60043417
Bastien, Lateshia
HS Program Consultant II
60043414
Floyd, LaTwanna
HS Program Consultant II
60043387

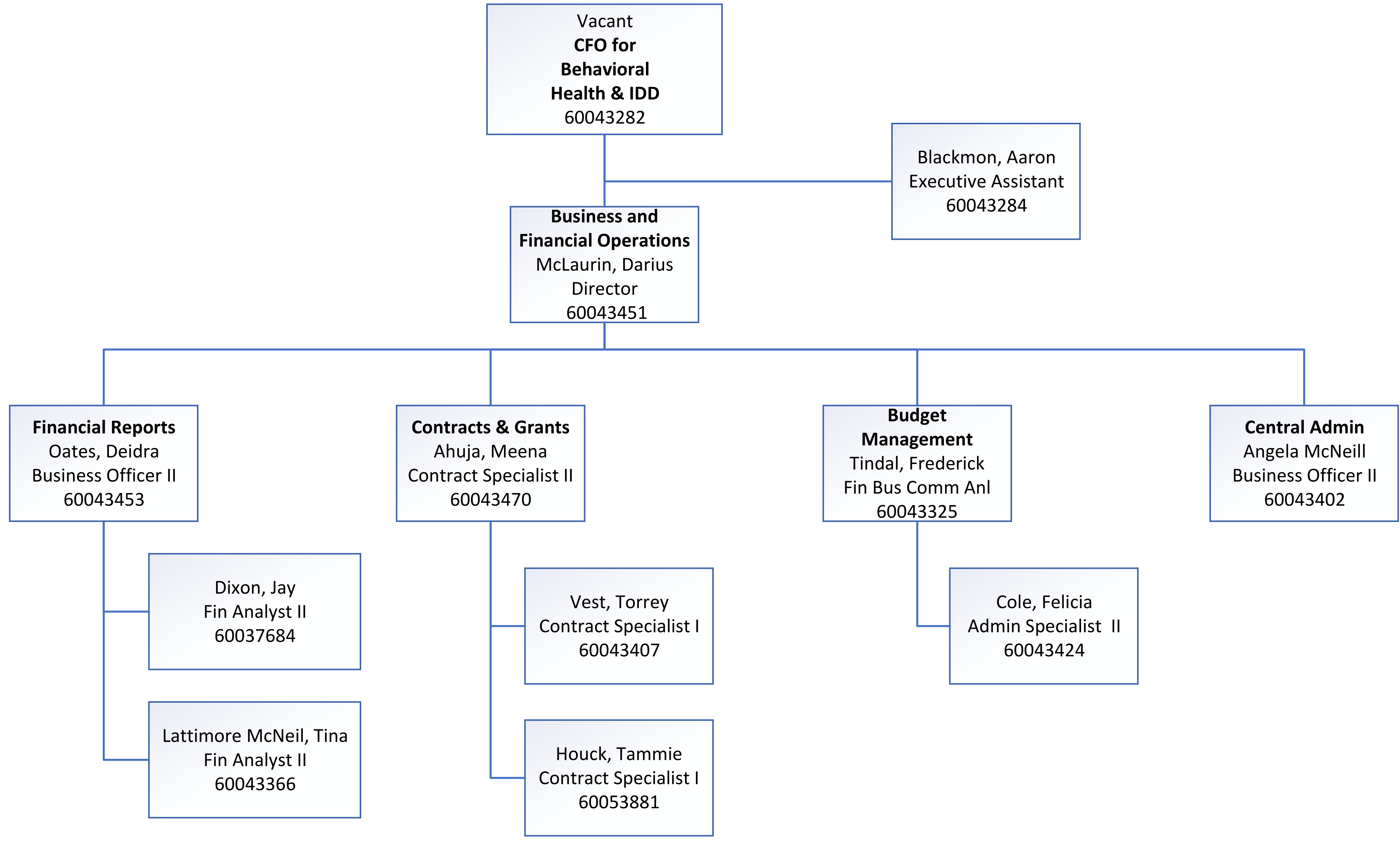


Office of the Chief Operating Officer
Rader, Renee
Deputy Director & COO
60043364
Legislative & Regulatory Affairs
Baker, Denise
HS Program Manager II
60043430
Facilities Liaison
Coatney, Madison
Admin Assistant I
60043326
Senior Business Analyst
Vacant
Policy Dev Analyst
60043494
Business Analyst
de Lagarde, Latoya
Bus and Fin Anst II
65026669
CFO BH&IDD
Vacant
60043282
Information Technology Manager
Hayn, Jed
Human Resources Manager
Williams, Monika
VACANT
Admin Specialist II
60043368
VACANT
HS Program Consultant III
60043439
Grimaldi, Mark
HS Prog Mgr I
60043363
Tripp, Mary
HS Prog Mgr II
60043477

Office of the Chief Medical Officer



Office of the Chief Financial Officer



Planning Steps

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

Narrative Question:

This step should identify the unmet service 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 required populations relevant to each block grant within the state's behavioral health system, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System** (URS), and state data. 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 with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under **EO 13985**. States are encouraged to refer to the **IOM reports**, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* and ***The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding***[1] in developing this narrative.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

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

Populations and Prevalence
With a population estimate of 10,698,973 residents as of July 1, 2022, North Carolina has the ninth largest population among 50 states (Annual and Cumulative Estimates of Resident Population Change for the United States, Regions, States, District of Columbia, and Puerto Rico and Region and State Rankings: April 1, 2020 to July 1, 2022 (NST-EST2022-CHG) Source: U.S. Census Bureau, Population Division Release Date: December 2022, https://www.census.gov/newsroom/press-kits/2022/2022-national-state-population-estimates.html).

Currently, an estimated 10.7 million people reside in North Carolina. Adults ages 18 and older make up 78.8% (8,382,718) of the total population. Youth ages 12-17 make up almost 7.6% (807,775) of the total population. (Population Source: NC Office of State Budget and Management (NC OSBM), State Demographer's Office, July 2022 population estimates, https://www.osbm.nc.gov/demog/county-projections.)

Based on prevalence estimates for persons in North Carolina with a substance use disorder, 1,140,435 adults (13.48%) and 41,439 youth ages 12-17 (5.13%) are in need of services for a substance use disorder. (Prevalence Source: SAMHSA, Office of Applied Studies, National Surveys on Drug Use and Health, 2019 and 2020, Model-Based Prevalence Estimates (50 States and the District of Columbia), published 12/29/21, Downloaded 3/21/22. Table 23, Substance Use Disorder in the Past Year, by Age Group and State: Percentages, 2020. https://www.samhsa.gov/data/report/2019-2020-nsduh-state-estimates-substance-use-and-mental-disorders).

The table below illustrates the number of North Carolina residents in need of SUD services by age range, with prevalence percentages from the National Surveys on Drug Use and Health, 2019 and 2020, published 12/29/21.

July 2021 Population Estimates				Persons in Need of SUD Services				
Ages 12-17	Ages 18-25	Ages +26	Total (Ages 12+)	Ages 12-17 Prevalence = 3.91%	Ages 18-25 Prevalence = 13.68%	Ages 26+ Prevalence = 6.26%	Total Estimated Adults (18+) with SUD	Total Estimated Persons (12+) with SUD
807,775	**1,108,071**	**7,194,647**	**9,190,493**	**41,439**	**300,820**	**839,615**	**1,140,435**	**1,181,874**

NC Substance Use Disorder Prevalence Rates Source: *SAMHSA, Office of Applied Studies, National Surveys on Drug Use and Health, 2019 and 2020: Model-Based Prevalence Estimates (50 States and the District of Columbia), published 12/29/21, Downloaded 3/21/22. Table 23, Substance Use Disorder in the Past Year, by Age Group and State: Percentages, 2020. Prevalence rate in NC for adolescents (ages 12-17) is 5.13 %. Prevalence for adults (ages 18-25) is 25.32% % and for adults (ages 26+) is 11.67% %. Total (age 12+) = 12.73%, Total (age 18+) = 13.48%. Substance Use Disorder*

is defined as meeting criteria for illicit drug or alcohol dependence or abuse in the 5th edition of DSM-V. https://www.samhsa.gov/data/report/2019-2020-nsduh-state-estimates-substance-use-and-mental-disorders).

US Substance Use Disorder Prevalence Rates Source: *SAMHSA, Office of Applied Studies, National Surveys on Drug Use and Health, 2020, published Oct 2021. Table 5.8B, SUD in Past Year among Persons Aged 12 or Older, by Age Group and Geographic and Socioeconomic Characteristics: Percentages 2019 and 2020. Prevalence rate in the US in 2020 for adolescents (ages 12-17) is 6.3%, 6.5% for those with Medicaid/CHIP, and 8.5% for those with no health insurance. Prevalence rates for adults (ages 18-25) is 24.4%, 19.8% for those with Medicaid/CHIP, and 21.7% for those with no health insurance. Prevalence rates for adults (ages 26+) is 14.0%, 20.4% for those with Medicaid, and 19.1% for those with no health insurance. Prevalence rates for all adults (ages 18+) is 15.4%, 20.3% for those with Medicaid/CHIP, and 19.6% for those with no health insurance. Prevalence rates for persons (ages 12+) is 14.5%, 17.9% for those with Medicaid/CHIP, and 19.1% for those with no health insurance. (https://www.samhsa.gov/data/report/2020-nsduh-detailed-tables) Published Oct 25, 2021. Substance Use Disorder is defined as meeting criteria for illicit drug or alcohol use disorder in the 5th edition of DSM-V.*

Population Data: *NC Office of State Budget and Management (OSBM). July 2022 population estimates. Last updated: 2/15/22. Downloaded: 3/21/22 (https://www.osbm.nc.gov/facts-figures/population-demographics/state-demographer/countystate-population-projections).*

According to the National Survey on Drug Use and Health (NSDUH), 2020, for persons in the US:

- The prevalence of a substance use disorder in the past year for those with annual incomes less than 100% of the federal poverty level was 17.5% for individuals aged 18+ and 16.3% for individuals aged 12+.
- The prevalence of a substance use disorder in the past year for those with annual incomes between 100 and 199% of federal poverty level was 16.2% for individuals aged 18+ and 15.3% for individuals aged 12+.
- The prevalence of a substance use disorder in the past year for those with annual incomes of 200% or more of federal poverty level was 14.6% for individuals aged 18+ and 13.9% for individuals aged 12+.
- The prevalence of a substance use disorder in the past year for persons aged 18+ with no health insurance was 19.6% compared to 15.4% for persons aged 18+ in the total population.
- The prevalence of a substance use disorder in the past year for persons aged 12+ with no health insurance was 19.1% compared to 14.5% for persons aged 12+ in the total population.

The NSDUH does not provide prevalence data by poverty level and health insurance status at the state level. Therefore, this is information was not available for persons in NC.

Prevalence Source: *Results from the 2020 National Survey on Drug Use and Health: Detailed Tables, October 2021, Table 5.8B Substance Use Disorder in Past Year among Persons Aged 12 or Older, by Age Group and Geographic and Socioeconomic Characteristics: Percentages, 2019 and 2020, https://www.samhsa.gov/data/report/2020-nsduh-detailed-tables.*

North Carolina is not a Medicaid expansion state. An estimated 12.7% (1,067,565) of non-elderly persons (under age 65) are uninsured based on applying uninsured rates for North Carolina from the Model-based Small Area Health Insurance Estimates (SAHIE) for Counties and States, 2020, to July 2022 NC OSBM population estimates for persons under age 65. Of this number of persons, 928,881 are aged 12-64, the age group for which prevalence estimates are available. Applying the 19.1% US prevalence rate for persons with a substance use disorder in the past year for persons aged 12+ with no health insurance to the number of uninsured ages 12-64 indicates there may be 177,416 uninsured persons in North Carolina in this age group who are in need of services for a substance use disorder. According to claims data in NCAnalytics as of 3/31/23, 43,928 individuals received at least one state-funded service for a substance use disorder in SFY2022. This is a 24.8% penetration rate.

Uninsured Source: *Model-based Small Area Health Insurance Estimates (SAHIE) for Counties and States 2020, produced by the U.S. Census Bureau/Small Area Health Insurance (SAHIE) Program, Internet Release Date: 8/10/22, https://www.census.gov/data/datasets/time-series/demo/sahie/estimates-acs.html.*

Population Source*: NC Office of State Budget and Management (OSBM), July 2022 population estimates, last updated: 2/15/22, https://www.osbm.nc.gov/demog/county-projections.*

Prevalence Source*: Results from the 2020 National Survey on Drug Use and Health: Detailed Tables, October 2021, Table 5.8B Substance Use Disorder in Past Year among Persons Aged 12 or Older, by Age Group and Geographic and Socioeconomic Characteristics: Percentages, 2019 and 2020, https://www.samhsa.gov/data/report/2020-nsduh-detailed-tables.*

Persons Served Source: *SFY2022 claims data in NCAnalytics, as of 3/31/23, prepared by the Quality Management Team, NC DHHS, Division of MH/DD/SUS, 5/22/23).*

Older Populations

The NC Office of State Budget and Management (NC OSBM) estimates that 25 percent of North Carolina's population will be over age 60 by the year 2026, an increase of 47 percent from 2012. By 2031, 26 percent of the population will be over age 60, an increase of 61 percent from 2012. Of the state's residents, 37.0 percent are now 50 or older, 24.1 percent are 60 or older, 12.3 percent are 70 or older, and 4.1 percent are 80 or older. The proportion of North Carolina's population that is 60 and older is growing more rapidly than other components of the population. By 2031 NC OSBM projects there will be more older adults

(ages 65 and older) than there will be children (under age 18). (https://www.osbm.nc.gov/demog/county-projections). This is significant because while overall SUD treatment admissions remained relatively flat, the proportion attributable to older adults, including African Americans and women, increased from 3.4% to 7.0% during the period from 2002 through 2012 nationally. Additionally, the proportion of admissions for alcohol use showed a downward trend, with upticks in admissions for cocaine, cannabis, heroin, non-prescription methadone and other opiates. The proportion of admissions with prior history of substance use treatment increased from 39% to 46%, although there have been more recent reports that found that compared to younger adults, the proportion of older adults seeking treatment for illicit drugs use for the first time is on the rise. (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5568321/). This information, coupled with the fact that North Carolina's aging population continues to increase, requires continued monitoring by the SSA to assure services are accessible and appropriate to meet the needs of the older population. Other strategies may be necessary to encourage older populations to seek services, such as stigma campaigns, transportation accommodations, integrated care, specialized workforce training on co-morbidities specific to older populations, etc.

Adolescents

The number of youth ages 12 to 17 treated for a primary SUD in North Carolina has traditionally been a small number (5632 in SFY22), although prevalence rates indicate there are over 41,000 youth in our state with substance misuse or substance use disorder. It is also noted that 52% of males and 57% of females involved in the juvenile justice system have a substance use disorder. Youth typically present with other behavioral or mental health issues and substance use may not be listed as the primary diagnosis – so while more youth than are accounted for under the SUBG-funded services system are receiving care, efforts continue to analyze the adolescent SUD services system to determine what strategies may be implemented to better assure a more accessible and responsive system. Emphasis will be placed on identifying and removing any barriers to accessing these services, increasing referrals and improving outcomes. An additional focus will be on transitional age youth with recovery supported housing needs.

Injecting Drug Use (IDU)/Persons Who Inject Drugs (PWID)

The increased incidence of injection drug use, driven by the overdose crisis, can lead to sharing and reuse of syringes and injection supplies and the associated spread of bloodborne infections in communities with limited syringe access. Syringe exchange is an evidence-based public health strategy to reduce the spread of infections like HIV and hepatitis C and address health needs of people who inject drugs.

North Carolina legalized syringe services programs (SSPs) in July 2016 with the enactment of GS 90-113.27. The law gives broad guidance for establishing an SSP and outlines core health services SSPs must provide to participants, including: access to syringes and injection

supplies at no cost and in quantities sufficient to prevent sharing and reuse (needs-based distribution); secure disposal of syringes and injection supplies; education on overdose prevention, communicable diseases, safer use and treatment for substance use disorder and mental health conditions; naloxone access (through the SSP or other local source); and referrals to substance use disorder and mental health treatment. The law requires SSPs to register with the Division of Public Health (DPH) and submit an annual report that includes data on provided services and impact. There are currently over 50 mobile and/or fixed syringe service sites in NC.

The STOP (Strengthen Opioid Misuse Prevention) Act of 2017 changed the SSP law's funding language from a prohibition on the use of all public funds to a prohibition on the use of state funds for the purchase of syringes and injection supplies. SSP leaders report the law change has helped some local communities support SSP services, but regularly express interest in seeing remaining funding barriers lifted to allow partners greater flexibility in supporting and sustaining this important work.

The number of acute HBV cases diagnosed in North Carolina in 2021 was 142, a rate of 1.3 cases per 100,000 population, a decrease from 185 cases in 2019 (1.8 cases per 100,000). However, the acute hepatitis B rate in NC is nearly double that of the US rate. In 2021, acute HBV diagnoses among White/Caucasian men and women comprised 73.2% of the total acute HBV. Injection drug use (IDU) has been a growing risk factor for acute hepatitis B in North Carolina. In 2021, IDU was reported by approximately 30% of people with acute hepatitis B and 8% of people diagnosed with chronic hepatitis B. it should be noted exposure is based on self-reported data. These data likely reflect under-reporting of stigmatized exposures, such as IDU. People may report more than one risk, and the source of exposure is difficult to determine for many cases. These data likely reflect under-reporting of higher risk exposures, such as IDU. *(North Carolina Electronic Disease Surveillance System (NC EDSS) (data as of October 1, 2022), enhanced HIV/AIDS Reporting System (eHARS) (data as of October 1, 2022), Surveillance for Viral Hepatitis, United States, 2000-2020 CDC reports (https://www.cdc.gov/hepatitis/statistics/index.htm).*

The number of newly diagnosed acute hepatitis C cases was 100 in 2020 in North Carolina; however, this number may be an underestimate due to the reduced availability of testing during the COVID-19 pandemic. It is estimated that at least 200,000 people living in North Carolina are infected with chronic hepatitis C. As of December 31, 2020, there were 72,552 reported cases of chronic hepatitis C. In 2020, there were 12,313 newly reported chronic hepatitis C cases. Again, however, these data should be interpreted with caution due to decreased testing availability.

In July 2021, the NC Department of Health and Human Services reported that the state surpassed 1,000 reported cases of hepatitis A associated with a national outbreak that began in April 2017. At that time, 63% of cases required hospitalization and 16 people had died. Since 2017, the Centers for Disease Control and Prevention has received more than 41,000 reports

of hepatitis A linked to a national outbreak with higher than expected hospitalization and death rates. North Carolina has been tracking this outbreak since April 2018, and reported cases have increased significantly since August 2020. NCDHHS and local health departments are coordinating outreach events, conducting case investigations and contact tracing, and providing hepatitis A vaccine to those at risk. Individuals who use drugs, are experiencing homelessness and men who have sex with men are at highest risk for infection during the current outbreak.

Since January 1, 2021, 495 outbreak associated cases of hepatitis A were reported, indicating a marked increase in transmission. Of those cases, 13% are also infected with hepatitis B and 48% with hepatitis C. Because hepatitis A causes inflammation of the liver, people with other forms of viral hepatitis or anyone with underlying liver disease is at risk of more serious illness if infected. *(North Carolina HIV/STD/Hepatitis Surveillance Unit. (2022). 2021 North Carolina Hepatitis B/C Surveillance Report. North Carolina Department of Health and Human Services, Division of Public Health, Communicable Disease Branch. Raleigh, North Carolina.)*

As of December 31, 2021, the number of people living with HIV who reside in North Carolina (including those initially diagnosed in another state) was 35,632. In 2021, 1,400 people were newly diagnosed with HIV among the adult and adolescent (over 13 years old) population, a rate of 15.7 per 100,000 population. The highest rate (72.9 per 100,000) of newly diagnosed HIV infections was among adult/adolescent Black/African American men. For adults and adolescents newly diagnosed with HIV in 2021, the most likely route of transmission was male-male sex (reported by 57.1%), followed by heterosexual sex (18.5%), and injection drug use (IDU) (2.6%); the most likely route of transmission was unknown for 18.3% of people newly diagnosed with HIV in 2021. *(North Carolina HIV/STD/Hepatitis Surveillance Unit, HIV/AIDS Reporting System (eHARS) (data as of June 6, 2022.)*

Justice Involved Population

North Carolina is ranked 21st for lowest prison incarceration rates out of 50 states. This middle ranking is indicative of the progress the state has made in the last 10 years and of the progress still to achieve. In 2010-11, the state prison population was 28,975, and by 2019-20 that had reduced to 20,383 with the largest decrease seen in people in prison for misdemeanors *(2019-2020 Fiscal Year Annual Report, North Carolina Department of Public Safetyhttps://files.nc.gov/ncdps/FY-2019-20-Annual-Statistical-Report.pdf accessed 1/23/2022.)* The total prison population of North Carolina for 19/20 including federal and private prisons, increased the total prison population to 34,079. In addition, the population of the state's 97 jails was 20,960. Justice involved individuals on supervision through parole and probation added another 14,212 and 76,905 individuals respectively.

Between 2010 and 2020, the number of young people in North Carolina's Juvenile Justice system declined by 60%. In 2020, a year after the Raise the Age legislation was adopted, 17,997 youth were supported by community programs within the juvenile crime prevention

councils. That same year 2,350 youth were detained in juvenile detention and youth development centers.

Combined, the total number of justice-involved individuals in North Carolina was 166,503; a rate of 15.93 per 1,000 residents. The challenges faced by these individuals and their families are multi-factorial, often systemic, and have long lasting consequences on their health, mental health, and socio-economic opportunities. Key statistics include the following:

Justice Involved Adults (aged 18+)

- Serious mental illness affects an estimated 14.5% of men and 31% of women in jails
- 60% of jail inmates reported having had symptoms of a mental health disorder in the prior twelve months
- 83% of jail inmates with mental illness did not receive mental health care after admission
- 68% of people in jail have a history of abusing drugs, alcohol, or both
- 40 times more likely to die from an opioid overdose within 2 weeks of reentry from incarceration
- North Carolinians who are black or African American, and who are Native American are vastly over-represented in the criminal justice system (109% average representation in prisons and jails compared to the general population)

Juvenile Justice population (age 6-18)

- Over half of youth in the justice system (from earliest involvement to facility involvement) have a diagnosed behavioral health issue
- Studies have shown about 2/3 of youth in justice facilities have a diagnosable mental health disorder compared to only 9 to 22% of general adolescent population
- Youth in juvenile facilities were 10 times more likely to experience psychosis than the general population
- A long-term study that followed up with youth who committed offenses found most were likely to have a substance use disorder, followed by anxiety, ADHD, Depression and then PTSD when first involved with the system
- Black or African American youth account for 50% of the total juvenile justice population and are more likely to receive residential placements.
- 42.6% of White youths who met diagnostic criteria received mental health services, compared to only 11.9% of Black youths who met diagnostic criteria

The most effective drivers to reduce incarceration rates and inequality in the justice system reside within the Department of Public Safety, Department of Public Instruction, and the Administrative Office of the Courts. The Division of Mental Health, Developmental Disabilities, and Substance Use Services has an effective and specific role to play to support these wider initiatives to ensure that once a person with behavioral health needs enters the

justice system, their needs are met, and they are supported to re-enter their communities with the ability to access treatment and continue their recovery, and there is a system in place to identify behavioral health needs and divert from the justice system at the earliest opportunity.

Minorities and Historically Marginalized Populations and Communities

The 91,799 drug overdose deaths that occurred in the United States in 2020 represent an approximately 30% increase from 2019. The COVID-19 pandemic and disruption in access to prevention, treatment, and harm reduction services likely contributed to this increase. Recent increases in drug overdose deaths were largely driven by illicitly manufactured fentanyl and fentanyl analogs and deaths involving stimulants, such as cocaine and psychostimulants with misuse potential, (e.g., methamphetamine) also increased in recent years and often co-occurred with opioids; some racial and ethnic minority groups were disproportionately affected.

From 2019 to 2020, overall drug overdose death rates increased in 25 states, including NC, and DC; the largest increases occurred among certain racial/ethnic minority populations. Relative rate increases were highest among Black (44%) and AI/AN persons (39%). Among White persons, the rate increased by 22%. Within racial/ethnic groups, overdose death rates also varied by age. Black persons aged 15–24 years experienced the largest relative rate increase from 2019 to 2020 (86%). Among AI/AN persons, the highest relative rate increase occurred among those aged 25–44 years (49%). Among White persons, those aged 15–24 years experienced the largest relative rate increase (34%).

This study highlights five critical findings on health disparities and inequities related to drug overdose deaths in the United States. First, from 2019 to 2020, disproportionate increases occurred among Black (44%) and AI/AN (39%) persons compared with those among White persons (22%). Among demographic subgroups, the rate among Black males aged ≥65 years increased to nearly seven times that of White males of the same age, and the rate among AI/AN females aged 25–44 years increased to nearly twice that of White females of the same age in 2020. Second, drug overdose death rates increased with increasing county-level income inequality, particularly among Black persons, among whom the overdose death rate was more than twice as high in areas with the highest income inequality as in areas with the lowest income inequality. Third, evidence of previous substance use treatment was lowest among Black decedents and approximately one half that of White decedents. Fourth, overdose death rates were highest in counties with higher potential substance use treatment capacity and mental health providers, and rates were more pronounced among Black and AI/AN persons than among White persons, likely associated with long-standing inequities in access to mental health and substance use care, including medications for opioid use disorder. Finally, evidence of naloxone administration was highest among AI/AN (21.5%) decedents and lowest among A/PI (16.4%) decedents but was low in all groups. *(Kariisa M, Davis NL, Kumar S, et al. Vital Signs: Drug Overdose Deaths, by Selected Sociodemographic and*

Social Determinants of Health Characteristics — 25 States and the District of Columbia, 2019–2020. MMWR Morb Mortal Wkly Rep 2022;71:940–947. DOI:http://dx.doi.org/10.15585/mmwr.mm7129e2.)

In 2020, non-Hispanic White North Carolinians had the second highest rate of overdoses (36.1 per 100,000 people). This represents a 32% increase from the 2019 rate. Since non-Hispanic White individuals account for 60% of the state's population, these high rates correspond to a large number of overdose deaths. However, while the overall population of American Indian/Alaska native (AI/AN) individuals in NC is smaller, the overdose death rate for those communities is the highest in the state at 83.6 per 100,000 people. AI/AN North Carolinians had a 93% increase in their overdose death rate from 2019 to 2020. Black North Carolinians had the second highest overdose death rate increase at 66% during the same time period. *(NC DHHS, Division of Public Health, Injury and Violence Prevention Branch, Opioid and Substance Use Action Plan Data Dashboard; https://www.ncdhhs.gov/opioid-and-substance-use-action-plan-data-dashboard.)*

In SFY22, 86,688 uninsured and Medicaid beneficiaries received SUD treatment services. Of that total, 22,985 or 27% were African American, 1844 or 2% were Indigenous and 2222 or 3% were Hispanic. The total number of minority individuals served was 27,051 or 31%, which is an under-representation of the population mix, and particularly for those living below the poverty line. In SFY23, the SUBG funded SUD primary prevention services for a total of 4,865,252 individuals reached. Of that total, 683,278 or 14% were African American, 200,204 or 4% were Indigenous and 248,598 or 5.5% were Hispanic. The total number of minority individuals served was 1,132,080 or 23%, which is an under-representation of the population mix.

There are initiatives underway to better assure a workforce that is illustrative of our population demographics through scholarship opportunities in Criteria A schools for students of color pursuing a career in SUD counseling, as well as focused expansion of collegiate recovery programs in Historically Black Colleges and Universities (HBCUs) and Minority-Serving institutions. However, assuring an adequate workforce is only one component of an approach that must be multi-pronged. Efforts to develop resources in marginalized and traditionally under-served communities are also underway, particularly through expansion of medication assisted treatment opportunities in OBOT and FQHC and community health center settings, numerous re-entry and diversion initiatives, implementation of mobile and medication units to provide SUD clinical services and MOUD, co-location of certified peer support specialists and health equity navigators, etc.

Problem Gambling

The COVID-19 pandemic saw drastic changes to the lives of a substantial portion of the world's population. At the onset of the pandemic experts expressed concern about the

impact it would have on peoples gambling practices, which have historically increased during times of crisis.

Those who suffer from problematic gambling or gambling disorder experience severe harms in their family situation, finances, mental health and functioning, and find they cannot stop, despite these harms. The COVID-19 pandemic increased psychological stresses and financial pressures that are also associated with problem gambling. At the same time, global COVID quarantines provided opportunity for increasingly isolated and stressed individuals to gamble online, and also for gambling advertisers to target these vulnerable populations. Stress, social isolation and symptoms of other mental health conditions increase the risk for individuals to experience harms related to gambling.

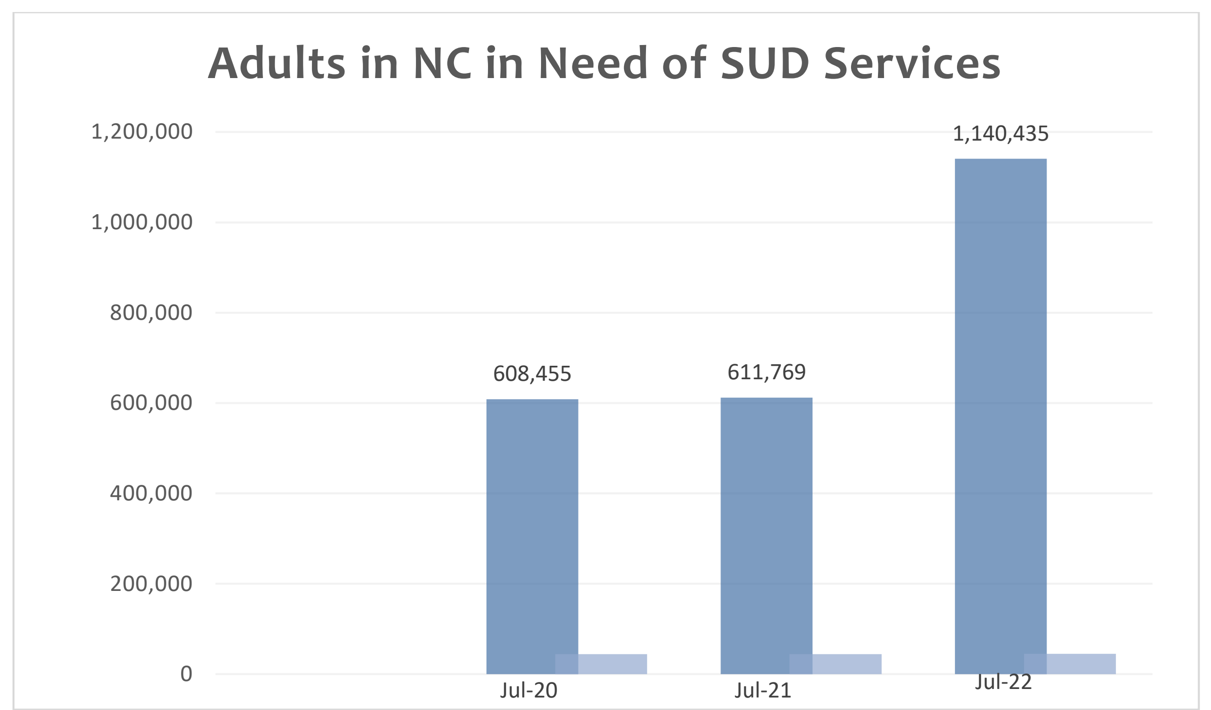
- In a study of 424 U.S. gamblers over 18, 15% of gamblers who did not gamble online before the pandemic moved to online gambling. Among those gamblers, alcohol, tobacco, cannabis, video gaming, porn, and social casino usage also increased.
- People were betting more money with online gambling. According to an Australian study, men increased their median monthly gambling expenditure from $687 to $1,075.
- Online gamblers were more likely to be classified by behavioral health professionals as moderate to high-risk gamblers.
- Research associated increased gambling during the pandemic with gambling problems and increased alcohol consumption.
- Research showed increased anxiety, depression, addictive behaviors, and substance use associated with gambling, with about 12% experienced moderately severe to severe depression.
- 25% indicated that they either lost their employment or had their hours reduced due to the pandemic.
- 50% indicated that their household income was negatively affected by the pandemic to some degree.

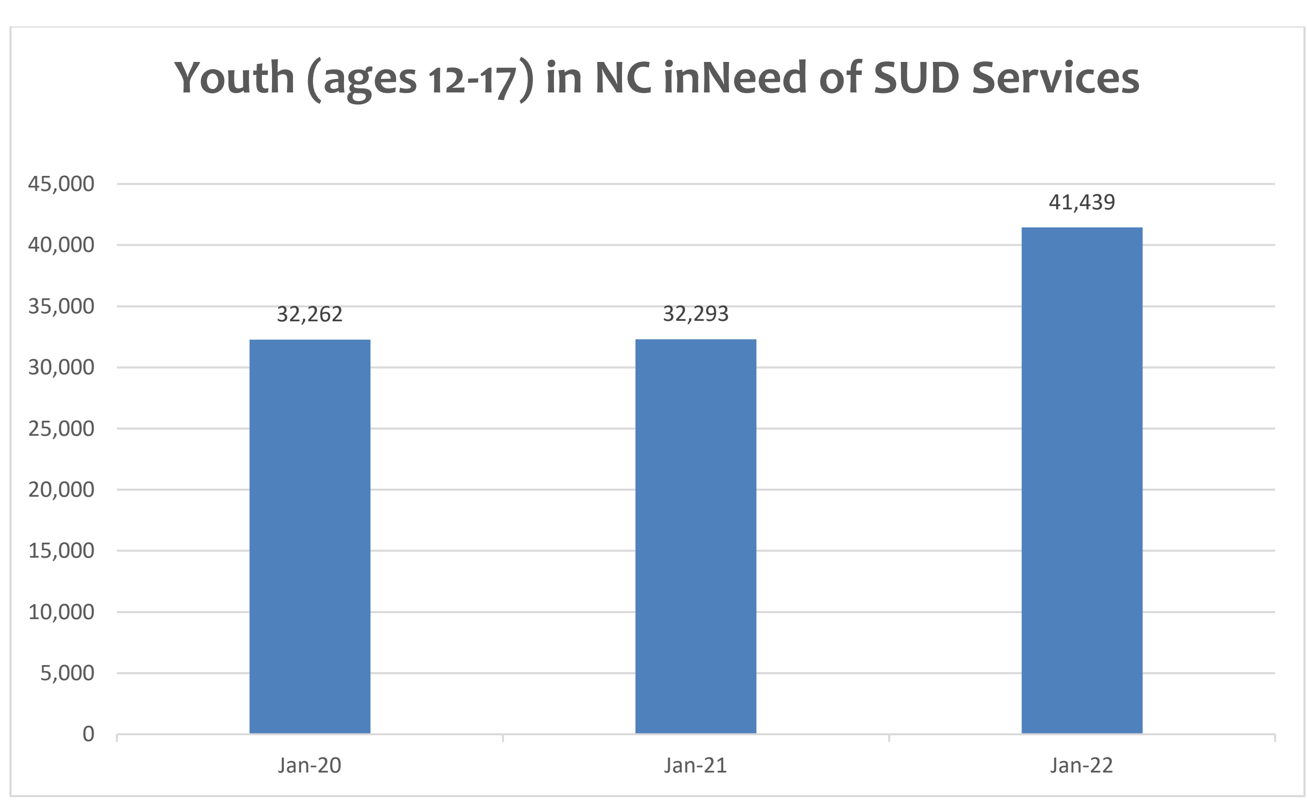
Continued COVID Impacts

The LME/MCOs with which the Division of Mental Health, Developmental Disabilities and Substance Use Services (the SSA) contracts have reported increased demand for substance use disorder (SUD) services since COVID restrictions have been lifted. Overdose death rates had plateaued and were expected to decrease over the next year; however, 2022 death data indicates 3875 North Carolinians died in 2022, which was an increase from 2352 deaths in 2020. While this is a decrease from confirmed deaths in 2021, 2022 death data are still provisional. These increased death rates are at least partially attributable to continued prevalence of fentanyl, most often found in heroin and cocaine.

Numerous data sources report increased alcohol use during the past year, particularly among individuals with co-occurring anxiety and depression. Other studies have reported women in

particular exhibited a 41% increase in alcohol consumption, as well as increases in binge drinking behaviors. The tables below illustrate the increase in need for SUD treatment and recovery services for adults and adolescents over the past three calendar years:





In a study recently released from the University at Buffalo, findings included that increased alcohol use and binge drinking were associated with higher odds of mental health disorders, highlighting the co-existence of alcohol overconsumption and mental health problems.   During the pandemic, a significant portion of study participants altered their drinking habits, with 23% of respondents increasing alcohol consumption and 8% decreasing; 4% reported binge drinking weekly or more. It was also noted that women, members of underrepresented groups and people who were worried about money who either increased their alcohol use or engaged in binge drinking during the pandemic experienced worse mental health, and people who reported no financial concerns tended to drink more often.

The number of and proportion of ED visits for medication and drug overdoses increased in 2021 compared with 2020. The count of visits increased from 14,958 visits in 2020 to 16,816 in 2021. Preliminary data for 2022 appears slightly higher at 16,937 visits. These visits were for unintentional and undetermined overdoses involving drugs and medications with dependency potential, including heroin, cocaine and prescribed opioids and benzodiazepines

Individuals who were receiving behavioral health services during the pandemic reported a worsening of symptoms during the pandemic, as reported in the North Carolina's *2020 Mental Health and Substance Use Disorder Services Client Perception of Care Survey.*

- More than one out of six respondents reported somewhat worse or much worse mental health symptoms since the beginning of the pandemic;
- Nearly one quarter of child family members reported their children under age 12 were doing worse in school;
- Substantial minorities of all age groups reported greater challenges in doing things they enjoyed.

These factors of an increased uninsured population and increased usage of substances point to a need and demand for treatment services that will potentially exceed current resources both from a programmatic as well as fiscal perspective.

Services

Community integration/recovery support is an 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 Use 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, as well as explore recent opportunities for partnership with HUD.

Because of the strong association between substance use and trauma, the state will continue to 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 use services including prevention, intervention, treatment and recovery for pregnant and parenting women and their families and women seeking custody of their child(ren). The NC Perinatal and Maternal Substance Use 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, family-centered, substance use disorder services that include, but are not limited to the following: screening, assessment, case management, outpatient substance use disorder 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, substance use prevention services, etc. Childcare and transportation are also provided or arranged for individuals to access services. 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 seven comprehensive residential substance use 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 has emphasized improved access to and retention in opioid treatment programs for pregnant women. All outpatient and residential programs in these two initiatives provide or arrange for medication assisted treatment. The programs coordinate care with Opioid Treatment Programs as well as OBOTS in their respective communities to support MOUD.

Over the past several years, North Carolina, like many states, has experienced an increase in opioid and heroin use, misuse and overdose. In response, the state has developed strategies and implemented several initiatives to address the problem. The State Opioid Response grants have provided the opportunity to consolidate those efforts, as well as enhance and expand services and supports to meet the needs of the citizens of North Carolina. Several sister agencies under DHHS that have current focus, initiatives or activities related to addressing the opioid crisis, in addition to the Division of Mental Health, Developmental Disabilities and Substance Use Services (the SSA), include the Division of Public Health (DPH), the Division of Health Benefits (NC Medicaid), the Office of Rural Health (ORH) and the Office of Emergency Medical Services (OEMS). The Attorney General's office is also highly involved. Epidemiologic data available from the Injury and Violence Prevention Branch, Injury Epidemiology and Surveillance Unit (NC DPH) show that prescription opioid poisoning deaths increased by 256 percent between 2000 and 2015 while deaths from heroin overdoses increased by 800 percent. And while strides were made in recent years that resulted in more individuals accessing treatment, decreased overdose and ED visit rates and decreased deaths due to overdose, some of these trends have reversed since the onset of the pandemic.

To combat the opioid crisis, the North Carolina Department of Health and Human Services worked with community partners to develop North Carolina's Opioid Action Plan (NC OAP). The NC OAP launched in June of 2017 and established thirteen data metrics to track and monitor the opioid epidemic. The opioid data dashboard is meant to provide integration and visualization of state and county-level metrics for stakeholders across NC to track progress towards reaching the goals outlined in NC OAP. The plan was updated in June 2019 (Opioid Action Plan 2.0), through feedback from partners and stakeholders, to continue to address the opioid crisis, and then again in May 2021 to include other substance use – the Opioid and Substance Use Action Plan 3.0. It includes local actions that counties, coalitions and communities can use to fight the opioid epidemic, which in 2018 alone, claimed nearly five lives per day due to unintentional overdose. The updated OSUAP Plan prioritizes three areas, with equity and lived experiences at the center:

- Prevent:
  - Prevent future addiction and address trauma by supporting children and families.
- Reduce harm:
  - Move beyond just opioids to address polysubstance use.
- Connect to Care:
  - Increase treatment access for justice-involved people.
  - Expand access to housing and employment supports.
  -

For more details, the action plan can be accessed here: Opioid and Substance Use Action Plan (OSUAP) 3.0.

The Opioid and Substance Use Action Plan Data Dashboard (https://www.ncdhhs.gov/opioid-and-substance-use-action-plan-data-dashboard) contains metrics that the state and external stakeholders utilize to measure. Those metrics include:

- Drug overdose deaths.
- Drug overdose ED visits.
- Patients receiving opioid prescriptions.
- Illicit opioid overdose deaths.
- Children in foster care due to parental substance use.
- Newborns affected by SU with a Plan of Safe Care referral.
- Acute hepatitis C infections.
- Calls to 211 for housing-related services.
- Unemployment.
- Patients receiving buprenorphine.
- People served by SUD treatment programs.
- Equity measures – deaths by population.

Tuberculosis Services

As stated in Step 1, tuberculosis screening has been incorporated into the comprehensive clinical assessment tool and/or assessment screening process for a number of years in North Carolina. A

sample screening tool with guidance instructions, was shared with LME/MCOs several years ago. LME/MCOs are responsible for assuring that contracted SUBG providers administer this screening and take appropriate action if indicated. Each LME/MCO reports on Universal TB Screening, Testing, Referral and Case Management Services in its Semi-Annual Compliance Reports to the Division. These reports are reviewed by Division staff to determine/ascertain compliance and need for technical assistance.

Clinical monitoring by the Division, which is conducted annually, includes chart reviews to determine if individuals are screened for TB, and referred for testing if the screen is positive. The most recent clinical monitoring indicated that 93% of assessments reviewed included a TB screen. LME/MCOs that scored less than 100% were placed on a plan of correction, which requires them to address this finding with their SUD providers. On a more positive note, of those that screened positive, 100% were referred for testing.

As North Carolina has not expanded Medicaid, many individuals with SUD are not Medicaid eligible and are un- or under-insured. Many cannot afford basic health care, so providers typically refer individuals for TB testing to local health departments.

Veterans and Military Families

North Carolina is home to a large number of active military, National Guard and Reserves, veterans, and military families, ranking fourth 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. North Carolina is home to over 750,000 veterans and has the greatest number of active duty troops on the East Coast. North Carolina is also in the top 5 per capita nationally for 21st Century veteran residents. In 2018, some 9,268 unique individual veterans from the state contacted or were referred to the VA as homeless or at risk of becoming homeless. Veterans account for only approximately 9.8% of the total population of North Carolina, but 18-20% of all homeless individuals in North Carolina. More than 2,589 veterans are currently incarcerated in North Carolina, of which some 22.7% are likely 21st Century veterans. On average, 3.5 veterans commit suicide in North Carolina every week.

DMH/DD/SAS serves the needs of the military through the Governor's Working Group on Veterans, Service Members and Their Families, a project that it supports and funds through the SUBG. 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. Areas of focus include Veterans suicide, homelessness and resource and care coordination services through four regional network programs (NCServes).

Additionally, in August 2020, the Veterans Life Center officially opened in Butner, North Carolina. The first of its kind, the Veterans Life Center is a residential program designed to help at-risk 21st Century veterans. The programming for this 100-bed facility includes provision and coordination of services for substance use, mental and physical health needs, life skills training, spiritual and family counseling and vocational education. (https://vlcnc.org/)

State Epidemiological Outcomes Workgroup

The State Epidemiological Outcomes Workgroup (SEOW) was formed in 2005 with funding from the NC Strategic Prevention Framework/State Incentive Grant (SPF/SIG) and continues today. The SEOW is comprised of representatives from NC Department of Public Health, Injury and Violence Prevention Branch, NC Department of Public Instruction, Addiction Professionals of North Carolina with Wake Forest University as the lead evaluator. The SEOW meets regularly to identify needs and to develop data resources to assist with planning. The SEOW will also review the bi-annual Youth Prevention Survey that was launched in 2017 (latest administration in SFY 23); provide feedback and support of the data dashboard or other data dashboards linking public data from various agencies with improved access to updated data; conduct continuous quality improvement checks on the state-wide prevention infrastructure; provide guidance on data-driven interventions to substance use prevention Block Grant. The state will coordinate and collaborate with its partners to address tobacco and ENDs priorities, as well as their associated needs and gaps in substance use prevention services. In accordance with SUPTRS BG guidelines outlined by SAMHSA for the 20% Primary Prevention Set-Aside, the substance use prevention system will continue to provide universal, selective, and indicated prevention activities in school and community settings. Providers are in the process of completing a tri-annual needs assessment to reevaluate and determine substance use consumption, consequences, and intervening variables for every county in the state. As a part of this process, populations at greatest risk are reassessed and new and emerging needs are identified, and strategies prioritized to reach those populations.

Additionally, with state funds, North Carolina supports a behavioral health disparities initiative, for which 7 communities are receiving in depth training in identifying and addressing behavioral health disparities. North Carolina views this project as a way to develop and test strategies for effectively addressing the needs of disparate populations across the state, with the intention of developing the capacity and involvement of prevention providers to address behavioral health disparities statewide.

In addition, the SUPTRS BG will also continue to provide treatment through activities outlined outside of the 20% Primary Prevention Activities. These will be provided to the priority groups identified by data, 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.

Primary Prevention Needs

Initiating substance use during childhood or adolescence is linked to substantial long-term health risks. Early (aged 12 to 14) to late (aged 15 to 17) adolescence is regarded as a critical risk period for the initiation of alcohol use (1,2,3), with multiple studies showing associations between age at first alcohol use and the occurrence of alcohol misuse or dependence (2,3,4). Nearly 97% of heavy adult drinkers started drinking before the age of 21 (5). Moreover, there is evidence across a range of other substances—including marijuana, cocaine, other psychostimulants, nicotine, and inhalants — that the risk of developing dependence or misuse is greater for individuals who initiate use of these substances in adolescence or early adolescence than for those who initiate use during adulthood. (3,4,6) For example, young people who have ever used e-cigarettes have seven times higher odds of becoming smokers one year later compared with those who have never vaped. (7)

In an effort to delay and prevent the onset of substance use in childhood and adolescence, the Prevention and Wellness team has made a concerted effort over the past eight years to ensure that SUPTRS BG funding is utilized in such a way that meets the identified needs of local communities. Data-driven efforts have centered on addressing consumption and consequences related to alcohol (underage drinking, FASD), tobacco, vapes, marijuana and opioids. While the intentional implementation of core evidence-based prevention strategies (i.e., environmental strategies) was associated with decreases in alcohol involved fatal crashes, alcohol attributable deaths, and emergency department visits related to heroin, a review of recent statewide data reflect a need to continue addressing the following substance consumption and related consequence through evidence-based prevention strategies.

1. *Alcohol Use* –According to the latest Youth Risk Behavior Survey (2021), 19% of high school youth report drinking alcohol on at least one day during the 30 days prior to the survey and 10% report binge drinking on at least one day during the 30 days prior to the survey (Figure 1). Among youth who report consuming alcohol, 75.1% get it from friends; 11.6% took it without permission and 6.4% bought it themselves (NC Youth and Young Adult Prevention Survey, 2023) (Figure 2). According to the 2023 NC Youth and Young Adult Prevention Survey, 31.5% of NC youth (12 – 20 years old) report that it is easy to get alcohol (Figure 3). Additionally, survey respondents report that alcohol is primarily stored in the kitchen refrigerator (49.4%) and is unlocked (46.8%). (Figure 4). Easy social access, particularly in the home, is correlated with increased alcohol consumption among respondents. Youth in homes where alcohol is stored in the refrigerator and unlocked spaces are more likely to drink compared to homes with no alcohol (16.6% vs 5.5%, respectively, Figure 5). Lastly, youth with lower perceived harms related to alcohol use were nearly four times more likely to have consumed alcohol in the past 30 days (NC Youth and Young Adult Prevention Survey, 2023 - Figure 6).

Figure 1

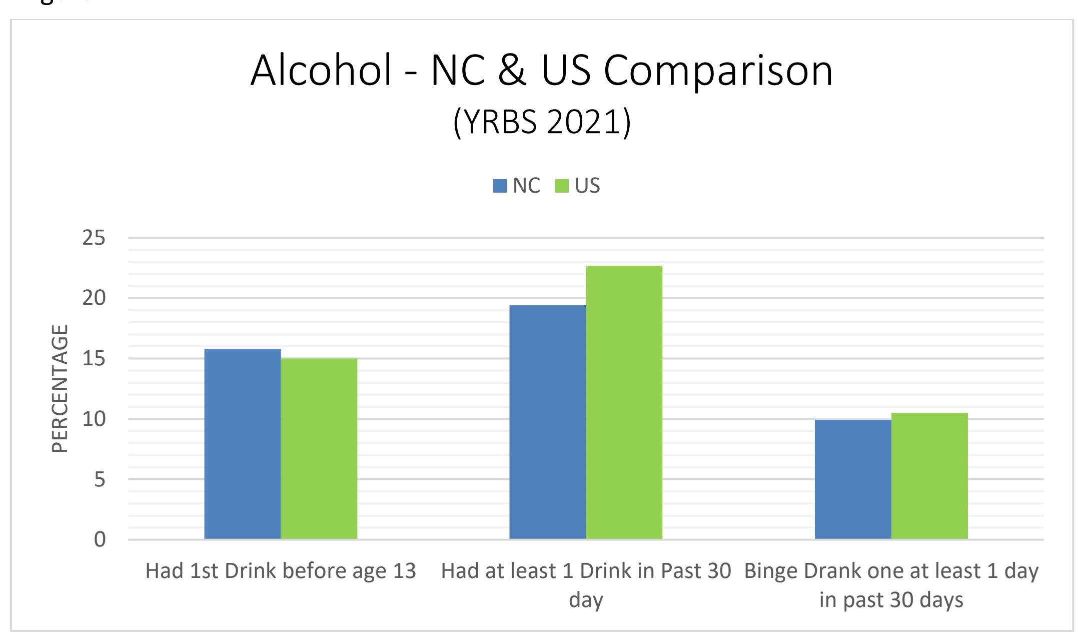


Figure 2

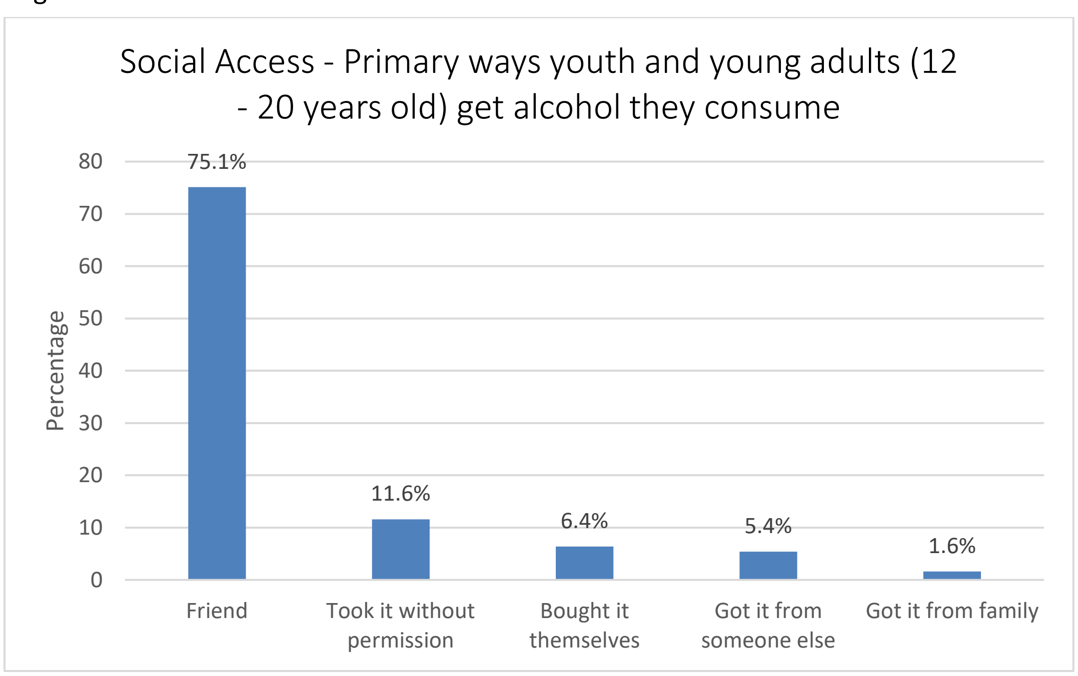


Figure 3

35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%

4.0%
31.5%

Difficult Easy

Figure 4

Percent of Homes with 12-20 Year Olds with Alcohol Stored in...

80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%

49.4%
32.9%
16.6%
13.7%
15.4%

Kitchen Refridgerator
Cabinet or Pantry
Bar Cart, Wine Rack, or Countertop
Garage
No Alcohol in Home

Figure 5

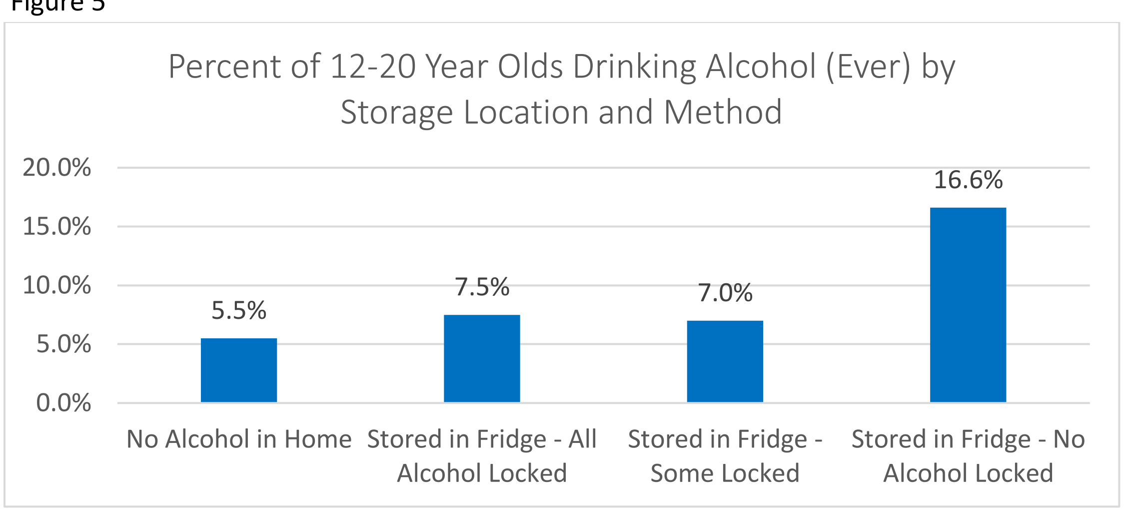
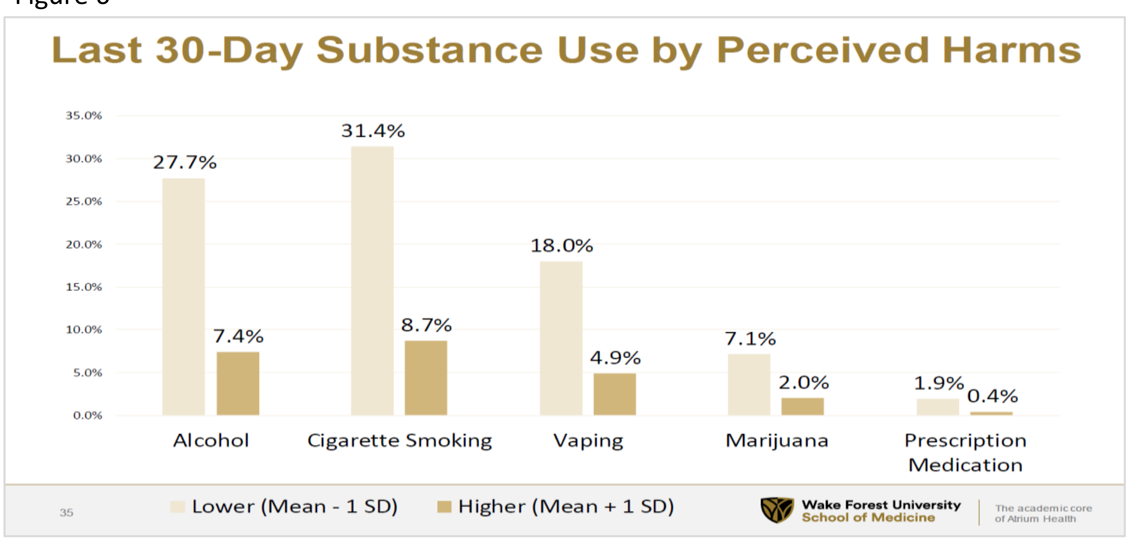


Figure 6



2. *Tobacco and E-cigarette Use* – According to the 2021 Youth Risk Behavior Survey (YRBS), 37.6% of NC high school youth report ever using vapor products; 23.8% report using vapor products on at least one day during the 30 days prior to the survey; 9.9% report using vapor products on 20 or more days during the 30 days prior to the survey (Figure 7). While 2021 use rates reflect a decrease compared to 2019 YRBS results, NC continues to reflect rates higher than the US averages. Additionally, vaping increased among youth and young adults during COVID-19 pandemic. 41% of youth and 23% of young adults reported vaping more than they did before the pandemic (Figure 8). Lastly, youth with lower perceived harms related to cigarette or vapor product use were 3.6 more likely to have smoked cigarettes or used vapor products in the past 30 days (NC Youth and Young Adult Prevention Survey, 2023 - Figure 6).

Figure 7

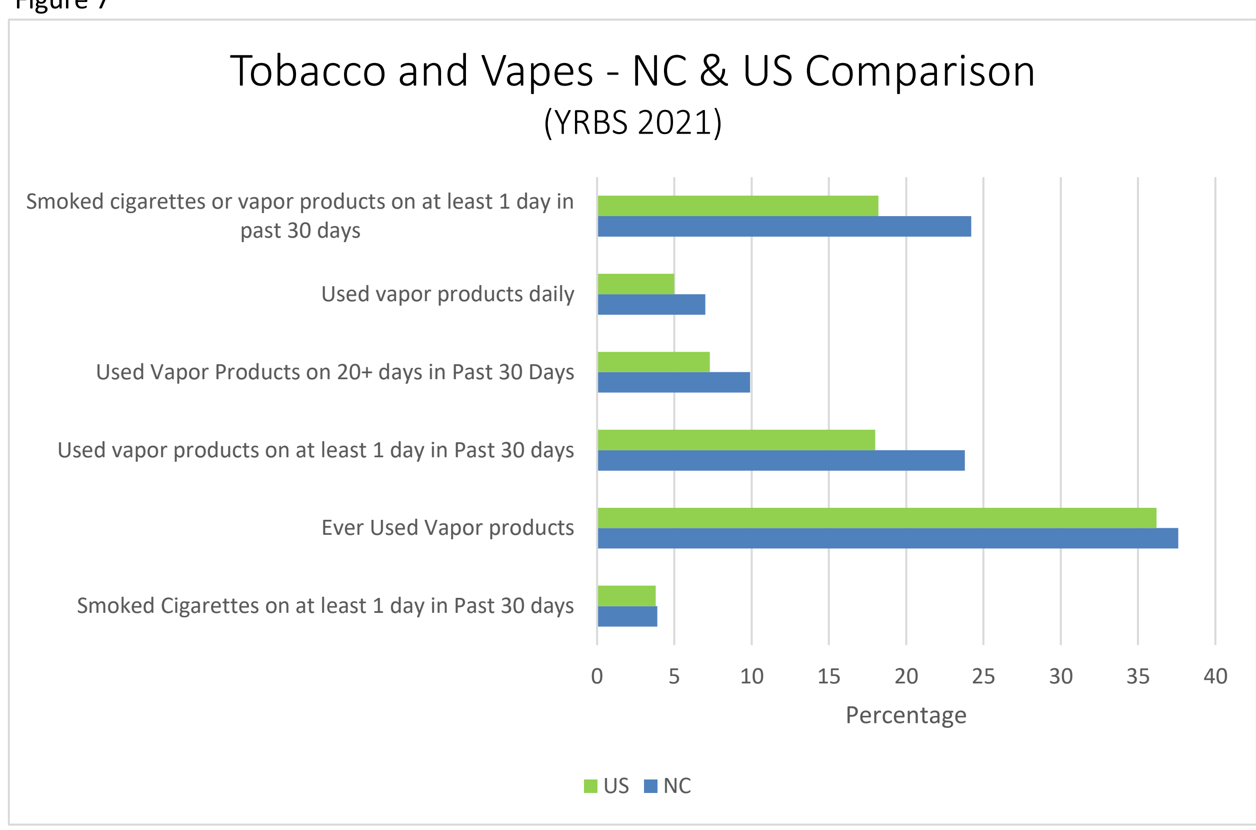
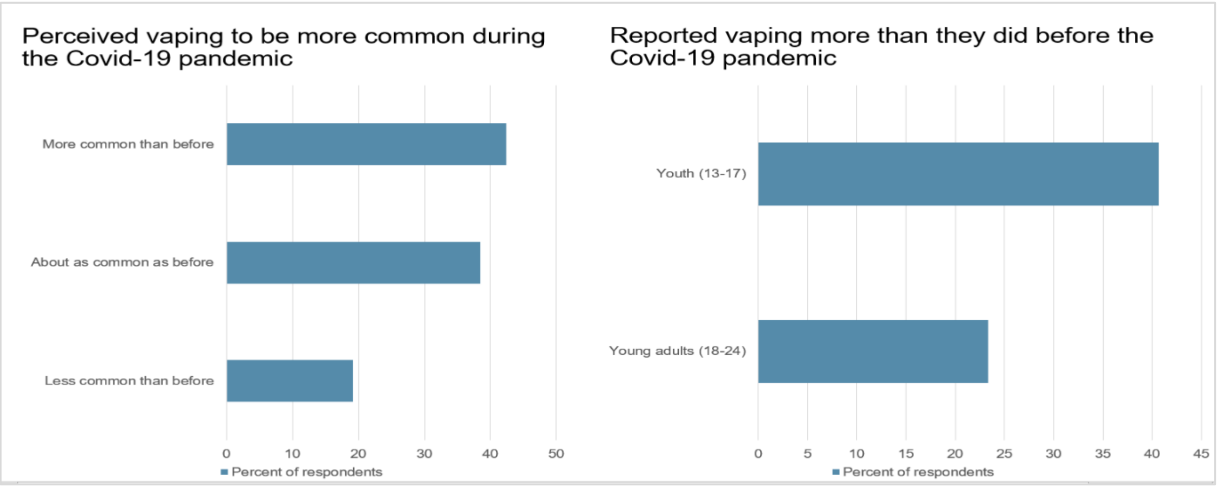
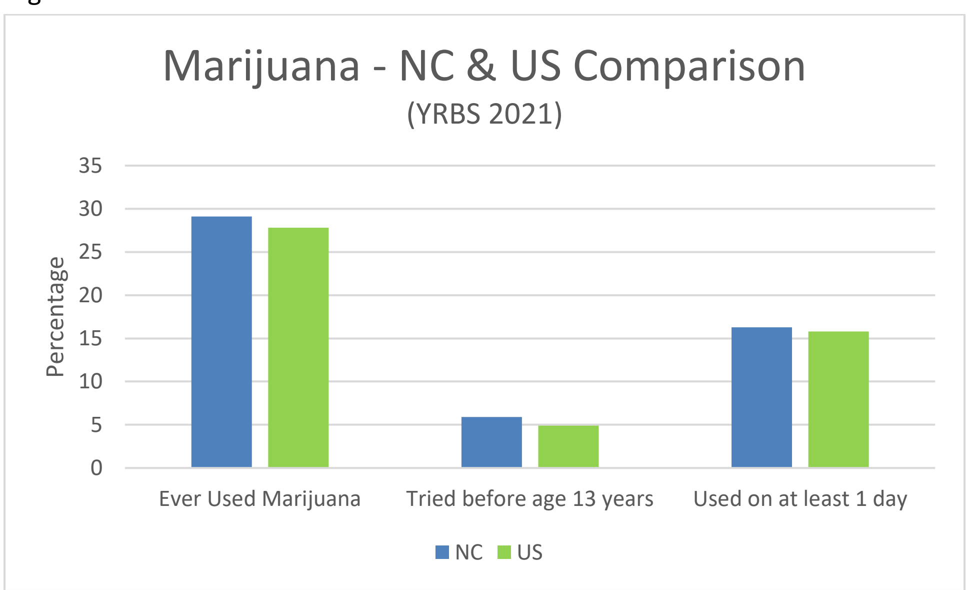


Figure 8



3. *Marijuana* – NC youth report higher marijuana rates compared to national rates. According to the 2021 Youth Risk Behavior Survey, 29.1% of high school youth report ever using marijuana; 16.3% report using marijuana on at least one day during the 30 days prior to the survey; and 5.9% report trying marijuana before the age of 13 years. (Figure 9). Lastly, youth with lower perceived harms related to marijuana use were 3.5 times more likely to have used marijuana in the past 30 days (NC Youth and Young Adult Prevention Survey, 2023 - Figure 6).

Figure 9



4. *Opioids and Other Synthetic Narcotics* - Emergency department visits related to **commonly prescribed opioids increased 19.7%** from 2019 to 2020. ED visits due to commonly prescribed opioids increased in 2021; and remained elevated in 2022 (Figures 10 and 11).

Figure 10

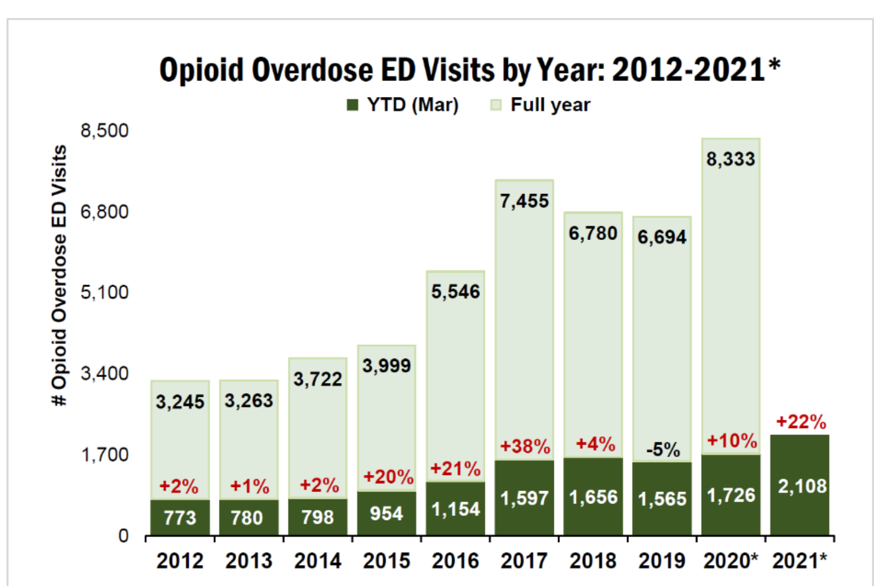
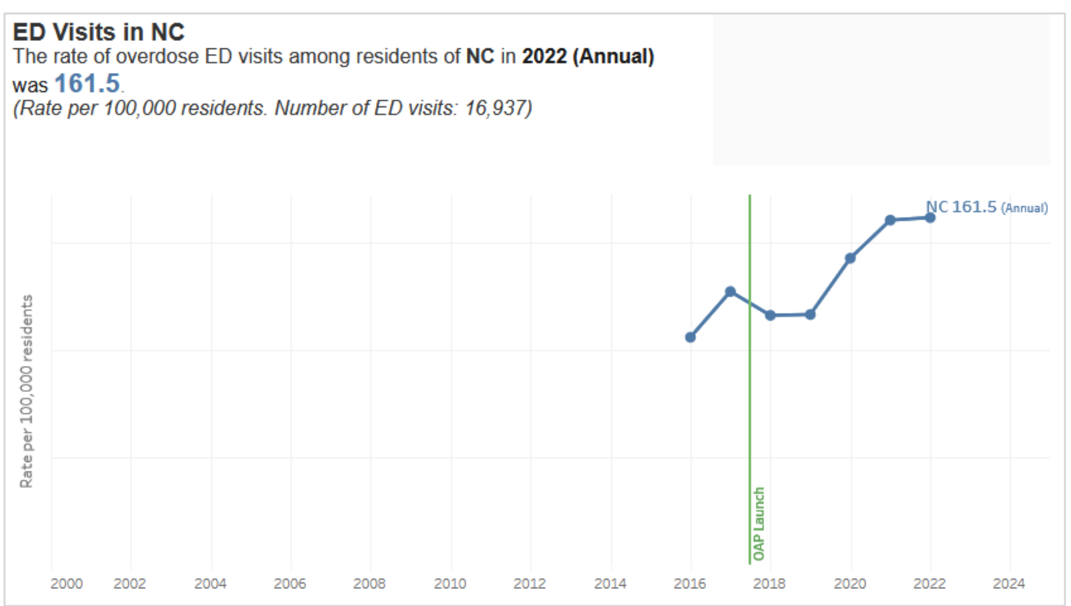
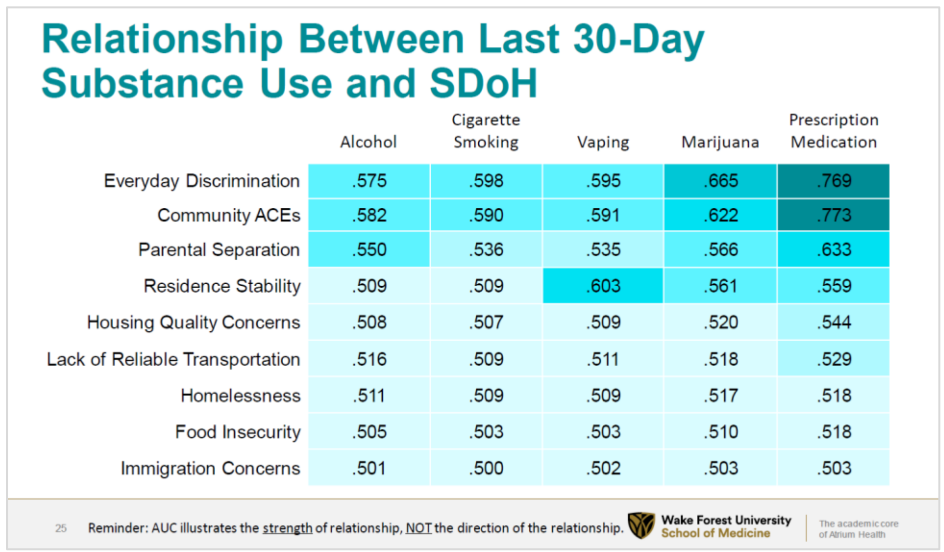


Figure 11



5. *Health Disparities and Equity* – While national and state level data reflect an overall decrease in substance use among youth and young adults, the NC Youth and Youth Adult Survey (2023) indicates that there continues to be disparate impact among certain populations. Specifically, youth and young adults experiencing social determinants of health such as everyday discrimination, community ACEs (adverse community experiences) and residence stability, are more likely to engage in vaping, marijuana use and prescription medication misuse (Figure 13). Additionally, there is a high correlation between community ACEs and everyday discrimination. Respondents experiencing higher community ACEs and everyday discrimination are more likely to engage in substance use in the past 30 days (Figure 14).

Figure 13

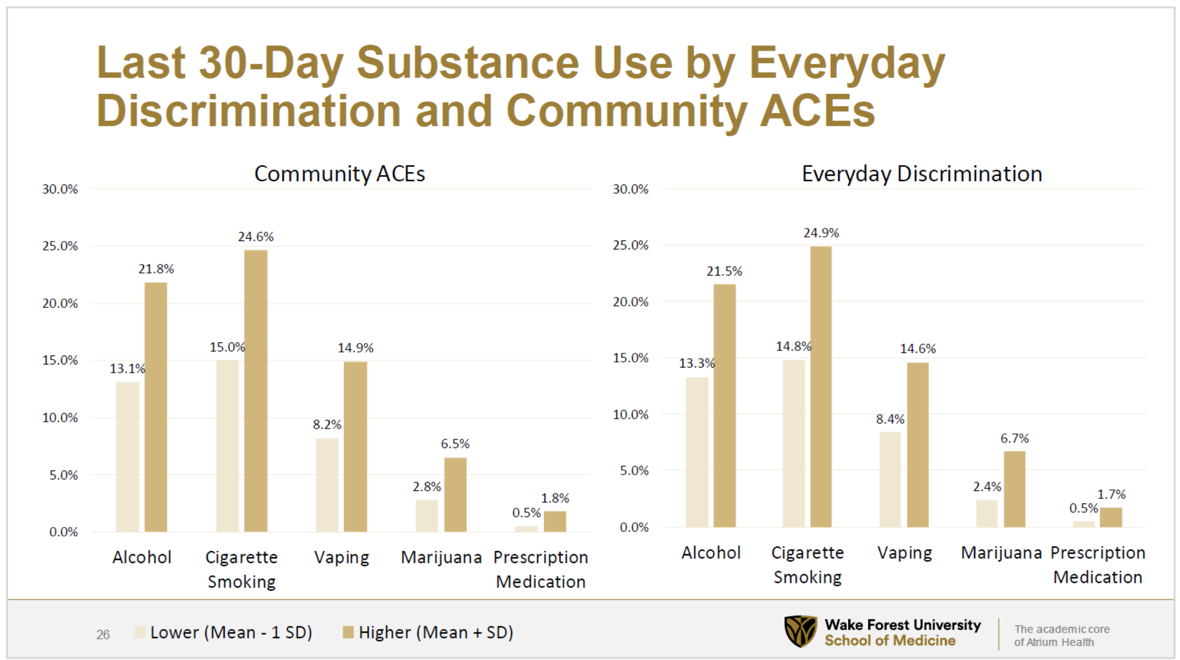


Relationship Between Last 30-Day Substance Use and SDoH

	Alcohol	Cigarette Smoking	Vaping	Marijuana	Prescription Medication
Everyday Discrimination	.575	.598	.595	.665	.769
Community ACEs	.582	.590	.591	.622	.773
Parental Separation	.550	.536	.535	.566	.633
Residence Stability	.509	.509	.603	.561	.559
Housing Quality Concerns	.508	.507	.509	.520	.544
Lack of Reliable Transportation	.516	.509	.511	.518	.529
Homelessness	.511	.509	.509	.517	.518
Food Insecurity	.505	.503	.503	.510	.518
Immigration Concerns	.501	.500	.502	.503	.503

25 Reminder: AUC illustrates the strength of relationship, NOT the direction of the relationship. Wake Forest University School of Medicine | The academic core of Atrium Health

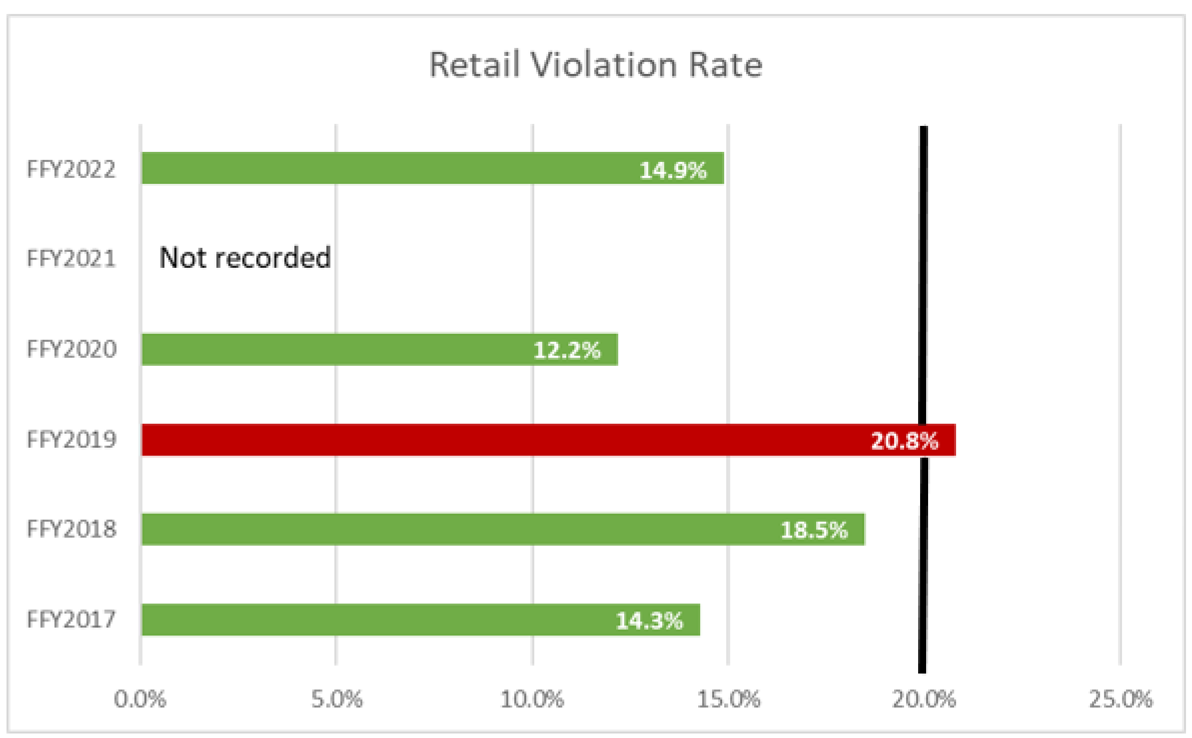
Figure 14



As such, the Prevention, Health Integration and Wellness Team has identified the following unmet priority needs:

1. Decreasing perceived easy access to alcohol, tobacco, vapes, marijuana and prescription drugs by youth (intermediate outcome).
2. Increasing perception of harm for youth use of alcohol, tobacco, vapes, marijuana and prescription drugs (intermediate outcome).
3. Decreasing past 30-day use of alcohol, tobacco, vapes, marijuana and prescription drugs among youth (long-term outcome).
4. Increasing prevention efforts to address disparities among marginalized and underserved populations.

In addition to aforementioned priorities, ***lowering the state tobacco retail violation rate (RVR)*** has been identified as a priority unmet need, as North Carolina has been close to and/or over the SAMHSA threshold rate of 20% in 2017, 2018 and 2019 and higher than the national weighted average RVR. In federal fiscal year (FFY) 2022, the annual Synar Survey was conducted by the DPS-ALE, surveying a total of 583 tobacco retailers which resulted in a **14.9%** weighted retailer violation rate (RVR).



In addition to the Synar Survey, North Carolina DHHS has a Food and Drug Administration (FDA) contract which conducts tobacco compliance checks. FDA primarily focuses on emerging tobacco products such as e-cigarettes, vapors and cigars.

Per the FDA tobacco website, between July 2021 to June 2022, the North Carolina FDA team conducted:

- 2,188 retail tobacco compliance inspections involving an underage person were completed by FDA. Of these, 499 (**22.8% violation rate**) resulted in violations issued from FDA due to sale to an underage person.
  The products sold during the 516 violations were:

- 255 e-cigarette/vapor
- 179 cigars
- 52 cigarettes in a package
- 6 smokeless tobacco
- 2 single cigarette
- 5 N/A

Critical Gaps

NC state law will, at some point, need to be changed to be consistent with federal law. Currently, NC's challenge is educating retailers on both the state and federal laws and exclusive enforcement of the state law due to jurisdiction restrictions.

The N.C. Youth Access to Tobacco Products law G.S. 14-313 (currently age 18) has several weak provisions such as no tobacco retailer licensing system, penalties for violations are only against the clerk and not the retailer, and preemption of the authority for state agencies and local sale, promotion, display, and distribution of tobacco products. Given the federal law change, there is a timely opportunity to educate policymakers on model elements to enable better enforcement and maintain good compliance rates.

DMH and DPH has worked with internal and external partners over the last several months mobilizing and building capacity to gain momentum on a T21 law that will enhance the NC's citizens public health and reduce youth tobacco access.

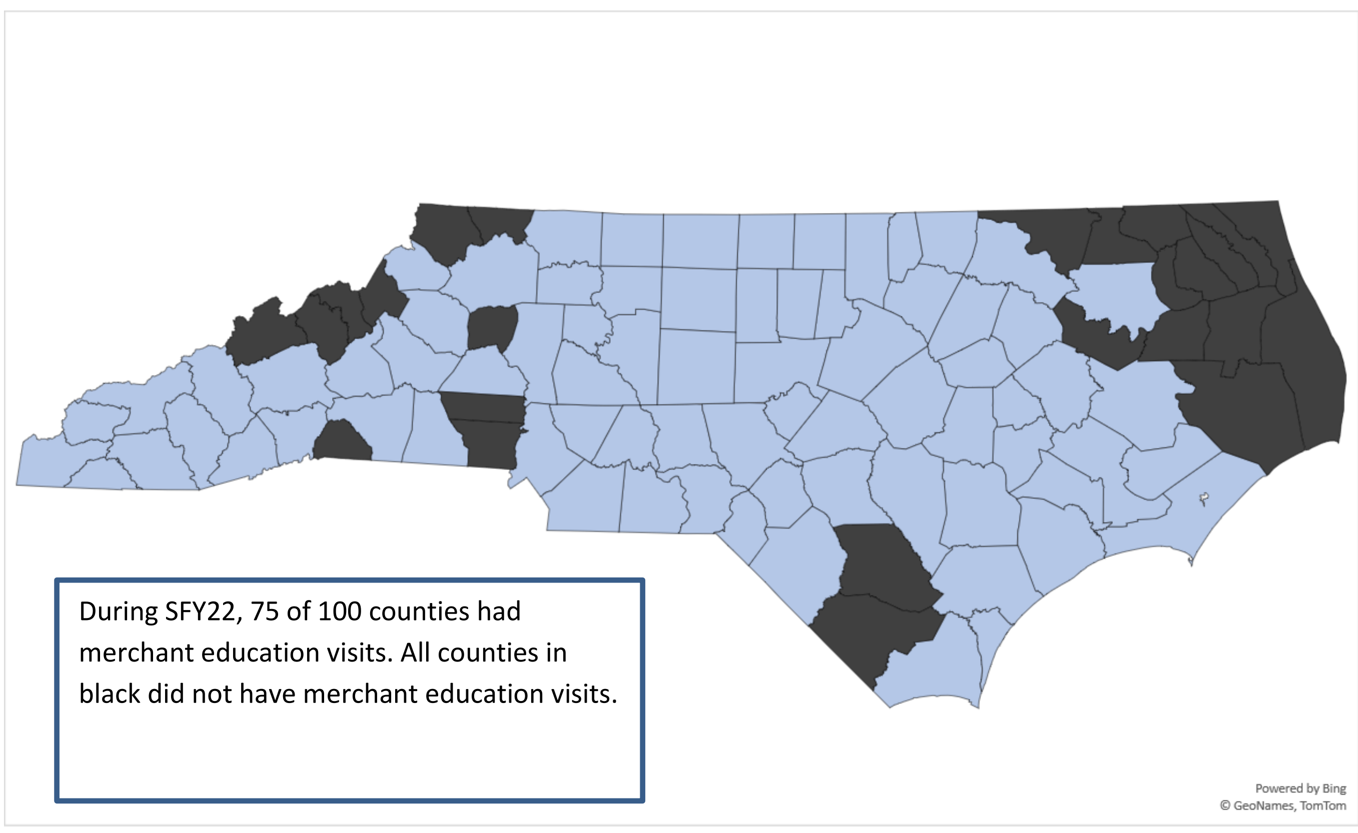
North Carolina Department of Public Safety Alcohol Law Enforcement (ALE) has statewide statutory authority and is currently enforcing the NC Youth access tobacco law. One provision requires retailers to have signage related to §14-313 prohibiting the purchase of tobacco products by persons under the age of 18 in contradiction to current federal law.

Addressing Gaps - Merchant Education

In response, the NC primary prevention office asked direct service prevention providers to expand their tobacco merchant education efforts by:

- Increasing the number of merchant education visits and coverage by county. The number of counties receiving merchant education was **75 out 100** counties in SFY 2022. As a result, in SFY23, DMH asked direct service prevention providers to visit merchants only twice per fiscal year and to reach additional retailers (versus going to the same merchant multiple times), continue to update their retail list and identify new and closed tobacco retailers in their catchment area.
- Encouraging providers to visit at least 90% of the tobacco retailers in their counties and/or census tract, neighborhood.
- Encouraging providers to expand upon merchant education and to conduct tobacco purchase surveys with a younger looking 21-year-olds and to share results where retailers "sold" products with local law enforcement and ALE officers.

A total of **6,546** merchant education visits were performed by prevention providers during SFY 2022.



Continued Success

During FFY 22 Synar Survey 583 survey compliance checks were completed by DPS ALE agents. Out of the 583 survey compliance checks, 77 retailers were out of compliance, resulting in a weighted RVR of **14.9%.** This is well below the 20% threshold set by SAMHSA and below the 20.8% retailer violation rate in FFY19. Despite this success, there is additional work to be done to continue the positive progress made during this survey period.

Next Steps

The FFY22 Synar Survey indicates that additional education and outreach needs to occur to encourage tobacco retailers to ask for an ID, appropriately check the ID and to not sell tobacco products to anyone under 21.

- Eighty-three (83%) percent (486/583) of the clerks asked for an ID, but in some cases still sold tobacco products.
- Sixteen (16.6%) percent (97/583) of the clerks did not ask for an ID. Of those not asking foran ID, 69.1% sold products to a minor.

The FFY20 Synar survey also demonstrated that gas stations, tobacco outlets and grocery stores are more likely to sell tobacco products to minors.

Continued collaboration and partnerships need to occur in FFY 23 to ensure continued law enforcement commitment to conducting more compliance checks and education to retailers

regarding the youth access to tobacco law. DMH would also like to see increased effort in building statewide partnerships to advocate for tobacco licensing. Merchant education efforts need to place more emphasis on encouraging retailers in gas stations, tobacco outlets and grocery stores to ask for and check IDs and not to sell tobacco products to minors. Finally, future Synar survey efforts should begin utilizing 18-20 years for the survey.

Prevention System Needs

North Carolina is embarking on a redesign of its prevention system which will significantly reduce substance use-related injuries, morbidity, and mortality for all North Carolinians. A central element of the redesign is enhancing grantee and contractor performance and accountability by standardizing expectations for the use of the Strategic Prevention Framework, particularly with regard to assessment, evidence-based strategies, process and outcome evaluation, and reporting.

The redesign reflects a shift to results-based management (RBM) with its focus on the following key elements:

- Identifying clear and measurable results to be achieved (e.g., impacts, outcomes, outputs)
- Identifying process and outcome indicators and associated targets for all desired results
- Targeting funding and other resources to the achievement of desired results
- Developing/strengthening systems to collect process and outcome data
- Using evaluation and monitoring data to compare actual results to desired results and make decisions about changes to strategies, activities, implementation, and future funding.

Key supports for this redesign involve (1) replacing the current intermediary structure for prevention with a more streamlined structure aligned with state prevention goals, and (2) redirecting prevention funding to better support the implementation and ongoing evaluation and monitoring of needed prevention strategies and services.

Resources

North Carolina will continue to utilize available funds including the SUBG, state dollars and federal discretionary grants, to better address the needs of individuals with substance use disorders. Program and fiscal staff conduct quarterly "budget variance" calls with all six LME/MCOs to discuss utilization of funds, particularly when it appears an LME/MCO is under-spending in certain areas. Although funds are limited, LME/MCOs are asked to address gaps – either in specific geographic locations or specifically identified services or types of services – by expanding their provider network and credentialing additional providers. For example, with the influx of funds targeted towards individuals with an opioid use disorder, the number of opioid treatment programs with a contract for public funds has increased substantially.

As mentioned earlier, North Carolina was approved for an 1115 SUD Demonstration Waiver that allows for reimbursement of SUD services in facilities with more than 16 beds. LME/MCOs are able to credential and contract with more Medicaid providers than state-funded providers because of

funding; increasing the number of individuals eligible for Medicaid benefits will better assure the availability of more resources, as well as access to care. Medicaid transformation remains underway as well. Much work has been done to develop standard and tailored plans that will better meet the needs of individuals with SUD.

Access to Care

The DMHDDSUS identified and continues to monitor access to care through the LME/MCOs. The Division has long required that LME/MCOs assure that individuals who contact them through their 24/7/365 access lines who are identified as in need of SUD treatment are provided an appointment with a community provider within 48 hours of the call. In other words, no SUD-related call is considered "routine;" all are classified as urgent or emergent. Staff on the Quality Management Team within the Division are monitoring the data specific to this standard and will report such to programmatic/clinical staff, particularly for any LME/MCO that does not meet or maintain this standard.

As stated above, with the influx of funds to address the opioid crisis, new providers have been credentialed to provide SUD treatment and recovery services. Additional work will continue to focus on areas of the state that are under-served. Some of these areas do not have the population to support an opioid treatment program; we are therefore attempting to better engage "non-traditional" providers such as office-based opioid treatment practices, FQHCs and other community health providers. Some of these practices, such as the FQHCs, serve not only individuals with an opioid use disorder, but other/all SUDs.

Quality

The Division assures quality in several ways. Monitoring is conducted annually to determine adherence to SUBG standards, rules and policies, both at the LME/MCO level, as well as the provider level. During these same annual SUBG monitoring visits, clinical monitoring is also conducted. Charts are reviewed to determine if comprehensive clinical assessments are conducted, that individuals are assessed for and provided the appropriate ASAM level of care and that evidence-based practices are utilized appropriately. This is in addition to clinical, programmatic and fiscal monitoring conducted by the LME/MCOs.

North Carolina also conducts independent peer reviews annually, although the majority of SUBG-funded providers are nationally accredited. Each year, specific services are identified for both adolescents and adults, and providers of those services are selected based on specific criteria, such as volume of billed services, proximity to other "like" providers, geographic location, etc. Peer reviewers undergo training and then review each other's programs. In addition to a standardized review, there is much opportunity for sharing of best practices, challenges, etc. Beginning next fiscal year, results will be aggregated and shared with all providers and LME/MCOs to function more as a learning lab of sorts and better disseminate this information.

Sources:

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2) Dawson, D. A., Goldstein, R. B., Chou, S. P., Ruan, W. J., & Grant, B. F. (2008). Age at first drink and the first incidence of adult-onset DSM-IV alcohol use disorders. Alcoholism: Clinical and Experimental Research, 32(12), 2149-2160. doi: 10.1111/j.1530-0277.2008.00806.x

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5) SAMHSA 2001

6) Chen, C.-Y., Storr, C. L., & Anthony, J. C. (2009). Early-onset drug use and risk for drug dependence problems. Addictive Behaviors, 34(3), 319-322. doi: 10.1016/j.addbeh.2008.10.021

7) Elizabeth C.Hair, Alexis A.Barton, Siobhan N.Perks, Jennifer Kreslake, Haijun Xiao, Lindsay Pitzer, Adam M. Leventhal, Donna M. Vallone. (2020) Association between e-cigarette use and future combustible cigarette use: Evidence from a prospective cohort of youth and young adults, 2017–2019 Science Direct

8) NC ABC Commission, Monthly Sales and Annual Revenue (2021). Retrieved from: https://abc.nc.gov/StoresBoards/SalesRevenueReports.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Opioid and Substance Use; Health Equity; Connect People to Care

Priority Type: SUT

Population(s): PWID

Goal of the priority area:

Increase in the percentage of members of historically marginalized populations/people of color who receive services in the OTP setting.

Strategies to attain the goal:

1. DMHDDSUS staff will work with LME-MCOs to better assure funding is targeted towards and contracts are initiated with OTPs with a focus on under-served areas and historically marginalized communities.
2. State Opioid Treatment Authority (SOTA) staff will promote outreach to and partnerships with historically marginalized populations and communities.
a. SOTA staff will promote partnerships between Opioid Treatment Programs (OTPs) and jails, prisons, and other settings where historically marginalized populations are disproportionately represented.
b. SOTA staff will promote outreach to and partnerships with faith-based and community organizations that represent and serve historically marginalized populations.
3. SOTA staff will provide feedback to OTP provider organizations on health equity measures during routine annual and special issue site visits.
4. SOTA staff will require any organization or business that wishes to open a new OTP in NC to include in their application a strategic plan for engaging historically marginalized individuals and communities.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of total OTP patients who identify as persons of color

Baseline Measurement: According to the Lighthouse Central Registry, as of 09.11.23, 85.3% of patients enrolled in NC's OTPs were white, 8.6% were black or African American, 2.3% were Hispanic.

First-year target/outcome measurement: In SFY24, increase the percentage of black or African American patients enrolled in OTPs by 1%.

Second-year target/outcome measurement: In SFY25, increase the percentage of black/African American patients enrolled OTPs by an additional 1%.

Data Source:

Lighthouse Central Registry

Description of Data:

Lighthouse Central Registry reports: Patient Report by Race, all sites; Patient Report by Ethnicity, all sites

Data issues/caveats that affect outcome measures:

Data are reported by the provider agency; data reports cannot be pulled for a specific date range, but may only be collected on the date of the report.

Priority #: 2

Priority Area: Opioid and Substance Use; Health Equity; Connect People to Care

Priority Type: SUT

Population(s): PWID

Goal of the priority area:

Increase the number of people receiving medication assisted treatment for opioid use disorder.

Strategies to attain the goal:

1. DMHDDSUS will work with LME-MCOs to assure that State Opioid Response (SOR) funding is targeted toward and contracts are initiated with OTPs with demonstrated ability to provide evidence-based treatment to uninsured individuals and to increase the number of uninsured person served by accessible MAT/MOUD OTP providers.
2. State Opioid Treatment Authority (SOTA) staff will promote partnerships between OTPs and jails/prisons to build capacity and move jail-based MAT/MOUD programs forward.
3. SOTA staff will promote outreach efforts and public/private/community partnerships between OTPs and key stakeholders in their communities.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of unique patients treated annually in OTPs

Baseline Measurement: According to the Lighthouse Central Registry, in SFY 22-23, 29,435 unique patients were served in NC's OTPs.

First-year target/outcome measurement: In SFY24, increase by 1% the number of unique individuals served in any NC OTP.

Second-year target/outcome measurement: In SFY25, increased by an additional 1% the number of individuals served in any NC OTP.

Data Source:

Lighthouse Central Registry

Description of Data:

Lighthouse Central Registry, Report of Unique Patients in treatment for a time period.

Data issues/caveats that affect outcome measures:

Report will only contain data from NC's licensed Opioid Treatment Programs. Office-based opioid treatment (OBOT) providers or private physicians are not included in this report.

Priority #: 3

Priority Area: Pregnant Women and Women with Dependent Children

Priority Type: SUT

Population(s): PWWDC

Goal of the priority area:

Access to gender responsive, family-centered SUD treatment services and supports for pregnant women and women with dependent children.

Strategies to attain the goal:

1. Maintain a dedicated Perinatal Substance Use Specialist position to ensure pregnant and parenting women receive appropriate screening and referral for SUD treatment and supports and prenatal care services through a toll-free hotline.
2. Maintain and update the statewide capacity management database to identify available treatment slots in the NC Perinatal and Maternal Substance Use and CASAWORKS for Families Residential Initiatives.
3. Increase awareness of substance use issues and available resources specific to pregnant and parenting women through collaboration with stakeholder and the provision of training and technical assistance.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of pregnant women and women with dependent children referred to gender-responsive SUD treatment through the toll-free hotline.

Baseline Measurement: During SFY23, 621 pregnant women and women with dependent children received referrals (126 of the 621 women were pregnant.)

First-year target/outcome measurement: Increase the number of treatment referrals by 1% in SFY24.

Second-year target/outcome measurement: Increase the number of treatment referrals by an additional 1% in SFY25.

Data Source:

Quarterly and annual Perinatal Substance Use Project reports for the toll-free hotline services.

Description of Data:

These reports include 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 #: 4

Priority Area: Pregnant Women and Women with Dependent Children

Priority Type: SUT

Population(s): PWWDC

Goal of the priority area:

Access to SUD treatment services for individuals with a substantiated Child Protective Services (CPS) case.

Strategies to attain the goal:

Maintain funding and accessibility to Qualified Professionals in Substance Abuse (QPSAs) statewide to conduct assessments with individuals referred by county CPS and offer appropriate SUD treatment referrals.

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 are referred for a SUD assessment.

Baseline Measurement: During SFY23, a total of 1,028 individuals received a SUD assessment based on referral by county CPS offices statewide.

First-year target/outcome measurement: Maintain the number of individuals receiving SUD assessment in SFY24.

Second-year target/outcome measurement: Increase the number of individuals receiving SUD assessment by 1% in SFY25.

Data Source:

Quarterly project reports for the WF/CPS Substance Use Initiative completed by the LME-MCOs.

Description of Data:

The data in this report include the number of individuals with a substantiated CPS case or found in need of services who were assessed.

Data issues/caveats that affect outcome measures:

1. The number of referrals by county DSS had decreased during the COVID pandemic although it appears they are stabilizing at this time.
2. Potential data issues include transition of LME-MCOs to Medicaid managed care Tailored Plans in SFY24 that may impact reporting. Staff is working with the LME- MCO to mitigate any data collection issues.

Priority #: 5

Priority Area: Tuberculosis Services

Priority Type: SUT

Population(s): TB

Goal of the priority area:

Tuberculosis screening and referral

Strategies to attain the goal:

1. Review of charts and other information during annual SUBG clinical monitoring monitoring.
2. Issuance of plans of correction if the above is not met.
3. Review of policies and procedures specific to tuberculosis screening in the SUBG Semi-Annual Compliance Reports.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of individuals who are evaluated for SUD treatment who are also screened for tuberculosis and referred to other services if indicated by a positive screen.

Baseline Measurement: Unknown - Due to COVID-19 and imposed travel restrictions for state employees, clinical monitoring activities that collect this information and data were not conducted this past state fiscal year.

First-year target/outcome measurement: A compliance rate of 98% will be achieved in SFY24.

Second-year target/outcome measurement: A compliance rate of 98% will be achieved in SFY25.

Data Source:

Annual SUBG clinical monitoring and reviews.

Description of Data:

A sample of provider records reviewed annually to determine compliance with federal regulations. Compliance with TB screening and referral to care (if indicated) is one the elements reviewed.

Data issues/caveats that affect outcome measures:

Plans for conducting on-site monitoring are currently not finalized due to internal staffing shortages and ongoing system transformation; virtual/desk audits may be conducted.

Priority #: 6

Priority Area: Youth Initiation and Tobacco Access

Priority Type: SUP

Population(s): PP, Other

Goal of the priority area:

Decrease youth initiation to tobacco products.

Strategies to attain the goal:

1. Train prevention providers on merchant education and tobacco survey best practices.
2. Improve Synar survey protocols and procedures.
3. Encourage prevention providers to partner with ALE to increase the number of statewide tobacco retailer trainings targeting local retailers.
4. Provide media training to prevention providers to increase the number of paid/earn media on tobacco prevention/enforcement campaigns.
5. Work with state vendor and subcontractors with an evaluator to increase data collection at the state and local level related to tracking statewide tobacco prevention and enforcement.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Underage tobacco sales retail violation rate

Baseline Measurement: In FFY23, 13% of retail establishments sold tobacco to an underage person.

First-year target/outcome measurement: In FFY24, it is projected NC will have a spike in the retail violation rate. We plan to conduct retail tobacco merchant education to at least 15% of the NC merchants, totaling 2266 visits in 68% of the counties in NC.

Second-year target/outcome measurement: In FFY25, we plan to conduct retail tobacco merchant education to at least 17% of the NC merchants, totaling 2900 visits in 75% of the counties in NC

Data Source:

Synar Retail Merchants ecco data tracking; Synar Survey

Description of Data:

North Carolina measures their progress in reducing youth access to tobacco in annual, random, unannounced inspections which is analyzed and reported in the annual Synar survey. The methodology requires approval from SAMHSA-CSAP. Prevention providers collect information about the location and number of times they visit tobacco retail establishments each year in an online ecco data tracking platform.

Data issues/caveats that affect outcome measures:

None anticipated, merchant visits and education are planned.

Priority #: 7

Priority Area: Community Integration

Priority Type: SUR

Population(s): PWWDC, PWID, Other

Goal of the priority area:

Access to recovery supported housing

Strategies to attain the goal:

1. DMH/DD/SUS will continue to provide no less than the current level of funding to Oxford House, Inc., which will support competitive salaries for staff to increase outreach efforts and the number of Oxford House beds:
2. Contractor will assure that LME-MCOs awareness of planned opening of Oxford Houses and contact for referral questions:
3. DMH/DD/SUS upon notification will notify LME-MCOs of opened Oxford Houses in their catchment ready to accept referrals:
4. Contractor will mentor and support an increased number of persons from incarceration to reenter society into NC Oxford Houses: and
5. Contractor will provide outreach-supported training, technical assistance and offer additional recovery support to support sustainability, quality, and increased access to existing NC Oxford Houses.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Improved understanding of specific Oxford house policies and procedures by residents and staff.

Baseline Measurement: At the end of SFY22, 26 educational trainings were conducted for 618 individuals (house members and Outreach staff) with 289 responses to the NC Oxford House Training/Education Survey.

First-year target/outcome measurement: One percent increase in the number of trainings offered in FY23.

Second-year target/outcome measurement: An additional one percent increase in the number of trainings offered in FY24.

Data Source:

DMH/DD/SUS Contractor Progress Report of activities and accomplishments and NC Oxford Housing Training/Education Survey annual report.

Description of Data:

Oxford House Training, Data and Reporting Specialist conducts, tracks and collects information for training sessions on policies and procedures related to medication-assisted treatment (MAT), medication-assisted recovery (MAR), and the safe storage and use of naloxone and participation to provide to State Coordinator for quarterly reporting and tracking. The NC Oxford House Resident

Recovery Supports Focus Survey is conducted and distributed annually to no less than 100 individuals, with the goal of fostering greater awareness of recovery supports needs of residents.

Data issues/caveats that affect outcome measures:

Estimated target value for the number to be trained is based on the anticipated participation from a percentage of house members and staff. Surveys are confidential and are voluntary self-reports, so may not capture 100% of the residents.

Indicator #: 2

Indicator: Number of re-entering individuals mentored and transitioned to recovery supported housing

Baseline Measurement: At the end of SFY21, a total of 240 new re-entering individuals in recovery were served and mentored through a combination of SUBG funds (60 individuals) and SOR funds (180 individuals).

First-year target/outcome measurement: No less than 62 persons will be mentored and transitioned from incarceration into an NC Oxford House at the end of SFY24 with SUBG funds.

Second-year target/outcome measurement: No less than 65 persons will be mentored and transitioned from incarceration into an NC Oxford House at the end of SFY25 with SUBG funds.

Data Source:

NC Reentry Programs data and Contractor Progress Report (submitted quarterly)

Description of Data:

Cumulative data (non-personally identifiable information) on the number of individuals Reentry Staff interviewed and those that were mentored and housed, along with the geographic info for correctional institutions where Staff has established and maintained programs, are identified.

Data issues/caveats that affect outcome measures:

None anticipated

Priority #: 8

Priority Area: TASC

Priority Type: SUT

Population(s): Other

Goal of the priority area:

To support people with substance use disorder and co-occurring disorders under criminal justice supervision with appropriate care management and connection to services.

Strategies to attain the goal:

1. Analyze NCTOPPS data to identify root cause of attrition from program, and geographic variances.
2. Work with TASC and Community Supervision partners to improve pathways and processes.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of TASC participants to successfully complete the program

Baseline Measurement: 56% TASC participants completed the program in 2021/2022

First-year target/outcome measurement: 60% of TASC participants complete program in 2 out of 4 regions in FY24

Second-year target/outcome measurement: 60% of TASC participants complete program in 3 out of 4 regions in FY25

Data Source:

NCTOPPS

Description of Data:

The NCTOPPS (Treatment Outcomes and Program Performance System) is a web-based program that gathers outcome performance data on behalf of mental health and substance use disorder consumers in North Carolina's publicly-funded system services. The NCTOPPS system provides reliable information that is used to measure the impact of treatment, to improve services and manage quality throughout the service system.

Data issues/caveats that affect outcome measures:

There is significant regional variation, with Regions 3 and 4 performing less well than Regions 1 and 2 in program completion (but better in other areas). Geographic location and provider issues are characteristic of these differences and will be taken into account when reviewing improvement strategies.

Priority #: 9

Priority Area: Juvenile Justice Behavioral Health

Priority Type: SUT

Population(s): Other

Goal of the priority area:

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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percentage of juvenile justice-involved youth who complete treatment

Baseline Measurement: Justice-involved youth have completed treatment at a decreasing rate since 2019, with an average of 51% over the last 5 years.

First-year target/outcome measurement: Juvenile Justice-involved youth will complete treatment at a rate of 47% or higher in FY24.

Second-year target/outcome measurement: Juvenile Justice-involved youth will complete treatment at a rate of 51% or higher in FY25.

Data Source:

NCTOPPS

Description of Data:

The NCTOPPS (Treatment Outcomes and Program Performance System) is a web-based program that gathers outcome performance data on behalf of mental health and substance use disorder consumers in North Carolina's publicly-funded system services. It provides reliable information used to measure the impacts of treatment, improve services, and manage quality throughout service system.

Data issues/caveats that affect outcome measures:

None anticipated.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2024/2025.
SUPTRS BG – ONLY include funds expended by the executive branch agency administering the SUPTRS BG.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds									
	A. SUPTRS BG	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	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (SUPTRS BG)[b]
1. Substance Use Prevention[c] and Treatment	$78,849,469.00		$77,744,514.00	$64,639,408.00	$363,096,358.00	$4,916,520.00	$0.00		$10,511,441.00	$25,899,468.00
a. Pregnant Women and Women with Dependent Children[c]	$15,745,000.00									
b. Recovery Support Services	$3,977,070.00									
c. All Other	$59,127,399.00		$77,744,514.00	$64,639,408.00	$363,096,358.00	$4,916,520.00			$10,511,441.00	$25,899,468.00
2. Primary Prevention[d]	$20,942,578.00		$0.00	$0.00	$0.00	$0.00	$0.00		$2,023,770.00	$2,041,920.00
a. Substance Use Primary Prevention	$20,942,578.00								$2,023,770.00	$2,041,920.00
b. Mental Health Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Other Psychiatric Inpatient Care										
5. Tuberculosis Services	$0.00									
6. Early Intervention Services for HIV	$0.00									
7. State Hospital										
8. Other 24-Hour Care										
9. Ambulatory/Community Non-24 Hour Care										
10. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately	$4,910,000.00								$45,000.00	
11. Crisis Services (5 percent set-aside)										
12. Total	**$104,702,047.00**	**$0.00**	**$77,744,514.00**	**$64,639,408.00**	**$363,096,358.00**	**$4,916,520.00**	**$0.00**	**$0.00**	**$12,580,211.00**	**$27,941,388.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025. Please enter SUPTRS BG ARP planned expenditures for the period of July 1, 2023 through June 30, 2025

[c] Prevention other than primary prevention

[d] The 20 percent set-aside funds in the SUPTRS BG must be used for activities designed to prevent substance misuse.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:
Updated per global revision request 05.14.24.

Planning Tables

Table 3 SUPTRS BG Persons in need/receipt of SUD treatment

To complete the Aggregate Number Estimated in Need column, please refer to the most recent edition of SAMHSA's National Survey on Drug Use and Health (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment column, please refer to the most recent edition of the Treatment Episode Data Set (TEDS) data prepared and submitted to SAMHSA's Behavioral Health Services Information System (BHSIS).

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	22,415	790
2. Women with Dependent Children	37,145	19,405
3. Individuals with a co-occurring M/SUD	561,642	29,149
4. Persons who inject drugs	122,388	12,544
5. Persons experiencing homelessness	933	5,163

Please provide an explanation for any data cells for which the state does not have a data source.

1. Pregnant Women aged 15-44 in NC estimated to have a SUD in 2022: 22,415. Data sources: • Pregnancy Rates. Pregnancies, Births and Abortions in the United States, 1973-2017: National and State Trends by Age, Isaac Maddow-Zimet and Kathryn Kost, Guttmacher Institute, published March 2021. (https://www.guttmacher.org/report/pregnancies-births-abortions-in-united-states-1973-2017) Pregnancy rate for women aged 15-44 in NC in 2017 = 85.0 per 1,000 women. In US = 87.4 per 1,000 women. Birth rate for women aged 15-44 in NC in 2017 = 59.5 per 1,000 women. In US = 60.4 per 1,000 women. Abortion rate for women aged 15-44 in NC in 2017 = 12.4 per 1,000 women. In US = 13.5 per 1,000 women. Fetal loss rate for women aged 15-44 in NC in 2017 = 13.1 per 1,000 women. In US = 13.5 per 1,000 women. Comparing the above birth and pregnancy rates for women aged 15-44 in NC, 59.5 ? 85.0 = 70% of pregnancies result in a live birth. • Fertility Rates. US DHHS, Center for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics Reports, Vol. 72, No. 1, January 31, 2023 Table 8. Birth rates, by age of mother: United States, each state and territory, 2021. Fertility rates reported are births per 1,000 women aged 15–44 years. In NC = 58.1. In the US = 56.3. Dividing 58.1 births per 1,000 women aged 15-

44 in NC in 2021 by the 70% of pregnancies that result in a live birth (from the first bullet), results in an expected pregnancy rate of 83.0 pregnancies per 1,000 women aged 15-44. • Population data. NC Office of State Budget and Management (NC OSBM), Population Estimates/Projections Data - Sex and Single Years of Age (2000-2050). https://www.osbm.nc.gov/demog/county-projections. Last updated 2/15/22. Downloaded 3/21/22. In NC as of July 2022, there were 2,126,468 women ages 15-44. • Prevalence Rates. SAMHSA, Center for Behavioral Health Statistics and Quality, Results from the 2020 National Survey on Drug Use and Health: Detailed Tables, October 2021. https://www.samhsa.gov/data/report/2020-nsduh-detailed-tables. . Published 10/25/21. Table 5.5B Substance Use Disorder in Past Year among Persons Aged 12 or Older, by Age Group and Demographic Characteristics: Percentages, 2019 and 2020. Substance Use Disorder is defined, based on criteria from DSM-5, as meeting criteria for illicit drug or alcohol dependence or abuse. State-specific rates by gender for NC not published. Used US rates applied to NC population. Prevalence in 2020 in the US for persons ages 12 and older with a SUD in the past year: Total 14.5%, Males 16.5%, Females 12.7%. Calculations: Applied the most current available national SUD prevalence rate for women (12.7% of women aged 12 and older) to the number of women in NC aged 15-44 years as of July 2022: 2,126,468 women x 12.7% = 270,061 women aged 15-44 in NC estimated to have a SUD. Divided this number by 1,000 and multiplied by 83.0 pregnancies per 1,000 women aged 15-44 = 22,415 pregnant women in NC estimated to have a SUD in 2022. 2. Women in Poverty with Dependent Children in Need of SUD Treatment: 37,145. Women with Dependent Children In SUD Treatment: 22,656. Data Sources: • Number In Treatment. Per the North Carolina Treatment Outcomes and Program Performance System (NCTOPPS) as of 9/22/21, the number of women in the SUD population with dependent children in NC receiving treatment in SFY2022 = 22,656. This number may not be limited to women in poverty. • Women with Dependent Children. In researching women with dependent children, almost all internet searches pointed to federal and state programs targeting aid to women and families with dependent children in poverty and federal block grant requirements around maintenance of effort for this population. Therefore, I focused prevalence estimates on this population as well. • Poverty Rate For Women. Per the North Carolina Justice Center Report titled, 2020 Poverty Report: Persistent poverty demands a just recovery for North Carolinians, by Logan Rockefeller Harris, Senior Policy Analyst, Budget and Tax Center, published October 29, 2020. https://www.ncjustice.org/publications/2020-poverty-report-persistent-poverty-demands-a-just-recovery-for-north-carolinians/. In 2019, 1.4 million North Carolinians, or about 1 in every 7 people in the state, lived in poverty. In 2019, the state had the 13th highest poverty rate in the country, and at 13.6%, the poverty rate was 3% higher than the U.S. rate of 10.5%. The poverty rate among North Carolina women is more than 20% higher than for men. 786,000 women, or 14.9%, experienced poverty, compared to 600,000 men, or 12.2%, experienced poverty. • Percent of Women In Poverty With Dependent Children. Per the Center For American Progress publication titled, The Straight Facts on Women in Poverty By Alexandra Cawthorne October 2008, which cited the U.S. Census Bureau, Current Population Survey, 2008 Annual Social and Economic Supplement, 26% of all adult women (age 18 and older) with incomes below the poverty line are single mothers, 12% are married with dependent children, 54% are single with no dependent children, and 8% are married with no dependent children. • Per the US Census Bureau publication Income and Poverty in the United States: 2020, September 14, 2021, Report Number P60-273, Emily A. Shrider, Melissa Kollar, Frances Chen, and Jessica Semega, https://www.census.gov/library/publications/2021/demo/p60-273.html, the poverty rate for families with a female householder in 2020 was 23.4%. This increased from 22.2% in 2019. • Prevalence Rates. SAMHSA, Center for Behavioral Health Statistics and Quality, Results from the 2020 National Survey on Drug Use and Health: Detailed Tables, October 2021, published 10/25/21, https://www.samhsa.gov/data/report/2020-nsduh-detailed-tables. Substance Use Disorder is defined as meeting DSM-5 criteria for illicit drug or alcohol dependence or abuse. State-specific rates by poverty level and gender for NC not published. Used US rates applied to NC population. Table 5.8B Substance Use Disorder in Past Year among Persons Aged 12 or Older, by Age Group and Geographic and Socioeconomic Characteristics: Percentages, 2019 and 2020. Prevalence in 2020 for persons ages 18 and older with a SUD in the past year by poverty level: Less Than 100% = 17.5% Table 5.5B Substance Use Disorder in Past Year among Persons Aged 12 or Older, by Age Group and Demographic Characteristics: Percentages, 2019 and 2020. Prevalence in 2020 for persons ages 18 and older with a SUD in the past year by gender: Total 15.4%, Males 17.7%, Females 13.2%. • Population data. NC Office of State Budget and Management (NC OSBM), Population Estimates/Projections Data - Sex and Single Years of Age (2000-2050). https://www.osbm.nc.gov/demog/county-projections. Last updated 2/15/22.

Downloaded 3/21/22. In NC as of July 2022, there are 4,373,647women ages 18 and older. Calculations: Where NC-specific rates were not available, used US rates applied to NC population. Using the Budget and Tax Center and NC OSBM data, 14.9% of women in NC in poverty (2019) x 4,373,647 women ages 18 and older in NC (July 2022) = 651,673 women in poverty. Per the Census Bureau, 38% of women (age 18 and older in 2008) in the US with incomes below the poverty line have dependent children. Multiplying 38% x 651,673 women in poverty in NC (July 2022) = 247,636 women in poverty with dependent children in NC. Per the NSDUH 2020 results, 17.5% of persons in the US less than 100% of poverty have a SUD. This is 13.6% higher than the 15.4% of persons ages 18+ in the US who have a SUD. Per the NSDUH 2020 results, 13.2% of females ages 18+ in the US have a SUD. If the prevalence of women less than 100% of poverty with a SUD is 13.6% higher than the total population, then one might expect 15.0% of females ages 18+ below 100% of poverty to have a SUD in the US. Applying national rates to the NC population, one might expect 15.0% x 247,636 women in poverty with dependent children in NC = 37,145 to have a SUD. 3. Individuals with co-occurring MI/SUD in NC in 2022: Adults Ages 18+ with Any MI + SUD 561,642 Adults Ages 18+ with SMI + SUD 184,420 Adolescents Ages 12-17 with MDE + SUD 21,810 Adolescents Ages 12-17 with MDE with severe impairment + SUD 14,540 Data Sources: • Prevalence Rates. Substance Abuse and Mental Health Services Administration. (October 2021). Results from the 2020 National Survey on Drug Use and Health: Detailed Tables (https://www.samhsa.gov/data/report/2020-nsduh-detailed-tables) Published October 25, 2021. State-specific rates for NC not published. Used US rates applied to NC population. AMI = Any Mental Illness MDE = Major Depressive Episode SMI = Serious Mental Illness SUD = Substance Use Disorder SUD/AMI: Table 8.9B Co-Occurring Substance Use Disorder and Any Mental Illness in Past Year: Among People Aged 18 or Older; by Age Group and Demographic Characteristics, Percentages, 2019 and 2020. Data is for 2020. SUD/SMI: Table 8.11B Co-Occurring Substance Use Disorder and Serious Mental Illness in Past Year: Among People Aged 18 or Older; by Age Group and Demographic Characteristics, Percentages, 2019 and 2020. Data is for 2020. SUD/MDE: Table 9.10B Co-Occurring Substance Use Disorder, Illicit Drug Use Disorder, or Alcohol Use Disorder and Major Depressive Episode (MDE) or MDE with Severe Impairment in Past Year: Among People Aged 12 to 17; by Gender, Percentages, 2019 and 2020. Data is for 2020. 6.7% of Adults Ages 18+ have co-occurring AMI + SUD 2.2% of Adults Ages 18+ have co-occurring SMI + SUD 12.2% of Adults Ages 18-25 have co-occurring AMI + SUD 4.6% of Adults Ages 18-25 have co-occurring SMI + SUD 9.2% of Adults Ages 26-49 have co-occurring AMI + SUD 3.2% of Adults Ages 26-49 have co-occurring SMI + SUD 5.9% of Adults Ages 26+ have co-occurring AMI + SUD 1.9% of Adults Ages 26+ have co-occurring SMI + SUD 3.1% of Adults Ages 50+ have co-occurring AMI + SUD 0.8% of Adults Ages 50+ have co-occurring SMI + SUD 2.7% of adolescents ages 12-17 have co-occurring MDE + SUD 1.8% of adolescents ages 12-17 have co-occurring MDE with severe impairment + SUD • Population data. NC Office of State Budget and Management (NC OSBM), Population Estimates/Projections Data - Sex and Single Years of Age (2000-2050). https://www.osbm.nc.gov/demog/county-projections. Last updated 2/15/22. Downloaded 3/21/22. In NC as of July 2022: Population ages 18+ = 8,382,718 Population ages 12-17 = 807,775 Calculations: Applied the most current available national SUD prevalence rates for adults ages 18+ and adolescents ages 12-17 to the number of people in NC as of July 2022 in the relevant age group: 6.7% x 8,382,718adults ages 18+ = 561,642 have co-occurring AMI + SUD 2.2% x 8,382,718 adults ages 18+ = 184,420 have co-occurring SMI + SUD 2.7% x 807,775 adolescents ages 12-17 = 21,810 have co-occurring MDE + SUD 1.8% x 807,775 adolescents ages 12 -17 = 14,540 have co-occurring MDE with severe impairment + SUD 4. Estimated persons aged 18+ who inject drugs in NC in 2022: 27,184. Data Sources: Prevalence. Estimated Number of People Who Inject Drugs in the United States, Heather Bradley,1Eric W. Hall,2Alice Asher,3Nathan W. Furukawa,3Christopher M. Jones,4Jalissa Shealey,1Kate Buchacz,3Senad Handanagic,3Nicole Crepaz,3and Eli S. Rosenberg,5,6 Clinical Infectious Diseases, 2023;76(1):96–102, Published on-line by Oxford University Press on behalf of Infectious Diseases Society of America, July 6, 2022. (https://pubmed.ncbi.nlm.nih.gov/35791261/) 1Department of Population Health Sciences, Georgia State University School of Public Health, Atlanta, Georgia, USA; 2Oregon Health Sciences University/Portland State University School of Public Health, Portland, Oregon, USA; 3National Center for HIV, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention, Atlanta, Georgia, USA; 4National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Atlanta, Georgia, USA; 5Department of Epidemiology and Biostatistics, University at Albany School of Public Health, SUNY, Albany, New York, USA; and 6Office of Public Health, New York State Department of Public Health, Albany, New York, USA There were

an estimated 3,694,500 People Who Inject Drugs (PWID) in the United States in 2018, representing 1.46% of the adult population. Using transparent, replicable methods and largely publicly available data, the authors provide the first update to the number of people who inject drugs in the United States in nearly 10 years. Findings suggest the population size of PWID has substantially grown in the past decade and that prevention services for PWID should be proportionally increased. • Prevalence. SAMHSA, Center for Behavioral Health Statistics and Quality, Results from the 2020 National Survey on Drug Use and Health: Detailed Tables, October 2021, published 10/25/21, https://www.samhsa.gov/data/report/2020-nsduh-detailed-tables. Table 1.102B Specific Hallucinogen, Inhalant, Needle, and Heroin Use in Lifetime among Persons Aged 12 or Older, by Age Group: Percentages, 2019 and 2020. Needle Use (Heroin, Cocaine, Methamphetamine) Ages 12+ in the US population in 2020 = 2.0% (Lifetime). • Population data. NC Office of State Budget and Management (NC OSBM), Population Estimates/Projections Data - Sex and Single Years of Age (2000-2050). https://www.osbm.nc.gov/demog/county-projections. Last updated 2/15/22. Downloaded 3/21/22. Population in NC as of July 2022: Ages 12+ = 9,190,493 Ages 13+ = 9,061,250 Ages 18+ = 8,382,718 Calculations: State-specific rates for NC not published. Used US rates applied to NC population. Past Year: Applying the past-year PWID rate of 1.46% of the US population ages 18+ to the number of people in NC aged 18+ as of July 2022: 1.46% x 8,382,718 adults aged 18+ = 122,388 estimated persons aged 18+ who inject drugs during the year in NC. Lifetime: The estimated number of persons who inject drugs during their lifetime is: Lifetime: 2.0% x 9,190,493 adolescents and adults aged 12+ = 183,810 estimated persons aged 12+ who inject drugs during their lifetime in NC. 5. Persons experiencing homelessness in NC in 2022 that suffered from chronic Substance Abuse: 933 (9.9%). Data Sources: • On one night during the last week of January 2022, 9,382 people experienced homelessness in NC (8.9 in every 10,000 people). Source: 2022 Annual Homeless Assessment Report to Congress: Part 1 Point-in-Time (PIT) Estimates of Homelessness in the US, Feb 2023, Downloaded 9/5/23. (https://www.hudexchange.info/homelessness-assistance/ahar/#2022-reports) • By Age Group: 1,743 (18.6%) were children and 7,639 (81.4%) were adults. Source: 2007 – 2022 PIT Estimates by State (xlsx) https://www.hudexchange.info/resource/6802/2022-ahar-part-1-pit-estimates-of-homelessness-in-the-us/). • SMI and Chronic Substance Abuse: 1,380 (14.7%) individuals were Severely Mentally Ill (SMI) and 933 (9.9%) suffered from chronic substance abuse. This represents a PIT number rather than an annualized number. Source: HUD 2022 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations for NC, 12/6/22. https://www.hudexchange.info/programs/coc/coc-homeless-populations-and-subpopulations-reports/?filter_Year=&filter_Scope=State&filter_State=NC&filter_CoC=&program=CoC&group=PopSub, Downloaded 9/6/23.

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Footnotes:

Planning Tables

Table 4 SUPTRS BG Planned Expenditures

States must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations, including the supplemental COVID-19 and ARP funds. Plan Table 4 must be completed for the FFY 2024 and FFY 2025 SUPTRS BG awards. The totals for each Fiscal Year should match the President's Budget Allotment for the state.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	FFY 2024		
Expenditure Category	**FFY 2024 SUPTRS BG Award**	**COVID-19 Award[1]**	**ARP Award[2]**
1 . Substance Use Disorder Prevention and Treatment[3]	$37,585,777.00	$10,511,441.00	$5,449,734.00
2 . Substance Use Primary Prevention	$10,471,289.00		
3 . Early Intervention Services for HIV[4]	$0.00		
4 . Tuberculosis Services	$0.00		
5 . Recovery Support Services[5]	$1,988,535.00		
6 . Administration (SSA Level Only)	$2,300,000.00		
7. Total	**$52,345,601.00**	**$10,511,441.00**	**$5,449,734.00**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19

Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the FY 2024 "standard" SUPTRS BG, which is October 1, 2023 - September 30, 2024. The SUPTRS BG ARP planned expenditures for the period of October 1, 2023 - September 30, 2024 should be entered here in the first ARP column, and the SUPTRS BG ARP planned expenditures for the period of October 1, 2024, through September 30, 2025, should be entered in the second ARP column.

[3]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 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 45 CFR § 96.128(b) of the Substance use disorder Prevention and Treatment Block Grant (SUPTRS BG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the AtlasPlus HIV data report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP). The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/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 SUPTRS BG funds with the flexibility to obligate and expend SUPTRS BG funds for EIS/HIV even though the state’s AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SUPTRS BG funds. 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 will be allowed to obligate and expend SUPTRS BG funds for EIS/HIV if they chose to do so and may elect to do so by providing written notification to the CSAT SPO as a part of the SUPTRS BG Application.

[5]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023.

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Footnotes:

Updated per global revision request 05.15.24.

Planning Tables

Table 5a SUPTRS BG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2023   Planning Period End Date: 9/30/2024

	A	B		
Strategy	IOM Target	FFY 2024		
		SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
1. Information Dissemination	Universal	$607,575	$242,852	$245,030
	Selected			
	Indicated			
	Unspecified			
	Total	**$607,575**	**$242,852**	**$245,030**
2. Education	Universal	$911,362	$364,278	$367,545
	Selected	$531,628	$212,496	$214,402
	Indicated	$75,947	$30,357	$30,629
	Unspecified			
	Total	**$1,518,937**	**$607,131**	**$612,576**
3. Alternatives	Universal	$91,136	$36,427	$36,755
	Selected	$53,163	$21,250	$21,440
	Indicated	$7,594	$3,036	$3,063
	Unspecified			
	Total	**$151,893**	**$60,713**	**$61,258**
4. Problem Identification and Referral	Universal			
	Selected	$141,767	$56,666	$57,174
	Indicated	$60,757	$24,285	$24,503
	Unspecified			
	Total	**$202,524**	**$80,951**	**$81,677**
	Universal	$1,265,781	$505,943	$510,480

5. Community-Based Processes	Selected			
	Indicated			
	Unspecified			
	Total	**$1,265,781**	**$505,943**	**$510,480**
6. Environmental	Universal	$1,316,412	$526,180	$530,899
	Selected			
	Indicated			
	Unspecified			
	Total	**$1,316,412**	**$526,180**	**$530,899**
7. Section 1926 (Synar)-Tobacco	Universal	$404,174		
	Selected			
	Indicated			
	Unspecified			
	Total	**$404,174**	**$0**	**$0**
8. Other	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$5,467,296**	**$2,023,770**	**$2,041,920**
Total SUPTRS BG Award[3]		**$52,345,601**	**$10,511,441**	**$5,449,734**
Planned Primary Prevention Percentage		**10.44%**	**19.25%**	**37.47%**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

Footnotes:

Planning Tables

Table 5b SUPTRS BG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Activity	FFY 2024 SUPTRS BG Award	FFY 2024 COVID-19 Award[1]	FFY 2024 ARP Award[2]
Universal Direct	$1,002,498	$400,705	$404,300
Universal Indirect	$3,593,942	$1,274,975	$1,286,409
Selected	$726,558	$290,412	$293,016
Indicated	$144,298	$57,678	$58,195
Column Total	**$5,467,296**	**$2,023,770**	**$2,041,920**
Total SUPTRS BG Award[3]	**$52,345,601**	**$10,511,441**	**$5,449,734**
Planned Primary Prevention Percentage	**10.44%**	**19.25%**	**37.47%**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the “standard” MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 1, 2025**, which is different from the expenditure period for the “standard” SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Footnotes:

Planning Tables

Table 5c SUPTRS BG Planned Primary Prevention Priorities (Required)

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2024 and FFY 2025 SUPTRS BG awards.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
Prioritized Substances			
Alcohol	✓	✓	✓
Tobacco	✓	✓	✓
Marijuana	✓	✓	✓
Prescription Drugs	✓	✓	✓
Cocaine	✓	✓	✓
Heroin	✓	✓	✓
Inhalants	✓	✓	✓
Methamphetamine	✓	✓	✓
Fentanyl	✓	✓	✓
Prioritized Populations			
Students in College	✓	✓	✓
Military Families	✓	✓	✓
LGBTQI+	✓	✓	✓
American Indians/Alaska Natives	✓	✓	✓
African American	✓	✓	✓

Hispanic	☑	☑	☑
Persons Experiencing Homelessness	☑	☑	☑
Native Hawaiian/Other Pacific Islanders	☑	☑	☑
Asian	☑	☑	☑
Rural	☑	☑	☑
Underserved Racial and Ethnic Minorities	☑	☑	☑

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

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Footnotes:

Planning Tables

Table 6 Non-Direct-Services/System Development

Please enter the total amount of the SUPTRS BG, COVID-19, or ARP funds expended for each activity.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Expenditure Category	FFY 2024				
	A. SUPTRS BG Treatment	B. SUPTRS BG Prevention	C. SUPTRS BG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems	$127,500.00				
2. Infrastructure Support	$1,371,703.00	$453,530.00		$363,655.00	
3. Partnerships, community outreach, and needs assessment	$450,000.00	$521,627.00		$346,000.00	$929,060.00
4. Planning Council Activities (MHBG required, SUPTRS BG optional)	$0.00				
5. Quality Assurance and Improvement	$142,153.00				
6. Research and Evaluation	$142,154.00	$776,481.00			
7. Training and Education	$5,572,286.00	$3,252,355.00		$1,750,622.00	$287,100.00
8. Total	**$7,805,796.00**	**$5,003,993.00**	**$0.00**	**$2,460,277.00**	**$1,216,160.00**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the federal planned expenditure period of October 1, 2023 - September 30, 2025. Please list ARP planned expenditures for each standard FFY period.

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Footnotes:

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required

Narrative Question

Across the United States, significant percentages of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not access needed behavioral health care. States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001**; **https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983**. The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1]Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. States should develop systems that vary the intensity of care coordination support based on the severity seriousness and complexity of individual need. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:

a) Adults with serious mental illness

b) Pregnant women with substance use disorders

c) Women with substance use disorders who have dependent children

d) Persons who inject drugs

e) Persons with substance use disorders who have, or are at risk for, HIV or TB

f) Persons with substance use disorders in the justice system

g) Persons using substances who are at risk for overdose or suicide

h) Other adults with substance use disorders

i) Children and youth with serious emotional disturbances or substance use disorders

j) Individuals with co-occurring mental and substance use disorders

Please see the MHBG for additional details on adults with SMI and children with SED.
While the Division supports access to services for priority populations, all individuals with an SUD are prioritized for connection to care within 48 hours of seeking services through our contractual agreement with the six LME/MCOs.
North Carolina implemented an Assertive Engagement service in April 2023 to provide outreach to adults and/or children who have mental health and/or substance use needs with functional impairments substantial enough to interfere with their ability to initiate or engage in necessary services and supports, and who have not effectively engaged with treatment services. Assertive Engagement can be a necessary step in the process of effectively treating these illnesses by identifying and offering what is necessary to establish a trusting relationship and to meet initial needs. Initial needs may include: shelter, food, clothing, transportation, and/or arrangement for acute medical care. Successful engagement is the first necessary step in the process that leads to rehabilitation and recovery. Assertive Engagement allows flexibility to meet the individual's particular needs in their own environment or other current location (i.e., home, hospitals, jails/prisons, shelters, streets, etc.). Assertive Engagement is designed as a short-term engagement service targeted to populations or specific individual circumstances that prevent the individual from fully participating in needed care for mental health and/or substance use. Assertive Engagement provides the flexibility to make contact with the individual while in a state or local hospital, inpatient psychiatric facility, crisis facility, withdrawal management facility, youth detention center, hospital emergency department, unsheltered or unhoused locations or encampments, in a shelter, or jails/prisons for the purposes of engagement. Assertive Engagement can and should be used until the individual is engaged with a provider for ongoing services.

NC is also implementing Comprehensive Case Management (CCM) for Adult Mental Health/Adult Substance Use. This is a 24/7 service for adults with either a primary mental health or primary substance use disorder, or co-occurring MH/SU/IDD/ TBI diagnosis, in addition to other designated eligibility criteria, who would benefit from time-limited case management assistance to access necessary behavioral health, physical health, health-related, and social services. The individual will receive their first CCM visit in the community to begin the hands-on case management services within 24 hours of receiving the referral.

In 2019, DMHDDSUS began working in collaboration with the Division of Health Benefits to implement the 1115 SUD Demonstration Waiver (approved by the Center for Medicare and Medicaid Services) that provided an avenue for NC to enhance the SUD continuum of services to address the opioid epidemic and other substance use disorder treatment needs. As a result, the Divisions have been working in coordination to update existing substance use disorder clinical polices and developing new policies missing from the NC SUD array of services. NC has utilized the American Society of Addiction Medicine Criteria (ASAM) as the standard of care for substance use disorder treatment services for over 20 years. Twelve of the existing state-funded SUD services are being updated to reflect the current ASAM Criteria and there are four new types and/or levels of care in development. Some key policy elements include:
• Prior Authorization: All services including withdrawal management and residential will include pass through units (unmanaged visits) to ensure timely access and reduce barriers.
• MAT Access: State-funded (including SUPTRS funded) services must provide or make provision for medication assisted treatment at all levels of care.
• Peer Support Specialist Services: Peer support services will be included in the service (staffing) or included as an allowable billable community-based service.
• Mental Health Services: All programs will be expected to access mental health services that cannot directly be provided by the program staff based on client needs.
Of note, the Division will be implementing Screening, Brief Intervention and Referral to Treatment (SBIRT), which includes MDs, physician extenders and all licensed professionals who can independently bill this service. Expanded place of service will include schools, shelters and other community settings. The implementation of this new service will provide an additional means for identifying substance misuse or disorders and referring individuals (including adolescents) for additional assessment and/or care.

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance parity enforcement and increase awareness of parity protections among the public and across the behavioral and general health care fields.

Parity requires health plans that cover Mental Health or Substance Use Disorder services to provide the same level of coverage for those services as is provided for physical health care services, with respect to the following:
• Annual and lifetime limits on coverage;
• Financial requirements: deductibles, co-payments, coinsurance, out-of-pocket expenses;
• Treatment limitations: limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment; and
• Availability of coverage for benefits provided by out-of-network providers.
In NC, there are two sections in the state insurance law about parity specific to mental health condition and substance use disorders. There is also a section in the state law for state employees that is relevant to parity. There is another section that forbids plans from discriminating against people with behavioral health conditions in their physical health treatment.
This section of the law applies to large employer fully-insured plans and small employer fully-insured plans and requires requires plans to use financial requirements, annual maximums, and lifetime maximums for mental health services that
are "no less favorable" than those used for other medical services. However, if plans use many different forms of these for varying physical health services, the Commissioner of the North Carolina Department of Insurance may use a mathematical formula to determine what they should be for mental health treatment.
For treatment of the following conditions, annual limits have to be the same as those used for treatment of other medical conditions:
Bipolar Disorder
Major Depressive Disorder

Obsessive Compulsive Disorder
Paranoid and Other Psychotic Disorder
Schizoaffective Disorder
Schizophrenia
Post-Traumatic Stress Disorder
Anorexia Nervosa
Bulimia
For all other mental health conditions in the DSM (except for substance use disorders), plans must cover 30 office visits for outpatient care and 30 days of inpatient care or a combination of inpatient care and outpatient care that could be measured in days (like partial hospitalization).

This section specific to substance use disorders requires large employer fully-insured plans and small employer fully-insured plans to offer optional coverage for substance use disorder services. Employers are not required to choose a plan that includes this coverage. The section requires that plans use annual limits, deductibles, and coinsurance for substance use disorder services that are "not less favorable" than those used for other medical services.

Plans are required to have an annual maximum of at least $8,000 and a lifetime maximum of $16,000.
Large employer fully-insured plans are required to comply with the Federal Parity Law.

If a patient or provider believes a health plan is violating the law or isn't administering the health plan according to the contract, they should file a complaint with the North Carolina Department of Insurance or call for consumer assistance at 855-408-1212.

3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

Although not a Medicaid expansion state at the time of this writing, in October 2018, CMS approved North Carolina's 1115 Demonstration Waiver application, which is effective 10.01.19 through 10.31.24. This waiver allows DHHS to implement managed care and phase certain populations into managed care over time. Under this waiver, North Carolina has the authority to incorporate several innovative features which will further the state's commitment to improving the well-being of individuals through a well-coordinated system of care that addresses both medical and non-medical drivers of health.
Additionally, North Carolina submitted and was approved for an 1115 SUD Demonstration Waiver that expands benefits to offer the complete ASAM continuum, waive IMD exclusion for SUD services, ensure providers' services meet evidence-based program and licensure standards, build SUD provider capacity, strengthen care coordination and care management for the SUD population and improve the prescription drug monitoring program.
Additionally, through the SUBG COVID-19 Supplemental funding, North Carolina began initiatives with over 20 federally qualified health centers (FQHCs) and community health centers for individuals with opioid use disorders. Primary objectives of these pilots include the provision of medication for opioid use disorders in non-traditional, less stigmatized settings, in conjunction with physical and medical health care for this uninsured population.

4. Describe how the state provides care coordination, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness

b) Adults with substance use disorders

c) Children and youth with serious emotional disturbances or substance use disorders

Care coordination functions are required through the Division's current contract with the LME/MCOs. Per the contract, the LME/MCO shall provide Care Coordination for high cost/high risk consumers in accordance with the requirements of N.C.G.S. §122C-115.4(b)(5). Clinical functions of care coordination shall be carried out by licensed care coordination staff for MH/SU Care Coordination or by Qualified Professionals for Care Coordination for consumers with Intellectual/Developmental Disabilities as defined at 10A NCAC 27G .0104(19). Administrative care coordination functions may be carried out by non-licensed staff working in a consultative role with the clinical care coordination staff. Care Coordinators for the child/youth MH/SU population shall be trained in system of care principles, child and family team training and family-driven, youth-guided foundational elements.

The LME/MCO will collaborate with the discharging facility to schedule follow-up appointments for consumers who have been provided services in inpatient hospital units, facility based crisis services, and non-hospital medical detoxification services within seven (7) calendar days of discharge. The LME/MCO will attempt to contact consumers who do not attend scheduled appointments within five (5) calendar days of the missed appointment.

The LME/MCO shall have a written plan for addressing care coordination needs, including definition of priority populations, levels and types of care coordination tasks, referral pathways to and from medical care managers, other referral sources and resources, and objective outcome measures for care coordination effectiveness.

Care coordination services are prioritized for certain populations including those being discharged inpatient settings and those that are high utilizers of services. Additionally LME/MCOs must provide one dedicated FTE to provide care coordination to individuals identified by the Department of Adult Corrections (DAC) as having severe mental illness and in need of care coordination upon re-entry from a detention facility.

5. Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

The state provides services and supports towards integrated care for individuals families with co-occurring mental health and substance use disorders through federal funds (i.e., Medicaid, Block Grant, discretionary grants) and state funds. Clinical Coverage Policy 8-C requires that all comprehensive clinical assessments include information on an individual's chronological general medical health history and current issues, as well as current medications for physical conditions. These assessment requirements are applicable to all consumers and adherence is reviewed and monitored regularly.

Additionally, Evaluation and Management (E&M) codes have been approved by the Division for many years and allow various levels and types of health screenings. These services are particularly critical for individuals participating in medication assisted treatment and as such are provided by physicians, PAs and NPs in all opioid treatment programs.

The state also has continued the integration of mental health, SUD and physical health needs under the Promoting Integration Primary Behavioral Health Care (PIPBHC) grant. NC is also the recipient of a Certified Community Behavioral Health Clinics (CCBHC) planning grant and and awarded $20 million in funding to five community-based agencies to expand access to evidence-based, integrated behavioral and physical health care in their communities under the CCBHC model. CCBHCs provide comprehensive, integrated services that support individuals with SMI,SED and co-occurring SMI or SED and Substance Use Disorder. Services include:
24/7 crisis intervention services
Outreach, screening and assessment
Person-centered treatment planning
Evidence-based treatment and recovery supports
Integrated behavioral and physical health care
Care coordination with primary care providers, hospitals and other medical providers
Connections with other providers and public service systems

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

None at this time.

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Required

Narrative Question

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[1], **Healthy People, 2030**[2], **National Stakeholder Strategy for Achieving Health Equity**[3], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) 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 **Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[4].

Collecting appropriate data are a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[5]. 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[6]. 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, LGBTQI+ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD 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 populations 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. In addition, LGBTQI+ individuals are at higher risk for suicidality due to discrimination, mistreatment, and stigmatization in society. 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 and is 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.

[1] **https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf**

[2] **https://health.gov/healthypeople**

[3] **https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf**

[4] **https://thinkculturalhealth.hhs.gov/**

[5] **https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status**

[6] **https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf**

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race ● Yes ○ No

b) Ethnicity ● Yes ○ No

c) Gender ● Yes ○ No

d) Sexual orientation ● Yes ○ No

e) Gender identity ○ Yes ● No

f) Age ● Yes ○ No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? ● Yes ○ No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ● Yes ○ No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? ○ Yes ● No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services (CLAS) Standards? ○ Yes ● No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ● Yes ○ No

7. Does the state have any activities related to this section that you would like to highlight?

There are initiatives underway to better assure a workforce that is illustrative of our population demographics through scholarship opportunities in Criteria C schools for students of color pursuing a career in SUD counseling, as well as targeted growth of collegiate recovery programs in Historically Black Colleges and Universities (HBCUs). Efforts to develop resources in marginalized and traditionally under-served communities are also underway, particularly through expansion of MOUD/MAT opportunities in OBOT and FQHC and community health center settings.
Through population data in each community, the State Opioid Treatment Authority (SOTA) is identifying disparities in access to OTP services by African American, Hispanic and homeless populations. This information is provided to the OTPs to strategize about how to address these disparities in their service delivery planning. One of the responsibilities in the proposed Opioid Treatment Service policy for the Program Director includes their role in community outreach and engagement with other community providers as well as law enforcement to ensure access and coordination of care. There are also efforts by the SOTA to support OTPs in their collaboration with local jails to ensure access to individuals with an OUD for induction and maintenance on MOUD (medication for opioid use disorder) and coordination of care upon discharge.

Please indicate areas of technical assistance needed related to this section

None at this time.

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value-based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services. The **National Center of Excellence for Integrated Health Solutions**[1] offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence for the efficacy and value of various mental and substance use prevention, SUD 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 IOM/NASEM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center (EBPRC) assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's EBPRC provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build 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[2], The New Freedom Commission on Mental Health[3], the IOM, NQF, and the **Interdepartmental Serious Mental Illness Coordinating Committee** (ISMICC)[4].

One activity of the EBPRC[5] was 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."[6] SAMHSA and other HHS federal partners, including the Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[7] are best practice guidelines for the SUD treatment. SAMHSA 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 SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[8] was developed to help move the latest information available on effective M/SUD 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 M/SUD practices that work. Each KIT 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, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services.

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[1] **https://www.thenationalcouncil.org/program/center-of-excellence/**

[2] 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

[3] 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 use disorder and Mental Health Services Administration.

[4] National Quality Forum (2007). *National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices*. Washington, DC: National Quality Forum.

[5] **https://www.samhsa.gov/ebp-resource-center/about**

[6] **http://psychiatryonline.org/**

[7] **http://store.samhsa.gov**

[8] **https://store.samhsa.gov/?f%5B0%5D=series%3A5558**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? ○ Yes ○ No

2. Which value based purchasing strategies do you use in your state (check all that apply):

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 and non-financial incentives for providers or consumers.

d) ☐ Provider involvement in planning value-based purchasing.

e) ☐ Use of accurate and reliable measures of quality in payment arrangements.

f) ☐ Quality measures focused on consumer outcomes rather than care processes.

g) ☐ Involvement in CMS or commercial insurance value-based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).

h) ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

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

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Footnotes:

Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

SAMHSA has 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.

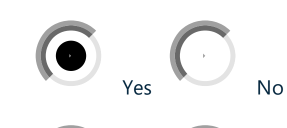
While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SUPTRS BG 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 made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify 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 SUPTRS BG funds are allocated to support evidence-based, culturally competent programs, substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SUPTRS BG. 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 M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have 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 respond to the following:

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



2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?

3. Does the state have any activities related to this section that you would like to highlight?

The monitoring requirements for DMHDDSUS provide methods to ensure that State, SUBG and other federal funds are utilized appropriately, in accordance with statutory and regulatory framework, and in support of programmatic goals. The procedures and practices include requirements for the completion of annual performance and financial audits, in addition to the active monitoring that occurs throughout the fiscal year. Any identified risks or issues are addressed via technical assistance, plans of correction and/or other elevated action.
The Program Integrity procedures for DMHDDSUS are incorporated into the Service System Integrity plan. The Service System Integrity plan promotes the following principles:
• Promote a cost efficient and effective behavioral health care system.
• Ensure adherence to statutory and regulatory standards and practices.
• Develop and monitor communication methods, training and technical assistance regarding service system integrity.
• Support appropriate strategies and approaches to carrying out effective Service System Integrity efforts.
• Proactively recognize areas of risk that may adversely affect Service System Integrity and proactively address vulnerabilities.
• Fair and reasonable enforcement of system integrity monitoring. Failure to comply with system integrity efforts may result in

plans of correction or other actions.

Please indicate areas of technical assistance needed related to this section

None at this time.

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Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

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**[56] 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 approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

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.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

2. What specific concerns were raised during the consultation session(s) noted above?

3. Does the state have any activities related to this section that you would like to highlight?

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

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Footnotes:

Environmental Factors and Plan

8. Primary Prevention - Required SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states 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 misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification and Referral*** that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Processes*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)?

(●) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply)

(●) Yes ( ) No

a) [x] Data on consequences of substance-using behaviors

b) [x] Substance-using behaviors

c) [x] Intervening variables (including risk and protective factors)

d) [x] Other (please list)

In an effort to understand disparities among under-served populations, data collection includes social determinants of health and community ACEs indicators.

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

a) [x] Children (under age 12)

b) ☑ Youth (ages 12-17)

c) ☑ Young adults/college age (ages 18-26)

d) ☑ Adults (ages 27-54)

e) ☑ Older adults (age 55 and above)

f) ☑ Cultural/ethnic minorities

g) ☑ Sexual/gender minorities

h) ☑ Rural communities

i) ☐ Others (please list)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

a) ☑ Archival indicators (Please list)

School report card data, ED data, Drug-related crashes and fatalities, overdose death and reversals, unemployment,

b) ☐ National survey on Drug Use and Health (NSDUH)

c) ☐ Behavioral Risk Factor Surveillance System (BRFSS)

d) ☑ Youth Risk Behavioral Surveillance System (YRBS)

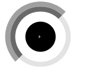
e) ☐ Monitoring the Future

f) ☐ Communities that Care

g) ☑ State - developed survey instrument

h) ☐ Others (please list)

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds?

 Yes No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based?

The criteria used include outcomes associated with a reduction of use and/or intentions to use ATOD, and/or information published in a peer reviewed journal. The Prevention team works with researchers from Wake Forest University and Pacific Research Institute (PIRE) to help review research and outcomes associated with potential prevention strategies. The current approved prevention strategies reflect interventions that demonstrate strong evidence positive outcomes associated with substance use reduction and intentions to use.

b) If no, (please explain) how SUPTRS BG funds are allocated:

6. Does your state integrate the National CLAS standards into the assessment step?

Yes No

a) If yes, please explain in the box below.

b) If no, please explain in the box below.

The CLAS standards have not been explicitly incorporated into the community assessment process. However, several standards have been addressed through processes recommended to identify disparities and promote equity, as well guidance regarding why and how to work with community partners in identifying community needs and capacity.

7. Does your state integrate sustainability into the assessment step?

Yes No

a) If yes, please explain in the box below.

Yes, sustainability is integrated into community assessment in three primary ways. First, in identifying high concern substances, communities are guided to assess the degree that substance misuse behaviors and related problems are changeable, including criteria such as are strategies currently available to address the behavior or problem, and are these strategies sustainable. Second, communities are guided through processes to determine if an intervening variable is changeable, and also if addressing it might impact multiple behaviors and problems. This includes whether strategies are available to address the behavior or problem, how many people they are likely to reach at what cost, and how great of an effect is likely to be achieved. And finally, sustainability is explicitly addressed as a part of the processes to address community capacity.

b) If no, please explain in the box below.

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states 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 misuse. The program must include, but is not limited to, the following strategies:

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Planning

1. Does your state have a statewide licensing or certification program for the substance use primary prevention workforce?

Yes No

a) If yes, please describe.

Yes, the North Carolina Addictions Specialist Professional Practice Board is the certifying body for substance use disorder professionals in NC including SUD prevention workforce. The became a duly chartered corporation in August 1984, and was granted statutory status by N.C.G.S. 90-113.30 of 1994. It was reorganized under the NC General Assembly in January 2020. The mission of the Board "to protect the public health, safety, and welfare; to protect the public from being harmed by unqualified persons; and to assure the highest degree of professional care and conduct on the part of credentialed substance use disorder professionals".

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use primary prevention workforce?

Yes No

a) If yes, please describe mechanism used.

Yes. The state has formed a Statewide Prevention Support Consortium (SPSC) that consists of training and technical assistance agencies, discretionary grant leads, prevention assessment and evaluation institutions, and other statewide prevention resources. The consortium ensures the effective implementation of high-quality prevention services, delivered in alignment with state business policies for the prevention system. Partners within the consortium supports the state and local providers through the provision of training in evidence-based programs, policies and practices; developing CSAP Six strategies best practice guidance; training and technical support in conducting local needs assessment and strategic planning; supporting process and outcome evaluation efforts; workforce development that supports credentialing and local capacity building efforts.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies?

Yes No

a) If yes, please describe mechanism used.

Yes, the state works with the North Carolina Training and Technical Assistance Center and Wake Forest University to assess community readiness as part of the needs assessment process conducted every three years.

4. Does your state integrate the National CLAS Standards into the capacity building step?

Yes No

a) If yes, please explain in the box below.

5. Does your state integrate sustainability into the capacity building step?

Yes No

a) If yes, please explain in the box below.

Yes, the state works with the SPSC to provide training and technical assistance that supports local providers as well as statewide prevention entities in integrating sustainability into their capacity building efforts.

b) If no, please explain in the box below.

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Planning

1. Does your state have a strategic plan that addresses substance use primary prevention that was developed within the last five years?

○ Yes ● No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SUPTRS BG?

○ Yes ○ No ● N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

a) ☐ Based on needs assessment datasets the priorities that guide the allocation of SUPTRS BG primary prevention funds

b) ☐ Timelines

c) ☐ Roles and responsibilities

d) ☐ Process indicators

e) ☐ Outcome indicators

f) ☐ Cultural competence component (i.e., National CLAS Standards)

g) ☐ Sustainability component

h) ☐ Other (please list):

i) ☑ Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? (●) Yes ( ) No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? (●) Yes ( ) No

a) If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

The criteria used include outcomes associated with a reduction of use and/or intentions to use ATOD, and/or information published in a peer reviewed journal. The Prevention team works with researchers from Wake Forest University and Pacific Research Institute (PIRE) to help review research and outcomes associated with potential prevention strategies. The current approved prevention strategies reflect interventions that demonstrate strong evidence positive outcomes associated with substance use reduction and intentions to use.

6. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? (●) Yes ( ) No

7. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? (●) Yes ( ) No

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8. Does your state integrate the National CLAS Standards into the planning step? ( ) Yes (●) No

a) If yes, please explain in the box below.

N/A

b) If no, please explain in the box below.

The CLAS standards have not been explicitly incorporated into the planning process. However, several standards have been addressed through processes recommended to identify disparities and promote equity. Diversity and equity are at the forefront of all planning efforts to ensure the needs of diverse communities and populations are met.

9. Does your state integrate sustainability into the planning step? (●) Yes ( ) No

a) If yes, please explain in the box below.

Yes, sustainability is incorporated into planning processes. Prevention planning considers how strategies and desired outcomes can be sustained long-term. This includes but are not limited to ensuring sufficient organization and community capacity to achieve position outcomes; formal partnerships; community support; effective implementation/fidelity to EBP strategies; cultural alignment; and adequate reach.

b) If no, please explain in the box below.

N/A

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Implementation

1. States distribute SUPTRS BG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☐ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☑ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☑ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☑ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☐ The SSA funds regional entities to provide prevention services.
- **f)** ☐ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☑ The SSA funds community coalitions to provide prevention services.
- **h)** ☑ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☑ The SSA directly funds other state agency prevention programs.
- **j)** ☐ Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SUPTRS BG primary prevention dollars

in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

Health fairs and other health promotion, e.g., conferences, meetings, seminars
Prevention focused websites, email blasts, and newsletters
Radio & TV public service announcements
Speaking engagements/community presentations

b) Education:

All Stars
All Stars Jr
AVOID
Catch My Breath
Celebrating Families
(Will be discontinued in FY 2022)
Guiding Good Choices
HALO (Healthy Alternatives for Little Ones)
Life Skills Training (LST)
Media Detective
Media Ready
Mentoring Support
Parent & Family Management Planning
Parent and Family Management Support
Prime For Life
(Will be discontinued in FY 2022)
Project ALERT
Project SUCCESS
Project Towards No Drug Abuse
Project Venture
Reconnecting Youth
Safe Dates
Second Steps
STEP
Storytelling for Empowerment
Strengthening Families (10-14)
Strong African American Families
Too Good for Drugs
Triple P Level 4
Unique You

c) Alternatives:

Drug free dances and parties.
Recreation Activities
Youth Leadership Development

d) Problem Identification and Referral:

Educational interventions primarily for youth referred due to school alcohol and drug policy violations.

e) Community-Based Processes:

Coalition/Task Force/Collaborative/Meetings
System Needs Assessment and Strategic Planning
State Level Workgroup
Sustainability Planning/Leveraging Resources
Communities Mobilizing for Change on Alcohol

f) Environmental:

Communication Campaigns: Social Norms
Communication Campaigns: Support for Prevention
Environmental Strategies Planning
Establishing, reviewing, or changing community and/or workplace ATOD policies
Establishing, reviewing, or changing school ATOD policies
Youth environmental management strategies
Publicized sobriety checkpoints
Responsible Beverage Service Training
Retailer alcohol compliance checks
Secure Alcohol Storage
Social Host

Talk it up. Lock it up.?
Festival/Event ATOD Restriction
Safe Stores
Lock Your Meds
Safer Prescriber Training
Secure Medication Storage and Safe Disposal
Synar

3. Does your state have a process in place to ensure that SUPTRS BG dollars are used only to fund primary prevention services not funded through other means?

Yes No

a) If yes, please describe.

We meet regularly with contractors, providers and LMEs to discuss allowable activities and meet monthly with our state budget office to discuss expenditures.

4. Does your state integrate National CLAS Standards into the implementation step?

Yes No

a) If yes, please describe in the box below.

N/A

b) If no, please explain in the box below.

The CLAS standards have not been explicitly incorporated into the implementation phase. However, several standards have been addressed through processes recommended to identify disparities and promote equity. Diversity and equity are at the forefront of all implementation efforts to ensure the needs of diverse communities and populations are met.

5. Does your state integrate sustainability into the implementation step?

Yes No

a) If yes, please describe in the box below.

Yes, sustainability is incorporated into implementation processes. Prevention implementation considers how strategies and desired outcomes can be sustained long-term. This includes but are not limited to ensuring sufficient organization and community capacity to achieve position outcomes; formal partnerships; community support; effective implementation/fidelity to EBP strategies; cultural alignment; and adequate reach.

b) If no, please explain in the box below

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use primary prevention that was developed within the last five years?

( ) Yes (•) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan.

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

a) [ ] Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks

b) [ ] Includes evaluation information from sub-recipients

c) [ ] Includes SAMHSA National Outcome Measurement (NOMs) requirements

d) [ ] Establishes a process for providing timely evaluation information to stakeholders

e) [ ] Formalizes processes for incorporating evaluation findings into resource allocation and decision-making

f) [ ] Other (please list:)

g) [x] Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SUPTRS BG funded prevention services:

a) [x] Numbers served

b) [x] Implementation fidelity

c) [x] Participant satisfaction

d) [x] Number of evidence based programs/practices/policies implemented

e) [x] Attendance

f) [x] Demographic information

g) [ ] Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SUPTRS BG funded prevention services:

a) [x] 30-day use of alcohol, tobacco, prescription drugs, etc

b) [ ] Heavy use

c) [ ] Binge use

d) [x] Perception of harm

e) [x] Disapproval of use

f) [x] Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

g) [ ] Other (please describe):

5. Does your state integrate the National CLAS Standards into the evaluation step? ( ) Yes (•) No

a) If yes, please explain in the box below.

N/A

b) If no, please explain in the box below.

The CLAS standards have not been explicitly incorporated into the evaluation phase. However, several standards have been addressed through processes recommended to identify disparities and promote equity. Diversity and equity are at the forefront of all evaluation efforts to ensure the needs of diverse communities and populations are met.

6. Does your state integrate sustainability into the evaluation step? (•) Yes ( ) No

a) If yes, please describe in the box below.

Yes, sustainability is incorporated into evaluation processes. Prevention planning considers how strategies and desired outcomes can be sustained long-term. This includes but are not limited to effective implementation/fidelity to EBP strategies; cultural alignment; and adequate reach.

b) If no, please explain in the box below.

Footnotes:

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SUPTRS BG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

		Yes	No
i)	Screening	●	○
ii)	Education	●	○
iii)	Brief Intervention	●	○
iv)	Assessment	●	○
v)	Detox (inpatient/residential)	●	○
vi)	Outpatient	●	○
vii)	Intensive Outpatient	●	○
viii)	Inpatient/Residential	●	○
ix)	Aftercare; Recovery support	●	○

b) Services for special populations:

		Yes	No
i)	Prioritized services for veterans?	●	○
ii)	Adolescents?	●	○
iii)	Older Adults?	○	●

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? — (●) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? — (●) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? — (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? — (●) Yes ( ) No

5 Has your state identified a need for any of the following:

- **a)** Open assessment and intake scheduling — ( ) Yes (●) No
- **b)** Establishment of an electronic system to identify available treatment slots — (●) Yes ( ) No
- **c)** Expanded community network for supportive services and healthcare — ( ) Yes (●) No
- **d)** Inclusion of recovery support services — ( ) Yes (●) No
- **e)** Health navigators to assist clients with community linkages — ( ) Yes (●) No
- **f)** Expanded capability for family services, relationship restoration, and custody issues? — ( ) Yes (●) No
- **g)** Providing employment assistance — ( ) Yes (●) No
- **h)** Providing transportation to and from services — ( ) Yes (●) No
- **i)** Educational assistance — ( ) Yes (●) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

Annual monitoring of the SUBG Women's Set-Aside programs;
2. Annual cross-site evaluation submission by statewide perinatal and maternal substance use initiative programs;
3. Review of NC TOPPS reporting;
4. Training and technical assistance;
5. Completion by LME-MCOs and review by staff of the SUBG Semi-Annual Compliance Reports; and
6. Weekly Program Managers COVID Check In Conference Calls since April 2020.

In addition to the Division's policy on plans of correction, the following are applicable:
• The North Carolina Perinatal and Maternal and CASAWORKS programs submit annual cross site reports that include narrative responses to block grant related criteria/questions and aggregate data that provides demographic information on the populations they serve. These reports are submitted in the first quarter following the SFY completion. They are then reviewed by

the Women's Substance Use Coordinator and the evaluation staff. If there are gaps or questions arising from these reviews, program managers are contacted directly for additional information or clarification. After these one to one contacts by phone and/or email, data forms are updated and report reviews are completed. When global issues arise not specific to just one program, they are addressed in conference calls and face to face meetings with the Women's Coordinator and the evaluation staff. Additional information such as focus groups or responses to questions from DMHDDSUS based on emerging issues, and/or additional information that the program deemed valuable to gather for their own quality improvement are reviewed. This information helps inform efforts, but is not rated since it is not part of the block grant requirements. Reporting forms with demographic data are combined and summary statistics are used by the Division.

• NCTOPPS reporting is reviewed as a part of the annual monitoring reviews to ensure submissions are timely and complete. Additionally, the program evaluator, on at least a bi-annual basis, receives a download of the NC TOPPS data and provides direct follow up with the program administrator if there are any inconsistencies with the data reporting. The program evaluator works with the program administrator to correct any data related issues.

• Division staff review the Semi Annual Block Grant Compliance Reports and request clarification or re-submission for any out of compliance concerns.

• Weekly conference calls with statewide perinatal, maternal & CASAWORKS program managers to address COVID cases, protocols, resources, policies and other technical assistance. This call is also utilized for programs to update the State on a weekly basis regarding any programmatic challenges or technical assistance needs.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

		Yes	No
a)	90 percent capacity reporting requirement	●	○
b)	14-120 day performance requirement with provision of interim services	●	○
c)	Outreach activities	●	○
d)	Syringe services programs, if applicable	●	○
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	●	○

2. Has your state identified a need for any of the following:

		Yes	No
a)	Electronic system with alert when 90 percent capacity is reached	●	○
b)	Automatic reminder system associated with 14-120 day performance requirement	○	●
c)	Use of peer recovery supports to maintain contact and support	○	●
d)	Service expansion to specific populations (e.g., military families, veterans, adolescents, LGBTQI+, older adults)?	○	●

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

1. Review of mandatory reporting measures of LME-MCOs, including the requirement to treat individuals with an SUD as "urgent," therefore requiring appointments for care within 48 hours of a call coming in to the LME/MCO's 24/7/365 crisis, screening, triage and referral helpline. LME/MCOs are also required connect individuals being discharged from an inpatient setting within seven days of discharge.
2. Annual monitoring of all SUBG-funded services.
3. Semi-Annual SUBG Compliance Reports are completed by LME-MCOs and reviewed by Division staff to assure compliance.
4. Monthly calls with LME-MCO clinical leadership staff to discuss challenges, barriers and successes.

It should be noted that compliance with the 90% capacity reporting requirement is specific to opioid treatment programs across North Carolina. All (currently 86) are required participate in a management/central registry program through a contracted vendor that provides daily census data. Although the majority of PWID are receiving services through one of the 86 programs, individuals who elect to receive clinical services other than medication-assisted treatment would not be captured under this system.

Tuberculosis (TB)

		Yes	No
1.	Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery?	●	○

2. Has your state identified a need for any of the following:

a) Business agreement/MOU with primary healthcare providers — Yes ( ) No (•)

b) Cooperative agreement/MOU with public health entity for testing and treatment — Yes ( ) No (•)

c) Established co-located SUD professionals within FQHCs — Yes ( ) No (•)

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

1. Annual monitoring of all SUBG-funded services.
2. Semi-Annual SUBG Compliance Reports are completed by LME/MCOs and reviewed by Division staff to assure compliance.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring such service delivery? — Yes ( ) No ( )

2. Has your state identified a need for any of the following:

a) Establishment of EIS-HIV service hubs in rural areas — Yes ( ) No ( )

b) Establishment or expansion of tele-health and social media support services — Yes ( ) No ( )

c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS — Yes ( ) No ( )

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SUPTRS BG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)F)? — Yes (•) No ( )

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? — Yes (•) No ( )

3. Do any of the programs use SUPTRS BG funds to support elements of a Syringe Services Program? — Yes (•) No ( )

If yes, plese provide a brief description of the elements and the arrangement

SUBG treatment funds have been used to purchase naloxone to be distributed to individuals at risk for opioid overdose.
Naloxone
has been deployed to various organizations, including opioid treatment programs, syringe service programs and other community organizations that have contact with or provide services to individuals who use opioids.

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement

Yes No

2. Has your state identified a need for any of the following:

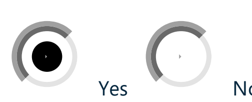
a) Workforce development efforts to expand service access

Yes No

b) Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services

Yes No

c) Establish a peer recovery support network to assist in filling the gaps


Yes No

d) Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities)

Yes No

e) Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations

Yes No

f) Explore expansion of services for:

i) MOUD

Yes No

ii) Tele-Health

Yes No

iii) Social Media Outreach

Yes No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered and person-directed care?

Yes No

2. Has your state identified a need for any of the following:

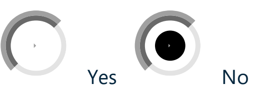
a) Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services

Yes No

b) Establish a program to provide trauma-informed care

Yes No

c) Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education


Yes No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)?

Yes No

2. Does your state provide any of the following:

a) Notice to Program Beneficiaries — Yes ○ No ●

b) An organized referral system to identify alternative providers? — Yes ● No ○

c) A system to maintain a list of referrals made by religious organizations? — Yes ○ No ●

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — Yes ○ No ●

2. Has your state identified a need for any of the following:

   a) Review and update of screening and assessment instruments — Yes ○ No ●

   b) Review of current levels of care to determine changes or additions — Yes ○ No ●

   c) Identify workforce needs to expand service capabilities — Yes ● No ○

   d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — Yes ● No ○

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — Yes ● No ○

2. Has your state identified a need for any of the following:

   a) Training staff and community partners on confidentiality requirements — Yes ● No ○

   b) Training on responding to requests asking for acknowledgement of the presence of clients — Yes ● No ○

   c) Updating written procedures which regulate and control access to records — Yes ○ No ●

   d) Review and update of the procedure by which clients are notified of the confidentiality of their records including the exceptions for disclosure: — Yes ○ No ●

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — Yes ● No ○

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

   a) Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

   During any given year, there are approximately 40 to 50 programs that receive SUBG funds through the LME-MCOs. Also, agencies must have attained national accreditation in order be credentialed by an LME-MCO (for a contract for enhanced services). Independent Review initiatives were put on hold during COVID and imposed travel restrictions for state employees and contracted vendors. It is scheduled to resume in FY24 and it is anticipated that 7 to 10 programs will

participate, which is typically about 10% of the total number of contracted providers.

3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan — Yes ○ No ●

b) Establishment of policies and procedures related to independent peer review — Yes ○ No ●

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — Yes ○ No ○

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — Yes ● No ○

If Yes, please identify the accreditation organization(s)

i) ☑ Commission on the Accreditation of Rehabilitation Facilities

ii) ☑ The Joint Commission

iii) ☑ Other (please specify)

COA - Council on Accreditation
CQL - Council on Quality and Leadership

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program?

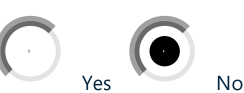
Yes No

2. Has your state identified a need for any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service

Yes No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing


Yes No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opportunity to receive training on an ongoing basis, concerning:

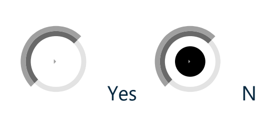
a) Recent trends in substance use disorders in the state

Yes No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services

Yes No

c) Performance-based accountability:


Yes No

d) Data collection and reporting requirements

Yes No

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs

Yes No

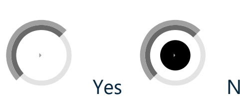
b) Addition of training sessions designed to increase employee understanding of recovery support services

Yes No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services

Yes No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort


Yes No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC?

Yes No

b) Mental Health TTC?

Yes No

c) Addiction TTC?

Yes No

d) State Targeted Response TTC?

Yes No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women

Yes No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis

Yes No

b) Early Intervention Services Regarding HIV

Yes No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment

Yes No

b) Professional Development

Yes No

c) Coordination of Various Activities and Services

Yes No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

http://www.ncga.state.nc.us/gascripts/statutes/StatutesTOC.pl?Chapter=0143B

http://www.ncleg.net/EnactedLegislation/Statutes/HTML/ByChapter/Chapter_122C.html

http://reports.oah.state.nc.usncac.asp?folderName=%5CTitle%2010A%20-%20Health%20and%20Human%20Services%5CChapter%2027%20Mental%20Health,%20Community%20Facilities%20Services

If the answer is No to any of the above, please explain the reason.

We are not considering seeking waivers for any of the requirements.

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

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.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2022-FFY 2023? Yes No

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma[1] is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. 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.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[2] paper.

[1] 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.*

[2] *Ibid*

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

1.	Does the state have a plan or policy for M/SUD providers that guides how they will address individuals with trauma-related issues?	Yes	No
2.	Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?	Yes	No
3.	Does the state provide training on trauma-specific treatment and interventions for M/SUD providers?	Yes	No
4.	Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?	Yes	No
5.	Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?	Yes	No
6.	Does the state use an evidence-based intervention to treat trauma?	Yes	No

7. Does the state have any activities related to this section that you would like to highlight.

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than a third of people in prisons and nearly half of people in jail have a history of mental health problems.[1] Almost two thirds of people in prison and jail meet criteria for a substance use disorder.[2] As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.[3] States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system.

Addressing the mental health and substance use disorder treatment and service needs of people involved in the criminal justice system requires a variety of approaches. These include:

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These types of approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a stronger array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts. SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice system involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.

[1]Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. Bureau of Justice Statistics, 1-16.

[2]Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[3]Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. “Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis.” Journal of the American Academy of Child and Adolescent Psychiatry 47(3):282–90.

Please respond to the following items

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

- Coordination across mental health, substance use disorder, criminal justice and other systems
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe.

Yes No

3. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?

Yes No

4. Does the state have any activities related to this section that you would like to highlight?

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

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14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

Narrative Question

In line with the goals of the Overdose Prevention Strategy and SAMHSA's priority on Preventing Overdose, SAMHSA strongly request that information related to medications in the treatment of substance use disorders be included in the application.

There is a voluminous literature on the efficacy of the combination of medications for addiction treatment and other interventions and therapies to treat substance use disorders, particularly opioid, alcohol, and tobacco use disorders. This is particularly the case for medications used in the treatment of opioid use disorder, also increasingly known as Medications for Opioid Use Disorder (MOUD). The combination of medications such as MOUD; counseling; other behavioral therapies including contingency management; and social support services, provided in individualized, tailored ways, has helped countless number of individuals achieve and sustain remission and recovery from their substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based, or non-medication inclusive, treatment for these conditions. The evidence base for medications as standards of care for SUDs is described in SAMHSA TIP 49 Incorporating Alcohol Pharmacotherapies Into Medical Practice and TIP 63 Medications for Opioid Use Disorders.

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to offer MOUD and medications for alcohol use disorder or have collaborative relationships with other providers that can provide all FDA-approved medications for opioid and alcohol use disorder and other clinically needed services.

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. States should use Block Grant funds for the spectrum of evidence-based interventions for opioids and stimulants including medications for opioids use disorders and contingency management.

In addition, SAMHSA also encourages states to require equitable access to and implementation of medications for opioid use disorder (MOUD), alcohol use disorder (MAUD) and tobacco use disorders within their systems of care.

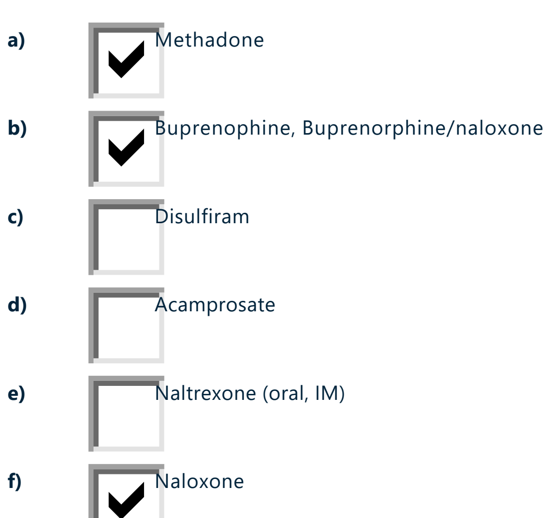
SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding the use of medications for substance use disorders? (●) Yes ( ) No

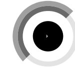
2. Has the state implemented a plan to educate and raise awareness of the use of medications for substance disorder, including MOUD, within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds?



- a) [x] Methadone
- b) [x] Buprenophine, Buprenorphine/naloxone
- c) [ ] Disulfiram
- d) [ ] Acamprosate
- e) [ ] Naltrexone (oral, IM)
- f) [x] Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based treatment with the use of FDA-approved medications for treatment of substance use disorders is combined with other therapies and services based on individualized assessments and needs?

 Yes No

5. Does the state have any activities related to this section that you would like to highlight?

The number of opioid treatment programs (OTPs) continues to increase in NC; as of September 2023, there were 86 programs serving over 21,000 individuals daily and approximately 30,000 individuals annually. Of the total OTPs, only two do not have contracts with an LME-MCO for uninsured individuals and/or Medicaid beneficiaries. Although monthly calls have traditionally been held with the Medical Directors of all OTPs, since the onset of the COVID pandemic, weekly calls have been conducted to better assure access to care is maintained in a safe manner. NC has two state-run facilities that offer MAT.
Session Law 2023, House Bill 190, was recently enacted which allows the state to fill geographic service gaps in rural and other under-served areas through implementation of medication units and mobile units. Geographically separated from its "home" opioid treatment program, a medication unit or mobile unit is often located within 30-90 miles of its "brick and mortar" main clinic. Medication and mobile units will have the authorization and capacity to administer medicine such as methadone and buprenorphine to curb withdrawal symptoms from opioid addiction, prevent relapse and quell the physical discomfort that frequently accompanies recovery from opioid use disorder. These units may provide a full range of medication-assisted treatment (MAT) services including individual and group counseling. NC is particularly interested in pursuing utilization of these mobile units for individuals who are in detention settings or prisons.
House Bill 190 can be accessed here: https://www.ncleg.gov/Sessions/2023/Bills/House/PDF/H190v7.pdf

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15. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *....to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to expend some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expanding 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

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-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

SAMHSA developed **Crisis Services: Meeting Needs, Saving Lives**, which includes "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as an **Advisory: Peer Support Services in Crisis Care** and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "**National Guidelines for Child and Youth Behavioral Health Crisis Care**" which offers best practicies, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

1. Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crsis receiving and stabilization centers.

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA guidelines.*
*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*
*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Other program implementation data that characterizes crisis services system development.

1. Someone to talk to: Crisis Call Capacity

a. Number of locally based crisis call Centers in state

i. In the 988 Suicide and Crisis lifeline network

ii. Not in the suicide lifeline network

b. Number of Crisis Call Centers with follow up protocols in place

c. Percent of 911 calls that are coded as BH related

2. Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

a. Independent of first responder structures (police, paramedic, fire)

b. Integrated with first responder structures (police, paramedic, fire)

c. Number that employs peers

3. Safe place to go or to be:

a. Number of Emergency Departments

b. Number of Emergency Departments that operate a specialized behavioral health component

c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)

a. Check one box for each row indicating state's stage of implementation

	Exploration Planning	**Installation**	**Early Implementation Less than 25% of counties**	**Partial Implementation About 50% of counties**	**Majority Implementation At least 75% of counties**	**Program Sustainment**
Someone to talk to	☐	☐	☐	☐	☐	☐
Someone to respond	☐	☐	☐	☐	☐	☐
Safe place to go or to be	☐	☐	☐	☐	☐	☐

b. Briefly explain your stages of implementation selections here.

3. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

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

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16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality M/SUD 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 M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

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. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. 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.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? — (•) Yes ( ) No

b) Required peer accreditation or certification? — (•) Yes ( ) No

c) Use Block grant funding of recovery support services? — (•) Yes ( ) No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? — (•) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? — (•) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

The State provides an expanding array of recovery-oriented, person-centered services available to adults with SMI/SPMI. Brief descriptions of these services are as follows:

Assertive Community Treatment (ACT) services consist of a community-based group of medical, behavioral health and rehabilitation professionals who use a team approach to meet the needs of an individual with SPMI. The ACT team addresses the breadth of an individual's needs and teaches psychiatric rehabilitation skills towards advancing personal recovery goals. The Certified Peer Support Specialist is a vital role on the team in promoting hope and self-determination that the individual can recover and regain meaningful roles and relationships in the community.

Community Support Team (CST) services consist of community-based mental health and substance abuse rehabilitation services and supports provided through a team approach to assist adults in achieving rehabilitative and recovery goals. CST is a 24/7 service that is designed to reduce presenting psychiatric or substance abuse symptoms and promote symptom stability, restore the individual's community living and interpersonal skills, provide first responder intervention and deescalate the current crisis, and ensure linkage to community services and resources.

Critical Time Intervention (CTI) is a time-limited, evidence-based practice that mobilizes support for the most vulnerable individuals during periods of transition. CTI promotes a focus on recovery and psychiatric rehabilitation and bridges the gap between institutional living and community services by ensuring that a person has enduring ties to their community and support systems during these critical periods.

Peer Support Services (PSS), provided by Peer Support staff, offers structured and scheduled activities for adults with SMI or substance abuse disorders. Services focus on the acquisition, development, and expansion of rehabilitative skills needed to move forward in recovery. PSS emphasizes personal safety, self-worth, connection to the community, self-advocacy, personal fulfillment, and development of social supports and effective communication skills.

Focus on developing Family Partner Coordinators, Family Partners, Youth Partners and Young Adult Partners working as peers and self-advocacy is vital to sustaining the strength of the SOC platform and interagency work on the individual and family and in the community, regionally and state at large.

Individual Placement and Support- Supported Employment (IPS-SE) is an evidence-based practice that helps individuals with SMI work at regular jobs of their choosing. It is a person-centered, behavioral health service that assists in choosing, acquiring, and maintaining competitively paid employment in the community for individuals 16 years and older who are unemployed or who have intermittent or interrupted employment. Employment Peer Mentors offer hope and motivation by drawing from their lived experience and employment history to encourage individuals to seek and maintain employment, wellness, and community integration.

Transition Management Services (TMS) is a service provided to individuals participating in the Transition to Community Living Initiative (TCLI), and was formerly called Tenancy Support Team (TST). TMS focuses on increasing the individual's ability to live as independently as possible, manage their illness, and reestablish his or her community roles related to the following life domains: emotional, social, safety, housing, medical and health, educational, vocational and legal.

The State is in the process of implementing Peer Operated Respite Services (PORS), which would provide a temporary place for individuals experiencing urgent emotional distress and/or an emergent crisis to voluntarily stay overnight for an average of 3-4

days. These support services will be provided in a home-like environment operated by a Consumer-Run Organization with Certified Peer Support Specialists. Through mutual relationship-building, the PORS will create an opportunity for individuals served to learn and grow with the staff and to find ways to support one another, and remain connected and engaged in their own lives and communities. DMH/DD/SUS expects that PORS will be an effective early intervention to prevent hospitalization and facilitate recovery.

Please refer to the MHBG Plan for additional information.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations

The state has integrated recovery-oriented principles and values into the NC Substance Use Prevention, Treatment and Recovery Services Block Grant plan, the NC Division of Mental Health, Developmental Disabilities and Substance Use Services' 1115 SUD Demonstration Waiver and NC's Opioid and Substance Use Action Plan, which was updated in May 2021. Recovery principles are integrated into state contracts as well as in many training events statewide. The state of North Carolina adopted Person Centered Planning in 2006 and has promoted the use of "person first" language since then.

The Division of Mental Health, Developmental Disabilities and Substance Use Services created a new position in 2015 to ensure that recovery-oriented principles are integrated into state policies. This position, titled the Consumer Policy Advisor, served on the Executive Leadership Team. That position has evolved into the Assistant Director for Community Engagement and Empowerment who oversees staff that work closely with the Consumer and Family Advisory Committees throughout the state (local and state-level), as well as stakeholders and advocates statewide to promote recovery-oriented principles and ensure the voices of individuals in recovery and family members impacted by substance use are heard at high levels of policy development.

DMHDDSUS and the Division of Health Benefits worked together to develop a statewide Peer Supports service definition. The state-funded service definition became effective August 1, 2019, while the Medicaid-funded peer support definition became effective the following year. Having an approved peer support service definition provides an additional mechanism of funding, and helps with the sustainability of those services.

The state also provides financial support to recovery community centers and organizations across the state. The Division identified two recovery community organizations through a competitive process to provide leadership, mentorship and programmatic and fiscal oversight to other recovery community centers statewide. Recovery community centers are staffed with certified peer support specialists and volunteers to provide a resources and community-based support for individuals seeking or in recovery. Other initiatives in SUBG-funded recovery community centers include recovery community messaging to individuals, families, stakeholders and treatment providers, Recovery Coach Academies. The state also encourages treatment providers to learn about recovery messaging and to teach the individuals going through treatment about recovery messaging and advocacy for better health care while in treatment. For FY23, the Division has obligated over $3 million in SUBG funds to support 13 recovery community centers and organizations.

The Division has contracted with the University of North Carolina, Behavioral Health Springboard, for a number of years to develop and support North Carolina's certified peer support specialist program. The NC Certified Peer Support Specialist Program (NCCPSS) defines Peer Support Specialists as people living in recovery from mental illness and/or substance use disorder who support others who can benefit from their experiences. The Program certifies persons with lived recovery experience in Serious Mental Illness (SMI), Substance Use Disorders (SUD) or both.

The NCCPSS Program certifies persons who meet the eligibility criteria in recovery from a significant mental illness and/or substance use disorder. Certification means that the Program acknowledges that the peer has met the requirements to support individuals with mental health or substance use disorder. The Program certifies peers for two years, and the CPSS is responsible for maintaining their certification by renewing their certificate by the due date. As of 08.25.23, the number of Certified Peer Support Specialists in North Carolina is 4605. Of the 4605 Certified Peer Support Specialists, 4522 reside in NC, and 83 reside in other states. Only two counties out of 100 do not have a peer support specialist residing there. Of the total, 1457 have expertise in substance use and an additional 1411 are certified under both substance use and mental health experience. 439 certified peers have military experience and 2479 of the total are employed as a peer support specialist, volunteer as such or are employed in a related field. Additional information can be found at: https://pss.unc.edu/

The Division has supported collegiate recovery programming since 2015 when the initiative was first established by then Governor McCrory due to concerns over alcohol consumption by college students and the need to provide a college atmosphere that was not "recovery hostile." These collegiate wellness and recovery programs focus on the issues related to substance use on college campuses by providing enhanced and expanded prevention, intervention, treatment referral and particularly recovery-oriented services to address the growing needs of students on college campuses.

DMHDDSUS currently provides funding to 18 schools, including 5 HBCUs (NC A&T, NC Central, Elizabeth City State, Fayetteville State & Winston-Salem State) and 2 Minority Serving Institutions (UNC-Greensboro, UNC-Pembroke). Other campuses with collegiate recovery programs include Appalachian State, East Carolina University, Elon University, High Point University, Mars Hill University, Methodist University, NC State, UNC-Asheville, UNC-Chapel Hill, UNC-Charlotte, UNC-Wilmington. The total annual funding is ~ $2.5m, ranging from $75,000 to $400,000 per school.

Collegiate recovery programs provide a supportive community and environment and resources for students who are living or desiring a lifestyle of recovery. They offer students the opportunity to experience college and pursue their education without sacrificing their recovery. Each program is designed by the school to meet the needs of their student population, but most include or plan to include:
• A dedicated space for students to gather to study, socialize and offer support to one another
• Substance-free activities such as sober tailgates, sober Spring Breaks
• Peer support services
• Access to naloxone
• Recovery support groups and personal/professional development workshops
• Outreach and education strategies to promote recovery awareness and reduce stigma
• Collaboration with on and off campus housing to provide recovery housing options (UNC-Chapel Hill partnered with Oxford House to secure the first Oxford House specifically for college students in the country)

For 32 years, the Division of Mental Health, Developmental Disabilities and Substance Use Services has had a long-standing collaborative relationship with Oxford House, Inc. which started with the establishment of the first two NC Oxford Houses in Asheville and in Durham. Oxford House, Inc. is the 501 (c) (3) umbrella organization of a national network of democratically run homes for individuals in recovery from substance use disorders, including opioid use disorder.

NC Oxford House units provides a cost-effective approach to support the active recovery of individuals in recovery from substance use and opioid use disorder. NC Oxford House units help fill the gap for peer operated recovery homes and provide a level of care not found in other settings.

As of 07.31.23, to support individuals in recovery from substance use and opioid use disorder, Oxford House, Inc. provided a total 304 recovery houses in NC, providing a total of 2374 recovery beds across the state. The following illustrates the numbers and types of house and beds available:
• Total Houses 262
• Total Beds 2048
• Men's Houses 194
• Men's Beds 1520
• Women's Houses 58
• Women's Beds 449
• Women's & Children's Houses 10
• Women's & Children's Beds 79

5. Does the state have any activities that it would like to highlight?

The Division continues to implement strategies, initiatives and programs to more fully develop a true recovery-oriented system of care. Specific initiatives under this funding will include the following:
• Expansion of Recovery Community Organizations and Centers. North Carolina currently provides funding to two recovery community organizations that operate recovery community centers and also act as mentors to additional recovery community centers (that also receive funding) across the state. These centers provide various types of recovery services and supports for individuals seeking or in sustained recovery. Additional funds will support the development of a process to identify and select communities primed for the development of recovery community centers in historically marginalized or under-served areas that can offer culturally appropriate services.
• Expansion of Collegiate Recovery Programs. North Carolina currently provides funding for 18 collegiate recovery programs. These programs offer a supportive environment, services and opportunities within the campus culture that reinforce the decision to engage in a lifestyle that does not include substance use.
• Expansion of Recovery Supported Housing and/or Targeted Housing. The Division of Mental Health, Developmental Disabilities and Substance Use Services provides funding support for various levels of recovery supported living.
• Expansion of Services Provided by Certified Peer Support Specialists. Peer Support Specialists are people living in recovery with mental illness and/or substance use disorder. Deliberate focus on embedding peers in non-traditional settings will continue, including in emergency departments, prisons and detention settings. Emphasis will be placed on furthering the co-location of peers in these settings, opioid treatment programs, recovery community centers, etc.

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

None requested at this time.

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17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

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 M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual 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 M/SUD 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 for 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 settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based 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. Does the state's Olmstead plan include:

Housing services provided	Yes	No
Home and community-based services	Yes	No
Peer support services	Yes	No
Employment services.	Yes	No

2. Does the state have a plan to transition individuals from hospital to community settings? Yes No

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?

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

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18. Children and Adolescents M/SUD Services –Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. 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 emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1]. Most mental 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.[2]. For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3].

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.[4].

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 point person 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 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

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 SUD and co-occurring M/SUD 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, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5].

According to data from the 2017 Report to Congress[6] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system.
2. improve emotional and behavioral outcomes for children and youth.
3. enhance family outcomes, such as decreased caregiver stress.
4. decrease suicidal ideation and gestures.
5. expand the availability of effective supports and services; and
6. 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 M/SUD 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 (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and

employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[2]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.

[3]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.

[4]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[5]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 **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[6] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED? Yes No

b) The resilience of children and youth with SED? Yes No

c) The recovery of children and youth with SUD? Yes No

d) The resilience of children and youth with SUD? Yes No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? Yes No

b) Health care? Yes No

c) Juvenile justice? Yes No

d) Education? Yes No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? Yes No

b) Costs? Yes No

c) Outcomes for children and youth services? Yes No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? Yes No

b) Mental health treatment and recovery services for children/adolescents and their families? Yes No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? Yes No

b) for youth in foster care? Yes No

c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems? Yes No

d) Does the state have an established FEP program? Yes No

Does the state have an established CHRP program? Yes No

e) Is the state providing trauma informed care? Yes No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

7. Does the state have any activities related to this section that you would like to highlight?

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

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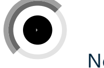
22. Public Comment on the State Plan - Required

Narrative Question

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings?

Yes  No

b) Posting of the plan on the web for public comment?

Yes No

If yes, provide URL:

While not really considered a public meeting or hearing, DMHDDSUS staff meet monthly with the SUBG Advisory Committee of the SUD Federation for input, review, feedback and more global distribution of the plan to SUD providers, stakeholders and other organizations across the state.
Once approved, the FY24-25 Plan will be posted on the DHHS website for review and comment by anyone interested.

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

https://www.ncdhhs.gov/divisions/mental-health-developmental-disabilities-and-substance-use-services/grants/substance-use-prevention-and-treatment-block-grant

c) Other (e.g. public service announcements, print media)

Yes No

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

None at this time.

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23. Syringe Services Program (SSP) - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.samhsa.gov/sites/default/files/grants/ssp-guidance-for-hiv-grants.pdf** ,
2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf**,
3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs** **http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf** ,

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
    - Include proposed protocols, timeline for implementation, and overall budget
    - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5] ***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and

HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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As of July 11, 2016, North Carolina (G.S. 90-113.27) allowed for the legal establishment of hypodermic syringe and needle exchange programs. Any governmental or nongovernmental organization "that promotes scientifically proven ways of mitigating health risks associated with drug use and other high risk behaviors" can start a syringe services program (SSP). Included in the law is a provision that protects SSP employees, volunteers and participants from being charged with possession of syringes or other injection supplies, including those with residual amounts of controlled substances present, if obtained or returned to a SSP. SSP employees, volunteers and participants must provide written verification (including a participant card or other documentation) to be granted limited immunity. Although NC has over 50 mobile and fixed syringe services programs, these are community-based organizations not financially supported by the SUBG. DMHDDSUS works collaboratively with the Division of Public Health to better assure SSPs have accurate and up-to-date information for referring individuals to treatment and accessing care coverage through the LME-MCOs, as well as providing funding for naloxone distribution to participants and their families.

Environmental Factors and Plan

Syringe Services Program (SSP) Information – Table A - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Dollar Amount of SUBG Funds to be Expended for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone Provider (Yes or No)
No Data Available					

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Footnotes:

N/A