



**Designing the Substance Abuse Treatment
System
For
Durham County, North Carolina**

May 2004

Executive Summary

The challenges faced by Durham County, NC and The Durham Center in creating a seamless continuum of addiction intervention and treatment for the citizens of Durham are intensified by the gaps in the current system. There are core services and programs to be developed, foundation building to be done and systems improvement to be completed in order to create a robust system. The Durham Center, through its new role as a Local Management Entity, is in a particularly important position to catalyze change within itself and even within the larger group of substance abuse treatment providers outside of its own sphere of responsibility. A major change must be the addition of a strong substance abuse capability within The Durham Center itself in order to promote a positive treatment philosophy and to ensure a champion for the cause of adequate and appropriate services. The new system needs to be consistent with the vision of the North Carolina Division of Mental Health/Developmental Disabilities/Substance Abuse Services Plan.

Parameters for reformation of the local care system

Tenets of the local reform effort need to reflect the state goals of the state plan, even for those providers and clients not captured in the Durham Center's newly defined target population, and include the following issues:

- No wrong door to treatment
- Commitment to quality that is delivered by competent professionals
- Plan for and create a comprehensive community service system
- Foster the development of a network of contract providers and build partnerships with community agencies and organizations
- Invest for results
- Influence a coordinated care approach to service planning utilizing the Person Centered Planning Processes
- Maximize available funding streams and reimbursement mechanisms to ensure adequate capacity available at community level
- Meet Federal funding guidelines for services to targeted populations

Federal projections regarding substance use and addiction rates within the population were used to estimate substance abuse service needs for Durham County. Data were not available to determine current use of substance abuse services. The data, which do exist, are co-mingled with mental health and other data.

Estimates regarding unmet need for the system revealed the following:

- The treatment capacity that currently exists for adult SA is fragmented with serious gaps in residential care and structured outpatient services. These prevent offering a true continuum of care. It is apparent that the correct services within the continuum may not exist and that the targeted populations are not currently being served.
- Services for adolescents are woefully inadequate and the capacity to serve adolescents does not currently exist within Durham County.
- Durham is not tracking services to target population groups, as prioritized by the state and federal funding streams utilized to support the substance abuse continuum of care. Consequently, it is imperative that new services ensure that those priority groups be targeted for inclusion in the new system and that clinical services utilize best practices for these populations to maximize the effectiveness of the services provided.

Substance abuse staff characteristics and needs

- Information is not available on the extent of qualified staff in Durham County programs. It is important that The Durham Center do an inventory of certified and licensed staff that provide substance abuse services within its own scope of services. An inventory of providers within the larger community would also be extremely helpful.
- In order to maximize the use of the funding and reimbursement potential, as well as employ evidenced-based best practice models, all clinical staff working with substance abuse clients at a minimum need to be currently credentialed at the appropriate level by the North Carolina Professional Substance Abuse Certification Board.
- It is also important that the Durham Center assure that basic training in addictions and best practices information be provided to those working in addictions programs. Ideally, this training would include providers not directly contracted with the Center. When services are arranged in a continuum staff can be organized in a manner that allows those with the skill and credentials to deal effectively with the substance abuse conditions presented by the client population.
- The addiction treatment philosophy and clinical supervision model should be developed and disseminated.
- Addiction treatment services need to be managed and clinically supervised by professionals who have demonstrated competence in treating addictions.

Summary of Recommendations for Durham County services and programs

- Develop Comprehensive Outpatient Treatment Programs (equivalent to the ASAM Level II.5) criteria.
- Create a residential capacity for both adults and adolescents
- Support, enhance, and solicit new addiction treatment providers to enhance the gaps in the existing service continuum for the service area.
- Insure all existing crisis center/intake points have Certified Substance Abuse Professionals assigned to the crisis assessment service to ensure accurate assessment, diagnosis, and appropriate placement of all substance related conditions.
- Ensure that clients admitted for services within the continuum of care meet the target population requirements as outlined by state and federal requirements for public funding.
- Develop and enhance relationships with the self-help community to ensure effective peer and family support for its recovering clients.

**PRIORITY RECOMMENDATIONS:
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Foundation Building	Systems Improvement	Service Development
<ul style="list-style-type: none"> • Create a substance abuse leadership position at The Durham Center • Create advisory panel of experts to advise on building the system • Add staff expertise to offer Technical Advice to contracted providers • Initiate a communications plan to keep the network and the community informed • Create a youth services advisory panel • Improve communications with providers around the RFP process 	<ul style="list-style-type: none"> • Inventory certified and licensed staff for substance abuse services • Create a Recovery Institute, possibly in collaboration with Duke University and/or UNC, for both training and research • Clarify expected client outcomes and track results • Create a coordinating council/network of providers • Institute a common assessment tool, track clients and provide adequate data collection and reporting systems 	<ul style="list-style-type: none"> • Initiate the development of a non-hospital residential treatment capacity (minimum 16 beds, LOS based on client need) • Initiate integrated outpatient services for co-occurring disorders • Initiate adolescent residential treatment capacity (8-12 beds) • Staff crisis and assessment centers with qualified personnel to improve diagnostic accuracy • Invest in prevention and intervention services

Designing the Substance Abuse Treatment System for Durham County, NC and The Durham Center

The Durham Center is in transition adhering to North Carolina's mental health system reform plan. The Durham Center, a major provider of public mental health/developmental disability/substance abuse services is divesting itself of the direct service activities and assuming the responsibilities of the LME (Local Management Entity) responsible for managing services. In this transition The Durham Center has undertaken the enormous responsibility to involve the community in planning and has provided a local business plan with quarterly updates to address the plan for transition of the current system to the new LME concept. The Durham Center has been implementing the changes identified in the plan through contracting for services and issuing RFP's to address some early identified gaps in service while at the same time continuing to conduct planning activities and facilitate the divestiture of previously provided services. It is working toward an orderly transition for patients and staff while keeping the community and its providers informed.

In order to address the need for designing the substance abuse treatment system for Durham County, the Durham Center enlisted the assistance of Durham Health Partners, a private local not-for-profit health planning organization. Durham Health Partners engaged the Technical Assistance Collaborative, Inc. (TAC) to provide the expertise on substance abuse services for the system analysis and design. TAC is a not-for-profit national organization that works to achieve positive outcomes on behalf of people with disabilities or other special needs by providing state-of-the-art information, capacity building, and technical expertise to organizations and policy makers in the areas of mental health, substance abuse, developmental disabilities, human services and affordable housing. The project requirements included:

- an analysis of the current community situation related to substance abuse treatment services for all populations in Durham County, not simply those targeted by the Durham Center's mandate
- specifications for an ideal treatment system that
 - adheres to state requirements and "best practices"
 - addresses needs in a "continuum of care" for substance abuse
 - recognizes ASAM levels of care and best practices as identified in the state plan, the Center for Substance Abuse Treatment (CSAT), and the Treatment Improvement Protocols (TIP's) issued by CSAT.

A situation analysis involved:

- the establishment of a “steering” group representative of key local stakeholders
 - Doug Wright, Chair, Durham Center Board
 - Ellen Holliman, Interim Director, Durham Center
 - Janice Stroud, Durham Center Staff
 - MaryAnn Black, Community Affairs, DUHS
 - Philip Cousin, Durham County Commission
 - Rebecca Reyes, Latino Health Project, DUHS
 - Roland Staton, Community Minister
 - Tony Mulvihill, Alcohol and Drug Council of NC
 - Kathy Neal, Alcohol and Drug Council of NC
 - Gudrun Parmer, Durham County Criminal Justice Resource Center
 - Myrtle Muntz, TAC Consultant
 - Patrick Lanahan, TAC Consultant
 - Thomas Gambill, Durham Health Partners
- a SWOT analysis
- patient and staff focus groups
- over 35 interviews with health care and substance abuse providers, community and political leadership, citizens, law enforcement, schools, and faith based organizations.

The process was designed to identify and evaluate what is in place, how programs interface, assess incidence and prevalence data, document best practice, assess how clients access substance abuse services, and recommend strategic actions within the context of public policy.

THE SWOT ANALYSIS

On February 5, 2004 a working session was held with the steering group to identify the strengths, weaknesses, opportunities and threats to the development of a strategic plan for chemical dependency services in Durham County. The session began with a brief update from The Durham Center that identified concerns regarding negative public relations issues about the Durham Center’s decision to discontinue its direct services. Also the contracted crisis service is getting underway slowly, staff concerns are surfacing and relationships with Duke University Health System are still to be worked out. Issues that have surfaced include losing workers from the Durham Center staff, fear of fragmented services, providing dual diagnosis services and loss of pharmacy services. In addition the RFP process is perceived to be delayed and is questioned by some providers. In terms of the County as a whole, there was consensus that the system is fragmented, has many gaps, lacks a true continuum of care, and has problems related to client access and continuity of care.

The TAC conducted the SWOT analysis. Members of the steering group were asked to respond to the following questions:

1. In developing a comprehensive system of chemical dependency services what are the strengths of the current system that are important to keep in place?
 - What do you do well?
 - What are your resources?
 - What are your advantages?
 - What do others see as your strengths?
2. What are the weaknesses of the system that you would like to see addressed?
 - What can you improve?
 - What do you do poorly?
 - What's missing?
3. What opportunities do you think exist that can be brought about through system reform?
 - Thinking about the strengths and weaknesses what opportunities exist in building this system?
4. What do you see as the threats to accomplishing successful system reform?
 - How is the funding situation?
 - Are the changes possible?

Responses from the group were ranked and prioritized by the participants. The top five responses in each category are listed. Only five responses were identified in the threats category.

Strengths

- Community support is strong (29)
- The Criminal Justice System is strong in chemical dependency concerns and services (21)
- The Health System community services are excellent including admissions and medical services (17)
- 12 Step Programs, the recovering community CPCS are strong (13)
- Substance Abuse and Mental Health Services are currently under the same administration (12)

Weaknesses

- There is no continuum of care or plan for such including the absences of detox, long term 3-6 month care, residential care and adolescent care (33)
- Serious lack of capacity to meet current needs (23)
- Lack of public awareness, stigma is great (22)
- High use of state hospital system, no close resource and limited \$ (17)
- Fragmentation of services inhibits continuity of care (15)

Opportunities

- Understand gaps and plan to meet needs (33)
- Collect better data (23)
- Optimize use of funds (21)
- Centralize calls and 24/7 hour referral 560-7100 (20)
- Create seamless system (18)

Threats

- Turf disturbances can cause strife and failed collaboration
- Resistance to change
- Political decisions
- Stigma which can reduce resources and cause negative actions
- Decreasing services due to decreasing resources

The group had the opportunity to identify side issues that did not seem to fit the SWOT analysis. One issue was identified.

- Contracting and procurement procedures cause problems

PATIENT FOCUS GROUPS

A patient focus group was held on the evening of March 17th. Eleven people participated, 3 women and 8 men. Length of sobriety ranged from 3 months to several years. One participant was a family member and two were dually diagnosed. Racial composition was 7 African-American and 4 Caucasian. Seven of the participants were from the Criminal Justice Resource Center programs. All clients were articulate and knowledgeable about the availability of services. They spoke of ways to overcome the system by claiming suicidal thoughts or getting arrested to access services. Their most frequently voiced concern is the lack of sufficient services to meet their needs on a timely basis.

Participants were asked to address three questions

1. In your recovery what were the most helpful services, associations, or aspects of your treatment experience?
2. What kind of help would you like to have had that was not available?
3. What do you consider the most important resource in maintaining your recovery?

CJRC clients unanimously identified the confinement in the STARR or DART programs as the most effective part of treatment. The educational components in which clients learned about their addiction and how to manage it were most frequently identified as effective. Clients cited the lack of intensive and residential treatment (unless incarcerated) as the most frequent barrier to recovery. Intensive case management, close monitoring and transitional housing were cited as the most important components of their ability to maintain the gains made in treatment. Certified and experienced counselors were a noted asset as was availability of 12 Step programs. The methadone program was seen as

excellent to meet the needs of the opiate addicts. Weaknesses cited include the lack of available Medicaid, medication cost, pharmacy services, no detox, limited dual diagnosis and gender-specific services, and waiting lists for any kind of housing.

COMMUNITY INTERVIEWS

In the process of designing a comprehensive alcohol and drug treatment system, the Technical Assistance Collaborative interviewed providers, key community leaders, political leadership, law enforcement officials, faith leaders, and health care and school personnel. Over 30 such interviews and program visits were conducted in order to identify the existing services, to learn what providers and others identified as the strengths and weaknesses of the system and to identify critical issues. Interviewees were asked to respond to these questions.

1. What is your role in service delivery?
2. As the Durham Center becomes the LME and services are provided through a developing comprehensive system of substance abuse services what are the strengths of the current system that are important to keep in place?
3. What are the weaknesses in this developing system that need to be addressed?
4. What opportunities do you think exist that can be brought about through this system reform?
5. What are the threats that should be taken into account that will impact the service delivery system or prevent the successful implementation of the plan?

Strengths

- Criminal Justice Resource Center providing substance abuse intensive outpatient day treatment services, case management, monitoring, drug education, aftercare, halfway house contracting, 28-day jail treatment program for persons on probation, parole or in jail.
- Dove House for homeless women, 1 year, Believe, Women's Urban Ministry, New Leaf for pregnant women 2 beds
- Drug Court with good judges who are willing to use clout to enable treatment
- Oxford House has 8 houses for men and 2 houses for women
- Methadone program exists with active case management
- Durham Center had integrated mental health, substance abuse and DD services which made coordination of clinical care at the patient level possible
- ASAM certified physician available
- DWI Program strong
- Duke ER
- Mental health center has 3-4 beds

- Durham County has 44 AA meetings each week, NA and AI Anon are present
- Rescue Mission, work and religious approach to treatment

Weaknesses

- There is no transitional housing for women, very limited service for pregnant women and little child care
- Employment Issues for parole or probationers are serious. No ID
- Transportation is major problem in getting people to treatment
- Life and work skills training not sufficient for probation or parole clientele
- Lack of inpatient facilities, No detox available except for natural detox in jail
- 1/3 of jail population is dual diagnosed
- Jail clients are not eligible for Medicaid
- The faith based community is not engaged in a meaningful manner
- There is no directory or inventory of services available
- The details of how to access Telecare are not outgenerally known
- Decentralization of services may cause fragmented services
- The Durham crisis center is gone, 2-3 agencies to work with for case management
- No evening services available
- People working in the system do not have sufficient information
- Peer support needs increasing
- Long and short term housing much needed
- Dual diagnosed may become fragmented
- Service capacity has been diminishing over past several years (i.e. loss of Oakleigh)
- Lack of leadership
- Prevention services are limited or not available
- No coherent plan for orderly expansion that identifies current \$ and describes options, There is no inventory of current spending for the system
- Suburban recovering community turned off
- Need to expand youth programs
- Need more aftercare, system is overloaded
- Not enough residential opportunities. Patients released after 3 days to same environment

Opportunities

- Increase clinical competence to determine changing levels of care
- Priority on cross trained people
- Create varied housing opportunities
- More providers = more choices = more quality
- Create parity
- LME can do better planning and training, must collaborate

- Require integrated services MH, SA
- Hire strong leader for substance abuse (drug czar) to put system together reporting to LME and County Manager
- Develop quality provider networks
- Create a positive empowering attitude. Change attitude of medical community about substance abuse as a lifestyle choice.
- Change legislation to allow payment for residential care for substance abuse services
- Provide role call training to police
- Make better use of faith based programs and willingness of faith community to help

Threats

- Not having appropriate personnel, need ASAM certified people
- Lacking leadership commitment
- Negative public attitude
- Attitude of providers is not positive or cooperative
- Access is “no Access”

The NC Division MH/DD/SA Services direction and parameters for the reform effort

The NC Division of MH/DD/SA Services has continued to redesign its own infrastructure as well as develop the mechanisms to respond to the local Area Programs/Local Management Entities by retooling efforts at the community level. Specific to the redesign of the state substance abuse system, the following Division initiatives were launched:

1. Best Practice Guidelines for Targeted Populations (see State Business Plan 2003, Communication Bulletin #008, May 2003).
2. Substance Abuse Service Definitions (See Draft SA Service Definitions document).
3. NC Division of Medical Assistance realignment of Medicaid billing codes for Substance Abuse Services (In process).

The Division’s Substance Abuse Best Practice Guidelines Document (DRAFT 7/15/03) outlines the expectations and benchmarks for a complete community substance abuse system. The basis for the new system, from the Division’s perspective is a researched, evidenced-based public system. Within the best practice guidelines, the Division relied upon tested community models from the Federal Center for Substance Abuse Treatment (CSAT), the National Institute of Drug Abuse (NIDA), and the Center for Substance Treatment (CSAT). The NC

Division of MH/DD/SA Services State Plan 2003 also speaks to the elements of an effective substance abuse system and provides the framework in which to redesign services into an effective and responsive continuum of care at the community level.

An organized system can be approached in a variety of ways. The uniqueness of each community however is the key factor considered in determining the systems configuration. Regardless of the design of the organized provider network system, the following are the essential elements:

- *Integrated: Each provider organization is expected to maintain relationships as part of a network responsible for delivering supports and services. The network is a constellation of provider organizations – a system.*
- *Coordinated: All aspects of a person-centered plan are to be carried out by the provider organization in a manner that reflects the interrelationship of each individual component of the plan.*
- *Comprehensive: A network should be comprised of a full complement of supports and services. This will include efforts to satisfy availability of high intensity low demand types of services. A system should be comprised of more than one network.*
- *Community: Each provider organization plays a viable and valued role as part of the local community.*

The Center for Substance Abuse Treatment's National Treatment Plan has also identified guidelines for best practice to build a seamless system offering high quality and effective treatment. These guidelines reflect elements of the best practice service delivery system that are appropriate to the community/local management entity level and easily incorporated into the plan for substance abuse services. While the Durham Center must obviously focus on services for their own target population, they are perhaps in the best position to catalyze change within the treatment community as a whole.

The guidelines include:

1. *Invest for results*. The wise use of resources requires investment and services that in turn must produce the desired results for clients and their families. Identification of expected outcomes is critical both for programs and individuals.
2. *"No wrong door" to treatment*. The challenge for The Durham Center will be to ensure that an individual seeking services will be identified and assessed and will receive appropriate services, either directly or through referral, no matter where he or she enters the system of community services.
3. *Commit to quality*. The Durham Center business plan identifies a significant commitment to continuous quality improvement. Systems to support these efforts are critical as are clear outcome expectations for providers.
4. *Change attitudes*. The Durham Center will need to make a significant commitment to community-wide prevention, education and outreach activities.

These efforts must assist in a significant reduction in stigma and change in community and provider attitudes regarding substance abuse.

5. *Build partnerships.* The Durham Center will need to encourage and develop mechanisms to support the development of the substance abuse provider network within its service area, including but not limited to its own target population. Gaps in the current service delivery system, transportation to existing services, and the lack of residential care and housing are immediate challenges that will need to be resolved by the treatment community as a whole as the system develops a complete continuum of substance abuse treatment.

The National Institute of Drug Abuse (NIDA) has identified an evidenced-based model of comprehensive addiction treatment services that reflects the concepts of an integrated, coordinated and comprehensive community service array for substance abuse services.

Ideally, the logical reason an LME develops a comprehensive continuum of services for their constituents is to promote early and ongoing recovery. Using The National Institute of Drug Abuse's (NIDA) core principles of best practice for effective substance abuse services as a guide, development of an effective community continuum of care can be based upon the following elements:

1. *No single treatment service is appropriate for all individuals.*

An effective treatment system has every level of care within its local network of community services. Appropriate matching of addiction severity to intensity of treatment services by utilization of NC Modified Patient Placement Criteria will ensure successful treatment outcomes. Treatment services should be delivered in the least restrictive and most clinically appropriate setting possible. The networks are responsible for ensuring that a repertoire of services exist which will allow treatment response to be tailored to the recipient's unique needs and life situations. Thus service responsiveness is person centered and not program centered.

2. *Treatment needs to be readily available.*

The local care management function for substance abuse services has to ensure that treatment services for each consumer are seamless without waiting lists or gaps between services particularly when the consumer is shifted between levels of care or referred to different providers. Substance abuse clients should receive treatment promptly on request to take advantage of motivational moments.

3. *Effective treatment attends to the multiple needs of the individual, not just his or her alcohol and drug use.*

Good quality of care starts at the front door of the continuum with the administration of a valid and reliable assessment tool administered by competent staff. The tool that The Durham Center selects for this purpose needs to reflect a multi-dimensional assessment, history, and diagnosis of addiction or alcohol/drug abuse. It is critical that all LME contracted providers use the elected tool, and ideally it would be adopted by the broader treatment

community. The assessment and treatment planning processes must include the significant collaterals in the consumer's life. A complete and effective continuum of care is inclusive of a comprehensive array of supports such as housing and transportation, childcare, peer supports, legal assistance, education and vocational assistance, medical and financial. Additionally, services and programs should be ethnically, culturally, socio-economically sensitive and gender specific. The Durham Center must build in fail-proof measures to insure that the contracted community provider network and clinicians have demonstrated skills and competence with the population of substance abusers and addicts they are contracted to serve.

4. *An individual's treatment and recovery plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.*

Person-centered treatment planning should include regular ongoing negotiation with the consumer, continuous monitoring and assessment, and ensuring that the community support plan is dynamic in nature addressing the changing needs of the consumer, their family, and their situation. If substance abuse treatment interventions are to be effective, many clients will experience frequent changes in their lives that will necessitate updates in their person centered plans in order for the intervention to remain timely and appropriate to fit the client's ongoing growth and needs. For substance abuse treatment to be most effective and responsive to the changing needs of the recovery environment, relapse prevention must be addressed within every level of care.

5. *Remaining in treatment an adequate period of time is critical for treatment effectiveness and successful recovery.*

Effective treatment principles include treatment plan goals as well as community support goals being accomplished prior to the individual's change in levels of care or discharge. This is true for each phase of treatment and for each referral. This may necessitate discharge planning from the first day of treatment and potentially longer stays in treatment programs to facilitate the accomplishment of person centered plan goals.

6. *Counseling (individual and group) and other behavioral therapies are critical components of effective treatment for addiction.*

Substance abuse treatment plans and community support plans for consumers need to reflect individual and group counseling as well as other behavioral therapies. Treatment goals are always an important component of these therapies.

7. *Medications are an important element of treatment for many individuals, especially when combined with counseling and other behavioral therapies.*

Medications play an important role in addiction recovery for some individuals. Effective treatment systems verify that every recipient of substance abuse treatment services is evaluated by appropriately trained personnel for appropriate medication concurrent with behaviorally assisted therapies. Because of the nature of addiction it is important that physicians be specifically trained in substance abuse or ASAM certified to ensure quality care.

8. *Addicted or drug-abusing individuals with co-existing mental disorders should have both disorders treated in an integrated manner.*

Effective treatment of co-occurring disorders includes evidence that screening, assessment, treatment planning and delivery of services assess the possibility of co-occurring disorders and, where present, treatment services are integrated in a coordinated and effective fashion. The integrated treatment model is an approach that combines elements of both mental health and addiction treatment into a unified and comprehensive treatment program for patients with dual disorders. Ideally, integrated treatment involves clinicians cross-trained in both mental health and addiction, as well as a unified case management approach, making it possible to monitor and treat patients through various psychiatric and AOD crises. An effective community treatment system accepts co-occurring disorders as routine and accommodates their needs. Clinicians working with co-occurring disorders must be trained to treat these conditions effectively and be supervised by individuals who have demonstrated competence with this population.¹

9. *Medical detoxification is only the first stage of addiction treatment and by itself, does little to change long-term alcohol and drug use.*

Effective treatment for addiction is a process and not a single event or service. Detoxification represents the initial beginning of the recovery process. It is crucial in an effective substance abuse system that clinical supervisors and clinicians employ extraordinary measures to insure that referrals for subsequent levels of care occur without a gap in time or waiting period for service delivery. Not every person who is intoxicated will require detoxification and not every person who is detoxified will require treatment. It is important to carefully assess and plan for appropriate services at the initial engagement to effectively use available resources. Currently the repeated use of ER facilities to deal with detox clients is ineffective and consumes valuable resources. The “revolving door” is in effect. Repeated admissions without positive outcomes consume valuable resources and maintain stigma.

¹ **Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse**

Treatment Improvement Protocol (TIP) Series 9

10. *Individuals who enter treatment under legal pressure have outcomes as favorable as those who enter treatment voluntarily.*

Outreach to effectively engage a consumer is imperative, particularly for those who are involuntary admissions. Collaborative efforts with Drug Courts, TASC and CJRC staff are imperative in the design of treatment and community support plans for those recipients who have criminal justice system involvement. CJRC programs provide important services and should be strengthened.

11. *Possible alcohol and drug use during treatment must be monitored continuously and interventions must be timely for treatment to be effective and recovery to occur.*

The use of biomedical measures to empower the consumers and staff is an essential ingredient in monitoring a recipient's progress toward their recovery. Urinalysis, breathalyzers, and blood workup processes as indicated need to be built into the cost of providing services.

12. *Treatment programs should provide assessment for HIV/AIDS, Hepatitis B and C, tuberculosis, and other infectious diseases, and provide counseling and case management services to help clients modify or change behaviors that place themselves or others at risk of infection.*

Contagious and infectious diseases are the norm for this population of recipients. Effective programs recognize the nature of these issues in their client population and provide appropriate and effective counseling and community support services to assist consumers in modifying their unhealthy behaviors to minimize or eliminate risk factors. Collaboration with those providing such services will maximize resources.

13. *Early and ongoing recovery from alcohol and drug addiction can be a long-term process and frequently requires multiple episodes of treatment to be effective.*

Relapse should not preclude readmission. Relapse patterns need to be evaluated and considered when utilizing the NC Patient Placement Criteria. Recipients who experience frequent relapse cycles need to be considered for placement to more intensive levels of care and are not to be excluded from admission to services.

What services make up a complete Continuum of Care and which services are in place in the Durham area?

The following chart(s) illustrate the current substance abuse services available within the Durham service areas, compared to the ASAM levels of care (a NC Division MH/DD/SA required patient placement criterion and a nationally accepted and evidenced-based benchmark in the addictions

treatment field). (See DRAFT NC Division of MH/DD/SA Substance Abuse Service Definitions.) The analysis of substance abuse services currently existing within the Durham service area revealed the following:

- The Adult System is currently not arranged in a continuum of care. Because the continuum has underdeveloped services, there is not much of a sense of a client proceeding through a logical treatment progression. Substance abuse services are often not clearly identified or differentiated from other services.
- Detox-Adult
 - Consumer feedback highlighted a weakness of the current system as not providing detox services located in the Durham area. Emergency Rooms are overused, the jail and shelters hold people who are in need of detox and the state hospital system is used inappropriately. The Durham Center has contracted for detox beds on a short-term basis with Freedom House as part of the crisis stabilization plan. A detox program should have the capacity for medical and social detox where assessments are completed with planned referral and transition to the next level.
- Outpatient-Adult
 - Since services are not arranged in a continuum and because all services are not available, there is not a logical flow to patient treatment.
 - Outpatient programs will need to be structured with phases for clients to transition as treatment goals are achieved.
 - The Durham area has an Opiate Maintenance Program (methadone) within its county boundaries.
 - Transportation, housing and childcare were listed as major access impediments for substance abuse services.
 - It is not apparent that a wide range of community support services are available in the current service array i.e. aftercare, relapse prevention, childcare, transportation, HIV counseling, peer supports etc. When these issues are addressed it is often within the context of group counseling or adult outpatient services.
- Residential-Adult
 - With the exception of TROSA, which is a therapeutic community model, there is no residential treatment program in Durham County. Freedom House does provide residential and outpatient programs and has opened a facility in Durham County. Residential services are primarily halfway, transitional and shelter. The Urban Ministries has developed a 30-day program serving 30 men and 10 women who are homeless.
 - CJRC provides the Starr program for persons who are incarcerated.

**Current 2003
Adult Substance Abuse Services
Durham Center**

Levels of care within the Continuum	ASAM Patient Placement Criteria	Services	Current Services in place in Durham county
Prevention	Level .05	Prevention Education Services	Partnership for a Drug Free NC* Alcohol and Drug Council of NC CJRC Drug Education Program for Parole and Probationers
Outpatient	N/A	Brief Strategic Intervention	
	N/A	SA Screening/Assessment/Referral	Telecare* TASC Partnership for a Drug Free NC Duke
	OMT	Opioid Maintenance Outpatient Setting	Yes
	Level I	Outpatient Individual and Group Counseling	Partnership for a Drug Free NC Duke Addictions
	Level II	Intensive Outpatient Program	Duke Alcoholism & Addictions Duke Evening Program CJRC
	Level II.5	Partial Hospitalization Day Treatment	CJRC Day Reporting Center
	N/A	Community Support Services including Relapse Prevention, Case Management, Transitional, Peer, and Aftercare/follow-up services	CJRC
Detoxification	Level I-D	Ambulatory/ Outpatient	
	Level III.2-D	Social Setting	Freedom House 8 beds
	Level III.7-D	Non-Hospital Medical	Freedom House

	Level IV-D	Medically Managed Intensive Inpatient Hospital	Telecare proposed 5 beds*
Residential	Level III.05	Transitional Independent Housing	Oxford Houses 8M 2W Healing Place
	Level III.1	Halfway House	Freedom House, Freedom House II Phoenix House, New Leaf, Fellowship Hall, Believe (W)
	Level III.3	Clinically Managed Medium Intensity Residential	STARR (in jail)
	Level III.5	Therapeutic Communities	TROSA (2 years)
	Level III.7	Medically Monitored Intensive Inpatient	
	Level IV	Hospital Inpatient Treatment	

* New Program

Adolescent substance abuse services exhibit much of the same weaknesses as the adult system in the Durham Area. Consumer and community feedback mentioned the dire need for adolescent substance abuse intervention, treatment, and support services for adolescents struggling with substance abuse issues. Essentially, services for adolescents available within Durham County include the Majors Program, limited prevention and outpatient services and the Drug Court. Community Guidance Services has had 3 certified substance abuse counselors in the Durham School System for the past 18 months. That program will end in June.

Detox

- Adolescent Detox services are not available in Durham

Residential

- No residential services for adolescents exist in the Durham area at this time, which means that an adolescent must leave their home county, family, and school system for an extended period of time if a residential program is needed.

Outpatient

- Basic mental health and adolescent outpatient services are offered to adolescents and their families. Many in-home services, respite, educational tutoring, mentoring, case management, peer supports etc. have proven essential to the success of an adolescent struggling to deal effectively with substance abuse recovery issues. These wraparound services are not currently available in the Durham area.

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Adolescent Substance Abuse Services
Durham**

Levels of care within the within the Continuum

ASAM Patient Placement Criteria

Services

Current Services in Durham County

Prevention

Level .05

Prevention Education Services

Partnership for Drug Free NC

Outpatient

N/A

Brief Strategic Intervention

N/A

SA Screening/Assessment/Referral)

Partnership for Drug Free NC

Duke

OMT

Opioid Maintenance Outpatient Setting

Level I

Outpatient Individual and Group Counseling

Partnership for Drug Free NC
Department of Social Services

Level II
Intensive Outpatient Program

Level II.5
Partial Hospitalization

N/A
Community Support Services including Relapse Prevention, Case Management, Transitional, Peer, and Aftercare/follow-up services

Detoxification
Level I-D
Ambulatory/
Outpatient

Level III.2-D
Social Setting

Level III.7-D
Non-Hospital Medical

Level IV-D
Medically Managed Intensive Inpatient Hospital

Residential
Level III.05
Transitional Independent Housing

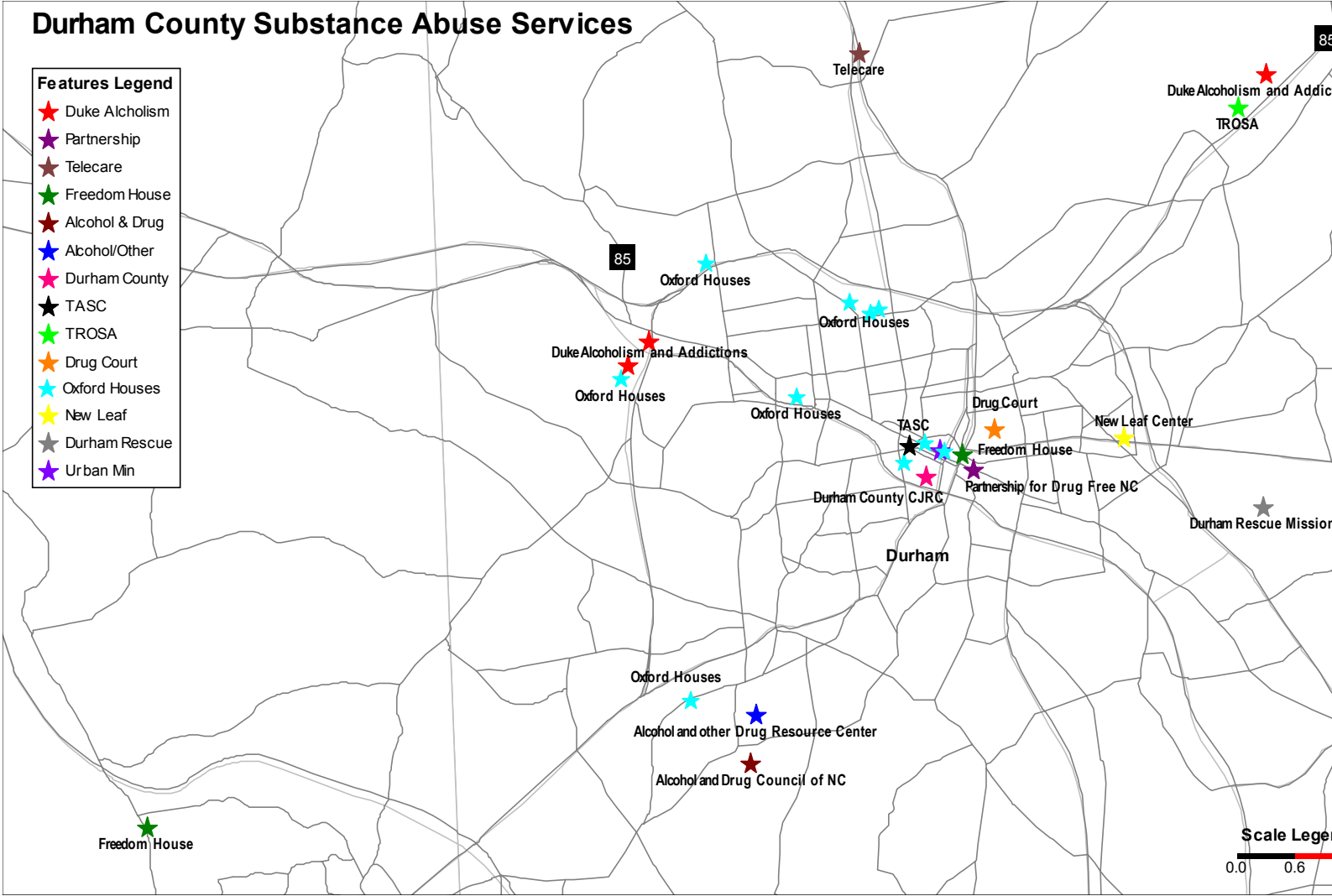
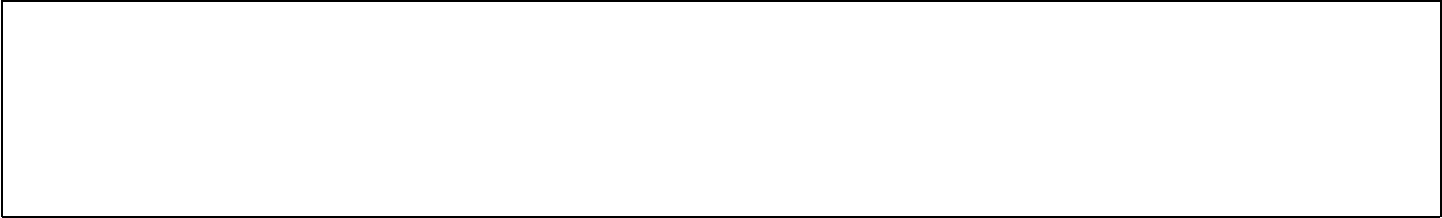
Level III.1
Halfway House

Level III.3
Clinically Managed Medium Intensity Residential

Level III.5
Therapeutic
Group Homes

Level III.7
Medically Monitored Intensive Inpatient

Level IV
Hospital Inpatient Treatment



Durham Behavioral Healthcare Substance Abuse Service capacity and utilization issues

Findings from The National Household Study of Alcohol and Drug Use, 2002 Survey CSAT/SAMHSA, concluded that there were different rates of abuse and dependency for different age ranges within the US population as a whole. By utilizing those percentage rates for the three most prominent age group populations served by Durham programs, capacity for substance abuse

treatment services can be estimated. While age ranges differ slightly in the National Survey on Drug Use and Health from the population data in the Durham County North Carolina 2003 Community Health Assessment it is clear that the rates of use are increasing and that the capacity estimated would be expected to grow in the coming years just as the population of Durham grows.

CSAT's Office for Applied Statistics utilizes a formula to project the treatment service capacity. CSAT projects that between 15 and 25% of the substance abusing and dependent population will present for treatment in any given year. The CSAT figure of 20% was applied to the estimated SA abuse and dependency population to project the treatment capacity needed for each of the population age groups and is illustrated in the following three charts.

**Estimated Substance Abuse Treatment Capacity needed for ages 10-19 years old
Durham County**

Durham County Total	Ages 10-19	SAMHSA Estimate/age group (1)	Estimated SA Population	SAMHSA Estimated Show/year (2)	Total Capacity Needed
233,314	28,609	8.9%	2546	20%	509

**Estimated Substance Abuse Treatment Capacity needed for ages 20-24 years old
Durham County**

Durham County Total	Ages 20-24	SAMHSA Estimate/age Group (1)	Estimated SA Population	SAMHSA Estimated Show/year (2)	Total Capacity Needed
233,314	21,076	21.7%	4573	20%	914

**Estimated Substance Abuse Treatment Capacity needed for ages 25+ years old
Durham County**

Durham County Total	Ages 25+	SAMHSA Estimate/age Group (1)	Estimated SA Population	SAMHSA Estimated Show/year	Total Capacity Needed
233,314	143,465	7.3%	10,472	20%	2094

(1) Results from the 2002 National Survey on Drug Use and Health: National Findings, Series H 22. U.S. Department of Health and Human Services <http://www.samhsa.gov>

(2) Office of Applied Statistics, Center for Substance Abuse Treatment, SAMHSA, 2002.

(3) Durham County N.C. 2003 Community Health Assessment: Health Profile
p.20

The potential gap in services has been identified in the Durham Center’s Local Business Plan using 2000 census data based on 223,000 population, the projected prevalence using national prevalence data and the current services provided in 2002 by The Durham Center. The age range used in the Local Business Plan and the National Household Survey is slightly different but both project similar gap data. The 2002 National Survey on Drug Use and Health use significantly higher prevalence estimates and should be considered in planning for services.

**Estimated Substance Abuse Treatment Gap
Durham**

FY 2000-2001	2002 Census	Prevalence	Estimated Served by The Durham Center	Estimated SA Population	Estimated Annual Capacity needed based on 20% presenting	GAP
Child SA 10-17	21,000	2%	50	420	84	34
Adult SA	172,000	6%	1450	10,302	2064	614
Co-Occurring Disorders	172,000	3%	0	5160	1032	1032

The results indicated that the largest gap in the substance abuse service delivery system is in the area of co-occurring disorders. There are substantial gaps in both adult and adolescent services. These estimates presume that only 20% of the Durham Substance Abusing/Dependent population present for treatment in a year. SAMHSA estimates that between 15-25% of the population needing treatment will present in a year’s time. The GAP analysis does not in any way indicate that the correct services are in place within the service area or that the identified targeted populations are being served in the current array of services. Based on the new findings of the results from the 2002 survey the gap could be substantially larger.

To a large extent, the greater challenge for The Durham Center will be to implement a transition plan which will move its current services, staff, and client base to form a complete continuum of care within the service area which screens/assesses and places targeted substance abuse populations into effective service modalities to meet their needs. At an even broader level, if the Durham Center is given the resources to do so, it can provide a supportive framework to facilitate a more complete and rational system of care for all Durham substance abuse treatment services.

How do the Required Substance Abuse Targeted Populations play into the scheme of reforming the local service delivery system?

The State of North Carolina receives the majority of its substance abuse money for public services from federal grant sources (83.3%) including funds from Substance Abuse Block Grant program/CSAT, Medicaid, US Department of Education, Social Services Block Grant, and State Incentive Grant. This obligates the NC Division of MH/DD/SA Services and its contracted agencies to serve the populations targeted by these funding sources.

Additionally, the Division is able to leverage funding through collaborative arrangements with other state divisions and departments to stretch public treatment resources to cover the difficult to serve substance abuse populations such as Child Protective Services, and the criminal justice populations.

Through the MH/DD/SA reform process, substance abuse targeted populations were defined as those recipients who meet the federal targeted groups or state targeted populations based upon the funding requirements.

SAPTBG (Federal Block Grant Requirements)

The Substance Abuse Prevention and Treatment Block Grant (SAPTBG) lists the following target populations as requirements:

1. 20% of the funds received from the SAPTBG must be spent on Prevention activities,
2. 5% is restricted to treatment services for women and their children,
3. The SAPTBG identifies the following priorities in terms of admissions:
 - a. Pregnant injecting drug users
 - b. Pregnant Substance Abusing Women
 - c. Injecting Drug Users
4. The SAPTBG also identifies services that must be provided directly or through referral for Pregnant Women and their children during the course of treatment:
 - a. Primary medical care (Women)
 - b. Primary Pediatric Care (Children)
 - c. Gender Specific Substance Abuse Treatment
 - d. Therapeutic Interventions (Children)

- e. Childcare
- f. Transportation.
5. Additionally the SAPTBG also requires Section VI: Universal TB Screening, Testing, Referral & Case Management Services, and Health Department MOA.
6. Activities for Reducing Youth Access to Tobacco Products Initiative (Synar Amendment)
7. Communicable Disease Risk Services for Injecting Drug Users & Those Clients Assessed at Risk for TB or HIV including the following:
 - a. *Client Admission and Interim Services*: Description of policies and practices that assure client admission within 14 days of request for services, or if at capacity, within 120 days of request for services, and provision of interim services within 48 hours of request for services.
 - b. *HIV Services*: Description of HIV referral, pre-test counseling, testing, and post-test counseling services.
 - c. *HIV MOA*: Copy of Memorandum of Agreement between the Area Program and the Local Health Department Pertaining to HIV Services.

In addition to targeting the population who are to receive priority services, the SAPTBG also places some restrictions on how the Federal funding can be spent. SAPTBG funding cannot be expended for the following:

- Inpatient hospital substance abuse programs, except when such treatment is a medical necessity and the individual cannot be treated in a community-based, non-hospital, residential treatment program.
- To make cash payments to recipients.
- To purchase or improve land; purchase, construct, or permanently improve (other than minor remodeling) any building or other facility; or purchase major medical equipment.
- To provide financial assistance to any entity other than a public or non-profit private entity.
- To provide individuals with hypodermic needles or syringes.²

North Carolina State Funding Target Population Requirements

Funding sources originating from state revenues or other divisions within the State such as the Division of Social Services (TANF & Child Protective Services), Department of Justice, or State revenue resources may have additional target population requirements.

An agreement called the “Primacy Rule” with the NC Division of MH/DD/SA Services requires that services for individuals with a primary diagnosis of mental

² Catalog of Federal Domestic Assistance. www.cfda.gov/public/viewprogram.asp?progid=1391

health and a secondary substance abuse diagnosis be supported by mental health funding. If an individual has a primary diagnosis of substance abuse and a secondary diagnosis of mental illness, then services are to be supported from substance abuse funding.

The targeted populations represent those citizens most in need of public services. An analysis of the The Durham Center substance abuse client population make-up should be conducted to identify the composition of the population. Since Medicaid is underutilized for substance abuse services and many of these targeted populations qualify for or are current Medicaid recipients, it would be prudent to shift the focus on targeted populations to those who have the potential for Medicaid reimbursement. An additional consideration for focusing on the targeted substance abuse population groups as identified by the Division is the potential for The Durham Center to be included in some of the federal CSAT grants and pilot projects currently under consideration by the State for the upcoming 3-5 years.

Substance Abuse prevention and treatment staff

In addition to the analysis of the the system's service capacity it will be important to analyze the capability of the staff to provide services and to align that capacity with the ability of The Durham Center and its provider network to bill for maximum reimbursement. There are no data available on the number or type of certified personnel in the system. It will be critical to do an inventory of the certified and licensed staff in order to maximize billing for Medicaid and other insurance providers. Training and development programs designed to support the delivery of services and to ensure quality services will be vital to the new system. Using the resources available at the University of North Carolina and Duke could assist in the development of a Recovery Institute with a capability for training and research. Both activities would attract new qualified personnel and provided much needed program evaluation and outcome studies. Currently TROSA is working with Duke to identify outcome information.

Recommendations for building the new substance abuse treatment system for Durham County

The Durham Center – Specific Recommendations:

Making the transition from an Area Program that provides substance abuse services to a Local Management Entity that builds a complete continuum of care and provides the design management, and assures the delivery of services to the targeted populations will necessitate a systemic change for The Durham Center as well as its provider network. Most likely the development of a complete continuum of care for substance abuse will involve specialty providers, comprehensive community providers, and core services units/agencies rather than independent practitioners. It will be important for the Durham Center to strengthen and support providers currently in its network and/or in the larger community system, particularly those with missions in substance abuse.

In its proposed services divestment plan, The Durham Center identifies that new agencies will be established, existing services will be transferred to other agencies, and new or additional services will be developed through a competitive bid process. The recommendations for the development of a complete continuum of care to address the area's substance abuse/dependency cases will encompass all of the options identified in the divestiture plan. As new service contracts are put in place, actions should be taken to assure coordination with existing services and to plug into the continuum of care being developed.

1. Initially The Durham Center must add leadership with substance abuse expertise capability to its administrative structure. Many of the strategies for developing effective and quality services will require knowledgeable and experienced leadership to enhance the quality of services, change attitudes and reduce the stigma associated with addiction. Technical assistance familiar with best practices and treatment improvement protocols will be key to developing an effective system. Assisting providers in their growth and development will enhance the system.
2. In addition to developing strong leadership in substance abuse it is important for The Durham Center to develop a communications plan for the dissemination of information for officials and consumers alike.
3. Equally important is the creation of a coordinating network for providers. Providers will flourish when they have the opportunity to learn about each other's services, collaborate on program planning, share resources and give feedback to The Durham Center on how they see the system developing. The Durham Center may want to empanel an advisory group of substance abuse experts to advise on strengthening the system as well as convening a youth coordinating council to effectively address substance abuse issues with youth.
4. The Durham system needs to be built upon a complete seamless continuum of care model with basic outpatient services including 24-hour crisis response, screening and assessment, intensive outpatient, and community Support services for adult and adolescent populations. Durham County is the 2nd highest user of state hospital admissions and the 3rd highest user of patient days in the state hospital. Comprehensive Outpatient Treatment Programs and residential treatment options could eliminate the need for some of these admissions while at the same time enhancing the quality of services. Additionally, Durham does not have a non-hospital residential treatment capacity. Some residential treatment capabilities exist with the Urban Ministries Shelter and Freedom House, and offer programs to address homogenous client groups. The opportunity exists to create other residential and/or comprehensive outpatient treatment programs and/or intensive outpatient programs such as all women/mothers, or co-occurring disorders, or adolescent that are not limited to just general admissions requiring this level of care.

5. The Durham Center needs to reallocate its' substance abuse treatment funding across the continuum of care to attract core service providers, specialty providers and comprehensive service providers in order to support and provide the new array of services.

Projecting Service levels in a continuum of care model is difficult because of the lack of service data. The Durham Center should begin by addressing the obvious gaps in service and building on the existing programs.

1. Transition to a comprehensive continuum of care should include the following actions.
 - a. Staff crisis centers with certified substance abuse professionals to insure appropriate clinical responses to alcohol and drug induced crisis. This will encourage accurate diagnosis and development of adequate person centered plans for substance abuse clients within the system.
 - b. Consider the possibility of establishing a residential program for adult and/or adolescent care requiring assessment, detox, non-medical inpatient, comprehensive outpatient treatment programs, and substance abuse community support services for the adult and adolescent populations. We recognize that there are community discussions about reopening Oakleigh as such a site.
 - c. Consider using the RFP process to identify a provider. The Durham Center must be sure to clarify its intentions and must provide a fair and open process with RFP's. While the process is competitive it must also be used with good judgment to select providers who enhance the system and create trust with other providers. The RFP system must be used to enhance collaboration of providers.
 - i. The RFP should require contract providers to make a strong effort to employ recovering individuals to facilitate the delivery of Medicaid reimbursable services such as community support for adults and adolescents and to enhance the LME's ability to strengthen its ties to the community and peer support community that exists within the service area.
 - ii. All staff employed within every service area treating substance abuse clients should at a minimum be registered with the North Carolina Certification Board for Substance Abuse professionals, including those staff delivering prevention services as well as all individuals who are supervising substance abuse services. Clinical supervision and substance abuse program management must be provided by those individuals who hold a valid supervision credential and/or license.

- iii. Contracts should be awarded to those providers who have the infrastructure to support adequate client reporting systems that can demonstrate that targeted populations are admitted into the service system. If this is not feasible initially, then The Durham Center needs to accommodate the development of the infrastructure to insure consistent response, tracking, and future QI activities.
 - iv. Contracts need to reflect the requirement that clients will be placed into levels of care appropriate to their symptoms and that clients will transition between levels of care seamlessly and without any gaps in services at any level or transfer juncture.
 2. Regarding the assessment tool: a valid and reliable assessment for adult and adolescent substance abuse needs to be implemented at the system's crisis response service as well as all entry points to the system. Every entry point in the Durham system needs to utilize the same tool so criteria can be tracked, measured and analyzed for admissions, symptoms, and placement trends. The tool selected needs to link the symptoms and severity to the ASAM criteria for patient placement within the system and provide the necessary data to analyze placement patterns over the course of time to insure retrospective clinical care analysis and future quality improvement tracking. Several computerized tools exist which could provide cost effective measures for accomplishing this. Data collection processes could be tailored into the computerized assessment that would make such summary and analysis seamless, time efficient and cost effective and segue to the systems client data collection process.
 3. In the Telecare Crisis Center, detox beds should be separate from the psychiatric crisis beds. They can be located within the same building but need to be staffed and maintained for detox services specifically including the ability to handle crisis, assessment, intervention, and referral. The substance abuse and mental health crisis clients should be housed in a separate bed unit as should adult and adolescent clients and the staff makeup of each unit should have demonstrated competencies with each of these particular populations and crisis services.
 4. A question that the Durham Center system will have to wrestle with in the design and implementation of the new system is how to insure that the system takes in the right population of clients to meet the federal and state mandates regarding targeted populations. A careful analysis of the current service population

characteristics needs to be performed to determine the extent of the shift in service populations to meet the required target populations, particularly in the adult SA client population. Included in the analysis should be a clear determination of diagnosis, client characteristics, and admission referral source, as well as severity upon admission and patient placement criteria used. The Durham Center may want to evaluate developing a process by which the client population projected to be served by the new system will include a higher portion of Medicaid eligible clients to increase reimbursement for services. Screening and assessment processes should only be performed by skilled competent credentialed staff. The system should front load its credentialed staff to these areas to insure that this shift will occur with minimal difficulties.

5. In addition to the mandated target populations mentioned above, a significant cultural/language issue which needs the LME's attention is the growing population of Hispanics/Latinos who have relocated to the area. Services offered in the new continuum of care need to accommodate the needs of this population. The Durham Center should explore the possibility of specialized services initiated by El Centro or Dr. Luke Smith (a physician interested in opening a clinic to serve a Latino population).

If substance abuse services are to be delivered in a cost effective fashion, then the makeup of the staff needs to reflect a much higher rate of professionals who can be eligible billing agents for the system. Virtually any staff member working with a substance abuse client needs to be at least registered with the NC Certification Board as an applicant, supervised by a Qualified Supervisor, and programs managed by the same. A current credential needs to be required for every employee in each clinical substance abuse service area, including those licensed by other professions. A highly credentialed workforce increases the system's ability to bill Medicaid and bring more resources into the system for treatment. Current Supervisors need to be certified at the supervisory level, strongly encouraged, or provided with incentives to qualify for that level of credential. Licensed professionals who are working with SA clients need to obtain their deemed status certification with the NC Certification Board to insure their competency with the population.

7. It is not at all apparent that The Durham Center has a strong connection with the self-help community that exists within its service area. There are 44 Alcoholics Anonymous groups in the area. Narcotics Anonymous groups, Cocaine Anonymous groups, and AI-anon groups also hold weekly meetings in Durham. If a substance abuse treatment service does not tap into its community self-help network for support of its alcoholics and addicts it is not availing itself, clients, or family members of one of the most

effective peer support recovery processes in existence. Additionally, community collaborative partners which exist in the school systems, criminal justice system, social services systems, particularly TANF and Child Protective Services all have funds and programs supporting recovery efforts within each of their systems. Both the self-help community as well as logical community partnerships need to be explored, strengthened, and encouraged to work collaboratively with this population. The Durham Center could establish a position to build a strong community collaborative effort with these groups, strengthen the peer supports which already are in existence for their clients and families, encourage the efficient expenditure of public dollars for this population, and explore new funding streams and payment arrangements. The recent release of the RFP creating a mentoring support system for case management may offer an opportunity to engage the recovering community. To maximize this opportunity The Durham Center needs to support this effort through providing coordinating support.

Redefining the substance abuse treatment system will require a tremendous effort by The Durham Center. The nature of addiction and the process of recovery require that care be person centered and strongly coordinated between providers. The provision of services that do not offer structured programs with intensive monitoring and follow up is not the effective use of resources. However, building a system takes time and the question becomes where to begin. The following chart reflects the priority recommendations for the most critical areas to be addressed.

Durham County – General Observations

1. The development of the new substance abuse treatment system will occur over time and will require changes in existing patterns and practices, and treatment capacity.
2. The recommendations made for the Durham Center apply at least in principle to the larger treatment community in Durham County. The Durham Center has the opportunity to model experienced based programs and provide leadership to the general community.
 - The same gaps in service, access issues, etc. tend to manifest in the larger non-Durham Center client population.
 - Quality and accountability issues are as important
3. The Durham Center is probably in the best position to facilitate change in the overall substance abuse treatment system in Durham County, because it must facilitate the same changes within its own direct sphere of responsibility. The Durham Center will have the opportunity to access federal and other grant programs that will expand the community programming. But:
 - It will not have direct authority over many aspects of the larger system

- It must not be expected to accomplish this within the resources allocated just for dealing with its own target population

**Priority Recommendations For Designing
The Substance Abuse Treatment System
For
Durham County**

Foundation Building	Systems Improvement	Service Development
<ul style="list-style-type: none"> • Create a substance abuse leadership position at The Durham Center • Create advisory panel of experts to advise on building the system • Add staff expertise to offer Technical Advice to providers • Initiate a communications plan to keep community informed • Create a youth services advisory panel • Improve communications with providers around the RFP process 	<ul style="list-style-type: none"> • Inventory certified and licensed staff for substance abuse services • Create a Recovery Institute for both training and research • Clarify expected client outcomes and track results • Create a coordinating council/network of providers • Institute a common assessment tool, track clients and provide adequate data collection and reporting systems 	<ul style="list-style-type: none"> • Initiate the development of a non-hospital residential treatment capacity (minimum 16 beds, LOS based on client need) • Initiate integrated outpatient services for co-occurring disorders • Initiate adolescent residential treatment capacity (8-12 beds) • Staff crisis and assessment centers with qualified personnel to improve diagnostic accuracy

Participants In the Planning Process

A special thank you to all those committed persons who gave freely of their time and so eloquently expressed their concerns so that a system of substances abuse services for Durham County North Carolina could be visualized. A special recognition is provided to Tony Mulvihill* who served on the task group, participated in interviewing and provided data for analysis.

Evester Bailey	The Durham Center
Mary Ann Black	Duke University
Peter Baker	Drug Court Administration
Honorable Richard Cheney	Adult Drug Court
Howard Clement	Durham City Council
Steven W. Chalmers	Durham Police Department
Marsha Connor	City of Durham
Wendell Davis	Durham County
James Finch, M.D.	The Durham Center
Steve Finch	Durham Regional Hospital ER
April Guilford, PhD	Partnership for Drug Free NC
Joe Harvard	Presbyterian Ministry
Mary Hill	Duke University
Worth L. Hill	Durham County Sheriffs office
Trish Hussey	Freedom House
Rev HYTE	Gotta Save
Dan Hudgins	Durham County Social Services
Whilamina Foster Long	CJRC
Kevin McDonald	TROSA
Honorable Marsha Morey	Juvenile Drug Court
Tony Mulvihill*	Alcohol/Drug Council of NC
Kathryn Thrash Nugumba M.D.	Lincoln Center
Honorable Elaine O'Neil	Family Drug Court
Gudrun Palmer	CJRC
Ellen W. Reckhow	Durham County Board of Commissioners
Brice Reynolds	The Durham Center
Lloyd Schmeidler	Urban Ministries
Marvin Schwartz M.D.	Duke University
Evelyn Schmidt M.D.	Lincoln Center
Kathy Shuart	Durham County Drug Court
Mike Smith	Durham County EMS
Rev. Tart	Durham Rescue Mission
Carolyn Titus	Durham County
Randy Tucker	STARR
Theresa Wahome PhD	Durham School System
David Weiner	Durham Congregations In Action