

**DURHAM COUNTY PROPOSED SUBSTANCE ABUSE SERVICES 10 YEAR PLAN
AND REQUEST FOR FUNDING FOR FISCAL YEAR 2006-2007**

**Substance Abuse:
A National Nightmare...**

Almost **12 million** Americans have substance dependencies; of this number
over **4 million** are under the age of 18

Almost **35 million** Americans used illicit drugs in 2004; of this number
over **5 million** were under the age of 18

Almost **55 million, or 1 in 5** Americans had engaged in binge drinking
within the last month of study; over **16 million** were classified as heavy alcohol users

(SAMHSA, for 2004)

...A Durham County Epidemic

Over **19,000** Durham County citizens are addicted to drugs or alcohol

(SAMHSA, for 2004, prevalence rates applied to Durham County)

The cost to Durham County of substance abuse was **over \$250 million** in 2003

(Alcohol/Drug Council of NC Epidemiological Data for 2003)

25% of all automobile fatalities in Durham County are caused by alcohol consumption

(Durham County Alcohol and Substance Abuse Community Surveillance Network)

The Cost-Efficiency of Substance Abuse Treatment

The national economic costs of alcohol abuse were estimated to be **\$184.6 billion**
and those of drug abuse were **\$143.4 billion** (SAMHSA, for 1998)

The total cost to society of substance abuse is nearly **25 times**
what the United States spends on treatment (SAMHSA)

For every **\$1** invested in treatment, there is a **\$12** savings in reduced health-care costs,
drug-related crime, criminal justice costs and theft (DHHS/NIH/NIDA, 1999/2000)

Providing substance abuse treatment for Medicaid patients through comprehensive managed
care programs can reduce total medical costs by **30%** (Journal of Behavioral Health Sciences & Research, 2005)

Recognition of the Need

The Durham Center (TDC) divested all of its direct services and began operating as a Local Management Entity since December 2004. Since that time, TDC has strived to develop a seamless and comprehensive treatment delivery system to serve the citizens of Durham County.

At the national level, advances in research in addiction and treatment have afforded us a better understanding of addiction and best practice approaches to treatment. There is scientific evidence that treatment is effective for individuals with substance abuse problems and clinical research has enhanced behavioral and pharmacological treatments regimens.

At the local level, The Durham Center has initiated a local crisis emergency program (Durham Center Access) to provide quality screening, triage, referral and stabilization services. The Durham County Board of Commissioners has provided consistent support and we have fostered improved relationships and better cooperation with academic partners, community providers and the Twelve Step community. New programs and services, like MAJORS (a substance abuse program for juveniles in the Court system), the Criminal Justice Resource Center and Opiate Replacement Therapy have been created.

Despite these efforts substantial gaps remain, critical services are still absent, reasonable and timely access to services is inconsistent or unavailable, and services that are available do not reflect best-practice approaches. Since its report *Designing the Substance Abuse Treatment System for Durham County (May 2004)* the Technical Assistance Collaborative (TAC) has been joined by subsequent assessments from a variety of other sources in identifying **deficiencies in the continuum of substance abuse services in Durham County** that have had significant negative impact on individuals, families and the community.

These deficiencies must be addressed through:

- ❖ Creation of a comprehensive and integrated substance abuse continuum of easily accessible and timely community-based services based on national standards of best practice
- ❖ Development and maintenance of a service continuum with coordinated strategies for addressing co-occurring medical and mental health issues
- ❖ Indoctrinating into this continuum a “no wrong door to treatment” policy, with access to services that is accurate, engaging and timely to correct the current situation in which too few individuals and families access needed services and a 66% no-show rate exists for those that are scheduled for services
- ❖ Sufficient funding to subsidize a dramatically-under-funded system resulting in the capacity to offer a full range of services for individuals with addiction and substance abuse issues
- ❖ Establishment of a System of Care framework and a system that is seamless across service agencies to correct the current service system that is underdeveloped and fragmented between public, private and self-help and core services

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- ❖ Development of programs designed to competently address the co-existing medical, psychiatric and social (housing, employment, etc.) needs of consumers
- ❖ Building of a skilled workforce with an adequate numbers of qualified substance abuse professionals that are well-trained, supervised and compensated
- ❖ Reduction and eventually elimination of the stigma of addictive illness, including the education and involvement of all stakeholders in widespread prevention efforts
- ❖ Building into the system timely and comprehensive identification of consumers in need through resources including hospital-based consultation services, universal screenings and in the criminal justice system
- ❖ Linking of funding opportunities of providers to performance and the successful achievement of established outcome indicators.

Durham's Current Service Continuum

Durham is in the midst of building a complete continuum of accessible and effective substance abuse services and supports with a focus on best practice and high quality to achieve positive outcomes. Our number one goal is to help consumers have more good days than bad days while moving through the process of recovery. The community has a number of Mental Health Providers who have shown an interest in working with the substance abuse population. Several have become or are in the process of becoming licensed by the State to perform substance abuse services. In addition, the new service definitions bring new services which are community-based and more in line with best practices.

However, careful analysis of the current continuum of substance abuse treatment services detailed in **Attachments B and C** reveals some significant holes and services that are not integrated, not based on scientific research and not easily accessible, resulting in poor outcomes for individuals with substance abusing behaviors and their families. The majority of Durham providers are either new to our community or struggling to maintain viability. Upon divestiture TDC contracted with one provider that provided outpatient treatment, MAJORS and prevention services, one TASC provider, one opioid treatment provider, one residential facility for women with children, one outpatient treatment facility serving women with children and one transitional living provider. To date three of those six providers have discontinued operations in Durham and five of these major service areas have been reopened through an RFP process. At this time there is no provider of child substance abuse residential services.

A detailed description of Methadone Management Treatment (Opiate Replacement Therapy) is contained in **Attachment D**.

There has been tremendous interest in bringing mental health and developmental disability services to Durham. Over the past year our Case Management/Community Support Providers

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have grown from 3-5 to almost thirty. In the substance abuse arena, however, there has not been the same interest due to insufficient funding, lack of trained and qualified staff, parity issues and difficulty in accessing and authorizing available funding. Funding deficiencies have resulted in agencies being unable to develop a strong infrastructure, support necessary training for staff, develop and implement quality improvement plans and pay staff reasonable wages.

A Dilemma in the Substance Abuse Workforce

Over the past several years North Carolina has experienced a substance abuse service workforce crisis. Several factors account for this crisis:

- ❖ Most substance abuse providers practicing prior to Mental Health Reform worked for area programs. Many of those experienced professionals moved to LME administrative positions and are no longer providing direct services.
- ❖ Legislative changes in September 2005 dictated what education, experience and knowledge one must have in order to deliver SA services. Consequently, some professionals are no longer able to practice at the same levels that they once were, leaving an underdeveloped workforce in place.
- ❖ Medicaid changes over the past couple of years require that licensed professionals provide the most intensive substance abuse services in order for providers to be reimbursed but those licensed providers are most often in leadership and supervisory roles and are unable to provide direct services simultaneously with their supervisory responsibilities.
- ❖ Funding deficits throughout the field result in Agency/Programs having to work from depleted budgets which do not support competitive salaries, ongoing training and the development of a sound infrastructure to provide needed administrative and clinical supervision. These issues have created a market which is largely unattractive to individuals desiring to enter the helping field and discouraging to existing substance abuse professionals.

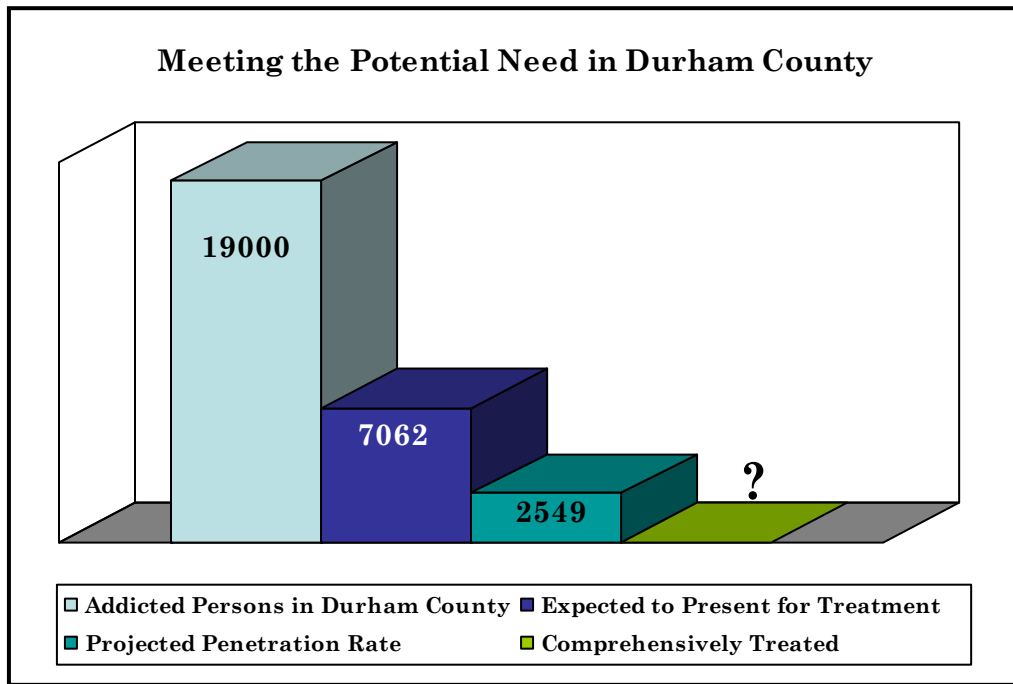
The workforce capacity is diminished nationwide and is being addressed at the highest levels but most estimates indicate that it will take many years to build an adequate workforce. This trend is evidenced in Durham County by Table 1 below which reflects staff/consumer ratios at or near the NC minimum requirement. Here most facilities are operating at or near capacity and to begin treating the unserved majority of the affected population, innovative initiatives must be developed to attract substance abuse professionals to Durham County.

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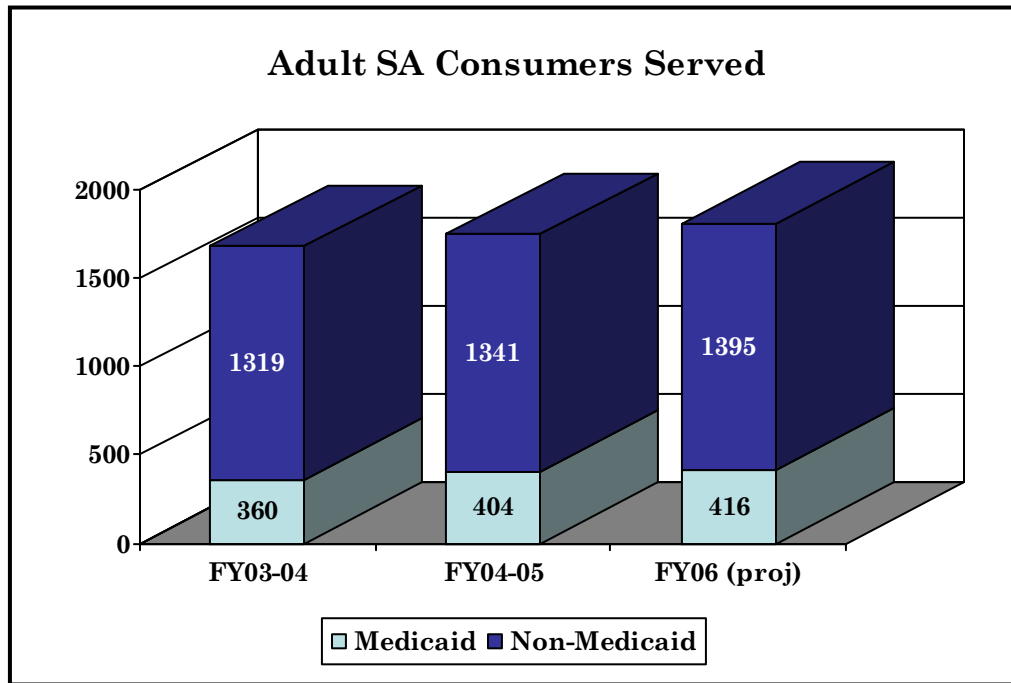
Table 1 - Substance Abuse Staffing (April 2006)

Provider	Licensed/Credentialed SA Staff Providing Direct Services	Unlicensed or Paraprofessional Staff Providing Direct Services	Staff/Consumer Ratio
Southlight	2	7	1:51
Healing with CAARE	2	5	1:40
Gilfort, Atkinson & Assoc./Dominion Ministries	0	5	1:7
Freedom House	2	6	1:2

Consumer Demand for Substance Abuse Services



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Provider Data

Table 2 - Total SA Consumer Traffic (FY06 to Date)

Provider	Referrals	Admissions	1 st Appt. No-Show Rate	Consumers with Open Authorizations (April 2006)
Southlight	388	153	61%	462
Healing with CAARE	106	45	58%	143
Gilfort, Atkinson & Assoc./Dominion Ministries	18	5	72%	35
Partnership for a Drug Free NC	167	41	75%	0
Duke Family Care				43
Freedom House (transitional Living and both halfway houses)				17

(Shaded areas receive no screening/triage referrals)

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Outcome Data

The North Carolina Treatment Outcomes and Program Performance System (NC-TOPPS) is the State outcome data collection system. Assessments are completed through consumer interviews at initiation of services and thereafter at three month intervals. Data from follow up assessments is insufficient prior to 2006. Below are the highlights from six-month follow up assessments for substance abuse consumers receiving services through Southlight Opioid Treatment Program as well as dual diagnosis consumers (SA/MH) receiving services through three mental health service providers, Area Services and Programs (ASAP), Triumph and Telecare. Six-month update data represents those who remained in services for at least six months and does not include data for those who discontinued treatment for any reason. The initial survey group numbered 221 and the 6-month update group was 190.

<i>SA diagnosed Consumers Receiving Opioid Treatment Through Southlight</i>

66% of consumers indicated heroin as their primary substance abuse problem; 33% indicated other opiates

- ❖ Self report of drug use (THC, cocaine, heroin or opiates) **reduced by 16 percentage points** (down from 60% at initial assessment to 44% at six months)
- ❖ Self report of drug use (alcohol) **reduced by 7 percentage points** (down from 10% in the initial assessment)
- ❖ At three-month assessments, 39% showed clean urinalysis; 49% showed clean urinalysis at six-month assessment, an **increase of 10 percentage points**
- ❖ 63% of consumers were considered in the labor force at the six-month assessment. Of those, 62% were employed, an increase of 8 percentage points from the initial assessment figures
- ❖ Consumers reported improved health and family relationships
 - ❖ Physical health – **improved by 15 percentage points** (only 25% reporting fair or poor at six-month assessment)
 - ❖ Emotional health – **improved by 19 percentage points** (only 27% reporting fair or poor at six-month assessment)
 - ❖ Family relationships – **improved by 16 percentage points** (only 20% reporting fair or poor at six-month assessment)
- ❖ **50% reduction** in the number of consumers who reported visiting an emergency room in the past three months (from 21% at initial assessment to 11% at the six-month assessment)

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*SA/MI Dual Diagnosed Consumers Receiving Mental Health Treatment at ASAP,
Telecare and Triumph*

40% of consumers reported cocaine/crack as their primary substance abuse problem; 39% reported alcohol; 17% reported marijuana and 3% reported heroin or other opiates

- ❖ Self report of drug use (THC, cocaine, heroin or opiates) **reduced by 15 percentage points** (down from 49% at initial assessment to 34% at six months)
- ❖ Self report of drug use (alcohol) **reduced by 11 percentage points** (down from 50% in the initial assessment)
- ❖ Urinalysis data is not complete for this population
- ❖ 49% of consumers were considered in the labor force at the six-month assessment. Of those, 32% were employed, **an increase of 3 percentage points**
- ❖ Consumers reported improved health and family relationships
 - ❖ Physical health – **improved by 15 percentage points** (42% reporting fair or poor at six-month assessment)
 - ❖ Emotional health – **improved by 24 percentage points** (49% reporting fair or poor at six-month assessment)
 - ❖ Family relationships – **improved by 11 percentage points** (49% reporting fair or poor at six-month assessment)
- ❖ **25% reduction** in the number of consumers who reported visiting an emergency room in the past three months (from 28% at initial assessment to 21% at the six-month assessment)

Freedom House

Men's halfway house (6 bed facility)

- ❖ 39% substance abuse diagnosis and 61% dual SA/MH diagnosis
- ❖ 94% average monthly utilization
- ❖ 22 total consumers served 1st through 3rd quarters of FY 06
- ❖ 7 consumers served per month on average
- ❖ 17 day average length of stay for discharged consumers*
- ❖ 65% completed service plans for a successful discharge
- ❖ 100% were engaged in treatment during their stay

Women's halfway house (10 bed facility)

- ❖ 45% substance abuse diagnosis and 55% dual SA/MH diagnosis
- ❖ 81% average monthly utilization

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- ❖ 31 total consumers served 1st through 3rd quarters of FY 06
- ❖ 10 consumers served per month on average
- ❖ 15 day average length of stay for discharged consumers*
- ❖ 52% completed service plans for a successful discharge
- ❖ 100% were engaged in treatment during their stay

Transitional Living Facility (6 bed facility)

- ❖ 32% substance abuse diagnosis, 49% SA/MH diagnosis and 15% mental health diagnosis only
- ❖ 79% average utilization
- ❖ 78 total consumers served 1st through 3rd quarters of FY06
- ❖ 12 consumers served per month on average
- ❖ 13 day average length of stay for discharged consumers
- ❖ 86% completed service plans for a successful discharge
- ❖ 91% engaged in treatment during their stay

** Continuing residents, some who have a length of stay of six months or more, are not included in the calculation of average stay*

Moving forward, The Durham Center will move rapidly toward full implementation of an existing array of performance-monitoring and quality-improvement activities which will provide more comprehensive and illuminating data in the future. This array is detailed in **Attachment E**.

The Plan

The numbers are staggering. The impact of substance abuse on our community is incomprehensible and devastating. In response to the significant deficiencies that have been identified through the TAC Report and the MGT Report and through The Durham Center's work in developing the service array, it has become obvious that a strong, long-term strategic action plan built in collaboration with our community partners is an essential next step. A second realization is the deficiency in the funding required to develop a sustainable and comprehensive array of services for Durham that can significantly reduce the negative impact of substance abuse on our community.

Therefore, a 10-Year Plan was developed through a collaborative effort that drew on local expertise and utilized community partners to identify gaps and barriers in services, establish community-wide goals and institute a realistic plan for the future. A Substance Abuse Advisory Committee (**Attachment F**) utilized a variety of important resources to create a plan that is consistent with SAMHSA National Outcome Measures, assures that goals and objectives are measurable and incorporates clinical best practices in service delivery.

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The Committee's mission is to reduce the incidence and impact of alcohol and drug use in Durham County to the lowest rates in North Carolina and to create the greatest opportunities for recovery in the State.

The Durham Center's Action Plan was developed to put into effect the Committee's recommendations and will begin to develop a comprehensive and integrated array of services and supports for individuals with substance abuse problems and their families through a System of Care framework.

North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services target populations have been identified as the priority groups for the Action Plan. However, The Durham Center remains committed to serving all individuals who present as having an alcohol or drug problem. The State target populations as well as a demographic breakdown of the substance abuse consumers served by The Durham Center in FY 2004-2005 can be found in **Attachments G and H**.

Values and Principles

The Action Plan incorporates the Advisory Committee's values and principles that are considered fundamental to the development and implementation of comprehensive County-wide substance abuse programs and services:

- ❖ Addiction is a treatable chronic illness
- ❖ Recovery is a life long process of restoring health, function and meaning to life
- ❖ Prevention will improve outcomes for the Durham community
- ❖ Abstinence is a foundation of the recovery process
- ❖ Treatment options should embrace spiritual growth
- ❖ Family impact of addiction requires family perspective in recovery
- ❖ Mutual support is a powerful recovery resource
- ❖ Many consumers have co-morbid issues that must be addressed to fully engage the individual in the recovery process
- ❖ Quality treatment builds on evidence and utilizes best practices.

Goals of the 10-Year Plan and Action Plan Strategies

Goal 1 – Stimulate a Recovery Culture within the Durham Community. Incorporate a sense of community ownership of substance abuse issues and reduce the stigma associated with substance abuse, creating a common understanding of addiction as a treatable disease. Over time we will develop local political support and the “will” to strengthen and sustain the local System of Care as the way business is done. As the community substance abuse treatment infrastructure builds capacity the focus of educational efforts will evolve to increasing consumer demand to ensure that the system serves a greater percentage of the affected population.

Action Plan Strategies:

- ❖ Take a leadership role in congealing the resources and technical expertise of community partner agencies interested in a substance abuse media campaign (i.e. Partnership for a Healthy Durham, Alcohol/Drug Council of NC, Durham Health Department)
- ❖ Develop a public-private partnership tapping into the Durham creative community (ad agencies, film/video production companies, etc.) to create and execute a wide-ranging substance abuse media campaign
- ❖ Recruit corporate support for a substance abuse media campaign
- ❖ Conduct focus groups with key stakeholders and audience segments to develop campaign messaging
- ❖ Produce a substance abuse media campaign leveraging contribution of services from private sector to include some or all of TV/radio, newspaper and other print, internet, direct mail, billboard, point of purchase, kiosk, and movie screen advertising
- ❖ Maintain a local newspaper presence through feature articles and advertising
- ❖ Provide community education through increased presence in the school system and at public events, such as town hall meetings and health fairs
- ❖ Promote Durham’s Network of Care through web page and other venues; maintain an up-to-date online Substance Abuse Provider Directory.

Goal 2 – Adapt Durham’s nationally-recognized System of Care (SOC) framework to the substance abuse service delivery system to achieve better outcomes for individuals with substance abuse problems and their families. The SOC framework shall consist of an integrated network of community services and resources to help people and families receive needed substance abuse services. SOC is developed and supported through collaboration among individuals, families, professionals and the community. Much more detailed information about System of Care is contained in **Attachment I**.

Action Plan Strategies:

- ❖ Develop and implement a System of Care Training Plan for Durham County based on the needs of service delivery to individuals with substance abusing behaviors and their families

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- ❖ Institute Teaching Case Conferences to provide training and consultation and to learn about service delivery and system-related issues through an interagency consortium format. Operational duties include development of protocols, entrance criteria and related forms
- ❖ Build infrastructure by hiring a System of Care consultant/expert to assist with the development of SOC in the substance abuse arena, including developing the architecture for the design of SOC, assisting in development of infrastructure, ensuring congruency with best practices, making recommendations on how to improve service array and build stakeholder buy-in and commitment to implementation

Goal 3 – Create a substance abuse services delivery system able to recruit, support and maintain a qualified workforce capable of meeting the demands of the community. This better-qualified workforce has been mandated by new service definitions, State legislation and best practice standards and increases the system’s ability to bill Medicaid and access additional funding streams. Finding and keeping qualified and credentialed substance abuse staff is a chronic problem not only in Durham, but statewide. Durham is proposing innovative strategies to address this problem.

Action Plan Strategies:

- ❖ Develop a training curriculum for both new and existing substance abuse professionals maximizing existing community educational resources; arrange for Provider Training for provider or staff which is applicable to SA Certification/Licensure requirements (SA, ASAM, Adolescent, Curriculum)
- ❖ Provide cross-training opportunities for other professionals who have contact with substance abusing consumers (medical personnel, Department of Social Services employees, law enforcement, etc.)
- ❖ As described above, Teaching Case Conferences will also be used to meet the substance abuse credentialing requirement for supervision
- ❖ Provide training scholarships for staff desiring to become credentialed and willing to commit to working in Durham
- ❖ Institute incentive bonuses modeled after Smart Start Wages Project
- ❖ Provide technical assistance in clinical supervision functions (clinical care reviews, etc.)

Goal 4 – Develop a sustainable provider community able to provide easily-accessible and high-quality services within existing rules and funding sources. Durham currently has a drastically underdeveloped group of providers often characterized by inconsistent service delivered by undertrained and poorly-supervised staff. The Durham Center will coordinate technical assistance to help existing and prospective providers develop and implement quality improvement processes, create proper growth expectations and remain healthy and viable businesses.

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Action Plan Strategies:

- ❖ Provide and/or arrange for technical assistance to members of the provider community on building and sustaining their agencies/programs
- ❖ Provide business development expertise by fostering partnerships with higher education institutions
- ❖ Investigate neighboring states for appropriate business models
- ❖ Develop a quality improvement and evaluation plan
- ❖ Incorporate performance-based contracting

Goal 5 – Develop a comprehensive array of high quality services and supports to meet the needs of individuals and families who suffer from drug or alcohol addiction or who are dually-diagnosed. The Durham substance abuse system remains an underfunded system with needs for startup or upfitting of existing agencies to develop the full continuum of needed services. Service needs for Durham center on expanding existing providers as well as filling in big gaps in the service array.

Action Plan Strategies:

- ❖ Address service gaps including (see budget attachment)
 - ❖ Development of a comprehensive prevention plan
 - ❖ Community Support Service
 - ❖ Substance Abuse Intensive Outpatient Treatment (SAIOP)
 - ❖ Day Treatment (SACOT)
 - ❖ Residential Treatment – Adults (12 bed structured short term)
- ❖ Conduct a yearly review of the community service array and make changes as appropriate
- ❖ Integrate primary health care and substance abuse services
- ❖ Provide community-based services and incorporate the entire family and other natural/informal supports into the treatment process
- ❖ Educate, recruit, train and promote providers who utilize known “best practices”

<p>The Best Practice Model</p> <p>A comprehensive disease management approach</p> <p>Enhanced partnerships with community agents for prevention, screening, intervention and treatment</p> <p>Treatment on demand</p> <p>Application of person-centered, stage-wide and outcome driven approaches</p> <p>Need based, adaptive and long-term supports</p> <p>Use of medications for stabilization and recovery</p> <p>Coordinated, integrated strategies for addressing co-occurring medical and mental health issues</p> <p>Use of evidence-based behavioral therapies</p>

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Budget

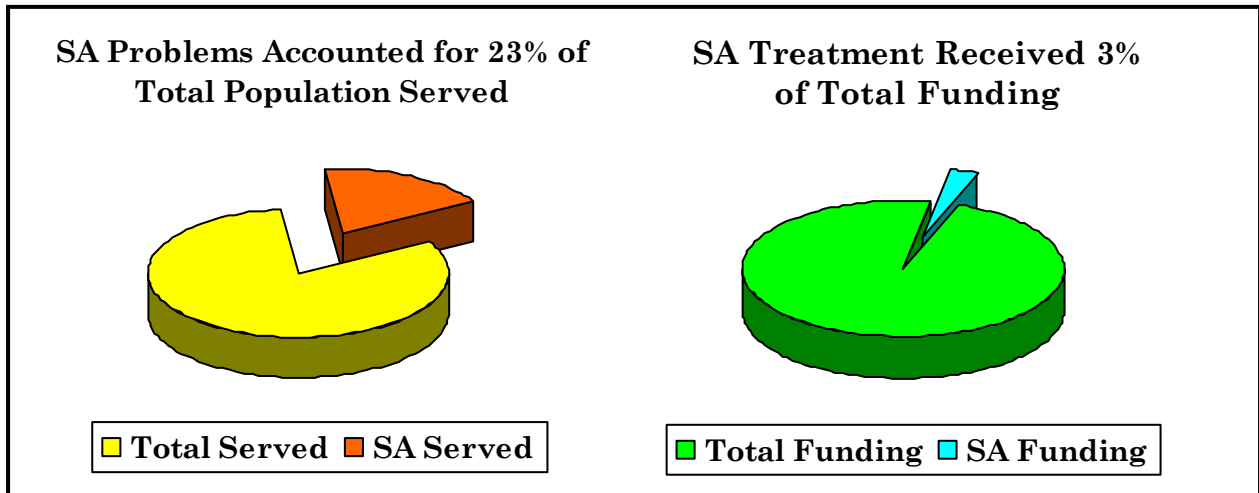
Currently substance abuse services in Durham County are significantly underfunded. The following table reflects the recent trend of declining State funding for substance abuse services:

IPRS Funding for Durham County Substance Abuse Services

FY 2004	FY 2005	FY 2006	FY 2007 (Preliminary)
\$2,544,741	\$2,210,752 (-13%)*	\$2,438,848 (-4%)*	\$2,233,833 (-12%)*

*relative to 2004 funding

The following chart reflects the disconnect between the portion of The Durham Center population presenting with substance abuse problems and the amount of total funding allocated for substance abuse treatment.



A budget has have been developed for the Plan that includes a variety of annual goals with accompanying fiscal requirements for FY07 and FY05. An example of these overarching goals includes:

- ❖ Educate and create an atmosphere of understanding and support within the community
- ❖ Continue to develop The Durham Center infrastructure needed to implement the Plan
- ❖ Persist in developing and managing the provider network to support the SOC philosophy of continuity of care and best practices
- ❖ Continue to review the existing service array and implement new programs required to expand and strengthen the SOC network.

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An Action Plan with identified consumer outcomes, performance indicators and costs has been developed to monitor the success in achieving goals and objectives and detailing the resources requested from Durham County for Fiscal Year 2007 and 2008. The Plan and accompanying cost analysis are contained separately as an insert to this presentation.

also note:

Glossary – **Attachment J**

List of References for Further Reading – **Attachment K**